

Medicare Advantage Special Needs in Erie County 2011

TYPE OF MEDICAL SERVICE	ORIGINAL MEDICARE	INDEPENDENT HEALTH	SECURE HORIZONS			WELLCARE
Doctor & Choice of Hospitals		Independent Health Medicare Family Choice NH only	Evercare Plan IH Medicaid Only	EvercarePlan RDP(PPO) Dual eligible only		Wellcare Access HMO Dual-Eligible only
PREMIUMS	?	\$34.10	\$31.80	In \$0	Out	\$0.00
PCP Visits	20%**	\$0	\$0	\$0-20%	\$0-20%	\$0
Routine Physical Exams	Welcome to Medicare only (1first 6 months)	\$0	\$0	\$0-20%	\$0-20%	\$0
Specialty Visits	20%**	\$0	0%-20%	\$0-20%	\$0-20%	\$0
Outpatient Mental Health	45%	\$0	20%	\$0-20%	30%	\$0
Outpatient Substance Abuse	20%**	\$0	20%	\$0-20%	30%	\$0
Outpatient Surgery	20% **	\$0-\$50	20%	\$0-20%	30%	\$0
Emergency Care	20% **	\$50	\$50	\$0	30%	\$0
Urgent Care	20% **	\$0	20%	\$0	30%	\$0
Ambulance Services	20% **	\$25	20%	\$0-20%	30%	\$0
Durable Medical Equipment	20% ** (must use supplier enrolled w/Medicare)	15%	20%	\$0-20%	30%	\$0
Prosthetic Devices	20% **	15%	20%	\$0-20%	30%	\$0
X Rays	20% **	\$0	0%-20%	\$0-20%	30%	\$0
Lab Services	\$0	\$0	\$0	\$0	30%	\$0
Radiation Therapy	20%	\$0	20%			\$0
Chiropractic Care	limited coverage 20% **	\$0	20%	\$0-20%	30%	\$0
Medically Necessary Foot Care	limited coverage 20% **	\$0	20%	\$0-20%	30%	\$0
Routine Foot Care	NOT COVERED	\$0 (6 per year)	\$0(6) visits per year	\$0(4) visits per year	30%	NOT COVERED
P.T.,O.T. and Speech Therapy	20% **	\$0	\$0	\$0-20%	30%	\$0

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PREMIUMS	?	\$34.10	\$31.80	In \$0	Out	\$0.00
Inpatient Hospital	? deductible; days 61-90:\$275;days 90+: \$550	\$100 each	\$0	\$0	30%	\$0
Inpatient Mental Health*	? deductible; days 61-90:\$275;days 90+: \$550	\$100 each	\$0;190 days lifetime limit	\$0 -190 days lifetime limit	30%; 190 days lifetime limit	\$0-190 day lifetime limit
Skilled Nursing Facility	\$0 days 1-20, then \$137.50 days 21-100	\$0- 100 days	\$0 Days 1-100	\$0	30%	\$0
Home Health Care	\$0	\$0	\$0	\$0	30%	\$0
Mammograms	20%	\$0	\$0	\$0	30%	\$0
Bone Mass Measurement	20% **	\$0	\$0	\$0	30%	\$0
Colorectal Screening Exams	\$0 to 20%**	\$0	\$0	\$0	30%	\$0
Flu, Pneumonia & Hepatitis B	\$0 flu/ 20%**hepitis B	\$0	\$0	\$0	30%	\$0
Prescription Drugs	0%-20% Part B covered only;NO PART D	\$150 deductible \$0,\$5,\$25,\$50,\$25	\$0,\$1.10,\$2.50 depending on subsidy level	\$0 deductible;\$0,\$1.10\$2.50//40,\$3.30,\$6.30 depending on subsidy level		\$0 deductible;\$0,\$1.10\$2.50//40,\$3.30,\$6.30 depending on subsidy level

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PREMIUMS	?	\$34.10	\$31.80	In \$0	Out	\$0.00
Vision services	20% + for 1 pair glasses/frames/contact lens after cataract surgery 20% + coverage for retinopathy exam 1 per yr for diabetics	\$0 (1) eyewear post cataract; \$0 eye exam \$0 glasses,contacts lenses frame upto \$150	\$0 (1) eyewear post cataract; 0%-20%eye exam \$0 glasses,contacts lenses frame upto \$150	\$0 (1) eyewear post cataract; 0%-20%eye exam \$0 glasses,contacts lenses frame upto \$150	\$0 (1) eyewear post cataract; 30%eye exam \$0 glasses,contact s lenses frame upto \$150	\$0 (1) eyewear post cataract; 0%eye exam \$0 glasses,contacts lenses frame upto \$100
Hearing Services	40% + Medically necessary exams only no aides	\$0 exams	\$0 exams	\$0-20%	30%	\$0 for medicare covered diagnostic only
Diabetic training and supplies	20%	\$0	\$0	\$0-20%	30%	\$0
Dental Coverage	limited coverage	\$0-\$50 Medicare covered only	\$0-\$50 Medicare covered only	\$0 (1) exam,cleaning x-ray;\$0-20% medicare covered services	50% preventative;30% Medicare covered	\$0 Medicare covered only