TITLE 22 – MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10 – Health Care Plan
Chapter 3 – Public Entity Membership

EMERGENCY RULE

22 CSR 10-3.064 HSA 3500 Plan Benefit Provisions and Covered Charges

PURPOSE: This rule establishes the policy of the board of trustees in regard to the HSA 3500 Plan, Plan Benefit Provisions, and Covered Charges of the Missouri Consolidated Health Care Plan.

EMERGENCY STATEMENT: This emergency rule must be in place by January 1, 2027, in accordance with the new plan year. Therefore, this emergency rule is necessary to serve a compelling governmental interest of protecting members (public entity employee members, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forego coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be filed as an emergency rule to maintain the integrity of the current health care plan. This emergency rule fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to public entity employee members, retirees, and their families as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rule, which covers the same material, will be published in the December 15, 2026, issue of the ***Missouri Register****. This emergency rule complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rule was filed November 16, 2026 becomes effective January 1, 2027 and expires June 29, 2027.*

(1) Deductible – per calendar year for network: per individual, three thousand five hundred dollars ($3,500); family, seven thousand dollars ($7,000), and for non-network: per individual, five thousand dollars ($5,000); family, ten thousand dollars ($10,000).

(A) Network and non-network deductibles are separate. Expenses cannot be shared or transferred between network and non-network benefits.

(B) Claims will not be paid until the applicable deductible is met.

(C) Services that do not apply to the deductible and for which applicable costs will continue to be charged include but are not limited to copayments; charges above the usual, customary, and reasonable (UCR) limit; the amount the member pays due to noncompliance; non-covered services and charges above the maximum allowed.

(D) The family deductible applies when two (2) or more family members are covered. The family deductible must be met before claim payment begins for any covered family member. Once the family deductible is met, the plan will start to pay claims for the entire family even if some family members have not met his/her own individual deductible.

(E) Medical and pharmacy expenses are combined to apply toward the network or non-network deductible amount, as appropriate.

(2) Coinsurance – Coinsurance amounts apply to covered services after deductible has been met. Coinsurance is no longer applicable for the remainder of the calendar year once the out-of-pocket maximum is reached.

(A) Network claims are paid at eighty percent (80%) until the out-of-pocket maximum is met.

(B) Non-network claims are paid at sixty percent (60%) until the out-of-pocket maximum is met.

(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 – eight thousand seven hundred dollars ($8,700);

2. Network out-of-pocket maximum for family – seventeen thousand four hundred dollars ($17,400). Any individual family member need only incur a maximum of eight thousand seven hundred dollars ($8,700) before the plan begins paying one hundred percent (100%) of covered charges for that individual;

3. Non-network out-of-pocket maximum for individual – fifteen thousand dollars ($15,000); and

4. Non-network out-of-pocket maximum for family – thirty thousand dollars ($30,000).

(B) Network and non-network out-of-pocket maximums are separate. Expenses cannot be shared or transferred between network and non-network benefits.

(C) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged include, but are not limited to charges above the usual, customary, and reasonable (UCR) limit; the amount the member pays due to noncompliance; and charges above the maximum allowed.

(D) Medical and pharmacy expenses are combined to apply toward the network or non-network out-of-pocket maximum, as appropriate.

(4) The following services will be paid as a network benefit when provided by a non-network provider:

(A) Emergency services and urgent care;

(B) Covered services that are not available through a network provider within one hundred (100) miles of the member's home. The member must contact the claims administrator before the date of service in order to have a closer non-network provider's claims approved as a network benefit. Such approval is for three (3) months. After three (3) months, the member must contact the claims administrator to reassess network availability; and

(C) Covered services when such services are provided in a network hospital or ambulatory surgical center and are an adjunct to a service being performed by a network provider. Examples of such adjunct services include, but are not limited to, anesthesiology, assistant surgeon, pathology, or radiology.

(5) Preventive care is not subject to deductible or coinsurance requirements and will be paid at one hundred percent (100%) when provided by a network provider.

(6) Influenza vaccinations provided by a non-network provider will be reimbursed up to twenty-five dollars ($25) once the member submits a receipt and a reimbursement form to the claims administrator.

(7) Nutrition counseling is paid at one hundred percent (100%) when provided by a network provider after deductible is met.

(8) Four (4) Diabetes Self-Management Education visits received through a network provider are covered at one hundred percent (100%) after deductible is met.

(9) Sterilization procedure for men is paid at one hundred percent (100%) when provided by a network provider after deductible is met.

(10) Virtual visits offered through the vendor's telehealth tool are covered at one hundred percent (100%) after deductible is met unless Internal Revenue Service (IRS) guidance permits it to be paid at one hundred percent (100%) prior to deductible being met.

(11) Diagnostic breast examinations, supplemental breast examinations as defined in section 376.1183, RSMo, and low-dose mammography screenings are covered at one hundred percent (100%) after deductible is met.

(12) Diagnostic colorectal screenings are covered at one hundred percent (100%) after deductible is met.

(13) Newborn's claims will be subject to deductible and coinsurance.

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

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

(16) 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.

(17) Non-network plan payment – Non-network medical claims that are not otherwise subject to a contractual discount arrangement are processed following the claims administrator's practice for non-network facility claims. Members may be held liable for the amount of the fee above the allowed amount.

(18) 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 time frame 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.

(19) 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.

(20) A subscriber does not qualify for the HSA 3500 Plan if s/he is claimed as a dependent on another person's tax return or, except for the plans listed in section (20) 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.

(21) 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.

(22) 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 Nov. 16, 2026, effective Jan. 1, 2027, expires June 29, 2027. A proposed rule covering this same material will be published in the December 15, 2026, issue of the ***Missouri Register****.*

PUBLIC COST: This emergency rule will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the time the emergency is in effect.

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PRIVATE COST: This emergency rule will not cost private entities more than five hundred dollars ($500) in the time the emergency is in effect.