

# West Central Region - 2022 Medicare Advantage and Cost Plans

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

## **Arthur County**

Blue Cross Blue Shield Nebraska MA Access PPO (PPO)  
Blue Cross Blue Shield Nebraska MA Core (HMO)  
UnitedHealthcare MedicareDirect Patriot (PFFS)  
UnitedHealthcare MedicareDirect Rx (PFFS)

## **Chase County**

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

## **Dawson County**

Blue Cross Blue Shield Nebraska MA Access PPO (PPO)  
Blue Cross Blue Shield Nebraska MA Core (HMO)  
UnitedHealthcare MedicareDirect Patriot (PFFS)  
UnitedHealthcare MedicareDirect Rx (PFFS)  
Wellcare Assist Open (PPO)  
Wellcare Giveback (HMO)  
Wellcare No Premium (HMO)  
Wellcare No Premium Open (PPO)

## **Dundy County**

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

## **Frontier County**

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)

## **Gosper County**

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)

## **Grant County**

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

## **Hayes County**

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

# West Central Region - 2022 Medicare Advantage and Cost Plans

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

## **Hitchcock County**

Blue Cross Blue Shield Nebraska MA Access PPO (PPO)  
Blue Cross Blue Shield Nebraska MA Core (HMO)  
UnitedHealthcare MedicareDirect Patriot (PFFS)  
UnitedHealthcare MedicareDirect Rx (PFFS)

## **Hooker County**

Blue Cross Blue Shield Nebraska MA Access PPO (PPO)  
Blue Cross Blue Shield Nebraska MA Core (HMO)  
UnitedHealthcare MedicareDirect Patriot (PFFS)  
UnitedHealthcare MedicareDirect Rx (PFFS)

## **Keith County**

Blue Cross Blue Shield Nebraska MA Access PPO (PPO)  
Blue Cross Blue Shield Nebraska MA Core (HMO)  
UnitedHealthcare MedicareDirect Patriot (PFFS)  
UnitedHealthcare MedicareDirect Rx (PFFS)  
Wellcare Assist Open (PPO)  
Wellcare Giveback (HMO)  
Wellcare No Premium (HMO)  
Wellcare No Premium Open (PPO)  
Blue Cross Blue Shield Nebraska MA Core (HMO)

## **Lincoln County**

Blue Cross Blue Shield Nebraska MA Access PPO (PPO)  
Blue Cross Blue Shield Nebraska MA Core (HMO)  
Wellcare Assist Open (PPO)  
Wellcare Giveback (HMO)  
Wellcare No Premium (HMO)  
Wellcare No Premium Open (PPO)

## **Logan County**

Blue Cross Blue Shield Nebraska MA Access PPO (PPO)  
Blue Cross Blue Shield Nebraska MA Core (HMO)  
UnitedHealthcare MedicareDirect Patriot (PFFS)  
UnitedHealthcare MedicareDirect Rx (PFFS)

## **McPherson County**

Blue Cross Blue Shield Nebraska MA Access PPO (PPO)  
Blue Cross Blue Shield Nebraska MA Core (HMO)  
UnitedHealthcare MedicareDirect Patriot (PFFS)  
UnitedHealthcare MedicareDirect Rx (PFFS)

## **Perkins County**

Blue Cross Blue Shield Nebraska MA Access PPO (PPO)  
Blue Cross Blue Shield Nebraska MA Core (HMO)  
UnitedHealthcare MedicareDirect Patriot (PFFS)  
UnitedHealthcare MedicareDirect Rx (PFFS)  
Wellcare Assist Open (PPO)  
Wellcare Giveback (HMO)  
Wellcare No Premium (HMO)  
Wellcare No Premium Open (PPO)

## **Red Willow County**

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

## **Thomas County**

Blue Cross Blue Shield Nebraska MA Access PPO (PPO)  
Blue Cross Blue Shield Nebraska MA Core (HMO)  
UnitedHealthcare MedicareDirect Patriot (PFFS)  
UnitedHealthcare MedicareDirect Rx (PFFS)

# 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 <i>Potential Total = \$1,580</i>
Outpatient Hospital Copay	\$295 - \$395
Skilled Nursing Facility Care Copay	\$0/day 1-20, \$160/day 21-51, \$0/day 52-100 <i>Out-of-pocket limit = \$4,900</i>
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 - <i>copays apply</i>
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.

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

	<b>BlueCross Blue Shield MA Access (PPO) H8181-001</b>	<b>BlueCross Blue Shield MA Core (HMO) H3170-003-2</b>	<b>Medica Prime Solution Core (Cost) H2450-046</b>	<b>Medica Prime Solution Premier (Cost) H2450-043</b>
<b>Phone Number</b>	844-899-6060	844-899-6060	800-906-5432	800-906-5432
<b>Regional Counties Offered</b>	<i>All West Central Counties</i>	<i>All West Central Counties</i>	<i>Frontier and Gosper</i>	<i>Frontier and Gosper</i>
<b>Plan Overview</b>				
<b>Monthly Premium</b>	\$26	\$0	\$69	\$125
<b>Medical Deductible</b>	\$0	\$0	\$0	\$0
<b>Out-of-pocket Limit</b>	\$4,500 in / \$10,000 out	\$6,250	\$4,000	\$3,000
<b>Benefits and Costs</b>				
<b>Primary Doctor Copay</b>	\$5	\$5	\$0	\$0
<b>Specialist Doctor Copay</b>	\$35	\$45	\$15	\$0
<b>Urgent Care Copay</b>	\$65	\$65	\$0-\$20	\$0
<b>Labs/Test/X-rays Copay</b>	\$0/ \$30/ \$20	\$10/ \$30/\$25	\$0 / \$10 / \$10	\$0
<b>Physical Therapy Copay</b>	\$40	\$40	\$15	\$0
<b>Emergency Room Copay</b>	\$90	\$90	\$50	\$0
<b>Ground Ambulance Copay</b>	\$325	\$350	\$50	\$0
<b>Inpatient Hospital Copay</b>	\$420 per day for days 1-4 \$0 days 5-90+ <i>Potential Total = \$1,680</i>	\$420 per day for days 1-4 \$0 days 5-90 <i>Potential Total = \$1,680</i>	\$300 per stay	\$100 per stay
<b>Outpatient Hospital Copay</b>	\$350 per visit	\$395 per visit	\$100 per visit	\$0 per visit
<b>Skilled Nursing Facility Care Copay</b>	\$0 day 1-20, \$188 /day 21-44, \$0/ day 45-100 <i>Out-of-pocket limit = \$4,500</i>	\$0 day 1-20, \$188 /day 21-53, \$0/ day 54-100 <i>Out-of-pocket limit = \$6,250</i>	\$0 day 1-20, \$50 day/days 21-100 <i>Out-of-pocket limit = \$4,000</i>	\$0 day 1-20, \$25 day/days 21-100 <i>Potential Total = \$3,000</i>
<b>Extra Benefits</b>				
<b>Dental Coverage</b>	Yes - up to \$1,350	Yes - up to \$900	Yes - up to \$300	Yes - up to \$400
<b>Vision Coverage</b>	Yes - up to \$200	Yes - up to \$100	Yes - up to \$100	Yes - up to \$200
<b>Additional Benefits</b>	Hearing, Fitness, OTC	Hearing, Fitness, OTC	Hearing, Fitness, OTC	Hearing, Fitness, OTC
<b>Prescription Coverage</b>				
<b>Drug Coverage Included</b>	Yes - <i>copays apply</i>	Yes - <i>copays apply</i>	<i>No prescription coverage</i>	<i>No prescription coverage</i>
<b>Your Total Drug Cost</b>	\$ _____	\$ _____	\$ _____	\$ _____

	<b>Medica Prime Solution Standard (Cost) H2450-044</b>	<b>Medica Prime Solution Thrift (Cost) H2450-030</b>	<b>UnitedHealthcare Medicare Direct Patriot (PFFS) H5435-001</b>	<b>UnitedHealthcare Medicare Direct Rx (PFFS)H5435-024</b>
<b>Phone Number</b>	800-747-8900	800-906-5432	800-555-5757	800-555-5757
<b>Regional Counties Offered</b>	<i>Frontier and Gosper</i>	<i>Frontier and Gosper</i>	<i>Arthur, Dawson, Hooker, Keith, Logan, McPherson, Perkins and Thomas</i>	<i>Arthur, Dawson, Hooker, Keith, Logan, McPherson, Perkins and Thomas</i>
<b>Plan Overview</b>				
<b>Monthly Premium</b>	\$0	\$34	\$40	\$74
<b>Medical Deductible</b>	\$0	\$50	\$0	\$0
<b>Out-of-pocket Limit</b>	\$4,500	\$6,700	\$6,700	\$6,700
<b>Benefits and Costs</b>				
<b>Primary Doctor Copay</b>	\$0	20%	\$25	\$25
<b>Specialist Doctor Copay</b>	\$35	20%	\$50	\$50
<b>Urgent Care Copay</b>	\$0 - \$35	\$25	\$40	\$40
<b>Labs/Test/X-rays Copay</b>	\$0/\$0 - \$35/\$0 - \$35	0 /20% /20%	\$0/\$25/\$15	\$0/ \$25 / \$15
<b>Physical Therapy Copay</b>	\$35	20%	\$40	\$40
<b>Emergency Room Copay</b>	\$90	\$50	\$90	\$90
<b>Ground Ambulance Copay</b>	\$200	20%	\$250	\$275
<b>Inpatient Hospital Copay</b>	\$280 per day for days 1-5 \$0 days 6-90 <i>Potential Total = \$1,400</i>	\$300/day for days 1-4; \$0/day for days 5-90 <i>Potential Total = \$1,200</i>	\$395 per day for days 1-4 \$0 days 5-90 <i>Potential Total = \$1,580</i>	\$395 per day for days 1-4 \$0 days 5-90 <i>Potential Total = \$1,580</i>
<b>Outpatient Hospital Copay</b>	\$150-\$200 per visit	20% per visit	\$0-395 per visit	\$0-\$395 per visit
<b>Skilled Nursing Facility Care Copay</b>	\$0/day 1-20, \$185.50/day 21-100 <i>Out-of-pocket limit = \$4,500</i>	\$0 day 1-20, \$185.50 day/days 21-100 <i>Out-of-pocket limit = \$6,700</i>	\$0/day 1-20, \$188/day 21-56, \$0/day 57-100 <i>Out-of-pocket limit = \$6,700</i>	\$0/day 1-20, \$188/day 21-56, \$0/day 57-100 <i>Out-of-pocket limit = \$6,700</i>
<b>Extra Benefits</b>				
<b>Dental Coverage</b>	Yes - up to \$500	No	No	No
<b>Vision Coverage</b>	Yes - up to \$150	No	No	No
<b>Additional Benefits</b>	Hearing, Fitness, OTC	No	No	No
<b>Prescription Coverage</b>				
<b>Drug Coverage Included</b>	<i>No prescription coverage</i>	<i>No prescription coverage</i>	<i>No prescription coverage</i>	<i>Yes - copays apply</i>
<b>Your Total Drug Cost</b>	\$ _____	\$ _____	\$ _____	\$ _____

	<b>Wellcare Assist Open (PPO) H1395-003</b>	<b>Wellcare Giveback (HMO) H1215-003</b>	<b>Wellcare No Premium (HMO) H1215-002</b>	<b>Wellcare No Premium Open (PPO) H1395-002</b>
<b>Phone Number</b>	844-917-0175	844-917-0175	844-917-0175	844-917-0175
<b>Regional Counties Offered</b>	<i>Dawson, Keith, Lincoln and Perkins</i>	<i>Dawson, Keith, Lincoln and Perkins</i>	<i>Dawson, Keith, Lincoln and Perkins</i>	<i>Dawson, Keith, Lincoln and Perkins</i>
<b>Plan Overview</b>				
<b>Monthly Premium</b>	\$23.20	\$0 <i>(Part B Premium Reduction \$30)</i>	\$0	\$0
<b>Medical Deductible</b>	\$0	\$0	\$0	\$0
<b>Out-of-pocket Limit</b>	\$4,500 in / \$10,000 out	\$4,500	\$3,900	\$4,900 in / \$10,000 out
<b>Benefits and Costs</b>				
<b>Primary Doctor Copay</b>	\$0	\$0	\$0	\$0
<b>Specialist Doctor Copay</b>	\$20	\$40	\$25	\$35
<b>Urgent Care Copay</b>	\$40	\$40	\$35	\$50
<b>Labs/Test/X-rays Copay</b>	\$0 / \$0-\$40 / \$0	\$0 / \$0-\$50 / \$0	\$0 / \$0-\$30 / \$0	\$0 / \$0-\$40 / \$0
<b>Physical Therapy Copay</b>	\$20	\$35	\$25	\$40
<b>Emergency Room Copay</b>	\$90	\$90	\$90	\$90
<b>Ground Ambulance Copay</b>	\$300	\$315	\$300	\$325
<b>Inpatient Hospital Copay</b>	\$225 per day for days 1-7 \$0 days 8-90 <i>Potential Total = \$1,575</i>	\$400 per day for days 1-5 \$0 days 6-90 <i>Potential Total = \$2,000</i>	\$375 per day for days 1-5 \$0 days 6-90 <i>Potential Total = \$1,875</i>	\$375 per day for days 1-5 \$0 days 6-90 <i>Potential Total = \$1,875</i>
<b>Outpatient Hospital Copay</b>	\$300 per visit	\$350 per visit	\$250 per visit	\$300 per visit
<b>Skilled Nursing Facility Care Copay</b>	\$0 day 1-20, \$188 per day/days 21-100 <i>Out-of-pocket limit = \$4,500</i>	\$0 day 1-20, \$188 per day/days 21-100 <i>Out-of-pocket limit = \$4,500</i>	\$0 day 1-20, \$188 per day/days 21-100 <i>Out-of-pocket limit = \$3,900</i>	\$0 day 1-20, \$188 per day/days 21-100 <i>Out-of-pocket limit = \$4,900</i>
<b>Extra Benefits</b>				
<b>Dental Coverage</b>	Yes - up to	Yes - up to	Yes - up to	Yes - up to
<b>Vision Coverage</b>	Yes - up to	Yes - up to	Yes - up to	Yes - up to
<b>Additional Benefits</b>	Hearing, Fitness, OTC	Hearing, Fitness, OTC	Hearing, Fitness, OTC	Hearing, Fitness, OTC
<b>Prescription Coverage</b>				
<b>Drug Coverage Included</b>	Yes - <i>copays apply</i>	Yes - <i>copays apply</i>	Yes - <i>copays apply</i>	Yes - <i>copays apply</i>
<b>Your Total Drug Cost</b>	\$ _____	\$ _____	\$ _____	\$ _____