Summary of Benefits

MEDICARE ADVANTAGE | 2025

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

ESSENCE HEALTHCARE®

Serving Southwest Missouri and Northwest Arkansas

Essence Advantage (HMO)

Essence Advantage Choice (PPO)

Summary of Benefits

January 1, 2025 – December 31, 2025

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

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

Sections in This Booklet

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

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

Hours of Operation

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

Phone Number and Website

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

Things to Know About Our Plans

Who can join?

To join **Essence Advantage** or **Essence Advantage Choice,** you must be entitled to Medicare Part A, be enrolled in Medicare Part B, be a United States citizen or are lawfully present in the United States and live in our service area. Our service area includes the Missouri counties of Barry, Christian, Dallas, Greene, Lawrence, Polk, Stone, Taney and Webster, and the Arkansas counties of Benton, Carroll, Madison and Washington.

What's an HMO?

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

What's a PPO?

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

Which doctors, hospitals and pharmacies can I use?

Essence Advantage and **Essence Advantage Choice** have a network of doctors, hospitals, pharmacies and other providers. If you use providers that aren't in our network, they must agree to treat you, and, if you're an HMO plan member, we may not pay for these services. Except in emergency or urgent situations, out-of-network providers may deny care. 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 or six tiers. You'll need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier, your deductible (if applicable) and what stage of the benefit you've reached. Later in this document, we discuss the benefit stages that occur: initial coverage and catastrophic coverage. If you have questions about the different benefit stages, please contact the plan for more information or access the Evidence of Coverage on our website.

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

	Essence Advantage (HMO)	Essence Advantage Choice (PPO) In-Network	Essence Advantage Choice (PPO) Out-of-Network
Monthly Plan Premium	**Both Plans** **$0** Per month You must continue to pay your Medicare Part B premium.		
Deductibles	**Both 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 in-network covered hospital and medical services. Your yearly limit(s) in this plan: **$3,350** for covered hospital and medical services you receive from in-network providers	The maximum out-of-pocket amount is the most that you pay out of pocket during the calendar year for in-network covered hospital and medical services. Your yearly limit(s) in this plan: **$3,500** for covered hospital and medical services you receive from in-network providers	The maximum out-of-pocket amount is the most that you pay out of pocket during the calendar year for combined in- and out-of-network covered hospital and medical services. Your yearly limit(s) in this plan: **$5,500** for covered hospital and medical services you receive from in- and out-of-network providers
	Both Plans If you reach the limit on out-of-pocket costs, hospital and medical services are still covered, and we pay the full cost for the rest of the year. Please note that you'll still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.		

Covered Medical and Hospital Benefits

	Essence Advantage (HMO)	Essence Advantage Choice (PPO) In-Network	Essence Advantage Choice (PPO) Out-of-Network
Inpatient Hospital Coverage	Our plan covers an unlimited number of days for an inpatient hospital stay. • **$275** Copay per day, per stay: days 1–5 • **$0** Copay per day, per stay: day 6 and beyond	Our plan covers an unlimited number of days for an inpatient hospital stay. • **$275** Copay per day, per stay: days 1–5 • **$0** Copay per day, per stay: day 6 and beyond	
	Prior authorization is required.	Prior authorization is required.	

	Essence Advantage (HMO)	Essence Advantage Choice (PPO) In-Network	Essence Advantage Choice (PPO) Out-of-Network
Outpatient Hospital Coverage	**$220** Copay for outpatient hospital services, including surgery Copay is charged per surgery.	**$210** Copay for outpatient hospital services, including surgery Copay is charged per surgery.	
	Prior authorization may be required.	Prior authorization may be required.	
Ambulatory Surgical Center (ASC)	**$220** Copay Prior authorization may be required.	**$210** Copay Prior authorization may be required.	**$210** Copay
Doctor Visits *(primary care providers and specialists)*	Primary care physician (PCP) visit: **$0** copay Specialist visit: **$20** copay Certain Medicare-covered services provided by a physician may require a prior authorization.	Primary care physician (PCP) visit: **$0** copay Specialist visit: **$30** copay Certain Medicare-covered services provided by a physician may require a prior authorization.	Primary care physician (PCP) visit: **$15** copay Specialist visit: **$30** copay
	Both Plans For details on a **shared allowance** that can be used on medical copays, see the Flexible Benefits Card section on page **16.**		
Preventive Care	**Both Plans** You pay nothing. Our plans cover many preventive services, including: • Abdominal aortic aneurysm screening • Annual wellness visit • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) • Cardiovascular disease testing • Cervical and vaginal cancer screening • Colorectal cancer screening		

	Essence Advantage (HMO)	Essence Advantage Choice (PPO) In-Network	Essence Advantage Choice (PPO) Out-of-Network
Preventive Care *(continued)*	**Both Plans** • 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 • Prostate cancer screening exams • Screening and counseling to reduce alcohol misuse • 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.		
Emergency Care	**Both Plans** **$125** Copay 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	**Both Plans** **$45** Copay within the United States **$125** Copay outside of the United States Urgently needed services are always considered in-network. We provide worldwide coverage. For details on a **shared allowance** that can be used on medical copays, see the Flexible Benefits Card section on page **16.**		

	Essence Advantage (HMO)	Essence Advantage Choice (PPO) In-Network	Essence Advantage Choice (PPO) Out-of-Network
Diagnostic Services/Labs/ Imaging *(Costs for these services may vary based on place of service.)*	Lab services: **$5** copay	Lab services: **$0** copay	Lab services: **40%** coinsurance
	Both Plans Diagnostic procedures and tests: **$30** copay Diagnostic colonoscopies: **$0** copay Diagnostic radiology services (such as MRI, CT and PET scans): **$200** copay Diagnostic mammograms: **$0** copay		
	Therapeutic radiology services (such as radiation treatment for cancer): **20%** coinsurance X-rays: **$20** copay Prior authorization may be required.	Therapeutic radiology services (such as radiation treatment for cancer): **20%** coinsurance X-rays: **$20** copay Prior authorization may be required.	Therapeutic radiology services (such as radiation treatment for cancer): **40%** coinsurance X-rays: **$20** copay
	Both Plans For details on a **shared allowance** that can be used on medical copays, see the Flexible Benefits Card section on page **16.**		
Hearing Services	**Both Plans** Medicare-covered exam to diagnose and treat hearing and balance issues: **$20** copay Routine hearing exam: **$20** copay **$1,000** Allowance for up to 2 hearing aids every 2 calendar years (both ears combined) One fitting/evaluation for hearing aids every 2 calendar years: **$0** copay For details on an **additional shared allowance** that can be used on hearing services and products, see the Flexible Benefits Card section on page **16.**		

	Essence Advantage (HMO)	Essence Advantage Choice (PPO) In-Network	Essence Advantage Choice (PPO) 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 (1 every calendar year) • Horizontal bitewing or intraoral tomosynthesis bitewing X-ray(s) (up to 4, once every calendar year) Medicare-covered comprehensive dental services: **$20** copay Prior authorization may be required for Medicare-covered services performed by an oral surgeon.	Medicare-covered comprehensive dental services: **$30** copay Prior authorization may be required for Medicare-covered services performed by an oral surgeon.	Medicare-covered comprehensive dental services: **$30** copay
	Both Plans For details on a **shared allowance** that can be used on dental services and products, see the Flexible Benefits Card section on page **16.**		

	Essence Advantage (HMO)	Essence Advantage Choice (PPO) In-Network	Essence Advantage Choice (PPO) Out-of-Network
Vision Services	Each visit to a specialist, such as an ophthalmologist or optometrist, for Medicare-covered benefits: **$20** copay Diabetic eye exams performed by a contracted specialist: **$0** copay 1 Pair of Medicare-covered eyeglass lenses (standard plastic single, bifocal, trifocal or lenticular lenses) after each cataract surgery: **$0** copay 1 Pair of Medicare-covered eyeglass frames or contact lenses after each cataract surgery: **$0** copay 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 routine eyewear (frames, lenses and contact lenses) every calendar year.	Each visit to a specialist, such as an ophthalmologist or optometrist, for Medicare-covered benefits: **$30** copay Diabetic eye exams performed by a contracted specialist: **$0** copay 1 Pair of Medicare-covered eyeglass lenses (standard plastic single, bifocal, trifocal or lenticular lenses) after each cataract surgery: **$0** copay 1 Pair of Medicare-covered eyeglass frames or contact lenses after each cataract surgery: **$0** copay 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 **$300** total for routine eyewear (frames, lenses and contact lenses) every calendar year (in- and out-of-network combined).	Each visit to a specialist, such as an ophthalmologist or optometrist, for Medicare-covered benefits: **$30** copay Diabetic eye exams: **$30** copay 1 Pair of Medicare-covered eyeglass lenses (standard plastic single, bifocal, trifocal or lenticular lenses) after each cataract surgery: **$0** copay 1 Pair of Medicare-covered eyeglass frames or contact lenses after each cataract surgery: **$0** copay 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 **$300** total for routine eyewear (frames, lenses and contact lenses) every calendar year (in- and out-of-network combined).
	Both Plans Upgrades may be available at an additional cost. For details on an **additional shared allowance** that can be used on vision services and eyewear, see the Flexible Benefits Card section on page **16.**		

	Essence Advantage (HMO)	Essence Advantage Choice (PPO) In-Network	Essence Advantage Choice (PPO) Out-of-Network
Mental Health Services	**Both Plans** Inpatient visit: Our plan covers an unlimited number of days for an inpatient hospital stay. • **$295** Copay per day, per stay: days 1–5 • **$0** Copay per day, per stay: day 6 and beyond Outpatient individual visit: **$15** copay Outpatient group visit: **$10** copay		
	Prior authorization may be required.	Prior authorization may be required.	
	Both Plans For details on a **shared allowance** that can be used on medical copays, see the Flexible Benefits Card section on page **16.**		
Skilled Nursing Facility (SNF)	The plan covers up to 100 days each benefit period. No prior hospital stay is required. • **$0** Copay per day, per stay: days 1–20 • **$160** Copay per day, per stay: days 21–100 Prior authorization is required. Admission to a new or different SNF facility within the same benefit period may start a new stay for copay administration purposes.	The plan covers up to 100 days each benefit period. No prior hospital stay is required. • **$0** Copay per day, per stay: days 1–20 • **$160** Copay per day, per stay: days 21–100 Prior authorization is required. Admission to a new or different SNF facility within the same benefit period may start a new stay for copay administration purposes.	The plan covers up to 100 days each benefit period. No prior hospital stay is required. **40%** Coinsurance per day, per stay: day 1 and beyond

	Essence Advantage (HMO)	Essence Advantage Choice (PPO) In-Network	Essence Advantage Choice (PPO) Out-of-Network
Physical Therapy	**Both Plans** **$40** Copay		
	A referral is required		
	Both Plans For details on a **shared allowance** that can be used on medical copays, see the Flexible Benefits Card section on page **16.**		
Ambulance	**$250** Copay	**$240** Copay	**$240** Copay
	Both Plans This copay applies to each one-way trip.		
	Prior authorization may be required for non-emergent transportation by ambulance.	Prior authorization may be required for non-emergent transportation by ambulance.	
Transportation	**Both Plans** Not covered		
Medicare Part B Drugs	Part B drugs (other than Part B insulin): You'll pay the lesser of **20%** or the adjusted beneficiary coinsurance amount as provided by the Centers for Medicare & Medicaid Services (CMS). Part B insulin (insulin administered through a durable medical equipment pump): You'll pay the lesser of **$35** or **20%** coinsurance, for a one-month supply. Prior authorization may be required.	Part B drugs (other than Part B insulin): You'll pay the lesser of **20%** or the adjusted beneficiary coinsurance amount as provided by the Centers for Medicare & Medicaid Services (CMS). Part B insulin (insulin administered through a durable medical equipment pump): You'll pay the lesser of **$35** or **20%** coinsurance, for a one-month supply. Prior authorization may be required.	Part B drugs (other than Part B insulin): You'll pay the lesser of **40%** 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 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 **$2,000.**		

Part D Prescription Drug Benefits

	Essence Advantage (HMO)	Essence Advantage Choice (PPO)
Deductible	**Both Plans** **$295** Per calendar year (applies for tiers 3–5 only) You must meet this deductible before standard cost-sharing will apply.	

	Essence Advantage (HMO)			Essence Advantage Choice (PPO)		
Initial Coverage	**Both Plans** You pay the amounts listed in the following tables until your total Part D out-of-pocket costs reach **$2,000**. 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.					
Preferred Retail Cost-Sharing	**30-Day Supply**	**60-Day Supply**	**90-Day Supply**	**30-Day Supply**	**60-Day Supply**	**90-Day Supply**
Tier 1 *(Preferred Generic)*	**$0** Copay	**$0** Copay	**$0** Copay	**$0** Copay	**$0** Copay	**$0** Copay
Tier 2 *(Generic)*	**$3** Copay	**$6** Copay	**$9** Copay	**$3** Copay	**$6** Copay	**$9** Copay
Tier 3 *(Preferred Brand)*	**$42** Copay	**$84** Copay	**$126** Copay	**$47** Copay	**$94** Copay	**$141** Copay
Tier 4 *(Non-Preferred Brand)*	**$95** Copay	**$190** Copay	**$285** Copay	**46%** Coinsurance	**46%** Coinsurance	**46%** Coinsurance
Tier 5 *(Specialty Drug)*	**29%** Coinsurance	**Not offered**		**29%** Coinsurance	**Not offered**	
Tier 6 *(Insulins)*	**$0** Copay	**$0** Copay	**$0** Copay	Tier 6 not offered. Insulins covered under tiers 1–5.		
Standard Retail Cost-Sharing	**30-Day Supply**	**60-Day Supply**	**90-Day Supply**	**30-Day Supply**	**60-Day Supply**	**90-Day Supply**
Tier 1 *(Preferred Generic)*	**$5** Copay	**$10** Copay	**$15** Copay	**$4** Copay	**$8** Copay	**$12** Copay
Tier 2 *(Generic)*	**$10** Copay	**$20** Copay	**$30** Copay	**$12** Copay	**$24** Copay	**$36** Copay
Tier 3 *(Preferred Brand)*	**$47** Copay	**$94** Copay	**$141** Copay	**$47** Copay	**$94** Copay	**$141** Copay
Tier 4 *(Non-Preferred Brand)*	**$100** Copay	**$200** Copay	**$300** Copay	**46%** Coinsurance	**46%** Coinsurance	**46%** Coinsurance
Tier 5 *(Specialty Drug)*	**29%** Coinsurance	**Not offered**		**29%** Coinsurance	**Not offered**	
Tier 6 *(Insulins)*	**$0** Copay	**$0** Copay	**$0** Copay	Tier 6 not offered. Insulins covered under tiers 1–5.		

	Essence Advantage (HMO)			Essence Advantage Choice (PPO)		
Standard Mail-Order Cost-Sharing	**30-Day Supply**	**60-Day Supply**	**90-Day Supply**	**30-Day Supply**	**60-Day Supply**	**90-Day Supply**
Tier 1 *(Preferred Generic)*	**Not offered**		**$0** Copay	**Not offered**		**$0** Copay
Tier 2 *(Generic)*	**Not offered**		**$7.50** Copay	**Not offered**		**$7.50** Copay
Tier 3 *(Preferred Brand)*	**Not offered**		**$105** Copay	**Not offered**		**$117.50** Copay
Tier 4 *(Non-Preferred Brand)*	**Not offered**		**$237.50** Copay	**Not offered**		**46%** Coinsurance
Tier 5 *(Specialty Drug)*	**29%** Coinsurance	**Not offered**		**29%** Coinsurance	**Not offered**	
Tier 6 *(Insulins)*	**Not offered**		**$0** Copay	Tier 6 not offered. Insulins covered under tiers 1–5.		
Out-of-Network Cost-Sharing	**30-Day Supply**	**60-Day Supply**	**90-Day Supply**	**30-Day Supply**	**60-Day Supply**	**90-Day Supply**
Tier 1 *(Preferred Generic)*	**$5** Co5ay	**Not offered**		**$4** Copay	**Not offered**	
Tier 2 *(Generic)*	**$10** Copay	**Not offered**		**$12** Copay	**Not offered**	
Tier 3 *(Preferred Brand)*	**$47** Copay	**Not offered**		**$47** Copay	**Not offered**	
Tier 4 *(Non-Preferred Brand)*	**$100** Copay	**Not offered**		**46%** Coinsurance	**Not offered**	
Tier 5 *(Specialty Drug)*	**29%** Coinsurance	**Not offered**		**29%** Coinsurance	**Not offered**	
Tier 6 *(Insulins)*	**$0** Copay	**Not offered**		Tier 6 not offered. Insulins covered under tiers 1–5.		
Catastrophic Coverage	**Both Plans** After your yearly out-of-pocket drug costs reach **$2,000,** you pay **$0** for all covered Part D drugs.					

Cost-sharing may change depending on the pharmacy you choose.

Other Covered Benefits

	Essence Advantage (HMO)	Essence Advantage Choice (PPO) In-Network	Essence Advantage Choice (PPO) Out-of-Network
Acupuncture	Medicare-covered services (chronic low back pain), up to 20 visits per calendar year: **$20** copay per visit	Medicare-covered services (chronic low back pain), up to 20 visits per calendar year: **$30** copay per visit	
	Both Plans For details on a **shared allowance** that can be used on medical copays, see the Flexible Benefits Card section on page **16.**		
Chiropractic Care	**Both Plans** Manual manipulation of the spine to correct subluxation: **$20** copay For details on a **shared allowance** that can be used on medical copays, see the Flexible Benefits Card section on page **16.**		
Diabetes Supplies and Services	**Both Plans** Diabetes self-management training: **$0** copay Diabetes monitoring supplies (including blood glucose monitors, lancets and blood glucose test strips*): **$0** copay When glucose meters and test strips are obtained at a pharmacy, coverage is limited to specific LifeScan and Abbott products. Diabetic therapeutic custom-molded shoes or inserts: **20%** coinsurance *See Evidence of Coverage for a complete listing.		
	Authorization is required for some items (e.g., diabetic custom-molded shoes and inserts, continuous glucose meters, insulin pumps).	Authorization is required for some items (e.g., diabetic custom-molded shoes and inserts, continuous glucose meters, insulin pumps).	
Durable Medical Equipment *(wheelchairs, oxygen, etc.)*	**20%** Coinsurance Prior authorization may be required.	**20%** Coinsurance Prior authorization may be required.	**40%** Coinsurance

	Essence Advantage (HMO)	Essence Advantage Choice (PPO) In-Network	Essence Advantage Choice (PPO) Out-of-Network
Flexible Benefits Card	**$500** Shared annual credit for certain medical copays and certain non-Medicare-covered dental, vision and hearing products and services	**$1,340** Shared annual credit for certain medical copays and certain non-Medicare-covered dental, vision and hearing products and services	
	Notes Members will receive one debit card, supplied by WEX. For dental, vision and hearing, the following are some examples of approved items and services (not a complete list): dental X-rays, fillings, crowns, eyewear, hearing aids, routine vision and hearing exams). For medical copays, the following Medicare-covered categories are allowed: doctor/provider visits (including telehealth, occupational, speech and physical therapy, substance abuse, mental health sessions, podiatry), urgent care, diagnostic services (such as labs, X-rays, CT scans, MRIs and therapeutic radiology) and dental, eye exam, acupuncture and chiropractic visits. The credit is applied annually at the start of membership. 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. For medical copay coverage: HMO plan members must use in-network providers; PPO members may use in- or out-of-network providers. The Flex Card isn't a credit card. It can't be converted to cash or used to pay plan premiums or for non-covered Flex Card services. For more information, please see the Evidence of Coverage.		
Foot Care *(podiatry services)*	**$20** Copay	**$30** Copay	**$30** Copay
	Both Plans For details on a **shared allowance** that can be used on medical copays, see the Flexible Benefits Card section on page **16.**		
Home Healthcare	**$0** Copay A referral is required.	**$0** Copay Prior authorization is required.	**40%** Coinsurance
Hospice	**Both Plans** When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not Essence Healthcare.		

	Essence Advantage (HMO)	Essence Advantage Choice (PPO) In-Network	Essence Advantage Choice (PPO) Out-of-Network
Outpatient Substance Abuse	**Both Plans** Individual visit: **$15** copay Group visit: **$10** copay		
	Prior authorization may be required.	Prior authorization may be required.	
	Both Plans For details on a **shared allowance** that can be used on medical copays, see the Flexible Benefits Card section on page **16.**		
Outpatient Rehabilitation Services	**Both Plans** Cardiac and pulmonary rehabilitation services: **$20** copay per day Occupational and speech therapy visits: **$40** copay A separate copayment for occupational therapy will apply if other outpatient therapy services are rendered on the same day.		
	A referral is required.	Prior authorization may be required.	
	Both Plans For details on a **shared allowance** that can be used on medical copays, see the Flexible Benefits Card section on page **16.**		
Over-the-Counter (OTC) Coverage	**$50** 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 16 for other Flex-Card-eligible benefits. Eligible OTC items include pain relievers, vitamins, first aid products and more.	Not covered	

	Essence Advantage (HMO)	Essence Advantage Choice (PPO) In-Network	Essence Advantage Choice (PPO) Out-of-Network
Over-the-Counter (OTC) Coverage *(continued)*	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	**Both Plans** Prosthetic devices: **20%** coinsurance Related medical supplies: **20%** coinsurance		
	Prior authorization may be required.	Prior authorization may be required.	
Virtual/ Telehealth Visits	**$0–$40** Copay You'll pay the same copay for the virtual/telehealth visit as if the services were received in the provider's office. A referral or authorization may be required (matches requirement for in-person visits).	**$0–$40** Copay You'll pay the same copay for the virtual/telehealth visit as if the services were received in the provider's office. Prior authorization may be required (matches requirement for in-person visits).	**$10–$40** Copay You'll pay the same copay for the virtual/telehealth visit as if the services were received in the provider's office.
	Both Plans For details on a **shared allowance** that can be used on medical copays, see the Flexible Benefits Card section on page **16.**		
Wellness Programs	**Both Plans** Health club membership/fitness classes through SilverSneakers®: **$0** copay		
		Oura Ring wellness tracker and Oura App membership. For more information, see the Evidence of Coverage.	

Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at 1-866-314-0911 (TTY: 711).

Understanding the Benefits

- [ ] The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs and benefits before you enroll. Visit EssenceHealthcare.com or call 1-866-314-0911 (TTY: 711) to view a copy of the EOC.
- [ ] Review the Provider Directory (or ask your doctor) to make sure the doctors you see now are in the network. See Understanding Important Rules for information regarding the rules for seeing providers outside of our network.
- [ ] Review the Provider Directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- [ ] Review the formulary to make sure your drugs are covered.

Understanding Important Rules

- [ ] In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- [ ] Benefits, premiums and/or copayments/coinsurance may change on January 1, 2026.
- [ ] 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.

Notice Of Availability of Language Assistance Services

English - ATTENTION: If you speak [insert language], free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-866-597-9560 (TTY: 711) or speak to your provider.

Español (Spanish) - ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-866-597-9560 (TTY: 711) o hable con su proveedor.

中文 (Simplified Chinese) - 如果您说[中文]，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 1-866-597-9560（文本电话：711）或咨询您的服务提供商。

中文 (Traditional Chinese) - 注意：如果您說[中文]，我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務，以無障礙格式提供資訊。請致電 1-866-597-9560（TTY：711）或與您的提供者討論。

العربية (Arabic) - تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 1-866-597-9560 (711) أو تحدث إلى مقدم الخدمة".

Polski (Polish) - UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 1-866-597-9560 (TTY: 711) lub porozmawiaj ze swoim dostawcą.

ထၢးနှာ်လီၤဖဲအံၤ (Karen) - ဆူ– နမ့ၢ်ကတိၤ ထၢးနှာ်လီၤဖဲအံၤ အဃိ, တၢ်အိဉ်ဒီး ကျိာ်တၢ်ဆီဉ်ထွဲမၤစၢၤ လၢတလၢာ် ဘူဉ်လာ်စ့ၤလၢနဂီၢ်လီၤ. တၢ်အိဉ်ဒီး တၢ်မၤစၢၤတၢ်နၢ်ဟူပီးလိဒီး တၢ်မၤစၢၤတၢ်မၤ လၢအ ကြၢးအဘဉ် လၢကဟ့ဉ်တၢ်ဂ့ၢ်တၢ်ကျိၤ လၢတၢ်မၤန့ၢ်အီၤသ့တဖဉ် လၢတလာ်ဘူဉ်လာ်စ့ၤ လၢနဂီၢ်လီၤ. ကိး 1-866-597-9560 (TTY: 711) မ့တမ့ၢ် ကတိၤတၢ်ဒီး နပှၤလၢဟ့ဉ် နၤတၢ်ကွၢ်ထွဲမၤစၢၤတက့ၢ်.

မြန်မာ (Burmese) - သတိပြုရန်- သင်က မြန်မာဘာသာစကား ပြောဆိုပါက၊ အခမဲ့ ဘာသာစကားအကူအညီ ဝန်ဆောင်မှုများကို ရနိုင်ပါသည်။ အသုံးပြုနိုင်သော ဖော်မတ်များဖြင့် အချက်အလက်များ ဖော်ပြပေးရန် သင့်လျော်သော အရန်အကူအညီများနှင့် ဝန်ဆောင်မှုများကိုလည်း အခမဲ့ ရရှိနိုင်ပါသည်။ 1-866-597-9560 (TTY: 711) သို့ဖုန်းခေါ်ပါ သို့မဟုတ် သင်၏ ဆောင်ရွက်ပေးသူနှင့် စကားပြောပါ။

Việt (Vietnamese) - LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-866-597-9560 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.

ESSENCE HEALTHCARE

ייִדיש (Yiddish) - נאטיץ: אויב איר רעדט ייִדיש, שפּראַך הילף סערוויסעס זענען בארעבטיגט פאר דיר פריי. צונעמען אַידס און באַדינונגס פֿאַר פּראַוווידינג אינפֿאָרמאַציע אין צוטריטלעך פֿאָרמאַטירונגען זענען אויך בנימצא פריי. רופן 1-866-597-9560 (TTY: 711) אָדער רעדן מיט דיין טרעגער.

Nederlands (Dutch) - LET OP: als je Nederlands spreekt, zijn er gratis taalhulpdiensten voor je beschikbaar. Passende hulpmiddelen en diensten om informatie in toegankelijke formaten te verstrekken, zijn ook gratis beschikbaar. Bel 1-866-597-9560 (TTY: 711) of spreek met je provider.

Français (French) - ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-866-597-9560 (TTY : 711) ou parlez à votre fournisseur.

Tagalog - Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-866-597-9560 (TTY: 711) o makipag-usap sa iyong provider.

한국어 (Korean) - 주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-866-597-9560 (TTY: 711)번으로 전화하거나 서비스 제공업체에 문의하십시오.

РУССКИЙ (Russian) - ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-866-597-9560 (TTY: 711) или обратитесь к своему поставщику услуг.

українська мова (Ukrainian) - УВАГА: Якщо ви розмовляєте українська мова, вам доступні безкоштовні мовні послуги. Відповідні допоміжні засоби та послуги для надання інформації у доступних форматах також доступні безкоштовно. Зателефонуйте за номером 1-866-597-9560 (TTY: 711) або зверніться до свого постачальника.

Deutsch (German) - ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-866-597-9560 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.

नेपाली (Nepali) - सावधान: यदि तपाईं नेपाली भाषा बोल्नुहुन्छ भने तपाईंका लागि निःशुल्क भाषिक सहायता सेवाहरू उपलब्ध छन्। पहुँचयोग्य ढाँचाहरूमा जानकारी प्रदान गर्न उपयुक्त सहायता र सेवाहरू पनि निःशुल्क उपलब्ध छन्। 1-866-597-9560 (TTY: 711) मा फोन गर्नुहोस् वा आफ्नो प्रदायकसँग कुरा गर्नुहोस्।

Bosanski (Bosnian) - PAŽNJA: Ako govorite bosanski, dostupne su vam besplatne jezičke usluge. Odgovarajuća pomagala i usluge za pružanje informacija u pristupačnim formatima takođe se pružaju besplatno. Pozovite 1-866-597-9560 (TTY: 711) ili kontaktirajte svog pružatelja usluga.

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

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

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