

Annual Notice of Change

MEDICARE ADVANTAGE | 2027

ESSENCE ADVANTAGE® CHOICE PLUS (PPO)

ESSENCE HEALTHCARE®

Serving the Greater Chicago area

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

Annual Notice of Change for 2027

You're enrolled as a member of Essence Advantage Choice Plus (PPO).

This material describes changes to our plan's costs and benefits next year.

- **You have from October 15 – December 7 to make changes to your Medicare coverage for next year.** If you don't join another plan by December 7, 2026, you'll stay in Essence Advantage Choice Plus.
- To change to a **different plan**, visit Medicare.gov or review the list in the back of your *Medicare & You 2027* handbook.
- Note this is only a summary of changes. More information about costs, benefits, and rules is in the *Evidence of Coverage*. Get a copy at MyEssenceHealthcare.com or call Customer Service at 1-866-597-9560 (TTY users call 711) to get a copy by mail.

More Resources

- This material is available for free in Spanish.
- Call Customer Service at 1-866-597-9560 (TTY users call 711) for more information. 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.

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 material says "we," "us," or "our," it means Essence Healthcare PPO, Inc. When it says "plan" or "our plan," it means Essence Advantage Choice Plus.
- **If you do nothing by December 7, 2026, you'll automatically be enrolled in Essence Advantage Choice Plus.** Starting January 1, 2027, you'll get your medical and drug coverage through Essence Advantage Choice Plus. Go to Section 3 for more information about how to change plans and deadlines for making a change.

Table of Contents

Summary of Important Costs for 2027 3

SECTION 1 Changes to Benefits & Costs for Next Year 6
Section 1.1 Changes to the Monthly Plan Premium 6
Section 1.2 Changes to Your Maximum Out-of-Pocket Amount 7
Section 1.3 Changes to the Provider/Pharmacy Network 8
Section 1.4 Changes to Benefits & Costs for Medical Services 9
Section 1.5 Changes to Part D Drug Coverage 14
Section 1.6 Changes to Prescription Drug Benefits & Costs 15

SECTION 2 Administrative Changes 21

SECTION 3 How to Change Plans 21
Section 3.1 Deadlines for Changing Plans 22
Section 3.2 Are there other times of the year to make a change? 22

SECTION 4 Get Help Paying for Prescription Drugs 22

SECTION 5 Questions? 23
Get Help from Essence Advantage Choice Plus 23
Get Free Counseling about Medicare 24
Get Help from Medicare 24

Summary of Important Costs for 2027

	2026 (this year)	2027 (next year)
Monthly plan premium* * Your premium can be higher or lower than this amount. Go to Section 1.1 for details.	$49	$49
Maximum out-of-pocket amount This is the most you'll pay out of pocket for covered Part A and Part B services. (Go to Section 1.2 for details.)	From network providers: $4,150 From network and out-of-network providers combined: $6,150	From network providers: $6,700 From network and out-of-network providers combined: $10,000
Primary care office visits	**In-Network** $0 per visit **Out-of-Network** $50 per visit	**In-Network** $0 per visit **Out-of-Network** $50 per visit
Specialist office visits	**In-Network** $25 per visit **Out-of-Network** 50% coinsurance per visit	**In-Network** $25 per visit **Out-of-Network** 50% coinsurance per visit
Inpatient hospital stays Includes various inpatient hospital stays such as acute care, rehabilitation and long-term care. An inpatient hospital stay starts the day you're formally admitted with a doctor's order and ends the day before you're discharged.	**In-Network** $295 copay per day, per stay: Days 1-7 $0 copay per day, per stay: Days 8-90 50% coinsurance: Days 91 and beyond **Out-of-Network** 50% coinsurance of the total cost	**In-Network** $350 copay per day, per stay: Days 1-7 $0 copay per day, per stay: Days 8-90 50% coinsurance: Days 91 and beyond **Out-of-Network** 50% coinsurance of the total cost

	2026 (this year)	2027 (next year)
Part D drug coverage (Go to Section 1.6 for details, including Yearly Deductible, Initial Coverage, and Catastrophic Coverage Stages.)	**Part D drug coverage deductible** $0 **Copays/Coinsurance** during the Initial Coverage Stage: **Preferred Pharmacy 30-day Supply** **Drug Tier 1:** $0 copay, including a month supply of each covered insulin product on this tier. **Drug Tier 2:** $5 copay, including a month supply of each covered insulin product on this tier. **Drug Tier 3:** $47 copay You pay no more than $35 per month supply of each covered insulin product on this tier. **Drug Tier 4:** 50% coinsurance You pay no more than $35 per month supply of each covered insulin product on this tier.	**Part D drug coverage deductible** $700 (Tiers 3-5) except for covered insulin products and most adult Part D vaccines **Copays/Coinsurance** during the Initial Coverage Stage: **Preferred Pharmacy 30-day Supply** **Drug Tier 1:** $0 copay, including a month supply of each covered insulin product on this tier. **Drug Tier 2:** $5 copay, including a month supply of each covered insulin product on this tier. **Drug Tier 3:** 25% coinsurance You pay no more than $35 per month supply of each covered insulin product on this tier. **Drug Tier 4:** 25% coinsurance You pay no more than $35 per month supply of each covered insulin product on this tier.

	2026 (this year)	2027 (next year)
Part D drug coverage (continued)	**Drug Tier 5:** 33% coinsurance You pay no more than $35 per month supply of each covered insulin product on this tier. **Standard Pharmacy 30-day Supply** **Drug Tier 1:** $4 copay, including a month supply of each covered insulin product on this tier. **Drug Tier 2:** $12 copay, including a month supply of each covered insulin product on this tier. **Drug Tier 3:** $47 copay You pay no more than $35 per month supply of each covered insulin product on this tier. **Drug Tier 4:** 50% coinsurance You pay no more than $35 per month supply of each covered insulin product on this tier. **Drug Tier 5:** 33% coinsurance You pay no more than $35 per month supply of each covered insulin product on this tier.	**Drug Tier 5:** 25% coinsurance You pay no more than $35 per month supply of each covered insulin product on this tier. **Standard Pharmacy 30-day Supply** **Drug Tier 1:** $4 copay, including a month supply of each covered insulin product on this tier. **Drug Tier 2:** $15 copay, including a month supply of each covered insulin product on this tier. **Drug Tier 3:** 25% coinsurance You pay no more than $35 per month supply of each covered insulin product on this tier. **Drug Tier 4:** 25% coinsurance You pay no more than $35 per month supply of each covered insulin product on this tier. **Drug Tier 5:** 25% coinsurance You pay no more than $35 per month supply of each covered insulin product on this tier.

	2026 (this year)	2027 (next year)
Part D drug coverage (continued)	**Catastrophic Coverage Stage:** During this payment stage, you pay nothing for your covered Part D drugs. You can have cost-sharing for drugs that are covered under our enhanced benefit.	**Catastrophic Coverage Stage:** During this payment stage, you pay nothing for your covered Part D drugs. You can have cost-sharing for drugs that are covered under our enhanced benefit.

SECTION 1 Changes to Benefits & Costs for Next Year

Section 1.1 Changes to the Monthly Plan Premium

	2026 (this year)	2027 (next year)
Monthly plan premium (You must also continue to pay your Medicare Part B premium.) There is no change for the upcoming benefit year.	$49	$49

Factors that could change your Part D Premium Amount

- Late Enrollment Penalty - Your monthly plan premium will be *more* if you're required to pay a lifetime Part D late enrollment penalty for going without Part D or other drug coverage that's at least as good as Medicare drug coverage (also referred to as creditable coverage) for 63 days or more.
- Higher Income Surcharge - If you have a higher income, you may have to pay an additional amount each month directly to the government for Medicare drug coverage.
- Extra Help - Your monthly plan premium will be *less* if you get Extra Help with your drug costs. Go to Section 3 for more information about Extra Help from Medicare.

Section 1.2 Changes to Your Maximum Out-of-Pocket Amount

Medicare requires all health plans to limit how much you pay out of pocket for the year. This limit is called the maximum out-of-pocket amount. Once you've paid this amount, you generally pay nothing for covered Part A and Part B services for the rest of the calendar year. For more information on which services count towards your maximum out-of-pocket see Chapter 4 of your Evidence of Coverage.

	2026 (this year)	2027 (next year)
In-network maximum out-of-pocket amount 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 costs for prescription drugs **don't count** toward your maximum out-of-pocket amount.	$4,150	$6,700 Once you've paid $6,700 out of pocket for covered Part A and Part B services, you'll 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 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 **don't count** toward your maximum out-of-pocket amount for medical services.	$6,150	$10,000 Once you've paid $10,000 out of pocket for covered Part A and Part B services, you'll 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/Pharmacy Network

Our network of providers has changed for next year. Review the 2027 *Provider/Pharmacy Directory* (located on our website at MyEssenceHealthcare.com) to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network. Here's how to get an updated *Provider/Pharmacy Directory*:

- Visit our website at MyEssenceHealthcare.com.
- Call Customer Service at 1-866-597-9560 (TTY users call 711) to get current provider information or to ask us to mail you a *Provider/Pharmacy Directory*.

We can make changes to the hospitals, doctors, and specialists (providers) that are part of our plan during the year. If a mid-year change in our providers affects you, call Customer Service at 1-866-597-9560 (TTY users call 711) for help. You may have a special enrollment period if your provider leaves the plan network.

Amounts you pay for your prescription drugs can depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered *only* if they are filled at one of our network pharmacies. Our network includes pharmacies with preferred cost-sharing, which may offer you lower cost-sharing than the standard cost-sharing offered by other network pharmacies for some drugs.

Our network of pharmacies has changed for next year. Review the 2027 *Provider/Pharmacy Directory* (located on our website at MyEssenceHealthcare.com) to see which pharmacies are in our network. Here's how to get an updated *Provider/Pharmacy Directory*:

- Visit our website at MyEssenceHealthcare.com.
- Call Customer Service at 1-866-597-9560 (TTY users call 711) to get current pharmacy information or to ask us to mail you a *Provider/Pharmacy Directory*.

We can make changes to the pharmacies that are part of our plan during the year. If a mid-year change in our pharmacies affects you, call Customer Service at 1-866-597-9560 (TTY users call 711) for help.

Section 1.4 Changes to Benefits & Costs for Medical Services

	2026 (this year)	2027 (next year)
Ambulance services	**In-Network** $275 copay for Medicare-covered air ambulance benefits. **Out-of-Network** $275 copay for Medicare-covered air ambulance benefits.	**In-Network** 20% coinsurance of the total cost for each Medicare-covered air ambulance service. **Out-of-Network** 20% coinsurance of the total cost for each Medicare-covered air ambulance service.
Cardiac rehabilitation services	**In-Network** Prior authorization is required for Medicare-covered cardiac rehabilitation services and intensive cardiac rehabilitation services.	**In-Network** Prior authorization is not required for Medicare-covered cardiac rehabilitation services and intensive cardiac rehabilitation services.
Chiropractic services	**In-Network** $20 copay for each Medicare-covered chiropractic visit.	**In-Network** $15 copay for each Medicare-covered chiropractic visit.
Emergency care	$150 copay for Medicare-covered emergency care within the U.S. $150 copay for emergency care outside the U.S.	$115 copay for Medicare-covered emergency care within the U.S. $115 copay for emergency care outside the U.S.

	2026 (this year)	2027 (next year)
Flexible benefit card	There is an annual credit of $2,500 via the Flexible Benefit Card that may be used for non-Medicare-covered (routine) services across the categories of dental, hearing, and vision.	There is an annual credit of $1,900 via the Flexible Benefit Card that may be used for non-Medicare-covered (routine) services across the categories of dental, hearing, and vision.
Health and wellness education programs	**Out-of-Network** There is no coinsurance, copay, or deductible for health and wellness education programs through Silver Sneakers®.	**Out-of-Network** 50% coinsurance with a maximum annual plan benefit of $100 per calendar year. After this maximum plan benefit limit is exhausted, you are responsible for 100% of the remaining costs.
	In-Network and Out-of-Network Oura Ring (member will receive one wearable device at no cost) and Oura Membership will be covered by the plan for as long as the member remains in the plan or the end of the calendar year, whichever comes first. Order limited to Oura Ring 4 in Silver, Brushed Silver, Black, Stealth, Gold or Rose Gold finishes. Eligible for one Oura Ring every two calendar years (one device every other calendar year).	**In-Network and Out-of-Network** Oura Ring and services is not covered.

	2026 (this year)	2027 (next year)
Home health agency care	**In-Network** Prior authorization is required.	**In-Network** Prior authorization is not required.
Inpatient hospital care	**In-Network** $295 copay per day, per stay: Days 1-7. $0 copay per day, per stay: Days 8-90. 50% coinsurance: Days 91 and beyond.	**In-Network** $350 copay per day, per stay: Days 1-7. $0 copay per day, per stay: Days 8-90. 50% coinsurance: Days 91 and beyond.
Inpatient services in a psychiatric hospital	**In-Network** $295 copay per day, per stay: Days 1-7. $0 copay per day, per stay: Days 8 and beyond.	**In-Network** $298 copay per day, per stay: Days 1-7. $0 copay per day, per stay: Days 8 and beyond.
Opioid treatment program services	**In-Network** $15 copay per visit for Medicare-covered opioid treatment program services.	**In-Network** $25 copay per visit for Medicare-covered opioid treatment program services.
Outpatient diagnostic tests and therapeutic services and supplies	**In-Network** Prior authorization is not required for Medicare-covered diagnostic radiology services. Prior authorization is not required for Medicare-covered x-rays.	**In-Network** Prior authorization is required for Medicare-covered diagnostic radiology services. Prior authorization is required for Medicare-covered x-rays.
Outpatient mental health care	**In-Network** $15 copay for each Medicare-covered outpatient mental health care individual visit.	**In-Network** $25 copay for each Medicare-covered outpatient mental health care individual visit.

	2026 (this year)	2027 (next year)
Outpatient mental health care (continued)	**In-Network (continued)** $10 copay for each Medicare-covered outpatient mental health care group session.	**In-Network (continued)** $20 copay for each Medicare-covered outpatient mental health care group session.
Outpatient rehabilitation services	**In-Network** $40 copay for each Medicare-covered occupational therapy visit. $40 copay for each Medicare-covered physical therapy and/or speech and language pathology visit.	**In-Network** $35 copay for each Medicare-covered occupational therapy visit. $35 copay for each Medicare-covered physical therapy and/or speech and language pathology visit.
Outpatient substance use disorder services	**In-Network** $15 copay for each Medicare-covered outpatient substance use disorder individual visit. $10 copay for each Medicare-covered outpatient substance use disorder group visit.	**In-Network** $25 copay for each Medicare-covered outpatient substance use disorder individual visit. $20 copay for each Medicare-covered outpatient substance use disorder group visit.
Over-the-counter items	There is a quarterly credit of $40 via the Flexible Benefit Card that may be used for over-the-counter items only.	There is a quarterly credit of $20 via the Flexible Benefit Card that may be used for over-the-counter items only. The quarterly OTC credit is separate from the Flexible benefit card combined credit. Unused balance will not carry over quarter-to-quarter and expires at the end of the year.

	2026 (this year)	2027 (next year)
Pulmonary rehabilitation services	**In-Network** Prior authorization is required for Medicare-covered pulmonary rehabilitation services.	**In-Network** Prior authorization is not required for Medicare-covered pulmonary rehabilitation services.
Skilled nursing facility (SNF) care	**In-Network** $20 copay per day, per stay: Days 1-20. $203 copay per day, per stay: Days 21-100.	**In-Network** $0 copay per day, per stay: Days 1-20. $220 copay per day, per stay: Days 21-100.
Supervised exercise therapy (SET)	**In-Network** Prior authorization is required for Medicare-covered Supervised exercise therapy (SET) services.	**In-Network** Prior authorization is not required for Medicare-covered Supervised exercise therapy (SET) services.
Urgently needed services	$45 copay for Medicare-covered urgently needed care within the U.S. $150 copay for urgently needed care outside the U.S.	$40 copay for Medicare-covered urgently needed care within the U.S. $115 copay for urgently needed care outside the U.S.
Vision care	**Routine vision care** The maximum plan allowance for routine eyewear is $200 every calendar year (allowance can be used in-network or out-of-network).	**Routine vision care** The maximum plan allowance for routine eyewear is $175 every calendar year (allowance can be used in-network or out-of-network).

Section 1.5 Changes to Part D 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 posted online at MyEssenceHealthcare.com.

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, we might make other changes that are allowed by Medicare rules that will affect you during the calendar year. We update our online Drug List at least monthly to provide the most up-to-date list of drugs. If we make a change that will affect your access to a drug you're taking, we'll send you a notice about the change.

If you're affected by a change in drug coverage at the beginning of the year or during the year, review Chapter 9 of your *Evidence of Coverage* and talk to your prescriber to find out your options, such as asking for a temporary supply, applying for an exception, and/or working to find a new drug. Call Customer Service at 1-866-597-9560 (TTY users call 711) for more information.

Section 1.6 Changes to Prescription Drug Benefits & Costs

Do you get Extra Help to pay for your drug coverage costs?

If you're in a program that helps pay for your drugs (Extra Help), **the information about costs for Part D drugs may not apply to you**. We sent you a separate material, called the *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs*, which tells you about your drug costs. If you get Extra Help and you don't get this material by October 15, 2026, call Customer Service at 1-866-597-9560 (TTY users call 711) and ask for the *LIS Rider*.

Drug Payment Stages

There are **3 drug payment stages:** the Yearly Deductible Stage, the Initial Coverage Stage, and the Catastrophic Coverage Stage.

- ***Stage 1: Yearly Deductible***

  You start in this payment stage each calendar year. During this stage, you pay the full cost of your Tier 3 (Preferred Brand), Tier 4 (Non-Preferred Drug) and Tier 5 (Specialty) drugs until you reach the yearly deductible.

- ***Stage 2: Initial Coverage***

  Once you pay the yearly deductible, you move to the Initial Coverage Stage. In this stage, our plan pays its share of the cost of your drugs, and you pay your share of the cost. You generally stay in this stage until your year-to-date Out-of-Pocket costs reach $2,400.

- ***Stage 3: Catastrophic Coverage***

  This is the third and final drug payment stage. In this stage, you pay nothing for your covered Part D drugs. You may have cost-sharing for drugs that are covered under our enhanced benefit. You generally stay in this stage for the rest of the calendar year.

Drug Costs in Stage 1: Yearly Deductible

The table shows your cost per prescription during this stage.

	2026 (this year)	2027 (next year)
Yearly Deductible	Because we have no deductible, this payment stage doesn't apply to you.	$700 **Standard cost-sharing** During this stage, you pay a $4 copay for a one-month supply for drugs on Tier 1 (Preferred Generic), a $15 copay for a one-month supply for drugs on Tier 2 (Generic), and the full cost of drugs on Tier 3 (Preferred Brand), Tier 4 (Non-Preferred Drug) and Tier 5 (Specialty) until you've reached the yearly deductible. **Preferred cost-sharing** During this stage, you pay a $0 copay for a one-month supply for drugs on Tier 1 (Preferred Generic), a $5 copay for a one-month supply for drugs on Tier 2 (Generic), and the full cost of drugs on Tier 3 (Preferred Brand), Tier 4 (Non-Preferred Drug) and Tier 5 (Specialty) until you've reached the yearly deductible.

Drug Costs in Stage 2: Initial Coverage

For drugs on Tier 3 (Preferred Brand), your Standard and Preferred cost-sharing in the Initial Coverage Stage is changing from a copay to coinsurance. Go to the following table for the changes from 2026 to 2027.

The table shows your cost per prescription for a one-month (30-day) supply filled at a network pharmacy with standard and preferred cost-sharing.

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. Most adult Part D vaccines are covered at no cost to you. For more information about the costs of vaccines, or information about the costs for a long-term supply or for mail-order prescriptions, go to Chapter 6 of your *Evidence of Coverage*.

Once you've paid $2,400 out of pocket for covered Part D drugs, you'll move to the next stage (the Catastrophic Coverage Stage).

	2026 (this year)	**2027** **(next year)**
Preferred Generic Tier 1:	Your cost for a one-month (30-day) supply: **Standard cost-sharing:** You pay $4 per prescription, including a month supply of each covered insulin product on this tier. **Mail-order cost-sharing:** Your cost for a one-month mail-order prescription (including insulin) is $0. **Preferred cost-sharing:** You pay $0 per prescription, including a month supply of each covered insulin product on this tier.	Your cost for a one-month (30-day) supply: **Standard cost-sharing:** You pay $4 per prescription, including a month supply of each covered insulin product on this tier. **Mail-order cost-sharing:** Your cost for a one-month mail-order prescription (including insulin) is $0. **Preferred cost-sharing:** You pay $0 per prescription, including a month supply of each covered insulin product on this tier.

	2026 (this year)	2027 (next year)
Generic Tier 2:	Your cost for a one-month (30-day) supply: **Standard cost-sharing:** You pay $12 per prescription, including a month supply of each covered insulin product on this tier. **Mail-order cost-sharing:** Your cost for a one-month mail-order prescription (including insulin) is $5. **Preferred cost-sharing:** You pay $5 per prescription, including a month supply of each covered insulin product on this tier.	Your cost for a one-month (30-day) supply: **Standard cost-sharing:** You pay $15 per prescription, including a month supply of each covered insulin product on this tier. **Mail-order cost-sharing:** Your cost for a one-month mail-order prescription (including insulin) is $5. **Preferred cost-sharing:** You pay $5 per prescription, including a month supply of each covered insulin product on this tier.
Preferred Brand Tier 3:	Your cost for a one-month (30-day) supply: **Standard cost-sharing:** You pay $47 per prescription. You pay no more than $35 per month supply of each covered insulin product on this tier. **Mail-order cost-sharing:** Your cost for a one-month mail-order prescription is $47. You pay no more than $35 per month supply of each covered insulin product on this tier.	Your cost for a one-month (30-day) supply: **Standard cost-sharing:** You pay 25% of the total cost. You pay no more than $35 per month supply of each covered insulin product on this tier. **Mail-order cost-sharing:** Your cost for a one-month mail-order prescription is 25% of the total cost. You pay no more than $35 per month supply of each covered insulin product on this tier.

	2026 (this year)	2027 (next year)
Preferred Brand (continued) Tier 3:	**Preferred cost-sharing:** You pay $47 per prescription. You pay no more than $35 per month supply of each covered insulin product on this tier.	**Preferred cost-sharing:** You pay 25% of the total cost. You pay no more than $35 per month supply of each covered insulin product on this tier.
Non-Preferred Drug Tier 4:	Your cost for a one-month (30-day) supply: **Standard cost-sharing:** You pay 50% of the total cost. You pay no more than $35 per month supply of each covered insulin product on this tier. **Mail-order cost-sharing:** Your cost for a one-month mail-order prescription is 50% of the total cost. You pay no more than $35 per month supply of each covered insulin product on this tier. **Preferred cost-sharing:** You pay 50% of the total cost. You pay no more than $35 per month supply of each covered insulin product on this tier.	Your cost for a one-month (30-day) supply: **Standard cost-sharing:** You pay 25% of the total cost. You pay no more than $35 per month supply of each covered insulin product on this tier. **Mail-order cost-sharing:** Your cost for a one-month mail-order prescription is 25% of the total cost. You pay no more than $35 per month supply of each covered insulin product on this tier. **Preferred cost-sharing:** You pay 25% of the total cost. You pay no more than $35 per month supply of each covered insulin product on this tier.

	2026 (this year)	2027 (next year)
Specialty Tier 5:	Your cost for a one-month (30-day) supply **Standard cost-sharing:** You pay 33% of the total cost. You pay no more than $35 per month supply of each covered insulin product on this tier. **Mail-order cost-sharing:** Your cost for a one-month mail-order prescription is 33% of the total cost. You pay no more than $35 per month supply of each covered insulin product on this tier. **Preferred cost-sharing:** You pay 33% of the total cost. You pay no more than $35 per month supply of each covered insulin product on this tier.	Your cost for a one-month (30-day) supply **Standard cost-sharing:** You pay 25% of the total cost. You pay no more than $35 per month supply of each covered insulin product on this tier. **Mail-order cost-sharing:** Your cost for a one-month mail-order prescription is 25% of the total cost. You pay no more than $35 per one-month mail-order supply of each covered insulin product. **Preferred cost-sharing:** You pay 25% of the total cost. You pay no more than $35 per month supply of each covered insulin product on this tier.

SECTION 2 Administrative Changes

For plan year 2027, we made a change to our Member website URL. The table below describes that change. Please contact Customer Service for more information.

	2026 (this year)	2027 (next year)
Member website URL	Member website URL: EverythingEssence.com	Member website URL: MyEssenceHealthcare.com

SECTION 3 How to Change Plans

To stay in Essence Advantage Choice Plus, you don't need to do anything. Unless you sign up for a different type of Medicare health plan or change to Original Medicare by December 7, 2026, you'll automatically be enrolled in our Essence Advantage Choice Plus.

If you want to change plans for 2027, follow these steps:

- **To change to a different Medicare health plan**, enroll in the new plan. You'll be automatically disenrolled from Essence Advantage Choice Plus. Remember, not all Medicare health plans cover prescription drugs. Also, be aware that for many plans, you can't join a Medicare health plan and simultaneously purchase a prescription drug plan.
- **To change to Original Medicare with separate Medicare drug coverage,** you can enroll in a Part D plan, and you'll automatically be disenrolled from Essence Advantage Choice Plus.
- **To change to Original Medicare without a drug plan,** you can send us a written request to disenroll. Call Customer Service at 1-866-597-9560 (TTY users call 711) for more information on how to do this. Or call **Medicare** at 1-800-MEDICARE (1-800-633-4227) and ask to be disenrolled. TTY users can call 1-877-486-2048. If you don't enroll in a Medicare drug plan, you may pay a Part D late enrollment penalty (go to Section 1.1).
- **To learn more about Original Medicare and the different types of Medicare plans**, visit Medicare.gov, check the *Medicare & You 2027* handbook, call your State Health Insurance Assistance Program (go to Section 5), or call 1-800-MEDICARE (1-800-633-4227). As a reminder, Essence Healthcare PPO, Inc. offers other Medicare health plans. These other plans can have different coverage, monthly plan premiums, and cost-sharing amounts.

Section 3.1 Deadlines for Changing Plans

People with Medicare can make changes to their coverage from **October 15 – December 7** each year.

If you enrolled in a Medicare Advantage plan for January 1, 2027, and don't like your plan choice, you can switch to another Medicare health plan (with or without separate Medicare drug coverage) or switch to Original Medicare (with or without separate Medicare drug coverage) between January 1 – March 31, 2027.

Section 3.2 Are there other times of the year to make a change?

In certain situations, people can have other chances to change their coverage during the year. Examples include people who:

- Have Medicaid
- Get Extra Help paying for their drugs
- Have or are leaving employer coverage
- Move out of our plan's service area

If you recently moved into or currently live in, 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 (with or without separate Medicare drug coverage) or switch to Original Medicare (with or without separate Medicare drug coverage) at any time. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for 2 full months after the month you move out.

SECTION 4 Get Help Paying for Prescription Drugs

You can qualify for help paying for prescription drugs. Different kinds of help are available:

- **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 help pay for your drug costs including monthly drug plan premiums, yearly deductibles, and coinsurance. Also, people who qualify won't have a late enrollment penalty. To see if you qualify, call:
    - 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048, 24 hours a day, 7 days a week.
    - Social Security at 1-800-772-1213 between 8 a.m. and 7 p.m., Monday -Friday for a representative. Automated messages are available 24 hours a day. TTY users call 1-800-325-0778.
    - Your State Medicaid Office.

- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible people living with HIV/AIDS have access to life-saving HIV medications. To be eligible for the ADAP operating in your state, you 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 drugs that are also covered by ADAP qualify for prescription cost-sharing help through the Illinois Medication Assistance Program. For information on eligibility criteria, covered drugs, how to enroll in the program, or, if you're currently enrolled, how to continue getting help, call IL ADAP at 1-800-825-3518 (TTY: 1-800-547-0466). Be sure, when calling, to inform them of your Medicare Part D plan name or policy number.

- **The Medicare Prescription Payment Plan.** The Medicare Prescription Payment Plan is a payment option that works with your current drug coverage to help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across the calendar year (January – December). Anyone with a Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage plan with drug coverage) can use this payment option. If you're participating in the Medicare Prescription Payment Plan and stay in the same Part D plan, your participation will be automatically renewed for 2027 you do not need to submit a new election request to continue participating in 2027. **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs.**

  Extra Help from Medicare and help from your ADAP, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan. To learn more about this payment option, call us at 1-866-845-1803 (TTY users call 1-800-716-3231) or visit Medicare.gov.

SECTION 5 Questions?

Get Help from Essence Advantage Choice Plus

- **Call Customer Service at 1-866-597-9560. (TTY users call 711.)**

  We're 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 2027 *Evidence of Coverage***

  This *Annual Notice of Change* gives you a summary of changes in your benefits and costs for 2027. For details, go to the 2027 *Evidence of Coverage* for Essence Advantage Choice Plus. The *Evidence of Coverage* is the legal, detailed description of our plan

benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. Get the *Evidence of Coverage* on our website at MyEssenceHealthcare.com or call Customer Service at 1-866-597-9560 (TTY users call 711) to ask us to mail you a copy.

- **Visit MyEssenceHealthcare.com**

  Our website has the most up-to-date information about our provider network (*Provider/Pharmacy Directory*) and our *List of Covered Drugs* (formulary/Drug List).

Get Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is an independent government program with trained counselors in every state. In Illinois, the SHIP is called Senior Health Insurance Program.

Call Senior Health Insurance Program to get free personalized health insurance counseling. They can help you understand your Medicare plan choices and answer questions about switching plans. Call Senior Health Insurance Program at 1-800-252-8966 (TTY: 711). Learn more about Senior Health Insurance Program by visiting their website ILaging.Illinois.gov/SHIP.

Get Help 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 can call 1-877-486-2048.

- **Chat live with Medicare.gov**

  You can chat live at Medicare.gov/talk-to-someone.

- **Write to Medicare**

  You can write to Medicare at PO Box 1270, Lawrence, KS 66044

- **Visit Medicare.gov**

  The official Medicare website has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area.

- **Read *Medicare & You* 2027**

  The *Medicare & You 2027* handbook is mailed to people with Medicare every fall. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. Get a copy at Medicare.gov or by calling 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Notice Of Availability of Language Assistance Services

English - ATTENTION: If you speak a language other than English, 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 ကျိာ်တၢ်ဆိဉ်ထွဲမၤစၢၤလၢတလာ် ဘူဉ်လာ်စ့ၤလၢနဂီၢ်လီၤ. တၢ်အိဉ်ဒီး တၢ်မၤစၢၤတၢ်နၢ်ဟူပီးလီဒီး တၢ်မၤစၢၤတၢ်မၤ လၢအကြၢးအဘဉ် လၢကဟ့ဉ်တၢ်ဂ့ၢ်တၢ်ကျိၤ လၢတၢ်မၤနၤ့်အီၤသ့တဖဉ် လၢတလာ်ဘူဉ်လာ်စ့ၤ လၢနဂီၢ်လီၤ. ကိး 1-866-597-9560 (TTY: 711) မ့တမ့ၢ် ကတိၤတၢ်ဒီး နပ့ၤလၢဟ့ဉ် နၤတၢ်ကွၢ်ထွဲမၤစၢၤတက့ၢ်.

မြန်မာ (Burmese) - သတိပြုရန်- သင်က မြန်မာဘာသာစကား ပြောဆိုပါက၊ အခမဲ့ ဘာသာစကားအကူအညီ ဝန်ဆောင်မှုများကို ရရှိနိုင်ပါသည်။ 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.

ייִדיש (Yiddish) - נאטיץ: אויב איר רעדט יידיש, שפּראַך הילף סערוויסעס זענען בארעבטיגט פאר דיר פריי. צונעמען אַידס און באַדינונגס פֿאַר פּראַווייַדינג אינפֿאָרמאַציע אין צוטריטלעך פֿאָרמאַטירונגען זענען אויך בנימצא פריי. רופן 711 :TTY) 1-866-597-9560) 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 također se pružaju besplatno. Pozovite 1-866-597-9560 (TTY: 711) ili kontaktirajte svog pružatelja usluga.

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. Oura Ring is not a medical device and is not intended to diagnose, treat, cure, monitor, or prevent medical conditions or illnesses. Please do not make any changes to your medication, nutrition, or workouts without first consulting your doctor or another medical professional.

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®

P.O. Box 5907
Troy, MI 48007
MyEssenceHealthcare.com