2024

Sales Presentation

Welcome!

About me:

- I am a licensed and certified eternalHealth plan representative
- I do not represent the government, Medicare, or Medicaid

During this time, we will discuss:

- Medicare Basics
- Medicare Advantage plan options
- Enrollment timeframes
- Prescription Drug Coverage
- About eternalHealth
- eternalHealth Plans and benefits

Medicare Basics

Four parts of Medicare

Part A: Hospital

Part B: Medical

Part C: Medicare Advantage

Part D: Drug Benefits

What is Medicare

Medicare is a program administered and regulated by the Centers for Medicare & Medicaid Services (CMS)

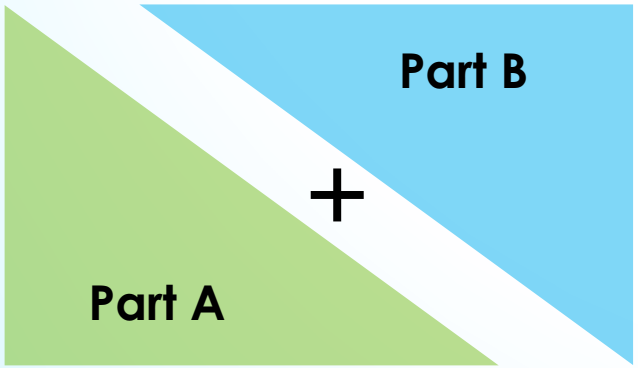
You are eligible for Medicare if you are:

- Age 65 or older
- Under 65 with certain disabilities
- A citizen or permanent resident of the United States
- Any age with end-stage renal disease (ESRD) or Lou Gehrig's disease

Medicare Coverage Options

Step 1:

Original Medicare



Provided by the Government

Step 2:

Additional coverage options

Medicare Supplement

Covers some of the costs not covered by Original Medicare

and/or
Part D

Prescription Drug Coverage

Medicare Advantage (Part C)

- Combines Part A & B (and sometimes D)
- Additional Benefits (like dental and vision)

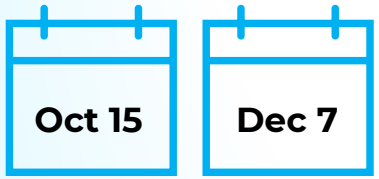
Offered by private companies

Medicare Advantage Eligibility

To enroll into a Medicare Advantage plan, you must:

- Have both, Medicare Parts A & B
- Continue to pay your Part B Premium
- Permanent residency in the plans service area at least 6 months out of a year
- Be a U.S. Citizen or lawfully present in the U.S.

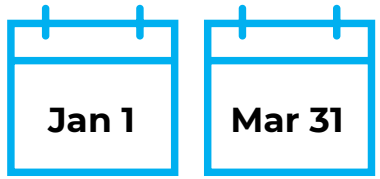
Enrollment Periods



Annual Enrollment Period (AEP)

Medicare Beneficiaries can change their health plan from Oct. 15th through Dec. 7th

Changes made during this time will become effective on Jan. 1st



Medicare Advantage Open Enrollment Period (MA OEP)

Individuals enrolled in a Medicare Advantage plan can disenroll and return to Original Medicare or change to a different Medicare Advantage plan from Jan 1st through Mar. 31st

The effective date for a change made during this time will be the 1st of the month after an enrollment request is received.

If you choose to return to Original Medicare, you have until Mar. 31st to enroll into a stand-alone prescription drug plan

Initial Coverage Enrollment Period (ICEP)

This is when most individuals are first eligible to enroll into a Medicare Advantage plan.

This period starts 3 months before your 65th birthday, continues through your birth month, and for 3 months after.

Special Enrollment Period (SEP)

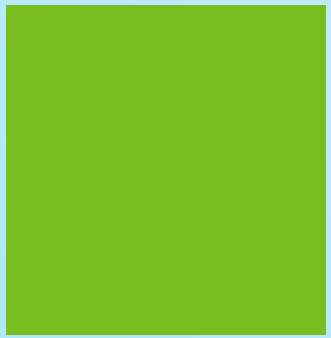
Throughout the year there may be special circumstances that allow a person to enroll in a Medicare Advantage plan outside of the regular enrollment periods.

This includes, but is not limited to; becoming eligible for Extra Help, moving outside of your current plans service area, or leaving your employer group plan.

Part D Coverage Stages

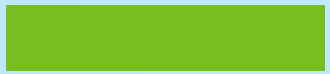
Stage 1
Deductible

You pay all costs until deductible is met



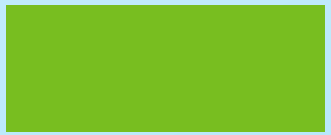
Stage 2
Initial Coverage Period

You and eternalHealth split costs. You often pay only a copay until you and eternalHealth have spent a total of $5,030



Stage 3
Coverage Gap

You pay no more than 25% of total drug costs until you have paid $8,000 out of pocket toward drug costs.



Stage 4
Catastrophic Coverage

You pay nothing for all covered drugs

Extra Help

Extra Help is a Medicare program that helps people who have limited income and resources pay for affordable costs related to Medicare prescription drug program costs, like:

- **Premiums**
- **Deductibles**
- **Coinsurance**

2023 Income Limits

Single: $1,823*

Married: $2,465*

2023 Resource Limits

Single: $15,160

Married: $30,240

eternalHealth

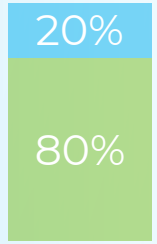
***Doesn't account for $20 grace**

Important Medicare Terms and Phrases

Medicare Terms and Phrases

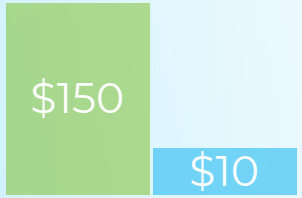
Premium: A fixed monthly amount you need to pay to be enrolled in a plan

Coinsurance: Costs are split between you and your insurance on a percentage basis.



Deductible: A fixed amount that you must pay before you plan begins to pay.

Copay: A preset, fixed amount you pay for each service



Prior Authorizations:
An authorization needed in advance to receive a medication or service

Part D Terms and Phrases

Formulary:
A list of prescription drugs that are covered by your plan

Tiers:
Plan Formularies divide medications into groups. Each group (tier) has a different level of cost sharing.

Step-therapy:
When you must first try a less expensive drug to see if it works for you. You may "step-up" to a more expensive drug if you and your doctor can show that a less expensive medication did not work for you.

Quantity Limitations:
Limitations set by your plan for medications.

Exception Requests:
A type of coverage determination. A member, their doctor, or representative may request a tiering or formulary exception

Transition Fills:
Typically, a one time, 30-day supply of a medication that you were taking. This allows you to get temporary coverage for s medication that are not on your new plans formulary or have certain coverage restrictions.

Enrollment Terms and Phrases

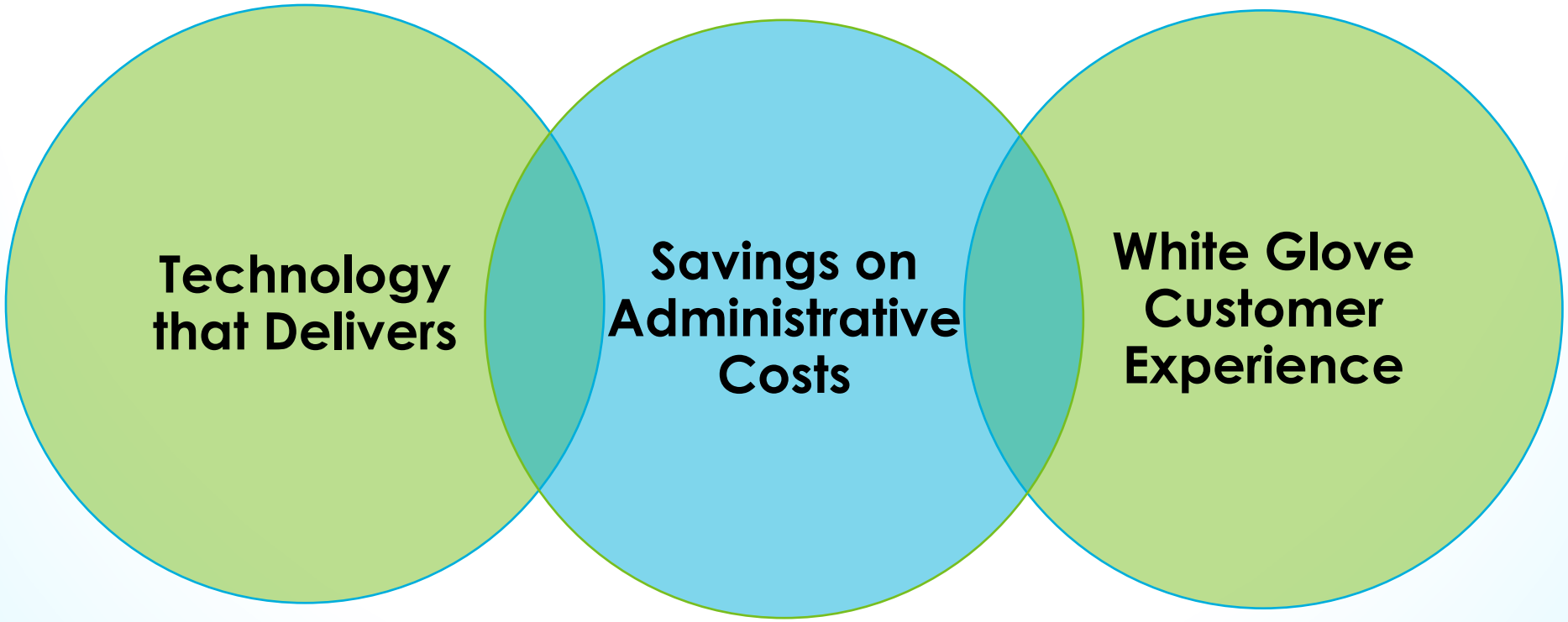
Plan Cancellations:
You can cancel an enrollment request by calling the plan prior to the effective date.

Enrollment Verification:
Once you enroll into a Medicare Advantage plan, you will receive a phone call or a letter from the plan to ensure you understood product type and plan rules.

Plan ID Card:
Once you enroll into a Medicare Advantage plan, you will no longer present your Original Medicare card at the doctor or pharmacy. Instead, you will use your plan's ID card.

Part D Late Enrollment Penalty:
If you decide not to enroll into a plan with prescription drug coverage when you are first eligible, and you don't have other creditable coverage, you will likely pay a penalty when you join a plan later.

Why eternalHealth



- eternalHealth has one comprehensive backend system that utilizes AI and Machine Learning technology.
- With using less integration there is less integration.
- This technology allows for savings on administrative costs.

With these savings we can allocate dollars towards what matters most:

- White glove customer experience
- Enriched Benefits and lower costs
- Product sustainability
- Member services
- Clinical outreach

- eternalHealth has a strong member support team that LISTENS.
- We treat every member with care. We want to know what is important to you!
- Our members are not just a number, they are unique individuals.

What Our Members Are Saying

"My experience has been awesome! All of the member services are great, anytime I call they have been so helpful with all my needs! They are very kind, very patient, and they do everything I need them to do!"

Liz, Suffolk County

"Nobody has ever cared for me like the Care Management team at eternalHealth has!"

Steve, Worcester County

"The team at eternalHealth have taken great care of me and listened to my concerns without judgement. I really appreciate all the work they have done for me so far. They are like having a good friend you can trust, and I am so happy I joined their plan."

William, Worcester County

Testimonials are provided by actual eternalHealth members.
Images do not depict actual eternalHealth members.

eternalHealth

eternalHealth Plan Overview

We know that everyone has different needs, which is why we crafted four plans that allow you to find a plan that best fits you and your lifestyle.

eternalHealth Horizon (HMO)

Best fit for an individual that does not receive Medicaid but still **qualifies for the Extra Help** Program through the Social Security Administration. This plan will provide affordable copays and comprehensive extra benefits.

eternalHealth Grand Give Back (HMO)

Best fit for those who are **new to Medicare and/or have low medical needs** as this plan has higher copays and coinsurance for some benefits and includes a Part B premium reduction of up to $80 per month. There is often a 3-4 month wait period, and CMS will work directly with Social Security to reduce your Part B premium. Members do not receive a check from this plan. This plan is not suited for those who do not pay a Part B premium, as they would not receive the "Give Back".

eternalHealth Valor Give Back (HMO-POS)

Designed for people who are on TRICARE for Life. This plan will allow people the flexibility to continue to see all the VA and TRICARE providers while also including a Part B premium reduction of up to $85 per month. It is important to understand that there is often a 3-4 month wait period, and CMS will work directly with Social Security to reduce their Part B premium. This plan is not suited for those who do not pay a Part B premium, as they would not receive the "Give Back".

Plan Highlights

eternalHealth Horizon (HMO)

- $43.20 Premium ($0 with LIS)
- $0 Primary Care & Specialist Visits
- $0 Urgent Care
- $3,350 MOOP
- $4,500 dental debit card, no preferred network
- $160 combined OTC and Grocery* allowance
- UNLIMITED Transportation
- Tiers 1-3: 100-day supply mail-order for 1-month copay

eternalHealth Grand Give Back (HMO)

- $80 Part B Premium Reduction
- $0 Primary Care & Specialist Visits
- $4,550 MOOP
- $4,000 dental allowance, no preferred network
- $115 combined OTC and Grocery* allowance
- UNLIMITED Transportation
- $185 Part D Deductible (T3-T5)
- Tiers 1-3: 100-day supply mail-order for 1-month copay

eternalHealth Valor Give Back (HMO-POS)

- $85 Part B Premium Reduction
- $0 Primary Care Visits (IN/OON)
- $0 Specialist Visits
- $5,500/$9,000 (IN/IN & OON) MOOP
- $2,500 dental allowance, no preferred network
- $125 combined OTC and Grocery* allowance
- UNLIMITED Transportation

**The benefits mentioned are a part of special supplemental program for the chronically ill. Not all members qualify.*

Next, we are going to review…

- ❑ Plan Benefits
- ❑ Formulary (How to look up covered medications)
- ❑ Providers
- ❑ How to enroll

eternalHealth of Arizona is an HMO plan with a Medicare contract for HMO and HMO-POS offerings. Enrollment in eternalHealth of Arizona depends on contract renewal.

Out-of-network/non-contracted providers are under no obligation to treat Plan members, except in emergency situations. Please call our customer service number at **1 (800)680-4568 (TTY 711),** *Oct 1 – Mar 31, 8am – 8pm, 7 days a week, and Apr 1 – Sep 30, 8am – 8pm Monday- Friday.* or see your Evidence of Coverage (EOC) for more information, including the cost-sharing that applies to out-of-network services.

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit Medicare.gov/about-us/accessibility-nondiscrimination-notice, or call 1-800-MEDICARE (1-800-633-4227) for more information. TTY users can call 1-877-486-2048.