Lincoln Region - 2022 Medicare Advantage and Cost Plans

The following plans counties make up the Nebraska SHIP's Lincoln region. Below is a list of counties and the plans available in each county. The following pages contain the plan details for each plan.

Butler County

AARP Medicare Advantage (HMO-POS)

AARP Medicare Advantage Choice Plan 1 (PPO)

AARP Medicare Advantage Choice Plan 2 (PPO)

AARP Medicare Advantage Patriot (PPO)

Aetna Medicare Eagle (HMO-POS)

Aetna Medicare Elite (PPO)

Aetna Medicare Premier (HMO-POS)

Aetna Medicare Premier (PPO)

Blue Cross Blue Shield Nebraska MA Access PPO (PPO)

Blue Cross Blue Shield Nebraska MA Core (HMO)

Medica Advantage Solution H3632-001 (PPO)

Medica Advantage Solution with CHI Health (HMO)

Fillmore County

AARP Medicare Advantage (HMO-POS)

AARP Medicare Advantage Choice Plan 1 (PPO)

AARP Medicare Advantage Choice Plan 2 (PPO)

AARP Medicare Advantage Patriot (PPO)

Aetna Medicare Eagle (HMO-POS)

Aetna Medicare Elite (PPO)

Aetna Medicare Premier (HMO-POS)

Aetna Medicare Premier (PPO)

Blue Cross Blue Shield Nebraska MA Access PPO (PPO)

Blue Cross Blue Shield Nebraska MA Core (HMO)

Medica Prime Solution Core (Cost)

Medica Prime Solution Premier (Cost)

Medica Prime Solution Standard (Cost)

Medica Prime Solution Thrift (Cost)

Wellcare Assist Open (PPO)

Wellcare Giveback (HMO)

Wellcare No Premium (HMO)

Wellcare No Premium Open (PPO)

Lancaster County

AARP Medicare Advantage (HMO-POS)

AARP Medicare Advantage Choice Plan 1 (PPO)

AARP Medicare Advantage Choice Plan 2 (PPO)

AARP Medicare Advantage Patriot (PPO)

Aetna Medicare Eagle (HMO-POS)

Aetna Medicare Elite (PPO)

Aetna Medicare Premier (HMO-POS)

Aetna Medicare Premier (PPO)

Blue Cross Blue Shield Nebraska MA Access PPO (PPO)

Blue Cross Blue Shield Nebraska MA Core (HMO)

Humana Gold Plus H0028-053 (HMO)

Humana Honor (PPO)

Humana Value Plus H5216-171 (PPO)

HumanaChoice H5216-014 (PPO)

HumanaChoice H5216-254 (PPO)

Medica Advantage Solution H3632-001 (PPO)

Medica Advantage Solution with CHI Health (HMO)

Wellcare Assist Open (PPO)

Wellcare Giveback (HMO)

Wellcare No Premium (HMO)

Wellcare No Premium Open (PPO)

Lincoln Region - 2022 Medicare Advantage and Cost Plans

The following plans counties make up the Nebraska SHIP's Lincoln region. Below is a list of counties and the plans available in each county. The following pages contain the plan details for each plan.

Polk County

AARP Medicare Advantage (HMO-POS)

AARP Medicare Advantage Choice Plan 1 (PPO)

AARP Medicare Advantage Choice Plan 2 (PPO)

AARP Medicare Advantage Patriot (PPO)

Aetna Medicare Eagle (HMO-POS)

Aetna Medicare Elite (PPO)

Aetna Medicare Premier (HMO-POS)

Aetna Medicare Premier (PPO)

Blue Cross Blue Shield Nebraska MA Access PPO (PPO)

Blue Cross Blue Shield Nebraska MA Core (HMO)

Medica Prime Solution Core (Cost)

Medica Prime Solution Premier (Cost)

Medica Prime Solution Standard (Cost)

Medica Prime Solution Thrift (Cost)

Saline County

AARP Medicare Advantage (HMO-POS)

AARP Medicare Advantage Choice Plan 1 (PPO)

AARP Medicare Advantage Choice Plan 2 (PPO)

AARP Medicare Advantage Patriot (PPO)

Aetna Medicare Eagle (HMO-POS)

Aetna Medicare Elite (PPO)

Aetna Medicare Premier (HMO-POS)

Aetna Medicare Premier (PPO)

Blue Cross Blue Shield Nebraska MA Access PPO (PPO)

Blue Cross Blue Shield Nebraska MA Core (HMO)

Humana Gold Plus H0028-053 (HMO)

Humana Honor (PPO)

HumanaChoice H5216-254 (PPO)

Medica Prime Solution Core (Cost)

Medica Prime Solution Premier (Cost)

Medica Prime Solution Standard (Cost)

Medica Prime Solution Thrift (Cost)

Wellcare Assist Open (PPO)

Wellcare Giveback (HMO)

Wellcare No Premium (HMO)

Wellcare No Premium Open (PPO)

Saunders County

AARP Medicare Advantage (HMO-POS)

AARP Medicare Advantage Choice Plan 1 (PPO)

AARP Medicare Advantage Choice Plan 2 (PPO)

AARP Medicare Advantage Patriot (PPO)

Aetna Medicare Eagle (HMO-POS)

Aetna Medicare Elite (PPO)

Aetna Medicare Premier (HMO-POS)

Aetna Medicare Premier (PPO)

Blue Cross Blue Shield Nebraska MA Access PPO (PPO)

Blue Cross Blue Shield Nebraska MA Core (HMO)

Humana Gold Plus H0028-053 (HMO)

Humana Honor (PPO)

Humana Value Plus H5216-171 (PPO)

HumanaChoice H5216-014 (PPO)

HumanaChoice H5216-254 (PPO)

Medica Advantage Solution H3632-001 (PPO)

Medica Advantage Solution with CHI Health (HMO)

Wellcare Assist Open (PPO)

Wellcare Giveback (HMO)

Wellcare No Premium (HMO)

Wellcare No Premium Open (PPO)

Lincoln Region - 2022 Medicare Advantage and Cost Plans

The following plans counties make up the Nebraska SHIP's Lincoln region. Below is a list of counties and the plans available in each county. The following pages contain the plan details for each plan.

Seward County

AARP Medicare Advantage (HMO-POS)

AARP Medicare Advantage Choice Plan 1 (PPO)

AARP Medicare Advantage Choice Plan 2 (PPO)

AARP Medicare Advantage Patriot (PPO)

Aetna Medicare Eagle (HMO-POS)

Aetna Medicare Elite (PPO)

Aetna Medicare Premier (HMO-POS)

Aetna Medicare Premier (PPO)

Blue Cross Blue Shield Nebraska MA Access PPO (PPO)

Blue Cross Blue Shield Nebraska MA Core (HMO)

Humana Gold Plus H0028-053 (HMO)

Humana Honor (PPO)

HumanaChoice H5216-254 (PPO)

Medica Prime Solution Core (Cost)

Medica Prime Solution Premier (Cost)

Medica Prime Solution Standard (Cost)

Medica Prime Solution Thrift (Cost)

York County

AARP Medicare Advantage (HMO-POS)

AARP Medicare Advantage Choice Plan 1 (PPO)

AARP Medicare Advantage Choice Plan 2 (PPO)

AARP Medicare Advantage Patriot (PPO)

Aetna Medicare Eagle (HMO-POS)

Aetna Medicare Elite (PPO)

Aetna Medicare Premier (HMO-POS)

Aetna Medicare Premier (PPO)

Blue Cross Blue Shield Nebraska MA Access PPO (PPO)

Blue Cross Blue Shield Nebraska MA Core (HMO)

Medica Prime Solution Core (Cost)

Medica Prime Solution Premier (Cost)

Medica Prime Solution Standard (Cost)

Medica Prime Solution Thrift (Cost)

Wellcare Assist Open (PPO)

Wellcare Giveback (HMO)

Wellcare No Premium (HMO)

Wellcare No Premium Open (PPO)

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.

	AARP Medicare Advantage (HMO-POS) ***H2802-001***	**AARP Medicare Advantage Choice Plan 1 (PPO)** ***H1278-001***	**AARP Medicare Advantage Choice Plan 2 (PPO) H1278-020**	**AARP Medicare Advantage Patriot (PPO)** ***H1278-018***
Phone Number	800-555-5757	800-555-5757	800-555-5757	800-555-5757
Regional Counties Offered	*Butler, Fillmore, Lancaster, Polk, Saline, Saunders, Seward and York*			
Plan Overview				
Monthly Premium	$0	$19	$0	$0 *(Part B Premium Reduction $30)*
Medical Deductible	$0	$0	$0	$0
Out-of-pocket Limit	$4,500	$3,900 in / $8,000 out	$4,500	$6,700 in / $8,000 out
Benefits and Costs				
Primary Doctor Copay	$5	$0	$5	$10
Specialist Doctor Copay	$45	$35	$45	$45
Urgent Care Copay	$40	$40	$40	$40
Labs/Test/X-rays Copay	$0 / $30 /$15	$0/ $30/$15	$0/ $30/$15	$0 / $30 /$15
Physical Therapy Copay	$40	$35	$40	$40
Emergency Room Copay	$90	$90	$90	$90
Ground Ambulance Copay	$250	$285	$280	$250
Inpatient Hospital Copay	$395 per day for days 1-4 $0 days 5-90+ *Potential Total = $1,580*	$350 per day for days 1-5 $0 days 6-90+ *Potential Total = $1,750*	$395 per day for days 1-5 $0 days 6-90+ *Potential Total = $1,975*	$295 per day for days 1– 6 $0 days 7-90+ *Potential Total = $1,770*
Outpatient Hospital Copay	$0 - $395 per visit	$0 - $350 per visit	$0 - $395 per visit	$0-$295 per visit
Skilled Nursing Facility Care Copay	$0/day 1-20, $188/day 21-44, $0/ day 45-100 *Out-of-pocket limit = $4,500*	$0/day 1-20, $188/day 21-41, $0/ day 42-100 *Out-of-pocket limit = $3,900*	$0/day 1-20, $188/day 21-44, $0/ day 45-100 *Out-of-pocket limit = $4,500*	$0/day 1-20, $188/day 21-56, $0/ day 57-100 *Out-of-pocket limit = $6,700*
Extra Benefits				
Dental Coverage	Yes - up to $1,000	Yes - up to $1,500	Yes - up to $1,000	Yes - up to $1,500
Vision Coverage	Yes - up to $200	Yes - up to $200	Yes - up to $100	Yes - up to $300
Additional Benefits	Hearing, Fitness, OTC, Insulin Savings	Hearing, Fitness, OTC, Insulin Savings	Hearing, Fitness, OTC, Insulin Savings	Hearing, Fitness, OTC
Prescription Coverage				
Drug Coverage Included	Yes - *copays apply*	Yes - *copays apply*	Yes - *copays apply*	*No prescription coverage*
Your Total Drug Cost	$____________________	$____________________	$____________________	$____________________

	Aetna Medicare Eagle (HMO-POS) H7149-007	**Aetna Medicare Elite (PPO) *H1608-038***	**Aetna Medicare Premier (HMO) *H7149-001***	**Aetna Medicare Premier (PPO) *H1608-012***
Phone Number	855-335-1407	855-335-1407	855-335-1407	855-335-1407
Regional Counties Offered	*Butler, Fillmore, Lancaster, Polk, Saline, Saunders, Seward and York Seward and York*			
Plan Overview				
Monthly Premium	$0 *(Part B Premium Reduction $25)*	$0	$0	$34
Medical Deductible	$0	$1,000* *(specific services)*	$0	$0
Out-of-pocket Limit	$6,700	$5,500 in / $8,000 out	$4,100	$5,000 in / $11,300 out
Benefits and Costs				
Primary Doctor Copay	$0	$0	$0	$10
Specialist Doctor Copay	$40	$35	$40	$40
Urgent Care Copay	$65	$65	$65	$65
Labs/Test/X-rays Copay	$0 / $20 / $20	$0 / $35 / $20	$0/ $40 / $15	$0/ $40 / $20
Physical Therapy Copay	$40	$40	$40	$40
Emergency Room Copay	$90	$90	$90	$90
Ground Ambulance Copay	$320	$350	$335	$315
Inpatient Hospital Copay	$225 per day for days 1-7 $0 days 8-90+ *Potential Total = $1,575*	$390 per day for days 1-5 $0 days 6-90 *(plus deductible)* *Potential Total = $2,950**	$390 per day for days 1-5 $0 days 6-90 *Potential Total = $1,950*	$390 per day for days 1-5 $0 days 6-90 *Potential Total = $1,950*
Outpatient Hospital Copay	$200 - $225 per visit	$300 - $400 per visit*	$300 - $400 per visit	$250 - $350 per visit
Skilled Nursing Facility Care Copay	$0 day 1-20, $184 per day/days 21-100 *Out-of-pocket limit = $6,700*	$0 day 1-20, $184 per day/days 21-100* *Out-of-pocket limit = $5,500*	$0 day 1-20, $184 per day/days 21-100 *Out-of-pocket limit = $4,100*	$0 day 1-20, $184 per day/days 21-100 *Out-of-pocket limit = $5,000*
Extra Benefits				
Dental Coverage	Yes - up to $2,000	Yes - up to $1,000	Yes - up to $1,300	Yes - up to $500
Vision Coverage	Yes - up to $300	Yes - up to $280	Yes - up to $240	Yes - up to $100
Additional Benefits	Hearing, Fitness, OTC	Hearing, Fitness, OTC	Hearing, Fitness, OTC	Hearing, Fitness, OTC
Prescription Coverage				
Drug Coverage Included	*No prescription coverage*	Yes - *copays apply*	Yes - *copays apply*	Yes - *copays apply*
Your Total Drug Cost	$___________________	$___________________	$___________________	$___________________

	BlueCross Blue Shield MA Access (PPO) *H8181-001*	BlueCross Blue Shield MA Core (HMO) *H3170-003-1*	BlueCross Blue Shield MA Core (HMO) *H3170-003-2*	Humana Gold Plus (HMO) *H0028—053-003*
Phone Number	844-899-6060	844-899-6060	844-899-6060	800-833-2364
Regional Counties Offered	*Butler, Fillmore, Lancaster, Polk, Saline, Saunders, Seward and York*	*Lancaster and Saunders*	*Butler, Fillmore, Polk, Saline, Seward and York*	*Lancaster, Saline, Saunders and Seward*
Plan Overview				
Monthly Premium	$26	$0	$0	$0
Medical Deductible	$0	$0	$0	$0
Out-of-pocket Limit	$4,500 in / $10,000 out	$6,250	$6,250	$3,850
Benefits and Costs				
Primary Doctor Copay	$5	$10	$5	$0
Specialist Doctor Copay	$35	$45	$45	$45
Urgent Care Copay	$65	$65	$65	$25
Labs/Test/X-rays Copay	$0/ $30/ $20	$10/$30-395 / $25-395	$10/ $30/$25	$0-$25 / $0-$95 / $0-$95
Physical Therapy Copay	$40	$40	$40	$40
Emergency Room Copay	$90	$90	$90	$90
Ground Ambulance Copay	$325	$350	$350	$290
Inpatient Hospital Copay	$420 per day for days 1-4 $0 days 5-90+ *Potential Total = $1,680*	$420 per day for days 1-4 $0 days 5-90 *Potential Total = $1,680*	$420 per day for days 1-4 $0 days 5-90 *Potential Total = $1,680*	$350 per day for days 1-5 $0 days 6-90+ *Potential Total = $1,750*
Outpatient Hospital Copay	$350 per visit	$395 per visit	$395 per visit	$225-$250 per visit
Skilled Nursing Facility Care Copay	$0 day 1-20, $188 /day 21-44, $0/ day 45-100 *Out-of-pocket limit = $4,500*	$0 day 1-20, $188 /day 21-53, $0/ day 54-100 *Out-of-pocket limit = $6,250*	$0 day 1-20, $188 /day 21-53, $0/ day 54-100 *Out-of-pocket limit = $6,250*	$0 day 1-20, $188 per day/days 21-100 *Out-of-pocket limit = $3,850*
Extra Benefits				
Dental Coverage	Yes - up to $1,350	Yes - up to $650	Yes - up to $900	Yes - up to $1,000
Vision Coverage	Yes - up to $200	Yes - up to $100	Yes - up to $100	Yes - up to $100
Additional Benefits	Hearing, Fitness, OTC	Hearing, Fitness, OTC	Hearing, Fitness, OTC	Hearing, Fitness, OTC, Insulin Savings
Prescription Coverage				
Drug Coverage Included	Yes - *copays apply*	Yes - *copays apply*	Yes - *copays apply*	Yes - *copays apply*
Your Total Drug Cost	$____________________	$____________________	$____________________	$____________________

	Humana Honor (PPO) ***H5216-278***	**Humana Value Plus (PPO)*H5216-171***	**Humana Choice (PPO)** ***H5216-254***	**Humana Choice (PPO)** ***H5216-014***
Phone Number	800-833-2364	800-833-2364	800-833-2364	800-833-2364
Regional Counties Offered	*Lancaster, Saline, Saunders and Seward*	*Lancaster and Saunders*	*Lancaster, Saline, Saunders and Seward*	*Lancaster and Saunders*
Plan Overview				
Monthly Premium	$0 *($50 Part B Premium Rebate)*	$25.90	$0	$60
Medical Deductible	$0	$203	$0	$0
Out-of-pocket Limit	$6,700 in / $10,000 out	$6,700 in/$10,000 out	$4,050 in / $6,700 out	$6,700 in / $10,000 out
Benefits and Costs				
Primary Doctor Copay	$0	$20	$0	$5
Specialist Doctor Copay	$40	$50	$40	$40
Urgent Care Copay	$25	20% of cost	$25	$25
Labs/Test/X-rays Copay	$0-$40/ $0-$50 /$0-$50	$0 - 20% of cost	$0-$40 / $0-$95 /$0-$95	$0-$40 / $0-$95 /$5-$95
Physical Therapy Copay	$40	20% Coinsurance	$40	$40
Emergency Room Copay	$90	$90	$90	$90
Ground Ambulance Copay	$290	20% Coinsurance	$290	$290
Inpatient Hospital Copay	$295 per day for days 1-6 $0 days 7-90 + *Potential Total = $1,770*	*$2,019 per stay*	$350 per day for days 1-5 $0 days 6-90+ *Potential Total = $1,750*	$360 per day for days 1-5 $0 days 6-90+ *Potential Total = $1,800*
Outpatient Hospital Copay	$200-$250 per visit	20% per visit	$3000-$350 per visit	$200-$250 per visit
Skilled Nursing Facility Care Copay	$0 day 1-20, $184 per day/days 21-100 *Out-of-pocket limit = $6,700*	$0 day 1-20, $188 per days 21-100 *Out-of-pocket limit = $6,700*	$0 day 1-20, $188 per day/days 21-100 *Out-of-pocket limit = $4,050*	$0 day 1-20, $188 per day/days 21-100 *Out-of-pocket limit = $6,700*
Extra Benefits				
Dental Coverage	Yes - up to $2,000	Yes - up to $2,000	Yes - up to $1,000	Additional premium
Vision Coverage	Yes - up to $300	Yes - up to $100	Yes - up to $100	Additional premium
Additional Benefits	Hearing, Fitness, OTC	Hearing, Fitness, OTC	Hearing, Fitness, OTC, Insulin Savings	Fitness, OTC
Prescription Coverage				
Drug Coverage Included	*No prescription coverage*	Yes - *copays apply*	Yes - *copays apply*	Yes - *copays apply*
Your Total Drug Cost	$____________________	$____________________	$____________________	$____________________

	Medica Advantage Solution with CHI Health (HMO) *HO798-001*	Medica Advantage Solution (PPO) *H3632-001*	Medica Prime Solution Core (Cost) *H2450-046*	Medica Prime Solution Premier (Cost) *H2450-043*	Medica Prime Solution Standard (Cost) *H2450-044*
Phone Number	800-906-5432	800-906-5432	800-906-5432	800-906-5432	800-747-8900
Regional Counties Offered	*Butler, Lancaster and Saunders*		*Fillmore, Polk, Saline, Seward and York*		
Plan Overview					
Monthly Premium	$0	$16	$69	$125	$0
Medical Deductible	$0	$0	$0	$0	$0
Out-of-pocket Limit	$4,000	$3,800 in /$8,000 out	$4,000	$3,000	$4,500
Benefits and Costs					
Primary Doctor Copay	$0	$0	$0	$0	$0
Specialist Doctor Copay	$45	$35	$15	$0	$35
Urgent Care Copay	$45	$0-35	$0-$20	$0	$0 - $35
Labs/Test/X-rays Copay	$0 / 20% / 20%	$0 / 15% / 15%	$0 / $10 / $10	$0	$0/$0 - $35/$0 - $35
Physical Therapy Copay	$40	$35	$15	$0	$35
Emergency Room Copay	$90	$90	$50	$0	$90
Ground Ambulance Copay	$250	$250	$50	$0	$200
Inpatient Hospital Copay	$350 per day for days 1-5 $0 days 6-90+ *Potential Total = $1,750*	$325 per day for days 1-5 $0 days 6-90 *Potential Total = $1,625*	$300 per stay	$100 per stay	$280 per day for days 1-5 $0 days 6-90 *Potential Total = $1,400*
Outpatient Hospital Copay	$295-$395 per visit	$295-$345 per visit	$100 per visit	$0 per visit	$150-$200 per visit
Skilled Nursing Facility Care Copay	$0 day 1-20, $184 per day/days 21-100 *Out-of-pocket limit = $4,000*	$0 day 1-20, $184 per day/days 21-100 *Out-of-pocket limit = $3,800*	$0 day 1-20, $50 day/days 21-100 *Out-of-pocket limit = $4,000*	$0 day 1-20, $25 day/days 21-100 *Potential Total = $3,000*	$0/day 1-20, $185.50/day 21-100 *Out-of-pocket limit = $4,500*
Extra Benefits					
Dental Coverage	Yes - up to $500	Yes - up to $1,000	Yes - up to $300	Yes - up to $400	Yes - up to $500
Vision Coverage	Yes - up to $100	Yes - up to $150	Yes - up to $100	Yes - up to $200	Yes - up to $150
Additional Benefits	Hearing, Fitness, OTC	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*	*No prescription coverage*
Your Total Drug Cost	$____________________	$____________________	$____________________	$____________________	$____________________

	Medica Prime Solution Thrift (Cost) ***H2450-030***	**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	800-906-5432				
Regional Counties Offered	*Fillmore, Polk, Saline, Seward and York*	*Fillmore, Lancaster, Saline, Saunders and York*			
Plan Overview					
Monthly Premium	$34	$23.20	$0 (*Part B Premium Reduction $30)*	$0	$0
Medical Deductible	$50	$0	$0	$0	$0
Out-of-pocket Limit	$6,700	$4,500 in / $10,000 out	$4,500	$3,900	$4,900 in / $10,000 out
Benefits and Costs					
Primary Doctor Copay	20%	$0	$0	$0	$0
Specialist Doctor Copay	20%	$20	$40	$25	$35
Urgent Care Copay	$25	$40	$40	$35	$50
Labs/Test/X-rays Copay	0 /20% /20%	$0 / $0-$40 / $0	$0 / $0-$50 / $0	$0 / $0-$30 / $0	$0 / $0-$40 / $0
Physical Therapy Copay	20%	$20	$35	$25	$40
Emergency Room Copay	$50	$90	$90	$90	$90
Ground Ambulance Copay	20%	$300	$315	$300	$325
Inpatient Hospital Copay	$300/day for days 1-4; $0/ day for days 5-90 *Potential Total = $1,200*	$225 per day for days 1-7 $0 days 8-90 *Potential Total = $1,575*	$400 per day for days 1-5 $0 days 6-90 *Potential Total = $2,000*	$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	20% per visit	$300 per visit	$350 per visit	$250 per visit	$300 per visit
Skilled Nursing Facility Care Copay	$0 day 1-20, $185..50 day/days 21-100 *Out-of-pocket limit = $6,700*	$0 day 1-20, $188 per day/days 21-100 *Out-of-pocket limit = $4,500*	$0 day 1-20, $188 per day/days 21-100 *Out-of-pocket limit = $4,500*	$0 day 1-20, $188 per day/days 21-100 *Out-of-pocket limit = $3,900*	$0 day 1-20, $188 per day/days 21-100 *Out-of-pocket limit = $4,900*
Extra Benefits					
Dental Coverage	No	Yes - up to	Yes - up to	Yes - up to	Yes - up to
Vision Coverage	No	Yes - up to	Yes - up to	Yes - up to	Yes - up to
Additional Benefits	No	Hearing, Fitness, OTC	Hearing, Fitness, OTC	Hearing, Fitness, OTC	Hearing, Fitness, OTC
Prescription Coverage					
Drug Coverage Included	*No prescription coverage*	Yes - *copays apply*	Yes - *copays apply*	Yes - *copays apply*	Yes - *copays apply*
Your Total Drug Cost	$____________________	$____________________	$____________________	$____________________	$____________________