

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

**PROPOSED AMENDMENT**

**22 CSR 10-3.055 Health Savings Account Plan Benefit Provisions and Covered Charges** The Missouri Consolidated Health Care Plan is amending section (3), adding section (10), and renumbering as necessary.

***PURPOSE: This amendment revises the out-of-pocket maximum for individual family members and adds one hundred percent (100%) coverage of virtual visits offered through the vendor's telehealth tool.***

(3) Out-of-pocket maximum.

(A) The family out-of-pocket maximum applies when two (2) or more family members are covered. The family out-of-pocket maximum must be met before the plan begins to pay one hundred percent (100%) of all covered charges for any covered family member. Out-of-pocket maximums are per calendar year, as follows:

1. Network out-of-pocket maximum for individual—four thousand nine hundred fifty dollars (\$4,950);

2. Network out-of-pocket maximum for family—nine thousand nine hundred dollars (\$9,900). Any individual family member need only incur a maximum of *[eight thousand one hundred fifty dollars (\$8,150)]* **eight thousand five hundred fifty dollars (\$8,550)** before the plan begins paying one hundred percent (100%) of covered charges for that individual;

3. Non-network out-of-pocket maximum for individual—nine thousand nine hundred dollars (\$9,900); and

4. Non-network out-of-pocket maximum for family—nineteen thousand eight hundred dollars (\$19,800).

**(10) Virtual visits offered through the vendor's telehealth tool are covered at one hundred percent (100%).**

*[(10)](11)* Newborn's claims will be subject to deductible and coinsurance.

*[(11)](12)* Each subscriber will have access to payment information of the family unit only when authorization is granted by the adult covered dependent(s).

*[(12)](13)* Expenses toward the deductible and out-of-pocket maximum will be transferred if the member changes medical plans or continues enrollment under another subscriber's plan within the same plan year.

*[(13)](14)* Maximum plan payment—Non-network medical claims that are not otherwise subject to a contractual discount arrangement are processed at one hundred ten percent (110%) of Medicare reimbursement for non-network professional claims and following the claims administrator's standard practice for non-network facility claims. Members may be held liable for the amount of the fee above the allowed amount.

*[(14)](15)* Any claim must be initially submitted within twelve (12) months following the date of service, unless otherwise specified in the network provider contract. The plan reserves the right to deny claims not timely filed. A provider initiated correction to the

originally filed claim must be submitted within the timeframe agreed in the provider contract, but not to exceed three hundred sixty-five (365) days from adjudication of the originally filed claim. Any claims reprocessed as primary based on action taken by Medicare or Medicaid must be initiated within three (3) years of the claim being incurred.

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

*[(16)]***(17)** A subscriber does not qualify for the HSA Plan if s/he is claimed as a dependent on another person's tax return or, except for the plans listed in section (17) of this rule, is covered under or enrolled in any other health plan that is not a high deductible health plan, including, but not limited to, the following types of insurance plans or programs:

- (A) Medicare (unless Medicare is secondary coverage to MCHCP);
- (B) TRICARE;
- (C) A health care flexible spending account (FSA), with the exception of participation in the premium-only, limited-purpose health FSA, and dependent care section;
- (D) Health reimbursement account (HRA); or
- (E) If the member has received medical benefits from The Department of Veterans Affairs (VA) at any time during the previous three (3) months, unless the medical benefits received consist solely of disregarded coverage or preventive care.

*[(17)]***(18)** A subscriber may qualify for this plan even if s/he is covered by any of the following:

- (A) Drug discount card;
- (B) Accident insurance;
- (C) Disability insurance;
- (D) Dental insurance;
- (E) Vision insurance; or
- (F) Long-term care insurance.

*[(18)]***(19)** Services performed in a country other than the United States may be covered if the service is included in 22 CSR 10-3.057. Emergency and urgent care services are covered as a network benefit. All other non-emergency services are covered as determined by the claims administrator. If the service is provided by a non-network provider, the member may be required to provide payment to the provider and then file a claim for reimbursement subject to timely filing limits.

*AUTHORITY: sections 103.059 and 103.080.3., RSMo 2016.\* Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. Emergency amendment filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Amended: Filed Dec. 22, 2010, effective June 30, 2011. Amended: Filed Nov. 1, 2011, effective May 30, 2012. Emergency amendment filed Oct. 30, 2012, effective Jan. 1, 2013, expired June 29, 2013. Amended: Filed Oct. 30, 2012, effective May 30, 2013. Emergency amendment filed Oct. 30, 2013, effective Jan. 1, 2014, expired June 29, 2014. Amended: Filed Oct. 30, 2013, effective June 30, 2014. Emergency amendment filed Oct. 29, 2014, effective Jan. 1, 2015, expired June 29, 2015. Amended: Filed Oct. 29, 2014, effective May 30, 2015. Emergency rescission and rule filed Oct. 28, 2015, effective Jan. 1, 2016, expired June 28, 2016. Rescinded and readopted: Filed Oct. 28, 2015, effective May 30, 2016. Emergency amendment filed Oct. 28, 2016, effective Jan. 1, 2017, expired June 29, 2017. Amended: Filed Oct. 28, 2016, effective May 30, 2017. Emergency amendment filed Oct. 31, 2018, effective Jan. 1, 2019, expired June 29, 2019. Amended: Filed Oct. 31, 2018, effective May 30, 2019. Emergency amendment filed Oct. 30, 2019, effective Jan. 1, 2020, expired June 28, 2020. Amended: Filed Oct. 30, 2019, effective May 30, 2020. Emergency amendment filed Oct. 26, 2020, effective Jan. 1, 2021, expires June 29, 2021. Amended: filed Oct. 26, 2020.*

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

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

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

*\*Original authority: 103.059, RSMo 1992 and 103.080, RSMo 2007, amended 2011.*