
2025 Summary of Benefits

Sonder Dual Complete (D-SNP)

January 1, 2025 – December 31, 2025



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SECTION I - INTRODUCTION TO SUMMARY OF BENEFITS

The benefit information for the plan listed below 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, please refer to the *Evidence of Coverage* at www.sonderhealthplans.com, or call us at 1-888-428-4440, TTY: 711. Coverage is applicable January 1, 2025 to December 31, 2025.

| Sonder Dual Complete (D-SNP) | | | | | |
|------------------------------|----------|-----------|------------|------------|------------|
| Counties Covered: | | | | | |
| Appling | Clayton | Glascok | Lincoln | Oglethorpe | Talbot |
| Baker | Clinch | Greene | Long | Paulding | Taliaferro |
| Banks | Cobb | Gwinnett | Macon | Peach | Taylor |
| Barrow | Columbia | Hancock | Madison | Pike | Treutlen |
| Bibb | Coweta | Haralson | Marion | Polk | Twiggs |
| Bleckley | Crawford | Harris | McDuffie | Putnam | Upton |
| Bryan | Dekalb | Heard | McIntosh | Quitman | Walton |
| Burke | Dodge | Henry | Meriwether | Randolph | Warren |
| Butts | Dooly | Jasper | Monroe | Richmond | Washington |
| Candler | Douglas | Jefferson | Montgomery | Rockdale | Wayne |
| Chatham | Emanuel | Jenkins | Morgan | Schley | Webster |
| Chattahoochee | Fayette | Johnson | Muscogee | Screven | Wilcox |
| Cherokee | Forsyth | Jones | Newton | Spalding | Wilkes |
| Clarke | Fulton | Lamar | Oconee | Stewart | Wilkinson |

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 (like **Sonder Dual Complete (D-SNP)**).

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what the Sonder Health Plans cover 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 call 1-877-486-2048.

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.
- Members and non-members can call us at 1-888-428-4440, TTY: 711.
- Our website: www.sonderhealthplans.com.

Who can join?

To join **Sonder Dual Complete (D-SNP)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and you must live in our service area. Sonder Dual Complete (HMO D-SNP) may enroll dual-eligibles who are SLMB Plus, QMB, QMB Plus, and FBDE.

Which doctors, hospitals, and pharmacies can I use?

Sonder Dual Complete (D-SNP) 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 (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 and Catastrophic Coverage.

If you have any questions about this plan's benefits or costs, please contact us.

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SECTION II - SUMMARY OF BENEFITS

PREMIUMS, DEDUCTIBLES, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES

| Out of Pocket Amounts | Sonder Dual Complete (D-SNP) |
|--|------------------------------|
| Monthly Plan Premium You must continue to pay your Medicare Part B premium. | \$0 |
| Deductible These plans do not have deductibles | \$0 |
| Maximum Out-of-Pocket Responsibility This includes copays and other costs for medical services for the year. This does not include prescription drugs. | \$9,350 |

| Medical Benefits | Sonder Dual Complete (D-SNP) | If eligible for Medicaid cost sharing assistance, you pay |
|---|------------------------------|---|
| Inpatient Hospital Per day for each admission Our plan covers an unlimited number of days for an inpatient hospital stay May require prior authorization. | 20% coinsurance | 0% coinsurance |
| Outpatient Hospital Outpatient hospital or Surgery May require prior authorization | 20% coinsurance | 0% coinsurance |
| Ambulatory Surgical Center May require prior authorization. May require a referral from your doctor | 20% coinsurance | 0% coinsurance |
| Doctor's Office Visits Primary care physician visit Specialist visit | 20% coinsurance | 0% coinsurance |
| Preventive Care <i>(e.g., flu vaccine, diabetic screenings)</i> | 20% coinsurance | 0% coinsurance |

| Medical Benefits | Sonder Dual Complete (D-SNP) | If eligible for Medicaid cost sharing assistance, you pay |
|---|---|--|
| See <i>Evidence of Coverage</i> for full list of Preventive Services. | | |
| Emergency Care Emergency Visit Worldwide Coverage - All worldwide urgent / emergency services | 20% coinsurance Not covered | 0% coinsurance Not covered |
| Urgently Needed Services Urgent Visit Worldwide Coverage All worldwide urgent / emergency services | 20% coinsurance Not covered | 0% coinsurance <u>Not covered</u> |
| Mental Health Care Outpatient group therapy visit (individual / group) Inpatient Mental Health Care per day for each admission | 20% coinsurance 20% coinsurance | 0% coinsurance 0% coinsurance |
| Diagnostic Services / Labs/ Imaging Diagnostic tests (office/facility) Lab Services Advanced Services (such as MRI, CT, PET Scan) X-Rays and Diagnostic Radiology (office/facility) Therapeutic Radiology | 20% coinsurance 20% coinsurance 20% coinsurance 20% coinsurance 20% coinsurance | 0% coinsurance 0% coinsurance 0% coinsurance 0% coinsurance 0% coinsurance |
| Skilled Nursing Facility Days 1-20 per day / per admission Days 21-100 per day / per admission | 20% coinsurance | 0% coinsurance |
| Outpatient Rehabilitation (Physical, Occupational, Speech Language) Per visit | 20% coinsurance | 0% coinsurance |

| Medical Benefits | Sonder Dual Complete (D-SNP) | If eligible for Medicaid cost sharing assistance, you pay |
|--|--|---|
| Medicare Part B Drugs For Part B drugs such as chemotherapy drugs | 20% coinsurance | 0% coinsurance |
| Ambulance Ground, one way Air, one way | 20% coinsurance | 0% coinsurance |
| Home Health Per visit | 20% coinsurance | 0% coinsurance |
| DME (Durable Medical Equipment) Covered equipment and supplies Oxygen | 20% coinsurance 20% coinsurance | 0% coinsurance 0% coinsurance |

| Prescription Drug Benefits | Sonder Dual Complete (D-SNP) | If eligible for Medicaid cost sharing assistance, you pay |
|---|--|---|
| Deductible This plan has no prescription drug deductible | \$0 | \$0 |
| Initial Coverage You pay until your out of pocket reaches this amount | \$2,000 | \$2,000 |
| 1 month/3 month/mail order Tier 1 (Preferred Generic) Tier 2 (Generic) • Insulin Tier 3 (Preferred Brand) • Insulin Tier 4 (Non-Preferred Drug) • Insulin Tier 5 (Specialty) | 25%/25%/25% 25%/25%/25% \$10/\$20/\$0 25%/25%/25% \$35/\$70/\$70 25%/25%/25% \$35/\$70/\$70 25%/25%/25% | \$1.60/\$4.80/\$4.80 \$1.60/\$4.80/\$4.80 \$1.60/\$4.80/\$0 \$4.90/\$14.70/\$14.70 \$4.90/\$14.70/\$14.70 \$4.90/\$14.70/\$14.70 \$4.90/\$14.70/\$14.70 \$4.90/\$14.70/\$14.70 |

| Prescription Drug Benefits | Sonder Dual Complete (D-SNP) | If eligible for Medicaid cost sharing assistance, you pay |
|---|------------------------------|---|
| Please call us or see the plan’s <i>Evidence of Coverage</i> on our website for complete information about costs for covered drugs. | | |
| Coverage Gap Starting in 2025, there is no longer a coverage gap | N/A | N/A |
| Catastrophic Amount After your yearly out of pocket drug costs reach \$2,000, you pay nothing | \$0 copay / \$0 coinsurance | \$0 copay / \$0 coinsurance |

| Additional Supplemental Benefits | Sonder Dual Complete (D-SNP) |
|--|---|
| Hearing Services Exam to diagnose and treat hearing and balance issues 1/year Routine hearing exam 1/year Hearing aids: You have the option to purchase hearing aids from two categories. This is for 1 hearing aid per year. | \$0 copay \$0 copay \$0 copay |
| Vision Services 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) Contact lenses, Eyeglasses (frames and lenses) | \$0 copay \$0 copay \$500 per year |
| Dental – Comprehensive and Preventive Services Comprehensive dental services, including: <ul style="list-style-type: none"> • Exams • Prophylaxis • Fluoride • X-rays • Non-routine services • Diagnostic services | \$0 copay per service \$5,000 per year allowance for Comprehensive and Preventive combined |

| Additional Supplemental Benefits | Sonder Dual Complete (D-SNP) |
|---|------------------------------|
| <ul style="list-style-type: none"> • Restorative services • Endodontics • Periodontics • Extractions • Prosthodontics <p>Preventive dental services:</p> <ul style="list-style-type: none"> • Oral exam (1 visit/6 months) • Cleaning (1 visit/ 6 months) • Fluoride (1 visit/ 6 months) • Dental X-rays (1 visit/ 2 years) | |
| <p>Transportation One-way trips per year for non-emergency transportation to plan approved health related locations.</p> | 50 one-way trips |
| <p>Fitness Benefit 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:</p> <ul style="list-style-type: none"> • Fitness center membership at a participating fitness center • Home kit, if unable to visit a fitness center or prefer to exercise at home • Daily virtual workout classes • Digital workout classes | \$0 copay |
| <p>Personal Emergency Response System You receive one personal emergency response system which includes a base unit and optional wearable device.</p> | \$0 copay |
| <p>Over The Counter Items Allowance towards the purchase of OTC items from the approved list</p> | \$300 per quarter |

| Additional Supplemental Benefits | Sonder Dual Complete (D-SNP) |
|--|--|
| <p>In-Home Support Services Services are provided in 4 hour per day increments and include:</p> <ul style="list-style-type: none"> • Respite Care • Caregiver Training • In-Home Safety Assessment • Medication Reconciliation <p>Support for activities of daily living such as bathing, dressing, grooming, meal preparation and light housekeeping.</p> | <p>\$0 copay</p> <p>4 hour per day increments up to 104 hours per year</p> |
| <p>Routine Foot Care Up to 6 visits per year</p> | <p>\$0 copay</p> |
| <p>Routine Chiropractic Services Up to 12 visits per year</p> | <p>\$0 copay</p> |

**Additional Supplemental Benefits –
Must Have Qualifying Condition**

Sonder Dual Complete (D-SNP)

SSBCI Benefits (Special Supplemental Benefits for the Chronically Ill) Only for Members Who Have Qualifying Chronic Medical Conditions

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

Benefits do not roll over.

| | |
|---|------------------------|
| <p>Flex Card Monthly allowance does not roll over.</p> <ul style="list-style-type: none"> • Gas • Home Safety / Access Modifications • Social /Active Club Membership • Internet / Cell Data • Sports License (Hunting / Fishing) • Pet Supplies | <p>\$295 per month</p> |
| <p>Grocery + Utilities Card Food, Produce, Utilities</p> | <p>\$250 per month</p> |
| <p>Meals Home delivered meals</p> | <p>10 per month</p> |
| <p>Non-Emergency Transportation One way trips</p> | <p>50</p> |

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 Health Plans, Inc. is an HMO plan with a Medicare contract. Enrollment in the plan described in this Summary of Benefits 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.