

MEDICARE ADVANTAGE / PDP ▾

Plan Details



Cigna

\$29.00

Plan: **Cigna Preferred Medicare (HMO)**

Max Out of Pocket: **\$5,900**

Annual Drug Deductible: **\$0.00**

ID: **H3949-30-0**

Star Rating: **4.0**

Plan Type: **Local HMO**

Part B Reduction: **No**

Effective Year: **2021**

City: **PHILADELPHIA**

State: **PA**

Zip: **19145**

Monthly premium deductible and limits on how much you pay for covered services

\$5900 in-network out of pocket maximum.

Acupuncture

Not covered

Ambulance

\$230 copay

Chiropractic care

Not covered. \$15 copay for Medicare-covered visits.

Dental services

\$35 copay for Medicare-covered services. Prophylaxis max of 1 every six months. Oral exam max of 1 (see carrier information for details). Xray max of 1 (see carrier information for details). Max of \$1500 comprehensive dental benefits for this plan every year.

Diabetes supplies and services

You pay nothing for diabetes self-management training.

0-20% coinsurance for Medicare-covered diabetes supplies and services.
20% coinsurance for therapeutic shoes or inserts.

Diagnostic tests lab and radiology services and x-rays (Costs for these services may be different if received in an outpatient surgery setting)

\$0-50 copay for Medicare-covered diagnostic procedures/tests. \$0-200 copay for Medicare-covered diagnostic radiological services (e.g., CT, MRI, etc). \$60 copay for other Medicare-covered therapeutic radiological services. \$40 copay for Medicare-covered x-rays.

Renal dialysis

20% per visit

Durable medical equipment (wheelchairs oxygen etc.)

20% per item

Doctor's office visits

Primary Physician: \$0 copay Specialist Physician: \$35 copay

Emergency care

\$90 per visit, waived if admitted within 24 hours. Maximum \$90 per visit.

Foot care (podiatry services)

\$35 copay for Medicare-covered visits.

Hearing services

Fitting max of 1 every three years. Both inner ear hearing aids max of 1 every three years. Both over-the-ear hearing aids max of 1 every three years. Routing hearing exam max of 1 every year. Max of 700 benefit for this plan for hearing aids every three years.

Home health care

You pay nothing

Hospice

You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care.

Inpatient hospital care

\$275 copay for days 1-7 \$0 copay for days 8-90

Mental health care

\$350 copay for days 1-5 \$0 copay for days 6-90

Over-the-counter items

Max of \$45 benefit for this plan every three months. All medications of the OTC list in Chapter 4 of Medicare Managed Care Manual are included.

Outpatient prescription drugs

20% coinsurance for chemo drugs. 20% coinsurance for prescriptions.

Tier 1 (Preferred Generic)

Pharmacy Type	30 day supply	60 day supply	90 day supply
Preferred Retail:	\$0	\$0	\$0
Standard Retail:	\$9	\$18	\$18
Preferred Mail Order:	\$0	\$0	\$0
Standard Mail Order:	\$9	\$18	\$18

Tier 2 (Generic)

Pharmacy Type	30 day supply	60 day supply	90 day supply
Preferred Retail:	\$5	\$10	\$10
Standard Retail:	\$15	\$30	\$30
Preferred Mail Order:	\$5	\$10	\$0
Standard Mail Order:	\$15	\$30	\$30

Tier 3 (Preferred Brand)

Pharmacy Type	30 day supply	60 day supply	90 day supply
Preferred Retail:	\$42	\$84	\$126
Standard Retail:	\$47	\$94	\$141
Preferred Mail Order:	\$42	\$84	\$126
Standard Mail Order:	\$47	\$94	\$141

Tier 4 (Non-Preferred Drug)

Pharmacy Type	30 day supply	60 day supply	90 day supply
Preferred Retail:	\$95	\$190	\$285
Standard Retail:	\$100	\$200	\$300
Preferred Mail Order:	\$95	\$190	\$285
Standard Mail Order:	\$100	\$200	\$300

Tier 5 (Specialty Tier)

Pharmacy Type	30 day supply	60 day supply	90 day supply
Preferred Retail:	33%	Not Offered	Not Offered
Standard Retail:	33%	Not Offered	Not Offered
Preferred Mail Order:	33%	Not Offered	Not Offered
Standard Mail Order:	33%	Not Offered	Not Offered

Outpatient rehabilitation

You pay nothing

\$40 copay for physical therapy and speech therapy. \$40 copay for occupational therapy.

Outpatient substance abuse

\$40 copay for group visits. \$40 copay for individual visits

Outpatient surgery

\$0-275 per visit

Preventive care

Annual physical exam not covered.

Prosthetic devices (braces artificial limbs etc.)

20% coinsurance for Medicare-covered medical supplies. 20% coinsurance for Medicare-covered prosthetic devices.

Skilled Nursing Facility (SNF)

\$0 copay for days 1-20 \$184 copay for days 21-100

Transportation

Max of 20 trips to plan-approved locations every year. Covered modes of transportation include medical transport, van, taxi to plan approved locations.

Urgently needed services

\$55 copay, waived if admitted within 24 hours.. Maximum \$65 per visit.

Vision services

Frame max of 1 every year. Glasses max of 1 every year. Lenses max of 1 every year. Routine eye exam max of 1 every year. \$0-35 copay for Medicare-covered eye exams. Max of \$300 combined benefit for this plan every year.

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