Baylor Scott & White Health Plan

BSW SeniorCare Advantage Platinum (PPO) offered by Baylor Scott & White Insurance Company, a subsidiary of Baylor Scott & White Health Plan

Annual Notice of Changes for 2024

You are currently enrolled as a member of BSW SeniorCare Advantage Platinum (PPO). Next year, there will be changes to the plan's costs and benefits. ***Please see page 4 for a Summary of Important Costs, including Premium.***

This document tells about the changes to your plan. To get more information about costs, benefits, or rules please review the *Evidence of Coverage*, which is located on our website at BSWHealthPlan.com/Medicare. You may also call Customer Service to ask us to mail you an *Evidence of Coverage*.

- **You have from October 15 until December 7 to make changes to your Medicare coverage for next year.**

What to do now

1. ASK: Which changes apply to you

☐ Check the changes to our benefits and costs to see if they affect you.

- Review the changes to Medical care costs (doctor, hospital).
- Review the changes to our drug coverage, including authorization requirements and costs.
- Think about how much you will spend on premiums, deductibles, and cost sharing.

☐ Check the changes in the 2024 "Drug List" to make sure the drugs you currently take are still covered.

☐ Check to see if your primary care doctors, specialists, hospitals, and other providers, including pharmacies will be in our network next year.

☐ Think about whether you are happy with our plan.

2. **COMPARE:** Learn about other plan choices

☐ Check coverage and costs of plans in your area. Use the Medicare Plan Finder at www.medicare.gov/plan-compare website or review the list in the back of your *Medicare & You 2024* handbook.

☐ Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan's website.

3. **CHOOSE:** Decide whether you want to change your plan

- If you don't join another plan by December 7, 2023, you will stay in BSW SeniorCare Advantage Platinum (PPO).
- To change to a **different plan**, you can switch plans between October 15 and December 7. Your new coverage will start on **January 1, 2024.** This will end your enrollment with BSW SeniorCare Advantage Platinum (PPO).
- If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can switch plans or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

Additional Resources

- This document is available for free in Spanish.
- Please contact our Customer Service number at 1-866-334-3141 for additional information. (TTY users should call 711.) Hours are 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). This call is free.
- This information is available in alternate formats (e.g. large print).
- **Coverage under this Plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About BSW SeniorCare Advantage Platinum (PPO)

- BSW SeniorCare Advantage PPO is offered by Baylor Scott & White Insurance Company, a Medicare Advantage organization with a Medicare contract and subsidiary of Baylor Scott & White Health Plan. Enrollment in BSW SeniorCare Advantage depends on contract renewal with Medicare.
- When this document says "we," "us," or "our", it means Baylor Scott & White Health Plan. When it says "plan" or "our plan," it means BSW SeniorCare Advantage Platinum (PPO).

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Summary of Important Costs for 2024

The table below compares the 2023 costs and 2024 costs for BSW SeniorCare Advantage Platinum (PPO) in several important areas. **Please note this is only a summary of costs**.

Cost	2023 (this year)	2024 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 1.1 for details.	$140	$132
Maximum out-of-pocket amounts This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details.)	From network providers: $4,200. From network and out-of-network providers combined: $8,950.	From network providers: $4,600. From network and out-of-network providers combined: $8,950.
Doctor office visits	**In-Network:** Primary care visits: $0 copay per visit. Specialist visits: $20 copay per visit. **Out-of-Network:** Primary care visits: 30% coinsurance per visit. Specialist visits: 30% coinsurance per visit.	**In-Network:** Primary care visits: $0 copay per visit. Specialist visits: $20 copay per visit. **Out-of-Network:** Primary care visits: 30% coinsurance per visit. Specialist visits: 30% coinsurance per visit.

Cost	2023 (this year)	2024 (next year)
Inpatient hospital stays	**In-Network:** **Inpatient Acute Maximum Out-of-Pocket:** $1,250 every stay. **Inpatient Hospital Stay:** Days 1 - 5: $250 copay each day per benefit period. Days 6 - 90: $0 copay each day per benefit period. **Cost per lifetime reserve day:** Days 1 - 6: $250 copay per day for each Medicare-covered hospital stay per benefit period. Days 7 - 60: $250 copayment per day for each Medicare-covered hospital stay per benefit period. **Out-of-Network:** 30% coinsurance.	**In-Network:** **Inpatient Acute Maximum Out-of-Pocket:** $1,250 every stay. **Inpatient Hospital Stay:** Days 1 - 5: $250 copay each day per stay. Days 6 - 90: $0 copay each day per stay. **Cost per lifetime reserve day:** Days 1 - 6: $250 copay per day for each Medicare-covered hospital stay. Days 7 - 60: $250 copayment per day for each Medicare-covered hospital stay. **Out-of-Network:** 30% coinsurance.
Part D prescription drug coverage (See Section 1.5 for details.)	Deductible: $50 (Tiers 3-5) except for covered insulin products and most adult Part D vaccines. Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: $2 at a network pharmacy.	Deductible: $50 (Tiers 3-5) except for covered insulin products and most adult Part D vaccines. Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: $5 at a standard network pharmacy or $0 at a preferred network pharmacy.

Cost	2023 (this year)	2024 (next year)
Part D prescription drug coverage (continued)	• Drug Tier 2: $12 at a network pharmacy.	• Drug Tier 2: $12 at a standard network pharmacy or $5 at a preferred network pharmacy.
	• Drug Tier 3: $45 at a network pharmacy.	• Drug Tier 3: $45 at a standard network pharmacy. You pay $45 at a preferred network pharmacy. You pay $35 per month supply of each covered insulin product on this tier.
	• Drug Tier 4: $95 at a network pharmacy.	• Drug Tier 4: $95 at a standard network pharmacy. You pay $95 at a preferred network pharmacy. You pay $35 per month supply of each covered insulin product on this tier.
	• Drug Tier 5: 32% at a network pharmacy.	• Drug Tier 5: 32% at a standard network pharmacy. You pay 32% at a preferred network pharmacy.

Cost	2023 (this year)	2024 (next year)
Part D prescription drug coverage (continued)	Catastrophic Coverage: • During this payment stage, the plan pays most of the cost for your covered drugs. • For each prescription, you pay whichever of these is larger: a payment equal to 5% of the cost of the drug (this is called **coinsurance**), or a copayment ($4.15 for a generic drug or a drug that is treated like a generic, and $10.35 for all other drugs).	Catastrophic Coverage: • During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2023 (this year)	2024 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$140	$132

- Your monthly plan premium will be *more* if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as creditable coverage) for 63 days or more.
- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.
- Your monthly premium will be *less* if you are receiving "Extra Help" with your prescription drug costs. Please see Section 6 regarding "Extra Help" from Medicare.

Section 1.2 – Changes to Your Maximum Out-of-Pocket Amounts

Cost	2023 (this year)	2024 (next year)
In-network maximum out-of-pocket amount Your costs for covered medical services (such as copays) from network providers count toward your in-network maximum out-of-pocket amount. Your plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$4,200	$4,600 Once you have paid $4,600 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services from network providers for the rest of the calendar year.
Combined maximum out-of-pocket amount Your costs for covered medical services (such as copays) from in-network and out-of-network providers count toward your combined maximum out-of-pocket amount. Your plan premium and costs for outpatient prescription drugs do not count toward your maximum out-of-pocket amount for medical services.	$8,950	$8,950 There is no change for the upcoming benefit year. Once you have paid $8,950 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services from network or out-of-network providers for the rest of the calendar year.

Medicare requires all health plans to limit how much you pay out-of-pocket for the year. These limits are called the maximum out-of-pocket amounts. Once you reach this amount, you generally pay nothing for covered Part A and Part B services for the rest of the year.

Section 1.3 – Changes to the Provider and Pharmacy Networks

Updated directories are located on our website at BSWHealthPlan.com/Medicare. You may also call Customer Service for updated provider and/or pharmacy information or to ask us to mail you a directory, which we will mail within three business days.

There are changes to our network of providers for next year. **Please review the 2024 *Provider Directory* to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network**.

There are changes to our network of pharmacies for next year. **Please review the 2024 *Pharmacy Directory* to see which pharmacies are in our network**.

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers), and pharmacies that are part of your plan during the year. If a mid-year change in our providers affects you, please contact Customer Service so we may assist.

Section 1.4 – Changes to Benefits and Costs for Medical Services

We are making changes to costs and benefits for certain medical services next year. The information below describes these changes.

Cost	2023 (this year)	2024 (next year)
Dental Services		
Preventive Dental	**In- and Out-of-Network**	**In- and Out-of-Network**
Dental X-Rays:	Dental X-rays one every three years.	One full mouth X-ray every 60 months covered at 100%. One bite-wing X-ray every 12 months covered at 100%.
Yearly Benefit Maximum:	$2,500 for all preventive and comprehensive dental services.	$3,500 for all preventive and comprehensive dental services.
Comprehensive Dental Services		
Non-routine Services:	Not offered.	0% - 50% coinsurance for each non-routine service. 0% coinsurance for problem-focused urgent or emergent exam and periapical X-rays (problem-focused X-rays). Other services rendered, such as fillings, endodontic services, and periodontics are covered at 50%. One non-routine service every year.
Diagnostic Services:	One diagnostic service every three years.	Up to eight periapical X-rays per visit.

Cost	2023 (this year)	2024 (next year)
Dental Services (continued)		
Restorative Services:		0% - 50% coinsurance for each restorative service.
	Dentures once every five years.	One set of dentures every five years.
	Crowns not covered.	One crown every year covered at 50%.
Periodontics:	One periodontal surgery every three years.	One periodontal surgery every 36 months.
	One visit every three years.	Periodontal maintenance up to four times every calendar year.
	One scaling and root planing every three years.	One scaling and root planing every 24 months.
Extractions: Unlimited.	50% coinsurance for each extraction.	$0 copay for each extraction service.
Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	Dentures through prosthodontist once every five years.	0% - 50% coinsurance for each prosthodontics and other oral/maxillofacial surgery service.
Benefits for dental services are administered and paid by Metropolitan Life Insurance Company. 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:		One set of dentures through prosthodontist every five calendar years covered 100%. Bridges covered through Prosthodontist once every 10 calendar years covered at 50%.

Cost	2023 (this year)	2024 (next year)
Dental Services (continued) • any other part of the maximum allowed charge for which we do not pay benefits; and • any amount in excess of the maximum allowed charge charged by the out-of-network dentist		
Hearing Services	**In-Network** Over-the-counter hearing aids are not covered as part of the hearing aid benefit. $1,000 allowance toward the purchase of hearing aids every three years.	**In-Network** Over-the-counter hearing aids are covered as a part of the hearing aid benefit. $1,500 allowance toward the purchase of hearing aids every three years.
Inpatient Hospital Care	**In-Network** Inpatient Hospital-Acute benefit is Original Medicare.	**In-Network** Inpatient Hospital-Acute benefit is per admission or per stay.
Inpatient Services in a Psychiatric Hospital	**In-Network** Inpatient Hospital Psychiatric Services benefit is Original Medicare.	**In-Network** Inpatient Hospital Psychiatric Services benefit is per admission or per stay.
Medicare Part B Prescription Drugs	**In-Network** 20% coinsurance for Medicare Part B chemotherapy and radiation drugs.	**In-Network** 0% - 20% coinsurance for Medicare Part B chemotherapy and radiation drugs.

Cost	2023 (this year)	2024 (next year)
Medicare Part B Prescription Drugs (continued)	20% coinsurance for other Medicare Part B drugs.	0% - 20% coinsurance for other Medicare Part B drugs. You pay no more than $35 for a one-month supply of covered insulin when used in an insulin pump.
Outpatient Blood	**In-Network** You pay 20% coinsurance after the third pint of blood.	**In-Network** You pay 20% coinsurance starting with the first pint of blood you need.
Pulmonary rehabilitation	**In-Network** You pay $20 copay for each Medicare-covered pulmonary rehabilitation services visit.	**In-Network** You pay $15 copay for each Medicare-covered pulmonary rehabilitation services visit.
Vision Services	**In- and Out-of-Network** Yearly eyewear maximum benefit: $125.	**In- and Out-of-Network** Yearly eyewear maximum benefit: $150. The Eyewear limit applies to all eyewear types including glasses, frames, lenses, contacts.

Section 1.5 – Changes to Part D Prescription Drug Coverage

Changes to Our "Drug List"

Our list of covered drugs is called a Formulary or "Drug List." A copy of our "Drug List" is provided electronically.

We made changes to our "Drug List," which could include removing or adding drugs, changing the restrictions that apply to our coverage for certain drugs or moving them to a different cost-sharing tier. **Review the "Drug List" to make sure your drugs will be covered next year and to see if there will be any restrictions, or if your drug has been moved to a different cost-sharing tier.**

Most of the changes in the "Drug List" are new for the beginning of each year. However, during the year, we might make other changes that are allowed by Medicare rules. For instance, we can immediately remove drugs considered unsafe by the FDA or withdrawn from the market by a product manufacturer. We update our online "Drug List" to provide the most up to date list of drugs.

If you are affected by a change in drug coverage at the beginning of the year or during the year, please review Chapter 9 of your *Evidence of Coverage* and talk to your doctor to find out your options, such as asking for a temporary supply, applying for an exception and/or working to find a new drug. You can also contact Customer Service for more information.

Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs may not apply to you.** We send you a separate insert, called the *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs* (also called the Low-Income Subsidy Rider or the LIS Rider), which tells you about your drug costs. If you receive "Extra Help" and you haven't received this insert by October 1, please call Customer Service and ask for the LIS Rider.

There are **four drug payment stages**. The information below shows the changes to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage.)

Changes to the Deductible Stage

Stage	2023 (this year)	2024 (next year)
Stage 1: Yearly Deductible Stage During this stage, **you pay the full cost** of your Part D Tier 3, Tier 4, and Tier 5 drugs until you have reached the yearly deductible. The deductible doesn't apply to covered insulin products and most adult Part D vaccines, including shingles, tetanus and travel vaccines.	The deductible is $50. During this stage, you pay $2 cost sharing for drugs on Tier 1: Preferred Generic, $12 cost-sharing for drugs on Tier 2: Generic, and the full cost of drugs on Tier 3: Preferred Brand, Tier 4: Non-Preferred and Tier 5: Specialty until you have reached the yearly deductible.	The deductible is $50. During this stage, you pay $5 for drugs on Tier 1 at a standard network pharmacy and $0 for drugs at a preferred network pharmacy; $12 for drugs on Tier 2 at a standard network pharmacy or $5 for drugs at a preferred network pharmacy. You pay the full cost of drugs on Tier 3, Tier 4, and Tier 5 until you have reached the yearly deductible.

Changes to Your Cost Sharing in the Initial Coverage Stage

Stage	2023 (this year)	2024 (next year)
Stage 2: Initial Coverage Stage Once you pay the yearly deductible, you move to the Initial Coverage Stage. During this stage, the plan pays its share of the cost of your drugs, and **you pay your share of the cost.**	Your cost for a one-month supply at a network pharmacy: **Tier 1: Preferred Generic** *Standard cost sharing:* You pay $2 per prescription. *Preferred cost sharing:* Not offered.	Your cost for a one-month supply at a network pharmacy: **Tier 1: Preferred Generic** *Standard cost sharing:* You pay $5 per prescription. *Preferred cost sharing:* You pay $0 per prescription.

Stage	2023 (this year)	2024 (next year)
Stage 2: Initial Coverage Stage		
For information about the costs for a long-term supply or for mail-order prescriptions, look in Chapter 6, Section 5 of your *Evidence of Coverage*.	**Tier 2: Generic** *Standard cost sharing:* You pay $12 per prescription.	**Tier 2: Generic** *Standard cost sharing:* You pay $12 per prescription.
Most adult Part D vaccines are covered at no cost to you.	*Preferred cost sharing:* Not offered.	*Preferred cost sharing:* You pay $5 per prescription.
We changed the tier for some of the drugs on our "Drug List." To see if your drugs will be in a different tier, look them up on the "Drug List."	**Tier 3: Preferred Brand** *Standard cost sharing:* You pay $45 per prescription.	**Tier 3: Preferred Brand** *Standard cost sharing:* You pay $45 per prescription.
	Preferred cost sharing: Not offered.	*Preferred cost sharing:* You pay $45 per prescription. You pay $35 per month supply of each covered insulin product in this tier.
	Tier 4: Non-Preferred Drug *Standard cost sharing:* You pay $95 per prescription.	**Tier 4: Non-Preferred Drug** *Standard cost sharing:* You pay $95 per prescription.
	Preferred cost sharing: Not offered.	*Preferred cost sharing:* You pay $95 per prescription. You pay $35 per month supply of each covered insulin product in this tier.

Stage	2023 (this year)	2024 (next year)
Stage 2: Initial Coverage Stage (continued)	**Tier 5: Specialty** *Standard cost sharing:* You pay 32% per prescription. *Preferred cost sharing:* Not offered. _____ Once your total drug costs have reached $4,660, you will move to the next stage (the Coverage Gap Stage).	**Tier 5: Specialty** *Standard cost sharing:* You pay 32% per prescription. *Preferred cost sharing:* You pay 32% per prescription. _____ Once your total drug costs have reached $5,030, you will move to the next stage (the Coverage Gap Stage).

Changes to the Coverage Gap and Catastrophic Coverage Stages

The other two drug coverage stages – the Coverage Gap Stage and the Catastrophic Coverage Stage – are for people with high drug costs. **Most members do not reach the Coverage Gap Stage or the Catastrophic Coverage Stage.**

Beginning in 2024, if you reach the Catastrophic Coverage Stage, you pay nothing for covered Part D drugs.

For specific information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in your *Evidence of Coverage*.

SECTION 2 Administrative Changes

Description	2023 (this year)	2024 (next year)
Member ID Number	Member ID number is all numeric (e.g. 10012345678)	Member ID is alpha numeric (e.g. MCR00012345)

Description	2023 (this year)	2024 (next year)
Customer Service Hours	Hours are 7 a.m. – 8 p.m., seven days a week (including major holidays).	Hours are 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).
Premium Grace Period	The premium grace period is four calendar months.	The premium grace period is two calendar months.
Pharmacy Network	One standard pharmacy network.	Two pharmacy networks. Preferred and Standard networks with cost-sharing differences between the Preferred and Standard pharmacy locations.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in BSW SeniorCare Advantage Platinum (PPO)

To stay in our plan, you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically be enrolled in our BSW SeniorCare Advantage Platinum (PPO).

Section 3.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change plans for 2024 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- – *OR*– You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan. If you do not enroll in a

Medicare drug plan, please see Section 1.1 regarding a potential Part D late enrollment penalty.

To learn more about Original Medicare and the different types of Medicare plans, use the Medicare Plan Finder (www.medicare.gov/plan-compare), read the *Medicare & You 2024* handbook, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2). As a reminder, Baylor Scott & White Health Plan (BSW SeniorCare Advantage Platinum (PPO)) offers other Medicare health plans and Medicare prescription drug plans. These other plans may differ in coverage, monthly premiums, and cost-sharing amounts.

Step 2: Change your coverage

- To **change to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from BSW SeniorCare Advantage Platinum (PPO).
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from BSW SeniorCare Advantage Platinum (PPO).
- To **change to Original Medicare without a prescription drug plan,** you must either:
    - Send us a written request to disenroll. Contact Customer Service if you need more information on how to do so.
    - – *OR* – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

SECTION 4 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7.** The change will take effect on January 1, 2024.

Are there other times of the year to make a change?

In certain situations, changes are also allowed at other times of the year. Examples include people with Medicaid, those who get "Extra Help" paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area.

If you enrolled in a Medicare Advantage Plan for January 1, 2024, and don't like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2024.

If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can change your Medicare coverage **at any time**. You can change to any other Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

SECTION 5 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is an independent government program with trained counselors in every state. In Texas, the SHIP is called Texas Health Information Counseling and Advocacy Program (HICAP).

It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. Texas Health Information Counseling and Advocacy Program (HICAP) counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call Texas Health Information Counseling and Advocacy Program (HICAP) at 1-800-252-9240. You can learn more about Texas Health Information Counseling and Advocacy Program (HICAP) by visiting their website (http://www.tdi.texas.gov/consumer/hicap).

SECTION 6 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs. Below we list different kinds of help:

- **"Extra Help" from Medicare.** People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. To see if you qualify, call:
    - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
    - The Social Security Office at 1-800-772-1213 between 8 am and 7 pm, Monday through Friday for a representative. Automated messages are available 24 hours a day. TTY users should call, 1-800-325-0778; or
    - Your State Medicaid Office (applications).
- **Help from your state's pharmaceutical assistance program.** Texas has a program called Texas HIV Medication Program (THMP) that helps people pay for prescription drugs based on their financial need, age, or medical condition. To learn more about the program, check with your State Health Insurance Assistance Program.
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the Texas HIV Medication Program (THMP). For information on eligibility criteria, covered drugs, or how to enroll in the program, please call Texas HIV Medication Program (THMP) at 1-800-255-1090.

SECTION 7 Questions?

Section 7.1 – Getting Help from BSW SeniorCare Advantage Platinum (PPO)

Questions? We're here to help. Please call Customer Service at 1-866-334-3141. (TTY only, call 711.) We are available for phone calls 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). Calls to these numbers are free.

Read your *2024 Evidence of Coverage* (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2024. For details, look in the *2024 Evidence of Coverage* for BSW SeniorCare Advantage Platinum (PPO). The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is located on our website at BSWHealthPlan.com/Medicare. You may also call Customer Service to ask us to mail you an *Evidence of Coverage*.

Visit our Website

You can also visit our website at BSWHealthPlan.com/Medicare. As a reminder, our website has the most up-to-date information about our provider network (*Provider Directory*) and our *List of Covered Drugs* (*Formulary/"Drug List"*).

Section 7.2 – Getting Help from Medicare

To get information directly from Medicare:

Call 1-800-MEDICARE (1-800-633-4227)

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Visit the Medicare Website

Visit the Medicare website (www.medicare.gov). It has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area. To view the information about plans, go to www.medicare.gov/plan-compare.

Read *Medicare & You 2024*

Read the *Medicare & You 2024* handbook. Every fall, this document is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this document, you can get it at the Medicare website (https://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf) or 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.

Form Approved
OMB# 0938-1421

BaylorScott&White Health Plan

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.

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 بمساعدتك. هذه خدمة مجانية . سيقوم شخص ما يتحدث العربية1-866-334-3141فوري، ليس عليك سوى الاتصال بنا على.

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。

Baylor Scott & White Health Plan

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.