Summary of Benefits

MEDICARE ADVANTAGE | 2024

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

ESSENCE HEALTHCARE®

Serving the greater St. Louis area (Missouri and Illinois)

Essence Advantage Choice (PPO)

Essence Advantage Choice Plus (PPO)

Summary of Benefits

January 1, 2024 – December 31, 2024

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

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

Sections in This Booklet

- Things to Know About **Essence Advantage 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 1-866-947-5816 (TTY: 711) to speak with a customer service representative.

Things to Know About Our PPO Plans

Hours of Operation

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

Phone Number and Website

- If you have questions, call 1-866-947-5816 (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 St. Louis City, the Missouri counties of Crawford, Franklin, Gasconade, Jefferson, Lincoln, Montgomery, St. Charles, St. Louis, Warren and Washington, and the Illinois counties of Bond, Clinton, Jersey, Macoupin, Madison, Monroe and St. Clair.

What's a PPO?

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

Which doctors, hospitals and pharmacies can I use?

Essence Advantage Choice and **Essence Advantage Choice Plus** have a network of doctors, hospitals, pharmacies and other providers. If you use providers that aren't in our network, they must agree to treat you. Except in emergency or urgent situations, out-of-network providers may deny care. You must generally use network pharmacies to fill your prescriptions for covered Part D drugs. Some of our network pharmacies have preferred cost-sharing. You may pay less if you use these pharmacies. You can see our plans' Provider Directory on EssenceHealthcare.com or call us, and we'll send you a copy.

What do we cover?

Like all Medicare health plans, we cover everything that Original Medicare covers—and *more.*

- **Our plan members get *all* of the benefits covered by Original Medicare.** For some of these benefits, you may pay more in our plan than you would in Original Medicare. For others, you may pay less.
- **Our plan members also get *more* than what's covered by Original Medicare.** Some of the extra benefits are outlined in this booklet.

What drugs do we cover?

We cover Part D drugs. 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'll send you a copy.

How will I determine my Part D drug costs?

Our plans group each medication into one of five tiers. You'll need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you've 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.		$22.20 Per month You must continue to pay your Medicare Part B premium.	
Deductibles	**Both Plans** These plans don't 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: $3,400 for covered hospital and medical services you receive from in-network providers	The maximum out-of-pocket amount is the most that you pay out of pocket during the calendar year for combined in- and out-of-network covered hospital and medical services. Your yearly limit(s) in this plan: $5,400 for covered hospital and medical services you receive from in- and out-of-network providers	The maximum out-of-pocket amount is the most that you pay out of pocket during the calendar year for in-network covered hospital and medical services. Your yearly limit(s) in this plan: $3,000 for covered hospital and medical services you receive from in-network providers	The maximum out-of-pocket amount is the most that you pay out of pocket during the calendar year for combined in- and out-of-network covered hospital and medical services. Your yearly limit(s) in this plan: $5,000 for covered hospital and medical services you receive from in- and out-of-network providers
	Both Plans If you reach the limit on out-of-pocket costs, hospital and medical services are still covered, and we pay the full cost for the rest of the year. Please note that you'll still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.			

Covered Medical and Hospital Benefits

	Essence Advantage 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 1-5 • $0 Copay per day, per stay: day 6 and beyond		Our plan covers an unlimited number of days for an inpatient hospital stay. • $275 Copay per day, per stay: days 1-5 • $0 Copay per day, per stay: day 6 and beyond	
	Prior authorization is required.		Prior authorization is required.	
Outpatient Hospital Coverage	**Both Plans** $280 Copay for outpatient hospital services, including surgery Copay is charged per surgery.			
	Prior authorization may be required.		Prior authorization may be required.	
Ambulatory Surgical Center (ASC)	**Both Plans** $180 Copay			
	Prior authorization may be required.		Prior authorization may be required.	
Doctor Visits *(primary care providers and specialists)*	Primary care physician (PCP) visit: $0 copay Specialist visit: $30 copay Certain Medicare-covered services provided by a physician may require a prior authorization.	Primary care physician (PCP) visit: $15 copay Specialist visit: $30 copay	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: $15 copay Specialist visit: $25 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're admitted to the same hospital within 24 hours for the same condition, you pay $0 for the emergency room visit. See the "Inpatient Hospital Care" section of this booklet for other costs. Emergency services are always considered in-network. We provide worldwide coverage.			
Urgently Needed Services	**Both Plans** $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: $30 copay Diagnostic colonoscopies: $0 copay Diagnostic radiology services (such as MRI, CT and PET scans): $200 copay Diagnostic mammograms: $0 copay Therapeutic radiology services (such as radiation treatment for cancer): 20% coinsurance X-rays: $15 copay Prior authorization may be required.	Lab services: 40% coinsurance Diagnostic procedures and tests: $30 copay Diagnostic colonoscopies: $0 copay Diagnostic radiology services (such as MRI, CT and PET scans): $200 copay Diagnostic mammograms: $0 copay Therapeutic radiology services (such as radiation treatment for cancer): 40% coinsurance X-rays: $15 copay	Lab services: $0 copay Diagnostic procedures and tests: $30 copay Diagnostic colonoscopies: $0 copay Diagnostic radiology services (such as MRI, CT and PET scans): $200 copay Diagnostic mammograms: $0 copay Therapeutic radiology services (such as radiation treatment for cancer): 20% coinsurance X-rays: $15 copay Prior authorization may be required.	Lab services: 40% coinsurance Diagnostic procedures and tests: $30 copay Diagnostic colonoscopies: $0 copay Diagnostic radiology services (such as MRI, CT and PET scans): $200 copay Diagnostic mammograms: $0 copay Therapeutic radiology services (such as radiation treatment for cancer): 40% coinsurance X-rays: $15 copay
Hearing Services	**Both Plans** Medicare-covered exam to diagnose and treat hearing and balance issues: $20 copay Routine hearing exam: $20 copay			
	$1,000 Allowance for up to 2 hearing aids every 2 calendar years (both ears combined)		$2,000 Allowance for up to 2 hearing aids every 2 calendar years (both ears combined)	
	One fitting/evaluation for hearing aids every 2 calendar years: $0 copay For details on an **additional shared allowance** that can be used on hearing 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
Dental Services	Preventive dental services: $0 copay **Preventive services include (but aren't limited to*):** • Periodic oral evaluation (2 every calendar year) • Comprehensive oral and periodontal exam (1 every 3 calendar years) • Limited oral evaluations (3 every calendar year) • Routine cleaning (2 every calendar year) • Fluoride treatment (2 every calendar year) • Horizontal bitewing X-ray(s) (up to 4), intraoral tomosynthesis bitewing and intraoral tomosynthesis periapical radiographic image (once every calendar year) • Intraoral complete series, intraoral tomosynthesis, vertical bitewings (7-8 images), panoramic radiographic image (once every 3 calendar years) • Intraoral occlusal radiographic image (2 every calendar year)			
	Medicare-covered dental services: $30 copay		Medicare-covered dental services: $25 copay	
	(In-Network) Prior authorization may be required for Medicare-covered services performed by an oral surgeon. Plan-covered comprehensive services: $0 copay **Comprehensive services include (but aren't limited to*):** **Restorative services** (amalgam/resin fillings, inlays/onlays, protective restorations, crowns and associated services) **Endodontics** (root canal treatment, retreatment root canal therapy, apicoectomy, pulpotomy and retrograde filling) **Periodontics** (maintenance following active therapy, scaling and root planing, full mouth debridement "deep cleaning," clinical crown lengthening and gingivectomy) **Extractions** (simple extractions, surgical extractions, coronectomy) **Major restoratives: prosthodontics** (removable dentures—complete, partial or immediate—overdentures, fixed dentures, including retainer crowns, endosteal implants, abutments/retainers, guided tissue regeneration) **Oral surgical procedures and other services** (anesthesia, including deep sedation, inhalation of nitrous oxide, IV and non-IV sedation, occlusal analysis, complete and limited adjustments) **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)			
	Yearly maximum benefit for combined preventive and comprehensive services: $5,000		Yearly maximum benefit for combined preventive and comprehensive services: $7,000	
	*See Evidence of Coverage for more details and a complete listing. Some limitations and exclusions apply. 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: $30 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: $25 copay	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	Diabetic eye exams: $30 copay	Diabetic eye exams performed by a contracted specialist: $0 copay	Diabetic eye exams: $25 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 lenses (standard plastic single, bifocal, trifocal or lenticular lenses) after each cataract surgery: 40% coinsurance	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 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: $0 copay	1 Pair of Medicare-covered eyeglass frames or contact lenses (or 2 six packs) after each cataract surgery: 40% coinsurance	1 Pair of Medicare-covered eyeglass frames or contact lenses (or 2 six packs) after each cataract surgery: $0 copay	1 Pair of Medicare-covered eyeglass frames or contact lenses (or 2 six packs) after each cataract surgery: 40% coinsurance
	Both Plans Our plan pays up to $200 for eyeglass frames or contact lenses after each cataract surgery. 1 Routine eye exam every calendar year: $0 copay Eye refractions and dilation are covered as part of the exam. 1 Pair of eyeglass lenses (standard plastic single, bifocal, trifocal or lenticular lenses) every calendar year: $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 calendar year: $0 copay Upgrades may be available at an additional cost. For details on an **additional shared allowance** that can be used on 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: $0 copay Outpatient group visit: $0 copay		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: $0 copay Outpatient group visit: $0 copay	
	Prior authorization may be required.		Prior authorization may be required.	
Skilled Nursing Facility (SNF)	The plan covers up to 100 days each benefit period. No prior hospital stay is required. • $0 Copay per day, per stay: days 1–20 • $170 Copay per day, per stay: days 21–100 Prior authorization is required. Admission to a new or different SNF within the same benefit period may start a new stay for copay administration purposes.	The plan covers up to 100 days each benefit period. No prior hospital stay is required. 40% Coinsurance per day, per stay: day 1 and beyond	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 within the same benefit period may start a new stay for copay administration purposes.	The plan covers up to 100 days each benefit period. No prior hospital stay is required. 40% Coinsurance per day, per stay: day 1 and beyond
Physical Therapy	**Both Plans** $40 Copay			

	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
Ambulance	$270 Copay		$250 Copay	
	Both Plans This copay applies to each one-way trip. Ambulance services are always considered in-network. Prior authorization may be required for non-emergent transportation by ambulance.			
Transportation	**Both Plans** $0 Copay Limited to 24 one-way trips to plan-approved health-related locations every year.			
Medicare Part B Drugs	Part B drugs (other than Part B insulin): You'll pay the lesser of 20% or the adjusted beneficiary coinsurance amount as provided by the Centers for Medicare & Medicaid Services (CMS). Part B insulin (insulin administered through a durable medical equipment pump): You'll pay the lesser of $35 or 20% coinsurance, for a one-month supply. Prior authorization may be required.	Part B drugs (other than Part B insulin): You'll pay the lesser of 40% or the adjusted beneficiary coinsurance amount as provided by the Centers for Medicare & Medicaid Services (CMS). Part B insulin (insulin administered through a durable medical equipment pump): You'll pay the lesser of $35 or 20% coinsurance, for a one-month supply.	Part B drugs (other than Part B insulin): You'll pay the lesser of 20% or the adjusted beneficiary coinsurance amount as provided by the Centers for Medicare & Medicaid Services (CMS). Part B insulin (insulin administered through a durable medical equipment pump): You'll pay the lesser of $35 or 20% coinsurance, for a one-month supply. Prior authorization may be required.	Part B drugs (other than Part B insulin): You'll pay the lesser of 40% or the adjusted beneficiary coinsurance amount as provided by the Centers for Medicare & Medicaid Services (CMS). Part B insulin (insulin administered through a durable medical equipment pump): You'll pay the lesser of $35 or 20% coinsurance, for a one-month supply.
	Both Plans Amounts you pay for Part B drugs count toward your maximum out-of-pocket amount; they don't count toward your Part D initial coverage limit or true out-of-pocket cost of $8,000.			

Part D Prescription Drug Benefits

	Essence Advantage Choice (PPO)			Essence Advantage Choice Plus (PPO)		
Deductible	**Both Plans** These plans don't have a deductible.					
Initial Coverage	**Both Plans** You pay the amounts listed in the following tables until your total yearly drug costs reach $5,030. 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.					
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
Tier 3 *(Preferred Brand)*	$45 Copay	$90 Copay	$135 Copay	$45 Copay	$90 Copay	$135 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	**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
Tier 2 *(Generic)*	$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
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	

	Essence Advantage Choice (PPO)			Essence Advantage Choice Plus (PPO)		
Standard Mail-Order Cost-Sharing	**30-Day Supply**	**60-Day Supply**	**90-Day Supply**	**30-Day Supply**	**60-Day Supply**	**90-Day Supply**
Tier 1 *(Preferred Generic)*	Not offered		$0 Copay	Not offered		$0 Copay
Tier 2 *(Generic)*	Not offered		$0 Copay	Not offered		$0 Copay
Tier 3 *(Preferred Brand)*	Not offered		$112.50 Copay	Not offered		$112.50 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	
Out-of-Network Cost-Sharing	**30-Day Supply**	**60-Day Supply**	**90-Day Supply**	**30-Day Supply**	**60-Day Supply**	**90-Day Supply**
Tier 1 *(Preferred Generic)*	$4 Copay	Not offered		$4 Copay	Not offered	
Tier 2 *(Generic)*	$12 Copay	Not offered		$12 Copay	Not offered	
Tier 3 *(Preferred Brand)*	$47 Copay	Not offered		$47 Copay	Not offered	
Tier 4 *(Non-Preferred Brand)*	$100 Copay	Not offered		$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'll pay for your drugs. The coverage gap begins after the total yearly drug cost (including what your plan has paid and what you've paid) reaches $5,030. 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 $8,000, which is the end of the coverage gap. Not everyone will enter the coverage gap. During the coverage gap, for tiers 1 and 2, you'll pay the same as during the initial coverage phase, or 25% of the drug cost (whichever is lower). Coverage gap costs for tiers 1 and 2 are shown in the following table. You'll need to use your formulary to locate your drug's tier. **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 Choice (PPO)			Essence Advantage Choice Plus (PPO)		
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
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)*	$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
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	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
Catastrophic Coverage	**Both Plans** After your yearly out-of-pocket drug costs reach $8,000, you pay $0 for all plan-covered drugs.					

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: $30 copay per visit		Medicare-covered services (chronic low back pain), up to 20 visits per calendar year: $25 copay per visit	
Chiropractic Care	**Both Plans** Manual manipulation of the spine to correct subluxation: $20 copay			
Diabetes Supplies and Services	**Both Plans** Diabetes self-management training: $0 copay Diabetes monitoring supplies (including blood glucose monitors, lancets and blood glucose test strips*): $0 copay When glucose meters and test strips are obtained at a pharmacy, coverage is limited to specific Abbott products. Diabetic therapeutic custom-molded shoes or inserts: 20% coinsurance *See Evidence of Coverage for a complete listing.			
	Authorization is required for some items (e.g., diabetic custom-molded shoes and inserts, continuous glucose meters, insulin pumps).		Authorization is required for some items (e.g., diabetic custom-molded shoes and inserts, continuous glucose meters, insulin pumps).	
Durable Medical Equipment *(wheelchairs, oxygen, etc.)*	20% Coinsurance Prior authorization may be required.	40% Coinsurance	20% Coinsurance Prior authorization may be required.	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
Flexible Benefits Card	$152 Shared credit per quarter, supplied in the form of a debit card, provided by WEX, to use on certain non-Medicare-covered dental, vision and hearing products and services as well as health-related over-the-counter (OTC) items		$375 Shared credit per quarter, supplied in the form of a debit card, provided by WEX, to use on certain non-Medicare-covered dental, vision and hearing products and services as well as health-related over-the-counter (OTC) items	
	Both Plans 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. For OTC items, the Flex Card can be used at approved retail locations and the online Essence OTC Store. Any unused balance carries over from quarter to quarter but expires at the end of the calendar year. The Flex Card isn't a credit card. It can't be converted to cash or used to pay plan premiums or for non-covered Flex Card services. For more information, please see the Evidence of Coverage.			
Foot Care *(podiatry services)*	$30 Copay		$25 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	**Both Plans** Individual visit: $0 copay Group visit: $0 copay			
	Prior authorization may be required.		Prior authorization may be required.	
Outpatient Rehabilitation Services	**Both Plans** Cardiac rehabilitation services: $20 copay per day Occupational, speech and language therapy visits: $40 copay			

	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 *(continued)*	**Both Plans** A separate copayment for occupational therapy will apply if other outpatient therapy services are rendered on the same day.			
	Prior authorization may be required.		Prior authorization may be required.	
Over-the-Counter (OTC) Coverage	$152 Credit per quarter, supplied in the form of a debit card (Flexible Benefits Card) provided by WEX.		$375 Credit per quarter, supplied in the form of a debit card (Flexible Benefits Card) provided by WEX.	
	Both Plans Allowance is shared between health-related OTC items, dental, vision and hearing. For more information, see the Flexible Benefits Card section on page 17.			
Prosthetic Devices	**Both Plans** Prosthetic devices: 20% coinsurance Related medical supplies: 20% coinsurance			
	Prior authorization may be required.		Prior authorization may be required.	
Virtual/ Telehealth Visits	**Both Plans** $0–$40 Copay You'll pay the same copay for the virtual/telehealth visit as if the services were received in the provider's office.			
	Prior authorization may be required (matches requirement for in-person visits).		Prior authorization may be required (matches requirement for in-person visits).	
Wellness Programs	**Both Plans** Health club membership/fitness classes through SilverSneakers®: $0 copay			

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. See Understanding Important Rules for information regarding the rules for seeing providers outside of our network.
- [ ] Review the Provider Directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- [ ] Review the formulary to make sure your drugs are covered.

Understanding Important Rules

- [ ] In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- [ ] Benefits, premiums and/or copayments/coinsurance may change on January 1, 2025.
- [ ] For our HMO plans, except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the Provider Directory).
- [ ] Our PPO plans allow you to see providers outside of our network (non-contracted providers). However, while we pay for covered services, the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care. In addition, you may pay a higher copay for services received by non-contracted providers.
- [ ] **Effect on Current Coverage.** If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage healthcare coverage will end once your new Medicare Advantage coverage starts. If you have Tricare, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact Tricare for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.

Notes

Notes

Notes

Essence Healthcare includes HMO and PPO plans with Medicare contracts. Enrollment in Essence Healthcare depends on contract renewal. All Essence plans include Part D drug coverage. To enroll, you must have both Medicare Parts A and B and reside in the plan service area.

You must continue to pay your Medicare Part B premium. Please note that enrollment is limited to specific times of the year.

Members enrolled in an Essence Healthcare PPO plan may see out-of-network providers (non-contracted providers). Out-of-network/non-contracted providers are under no obligation to treat plan members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

Essence Healthcare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

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®

13900 Riverport Drive
St. Louis, MO 63043
EssenceHealthcare.com

Our service area: St. Louis City, the Missouri counties of Crawford, Franklin, Gasconade, Jefferson, Lincoln, Montgomery, St. Charles, St. Louis, Warren and Washington, and the Illinois counties of Bond, Clinton, Jersey, Macoupin, Madison, Monroe and St. Clair

Form Approved
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Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-866-597-9560 (TTY: 711). Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-866-597-9560 (TTY: 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-866-597-9560 (TTY: 711). 我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-866-597-9560 (TTY: 711)。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-866-597-9560 (TTY: 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-866-597-9560 (TTY: 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-866-597-9560 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-866-597-9560 (TTY: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-866-597-9560 (TTY: 711) 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-866-597-9560 (TTY: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-866-597-9560 (TTY: 711) . سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-866-597-9560 (TTY: 711) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-866-597-9560 (TTY: 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-866-597-9560 (TTY: 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-866-597-9560 (TTY: 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-866-597-9560 (TTY: 711). Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。通訳をご用命になるには、1-866-597-9560 (TTY: 711) にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサービスです。