SHARP HEALTH PLAN

2020 Plan Selection Form

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.

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**
($0 monthly premium, Dental not included)

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

☐ **Sharp Direct Advantage Basic plus Dental**
($12 monthly premium, Dental Advantage by Delta Dental* included)

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

☐ **Sharp Direct Advantage Premium**
($62 monthly premium, Dental not included)

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

☐ **Sharp Direct Advantage Premium plus Dental**
($74 monthly premium, Dental Advantage by Delta Dental* included)

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

* Delta Dental refers to Delta Dental of California.

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 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, larger print

Please Read and Sign Below	
Please contact Sharp Health Plan at 1-855-562-8853 (TTY/TDD users should call 711) if you need information in an accessible format or language other than what is listed on the previous page. Our office hours are from October 1 to March 31: 7 days per week 8:00 a.m. to 8:00 p.m., and from April 1 to September 30: Monday through Friday, 8:00 a.m. to 8:00 p.m. and on weekends and holidays, your call will be handled by our voicemail system.	
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.

Nondiscrimination Notice

Sharp 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. Sharp Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Sharp Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (such as large print, audio, accessible electronic formats, or other 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 Customer Care at 1-800-359-2002.

If you believe that Sharp 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 our Civil Rights Coordinator at:

- Address: Sharp Health Plan Appeal/Grievance Department 8520 Tech Way, Suite 200, San Diego, CA 92123-1450
- Telephone: 1-800-359-2002 (TTY: 711) Fax: (619) 740-8572

You can file a grievance in person or by mail, fax, or you can also complete the online Grievance/Appeal form on the Plan's website sharphealthplan.com. Please call our Customer Care team at 1-800-359-2002 if you need help filing a grievance. 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, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Multi-Language Interpreter Services

English
ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1-800-359-2002 (TTY:711).

Español (Spanish)
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-359-2002 (TTY:711).

繁體中文 (Chinese)
注意 : 如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-359-2002 (TTY:711).。

Tiếng Việt (Vietnamese)
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-359-2002 (TTY:711).

Tagalog (Tagalog – Filipino):
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-359-2002 (TTY:711).

한국어 **(Korean):**
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-359-2002 (TTY:711) 번으로 전화해 주십시오**.**

Հայերեն **(Armenian):**
ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-800-359-2002 (TTY (հեռատիպ)՝ 711).

فارسی **(Farsi):**
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما
فراهم می باشد. با (TTY:711) 1-800-359-2002 تماس بگیرید**.**

Русский (Russian):
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-359-2002 (телетайп: 711).

日本語 **(Japanese):**
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-359-2002 (TTY:711) まで、お電話にてご連絡ください。

العربية **(Arabic):**
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-2002-359-800 (رقم
هاتف الصم والبكم :711).

ਪੰਜਾਬੀ **(Punjabi):**
ਧਿਆਨ ਦਓਿ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਚਿ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-800-359-2002 (TTY:711) 'ਤੇ ਕਾਲ ਕਰੋ।

ខ្មែរ **(Mon Khmer, Cambodian):**
ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-359-2002 (TTY:711)។

Hmoob (Hmong):
LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-359-2002 (TTY:711).

हिंदी **(Hindi):**
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-359-2002 (TTY:711) पर कॉल करें।

ภาษาไทย **(Thai):**
เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-359-2002 (TTY:711).