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Rebecca McDowell Cook

Secretary of State

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June 15, 2000	**July 17, 2000**	July 31, 2000	August 30, 2000

Documents will be accepted for filing on all regular workdays from 8:00 a.m. until 5:00 p.m. We encourage early filings to facilitate the timely publication of the *Missouri Register*. Orders of Rulemaking appearing in the *Missouri Register* will be published in the *Code of State Regulations* and become effective as listed in the chart above. Advance notice of large volume filings will facilitate their timely publication. We reserve the right to change the schedule due to special circumstances. Please check the latest publication to verify that no changes have been made in this schedule.

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RULES—Cite material in the *Missouri Register* by volume and page number, for example, Vol. 24, *Missouri Register*, page 27. The approved short form of citation is 24 MoReg 27.

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

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

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

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

RSMo—Cite material in the RSMo by date of legislative action. The note in parentheses gives the original and amended legislative history. The Office of the Revisor of Statutes recognizes that this practice gives users a concise legislative history.

Rules appearing under this heading are filed under the authority granted by section 536.025, RSMo Supp. 1998. An emergency rule may be adopted by an agency if the agency finds that an immediate danger to the public health, safety or welfare, or a compelling governmental interest requires emergency action; follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances; follows procedures which comply with the protections extended by the *Missouri* and the *United States Constitutions*; limits the scope of such rule to the circumstances creating an emergency and requiring emergency procedure, and at the time of or prior to the adoption of such rule files with the secretary of state the text of the rule together with the specific facts, reasons and findings which support its conclusion that there is an immediate danger to the public health, safety or welfare which can be met only through the adoption of such rule and its reasons for concluding that the procedure employed is fair to all interested persons and parties under the circumstances.

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

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

Title 12—DEPARTMENT OF REVENUE
Division 10—Director of Revenue
Chapter 2—Income Tax

EMERGENCY AMENDMENT

12 CSR 10-2.015 Employers' Withholding of Tax. The director proposes to amend section (10), subsections (21)(B), (22)(A) and (B), and sections (23)(A), (27) and (30).

PURPOSE: The purpose of this amendment is to bring the Form MO W-3 due date in agreement with the Internal Revenue Service due date for Form W-3, change the threshold for monthly filers and bring the retention of undeliverable employee Form W-2s in agreement with the Internal Revenue Service.

EMERGENCY STATEMENT: The director of revenue is authorized by statute to administer withholding tax and establish filing frequency thresholds. This emergency amendment is necessary to ensure public awareness of administrative changes, which is beneficial and necessary to good tax compliance. This emergency amendment is necessary to preserve a compelling governmental interest requiring an early effective date, in that the amendment brings the Missouri Form MO W-3 due dates in agreement with the Internal Revenue Service (IRS) due dates for the Form MO W-3 and establishes filing frequency thresholds for monthly filers. The director finds that there is an immediate danger to the public welfare, which can only be addressed through this emergency amendment. The director has followed procedures calculated to assure fairness to all interested persons and parties and has complied with the protections extended by the ***Missouri*** *and* ***United States Constitutions****. The director has limited the scope of the emergency amendment to the circumstances creating the emergency. Emergency amendment filed November 30, 1999, effective December 10, 1999, expires June 6, 2000.*

(10) Resident of Missouri Employed in Another State. A Missouri resident paying income tax to another state because of employment in that state may file a Withholding Affidavit For Missouri Residents, Form MO W-4C**.** *[which provides for exclusion from withholding when fifty percent (50%) or more of the services are performed in a state other than Missouri. The original copy must be mailed to the Department of Revenue and the duplicate retained by the employer as the basis for not withholding from the employee's wages. When a Missouri resident is employed less than fifty percent (50%) in another state having a state income tax, only income received for services performed in Missouri or another state not having a state income tax is subject to Missouri withholding. In determining the amount of tax to be withheld, the employer should use only the balance of income not subject to withholding by another state.]* **If the employee does not complete Form MO W-4C, the employer may withhold Missouri taxes on all services performed, regardless of where performed. All income received for services performed in another state not having a state income tax is subject to Missouri withholding. If services are performed partly within and partly without the state, only wages paid for that portion of the services performed within Missouri are subject to Missouri withholding tax, provided that the services performed in the other state are subject to the other state's withholding provisions. If a service is partly within and partly without Missouri and only a portion of an employee's wages is subject to Missouri withholding tax, then the amount of Missouri tax required to be withheld is calculated using a percentage of the amount listed in the withholding tables. The calculation begins by determining the amount that would be withheld if all the wages were subject to Missouri withholding. This amount is then multiplied by a percent, which is determined by dividing the wages subject to Missouri withholding tax by the total federal wages.**

(21) Filing Frequency Requirements. Missouri withholding returns must be filed by the due date as long as an account is maintained with the Missouri Department of Revenue, even if there was no payroll for the reporting period. Returns must be filed each reporting period, even though there may not have been any tax withheld. There are four (4) filing frequencies: quarter-monthly, monthly, quarterly and annually (section 143.221 and 143.225, RSMo). A newly registered employer is initially assigned a filing frequency on the basis of his/her estimation of future withholdings. If the assigned filing frequency differs from the filing requirements established by statute, it is the employer's responsibility to immediately notify the Department of Revenue. The time for filing shall be as follows:

(B) Monthly. Employers required to withhold *[two]* **five** hundred *[fifty]* dollars *[($250)]* **($500)** per month for at least two (2) months during the preceding twelve (12) months shall file on a monthly basis;

(22) Reporting Requirement. Every employer withholding Missouri income tax from employee's wages is required by statute to report and remit the tax to the state of Missouri on the Missouri

Form MO-941. See regulation 12 CSR 10-2.016 for information on filing a Form MO-941P to remit required payments on Quarter-Monthly accounts.

(A) A separate reporting form must be filed for each reporting period. A personalized booklet of reporting forms detailing the employer's name, address, employer identification number, filing frequency and due date is provided to each active account. The voucher booklet supplied to an employer required to pay on a quarter-monthly basis also includes payment vouchers Form MO-941P, for the four (4) quarter-monthly periods. If an employer misplaces, damages or does not receive the necessary reporting forms, replacement forms should be requested, allowing sufficient time to file a timely return. If a blank form is used, the employer's name, address and identification number must appear as filed on previous returns and the period for which the remittance is made must be indicated. Failure to receive reporting forms does not relieve the employer of responsibility to report and remit tax withheld. If an employer temporarily ceases to pay wages a return must be filed for each period indicating that no tax was withheld. Failure to do so will result in the issuance of *[estimated billing]* **non-filer** notices.

(B) On or before *[January 31]* **February 28**, or with the final return filed at an earlier date, each employer must file a Form MO W-3 **(Transmittal of Wage and Tax Statements)** and copies of all withholding tax statements, Form W-2/**1099R**, copy 1, for the year. **Do not include the fourth quarter or 12th month return with the Form W-2(s)/1099R(s) and Form MO W-3. The last annual remittance must be sent separately with Form MO-941**. Large numbers of forms may be forwarded to the Department of Revenue in packages of convenient size. Each package must be identified with the name and account number of the employer and the packages must be consecutively numbered. Any employee's copies of the Withholding Statement (Form W-2/**1099R**) which cannot be delivered to the employee after reasonable effort is exerted, *[should be transmitted to the Missouri Department of Revenue by July 31 of the next calendar year]* **must be kept by the employer for at least four (4) years**. *[Any branch establishments of the employer may send any undeliverable employee's copies directly to the Department of Revenue.]* The Department of Revenue will accept computer produced magnetic tape records instead of the paper Form W-2/**1099R.** The employer must meet tape data specifications which are established by the Department of Revenue. **The Department follows specifications outlined in Social Security Administration Publication 42-007. Employers must also include the Supplemental record (Code S or Code 1 S).**

(23) Time and Place for Filing Returns and Remitting Tax.

(A) All returns and remittances must be filed with the Department of Revenue at the specific address indicated on the *[voucher]* **form**. The dates on which the returns and payments are due are as follows:

1. Quarter-Monthly (see 12 CSR 10-2.016). The quarter-monthly periods are: the first seven (7) days of a calendar month; the eighth to the fifteenth day of a calendar month; the sixteenth to the twenty-second day of a calendar month; and the twenty-third day through the last day of a calendar month. Payments must be mailed within three (3) banking days after the end of the quarter-monthly period or received by the Department of Revenue or its designated depository within four (4) banking days after the end of the quarter-monthly period. A monthly return (MO-941) reconciling the quarter-monthly payments and detailing any underpayment of tax is due by the fifteenth day of the following month except for the third month of a quarter in which case the MO-941 is due the last day of the succeeding month;

2. Monthly. Return and payment must be made by the fifteenth day of the following month except for the third month of a quarter in which case the return is due the last day of the succeeding month;

3. Quarterly. Return and payment must be made on or before the last day of the month following the close of the calendar quarter; and

4. Annually. Return and payment must be made on or before January 31 of the succeeding year.

(27) Failure to Pay Taxes Withheld—Special Deposits. Any employer who fails to remit income tax withheld, or to file tax returns as required, may be required to deposit the taxes in a special trust account for Missouri (see *[sub]*section 32.052, RSMo). Penalties are provided for failure to make payment. If the director of revenue finds that the collection of taxes required to be deducted and withheld by an employer may be jeopardized by delay, s/he may require the employer to remit the tax or make a return at any time. A lien outstanding with regard to any tax administered by the director shall be a sufficient basis for this action (see *[sub]*section 143.221.4, RSMo). In addition, any officer, director, statutory trustee or employee of any corporation who has direct control, supervision or responsibility for filing returns and making payments of the tax, who fails to file and make payment, may be personally assessed the tax, including interest, additions to tax and penalties pursuant to *[sub]*section 143.241.2, RSMo.

(30) Penalties, Interest and Additions to Tax.

(B) An employer's failure to file a timely return, unless due to reasonable cause and not due to willful neglect, will result in additions to tax of five percent (5%) per month or a fraction of a month not to exceed twenty-five percent (25%) pursuant to *[subdivision 143.741(1)]* **section 143.741.1**, RSMo.

(C) A deficiency is subject to an addition to tax of five percent (5%) if the delinquency is due to negligence or disregard of rules, or fifty percent (50%) if the deficiency is due to fraud pursuant to *[subdivision 143.751(1) and (2)]* **section 143.751.1 and .2**, RSMo.

(D) Failure to timely pay tax requires a five percent (5%) addition to tax pursuant to *[subdivision 143.751(3)]* **section 143.751.3**, RSMo.

(E) A quarter-monthly penalty of five percent (5%*[0]*) in lieu of all other penalties, interest or additions to tax will be imposed on a quarter-monthly period underpayment pursuant to section 143.225.**6**, RSMo.

(F) A person who willfully fails to collect, account for or pay withholding taxes is subject to a penalty equal to the amount not paid to the state, pursuant to section 143.751*[(4)]***.4**, RSMo. In addition, any officer, director, statutory trustee or employee of any corporation who has direct control, supervision or responsibility for filing returns and making payments of the tax, who fails to file and make payment, may be personally assessed the tax, including interest, additions to tax and penalties pursuant to *[subsection]* **section** 143.241.1, RSMo.

(G) *[Criminal penalties]* **Penalties for criminal offenses** are also provided *[in]* **throughout** sections 143.911–143.951, RSMo.

(I) Failure to file a timely Wage and Tax Statement, W-2, is subject to a penalty of two dollars ($2) per statement not to exceed one thousand dollars ($1,000) unless the failure is due to reasonable cause and not willful neglect pursuant to *[subdivision 143.741(2)]* **section 143.741.2**, RSMo.

AUTHORITY: section 143.961, RSMo 1994. This rule was previously filed as "Missouri Employer's Tax Guide" Feb. 20, 1973, effective March 2, 1973. Original rule filed Jan. 29, 1974, effective Feb. 8, 1974. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Nov. 30, 1999, effective Dec. 10, 1999, expires June 6, 2000. A proposed amend-*

*ment covering this same material is published in this issue of the **Missouri Register**.*

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

EMERGENCY AMENDMENT

22 CSR 10-2.010 Definitions. The board is amending section (1).

PURPOSE: The amendment includes changes in the definitions made by the board of trustees regarding the key terms within the Missouri Consolidated Health Care Plan.

*EMERGENCY STATEMENT: This rule has a variety of changes from the current regulation. It must be in place by January 1, 2000, in accordance with the renewal of our current contracts. Therefore, this rule is necessary to protect members (employees, retirees and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies responsibility for eligible charges, beginning with the first day of coverage for the new plan year. It also provides further direction for appeals related to the operation of the plan. Many of these changes are required by either federal or state law. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be registered immediately in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 1, 2000, in order that an immediate danger is not imposed on the public welfare. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. This emergency amendment complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. This emergency amendment is calculated to assure fairness to all interested persons and parties under the circumstances. Emergency amendment filed December 6, 1999, becomes effective January 1, 2000, and expires on June 28, 2000.*

(1) When used in this plan document, these words and phrases have the meaning—

(HH) Plan document—This statement of the terms and conditions of the plan *[revised and effective January 1, 1995,]* as adopted by the plan administrator;

(MM) Prior plan—The terms and conditions of a plan in effect for *[a]* **the** period preceding *[January 1, 1995]* **coverage in the MCHCP**;

(PP) Review agency—A company responsible for administration of *[the four (4) components of the Health Check program under the direction of the claims administrator]* **clinical management programs**;

*AUTHORITY: section 103.059, RSMo 1994. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed Dec. 6, 1999, effective Jan. 1, 2000, expires June 28, 2000. A proposed rule covering this same material is published in this issue of the **Missouri Register**.*

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

EMERGENCY AMENDMENT

22 CSR 10-2.020 Membership Agreement and Participation Period. The board is amending sections (1), (3) and (4).

PURPOSE: The amendment includes changes and additions made by the board of trustees regarding the employee's membership agreement and membership period for participation in the Missouri Consolidated Health Care Plan.

*EMERGENCY STATEMENT: This rule has a variety of changes from the current regulation. It must be in place by January 1, 2000, in accordance with the renewal of our current contracts. Therefore, this rule is necessary to protect members (employees, retirees and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies responsibility for eligible charges, beginning with the first day of coverage for the new plan year. It also provides further direction for appeals related to the operation of the plan. Many of these changes are required by either federal or state law. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be registered immediately in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 1, 2000, in order that an immediate danger is not imposed on the public welfare. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. This emergency amendment complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. This emergency amendment is calculated to assure fairness to all interested persons and parties under the circumstances. Emergency amendment filed December 6, 1999, becomes effective January 1, 2000, and expires on June 28, 2000.*

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

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

1. For groups of less than 500 employees, the MCHCP will be the only health care offering made to its eligible members. For groups of 500 or more employees the entity may maintain a self-insured indemnity plan or one point-of-service (POS) option (either self-insured or on a fully-insured directly contracted basis), but may not offer a competing plan of the same type through the MCHCP **(also see number (1)(A)8.)**

2. It will contribute at least twenty-five dollars ($25) per month toward each active employee's premium;

3. Individual and family deductibles, if appropriate, will be applied. Deductibles previously paid to meet the requirements of the terminating plan may be credited for those joining one of the indemnity options. Appropriate proof of said deductibles will be required;

4. Eligible members joining the MCHCP who were covered by any medical plan offered by the public entity or an individual policy will not be subject to any pre-existing condition;

5. Eligible members joining the MCHCP at the time of the initial eligibility of the public entity will not have to prove insurability;

6. For groups contracting only with the MCHCP, at least seventy-five percent (75%) of all eligible employees must join the MCHCP. For groups of 500 employees or more that choose one of the alternative options identified in paragraph (1)(A)1., the entity must maintain seventy-five percent (75%) coverage of all their employees covered through all of their offerings;

7. An eligible employee is one that is not covered by another group sponsored plan;

8. *[Public entities joining the plan will be able to select whatever plans they wish from those available through the MCHCP to be offered to their eligible members]* **Public entities joining the MCHCP must allow their eligible subscribers the option of choosing the managed health care plans that are available through the MCHCP that are licensed in a county in which the subscriber either lives or works**;

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

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

(3) The participation period shall begin on the participant's effective date in the plan. Participation shall continue until this plan or coverage in this rule is terminated for any reason. However, transfer from the prior plan to this plan will be automatic upon the effective date of this plan *[, except that any participant confined to a hospital on the effective date of this plan shall be continued under the prior plan until discharged from the hospital]*.

(4) The effective date of participation shall be determined, subject to the effective date provision in subsection (4)(C), as follows:

(B) Dependent Coverage. Dependent participation cannot precede the employee's participation. Application for participants must be made in accordance with the following provisions. For family coverage, once an employee is participating with respect to dependents, newly acquired dependents are automatically covered on their effective dates as long as the plan administrator is notified within thirty-one (31) days of the person becoming a dependent. The employee is required to notify the plan administrator on the appropriate form of the dependent's name, date of birth, eligibility date and Social Security number, if available. Claims will not be processed until the required information is provided—

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

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

3. Unless required under federal guidelines—

A. An emancipated dependent who regains his/her dependent status is not eligible for coverage until the next open enrollment period; and

B. An eligible dependent that is covered under a spouse's health plan who loses eligibility under the criteria stipulated for dependent status under the spouse's health plan is not eligible for coverage until the next open enrollment period**. (Note: Subparagraphs (4)(B)3.A. and B. do not include dependents of retirees or long-term disability members covered under the plan.)**;

(C) Effective Date *Proviso*.

1. In any instance when the employee is not actively working full-time on the date participation would otherwise have become effective, participation shall not become effective until the date the employee returns to full-time active work. However, this provision shall not apply for public entities (or any individual who is a member of that public entity) when the MCHCP is replacing coverage for that public entity.

[2. If any dependent, other than a newborn child, is confined in a hospital on the date participation with respect to dependent coverage would otherwise become effective, participation shall become effective on the day after the date of discharge from the hospital; and]

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

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

*AUTHORITY: section 103.059, RSMo 1994. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed Dec. 6, 1999, effective Jan. 1, 2000, expires June 28, 2000. A proposed amendment covering this same material is published in this issue of the **Missouri Register**.*

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

EMERGENCY AMENDMENT

22 CSR 10-2.040 Indemnity Plan Summary of Medical Benefits. The board is amending sections (1), (3), (4), (7) and (9).

PURPOSE: The amendment includes changes made by the board of trustees regarding medical benefits for participants in the Missouri Consolidated Health Care Plan.

EMERGENCY STATEMENT: This rule has a variety of changes from the current regulation. It must be in place by January 1, 2000, in accordance with the renewal of our current contracts. Therefore, this rule is necessary to protect members (employees, retirees and their families) enrolled in the Missouri Consolidated

Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies responsibility for eligible charges, beginning with the first day of coverage for the new plan year. It also provides further direction for appeals related to the operation of the plan. Many of these changes are required by either federal or state law. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be registered immediately in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 1, 2000, in order that an immediate danger is not imposed on the public welfare. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. This emergency amendment complies with the protections extended by the ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. This emergency amendment is calculated to assure fairness to all interested persons and parties under the circumstances. Emergency amendment filed December 6, 1999, becomes effective January 1, 2000, and expires on June 28, 2000.*

(1) Lifetime maximum, *[one (1)]* **three (3)** million dollars.

(3) Deductible Amount—Per individual for the indemnity plan *[and the limited indemnity plan]* each calendar year, three hundred dollars ($300), family limit each calendar year, nine hundred dollars ($900).

(4) *[Copayment]* **Coinsurance**.

(C) *[Limited Indemnity Plan]* **Non-Network Services**—Same as subsections (4)(A) and (B), except covered charges are reimbursed on a seventy percent (70%) basis.

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

(9) Prescription Drug Program—The indemnity plan provides *[a carve-out program for prescription drugs. The program consists of]* coverage for maintenance and nonmaintenance medications, as described in the following:

[(A) Nonmaintenance Medications—For those prescription drugs needed for short-term use only, the member will be responsible for twenty percent (20%) of a discounted rate after satisfaction of the twenty-five dollar ($25) individual deductible (seventy-five dollars ($75) maximum family deductible).

1. The prescription must be written for less than a thirty (30)-day supply.

2. If the member chooses a brand name medication when there is a generic available, s/he will be responsible for twenty percent (20%) of the generic medication's cost (after satisfaction of the deductible), as well as the difference between the cost of the brand name medication and the generic medication. This difference does not apply to the out-of-pocket maximum. This provision does not apply if the doctor has indicated on the prescription that the brand name is necessary.

(B) Maintenance Medications—For those medications listed on the maintenance medication list, as determined by the claims administrator, the member will be responsible for a fifteen-dollar ($15) copayment for each brand name medication and a five-dollar ($5) copayment for each generic medication.

1. The prescription must be written for a thirty to ninety (30–90) day supply.

2. Maintenance medications may be purchased from either a participating local pharmacy or the mail order facility.

3. Unless an exception is approved by the drug/claims administrator for a medically necessary reason, oral contraceptives must be obtained from an approved formulary list.

(C) Out-of-Pocket Maximum—There is a maximum out-of-pocket (including deductibles) of four hundred dollars ($400) per individual, with a maximum family out-of-pocket of twelve hundred dollars ($1,200). The out-of-pocket maximum applies to both maintenance and nonmaintenance medications. Once a member has reached the four hundred dollar ($400)-maximum his/her covered drugs will be covered at 100% for the remainder of the calendar year.]

(A) Non-Maintenance Medications—

1. *In-Network*

A. $5 Copay for 30-day supply for generic drug on the formulary

B. $10 Copay for 30-day supply for brand drug on the formulary

C. $15 Copay for 30-day supply for non-formulary drug

2. *Non-Network*—The deductible will apply. After satisfaction of the deductible, claims will be paid at 50% coinsurance. Charges will not be applied to the out-of-pocket maximum.

(B) Maintenance Medications—Prescriptions may be filled through a mail order program for up to a 90-day supply for twice the regular copayment for a drug on the maintenance list.

[(D)] **(C)** Nonparticipating Pharmacies—If a member chooses to use a nonparticipating pharmacy, s/he will be required to pay the full cost of the prescription, then file a claim with the prescription drug administrator. S/he will be reimbursed the amount that would have been allowed at a participating pharmacy, less any applicable deductibles or coinsurance. Any difference between the amount paid by the member at a nonparticipating pharmacy and the amount that would have been allowed at a participating pharmacy will not be applied to the out-of-pocket maximum.

AUTHORITY: section 103.059, RSMo 1994. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Dec. 6, 1999, effective Jan. 1, 2000, expires June 28, 2000. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

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

EMERGENCY AMENDMENT

22 CSR 10-2.050 Indemnity Plan Benefit Provisions and Covered Charges. The board is amending subsection (2)(C).

PURPOSE: The amendment includes changes made by the board of trustees regarding benefit provisions and covered charges in the Missouri Consolidated Health Care Plan.

EMERGENCY STATEMENT: This rule has a variety of changes from the current regulation. It must be in place by January 1, 2000, in accordance with the renewal of our current contracts. Therefore, this rule is necessary to protect members (employees, retirees and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies responsibility for eligible charges, beginning with the first day of coverage for the new plan year. It also provides further direction for appeals related to the operation of the plan. Many of these changes are required by either federal or state law. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be registered immediately in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 1, 2000, in order that an immediate danger is not imposed on the public welfare. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. This emergency amendment complies with the protections extended by the ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. This emergency amendment is calculated to assure fairness to all interested persons and parties under the circumstances. Emergency amendment filed December 6, 1999, becomes effective January 1, 2000, and expires on June 28, 2000.*

(2) Covered Charges.

(C) Covered charges are divided into mutually exclusive types and each covered charge shall be deemed to be covered on the date the medical benefit, service or supply is received.

1. Type A charges for hospital daily room and board and routine nursing. The maximum covered charge for a private room is the hospital's most common semiprivate room rate unless a private room is recommended by a physician and approved by the claims administrator or the plan's medical review agency.

2. Type B charges for intensive care, concentrated care, coronary care or other special hospital unit designed to provide special care for critically ill or injured patients.

3. Type C charges for preadmission testing (X-ray and laboratory tests) which are conducted and which are necessary for hospital admission and which are not duplicated for screening purposes upon admission to the hospital.

4. Type D special hospital charges for inpatient medical care and supplies received during any period room and board charges are made except—

A. Those included in paragraphs (2)(C)1.–3.; and

B. Special nursing care.

5. Type E charges for outpatient medical care or supplies.

6. Type F surgery and anesthesia charges of a provider for the giving of anesthesia not included in paragraphs (2)(C)4. and 5.

7. Type G psychiatric service charges of a provider licensed to provide services which relate to care of mental conditions.

8. Type H professional service charges not included in paragraphs (2)(C)2.–7. made by a provider or by a laboratory for diagnostic laboratory and X-ray exams.

9. Type I nursing services of a registered nurse (RN), licensed practical nurse (LPN) or licensed vocational nurse (LVN) on his/her own behalf.

10. Type J professional service charges of a licensed physical therapist, occupational therapist, audiologist or respiratory therapist, subject to medical necessity review by claims administrator.

11. Type K transportation charges not included in paragraphs (2)(C)3. and 4. for professional air or ground ambulance services for local transportation to and from a hospital, from a hospital to and from a local facility which provides specialized testing or treatment or from a hospital to a skilled nursing facility; and charges for travel within the United States by a scheduled railroad, airline or ambulatory carrier to, but not back from, the nearest hospital equipped to furnish needed special treatment.

12. Type L charges for orthopedic or prosthetic devices and hospital-type equipment not included in paragraphs (2)(C)4. and 5. for—

A. Man-made limbs or eyes for the replacing of natural limbs or eyes;

B. Casts, splints or crutches;

C. Purchase of a truss or brace as a direct result of—

(I) An injury or sickness which began while covered under these rules; or

(II) A disabling condition existing since birth;

D. Oxygen and rental of equipment for giving oxygen; rental of wheelchair **or scooter (manual or powered)** or hospital equipment to aid in breathing;

E. Dialysis equipment rental, supplies, upkeep and the training of the participant or an attendant to run the equipment; *[and]*

F. Colostomy bags and ureterostomy bags*[.]***;**

G. Bilateral hearing aids; and

H. Augmentative communication devices.

13. Type M charges for prescription drugs from a licensed pharmacist**;** or for anesthesia when given by a provider if not included in paragraphs (2)(C)3.–6.

14. Type N charges for skilled nursing care including room and board when the stay is medically necessary, as determined by the claims administrator.

15. Type O charges for the services of a licensed speech therapist if the charges are made for speech therapy used for the purpose of correcting speech loss or damage which—

A. Is due to a sickness or injury, other than a functional nervous disorder or surgery due to such sickness or injury; or

B. Follows surgery to correct a birth defect.

16. Type P charges for services and supplies from a home health care agency which are medically necessary, as determined by the claims administrator.

17. Type Q charges for outpatient treatment of mental and nervous conditions.

18. Type R charges for outpatient treatment of alcohol and drug abuse.

19. Type S charges for hospice services.

20. Type T charges for education and training if it will promote the patient to a lower level of medical/nursing care.

21. Type U charges for surgical and medical procedures performed by a podiatrist.

22. Type V charges for transplants.

23. Type W charges for services rendered by a physician or other provider.

24. Type Y charges for normally covered services arising from a non-covered service.

AUTHORITY: section 103.059, RSMo Supp. 1994. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Dec. 6, 1999, effective Jan. 1, 2000, expires June 28, 2000. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

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

EMERGENCY AMENDMENT

22 CSR 10-2.060 Indemnity Plan Limitations. The board is amending section (1).

PURPOSE: The amendment includes changes made by the board of trustees regarding limitations for participants in the Missouri Consolidated Health Care Plan Indemnity Plan.

EMERGENCY STATEMENT: This rule has a variety of changes from the current regulation. It must be in place by January 1, 2000, in accordance with the renewal of our current contracts. Therefore, this rule is necessary to protect members (employees, retirees and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies responsibility for eligible charges, beginning with the first day of coverage for the new plan year. It also provides further direction for appeals related to the operation of the plan. Many of these changes are required by either federal or state law. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be registered immediately in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 1, 2000, in order that an immediate danger is not imposed on the public welfare. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. This emergency amendment complies with the protections extended by the ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. This emergency amendment is calculated to assure fairness to all interested persons and parties under the circumstances. Emergency amendment filed December 6, 1999, becomes effective January 1, 2000, and expires on June 28, 2000.*

(1) Benefits shall not be payable for, or in connection with, any medical benefits, services or supplies which do not come within the definition of covered charges, or any of the following:

(C) Cosmetic, plastic, reconstructive or restorative surgery performed for the purpose of improving appearance unless such expenses are incurred for repair of a disfigurement caused from any of the following:

1. An accidental injury which was sustained while covered under these rules;
2. A sickness first manifested while covered under these rules;
3. Any other accidental injury or sickness but only for expenses incurred after this coverage has been in force for at least *[twelve (12)]* **six (6)** months; or
4. A birth defect;

(D) Hearing aids **once every two years** and the fitting, eye refractions and glasses, contact lenses or their fitting of eye glasses or contact lenses (other than the first pair of contact lenses or eye glasses or the fitting after cataract surgery which is performed while covered under these rules);

(H) *[To the extent provided by law, intentionally self-inflicted injury or illness, or i]***I**njury or sickness resulting from taking part in the commission of a felony;

(M) Except as may otherwise be specifically provided, expenses for equipment, services or supplies for any of the following, regardless of whether or not prescribed by a physician or provider:

1. Experimental/investigational procedures, as defined in the claims administrator's guidelines;
2. Exercise for the eyes;
3. Psychological testing;
4. Nerve stimulators with the exception of TENS units;
5. Any treatment of obesity due solely to overeating;
6. Custodial care;
7. *[In vitro and i]In vivo* artificial insemination **including gamete intrafallopian transfer/zygote intrafallopian transfer (GIFT/ZIFT)**;
8. Travel **(see EE)**, lodging **(see EE)**, recreation or exercise;
9. Air conditioners, purifiers or humidifiers;
10. Nonprescription drug items (except insulin and other diabetic supplies); and
11. Acupuncture, acupressure, and biofeedback;

(R) *[Alcohol]* **Outpatient alcohol** and drug abuse treatments are limited to**:** *[two (2) inpatient treatments per lifetime, the copayment does not apply to the out-of-pocket maximum and there is a lifetime maximum of fifty thousand dollars ($50,000).*

1. Network provider—up to thirty (30) days per calendar year paid at ninety percent (90%). In addition to three hundred dollar ($300)-medical deductible, there is also a one hundred dollar ($100) per day deductible for up to five (5) days.

2. Non-network provider—up to thirty (30) days per calendar year paid at seventy percent (70%). In addition to three hundred dollar ($300)-medical deductible, there is also a one hundred fifty dollar ($150) deductible for up to five (5) days;]

1. Network provider
A. First five (5) visits paid with a $10 co-payment.
B. Visit six (6) through ten (10) with a $15 co-payment.
C. Additional visits paid with a $20 co-payment.
2. Non-network provider
A. Subject to deductible and 50% co-insurance;

[(S) Inpatient mental illness services are limited to thirty (30) days per year, and the copayment does not apply to the out-of-pocket maximum.

1. Network provider—paid at ninety (90%) percent.
2. Nonnetwork provider—paid at seventy percent (70%).
3. Partial day treatment—included acute day treatment and partial hospitalization. Treated as one-half (1/2) inpatient day toward thirty (30)-day maximum.
A. Network provider—paid at ninety percent (90%).
B. Nonnetwork provider—paid at seventy percent (70%);]

[(T)] **(S)** Outpatient mental illness services are limited to**:** *[fifty (50) visits per year. The copayment does not apply to the out-of-pocket maximum.]*

1. Network provider.
A. First five (5) visits paid *[at ninety percent (90%).]* **with a $10 co-payment.**
B. Visit six (6) through *[twenty (20) paid at seventy percent (70%).]* **ten (10) with a $15 co-payment.**
C. *[Visit twenty-one through fifty (21–50) paid at fifty (50) percent.]* **Additional visits paid with a $20 co-payment.**
2. Non-network provider
A. *[First five (5) visits paid at seventy percent (70%).*
B. Visit six through twenty (6–20) paid at fifty percent (50%).
C. Visit twenty-one through fifty (21–50) paid at fifty percent (50%).] **Subject to deductible and 50% co-insurance;**
[3. Intensive outpatient services

A. Network provider paid at ninety percent (90%).

B. Non-network provider paid at seventy percent (70%);]

[(U)] **(T)** Marital and family counseling for group or individual psychotherapy;

[(V)] **(U)** Chiropractic services are limited to a maximum allowable charge of fifty dollars ($50) per visit, and a two thousand dollar ($2,000) total annual maximum; Diagnostic lab and X-ray services are not included in fifty dollar ($50) maximum per visit, but are included in two thousand-dollar ($2,000) total annual maximum;

[(W)] **(V)** Associated charges for noncovered services;

[(X)] **(W)** Any services not specifically included as a covered benefit;

[(Y)] **(X)** Vitamins and nutrient supplements, except prescription prenatal vitamins, vitamin B_{12} shots, and certain vitamin therapies as determined by the claims administrator;

[(Z)] **(Y)** Treatment of temporal mandibular joint dysfunction (TMJ) will be covered under the plan up to maximum reimbursement of five hundred dollars ($500) per lifetime;

[(AA)] **(Z)** Reversals of tubal ligations and vasectomies;

[(BB) Cardiac rehabilitation treatments are limited to thirty-six (36) visits per calendar year;]

[(CC)] **(AA)** X-ray and office charges associated with flat feet;

[(DD)] **(BB)** Preferred Provider Organization (PPO) office visit copayments;

[(EE)] **(CC)** Transplants are limited to heart, lung, liver, kidney, cornea**,** *[and]* bone marrow, **pancreas and intestinal,** and are subject to medical necessity and effectiveness criteria and payment levels as determined by the claims administrator's guidelines *[. Benefits are limited to one hundred fifty thousand dollars ($150,000) for services associated with the admission of the actual organ transplant with remainder of transplant cost applied to one (1) million dollar lifetime maximum.]***;**

Benefits are allowed in accordance with the following schedule:

Benefit Description	**The First Health National Transplant Program**	**First Health Network (PPO) Hospital**	**Non-PPO Hospital**	**Additional Limitations and Explanations**
Plan Pays	**100%**	**90% of NTP fees**	**70%* of NTP fees**	**Travel, lodging and meals allowance is for the transplant recipient and his or her immediate family travel companion (under age 19, both parents). The plan's co-payment will be reduced by 10% when not using The First Health National Transplant Program if you do not follow the procedures required by the clinical management services program. This penalty and your non-PPO coinsurance do not apply to the out-of-pocket maximum.**
Annual Deductible	**NO**	**YES**	**YES**	
Organ Donor Costs Per Transplant	**Unlimited**	**$10,000**	**$10,000**	
Travel, Lodging And Meals Allowance Per Transplant	**$10,000**	**None**	**None**	
Lifetime benefit Maximum	**Subject To Plan Maximum**	**Subject To Plan Maximum**	**Subject To Plan Maximum**	

[(FF)] **(DD)** Skilled nursing charges limited to one hundred twenty (120) days per calendar year*[.]***;**

(EE) In vivo artificial insemination subject to deductible and 50% co-insurance, which does not apply to the out-of-pocket maximum. Not covered out-of-network;

(FF) Eye refractions limited to one annually and only if provided in the network; and

(GG) Treatment of nearsightedness, farsightedness and astigmatism.

AUTHORITY: section 103.059, RSMo 1994. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Dec. 6, 1999, effective Jan. 1, 2000, expires June 28, 2000. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

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

EMERGENCY AMENDMENT

22 CSR 10-2.063 HMO/POS/POS98 Summary of Medical Benefits. The Board is amending subsection (1)(Z).

PURPOSE: The amendment includes changes made by the board of trustees regarding the medical benefits of the HMO/POS and POS98 plans in the Missouri Consolidated Health Care Plan Indemnity Plan.

EMERGENCY STATEMENT: This rule has a variety of changes from the current regulation. It must be in place by January 1, 2000, in accordance with the renewal of our current contracts. Therefore, this rule is necessary to protect members (employees, retirees and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies responsibility for eligible charges, beginning with the first day of coverage for the new plan year. It also provides further direction for appeals related to the operation of the plan. Many of these changes are required by either federal or state law. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be registered immediately in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 1, 2000, in order that an immediate danger is not imposed on the public welfare. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. This emergency amendment complies with the protections extended by the ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. This emergency amendment is*

calculated to assure fairness to all interested persons and parties under the circumstances. Emergency amendment filed December 6, 1999, becomes effective January 1, 2000, and expires on June 28, 2000.

(1) Covered Charges.

(Z) Prescription Drugs—*[Maximum thirty (30)-day supply, five dollar ($5) copayment.]* Insulin, syringes, test strips and glucometers are included in this coverage. *[Additional restrictions may apply for use of nonformulary medication with HMO/POS. POS98 lessor of twenty dollar ($20) copayment or cost of drug for nonformulary drug.]* **There is no out-of-pocket maximum. Member is responsible only for the lessor of the applicable co-payment or the cost of the drug.**

$5 Copay for 30-day supply for generic drug on the formulary
$10 Copay for 30-day supply for brand drug on the formulary
$15 Copay for 30-day supply for non-formulary drug

AUTHORITY: section 103.059, RSMo 1994. Emergency rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 13, 1995, effective May 1, 1995, expired Aug. 28, 1995. Original rule filed Dec. 21, 1994, effective June 30, 1995. For intervening history, please consult the ***Code of State Regulations.*** *Emergency amendment filed Dec. 6, 1999, effective Jan. 1, 2000, expires June 28, 2000. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

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

EMERGENCY AMENDMENT

22 CSR 10-2.075 Review and Appeals procedure. The board is amending subsection (5)(D).

PURPOSE: This amendment includes changes made by the board of trustees regarding the review and appeals procedure for participants in the Missouri Consolidated Health Care Plan.

EMERGENCY STATEMENT: This rule has a variety of changes from the current regulation. It must be in place by January 1, 2000, in accordance with the renewal of our current contracts. Therefore, this rule is necessary to protect members (employees, retirees and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies responsibility for eligible charges, beginning with the first day of coverage for the new plan year. It also provides further direction for appeals related to the operation of the plan. Many of these changes are required by either federal or state law. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be registered immediately in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 1, 2000, in order that an immediate danger is not imposed on the public welfare. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. This emergency amendment complies with the protections extended by the ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. This emergency amendment is calculated to assure fairness to all interested persons and parties under the circumstances. Emergency amendment filed December 6, 1999, becomes effective January 1, 2000, and expires on June 28, 2000.*

(5) All insured members of the Missouri Consolidated Health Care Plan (MCHCP) shall use the claims and administration procedures established by the HMO, POS or Indemnity health plan contract applicable to the insured member. Only after these procedures have been exhausted may the insured appeal to the MCHCP board of trustees to review the decision of the health plan contractor.

(D) Administrative decisions made solely by MCHCP may be appealed directly to the board of trustees, by either an insured member or health plan contractor.

1. All the provisions of this rule, where applicable, shall apply to these appeals.

2. The parties to such appeal shall be the appellant and the MCHCP shall be respondent.

3. The appellant, if aggrieved by the final decision of the board, shall have the right of appeal as stated in subsection (5)(C) herein.

4. In reviewing these appeals, the board and/or staff may consider:

• Newborns—

Notwithstanding any other rule, if a member currently has children coverage under the plan, he/she may enroll his/her newborn retroactively to the date of birth if the request is made within six months of the child's date of birth. If a member does not currently have children coverage under the plan but states that the required information was provided within the 31-day enrollment period, he/she must sign an affidavit stating that their information was provided within the required time period. The affidavit must be notarized and received in the MCHCP office within 31 days after the date of notification from the MCHCP.

Once the MCHCP receives the signed affidavit from the member, coverage for the newborn will be backdated to the date of birth, if the request was made within six months of the child's date of birth. The approval notification will include language that the MCHCP has no contractual authority to require the contractors to pay for claims that are denied due to the retroactive effective date. If an enrollment request is made under either of these two scenarios past six months following a child's date of birth, the information will be forwarded to the MCHCP Board for a decision.

• Credible Evidence—Notwithstanding any other rule, the MCHCP may grant an appeal and not hold the member responsible when there is credible evidence that there has been an error or miscommunication, either through the member's payroll/personnel office or the MCHCP, that was no fault of the member.

• Change of Plans Due to Dependent Change of Address—A member may change plans outside the open enrollment period if his/her covered dependents move out of state and their current plan cannot provide coverage.

AUTHORITY: section 103.059, RSMo 1994. Emergency rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 13, 1995, effective May 1, 1995, expired Aug. 28, 1995. Original rule filed Dec. 21, 1994, effective June 30, 1995. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Dec. 6, 1999, effective Jan. 1, 2000, expires June 28, 2000. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*