The Complete 5-Star Plan Guide

GET A BETTER PLAN TODAY

ESSENCE ADVANTAGE® (HMO)

ESSENCE HEALTHCARE®

Serving the Cincinnati area (Kentucky and Indiana)

The Opportunity

You may be eligible for a special Medicare enrollment period because Essence Healthcare is a 5-star plan in 2024.

During the 5-Star Special Enrollment Period, you may only enroll in an Essence HMO plan. You may be eligible for other Essence plans during standard Medicare enrollment windows or a different Special Enrollment Period. See page 20 for more information.

What's the 5-Star Special Enrollment Period?

Each year in October, the Centers for Medicare & Medicaid Services (CMS) releases Medicare Advantage (MA) plan ratings. **For 5-star plans, enrollment is allowed throughout the year** instead of only during standard periods.

CMS created the 5-Star Special Enrollment Period so Medicare beneficiaries can experience the exceptional service and benefits of a 5-star plan.

During the 5-Star Special Enrollment Period, you can:

- Join a 5-star MA plan for the first time.
- Switch from another health plan to a 5-star MA plan.

ESSENCE HEALTHCARE®

★★★★★

AWARDED MEDICARE'S HIGHEST RATING

2022 | 2023 | 2024

Table of Contents

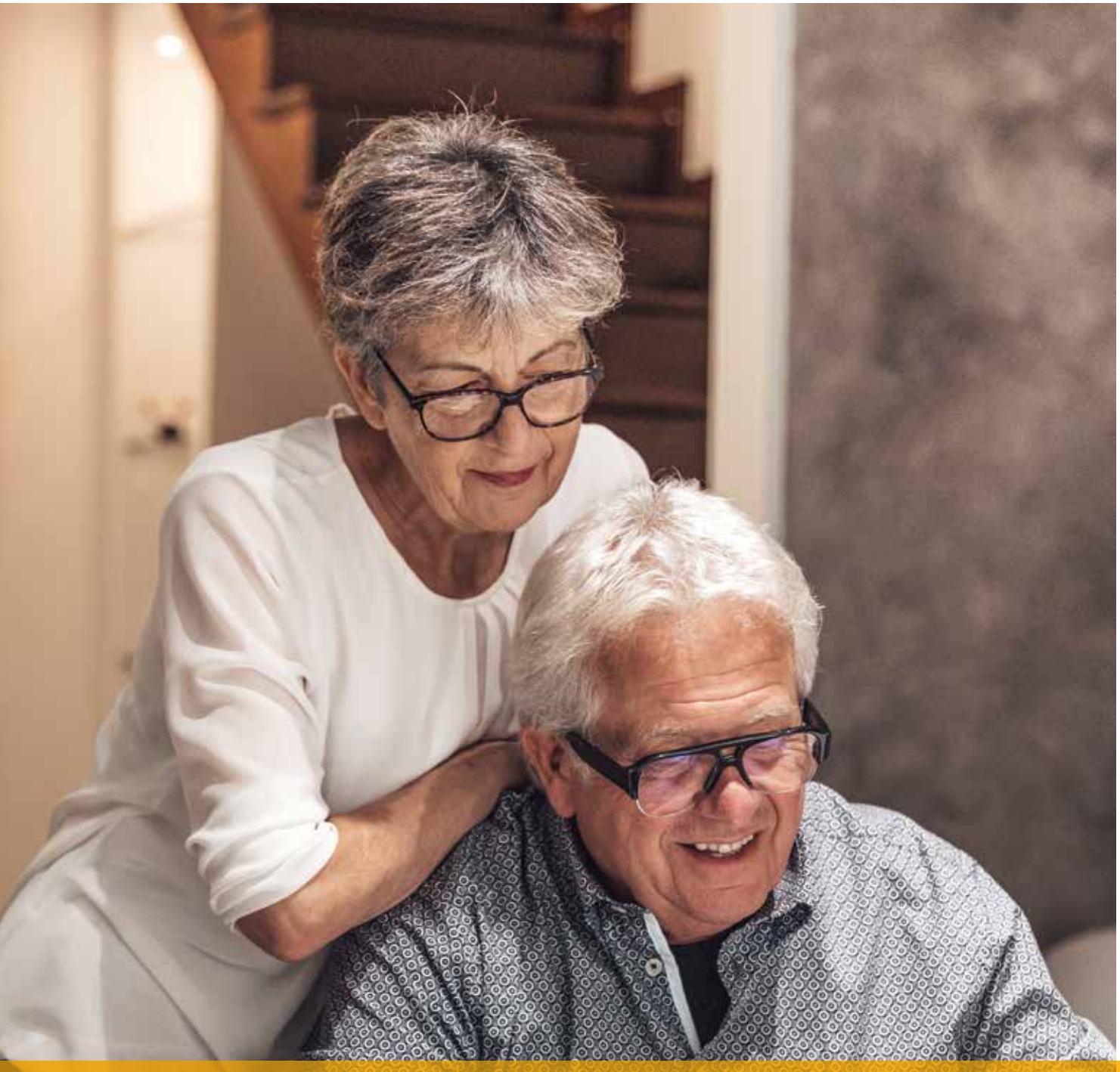
5-Star Explained
page 6

What We Offer
page 9

FAQs
page 16

Ready to Enroll
page 19

Plan Details
page 34



5 Benefits of a 5-Star Plan

1. The Benefits

Your benefits should evolve and improve in ways that matter.

Essence listens and learns from its members. From dental, vision and over-the-counter coverage to a preloaded Flex Card that lets you use your extras as you see fit, we work to include benefits that grow with you through any stage of life.

2. The Savings

Cost should never be a roadblock to maintaining your health and savings.

With a $0 monthly plan premium and low or no copays for important services and prescriptions, Essence helps you stay healthy while saving more.

3. The Care Team

You deserve the best doctors and a health plan that does more than send bills.

Essence works together with you and with leading area providers on a mission to keep you healthy. Think of us as your partners in health.

4. The Service

You need a customer service team that's easily accessible and knowledgeable.

Essence Customer Service is 100 percent U.S. based and is extensively trained on your health plan. You'll experience quick connection with a live Essence expert.

5. The Timing

One of the best things about a 5-star plan is that you can enroll NOW and get the best Medicare has to offer.

- Miss your initial or annual enrollment deadline?
- Unhappy with your current plan?
- Need more benefits or benefit allowances?

It's easy to enroll in an Essence plan.

Using Star Ratings to Get the Best Plan

Star ratings give you an unbiased view of a health plan by offering a single summary score that makes it easy for you to compare different plans based on quality and performance. They're a lot like Consumer Reports® but specific to Medicare plans.

CMS rates plans using over 50 quality measures that fall into five categories:

- Staying healthy
- Managing chronic conditions
- Member experience
- Member complaints and appeals
- Customer service

★★★★★ = **Excellent**
★★★★ = **Above Average**
★★★ = **Average**
★★ = **Below Average**
★ = **Poor**

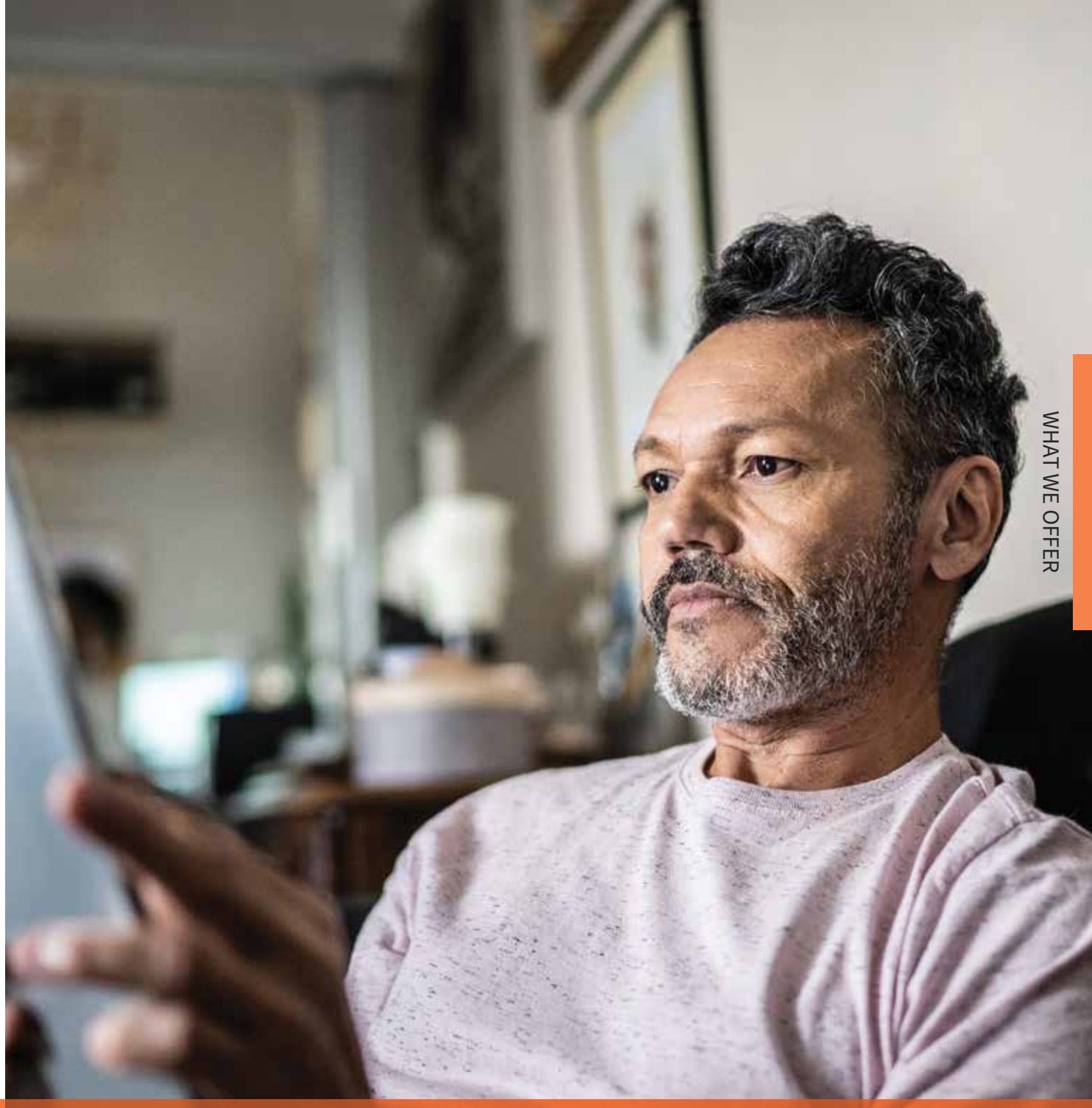
Those quality measures lend themselves to an Overall Plan Rating, which can range from 1 to 5 stars. The higher the rating, the better a plan performed in each of the five main categories.

What Makes a 5-Star Plan Special?

Staying healthy and managing chronic conditions:
5-Star plans take actions to better the health of their members. They also excel in helping members manage chronic health conditions.

Member experience and complaints:
A 5-star plan has positive survey responses from members, fewer complaints and tends to keep its members year after year.

Customer service:
A 5-star plan handles customer requests in a timely, thorough manner and leaves members satisfied with their customer service experience.



What We Offer

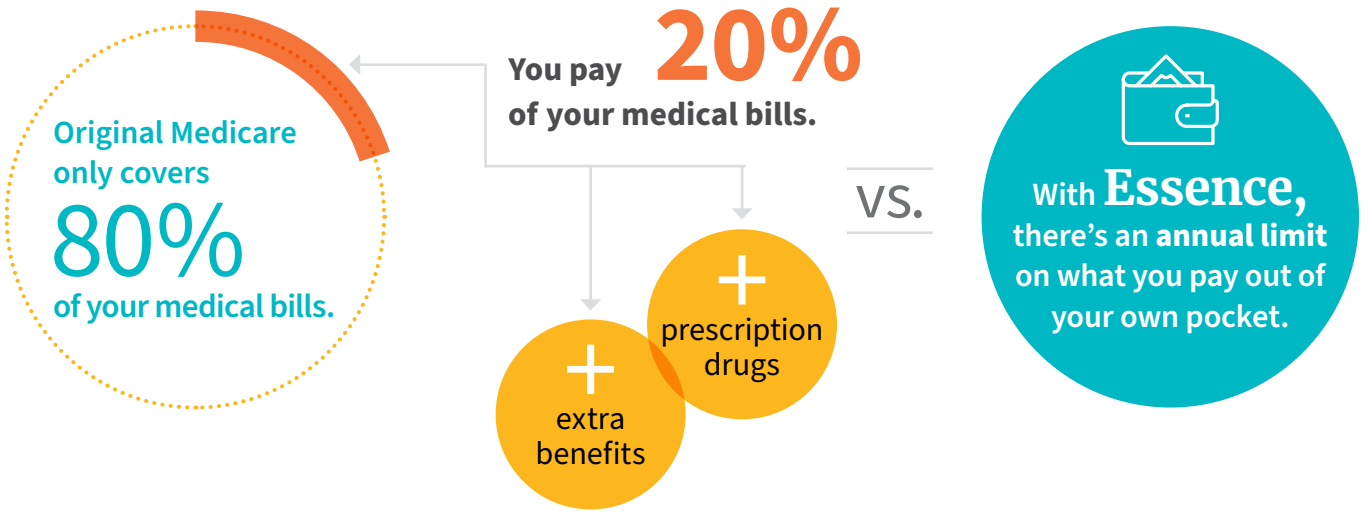
The Essence Difference

Hospital and Medical Coverage

Essence provides all the hospital (Part A) and medical (Part B) coverage you find with Original Medicare, but there are some key differences that we think you'll like. With Essence, you'll pay a low copay for the majority of your hospital and medical services and, in some instances, no copay at all. We also don't include any annoying deductibles in our plans, which means we start covering you on day one.

One of the best differences between Essence and Original Medicare is that we put a limit on what you pay out of your own pocket each year for any hospital and medical services.

This limit is referred to as maximum out-of-pocket protection (MOOP). No matter what happens, you'll never pay more than the MOOP limit.



Did You Know?

Your maximum out-of-pocket limit is different than a deductible. A MOOP limit is the total amount that you could pay annually for covered hospital and medical services. Once you meet this limit, you won't have to pay any more money for covered services during that year. Note that there are some services that don't count toward your MOOP limit, such as certain eyewear or dental work. A deductible is the amount that you must pay out of pocket before a plan starts paying their share of a covered service. With Essence, you won't have a deductible.

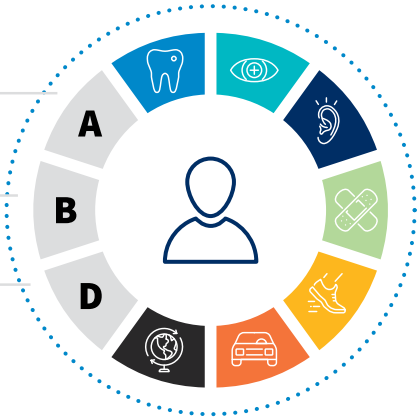
The Complete Protection Package

Unlike other traditional Medicare options, Medicare Advantage plans, including Essence, bundle your hospital, medical and prescription drug coverage into one plan. You'll also get important extras. And we do this for a $0 monthly premium.

Original Medicare

- Hospital Coverage (Part A)
- Medical Coverage (Part B)

Prescription Drug Coverage (Part D)



Money-Saving Extras*

- **Dental Coverage**
- **Vision Coverage**
- **Hearing Coverage**
- **Over-the-Counter (OTC) Coverage**
- **Fitness Club Memberships/ SilverSneakers®**
- **Transportation Assistance**
- **Coverage when Traveling**

The Essence Advantage

Everything you want and need in one convenient, affordable plan

Core + MORE

Preloaded Flex Card

All Essence plans include core extras like dental, vision and hearing. With our Flex Card, you'll get MORE MONEY to spend in those categories, and on OTC items. Use your card at eligible retail locations, the online Essence OTC Store and with out-of-network providers—on what's important to you.

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. See page 13 for more information. *Benefit limitations and exclusions may apply to extra benefits.

Plan Benefit Highlights:
Hospital, Medical and Extra Benefits

Below are some of the many benefits included in the Essence HMO plan. For more details and benefits, please see the **Summary of Benefits** starting on page 34.

Essence Advantage (HMO)—**$0** monthly premium	
Annual Deductible	**$0** Per calendar year
Preventive Care/Screenings	**$0** Copay
Primary Care Physician Visits*	**$0** Copay
Specialist Doctor Visits*	**$30** Copay
Urgent Care	**$30** Copay
Emergency Care	**$110** Copay
Lab Services	**$5** Copay
Inpatient Hospital Care	**$295** Days 1–5 **$0** Day 6 & beyond
Outpatient Surgery at Hospital	**$285** Copay
Outpatient Surgery at ASC**	**$245** Copay
Maximum Out-of-Pocket Limit	**$3,650** Per calendar year

*If your doctor offers **telehealth visits,** you'll have the same copay as an in-office visit. **Ambulatory Surgical Center. ***Health-related locations, including provider offices, adult day care, rehabilitation clinics, dental offices, pharmacies and more. †For use on certain non-Medicare-covered items and services in the categories of dental, vision, hearing and OTC.

Flexible Benefits Card

All Essence plans include core extras like dental, vision and hearing. With our Flex Card, you'll get MORE MONEY to spend in those categories, and on OTC items. Use your card at eligible retail locations, the online Essence OTC Store and with out-of-network providers—on what's important to you. Whether you need the total amount for one category or want to split it among others—it's up to you!

Dental	**$0** Copay for preventive dental, such as cleanings, exams, X-rays and more **$3,000** Annual allowance for comprehensive dental, such as fillings, extractions, endodontics, implants, dentures and more. Allowance applies to combined comprehensive and preventive services.
Vision	**$0** Copay for routine eye exam **$0** Copay for eyewear (eyeglass frames and lenses or contact lenses) **$200** Allowance for frames or contacts every calendar year
Hearing	**$20** Copay for routine hearing exam **$2,000** Allowance for up to 2 hearing aids (all types) every 2 calendar years (both ears combined) **$0** Copay for hearing aid fitting/evaluation (covered once every 2 calendar years)
Transportation Assistance	**$0** Copay for 24 one-way trips to approved locations per calendar year***
Fitness/Gym Membership	SilverSneakers included at no additional cost
Preloaded Flexible Benefits Card†	**$520** Shared annual allowance for **OTC items, dental, vision and hearing** Applied quarterly in $130 increments **Amounts listed apply for both in- and out-of-network services.**

Plan Benefit Highlights:
Part D Drug Coverage

Below are some of the Part D prescription drug benefits included in the Essence HMO plan. For more details and benefits, please see the **Summary of Benefits** starting on page 34.

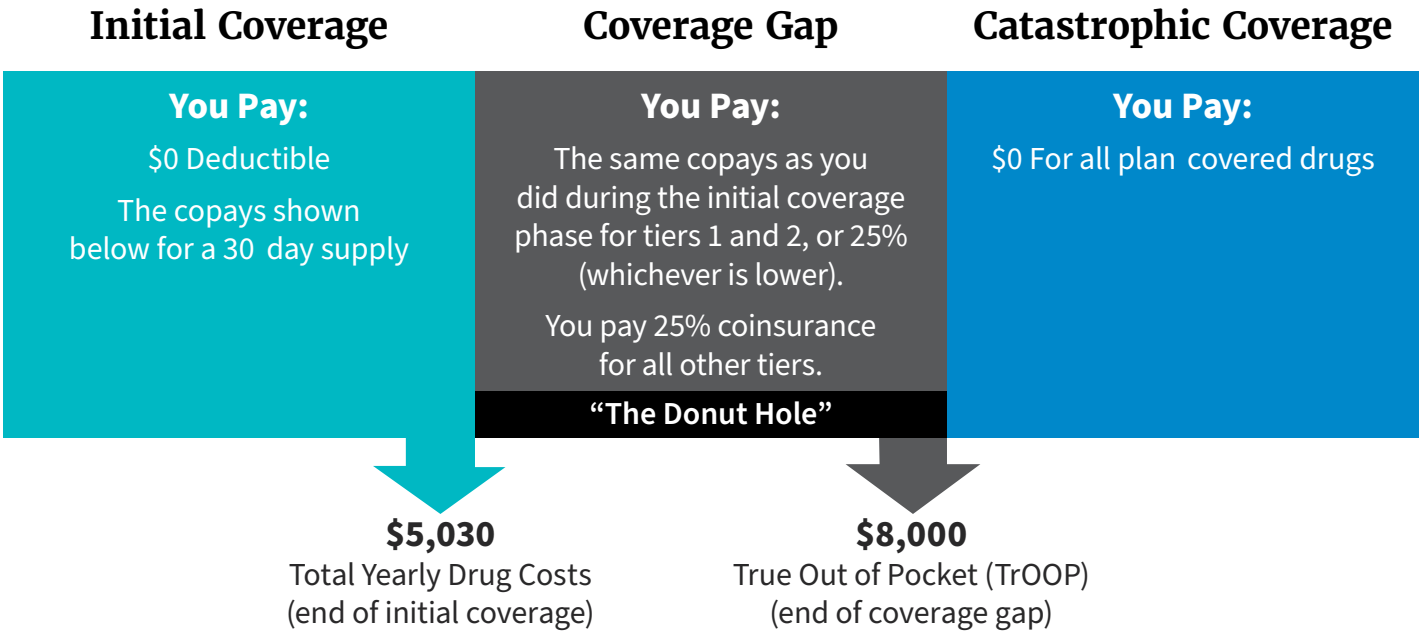
New for 2024! Gap Coverage and Catastrophic Coverage

Essence has eliminated copays on generic drugs during the gap.* And if you hit the **catastrophic phase, you won't pay anything for covered drugs.**

	Preferred Pharmacy Benefits (30-day supply)				
	Tier 1 **Preferred Generic**	Tier 2 **Generic**	Tier 3 **Preferred Brand**	Tier 4 **Non-Preferred Brand**	Tier 5 **Specialty Drug**
Essence Advantage (HMO)	**$0** Copay	**$0** Copay	**$40** Copay	**$95** Copay	**33%** Coinsurance

*Coverage gap copay amounts applicable at preferred pharmacies. **Prices shown are for a 30-day supply.

Part D Coverage Phases**



Non-Preferred Pharmacy Benefits (30-day supply)

Tier 1 **Preferred Generic**	Tier 2 **Generic**	Tier 3 **Preferred Brand**	Tier 4 **Non Preferred Brand**	Tier 5 **Specialty Drug**
$5 Copay	**$10** Copay	**$47** Copay	**$100** Copay	**33%** Coinsurance

Important—you won't pay more than $35 for a one-month supply of each **insulin** product covered by our plan.

Frequently Asked Questions

Part of making sure you're getting the best coverage for your unique needs is having no unanswered questions. Listed below are some of the most common questions we hear from Medicare shoppers. If you have additional questions, one of our customer service team members is ready and waiting to help; just give us a call at 1-877-322-2250 (TTY: 711).

"There's no monthly premiums, but I still get the same coverage I had when I was working and when you're retired, that's very important."

–Mike V., Essence member

How can you offer a plan for a $0 premium?

Medicare pays private insurance companies, like Essence, to manage Medicare Advantage plans and better serve people with Medicare. By working cooperatively with doctors and hospitals, eliminating waste and focusing on helping our members stay healthy, we're able to save money. We then pass those savings on to our members in the form of generous benefits, lower copays and a $0 premium.

Does your plan come with a deductible?

As an Essence member, you won't have to meet medical or pharmacy deductibles. Your coverage begins with the first dollar you spend. Typically, Original Medicare's Part B does come with a deductible, but when you sign up for an Essence plan, we cover that deductible for you so that you can start enjoying the many benefits we offer as soon as you join our plan.

What is the maximum out-of-pocket limit?

Sometimes, people think that maximum out-of-pocket protection, often referred to as MOOP, is the same thing as a deductible. The MOOP amount puts a limit on what you have to pay out of your own pocket each year for covered medical expenses. Once you reach your MOOP limit in a given year, you'll no longer have to pay copays or coinsurance for medical or hospital-related services. This is a great feature that protects your savings and makes it easy to budget for your healthcare costs—because you know you'll never pay more than the maximum out-of-pocket limit for covered medical expenses.

If I join Essence, will I lose my Original Medicare coverage?

No. When you join Essence, you're still participating in Medicare and still have all the rights and protections you're entitled to as a Medicare beneficiary.

Is this a Medicare supplement?

No. We aren't a Medicare supplement. A Medicare supplement is a private company that charges up-front monthly premiums to help cover what Original Medicare doesn't cover. It's important to note that supplements don't include Part D prescription drug coverage or extra benefits like dental and vision. Essence Healthcare is a Medicare Advantage (MA) plan. Medicare pays companies like Essence to manage MA plans. Because of this, we're able to offer all-in-one plans that include hospital, medical and Part D prescription drug coverage as well as valuable extras like dental and vision benefits for a $0 monthly premium.

How does the Flex Card work?

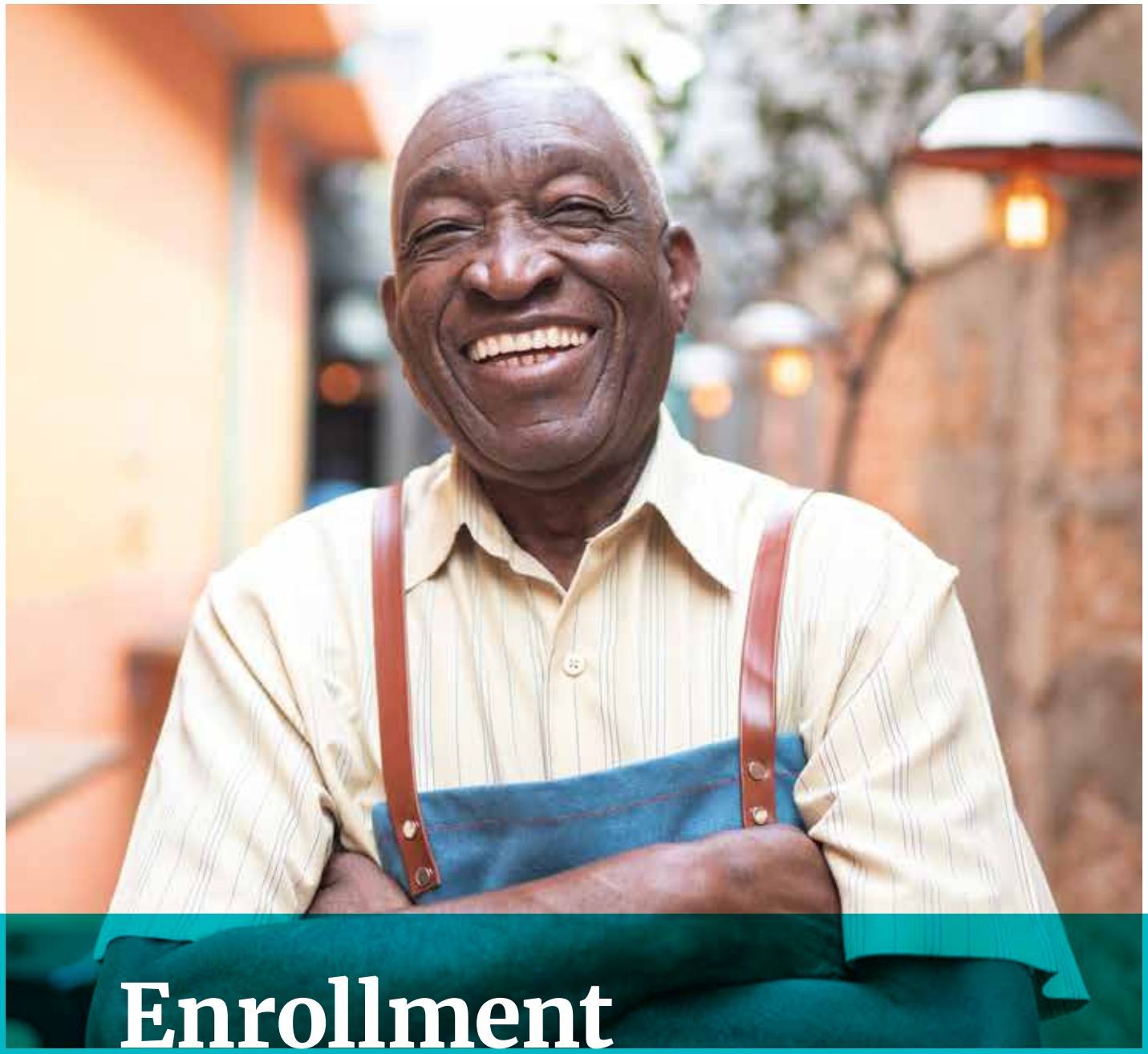
As an Essence member, you get built-in dental, vision and hearing benefits. Your debit Flex Card gives you more money to spend on certain non-Medicare-covered items and services in those categories, and on over-the-counter items. Examples include eyewear, hearing aids or dental services, such as X-rays or fillings, if you've run out of your existing plan coverage. You can use up to your whole allowance in any of the allowed categories—with both in-network and out-of-network providers. Your card is valid at eligible physical retail locations or the online Essence OTC Store. For more information on eligible items and locations, call Essence Customer Service.

Your total annual allowance is divided into equal amounts that are loaded on the card at the beginning of each quarter. Funds roll over from quarter to quarter but expire at the end of the calendar year. Your 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.

Will I need a referral to see a specialist?

Regardless of whether you're an HMO or PPO plan member, you won't need a referral to see specialists.

ESSENCE
HEALTHCARE
A Healthy Tomorrow Starts Today.



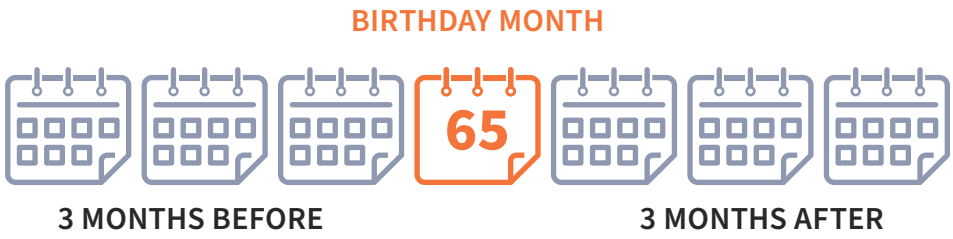
Enrollment Information

Medicare Enrollment Periods	20
How to Enroll	21
Pre-Enrollment Checklist	22
What to Expect After Enrollment	23
Essence Enrollment Application	25

Medicare Enrollment Periods

Medicare has different enrollment periods for Medicare beneficiaries. The chart below explains the enrollment periods, their time frames and requirements for enrolling during that time.

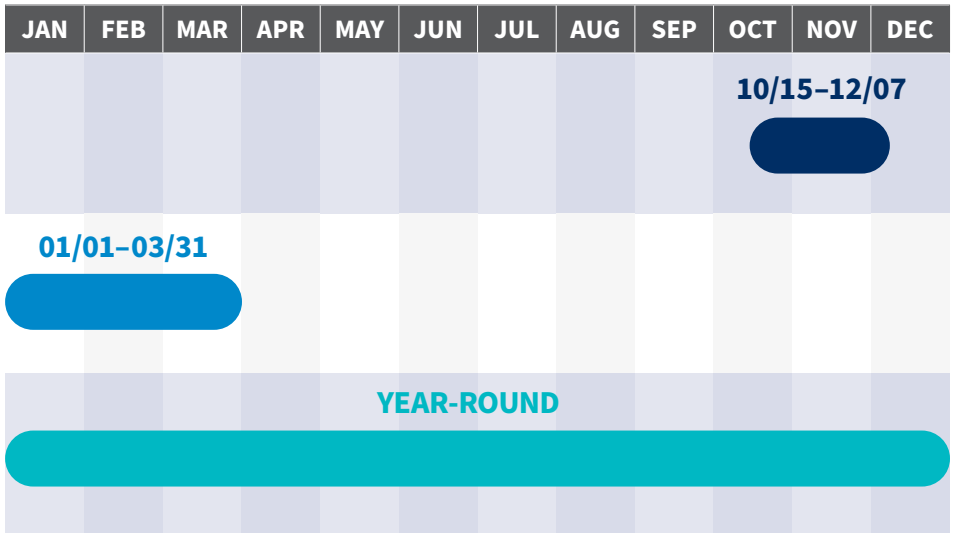
Initial Enrollment Period (IEP)
Sign up for Medicare for the first time.



Annual Enrollment Period (AEP)
Switch, drop or join a different Medicare plan.*

Open Enrollment Period (OEP)
Make a one-time election to change your Medicare Advantage plan.*

Special Enrollment Period (SEP)
Enroll in a Medicare plan if you qualify.**



Reminder:

If you're using the 5-Star Special Enrollment Period, you may enroll in an Essence HMO plan. If you're enrolling during any other enrollment period, you may choose an HMO or PPO Essence plan.

*You can also switch to Original Medicare as well as add or drop Part D coverage.
**Examples of when you'd qualify include a recent move, leaving employer or union coverage, or having a 5-star-rated plan available in your area.

How to Enroll

Below are ways you can enroll in an Essence plan.

Enroll with your licensed Essence agent or insurance broker.
Your agent or broker can help you complete the enrollment application.

Enroll over the phone.
Simply give us a call and an experienced local Essence representative will be happy to enroll you over the phone. Call toll-free: 1-877-322-2250 (TTY: 711), 8 a.m. to 8 p.m., seven days a week.

Enroll online.
Go to **EssenceHealthcare.com** and click “Enroll Now.”

Enroll by mail.
Complete the enrollment application located in the back of this kit and mail it using the postage-paid envelope included.

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 1-877-322-2250 (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 1-877-322-2250 (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 plan, 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 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.
- [ ] **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.

What to Expect After Enrollment

Enrolling in an Essence plan is the beginning of many things: benefits designed to get and keep you healthy during any stage of life, having a healthcare team who works hard for you from the minute you sign up, and it's the start of a plan that eliminates roadblocks and increases financial security so you can focus on your health. We hope you're as excited as we are for this new journey. Here's a list of items to expect after you enroll.

Receipt of Your Completed Enrollment Application

Depending on how you enroll, you'll get a copy of the receipt or a confirmation number. If you enrolled via paper form, you'll get an enrollment verification letter instead.

Enrollment Verification Letter

This letter confirms your intent to enroll in an Essence plan and summarizes the conditions and terms of becoming an Essence member.

Member ID Card

You'll receive two member ID cards in the mail. Be sure to bring your new member ID card every time you visit the doctor, hospital, pharmacy or dentist.

Welcome Kit

This kit includes important plan information and documents needed to get familiar with your plan.

Financial Assistance Letter

If you qualify, you may receive a letter on how to get extra help with your Medicare premiums and other healthcare costs.

ESSENCE
HEALTHCARE
A Healthy Tomorrow Starts Today.

OMB No. 0938-1378
Expires: 7/31/2024

2024 Enrollment Request Form

Use this form to enroll in an Essence Healthcare plan.

Who can use this form?

People with Medicare who want to join a Medicare Advantage Plan.

To join a plan, you must:

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area

Important: To join a Medicare Advantage Plan, you must also have both:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)

When do I use this form?

You can join a plan:

- Between October 15 – December 7 each year (for coverage starting January 1)
- Within 3 months of first getting Medicare
- In certain situations where you're allowed to join or switch plans

Visit Medicare.gov to learn more about when you can sign up for a plan.

What do I need to complete this form?

- Your Medicare Number (the number on your red, white, and blue Medicare Card)
- Your permanent address and phone number

Note: You must complete all items in Section 1. The items in Section 2 are optional – you can't be denied coverage because you don't fill them out.

Reminders:

- If you want to join a plan during fall open enrollment (October 15 – December 7), the plan must get your completed form by December 7.
- Your plan will send you a monthly invoice for the plan's premium and any applicable Late Enrollment Penalty. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

What happens next?

Send your completed and signed form to:

Essence Healthcare
P.O. Box 12487
St. Louis, MO 63132

You can also enroll online at EssenceHealthcare.com.

Once we process your request to join, we'll contact you.

How do I get help with this form?

Call Essence Healthcare at 1-877-322-2250. TTY users can call 711. Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

En español: Llame a Essence Healthcare al 1-877-296-1555 (TTY: 711) o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

Individuals experiencing homelessness

- If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g., social security checks) may be considered your permanent residence address.

Please contact Essence Healthcare Sales at 1-877-322-2250 if you need assistance completing this form. TTY users can call the national relay service toll-free at 711.

Section 1 – All fields on this page are required (unless marked optional)

Select the plan you want to join:

☐ **Essence Advantage® (HMO) H2610-023 (Includes the Kentucky counties of Boone, Bracken, Campbell, Gallatin, Grant, Kenton and Pendleton, and the Indiana counties of Dearborn, Franklin and Ohio) – $0 per month**

~~*Essence Advantage® (HMO) H3189-001 (Includes the Ohio counties of Brown, Butler, Clermont, Clinton, Hamilton and Warren) – $0 per month*~~

~~*Essence Advantage® Choice (PPO) H6200-007 (Includes the Kentucky counties of Boone, Bracken, Campbell, Gallatin, Grant, Kenton and Pendleton, and the Indiana counties of Dearborn, Franklin and Ohio) – $0 per month*~~

~~*Essence Advantage® Choice (PPO) H4620-001 (Includes the Ohio counties of Brown, Butler, Clermont, Clinton, Hamilton and Warren) – $0 per month*~~

PPO PLAN NOT AVAILABLE AS PART OF THE 5-STAR SPECIAL ENROLLMENT PERIOD

Your Information

FIRST Name:	LAST Name:	Middle Initial (Optional):
Birth Date (MM/DD/YYYY): __ __/__ __/__ __ __ __	Phone Number (Select primary phone number):	
Sex: ☐ Male ☐ Female	☐ Mobile (__ __ __) __ __ __ - __ __ __ __	
	☐ Home (__ __ __) __ __ __ - __ __ __ __	
Permanent Residence Street Address (Do not enter a PO Box):		County (Optional):
City:	State:	Zip Code:

Mailing Address, if different from your permanent address (PO Box allowed):
Street Address:

City:	State:	Zip Code:

E-mail address (Optional):

Save paper, go paperless! (Optional)

☐ **Email Opt-in: Member Communications** I want to receive important reminders, benefit education information, program discounts, and general health information by email.

Your Medicare Information

Medicare Number: __ __ __ __ - __ __ __ - __ __ __ __

Answer these important questions:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Essence Healthcare? ☐ Yes ☐ No

If "yes," please list your other coverage and your identification (ID) number(s) for this coverage. If you have coverage through TRICARE, the VA, an employer/union, your coverage may be affected once your MA coverage starts. Please contact TRICARE, the VA, or your employer/union for more information.

Name of other coverage:	Member number for this coverage:	Group number for this coverage:

IMPORTANT: Read and Sign Below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Essence Healthcare.
- By joining this Medicare Advantage plan, I acknowledge that Essence Healthcare will share my information with Medicare, who may use it to track my enrollment, and with other plans to make payments, and for other purposes allowed by Federal Law that authorize the collection of this information (see Privacy Act Statement below).
- Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.
- I understand that people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.
- I understand that when my Essence Healthcare coverage begins, I must get all of my medical and prescription drug benefits from Essence Healthcare. Benefits and services provided by Essence Healthcare and contained in my Essence Healthcare "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Essence Healthcare will pay for benefits or services that are not covered. I will read the Evidence of Coverage document from Essence Healthcare when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. You can also find the Evidence of Coverage, Star Ratings and Summary of Benefits for an Essence plan at EssenceHealthcare.com.
- Once I am a member of Essence Healthcare, I understand that I have the right to appeal plan decisions about payment or services if I disagree.
- I understand that I can be enrolled in only one MA or Part D plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA or Part D plan.
- I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (as described above), this signature certifies that:
  1) This person is authorized under State law to complete this enrollment, and
  2) Documentation of this authority is available upon request by Medicare.

Signature:	**Today's Date:**

If you are the authorized representative, sign above and fill out these fields:

Name:

Address:	Relationship to Enrollee:	Phone Number:

Section 2 – All fields in this section are optional

Answering these questions is your choice.
You cannot be denied coverage because you do not fill them out.

Are you of Hispanic, Latino/a, or Spanish origin? Select all that apply.

- ☐ No, not of Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Puerto Rican
- ☐ Yes, another Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Mexican, Mexican American, Chicano/a
- ☐ Yes, Cuban
- ☐ I choose not to answer.

What is your race? Select all that apply.

- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Black or African American
- ☐ Chinese
- ☐ Filipino
- ☐ Guamanian or Chamorro
- ☐ Japanese
- ☐ Korean
- ☐ Native Hawaiian
- ☐ Other Asian
- ☐ Other Pacific Islander
- ☐ Samoan
- ☐ Vietnamese
- ☐ White
- ☐ I choose not to answer.

Communication Options:

Select one if your preferred spoken language is a language other than English.

- ☐ Arabic
- ☐ Chinese
- ☐ French
- ☐ French Creole
- ☐ German
- ☐ Gujarati
- ☐ Korean
- ☐ Polish
- ☐ Portuguese
- ☐ Spanish
- ☐ Tagalog
- ☐ Vietnamese

Select one if you want us to send you information in a language other than English.

- ☐ Arabic
- ☐ Chinese
- ☐ French
- ☐ French Creole
- ☐ German
- ☐ Gujarati
- ☐ Korean
- ☐ Polish
- ☐ Portuguese
- ☐ Spanish
- ☐ Tagalog
- ☐ Vietnamese

Select one if you want us to send you information in an accessible format.

- ☐ Braille
- ☐ Large Print

Please contact Essence Healthcare at 1-877-322-2250 if you need information in an accessible format or language other than what is listed above or if your preferred spoken language is a language other than those listed above. Our office hours are 8:00 a.m. to 8:00 p.m., 7 days a week. You may receive a messaging service on weekends from April 1 through September 30 and holidays. TTY users can call 711.

List your primary care physician (PCP), clinic or health center:

Primary Care Physician (PCP):	PCP # from Provider Directory:	Is this your current physician?
Dr. _____ (First Name) (Last Name)		☐ Yes ☐ No

STOP PLEASE READ THIS IMPORTANT INFORMATION STOP

If you currently have health coverage from an employer or union, joining Essence Healthcare could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Essence Healthcare. Read the communications your employer or union sends you. If you have questions, visit their website or contact the office listed in their communications. If there isn't any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Paying your plan premiums

Whether you are enrolled in a premium or non-premium plan, you may pay your plan premium and any applicable Late Enrollment Penalty that you have or may owe **by automatic deduction from your Social Security (SSA) or Railroad Retirement Board (RRB) benefit check.** You may also choose to pay by Electronic Funds Transfer (EFT) from your bank, Credit card, Debit card, or check via mail each month.

If you have to pay a Part-D Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium. The amount is usually taken out of your Social Security Benefit, or you may get a bill from Medicare (or the RRB). DON'T pay Essence Healthcare the Part D-IRMAA.

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs, including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.socialsecurity.gov/prescriptionhelp.

If you qualify for Extra Help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare does not cover.

Please select a premium payment option:

☐ **Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check.**

I get monthly benefits from: ☐ Social Security ☐ RRB

It can take up to 90 days to receive SSA/RRB withhold acceptance. SSA/RRB will begin deducting on the date of acceptance. Members will receive an invoice for any months prior to the withhold acceptance date by SSA/RRB, which will be their responsibility to pay. In limited circumstances, Medicare may not allow for the SSA/RRB deduction option and may instruct the plan to directly bill the member. If this occurs, you will be notified in writing. If you select this payment option, you will not receive a monthly invoice.

☐ **Electronic Funds Transfer (EFT) from your bank account each month.**

If you choose to have the funds taken directly out of your checking account, this is referred to as Electronic Funds Transfer (EFT). If you elect this method of payment, you will receive a letter from the plan requesting a Voided Check be returned with the letter for account setup. Do not submit a voided check at time of enrollment. Your request will be processed within 60 business days of receipt of returned voided check and letter. Premiums are deducted from your bank account on the 2nd day of the month for the current month's coverage. If you select this payment option, you will not receive a monthly invoice.

☐ **Direct Pay**

A monthly invoice will be mailed to you and you can choose whether to pay by check, money order, or online.

PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50, 422.60, 423.30 and 423.32 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

FOR OFFICE USE ONLY						
Confirmation # (Quick Entry or Phone Enroll):			**Application Log #**:			**Plan Receipt Date:**
Plan ID #:			**Effective Date of Coverage:**			
Election Periods:	☐ ICEP (I)	☐ IEP (E)	☐ 2nd IEP (F)	☐ AEP (A)	☐ OEP (M)	☐ OEPI (T)

Special Election Periods (Must check all that apply)**:**

SEP (S)

☐ SPAP (38)
☐ Retro Entitlement (32)
☐ Contract/Plan Non-Renewal (12)
☐ Contract Term – Immediate (11)
☐ Contract Term – CMS (11)
☐ FEMA/Disaster (01)
☐ CMS Identified Consistent Poor Performing Plan (40)
☐ Cost Plan Non-Renewal (28)
☐ Lawfully Present (37)
☐ Loss of SNP (35)
☐ Involuntary Loss/Cred. Coverage (22)
☐ Contract Term – MAO (12)
☐ Plan Placed in Receivership (39)
☐ Accessible Format Delay (21)
☐ PACE Transition (27)
☐ Part B General Enrollment (34)

SEP (V)

☐ Permanent Move

SEP (W)

☐ Gain or Loss of Employer Coverage

SEP (L) Allowed once per Quarter

☐ Dual Eligible/Has Medicaid
☐ Has Non-Dual with LIS

SEP (U)

☐ Gain/Loss/Change in Dual Eligible Status
☐ Gain/Loss/Change in Non-Dual LIS
☐ Gain/Loss/Change of Medicaid

SEP (R)

☐ 5-Star SEP

Producer Name:	**Producer NPN:**	**Application Receipt Date:**

Scope of Appointment

The Centers for Medicare & Medicaid Services requires agents to document the scope of a marketing appointment prior to any individual sales meeting to ensure understanding of what will be discussed between the agent and the Medicare beneficiary (or their authorized representative). All information provided on this form is confidential and should be completed by the person enrolling in a Medicare plan, or their authorized representative.

Please initial below beside the type of product(s) you want the agent to discuss.
(Refer to the following page for product type descriptions.)

- ☐ **Stand-Alone Medicare Prescription Drug Plans (Part D)**
- ☐ **Medicare Advantage Plans (Part C) and Cost Plans**
- ☐ **Dental/Vision/Hearing Products**
- ☐ **Hospital Indemnity Products**
- ☐ **Medicare Supplement (Medigap) Products**

By signing this form, you agree to a meeting with a sales agent to discuss the types of products you initialed above. *Please note, the person who'll discuss the products is either employed or contracted by a Medicare plan. They don't work directly for the federal government. This individual may also be paid based on your enrollment in a plan. Signing this form DOESN'T obligate you to enroll in a plan, affect your current or future Medicare enrollment status or automatically enroll you in the plan(s) discussed.*

Beneficiary or Authorized Representative Signature and Signature Date:

Signature:	Date:

If you're the authorized representative, please sign above and print below.

Representative's Name:	Your Relationship to the Beneficiary:

To Be Completed by Agent:

Agent Name:	Agent Phone Number:
Beneficiary Name:	Beneficiary Phone Number:
Beneficiary Address:	
Initial Method of Contact: (Indicate here if beneficiary was a walk-in.)	
Agent's Signature:	
Plan(s) the Agent Represented During This Meeting:	Date Appointment Completed:

Scope of Appointment documentation is subject to CMS record retention requirements.

Stand-Alone Medicare Prescription Drug Plans (Part D)

Medicare Prescription Drug Plan (PDP): A stand-alone drug plan that adds prescription drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private-Fee-for-Service Plans and Medicare Medical Savings Account Plans.

Medicare Advantage Plans (Part C) and Cost Plans

Medicare Health Maintenance Organization (HMO) Plan: A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. In most HMOs, you can only get your care from doctors or hospitals in the plan's network (except in emergent or urgent situations).

Medicare Preferred Provider Organization (PPO) Plan: A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. PPOs have network doctors and hospitals but you can also use out-of-network providers, usually at a higher cost.

Medicare Private Fee-For-Service (PFFS) Plan: A Medicare Advantage Plan in which you may go to any Medicare-approved doctor, hospital and provider that accepts the plan's payment, terms and conditions and agrees to treat you; not all providers will. If you join a PFFS Plan that has a network, you can see any of the network providers who've agreed to always treat plan members. You'll usually pay more to see out-of-network providers.

Medicare Point of Service (POS) Plan: A type of Medicare Advantage Plan available in a local or regional area, which combines the best feature of an HMO with an out-of-network benefit. Like the HMO, members are required to designate an in-network physician to be the primary healthcare provider. You can use doctors, hospitals and providers outside of the network for an additional cost.

Medicare Special Needs Plan (SNP): A Medicare Advantage Plan that has a benefit package designed for people with special healthcare needs. Examples of the specific groups served include people who have both Medicare and Medicaid, people who reside in nursing homes and people who have certain chronic medical conditions.

Medicare Medical Savings Account (MSA) Plan: MSA Plans combine a high deductible health plan with a bank account. The plan deposits money from Medicare into the account. You can use it to pay your medical expenses until your deductible is met.

Medicare Cost Plan: In a Medicare Cost Plan, you can go to providers both in and out of network. If you get services outside of the plan's network, your Medicare-covered services will be paid for under Original Medicare, but you'll be responsible for Medicare coinsurance and deductibles.

Medicare-Medicaid Plan (MMP): An MMP is a private health plan designed to provide integrated and coordinated Medicare and Medicaid benefits for dual-eligible Medicare beneficiaries.

Dental/Vision/Hearing Products

Plans offering additional benefits for consumers who are looking to cover needs for dental, vision or hearing. These plans aren't affiliated or connected to Medicare.

Hospital Indemnity Products

Plans offering additional benefits that are payable to consumers based upon their medical utilization; they're sometimes used to defray copays/coinsurance. These plans aren't affiliated or connected to Medicare.

Medicare Supplement (Medigap) Products

Plans offering a supplemental policy to fill "gaps" in Original Medicare coverage. A Medigap policy typically pays some or all of the deductible and coinsurance amounts applicable to Medicare-covered services and sometimes covers items and services that aren't covered by Medicare, such as care outside of the country. These plans aren't affiliated or connected to Medicare.

Essence Healthcare includes HMO and PPO plans with Medicare contracts. Enrollment in Essence Healthcare depends on contract renewal. Essence Healthcare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

For agent use

Receipt of Application

Use this form to record the receipt of your signed and completed Essence Healthcare application form. Make sure to keep this document for your files.

Online Enrollment

_____

Confirmation Code

Paper Enrollment

_____

Agent Name

_____

Date

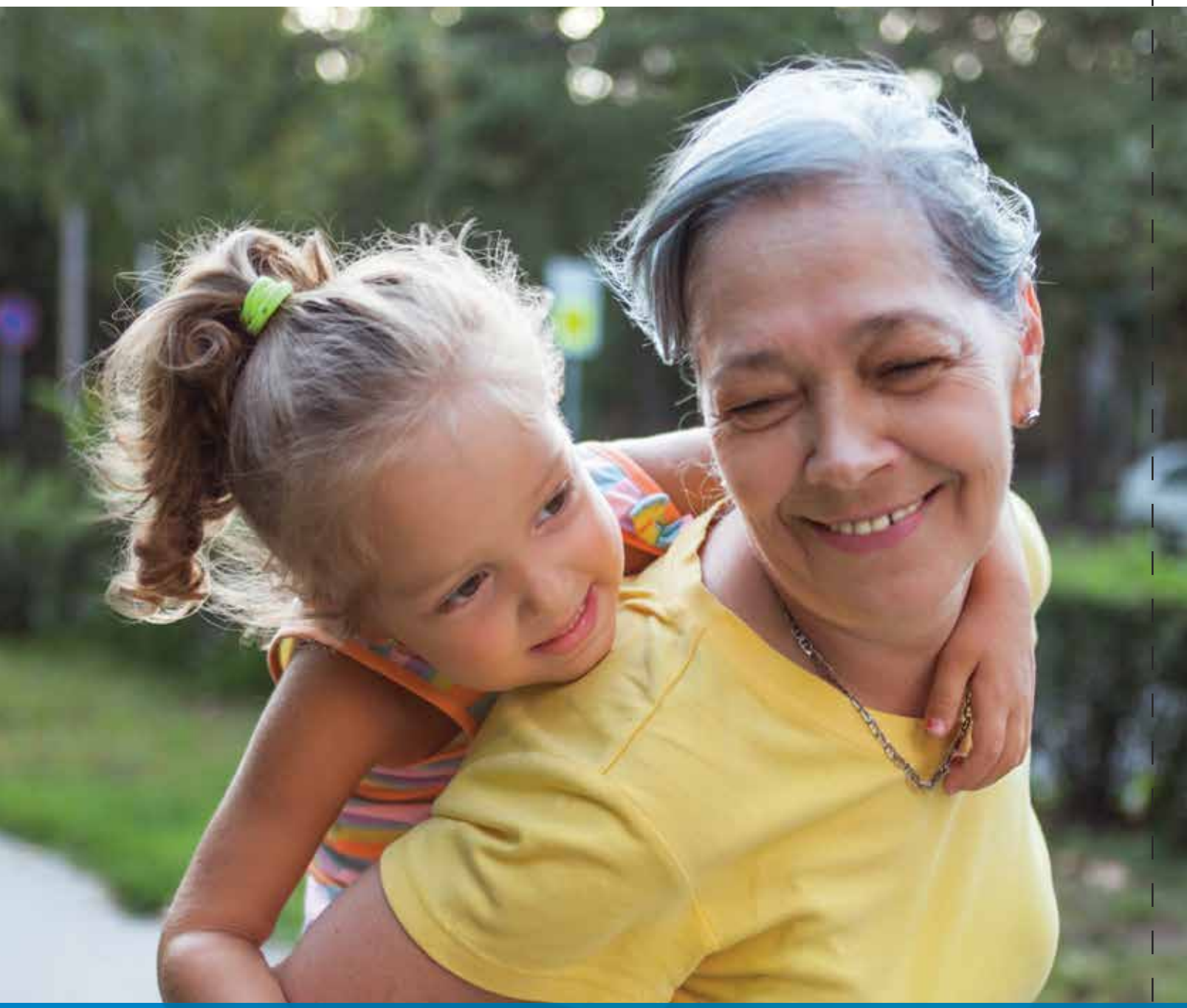
_____

Agent Phone Number

You can contact Essence directly at **1-866-597-9560** (TTY: 711) from 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 includes HMO and PPO plans with Medicare contracts. Enrollment in Essence Healthcare depends on contract renewal. Essence Healthcare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

Y0027_24-100_C



2024 Summary of Benefits

Essence Advantage (HMO)

~~Essence Advantage Choice (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** and ~~Essence Advantage Choice~~
- 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 1-877-322-2250 (TTY: 711) to speak with a customer service representative.

Things to Know About Our 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 1-877-322-2250 (TTY: 711) to speak with a customer service representative.
- Our website: EssenceHealthcare.com

Things to Know About Our Plans (cont.)

Who can join?

To join **Essence Advantage** or ~~Essence Advantage Choice,~~ 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 Kentucky counties of Boone, Bracken, Campbell, Gallatin, Grant, Kenton and Pendleton, the Ohio counties of Brown, Butler, Clermont, Clinton, Hamilton and Warren, and the Indiana counties of Dearborn, Franklin and Ohio.

What's 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.

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 and ~~Essence Advantage Choice~~ 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, and, if you're an HMO plan member, we may not pay for these services. 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 (HMO)	Essence Advantage Choice (PPO) In-Network	Essence Advantage Choice (PPO) Out-of-Network
Monthly Plan Premium	**Both Plans** $0 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: $3,650 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 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~~	~~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:~~ ~~$5,900 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 (HMO)	Essence Advantage Choice (PPO) In-Network	Essence Advantage Choice (PPO) Out-of-Network
Inpatient Hospital Coverage	Our plan covers an unlimited number of days for an inpatient hospital stay. • $295 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.~~ • ~~$375 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	$285 Copay for outpatient hospital services, including surgery Copay is charged per surgery.	~~$325 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)	$245 Copay	~~$285 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: $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~~
Preventive Care	**Both Plans** You pay nothing. Our plans cover many preventive services, including: • Abdominal aortic aneurysm screening • Annual wellness visit • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease risk reduction visit (therapy for cardiovascular disease)		

PPO PLAN NOT AVAILABLE AS PART OF THE 5-STAR SPECIAL ENROLLMENT PERIOD

	Essence Advantage (HMO)	Essence Advantage Choice (PPO) In-Network	Essence Advantage Choice (PPO) Out-of-Network
Preventive Care *(continued)*	**Both Plans** • 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	$30 Copay within the United States $110 Copay outside of the United States Urgently needed services are always considered in-network. We provide worldwide coverage.	~~$45 Copay within the United States~~ ~~$110 Copay outside of the United States~~ ~~Urgently needed services are always considered in-network.~~ ~~We provide worldwide coverage.~~	

PPO PLAN NOT AVAILABLE AS PART OF THE 5-STAR SPECIAL ENROLLMENT PERIOD

	Essence Advantage (HMO)	Essence Advantage Choice (PPO) In-Network	Essence Advantage Choice (PPO) Out-of-Network
Diagnostic Services/Labs/ Imaging *(Costs for these services may vary based on place of service.)*	Lab services: $5 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: $20 copay Prior authorization may be required.	~~Lab services: $5 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: $30 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: $30 copay~~
Hearing Services	$2,000 Allowance for up to 2 hearing aids every calendar year (both ears combined)	~~$1,000 Allowance for up to 2 hearing aids every calendar year (both ears combined)~~	
	Both Plans Medicare-covered exam to diagnose and treat hearing and balance issues: $20 copay Routine hearing exam: $20 copay One fitting/evaluation for hearing aids every calendar year: $0 copay For details on an **additional shared allowance** that can be used on hearing products, see the Flexible Benefits Card section on page 49.		

PPO PLAN NOT AVAILABLE AS PART OF THE 5-STAR SPECIAL ENROLLMENT PERIOD

	Essence Advantage (HMO)	Essence Advantage Choice (PPO) In-Network	Essence Advantage Choice (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 comprehensive dental services: $30 copay		
	Prior authorization may be required for Medicare-covered services performed by an oral surgeon.	~~(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: $3,000	~~Yearly maximum benefit for combined preventive and comprehensive services: $5,000~~	
	*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 49.		

PPO PLAN NOT AVAILABLE AS PART OF THE 5-STAR SPECIAL ENROLLMENT PERIOD

	Essence Advantage (HMO)	Essence Advantage Choice (PPO) In-Network	Essence Advantage Choice (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: $30 copay~~
	Diabetic eye exams performed by a contracted specialist: $0 copay	~~Diabetic eye exams performed by a contracted specialist: $0 copay~~	~~Diabetic eye exams: $30 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: $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: $0 copay~~	~~1 Pair of Medicare-covered eyeglass frames or contact lenses (or 2 six packs) after each cataract surgery: 40% coinsurance~~
	Our plan pays up to $200 for eyeglass frames or contact lenses after each cataract surgery	~~Our plan pays up to $200 for eyeglass frames or contact lenses after each cataract surgery.~~	
	Both Plans 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 49.		

PPO PLAN NOT AVAILABLE AS PART OF THE 5-STAR SPECIAL ENROLLMENT PERIOD

	Essence Advantage (HMO)	Essence Advantage Choice (PPO) In-Network	Essence Advantage Choice (PPO) Out-of-Network
Mental Health Services	Inpatient visit: Our plan covers an unlimited number of days for an inpatient hospital stay. • $275 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	~~Inpatient visit:~~ ~~Our plan covers an unlimited number of days for an inpatient hospital stay.~~ • ~~$375 Copay per day, per stay: days 1–4~~ • ~~$0 Copay day 5 and beyond~~ ~~Outpatient individual visit: $15 copay~~ ~~Outpatient group visit: $10 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 • $188 Copay per day, per stay: days 21–100 Prior authorization is required. Admission to a new or different SNF facility within the same benefit period may start a new stay for copay administration purposes.	~~The plan covers up to 100 days each benefit period. No prior hospital stay is required.~~ • ~~$0 Copay per day, per stay: days 1–20~~ • ~~$184 Copay per day, per stay: days 21–100~~ ~~Prior authorization is required.~~ ~~Admission to a new or different SNF facility within the same benefit period may start a new stay for copay administration purposes.~~	~~The plan covers up to 100 days each benefit period. No prior hospital stay is required.~~ ~~40% Coinsurance per day, per stay: day 1 and beyond~~

PPO PLAN NOT AVAILABLE AS PART OF THE 5-STAR SPECIAL ENROLLMENT PERIOD

	Essence Advantage (HMO)	Essence Advantage Choice (PPO) In-Network	Essence Advantage Choice (PPO) Out-of-Network
Physical Therapy	$30 Copay	~~$35 Copay~~	
Ambulance	$240 Copay	~~$290 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 calendar 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 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 (HMO)			Essence Advantage Choice (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)*	$40 Copay	$80 Copay	$120 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)*	$5 Copay	$10 Copay	$15 Copay	~~$4 Copay~~	~~$8 Copay~~	~~$12 Copay~~
Tier 2 *(Generic)*	$10 Copay	$20 Copay	$30 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~~	

PPO PLAN NOT AVAILABLE AS PART OF THE 5-STAR SPECIAL ENROLLMENT PERIOD

	Essence Advantage (HMO)			Essence Advantage Choice (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		$100 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)*	$5 Copay	Not offered		~~$4 Copay~~	~~Not offered~~	
Tier 2 *(Generic)*	$10 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~~	

PPO PLAN NOT AVAILABLE AS PART OF THE 5-STAR SPECIAL ENROLLMENT PERIOD

	Essence Advantage (HMO)			Essence Advantage Choice (PPO)		
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.					
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)*	$5 Copay	$10 Copay	$15 Copay	~~$4 Copay~~	~~$8 Copay~~	~~$12 Copay~~
Tier 2 *(Generic)*	$10 Copay	$20 Copay	$30 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		$0 Copay	~~Not offered~~		~~$0 Copay~~
Tier 2 *(Generic)*	Not offered		$0 Copay	~~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 (HMO)	Essence Advantage Choice (PPO) In-Network	Essence Advantage Choice (PPO) Out-of-Network
Acupuncture	**Both Plans** Medicare-covered services (chronic low back pain), up to 20 visits per calendar year: $30 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.	~~20% Coinsurance~~ ~~Prior authorization may be required.~~	~~40% Coinsurance~~

PPO PLAN NOT AVAILABLE AS PART OF THE 5-STAR SPECIAL ENROLLMENT PERIOD

	Essence Advantage (HMO)	Essence Advantage Choice (PPO) In-Network	Essence Advantage Choice (PPO) Out-of-Network
Flexible Benefits Card	$130 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.	~~$125 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)*	**Both Plans** $30 Copay		
Home Healthcare	$0 Copay	~~$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: $15 copay | Group visit: $10 copay		
	Prior authorization may be required.	~~Prior authorization may be required.~~	
Outpatient Rehabilitation Services	Cardiac rehabilitation services: $15 copay per day Occupational, speech and language therapy visits: $30 copay A separate copayment for occupational therapy will apply if other outpatient therapy services are rendered on the same day.	~~Cardiac rehabilitation services: $15 copay per day~~ ~~Occupational, speech and language therapy visits: $35 copay~~ ~~A separate copayment for occupational therapy will apply if other outpatient therapy services are rendered on the same day.~~	
		~~Prior authorization may be required.~~	

PPO PLAN NOT AVAILABLE AS PART OF THE 5-STAR SPECIAL ENROLLMENT PERIOD

	Essence Advantage (HMO)	Essence Advantage Choice (PPO) In-Network	Essence Advantage Choice (PPO) Out-of-Network
Over-the-Counter (OTC) Coverage	$130 Credit per quarter, supplied in the form of a debit card (Flexible Benefits Card) provided by WEX.	~~$125 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 49.		
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	$0–$30 Copay You'll pay the same copay for the virtual/telehealth visit as if the services were received in the provider's office.	~~$0–$35 Copay~~ ~~You'll pay the same copay for the virtual/telehealth visit as if the services were received in the provider's office.~~	~~$10–$35 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		

IMPORTANT INFORMATION:
2024 Medicare Star Ratings

Official U.S. Government Medicare Information

Essence Healthcare - H2610

For 2024, Essence Healthcare - H2610 received the following Star Ratings from Medicare:

Overall Star Rating:	★★★★★
Health Services Rating:	★★★★½
Drug Services Rating:	★★★★½

Every year, Medicare evaluates plans based on a 5-star rating system.

Why Star Ratings Are Important

Medicare rates plans on their health and drug services.

This lets you easily compare plans based on quality and performance.

Star Ratings are based on factors that include:

- Feedback from members about the plan's service and care
- The number of members who left or stayed with the plan
- The number of complaints Medicare got about the plan
- Data from doctors and hospitals that work with the plan

More stars mean a better plan – for example, members may get better care and better, faster customer service.

The number of stars show how well a plan performs.

★★★★★	EXCELLENT
★★★★☆	ABOVE AVERAGE
★★★☆☆	AVERAGE
★★☆☆☆	BELOW AVERAGE
★☆☆☆☆	POOR

Get More Information on Star Ratings Online

Compare Star Ratings for this and other plans online at medicare.gov/plan-compare.

Questions about this plan?

Contact Essence Healthcare 7 days a week from 8:00 a.m. to 8:00 p.m. Eastern time at **877-218-6018** (toll-free) or 711 (TTY), from October 1 to March 31. Our hours of operation from April 1 to September 30 are Monday through Friday from 8:00 a.m. to 8:00 p.m. Eastern time. Current members please call **866-597-9560** (toll-free) or 711 (TTY).

Essence Healthcare includes HMO and PPO plans with Medicare contracts. Enrollment in Essence Healthcare depends on contract renewal. This star rating for contract H2610 applies to plans offered in the Kentucky counties of Boone, Bracken, Campbell, Gallatin, Grant, Kenton and Pendleton and the Indiana counties of Dearborn, Franklin and Ohio.

ESSENCE
HEALTHCARE
A Healthy Tomorrow Starts Today.

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。

Every year, Medicare evaluates plans based on a 5-star rating system. Star ratings may vary by contract or market. For plan year 2024, plans under Essence Healthcare's H2610 (HMO) contract achieved a 5-star Overall Plan Rating. Plans under Essence's H6200 (PPO) contract are too new to be measured for a Star rating.

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 HMO plan 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 Healthcare will be responsible for the costs.

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.

ESSENCE HEALTHCARE®

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

Toll-free: 1-877-322-2250 (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.

Our service area: the Kentucky counties of Boone, Bracken, Campbell, Gallatin, Grant, Kenton and Pendleton and the Indiana counties of Dearborn, Franklin and Ohio