2026

Annual Notice of Changes

AIPCares.com

MedicareRx Prescription Drug Coverage

Arkansas Integrated Providers

AIP Dual Advantage (HMO D-SNP)

H1587_001ANOC26_M

Arkansas Integrated Providers (AIP) Dual Advantage (HMO D-SNP) offered by Arkansas Superior Select, Inc.

Annual Notice of Change for 2026

You're enrolled as a member of Arkansas Integrated Providers (AIP) Dual Advantage.

This material describes changes to our plan's costs and benefits next year.

- **You have from October 15 – December 7 to make changes to your Medicare coverage for next year.** If you don't join another plan by December 7, 2025, you'll stay in AIP Dual Advantage.
- To change to a **different plan**, visit www.Medicare.gov or review the list in the back of your *Medicare & You 2026* handbook.
- Note this is only a summary of changes. More information about costs, benefits, and rules is in the *Evidence of Coverage***.** Get a copy at www.AIPCares.com or call Member Services at 1-866-488-5457 (TTY users call 711) to get a copy by mail.

More Resources

- Call Member Services at 1-866-488-5457 (TTY users call 711) for more information. Hours are 8 a.m. to 8 p.m., 7 days a week . This call is free.
- This document may be available in alternate formats (braille, etc.). Please contact Member Services for more information.

About AIP Dual Advantage

- AIP Dual Advantage (HMO D-SNP) is a Health Plan with a Medicare contract. Enrollment in AIP Dual Advantage depends on contract renewal. Our plan also has a written agreement with the Arkansas Medicaid program to coordinate your Medicaid benefits.
- When this material says "we," "us," or "our," it means Arkansas Superior Select, Inc. When it says "plan" or "our plan," it means Arkansas Integrated Providers (AIP) Dual Advantage.
- On January 1, 2026, our plan name will change from Tribute Advantage to Arkansas Integrated Providers (AIP) Dual Advantage. We'll send you a new member ID card with our new name. From here on, our new name, AIP Dual Advantage, will be on all materials.

- **If you do nothing by December 7, 2025, you'll automatically be enrolled in Arkansas Integrated Providers (AIP) Dual Advantage.** Starting January 1, 2026, you'll get your medical and drug coverage through AIP Dual Advantage. Go to Section 3.1 for more information about how to change plans and deadlines for making a change.

H1587_001ANOC26_M File & Use 09/27/2025

Table of Contents

Summary of Important Costs for 2026

	2025 (this year)	2026 (next year)
Monthly plan premium* * Your premium can be higher than this amount. Go to Section 1.1 for details.	$0	**$0** **No change**
Maximum out-of-pocket amount This is the most you'll pay out of pocket for covered Part A and Part B services. (Go to Section 1.2 for details.)	$9350 You are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.	**$9250** **You are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.**
Primary care office visits	$0 per visit	**$0 per visit**
Specialist office visits	$0 per visit	**$0 per visit**
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you're formally admitted to the hospital with a doctor's order. The day before you're discharged is your last inpatient day.	$0	**$0**

	2025 (this year)	2026 (next year)
Part D drug coverage deductible (Go to Section 1.7 for details.)	$0	**$0**
Part D drug coverage (Go to Section 1.7 for details, including Yearly Deductible, Initial Coverage, and Catastrophic Coverage Stages.)	Copayment during the Initial Coverage Stage: Drug Tier 1: For generic either: • $0 copay; or • $1.60 copay; or • $4.90 copay For all other drugs: • $0 copay; or • $4.80 copay; or • $12.15 copay Catastrophic Coverage Stage: During this payment stage, you pay nothing for your covered Part D drugs.	**Copayment during the Initial Coverage Stage:** **Drug Tier 1:** **For generic either:** • **$0 copay; or** • **$1.60 copay; or** • **$5.10 copay** **For all other drugs:** • **$0 copay; or** • **$4.90 copay; or** • **$12.65 copay** **Catastrophic Coverage Stage:** **During this payment stage, you pay nothing for your covered Part D drugs.**

SECTION 1 Changes to Benefits & Costs for Next Year

Section 1.1 Changes to the Monthly Plan Premium

	2025 (this year)	2026 (next year)
Monthly plan premium (You must also continue to pay your Medicare Part B premium unless it's paid for you by Medicaid.)	$0	**$0** **No change**
Part B premium reduction This amount will be deducted from your Part B premium. This means you'll pay less for Part B.	$2.40	**$18.10**

Section 1.2 Changes to Your Maximum Out-of-Pocket Amount

Medicare requires all health plans to limit how much you pay out of pocket for the year. This limit is called the maximum out-of-pocket amount. Once you've paid this amount, you generally pay nothing for covered Part A and Part B services.

	2025 (this year)	2026 (next year)
Maximum out-of-pocket amount Because our members also get help from Medicaid, very few members ever reach this out-of-pocket maximum. You are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.	$9,350	**$9,250** **Once you've paid $9,250 out of pocket for covered Part A and Part B services, you'll pay nothing for your covered Part A and Part B services for the rest of the calendar year.**

	2025 (this year)	2026 (next year)
Maximum out-of-pocket amount (continued) Your costs for covered medical services (such as copayments and deductibles) **count** toward your maximum out-of-pocket amount. Your costs for prescription drugs **don't count** toward your maximum out-of-pocket amount.		

Section 1.3 Changes to the Provider Network

Our network of providers has changed for next year. Review the 2026 *Provider Directory* www.AIPCares.com to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network. Here's how to get an updated *Provider Directory*:

- Visit our website at www.AIPCares.com.
- Call Member Services at 1-866-488-5457 (TTY users call 711) to get current provider information or to ask us to mail you a *Provider Directory*.

We can make changes to the hospitals, doctors, and specialists (providers) that are part of our plan during the year. If a mid-year change in our providers affects you, call Member Services at 1-866-488-5457 (TTY users call 711) for help. For more information on your rights when a network provider leaves our plan, go to Chapter 3, Section 2.3 of your *Evidence of Coverage*.

Section 1.4 Changes to the Pharmacy Network

Amounts you pay for your prescription drugs can depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered *only* if they are filled at one of our network pharmacies.

Our network of pharmacies has changed for next year. Review the 2026 *Pharmacy Directory* www.AIPcares.com to see which pharmacies are in our network. Here's how to get an updated *Pharmacy Directory*:

- Visit our website at www.AIPcares.com.

- Call Member Services at 1-866-488-5457 (TTY users call 711) to get current pharmacy information or to ask us to mail you a *Pharmacy Directory*.

We can make changes to the pharmacies that are part of our plan during the year. If a mid-year change in our pharmacies affects you, call Member Services at 1-866-488-5457 (TTY users call 711) for help.

Section 1.5 Changes to Benefits & Costs for Medical Services

The Annual Notice of Change tells you about changes to your Medicare benefits and costs.

	2025 (this year)	2026 (next year)
Non-Medicare Covered Diagnostic and Preventive Dental Services	Non-Medicare covered diagnostic and preventive dental services are covered as a supplemental benefit with a $1,500 annual benefit limit. You pay 20% coinsurance for this covered supplemental benefit.	**Non-Medicare covered diagnostic and preventive dental services are <u>not</u> covered as a supplemental benefit.**
Non-Medicare Covered Eye Exams, Eyewear, Contact Lenses, Eyeglasses (lenses and frames), and Upgrades	Non-Medicare covered eye exams, eyewear, contact lenses, eyeglasses (lenses and frames), and upgrades are covered as a supplemental benefit with a $1,500 annual benefit limit. You pay 20% coinsurance for this covered supplemental covered benefit.	**Non-Medicare covered eye exams, eyewear, contact lenses, eyeglasses (lenses and frames), and upgrades are covered as a supplemental benefit with a $1,500 annual benefit limit.** **You pay 0% coinsurance for this covered supplemental covered benefit.**

Non-Medicare Covered Routine Hearing Exams, Fitting and Evaluation for Hearing Aids, and Hearing Aids	Non-Medicare covered routine hearing exams, fitting and evaluation for hearing aids, and hearing aids are covered as a supplemental benefit with a $1,500 annual benefit limit. You pay 20% coinsurance for this supplemental covered benefit.	**Non-Medicare covered routine hearing exams, fitting and evaluation for hearing aids, and hearing aids are covered as a supplemental benefit with a $1,500 annual benefit limit.** **You pay 0% coinsurance for this supplemental covered benefit.**
Personal Emergency Response System (PERS)	Personal Emergency Response System (PERS) is not a covered benefit.	**You pay a $0 copay for a Personal Emergency Response System (PERS) device and monitoring program.** **Referral from a Case Manager is required.**

Point of Service (POS) out-of-network coverage	Out-of-network services are available for cardiac and pulmonary rehabilitation services, supervised exercise therapy for peripheral artery disease, partial, outpatient, and observation hospital services, primary care and specialist physician services, chiropractic services, mental health specialty services (group and individual sessions), podiatry services, psychiatric services (group and individual sessions), occupational/ physical/speech pathology therapy services, opioid treatment program and outpatient substance abuse services, diagnostic procedures and tests, lab services, diagnostic and therapeutic radiological services, outpatient x-ray services, ambulatory surgical center services, outpatient blood services, ambulance services, durable medical equipment (DME), prosthetics and medical supplies, diabetic supplies and services, dialysis services, Medicare-covered preventative services,	**Out-of-network services are <u>not</u> a covered benefit.**

Point of Service (POS) out-of-network coverage (continued)	kidney disease education services, glaucoma screening, diabetic self-management training, barium enemas, digital rectal exams, EKG following welcome visit, Medicare Part B Rx Drugs, vision and hearing services. Authorization required for some services, see Pre-Authorization Requirements.	

Prior Authorization Requirements	You are required to get a prior authorization from the plan for the following benefits: Meal Benefit You are not required to get a prior authorization from the plan for the following benefits: Cardiac and Intensive Cardiac Rehabilitation Services Pulmonary Rehabilitation Services Supervised Exercise Therapy (SET) for Peripheral Artery Disease (PAD) Services Diagnostic and Therapeutic Radiological Services Individual and Group Session for Outpatient Substance Abuse	**You are required to get a prior authorization from the plan for the following benefits:** **Cardiac and Intensive Cardiac Rehabilitation Services** **Pulmonary Rehabilitation Services** **Supervised Exercise Therapy (SET) for Peripheral Artery Disease (PAD) Services** **Diagnostic and Therapeutic Radiological Services** **Individual and Group Session for Outpatient Substance Abuse** **You are not required to get a prior authorization from the plan for the following benefits:** **Meal Benefit**

Referral Requirements	You are not required to get a referral from the plan for the following benefits: Advanced Placement of Durable Medical Equipment (DME)	**You are required to get a referral from the plan for the following benefits:** **Meal Benefit** **Advanced Placement of Durable Medical Equipment (DME)** **Personal Emergency Response System (PERS)**
Special Supplemental Benefits for the Chronically Ill (SSBCI)	You pay a $0 copay for $225 per month debit card for the purchase of healthy food, produce or OTC items. This amount will not renew month to month. Not all members qualify.[1] See Evidence of Coverage for details.	**You pay a $0 copay for $265 per month debit card for the purchase of healthy food and produce. This amount will not renew month to month. Not all members qualify.[1]** **See Evidence of Coverage for details.**

[1]The healthy food, produce and OTC benefits mentioned are part of a special supplemental program for people with qualifying chronic conditions. Certain restrictions may apply. Call Member Services at 1-866-488-5457 (TTY 711) to see if you qualify. Not all members qualify.

Section 1.6 Changes to Part D Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a formulary or Drug List. A copy of our Drug List is provided electronically.

We made changes to our Drug List, which could include removing or adding drugs, changing 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 see if there will be 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 rules that will affect you during the calendar year. We update our online Drug List at least monthly to provide the most up-to-date list of drugs. If we make a change that will affect your access to a drug you're taking, we'll send you a notice about the change.

If you're affected by a change in drug coverage at the beginning of the year or during the year, review Chapter 9 of your *Evidence of Coverage* and talk to your prescriber to find out your options, such as asking for a temporary supply, applying for an exception, and/or working to find a new drug. Call Member Services at 1-866-488-5457 (TTY users call 711) for more information.

Section 1.7 Changes to Prescription Drug Benefits & Costs

Do you get Extra Help to pay for your drug coverage costs?

If you're in a program that helps pay for your drugs (Extra Help), **the information about costs for Part D drugs may not apply to you.** We sent you a separate material, called the *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs*, which tells about your drug costs. If you get Extra Help and you don't get this material by 9/30/2025, call Member Services at 1-866-488-5457 (TTY users call 711) and ask for the *LIS Rider*.

Drug Payment Stages

There are 3 **drug payment stages:** the Yearly Deductible Stage, the Initial Coverage Stage, and the Catastrophic Coverage Stage. The Coverage Gap Stage and the Coverage Gap Discount Program no longer exist in the Part D benefit.

- ***Stage 1: Yearly Deductible***

  We have no deductible, so this payment stage doesn't apply to you.

- ***Stage 2: Initial Coverage***

  In this stage, our plan pays its share of the cost of your drugs, and you pay your share of the cost. You generally stay in this stage until your year-to-date total drug costs reach $2,100.

- ***Stage 3: Catastrophic Coverage***

  This is the third and final drug payment stage. In this stage, you pay for your covered Part D drugs. You generally stay in this stage for the rest of the calendar year.

The Coverage Gap Discount Program has been replaced by the Manufacturer Discount Program. 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.

The table shows your cost per prescription during this stage.

	2025 (this year)	2026 (next year)
Yearly Deductible	Because we have no deductible, this payment stage doesn't apply to you.	**Because we have no deductible, this payment stage doesn't apply to you.**

Drug Costs in Stage 2: Initial Coverage

The table shows your cost per prescription for a one-month supply filled at a network pharmacy with standard cost sharing.

Most adult Part D vaccines are covered at no cost to you. For more 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 of your *Evidence of Coverage*.

Once you've paid $2,100 out of pocket for covered Part D drugs, you'll move to the next stage (the Catastrophic Coverage Stage).

	2025 (this year)	2026 (next year)
Initial Coverage	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing is: Drug Tier 1: For generic either: • $0 copay; or • $1.60 copay; or • $4.90 copay For all other drugs: • $0 copay; or • $4.80 copay; or • $12.15 copay	**Your cost for a one-month supply filled at a network pharmacy with standard cost sharing is:** **Drug Tier 1:** **For generic either:** • **$0 copay; or** • **$1.60 copay; or** • **$5.10 copay** **For all other drugs:** • **$0 copay; or** • **$4.90 copay; or** • **$12.65 copay**

Changes to the Catastrophic Coverage Stage

For specific information about your costs in the Catastrophic Coverage Stage, go to Chapter 6, Section 6, in your *Evidence of Coverage*.

SECTION 2 Administrative Changes

	2025 (this year)	2026 (next year)
On January 1, 2026, our plan name will change	The plan name is Tribute Advantage (HMO-POS D-SNP)	**The plan name is Arkansas Integrated Providers (AIP) Dual Advantage (HMO D-SNP)**
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 1-866-488-5457 (TTY users call 711) or visit www.Medicare.gov.**

SECTION 3 How to Change Plans

To stay in AIP Dual Advantage, you don't need to do anything. Unless you sign up for a different plan or change to Original Medicare by December 7, you'll automatically be enrolled in our AIP Dual Advantage.

If you want to change plans for 2026, follow these steps:

- **To change to a different Medicare health plan**, enroll in the new plan. You'll be automatically disenrolled from AIP Dual Advantage.
- **To change to Original Medicare with Medicare drug coverage,** enroll in the new Medicare drug plan. You'll be automatically disenrolled from AIP Dual Advantage.

- **To change to Original Medicare without a drug plan,** you can send us a written request to disenroll. Call Member Services at 1-866-488-5457 (TTY users call 711) for more information on how to do this. Or call **Medicare** at 1-800-MEDICARE (1-800-633-4227) and ask to be disenrolled. TTY users can call 1-877-486-2048. If you don't enroll in a Medicare drug plan, you may pay a Part D late enrollment penalty (go to Section 1.1).
- **To learn more about Original Medicare and the different types of Medicare plans,** visit www.Medicare.gov, check the *Medicare & You 2026* handbook, call your State Health Insurance Assistance Program (go to Section 5), or call 1-800-MEDICARE (1-800-633-4227. As a reminder, Arkansas Superior Select, Inc offers other Medicare health plans. These other plans can differ in coverage, monthly plan premiums, and cost-sharing amounts.

Section 3.1 Deadlines for Changing Plans

People with Medicare can make changes to their coverage from **October 15 – December 7** each year.

If you enrolled in a Medicare Advantage plan for January 1, 2026, and don't like your plan choice, you can switch to another Medicare health plan (with or without Medicare drug coverage) or switch to Original Medicare (with or without Medicare drug coverage) between January 1 – March 31, 2026.

Section 3.2 Are there other times of the year to make a change?

In certain situations, people may have other chances to change their coverage during the year. Examples include people who:

- Have Medicaid
- Get Extra Help paying for their drugs
- Have or are leaving employer coverage
- Move out of our plan's service area

Because you have Medicaid, you can end your membership in our plan by choosing one of the following Medicare options in any month of the year:

  - Original Medicare *with* a separate Medicare prescription drug plan,
  - Original Medicare *without* a separate Medicare prescription drug plan (If you choose this option, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.), or

- If eligible, an integrated D-SNP that provides your Medicare and most or all of your Medicaid benefits and services in one plan.

If you recently moved into or currently live in an institution (like a skilled nursing facility or long-term care hospital), you can change your Medicare coverage **at any time**. You can change to any other Medicare health plan (with or without Medicare drug coverage) or switch to Original Medicare (with or without Medicare drug coverage) at any time. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for 2 full months after the month you move out.

SECTION 4 Get Help Paying for Prescription Drugs

You may qualify for help paying for prescription drugs. Different kinds of help are available:

- **Extra Help from Medicare.** People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs, including monthly drug plan premiums, yearly deductibles, and coinsurance. Also, people who qualify won't have a late enrollment penalty. To see if you qualify, call:
  - 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048, 24 hours a day, 7 days a week.
  - Social Security at 1-800-772-1213 between 8 a.m. and 7 p.m., Monday – Friday for a representative. Automated messages are available 24 hours a day. TTY users can call, 1-800-325-0778.
  - Your State Medicaid office.

- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible people living with HIV/AIDS have access to life-saving HIV medications. To be eligible for the ADAP operating in your state, you must meet certain criteria, including proof of state residence and HIV status, low income as defined by the state, and uninsured/under-insured status. Medicare Part D drugs that are also covered by ADAP qualify for prescription cost-sharing help through the Arkansas AIDS Drug Assistance Program. For information on eligibility criteria, covered drugs, how to enroll in the program, or, if you're currently enrolled, how to continue getting help, call 501-661-2408. Be sure, when calling, to inform them of your Medicare Part D plan name or policy number.
- **The Medicare Prescription Payment Plan.** The Medicare Prescription Payment Plan is a payment option that works with your current drug coverage to help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across the calendar year (January – December). Anyone with a Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage plan with drug coverage)

can use this payment option **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs.**

Extra Help from Medicare and help from your SPAP and ADAP, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan. All members are eligible to participate the Medicare Prescription Payment Plan, regardless of income level. To learn more about this payment option, call us at 1-866-488-5457 (TTY users call 711) or visit www.Medicare.gov.

SECTION 5 Questions?

Get Help from AIP Dual Advantage

- **Call Member Services at 1-866-488-5457. (TTY users call 711.)**

  We're available for phone calls 8 a.m. to 8 p.m., 7 days a week. Calls to these numbers are free.

- **Read your 2026 *Evidence of Coverage***

  This *Annual Notice of Change* gives you a summary of changes in your benefits and costs for 2026. For details, go to the 2026 *Evidence of Coverage* for AIP Dual Advantage. The *Evidence of Coverage* is the legal, detailed description of our plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. Get the *Evidence of Coverage* on our website at www.AIPCares.com or call Member Services at 1-866-488-5457 (TTY users call 711) to ask us to mail you a copy.

- **Visit www.AIPCares.com**

  Our website has the most up-to-date information about our provider network (*Provider Directory/Pharmacy Directory*) and our *List of Covered Drugs* (formulary/Drug List).

Get Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is an independent government program with trained counselors in every state. In Arkansas, the SHIP is called Arkansas Senior Health Insurance Information Program (SHIIP).

Call Arkansas Senior Health Insurance Information Program (SHIIP) to get free personalized health insurance counseling. They can help you understand your Medicare and Medicaid plan choices and answer questions about switching plans. Call Arkansas Senior Health Insurance

Information Program (SHIIP) at 1-800-224-6330. Learn more about Arkansas Senior Health Insurance Information Program (SHIIP) by visiting https://www.insurance.arkansas.gov/consumer-services/senior-health/.

Get Help from Medicare

- **Call 1-800-MEDICARE (1-800-633-4227)**

  You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users can call 1-877-486-2048.

- **Chat live with www.Medicare.gov**

  You can chat live at www.Medicare.gov/talk-to-someone.

- **Write to Medicare**

  You can write to Medicare at PO Box 1270, Lawrence, KS 66044

- **Visit www.Medicare.gov**

  The official Medicare website has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area.

- **Read *Medicare & You* 2026**

  The *Medicare & You 2026* handbook is mailed to people with Medicare every fall. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. Get a copy at www.Medicare.gov or by calling 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Get Help from Medicaid

Call Arkansas Medicaid at 1-800-482-8988. TTY users call 1-800-285-1311 for help with Medicaid enrollment or benefit questions.