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0 GEORGIA/SOUTH CAROLINA



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2017 l•

SUMMARY OF BENEFITS

Eon Deluxe (HMO SNP) and Eon Plus (HMO SNP)

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



**2017 Summary of Benefits for**

**Eon Deluxe (HMO SNP) and Eon Plus (HMO SNP)**

This is a summary of drug and health services covered by Eon Health January 1, 2017 - December 31, 2017

Eon Health has acontract with Medicare tooffer HMO and PPOplans. Eon Health alsohas acontract with the Georgia MedicaidProgram and a contract with the South Carolina Medicaidprogram. Enrollment in Eon Health depends oncontract renewal.

The benefit information provided is a summary of what we cover and what you pay.Itdoes 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." You can obtain a copy of our Evidence of Coverage by calling us at: Current Members:1-888-906-3889, Prospective Members: 1-844-895-8643, TTY: 711or visiting our website at [www.eonhealthplan.com.](http://www.eonhealthplan.com/)

Eon Health has a network of doctors, hospitals,pharmacies, and other providers. Ifyou use the providers that are not inour network, the plan may not pay for these services

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

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

**Introduction**

Eon Deluxe and Eon Plus are Medicare Advantage HMO Special Needs Plans (SNP) offered in Georgia and South Carolina. Georgia

Tojoin Eon Deluxe, you must be entitled to Medicare Part A, enrolled in both Medicare Part B and *Geo-rgia Medicaid Program,* and live in our service area.

Tojoin Eon Plus, you must be entitled to Medicare Part A, enrolled in Medicare Part B, receive assistance from Georgia Medicaid and live in our service area.

South Carolina

Tojoin Eon Deluxe, you must be entitled to Medicare Part A, enrolled in both Medicare Part B and *South Carolina Medicaid Program-* Healthy Connections, and live in our service area.

Tojoin Eon Plus, you must be entitled to Medicare Part A, enrolled in Medicare Part B, receive assistance from South Carolina Medicaid and live in our service area.

Eon Deluxe and Eon Plus Service Area

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| State | Service Area |
| 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, Mor!JID, Newton, Oconee, Oglethorpe, Peach, Pickens, Pike, Pulaski, Putnam, Rabun, Rockdale, Schley, Screven, Stephens, Talbot, Taliaferro, Taylor, Twie:e:s, Walton, White, Wilcox, Wilkinson counties |
| South Carolina | Beaufort, Chester, Colleton, Fairfield, 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 SNP Plan Highlights



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| Eon Deluxe  HMO SNP [ • .  Monthly Premium  $0 |
| Doctor Visits  $0 PCP  $0 Specialist |
| Generic Prescriptions  As low as $0 |
| Fitness Program  SilverSneak:ers® |
| Dental Care  Preventative • Comprehensive • Dentures  Vision Care  $100 towards glasses or contact lenses  Hearing Care  Exams and up to $750 for hearing aids  Transportation  12 one-way to plan-approved locations  Over-the-Counter Medication  $15 allowance per month |

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| **Benefits** | **Eon Deluxe** |
| Monthly Plan Premium | $0 per month |
| Deductible | $0 |
| Maximum Out-of-Pocket Responsibility  *(does not include prescription drugs)* | $3,400 annually |
| Inpatient Hospital Coverage1 | $0/Day for Days 1-6  $0/Day for Days 7-90 |
| Doctor Visits1 (Primary and Specialist) | Primary care physician visit: $0 copay |
| Specialist visit: $0 copay |
| Preventive Care | $0 copay |
| Emergency Care | $0 copay |
| Urgently Needed Services | SO copay |
| Diagnostic Services/Labs/Imaging 1 | Diagnostic radiology services (such as MR.Is, CT scans): 0% coinsurance |
| Di8.2Ilostic tests and procedures: $0 copay |
| Lab services:$0 copay |
| Outpatient x-rays:$0 copay |
| Therapeutic radiology services (such as radiation treatment for cancer): 0% coinsurance |
| Hearing Services1 | Exam to diagnose and treat hearing and balance issues:$0 copay |
| Routine hearing exam (for up to l every year):$0 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. |

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| **Benefits** | **Eon Deluxe** |
| Dental Services1 | Preventive dental services:  -Cleaning (for up to 1 every six months): $0 copay  -Dental x-ray(s) (for up to 1every six months):$0 copay  -Oral exam (for up to 1every 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  Comprehensive dental services coverage limit is $500 every year.$0 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 1complete 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):$0 copay |
| Routine eye exam (for up to 1every year):$0 copay |
| Contact lenses:(for up to 1every year): $0 copay  Eyeglasses (frames and lenses):(for up to 1every year):$0 copay Eyeglasses or contact lenses after cataract surgery:$0 copay |
| $100 every year for contact lenses and eyeglasses (frames and lenses) |
| Mental Health Services1 | Inpatient  $0/Day for Days 1-6  $0/Day for Days 7-90 |
| Outpatient group therapy visit: $0 copay Outpatient individual therapy visit: $0 copay |
| Skilled Nursing Facility (SNF) 1 | $0/Day for Days 1-20  $0/Day for Days 21-100 |

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| **Benefits** | **Eon Deluxe** |
| Rehabilitation Services (Outpatient) 1 | Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions for a period of up to 36 weeks):0% Coinsurance |
| Occupational therapy visit:$0 copay |
| Physical therapy visit:$0 copay |
| Speech and language therapy visit:$0 copay |
| Ambulance1 | $0 copay |
| Transportation 1 | $0 copay/ 12 one way trips |
| Foot Care (podiatry services) | Foot exams and treatment if you have diabetes related nerve damage and/or meet certain conditions:$0 copay  Routine foot care:$0 copay |
| Medical Equipment/Supplies1 | 0% Coinsurance |
| Prosthetic devices:0% coinsurance  Related medical supplies:0% coinsurance |
| 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 |
| Medicare Part B drugs1 | OOA> coinsurance |

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| **Benefits** | **Eon Deluxe** |
| PRESCRIPTION DRUG BENEFITS | |
| Initial Coverage Retail | For generic drugs (including brand drugs treated as generic), either:  $0 copay/ $1.20 copay/ $3.30 copay |
| For all other drugs,either:  $0 copay/ $3.70 copay/ $8.25 copay |
| Coverage Gap | For generic drugs (including brand drugs treated as generic), either:  $0 copay/ $1.20 copay/ $3.30 copay |
| For all other drugs,either:  $0 copay/ $3.70 copay/ $8.25 copay |
| Catastrophic Coverage | For generic drugs (including brand drugs treated as generic), either:  $0 copay |
| For all other drugs,either:  $0 copay |
| Over-the-Counter Items | Members receive a $15 allowance every month |



# 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 SNP Plan Highlights



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| Monthly Premium  Georgia residents $0-$25.80 South Carolina Residents $0-$26.00 |
| Doctor Visits  $0 or $20 PCP  $0 or $45 Specialist |
| Generic Prescriptions  As low as $0 |
| Fitness Program  SilverSneakers® |
| Dental Care  Preventative • Comprehensive • Dentures  Vision Care  $100 towards glasses or contact lenses  Hearing Care  Exams and up to $750 for hearing aids  Transportation  12 one-way to plan-approved locations  Over-the-Counter Medication  $15 allowance per month |



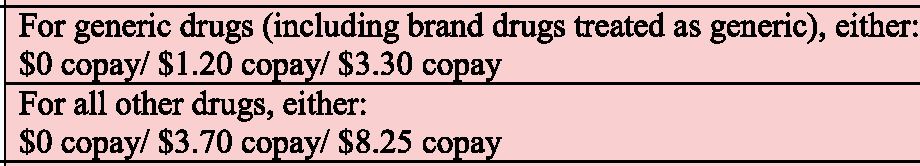
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| **Benefits** |  | |
| Monthly Plan Premium | Georgia residents $0-$25.80  South Carolina residents $0-$26.00 | |
| Deductible | $0 | |
| Maximum Out-of-Pocket Responsibility  *(does not includeprescription drugs)* | $6,700 annually | |
| Inpatient Hospital Coverage1 |  | $0 or $280/Day for Days 1-6  $0/Day for Days 7-90  Specialist visit: $0 or $45 copay |
| Doctor Visits1  (Primary and Specialist) |  |
| Preventive Care | $0 copay | |
| Emergency Care | $0 or $75 copay | |
| Urgently Needed Services | $0 or $45 copay | |
| Diagnostic Services/Labs/lmaging1 | Diagnostic radiology services (such as MRls, CT scans): 0% or 20% coinsurance | |
| Diagnostic tests and procedures: $0 copay | |
| Lab services: $0 copay | |
| Outpatient x-rays: $0 or $25 copay | |
| Therapeutic radiology services (such as radiation treatment for cancer): 0% or 20% coinsurance | |
| Hearing Services1 | Exam to diagnose and treat hearing and balance issues: $0 or $25 copay | |
| Routine hearing exam (for up to 1 every year): $0 or $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. | |



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| **Benefits** |  |
| Dental Services! | Preventive dental services:   * 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 * 1panoramic x-ray every five years: $0 copay |
| Comprehensive dental services coverage limit is $500 every year.  $0 or $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 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): $0 or $25 copay |
| Routine eye exam (for up to 1every 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 |
| $100 every year for contact lenses and eyeglasses (frames and lenses) |
| Mental Health Services1 | Inpatient  $0 or $265/Day for Days 1-6  $0/Da for Da s 7-90 |
| Outpatient group therapy visit: $0 or $40 copay Outpatient individual therapy visit: $0 or $40 copay |
| Skllled Nursing Facllity (SNF) 1 | $0/Day for Days 1-20  $0 or $150/Day for Days 21-100 |



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| **Benefits** |  |
| Rehabilitation Services (Outpatient)1 | Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions for a period of up to 36 weeks): 0% or 20% Coinsurance  Occupational therapy visit: $0 or $40 copay |
| Physical therapy visit: $0 or $40 copay |
| Speech and language therapy visit: $0 or $40 copay |
| Ambulance1 | $0 or $300 copay |
| Transportation 1 | $0 copay/ 12 one way trips |
| Foot Care (podiatry services) | Foot exams and treatment if you have diabetes related nerve damage and/or meet certain conditions: $0 or $45 copay  Routine foot care: Not Covered |
| Medical Equipment/Supplies 1 | 0% or 200./o Coinsurance |
| Prosthetic devices:0% or 20% coinsurance Related medical supplies: 0% or 20% coinsurance |
| 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 |
| Medicare Part B drugs1 | 20% coinsurance |



Initial Coverage Retail

For generic drugs (including brand drugs treated as generic), either:

$0 copay/ $1.20 copay/ $3.30 copay

Over the Counter Items Members receive a $15 allowance every month

**Benefits**

PRESCRIPTION DRUG BENEFITS

For all other drugs, either:

$0 copay/ $3.70 copay/ $8.25 copay

Coverage Gap

Catastrophic Coverage

For generic drugs (including brand drugs treated as generic), either:

$0 copay

For all other drugs, either:

$0 copay

Statement of Medicaid Benefits and Cost-Sharing Protections

Eligibility

Eon Deluxe (HMO SNP)

The Eon Deluxe Plan is available to anyone with both Medicare Parts A and B and who receives Medical Assistance from the state Medicaid program to cover Medicare cost-sharing.

* Eon Deluxe (HMO SNP) members with Full benefit Medicaid status (Full Benefit Dual Eligible (FBDE), Qualified Medicare Beneficiary Plus (QMB +) and Specified Low-Income Medicare Beneficiary Plus (SLMB +) are covered by the state Medicaid program for their Medicare cost sharing.
* Eon Deluxe (HMO SNP) Plan with full Medicaid coverage are enrolled in the State Medicaid program that pays their Medicare cost sharing. These members are also eligible to receive additional Medicaid benefits describe below.

Eon Plus (HMO SNP)

* Eon Plus (HMO SNP) members with Qualified Medicare Beneficiary Plus (QMB), Specified Low-Income Medicare Beneficiary (SLMB), Qualified Individual (QI) and Qualified Disabled and Working Individual (QDWI) status receive state assistance from the state Medicaid program for their Medicare cost sharing.

Cost Sharing and Cost-sharing Protections for All Members

In Eon Deluxe plan, the state Medicaid program pays the cost sharing for Medicare-covered medical services you receive. You pay no cost sharing for the Medicare-covered benefits described in the Covered Medical and Hospital Benefits section of this Summary of Benefits. You will pay small copayments for prescriptions covered under the Medicare Part D prescription drug benefit. When you receive health services, the provider should only bill Eon Deluxe (HMO SNP) or the state Medicaid program for the cost of those services and cost-sharing amounts. The provider should not bill you for services or cost sharing.

In Eon Plus plan, the state Medicaid program may pay the cost sharing for Medicare-covered medical services you receive dependent on your level of Medicaid eligibility.You will pay small copayments for prescriptions covered under the Medicare Part D prescription drug benefit. When you receive health services, the provider should only bill Eon Plus (HMO SNP) or the state Medicaid program for the cost of those services and cost­ sharing amounts. The provider should not bill you for services or cost sharing.

Ifyou receive care from a non-contracted provider, the provider may not understand Eon Deluxe, Eon Plus or these billing rules.Ifyou receive a bill from a provider for Medicare-covered services, please notify Member Services so we can help you.

Please see Chapter 7 of your Eon Deluxe Evidence of Coverage for more information.

The benefits described below are covered by Medicaid. The benefits described in the Covered Medical and Hospital Benefits section of the Summary of Benefits are covered by Medicare. For each benefit listed below, you can see what your state Medicaid covers and what our plan covers. What you pay for covered services may depend on your level of Medicaid eligibility.



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| Benefit | Georgia Medicaid | Eon Deluxe |  |
| Ambulance (medically necessary ambulance services) | For dual-eligible members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted.  $0 per visit if emergent  $3 per visit will be imposed if the condition is not an emergent medical condition. | $0 copay | $0 or $300 copay |
| Dental Services | Preventive, diagnostic and treatment services provided to Members under age 21.  Emergency Services only for Members age 21 and older.  Children < 21: $0 per visit - Services include exams, cleanings, X-rays, fillings, dentures, oral surgery and orthodontic treatment.  Adults 21+ (emergency only): $0 co-pay | Preventive dental services:   * 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   * 1panoramic x-ray every five ears:$0 co a | Preventive dental services:   * Cleaning (for up to 1every 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 |

Benefit Georgia Medicaid Eon Deluxe Comprehensive dental services coverage limit is

$500 every year. $0 copay

* + Coverage is limited to fillings,simple extractions and denture repair.Additional dental services, such as root canals, crovvns, surgical

extractions,denture relines and periodontal (gum) treatments,are not covered.

* 1partial or 1complete denture per arch every five years.$0 copay

Comprehensive dental services coverage limit is

$500 every year.

$0 or $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 ears. $0 co a

Diagnostic Tests, X-Rays, Lab Services, and Radiology Services



For dual-eligible members, Diagnostic radiology Diagnostic radiology Medicaid pays for this service if it services (such as MR.Is, CT services (such as MR.Is, CT is not covered by Medicare or scans):0% coinsurance scans):

when the Medicare benefit is 0% or 20% coinsurance exhausted. Diagnostic tests and Diagnostic tests and

procedures: procedures:

$3 co-pay if outpatient based $0 co a $0 co a

\*Not covered: portable X-ray Lab services:$0 copay Lab services: $0 copay services; services provided in Outpatient x-rays: Outpatient x-rays:

facilities not meeting the definition ....\_o\_co......a......\_ s\_o\_o\_r\_$\_2\_5\_c\_o a.. 1

of an independent laboratory or X- Therapeutic radiology Therapeutic radiology

ray facility; services or procedures services (such as radiation services (such as radiation referred to another testing facility; treatment for cancer): treatment for cancer): services furnished by a State or 0% coinsurance 0% or 200/o coinsurance public laboratory; services or

procedures performed by a facility



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| Benefit | Georgia Medicaid | Eon Deluxe |  |
|  | not certified to perform them. |  |  |
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| Benefit | Georgia Medicaid | Eon Deluxe |  |
|  | exhausted.  $0 co-pay for Medicaid-covered services.  \*Not covered outside the U.S. except under limited circumstances. Contact the plan for more details. |  |  |
| Hearing Services | For dual-eligible members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted.  \*Not covered for members age 21 and older. Available under EPSDT as part of a written service plan. | Exam to diagnose and treat hearing and balance issues:  $0 co a | Exam to diagnose and treat hearing and balance issues:  $0 or $25 co a |
| Routine hearing exam (for  up to 1every year):  $0 co | Routine hearing exam (for up to 1 every year):  $0 or $25 co a |
| Hearing aid fitting/evaluation (for up to 1eve 3 ears):$0 co a | Hearing aid fitting/evaluation (for up to 1 every 3 years):  $0 copa |
| Our plan pays up to $750  every three years for hearing aids.Benefit amount applies to both ears combined. | Our plan pays up to $750 every three years for hearing aids. Benefit amount applies to both ears combined. |
| Home Health Care | For dual-eligible members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted.  \*Not covered: social services, | $0 copay | $0 copay |



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| Benefit | Georgia Medicaid | Eon Deluxe |  |
|  | chore services, meals on wheels, audiology services. |  |  |
| Hospice | For dual-eligible members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted.  $3 co-pay  \*Available to Members certified as being terminally illand having a medical prognosis oflife expectancy of six (6) months or less. | You pay nothing for hospice care from a Medicare-certified hospice.  You may have to pay part of the costs for drugs and respite care.Hospice is covered outside of our plan. Please contact us for more details | You pay nothing for hospice care from a Medicare- certified hospice. You may have to pay part of the costs for drugs and respite care.  Hospice is covered outside of our plan. Please contact us  for more details |
| Inpatient Hospital Care  (Includes Substance Abuse and Rehabilitation Services) | For dual-eligible members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted.  $12.50 per admission for members over age. | $0/Day for Days 1-6  $0/Day for Days 7-90 | $0 or $280/Day for Days 1-6  $0/Day for Days 7-90 |
| Outpatient Mental Health Care | For dual-eligible members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted.  $3.00 member co- a ent is | Outpatient group therapy visit:  $0 copay  Outpatient individual therapy visit:  $0 copay | Outpatient group therapy visit:  $0 or $40 copay  Outpatient individual therapy visit:  $0 or $40 copay |



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| Benefit | Georgia Medicaid | Eon Deluxe |  |
|  | required on all non-emergency outpatient hospital visits.  \*Community Mental Health Rehabilitation services are only available as part of a written service plan.  Pregnant women, members under twenty-one (21) years of age, nursing facility members, community care participants, Qualified Medicare  Beneficiary (QMB), and hospice care participants are not subject to the co-payment.  When the outpatient cost-based settlements are made for hospital services, the co-payment plus Medicaid payment will be compared to the allowable cost to determine the amount of final settlement. |  |  |
| Outpatient Substance Abuse | For dual-eligible members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted.  $3 co-pay  \*Substance abuse treatment, | Outpatient group therapy visit: $0 copay Outpatient individual therapy visit: $0 copay | Outpatient group therapy visit: $0 or $45 copay Outpatient individual therapy visit: $0 or $45 copay |



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| Benefit | Georgia Medicaid | Eon Deluxe |  |
|  | Inpatient and rehabilitative, are covered as part of a written service plan. |  |  |
| Outpatient Surgery | For dual-eligible members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted. | Ambulatory surgical center:  $0 co a | Ambulatory surgical center:  $0 or $200 copay |
| Outpatient hospital:  $0 copay | Outpatient hospital:  $0 or $245 copay |
| Over-the-Counter Items | Not Covered | Members receive a $15 allowance every month | Members receive a $15 allowance every month |
| Podiatry Services | For dual-eligible members, | Foot exams and treatment | Foot exams and treatment if |
| Medicaid pays for this service if it | ifyou have diabetes related | you have diabetes related |
| is not covered by Medicare or | nerve damage and/or meet | nerve damage and/or meet |
| when the Medicare benefit is | certain conditions: | certain conditions: |
| exhausted. | $0 copay | $0 or $45 copay |
| Cost-based: | Routine foot care:  $0 copay | Routine foot care: Not covered |
| $10.00 or less -$0.50 |
| $10.01-$25.00 - $1.00 |
| $25.01-$50.00 -$2.00 |
| $50.01 or more -$3.00 |
| \*Not covered: services for flatfoot; |
| subluxation; routine foot care, |
| supportive devices; vitamin B-12 |
| injections. |



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| Benefit | Georgia Medicaid | Eon Deluxe |  |
| Prosthetic Devices  (includes braces, artificial limbs and eyes, etc.) | For dual-eligible members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted.  $3 co-pay  \*Not covered for Members age 21and older: orthopedic shoes and supportive devices for the feet which are not an integral part of a leg brace; hearing aids and accessones. | Prosthetic devices: 0% coinsurance  Related medical supplies: 0% coinsurance | Prosthetic devices:  0% or 200/o coinsurance  Related medical supplies: 0% or 200/o coinsurance |



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| Eon Deluxe | |
| Initial Coverage Retail | Initial Coverage Retail |
| For generic drugs (including brand drugs treated as generic), either:  $0 copay/ $1.20 copay/  $3.30 copay | For generic drugs (including brand drugs treated as generic), either:  $0 copay/ $1.20 copay/ $3.30 copay |
| For all other drugs, either:  $0 copay/ $3.70 copay/  $8.25 copay | For all other drugs, either:  $0 copay/ $3.70 copay/ $8.25 copay |
| Coverage Gap | Coverage Gap |
| For generic drugs (including brand drugs treated as generic), either:  $0 copay/ $1.20 copay/  $3.30 co a | For generic drugs (including brand drugs treated as generic), either:  $0 copay/ $1.20 copay/ $3.30 co a |
| For all other drugs, either:  $0 copay/ $3.70 copay/  $8.25 co a | For all other drugs, either:  $0 copay/ $3.70 copay/ $8.25 co a |
| Catastrophic Coverage | Catastrophic Coverage |
| For generic drugs (including brand drugs treated as generic), either:  $0 copay | For generic drugs (including brand drugs treated as generic), either:  $0 copay |
| For all other drugs, either:  $0 copay | For all other drugs, either:  $0 copay |

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| Benefit |  | Georgia Medicaid |  |
| Prescription Drug Benefits | For dual-eligible members, Medicaid pays for this service if it is not covered by Medicare.  Cost-based:  $10.00 or less -$0.50  $10.01 - $25.00 -$1.00  $25.01 - $50.00 -$2.00  $50.01 or more -$3.00  \*Not covered: certain outpatient drugs pursuant to Section 1927(d) of the Social Security Act. Additionally, certain over the counter (OTC) drugs must be included, pursuant to the Georgia State Policies and Procedures Manual. | |  |



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| Benefit | Georgia Medicaid | Eon Deluxe | |
| Preventive Care | For dual-eligible members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted. | $0 copay | $0 copay |
| Outpatient Rehabilitation Services | For dual-eligible members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted.  $3 per visit  \*Not covered for Members age 21and older. Available under EPSDT as part of a written service plan. | Occupational therapy visit:  $0 copay | Occupational therapy visit:  $0 or $40 copay |
| Physical therapy visit:  $0 copay | Physical therapy visit:  $0 or $40 copay |
| Speech and language therapy visit: $0 copay | Speech and language therapy visit:  $0 or $40 copay |
| Cardiac and Pulmonary Rehabilitation Services | Covered if medically necessary for dual-eligible members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted. | Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per  day for up to 36 sessions up to 36 weeks):  0% Coinsurance | Cardiac (heart) rehab  services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks):  00/o or 20% Coinsurance |
| Skilled Nursing Facility (SNF)  (In a Medicare-certified Skilled Nursing Facility) | For dual-eligible members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted. | $0/Day for Days 1-20  $0/Day for Days 21-100 | $0/Day for Days 1-20  $0 or $150/Day for Days 21- 100 |



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| Benefit | Georgia Medicaid | Eon Deluxe |  |
| Transportation (Routine) | The following Transportation Services are a benefit of Georgia Medicaid:  Non-emergency transportation  -NET services are defined as medically necessary transportation for any member (and escort, if required,) who has no other means of transportation available to any Medicaid reimbursable service for the  purpose of receiving treatment, medical evaluation, obtaining prescription drugs or medical equipment.  For dual-eligible members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted. | $0 copay/ 12 one way | $0 copay/ 12 one way |
| Urgently Needed Services (This is NOT emergency care, and inmost cases, is out of the service area.) | For dual-eligible members, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted. | $0 copay | $0 or $45 copay |

Benefit Georgia Medicaid Eon Deluxe



Vision Services Medically necessary diagnostic Exam to diagnose and treat Exam to diagnose and treat services may be covered. diseases and conditions of diseases and conditions of Services may only be covered the eye (including yearly the eye (including yearly

if performed for medical glaucoma screening): glaucoma screening): reasons and not for refractive $0 co a $0 or $25 co a

purposes for members twenty- Routine eye exam (for up Routine eye exam (for up to

one (21) years of age or older. to 1every year):$0 copay 1 every year): $0 copay

Cost-based: Contact lenses:(for up to 1 Contact lenses: (for up to 1

$10.00 or less -$0.50 every year): $0 copay every year): $0 copay

Eyeglasses (frames and Eyeglasses (frames and

$10.01 - $25.00 -$1.00 lenses):(for up to 1 every lenses): (for up to 1 every

$25.01 - $50.00 -$2.00 year):$0 copay year): $0 copay

Eyeglasses or contact Eyeglasses or contact lenses

$50.01 or more -$3.00 lenses after cataract after cataract surgery:

s :$0 a $0 co a

\*Not covered for members age $100 every year for contact $100 every year for contact 21 and older: routine refractive lenses and eyeglasses lenses and eyeglasses services and optical devices. (frames and lenses) (frames and lenses)

Health/Wellness Education For dual-eligible members, Free health club Free health club

membership, membership,

* + Written health education Medicaid pays for this service SilverSneakers• and or SilverSneakers• and or materials, including if it is not covered by Medicare Free @HomePak (workout Free @HomePak (workout newsletters or when the Medicare benefit is Kit) for those with limited Kit) for those with limited
* Nutritional Training exhausted. access to a network fitness access to a network fitness
* Additional Smoking center center Cessation
* Other Wellness Benefits



The South Carolina Medicaid program requires many beneficiaries to pay a small part of their medical bill for some services called

a co-payment. Certain groups do not pay co-payments for the medical services they receive: Children, Pregnant Women, People in a Nursin Home, Peo le receivin Home and Communi Based Waiver Services, and Peo le receivin Famil Plannin .

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| Benefit | South Carolina | Eon Deluxe |  |
| Ambulance (medically necessary ambulance services | Copayment may apply | $0 copay | $0 or $300 copay |
| Dental Services | $3.40 copayment | Preventive dental services:  • Cleaning (for up to 1 every six months):$0 copay  • Dental x-ray(s) (for up to 1 every six months) :SO 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 | Preventive dental services:   * 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 1dental bitewing x-ray per side every six months: $0 copay * 1panoramic x-ray every five years: $0 copay |



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| Benefit | South Carolina | Eon Deluxe |  |
|  |  | Comprehensive dental  services coverage limit is $500 every year. $0 copay  • Coverage is limited to fillings, simple  extractions and denture repair. Additional dental services, such asroot canals, crowns, surgical extractions,denture relines and periodontal (gum) treatments, are not covered.   * 1partial or 1complete denture per arch every five years. $0 copay | Comprehensive dental  services coverage limit is $500 every year.$0 or $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 |
| Diagnostic Tests,X-Rays, Lab Services, and Radiology Services | $3.40 copayment | Diagnostic radiology services (such as MR.Is, CT scans): 0% coinsurance | Diagnostic radiology services (such as MRis, CT scans): 0% or 200/o coinsurance |
| Diagnostic tests and procedures:  $0 co a | Diagnostic tests and procedures:  $0 co a |
| Lab services:$0 copay | Lab services: $0 copay |
| Outpatient x-rays:  $0 co a | Outpatient x-rays:  $0 or $25 copay |
| Therapeutic radiology services (such as radiation treatment  for cancer):  0% coinsurance | Therapeutic radiology services (such as radiation treatment  for cancer):  0% or 200/o coinsurance |
| Doctor Visits | $3.30 copayment | Primary carephysician visit:  $0 copay | Primary care physician visit:  $0 or $20 copay |
| Specialist visit: $0 copay | Specialist visit: $0 or $45 |



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| Benefit | South Carolina | Eon Deluxe |  |
|  |  |  | copay |
| Emergency Care | $0 copayment | $0 copay | $0 or $75 copay |
| Foot Care (podiatry services) | $1.15 copayment | Foot exams and treatment if  you have diabetes related nerve damage and/or meet certain conditions:$0 copay Routine foot care:$0 copay | Foot exams and treatment if you have diabetes related nerve damage and/or meet certain conditions:  $0 or $45 copay  Routine foot care: Not covered |
| Hearing Services | Copayment may apply | Exam to diagnose and treat hearing and balance issues:  $0 co a | Exam to diagnose and treat  hearing and balance issues:  $0 or $25 co a |
| Routine hearing exam (for up to 1every year):  $0 co a | Routine hearing exam (for up to 1every year):  $0 or $25 co a |
| Hearing aid fitting/evaluation (for up to 1every 3 years):  $0 co a | Hearing aid fitting/evaluation (for up to 1 every 3 years):  $0 copa |
| Our plan pays up to $750  every three years for hearing aids. Benefit amount applies to both ears combined. | Our plan pays up to $750 every three years for hearing aids. Benefit amount applies to both ears combined. |
| Home Health Care | $3.30 copayment | $0 copay | $0 copay |
| Hospice | $0 copayment | You pay nothing for hospice care from a Medicare-certified hospice.You may hav e topay part of the costs for drugs and respite care.Hospice is covered outside of our plan.  Please contact us for more details | You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the costs for drugs and respite care. Hospice is covered outside of our plan.  Please contact us for more details |



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| Benefit | South Carolina | Eon Deluxe |  |
| Inpatient Hospital Care  (Includes Substance Abuse an | $25 copayment  d | $0/Day for Days 1-6  $0/Day for Days 7-90 | $0 or $280/Day for Days 1-6  $0/Day for Days 7-90 |

Rehabilitation Services)

|  |  |  |  |
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| Medical Equipment/Supplies | $3.40 copayment | 0% Coinsurance | 0% or 200/o Coinsurance |
|  |  | Prosthetic devices: | Prosthetic devices:0% or 20% |
|  |  | 0% coinsurance  Related medical supplies: 0% coinsurance | coinsurance  Related medical supplies: 0% or 200/o coinsurance |
| Outpatient Hospital Services (non-emergency) | $3.40 copayment | $0 copay | $0 or $245 copay |
| Outpatient Mental Health Care | Copayment may apply | Outpatient group therapy visit:  $0 copay  Outpatient individual therapy visit: $0 co a | Outpatient group therapy visit:  $0 or $40 copay  Outpatient individual therapy visit: $0 or $40 co a |
| Outpatient Substance Abuse | Copayment may apply | Outpatient group therapy visit:  $0 copay | Outpatient group therapy visit:  $0 or $45 copay |
|  |  | Outpatient individual therapy visit: $0 copay | Outpatient individual therapy visit: $0 or $45 co a |
| Outpatient Surgery | $3.30 copayment | Ambulatory surgical center:  $0 copay | Ambulatory surgical center:  $0 or $200 copay |



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| Benefit | South Carolina | Eon Deluxe |  |
| Prescription Drug Benefits | $3.40 copayment | Initial Coverage Retail | Initial Coverage Retail |
| For generic drugs(including brand drugs treated as generic),either:  $0 copay/ $1.20 copay/ $3.30 copay | For generic drugs (including brand drugs treated as generic), either:  $0 copay/ $1.20 copay/ $3.30 copay |
| For all other drugs,either:  $0 copay/ $3.70 copay/ $8.25 copay | For all other drugs, either:  $0 copay/ $3.70 copay/ $8.25 copay |
| Coverage Gap | Coverage Gap |
| For generic drugs(including brand drugs treated as generic),either:  $0 copay/ $1.20 copay/ $3.30 copay | For generic drugs (including brand drugs treated as generic), either:  $0 copay/ $1.20 copay/ $3.30 copay |
| For all other drugs, either:  $0 copay/ $3.70 copay/ $8.25 copay | For all other drugs, either:  $0 copay/ $3.70 copay/ $8.25 copay |
| Catastrophic Coverage | Catastrophic Coverage |
| For generic drugs (including brand drugs treated as generic),either:  $0 copay | For generic drugs (including brand drugs treated as generic), either:  $0 copay |
| For all other drugs, either:  $0 copay | For all other drugs, either:  $0 copay |



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| Benefit | South Carolina | Eon Deluxe |  |
| Preventive Care | Copayment may apply | $0 copay | $0 copay |
| Outpatient Rehabilitation Services  (Occupational Therapy, Physical Therapy, Speech and Language Therapy) | Copayment may apply | Occupational therapy visit:  $0 copay | Occupational therapy visit:  $0 or $40 copay |
| Physical therapy visit:  $0 copay | Physical therapy visit:  $0 or $40 copay |
| Speech and language therapy visit:  $0 copay | Speech and language therapy visit:  $0 or $40 copay |
| Cardiac and Pulmonary Rehabilitation Services | Copayment may apply | Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions for a period of up to 36 weeks :0% Coinsurance | Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions for a period of up to  36 weeks : 00/o or 20% Coinsurance |
| Skilled Nursing Facility  (SNF) | Copayment may apply | $0/Day for Days 1-20  $0/Day for Days 21-100 | $0/Day for Days 1-20  $0 or $150/Day for Days 21- 100 |
| Transportation | Copayment may apply | $0 copay/ 12 one way | $0 copay/ 12 one way |
| Vision Services | $3.30 copayment | Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening):  $0 co a | Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening):  $0 or $25 co a |
| Routine eye exam (for up to 1 every year):$0 copay | Routine eye exam (for up to 1 every year): $0 copay |



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| Benefit | South Carolina | Eon Deluxe |  |
|  |  | Contact lenses:(for up to 1 every year): $0 copay Eyeglasses (frames and lenses):(for up to 1every year):$0 copay  Eyeglasses or contact lenses after cataract surgery:$0  co a | Contact lenses: (for up to 1 every year): $0 copay Eyeglasses (frames and lenses): (for up to 1every year): $0 copay  Eyeglasses or contact lenses after cataract surgery: $0  c a |
| $100 every year for contact lenses and eyeglasses (frames and lenses . | $100 every year for contact lenses and eyeglasses (frames and lenses . |



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.

**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)

