

# SHARP Health Plan

## 2024 Plan Selection Form

### Sharp HealthCare Group Retiree Enrollment

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.

**Note:** For faster processing time, please use your Sharp Health Plan online account to make your plan selection.

Please provide the following information:			
Date: MM/DD/YYYY		Member ID:	
Last Name:	First Name:	Middle Initial:	<input type="checkbox"/> Mr. <input type="checkbox"/> Ms. <input type="checkbox"/> Mrs.
Please check which plan you want to enroll in.			
<b>Sharp Direct Advantage Basic Plan</b> With our Sharp Direct Advantage Basic Plan, dental is not included. You have the option to select either a DHMO or PPO dental plan. Please select one of the options below. <input type="checkbox"/> \$0 monthly premium, Dental not included <input type="checkbox"/> \$13 monthly premium, Delta Dental Medicare Advantage DHMO <input type="checkbox"/> \$50 monthly premium, Delta Dental Medicare Advantage PPO <ul style="list-style-type: none"><li>• Annual out of pocket maximum: \$3,400</li><li>• Primary care physician copay: \$5</li><li>• Specialist copay: \$20</li><li>• Emergency room copay: \$50</li><li>• Inpatient copay: \$125 a day, days 1-5</li><li>• Durable medical equipment: 20% coinsurance</li></ul>			
<b>Sharp Direct Advantage Premium Plan</b> With our Sharp Direct Advantage Premium Plan, dental is not included. You have the option to select either a DHMO or PPO dental plan. Please select one of the options below. <input type="checkbox"/> \$68 monthly premium, Dental not included <input type="checkbox"/> \$81 monthly premium, Delta Dental Medicare Advantage DHMO <input type="checkbox"/> \$118 monthly premium, Delta Dental Medicare Advantage PPO <ul style="list-style-type: none"><li>• Annual out of pocket maximum: \$3,400</li><li>• Primary care physician copay: \$5</li><li>• Specialist copay: \$10</li><li>• Emergency room copay: \$50</li><li>• Inpatient copay: \$50 a day, days 1-6</li><li>• Durable medical equipment: 15% coinsurance</li></ul>			

## Paying 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.

You can pay your monthly plan premium (including any late enrollment penalty you have or may owe) by mail, Electronic Funds Transfer (EFT), or credit card each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board Check each month.

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. 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:

- Get a bill. (If a payment applies, you will be able to pay by check or credit card monthly.)
- Electronic funds transfer (EFT) from your bank account on the 1<sup>st</sup> of each month. If the 1<sup>st</sup> of the month falls on a weekend or bank holiday, your draft will occur on the next banking day. Please enclose a VOIDED check or provide the following:

Account type:  Checking  Savings

Account holder name: \_\_\_\_\_ Bank name: \_\_\_\_\_

Bank routing number: \_\_\_\_\_ Bank account number: \_\_\_\_\_

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  Braille, audio, larger print

**Sign below**

**Signature:**

x

**Today's Date:**

If you are the authorized representative, you must sign above and provide the following information:

Name:

Address:

Relationship to Enrollee:

Phone Number: (     )



**Please mail this form to:**

**Sharp Health Plan**

**Medicare Sales**

**8520 Tech Way, Suite 201**

**San Diego, CA 92123-1450**



**Questions?**

We're here to help. Call us at 1-855-562-8853.