



Rules of
Department of Insurance,
Financial Institutions and
Professional Registration
Division 400—Life, Annuities and Health
Chapter 2—Accident and Health Insurance in General

Title	Page
20 CSR 400-2.010 Insured’s Right to Examination of Accident and Sickness Coverage	3
20 CSR 400-2.020 Hospital Indemnity Contracts Not Affected by Government Hospital	3
20 CSR 400-2.030 Group Coordination of Benefits	3
20 CSR 400-2.040 Notice to Parents of Group and Blanket Student Accident Policies	9
20 CSR 400-2.050 Notice of Renewal Dates on Renewable Policies.....	9
20 CSR 400-2.060 Policy Approval Criteria	9
20 CSR 400-2.065 Actual Payment as Basis for Policy or Plan Calculations	11
20 CSR 400-2.070 Conversion Privilege	12
20 CSR 400-2.080 Conversion: Semiprivate Room Rate	13
20 CSR 400-2.090 Group Health Classification	13
20 CSR 400-2.100 Standards for HIV Testing	14
20 CSR 400-2.110 Life and Health Benefits Relating to HIV Infection.....	16
20 CSR 400-2.120 Application Questions and Underwriting Practices Relating to HIV Infection.....	16
20 CSR 400-2.130 Group Health Filings	16
20 CSR 400-2.135 Health Benefit Plans Issued to Associations with Small and Large Employers	26
20 CSR 400-2.140 Speech and Hearing Disorders—Definitions	26
20 CSR 400-2.150 Stop-Loss Coverage for Self-Insured Health Plans (Voided: December 27, 1995).....	27



20 CSR 400-2.160	Mental Health Services Allowed Out-of-Network	27
20 CSR 400-2.165	Access to Providers for Treatment of Mental Health Conditions.....	27
20 CSR 400-2.170	Early Intervention Part C Coverage	28



Title 20—DEPARTMENT OF INSURANCE

Division 400—Life, Annuities and Health Chapter 2—Accident and Health Insurance in General

20 CSR 400-2.010 Insured's Right to Examination of Accident and Sickness Coverage

PURPOSE: This rule allows persons ten days following the date of delivery in which to examine accident or health insurance coverage and to return that coverage for a full refund of premium.

(1) Applicability. This rule applies to all individual policies subject to sections 376.770–376.795, RSMo and all group insurance certificates defined in section 376.421.2, RSMo which are mass marketed or marketed on an individual basis to citizens of this state. This rule does not apply to single premium short duration trip or travel-type coverage. Mass-marketed health insurance, for purposes of this rule, means the insurance under any individual, franchise, group or blanket policy of accident or health insurance which is offered by means of direct response solicitation through a sponsoring organization or through the mails or other mass communications media and under which the insured person pays all or substantially all of the cost of his/her insurance.

(2) The face page of all individual contacts and group certificates which are subject to this rule must contain a conspicuous and clearly captioned paragraph stating in substance that—

(A) The person to whom the coverage is issued may return the policy or certificate within at least ten (10) days of delivery for a full refund of all premiums paid; and

(B) Any coverage returned for a refund of premium will be null and void from its inception.

(3) All these insurance companies shall remit to the person to whom the policy was issued the gross amount of the premium paid in the event the insured elects to return the policy. No insurance company is permitted to deduct or fail to return that portion of the premium retained by the company's insurance producer or any other expense connected with the premium.

(4) No contract or coverage subject to the provisions of this rule shall be approved by

the Department of Insurance unless it meets the requirements of this rule.

AUTHORITY: sections 354.120, 354.380, 374.045 and 376.777, RSMo 2000.* This rule was previously filed as 4 CSR 190-14.010. Original rule filed Dec. 5, 1969, effective Dec. 15, 1969. Amended: Filed Aug. 12, 1974, effective Aug. 22, 1974. Amended: Filed Dec. 1, 1989, effective June 30, 1990. Amended: Filed July 12, 2002, effective Jan. 30, 2003.

*Original authority: 354.120, RSMo 1973, amended 1983, 1993, 1995; 354.380, RSMo 1983; 374.045, RSMo 1967, amended 1993, 1995; and 376.777, RSMo 1959, amended 1984.

20 CSR 400-2.020 Hospital Indemnity Contracts Not Affected by Government Hospital

PURPOSE: This rule prohibits insurers from refusing to pay benefits under certain contracts because of hospitalization in government hospitals and was promulgated pursuant to the provisions of section 374.045, RSMo and implements sections 376.405 and 376.777, RSMo.

(1) The term hospital indemnity policy includes all insurance contracts, riders or forms supplementary to them, where the contingency insured against is loss of time due to or resulting from hospitalization, with cash benefits derived being payable daily, weekly or monthly or in any other manner.

(2) No policy, rider endorsement or other form supplemental to them will be approved for sale in this state, if the policy or form excludes any indemnity payments for time spent in a veterans' or any other government-sponsored or supported hospital. Nor shall indemnity benefits be reduced or altered because of confinement in a government-sponsored or supported institution which otherwise meets the definition of hospital in the contract. Existing contracts excluding indemnity payments shall be disapproved for sale in Missouri until the exclusion is deleted. Disapprovals of policies under this rule shall be effected as provided in section 376.405 or 376.777(7), RSMo (1986).

AUTHORITY: sections 374.045, 376.405 and 376.777, RSMo 1986.* This rule was previously filed as 4 CSR 190-14.030. Original rule filed June 22, 1970, effective July 2, 1970. Amended: Filed Dec. 20, 1974, effective Dec. 30, 1974.

*Original authority: 374.045, RSMo 1967; 376.405, RSMo 1959; and 376.777, RSMo 1959, amended 1984.

20 CSR 400-2.030 Group Coordination of Benefits

PURPOSE: This rule restricts the use of coordination of benefits provisions in group health insurance plans to those situations where they may be equitably applied.

(1) Applicability. The purpose of this rule is to—

(A) Permit, but not require, plans to include a coordination of benefits (COB) provision;

(B) Establish an order in which plans pay their claims;

(C) Provide the authority for orderly transfer of information needed to pay claims promptly;

(D) Reduce duplication of benefits by permitting a reduction of the benefits paid by a plan where the plan, pursuant to rules established by this rule, does not have to pay its benefits first;

(E) Reduce claims payment delays; and

(F) Make all contracts that contain a COB provision consistent with this rule.

(2) Definitions. The following words and terms, when used in this rule, shall have the following meanings unless the context clearly indicates otherwise:

(A) Allowable expenses.

1. Allowable expense means the necessary, reasonable and customary item of expense for health care when the item of expense is covered at least in part under any of the plans involved, except where a statute requires a different definition.

2. Notwithstanding this definition, items of expense under coverages, such as dental care, vision care, prescription drug or hearing-aid programs, may be excluded from the definition of allowable expense. A plan which provides benefits only for any of these items of expense may limit its definition of allowable expenses to like items of expense.

3. When a plan provides benefits in the form of service, the reasonable cash value of each service will be considered as both an allowable expense and a benefit paid.

4. The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an allowable expense under this definition unless the patient's stay in a private hospital room is medically necessary in terms of generally accepted medical practice.

5. When COB is restricted in its use to specific coverage in a contract (for example, major medical or dental), the definition of



allowable expense must include the corresponding expenses or services to which COB applies.

6. When benefits are reduced under a primary plan because a covered person does not comply with the plan provisions, the amount of this reduction will not be considered an allowable expense. Examples of these provisions are those related to second surgical opinions, precertification of admissions or services and preferred provider arrangements.

A. Only benefit reductions based upon provisions similar in purpose to those described previously and which are contained in the primary plan may be excluded from allowable expenses.

B. This provision shall not be used by a secondary plan to refuse to pay benefits because a health maintenance organization (HMO) member has elected to have health care services provided by a non-HMO provider and the HMO, pursuant to its contract, is not obligated to pay for providing those services. Note: Paragraph (2)(A)6. is not intended to allow a secondary plan to exclude expenses that are applied towards the satisfaction of the deductible, copayments or coinsurance amounts required by the primary plan, except for the benefit reductions expressly described in this paragraph;

(B) Claim. A request for benefits of a plan to be provided or paid is a claim. The benefit claimed may be in the form of—

1. Services (including supplies);
2. Payment for all or a portion of the expenses incurred;
3. A combination of paragraphs (2)(B)1. and 2.; or
4. An indemnification;

(C) Claim determination period. This is the period of time, which must not be less than twelve (12) consecutive months over which allowable expenses are compared with total benefits payable in the absence of COB, to determine whether overinsurance exists and how much each plan will pay or provide.

1. The claim determination period is usually a calendar year, but a plan may use some other period of time that fits the coverage of the group contract. A person may be covered by a plan during a portion of a claim determination period if that person's coverage starts or ends during the claim determination period.

2. As each claim is submitted, each plan is to determine its liability and pay or provide benefits based upon allowable expenses incurred to that point in the claim determination period. That determination is subject to

adjustment as later allowable expenses are incurred in the same claim determination period;

(D) Coordination of benefits. This is a provision establishing an order in which plans pay their claims;

(E) Hospital indemnity benefits. These are benefits not related to expenses incurred. The term does not include reimbursement-type benefits even if they are designed or administered to give the insured the right to elect indemnity-type benefits at the time of claim;

(F) Plan. Plan means a form of coverage with which coordination is allowed. The definition of plan in the group contract must state the types of coverage which will be considered in applying the COB provision of that contract. The right to include a type of coverage is limited by the rest of this definition.

1. The definition of plan shown in the sample COB provision, attached to this rule as Appendix A, is an example of what may be used. Any definition that satisfies this subsection may be used.

2. This rule uses the term plan. However, a group contract instead may use program or some other term.

3. Plan may include:

A. Group insurance and group subscriber contracts;

B. Uninsured arrangements of group or group-type coverage;

C. Group or group-type coverage through HMOs and other prepayment, group practice and individual practice plans;

D. Group-type contracts. Group-type contracts are contracts which are not available to the general public and can be obtained and maintained only because of membership in or connection with a particular organization or group. Group-type contracts answering this description may be included in the definition of plan, at the option of the insurer or the service provider and the contract client, whether or not uninsured arrangements or individual contract forms are used and regardless of how the group-type coverage is designed (for example, franchise or blanket). Individually underwritten and issued guaranteed renewable policies would not be considered group-type even though purchased through payroll deduction at a premium savings to the insured since the insured would have the right to maintain or renew the policy independently of continued employment with the employer. Note: The purpose and intent of this provision are to identify certain plans of coverage which may utilize other than a group contract but are administered on a basis more characteristic of group insurance.

These group-type contracts are distinguished by two (2) factors—1) they are not available to the general public, but may be obtained only through membership in, or connection with, the particular organization or group through which they are marketed (for example, through an employer payroll withholding system) and 2) they can be obtained only through that affiliation (for example, the contracts might provide that they cannot be renewed if the insured leaves the particular employer or organization, in which case they would meet the group-type definition). On the other hand, if these contracts are guaranteed renewable allowing the insured the right to renewal regardless of continued employment or affiliation with the organization, they would not be considered group-type;

E. Group or group-type hospital indemnity benefits which exceed one hundred dollars (\$100) per day;

F. The medical benefits coverage in group, group-type and individual automobile no-fault type contracts but, as to traditional automobile fault contracts, only the medical benefits written on a group or group-type basis may be included; and

G. Medicare or other governmental benefits, except as provided in subparagraph (2)(F)4.F. That part of the definition of plan may be limited to the hospital, medical and surgical benefits of the governmental program.

4. Plan shall not include:

A. Individual or family insurance contracts;

B. Individual or family subscriber contracts;

C. Individual or family coverage under other prepayment, group practice and individual practice plans;

D. Group or group-type hospital indemnity benefits of one hundred dollars (\$100) per day or less;

E. School accident-type coverages. These contracts cover grammar, high school and college students for accidents only, including athletic injuries, either on a twenty-four (24)-hour basis or on a to-and-from-school basis; and

F. A state plan under Medicaid and shall not include a law or plan when its benefits are in excess of those of any private insurance plan or other nongovernmental plan;

(G) Primary plan. A primary plan is a plan whose benefits for a person's health care coverage must be determined without taking the



existence of any other plan into consideration. A plan is a primary plan if either of the following conditions is true:

1. The plan either has no order of benefit determination rules or it has rules which differ from those permitted by this rule. There may be more than one (1) primary plan; or

2. All plans which cover the person, use the order of benefit determination rules required by this rule and under those rules the plan determines its benefits first;

(H) Secondary plan. A secondary plan is a plan which is not a primary plan. If a person is covered by more than one (1) secondary plan, the order of benefit determination provisions of this rule decide the order in which their benefits are determined in relation to each other. The benefits of each secondary plan may take into consideration the benefits of the primary plan(s) and the benefits of any other plan which, under the provisions of this rule, has its benefits determined before those of that secondary plan; and

(I) This plan. In a COB provision, this term refers to the part of the group contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the group contract providing health care benefits is separate from this plan. A group contract may apply one (1) COB provision to certain of its benefits (such as dental benefits), coordinating only with like benefits, and may apply other separate COB provisions to coordinate other benefits.

(3) Model COB Contract Provision.

(A) General Appendix A contains a model COB provision for use in group contracts. That use is subject to the provisions of subsections (3)(B) and (C) and to the provisions of section (4).

(B) Flexibility. A group contract's COB provision does not have to use the words and format shown in Appendix A. Changes may be made to fit the language and style of the rest of the group contract or to reflect the difference among plans which provide services, which pay benefits for expenses incurred and which indemnify. No other substantive changes are allowed.

(C) Prohibited Coordination of Benefit Design.

1. Contracts meeting the definition of plan as defined in subsection (2)(F) may not reduce benefits on the basis that—

A. Another plan exists;

B. A person is or could have been covered under another plan, except with respect to Part B of Medicare; or

C. A person has elected an option under another plan providing a lower level of benefits than another option which could have been elected.

2. No contract may contain a provision that its benefits are excess or always secondary to any plan as defined in this regulation, except in accord with the rules permitted by this regulation.

(4) Rules for Coordination of Benefits—Order of Benefits.

(A) General. The general order of benefits is as follows:

1. The primary plan must pay or provide its benefits as if the secondary plan(s) did not exist. A plan that does not include a coordination of benefits provision may not take the benefits of another plan as defined in subsection (2)(F) into account when it determines its benefits. There is one (1) exception—a contract holder's coverage that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder; and

2. A secondary plan may take the benefits of another plan into account only when, under these rules, it is secondary to that other plan.

(B) Order of Benefit Determination. Use the first of the following rules which applies:

1. Nondependent/dependent. The benefits of the plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the plan which covers the person as a dependent, except that, if the person is also a Medicare beneficiary and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is—

A. Secondary to the plan covering the person as a dependent; and

B. Primary to the plan covering the person as other than a dependent (for example, a retired employee), then the benefits of the plan covering the person as a dependent are determined before those of the plan covering that person as other than a dependent;

2. Dependent child/parents not separated or divorced. The rules for the order of benefits for a dependent child when the parents are not separated or divorced are as follows:

A. The benefits of the plan of the parent whose birthday falls earlier in a year are

determined before those of the plan of the parent whose birthday falls later in that year;

B. If both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time;

C. The word birthday refers only to the month and day in a calendar year, not the year in which the person was born; and

D. If the other plan does not have the rule described in subparagraphs (4)(B)2.A.–C. and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits;

3. Dependent child/separated or divorced parents. If two (2) or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

A. First, the plan of the parent with custody of the child;

B. Then, the plan of the spouse of the parent with the custody of the child; and

C. Finally, the plan of the parent not having custody of the child;

D. If the specific terms of a court decree state that one (1) of the parents is responsible for the health care expenses of the child and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent or spouse of the other parent shall be the secondary plan(s). This subparagraph does not apply with respect to any claim determination period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge; or

E. If the specific terms of the court decree state that the parents shall share joint custody, without stating that one (1) of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined in paragraph (4)(B)2., dependent child/parents not separated or divorced;

4. Active/inactive employee. The benefits of a plan which covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a plan which covers that person as a laid off or retired employee (or as that employee's dependent). If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. Note: This



paragraph does not supersede paragraph (4)(B)1. Coverage provided an individual as a retired worker and as a dependent of that individual's spouse as an active worker will be determined under paragraph (4)(B)1. This rule covers the situation where one (1) individual is covered under one (1) policy as an active worker and under another policy as a retired worker. It would also apply to an individual covered as a dependent under both of those policies;

5. Continuation coverage.

A. If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the following shall be the order of benefit determination:

(I) First, the benefits of a plan covering the person as an employee, member or subscriber (or as that person's dependent); and

(II) Second, the benefits under the continuation coverage.

B. If the other plan does not have the rule described previously and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. Note: The Consolidated Omnibus Budget Reconciliation Act of 1987 (COBRA) originally provided that coverage under a new group health plan caused the COBRA coverage to end. An amendment passed as part of H.R. 3299 (1989) allows the COBRA coverage to continue if the other group plan contains any preexisting condition limitation. In this instance, two (2) policies will cover an individual and the previous rule will be used to determine which of them assumes the primary position; and

6. Longer/shorter length of coverage. If none of these rules determines the order of benefits, the benefits of the plan which covered an employee, member or subscriber longer are determined before those of the plan which covered that person for the shorter term.

A. To determine the length of time a person has been covered under a plan, two (2) plans shall be treated as one (1) if the claimant was eligible under the second within twenty-four (24) hours after the first ended.

B. The start of a new plan does not include:

(I) A change in the amount or scope of a plan's benefits;

(II) A change in the entity which pays, provides or administers the plan's benefits; or

(III) A change from one (1) type of plan to another (such as, from a single

employer plan to that of a multiple employer plan).

C. The claimant's length of time covered under a plan is measured from the claimant's first date of coverage under that plan. If that date is not readily available, the date the claimant first became a member of the group shall be used as the date from which to determine the length of time the claimant's coverage under the present plan has been in force.

(5) Procedure to be Followed by Secondary Plan—Total Allowable Expenses.

(A) When it is determined pursuant to section (4) that a plan is a secondary plan, it may reduce its benefits so that the total benefits paid or provided by all plans during a claim determination period are not more than total allowable expenses. The amount by which the secondary plan's benefits have been reduced shall be used by the secondary plan to pay allowable expenses, not otherwise paid, which were incurred during the claim determination period by the person for whom the claim is made. As each claim is submitted, the secondary plan determines its obligation to pay for allowable expenses based on all claims which were submitted up to that point in time during the claim determination period.

(B) The benefits of the secondary plan will be reduced when the sum of the benefits that would be payable for the allowable expenses under the secondary plan, in the absence of this COB provision, and the benefits that would be payable for the allowable expenses under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made exceeds those allowable expenses in a claim determination period. In that case, the benefits of the secondary plan will be reduced so that they and the benefits payable under the other plans do not total more than those allowable expenses.

1. When the benefits of this plan are reduced as described previously, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this plan.

2. Paragraph (5)(B)1. may be omitted if the plan provides only one (1) benefit, or may be altered to suit the coverage provided.

(6) Miscellaneous Provisions.

(A) Reasonable Cash Values of Services. A secondary plan which provides benefits in the form of services may recover the reasonable cash value of providing the services from the

primary plan, to the extent that benefits for the services are covered by the primary plan and have not already been paid or provided by the primary plan. Nothing in this provision shall be interpreted to require a plan to reimburse a covered person in cash for the value of the services provided by a plan which provides benefits in the form of services.

(B) Excess and Other Nonconforming Provisions.

1. Some plans have order of benefit determination provisions not consistent with this rule which declare that the plan's coverage is excess to all others or always secondary. This occurs because certain plans may not be subject to insurance regulation or because some group contracts have not been conformed yet with this regulation.

2. A plan with order of benefit determination rules which comply with this rule (complying plan) may coordinate its benefits with a plan which is excess or always secondary or which uses order of benefit determination provisions which are inconsistent with those contained in this rule (noncomplying plan) on the following basis:

A. If the complying plan is the primary plan, it shall pay or provide its benefits on a primary basis;

B. If the complying plan is the secondary plan, it shall pay or provide its benefits first, nevertheless, but the amount of the benefits payable shall be determined as if the complying plan were the secondary plan. In this situation, the payment shall be the limit of the complying plan's liability; and

C. If the noncomplying plan does not provide the information needed by the complying plan to determine its benefits within a reasonable time after it is requested to do so, the complying plan shall assume that the benefits of the noncomplying plan are identical to its own, and shall pay its benefits accordingly. However, the complying plan must adjust any payments it makes based on this assumption whenever information becomes available as to the actual benefits of the noncomplying plan.

3. If the noncomplying plan reduces its benefits so that the employee, subscriber or member receives less in benefits than s/he would have received had the complying plan paid or provided its benefits as the secondary plan and the noncomplying plan paid or provided its benefits as the primary plan, then the complying plan shall advance to or on behalf of the employee, subscriber or member an amount equal to that difference. However, in no event shall the complying plan advance more than the complying plan would



have paid had it been the primary plan less any amount it previously paid. In consideration of this advance, the complying plan shall be subrogated to all rights of the employee, subscriber or member against the noncomplying plan. This advance by the complying plan also shall be without prejudice to any claim it may have against the noncomplying plan in the absence of that subrogation.

(C) Allowable Expense. A term, such as usual and customary, usual and prevailing or reasonable and customary, may be substituted for the term necessary, reasonable and customary. Terms, such as medical care or dental care, may be substituted for health care to describe the coverages to which the COB provisions apply.

(D) Facility of Payment and Recovery.

1. Whenever payments which should have been made under a plan have been made under any other plans, the insurer or service plan shall have the right, exercisable alone and in its sole discretion, to pay over to any organizations making the other payments any amounts it shall determine to be warranted in order to satisfy the intent of this rule and amounts so paid shall be deemed to be benefits paid under that plan and to the extent of these payments, the insurer or service plan shall be fully discharged from liability under its plan.

2. Whenever payments have been made by the insurer with respect to allowable expenses in a total amount at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this rule, the insurer or service plan shall have the right to recover these payments, to the extent of the excess, from among one (1) or more of the following, as the insurer or service plan shall determine: any persons to, or for, or with respect to whom the payments were made; any other insurers, service plans; or any other organizations.

3. Subrogation will not be allowed in any plan as distinguished from the rights to recovery.

(7) Effective Date, Existing Contracts.

(A) This subsection is applicable to every group contract which provides health care benefits and which is issued on or after the effective date of this rule (July 1, 1972).

(B) A group contract which provides health care benefits, is in force at the time of promulgation of these rules and which contains a COB provision not fully in compliance with these rules shall be brought into compliance with this rule by the later of—

1. The next anniversary date or renewal date of the group contract; or

2. The expiration of any applicable collectively bargained contract pursuant to which it was written.

Appendix A Model COB Provisions

Coordination of the Group Contracts Benefits With Other Benefits

I. APPLICABILITY

A. This coordination of benefits (COB) provision applies to this plan when an employee or the employee's covered dependent has health care coverage under more than one (1) plan. Plan and this plan are defined here.

B. If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of this plan are determined before or after those of another plan. The benefits of this plan—

(1) Shall not be reduced when, under the order of benefit determination rules, this plan determines its benefits before another plan; but

(2) May be reduced when, under the order of benefits determination rules, another plan determines its benefits first. This reduction is described in Section IV. Effect on the Benefits of This Plan—

II. DEFINITIONS

A. Plan is any of these which provides benefits or services for, or because of, medical or dental care or treatment:

(1) Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.

(2) Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act). Each contract or other arrangement for coverage under (1) or (2) is a separate plan. Also, if an arrangement has two (2) parts and COB rules apply only to one (1) of the two (2), each of the parts is a separate plan.

B. This plan is the part of the group contract that provides benefits for health care expenses.

C. Primary plan/secondary plan. The order of benefit determination rules state whether this plan is a primary plan or secondary plan as to another plan covering the person. When this plan is a primary plan, its benefits are determined before those of the other plan and without considering the other plan's benefits. When this plan is a secondary plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits. When there are more than two (2) plans covering the person, this plan may be a primary plan as to one (1) or more other plans and may be a secondary plan as to a different plan(s).

D. Allowable expense means a necessary, reasonable and customary item of expense for health care, when the item of expense is covered at least in part by one (1) or more plans covering the person for whom the claim is made. The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an allowable expense under this definition unless the patient's stay in a private hospital room is medically necessary either in terms of generally accepted medical practice or as specifically defined in the plan. When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an allowable expense and a benefit paid. When benefits are reduced under a primary plan because a covered person does not comply with the plan provisions, the amount of that reduction will not be considered an allowable expense. Examples of these provisions are those related to second surgical opinions, precertification of admissions or services, and preferred provider arrangements.

E. Claim determination period means a calendar year. However, it does not include any part of a year during which a person has no coverage under this plan or any part of a year before the date this COB provision or similar provision takes effect.

III. ORDER OF BENEFIT DETERMINATION RULES

A. General. When there is a basis for a claim under this plan and another plan. This plan is a secondary plan which has its benefits determined after those of the other plan, unless—

(1) The other plan has rules coordinating its benefits with those of this plan; and

(2) Both those rules and this plan's rules, in subsection III.B., require that this plan's benefits be determined before those of the other plan.



B. Rules. This plan determines its order of benefits using the first of the following rules which applies:

(1) Nondependent/dependent. The benefits of the plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the plan which covers the person as a dependent; except that—if the person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is—

(a) Secondary to the plan covering the person as a dependent; and

(b) Primary to the plan covering the person as other than a dependent (for example, a retired employee), then the benefits of the plan covering the person as a dependent are determined before those of the plan covering that person as other than a dependent.

(2) Dependent child/parents not separated or divorced. Except as stated in paragraph III.B.(3), when this plan and another plan cover the same child as a dependent of different persons, called parents—

(a) The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but

(b) If both parents have the same birthday, the benefits of the plan which covered one (1) parent longer are determined before those of the plans which covered the other parent for a shorter period of time. However, if the other plan does not have the rule described previously in III.B.(2)(a) or (b) and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

(3) Dependent child/separated or divorced. If two (2) or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

(a) First, the plan of the parent with custody of the child;

(b) Then, the plan of the spouse of the parent with the custody of the child; and

(c) Finally, the plan of the parent not having custody of the child. However, if the specific terms of a court decree state that one (1) of the parents is responsible for the health care expense of the child and the entity obligated to pay or provide the benefits of the plan of that parent or spouse of the other parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the sec-

ondary plan. This paragraph does not apply with respect to any claim determination period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

(4) Joint custody. If the specific terms of a court decree state that the parents shall share joint custody, without stating that one (1) of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined in paragraph III.B.(2).

(5) Active/inactive employee. The benefits of a plan which covers a person as an employee who is neither laid off nor retired are determined before those of a plan which covers that person as a laid off or retired employee. The same would hold true if a person is a dependent of a person covered as a retiree and an employee. If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule (5) is ignored.

(6) Continuation coverage. If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the following shall be the order of benefit determination:

(a) First, the benefits of a plan covering the person as an employee, member or subscriber (or as that person's dependent); and

(b) Second, the benefits under the continuation coverage. If the other plan does not have the rule described here and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

(7) Longer/shorter length of coverage. If none of the previous rules determines the order of benefits, the benefits of the plan which covered an employee, member or subscriber longer are determined before those of the plan which covered that person for the shorter term.

IV. EFFECT ON THE BENEFITS OF THIS PLAN

A. When This Section Applies. This section IV. applies when, in accordance with section III., Order of Benefit Determination Rules, this plan is a secondary plan as to one (1) or more other plans. In that event the benefits of this plan may be reduced under this section. Other plan(s) are referred to as the other plans in IV.B. immediately following.

B. Reduction in this plan's benefits. The benefits of this plan will be reduced when the sum of:

(1) The benefits that would be payable for the allowable expense under this plan in the absence of this COB provision; and

(2) The benefits that would be payable for the allowable expenses under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made, exceeds those allowable expenses in a claim determination period. In that case, the benefits of this plan will be reduced so that they and the benefits payable under the other plans do not total more than those allowable expenses. When the benefits of this plan are reduced as described previously, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this plan.

V. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts are needed to apply these COB rules. (Insurer) has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. (Insurer) need not tell, or get the consent of, any person to do this. Each person claiming benefits under this plan must give (insurer) any facts it needs to pay the claim.

VI. FACILITY OF PAYMENT

A payment made under another plan may include an amount which should have been paid under This Plan. If it does, (insurer) may pay that amount to the organization which made the payment. That amount will then be treated as though it were a benefit paid under this plan. (Insurer) will not have to pay that amount again. The term, payment made includes providing benefits in the form of services, in which case payment made means reasonable cash value of the benefits provided in the form of services.

VII. RIGHT OF RECOVERY

If the amount of the payments made by (insurer) is more than it should have paid under this COB provision, it may recover the excess from one (1) or more of—

A. The person it has paid or for whom it has paid;

B. Insurance companies; or

C. Other organizations. The amount of the payments made includes the reasonable cash value of any benefits provided in the form services.



VIII. Subrogation will not be allowed in any plan as distinguished from the rights to recovery.

AUTHORITY: sections 354.120, 374.045 and 376.405, RSMo 1986. This rule was previously filed as 4 CSR 190-14.050. Original rule filed June 15, 1972, effective July 1, 1972. Amended: Filed Dec. 20, 1974, effective Dec. 30, 1974. Amended: Filed Jan. 13, 1982, effective April 15, 1982. Emergency amendment filed May 12, 1982, effective May 24, 1982, expired Sept. 10, 1982. Amended: Filed May 12, 1982, effective Oct. II, 1982. Amended: Filed July 3, 1985, effective Jan. 1, 1986. Amended: Filed Dec. 1, 1989, effective May 1, 1990. Amended: Filed April 4, 1991, effective Oct. 31, 1991.*

**Original authority: 354.120, RSMo 1973, amended 1983; 374.045, RSMo 1967; and 376.405, RSMo 1959, amended 1984.*

20 CSR 400-2.040 Notice to Parents of Group and Blanket Student Accident Policies

PURPOSE: This rule describes certain notices and contents of these notices to be given to parents of students concerning group and blanket student accident insurance policies. This rule was adopted pursuant to the provisions of section 374.045, RSMo and implements sections 376.405 and 376.777(7), RSMo.

(1) Whenever any blanket, group, individual or other student accident insurance is sold to students of any school or college for which any premium is paid by the student or his/her parents or guardian, the parents or guardian shall be notified before they are required to contribute to the premium for this insurance, by brochure or folder attached to the envelope or other container for remittal of premium, the factors listed in the following:

(A) A true and accurate description of the coverage afforded by the policy in clearly understandable and concise language. This must include:

1. The deductible amount, if any;
2. The existence and primary effect of any coordination of benefits provision;
3. The effects of any excess provisions;
4. Whether the coverage is for twenty-four (24) hours each day or for a lesser time interval (if a lesser time interval is indicated, a description of that time interval must be included);

5. A statement as to whether the protection is for the full calendar year or for the

school term or other clearly defined time interval;

6. Amount of premium for each child covered;

7. Where claim forms may be obtained;

8. The policy number or the insurer's method of identifying the policy; and

9. The name and address of the insurance company issuing the policy.

(2) If a certificate is issued to the parent or guardian or child on this policy, then the items listed may be included in the certificate. The notice or certificate shall be delivered to the parents' or guardians' home.

AUTHORITY: sections 374.045, 376.405 and 376.777, RSMo 1986. This rule was previously filed as 4 CSR 190-14.070. Original rule filed Sept. 18, 1974, effective Sept. 28, 1974.*

**Original authority: 374.045, RSMo 1967; 376.405, RSMo 1959, amended 1984; and 376.777, RSMo 1959, amended 1984.*

20 CSR 400-2.050 Notice of Renewal Dates on Renewable Policies

PURPOSE: This rule specifies requirements for notice of renewal dates for policies of accident and sickness insurance. This rule was adopted pursuant to the provisions of section 374.045, RSMo and implements and defines sections 375.445 and 376.777, RSMo.

(1) All companies issuing renewable individual health and accident policies in Missouri on which premiums are remitted directly by the policyholder to the company shall mail or deliver written notice of renewal to the insured not less than seven (7) days before a monthly renewal after a longer period of time.

(A) This notice shall contain the following information in language concise and readily understandable to the policyholder:

1. Date the premium is due;
2. Amount of premium then due;
3. Period of time for which that premium will keep the policy in effect; and
4. Any change in benefits effective upon renewal.

(2) This rule shall not include indirect payment plans as preauthorized checks or payroll deduction plans. Preissued coupon booklets are exempted where delivered personally or by certified mail.

AUTHORITY: sections 374.045, 375.445 and 376.777, RSMo 1986. This rule was previously filed as 4 CSR 190-14.080. Original rule filed Sept. 18, 1974, effective Sept. 28, 1974.*

**Original authority: 374.045 and 375.445, RSMo 1967; and 376.777, RSMo 1959 amended 1984.*

20 CSR 400-2.060 Policy Approval Criteria

PURPOSE: This rule specifies the criteria that must be found in policies of accident and health insurance before the director will approve these policies for use in this state. This rule is adopted pursuant to the provisions of section 374.045, RSMo and implements and defines sections 375.936, 376.405, 376.775 and 376.777, RSMo.

(1) Application. From the effective date of this rule, application forms, policies, riders and endorsements to policies of health and accident insurance will not be approved for use in this state unless they conform to the criteria stated. This disapproval shall meet the statutory procedural requirements of sections 376.405 and 376.777, RSMo.

(2) Definitions in Policy Submittals.

(A) Alcoholism treatment facility shall be substantially defined in policies as a residential or nonresidential facility certified by the Department of Mental Health for treatment of alcoholism.

(B) Hospital shall be substantially defined in policies as a legally constituted institution (or an institution which operates pursuant to law) having organized facilities for the care and treatment of sick and injured persons on a resident or inpatient basis, including facilities for diagnosis and surgery under the supervision of a staff of one (1) or more licensed physicians and which provides twenty-four (24)-hour nursing service by registered nurses on duty or call. It does not mean convalescent, nursing, rest or extended care facilities or facilities operated exclusively for treatment of the aged, drug addict or alcoholic, even though the facilities are operated as a separate institution by a hospital. Notwithstanding any other language in this rule, the definition of hospital contained in this rule shall not apply to Medicare supplement policies.

(C) Intensive care unit shall be substantially defined in policies as that part of a hospital service specifically designed as an intensive care unit permanently equipped and staffed to provide more extensive care for critically ill or injured patients than available



in other hospital rooms or wards, the care to include close observation by trained and qualified personnel whose duties are primarily confined to the part of the hospital for which an additional charge is made.

(3) Elements of Coverage Required.

(A) If individual benefits are not actually provided for those insured who have joined the military, the contract must contain a phrase or wording advising same and substantially indicating that—"Upon notice to the company of entry into such service, the *pro rata* unearned premiums shall be refunded." Companies, as an optional provision, may utilize a military suspension clause permitting the insured to reinstate his/her policy after discharge from the military without showing evidence of insurability.

(B) If benefits under any individual contract of accident or sickness are reduced or reducible because of the insured's age, the policy must so state in conspicuous print in a conspicuous location in the policy.

(C) No application form will be approved containing such statements as "No information acquired by any representative of the company shall be binding upon the company unless written herein." The company may specifically disclaim any insurance producer's authority to waive a complete answer to any question in the application, pass on insurability, make or alter any contract or waive any of the company's other rights or requirements.

(D) No hospital reimbursement policy may exclude payment for services rendered in a government or state hospital if the insured is legally required to pay for the services or charges in the absence of insurance. Any exclusion subsequently approved must therefore state "unless the insured is legally required to pay in the absence of insurance." This provision does not apply to hospital or cash indemnity contracts subject to 20 CSR 400-2.020.

(E) In calculating benefits payable, the policy or certificate deductible first shall be applied to the allowable expenses covered by the policy or certificate prior to applying any applicable coinsurance factor.

(F) Any policy or certificate of accident or health insurance or any accidental death or dismemberment benefit provided in or supplemental to a policy or certificate of accident or health insurance shall not include any language which requires that accidental bodily injury be effected solely through external, violent and accidental means. Any policy or certificate of accident or health insurance, or

any benefit for accidental death or dismemberment provided in or supplemental to, a policy or certificate of accident or health insurance shall not exclude payment of benefits for any covered loss, as provided in the contract, due to suicide or any attempt at suicide while insane; unintentional or nonvoluntary inhalation of gas or taking of poisons; pyogenic infections which result from an accidental bodily injury; bacterial infections which result from the accidental ingestion of contaminated substances; or the insured's being under the influence of drugs if these drugs were taken as prescribed by a physician.

(G) All group health insurance policies providing coverage on an expense-incurred basis, all group service or indemnity contracts issued by a not-for-profit health service corporation, all self-insured group health benefit plans, of any type or description and all these health plans or policies that are individually underwritten or provide for coverage for specific individuals and the members of their families as nongroup policies, which provide for hospital treatment, shall provide coverage while confined in a hospital or alcoholism treatment facility, for the treatment of alcoholism on the same basis as coverage for any other illness, except that coverage may be limited to thirty (30) days in any policy or contract benefit period.

(4) Essential Conditions to be Contained.

(A) If a certificate or coverage booklet used in lieu of a certificate is to be delivered to a member of a group insured under a master contract, the certificate or coverage booklet must be submitted for approval with the master contract. This also shall apply to blanket policies.

(B) Provisions in master contracts for group plans which are necessarily unique to each particular group policyholder, such as eligibility requirements, benefit amounts and time or waiting periods, may be filed as being variable with appropriate examples. This must be accompanied by a statement describing the nature and scope of the variations. Other less variable language, such as inclusion or exclusion of certain clauses, must be submitted with all variations.

(C) The definition of total disability may be no more restrictive than the following: Total disability means the insured's inability, because of sickness or injury, to perform the material and substantial duties of the insured's occupation for a period of at least twelve (12) months, unless the total benefit period is less than twelve (12) months. After

the initial benefit period, total disability shall mean the insured's inability to perform the material and substantial duties of any occupation for which the insured is qualified by education, training or experience. In a policy that also provides benefits for residual disability, however, the definition of total disability may require that the insured not be gainfully employed in any occupation.

(D) Residual disability shall be defined in relation to the insured's reduction in earnings and may be related either to the insured's inability to perform some part of the material and substantial duties of employment or to perform all usual business duties for as much time as is usually required. A policy which provides residual disability benefits may require a qualification period, during which the insured must be continuously, totally disabled before residual disability benefits are payable. The qualification period for residual benefits may be longer than the elimination period for total disability. In lieu of the term residual disability, an insurer may use proportionate disability or other term of similar import which in the opinion of the director adequately and fairly describes the benefit.

(E) Each company, within sixty (60) days of home office receipt of the application for an individually underwritten health or accident insurance contract, shall notify a prospective insured as to whether or not the application has been accepted or else give the prospective insured the reason for any further delay.

(F) No policy may exclude coverage for self-inflicted injuries resulting from attempted suicide while insane. Exclusions or exemptions which presently exclude coverage for death or injury arising out of a suicide or any attempt suicide while sane or insane or which exclude coverage for intentionally self-inflicted injuries shall delete the words . . . or insane and provide for payment for self-inflicted injuries while insane. A policy may exclude coverage for intentionally self-inflicted injury obviously not an attempted suicide.

(G) Policy language intended to exclude coverage for occupational injuries or illnesses may exclude injuries or illnesses arising out of or in the course of employment or an occupation for wage, profit or gain. More restrictive provisions which exclude coverage for duties performed on an occasional or sporadic basis will not be permitted.

(5) Benefit Reduction Clauses.

(A) No disability insurance policy forms may provide for reduction in the amount of benefits payable to the insured under the



insurance policy due to eligibility for disability or retirement benefits under the Social Security program or any partially or wholly employer-funded plans unless—

1. The policy provides a minimum amount payable regardless of the reduction of fifteen percent (15%) of the benefits specified in the contract or fifty dollars (\$50) per month, whichever is greater;

2. The amount of the reduction is not increased with any increase in the level of Social Security benefits payable which becomes effective after the first day for which the insurance disability benefits become payable; and

3. In no event shall a reduction in the benefits be made due to eligibility or receipt of retirement benefits resulting from employment other than employment through which the disability insurance benefits were made available.

(B) All group disability income policies delivered or issued for delivery after June 15, 1982 shall comply with its provisions upon delivery or issue. All existing group policies shall be amended to comply on the next renewal anniversary date following June 15, 1982.

(6) Ambulatory Surgical Centers.

(A) No individual or group accident and sickness insurance policy will be approved by the director which does not provide coverage for all services performed at a duly licensed ambulatory surgical center which are covered as a hospital inpatient benefit, are within the scope of the license of the ambulatory surgical center and would normally require hospital rather than office or clinic care. In keeping with the essential purpose of ambulatory surgical centers, this rule in no way shall be construed to require the same level or dollar amount of benefits to be paid for services performed in an ambulatory surgical center as is paid to a hospital or on account of inpatient hospital treatment.

(B) Any policy not in compliance with this rule shall be deemed to provide equal benefits in scope and amount for ambulatory surgical center services as for inpatient hospital care until amended or replaced by an approved policy form.

(7) Variable Deductible.

(A) The variable deductible provision may be stated in substance as to basic deductible (a stated dollar amount) or the other coverage deductible (stated as the amount of benefits payable under other valid coverage for the same loss) whichever is greater. A variable

deductible may not be stated as the aggregate of the basic deductible plus the other coverage deductible.

(B) All policies forms utilizing a variable deductible shall contain a prominent notice (printed, stamped or attached to their policy face page or schedule page) stating that the actual deductible amount for each claim may vary depending on other medical expense insurance the insured may have.

(C) Other valid coverage shall include only benefits actually provided for the same loss by medical expense coverage by any other group or individual hospital, surgical or medical insurance policy or medical practice or other prepayment plan or any other plan or program whether insured or uninsured or by reason of state or federal law. Other valid coverage may also include automobile medical payment coverage provided that this inclusion is clearly disclosed in the policy.

(D) If at the time a claim arises the variable deductible results in the imposition of a deductible amount greater than the stated basic deductible, the disposition of the claim shall include a clear written statement to the insured explaining how benefits were calculated and the effect of the variable deductible. This written notice shall advise the insured, as follows:

1. To review his/her insurance needs because of other coverage;

2. S/he may request an increased basic deductible if the present basic deductible is not the highest available through the insurer, at an appropriate reduction in premium rate in accordance with the applicable rates on file by the insurer; and

3. If appropriate, any subsequent request to decrease the basic deductible will require evidence of insurability acceptable to the insurer.

(E) Variable deductible may be contained only in insurance policies or certificates which are individually underwritten.

(F) If more than one (1) policy containing a variable deductible provides benefits for medical expenses incurred due to a loss by one (1) individual, the amount of benefits payable by each company shall be determined as follows:

1. After applying benefits payable under any plan(s) not containing variable deductibles, each variable deductible plan shall share remaining expenses on a *pro rata* basis; and

2. Each variable deductible plan's *pro rata* share of expenses shall be that portion of the total remaining expenses as each plan's

benefits bears to the total benefits payable under all variable deductible plans.

AUTHORITY: sections 374.045, 375.936, 376.405, 376.775 and 376.777, RSMo 2000. This rule was previously filed as 4 CSR 190-14.090. Original rule filed Feb. 26, 1975, effective March 15, 1975. Amended: Filed Dec. 23, 1975, effective March 1, 1976. Amended: Filed Aug. 16, 1979, effective Nov. 15, 1979. Amended: Filed Feb. 17, 1982, effective June 15, 1982. Amended: Filed May 13, 1983, effective Nov. 11, 1983. Amended: Filed Sept. 12, 1984, effective March 11, 1985. Amended: Filed May 13, 1985, effective Aug. 26, 1985. Amended: Filed July 12, 2002, effective Jan. 30, 2003.*

**Original authority: 374.045, RSMo 1967, amended 1993, 1995; 375.936, RSMo 1959, amended 1967, 1969, 1971, 1976, 1978, 1983, 1991; 376.405, RSMo 1959, amended 1984; 376.775, RSMo 1959; and 376.777, RSMo 1959, amended 1984.*

Op. Atty. Gen. No. II2, Edmiston, 6-21-76. Insurance companies are required to pay a filing fee pursuant to section 374.230(6), RSMo for documents filed with the director of the Division of Insurance pursuant to sections 376.405, 376.675, 376.777, RSMo (1969) and section 379.321, RSMo (Supp. 1975). The filing fee imposed by section 374.230(6) is for each document and not each page of each document. The filing fee paid pursuant to section 374.230(6) is not, pursuant to section 148.400, RSMo, deductible from the premium taxpayable by such companies.

20 CSR 400-2.065 Actual Payment as Basis for Policy or Plan Calculations

PURPOSE: This rule effectuates or aids in the interpretation of the following sections: 354.085 and 354.430(1), RSMo relating to certain policy forms that contain provisions which are deceptive, ambiguous, misleading, unfair, unjust, or inequitable; 354.350 and 375.445, RSMo regarding the carrying out of contracts in good faith; 354.410.1(2) and 354.430.3(2), RSMo pertaining to reasonable requirements for copayments; 354.085, 376.405 and 376.777, RSMo regarding whether policy forms contain such words, phraseology, conditions and provisions which are specific, certain and reasonably adequate to meet the needed requirements for the protection of those insured; and 354.410.1(9), RSMo relating to operating contrary to the public interest.



(1) Definitions. As used in this rule—

(A) “Actual payment,” the real total dollar amount actually paid or to be paid in fact, by a health insurer, or by the health insurer and the insured when the insured is responsible for some part of the cost, to a health services provider for a health service(s) pursuant to a health plan. Annual adjustments in amounts paid to providers which are based on referral rates, quality or cost effectiveness measurements, or other similar contractual provisions may be excluded from the calculation of actual payments, at the option of the health insurer.

(B) “Expense participation,” a financial contribution that the insured is required by the health plan to pay for a health service(s). “Expense participation” includes, but is not limited to, these forms of expense participation: deductibles, copayments, coinsurance, and additional charges by the health insurer that are caused by a failure to follow the utilization management or other requirements of the health plan;

(C) “Health insurer,” any person, fraternal benefit society, and any other legal entity engaged in the business of insurance, including producers, adjusters, public adjusters and third-party administrators. “Health insurer” shall also mean health services corporations, health maintenance corporations, prepaid limited health care service plans, optometric and other similar health service plans, preferred provider plans, managed care plans, point-of-service plans, and multiple employer self-insured health plans. For the purpose of this rule, these foregoing entities are deemed to be engaged in the business of insurance. “Health insurer” shall also include all companies organized, incorporated or doing business under the provisions of Chapters 374, 375, 376, 378, 379, RSMo; provided that only persons or entities which offer, issue, manage or administer a health plan shall be deemed to be a “health insurer;”

(D) “Health plan,” any insurance contract, policy or certificate, or any contract, plan or arrangement, which provides for the payment of a health service provider’s charges for health services provided to insured. “Health plan” does not include any policy of workers compensation insurance or the medical payments portion of any automobile, homeowners or other property and casualty insurance policy;

(E) “Health services,” any service or product for which provision for benefits has been made under a health plan, including but not limited to, the health care and services provided by hospitals, or other health care institutions, organizations, associations or groups, and by doctors of medicine, osteopathy, chiropractic, psychiatry, optometry, and podiatry, and shall also include nursing services,

preventative health care services, health screening, prenatal care, medical appliances, equipment and supplies, drugs, medicines, ambulance services, mental health services, supplemental services, and other therapeutic services and supplies, and laboratory analysis, physical examinations, the rendering of assistance to physicians, and services for drugs and alcohol abuse, physiotherapy, anesthesiology, and anesthesia;

(F) “Health services provider,” any person or entity providing health services;

(G) “Insured,” any individual covered by a health plan; and

(H) “Person,” any natural or artificial entity, or aggregate of such entities, including, but not limited to, individuals, partnerships, associations, trusts or corporations.

(2) Expense Participation. Under any health plan which provides for expense participation, whether in the form of coinsurance, copayments, a deductible or otherwise, such that the expense participation is to be computed as a percentage of, or as a function of the health service provider’s charge(s) for a health service(s), the charge used in such computation shall always and solely be no greater than the actual payment(s) made to the health service provider.

(3) Benefit Caps. Under any health plan which establishes benefit maximums or caps, such benefit maximums or caps shall always and solely be determined using a basis that is no greater than the actual payment(s) made to the health service provider.

(4) No Limitation. Nothing in this rule limits a health insurer’s right to pay some or all of an insured’s expense participation share of any charge for health services, or to exceed an insured’s benefit maximum or cap.

(5) Insurer-Provider Contract. This rule addresses the basis for calculating expense participation and benefit maximums or caps, and in no way affects the relationship or negotiations between health insurers and health services providers.

AUTHORITY: sections 354.120, 374.045 and 376.405, RSMo 2000 and sections 354.085 and 354.485, RSMo Supp. 2007. Original rule filed Nov. 1, 2007, effective July 30, 2008.*

**Original authority: 354.085, RSMo 1973, amended 1983, 2000; 354.120, RSMo 1973, amended 1983, 1993, 1995; 354.485, RSMo 1983, amended 2007; 374.045, RSMo 1967, amended 1993, 1995; and 376.405, RSMo 1959, amended 1984.*

20 CSR 400-2.070 Conversion Privilege

PURPOSE: This rule requires a conversion privilege from group health insurance policies. Family health insurance coverage should not terminate abruptly upon the death of one family member, leaving the surviving family members without health insurance coverage by effect of group contract terms. These contracts are not “reasonably adequate to meet needed requirements for the protection of those insured,” section 376.405, RSMo and will not be approved for use in this state. This rule was adopted pursuant to section 374.045, RSMo 1986 and implements sections 376.405 and 376.777, RSMo.

(1) Group Conversion Privilege Required.

(A) Any insurer authorized to write accident and sickness insurance in this state must offer a conversion privilege as part of each group policy to apply following the death of any certificate holder or other person upon whose employment, membership or other status eligibility for the coverage is predicated.

(B) Each conversion privilege must—

1. Consist of an offer by the insurer to issue to the surviving spouse or other dependents without evidence of insurability a conversion policy upon written application by the surviving spouse or dependents;

2. Be effective from the termination of coverage under the group plan with no intervening periods of contestability, time limit on certain defenses or preexisting conditions any greater than the unexpired portion of those provisions in the group contract from which the conversion is being made;

3. Extend the option to convert if the surviving spouse has not been notified by either the insurer or the group policyholder within fifteen (15) days prior to expiration of the thirty (30)-day conversion period, an additional thirty (30) days after the expiration of the thirty (30)-day conversion period; and

4. Be explained in each certificate, booklet certificate or other evidence of coverage under the group policy.

(2) Extent of Coverage. Any conversion policy issued pursuant to the requirements of sections 376.395–376.404, RSMo must include coverage for maternity expense if the group policy provided this coverage. The requirements of this section shall apply only to certificates of insurance delivered or issued for delivery to Missouri residents.



AUTHORITY: sections 374.045, 376.405 and 376.777, RSMo 1986. This rule was previously filed as 4 CSR 190-14.100. Original rule filed Dec. 23, 1975, effective Feb. 1, 1976. Amended: Filed Feb. 14, 1984, effective June 18, 1984.*

**Original authority: 374.045, RSMo 1967; 376.405, RSMo 1939, amended 1967; and 376.777, RSMo 1959, amended 1984.*

20 CSR 400-2.080 Conversion: Semiprivate Room Rate

PURPOSE: This rule establishes the average semiprivate room rate charged in the largest major metropolitan area of this state. This rate is designed for use in connection with conversion of group policies. This rule is adopted pursuant to the provisions of sections 354.120, 375.045 and 376.395-376.404, RSMo.

(1) Definitions.

(A) Average semiprivate room rate means the average prevailing charge for a semiprivate room in the St. Louis major metropolitan area.

(B) Semiprivate room means a hospital room consisting of two (2) or more beds.

(2) The average semiprivate room rate for purposes of sections 376.395-376.404, RSMo shall be an amount of no more than two hundred fifty-five dollars (\$255) per day. This rate may be redetermined by the director of insurance from time-to-time, but shall not be made more often than once every three (3) years as provided in section 376.397, RSMo.

AUTHORITY: sections 354.120, 374.045, 376.395, 376.397, 376.398, 376.401, 376.403 and 376.404, RSMo 1986. This rule was previously filed as 4 CSR 190-14.120. Original rule filed Feb. 23, 1983, effective June 15, 1983. Amended: Filed Aug. 29, 1986, effective Dec. 11, 1986. Amended: Filed Oct. 13, 1989, effective Jan. 15, 1990.*

**Original authority: 354.120, RSMo 1973 amended 1983; 374.045, RSMo 1967; 376.395, 376.397, 376.398, 376.401, 376.403, RSMo 1981; and 376.404, RSMo 1959, amended 1984.*

20 CSR 400-2.090 Group Health Classification

PURPOSE: This rule implements the provisions of sections 375.786 (unauthorized insurers), 375.791.2 (foreign insurers),

375.014 (agent licensing), 375.071 (broker licensing), 376.405 (group insurance form filing and approval) and 376.421, RSMo (authorized group insurance), defines certain underwriting and rating practices as prohibited pursuant to section 375.936, RSMo (unfair trade practices) and ensures that group health insurance coverages solicited and sold in the state conform to applicable Missouri requirements.

(1) No health insurance of any kind may be solicited or sold, or both, to an employer, union or similar organizational unit located in Missouri unless the insurer for which it is being solicited or sold, or both, has a valid certificate of authority in accordance with the requirements of sections 375.786 and 375.791.2, RSMo.

(2) No health insurance of any kind may be solicited or sold, or both, to an employer, union or similar organizational unit located in Missouri unless the person or entity making these solicitations or sales, or both, is a duly licensed insurance producer in accordance with the requirements of sections 375.014 and 375.071, RSMo and holds a current and valid appointment with the insurer for which these solicitations or sales, or both, are made.

(3) Section 376.421.1, RSMo defines those entities eligible for group health insurance issued in Missouri. Section 376.421.2, RSMo applies to group coverages offered or provided in Missouri other than specifically authorized in section 376.421.1, RSMo. Individual evidence of insurability may be required as to both section 376.421.1 and 376.421.2, RSMo groups and these groups may exclude or limit coverage as to any individual as to whom evidence of insurability is unsatisfactory.

(4) Group policies issued to a multiple employer or union trust in Missouri or any other state as described in section 376.421.1(4), RSMo under which coverages are solicited and sold to employer, union or other organizational units located in Missouri shall be subject to the following requirements of this section:

(A) The following practices based solely on individual health conditions, individual claims experience or deterioration of health shall be deemed an unfair discrimination in violation of section 375.936(11)(b), RSMo:

1. Any adjustment of premium contribution applicable to an individual within a unit of the group;

2. Any requirement that an individual(s) within a unit of the group must be reinstated or reunderwritten as a condition of continued eligibility in the group; and

3. The termination of eligibility of any individual within a unit of the group;

(B) Any entity issuing a policy to a trust to provide coverage to multiple employers, unions or similar organizational units, as to these employers, unions or similar organizational units located in Missouri, shall be subject to the following disclosure requirements:

1. All solicitation or sales materials used at point of solicitation; the group policy and other plan documents, if any, issued to the employer, union or similar organizational unit; and the certificates or other evidence of coverage delivered to covered members must disclose, in terms sufficiently clear to put a reasonably prudent person on notice, the following matters:

A. Whether tier or different rate levels, different trusts, different pools or any other similar mechanisms have been established for the purpose of effecting different premium rates applicable to an individual unit covered by the group policy and, if so, the frequency within which a unit may be reclassified for a different rate and the formula or amount by which these rate level classifications differ;

B. Whether renewal rates will be calculated on the basis of experience within the entire group or on the basis of experience as to individual units or on a combination of both;

C. Whether and to what extent individual units within the group can be cancelled or nonrenewed solely on the basis of deterioration of health of one (1) or more covered members within the unit; and

D. The period of time in advance of the premium due date within which notification is provided as to any premium rate change applicable to the policyholder or any individual unit to which the change applies; and

2. Failure to provide adequate disclosure in accordance with this paragraph shall be deemed an unfair trade practice in violation of section 375.936(6), RSMo.

(C) All these coverages solicited and sold to employers, unions or similar organizational units located in Missouri shall conform in all respects to applicable requirements of Missouri law.

(5) This rule supersedes the previous version of 20 CSR 400-2.090 which was effective January 1, 1989. Sections (1)-(3) and



subsection (4)(A) of this new rule shall take effect on September 15, 1989. Subsections (4)(B) and (C) of this rule shall take effect and apply to all solicitations or sales, or both, commencing on and after December 14, 1989.

AUTHORITY: section 374.045, RSMo 2000. This rule was previously filed as 4 CSR 190-14.130. Original rule filed July 14, 1988, effective Jan. 1, 1989. Rescinded and readopted: Filed June 6, 1989, effective Sept. 15, 1989. Amended: Filed July 12, 2002, effective Jan. 30, 2003.*

**Original authority: 374.045, RSMo 1967, amended 1993, 1995.*

20 CSR 400-2.100 Standards for HIV Testing

PURPOSE: This rule establishes standards for the use of HIV testing by insurers, health service corporations and health maintenance organizations. This rule is promulgated pursuant to section 374.045, RSMo and implements section 191.671, RSMo.

(1) Definitions.

(A) Applicant shall mean the proposed insured.

(B) HIV means the human immunodeficiency virus that causes acquired immunodeficiency syndrome (AIDS).

(C) HIV testing shall mean the performing of a serological test or other tests upon a biological specimen to determine the presence of HIV or its antibodies in the specimen.

(D) Policy shall mean all life and health insurance policies or contracts including both individual and group coverages.

(2) Whenever an applicant is requested to submit to HIV testing in connection with an application for an insurance policy, the insurer shall—

(A) Obtain written informed consent from the applicant;

(B) Reveal the use of the test to the applicant;

(C) Provide the applicant with basic information on the means of HIV transmission, HIV testing methodology, the meaning of the results for the specific test(s) to be utilized, behaviors necessary to reduce the risk of infection with HIV, and sources of further information on HIV infection/aids such as the National AIDS Hotline or the Missouri AIDS Hotline;

(D) Make all reasonable efforts to obtain

from the applicant the name and address of a physician to which HIV testing results that are other than normal will be reported;

(E) Ensure that an initial positive HIV screening test is followed by a confirmatory test, for example, following the ELISA and Western Blot protocols; and

(F) Disclose the HIV test results in accordance with section 191.671, RSMo. If the applicant does not designate a physician, the insurer, health service corporation or health maintenance organization shall disclose the identity of any applicant residing in Missouri having a confirmed positive HIV test result to the Missouri Department of Health—Bureau of STD/HIV Prevention, P.O. Box 570, Jefferson City, MO 65102. Any disclosure to the Missouri Department of Health shall be made in accordance with procedures acceptable to the Bureau of STD/HIV Prevention.

(3) A medical test to determine the presence of HIV virus, its component parts, its antibodies or other evidence of HIV infections, or a medical test for sickness or medical condition derived from this infection shall only be required of or given to a person if the test is based on the person's current medical condition or medical history or triggered by threshold coverage amounts which apply to all persons within the risk class.

AUTHORITY: section 374.045, RSMo Supp. 1995. This rule was previously filed as 4 CSR 190-14.140. Original rule filed Aug. 15, 1988, effective Jan. 13, 1989. Amended: Filed May 31, 1996, effective Jan. 30, 1997.*

**Original authority: 374.045, RSMo 1967, amended 1993, 1995.*



EXHIBIT A

Examiner [grid]
Address [grid]

Insurer [grid]
Address [grid]

NOTICE AND CONSENT FOR TESTING OF BIOLOGICAL SPECIMENS TO INCLUDE HIV (AIDS VIRUS) TESTING

To determine your insurability, the Insurer named above (the Insurer) has requested that you provide a biological specimen for testing and analysis. All tests will be performed by a licensed laboratory.

Unless precluded by law, tests will be performed to determine the presence of HIV (the AIDS virus), its component parts, or its antibodies. These tests are extremely reliable. Other tests which may be performed include determinations of blood cholesterol and related lipids (fats), cotinine, cocaine, and screening for liver or kidney disorders, diabetes, and immune disorders.

All test results will be treated confidentially. They will be reported by the laboratory to the Insurer. When necessary for business reasons in connection with insurance you have or have applied for with the Insurer, the Insurer may disclose test results to others such as its affiliates, reinsurers, employees or contractors. If a biological specimen other than blood is tested to determine the presence of HIV virus, its component parts, or its antibodies, the Insurer may at a later time request a specimen of your blood for further HIV testing. If you choose to decline that request, the results of all testing which has been performed will be provided to the physician which you have designated to receive such results. In addition, if the insurer is a member of the Medical Information Bureau (MIB, Inc.) and you choose to decline the request that you submit a blood specimen for further HIV testing, the Insurer will report to the MIB, Inc. a generic code which specifies only a non-specific blood test has been ordered and not received. Regardless of the number of tests requested, if the final HIV testing results (including the results of any confirmatory tests dictated by standard medical practice) are other than normal, the Insurer will report to the MIB, Inc. a generic code which signifies only a non-specific test abnormality. If your final HIV testing results are normal, no report will be made about it to the MIB, Inc. Other test results may be reported to the MIB, Inc. in a more specific manner. The organizations described in this paragraph may maintain the test results in a file or data bank. There will be no other disclosure of test results or even that the tests have been done except as may be required or permitted by law or as authorized by you.

If your HIV tests are normal, no routine notification will be sent to you. If the HIV test results are other than normal, the Insurer will contact you. The Insurer may also contact you if there are other abnormal test results which, in the Insurer's opinion, are significant. The Insurer may ask you to confirm the name of a physician to whom you authorize disclosure and with whom you may wish to discuss the results. If you are a resident of Missouri and your HIV test(s) indicates confirmed infection with HIV and you have not provided the Insurer with the name of a physician to whom you authorize disclosure of test results, the Insurer will disclose test results to the Missouri Department of Health as required by law.

Positive HIV test results or other significant abnormalities detected by additional tests of biological specimens will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged or that other policy changes may be necessary.

Physician [grid] Address [grid]

I have read and I understand this Notice of Consent for Testing of biological specimens, which includes HIV testing. I voluntarily consent to provide biological specimen(s) for testing, to the testing of such specimen(s) and the disclosure of the test results as described above. I understand that I have the right to request and receive a copy of this information. A photocopy of this form will be as valid as the original.

[grid]
Proposed Insured

[grid]
Date of Birth

[grid]
Date

[grid]
State of Residence

Signature of Proposed Insured



**20 CSR 400-2.110 Life and Health Benefits
Relating to HIV Infection**

PURPOSE: This rule effectuates or aids in the interpretation of sections 354.085, 354.485, 376.405, 376.675 and 376.777, RSMo regarding life and health benefits relating to HIV infection.

(1) Definitions. For the purposes of this regulation—

(A) AIDS means acquired immunodeficiency syndrome;

(B) ARC means AIDS related complex; and

(C) HIV means human immunodeficiency virus as these terms from time-to-time may be defined by the Federal Center for Disease Control.

(2) General Exclusions.

(A) On the effective date of this rule (January 13, 1989) all new or renewed individual or group policies, certificates, riders, endorsements or other supplemental forms which provide accident or health benefits issued by an insurance company, health service corporation, health maintenance organization or fraternal benefit society, other than those providing coverage only for specified diseases, shall cover HIV infection, including AIDS and ARC, as they would any other serious medical condition.

(B) All life insurance policies, other than those providing coverage for specific causes of death only, shall cover death from AIDS or ARC-related causes as they would death from any other cause.

AUTHORITY: section 374.045, RSMo 1986. This rule was previously filed as 4 CSR 190-14.145(1) and (2). Original rule filed Aug. 15, 1988, effective Jan. 13, 1989.*

**Original authority: 374.045, RSMo 1967.*

**20 CSR 400-2.120 Application Questions
and Underwriting Practices Relating to
HIV Infection**

PURPOSE: This rule effectuates or aids in the interpretation of sections 354.085, 354.485, 376.405, 376.675 and 376.777, RSMo regarding applications and underwriting practices relating to HIV infection.

(1) Definitions. For the purposes of this rule—

(A) AIDS means acquired immunodeficiency syndrome;

(B) ARC means AIDS related complex; and

(C) HIV means human immunodeficiency virus as these terms from time-to-time may be defined by the Federal Center for Disease Control.

(2) Application Questions and Underwriting Practices Relating to HIV Infection.

(A) No question shall be used that is designed to determine, or which would aid in determining, the sexual orientation of the applicant.

(B) The following provisions govern medical questions relating to HIV infection:

1. Questions relating to the applicant's having or having been diagnosed as having HIV infection, including AIDS or ARC, are permissible if the questions are factual and designed to establish the existence of the condition. For example, insurers shall not ask such questions as "Do you believe you may have . . . ?" or "Have you had any indications of . . . ?", but insurers may ask "Have you been positively diagnosed or treated for . . . ?"; and

2. Questions relating to HIV infection, including AIDS and ARC, may be asked, but only if questions related to other high risk medical conditions also are asked. The questions must be presented and asked, and the answers used, in the same manner as other questions and their answers relating to other high risk medical conditions.

(C) Questions relating to medical and other factual matters that are intended to reveal the possible existence of a medical condition are permissible if they are not used to determine, or which would aid in determining, the sexual orientation of the applicant and if the applicant is given an opportunity to provide a detailed explanation for any affirmative answers given in the application. For example, insurers may ask such questions as, "Have you had chronic cough, significant weight loss, chronic fatigue, diarrhea, enlarged glands . . . ?" The questions must pertain to a finite period of time preceding completion of the application, not to exceed ten (10) years. The finite period does not apply to questions concerning prior diagnosis, treatment or testing.

(D) Questions relating to the applicant's having, or having been diagnosed as having, or having been advised to seek treatment for, a sexually transmitted disease are permissible.

(E) Neither the marital status, the living arrangements, the occupation, the gender, the medical history, the beneficiary designation

nor the zip code or other territorial classification of an applicant may be used to rate an applicant or to determine, or aid in determining, the applicant's sexual orientation.

(F) For purposes of rating an applicant for health and life insurance, an insurer may impose territorial rates, but only if the rates are based on sound actuarial principles and are related to actual or reasonably anticipated experience. If an insurer imposes territorial rates, it shall first provide the director with satisfactory actuarial evidence to support these rates.

(G) No adverse underwriting decision shall be based on information that the applicant has demonstrated AIDS, ARC or other HIV infection-related concerns by seeking counseling. This section does not apply to an applicant seeking treatment or counseling after having been positively diagnosed as being infected with the HIV virus.

AUTHORITY: section 374.045, RSMo 1986. This rule was previously filed as 4 CSR 190-14.145(1) and (3). Original rule filed Aug. 15, 1988, effective Jan. 13, 1989.*

**Original authority: 374.045, RSMo 1967.*

20 CSR 400-2.130 Group Health Filings

PURPOSE: This rule effectuates or aids in the interpretation of section 376.421, RSMo. The rule specifies how the Department of Insurance will determine whether group health coverage provided, solicited or issued in Missouri complies with the descriptions of groups in section 376.421, RSMo.

(1) As used in this rule, the following terms mean:

(A) Discretionary group, any group not described in section 376.421.1, RSMo;

(B) MDI, the Missouri Department of Insurance; and

(C) True group, any group described in section 376.421.1, RSMo.

(2) Group health policies delivered in Missouri are subject to the following:

(A) Any policy must be delivered to a true group or to a discretionary group;

(B) Any policy form issued to a discretionary group must be approved by the MDI under section 376.421.2(1), RSMo. This policy filed with the MDI must be accompanied by an affidavit and necessary exhibits on a form approved by the MDI, as included herein;



(C) Whenever reasonably necessary to determine whether a group policy is being issued by a true group, the MDI may require an affidavit on a form approved by the MDI, as included herein, to determine whether a group is a true group;

(D) Any policy filed with the MDI under this section of this rule is a filing required by law and the filing fee, required by section 374.230(6), RSMo, must be paid; and

(E) If a company violates section 376.421, RSMo or this rule with an unfiled policy, the failure to file will be evidence that the violation was willful.

(3) Group health policies not delivered in Missouri are subject to the following:

(A) Any coverage solicited or sold in this state, whether by direct mail, insurer producer contact, telephone contact or advertisement, must be delivered to a true group or a discretionary group;

(B) Whether a group is a true group will be determined by the descriptions contained in section 376.421.1, RSMo, not by the descriptions or lack of descriptions in another state's law;

(C) Whenever reasonably necessary to determine whether a group policy is being issued to a true group, the MDI may require an affidavit on a form approved by the MDI, as included herein, to determine whether a group is a true group;

(D) The MDI shall require an affidavit with necessary exhibits on a form approved by the MDI, as included herein, for any policy issued to a discretionary group. This affidavit will be unnecessary only if another state having a law substantially similar to section 376.421.2(1), RSMo has approved the policy as a discretionary group policy;

(E) Any policy found by the MDI to be delivered to a true group or to a discretionary group which is approved by another state under subsection (3)(D) is filed for information only. The MDI will not charge a filing fee for a policy filed for information only. Any other policy is a filing required by law for which the filing fee under section 374.230(6), RSMo must be paid; and

(F) If a company violates section 376.421, RSMo or this rule with an unfiled policy, the failure to file will be evidence that the violation was willful.



STATE OF _____)
)
COUNTY OF _____) ss.:

I, _____, on my oath swear that the following statement are
name

true to the best of my knowledge:

1. _____ (the person)
is/are a creditor, parent holding company of a creditor or a trustee or trustees or agent designated by two or more
creditors.

2. The person named in statement number 1. will be the policyholder of a group health policy to insure debtors of
the creditor or creditors with respect to their indebtedness.

3. The policy which will be issued is a group health policy issued by _____
insurance company
with form number _____.

4. I represent the person named in statement number 1. in the following capacity: _____

Signature: _____

Type or print name:

Sworn to and subscribed before me this _____ day of _____, _____. My
commission expires _____, _____.

Notary Public

Affidavit 376.421.1(2)



STATE OF _____)
)
COUNTY OF _____) ss.:

I, _____, on my oath swear that the following statement are
name

true to the best of my knowledge:

1. _____ is a trust, or the trustee of a fund established or adopted by two or more employers, or by one or more labor unions or similar employee organizations, or by one or more employers and one or more labor unions or similar employee organizations.

2. The trust or trustee named in statement number 1. will be the policy holder of a group health policy issued by

_____ insurance company

3. I represent the trust or trustee named in statement number 1. in the following capacity: _____

Signature: _____

Type or print name:

Sworn to and subscribed before me this _____ day of _____, _____ . My

commission expires _____, _____ .

Notary Public

Affidavit 376.421.1(4)



STATE OF _____)
) ss.:
COUNTY OF _____)

I, _____, on my oath swear that the following statement are
name

true to the best of my knowledge:

1. _____ is a credit union or is or are a trustee, trustees or agent designated by two or more credit unions.

2. I represent the credit union or trustee, trustees or agent named in statement 1. in the following capacity: _____

3. The credit union or trustee, trustees or agent named in statement 1. will be the policyholder of a group health policy from _____ insurance company with form number _____

Signature: _____

Type or print name:

Sworn to and subscribed before me this _____ day of _____, _____. My commission expires _____, _____.

Notary Public

Affidavit 376.421.1(6)



STATE OF _____)
)
COUNTY OF _____) ss.:

I, _____, on my oath swear that the following statement are
name

true to the best of my knowledge:

- 1. I hold the following office of the _____
name of insurance company
- 2. I am authorized to execute this affidavit.
- 3. The company plans to issue group health policy form number _____ (the group policy).
- 4. The issuance of the group policy is not contrary to the best interest of the public because: _____

(Attach additional pages if necessary.)

5. The issuance of the group policy would result in economies of acquisition or administration described as follows: _____

(Attach additional pages if necessary.)

6. The benefits are reasonable in relation to the premiums charged for the group policy as evidenced by the attached statement of the company's actuary. (Attach actuary's statement.)

Signature: _____

Type or print name:

Sworn to and subscribed before me this _____ day of _____, _____. My
commission expires _____, _____.

Notary Public

Affidavit 376.421.2



AUTHORITY: section 374.045, RSMo 2000.* This rule was previously filed as 4 CSR 190-14.170. Original rule filed Oct. 5, 1989, effective May 1, 1990. Amended: Filed April 23, 1999, effective Nov. 30, 1999. Amended: Filed July 12, 2002, effective Jan. 30, 2003.

*Original authority: 374.045, RSMo 1967, amended 1993, 1995.

20 CSR 400-2.135 Health Benefit Plans Issued to Associations with Small and Large Employers

PURPOSE: This rule establishes the requirements for health carriers seeking an exemption under section 376.421.1(5)(e), (HB 1827, 93rd General Assembly, Second Regular Session (2006)).

(1) Definitions. When used in this regulation—

(A) “Health benefit plan” shall have the definition as found in section 376.1350, RSMo;

(B) “Health carrier” shall have the definition as found in section 376.1350, RSMo;

(C) “Producer” shall have the definition as found in section 375.012, RSMo; and

(D) “Small employer” shall have the definition as found in section 379.930.2, RSMo.

(2) Request for Suspension of Rate Restriction. A health carrier seeking an exemption under section 376.421.1(5)(e), RSMo for a policy issued to an association, a trust or to the trustees of a fund established, created and maintained for the benefit of members of one (1) or more associations which is insuring large employers and small employers shall:

(A) File with the department completed affidavit forms approved by this rule at the time of policy inception;

(B) File with the department completed affidavit forms approved by this rule within the thirty (30)-day period prior to the annual renewal for any additional year during which an exemption under section 376.421.1(5)(e), RSMo is sought;

(C) Maintain copies of current affidavits required by this rule with the health carrier’s master policy for the length of time required by section 374.205, RSMo and 20 CSR 300-2.200;

(D) Submit data to the department to track the market impact of this type of association health benefit plan. The data elements will be identified and submitted on the Missouri A&H Supplement form or the annual HMO

Supplement data, Supplement 2, as appropriate for the license type of the carrier submitting the data;

(E) Comply with 20 CSR 400-2.130 except that completion of the forms required in subsection (2)(A) of this rule shall constitute compliance with 20 CSR 400-2.130(2)(C) for issuance of policies to an association, a trust or to the trustees of a fund established, created and maintained for the benefit of members of one (1) or more associations; and

(F) Comply with all provisions of the Small Employer Health Insurance Availability Act found in sections 379.930-379.952, RSMo except for the exempted provision of section 379.936.1(1), RSMo.

(3) Producer Disclosure. Producers shall disclose the exemption to the association or trust and to the small employers insured under the association health benefit plan.

(4) Application Forms. The following forms have been adopted and approved for filing with the department:

(A) Association’s Request for Suspension of Index Rate Restriction Affidavit (“Form AHP1”), revised September 2006, or any form which substantially comports with the specified form; and

(B) Producer’s Request for Suspension of Index Rate Restriction Affidavit (“Form AHP2”), revised September 2006, or any form which substantially comports with the specified form; and

(C) Health Carrier’s Request for Suspension of Index Rate Restriction Affidavit (“Form AHP3”), revised September 2006, or any form which substantially comports with the specified form.

(5) Availability of Forms. The department on request will supply in printed format the forms listed in this rule. Accurate reproduction of the forms may be utilized for filing in lieu of the printed forms. All application forms referenced herein are available at <http://www.insurance.mo.gov>.

AUTHORITY: sections 374.045 and 374.205, RSMo 2000, and 376.421, RSMo (HB 1827, 93rd General Assembly, Second Regular Session 2006).* Original rule filed Sept. 1, 2006, effective Feb. 28, 2007.

*Original authority: 374.045, RSMo 1967, amended 1993, 1995; 374.205, RSMo 1992, amended 1997, 1999; 376.421, RSMo 1985, amended 1986, 2006.

20 CSR 400-2.140 Speech and Hearing Disorders—Definitions

PURPOSE: This rule defines certain terms to ensure their uniform application in group health insurance and other designated coverage. This rule is promulgated pursuant to section 376.781, RSMo.

(1) The purpose of this rule is to set forth the terms and definitions which must be utilized in a policy, certificate, contract or plan document which provides speech and hearing benefits.

(2) Definitions. For the purposes of this rule—

(A) Loss or impairment of speech or hearing shall include communicative disorders resulting from genetic defects, birth defects, injury, illness, disease, developmental disabilities or delays or other causes whether of organic or nonorganic etiology and whether or not the person suffering from that loss or impairment had the capacity for speech, language or hearing before the loss or impairment occurred;

(B) Necessary care and treatment shall include services to identify, assess, diagnose and consult about the need for treatment and to evaluate and monitor the effectiveness of treatment whether by instrumental, perceptual or standard procedures as well as the provision of treatment for any of the previously mentioned communicative disorders. These services shall include, but not be limited to:

1. Diagnostic and extended evaluation of hearing, which may include pure tone air conduction thresholds, speech thresholds, bone conduction thresholds, prediction of hearing loss from acoustic reflex, reflex eliciting auditory test, communication handicap inventories, word/sentence recognition tests and evoked potential monitoring and testing;

2. Determining range, nature and degree of hearing function related to a patient’s auditory efficiency;

3. Comprehensive behavioral evaluation for sensorineural site which includes advanced acoustic reflex tests, tests of auditory adaptation, tests of frequency discrimination and tests of intensity discrimination;

4. Testing, adjusting and evaluating auditory prosthetic devices which may include sound field tests, such as aided word/sentence recognition, real ear measures, warble tone thresholds, narrow band noise thresholds, and comfortable and



uncomfortable loudness levels while wearing an auditory prosthesis;

5. Differentiation between organic and nonorganic hearing disabilities through evaluation of total response pattern and use of acoustic tests;

6. Planning, directing, conducting or participating in conservation, habilitative and rehabilitative programs including hearing aid selection and orientation, counseling, guidance, auditory training, speech reading, language habilitation and speech conservation;

7. Coordinating and consulting with educational, medical and other professional groups, and with patients and their families;

8. Diagnosing and evaluating speech and language competencies of individuals, including assessment of speech and language skills as related to educational, medical, developmental, social and psychological factors;

9. The services enumerated in paragraphs (2)(B)1.-8. shall be designed to evaluate and treat individuals to develop or utilize speech, language and other communicative skills to the maximum extent possible to remedy any loss or impairment for which services are being provided. However, nothing in this rule shall be construed to require services to improve public speaking, care of the professional voice or accent reduction;

10. Cognitive training secondary to open or closed head injury, regardless of cause;

11. Assisting individuals with voice disorders to develop proper control of the vocal and respiratory systems for correct voice production;

12. Evaluating and treating children with delayed or impaired speech or language disorders;

13. Determining the need for augmentative/prosthetic communication systems whether or not that system or that device replaces a body part. These systems or devices may include, but are not limited to, sign language, gesture systems, communication boards, electronic automated devices, mechanical devices, alaryngeal prosthesis, palatal prosthesis and synthetic voice systems; and

14. Planning, directing, or conducting habilitative and rehabilitative treatment programs to restore or provide communicative efficiency to individuals with communication problems of organic and nonorganic etiology, such as partial to total glossectomy, partial to total laryngectomy, or both; and

(C) Other covered services shall mean any other medically necessary medical or health care services, or both, for which coverage is

provided whether or not for acute conditions, provided while a patient in a hospital, or provided by or in a rehabilitation center, skilled nursing facility, clinic, home health agency or community-based program. This means that limitations on coverage may not be specific to speech, language and hearing disorders or for services rendered by speech language pathologists and audiologists.

(3) The communicative disorders generally treated by speech/language pathologists and audiologists shall include, but not be limited to, aphasia; motor speech disorders; delayed speech or language ability; total or partial speech or language loss or deficit; swallowing disorders; total or partial hearing loss or deficit; disorders of verbal and written language, articulation, voice, fluency, mastication, deglutition, cognition, auditory or visual processing and memory, and interactive communications; and disorders of air conduction, bone conduction, word/sentence recognition and acoustic impedance.

AUTHORITY: sections 374.045 and 376.781.6, RSMo 1986.* Original rule filed March 25, 1991, effective Oct. 31, 1991.

*Original authority: 374.045, RSMo 1967 and 376.781.6, RSMo 1984.

20 CSR 400-2.150 Stop-Loss Coverage for Self-Insured Health Plans

Editor's Note: The Circuit Court of Cole County issued a decision regarding docket number CV195-1326CC on December 27, 1995, finding that Department of Insurance rule 20 CSR 400-2.150 was void because it is contrary to state law and is preempted by federal law. The director of the Department of Insurance was permanently enjoined from enforcing this rule. The director has decided to appeal the decision of the circuit court.

20 CSR 400-2.160 Mental Health Services Allowed Out-of-Network

PURPOSE: This rule sets forth with greater specificity the breadth of options available for the provision of mental health services. This rule is promulgated pursuant to section 376.814, RSMo, and implements section 376.811.4, RSMo.

Pursuant to section 376.811.4, RSMo Supp. 1997, an insurance company, health services corporation or health maintenance organization, must offer in all health insurance poli-

cies at least two sessions per year for the purpose of diagnosis or assessment of mental health. This offer may not limit the choice of psychiatrist, licensed psychologist, licensed professional counselor or licensed clinical social worker who provides the service. An insured may seek these services outside an insurer's network.

AUTHORITY: sections 376.811.4 and 376.814, RSMo 1994.* Original rule filed Nov. 3, 1997, effective June 30, 1998.

*Original authority: 376.811, RSMo 1991, amended 1997 and 376.814, RSMo 1991, amended 1993.

20 CSR 400-2.165 Access to Providers for Treatment of Mental Health Conditions

PURPOSE: This rule describes timely and appropriate access to mental health care, adequate distribution of the quantity, location and specialty of mental health care providers, and administrative and clinical protocols that protect access to medically necessary mental health treatment for any insured. This rule is promulgated pursuant to section 376.1550, RSMo.

(1) Definitions.

(A) "Administrative protocols" include, but are not limited to, a provider network, referral requirements, prior authorization requirements, and utilization review.

(B) "Clinical protocols" include, but are not limited to, visit limitations, length-of-stay limitations, formularies, step-therapy requirements, and drug quantity limitations.

(C) Categories of counties—

1. Urban counties—Counties with a population of two hundred thousand (200,000) or more persons;

2. Basic counties—Counties with a population between fifty thousand (50,000) persons and one hundred ninety-nine thousand nine hundred ninety-nine (199,999) persons;

3. Rural counties—Counties with a population of fewer than fifty thousand (50,000) persons; and

4. Population figures shall be based on census data as reported in the latest edition of the *Official Manual State of Missouri*.

(D) "Director" means the director of the Department of Insurance.

(E) "Health benefit plan" has the same meaning as stated at section 376.1350, RSMo.

(F) "Health carrier" has the same meaning as stated at section 376.1350, RSMo.



(G) “HMO” means health maintenance organizations licensed pursuant to Chapter 354, RSMo.

(H) “Insured” means any person entitled to benefits under a health benefit plan.

(I) “Insurer” means a health carrier that is not an HMO.

(J) “Mental health condition” means any condition or disorder defined by the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* except for chemical dependency.

(K) “Provider” means any professional or institution which is licensed or otherwise authorized in this or any other state to furnish health care services.

(L) “Utilization review” has the same meaning as stated at section 376.1350, RSMo.

(2) Applicability.

(A) This rule shall apply to all health benefit plans, except for the types of health benefit plans covered under subsection (2)(C) of this rule.

(B) This rule shall apply to managed care organizations providing mental health benefits under a health benefit plan that does not otherwise provide for management of care under the plan or that does not provide for the same degree of management of care for all health conditions.

(C) This rule shall not apply to:

1. Health benefit plans issued by an HMO;

2. Health benefit plans issued by insurers that provide for the same degree of management of care under the plan for all health conditions;

3. Individual health benefit plans, including those that cover dependents;

4. Individually underwritten group health benefit plans;

5. Supplemental insurance policies, including life care contracts, accident-only policies, specified disease policies, hospital policies providing a fixed daily benefit only, Medicare supplement policies, long-term care policies, hospitalization-surgical care policies, or short-term major medical policies of six (6) months or less duration; and

6. Any other supplemental policy as determined by the director.

(3) Timely Access to Care—Appointments with or admissions to medical providers must be available no later than as follows:

(A) For routine care, without symptoms—within thirty (30) days from the time the enrollee contacts the provider;

(B) For routine care, with symptoms—within five (5) business days from the time the insured contacts the provider;

(C) For urgent care for situations which require immediate care, but which do not constitute emergencies as defined by section 376.1350, RSMo—within twenty-four (24) hours from the time the insured contacts the provider;

(D) For emergency care—an appropriate mental health provider or emergency care facility shall be available twenty-four (24) hours per day, seven (7) days per week for people who require emergency care as defined by section 376.1350, RSMo; and

(E) For telephone access—a licensed mental health care professional shall be available twenty-four (24) hours per day, seven (7) days per week.

(4) Adequate Quantity of Health Care Providers—A system for delivery of treatment for mental health conditions shall have sufficient quantities of mental health care providers to meet the timely access requirements stated in section (3) of this rule.

(5) Appropriate Access to Care and Adequate Location and Distribution of Health Care Providers.

(A) A health benefit plan or managed care organization may establish a system for delivery of treatment for mental health conditions that includes utilization review. Such system shall comply with the provisions of sections 376.1350 to 376.1389, RSMo.

(B) If a provider network lacks an appropriate provider or it cannot assure access to medically necessary care without unreasonable delay, then coverage of mental health treatment outside the network shall place no greater cost upon the insured than if the treatment were delivered inside the network.

(C) For purposes of subsection (5)(B) of this rule, an appropriate provider is one that is reasonably suited to provide treatment that reflects the insured’s age, diagnosis, anticipated length of treatment, and any other relevant factors.

(6) Administrative and Clinical Protocols.

(A) Administrative and clinical protocols applied by an insurer, either directly or indirectly through a managed care organization shall:

1. Be clearly and completely stated in written or electronic materials distributed to any insured or prospective insured, except that merely posting the information on a website shall not by itself meet this requirement;

2. Be clearly and completely stated in written or electronic materials distributed to any provider responsible for providing treatment to an insured; and

3. Be available for review by the director within thirty (30) days of the director making a request to review protocols.

(B) Administrative and clinical protocols applied by an insurer, either directly or indirectly through a managed care organization, shall not serve to reduce access to medically necessary treatment for any insured.

(7) Filings with the Director. On October 15 of each year, all insurers shall file with the director a certification of compliance with the provisions of this rule and section 376.1550, RSMo, for all health benefit plans. The certification shall be in a format prescribed by the director, and shall contain, at a minimum, the following information:

(A) The legal name and National Association of Insurance Commissioners (NAIC) number of the insurer;

(B) The number of insureds covered by health benefit plans that the insurer believes to be subject to this rule, if any;

(C) If applicable, a statement of the reasons an insurer believes none of its health benefit plans are subject to this rule, referencing the exceptions listed in paragraphs (2)(C)1. through (2)(C)6. of this rule;

(D) The insurer’s certification of compliance with all the applicable provisions of this rule, unless subsection (7)(C) applies; and

(E) If the insurer provides coverage of mental health benefits through a managed care organization, the name, address and contact information of that organization.

AUTHORITY: section 376.1550, RSMo Supp. 2005. Original rule filed Aug. 26, 2005, effective March 30, 2006.*

**Original authority: 376.1550, RSMo 2004.*

20 CSR 400-2.170 Early Intervention Part C Coverage

PURPOSE: This rule implements the requirements of section 376.1218, RSMo, with respect to the Missouri early intervention system and clarifies insurance carriers’ obligations under the new law.

(1) Definitions: The terms used in this rule or in section 376.1218, RSMo, shall have the following meanings:



(A) “Assistive technology device” means any item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase, maintain or improve the functional capabilities of children with disabilities.

(B) “Direct written premium” means:

1. The total amount of premium reported for health benefit plans, as defined in 376.1350, RSMo, on the Annual Statement Supplement for the State of Missouri for health carriers required to file this supplement; or

2. The total amount of premium reported for health benefit plans, as defined in 376.1350, RSMo, on the Exhibit of Premiums, Enrollment, and Utilization for the State of Missouri included in the health carrier’s annual financial statement, for all other health carriers not covered in paragraph (1)(B)1.

(C) “Early intervention services” means medically necessary speech and language therapy, occupational therapy, physical therapy, and assistive technology devices for children from birth to age three (3) who are identified by the Part C early intervention system as eligible for services under Part C of the Individuals with Disabilities Education Act, 20 U.S.C. Section 1431, et seq.

(D) “First Steps” refers to the Missouri early intervention system under the federal Infant and Toddler Program, Part C of the Individuals with Disabilities Act, 20 U.S.C. Section 1431, et seq.

(E) “Group of carriers affiliated by or under common ownership or control” means health carriers with a common four (4)-digit group code as assigned by the National Association of Insurance Commissioners.

(F) “Health benefit plan,” “health care professional,” and “health carrier” shall each have their respective meanings as such terms are defined in 376.1350, RSMo.

(G) “Individualized family service plan” means a written plan for providing early intervention services to an eligible child and the child’s family, that is adopted in accordance with 20 U.S.C. Section 1436.

(H) “Participating provider” means a provider who, under a contract with the health carrier or with its contractor or subcontractor, has agreed to provide health care services to enrollees with an expectation of receiving payment, other than coinsurance, co-payments or deductibles, directly or indirectly from the health carrier.

(2) Health benefit plans shall provide this coverage on the first date on or after January 1, 2006, on which the contract or certificate is delivered, issued for delivery, continued or renewed in this state.

(3) Health Carriers to Recognize First Steps as Provider.

(A) First Steps shall be considered the rendering provider for all claims covered under section 376.1218, RSMo, and this rule.

(B) First Steps shall be considered a participating and/or network provider by all health carriers. All health carriers shall use the Missouri standardized credentialing form or the Federal W-9 tax form to establish network provider status for First Steps. Health carriers shall take all necessary steps to assure that claims submitted by First Steps are not denied, delayed, or reduced for reasons related to network participation.

(4) Requirements for Acceptance and Payment of Claims.

(A) Health carriers shall have the option to pay claims for First Steps services in one (1) of three (3) ways:

1. A health carrier shall pay individual claims submitted for each service to First Steps as the rendering provider, and such coverage shall be limited to three thousand dollars (\$3,000) for each covered child per policy per calendar year, with a lifetime policy maximum of nine thousand dollars (\$9,000) per child. Such payments shall not exceed one-half of one percent (0.5%) of the direct written premium for health benefit plans; or

2. A health carrier and all of its affiliates together shall submit a lump sum payment to First Steps for one-half of one percent (0.5%) of the direct written premiums reported to the Department of Insurance on each health carrier’s most recently filed annual financial statement, per calendar year, which shall satisfy each affiliated health carrier’s payment obligation for First Steps services for such calendar year; or

3. A health carrier and all of its affiliates together shall make a lump sum payment of five hundred thousand dollars (\$500,000), per calendar year, to First Steps, which shall satisfy the health carrier and its affiliates’ payment obligation for First Steps services for such calendar year.

4. As between paragraphs 2. and 3. of this subsection, the health carrier shall pay whichever amount is less.

(B) Payment of individually submitted claims under paragraph (4)(A)1. shall be sub-

ject to the requirements of sections 376.383 and 376.384, RSMo, as of January 1, 2007.

(C) For health carriers opting to make payments on individual claims under paragraph (4)(A)1.:

1. Such health carriers shall be responsible for keeping records to determine when the maximum three thousand dollars (\$3,000) per child, per policy, per calendar year has been reached. If there is an irreconcilable discrepancy between a health carrier’s records and Missouri Department of Elementary and Secondary Education (DESE) records, DESE’s records shall prevail.

2. Such health carriers shall amend their applicable coverage documents to reflect First Steps benefits, and may do so by endorsement.

A. Such documents shall contain the same or substantially the same benefit description as stated in section 376.1218, RSMo, subsection 1.

3. Health carriers shall receive and issue payment for First Steps claims.

A. All claim payments shall be sent to DESE’s designee.

B. Health carriers shall submit all First Steps remittance advices to DESE’s designee in an electronic format consistent with federal administrative simplification standards, format and content adopted pursuant to the Health Insurance Portability and Accountability Act of 1996. Such remittance advices shall be submitted in a format agreed to by DESE.

C. Health carriers shall not deny, delay or reduce payment of First Steps claims based on their own determination of medical necessity or diagnosis, but shall in all cases defer to the services stated on the individual family service plan.

D. Health carriers shall not bundle claims for First Steps services.

E. For all adjustments on claim overpayments, such health carriers shall submit to DESE’s designee in an electronic format consistent with federal administrative simplification standards, format and content adopted pursuant to the Health Insurance Portability and Accountability Act of 1996, remittance advices on a per claim adjustment reflecting the individual and cumulative claim adjustment. Such remittance advices shall be submitted in a format agreed to by DESE.

4. Coordination of benefits requirements.

A. All health benefit plans in effect during a calendar year or any portion thereof, shall be obligated under the provisions of section 376.1218, RSMo for reimbursement



of the early intervention services provided for any covered child entitled to early intervention services as described in section 376.1218, RSMo up to the maximum annual reimbursable amount of three thousand dollars (\$3,000) with a nine thousand dollar (\$9,000)-lifetime maximum per child.

B. Failure of a parent or guardian to elect to assign a right of recovery or indemnification to the First Steps program shall not reduce claim payments to First Steps from secondary plans as defined in 20 CSR 400-2.030.

C. Notification from DESE that a primary plan, as defined in 20 CSR 400-2.030, has submitted a lump sum payment under paragraphs (4)(A)2. or 3. shall be sufficient notice to a secondary plan that such primary plan has fulfilled its payment obligations for First Steps services for that year.

(D) Health carriers shall accept and reimburse First Steps claims up to one (1) year after the date of service. Health carriers that otherwise require participating providers to submit claims in a shorter period of time than one (1) year shall waive this requirement for First Steps claims.

1. Health carriers that allow more than one (1) year for claims submission shall allow the same amount of time for First Steps claims submissions.

(E) There will be a presumption that the charges for First Steps services provided under section 376.1218, RSMo, and this rule, are being billed at an applicable Medicaid rate for such services or assistive technology devices.

(F) Health carriers electing a lump sum payment under paragraphs (4)(A)2. or 3. will be invoiced by DESE after January 1 of each year, with payments due no later than January 31 of that year. The lump sum payment shall be due no later than January 31 of each year regardless of the effective dates of the individual insurance plans.

(G) Health carriers that elect a lump sum payment under paragraphs (4)(A)2. or 3. and then fail to make such payment no later than January 31 of that year, shall be considered in violation of insurance law and be subjected to penalty, as allowed under the insurance laws of the state of Missouri.

(H) Lump sum payments under paragraphs (4)(A)2. and 3. shall not be credited against any health benefit plan lifetime maximum aggregates.

(I) For health carriers electing the lump sum payment option under paragraph (4)(A)2., the amount of direct written premium used to determine such health carriers'

payment obligations for First Steps services will be the amount on record with the Missouri Department of Insurance on the most recently filed annual financial statement and any filed amendments as of September 1 of each year.

(5) Prior Authorization.

(A) Health carriers shall not require prior authorization for First Steps treatments and shall not deny, delay or reduce claim payments for failure to obtain prior authorization.

(6) Transactions Affecting Affiliation of Health Carriers.

(A) In the event of a transaction affecting affiliation of health carriers, the NAIC group code as of December 31 of the preceding year that payment for First Steps claims is due will determine affiliation of health carriers, and also, the total amount due to DESE if the applicable health carriers elect a lump sum payment option under paragraphs (4)(A)2. and 3.

AUTHORITY: sections 374.045, RSMo 2000 and 376.1218, RSMo Supp. 2005. Emergency rule filed Dec. 20, 2005, effective Jan. 1, 2006, expired June 29, 2006. Original rule filed Dec. 20, 2005, effective June 30, 2006.*

**Original authority: 374.045, RSMo 1967, amended*