Medicare Advantage
2021 Plans

This guide is not a comprehensive list of benefits.
Contact the plan for specific coverage details, copayments, restrictions and limitations.

Prescription drug costs included are estimates from the Medicare.gov website.
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**

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<tr>
<td>Regional Counties Offered</td>
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**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** - 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.
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<tr>
<td>Ground Ambulance Copay</td>
<td>$200 per visit</td>
<td>$290</td>
<td>$290</td>
<td>$290</td>
<td></td>
</tr>
<tr>
<td>Inpatient Hospital Copay</td>
<td>$325 per day for days 1-5</td>
<td>$350 per day for days 1-5</td>
<td>$360 per day for days 1-5</td>
<td>$350 per day for days 1-5</td>
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</tr>
<tr>
<td></td>
<td>$0 days 6-90</td>
<td>$0 days 6-90+</td>
<td>$0 days 6-90+</td>
<td>$0 days 6-90+</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Potential Total = $1,625</td>
<td>Potential Total = $1,750</td>
<td>Potential Total = $1,800</td>
<td>Potential Total = $1,750</td>
<td></td>
</tr>
<tr>
<td>Outpatient Hospital Copay</td>
<td>$275</td>
<td>$45-$350 per visit</td>
<td>$45-$250 per visit</td>
<td>$45-$250 per visit</td>
<td></td>
</tr>
<tr>
<td>Skilled Nursing Facility Care Copay</td>
<td>$0 day 1-20, $178 per day/days 21-100</td>
<td>$0 day 1-20, $184 per day/days 21-100</td>
<td>$0 day 1-20, $184 per day/days 21-100</td>
<td>$0 day 1-20, $184 per day/days 21-100</td>
<td></td>
</tr>
<tr>
<td>Extra Benefits</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental Coverage</td>
<td>Yes - up to $1,500</td>
<td>Yes - up to $1,000</td>
<td>Additional premium</td>
<td>Yes - up to $1,000</td>
<td></td>
</tr>
<tr>
<td>Vision Coverage</td>
<td>Yes</td>
<td>Yes - up to $100</td>
<td>Additional premium</td>
<td>Yes - up to $100</td>
<td></td>
</tr>
<tr>
<td>Additional Benefits</td>
<td>Hearing, Fitness, OTC</td>
<td>Hearing, Fitness, OTC</td>
<td>Fitness, OTC</td>
<td>Hearing, Fitness, OTC</td>
<td></td>
</tr>
<tr>
<td>Prescription Coverage</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drug Coverage Included</td>
<td>Yes - copays apply</td>
<td>Yes - copays apply</td>
<td>Yes - copays apply</td>
<td>Yes - copays apply</td>
<td></td>
</tr>
<tr>
<td>Your Total Drug Cost</td>
<td>$___________________</td>
<td>$___________________</td>
<td>$___________________</td>
<td>$___________________</td>
<td></td>
</tr>
<tr>
<td>------------------------</td>
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<td>----------------------------------</td>
<td>----------------------------------------</td>
<td>--------------------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>Phone Number</strong></td>
<td>800-833-2364</td>
<td>800-833-2364</td>
<td>800-906-5432</td>
<td>800-906-5432</td>
<td></td>
</tr>
<tr>
<td><strong>Hospital Systems</strong></td>
<td>CHI, NE-Med, MHS</td>
<td>CHI, NE-Med, MHS</td>
<td>CHI</td>
<td>CHI</td>
<td></td>
</tr>
<tr>
<td><strong>Plan Overview</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Monthly Premium</strong></td>
<td>$0 (Part B Premium Reduction)</td>
<td>$27.80</td>
<td>$39</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td><strong>Medical Deductible</strong></td>
<td>$0</td>
<td>Unavailable</td>
<td>$0</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td><strong>Out-of-pocket Limit</strong></td>
<td>$6,700 in / $10,000 out</td>
<td>$6,700 in/$10,000 out</td>
<td>$5,500 in /$7,100 out</td>
<td>$5,500</td>
<td></td>
</tr>
<tr>
<td><strong>Benefits and Costs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Primary Doctor Copay</strong></td>
<td>$10</td>
<td>$20</td>
<td>$0</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td><strong>Specialist Doctor Copay</strong></td>
<td>$45</td>
<td>$50</td>
<td>$35</td>
<td>$50</td>
<td></td>
</tr>
<tr>
<td><strong>Urgent Care Copay</strong></td>
<td>$10-$45</td>
<td>$20-$50</td>
<td>$0-$35</td>
<td>$0-$45</td>
<td></td>
</tr>
<tr>
<td><strong>Labs/Test/X-rays Copay</strong></td>
<td>$0-$40/ $0-$50 /$10-$50</td>
<td>$0/ $0-$50 / $20-$50</td>
<td>$0 / 15% / 15%</td>
<td>$0 / 20% / 20%</td>
<td></td>
</tr>
<tr>
<td><strong>Physical Therapy Copay</strong></td>
<td>$40</td>
<td>20% Coinsurance</td>
<td>$35</td>
<td>$40</td>
<td></td>
</tr>
<tr>
<td><strong>Emergency Room Copay</strong></td>
<td>$90</td>
<td>$90</td>
<td>$90</td>
<td>$90</td>
<td></td>
</tr>
<tr>
<td><strong>Ground Ambulance Copay</strong></td>
<td>$290</td>
<td>20% Coinsurance</td>
<td>$200</td>
<td>$200</td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient Hospital Copay</strong></td>
<td>$295 per day for days 1-6 $0 days 7-90 + Potential Total = $1,770</td>
<td>$2,019 per stay</td>
<td>$325 per day for days 1-5 $0 days 6-90 Potential Total = $1,625</td>
<td>$350 per day for days 1-5 $0 days 6-90+ Potential Total = $1,750</td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient Hospital Copay</strong></td>
<td>$45-$250 per visit</td>
<td>$50 or 20% per visit</td>
<td>$250 per visit</td>
<td>$295 per visit</td>
<td></td>
</tr>
<tr>
<td><strong>Skilled Nursing Facility Care Copay</strong></td>
<td>$0 day 1-20, $184 per day/days 21-100</td>
<td>$0 day 1-20, $184 per day 21-100</td>
<td>$0 day 1-20, $184 per day/days 21-100</td>
<td>$0 day 1-20, $184 per day/days 21-100</td>
<td></td>
</tr>
<tr>
<td><strong>Extra Benefits</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Dental Coverage</strong></td>
<td>Yes - up to $1,000</td>
<td>Yes - up to $2,000</td>
<td>Yes - up to $750</td>
<td>Yes - up to $400</td>
<td></td>
</tr>
<tr>
<td><strong>Vision Coverage</strong></td>
<td>Yes - up to $100</td>
<td>Yes - up to $100</td>
<td>Yes - up to $150</td>
<td>Yes - up to $100</td>
<td></td>
</tr>
<tr>
<td><strong>Additional Benefits</strong></td>
<td>Hearing, Fitness, OTC</td>
<td>Hearing, Fitness, OTC</td>
<td>Hearing, Fitness, OTC</td>
<td>Hearing, Fitness, OTC</td>
<td></td>
</tr>
<tr>
<td><strong>Prescription Coverage</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Drug Coverage Included</strong></td>
<td>No prescription coverage</td>
<td>Yes - copays apply</td>
<td>Yes - copays apply</td>
<td>Yes - copays apply</td>
<td></td>
</tr>
<tr>
<td><strong>Your Total Drug Cost</strong></td>
<td>$___________________</td>
<td>$___________________</td>
<td>$___________________</td>
<td>$___________________</td>
<td></td>
</tr>
</tbody>
</table>