Summary of Benefits – EON Gold (PPO C-SNP)

January 1, 2020 - December 31, 2020

EON Health, Inc. (GA) is the health plan that cares. We cover everything Original Medicare covers and provide you with additional benefits to optimize your health care needs. Our goal is to promote healthy outcomes by providing robust primary and preventative care, access to health and wellness services, and a unique approach to health care delivery. As a member of our plan, your health care matters. We have enhanced some of our 2020 plan benefits based on member feedback.

This booklet gives you a summary of what we cover and what you as a member can expect to pay. Please keep in mind, however, it doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call us or refer to your "Evidence of Coverage Booklet." You can also find a copy on our website at *www.eonhealthplan.com***.**

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 (such as **EON Gold PPO**.

Tips for comparing your Medicare choices

- 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 http://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 http://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 should call 1-877-486-2048.

Sections in this booklet

- Things to Know About **EON Gold PPO**
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits
- Prescription Drug Benefits

EON Health, Inc. (GA) is a PPO plan sponsor with a Medicare contract. Enrollment in EON Gold (PPO C-SNP) 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 co-payments/co-

insurance may change on January 1 of each year. You must continue to pay your Medicare Part B premium.

Things to Know About **EON Gold PPO**

Hours of Operation	• From October 1 – March 31, you can call us 7 days a week from 8:00 a.m. to 8:00 p.m. • From April 1 – September 30, you can call us Monday through Friday from 8:00 a.m. to 8:00 p.m.
EON Gold PPO **Phone numbers and website**	• If you are a member of this plan, call toll-free (855) 249-7811 • TTY/TDD users can call **711** • If you are not a member of this plan, call toll-free *1-888-906-3889* • Our website: *www.eonhealthplan.com*
Who can join?	To join **EON Gold 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.
Which doctors, hospitals, and pharmacies can I use?	**EON Gold PPO** 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 directory and pharmacy directory on our website (*www.eonhealthplan.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. • **For some of these benefits, you may pay more in our plan than you would in Original Medicare.** For others, you may pay less.

	• **Our plan members also get more than what is covered by Original Medicare.** Some of the extra benefits are outlined in this booklet. We cover Part D drugs. In addition, we cover Part B drugs such as 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, *www.eonhealthplan.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 six "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, Coverage Gap, and Catastrophic Coverage.

Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services

How much is the monthly premium?	**$15** per month. In addition, you must keep paying your Medicare Part B premium.
How much is the deductible?	**In-Network** **Part C (Medical): $0** **Part D (Pharmacy): $250 (Only applies to Tiers 3, 4 and 5)** **Out-of-Network** **Part C (Medical): $500** **Part D (Pharmacy): $250 (Only applies to Tiers 3, 4 and 5)**
Is there any limit on how much I will pay for my covered services? **What is my maximum out-of-pocket responsibility?**	Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. Your yearly limit(s) in this plan: **$6,700** for services you receive from in-network and out-of-network providers. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.
Is there a limit on how much the plan will pay?	Our plan has a coverage limit every year for certain in-network benefits. Contact us for the services that apply.

Covered Medical and Hospital Benefits

Benefit	*Original Medicare*	*EON Gold (PPO C-SNP)*
Inpatient Hospital Care (1)	In 2019, the amounts for each benefit period are: • You pay a $1,364 deductible and no coinsurance for days 1–60 of each benefit period. • You pay **$341** benefit period. • You pay **$682** per "lifetime reserve day" after day 90 of each benefit period (up to a maximum of 60 days over your lifetime). • You pay all costs for each day after you use all the lifetime reserve days. These amounts may change for 2020.	Our plan covers 90 days for an inpatient hospital stay. Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days. In-Network Services • You pay a **$300** copay per day for days 1 through 5. • **$0** per day for days 6 through 90. Out-of-Network Services • You pay **40%** of the Medicare-approved amount. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.
Doctor's Office Visits (1)	If the Part B deductible **($185 in 2019)** applies, you must pay all costs (up to the Medicare-approved amount) until you meet the yearly Part B deductible. You pay **20%** of the Medicare-approved amount (except for certain preventive services for which you may pay nothing).	In-Network Services • You pay a **$0** copay for a Primary care physician visit. • You pay a $15 copay for a Primary care Telehealth visit. • You pay a **$25** copay for all other Specialist visit. Out-of-Network Services • You pay **40%** of the Medicare-approved amount.
Preventative Care	Medicare-covered preventive services covered at zero cost sharing and includes:	You are covered for all preventive services covered under Original Medicare at zero cost sharing.

	• "Welcome to Medicare" preventive visit (one-time) • Yearly "Wellness" visit • Abdominal aortic aneurysm screening 43 Alcohol misuse screening and counseling • Bone mass measurement (bone density) • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular disease screenings • Cervical and vaginal cancer screening • (colonoscopy, fecal occult blood test, flexible sigmoidoscopy) • Depression screening • Diabetes screenings • Diabetes self-management training • Flu vaccines • Glaucoma tests • Hepatitis B vaccines • Hepatitis C screening test • HIV screening • Lung cancer screening with low dose computed tomography (LDCT) screening • Medical nutrition therapy services • Medicare Diabetes Prevention Program (MDPP) • Obesity screening and counseling • Pneumococcal vaccine • Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling • Smoking and tobacco use cessation counseling	Any additional preventive services approved by Medicare mid-year will be covered by the plan or by Original Medicare. Authorization rules may apply for non-participating providers. Plan covers a physical exam annually. In-Network Preventive Services • You pay a $0 copay.
Emergency Care	You pay a specified copayment for the hospital emergency department visit, and you pay **20%** of the Medicare-	• You pay a **$80** copay for Emergency care.

	approved amount for the doctor's or other health care provider's services. You pay a **20%** coinsurance for facility services. Emergency services copay cannot exceed Part A inpatient hospital deductible for each service provided by the hospital. Not covered outside the U.S. except under limited circumstances.	If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs. Not covered outside the U.S.
Urgently Needed Services	You pay **20%** of the Medicare-approved amount for the doctor's or other health care provider's services. Medicare covers urgently needed care to treat a sudden illness or injury that isn't a medical emergency. In a hospital outpatient setting, you also pay the hospital a copayment.	• You pay a **$50** copay for Urgent care services.
Diagnostic Tests, Lab and Radiology Services, and X-Rays (*Costs for these services may vary based on place of services)* **(1)**	You pay **20%** of the Medicare-approved amount for Medicare covered X-rays, MRIs, CT scans, EKG/ECGs, and some other diagnostic tests. If you get the test at a hospital as an outpatient, you also pay the hospital coinsurance of **20%** but in most cases, this amount can't be more than the Part A hospital stay deductible. Medicare covers laboratory services including certain blood tests, urinalysis, certain tests on tissue specimens, and some screening tests. You generally pay nothing for these services.	In-Network Services • Diagnostic radiology services (such as MRIs, CT scans): You pay **20%** of the Medicare-approved amount. • Diagnostic tests and procedures: **20%** of the Medicare-approved amount**.** • Outpatient x-rays: **$25.** • Lab services: **$5.** • Therapeutic radiology services (such as radiation treatment for cancer): You pay a **20%** of the Medicare-approved amount copay. Out-of-Network Services • You pay 40% of the Medicare-approved amount**.**
Hearing Services (1)	You pay **20%** coinsurance for a Medicare-covered diagnostic hearing	In-Network Medicare-Covered Services:

	exam to diagnose and treat hearing and balance issues. Routine hearing exams and hearing aids are not covered by Original Medicare.	A Medicare-covered hearing exam to diagnose and treat hearing and balance issues: • In-Network: You pay a **$25** copay when in-network. • Out-of-Network: You pay 40% of the total cost In-Network supplemental hearing benefits: • A routine hearing exam (one (1) per year): **$25 copay.** • Hearing aid fitting/ evaluations (for 1 every 3 years): **$0 copay.** • Hearing aids are covered with an allowance of **$750** every 3 years. Out-of-Network supplemental hearing benefits: • You pay 50% of covered expenses
Dental Services (1)	Medicare does not cover most dental services (this includes services in connection with preventative care, treatment, filling, removal, or replacement of teeth).	Medicare-covered dental services: You pay a $50 copay. Preventive dental services: • Oral exam, cleaning, fluoride treatment (for up to one (1) every 6 months): **$0 copay.** • **Dental xrays, bitewing xrays** (for up to one (1) every year): **$0 copay** • Panoramic (for up to one (1) every 5 years): **$0 copay.** Comprehensive dental services: • Restorative Services: $0 copay • Root canals: $0 copay**.** • Endodontics: $0 copay. • Periodontics: $0 copay. • Extractions: $0 copay • Dentures or fixed prosthetics: $0 copay**.**

		Our plan pays up to **$500** every year for most dental services. Out-of-Network Services • You pay 50% of covered expenses for preventive dental. You pay 40% of covered expenses for comprehensive dental.
Vision Services (1)	You pay **20%** coinsurance for diagnosis and treatment of diseases and conditions of the eye, including an annual glaucoma screening for people at risk. Medicare covers one pair of eyeglasses with standard frames (or one set of contact lenses) after cataract surgery that implants an intraocular lens.	Medicare-covered exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening). In-Network Services • You pay a **$25** copay. Out-of-Network Services • You pay a **40% of the cost**. The plan covers one (1) pair of eye-glasses with standard frames (or one set of contact lenses) at no cost after a cataract surgery that implants an intraocular lens. • A routine eye exam (one (1) per year): **$0 copay.** • Eyeglasses (frames and lenses) or contact lenses (one (1) per year): **$0.** Our plan pays a maximum of **$200** per year for eyeglasses (frames and lenses) or contact lenses. Out-of-Network Services: You pay 50% of covered expenses
Inpatient Mental Health Care (1)	In 2019, the amounts for each benefit period are: • You pay a **$1,364** deductible and no coinsurance for days 1–60 of each benefit period. • You pay **$341** per day for days 61–90 of each benefit period.	**Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital.** • You pay **$300** copay per day for days 1 through 5. • **$0** per day for days 6 through 90.

	• You pay **$682** per "lifetime reserve day" after day 90 of each benefit period (up to a maximum of 60 days over your lifetime). • You pay all costs for each day after you use all the lifetime reserve days. Inpatient psychiatric care in a freestanding psychiatric hospital is limited to 190 days in a lifetime. These amounts may change for 2020.	Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. You pay all costs for each day after you use all the lifetime reserve days. Out-of-Network Services • You pay **40%** of the Medicare-approved amount.
Outpatient Mental Health Care (1)	Generally, you pay **20%** of the Medicare-approved amount: • Visits to a doctor or other health care provider to diagnose your condition or monitor or change your prescriptions. • Outpatient treatment of your condition (like counseling or psychotherapy). • Partial hospitalization program: is a structured program of active outpatient psychiatric treatment that is more intense than the care received in our doctor's or therapist's office and is an alternative to inpatient hospitalization.	In-Network Services • Outpatient individual therapy visit: You pay a **$40** copay. • Outpatient group therapy visit: You pay a **$40** copay. • Outpatient partial hospitalization visit: You pay a **$50** copay. Out-of-Network Services • You pay 40% of covered expenses.
Skilled Nursing Facility (SNF) (1)	In 2019, you pay: Medicare requires a three (3) day inpatient hospital stay prior a SNF admission. • $0 for the first 20 days of each benefit period. • **$170.50** per day for days 21–100 of each benefit period. • All costs for each day after day 100 in a benefit period.	Our plan covers up to 100 days in a SNF. A three (3) day inpatient hospital stay is not required prior to a SNF admission. In-Network Services • **$0** per day for days 1 through 20. • You pay **$167** copay per day for days 21 through 100. Out-of-Network Services • You pay 40% of covered expenses.

	These amounts may change for 2020.	
Outpatient Rehabilitation (1)	Cardiac (heart) rehab services: You pay **20%** of the Medicare-approved amount if you get the services in a doctor's office. In a hospital outpatient setting, you also pay the hospital a copayment. Occupational therapy: You pay **20%** of the Medicare-approved amount. Physical therapy and speech therapy: You pay **20%** of the Medicare-approved amount.	In-Network Services • Cardiac (heart) and pulmonary rehab services: You pay a $0 copay. • Occupational therapy visit: You pay a **$40** copay. • Physical therapy and speech and language therapy visit: You pay a **$40** copay. Out-of-Network Services • You pay 40% of covered expenses.
Ambulance	You pay **20%** of the Medicare-approved amount.	• For each covered one-way trip on ground: You pay a **$225** copay. • Covered air transportation: You pay **$225** of the total cost.
Transportation (non-emergency)	Not Covered	Non-emergency transportation is not covered by this plan.
Foot Care *(podiatry services)* **(1)**	You pay **20%** of the Medicare-approved amount. Medicare covers foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions.	In-Network Services • You pay a **$50** copay for Medicare covered Podiatry care and Routine Foot Care. Out-of-Network Services • You pay 40% of covered expenses.
Durable Medical Equipment (wheelchairs, oxygen, etc.) **(1)**	You pay **20%** of the Medicare-approved amount.	In-Network Services • Durable Medical Equipment (DME): You pay **20%** of the total cost. Out-of-Network Services • Durable Medical Equipment (DME): You pay **40%** of the total cost. If you go to a preferred vendor, your cost may be less. Contact us for a list of preferred vendors.
Wellness Programs		

Health Club Membership SilverSneakers® Fitness	Not covered	**$0** to belong to a participating health club while you are a member of our plan. You can find a list of participating clubs on our website at *www.eonhealthplan.com* , or call Member Services.
Over-the-Counter Items	Not covered	In-Network Services • Our plan will pay up to **$15** every month for the purchase of covered over-the-counter items. Out-of-Network Services • Our plan will pay up to **$15** every month for the purchase of covered over-the-counter items. You pay **50%** of the approved amount Please visit our website to see our list of covered over-the-counter items.
Part B Drugs (1)	For chemotherapy given in a doctor's office or freestanding clinic, you pay **20%** of the Medicare-approved amount, and the Part B deductible may apply. You pay **20%** of the Medicare-approved amount for other covered drugs, and the Part B may deductible apply.	In-Network Services • For Part B drugs such as chemotherapy drugs: **20%** of the total cost. • Other Part B drugs: **20%** of the total cost. Out-of-Network Services • For Part B drugs such as chemotherapy drugs: 4**0%** of the total cost. • Other Part B drugs: 4**0%** of the total cost.
Outpatient Substance Abuse (1)	You pay **20%** coinsurance of the Medicare-approved amount.	In-Network Services • Outpatient individual therapy visit: You pay a **$45** copay. • Outpatient group therapy visit: You pay a **$45** copay. Out-of-Network Services • You pay 40% of covered expenses.

Outpatient Hospital Care (1)	You pay a **20%** coinsurance for the doctor's services. You pay a **20%** Specified coinsurance for outpatient hospital facility services. The coinsurance cannot exceed the Part A inpatient hospital deductible. You pay a **20%** coinsurance for ambulatory surgical center facility services.	In-Network Services • Outpatient hospital services: You pay a **$225** copay. • Outpatient observation services: You pay a **$225** copay. • Ambulatory surgical center: You pay a **$200** copay. Out-of-Network Services • You pay 40% of covered expenses
Diabetes Supplies and Services (1)	You pay **20%** coinsurance for diabetes supplies. You pay **20%** coinsurance for diabetes self-management training. You pay **20%** coinsurance for diabetic therapeutic shoes or inserts.	In-Network Services • Diabetes monitoring supplies: **0%** of the total cost. • Diabetes self-management training: **0%** of the total cost. • Therapeutic shoes or inserts: **0%** of the total cost. Out-of-Network Services • You pay 40% of covered expenses Plan covers specified manufactures for diabetes monitoring supplies.
Prescription Drug Benefits		
Initial Coverage		
Deductible	Center for Medicare and Medicaid Services defined Standard Benefit Plan deductible for 2020 is **$435.**	**$250** Deductible. Applies only to Tiers 3, 4 and 5.
Initial Coverage	In Original Medicare, if you don't already have creditable prescription drug coverage (for example, from a current or former employer or union) and you would like Medicare prescription drug coverage, you must join a Medicare Prescription Drug Plan, or you can get all your Medicare	You pay the following until your total yearly drug costs reach **$4,020**. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You may get your drugs at network retail pharmacies and mail order pharmacies.

	coverage, by joining a Medicare Advantage Plan.	If you reside in a long-term care facility, you pay the same as at a retail pharmacy. Medications administered as part of home infusion therapy require a **20% coinsurance**. You may get drugs from an out-of-network retail pharmacy at the same cost as an in-network retail pharmacy. For retail cost-sharing see table 1. For mail order cost-sharing see table 2. For LTC care cost sharing see table 3.

Table 1

Standard retail cost-sharing (in-network)	**One-Month supply**	**Three-Month supply**
Tier 1 Preferred Generic	**$0** copay	**$0** copay
Tier 2 Generic	**$15** copay	**$45** copay
Tier 3 Preferred Brand	**$47** copay	**$141** copay
Tier 4 Non-Preferred Brand	**$100** copay	**$300** copay
Tier 5 Specialty Tier	**28%** of the cost	**28%** of the cost
Tier 6 Select Care Drugs	**$9** copay	**$27** copay

Table 2

Preferred Mail Order Cost-Sharing	One-month supply	Three-month supply
Tier 1 Preferred Generic	**$0** copay	**$0** copay
Tier 2 Generic	**$15** copay	**$30** copay
Tier 3 Preferred Brand	**$47** copay	**$94**copay
Tier 4 Non-Preferred Brand	**$100** copay	**$200** copay
Tier 5 Select Care Drugs	**28%** of the cost	**28%** of the cost
Tier 6 Select Care Drugs	**$9** copay	**$18** copay

Table 3

Long-term care (LTC) cost-sharing	One-month supply
Tier 1	**$0** copay

Preferred Generic	
Tier 2 Generic	**$15** copay
Tier 3 Preferred Brand	**$47** copay
Tier 4 Non-Preferred Brand	**$100** copay
Tier 5 Specialty Tier	**28%** of the cost
Tier 6 Select Care Drugs	**$9** copay

Coverage Gap	Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches **$4,020**. After you enter the coverage gap, you pay **25%** of the plan's cost for covered brand name drugs and **37%** of the plan's cost for covered generic drugs until your costs total **$6,350** gap.
Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach **$6,350,** you pay the greater of: • **5%** of the cost, or • **$3.60** copay for generic (including brand drugs treated as generic) and **$8.95** for all other drugs.
Other Care and Services	

Chiropractic Care (1)	Medicare covers manipulation of the spine if medically necessary to correct a subluxation when provided by a chiropractor or other qualified provider. You pay **20%** of the Medicare-approved amount.	Medicare-covered Services: Manipulation of the spine to correct a subluxation (when one (1) or more of the bones of your spine move out of position): In-Network Services • You pay a **$20** copay. Out-of-Network Services • You pay 40% of covered expenses Four (4) Routine Chiropractic Care Visits: In-Network Services • You pay a **$20** copay. Out-of-Network Services • You pay a 40% coinsurance of covered expenses.
Home Health Care (1)	You pay **$0** copay for covered home health care services.	In-Network Services • You pay a **$0** copay. Out-of-Network Services • You pay 40% of covered expenses
Opioid Treatment Services (1)		You pay a $40 copay for Medicare-covered Opioid Treatment Services.
Hospice	You pay part of the cost for outpatient drugs and you may pay part of the cost for inpatient respite care. You must get care from a Medicare certified hospice.	You must get care from a Medicare certified hospice. You must consult with your plan before you select hospice.
Prosthetic Devices *(braces, artificial limbs, etc.)* **(1)**	For Medicare to cover your prosthetic or orthotic, you must go to a supplier that's enrolled in Medicare. You pay **20%** of the Medicare-approved amount.	In- and Out-of-Network Services • Prosthetic devices: You pay **20%** of the total cost. • Related medical supplies: You pay **20%** of the total cost. Out-of-Network Services • You pay **40%** of the total cost.

Renal Dialysis (1)	You pay **20%** of the Medicare-approved amount.	In-Network Services • You pay **20%** of the total cost. Out-of-Network Services • You pay **40%** of the total cost.

(1)**This service may require prior authorization**

EON Health, Inc. (GA) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. EON Health does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

EON Gold**:**

- **Provides free aids and services to people with disabilities to communicate effectively with us, such as:**
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- **Provides free language services to people whose primary language is not English, such as:**
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Member Services at *1-888-906-3889* (TTY: 711).

If you believe that EON Gold has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator:

Attn: Civil Rights Coordinator
EON Health
250 S. Northwest Highway
Park Ridge, IL 60068

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Member Services department is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal. hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201,1- 800-368-1019,800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

English: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-*888-906-3889* (TTY: 711).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-*888-906-3889* (TTY: 711).

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-*888-906-3889* (TTY: 711).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-*888-906-3889* (TTY: 711)번으로 전화해 주십시오.

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-*888-906-3889*（TTY：711。

Gujarati: **ન ા: જ ો ર ાત ી બ ોલત ા હ ો, ત ો ન ન:શ લ ુ ક ભ ાષ ા સ હ ાય સ ે વ ાઓ ત મ ાર ા સ ય ુ ત મ ે ગ જ ુ મ ા ટ ે ઉ પ લ બ ્ધ છ ે. ફ ો ન ક ર ો** 1-*888-906-3889* (TTY: 711).

French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-*888-906-3889* (ATS : 711).

Amharic : ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-*888-906-3889* (መስማት ለተሳናቸው: 711).

Hindi: ध्य न द ें: यदद आप द ि ंदी ब ोलत े ै ं त ो आपक े दलए म ु फ ् त म ें भ ाष ा स ायत ा स ेव ाए ं उपलब ् ध ै ं । 1-*888-906- 3889* (TTY: 711) पर क ॉल कर ें ।

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-*888-906-3889* (TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-*888-906-3889* (телетайп: 711).

Arabic: ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-*888-906-3889* (رقم هاتف الصم والبكم: 711.)

Portuguese: ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-*888-906-3889* (TTY: 711).

Persian (Farsi): **توجه:** اگر به زبان فارسی گفتگو می کنید، تس هیالت زبانی بصورت رایگان تماس بگیرید.(TTY: 711) 1-*888-906-3889* برای شما فراهم می باشد. با

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-*888-906-3889* (TTY: 711).

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-*888-906-3889*（TTY:711）まで、お電話にてご連絡ください。