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

PROPOSED AMENDMENT

22 CSR 10-3.090 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.

(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.

(A) PPO 750 Plan and PPO 1250 Plan Prescription Drug Coverage.

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*[; formulary generic birth control and tobacco cessation prescriptions covered at one hundred percent (100%)]*.

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*[; formulary brand birth control and tobacco cessation prescriptions covered at one hundred percent (100%)]*.

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 *[(as designated as such by the PBM)]* 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 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 with a prorated copayment. If the member is able to continue with the medication, the remaining supply will be shipped with 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; and

(d) Specialty drug *[(as designated as such by the PBM)]* copayment: *[seventy-five]* **one hundred** dollars (*[$75]* **$100**) for up to a thirty-one- (31-) 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**,***[: 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**.

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, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. For intervening history, please consult the* ***Code of State Regulations****. Emergency amendment filed Nov. 12, 2025, effective Jan. 1, 2026, expires June 29, 2026. Amended: filed Nov. 12, 2025.*

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, John Wiemann, 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.*