2025 Summary of Benefits

eternalHealth Freedom (PPO)

eternalHealth Give Back (PPO)

The Next Generation of Medicare Advantage

H2694_SB25_PPO_M

Summary of Benefits

What does this document contain?

This summary of benefits serves as a resource to understand the coverage and costs associated with eternalHealth's Freedom and Give Back PPO plans. The information in this document is for the plan year beginning January 1, 2025, and ending December 31, 2025.

What are the eligibility requirements for this plan?

To be eligible for this plan, you must

- be enrolled in both Medicare Parts A & B and
- live in Bristol, Middlesex, Norfolk, Plymouth, Suffolk, or Worcester County in Massachusetts.

Does this plan cover my current healthcare needs?

To find out if this plan covers your current prescription drugs, doctors, and pharmacies, please visit us at www.eternalhealth.com to view our online drug list and directory. If you have questions or would like a paper copy mailed to you, please call us at 1-800-680-4568 (TTY 711).

Where can I learn more about Medicare?

The ***Medicare & You*** **handbook** is a great resource and can be found at www.medicare.gov. You can also request a paper copy to be mailed to you by calling 1-800-MEDICARE (1-800-633-4227). TTY users can dial 1-877-486-2048, 24 hours a day, 7 days a week.

What is a deductible?

A deductible is the amount of money you pay out of pocket before your health plan begins to pay. Once you reach the defined threshold, you will only have to pay coinsurance or a copayment.

What is a copayment?

A copayment (also known as copay) is a fixed amount of money you pay out of pocket when you receive care.

What is coinsurance?

Coinsurance is a percentage you pay out of pocket for the cost of your care.

Where can I find more information?

If you would like more information, please see eternalHealth's Evidence of Coverage at www.eternalhealth.com under Member Resources.

You can call customer service at 1-800-680-4568 (TTY 711) from:

October 1 to March 31, 8am to 8pm, 7 days a week.
April 1 to September 30, 8am to 8pm, Monday to Friday, 10am to 2pm, Saturday.

My Monthly Premium, Deductible, and Maximum Out of Pocket

	eternalHealth Freedom (PPO) H2694-001	eternalHealth Give Back (PPO) H2694-002
Monthly Premium *You Must Continue to Pay Your Part B Premium.*	$0	$0
Part B Reduction (Give Back)	This plan does not offer a Part B reduction.	Up to $70 per month reduced from your Part B premium.
Deductibles and Maximum Out of Pocket		
Medical Deductible	This plan does not have a medical deductible.	This plan does not have a medical deductible.
Pharmacy (Part D) Deductible	**Tier 1, Tier 2, and Tier 3** $0 deductible. **Tier 4 and Tier 5** $185 deductible.	**Tier 1, Tier 2, and Tier 3** $0 deductible. **Tier 4 and Tier 5** $300 deductible.
Maximum Out-of-Pocket Responsibility *This is the maximum amount you will pay during the plan year for copays, coinsurance, medical services, supplies, and Part B-covered medication. Any out-of-pocket expenses for prescription drugs and other benefits do not apply.*	$6,000 for services you receive from in-network providers. $9,000 for services you receive from out-of-network providers and in-network providers combined.	$6,500 for services you receive from in-network providers. $10,000 for services you receive from out-of-network providers and in-network providers combined.

My Covered Hospital and Medical Benefits and Services

	eternalHealth Freedom (PPO) H2694-001	eternalHealth Give Back (PPO) H2694-002
Inpatient and Outpatient Hospital Services		
Inpatient Hospital Coverage *Prior Authorization is Required In-Network.*	**In-Network:** $370 copay per day for days 1-5. $0 copay per day for day 6-90. $0 copay per day for days 91+. **Out-of-Network:** 30% coinsurance per stay.	**In-Network:** $395 copay per day for days 1-5. $0 copay per day for day 6-90. $0 copay per day for days 91+. **Out-of-Network:** 30% coinsurance per stay.

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Outpatient Hospital Coverage *Prior Authorization is Required In-Network.*	**Diagnostic Colonoscopy** $0 copay at any in-network location. **Outpatient Hospital** $350 copay for surgery performed at an outpatient hospital. **Observation Stay** $350 copay per stay. **Out-of-Network:** 20% coinsurance per service.	**Diagnostic Colonoscopy** $0 copay at any in-network location. **Outpatient Hospital** $350 copay for surgery performed at an outpatient hospital. **Observation Stay** $350 copay per stay. **Out-of-Network:** 20% coinsurance per service.
Ambulatory Surgical Center (ASC) Services *Prior Authorization is Required In-Network.*	**Diagnostic Colonoscopy** $0 copay if performed at an ASC. **Ambulatory Surgical Center** $250 copay for surgery performed at an ASC. **Out-of-Network:** 20% coinsurance per service.	**Diagnostic Colonoscopy** $0 copay if performed at an ASC. **ASC** $250 copay for surgery performed at an ASC. **Out-of-Network:** 20% coinsurance per service.
Doctor Office Visits		
Doctor Visits *A Referral is Required for Specialist Visits In-Network.*	**Primary Care Provider (PCP) Visits:** **In-Network:** $0 copay per visit. **Out-of-Network:** $0 copay per visit. **Specialist Visits:** **In-Network:** $0 copay per visit. **Out-of-Network:** $20 copay per visit.	**Primary Care Provider (PCP) Visits:** **In-Network:** $0 copay per visit. **Out-of-Network:** $0 copay per visit. **Specialist Visits:** **In-Network:** $0 copay per visit. **Out-of-Network:** $20 copay per visit.

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Preventive Care	**In-Network:** $0 copay per service. **Out-of-Network:** $0 copay per service.	**In-Network:** $0 copay per service. **Out-of-Network:** $0 copay per service.
	Our plans cover many preventive services, including: • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colorectal cancer screenings (Colonoscopy, Fecal occult blood test, Flexible sigmoidoscopy) * • Depression screening • Diabetes screenings • HIV screening • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screening (PSA) • Sexually transmitted infection screening and counseling • Lung cancer screening (low dose computed tomography [LDCT]) • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Flu shots, pneumococcal shots, Hepatitis B shots (limitations may apply) • "Welcome to Medicare" preventive visit (one-time) • Any additional preventive services approved by Medicare during the calendar year will be covered.	
Emergency Services		
Emergency Care	**In-Network:** $100 copay per visit. **Out-of-Network:** $100 copay per visit.	**In-Network:** $100 copay per visit. **Out-of-Network:** $100 copay per visit.
	Your copay is waived if you are admitted to the hospital within 24 hours. Your plan includes worldwide coverage for emergency care up to $25,000 per calendar year. You must pay the cost out-of-pocket and then submit to plan for reimbursement. Please see the Evidence of Coverage for more information.	

	eternalHealth Freedom (PPO) H2694-001	eternalHealth Give Back (PPO) H2694-002
Urgently Needed Services	**In-Network:** $0 copay for urgently needed services for PCP-related services. $25 copay for urgently needed services from an urgent care center or walk-in center. **Out-of-Network:** $0 copay for urgently needed services for PCP-related services. $25 copay for urgently needed services from an urgent care center or walk-in center.	**In-Network:** $0 copay for urgently needed services for PCP-related services. $25 copay for urgently needed services from an urgent care center or walk-in center. **Out-of-Network:** $0 copay for urgently needed services for PCP-related services. $25 copay for urgently needed services from an urgent care center or walk-in center.
	Your plan includes worldwide coverage for urgently needed services. You must pay the cost out-of-pocket and then submit to plan for reimbursement. Please see the Evidence of Coverage for more information.	
Diagnostic Services/Labs/Imaging		
Diagnostic Radiology (Such as MRIs, CT scans) *Prior Authorization is Required In-Network.*	**In-Network:** $150 copay for Ultrasounds. $250 copay for Outpatient CT, MRI and PET scans. **Out-of-Network:** 20% coinsurance per service.	**In-Network:** $150 copay for Ultrasounds. $300 copay for Outpatient CT, MRI and PET scans. **Out-of-Network:** 20% coinsurance per service.
Diagnostic Test and Procedures *Prior Authorization is Required In-Network.*	**In-Network:** $0 copay per service in an office setting. $10 copay per service at a free-standing lab facility. **Out-of-Network:** 20% coinsurance per visit.	**In-Network:** $0 copay per service in an office setting. $20 copay per service at a free-standing lab facility. **Out-of-Network:** 20% coinsurance per visit.
Lab Services *Prior Authorization is Required for In-Network High-Cost Genetic Testing and Molecular Studies.*	**In-Network:** $0 copay per service in an office setting. $10 copay per service at a free-standing lab facility. **Out-of-Network:** 20% coinsurance per visit.	**In-Network:** $0 copay per service in an office setting. $10 copay per service at a free-standing lab facility. **Out-of-Network:** 20% coinsurance per visit.

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Outpatient X-Ray	**In-Network:** $15 copay per service. **Out-of-Network:** 20% coinsurance per visit.	**In-Network:** $20 copay per service. **Out-of-Network:** 20% coinsurance per visit.
Hearing Services		
Medicare-Covered Hearing Exam	**In-Network:** $25 copay per service. **Out-of-Network:** $50 copay per service.	**In-Network:** $25 copay per service. **Out-of-Network:** $50 copay per service.
Routine Hearing Exam One (1) Visit Per Year.	**In-Network:** $0 copay per exam with an Amplifon provider. **Out-of-Network:** 50% coinsurance with an out-of-network (non Amplifon) hearing provider.	**In-Network:** $0 copay per exam with an Amplifon provider. **Out-of-Network:** 50% coinsurance with an out-of-network (non Amplifon) hearing provider.
Hearing Aids Up to two (2) aids per year. One (1) Hearing Aid Per Ear, Per Year.	**In-Network:** $595 copay based on your selection through Amplifon. $895 copay based on your selection through Amplifon. Hearing aid purchase includes: • 60-day risk free trial • Complimentary aftercare • New virtual services including virtual screening, personalized coaching, and on-demand virtual visits. **Out-of-Network** 50% coinsurance with an out-of-network (non Amplifon) hearing provider.	**In-Network:** $595 copay based on your selection through Amplifon. $895 copay based on your selection through Amplifon. Hearing aid purchase includes: • 60-day risk free trial • Complimentary aftercare • New virtual services including virtual screening, personalized coaching, and on-demand virtual visits. **Out-of-Network** 50% coinsurance with an out-of-network (non Amplifon) hearing provider.
Dental Services		
Medicare-Covered Dental Services	**In-Network:** $30 copay per service. **Out-of-Network:** 20% coinsurance per service.	**In-Network:** $45 copay per service. **Out-of-Network:** $50 copay per service.

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Non-Medicare Covered Dental Services	Preventive and comprehensive services: $3,000 Annual Allowance eternalHealth will pay as much as $3,000 per year for comprehensive and preventive services, with no required network. There are no restrictions or limitations. Please see the Evidence of Coverage for more information.	Preventive and comprehensive services: $2,500 Annual Allowance eternalHealth will pay as much as $2,500 per year for comprehensive and preventive services, with no required network. There are no restrictions or limitations. Please see the Evidence of Coverage for more information.
	With this plan, you receive an eternalPlus Benefits Card that will include this benefit and may be used at the dental provider of your choice.	
Vision Services		
Medicare-Covered Eye Exam	**In-Network:** $25 copay per exam. **Out-of-Network:** $50 copay per exam.	**In-Network:** $25 copay per exam. **Out-of-Network:** $50 copay per exam.
Eyewear After Cataract Surgery (Medicare-Covered Standard Eyewear)	**In-Network:** $0 copay for one pair of standard eyewear after cataract surgery. **Out-of-Network:** $0 copay for one pair of standard eyewear after cataract surgery.	**In-Network:** $0 copay for one pair of standard eyewear after cataract surgery. **Out-of-Network:** $0 copay for one pair of standard eyewear after cataract surgery.
Routine Eye Exams One (1) visit per year.	**In-Network:** $0 copay per exam with a participating EyeMed provider. **Out-of-Network:** 50% coinsurance. You will need to pay out of pocket and submit for reimbursement. Please see the Evidence of Coverage for more information.	**In-Network:** $0 copay per exam with a participating EyeMed provider. **Out-of-Network:** 50% coinsurance. You will need to pay out of pocket and submit for reimbursement. Please see the Evidence of Coverage for more information.

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Eyewear (for covered eyewear you pay any balance more than the annual limit)	**In-Network:** Up to $200 per calendar year for prescription eyewear or contact lenses purchased from an EyeMed provider. **Out-of-Network:** eternalHealth will reimburse as much as $200 per year towards prescription eyewear or contact lenses. You will need to pay out of pocket and submit for reimbursement. Please see the Evidence of Coverage for more information.	**In-Network:** Up to $200 per calendar year for prescription eyewear or contact lenses purchased from an EyeMed provider. **Out-of-Network:** eternalHealth will reimburse as much as $200 per year towards prescription eyewear or contact lenses. You will need to pay out of pocket and submit for reimbursement. Please see the Evidence of Coverage for more information.
Mental Health Services		
Inpatient Mental Health Care *Prior Authorization is required In-Network.*	**In-Network:** $370 copay per day for days 1-5. $0 copay per day for days 6-90. $0 copay per day for days 91+. **Out of Network:** 30% coinsurance per stay.	**In-Network:** $395 copay per day for days 1-5. $0 copay per day for days 6-90. $0 copay per day for days 91+. **Out of Network:** 30% coinsurance per stay.
	There is a Medicare 190-day lifetime limit for care in a free-standing psychiatric hospital for both in-network and out-of-network services. Please see the Evidence of Coverage for additional important information.	
Outpatient mental health care	**In-Network:** $25 copay per visit. **Out-of-Network:** $50 copay	**In-Network:** $25 copay per visit. **Out-of-Network:** $50 copay
Opioid Treatment Program Service	**In-Network:** $25 copay per service. **Out-of-Network:** $50 copay per service.	**In-Network:** $45 copay per service. **Out-of-Network:** $50 copay per service.

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Additional Services		
Skilled Nursing Facility (SNF) *Prior Authorization is Required In-Network. No Prior Hospital Stay Required.*	**In-Network:** $0 copay per day for days 1-20. $203 copay per day for days 21-100. **Out-of-Network:** 25% coinsurance per stay.	**In-Network:** $0 copay per day for days 1-20. $203 copay per day for days 21-100. **Out-of-Network:** 30% coinsurance per stay.
Occupational, Physical and Speech Therapy *Prior Authorization is required.*	**In-Network:** $20 copay per visit. **Out-of-Network:** $50 copay per visit.	**In-Network:** $20 copay per visit. **Out-of-Network:** $50 copay per visit.
Ambulance Services *Prior Authorization is required for in-network non-emergent ambulance services.*	**In-Network:** $300 copay per service for ground/air ambulance. **Out-of-Network:** $300 copay per service for ground/air ambulance.	**In-Network:** $300 copay per service for ground/air ambulance. **Out-of-Network:** $300 copay per service for ground/air ambulance.
	This plan also covers you for emergency transportation Worldwide. You will need to pay out-of-pocket and submit for reimbursement. Please see the Evidence of Coverage for more information.	
Transportation	**In-Network:** You pay a $0 copayment for 24 one-way trips to and from healthcare-related locations such as your doctor appointments, dentist appointments or the pharmacy. Rides must be scheduled through the plan's approved vendor to be covered. **Out-of-Network:** 50% coinsurance for up to 24 one-way trips per calendar year. You must pay out of pocket and submit for reimbursement. Please see the Evidence of Coverage for more information.	**In-Network:** You pay a $0 copayment for unlimited rides for trips to and from healthcare-related locations such as your doctor appointments, dentist appointments or the pharmacy. Rides must be scheduled through the plan's approved vendor to be covered. **Out-of-Network:** 50% coinsurance. You must pay out of pocket and submit for reimbursement. Please see the Evidence of Coverage for more information.

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Part B Prescription Drugs *Prior Authorization is required for certain medications based on CMS guidance*.	**In-Network:** 0% - 20% Coinsurance. 20% coinsurance with a maximum copay per month of $35 for Part B insulins. Lesser copays will be applied as required by the Inflation Reduction Act (IRA). **Out-of-Network:** 20% coinsurance. 20% coinsurance with a maximum copay per month of $35 for Part B insulins. Lesser copays will be applied as required by the Inflation Reduction Act (IRA).	**In-Network:** 0% - 20% Coinsurance. 20% coinsurance with a maximum copay per month of $35 for Part B insulins. Lesser copays will be applied as required by the Inflation Reduction Act (IRA). **Out-of-Network:** 20% coinsurance. 20% coinsurance with a maximum copay per month of $35 for Part B insulins. Lesser copays will be applied as required by the Inflation Reduction Act (IRA).

My Prescription Drug Benefits

There are three drug payment stages for your prescription drug coverage under eternalHealth Forever (HMO) plan. How much you pay depends on what stage you are in when you get a prescription filled or refilled. The stages are:

Stage 1: Yearly Deductible Stage
Stage 2: Initial Coverage Stage
Stage 3: Catastrophic Coverage Stage

Important Message About What You Pay for Vaccines - Our plan covers most Part D vaccines at no cost to you, even if you haven't paid your deducible. Call Pharmacy Member Services for more information at 1-800-891-6989 (TTY users call 711).

Important Message About What You Pay for Insulin - You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on even if you haven't paid your deductible.

Deductible Stage

After you pay your yearly deductible (for certain tiers), our plan starts to cover some of your costs. There are no deductibles on Tiers 1, 2, and 3 so you will pay those copays. Tiers 4 and 5 have the deductible listed below.

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Deductible Tiers 1, 2, and 3	$0	$0
Deductible Tiers 4 and 5	$185	$300

Initial Coverage Stage

You will stay in the Initial Coverage Stage until the total amount for the prescription drugs you and our plan pay reaches $2,000.

Retail Cost Sharing	eternalHealth Freedom (PPO) H2694-001			eternalHealth Give Back (PPO) H2694-002		
Drug Tier	**30-day supply**	**60-day supply**	**100-day supply**	**30-day supply**	**60-day supply**	**100-day supply**
Tier 1 (Preferred Generic)	$0 copay.	$0 copay.	$0 copay.	$0 copay.	$0 copay.	$0 copay.
Tier 2 (Generic)	$5 copay	$10 copay	$15 copay	$5 copay	$10 copay	$15 copay
Tier 3 (Preferred Brand)	$47 copay	$94 copay	$141 copay	$47 copay	$94 copay	$141 copay
Tier 4 (Non-Preferred Drug)	27% coinsurance	27% coinsurance	27% coinsurance	29% coinsurance	29% coinsurance	29% coinsurance
Tier 5 (Specialty)	30% coinsurance	N/A	N/A	29% coinsurance	N/A	N/A

Mail Order Cost Sharing	eternalHealth Freedom (PPO) H2694-001			eternalHealth Give Back (PPO) H2694-002		
Drug Tier	**30-day supply**	**60-day supply**	**100-day supply**	**30-day supply**	**60-day supply**	**100-day supply**
Tier 1 (Preferred Generic)	$0 copay.	$0 copay.	$0 copay.	$0 copay.	$0 copay.	$0 copay.
Tier 2 (Generic)	$5 copay	$10 copay	$10 copay	$5 copay	$10 copay	$10 copay
Tier 3 (Preferred Brand)	$47 copay	$94 copay	$94 copay	$47 copay	$94 copay	$94 copay
Tier 4 (Non-Preferred Drug)	27% coinsurance	27% coinsurance	27% coinsurance	29% coinsurance	29% coinsurance	29% coinsurance
Tier 5 (Specialty)	30% coinsurance	N/A	N/A	29% coinsurance	N/A	N/A

Note: Costs may differ based on pharmacy type such as mail order, long-term care (LTC) or home infusion, and 30-day, 60-day or 100-day supply.

Catastrophic Coverage Stage

You qualify for the Catastrophic Coverage Stage when your out-of-pocket costs have reached $2,000. Once you are in the Catastrophic Coverage Stage, you will pay nothing for a covered Part D drug for the remainder of the calendar year.

My Additional Covered Benefits and Services

	eternalHealth Freedom (PPO) H2694-001	eternalHealth Give Back (PPO) H2694-002
Telehealth Services *Medicare covered Primary care Physician (PCP) and Physician Specialist Services. This benefit may not be offered by all providers. Check availability directly with your PCP or Specialist.*	**In-Network:** $0 copay per service. **Out-of-Network:** $0 copay per PCP service. $20 copay per Specialist service.	**In-Network:** $0 copay per service. **Out-of-Network:** $0 copay per PCP service. $20 copay per Specialist service.
Medicare-Covered Acupuncture Visits	**In-Network:** $25 copay per visit. **Out-of-Network:** $50 copay per visit.	**In-Network:** $25 copay per visit. **Out-of-Network:** $50 copay per visit.

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Routine Acupuncture	**In-Network:** $25 copay per visit. Limit of 20 visits per calendar year combined with routine chiropractic care. **Out-of-Network:** $50 copay per visit. Limit of 20 visits per calendar year combined with routine chiropractic care.	Not covered.
Medicare-Covered Chiropractic Care	**In-Network:** $20 copay per visit. **Out-of-Network:** $50 copay per visit.	**In-Network:** $20 copay per visit. **Out-of-Network:** $50 copay per visit.
Routine Chiropractic Care	**In-Network:** $25 copay per visit. Limit of 20 visits per calendar year combined with routine acupuncture. **Out-of-Network:** $50 copay per visit. Limit of 20 visits per calendar year combined with routine acupuncture.	Not covered.
Therapeutic Massage	**In-Network:** $20 copay per visit. Limit of 20 visits per calendar year. **Out-of-Network:** $50 copay per visit. Limit of 20 visits per calendar year.	Not covered.

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Kidney Disease Treatment Services	**Dialysis Treatment (both facility and clinic visits)** **In-Network:** 20% coinsurance per service. **Out-of-Network:** 20% coinsurance per service. **Kidney Disease Education Services** **In-Network:** $0 copay per service. **Out-of-Network:** $0 copay per service.	**Dialysis Treatment (both facility and clinic visits)** **In-Network:** 20% coinsurance per service. **Out-of-Network:** 20% coinsurance per service. **Kidney Disease Education Services** **In-Network:** $0 copay per service. **Out-of-Network:** $0 copay per service.
Foot Care (Podiatry Services) *Prior Authorization is Required In-Network.*	**In-Network:** $0 copay for Diabetic foot care. $25 copay for all other services. **Out-of-Network:** $50 copay for Diabetic foot care. $50 copay for all other services.	**In-Network:** $0 copay for Diabetic foot care. $25 copay for all other services. **Out-of-Network:** $50 copay for Diabetic foot care. $50 copay for all other services.
Durable Medical Equipment (DME) and Prosthetic Devices *Prior Authorization May be Required In-Network. Please Contact Member Services for More Information.*	**In-Network:** 20% coinsurance. **Out-of-Network:** 20% coinsurance.	**In-Network:** 20% coinsurance. **Out-of-Network:** 20% coinsurance.

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Diabetic Supplies *Prior Authorization is required in-network for Diabetic Supplies and Quantity Limits apply. These restrictions are aligned with traditional Medicare requirements.*	**Test Strips:** You pay 0% coinsurance for preferred brand (Touch/Life Scan Brand) test strips. All other brands are excluded and would need an approved exception. If approved, you pay 20% coinsurance. **Continuous Glucose Monitors:** You pay 0% coinsurance for preferred brand (Dexcom and Freestyle Libre) Medicare-covered Continuous Glucose Monitors (CGM) when ordered by a physician and filled at a network pharmacy. All other brands are excluded and would need an approved exception. If approved, you pay 20% coinsurance. **Other Blood Glucose Testing Supplies** 20% coinsurance. **Medicare-covered Diabetic Therapeutic Shoes or Inserts** 20% coinsurance. **Out-of-Network:** 20% coinsurance	**Test Strips:** You pay 0% coinsurance for preferred brand (Touch/Life Scan Brand) test strips. All other brands are excluded and would need an approved exception. If approved, you pay 20% coinsurance. **Continuous Glucose Monitors:** You pay 0% coinsurance for preferred brand (Dexcom and Freestyle Libre) Medicare-covered Continuous Glucose Monitors (CGM) when ordered by a physician and filled at a network pharmacy. All other brands are excluded and would need an approved exception. If approved, you pay 20% coinsurance. **Other Blood Glucose Testing Supplies** 20% coinsurance. **Medicare-covered Diabetic Therapeutic Shoes or Inserts** 20% coinsurance. **Out-of-Network:** 20% coinsurance

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Cardiac & Pulmonary Rehabilitation Services *Prior Authorization is Required for In-Network Cardiac and Pulmonary Rehabilitation services.*	**In-Network:** **Cardiac & Pulmonary Rehabilitation Services:** $0 copay per service. **Supervised Exercise Therapy for Peripheral Arterial Disease (SET-PAD)** $0 copay per service. **Out-of-Network:** **Cardiac & Pulmonary Rehabilitation Services:** $50 copay per service. **Supervised Exercise Therapy for Peripheral Arterial Disease (SET-PAD)** $50 copay per service.	**In-Network:** **Cardiac & Pulmonary Rehabilitation Services:** $0 copay per service. **Supervised Exercise Therapy for Peripheral Arterial Disease (SET-PAD)** $0 copay per service. **Out-of-Network:** **Cardiac & Pulmonary Rehabilitation Services:** $50 copay per service. **Supervised Exercise Therapy for Peripheral Arterial Disease (SET-PAD)** $50 copay per service.
Annual Physical Exams	**In-Network:** $0 copay per exam. **Out-of-Network:** $0 copay per exam.	**In-Network:** $0 copay per exam. **Out-of-Network:** $0 copay per exam.
Over the Counter (OTC)	$55 Per calendar quarter (every three months). This amount does not roll over from quarter to quarter. Eligible items are listed in the OTC Catalog. To purchase eligible items, you can order online through your portal, over the phone, via mail order, or by visiting participating stores.	$45 Per calendar quarter (every three months). This amount does not roll over from quarter to quarter. Eligible items are listed in the OTC Catalog. To purchase eligible items, you can order online through your portal, over the phone, via mail order, or by visiting participating stores.
	With this plan, you receive an eternalPlus Benefits Card that will include this benefit. Must use our designated vendor for this benefit. Please see the Evidence of Coverage for more information.	

	eternalHealth Freedom (PPO) H2694-001	eternalHealth Give Back (PPO) H2694-002
SSBCI Grocery *Members having Diabetes, Cancer, Cardiovascular disorders, Chronic and disabling mental health conditions & End-stage renal disease (ESRD) are eligible to use their standard OTC benefit combined with an additional healthy grocery benefit every three months towards a food and produce benefit or OTC.* *This benefit is for members who qualify. Not all members will qualify for this benefit.*	Not covered.	$50 Per calendar quarter (every three months). This amount does not roll over from quarter to quarter. Eligible items are listed in the OTC Catalog. To purchase eligible items, you can order online through your portal, over the phone, via mail order, or by visiting participating stores. With this plan, you receive an eternalPlus Benefits Card that will include this benefit if eligible. Must use our designated vendor for this benefit.
Health and Wellness programs - Fitness	You pay a $0 copay for this benefit. Members have access to three fitness benefits. 1. OnePass offers a robust and flexible fitness benefit, which gives members access to various gyms, boutique fitness studios, online fitness videos, and a personalized online brain training program for improved cognitive health. Members may also choose to receive a home kit if they prefer working out at home. There are three kits offered. • Fit Kit • Yoga Kit • Dance Kit	You pay a $0 copay for this benefit. Members have access to two fitness benefits. 1. OnePass offers a robust and flexible fitness benefit, which gives members access to various gyms, boutique fitness studios, online fitness videos, and a personalized online brain training program for improved cognitive health. Members may also choose to receive a home kit if they prefer working out at home. There are three kits offered. • Fit Kit • Yoga Kit • Dance Kit

	2. Members receive $350 annually on their eternalPlus Benefits Card which can be used to pay for fitness trackers, home fitness equipment, such as stationary bikes and weights, golf green fees, tennis and pickleball. 3. Members have access to Kaia Health for digital MSK. Please see the Evidence of Coverage (EOC) for more information.	2. Members have access to Kaia Health for digital MSK. Please see the Evidence of Coverage for more information.
Meals	You pay a $0 copayment for this benefit. After a discharge from an inpatient stay at a hospital, you may be eligible to have up to two weeks (28 meals) of fully prepared, nutritious meals delivered to your home to help you recover from your illness/injuries and or manage your health conditions. Upon your discharge, our care management team will coordinate your meal benefit. (Meals must be ordered by an eternalHealth care manager). If the criteria are met, meals are prepared and delivered to your home by a plan approved vendor at no cost to you.	You pay a $0 copayment for this benefit. After a discharge from an inpatient stay at a hospital, you may be eligible to have up to two weeks (28 meals) of fully prepared, nutritious meals delivered to your home to help you recover from your illness/injuries and or manage your health conditions. Upon your discharge, our care management team will coordinate your meal benefit. (Meals must be ordered by an eternalHealth care manager). If the criteria are met, meals are prepared and delivered to your home by a plan approved vendor at no cost to you.
In-Home Support	Not covered.	You pay a $0 copayment for this benefit. In-Home Support assistance through Papa includes 60 hours annually for services such as: • Household chores – light cleaning, organization, laundry • Technical Assistance – learning telehealth services to connect with physicians, accessing health plan portals, installing devices • Exercise and Activity- walking or biking assistance • Virtual services

Pre-Enrollment Checklist

Prior to making an enrollment decision, it is important that you fully understand the coverage you are going to be receiving. If you have any questions regarding your coverage options, you can call to speak to us at 1 (800) 893-9457 (TTY 711).

Understanding the Benefits

☐The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits that are important to you before enrolling. Visit www.eternalHealth.com/Forms-Documents or call 1 (800) 893-9457 (TTY 711) to view a copy of the EOC.

☐Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.

☐Review the pharmacy directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

☐Review the formulary to make sure your drugs are covered.

Understanding Important Rules

☐You must continue to pay your Medicare Part B premium. This premium is typically taken out of your social security check each month.

☐Benefits, premiums and/or copayments/co-insurance may change on January 1, 2025

☐Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).

☐Select benefits and services may require a prior authorization.

Notice of Non-Discrimination: Discrimination is Against the Law

eternalHealth complies with applicable Federal civil rights laws and does not discriminate based on race, color, national origin, age, disability, religion, or sex. eternalHealth does not exclude people or treat them differently because of race, color, national origin, age, disability, religion, or sex.

eternalHealth:

- 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 eternalHealth Member Services at **1-800-680-4568 (TTY 711)**

If you believe that eternalHealth 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:

eternalHealth (Mail)
eternalHealth, Inc.
eH Privacy Officer
C/O Appeals & Grievances
PO Box 1377
Westborough, MA 01581

eternalHealth (Phone/Fax)
Local Phone Number: 617-684-2348 (TTY 711)
Toll Free Phone Number: 1-800-680-4568 (TTY 711)
Fax: 1-866-326-1073

eternalHealth (In Person)
eternalHealth, Inc.
31 St. James Ave, Suite 950
Boston, MA 02116

You can file a grievance in person, by mail, or fax. If you need help filing a grievance, eternalHealth Member Services 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, D.C. 20201

Phone: 1-800-368-1019, 800-537-7697 (TDD)

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

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1 (800) 680-4568 (TTY 711). Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1 (800) 680-4568 (TTY 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1 (800) 680-4568 (TTY 711)。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1 (800) 680-4568 (TTY 711)。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1 (800) 680-4568 (TTY 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1 (800) 680-4568 (TTY 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1 (800) 680-4568 (TTY 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1 (800) 680-4568 (TTY 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1 (800) 680-4568 (TTY 711) 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1 (800) 680-4568 (TTY 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Form CMS-10802
(Expires 12/31/25)

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1 (800) 680-4568 (TTY 711). سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1 (800) 680-4568 (TTY 711) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1 (800) 680-4568 (TTY 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1 (800) 891-6989 (TTY 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1 (800) 680-4568 (TTY 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1 (800) 680-4568 (TTY 711). Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、
1 (800) 680-4568 (TTY 711) にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。

eternalHealth is an HMO plan with a Medicare Contract for HMO and PPO offerings. Enrollment in eternalHealth depends on contract renewal. The benefit information provided does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please call 1-800-680-4568 (TTY 711) and request the “Evidence of Coverage” or access it online at www.eternalHealth.com.