Service Request Type (Source: Sig Advantage 2021 PBP - Evidence of Coverage)	Applies to Sig Adv Plan (SAP), Sig Adv Community (SAC), or Both	PA Required (Yes / No)	Plan Notification within 24-hours Following Admission Event (Yes / No)	Continuation of Services Approval Required (Yes/No)	Pre-claim Retrospective Review Allowed (Yes/No)	2020 to 2021 Change?
Ambulance Services (Non-emergent)	Both	Yes	No	NA	No	No
Ambulatory Surgical Centers (ASC) Services	Both	Yes	No	NA	No	No
Cardiac & Pulmonary Rehab Services	Both	Yes	No	Yes	No	No
Chiropractic Services	Both	Yes	No	Yes	No	Yes
Diabetic Supplies and Services / Diabetic Therapeutic Shoes and Inserts **(Excess of $250 billed charges each month)**	Both	Yes	No	Yes	No	New add to list only
Durable Medical Equipment (DME) **(Excess of $250 billed charges each month)**	Both	Yes	No	Yes	No	No
Emergent/Urgent Services (USA territories only)*	Both	No	Yes	NA	Yes	No
Home Health Services	Both	Yes	No	Yes	No	No
INN Specialist Referrals* **- If PA is preferred – initiate the review.** **- If a non-contract specialty referral request, attempt to redirect within SA network)**	Both	No	No	No	No	No
Inpatient Hospital - Acute	Both	Yes	Yes	Yes	No	No
Inpatient Hospital - Psychiatric	Both	Yes	Yes	Yes	No	No
Nurse Practitioner (NP) visits*	Both	No	No	No	No	No
Opioid Treatment Program Services	Both	Yes	Yes	Yes	No	**Yes**
Outpatient Blood Services (Transfusions)*	Both	No	No	No	No	New add to list only
Outpatient Diagnostic High tech Radiological Services (e.g. MRI, MRA, PET, CTA, CT Scans, and SPECT) No authorization required for general X-ray Services	Both	Yes	No	NA	No	New add to list only
Outpatient Diagnostic Procedures, Tests, and Lab Services **EXCEPTION: Tests rendered in network nursing facility or network physician office - PA NOT REQUIRED***	Both	Yes	No	NA	No	No
Outpatient Hospital Services	Both	Yes	No	NA	No	No
Outpatient Observations	Both	Yes	Yes	Yes	No	No
Outpatient Psychiatric Services*	Both	No	No	No	No	No
Outpatient Substance Abuse Services*	Both	No	No	No	No	New add to list only
Part B Chemotherapy Drugs following initial chemotherapy (Excess of $250 each month)	Both	Yes	No	Yes	No	No
Part B Drugs Chemotherapy - Initial Only	Both	Yes	No	Yes	No	No
Part B Drugs-Other (Excess of $250 each month)	Both	Yes	No	Yes	No	No
Partial Hospitalization	Both	Yes	No	Yes	No	No
Podiatry Services (Routine Foot Care)*	Both	No	No	NA	No	New add to list only
Prosthetics / Medical Supplies **(Excess of $250 billed charges each month)**	Both	Yes	No	Yes	No	No
Renal (Kidney) Dialysis*	Both	No	No	No	No	No
Skilled Nursing Facility Admission	Both	Yes	Yes	Yes	No	No
Supplemental Benefit: Over-the-Counter (OTC) Items including Incontinence Supplies* **($40/month) Must use Preferred Provider.**	**Both**	No	No	No	No	**Yes**
Supplemental Dental Services:* ***Preventive*** *(2 Oral exam visitis; 2 Dental x-rays; and 2 prophylaxis/cleaning visits) per plan year.* ***Comprehensive*** *(Medicare-covered Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery)* *Note: All covered supplemental dental benefits are* ***limited to a combined total maximum plan benefit of $1550***	Both	No	No	No	No	Yes
Supplental Benefit: Vision Services* *One (1) Routine Eye Exam and $150 toward eyewear cost**	Both	No	No	No	No	No
Supplmental Benefit: Telehealth Services* *Includes Primary Care Visits, Physician Specialist Services, Individual and Group Sessions for Psychiatric Services, Kidney Disease Education Services, Diabetes Self-Management Training and Dialysis Services*	**Both**	No	No	No	No	Yes
Suuplemental Benefit: Foot Care* *Plan covers an additional 6 Podiatry visits per year.*	Both	No	No	No	No	No
Suuplemental Benefit: Hearing Services* *Routine Hearing Exam and Hearing-aid Fittings (Plan pays up to $1500 every two years)**	Both	No	No	No	No	Yes
Therapeutic Radiology Services*	Both	No	No	NA	No	New add to list only
Therapy Services (PT/OT/ST - Capped)* Performed at NF/ALF	Both	No	No	No	No	No
Transportation Services* Plans cover **50 one-way trips to approve medical locations** with no cost share for members)	Both	No	No	NA	No	**Yes**

NOTE: *Services must be provided according to the Medicare Coverage Guidelines and limitations and are subject to review. All medical care, services, supplies and equipment must be medically necessary. For benefits verification, please refer to Member's Evidence of Coverage posted at: www.signatureadvantageplan.com; or call Member Services at 844-214-8633.*

*** Indicates - No preauthorization required for these services.**

The PCP/NFist or Specialist is responsible for requesting prior authorization of all scheduled admissions or services and procedures, for referring a member for an elective admission, and outpatient service. Signature Advantage recommends calling at least five (5) days in advance of the scheduled admission, procedure, or service. Requests for prior authorization are prioritized according to level of medical necessity. ***For prior authorizations, providers should call: (844) 214-8633.***