



GREATER ST. LOUIS AREA

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

Get help finding the right plan for you. Simply ask your licensed sales agent for more information or call Essence Healthcare at **1-866-488-0243** (TTY 711).

= 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	\$0 Per calendar year
Preventive Care/Screenings	\$0 Copay	\$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	\$0 Copay (INN) 40% Coinsurance (OON)	\$0 Copay (INN & OON)
Specialist Doctor Visits	\$30 Copay	\$30 Copay	\$30 Copay	\$30 Copay	\$40 Copay (INN) 40% Coinsurance (OON)	\$0 Copay (INN & OON)
Lab Services	\$0 Copay	\$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: \$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	\$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	\$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/\$4/\$0	\$0/\$15/\$0
Tier 2 (Generic)	\$3/\$12/\$6	\$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	\$45/\$47/\$90	\$47/\$47/\$94	\$47/\$47/\$94
Tier 4 (Non-Preferred Brand)	\$75/\$100/\$150	\$75/\$100/\$150	\$95/\$100/\$190	\$95/\$100/\$190	50%/50%/50%	50%/50%/50%
Tier 5† (Specialty Drug)	29%/29%/NA	33%/33%/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	\$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. Ask for a plan’s 2026 Information Kit if you’d like to see a full explanation of copayments or coinsurance.

 = Flex Card eligible INN = in-network OON = out-of-network	Essence Advantage Select (HMO)*	Essence Advantage (HMO)	Essence Advantage Plus (HMO)	Essence Advantage Choice (PPO)*	Essence Advantage Premier Plus (PPO)**
	\$0 Monthly premium	\$0 Monthly premium	\$59 Monthly premium	\$0 Monthly premium	\$254 Monthly premium
Benefits					
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 or contact lenses) every calendar year 	\$0 Copay for routine eye exam \$200 Allowance for routine eyewear (frames, lenses or contact lenses) every calendar year 	\$0 Copay for routine eye exam \$300 Allowance for routine eyewear (frames, lenses or contact lenses) every calendar year 	\$0 Copay for routine eye exam (INN & OON) \$200 Allowance for routine eyewear (frames, lenses or 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.