

Benefits-at-a-Glance

Sharp Direct Advantage Basic (HMO) Former Sharp HealthCare Employees And Dependents

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.	\$0 per month
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Annual Deductible and Out of Pocket Maximum

There are no deductibles for the medical benefits under this plan	\$0
Annual out of pocket maximum ¹	\$3,400

Lifetime Maximum

There are no lifetime maximums for this plan	Unlimited
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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.	\$5 / visit
Specialist Physician office visit for consultation, treatments, diagnostic testing, etc.	\$20 / visit
Chiropractic care (manipulation of spine to correct subluxation)	\$20 / visit
Medicare-covered eye exams (to diagnose and treat diseases and conditions of the eye)	\$20 / visit
Laboratory services	\$5
X-rays	\$5
Diagnostic radiology (including but not limited to MRI, MRA, MRS, CT scan, PET, MUGA, SPECT)	10% coinsurance ³
Allergy testing	\$5
Allergy injections	\$5

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

Outpatient surgery	\$150 / visit
Infusion therapy (including but not limited to chemotherapy)	Variable ⁴
Dialysis	\$0
Physical, occupational and speech therapy	\$20 / visit
Therapeutic radiology (including but not limited to radiation therapy)	10% coinsurance ³

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Covered Benefits, continued

Copayments

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	\$200
Urgent care services	\$25 / visit

Hospitalization Services

Inpatient services	\$125 / day for days 1-5 \$0 / day for days 6+
Organ transplant	\$125 / day for days 1-5 \$0 / day for days 6+
Inpatient rehabilitation	\$125 / day for days 1-5 \$0 / day for days 6+

Durable Medical Equipment and Other Supplies

Durable medical equipment	20% coinsurance ³
Diabetic supplies	20% coinsurance ³
Prosthetics and orthotics	20% coinsurance ³

Mental Health Services

Inpatient	\$125 / day for days 1-5 \$0 / day for days 6+
Office visits (group & individual sessions)	\$5 / visit

Chemical Dependency Services

Emergency services for acute alcohol or drug detoxification	\$50 / visit
Inpatient	\$125 / day for days 1-5 \$0 / day for days 6+
Office visits (group & individual sessions)	\$5 / visit

Skilled Nursing, Home Health and Hospice Services

Skilled nursing facility services (maximum of 100 days per benefit period)	\$0 / day for days 1-20 \$150 / day for days 21-57 \$0 / day for days 58-100
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	\$2 / \$6 / \$40 / \$90 / 33% / \$0
Initial Coverage - 90 day supply by mail order (for maintenance medications only): Preferred Generic / Generic / Preferred Brand / Non-Preferred Drugs / Select Care	\$4 / \$12 / \$80 / \$180 / \$0

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Covered Benefits, continued

Copayments

Prescription Drug Coverage, continued

Part D Coverage Gap - The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches \$4,020	25% of plan's cost for covered brand name drugs / 25% of plan's cost for covered generic drugs until your costs total \$6,350
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Catastrophic Coverage - After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$6,350	You pay the greater of: 5% of the cost, or \$3.60 copay for generic (including brand drugs treated as generic) and a \$8.95 copay for all other drugs
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Other

Chiropractic services (maximum of 30 visits per benefit year)	\$10 / visit
Hearing aids or ear molds allowance	\$1,000 / 36 months
Vision Services: Routine eye exam copay / Lens copay / Frame allowance / Contact allowance	\$20 / \$20 / \$95 / \$105
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 Of contracted rates

⁴ 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.