Your MI Health Link plan Aetna Better Health Premier Plan is changing. In 2026, you will be enrolled in MI Coordinated Health for your Medicare and most of your Medicaid benefits. This plan is provided by AETNA BETTER HEALTH OF MICHIGAN INC., which is the same company that currently provides your MI Health Link program coverage. Your new plan is part of the MI Coordinated Health program which will continue to coordinate your Medicare and Michigan Medicaid services and supports. You will still get the same health care benefits as you do now.

You will continue to get services through MI Health Link until December 31, 2025. On January 1, 2026, you will automatically start getting services through MI Coordinated Health. You do not need to do anything to keep your current benefits and health plan.

Your new plan will help you with all your healthcare needs and will continue to coordinate your benefits and care. This includes medical, dental, vision, hearing, home and community-based services, medical supplies, Medicare Prescription Drug coverage, and Medicaid drugs. The plan will include the doctors you use now or help you find a new doctor that you like. You will start getting letters about this change in October 2025. You will get one set of member materials, for example one Member ID Card and information on how to view your *Member Handbook* online or request a printed copy.

You don’t have to do anything to keep getting your health care from AETNA BETTER HEALTH OF MICHIGAN INC., however, if you have questions about your coverage in 2026, contact your current MI Health Link plan at **1-855-676-5772** (TTY: **711**), 8 AM to 8 PM, 7 days a week. You can find more information about your enrollment options in Section G of the enclosed *Annual Notice of Change*.

Aetna Medicare HIDE (HMO D-SNP) offered by AETNA BETTER HEALTH OF MICHIGAN INC.

Annual Notice of Change for 2026

Introduction

You're currently enrolled as a member of our plan. Next year, there will be some changes to our benefits, coverage, rules, and costs. This *Annual Notice of Change* tells you about the changes and where to find more information about them. To get more information about costs, benefits, or rules please review the *Member Handbook*, which is located on our website at AetnaMedicare.com/MICHDSNP. Call Member Services at the number at the bottom of the page to get a copy by mail. Key terms and their definitions appear in alphabetical order in the last chapter of your *Member Handbook*.

Additional Resources

- This document is available for free in Spanish. Este documento está disponible de forma gratuita en español.
- This document is available for free in Arabic.

يتوفر هذا المستند مجانًا بالعربية.

- **You can get this Annual Notice of Change for free in other formats, such as large print, braille, or audio. Call 1-855-676-5772 (TTY users should call 711). Hours are 8 AM to 8 PM, 7 days a week. The call is free.**
- Aetna Medicare HIDE (HMO D-SNP) wants to make sure you understand your health plan information. If a different language or format works better for you, call Member Services at the number listed at the bottom of this page to request a change. (This is called a “standing request.”)
- We will continue sending you mailings and other communications in your requested format.
- If you want to change your standing request for a preferred language or format, call Member Services.
- We have free interpreter services to answer any questions that you may have about our health or drug plan. To get an interpreter just call us at 1-855-676-5772 (**TTY:** 711). Someone that speaks Spanish, Arabic can help you. This is a free service.

Notice of Availability (NOA)

TTY: 711

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

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صول على خدمات اللغة مجانًا، اتصل بالرقم الموجود على بطاقة العضوية الخاصة بك. (Arabic)

如欲使用免費語言服務，請致電您 ID 卡上的電話號碼。 (Chinese)

Tajaajila afaanii bilisaan argachuuf, lakkoofsa Waraqaa Eenyummeessaa (ID) keessan irra jiru irratti bilbilaa. (Cushite)

Pour accéder gratuitement aux services linguistiques, appelez le numéro figurant sur votre carte d'identité. (French)

Pou w jwenn aksè ak sèvis lang gratis pou ou, rele nimewo ki sou kat idantite w la. (French Creole)

Um kostenlos auf Sprachdienste zuzugreifen, rufen Sie die Nummer auf Ihrem Ausweis an. (German)

Inā ake ʻoe e ili mai no ke kōkua manuahi me ka unuhi, e kelepona ʻoe i ka helu ma kou kāleka ID. (Hawaiian)

Kom tau txais cov kev pab cuam txhais lus yam tsis sau nqi ntawm koj, thov hu rau tus xov tooj nyob ntawm koj daim npav ID. (Hmong)

Per accedere gratuitamente ai servizi linguistici, chiama il numero riportato sul tuo tesserino identificativo. (Italian)

無料の言語サービスをご利用いただくには、ご自身のIDカードに記載されている番号にお電話ください。 (Japanese)

လၢကမၤန့ၢ် ကျဘ့ၣ်တၢ်မၤစၢၤတၢ်မၤ လၢတလိၣ်လာ်ဘူၣ်လာ်စ့ၤ လၢနဂီၢ်အဂီၢ်, ကိးနီၣ်ဂံၢ် လၢအအိၣ်ဖဲန ID အဖီခိၣ်န ၌တက့ၢ်. (Karen)

무료로 언어 서비스를 이용하려면 ID 카드에 적힌 전화번호로 전화하세요. (Korean)

ເພ່ ອ ້ ຂ ້ າ ຖ ກ ານ ບ ໍ ລ ກ ານ ພ າ ສ າ ໂ ດ ຍ ບ ເ ສ ຍ ຄ ່ າ ໃ ຊ ້ ຈ ່ າ ຍ ໃ ດ ໆ ແ ກ ່ ທ ່ ານ, ໃ ຫ ້ ໂ ທ ຫ າ ບ ໍ ທ ່ ຽ ໃ ນ ບ ັ ດ ປ ະ ຈ ໍ າ ຕ ວ ຂ ອ ງ ທ. (Laotian)

ដើម្បី ទទួល នេស ផែ ក យេមិនគិតៃថ ពីអ កសូមទូរសព លេខដល នេ លើ តស ល់ខ នរបស់អ ក។ (Mon-Khmer, Cambodian)

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

Aby uzyskać bezpłatny dostęp do usług językowych, zadzwoń pod numer podany na karcie ID. (Polish)

Ligue para o número que está no seu cartão de identificação para receber assistência linguística gratuita. (Portuguese)

Чтобы получить бесплатные языковые услуги, позвоните по номеру телефона, указанному на вашей идентификационной карте. (Russian)

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

Upang ma-access ang mga serbisyo sa wika nang wala kang babayaran, tawagan ang numero sa iyong ID card. (Tagalog)

Để truy cập dịch vụ ngôn ngữ miễn phí, hãy gọi đến số điện thoại trên thẻ ID của quý vị. (Vietnamese)

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Table of Contents

A. Disclaimers

- Due to legislation in Arkansas, effective January 1, 2026, you may not be able to utilize the following services within the state of Arkansas, unless a court takes action: CVS Retail, CVS Caremark Mail Service, CVS Specialty, and OMNI Care long term pharmacies.

B. Reviewing your Medicare and Michigan Medicaid coverage for next year

It's important to review your coverage now to make sure it will still meet your needs next year. If it doesn't meet your needs, you may be able to leave our plan. Refer to **Section E** for more information on changes to your benefits for next year.

New members to Aetna Medicare HIDE (HMO D-SNP): In most instances you'll be enrolled in Aetna Medicare HIDE (HMO D-SNP) for your Medicare benefits the 1st day of the month after you request to be enrolled in Aetna Medicare HIDE (HMO D-SNP). You may still receive your Michigan Medicaid benefits from your previous Michigan Medicaid health plan for one additional month. After that, you'll receive your Michigan Medicaid services through Aetna Medicare HIDE (HMO D-SNP). There will be no gap in your Michigan Medicaid coverage. Please call us at the number at the bottom of the page if you have any questions.

If you choose to leave our plan, your membership will end on the last day of the month in which your request was made. You'll still be in the Medicare and Michigan Medicaid programs as long as you are eligible.

If you leave our plan, you can get information about your:

- Medicare options in the table in **Section G2.**
- Michigan Medicaid options in **Section G2**.

B1. Information about Aetna Medicare HIDE (HMO D-SNP)

- Aetna Medicare HIDE (HMO D-SNP) is a health plan that contracts with both Medicare and Michigan Medicaid to provide benefits of both programs to members. Enrollment depends on contract renewal.
- When this *Annual Notice of Change* says "we," "us," "our," or "our plan," it means Aetna Medicare HIDE (HMO D-SNP).

B2. Important things to do

- **Check if there are any changes to our benefits and costs that may affect you.**
  - Are there any changes that affect the services you use?
  - Review benefit and cost changes to make sure they'll work for you next year.
  - Refer to **Section E1** for information about benefit and cost changes for our plan.
- **Check if there are any changes to our drug coverage that may affect you.**
  - Will your drugs be covered? Are they in a different cost-sharing tier? Can you use the same pharmacies? Will there be any changes such as prior authorization, step therapy or quantity limits?
  - Review the changes to make sure our drug coverage will work for you next year.
  - Refer to **Section E2** for information about changes to our drug coverage.
  - Your drug costs may have risen since last year.
    - Talk to your doctor about lower cost alternatives that may be available for you; this may save you in annual out-of-pocket costs throughout the year.
    - Keep in mind that your plan benefits will determine exactly how much your own drug

costs may change.

- **Check if your providers and pharmacies will be in our network next year.**
  - Are your doctors, including your specialists, in our network? What about your pharmacy? What about the hospitals or other providers you use?
  - Refer to **Section D** for information about our *Provider and Pharmacy Directory*.
- **Think about your overall costs in the plan.**
  - How much will you spend out-of-pocket for the services and drugs you use regularly?
  - How do the total costs compare to other coverage options?
- **Think about whether you're happy with our plan.**

If you decide to stay with Aetna Medicare HIDE (HMO D-SNP):
If you want to stay with us next year, it's easy – you don't need to do anything. If you don't make a change, you automatically stay enrolled in Aetna Medicare HIDE (HMO D-SNP).

If you decide to change plans:
If you decide other coverage will better meet your needs, you may be able to switch plans (refer to **Section G2** for more information). If you enroll in a new plan, or change to Original Medicare, your new coverage will begin on the first day of the following month.

C. Changes to our plan name

On January 1, 2026, our plan name changes from Aetna Better Health Premier Plan to Aetna Medicare HIDE (HMO D-SNP). We will mail you a new ID card and the new plan name will appear on all of our plan documents and letters. Please begin using your new card starting January 1, 2026.

D. Changes to our network providers and pharmacies

Amounts you pay for your drugs depends on which pharmacy you use. Our plan has a network of pharmacies. In most cases, your prescriptions are covered *only* if they're filled at one of our network pharmacies.

Our provider and pharmacy networks have changed for 2026.

Please review the 2026 *Provider and Pharmacy Directory* to find out if your providers (primary care provider, specialists, hospitals, etc.) or pharmacy are in our network. An updated *Provider and Pharmacy Directory* is located on our website at AetnaMedicare.com/MICHDSNP. You may also call Member Services at the numbers at the bottom of the page for updated provider information or to ask us to mail you a *Provider and Pharmacy Directory*.

It's important that you know that we may also make changes to our network during the year. If your provider leaves our plan, you have certain rights and protections. For more information, refer to **Chapter 3** of your *Member Handbook* or call Member Services at the number at the bottom of the page for help.

E. Changes to benefits and costs for next year

E1. Changes to benefits for medical services

We're changing our coverage for certain medical services next year. The table below describes these changes.

	2025 (this year)	2026 (next year)
Aetna Medicare Extra Benefits Card	With this plan, you get an Extra Benefits Card to help you pay for certain everyday expenses. Your plan includes an **Over-the-Counter (OTC) Wallet** with a $60 monthly benefit amount (allowance). If you are eligible for Special Supplemental Benefits for the Chronically Ill (SSBCI), you also get an **Extra Supports Wallet** with a $50 monthly benefit amount (allowance). Extra Supports Wallet spending categories include: • Healthy Foods • Utilities See the *Member Handbook* for more information and eligibility requirements.	With this plan, you get an Extra Benefits Card to help you pay for certain everyday expenses. Your plan includes an **Over-the-Counter (OTC) Wallet** with a $220 monthly benefit amount (allowance). If you're eligible for Special Supplemental Benefits for the Chronically Ill (SSBCI), your Over-the-Counter (OTC) Wallet will change to the **Extra Supports Wallet with additional spending categories**. Extra Supports Wallet spending categories include: • Healthy Foods • Over-the-counter (OTC) products • Transportation • Utilities • Personal care products **Important:** Keep your Extra Benefits Card. You won't receive a new card in the mail for the 2026 plan year. See the *Member Handbook* for more information and eligibility requirements.
Annual routine physical	Annual routine physical exams are not covered.	You pay a $0 copay for each non-Medicare covered service.
Breast cancer screening (mammograms)	You pay a $0 copay for one screening mammogram every 12 months for women age 40 and older.	You pay a $0 copay for one screening mammogram each calendar year for women age 40 and older.
Chiropractic Services (additional)	Additional (non-Medicare covered) chiropractic services are not covered	You pay a $0 copay for each additional (non-Medicare covered) service (twelve visits every year). Additional (non-Medicare covered) chiropractic services are provided by Aetna's network of providers.
Cell phone benefit	Qualified members are eligible to receive a smartphone with talk time and data through the Lifeline vendor.	The cell phone benefit is not covered.

	2025 (this year)	2026 (next year)
Colorectal cancer screening	You pay a $0 copay for screening fecal-occult blood tests for patients 45 years and older (once every 12 months).	You pay a $0 copay for screening fecal-occult blood tests for patients 45 years and older (twice per calendar year). You pay a $0 copay for Guaiac-based fecal-occult blood tests for patients 45 years and older (twice per calendar year).
Community transition services	The plan will pay for one-time expenses for you to transition from a nursing home to another residence where you are responsible for your own living arrangement.	Community Transition Services are not covered.
Counseling to stop smoking or tobacco use	You pay a $0 copay for each non-Medicare covered service (42 visits every year).	You pay a $0 copay for each non-Medicare covered service (unlimited visits every year).

Dental services (additional)	Our plan will pay for the following services:
	
	• examinations and evaluations (once every six months)
	• cleanings (once every six months)
	• silver diamine fluoride treatment (maximum of six applications per lifetime)
	• X-rays
	  • bitewing x-rays are a covered benefit (once in a 12-month period)
	  • panoramic x-ray (once every five years)
	  • full mouth or complete series of x-rays (once every five years)
	• fillings
	• tooth extractions
	• complete or partial dentures (once every five years)
	• sealants (once every three years, if criteria are met)
	• indirect restorations (crowns) (once every 5 years per tooth, if criteria are met)
	• root canal therapy/re-treatment of previous root canal
	• comprehensive periodontal evaluation
	• scaling in presence of inflammation
		Additional dental services maximum benefit: Plan pays $2,600 every year for additional preventive dental services and additional comprehensive dental services combined.
		
		Additional (non-Medicare covered) dental services are provided by DentaQuest.
		
		Preventive dental services:
		
		• Oral exams: $0 copay
		• X-rays: $0 copay
		• Other diagnostic dental services: $0 copay
		• Cleanings: Not covered
		• Fluoride treatments: Not covered
		• Other preventive dental services: $0 copay
		
		Comprehensive dental services:
		
		• Restorative services: $0 copay
		• Endodontics: $0 copay
		• Periodontics: $0 copay
		• Prosthodontics, fixed: $0 copay
		• Prosthodontics, removable: $0 copay

This service is continued on the next page

	2025 (this year)	2026 (next year)
Dental services (additional) (continued)		
	• periodontal scaling and root planning • other periodontal maintenance	• Maxillofacial prosthetics: Not covered • Oral and maxillofacial surgery: $0 copay • Implant services: Not covered • Orthodontics: Not covered • Adjunctive general services: $0 copay See the dental schedule in the *Member Handbook* for additional details.
Emergency care (worldwide)	Emergency care services (worldwide) are not covered.	You pay a $0 copay for each non-Medicare covered service. Cost sharing is waived if admitted to the hospital. There is a $250,000 combined maximum benefit amount for worldwide emergency care, emergency transportation and urgently needed care.
Emergency transportation (worldwide)	Emergency transportation services (worldwide) are not covered	You pay a $0 copay for each non-Medicare covered service. Cost sharing is not waived if admitted to the hospital. There is a $250,000 combined maximum benefit amount for worldwide emergency care, emergency transportation and urgently needed care.
Eye exams (follow up diabetic eye exams)	Eye exams (follow up diabetic eye exams) are not covered	You pay a $0 copay for each non-Medicare covered service.
Eye exams (non-Medicare covered)	You pay a $0 copay for each non-Medicare covered service (one exam every two years).	You pay a $0 copay for each non-Medicare covered service (one exam every year).

	2025 (this year)	2026 (next year)
Eyewear — prescription (non-Medicare covered)	Additional prescription eyewear maximum benefit: There is no maximum benefit amount for additional prescription eyewear The plan will pay for an initial pair of eye glasses. Replacement glasses are offered once every year. The plan will pay for contact lenses for people with certain conditions.	Additional prescription eyewear maximum benefit: Plan pays $250 every year for additional prescription eyewear. Covered prescription eyewear: • Contact lenses: $0 copay • Eyeglasses (lenses and frames): $0 copay • Eyeglass lenses: $0 copay • Eyeglass frames: $0 copay • Upgrades (including UV protection and scratch coating): $0 copay Additional prescription eyewear services are provided by VSP. See the *Member Handbook* for more information.
Fall prevention	Fall prevention services are not covered	Our plan provides you with a $100 annual allowance for purchasing certain clinically appropriate home and bathroom safety devices that can help you manage physical impairments and improve your ability to move safely around your home. See your *Member Handbook* for more information.
Hearing aid fitting and evaluations	You pay a $0 copay for each non-Medicare covered service (twice per year)	You pay a $0 copay for each non-Medicare covered service (one hearing aid fitting/evaluation every year).
Hearing aids	Hearing aid maximum benefit allowance: There is no maximum benefit amount for hearing aids. You are eligible for two hearing aids once every five years.	Hearing aid maximum benefit allowance: Plan pays $1,500 per ear for hearing aids every year. You are eligible for two hearing aids every year. Hearing aids are provided by NationsHearing. See the *Member Handbook* for more information.
Hearing exams (routine)	Hearing exams (routine) are not covered	You pay a $0 copay for each non-Medicare covered service (one exam every year).

	2025 (this year)	2026 (next year)
In-home support - personal care services	In-home support - personal care services are not covered	You may be eligible to receive up to 40 hours of in-home support personal care services per year. This benefit can provide help with meal preparation, light housekeeping such as assistance with your bed, or small household tasks, assisting you to walk or move around, assisting you with personal care and hygiene, medication reminders, and other activities of daily living that are focused on improving or maintaining the status of your health. See the *Member Handbook* for more information and eligibility criteria.
Meal benefit (post-discharge)	You pay a $0 copay for 20 meals delivered to your home after a hospital discharge	You pay a $0 copay for 28 meals over a 14-day period after discharge from an Inpatient Acute Hospital, Inpatient Psychiatric Hospital or Skilled Nursing Facility. See the *Member Handbook* for more information. Meals are provided by NationsMarket.
Medicare Part B prescription drugs	Our Part B step program categories and targeted drugs may change yearly. Please visit the following link to review our list of Medicare Part B drugs that may be subject to step therapy: **Aetna.com/PartB-Step**. See the *Member Handbook* for more information.	
Urgently needed services (worldwide)	Urgently needed care services (worldwide) are not covered.	You pay a $0 copay for each non-Medicare covered service. Cost sharing is not waived if admitted to the hospital. There is a $250,000 combined maximum benefit amount for worldwide emergency care, emergency transportation and urgently needed care.
Wigs	Wigs are not covered.	Plan pays up to $400 every year for covered wigs related to hair loss from chemotherapy.

E2. Changes to drug coverage

Changes to our *Drug List*
An updated *List of Covered Drugs* is located on our website at **AetnaMedicare.com/MICHDSNP**. You may also call Member Services at the numbers at the bottom of the page for updated drug information or to ask us to mail you a *List of Covered Drugs*. The *List of Covered Drugs* is also called the "*Drug List*."

We made changes to our *Drug List*, which could include removing or adding drugs, changing drugs we cover and changes to the restrictions that apply to our coverage for certain drugs or moving them to a

different cost-sharing tier.

Review the *Drug List* to **make sure your drugs will be covered next year** and to find out if there are any restrictions or if your drug has been moved to a different cost-sharing tier.

Most of the changes in the *Drug List* are new for the beginning of each year. However, we might make other changes that are allowed by Medicare and/or the state that will affect you during the calendar year. We update our online *Drug List* at least monthly to provide the most up to date *Drug List*. If we make a change that will affect a drug you're taking, we'll send you a notice about the change.

If you're affected by a change in drug coverage, we encourage you to:

- Work with your doctor (or other prescriber) to find a different drug that we cover.
  - You can call Member Services at the numbers at the bottom of the page or contact your Care Coordinator to ask for a *List of Covered Drugs* that treat the same condition.
  - This list can help your provider find a covered drug that might work for you.
- Ask us to cover a temporary supply of the drug.
  - In some situations, we'll cover a **temporary** supply of the drug during the first 90 days of the calendar year.
  - This temporary supply is for up to 30 days in an outpatient setting and 31 days in a long-term care facility. (To learn more about when you can get a temporary supply and how to ask for one, refer to **Chapter 5** of your *Member Handbook*.)
  - When you get a temporary supply of a drug, talk with your doctor about what to do when your temporary supply runs out. You can either switch to a different drug our plan covers or ask us to make an exception for you and cover your current drug.
  - If your prescription is written for fewer days, we'll allow multiple fills to provide up to a maximum of 30 days of medication in an outpatient setting and 31 days in a long-term care facility. You must fill the prescription at a network pharmacy.
  - Long-term care pharmacies may provide your prescription drug in small amounts at a time to prevent waste.
  - If you received a formulary exception for a drug you currently take, please refer to the letter that you received that gave permission for the exception. This letter will tell you if the exception continues after 2025. If it says your formulary exception will expire in or at the end of 2025, you will need to submit a new exception request for the drug for 2026 if its formulary status has not changed.
  - You may review the 2026 comprehensive formulary on our website at AetnaMedicare.com/MICHDSNP to see if the changes affect your drug. Please call Member Services at the numbers at the bottom of the page to request a formulary exception for 2026

Changes to drug costs

There are two payment stages for your Medicare Part D drug coverage under our plan. How much you pay depends on which stage you're in when you get a prescription filled or refilled. These are the two stages:

Stage 1 Initial Coverage Stage	Stage 2 Catastrophic Coverage Stage
During this stage, our plan pays part of the costs of your drugs, and you pay your share. Your share is called the copay. You begin this stage when you fill your first prescription of the year.	During this stage, the plan pays all of the costs of your drugs through December 31, 2026. You begin this stage after you pay a certain amount of out-of-pocket costs.

The Initial Coverage Stage ends when your total out-of-pocket costs for drugs reaches $2,100. At that point, the Catastrophic Coverage Stage begins. Our plan covers all of your drug costs from then until the end of the year. Refer to **Chapter 6** of your *Member Handbook* for more information on how much you pay for drugs.

Under the Manufacturer Discount Program, drug manufacturers pay a portion of our plan's full cost for covered Part D brand name drugs and biologics during the Initial Coverage Stage and the Catastrophic Coverage Stage. Discounts paid by manufacturers under the Manufacturer Discount program don't count toward out-of-pocket costs.

E3. Stage 1: "Initial Coverage Stage"

During the Initial Coverage Stage, our plan pays a share of the cost of your covered drugs, and you pay your share. Your share is called the copay. The copay depends on what cost-sharing tier the drug is in and where you get it. You pay a copay each time you fill a prescription. If your covered drug costs less than the copay, you pay the lower price.

We moved some of the drugs on our *Drug List* to a lower or higher drug tier. If your drugs move from tier to tier, this could affect your copay. To find out if your drugs are in a different tier, look them up in our *Drug List*.

The following table shows your costs for a one-month supply filled at a network pharmacy with standard copays in each of our 5 drug tiers. These amounts apply **only** during the time when you're in the Initial Coverage Stage.

Most adult Part D vaccines are covered at no cost to you. For information about the costs of vaccines, or information about the costs for a long-term supply or for mail-order prescriptions go to **Chapter 6, Section D** of your *Member Handbook*.

	2025 (this year)	2026 (next year)
Part D Drug Coverage	For covered generic drugs (including brand drugs treated as generic), $0 per prescription. For all other covered drugs, $0 per prescription.	**If you qualify for "Extra Help" from Medicare to help pay for your prescription drugs, you pay:** Yearly Deductible: **$0** Generic drugs (including brand drugs treated as generic): either $0 or $1.60 or $5.10 per prescription All other drugs: either $0 or $4.90 or $12.65 per prescription **If you do no not qualify for "Extra Help" from Medicare to help pay for your prescription drugs, you pay:**
Drugs in Tier 1 (Preferred Generic) Cost for a one-month supply of a drug in Tier 1 that is filled at a network pharmacy	Your copay for a one-month (up to a 30-day supply in an outpatient setting and 31 days in a long-term care facility) supply is **$0**. Your cost for a one-month (up to a 30-day) supply of each covered insulin product is **$0**. Your copay for a one-month (30-day) mail-order prescription is **$0**.	Your copay for a one-month (up to a 30-day supply in an outpatient setting and 31 days in a long-term care facility) supply is **$0.** Your copay for a one-month (30-day) mail-order prescription is **$0**.
Drugs in Tier 2 (Generic) Cost for a one-month supply of a drug in Tier 2 that is filled at a network pharmacy	Your copay for a one-month (up to a 30-day supply in an outpatient setting and 31 days in a long-term care facility) supply is **$0**. Your cost for a one-month (up to a 30-day) supply of each covered insulin product is **$0**. Your copay for a one-month (30-day) mail-order prescription is **$0**.	Your copay for a one-month (up to a 30-day supply in an outpatient setting and 31 days in a long-term care facility) supply is **$0.** Your copay for a one-month (30-day) mail-order prescription is **$0**.

	2025 (this year)	2026 (next year)
Drugs in Tier 3 (Preferred Brand) Cost for a one-month supply of a drug in Tier 3 that is filled at a network pharmacy	Your copay for a one-month (up to a 30-day supply in an outpatient setting and 31 days in a long-term care facility) supply is **$0**. Your cost for a one-month (up to a 30-day) supply of each covered insulin product is **$0**. Your copay for a one-month (30-day) mail-order prescription is **$0**.	**Yearly deductible:** You'll pay a yearly deductible of **$615** on your Tier 3 drugs. You pay the full cost of your Tier 3 drugs until you've reached the yearly deductible. Your copay for a one-month (up to a 30-day supply in an outpatient setting and 31 days in a long-term care facility) supply is **22%**. Your cost for a one-month (up to a 30-day) supply of each covered insulin product is a maximum of **$35**. Your copay for a one-month (30-day) mail-order prescription is **22%**.
Drugs in Tier 4 (Non-Preferred Drug) Cost for a one-month supply of a drug in Tier 4 that is filled at a network pharmacy	Our plan's *Drug List* only had 3 tiers for 2025.	**Yearly deductible:** You'll pay a yearly deductible of **$615** on your Tier 4 drugs. You pay the full cost of your Tier 4 drugs until you've reached the yearly deductible. Your copay for a one-month (up to a 30-day supply in an outpatient setting and 31 days in a long-term care facility) supply is **25%**. Your cost for a one-month (up to a 30-day) supply of each covered insulin product is a maximum of **$35**. Your copay for a one-month (30-day) mail-order prescription is **25%**.

	2025 (this year)	2026 (next year)
Drugs in Tier 5 (Specialty) Cost for a one-month supply of a drug in Tier 5 that is filled at a network pharmacy	Our plan's *Drug List* only had 3 tiers for 2025.	**Yearly deductible:** You'll pay a yearly deductible of **$615** on your Tier 5 drugs. You pay the full cost of your Tier 5 drugs until you've reached the yearly deductible. Your copay for a one-month (up to a 30-day supply in an outpatient setting and 31 days in a long-term care facility) supply is **25%**. Your cost for a one-month (up to a 30-day) supply of each covered insulin product is a maximum of **$35**. Your copay for a one-month (30-day) mail-order prescription is **25%**.

The Initial Coverage Stage ends when your total out-of-pocket costs reach $2,100. At that point the Catastrophic Coverage Stage begins. The plan covers all your drug costs from then until the end of the year. Refer to Chapter 6 of your Member Handbook for more information about how much you will pay for prescription drugs.

E4. Stage 2: "Catastrophic Coverage Stage"

When you reach the out-of-pocket limit **$2,100** for your drugs, the Catastrophic Coverage Stage begins and you pay nothing for your covered drugs. You stay in the Catastrophic Coverage Stage until the end of the calendar year.

For more information about your costs in the Catastrophic Coverage stage, refer to **Chapter 6** of your *Member Handbook*.

F. Administrative Changes

Description	2025 (this year)	2026 (next year)
Behavioral health services administration	In 2025, all behavioral health services are available to plan members through the local Pre-paid Inpatient Health Plan (PIHP) provider network. These services are available and coordinated through your Care Coordinator and the PIHP.	Some behavioral health services are available to members through the local Pre-paid Inpatient Health Plan (PIHP) provider network, while others are available through our plan. These services are available and coordinated through your Care Coordinator and the PIHP. If you need behavioral health services, talk to your Care Coordinator.

Description	2025 (this year)	2026 (next year)
Blood glucose monitors and medical diabetic supplies	In 2025, the preferred manufacturer for blood glucose monitors and medical diabetic supplies is OneTouch/LifeScan. Prior authorization may be required for manufacturers other than OneTouch/LifeScan.	In 2026, the preferred manufacturer for blood glucose monitors and medical diabetic supplies is Accu-Chek/Roche and TRUE/Trividia. Prior authorization is required for manufacturers other than Accu-Chek/Roche or TRUE/Trividia.
Continuous glucose monitors and sensors	In 2025, Dexcom and FreeStyle Libre continuous glucose monitors and supplies are available at participating pharmacies. Your provider must obtain authorization for a continuous glucose monitor. Sensors can be obtained without prior authorization from the plan.	In 2026, Dexcom and FreeStyle Libre continuous glucose monitors and sensors are available without a prior authorization at network pharmacies with a history of insulin usage in the past 6 months. Prior authorization for monitors and sensors may apply as well as exception requests if exceeding quantity limits that align to Medicare coverage guidance.
Contract and PBP number	In 2025 your plan's contract and PBP number are H8026-001.	In 2026, your plan's contract and PBP number will be H9314-001.
Medicare Prescription Payment Plan	The Medicare Prescription Payment Plan is a payment option that began this year and can help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across the calendar year (January-December). You may be participating in this payment option.	If you're participating in the Medicare Prescription Payment Plan and stay in the same Part D plan, your participation will be automatically renewed for 2026. To learn more about this payment option, call us at **1-855-676-5772** (TTY users call **711**) or visit **Medicare.gov**
Member Services hours of operation	In 2025, Member Services hours of operation are 24 hours a day, 7 days a week.	In 2026, Member Services hours of operation will be 8 AM to 8 PM, 7 days a week.
Plan website address	In 2025, your plan's website is **AetnaBetterHealth.com/Michigan-mmp**.	In 2026, your plan's website will be **AetnaMedicare.com/MICHDSNP** .

G. Choosing a plan

G1. Staying in our plan
We hope to keep you as a plan member.

You don't have to do anything to stay in our plan. Unless you sign up for a different Medicare plan or change to Original Medicare, you'll automatically stay enrolled as a member of our plan for 2026.

G2. Changing plans

Most people with Medicare can end their membership during certain times of the year. Because you have Michigan Medicaid MICH plan, you can end your membership in our plan any month of the year.
In addition, you may end your membership in our plan during the following periods:

- The **Open Enrollment Period**, which lasts from October 15 to December 7. If you choose a new plan during this period, your membership in our plan ends on December 31 and your membership in the new plan starts on January 1.
- The **Medicare Advantage (MA) Open Enrollment Period**, which lasts from January 1 to March 31. If you choose a new plan during this period, your membership in the new plan starts the first day of the next month.

There may be other situations when you're eligible to make a change to your enrollment. For example, when:

- you moved out of our service area,
- your eligibility for Michigan Medicaid or Extra Help changed, **or**
- you recently moved into or are currently getting care in an institution (like a skilled nursing facility or a long-term care hospital). If you recently moved out of an institution, you can change plans or change to Original Medicare for two full months after the month you move out.

Your Medicare services

You have three options for getting your Medicare services listed below any month of the year. You have an additional option listed below during certain times of the year including the **Open Enrollment Period** and the **Medicare Advantage Open Enrollment Period** or other situations described in **Section G2** By choosing one of these options, you automatically end your membership in our plan:

1. **You can change to:** **Another plan that provides your Medicare and most or all of your Medicaid benefits and services in one plan, also known as an integrated dual-eligible special needs plan (D-SNP) or a Program of All-inclusive Care for the Elderly (PACE) plan, if you qualify.**	**Here is what to do:** Call Medicare at 1-800-MEDICARE (**1-800-633-4227**). TTY users should call **1-877-486-2048**. For Program of All-inclusive Care for the Elderly (PACE) inquiries, call **877-2MI-PACE**. If you need help or more information: • Call the MI Options at **1-800-803-7174** or **1-800-975-7630** Monday–Friday 8:00 AM to 7:00 PM. TTY users should call **1-888-263-5897** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. The call and help are free. For more information or to find a local MI Options office in your area, please visit **michigan.gov/mdhhs/adult-child-serv/adults-and-seniors/acls/state-health-insurance-assistance-program** **OR** Enroll in a new integrated D-SNP. You'll automatically be disenrolled from our plan when your new plan's coverage begins. You can also contact the plan you wish to enroll in directly.

2. **You can change to:** **Original Medicare with a separate Medicare drug plan** **To apply for Medicaid, complete an application online at www.michigan.gov/mibridges.**	**Here is what to do:** Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. If you need help or more information: • Call the MI Options at 1-800-803-7174 or 1-800-975-7630 Monday–Friday 8:00 AM to 7:00 PM. TTY users should call 1-888-263-5897 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. The call and help are free. For more information or to find a local MI Options office in your area, please visit michigan.gov/mdhhs/adult-child-serv/adults-and-seniors/acls/state-health-insurance-assistance-program **OR** Enroll in a new Medicare drug plan. You'll automatically be disenrolled from our plan when your Original Medicare coverage begins.

3. **You can change to:** **Original Medicare without a separate Medicare drug plan** **To apply for Medicaid, complete an application online at www.michigan.gov/mibridges.** **NOTE:** If you switch to Original Medicare and don't enroll in a separate Medicare drug plan, Medicare may enroll you in a drug plan, unless you tell Medicare you don't want to join. You should only drop drug coverage if you have drug coverage from another source, such as an employer or union. If you have questions about whether you need drug coverage, call MI Options at 1-800-803-7174 or 1-800-975-7630 Monday–Friday 8:00 AM to 7:00 PM. TTY users should call 1-888-263-5897 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.	**Here is what to do:** Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. If you need help or more information: • Call the MI Options at 1-800-803-7174 or 1-800-975-7630 Monday–Friday 8:00 AM to 7:00 PM. TTY users should call 1-888-263-5897 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking The call and help are free. For more information or to find a local MI Options office in your area, please visit michigan.gov/mdhhs/adult-child-serv/adults-and-seniors/acls/state-health-insurance-assistance-program You'll automatically be disenrolled from our plan when your Original Medicare coverage begins.

4. **You can change to:** **Any Medicare health plan** during certain times of the year including the **Open Enrollment Period** and the **Medicare Advantage Open Enrollment Period** or other situations described in Section **G2**.	**Here is what to do:** Call Medicare at 1-800-MEDICARE (**1-800-633-4227**). TTY users should call **1-877-486-2048**. For Program of All-inclusive Care for the Elderly (PACE) inquiries, call **877-2MI-PACE**. If you need help or more information: • Call the MI Options at **1-800-803-7174** or **1-800-975-7630** Monday–Friday 8:00 AM to 7:00 PM. TTY users should call **1-888-263-5897** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking The call and help are free. **OR** Enroll in a new Medicare plan. You'll automatically be disenrolled from our Medicare plan when your new plan's coverage begins.

Your Michigan Medicaid services

For questions about how to get your Michigan Medicaid services after you leave our plan, contact the Beneficiary Help Line: **1-800-642-3195** or **beneficiarysupport@michigan.gov**. For more information log on to **www.michigan.gov/mdhhs/assistance-programs/medicaid/portalhome/beneficiaries/support**. Ask how joining another plan or returning to Original Medicare affects how you get your Michigan Medicaid coverage.

H. Getting help

H1. Our plan

We're here to help if you have any questions. Call Member Services at the numbers at the bottom of the page during the days and hours of operation listed. These calls are toll-free.

Read your *Member Handbook*
Your *Member Handbook* is a legal, detailed description of our plan's benefits. It has details about benefits and costs for 2026. It explains your rights and the rules to follow to get services and drugs we cover.

The *Member Handbook* for 2026 will be available by October 15. An up-to-date copy of the *Member Handbook* is available on our website at **AetnaMedicare.com/MICHDSNP**. You may also call Member Services at the numbers at the bottom of the page to ask us to mail you a *Member Handbook* for 2026.

Our website
You can visit our website at **AetnaMedicare.com/MICHDSNP**. As a reminder, our website has the most up-to-date information about our provider and pharmacy network (*Provider and Pharmacy Directory*) and our *Drug List (List of Covered Drugs)*.

H2. MI Options

You can also call the state health insurance program (SHIP). In Michigan the SHIP program is called MI Options. MI Options can help you understand your plan choices and answer questions about switching plans. MI Options isn't connected with us or with any insurance company or health plan. MI Options has trained counselors in every county and services are free. MI Options phone number is **1-800-803-7174** or **1-800-975-7630**, TTY: **1-888-263-5897** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. For more information or to find a local MI Options office in your area, please visit **michigan.gov/mdhhs/adult-child-serv/adults-and- seniors/acls/state-health-insurance-assistance-program**.

H3. MI Community, Home, and Health Ombudsman (MI CHHO)

MI Community, Home, and Health Ombudsman (MI CHHO) serves as an advocate and problem-solver for people enrolled in Michigan's MICH program. MI CHHO isn't connected with any insurance company or health plan and all of its services are free and it keeps all information confidential. Call MI CHHO if you have trouble or delay with your MICH plan providing medical care, services, equipment, other benefits, or with the quality of care. MI CHHO can also help you learn about MICH and options for care in the community, including your rights. You can call MI Community, Home, and Health Ombudsman (MI CHHO) if your MICH plan has denied medical care, services, equipment, or other benefits - including help with appeals.

Contact us at our toll-free hotline at: 1-888-746-6456.

H4. Medicare

To get information directly from Medicare:

- Call 1-800-MEDICARE (**1-800-633-4227**). TTY users should call **1-877-486-2048**.
- chat live at **www.Medicare.gov/talk-to-someone**
- write to Medicare at PO Box 1270, Lawrence, KS 66044.

Medicare's Website
You can visit the Medicare website (**Medicare.gov**). If you choose to disenroll from our plan and enroll in another Medicare plan, the Medicare website has information about costs, coverage, and quality ratings to help you compare plans.

You can find information about Medicare plans available in your area by using the Medicare Plan Finder on Medicare's website. (For information about plans, refer to **Medicare.gov** and click on "Find plans.")

Medicare & You 2026
You can read the *Medicare & You 2026* handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. This handbook is also available in Spanish, Chinese, and Vietnamese.

If you don't have a copy of this booklet, you can get it at the Medicare website (**medicare.gov/medicare- and-you**) or by calling Call 1-800-MEDICARE (**1-800-633-4227**). TTY users should call **1-877-486-2048**.

H5. Michigan Medicaid

Michigan Medicaid is a health care program that provides comprehensive health care services to low income adults and children. Services covered by Medicaid are offered through what's called fee-for-service or through Medicaid Health Plans:

- Fee-for-service is the term for Medicaid paid services that aren't provided through a health plan. This means that Medicaid pays for the service. People under fee-for-service will use the MIhealth card to receive services.

- Additional information regarding MIhealth can be found by accessing the following website **https://www.michigan.gov/mdhhs/assistance-programs/healthcare/adults/quicklinks/the-mihealth-card**.
- Most people must join a health plan. The health plan pays for most of the services. For people that need to join a health plan, Michigan Enrolls will send a letter with more information. After enrollment with a health plan, both the MIhealth card and the health plan card are needed to access services. For additional information regarding joining a health plan, please visit the following website **https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Folder2/Folder14/Folder1/Folder114/MHP_Service_Area_Listing.pdf?rev=fe2f344f7c46481fb39eb034a8601cd5&hash=D59C718240AE79F1F708D4103AD823A8**.

Costs

Enrollees don’t have to pay the full cost of covered services; however, a small amount called a co-pay may be required. People age 21 and older may have a co-pay for the services listed in the Beneficiary Co-Payment Requirements. To see a list of co-pay amounts in this chart, please visit **https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Folder1/Folder60/WebCo- PayTable_11-02-06.pdf?rev=39dfeae1839e4434b66f503f84d63e45&hash=18CE85BF53 B120E81739BD1F781CE2B8**.

H6. The Medicare Prescription Payment Plan

The Medicare Prescription Payment Plan is a payment option that may help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across the calendar year (January-December) as monthly payments. This program doesn't save you money or lower your drug costs.

“Extra Help” from Medicare and help from your state’s pharmaceutical assistance program (SPAP) and the AIDS Drug Assistance Program (ADAP), for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan alone. All enrollees are eligible to participate in this program, regardless of income level. To learn more about this program please contact us at the phone number at the bottom of this page or visit **Medicare.gov**.

Aetna Medicare HIDE (HMO D-SNP)– Non-Discrimination Notice

Aetna Medicare HIDE (HMO D-SNP) complies with applicable Federal civil rights laws and does not discriminate based on race, color, national origin, age, disability, or sex (consistent with 45 CFR § 92.101(a)(2)). We do not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

We provide people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:

- Free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (braille, large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages
    - Electronic and written translated documents
- Reasonable modifications for individuals with disabilities

If you need these services, call
Aetna Medicare HIDE (HMO D-SNP) at **1-855-676-5772**. For **TTY/TDD** services, call **711**.

If you believe that Aetna Medicare HIDE (HMO D-SNP) has failed to provide these services or discriminated in another way based on race, color, national origin, age, disability, or sex, you can file a grievance with:

Civil Rights Coordinator
Attn: 1557 Coordinator
CVS Pharmacy, Inc.
1 CVS Drive, MC 2332,
Woonsocket, RI 02895

1-833-220-0349 (TTY: 711)
Email: Coordinator1557@cvshealth.com

You can file a grievance in person or by mail, phone, or email. If you need help filing a grievance, the **Civil Rights Coordinator** is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW.
Room 509F, HHH Building
Washington, DC 20201
800–368–1019, (TDD: 800–537–7697).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
This notice is available at Aetna Inc.'s website: https://www.aetna.com/medicare

H9314_NDN_2025

How we guard your privacy

What personal information is — and what it isn't
By "personal information," we mean information that can be used to identify you. It can include financial and health information. It doesn't include what the public can easily see. For example, anyone can look at what your plan covers.

How we get information about you
We get information about you from many sources, including you. We also get information from your employer, other insurers, or health care providers like doctors.

When information is wrong
Do you think there's something wrong or missing in your personal information? You can ask us to change it. The law says we must do this in a timely way. If we disagree with your change, you can file an appeal. Information on how to file an appeal is on our member website. Or you can call the toll-free number on your ID card.

How we use this information
When the law allows us, we use your personal information both inside and outside our company. The law says we don't need to get your OK when we do. We may use it for your health care or use it to run our plans. We also may use your information when we pay claims or work with other insurers to pay claims. We may use it to make plan decisions, to do audits, or to study the quality of our work. This means we may share your information with doctors, dentists, pharmacies, hospitals or other caregivers. We also may share it with other insurers, vendors, government offices, or third-party administrators. But by law, all these parties must keep your information private.

When we need your permission
There are times when we do need your permission to disclose personal information. This is explained in our Notice of Privacy Practices, which took effect October 10, 2020. This notice clarifies how we use or disclose your Protected Health Information (PHI):

- For workers' compensation purposes
- As required by law
- About people who have died
- For organ donation
- To fulfill our obligations for individual access and HIPAA compliance and enforcement

To get a copy of this notice, just visit our member website or call the toll-free number on your ID card.

Aetna Medicare HIDE (HMO D-SNP)

You can view your 2026 plan benefit information online

This notice is to help you find important plan information. All information will be available online by October 15, 2025.

Where to look

View your plan information online by visiting:	**AetnaMedicare.com/MICHDSNP**
También puede ver este sitio web en español. Visite	**Aetnamedicare.com/MichDSNP-ES**

What to look for

You can learn more about your plan benefits, programs and services, your member rights and responsibilities, and how to file a complaint or appeal online. To request a printed copy of a document, call the phone number listed. You can also obtain language assistance by calling **1-855-676-5772** (**TTY: 711**).

Member Handbook	A complete description of your plan's coverage. **AetnaMedicare.com/MICHDSNP** **1-855-676-5772** (**TTY: 711**), 8 AM to 8 PM, 7 days a week
List of covered drugs (formulary)	A list of drugs your plan covers. It has the drug's tier level, as well as any special requirements, such as prior authorization, quantity limits or step therapy. **AetnaMedicare.com/MICHDSNP** **1-855-676-5772** (**TTY: 711**), 8 AM to 8 PM, 7 days a week
Provider directory	You can find a doctor near you by using our online search directory. **AetnaMedicare.com/MICHDSNP** **1-855-676-5772** (**TTY: 711**), 8 AM to 8 PM, 7 days a week
Pharmacy directory	You can find a pharmacy near you by using our online search directory. **AetnaMedicare.com/MICHDSNP** **1-855-676-5772** (**TTY: 711**), 8 AM to 8 PM, 7 days a week

Participating health care providers are independent contractors and are neither agents nor employees of Aetna. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change. The formulary and/or pharmacy network may change at any time. You will receive notice when necessary.

H9314_5621809_2026_C
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Due to legislation in Arkansas, effective January 1, 2026, you may not be able to utilize the following services within the state of Arkansas, unless a court takes action: CVS Retail, CVS Caremark Mail Service, CVS Specialty, and OMNI Care long term pharmacies.

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1107142-02-03

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Aetna Medicare HIDE (HMO D-SNP) Member Services

Method	Member Services – Contact Information
CALL	1-855-676-5772 Calls to this number are free. Hours of operation are 8 AM to 8 PM, 7 days a week. Member Services also has free language interpreter services available for non-English speakers.
TTY	711 Calls to this number are free. Hours of operation are 8 AM to 8 PM, 7 days a week.
WRITE	Aetna Medicare HIDE Aetna Duals COE Member Correspondence PO Box 982980 El Paso, TX 79998
WEBSITE	Go to AetnaMedicare.com/MICHDSNP or scan this code with your smartphone to visit our website.

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