GlobalHealth

Texas LoneStar Gold (HMO)

ANNUAL NOTICE OF CHANGES

January 1–December 31, 2023

1-844-200-8167 (toll-free)
8 am to 8 pm, 7 days a week, (October 1 – March 31), and
8 am to 8 pm, Monday – Friday, (April 1 – September 30)
www.GlobalHealth.com

GlobalHealth is an HMO/SNP HMO plan with a Medicare contract and a state Medicaid contract for D-SNP. Enrollment in GlobalHealth depends on contract renewal.

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Texas LoneStar Gold (HMO) offered by GlobalHealth of Texas, Inc.

Annual Notice of Changes for 2023

You are currently enrolled as a member of Global Classic (HMO). Next year, there will be changes to the plan's costs and benefits. ***Please see page 4 for a Summary of Important Costs, including Premium.***

This document tells about the changes to your plan. To get more information about costs, benefits, or rules please review the *Evidence of Coverage*, which is located on our website at www.GlobalHealth.com. You may also call Customer Care to ask us to mail you an *Evidence of Coverage*.

- **You have from October 15 until December 7 to make changes to your Medicare coverage for next year.**

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.

- Review the changes to Medical care costs (doctor, hospital).
- Review the changes to our drug coverage, including authorization requirements and costs.
- Think about how much you will spend on premiums, deductibles, and cost-sharing.

☐ Check the changes in the 2023 Drug List to make sure the drugs you currently take are still covered.

☐ Check to see if your primary care doctors, specialists, hospitals and other providers, including pharmacies will be in our network next year.

☐ 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 the Medicare Plan Finder at www.medicare.gov/plan-compare website or review the list in the back of your *Medicare & You 2023* handbook.

☐ 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

OMB Approval 0938-1051 (Expires: February 29, 2024)

- If you don't join another plan by December 7, 2022, you will stay in Texas LoneStar Gold (HMO).
- To change to a **different plan,** you can switch plans between October 15 and December 7. Your new coverage will start on **January 1, 2023**. This will end your enrollment with Texas LoneStar Gold (HMO).
- If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can switch plans or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

Additional Resources

- This document is available for free in Spanish.
- Please contact our Customer Care number at 1-844-200-8167 (toll-free) for additional information. (TTY users should call 711.) Hours are 8 am to 8 pm, 7 days a week, (October 1 – March 31), and 8 am to 8 pm, Monday – Friday, (April 1 – September 30).
- This information is also available in large print.
- **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 Texas LoneStar Gold (HMO)

- GlobalHealth is an HMO/SNP HMO plan with a Medicare contract and a state Medicaid contract for D-SNP. Enrollment in GlobalHealth depends on contract renewal.
- When this document says "we," "us," or "our", it means GlobalHealth of Texas, Inc. When it says "plan" or "our plan," it means Texas LoneStar Gold (HMO).

Annual Notice of Changes for 2023
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Summary of Important Costs for 2023

The table below compares the 2022 costs and 2023 costs for Texas LoneStar Gold (HMO) in several important areas. **Please note this is only a summary of costs**.

Cost	2022 (this year)	2023 (next year)
Monthly plan premium* * Your premium may be higher than this amount. See Section 2.1 for details.	$0	$0
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 2.2 for details.)	$3,400	$3,900
Doctor office visits	Primary care visits: $0 per visit Specialist visits: $30 per visit	Primary care visits: $0 per visit Specialist visits: $30 per visit
Inpatient hospital stays	You pay a $250 copay per day for days 1 through 7. There is no coinsurance, copayment, or deductible for days 8 through 90. There is no coinsurance, copayment, or deductible for days 91 through 190.	You pay a $195 copay per day for days 1 through 7. There is no coinsurance, copayment, or deductible for days 8 through 90. There is no coinsurance, copayment, or deductible for days 91 through 190.
Part D prescription drug coverage (See Section 2.5 for details.)	Deductible: $0 Copayment/Coinsurance during the Initial Coverage Stage: Standard 30-day Retail Cost-Share: • Drug Tier 1: $10 • Drug Tier 2: $20 • Drug Tier 3: $47	Deductible: $0 Copayment/Coinsurance during the Initial Coverage Stage: Standard 30-day Retail Cost-Share: • Drug Tier 1: $5 • Drug Tier 2: $15 • Drug Tier 3: $47

Cost	2022 (this year)	2023 (next year)
	• Drug Tier 4: $100 • Drug Tier 5: 33% of the total cost. Preferred 30-day Retail Cost-Share: • Drug Tier 1: $5 • Drug Tier 2: $15 • Drug Tier 3: $42 • Drug Tier 4: $90 • Drug Tier 5: 33% of the total cost. Standard 30-day Mail-order Cost-Share: • Drug Tier 1: $10 • Drug Tier 2: $20 • Drug Tier 3: $47 • Drug Tier 4: $100 • Drug Tier 5: 33% of the total cost. Preferred 30-day Mail-order Cost-Share: • Drug Tier 1: $5 • Drug Tier 2: $15 • Drug Tier 3: $42 • Drug Tier 4: $90 • Drug Tier 5: 33% of the total cost Standard 100-day Retail Cost-Share: • Drug Tier 1: $30 • Drug Tier 2: $60 • Drug Tier 3: $141	• Drug Tier 3 Insulin: $35 • Drug Tier 4: $100 • Drug Tier 4 Insulin: $35 • Drug Tier 5: 33% of the total cost. • Drug Tier 5 Insulin: $35 Preferred 30-day Retail Cost-Share: • Drug Tier 1: $0 • Drug Tier 2: $10 • Drug Tier 3: $42 • Drug Tier 3 Insulin: $35 • Drug Tier 4: $90 • Drug Tier 4 Insulin: $35 • Drug Tier 5: 33% of the total cost. • Drug Tier 5 Insulin: $35 Standard 30-day Mail-order Cost-Share: • Drug Tier 1: $5 • Drug Tier 2: $15 • Drug Tier 3: $47 • Drug Tier 3 Insulin: $35 • Drug Tier 4: $100 • Drug Tier 4 Insulin: $35

Cost	2022 (this year)	2023 (next year)
	• Drug Tier 4: $300 Preferred 100-day Retail Cost-Share: • Drug Tier 1: $10 • Drug Tier 2: $30 • Drug Tier 3: $84 • Drug Tier 4: $270 Standard 100-day Mail-order Cost-Share: • Drug Tier 1: $30 • Drug Tier 2: $60 • Drug Tier 3: $141 • Drug Tier 4: $300 Preferred 100-day Mail-order Cost-Share: • Drug Tier 1: $10 • Drug Tier 2: $30 • Drug Tier 3: $84 • Drug Tier 4: $270	• Drug Tier 5: 33% of the total cost. • Drug Tier 5 Insulin: $35 Preferred 30-day Mail-order Cost-Share: • Drug Tier 1: $0 • Drug Tier 2: $10 • Drug Tier 3: $42 • Drug Tier 3 Insulin: $35 • Drug Tier 4: $90 • Drug Tier 4 Insulin: $35 • Drug Tier 5: 33% of the total cost • Drug Tier 5 Insulin: $35 Standard 100-day Retail Cost-Share: • Drug Tier 1: $15 • Drug Tier 2: $45 • Drug Tier 3: $141 • Drug Tier 3 Insulin: $105 • Drug Tier 4: $300 • Drug Tier 4 Insulin: $105 Preferred 100-day Retail Cost-Share: • Drug Tier 1: $0 • Drug Tier 2: $20 • Drug Tier 3: $84

Cost	2022 (this year)	2023 (next year)
		• Drug Tier 3 Insulin: $84 • Drug Tier 4: $270 • Drug Tier 4 Insulin: $105 Standard 100-day Mail-order Cost-Share: • Drug Tier 1: $15 • Drug Tier 2: $45 • Drug Tier 3: $141 • Drug Tier 3 Insulin: $105 • Drug Tier 4: $300 • Drug Tier 4 Insulin: $105 Preferred 100-day Mail-order Cost-Share: • Drug Tier 1: $0 • Drug Tier 2: $20 • Drug Tier 3: $84 • Drug Tier 3 Insulin: $84 • Drug Tier 4: $270

SECTION 1 We Are Changing the Plan's Name

On January 1, 2023, our plan name will change from Global Classic (HMO) to Texas LoneStar Gold (HMO).

You will receive a new member ID card in the mail. The new plan name will be reflected on member communications beginning January 1, 2023.

SECTION 2 Changes to Benefits and Costs for Next Year

Section 2.1 – Changes to the Monthly Premium

Cost	2022 (this year)	2023 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$0	$0

- Your monthly plan premium will be *more* if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as "creditable coverage") for 63 days or more.
- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.

Section 2.2 – 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 reach this amount, you generally pay nothing for covered Part A and Part B services for the rest of the year.

Cost	2022 (this year)	2023 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount. Your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$3,400	$3,900 Once you have paid $3,900 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 2.3 – Changes to the Provider and Pharmacy Networks

Updated directories are located on our website at www.GlobalHealth.com. You may also call Customer Care for updated provider and/or pharmacy information or to ask us to mail you a *directory*.

There are changes to our network of providers for next year. **Please review the *2023 Provider Directory* to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network**.

There are changes to our network of pharmacies for next year. **Please review the *2023 Pharmacy Directory* to see which pharmacies are in our network**.

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers), and pharmacies that are part of your plan during the year. If a mid-year change in our providers affects you, please contact Customer Care so we may assist.

Section 2.4 – Changes to Benefits and Costs for Medical Services

We are making changes to our costs and benefits for certain medical services next year. The information below describes these changes.

Cost	2022 (this year)	2023 (next year)
Advance care planning	Advance care planning automated services are not covered.	There is no coinsurance, copay, or deductible for advance care planning to create your living will and/or health care power of attorney documents through Vital Decisions.
Dental services - comprehensive	Restorative services: • You pay 30% of the total cost for fillings. Periodontics: • There is no coinsurance, copay, or deductible for periodontic cleanings. See Dental services - preventive. • You pay 30% of the total cost for periodontics. Extractions: • You pay 30% of the total cost for extraction services. We will only pay up to a total of $1,000 for comprehensive dental services per year.	Non-routine services: • There is no coinsurance, copay, or deductible for nitrous oxide and other sedation. • You pay 20% of the total cost for other non-routine services. Diagnostic services: • There is no coinsurance, copay, or deductible for diagnostic services. Restorative services: • There is no coinsurance, copay, or deductible for fillings. • You pay 20% of the total cost for other restorative services.

Cost	2022 (this year)	2023 (next year)
		Endodontics: • You pay 20% of the total cost for endodontics. Periodontics: • There is no coinsurance, copay, or deductible for periodontic cleanings. See Dental services - preventive. • You pay 20% of the total cost for periodontics. Extractions: • You pay 20% of the total cost for extraction services. Prosthodontics • You pay 20% of the total cost for prosthodontics. We will only pay up to a total of $1,500 for preventive and comprehensive dental services per year.
Dental services - preventive	There is no maximum benefit allowance for preventive dental services.	We will only pay up to a total of $1,500 for preventive and comprehensive dental services per year. You pay the amount that exceeds this allowance. Any amount you pay above the plan allowance does not count toward the maximum out-of-pocket amount.
Emergency care	You pay a $120 copay per visit for all Medicare-covered emergency care services received during the visit.	You pay a $90 copay per visit for all Medicare-covered emergency care services received during the visit.

Cost	2022 (this year)	2023 (next year)
Emergency care - worldwide coverage	You pay a $120 copay per visit for emergency services outside the United States and its territories.	You pay a $90 copay per visit for emergency services outside the United States and its territories.
Hearing services - hearing aids	We will only pay up to a total of $500 for hearing aid devices per year.	We will only pay up to a total of $750 for hearing aid devices per year.
Home health support services	Home health support services is not covered.	There is no coinsurance, copay, or deductible for home health support services. Limited to 60 hours per year for tasks such as light housekeeping and meal preparation.
Inpatient hospital care	For each Medicare-covered hospital stays at an in-network hospital: • You pay a $250 copay per day for days 1 through 7. • There is no coinsurance, copay, or deductible for days 8 through 90. • There is no coinsurance, copay, or deductible for days 91 through 190.	For each Medicare-covered hospital stay at an in-network hospital: • You pay a $195 copay per day for days 1 through 7. • There is no coinsurance, copay, or deductible for days 8 through 90. • There is no coinsurance, copay, or deductible for days 91 through 190.
Inpatient mental health care	For each Medicare-covered hospital stays at an in-network hospital: • You pay a $250 copay per day for days 1 through 7. • There is no coinsurance, copay, or deductible for days 8 through 90.	For each Medicare-covered hospital stay at an in-network hospital: • You pay a $195 copay per day for days 1 through 7. • There is no coinsurance, copay, or deductible for days 8 through 90.

Cost	2022 (this year)	2023 (next year)
Medicare Part B prescription drugs	You pay 20% of the total cost for Medicare Part B covered drugs. **Prior authorization may be required.** For chemotherapy: You pay 20% of the total cost for Medicare Part B covered drugs. **Prior authorization may be required.**.	You pay 20% of the total cost for Medicare Part B covered drugs. **Prior authorization may be required.** For chemotherapy: You pay 20% of the total cost for Medicare Part B covered drugs. **Prior authorization may be required.** You will pay no more than the dollar amount of the adjusted coinsurance percentage that applies to the specific Part B rebatable drug (typically a single source drug, e.g. brand drug) based on the date of service **beginning April 1, 2023.** This applies to specific Part B drugs and may include chemotherapy drugs. You will pay no more than $35 for a one-month's supply of Part B insulin **beginning July 1, 2023.** This applies to insulin used in an insulin pump. **Prior authorization may be required.**
Over-the-counter (OTC) drugs and supplies	You are eligible for a $50 quarterly benefit to be used toward the purchase of over-the-counter (OTC) health and wellness products available through our mail order services, including nicotine replacement therapy.	You are eligible for a $75 quarterly benefit to be used toward the purchase of over-the-counter (OTC) health and wellness products available through our mail order services, including nicotine replacement therapy, through the Smart Wallet.
Personal emergency response system	Personal emergency response system is <u>not</u> covered.	There is no coinsurance, copay, or deductible for personal

Cost	2022 (this year)	2023 (next year)
		emergency response system device and monitoring.
Pulmonary rehabilitation services	You pay a $30 copay per outpatient visit for Medicare-covered pulmonary rehabilitation services.	You pay a $20 copay per outpatient visit for Medicare-covered pulmonary rehabilitation services.
Smart Wallet	Smart Wallet is not covered.	The Smart Wallet is a prepaid debit card with a combined annual limit of $500 to reduce your out of pocket expenses for dental, vision, and hearing services.
Supervised exercise therapy	You pay a $30 copay per outpatient visit for Medicare-covered SET services.	You pay a $25 copay per outpatient visit for Medicare-covered SET services.
Urgently needed services	You pay a $65 copay per visit for Medicare-covered urgently needed services, except specialized diagnostic tests, during the visit.	You pay a $60 copay per visit for Medicare-covered urgently needed services, except specialized diagnostic tests, during the visit.
Urgently needed services - worldwide coverage	You pay a $120 copay per visit for urgently needed services outside the United States and its territories.	You pay a $90 copay per visit for urgently needed services outside the United States and its territories.

Section 2.5 – 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.

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.**

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. For instance, we can

immediately remove drugs considered unsafe by the FDA or withdrawn from the market by a product manufacturer. We update our online Drug List to provide the most up-to-date list of drugs.

If you are affected by a change in drug coverage at the beginning of the year or during the year, please review Chapter 9 of your *Evidence of Coverage* and talk to your doctor to find out your options, such as asking for a temporary supply, applying for an exception and/or working to find a new drug. You can also contact Customer Care for more information.

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 sent you 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. If you receive "Extra Help" and you haven't received this insert by September 30, 2023, please call Customer Care and ask for the "LIS Rider."

There are four "drug payment stages." The information below shows the changes 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.)

Important Message About What You Pay for Vaccines – Our plan covers most Part D vaccines at no cost to you. Call Customer Care for more information.

Important Message About What You Pay for Insulin – You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.

Changes to the Deductible Stage

Stage	2022 (this year)	2023 (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

Please see the following chart for the changes from 2022 to 2023.

Stage	2022 (this year)	2023 (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 at a network pharmacy: **Tier 1 - Preferred Generic:** *Standard cost-sharing:*	Your cost for a one-month supply at a network pharmacy: **Tier 1 - Preferred Generic:** *Standard cost-sharing:*

Stage	2022 (this year)	2023 (next year)
The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy. For information about the costs for a long-term supply or for mail-order prescriptions, look in Chapter 6, Section 5 of your *Evidence of Coverage*. We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.	You pay $10 per prescription. *Preferred cost-sharing:* You pay $5 per prescription. **Tier 2 - Generic:** *Standard cost-sharing:* You pay $20 per prescription. *Preferred cost-sharing:* You pay $15 per prescription. **Tier 3 - Preferred Brand:** *Standard cost-sharing:* You pay $47 per prescription. *Preferred cost-sharing:* You pay $42 per prescription. **Tier 4 - Non-Preferred Drug:** *Standard cost-sharing:* You pay $100 per prescription. *Preferred cost-sharing:* You pay $90 per prescription. **Tier 5 - Specialty:** *Standard cost-sharing:* You pay 33% of the total cost. *Preferred cost-sharing:* You pay 33% of the total cost. _____ Once your total drug costs have reached $4,430, you will	You pay $5 per prescription. *Preferred cost-sharing:* You pay $0 per prescription. **Tier 2 - Generic:** *Standard cost-sharing:* You pay $15 per prescription. *Preferred cost-sharing:* You pay $10 per prescription. **Tier 3 - Preferred Brand:** *Standard cost-sharing:* You pay $35 per insulin prescription. You pay $47 per prescription for all other drugs. *Preferred cost-sharing:* You pay $35 per insulin prescription. You pay $42 per prescription for all other drugs. **Tier 4 - Non-Preferred Drug:** *Standard cost-sharing:* You pay $35 per insulin prescription. You pay $100 per prescription for all other drugs. *Preferred cost-sharing:* You pay $35 per insulin prescription.

Stage	2022 (this year)	2023 (next year)
	move to the next stage (the Coverage Gap Stage).	You pay $90 per prescription for all other drugs. **Tier 5 - Specialty:** *Standard cost-sharing:* You pay $35 per insulin prescription. You pay 33% of the total cost for all other drugs. *Preferred cost-sharing:* You pay $35 per insulin prescription. You pay 33% of the total cost for all other drugs. _____ Once your total drug costs have reached $4,660, you will move to the next stage (the Coverage Gap Stage).

SECTION 3 Administrative Changes

Description	2022 (this year)	2023 (next year)
Excluded drugs	Excluded drugs are not covered.	Excluded drugs are included in Tier 1 and Tier 2.
Over-the-counter administration	Spend your allowance on over-the-counter items and products through a mail-order catalog. See your *Evidence of Coverage* or go to www.GlobalHealth.com for more information.	Spend your debit card allowance on over-the-counter items and products through a mail-order catalog or in many stores. You will receive a new debit card, called Smart Wallet. See your *Evidence of Coverage* or go to www.

Description	2022 (this year)	2023 (next year)
		GlobalHealth.com for more information.

SECTION 4 Deciding Which Plan to Choose

Section 4.1 – If you want to stay in Texas LoneStar Gold (HMO)

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 Texas LoneStar Gold (HMO).

Section 4.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change plans for 2023 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. If you do not enroll in a Medicare drug plan, please see Section 2.1 regarding a potential Part D late enrollment penalty.

To learn more about Original Medicare and the different types of Medicare plans, use the Medicare Plan Finder (www.medicare.gov/plan-compare), read the *Medicare & You 2023* handbook, call your State Health Insurance Assistance Program (see Section 6), or call Medicare (see Section 8.2). As a reminder, GlobalHealth of Texas, 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 Texas LoneStar Gold (HMO).
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Texas LoneStar Gold (HMO).
- To **change to Original Medicare without a prescription drug plan**, you must either:
  - Send us a written request to disenroll. Contact Customer Care if you need more information on how to do so.
  - – *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.

SECTION 5 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7.** The change will take effect on January 1, 2023.

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

In certain situations, changes are also allowed at other times of the year. Examples include 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.

If you enrolled in a Medicare Advantage plan for January 1, 2023, 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, 2023.

If you recently moved into, currently live in, or just moved out of 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 (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

SECTION 6 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is an independent government program with trained counselors in every state. In Texas, the SHIP is called Health Information, Counseling, and Advocacy Program (HICAP).

It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. Health Information, Counseling, and Advocacy Program (HICAP) 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 Health Information, Counseling, and Advocacy Program (HICAP) at 1-800-252-9240. You can learn more about Health Information, Counseling, and Advocacy Program (HICAP) by visiting their website (https://hhs.texas.gov/services/health/medicare).

SECTION 7 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs. Below we list different kinds of help:

- **"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 prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. To see if you qualify, 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 8 am and 7 pm, Monday through Friday for a representative. Automated messages are available 24 hours a day. TTY users should call, 1-800-325-0778; or
- Your State Medicaid Office (applications).

- **Help from your state's pharmaceutical assistance program.** Texas has a program called Texas THMP State Pharmacy Assistance Program (SPAP) that helps people pay for prescription drugs based on their financial need, age, or medical condition. To learn more about the program, check with your State Health Insurance Assistance Program.
- **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 Texas HIV Medication Program (THMP). For information on eligibility criteria, covered drugs, or how to enroll in the program, please call Texas HIV Medication Program (THMP) at 1-800-255-1090.

SECTION 8 Questions?

Section 8.1 – Getting Help from Texas LoneStar Gold (HMO)

Questions? We're here to help. Please call Customer Care at 1-844-200-8167 (toll-free). (TTY only, call 711). We are available for phone calls 8 am to 8 pm, 7 days a week, (October 1 – March 31), and 8 am to 8 pm, Monday – Friday, (April 1 – September 30). Calls to these numbers are free.

Read your *2023 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 2023. For details, look in the *2023 Evidence of Coverage* for Texas LoneStar Gold (HMO). 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.GlobalHealth.com. You may also call Customer Care to ask us to mail you an *Evidence of Coverage*.

Visit our Website

You can also visit our website at www.GlobalHealth.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 8.2 – 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

Visit the Medicare website (www.medicare.gov). It has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area. To view the information about plans, go to www.medicare.gov/plan-compare.

Read *Medicare & You 2023*

Read the *Medicare & You 2023* handbook. Every 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 document, you can get it at the Medicare website (https://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf) 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.

Customer Care: 1-844-200-8167 (toll-free)
TTY users call 711
8 am to 8 pm, 7 days a week, (October 1 – March 31), and 8 am to 8 pm, Monday – Friday, (April 1 – September 30)
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