2024 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	$174.70	$0		$40		$47		$136	
Deductible	$240	$0		$0		$0		$0 Deductible; **$50/qtr 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/$200	30%	$250	30%	150/$200	30%
Emergency Care	20% **	$100; $100 World Wide Coverage		$100; $100 World Wide Coverage		$135; $135 World Wide Coverage		$135, $135 worldwide coverage	
Urgent Care	20% **	35/$100		35/$100		35/$135		35/$135	
Ambulance Services	20% **	$335		$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	0-50%	30%	$0	30%	0-$50	30%	$0	30%
Radiation Therapy	20%	20%	30%	20%	30%	20%	30%	20%	30%
Diagnostic Radiology	20%	$100/$250	30%	$100/$200	30%	$100-$300	30%	$100-$200	30%
Chiropractic Care	20% limited coverage	$15-$30	30%	$15-$25	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% **	$30	30%	$15	30%	$35	30%	$25	30%
Cardiac Rehab	20%	$15	30%	$15	30%	$20	30%	$15	30%
Dialysis	20%	20%	30%	20%	20%	20%	20%	20%	30%

Accurate as of 4/17/2024

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		Wellcare Advantage No Premium - PFFS		**Wellcare Advantage Premium Enhanced - PFFS**		**Wellcare Premium Enhanced PFFS**		**WellCare Premium Ultra PFFS**	
PREMIUMS	$174.70	$0		$40		$47		$136	
Deductible	$240	$0		$0		$0		0 Deductible; **$50/qtr OTC**	
		In	Out	In	Out	In	Out	In	Out
Inpatient Hospital	$1,632	$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 6-150	$300/day days 1-7, $0/day days 8-190	$500 per stay	$300/day days 1-7, $0/day days 8-120
Inpatient Mental Health*	$1,632	$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 $200/day for days 21-100	$0 day days 1-20; $203 day days 21-60; $0/day days 61-100	$0 day days 1-20; $250 day days 21-100	$0 day days 1-20; $203 day days 21-70; $0/day days 71-100	$0 day days 1-20; $203 day days 21-100	$0 day days 1-20; $203 day days 21-100; $0/day days 41-100	$0 day days 1-20; $250 day days 21-100	$0 day days 1-20; $203 day days 21-50; $0/day days 51-100	$0 day days 1-20; $203 day days 21-100
Home Health Care	$0	$0	30%	$0	30%	$0	30%	$0	$0-30%
Mammograms	$0	$0	0%	$0	0%	$0	0%	$0	$0-30%
Bone Mass Measurement	$0	$0	0%	$0	0%	$0	0%	$0	$0-30%
Colorectal Screening Exams	$0	$0	0%	$0	0%	$0	0%	$0	$0-30%
Flu, Pneumonia & Hepatitis B	$0	$0	0%	$0	0%	$0	0%	$0	$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 $0/$7/$42/48%/ 33%; No Deductible 20% Part B	(Standard) Copays $6/$21/$126/50%/33%; No Deductible; 30% Part B	Copays $0/$5/$42/50%/33% No Deductible 20% Part B	Copays $0/$15/$126/50%/33% No Deductible 30% Part B
Vision services	20% + 1 pair glasses/frames/contact after cateract surgery 20% + retinopathy exam 1/x yr for diabetics	$0-$25/$30 copay for Routine Eye exam only; $35-$50/40% coinsurance OON for Routine Eye exam only							
Hearing Services	20%	$0-$25/$30 In Network: Exams & Screenings $35-$50/40% Out of Network: Exams & Screenings (*Hearing Aids Not Covered*)							
Diabetic training and supplies	20%	$0-20% (specific brands)	20%	$0-20% (specific brands)	30%	$0-20%	30%	$0-20%	20%-30%
Dental Coverage	limited coverage	$30 Medicare Covered Only	$50 Medicare Covered Only	$25 Medicare Covered Only	$35 Medicare Covered Only	$35-$60 Medicare Covered Only	$60-50% Medicare Covered Only	$0-$25 Medicare Covered Only	$35-50% Medicare Covered Only
Max out of Pocket		$6,700		$6,700		$3,400		$3,000	
Full LIS		No RX		No RX					
Full LIS & EPIC		No RX		No RX					

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