

Dear Baylor Scott & 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 Baylor Scott & White Health Plan, fill out the enclosed plan selection form to make your choice. Check off the plan you want, and sign the form. Then mail the completed form back to us.

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 join our plan when you first enroll in Medicare, you can switch to another plan or get Original Medicare (and join a stand-alone Medicare Prescription Drug Plan). If you're not happy with your choice in our plan, you can make a change during the first three months you have Medicare.

If you select another plan and we receive your completed selection form by the end of the month, your new benefit plan will begin on the first day of the following month. Your monthly plan premium will be as shown for the plan you select on the following page, and you may continue to see any Covenant Health Advantage primary care doctors and specialists.

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

To help you with your decision, we have also included a 2025 benefit overview for the available options.

If you have any questions, please call Baylor Scott & White Health Plan at 1-877-845-3901. TTY users should call 711. We are open 8:00 AM to 5:00 PM, Monday through Friday.

Thank you.

PLAN SELECTION FORM

Date: _____

Member Name: _____

Member Number: _____

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

Please check the appropriate box below:

	Monthly Premium	PCP/Specialist Office Visit	Maximum Out-of-Pocket
<input type="checkbox"/> Covenant Health Advantage HMO without Rx	\$0	\$0 / \$30	\$5,600
<input type="checkbox"/> Covenant Health Advantage HMO with Rx	\$0	\$0 / \$30	\$5,900

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

Account Holder Name: _____

Bank Routing Number: _____

Bank Account Number: _____

Account Type: Checking Savings

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

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

PLAN SELECTION FORM

<u>The fields in this section are optional</u>			
Answering these questions is your choice. You can't be denied coverage because you don't fill them out.			
<p>Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.</p> <p> <input type="checkbox"/> No, not of Hispanic, Latino/a, or Spanish origin <input type="checkbox"/> Yes, Mexican, Mexican American, Chicano/a <input type="checkbox"/> Yes, Puerto Rican <input type="checkbox"/> Yes, Cuban <input type="checkbox"/> Yes, another Hispanic, Latino/a, or Spanish origin <input type="checkbox"/> I choose not to answer. </p>			
<p>What's your race? Select all that apply.</p> <table style="width: 100%;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> American Indian or Alaska Native Asian: <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 </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Black or African American Native Hawaiian and Pacific Islander: <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> I choose not to answer. </td> </tr> </table>		<input type="checkbox"/> American Indian or Alaska Native Asian: <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"/> Black or African American Native Hawaiian and Pacific Islander: <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> I choose not to answer.
<input type="checkbox"/> American Indian or Alaska Native Asian: <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"/> Black or African American Native Hawaiian and Pacific Islander: <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> I choose not to answer.		

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 Baylor Scott & White Health Plan at 1-833-442-2405 (TTY users should call 711) if you need information in an accessible format or language than what is listed above. We are available October 1 - March 31, 8:00 AM to 8:00 PM, seven days a week (excluding major holidays); April 1 - September 30, 8:00 AM to 5:00 PM, Monday through Friday (excluding major holidays).

Baylor Scott & White Health Plan offers plan documents electronically through our member portal at Covenant.BSWHealthPlan.com and on our website at BSWHealthPlan.com/Medicare. Please call Customer Service at the number above to request paper copies of these documents.

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:

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

Fax (254) 298-3567
Email: HPCustomerEngagement@BSWHealth.org
Phone: 1-877-845-3901

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

Covenant Health Advantage HMO is offered by Baylor Scott & White Care Plan, a Medicare Advantage organization with a Medicare contract and subsidiary of Baylor Scott & White Health Plan. Enrollment in Covenant Health Advantage HMO depends on contract renewal with Medicare. Covenant Health Advantage HMO es ofrecido por Baylor Scott & White Care Plan, una organización de Medicare Advantage con contrato con Medicare y subsidiaria de Baylor Scott & White Health Plan. La inscripción en Covenant Health Advantage HMO depende de la renovación del contrato con Medicare.

Baylor Scott & 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. Baylor Scott & 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. Baylor Scott & 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.