TITLE 22 – MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10 – Health Care Plan
Chapter 2 – State Membership

EMERGENCY AMENDMENT

22 CSR 10-2.090 Pharmacy Benefit Summary. The Missouri Consolidated Health Care Plan is amending the purpose statement and subsections (1)(A) and (1)(B).

*PURPOSE: This rule establishes the policy of the board of trustees in regard to the benefit provisions, covered charges, limitations, and exclusions [of the] **applicable to the** pharmacy benefit [for] **under** the PPO 750 Plan, PPO 1250 Plan, **PPO 2500 Plan,** [and Health Savings Account] **HSA 1800 Plan, and HSA 3500** Plan of the Missouri Consolidated Health Care Plan.*

PURPOSE: This amendment adds the new medical plans offered in 2027 and revises the name of the HSA Plan to the HSA 1800 Plan.

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2027, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, 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 amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, will be published in the December 15, 2026, issue of the **Missouri Register**. This emergency amendment complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed November 16, 2026, becomes effective January 1, 2027, and expires June 29, 2027.*

(1) The pharmacy benefit provides coverage for prescription drugs. Vitamin and nutrient coverage is limited to prenatal agents, therapeutic agents for specific deficiencies and conditions, and hematopoietic agents as prescribed by a provider to non-Medicare primary members.

(A) PPO 750 Plan**,** *[and]* PPO 1250 Plan**, and PPO 2500 Plan**.

1. Network:

A. Preferred formulary generic drug copayment: fifteen dollars ($15) for up to a thirty-one- (31-) day supply; thirty dollars ($30) for up to a sixty- (60-) day supply; and forty-five dollars ($45) for up to a ninety- (90-) day supply for a generic drug on the formulary;

B. Preferred formulary brand drug copayment: fifty dollars ($50) for up to a thirty-one- (31-) day supply; one hundred dollars ($100) for up to a sixty- (60-) day supply; and one hundred fifty dollars ($150) for up to a ninety- (90-) day supply for a brand drug on the formulary;

C. Non-preferred formulary drug and approved excluded drug copayment: one hundred twenty dollars ($120) for up to a thirty-one- (31-) day supply; two hundred forty dollars ($240) for up to a sixty- (60-) day supply; and three hundred sixty dollars ($360) for up to a ninety- (90-) day supply for a drug not on the formulary;

D. Specialty drug copayment: one hundred dollars ($100) for up to a thirty-one- (31-) day supply for a specialty drug on the formulary;

E. Diabetic drug (as designated as such by the PBM) copayment: fifty percent (50%) of the applicable network copayment;

F. Ninety- (90-) day supply of prescriptions may be filled through the pharmacy benefit manager's (PBM's) home delivery program or at select retail pharmacies, as designated by the PBM;

G. Home delivery programs.

(I) Maintenance prescriptions may be filled through the PBM's home delivery program.

(II) Specialty drugs are covered only through the specialty home delivery network for up to a thirty-one- (31-) day supply unless the PBM has determined that the specialty drug is eligible for up to a ninety- (90-) day supply. All specialty prescriptions must be filled through the PBM's specialty pharmacy, unless the prescription is identified by the PBM as emergent. The first fill of a specialty prescription identified to be emergent may be filled through a retail pharmacy.

(a) Specialty split-fill program – The specialty split-fill program applies to select specialty drugs as determined by the PBM. For the first three (3) months, members will be shipped a fifteen- (15-) day supply and charged a prorated copayment. If the member is able to continue with the medication, the remaining supply will be shipped and the member will be charged the remaining portion of the copayment. Starting with the fourth month, an up to thirty-one- (31-) day supply will be shipped if the member continues on treatment.

(III) Prescriptions filled through home delivery programs have the following copayments:

(a) Preferred formulary generic drug copayments: fifteen dollars ($15) for up to a thirty-one- (31-) day supply; thirty dollars ($30) for up to a sixty- (60-) day supply; and thirty-seven dollars and fifty cents ($37.50) for up to a ninety- (90-) day supply for a generic drug on the formulary;

(b) Preferred formulary brand drug copayments: fifty dollars ($50) for up to a thirty-one- (31-) day supply; one hundred dollars ($100) for up to a sixty- (60-) day supply; and one hundred twenty-five dollars ($125) for up to a ninety- (90-) day supply for a brand drug on the formulary;

(c) Non-preferred formulary drug and approved excluded drug copayments: one hundred twenty dollars ($120) for up to a thirty-one- (31-) day supply; two hundred forty dollars ($240) for up to a sixty- (60-) day supply; and three hundred dollars ($300) for up to a ninety- (90-) day supply for a drug not on the formulary;

(d) Specialty drug copayment: one hundred dollars ($100) for up to a thirty-one- (31-) day supply; two hundred dollars ($200) for up to sixty (60-) day supply; and three hundred dollars ($300) for up to ninety- (90-) day supply for a

specialty drug on the formulary;

H. Diabetic drug (as designated as such by the PBM) copayment: fifty percent (50%) of the applicable network copayment;

I. Only one (1) copayment is charged if a combination of different manufactured dosage amounts must be dispensed in order to fill a prescribed single dosage amount;

J. The copayment for a compound drug is based on the primary drug in the compound. The primary drug in a compound is the most expensive prescription drug in the mix. If any ingredient in the compound is excluded by the plan, the compound will be denied;

K. If the copayment amount is more than the cost of the drug, the member is only responsible for the cost of the drug;

L. If the physician allows for generic substitution and the member chooses a brand-name drug, the member is responsible for the generic copayment and the cost difference between the brand-name and generic drug which shall not apply to the out-of-pocket maximum;

M. Preferred select brand drugs, as determined by the PBM, the member shall pay the applicable generic copayment; and

N. Prescription drugs and prescribed over-the-counter drugs as recommended by the U.S. Preventive Services Task Force (categories A and B) and, for women, by the Health Resources and Services Administration are covered at one hundred percent (100%) when filled at a network pharmacy. The following are also covered at one hundred percent (100%) when filled at a network pharmacy:

(I) Vaccine recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

(II) Prescribed preferred diabetic test strips and lancets; and

(III) One (1) preferred glucometer.

2. Non-network: If a member chooses to use a non-network pharmacy for non-specialty prescriptions, s/he will be required to pay the full cost of the prescription and then file a claim with the PBM. The PBM will reimburse the cost of the drug based on the network discounted amount as determined by the PBM, less the applicable network copayment.

3. Out-of-pocket maximum.

A. Network and non-network out-of-pocket maximums are separate.

B. The family out-of-pocket maximum is an aggregate of applicable charges received by all covered family members of the plan. Any combination of covered family member applicable charges may be used to meet the family out-of-pocket maximum. Applicable charges received by one (1) family member may only meet the individual out-of-pocket maximum amount.

C. Network individual – four thousand one hundred fifty dollars ($4,150).

D. Network family – eight thousand three hundred dollars ($8,300).

E. Non-network – no maximum.

(B) *[Health Savings Account (HSA)]* **HSA 1800 Plan and HSA 3500** Plan Prescription Drug Coverage. Medical and pharmacy expenses are combined to apply toward the appropriate network or non-network deductible and out-of-pocket maximum specified in 22 CSR 10-2.053 **and 22 CSR 10-2.056**.

1. Network:

A. Preferred formulary generic drug: ten percent (10%) coinsurance up to fifty dollars ($50) per thirty-one- (31-) day supply after deductible has been met for a generic drug on the formulary;

B. Preferred formulary brand drug: twenty percent (20%) coinsurance up to one hundred dollars ($100) per thirty-one- (31-) day supply after deductible has been met for a brand drug on the formulary;

C. Non-preferred formulary drug and approved excluded drug: forty percent (40%) coinsurance up to two hundred dollars ($200) after deductible has been met;

D. Diabetic drug (as designated as such by the PBM) coinsurance: fifty percent (50%) of the applicable network coinsurance, not to exceed –

(I) Twenty-five dollars ($25) per thirty-one- (31-) day supply for generic drugs;

(II) Fifty dollars ($50) per thirty-one- (31-) day supply for preferred formulary brand drug; and

(III) One hundred dollars ($100) per thirty-one- (31-) day supply for non-preferred formulary drug;

E. Ninety- (90-) day supply of prescriptions may be filled through the pharmacy benefit manager's (PBM's) home delivery program or at select retail pharmacies, as designated by the PBM;

F. Home delivery programs.

(I) Maintenance prescriptions may be filled through the PBM's home delivery program.

(II) Specialty drugs are covered only through the specialty home delivery network for up to a thirty-one- (31-) day supply unless the PBM has determined that the specialty drug is eligible for up to a ninety- (90-) day supply. All specialty prescriptions must be filled through the PBM's specialty pharmacy, unless the prescription is identified by the PBM as emergent. The first fill of a specialty prescription identified to be emergent may be filled through a retail pharmacy.

(a) Specialty split-fill program – The specialty split-fill program applies to select specialty drugs as determined by the PBM. For the first three (3) months, members will be shipped a fifteen- (15-) day supply. If the member is able to continue with the medication, the remaining supply will be shipped. Starting with the fourth month, an up to thirty-one- (31-) day supply will be shipped if the member continues on treatment;

G. Prescription drugs and prescribed over-the-counter drugs as recommended by the U.S. Preventive Services Task Force (categories A and B) and, for women, by the Health Resources and Services Administration are covered at one hundred percent (100%) when filled at a network pharmacy;

H. Vaccines and administration as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention are covered at one hundred percent (100%) when filled at a network pharmacy;

I. The following are covered at one hundred percent (100%) when filled at a network pharmacy:

(I) Prescribed preferred diabetic test strips and lancets; and

(II) One (1) preferred glucometer;

J. If any ingredient in a compound drug is excluded by the plan, the compound will be denied; and

K. Drugs permitted by the Internal Revenue Service (IRS) in Notice 2019-45 and selected by the plan are not subject to the deductible when filled at a network pharmacy. Applicable coinsurance will apply.

2. Non-network: If a member chooses to use a non-network pharmacy, s/he will be required to pay the full cost of the prescription and then file a claim with the PBM. The PBM will reimburse the cost of the drug based on the network discounted amount as determined by the PBM, less the applicable deductible or coinsurance.

A. Preferred formulary generic drug: forty percent (40%)

coinsurance after deductible has been met for up to a thirty-one- (31-) day supply for a generic drug on the formulary.

B. Preferred formulary brand drug: forty percent (40%) coinsurance after deductible has been met for up to a thirty-one- (31-) day supply for a brand drug on the formulary.

C. Non-preferred formulary drug and approved excluded drug: fifty percent (50%) coinsurance after deductible has been met for up to a thirty-one- (31-) day supply for a drug not on the formulary.

D. Diabetic drug (as designated as such by the PBM) coinsurance: fifty percent (50%) of the applicable non-network coinsurance after deductible has been met.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 22, 2005, effective Jan. 1, 2006, expired June 29, 2006. Original rule filed Dec. 22, 2005, effective June 30, 2006. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed Nov. 16, 2026, effective Jan. 1, 2027, expires June 29, 2027. An emergency and a proposed amendment covering this same material is published in the December 15, 2026, issue of the* ***Missouri Register****.*

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

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