2022 Summary of Benefits

eternalHealth Freedom PPO

($0 PPO)

Your
Forever Partner
In Healthcare.

H2694_FR_SBC22_M 10/13/2021

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 PPO plan. The information in this document is for the plan year beginning January 1, 2022 and ending December 31, 2022.

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 Middlesex, Suffolk, or Worcester 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 1-800-891-6989.

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) 24 hours a day/7 days a week. TTY users can call 711.

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?

The complete list of services covered by eternalHealth Freedom PPO can be found in the Evidence of Coverage (EOC) under Member Resources on eternalHealth's website at www.eternalhealth.com.

Alternatively, you can call us 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, Saturdays.

H2694_FR_SBC22_M 10/13/2021

My Monthly Premium, Deductible, and Maximum Out of Pocket

Monthly Premium	$0 premium.
Medical Deductible	This plan does not have a deductible.
Pharmacy (Part D) Deductible	**Generic Drugs (Tier 1 and Tier 2)** $0 deductible **Brand Drugs & Specialty Drugs (Tier 3, Tier 4, and Tier 5)** $185 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 supplemental benefits do not apply.	**In-Network** $6,700 **In-Network & Out-of-Network Combined** $7,500

My Covered Hospital and Medical Benefits and Services

	In-Network	Out-of-Network
Inpatient Hospital Coverage Authorization will be required.	**Inpatient Hospital Services** **Days 1 - 5** $385 copay per day. **Days 6 - 90** $0 copay per day. **Inpatient Hospital Psychiatric Services** **Days 1 - 5** $370 copay per day. **Days 6 - 90** $0 copay per day.	**Inpatient Hospital Services** 30% coinsurance. **Inpatient Hospital Psychiatric Services** 30% coinsurance.
Outpatient Hospital Coverage Authorization will be required for procedures performed in an Outpatient Hospital or Ambulatory Surgical Center.	**Diagnostic Colonoscopies** $0 copay per service. **Ambulatory Surgical Center (ASC)** $350 copay per visit. **Outpatient Hospital** $350 copay per visit. **Observation Stays** $350 copay per stay.	**Diagnostic Colonoscopies** 30% coinsurance. **Ambulatory Surgical Center (ASC)** 30% coinsurance. **Outpatient Hospital** 30% coinsurance. **Observation Stays** 30% coinsurance.

H2694_FR_SBC22_M 10/13/2021

<table>
<tr><th></th><th>In-Network</th><th>Out-of-Network</th></tr>
<tr><td>Doctor Visits</td><td>Primary Care Visits
$0 copay.

Specialist Visits
$40 copay.</td><td>Primary Care Visits
$20 copay per visit.

Specialist Visits
30% coinsurance.</td></tr>
<tr><td rowspan="2">Preventive Care</td><td>$0 copay per service.</td><td>30% coinsurance.</td></tr>
<tr><td colspan="2">Preventive services are available at no cost if you use an in-network provider for:
Abdominal Aortic Aneurysm (AAA) Screening.
Alcohol Misuse Screening & Counseling
Annual Wellness Visit
Bone Mass Measurements (bone density)
Cardiovascular Disease Screening Tests
Cervical Cancer Screening
Colorectal Cancer Screening
Counseling to Prevent Tobacco Use
COVID-19 Vaccine Immunization
Depression Screening
Diabetes Screening
Diabetes Self-Management Training
Flu Shot & Administration
Glaucoma Screening
Hepatitis B Screening
Hepatitis B Shot & Administration
Hepatitis C Screening
HIV Screening
Initial Preventive Physical Exam</td></tr>
</table>

H2694_FR_SBC22_M 10/13/2021

	In-Network	Out-of-Network
Preventive Care (Continued)	• Intensive Behavioral Therapy (IBT) for Cardiovascular Disease • Intensive Behavioral Therapy (IBT) for Obesity • Lung Cancer Screening • Mammography Screening • Medical Nutrition Therapy • Medicare Diabetes Prevention Program • Pap Tests Screening • Pneumococcal Shot & Administration • Prolonged Preventive Services • Prostate Cancer Screening • Screening Pelvic Exam • Sexually Transmitted Infection (STI) Screening & High Intensity Behavioral Counseling (HIBC) to Prevent STIs	
Emergency Care You do not have to pay this copay if you are admitted to the hospital within 24 hours. If admitted, refer to the Inpatient Hospital Coverage section. This plan also covers you for Emergency Care provided worldwide.	$90 copay per visit.	$90 copay per visit.
Urgently Needed Services This plan also covers you for Urgent Care provided worldwide.	**Primary Care Visit** $0 copay. **Specialty/Urgent Care Center Visit** $40 copay.	**Primary Care Visit** $20 copay. **Specialty/Urgent Care Center Visit** $40 copay.

	In-Network	Out-of-Network
Diagnostic Services, Labs, and Imaging Authorization may be required. Blood Services, Diagnostic Test & Lab Services, Medicare – covered X-Rays, Medicare- covered Therapeutic Radiological Services, and Medicare-covered Diagnostic Services which includes: • Computed Tomography (CT) • Magnetic Resonance Imaging (MRI) • Positron Emission Tomography (PET) • Other Diagnostic/General Imaging	**Blood Services** $0 copay per service. **Diagnostic Tests** $30 copay per service. **Lab Services** $0 copay per service. **Medicare-covered X-Ray Services** $15 copay per service. **Medicare-covered Therapeutic Radiological Services** $60 copay per service. **Medicare-covered Diagnostic Services** $125 copay per service.	**Blood Services** 30% coinsurance. **Diagnostic Tests & Lab Services** 30% coinsurance. **Medicare-covered X-Ray Services** 30% coinsurance. **Medicare-covered Therapeutic Radiological Services** 30% coinsurance. **Medicare-covered Diagnostic Services** 30% coinsurance.
Medicare Covered Hearing Care	**Routine Hearing Exams** $0 copay per exam.	**Routine Hearing Exams** 30% coinsurance.
Routine Hearing Care This benefit does not apply to your maximum out-of-pocket (MOOP) amount.	**Routine Fitting Exams** $0 copay per exam. **Hearing Aids** Hearing aid cost will be either $595 or $895, based upon your selection through Amplifon.	**Routine Fitting Exams** 30% coinsurance. **Hearing Aids** $0 copay per hearing aid with a very limited selection.

	In-Network	Out-of-Network
Medicare Covered Dental Services An example of this is reconstruction of the jaw following an accidental injury.	$30 copay.	30% coinsurance.
Preventive Dental Care This benefit does not apply to your maximum out-of-pocket (MOOP) amount. Preventive Services include: • Oral Exams (2 per plan year) • Prophylaxis (Cleaning) (2 per plan year) • Dental X-Rays (2 per plan year)	$0 copay.	30% coinsurance.
Comprehensive Dental Services This benefit does not apply to your maximum out-of-pocket (MOOP) amount. Comprehensive Dental Services include: • Diagnostic Services • Endodontics • Extractions • Other Oral/Maxillofacial Surgery Extractions • Periodontics • Prosthodontics • Restorative Services	50% coinsurance.	50% coinsurance.

	In-Network	Out-of-Network
Medicare Covered Eye Exams	$15 copay per exam.	30% coinsurance.
Routine Eye Exams This benefit does not apply to your maximum out-of-pocket (MOOP) amount.	$0 Copay.	$0 Copay.
Eyewear Benefits This benefit does not apply to your maximum out-of-pocket (MOOP) amount.	A maximum of $200 is covered by the plan for eyewear per year.	
Mental Health and Substance Abuse Services Authorization will be required	**Individual or Group Therapy Sessions** $25 copay per session. **Mental Health Partial Hospitalization** $25 copay per day. **Opioid Treatment Program Services** $25 copay per visit.	**Individual or Group Therapy Sessions** $50 copay per session. **Mental Health Partial Hospitalization** 30% coinsurance. **Opioid Treatment Program Services** $25 copay per visit.
Skilled Nursing Facility (SNF) Authorization will be required. No prior hospital stay required.	**Skilled Nursing Services Days 1 - 20** $0 copay per day. **Days 21 - 58** $184 copay per day. **Days 59 - 100** $0 copay per day.	**Skilled Nursing Services** 30% coinsurance per stay.

	In-Network	Out-of-Network
Occupational, Physical and Speech Therapy	$40 copay per visit.	30% coinsurance.
Ambulance Services This plan covers you for ambulance transportation. Authorization will be required for non-emergency Medicare services. This plan also covers you for emergency transportation provided worldwide.	**Ground/Air Ambulance** $275 copay per service.	
Non-Emergency Medical Transportation	This plan does not cover non-emergent medical transportation.	
Part B Prescription Drugs Authorization may be required. Generally, Part B drugs are not self-administered. These drugs can be given in a doctor's office as part of a medical service. In a hospital outpatient department, coverage is generally limited to drugs that are given by infusion or injection.	20% coinsurance.	30% coinsurance.

My Prescription Drug Benefits

Pharmacy (Part D) Deductible

- **Generic Drugs (Tier 1 and Tier 2)**
  $0 deductible
- **Brand Drugs & Specialty Drugs (Tier 3, Tier 4, and Tier 5)**
  $185 deductible

Initial Coverage

You stay in the Initial Coverage Stage until the total amount for the prescription drugs you have filled and refilled reaches the **$4,430 limit for the Initial Coverage Stage**.

	Retail*	Mail Order*
Tier 1 (Preferred Generic)	**30-day supply:** $0 Copay **100-day supply:** $0 Copay	**30-day supply:** $0 Copay **100-day supply:** $0 Copay
Tier 2 (Non-preferred Generic)	**30-day supply:** $5 Copay **100-day supply:** $15 Copay	**30-day supply:** $5 Copay **100-day supply:** $5 Copay
Tier 3 (Preferred Brand)	**30-day supply:** $47 Copay **100-day supply:** $141 Copay	**30-day supply:** $47 Copay **100-day supply:** $47 Copay
Tier 4 (Non-Preferred Brand)	**30-day supply:** $100 Copay **100-day supply:** $300 Copay	**30-day supply:** $100 Copay **100-day supply:** $300 Copay
Tier 5 (Specialty Drugs)	**30-day supply:** 30% Coinsurance **100-day supply:** Not covered	**30-day supply:** 30% Coinsurance **100-day supply:** Not covered

- Out-of-Network cost-sharing aligns with the 30-day supply amounts, however, is limited to 10-day supply.

Coverage Gap

During the Coverage Gap Stage, you receive a discount on brand name drugs and pay no more than 25% of the costs of generic drugs.

You stay in the Coverage Gap Stage until your out-of-pocket costs reach $7,050.

Catastrophic Coverage Stage

You qualify for the Catastrophic Coverage Stage when your out-of-pocket costs have reached the $7,050 limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year.

During this stage, the plan will pay most of the cost for your drugs.

Your share of the cost for a covered drug will be either coinsurance or a copayment, whichever is the larger amount:

- *either* coinsurance of 5% of the cost of the drug
- *or* – $3.95 for a generic drug or a drug that is treated like a generic and $9.85 for all other drugs.

Our plan pays the rest of the cost.

My Additional Covered Benefits and Services

	In-Network	Out-of-Network
Telehealth Services Medicare covered Primary Care Physician (PCP) and Physician Specialist Services	$0 copay per service.	$0 copay per service.
Medicare-Covered Acupuncture Visits	$40 copay per visit.	30% coinsurance.
Medicare-Covered Chiropractic Care	$20 copay per visit.	30% coinsurance.
Kidney Disease Treatment Services	**Dialysis Treatment (both facility and clinic visits)** 20% coinsurance. Dialysis received during an inpatient hospital stay will be covered under your hospital inpatient benefit. **Kidney Disease Education Services** $0 copay. **Other Medicare covered Services** 20% coinsurance.	**Dialysis Treatment (both facility and clinic visits)** 30% coinsurance. Dialysis received during an inpatient hospital stay will be covered under your hospital inpatient benefit. **Kidney Disease Education Services** 30% coinsurance. **Other Medicare covered Services** 30% coinsurance.

	In-Network	Out-of-Network
Foot Care (Podiatry Services)	$45 copay per doctor visit. If a surgical procedure is done in an outpatient facility setting, the facility copay applies. Please refer to the section on Outpatient Hospital Coverage above for more details.	30% coinsurance.
Home Health Services Authorization will be required.	$0 copay per visit.	30% coinsurance.
Durable Medical Equipment (DME), Diabetic Supplies, and Prosthetic Devices Authorization may be required.	20% coinsurance.	30% coinsurance.
Cardiac & Pulmonary Rehabilitation Services Authorization may be required.	$30 copay per service	30% coinsurance

	In-Network	Out-of-Network
Fitness Benefits This benefit does not apply to your maximum out-of-pocket (MOOP) amount. You will be reimbursed if you participate in or purchase any of the following: gym memberships, fitness apps, aquatic centers, or fitness classes.	$15 per month. This amount does not roll over from month to month.	
Over-the-counter (OTC) Items This benefit does not apply to your maximum out-of-pocket (MOOP) amount.	$50 per calendar quarter (every three months). This amount does not roll over from quarter to quarter.	
Personal Emergency Response Device (PERS) This benefit does not apply to your maximum out-of-pocket (MOOP) amount. Authorization will be required.	Fully covered with no cost to you.	30% coinsurance.

Notice of Non-Discrimination

eternalHealth complies with applicable Federal civil rights laws and does not discriminate based on race, color, national origin, age, disability, or sex. eternalHealth does not exclude people or treat them differently because of race, color, national origin, age, disability, 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's Civil Rights Coordinator at the phone number and address listed below.

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, Inc.
Attention: Civil Rights Coordinator
376 Boylston St.,
Suite 501,
Boston, MA 02116
Local Phone Number: 617-934-5384
Toll Free Phone Number: 800-960-4585
(Fax): 1 (866) 395-8219
Email: civilrights@eternalhealth.com

You can file a grievance in person, by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator 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.

Language Services

English: Attention: If you speak English, language services are available free of charge. Call 1-800-891-6989 (TTY: 711).

Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-891-6989 (TTY: 711).

Português (Portuguese): ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-891-6989 (TTY: 711).

繁體中文 (Chinese): 注意：如果您会说中文，可免费获得语言协助服务。呼叫 1-800-891-6989 (TTY：711).

Kreyòl Ayisyen (French Creole/Haitian Creole): ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-891-6989 (TTY: 711).

Français (French): ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-891-6989 (ATS : 711).

Disclaimer

eternalHealth, Inc. is an HMO plan with a Medicare contract. Enrollment in eternalHealth, Inc. depends on contract renewal. This information is not a complete description of benefits. Call 1-800-680-4568 (TTY 711) for more information.

Out-of-network/noncontracted providers are under no obligation to treat members, except in emergency situations. Please call our member services number or see your Evidence of Coverage for more information, including the cost- sharing that applies to out-of-network services.

H2694_FR_SBC22_M 10/13/2021