# Summary of Benefits

MEDICARE ADVANTAGE | 2023

ESSENCE ADVANTAGE GOLD (HMO) - ESSENCE ADVANTAGE PLATINUM (HMO)
ESSENCE ADVANTAGE SELECT (HMO)

ESSENCE HEALTHCARE™

Serving the California county of Santa Clara

# 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 Gold (HMO)**, **Essence Advantage Platinum (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 Gold**, **Essence Advantage Platinum** and **Essence Advantage Select**
- Monthly Premium, Deductibles and Limits on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits
- Optional Supplemental 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 1-844-205-8422 (TTY: 711) to speak with a customer service representative.

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# Things to Know About Essence Advantage Gold, Essence Advantage Platinum 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 Gold/Essence Advantage Platinum/Essence Advantage Select Phone Number and Website

- If you have questions, call 1-844-205-8422 (TTY: 711) to speak with a customer service representative.
- Our website: EssenceHealthcare.com

## Who can join?

To join **Essence Advantage Gold**, **Essence Advantage Platinum** 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 county in California: Santa Clara.

## 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 Gold**, **Essence Advantage Platinum** 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. 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 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 Gold (HMO) | Essence Advantage Platinum (HMO) | Essence Advantage Select (HMO) |
|---|---|---|---|
| **Monthly Plan Premium** | $30 Per month<br>You must continue to pay your Medicare Part B premium. | $79 Per month<br>You must continue to pay your Medicare Part B premium. | $0 Per month<br>You must continue to pay your Medicare Part B premium. |
| **Deductibles** | **All Plans**<br>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.<br>Your yearly limit(s) in this plan:<br>• $5,500 for covered hospital and medical services you receive from in-network providers<br>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.<br>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.<br>Your yearly limit(s) in this plan:<br>• $4,500 for covered hospital and medical services you receive from in-network providers<br>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.<br>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.<br>Your yearly limit(s) in this plan:<br>• $4,900 for covered hospital and medical services you receive from in-network providers<br>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.<br>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 Gold (HMO) | Essence Advantage Platinum (HMO) | Essence Advantage Select (HMO) |
|---|---|---|---|
| **Inpatient Hospital Coverage** | Our plan covers an unlimited number of days for an inpatient hospital stay.<br>$275 Copay per day, per stay: days 1–7<br>$0 Copay per day, per stay: day 8 and beyond<br>Prior authorization is required. | Our plan covers an unlimited number of days for an inpatient hospital stay.<br>$250 Copay per day, per stay: days 1–7<br>$0 Copay per day, per stay: day 8 and beyond<br>Prior authorization is required. | Our plan covers an unlimited number of days for an inpatient hospital stay.<br>$300 Copay per day, per stay: days 1–7<br>$0 Copay per day, per stay: day 8 and beyond<br>Prior authorization is required. |
| **Outpatient Hospital Coverage** | $250 Copay<br>Prior authorization may be required. | $240 Copay<br>Prior authorization may be required. | $290 Copay<br>Prior authorization may be required. |
| **Ambulatory Surgical Center (ASC)** | $250 Copay<br>Prior authorization may be required. | $240 Copay<br>Prior authorization may be required. | $250 Copay<br>Prior authorization may be required. |
| **Doctor Visits** *(primary care providers and specialists)* | Primary care physician (PCP) visit: $5 copay<br>Specialist visit: $35 copay<br>A referral is required for specialist visits.<br>Certain Medicare-covered services provided by a physician may require a prior authorization. | Primary care physician (PCP) visit: $0 copay<br>Specialist visit: $20 copay<br>A referral is required for specialist visits.<br>Certain Medicare-covered services provided by a physician may require a prior authorization. | Primary care physician (PCP) visit: $0 copay<br>Specialist visit: $25 copay<br>A referral is required for specialist visits.<br>Certain Medicare-covered services provided by a physician may require a prior authorization. |
| **Preventive Care** | **All Plans**<br>You pay nothing.<br>Our plans cover many preventive services, including:<br>• Abdominal aortic aneurysm screening<br>• Annual wellness visit<br>• Bone mass measurement | | |

| | Essence Advantage Gold (HMO) | Essence Advantage Platinum (HMO) | Essence Advantage Select (HMO) |
|---|---|---|---|
| **Preventive Care** *(continued)* | **All Plans**<br>• Breast cancer screening (mammogram)<br>• Cardiovascular disease risk reduction visit (therapy for cardiovascular disease)<br>• Cardiovascular disease testing<br>• Cervical and vaginal cancer screening<br>• Colorectal cancer screening<br>• Depression screening<br>• Diabetes screening<br>• Diabetes self-management training and diabetic services<br>• Health and wellness education programs<br>• HIV screening<br>• Immunizations (pneumonia, hepatitis B, COVID-19 and influenza)<br>• Medical nutrition therapy<br>• Medicare Diabetes Prevention Program (MDPP)<br>• Obesity screening and therapy to promote sustained weight loss<br>• Prostate cancer screening exams<br>• Screening and counseling to reduce alcohol misuse<br>• Screening for lung cancer with low-dose computed tomography (LDCT)<br>• Screening for sexually transmitted infections (STIs) and counseling to prevent STIs<br>• Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)<br>• Vision care<br>• "Welcome to Medicare" preventive visit (one-time)<br>Any additional preventive services approved by Medicare during the contract year will be covered. | | |
| **Emergency Care** | **All Plans**<br>$110 Copay<br>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.<br>We provide worldwide coverage. | | |
| **Urgently Needed Services** | **All Plans**<br>$35 Copay within the United States<br>$110 Copay outside of the United States<br>We provide worldwide coverage. | | |

| | Essence Advantage Gold (HMO) | Essence Advantage Platinum (HMO) | Essence Advantage Select (HMO) |
|---|---|---|---|
| **Diagnostic Services/Labs/ Imaging** *(Costs for these services may vary based on place of service.)* | Lab services: $10 copay<br>Diagnostic procedures and tests: $45 copay<br>Diagnostic colonoscopies: $0 copay<br>Diagnostic radiology services (such as MRI, CT and PET scans): $210 copay<br>Diagnostic mammograms: $0 copay<br>Therapeutic radiology services (such as radiation treatment for cancer): 20% coinsurance<br>X-rays: $45 copay<br>Prior authorization may be required. | Lab services: $10 copay<br>Diagnostic procedures and tests: $25 copay<br>Diagnostic colonoscopies: $0 copay<br>Diagnostic radiology services (such as MRI, CT and PET scans): $210 copay<br>Diagnostic mammograms: $0 copay<br>Therapeutic radiology services (such as radiation treatment for cancer): 20% coinsurance<br>X-rays: $25 copay<br>Prior authorization may be required. | Lab services: $5 copay<br>Diagnostic procedures and tests: 20% coinsurance<br>Diagnostic colonoscopies: $0 copay<br>Diagnostic radiology services (such as MRI, CT and PET scans): 20% coinsurance<br>Diagnostic mammograms: $0 copay<br>Therapeutic radiology services (such as radiation treatment for cancer): 20% coinsurance<br>X-rays: $45 copay<br>Prior authorization may be required. |
| **Hearing Services** | **Both Plans**<br>Medicare-covered exam to diagnose and treat hearing and balance issues: $0 copay<br>A referral is required for Medicare-covered hearing services. | | Medicare-covered exam to diagnose and treat hearing and balance issues: $20 copay<br>A referral is required for Medicare-covered hearing services.<br>Routine hearing exam: $20 copay<br>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 62. |
| **Dental Services** | Medicare-covered comprehensive dental services: $35 copay<br>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: $20 copay<br>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: $25 copay<br>A referral is required to visit an oral surgeon for Medicare-covered services and those services may require a prior authorization. |

| | Essence Advantage Gold (HMO) | Essence Advantage Platinum (HMO) | Essence Advantage Select (HMO) |
|---|---|---|---|
| **Dental Services** *(continued)* | See page 58 for information on optional supplemental dental coverage that can be purchased separately. | See page 58 for information on option supplemental dental coverage that can be purchased separately. | Preventive dental services: $0 copay<br>**Preventive services include:**<br>• Periodic oral evaluation (2 every calendar year)<br>• Comprehensive oral exam (2 every calendar year)<br>• Routine cleaning (2 every calendar year)<br>• Fluoride treatment (1 every calendar year)<br>• Horizontal bitewing X-ray(s) (up to 4, once every calendar year)<br>For details on an **additional shared allowance** that can be used on dental services and products, see the Flexible Benefits Card section on page 62. |
| **Vision Services** | Each visit to a specialist, such as an ophthalmologist or optometrist, for Medicare-covered eye exam: $35 copay<br>A referral is required.<br>Medicare-covered eye exam if performed by a primary care physician: $5 copay | Each visit to a specialist, such as an ophthalmologist or optometrist, for Medicare-covered eye exam: $20 copay<br>A referral is required.<br>Medicare-covered eye exam if performed by a primary care physician: $0 copay | Each visit to a specialist, such as an ophthalmologist or optometrist, for Medicare-covered eye exam: $25 copay<br>A referral is required.<br>Medicare-covered eye exam if performed by a primary care physician: $0 copay<br>Diabetic eye exams performed by a contracted specialist: $0 copay<br>1 pair of Medicare-covered eyeglasses (standard plastic single, bifocal, trifocal or lenticular lenses) or contact lenses after each cataract surgery. Our plan pays up to $150 for eyeglass frames or contact lenses after each cataract surgery: $0 copay<br>1 Routine eye exam every calendar year: $0 copay |
| | **Both Plans**<br>See page 58 for information on optional supplemental vision coverage that can be purchased separately. | | |

| | Essence Advantage Gold (HMO) | Essence Advantage Platinum (HMO) | Essence Advantage Select (HMO) |
|---|---|---|---|
| **Vision Services** *(continued)* | | | Eye refractions and dilation are covered during a routine exam performed by a contracted routine vision provider.<br>For details on an **additional shared allowance** that can be used on vision services and eyewear, see the Flexible Benefits Card section on page 62. |
| **Mental Health Services** | Inpatient visit:<br>Our plan covers an unlimited number of days for an inpatient hospital stay.<br>$270 Copay per day, per stay: days 1–6<br>$0 Copay per day, per stay: day 7 and beyond<br>Outpatient individual visit: $30 copay<br>Outpatient group visit: $20 copay<br>Prior authorization may be required. | Inpatient visit:<br>Our plan covers an unlimited number of days for an inpatient hospital stay.<br>$270 Copay per day, per stay: days 1–6<br>$0 Copay per day, per stay: day 7 and beyond<br>Outpatient individual visit: $20 copay<br>Outpatient group visit: $10 copay<br>Prior authorization may be required. | Inpatient visit:<br>Our plan covers an unlimited number of days for an inpatient hospital stay.<br>$270 Copay per day, per stay: days 1–6<br>$0 Copay per day, per stay: day 7 and beyond<br>Outpatient individual visit: $15 copay<br>Outpatient group visit: $10 copay<br>Prior authorization may be required. |
| **Skilled Nursing Facility (SNF)** | The plans cover up to 100 days each benefit period. No prior hospital stay is required.<br>• $0 Copay per day, per stay: days 1–20<br>• $150 Copay per day, per stay: days 21–100<br>Prior authorization is required. | The plans cover up to 100 days each benefit period. No prior hospital stay is required.<br>• $0 Copay per day, per stay: days 1–20<br>• $100 Copay per day, per stay: days 21–100<br>Prior authorization is required. | The plans cover up to 100 days each benefit period. No prior hospital stay is required.<br>• $0 Copay per day, per stay: days 1–20<br>• $150 Copay per day, per stay: days 21–100<br>Prior authorization is required. |

| | Essence Advantage Gold (HMO) | Essence Advantage Platinum (HMO) | Essence Advantage Select (HMO) |
|---|---|---|---|
| **Skilled Nursing Facility (SNF)** *(continued)* | Admission to a new or different SNF facility within the same benefit period may start a new stay for copay administration purposes. | Admission to a new or different SNF facility within the same benefit period may start a new stay for copay administration purposes. | 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<br>A referral is required. | $20 Copay<br>A referral is required. | $30 Copay<br>A referral is required. |
| **Ambulance** | $210 Copay<br>This copay applies to each one-way trip.<br>Prior authorization may be required for non-emergent transportation by ambulance. | $200 Copay<br>This copay applies to each one-way trip.<br>Prior authorization may be required for non-emergent transportation by ambulance. | $210 Copay<br>This copay applies to each one-way trip.<br>Prior authorization may be required for non-emergent transportation by ambulance. |
| **Transportation** | $0 Copay<br>Limited to 24 one-way trips to plan-approved health-related locations every year. | $0 Copay<br>Limited to 36 one-way trips to plan-approved health-related locations every year. | $0 Copay<br>Limited to 24 one-way trips to plan-approved health-related locations every year. |
| **Medicare Part B Drugs** | **All Plans**<br>For Part B drugs such as chemotherapy drugs: 20% coinsurance<br>Other Part B drugs, including insulin administered via a durable medical equipment insulin pump: 20% coinsurance<br>Prior authorization is required.<br>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. | | |

# Optional Supplemental Benefits

Essence Advantage Gold and Platinum members can purchase supplemental dental and vision coverage for an additional premium. The optional supplemental benefits package is not available for Essence Advantage Select plan members.

| | OSB Package (Dental (DHMO) and Vision) |
|---|---|
| **Monthly Plan Premium** | An additional $20 per month |
| **Deductibles** | This plan does not have a deductible. |
| **Dental Services** | **Preventive dental services:** $0 copay<br>**Preventive services include:**<br>• Periodic oral evaluation (2 every calendar year)<br>• Routine cleaning (2 every calendar year)<br>• Fluoride treatment (2 every calendar year)<br>• Horizontal bitewing X-ray(s) (1 series, once every 6 months)<br>• Intraoral complete series of radiographic images (1 series, once every 2 calendar years)<br>**Comprehensive services include (but are not limited to*):**<br>**Non-routine services** (non-routine cleaning, inspection of removable denture and home bleaching tray and gel): $0–$125 copay<br>**Diagnostic services** (radiographic images and post-operative re-evaluation visit): $0–$5 copay<br>**Restorative services** (amalgam fillings and titanium crowns): $8–$395 copay<br>**Endodontics** (pulp cap and mandibular partial dentures): $5–$395 copay<br>**Periodontics** (scaling for severe gingival inflammation and osseous surgery): $5–$385 copay<br>**Extractions** (extraction of an erupted tooth and coronectomy): $14–$140 copay<br>**Prosthodontics, other oral/maxillofacial surgery and other services** (adjusting complete or partial dentures and 3/4 cast high noble metal retainer crown): $18–$445 copay<br>*See Evidence of Coverage for more details and a complete listing. Some limitations and exclusions apply. |
| **Vision Services** | 1 Routine eye exam every calendar year: $25 copay<br>Eyeglass lenses (standard plastic single, bifocal, trifocal or lenticular lenses) every 2 calendar years: $25 copay<br>$150 Allowance for eyeglass frames or contact lenses every 2 calendar years: $25 copay<br>Upgrades may be available at an additional cost. |

# Part D Prescription Drug Benefits

| | Essence Advantage Gold (HMO) | Essence Advantage Platinum (HMO) | Essence Advantage Select (HMO) |
|---|---|---|---|
| **Deductible** | **All Plans**<br>These plans do not have a deductible. | | |
| **Initial Coverage** | **All Plans**<br>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.<br>If you reside in a long-term care facility, you pay the same as at a standard retail pharmacy.<br>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** | **All Plans**<br>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.* | | |

| Standard Retail Cost-Sharing | 30-Day Supply | 60-Day Supply | 90-Day Supply | 30-Day Supply | 60-Day Supply | 90-Day Supply |
|---|---|---|---|---|---|---|
| **Tier 1** *(Preferred Generic)* | $5 Copay | $10 Copay | $15 Copay | $0 Copay | $0 Copay | $0 Copay |
| **Tier 2** *(Generic)* | $15 Copay | $30 Copay | $45 Copay | $10 Copay | $20 Copay | $30 Copay |
| Select Insulins* | $15 Copay | $30 Copay | $45 Copay | $10 Copay | $20 Copay | $30 Copay |
| **Tier 3** *(Preferred Brand)* | $47 Copay | $94 Copay | $141 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)* | $100 Copay | $200 Copay | $300 Copay | $95 Copay | $190 Copay | $285 Copay |
| **Tier 5** *(Specialty Drug)* | 33% Coinsurance | Not offered | | 33% Coinsurance | Not offered | |
| **Tier 6** *(Select Care Drugs)*** | $0 Copay | $0 Copay | $0 Copay | $0 Copay | $0 Copay | $0 Copay |

| | Essence Advantage Gold (HMO) | | Essence Advantage Platinum (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** |
| **Tier 1** *(Preferred Generic)* | Not offered | | $10 Copay | Not offered | Not offered | $0 Copay |
| **Tier 2** *(Generic)* | Not offered | | $30 Copay | Not offered | Not offered | $20 Copay |
| Select Insulins* | Not offered | | $30 Copay | Not offered | Not offered | $20 Copay |
| **Tier 3** *(Preferred Brand)* | Not offered | | $94 Copay | Not offered | Not offered | $90 Copay |
| Select Insulins* | Not offered | | $94 Copay | Not offered | Not offered | $90 Copay |
| **Tier 4** *(Non-Preferred Brand)* | Not offered | | $200 Copay | Not offered | Not offered | $190 Copay |
| **Tier 5** *(Specialty Drug)* | Not offered | | | Not offered | | |
| **Tier 6** *(Select Care Drugs)*** | Not offered | | $0 Copay | Not offered | | $0 Copay |
| **Coverage Gap** | **All Plans**<br>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.<br>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.<br>During the coverage gap, your costs for tier 1 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.<br>**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.<br>If you're eligible for the Insulin Savings Program, your cost-share for Select Insulins won't increase during the coverage gap. | | | | | |

*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.

**Select care drugs are all tier 6 drugs and are used for treatment of diabetes, high cholesterol and high blood pressure.

| | Essence Advantage Gold (HMO) | | Essence Advantage Platinum (HMO) | Essence Advantage Select (HMO) | | |
|---|---|---|---|---|---|---|
| **Standard Retail Cost-Sharing** | **30-Day Supply** | **60-Day Supply** | **90-Day Supply** | **30-Day Supply** | **60-Day Supply** | **90-Day Supply** |
| **Tier 1** *(Preferred Generic)* | $5 Copay | $10 Copay | $15 Copay | $0 Copay | $0 Copay | $0 Copay |
| **Tier 6** *(Select Care Drugs)*** | $0 Copay | $0 Copay | $0 Copay | $0 Copay | $0 Copay | $0 Copay |
| **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 | | $10 Copay | Not offered | | $0 Copay |
| **Tier 6** *(Select Care Drugs)*** | Not offered | | $0 Copay | Not offered | | $0 Copay |
| **Catastrophic Coverage** | **All Plans**<br>After your yearly out-of-pocket drug costs reach $7,400, you pay the greater of:<br>• 5% Coinsurance or<br>• $4.15 Copay for generic (including brand-name drugs treated as generic) or a $10.35 Copay for other drugs (one-month supply)<br>**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 Gold (HMO) | Essence Advantage Platinum (HMO) | Essence Advantage Select (HMO) |
|---|---|---|---|
| **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: $20 copay per visit<br>Supplemental services, up to 15 visits per calendar year: $10 copay per visit<br>Supplemental services must be received through a contracted provider. | Medicare-covered services (chronic low back pain), up to 20 visits per calendar year: $25 copay per visit |

| | Essence Advantage Gold (HMO) | Essence Advantage Platinum (HMO) | Essence Advantage Select (HMO) |
|---|---|---|---|
| **Additional Smoking and Tobacco Cessation Counseling** | **All Plans**<br>In addition to the 8 visits covered under Original Medicare, all of our plans include coverage for up to an additional 8 group visits at no cost to you. | | |
| **Chiropractic Care** | **All Plans**<br>Manual manipulation of the spine to correct subluxation: $20 copay<br>A referral is required. | | |
| **Diabetes Supplies and Services** | **All Plans**<br>Diabetes self-management training: $0 copay<br>Diabetes monitoring supplies (including blood glucose monitors, lancets and blood glucose test strips*): $0 copay<br>When glucose meters and test strips are obtained at a pharmacy, coverage is limited to specific Abbott products.<br>Diabetic therapeutic custom-molded shoes or inserts: $0 copay<br>Authorization is required for some items (e.g., diabetic custom-molded shoes and inserts, continuous glucose meters, insulin pumps).<br>*See Evidence of Coverage for a complete listing. | | |
| **Durable Medical Equipment** *(wheelchairs, oxygen, etc.)* | **All Plans**<br>20% Coinsurance<br>Prior authorization may be required. | | |
| **Flexible Benefits Card** | Not offered | $75 Credit per quarter, supplied in the form of a debit card, provided by WEX, to use on health-related over-the-counter products<br>Any unused balance will not carry over from quarter to quarter and will expire at the end of the calendar year.<br>For more information, please see the Evidence of Coverage. | $250 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 services and products as well as health-related over-the-counter items<br>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.<br>Any unused balance carries over from quarter to quarter and will expire at the end of the calendar year.<br>For more information, please see the Evidence of Coverage. |

| | Essence Advantage Gold (HMO) | Essence Advantage Platinum (HMO) | Essence Advantage Select (HMO) |
|---|---|---|---|
| **Foot Care** *(podiatry services)* | $35 Copay<br>A referral is required. | $20 Copay<br>A referral is required. | $25 Copay<br>A referral is required. |
| **Home Healthcare** | **All Plans**<br>$0 Copay<br>A referral is required. | | |
| **Hospice** | **All Plans**<br>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. | | |
| **Meal Benefit** | **Both Plans**<br>**Immediately following surgery or inpatient hospital stay:**<br>$0 copay for up to 28 days, maximum of 56 meals per calendar year<br>Limited to 1 occurrence per calendar year<br>**If you have a chronic condition, including, but not limited to, some cardiovascular disorders, COPD or diabetes:**<br>$0 Copay for up to 14 days, maximum of 28 meals per calendar year<br>Limited to 1 occurrence per calendar year | | Not Covered |
| **Nurse Hotline** | **Both Plans**<br>24-Hour nursing hotline available at no additional cost (1-844-546-8773, TTY: 711) | | Not covered |
| **Outpatient Rehabilitation Services** | Cardiac rehabilitation services: $20 copay per day<br>Occupational, speech and language therapy visits: $30 copay<br>A separate copayment for occupational therapy will apply if other outpatient therapy services are rendered on the same day.<br>A referral is required. | Cardiac rehabilitation services: $20 copay per day<br>Occupational, speech and language therapy visits: $20 copay<br>A separate copayment for occupational therapy will apply if other outpatient therapy services are rendered on the same day.<br>A referral is required. | Cardiac rehabilitation services: $20 copay per day<br>Occupational, speech and language therapy visits: $30 copay<br>A separate copayment for occupational therapy will apply if other outpatient therapy services are rendered on the same day.<br>A referral is required. |

| | Essence Advantage Gold (HMO) | Essence Advantage Platinum (HMO) | Essence Advantage Select (HMO) |
|---|---|---|---|
| **Outpatient Substance Abuse** | Individual visit: $30 copay<br>Group visit: $20 copay<br>Prior authorization may be required. | Individual visit: $20 copay<br>Group visit: $10 copay<br>Prior authorization may be required. | Individual visit: $15 copay<br>Group visit: $10 copay<br>Prior authorization may be required. |
| **Over-the Counter (OTC) Coverage** | Not offered | $75 Credit per quarter, supplied in the form of a debit card (Flexible Benefits Card), provided by WEX, to use on health-related OTC items<br><br>For more information, see Flexible Benefits Card section on page 62. | $250 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.<br>For more information, see Flexible Benefits Card section on page 62. |
| **Prosthetic Devices** | **All Plans**<br>Prosthetic devices: 20% coinsurance<br>Related medical supplies: 20% coinsurance<br>Prior authorization may be required. | | |
| **Virtual/ Telehealth Visits** | $5–$35 Copay<br>You will pay the same copay for the virtual/telehealth visit as if the services were received in the provider's office.<br>A referral or authorization may be required. | $0–$20 Copay<br>You will pay the same copay for the virtual/telehealth visit as if the services were received in the provider's office.<br>A referral or authorization may be required. | $0–$30 Copay<br>You will pay the same copay for the virtual/telehealth visit as if the services were received in the provider's office.<br>A referral or authorization may be required. |
| | **All Plans**<br>Primary care physician telehealth visits (through Teladoc®): $10 copay<br>Services offered through Teladoc app on your iPhone or Android smartphone, via Teladoc.com or by calling toll-free at 1-800-Teladoc (1-800-835-2362) | | |
| **Wellness Programs** | Not offered | Health club membership/ fitness classes through Silver&Fit®: $0 copay | Health club membership/ fitness classes through Silver&Fit®: $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 1-844-205-8422 (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 1-844-205-8422 (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).

# 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.

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.

**Toll-free: 1-844-205-8422 (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.

The Silver&Fit program is provided by American Specialty Health Fitness, Inc., a subsidiary of American Specialty Health Incorporated (ASH). Silver&Fit is a federally registered trademark of ASH and used with permission herein. Participating facilities and fitness chains may vary by location and are subject to change.

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