



## PLAN SELECTION FORM

Dear Scott and White Health Plan Member:

We know you have a choice in health plans, and we are glad you have chosen us—SeniorCare (Cost), a Medicare HMO plan. With affordable copays, no referrals required to see a specialist, and access to top-ranked Baylor Scott & White Health providers and hospitals, SeniorCare is the right choice for your health care needs.

To make a change in the Medicare Cost plan you have with Scott and White Health Plan, fill out the enclosed plan selection form to make your choice. Check off the plan you want, and sign the form. Then mail the completed form back to us in the postage-paid envelope.

Please be aware that you can change health plans only at certain times during the year. Between October 15<sup>th</sup> and December 7<sup>th</sup> each year, anyone can join our plan. In addition, from January 1 through February 14, anyone enrolled in a Medicare Advantage Plan (except an MSA plan) has an opportunity to disenroll from that plan and return to Original Medicare. Anyone who disenrolls from a Medicare Advantage plan during this time can join a stand-alone Medicare Prescription Drug Plan during the same period. Generally, you may not make changes at other times unless you meet certain special exceptions, such as if you move out of the plan's service area, want to join a plan in your area with a 5-star rating, or qualify for extra help paying for prescription drug coverage.

If you qualify for extra help with your prescription drug costs, you may enroll in, or disenroll from, a plan at any time. If you lose this extra help during the year, your opportunity to make a change continues for two months after you are notified that you no longer qualify for extra help.

If you select another plan and we receive your completed selection form by date, your new benefit plan will begin in month/year. Your monthly plan premium will be premium amount and you may continue to see any Scott and White Health Plan primary care doctors and specialists.

Complete the attached form only if you wish to change plans.

To help you with your decision, we have also included 2018 benefits overview for the available options.

If you have any questions, please call Scott and White Health Plan at 1-866-334-3141. TTY users should call 1-800-735-2989. We are open 7 a.m. to 8 p.m., seven days a week.

Thank you.





## PLAN SELECTION FORM

Date: \_\_\_\_\_

Member Name: \_\_\_\_\_

Member Number: \_\_\_\_\_

I want to transfer from my current plan to the plan I have selected below. I understand that if this form is received by the end of any month, my new plan will generally be effective the 1st of the following month.

Please check only the box(es) of the plan(s) you want to change.

	Monthly Premium	PCP/Specialist Office Visit	Maximum Out-of-Pocket
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### Medical Plan Options

I want to change my SeniorCare medical plan to:

<input type="checkbox"/> SeniorCare Select	\$0	\$20 / \$50	\$6,700
<input type="checkbox"/> SeniorCare Preferred	\$90	\$15 / \$15	\$3,400
<input type="checkbox"/> SeniorCare VIP	\$130	\$10 / \$10	\$3,400
<input type="checkbox"/> SeniorCare Premium	\$183	\$0 / \$0	\$3,400

### Prescription Drug Options

I want to add or change my prescription drug plan to:

<input type="checkbox"/> Value Rx (available with Select Only)	\$57.60	\$285 deductible; applies to all tiers
<input type="checkbox"/> Basic Rx (available with Preferred, VIP, or Premium)	\$76.50	\$100 deductible; applies to tiers 3-5
<input type="checkbox"/> Enhanced Rx (available with Preferred, VIP, or Premium)	\$123.20	\$50 deductible; applies to tiers 3-5
<input type="checkbox"/> Cancel my SeniorCare Rx plan		

### Dental:

- I want to add dental insurance coverage for an additional monthly premium \$13
- I want to cancel my dental insurance coverage

### Your Plan Premium

**You can pay your monthly plan premium, including any late enrollment penalty that you currently have or may owe, by mail, Electronic Funds Transfer (EFT), or credit card each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board check each month.**

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this extra help, contact your local Social Security office or call 1-800-MEDICARE (1-800-633-4227), 24 hours per day, 7 days per week. TTY/TDD users should call 1-877-486-2048.

If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium for this benefit. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare does not cover.



## PLAN SELECTION FORM

If you don't select a payment option, you will receive a bill each month.

Please select a premium payment option:

- Receive a monthly bill
- Electronic Funds Transfer (EFT) from your bank account each month. Please enclose a VOIDED check or provide the following:

Account Holder Name: \_\_\_\_\_

Bank Routing Number: \_\_\_\_\_

Bank Account Number: \_\_\_\_\_

Account Type:     Checking     Savings

- Automatic deduction from your monthly Social Security or RRB benefit check.  
*I get monthly benefits from*     Social Security     RRB

(The Social Security or RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

**Please check one of the boxes below if you would prefer us to send you information in a language other than English or in another format:**

- Spanish

Please contact Scott and White Health Plan at 1-866-334-3141 (TTY users should call 1-800-735-2989) if you need information in another format or language than what is listed above. Our office hours are 7 a.m. to 8 p.m., seven days a week.

### Please Read and Sign Below

**By completing this enrollment application, I agree to the following:**

Scott and White Health Plan is a Medicare health plan and I will need to keep my Medicare Part B. I can be in only one Medicare health plan at a time. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. I know I may disenroll from this plan at any time by sending a written request to Scott and White Health Plan or by calling 1-800-MEDICARE (1-800-633-4227) anytime, 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Scott and White Health Plan serves a specific service area. If I move out of the area that Scott and White Health Plan serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of Scott and White Health Plan, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Scott and White Health Plan when I receive it to know which rules I must follow to receive coverage with this Medicare health plan.



## PLAN SELECTION FORM

I understand that beginning on the date Scott and White Health Plan coverage starts, in order for Scott and White Health Plan to fully cover my medical services (except for emergency or urgently needed services), all of my health care must be provided by or arranged by Scott and White Health Plan. If I obtain services not provided or arranged by the plan, I will be responsible for all Medicare deductibles and coinsurance, as well as any additional charges as prescribed by the Medicare program. I may also be liable for charges not covered by Medicare.

Medicare beneficiaries are generally not covered under Medicare while out of the country except for limited coverage in Canada and Mexico. Services authorized by Scott and White Health Plan and other services contained in my Scott and White Health Plan Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered.

**Release of Information:** By joining this Medicare health plan, I acknowledge that Scott and White Health Plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Scott and White Health Plan will release my information, including my prescription drug event data to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the state where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request by Scott and White Health Plan or by Medicare.

<b>Signature:</b>	<b>Today's Date:</b>
If you are the authorized representative, you must sign above and provide the following information:	
Name: _____	
Address: _____	
Phone Number: (      ) _____	
Relationship to Enrollee: _____	

**Please mail this form to:**

Scott and White Health Plan  
 ATTN: Customer Engagement Dept.  
 MS-A4-126  
 1206 West Campus Drive  
 Temple, TX 76502

**Fax:** (254) 298-3567  
**Email:** [swhpretention@bswhealth.org](mailto:swhpretention@bswhealth.org)



## PLAN SELECTION FORM

SeniorCare (Cost) HMO is offered by Scott and White Health Plan, a Medicare Advantage organization with a Medicare contract. Enrollment in SeniorCare depends on contract renewal. The SeniorCare contract ends December 31, 2018.

Dental insurance is provided by Metropolitan Life Insurance Company (MetLife). Each insurer has sole financial responsibility for its own products.

You must continue to pay your Medicare Part B premium.

Premiums are not based on age, gender, or geographic region. Rates are illustrative only. A person should not send money to the issuer of the health benefit plan until the person completes an application for coverage.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums and/or copayments/coinsurance may change on January 1 of each year.

**ATTENTION:** If you speak English, language assistance services, free of charge, are available to you. Call 1-866-334-3141 (TTY: 1-800-735-2989). **ATENCIÓN:** Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-334-3141 (TTY: 1-800-735-2989). **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:1-800-735-2989).

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 cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. Scott and White Health Plan tuân thủ luật dân quyền hiện hành của Liên bang và không phân biệt đối xử dựa trên chủng tộc, màu da, nguồn gốc quốc gia, độ tuổi, khuyết tật, hoặc giới tính.