

Summary of Benefits

MEDICARE ADVANTAGE | 2027

ESSENCE ADVANTAGE® (HMO) - ESSENCE ADVANTAGE® CHOICE (PPO)

ESSENCE HEALTHCARE®

Serving Southwest Missouri and Northwest Arkansas

Essence Advantage (HMO) H2610-015
Essence Advantage Choice (PPO) H6200-004

Summary of Benefits

January 1, 2027 – December 31, 2027

This booklet gives you a summary of what we cover and what you pay. It doesn't list every limitation, exclusion, or covered service. To get a complete list of services we cover, view the Evidence of Coverage online at EssenceHealthcare.com.

If you want to know more about the coverage and costs of Original Medicare, look in your current Medicare & You handbook. View it online at Medicare.gov, or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.

Sections in This Booklet

- Things to Know About **Essence Advantage** and **Essence Advantage Choice**
- Monthly Premium, Deductibles, and Limits on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits
- Prescription Drug Benefits
- Other Covered Benefits

This document is available in other formats such as Braille and large print. This document may be available in a non-English language. For additional information, call 1-866-314-0911 (TTY: 711) to speak with a customer service representative.

Hours of Operation

- From October 1 to March 31, you can call us seven days a week from 8 a.m. to 8 p.m.
- From April 1 to September 30, you can call us Monday through Friday from 8 a.m. to 8 p.m.

Phone Number and Website

- If you have questions, call 1-866-314-0911 (TTY: 711) to speak with a customer service representative.
- Our website: EssenceHealthcare.com

Things to Know About Our Plans

Who can join?

To join **Essence Advantage** or **Essence Advantage Choice,** you must be entitled to Medicare Part A, be enrolled in Medicare Part B, be a United States citizen or are lawfully present in the United States, and live in our service area. Our service area for all plans: the Missouri counties of Barry, Christian, Dallas, Greene, Lawrence, Polk, Stone, Taney, and Webster, and the Arkansas counties of Benton, Carroll, Madison, and Washington. Our HMO plan is also available in Barton, Cedar, and Dade counties in Missouri, and Crawford, Franklin, Johnson, Logan, Newton, Scott, and Sebastian counties in Arkansas. Our PPO plan is not offered in these additional counties.

What's an HMO?

An HMO, or Health Maintenance Organization, is a type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. It generally won't cover out-of-network care except in an emergency.

What's a PPO?

A PPO, or Preferred Provider Organization, is a health insurance plan that offers a network of providers but also allows you to seek care from out-of-network providers. You may pay less if you use providers that belong to the plan's network.

Which doctors, hospitals, and pharmacies can I use?

Essence Advantage and **Essence Advantage Choice** have a network of doctors, hospitals, pharmacies, and other providers. HMO plan members must use plan providers unless prior approval is given by the plan, except in emergency or urgent care situations. PPO plan members may see out-of-network providers. Out-of-network providers are under no obligation to treat plan members, except in emergency situations. You must generally use network pharmacies to fill your prescriptions for covered Part D drugs. Some of our network pharmacies have preferred cost-sharing. You may pay less if you use these pharmacies. You can see our plans' Provider Directory on EssenceHealthcare.com or call us, and we'll send you a copy.

What do we cover?

Like all Medicare health plans, we cover everything that Original Medicare covers—and *more.*

- **Our plan members get *all* of the benefits covered by Original Medicare.** For some of these benefits, you may pay more in our plan than you would in Original Medicare. For others, you may pay less.
- **Our plan members also get *more* than what's covered by Original Medicare.** Some of the extra benefits are outlined in this booklet.

What drugs do we cover?

We cover Part D drugs. You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on EssenceHealthcare.com or call us, and we'll send you a copy. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider.

How will I determine my Part D drug costs?

Our plans group each medication into one of five tiers. You'll need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier, your deductible (if applicable), and what stage of the benefit you've reached. Later in this document, we discuss the benefit stages that occur: initial coverage and catastrophic coverage. If you have questions about the different benefit stages, please contact the plan for more information or access the Evidence of Coverage on our website.

Monthly Premium, Deductibles, and Limits on How Much You Pay for Covered Services

	Essence Advantage (HMO)	Essence Advantage Choice (PPO) In-Network	Essence Advantage Choice (PPO) Out-of-Network
Monthly Plan Premium	**Both Plans:** **$0** Per month You must continue to pay your Medicare Part B premium.		
Deductibles	This plan doesn't have medical or hospital deductibles.	**$260** Per calendar year You must meet your deductible before standard cost-sharing will apply. See individual categories throughout this document for more details. **The medical deductible applies to the following INN services:** Inpatient hospital coverage, outpatient hospital coverage, ambulatory surgical center, emergency care outside of the U.S., urgently needed services outside of the U.S., select diagnostic and therapeutic radiology services, select mental health services, skilled nursing facility, ambulance **The medical deductible applies to the following OON services:** Inpatient hospital coverage, outpatient hospital coverage, ambulatory surgical center, doctor visits, diagnostic and therapeutic radiology services, select hearing services, dental services, select vision services, mental health services, skilled nursing facility, physical therapy, ambulance, select Medicare Part B drugs, acupuncture, chiropractic care, diabetes supplies and shoes/inserts, durable medical equipment, foot care, home healthcare, outpatient substance abuse, outpatient rehabilitation services, prosthetic devices	
Maximum Out-of-Pocket Responsibility *(does not include Part D prescription drugs)*	The maximum out-of-pocket amount is the most that you pay out of pocket during the calendar year for in-network covered hospital and medical services. Your yearly limit(s) in this plan: **$4,000** for covered hospital and medical services you receive from in-network providers	The maximum out-of-pocket amount is the most that you pay out of pocket during the calendar year for in-network covered hospital and medical services. Your yearly limit(s) in this plan: **$8,200** for covered hospital and medical services you receive from in-network providers	The maximum out-of-pocket amount is the most that you pay out of pocket during the calendar year for combined in- and out-of-network covered hospital and medical services. Your yearly limit(s) in this plan: **$10,200** for covered hospital and medical services you receive from in- and out-of-network providers

	Essence Advantage (HMO)	Essence Advantage Choice (PPO) In-Network	Essence Advantage Choice (PPO) Out-of-Network
Maximum Out-of-Pocket Responsibility *(continued)*	**Both Plans** If you reach the limit on out-of-pocket costs, hospital and medical services are still covered, and we pay the full cost for the rest of the year. Please note that you'll still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.		

Covered Medical and Hospital Benefits

	Essence Advantage (HMO)	Essence Advantage Choice (PPO) In-Network	Essence Advantage Choice (PPO) Out-of-Network
Inpatient Hospital Coverage	Our plan covers an unlimited number of days for an inpatient hospital stay. • **$325** Copay/day, per stay: days 1–5 • **$0** Copay/day, per stay: day 6 and beyond	Our plan covers an unlimited number of days for an inpatient hospital stay. • **$298** Copay/day, per stay after deductible: days 1–7 • **$0** Copay/day, per stay: day 8 and beyond	
	Prior authorization is required.	Prior authorization is required.	
Outpatient Hospital Coverage	**$325** Copay for outpatient hospital services, including surgery Copay is charged per surgery.	**$325** Copay for outpatient hospital services, including surgery, after deductible Copay is charged per surgery.	**40%** Coinsurance for outpatient hospital services, including surgery, after deductible
	Prior authorization may be required.	Prior authorization may be required.	
Ambulatory Surgical Center (ASC)	**$220** Copay Prior authorization may be required.	**$225** Copay after deductible Prior authorization may be required.	**40%** Coinsurance after deductible
Doctor Visits *(primary care providers and specialists)*	Primary care physician (PCP) visit: **$0** copay Specialist visit: **$20** copay Certain Medicare-covered services provided by a physician may require a prior authorization.	Primary care physician (PCP) visit: **$0** copay Specialist visit: **$30** copay Certain Medicare-covered services provided by a physician may require a prior authorization.	Primary care physician (PCP) visit: **$30** copay after deductible Specialist visit: **$30** copay after deductible

<table>
<tr><th></th><th>Essence Advantage (HMO)</th><th>Essence Advantage Choice (PPO)
In-Network</th><th>Essence Advantage Choice (PPO)
Out-of-Network</th></tr>
<tr><td>Preventive Care</td><td colspan="3">Both Plans
You pay nothing.
Our plans cover many preventive services, including:
• Abdominal aortic aneurysm screening
• Annual wellness visit
• Bone mass measurement
• Breast cancer screening (mammogram)
• Cardiovascular disease risk reduction visit (therapy for cardiovascular disease)
• Cardiovascular disease testing
• Cervical and vaginal cancer screening
• Colorectal cancer screening
• Depression screening
• Diabetes screening
• Diabetes self-management training and diabetic services
• Health and wellness education programs
• HIV screening
• Immunizations (pneumonia, hepatitis B, COVID-19, and influenza)
• Medical nutrition therapy
• Medicare Diabetes Prevention Program (MDPP)
• Obesity screening and therapy to promote sustained weight loss
• Pre-exposure prophylaxis (PrEP) for HIV prevention
• Prostate cancer screening exams
• Screening and counseling to reduce alcohol misuse
• Screening for hepatitis C virus infection
• Screening for lung cancer with low-dose computed tomography (LDCT)
• Screening for sexually transmitted infections (STIs) and counseling to prevent STIs
• Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)
• Vision care
• “Welcome to Medicare” preventive visit (one-time)
Any additional preventive services approved by Medicare during the contract year will be covered.</td></tr>
<tr><td rowspan="2">Emergency Care</td><td>$150 Copay within the United States

$150 Copay outside the United States</td><td colspan="2">$115 Copay within the United States

$115 Copay outside of the United States after deductible</td></tr>
<tr><td colspan="3">Both Plans
If you’re admitted to the same hospital within 24 hours for the same condition, you pay $0 for the emergency room visit. See the “Inpatient Hospital Care” section of this booklet for other costs.
Emergency services are always considered in-network.
We provide worldwide coverage.</td></tr>
</table>

	Essence Advantage (HMO)	Essence Advantage Choice (PPO) In-Network	Essence Advantage Choice (PPO) Out-of-Network
Urgently Needed Services	**$45** Copay within the United States **$150** Copay outside of the United States	**$40** Copay within the United States **$115** Copay outside of the United States after deductible	
	Both Plans Urgently needed services are always considered in-network. We provide worldwide coverage.		
Diagnostic Services/Labs/ Imaging *(Costs for these services may vary based on place of service.)*	Lab services: **$5** copay Diagnostic procedures and tests: **$35** copay Diagnostic colonoscopies: **$0** copay Diagnostic radiology services (such as MRI, CT and PET scans): **$200** copay Diagnostic mammograms: **$0** copay Therapeutic radiology services (such as radiation treatment for cancer): **20%** coinsurance X-rays: **$20** copay Prior authorization may be required.	Lab services: **$0** copay Diagnostic procedures and tests: **$35** copay after deductible Diagnostic colonoscopies: **$0** copay Diagnostic radiology services (such as MRI, CT and PET scans): **$200** copay after deductible Diagnostic mammograms: **$0** copay Therapeutic radiology services (such as radiation treatment for cancer): **20%** coinsurance after deductible X-rays: **$20** copay after deductible Prior authorization may be required.	Lab services: **40%** coinsurance after deductible Diagnostic procedures and tests: **40%** coinsurance after deductible Diagnostic colonoscopies: **$0** copay after deductible Diagnostic radiology services (such as MRI, CT and PET scans): **40%** coinsurance after deductible Diagnostic mammograms: **$0** copay after deductible Therapeutic radiology services (such as radiation treatment for cancer): **40%** coinsurance after deductible X-rays: **40%** coinsurance after deductible
Hearing Services	Medicare-covered exam to diagnose and treat hearing and balance issues: **$20** copay	Medicare-covered exam to diagnose and treat hearing and balance issues: **$20** copay	Medicare-covered exam to diagnose and treat hearing and balance issues: **$20** copay after deductible

	Essence Advantage (HMO)	Essence Advantage Choice (PPO) In-Network	Essence Advantage Choice (PPO) Out-of-Network
Hearing Services *(continued)*	**Both Plans** Routine hearing exam: **$20** copay **$1,000** Allowance for up to 2 hearing aids every 2 calendar years (both ears combined) One fitting/evaluation for hearing aids every 2 calendar years: **$0** copay For details on an **additional shared allowance** that can be used on hearing services and products, see the Flexible Benefits Card section on page **15.**		
Dental Services	Preventive dental services: **$0** copay **Preventive services include:** • Periodic, comprehensive, or limited oral exam (2 every calendar year) • Routine cleaning (2 every calendar year) • Fluoride treatment (2 every calendar year) • Bitewing images (2 series every calendar year) • 1 Panoramic film (once every 3 calendar years) Medicare-covered comprehensive dental services: **$20** copay Prior authorization may be required for Medicare-covered services performed by an oral surgeon.	Medicare-covered comprehensive dental services: **$30** copay Prior authorization may be required for Medicare-covered services performed by an oral surgeon.	Medicare-covered comprehensive dental services: **$30** copay after deductible
	Both Plans: For details on a shared allowance that can be used on dental services and products, see the Flexible Benefits Card section on page **15.**		
Vision Services	Each visit to a specialist, such as an ophthalmologist or optometrist, for Medicare-covered benefits: **$20** copay Diabetic eye exams performed by a contracted specialist: **$0** copay	Each visit to a specialist, such as an ophthalmologist or optometrist, for Medicare-covered benefits: **$30** copay Diabetic eye exams performed by a contracted specialist: **$0** copay	Each visit to a specialist, such as an ophthalmologist or optometrist, for Medicare-covered benefits: **$30** copay after deductible Diabetic eye exams: **$30** copay after deductible

	Essence Advantage (HMO)	Essence Advantage Choice (PPO) In-Network	Essence Advantage Choice (PPO) Out-of-Network
Vision Services *(continued)*	1 Pair of Medicare-covered eyeglass lenses (standard plastic single, bifocal, trifocal, or lenticular lenses) after each cataract surgery: **$0** copay	1 Pair of Medicare-covered eyeglass lenses (standard plastic single, bifocal, trifocal, or lenticular lenses) after each cataract surgery: **$0** copay	1 Pair of Medicare-covered eyeglass lenses (standard plastic single, bifocal, trifocal, or lenticular lenses) after each cataract surgery: **$0** copay after deductible
	1 Pair of Medicare-covered eyeglass frames or contact lenses after each cataract surgery: **$0** copay	1 Pair of Medicare-covered eyeglass frames or contact lenses after each cataract surgery: **$0** copay	1 Pair of Medicare-covered eyeglass frames or contact lenses after each cataract surgery: **$0** copay after deductible
	1 Routine eye exam every calendar year: **$0** copay	1 Routine eye exam every calendar year: **$0** copay	1 Routine eye exam every calendar year: **$0** copay
	Eye refractions and dilation are covered as part of the exam.	Eye refractions and dilation are covered as part of the exam.	Eye refractions and dilation are covered as part of the exam.
	Our plan pays up to **$200** for one routine eyewear item such as eyeglasses (lenses and frames) or contact lenses every calendar year.	Our plan pays up to **$175** total for one routine eyewear item such as eyeglasses (lenses and frames) or contact lenses every calendar year (in- and out-of-network combined).	Our plan pays up to **$175** total for one routine eyewear item such as eyeglasses (lenses and frames) or contact lenses every calendar year (in- and out-of-network combined).
	Both Plans Upgrades may be available at an additional cost out of pocket or via the Flex Card. For details on an **additional shared allowance** that can be used on vision services and eyewear, see the Flexible Benefits Card section on page **15.**		
Mental Health Services	Inpatient visit: Our plan covers an unlimited number of days for an inpatient hospital stay. • **$325** Copay/day, per stay: days 1–5 • **$0** Copay/day, per stay: day 6 and beyond	Inpatient visit: Our plan covers an unlimited number of days for an inpatient hospital stay. • **$298** Copay/day, per stay after deductible: days 1–7 • **$0** Copay/day, per stay: day 8 and beyond	Inpatient visit: Our plan covers an unlimited number of days for an inpatient hospital stay. • **$298** Copay/day, per stay after deductible: days 1–7 • **$0** Copay/day, per stay: day 8 and beyond
	Outpatient individual visit: **$15** copay	Outpatient individual visit: **$25** copay	Outpatient individual visit: **$25** copay after deductible
	Outpatient group visit: **$10** copay	Outpatient group visit: **$20** copay	Outpatient group visit: **$20** copay after deductible
	Prior authorization may be required for outpatient and inpatient mental health services.	Prior authorization may be required for outpatient and inpatient mental health services.	

	Essence Advantage (HMO)	Essence Advantage Choice (PPO) In-Network	Essence Advantage Choice (PPO) Out-of-Network
Skilled Nursing Facility (SNF)	Our plan covers up to 100 days each benefit period. No prior hospital stay is required. • **$0** Copay/day, per stay: days 1–20 • **$160** Copay/day, per stay: days 21–100 Prior authorization is required. Admission to a new or different SNF facility within the same benefit period may start a new stay for copay administration purposes.	Our plan covers up to 100 days each benefit period. No prior hospital stay is required. • **$0** Copay/day, per stay after deductible: days 1–20 • **$220** Copay/day, per stay after deductible: days 21–100 Prior authorization is required. Admission to a new or different SNF facility within the same benefit period may start a new stay for copay administration purposes.	Our plan covers up to 100 days each benefit period. No prior hospital stay is required. **40%** Coinsurance/day, per stay after deductible: day 1 and beyond
Physical Therapy	**$40** Copay	**$35** Copay	**$35** Copay after deductible
Ambulance	**$250** Copay	**$240** Copay after deductible	**$240** Copay after deductible
	Both Plans: This copay applies to each one-way trip.		
	Prior authorization may be required for non-emergent transportation by ambulance.	Prior authorization may be required for non-emergent transportation by ambulance.	
Transportation	**Both Plans:** Not covered		
Medicare Part B Drugs	Part B drugs (other than Part B insulin): You'll pay the lesser of **20%** or the adjusted beneficiary coinsurance amount as provided by the Centers for Medicare & Medicaid Services (CMS). Part B insulin (insulin administered through a durable medical equipment pump): You'll pay the lesser of **$35** or **20%** coinsurance, for a one-month supply. Prior authorization may be required for certain Part B drugs except insulin.	Part B drugs (other than Part B insulin): You'll pay the lesser of **20%** or the adjusted beneficiary coinsurance amount as provided by the Centers for Medicare & Medicaid Services (CMS). Part B insulin (insulin administered through a durable medical equipment pump): You'll pay the lesser of **$35** or **20%** coinsurance, for a one-month supply. Prior authorization may be required for certain Part B drugs except insulin.	Part B drugs (other than Part B insulin): You'll pay the lesser of **40%** after deductible or the adjusted beneficiary coinsurance amount as provided by the Centers for Medicare & Medicaid Services (CMS). Part B insulin (insulin administered through a durable medical equipment pump): You'll pay the lesser of **$35** or **20%** coinsurance, for a one-month supply.

	Essence Advantage (HMO)	Essence Advantage Choice (PPO) In-Network	Essence Advantage Choice (PPO) Out-of-Network
Medicare Part B Drugs *(continued)*	**Both Plans** Amounts you pay for Part B drugs count toward your maximum out-of-pocket amount; they don't count toward your Part D initial coverage limit of **$2,400.**		

Part D Prescription Drug Benefits

	Essence Advantage (HMO)	Essence Advantage Choice (PPO)
Deductible	**$450** Per calendar year (applies for tiers 3–5 only)	**$700** Per calendar year (applies for tiers 3–5 only)
	Both Plans You must meet this deductible before standard cost-sharing will apply.	
Initial Coverage	**Both Plans** You pay the amounts listed in the following tables until your total Part D out-of-pocket costs reach **$2,400.** You won't pay more than **$35** for a one-month supply of each insulin product covered by our plan for all cost-sharing tiers. If you reside in a long-term care facility, you pay the same as at a standard retail pharmacy. You may get drugs from an out-of-network pharmacy at the same cost as a standard retail pharmacy. Coverage is limited to certain situations if you go out of network.	

	Essence Advantage (HMO)		Essence Advantage Choice (PPO)	
Preferred Retail Cost-Sharing **$** = Copay **%** = Coinsurance	**30-Day**	**90-Day**	**30-Day**	**90-Day**
Tier 1 *(Preferred Generic)*	**$0**	**$0**	**$0**	**$0**
Tier 2 *(Generic)*	**$3**	**$9**	**$5**	**$15**
Tier 3 *(Preferred Brand)*	**$45**	**$135**	**25%**	**25%**
Tier 4 *(Non-Preferred Drug)*	**$95**	**$285**	**25%**	**25%**
Tier 5* *(Specialty Drug)*	**28%**	N/A	**25%**	N/A

	Essence Advantage (HMO)		Essence Advantage Choice (PPO)	
Standard Retail Cost-Sharing **$** = Copay **%** = Coinsurance	**30-Day**	**90-Day**	**30-Day**	**90-Day**
Tier 1 *(Preferred Generic)*	**$5**	**$15**	**$4**	**$12**
Tier 2 *(Generic)*	**$10**	**$30**	**$15**	**$45**
Tier 3 *(Preferred Brand)*	**$47**	**$141**	**25%**	**25%**
Tier 4 *(Non-Preferred Drug)*	**$100**	**$300**	**25%**	**25%**
Tier 5* *(Specialty Drug)*	**28%**	N/A	**25%**	N/A
Standard Mail-Order Cost-Sharing **$** = Copay **%** = Coinsurance	**90-Day**		**90-Day**	
Tier 1 *(Preferred Generic)*	**$0**		**$0**	
Tier 2 *(Generic)*	**$6**		**$10**	
Tier 3 *(Preferred Brand)*	**$90**		**25%**	
Tier 4 *(Non-Preferred Drug)*	**$190**		**25%**	
Tier 5* *(Specialty Drug)*	N/A		N/A	

	Essence Advantage (HMO)	Essence Advantage Choice (PPO)
Out-of-Network Cost-Sharing **$** = Copay **%** = Coinsurance	**30-Day**	**30-Day**
Tier 1 *(Preferred Generic)*	**$5**	**$4**
Tier 2 *(Generic)*	**$10**	**$15**
Tier 3 *(Preferred Brand)*	**$47**	**25%**
Tier 4 *(Non-Preferred Drug)*	**$100**	**25%**
Tier 5 *(Specialty Drug)*	**28%**	**25%**
Catastrophic Coverage	**Both Plans** After your yearly out-of-pocket drug costs reach **$2,400,** you pay **$0** for all covered Part D drugs.	

Cost-sharing may change depending on the pharmacy you choose.
*The Centers for Medicare & Medicaid Services limits tier 5 drugs to a 30-day supply.

Other Covered Benefits

	Essence Advantage (HMO)	Essence Advantage Choice (PPO) In-Network	Essence Advantage Choice (PPO) Out-of-Network
Acupuncture	Medicare-covered services (chronic low back pain), up to 20 visits per calendar year: **$20** copay per visit	Medicare-covered services (chronic low back pain), up to 20 visits per calendar year: **$30** copay per visit	Medicare-covered services (chronic low back pain), up to 20 visits per calendar year: **$30** copay per visit after deductible
Chiropractic Care	Manual manipulation of the spine to correct subluxation: **$20** copay	Manual manipulation of the spine to correct subluxation: **$15** copay	Manual manipulation of the spine to correct subluxation: **40%** coinsurance after deductible
Diabetes Supplies and Services	**Both Plans:** Diabetes self-management training: **$0** copay		
	Diabetes monitoring supplies (including blood glucose monitors, lancets, and blood glucose test strips): **$0** copay	Diabetes monitoring supplies (including blood glucose monitors, lancets, and blood glucose test strips): **$0** copay	Diabetes monitoring supplies (including blood glucose monitors, lancets, and blood glucose test strips): **$0** copay after deductible

	Essence Advantage (HMO)	Essence Advantage Choice (PPO) In-Network	Essence Advantage Choice (PPO) Out-of-Network
Diabetes Supplies and Services *(continued)*	When glucose meters and test strips are obtained at a pharmacy, coverage is limited to specific Abbott and Roche products. Diabetic therapeutic custom-molded shoes or inserts: **20%** coinsurance See Evidence of Coverage for more details.	When glucose meters and test strips are obtained at a pharmacy, coverage is limited to specific Abbott and Roche products. Diabetic therapeutic custom-molded shoes or inserts: **20%** coinsurance See Evidence of Coverage for more details.	When glucose meters and test strips are obtained at a pharmacy, coverage is limited to specific Abbott and Roche products. Diabetic therapeutic custom-molded shoes or inserts: **20%** coinsurance after deductible See Evidence of Coverage for more details.
	Authorization is required for some items (e.g., continuous glucose meters, insulin pumps).	Authorization is required for some items (e.g., continuous glucose meters, insulin pumps).	
Durable Medical Equipment *(wheelchairs, oxygen, etc.)*	**20%** Coinsurance Prior authorization may be required.	**20%** Coinsurance Prior authorization may be required.	**40%** Coinsurance after deductible
Flexible Benefits Card	**$2,000** Shared annual credit for certain non-Medicare-covered dental, vision, and hearing products and services	**$400** Shared annual credit for certain non-Medicare-covered dental, vision, and hearing products and services	
	Notes Members will receive one debit card, supplied by WEX. For dental, vision and hearing, the following are some examples of approved items and services (not a complete list): dental X-rays, fillings, crowns, eyewear, hearing aids, routine vision and hearing exams. There are no restrictions on how much of the allowance can be spent in each allowed category. Any unused balance expires at the end of the calendar year. Flex Card may be used with both in-network and out-of-network providers for dental, vision, and hearing services. The Flex Card isn't a credit card. It can't be converted to cash or used to pay plan premiums or for non-covered Flex Card services. For more information, please see the Evidence of Coverage.		
Foot Care *(podiatry services)*	**$20** Copay	**$30** Copay	**$30** Copay after deductible
Home Healthcare	**$0** Copay	**$0** Copay	**40%** Coinsurance after deductible

	Essence Advantage (HMO)	Essence Advantage Choice (PPO) In-Network	Essence Advantage Choice (PPO) Out-of-Network
Hospice	**Both Plans** When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not Essence Healthcare.		
Outpatient Substance Abuse	Individual visit: **$15** copay Group visit: **$10** copay	Individual visit: **$25** copay Group visit: **$20** copay	Individual visit: **$25** copay after deductible Group visit: **$20** copay after deductible
	Prior authorization may be required.	Prior authorization may be required.	
Outpatient Rehabilitation Services	Cardiac and pulmonary rehabilitation services: **$20** copay per day Occupational and speech therapy visits: **$40** copay A separate copayment for occupational therapy will apply if other outpatient therapy services are rendered on the same day.	Cardiac and pulmonary rehabilitation services: **$20** copay per day Occupational and speech therapy visits: **$35** copay A separate copayment for occupational therapy will apply if other outpatient therapy services are rendered on the same day.	Cardiac and pulmonary rehabilitation services: **$20** copay per day after deductible Occupational and speech therapy visits: **$35** copay after deductible A separate copayment for occupational therapy will apply if other outpatient therapy services are rendered on the same day.
Over-the-Counter (OTC) Coverage	**$20** Quarterly credit Credit is supplied in the form of a debit card (Flexible Benefits Card). All Flex Card allowances, including those for other benefits, will be loaded onto one Flex Card. See the Flex Card section on page **15** for other Flex-Card-eligible benefits. Eligible OTC items include pain relievers, vitamins, first aid products, and more. The OTC credit is applied quarterly and can be used on OTC items only, at approved retail locations and the online Essence OTC Store. Any unused balance expires at the end of each quarter.	Not covered	

	Essence Advantage (HMO)	Essence Advantage Choice (PPO) In-Network	Essence Advantage Choice (PPO) Out-of-Network
Prosthetic Devices	Prosthetic devices: **20%** coinsurance Related medical supplies: **20%** coinsurance	Prosthetic devices: **20%** coinsurance Related medical supplies: **20%** coinsurance	Prosthetic devices: **20%** coinsurance after deductible Related medical supplies: **20%** coinsurance after deductible
	Prior authorization may be required.	Prior authorization may be required.	
Virtual/ Telehealth Visits	**$0–$40** Copay You'll pay the same copay for the virtual/telehealth visit as if the services were received in the provider's office. Prior authorization may be required (matches requirement for in-person visits).	**$0–$45** Copay You'll pay the same copay for the virtual/telehealth visit as if the services were received in the provider's office. Prior authorization may be required (matches requirement for in-person visits).	Not covered
Wellness Programs	Health club membership/ fitness classes through SilverSneakers®: **$0** copay	Health club membership/ fitness classes through SilverSneakers®: **$0** copay	For fitness centers that do not participate in the SilverSneakers® program but offer similar amenities, out-of-pocket expenses may be reimbursed at **50%,** subject to a **$100** max allowance per year. Reimbursement may be requested from the plan. See Evidence of Coverage for more details.

Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at 1-866-314-0911 (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 before you enroll. Visit EssenceHealthcare.com or call 1-866-314-0911 (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. See Understanding Important Rules for information regarding the rules for seeing providers outside of our network.
- [ ] Review the Provider 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

- [ ] In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- [ ] Benefits, premiums, and/or copayments/coinsurance may change on January 1, 2028.
- [ ] For our HMO plans, 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).
- [ ] Our PPO plans allow you to see providers outside of our network (non-contracted providers). However, while we pay for covered services, the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care. In addition, you may pay a higher copay for services received by non-contracted providers.
- [ ] **Effect on Current Coverage.** If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage healthcare coverage will end once your new Medicare Advantage coverage starts. If you have TRICARE®, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact TRICARE for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.

Essence Healthcare includes HMO and PPO plans with Medicare contracts. Enrollment in Essence Healthcare depends on contract renewal. All Essence plans include Part D drug coverage. To enroll, you must have both Medicare Parts A and B and reside in the plan service area.

You must continue to pay your Medicare Part B premium. Please note that enrollment is limited to specific times of the year.

Members enrolled in an Essence Healthcare HMO plan must use plan providers except in emergency or urgent care situations. If a member obtains care from an out-of-network provider without prior approval from Essence Healthcare, neither Medicare nor Essence Healthcare will be responsible for the costs.

Members enrolled in an Essence Healthcare PPO plan may see out-of-network providers (non-contracted providers). Out-of-network/non-contracted providers are under no obligation to treat plan members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

Essence Healthcare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.



13900 Riverport Drive
St. Louis, MO 63043
EssenceHealthcare.com

Toll-free: 1-866-314-0911 (TTY: 711)
8 a.m. to 8 p.m., seven days a week

You may reach a messaging service on weekends from April 1 through September 30 and holidays. Please leave a message, and your call will be returned the next business day.

Our service area for all plans: the Missouri counties of Barry, Christian, Dallas, Greene, Lawrence, Polk, Stone, Taney, and Webster, and the Arkansas counties of Benton, Carroll, Madison, and Washington.

Our HMO plan is also available in Barton, Cedar, and Dade counties in Missouri, and Crawford, Franklin, Johnson, Logan, Newton, Scott, and Sebastian counties in Arkansas. Our PPO plan is not offered in these additional counties.