Scott&White HEALTH PLAN

VITAL*TRADITIONS*

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

1 To Enroll in Vital Traditions, Please Provide the Following Information:

Please check which medical plan you want to enroll in:

☐ **Vital Traditions HMO $0** ☐ **Vital Traditions HMO w/Dental $17**

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:	County:	State:	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 A and Part B to join a Medicare Advantage plan.

3 Paying Your Plan Premium

If we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we need to know how you would prefer to pay it. You can pay 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 (RRB) benefit check each month. If you are assessed a Part D-Income related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or the RRB. DO NOT pay Scott and White Health Plan the Part D-IRMAA.

3 Paying Your Plan Premium - continued

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 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. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

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

Please select a premium payment option:

☐ Get 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 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.)

4 Please read and answer these important questions:

1. Do you have End-Stage Renal Disease (ESRD) ? ☐ Yes ☐ No

If you have had a successful kidney transplant and/or you don't need regular dialysis anymore, **please attach a note or records** from your doctor showing you have had a successful kidney transplant or you don't need dialysis, otherwise we may need to contact you to obtain additional information.

2. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.

Will you have other prescription drug coverage in addition to Vital Traditions? 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: _____

3. Are you a resident in a long-term care facility, such as a nursing home? ☐ Yes ☐ No
If "yes," please provide the following information:
Name of Institution: _____
Address & Phone Number of Institution (number and street): _____

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

5. Do you or your spouse work? ☐ Yes ☐ No

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

☐ Spanish

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

Please Read This Important Information

If you currently have health coverage from an employer or union, joining Vital Traditions could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Vital Traditions. 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 Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. I can be in only one Medicare Advantage plan at a time, and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (Example: October 15 - December 7 of every year), or under certain special circumstances.

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 get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date Scott and White Health Plan coverage begins, I must get all of my health care from Scott and White Health Plan, except for emergency or urgently needed services or out-of-area dialysis services. 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. Without authorization, **NEITHER MEDICARE NOR SCOTT AND WHITE HEALTH PLAN WILL PAY FOR THE SERVICES.**

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Scott and White Health Plan, he/she may be paid based on my enrollment in Scott and White Health Plan.

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 from Medicare.

Signature:	**Today's Date:**

If you are the authorized representative, you must sign above and 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: _____

Vital Traditions HMO is offered by Scott and White Health Plan through its subsidiary Insurance Company of Scott and White, a Medicare Advantage organization with a Medicare contract. Enrollment in Vital Traditions depends on contract renewal.

You must continue to pay your Part B premium.

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.

Name: _____ **Date:** _____

Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

☐ I am new to Medicare.

☐ I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on (insert date)_____.

☐ I recently was released from incarceration. I was released on (insert date) _____.

☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date)_____.

☐ I recently obtained lawful presence status in the United States. I got this status on (insert date)_____.

☐ I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.

☐ I get extra help paying for Medicare prescription drug coverage.

☐ I no longer qualify for extra help paying for my Medicare prescription drugs. I stopped receiving extra help on (insert date) _____.

☐ I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long term care facility). I moved/will move into/out of the facility on (insert date) _____.

☐ I recently left a PACE program on (insert date) _____.

☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date)_____.

☐ I am leaving employer or union coverage on (insert date)_____.

☐ I belong to a pharmacy assistance program provided by my state.

☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.

☐ I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date)_____.

If none of these statements applies to you or you're not sure, please contact Scott and White Health Plan at 1-800-782-5068 (TTY users should call 1-800-735-2989) to see if you are eligible to enroll. We are open Monday through Friday, 8 a.m. - 5 p.m.

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

Language Assistance

English:
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).

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

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).

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, 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.