Scott&White HEALTH PLAN

SENIORCARE (COST)

Please contact Scott and White Health Plan if you need information in another language or format.

1 To Enroll in SeniorCare (Cost), Please Provide the Following Information:

Please check which plan you want to enroll in:

- ☐ SeniorCare Select $0
- ☐ SeniorCare Select & Dental $13
- ☐ SeniorCare Select w/ Value Rx $57.60
- ☐ SeniorCare Select w/ Value Rx & Dental $70.60
- ☐ SeniorCare Preferred $90
- ☐ SeniorCare Preferred & Dental $103
- ☐ SeniorCare Preferred w/Basic Rx $166.50
- ☐ SeniorCare Preferred w/ Basic Rx & Dental $179.50
- ☐ SeniorCare Preferred w/Enhanced Rx $213.20
- ☐ SeniorCare Preferred w/ Enhanced Rx & Dental $226.20
- ☐ SeniorCare VIP $130
- ☐ SeniorCare VIP & Dental $143
- ☐ SeniorCare VIP w/ Basic Rx $206.50
- ☐ SeniorCare VIP w/ Basic Rx & Dental $219.50
- ☐ SeniorCare VIP w/Enhanced Rx $253.20
- ☐ SeniorCare VIP w/ Enhanced Rx & Dental $266.20
- ☐ SeniorCare Premium $183
- ☐ SeniorCare Premium & Dental $196
- ☐ SeniorCare Premium w/ Basic Rx $259.50
- ☐ SeniorCare Premium w/ Basic Rx & Dental $272.50
- ☐ SeniorCare Premium w/ Enhanced Rx $306.20
- ☐ SeniorCare Premium w/Enhanced Rx & Dental $319.20

You must continue to pay your Part B premium.
Please indicate your requested enrollment effective date: 10/13/2017

LAST Name: FIRST Name: Middle Initial: ☐ Mr. ☐ Mrs. ☐ Ms.

Birth Date: (_ _ / _ _ / _ _ _ _) (M M / D D / Y Y Y Y)	Sex: ☐ M ☐ F	Home Phone Number: ( )	Alternate Phone Number: ( )

Permanent Residence Street Address: (P.O. Box is not allowed)

City:	State:	County:	ZIP Code:

Mailing Address (only if different from your Permanent Residence Address:)

Street Address: City: State: ZIP Code:

Emergency contact: _____
Phone Number: (_____ **Relationship to You:** _____

E-mail Address: _____

2 Please Provide Your Medicare Insurance Information:

Please take out your red, white and blue Medicare card to complete this section.

- Fill out this information as it appears on your Medicare card.

  - OR -

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Name (as it appears on your Medicare card):
_____
Medicare Number_____
Is Entitled To: Effective Date:
HOSPITAL (Part A) _____
MEDICAL (Part B) _____
You must have Medicare Part B to join a Medicare cost plan.

3 Your Plan Premium Payment Options:

You can pay your monthly plan premium (if applicable) 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 check each month.

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at **www.socialsecurity.gov/prescriptionhelp**.

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.

If you don't select a payment option, you will get 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 Railroad Retirement Board (RRB) benefit check.

I get monthly benefits from: ☐ Social Security ☐ RRB

(The Social Security/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 not include all premiums due from your enrollment effective date up to the point withholding begins. We will send you a paper bill for those months before deduction from your Social Security/RRB check starts. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

4 Please read and answer these important questions:

1. Do you have End-Stage Renal Disease (ESRD) ? ☐ Yes ☐ No
   If you answered "yes" to this question and you do not need regular dialysis anymore, or have had a successful kidney transplant, **please attach a note or records** from your doctor showing you do not need dialysis or have had a successful kidney transplant.

2. Do you or your spouse work? ☐ Yes ☐ No
   Do you have health coverage through you or your spouse's current or former employer? ☐ Yes ☐ No
   If "yes," please provide the following information:
   Employer Name:_____ Employer Address:_____
   Policy Holder Name: _____ Policy Number:_____

3. Are you enrolled in your State Medicaid program? ☐ Yes ☐ No
   If "yes," please provide your Medicaid number: _____

Answer #4 *only* if selecting SeniorCare with Rx:

4. Some individuals may have other drug coverage, including other private insurance, such as through an employer or spouse's employer, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.

Do you or will you have other prescription drug coverage in addition to SeniorCare? Yes ☐ No ☐
If "yes," please list your other coverage and your identification (ID) number(s) for this coverage:

Name of other coverage:	ID # for this coverage:	Group # for this coverage:
_____	_____	_____

Please check the box below if you would prefer us to send you information in a language other than English: ☐ Spanish

Please Read This Important Information

If you currently have health coverage from an employer or union, joining SeniorCare could affect your employer or union health benefits. If you have health coverage from an employer or union, joining SeniorCare and selecting the Medicare prescription drug benefit may change how your current coverage works. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there isn't any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

5 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.

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 the Medicare 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 State law 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.

Your Signature:	**Today's Date:**

If you are the authorized representative, you must provide the following information:

Name: _____

Address: _____

Phone Number: (_____) _____ - _____

Relationship to Enrollee: _____

Office Use Only:

Agent Name:_____ NPN: _____

Agent Signature: _____ Date:_____

Enrollment Period: ☐ **IEP** ☐ **AEP** ☐ **SEP (type):**_____

Effective Date of Coverage: _____

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.

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 bi ệt đối xử dựa trên chủng tộc, màu da, nguồn gốc quốc gia, độ tuổi, khuyết tật, hoặc giới tính.

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

Language Assistance

English:
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Spanish:
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-334-3141 (TTY: 1-800-735-2989).

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: 1-800-735-2989).

Chinese:
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-866-334-3141（TTY：1-800-735-2989）。

Korean:
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.
1-866-334-3141 (TTY: 1-800-735-2989) 번으로 전화해 주십시오.

Arabic:
ملحوظة: اذإ كنت تتحدذا ثكر اللغة، فإن خدماا تلمساعدا ةللغوية تتوافر لك بالمجاا .نتصل برقم 1-866-334-3141 (رقم هاتف الصم اولبكم: 1-800-735-2989).

Urdu:
خبرا :رادگر ودرا پــآ بولتے ہیں، تو پــآ کو زبان کی مدد کی خدمات مفت میں دستیاب ہا ۔ ہیں
کریں .1-866-334-3141 (TTY: 1-800-735-2989)

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: 1-800-735-2989).

French:
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-334-3141 (ATS : 1-800-735-2989).

Hindi:
धय न द: यद आप ह द ब लत ह त आपक ल ए मफत म भ ष सह यत सव ए उपलबध ह। 1-866-334-3141 (TTY: 1-800-735-2989) पर क ल कर।

Persian:
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلاز تـبانی بصار تـرویگان بارامشد ی فمهار می باشد. با 1-866-334-3141 (TTY: 1-800-735-2989) تماس بگیرید.

German:
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-866-334-3141 (TTY: 1-800-735-2989).

Gujarati:
સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-866-334-3141 (TTY: 1-800-735-2989).

Russian:
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-334-3141 (телетайп: 1-800-735-2989).

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:1-800-735-2989）まで、お電話にてご連絡ください。

Laotian:
ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍ ລິການຊ່ວຍເຫ ຼືອດ້ານພາສາ, ໂດຍບໍ ່ເສັ ຽຄ່າ, ແມ່ນມ ີພ້ ອມໃຫ້ ທ່ານ. ໂທຣ 1-866-334-3141 (TTY: 1-800-735-2989).

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Nondiscrimination Notice

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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, audio, accessible electronic formats, other 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 Patricia Balz.

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:

Patricia Balz, Vice President of Human Resources
2401 South 31st Street, MS-17-212, Temple, Texas 76508
254-724-8650, 254-724-1631
patricia.balz@bswhealth.org

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Patricia Balz, Vice President of Human Resources, 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, 800-537-7697 (TTY)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.