



GREATER LOUISVILLE AND LEXINGTON AREAS

2026 Medicare Advantage Plan Information

**Our service area:** the Kentucky counties of Anderson, Bourbon, Bullitt, Carroll, Clark, Fayette, Harrison, Henry, Jefferson, Larue, Meade, Mercer, Nelson, Oldham, Owen, Robertson, Shelby, Spencer, Trimble, Washington and Woodford, and the Indiana counties of Clark, Crawford, Floyd, Harrison, Jefferson, Ripley, Scott, Switzerland and Washington

 = Flex Card eligible

Essence Advantage (HMO)\*

\$0 Monthly premium

Essence Advantage Choice (PPO)\*

\$19.80 Monthly premium

| Plan Benefits                                                                               |                                                                                                     |                                                                                                                                                                                                |
|---------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Annual Medical Deductible                                                                   | \$0 Per calendar year                                                                               | \$0 Per calendar year                                                                                                                                                                          |
| Preventive Care/ Screenings                                                                 | \$0 Copay                                                                                           | In- & out-of-network: \$0 copay                                                                                                                                                                |
| Primary Care Physician Visits                                                               | \$0 Copay                                                                                           | In-network: \$0 copay<br>Out-of-network: 40% coinsurance                                                    |
| Specialist Doctor Visits                                                                    | \$35 Copay       | In-network: \$30 copay<br>Out-of-network: 40% coinsurance                                                 |
| Lab Services                                                                                | \$0 Copay                                                                                           | In-network: \$0 copay<br>Out-of-network: 40% coinsurance                                                  |
| Inpatient Hospital Coverage                                                                 | \$325 Copay/day (days 1–5)<br>\$0 Copay/day (day 6 & beyond)                                        | In-network:<br>\$375 Copay/day (days 1–7)<br>\$0 Copay/day (day 8 & beyond)<br>Out-of-network:<br>40% Coinsurance (days 1–7)<br>40% Coinsurance (days 8–90)<br>\$0 Copay/day (day 91 & beyond) |
| Outpatient Surgery at Ambulatory Surgical Center                                            | \$245 Copay                                                                                         | In-network: \$255 copay<br>Out-of-network: 40% coinsurance                                                                                                                                     |
| Maximum Out-of-Pocket Limit                                                                 | \$3,350 Per calendar year                                                                           | In-network: \$4,150 per calendar year<br>Out-of-network: \$6,150 per calendar year<br>(in-network & out-of-network combined)                                                                   |
| Prescription Drugs – Preferred Retail (30-day)/Standard Retail (30-day)/Mail Order (90-day) |                                                                                                     |                                                                                                                                                                                                |
| Tier 1<br>(Preferred Generic)                                                               | \$0/\$5/\$0                                                                                         | \$0/\$4/\$0                                                                                                                                                                                    |
| Tier 2<br>(Generic)                                                                         | \$3/\$10/\$6                                                                                        | \$3/\$12/\$6                                                                                                                                                                                   |
| Tier 3<br>(Preferred Brand)                                                                 | \$45/\$47/\$90                                                                                      | \$47/\$47/\$94                                                                                                                                                                                 |
| Tier 4<br>(Non-Preferred Brand)                                                             | \$95/\$100/\$190                                                                                    | 50%/50%/50%                                                                                                                                                                                    |
| Tier 5†<br>(Specialty Drug)                                                                 | 29%/29%/NA                                                                                          | 29%/29%/NA                                                                                                                                                                                     |
| Tier 6<br>(Select Care Drugs)                                                               | \$0/\$0/\$0                                                                                         | Tier 6 not offered.<br>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. |                                                                                                                                                                                                |

\*\$340 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

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|--------------------------------------------------------------|-------------------------------------------------------------------------|
| <b>Essence Advantage (HMO)</b><br><b>\$0</b> Monthly premium | <b>Essence Advantage Choice (PPO)</b><br><b>\$19.80</b> Monthly premium |
|--------------------------------------------------------------|-------------------------------------------------------------------------|

| Benefits                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                       |
|------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Preloaded Flexible Benefits Card</b><br> | <b>\$1,600</b> Shared annual allowance for non-Medicare-covered <b>dental, vision and hearing items and services, plus medical copays</b><br><br><b>\$40</b> Quarterly allowance for OTC items<br><br>See Summary of Benefits for approved medical copay categories.<br><br>The Flex Card can be used with both in- and out-of-network providers. For medical copays, providers must be in network. | <b>\$1,000</b> Shared annual allowance for non-Medicare-covered <b>dental, vision and hearing items and services, plus medical copays</b><br><br>See Summary of Benefits for approved medical copay categories.<br><br>The Flex Card can be used with both in- and out-of-network providers.                                                                                                                          |
| <b>Dental</b>                                                                                                                | <b>\$0</b> Copay for preventive dental, such as cleanings, exams, X-rays and more<br><br>Additional preventive and comprehensive services via Flex Card<br><br>                                                                                                                                                  | Preventive and comprehensive services via Flex Card<br><br>                                                                                                                                                                                                                                                                        |
| <b>Vision</b>                                                                                                                | <b>\$0</b> Copay for routine eye exam<br><br><b>\$200</b> Allowance for routine eyewear (frames, lenses or contact lenses) every calendar year<br><br>                                                                                                                                                           | <b>\$0</b> Copay for routine eye exam<br><br><b>\$200</b> Allowance for routine eyewear (frames, lenses or contact lenses) every calendar year (in- & out-of-network combined)<br><br>                                                                                                                                           |
| <b>Hearing</b>                                                                                                               | <b>\$20</b> Copay for routine hearing exam<br><br><b>\$2,000</b> Allowance for up to 2 hearing aids (all types) every calendar year (both ears combined)<br><br><b>\$0</b> Copay for hearing aid fitting/evaluation (covered once every calendar year)<br><br>                                                   | In- & out-of-network: <b>\$20</b> copay for routine hearing exam<br><br>In- & out-of-network: <b>\$1,000</b> allowance for up to 2 hearing aids (all types) every calendar year (both ears combined)<br><br>In- & out-of-network: <b>\$0</b> copay for hearing aid fitting/evaluation (covered once every calendar year)<br><br> |
| <b>Fitness/Gym Membership</b>                                                                                                | SilverSneakers® included at no additional cost                                                                                                                                                                                                                                                                                                                                                      | SilverSneakers® included at no additional cost                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Wellness Tracker</b>                                                                                                      | 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                                                                                                                                                                                                                                                                                                                                         |
| <b>Transportation Assistance</b>                                                                                             | <b>\$0</b> Copay for 20 one-way trips to approved locations per calendar year                                                                                                                                                                                                                                                                                                                       | Not covered                                                                                                                                                                                                                                                                                                                                                                                                           |

Get help finding the right plan for you. Simply ask your licensed sales agent for more information or call Essence Healthcare at **1-855-771-2239** (TTY 711).

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.