

Benefits-at-a-Glance

Sharp Direct Advantage (HMO)

SDPEBA EGWP HMO NG 1 L

City of San Diego Medicare-eligible Retirees & dependents sponsored by SDPEBA

This information is not a complete description of benefits. Call 1-855-562-8853 (TTY/TDD 711) for more information. The Evidence of Coverage should be consulted for a detailed description of benefits and limitations.

Covered Benefits

Copayments

Sharp Health Plan Monthly Premium

You must have Medicare Part A and be enrolled in Medicare Part B, and continue to pay your Part B premiums.

\$201 per month

Annual Deductible and Out of Pocket Maximum

There are no deductibles for the medical benefits under this plan

\$0

Annual out of pocket maximum¹

\$1,500

Lifetime Maximum

There are no lifetime maximums for this plan

Unlimited

Preventive Care²

Routine adult physical exams, immunizations and related laboratory services

\$0

Laboratory, radiology, and other services for the early detection of disease when ordered by a Physician

\$0

Routine gynecological exams, immunizations and related laboratory services

\$0

Mammography

\$0

Prostate cancer screening

\$0

Colorectal cancer screenings including sigmoidoscopy and colonoscopy

\$0

Professional Services

Primary Care Physician office visit for consultation, treatments, diagnostic testing, etc.

\$10 / visit

Specialist Physician office visit for consultation, treatments, diagnostic testing, etc.

\$10 / visit

Chiropractic care (manipulation of spine to correct subluxation)

\$10 / visit

Laboratory services

\$0

X-rays

\$0

Diagnostic radiology (including but not limited to MRI, MRA, MRS, CT scan, PET, MUGA, SPECT)

\$0

Allergy testing

\$0

Allergy injections

\$0

Outpatient Services (including but not limited to surgical, diagnostic and therapeutic services)

Outpatient surgery

\$50 / visit

Infusion therapy (including but not limited to chemotherapy)

Variable³

Dialysis

\$0

Physical, occupational and speech therapy

\$10 / visit

Therapeutic Radiology (including but not limited to radiation therapy)

Variable³

H5386_2019 Benefits Flyer Basic_M

1-855-562-8853 (TTY 711) 8 a.m. - 6 p.m. Monday through Friday |

sharpmedicareadvantage.com | 08.01.19 - 07.31.20 | SDPEBA EGWP HMO NG 1 L | 20664 |



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| <i>Covered Benefits, continued</i> | <i>Copayments</i> |
|--|---------------------------------------|
| Hospitalization Services | |
| Inpatient services | \$0 |
| Organ transplant | \$0 |
| Inpatient rehabilitation | \$0 |
| Emergency and Urgent Care Services | |
| Emergency room services (waived if admitted to the hospital) | \$50 / visit |
| Ambulance in connection with hospital admission or emergency services | \$0 |
| Urgent care services | \$10 / visit |
| Durable Medical Equipment and Other Supplies | |
| Durable medical equipment | \$0 |
| Diabetic supplies | \$0 |
| Prosthetics and orthotics | \$0 |
| Mental Health Services | |
| Inpatient | \$0 |
| Office visits (group & individual sessions) | \$10 / visit |
| Chemical Dependency Services | |
| Emergency services for acute alcohol or drug detoxification | \$50 / visit |
| Inpatient | \$0 |
| Office visits (group & individual sessions) | \$10 / visit |
| Skilled Nursing, Home Health and Hospice Services | |
| Skilled nursing facility services (maximum of 100 days per benefit period) | \$0 |
| Home health services | \$0 |
| Hospice care - inpatient | \$0 |
| Hospice care - outpatient | \$0 |
| Prescription Drug Coverage | |
| Initial Coverage - 30 day supply: Preferred Generic / Generic / Preferred Brand / Non-Preferred Drugs / Specialty / Select Care | \$10 / \$10 / \$20 / \$20 / 25% / \$0 |
| Initial Coverage - 90 day supply by mail order (for maintenance medications only): Preferred Generic / Generic / Preferred Brand / Non-Preferred Drugs / Select Care | \$20 / \$20 / \$40 / \$40 / \$0 |
| Part D Coverage Gap | No Coverage Gap |

Catastrophic Coverage - After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$5,100

You pay the greater of:
5% of the cost, or \$3.40 copay for generic (including brand drugs treated as generic) and a \$8.50 copay for all other drugs



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Covered Benefits, continued

Copayments

Other

| | |
|--|-----------------------------|
| Chiropractic/Acupuncture services (maximum of 30 visits per benefit year) | \$10 / visit |
| Hearing aids or ear molds allowance | \$1,000 / 36 months |
| Vision Services: Exam copay / Lens copay / Frame allowance / Contact allowance | \$20 / \$20 / \$130 / \$130 |
| Silver & Fit Gym Membership or Silver & Fit At Home Fitness Program | \$0 |

Notes

¹ Only Medical and Hospital care accumulate towards the out-of-pocket maximum. Paying your monthly premiums and cost-sharing for your Part D prescription drugs is still required.

² Includes preventive services with a rating of A or B from the US Preventive Services Task Force; immunizations recommended by the Centers for Disease Control and Prevention; and preventive care and screenings supported by the Health Resources and Services Administration. If preventive care is received at the time of other services, the applicable copayment for such services other than preventive care may apply.

³ Cost-sharing depends on type and location of service

Sharp Health Plan is an HMO with a Medicare contract. Enrollment with Sharp Health Plan depends on contract renewal.

