2025 Summary of Benefits

eternalHealth Valor Give Back (HMO-POS)

The Next Generation of Medicare Advantage.

H3551-003_SB25_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, 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 Maricopa or Pima 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.	You pay $0 copay per day for days 1-60 (of each benefit period) once you meet your Part A deductible. You pay a $408 coinsurance amount per day for days 61-90 (of each benefit period). After day 90 (of each benefit period): you pay a $816 coinsurance amount per day while using your 60 lifetime reserve days. These are 2024 Medicare cost-sharing amounts. eternalHealth will update with	You pay $0 copay per day for days 1-60 (of each benefit period) once you meet your Part A deductible. You pay a $408 coinsurance amount per day for days 61-90 (of each benefit period). After day 90 (of each benefit period): you pay a $816 coinsurance amount per day while using your 60 lifetime reserve days. These are 2024 Medicare cost-sharing amounts. eternalHealth will update

	2025 amounts as soon as possible once released.	with 2025 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.	**Diagnostic Colonoscopy** 20% coinsurance. **Outpatient Hospital** 20% coinsurance. **Observation Stays** 20% coinsurance.	**Diagnostic Colonoscopy** 50% coinsurance. **Outpatient Hospital** 50% coinsurance. **Observation Stays** 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:** $25 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 $120 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 $60 for each visit.	20% coinsurance up to a maximum of $55 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 in-network.	20% coinsurance	50% coinsurance
Diagnostic tests and procedures	20% coinsurance	50% coinsurance

Prior Authorization is required in-network.		
	eternalHealth Valor Give Back (HMO-POS) H3551-003	
	In-Network	**Out-Of-Network**
Lab services Prior Authorization is required in-network 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 Amplifon 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 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. You must use an Amplifon provider for this benefit. Please see the Evidence of Coverage for more information.	Not covered.
Dental services		
Limited 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	**$2,500 Annual Allowance** 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.	**$2,500 Annual Allowance** 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, continued		
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		
Inpatient mental health care Prior Authorization is required in-network. These are 2024 Medicare cost-sharing amounts. eternalHealth will update with 2025 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.	You pay $0 copay per day for days 1-60 (of each benefit period) once you meet your Part A deductible. You pay a $408 coinsurance amount per day for days 61-90 (of each benefit period). After day 90 (of each benefit period): you pay a $816 coinsurance amount per day while using your 60 lifetime reserve days.	You pay $0 copay per day for days 1-60 (of each benefit period) once you meet your Part A deductible. You pay a $408 coinsurance amount per day for days 61-90 (of each benefit period). After day 90 (of each benefit period): you pay a $816 coinsurance amount per day while using your 60 lifetime reserve days.
Additional services		
Skilled Nursing Facility (SNF) Prior Authorization is required. No prior hospital stay is required.	$0 copay per day for days 1-20. $204 copay per day for days 21-100. After day 100 there is no coverage.	$0 copay per day for days 1-20. $204 copay per day for days 21-100. After day 100 there is no coverage.
Occupational, Physical and Speech Therapy Prior Authorization is required.	$30 copay per visit.	50% coinsurance.

	eternalHealth Valor Give Back (HMO-POS) H3551-003	
	In-Network	**Out-Of-Network**
Ambulance Services Prior Authorization is required for in-network non-emergent ambulance services.	20% coinsurance.	50% coinsurance.
Transportation	You pay a $0 copayment for 24 one-way 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. Please see the Evidence of Coverage for more information.	Not covered.
Part B Prescription Drugs Prior Authorization is required for certain medications based on CMS guidance.	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).	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).
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.

	eternalHealth Valor Give Back (HMO-POS) H3551-003	
	In-Network	**Out-Of-Network**
Medicare-Covered Chiropractic Care	$20 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) Prior Authorization is required.	20% coinsurance	50% coinsurance.
Durable Medical Equipment (DME) and Prosthetic Devices Prior Authorization is required.	20% coinsurance.	50% coinsurance.
Diabetic Supplies *Prior Authorization is Required for Diabetic Supplies and quantity limits apply. These restrictions are aligned with traditional Medicare requirements.*	**Test Strips** You pay 20% coinsurance for preferred brand (LifeScan & Roche) 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 (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 for diabetic supplies accessed at non-pharmacy networks. **Other Blood Glucose Testing Supplies:** 20% coinsurance	**Test Strips** 50% coinsurance. **Continuous Glucose Monitors** 50% coinsurance. **Other Blood Glucose Testing Supplies** 50% coinsurance.

	eternalHealth Valor Give Back (HMO-POS) H3551-003	
	In-Network	**Out-Of-Network**
Medicare-covered Diabetic Therapeutic Shoes or Inserts	20% coinsurance.	50% coinsurance
Cardiac & Pulmonary Rehabilitation Services Prior Authorization is required.	**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.
Annual Physical Exams	$0 copay per exam.	Not Covered.
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.	
SSBCI - Essentials Wallet *This benefit is for members who qualify. Not all members will qualify for this benefit.*	Eligible members will receive $300 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 & End-stage renal disease (ESRD) may be eligible.	

	eternalHealth Valor Give Back (HMO-POS) H3551-003
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. There are three kits offered. 1. Fit Kit: resistance band, exercise tubing, door anchor, exercise cards specific to balance, coordination, agility, strength, cardio and flexibility 2. Yoga Kit: DVA with two, 20-minute videos + yoga mat, yoga block, yoga strap 3. Dance Kit: Zumba Gold dance kit includes quick start and 20-minute express DVD Members receive $300 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. 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, 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: 1-866-692-7270

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.

Multi-language Interpreter Services

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.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم بمساعدتك. هذه خدمة فوري، ليس عليك سوى الاتصال بنا على (T1-800-680-4568, TTY:711. سيقوم شخص ما يتحدث العربية 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.

Portugués: 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 1-800-680-4568 (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.