PDP Annual Formulary Change Notice
Frequently Asked Questions

How do I find out all the available drug options for 2025?
You can review the abridged (short) drug list provided in your Annual Notice of Changes; we mailed it in September. For the comprehensive (full list) drug list, you can go to Cigna.com/member-resources. For help finding your medications, you can call Customer Service at 1-800-297-1482 (TTY 711).

How much will I pay for insulin in 2025?
You'll never pay more than $35 for a one-month supply of covered insulins. This also applies to combination products that include at least one type of insulin. For extended-day supplies, your cost won't be more than $70 for up to a two-month supply or $105 for up to a three-month supply. If you receive Extra Help, you'll continue to pay your Extra Help cost.

What if there's a change and I cannot afford the new cost?
If you can't afford the cost of your prescription drug, you may qualify for the Low Income Subsidy (LIS). Medicare provides LIS as part of the Extra Help program. For more information about the program, please call 1-800-297-1482 (TTY 711). Or you may be able to lower your costs through the tier exception process.

Keep in mind, our plan limits allowed tier reductions. For 2025, the following medications are not eligible for a tier reduction approval: Tier 5 medications and non-formulary medications approved under the formulary exception process.

To learn more or start a request, call 1-800-297-1482 (TTY 711).

Why is my generic medication not in Tier 1 or Tier 2?
Each year, we provide our customers a broad list of low-cost Tier 1 and Tier 2 drugs. But we aren't always able to keep all generic medications in these tiers. Some generic medications may be in Tier 3, Tier 4 or Tier 5. Keep in mind, the name "Tier 3-Preferred Brand Drugs" is just a description of the majority of the drugs in that tier. It does not mean there are only brand drugs in that tier.

What if I can't change my current medication and need to have it covered?
We encourage you to bring this letter to your health care provider. That way you can discuss your alternative drug options. If you and your provider decide not to change your medication, then you, your provider or your authorized representative can ask us to keep

paying for your current drug(s). This is called an exception. To begin the request for an exception, call 1-800-297-1482 (TTY 711).

If you ask for an exception, your provider must send us a statement. And it must say the requested drug is medically necessary for treating your condition because none of the drugs we cover would work as well. Or the statement must say the drugs we cover would have a bad effect on you. If the exception involves a prior authorization, a quantity limit or another limit we've placed on that drug, then the provider's statement must include reasons. It must say the prior authorization or the limit isn't appropriate for your condition or would have a bad effect on you. After we receive your doctor's statement, we'll tell you our decision within 72 hours.

To ask for an expedited review, which we would decide within 24 hours, your provider needs to inform us your life, health or ability to regain maximum function may be seriously impacted by waiting for a standard request decision.

What if my request is denied?
If your request is denied, you have the right to appeal by asking us to review the decision. Keep in mind, you must request the appeal by phone or in writing within 60 calendar days from the date of our first decision.

What if I need more time to find a correct replacement drug?
During the first 90 days of the new plan year, we will cover one (1) prescription for up to a 30-day supply as a temporary refill for prescription drugs not on our 2025 drug list. And we'll do the same for drugs with a prior authorization requirement or another limit. But after the first temporary refill, we generally won't cover any more of these refills unless you're approved for an exception. Of course, you should get these medications refilled by an in-network pharmacy.

What is prior authorization?
This means you or your health care provider will need to get an approval from our plan before you begin taking a specific medication. If you don't get the required approval, we may not cover that prescription drug.

What are quantity limits?
This means we limit the amount of the drug we will cover. For example, if we allow one tablet per day for Drug ABC, a one-month supply would be a quantity of 30 tablets per 30 days (abbreviated as "30/30").

What is step therapy?
This means you must first try certain prescription drugs to treat your medical condition before we'll cover another drug for that condition. For example, if Drug A and Drug B both treat your condition, we may not cover Drug B unless you try Drug A first. If Drug A doesn't work for you, then we would cover Drug B.

Why do I need prior authorization for diabetic supplies?
Medicare Part D covers medical supplies for taking insulin, such as:

- Insulin syringes or pen needles
- Alcohol pads
- Gauze bandages

While these supplies can be used for other purposes, Part D will only cover them for insulin injections. A prior authorization checks that these supplies aren't being used for other purposes.

Why are oral phosphate binders no longer covered by Part D?
In 2025, Medicare will include the cost of oral phosphate binders in the payment to dialysis providers for treating end-stage renal disease patients. So the dialysis providers are responsible for dispensing these medications. If you're receiving dialysis, please ask your provider about getting oral phosphate binders.

If you're not receiving dialysis, you'll have to pay the full cost for these medications.

What does "removed from Part D coverage" mean?
This means Part D no longer covers a medication because it didn't meet Part D requirements.

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