SHARP HEALTH PLAN

2019-20 Sharp Direct Advantage[SM] Employer Group Enrollment Form

Completing your enrollment is your first step to becoming a Sharp Direct Advantage member. You can enroll by mail, by phone, in person or online. For help completing the enrollment form, or to complete your enrollment over the phone, call us at 1-855-562-8853 (TTY/TDD 711). Or, visit **sharpmedicareadvantage.com/enroll/enroll-online** to enroll online.

This plan is open to all Medicare-eligible City of San Diego retirees, sponsored by San Diego Public Employee Benefit Association (SDPEBA). SDPEBA membership is not required to join this plan. Please contact Sharp Health Plan if you need information in another language or format (Braille).

How to fill out this form

- Answer all questions and print your answers using blue or black ink. Fill in check boxes with an X.
- Sign the form on page 5 and date it. **Be sure you have read all the pages before you sign.**
- Mail or drop off the original, signed form to:
  Sharp Health Plan, Medicare Dept.
  8520 Tech Way, Suite 201
  San Diego, CA 92123

Important Information

- The Medicare application is intended for individual coverage only. If you and your spouse/dependent are both applying for coverage, then each of you will need to complete a separate enrollment form.
- **Note –** If your spouse/dependent is not eligible for Medicare, then he/she will need to complete the Non-Medicare / Early Retiree enrollment form. Please contact SDPEBA at 1-888-315-8027 or visit **sdpeba.org** to download the enrollment form.

City of San Diego Retiree		
Are you the City of San Diego Retiree? ☐ Yes ☐ No		
If you are not, are you the surviving spouse of a City of San Diego Retiree? ☐ Yes ☐ No		
Retiree Last Name:	Retiree First Name:	Retiree Middle Initial:
Are you Medicare eligible? ☐ Yes If yes, complete the enclosed Medicare Enrollment Application. ☐ No If no, complete the Early Retiree Enrollment Application. (1-888-315-8027 / **sdpeba.org**) If yes, are you covering a spouse / dependent? ☐ Yes (If yes, complete section below.) ☐ No		
Spouse / Dependent of City of San Diego Retiree		
Last Name:	First Name:	Middle Initial:
Are you Medicare eligible? ☐ Yes If yes, complete an additional Medicare Enrollment Application. ☐ No If no, complete the Early Retiree Enrollment Application. (1-888-315-8027 / **sdpeba.org**)		

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Office Use Only:

Name of staff member/agent/broker (if assisted in enrollment):__________ CA License #:__________

Plan ID #: 802 Received date:__________ ICEP/IEP: ______ AEP: ______ SEP (type): X Not Eligible: ______

PCP #:__________ Application #:__________

To enroll in Sharp Direct Advantage please provide the following information:				
Effective Date of Coverage: MM/DD/YY (/ 01 /)				
Employer or Union Name: **San Diego Public Employee Benefit Association (SDPEBA)**				
I would like to enroll in the following plan. ☑ Sharp Direct Advantage (HMO) ($201 per month) (81004)	This plan is for Medicare enrolled retirees only. If you are not eligible for Medicare, please contact SDPEBA for the Non-Medicare Enrollment Form at 1-888-315-8027 or visit **sdpeba.org** to download the enrollment form.			
Last Name:	First Name:	Middle Initial:		
Birth Date: MM/DD/YY (/ /)	Sex ☐ M ☐ F	Primary Phone Number: ( )	Cell Phone Number: ( )	
Permanent Residence Street Address (P.O. Box is not allowed):				
City:	County:	State:	ZIP Code:	
Mailing Address (only if different from your Permanent Residence Address):				
City:	State:	ZIP Code:		
Email Address:				
☐ Yes, I'd like to receive health plan news and information via email or text message. (Message & data rates may apply)				

Please provide your Medicare insurance information	
Please take out your red, white and blue Medicare card to complete this section. • Fill out this information as it appears on your Medicare card. - OR - • Attach a copy of your Medicare card, or your letter from Social Security, or the Railroad Retirement Board.	Name (as it appears on your Medicare card): ______________ Medicare Number: ______________ Is Entitled To / Effective Date HOSPITAL (Part A) ______________ MEDICAL (Part B) ______________

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

Mail to: Sharp Health Plan | Medicare Dept.
8520 Tech Way, Suite 201 | San Diego, CA 92123

Please read and answer these important questions:

1. Are you the City of San Diego retiree? ☐ **Yes** ☐ **No**

If yes, retirement date (MM/DD/YY): _____________ If no, name of retiree: ___________________________

2. Are you covering a Medicare-eligible spouse or dependent(s) under this employer or Union plan?

☐ **Yes** ☐ **No** If yes, name of spouse/dependent(s): ____

If you intend to cover a Medicare or Non-Medicare eligible spouse/dependent, then he/she will need to complete a separate enrollment application (Medicare or Early Retiree).

3. Do you or your spouse work? ☐ **Yes** ☐ **No**

4. Do you have End-Stage Renal Disease (ESRD)? ☐ **Yes** ☐ **No**

If you have had a successful kidney transplant and/or you don't need regular dialysis anymore, **please attach a note or records** from your doctor showing you have had a successful kidney transplant or you don't need dialysis, otherwise we may need to contact you to obtain additional information.

5. Some individuals may have other drug coverage, including other private insurance, Worker's Compensation, VA benefits or State pharmaceutical assistance programs.

Will you have other prescription drug coverage in addition to Sharp Direct Advantage? ☐ **Yes** ☐ **No**

If "yes", please list your other coverage and your identification (ID) number(s) for this coverage:

Name of other coverage: ________________________________ ID # for this coverage: ___________________

6. Are you a resident in a long-term care facility, such as a nursing home? ☐ **Yes** ☐ **No**

If "yes," please provide the following information:

Name of institution: ______________________________ Phone number of institution: ___________________

Address of institution (number and street): ____

7. Please choose a Primary Care Physician (PCP): Existing patient: ☐ **Yes** ☐ **No**

PCP Name: ____ PCP Medical Group: _________________________

Need to find a doctor? Visit **sharpmedicareadvantage.com/findadoctor** to use our online search tool.

8. Please check one of the boxes below if you would prefer us to send you future information in a language other than English or in an accessible format:

☐ Spanish ☐ Accessible format (like Braille, audio or large print): _________________________________

9. What is your current health coverage type and insurance company?

Please contact Sharp Health Plan at 1-855-562-8853 if you need information in an accessible format or language other than what is listed above (TTY/TDD users should call 711). Our office hours are Oct. 1 – March 31 from 8 a.m. – 8 p.m. Pacific time, 7 days a week; April 1 – Sept. 30 from 8 a.m. – 8 p.m., Monday through Friday. Calling after hours will direct you to our voicemail system and a Customer Care representative will return your call the next business day.

Sharp Health Plan is an HMO plan with a Medicare contract. Enrollment in Sharp Health Plan depends on contract renewal. You must continue to pay your Part B premium. This information is not a complete description of benefits. Contact the plan for more information. Sharp Health Plan provides the Evidence of Coverage, Formulary and Provider Directory online at **sharpmedicareadvantage.com**. Members can request a paper copy be mailed to them by calling Customer Care at the phone number listed above.

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Exhibit 1a: Information to include on or with Enrollment Mechanism – Attestation of Eligibility for an Enrollment Period

Typically, you may enroll in a Medicare Advantage plan only during the City of San Diego Medicare Retirees' open enrollment period which is in June each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an enrollment period. If we later determine that this information is incorrect, you may be disenrolled.

- ☐ I am a retiree or spouse/domestic partner/dependent of a retiree of the City of San Diego enrolling during open enrollment (June 3 - June 28, 2019).
- ☐ I am new to Medicare.
- ☐ I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on (insert date) ___________________.
- ☐ I recently was released from incarceration. I was released on (insert date) ___________________.
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) ___________________.
- ☐ I recently obtained lawful presence status in the United States. I got this status on (insert date) ___________________.
- ☐ I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
- ☐ I get extra help paying for Medicare prescription drug coverage.
- ☐ I no longer qualify for extra help paying for my Medicare prescription drugs. I stopped receiving extra help on (insert date) ___________________.
- ☐ I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long-term-care facility). I moved/will move into/out of the facility on (insert date) ___________________.
- ☐ I recently left a PACE program on (insert date) ___________________.
- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date) ___________________.
- ☐ I am leaving employer or union coverage on (insert date) ___________________.
- ☐ I belong to a pharmacy assistance program provided by my state.
- ☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- ☐ I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date) ___________________.

If none of these statements apply to you or you're not sure, please contact Sharp Health Plan at 1-855-562-8853 (TTY / TDD users should call 711) to see if you are eligible to enroll. Our office hours are Oct. 1 – March 31 from 8 a.m. – 8 p.m. Pacific time, 7 days a week; April 1 – Sept. 30 from 8 a.m. – 8 p.m., Monday through Friday. Calling after hours will direct you to our voicemail system and a Customer Care representative will return your call the next business day.

Please Read and Sign Below

By completing this enrollment application, I agree to the following:

Sharp Direct Advantage is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. I can be in one Medicare Advantage plan at a time, and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan. It is my responsibility to inform the plan of any prescription drug coverage that I have or may get in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year if an enrollment period is available (Example: Annual Enrollment Period), or under certain special circumstances.

Sharp Direct Advantage serves a specific service area. If I move out of the area that Sharp Direct Advantage serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of Sharp Direct Advantage, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Sharp Direct Advantage when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date Sharp Direct Advantage coverage begins, I must get all of my health care from Sharp Direct Advantage, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Sharp Direct Advantage and other services contained in my Sharp Direct Advantage Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR Sharp Direct Advantage WILL PAY FOR THE SERVICES.**

I understand that if I am getting assistance from a sales agent, broker or other individual employed by or contracted with Sharp Direct Advantage, he/she may be paid based on my enrollment in Sharp Direct Advantage.

Release of Information: By joining this Medicare health plan, I acknowledge that Sharp Direct Advantage will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Sharp Direct Advantage will release my information including my prescription drug event data to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request from Medicare.

Signature: **x**	**Today's Date:**

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

Name:	Relationship to Enrollee:
Address:	Phone Number: ( )

Mail to: Sharp Health Plan | Medicare Dept.
8520 Tech Way, Suite 201 | San Diego, CA 92123

Next steps
• We'll review your form to ensure it's complete. Then we'll let you know by mail that we've received it. • We'll let Medicare know that you've applied for Sharp Direct Advantage. • Within 10 calendar days after Medicare confirms you're eligible, we'll let you know when your coverage starts. Then we'll send your Sharp Direct Advantage ID card and information for new members.

Non-discrimination 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 1-855-562-8853

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: 1-855-562-8853 (TTY / TDD: 711)
  Fax: 1-619-740-8572

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 1-855-562-8853 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**.

Language Assistance 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 1-800-359-2002 (رقم هاتف الصم والبكم: 711).

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

ខ្មែរ (Mon Khmer, Cambodian):
ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា 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).

Mail to: Sharp Health Plan | Medicare Dept.
8520 Tech Way, Suite 201 | San Diego, CA 92123