MEDICARE ADVANTAGE / PDP

Plan Details

Cigna

$0.00

Plan: **Cigna True Choice Medicare (PPO)**

Max Out of Pocket: **$7,200**

Annual Drug Deductible: **$0.00**

ID: **H7849-6-0**

Star Rating: ***No Rating***

Plan Type: **Local PPO**

Part B Reduction: **No**

Effective Year: **2021**

City: **PHILADELPHIA**

State: **PA**

Zip: **19145**

Acupuncture

Out of Network: You pay nothing. Plan benefit max of $300.

In Network: You pay nothing.

Chiropractic care

Out of Network: $55 copay.

In Network: Not covered. $20 copay for Medicare-covered visits.

Dental services

Out of Network: You pay nothing. (Preventive Dental)

Out of Network: $55 copay. (Comprehensive Dental)

Out of Network: You pay nothing. (Comprehensive Dental)

In Network: $40 copay for Medicare-covered services. Max of $1500 combined preventive and comprehensive dental benefits for this plan every year.

Diabetes supplies and services

Out of Network: 30% coinsurance.

In Network: You pay nothing for diabetes self-management training.

In Network: 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)

Out of Network: 30% coinsurance. (Diagnostic Procedures/Tests)

Out of Network: 0-30% coinsurance. (Lab Services)

Out of Network: 30% coinsurance. (Diagnostic Radiological Services)

Out of Network: 30% coinsurance. (Therapeutic Radiological Services)

Out of Network: 30% coinsurance. (Outpatient X-Ray Services)

In Network: $0-50 copay for Medicare-covered diagnostic procedures/tests. $0-225 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.

Doctor's office visits

Out of Network: $40 copay. (Primary Care Physician Services)

Out of Network: $55 copay. (Physician Specialist Services)

In Network: Primary Physician: $0 copay Specialist Physician: $40 copay

Durable medical equipment (wheelchairs oxygen etc.)

Out of Network: 30% coinsurance.

In Network: 20% per item

Foot care (podiatry services)

Out of Network: $55 copay.

In Network: $30 copay for Medicare-covered visits.

Hearing services

Out of Network: $55 copay. (Hearing Exams)

Out of Network: 30% coinsurance. (Hearing Exams)

Out of Network: You pay nothing. (Hearing Aids)

In Network: 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

Out of Network: 30% coinsurance.

In Network: You pay nothing

Mental health care

Out of Network: $55 copay.

Out of Network: 30% coinsurance for stay

In Network: $295 copay for days 1-6 $0 copay for days 7-90

Outpatient rehabilitation

Out of Network: 30% coinsurance. (Cardiac Rehabilitation Services)

Out of Network: 30% coinsurance. (Intensive Cardiac Rehabilitation Services)

Out of Network: 30% coinsurance. (Pulmonary Rehabilitation Services)

Out of Network: $55 copay. (Occupational Therapy Services)

Out of Network: $55 copay. (Physical Therapy and Speech-Language Pathology Services)

In Network: $10 copay for Medicare-covered cardiac rehabilitation services. $10 copay for Medicare-covered intensive cardiac rehabilitation services. $10 copay for Medicare-covered pulmonary rehabilitation services.

In Network: $35 copay for physical therapy and speech therapy. $35 copay for occupational therapy.

Outpatient substance abuse

Out of Network: $55 copay.

In Network: $40 copay for group visits. $40 copay for individual visits

Outpatient surgery

Out of Network: 30% coinsurance. (Ambulatory Surgical Center (ASC) Services)

In Network: $0-295 per visit

Prosthetic devices (braces artificial limbs etc.)

Out of Network: 30% coinsurance.

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

Renal dialysis

Out of Network: 30% coinsurance.

In Network: 20% per visit

Vision services

Out of Network: 30% coinsurance. (Eye Exams)

Out of Network: $0-55 copay. (Eye Exams)

Out of Network: 30% coinsurance. (Eyewear)

Out of Network: You pay nothing. (Eyewear)

In Network: 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. $0-40 copay for Medicare-covered eye exams. Max of $150 combined benefit for this plan every year.

Outpatient prescription drugs

Out of Network: 30% coinsurance.

In Network: 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

Inpatient hospital care

Out of Network: 30% coinsurance for stay

In Network: $295 copay for days 1-6 $0 copay for days 7-90

Skilled Nursing Facility (SNF)

Out of Network: 30% coinsurance for stay

In Network: $0 copay for days 1-20 $184 copay for days 21-100

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

$11300 in and out-of-network out of pocket maximum. $7200 in-network out of pocket maximum.

Ambulance

$215 copay

Emergency care

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

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.

Over-the-counter items

Not covered in plan.

Preventive care

Annual physical exam not covered.

Transportation

Not covered

Urgently needed services

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

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