2021

Summary of Benefits

H1748001 (HMO)
Sonder Complete Health Medicare Advantage

Our service area includes the following counties in Georgia: Cobb, Dekalb, Fulton and Gwinnett.

Sonder Health Plans, Inc. is an HMO with a Medicare contract. Enrollment in Sonder Health Plans, Inc. depends on contract renewal.

H1748_SB_MAPD_HMO001_21__M

Selected Benefits	Enrollee Details
Monthly Plan Premium	$0
Health plan deductible	$0
Other health plan deductibles?	No
Maximum out-of-pocket enrollee responsibility *(does not include prescription drugs)*	$5,900 In-network
Choice of Doctors?	Plan Doctors for Most Services
Optional supplemental benefits?	No
Prescription Drugs Covered?	Yes
Additional benefits and/or reduced cost-sharing for enrollees with certain health conditions?	No

Health and Medical Benefits		Authorization	Referral
Selected Benefits	**Cost Share Information**		
Inpatient hospital coverage	$295 per day for days 1 through 6 $0 per day for days 7 through 90	Yes	No
Outpatient hospital coverage	$275 copay per visit	No	No
Doctor visits	Primary $0 copay	N/A	N/A
	Specialist $25 copay per visit	No	Yes
Preventive care	$0 copay	No	Yes
Emergency care/urgent care	Emergency $90 copay per visit (always covered)	N/A	N/A
	Urgent care$40 copay per visit (always covered)	N/A	N/A
Diagnostic procedures/lab services/imaging	Diagnostic tests and procedures $0-55 copay	No	Yes

	Lab services $0 copay	No	Yes
	Diagnostic radiology services *(e.g., MRI)* $25-290 copay	No	Yes
	Outpatient x-rays $60 copay	No	Yes
Hearing	Hearing exam $40 copay	No	Yes
	Fitting/evaluation Not covered	N/A	N/A
	Hearing aids $849 copay	No	Yes
Preventive dental	Oral exam $0 copay There may be limits on how much the plan will provide.	No	Yes
	Cleaning $0 copay	No	Yes

	There may be limits on how much the plan will provide.		
	Fluoride treatment $0 copay There may be limits on how much the plan will provide.	No	Yes
	Dental x-ray(s) $0 copay There may be limits on how much the plan will provide.	No	Yes
Comprehensive dental	Non-routine services Not covered	N/A	N/A
	Diagnostic services Not covered	N/A	N/A
	Restorative services Not covered	N/A	N/A

	Endodontics Not covered	N/A	N/A
	PeriodonticsNot covered	N/A	N/A
	Extractions Not covered	N/A	N/A
	Prosthodontics, other oral/maxillofacial surgery, other services Not covered	N/A	N/A

Vision	Routine eye exam $0 copay There may be limits on how much the plan will provide.	No	Yes
	Other Not covered	N/A	N/A
	Contact lenses $0 copay There may be limits on how much the plan will provide.	No	Yes
	Eyeglasses (frames and lenses) $0 copay There may be limits on how much the plan will provide.	No	Yes
	Eyeglass frames Not covered	N/A	N/A
	Eyeglass lenses Not covered	N/A	N/A

	Upgrades Not covered	N/A	N/A
Mental health services	Inpatient hospital - psychiatric $295 per day for days 1 through 5 $0 per day for days 6 through 90	Yes	No
	Outpatient group therapy visit with a psychiatrist $40 copay	No	Yes
	Outpatient individual therapy visit with a psychiatrist $40 copay	No	Yes
	Outpatient group therapy visit $40 copay	No	Yes
	Outpatient individual therapy visit $40 copay	No	Yes
Skilled Nursing Facility	$0 per day for days 1 through 20 $184 per day for days 21 through 100	Yes	No
Rehabilitation services	Occupational therapy visit $40 copay	No	Yes

	Physical therapy and speech and language therapy visit $40 copay	No	Yes
Ground Ambulance	$225 copay	N/A	N/A
Transportation	$0 copay There may be limits on how much the plan will provide.	No	Yes
Foot care *(podiatry services)*	Foot exams and treatment $30 copay	No	Yes
	Routine foot care Not covered	N/A	N/A
Medical equipment/supplies	Durable medical equipment *(e.g., wheelchairs, oxygen)* 20% coinsurance per item	Yes	N/A
	Prosthetics *(e.g., braces, artificial limbs)* 20% coinsurance per item	No	N/A
	Diabetes supplies $0 copay	No	N/A
Wellness programs *(e.g., fitness, nursing hotline)*	Covered	No	Yes
Medicare Part B drugs	Chemotherapy 20% coinsurance	No	N/A
	Other Part B drugs 20% coinsurance	No	N/A

Outpatient Prescription Drugs	
Drug Coverage Information	
Monthly Premium	$0.00
Deductible	$0.00
Formulary Website	www.sonderhealthplans.com

Initial Coverage Phase (After you pay your deductible, if applicable, up to the initial coverage limit of $4,130)			
Tier	**Standard Retail**		**Standard Mail Order**
	1 Month	**3 Month**	**3 Month**
1 (Preferred Generic)	$0.00 copay	$0.00 copay	$0.00 copay
2 (Generic)	$10.00 copay	$30.00 copay	$30.00 copay
3 (Preferred Brand)	$44.00 copay	$132.00 copay	$132.00 copay
4 (Non-Preferred Drug)	$95.00 copay	$285.00 copay	$285.00 copay
5 (Specialty Tier)	33%	33%	33%

Gap Coverage Phase (After the total drug costs paid by you and the plan reach $4,130, up to the out-of-pocket threshold of $6,550)			
Tier	**Standard Retail**		**Standard Mail Order**
	1 Month	**3 Month**	**3 Month**
1 (Preferred Generic)	$0.00 copay	$0.00 copay	$0.00 copay
For all other drugs, you pay 25% for generic drugs and 25% for brand-name drugs.			

Catastrophic Coverage Phase (When your annual out-of-pocket costs exceed $6,550)	
Generic drugs	$3.70 copay or 5% (whichever costs more)
Brand-name drugs	$9.20 copay or 5% (whichever costs more)