



January 2024

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

Starting **January 1, 2024**, you'll see changes to the drugs your **Aetna Health Exchange Plan-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 **January 1, 2024**. 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 **January 1, 2024**.

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.

Changes beginning January 1, 2024

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.

UPPER CASE = brand-name drug

lower case = generic drug

Drug Name	Change(s)
acamprosate calcium dr	Moving to preferred generic tier
ADZENYS XR TAB 12.5MG	Drug list addition (non-preferred); Quantity limits apply. Covered up to 30 tabs every 30 days
ADZENYS XR TAB 15.7 MG	Drug list addition (non-preferred); Quantity limits apply. Covered up to 30 tabs every 30 days
ADZENYS XR TAB 18.8MG	Drug list addition (non-preferred); Quantity limits apply. Covered up to 30 tabs every 30 days
ADZENYS XR TAB 3.1MG	Drug list addition (non-preferred); Quantity limits apply. Covered up to 60 tabs every 30 days
ADZENYS XR TAB 6.3MG	Drug list addition (non-preferred); Quantity limits apply. Covered up to 60 tabs every 30 days
ADZENYS XR TAB 9.4MG	Drug list addition (non-preferred); Quantity limits apply. Covered up to 60 tabs every 30 days
ALVESCO AER 160MCG	Drug list addition (non-preferred); Quantity limits apply. Covered up to 2 packages every 30 days
ALVESCO AER 80MCG	Drug list addition (non-preferred); Quantity limits apply. Covered up to 3 packages every 30 days
amlodipine / valsartan / hctz	Non-formulary; not covered
amlodipine / valsartan / hydrochlorothiazide	Non-formulary; not covered
APRETUDE	Not covered under pharmacy benefit. May be covered under the medical benefit
BASAGLAR TEMPO PEN	Non-formulary; not covered
BREO ELLIPTA	Moving to preferred brand tier
colesevelam hydrochloride	Drug list addition (non-preferred)
DESCOVY	Moving to preferred brand tier
DOPTELET (NDC* 71369002015 and 71369002010)	Drug list addition (non-preferred specialty); Preauthorization required; Quantity limits apply. Covered up to 1 carton per 5 days
DOPTELET (NDC* 71369002030 only)	Drug list addition (non-preferred specialty); Preauthorization required; Quantity limits apply. Covered up to 60 tabs every 30 days
DULERA	Non-formulary; not covered
EMFLAZA	Non-formulary; not covered
EMGALITY	Drug list addition (preferred); Step therapy required
EPCLUSA	Moving to non-preferred brand tier
EPIDIOLEX	Moving to preferred specialty tier

Drug Name	Change(s)
FARXIGA	Non-formulary; not covered
glatiramer acetate	Moving to non-preferred generic tier
glatopa	Moving to non-preferred generic tier
GLYXAMBI	Moving to preferred brand tier
HARVONI	Moving to non-preferred brand tier
HUMULIN 70 / 30 (NDC* 00002871501 and 00002871517)	Non-formulary drug (Other NDCs covered)
HUMULIN 70 / 30 KWIKPEN (NDC* 00002880301 and 00002880359)	Non-formulary drug (Other NDCs covered)
HUMULIN N (NDC* 00002831501 only)	Non-formulary drug (Other NDCs covered)
HUMULIN N KWIKPEN (NDC* 00002880501 and 00002880559)	Non-formulary drug (Other NDCs covered)
HUMULIN R (NDC* 00002821501 and 00002821517)	Non-formulary drug (Other NDCs covered)
INSULIN DEGLUDEC	Moving to preferred brand tier; Step therapy removed
INSULIN DEGLUDEC FLEXTUOC	Moving to preferred brand tier; Step therapy removed
JARDIANCE	Moving to preferred brand tier
LEDIPASVIR / SOFOSBUVIR	Moving to non-preferred brand tier
LINZESS	Drug list addition (preferred); Preauthorization required
MAVYRET	Non-formulary; not covered
methylphenidate	Drug list addition (non-preferred); Quantity limits apply. Covered up to 30 patches every 30 days
naproxen sodium	Drug list addition (non-preferred)
naproxen sodium er	Drug list addition (non-preferred)
PLEGRIDY	Drug list addition (non-preferred specialty); Preauthorization required; Quantity limits apply. Covered up to 2 injections every 28 days
PLEGRIDY STARTER PACK	Drug list addition (non-preferred specialty); Preauthorization required; Quantity limits apply. Covered up to 2 injections every 28 days
PRALUENT	Non-formulary; not covered
PREZISTA	Non-formulary; not covered
PROMACTA	Non-formulary; not covered
REPATHA	Drug list addition (preferred specialty); Preauthorization required; Quantity limits apply. Covered up to 3 pens every 28 days
REPATHA PUSHTRONEX SYSTEM	Drug list addition (preferred specialty); Preauthorization required; Quantity limits apply. Covered up to 1 cartridge every 28 days
REPATHA SURECLICK	Drug list addition (preferred specialty); Preauthorization required; Quantity limits apply. Covered up to 3 pens every 28 days
RUXIENCE	Moving to non-preferred brand tier; Preauthorization required
SOFOBUVIR / VELPATASVIR	Moving to non-preferred brand tier

Drug Name	Change(s)
SYNJARDY	Moving to preferred brand tier; Step therapy required
SYNJARDY XR	Moving to preferred brand tier; Step therapy required
teriflunomide	Drug list addition (non-preferred specialty); Preauthorization required; Quantity limits apply. Covered up to 30 tabs every 30 days
TRELEGY ELLIPTA	Moving to preferred brand tier
TRESIBA	Drug list addition (preferred); Step therapy removed
TRESIBA FLEXTOUCH	Moving to preferred brand tier; Step therapy removed
VERZENIO	Moving to preferred specialty tier; Preauthorization required; Quantity limits apply. Covered up to 56 tablets every 28 days
VOSEVI	Moving to non-preferred brand tier
VYVANSE CAP 10MG	Drug list addition (preferred); Quantity limits apply. Covered up to 60 caps every 30 days
VYVANSE CAP 20MG	Drug list addition (preferred); Quantity limits apply. Covered up to 60 caps every 30 days
VYVANSE CAP 30MG	Drug list addition (preferred); Quantity limits apply. Covered up to 60 caps every 30 days
VYVANSE CAP 40MG	Drug list addition (preferred); Quantity limits apply. Covered up to 30 caps every 30 days
VYVANSE CAP 50MG	Drug list addition (preferred); Quantity limits apply. Covered up to 30 caps every 30 days
VYVANSE CAP 60MG	Drug list addition (preferred); Quantity limits apply. Covered up to 30 caps every 30 days
VYVANSE CAP 70MG	Drug list addition (preferred); Quantity limits apply. Covered up to 30 caps every 30 days
XIGDUO XR	Non-formulary; not covered
ZIEXTENZO	Non-formulary; not covered

* 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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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 the back of your member ID card.

Information is subject to change. In accordance with state law or insurer policies, changes to drug coverage are not effective for commercial fully insured plans (including HMOs) in Louisiana, New York, Texas, and in most circumstances Connecticut and Vermont, until the plans' renewal date.

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Policy forms issued in Oklahoma include: AL OK HCOC, HC OK HCOC.

Policy forms issued in Missouri include: AL HGrpPol 07, AL SG HGrpPol-1A 01, HI HGrpAg 05, HI GrpAgAmend-2022 01, HO HGrpPol 04, HO GrpPolAmend-2022 01, HI SG HGrpAg-1A 01. AL IVL HPOL-1A-2023-EPO-HIX 02, AL IVL SOB 1A EPO HIX 02R2, AL IVL HPOL-1A-2023-EPO 02, AL IVL SOB 1A EPO 02R1.

Aetna complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Aetna provides free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,
P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779),
1-800-648-7817, TTY: 711,
Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

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Hawaiian	No ka wala'au 'ana me ka lawelawe 'olelo e kahea aku i ka helu kelepona ma kāu kāleka ID. Kāki 'ole 'ia kēia kōkua nei.
Hindi	बिना किसी कीमत के भाषा सेवाओं का उपयोग करने के लिए, अपने आईडी कार्ड पर दिए नंबर पर कॉल करें।
Hmong	Yuav kom tau kev pab txhais lus tsis muaj nqi them rau koj, hu tus naj npawb ntawm koj daim npav ID.
Igbo	Inweta enyemaka asụsụ na akwughi ugwo obula, kpoo nomba no na kaadi njirimara gi
Ilocano	Tapno maakses dagiti serbisio ti pagsasao nga awanan ti bayadna, awagan ti numero nga adda ayan ti ID kardmo.
Indonesian	Untuk mengakses layanan bahasa tanpa dikenakan biaya, silakan hubungi nomor telepon di kartu asuransi Anda.
Italian	Per accedere ai servizi linguistici senza alcun costo per lei, chiami il numero sulla tessera identificativa.
Japanese	無料の言語サービスは、IDカードにある番号にお電話ください。
Karen	လၢတၢ်ကၢၤန့ၢ်ဂၢ်တၢ်မၤစၢၤအတၢ်ဖဲးတၢ်မၤတဖၣ် လၢတၢ်အိၣ်ဒီးအပူၤလၢနကတၢ်ဟ့ၣ်အိၣ်အဂီၢ်,ကိးဘၣ်လီၤတဖၣ်နီၣ်ဂံၢ်လၢအအိၣ်လၢနခိၣ်ဂီၢ် (ID) အလီၤန့ၣ်တက့ၢ်.
Korean	무료 다국어 서비스를 이용하려면 보험 ID 카드에 수록된 번호로 전화해 주십시오.
Kru-Bassa	I nyuu kosna mahola ni language services ngui nsaa wogui wo, sebel i nsinga i ye ntilga i kat yong matibla
Kurdish	بو دەسپێر اگەشتن بە خزمەتگوزاری زمان بەی تێچوون بو تو، پەيوەندی بکە بە ژمارەى سەر ئای دی (ID) کارتێ خۆت.
Lao	ເພື່ອເຂົ້າເຖິງບໍລິການພາສາທີ່ບໍ່ສະຄວ່າ, ໃຫ້ໂທຫາເບີໂທຢູ່ໃນບັດປະຈຳຕົວຂອງທ່ານ.
Marathi	आपल्याला कोणत्याही शुल्काशिवाय भाषा सेवांपर्यंत पोहोचण्यासाठी, आपल्या ID कार्डावरील क्रमांकावर फोन करा.
Marshallese	Nan bōk jipañ kōn kajin ilo an ejjelōk wōṇean ṇan kwe, kwōn kallok nōmba eo ilo kaat in ID eo am.
Micronesia-Ponapean	Pwehn alehdi sawas en lokaia kan ni sohte pweipwei, koahlih nempe nan amhw doaropwe en ID.
Mon-Khmer, Cambodian	ដើម្បីទទួលបានសេវាកម្មភាសាដែលឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរសព្ទទៅកាន់លេខដែលមាននៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់លោកអ្នក។
Navajo	T'áá ni nizaad k'ehjí bee níká a'doowol doo búáh ílínígóó naaltsoos bee atah níłjigo nanitinígíí bee néého'dólzínígíí béesh bee hane'í biká'ígíí áají' hólne'.
Nepali	भाषासम्बन्धी सेवाहरूमाथि निःशुल्क पहुँच राख्न आफ्नो कार्डमा रहेको नम्बरमा कल गर्नुहोस्।
Nilotic-Dinka	Të koor yin ran de wëër de thokic ke cin wëu kor keek tënɔŋ yin. Ke yin col ran ye koc kuony në namba de abac tō në ID kard duɔn de tīt de nyin de panakim köu.
Norwegian	For tilgang til kostnadsfri språktjenester, ring nummeret på ID-kortet ditt.
Pennsylvanian-Dutch	Um Schprooch Services zu griege mitaus Koscht, ruff die Nummer uff dei ID Kaart.

