BaylorScott&White Health Plan | BaylorScott&White Insurance Company | BaylorScott&White Care Plan

## Effective October 1, 2023:

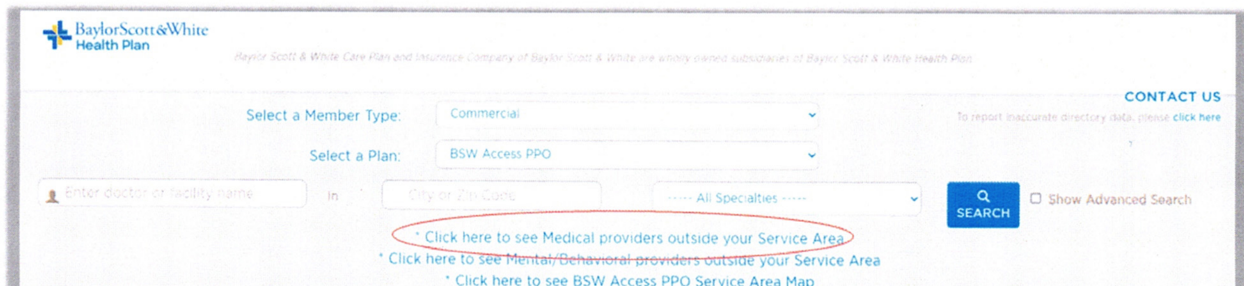
BSW Access PPO NETWORK (UnitedHealthcare) – available to members who live and/or work within the BSWHP 141 county service area.

- Plan Selection has changed to include options for BSW PPO Access Plans.
    - A group can choose up to three plans. Exception: 4 plans are allowed as long as at least one plan option is a BSW PPO Access plan.
    - We encourage the group to select a BSW PPO Access plan at renewal if they anticipate hiring someone outside of the BSWHP 141 county service area throughout the policy year. No additional plans or plan changes will be allowed mid policy year.
    - BSW Access PPO is now available to employees that live and/or work within the BSWHP 141 county service area.
    - BSW Access PPO rates are no longer the same as the BSW PPO rates.
    - Reminder: Employees who live and work outside of the BSWP 141 county service area MUST enroll on a BSW PPO Access plan.
    - *BSW Access PPO plans are still available to members that live and work outside the State of Texas.

*Please refer to Small Group Underwriting Assumptions that is included in your rate packet for eligible states outside of Texas.

## Find a Provider - PPO Access:

- Go to BSWHealthPlan.com/FindProvider
- Click on "Employer Group Networks" tab
- Choose "BSW Access PPO" from the chart
- Start your search!
- To find providers outside the 141-county BSWH service area, click on "Click here to see Medical providers outside your service area." This will route to the UnitedHealthcare provider network.



**BaylorScott&White Health Plan**

| Group Name | HealthGuys Inc. |
|---|---|
| Top Account Number | 05676 |
| Medical Rider | SHG24A17 |
| Waive New Hire During Open Enrollment | ☑ Yes ☐ No |

**Mandatory**

## Group Enrollment HMO Application & Change Form

**PLAN TYPE** Silver HMO 7D 3800

**Consumer Choice Benefit Plans: 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 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.**

| **An enrollee may select an obstetrician or gynecologist as their primary care physician, as set forth in the Texas Insurance Code Chapter 1451, Subchapter F. Enrollee may designate the selection here:** |
|---|
| **Enrollee is not required to select an obstetrician or gynecologist but may instead receive obstetrical or gynecological services from her primary care physician.** |

**SECTION 1: REQUESTED ACTION - Check all the boxes that apply and complete the additional sections that correspond to your selection.**

- Hire date is mandatory on all new enrollees and open enrollment elections.
- Late enrollees are not eligible for coverage until the next open enrollment period. Please refer to your coverage documents.
- Enrollment outside of open enrollment must have a qualifying event and be able to produce required documentation.
- Enrollees terminating coverage may be subject to TIC 843.210.
- To avoid delays, please ensure this application is filled out legibly and completely. Incomplete applications **will not** be processed. You can email your completed application to [HPGROUPENROLLMENT@bswhealth.org]. Please allow 5 business days for processing.

**If declining coverage, complete Section 2 and 6 (If an employee is currently enrolled and does not wish to renew, the action to request is a termination, not a declination.)**

### Enrollment Event – Check ALL boxes that apply.

| | | | | |
|---|---|---|---|---|
| ☐ Open Enrollment<br>☐ New Hire<br>☐ Current Member | Date of Hire<br>__/__/____ | **Qualifying Event?** ☐ Yes ☐ No<br>*Select the appropriate event and enter event date. Effective date subject to SEP guidelines* | | **Termination/Cancellation Date**<br>__/__/____ |
| ☐ Rehire | Date of Rehire<br>__/__/____ | ☐ Birth/Adoption<br>**Proof of Adoption Required** | Date of birth/adoption<br>__/__/____ | ☐ Terminate Contract<br>*(Enrollee and all dependents)*<br>☐ Medical ☐ Dental ☐ Life |
| **Other Changes**<br>☐ Add Dependent(s)<br>☐ Change Plan Option<br>☐ Address Update<br>☐ Date of Birth<br>☐ Name Change<br>☐ COBRA Start Date __/__/____ | | ☐ Marriage<br>**Proof of Marriage Required** | Date of marriage<br>__/__/____ | ☐ Terminate Dependent(s)<br>*Complete Sections 4, 5, and 6* |
| | | ☐ Loss of Coverage<br>**Proof of Loss Required** | Date coverage ended<br>__/__/____ | Reason for Termination<br>☐ Termination of Employment<br>☐ Retirement<br>☐ Termination of Benefits<br>☐ Death: Date __/__/____ |
| | | ☐ Court Order<br>**Court Order or Decree Required** | Date of order<br>__/__/____ | |

**SECTION 2: DECLINATION OF COVERAGE**

Retain the form for your records only. The form does not need to be sent to Scott and White Health Plan d/b/a Baylor Scott & White Health Plan for current groups. Waivers are required for new group submissions. If an employee is currently enrolled and does not wish to renew coverage, the action requested is a termination, not a declination.

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself of your dependents in this plan, provided that you request enrollment within thirty-one (31) days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, placement for adoption, or children who have become the subject of a suit of adoption by the enrollee, you may be able to enroll yourself and your dependents, provided that you request enrollment within thirty-one (31) days after the marriage, birth, adoption, or placement for adoption.

☐ I decline enrollment in Scott and White Health Plan d/b/a Baylor Scott & White Health Plan during my initial eligibility period due to the reason listed below. **(employee) (OR)**

☐ I decline enrollment in Scott and White Health Plan d/b/a Baylor Scott & White Health Plan for my **dependents** during my initial eligibility period due to the reason listed below.

**Reason for Declining Coverage:**

☐ I and/or my dependents are covered under another health plan benefits plan.

☐ Other reason for declining coverage (please specify):

**SECTION 3: OTHER COVERAGE (REQUIRED)**

Will you or your dependents, applying for coverage, be covered under another group health plan or Medicare? ☐ Yes ☐ No (If yes, complete below)

| Insurance Company Name | Name of Policyholder ______<br>Policy number ______<br>Policy number and coverage start date __/__/____ |
|---|---|

**SECTION 4: EMPLOYEE INFORMATION – All information in this section is necessary for accurate and timely processing.**

| | | | | | | |
|---|---|---|---|---|---|---|
| **Coverage Selection**<br>**Medical** ☐ Add ☐ Term ☐ Change ☐ No Change | | | **Dental**<br>☐ Add ☐ Term ☐ Change ☐ No Change | | | **Life**<br>☐ Add ☐ Term |
| * Social Security Number | First Name | | MI | Last Name | | Suffix |
| Mailing Address | | | Apt | City | State | Zip |
| Residential Address (If different than above) | | | Apt | City | State | Zip |
| Primary Phone | | Secondary Phone | Email Address | | | |
| Employment Status<br>☐ Active ☐ Retiree ☐ COBRA ☐ Exempt | | Marital Status<br>☐ Single/Divorced/Widow<br>☐ Married ☐ Other | ☐ Male ☐ Female | | | Date of Birth<br>__/__/____ |
| Primary Spoken Language<br>☐ English ☐ Spanish ☐ Other (please indicate) | | Written Language<br>☐ English ☐ Spanish ☐ Other (please indicate) | | | | |
| Do you have a disability affecting your ability to communicate or read? ☐ Yes ☐ No | | | | | | |

**SECTION 5: DEPENDENT INFORMATION – Complete all applicable information in this section.**

List all family members currently active and action needed. Please complete every field in its entirety to ensure correct processing.

| | | | | |
|---|---|---|---|---|
| **Medical**<br>☐ Add ☐ Term<br>☐ Demographic Change<br>☐ No Change | First Name | MI | Last Name | Suffix |
| | * Social Security Number | ☐ Male ☐ Female | Date of Birth __/__/____ | |
| **Dental**<br>☐ Add ☐ Term<br>☐ Demographic Change<br>☐ No Change | Primary Language<br>Spoken: ☐ English ☐ Spanish ☐ Other __________<br>Written: ☐ English ☐ Spanish ☐ Other __________ | | ☐ Spouse ☐ Domestic Partner* ☐ Child<br>☐ Grand Child<br>☐ Other Eligible Dependent | |
| | Disability affecting your ability to communicate or read? ☐ Yes ☐ No | | | |

| | | | | |
|---|---|---|---|---|
| **Medical**<br>☐ Add ☐ Term<br>☐ Demographic Change<br>☐ No Change | First Name | MI | Last Name | Suffix |
| | * Social Security Number | ☐ Male ☐ Female | Date of Birth __/__/____ | |
| **Dental**<br>☐ Add ☐ Term<br>☐ Demographic Change<br>☐ No Change | Primary Language<br>Spoken: ☐ English ☐ Spanish ☐ Other __________<br>Written: ☐ English ☐ Spanish ☐ Other __________ | | ☐ Spouse ☐ Domestic Partner* ☐ Child<br>☐ Grand Child<br>☐ Other Eligible Dependent | |
| | Disability affecting your ability to communicate or read? ☐ Yes ☐ No | | | |

| | | | | |
|---|---|---|---|---|
| **Medical**<br>☐ Add ☐ Term<br>☐ Demographic Change<br>☐ No Change | First Name | MI | Last Name | Suffix |
| | * Social Security Number | ☐ Male ☐ Female | Date of Birth __/__/____ | |
| **Dental**<br>☐ Add ☐ Term<br>☐ Demographic Change<br>☐ No Change | Primary Language<br>Spoken: ☐ English ☐ Spanish ☐ Other __________<br>Written: ☐ English ☐ Spanish ☐ Other __________ | | ☐ Spouse ☐ Domestic Partner* ☐ Child<br>☐ Grand Child<br>☐ Other Eligible Dependent | |
| | Disability affecting your ability to communicate or read? ☐ Yes ☐ No | | | |

| | | | | |
|---|---|---|---|---|
| **Medical**<br>☐ Add ☐ Term<br>☐ Demographic Change<br>☐ No Change | First Name | MI | Last Name | Suffix |
| | * Social Security Number | ☐ Male ☐ Female | Date of Birth __/__/____ | |
| **Dental**<br>☐ Add ☐ Term<br>☐ Demographic Change<br>☐ No Change | Primary Language<br>Spoken: ☐ English ☐ Spanish ☐ Other __________<br>Written: ☐ English ☐ Spanish ☐ Other __________ | | ☐ Spouse ☐ Domestic Partner* ☐ Child<br>☐ Grand Child<br>☐ Other Eligible Dependent | |
| | Disability affecting your ability to communicate or read? ☐ Yes ☐ No | | | |

| | | | | |
|---|---|---|---|---|
| **Medical**<br>☐ Add ☐ Term<br>☐ Demographic Change<br>☐ No Change | First Name | MI | Last Name | Suffix |
| | * Social Security Number | ☐ Male ☐ Female | Date of Birth __/__/____ | |
| **Dental**<br>☐ Add ☐ Term<br>☐ Demographic Change<br>☐ No Change | Primary Language<br>Spoken: ☐ English ☐ Spanish ☐ Other __________<br>Written: ☐ English ☐ Spanish ☐ Other __________ | | ☐ Spouse ☐ Domestic Partner* ☐ Child<br>☐ Grand Child<br>☐ Other Eligible Dependent | |
| | Disability affecting your ability to communicate or read? ☐ Yes ☐ No | | | |

| SECTION 6: ACKNOWLEDGMENT SIGNATURE | | |
|---|---|---|
| I hereby certify to the best of my knowledge the answers given are correct, truthful, and complete. Further, I hereby authorize my licensed physician, medical practitioner, hospital, clinic or other medically related facility, organization, institution, or person, that has any records or knowledge of me, my family, or our health, to give Scott and White Health Plan d/b/a Baylor Scott & White Health Plan any such information requested. A photographic copy of this authorization shall be valid. I understand that I or my dependents may be covered by another group insurance, and I will cooperate fully with the health plan in providing information necessary to coordinate benefits.<br><br>**[☐ I HAVE READ AND ACCEPT THE BELOW AGREEMENT**<br>I understand that the Evidence of Coverage, Explanation of Benefits, and other required documents, notices, and communications may be mailed or transmitted electronically to me. By checking this box and initialing below, I am consenting to the electronic delivery of these communications. If the box is not selected, I will receive paper communications. Consent may be withdrawn at any time by contacting the Scott and White Health Plan d/b/a Baylor Scott & White Health Plan at [800-321-7947]. If consent is withdrawn, paper documents will be provided during the policy benefit period.<br>__________ Initial] | | |
| Signature | Print Name | Date (MM/DD/YYYY) |

| Send completed application by one of the following methods: | |
|---|---|
| **Email** | [Email: HPGROUPENROLLMENT@bswhealth.org]<br>**[Subject line: Group Name/Group Number/Division]** |
| **Fax** | [Fax 254-298-3199] |
| **Mail** | [Scott and White Health Plan d/b/a Baylor Scott & White Health Plan<br>MS-A4-126<br>1206 West Campus Drive<br>Temple, TX 76502] |