January 1, 2021

Changes coming to your plan's pharmacy drug lists

There will be changes to the **Aetna Funding Advantage Small Group Value Plus Plan** drug list that applies to your plan starting on **January 1, 2021**. It's important that you review the changes in the chart below. Talk to your health care provider about how these changes might impact you.

What if I need a prescription drug that requires a medical exception?

You or your prescriber can request a medical exception to the changes in this letter. If you would like to ask for an exception, talk with your prescriber. Or, you can call us at the toll-free number on your Member ID card.

We'll contact you and your prescriber with our decision. If we approve your exception, you will pay your plan copay or cost-share. But first you must meet any deductible or out-of-pocket requirements of your pharmacy plan.

How to find a preferred medicine that's right for you

You can visit the website that's shown on your member ID card. Then log in to your account. To better understand how your plan's pharmacy benefits work, call us at the number on your member ID card.

Key for table below

If your plan doesn't have formulary exclusions, you will pay the non-preferred copay.

Generic expected - When a generic drug is expected, the generic drug will be covered in place of the brand-name drug. The brand-name drug is likely to become non-formulary or covered at a higher cost.

* Changes apply if your plan includes this program. Refer to your plan documents.

UPPER CASE = brand-name medication **lower case** = generic medication

Prescription Drug	Change(s)
ABILIFY MAINTENA	Preferred brand drug
ACCU-CHEK AVIVA PLUS	Not covered for plans with Formulary Exclusions; Quantity limits removed
ACCU-CHEK COMPACT PLUS	Not covered for plans with Formulary Exclusions; Quantity limits removed
ACCU-CHEK GUIDE	Not covered for plans with Formulary Exclusions; Quantity limits removed
ACCU-CHEK LANCETS / LANCING DEVICES	Non-preferred brand drug
ACCU-CHEK SMARTVIEW STRIPS	Not covered for plans with Formulary Exclusions; Quantity limits removed
acetaminophen / codeine	You can fill up to 90ml/ day

Prescription Drug	Change(s)
ADDERALL TAB 10MG	Step therapy removed; You can fill up to 3/ day
ADDERALL TAB 12.5MG	Step therapy removed; You can fill up to 3/ day
ADDERALL TAB 15MG	Step therapy removed; You can fill up to 2/ day
ADDERALL TAB 20MG	Step therapy removed; You can fill up to 2/ day
ADDERALL TAB 30MG	Step therapy removed; You can fill up to 1/ day
ADDERALL TAB 5MG	Step therapy removed; You can fill up to 3/ day
ADDERALL TAB 7.5MG	Step therapy removed; You can fill up to 3/ day
ADDERALL XR CAP 10MG	Non-preferred brand drug; Step therapy removed
ADDERALL XR CAP 15MG	Non-preferred brand drug; Step therapy removed; You can fill up to 1/ day
ADDERALL XR CAP 20MG	Non-preferred brand drug; Step therapy removed; You can fill up to 1/ day
ADDERALL XR CAP 25MG	Non-preferred brand drug; Step therapy removed; You can fill up to 1/ day
ADDERALL XR CAP 30MG	Non-preferred brand drug; Step therapy removed; You can fill up to 1/ day
ADDERALL XR CAP 5MG	Non-preferred brand drug; Step therapy removed
ADHANSIA XR	Preauthorization removed; Step therapy removed
ADZENYS ER	Not covered for plans with Formulary Exclusions; Step therapy removed
ADZENYS XR-ODT	Preauthorization removed; Step therapy removed
AIRDUO RESPICLICK	Not covered for plans with Formulary Exclusions; You must first try ADVAIR, ANORO ELLIPTA, BREO ELLIPTA, SYMBICORT*
AKYNZEO	Not covered for plans with Formulary Exclusions; Preauthorization removed; Step therapy removed; Quantity limits removed
ALECENSA	Preferred specialty drug
ALUNBRIG	Preferred specialty drug
AMITIZA	Not covered for plans with Formulary Exclusions; Quantity limits removed
amnesteem	Quantity limits removed
amphet / dextr cap 15mg er	You can fill up to 1/ day
amphet / dextr cap 20mg er	You can fill up to 1/ day
amphet / dextr cap 25mg er	You can fill up to 1/ day
amphet / dextr cap 30mg er	You can fill up to 1/ day
amphet / dextr tab 10mg	You can fill up to 3/ day
amphet / dextr tab 12.5mg	You can fill up to 3/ day
amphet / dextr tab 15mg	You can fill up to 2/ day
amphet / dextr tab 20mg	You can fill up to 2/ day
amphet / dextr tab 30mg	You can fill up to 1/ day
amphet / dextr tab 5mg	You can fill up to 3/ day
amphet / dextr tab 7.5mg	You can fill up to 3/ day
amphetamine tab 10mg	You can fill up to 3/ day
amphetamine tab 12.5mg	You can fill up to 3/ day
amphetamine tab 15mg	You can fill up to 2/ day
amphetamine tab 20mg	You can fill up to 2/ day
amphetamine tab 30mg	You can fill up to 1/ day
amphetamine tab 5mg	You can fill up to 3/ day

Prescription Drug	Change(s)
amphetamine tab 7.5mg	You can fill up to 3/ day
ANGELIQ	Not covered for plans with Formulary Exclusions
ANNOVERA	Preferred brand drug
ANZEMET	Not covered for plans with Formulary Exclusions; Quantity limits removed
APADAZ	You can fill up to 168/ month
APOKYN	Not covered for plans with Formulary Exclusions
APTENSIO XR	Not covered for plans with Formulary Exclusions; Preauthorization removed; Step therapy removed
ARALAST NP	Not covered for plans with Formulary Exclusions
ARISTADA INITIO	Non-preferred brand drug
ARYMO ER TAB	Not covered for plans with Formulary Exclusions; Step therapy removed
atomoxetine	You can fill up to 1/ day
atropine sulfate	Not covered under pharmacy benefit
AZOPT	Not covered for plans with Formulary Exclusions
benzhydrocodone / acetaminophen	You can fill up to 168/ month
BENZIQ	Preferred brand drug
BENZIQ LS	Preferred brand drug
BEPREVE	Not covered for plans with Formulary Exclusions
BESIVANCE	Not covered for plans with Formulary Exclusions
BETIMOL	Preferred brand drug
BETOPTIC-S	Not covered for plans with Formulary Exclusions
BEVESPI AEROSPHERE	Not covered for plans with Formulary Exclusions; Quantity limits removed
BIJUVA	Preferred brand drug; Quantity limits removed
BREZTRI AEROSPHERE	Preferred brand drug; You can fill up to 1 inhaler/ month*
BUNAVAIL	Not covered for plans with Formulary Exclusions
butalbital / aspirin / caffeine / codeine	You can fill up to 48/ month
CALCIUM-FOLIC ACID PLUS D	Not covered for plans with Formulary Exclusions
CILOXAN	Not covered for plans with Formulary Exclusions
CIPRO HC	Not covered for plans with Formulary Exclusions
CIPRODEX	Not covered for plans with Formulary Exclusions
claravis	Quantity limits removed
CLENPIQ	Preferred brand drug
CONCERTA TAB 36MG	You can fill up to 2/ day
CONCERTA TAB 54MG	You can fill up to 1/ day
CORVITE 150	Not covered for plans with Formulary Exclusions
CORVITE FE	Not covered for plans with Formulary Exclusions
cyclobenzaprine hcl	Not covered for plans with Formulary Exclusions
DARAPRIM	Not covered for plans with Formulary Exclusions

Prescription Drug	Change(s)
DAYTRANA	Not covered for plans with Formulary Exclusions; Preauthorization removed; Step therapy removed
DEPO-SUBQ PROVERA 104	Not covered for plans with Formulary Exclusions
DESOXYN	Preauthorization removed; Step therapy removed
DEXEDRINE CAP 10MG CR	Step therapy removed
DEXEDRINE CAP 15MG CR	Step therapy removed; You can fill up to 2/ day
DEXEDRINE CAP 5MG CR	Step therapy removed
dexmethylphenidate hcl	You can fill up to 2/ day
dexmethylphenidate hcl er	Preauthorization removed; Step therapy removed; You can fill up to 1/ day
dextroamphet cap 15mg er	You can fill up to 2/ day
DIALYVITE	Not covered for plans with Formulary Exclusions
DIFFERIN	Not covered for plans with Formulary Exclusions; Step therapy removed
DOPTELET	Preferred specialty drug
dorzolamide hcl / timolol maleate	Preferred generic drug
DOVATO	You can fill up to 1/ day*
doxepin hydrochloride cream	Not covered for plans with Formulary Exclusions; You must first try 1 of betamethasone, clobetasol, fluocinolone, hydrocortisone AND 1 of tacrolimus, EUCRISA*
DUAVEE	Not covered for plans with Formulary Exclusions; Quantity limits removed
DUOBRII	Preferred brand drug; Quantity limits removed
DUPIXENT	Preferred specialty drug
DUPIXENT INJ 200 / 1.14ML	Preferred specialty drug; You can fill up to 2 inj/ 14 days*
DUROLANE	Preferred specialty drug; Step therapy removed
ed-spaz	Preferred generic drug
EMEND	Not covered for plans with Formulary Exclusions; Quantity limits removed
EMEND SUS 125MG	Not covered for plans with Formulary Exclusions
ENBREL	You can fill up to 8 inj/ month*
ENSTILAR	Preferred brand drug; Quantity limits removed
ERIVEDGE	Preferred specialty drug
ESTRING	Not covered for plans with Formulary Exclusions
EVZIO	Step therapy removed; You can fill up to 2 cartons(4 auto-injectors)/ 180 days*
FABIOR	Not covered for plans with Formulary Exclusions; Step therapy removed
FEMRING	Not covered for plans with Formulary Exclusions; Quantity limits removed
FINACEA	Preferred brand drug; Preauthorization required*
FLAREX	Preferred brand drug
fluticasone propionate / salmeterol diskus	Not covered for plans with Formulary Exclusions; You must first try ADVAIR, ANORO ELLIPTA, BREO ELLIPTA, SYMBICORT*
FOCALIN	You can fill up to 2/ day
FOCALIN XR	You can fill up to 1/ day
folic acid	Preferred generic drug

Prescription Drug	Change(s)
GAMUNEX-C	Not covered for plans with Formulary Exclusions
GEL-ONE	Not covered for plans with Formulary Exclusions; Step therapy removed
GELSYN-3	Preferred specialty drug; Step therapy removed
GENVISC 850	You must first try 3 of GELSYN-3, SUPARTZ, EUFLEXXA, DUROLANE*
GLASSIA	Not covered for plans with Formulary Exclusions
glydo	You can fill up to 2 ml/ day*
GOLYTELY	Not covered for plans with Formulary Exclusions
GRASTEK	You must first try 1 oral antihistamine and 1 intranasal corticosteroid*
HOMATROPAIRE	Not covered under pharmacy benefit
homatropine hbr	Not covered under pharmacy benefit
HUMATROPE	Not covered for plans with Formulary Exclusions
HYALGAN	You must first try 3 of GELSYN-3, SUPARTZ, EUFLEXXA, DUROLANE*
hydrocodone / acetaminophen	You can fill up to 6/ day
hydrocodone bitartrate / acetaminophen	You can fill up to 90ml/ day
HYMOVIS	You must first try 3 of GELSYN-3, SUPARTZ, EUFLEXXA, DUROLANE*
hyoscyamine sulfate	Preferred generic drug
hyoscyamine sulfate er	Preferred generic drug
hyoscyamine sulfate odt	Preferred generic drug
hyoscyamine sulfate sr	Preferred generic drug
HYSINGLA ER	Not covered for plans with Formulary Exclusions
IMVEXXY	Preferred brand drug
INBRIJA	Preferred specialty drug
INCRUSE ELLIPTA	Not covered for plans with Formulary Exclusions; Quantity limits removed
INTRAROSA	Not covered for plans with Formulary Exclusions; Quantity limits removed
ISORDIL TITRADOSE	Not covered for plans with Formulary Exclusions
isosorbide dinitrate	Not covered for plans with Formulary Exclusions
isotretinoin	Quantity limits removed
JORNAY PM	Step therapy removed
KADIAN	Not covered for plans with Formulary Exclusions
KESIMPTA	Preferred specialty drug
KEVZARA	Step therapy removed
KYLEENA	Preferred brand drug
LACRISERT	Not covered for plans with Formulary Exclusions
LAMICTAL	Non-preferred brand drug; Step therapy removed
latanoprost	Preferred generic drug
LATUDA	Preferred brand drug; Step therapy removed; Quantity limits removed
LATUDA TAB 60MG	Preferred brand drug; Step therapy removed

Prescription Drug	Change(s)
lidocaine	Not covered for plans with Formulary Exclusions
lidocaine hcl gel 2%	You can fill up to 2 ml/ day*
lidocaine hcl solution	Preferred generic drug
lidocaine sol 4%	Preferred generic drug
LIDODERM	Non-preferred brand drug; Step therapy removed; Quantity limits removed
LILETTA	Not covered for plans with Formulary Exclusions
LONHALA MAGNAIR REFILL KIT	Not covered for plans with Formulary Exclusions; You must first try SPIRIVA, YUPELRI*
MAGNEBIND 400	Not covered for plans with Formulary Exclusions
MAXIDEX	Not covered for plans with Formulary Exclusions
MENEST	Not covered for plans with Formulary Exclusions
meperidine hcl tab	Not covered for plans with Formulary Exclusions; You can fill up to 18/ month
meperidine sol 50mg / 5ml	Not covered for plans with Formulary Exclusions; You can fill up to 90ml/ month
mesalamine	Preferred generic drug
methadone con 10mg / ml	You can fill up to 1ml/ day
METHADOSE CON 10MG / ML	You can fill up to 1ml/ day
METHADOSE SUGAR-FREE	You can fill up to 1ml/ day
methylphenidate hcl	You can fill up to 3/ day
methylphenidate hydrochloride er 36mg tab	You can fill up to 2/ day
methylphenidate hydrochloride er 54mg tab	You can fill up to 1/ day
MIRENA	Preferred brand drug
MONOVISC	Not covered for plans with Formulary Exclusions
MULPLETA	Preferred specialty drug
myorisan	Quantity limits removed
NAYZILAM	Preferred brand drug
NEPHPLEX RX	Not covered for plans with Formulary Exclusions
NEULASTA / ONPRO	Not covered for plans with Formulary Exclusions; Quantity limits removed
NEXIUM 24HR	Generic expected
NEXLETOL	Preferred brand drug
NEXLIZET	Preferred brand drug
NIFEREX	Not covered for plans with Formulary Exclusions
NINLARO	Preferred specialty drug
NORDITROPIN FLEXPRO	Preferred specialty drug; Step therapy removed
NOVOFINE 32GX6MM	Not covered for plans with Formulary Exclusions
NOVOFINE AUTOCOVER 30GX8MM	Not covered for plans with Formulary Exclusions
NOVOFINE PLUS 32GX4MM	Not covered for plans with Formulary Exclusions

Prescription Drug	Change(s)
NOVOLIN 70 / 30 FLEXPEN RELION	Not covered for plans with Formulary Exclusions
NOVOTWIST 32GX5MM	Not covered for plans with Formulary Exclusions
NUCALA	Preferred specialty drug
NUCALA INJ 100MG / ML	Preferred specialty drug
NUCYNTA	Preferred brand drug; Step therapy removed
NUCYNTA ER	Preferred brand drug; Step therapy removed
NUFERA	Not covered for plans with Formulary Exclusions
nulev	Preferred generic drug
NUVARING	Not covered for plans with Formulary Exclusions
OBIZUR	Not covered for plans with Formulary Exclusions
OCUVEL	Not covered for plans with Formulary Exclusions
ODACTRA	You must first try 1 oral antihistamine and 1 intranasal corticosteroid*
ODOMZO	Preferred specialty drug
omeprazole	Preferred generic drug; You can fill up to 90 caps/365 days*
omeprazole otc	You can fill up to 90 caps/365 days*
OMNIPOD	Preferred brand drug
ONETOUCH LANCETS / LANCING DEVICES	Preferred brand drug
ONETOUCH ULTRA	Preferred brand drug; Step therapy removed
ONETOUCH VERIO TEST STRIPS	Preferred brand drug; Step therapy removed
ORACEA	Preferred brand drug; Step therapy removed; Quantity limits removed
ORALAIR	You must first try 1 oral antihistamine and 1 intranasal corticosteroid*
ORTHOVISC	Not covered for plans with Formulary Exclusions
oscimin	Preferred generic drug
oscimin sr	Preferred generic drug
OSPHENA	Not covered for plans with Formulary Exclusions; Quantity limits removed
OXAYDO	Not covered for plans with Formulary Exclusions
OXYCONTIN	Not covered for plans with Formulary Exclusions
oxymorphone hydrochloride er	Not covered for plans with Formulary Exclusions
PAXIL	Not covered for plans with Formulary Exclusions; Quantity limits removed
PCP 100	Not covered under pharmacy benefit
PERSERIS	Preferred brand drug
phenobarbital / belladonna alkaloids	Not covered under pharmacy benefit
PREFEST	Not covered for plans with Formulary Exclusions; Quantity limits removed
PREMARIN	Not covered for plans with Formulary Exclusions
PREMPHASE	Not covered for plans with Formulary Exclusions
PREMPRO	Not covered for plans with Formulary Exclusions
PROLASTIN-C	Preferred specialty drug

Prescription Drug	Change(s)
PROLENSA	Not covered for plans with Formulary Exclusions
PROMACTA TAB 12.5MG	You can fill up to 1/ day*
RAGWITEK	You must first try 1 oral antihistamine and 1 intranasal corticosteroid*
RELISTOR	Not covered for plans with Formulary Exclusions; Preauthorization removed; Quantity limits removed
RHOFADE	Not covered for plans with Formulary Exclusions; Quantity limits removed
ribavirin inh	Preferred generic drug
RITALIN LA	Step therapy removed
RITALIN TAB	You can fill up to 3/ day
RYDAPT	Preferred specialty drug
SANCUSO	Preferred brand drug
SANDOSTATIN LAR DEPOT	Not covered for plans with Formulary Exclusions
SAPHRIS	Preferred brand drug; Preauthorization removed; Step therapy removed; Quantity limits removed
SIGNIFOR LAR	Not covered for plans with Formulary Exclusions; Quantity limits removed
SIMBRINZA	Preferred brand drug
SKYLA	Preferred brand drug
SOMATULINE DEPOT	Preferred specialty drug; You can fill up to 1 inj/ month*
SOMAVERT	Not covered for plans with Formulary Exclusions
SOOLANTRA	Not covered for plans with Formulary Exclusions; Step therapy removed
STRATTERA	You can fill up to 1/ day
SUPARTZ FX	Preferred specialty drug; Step therapy removed
SUPREP BOWEL PREP KIT	Not covered for plans with Formulary Exclusions
symax-sl	Preferred generic drug
SYNVISC	You must first try 3 of GELSYN-3, SUPARTZ, EUFLEXXA, DUROLANE*
SYNVISC ONE	You must first try 3 of GELSYN-3, SUPARTZ, EUFLEXXA, DUROLANE*
TACLONEX OIN	Preferred brand drug; Step therapy removed; Quantity limits removed
TACLONEX SUS	Preferred brand drug; Quantity limits removed
tadalafil	Preferred generic drug; Preauthorization required*; You can fill up to 1/ day*
TAZORAC	Not covered for plans with Formulary Exclusions; Preauthorization removed
TECFIDERA	Not covered for plans with Formulary Exclusions; Quantity limits removed
TECFIDERA STARTER PACK	Not covered for plans with Formulary Exclusions; Quantity limits removed
TIMOPTIC OCUDOSE	Not covered for plans with Formulary Exclusions
TOBRADEX	Not covered for plans with Formulary Exclusions
TOBRADEX ST	Not covered for plans with Formulary Exclusions
TOUJEO MAX SOLOSTAR	Preferred brand drug; Step therapy removed
TOUJEO SOLOSTAR	Preferred brand drug; Step therapy removed
TRACLEER TAB 32MG	Not covered for plans with Formulary Exclusions
tramadol hcl	You can fill up to 1/ day

Prescription Drug	Change(s)
tramadol hydrochloride / acetaminophen	You can fill up to 40/ month
TRIVISC	You must first try 3 of GELSYN-3, SUPARTZ, EUFLEXXA, DUROLANE*
TRULANCE	Not covered for plans with Formulary Exclusions; Quantity limits removed
TRUVADA	Preferred brand drug; If drug is covered by your plan, you will now pay a copay for this drug
TUXARIN ER	Not covered for plans with Formulary Exclusions
UDENYCA	Not covered for plans with Formulary Exclusions; Quantity limits removed
ULTRACET	You can fill up to 40/ month
V-GO	Preferred brand drug
VALTOCO	Preferred brand drug; Preauthorization removed
VARUBI	Not covered for plans with Formulary Exclusions; Quantity limits removed
VENTOLIN HFA	Not covered for plans with Formulary Exclusions
VIIBRYD kit	Not covered for plans with Formulary Exclusions
VIIBRYD tab	Not covered for plans with Formulary Exclusions; Quantity limits removed
virt-vite forte	Preferred generic drug
VISCO-3	Not covered for plans with Formulary Exclusions; Step therapy removed
VITAL-D RX	Not covered for plans with Formulary Exclusions
VONVENDI	Not covered for plans with Formulary Exclusions
VYVANSE CAP 40MG	You can fill up to 1/ day
VYVANSE CAP 50MG	Preauthorization removed; You must first try 3 of generic amphetamine, amphetamine/dextroamphetamine, dexmethylphenidate, dextroamphetamine, methamphetamine, methylphenidate*; You can fill up to 1/ day
VYVANSE CAP 60MG	Preauthorization removed; You must first try 3 of generic amphetamine, amphetamine/dextroamphetamine, dexmethylphenidate, dextroamphetamine, methamphetamine, methylphenidate*; You can fill up to 1/ day
VYVANSE CAP 70MG	Preauthorization removed; You must first try 3 of generic amphetamine, amphetamine/dextroamphetamine, dexmethylphenidate, dextroamphetamine, methamphetamine, methylphenidate*; You can fill up to 1/ day
VYVANSE CHW 40MG	Preauthorization removed; You must first try 3 of generic amphetamine, amphetamine/dextroamphetamine, dexmethylphenidate, dextroamphetamine, methamphetamine, methylphenidate*; You can fill up to 1/ day
VYVANSE CHW 50MG	Preauthorization removed; You must first try 3 of generic amphetamine, amphetamine/dextroamphetamine, dexmethylphenidate, dextroamphetamine, methamphetamine, methylphenidate*; You can fill up to 1/ day

Prescription Drug	Change(s)
VYVANSE CHW 60MG	Preauthorization removed; You must first try 3 of generic amphetamine, amphetamine/dextroamphetamine, dexmethylphenidate, dextroamphetamine, methamphetamine, methylphenidate*; You can fill up to 1/ day
WESTAB MAX	Preferred generic drug
wixela inhub	Not covered for plans with Formulary Exclusions; You must first try ADVAIR, ANORO ELLIPTA, BREO ELLIPTA, SYMBICORT*
XCOPRI	Preferred brand drug; Preauthorization removed
XOSPATA	Preferred specialty drug
XTAMPZA ER	Preferred brand drug; Step therapy removed
ZEMAIRA	Not covered for plans with Formulary Exclusions
zenatane	Quantity limits removed
ZENZEDI TAB 15MG	Step therapy removed; You can fill up to 2/ day
ZENZEDI TAB 20MG	Step therapy removed; You can fill up to 2/ day
ZENZEDI TAB 30MG	Step therapy removed; You can fill up to 1/ day
ZEPOSIA	Preferred specialty drug; Step therapy removed
ZIEXTENZO	Preferred specialty drug; Step therapy removed
ZINBRYTA	You must first try 2 of BETASERON, COPAXONE, MAYZENT, VUMERITY, ZEPOSIA*
ZIRGAN	Not covered for plans with Formulary Exclusions

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, and their affiliates (Aetna).

Some health benefits and health insurance plans are offered, administered and/or underwritten by Aetna Health Inc., 151 Farmington Avenue, Hartford, CT 06156. Each insurer has sole financial responsibility for its own products.

Not all health services are covered. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change.

Aetna receives rebates from drug manufacturers that may be taken into account in determining drug lists. Information is subject to change. The drugs on the Pharmacy Drug Guide (formulary), Formulary Exclusions, Precertification, Quantity Limit and Step Therapy Lists are subject to change. In certain states, including Arkansas, Colorado, Connecticut, Delaware, Georgia, Illinois, Louisiana, Maryland, Minnesota, North Dakota, Pennsylvania and Texas, step therapy programs do not apply to fully insured members utilizing prescription drugs for the treatment of stage-four advanced, metastatic cancer.

In accordance with state law, commercial fully insured (including HMO) members in Louisiana and Texas (except Federal Employee Health Benefit Plan members) who are receiving coverage for drugs that are added or removed from the Pharmacy Drug Guide and Specialty Drug List will continue to have those drugs covered at the same benefit level until their plan's renewal date. In Texas, preauthorization approval is known as "preservice utilization review." It is not "verification" as defined by Texas law. Preauthorization means a determination that healthcare services proposed to be provided to a patient are medically necessary and appropriate.

In accordance with state law, certain fully insured commercial California members (except Federal Employee Health Benefit Plan members) who obtained approval from an Aetna plan for coverage of drugs that are later added to the Preauthorization or Step Therapy Lists or removed from the Pharmacy Drug Guide will continue to have those drugs covered, for as long as the treating in-network provider continues prescribing them, provided that the drug is appropriately prescribed and is considered safe and effective for treating the enrollee's medical condition. Aetna reserves the right to periodically request clinical information from your provider to assess your medical condition and the appropriateness of your ongoing treatment. Failure to provide clinical information could result in subsequent denial of coverage for this medication.

In accordance with state law, fully insured commercial Connecticut preferred provider organization (PPO) members (except Federal Employee Health Benefit Plan members) covered under a policy and using a drug for treatment of a chronic illness prior to the drug's removal from the Pharmacy Drug Guide will continue to have the medication covered, provided the prescriber states in writing that the drug is medically necessary and more medically beneficial than other covered drugs. Nothing in this section shall preclude the prescribing provider from prescribing another drug covered by the plan that is medically appropriate for the enrollee, nor shall anything in this section be construed to prohibit generic drug substitutions.

This material is for information only. It contains only a partial, general description of plan benefits or programs and does not constitute a contract. Aetna is part of the CVS Health family of companies.

Policy forms issued in Oklahoma include: AL COC00010, HC COC00010.
Policy forms issued in Missouri include: AL HGrpPol 01R5, HI HGrpAg 05, HO HGrpPol 04, AL SG GrpPOLAmend 2020 01, HI SG GrpAgAmend 2020 01.

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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TTY: 711

To access language services at no cost to you, call the number on your ID card.

Para acceder a los servicios de idiomas sin costo, llame al número que figura en su tarjeta de identificación. (Spanish)

如欲使用免費語言服務，請致電您 ID 卡上的電話號碼 (Chinese)

Afin d'accéder aux services langagiers sans frais, veuillez composer le numéro inscrit sur votre carte d'identité. (French)

Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tawagan ang numero sa inyong ID card. (Tagalog)

T’áá ni nizaad k’ehjí bee níká a’doowoł doo bą́ą́h ílínígóó naaltsoos bee atah nílı̨́go nanitinígíí bee néého’dólzinígíí béésh bee hane’í bikáá’ áajı̨’ hólne’. (Navajo)

Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie die Nummer auf Ihrer ID-Karte an. (German)

Për shërbime përkthimi falas për ju, telefononi në numrin që gjendet në kartën tuaj të identitetit. (Albanian)

የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በመታወቂያዎት ላይ ያለውን ቁጥር ይደውሉ። (Amharic)

للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم الموجود على بطاقتك الشخصية. (Arabic)

Անվճար լեզվական ծառայություններից օգտվելու համար զանգահարեք ձեր ինքնության (ID) քարտի վրա նշված հեռախոսահամարով: (Armenian)

Kugira uronke serivisi z’indimi atakiguzi, Hamagara inumero iri kuri karangamuntu kawe. (Bantu)

আপনাকে বিনামূল্যে ভাষা পরিষেবা পেতে হলে আপনার পরিচয়পত্রে দেওয়া নম্বরে টেলিফোন করুন। (Bengali)

Ngadto maakses ang mga serbisyo sa pinulongan alang libre, tawagan sa numero sa nimong ID card. (Bisayan-Visayan)

သင့်အနေဖြင့် အခကြေးငွေ မပေးရပဲ ဘာသာစကားဝန်ဆောင်မှုများ ရရှိနိုင်ရန်၊ သင့် ID ကတ်ပေါ်တွင်ရှိသော ဖုန်းနံပတ်အား ခေါ်ဆိုပါ။ (Burmese)

Per accedir a serveis lingüístics sense cap cost per vostè, telefoni al número indicat a la seva targeta d’identificació. (Catalan)

Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang i numiru gi iyo-mu kard aidentifikasion. (Chamorro)

ᏩᎩᏍᏗ ᎦᏬᏂᎯᏍᏗ ᎢᏯᎾᏓᏅᏁᏗ Ꮭ ᎠᎱᏍᏗ ᏗᏣᎬᏣᏔᏁᏗ ᏱᎩ, ᏫᏴᎯᏏᏔᏅᏏ ᎾᏍᎩ ᏗᏎᏍᏗ ᏦᏕᎠᏯᏢ ᎣᎾᎢ ID ᏆᏂᏲᏍᏗ ᏣᏉᏢᎢ. (Cherokee)

Anumpa tohsholi I toksvli ya peh pilla ho ish I paya hinla kvt chi holisso iskitini holhtena takanli ma I paya. (Choctaw)

Tajaajiiloota afaanii gatii bilisaa ati argaachuuf,lakkoofsa duugda waraaqaa eenyummaa (ID) kee irraa jiruun bilbili. (Cushite-Oromo)

Voor gratis toegang tot taaldiensten, bel het nummer op uw ID-kaart. (Dutch)

Pou jwenn sèvis lang gratis, rele nimewo telefòn ki sou kat idantite ou a. (French Creole-Haitian)

Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό που αναγράφεται στην κάρτα σας προνομίων μέλους. (Greek)

તમારે કોઇ જાતના ખર્ચ વિના ભાષાની સેવાઓની પહોંચ માટે, તમારા આઇડી કાર્ડ ઉપરના નંબરને કોલ કરો. (Gujarati)

No ka wala'au 'ana me ka lawelawe 'ōlelo e kahea aku i ka helu kelepona ma kāu kāleka ID. Kāki 'ole 'ia kēia kōkua nei. (Hawaiian)

आपके लिए बिना किसी कीमत के भाषा सेवाओं का उपयोग करने के लिए, अपने आईडी कार्ड पर दिये नम्बर पर कॉल करें। (Hindi)

Xav tau kev pab txhais lus tsis muaj nqi them rau koj, hu tus naj npawb ntawm koj daim npav ID. (Hmong)

Iji nwetaòhèrè na ọrụ gasị asụsụ n'efu, kpọọ nọmba no na kaadị ID gị. (Ibo)

Tapno maaksesyo dagiti serbisio maipapan iti pagsasao nga awan ti bayadanyo, tawagan ti numero idiay ID cardyo. (Ilocano)

Untuk mengakses layanan bahasa tanpa dikenakan biaya, hubungi nomor telepon di kartu identitas Anda. (Indonesian)

Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero sulla tessera identificativa. (Italian)

言語サービスを無料でご利用いただくには、IDカードに記載の番号にお電話ください。(Japanese)

လၢတၢ်ကမၤန့ၢ်ကျိာ်အတၢ်မၤစၢၤအတၢ်ဖံးတၢ်မၤတဖၣ်လၢတအိၣ်ဒီးအပှ့ၤလၢနကဘၣ်ဟ့ၣ်အီၤဘၣ်နှၣ်,ကိးဘၣ်လီတဲစိနီၣ်ဂံၢ်လၢအိၣ်လၢနတၢ်ဂီၤခိၣ် (ID) အခးလီၤန့ၣ်တက့ၢ် (Karen)

무료 언어 서비스를 이용하려면 보험 ID 카드에 수록된 번호로 전화해 주십시오. (Korean)

M̀ dyi wuɖu-dù kà kò ɖò ɓě dyi mɔ́uń nì pídyi ní, nìí, ɖá nɔ́ɓà nìà nì ID káàɔ̀ kɔ̃ɛ. (Kru-Bassa)

بۆ دەستپێڕاگەیشتن بە خزمەتگوزاری زمان بەبێ تێچوون بۆ تۆ، پەیوەندی بکە بە ژمارەی سەر ئای دی(ID) کارتی خۆت.
(Kurdish)

ເພື່ອເຂົ້າໃຊ້ການບໍລິການພາສາໂດຍບໍ່ເສຍຄ່າຕໍ່ກັບທ່ານ,
ໃຫ້ໂທຫາເບີໂທທີ່ບອກໄວ້ໃນບັດປະຈຳຕົວຂອງທ່ານ. (Laotian)

कोणत्याही शुल्काशिवाय भाषा सेवा प्राप्त करण्यासाठी, तुमच्या ID कार्डावरील क्रमांकावर फोन करा. (Marathi)

Nan etal nan jikin jiban ko ikijen kajin ilo an ejelok onen nan kwe, kirlok nomba eo ilo ID kaat eo am. (Marshallese)

Pwehn alehdi sawas en lokaia kan ni sohte pweipwei, koahlih nempe nan amhw doaropwe en ID. (Micronesian-Pohnpeian)

ដើម្បីទទួលបានសេវាកម្មភាសាដែលឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរស័ព្ទទៅកាន់
លេខដែលមាននៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់លោកអ្នក។ (Mon-Khmer, Cambodian)

निःशुल्क भाषा सेवा प्राप्त गर्न आफ्नो परिचयपत्रमा भएको नम्बरमा टेलिफोन गर्नुहोस् । (Nepali)

Të kɔɔr yïn wëër de thokic ke cïn wëu kɔr keek tënɔŋ yïn. Ke cɔl kɔc ye kɔc kuɔny në nɔmba de abac tɔ̈ në ID kard du kɔ̈u. (Nilotic-Dinka)

For tilgang til kostnadsfri språktjenester, ring nummeret på ID-kortet ditt. (Norwegian)

Um Schprooch Services zu griege mitaus Koscht, ruff die Nummer uff dei ID Kaart. (Pennsylvania Dutch)

برای دسترسی به خدمات زبان به طور رایگان، با شماره قید شده روی کارت شناسایی خود تماس بگیرید. (Persian-Farsi)

Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonić numer telefonu na Twojej Karcie Identykującej (Polish)

Para acessar os serviços de idiomas sem custo para você, ligue para o número que consta na sua identidade. (Portuguese)

ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ ਤੇ ਫ਼ੋਨ ਕਰੋ। (Punjabi)

Pentru a accesa gratuit serviciile de limbă, apelați numărul de pe cardul dvs. de identificare. (Romanian)

Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону, приведенному на вашей карточке участника плана. (Russian)

Mo le mauaina o auaunaga tau gagana e aunoa ma se totogi, vala’au le numera I luga o lau pepa ID. (Samoan)

Za besplatne prevodilačke usluge pozovite broj naveden na Vašoj identifikacionoj kartici. (Serbo-Croatian)

Heeba a nasta jangirde djey wolde, apelou lamba djey do windi ha dereji Maada. (Sudanic-Fulfulde)

Kupata huduma za lugha bila malipo kwako, piga nambari iliyo kwenye kadi yako ya kitambulisho. (Swahili)

ܟܝ ܗܫܩܠܐ ܬܠܘܗܝ ܥܠ ܝܠܚܬܐ ܕܡܫܒܠܢܘܬܐ ܕܠܫܢܐ ܡܓܢܢܐܝܬ، ܩܪܘܢ ܠ ܡܢܝܢܐ ܥܠ ܦܬܩܐ ܕܗܘܝܬܘܟܘܢ. (Syriac-Assyrian)

మీరు భాష సేవలను ఉచితంగా అందుకునేందుకు, మీ ID కార్డుపై ఉన్న నంబరుకు కాల్ చేయండి. (Telugu)

หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทรหมายเลขที่แสดงอยู่บนบัตรประจำตัวของท่าน (Thai)

Kapau ‘oku ke fiema’u ta’etōtōngi ‘a e ngaahi sēvesi kotoa pē he ngaahi lea kotoa, telefoni ki he fika ‘oku hā atu ‘i ho’o ID kaati. (Tongan)

Ren omw kopwe angei aninisin eman chon awewei (ese kamo), kopwe kori ewe nampa mei mak won noum ena katen ID (Trukese)

Sizin için ücretsiz dil hizmetlerine erişebilmek için, kartınızdaki numarayı arayın. (Turkish)

Щоб отримати безкоштовний доступ до мовних послуг, задзвоніть за номером, вказаним на Вашій ідентифікайній картці. (Ukrainian)

بلاقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، اپنے شناختی کارڈ پر درج نمبرپر بات کریں۔ (Urdu)

Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số điện thoại ghi trên thẻ ID (Nhận dạng) của quý vị. (Vietnamese)

צוטריט שפּראַך באַדינונגען אין קיין פּרייַז צו איר, רופן די נומער אויף דיין שייַן קאָרט. (Yiddish)

Lati wọnú awọn isẹ èdè l’ọfẹ fun ọ, pe nọmba ori káádi idánimọ rẹ. (Yoruba)