SHARP Health Plan

2025 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 on 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:	☐ Mr. ☐ Ms. ☐ Mrs.

Please check which plan you want to enroll in.

Sharp Direct Advantage Basic Plan

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:

- ☐ **$0 monthly premium, Dental not included**
- ☐ **$13 monthly premium, Delta Dental Medicare Advantage DHMO**
- ☐ **$40 monthly premium, Delta Dental Medicare Advantage PPO**

- Annual out of pocket maximum: $3,400
- Primary care physician copay: $5
- Specialist copay: $20
- Emergency room copay: $50
- Inpatient copay: $125 a day, days 1-5
- Durable medical equipment: 20% coinsurance

Sharp Direct Advantage Premium Plan

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:

- ☐ **$71 monthly premium, Dental not included**
- ☐ **$84 monthly premium, Delta Dental Medicare Advantage DHMO**
- ☐ **$111 monthly premium, Delta Dental Medicare Advantage PPO**

- Annual out of pocket maximum: $3,400
- Primary care physician copay: $5
- Specialist copay: $10
- Emergency room copay: $50
- Inpatient copay: $50 a day, days 1-6
- Durable medical equipment: 15% coinsurance

Pay 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 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:

☐ Get a bill. (If a payment applies, you can pay monthly by check or credit card.)

☐ Electronic funds transfer (EFT) from your bank account on the 1st of each month. If the 1st 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 or 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.