Summary of Benefits

MEDICARE ADVANTAGE | 2023

ESSENCE ADVANTAGE® (HMO) – ESSENCE ADVANTAGE PLUS® (HMO) – ESSENCE ADVANTAGE SELECT® (HMO)

ESSENCE HEALTHCARE™

Serving St. Louis City, the Missouri counties of Crawford, Franklin, Jefferson, Lincoln, St. Charles, St. Louis and Warren, and the Illinois counties of Madison, Monroe and St. Clair

Summary of Benefits

January 1, 2023 – December 31, 2023

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, call us and ask for the Evidence of Coverage, or you can view it on EssenceHealthcare.com.

This Summary of Benefits booklet gives you a summary of what **Essence Advantage (HMO), Essence Advantage Plus (HMO)** and **Essence Advantage Select (HMO)** cover and what you pay.

- If you want to compare our plans with other Medicare health plans, ask the other plans for their Summary of Benefits booklets or use the Medicare Plan Finder on Medicare.gov.
- 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, Essence Advantage Plus** and **Essence Advantage Select**
- 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 1-866-947-5816 (TTY: 711) to speak with a customer service representative.

Things to Know About Essence Advantage, Essence Advantage Plus and Essence Advantage Select

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.

Essence Advantage/Essence Advantage Plus/Essence Advantage Select Phone Number and Website

- If you have questions, call 1-866-947-5816 (TTY: 711).
- Our website: EssenceHealthcare.com

Who can join?

To join **Essence Advantage, Essence Advantage Plus** or **Essence Advantage Select,** 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 following counties in Illinois: Madison, Monroe and St. Clair; and in Missouri: Crawford, Franklin, Jefferson, Lincoln, St. Charles, St. Louis, Warren and St. Louis City

What is 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. An HMO may require you to live or work in its service area to be eligible for coverage.

Which doctors, hospitals and pharmacies can I use?

Essence Advantage, Essence Advantage Plus and **Essence Advantage Select** have a network of doctors, hospitals, pharmacies and other providers. If you use providers that are not in our network, the plan may not pay for these services. 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 plan's Provider Directory on EssenceHealthcare.com or call us, and we will 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 is covered by Original Medicare.** Some of the extra benefits are outlined in this booklet.

What drugs do we cover?

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

How will I determine my drug costs?

Our plans group each medication into one of six tiers. You will 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 and what stage of the benefit you have reached. Later in this document, we discuss the benefit stages that occur: initial coverage, coverage gap 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 Plus (HMO)	Essence Advantage Select (HMO)
Monthly Plan Premium	$0 Per month. You must continue to pay your Medicare Part B premium.	$60 Per month. You must continue to pay your Medicare Part B premium.	$0 Per month. You must continue to pay your Medicare Part B premium.
Deductibles	All Plans These plans do not have a deductible.		
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: $1,950 for covered hospital and medical services you receive from in-network providers 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 will still need to pay your monthly premiums and cost-sharing for your 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: $1,700 for covered hospital and medical services you receive from in-network providers 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 will still need to pay your monthly premiums and cost-sharing for your 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: $2,800 for covered hospital and medical services you receive from in-network providers 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 will 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 Plus (HMO)	Essence Advantage Select (HMO)
Inpatient Hospital Coverage	Our plan covers an unlimited number of days for an inpatient hospital stay. • $240 Copay per day, per stay: days 1–8 • $0 Copay per day, per stay: day 9 and beyond Prior authorization is required.	Our plan covers an unlimited number of days for an inpatient hospital stay. • $195 Copay per day, per stay: days 1–9 • $0 Copay per day, per stay: day 10 and beyond Prior authorization is required.	Our plan covers an unlimited number of days for an inpatient hospital stay. • $260 Copay per day, per stay: days 1–8 • $0 Copay per day, per stay: day 9 and beyond Prior authorization is required.

	Essence Advantage (HMO)	Essence Advantage Plus (HMO)	Essence Advantage Select (HMO)
Outpatient Hospital Coverage	$230 Copay or 20% coinsurance, depending on the service or visit Prior authorization may be required.	$150 Copay or 20% coinsurance, depending on the service or visit Prior authorization may be required.	$250 Copay or 20% coinsurance, depending on the service or visit Prior authorization may be required.
Ambulatory Surgical Center (ASC)	$175 Copay Prior authorization may be required.	$100 Copay Prior authorization may be required.	$175 Copay Prior authorization may be required.
Doctor Visits *(primary care providers and specialists)*	Primary care physician (PCP) visit: $0 copay Specialist visit: $25 copay A referral is required for specialist visits. Certain Medicare-covered services provided by a physician may require a prior authorization.	Primary care physician (PCP) visit: $0 copay Specialist visit: $30 copay A referral is required for specialist visits. Certain Medicare-covered services provided by a physician may require a prior authorization.	Primary care physician (PCP) visit: $0 copay Specialist visit: $30 copay A referral is required for specialist visits. Certain Medicare-covered services provided by a physician may require a prior authorization.
Preventive Care	**All Plans** You pay nothing. Our plans cover many preventive services, including: • Abdominal aortic aneurysm screening • Annual wellness visit • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) • Cardiovascular disease testing • Cervical and vaginal cancer screening • Colorectal cancer screening • Depression screening • Diabetes screening • Diabetes self-management training and diabetic services • Health and wellness education programs • HIV screening • Immunizations (pneumonia, hepatitis B, COVID-19 and influenza) • Medical nutrition therapy • Medicare Diabetes Prevention Program (MDPP) • Obesity screening and therapy to promote sustained weight loss • Prostate cancer screening exams		

	Essence Advantage (HMO)	Essence Advantage Plus (HMO)	Essence Advantage Select (HMO)
Preventive Care *(continued)*	**All Plans** • 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	**All Plans** $125 Copay If you are 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. We provide worldwide coverage.		
Urgently Needed Services	$35 Copay within the United States $125 Copay outside of the United States We provide worldwide coverage.	$25 Copay within the United States $125 Copay outside of the United States We provide worldwide coverage.	$35 Copay within the United States $125 Copay outside of the United States We provide worldwide coverage.
Diagnostic Services/Labs/ Imaging *(Costs for these services may vary based on place of service.)*	**All Plans** Lab services: $0 copay Diagnostic procedures and tests: 20% coinsurance Diagnostic colonoscopies: $0 copay Diagnostic radiology services (such as MRI, CT and PET scans): 20% coinsurance Diagnostic mammograms: $0 copay Therapeutic radiology services (such as radiation treatment for cancer): 20% coinsurance X-rays: $20 copay Prior authorization may be required.		
Hearing Services	**Both Plans** Medicare-covered exam to diagnose and treat hearing and balance issues: $20 copay Routine hearing exam: $20 copay A referral is required for Medicare-covered hearing services.		Medicare-covered exam to diagnose and treat hearing and balance issues: $20 copay Routine hearing exam: $20 copay A referral is required for Medicare-covered hearing services.

	Essence Advantage (HMO)	Essence Advantage Plus (HMO)	Essence Advantage Select (HMO)
Hearing Services *(continued)*	**Both Plans** $1,000 Allowance for up to 2 hearing aids every 2 calendar years (both ears combined), no network restrictions One fitting/evaluation for hearing aids every 2 calendar years: $0 copay		$1,000 Allowance for up to 2 hearing aids every 2 calendar years (both ears combined), no network restrictions 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 hearing aids, see the Flexible Benefits Card section on page 50.
Dental Services	Preventive dental services: $0 copay **Preventive services include:** • Periodic oral evaluation (2 every calendar year) • Comprehensive oral exam (1 every 3 calendar years) • Routine cleaning (2 every calendar year) • Fluoride treatment (1 every calendar year) • Horizontal bitewing X-ray(s) (up to 4, once every calendar year)	Preventive dental services: $0 copay **Preventive services include:** • Periodic oral evaluation (2 every calendar year) • Comprehensive oral exam (1 every 3 calendar years) • Routine cleaning (2 every calendar year) • Fluoride treatment (1 every calendar year) • Horizontal bitewing X-ray(s) (up to 4, once every calendar year)	Preventive and enhanced preventive dental services: $0 copay **Preventive and enhanced preventive services include:** • Periodic oral evaluation (2 every calendar year) • Comprehensive oral and periodontal exam (1 every 3 calendar years) • Routine cleaning (2 every calendar year) • Fluoride treatment (2 every calendar year) • Horizontal bitewing X-ray images (up to 4, once every calendar year) • Limited oral evaluations (3 every calendar year) • Intraoral complete series, vertical bitewings (7-8 images) or panoramic radiographic image (once every 3 calendar years) • Periodontal maintenance following active therapy (4 every calendar year) • Minor treatment for pain relief (emergency)

	Essence Advantage (HMO)	Essence Advantage Plus (HMO)	Essence Advantage Select (HMO)
Dental Services *(continued)*	Medicare-covered comprehensive dental services: $25 copay A referral is required to visit an oral surgeon for Medicare-covered services and those services may require a prior authorization.	Medicare-covered comprehensive dental services: $30 copay A referral is required to visit an oral surgeon for Medicare-covered services and those services may require a prior authorization.	Medicare-covered comprehensive dental services: $30 copay A referral is required to visit an oral surgeon for Medicare-covered services and those services may require a prior authorization. **Comprehensive services include (but are not limited to*):** **Restorative services** (amalgam/resin fillings, inlays/onlays, protective restorations, crowns/post and core or crown buildup, crown repair when material failure and retrograde filling): 20%–50% coinsurance **Endodontics** (root canal treatment, retreatment root canal therapy, apicoectomy and pulpotomy): 50% coinsurance **Periodontics** (periodontal surgery, scaling and root planning, full mouth debridement "deep cleaning," clinical crown lengthening and gingivectomy): 50% coinsurance **Extractions** (simple extractions, surgical extractions, general anesthesia—when clinically necessary): 20%-50% coinsurance **Major Restoratives: Prosthodontics** (Dentures—complete, partial, or immediate and fixed bridges): 50% coinsurance **Other oral surgical procedures**, including alveoloplasty and vestibuloplasty, 1 per quadrant or arch per lifetime: 50% coinsurance

	Essence Advantage (HMO)	Essence Advantage Plus (HMO)	Essence Advantage Select (HMO)
Dental Services *(continued)*			**Prosthetic maintenance** (bridge or denture repair, adjustment to dentures, tissue conditioning, repair, replacement, or addition of teeth to existing partial or full dentures, rebase and reline dentures and recement bridges, crowns, onlays and inlays crowns): 20% coinsurance Yearly maximum benefit for preventative and comprehensive services: $1,500 For details on an **additional shared allowance** that can be used on dental services and products, see the Flexible Benefits Card section on page 50. *See Evidence of Coverage for more details and a complete listing. Some limitations and exclusions apply.
Vision Services	Each visit to a specialist, such as an ophthalmologist or optometrist, for Medicare-covered benefits: $25 copay	Each visit to a specialist, such as an ophthalmologist or optometrist, for Medicare-covered benefits: $30 copay	Each visit to a specialist, such as an ophthalmologist or optometrist, for Medicare-covered benefits: $30 copay For details on an **additional shared allowance** that can be used on vision services and eyewear, see the Flexible Benefits Card section on page 50.
	All Plans Diabetic eye exams performed by a contracted specialist: $0 copay* A referral is required for Medicare-covered eye exams. 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 1 pair of Medicare-covered contact lenses (or 2 six packs) after each cataract surgery. Our plan pays up to $200 for eyeglass frames or contact lenses after each cataract surgery: $0 copay 1 Routine eye exam every calendar year: $0 copay		

	Essence Advantage (HMO)	Essence Advantage Plus (HMO)	Essence Advantage Select (HMO)
Vision Services *(continued)*	Refraction covered as part of exam 1 Pair of eyeglass lenses (standard plastic single, bifocal, trifocal or lenticular lenses) every 2 calendar years: $0 copay Our plan pays up to $200 for 1 pair of eyeglass frames or 1 pair of contact lenses (or 2 six packs), every 2 calendar years: $0 copay Upgrades may be available at an additional cost.		
Mental Health Services	Inpatient visit: Our plan covers an unlimited number of days for an inpatient hospital stay. • $240 Copay per day, per stay: days 1–8 • $0 Copay per day, per stay: day 9 and beyond Outpatient individual visit: $15 Copay Outpatient group visit: $10 Copay Prior authorization may be required.	Inpatient visit: Our plan covers an unlimited number of days for an inpatient hospital stay. • $195 Copay per day, per stay: days 1–6 • $0 Copay per day, per stay: day 7 and beyond Outpatient individual visit: $15 Copay Outpatient group visit: $10 Copay Prior authorization may be required.	Inpatient visit: Our plan covers an unlimited number of days for an inpatient hospital stay. • $260 Copay per day, per stay: days 1–6 • $0 Copay per day, per stay: day 7 and beyond Outpatient individual visit: $15 Copay Outpatient group visit: $10 Copay Prior authorization may be required.
Skilled Nursing Facility (SNF)	Both Plans The plans cover up to 100 days each benefit period. No prior hospital stay is required. • $0 Copay per day, per stay: days 1–20 • $125 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 • $170 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.
Physical Therapy	$30 Copay A referral is required.	$20 Copay A referral is required.	$35 Copay A referral is required.

*All members of the Essence Advantage Select plan have a $0 copay for diabetic eye exams. Essence Advantage and Advantage Plus plan members have a $0 copay, but this benefit is part of a special supplemental program for the chronically ill. Not all members qualify.

	Essence Advantage (HMO)	Essence Advantage Plus (HMO)	Essence Advantage Select (HMO)
Ambulance	$220 Copay This copay applies to each one-way trip. Prior authorization may be required for non-emergent transportation by ambulance.	$150 Copay This copay applies to each one-way trip. Prior authorization may be required for non-emergent transportation by ambulance.	$220 Copay This copay applies to each one-way trip. Prior authorization may be required for non-emergent transportation by ambulance.
Transportation	All Plans $0 Copay | Limited to 24 one-way trips to plan approved health-related locations every year		
Medicare Part B Drugs	All Plans For Part B drugs such as chemotherapy drugs: 20% coinsurance Starting April 1, 2023, if a Part B prescription drug's price has increased at a rate faster than the rate of inflation, we'll reduce your coinsurance for that drug by a certain amount as directed by the Centers for Medicare & Medicaid Services (CMS). CMS will tell Essence Healthcare what your coinsurance should be for that drug. Your coinsurance will never exceed 20 percent but could be lower based on information we receive from CMS. Other Part B drugs, including insulin administered via a durable medical equipment insulin pump: 20% coinsurance For Part B insulin (insulin administered through a durable medical equipment pump), you won't pay more than $35 for a one-month supply beginning July 1, 2023. Prior authorization is required. Amounts you pay for Part B drugs count toward your maximum out-of-pocket amount; they do not count toward your Part D initial coverage limit or true out-of-pocket cost of $7,400.		

Part D Prescription Drug Benefits

	Essence Advantage (HMO)	Essence Advantage Plus (HMO)	Essence Advantage Select (HMO)
Deductible	All Plans These plans do not have a deductible.		
Initial Coverage	All Plans You pay the following until your total yearly drug costs reach $4,660. Total yearly drug costs are the total drug costs paid by both you and your Part D plan. If you reside in a long-term care facility, you pay the same as at a standard retail pharmacy. You may get drugs from an out-of-network pharmacy at the same cost as a standard retail pharmacy. Coverage is limited to certain situations if you go out of network.		

	Essence Advantage (HMO)			Essence Advantage Plus (HMO)			Essence Advantage Select (HMO)		
Preferred Retail Cost-Sharing	**30-Day Supply**	**60-Day Supply**	**90-Day Supply**	**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	$0 Copay	$0 Copay	$0 Copay
Tier 2 *(Generic)*	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay
Tier 3 *(Preferred Brand)*	$39 Copay	$78 Copay	$117 Copay	$34 Copay	$68 Copay	$102 Copay	$39 Copay	$78 Copay	$117 Copay
Tier 4 *(Non-Preferred Brand)*	$75 Copay	$150 Copay	$225 Copay	$65 Copay	$130 Copay	$195 Copay	$75 Copay	$150 Copay	$225 Copay
Tier 5 *(Specialty Drug)*	33% Coinsurance	Not offered	Not offered	33% Coinsurance	Not offered	Not offered	33% Coinsurance	Not offered	Not offered
Tier 6 *(Insulins)*	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay
Standard Retail Cost-Sharing	**30-Day Supply**	**60-Day Supply**	**90-Day Supply**	**30-Day Supply**	**60-Day Supply**	**90-Day Supply**	**30-Day Supply**	**60-Day Supply**	**90-Day Supply**
Tier 1 *(Preferred Generic)*	$4 Copay	$8 Copay	$12 Copay	$4 Copay	$8 Copay	$12 Copay	$4 Copay	$8 Copay	$12 Copay
Tier 2 *(Generic)*	$12 Copay	$24 Copay	$36 Copay	$12 Copay	$24 Copay	$36 Copay	$12 Copay	$24 Copay	$36 Copay
Tier 3 *(Preferred Brand)*	$47 Copay	$94 Copay	$141 Copay	$42 Copay	$84 Copay	$126 Copay	$47 Copay	$94 Copay	$141 Copay
Tier 4 *(Non-Preferred Brand)*	$100 Copay	$200 Copay	$300 Copay	$80 Copay	$160 Copay	$240 Copay	$100 Copay	$200 Copay	$300 Copay
Tier 5 *(Specialty Drug)*	33% Coinsurance	Not offered	Not offered	33% Coinsurance	Not offered	Not offered	33% Coinsurance	Not offered	Not offered
Tier 6 *(Insulins)*	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay

	Essence Advantage (HMO)			Essence Advantage Plus (HMO)			Essence Advantage Select (HMO)		
Standard Mail-Order Cost-Sharing	**30-Day Supply**	**60-Day Supply**	**90-Day Supply**	**30-Day Supply**	**60-Day Supply**	**90-Day Supply**	**30-Day Supply**	**60-Day Supply**	**90-Day Supply**
Tier 1 *(Preferred Generic)*	Not offered	Not offered	$0 Copay	Not offered	Not offered	$0 Copay	Not offered	Not offered	$0 Copay
Tier 2 *(Generic)*	Not offered	Not offered	$0 Copay	Not offered	Not offered	$0 Copay	Not offered	Not offered	$0 Copay
Tier 3 *(Preferred Brand)*	Not offered	Not offered	$97.50 Copay	Not offered	Not offered	$85 Copay	Not offered	Not offered	$97.50 Copay
Tier 4 *(Non-Preferred Brand)*	Not offered	Not offered	$187.50 Copay	Not offered	Not offered	$162.50 Copay	Not offered	Not offered	$187.50 Copay
Tier 5 *(Specialty Drug)*	33% Coinsurance	Not offered	Not offered	33% Coinsurance	Not offered	Not offered	33% Coinsurance	Not offered	Not offered
Tier 6 *(Insulins)*	Not offered	Not offered	$0 Copay	Not offered	Not offered	$0 Copay	Not offered	Not offered	$0 Copay
Coverage Gap	Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what your plan has paid and what you have paid) reaches $4,660. After you enter the coverage gap, you pay 25% of the plan's cost for covered brand-name drugs and 25% of the plan's cost for covered generic drugs until your out-of-pocket costs total $7,400, which is the end of the coverage gap. Not everyone will enter the coverage gap.			Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what your plan has paid and what you have paid) reaches $4,660. After you enter the coverage gap, you pay 25% of the plan's cost for covered brand-name drugs until your out-of-pocket costs total $7,400, which is the end of the coverage gap. Not everyone will enter the coverage gap. During the coverage gap, your costs for tier 1, tier 2 and tier 6 drugs (shown in the following table) will remain the same as during the initial coverage phase of your prescription drug benefit. You will need to use your formulary to locate your drug's tier.			Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what your plan has paid and what you have paid) reaches $4,660. After you enter the coverage gap, you pay 25% of the plan's cost for covered brand-name drugs and 25% of the plan's cost for covered generic drugs until your out-of-pocket costs total $7,400, which is the end of the coverage gap. Not everyone will enter the coverage gap.		
	All Plans: Important—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.								

	Essence Advantage (HMO)	Essence Advantage Plus (HMO)				Essence Advantage Select (HMO)
Preferred Retail Cost Sharing		**Drugs Covered**	**30-Day Supply**	**60-Day Supply**	**90-Day Supply**	
Tier 1 *(Preferred Generic)*	No additional coverage	All	$0 Copay	$0 Copay	$0 Copay	No additional coverage
Tier 2 *(Generic)*		All	$0 Copay	$0 Copay	$0 Copay	
Tier 6 *(Insulins)*		All	$0 Copay	$0 Copay	$0 Copay	
Standard Retail Cost Sharing		**Drugs Covered**	**30-Day Supply**	**60-Day Supply**	**90-Day Supply**	
Tier 1 *(Preferred Generic)*	No additional coverage	All	$4 Copay	$8 Copay	$12 Copay	No additional coverage
Tier 2 *(Generic)*		All	$12 Copay	$24 Copay	$36 Copay	
Tier 6 *(Insulins)*		All	$0 Copay	$0 Copay	$0 Copay	
Standard Mail Order Cost Sharing		**Drugs Covered**	**30-Day Supply**	**60-Day Supply**	**90-Day Supply**	
Tier 1 *(Preferred Generic)*	No additional coverage	All	Not offered	Not offered	$0 Copay	No additional coverage
Tier 2 *(Generic)*		All	Not offered	Not offered	$0 Copay	
Tier 6 *(Insulins)*		All	Not offered	Not offered	$0 Copay	
Catastrophic Coverage	**All Plans** After your yearly out-of-pocket drug costs reach $7,400, you pay the greater of: • 5% Coinsurance or • $4.15 Copay for generic (including brand-name drugs treated as generic) or a $10.35 copay for other drugs (one-month supply) **Important**—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.					

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

Other Covered Benefits

	Essence Advantage (HMO)	Essence Advantage Plus (HMO)	Essence Advantage Select (HMO)
Acupuncture	Medicare-covered services (chronic low back pain), up to 20 visits per calendar year: $25 copay	Medicare-covered services (chronic low back pain), up to 20 visits per calendar year: $30 copay	Medicare-covered services (chronic low back pain), up to 20 visits per calendar year: $30 copay
Chiropractic Care	Manual manipulation of the spine to correct subluxation: $20 copay A referral is required.	Manual manipulation of the spine to correct subluxation: $15 copay A referral is required.	Manual manipulation of the spine to correct subluxation: $20 copay A referral is required.

	Essence Advantage (HMO)	Essence Advantage Plus (HMO)	Essence Advantage Select (HMO)
Diabetes Supplies and Services	**All Plans** Diabetes self-management training: $0 copay Diabetes monitoring supplies (including blood glucose monitors, lancets and blood glucose test strips*): 0% coinsurance When glucose meters and test strips are obtained at a pharmacy, coverage is limited to specific Bayer/Ascensia products. Diabetic therapeutic custom-molded shoes or inserts: 20% coinsurance Authorization is required for some items (e.g., diabetic custom-molded shoes and inserts, continuous glucose meters, insulin pumps). *See Evidence of Coverage for a complete listing.		
Durable Medical Equipment *(wheelchairs, oxygen, etc.)*	**All Plans** 20% Coinsurance Prior authorization may be required.		
Flexible Benefits Card	**Both Plans** $110 Credit per quarter, supplied in the form of a debit card, provided by WEX, to use on health-related over-the-counter products Any unused balance will not carry over from quarter to quarter and will expire at the end of the calendar year. For more information, please see the Evidence of Coverage.		$160 Shared credit per quarter, supplied in the form of a debit card, provided by WEX, to use on non-Medicare-covered dental, vision and hearing products and services as well as health-related over-the-counter items. There are no restrictions on how much of the allowance can be spent in each category. Flex Card may be used with both in-network and out-of-network providers. Any unused balance will not carry over from quarter to quarter and will expire at the end of the calendar year. For more information, please see the Evidence of Coverage.
Foot Care *(podiatry services)*	$25 Copay A referral is required.	$30 Copay A referral is required.	$30 Copay A referral is required.
Home Healthcare	**All Plans** $0 Copay A referral is required.		
Hospice	**All Plans** When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not Essence Healthcare.		

	Essence Advantage (HMO)	Essence Advantage Plus (HMO)	Essence Advantage Select (HMO)
Outpatient Rehabilitation Services	Cardiac rehabilitation services: $20 copay per day Occupational, speech and language therapy visits: $30 copay A separate copayment for occupational therapy will apply if other outpatient therapy services are rendered on the same day. A referral is required.	Cardiac rehabilitation services: $20 copay per day Occupational, speech and language therapy visits: $20 copay A separate copayment for occupational therapy will apply if other outpatient therapy services are rendered on the same day. A referral is required.	Cardiac rehabilitation services: $20 copay per day Occupational, speech and language therapy visits: $35 copay A separate copayment for occupational therapy will apply if other outpatient therapy services are rendered on the same day. A referral is required.
Outpatient Substance Abuse	All Plans Individual visit: $15 copay Group visit: $10 copay Prior authorization may be required.		
Over-the-Counter (OTC) Coverage	Both Plans $110 Credit per quarter, supplied in the form of a debit card (Flexible Benefits Card), provided by WEX, to use on health-related OTC items For more information, see the Flexible Benefits Card section on page 50.		$160 Shared credit per quarter, supplied in the form of a debit card (Flexible Benefits Card) provided by WEX. Allowance is shared between health-related OTC items, dental, vision and hearing. For more information, see the Flexible Benefits Card section on page 50.
Prosthetic Devices	All Plans Prosthetic devices: 20% coinsurance Related medical supplies: 20% coinsurance Prior authorization may be required.		
Virtual/ Telehealth Visits	$0–$30 Copay You will 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.	$0–$30 Copay You will 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.	$0–$35 Copay You will 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.
Wellness Programs	All Plans Health club membership/fitness classes through SilverSneakers®: $0 copay		

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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 1-866-947-5816 (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 1-866-947-5816 (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. If they are not listed, it means you will likely have to select a new doctor.
- [ ] 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, 2024.
- [ ] 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).

Essence Healthcare includes HMO, HMO-POS and PPO plans with Medicare contracts. Essence Healthcare also includes an HMO D-SNP plan with a contract with Medicare and the state Medicaid program. 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 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, neither Medicare nor Essence will be responsible for the costs.

Out-of-network/non-contracted providers are under no obligation to treat Essence Healthcare 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.

Toll-free: 1-866-947-5816 (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.

ESSENCE HEALTHCARE™

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