

2019 Medicare PPO Plans for Erie County

TYPE OF MEDICAL SERVICE	ORIGINAL MEDICARE	MVP Healthcare 1-888-280-6205		Independent Health (716)635-4900		BlueCross/BlueShield 1-800-248-9296			
		Well Select with Part D		Medicare Passport Advantage PPO		Forever Blue PPO Value		Forever Blue PPO 751	
PREMIUMS	\$135.50	\$73		\$95		\$138		\$197	
Deductible	\$185	\$0		\$0		\$0		\$0	
		IN	OUT	IN	OUT	IN	OUT	IN	OUT
PCP Visits	20%**	\$15	\$60	\$0	\$25	\$15	35%	\$5	25%
Wellness Exam	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Specialty Visits	20%**	\$50	\$60	\$45	\$75	\$35	35%	\$27	25%
Outpatient Mental Health	20%	\$40	\$60	\$40	40%	\$40	50%	\$40	50%
Outpatient Substance Abuse	20%**	\$40	\$60	40%	40%	50%	50%	50%	50%
Outpatient Surgery	20%**	\$300/\$400	40%	\$300/\$350	40%	\$250/\$325	35%	\$200/\$275	25%
Emergency Care	20%**	\$90	\$90	\$90	\$90	\$90	\$90	\$90	\$90
Urgent Care	20%**	\$50	\$50	\$65	\$65	\$65	\$65	\$65	\$65
Ambulance Services	20%**	\$200	\$200	\$250	\$250	\$250	\$250	\$200	\$200
Durable Medical Equipment	20% Medicare Approved	20%	20%	20%	50%	20%	50%	20%	50%
Prosthetic Devices	20%	20%	40%	20%	50%	20%	50%	20%	50%
Cardiac Rehab	20%	36session=\$40	36session=\$60	\$0	Not Covered	\$5	35%	\$15	25%
X-Rays	20%**	\$60	\$60	\$40	40%	\$50	35%	\$40	25%
Diagnostic Services	20%	\$100	40%	\$150	40%	\$150	35%	\$75	25%
Lab Services	\$0	\$10	40%	\$5	40%	\$5	35%	\$5	25%
Radiation Therapy	20%	20%	40%	20%	50%	\$60	35%	\$50	25%
Chiropractic Care	limited coverage 20%**	\$20	\$60	\$20	40%	\$20	35%	\$20	25%
Medically Necessary Foot Care	20%** (medical limits apply)	\$50	\$60	\$45	\$75	\$35	35%	\$27	25%
Routine Foot Care	Not Covered	\$50	\$60	Not Covered	Not Covered	\$35	35%	\$27	25%
P.T., O.T. and Speech Therapy	20%**	\$40	\$60	\$15	40%	\$25	35%	\$25	25%
Inpatient Hospital	\$1,364 deductible	\$350/day days 1-5; \$0/day days 6+	40%	\$310/day days 1-6 \$0/day days 7+	40%	\$250/day days 1-7 \$0/day days 8+	35%	\$205/day days 1-7 \$0/day days 8+	30%
Inpatient Mental Health*	\$1,364 deductible	\$315/day days 1-5 \$0/day days 6+	40%	\$310/day days 1-6 \$0/day days 7+	40%	\$270/day days 1-6 \$0/day days 7+	35%	\$270/day days 1-6 \$0/day days 7+	30%

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TYPE OF MEDICAL SERVICE	ORIGINAL MEDICARE	MVP Healthcare 1-888-280-6205		Independent Health (716)635-4900		BlueCross/BlueShield 1-800-248-9296			
		Well Select with Part D		Medicare Passport Advantage PPO		Forever Blue PPO Value		Forever Blue PPO 751	
PREMIUMS	\$135.50	\$73		\$95		\$138		\$197	
Deductible	\$185	\$0		\$0		\$0		\$0	
		IN	OUT	IN	OUT	IN	OUT	IN	OUT
Skilled Nursing Facility	\$0/day days 1-20 \$170.50/day days 21-100	\$0/day days 1-20; \$172/day days 21-100	40%	\$0/day days 1-20 \$172/day days 21-100	40%	\$0/day days 1-20 \$167.50/day days 21-100	35%	\$0/day days 1-20 \$164.50/day days 21-100	30%
Home Health Care	\$0	\$0	40%	\$0	\$0	\$0	35%	\$0	25%
Mammograms	\$0	\$0	\$0	\$0	\$0	\$0	35%	\$0	25%
Bone Mass Measurement	\$0	\$0	\$0	\$0	\$0	\$0	35%	\$0	25%
Colorectal Screening	\$0	\$0	\$0	\$0	\$0	\$0	35%	\$0	25%
Flu, Pneumonia & Hepatitis B	\$0	\$0	\$0	\$0	\$0	\$0	35%	\$0	25%
Dialysis	20%	20%	20%	20%	40%	20%	20%	\$20	\$20/20%
Prescription Drugs	20% Part B Covered only No Part D	Copays \$0/\$12/\$47/27%/25%, \$400 Deductible, 20%-Part B Drugs	Copays \$0/\$12/\$47/27%/25%, \$400 Deductible, 20%-Part B Drugs	Copays \$0/\$20/\$47/\$100/33%, \$50 Deductible Tiers 3-5, 20%-Part B Drugs	Copays \$0/\$20/\$47/\$100/32%, \$50 Deductible Tiers 3-5, 20%-Part B Drugs	Copays \$4/\$10/\$42/50%/33%, No Deductible, 20%-Part B Drugs	Copays \$4/\$10/\$42/50%/33%, No Deductible, 35%-Part B Drugs	Copays \$2/\$8/\$42/\$94/33%, No Deductible, 20%-Part B Drugs	Copays \$2/\$8/\$42/\$94/33%, No Deductible, 25%-Part B Drugs
Vision Services	20% + for 1 pair glasses/frames/contact lens after cataract surgery 20% + coverage for retinopathy exam 1 per year for diabetics	\$20 exam; no eyewear	\$20 exam; no eyewear	\$0 Eye Exam \$200/yr Eyeglasses Allowance	Not Covered	\$25 Eye Exam \$100/yr Eyeglasses Allowance	35% Eye Exam \$100/yr Eyeglasses Allowance	\$25 Eye Exam \$100/yr Eyeglasses Allowance	20% Eye Exam \$100/yr Eyeglasses Allowance
Hearing Services	20%**	\$20 Exam, \$699-\$999/aid up to 2 aids/yr.	Not Covered	\$0/\$45 Exam; \$599-\$899 per aid/per year	Not Covered	\$35/\$45 Exam, \$699-\$999 per aid/per year	\$45/35% Exam, \$699-\$999 per aid/per year	\$27/\$45 Exam, \$699-\$999 per aid/per year	\$45/25% Exam, \$699-\$999 per aid/per year
Diabetic Training and Supplies	20%	20%	40%	\$0	40%	\$0	50%	\$0	50%
Dental Coverage	limited coverage 20%**	\$240/yr. max for preventive services	\$240/yr. max for preventive services	\$20: 2 routine cleanings, exams/bitewing x-rays/yr; full mouth/every 3yrs	Not Covered	\$10 Copay per preventive service	\$10 Copay per preventive service	\$10 Copay per preventive service	\$10 Copay per preventive service
Max out of Pocket		\$6,700	\$10,000	\$6,700	\$10,000	\$6,700	\$10,000	\$6,700	\$10,000
Full LIS		\$35.00		\$55.70		\$98.67		\$157.67	
Full LIS & EPIC		\$35.00		\$16.37		\$76.90		\$124	

2019 Medicare PPO Plans for Erie County

TYPE OF MEDICAL SERVICE	ORIGINAL MEDICARE	United Healthcare Medicare Complete Choice 1-800-555-5757								WellCare Today's Options 1-866-527-0056			
		Plan 1		Plan 3		Plan 4		Essential No RX		Advantage Plus 150A		Advantage Plus 550B	
PREMIUMS	\$135.50	\$16		\$46		\$76		\$0		\$111		\$14	
Deductible	\$185	\$0		\$0		\$0		\$0		\$0		\$0	
		IN	OUT	IN	OUT	IN	OUT	IN	OUT	IN	OUT	IN	OUT
PCP Visits	20%**	\$10	\$50	\$10	\$50	\$5	\$50	\$10	\$50	\$0	\$10	\$5	\$25
Wellness Exam	\$0	\$0	0-40%	\$0	0-40%	\$0	0-40%	\$0	40%	\$0	\$0	\$0	\$0
Specialty Visits	20%**	\$45	\$75	\$35	\$75	\$30	\$75	\$45	\$75	\$25	\$35	\$35	\$60
Outpatient Mental Health	20%	\$30/\$40	\$35/\$45	\$30/\$40	\$35/\$45	\$30/\$40	\$35/\$45	\$30/\$40	\$35/\$45	\$30	30%	\$40	30%
Outpatient Substance Abuse	20%**	\$30/\$40	\$35/\$45	\$30/\$40	\$35/\$45	\$30/\$40	\$35/\$45	\$30/\$40	\$35/\$45	\$30	30%	\$40	30%
Outpatient Surgery	20%**	\$325	40%	\$295	40%	\$250	40%	\$325	40%	\$150-\$200	30%	\$250-\$300	30%
Emergency Care	20%**	\$90	\$90	\$90	\$90	\$90	\$90	\$90	\$90	\$120	\$120	\$90	\$90
Urgent Care	20%**	\$30-\$40	\$30-\$40	\$30-\$40	\$30-\$40	\$30-\$40	\$30-\$40	\$30-\$40	\$30-\$40; \$80	\$35	\$35	\$35	\$35
Ambulance Services	20%**	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$285	\$285	\$300	\$300
Durable Medical Equipment	20% Medicare Approved	20%	50%	20%	50%	20%	50%	20%	50%	20%	30%	20%	30%
Prosthetic Devices	20%	20%	40%	20%	40%	20%	40%	20%	40%	20%	30%	20%	30%
Cardiac Rehab	20%	\$20	40%	\$20	40%	\$20	40%	\$20	40%	\$15	30%	\$40	30%
X-Rays	20%**	\$14	\$21	\$14	\$21	\$14	\$21	\$14	\$21	\$15	30%	\$15	30%
Diagnostic Services	20%	20%	40%	20%	40%	20%	40%	20%	40%	100/\$200	30%	\$100	\$200
Lab Services	\$0	\$10	\$10	\$10	\$10	\$10	\$10	\$10	\$10	\$0	30%	\$0	30%
Radiation Therapy	20%	20%	40%	20%	40%	20%	40%	20%	40%	20%	30%	20%	30%
Chiropractic Care	limited coverage 20%**	\$20	\$75	\$20	\$75	\$20	\$75	\$20	\$75	\$20 (Medical)	30% (Medical)	\$20	30%
Medically Necessary Foot Care	20%** (medical limits apply)	\$45	\$75	\$35	\$75	\$30	\$75	\$45	\$75	\$35-limitations	30%-limitations	\$50-limitations	30%-limitations
Routine Foot Care	not covered	6visits/yr=\$45ea	6visits/yr=\$75ea	6visits/yr=\$35ea	6visits/yr=\$75ea	6visits/yr=\$25ea	6visits/yr=\$75ea	6visits/yr=\$45ea	6visits/yr=\$75ea	Not Covered	Not Covered	Not Covered	Not Covered
P.T., O.T. and Speech Therapy	20%**	\$40	\$75	\$35	\$75	\$30	\$75	\$40	\$75	\$15	30%	\$40	30%
Inpatient Hospital	\$1364 Deductible	\$395/day days 1-4 \$0/day days 5+	\$500/day days 1-20 \$0/day days 21+	\$360/day days 1-4 \$0/day days 5+	\$500/day days 1-20 \$0/day days 21+	\$295/day days 1-4 \$0/day days 5+	\$500/day days 1-20 \$0/day days 21+	\$395/day days 1-4 \$0/day days 5+	\$500/day days 1-20 \$0/day days 21+	\$500/stay	\$300/day for days 1-7; \$0/day for days 8+	\$295/day for days 1-5; \$0/day for days 6+	\$300/day for days 1-7; \$0/day for days 8+
Inpatient Mental Health*	\$1364 Deductible	\$395/day days 1-4 \$0/day days 5-90	\$500/day days 1-20 \$0/day days 21-90	\$360/day days 1-4 \$0/day days 5-90	\$500/day days 1-20 \$0/day days 21-90	\$295/day days 1-4 \$0/day days 5-90	\$500/day days 1-20 \$0/day days 21-90	\$395/day days 1-4 \$0/day days 5-90	\$500/day days 1-20 \$0/day days 21-90	\$500/stay	\$300/day for days 1-7; \$0/day for days 8+	\$295/day for days 1-5; \$0/day for days 6+	\$300/day for days 1-7; \$0/day for days 8+

2019 Medicare PPO Plans for Erie County

TYPE OF MEDICAL SERVICE	ORIGINAL MEDICARE	United Healthcare Medicare Complete Choice 1-800-555-5757						WellCare Today's Options 1-866-249-8668					
		Plan 1		Plan 3		Plan 4		Essential No RX		Advantage Plus 150A		Advantage Plus 550B	
PREMIUMS	\$135.50	\$16		\$46		\$76		\$0		\$111		\$14	
Deductible	\$185	\$0		\$0		\$0		\$0		\$0		\$0	
		IN	OUT	IN	OUT	IN	OUT	IN	OUT	IN	OUT	IN	OUT
Skilled Nursing Facility	Days 1-20 \$0 Days 21-100 \$170.50/day	\$0/day days 1-20 \$160/day days 21-62 \$0/day days 63-100	\$250/day days 1-40 \$0/day days 41-100	\$0/day days 1-20 \$160/day days 21-62; \$0/day days 63-100	\$250/day days 1-40 \$0/day days 41-100	\$0/day days 1-20 \$160/day days 21-54 \$0/day days 55-100	\$250/day days 1-40 \$0/day days 41-100	\$0/day days 1-20 \$160/day days 21-62 \$0/day days 63-100	\$250/day days 1-40 \$0/day days 41-100	\$0/day for days 1-20; \$150/day for days 21-100	\$0/day for days 1-20; \$200/day for days 21-100	\$0/day for days 1-20; \$165/day for days 21-100	\$0/day for days 1-20; \$250/day for days 21-100
Home Health Care	\$0	\$0	50%	\$0	50%	\$0	50%	\$0	50%	\$0	30%	\$0	\$0
Mammograms	\$0	\$0	\$0-40%	\$0	\$0-40%	\$0	\$0-40%	\$0	\$0-40%	\$0	30%	\$0	30%
Bone Mass Measurement	\$0	\$0	\$0-40%	\$0	\$0-40%	\$0	\$0-40%	\$0	\$0-40%	\$0	30%	\$0	30%
Colorectal Screening	\$0	\$0	\$0-40%	\$0	\$0-40%	\$0	\$0-40%	\$0	\$0-40%	\$0	30%	\$0	30%
Flu, Pneumonia & Hepatitis B	\$0	\$0	\$0-40%	\$0	\$0-40%	\$0	\$0-40%	\$0	\$0-40%	\$0	30%	\$0	30%
Dialysis	20%	20%	20%	20%	20%	20%	20%	20%	20%	20%	30%	20%	30%
Prescription Drugs	20% Part B Covered only No Part D	Copays \$3/\$12/\$47/\$100/26%, \$350 Deductible; Tiers 3-5, 20%-Part B Drugs	Copays \$3/\$12/\$47/\$100/26%, \$350 Deductible Tiers 3-5, 40%-Part B Drugs	Copays \$3/\$12/\$47/\$100/27%, \$275 Deductible Tiers 3-5, 20%-Part B Drugs	Copays \$3/\$12/\$47/\$100/28%, \$275 Deductible Tiers 3-5, 40%-Part B Drugs	Copays \$3/\$12/\$47/\$100/31%; \$150 Deductible, Tiers 3-5, 20%-Part B Drugs	Copays \$3/\$12/\$47/\$100/31%, \$150 Deductible, Tiers 3-5, 40%-Part B Drugs	Part D=not covered; Part B=20%	Part D=not covered; Part B=40%	Copays \$5/\$10/\$45/\$85/33%, No Deductible, 20%-Part B Drugs	Copays \$5/\$10/\$45/\$85/33% , No Deductible, 30%-Part B Drugs	Copays \$7/\$12/\$47/\$100/33%, No Deductible, 20%-Part B Drugs	Copays \$2/\$7/\$37/\$90/33% , No Deductible, 30%-Part B Drugs
Vision Services	20% + for 1 pair glasses/frames/contact lens after cataract surgery 20% + coverage for retinopathy exam 1 per year for diabetics	\$20 Eye Exam \$0 Post-cataract Surgery Eyewear	\$45 Eye Exam 40% Post-cataract Surgery Eyewear	\$20 Eye Exam \$0 Post-cataract Surgery Eyewear	\$75 Eye Exam 40% Post-cataract Surgery Eyewear	\$20 Eye Exam \$0 Post-cataract Surgery Eyewear	\$75 Eye Exam 40% Post-cataract Surgery Eyewear	\$20 Eye Exam \$0 Post-cataract Surgery Eyewear	\$75 Eye Exam 40% Post-cataract Surgery Eyewear	\$0 Eye Exam \$100/yr Eyewear Allowance	30% Eye Exam \$100/yr Eyewear Allowance	\$0 Eye Exam \$100/yr Eyewear Allowance	30% Eye Exam \$100/yr Eyewear Allowance
Hearing Services	20%**	Exam=\$10;2aids/yr=\$330-\$380ea	Exam=\$75;2aids/yr=\$330-\$380ea	Exam=\$10;2aids/yr=\$330-\$380ea	Exam=\$75;2aids/yr=\$330-\$380ea	Exam=\$5;2aids/yr=\$330-\$380ea	Exam=\$75;2aids/yr=\$330-\$380ea	Exam=\$10;2aids/yr=\$330-\$380ea	Exam=\$75;2aids/yr=\$330-\$380ea	\$20 exam; \$1,500/yr toward 2 aids	50% exam; 50% and max \$1,500/yr toward 2 aids	\$20 exam; \$1,500/yr toward 2 aids	50% exam; 50% and max \$1,500/yr toward 2 aids
Diabetic Training and Supplies	20%	\$0-20%	40%	\$0-20%	40%	\$0-20%	40%	\$0-20%	40%	0-20%	30%	20%	30%
Dental Coverage	limited coverage 20%**	Not Covered * Optional Dental Coverage	Not Covered * Optional Dental Coverage	Limited \$0 * Optional Dental Coverage	Limited 50% * Optional Dental Coverage	Limited \$0 * Optional Dental Coverage	Limited 75% * Optional Dental Coverage	Not Covered * Optional Dental Coverage	Not Covered * Optional Dental Coverage	\$0 preventive; other up to \$500/yr.	20% preventive; other up tp \$500/yr.	\$0 preventive; other up to \$500/yr	20% preventive; other up to \$500/yr
Max out of Pocket		\$6,700	\$10,000	\$6,700	\$10,000	\$5,400	\$10,000	\$6,700	\$10,000	\$3,400	\$3,400	\$6,700	6,700
Full LIS		\$0		\$24.80		\$42.40		No RX					
Full LIS & EPIC		\$0		\$24.80		\$42.40		No RX					

2019 Medicare PPO Plans for Erie County

TYPE OF MEDICAL SERVICE	ORIGINAL MEDICARE	AETNA MEDICARE 585-520-3857			
		Medicare Elite PPO		Medicare Premier PPO	
PREMIUMS	\$135.50	\$17		\$27	
Deductible	\$185	\$1,000 (limited)		\$0	
		IN	OUT	IN	OUT
PCP Visits	20%	\$15	\$50	\$10	\$50
Wellness Exam	\$0	\$0	\$0	\$0	\$0
Specialty Visits	0%	\$40	\$50	\$35	\$50
Outpatient Mental Health	20%	\$1,616/stay (after deductible)	30% (after deductible)	\$35	30%
Outpatient Substance Abuse	20%	\$40	30% (after deductible)	\$35	30%
Outpatient Surgery	20%	\$0-\$350 (after deductible)	30% (after deductible)	\$300	30%
Emergency Care	20%	\$90	\$90	\$90	\$90
Urgent Care	20%	\$15-\$40	\$90	\$10-\$35	\$90
Ambulance Services	20%	\$270	\$270	\$270	\$270
Durable Medical Equipment	20% Medicare Approved	20%	30% (after deductible)	20%	30%
Prosthetic Devices	20%	20%	30% (after deductible)	20%	30%
Cardiac Rehab	20%				
X-Rays	20%	\$50	30% (after deductible)	\$50	30%
Diagnostic Services	20%	20%	30%	20%	30%
Lab Services	\$0	\$0	30% (after deductible)	\$0	\$20
Radiation Therapy	20%	20%	30% (after deductible)		
Chiropractic Care	limited coverage 20%**	\$20	30% (after deductible)	\$20	30%
Medically Necessary Foot Care	20%** (medical limits apply)	\$40	\$50 (after deductible)	\$35	\$50
Routine Foot Care	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
P.T., O.T. and Speech Therapy	20%	\$40	30% (after deductible)	\$35	30%
Inpatient Hospital	\$1,364 deductible	\$675/stay (after deductible)	\$500/day for days 1-20; \$0/day for day 21-90 (after deductible)	\$370/day for days 1-5; \$0/days for days 6+	\$500/day for days 1-20; \$0/day for days 21+
Inpatient Mental Health*	\$1,364 deductible	\$1,616/stay (after deductible)	30%/stay (after deductible)	\$1,616/stay	30%

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TYPE OF MEDICAL SERVICE	ORIGINAL MEDICARE	AETNA MEDICARE 585-520-3857			
		Medicare Elite PPO		Medicare Premier PPO	
PREMIUMS	\$135.50	\$17		\$27	
Deductible		\$1,000 (limited)			
		IN	OUT	IN	OUT
Skilled Nursing Facility	\$0/day for days 1-20, \$170.50/day for days 21-100	\$0/day for days 1-20; \$172/day for days 21-100 (after deductible)	30%/stay (after deductible)	\$0/day for days 1-20; \$170.50/day days 21-100	30%/stay
Home Health Care	\$0	\$0	\$0	\$0	\$0
Mammograms	\$0	\$0		\$0	\$0
Bone Mass Measurement	\$0	\$0	\$0	\$0	\$0
Colorectal Screening	\$0	\$0	\$0	\$0	\$0
Flu, Pneumonia & Hepatitis B	\$0	\$0	\$0	\$0	\$0
Dialysis	20%	20% (after deductible)	20% (after deductible)	20%	20%
Prescription Drugs	20% Part B Covered only; No Part D	Copays \$2/\$5/\$47/\$100/30%; \$145 deductible Tiers 3-5; Part B Drugs-20%	Copays \$2/\$5/\$47/\$100/30%; \$145 deductible Tiers 3-5; Part B Drugs-20%	Copays \$2/\$5/\$47/\$100/30%; \$145 deductible Tiers 3-5; Part B Drugs-20%	Copays \$2/\$5/\$47/\$100/30%; \$145 deductible Tiers 3-5; Part B Drugs-20%
Vision Services	20% + for 1 pair glasses/framses contact lens after cataract surgery; 20% + coverage for retinopathy exam 1/year for diabetics	\$0-\$40; \$200/yr eyewear coverage	\$50-30% exam; \$200/yr. eyewear coverage (after deductible)	\$0-\$35 exam; \$250/yr. eyewear coverage	\$50-30% exam; \$250/yr. eyewear coverage
Hearing Services	20%**	\$0-\$40;exam; \$500/yr. max for 2 aids	\$50 exam (after deductible); \$500 max for 2 aids	\$0-\$35 exam; \$1,000/yr. max for 2 aids	\$50 exam; \$1,000/yr. max for 2 aids
Diabetic Training and Supplies	20%	\$0-20% (specific brands covered)	\$0-20% (after deductible)	\$0-20% (specific brands covered)	\$0-20% (specific brands covered)
Dental Coverage	limited coverage 20%**	\$300/yr. max for preventive and comprehensive	\$300/yr. max for preventive and comprehensive	\$1,000/yr. max for preventive and comprehensive	\$1,000/yr. for preventive and comprehensive
Max out of Pocket		\$6,700	\$6,700	\$6,700	\$6,700
Full LIS		\$0		\$7.90	
Full LIS & EPIC					