



Your Doctors, Your Neighbors, Your Friends



2023 The Summary of Benefits

Sonder Diabetes
Wellness
(HMO-SNP)

Medicare Advantage Plan
H1748003

Meet your Sonder Medicare Advantage Plan.

Discover your Sonder Diabetes Wellness (HMO CSNP H1748003) Medicare Advantage plan and the services covered. The benefit information provided is a summary of what we cover and what you pay.

Your Summary of Benefits doesn't list every service that we cover or list every limitation or exclusion. For a complete list of services we cover, refer to the "Evidence of Coverage," which can be found at www.sonderhealthplans.com/eoc. You may also request a copy of your EOC from the Sonder Member Services team.

To be eligible for a Sonder Health Diabetes Wellness Plan, you must:

- Have Original Medicare Part A & B
- Diagnosis of Diabetes
- Live within one of our service areas
 - Cherokee, Clayton, Cobb, Coweta, DeKalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Henry, or Rockdale

Plan name:

Sonder Diabetes Wellness Chronic Special Needs Plan (HMO CSNP H1748003)

Connect with your Member Services Team:

Members should call toll-free at 1 (888) 428-4440

TTY/TDD 711

April 1st – September 30th

Monday to Friday Hours: 8.00 am – 8.00 pm

October 1st – March 31st

7 days a week Hours: 8.00 am – 8.00 pm

Or visit us at:

<https://www.sonderhealthplans.com>

ATENCIÓN: Si habla español, los servicios de asistencia lingüística, están disponibles para usted, gratis. Llame al 1-888-428-4440 (TTY/TDD: 711).

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

Sonder Health Plans, Inc. complies with applicable Federal Civil Rights laws and does not discriminate based on race, color, national origin, age, disability, sex, sexual orientation, gender, gender identity, ancestry, marital status, or religion in our programs and activities, including in admission to, or access to, treatment/participation in, our programs and activities. If you believe your civil rights have been violated, please contact Member Services at the number below to file a complaint/grievance. If you require interpretation services, please contact Member Services for assistance at 1-888-428-4440, TTY/TDD users call: 711.

Monthly Premium, Deductibles and Limits

	In-Network
Plan Costs	
Monthly Premium	\$0
Deductible	\$0
Max-Out-Of-Pocket (MOOP)	\$3,650

Selected Benefits	Enrollee Details
Other Plan Deductibles	No
Choice of Providers	No, In-Network doctors must be used (except in emergencies)
Optional Supplemental Benefits	No
Prescription Drug Coverage	Yes
Additional benefits and/or reduced cost sharing for enrollees with certain health conditions	Yes
Out of Network Coverage	No

Your Covered Preventative Services

Below is the list of some preventative services and screenings covered by your plan.

- One time “Welcome to Medicare” Preventive Visit—within the first 12 months you have Medicare Part B (Medical Insurance)
- Yearly “Wellness” Visit—get this visit 12 months after your “Welcome to Medicare” preventive visit or 12 months after your Part B effective date
- Abdominal Aortic Aneurysm Screening
- Alcohol Misuse Screening and Counseling
- Bone Mass Measurement (Bone Density Test)
- Cardiovascular Disease (Behavioral Therapy)
- Cardiovascular Screenings (cholesterol, lipids, triglycerides)
- Colorectal Cancer Screenings (including colonoscopies)
- Depression Screening
- Diabetes Screening
- Diabetes Self-management Training
- Flu Shot
- Glaucoma Test
- Hepatitis B Screening
- Hepatitis C Screening
- HIV Screening
- Lung Cancer Screening
- Mammogram (screening for breast cancer)
- Medical Nutrition Therapy Services
- Medicare Diabetes Prevention Program
- Obesity Screening and Counseling
- Pap Test and Pelvic Exam (includes a breast exam)
- Pneumococcal Shots
- Prostate Cancer Screening
- Sexually Transmitted Infection Screening and Counseling
- Counseling to Prevent Tobacco Use and Tobacco-Caused Disease

Your “Guide to Medicare Preventive Services” has more information about these and other preventative services, including costs and conditions that may apply. Visit [Medicare.gov/publications](https://www.Medicare.gov/publications) for the entire comprehensive list.

Covered Medical and Hospital Benefits

	Cost Information	Authorization Needed	Referral Needed
Inpatient Hospital Coverage			
Days 1-5	\$350 copay	Yes	No
Days 6-90	\$0 copay	Yes	No
Outpatient Hospital Coverage			
Outpatient Hospital Services	\$280 copay	Yes	Yes
Outpatient Hospital Observation	\$275 copay	Yes	No
Ambulatory Surgical Centers (ASC)	\$180 copay	Yes	No
Doctor Office Visits			
Primary Care Provider (PCP)	\$0 copay	N/A	N/A
Specialists	\$0 copay	No	Yes
Preventative Care (Refer to page 3 for list of covered services)	\$0 copay	No	Yes
Emergency Care			
Emergency Room	\$120 copay	N/A	N/A
Urgent Care	\$25 copay	N/A	N/A
Diagnostic Services, Labs and Imaging			
Diagnostic Radiology	\$0-\$275 copay	Yes	Yes
Lab Services	\$0 copay	No	No
Diagnostic Tests and Procedures	\$275 copay	Yes	Yes
Outpatient X-Rays	\$0 copay	No	No
Therapeutic Radiology	20% coinsurance	Yes	No
Hearing Services - Per Year			
Hearing Exam	\$0 copay	No	No
Hearing Aids	\$1000 Max Benefit Allowance	No	No

	Cost Information	Authorization Needed	Referral Needed
Dental Services - Preventative & Comprehensive - Per Year			
Oral Exam	\$0 copay 1 Oral Exam Every 6 Months	No	No
Cleaning - Prophylaxis	\$0 copay 1 Every 6 Months	No	No
Fluoride Treatment	\$0 copay 1 Treatment Every 6 Months	No	No
Dental X-Rays	\$0 copay 1 X-Ray Every 2 Years	No	No
Non-Routine Services	\$0 copay	No	No
Restorative Services	\$0 copay	No	No
Endodontics	\$0 copay	No	No
Periodontics	\$0 copay	No	No
Extractions	\$0 copay	No	No
Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services (unless specified in Evidence of Coverage)	\$0 copay	No	No
Dentures – partial & implants	\$0 copay	No	No
Combined Maximum Benefit	\$1,500		
Vision Services - Per Year			
Routine Eye Exam (annually)	\$0 copay	No	No
Contact Lenses/Eyeglasses (frames & lenses)	\$200 Annual Maximum		
Mental Health Services			
Inpatient Hospital Psychiatric Services			
Days 1-5	\$350	Yes	No
Days 6-90	\$0	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 with a Psychologist/Counselor	\$40 copay	Yes	Yes
Outpatient Individual Therapy Visit with a Psychologist/Counselor	\$40 copay	Yes	Yes

	Cost Information	Authorization Needed	Referral Needed
Skilled Nursing Facility			
Days 1-20	\$0	Yes	No
Days 21-100	\$184	Yes	No
Rehabilitation Therapy			
Physical Therapy	\$40 copay	Yes	No
Occupational Therapy	\$40 copay	Yes	No
Speech Therapy	\$40 copay	Yes	No
Cardiovascular & Pulmonary Rehab	\$0 copay	Yes	No
Emergency Ambulance			
Ground Ambulance	\$225 copay	N/A	N/A
Air Ambulance	\$450 copay	N/A	N/A
Chiropractic Services (Medicare Covered Chiropractic Services)			
	\$20 copay	Yes	Yes
Foot Care (Podiatry Services)			
Foot Exams and Treatment Medical or surgical treatment of injuries and routine foot care for certain medical conditions.	\$40 copay	No	Yes
Home Health Care			
	\$10 copay	Yes	Yes
Medical Equipment/Supplies			
Durable Medical Equipment (DME)	20% coinsurance	Yes	Yes
Medical Supplies	20% coinsurance	Yes	Yes
Prosthetics (e.g., braces, artificial limbs)	20% coinsurance	Yes	Yes
Diabetic Supplies	\$0 copay	Yes	Yes
Therapeutic Shoes or Inserts	\$0 copay	No	Yes
Transportation Services			
Non-Emergency Transportation 12 One-Way Trips	\$0 copay	No	No
Outpatient Substance Abuse			
	\$75 copay	No	Yes

	Cost Information	Authorization Needed	Referral Needed
Renal Dialysis			
Renal Dialysis	20% coinsurance	Yes	No
Fitness and Wellness			
Silver & Fit Fitness Program	\$0 copay	No	No
Meals			
	2 meals a day for 14 days provided immediately following each qualifying surgery or inpatient hospitalization. Up to 4 times per year.	Yes	No
Over-The-Counter			
	\$100 per quarter		
Grocery Card			
	\$52 Monthly Benefit	N/A	Yes

Part D Prescriptions

Deductible	\$0
ICL	\$4,660

Cost Information

Tier 1

1 Month Supply (up to 30-days)	\$0 copay
3 Month Supply (61-90 days)	\$0 copay
Mail	\$0 copay

Tier 2

1 Month Supply (up to 30-days)	\$15 copay
3 Month Supply (61-90 days)	\$45 copay
Mail	\$45 copay

Tier 3

1 Month Supply (up to 30-days)	\$47 copay
3 Month Supply (61-90 days)	\$141 copay
Mail	\$141 copay

Cost Information	
Tier 4	
1 Month Supply (up to 30-days)	\$100 copay
3 Month Supply (61-90 days)	\$300 copay
Mail	\$300 copay
Tier 5	
1 Month Supply (up to 30-days)	33% coinsurance
3 Month Supply (61-90 days)	33% coinsurance
Mail	33% coinsurance
Tier 6	
1 Month Supply (up to 30-days)	\$0 copay
3 Month Supply (61-90 days)	\$0 copay
Mail	\$0 copay
Gap Coverage	
After the total drug costs paid by you and the plan reach \$4,660, up to the out-of-pocket threshold of \$7,400	
Generic drugs	25%
Brand-name drugs	25%
Catastrophic Coverage	
When your annual out-of-pocket costs exceed \$7,400	
Generic drugs	\$4.15 copay or 5% (whichever is the larger amount)
Brand-name drugs	\$10.35 copay or 5% (whichever is the larger amount)

Medicare Part B Prescription Drugs			
Chemotherapy Services	20% coinsurance	Yes	N/A
Other Part B Prescription Drugs	20% coinsurance	Yes	N/A

Looking for something?

To view our comprehensive formularies, please visit

<https://sonderhealthplans.com/for-members/member-resources/pharmacy-services/>

To search our provider network, please visit www.sonderhealthplans.com/find-a-doctor/.

You may qualify for Extra Help!

Beneficiaries with limited income may qualify for Extra Help.

These beneficiaries may qualify for Extra Help to pay prescription drug premiums and costs.

Beneficiaries can call Medicare to see if they qualify for Extra Help:

1-800-Medicare (1-800-633-4227)

TDD/TTY relay users should call 1-877-486-2048,

24 hours a day/7 days a week.

You may also go to www.medicare.gov.