

Benefits-at-a-Glance

Sharp Direct Advantage Extra (HMO)

This information is not a complete description of benefits. Call 1-833-346-4322 (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.

See EOC insert for monthly plan premium

Annual Deductible and Out of Pocket Maximum

There are no deductibles for the medical benefits and pharmacy coverage under this plan	\$0
Annual out of pocket maximum ^{1,2}	\$1,500

Lifetime Maximum

There are no lifetime maximums for this plan	Unlimited
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Preventive Care³

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, treatment, diagnostic testing, etc.	\$5 / visit
Specialist Physician office visit for consultation, treatment, diagnostic testing, etc.	\$10 / visit
Acupuncture services (Medicare-covered) for chronic low back pain	
Professional services provided by a Physician	\$10 / visit
Professional services provided by a non-Physician or Specialist	\$10 / visit
Chiropractic care (Medicare-covered) for manipulation of spine to correct subluxation	\$10 / visit
Eye exams (Medicare-covered) to diagnose and treat diseases and conditions of the eye	\$0
Hearing exams (Medicare-covered) to diagnose and treat hearing and balance issues	\$0
Laboratory tests and services	\$0
X-Rays	\$0
Diagnostic radiology (including but not limited to MRI, MRA, MRS, CT scan, PET, MUGA, SPECT)	\$20 / procedure
Allergy testing	\$0
Allergy injections	\$0

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

Outpatient surgery	\$25 / visit
Home Infusion therapy (including but not limited to chemotherapy)	
Drugs, equipment and supplies	10% coinsurance
Professional services provided by a specialist	\$10
Professional services provided at the home	\$0
Dialysis	10% coinsurance
Rehabilitation services: physical, occupational and speech therapy	\$10 / visit (PT/SP) \$30 / visit (OT)
Therapeutic Radiology (including but not limited to radiation therapy)	\$60 / procedure

Hospitalization (including but not limited to inpatient services, organ transplant, and inpatient rehabilitation)

Inpatient facility	\$50 / admission
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Emergency and Urgent Care Services

Emergency room facility fee (waived if admitted to the hospital)	\$50 / visit
Ambulance in connection with hospital admission or emergency services	\$50
Urgent care services	\$10 / visit

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Covered Benefits

Copayments

Durable Medical Equipment and Other Supplies	
Durable medical equipment	10% coinsurance
Diabetic supplies	\$0
Prosthetics and orthotics	10% coinsurance
Mental Health Services	
Inpatient facility	\$50 / admission
Office visits (group & individual sessions)	\$5 / visit
Substance Use Disorder Services	
Emergency services for acute alcohol or drug detoxification	\$50 / visit
Inpatient facility	\$50 / admission
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
	\$0 / day for days 21-41
	\$0 / day for days 42-100
Home health services	\$0
Hospice care - inpatient	\$0
Hospice care - outpatient	\$0
Prescription Drug Coverage ⁶	
Initial Coverage - 30 day supply: Preferred Generic / Generic / Preferred Brand / Non-Preferred Drugs / Specialty / Select Care	\$2 / \$8 / \$40 / \$95 / 33% / \$0
Initial Coverage - 90 day supply by mail order (for maintenance medications only): Preferred Generic / Generic / Preferred Brand / Non-Preferred Drugs / Select Care	\$0 / \$0 / \$80 / \$190 / \$0
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 \$4,430	25% of plan's cost for covered brand name drugs / 25% of plan's cost for covered generic drugs until your costs total \$7,050
Catastrophic Coverage - After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$7,050	You pay the greater of: 5% of the cost, or \$3.95 copay for generic (including brand drugs treated as generic) and a \$9.85 copay for all other drugs
Other ²	
Acupuncture/Chiropractic services (maximum of 30 combined visits per benefit year)	\$10 / visit
Hearing aids or ear molds allowance	\$3,500 / 36 months
Silver & Fit Gym Membership or Silver & Fit At Home Fitness Program	\$0
Vision Services: Routine eye exam copay / Lens copay / Frame or Contact allowance	\$0 / \$20 / \$400

Notes

¹Only Medicare covered services (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.

²Copayments for mandatory supplemental benefits (Acupuncture, Chiropractic Services, Hearing, Silver & Fit, and Vision) do not apply to the annual out-of-pocket maximum.

³Includes 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.

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