



2020 Enrollment Guide

INDIVIDUAL AND FAMILY



Scott & White
HEALTH PLAN



Part of
Baylor Scott & White
HEALTH

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Introduction/Enrollment Guide

HMO Enrollment Application

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Contact Information at a Glance

Sales/To Speak to a Licensed Insurance Agent

1-866-522-2515 (TTY: 711)

8 a.m. – 5 p.m. • Monday – Friday

Fax for Enrollment Applications

(254) 298-3199

Customer Service

1-800-321-7947 (TTY: 711)

7 a.m. – 7 p.m. • Monday – Friday

swhp.org

HMO products are offered through Scott and White Health Plan and Scott & White Care Plans. Insured PPO and EPO products are offered through Insurance Company of Scott and White. All are Texas registered insurance companies. Scott & White Care Plans and Insurance Company of Scott and White are wholly owned subsidiaries of Scott and White Health Plan. These companies will be referred to collectively in this document as Scott and White Health Plan.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-321-7947 (TTY: 711). **ATENCIÓN:** Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (TTY: 711). **CHÚ Ý:** Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-321-7947 (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 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.

You're closer than ever to healthcare coverage savings.

For affordable healthcare coverage, turn to Scott and White Health Plan, the local experts almost 200,000 Texans trust.

We understand how challenging it can be to choose the right plan for your specific needs. That's why we offer a team of experienced agents who can help you evaluate your options. Call one of our agents today at 1-866-522-2515 or contact your independent agent if you would like assistance.

About Baylor Scott & White Health

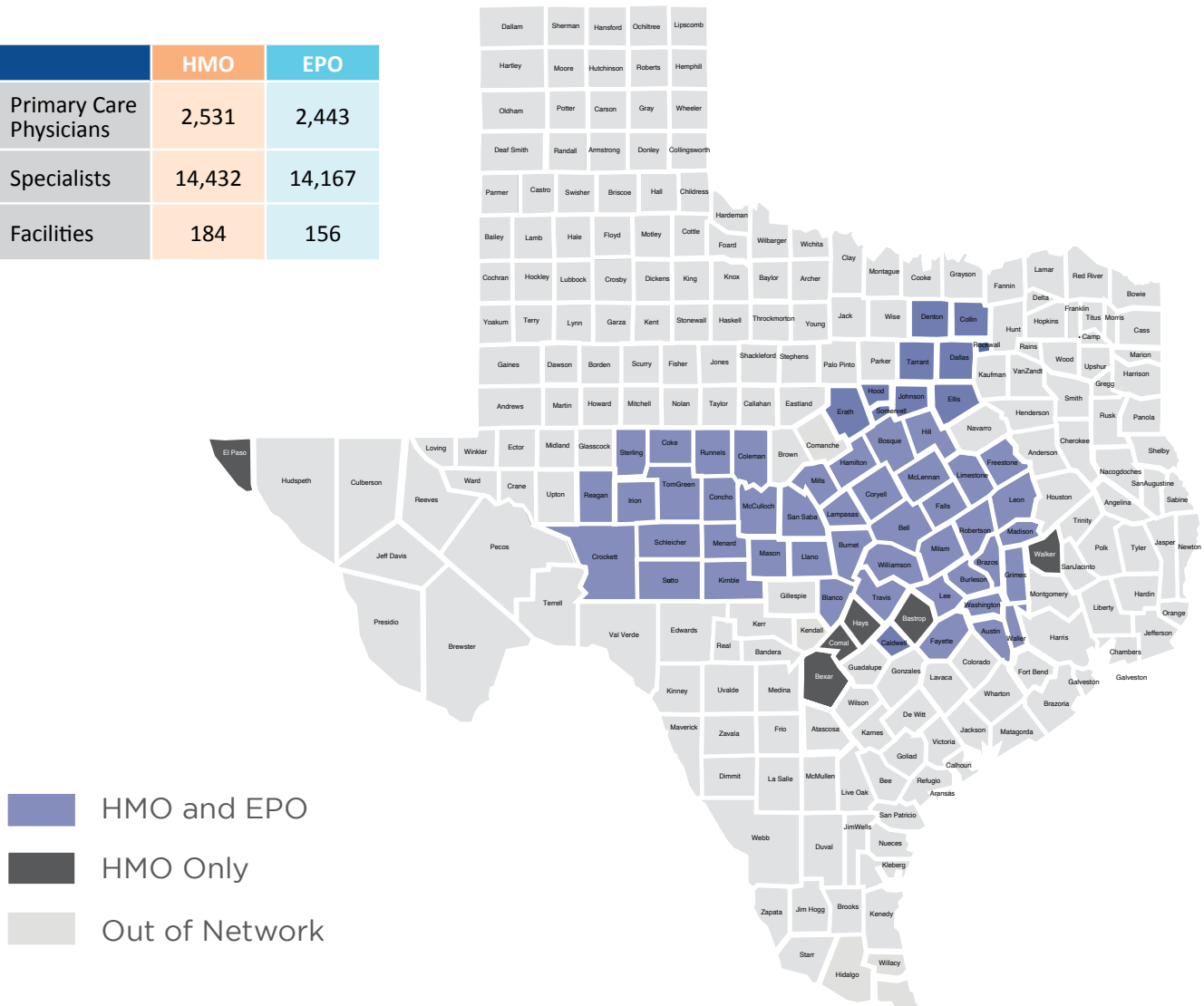
As the largest not-for-profit healthcare system in Texas and one of the largest in the United States, Baylor Scott & White Health was born from the 2013 combination of Baylor Healthcare System and Scott & White Healthcare. Today, Baylor Scott & White Health includes 50 hospitals, more than 900 patient care sites, more than 7,800 physicians, over 46,000 employees and Scott and White Health Plan. With a commitment to and a track record of innovation, collaboration, integrity and compassion for the patient, Baylor Scott & White Health strives to be one of the nation's exemplary healthcare organizations.

With access to the Baylor Scott & White Health system in Central and North Texas, you can expect better health, better care, and better value with our Individual and Family Plans.

Health plans trusted by almost 200,000 Texans.

The HMO and EPO offer access to more than 14,000 in-network doctors and the renowned Baylor Scott & White Health system. Other physicians and providers are available in our networks. The HMO and EPO offer coverage within the network only, except in the case of an emergency. If you choose to get non-emergency services out-of-network, you will be personally responsible for payment of all charges.

	HMO	EPO
Primary Care Physicians	2,531	2,443
Specialists	14,432	14,167
Facilities	184	156



HMO and EPO available in 55 counties: Austin, Bell, Blanco, Bosque, Brazos, Burleson, Burnet, Caldwell, Coke, Coleman, Collin, Concho, Coryell, Crockett, Dallas, Denton, Ellis, Erath, Falls, Fayette, Freestone, Grimes, Hamilton, Hill, Hood, Irion, Johnson, Kimble, Lampasas, Lee, Leon, Limestone, Llano, Mason, McCulloch, McLennan, Madison, Menard, Milam, Mills, Reagan, Robertson, Rockwall, Runnels, San Saba, Schleicher, Somervell, Sterling, Sutton, Tarrant, Tom Green, Travis, Waller, Washington, and Williamson

HMO coverage is available in 6 additional counties: Bastrop, Bexar, Comal, El Paso, Hays, and Walker

Benefits Overview

Effective January 1, 2020	IND Bronze HMO 7500	IND Bronze EPO 7500
Benefit	HMO In-Network (No Out-of-Network)	EPO In-Network (No Out-of-Network)
Plan Coinsurance	80%	80%
Member Coinsurance	20%	20%
Individual Deductible ¹ Family Deductible	\$7,500 \$15,000	\$7,500 \$15,000
Individual Max Out Of Pocket ² Family Max Out Of Pocket	\$8,150 \$16,300	\$8,150 \$16,300
Primary Care Office Visit (adult)	\$30 copay/visit	\$30 copay/visit
Primary Care Office Visit (pediatric) ³	\$0 copay/visit	\$0 copay/visit
Specialist Office Visit	\$75 copay/visit	\$75 copay/visit
Urgent Care	\$75 copay/visit	\$75 copay/visit
Emergency Room	Deductible then 20%	Deductible then 20%
Imaging (PET, CT, MRI)	Deductible then 20%	Deductible then 20%
Outpatient Lab and X-Ray	Deductible then 20%	Deductible then 20%
Inpatient Hospitalization	Deductible then 20%	Deductible then 20%
ACA Preventive Drugs ⁴	\$0	\$0
Preferred Generic Drugs ⁴	\$25	\$25
Preferred Brand Drugs ⁴	\$55 after deductible	\$55 after deductible
Non-Preferred Brand ⁴	\$150 after deductible	\$150 after deductible
Specialty Drugs	\$500 after deductible	\$500 after deductible

How do the plans work?

To maximize your HMO or EPO benefits, all care (except for emergencies) must be provided by network providers. If you get non-emergency services out-of-network, you will be personally responsible for payment of all charges.

Is a primary care physician (PCP) required to direct care?

No. You do not have to select a PCP to direct your care. You can see a specialist without a referral.

(1) Deductibles and out-of-pocket responsibility apply per calendar year.

(2) All copays, deductibles, and coinsurance apply to the out-of-pocket maximum.

(3) The pediatric copay applies to all PCP office visits for a covered dependent through the age of 18.



(4) 3x copay for 90-day maintenance-eligible drugs

Preventive medications are covered in full – deductible and coinsurance do not apply.

SCOTT AND WHITE HEALTH PLAN and the INSURANCE COMPANY OF SCOTT AND WHITE ARE QUALIFIED HEALTH PLAN ISSUERS.



Central Texas — Monthly Premiums

Applies to the following counties: Austin, Bastrop, Bell, Bexar, Blanco, Bosque, Brazos, Burleson, Burnet, Caldwell, Coke, Coleman, Comal, Concho, Coryell, Crockett, El Paso, Erath, Falls, Fayette, Freestone, Grimes, Hamilton, Hays, Hill, Hood, Irion, Kimble, Lampasas, Lee, Leon, Limestone, Llano, Mason, McCulloch, McLennan, Madison, Menard, Milam, Mills, Reagan, Robertson, Runnels, San Saba, Schleicher, Somervell, Sterling, Sutton, Tom Green, Travis, Walker, Waller, Washington, and Williamson

	IND Bronze HMO 7500 		IND Bronze EPO 7500 	
Age	Non-Tobacco User	Tobacco User	Non-Tobacco User	Tobacco User
0-14	\$385.08	\$577.23	\$434.34	\$651.07
15	\$419.31	\$628.54	\$472.95	\$708.94
16	\$432.40	\$648.16	\$487.71	\$731.07
17	\$445.48	\$667.78	\$502.47	\$753.20
18	\$459.58	\$688.91	\$518.37	\$777.03
19	\$473.67	\$710.03	\$534.26	\$800.86
20	\$488.27	\$731.92	\$550.73	\$825.54
21-24	\$503.37	\$754.55	\$567.76	\$851.07
25	\$505.38	\$757.57	\$570.03	\$854.48
26	\$515.45	\$772.66	\$581.39	\$871.50
27	\$527.53	\$790.77	\$595.01	\$891.93
28	\$547.16	\$820.20	\$617.16	\$925.12
29	\$563.27	\$844.34	\$635.32	\$952.35
30	\$571.33	\$856.42	\$644.41	\$965.97
31	\$583.41	\$874.53	\$658.04	\$986.40
32	\$595.49	\$892.64	\$671.66	\$1,006.82
33	\$603.04	\$903.95	\$680.18	\$1,019.59
34	\$611.09	\$916.03	\$689.26	\$1,033.20
35	\$615.12	\$922.06	\$693.80	\$1,040.01
36	\$619.15	\$928.10	\$698.35	\$1,046.82
37	\$623.17	\$934.14	\$702.89	\$1,053.63
38	\$627.20	\$940.17	\$707.43	\$1,060.44
39	\$635.25	\$952.24	\$716.51	\$1,074.06
40	\$643.31	\$964.32	\$725.60	\$1,087.67
41	\$655.39	\$982.43	\$739.23	\$1,108.10
42	\$666.97	\$999.78	\$752.28	\$1,127.67
43	\$683.07	\$1,023.93	\$770.45	\$1,154.91
44	\$703.21	\$1,054.11	\$793.16	\$1,188.95
45	\$726.87	\$1,089.57	\$819.85	\$1,228.95
46	\$755.06	\$1,131.83	\$851.64	\$1,276.61
47	\$786.77	\$1,179.37	\$887.41	\$1,330.23
48	\$823.01	\$1,233.69	\$928.29	\$1,391.51
49	\$858.75	\$1,287.27	\$968.60	\$1,451.93
50	\$899.02	\$1,347.63	\$1,014.02	\$1,520.02
51	\$938.79	\$1,407.24	\$1,058.87	\$1,587.25
52	\$982.58	\$1,472.89	\$1,108.27	\$1,661.30
53	\$1,026.88	\$1,539.29	\$1,158.23	\$1,736.19
54	\$1,074.70	\$1,610.97	\$1,212.17	\$1,817.04
55	\$1,122.52	\$1,682.65	\$1,266.11	\$1,897.90
56	\$1,174.36	\$1,760.37	\$1,324.59	\$1,985.56
57	\$1,226.71	\$1,838.84	\$1,383.63	\$2,074.07
58	\$1,282.59	\$1,922.60	\$1,446.66	\$2,168.54
59	\$1,310.27	\$1,964.10	\$1,477.88	\$2,215.35
60	\$1,366.15	\$2,047.85	\$1,540.90	\$2,309.82
61	\$1,414.47	\$2,120.29	\$1,595.41	\$2,391.52
62	\$1,446.18	\$2,167.83	\$1,631.18	\$2,445.14
63	\$1,485.95	\$2,227.44	\$1,676.03	\$2,512.37
64+	\$1,510.09	\$2,263.64	\$1,703.26	\$2,553.20

North Texas — Monthly Premiums

Applies to the following counties: Collin, Dallas, Denton, Ellis, Johnson, Rockwall and Tarrant

	IND Bronze HMO 7500 		IND Bronze EPO 7500 	
Age	Non-Tobacco User	Tobacco User	Non-Tobacco User	Tobacco User
0-14	\$430.50	\$645.32	\$485.57	\$727.86
15	\$468.76	\$702.68	\$528.73	\$792.56
16	\$483.40	\$724.61	\$545.23	\$817.30
17	\$498.03	\$746.54	\$561.73	\$842.04
18	\$513.78	\$770.16	\$579.51	\$868.68
19	\$529.54	\$793.78	\$597.28	\$895.32
20	\$545.86	\$818.24	\$615.69	\$922.91
21-24	\$562.74	\$843.55	\$634.73	\$951.46
25	\$564.99	\$846.92	\$637.27	\$955.26
26	\$576.25	\$863.80	\$649.96	\$974.29
27	\$589.75	\$884.04	\$665.20	\$997.13
28	\$611.70	\$916.94	\$689.95	\$1,034.23
29	\$629.71	\$943.93	\$710.26	\$1,064.68
30	\$638.71	\$957.43	\$720.42	\$1,079.90
31	\$652.22	\$977.68	\$735.65	\$1,102.74
32	\$665.72	\$997.92	\$750.88	\$1,125.57
33	\$674.17	\$1,010.57	\$760.40	\$1,139.85
34	\$683.17	\$1,024.07	\$770.56	\$1,155.07
35	\$687.67	\$1,030.82	\$775.64	\$1,162.68
36	\$692.17	\$1,037.57	\$780.72	\$1,170.29
37	\$696.67	\$1,044.32	\$785.79	\$1,177.90
38	\$701.18	\$1,051.06	\$790.87	\$1,185.52
39	\$710.18	\$1,064.56	\$801.03	\$1,200.74
40	\$719.18	\$1,078.06	\$811.18	\$1,215.96
41	\$732.69	\$1,098.30	\$826.42	\$1,238.80
42	\$745.63	\$1,117.70	\$841.01	\$1,260.68
43	\$763.64	\$1,144.70	\$861.33	\$1,291.13
44	\$786.15	\$1,178.44	\$886.72	\$1,329.19
45	\$812.60	\$1,218.09	\$916.55	\$1,373.90
46	\$844.11	\$1,265.33	\$952.09	\$1,427.19
47	\$879.57	\$1,318.47	\$992.08	\$1,487.13
48	\$920.08	\$1,379.21	\$1,037.78	\$1,555.63
49	\$960.04	\$1,439.10	\$1,082.85	\$1,623.19
50	\$1,005.06	\$1,506.58	\$1,133.62	\$1,699.30
51	\$1,049.51	\$1,573.22	\$1,183.77	\$1,774.47
52	\$1,098.47	\$1,646.61	\$1,238.99	\$1,857.24
53	\$1,147.99	\$1,720.84	\$1,294.85	\$1,940.97
54	\$1,201.45	\$1,800.98	\$1,355.14	\$2,031.36
55	\$1,254.92	\$1,881.12	\$1,415.44	\$2,121.75
56	\$1,312.88	\$1,968.00	\$1,480.82	\$2,219.75
57	\$1,371.40	\$2,055.73	\$1,546.83	\$2,318.70
58	\$1,433.87	\$2,149.37	\$1,617.29	\$2,424.31
59	\$1,464.82	\$2,195.76	\$1,652.20	\$2,476.64
60	\$1,527.28	\$2,289.40	\$1,722.65	\$2,582.26
61	\$1,581.31	\$2,370.38	\$1,783.59	\$2,673.60
62	\$1,616.76	\$2,423.52	\$1,823.57	\$2,733.54
63	\$1,661.22	\$2,490.16	\$1,873.72	\$2,808.70
64+	\$1,688.21	\$2,530.63	\$1,904.18	\$2,854.37

Bonus Benefits



Affordable Prescriptions

We believe the high cost of prescriptions should never stand in the way of your healthcare. So, our plans offer members affordable prescription coverage and an option to take advantage of our mail-order service for extra convenience and even more savings. 90-day supplies of maintenance-eligible prescriptions are available through Baylor Scott & White Pharmacies, participating 90-day retail pharmacies or mail order.

Other in-network pharmacies include CVS, Walgreens, Wal-Mart, HEB, Kroger, Tom Thumb, Albertsons, Sam's Club, Market Street, Costco and many more.

To see participating pharmacies, go to portal.swhp.org/search. Select a Member Type (commercial) then Select a Plan:

HMO Network - Individual/Family
or EPO Network - Individual/Family
from the drop-down list to find a pharmacy. To see our prescription drug list, visit us at swhp.org/en-us/members/manage-your-plan/pharmacy-information.



Vision Care

Pediatric Vision Services

If you have dependents that are 18 and under, they are covered for eye exams and prescription eyewear when that eyewear is prescribed by a provider and is obtained at a network optical dispensary.

They're covered for one pair of contact lenses or prescription glasses per year (up to \$300 allowance on frames).

Your Evidence of Coverage or Policy will have full details.

Optional Dental Insurance Benefits

Optional pediatric dental insurance coverage through Metropolitan Life Insurance Company (MetLife)

Ages 0-18

- Monthly premium \$36.28 per person
- Essential Health Benefit
- \$100 deductible
- \$350 maximum out-of-pocket limit in network
- Unlimited annual maximum in network
- Includes orthodontia
(Must be medically necessary)

Optional adult dental insurance coverage through MetLife

- Monthly premium \$31.88 per person
- \$0 deductible
- \$1,000 annual maximum benefit limit
- No waiting periods



Dental insurance benefits are available for an additional cost.

Group dental insurance policies featuring the MetLife Preferred Dentist Program are underwritten by Metropolitan Life Insurance Company, 200 Park Avenue, New York, NY 10166.

How to enroll.

We're glad you've chosen us for your healthcare coverage. We'll be with you every step of the way to answer any questions you may have. To join, you must submit an application in one of the following ways:

Mail, Email or Fax

Fill out the appropriate application (HMO or EPO) beginning on the following pages. Then:

- **Mail** it to the address found on the application's front page.
Scott and White Health Plan
Attention: Enrollment
1206 West Campus Drive, MS-A4-126
Temple, Texas 76502
- **Email** it to **SWHPElectronicEnrollment@bswhealth.org**.
- **OR fax** it to **1-254-298-3199**.

Questions? Call us at **1-866-522-2515**



Primary Applicant's Last Name	Applicant's Social Security Number
Agent Name	Agent NPN
Home Office Use ONLY	Eff Date:

HMO Application Instructions *(Health Maintenance Organization)*

TEXAS DEPARTMENT OF INSURANCE REQUIRED DISCLOSURE NOTICE FOR ALL INDIVIDUAL HMO CONSUMER CHOICE BENEFIT PLANS ISSUED IN TEXAS

Applicable if selecting a Consumer Choice Health Benefit Plan

You have the option to choose this Consumer Choice of Benefits Health Maintenance Organization health care plan that, either in whole or in part, does not provide state-mandated health benefits normally required in evidences of coverage in Texas. This standard health benefit plan may provide a more affordable health plan for you although, at the same time, it may provide you with fewer health plan benefits than those normally included as state-mandated health benefits in Texas. If you choose this standard health benefit plan, please consult with your insurance agent to discover which state-mandated health benefits are excluded in this evidence of coverage.

To help us process your application promptly, please remember to:

- Print all answers in **black ink** legibly. Pencil will not be accepted.
- Make sure to personally sign the application as the Primary Applicant. Anyone over the age of 18 applying for coverage must sign the appropriate signature line (unless parent has Power of Attorney).
- If it is necessary to correct any errors, simply cross off what is incorrect and write initials next to the correct information.
- Please do not use correction fluid or tape.
- If more space is needed, attach separate page(s) and list section(s) and question number(s), then sign and date each page.
- If you have been covered by SWHP, or an affiliated company, within the past 12 months and the evidence of coverage was terminated for nonpayment of premium, you will be required to pay the past due amount and the initial premium for the new coverage before your evidence of coverage will be effective

Please submit an application via one of the following methods:

- Mail: Scott and White Health Plan, Attention: Enrollment, 1206 West Campus Dr., MS-A4-126, Temple, TX 76502
- Fax: (254) 298-3199
- Email: swhpElectronicEnrollment@bswhealth.org

If you have any questions, please call your agent or an Internal Sales Specialist at (866) 522-2515.

OPEN ENROLLMENT (OE): November 1 – December 15 Submission Dates

Application received prior to the end of Open Enrollment	Effective date will be January 1
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SEP ENROLLMENT (SEP): Year Round Submission Dates

If applying outside of Open Enrollment, you must have experienced one of the events below (during the last 60 days) in order to apply. Please answer the following questions only if applying for a Special Enrollment Period.

Requested Effective Date

☐ I and/or my dependent(s) lost Minimum Essential Coverage: (Choose one of the two options)

☐ Involuntary loss of Minimum Essential Coverage (example: losing group coverage, divorce & aging off parents plan at age 26)

☐ Losing or replacing current Scott and White Health Plan or Insurance Company of Scott and White? **If yes, please provide the plan identification number(s):**

Date of Event

Date Coverage Ends

☐ Birth, Adoption, placement for adoption or foster care or become a party to a suit to adopt
(Effective date will be date of birth or date of adoption/placement)

Date of Event

☐ Relocation to a new service area

Date of Event

☐ Marriage or gaining dependent due to marriage

Date of Event

☐ Gaining Citizenship

Date of Event

☐ Release from incarceration

Date of Event

Send all SEP supporting documents to: swhpElectronicEnrollment@bswhealth.org or fax to 254-298-3199. Applications submitted for a Special Enrollment Period will not be processed without supporting documentation.



Primary Applicant's Last Name	Applicant's Social Security Number
Agent Name	Agent NPN
Home Office Use ONLY	Eff Date:

HMO Enrollment Application

(Health Maintenance Organization)

SECTION 1: PRIMARY APPLICANT (If Purchaser is different than Primary Applicant, include Purchaser's information in Section 8)						
First Name	MI	Last Name			Suffix	
**** Social Security Number	Date of Birth (MM/DD/YYYY)	Age *	<input type="checkbox"/> Male <input type="checkbox"/> Female	Within the past 6 months, have you used tobacco 4 or more times per week on average? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Marital Status <input type="checkbox"/> Single/Divorced/Widow <input type="checkbox"/> Married <input type="checkbox"/> Other _____				Are you a US citizen or US national? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Race (optional- check only one) <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> American Indian/Alaska American <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian/Chamorro <input type="checkbox"/> Samoan <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Other						
Residential Address	Apt	City	State	Zip	County	
Mailing Address (If different than above)	Apt	City	State	Zip	County	
Primary Phone		Cell <input type="checkbox"/> Landline <input type="checkbox"/>	Secondary Phone		Cell <input type="checkbox"/> Landline <input type="checkbox"/>	
Email Address			Preferred Contact Method <input type="checkbox"/> Email <input type="checkbox"/> Mail			
Primary Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other (Please Specify): _____			Do you have a disability affecting your ability to communicate or read? <input type="checkbox"/> Yes <input type="checkbox"/> No			
*** Apply for Dental Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No			If yes, please explain _____			

SECTION 2: DEPENDENT INFORMATION						
DEPENDENT	First Name	MI	Last Name			Suffix
	**** Social Security Number	Date of Birth (MM/DD/YYYY)	Age *	Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Child	<input type="checkbox"/> Male <input type="checkbox"/> Female	Tobacco Use** <input type="checkbox"/> Yes <input type="checkbox"/> No
	Are you a US citizen or US national? <input type="checkbox"/> Yes <input type="checkbox"/> No			*** Apply for Dental Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No		
DEPENDENT	First Name	MI	Last Name			Suffix
	**** Social Security Number	Date of Birth (MM/DD/YYYY)	Age *	Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Child	<input type="checkbox"/> Male <input type="checkbox"/> Female	Tobacco Use** <input type="checkbox"/> Yes <input type="checkbox"/> No
	Are you a US citizen or US national? <input type="checkbox"/> Yes <input type="checkbox"/> No			*** Apply for Dental Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No		
DEPENDENT	First Name	MI	Last Name			Suffix
	**** Social Security Number	Date of Birth (MM/DD/YYYY)	Age *	Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Child	<input type="checkbox"/> Male <input type="checkbox"/> Female	Tobacco Use** <input type="checkbox"/> Yes <input type="checkbox"/> No
	Are you a US citizen or US national? <input type="checkbox"/> Yes <input type="checkbox"/> No			*** Apply for Dental Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No		
DEPENDENT	First Name	MI	Last Name			Suffix
	**** Social Security Number	Date of Birth (MM/DD/YYYY)	Age *	Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Child	<input type="checkbox"/> Male <input type="checkbox"/> Female	Tobacco Use** <input type="checkbox"/> Yes <input type="checkbox"/> No
	Are you a US citizen or US national? <input type="checkbox"/> Yes <input type="checkbox"/> No			*** Apply for Dental Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No		

*Age as of Effective date

**Within the past 6 months, have you used tobacco 4 or more times per week on average?

***The Affordable Care Act (ACA) requires us to be reasonably assured that you and each member on this evidence of coverage have or are seeking coverage for pediatric dental services that are Essential Health Benefits.

****If someone needs help getting a SSN, call (800)772-1213 or visit socialsecurity.gov. TTY users should call (800)325-0778



Primary Applicant's Last Name	Applicant's Social Security Number										
	<table border="1"> <tr> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table>										
Agent Name	Agent NPN										

SECTION 3: CHOOSE YOUR COVERAGE

☐ Select ACA Ind HMO Bronze 7500

SECTION 4: DENTAL ACKNOWLEDGEMENT

The Affordable Care Act ("ACA") requires us to be reasonably assured that you and each member on this evidence of coverage have or are seeking coverage for Pediatric Dental Services that are Essential Health Benefits.

To choose Dental coverage for one or all members on plan, choose appropriate boxes on page 2 of application, sections 1 and/or 2.

If **declining** Dental coverage, your signature in section 7 will verify you have obtained coverage for Pediatric Dental Essential Health Benefits (dependents 0-18 years old) through another policy.

Prices for Dental Coverage for each member of evidence of coverage are:

Ages 0-18 years	\$36.28/month per member
Ages 19 years and over	\$31.88/month per member

NOTE: You will receive a separate ID number for Dental Policies. Premium for Dental must be paid separately from Medical.

DEDUCTIBLES Section 11.506(2)(B), Subchapter F, Title 28 Texas Insurance Code Applicable to Consumer Choice Health Benefit Plans

A deductible shall be for specific dollar amount of the cost of the basic, limited or single health care service. An HMO shall charge a deductible only for services performed out of the HMO's service area or for services performed by a physician or provider who is not in the HMO's delivery network.

Deductibles may apply to some services provided by HMO Participating Providers in the HMO service area. Deductibles may apply to Professional Services, Inpatient Hospital Services, Outpatient Facility Services, Outpatient Lab and X-Ray Services, Rehabilitation Services, Maternity Care and Family Planning, Behavioral Health Services, Emergency and Ambulance Services, Extended Care Services, some Preventive Care Services, Dental Surgical Procedures, Cosmetic, Reconstructive or Plastic Surgery, Allergy Care, Diabetes Care, Prosthetic Appliances, Orthotic Devices, Durable Medical Equipment, Hearing Aids and Prescription Drugs.

ATTENTION FEMALE MEMBERS: In selecting your PCP, remember that your PCP's network may affect your choice of OB/GYN. You have the right to receive services from an OB/GYN without first obtaining a referral from your PCP. You are not required to designate an OB/GYN. You may elect to receive OB/GYN services from your PCP.

Name of preferred OB/GYN : (Please note that you may change your selection at any time)

SECTION 5: REPLACEMENT COVERAGE INFORMATION

Will this insurance replace any current health insurance plan or evidence of coverage with Scott and White Health Plan or Insurance Company of Scott and White?

☐ Yes ☐ No

If you have been covered by SWHP, or an affiliated company, within the past 12 months and the evidence of coverage was terminated for nonpayment of premium, you will be required to pay the past due amount and the initial premium for the new coverage before your evidence of coverage will be effective.

If yes, please provide the plan or evidence of coverage number(s):

Date Coverage Ends:



Primary Applicant's Last Name	Applicant's Social Security Number
	<input type="text"/>
Agent Name	Agent NPN

SECTION 6: Agent Information (If applicable)

Agent's Certification: I certify that I sent the application to the Applicant(s) for completion, or I personally asked the questions and recorded the answers as given. I further certify that I have no knowledge of any other medical information about the Applicant(s) not contained in this application and that written material explaining the benefits, exclusions and provisions of the Contract was sent to the Applicant(s). I certify that I have delivered the required Outline of Coverage, and if requested, the Disclosure Statement.

Third-Party payments will not be accepted for ACA plans, except those required by Federal guidance. (This would include Employer payments for Employee coverage, Company checks unless Sole Proprietorship, Provider payments and Foundation payments. Payments for family members or Family Trusts are not considered a Third-Party payment.)

Agent's Signature	Date (MM/DD/YYYY)	Agent's NPN
Print Agent's Name	Agent's Phone	

SECTION 7: CERTIFICATION

I understand the initial monthly premium payment must be paid in advance prior to the issuance of a plan. SWHP will not approve or deny my application on any basis which is prohibited by law. If declining Pediatric Dental coverage (on page 2, sections 1 and/or 2), I understand I must obtain coverage for Pediatric Dental Essential Health Benefits (dependents 0-18 years old) through another policy. I hereby certify that to the best of my knowledge the answers given here are current, truthful and complete. A photographic copy of this authorization shall be valid as the original.

Third-Party payments will not be accepted for ACA plans, except those required by Federal guidance. (This would include Employer payments for Employee coverage, Company checks unless Sole Proprietorship, Provider payments and Foundation payments. Payments for family members or Family Trusts are not considered a Third-Party payment.)

Primary Applicant's Signature (or Parent/Guardian if Child Only Plan)	Date (MM/DD/YYYY)
X	
Spouse's Signature	Date (MM/DD/YYYY)
X	
Dependent's Signature (Only if 18 or over and to be insured)	Date (MM/DD/YYYY)
X	
Dependent's Signature (Only if 18 or over and to be insured)	Date (MM/DD/YYYY)
X	
Dependent's Signature (Only if 18 or over and to be insured)	Date (MM/DD/YYYY)
X	



Primary Applicant's Last Name	Applicant's Social Security Number
Agent Name	Agent NPN

SECTION 8: BILLING INFORMATION

Purchaser's Information (If different than Primary Applicant)

First Name	MI	Last Name	Suffix
Relationship to Applicant	Mailing Address	City	State
Signature	Date		Zip

Third-Party payments will not be accepted for ACA plans, except those required by Federal guidance. (This would include Employer payments for Employee coverage, Company checks unless Sole Proprietorship, Provider payments and Foundation payments. Payments for family members or Family Trusts are not considered a Third-Party payment.)

INITIAL PAYMENT

Upon receipt of Welcome email and/or letter, you must make a payment by one of the following to activate your coverage:

- Member portal located at <https://portal.swhp.org/#/registration-1>
- e-PAY (877)729-3763
- Mail check to: SWHP, PO Box 846035, Dallas, TX 75284-6035
- Contact Customer Service at (800)321-7947

Important: If initial payment by Credit/Debit Card is electronically declined, coverage will not be issued. If an ongoing ACH bank draft payment is electronically declined, your coverage will be terminated back to the first of the month in which the draft was declined. A new application will be required to obtain future coverage (pending Special Enrollment Period qualification). Any amount not paid by your financial institution will be assessed a \$30 fee.

If you have been covered by SWHP, or an affiliated company, within the past 12 months and the evidence of coverage was terminated for nonpayment of premium, you will be required to pay the past due amount and the initial premium for the new coverage before your evidence of coverage will be effective

ONGOING PAYMENTS (MUST COMPLETE)

- ☐ Automatic Bank Draft (complete EFT information below)
- ☐ Monthly Billing Statement (paper)
- ☐ Pay Online at <https://portal.swhp.org/#/registration-1> (requires registration in member portal)

AUTOMATIC BANK DRAFT (First month's initial premium MUST be made manually. Bank Draft will go into effect Second month)

<input type="checkbox"/> Checking	
<input type="checkbox"/> Savings	
Name of Bank	
Routing Number	
Account Number	
Name on Account	
Authorized Signature for Account	Date

Terms of Agreement: My account at the institution named above has sufficient funds to pay all debits and charge credits. SWHP shall activate electronic debit, charge or credit entries to pay premiums/charges for authorized plan, and the entries are my transaction receipt. I understand that by electing Automatic Bank Draft and with my signature in ONGOING PAYMENT section above, I am accepting the terms of the ONGOING PAYMENT Agreement. **NOTE: SWHP will not process Auto Bank Draft until month following receipt of the initial premium payment to activate coverage.**



**REQUIRED DISCLOSURE NOTICE FOR ALL INDIVIDUAL CONSUMER CHOICE
BENEFIT PLANS ISSUED IN TEXAS**

As required by 28 TAC §21.3530, I have been informed that the Consumer Choice Standard Benefit Plan that I am purchasing does not include all state mandated health benefits. I understand that the following benefits are provided at a reduced level from what is mandated, or are excluded completely from the plan:

Mandated Benefit Description	Benefit	Benefit
	Reduced	Excluded
28 TAC 11.506(2)(B) - Deductibles	X	

This HMO Consumer Choice Health Benefit Plan may include requirements and/or restrictions on deductibles, coinsurance, copayments, or annual or lifetime maximum benefit amounts that differ from other HMO plans. I understand that I may obtain from the Department of Insurance a consumer brochure with more information on Consumer Choice Health Benefit Plans, either by visiting the TDI website at www.tdi.texas.gov, or by calling 1 -800-252-3439. I also affirm that at the same time I was offered this Consumer Choice Benefit Plan, I was offered a plan that contained all state mandated health benefits.

Name of Applicant		Signature of Applicant		
Name of Business (if applicable)			Date	
Address	City	State	Zip	

Note: This form must be retained by the carrier issuing the evidence of coverage and must be provided to the Commissioner of Insurance upon request. **You have the right to a copy of this written disclosure statement free of charge.** A new form must be completed upon each subsequent renewal of this policy.

Post Enrollment Instructions

Welcome to Scott and White Health Plan. Please keep this page to use as a reference guide for your application process. Thank you for applying. We look forward to servicing your healthcare needs.

SECTION 9: NEXT STEPS	
1	If applying for Open Enrollment, proceed to Step 3 below:
2	If applying for Special Enrollment: Please send all SEP supporting documents to: swhpelectronicenrollment@bswhealth.org or fax to 254-298-3199. Applications submitted for Special Enrollment Period will not be processed without supporting documentation.
3	Wait approximately 5-7 business days to receive a response via email and/or letter from SWHP, giving instructions for making the initial premium payment.
4	To make initial payment: <ul style="list-style-type: none"> Login to member portal at https://portal.swhp.org/#/registration-1 (If you do not have your member number yet, you can search by Social Security Number and date of birth) Call e-PAY line at (877) 729-3763 Mail check to: SWHP, PO Box 846035, Dallas, TX 75284-6035 Contact Customer Service at (800) 321-7947
5	After initial payment is made, the payment takes 24-48 hours to post to your account. Once payment is posted, your ID Card will generate and be mailed to you. Please allow 7-10 days after payment has posted to receive your ID Card by mail. You can also print a temporary card from your member portal once payment has posted. Check ID Card to make sure all insured members are listed on card.

IMPORTANT INFORMATION	
Customer Service	(800) 321-7947
Member Portal	https://portal.swhp.org/#/registration-1 Need Social Security Number OR Member ID Number & Date of Birth to register Secure messaging can be sent through your member portal to departments and receive quick responses.
Contract ID # vs Member ID #	Contract ID # is first 9 digits of Member ID # (Example: Contract # is 123456789) Member ID # is 11 digits (Example: Member # 12345678900) Each member on the contract will have sequential numbering as the suffix: (Example: -00, -01, -02, -03 for Contract holder plus 3 dependents)
Dental	Member will have a separate Dental ID # if dental coverage was chosen, and the dental premium must be paid separate from the medical premium. Member will not receive a Dental ID Card. Dental offices will verify benefits with the contract holder's Social Security Number. Locate Dental Provider: https://metlocator.metlife.com/metlocator/execute/Search (PDP Plus Network Provider)
Note regarding the cancellation of existing coverage: It is best that applicant not cancel any coverage until receiving confirmation of acceptance from SWHP.	

(Attach Agent Business Card Here)

AGENT'S INFORMATION

Print Agent's Name

Agent's Phone



Primary Applicant's Last Name	Applicant's Social Security Number
Agent Name	Agent NPN
Home Office Use ONLY	Eff Date:

EPO Application Instructions

(Exclusive Provider Organization)

To help us process your application promptly, please remember to:

- Print all answers in **black ink** legibly. Pencil will not be accepted.
- Make sure to personally sign the application as the Primary Applicant. Anyone over the age of 18 applying for coverage must sign the appropriate signature line (unless parent has Power of Attorney).
- If it is necessary to correct any errors, simply cross off what is incorrect and write initials next to the correct information.
- Please do not use correction fluid or tape.
- If more space is needed, attach separate page(s) and list section(s) and question number(s), then sign and date each page.
- **If you have been covered by ICSW, or an affiliated company, within the past 12 months and the policy was terminated for nonpayment of premium, you will be required to pay the past due amount and the initial premium for the new coverage before your policy will be effective.**

Please submit an application via one of the following methods:

- Mail: Insurance Company of Scott and White, Attention: Enrollment, 1206 West Campus Dr., MS-A4-126, Temple, TX 76502
- FAX: (254) 298-3199
- Email: swhpElectronicEnrollment@bswhealth.org

If you have any questions, please call your agent or an Internal Sales Specialist at (866) 522-2515.

OPEN ENROLLMENT (OE): November 1 – December 15 Submission Dates

Application received prior to the end of Open Enrollment	Effective date January 1
--	--------------------------

SEP ENROLLMENT (SEP): Year Round Submission Dates

If applying outside of Open Enrollment, you must have experienced one of the events below (during the last 60 days) in order to apply. Please answer the following questions only if applying for a Special Enrollment Period.

Requested Effective Date	
<input type="checkbox"/> I and/or my dependent(s) lost Minimum Essential Coverage: (Choose one of the two options)	
<input type="checkbox"/> Involuntary loss of Minimum Essential Coverage (example: losing group coverage, divorce & aging off parents plan at age 26)	Date of Event
<input type="checkbox"/> Losing or replacing current Scott and White Health Plan or Insurance Company of Scott and White? If yes, please provide the policy number(s): _____	Date Coverage Ends
<input type="checkbox"/> Birth, Adoption, placement for adoption or foster care or become a party to a suit to adopt (Effective date will be date of birth or date of adoption/placement/becomes party to a suit to adopt)	Date of Event
<input type="checkbox"/> Relocation to a new service area	Date of Event
<input type="checkbox"/> Marriage or gaining dependent due to marriage	Date of Event
<input type="checkbox"/> Gaining Citizenship	Date of Event
<input type="checkbox"/> Release from incarceration	Date of Event

Send all SEP supporting documents to: swhpElectronicEnrollment@bswhealth.org or fax to 254-298-3199. Applications submitted for a Special Enrollment Period will not be processed without supporting documentation.



Primary Applicant's Last Name		Applicant's Social Security Number	
Agent Name		Agent NPN	
Home Office Use ONLY		Eff Date:	

EPO Enrollment Application

(Exclusive Provider Organization)

SECTION 1: PRIMARY APPLICANT (If Purchaser is different than Primary Applicant, include Purchaser's information in Section 8)							
First Name			MI	Last Name			Suffix
**** Social Security Number		Date of Birth (MM/DD/YYYY)		Age *	<input type="checkbox"/> Male <input type="checkbox"/> Female	Within the past 6 months, have you used tobacco 4 or more times per week on average? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Marital Status <input type="checkbox"/> Single/Divorced/Widow <input type="checkbox"/> Married <input type="checkbox"/> Other _____					Are you a US citizen or US national? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Race (optional- check only one) <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> American Indian/Alaska American <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian/Chamorro <input type="checkbox"/> Samoan <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Other							
Residential Address			Apt	City	State	Zip	County
Mailing Address (If different than above)			Apt	City	State	Zip	County
Primary Phone			Cell <input type="checkbox"/> Landline <input type="checkbox"/>	Secondary Phone			Cell <input type="checkbox"/> Landline <input type="checkbox"/>
Email Address					Preferred Contact Method <input type="checkbox"/> Email <input type="checkbox"/> Mail		
Primary Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other (Please Specify): _____				Do you have a disability affecting your ability to communicate or read? <input type="checkbox"/> Yes <input type="checkbox"/> No			
*** Apply for Dental Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No				If yes, please explain _____			

SECTION 2: DEPENDENT INFORMATION								
DEPENDENT	First Name			MI	Last Name			Suffix
	**** Social Security Number		Date of Birth (MM/DD/YYYY)		Age *	Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Child	<input type="checkbox"/> Male <input type="checkbox"/> Female	Tobacco Use** <input type="checkbox"/> Yes <input type="checkbox"/> No
	Are you a US citizen or US national? <input type="checkbox"/> Yes <input type="checkbox"/> No				*** Apply for Dental Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No			
DEPENDENT	First Name			MI	Last Name			Suffix
	**** Social Security Number		Date of Birth (MM/DD/YYYY)		Age *	Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Child	<input type="checkbox"/> Male <input type="checkbox"/> Female	Tobacco Use** <input type="checkbox"/> Yes <input type="checkbox"/> No
	Are you a US citizen or US national? <input type="checkbox"/> Yes <input type="checkbox"/> No				*** Apply for Dental Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No			
DEPENDENT	First Name			MI	Last Name			Suffix
	**** Social Security Number		Date of Birth (MM/DD/YYYY)		Age *	Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Child	<input type="checkbox"/> Male <input type="checkbox"/> Female	Tobacco Use** <input type="checkbox"/> Yes <input type="checkbox"/> No
	Are you a US citizen or US national? <input type="checkbox"/> Yes <input type="checkbox"/> No				*** Apply for Dental Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No			
DEPENDENT	First Name			MI	Last Name			Suffix
	**** Social Security Number		Date of Birth (MM/DD/YYYY)		Age *	Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Child	<input type="checkbox"/> Male <input type="checkbox"/> Female	Tobacco Use** <input type="checkbox"/> Yes <input type="checkbox"/> No
	Are you a US citizen or US national? <input type="checkbox"/> Yes <input type="checkbox"/> No				*** Apply for Dental Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No			

*Age as of effective date

**Within the past 6 months, have you used tobacco 4 or more times per week on average?

***The Affordable Care Act (ACA) requires us to be reasonably assured that you and each member on this policy have or are seeking coverage for pediatric dental services that are Essential Health Benefits.

****If someone needs help getting a SSN, call (800) 772-1213 or visit socialsecurity.gov. TTY users should call (800) 325-0778.



Primary Applicant's Last Name	Applicant's Social Security Number										
	<table border="1"> <tr> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table>										
Agent Name	Agent NPN										

SECTION 3: CHOOSE YOUR COVERAGE

Select ACA Ind EPO Bronze 7500

SECTION 4: DENTAL ACKNOWLEDGEMENT

The Affordable Care Act ("ACA") requires us to be reasonably assured that you and each member on this policy have or are seeking coverage for Pediatric Dental Services that are Essential Health Benefits.

To choose Dental coverage for one or all members on policy, choose appropriate boxes on page 2 of application, sections 1 and/or 2.

If **declining** Dental coverage, your signature in section 7 will verify you have obtained coverage for Pediatric Dental Essential Health Benefits (dependents 0-18 years old) through another policy.

Prices for Dental Coverage for each member of policy are:

Ages 0-18 years	\$36.28 /month per member
Ages 19 years and over	\$31.88 /month per member

NOTE: You will receive a separate ID number for Dental Policies. Premium for Dental must be paid separately from Medical.

SECTION 5: REPLACEMENT COVERAGE INFORMATION

Will this insurance replace any current health insurance policy with Scott and White Health Plan or Insurance Company of Scott and White?

☐ Yes ☐ No

If you have been covered by SWHP, or an affiliated company, within the past 12 months and the evidence of coverage was terminated for nonpayment of premium, you will be required to pay the past due amount and the initial premium for the new coverage before your evidence of coverage will be effective.

If yes, please provide the policy number(s):

Date Coverage Ends:

SECTION 6: Agent Information (If applicable)

Agent's Certification: I certify that I sent the application to the Applicant(s) for completion, or I personally asked the questions and recorded the answers as given. I further certify that I have no knowledge of any other medical information about the Applicant(s) not contained in this application and that written material explaining the benefits, exclusions and provisions of the Contract was sent to the Applicant(s). I certify that I have delivered the required Outline of Coverage, and if requested, the Disclosure Statement.

Third-Party payments will not be accepted for ACA plans, except those required by Federal guidance. (This would include Employer payments for Employee coverage, Company checks unless Sole Proprietorship, Provider payments and Foundation payments. Payments for family members or Family Trusts are not considered a Third-Party payment.)

Agent's Signature	Date (MM/DD/YYYY)	Agent's NPN
Print Agent's Name	Agent's Phone	



Primary Applicant's Last Name	Applicant's Social Security Number
Agent Name	Agent NPN

SECTION 7: CERTIFICATION

I understand the initial monthly premium payment must be paid in advance prior to the issuance of a policy. SWHP will not approve or deny my application on any basis which is prohibited by law. If declining Pediatric Dental coverage (on page 2, sections 1 and/or 2), I understand I must obtain coverage for Pediatric Dental Essential Health Benefits (dependents 0-18 years old) through another policy. I hereby certify that to the best of my knowledge the answers given here are current, truthful and complete. A photographic copy of this authorization shall be valid as the original.

Third-Party payments will not be accepted for ACA plans, except those required by Federal guidance. (This would include Employer payments for Employee coverage, Company checks unless Sole Proprietorship, Provider payments and Foundation payments. Payments for family members or Family Trusts are not considered a Third-Party payment.)

☐ **I HAVE READ AND ACCEPT THE BELOW AGREEMENT**

You understand that Policy and other required documents, notices, and communications may be mailed or transmitted electronically. By checking this box You are consenting to the electronic delivery of certain communications. If the box is not selected You will receive paper communications. Consent may be withdrawn at any time by submitting a written request to Health Plan and paper documents will be provided.

Primary Applicant's Signature (or Parent/Guardian if Child Only Policy)	Date (MM/DD/YYYY)
X	
Spouse's Signature	Date (MM/DD/YYYY)
X	
Dependent's Signature (Only if 18 or over and to be insured)	Date (MM/DD/YYYY)
X	
Dependent's Signature (Only if 18 or over and to be insured)	Date (MM/DD/YYYY)
X	
Dependent's Signature (Only if 18 or over and to be insured)	Date (MM/DD/YYYY)
X	



Primary Applicant's Last Name	Applicant's Social Security Number										
	<table border="1"> <tr> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table>										
Agent Name	Agent NPN										

SECTION 8: BILLING INFORMATION				
Purchaser's Information (If different than Primary Applicant)				
First Name	MI	Last Name	Suffix	
Relationship to Applicant	Mailing Address	City	State	Zip
Signature			Date	

Third-Party payments will not be accepted for ACA plans, except those required by Federal guidance. (This would include Employer payments for Employee coverage, Company checks unless Sole Proprietorship, Provider payments and Foundation payments. Payments for family members or Family Trusts are not considered a Third-Party payment.)

INITIAL PAYMENT

Upon receipt of Welcome email and/or letter, you must make a payment by one of the following to initiate your coverage:

- Member portal located at <https://portal.swhp.org/#/registration-1>
- e-PAY (877)729-3763
- Mail check to: SWHP, PO Box 846035, Dallas, TX 75284-6035
- Contact Customer Service at (800)321-7947

Important: If initial payment by Credit/Debit Card is electronically declined, policy will not be issued. If an ongoing ACH bank draft payment is electronically declined, your policy will be terminated back to the first of the month in which the draft was declined. A new application will be required to obtain future coverage (pending Special Enrollment Period qualification). Any amount not paid by your financial institution will be assessed a \$30 fee.

If you have been covered by ICSW, or an affiliated company, within the past 12 months and the policy was terminated for nonpayment of premium, you will be required to pay the past due amount and the initial premium for the new coverage before your policy will be effective.

ONGOING PAYMENTS (MUST COMPLETE)

- ☐ Automatic Bank Draft (complete EFT information below)
- ☐ Monthly Billing Statement (paper)
- ☐ Pay Online at <https://portal.swhp.org/#/registration-1> (requires registration in member portal)

AUTOMATIC BANK DRAFT (First month's initial premium MUST be made manually. Bank Draft will go into effect Second month)

<input type="checkbox"/> Checking <input type="checkbox"/> Savings			
Name of Bank			
Routing Number			
Account Number			
Name on Account			
Authorized Signature for Account		Date	

Terms of Agreement: My account at the institution named above has sufficient funds to pay all debits and charge credits. ICSW shall initiate electronic debit, charge or credit entries to pay premiums/charges for authorized policy, and the entries are my transaction receipt. I understand that by electing Automatic Bank Draft and with my signature in ONGOING PAYMENT section above, I am accepting the terms of the ONGOING PAYMENT Agreement. **NOTE: ICSW will not process Auto Bank Draft until month following receipt of the initial premium payment to initiate coverage.**

Post Enrollment Instructions

Welcome to Insurance Company of Scott and White. Please keep this page to use as a reference guide for your application process. Thank you for applying. We look forward to servicing your health care needs.

SECTION 9: NEXT STEPS

1	If applying for Open Enrollment, proceed to Step 3 below:
2	If applying for Special Enrollment: Please send all SEP supporting documents to: swhelectronicenrollment@bswhealth.org or fax to 254-298-3199. Applications submitted for Special Enrollment Period will not be processed without supporting documentation.
3	Wait approximately 5-7 business days to receive a response via email and/or letter from ICSW, giving instructions for making the initial premium payment.
4	To make initial payment: <ul style="list-style-type: none"> Login to member portal at https://portal.swhp.org/#/registration-1 (If you do not have your member number yet, you can search by Social Security Number and date of birth) Call e-PAY line at (877) 729-3763 Mail check to: SWHP, PO Box 846035, Dallas, TX 75284-6035 Contact Customer Service at (800) 321-7947
5	After initial payment is made, the payment takes 24-48 hours to post to your account. Once payment is posted, your ID Card will generate and be mailed to you. Please allow 7-10 days after payment has posted to receive your ID Card by mail. You can also print a temporary card from your member portal once payment has posted. Check ID Card to make sure all insured members are listed on card.

IMPORTANT INFORMATION

Customer Service	(800) 321-7947
Member Portal	https://portal.swhp.org/#/registration-1 Need Social Security Number OR Member ID Number & Date of Birth to register Secure messaging can be sent through your member portal to departments and receive quick responses.
Contract ID # vs Member ID #	Contract ID # is first 9 digits of Member ID # (Example: <i>Contract # is 123456789</i>) Member ID # is 11 digits (Example: <i>Member # 12345678900</i>) Each member on the contract will have sequential numbering as the suffix: (Example: <i>-00, -01, -02, -03 for Contract holder plus 3 dependents</i>)
Dental	Member will have a separate Dental ID # if dental coverage was chosen, and the dental premium must be paid separate from the medical premium. Member will not receive a Dental ID Card. Dental offices will verify benefits with the contract holder's Social Security Number. Locate Dental Provider: https://metlocator.metlife.com/metlocator/execute/Search (PDP Plus Network Provider)
Note regarding the cancellation of existing coverage: It is best that applicant not cancel any coverage until receiving confirmation of acceptance from ICSW.	

(Attach Agent Business Card Here)

AGENT'S INFORMATION

Print Agent's Name

Agent's Phone



Nondiscrimination Notice

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-321-7947 (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:
 - 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>.

2020 Enrollment Guide

INDIVIDUAL AND FAMILY



Scott & White
HEALTH PLAN



Part of
Baylor Scott & White
HEALTH

Sales/To Speak to a Licensed Insurance Agent

1-866-522-2515 (TTY: 711)

8 a.m. – 5 p.m. • Monday – Friday

Customer Service

1-800-321-7947 (TTY: 711)

7 a.m. – 7 p.m. • Monday – Friday