Sonder Health Plans 2024 Benefit Qualification and Election Form

(Sonder Complete, Sonder Dual Complete or Sonder "My Choice" Tiers plans)

First Name: _____ **Last Name:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____ **Phone Number:** _____

Completing this form provides Sonder with the information needed to make a determination regarding your qualification for Special Supplemental Benefits for the Chronically ill (SSBCI). SSBCI includes supplemental benefits that are not primarily health related and may include benefits like a Flexible Spending Card, Gas Card, and Prepared Meals.

STEP 1: Complete the SSBCI Benefit Qualification below:

SSBCI Benefit Qualification:

Please indicate below if you have one or more of the following medical conditions:

- ❒ **Autoimmune disorders limited to:**
  - Polyarteritis nodosa,
  - Polymyalgia rheumatica
  - Polymyositis
  - Rheumatoid arthritis
  - Systemic lupus erythematosus
- ❒ **Cancer**
- ❒ **Cardiovascular disorders limited to:**
  - Cardiac arrhythmias
  - Coronary artery disease
  - Peripheral vascular disease
  - Chronic venous thromboembolic disorder
- ❒ **Chronic heart failure**
- ❒ **End-stage liver disease**
- ❒ **Diabetes mellitus**
- ❒ **End-stage renal disease (ESRD) requiring dialysis**
- ❒ **Dementia**
- ❒ **Neurologic disorders limited to:**
  - Amyotrophic lateral sclerosis (ALS)
  - Epilepsy
  - Extensive paralysis (i.e., hemiplegia, quadriplegia, paraplegia, monoplegia)
  - Huntington's disease
  - Multiple sclerosis
  - Parkinson's disease
  - Polyneuropathy
  - Spinal stenosis
  - Stroke-related neurologic deficit
- ❒ **Stroke**
- ❒ **Chronic lung disorders limited to:**
  - Asthma
  - Chronic bronchitis
  - Emphysema
  - Pulmonary fibrosis
  - Pulmonary hypertension
- ❒ **HIV/AIDS**
- ❒ **Severe hematologic disorders limited to:**
  - Aplastic anemia
  - Hemophilia
  - Immune thrombocytopenic purpura
  - Myelodysplastic syndrome
  - Sickle-cell disease (excluding sickle-cell trait)
  - Chronic venous thromboembolic disorder
- ❒ **Chronic and disabling mental health conditions limited to:**
  - Bipolar disorders
  - Major depressive disorders
  - Paranoid disorder
  - Schizophrenia
  - Schizoaffective disorder
- ❒ **Chronic alcohol and/or other drug dependence**

STEP 2: The following section should only be completed if you have enrolled into the Sonder "My Choice" Tiers Plan.

Sonder "My Choice" Tiers Plan Benefit Election
Category 1 – SSBCI Benefits ***Please select one of the following benefits if you have indicated you have one of the qualifying medical conditions listed above:***
❒ Grocery Card Benefit – You receive an allowance of $400 per month to apply towards the purchase of groceries. ❒ Gasoline Card Benefit – You receive an allowance of $325 per month to apply towards the purchase of gasoline. ❒ Cosmetic/Elective Procedures – You receive reimbursement of up to $3,500 if 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.
Category 2 – Additional Allowance for Supplemental Benefits
❒ 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.

I acknowledge and understand that as a member of the Sonder Tiers "My Choice" Medicare Advantage HMO, I am entitled to a one-time annual election of one benefit from each category listed above. I understand that once my election has been made, I am not able to change my election throughout the benefit year even if I have not utilized the benefit selected. By signing below, I accept these terms and authorize Sonder Health Plans to administer the selected benefits on my behalf:

Member Signature: _____ Date: _____

For Internal Use Only:
Please complete if selections were made via telephonic call with Member Services: **Member Service Rep: _____** **Date: _____ Time: _____**