GREATER ST. LOUIS AREA

ESSENCE HEALTHCARE®

First Look:

2026 Plan Benefit Highlights

ESSENCE ADVANTAGE SELECT® (HMO)—H2610-016
ESSENCE ADVANTAGE® (HMO)—H2610-005
ESSENCE ADVANTAGE PLUS® (HMO)—H2610-006
ESSENCE ADVANTAGE® CHOICE (PPO)—H6200-001
ESSENCE ADVANTAGE® PREMIER PLUS (PPO)—H6200-008

This document provides a first look at the Essence plan benefit highlights. It contains **confidential and proprietary information** and is for producer use only. Distribution to customers, other insurers or any other person, company or entity is strictly prohibited.

Please note, benefit information is not final and is subject to change.

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2026 Medicare Advantage Plan Information

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

★★★★½ 4.5+ out of 5—5 years in a row (HMO plans 2021–2025)

Every year, Medicare evaluates plans based on a 5-star rating system. Essence HMO plans (H2610 contract) received a 5-out-of-5-star Overall Plan Rating for 2022–2024 and a 4.5-star rating for 2025. Essence PPO plans (H6200 contract) achieved a 4-star Overall Plan Rating for 2025.

= Flex Card eligible

INN = in-network
OON = out-of-network

	Essence Advantage Select (HMO)* $0 Monthly premium	**Essence Advantage (HMO)** $0 Monthly premium	**Essence Advantage Plus (HMO)** $59 Monthly premium	**Essence Advantage Choice (PPO)*** $0 Monthly premium	**Essence Advantage Premier Plus (PPO)**** $254 Monthly premium
Plan Benefits					
Annual Medical Deductible	**$0** Per calendar year	**$0** Per calendar year	**$0** Per calendar year	**$0** Per calendar year	**$0** Per calendar year
Preventive Care/Screenings	**$0** Copay	**$0** Copay	**$0** Copay	**$0** Copay (INN & OON)	**$0** Copay (INN & OON)
Primary Care Physician Visits	**$0** Copay	**$0** Copay	**$0** Copay	**$0** Copay (INN) **40%** Coinsurance (OON)	**$0** Copay (INN & OON)
Specialist Doctor Visits	**$30** Copay	**$30** Copay	**$30** Copay	**$40** Copay (INN & OON) **40%** Coinsurance (OON)	**$0** Copay (INN & OON)
Lab Services	**$0** Copay	**$0** Copay	**$0** Copay	**$0** Copay (INN) **40%** Coinsurance (OON)	**$0** Copay (INN & OON)
Inpatient Hospital Coverage	Days 1–7: **$240** copay/day Day 8 & beyond: **$0** copay/day	Days 1–7: **$325** copay/day Day 8 & beyond: **$0** copay/day	Days 1–7: **$250** copay/day Day 8 & beyond: **$0** copay/day	Days 1–7: **$330** copay/day (INN), **40%** coinsurance (OON) Days 8 & beyond: **$0** copay/day (INN), **40%** coinsurance (OON)	**$500** Copay per stay (INN & OON)
Outpatient Surgery at Ambulatory Surgical Center	**$175** Copay	**$175** Copay	**$125** Copay	**$295** Copay (INN) **40%** Coinsurance (OON)	**$0** Copay(INN & OON)
Maximum Out-of-Pocket Limit	**$3,900** Per calendar year	**$3,400** Per calendar year	**$2,900** Per calendar year	**$5,400** Per calendar year (INN) **$7,400** Per calendar year (INN & OON combined)	**$2,000** Per calendar year (INN & OON combined)
Prescription Drugs – Preferred Retail (30-day)/Standard Retail (30-day)/Mail Order (90-day)					
Tier 1 *(Preferred Generic)*	**$0/$4/$0**	**$0/$4/$0**	**$0/$4/$0**	**$0/$4/$0**	**$0/$15/$0**
Tier 2 *(Generic)*	**$3/$12/$6**	**$3/$12/$6**	**$3/$12/$6**	**$5/$12/$10**	**$3/$20/$6**
Tier 3 *(Preferred Brand)*	**$45/$47/$90**	**$45/$47/$90**	**$45/$47/$90**	**$47/$47/$94**	**$47/$47/$94**
Tier 4 *(Non-Preferred Brand)*	**$75/$100/$150**	**$75/$100/$150**	**$95/$100/$190**	**50%/50%/50%**	**50%/50%/50%**
Tier 5† *(Specialty Drug)*	**29%/29%**/NA	**33%/33%**/NA	**33%/33%**/NA	**29%/29%**/NA	**25%/25%**/NA
Tier 6 *(Select Care Drugs)*	**$0/$0/$0**	**$0/$0/$0**	**$0/$0/$0**	Tier 6 not offered. Insulins covered under tiers 1–5.	Tier 6 not offered. Insulins covered under tiers 1–5.
Catastrophic Coverage	After your yearly out-of-pocket drug costs reach **$2,100**, you pay **$0** for all covered part D drugs. Cost-sharing may change depending on the pharmacy you choose.				

*$340 Deductible for tiers 3–5 (applies once regardless of pharmacy type) **$615 Deductible for tiers 3–5 (applies once regardless of pharmacy type) †The Centers for Medicare & Medicaid Services limits tier 5 drugs to a 30-day supply.

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Benefits	Essence Advantage Select (HMO)* $0 Monthly premium	Essence Advantage (HMO) $0 Monthly premium	Essence Advantage Plus (HMO) $59 Monthly premium	Essence Advantage Choice (PPO)* $0 Monthly premium	Essence Advantage Premier Plus (PPO)** $254 Monthly premium
Preloaded Flexible Benefits Card	**$2,900** Shared annual allowance for non-Medicare covered **dental, vision and hearing items and services** **$40** Quarterly allowance for OTC items The Flex Card can be used with both in- and out-of-network providers.	**$250** Shared annual allowance for non-Medicare-covered **dental, vision and hearing items and services** **$45** Quarterly allowance for OTC items The Flex Card can be used with both in- and out-of-network providers.	**$2,000** Shared annual allowance for non-Medicare-covered **dental, vision and hearing items and services, plus medical copays** **$40** Quarterly allowance for OTC items The Flex Card can be used with both in- and out-of-network providers. For medical copays, providers must be in- network.	**$1,840** Shared annual allowance for non-Medicare-covered **dental, vision and hearing items and services** The Flex Card can be used with both in- and out-of-network providers.	Not covered
Dental	**$0** Copay for preventive dental, such as cleanings, exams, X-rays and more Additional preventive and comprehensive services via Flex Card	**$0** Copay for preventive dental, such as cleanings, exams, X-rays and more Additional preventive and comprehensive services via Flex Card	**$0** Copay for preventive dental, such as cleanings, exams, X-rays and more Additional preventive and comprehensive services via Flex Card	Preventive and comprehensive services via Flex Card	Medicare-covered services only
Vision	**$0** Copay for routine eye exam **$200** Allowance for routine eyewear (frames, lenses and contact lenses) every calendar year	**$0** Copay for routine eye exam **$200** Allowance for routine eyewear (frames, lenses and contact lenses) every calendar year	**$0** Copay for routine eye exam **$300** Allowance for routine eyewear (frames, lenses and contact lenses) every calendar year	**$0** Copay for routine eye exam (INN & OON) **$200** Allowance for routine eyewear (frames, lenses and contact lenses) every calendar year (INN & OON combined)	Medicare-covered services only
Hearing	**$20** Copay for routine hearing exam **$1,000** 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)	**$20** Copay for routine hearing exam **$1,000** 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)	**$20** Copay for routine hearing exam **$1,000** 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)	**$20** Copay for routine hearing exam (INN & OON) **$1,000** Allowance for up to 2 hearing aids (all types) every 2 calendar years (both ears combined) (INN & OON) **$0** Copay for hearing aid fitting/evaluation (covered once every 2 calendar years) (INN & OON)	**$0** Copay for routine hearing exam (INN & OON) **$1,000** Allowance for up to 2 hearing aids (all types) every 2 calendar years (both ears combined) (INN & OON) **$0** Copay for hearing aid fitting/evaluation (covered once every 2 calendar years) (INN & OON)
Fitness/Gym Membership	SilverSneakers® included at no additional cost	SilverSneakers® included at no additional cost	SilverSneakers® included at no additional cost	SilverSneakers® included at no additional cost	SilverSneakers® included at no additional cost
Wellness Tracker	Oura Ring wearable device, Oura App and Oura Membership at no additional cost	Not covered	Oura Ring wearable device, Oura App and Oura Membership at no additional cost	Oura Ring wearable device, Oura App and Oura Membership at no additional cost	Not covered
Transportation Assistance	Not covered	**$0** Copay for 20 one-way trips to approved locations per calendar year	**$0** Copay for 20 one-way trips to approved locations per calendar year	Not covered	Not covered

For more details and benefits, please review our Summary of Benefits. Essence Healthcare includes HMO and PPO plans with Medicare contracts. Enrollment in Essence Healthcare depends on contract renewal.