EMERGENCY RULE

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 subsection (1)(A).

PURPOSE: This amendment revises PPO 750 Plan and PPO 1250 Plan copayment amounts.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2026, 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, is published in this 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 12, 2025, becomes effective January 1, 2026, and expires June 29,

- (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.
 - 1. Network:
- A. Preferred formulary generic drug copayment: *[ten]* **fifteen** dollars (*[\$10]* **\$15**) for up to a thirty-one- (31-) day supply; *[twenty]* **thirty** dollars (*[\$20]* **\$30**) for up to a sixty- (60-) day supply; and *[thirty]* **forty-five** dollars (*[\$30]* **\$45**) for up to a ninety- (90-) day supply for a generic drug on the formulary;
- B. Preferred formulary brand drug copayment: [forty] fifty dollars ([\$40] \$50) for up to a thirty-one- (31-) day supply; [eighty] one hundred dollars ([\$80] \$100) for up to a sixty- (60-) day supply; and one hundred [twenty] fifty dollars ([\$120] \$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 ([\$100] \$120) for up to a thirty-one- (31-) day supply; two hundred **forty** dollars ([\$200] \$240) for up to a sixty- (60-) day supply; and three hundred **sixty** dollars ([\$300] \$360) for up to a ninety- (90-) day supply for a drug not on the formulary;
- D. Specialty drug copayment: [seventy-five] one hundred dollars ([\$75] \$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: [ten] fifteen dollars ([\$10] \$15) for up to a thirty-one- (31-) day supply; [twenty] thirty dollars ([\$20] \$30) for up to a sixty- (60) day supply; and [twenty-five] thirty-seven dollars and fifty cents ([\$25] \$37.50) for up to a ninety- (90-) day supply for a generic drug on the formulary;
- (b) Preferred formulary brand drug copayments: [forty] fifty dollars ([\$40] \$50) for up to a thirty-one- (31-) day supply; [eighty] one hundred dollars ([\$80] \$100) for up to a sixty- (60-) day supply; and one hundred twenty-five dollars ([\$100] \$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 ([\$100] \$120) for up to a thirty-one- (31-) day supply; two hundred **forty** dollars ([\$200] \$240) for up to a sixty- (60-) day supply; and [two] three hundred [fifty] dollars ([\$250] \$300) for up to a ninety- (90-) day supply for a drug not on the formulary;
- (d) Specialty drug copayment: [seventy-five] one hundred dollars ([\$75] \$100) for up to a thirty-one- (31-) day supply; [one] two hundred [fifty] dollars ([\$150] \$200) for up to sixty (60-) day supply; and [two] three hundred [twenty-five] dollars ([\$225] \$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

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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,[: ten dollars (\$10) for up to a thirty-one- (31-) day supply; twenty dollars (\$20) for up to a sixty- (60-) day supply; and twenty-five dollars (\$25) for up to a ninety- (90-) day supply] 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.

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. 12, 2025, effective Jan. 1, 2026, expires June 29, 2026. An emergency amendment and a proposed amendment covering this same material will be published in the Dec. 15, 2025, 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 this emergency is effective.

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