SONDER HEALTH PLANS

Your Doctors, Your Neighbors, Your Friends

2023 The Summary of Benefits

Sonder Dual Complete (HMO D-SNP)

Medicare Advantage Plan
H1748005

Meet your Sonder Medicare Advantage Plan.

Discover your Sonder Dual Complete (HMO DSNP H1748005) 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 Dual Complete Plan, you must:

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

Plan name:

Sonder Dual Complete Medicare Advantage Plan (HMO DSNP H1748005)

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 preventive services, including costs and conditions that may apply. Visit 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	**$0** copay	Yes	No
Days 6-90	**$0** copay	Yes	No
Outpatient Hospital Coverage			
Outpatient Hospital Services	**$0** copay	Yes	Yes
Outpatient Hospital Observation	**$0** copay	Yes	No
Ambulatory Surgical Centers (ASC)	**$0** 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	**$0** copay	N/A	N/A
Urgent Care	**$0** copay	N/A	N/A
Diagnostic Services, Labs and Imaging			
Diagnostic Radiology	**$0** copay	Yes	Yes
Lab Services	**$0** copay	No	No
Diagnostic Tests and Procedures	**$0** copay	No	Yes
Outpatient X-Rays	**$0** copay	No	No
Therapeutic Radiology	**$0** copay	Yes	No
Hearing Services - Per Year			
Hearing Exam	**20%** coinsurance	No	No
Hearing Aids	**$1,000** 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	**$3,500**		
Vision Services - Per Year			
Routine Eye Exam	**$0** copay	No	No
Contact Lenses/Eyeglasses (frames & lenses)	**$300** Annual Maximum		
Mental Health Services			
Inpatient Hospital Psychiatric Services			
Days 1-5	**$0**	Yes	No
Days 6-90	**$0**	Yes	No
Outpatient Group Therapy Visit with a Psychiatrist	**$0** copay	No	Yes
Outpatient Individual Therapy Visit with a Psychiatrist	**$0** copay	No	Yes
Outpatient Group Therapy Visit with a Psychologist/Counselor	**$0** copay	Yes	Yes
Outpatient Individual Therapy Visit with a Psychologist/Counselor	**$0** copay	Yes	Yes

	Cost Information	Authorization Needed	Referral Needed
Skilled Nursing Facility			
Days 1-20	**$0**	Yes	No
Days 21-100	**$0**	Yes	No
Rehabilitation Therapy			
Physical Therapy	**$0** copay	Yes	No
Occupational Therapy	**$0** copay	Yes	No
Speech Therapy	**$0** copay	Yes	No
Cardiovascular & Pulmonary Rehab	**$0** copay	Yes	No
Ambulance			
Ground Ambulance	**$0** copay	N/A	N/A
Air Ambulance	**$0** copay	N/A	N/A
Chiropractic Services (Medicare Covered Chiropractic Services)			
	$0 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.	**$0** copay	No	Yes
Home Health Care			
	$0 copay	Yes	Yes
Medical Equipment/Supplies			
Durable Medical Equipment (DME)	**$0** copay	Yes	Yes
Medical Supplies	**$0** copay	Yes	Yes
Prosthetics (e.g., braces, artificial limbs)	**$0** copay	Yes	No
Diabetic Supplies	**$0** copay	Yes	Yes
Therapeutic Shoes or Inserts	**$0** copay	Yes	No
Transportation Services			
Non-Emergency Transportation	**$0** copay 36 One-Way Trips	No	No
Outpatient Substance Abuse			
	$0 copay	No	Yes

	Cost Information	Authorization Needed	Referral Needed
Renal Dialysis			
Renal Dialysis	**$0** copay	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			
	$400 per quarter		
Grocery Card			
	$60 Monthly Benefit	N/A	Yes

Part D Prescriptions

Cost-Share amounts may vary from those listed below if you qualify for Low-Income Subsidy (LIS), also known as Medicare's "Extra Help" Program.
For more information regarding LIS, please refer to Chapter 2, Section 7 of the Sonder Dual Complete EOC for more information.

Deductible	**$505**
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)	**$20** copay
3 Month Supply (61-90 days)	**$60** copay
Mail	**$60** copay
Tier 3	
1 Month Supply (up to 30-days)	**$47** copay
3 Month Supply (61-90 days)	**$141** copay
Mail	**$141** copay

Tier 4	
1 Month Supply (up to 30-days)	**$95** copay
3 Month Supply (61-90 days)	**$285** copay
Mail	**$285** copay
Tier 5	
1 Month Supply (up to 30-days)	**25%** coinsurance
3 Month Supply (61-90 days)	**25%** coinsurance
Mail	**25%** coinsurance
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	**$0**	Yes	N/A
Other Part B Prescription Drugs	**$0**	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.