2024 Western Medicare Advantage and Cost Plans

Below is a list of counties and the plans available in each county. The following pages contain the plan details for each plan.

Banner County

HumanaChoice H5216-254 (PPO)
Humana USAA Honor (PPO)
Humana USAA Honor with Rx (PPO)
Medica Prime Solution Thrift (Cost)
Medica Prime Solution Premier (Cost)
Medica Prime Solution Standard (Cost)
Medica Prime Solution Core (Cost)
UHC MedicareDirect Patriot No Rx PF-MA01 (PFFS)
UHC MedicareDirect PF-0001 (PFFS)
Wellcare No Premium (HMO)
Wellcare Giveback (HMO)
Wellcare No Premium Open (PPO)
Wellcare Assist Open (PPO)

Box Butte County

Medica Prime Solution Thrift (Cost)
Medica Prime Solution Premier (Cost)
Medica Prime Solution Standard (Cost)
Medica Prime Solution Core (Cost)
UHC MedicareDirect Patriot No Rx PF-MA01 (PFFS)
UHC MedicareDirect PF-0001 (PFFS)

Cheyenne County

HumanaChoice H5216-254 (PPO)
Humana USAA Honor (PPO)
Humana USAA Honor with Rx (PPO)
Medica Prime Solution Thrift (Cost)
Medica Prime Solution Premier (Cost)

Cheyenne County

Medica Prime Solution Standard (Cost)
Medica Prime Solution Core (Cost)

Dawes County

Medica Prime Solution Thrift (Cost)
Medica Prime Solution Premier (Cost)
Medica Prime Solution Standard (Cost)
Medica Prime Solution Core (Cost)

Deuel County

Blue Cross Blue Shield Nebraska MA Core (HMO)
Blue Cross Blue Shield Nebraska MA Access PPO (PPO)
Blue Cross Blue Shield Nebraska MA Connect PPO (PPO)

Garden County

Blue Cross Blue Shield Nebraska MA Core (HMO)
Blue Cross Blue Shield Nebraska MA Access PPO (PPO)
Blue Cross Blue Shield Nebraska MA Connect PPO (PPO)

Kimball County

HumanaChoice H5216-254 (PPO)
Humana USAA Honor (PPO)
Humana USAA Honor with Rx (PPO)
Medica Prime Solution Thrift (Cost)
Medica Prime Solution Premier (Cost)
Medica Prime Solution Standard (Cost)
Medica Prime Solution Core (Cost)

Morrill County

HumanaChoice H5216-254 (PPO)
Humana USAA Honor (PPO)
Humana USAA Honor with Rx (PPO)
Medica Prime Solution Thrift (Cost)
Medica Prime Solution Premier (Cost)
Medica Prime Solution Standard (Cost)
Medica Prime Solution Core (Cost)
UHC MedicareDirect Patriot No Rx PF-MA01 (PFFS)
UHC MedicareDirect PF-0001 (PFFS)

Scotts Bluff County

HumanaChoice H5216-254 (PPO)
Humana USAA Honor (PPO)
Humana USAA Honor with Rx (PPO)
Medica Prime Solution Thrift (Cost)
Medica Prime Solution Premier (Cost)
Medica Prime Solution Standard (Cost)
Medica Prime Solution Core (Cost)
Wellcare No Premium (HMO)
Wellcare Giveback (HMO)
Wellcare No Premium Open (PPO)
Wellcare Assist Open (PPO)

Below is a list of counties and the plans available in each county. The following pages contain the plan details for each plan.

Sheridan County

Medica Prime Solution Thrift (Cost)

Medica Prime Solution Premier (Cost)

Medica Prime Solution Standard (Cost)

Medica Prime Solution Core (Cost)

UHC MedicareDirect Patriot No Rx PF-MA01 (PFFS)

UHC MedicareDirect PF-0001 (PFFS)

Sioux County

HumanaChoice H5216-254 (PPO)

Humana USAA Honor (PPO)

Humana USAA Honor with Rx (PPO)

Medica Prime Solution Thrift (Cost)

Medica Prime Solution Premier (Cost)

Medica Prime Solution Standard (Cost)

Medica Prime Solution Core (Cost)

Understanding Medicare Advantage Plan Benefits

Plan Overview

Monthly Premium - The dollar amount you owe to have this insurance. Part B premiums are paid in addition to this monthly premium.

Medicare Deductible - The amount you pay for health care services before your insurance begins to pay. Reach out to the plan for details on what applies to the deductible. Prescription drug costs do not count towards this deductible.

Out-of-Pocket Limit - The most you could pay for covered services in the year. After you spend this amount on deductibles, copayments, and coinsurance, your plan pays 100% of the costs of covered benefits. The **out-of-pocket** limit doesn't include monthly premiums or the cost of prescriptions.

Benefits and Costs

Copays - A set amount that you pay for a specific health care service. Each service has its own unique copay. Typically you pay copays after your deductible has been met.

Coinsurance - A percentage you pay for a specific health care service. Typically you pay coinsurance after your deductible has been met.

Prescription Coverage

Most Medicare Advantage plans have prescription coverage included, therefore you cannot purchase a separate Part D plan. In some instances, such as a Cost Plan, a Part D plan may be added. Deductibles, copays and coinsurance will apply to prescriptions and do not count towards the Medical Deductible or out-of-pocket limit.

	Nebraska Sample MA Plan (PPO) *A1234-567*
Phone Number	555-555-555
Regional Counties Offered	Butler, Lancaster, Saline, Saunders, Seward
Plan Overview	
Monthly Premium	$0
Medical Deductible	$0
Out-of-pocket Limit	$4,500
Benefits and Costs	
Primary Doctor Copay	$5
Specialist Doctor Copay	$45
Urgent Care Copay	$30-$40
Labs/ Test/ X-rays Copay	$10/ $30/ $14
Physical Therapy Copay	$40
Emergency Room Copay	$90
Ground Ambulance Copay	$225
Inpatient Hospital Copay	$395 per day for days 1-4 $0 days 5-90 *Potential Total = $1,580*
Outpatient Hospital Copay	$295 - 395
Skilled Nursing Facility Care Copay	$0/day 1-20, $160/day 21-51, $0/day 52-100 *Out-of-pocket limit = $4,900*
Extra Benefits	
Dental Coverage	Yes - up to $1,500
Vision Coverage	Yes - up to $200
Additional Benefits	Hearing, Fitness, OTC
Prescription Coverage	
Drug Coverage Included	Yes - *copays apply*
Your Total Drug Cost	$_____

Plan Name, Plan Type and Number

HMO - This type of plan has a network of providers (doctors, hospitals, specialist, etc.). Enrollees must use in-network providers in order for the plan to cover the service, some plans may offer exceptions to this policy.

PPO - This type of plan has a network of providers. Enrollees who use in-network providers typically pay less out-of-pocket. If an out-of-network provider is used, the service will be more expensive.

PFF - This type of plan does NOT have a network of providers. Enrollees must check with their providers before each visit to ensure they will accept the plan.

Cost - This type of plan has a network of providers. Enrollees who use in-network providers typically pay less out-of-pocket. If an out-of-network provider is used, standard Medicare Parts A and B costs apply.

Extra Benefits

Dental Coverage– Coverage for dental expenses. The amount listed is the total the plan will pay for dental care in the calendar year. Some plans require the use of network dentists, others offer reimbursement for any dentist. Contact plan for details.

Vision Coverage - Coverage for vision expenses. The amount listed is the total the plan will pay for vision care in the calendar year. Some plans require the use of network providers, others offer reimbursement for any provider. Contact plan for details.

Additional Benefits - Benefits often include assistance with **hearing services** including hearing aids, **fitness benefits** such as a gym membership, and **over-the-counter (OTC)** medication. Contact the plan for a full list of their specific additional benefits.

	Blue Cross Blue Shield Nebraska MA Access PPO (PPO) H8181-001	***Blue Cross Blue Shield Nebraska MA Connect PPO (PPO) H8181-002***	***Blue Cross Blue Shield Nebraska MA Core (HMO) H3170-003***	**Humana USAA Honor (PPO) H5216-329**
Phone Number	844-899-6060	844-899-6060	844-899-6060	800-833-2364
Regional Counties Offered	*See County List*	*See County List*	*See County List*	*See County List*
Plan Overview				
Monthly Premium	$25	$0	$0	$0 *(Part B Premium Reduction up to $100)*
Medical Deductible	$0	$0	$0	$0
Out-of-pocket Limit	$3,900 in / $8,000 out	$4,500 in / $8,000 out	$3,900	$6,700 in/$8,950 out
Benefits and Costs				
Primary Doctor Copay	$0	$0	$0	$0
Specialist Doctor Copay	$40	$40	$40	$40
Urgent Care Copay	$60	$60	$60	$55
Labs/ Test/ X-rays Copay	$0/ $30-395/ $20	$0/ $30-395/ $25	$0/ $30-395/ $25	$0-35/ $0-55 or 25%/ $0-55
Physical Therapy Copay	$40	$40	$40	$35
Emergency Room Copay	$120	$120	$120	$100
Ground Ambulance Copay	$350	$350	$350	$265
Inpatient Hospital Copay	$375 per day for days 1-4 $0 days 5-90 *Potential Total = $1,500*	$375 per day for days 1-4 $0 days 5-90 *Potential Total = $1,500*	$400 per day for days 1-4 $0 days 7-90+ *Potential Total = $1,600*	$425 per day for days 1-5 $0 days 6-90+ *Potential Total = $2,125*
Outpatient Hospital Copay	$395 per visit	$0-250 per visit	$395 per visit	$0-325 per visit
Skilled Nursing Facility Care Copay	$0 day 1-20, $196/day 21-50, $0/day 51-100	$0 day 1-20, $196/day 21-50, $0/day 51-100	$0 day 1-20, $196/day 21-53, $0/day 54-100	$0 day 1-20, $203 per days 21-100
Extra Benefits				
Dental Coverage	Yes - up to $1,750	Yes - up to $1,350	Yes - up to $1,425	Yes - up to $1,000
Vision Coverage	Yes - up to $200	Yes - up to $200	Yes - up to $200	Yes - up to $75
Additional Benefits	Hearing, Fitness, OTC	Hearing, Fitness, OTC,	Hearing, Fitness, OTC	Hearing, Fitness, OTC
Prescription Coverage				
Drug Coverage Included	Yes - *copays apply*	Yes - *copays apply*	Yes - *copays apply*	*No prescription coverage*
Your Total Drug Cost	$_____	$_____	$_____	$_____

	Humana USAA Honor with Rx (PPO) H5216-340	***HumanaChoice H5216-254 (PPO) H5216-254***	***Medica Prime Solution Core (Cost) H2450-046***	***Medica Prime Solution Premier (Cost) H2450-043***
Phone Number	800-833-2364	800-833-2364	800-906-5432	800-906-5432
Regional Counties Offered	*See County List*	*See County List*	*See County List*	*See County List*
Plan Overview				
Monthly Premium	$0 *(Part B Premium Reduction up to $84)*	$0	$82	$140
Medical Deductible	$450	$0	$0	$0
Out-of-pocket Limit	$5,900 in / $9,550 out	$3,900 in /$9,550 out	$4,000	$3,000
Benefits and Costs				
Primary Doctor Copay	$0	$0	$0	$0
Specialist Doctor Copay	$50	$35	$15	$0
Urgent Care Copay	$60	$60	$40	$0
Labs/ Test/ X-rays Copay	$0-50/ $0-100/ $0-125	$0/ $0-95/ $0-125	$0/ $0 - 15/ $10	$0/ $0/ $0
Physical Therapy Copay	$40	$40	$15	$0
Emergency Room Copay	$120	$120	$50	$0
Ground Ambulance Copay	$300	$300	$50	$0
Inpatient Hospital Copay	$425 per day for days 1-5 $0 days 6-90+ *Potential Total = $2,125*	$395 per day for days 1-7 $0 days 8-90 *Potential Total = $2,555*	$300 per stay	$100 per stay
Outpatient Hospital Copay	$0-400 per visit	$395 per visit	$150 per visit	$100 per visit
Skilled Nursing Facility Care Copay	$10 day 1-20, $ 203 per day/days 21-100	$0 day 1-20, $196 day/days 21-100	$0 day 1-20, $50 day/days 21-100	$0 day 1-20, $25 day/days 21-100
Extra Benefits				
Dental Coverage	Yes - up to $4,000	Yes - up to $2,500	Yes - up to $300	Yes - up to $400
Vision Coverage	Yes - up to $250	Yes - up to $200	Yes - up to $100	Yes - up to $200
Additional Benefits	Hearing, Fitness, OTC,	Hearing, Fitness, OTC	Hearing, Fitness, OTC	Hearing, Fitness, OTC
Prescription Coverage				
Drug Coverage Included	Yes - *copays apply*	Yes - *copays apply*	*No prescription coverage*	*No prescription coverage*
Your Total Drug Cost	$_____	$_____	$_____	$_____

	Medica Prime Solution Standard (Cost) H2450-044	***Medica Prime Solution Thrift (Cost) H2450-030***	***UHC MedicareDirect Patriot No Rx PF-MA01 (PFFS) H5435-001***	***UHC MedicareDirect PF-0001 (PFFS) H5435-024***
Phone Number	800-906-5432	800-906-5432	800-555-5757	800-555-5757
Regional Counties Offered	*See County List*	*See County List*	*See County List*	*See County List*
Plan Overview				
Monthly Premium	$0	$43	$0	$81
Medical Deductible	$0	$50	$0	$0
Out-of-pocket Limit	$5,000	$6,700	$6,700	$6,700
Benefits and Costs				
Primary Doctor Copay	$15	20%	$0 - 20	$0 - 25
Specialist Doctor Copay	$50	20%	$0 - 55	$0 - 55
Urgent Care Copay	$15 - 50	$25	$0 - 40	$0 - 40
Labs/ Test/ X-rays Copay	$0/ $15-50/ $15 - 50	$0/ 20%/ 20%	$0/ $50/ $25	$0/ $50/ $25
Physical Therapy Copay	$50	20%	$0 - 40	$0 - 40
Emergency Room Copay	$120	$50	$100	$100
Ground Ambulance Copay	$250	20%	$290	$290
Inpatient Hospital Copay	$325 per day for days 1-4 $0 days 5-90 *Potential Total = $1,300*	$300 per day for days 1-4 $0 days 5-90 *Potential Total = $1,200*	$420 per day for days 1-5 $0 days 6-90 *Potential Total = $2,100*	$420 per day for days 1-5 $0 days 6-90 *Potential Total = $2,100*
Outpatient Hospital Copay	$325 per visit	20% per visit	$0 - 420 per visit	$0 - 420 per visit
Skilled Nursing Facility Care Copay	$0 day 1-20, $203 day/days 21-100	$0 day 1-20, $203 day/days 21-100	$0 day 1-20, $203 day/days 21-100	$0 day 1-20, $203 day/days 21-100
Extra Benefits				
Dental Coverage	Yes - up to $400	No	Yes - up to $500	Yes - up to $500
Vision Coverage	Yes - up to $150	No	Yes - up to $100	Yes - up to $100
Additional Benefits	Hearing, Fitness, OTC	No	Hearing	Hearing
Prescription Coverage				
Drug Coverage Included	*No prescription coverage*	*No prescription coverage*	*No prescription coverage*	Yes - *copays apply*
Your Total Drug Cost	$_____	$_____	$_____	$_____

	Wellcare Assist Open (PPO) H1395-003	***Wellcare Giveback (HMO) H1215-003***	***Wellcare No Premium (HMO) H1215-002***	***Wellcare No Premium Open (PPO) H1395-002***
Phone Number	844-917-0175	844-917-0175	844-917-0175	844-917-0175
Regional Counties Offered	*See County List*	*See County List*	*See County List*	*See County List*
Plan Overview				
Monthly Premium	$24.70	$0 *(Part B Premium Reduction up to $86)*	$0	$0
Medical Deductible	$0	$0	$0	$0
Out-of-pocket Limit	$4,500 in /$8,950 out	$8,850	$3,600	$3,900 in /$8,950 out
Benefits and Costs				
Primary Doctor Copay	$0	$0	$0	$0
Specialist Doctor Copay	$20	$50	$25	$35
Urgent Care Copay	$40	$35	$35	$0 - 40
Labs/ Test/ X-rays Copay	$0 - 50/ $0-40/ $0	$0 - 50/ $0 - 50/ $15	$0 - 50/ $0 - 30/ $0	$0 - 50/ $0 - 40/ $0
Physical Therapy Copay	$20	$40	$25	$35
Emergency Room Copay	$120	$100	$135	$120
Ground Ambulance Copay	$300	$315	$300	$325
Inpatient Hospital Copay	$225 per day for days 1-7 $0 days 5-90 *Potential Total = $1,575*	$1,450 per stay	$375 per day for days 1-5 $0 days 6-90 *Potential Total = $1,875*	$375 per day for days 1-5 $0 days 6-90 *Potential Total = $1,875*
Outpatient Hospital Copay	$0 - 300 per visit	$0 - 350 per visit	$0 - 250 per visit	$0 - 300 per visit
Skilled Nursing Facility Care Copay	$0/day 1-20, $203/day 21-50 $0/day 51-100	$0/day 1-20, $185/day 21-70 $0/day 71-100	$0/day 1-20, $203/day 21-40 $0/day 41-100	$0/day 1-20, $203/day 21-50 $0/day 51-100
Extra Benefits				
Dental Coverage	Yes - up to $2000	Yes. See Evidence of Coverage	Yes - up to $2000	Yes - up to $1,500
Vision Coverage	Yes - up to $200	Yes - up to $100	Yes - up to $200	Yes - up to $200
Additional Benefits	Hearing, Fitness, OTC	Hearing, Fitness	Hearing, Fitness, OTC	Hearing, Fitness, OTC
Prescription Coverage				
Drug Coverage Included	Yes - *copays apply*	Yes - *copays apply*	Yes - *copays apply*	Yes - *copays apply*
Your Total Drug Cost	$_____	$_____	$_____	$_____