2026 Summary of Benefits

eternalHealth Valor Give Back (HMO-POS)

The Next Generation of Medicare Advantage.

H3551-003_SB26_VGB__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 Valor Give Back (HMO-POS) plan. The information in this document is for the plan year beginning January 1, 2026, and ending December 31, 2026.

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 Graham, Maricopa, Pima, or Pinal County in Arizona.

Does this plan cover my current healthcare needs?

This plan does not offer Part D prescription drugs, for more information please visit us at www.eternalhealth.com. 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.

My Monthly Premium, Deductible, and Maximum Out of Pocket

	eternalHealth Valor Give Back (HMO-POS) H3551-003	
	In-Network	**Out-Of-Network**
Monthly Premium	$0	
Medicare Part B Buy Down (Give Back)	Up to $100 per month reduced from your Part B premium.	
Medical Deductible	This plan does not have a deductible.	
Pharmacy (Part D) Deductible	This plan does not offer Part D Prescription Drugs.	
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.	$5,500	$9,000

My Covered Hospital and Medical Benefits and Services

	eternalHealth Valor Give Back (HMO-POS) H3551-003	
	In-Network	**Out-Of-Network**
Inpatient Hospital Coverage Prior Authorization is required.	In each benefit period, you pay: • Days 1–60 (of each benefit period): $0 after you meet your Part A deductible. • Days 61–90 (of each benefit period): $419 each day. • After day 90 (of each benefit period): $838 each day for each lifetime reserve day (up to 60 days over your lifetime). These are 2025 Medicare cost-sharing amounts. eternalHealth will update with 2026 amounts as soon as possible once released.	In each benefit period, you pay: • Days 1–60 (of each benefit period): $0 after you meet your Part A deductible. • Days 61–90 (of each benefit period): $419 each day. • After day 90 (of each benefit period): $838 each day for each lifetime reserve day (up to 60 days over your lifetime). These are 2025 Medicare cost-sharing amounts. eternalHealth will update with 2026 amounts as soon as possible once released.

	eternalHealth Valor Give Back (HMO-POS) H3551-003	
	In-Network	**Out-Of-Network**
Outpatient Hospital Coverage Prior Authorization is required for outpatient hospital services only.	**Diagnostic Colonoscopy** 20% coinsurance. **Outpatient Hospital** 20% coinsurance. **Observation Stays** 20% coinsurance. **Outpatient Clinic Visit** 20% coinsurance	**Diagnostic Colonoscopy** 50% coinsurance. **Outpatient Hospital** 50% coinsurance. **Observation Stays** 50% coinsurance. **Outpatient Clinic Visit** 50% coinsurance
Ambulatory Surgical Center (ASC) Services Prior Authorization is required.	**Diagnostic Colonoscopy** 20% coinsurance if performed at an ASC. **Ambulatory Surgical Center** 20% coinsurance for surgery performed at an ASC.	**Diagnostic Colonoscopy** 50% coinsurance if performed at an ASC. **Ambulatory Surgical Center** 50% coinsurance for surgery performed at an ASC.
Doctor Visits A referral is required for specialist visits.	**Primary Care Provider (PCP) Visits:** $0 copay per visit. **Specialist Visits:** $0 copay per visit.	**Primary Care Provider (PCP) Visits:** $0 copay per visit. **Specialist Visits:** $0 copay per visit.
Preventive care	You pay a $0 copay per service.	You pay a $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.	
	eternalHealth Valor Give Back (HMO-POS) H3551-003	
	In-Network	**Out-Of-Network**
Emergency services		
Emergency care	20% coinsurance up to a maximum of $125 for each visit.	20% coinsurance up to a maximum of $125 for each visit.
	Your copay is waived if you are admitted to the hospital within 24 hours. Your plan also includes worldwide coverage for emergency care up to $25,000 per calendar year. You will need to pay out of pocket and then submit for reimbursement. Please see the Evidence of Coverage for more information.	
Urgently Needed Services	20% coinsurance up to a maximum of $50 for each visit.	20% coinsurance up to a maximum of $50 for each visit.
	Your plan also includes worldwide coverage for urgently needed services. You will need to pay out of pocket and then submit 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.	20% coinsurance	50% coinsurance
Diagnostic tests and procedures Prior Authorization is required.	20% coinsurance	50% coinsurance

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	In-Network	**Out-Of-Network**
Lab services Prior Authorization is required for high-cost genetic testing and molecular studies.	20% coinsurance	50% coinsurance
Outpatient x-ray	20% coinsurance	50% coinsurance
Hearing services		
Medicare-covered hearing exam	20% coinsurance.	50% coinsurance.
Routine hearing exam One (1) visit per year.	$0 copay per exam with a participating NationsHearing provider.	Not covered.
Hearing aids Up to two (2) aids per year. One (1) hearing aid per ear, per year.	$595 copay based on your selection through NationsHearing. $895 copay based on your selection through NationsHearing. Hearing aid purchase includes: • First year of follow-up provider visits for fitting and adjustments • 2-year battery support • 3-year warranty coverage for loss, repairs, or damage You must use a NationsHearing provider for this benefit. Please see the Evidence of Coverage for more information.	Not covered.
Dental services		
Medicare-covered dental services	20% coinsurance.	50% coinsurance.

	eternalHealth Valor Give Back (HMO-POS) H3551-003	
	In-Network	**Out-Of-Network**
Non-Medicare covered dental services	eternalHealth will pay as much as $2,500 per year for preventive and comprehensive services, with no required network. This allowance will be available for use on your eternalPlus Benefits card and may be used at the dental provider of your choice. There are no restrictions or limitations. Please see the Evidence of Coverage for more information.	eternalHealth will pay as much as $2,500 per year for preventive and comprehensive services, with no required network**.** This allowance will be available for use on your eternalPlus Benefits card and may be used at the dental provider of your choice. There are no restrictions or limitations. Please see the Evidence of Coverage for more information.
Vision services		
Medicare-covered eye exam	20% coinsurance.	50% coinsurance.
Eyewear after cataract surgery (Medicare-covered standard eyewear**)**	20% coinsurance for one pair of standard eyewear after cataract surgery.	50% coinsurance for one pair of standard eyewear after cataract surgery.
Routine eye exam One (1) visit per year.	$0 copay per exam with a participating EyeMed provider.	Not covered.
Eyewear For covered eyewear you pay any balance more than the annual limit.	Up to $200 per calendar year for prescription eyewear or contact lenses purchased from an EyeMed provider.	Not covered.
Mental Health Services		
Outpatient mental health services	20% coinsurance	50% coinsurance
Opioid treatment program services	20% coinsurance	50% coinsurance

	eternalHealth Valor Give Back (HMO-POS) H3551-003	
	In-Network	**Out-Of-Network**
Mental Health Services (continued)		
Inpatient mental health care Prior Authorization is required except in an emergency. These are 2025 Medicare cost-sharing amounts. eternalHealth will update with 2026 amounts as soon as possible once released. 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 your Evidence of Coverage for additional important information.	In each benefit period, you pay: • Days 1–60 (of each benefit period): $0 after you meet your Part A deductible. • Days 61–90 (of each benefit period): $419 each day. • After day 90 (of each benefit period): $838 each day for each lifetime reserve day (up to 60 days over your lifetime). These are 2025 Medicare cost-sharing amounts. eternalHealth will update with 2026 amounts as soon as possible once released.	In each benefit period, you pay: • Days 1–60 (of each benefit period): $0 after you meet your Part A deductible. • Days 61–90 (of each benefit period): $419 each day. • After day 90 (of each benefit period): $838 each day for each lifetime reserve day (up to 60 days over your lifetime). These are 2025 Medicare cost-sharing amounts. eternalHealth will update with 2026 amounts as soon as possible once released.
Additional services		
Skilled Nursing Facility (SNF) Prior Authorization is required. No prior hospital stay is required.	$0 copay per day for days 1-20. $209.50 copay per day for days 21-100. After day 100 there is no coverage. These are 2025 cost-sharing amounts and may change for 2026. eternalHealth Valor Give Back (HMO-POS) will provide updated rates as soon as they are released.	$0 copay per day for days 1-20. $209.50 copay per day for days 21-100. After day 100 there is no coverage. These are 2025 cost-sharing amounts and may change for 2026. eternalHealth Valor Give Back (HMO-POS) will provide updated rates as soon as they are released.
Occupational, Physical and Speech Therapy	$30 copay per visit.	50% coinsurance.
Ambulance Services Prior Authorization required for non-emergency ambulance services.	20% coinsurance.	50% coinsurance.

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	In-Network	**Out-Of-Network**
Transportation Please see the Evidence of Coverage for more information	You pay a $0 copayment for 24 one-way rides up to 60 miles each way 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.	Not covered.
Medicare Part B Prescription Drugs Prior Authorization is required for certain Part B medications. Medicare Part B drugs may be subject to Step Therapy requirements. Part B Step Therapy Drug Categories: • Asthma • Bevacizumab • Bone Resorption Inhibitors • Colony Stimulating Factors • Eye Injections • Familial Hypercholesterolemia • Gout • Immune Globulins • Nausea • Neurotoxins • Pemetrexed • Pertuzumab • Rituximab • Trastuzumab • Viscosupplements This link will take you to a list of Part B drugs that may be subject to Step Therapy: **www.eternalhealth.com**	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). These prescription drugs are covered under Part B and not covered under the Medicare Prescription Drug Program.	50% coinsurance. 50% 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). These prescription drugs are covered under Part B and not covered under the Medicare Prescription Drug Program.

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	In-Network	**Out-Of-Network**
Telehealth Services Medicare covered Primary Care Physician (PCP) and Physician Specialist Services. This benefit may not be offered by all providers.	$0 copay per service.	Not covered.
Medicare-Covered Acupuncture Visits	$20 copay per visit.	50% coinsurance
Routine Acupuncture and Chiropractic Care	$25 copay per visit. Limit of 20 visits per calendar year combined with routine chiropractic care.	50% coinsurance. Limit of 20 visits per calendar year combined with routine chiropractic care.
Medicare-Covered Chiropractic Care	$15 copay per visit.	50% coinsurance.
Kidney Disease Treatment Services	20% coinsurance.	50% coinsurance.
Kidney disease education services	20% coinsurance.	50% coinsurance.
Foot Care (Podiatry Services)	$20 copay per visit.	50% coinsurance.
Durable Medical Equipment (DME) and Prosthetic Devices Prior Authorization is required.	20% coinsurance.	50% coinsurance.
Cardiac & Pulmonary Rehabilitation Services	**Cardiac & Pulmonary Rehabilitation Services** 20% coinsurance. **Supervised Exercise Therapy for Peripheral Arterial Disease (SET-PAD)** 20% coinsurance.	**Cardiac & Pulmonary Rehabilitation Services** 50% coinsurance. **Supervised Exercise Therapy for Peripheral Arterial Disease (SET-PAD)** 50% coinsurance.

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	In-Network	**Out-Of-Network**
Diabetic Supplies Prior Authorization is required for Diabetic Supplies and quantity limits apply. Please contact Member Services for more information. **Preferred Products through the Pharmacy Benefit:** **Test Strips:** Roche (AccuChek) and Ascencia (Contour) are covered with Prior Authorization and Quantity Limits. All other brands are excluded and would need an approved exception. **Continuous Glucose Monitors (CGM):** Abbott (Freestyle Libre) and Dexcom are covered with Prior Authorization and Quantity Limits. All other brands are excluded and would need an approved exception.	**Test Strips** You pay 20% coinsurance for preferred 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 20% coinsurance for preferred brand Medicare covered Continuous Glucose Monitors (CGM). All other brands are excluded and would need an approved exception. If approved, you pay 20% coinsurance for diabetic supplies accessed at non-pharmacy networks (i.e., durable medical equipment (DME) suppliers). **Other Blood Glucose Testing Supplies** 20% coinsurance.	**Test Strips** 50% coinsurance. **Continuous Glucose Monitors** 50% coinsurance. **Other Blood Glucose Testing Supplies** 50% coinsurance.
Medicare-covered Diabetic Therapeutic Shoes or Inserts Prior Authorization is required.	20% coinsurance.	50% coinsurance
Annual Physical Exams	$0 copay per exam.	Not Covered.

	eternalHealth Valor Give Back (HMO-POS) H3551-003	
Over the Counter (OTC) items	$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 will receive an eternalPlus Benefits card that will include this benefit. Please see the Evidence of Coverage for more information.	Not covered.
SSBCI - Essentials Wallet *This benefit is for members who qualify. Not all members will qualify for this benefit.*	Eligible members will receive $200 every three months to use for grocery and produce, utilities, automobile gas and minor home and bathroom safety modifications. This amount does not roll over from quarter to quarter. Please see the Evidence of Coverage for more information. Members having Diabetes, Cancer, Cardiovascular disorders, Chronic and disabling mental health conditions & Chronic Kidney Disease (CKD) may be eligible.	
Health and Wellness Programs - Fitness	You pay a $0 copay for this benefit. 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. Members receive $250 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 court fees and bowling fees. Members have access to Kaia Health for digital MSK. Please see the Evidence of Coverage for more information.	

This plan does not cover Part D Prescription Drugs.

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, 2027

☐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)
Attention: Compliance & Privacy
31 St. James Avenue Suite 950
Boston, MA 02116

eternalHealth (e-mail)
compliance@eternalhealth.com

eternalHealth (Phone/Fax)
Local Phone Number: 617-693-7391
Toll Free: 1-800-680-4568
TTY: 711
Fax: 866-395-8219

You can file a grievance in person, by mail, or fax. If you need help filing a grievance, eternalHealth Compliance 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 https://www.hhs.gov/ocr/complaints/index.html

Notice of Availability

English: ATTENTION: If you speak a language other than English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call **1 (800) 680-4568 (TTY 711)** or speak to your provider.

Español: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al **1 (800) 680-4568 (TTY 711)** o hable con su proveedor.

台語

注意：如果您說[台語]，我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務，以無障礙格式提供資訊。請致電 1 (800) 680-4568 (TTY 711)或與您的提供者討論。

Tagalog

PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa **1 (800) 680-4568 (TTY 711)** o makipag-usap sa iyong provider.

Français

ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le **1 (800) 680-4568 (TTY 711)** ou parlez à votre fournisseur.

Việt

LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số **1 (800) 680-4568 (TTY 711)** hoặc trao đổi với người cung cấp dịch vụ của bạn.

Deutsch

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie **1 (800) 680-4568 (TTY 711)** an oder sprechen Sie mit Ihrem Provider

한국어

주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. **1 (800) 680-4568 (TTY 711)**번으로 전화하거나 서비스 제공업체에 문의하십시오.

РУССКИЙ

ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону **1 (800) 680-4568 (TTY 711)** или обратитесь к своему поставщику услуг.

العربية

تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا **1 (800) 680-4568 (TTY 711)**أو تحدث إلى مقدم الخدمة".

हिंदी

ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। **1 (800) 680-4568 (TTY 711)** पर कॉल करें या अपने प्रदाता से बात करें।

Italiano

ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l' **1 (800) 680-4568 (TTY 711)** o parla con il tuo fornitore.

Português do Brasil

ATENÇÃO: Se você fala [inserir idioma], serviços gratuitos de assistência linguística estão disponíveis para você. Auxílios e serviços auxiliares apropriados para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para **1 (800) 680-4568 (TTY 711)** ou fale com seu provedor.

Kreyòl Ayisyen

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd aladispozisyon w gratis pou lang ou pale a. Èd ak sèvis siplemantè apwopriye pou bay enfòmasyon nan fòma aksesib yo disponib gratis tou. Rele nan **1 (800) 680-4568 (TTY 711)** oswa pale avèk founisè w la.

POLSKI

UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer **1 (800) 680-4568 (TTY 711)** lub porozmawiaj ze swoim dostawcą.

日本語

注：日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル（誰もが利用できるよう配慮された）な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。1 (800) 680-4568 (TTY 711) までお電話ください。または、ご利用の事業者にご相談ください。

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.