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.

To make a change in the Medicare Advantage plan you have with Scott and White Health Plan, fill out the enclosed plan selection form, check the plan you want, sign the form, and mail it back to us using the address on the form.

When can you change plans?

You can change health plans only at certain times during the year. From October 15 - December 7, you can join, switch or drop a Medicare health or drug plan for the following year. In addition, from January 1 - March 31, anyone enrolled in a Medicare Advantage Plan (except an MSA plan) can switch plans or return to Original Medicare (and join a stand-alone Medicare Prescription Drug Plan).

Generally, you can't make changes at other times except in certain situations, such as if you move out of your plan's service area, want to join a plan in your area with a 5-star rating, or qualify for (or lose) Extra Help paying for prescription drug coverage. If you lose Extra Help, you may be eligible for a Special Enrollment Period due to that change, and would be allowed one opportunity to make a new plan selection within three months of the change, or notification of the change, whichever is later. If you qualify for Extra Help with your prescription drug costs, you may enroll in, or disenroll from, a Medicare Advantage Prescription Drug plan once per calendar quarter during the first nine months of the year.

Need assistance?

Complete the attached form only if you wish to change plans; otherwise, enrollment in your current plan will continue. The form includes monthly plan premiums and basic coverage information to assist you in making your selection. Additional benefits information can be found on our website at advantage.swhp.org.

If you have any questions or would like guided assistance, please call Scott and White Health Plan at 1-877-845-3901. TTY users should call 711. We are open 8 a.m. to 5 p.m., Monday through Friday.

Thank you.

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

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 the appropriate box below:	Monthly Premium	PCP/Specialist Office Visit	Maximum Out-of-Pocket
____ BSW SeniorCare Advantage HMO Select without Rx	$0	$0 / $25	$5,900
____ BSW SeniorCare Advantage HMO Preferred without Rx	$83	$0 / $25	$4,500
____ BSW SeniorCare Advantage HMO Premium without Rx	$199	$0 / $0	$4,500
____ BSW SeniorCare Advantage HMO Select with Rx	$0	$0 / $25	$6,300
____ BSW SeniorCare Advantage HMO Preferred with Rx	$132	$0 / $25	$4,500
____ BSW SeniorCare Advantage HMO Premium with Rx	$241.50	$0 / $0	$4,500

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.

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

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(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 an accessible format:

☐ Spanish ☐ Large Print

Please contact Scott and White Health Plan at 1-866-334-3141 (TTY users should call 711) if you need information in an accessible format or language than what is listed above. Our office hours are 7 a.m. to 8 p.m., seven days a week.

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: _____	

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
Phone: 1-877-845-3901

Office Use Only
Tracking Number: _____
(Example: time/mo/date/yr/first & last initials (0915 11052017 ES)
Division #: _____ **Plan Representative #:** _____ **Area #** _____
Effective Date of Coverage: _____ ☐ IEP ☐ AEP ☐ OEP ☐ SEP (type):
Confirmed Current Plan Information: (initials) **Date:**