



January 30, 2026

## There are upcoming changes\* to your plan's drug coverage — and we want to be sure you're ready

Starting **April 1, 2026** you'll see changes to the drugs your **Standard Opt Out Plan-Aetna Illinois** covers. It's important that you review the changes in the chart enclosed. Talk to your doctor about how these changes might impact you.

### **Find out how to keep your costs low**

If the status of your current drug is changing, you may pay more for refilling them on or after **April 1, 2026**. So, we want to make sure you understand your options and what to do next.

### **What to do if your drugs are changing**

Talk to your doctor to find out if changing to a preferred drug is right for you. If they agree, have them send a new prescription to your pharmacy so it's ready for you to fill **April 1, 2026**.

Your doctor may decide it's best for you to stay on your current drug. If so, they can ask for medical exception. Or you can call us at the number on your member ID card to request one. If approved, you'll still pay your plan copay or cost-share, after you meet your plan's deductible or out-of-pocket requirements.

### **Need more support? We're here to help.**

- Visit the website listed on your member ID card to view your current plan details.
- Call us at the number on your member ID card.

\* In accordance with state law or insurer policies, changes to drug coverage are not effective for commercial fully insured plans (including HMOs) in **Arizona, Iowa, Minnesota, Louisiana, New York, North Dakota, Texas**, and in most circumstances **Connecticut and Vermont**, until the plans' renewal date. Additional state specific disclaimers for **Maryland, Tennessee and Washington** are listed later within this document.

## Changes beginning April 1, 2026

On or after this date, log in to your member website. Here, you can search for and estimate the cost of your drug(s). You can also find options that may cost you less. Keep in mind, these costs will depend on several things, like where you are with your deductible.

The changes listed in this chart are based on your plan information as of the date of this letter. Some drugs listed may require prior authorization. For more drug coverage information, view your formulary plan on the website listed on your member ID card.

**UPPER CASE** = brand-name drug

**lower case** = generic drug

| DRUG_NAME | CHANGES                                                                                                                            |
|-----------|------------------------------------------------------------------------------------------------------------------------------------|
| BONSITY   | Drug list addition (preferred specialty); Preauthorization required; Quantity limits apply. Covered up to 1 pen every 28 days      |
| BRILINTA  | Moving to non-preferred brand tier                                                                                                 |
| COPAXONE  | Moving to non-preferred specialty tier                                                                                             |
| DIFICID   | Moving to non-preferred brand tier                                                                                                 |
| FORTEO    | Non-formulary; not covered. Covered options include: teriparatide, zoledronic acid, BONSITY, OSPOMYV, STOBOCLO, TYMLOS             |
| OSPOMYV   | Drug list addition (preferred specialty); Preauthorization required; Quantity limits apply. Covered up to 1 syringe every 6 months |
| PROLIA    | Non-formulary; not covered. Covered options include: teriparatide, zoledronic acid, BONSITY, OSPOMYV, STOBOCLO, TYMLOS             |
| SAXENDA   | Moving to non-preferred brand tier                                                                                                 |
| STOBOCLO  | Drug list addition (preferred specialty); Preauthorization required; Quantity limits apply. Covered up to 1 syringe every 6 months |
| SYMBICORT | Moving to non-preferred brand tier                                                                                                 |

Information is subject to change.

Your plan may not cover certain drugs to treat conditions such as infertility, erectile dysfunction and weight loss. Not all health services are covered. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. To check coverage and copay information for a specific medicine, log into your member website. For questions, please call the toll-free number on your member ID card.

For fully insured plans (including HMOs) in **Maryland**, changes in prior authorization requirements for previously authorized **immune globulin (human) and drugs used in the treatment of a mental disorder** may not apply on reauthorization under certain conditions.

For fully insured plans in **Washington**, certain changes to **drugs prescribed for the treatment of a serious mental illness** may not apply until the plans' renewal date under certain conditions.

For fully insured plans in **Tennessee**, certain changes to **drugs previously authorized** may not apply until the plans' renewal date under certain conditions.

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Drug products are identified by unique numerical product identifiers, called National Drug Codes (NDC), which identify the manufacturer, strength, dosage form, formulation and package size.

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**Policy forms issued in Oklahoma include:**

Medical Multiple: AL HGrpPol 09, AL HCOC 14, AL HSOB 12, AL HSOBNM 12.

HMO-POS Combo: HI HGrpAg 07, HI GrpAgAmend-2025 01, HC HCOC 13, HC HSOB 12.

**Policy forms issued in Missouri include:**

HMO: HI HGrpAg 07, HI GrpAgAmend-2025 01, HI HCOC 13, HI HSOB 12.

POS: HO HGrpPol 05, HO POSRider 11.

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