



## **2019 Summary of Benefits Eon Select (HMO) and Eon Choice (PPO) GEORGIA / SOUTH CAROLINA**

**For more information:  
Current Members: 1-888-906-3889 (TTY: 711)  
Prospective Members: 1-844-895-8643 (TTY:711)**

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 State pays the Part B premium for full dual members. Premium, co-pays, co-insurance, and deductibles may vary based on the level of Extra Help you receive. Please contact the plan for further details. Eon Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.





# 2019 Summary of Benefits

## Eon Select (HMO)

H6672, Plan 004

H9403, Plan 004

**January 1, 2019 - December 31, 2019**

**Eon Health** is a Medicare Advantage HMO plan with a Medicare contract. Enrollment in the Plan depends on contract renewal.

The benefit information provided does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please request the "Evidence of Coverage."

To join **Eon Select (HMO)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. Our service area includes the following counties in **Georgia**: Baker, Baldwin, Banks, Barrow, Bibb, Bleckley, Bryan, Butts, Chatham, Cherokee, Clayton, Clinch, Crawford, Dawson, DeKalb, Dodge, Dooly, Fayette, Forsyth, Franklin, Greene, Hancock, Hart, Heard, Henry, Houston, Jasper, Jones, Lamar, Lumpkin, Macon, Madison, McIntosh, Meriwether, Monroe, Morgan, Newton, Oconee, Oglethorpe, Peach, Pickens, Pike, Pulaski, Putnam, Rabun, Rockdale, Schley, Screven, Stephens, Talbot, Taliaferro, Taylor, Twiggs, Walton, White, Wilcox and Wilkinson. **South Carolina**: Beaufort, Chester, Colleton, Fairfield, Greenville, Hampton, Jasper, Lee, Saluda, Spartanburg and Union.

Except in emergency situations, if you use the providers that are not in our network, we may not pay for these services.

You can see our Provider and Pharmacy Directory on our website at [www.eonhealthplan.com](http://www.eonhealthplan.com).

You can see our Formulary (List of Part D prescription drugs) on our website at [www.eonhealthplan.com](http://www.eonhealthplan.com).

For coverage and costs of Original Medicare, look in your current "**Medicare & You**" handbook. View it online at [www.medicare.gov](http://www.medicare.gov) or get a copy by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048

For more information, please call us at 1-888-906-3889 (TTY users should call 711) or visit us at [www.eonhp.com](http://www.eonhp.com). Our call center is open from October 1 through March 31, Monday through Sunday, 8:00am – 8:00pm ET and from April 1 through September 30, Monday through Friday, 8:00am – 8:00pm ET (you may leave a voicemail Saturday, Sunday and Federal Holidays). Eon Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Premiums and Benefits	Eon Select HMO
Monthly Plan Premium	\$0 per month
Deductible	Part C (Medical) \$0 Part D (Pharmacy) \$250 only applies to Tiers 3, 4, and 5
Maximum Out-of-Pocket Responsibility <i>(does not include prescription drugs)</i>	\$6,700 annually
Inpatient Hospital <sup>1</sup>	\$300 / day for days 1-5 \$0 / day for days 6-90
Outpatient Hospital <sup>1</sup>	\$200 copay Ambulatory Surgical Center \$225 copay Outpatient Hospital
Doctor Visits <ul style="list-style-type: none"> <li>• Primary</li> <li>• Specialists</li> </ul>	\$10 copay \$50 copay
Preventive Care (e.g., flu vaccine, diabetic screenings)	\$0 copay
Emergency Care	\$80 copay
Urgently Needed Services	\$50 copay
Diagnostic Services / Labs / Imaging <sup>1</sup>	Diagnostic radiology services (such as MRI's, CT scans): 20% coinsurance Diagnostic tests and procedures: 20% coinsurance Lab services: \$5 copay Outpatient X-rays: \$25 copay
Hearing Services <sup>1</sup>	Exam to diagnose and treat hearing and balance issues: \$25 copay Routine hearing exam (for up to 1 every year): \$25 copay Hearing and fitting /evaluation (for up to 1 every 3 years): \$0 copay. Our plan pays up to \$750 every three years for hearing aids. Benefit amount applies to both ears combined.

<sup>1</sup>May require prior authorization

Premiums and Benefits	Eon Select HMO
Dental Services <sup>1</sup>	<p><b>Preventive dental services:</b>  Cleaning (for up to 1 every six months): \$0 copay. Dental x-ray(s) (for up to 1 every six months): \$0 copay. Oral exam (for up to 1 every six months): \$0 copay. 1 dental bitewing x-ray per side every six months: \$0 copay. 1 panoramic x-ray every five years: \$0 copay.</p> <p><b>Comprehensive dental services:</b>  Coverage limit is \$800 every year.  \$0 copay for non-Medicare covered services.  \$50 copay for Medicare covered services. Coverage is limited to fillings, simple extractions, dentures, and denture repair. Additional dental services, such as root canals, crowns, surgical extractions, denture relines and periodontal (gum) treatments, are not covered.  1 partial or 1 complete denture per arch every five years. \$0 copay.</p>
Vision Services <sup>1</sup>	<p>Exam to diagnose and treat diseases and conditions of the eye: \$25 copay.  Annual Glaucoma screening: \$0 copay.  Routine eye exam (for up to 1 every year): \$0 copay.  Contact lenses: (for up to 1 every year): \$0 copay.  Eyeglasses (frames and lenses): (for up to 1 every year): \$0 copay.  Eyeglasses or contact lenses after cataract surgery: \$0 copay.  \$175 every year for contact lenses and or eyeglasses (frames and lenses).</p>
Mental Health Services <sup>1</sup>	<p>Inpatient:  \$300 / day for days 1-5  \$0 / day for days 6-90</p>
	<p>Outpatient:  Group therapy visit: \$40 copay  Individual therapy visit: \$40 copay</p>
Skilled Nursing Facility (SNF) <sup>1</sup>	<p>\$0 / day for days 1-20  \$167 / day for days 21-100</p>
Physical Therapy <sup>1</sup>	Physical therapy visit: \$40 copay
Ambulance <sup>1</sup>	\$225 copay
Transportation	Not covered
Emergency Care	\$80 copay.
Medicare Part B Drugs <sup>1</sup>	20% coinsurance

<sup>1</sup>May require prior authorization

Premiums and Benefits	Eon Select HMO		
Outpatient Prescription Drugs			
	Retail Rx 30-day supply	Retail Rx 90-day supply	Mail Order 90-day supply
Initial Coverage			
Tier 1: Preferred Generic	You pay \$2	You pay \$6	You pay \$4
Tier 2: Non-Preferred Generic	You pay \$10	You pay \$30	You pay \$20
Tier 3: Preferred Brand	You pay \$45	You pay \$135	You pay \$90
Tier 4: Non-Preferred Brand	You pay \$95	You pay \$285	You pay \$190
Tier 5: Specialty Tier	You pay 28%	You pay 28%	You pay 28%

Cost-sharing may change when entering another phase of the Part D benefit.

Benefits	Eon Silver/Additional Health Benefits
Chiropractic Care	<p>Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position):</p> <ul style="list-style-type: none"> <li>• Manual manipulation of the spine to correct subluxation: \$20 copay.</li> <li>• Routine chiropractic visits up to 4 visits per year: \$20 copay.</li> </ul>
Foot Care (Podiatry Services)	<p>Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs): \$45 copay.  Routine foot care for members with certain medical conditions affecting the lower limbs: \$45 copay.</p>
Meals <sup>1</sup>	Up to 20 meals up to 28 days immediately following an inpatient stay.
Over-the-Counter (OTC) items	Members receive a \$20 allowance every month.
Wellness Programs (e.g. fitness)	<p>Fitness program SilverSneakers®:  Membership to an in-network fitness facility.  One "Steps Kit" per year for those members with limited access to a network fitness center.</p>

<sup>1</sup>May require prior authorization



# 2019 Summary of Benefits

## Eon Choice (PPO)

H2334, Plan 003

H9589, Plan 003

**January 1, 2019 - December 31, 2019**

**Eon Health** is a Medicare Advantage PPO plan with a Medicare contract. Enrollment in the Plan depends on contract renewal.

The benefit information provided does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please request the "Evidence of Coverage."

To join **Eon Choice (PPO)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. Our service area includes the following counties in **Georgia**: Baker, Baldwin, Banks, Barrow, Bibb, Bleckley, Bryan, Butts, Chatham, Cherokee, Clayton, Clinch, Crawford, Dawson, DeKalb, Dodge, Dooly, Fayette, Forsyth, Franklin, Greene, Hancock, Hart, Heard, Henry, Houston, Jasper, Jones, Lamar, Lumpkin, Macon, Madison, McIntosh, Meriwether, Monroe, Morgan, Newton, Oconee, Oglethorpe, Peach, Pickens, Pike, Pulaski, Putnam, Rabun, Rockdale, Schley, Screven, Stephens, Talbot, Taliaferro, Taylor, Twiggs, Walton, White, Wilcox and Wilkinson.

**South Carolina**: Beaufort, Chester, Colleton, Fairfield, Greenville, Hampton, Jasper, Lee, Saluda, Spartanburg and Union.

Except in emergency situations, if you use the providers that are not in our network, your costs may be higher, deductibles and coinsurances may apply.

You can see our Provider and Pharmacy Directory on our website at [www.eonhealthplan.com](http://www.eonhealthplan.com).

You can see our Formulary (List of Part D prescription drugs) on our website at [www.eonhealthplan.com](http://www.eonhealthplan.com).

For coverage and costs of Original Medicare, look in your current "**Medicare & You**" handbook. View it online at [www.medicare.gov](http://www.medicare.gov) or get a copy by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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Premiums and Benefits	Eon Choice Health Benefits	
	Eon Choice PPO In-Network	Eon Choice PPO Out-of-Network
Monthly Plan Premium	\$25 per month	
Deductible	Part C (Medical) \$0	Part C (Medical) \$500
	Part D (Pharmacy) \$150 only applies to Tiers 3, 4, and 5 (In-Network and Out-of-Network)	
Maximum Out-of-Pocket Responsibility ( <i>does not include prescription drugs</i> )	\$6,700 annually	\$10,000: Services received from in-network providers WILL count toward this limit.
Inpatient Hospital	\$395 / day for days 1-4 \$0 / day for days 5-90	\$395 / day for days 1-4 \$0 / day for days 5-90
Outpatient Hospital coverage <sup>1</sup>	20% copay Ambulatory Surgical Center	20% coinsurance Ambulatory Surgical Center
	20% copay Outpatient Hospital	20% coinsurance Outpatient Hospital
Doctor Visits ( <i>Primary and Specialist</i> )	Primary Care Physician visit: \$10 copay. Specialist visit: \$45 copay	Primary Care Physician visit: \$20 copay. Specialist visit: \$45 copay
Preventive Care (e.g. flu vaccine, diabetic screenings)	\$0 copay	0% coinsurance
Emergency Care	\$80 copay	\$80 copay
Urgently Needed Services	\$35 copay	\$35 copay
Diagnostic Services/Labs/Imaging	Diagnostic radiology services (such as MRIs, CT scans): 20% coinsurance	Diagnostic radiology services (such as MRIs, CT scans): 20% coinsurance
	Diagnostic tests and procedures: 20% coinsurance	Diagnostic tests and procedures: 20% coinsurance
	Lab services: \$10 copay	Lab services: \$10 coinsurance
	Outpatient X-rays: \$14 copay	Outpatient X-rays: \$14 coinsurance
	Therapeutic radiology services (such as radiation treatment for cancer): 20% coinsurance	Therapeutic radiology services (such as radiation treatment for cancer): 40% coinsurance
Hearing Services	Exam to diagnose and treat hearing and balance issues: \$25 copay.	Exam to diagnose and treat hearing and balance issues: 40% coinsurance
	Routine hearing exam (for up to 1 every year): \$25 copay.	50% coinsurance
	Hearing aid fitting/evaluation (for up to 1 every 3 years): \$0 copay.	50% coinsurance
	Our plan pays up to \$750 every three years for hearing aids. Benefit amount applies to both ears combined.	50% coinsurance

<sup>1</sup>May require prior authorization

Premiums and Benefits	Eon Choice/Health Benefits	
	Eon Choice PPO In-Network	Eon Choice PPO Out-of-Network
Dental Services <sup>1</sup>	<b>Preventive dental services:</b> Cleaning (for up to 1 every six months): \$0 copay. Dental x-ray(s) (for up to 1 every six months): \$0 copay Oral exam (for up to 1 every six months): \$0 copay. Dental bitewing x-ray per side (for up to 1 every six months): \$0 copay. Panoramic x-ray (for up to 1 every five years): \$0 copay.	<b>Preventive dental services:</b> Cleaning (for up to 1 every six months): 50% coinsurance. Dental x-ray(s) (for up to 1 every six months): 50% coinsurance. Oral exam (for up to 1 every six months): 50% coinsurance. Dental bitewing x-ray per side (for up to 1 every six months): 50% coinsurance. Panoramic x-ray (for up to 1 every five years): 50% coinsurance.
	Comprehensive dental services: \$50 copay for Medicare-covered comprehensive benefits	Comprehensive dental services: \$50 copay for Medicare-covered comprehensive benefits
Vision Services <sup>1</sup>	Exam to diagnose and treat diseases and conditions of the eye: \$25 copay.	Exam to diagnose and treat diseases and conditions of the eye: 40% coinsurance.
	Glaucoma Screening: \$25 copay	Glaucoma Screening: 40% coinsurance.
	Routine eye exam (for up to 1 every year): \$10 copay.	50% coinsurance
	Contact lenses: (for up to 1 every year): \$0 copay. Eyeglasses (frames and lenses): (for up to 1 every year): \$0 copay. Eyeglasses or contact lenses after cataract surgery: \$0 copay.	50% coinsurance
	\$135 every year for contact lenses and or eyeglasses (frames and lenses).	50% coinsurance
Mental Health Services <sup>1</sup>	Inpatient: \$300 / day for days 1-5 \$0 / day for days 6 – 90	Inpatient: 40% coinsurance
	Outpatient: Group therapy visit: \$40 copay Individual therapy visit: \$40 copay.	Outpatient: Group therapy visit: 40% coinsurance Individual therapy visit: 40% coinsurance.
Skilled Nursing Facility (SNF) <sup>1</sup>	\$0 / day for days 1-20 \$167 / day for days 21-100	40% Coinsurance
Physical Therapy <sup>1</sup>	Physical therapy visit: \$40 copay	Physical therapy visit: 40% coinsurance
Ambulance <sup>1</sup>	\$250 copay	\$250 copay
Transportation	Not covered	Not covered
Medicare Part B Drugs <sup>1</sup>	20% coinsurance	20% coinsurance

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### Outpatient Prescription Drugs

	Retail Rx 30-day supply	Retail Rx 90-day supply	Mail Order 90-day supply
Initial Coverage			
Tier 1: Preferred Generic	You pay \$2	You pay \$6	You pay \$4
Tier 2: Non-Preferred Generic	You pay \$10	You pay \$30	You pay \$20
Tier 3: Preferred Brand	You pay \$45	You pay \$135	You pay \$90
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Cost-sharing may change when entering another phase of the Part D benefit.

Benefits	Eon Choice/Additional Health Benefits	Eon Choice/Additional Health Benefits
	In-Network	Out-of-Network
Chiropractic Care	Manual manipulation of the spine to correct subluxation: \$20 copay. Routine chiropractic visits up to 4 visits per year: \$20 copay.	Manipulation of the spine to correct a subluxation (20% coinsurance). Routine chiropractic visits up to 4 visits per year: 50% coinsurance.
Foot Care (Podiatry Services)	Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs): \$0 copay. Routine foot care for members with certain medical conditions affecting the lower limbs: \$0 copay.	Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs): \$45 copay. Routine foot care for members with certain medical conditions affecting the lower limbs: \$45 copay.
Meals <sup>1</sup>	Up to 20 meals up to 30 days immediately following an inpatient stay. There is no copay, coinsurance, or deductible.	Up to 20 meals up to 30 days immediately following an inpatient stay. There is no copay, coinsurance, or deductible.
Over-the-Counter (OTC) items	Members receive a \$20 allowance every month.	Members receive a \$20 allowance every month.
Wellness Programs (e.g. fitness)	Fitness program SilverSneakers®: Membership to an in-network fitness facility. One "Steps Kit" per year for those members with limited access to a network fitness center. \$0 copay.	Fitness program SilverSneakers®: Membership to an in-network fitness facility. One "Steps Kit" per year for those members with limited access to a network fitness center. 50% coinsurance.

<sup>1</sup>May require prior authorization



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