

Y0122\_0057AAccepted

#### GEORGIA/SOUTH CAROLINA

•

2017

:SUMMARY OF BENEFITS

* Eon Select (MAPD HMO),Eon Choice (MAPD PPO) and Eon Prime (MAPD PPO)

•

•

For more information,call 1-844-895-8643



**2017 Summary of Benefits for**

**Eon Select (HMO)**

**Eon Choice (PPO) and Eon Prime (PPO)**

Thisis a summary ofdrug and health servicescoveredby Eon Health January 1,2017 -December 31,2017

Eon Health has a contract with Medicare to offer HMO and PPO plans. Eon Health also has a contract with the Georgia Medicaid Program and a contract with the South Carolina Medicaid program. Emollment in Eon Health depends on contract renewal.

Thebenefit informationprovided isasummary ofwhatwe cover andwhat youpay.It doesnot list every servicethatwe cover orlist every limitation or exclusion. Togeta complete list of services we cover,please request the "Evidence of Coverage." Youcanobtain a copy of our Evidence of Coverageby calling us at 1-844-895-8643 orvisiting ourwebsite at[www.](http://www/)eonhealthplan.com

Eon Select: Eon Health has a network of doctors, hospitals, pharmacies, and other providers. Ifyou use the providers that are not in

our network, the plan may not pay for these services.

Eon Choice and Eon Prime: Eon Health has a network of doctors, hospitals, pharmacies, and other providers. Ifyou use the providers that are not inour network, your costs may be higher, deductibles and coinsurances may apply.

You cansee ourProvider and Pharmacy Directory onour website at[www.](http://www/)eonhealthplan.com .

You seeour Formulary (Listof Part Dprescription drugs) onour website at[www.](http://www/)eonhealthplan.com

## Introduction

#### **Eon Select** is a Medicare Advantage HMO offered in Georgia and South Carolina.

**Eon Choice and Eon Prime** are Medicare Advantage PPOs offered in Georgia and South Carolina.

To join **Eon Select, Eon Choice and Eon Prime,** you must be entitled to Medicare Part A, enrolled in Medicare Part B and live in our service area.

**Eon Select, Eon Choice and Eon Prime Service Area**

|  |  |
| --- | --- |
| State | Service Area |
| Georgia | Baker, Baldwin, Banks, Barrow, Bibb, Bleckley, Bryan, Butts, Chatham, Cherokee, Clayton, Clinch, Crawford, Dawson, De.Kalb, 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, Wilkinson counties |
| South Carolina | Beaufort, Chester, Colleton, Fair.field, Greenville, Hampton, Jasper, Lee, Saluda, Spartanburg, Union counties |



# HMO Summary of Benefits

##### Health Maintenance Organization (HMO) plans- In most HMOs, you can only go to doctors, other health care providers, or hospitals in the plan's network except in an urgent or emergency situation.

**HMO Plan Highlights**



|  |
| --- |
| **Eon Select**  HMO I • . |
| Monthly Premium  $0 |
| Prescription Drugs  Low copayment for generic drugs |
| Fitness Program  SilverSneakers® |
| Dental Care  Preventative • Comprehensive • Dentures  Vision Care  $135 towards glasses or contact lenses  Hearing Care  Up to $750 towards hearing aids |
| Over-the-Counter Medication  $19 allowance per month |
| Chiropractic  Routine Visit $20 copay (4 visits per year) |

|  |  |
| --- | --- |
| **Benefits** | **Eon Select** |
| Monthly Plan Premium | $0 |
| Deductible | Part C (Medical) - $0  Part D (Pharmacy) - $250 Only applies to Tiers 3A, and *5* |
| Maximum Out-of-Pocket Responsibility  *(does not includeprescription drugs)* | $6,700 annually |
| Inpatient Hospital Coverage1 | $280/Day for Days 1-6  $0/Day for Days 7-90 |
| Doctor Visits1  (Primary and Specialist) | Primary care physician visit:  $20 copay |
| Specialist visit:  $45 copay |
| Preventive Care | $0 copay |
| Emergency Care | $75 copay |
| Urgently Needed Services | $45 copay |
| Diagnostic Services/Labs/Imaging 1 | Diagnostic radiology services (such as MRis, CT scans): 20% coinsurance |
| Diagnostic tests and procedures:  $0 copay |
| Lab services:  $0 copay |
| Outpatient x-rays:  $25 copay |
| Therapeutic radiology services (such as radiation treatment for cancer): 20% coinsurance |
| Hearing Services | Exam to diagnose and treat hearing and balance issues:  $25 copay |
| Routine hearing exam (for up to 1 every year):  $25 copay |
| Hearing aid 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 |

|  |  |
| --- | --- |
| **Benefits** | **Eon Select** |
| Dental Services | Preventive dental services:   * Cleaning (for up to I 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   * 1panoramic x-ray every five years:   $0 copay |
| Comprehensive dental services:  $25 copay and coverage limit of $500 every year   * Coverage is limited to fillings, simple extractions and denture repair.Additional dental services, such as root canals, crowns, surgical extractions, denture relines and periodontal (gum) treatments, are not covered. * 1partial or 1 complete denture per arch every five years.   $0 copay |
| Vision Services | Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening):  $25 copay |
| Routine eye exam (for up to 2 every year):  $10 copay |
| Contact lenses: (for up to 1 every year):  $10 copay  Eyeglasses (frames and lenses): (for up to 1 every year):  $10 copay  Eyeglasses or contact lenses after cataract surgery:  $10 copay |
| $135 every year for contact lenses and eyeglasses (frames and lenses). |

|  |  |
| --- | --- |
| **Benefits** | **Eon Select** |
| Mental Health Services | Inpatient  $265/Day for Days 1-6  $0/Day for Days 7-90 |
| Outpatient group therapy visit:  $40 copay  Outpatient individual therapy visit:  $40 copay |
| Skilled Nursing Facility (SNF) | $0/Day for Days 1-20  $150/Day for Days 21-100 |
| Rehabilitation Services (Outpatient) | Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions over a period of up to 36 weeks):  20% Coinsurance |
| Occupational therapy visit:  $40 copay |
| Physical therapy visit:  $40 copay |
| Speech and language therapy visit:  $40 copay |
| Ambulance1 | $300 copay |
| Transportation | Not Covered |
| Foot Care (podiatry services) | Foot exams and treatment ifyou have diabetes related nerve damage and/or meet certain conditions:  $45 copay Routine foot care: Not Covered |
| Medical Equipment/Supplies 1 | 20% Coinsurance |
| Prosthetic devices: 20% coinsurance  Related medical supplies: 20% coinsurance |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Benefits** | **Eon Select** | | | |
| Wellness Programs (e.g. fitness) | Free health club membership, SilverSneakers• and or Free @HomePak {workout Kit) for those with limited access to a network fitness center members with limited access to a network fitness center | | | |
| Medicare Part B drugs | 20% coinsurance | | | |
| PRESCRIPTION DRUG BENEFITS | | | | |
| Annual Prescription  Deductible | $0 per year for Tier 1and Tier 2  $250 per year for Tier 3, Tier 4 and Tier 5 | | | |
| Initial Coverage Retail | Tier 1: 1month supply - $4 2 month suooly - $8 3 month suooly - $12 | | | |
| Tier 2: | 1month supply - $12 | 2 month supply - $24 | 3 month supply - $36 |
| Tier 3: | 1month supply - $47 | 2 month supply - $94 | 3 month supply - $141 |
| Tier 4: | 1month supply - $100 2 month supply - $200 | | 3 month supply - $300 |
| Tier 5: | 1month 28% 2 month supply - 28% 3 month supply - 28% | | |
| Initial Coverage Mail Order | Tier 1: 3 month supply $8 | | | |
| Tier 2: | 3 month supply $24 | | |
| Tier 3: | 3 month supply $94 | | |
| Tier 4: | 3 month supply $200 | | |
| Tier 5: 3 month supply 28% | | | |
| Coverage Gap | After you enter the coverage gap, you pay 40% of the plan's cost for covered brand name drugs and 51% of the plan's cost for covered generic drugs until your costs total $4,950, which is the end of the coverage gap. Not everyone will enter the coverage gap. | | | |
| Catastrophic Coverage | for generic (including brand drugstreated as generic) 5% of the cost, or $3.30 copay whichever is greater | | | |
| for all other drugs:  5% of the cost, or $8.25 copay whichever is greater | | | |
| Over-the-Counter Items | Members receive a $19 allowance every month | | | |



# PPO Summary of Benefits

##### Preferred Provider Organization {PPO) plans- In a PPO, you pay less if you use doctors, hospitals, and other health care providers that belong to the plan's network. You usually pay more if you use doctors, hospitals, and providers outside of the network.



|  |
| --- |
| Eon Choice  PPO [ • . |
| Monthly Premium  $39 |
| Prescription Drugs  Low copayments for generic drugs |
| Fitness Program  SilverSneakers® |
| Dental Care  Preventative • Comprehensive • Dentures  Vision Care  $135 towards glasses or contact lenses  Hearing Care  Exams and up to $750 for hearing aids  Over-the-Counter Medication  $19 allowance per month |
| Chiropractic Care Routine visit $20 copay (4 visits per year) |

|  |
| --- |
| Monthly Premium  $59 |
| Prescription Drugs  $0 copay for generic drugs |
| Fitness Program  SilverSneakers® |
| Dental Care  Preventative • Comprehensive • Dentures  Vision Care  $135 towards glasses or contact lenses  Hearing Care  Exams and up to $750 for hearing aids  Over-the-Counter Medication  $19 allowance per month |
| Chiropractic Care Routine visit $20 copay (4 visits per year) |



|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Benefits** | **Eon Choice** | |  | |
| Monthly Plan Premium | $39.00 | | $59.00 | |
|  | IN-NETWORK | OUT-OF-NETWORK | IN-NETWORK | OUT-OF-NETWORK |
| Part C (Medical) Deductible | No Deductible | $500 | No Deductible | $250 |
| Part D (Pharmacy) Deductible | $250 Tiers 3,4,5  (In-Network and Out-of-Network) | | $200 Tiers 3,4,5  In-Network and Out-of-Network | |
| Maximum Out-of-Pocket Responsibility  *(does not include prescripti on drugs)* | $6,700 annually | $10,000 annually, limit for services received from in­ network providers WILL count toward this limit. | $6,700 annually | $10,000 annually, limit for services received from in-network providers WILL count toward this limit. |
| Inpatient Hospital Coverage1 | $280/Day for Days 1 - 6  $0/Day for Days 7 - 90 | 40% coinsurance | $250/Day for Days  1-6  $0/Day for Days  7 - 90 | 30% coinsmance |
| Doctor Visits1  (Primary and Specialist) | Primary care physician visit:  $20 co a | Primary care physician visit: 40% coinsurance | Primary care  physician visit:  $15 copay | Primary care physician visit: 30% coinsmance |
| Specialist visit:  $45 co a | Specialist visit: 40% coinsurance | Specialist visit:  $35 co a | Specialist visit: 30% coinsurance |
| Preventive Care | $0 copay | 0% coinsurance | $0 copay | 0% coinsurance |
| Emergency Care | $75 copay | $75 copay | $75 copay | $75 copay |
| Urgently Needed Services | $45 copay | $45 copay | $35 copay | $35 copay |
| Diagnostic Services/Labs/Imaging 1 | Diagnostic radiology services (such as MRis, CT scans):  200/o coinsurance | Diagnostic radiology services (such as MR.Is, CT scans):  40% coinsurance | Diagnostic radiology services (such as MRis, CT scans):  20% coinsurance | Diagnostic radiology services (such as MRis, CT scans):  30% coinsurance |
| Diagnostic tests and procedures:  $0 co a | Diagnostic tests and procedures:  40% coinsurance | Diagnostic tests and procedmes:  $0 co a | Diagnostic tests and procedures:  30% coinsurance |



**Benefits Eon Choice**

IN-NETWORK OUT-OF-NETWORK IN-NETWORK OUT-OF-NETWORK

Diagnostic Lab services: $0 Lab services: Lab services: Lab services: Services/Labs/Imaging1 co a 40% coinsurance $0 30% coinsurance

Outpatient x-rays: Outpatient x-rays: Outpatient x-rays: Outpatient x-rays:

$25 copay 40% coinsurance $25 copay 30% coinsurance

Therapeutic Therapeutic radiology Therapeutic radiology Therapeutic radiology services radiology services services (such as radiation services (such asradiation (such as radiation treatment for (such as radiation treatment for cancer): treatment for cancer): cancer):

treatment for 40% coinsurance 20% coinsurance 30% coinsurance cancer):

20% coinsurance

Hearing Services Exam to diagnose Exam to diagnose and treat Exam to diagnose and treat Exam to diagnose and treat and treat hearing hearing and balance issues: hearing and balance issues: hearing and balance issues: and balance issues: 40% coinsurance $25 copay 30% coinsurance

$25 co a

Routine hearing 50% coinsurance Routinehearing exam (for up 50% coinsurance exam (for up to 1 to 1every year):

every year): $25 copay

$25 co a

Hearing aid 50% coinsurance Hearing aid fitting/evaluation 50% coinsurance fitting/evaluation (for up to 1every 3 years):

(for up to 1every 3 $0 copay

years):

$0 co a

Our plan pays up to 50% coinsurance Our plan pays up to $750 50% coinsurance

$750 every three every three years for hearing

years for hearing aids.Benefit amount applies

aids. Benefit to both ears combined.

amount applies to both ears combined.



|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Benefits** | **Eon Choice** | |  | OUT-OF-NETWORK  50% coinsurance  Coverage limit is $500 every year -  500/o coinsurance   * 1partial or 1 complete denture per arch every five years.   500/o coinsurance |
| Dental Services | IN-NETWORK  Preventive dental services:   * Cleaning   (for up to 1 every six mths):  $0 copay   * Dental x-ray(s)   (for up to 1 every six mths):  $0 copay   * Oral exam   (for up to 1 every six mths):  $0 copay   * 1dental bitewing x-ray   per side every six mths:  $0 copay   * 1panoramic x-ray every five years:   $0 copay  Comprehensive dental services: coverage limit is  $500 every year - $25 copay  Coverage is limited to fillings, simple extractions 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 | OUT-OF-NETWORK  500/o coinsurance  Coverage limit is $500  every year -  50% coinsurance   * 1partial or 1 complete denture per arch every five years.   50% coinsurance | IN-NETWORK  Preventive dental services:   * Cleaning   (for up to 1 every six mths):  $0 copay   * Dental x-ray(s)   (for up to 1 every six mths):  $0 copay   * Oral exam   (for up to 1every six mths):  $0 copay   * 1dental bitewing X-ray   per side every six mths:  $0 copay   * 1panoramic x-ray every five years:   $0 copay  Comprehensive dental services:coverage limit is  $500 every year - $25 copay  Coverage is limited to  :fillings, simple extractions and denture repair.  Additional dental services, such as root canals, crowns, surgical extractions, denture relines and periodontal (gum) treatments are not covered.   * 1partial or 1complete denture per arch every five years.   $0 copay |



|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Benefits** | **Eon Choice** | |  | OUT-OF-NETWORK |
|  | IN-NETWORK | OUT-OF-NETWORK | IN-NETWORK |
| Vision Services | Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening):  $25 copay | Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening):  40% coinsurance | Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening):  $25 copay | Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening):  300/o coinsurance |
| Routine eye exam  (for up to 2 every year):  $10 co a | 50% coinsurance | Routine eye exam  (for up to 2 every year):  $10 co a | 500/o coinsurance |
| Contact lenses:  (for up to 1 every year):  $10 copay Eyeglasses:  (for up to 1 every year):  $10 copay  Eyeglasses or contact lenses after cataract surgery:  $10 co a | 50% coinsurance | Contact lenses:  (for up to 1every year):  $10 copay Eyeglasses:  (for up to 1every year):  $10 copay  Eyeglasses or contact lenses after cataract surgery:  $10 co a | 500/o coinsurance |
| $135 every year towards eyeglasses or contact lenses | $135 every year towards eyeglasses or contact lenses 50% coinsurance | $135 every year towards eyeglasses or contact lenses | $135 every year towards eyeglasses or contact lenses *500/o* coinsurance |



|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Benefits** | **Eon Choice** | |  |  |
|  | IN-NETWORK | OUT-OF-NETWORK | IN-NETWORK | OUT-OF-NETWORK |
| Mental Health Services | $265/Day for Days 1 - 6  $0/Da for Da s 7 - 90 | 40% coinsurance | $250/Day for Days 1 - 6  $0/Da for Da s 7 - 90 | 30% coinsurance |
| Outpatient group therapy  visit:  $40 copay  Outpatient individual therapy visit:  $40 copay | Outpatient group therapy visit:  40% coinsurance Outpatient individual therapy visit:  40% coinsurance | Outpatient group therapy  visit:  $35 copay  Outpatient individual therapy visit:  $35 copay | Outpatient group therapy visit:  30% coinsurance Outpatient individual therapy visit:  30% coinsurance |
| Skilled Nursing Facility (SNF) | $0/Day for Days 1 -20  $150/Da for Da s 21-100 | 40% coinsurance | $0/Day for Days 1 -20  $125/Da for Da s 21-100 | 30% coinsurance |
| Rehabilitation Services (Outpatient) | Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions over a period of up to 36 weeks): 20% Coinsurance | Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions over a period of up to 36 weeks): 40% coinsurance | Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions over a period of up to 36 weeks): 20% Coinsurance | Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions over a period of up to 36 weeks): 30% coinsurance |
| Occupational therapy visit:  $40 copay | Occupational therapy visit:  40% coinsurance | Occupational therapy visit:  $35 copay | Occupational therapy visit:  30% coinsurance |
| Physical therapy visit:  $40 copay | Physical therapy visit: 40% coinsurance | Physical therapy visit:  $35 copay | Physical therapy visit: 30% coinsurance |
| Speech and language  therapy visit:  $40 copay | Speech and language therapy visit:  40% coinsurance | Speech and language  therapy visit:  $35 copay | Speech and language therapy visit:  30% coinsurance |



|  |  |  |  |
| --- | --- | --- | --- |
| **Benefits** | **Eon Choice** | |  |
|  |  | IN-NETWORK OUT-OF-NETWORK  $300 copay $300 copay  Not Covered Not Covered  Foot exams and treatment Foot exams and treatment if you have diabetes related if you have diabetes related nerve dam.age and/or meet nerve damage and/or meet certain conditions: certain conditions:  $45 copay 40% coinsurance  Routine foot care: Routine foot care:  Not Covered Not Covered  20% coinsurance 40% coinsurance  Prosthetic devices: Prosthetic devices:  200/o coinsurance 40% coinsurance  Related medical supplies: Related medical supplies: 200/o coinsurance 40% coinsurance | IN-NETWORK OUT-OF-NETWORK  $275 copay $275 copay  Not Covered Not Covered  Foot exams and treatment Foot exams and treatment if you have diabetes related if you have diabetes related nerve damage and/or meet nerve damage and/or meet certain conditions: certain conditions:  $35 c 30% coinsurance  Routine foot care: Routine foot care:  Not Covered Not Covered  20% coinsurance 300/o coinsurance  Prosthetic devices: Prosthetic devices:  20% coinsurance 300/o coinsurance  Related medical supplies: Related medical supplies: 20% coinsurance 300/o coinsurance |
| Ambulance' |  |
| Transportation |  |
| Foot Care (podiatry services) |  |
| Medical Equipment/  Supplies• |  |
| Wellness Programs (e.g. fitness) | Free health club membership, SilverSneakers® and/or Free@Homepak (workout Kit) for those with limited access to a network fitness center | | Free health club membership, SilverSneakers® and/or Free@Homepak (workout Kit) for those with limited access to a network fitness center |
| Medicare Part B Drugs | 200/o coinsurance 40% coinsurance | | 20% coinsurance 30% coinsurance |



|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Benefits** | **Eon Choice** | |  | |
| PRESCRIPTION DRUG BENEFITS | | | | |
|  | RETAIL MAILORDER | | RETAIL MAIL ORDER | |
| Annual Prescription Deductible | $0 per year for Tier 1 and Tier 2  $250 per year for Tier 3, Tier 4 and Tier *5* | | $0 per year for Tier 1and Tier 2  $250 per year for Tier 3, Tier 4 and Tier *5* | |
| Initial Coverage Retail | Tier 1: 1 month supply $4 2 month supply $8  3 month supply $12 | Tier 1:3 month supply $8 | Tier 1: 1month supply $0 2 month supply $0  3 month supply $0 | Tier 1: 3 month supply SO |
| Tier 2: 1 month supply $12 2 month supply $24 3 month supply $36 | Tier 2: 3 month supply $24 | Tier 2: 1month supply $12 2 month supply $24  3 month su 1 $36 | Tier 2: 3 month supply $24 |
| Tier 3: 1 month supply $47 2 month supply $94 3 month supply $141 | Tier 3: 3 month supply $94 | Tier 3: 1month supply $47 2 month supply $94  3 month su ly $141 | Tier 3: 3 month supply $94 |
| Tier 4: 1 month supply $100 2 month supply $200 3 month supply $300 | Tier 4: 3 month supply $200 | Tier 4: 1month supply $100 2 month supply $200 3 month su ly $300 | Tier 4: 3 month supply  $200 |
| Tier 5: 1 month supply 28%   1. month supply 28% 2. month supply 28% | Tier 5: 3 month supply 28% | Tier 5: 1month supply 28%   1. month supply 28% 2. month su 1 28% | Tier 5: 3 month supply 28% |
| Coverage Gap | After you enter the coverage gap, you pay 40% of the plan's cost for covered brand name drugs and 51% of the plan's cost for covered generic drugs until your costs total $4,950, which is the end of the coverage gap. Not everyone will enter the coverage gap. | | After you enter the coverage gap, you pay 40% of the plan's cost for covered brand name drugs and 51% of the plan's cost for covered generic drugs until your costs total  $4,950,which is the end of the coverage gap.Not everyone will enter the coverage gap. | |
| Catastrophic Coverage | for generic (including brand drugs treated as generic)  *5%* of the cost, or $3.30 copay whichever is greater  for all other drugs:  *5%* of the cost, or $8.25 copay whichever is greater | | for generic (including brand drugs treated as generic)  *5%* of the cost, or $3.30 copay whichever is greater  for all other drugs:  *5%* of the cost, or $8.25 copay whichever is greater | |
| Over-the-Counter Items | Members receive a $19 allowance every month | | Members receive a $19 allowance every month | |

This page intentionally left blank



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.

**Current Members 1-888-906-3889**

TTY:711

**Prospective Members 1-844-895-8643**

TTY:711

**Hours of Operation:**

**From October 15 - February 14:** Seven days a week, 8:00am - 8:00pm **February 15 - October 14:** Monday through Friday, 8:00am - 8:00pm (You may leave a voicemail Saturday, Sunday and Holidays)

