Western Region - 2022 Medicare Advantage and Cost Plans

The following plans counties make up the Nebraska SHIP's Western region. 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

UnitedHealthcare MedicareDirect Patriot (PFFS)

UnitedHealthcare MedicareDirect Rx (PFFS)

Box Butte County

UnitedHealthcare MedicareDirect Patriot (PFFS)

UnitedHealthcare MedicareDirect Rx (PFFS)

Cheyenne County

Medica Prime Solution Core (Cost)

Medica Prime Solution Premier (Cost)

Medica Prime Solution Standard (Cost)

Medica Prime Solution Thrift (Cost)

UnitedHealthcare MedicareDirect Patriot (PFFS)

UnitedHealthcare MedicareDirect Rx (PFFS)

Dawes County

Medica Prime Solution Core (Cost)

Medica Prime Solution Premier (Cost)

Medica Prime Solution Standard (Cost)

Medica Prime Solution Thrift (Cost)

Deuel County

Blue Cross Blue Shield Nebraska MA Access PPO (PPO)

Blue Cross Blue Shield Nebraska MA Core (HMO)

Garden County

Blue Cross Blue Shield Nebraska MA Access PPO (PPO)

Blue Cross Blue Shield Nebraska MA Core (HMO)

Kimball County

No plans available is Kimball County

Morrill County

UnitedHealthcare MedicareDirect Patriot (PFFS)

UnitedHealthcare MedicareDirect Rx (PFFS)

Scotts Bluff County

UnitedHealthcare MedicareDirect Patriot (PFFS)

UnitedHealthcare MedicareDirect Rx (PFFS)

Wellcare Assist Open (PPO)

Wellcare Giveback (HMO)

Wellcare No Premium (HMO)

Wellcare No Premium Open (PPO)

Sheridan County

UnitedHealthcare MedicareDirect Patriot (PFFS)

UnitedHealthcare MedicareDirect Rx (PFFS)

Sioux County

No plans available is Sioux County

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.

	BlueCross Blue Shield MA Access (PPO) ***H8181-001***	**BlueCross Blue Shield MA Core (HMO)** ***H3170-003-2***	**Medica Prime Solution Core (Cost)** ***H2450-046***	**Medica Prime Solution Premier (Cost)** ***H2450-043***
Phone Number	844-899-6060	844-899-6060	800-906-5432	800-906-5432
Regional Counties Offered	*Deuel and Garden*	*Deuel and Garden*	*Cheyenne and Dawes*	*Cheyenne and Dawes*
Plan Overview				
Monthly Premium	$26	$0	$69	$125
Medical Deductible	$0	$0	$0	$0
Out-of-pocket Limit	$4,500 in / $10,000 out	$6,250	$4,000	$3,000
Benefits and Costs				
Primary Doctor Copay	$5	$5	$0	$0
Specialist Doctor Copay	$35	$45	$15	$0
Urgent Care Copay	$65	$65	$0-$20	$0
Labs/Test/X-rays Copay	$0/ $30/ $20	$10/ $30/$25	$0 / $10 / $10	$0
Physical Therapy Copay	$40	$40	$15	$0
Emergency Room Copay	$90	$90	$50	$0
Ground Ambulance Copay	$325	$350	$50	$0
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*	$300 per stay	$100 per stay
Outpatient Hospital Copay	$350 per visit	$395 per visit	$100 per visit	$0 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, $50 day/days 21-100 *Out-of-pocket limit = $4,000*	$0 day 1-20, $25 day/days 21-100 *Potential Total = $3,000*
Extra Benefits				
Dental Coverage	Yes - up to $1,350	Yes - up to $900	Yes - up to $300	Yes - up to $400
Vision Coverage	Yes - up to $200	Yes - up to $100	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***	**UnitedHealthcare Medicare Direct Patriot (PFFS)** ***H5435-001***	**UnitedHealthcare Medicare Direct Rx (PFFS)*H5435-024***
Phone Number	800-747-8900	800-906-5432	800-555-5757	800-555-5757
Regional Counties Offered	*Cheyenne and Dawes*	*Cheyenne and Dawes*	*Banner, Box Butte, Cheyenne, Morrill, Scotts Bluff and Sheridan*	*Banner, Box Butte, Cheyenne, Morrill, Scotts Bluff and Sheridan*
Plan Overview				
Monthly Premium	$0	$34	$40	$74
Medical Deductible	$0	$50	$0	$0
Out-of-pocket Limit	$4,500	$6,700	$6,700	$6,700
Benefits and Costs				
Primary Doctor Copay	$0	20%	$25	$25
Specialist Doctor Copay	$35	20%	$50	$50
Urgent Care Copay	$0 - $35	$25	$40	$40
Labs/Test/X-rays Copay	$0/$0 - $35/$0 - $35	0 /20% /20%	$0/$25/$15	$0/ $25 / $15
Physical Therapy Copay	$35	20%	$40	$40
Emergency Room Copay	$90	$50	$90	$90
Ground Ambulance Copay	$200	20%	$250	$275
Inpatient Hospital Copay	$280 per day for days 1-5 $0 days 6-90 *Potential Total = $1,400*	$300/day for days 1-4; $0/day for days 5-90 *Potential Total = $1,200*	$395 per day for days 1-4 $0 days 5-90 *Potential Total = $1,580*	$395 per day for days 1-4 $0 days 5-90 *Potential Total = $1,580*
Outpatient Hospital Copay	$150-$200 per visit	20% per visit	$0-395 per visit	$0-$395 per visit
Skilled Nursing Facility Care Copay	$0/day 1-20, $185.50/day 21-100 *Out-of-pocket limit = $4,500*	$0 day 1-20, $185.50 day/days 21-100 *Out-of-pocket limit = $6,700*	$0/day 1-20, $188/day 21-56, $0/day 57-100 *Out-of-pocket limit = $6,700*	$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 $500	No	No	No
Vision Coverage	Yes - up to $150	No	No	No
Additional Benefits	Hearing, Fitness, OTC	No	No	No
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	*Scotts Bluff*	Scotts Bluff	*Scotts Bluff*	*Scott Bluff*
Plan Overview				
Monthly Premium	$23.20	$0 *(Part B Premium Reduction $30)*	$0	$0
Medical Deductible	$0	$0	$0	$0
Out-of-pocket Limit	$4,500 in / $10,000 out	$4,500	$3,900	$4,900 in / $10,000 out
Benefits and Costs				
Primary Doctor Copay	$0	$0	$0	$0
Specialist Doctor Copay	$20	$40	$25	$35
Urgent Care Copay	$40	$40	$35	$50
Labs/Test/X-rays Copay	$0 / $0-$40 / $0	$0 / $0-$50 / $0	$0 / $0-$30 / $0	$0 / $0-$40 / $0
Physical Therapy Copay	$20	$35	$25	$40
Emergency Room Copay	$90	$90	$90	$90
Ground Ambulance Copay	$300	$315	$300	$325
Inpatient Hospital Copay	$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	$300 per visit	$350 per visit	$250 per visit	$300 per visit
Skilled Nursing Facility Care Copay	$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	Yes - up to	Yes - up to	Yes - up to	Yes - up to
Vision Coverage	Yes - up to	Yes - up to	Yes - up to	Yes - up to
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*	Yes - *copays apply*
Your Total Drug Cost	$_____	$_____	$_____	$_____