



April 30, 2026

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

Starting **July 1, 2026** you'll see changes to the drugs your **Advanced Control 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 **July 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 **July 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 July 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
ANNOVERA	Non-formulary; not covered. Covered options include: etonogestrel-ethinyl estradiol vaginal ring, Haloette; For clients that have adopted the Affordable Care Act (ACA) Women's Preventive Services Benefit, this drug will be covered without cost sharing;
BRIUMVI	Drug list addition (preferred specialty); Preauthorization required; Quantity limits apply. Covered up to 3 vials every 168 days
COMBIVENT RESPIMAT	Non-formulary; not covered. Covered options include: ipratropium-albuterol inhalation solution, ANORO ELLIPTA, STIOLTO RESPIMAT
EPYSQLI	Drug list addition (preferred specialty); Preauthorization required; Quantity limits apply. Covered up to 12 vials every 28 days
EUCRISA	Preauthorization required; Quantity limits apply. Covered up to 60 g every 25 days
INVEGA HAFYERA	Drug list addition (preferred brand)
INVEGA SUSTENNA	Moving to preferred brand tier
INVEGA TRINZA	Drug list addition (preferred brand)
ORENCIA INJ 50/0.4ML	Moving to non-preferred specialty tier
ORENCIA INJ 87.5/0.7ML	Moving to non-preferred specialty tier
PERSERIS	Moving to non-preferred brand tier

DRUG_NAME	CHANGES
PYZCHIVA SC (by Sandoz)	Non-formulary; not covered. Covered options include: Crohn's Disease: ADALIMUMAB-ADAZ, ADALIMUMAB-FKJP, ENTYVIO SC, HYRIMOZ (by Cordavis), PYZCHIVA SC (by Cordavis), RINVOQ, SKYRIZI SC, TREMFYA SC, YESINTEK SC; Psoriasis: ADALIMUMAB-ADAZ, ADALIMUMAB-FKJP, BIMZELX, HYRIMOZ (by Cordavis), OTEZLA, OTEZLA XR, PYZCHIVA SC (by Cordavis), SKYRIZI SC, SOTYKTU, TREMFYA SC, YESINTEK SC; Psoriatic Arthritis: ADALIMUMAB-ADAZ, ADALIMUMAB-FKJP, COSENTYX SC, ENBREL, HYRIMOZ (by Cordavis), OTEZLA, OTEZLA XR, PYZCHIVA SC (by Cordavis), RINVOQ, SKYRIZI SC, TREMFYA SC, YESINTEK SC; Ulcerative Colitis: ADALIMUMAB-ADAZ, ADALIMUMAB-FKJP, ENTYVIO SC, HYRIMOZ (by Cordavis), PYZCHIVA SC (by Cordavis), RINVOQ, SKYRIZI SC, TREMFYA SC, VELSIPITY, YESINTEK SC, ZEPOSIA
SOLIRIS	Non-formulary; not covered. Covered options include: EMPAVELI, EPYSQLI
SPRAVATO 56MG DOSE	Moving to preferred specialty tier
SPRAVATO 84MG DOSE	Moving to preferred specialty tier
STELARA SC	Non-formulary; not covered. Covered options include: Crohn's Disease: ADALIMUMAB-ADAZ, ADALIMUMAB-FKJP, ENTYVIO SC, HYRIMOZ (by Cordavis), PYZCHIVA SC (by Cordavis), RINVOQ, SKYRIZI SC, TREMFYA SC, YESINTEK SC; Psoriasis: ADALIMUMAB-ADAZ, ADALIMUMAB-FKJP, BIMZELX, HYRIMOZ (by Cordavis), OTEZLA, OTEZLA XR, PYZCHIVA SC (by Cordavis), SKYRIZI SC, SOTYKTU, TREMFYA SC, YESINTEK SC; Psoriatic Arthritis: ADALIMUMAB-ADAZ, ADALIMUMAB-FKJP, COSENTYX SC, ENBREL, HYRIMOZ (by Cordavis), OTEZLA, OTEZLA XR, PYZCHIVA SC (by Cordavis), RINVOQ, SKYRIZI SC, TREMFYA SC, YESINTEK SC; Ulcerative Colitis: ADALIMUMAB-ADAZ, ADALIMUMAB-FKJP, ENTYVIO SC, HYRIMOZ (by Cordavis), PYZCHIVA SC (by Cordavis), RINVOQ, SKYRIZI SC, TREMFYA SC, VELSIPITY, YESINTEK SC, ZEPOSIA

DRUG_NAME	CHANGES
TWYNEO	Non-formulary; not covered. Covered options include: adapalene gel 0.1%, adapalene-benzoyl peroxide, benzoyl peroxide-erythromycin, clindacin-P, clindamycin-benzoyl peroxide gel 1.2%-2.5%, 1.2%-3.75%, dapsone, differin gel 0.1%, ery pads, erythromycin, sulfacetamide, tretinoin cream, gel 0.01%, 0.025%, 0.04%, 0.1%, AKLIEF, EPIDUO, EPIDUO FORTE, WINLEVI
TYRUKO	Drug list addition (preferred specialty); Preauthorization required; Quantity limits apply. Covered up to 1 vial every 28 days
UDENYCA ONBODY	Non-formulary; not covered. Covered options include: FULPHILA
ULTOMIRIS	Drug list addition (non-preferred specialty); Preauthorization required; Quantity limits apply. Covered up to 8 cartridges every 28 days
XELJANZ SOL 1MG/ML	Moving to non-preferred specialty tier
XYOSTED	Drug list addition (non-preferred brand); Preauthorization required

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

PPO: AL HGrpPol 07, AL GrpPolAmend-2024 01, AL GrpPolAmend-2025 01, AL HCOC-PPO 14, AL HSOB-PPO 12

EPO: AL HGrpPol 07, AL GrpPolAmend-2024 01, AL GrpPolAmend-2025 01, AL HCOC-EPO 14, AL HSOB-EPO 12

TC: AL HGrpPol 07, AL GrpPolAmend-2024 01, AL GrpPolAmend-2025 01, AL HCOC-TC 14, AL HSOB-TC 12

