

MEMBER GRIEVANCE SUBMITTAL FORM



The health care you receive and your experience with Sonder Health Plans is important to us. If you have a complaint related to our Plan or any aspect of the care you have received, we want to know about it. You can use this form to tell us about your issue and to let us know how we can help.

Complaints should be filed with the Plan no later than 60 days from the date of the event/issue.

To submit a complaint to Sonder Health Plans, please complete this form and submit it to us, along with any supporting documents (such as medical records, medical bills, a copy of your Explanation of Benefits, or a letter from your doctor). You can submit them by mail or fax at the below.

Mail to:

Sonder Health Plans
ATTN: Grievance & Appeals Department
6190 Powers Ferry Road, Suite 320
Atlanta, GA 30339

Fax to:

(941) 866-2319

If you have any questions or need assistance with this form, please call the Grievance and Appeals Department directly at (888) 428-2110, Option 2; TTY 711, Monday-Friday from 8 a.m. - 5 p.m.

Member Information

Name (first and last): _____

Member Date of Birth: _____ Member Sonder Plan ID: _____

Street Address: _____

City: _____ Zip: _____ Phone: _____

If you are not the Member and are submitting this grievance on behalf of the Member, please submit a completed Appointment of Representative (AOR) Form, which can be located on our website, under the How to Appoint a Representative tab, at: <https://sonderhealthplans.com/for-members/member-resources/find-a-document-or-form/>. You can also request the AOR form from Member Services at (888) 428-4440. The AOR Form must be completed, signed by the Member, and dated within a year to be valid. If you are already legally authorized to represent the Member, please attach the documentation (such as power of attorney or health care proxy) for our review. Providers are not required to complete an AOR Form.

Issue Type

Type(s) of Complaint (select as applicable):

- | | | |
|---|---|--|
| <input type="checkbox"/> Issues with Care Received | <input type="checkbox"/> Telephone Hold Times | <input type="checkbox"/> Transportation Issues |
| <input type="checkbox"/> Referral/Authorization Delay | <input type="checkbox"/> Office Wait Times | <input type="checkbox"/> Translation Accessibility |
| <input type="checkbox"/> Denial of an Authorization | <input type="checkbox"/> Appointment Availability | <input type="checkbox"/> Member Documents |
| <input type="checkbox"/> Denial of a Payment | <input type="checkbox"/> Provider Network | <input type="checkbox"/> Other: _____ |

Issue Information

Date(s) of Service/Event/Issue: _____

Please provide a detailed summary of what happened. Include any dates and times, as well as any names of individuals (such as our employees, physician(s) and/or their staff, pharmacies, and other vendors or suppliers) involved. You may add additional pages if you need more space to include all the event details:

Additional Information (complete as applicable)

Is this related to a Medical Service or Device? ☐ Yes ☐ No

Is this related to a Medication? ☐ Yes ☐ No

Authorization or Claim number (if applicable): _____

Physician/Prescriber (if applicable): _____

Supporting Documentation Attached

What attachments (if any) are you including with this completed form:

- | | | |
|--|--|---------------------------------------|
| <input type="checkbox"/> Explanation of Benefits | <input type="checkbox"/> Bill Received | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Letter from your doctor | <input type="checkbox"/> Medical Record(s) | |
| <input type="checkbox"/> AOR Form | | |

How long will Sonder Health Plans take to process your grievance?

Sonder Health Plans will process grievances as quickly as possible and based on the Members health status, but no later than 30 days from the receipt of the request, or within 24 hours for expedited grievances.

Note: Sonder Health Plans may take a 14-day extension if the Member requests the extension, or if the Plan needs additional information and feels the delay is in the best interest of the Member. If Sonder Health Plans takes an extension, we will notify the Member in writing of the extension and explain the reason for the delay.

Do you need an expedited grievance?

Select if applicable:

- ☐ Yes, because I believe that I need to receive a decision within 24 hours.
- ☐ Yes, because I have included a letter from my physician stating that he/she feels this issue needs to be expedited.
- ☐ Yes, because this grievance is related to a decision not to grant me an expedited decision on an authorization for a medical service or device.
- ☐ Yes, because this grievance is related to a decision not to grant me an expedited decision on an authorization for a medication or drug that I have not yet received.
- ☐ Yes, because this grievance is related to the Plan's notification that they are extending the timeframe to make a decision on a request for an authorization or appeal for medical services or a medical device.

Submitter Information & Signature

Select Submitter Type:

- ☐ I am the **Member** related to this complaint
- ☐ I am the **Member's Representative**

Submitter Name (Print first and last): _____

Submitter Signature: _____ Date: _____

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

IMPORTANT MEMBER INFORMATION

Discrimination is against the law. Sonder Health Plans, Inc. does not and shall not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender, gender identity, ancestry, marital status, or religion. Sonder Health Plans complies with applicable Federal Civil Rights laws. If you believe that you have been discriminated against by Sonder Health Plans, there are ways to get help.

You may file a complaint, also known as a grievance, with us at:

Sonder Health Plans
ATTN: Grievance & Appeals Department
6190 Powers Ferry Road, Suite 320
Atlanta, GA 30339

If you need help filing a grievance, call Sonder Member Services department at 1 (888) 428-4440, TTY 711. We are open 8 a.m. to 8 p.m. seven days a week from October 1st to March 31st, and 8 a.m. to 8 p.m. Monday-Friday from April 1st to September 30th. You may also leave a voicemail after hours, Saturdays, Sundays, and holidays and we will return your call within one business day.

Additionally, you have the right to file a civil rights complaint with the U.S. Department of Health and Human Services (HHS), Office for Civil Rights (OCR), electronically through the OCR Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/smartscreen/main.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 (TDD 1-800-537-7697). Complaint forms are also made available at <https://www.hhs.gov/ocr/complaints/index.html>.

Sonder Health Plans provides auxiliary aids and services, free of charge, such as qualified sign language interpreters and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate, contact 1-888-428-4440 (TTY: 711) for assistance.

Multi-Language Insert**Multi-language Interpreter Services**

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-888-428-4440. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-888-428-4440. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-888-428-4440。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-888-428-4440。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-888-428-4440. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-888-428-4440. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quý vị cần thông dịch viên xin gọi 1-888-428-4440 sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-888-428-4440. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-888-428-4440 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-888-428-4440. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-8884284440. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-888-428-4440 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-888-428-4440. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-888-428-4440. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-888-428-4440. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-888-428-4440. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがあります。通訳をご用命になるには、1-888-428-4440 にお電話ください。日本語を話す人 者が支援いたします。これは無料のサービスです。