

Summary of Benefits

MEDICARE ADVANTAGE | 2027

ESSENCE ADVANTAGE SELECT® (HMO) - ESSENCE ADVANTAGE® CHOICE (PPO)
ESSENCE ADVANTAGE® CHOICE PLUS (PPO) - ESSENCE ADVANTAGE® PREMIER PLUS (PPO)

ESSENCE HEALTHCARE®

Serving the Greater Chicago area

Essence Advantage Select (HMO) H2610-027
Essence Advantage Choice (PPO) H6200-009
Essence Advantage Choice Plus (PPO) H6200-010
Essence Advantage Premier Plus (PPO) H6200-011

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 Select, Essence Advantage Choice, Essence Advantage Choice Plus,** and **Essence Advantage Premier Plus**
- 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 1-855-603-3733 (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 1-855-603-3733 (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 Select, Essence Advantage Choice, Essence Advantage Choice Plus,** or **Essence Advantage Premier Plus,** 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 includes the Illinois counties of Cook, DuPage, and Will. Our HMO plan is also available in Kane and Kendall counties in Illinois. PPO plans are 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 Select, Essence Advantage Choice, Essence Advantage Choice Plus, and **Essence Advantage Premier Plus** 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 Select (HMO)	Essence Advantage Choice (PPO)	Essence Advantage Choice Plus (PPO)	Essence Advantage Premier Plus (PPO)
	Key: **INN** = in-network, **OON** = out-of-network			
Monthly Plan Premium	**$0** Per month	**$0** Per month	**$49** Per month	**$267** Per month
	All Plans: You must continue to pay your Medicare Part B premium.			
Deductibles	**All Plans** These plans don't have medical or hospital deductibles.			
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 **INN** covered hospital and medical services. Your yearly limit(s) in this plan: **$2,900** for covered hospital and medical services you receive from **INN** providers	The maximum out-of-pocket amount is the most that you pay out of pocket during the calendar year for **INN** or combined **INN** and **OON** covered hospital and medical services. Your yearly limit(s) in this plan: **$4,450** for covered hospital and medical services you receive from **INN** providers **$6,450** for covered hospital and medical services you receive from **INN** and **OON** providers	The maximum out-of-pocket amount is the most that you pay out of pocket during the calendar year for **INN** or combined **INN** and **OON** covered hospital and medical services. Your yearly limit(s) in this plan: **$6,700** for covered hospital and medical services you receive from **INN** providers **$10,000** for covered hospital and medical services you receive from **INN** and **OON** providers	The maximum out-of-pocket amount is the most that you pay out of pocket during the calendar year for **INN** or combined **INN** and **OON** covered hospital and medical services. Your yearly limit(s) in this plan: **$2,900** for covered hospital and medical services you receive from **INN** and **OON** providers
	All 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 Select (HMO)	Essence Advantage Choice (PPO)	Essence Advantage Choice Plus (PPO)	Essence Advantage Premier Plus (PPO)
	Key: **INN** = in-network, **OON** = out-of-network			
Inpatient Hospital Coverage	**All Plans:** Our plans cover an unlimited number of days for an inpatient hospital stay.			
	• Days 1–7: **$195** copay/day, per stay • Days 8–90: **$0** copay/day, per stay • Day 91 and beyond: **$0** copay/day, per stay	• Days 1–7: **$370** copay/day, per stay **(INN), 50%** coinsurance **(OON)** • Days 8–90: **$0** copay/day, per stay **(INN), 50%** coinsurance **(OON)** • Day 91 and beyond: **50%** coinsurance **(INN & OON)**	• Days 1–7: **$350** copay/day, per stay **(INN), 50%** coinsurance **(OON)** • Days 8–90: **$0** copay/day, per stay **(INN), 50%** coinsurance **(OON)** • Day 91 and beyond: **50%** coinsurance **(INN & OON)**	• Days 1–7: **$300** copay/day, per stay **(INN & OON)** • Days 8–90: **$0** copay/day, per stay **(INN & OON)** • Day 91 and beyond: **$0** copay/day, per stay **(INN & OON)**
	All Plans (INN): Prior authorization is required.			
Outpatient Hospital Coverage	**$325** Copay for outpatient hospital services, including surgery Copay is charged per surgery.	**$395** Copay **(INN), 50%** coinsurance **(OON)** for outpatient hospital services, including surgery Copay is charged per surgery.	**$345** Copay **(INN), 50%** coinsurance **(OON)** for outpatient hospital services, including surgery Copay is charged per surgery.	**$0** Copay for outpatient hospital services, including surgery **(INN & OON)**
	All Plans (INN) Prior authorization may be required.			
Ambulatory Surgical Center (ASC)	**$225** Copay	**$295** Copay **(INN), 50%** coinsurance **(OON)**	**$245** Copay **(INN), 50%** coinsurance **(OON)**	**$0** Copay **(INN & OON)**
	All Plans (INN) Prior authorization may be required.			
Doctor Visits *(primary care providers and specialists)*	Primary care physician (PCP) visit: **$0** copay Specialist visit: **$25** copay	Primary care physician (PCP) visit: **$0** copay **(INN), $50** copay **(OON)** Specialist visit: **$30** copay **(INN), 50%** coinsurance **(OON)**	Primary care physician (PCP) visit: **$0** copay **(INN), $50** copay **(OON)** Specialist visit: **$25** copay **(INN), 50%** coinsurance **(OON)**	Primary care physician (PCP) visit: **$0** copay **(INN & OON)** Specialist visit: **$0** copay **(INN & OON)**

<table>
<tr><th></th><th>Essence Advantage Select (HMO)</th><th>Essence Advantage Choice (PPO)</th><th>Essence Advantage Choice Plus (PPO)</th><th>Essence Advantage Premier Plus (PPO)</th></tr>
<tr><td></td><td colspan="4">Key: INN = in-network, OON = out-of-network</td></tr>
<tr><td>Doctor Visits
(continued)
(primary care providers and specialists)</td><td>A referral may be required for specialist visits, and certain Medicare-covered services provided by a physician may require a prior authorization.</td><td colspan="3">PPO Plans (INN)
Certain Medicare-covered services provided by a physician may require a prior authorization.</td></tr>
<tr><td>Preventive Care</td><td colspan="4">All 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>
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	Essence Advantage Select (HMO)	Essence Advantage Choice (PPO)	Essence Advantage Choice Plus (PPO)	Essence Advantage Premier Plus (PPO)
	Key: **INN** = in-network, **OON** = out-of-network			
Emergency Care	**$125** Copay within the United States **$125** Copay outside of the Unites States	**$150** Copay within the United States **$150** Copay outside of the Unites States	**$115** Copay within the United States **$115** Copay outside of the Unites States	**$0** Copay within the United States **$0** Copay outside of the Unites States
	All 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.			
Urgently Needed Services	**$45** Copay within the United States **$125** Copay outside of the United States	**$65** 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	**$0** Copay within the United States **$0** Copay outside of the United States
	All 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: **$0** copay Diagnostic procedures and tests: **$40** copay Diagnostic colonoscopies: **$0** copay Diagnostic radiology services (such as MRI, CT, and PET scans): **$200** copay	Lab services: **$0** copay **(INN)**, **50%** coinsurance **(OON)** Diagnostic procedures and tests: **$95** copay **(INN)**, **50%** coinsurance **(OON)** Diagnostic colonoscopies: **$0** copay **(INN & OON)** Diagnostic radiology services (such as MRI, CT, and PET scans): **$325** copay **(INN)**, **50%** coinsurance **(OON)**	Lab services: **$0** copay **(INN)**, **50%** coinsurance **(OON)** Diagnostic procedures and tests: **$50** copay **(INN)**, **50%** coinsurance **(OON)** Diagnostic colonoscopies: **$0** copay **(INN & OON)** Diagnostic radiology services (such as MRI, CT, and PET scans): **$250** copay **(INN)**, **50%** coinsurance **(OON)**	Lab services: **$0** copay **(INN & OON)** Diagnostic procedures and tests: **$0** copay **(INN & OON)** Diagnostic colonoscopies: **$0** copay **(INN & OON)** Diagnostic radiology services (such as MRI, CT, and PET scans): **$0** copay **(INN & OON)**

	Essence Advantage Select (HMO)	Essence Advantage Choice (PPO)	Essence Advantage Choice Plus (PPO)	Essence Advantage Premier Plus (PPO)
	Key: **INN** = in-network, **OON** = out-of-network			
Diagnostic Services/Labs/ Imaging *(continued)* *(Costs for these services may vary based on place of service.)*	Therapeutic radiology services (such as radiation treatment for cancer): **20%** coinsurance	Therapeutic radiology services (such as radiation treatment for cancer): **20%** coinsurance **(INN),** **50%** coinsurance **(OON)**	Therapeutic radiology services (such as radiation treatment for cancer): **20%** coinsurance **(INN),** **50%** coinsurance **(OON)**	Therapeutic radiology services (such as radiation treatment for cancer): **$0** copay **(INN & OON)**
	X-rays: **$20** copay	X-rays: **$25** copay **(INN),** **50%** coinsurance **(OON)**	X-rays: **$30** copay **(INN),** **50%** coinsurance **(OON)**	X-rays: **$0** copay **(INN & OON)**
	Diagnostic mammograms: **$0** copay	Diagnostic mammograms: **$0** copay **(INN & OON)**	Diagnostic mammograms: **$0** copay **(INN & OON)**	Diagnostic mammograms: **$0** copay **(INN & OON)**
	All Plans (INN): Prior authorization may be required.			
Hearing Services	Medicare-covered exam to diagnose and treat hearing and balance issues: **$20** copay A referral may be required for Medicare-covered visits.	**Both Plans** Medicare-covered exam to diagnose hearing and balance issues: **$20** copay **(INN), $20** copay **(OON)**		Medicare-covered exam to diagnose and treat hearing and balance issues: **$0** copay **(INN & OON)**
	Routine hearing exam: **$20** copay	Routine hearing exam: **$20** copay **(INN), $20** copay **(OON)**		Routine hearing exam: **$0** copay **(INN & OON)**
	All Plans (INN & OON) **$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 **18.**	**Both Plans (INN & OON)** For details on an **additional shared allowance** that can be used on hearing services and products, see the Flexible Benefits Card section on page **18.**		

	Essence Advantage Select (HMO)	Essence Advantage Choice (PPO)	Essence Advantage Choice Plus (PPO)	Essence Advantage Premier Plus (PPO)
	Key: INN = in-network, **OON** = out-of-network			
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 dental services: **$25** copay	Medicare-covered dental services: **$30** copay **(INN), 50%** coinsurance **(OON)**	Medicare-covered dental services: **$25** copay **(INN), 50%** coinsurance **(OON)**	Medicare-covered dental services: **$0** Copay **(INN & OON)**
	A referral may be required to visit an oral surgeon for Medicare-covered services and those services may require a prior authorization.	**PPO Plans (INN)** Prior authorization may be required for Medicare-covered services performed by an oral surgeon.		
	For details on a **shared allowance** that can be used on dental services and products, see the Flexible Benefits Card section on page **18.**	**Both Plans (INN & OON)** For details on a **shared allowance** that can be used on dental services and products, see the Flexible Benefits Card section on page **18.**		

	Essence Advantage Select (HMO)	Essence Advantage Choice (PPO)	Essence Advantage Choice Plus (PPO)	Essence Advantage Premier Plus (PPO)
	Key: INN = in-network, **OON** = out-of-network			
Vision Services	Each visit to a specialist, such as an ophthalmologist or optometrist, for Medicare-covered benefits: **$25** copay Diabetic eye exams performed by a contracted specialist: **$0** copay A referral may be required for specialist visits.	Each visit to a specialist, such as an ophthalmologist or optometrist, for Medicare-covered benefits: **$30** copay **(INN), 50%** coinsurance **(OON)** Diabetic eye exams performed by a contracted specialist: **$0** copay **(INN), 50%** coinsurance **(OON)**	Each visit to a specialist, such as an ophthalmologist or optometrist, for Medicare-covered benefits: **$25** copay **(INN), 50%** coinsurance **(OON)** Diabetic eye exams performed by a contracted specialist: **$0** copay **(INN), 50%** coinsurance **(OON)**	Each visit to a specialist, such as an ophthalmologist or optometrist, for Medicare-covered benefits: **$0** copay **(INN & OON)** Diabetic eye exams performed by a contracted specialist: **$0** copay **(INN & OON)**
	1 Pair of Medicare-covered eyeglass lenses (standard plastic single, bifocal, trifocal, or lenticular lenses) after each cataract surgery: **$0** copay	**PPO Plans** 1 Pair of Medicare-covered eyeglass lenses (standard plastic single, bifocal, trifocal, or lenticular lenses) after each cataract surgery: **$0** copay **(INN & OON)**		
	1 Routine eye exam every calendar year: **$0** copay 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. Upgrades may be available at an additional cost out of pocket or via the Flex Card.	**Both Plans** 1 Routine eye exam every calendar year: **$0** copay **(INN & OON)** Eye refractions and dilation are covered as part of the exam **(INN & OON).** Our plans pay up to **$175** total for one routine eyewear item such as eyeglasses (lenses and frames) or contact lenses every calendar year **(INN & OON combined).** Upgrades may be available at an additional cost out of pocket or via the Flex Card **(INN & OON).**		

	Essence Advantage Select (HMO)	Essence Advantage Choice (PPO)	Essence Advantage Choice Plus (PPO)	Essence Advantage Premier Plus (PPO)
	Key: **INN** = in-network, **OON** = out-of-network			
Vision Services *(continued)*	For details on an **additional shared allowance** that can be used on vision services and eyewear, see the Flexible Benefits Card section on page **18.**	**Both Plans (INN & OON)** For details on an **additional shared allowance** that can be used on vision services and eyewear, see the Flexible Benefits Card section on page **18.**		
Mental Health Services	Inpatient visit: Our plan covers an unlimited number of days for an inpatient hospital stay. • Days 1–7: **$195** copay/day, per stay • Days 8–90: **$0** copay/day, per stay • Day 91 and beyond: **$0** copay/day, per stay	Inpatient visit: Our plan covers an unlimited number of days for an inpatient hospital stay. • Days 1–7: **$370** copay/day, per stay **(INN), 50%** coinsurance **(OON)** • Days 8–90: **$0** copay/day, per stay **(INN), 50%** coinsurance **(OON)** • Day 91 and beyond: **$0** copay/day, per stay **(INN), 50%** coinsurance **(OON)**	Inpatient visit: Our plan covers an unlimited number of days for an inpatient hospital stay. • Days 1–7: **$298** copay/day, per stay **(INN), 50%** coinsurance **(OON)** • Days 8–90: **$0** copay/day, per stay **(INN), 50%** coinsurance **(OON)** • Day 91 and beyond: **$0** copay/day, per stay **(INN), 50%** coinsurance **(OON)**	Inpatient visit: Our plan covers an unlimited number of days for an inpatient hospital stay: • Days 1–7: **$300** copay/day, per stay **(INN & OON)** • Days 8–90: **$0** copay/day, per stay **(INN & OON)** • Day 91 and beyond: **$0** copay/day, per stay **(INN & OON)**
	Outpatient individual visit: **$25** copay Outpatient group visit: **$20** copay	**Both Plans** Outpatient individual visit: **$25** copay **(INN), 50%** coinsurance **(OON)** Outpatient group visit: **$20** copay **(INN), 50%** coinsurance **(OON)**		Outpatient individual visit: **$0** copay **(INN & OON)** Outpatient group visit: **$0** copay **(INN & OON)**
	All Plans (INN) Prior authorization may be required for outpatient and inpatient mental health services.			

	Essence Advantage Select (HMO)	Essence Advantage Choice (PPO)	Essence Advantage Choice Plus (PPO)	Essence Advantage Premier Plus (PPO)
	Key: **INN** = in-network, **OON** = out-of-network			
Skilled Nursing Facility (SNF)	This plan covers up to 100 days each benefit period. No prior hospital stay is required. • Days 1–20: **$0** copay/day, per stay • Days 21–100: **$200** copay/day, per stay	This plan covers up to 100 days each benefit period. No prior hospital stay is required. • Days 1–20: **$0** copay/day, per stay **(INN), 50%** coinsurance/day, per stay **(OON)** • Days 21–100: **$219** copay/day, per stay **(INN), 50%** coinsurance/day, per stay **(OON)**	This plan covers up to 100 days each benefit period. No prior hospital stay is required. • Days 1–20: **$0** copay/day, per stay **(INN), 50%** coinsurance/day, per stay **(OON)** • Days 21–100: **$220** copay/day, per stay **(INN), 50%** coinsurance/day, per stay **(OON)**	This plan covers up to 100 days each benefit period. No prior hospital stay is required. • Days 1–20: **$0** copay/day, per stay **(INN & OON)** • Days 21–100: **$0** copay/day, per stay **(INN & OON)**
	All Plans (INN) Prior authorization is required. Admission to a new or different SNF within the same benefit period may start a new stay for copay administration purposes.			
Physical Therapy	**$35** Copay	**$40** Copay **(INN), 50%** coinsurance **(OON)**	**$35** Copay **(INN), 50%** coinsurance **(OON)**	**$0** Copay **(INN & OON)**
Ambulance	Ground ambulance services: **$240** copay Air ambulance services: **$240** copay	Ground ambulance services: **$280** copay **(INN & OON)** Air ambulance services: **20%** coinsurance **(INN & OON)**	Ground ambulance services: **$275** copay **(INN & OON)** Air ambulance services: **20%** coinsurance **(INN & OON)**	Ground ambulance services: **$0** copay **(INN & OON)** Air ambulance services: **$0** copay **(INN & OON)**
	This copay applies to each one-way trip.	**PPO Plans** This copay applies to each one-way trip **(INN and OON).**		
	All Plans (INN) Prior authorization may be required for non-emergent transportation by ambulance.			
Transportation	**All Plans** Not covered			

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	Key: INN = in-network, OON = out-of-network			
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.	**Both Plans** Part B drugs (other than Part B insulin): You'll pay the lesser of **20% (INN), 50% (OON),** 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 **(INN & OON),** for a one-month supply.	Part B drugs (other than Part B insulin): You'll pay the lesser of **20% (INN & OON)** 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 **(INN & OON),** for a one-month supply.	
	All Plans (INN): Prior authorization may be required for certain Part B drugs except insulin.			
	All 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 Select (HMO)	Essence Advantage Choice (PPO)	Essence Advantage Choice Plus (PPO)	Essence Advantage Premier Plus (PPO)
	Key: INN = in-network, OON = out-of-network			
Deductible	**$300** Per calendar year (applies for tiers 4–5 only) You must meet this deductible before standard cost-sharing will apply.	**PPO Plans** **$700** Per calendar year (applies for tiers 3–5 only) You must meet this deductible before standard cost-sharing will apply.		

	Essence Advantage Select (HMO)		Essence Advantage Choice (PPO)		Essence Advantage Choice Plus (PPO)		Essence Advantage Premier Plus (PPO)	
	Key: **INN** = in-network, **OON** = out-of-network							
Initial Coverage	**All 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 **$35** for a one-month supply of each insulin product covered by our plan for all cost-sharing tiers. If you reside in a long-term care facility, you pay the same as at a standard retail pharmacy. You may get drugs from an out-of-network pharmacy at the same cost as a standard retail pharmacy. Coverage is limited to certain situations if you go out of network.							
	Essence Advantage Select (HMO)		**Essence Advantage Choice (PPO)**		**Essence Advantage Choice Plus (PPO)**		**Essence Advantage Premier Plus (PPO)**	
Preferred Retail Cost-Sharing **$** = Copay **%** = Coinsurance	**30-Day**	**90-Day**	**30-Day**	**90-Day**	**30-Day**	**90-Day**	**30-Day**	**90-Day**
Tier 1 *(Preferred Generic)*	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Tier 2 *(Generic)*	**$3**	**$9**	**$5**	**$15**	**$5**	**$15**	**$5**	**$15**
Tier 3 *(Preferred Brand)*	**$45**	**$135**	**25%**	**25%**	**25%**	**25%**	**25%**	**25%**
Tier 4 *(Non-Preferred Drug)*	**$95**	**$285**	**28%**	**28%**	**25%**	**25%**	**26%**	**26%**
Tier 5* *(Specialty Drug)*	**30%**	N/A	**25%**	N/A	**25%**	N/A	**25%**	N/A
Standard Retail Cost-Sharing **$** = Copay **%** = Coinsurance	**30-Day**	**90-Day**	**30-Day**	**90-Day**	**30-Day**	**90-Day**	**30-Day**	**90-Day**
Tier 1 *(Preferred Generic)*	**$4**	**$12**	**$4**	**$12**	**$4**	**$12**	**$10**	**$30**
Tier 2 *(Generic)*	**$12**	**$36**	**$15**	**$45**	**$15**	**$45**	**$15**	**$45**
Tier 3 *(Preferred Brand)*	**$47**	**$141**	**25%**	**25%**	**25%**	**25%**	**25%**	**25%**
Tier 4 *(Non-Preferred Drug)*	**$100**	**$300**	**28%**	**28%**	**25%**	**25%**	**26%**	**26%**
Tier 5* *(Specialty Drug)*	**30%**	N/A	**25%**	N/A	**25%**	N/A	**25%**	N/A

	Essence Advantage Select (HMO)	Essence Advantage Choice (PPO)	Essence Advantage Choice Plus (PPO)	Essence Advantage Premier Plus (PPO)
Standard Mail-Order Cost-Sharing **$** = Copay **%** = Coinsurance	**90-Day**	**90-Day**	**90-Day**	**90-Day**
Tier 1 *(Preferred Generic)*	**$0**	**$0**	**$0**	**$0**
Tier 2 *(Generic)*	**$6**	**$10**	**$10**	**$10**
Tier 3 *(Preferred Brand)*	**$90**	**25%**	**25%**	**25%**
Tier 4 *(Non-Preferred Drug)*	**$190**	**28%**	**25%**	**26%**
Tier 5* *(Specialty Drug)*	N/A	N/A	N/A	N/A
Out-of-Network Cost-Sharing **$** = Copay **%** = Coinsurance	**30-Day**	**30-Day**	**30-Day**	**30-Day**
Tier 1 *(Preferred Generic)*	**$4**	**$4**	**$4**	**$10**
Tier 2 *(Generic)*	**$12**	**$15**	**$15**	**$15**
Tier 3 *(Preferred Brand)*	**$47**	**25%**	**25%**	**25%**
Tier 4 *(Non-Preferred Drug)*	**$100**	**28%**	**25%**	**26%**
Tier 5 *(Specialty Drug)*	**30%**	**25%**	**25%**	**25%**
Catastrophic Coverage	**All 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 Select (HMO)	Essence Advantage Choice (PPO)	Essence Advantage Choice Plus (PPO)	Essence Advantage Premier Plus (PPO)
	Key: INN = in-network, **OON** = out-of-network			
Acupuncture	Medicare-covered services (chronic low back pain), up to 20 visits per calendar year: **$25** copay per visit	Medicare-covered services (chronic low back pain), up to 20 visits per calendar year: **$30** copay **(INN), 50%** coinsurance **(OON)**	Medicare-covered services (chronic low back pain), up to 20 visits per calendar year: **$25** copay **(INN), 50%** coinsurance **(OON)**	Medicare-covered services (chronic low back pain), up to 20 visits per calendar year: **$0** copay per visit **(INN & OON)**
Chiropractic Care	Manual manipulation of the spine to correct subluxation: **$20** copay A referral may be required.	Manual manipulation of the spine to correct subluxation: **$20** copay **(INN), 50%** coinsurance **(OON)**	Manual manipulation of the spine to correct subluxation: **$15** copay **(INN), 50%** coinsurance **(OON)**	Manual manipulation of the spine to correct subluxation: **$0** copay **(INN & OON)**
Diabetes Supplies and Services	Diabetes self-management training: **$0** copay	**Both Plans** Diabetes self-management training: **$0** copay **(INN & OON)**		
	Diabetes monitoring supplies (including blood glucose monitors, lancets, and blood glucose test strips): **$0** copay	**Both Plans** Diabetes monitoring supplies (including blood glucose monitors, lancets, and blood glucose test strips): **$0** copay **(INN), 50%** coinsurance **(OON)**		Diabetes monitoring supplies (including blood glucose monitors, lancets, and blood glucose test strips): **$0** copay **(INN & OON)**
	All Plans When glucose meters and test strips are obtained at a pharmacy, coverage is limited to specific Abbott and Roche products **(INN & OON)**.			
	Diabetic therapeutic custom-molded shoes or inserts: **20%** coinsurance	Diabetic therapeutic custom-molded shoes or inserts: **0%** coinsurance **(INN), 50%** coinsurance **(OON)**	Diabetic therapeutic custom-molded shoes or inserts: **20%** coinsurance **(INN), 50%** coinsurance **(OON)**	Diabetic therapeutic custom-molded shoes or inserts: **0%** coinsurance **(INN & OON)**
	All Plans (INN) Authorization is required for some items (e.g., continuous glucose meters, insulin pumps). See Evidence of Coverage for more details.			

	Essence Advantage Select (HMO)	Essence Advantage Choice (PPO)	Essence Advantage Choice Plus (PPO)	Essence Advantage Premier Plus (PPO)
	Key: **INN** = in-network, **OON** = out-of-network			
Durable Medical Equipment *(wheelchairs, oxygen, etc.)*	**20%** Coinsurance	**Both Plans** **20%** Coinsurance **(INN),** **50%** coinsurance **(OON)**		**0%** Coinsurance **(INN & OON)**
	All Plans (INN) Prior authorization may be required.			
Flexible Benefits Card	**$2,500** Shared annual credit for certain non-Medicare-covered dental, vision, and hearing products and services	**$650** Shared annual credit for certain non-Medicare-covered dental, vision, and hearing products and services	**$1,900** Shared annual credit for certain non-Medicare-covered dental, vision, and hearing products and services	Not offered
	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)*	**$25** Copay A referral may be required.	**$30** Copay **(INN),** **50%** coinsurance **(OON)**	**$25** Copay **(INN),** **50%** coinsurance **(OON)**	**$0** Copay **(INN & OON)**
Home Healthcare	**$0** Copay	**Both Plans** **$0** Copay **(INN),** **50%** coinsurance **(OON)**		**$0** Copay **(INN & OON)**

	Essence Advantage Select (HMO)	Essence Advantage Choice (PPO)	Essence Advantage Choice Plus (PPO)	Essence Advantage Premier Plus (PPO)
	Key: **INN** = in-network, **OON** = out-of-network			
Hospice	**All 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: **$25** copay Group visit: **$20** copay	**Both Plans** Individual visit: **$25** copay **(INN), 50%** coinsurance **(OON)** Group visit: **$20** copay **(INN), 50%** coinsurance **(OON)**		**$0** Copay **(INN & OON)**
	All Plans (INN) Prior authorization is required.			
Outpatient Rehabilitation Services	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: **$25** copay **(INN), 50%** coinsurance **(OON)** Occupational and speech therapy visits: **$40** Copay **(INN), 50%** coinsurance **(OON)** 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 **(INN), 50%** coinsurance **(OON)** Occupational and speech therapy visits: **$35** Copay **(INN), 50%** coinsurance **(OON)** A separate copayment for occupational therapy will apply if other outpatient therapy services are rendered on the same day.	Cardiac and pulmonary rehabilitation services: **$0** copay per day **(INN & OON)** Occupational and speech therapy visits: **$0** copay **(INN & OON)**

	Essence Advantage Select (HMO)	Essence Advantage Choice (PPO)	Essence Advantage Choice Plus (PPO)	Essence Advantage Premier Plus (PPO)
	Key: INN = in-network, **OON** = out-of-network			
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 **18** 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	**$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 **18** 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
Prosthetic Devices	Prosthetic devices: **20%** coinsurance Related medical supplies: **20%** coinsurance	**Both Plans** Prosthetic devices: **20%** coinsurance **(INN),** **50%** coinsurance **(OON)** Related medical supplies: **20%** coinsurance **(INN),** **50%** coinsurance **(OON)**		Prosthetic devices: **0%** coinsurance **(INN & OON)** Related medical supplies: **0%** coinsurance **(INN & OON)**
	All Plans (INN) Prior authorization may be required.			

	Essence Advantage Select (HMO)	Essence Advantage Choice (PPO)	Essence Advantage Choice Plus (PPO)	Essence Advantage Premier Plus (PPO)
	Key: **INN** = in-network, **OON** = out-of-network			
Virtual/ Telehealth Visits	**$0–$70** Copay	**$0–$65** Copay **(INN)**	**$0–$55** Copay **(INN)**	**$0** Copay **(INN)**
	A referral or authorization may be required (matches requirement for in-person visits).	**PPO Plans** Prior authorization may be required (matches requirement for in-person visits).		
	All Plans If your in-network doctor offers telehealth visits, you'll pay the same copay as an in-office visit. Telehealth is not covered with out-of-network providers.			
Wellness Programs	Health club membership/fitness classes through SilverSneakers®: **$0** copay	**PPO Plans** Health club/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 1-855-603-3733 (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 1-855-603-3733 (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.

ESSENCE HEALTHCARE®

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

Toll-free: 1-855-603-3733 (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 Illinois counties of Cook, DuPage, and Will.

Our HMO plan is also available in Kane and Kendall counties in Illinois. PPO plans are not offered in these additional counties.