# Annual Notice of Change

MEDICARE ADVANTAGE | 2024

ESSENCE ADVANTAGE® CHOICE PLUS (PPO)

ESSENCE HEALTHCARE®

Serving the greater St. Louis area (Missouri and Illinois)

# Essence Advantage Choice Plus (PPO) *offered by* Essence Healthcare PPO, Inc.

# Annual Notice of Changes for 2024

You are currently enrolled as a member of Essence Advantage Choice Plus. Next year, there will be changes to the plan's costs and benefits. ***Please see page 6 for a Summary of Important Costs, including Premium.***

This document tells about the changes to your plan. To get more information about costs, benefits, or rules please review the *Evidence of Coverage*, which is located on our website at EverythingEssence.com. You may also call Customer Service to ask us to mail you an *Evidence of Coverage*.)

- **You have from October 15 until December 7 to make changes to your Medicare coverage for next year.**

## What to do now

**1. ASK:** Which changes apply to you

☐ Check the changes to our benefits and costs to see if they affect you.

- Review the changes to Medical care costs (doctor, hospital).
- Review the changes to our drug coverage, including authorization requirements and costs.
- Think about how much you will spend on premiums, deductibles, and cost sharing.

☐ Check the changes in the 2024 "Drug List" to make sure the drugs you currently take are still covered.

☐ Check to see if your primary care doctors, specialists, hospitals, and other providers, including pharmacies will be in our network next year.

☐ Think about whether you are happy with our plan.

**2. COMPARE:** Learn about other plan choices

☐ Check coverage and costs of plans in your area. Use the Medicare Plan Finder at Medicare.gov/plan-compare website or review the list in the back of your *Medicare & You 2024* handbook.

☐ Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan's website.

3. **CHOOSE:** Decide whether you want to change your plan
    - If you don't join another plan by December 7, 2023, you will stay in Essence Advantage Choice Plus.
    - To change to a **different plan**, you can switch plans between October 15 and December 7. Your new coverage will start on **January 1, 2024.** This will end your enrollment with Essence Advantage Choice Plus.
    - If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can switch plans or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

## Additional Resources

- Please contact our Customer Service number at 1-866-597-9560 for additional information. (TTY users should call 711.) Hours are 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. This call is free.
- This document may be available in other formats such as braille, large print or other alternate formats.
- **Coverage under this Plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at IRS.gov/Affordable-Care-Act/Individuals-and-Families for more information.

## About Essence Advantage Choice Plus

- Essence Healthcare is a PPO plan with a Medicare contract. Enrollment in Essence Healthcare depends on contract renewal.
- When this document says "we," "us," or "our", it means Essence Healthcare PPO, Inc.. When it says "plan" or "our plan," it means Essence Advantage Choice Plus.

## Multi-Language Insert

## 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 1-866-597-9560 (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 1-866-597-9560 (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 1-866-597-9560 (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 1-866-597-9560 (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 1-866-597-9560 (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 1-866-597-9560 (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 1-866-597-9560 (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 1-866-597-9560 (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 1-866-597-9560 (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 1-866-597-9560 (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 فوري، ليس عليك سوى الاتصال بنا على 1-866-597-9560 (711). سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

**Hindi:** हमारे स्वास्थ्य या दवा योजना के बारे में आपके किसी भी पश्नर् का उत्तर देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएं हैं। दुभाषिया पर्राप्त करने के लिए, बस हमें 1-866-597-9560 (711). पर कॉल करें। अंगरे्जी/भाषा बोलने वाला कोई व्यिक्त आपकी मदद कर सकता है। यह एक निश्शुल्क 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 1-866-597-9560 (TTY:711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

**Portuguese:** 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 1-866-597-9560 (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 1-866-597-9560 (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 1-866-597-9560 (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、1-866-597-9560 (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。

# *Annual Notice of Changes* for 2024
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## Summary of Important Costs for 2024

The table below compares the 2023 costs and 2024 costs for Essence Advantage Choice Plus in several important areas. **Please note this is only a summary of costs**.

| Cost | 2023 (this year) | 2024 (next year) |
|---|---|---|
| **Monthly plan premium*** <br> * Your premium may be higher or lower than this amount. See Section 1.1 for details. | $27 | $22.20 |
| **Maximum out-of-pocket amounts** <br> This is the most you will pay out-of-pocket for your covered Part A and Part B services. <br> (See Section 1.2 for details.) | **In-Network** <br> From network providers: $3,900 maximum out-of-pocket amount. <br><br> **Combined Out-of-Network** <br> From network and out-of-network providers: $7,900 maximum out-of-pocket amount. | **In-Network** <br> From network providers: $3,000 maximum out-of-pocket amount. <br><br> **Combined Out-of-Network** <br> From network and out-of-network providers: $5,000 maximum out-of-pocket amount. |
| **Doctor office visits** | **In-Network** <br> Primary care visits: $0 per visit <br> Specialist visits: $25 per visit <br><br> **Out-of-Network** <br> Primary care visits: $20 per visit <br> Specialist visits: $50 per visit | **In-Network** <br> Primary care visits: $0 per visit <br> Specialist visits: $25 per visit <br><br> **Out-of-Network** <br> Primary care visits: $15 per visit <br> Specialist visits: $25 per visit |
| **Inpatient hospital stays** | **In-Network** <br> $290 copay per day, per stay: Days 1-6 <br> $0 copay per day, per stay: Days 7 and beyond | **In-Network** <br> $275 copay per day, per stay: Days 1-5 <br> $0 copay per day, per stay: Days 6 and beyond |

| Cost | 2023 (this year) | 2024 (next year) |
|---|---|---|
| **Inpatient hospital stays (continued)** | **Out-of-Network**<br>40% coinsurance for each Medicare-covered inpatient hospital stay (based on the Medicare allowable amount). | **Out-of-Network**<br>$275 copay per day, per stay: Days 1-5<br>$0 copay per day, per stay: Days 6 and beyond |
| **Part D prescription drug coverage**<br>(See Section 1.5 for details.) | Deductible: $0<br><br>Copays/Coinsurance during the Initial Coverage Stage:<br><br>**Preferred Pharmacy 30-day Supply**<br>• Drug Tier 1: $0 copay, including a month supply of each covered insulin product on this tier.<br>• Drug Tier 2: $0 copay, including a month supply of each covered insulin product on this tier.<br>• Drug Tier 3: $45 copay You pay $35 per month supply of each covered insulin product on this tier.<br>• Drug Tier 4: $95 copay You pay $35 per month supply of each covered insulin product on this tier. | Deductible: $0<br><br>Copays/Coinsurance during the Initial Coverage Stage:<br><br>**Preferred Pharmacy 30-day Supply**<br>• Drug Tier 1: $0 copay, including a month supply of each covered insulin product on this tier.<br>• Drug Tier 2: $0 copay, including a month supply of each covered insulin product on this tier.<br>• Drug Tier 3: $45 copay You pay $35 per month supply of each covered insulin product on this tier.<br>• Drug Tier 4: $95 copay You pay $35 per month supply of each covered insulin product on this tier. |

| Cost | 2023 (this year) | 2024 (next year) |
|---|---|---|
| **Part D prescription drug coverage (continued)** | • Drug Tier 5:<br>33% coinsurance<br>You pay $35 per month supply of each covered insulin product on this tier.<br><br>**Standard Pharmacy 30-day Supply**<br>• Drug Tier 1:<br>$4 copay, including a month supply of each covered insulin product on this tier.<br>• Drug Tier 2:<br>$12 copay, including a month supply of each covered insulin product on this tier.<br>• Drug Tier 3:<br>$47 copay<br>You pay $35 per month supply of each covered insulin product on this tier.<br>• Drug Tier 4:<br>$100 copay<br>You pay $35 per month supply of each covered insulin product on this tier.<br>• Drug Tier 5:<br>33% coinsurance<br>You pay $35 per month supply of each covered insulin product on this tier. | • Drug Tier 5:<br>33% coinsurance<br>You pay $35 per month supply of each covered insulin product on this tier.<br><br>**Standard Pharmacy 30-day Supply**<br>• Drug Tier 1:<br>$4 copay, including a month supply of each covered insulin product on this tier.<br>• Drug Tier 2:<br>$12 copay, including a month supply of each covered insulin product on this tier.<br>• Drug Tier 3:<br>$47 copay<br>You pay $35 per month supply of each covered insulin product on this tier.<br>• Drug Tier 4:<br>$100 copay<br>You pay $35 per month supply of each covered insulin product on this tier.<br>• Drug Tier 5:<br>33% coinsurance<br>You pay $35 per month supply of each covered insulin product on this tier. |

| Cost | 2023 (this year) | 2024 (next year) |
|---|---|---|
| **Part D prescription drug coverage (continued)** | Catastrophic Coverage:<br>• During this payment stage, the plan pays most of the cost for your covered drugs.<br>• For each prescription, you pay whichever of these is larger: a payment equal to 5% of the cost of the drug (this is called **coinsurance**), or a copayment ($4.15 for a generic drug or a drug that is treated like a generic, and $10.35 for all other drugs.). | Catastrophic Coverage:<br>• During this payment stage, the plan pays the full cost for your covered Part D drugs and for excluded drugs that are covered under our enhanced benefit. You pay nothing. |

# SECTION 1 Changes to Benefits and Costs for Next Year

## Section 1.1 – Changes to the Monthly Premium

| Cost | 2023 (this year) | 2024 (next year) |
|---|---|---|
| **Monthly premium**<br>(You must also continue to pay your Medicare Part B premium.) | $27 | $22.20 |

- Your monthly plan premium will be *more* if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as creditable coverage) for 63 days or more.
- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.
- Your monthly premium will be *less* if you are receiving "Extra Help" with your prescription drug costs. Please see Section 7 regarding "Extra Help" from Medicare.

## Section 1.2 – Changes to Your Maximum Out-of-Pocket Amounts

Medicare requires all health plans to limit how much you pay out-of-pocket for the year. These limits are called the maximum out-of-pocket amounts. Once you reach this amount, you generally pay nothing for covered Part A and Part B services for the rest of the year.

| Cost | 2023 (this year) | 2024 (next year) |
|---|---|---|
| **In-network maximum out-of-pocket amount**<br>Your costs for covered medical services (such as copays) from network providers count toward your in-network maximum out-of-pocket amount. Your plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount. | $3,900 | $3,000<br>Once you have paid $3,000 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services from network providers for the rest of the calendar year. |
| **Combined maximum out-of-pocket amount**<br>Your costs for covered medical services (such as copays) from in-network and out-of-network providers count toward your combined maximum out-of-pocket amount. Your plan premium and costs for outpatient prescription drugs do not count toward your maximum out-of-pocket amount for medical services. | $7,900 | $5,000<br>Once you have paid $5,000 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services from network or out-of-network providers for the rest of the calendar year. |

## Section 1.3 – Changes to the Provider and Pharmacy Networks

Updated directories are located on our website at EverythingEssence.com. You may also call Customer Service for updated provider and/or pharmacy information or to ask us to mail you a directory, which we will mail within three business days.

There are changes to our network of providers for next year. **Please review the 2024 *Provider/Pharmacy Directory* to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network**.

There are changes to our network of pharmacies for next year. **Please review the 2024 *Provider/Pharmacy Directory* to see which pharmacies are in our network**.

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers), and pharmacies that are part of your plan during the year. If a mid-year change in our providers affects you, please contact Customer Service so we may assist.

## Section 1.4 – Changes to Benefits and Costs for Medical Services

We are making changes to costs and benefits for certain medical services next year. The information below describes these changes.

| Cost | 2023 (this year) | 2024 (next year) |
|---|---|---|
| **Acupuncture for chronic low back pain** | **Out-of-Network**<br>You pay a $50 copay for each Medicare-covered acupuncture visit. | **Out-of-Network**<br>You pay a $25 copay for each Medicare-covered acupuncture visit. |
| **Cardiac rehabilitation services** | **Out-of-Network**<br>You pay a 40% coinsurance for Medicare-covered cardiac rehabilitation services (based on the Medicare allowable amount).<br><br>You pay a 40% coinsurance for Medicare-covered intensive cardiac rehabilitation services (based on the Medicare allowable amount). | **Out-of-Network**<br>You pay a $20 copay per day for Medicare-covered cardiac rehabilitation services.<br><br>You pay a $20 copay per day for Medicare-covered intensive cardiac rehabilitation services. |
| **Chiropractic services** | **Out-of-Network**<br>You pay a 40% coinsurance for each Medicare-covered visit (based on the Medicare allowable amount). | **Out-of-Network**<br>You pay a $20 copay for each Medicare-covered visit. |
| **Dental services** | **Medicare-covered:**<br>**Out-of-Network**<br>You pay a $50 copay for Medicare-covered dental services.<br><br>**Routine dental:**<br><br>**Enhanced preventive dental**<br>**In-Network and Out-of-Network:**<br>Diagnostic<br>Periodic oral evaluation – 2 every calendar year. | **Medicare-covered:**<br>**Out-of-Network**<br>You pay a $25 copay for Medicare-covered dental services.<br><br>**Routine dental:**<br><br>**Enhanced preventive dental**<br>**In-Network and Out-of-Network**<br>Diagnostic<br>Periodic, extensive oral and re-evaluation problem focused – 2 every calendar year. |

| Cost | 2023 (this year) | 2024 (next year) |
|---|---|---|
| **Dental services (continued)** | Limited oral evaluation – 2 every calendar year. | Limited oral evaluation – 3 every calendar year. |
| | Comprehensive oral exam – 1 every 3 calendar years. | Comprehensive oral and periodontal evaluations – 1 every 3 calendar years. |
| | | Intraoral complete series, intraoral tomosynthesis, vertical bitewings (7-8 images and panoramic radiographic images – 1 every 3 calendar years. |
| | | Intraoral tomosynthesis-bitewing, and intraoral tomosynthesis-periapical radiographic – 1 every calendar year. |
| | | Intraoral occlusal radiographic image – 2 every calendar year. |
| | Preventive<br>Fluoride treatments (topical application - 1 every calendar year. | Preventive<br>Fluoride treatments (topical application - 2 every calendar year. |
| | | Scaling in presence of generalized moderate or severe gingival inflammation, full mouth – 2 every calendar year. |
| | | $7,000 maximum benefit per calendar year (combined enhanced preventive and comprehensive. |
| | **Comprehensive dental**<br>**In-Network and Out-of-Network**<br>Covered only via the Flexible Benefit Card. | **Comprehensive dental**<br>**In-Network and Out-of-Network**<br>Restorative Services:<br>Amalgam and resin fillings - 1 per tooth, per surface every 2 calendar years. |
| | | Inlays/onlays, crown and associated services - 1 per tooth, every 5 calendar years. |
| | | Endodontics:<br>Root canal treatment / Retreatment root canal therapy / Apicoectomy / |

| Cost | 2023 (this year) | 2024 (next year) |
|---|---|---|
| **Dental services (continued)** | | Pulpotomy/Retrograde filling - 1 per tooth per lifetime.<br><br><u>Periodontics:</u><br>Scaling and root planing - 1 per quadrant every 3 calendar years.<br><br>Full mouth debridement - 1 every 3 calendar years.<br><br>Clinical crown lengthening - 1 per tooth per lifetime.<br><br>Gingivectomy-gingivoplasty, gingival flap procedure, osseous surgery - 1 per quadrant every 3 calendar years.<br><br>Periodontal Maintenance (following active therapy) - 4 every calendar year.<br><br><u>Extractions:</u><br>Simple extractions / Surgical extractions/Coronectomy - 1 per tooth per lifetime.<br><br><u>Prosthodontics, Other Oral/ Maxillofacial Surgery, Other Services:</u><br>Removable complete, partial, immediate, overdentures or fixed dentures including retainer crowns, endosteal implants and abutments/ retainers and guided tissue regeneration - 1 every 5 calendar years.<br><br>Bridge repair - 1 per 2 calendar years.<br><br>Adjustment to Dentures – 2 adjustments per arch per calendar year.<br><br>Tissue Conditioning – allowed in conjunction with fabrication of new denture. |

| Cost | 2023 (this year) | 2024 (next year) |
|---|---|---|
| **Dental services (continued)** | There is a quarterly credit of $625 via the Flexible Benefit Card that may be used across the categories of dental, hearing, over-the-counter items, and vision (combined In-Network and Out-of-Network). | Repair, Replace or Add Teeth to Existing Partial or Full Dentures – 1 per tooth per calendar year.<br>Rebase and reline dentures – 1 per denture every 3 calendar years.<br>Recement bridges, crowns, onlays and inlays crowns – 1 per tooth every 2 calendar years.<br>Anesthesia including deep sedation, inhalation of nitrous oxide, IV and non-IV sedation consultations - 1 per provider per year.<br>Visits at extended care facility or surgical center- 6 per calendar year.<br>Occlusal analysis and complete adjustments- 1 per 5 calendar years.<br>Limited adjustments - e per calendar year.<br><u>Non-routine & Diagnostic services:</u> Covered only via the Flexible Benefit Card.<br>We made clarifying changes to how we report comprehensive dental non-routine and diagnostic services to Medicare. However, the benefit did not change.<br>There is a $7,000 maximum benefit per calendar year (combined enhanced preventive and comprehensive. In addition to the maximum benefit, there is a quarterly credit of $375 via the Flexible Benefit Card that may be used across the categories of dental, hearing, over-the-counter items, and vision (combined In-Network and Out-of-Network). |

| Cost | 2023 (this year) | 2024 (next year) |
|---|---|---|
| **Dental services (continued)** | | Please refer to Chapter 4, Section 2.2 in your 2024 Evidence of Coverage for specific details on the Flexible Benefit Card. |
| **Diabetes self-management training, diabetic services, and supplies** | **Out-of-Network**<br>You pay a 40% coinsurance for Medicare-covered diabetes monitoring supplies (based on the Medicare allowable amount).<br><br>You pay a 40% coinsurance for Medicare-covered diabetic therapeutic custom-molded shoes or inserts (based on the Medicare allowable amount). | **Out-of-Network**<br>You pay a $0 copay for Medicare-covered diabetes monitoring supplies.<br><br>You pay a 20% coinsurance for Medicare-covered diabetic therapeutic custom-molded shoes or inserts (based on the Medicare allowable amount). |
| **Hearing services** | **Out-of-Network**<br>You pay a 40% coinsurance for Medicare-covered hearing exam (based on the Medicare allowable amount).<br><br>**In-Network and Out-of-Network**<br>Fitting/evaluation for hearing aids covered only via the Flexible Benefit Card.<br><br><u>Hearing aids:</u><br>No allowance.<br><br>There is a quarterly credit of $625 via the Flexible Benefit Card that may be used across the categories of dental, hearing, over-the-counter items, and vision (combined In-Network and Out-of-Network). | **Out-of-Network**<br>You pay a $20 copay for Medicare-covered hearing exam.<br><br>**In-Network and Out-of-Network**<br>You pay a $0 copay for 1 fitting/evaluation for hearing aids covered once every 2 calendar years.<br><br><u>Hearing aids:</u><br>$2,000 allowance every 2 calendar years (both ears combined).<br><br>There is a quarterly credit of $375 via the Flexible Benefit Card that may be used across the categories of dental, hearing, over-the-counter items, and vision (combined In-Network and Out-of-Network). |

| Cost | 2023 (this year) | 2024 (next year) |
|---|---|---|
| **Hearing services (continued)** | | Please refer to Chapter 4, Section 2.2 in your 2024 Evidence of Coverage for specific details on the Flexible Benefit Card. |
| **Inpatient hospital care** | **In-Network**<br>You pay a $290 copay per day, per stay: Days 1-6.<br>You pay a $0 copay per day, per stay: Days 7 and beyond.<br><br>**Out-of-Network**<br>You pay a 40% coinsurance for each Medicare-covered inpatient hospital stay (based on the Medicare allowable amount). | **In-Network**<br>You pay a $275 copay per day, per stay: Days 1-5.<br>You pay a $0 copay per day, per stay: Days 6 and beyond.<br><br>**Out-of-Network**<br>You pay a $275 copay per day, per stay: Days 1-5.<br>You pay a $0 copay per day, per stay: Days 6 and beyond. |
| **Inpatient services in a psychiatric hospital** | **Out-of-Network**<br>You pay a 40% coinsurance for each Medicare-covered inpatient mental health stay (based on the Medicare allowable amount). | **Out-of-Network**<br>You pay a $295 copay per day, per stay: Days 1-6.<br>You pay a $0 copay per day, per stay: Days 7 and beyond. |
| **Opioid treatment program services** | **In-Network**<br>You pay a $15 copay per visit for Medicare-covered opioid treatment program services.<br><br>**Out-of-Network**<br>You pay a 40% coinsurance per visit for Medicare-covered opioid treatment program services (based on the Medicare allowable amount). | **In-Network**<br>You pay a $0 copay per visit for Medicare-covered opioid treatment program services.<br><br>**Out-of-Network**<br>You pay a $0 copay per visit for Medicare-covered opioid treatment program services. |

| Cost | 2023 (this year) | 2024 (next year) |
|---|---|---|
| **Outpatient diagnostic tests and therapeutic services and supplies** | **In-Network**<br>You pay a 0%-20% coinsurance for Medicare-covered diagnostic procedures and tests.<br><br>You pay a 0%-20% coinsurance for Medicare-covered diagnostic radiology services (not including x-rays).<br><br>**Out-of-Network**<br>You pay a 40% coinsurance for Medicare-covered x-rays (based on the Medicare allowable amount).<br><br>You pay a $0 copay for Medicare-covered lab services.<br><br>You pay a 40% coinsurance for Medicare-covered diagnostic procedures and tests (based on the Medicare allowable amount).<br><br>You pay a 40% coinsurance for Medicare-covered diagnostic radiology services (not including x-rays) (based on the Medicare allowable amount).<br><br>You pay a 40% coinsurance for outpatient blood services (storage and administration) (based on the Medicare allowable amount). | **In-Network**<br>You pay a $0-$30 copay for Medicare-covered diagnostic procedures and tests.<br><br>You pay a $0-$200 copay for Medicare-covered diagnostic radiology services (not including x-rays).<br><br>**Out-of-Network**<br>You pay a $15 copay for Medicare-covered x-rays.<br><br>You pay a 40% coinsurance for Medicare-covered lab services.<br><br>You pay a $0-$30 copay for Medicare-covered diagnostic procedures and tests.<br><br>You pay a $0-$200 copay for Medicare-covered diagnostic radiology services (not including x-rays).<br><br>You pay a $0 copay for outpatient blood services (storage and administration). |

| Cost | 2023 (this year) | 2024 (next year) |
|---|---|---|
| **Outpatient hospital observation** | **Out-of-Network**<br>You pay a 40% coinsurance for Medicare-covered outpatient hospital observation services (based on the Medicare allowable amount). | **Out-of-Network**<br>You pay a $280 copay for Medicare-covered outpatient hospital observation services. |
| **Outpatient hospital services** | **In-Network**<br>You pay a 20% coinsurance for Medicare-covered outpatient hospital services.<br><br>**Out-of-Network**<br>You pay a 40% coinsurance for Medicare-covered outpatient hospital services (based on the Medicare allowable amount). | **In-Network**<br>You pay a $280 copay for Medicare-covered outpatient hospital services.<br><br>**Out-of-Network**<br>You pay a $280 copay for Medicare-covered outpatient hospital services. |

| Cost | 2023 (this year) | 2024 (next year) |
|---|---|---|
| **Outpatient mental health care** | **In-Network**<br>You pay a $15 copay for each Medicare-covered mental health individual visit.<br><br>You pay a $10 copay for each Medicare-covered mental health group visit.<br><br>You pay a $15 copay for each Medicare-covered psychiatric service individual visit.<br><br>You pay a $10 copay for each Medicare-covered psychiatric service group visit.<br><br>**Out-of-Network**<br>You pay a 40% coinsurance for each Medicare-covered mental health individual visit. (based on the Medicare allowable amount).<br><br>You pay a 40% coinsurance for each Medicare-covered mental health group visit (based on the Medicare allowable amount).<br><br>You pay a 40% coinsurance for each Medicare-covered psychiatric service individual visit (based on the Medicare allowable amount).<br><br>You pay a 40% coinsurance for each Medicare-covered psychiatric service group visit (based on the Medicare allowable amount). | **In-Network**<br>You pay a $0 copay for each Medicare-covered mental health individual visit.<br><br>You pay a $0 copay for each Medicare-covered mental health group visit.<br><br>You pay a $0 copay for each Medicare-covered psychiatric service individual visit.<br><br>You pay a $0 copay for each Medicare-covered psychiatric service group visit.<br><br>**Out-of-Network**<br>You pay a $0 copay for each Medicare-covered mental health individual visit.<br><br>You pay a $0 copay for each Medicare-covered mental health group visit.<br><br>You pay a $0 copay for each Medicare-covered psychiatric service individual visit.<br><br>You pay a $0 copay for each Medicare-covered psychiatric service group visit. |

| Cost | 2023 (this year) | 2024 (next year) |
|---|---|---|
| **Outpatient rehabilitation services** | **Out-of-Network**<br>You pay a 40% coinsurance for each Medicare-covered occupational therapy visit (based on the Medicare allowable amount).<br><br>You pay a 40% coinsurance for each Medicare-covered physical therapy and/or speech and language pathology visit (based on the Medicare allowable amount). | **Out-of-Network**<br>You pay a $40 copay for each Medicare-covered occupational therapy visit.<br><br>You pay a $40 copay for each Medicare-covered physical therapy and/or speech and language pathology visit. |
| **Outpatient substance abuse services** | **In-Network**<br>You pay a $15 copay for each Medicare-covered individual visit.<br><br>You pay a $10 copay for each Medicare-covered group visit.<br><br>**Out-of-Network**<br>You pay a 40% coinsurance for each Medicare-covered individual visit (based on the Medicare allowable amount).<br><br>You pay a 40% coinsurance for each Medicare-covered group visit (based on the Medicare allowable amount). | **In-Network**<br>You pay a $0 copay for each Medicare-covered individual visit.<br><br>You pay a $0 copay for each Medicare-covered group visit.<br><br>**Out-of-Network**<br>You pay a $0 copay for each Medicare-covered individual visit.<br><br>You pay a $0 copay for each Medicare-covered group visit. |

| Cost | 2023 (this year) | 2024 (next year) |
|---|---|---|
| **Outpatient surgery, including services provided at a hospital outpatient facilities and ambulatory surgery centers** | **In-Network**<br>You pay a $240 copay for each Medicare-covered surgery at an ambulatory surgery center.<br><br>**Out-of-Network**<br>You pay a 40% coinsurance for each Medicare-covered surgery at an outpatient hospital facility (based on the Medicare allowable amount).<br><br>You pay a 40% coinsurance for each Medicare-covered surgery at an ambulatory surgery center (based on the Medicare allowable amount). | **In-Network**<br>You pay a $180 copay for each Medicare-covered surgery at an ambulatory surgery center.<br><br>**Out-of-Network**<br>You pay a $280 copay for each Medicare-covered surgery at an outpatient hospital facility.<br><br>You pay a $180 copay for each Medicare-covered surgery at an ambulatory surgery center. |
| **Partial hospitalization services** | **Out-of-Network**<br>You pay a 40% coinsurance for Medicare-covered partial hospitalization services (based on the Medicare allowable amount). | **Out-of-Network**<br>You pay a $45 copay for each Medicare-covered partial hospitalization services. |
| **Physician/ Practitioner services, including doctor's office visits** | **Out-of-Network**<br>You pay a $20 copay for each Medicare-covered primary care provider visit.<br><br>You pay a $50 copay for each Medicare-covered specialist visit.<br><br>You pay a $20-$50 copay range, or 40% coinsurance for each virtual/telehealth visit. | **Out-of-Network**<br>You pay a $15 copay for each Medicare-covered primary care provider visit.<br><br>You pay a $25 copay for each Medicare-covered specialist visit.<br><br>You pay a $0-$40 copay range for each virtual/telehealth visit. |
| **Podiatry services** | **Out-of-Network**<br>You pay a $50 copay for each Medicare-covered podiatry service. | **Out-of-Network**<br>You pay a $25 copay for each Medicare-covered podiatry service. |

| Cost | 2023 (this year) | 2024 (next year) |
|---|---|---|
| **Prosthetic devices and related supplies** | **Out-of-Network**<br>You pay a 40% coinsurance for Medicare-covered prosthetic devices (based on the Medicare allowable amount).<br><br>You pay a 40% coinsurance for Medicare-covered medical supplies (based on the Medicare allowable amount). | **Out-of-Network**<br>You pay a 20% coinsurance for Medicare-covered prosthetic devices(based on the Medicare allowable amount).<br><br>You pay a 20% coinsurance for Medicare-covered medical supplies (based on the Medicare allowable amount). |
| **Pulmonary rehabilitation services** | **Out-of-Network**<br>You pay a 40% coinsurance for Medicare-covered pulmonary rehabilitation services (based on the Medicare allowable amount). | **Out-of-Network**<br>You pay a $20 copay per day for Medicare-covered pulmonary rehabilitation services. |
| **Services to treat kidney disease** | **Out-of-Network**<br>You pay a 40% coinsurance for Medicare-covered renal dialysis (based on the Medicare allowable amount). | **Out-of-Network**<br>You pay a 20% coinsurance for Medicare-covered renal dialysis (based on the Medicare allowable amount). |
| **Supervised Exercise Therapy (SET)** | **Out-of-Network**<br>You pay a 40% coinsurance for Medicare-covered Supervised Exercise Therapy (SET) services (based on the Medicare allowable amount). | **Out-of-Network**<br>You pay a $20 copay per day for Medicare-covered Supervised Exercise Therapy (SET) services. |

| Cost | 2023 (this year) | 2024 (next year) |
|---|---|---|
| **Vision care** | **Medicare-covered:**<br>**In-Network**<br>You pay a $0 copay for 1 pair of Medicare-covered eyeglass frames or 1 pair of Medicare-covered contact lenses (or 2 six packs) after each cataract surgery. Our plan has no additional allowance for eyeglass frames or contact lenses after each cataract surgery.<br><br>**Out-of-Network**<br>You pay a $50 copay for each visit to a specialist, such as an ophthalmologist or optometrist, for Medicare-covered benefits.<br><br>You pay a 40% coinsurance for 1 pair of Medicare-covered eyeglass frames or 1 pair of Medicare-covered contact lenses (or 2 six packs) after each cataract surgery (based on the Medicare allowable amount). Our plan has no additional allowance for eyeglass frames or contact lenses after each cataract surgery. | **Medicare-covered:**<br>**In-Network**<br>You pay a $0 copay for 1 pair of Medicare-covered eyeglass frames or 1 pair of Medicare-covered contact lenses (or 2 six packs) after each cataract surgery. Our plan pays up to $200 (combined In-Network and Out-of-Network) for eyeglass frames or contact lenses after each cataract surgery.<br><br>**Out-of-Network**<br>You pay a $25 copay for each visit to a specialist, such as an ophthalmologist or optometrist, for Medicare-covered benefits.<br><br>You pay a 40% coinsurance for 1 pair of Medicare-covered eyeglass frames or 1 pair of Medicare-covered contact lenses (or 2 six packs) after each cataract surgery (based on the Medicare allowable amount). Our plan pays up to $200 (combined In-Network and Out-of-Network) for eyeglass frames or contact lenses after each cataract surgery. |

| Cost | 2023 (this year) | 2024 (next year) |
|---|---|---|
| **Vision care (continued)** | **Routine vision care:**<br>**In-Network**<br>Covered only via the Flexible Benefit Card. | **Routine vision care:**<br>**In-Network**<br>You pay a $0 copay for 1 pair of eyeglass lenses (standard plastic single, bifocal, trifocal, or lenticular) every calendar year.<br>You pay a $0 copay for 1 pair of eyeglass frames or contact lenses (or 2 six packs) every calendar year. Our plan pays up to $200 (combined In-Network and Out-of-Network) every calendar year for eyeglass frames or contact lenses. For upgrades to eyeglass lenses and contact lenses:<br>You pay a $15 copay for UV treatment, tint, or standard plastic scratch coating.<br>You pay a $65 copay for standard progressive lenses and standard anti-reflective coating.<br>You pay an 80% coinsurance for premium progressive lenses and other coatings, oversized lenses, prism and other lens options.<br>You pay a 90% coinsurance for contact lenses premium fit and follow-up. |
| | **Out-of-Network**<br>Covered only via the Flexible Benefit Card. | **Out-of-Network**<br>Our plan pays up to $200 (combined In-Network and Out-of-Network) every calendar year for eyeglass frames and contact lenses. |

| Cost | 2023 (this year) | 2024 (next year) |
|---|---|---|
| **Vision care (continued)** | There is a quarterly credit of $625 via the Flexible Benefit Card that may be used across the categories of dental, hearing, over-the-counter items, and vision (combined In-Network and Out-of-Network). | There is a quarterly credit of $375 via the Flexible Benefit Card that may be used across the categories of dental, hearing, over-the-counter items, and vision (combined In-Network and Out-of-Network).<br><br>Please refer to Chapter 4, Section 2.2 in your 2024 Evidence of Coverage for specific details on the Flexible Benefit Card. |

## Section 1.5 – Changes to Part D Prescription Drug Coverage

### Changes to Our "Drug List"

Our list of covered drugs is called a Formulary or "Drug List." A copy of our "Drug List" is provided electronically.

We made changes to our "Drug List," which could include removing or adding drugs, changing the restrictions that apply to our coverage for certain drugs or moving them to a different cost-sharing tier. **Review the "Drug List" to make sure your drugs will be covered next year and to see if there will be any restrictions, or if your drug has been moved to a different cost-sharing tier.**

Most of the changes in the "Drug List" are new for the beginning of each year. However, during the year, we might make other changes that are allowed by Medicare rules. For instance, we can immediately remove drugs considered unsafe by the FDA or withdrawn from the market by a product manufacturer. We update our online "Drug List" to provide the most up to date list of drugs.

If you are affected by a change in drug coverage at the beginning of the year or during the year, please review Chapter 9 of your Evidence of Coverage and talk to your doctor to find out your options, such as asking for a temporary supply, applying for an exception and/or working to find a new drug. You can also contact Customer Service for more information.

### Changes to Prescription Drug Costs

**Note:** If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs may not apply to you.** We sent you a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also called the Low-Income Subsidy Rider or the LIS Rider), which tells you about your drug costs. If you receive "Extra Help" and you haven't received this insert by October 15, 2023, please call Customer Service and ask for the LIS Rider.

There are four **drug payment stages**. The information below shows the changes to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage.)

## Changes to the Deductible Stage

| Stage | 2023 (this year) | 2024 (next year) |
|---|---|---|
| **Stage 1: Yearly Deductible Stage** | Because we have no deductible, this payment stage does not apply to you. | Because we have no deductible, this payment stage does not apply to you. |

## Changes to Your Cost Sharing in the Initial Coverage Stage

| Stage | 2023 (this year) | 2024 (next year) |
|---|---|---|
| **Stage 2: Initial Coverage Stage**<br>During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost.**<br><br>The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy. For information about the costs for a long-term supply or for mail-order prescriptions, look in Chapter 6, Section 5 of your *Evidence of Coverage*.<br><br>Most adult Part D vaccines are covered at no cost to you.<br><br>We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List. | Your cost for a one-month supply filled at a network pharmacy:<br><br>**Preferred Generic:**<br>*Standard cost sharing:*<br>You pay $4 per prescription, including a month supply of each covered insulin product on this tier.<br>*Preferred cost sharing:*<br>You pay $0 per prescription, including a month supply of each covered insulin product on this tier.<br><br>**Generic:**<br>*Standard cost sharing:*<br>You pay $12 per prescription, including a month supply of each covered insulin product on this tier.<br>*Preferred cost sharing:*<br>You pay $0 per prescription, including a month supply of each covered insulin product on this tier. | Your cost for a one-month supply filled at a network pharmacy:<br><br>**Preferred Generic:**<br>*Standard cost sharing:*<br>You pay $4 per prescription, including a month supply of each covered insulin product on this tier.<br>*Preferred cost sharing:*<br>You pay $0 per prescription, including a month supply of each covered insulin product on this tier.<br><br>**Generic:**<br>*Standard cost sharing:*<br>You pay $12 per prescription, including a month supply of each covered insulin product on this tier.<br>*Preferred cost sharing:*<br>You pay $0 per prescription, including a month supply of each covered insulin product on this tier. |

| Stage | 2023 (this year) | 2024 (next year) |
|---|---|---|
| **Stage 2: Initial Coverage Stage (continued)** | **Preferred Brand:**<br>*Standard cost sharing:*<br>You pay $47 per prescription.<br>You pay $35 per month supply of each covered insulin product on this tier.<br>*Preferred cost sharing:*<br>You pay $45 per prescription.<br>You pay $35 per month supply of each covered insulin product on this tier. | **Preferred Brand:**<br>*Standard cost sharing:*<br>You pay $47 per prescription.<br>You pay $35 per month supply of each covered insulin product on this tier.<br>*Preferred cost sharing:*<br>You pay $45 per prescription.<br>You pay $35 per month supply of each covered insulin product on this tier. |
| | **Non-Preferred Brand:**<br>*Standard cost sharing:*<br>You pay $100 per prescription.<br>You pay $35 per month supply of each covered insulin product on this tier.<br>*Preferred cost sharing:*<br>You pay $95 per prescription.<br>You pay $35 per month supply of each covered insulin product on this tier. | **Non-Preferred Brand:**<br>*Standard cost sharing:*<br>You pay $100 per prescription.<br>You pay $35 per month supply of each covered insulin product on this tier.<br>*Preferred cost sharing:*<br>You pay $95 per prescription.<br>You pay $35 per month supply of each covered insulin product on this tier. |
| | **Specialty Tier:**<br>*Standard cost sharing:*<br>You pay 33% of the total cost.<br>You pay $35 per month supply of each covered insulin product on this tier.<br>*Preferred cost sharing:*<br>You pay 33% of the total cost.<br>You pay $35 per month supply of each covered insulin product on this tier. | **Specialty Tier:**<br>*Standard cost sharing:*<br>You pay 33% of the total cost.<br>You pay $35 per month supply of each covered insulin product on this tier.<br>*Preferred cost sharing:*<br>You pay 33% of the total cost.<br>You pay $35 per month supply of each covered insulin product on this tier. |

| Stage | 2023 (this year) | 2024 (next year) |
|---|---|---|
| **Stage 2: Initial Coverage Stage (continued)** | _____ | _____ |
| | Once your total drug costs have reached $4,660, you will move to the next stage (the Coverage Gap Stage). | Once your total drug costs have reached $5,030, you will move to the next stage (the Coverage Gap Stage). |

## Changes to the Coverage Gap and Catastrophic Coverage Stages

The other two drug coverage stages – the Coverage Gap Stage and the Catastrophic Coverage Stage – are for people with high drug costs. **Most members do not reach the Coverage Gap Stage or the Catastrophic Coverage Stage**.

**Beginning in 2024, if you reach the Catastrophic Coverage Stage, you pay nothing for covered Part D drugs and for excluded drugs that are covered under our enhanced benefit.**

For specific information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in your *Evidence of Coverage*.

## SECTION 2 Administrative Changes

In plan year 2024 there will be a change to the service area. The table below describes that change. Please contact Customer Service for more information.

| Description | 2023 (this year) | 2024 (next year) |
|---|---|---|
| **Service Area** | Our service area includes these counties in Missouri: Crawford, Franklin, Jefferson, Lincoln, Saint Charles, Saint Louis, Warren, and Saint Louis City. | Our service area includes these counties in Missouri: Crawford, Franklin, Gasconade, Jefferson, Lincoln, Montgomery, Saint Charles, Saint Louis, Warren, Washington, and Saint Louis City. |
| | Our service area includes these counties in Illinois: Madison, Monroe, and St. Clair. | Our service area includes these counties in Illinois: Bond, Clinton, Jersey, Macoupin, Madison, Monroe, and St. Clair. |

# SECTION 3 Deciding Which Plan to Choose

## Section 3.1 – If you want to stay in Essence Advantage Choice Plus

**To stay in our plan, you don't need to do anything.** If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically be enrolled in our Essence Advantage Choice Plus.

## Section 3.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change plans for 2024 follow these steps:

### Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- – *OR*– You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan. If you do not enroll in a Medicare drug plan, please see Section 2.1 regarding a potential Part D late enrollment penalty.

To learn more about Original Medicare and the different types of Medicare plans, use the Medicare Plan Finder (Medicare.gov/plan-compare), read the *Medicare & You 2024* handbook, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2).

As a reminder, Essence Healthcare PPO, Inc. offers other Medicare health plans. These other plans may differ in coverage, monthly premiums, and cost-sharing amounts.

### Step 2: Change your coverage

- To **change to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from Essence Advantage Choice Plus.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Essence Advantage Choice Plus.
- To **change to Original Medicare without a prescription drug plan**, you must either:
    - Send us a written request to disenroll. Contact Customer Service if you need more information on how to do so.
    - – *OR* – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

## SECTION 4 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7.** The change will take effect on January 1, 2024.

### Are there other times of the year to make a change?

In certain situations, changes are also allowed at other times of the year. Examples include people with Medicaid, those who get "Extra Help" paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area.

If you enrolled in a Medicare Advantage Plan for January 1, 2024, and don't like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2024.

If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can change your Medicare coverage **at any time**. You can change to any other Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

## SECTION 5 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is an independent government program with trained counselors in every state. In Missouri, the SHIP is called Community Leaders Assisting the Insured of Missouri (CLAIM). In Illinois, the SHIP is called Senior Health Insurance Program.

It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. CLAIM of Missouri and Senior Health Insurance Program of Illinois counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans.

In Missouri, you can call CLAIM at 1-800-390-3330 (TTY: 711*)*. You can learn more about CLAIM by visiting their website MissouriClaim.org.

In Illinois, you can call Senior Health Insurance Program at 1-800-252-8966 (TTY: 1-888-206-1327). You can learn more about Senior Health Insurance Program by visiting their website ILaging.Illinois.gov.

## SECTION 6 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs. Below we list different kinds of help:

- **"Extra Help" from Medicare.** People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. To see if you qualify, call:
    - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
    - The Social Security Office at 1-800-772-1213 between 8 am and 7 pm, Monday through Friday for a representative. Automated messages are available 24 hours a day. TTY users should call, 1-800-325-0778; or
    - Your State Medicaid Office (applications).
- **Help from your state's pharmaceutical assistance program.** Missouri has a program called Missouri Rx (MORx) that helps people pay for prescription drugs based on their financial need, age, or medical condition. To learn more about the program, check with your State Health Insurance Assistance Program.
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the Missouri AIDS Drug Assistance Program or Illinois Medication Assistance Program. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call 573-751-6439 (TTY: 711) for MO ADAP or 1-800-825-3518 (TTY: 1-800-547-0466) for IL ADAP.

## SECTION 7 Questions?

### Section 7.1 – Getting Help from Essence Advantage Choice Plus

Questions? We're here to help. Please call Customer Service at 1-866-597-9560. (TTY only, call 711) We are available for phone calls seven days a week from 8 a.m. to 8 p.m. 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. Calls to this number are free.

### Read your *2024 Evidence of Coverage* (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2024. For details, look in the *2024 Evidence of Coverage* for Essence Advantage Choice Plus. The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is located on our website at EverythingEssence.com. You may also call Customer Service to ask us to mail you an *Evidence of Coverage*.

### Visit our Website

You can also visit our website at EverythingEssence.com. As a reminder, our website has the most up-to-date information about our provider network (*Provide/Pharmacy Directory*) and our *List of Covered Drugs (Formulary/"Drug List").*

## Section 7.2 – Getting Help from Medicare

To get information directly from Medicare:

### Call 1-800-MEDICARE (1-800-633-4227)

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

### Visit the Medicare Website

Visit the Medicare website (Medicare.gov). It has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area. To view the information about plans, go to Medicare.gov/plan-compare.

### Read *Medicare & You 2024*

Read the *Medicare & You 2024* handbook. Every fall, this document is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this document, you can get it at the Medicare website (Medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Essence Healthcare is a PPO plan with a Medicare contract. Enrollment in Essence Healthcare depends on contract renewal.

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.

Toll-free: 1-866-597-9560 (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.

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®

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