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## Matt Blunt

## Secretary of State

# MISSOURI REGISTER

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# MISSOURI REGISTER

February 3, 2003 Vol. 28 No. 3 **Pages 219–280**

# IN THIS ISSUE:



| Register Filing Deadlines | Register Publication Date | Code Publication Date | Code Effective Date |
|---|---|---|---|
| December 2, 2002 | **January 2, 2003** | January 29, 2003 | February 28, 2003 |
| December 16, 2002 | **January 16, 2003** | January 29, 2003 | February 28, 2003 |
| January 2, 2003 | **February 3, 2003** | February 28, 2003 | March 30, 2003 |
| January 16, 2003 | **February 18, 2003** | February 28, 2003 | March 30, 2003 |
| February 3, 2003 | **March 3, 2003** | March 31, 2003 | April 30, 2003 |
| February 18, 2003 | **March 17, 2003** | March 31, 2003 | April 30, 2003 |
| March 3, 2003 | **April 1, 2003** | April 30, 2003 | May 30, 2003 |
| March 17, 2003 | **April 15, 2003** | April 30, 2003 | May 30, 2003 |
| April 1, 2003 | **May 1, 2003** | May 31, 2003 | June 30, 2003 |
| April 15, 2003 | **May 15, 2003** | May 31, 2003 | June 30, 2003 |
| May 1, 2003 | **June 2, 2003** | June 30, 2003 | July 30, 2003 |
| May 15, 2003 | **June 16, 2003** | June 30, 2003 | July 30, 2003 |
| June 2, 2003 | **July 1, 2003** | July 31, 2003 | August 30, 2003 |
| June 16, 2003 | **July 15, 2003** | July 31, 2003 | August 30, 2003 |
| July 1, 2003 | **August 1, 2003** | August 31, 2003 | September 30, 2003 |
| July 15, 2003 | **August 15, 2003** | August 31, 2003 | September 30, 2003 |
| August 1, 2003 | **September 2, 2003** | September 30, 2003 | October 30, 2003 |
| August 15, 2003 | **September 15, 2003** | September 30, 2003 | October 30, 2003 |
| September 2, 2003 | **October 1, 2003** | October 31, 2003 | November 30, 2003 |
| September 15, 2003 | **October 15, 2003** | October 31, 2003 | November 30, 2003 |
| October 1, 2003 | **November 3, 2003** | November 30, 2003 | December 30, 2003 |
| October 15, 2003 | **November 17, 2003** | November 30, 2003 | December 30, 2003 |

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

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## HOW TO CITE RULES AND RSMo

**RULES—**Cite material in the *Missouri Register* by volume and page number, for example, Vol. 26, *Missouri Register*, page 27. The approved short form of citation is 26 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.

# FROM THIS ANGLE . . .

**Emergency rulemakings?**

Emergency rulemakings have very specific statutory criteria that must be met before they can be accepted for filing. Secretary Blunt reviews all emergency rules, amendments, etc., that are filed with our office. Please remember to consult section 536.025, RSMo 2000, for the expanded provisions, which constitute an emergency rulemaking. For example, some of the criteria are:

1. An immediate danger to public health safety and welfare exists; the rulemaking is necessary to preserve a compelling governmental interest which requires an early effective date;
2. Follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances;
3. Follows procedures which comply with the protections extended by the ***Missouri*** and ***United States Constitutions***; and
4. Limits the scope of such rulemaking to the circumstances creating an emergency and requiring emergency action;

Your emergency statement must follow the statutory guidelines set out by section 536.025 and meet the specific criteria outlined therein including the specific facts, reasons and findings that support the agency's conclusions to file an emergency rulemaking. Also remember, emergency rulemakings may only be effective for 180 days or 30 legislative days, whichever period is longer. Consult section 536.025 in its entirety when your agency contemplates an emergency rulemaking.

**Rules, amendments, rescissions, more rules? Have you consulted the Rulemaking Manual?!**

When preparing to write or file new rules, amendments, rescissions or emergency rules, please consult ***Rulemaking 1-2-3, Missouri Style*** for assistance in compiling your paperwork. Alternatively, please call us and we will assist you. If you do not have the new manual, you may call us and obtain a copy – or you may access the online version at www.sos.state.mo.us/adrules/manual/manual.asp. This is a very "user friendly" manual and will walk you through each step of the process.

## Training?

Just a reminder . . . we are able to offer individual or group training sessions at your office or ours – if you need help with preparing or filing your administrative rules. Many agencies find our offer very helpful. Just give us a call to schedule your session today – even if it is just a five minute one-on-one to look over your draft documents before filing. It is our responsibility to assist you in properly preparing your rulemakings for filing – and in assuring your documents are accurate and complete.

## Welcome Heather!

Please join us in welcoming our newest staff member, Heather Downs. Heather has been with our office in a part-time position in another division. We are happy to have Heather as our newest Computer Equipment Operator I in Administrative Rules. Next time you are in, let us introduce you to Heather. We are happy to have her here with us!

## Revisions/Changes in Rules/Final Orders of Rulemaking?

If you are contemplating changes to your current rules – or if you are changing language within the text of your final order of rulemaking, ***please, please, please*** contact us for the current version of your text that either appears in ***Code*** or the current proposed version as it was published in the ***Missouri Register***, whichever circumstance is applicable. This will save many hours of re-keying for you – and countless errors for us . . . . Please give us a call and we will send you the most up-to-date version electronically.

As always, please contact us if we may assist you in *any way* with the rulemaking process.

Lynne C. Angle
Director, Administrative Rules

Under this heading will appear the text of proposed rules and changes. The notice of proposed rulemaking is required to contain an explanation of any new rule or any change in an existing rule and the reasons therefor. This is set out in the Purpose section with each rule. Also required is a citation to the legal authority to make rules. This appears following the text of the rule, after the word "Authority."

Entirely new rules are printed without any special symbology under the heading of the proposed rule. If an existing rule is to be amended or rescinded, it will have a heading of proposed amendment or proposed rescission. Rules which are proposed to be amended will have new matter printed in boldface type and matter to be deleted placed in brackets.

An important function of the *Missouri Register* is to solicit and encourage public participation in the rulemaking process. The law provides that for every proposed rule, amendment or rescission there must be a notice that anyone may comment on the proposed action. This comment may take different forms.

If an agency is required by statute to hold a public hearing before making any new rules, then a Notice of Public Hearing will appear following the text of the rule. Hearing dates must be at least thirty (30) days after publication of the notice in the *Missouri Register.* If no hearing is planned or required, the agency must give a Notice to Submit Comments. This allows anyone to file statements in support of or in opposition to the proposed action with the agency within a specified time, no less than thirty (30) days after publication of the notice in the *Missouri Register*.

An agency may hold a public hearing on a rule even though not required by law to hold one. If an agency allows comments to be received following the hearing date, the close of comments date will be used as the beginning day in the ninety (90)-day-count necessary for the filing of the order of rulemaking.

If an agency decides to hold a public hearing after planning not to, it must withdraw the earlier notice and file a new notice of proposed rulemaking and schedule a hearing for a date not less than thirty (30) days from the date of publication of the new notice.

Proposed Amendment Text Reminder:
**Boldface text indicates new matter**.
*[Bracketed text indicates matter being deleted.]*

## Title 1—OFFICE OF ADMINISTRATION
## Division 20—Personnel Advisory Board and Division of Personnel
## Chapter 2—Classification and Pay Plans

### PROPOSED AMENDMENT

**1 CSR 20-2.015 Broad Classification Bands for Managers**. The Personnel Advisory Board is amending paragraph (6)(B)2.

*PURPOSE: This amendment is necessary to allow for consistent application of rules governing layoffs.*

(6) Separation, Suspension and Demotion. The provisions of 1 CSR 20-3.070 are applicable in the administration of broad classification bands for managers in agencies covered by the merit system provisions of the State Personnel Law, except as specifically outlined in this section, or necessary for implementation.

(B) Demotions and Transfers. An appointing authority may demote an employee in accordance with the following:

1. No demotion for cause shall be made unless the employee to be demoted meets the minimum qualifications for the lower position demoted to, and shall not be made if any regular employee in the affected class and band or range would be laid off by reason of the action; and

2. An appointing authority, upon written request of the regular employee affected, shall demote such employee in lieu of layoff to a position in a lower band in the same class; or shall demote or transfer such employee *[to another class for which the employee meets the qualifications; or]* to an appropriate class and pay range in the same occupational job series; or to a position in which the employee previously has served and has obtained regular status in the division of service involved; even though these actions may result in additional layoffs. **An appointing authority may also, upon written request of the regular employee affected, demote or transfer such employee in lieu of layoff to another class for which the employee meets the qualifications, even if these actions may result in additional layoffs.** In the event of a demotion to a lower band, or a demotion or transfer to a class and pay range in lieu of layoff, an employee shall have his/her name placed on the appropriate register.

*AUTHORITY: section 36.070, RSMo [Supp. 1998] **2000**. Original rule filed March 11, 1999, effective Sept. 30, 1999. Emergency amendment filed Jan. 2, 2003, effective Jan. 12, 2003, expires July 10, 2003. Amended: Filed Jan. 15, 2003.*

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

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

*NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Director of Personnel, Office of Administration, P.O. Box 388, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. A public hearing on this proposed amendment is scheduled for 1:00 p.m., March 11, 2003 in Room 500 of the Harry S Truman State Office Building, 301 High Street, Jefferson City, Missouri.*

## Title 3—DEPARTMENT OF CONSERVATION
## Division 10—Conservation Commission
## Chapter 9—Wildlife Code: Confined Wildlife: Privileges, Permits, Standards

### PROPOSED AMENDMENT

**3 CSR 10-9.230 Class I Wildlife**. The commission is amending provisions of this rule.

*PURPOSE: This amendment provides wording to clarify captive animals included as Class I wildlife.*

Class I wildlife shall include bullfrogs and green frogs and birds (including ring-necked pheasants and gray partridge) native to the continental United States, and those species of mammals (except bison and those listed in 3 CSR 10-9.240) and nonvenomous reptiles and amphibians native to Missouri. **Elk defined as livestock pursuant to the *Revised Statutes of Missouri* section 277.020 that are held separate so as to prevent comingling with mule deer and white-tailed deer are exempt from permit requirements.**

*AUTHORITY: sections 40 and 45 of Art. IV, Mo. Const. Original rule filed June 9, 1993, effective Jan. 31, 1994. For intervening history, please consult the* ***Code of State Regulations****. Amended: Filed Dec. 26, 2002.*

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

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

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with John W. Smith, Deputy Director, Department of Conservation, PO Box 180, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the* ***Missouri Register****. No public hearing is scheduled.*

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

### PROPOSED AMENDMENT

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

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

*PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. Therefore, the material which is so incorporated is on file with the agency who filed this rule, and with the Office of the Secretary of State. Any interested person may view this material at either agency's headquarters or the same will be made available at the Office of the Secretary of State at a cost not to exceed actual cost of copy reproduction. The entire text of the rule is printed here. This note refers only to the incorporated by reference material.*

(1) When used in *[this]* **these rules or the** plan document, these words and phrases have the meaning—

(F) Benefits—Amounts payable by the plan as determined by the schedule of benefits and their limitations and exclusions *[(22 CSR 10-2.040), (22 CSR 10-2.045), (22 CSR 10-2.050), (22 CSR 10-2.055), (22 CSR 10-2.060), (22 CSR 10-2.063), (22 CSR 10-2.064), (22 CSR 10-2.065), and (22 CSR 10-2.066)]* as interpreted by the plan administrator;

(H) Claims administrator—An organization or group responsible for the processing of claims and associated services for the **plan's self-insured benefit programs and** preferred provider organization (PPO) *[and co-pay plans]*;

(N) Dependents—The lawful spouse of the employee, the employee's unemancipated child(ren) and certain survivors of employees, as provided in *[this]* **the** plan document **and these rules**, for whom application has been made and has been accepted for participation in the plan;

(O) Eligibility date—Refer to 22 CSR 10-2.020 for effective date provisions.

1. Newly-hired employees and their eligible dependents, or employees rehired after their participation terminates and their eligible dependents, are eligible to participate in the plan on the first day of the month following the employee's date of employment or reemployment.

2. Employees transferred from a department or other public entity with coverage under another medical care plan into a department or other public entity covered by this plan and their eligible dependents who were covered by the other medical care plan will be eligible for participation subject to *[the provisions of 22 CSR 10-2.060(1)(Q)1.]* **any applicable pre-existing conditions as outlined in the plan document.**

3. Employees who terminate all employment with the state (not simply move from one agency to another) and are rehired as a new state employee before termination of participation, and their eligible dependents who were covered by the *[PPO]* plan, will be eligible for participation immediately.

4. Employees who terminate all employment with the state (not simply move from one agency to another) and are rehired as a new state employee in the subsequent month, and their eligible dependents who were covered by the *[PPO]* plan, will be eligible for participation retroactive to the date following termination of participation;

(P) Emancipated child(ren)—A child(ren) who is—

1. Employed on a full-time basis;

2. Eligible for group health benefits in his/her own behalf;

3. Maintaining a residence separate from his/her parents or guardian—except for full-time students in an accredited school or institution of higher learning; **or**

4. Married; *[or]*

*[5. Not dependent upon parents or guardian for at least fifty percent (50%) support;]*

*[(BB) Medicare HMO (risk contract)—An HMO exclusively for members residing in specified areas and covered by Medicare whereby benefits are provided in accordance with a plan approved by federal regulation;]*

*[(CC)]* **(BB)** Nurse—A registered nurse (RN), licensed practical nurse (LPN) or licensed vocational nurse (LVN). Nurse shall also include an employee of an institution operated principally for treating sick and injured persons through spiritual means which meets the requirements of a hospital as defined in this rule;

*[(DD)]* **(CC)** Open enrollment period—A period designated by the plan during which members may enroll, switch, or change their level of coverage in any of the available health care options with the new coverage becoming effective as of the beginning of the new plan year;

*[(EE)]* **(DD)** Out-of-area—Applies to claims of members living in specified zip code areas where the number of available providers does not meet established criteria;

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

*[(GG)]* **(FF)** Participant—Any employee or dependent *[who has been]* accepted for membership in the plan;

*[(HH)]* **(GG)** Physically or mentally disabled—The inability of a person to be self-sufficient as the result of a condition diagnosed by a physician as a continuing condition;

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

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

*[(KK)]* **(JJ)** Plan administrator—The trustees of the Missouri Consolidated Health Care Plan;

*[(LL)]* **(KK)** Plan document—*[This]* **The** statement of the terms and conditions of the plan as adopted by the plan administrator **in the applicable "Missouri Consolidated Health Care Plan Member Handbook" and incorporated by reference**;

*[(MM)]* **(LL)** Plan year—Same as benefit year;

*[(NN)]* **(MM)** Point-of-service—A plan which provides a wide range of comprehensive health care services, like an HMO, if in-network providers are utilized, and like a PPO plan, if non-network providers are utilized;

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

*[(PP)]* **(OO)** Preferred provider organization (PPO)—An arrangement with providers where discounted rates are given to members of the plan who, in turn, are offered a financial incentive to use these providers;

*[(QQ)]* (**PP**) Premium option—A set of covered benefits with specified co-payment and coinsurance amounts;

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

*[(SS)]* **(RR)** Provider—Hospitals, physicians, chiropractors, medical agencies, or other specialists who provide medical care within the scope of his/her practice and are recognized under the provisions and administrative guidelines of the plan. Provider also includes a qualified practitioner of an organization which is generally recognized for health insurance reimbursement purposes and whose principles and practices of spiritual healing are well established and recognized;

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

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

*[(VV)]* **(UU)** Second opinion program—A consultation and/or exam with a physician qualified to perform the procedure who is not affiliated with the attending physician/surgeon, for the purpose of evaluating the medical necessity and advisability of undergoing a surgical procedure or receiving a service;

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

1. It is operated pursuant to law and is primarily engaged in providing, for compensation from its patients, the following services for persons convalescing from sickness or injury: room, board and twenty-four (24) hour-a-day nursing service by one (1) or more professional nurses and nursing personnel as are needed to provide adequate medical care;

2. It provides the services under the supervision of a proprietor or employee who is a physician or registered nurse; and it maintains adequate medical records and has available the services of a physician under an established agreement, if not supervised by a physician or registered nurse; and

3. A skilled nursing facility shall be deemed to include institutions meeting the criteria in subsection (1)(VV) of this rule which are established for the treatment of sick and injured persons through spiritual means and are operated under the authority of organizations which are recognized under Medicare (Title I of Public Law 8997);

*[(XX) Staff model—A set of covered benefits established by the HMO similar to the premium and standard options, but with varying co-payment and coinsurance amounts;]*

*[(YY)]* **(WW)** Standard option—A set of covered benefits similar to the premium option, but with higher co-payment and coinsurance amounts;

*[(ZZ)]* **(XX)** State—Missouri;

*[(AAA)]* **(YY)** Unemancipated child(ren)—A natural child(ren), a legally adopted child(ren) or a child(ren) placed for adoption, and a dependent disabled child(ren) over twenty-three (23) years of age (during initial eligibility period only and appropriate documentation may be required by the plan), and the following:

1. Stepchild(ren);

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

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

4. Other child(ren) for whom the employee is legal custodian subject to specific approval by the plan administrator. *[This child(ren) must rely on the parent/custodian for his/her major financial support (appropriate documentation may be required).]* Except for a disabled child(ren) as described in subsection (1)(GG) of this rule, an unemancipated child(ren) is eligible from birth to the end of the month in which s/he is emancipated, as defined here, or attains age twenty-three (23) (twenty-five (25) if attending school full-time and the public entity joining the plan had immediate previous coverage allowing this provision) (see 22 CSR 10-2.020(5)(D)2. for continuing coverage on handicapped child(ren) beyond age twenty-three (23)); and

5. Stepchild(ren) who are not domiciled with the employee, provided the natural parent who is legally responsible for providing coverage is also covered as a dependent under the plan; and

*[(BBB)]***(ZZ)** Usual, customary, and reasonable charge.

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

2. Customary—The range of fees charged in a geographic area by physicians of comparable skills and qualifications for the same performance of similar service;

3. Reasonable—The flexibility to take into account any unusual clinical circumstances involved in performing a particular service; and

4. A formula is used to determine the customary maximum. The customary maximum is the usual charge submitted by ninety percent (90%) of the doctors for ninety percent (90%) of the procedures reported.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the* ***Code of State Regulations****. Emergency amendment filed Dec. 20, 2002, effective Jan. 1, 2003, expires June 29, 2003. Amended: Filed Dec. 20, 2002.*

*PUBLIC COST: The fiscal impact of this proposed amendment is estimated to be less than five hundred dollars ($500) in the aggregate for state agencies or political subdivisions.*

*PRIVATE COST: There is a potential for some individual state members to incur additional costs in excess of five hundred dollars ($500) due to the changes in some of the co-payment levels. However, it is impossible to accurately estimate the number of persons this would impact or the associated costs because it will be dependent upon the plan chosen and the amount and type of individual health care needs that arise during the year. Higher co-payments for pharmacy could be offset in some cases if members switch to generic drugs when possible. Higher co-payments for medical benefits could also be offset if the co-payment exceeds fifty (50%) percent of the cost of the service.*

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

**FISCAL NOTE**
**PRIVATE ENTITY COST**

## I. RULE NUMBER

Title: 22 – Missouri Consolidated Health Care Plan

Division: Division 10

Chapter: Chapter 2

Type of Rulemaking: Proposed Amendment to Rule

Rule Number and Name: 2.010 Definitions

## II. SUMMARY OF FISCAL IMPACT

| Estimate of the number of entities by class which would likely be affected by adoption of the proposed rule: | Classification by types of the business entities which would likely be affected: | Estimate in the aggregate as to the cost of compliance with the rule by the affected entities: |
|---|---|---|
| Percentage of 104,121 state members using pharmacy benefits | Individuals enrolled in the MCHCP | $ 4.3 Million |
| Percentage of 104,121 state members using medical benefits | Individuals enrolled in the MCHCP | $ 7.06 Million |

## III. WORKSHEET

The plan design is being modified to counter increases in cost and utilization.

The co-payment amount for brand prescriptions on the formulary is increasing from $20 to $25, and the co-payment amount for non-formulary drugs is increasing from $35 to $40.

The co-payment amount for office visits is increasing from $20 to $30 for the standard HMO plans and from $10 to $20 for the premium HMO plans. The co-payment amounts for hospitalizations are increasing from $200 to $400 for the standard HMO plans and from $0 to $200 for the premium HMO plans.

## IV. ASSUMPTIONS

It is estimated that the change in coverage for the pharmacy benefit will cost all state members approximately a total $ 4.3 million. These amounts are based upon current utilization patterns and the resulting actuarial projections for next year using the revised plan design.

It is estimated that the change in coverage for the medical benefit will cost all state members approximately a total $ 7.06 million. This amount is based upon the estimated utilization rates for calendar year 2001

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

## PROPOSED AMENDMENT

**22 CSR 10-2.020 Membership Agreement and Participation Period.** The board is amending subparagraph (4)(B)3.A., paragraphs (7)(B)3. and 4. and paragraph (8)(A)7.

*PURPOSE: This amendment includes changes in the membership agreement and participation period made by the board of trustees regarding the Missouri Consolidated Health Care Plan.*

(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]* **immediately** eligible for coverage *[until the next open enrollment period]* **if an application is submitted within thirty-one (31) days of regaining dependent status**; and

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

(7) Continuation of Coverage.

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

1. Eligibility Criteria:

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

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

C. Coverage since first eligible;

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

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

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

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

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

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

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

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

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

1. Employees terminating for reasons other than gross misconduct may continue coverage for themselves and their covered dependents for eighteen (18) months at their own expense.

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

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

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

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

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

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

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

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the* ***Code of State Regulations****. Emergency amendment filed Dec. 20, 2002, effective Jan. 1, 2003, expires June 29, 2003. Amended: Filed Dec. 20, 2002.*

*PUBLIC COST: The fiscal impact of this proposed amendment is estimated to be less than five hundred dollars ($500) in the aggregate for state agencies or political subdivisions.*

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

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

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

## PROPOSED RESCISSION

**22 CSR 10-2.040 PPO Plan Summary of Medical Benefits**. This rule provided a summary of the medical benefits under the PPO plan.

*PURPOSE: This rule is being rescinded as this benefit plan is no longer available.*

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the **Code of State Regulations**. Emergency rescission filed Dec. 20, 2002, effective Jan. 1, 2003, expires June 29, 2003. Rescinded: Filed Dec. 20, 2002.*

*PUBLIC COST: The fiscal impact of this proposed rescission is estimated to be less than five hundred dollars ($500) in the aggregate for state agencies or political subdivisions.*

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

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

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

## PROPOSED AMENDMENT

**22 CSR 10-2.045 Co-Pay *and PPO* Plan** *[Summary of Medical Benefits]* ***Summaries***. The board is deleting sections (1)–(6) and section (9) and renumbering sections (7) and (8) of this rule.

*PURPOSE: This amendment includes changes made by the board of trustees regarding medical benefits for participants in the Missouri Consolidated Health Care Plan Co-Pay and PPO Plans.*

*[(1) Lifetime Maximum:*

*(A) Network—no limit.*

*(B) Out-of-Network, Out-of-Area—three (3) million dollars.*

*(2) Automatic Annual Reinstatement—Maximum, five thousand dollars ($5,000).*

*(3) Non-Network and Out-of-Area Deductible Amount—*

*(A) Network—zero.*

*(B) Out-of-Network, Out-of-Area—three hundred dollars ($300) individual, nine hundred dollars ($900) family, per calendar year.*

*(4) Coinsurance.*

*(A) Individual—*

*1. Network—Eighty percent (80%) coinsurance applies to specific benefits. After satisfying the two thousand dollar ($2,000) individual out-of-pocket maximum, claims will be paid at one hundred percent (100%) of any excess of covered charges in the calendar year. Please refer to the schedule of benefits.*

*2. Non-network—Seventy percent (70%) coinsurance applies to covered services. After satisfying the four thousand five hundred dollar ($4,500) individual out-of-pocket maximum, claims will be paid at one hundred percent (100%) of any excess of covered charges in the calendar year.*

*3. Out-of-area—Eighty percent (80%) coinsurance applies to covered services after satisfying one thousand five hundred dollar ($1,500) individual out-of-pocket maximum. Claims will be paid at one hundred percent (100%) of any excess of covered charges in the calendar year.*

*(B) Family—*

*1. Network—Eighty percent (80%) coinsurance applies to specific benefits. After satisfying the six thousand dollar ($6,000) family out-of-pocket maximum, claims will be paid at one hundred percent (100%) of any excess of covered charges in the calendar year. Please refer to the schedule of benefits.*

*2. Non-network—Seventy percent (70%) coinsurance applies to covered services. After satisfying the nine thousand dollar ($9,000) family out-of-pocket maximum, claims will be paid at one hundred percent (100%) of any excess of covered charges in the calendar year.*

*3. Out-of-area—Eighty percent (80%) coinsurance applies to covered services after satisfying three thousand dollar ($3,000) family out-of-pocket maximum. Claims will be paid at one hundred percent (100%) of any excess of covered charges in the calendar year.*

*(C) Non-Network Services—Same as subsections (4)(A) and (B) of this rule, except covered charges are reimbursed on a seventy percent (70%) basis.*

*(5) The employee or dependent will only be responsible for a fifteen dollar ($15) co-payment for an office visit for covered services if a physician or provider is utilized who is enrolled in a preferred provider network that has contracted with the plan administrator.*

*(6) Hospital Room Charges—The hospital's most common charge for semi-private accommodations, unless a private room has been recommended by a physician and approved by the claims administrator or the plan's medical review agency.]*

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

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

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

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

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

(E) Penalties—Members not complying with subsections *[(7)]***(1)**(A) and (B) of this rule may be subject to a financial penalty in connection with their covered benefits. (Note: The utilization review program will be operated in accordance with the administrative guidelines.)

*[(8)]* **(2)** Participants eligible for Medicare who are not eligible for this plan as their primary plan, shall be eligible for benefits no less than those benefits for participants not eligible for Medicare. For such participants who elect to continue their coverage, benefits of this plan shall be coordinated with Medicare benefits on the then standard coordination of benefits basis to provide up to one hundred percent (100%) reimbursement for covered charges.

(A) If a participant eligible for Medicare who is not eligible for this plan as the primary plan is not covered by Medicare, an estimate of Medicare Part A and/or Part B benefits shall be made and used for coordination or reduction purposes in calculating benefits. Benefits will be calculated on a claim submitted basis so that if, for a given claim, Medicare reimbursement was for more than the benefits provided by this plan without Medicare, the balance will not be considered when calculating subsequent claims; and

(B) If any retired participants or long-term disability recipients, their eligible dependents or surviving dependents eligible for coverage elect not to be continuously covered from the date first eligible, or do not apply for coverage within thirty-one (31) days of their eligibility date, they shall not thereafter be eligible for coverage.

*[(9) Prescription Drug Program—The co-pay plan provides coverage for prescription drugs, as described in the following:*

*(A) Medications.*

*1. In-Network.*

*A. Ten dollar ($10) co-pay for thirty (30)-day supply for generic drug on the formulary.*

*B. Twenty dollar ($20) co-pay for thirty (30)-day supply for brand drug on the formulary.*

*C. Thirty-five dollar ($35) co-pay for thirty (30)-day supply for non-formulary drug.*

*2. Prescriptions filled with a brand drug when a generic is available will be subject to the generic co-payment amount and the member must also pay the difference in the cost between the generic and brand drugs.*

*3. Mail Order Program—Prescriptions may be filled through a mail order program for up to a ninety (90)-day supply for twice the regular co-payment.*

*(B) Non-Network Pharmacies—If a member chooses to use a non-network pharmacy, s/he will be required to pay the full cost of the prescription, then file a claim with the prescription drug administrator. S/he will be reimbursed the amount that would have been allowed at an in-network pharmacy, less any applicable co-payment. Any difference between the amount paid by the member at a non-network pharmacy and the amount that would have been allowed at an in-network pharmacy will not be applied to the out-of-pocket maximum.]*

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 12, 2000, effective Jan. 1, 2001, expires June 29, 2001. Original rule filed Dec. 12, 2000, effective June 30, 2001. For intervening history, please consult the* ***Code of State Regulations****. Emergency amendment filed Dec. 20, 2002, effective Jan. 1, 2003, expires June 29, 2003. Amended: Filed Dec. 20, 2002.*

*PUBLIC COST: The fiscal impact of this proposed amendment is estimated to be less than five hundred dollars ($500) in the aggregate for state agencies or political subdivisions.*

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

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

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

## PROPOSED RESCISSION

**22 CSR 10-2.050 PPO Plan Benefit Provisions and Covered Charges**. This rule provided a summary of the benefit provisions and covered charges under the PPO plan.

*PURPOSE: This rule is being rescinded as this benefit plan is no longer available.*

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the* ***Code of State Regulations****. Emergency rescission filed Dec. 20, 2002, effective Jan. 1, 2003, expires June 29, 2003. Rescinded: Filed Dec. 20, 2002.*

*PUBLIC COST: The fiscal impact of this proposed rescission is estimated to be less than five hundred dollars ($500) in the aggregate for state agencies or political subdivisions.*

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

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Missouri Consolidated Health Care Plan, Ron Meyer, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must*

*be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

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

### PROPOSED AMENDMENT

**22 CSR 10-2.055 Co-Pay *and PPO* Plan Benefit Provisions and Covered Charges**. The board is amending this rule in regard to the modified benefit provisions and covered charges.

*PURPOSE: This amendment includes changes made by the board of trustees regarding benefit provisions and covered charges in the Missouri Consolidated Health Care Plan Co-Pay and PPO Plans.*

*[(1) Covered Charges.*

*(A) Allergy Injections—Fifteen dollar ($15) co-payment for office visit also covers injection. Ten dollar ($10) co-payment per injection received if not during office visit.*

*(B) Ambulance Service—Ground services covered with fifty dollar ($50) co-payment if medically necessary or with prior approval. Air services covered on same basis, twenty percent (20%) coinsurance and deductible for non-emergencies.*

*(C) Birth Control Pills—Birth control pills on the formulary covered at one hundred percent (100%). Not covered out-of-network.*

*(D) Chiropractic Benefits—Charges subject to fifteen dollar ($15) co-payment; fifty dollar ($50) co-pay per visit maximum, two thousand dollar ($2,000) annual maximum (out-of-network only).*

*(E) Complications—Normally covered charges arising as a complication of a noncovered service.*

*(F) Dental Care—Treatment to reduce trauma as a result of accidental injury and restorative services that are a result of that injury. Fifteen dollar ($15) office visit co-pay, regardless of where services are rendered.*

*(G) Durable Medical Equipment—Twenty percent (20%) coinsurance. Coverage for certain prosthetic devices and durable medical equipment, including customized orthotics.*

*(H) Emergency Care—Fifty dollar ($50) co-payment in or out of service area. Waived if admitted.*

*(I) Eye Care—Treatment of disease or to reduce trauma as a result of accident. Annual exam covered with a fifteen dollar ($15) co-payment.*

*(J) Growth Hormone Therapy—Subject to twenty percent (20%) coinsurance, medical necessity and prior authorization.*

*(K) Hearing Aids and Testing—Covered once every two (2) years, subject to twenty percent (20%) co-payment and fifteen dollar ($15) co-payment for annual hearing test.*

*(L) Home Health Care—Covered when authorized by claims administrator.*

*(M) Hospice Care—Covered with prior authorization.*

*(N) Hospital Benefit for Mental and Nervous Disorder—One hundred dollar ($100) co-payment per admission. Four hundred dollar ($400) annual inpatient hospital maximum. Must be pre-certified.*

*(O) Hospital Benefits for Chemical Dependency—One hundred dollar ($100) co-payment per admission. Four hundred dollar ($400) annual inpatient hospital maximum. Must be precertified.*

*(P) Hospital Room and Board—One hundred dollar ($100) co-payment per admission. Four hundred dollar ($400) annual maximum. Must be precertified.*

*(Q) Injections—All injections provided in full (except allergy and contraceptive injections).*

*(R) Infertility—Coverage limited to fifty percent (50%) for in vivo services, including provider, and prescription drug charges. Exclusions include reversals of voluntary sterilization, in vitro fertilization, gamete intrafallopian transfer (GIFT), and zygote intrafallopian transfer (ZIFT). Not covered out-of-network. Deductible applies to out-of-area.*

*(S) Maternity Coverage—Fifteen dollar ($15) co-payment for initial visit. All other prenatal visits, delivery costs and routine post-natal visits covered at one hundred percent (100%). No travel exclusions, restrictions or limitation allowed.*

*(T) Nutrient Supplement—Not covered out-of-network.*

*(U) Organ Transplants—The following organ transplants covered at one hundred percent (100%) through the National Transplant Program: bone marrow, cornea, kidney, liver, heart, lung, pancreas, intestinal, or any combination, when: 1) neither experimental nor investigational, and 2) medically necessary as determined by the claims administrator. Donor expenses are covered. No waiting periods allowed. Non-network and out-of-area limited to maximum surgical schedule.*

*(V) Outpatient Diagnostic Lab and X-Ray—Provided in full.*

*(W) Outpatient Mental and Nervous Disorder and Chemical Dependency—Fifteen dollar ($15) co-payment per visit.*

*(X) Oxygen—(Outpatient) Subject to twenty percent (20%) coinsurance. Covered under Durable Medical Equipment.*

*(Y) Physical Therapy and Rehabilitation Services—Ten dollar ($10) co-payment per visit for outpatient therapy. Limited to sixty (60) visits per incident. Additional visits if medically necessary.*

*(Z) Physician Charges.*

*1. Inpatient—Provided in full.*

*2. Outpatient—Provided in full after fifteen dollar ($15) co-payment per office visit.*

*3. Internet—Covered when enrolled in the Care Support Program and registered for the service.*

*(AA) Plan Maximum—Not applicable for network services, out-of-network and out-of-area limited to three (3) million dollars with five thousand dollar ($5,000) reinstatement.*

*(BB) Prescription Drugs—Insulin, syringes, test strips and glucometers are included in this coverage. There is no out-of-pocket maximum. Member is responsible only for the lesser of the applicable co-payment or the cost of the drug.*

*1. Ten dollar ($10) co-pay for thirty (30)-day supply for generic drug on the formulary.*

*2. Twenty dollar ($20) co-pay for thirty (30)-day supply for brand drug on the formulary.*

*3. Thirty-five dollar ($35) co-pay for thirty (30)-day supply for non-formulary drug.*

*4. Ninety (90)-day supply of medication for two (2) co-payments (mail order only).*

*(CC) Preventive Services—Annual physical exams, mammograms (subject to schedule), pap smears, well-baby care, immunizations. Annual well-woman exam without referral to a network provider.*

*(DD) Prosthetics—Provided in full for initial placement. Twenty percent (20%) coinsurance for coverage for repair or replacement due to change in medical condition.*

*(EE) Skilled Nursing—Provided in full. Limited to one hundred and twenty (120) days.*

*(FF) Surgery.*

*1. Inpatient—Provided in full.*

*2. Outpatient—Fifty dollar ($50) co-payment.]*

**(1) Benefit Provisions.**

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

**(B) Any deductible requirement applies each calendar year to covered charges. The requirement is met as soon as covered charges incurred in a calendar year, which are not paid in part or in whole by the plan, equals the deductible amount.**

**(C) Any family deductible requirement is met as soon as covered charges in a calendar year, which are not paid in part or in whole by the plan, equals the family deductible requirement.**

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

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

**(2) Covered Charges.**

**(A) 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 noncovered service, and which are:**

**1. Prescribed by a doctor or provider for the therapeutic treatment of injury or sickness;**

**2. To the extent they do not exceed any limitation;**

**3. Not excluded by the limitations; and**

**4. For not more than the usual, reasonable, and customary charge as determined by the claims administrator for the services provided, will be considered covered charges.**

**(B) To determine if services and/or supplies are medically necessary and customary and if charges are not more than usual, reasonable, and customary, the claims administrator will consider the following:**

**1. The medical benefits or supplies usually rendered or prescribed for the condition; and**

**2. The usual, reasonable, and customary charges in the area in which services and/or supplies are provided.**

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 12, 2000, effective Jan. 1, 2001, expired June 29, 2001. Original rule filed Dec. 12, 2000, effective June 30, 2001. For intervening history, please consult the* ***Code of State Regulations****. Emergency amendment filed Dec. 20, 2002, effective Jan. 1, 2003, expires June 29, 2003. Amended: Filed Dec. 20, 2002.*

*PUBLIC COST: The fiscal impact of this proposed amendment is estimated to be less than five hundred dollars ($500) in the aggregate for state agencies or political subdivisions.*

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

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

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

## PROPOSED RESCISSION

**22 CSR 10-2.060 PPO and Co-Pay Plan Limitations**. This rule provided the limitations of the PPO and Co-Pay plans.

*PURPOSE: This rule is being rescinded as the information is contained in the Plan Document.*

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the* ***Code of State Regulations****. Emergency rescission filed Dec. 20, 2002, effective Jan. 1, 2003, expires June 29, 2003. Rescinded: Filed Dec. 20, 2002.*

*PUBLIC COST: The fiscal impact of this proposed rescission is estimated to be less than five hundred dollars ($500) in the aggregate for state agencies or political subdivisions.*

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

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

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

## PROPOSED RESCISSION

**22 CSR 10-2.063 HMO/POS Premium Option Summary of Medical Benefits**. This rule provided a summary of the medical benefits under the HMO/POS Premium Option.

*PURPOSE: This rule is being rescinded as the information is contained in the Plan Document.*

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 13, 1995, effective May 1, 1995, expired Aug. 28, 1995. Original rule filed Dec. 21, 1994, effective June 30, 1995. For intervening history, please consult the* ***Code of State Regulations****. Emergency rescission filed Dec. 20, 2002, effective Jan. 1, 2003, expires June 29, 2003. Rescinded: Filed Dec. 20, 2002.*

*PUBLIC COST: The fiscal impact of this proposed rescission is estimated to be less than five hundred dollars ($500) in the aggregate for state agencies or political subdivisions.*

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

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

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

### PROPOSED RESCISSION

**22 CSR 10-2.064 HMO/POS Standard Option Summary of Medical Benefits**. This rule provided a summary of the medical benefits of the HMO/POS Standard Option.

*PURPOSE: This rule is being rescinded as the information is contained in the Plan Document.*

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 12, 2000, effective Jan. 1, 2001, expires June 29, 2001. Original rule filed Dec. 12, 2000, effective June 30, 2001. For intervening history, please consult the **Code of State Regulations**. Emergency rescission filed Dec. 20, 2002, effective Jan. 1, 2003, expires June 29, 2003. Rescinded: Filed Dec. 20, 2002.*

*PUBLIC COST: The fiscal impact of this proposed rescission is estimated to be less than five hundred dollars ($500) in the aggregate for state agencies or political subdivisions.*

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

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

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

### PROPOSED RESCISSION

**22 CSR 10-2.067 HMO and POS Limitations**. This rule provided the limitations of the HMO and POS plans.

*PURPOSE: This rule is being rescinded as the information is contained in the Plan Document.*

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 13, 1995, effective May 1, 1995, expired Aug. 28, 1995. Original rule filed Dec. 21, 1994, effective June 30, 1995. For intervening history, please consult the **Code of State Regulations**. Emergency rescission filed Dec. 20, 2002, effective Jan. 1, 2003, expires June 29, 2003. Rescinded: Filed Dec. 20, 2002.*

*PUBLIC COST: The fiscal impact of this proposed rescission is estimated to be less than five hundred dollars ($500) in the aggregate for state agencies or political subdivisions.*

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

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

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

### PROPOSED AMENDMENT

**22 CSR 10-2.075 Review and Appeals Procedure**. The board is amending section (5) and paragraph (5)(B)2.

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

(5) All insured members of the Missouri Consolidated Health Care Plan (MCHCP) shall use the claims and administration procedures established by the health maintenance organization (HMO), point-of-service (POS)**,** *[or]* preferred provider organization (PPO) **or co-pay** health plan contract applicable to the insured member. Only after these procedures have been exhausted may the insured appeal to the Missouri Consolidated Health Care Plan Board of Trustees to review the decision of the health plan contractor.

(B) The board may utilize a hearing officer, such as the Administrative Hearing Commission, to conduct a fact-finding hearing and make proposed findings of fact and conclusions of law.

1. The hearing will be scheduled by the MCHCP.

2. The parties to the hearing will be the insured and the applicable health plan *[contractor]*.

3. All parties shall be notified, in writing of the date, time and location of the hearing.

4. All parties shall have the right to appear at the hearing and submit written or oral evidence. The appealing party shall be responsible for all copy charges incurred by MCHCP in connection with any documentation that must be obtained through the MCHCP. These fees will be reimbursed should the party prevail in his/her appeal. They may cross-examine witnesses. They need not appear and may still offer written evidence. The strict rules of evidence shall not apply.

5. The party appealing to the board shall carry the burden of proof.

6. The independent hearing officer shall propose findings of fact and conclusions of law, along with its recommendation, to the board. Copies of the summary, findings, conclusions and recommendations shall be sent to all parties.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 13, 1995, effective May 1, 1995, expired Aug. 28, 1995. Original rule filed Dec. 21, 1994, effective June 30, 1995. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed Dec. 20, 2002, effective Jan. 1, 2003, expires June 29, 2003. Amended: Filed Dec. 20, 2002.*

*PUBLIC COST: The fiscal impact of this proposed amendment is estimated to be less than five hundred dollars ($500) in the aggregate for state agencies and political subdivisions.*

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

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Ron Meyer, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must*

*be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

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

### PROPOSED AMENDMENT

**22 CSR 10-2.080 Miscellaneous Provisions**. The board is amending section (2).

*PURPOSE: This amendment includes changes made by the board of trustees regarding the miscellaneous provisions of the Missouri Consolidated Health Care Plan.*

(2) Facility of Payment. Preferred provider organization (PPO) **and co-pay** plan benefits will be paid to the employee if living and capable of giving a valid release for the payment due. If the participant, while living, is physically, mentally or for any other reason incapable of giving a valid release for any payment due, the claims administrator at his/her option, unless and until request is made by the duly appointed guardian, may pay benefits which may become due to any blood relative or relative connected by marriage to the participant, or to any other person or institution appearing to the claims administrator to have assumed responsibility for the affairs of the participant. Any payments made by the claims administrator in good faith pursuant to this provision shall fully discharge the claims administrator to the extent of the payment. Any benefit unpaid at the time of the employee's death will be paid to the employee's estate. If any benefits shall be payable to the estate of the employee, the claims administrator may pay these benefits to any relative by blood or connection by marriage of the employee who is deemed by the claims administrator to be equitably entitled to it. Any payments made by the claims administrator in good faith pursuant to this provision shall fully discharge the claims administrator to the extent of this payment. Subject to any acceptable written direction and assignment by the employee, any benefits provided, at the claims administrator's *[opinion]* **option**, may be paid directly to an eligible provider rendering covered services; but it is not required that the service be rendered by a particular provider.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed Dec. 20, 2002, effective Jan. 1, 2003, expires June 29, 2003. Amended: Filed Dec. 20, 2002.*

*PUBLIC COST: The fiscal impact of this proposed amendment is estimated to be less than five hundred dollars ($500) in the aggregate for state agencies or political subdivisions.*

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

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