2024 Summary of Benefits

Medicare Advantage Plans with Part D Prescription Drug Coverage

Sonder Tiers Medicare Advantage (HMO)

January 1, 2024 – December 31, 2024

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1 SECTION I - INTRODUCTION TO SUMMARY OF BENEFITS

The benefit information provided is a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call us and ask for the "Evidence of Coverage." You can also see the Evidence of Coverage on our website, www.sonderhealthplans.com.

You have choices about how to get your Medicare benefits

- One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government.
- Another choice is to get your Medicare benefits by joining a Medicare health plan (such as **Sonder Tiers Medicare Advantage (HMO)**).

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **Sonder Tiers Medicare Advantage (HMO)** covers and what you pay.

- If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on www.medicare.gov.
- If you want to know more about the coverage and costs of Original Medicare, look in your current **"Medicare & You"** handbook. View it online at www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Sections in this booklet

- Things to Know About **Sonder Tiers Medicare Advantage (HMO).**
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services.
- Covered Medical and Hospital Benefits.
- Prescription Drug Benefits.

This document is available in other formats such as Braille and large print.

This document may be available in a non-English language. For additional information, call us at 1-888-428-4440 (TTY: 711).

Things to Know About Sonder Tiers Medicare Advantage (HMO)

Hours of Operation & Contact Information

- From October 1 to March 31, we're open 8 a.m. – 8 p.m., 7 days a week.
- From April 1 to September 30, we're open 8 a.m. – 8 p.m., Monday through Friday.
- If you are a member of this plan, call us at 1-888-428-4440, TTY: 711.
- If you are not a member of this plan, call us at 1-888-428-4440, TTY: 711.
- Our website: www.sonderhealthplans.com.

Who can join?

To join **Sonder Tiers Medicare Advantage (HMO)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and you must live in our service area. Our service area includes these counties in Georgia: Cherokee, Clayton, Cobb, Coweta, DeKalb, Douglas, Fayette, Fulton, Gwinnett, Henry, Paulding and Rockdale.

Which doctors, hospitals, and pharmacies can I use?

Sonder Tiers Medicare Advantage (HMO) has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, the plan may not pay for these services.

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.

You can see our plan's provider and pharmacy directory at our website (http://www.sonderhealthplans.com).

Or, call us and we will send you a copy of the provider and pharmacy directories.

What do we cover?

Like all Medicare health plans, we cover everything that Original Medicare covers – and *more*. Some of the extra benefits are outlined in this booklet.

We cover Part D drugs. In addition, we cover Part B drugs including chemotherapy and some drugs administered by your provider.

- You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, http://www.sonderhealthplans.com.
- Or, call us and we will send you a copy of the formulary.

How will I determine my drug costs?

Our plan groups each medication into one of five "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the benefit stages that occur: Initial Coverage, Coverage Gap and Catastrophic Coverage.

If you have any questions about this plan's benefits or costs, please contact Sonder Health Plans, Inc.

2 SECTION II - SUMMARY OF BENEFITS

Sonder Tiers Medicare Advantage (HMO)

MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES	
Monthly Plan Premium	You do not pay a separate monthly plan premium for Sonder Tiers Medicare Advantage (HMO). You must continue to pay your Medicare Part B premium.
Deductible	Medical Deductible: $0 Deductible. Prescription Drug Deductible: $0 Deductible.
Maximum Out-of-Pocket Responsibility	Your yearly limit(s) in this plan: • $6,700 for services you receive from in-network providers. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.
COVERED MEDICAL AND HOSPITAL BENEFITS	
Inpatient Hospital	**In-Network:** Days 1-5: $350 Copay per day for each admission. Days 6-90: $0 Copay per day. Our plan covers an unlimited number of days for an inpatient hospital stay. May require prior authorization.
Outpatient Hospital	**In-Network:** Outpatient hospital: $250 Copay. Outpatient Surgery: $250 Copay. May require prior authorization. May require a referral from your doctor.
Ambulatory Surgical Center	**In-Network:** Ambulatory Surgical Center: $150 Copay. May require prior authorization. May require a referral from your doctor.

Doctor's Office Visits	**<u>In-Network:</u>** Primary care physician visit: $0 Copay. Specialist visit: $0 Copay.
Preventive Care *(e.g., flu vaccine, diabetic screenings)*	**<u>In-Network:</u>** $0 Copay for all preventive services covered under Original Medicare at zero cost sharing. Any additional preventive services approved by Medicare during the contract year will be covered.
Emergency Care	**<u>In-Network:</u>** $100 Copay per visit. Worldwide Emergency Coverage: $0 copay, $10,000 maximum allowable for all worldwide urgent/emergency services.
Urgently Needed Services	**<u>In-Network:</u>** $30 Copay per visit. Worldwide Urgent Coverage: $0 copay, $10,000 maximum allowable for all worldwide urgent/emergency services.
Diagnostic Services / Labs/ Imaging	**<u>In-Network:</u>** Diagnostic tests and procedures: $0 - $100 Copay. Lab services: $0 Copay. Diagnostic Radiology Services (such as MRI, CAT Scan): $150 Copay - $300 Copay X-rays: $0 - $100 Copay. Therapeutic radiology services (such as radiation treatment for cancer): 20% Coinsurance. May require a referral from your doctor.
Hearing Services	**<u>In-Network:</u>** Exam to diagnose and treat hearing and balance issues: $40 Copay. Routine hearing exam: $0 Copay. You have an option for additional hearing benefits available in the **Additional Allowance for Supplemental Benefits** section.

Dental Services	**<u>In-Network:</u>** Preventive dental services: • Oral exam (up to 1 visit(s) every six months): $0 Copay. • Cleaning (up to 1 visit(s) every six months): $0 Copay. • Fluoride treatment (up to 1 visit(s) every six months): $0 Copay. • Dental X-rays (up to 1 visit(s) every two years): $0 Copay. Comprehensive: • Medicare Covered Only: $40 Copay. You have an option for additional dental benefits available in the **Additional Allowance for Supplemental Benefits** section.
Vision Services	**<u>In-Network:</u>** Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): Routine eye exam (up to 1 visit(s) every year): $0 Copay. Eyeglasses or contact lenses after cataract surgery: $40 Copay. You have an option for additional vision benefits available in the **Additional Allowance for Supplemental Benefits** section.
Mental Health Care	**<u>In-Network:</u>** Outpatient group therapy visit: Individual therapy visit: $40 Copay. Inpatient Mental Health Care: Days 1-5: $350 Copay per day for each admission. Days 6-90: $0 Copay per day.
Skilled Nursing Facility (SNF)	**<u>In-Network:</u>** Days 1-20: $0 Copay per day. Days 21-100: $203 Copay per day.
Outpatient Rehabilitation	**<u>In-Network:</u>** Occupational therapy visit: $25 Copay. Physical therapy and speech and language therapy visit: $25 Copay.

<table>
<tr><td></td><td>May require prior authorization.
May require a referral from your doctor.</td></tr>
<tr><td>Ambulance</td><td><u>In-Network:</u>
Ground Ambulance: $400 Copay.
Air Ambulance: $500 Copay.</td></tr>
<tr><td>Medicare Part B Drugs</td><td><u>In-Network:</u>
For Part B drugs such as chemotherapy drugs: 20% Coinsurance
Other Part B drugs: $35 for Insulin
May require prior authorization.</td></tr>
<tr><td colspan="2">PRESCRIPTION DRUG BENEFITS</td></tr>
<tr><td>Deductible</td><td>Prescription Drug Deductible: $0 Copay.</td></tr>
<tr><td>Initial Coverage</td><td>You pay the following until your total yearly drug costs reach $5,030. Total yearly drug costs are the drug costs paid by both you and our Part D plan.
<table>
<tr><th colspan="4">Standard Retail Cost-Sharing</th></tr>
<tr><th>Tier</th><th>One-month supply</th><th>Two-month supply</th><th>Three-month supply</th></tr>
<tr><td>Tier 1 (Preferred Generic)</td><td>$0 Copay</td><td>Not Applicable</td><td>$0 Copay</td></tr>
<tr><td>Tier 2 (Generic)</td><td>$10 copay</td><td>Not Applicable</td><td>$30 copay</td></tr>
<tr><td>Tier 3 (Preferred Brand)</td><td>$44 copay</td><td>Not Applicable</td><td>$132 copay</td></tr>
<tr><td>Tier 4 (Non-Preferred Drug)</td><td>$95 copay</td><td>Not Applicable</td><td>$285 copay</td></tr>
<tr><td>Tier 5 (Specialty Tier)</td><td>33% coinsurance</td><td>Not Applicable</td><td>33% coinsurance</td></tr>
</table></td></tr>
</table>

Preferred Retail Cost-Sharing			
Tier	**One-month supply**	**Two-month supply**	**Three-month supply**
Tier 1 (Preferred Generic)	Not Applicable	Not Applicable	Not Applicable
Tier 2 (Generic)	Not Applicable	Not Applicable	Not Applicable
Tier 3 (Preferred Brand)	Not Applicable	Not Applicable	Not Applicable
Tier 4 (Non-Preferred Drug)	Not Applicable	Not Applicable	Not Applicable
Tier 5 (Specialty Tier)	Not Applicable	Not Applicable	Not Applicable
Standard Mail Order			
Tier	**One-month supply**	**Two-month supply**	**Three-month supply**
Tier 1 (Preferred Generic)	Not Applicable	Not Applicable	$0 Copay
Tier 2 (Generic)	Not Applicable	Not Applicable	$0 Copay
Tier 3 (Preferred Brand)	Not Applicable	Not Applicable	$88 copay
Tier 4 (Non-Preferred Drug)	Not Applicable	Not Applicable	$285 copay
Tier 5 (Specialty Tier)	Not Applicable	Not Applicable	33% coinsurance

Your cost-sharing may be different if you use a Long Term Care pharmacy, or an out-of-network pharmacy, or if you purchase a long-term supply (up to 90 days) of a drug.

Please call us or see the plan's **"Evidence of Coverage"** on our website (www.sonderhealthplans.com) for complete information about your costs for covered drugs.

<table>
<tr><td>Coverage Gap</td><td>The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $5,030.

After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and 25% of the plan's cost for covered generic drugs until your costs total $8,000, which is the end of the coverage gap.

Our plan covers Tier 1 Preferred Generics in the coverage gap.
<table>
<tr><th colspan="2">Standard Retail Cost-Sharing</th></tr>
<tr><th>Tier</th><th>One-month supply</th></tr>
<tr><td>Tier 1 (Preferred Generic)</td><td>$0 Copay</td></tr>
</table></td></tr>
<tr><td>Catastrophic Amount</td><td>After your yearly out-of-pocket drug costs reach $8,000, you pay nothing.</td></tr>
</table>

<table>
<tr><th colspan="2">ADDITIONAL BENEFITS AVAILABLE TO YOU</th></tr>
<tr><td>Fitness Benefit</td><td>$0 Copay

You receive access to the Silver&Fit Healthy Aging and Exercise program. As part of this program, you have the following options available to you:
Fitness center membership at a participating fitness center near you
Home kit, if you are unable to visit a fitness center or prefer to exercise at home
Daily virtual workout classes streamed live on popular social media outlets
Digital workout classes available on mobile app or website</td></tr>
<tr><td>Over The Counter Items</td><td>You receive $200 per quarter allowance towards the purchase of OTC items from the approved list.</td></tr>
<tr><td>SSBCI Benefits for members who have qualifying Chronic medical conditions</td><td>Eligible Chronic Conditions Include: Chronic alcohol and other drug dependence; Autoimmune disorders; Cancer; Cardiovascular disorders; Chronic heart failure; Dementia; Diabetes; End-stage liver disease; End-stage renal disease (ESRD); Severe hematologic disorders; HIV/AIDS; Chronic lung disorders; Chronic and disabling mental health conditions; Neurologic disorders; and Stroke.

<table>
<tr><td>If you have one of the chronic medical conditions listed above, you may select ONE of the benefits listed below:</td></tr>
<tr><td>Grocery Card Benefit – You receive an allowance of $400 per month to apply towards the purchase of groceries.</td></tr>
<tr><td>Gasoline Card Benefit – You receive an allowance of $325 per month to apply towards the purchase of gasoline</td></tr>
</table></td></tr>
</table>

	Cosmetic/Elective Procedures – You receive reimbursement of up to $3,500 when you elect one of the following select cosmetic surgeries: blepharoplasty, cauliflower ear, sebaceous cyst or cleft palate. Mobility Device Allowance – You receive an allowance of up to $2,500 towards the purchase of a mobility device, such as a scooter.
Additional Allowance for Supplemental Benefits	You may select ONE of the benefits listed below: Additional Dental Coverage – You receive an allowance of $4,000 towards comprehensive dental services. Additional Vision Coverage – You receive an allowance of $3,500 towards comprehensive vision services, including procedures. Additional Hearing Coverage – You receive an allowance of up to $3,000 towards comprehensive hearing services, including hearing aids.

DISCLAIMERS

This document is available in other alternate formats.

ATTENTION: If you speak Spanish, language assistance services, free of charge, are available to you. Call 1-888-428-4440 (TTY: 711).

ATENCIÓN: Si habla español, hay servicios de traducción, libre de cargos, disponibles para usted. Llame al 1-888-428-4440 (TTY: 711).

Sonder Tiers Medicare Advantage is an HMO plan with a Medicare contract. Enrollment in **Sonder Tiers Medicare Advantage** depends on contract renewal.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums and/or copayments/coinsurance may change on January 1 of each year.

You must continue to pay your Medicare Part B premium.

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

Out-of-network/non-contracted providers are under no obligation to treat Sonder Health Plans, Inc. members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. Please call our Member Services number or see your “Evidence of Coverage” for more information, including the cost-sharing that applies to out-of-network services.

Health coverage is offered by Sonder Health Plans, Inc.

Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at 1-888-428-4440 (TTY 711).

Understanding the Benefits

- ☐ The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit www.sonderhealthplans.com or call 1-888-428-4440 (TTY 711) to view a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ☐ Review the formulary to make sure your drugs are covered.

Understanding Important Rules

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2025.
- ☐ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).