

2027 Summary of Benefits

eternalHealth Freedom (PPO)

eternalHealth Give Back (PPO)

The Next Generation of Medicare Advantage

Y0160_SB27_PPO_M

This booklet gives you a summary of drug and health services covered by eternalHealth Freedom (PPO) and eternalHealth Give back (PPO) and what you pay.

This information is not a complete description of benefits. Call 1-800-680-4568 (TTY 711) for more information. To get a complete list of services covered by eternalHealth, call our Member Service department and ask for the Evidence of Coverage (EOC). You can also access the EOC online at our website, eternalhealth.com/for-members/forms-and-documents.

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, 2027, and ending December 31, 2027.

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, 8amto 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 $48 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 and Tier 2** $0 deductible. **Tier 3, Tier 4, and Tier 5** $275 deductible.	**Tier 1 and Tier 2** $0 deductible. **Tier 3, Tier 4, and Tier 5** $400 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.*	$6,500 for services you receive from in-network providers. $9,500 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 1-6. $0 copay per day for days 7-90. $0 copay per day for days 91+. **Out-of-Network:** 30% coinsurance per stay.	**In-Network:** $435 copay per day for days 1-7. $0 copay per day for days 8-90. $0 copay per day for days 91+. **Out-of-Network:** 45% coinsurance per stay.
Outpatient Hospital Coverage Prior Authorization is Required In-Network.	**In-Network:** **Diagnostic Colonoscopy** $0 copay at any in-network location. **Outpatient Hospital** $400 copay for surgery performed at an outpatient hospital. **Observation Stay** $350 copay per stay. **Outpatient Hospital Clinic visit:** $0 copay per visit. **Out-of-Network:** **Outpatient Hospital Services:** 45% coinsurance for surgery performed at an outpatient hospital facility. **Observation Stay:** 30% coinsurance per stay. **Outpatient hospital clinic visits:** You pay a $50 copayment per visit.	**In-Network:** **Diagnostic Colonoscopy** $0 copay at any in-network location. **Outpatient Hospital** $425 copay for surgery performed at an outpatient hospital. **Observation Stay** $350 copay per stay. **Outpatient Hospital Clinic visit:** $35 copayment per visit. **Out-of-Network:** **Outpatient Hospital Services:** 45% coinsurance for surgery performed at an outpatient hospital facility. **Observation Stay:** 30% coinsurance per stay. **Outpatient Hospital Clinic visit:** You pay a $50 copayment per visit.

	eternalHealth Freedom (PPO) H2694-001	eternalHealth Give Back (PPO) H2694-002
Ambulatory Surgical Center (ASC) Services Prior Authorization is required in-network.	**In-Network and Out-of-Network:** **Diagnostic Colonoscopy** $0 copay if performed at an ASC. **In-Network:** **Ambulatory Surgical Center** $300 copay for surgery performed at an ASC. **Out-of-Network:** **Ambulatory Surgical Center Services** 30% coinsurance per service.	**In-Network and Out-of-Network:** **Diagnostic Colonoscopy** $0 copay if performed at an ASC. **In-Network:** **Ambulatory Surgical Center** $300 copay for surgery performed at an ASC. **Out-of-Network:** **Ambulatory Surgical Center Services** 30% coinsurance per service.
Doctor Office Visits		
Doctor Visits	**Primary Care Provider (PCP) Visits:** **In-Network:** $0 copay per visit. **Out-of-Network:** $0 copay per visit. **Specialist Visits:** **In-Network:** $10 copay per visit. **Out-of-Network:** $40 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:** $10 copay per visit. **Out-of-Network:** $40 copay per visit.
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 and Out-of-Network:** $125 copay per visit.	**In-Network and Out-of-Network:** $130 copay per visit.
	Your copay is waived if you are admitted to the hospital within 24 hours. If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must have your inpatient care at the out-of-network hospital authorized by the plan and your cost is the cost sharing you would pay at a network hospital. 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.	

Urgently Needed Services	**In-Network and Out-of-Network:** $25 copay per visit.	**In-Network and Out-of-Network:** $25 copay per visit.
	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 may be required required In-Network. Please contact Member Services for more information.	**In-Network:** $100 copay for Ultrasounds. $250 copay for Outpatient CT, MRI and PET scans. **Out-of-Network:** 30% coinsurance per service.	**In-Network:** $80 copay for Ultrasounds. $300 copay for Outpatient CT, MRI and PET scans. **Out-of-Network:** 30% coinsurance per service
Therapeutic Radiological Services Prior Authorization is required In-Network.	**In-Network:** You pay a $60 copayment for Medicare-covered radiation therapy, including technician materials and supplies. **Out-of-Network:** You pay a 30% coinsurance.	**In-Network:** You pay a $60 copayment for Medicare-covered radiation therapy, including technician materials and supplies. **Out-of-Network:** You pay a 30% coinsurance.
Diagnostic Tests and Procedures Prior Authorization may be required In-Network. Please contact Member Services for more information.	**In-Network:** $0 copay per service in an office setting $10 copay per service at a free-standing facility. **Out-of-Network:** 30% 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:** 30% coinsurance per visit.
Lab Services Prior Authorization may be required In-Network. Please contact Member Services for more information.	**In-Network:** $0 copay per service in an office setting. $10 copay per service at a free-standing lab facility.	**In-Network:** $0 copay per service in an office setting. $20 copay per service at a free-standing lab facility.

	Out-of-Network: 30% coinsurance per visit.	**Out-of-Network:** 30% coinsurance per visit.
Outpatient X-Ray	**In-Network:** $15 copay per service. **Out-of-Network:** 30% coinsurance per visit.	**In-Network:** $20 copay per service. **Out-of-Network:** 30% coinsurance per visit.
Dental Services		
Medicare-Covered Dental Services	**In-Network:** $35 copay per service. **Out-of-Network:** $50 copay per service.	**In-Network:** $35 copay per service. **Out-of-Network:** $50 copay per service.
Non-Medicare Covered Dental Services	Preventive and comprehensive services: $2,000 Annual Allowance. eternalHealth will pay as much as $2,000 per year for comprehensive and preventive services, with no required network. Please see the Evidence of Coverage for more information.	Preventive and comprehensive services: $1,750 Annual Allowance. eternalHealth will pay as much as $1,750 per year for comprehensive and preventive services, with no required network. Please see the Evidence of Coverage for more information.
Hearing Services		
Medicare-Covered Hearing Exam	**In-Network:** $35 copay per service. **Out-of-Network:** $50 copay per service.	**In-Network:** $35 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 a NationsHearing provider. **Out-of-Network:** $0 copay with an out-of-network (non-NationsHearing) hearing provider. You will need to pay out of pocket and submit for reimbursement.	**In-Network:** $0 copay per exam with a NationsHearing provider. **Out-of-Network:** $0 copay with an out-of-network (non-NationsHearing) hearing provider. You will need to pay out of pocket and submit for reimbursement.
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 NationsHearing. $895 copay based on your selection through NationsHearing. Hearing aid purchase includes: • First year of follow-up visits for fitting and adjustments • 2-year battery support • 3-year warranty coverage for loss, repairs, or damage. **Out-of-Network** $595 copay based on your selection through NationsHearing. $895 copay based on your selection through NationsHearing.	**In-Network:** $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 visits for fitting and adjustments • 2-year battery support • 3-year warranty coverage for loss, repairs, or damage. **Out-of-Network** $595 copay based on your selection through NationsHearing. $895 copay based on your selection through NationsHearing.
Vision Services		
Medicare-Covered Eye Exam	**In-Network:** $35 copay per exam. **Out-of-Network:** $50 copay per exam.	**In-Network:** $35 copay per exam. **Out-of-Network:** $50 copay per exam.
Eyewear After Cataract Surgery (Medicare-Covered Standard Eyewear)	**In-Network and Out-of-Network:** $0 copay for one pair of **standard** eyewear after cataract surgery.	**In-Network and 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:** $0 Copay 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:** $0 Copay You will need to pay out of pocket and submit for reimbursement. Please see the Evidence of Coverage for more information.
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 in a Psychiatric hospital Prior Authorization is required In-Network, except in an emergency.	**In-Network:** $350 copay per day for days 1-6. $0 copay per day for days 7-90. $0 copay per day for days 91+. **Out of Network:** 30% coinsurance per stay.	**In-Network:** $335 copay per day for days 1-7. $0 copay per day for days 8-90. $0 copay per day for days 91+. **Out of Network:** 45% 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:** $30 copay per visit. **Out-of-Network:** $50 copay per visit	**In-Network:** $30 copay per visit. **Out-of-Network:** $50 copay per visit
Opioid Treatment Program Service	**In-Network:** $30 copay per service. **Out-of-Network:** $50 copay per service.	**In-Network:** $30 copay per service. **Out-of-Network:** $50 copay per service.
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, up to 100 days.	**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, up to 100 days.
Occupational, Physical and Speech Therapy	**In-Network:** $20 copay per visit. **Out-of-Network:** $50 copay per visit.	**In-Network:** $30 copay per visit. **Out-of-Network:** $50 copay per visit.
Ambulance Services Prior Authorization is required for in-network non-emergency ambulance services.	**In-Network and Out-of-Network:** You pay a $300 copayment for each Medicare-covered one-way ambulance trip.	**In-Network and Out-of-Network:** You pay a $300 copayment for each Medicare-covered one-way ambulance trip.
	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:** Members have access to 24 one-way rides to plan approved locations (medical, dental, pharmacy) with a maximum distance of 60 miles per ride. Rides must be accessed through the plan's approved vendor to be covered.	**In-Network:** Members have access to 12 one-way rides to plan approved locations (medical, dental, pharmacy) with a maximum distance of 60 miles per ride. Rides must be scheduled through the plan's approved vendor to be covered.

	Out-of-Network: $0 copayment for up to 24 one way trips per year with a maximum distance of 60 miles per ride to medical/dental appointments or to your pharmacy. Member must pay out of pocket and submit receipts to eternalHealth for reimbursement. You must file a claim with NationsBenefits to get reimbursed. The claim form can be found at Member Resources - eternalHealth or by calling Member Services for the claim form. Please see the Evidence of Coverage for more information.	**Out-of-Network:** $0 copayment for up to 12 one way trips per year with a maximum distance of 60 miles per ride to medical/dental appointments or to your pharmacy. Member must pay out of pocket and submit receipts to eternalHealth for reimbursement. You must file a claim with NationsBenefits to get reimbursed. The claim form can be found at Member Resources - eternalHealth or by calling Member Services for the claim form. Please see the Evidence of Coverage for more information.
Medicare Part B Prescription Drugs Prior Authorization is required in-network. Medicare Part B drugs may be subject to Step Therapy requirements. This link will take you to a list of Part B drugs that may be subject to Step Therapy: www.eternalhealth.com	**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:** 50% Coinsurance These prescription drugs are covered under Part B and not covered under the Medicare Prescription Drug Program.	**In-Network: Out-of-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). These prescription drugs are covered under Part B and not covered under the Medicare Prescription Drug Program.

My Prescription Drug Benefits

There are three drug payment stages for your prescription drug coverage under eternalHealth Freedom (PPO) and eternalHealth Give Back (PPO) 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 and 2, so you will pay those copays. Tiers 3, 4, and 5 have the deductible listed below.

	eternalHealth Freedom (PPO) H2694-001	eternalHealth Give Back (PPO) H2694-002
Deductible Tiers 1 and Tier 2	$0	$0
Deductible Tiers 3, 4, and 5	$275	$400

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 $2,400.

Retail Cost Sharing	eternalHealth Freedom (PPO) H2694-001			eternalHealth Give Back (PPO) H2694-002		
Drug Tier	**30-day supply**	**60-day supply NA**	**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	$0 copay	$0 copay	$0 copay

Tier 3 (Preferred Brand)	25% of the total cost	25% of the total cost	25% of the total cost	25% of the total cost	25% of the total cost	25% of the total cost
Tier 4 (Non-Preferred Drug)	32% of the total cost	32% of the total cost	32% of the total cost	35% of the total cost	35% of the total cost	35% of the total cost
Tier 5 (Specialty)	30% of the total cost	N/A	N/A	28% of the total cost	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 NA**	**100-day supply NA**
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	$0 copay	$0 copay	$0 copay
Tier 3 (Preferred Brand)	25% of the total cost	25% of the total cost	25% of the total cost	25% of the total cost	25% of the total cost	25% of the total cost
Tier 4 (Non-Preferred Drug)	32% of the total cost	32% of the total cost	32% of the total cost	35% of the total cost	35% of the total cost	35% of the total cost
Tier 5 (Specialty)	30% of the total cost	N/A	N/A	28% of the total cost	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 $2,400. 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 *This benefit may not be offered by all providers. Check availability directly with your PCP or Specialist.*	**In-Network:** $0 copay per visit with a PCP. $10 copay per visit with a Specialist. **Out-of-Network:** $0 copay per PCP service. $40 copay per Specialist service.	**In-Network:** $0 copay per visit with a PCP. $10 copay per visit with a Specialist. **Out-of-Network:** $0 copay per PCP service. $40 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.
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:** $15 copay per visit. **Out-of-Network:** $50 copay per visit.	**In-Network:** $15 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.

Kidney Disease Treatment Services	**Dialysis Treatment (both facility and clinic visits)** **In-Network:** 20% coinsurance per service. **Out-of-Network:** 30% coinsurance per service. **Kidney Disease Education Services In-Network and Out-of-Network:** No copayment, coinsurance or deductible.	**Dialysis Treatment (both facility and clinic visits)** **In-Network:** 20% coinsurance per service. **Out-of-Network:** 30% coinsurance per service. **Kidney Disease Education Services In-Network and Out-of-Network:** No copayment, coinsurance or deductible.
Foot Care (Podiatry Services)	**In-Network:** $0 copay for Diabetic foot care. $30 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. $35 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:** 30% coinsurance	**In-Network:** 20% coinsurance. **Out-of-Network:** 30% coinsurance

Cardiac & Pulmonary Rehabilitation Services	**In-Network:** **Cardiac & Pulmonary Rehabilitation Services:** $0 copay per service. **Supervised Exercise Therapy for Peripheral Arterial Disease (SET-PAD)** $25 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)** $25 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 and Out-of-Network:** $0 copay per exam.	**In-Network and Out-of-Network:** $0 copay per exam.

Diabetic Supplies Prior Authorization is required in-network for diabetic services and supplies and quantity limits apply. **Preferred Products through the Pharmacy Benefit:** **Test Strips:** Roche (Accu-Chek) 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 0% 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 0% coinsurance for preferred brand Continuous Glucose Monitors (CGM). All others would require an exception. If approved, you pay 20% coinsurance. If obtained through a Durable Medical Equipment (DME provider) your cost-share will be 20%. **Testing Supplies** You pay 20% for blood glucose testing supplies including lancets and glucose control solutions **Medicare-covered Diabetic Therapeutic Shoes or Inserts** 20% coinsurance. **Out-of-Network:** 20% coinsurance **In-Network and Out-of-Network:** **Diabetes Self-Management Training**: There is no coinsurance, copayments or deductible for diabetes self-management training.	**Test Strips:** You pay 0% 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 0% coinsurance for preferred brand Continuous Glucose Monitors (CGM). All others would require an exception. If approved, you pay 20% coinsurance. If obtained through a Durable Medical Equipment (DME provider) your cost-share will be 20%. **Testing Supplies** You pay 20% for blood glucose testing supplies including lancets and glucose control solutions **Medicare-covered Diabetic Therapeutic Shoes or Inserts** 20% coinsurance. **Out-of-Network:** 20% coinsurance **In-Network and Out-of-Network:** **Diabetes Self-Management Training**: There is no coinsurance, copayments or deductible for diabetes self-management training.
Over the Counter (OTC)	$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	$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.	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.	
SSBCI Grocery* Members having Diabetes, Cancer, Cardiovascular disorders, Chronic and disabling mental health conditions & chronic kidney disease (CKD) 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.
In-Home Support	Not covered.	You pay a $0 copayment for this benefit. In-Home Support assistance through Papa includes 30 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

Alternative Therapies – Myndstream	$0 copayment for this benefit. This benefit provides members with personalized, on-demand therapeutic music experiences designed to support symptom management, functional status, and overall health and wellbeing.	Not covered.
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. 2. Members receive $250 annually on their eternalPlus Benefits Card which can be used to pay for home fitness equipment, such as stationary bikes and weights, golf green fees, tennis and pickleball court fees, and bowling fees. Please see the Evidence of Coverage (EOC) for more information.	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. 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	You pay a $0 copayment for this benefit. After a discharge from an inpatient stay at a hospital, you may be eligible

	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.	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.

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

eternalHealth (e-mail)
compliance@eternalhealth.com

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.

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 **(TTY 711) 1 (800) 680-4568**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.