Summary of Benefits

MEDICARE ADVANTAGE | 2023

ESSENCE ADVANTAGE CHOICE (PPO) - ESSENCE ADVANTAGE CHOICE PLUS (PPO)

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 Choice (PPO)** and **Essence Advantage Choice Plus (PPO)** 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 Choice** and **Essence Advantage Choice Plus**
- Monthly Premium, Deductibles and Limits on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits
- Prescription Drug Benefits
- Other Covered Benefits

This document is available in other formats such as Braille and large print. This document may be available in a non-English language. For additional information, call 1-866-536-1051 (TTY: 711) to speak with a customer service representative.

H6200_23-330_M

Things to Know About Essence Advantage Choice and Essence Advantage Choice Plus

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 Choice/Essence Advantage Choice Plus Phone Number and Website

- If you have questions, call 1-866-536-1051 (TTY: 711) to speak with a customer service representative.
- Our website: EssenceHealthcare.com

Who can join?

To join **Essence Advantage Choice** or **Essence Advantage Choice Plus**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, be a United States citizen or are lawfully present in the United States and live in our service area. Our service area includes the 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 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. A PPO 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 Choice and **Essence Advantage Choice Plus** have a network of doctors, hospitals, pharmacies and other providers. If you use providers that are not in our network, they must agree to treat you. 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. You can see our plans' 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 five 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 Choice (PPO) In-Network	**Essence Advantage Choice (PPO)** Out-of-Network	**Essence Advantage Choice Plus (PPO)** In-Network	**Essence Advantage Choice Plus (PPO)** Out-of-Network
Monthly Plan Premium	$0 Per month You must continue to pay your Medicare Part B premium.		$27 Per month You must continue to pay your Medicare Part B premium.	
Deductibles	**Both 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: • $4,200 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 combined in- and out-of-network covered hospital and medical services. Your yearly limit(s) in this plan: • $8,950 for covered hospital and medical services you receive from in- and out-of-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: • $3,900 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 combined in- and out-of-network covered hospital and medical services. Your yearly limit(s) in this plan: • $7,900 for covered hospital and medical services you receive from in- and out-of-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 Choice (PPO) In-Network	Essence Advantage Choice (PPO) Out-of-Network	Essence Advantage Choice Plus (PPO) In-Network	Essence Advantage Choice Plus (PPO) Out-of-Network
Inpatient Hospital Coverage	Our plan covers an unlimited number of days for an inpatient hospital stay. $290 Copay per day, per stay: days 1–6 $0 Copay per day, per stay: day 7 and beyond Prior authorization is required.	Our plan covers an unlimited number of days for an inpatient hospital stay. 40% Coinsurance per day, per stay: day 1 and beyond	Our plan covers an unlimited number of days for an inpatient hospital stay. $290 Copay per day, per stay: days 1–6 $0 Copay per day, per stay: day 7 and beyond Prior authorization is required.	Our plan covers an unlimited number of days for an inpatient hospital stay. 40% Coinsurance per day, per stay: day 1 and beyond
Outpatient Hospital Coverage	$280 Copay per surgery for outpatient hospital surgery 20% Coinsurance for other outpatient hospital services Prior authorization may be required.	40% Coinsurance for all Medicare-covered outpatient hospital services	$280 Copay per surgery for outpatient hospital surgery 20% Coinsurance for other outpatient hospital services Prior authorization may be required.	40% Coinsurance for all Medicare-covered outpatient hospital services
Ambulatory Surgical Center (ASC)	$240 Copay Prior authorization may be required.	40% Coinsurance	$240 Copay Prior authorization may be required.	40% Coinsurance
Doctor Visits *(primary care providers and specialists)*	Primary care physician (PCP) visit: $0 copay Specialist visit: $35 copay Certain Medicare-covered services provided by a physician may require a prior authorization.	Primary care physician (PCP) visit: $25 copay Specialist visit: $70 copay	Primary care physician (PCP) visit: $0 copay Specialist visit: $25 copay Certain Medicare-covered services provided by a physician may require a prior authorization.	Primary care physician (PCP) visit: $20 copay Specialist visit: $50 copay
Preventive Care	**Both Plans** You pay nothing. Our plans cover many preventive services, including: • Abdominal aortic aneurysm screening • Annual wellness visit • Bone mass measurement			

	Essence Advantage Choice (PPO) In-Network	Essence Advantage Choice (PPO) Out-of-Network	Essence Advantage Choice Plus (PPO) In-Network	Essence Advantage Choice Plus (PPO) Out-of-Network
Preventive Care *(continued)*	**Both Plans** • 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 • 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** $110 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. Emergency services are always considered in-network. We provide worldwide coverage.			
Urgently Needed Services	**Both Plans** $40 Copay within the United States $110 Copay outside of the United States Urgently needed services are always considered in-network. We provide worldwide coverage.			

	Essence Advantage Choice (PPO) In-Network	Essence Advantage Choice (PPO) Out-of-Network	Essence Advantage Choice Plus (PPO) In-Network	Essence Advantage Choice Plus (PPO) Out-of-Network
Diagnostic Services/Labs/ Imaging *(Costs for these services may vary based on place of service.)*	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: $15 copay Prior authorization may be required.	Lab services: $0 copay Diagnostic procedures and tests: 40% coinsurance Diagnostic colonoscopies: 40% coinsurance Diagnostic radiology services (such as MRI, CT and PET scans): 40% coinsurance Diagnostic mammograms: 40% coinsurance Therapeutic radiology services (such as radiation treatment for cancer): 40% coinsurance X-rays: 40% coinsurance	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: $15 copay Prior authorization may be required.	Lab services: $0 copay Diagnostic procedures and tests: 40% coinsurance Diagnostic colonoscopies: 40% coinsurance Diagnostic radiology services (such as MRI, CT and PET scans): 40% coinsurance Diagnostic mammograms: 40% coinsurance Therapeutic radiology services (such as radiation treatment for cancer): 40% coinsurance X-rays: 40% coinsurance
Hearing Services	Medicare-covered exam to diagnose and treat hearing and balance issues: $20 copay Routine hearing exam: $20 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 17.	Medicare-covered exam to diagnose and treat hearing and balance issues: 40% coinsurance Routine hearing exam: $20 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 17.	Medicare-covered exam to diagnose and treat hearing and balance issues: $20 copay Routine hearing exam: $20 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 17.	Medicare-covered exam to diagnose and treat hearing and balance issues: 40% coinsurance Routine hearing exam: $20 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 17.

	Essence Advantage Choice (PPO) In-Network	Essence Advantage Choice (PPO) Out-of-Network	Essence Advantage Choice Plus (PPO) In-Network	Essence Advantage Choice Plus (PPO) Out-of-Network
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 images (up to 4 images, once every calendar year) Medicare-covered comprehensive dental services: $35 copay Prior authorization may be required for Medicare-covered services performed by an oral surgeon. For details on an **additional shared allowance** that can be used on dental services and products, see the Flexible Benefits Card section on page 17.	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 images (up to 4 images, once every calendar year) Medicare-covered comprehensive dental services: $70 copay For details on an **additional shared allowance** that can be used on dental services and products, see the Flexible Benefits Card section on page 17.	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 images (up to 4 images, once every calendar year) Medicare-covered comprehensive dental services: $25 copay Prior authorization may be required for Medicare-covered services performed by an oral surgeon. For details on an **additional shared allowance** that can be used on dental services and products, see the Flexible Benefits Card section on page 17.	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 images (up to 4 images, once every calendar year) Medicare-covered comprehensive dental services: $50 copay For details on an **additional shared allowance** that can be used on dental services and products, see the Flexible Benefits Card section on page 17.

	Essence Advantage Choice (PPO) In-Network	Essence Advantage Choice (PPO) Out-of-Network	Essence Advantage Choice Plus (PPO) In-Network	Essence Advantage Choice Plus (PPO) Out-of-Network
Vision Services	Each visit to a specialist, such as an ophthalmologist or optometrist, for Medicare-covered benefits: $35 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 (or 2 six packs) after each cataract surgery: $0 copay 1 Routine eye exam every calendar year: $0 copay Eye refractions and dilation are covered during a routine exam performed by a contracted routine vision provider. For details on an **additional shared allowance** that can be used on vision services and eyewear, see the Flexible Benefits Card section on page 17.	Each visit to a specialist, such as an ophthalmologist or optometrist, for Medicare-covered benefits: $70 copay Diabetic eye exams: $70 copay 1 Pair of Medicare-covered eyeglass lenses (standard plastic single, bifocal, trifocal or lenticular lenses) after each cataract surgery: 40% coinsurance 1 Pair of Medicare-covered eyeglass frames or contact lenses (or 2 six packs) after each cataract surgery: 40% coinsurance 1 Routine eye exam every calendar year: $0 copay Eye refractions and dilation are covered during a routine exam performed by a contracted routine vision provider. For details on an **additional shared allowance** that can be used on vision services and eyewear, see the Flexible Benefits Card section on page 17.	Each visit to a specialist, such as an ophthalmologist or optometrist, for Medicare-covered benefits: $25 copay Diabetic eye exams performed by a contracted specialist: $0 copay 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 (or 2 six packs) after each cataract surgery: $0 copay 1 Routine eye exam every calendar year: $0 copay Eye refractions and dilation are covered during a routine exam performed by a contracted routine vision provider. For details on an **additional shared allowance** that can be used on vision services and eyewear, see the Flexible Benefits Card section on page 17.	Each visit to a specialist, such as an ophthalmologist or optometrist, for Medicare-covered benefits: $50 copay Diabetic eye exams: $50 copay 1 Pair of Medicare-covered eyeglass lenses (standard plastic single, bifocal, trifocal or lenticular lenses) after each cataract surgery: 40% coinsurance 1 Pair of Medicare-covered eyeglass frames or contact lenses (or 2 six packs) after each cataract surgery: 40% coinsurance 1 Routine eye exam every calendar year: $0 copay Eye refractions and dilation are covered during a routine exam performed by a contracted routine vision provider. For details on an **additional shared allowance** that can be used on vision services and eyewear, see the Flexible Benefits Card section on page 17.

	Essence Advantage Choice (PPO) In-Network	Essence Advantage Choice (PPO) Out-of-Network	Essence Advantage Choice Plus (PPO) In-Network	Essence Advantage Choice Plus (PPO) Out-of-Network
Mental Health Services	Inpatient visit: Our plan covers an unlimited number of days for an inpatient hospital stay. $300 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.	Inpatient visit: Our plan covers an unlimited number of days for an inpatient hospital stay. 40% Coinsurance per day, per stay: day 1 and beyond Outpatient individual visit: 40% coinsurance Outpatient group visit: 40% coinsurance	Inpatient visit: Our plan covers an unlimited number of days for an inpatient hospital stay. $295 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. 40% Coinsurance per day, per stay: day 1 and beyond Outpatient individual visit: 40% coinsurance Outpatient group visit: 40% coinsurance
Skilled Nursing Facility (SNF)	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 • $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.	The plans cover up to 100 days each benefit period. No prior hospital stay is required. 40% Coinsurance per day, per stay: day 1 and beyond	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 • $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.	The plans cover up to 100 days each benefit period. No prior hospital stay is required. 40% Coinsurance per day, per stay: day 1 and beyond
Physical Therapy	$40 Copay	40% Coinsurance	$40 Copay	40% Coinsurance

	Essence Advantage Choice (PPO) In-Network		Essence Advantage Choice Plus (PPO) In-Network	
Ambulance	$270 Copay This copay applies to each one-way trip. Prior authorization may be required for non-emergent transportation by ambulance.		$250 Copay This copay applies to each one-way trip. Prior authorization may be required for non-emergent transportation by ambulance.	
Transportation	$0 Copay Limited to 24 one-way trips to plan-approved health-related locations every year.		$0 Copay Limited to 24 one-way trips to plan-approved health-related locations every year.	
Medicare Part B Drugs	For Part B drugs such as chemotherapy drugs: 20% coinsurance Other Part B drugs, including insulin administered via a durable medical equipment insulin pump: 20% coinsurance Prior authorization may be 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.	For Part B drugs such as chemotherapy drugs: 40% coinsurance Other Part B drugs, including insulin administered via a durable medical equipment insulin pump: 40% coinsurance Prior authorization may be 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.	For Part B drugs such as chemotherapy drugs: 20% coinsurance Other Part B drugs, including insulin administered via a durable medical equipment insulin pump: 20% coinsurance Prior authorization may be 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.	For Part B drugs such as chemotherapy drugs: 40% coinsurance Other Part B drugs, including insulin administered via a durable medical equipment insulin pump: 40% coinsurance Prior authorization may be 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 Choice (PPO)	Essence Advantage Choice Plus (PPO)
Deductible	**Both Plans** These plans do not have a deductible.	
Initial Coverage	**Both Plans** You pay the amounts listed in the following tables until your total yearly drug costs reach $4,660. For insulins, 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. 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.	
Insulin Coverage	**Both Plans** You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter the cost-sharing tier, the coverage phase, your Extra Help status or whether the insulin product is considered a Select Insulin under the plan's Prescription Drug Formulary.*	

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)*	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay
Select Insulins*	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay
Tier 3 *(Preferred Brand)*	$45 Copay	$90 Copay	$135 Copay	$45 Copay	$90 Copay	$135 Copay
Select Insulins*	$35 Copay	$70 Copay	$105 Copay	$35 Copay	$70 Copay	$105 Copay
Tier 4 *(Non-Preferred Brand)*	$95 Copay	$190 Copay	$285 Copay	$95 Copay	$190 Copay	$285 Copay
Tier 5 *(Specialty Drug)*	33% Coinsurance	Not offered		33% Coinsurance	Not offered	

Standard Retail Cost-Sharing	Essence Advantage Choice (PPO) In-Network 30-Day Supply	60-Day Supply	90-Day Supply	Essence Advantage Choice Plus (PPO) In-Network 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
Tier 2 *(Generic)*	$12 Copay	$24 Copay	$36 Copay	$12 Copay	$24 Copay	$36 Copay
Select Insulins*	$12 Copay	$24 Copay	$36 Copay	$12 Copay	$24 Copay	$36 Copay
Tier 3 *(Preferred Brand)*	$47 Copay	$94 Copay	$141 Copay	$47 Copay	$94 Copay	$141 Copay
Select Insulins*	$35 Copay	$70 Copay	$105 Copay	$35 Copay	$70 Copay	$105 Copay
Tier 4 *(Non-Preferred Brand)*	$100 Copay	$200 Copay	$300 Copay	$100 Copay	$200 Copay	$300 Copay
Tier 5 *(Specialty Drug)*	33% Coinsurance	Not offered		33% Coinsurance	Not offered	

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		$0 Copay	Not offered		$0 Copay
Select Insulins*	Not offered		$0 Copay	Not offered		$0 Copay
Tier 3 *(Preferred Brand)*	Not offered		$112.50 Copay	Not offered		$112.50 Copay
Select Insulins*	Not offered		$105 Copay	Not offered		$105 Copay
Tier 4 *(Non-Preferred Brand)*	Not offered		$237.50 Copay	Not offered		$237.50 Copay
Tier 5 *(Specialty Drug)*	33% Coinsurance	Not offered		33% Coinsurance	Not offered	

*Select Insulins are those that are part of the Insulin Savings Program and incur low, consistent copays through the coverage gap. Insulins administered via a durable medical equipment insulin pump are not included in the program. For information regarding which insulins are Select Insulins under the plan's benefit, refer to the plan's Prescription Drug Formulary. See the Evidence of Coverage for more information regarding Select Insulins, including full cost-sharing information. The program doesn't apply during the catastrophic coverage stage or if you receive Extra Help.

Out-of-Network Cost-Sharing	Essence Advantage Choice (PPO) 30-Day Supply	60-Day Supply	90-Day Supply	Essence Advantage Choice Plus (PPO) 30-Day Supply	60-Day Supply	90-Day Supply
Tier 1 *(Preferred Generic)*	$4 Copay	Not offered		$4 Copay	Not offered	
Tier 2 *(Generic)*	$12 Copay	Not offered		$12 Copay	Not offered	
Select Insulins*	$12 Copay	Not offered		$12 Copay	Not offered	
Tier 3 *(Preferred Brand)*	$47 Copay	Not offered		$47 Copay	Not offered	
Select Insulins*	$35 Copay	Not offered		$35 Copay	Not offered	
Tier 4 *(Non-Preferred Brand)*	$100 Copay	Not offered		$100 Copay	Not offered	
Tier 5 *(Specialty Drug)*	33% Coinsurance	Not offered		33% Coinsurance	Not offered	
Coverage Gap	**Both Plans** 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. **Important**—You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, even if the insulin product is not considered a Select Insulin under the plan's Prescription Drug Formulary or you're not eligible for the Insulin Savings Program. If you're eligible for the Insulin Savings Program, your cost-share for Select Insulins won't increase during the coverage gap.					
Catastrophic Coverage	**Both 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 Choice (PPO) In-Network	Essence Advantage Choice (PPO) Out-of-Network	Essence Advantage Choice Plus (PPO) In-Network	Essence Advantage Choice Plus (PPO) Out-of-Network
Acupuncture	Medicare-covered services (chronic low back pain), up to 20 visits per calendar year: $35 copay per visit	Medicare-covered services (chronic low back pain), up to 20 visits per calendar year: $70 copay per visit	Medicare-covered services (chronic low back pain), up to 20 visits per calendar year: $25 copay per visit	Medicare-covered services (chronic low back pain), up to 20 visits per calendar year: $50 copay per visit
Chiropractic Care	Manual manipulation of the spine to correct subluxation: $20 copay	Manual manipulation of the spine to correct subluxation: 40% coinsurance	Manual manipulation of the spine to correct subluxation: $20 copay	Manual manipulation of the spine to correct subluxation: 40% coinsurance
Diabetes Supplies and Services	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 Abbott 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.	Diabetes self-management training: $0 copay Diabetes monitoring supplies (including blood glucose monitors, lancets and blood glucose test strips*): 40% coinsurance When glucose meters and test strips are obtained at a pharmacy, coverage is limited to specific Abbott products. Diabetic therapeutic custom-molded shoes or inserts: 40% coinsurance *See Evidence of Coverage for a complete listing.	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 Abbott 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.	Diabetes self-management training: $0 copay Diabetes monitoring supplies (including blood glucose monitors, lancets and blood glucose test strips*): 40% coinsurance When glucose meters and test strips are obtained at a pharmacy, coverage is limited to specific Abbott products. Diabetic therapeutic custom-molded shoes or inserts: 40% coinsurance *See Evidence of Coverage for a complete listing.
Durable Medical Equipment *(wheelchairs, oxygen, etc.)*	20% Coinsurance Prior authorization may be required.	40% Coinsurance	20% Coinsurance Prior authorization may be required.	40% Coinsurance
Flexible Benefits Card	$375 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 carries over from quarter to quarter but will expire at the end of the calendar year. For more information, please see the Evidence of Coverage.		$625 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 carries over from quarter to quarter but will expire at the end of the calendar year. For more information, please see the Evidence of Coverage.	
Foot Care *(podiatry services)*	$35 Copay	$70 Copay	$25 Copay	$50 Copay
Home Healthcare	$0 Copay Prior authorization is required.	40% Coinsurance	$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.			
Outpatient Substance Abuse	Individual visit: $15 copay Group visit: $10 copay Prior authorization may be required.	Individual visit: 40% coinsurance Group visit: 40% coinsurance	Individual visit: $15 copay Group visit: $10 copay Prior authorization may be required.	Individual visit: 40% coinsurance Group visit: 40% coinsurance

	Essence Advantage Choice (PPO) In-Network	Essence Advantage Choice (PPO) Out-of-Network	Essence Advantage Choice Plus (PPO) In-Network	Essence Advantage Choice Plus (PPO) Out-of-Network
Outpatient Rehabilitation Services	Cardiac rehabilitation services: $20 copay per day Occupational, speech and language therapy visits: $40 copay A separate copayment for occupational therapy will apply if other outpatient therapy services are rendered on the same day. Prior authorization may be required.	Cardiac rehabilitation services: 40% coinsurance per day Occupational, speech and language therapy visits: 40% coinsurance	Cardiac rehabilitation services: $20 copay per day Occupational, speech and language therapy visits: $40 copay A separate copayment for occupational therapy will apply if other outpatient therapy services are rendered on the same day. Prior authorization may be required.	Cardiac rehabilitation services: 40% coinsurance per day Occupational, speech and language therapy visits: 40% coinsurance
Over-the-Counter (OTC) Coverage	$375 Shared credit per quarter, supplied in the form of a debit card (Flexible Benefits Card), provided by WEX, to use on health-related OTC items Credit can be shared across OTC items, dental, vision and hearing. For more information, see the Flexible Benefits Card section on page 17.		$625 Shared credit per quarter, supplied in the form of a debit card (Flexible Benefits Card), provided by WEX, to use on health-related OTC items Credit can be shared across OTC items, dental, vision and hearing. For more information, see the Flexible Benefits Card section on page 17.	
Prosthetic Devices	Prosthetic devices: 20% coinsurance Related medical supplies: 20% coinsurance Prior authorization may be required.	Prosthetic devices: 40% coinsurance Related medical supplies: 40% coinsurance	Prosthetic devices: 20% coinsurance Related medical supplies: 20% coinsurance Prior authorization may be required.	Prosthetic devices: 40% coinsurance Related medical supplies: 40% coinsurance

	Essence Advantage Choice (PPO) In-Network	Essence Advantage Choice (PPO) Out-of-Network	Essence Advantage Choice Plus (PPO) In-Network	Essence Advantage Choice Plus (PPO) Out-of-Network
Virtual/ Telehealth Visits	$0–$40 Copay You will 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.	$25–$70 Copay or 40% coinsurance You will pay the same copay for the virtual/telehealth visit as if the services were received in the provider's office.	$0–$40 Copay You will 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.	$20–$50 Copay or 40% coinsurance You will pay the same copay for the virtual/telehealth visit as if the services were received in the provider's office.
Wellness Programs	**Both Plans** Health club membership/fitness classes through SilverSneakers®: $0 copay			

Index

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 1-866-536-1051 (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 1-866-536-1051 (TTY: 711) to view a copy of the EOC.
- ☐ 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.
- ☐ Our plan allows 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.

Notes

Notes

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.

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.

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™

Corporate Headquarters
13900 Riverport Drive
Maryland Heights, MO 63043
EssenceHealthcare.com