

2022 Medicare Advantage PFFS in Erie County

TYPE OF MEDICAL SERVICE	ORIGINAL MEDICARE	Wellcare Medicare 1-866-822-1339							
		Wellcare Advantage No Premium - PFFS		Wellcare Advantage Premium Enhanced - PFFS		Wellcare Premium Enhanced PFFS		WellCare Premium Ultra PFFS	
PREMIUMS	\$170.10	\$0		\$62		\$55		\$156	
Deductible	\$233	\$0		\$0		\$0		\$0 Deductible; \$20/yr OTC card	
		In	Out	In	Out	In	Out	In	Out
PCP Visits	20%**	\$5	\$15	\$0	\$10	\$10	\$25	\$0	\$10
Wellness Exam	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Specialty Visits	20%**	\$30	\$50	\$25	\$35	\$35	\$60	\$25	\$35
Outpatient Mental Health	20%	\$25	30%	\$25	30%	\$25	30%	\$25	30%
Outpatient Substance Abuse	20%**	\$25	30%	\$25	30%	\$25	30%	\$25	30%
Outpatient Surgery	20% **	\$200	30%	\$150	30%	\$250	30%	\$150	30%
Emergency Care	20% **	\$90; \$90 World Wide Coverage		\$90; \$90 World Wide Coverage		\$120; \$120 World Wide Coverage		\$120, \$120 worldwide coverage	
Urgent Care	20% **	\$35		\$35		\$35		\$35	
Ambulance Services	20% **	\$350		\$300		\$350		\$350	
Durable Medical Equipment	20% ** (must use Medicare supplier)	20%	20%	20%	30%	20%	30%	20%	30%
Prosthetic Devices	20% **	20%	20%	20%	30%	20%	30%	20%	30%
X Rays	20% **	\$0	30%	\$0	30%	\$0	30%	\$0	30%
Lab Services	\$0	\$0	30%	\$0	30%	\$0	30%	\$0	30%
Radiation Therapy	20%	20%	30%	20%	30%	20%	30%	20%	30%
Diagnostic Radiology	20%	\$100/\$200	30%	\$100/\$200	30%	\$100-\$300	30%	\$100-\$200	30%
Chiropractic Care	20% limited coverage	\$20	30%	\$20	30%	\$20	30%	\$20	30%
Medically Necessary Foot Care	20% limited coverage	\$30 Certain conditions only	\$50 Certain conditions only	\$25 Certain conditions only	\$35 Certain conditions only	\$35 Certain conditions only	\$60 Certain conditions only	\$25 Certain conditions only	\$35 Certain conditions only
Routine Foot Care	NOT COVERED	*Restrictions May Apply		*Restrictions May Apply		*Restrictions May Apply		*Restrictions May Apply	
P.T.,O.T. and Speech Therapy	20% **	\$35	30%	\$15	30%	\$40	30%	\$15	30%
Cardiac Rehab	20%	\$35	30%	\$15	30%	\$40	30%	\$15	30%
Dialysis	20%	20%	30%	20%	30%	20%	30%	20%	30%

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PREMIUMS	\$170.10	\$0		\$62		\$55		\$156	
Deductible	\$233	\$0		\$0		\$0		\$0	
		In	Out	In	Out	In	Out	In	Out
Inpatient Hospital	\$1,556	\$260/day days 1-6, \$0/day days 7+	\$300/day days 1-7, \$0/day days 8-90	\$650 per stay	\$388/day days 1-7, \$0/day days 8-90	\$295/day days 1-5, \$0/day days 6-90	\$300/day days 1-7, \$0/day days 8-90	\$500 per stay	\$300/day days 1-7, \$0/day days 8-90
Inpatient Mental Health*	\$1,556	\$260/day days 1-6, \$0/day days 7-90	\$300/day days 1-7, \$0/day days 8-90	\$500 Per Stay	\$300/day days 1-7, \$0/day days 8-90	\$295/day days 1-5, \$0/day days 6-90	\$300/day days 1-7, \$0/day days 8-90	\$500 Per Stay	\$300/day days 1-7, \$0/day days 8-90
Skilled Nursing Facility	\$0 day days 1-20 \$194.50/day for days 21-100	\$0 day days 1-20; \$165 day days 21-100	\$0 day days 1-20; \$250 day days 21-100	\$0 day days 1-20; \$150 day days 21-100	\$0 day days 1-20; \$200 day days 21-100	\$0 day days 1-20; \$165 day days 21-100	\$0 day days 1-20; \$250 day days 21-100	\$0 day days 1-20; \$150 day days 21-100	\$0 day days 1-20; \$200 day days 21-100
Home Health Care	\$0	\$0	30%	\$0	30%	\$0	30%	\$0	30%
Mammograms	\$0	\$0	30%	\$0	30%	\$0	30%	\$0	30%
Bone Mass Measurement	\$0	\$0	30%	\$0	30%	\$0	30%	\$0	30%
Colorectal Screening Exams	\$0	\$0	30%	\$0	30%	\$0	30%	\$0	30%
Flu, Pneumonia & Hepatitis B	\$0	\$0	30%	\$0	30%	\$0	30%	\$0	30%
Prescription Drugs	20% Part B covered only NO PART D	No RX; 20% Part B Only	No RX 30% Part B Only	No RX 20% Part B Only	No RX 30% Part B Only	(Preferred) Copays \$1/\$7/\$37/48%/33%; No Deductible 20% Part B	(Standard) Copays \$6/\$12/\$47/50%/33%; No Deductible; 30% Part B	Copays \$0/\$5/\$35/42%/33% No Deductible 20% Part B	Copays \$5/\$10/\$45/44%/33% No Deductible 30% Part B
Vision services	20% + 1 pair glasses/frames/contact after cataract surgery 20% + retinopathy exam 1/x yr for diabetics	\$0 copay for Routine Eye exam only; 40% coinsurance OON for Routine Eye exam only							
Hearing Services	20%	\$0 In Network: Exams & Screenings 40% Out of Network: Exams & Screenings (<i>Hearing Aids Not Covered</i>)							
Diabetic training and supplies	20%	\$0-20% (specific brands)	20%	\$0-20% (specific brands)	30%	\$0-20%	30%	\$0-20%	30%
Dental Coverage	limited coverage	\$30 Medicare Covered Only	\$50 Medicare Covered Only	\$25 Medicare Covered Only	\$35 Medicare Covered Only	\$35 Medicare Covered Only	\$60 Medicare Covered Only	\$25 Medicare Covered Only	\$35 Medicare Covered Only
Max out of Pocket		\$6,700/\$10,000		\$6,700/\$10,000		\$6,700/\$10,000		\$6,700/\$10,000	
Full LIS		No RX		No RX					
Full LIS & EPIC		No RX		No RX					