Eligibility Response

Response Generated: 1/16/2026 8:39:31 am CT

Your Request

Payer	CIGNA
Provider ID (NPI)	1487113239 - HomeCentris Home Health
Service Dates	1/16/2026
Last Name	WIGGINS
First Name	SURVESTER
Middle Name/Init	I
Member ID	31342304
DOB	3/31/1929
EVC Number	834164593

Patient Demographics

Address	5500 LEXINGTON RD APT 416, GWYNN OAK, MD 21207-5818
Gender	F

Eligibility State:	Active Coverage
	Display on Dashboard
	Currently Unreviewed
Owner:	Me (Sta. Rita, Jasmin)
Follow-up Status:	Financial Counseling/Self Pay Front Desk POS Collection
Follow-up Date:	mm/dd/yyyy
Add Request to Batch	Choose a Batch

Update Request

Service Coverage Overview

0 User Note(s)

Eligibility Summary: Active Coverage

Plan Name:	HealthSpring TotalCare Plus (HMO D-SNP)
Plan Start Date:	1/1/2024
Plan End Date:	
Sub. Group Number:	H2108_041_000 - HealthSpring TotalCare Plus (HMO D-SNP)

Primary Care Provider

PCP Name:	MidAtlantic MA HMO Trendsetters IPA
Service Type:	Medical Care
PCP Name:	BHAVANDEEP BAJAJ
Address:	3455 WILKENS AVE STE L10, BALTIMORE, MD 21229
NPI:	1003011214
Telephone:	(410) 644-4444
Service Type:	Medical Care

Service Types

Go To Top

Displaying 48 of 48 sections

Edit Display Show All Hide All

Health Benefit Plan Coverage (30)

Hide

Insurance Type:	Health Maintenance Organization (HMO)
Active Coverage:	(In Plan Network)
Coverage Level:	Individual
Deductible:	$283.00 (In Plan Network) Message: $283 MEDICARE-DEFINED PART B DEDUCTIBLE Message: Part A/B deductible
Out of Pocket (Stop Loss):	$9,250.00 / Calendar Year (In Plan Network) Message: $9,250 Message: Maximum Out-of-Pocket Cost (MOOP) $9,250.00 / Remaining (In Plan Network) Message: TOTAL MOOP REMAINING AMOUNT IS $9250.00 Message: Out-Of-Pocket (MOOP) remaining amount

Acupuncture (64)

Hide

Active Coverage:	(In Plan Network)
Coverage Basis:	(In Plan Network) **Authorization Required**
Coverage Level:	Individual
Co-Insurance:	20% (In Plan Network) **Authorization Required** Message: 20 coinsurance;Medicare-covered Acupuncture - 20 Message: Limited to 12 visits per year in 90 days by a licensed provider for chronic low back pain. Additional 8 sessions may be covered. No more than 20 acupuncture treatments allowed per year Message: Other Health Care Professional

Ambulatory Service Center Facility (13)

Hide

Active Coverage:	(In Plan Network)
Coverage Basis:	(In Plan Network) **Authorization Required**
Coverage Level:	Individual
Co-Insurance:	20% (In Plan Network) **Authorization Required** Message: 0 coinsurance for any surgical procedures (e.g. polyp removal) during a colorectal screening. After plan deductible, 20 coinsurance for all other Ambulatory Surgical Center (ASC) services. Message: Ambulatory Surgical Center (ASC) Services

Anesthesia (7)

Hide

Active Coverage:	(In Plan Network)
Coverage Basis:	(In Plan Network) **Authorization Required**
Coverage Level:	Individual

Co-Insurance:	20% (In Plan Network) **Authorization Required** Message: 20 coinsurance Message: Physician Specialist

Audiology Exam (71)

Hide

Active Coverage:	(In Plan Network)
Coverage Level:	Individual
Co-Insurance:	20% (In Plan Network) Message: 20 coinsurance Message: Hearing Exams (Medicare-covered)
Co-Payment:	$0.00 (In Plan Network) Message: $0 copay for 1 visit every Year Message: To schedule an appointment, call Hearing Care Solutions, Mon - Fri at 866-872-1001 from 7 a.m. to 7 p.m. CST Message: Routine Hearing Exams Message: Multiple fittings are allowed with the original provider if necessary to ensure hearing aids are accurately fitted. To schedule an appointment, call 1-866-872-1001 Mon - Fri from 7 a.m. to 7 p.m. CST Message: Hearing Aid Evaluation/Fitting

Cardiac (BL)

Hide

Active Coverage:	(In Plan Network)
Coverage Level:	Individual
Co-Payment:	$0.00 (In Plan Network) Message: $0 copay Message: Medicare-covered Preventive services

Cardiac Rehabilitation (BG)

Hide

Active Coverage:	(In Plan Network)
Coverage Basis:	(In Plan Network) **Authorization Required**
Coverage Level:	Individual
Co-Insurance:	20% (In Plan Network) **Authorization Required** Message: 20 coinsurance Message: Supervised Exercise Therapy (SET) for Symptomatic PAD Services 20% (In Plan Network) Message: 20 coinsurance Message: Cardiac Rehab Services Message: Pulmonary Rehab Services

Chemotherapy (78)

Hide

Active Coverage:	(In Plan Network)
Coverage Basis:	(In Plan Network) **Authorization Required**
Coverage Level:	Individual
Co-Insurance:	0% (In Plan Network) **Authorization Required** Message: 0 coinsurance is to reflect the lowest possible coinsurance for a Part B rebatable drug per CMS guidance, up to 20 coinsurance.

	Message: Other Medicare Part B Drugs Message: Medicare Part B Chemotherapy/Radiation Drugs 20% (In Plan Network) Message: 0 - 20 coinsurance up to $35 Message: Medicare Part B Insulin Drugs

Chiropractic (33)

Hide

Active Coverage:	(In Plan Network)
Coverage Basis:	(In Plan Network) **Authorization Required**
Coverage Level:	Individual
Co-Insurance:	20% (In Plan Network) **Authorization Required** Message: 20 coinsurance Message: Chiropractic (Medicare-covered)

Dental Care (35)

Hide

Insurance Type:	Health Maintenance Organization (HMO)
Active Coverage:	Description: Dental HMO Eligibility Begin: 1/1/2024

Diagnostic Lab (5)

Hide

Active Coverage:	(In Plan Network)
Coverage Basis:	(In Plan Network) **Authorization Required**
Coverage Level:	Individual
Co-Insurance:	20% (In Plan Network) **Authorization Required** Message: 0 coinsurance for EKG. After plan deductible, 20 coinsurance for all other diagnostic procedures and tests. Message: Diagnostic Procedures/Tests Message: After plan deductible, 20 coinsurance applies to genetic testing (except Cologuard and Molecular Pathology Interpretation). 0 coinsurance applies to all other diagnostic lab services. Message: Lab Services

Diagnostic Medical (73)

Hide

Active Coverage:	(In Plan Network)
Coverage Basis:	(In Plan Network) **Authorization Required**
Coverage Level:	Individual
Co-Insurance:	20% (In Plan Network) **Authorization Required** Message: After plan deductible, 20 coinsurance applies to genetic testing (except Cologuard and Molecular Pathology Interpretation). 0 coinsurance applies to all other diagnostic lab services. Message: Lab Services Message: 0 coinsurance for diagnostic mammography and ultrasounds. After plan deductible, 20 coinsurance for all other diagnostic and nuclear medicine radiological services. Message: Diagnostic Radiological Services Message: 0 coinsurance for EKG. After plan deductible, 20 coinsurance for all other diagnostic procedures and tests. Message: Diagnostic Procedures/Tests

Diagnostic X-Ray (4)

Hide

Active Coverage:	(In Plan Network)
Coverage Basis:	(In Plan Network) **Authorization Required**
Coverage Level:	Individual
Co-Insurance:	20% (In Plan Network) **Authorization Required** Message: 0 coinsurance for diagnostic mammography and ultrasounds. After plan deductible, 20 coinsurance for all other diagnostic and nuclear medicine radiological services. Message: Diagnostic Radiological Services 20% (In Plan Network) Message: 20 coinsurance Message: X-Ray Services

Dialysis (76)

Hide

Active Coverage:	(In Plan Network)
Coverage Basis:	(In Plan Network) **Authorization Required**
Coverage Level:	Individual
Co-Insurance:	20% (In Plan Network) **Authorization Required** Message: 20 coinsurance Message: Dialysis Services
Co-Payment:	$0.00 (In Plan Network) Message: $0 copay Message: Kidney Disease Education Services

Durable Medical Equipment Purchase (12)

Hide

Active Coverage:	(In Plan Network)
Coverage Basis:	(In Plan Network) **Authorization Required**
Coverage Level:	Individual
Co-Insurance:	20% (In Plan Network) **Authorization Required** Message: 20 coinsurance Message: DME Message: Medical Supplies
Co-Payment:	$1,800.00 (In Plan Network) Message: $399 - $1800 copay per device for 2 every Year Message: Hearing aid devices do not include assisted listening devices, amplifiers or disposable devices. To schedule an appointment, call Hearing Care Solutions Mon - Fri at 866-872-1001 from 7 a.m. to 7 p.m. CST Message: Hearing Aids $399.00 (In Plan Network) Message: $399 - $1800 copay per device for 2 every Year Message: Hearing aid devices do not include assisted listening devices, amplifiers or disposable devices. To schedule an appointment, call Hearing Care Solutions Mon - Fri at 866-872-1001 from 7 a.m. to 7 p.m. CST Message: Hearing Aids

Durable Medical Equipment Rental (18)

Hide

Active Coverage:	(In Plan Network)
Coverage Basis:	(In Plan Network) **Authorization Required**

Coverage Level:	Individual
Co-Insurance:	20% (In Plan Network) **Authorization Required** Message: 20 coinsurance Message: DME

Emergency Services (86)

Hide

Active Coverage:	(In Plan Network)
Coverage Level:	Individual
Co-Payment:	$115.00 (In Plan Network) Message: $115 copay Message: Copay is waived if admitted to the hospital within 24 hours Message: Emergency Services

Generic Prescription Drug (92)

Hide

Active Coverage:	(In Plan Network)
Coverage Level:	Individual
Co-Payment:	$0.00 (In Plan Network) Message: Initial Coverage - Tier 1 Preferred Generic Drugs.Preferred Mail Order Pharmacy Cost Share - One Month Supply Message: Initial Coverage - Tier 1 Preferred Generic Drugs.Preferred Mail Order Pharmacy Cost Share - Two Month Supply Message: Initial Coverage - Tier 1 Preferred Generic Drugs.Preferred Retail Pharmacy Cost Share - One Month Supply Message: Initial Coverage - Tier 1 Preferred Generic Drugs.Preferred Mail Pharmacy Cost Share - Three Month Supply Message: Initial Coverage - Tier 1 Preferred Generic Drugs.Preferred Retail Pharmacy Cost Share - Three Month Supply Message: Initial Coverage - Tier 2 Generic Drugs.Preferred Retail Pharmacy Cost Share - One Month Supply Message: Initial Coverage - Tier 2 Generic Drugs.Preferred Retail Pharmacy Cost Share - Three Month Supply Message: Initial Coverage - Tier 2 Generic Drugs.Preferred Retail Pharmacy Cost Share - Two Month Supply Message: Initial Coverage - Tier 2 Generic Drugs.Preferred Mail Order Pharmacy Cost Share - Two Month Supply Message: Initial Coverage - Tier 2 Generic Drugs.Preferred Mail Pharmacy Cost Share - Three Month Supply $0.00 (In Plan Network) Message: Initial Coverage - Tier 2 Generic Drugs.Preferred Mail Order Pharmacy Cost Share - One Month Supply Message: Initial Coverage - Tier 1 Preferred Generic Drugs.Preferred Retail Pharmacy Cost Share - Two Month Supply $15.00 (In Plan Network) Message: Initial Coverage - Tier 1 Preferred Generic Drugs.Standard Mail Pharmacy Cost Share - Three Month Supply Message: Initial Coverage - Tier 1 Preferred Generic Drugs.Standard Retail Pharmacy Cost Share - Three Month Supply $10.00 (In Plan Network) Message: Initial Coverage - Tier 1 Preferred Generic Drugs.Standard Mail Order Pharmacy Cost Share - Two Month Supply Message: Initial Coverage - Tier 1 Preferred Generic Drugs.Standard Retail Pharmacy Cost Share - Two Month Supply Message: Initial Coverage - Tier 2 Generic Drugs.LTC Pharmacy Cost Share - One Month Supply Message: Initial Coverage - Tier 2 Generic Drugs.Standard Mail Order Pharmacy Cost Share - One Month Supply Message: Initial Coverage - Tier 2 Generic Drugs.Standard Retail Pharmacy Cost Share - One Month Supply $30.00 (In Plan Network) Message: Initial Coverage - Tier 2 Generic Drugs.Standard Mail Pharmacy Cost Share - Three Month Supply Message: Initial Coverage - Tier 2 Generic Drugs.Standard Retail Pharmacy Cost Share - Three Month Supply

	$20.00 (In Plan Network) Message: Initial Coverage - Tier 2 Generic Drugs.Standard Mail Order Pharmacy Cost Share - Two Month Supply Message: Initial Coverage - Tier 2 Generic Drugs.Standard Retail Pharmacy Cost Share - Two Month Supply $5.00 (In Plan Network) Message: Initial Coverage - Tier 1 Preferred Generic Drugs.Standard Retail Pharmacy Cost Share - One Month Supply Message: Initial Coverage - Tier 1 Preferred Generic Drugs.Standard Mail Order Pharmacy Cost Share - One Month Supply Message: Initial Coverage - Tier 1 Preferred Generic Drugs.LTC Pharmacy Cost Share - One Month Supply

Hospital (47)

Hide

Active Coverage:	(In Plan Network)
Coverage Basis:	(In Plan Network) **Authorization Required**
Coverage Level:	Individual
Co-Insurance:	20% (In Plan Network) **Authorization Required** Message: 2026 STANDARD MEDICARE Message: Our plan covers an unlimited number of days for a Medicare-covered hospital stay Message: Inpatient Hospital Acute
Co-Payment:	$80.00 (In Plan Network) **Authorization Required** Message: $80 copay Message: Intensive Outpatient Services Message: Partial Hospitalization

Hospital - Ambulatory Surgical (53)

Hide

Active Coverage:	(In Plan Network)
Coverage Basis:	(In Plan Network) **Authorization Required**
Coverage Level:	Individual
Co-Insurance:	20% (In Plan Network) **Authorization Required** Message: 0 coinsurance for any surgical procedures (e.g. polyp removal) during a colorectal screening. After plan deductible, 20 coinsurance for all other Ambulatory Surgical Center (ASC) services. Message: Ambulatory Surgical Center (ASC) Services

Hospital - Emergency Accident (51)

Hide

Active Coverage:	(In Plan Network)
Coverage Level:	Individual
Co-Payment:	$115.00 (In Plan Network) Message: $115 copay Message: Copay is waived if admitted to the hospital within 24 hours Message: Emergency Services

Hospital - Emergency Medical (52)

Hide

Active Coverage:	(In Plan Network)
Coverage Level:	Individual
Co-Payment:	$115.00 (In Plan Network)

	Message: $115 copay Message: Copay is waived if admitted to the hospital within 24 hours Message: Emergency Services

Hospital - Inpatient (48)

Hide

Active Coverage:	(In Plan Network)
Coverage Basis:	(In Plan Network) **Authorization Required**
Coverage Level:	Individual
Co-Insurance:	20% (In Plan Network) **Authorization Required** Message: 2026 STANDARD MEDICARE Message: Our plan covers an unlimited number of days for a Medicare-covered hospital stay Message: Inpatient Hospital Acute

Hospital - Outpatient (50)

Hide

Active Coverage:	(In Plan Network)
Coverage Basis:	(In Plan Network) **Authorization Required**
Coverage Level:	Individual
Co-Insurance:	20% (In Plan Network) **Authorization Required** Message: 0 coinsurance for any surgical procedures (e.g. polyp removal) during a colorectal screening. After plan deductible, 20 coinsurance for all other outpatient services not provided in an Ambulatory Surgical Center. Message: Outpatient Hospital Services Message: 20 coinsurance Message: Observation Services
Co-Payment:	$0.00 (In Plan Network) Message: $0 copay Message: Outpatient Blood Services

Immunizations (80)

Hide

Active Coverage:	(In Plan Network)
Coverage Basis:	(In Plan Network) **Authorization Required**
Coverage Level:	Individual
Co-Insurance:	0% (In Plan Network) **Authorization Required** Message: 0 coinsurance is to reflect the lowest possible coinsurance for a Part B rebatable drug per CMS guidance, up to 20 coinsurance. Message: Other Medicare Part B Drugs Message: Medicare Part B Chemotherapy/Radiation Drugs 20% (In Plan Network) Message: 0 - 20 coinsurance up to $35 Message: Medicare Part B Insulin Drugs

Mail Order Prescription Drug (90)

Hide

Active Coverage:	(In Plan Network)
Coverage Level:	Individual
Co-Insurance:	23% (In Plan Network)

	Message: Initial Coverage - Tier 3 Preferred Brand Name Drugs.Preferred Mail Order Pharmacy Cost Share - Two Month Supply Message: Initial Coverage - Tier 3 Preferred Brand Name Drugs.Preferred Mail Pharmacy Cost Share - Three Month Supply Message: Initial Coverage - Tier 3 Preferred Brand Name Drugs.Standard Mail Order Pharmacy Cost Share - One Month Supply Message: Initial Coverage - Tier 3 Preferred Brand Name Drugs.Standard Mail Order Pharmacy Cost Share - Two Month Supply Message: Initial Coverage - Tier 3 Preferred Brand Name Drugs.Preferred Mail Order Pharmacy Cost Share - One Month Supply Message: Initial Coverage - Tier 3 Preferred Brand Name Drugs.Standard Mail Pharmacy Cost Share - Three Month Supply 25% (In Plan Network) Message: Initial Coverage - Tier 4 Non-Preferred Drugs.Standard Mail Pharmacy Cost Share - Three Month Supply Message: Initial Coverage - Tier 5 Specialty Drugs.Standard Mail Order Pharmacy Cost Share - One Month Supply Message: Initial Coverage - Tier 4 Non-Preferred Drugs.Preferred Mail Order Pharmacy Cost Share - One Month Supply Message: Initial Coverage - Tier 4 Non-Preferred Drugs.Standard Mail Order Pharmacy Cost Share - One Month Supply Message: Initial Coverage - Tier 4 Non-Preferred Drugs.Preferred Mail Order Pharmacy Cost Share - Two Month Supply Message: Initial Coverage - Tier 5 Specialty Drugs.Preferred Mail Order Pharmacy Cost Share - One Month Supply Message: Initial Coverage - Tier 4 Non-Preferred Drugs.Preferred Mail Pharmacy Cost Share - Three Month Supply Message: Initial Coverage - Tier 4 Non-Preferred Drugs.Standard Mail Order Pharmacy Cost Share - Two Month Supply

Medical Care (1)

Hide

Active Coverage:	(In Plan Network)
Coverage Basis:	(In Plan Network) **Authorization Required**
Coverage Level:	Individual
Co-Insurance:	20% (In Plan Network) Message: 20 coinsurance Message: Primary Care Physician Message: For nonemergency care, talk with a telehealth doctor via phone or video for minor illnesses. MDLIVE Telehealth 1-866-918-7836. 24 hours a day, 7 days a week. Message: MDLive Telehealth Services 20% (In Plan Network) **Authorization Required** Message: 20 coinsurance Message: Physician Specialist

Mental Health (MH)

Hide

Active Coverage:	(In Plan Network)
Coverage Basis:	(In Plan Network) **Authorization Required**
Coverage Level:	Individual
Co-Insurance:	20% (In Plan Network) **Authorization Required** Message: 20 coinsurance Message: Behavioral Health Telehealth Services Message: Mental Health Specialty-Individual Message: Physician Specialist Message: Mental Health Specialty-Group 20% (In Plan Network) **Authorization Required** Message: 2026 STANDARD MEDICARE

	Message: In some instances, a readmission policy may apply in which the benefit will continue from original admission. Message: Inpatient Hospital Psychiatric
Co-Payment:	$0.00 (In Plan Network) Message: $0 copay Message: Medicare-covered Preventive services

MRI/CAT Scan (62)

Hide

Active Coverage:	(In Plan Network)
Coverage Basis:	(In Plan Network) **Authorization Required**
Coverage Level:	Individual
Co-Insurance:	20% (In Plan Network) **Authorization Required** Message: 0 coinsurance for diagnostic mammography and ultrasounds. After plan deductible, 20 coinsurance for all other diagnostic and nuclear medicine radiological services. Message: Diagnostic Radiological Services

Occupational Therapy (AD)

Hide

Active Coverage:	(In Plan Network)
Coverage Basis:	(In Plan Network) **Authorization Required**
Coverage Level:	Individual
Co-Insurance:	20% (In Plan Network) **Authorization Required** Message: 20 coinsurance Message: Occupational Therapy

Pharmacy (88)

Hide

Active Coverage:	(In Plan Network)
Coverage Level:	Individual
Co-Insurance:	25% (In Plan Network) Message: Initial Coverage - Tier 4 Non-Preferred Drugs.Standard Retail Pharmacy Cost Share - One Month Supply Message: Initial Coverage - Tier 5 Specialty Drugs.Standard Retail Pharmacy Cost Share - One Month Supply Message: Initial Coverage - Tier 4 Non-Preferred Drugs.Preferred Retail Pharmacy Cost Share - Three Month Supply Message: Initial Coverage - Tier 4 Non-Preferred Drugs.LTC Pharmacy Cost Share - One Month Supply Message: Initial Coverage - Tier 4 Non-Preferred Drugs.Standard Retail Pharmacy Cost Share - Three Month Supply Message: Initial Coverage - Tier 5 Specialty Drugs.LTC Pharmacy Cost Share - One Month Supply Message: Initial Coverage - Tier 4 Non-Preferred Drugs.Preferred Retail Pharmacy Cost Share - One Month Supply Message: Initial Coverage - Tier 5 Specialty Drugs.Preferred Retail Pharmacy Cost Share - One Month Supply Message: Initial Coverage - Tier 4 Non-Preferred Drugs.Preferred Retail Pharmacy Cost Share - Two Month Supply Message: Initial Coverage - Tier 4 Non-Preferred Drugs.Standard Retail Pharmacy Cost Share - Two Month Supply 23% (In Plan Network) Message: Initial Coverage - Tier 3 Preferred Brand Name Drugs.Preferred Retail Pharmacy Cost Share - One Month Supply Message: Initial Coverage - Tier 3 Preferred Brand Name Drugs.Preferred Retail Pharmacy Cost Share - Two Month Supply Message: Initial Coverage - Tier 3 Preferred Brand Name Drugs.LTC Pharmacy Cost Share - One Month Supply Message: Initial Coverage - Tier 3 Preferred Brand Name Drugs.Standard Retail Pharmacy Cost Share - One Month Supply Message: Initial Coverage - Tier 3 Preferred Brand Name Drugs.Standard Retail Pharmacy Cost Share - Three Month Supply Message: Initial Coverage - Tier 3 Preferred Brand Name Drugs.Standard Retail Pharmacy Cost Share - Two Month

	Supply Message: Initial Coverage - Tier 3 Preferred Brand Name Drugs.Preferred Retail Pharmacy Cost Share - Three Month Supply

Physical Medicine (AE)

Hide

Active Coverage:	(In Plan Network)
Coverage Basis:	(In Plan Network) **Authorization Required**
Coverage Level:	Individual
Co-Insurance:	20% (In Plan Network) **Authorization Required** Message: 20 coinsurance Message: PT and SP

Podiatry (93)

Hide

Active Coverage:	(In Plan Network)
Coverage Level:	Individual
Co-Insurance:	20% (In Plan Network) Message: 20 coinsurance Medicare Part B covers podiatry services?for medically necessary treatment of foot injuries, diseases, or other medical conditions affecting the foot, ankle, or lower leg. Message: Podiatry (Medicare-covered)
Co-Payment:	$0.00 12 Visits / Calendar Year (In Plan Network) Message: $0 copay per visit for 12 visits every Year Message: Routine Podiatry

Professional (Physician) Visit - Home (A3)

Hide

Active Coverage:	(In Plan Network)
Coverage Basis:	(In Plan Network) **Authorization Required**
Coverage Level:	Individual
Co-Insurance:	20% (In Plan Network) Message: 20 coinsurance Message: Primary Care Physician Message: For nonemergency care, talk with a telehealth doctor via phone or video for minor illnesses. MDLIVE Telehealth 1-866-918-7836. 24 hours a day, 7 days a week. Message: MDLive Telehealth Services 20% (In Plan Network) **Authorization Required** Message: 20 coinsurance Message: Physician Specialist
Co-Payment:	$0.00 (In Plan Network) **Authorization Required** Message: $0 copay Message: Home Health

Professional (Physician) Visit - Inpatient (99)

Hide

Active Coverage:	(In Plan Network)
Coverage Basis:	(In Plan Network) **Authorization Required**
Coverage Level:	Individual

Co-Insurance:	20% (In Plan Network) Message: 20 coinsurance Message: Primary Care Physician Message: For nonemergency care, talk with a telehealth doctor via phone or video for minor illnesses. MDLIVE Telehealth 1-866-918-7836. 24 hours a day, 7 days a week. Message: MDLive Telehealth Services 20% (In Plan Network) **Authorization Required** Message: 20 coinsurance Message: Physician Specialist

Professional (Physician) Visit - Office (98)

Hide

Active Coverage:	(In Plan Network)
Coverage Basis:	(In Plan Network) **Authorization Required**
Coverage Level:	Individual
Co-Insurance:	20% (In Plan Network) **Authorization Required** Message: 20 coinsurance Message: Physician Specialist 20% (In Plan Network) Message: 20 coinsurance Message: Annual Physical Exam Message: For nonemergency care, talk with a telehealth doctor via phone or video for minor illnesses. MDLIVE Telehealth 1-866-918-7836. 24 hours a day, 7 days a week. Message: MDLive Telehealth Services Message: Primary Care Physician

Professional (Physician) Visit - Outpatient (A0)

Hide

Active Coverage:	(In Plan Network)
Coverage Basis:	(In Plan Network) **Authorization Required**
Coverage Level:	Individual
Co-Insurance:	20% (In Plan Network) Message: 20 coinsurance Message: Primary Care Physician Message: For nonemergency care, talk with a telehealth doctor via phone or video for minor illnesses. MDLIVE Telehealth 1-866-918-7836. 24 hours a day, 7 days a week. Message: MDLive Telehealth Services 20% (In Plan Network) **Authorization Required** Message: 20 coinsurance Message: Physician Specialist

Prosthetic Device (75)

Hide

Active Coverage:	(In Plan Network)
Coverage Basis:	(In Plan Network) **Authorization Required**
Coverage Level:	Individual
Co-Insurance:	20% (In Plan Network) **Authorization Required** Message: 20 coinsurance Message: Prosthetic Devices

Radiation Therapy (6)

Hide

Active Coverage:	(In Plan Network)
Coverage Basis:	(In Plan Network) **Authorization Required**
Coverage Level:	Individual
Co-Insurance:	20% (In Plan Network) **Authorization Required** Message: 20 coinsurance Message: Therapeutic Radiological Services Message: 0 coinsurance for diagnostic mammography and ultrasounds. After plan deductible, 20 coinsurance for all other diagnostic and nuclear medicine radiological services. Message: Diagnostic Radiological Services

Routine Physical (81)

Hide

Active Coverage:	(In Plan Network)
Coverage Level:	Individual
Co-Payment:	$0.00 (In Plan Network) Message: $0 copay Message: Medicare-covered Preventive services

Skilled Nursing Care (AG)

Hide

Active Coverage:	(In Plan Network)
Coverage Basis:	(In Plan Network) **Authorization Required**
Coverage Level:	Individual
Co-Insurance:	20% (In Plan Network) **Authorization Required** Message: 2026 STANDARD MEDICARE Message: In some instances, a readmission policy may apply in which the benefit will continue from original admission. Message: Skilled Nursing Facility (SNF)

Smoking Cessation (67)

Hide

Active Coverage:	(In Plan Network)
Coverage Level:	Individual
Co-Payment:	$0.00 (In Plan Network) Message: $0 copay Message: Medicare-covered Preventive services

Speech Therapy (AF)

Hide

Active Coverage:	(In Plan Network)
Coverage Basis:	(In Plan Network) **Authorization Required**
Coverage Level:	Individual
Co-Insurance:	20% (In Plan Network) **Authorization Required** Message: 20 coinsurance

	Message: PT and SP

Substance Abuse (AI)

Hide

Active Coverage:	(In Plan Network)
Coverage Basis:	(In Plan Network) **Authorization Required**
Coverage Level:	Individual
Co-Insurance:	20% (In Plan Network) **Authorization Required** Message: 20 coinsurance Message: Opioid Treatment Services Message: OP Substance Abuse-Individual Message: OP Substance Abuse-Group

Surgical (2)

Hide

Active Coverage:	(In Plan Network)
Coverage Basis:	(In Plan Network) **Authorization Required**
Coverage Level:	Individual
Co-Insurance:	20% (In Plan Network) **Authorization Required** Message: 0 coinsurance for any surgical procedures (e.g. polyp removal) during a colorectal screening. After plan deductible, 20 coinsurance for all other Ambulatory Surgical Center (ASC) services. Message: Ambulatory Surgical Center (ASC) Services Message: 0 coinsurance for any surgical procedures (e.g. polyp removal) during a colorectal screening. After plan deductible, 20 coinsurance for all other outpatient services not provided in an Ambulatory Surgical Center. Message: Outpatient Hospital Services Message: 20 coinsurance Message: Observation Services Message: Physician Specialist 20% (In Plan Network) Message: 20 coinsurance Message: Primary Care Physician Message: For nonemergency care, talk with a telehealth doctor via phone or video for minor illnesses. MDLIVE Telehealth 1-866-918-7836. 24 hours a day, 7 days a week. Message: MDLive Telehealth Services

Surgical Assistance (8)

Hide

Active Coverage:	(In Plan Network)
Coverage Basis:	(In Plan Network) **Authorization Required**
Coverage Level:	Individual
Co-Insurance:	20% (In Plan Network) **Authorization Required** Message: 0 coinsurance for any surgical procedures (e.g. polyp removal) during a colorectal screening. After plan deductible, 20 coinsurance for all other Ambulatory Surgical Center (ASC) services. Message: Ambulatory Surgical Center (ASC) Services Message: 0 coinsurance for any surgical procedures (e.g. polyp removal) during a colorectal screening. After plan deductible, 20 coinsurance for all other outpatient services not provided in an Ambulatory Surgical Center. Message: Outpatient Hospital Services Message: 20 coinsurance Message: Observation Services Message: Physician Specialist 20% (In Plan Network)

	Message: 20 coinsurance Message: Primary Care Physician Message: For nonemergency care, talk with a telehealth doctor via phone or video for minor illnesses. MDLIVE Telehealth 1-866-918-7836. 24 hours a day, 7 days a week. Message: MDLive Telehealth Services

Urgent Care (UC)

Hide

Active Coverage:	(In Plan Network)
Coverage Level:	Individual
Co-Payment:	$115.00 (In Plan Network) Message: $115 copay Message: Copay is waived if admitted to the hospital within 24 hours. Copay waived if admitted to the hospital within 24 hours. Maximum coverage of $50,000 per year Message: Worldwide Emergency/Urgent Coverage/Emergency Transportation $40.00 (In Plan Network) Message: $40 copay Message: Copay is waived if admitted to the hospital within 24 hours Message: Urgently Needed Services

Vision (Optometry) (AL)

Hide

Active Coverage:	(In Plan Network)
Coverage Level:	Individual
Co-Insurance:	20% (In Plan Network) Message: 0 coinsurance for Medicare-covered diabetic retinopathy screening. After plan deductible, 20 coinsurance for all other Medicare-covered vision services. Message: Eye Exams (Medicare-covered)
Co-Payment:	$0.00 (In Plan Network) Message: $0 copay for 1 eyeglass lenses every year Message: Eyeglass Lenses (Supplemental) Message: $0 copay for 1 eyeglasses frames every year Message: Eyeglasses Frames (Supplemental) Message: $0 copay Message: Medicare-covered Glaucoma Screening Message: Limited to one pair of eyeglasses or contact lenses after each cataract surgery Message: Eye wear (Medicare-covered) Message: $0 copay for 1 eyeglasses(Lenses and Frames) every year Message: Eyeglasses (Lenses and Frames) (Supplemental) $0.00 (In Plan Network) Message: Routine Eye Wear Coverage Message: $0 copay for Unlimited contact lenses Message: Upgrades (Supplemental) $0.00 1 Visits / Calendar Year (In Plan Network) Message: $0 copay for 1 routine exam every Year.For questions about eye exams, call EyeMed at 1-888-886-1995 (TTY 711) Mon.- Fri. from 8 00 a.m. to 2 a.m. EST, Saturday, 8 a.m. to 11 p.m. EST, Sunday, 11 a.m. to 8 p.m. EST . You can also visit EyeMed.com/CignaMedicare to f Message: ind a network vision provider in your area Message: Routine Eye Exams $300.00 (In Plan Network) Message: $300 combined allowance amount every year Message: The allowance may only be applied to one set of eyewear per year. Customers may choose an eyeglass frame/lenses/lens combination or contact lenses, but not both. Message: Max Coverage Amount for Routine Eye Wear Coverage (Supplemental)