

Sonder Dual Complete (HMO D-SNP) offered by Sonder Health Plans, Inc.

Annual Notice of Changes for 2024

You are currently enrolled as a member of Sonder Dual Complete (HMO D-SNP). Next year, there will be changes to the plan's costs and benefits. *Please see page 4 for a Summary of Important Costs, including Premium.*

This document tells about the changes to your plan. To get more information about costs, benefits, or rules please review the *Evidence of Coverage*, which is located on our website at www.sonderhealthplans.com. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

What to do now

1. ASK: Which changes apply to you

- Check the changes to our benefits and costs to see if they affect you.
 - Review the changes to Medical care costs (doctor, hospital).
 - Review the changes to our drug coverage, including authorization requirements and costs.
 - Think about how much you will spend on premiums, deductibles, and cost sharing.
- Check the changes in the 2024 “Drug List” to make sure the drugs you currently take are still covered.
- Check to see if your primary care doctors, specialists, hospitals and other providers, including pharmacies will be in our network next year.
- Think about whether you are happy with our plan.**2. COMPARE:** Learn about other plan choices
- Check coverage and costs of plans in your area. Use the Medicare Plan Finder at www.medicare.gov/plan-compare website or review the list in the back of your *Medicare & You 2024* handbook.
- Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan's website.

3. CHOOSE: Decide whether you want to change your plan

- If you don't join another plan by December 7, 2023, you will stay in Sonder Dual Complete (HMO D-SNP).
- To **change to a different plan**, you can switch plans between October 15 and December 7. Your new coverage will start on **January 1, 2024**. This will end your enrollment with Sonder Dual Complete (HMO D-SNP).
- Look in section 2, page 13 to learn more about your choices.
- If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can switch plans or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

Additional Resources

- This document is available for free in Spanish and Korean.
- Please contact our Member Services number at 1-888-428-4440 for additional information. (TTY users should call 711). Hours are 7 days a week 8.00 am – 8.00 pm EST (October 1st – March 31st) or Monday to Friday 8:00 am to 8:00 pm EST (April 1st – September 30th). This call is free.
- This document may be available in alternate formats, such as braille, large print, and audio.
- **Coverage under this Plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About Sonder Dual Complete (HMO D-SNP)

- Sonder Health Plans, Inc. is an HMO with a Medicare Advantage contract. The plan also has a written agreement with the Georgia Medicaid program to coordinate your Medicaid benefits.
 - When this document says “we,” “us,” or “our,” it means Sonder Health Plans, Inc. When it says “plan” or “our plan,” it means Sonder Dual Complete (HMO D-SNP).
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Summary of Important Costs for 2024

The table below compares the 2023 costs and 2024 costs for Sonder Dual Complete (HMO D-SNP) in several important areas. **Please note this is only a summary of costs. If you are eligible for Medicare cost sharing assistance under Medicaid, you pay \$0 for your deductible, doctor office visits, and inpatient hospital stays.**

Cost	2023 (this year)	2024 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 1.1 for details.	\$0	\$0
Deductible	\$0	\$0
Doctor office visits	Primary care visits: \$0 per visit Specialist visits: \$0 per visit	Primary care visits: \$0 per visit Specialist visits: \$0 per visit
Inpatient hospital stays	\$0	\$0
Part D prescription drug coverage (See Section 2.5 for details.)	Copayment/Coinsurance during the Initial Coverage Stage: <ul style="list-style-type: none"> • Drug Tier 1: \$0 • Drug Tier 2: \$20 • Drug Tier 3: \$47 • You pay \$35 per month supply of each covered insulin product on this tier. • Drug Tier 4: \$95 • Drug Tier 5: 25% Catastrophic Coverage: <ul style="list-style-type: none"> • During this payment stage, the plan pays 	Copayment/Coinsurance as applicable during the Initial Coverage Stage: <ul style="list-style-type: none"> • Drug Tier 1: 0% • Drug Tier 2: 0% • Drug Tier 3: 0% • You pay \$35 per month supply of each covered insulin product on this tier. • Drug Tier 4: 0% • Drug Tier 5: 0% Catastrophic Coverage: <ul style="list-style-type: none"> • During this payment stage, the plan pays the

	<p>most of the cost for your covered drugs.</p> <ul style="list-style-type: none"> • For each prescription, you pay whichever of these is larger: a payment equal to 5% of the cost of the drug (this is called coinsurance), or a copayment (\$4.15 for a generic drug or a drug that is treated like a generic, and \$10.35 for all other drugs.). 	<p>full cost for your covered Part D drugs.</p> <ul style="list-style-type: none"> • You may have cost sharing for drugs that are covered under our enhanced benefit.
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<p>Maximum out-of-pocket amount This is the <u>most</u> you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details.)</p>	<p>\$3,650 You are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.</p>	<p>\$3,850 You are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.</p>
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SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2023 (this year)	2024 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium unless it is paid for you by Medicaid.)	\$0	\$0

Section 1.2 – Changes to Your Maximum Out-of-Pocket Amount

Medicare requires all health plans to limit how much you pay out-of-pocket for the year. This limit is called the maximum out-of-pocket amount. Once you reach this amount, you generally pay nothing for covered Part A and Part B services for the rest of the year.

Cost	2023 (this year)	2024 (next year)
Maximum out-of-pocket amount Because our members also get assistance from Medicaid, very few members ever reach this out-of-pocket maximum. Your plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	\$3,650 You are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.	\$3,850 You are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.

Section 1.3 – Changes to the Provider and Pharmacy Networks

Updated directories are located on our website at www.sonderhealthplans.com. You may also call Member Services for updated provider and/or pharmacy information or to ask us to mail you a directory, which we will mail within three business days.

There are changes to our network of providers for next year. **Please review the 2024 Provider Directory to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network.**

There are no changes to our network of pharmacies for next year.

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers), and pharmacies that are a part of your plan during the year. If a mid-year change in our providers affects you, please contact Member Services so we may assist.

Section 1.4 – Changes to Benefits and Costs for Medical Services

Please note that the *Annual Notice of Changes* tells you about changes to your Medicare benefits and costs.

We are making changes to costs and benefits for certain medical services next year. The information below describes these changes.

Cost	2023 (this year)	2024 (next year)
Grocery Card	<p>In-Network: Members who have a qualifying Chronic medical condition receive a \$50 per month allowance for the purchase of groceries</p>	<p>In-Network: Members receive a \$75 per month allowance for the purchase of groceries</p>
Gasoline Card	<p>In-Network: Not Covered</p>	<p>In-Network: Members receive a \$25 per month allowance for the purchase of gasoline.</p>
Dental – Comprehensive and Preventive Services	<p>In-Network: You receive \$3,500 per year allowance towards the purchase of comprehensive and preventive dental services, including:</p> <ul style="list-style-type: none"> • Exams • Prophylaxis • Fluoride • X-rays • Non-routine services • Diagnostic services • Restorative services • Endodontics • Periodontics • Extractions • Prosthodontics 	<p>In-Network: You receive \$5,000 per year allowance towards the purchase of comprehensive and preventive dental services, including:</p> <ul style="list-style-type: none"> • Exams • Prophylaxis • Fluoride • X-rays • Non-routine services • Diagnostic services • Restorative services • Endodontics • Periodontics • Extractions • Prosthodontics

Cost	2023 (this year)	2024 (next year)
Over The Counter	In-Network: You receive \$400 per quarter allowance towards the purchase of OTC items from the catalog.	In-Network: You receive \$500 per quarter allowance towards the purchase of OTC items from the catalog.
SSBCI Benefits for members who have qualifying Chronic medical conditions	In-Network: Not Covered	In-Network: You receive an allowance of \$275 per month to apply towards the list of services below: <ul style="list-style-type: none"> • Home safety/access modifications • Social and active club membership • Internet/cell data • State of Georgia sports license (hunting / fishing)
Routine Meal Delivery	In-Network: Not Covered	In-Network: Members who have a qualifying Chronic medical condition receive up to 10 meals delivered to their home per month. No qualifying event is required
Non-Emergent, Medical Transportation	In-Network: You receive up to 36 one-way trips for non-emergent, primarily medical purposes	In-Network: You receive up to 50 one-way trips for non-emergent, primarily medical purposes
Non-Emergent, Non- Medical Transportation	In-Network: Not Covered	In-Network: Members who have a qualifying Chronic medical condition receive 50 one-way trips for non-emergent transportation. Trips do not need to be medical in nature.

Cost	2023 (this year)	2024 (next year)
Personal Emergency Response System	In-Network: Not Covered	In-Network: You receive one personal emergency response system which includes a base unit and optional wearable device
In-Home Support Services	In-Network: Not Covered	In-Network: You receive in-home support services for \$0 copay. Services are provided in 4 hour per day increments up to 104 hours per year. Services available include: <ul style="list-style-type: none"> • Respite care • Caregiver training • In-home safety assessment • Medication reconciliation • Support for activities of daily living including things such as bathing, dressing, grooming, meal preparation and light housekeeping
Routine Foot Care	In-Network Not Covered	In-Network You pay \$0 for up to 6 visits per year.
Routine Chiropractic Services	In-Network Not Covered	In-Network You pay \$0 for up to 12 visits per year.
Routine Vision Hardware	In-Network You receive an annual allowance of \$300 towards the purchase of contact lenses or eyeglasses (lenses and frames)	In-Network You receive an annual allowance of \$500 towards the purchase of contact lenses or eyeglasses (lenses and frames)
Hearing Aids	In-Network You receive an annual allowance of \$1,000 towards the purchase of hearing aids	In-Network You pay \$0 for a hearing aid from the list of available devices

Section 1.5 – Changes to Part D Prescription Drug Coverage

Changes to Our “Drug List”

Our list of covered drugs is called a Formulary or “Drug List.” A copy of our “Drug List” is provided electronically. **You can get the *complete* “Drug List”** by calling Member Services (see the back cover) or visiting our website (www.sonderhealthplans.com).

We made changes to our “Drug List,” which could include removing or adding drugs, changing the restrictions that apply to our coverage for certain drugs or moving them to a different cost-sharing tier. **Review the “Drug List” to make sure your drugs will be covered next year and to see if there will be any restrictions, or if your drug has been moved to a different cost-sharing tier.**

Most of the changes in the “Drug List” are new for the beginning of each year. However, during the year, we might make other changes that are allowed by Medicare rules. For instance, we can immediately remove drugs considered unsafe by the FDA or withdrawn from the market by a product manufacturer. We update our online “Drug List” to provide the most up to date list of drugs.

If you are affected by a change in drug coverage at the beginning of the year or during the year, please review Chapter 9 of your Evidence of Coverage and talk to your doctor to find out your options, such as asking for a temporary supply, applying for an exception and/or working to find a new drug. You can also contact Member Services for more information.

Changes to Prescription Drug Costs

There are four **drug payment stages**.

The information below shows the changes to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage.)

Important Message About What You Pay for Vaccines - Our plan covers most Part D vaccines at no cost to you even if you haven’t paid your deductible. Call Member Services for more information.

Changes to the Deductible Stage

Stage	2023 (this year)	2024 (next year)
<p>Stage 1: Yearly Deductible Stage During this stage, you pay the full cost of your Part D drugs until you have reached the yearly deductible. The deductible doesn't apply to covered insulin products and most adult Part D vaccines, including shingles, tetanus and travel vaccines.</p>	<p>Because we have no deductible, this payment stage does not apply to you.</p>	<p>Because we have no deductible, this payment stage does not apply to you.</p>

Changes to Your Cost Sharing in the Initial Coverage Stage

Stage	2023 (this year)	2024 (next year)
<p>Stage 2: Initial Coverage Stage Once you pay the yearly deductible, you move to the Initial Coverage Stage. During this stage, the plan pays its share of the cost of your drugs, and you pay your share of the cost.</p> <p>Most adult Part D vaccines are covered at no cost to you. The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy. For information about the costs for a long-term supply or for mail-order prescriptions, look in Chapter 6, Section 5 of your <i>Evidence of Coverage</i>.</p> <p>We changed the tier for some of the drugs on our "Drug List". To see if your drugs will be in a different tier, look them up on the "Drug List".</p>	<p>Your cost for a one-month supply filled at a network pharmacy:</p> <p>Preferred Generics: You pay \$0 copayment per month supply for drugs on Tier 1</p> <p>Generics: You pay \$20 copayment per month supply for drugs on Tier 2</p> <p>Preferred Brand: You pay \$47 copayment per month supply for drugs on Tier 3</p> <p>You pay \$35 per month supply of each covered insulin product on Tier 3.</p> <p>Non-Preferred Brand: You pay \$95 copayment per month supply for drugs on Tier 4.</p>	<p>Your cost for a one-month supply filled at a network pharmacy:</p> <p>Preferred Generics: You pay 25% of the total cost</p> <p>Generics: You pay 25% of the total cost</p> <p>Preferred Brand: You pay 25% of the total cost.</p> <p>You pay \$35 per month supply of each covered insulin product on this tier.</p> <p>Non-Preferred Brand: You pay 25% of the total cost</p>

Stage	2023 (this year)	2024 (next year)
	<p>Specialty Tier: You pay 25% of the total cost</p> <p>Once your total drug costs have reached \$4,660 you will move to the next stage (the Coverage Gap Stage) <i>OR</i> you have paid \$7,400 out-of-pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).</p>	<p>Specialty Tier: You pay 25% of the total cost</p> <p>Once your total drug costs have reached \$5,030 you will move to the next stage (the Coverage Gap Stage) <i>OR</i> you have paid \$8,000 out-of-pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).</p>

Changes to your VBID Part D Benefit

For 2024, the Sonder Dual Complete (HMO D-SNP) is a CMS approved VBID participating health plan. The Sonder Dual Complete (HMO D-SNP) is eliminating all Part D cost share for you. **You pay nothing for Part D drugs. You may have cost sharing for drugs that are covered under our enhanced benefit.**

Changes to the Coverage Gap and Catastrophic Coverage Stages

The other two drug coverage stages – the Coverage Gap Stage and the Catastrophic Coverage Stage – are for people with high drug costs. **Most members do not reach the Coverage Gap Stage or the Catastrophic Coverage Stage.**

Beginning in 2024, if you reach the Catastrophic Coverage Stage, you pay nothing for covered Part D drugs. You may have cost sharing for excluded drugs that are covered under our enhanced benefit.

For specific information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in your *Evidence of Coverage*.

SECTION 2 Deciding Which Plan to Choose

Section 2.1 – If you want to stay in Sonder Dual Complete (HMO D-SNP)

To stay in our plan, you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically be enrolled in our Sonder Dual Complete (HMO D-SNP).

Section 2.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change plans for 2024 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- -- *OR*-- You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan.

To learn more about Original Medicare and the different types of Medicare plans, use the Medicare Plan Finder (www.medicare.gov/plan-compare), read the *Medicare & You 2024* handbook, call your State Health Insurance Assistance Program (see Section 4), or call Medicare (see Section 6.2).

As a reminder, Sonder Health Plans, Inc. offers other Medicare health plans. These other plans may differ in coverage, monthly premiums, and cost sharing amounts.

Step 2: Change your coverage

- To **change to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from Sonder Dual Complete (HMO D-SNP).
- To **change to Original Medicare with a prescription drug plan**, enroll in the new drug plan. You will automatically be disenrolled from Sonder Dual Complete (HMO D-SNP).
- To **change to Original Medicare without a prescription drug plan**, you must either:
 - Send us a written request to disenroll . Contact Member Services if you need more information on how to do so.
 - – *or* – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

If you switch to Original Medicare and do **not** enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan unless you have opted out of automatic enrollment.

SECTION 3 Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7**. The change will take effect on January 1, 2024.

Are there other times of the year to make a change?

In certain situations, changes are also allowed at other times of the year. Examples include people with Medicaid, those who get “Extra Help” paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area.

Because you have Georgia Medicaid, you may be able to end your membership in our plan or switch to a different plan one time during each of the following **Special Enrollment Periods**:

- January to March
- April to June
- July to September

If you enrolled in a Medicare Advantage plan for January 1, 2024, and don’t like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2024.

If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can change your Medicare coverage **at any time**. You can change to any other Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

SECTION 4 Programs That Offer Free Counseling about Medicare and Medicaid

The State Health Insurance Assistance Program (SHIP) is an independent government program with trained counselors in every state. In Georgia, the SHIP is called Georgia SHIP.

It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. Georgia SHIP counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call Georgia SHIP at 1-866-552-4464 and

select Option 4. You can learn more about Georgia SHIP by visiting their website (<https://aging.georgia.gov/georgia-ship>).

For questions about your Georgia Medicaid benefits, contact Georgia Medicaid at 877-423-4746, Monday to Friday, 8:00 am - 5:00 pm, EST. Ask how joining another plan or returning to Original Medicare affects how you get your Georgia Medicaid coverage.

SECTION 5 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs. Below we list different kinds of help:

- **“Extra Help” from Medicare.** Because you have Medicaid, you are already enrolled in “Extra Help,” also called the Low-Income Subsidy. “Extra Help” pays some of your prescription drug premiums, annual deductibles and coinsurance. Because you qualify, you do not have a coverage gap or late enrollment penalty. If you have questions about “Extra Help”, call:
 - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
 - The Social Security Office at 1-800-772-1213 between 8 am and 7 pm, Monday through Friday for a representative. Automated messages are available 24 hours a day. TTY users should call, 1-800-325-0778; or
 - Your State Medicaid Office (applications).
- **Prescription Cost sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost sharing assistance through the Georgia ADAP. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call 1-404-656-9805 or email at GAADAP@dhp.ga.gov.

SECTION 6 Questions?

Section 6.1 – Getting Help from Sonder Dual Complete (HMO D-SNP)

Questions? We’re here to help. Please call Member Services at 1-888-428-4440. (TTY only, call 711). We are available for phone calls 7 days a week 8.00 am – 8.00 pm EST (October 1st –

March 31st) or Monday to Friday 8:00 am to 8:00 pm EST (April 1st – September 30th). Calls to these numbers are free.

Read your 2024 Evidence of Coverage (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2024. For details, look in the *2024 Evidence of Coverage* for Sonder Dual Complete (HMO D-SNP). The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is located on our website at www.sonderhealthplans.com. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

Visit our Website

You can also visit our website at www.sonderhealthplans.com. As a reminder, our website has the most up-to-date information about our provider network (*Provider Directory*) and our *List of Covered Drugs (Formulary/“Drug List”)*.

Section 6.2 – Getting Help from Medicare

To get information directly from Medicare:

Call 1-800-MEDICARE (1-800-633-4227)

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Visit the Medicare Website

Visit the Medicare website (www.medicare.gov). It has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area. To view the information about plans, go to www.medicare.gov/plan-compare.

Read Medicare & You 2024

Read the *Medicare & You 2024* handbook. Every fall, this document is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this document, you can get it at the Medicare website (<https://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf>) or 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.

Section 6.3 – Getting Help from Medicaid

To get information from Medicaid you can call Georgia Medicaid at 877-423-4746. TTY users should call 711.