Baylor Scott & White Health Plan | BSW SENIORCARE ADVANTAGE • HMO-POS

Summary of Benefits

Medicare Advantage HMO-POS

CENTRAL TEXAS

THE POWER TO LIVE BETTER

H8142_001-006CTXSB2024_M

This is a summary of drug and health services covered in the BSW SeniorCare Advantage HMO-POS plan, offered by Baylor Scott & White Health Plan.

Summary of Benefits

January 1, 2024 - December 31, 2024

BSW SeniorCare Advantage HMO-POS is offered by Baylor Scott & White Health Plan, a Medicare Advantage organization with a Medicare contract. Enrollment in BSW SeniorCare Advantage depends on contract renewal with Medicare.

This booklet gives you a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, refer to the *Evidence of Coverage*, available on our website at BSWHealthPlan.com/Medicare by October 15, 2023.

Tips for comparing your Medicare choices

This Summary of Benefits gives you a summary of what BSW SeniorCare Advantage HMO-POS covers and what you pay.

- If you want to compare our plan with other Medicare plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on https://www.medicare.gov.
- If you want to know more about the coverage and costs of Original Medicare, look in your current **"Medicare & You"** handbook. View it online at https://www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Things to know about BSW SeniorCare Advantage HMO-POS

- If you are a member of this plan, you can call us toll free at 1-866-334-3141 or TTY 711, October 1 through March 31 from 7 a.m. – 8 p.m., seven days a week (excluding major holidays); and April 1 through September 30 from 7 a.m. – 8 p.m., Monday through Friday (excluding major holidays).
- If you are not a member of this plan, you can call us toll free at 1-800-782-5068 or TTY 711, October 1 through March 31 from 8 a.m. – 8 p.m., seven days a week (excluding major holidays); and April 1 through September 30 from 8 a.m. – 5 p.m., Monday through Friday (excluding major holidays).
- Our website: BSWHealthPlan.com/Medicare

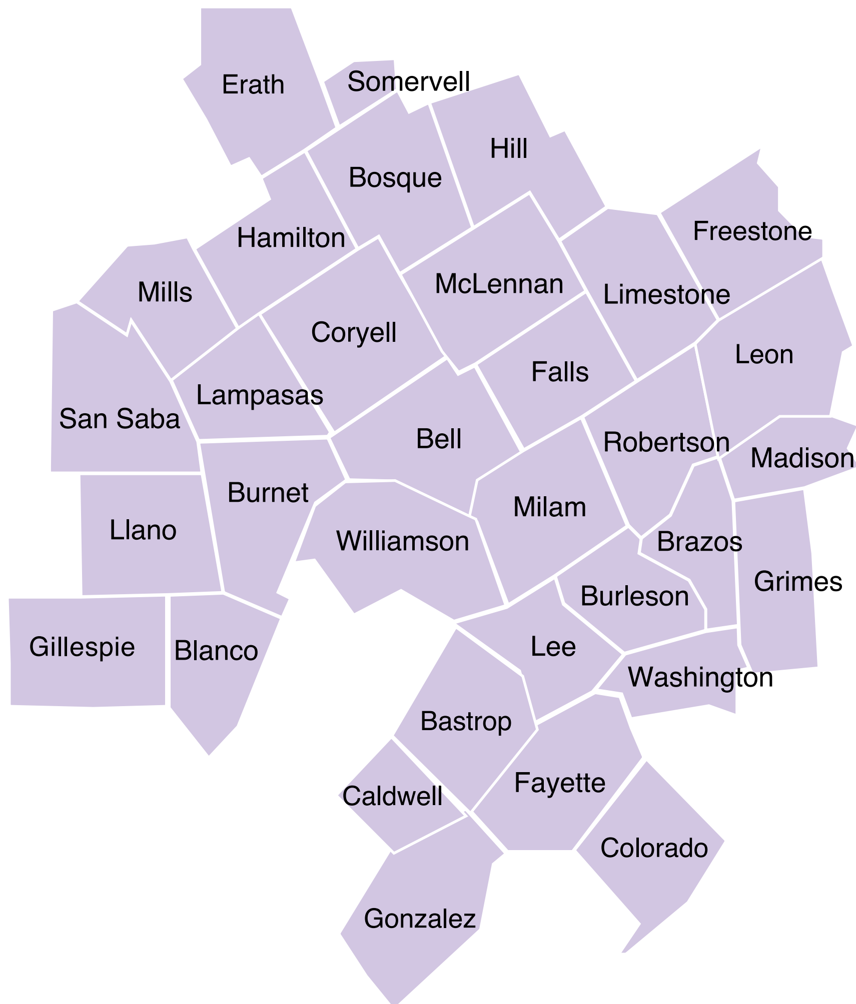
This document is available in other formats such as large print. The document may be available in a non-English language.

Who can join?

To join BSW SeniorCare Advantage HMO-POS, you must have Medicare Part A and Medicare Part B, and live in our service area. Our service area includes these counties in Texas: Bastrop, Bell, Blanco, Bosque, Brazos, Burleson, Burnet, Caldwell, Colorado, Coryell, Erath, Falls, Fayette, Freestone, Gillespie, Gonzales, Grimes, Hamilton, Hill, Lampasas, Lee, Leon, Limestone, Llano, McLennan, Madison, Milam, Mills, Robertson, San Saba, Somervell, Washington, and Williamson.

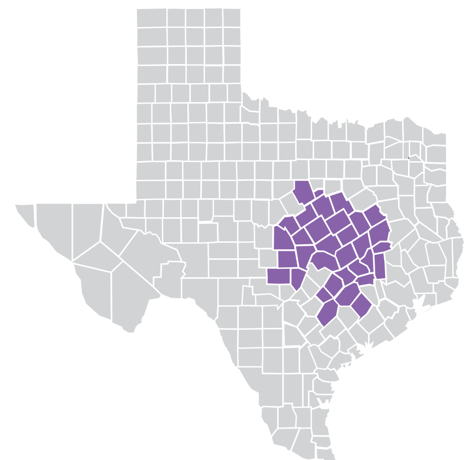
What is the service area for Central Texas

BSW SeniorCare Advantage HMO-POS?



The counties in the service area are listed below:

Bastrop, Bell, Blanco, Bosque, Brazos, Burleson, Burnet, Caldwell, Colorado, Coryell, Erath, Falls, Fayette, Freestone, Gillespie, Gonzales, Grimes, Hamilton, Hill, Lampasas, Lee, Leon, Limestone, Llano, Madison, McLennan, Milam, Mills, Robertson, San Saba, Somervell, Washington, Williamson



Which doctors, hospitals, and pharmacies can I use?

BSW SeniorCare Advantage HMO-POS has a network directory of doctors, hospitals, pharmacies, and other providers that can be found on our website at BSWHealthPlan.com/Medicare. You must use network providers and pharmacies for covered services, unless authorized by the Plan.

What do we cover?

Like all Medicare health plans, we cover everything that Original Medicare covers – and more.

- Our plan members get all of the benefits covered by Original Medicare. For some of these benefits, you may pay more in our plan than you would in Original Medicare. For others, you pay less.
- Our plan members also get more than what is covered by Original Medicare. Some of the extra benefits are outlined in this booklet.

BSW SeniorCare Advantage HMO-POS covers Medicare Part B and Part D drugs. Certain limitations may apply.

Premiums and Benefits	Select	Preferred	Premium
Monthly Plan Premium			
With Part D prescription drug coverage	You pay $0 per month.	You pay $135 per month.	You pay $243 per month.
Without Part D prescription drug coverage	You pay $0 per month.	You pay $83 per month.	You pay $199 per month.
You must continue to pay your Medicare Part B Premium.	BSW SeniorCare Advantage Select (HMO-POS) without Part D prescription drug coverage pays $50 toward your Part B premium. This reduction is applied on your Social Security check. For questions about Social Security, please contact or go to ssa.gov for more information.	BSW SeniorCare Advantage Preferred (HMO-POS) without Part D prescription drug coverage pays $50 toward your Part B premium. This reduction is applied on your Social Security check. For questions about Social Security, please contact or go to ssa.gov for more information.	BSW SeniorCare Advantage Premium (HMO-POS) without Part D prescription drug coverage pays $50 toward your Part B premium. This reduction is applied on your Social Security check. For questions about Social Security, please contact or go to ssa.gov for more information.
Deductible	You pay $0.	You pay $0.	You pay $0.
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)			
With Part D prescription drug coverage	You pay $5,800 annually.	You pay $4,600 annually.	You pay $4,800 annually.
Without Part D prescription drug coverage	You pay $5,900 annually.	You pay $4,500 annually.	You pay $4,500 annually.
Inpatient Hospital*	Days 1 - 6: $325 copay each day per stay. Days 7 - 90: $0 copay each day per stay.	$700 copay per stay.	$100 copay per stay.
Outpatient Hospital*			
Ambulatory Surgery Center	You pay $250 copay per visit.	You pay $100 copay per visit.	You pay $0 copay per visit.
Outpatient Hospital Services	You pay $325 copay per visit.	You pay $15 copay per visit.	You pay $0 copay per visit.

***Prior Authorization is required.**

Premiums and Benefits	Select	Preferred	Premium
Doctor Visits			
Primary Care Providers	You pay $0 copay per visit.	You pay $0 copay per visit.	You pay $0 copay per visit.
Specialist	You pay $25 copay per visit.	You pay $25 copay per visit.	You pay $0 copay per visit.
Preventive Care	You pay $0 copay.	You pay $0 copay.	You pay $0 copay.
Emergency Care If you are admitted to the hospital within 24 hours, for the same condition, the copay is waived.	You pay $100 copay per visit.	You pay $100 copay per visit.	You pay $90 copay per visit.
Urgently Needed Services If you are admitted to the hospital within 24 hours, for the same condition, the copay is waived.	You pay $50 copay per visit.	You pay $40 copay per visit.	You pay $40 copay per visit.
Diagnostic Services/Labs/Imaging*			
Diagnostic Tests and Procedures	You pay $0 copay.	You pay $0 copay.	You pay $0 copay.
Lab Services	You pay $0 copay.	You pay $0 copay.	You pay $0 copay.
Diagnostic Radiology Services (e.g. MRI, CAT Scan)	You pay $75 - $300 copay.	You pay $0 - $15 copay.	You pay $0 copay.
Outpatient X-Rays	You pay $0 copay.	You pay $0 copay.	You pay $0 copay.
Hearing Services			
Medicare-covered Hearing Exam	You pay $40 copay per Medicare-covered hearing exam.	You pay $15 copay per Medicare-covered hearing exam.	You pay $0 copay per Medicare-covered hearing exam.
Routine Hearing Exam Limited to one exam each year.	You pay $0 copay per exam.	You pay $0 copay per exam.	You pay $0 copay per exam.

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Premiums and Benefits	Select	Preferred	Premium
Hearing Aids			
With Part D prescription drug coverage	$1,500 allowance toward the purchase of hearing aids every three years.	$1,000 allowance toward the purchase of hearing aids every three years.	$1,000 allowance toward the purchase of hearing aids every three years.
Without Part D prescription drug coverage	$1,000 allowance toward the purchase of hearing aids every three years.	$1,000 allowance toward the purchase of hearing aids every three years.	$1,000 allowance toward the purchase of hearing aids every three years.
Dental Services	**In-Network and Out-of-Network Combined**	**In-Network and Out-of-Network Combined**	**In-Network and Out-of-Network Combined**
Preventive Dental			
Oral Exams: One exam every six months.	$0 copay for each preventive oral exam.	$0 copay for each preventive oral exam.	$0 copay for each preventive oral exam.
Prophylaxis (Cleaning): One cleaning every six months.	$0 copay for each preventive cleaning.	$0 copay for each preventive cleaning.	$0 copay for each preventive cleaning.
Dental X-Rays: One full mouth X-ray every 60 months. One bite-wing X-ray every 12 months.	$0 copay for each preventive X-ray.	$0 copay for each preventive X-ray.	$0 copay for each preventive X-ray.
Yearly Benefit Maximum:	$3,500 for all preventive and comprehensive dental services.	$3,500 for all preventive and comprehensive dental services.	$3,500 for all preventive and comprehensive dental services.
Comprehensive Dental Services			
Non-routine Services: One non-routine service every six months. 0% cost-sharing for problem-focused urgent or emergent exam and periapical X-rays (problem-focused X-rays).	0% - 50% coinsurance for each non-routine service.	0% - 50% coinsurance for each non-routine service.	0% - 50% coinsurance for each non-routine service.

***Prior Authorization is required.**

Premiums and Benefits	Select	Preferred	Premium
Dental Services (continued) Other services rendered, such as fillings, endodontics services, and periodontics are covered at 50%.			
Diagnostic Services: Up to eight periapical X-rays per visit.	$0 copay for each diagnostic service.	$0 copay for each diagnostic service.	$0 copay for each diagnostic service.
Restorative Services: One set of dentures every five years covered at 100%. One filling every 24 months covered at 100%. One crown/inlays/ onlays/bridges/implants (one per tooth position) every 10 years covered at 50%.	0% - 50% coinsurance for each restorative service.	0% - 50% coinsurance for each restorative service.	0% - 50% coinsurance for each restorative service.
Endodontics: One root canal per tooth per lifetime.	50% coinsurance for each endodontics service.	50% coinsurance for each endodontics service.	50% coinsurance for each endodontics service.
Periodontics: One periodontal surgery every 36 months. Periodontal maintenance up to four times every calendar year. One scaling and root planing every 24 months.	50% coinsurance for each periodontics service.	50% coinsurance for each periodontics service.	50% coinsurance for each periodontics service.
Extractions: Unlimited.	$0 copay for each extraction service.	$0 copay for each extraction service.	$0 copay for each extraction service.

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Premiums and Benefits	Select	Preferred	Premium
Dental Services (continued) **Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:** One set of dentures through prosthodontist every five calendar years covered at 100%. Bridges covered through prosthodontist once every 10 calendar years at 50%. Benefits for dental services are administered and paid by Metropolitan Life Insurance Company. Exclusions and limitations apply. See the *Evidence of Coverage* for full details on the dental benefit. If a covered service is performed by an out-of-network dentist, we will base the benefit on the covered percentage of the maximum allowed charge. Out-of-network dentists may charge more than the maximum allowed charge. If an out-of-network dentist performs a covered service, you will be responsible for paying: • any other part of the maximum allowed charge for which we do not pay benefits; and	0% - 50% coinsurance for each prosthodontics and other oral/maxillofacial surgery service.	0% - 50% coinsurance for each prosthodontics and other oral/maxillofacial surgery service.	0% - 50% coinsurance for each prosthodontics and other oral/maxillofacial surgery service.

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Premiums and Benefits	Select	Preferred	Premium
Dental Services (continued) • any amount in excess of the maximum allowed charge charged by the out-of-network dentist.			
Vision Services			
Eyewear			
With Part D prescription drug coverage	$150 allowance toward the purchase of eyewear each year.	$125 allowance toward the purchase of eyewear each year.	$125 allowance toward the purchase of eyewear each year.
Without Part D prescription drug coverage	$125 allowance toward the purchase of eyewear each year.	$125 allowance toward the purchase of eyewear each year.	$125 allowance toward the purchase of eyewear each year.
Routine Eye Exam	You pay $0 copay for one routine eye exam per year.	You pay $0 copay for one routine eye exam per year.	You pay $0 copay for one routine eye exam per year.
Mental Health Services			
Inpatient*	Days 1 - 5: $318 copay each day per stay. Days 6 - 90: $0 copay each day per stay.	$700 copay per stay.	$100 copay per stay.
Outpatient Individual or Group Therapy	You pay $30 copay per visit.	You pay $15 copay per visit.	You pay $0 copay per visit.
Skilled Nursing Facility (SNF) Care*	Days 1 - 20: $0 copay each day. Days 21 - 100: $200 copay each day.	Days 1 - 20: $0 copay each day. Days 21 - 100: $50 copay each day.	Days 1 - 20: $0 copay each day. Days 21 - 100: $15 copay each day.
Physical Therapy			
Occupational Therapy	You pay $35 copay per visit.	You pay $25 copay per visit.	You pay $10 copay per visit.
Physical Therapy and Speech and Language Therapy *	You pay $35 copay per visit.	You pay $25 copay per visit.	You pay $10 copay per visit.

***Prior Authorization is required.**

Premiums and Benefits	Select	Preferred	Premium
Ambulance Service			
Ground Ambulance			
With Part D prescription drug coverage	You pay $300 copay.	You pay $75 copay.	You pay $40 copay.
Without Part D prescription drug coverage	You pay $265 copay.	You pay $75 copay.	You pay $40 copay.
Air Ambulance			
With Part D prescription drug coverage	You pay $300 copay.	You pay $75 copay.	You pay $40 copay.
Without Part D prescription drug coverage	You pay $265 copay.	You pay $75 copay.	You pay $40 copay.
Transportation (Additional Routine)	You pay $0 copay for up to 24 one-way trips per year, or 12 round trips up to 50 miles each way.	You pay $0 copay for up to 24 one-way trips per year, or 12 round trips up to 50 miles each way.	You pay $0 copay for up to 24 one-way trips per year, or 12 round trips up to 50 miles each way.
Medicare Part B Prescription Drugs			
Chemotherapy Drugs Prior Authorization may be required. Step Therapy may be required.	You pay 0% - 20% coinsurance.	You pay 0% - 20% coinsurance.	You pay 0% - 20% coinsurance.
Other Part B Drugs Prior Authorization may be required. Step Therapy may be required. You pay no more than $35 for a one-month supply of covered insulin when used in an insulin pump.	You pay 0% - 20% coinsurance.	You pay 0% - 20% coinsurance.	You pay 0% - 20% coinsurance.

***Prior Authorization is required.**

Premiums and Benefits	Select	Preferred	Premium
Wellness Program (e.g. fitness)	Silver and Fit is a fitness program that provides members with a complimentary gym membership at participating gyms in your area. This benefit is at no additional cost to you.	Silver and Fit is a fitness program that provides members with a complimentary gym membership at participating gyms in your area. This benefit is at no additional cost to you.	Silver and Fit is a fitness program that provides members with a complimentary gym membership at participating gyms in your area. This benefit is at no additional cost to you.
Home Health Care*	You pay $0 copay per visit.	You pay $0 copay per visit.	You pay $0 copay per visit.
Foot Care (Podiatry Services) Medicare-covered foot exams and treatment.	You pay $40 copay per visit.	You pay $15 copay per visit.	You pay $0 copay per visit.
Telehealth Services - PCP, Specialist, and Individual or Group Sessions for Psychiatric Services	You pay $0 copay per visit.	You pay $0 copay per visit.	You pay $0 copay per visit.
Opioid Treatment Service*	You pay $45 copay per visit.	You pay $15 copay per visit.	You pay $0 copay per visit.
Meal Benefit	You pay $0 copay for 14 meals per hospital discharge to home; limit three discharges per year.	You pay $0 copay for 14 meals per hospital discharge to home; limit three discharges per year.	You pay $0 copay for 14 meals per hospital discharge to home; limit three discharges per year.
Over-the-Counter Items			
With Part D prescription drug coverage	Quarterly $50 swipe and save allowance toward over-the-counter items such as medicine, or products related to eye care, wellness, or personal care.	Quarterly $30 swipe and save allowance toward over-the-counter items such as medicine, or products related to eye care, wellness, or personal care.	Quarterly $30 swipe and save allowance toward over-the-counter items such as medicine, or products related to eye care, wellness, or personal care.

***Prior Authorization is required.**

Premiums and Benefits	Select	Preferred	Premium
Over-the-Counter Items (continued)			
Without Part D prescription drug coverage	Quarterly $30 swipe and save allowance toward over-the-counter items such as medicine, or products related to eye care, wellness, or personal care.	Quarterly $30 swipe and save allowance toward over-the-counter items such as medicine, or products related to eye care, wellness, or personal care.	Quarterly $30 swipe and save allowance toward over-the-counter items such as medicine, or products related to eye care, wellness, or personal care.
Worldwide Emergency/Urgent Services			
Emergency Care	You pay $0 copay per visit.	You pay $0 copay per visit.	You pay $0 copay per visit.
Urgent Care	You pay $0 copay per visit.	You pay $0 copay per visit.	You pay $0 copay per visit.
Emergency/Urgent Transportation	You pay $0 copay per trip.	You pay $0 copay per trip.	You pay $0 copay per trip.
Yearly Benefit Maximum	$5,000 maximum plan benefit coverage amount.	$5,000 maximum plan benefit coverage amount.	$5,000 maximum plan benefit coverage amount.

***Prior Authorization is required.**

Plans may offer supplemental benefits in addition to Part C benefits and Part D benefits.

Referrals and Authorizations

Referrals from your primary provider for services are not required; however, many services require prior authorization. For complete details, refer to the *Evidence of Coverage*, available on our website at BSWHealthPlan.com/Medicare by October 15, 2023.

Outpatient Prescription Drugs			
	BSW SeniorCare Advantage Select Rx (HMO-POS)		
Deductible	$0.		
Initial Coverage	You stay in this stage until your yearly drug costs total $5,030. Total yearly drug costs are the total drug costs paid by both you and your Part D plan. You may get your drugs at network retail pharmacies and mail order pharmacies. Costs may differ based on pharmacy type or status (e.g., mail order, long-term care (LTC) or home infusion, and 30- or 90-day supply).		
	Standard Retail 30-Day Supply	**Preferred Retail 30-Day Supply**	**Mail Order 90-Day Supply**
Tier 1 (Preferred Generic)	You pay $10.	You pay $0.	You pay $0.
Tier 2 (Generic)	You pay $20.	You pay $13.	You pay $0.
Tier 3 (Preferred Brand)	You pay $47.	You pay $47.	You pay $94.
Tier 4 (Non-Preferred)	You pay $100.	You pay $100.	You pay $200.
Tier 5 (Specialty)	You pay 33% of the cost.	You pay 33% of the cost.	Not Available
Coverage Gap	After your total drug costs (including what our plan has paid and what you have paid) reach $5,030, you will pay no more than 25% coinsurance for generic drugs or 25% coinsurance for brand name drugs.		
Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $8,000, you pay $0.		

Most adult Part D vaccines are covered at no cost to you.

You pay no more than $35 for a one-month supply of each covered insulin, no matter what cost-sharing tier it's on.

Information on Your Prescription Benefit

You can view the formulary (drug list) and any formulary restrictions on our website. Your costs for some drugs may be less at pharmacies that offer preferred cost sharing. To view the formulary (drug list) and pharmacy directory, go to BSWHealthPlan.com/Medicare.

We encourage you to let us know right away, if after becoming a member you have questions, concerns, or problems related to your prescription benefits. For assistance, call our Customer Service Department at 1-866-334-3141, 7 a.m. – 8 p.m., October 1 through March 31 from 7 a.m. – 8 p.m., seven days a week (excluding major holidays); and April 1 through September 30 from 7 a.m. – 8 p.m. Monday through Friday (excluding major holidays).

Outpatient Prescription Drugs			
	BSW SeniorCare Advantage Preferred Rx (HMO-POS)		
Deductible	$0.		
Initial Coverage	You stay in this stage until your yearly drug costs total $5,030. Total yearly drug costs are the total drug costs paid by both you and your Part D plan. You may get your drugs at network retail pharmacies and mail order pharmacies. Costs may differ based on pharmacy type or status (e.g., mail order, long-term care (LTC) or home infusion, and 30- or 90-day supply).		
	Standard Retail 30-Day Supply	**Preferred Retail 30-Day Supply**	**Mail Order 90-Day Supply**
Tier 1 (Preferred Generic)	You pay $8.	You pay $0.	You pay $0.
Tier 2 (Generic)	You pay $15.	You pay $8.	You pay $0.
Tier 3 (Preferred Brand)	You pay $45.	You pay $45.	You pay $90.
Tier 4 (Non-Preferred)	You pay $95.	You pay $95.	You pay $190.
Tier 5 (Specialty)	You pay 33% of the cost.	You pay 33% of the cost.	Not Available
Coverage Gap	After your total drug costs (including what our plan has paid and what you have paid) reach $5,030, you will pay no more than 25% coinsurance for generic drugs or 25% coinsurance for brand name drugs.		
Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $8,000, you pay $0.		

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Outpatient Prescription Drugs			
	BSW SeniorCare Advantage Premium Rx (HMO-POS)		
Deductible	$0.		
Initial Coverage	You stay in this stage until your yearly drug costs total $5,030. Total yearly drug costs are the total drug costs paid by both you and your Part D plan. You may get your drugs at network retail pharmacies and mail order pharmacies. Costs may differ based on pharmacy type or status (e.g., mail order, long-term care (LTC) or home infusion, and 30- or 90-day supply).		
	Standard Retail 30-Day Supply	**Preferred Retail 30-Day Supply**	**Mail Order 90-Day Supply**
Tier 1 (Preferred Generic)	You pay $7.	You pay $0.	You pay $0.
Tier 2 (Generic)	You pay $12.	You pay $5.	You pay $0.
Tier 3 (Preferred Brand)	You pay $45.	You pay $45.	You pay $90.
Tier 4 (Non-Preferred)	You pay $95.	You pay $95.	You pay $190.
Tier 5 (Specialty)	You pay 33% of the cost.	You pay 33% of the cost.	Not Available
Coverage Gap	After your total drug costs (including what our plan has paid and what you have paid) reach $5,030, you will pay no more than 25% coinsurance for generic drugs or 25% coinsurance for brand name drugs.		
Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $8,000, you pay $0.		

Most adult Part D vaccines are covered at no cost to you.

You pay no more than $35 for a one-month supply of each covered insulin, no matter what cost-sharing tier it's on.

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You can view the formulary (drug list) and any formulary restrictions on our website. Your costs for some drugs may be less at pharmacies that offer preferred cost sharing. To view the formulary (drug list) and pharmacy directory, go to BSWHealthPlan.com/Medicare.

We encourage you to let us know right away, if after becoming a member you have questions, concerns, or problems related to your prescription benefits. For assistance, call our Customer Service Department at 1-866-334-3141, 7 a.m. – 8 p.m., October 1 through March 31 from 7 a.m. – 8 p.m., seven days a week (excluding major holidays); and April 1 through September 30 from 7 a.m. – 8 p.m. Monday through Friday (excluding major holidays).

Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at 1-866-334-3141 (TTY: 711), October 1 through March 31 from 7 a.m. – 8 p.m., seven days a week (excluding major holidays); and April 1 through September 30 from 7 a.m. – 8 p.m. Monday through Friday (excluding major holidays).

Understand the Benefits

- ☐ The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit BSWHealthPlan.com/Medicare or call 1-866-334-3141 to view a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ☐ If your plan includes Part D coverage, review the formulary to make sure your drugs are covered.

Understand Important Rules

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments/coinsurance may change on January 1, 2025.
- ☐ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).
- ☐ Effect on Current Coverage. If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage healthcare coverage will end once your new Medicare Advantage coverage starts. If you have Tricare, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact Tricare for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.

Form Approved
OMB# 0938-1421

Multi-Language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-866-334-3141. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-866-334-3141. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-866-334-3141。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-866-334-3141。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-866-334-3141. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-866-334-3141. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-866-334-3141 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-866-334-3141. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

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Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-866-334-3141 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-866-334-3141. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-866-334-3141. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-866-334-3141 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-866-334-3141. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-866-334-3141. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-866-334-3141. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-866-334-3141. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、1-866-334-3141 にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。

Nondiscrimination Notice

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 does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Baylor Scott & 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 Baylor Scott & White Health Plan Compliance Officer at 1-214-820-8888 or send an email to HPCompliance@BSWHealth.org.

If you believe that Baylor Scott & 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:

Baylor Scott & White Health Plan, Compliance Officer

1206 West Campus Drive, Suite 151

Temple, Texas 76502

Compliance HelpLine; 1-888-484-6977 or https://app.mycompliancereport.com/report?cid=swhp

You can file a grievance in person or by mail, online, or email. If you need help filing a grievance, the 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.

Baylor Scott & White Health Plan | BSW SENIORCARE ADVANTAGE • HMO-POS

BSW SeniorCare Advantage HMO-POS is offered by Baylor Scott & White Health Plan, a Medicare Advantage organization with a Medicare contract. Enrollment in BSW SeniorCare Advantage depends on contract renewal with Medicare.

You must continue to pay your Medicare Part B premium.

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