Scott&White HEALTH PLAN
PART OF BAYLOR SCOTT & WHITE HEALTH

SeniorCare Advantage Select (HMO) offered by Scott and White Health Plan

2019 Benefit Notice

You are currently enrolled as a member of SeniorCare (Cost) Select. Because Scott and White Health Plan will no longer offer a Cost plan in 2019, you will be enrolled as a member of SeniorCare Advantage Select (HMO) in 2019. There will be some changes to the plan's costs and benefits. *This booklet tells about the changes.*

- **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.
- 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 3.1 and 3.5 for information about benefit and cost changes for our plan.

☐ Check to see if your doctors and other providers will be in our network next year.
- Are your doctors in our network?
- What about the hospitals or other providers you use?
- Look in Section 3.3 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

OMB Approval 0938-1051 (Pending OMB Approval)

☐ Check coverage and costs of plans in your area.

- Use the personalized search feature on the Medicare Plan Finder at https://www.medicare.gov website. Click "Find health & drug plans."
- Review the list in the back of your Medicare & You handbook.
- Look in Section 5.2 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 want to **keep** SeniorCare Advantage Select (HMO), you don't need to do anything. You will stay in SeniorCare Advantage Select (HMO).
   - To change to a **different plan** that may better meet your needs, you can switch plans between October 15 and December 7.

4. **ENROLL:** To change plans, join a plan between **October 15** and **December 7, 2018**

   - If you **don't join another plan by December 7, 2018**, you will be enrolled in SeniorCare Advantage Select (HMO).
   - If you **join another plan by December 7, 2018**, your new coverage will start on January 1, 2019.

Additional Resources

- This document is available for free in Spanish.
- Please contact our Customer Service number at 1-866-334-3141 for additional information. (TTY users should call 711). Hours are 7 a.m. – 8 p.m., seven days a week.
- This information is also available in alternate formats (e.g., 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 https://www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About SeniorCare Advantage Select (HMO)

- SeniorCare Advantage HMO is offered by Scott and White Health Plan, a Medicare Advantage organization with a Medicare contract. Enrollment in SeniorCare Advantage depends on contract renewal.
- When this booklet says "we," "us," or "our," it means Scott and White Health Plan. When it says "plan" or "our plan," it means SeniorCare Advantage Select (HMO).

Summary of Important Costs for 2019

The table below compares the 2018 costs and 2019 costs for SeniorCare Advantage Select (HMO) in several important areas. **Please note this is only a summary of changes. It is important to read the rest of this *2019 Benefit Notice*** and review the *Evidence of Coverage* to see if other benefit or cost changes affect you.

Cost	2018 (this year)	2019 (next year)
Monthly plan premium	$0	$0
Maximum out-of-pocket amounts This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 3.2 for details.)	$6,700	$5,300
Doctor office visits	Primary care visits: $20 copayment per visit Specialist visits: $50 copayment per visit	Primary care visits: $0 copayment per visit Specialist visits: $40 copayment 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.	$375 copayment each day for days 1 to 5 and $0 copayment each day for days 6 to 90 for Medicare-covered hospital care.	Inpatient Acute Maximum Out-of-Pocket $1,750 $350 copayment each day for days 1 to 5 and $0 copayment each day for days 6 to 90 for Medicare-covered hospital care.

2019 Benefit Notice
Table of Contents

SECTION 1 We Are Changing the Plan's Name

On January 1, 2019, our plan name will change from SeniorCare (Cost) Select to SeniorCare Advantage Select (HMO). You will receive a new ID card. Benefit changes are highlighted throughout this document.

SECTION 2 Unless You Choose Another Plan, You Will Be Automatically Enrolled in SeniorCare Advantage Select (HMO) in 2019

On January 1, 2019, Scott and White Health Plan will be combining SeniorCare (Cost) Select with one of our plans, SeniorCare Advantage Select (HMO).

If you do nothing to change your Medicare coverage by December 7, 2018, we will automatically enroll you in our SeniorCare Advantage Select (HMO). This means starting January 1, 2019, you will be getting your medical coverage through SeniorCare Advantage Select (HMO). If you want to, you can change to a different Medicare health plan. You can also switch to Original Medicare. If you want to change, you can do so between January 1 and March 31. You can also change plans between October 15 and December 7. If you are eligible for Extra Help, you may be able to change plans during other times.

The information in this document tells you about the differences between your current benefits in SeniorCare (Cost) Select and the benefits you will have on January 1, 2019 as a member of SeniorCare Advantage Select (HMO).

SECTION 3 Changes to Benefits and Costs for Next Year

Section 3.1 Changes to the Monthly Premium

Cost	2018 (this year)	2019 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$0	$0

Section 3.2 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	2018 (this year)	2019 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount.	$6,700	$5,300 Once you have paid $5,300 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 3.3 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 advantage.swhp.org. You may also call Customer Service for updated provider information or to ask us to mail you a Provider Directory. **Please review the 2019 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, Medicare requires that we 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 and managing your care.

Section 3.4 Changes to Benefits and Costs for Medical Services

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, *Medical Benefits Chart (what is covered and what you pay),* in your *2019 Evidence of Coverage*.

Cost	2018 (this year)	2019 (next year)
Additional outpatient blood services	You pay for the first three pints of blood, then 20% coinsurance of the Medicare-approved amount for additional pints of blood.	You pay 20% coinsurance starting with the first pint of blood you need.
Ambulance services - Air transportation - Cost Sharing	You pay a $100 copayment for each Medicare-covered service. Copayment is waived if you are admitted to a hospital.	You pay a $265 copayment for each Medicare-covered service. Copayment is not waived if you are admitted to a hospital.
Ambulance services - Ground transportation - Cost Sharing	You pay a $100 copayment for each Medicare-covered service. Copayment is waived if you are admitted to a hospital.	You pay a $265 copayment for each Medicare-covered service. Copayment is not waived if you are admitted to a hospital.
Annual routine physical exam - Cost Sharing	You pay a $20 copayment.	The medical benefit is not covered.
Chiropractic services - Cost Sharing	You pay a 20% coinsurance for each Medicare-covered service.	You pay a $20 copayment for each Medicare-covered service.
Dental services - Comprehensive dental services - Diagnostic Services - Cost Sharing	The medical benefit is not covered.	You pay a $0 copayment.
Dental services - Comprehensive dental services - Diagnostic Services - Periodicity	The medical benefit is not covered.	Limited to 1 diagnostic service every six months.

Cost	2018 (this year)	2019 (next year)
Dental services - Comprehensive dental services - Extractions - Cost Sharing	The medical benefit is not covered.	You pay 50% coinsurance.
Dental services - Comprehensive dental services - Extractions - Periodicity	The medical benefit is not covered.	Limited to 1 every five years.
Dental services - Comprehensive dental services - Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services - Cost Sharing	The medical benefit is not covered.	You pay 50% coinsurance.
Dental services - Comprehensive dental services - Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services - Periodicity	The medical benefit is not covered.	Limited to 1 every five years.
Dental services - Preventive and comprehensive dental services - Maximum Plan Amount	The medical benefit is not covered.	Up to a $1,500 combined credit every year for all additional preventive and comprehensive dental services.
Dental services - Preventive dental services - Dental X-Rays - Cost Sharing	The medical benefit is not covered.	You pay a $0 copayment.
Dental services - Preventive dental services - Dental X-Rays - Periodicity	The medical benefit is not covered.	Limited to 1 X-ray every three years.
Dental services - Preventive dental services - Oral Exams - Cost Sharing	The medical benefit is not covered.	You pay a $0 copayment.
Dental services - Preventive dental services - Oral Exams - Periodicity	The medical benefit is not covered.	Limited to 1 oral exam every six months.
Dental services - Preventive dental services - Prophylaxis (Cleaning) - Cost Sharing	The medical benefit is not covered.	You pay a $0 copayment.

Cost	2018 (this year)	2019 (next year)
Dental services - Preventive dental services - Prophylaxis (Cleaning) - Periodicity	The medical benefit is not covered.	Limited to 1 cleaning every six months.
Diabetes self-management training, diabetic services and supplies - Diabetes supplies - Cost Sharing	You pay a 20% coinsurance for each Medicare-covered service.	You pay a $0 copayment for each Medicare-covered service.
Diabetes self-management training, diabetic services and supplies - Diabetic therapeutic shoes or inserts - Cost Sharing	You pay a 20% coinsurance for each Medicare-covered service.	You pay a $0 copayment for each Medicare-covered service.
Emergency care - Cost Sharing	You pay a $200 copayment for each Medicare-covered service.	You pay a $80 copayment for each Medicare-covered service.
Hearing services - Routine hearing exams - Cost Sharing	The medical benefit is not covered.	You pay a $40 copayment.
Hearing services - Routine hearing exams - Periodicity	The medical benefit is not covered.	Limited to 1 visit every year.
Hearing services - Fitting-evaluation(s) for hearing aids - Periodicity	The medical benefit is not covered.	Limited to 1 visit every year.
Hearing services - Fitting-evaluation(s) for hearing aids - Cost Sharing	The medical benefit is not covered.	You pay a $0 copayment.
Hearing services - Hearing aids - Cost sharing	The medical benefit is not covered.	You pay a $0 copayment.
Hearing services - Hearing aids - Maximum plan amount	The medical benefit is not covered.	Up to a $1,000 credit for both ears combined every three years for hearing aids.
Hearing services - Hearing aids - Periodicity	The medical benefit is not covered.	Credit applies once every three years.

Cost	2018 (this year)	2019 (next year)
Hearing services - Medicare-covered hearing exam - Cost Sharing	You pay a $50 copayment for each Medicare-covered service.	You pay a $40 copayment for each Medicare-covered service.
Inpatient hospital care - Cost Sharing	$375 copayment each day for days 1 to 5 and $0 copayment each day for days 6 to 90 for Medicare-covered hospital care.	$350 copayment each day for days 1 to 5 and $0 copayment each day for days 6 to 90 for Medicare-covered hospital care.
Inpatient hospital care - Reserve lifetime days	There is no coinsurance, copayment, or deductible for a Medicare-covered reserve lifetime days.	$350 copayment each day for days 1 to 5 and $350 copayment each day for days 6 to 60 for Medicare-covered reserve lifetime days.
Inpatient hospital care - Service category maximum out-of-pocket	There is no out-of-pocket maximum.	Up to a $1,750 out-of-pocket maximum every stay.
Inpatient mental health care - Cost Sharing	You pay a $375 copayment each day for days 1 to 5 and $0 copayment each day for days 6 to 90 for Medicare-covered hospital care.	You pay a $318 copayment each day for days 1 to 5 and $0 copayment each day for days 6 to 90 for Medicare-covered hospital care.
Inpatient mental health care - Reserve lifetime days	There is no coinsurance, copayment, or deductible for a Medicare-covered reserve lifetime days.	$318 copayment each day for days 1 to 5 and $318 copayment each day for days 6 to 60 for Medicare-covered reserve lifetime days.
Outpatient diagnostic procedures, tests, and lab services – Medicare-covered diagnostic procedures/tests	You pay a 20% coinsurance for each Medicare-covered service.	You pay a $0 copayment for each Medicare-covered service.

Cost	2018 (this year)	2019 (next year)
Outpatient diagnostic tests and therapeutic services and supplies - Diagnostic radiological services - Cost Sharing	You pay a 20% coinsurance for each Medicare-covered service.	You pay a $75 - $300 copayment depending on the Medicare-covered service.
Outpatient diagnostic tests and therapeutic services and supplies - Lab services - Cost Sharing	You pay a 20% coinsurance for each Medicare-covered service.	You pay a $0 copayment for each Medicare-covered service.
Outpatient diagnostic tests and therapeutic services and supplies - Outpatient x-ray services - Cost Sharing	You pay a 20% coinsurance for each Medicare-covered service.	You pay a $0 copayment for each Medicare-covered service.
Outpatient mental health care - Non-psychiatric services - Group sessions - Cost Sharing	You pay a $15 copayment for each Medicare-covered service.	You pay a $40 copayment for each Medicare-covered service.
Outpatient mental health care - Non-psychiatric services - Individual sessions - Cost Sharing	You pay a $15 copayment for each Medicare-covered service.	You pay a $40 copayment for each Medicare-covered service.
Outpatient mental health care - Psychiatric services - Group Session - Cost Sharing	You pay a 20% coinsurance for each Medicare-covered service.	You pay a $40 copayment for each Medicare-covered service.
Outpatient mental health care - Psychiatric services - Individual sessions - Cost Sharing	You pay a 20% coinsurance for each Medicare-covered service.	You pay a $40 copayment for each Medicare-covered service.
Outpatient rehabilitation services - Occupational therapy - Cost Sharing	You pay a 20% coinsurance for each Medicare-covered service.	You pay a $25 copayment for each Medicare-covered service.
Outpatient rehabilitation services - Physical therapy and speech-language pathology - Cost Sharing	You pay a 20% coinsurance for each Medicare-covered service.	You pay a $25 copayment for each Medicare-covered service.

Cost	2018 (this year)	2019 (next year)
Outpatient substance abuse services - Group sessions - Cost Sharing	You pay a 20% coinsurance for each Medicare-covered service.	You pay a $45 copayment for each Medicare-covered service.
Outpatient substance abuse services - Individual sessions - Cost Sharing	You pay a 20% coinsurance for each Medicare-covered service.	You pay a $45 copayment for each Medicare-covered service.
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers - Ambulatory surgical center - Cost Sharing	You pay a 20% coinsurance for each Medicare-covered service.	You pay a $275 copayment for each Medicare-covered service.
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers - Outpatient hospital services - Cost Sharing	You pay a 20% coinsurance for each Medicare-covered service.	You pay a $350 copayment for each Medicare-covered outpatient hospital service. A 20% coinsurance will be applied to transfusion services.
Partial hospitalization services - Cost Sharing	You pay a 20% coinsurance for each Medicare-covered service.	You pay a $40 copayment for each Medicare-covered service.
Physician/Practitioner services, including doctor’s office visits - Other healthcare professionals - Cost Sharing	You pay a $50 copayment for each Medicare-covered service.	You pay a $45 copayment for each Medicare-covered service.
Physician/Practitioner services, including doctor’s office visits - Primary care - Cost Sharing	You pay a $20 copayment for each Medicare-covered service.	You pay a $0 copayment for each Medicare-covered service.
Physician/Practitioner services, including doctor’s office visits - Specialist - Cost Sharing	You pay a $50 copayment for each Medicare-covered service.	You pay a $40 copayment for each Medicare-covered service.
Podiatry services - Medicare-covered - Cost Sharing	You pay a 20% coinsurance for each Medicare-covered service.	You pay a $45 copayment for each Medicare-covered service.

Cost	2018 (this year)	2019 (next year)
Skilled nursing facility (SNF) care - Cost Sharing	You pay a $0 copayment each day for days 1 to 20 and $125 copayment each day for days 21 to 100 for Medicare-covered SNF care.	You pay a $0 copayment each day for days 1 to 20 and $167.50 copayment each day for days 21 to 100 for Medicare-covered SNF care.
Urgently needed services - Cost Sharing	You pay a $40 copayment for each Medicare-covered service.	You pay a $50 copayment for each Medicare-covered service.
Vision care - Routine eye wear - Contact lenses - Periodicity	The medical benefit is not covered.	Limited to 12 pairs of contact lenses each year.
Vision care - Routine eye wear - Eyeglass frames - Cost Sharing	The medical benefit is not covered.	You pay a $0 copayment.
Vision care - Routine eye wear - Eyeglass frames - Periodicity	The medical benefit is not covered.	Limited to 1 pair of eyeglass frames every year.
Vision care - Routine eye wear - Contact lenses - Cost Sharing	The medical benefit is not covered.	You pay a $0 copayment.
Vision care - Routine eye wear - Eyeglass lenses - Periodicity	The medical benefit is not covered.	Limited to 1 set of eyeglass lenses every year.
Vision care - Routine eye wear - Eyeglasses (lenses and frames) - Cost Sharing	The medical benefit is not covered.	You pay a $0 copayment.
Vision care - Routine eye wear - Eyeglasses (lenses and frames) - Periodicity	The medical benefit is not covered.	Limited to 1 pair of eyeglasses (lenses and frames) every year.
Vision care - Routine eye wear - Maximum plan amount	The medical benefit is not covered.	Up to a $125 combined credit every year for all additional eyewear.
Vision care - Medicare-covered eye exam - Cost Sharing	You pay a $50 copayment for each Medicare-covered service.	You pay a $40 copayment for each Medicare-covered service.

SECTION 4 Administrative Changes

Process	2018 (this year)	2019 (next year)
Prior authorization requirements have changed.	Prior authorization may not have been required for advanced imaging (PET/MRI/CT) and nuclear medicine; cardiology imaging and certain related procedures; and joint, spine, and pain management procedures.	Prior authorization is required for advanced imaging (PET/MRI/CT) and nuclear medicine; cardiology imaging and certain related procedures; and joint, spine, and pain management procedures — except in an emergency.
The Customer Service phone number changed. The prior year's Customer Service phone number will continue to route to our Service Center.	1-888-423-7633	1-866-334-3141
The phone number to pay your premium over the phone has changed.	1-877-255-1400	1-844-722-6251
The Customer Service TTY number changed. The prior year's Customer Service TTY number will continue to route to our Service Center.	1-800-735-2989	711
Requirements for Medicare Part B prescription drug step therapy have changed.	Step therapy was not required.	Step therapy may be required. Step therapy is a type of prior authorization. It requires you to first try a less expensive drug that has been proven effective for most people with your condition before you can move up a “step” to a more expensive drug.

SECTION 5 Deciding Which Plan to Choose

Section 5.1 If you want to stay in SeniorCare Advantage Select (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 stay enrolled as a member of our plan for 2019.

Section 5.2 If you want to change plans

We hope to keep you as a member next year but if you want to change for 2019 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 2019*, call your State Health Insurance Assistance Program (see Section 7), or call Medicare (see Section 9.2).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to https://www.medicare.gov and click "Find health & drug plans." **Here, you can find information about costs, coverage, and quality ratings for Medicare plans.**

As a reminder, Scott and White Health Plan offers other Medicare health plans and Medicare prescription drug 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 SeniorCare Advantage Select (HMO).
- To **change to Original Medicare with a prescription drug plan**, enroll in the new drug plan. You will automatically be disenrolled from SeniorCare Advantage Select (HMO).
- To **change to Original Medicare without a prescription drug plan**, you must either:
  - Send us a written request to disenroll. Contact Customer Service if you need more information on how to do this (phone numbers are in Section 9.1 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.

SECTION 6 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, 2019.

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. For more information, see Chapter 8, Section 2.3 of the *Evidence of Coverage*.

Note: If you're in a drug management program, you may not be able to change plans.

If you enrolled in a Medicare Advantage Plan for January 1, 2019, 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, 2019. For more information, see Chapter 8, Section 2.2 of the *Evidence of Coverage*.

SECTION 7 Programs That Offer Free Counseling about Medicare

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

Texas Health Information Counseling and Advocacy Program (HICAP) 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. Texas 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 Texas Health Information Counseling and Advocacy Program (HICAP) at 1-800-252-9240. You can learn more about Texas Health Information Counseling and Advocacy Program (HICAP) by visiting their website (http://www.tdi.texas.gov/consumer/hicap).

SECTION 8 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. Many people are eligible and don't even know it. 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 7 a.m. and 7 p.m., Monday through Friday. TTY users should call 1-800-325-0778 (applications); or
- Your State Medicaid Office (applications).

- **Help from your state's pharmaceutical assistance program.** Texas has a program called Texas HIV 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 (the name and phone numbers for this organization are in Section 7 of this booklet).
- **What if you have coverage from an AIDS Drug Assistance Program (ADAP)?** The AIDS Drug Assistance Program (ADAP) helps ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance. In Texas assistance is provided through the Texas HIV Medication Program (THMP). For information on eligibility criteria, covered drugs, or how to enroll in the program, please call 1-800-255-1090. Note: To be eligible for the ADAP operating in your State, 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.

If you are currently enrolled in an ADAP, it can continue to provide you with Medicare Part D prescription cost-sharing assistance for drugs on the ADAP formulary. In order to be sure you continue receiving this assistance, please notify your local ADAP enrollment worker of any changes in your Medicare Part D plan name or policy number. Call 1-800-255-1090.

For information on eligibility criteria, covered drugs, or how to enroll in the program, please call 1-800-255-1090.

SECTION 9 Questions?

Section 9.1 Getting Help from SeniorCare Advantage Select (HMO)

Questions? We're here to help. Please call Customer Service at 1-866-334-3141. (TTY only, call 711.) We are available for phone calls 7 a.m. – 8 p.m., seven days a week. Calls to these numbers are free.

Read your 2019 *Evidence of Coverage* (it has details about next year's benefits and costs)

This *2019 Benefit Notice* gives you a summary of changes in your benefits and costs for 2019. For details, look in the 2019 *Evidence of Coverage* for SeniorCare Advantage Select (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 available electronically.

Visit our Website

You can also visit our website at advantage.swhp.org. As a reminder our website has the most up-to-date information about our provider network (Provider Directory).

Section 9.2 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 (https://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 https://www.medicare.gov and click on "Find health & drug plans.")

Read *Medicare & You 2019*

You can read the *Medicare & You* 2019 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 (https://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.

Language Assistance/ Asistencia de idiomas

Scott&White HEALTH PLAN
PART OF BAYLOR SCOTT & WHITE HEALTH

English:
ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-866-334-3141 (TTY: 711).

Spanish:
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-334-3141 (TTY: 711).

Vietnamese:
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-866-334-3141 (TTY: 711).

Chinese:
注意：如果 使用繁體中文, 可以免費獲得語言援助服務。請致電 1-866-334-3141 (TTY：711)。

Korean:
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-334-3141 (TTY: 711) 번으로 전화해 주십시오.

Arabic:
هاتف الصم والبكم: 711 .ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-866-334-3141 (رقم

Urdu:
خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال 1-866-334-3141 (TTY: 711). کریں

Tagalog:
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-866-334-3141 (TTY: 711).

French:
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-334-3141 (ATS : 711).

Hindi:
ध्यान दें: यदिआप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध है। 1-866-334-3141 (TTY: 711) पर कॉल करें।

Persian:
فراهم می باشد. با 1-866-334-3141 (TTY: 711) تماس بگیرید. توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما

German:
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-866-334-3141 (TTY: 711).

Gujarati:
સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-866-334-3141 (TTY: 711).

Russian:
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-334-3141 (телетайп: 711).

Japanese:
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-866-334-3141 (TTY:711) まで、お電話にてご連絡ください。

Laotian:
ໂປດຊາບ: ຖ້າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-866-334-3141 (TTY: 711).

Scott&White
HEALTH PLAN
PART OF BAYLOR SCOTT & WHITE HEALTH

Nondiscrimination Notice

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-866-334-3141 (TTY: 711).

Scott and White Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Scott and White Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Scott and White Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print and accessible electronic formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Scott and White Health Plan (SWHP) Compliance Officer at 1-214-820-8888 or send an email to SWHPComplianceDepartment@BSWHealth.org.

If you believe that Scott and White Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

SWHP Compliance Officer
1206 West Campus Drive, Suite 151
Temple, Texas 76502

Compliance HelpLine; 1-888-484-6977 or https://app.mycompliancereport.com/report.aspx?cid=swhp

You can file a grievance in person or by mail, online, or email. If you need help filing a grievance, the SWHP Compliance Officer is available to help you.

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

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at https://www.hhs.gov/civil-rights/filing-a-complaint/index.html.