Tribute ADVANTAGE
(HMO-POS D-SNP)

2022

ANNUAL NOTICE OF CHANGES

MedicareRx
Prescription Drug Coverage

Member Services: 1-877-372-1033 (TTY users call 711)
8:00 a.m. to 8:00 p.m., 7 days a week
SuperiorSelectMedicare.com

H1587_001ANOC22_M

Tribute Advantage (HMO-POS D-SNP) offered by Arkansas Superior Select, Inc.

Annual Notice of Changes for 2022

You are currently enrolled as a member of Tribute Advantage (HMO-POS D-SNP). Next year, there will be some changes to the plan's costs and benefits. *This booklet tells about the changes.*

What to do now

1. ASK: Which changes apply to you

☐ Check the changes to our benefits and costs to see if they affect you.

- It's important to review your coverage now to make sure it will meet your needs next year.
- Do the changes affect the services you use?
- Look in Sections 1.5 and 1.6 for information about benefit and cost changes for our plan.

☐ Check the changes in the booklet to our prescription drug coverage to see if they affect you.

- Will your drugs be covered?
- Are your drugs in a different tier, with different cost sharing?
- Do any of your drugs have new restrictions, such as needing approval from us before you fill your prescription?
- Can you keep using the same pharmacies? Are there changes to the cost of using this pharmacy?
- Review the 2022 Drug List and look in Section 1.6 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. To get additional information on drug prices visit go.medicare.gov/drugprices and click the "dashboards" link in the middle of the second Note toward the bottom of the page. These dashboards highlight which manufacturers have been increasing their prices and also show other year-to-year drug price information. Keep in mind that your plan benefits will determine exactly how much your own drug costs may change.

☐ Check to see if your doctors and other providers will be in our network next year.

- Are your doctors, including specialists you see regularly, in our network?
- What about the hospitals or other providers you use?

- Look in Section 1.3 for information about our *Provider Directory*.

☐ Think about your overall health care costs.

- How much will you spend out-of-pocket for the services and prescription drugs you use regularly?
- How much will you spend on your premium and deductibles?
- How do your total plan costs compare to other Medicare coverage options?

☐ Think about whether you are happy with our plan.

2. **COMPARE:** Learn about other plan choices

☐ Check coverage and costs of plans in your area.

- Use the personalized search feature on the Medicare Plan Finder at www.medicare.gov/plan-compare website.
- Review the list in the back of your *Medicare & You 2022* handbook.
- Look in Section 2.2 to learn more about your choices.

☐ Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan's website.

3. **CHOOSE:** Decide whether you want to change your plan

- If you don't join another plan by December 7, 2021, you will be enrolled in Tribute Advantage.
- If you want to **change to a different plan** that may better meet your needs, you can switch plans between October 15 and December 7. Look in section 2.2, page 13 to learn more about your choices.

4. **ENROLL:** To change plans, join a plan between **October 15** and **December 7, 2021**

- If you don't join another plan by **December 7, 2021**, you will be enrolled in Tribute Advantage.
- If you join another plan between **October 15** and **December 7, 2021**, your new coverage will start on **January 1, 2022**. You will be automatically disenrolled from your current plan.

Additional Resources

- Please contact our Member Services number at 1-877-372-1033 for additional information. (TTY users should call 711.) Hours are 8 a.m. - 8 p.m., 7 days a week.
- This document may be available in an alternate form (braille, etc.). Please contact Member Services for more information.
- **Coverage under this Plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared

responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About Tribute Advantage (HMO-POS D-SNP)

- Tribute Advantage (HMO-POS D-SNP) is a Health Plan with a Medicare Contract. The plan also has a written agreement with the Arkansas Medicaid program to coordinate your Medicaid benefits.
- When this booklet says "we," "us," or "our," it means Tribute Health Plans. When it says "plan" or "our plan," it means Tribute Advantage.

Summary of Important Costs for 2022

The table below compares the 2021 costs and 2022 costs for Tribute Advantage in several important areas. **Please note this is only a summary of changes**. A copy of the *Evidence of Coverage* is located on our website at www.SuperiorSelectMedicare.com. You may also call Member Services to ask us to mail you an *Evidence of Coverage*. If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0 for your deductible, doctor office visits, and inpatient hospital stays.

Cost	2021 (this year)	2022 (next year)
Monthly plan premium* * Your premium may be higher than this amount. See Section 1.1 for details.	$0.00	$0.00
Doctor office visits	Primary care visits: $0 per visit Specialist visits: $0 per visit	Primary care visits: $0 per visit Specialist visits: $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 are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day**.**	$0	$0

Cost	2021 (this year)	2022 (next year)
Part D prescription drug coverage (See Section 1.6 for details.)	Deductible: $0 Copayment during the Initial Coverage Stage: • Drug Tier 1: For generic drugs (including brand drugs treated as generic), either $0 copay; or $1.30 copay; or $3.70 copay • For all other drugs, either $0 copay; $4.00 copay; or $9.20 copay	Deductible: $0 Copayment during the Initial Coverage Stage: • Drug Tier 1: For generic drugs (including brand drugs treated as generic), either $0 copay; or $1.35 copay; or $3.95 copay • For all other drugs, either $0 copay; $4.00 copay; or $9.85 copay
Maximum out-of-pocket amount This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details.)	$6,700 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	$7,550 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.

Annual Notice of Changes for 2022
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SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2021 (this year)	2022 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium unless it is paid for you by Medicaid.)	$0	$0

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

To protect you, Medicare requires all health plans to limit how much you pay "out-of-pocket" during the year. This limit is called the "maximum out-of-pocket amount." Once you reach this amount, you generally pay nothing for covered Part A and Part B services for the rest of the year.

Cost	2021 (this year)	2022 (next year)
Maximum out-of-pocket amount **Because our members also get assistance 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. Your costs for covered medical services (such as copays and deductibles) count toward your maximum out-of-pocket amount. Your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$6,700	$7,550 Once you have paid $7,550 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year.

Section 1.3 – Changes to the Provider Network

There are changes to our network of providers for next year. An updated *Provider Directory* is located on our website at www.SuperiorSelectMedicare.com. You may also call Member Services for updated provider information or to ask us to mail you a *Provider Directory*. **Please review the 2022 *Provider Directory* to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network**.

It is important that you know that we may make changes to the hospitals, doctors, and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan, but if your doctor or specialist does leave your plan you have certain rights and protections summarized below:

- Even though our network of providers may change during the year, we must furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider to manage your care.

Section 1.4 – Changes to the Pharmacy Network

Amounts you pay for your prescription drugs may 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.

There are changes to our network of pharmacies for next year. An updated *Pharmacy Directory* is located on our website at www.SuperiorSelectMedicare.com . You may also call Member Services for updated provider information or to ask us to mail you a Pharmacy Directory. **Please review the 2022 *Pharmacy Directory* to see which pharmacies are in our network**.

Section 1.5 – Changes to Benefits and Costs for Medical Services

Please note that the *Annual Notice of Changes* tells you about changes to your Medicare benefits and costs.

We are changing our coverage for certain medical services next year. The information below describes these changes. For details about the coverage and costs for these services, see Chapter 4, *Benefits Chart (what is covered and what you pay*), in your 2022 *Evidence of Coverage*. A copy of the *Evidence of Coverage* is located on our website at www.SuperiorSelectMedicare.com. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

Opioid treatment program services

Members of our plan with opioid use disorder (OUD) can receive coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services:

- U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications.
- Dispensing and administration of MAT medications (if applicable)
- Substance use counseling
- Individual and group therapy
- Toxicology testing
- Intake activities
- Periodic assessments

Cost	2021 (this year)	2022 (next year)
Annual Physical Exam	One Annual Physical Exam **is** provided as a supplemental benefit under Part C.	One Annual Physical Exam **is not** provided as a supplemental benefit under Part C.
Hearing Exams and hearing aids	Hearing exams and hearing aids are not covered under a supplemental benefit You pay nothing for Medicare Covered Hearing Services	Hearing exam: One routine hearing exam is covered per year. Routine exam and fitting/evaluation is limited to Access Medical Clinic locations only. Hearing Aids: Hearing aids covered, up to $500 for both ears combined every year.

Hearing Exams and hearing aids (continued)		Benefit is subject to a 6 month waiting period. Services required at Access Medical Clinic locations.
Over the Counter (OTC) Blood Pressure Monitor	Not covered.	One electronic blood pressure meter will be provided at the plans' cost to members with diabetes, pre-diabetes, hypertension or pre-hypertensive or other members as defined and approved by case managers.
Over the Counter (OTC) Wellness Box	Not covered.	Plan will provide 1 OTC Wellness box with $25 worth of supplies such as first aid items, low-cost supplies or devices with a limit of 1 per year.
Pre-Diabetic Shoes or Inserts	Not covered.	20% coinsurance for members with diabetes or in a pre-diabetic state and with other foot related issues.
Pre-Authorization Requirements	You are required to get a prior authorization from the plan for these covered services: Acute Inpatient Hospitalization Inpatient Psychiatric Hospitalization SNF Services Partial Hospitalization Home Health Services Occupational Therapy Services Mental Health Specialty Services Psychiatric Services Physical Therapy and Speech Pathology Services Durable Medical Equipment (required for services in	You are required to get a prior authorization from the plan for these covered services: Acute Inpatient Hospitalization Inpatient Psychiatric Hospitalization SNF Services Partial Hospitalization Durable Medical Equipment Prosthetics/Medical Supplies Home Health Services Occupational Therapy Services Mental Health Specialty Services Psychiatric Services Physical Therapy and Speech Pathology Services Outpatient Diagnostic and Therapeutic Radiological Services

Pre-Authorization Requirements (continued)	excess of $1,000 of billed charges) Prosthetics/Medical Supplies (required for services in excess of $1,000 of billed charges) Advanced Placement of Durable Medical Equipment You are <u>not</u> required to get an authorization from the plan for these covered services: Additional Telehealth Services Ambulatory Surgical Center Services Non-emergency Medicare Ambulance Services Dialysis Services Medicare Part B Drugs Medicare-covered Outpatient Hospital Services Medicare-covered Observation Services No authorization required for providers under a quality-based or similar arrangement.	Advanced Placement of Durable Medical Equipment Medicare Part B (select cell and gene-based Part B therapies) The following Point of Service (POS) benefits: Inpatient Acute Hospitalization Inpatient Psychiatric Hospitalization SNF Services Partial Hospitalization Home Health Services Occupational Therapy Services Mental Health Specialty Services Psychiatric Services Physical Therapy and Speech Pathology Services Diagnostic and Therapeutic Radiological Services Durable Medical Equipment Prosthetics/Medical Supplies You are <u>not</u> required to get an authorization from the plan for these covered services: Cardiac and Pulmonary Rehabilitation Services Chiropractic Services Physician Specialist Services Podiatry Services Opioid Treatment Program Services X-Ray Services Outpatient Hospital Services Outpatient Substance Abuse Outpatient Blood Services Diabetic Supplies and Services Additional Telehealth Services Ambulatory Surgical Center Services Non-emergency Medicare Ambulance Services Dialysis Services Medicare-covered Outpatient Hospital Services

Pre-Authorization Requirements (continued)		Medicare-covered Observation Services No authorization required for providers under a quality-based or similar arrangement.
Support for Caregivers of Enrollees	Telephonic or face-to-face counseling and supportive services provided by the case managers / interdisciplinary care team members to include, but not limited to, such services as community to long-term care admission transition consultation, palliative care program education, behavioral health intervention / crisis management planning, and advanced care plan discussions.	Support for Caregivers of Enrollees is not covered under a supplemental benefit
Telehealth	You pay nothing for Telehealth services for certain other Health Care Professionals.	Telehealth services for certain other Health Care Professionals are not covered.
Transportation	You are provided 1 round-trip transportation to your Annual Wellness exam, once per year.	Transportation is not covered.

Section 1.6 – Changes to Part D Prescription 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.

Certain drugs may be covered for some medical conditions, but are considered non-formulary for other medical conditions. Drugs that are covered for only select medical conditions will be identified on our Drug List and in Medicare Plan Finder, along with the specific medical conditions that they cover.

We made changes to our Drug List, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions.**

If you are affected by a change in drug coverage, you can:

- **Work with your doctor (or other prescriber) and ask the plan to make an exception** to cover the drug. **We encourage current members** to ask for an exception before next year.
    - To learn what you must do to ask for an exception, see Chapter 9 of your *Evidence of Coverage (What to do if you have a problem or complaint (coverage decisions, appeals, complaints))* or call Member Services.
- **Work with your doctor (or prescriber) to find a different drug** that we cover. You can call Member Services to ask for a list of covered drugs that treat the same medical condition.

In some situations, we are required to cover a temporary supply of a non-formulary drug in the first 90 days of the plan year or the first 90 days of membership to avoid a gap in therapy. (To learn more about when you can get a temporary supply and how to ask for one, see Chapter 5, Section 5.2 of the *Evidence of Coverage.*) During the time when you are getting a temporary supply of a drug, you should talk with your doctor to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug.

Most of the changes in the Drug List are new for the beginning of each year. However, during the year, we might make other changes that are allowed by Medicare rules.

Starting in 2022, we may immediately remove a brand name drug on our Drug List if, at the same time, we replace it with a new generic drug on the same or lower cost-sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the brand name drug on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions or both.

This means, for instance, if you are taking a brand name drug that is being replaced or moved to a higher cost-sharing tier, you will no longer always get notice of the change 30 days before we make it or get a month's supply of your brand name drug at a network pharmacy. If you are taking the brand name drug, you will still get information on the specific change we made, but it may arrive after the change is made.

When we make these changes to the Drug List during the year, you can still work with your doctor (or other prescriber) and ask us to make an exception to cover the drug. We will also continue to update our online Drug List as scheduled and provide other required information to reflect drug changes. (To learn more about changes we may make to the Drug List, see Chapter 5, Section 6 of the Evidence of Coverage.)

Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs may not apply to you.** We have included a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also called the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug costs. Because you receive "Extra Help" and didn't receive this insert with this packet please call Member Services and ask for the "LIS Rider."

There are four "drug payment stages." How much you pay for a Part D drug depends on which drug payment stage you are in. (You can look in Chapter 6, Section 2 of your Evidence of Coverage for more information about the stages.)

The information below shows the changes for next year to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage. To get information about your costs in these stages, look in your Summary of Benefits or at Chapter 6, Sections 6 and 7, in the Evidence of Coverage, which is located on our website at www.SuperiorSelectMedicare.com. You may also call Member Services to ask us to mail you an Evidence of Coverage.)

Changes to the Deductible Stage

Stage	2021 (this year)	2022 (next year)
Stage 1: Yearly Deductible Stage	Because we have no deductible, this payment stage does not apply to you.	Because we have no deductible, this payment stage does not apply to you.

Changes to Your Cost Sharing in the Initial Coverage Stage

To learn how copayments and coinsurance work, look at Chapter 6, Section 1.2, *Types of out-of-pocket costs you may pay for covered drugs* in your *Evidence of Coverage*.

Stage	2021 (this year)	2022 (next year)
Stage 2: Initial Coverage Stage During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost.**	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing: For members with "Extra Help": For generic drugs (including brand name drugs treated as generic), either: $0 copay; or $1.30 copay; or $3.70 copay. For all other drugs, either: $0 copay; or $4.00 copay; or $9.20 copay OR For member without "Extra Help": Drug Tier 1: You pay 25% Once your total drug costs have reached $4,130, you will move to the next stage (the Coverage Gap Stage).	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing: For members with "Extra Help": For generic drugs (including brand name drugs treated as generic), either: $0 copay; or $1.35 copay; or $3.95 copay. For all other drugs, either: $0 copay; or $4.00 copay; or $9.85 copay OR For member without "Extra Help": Drug Tier 1: You pay 25% Once your total drug costs have reached $4,430, you will move to the next stage (the Coverage Gap Stage).
Stage 2: Initial Coverage Stage (continued) The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy that provides standard cost sharing. For information about the costs look in Chapter 6, Section 5 of your *Evidence of Coverage*.	Once you have paid $6,550 out-of-pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage). If you have "Extra Help", the Coverage Gap Stage does not apply to you.	Once you have paid $7,050 out-of-pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage). If you have "Extra Help", the Coverage Gap Stage does not apply to you.

Changes to the Coverage Gap and Catastrophic Coverage Stages

The Coverage Gap Stage and the Catastrophic Coverage Stage are two other drug coverage stages for people with high drug costs. **Most members do not reach either stage**.

For information about your costs in these stages, look at your *Summary of Benefits* or at Chapter 6, Sections 6 and 7, in your *Evidence of Coverage*.

SECTION 2 Deciding Which Plan to Choose

Section 2.1 – If you want to stay in Tribute Advantage

To stay in our plan you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically be enrolled in our Tribute Advantage.

Section 2.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change for 2021 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- -- OR-- You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan.

To learn more about Original Medicare and the different types of Medicare plans, read Medicare & You 2021, call your State Health Insurance Assistance Program (see Section 4), or call Medicare (see Section 6.2).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to www.medicare.gov/plan-compare. **Here, you can find information about costs, coverage, and quality ratings for Medicare plans.**

As a reminder, Arkansas Superior Select, Inc. offers other Medicare health plans. These other plans may differ in coverage, monthly premiums, and cost-sharing amounts.

Step 2: Change your coverage

- To **change to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from Tribute Advantage.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Tribute Advantage.

- To **change to Original Medicare without a prescription drug plan**, you must either:
    - Send us a written request to disenroll. Contact Member Services if you need more information on how to do this (phone numbers are in Section 6.1 of this booklet).
    - – or – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

  If you switch to Original Medicare and do **not** enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan unless you have opted out of automatic enrollment.

SECTION 3 Changing Plans

If you want to change to a different plan or Original Medicare for next year, you can do it from October 15 to December 7. The change will take effect on January 1, 2022.

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

In certain situations, changes are also allowed at other times of the year. For example, people with Medicaid, those who get "Extra Help" paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area may be allowed to make a change at other times of the year.

If you enrolled in a Medicare Advantage plan for January 1, 2022, and don't like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2022. For more information, see Chapter 10, Section 2.3 of the *Evidence of Coverage*.

SECTION 4 Programs That Offer Free Counseling about Medicare and Medicaid

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

Senior Health Insurance Information (SHIIP) is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. Senior Health Insurance Information (SHIIP) counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call Senior Health Insurance Information (SHIIP) at 800-224-6330. You can learn more about Senior Health Insurance Information (SHIIP) by visiting their website (https://www.insurance.arkansas.gov/pages/consumer-services/senior-health/).

For questions about your Arkansas Medicaid benefits, contact Arkansas Medicaid, 1-800-482-8988, TTY users should call 1-800-285-1311, 8:00 a.m. to 4:30 p.m. -Monday through Friday. Ask how joining another plan or returning to Original Medicare affects how you get your Arkansas Medicaid coverage.

SECTION 5 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs.

- **"Extra Help" from Medicare.** Because you have Medicaid, you are already enrolled in 'Extra Help,' also called the Low Income Subsidy. Extra Help pays some of your prescription drug premiums, annual deductibles and coinsurance. Because you qualify, you do not have a coverage gap or late enrollment penalty. If you have questions about Extra Help, call:
    - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
    - The Social Security Office at 1-800-772-1213 between 7 am and 7 pm, Monday through Friday. TTY users should call, 1-800-325-0778 (applications); or
    - Your State Medicaid Office (applications).
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals 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 prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the Arkansas ADAP. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call 501-661-2408.

SECTION 6 Questions?

Section 6.1 – Getting Help from Tribute Advantage

Questions? We're here to help. Please call Member Services at 1-877-372-1033. (TTY only, call 711.) We are available for phone calls 8 a.m. -8 p.m. 7 days a week. Calls to these numbers are free.

Read your 2022 *Evidence of Coverage* (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2022. For details, look in the 2022 *Evidence of Coverage* for Tribute Advantage. The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the

rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is located on our website at www.SuperiorSelectMedicare.com. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

Visit our Website

You can also visit our website at www.SuperiorSelectMedicare.com. As a reminder, our website has the most up-to-date information about our provider network (*Provider Directory*) and our list of covered drugs (Formulary/Drug List).

Section 6.2 – Getting Help from Medicare

To get information directly 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 should call 1-877-486-2048.

Visit the Medicare Website

You can visit the Medicare website (www.medicare.gov). It has information about cost, coverage, and quality ratings to help you compare Medicare health plans. You can find information about plans available in your area by using the Medicare Plan Finder on the Medicare website. (To view the information about plans, go to www.medicare.gov/plan-compare).

Read *Medicare & You 2022*

You can read *Medicare & You 2022* 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. If you don't have a copy of this booklet, you can get it at the Medicare website (www.medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Section 6.3 – Getting Help from Medicaid

To get information from Medicaid you can call Arkansas Medicaid at 1-800-482-8988. TTY users should call 1-800-285-1131.