Medicare Advantage

2021 Plans

VOLUNTEERS ASSISTING SENIORS

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*
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 (PPO)** ***H1278-001***	**AARP Medicare Advantage Patriot (PPO)** ***H1278-018***	**Aetna Medicare Elite (PPO)** ***H1608-038***	**Aetna Medicare Premier (HMO)** ***H7149-001***
Phone Number	800-555-5757	800-555-5757	800-555-5757	855-275-6627	855-275-6627
Regional Counties Offered	*Cass, Dodge, Douglas, Sarpy and Washington*	*Cass, Dodge, Douglas, Sarpy and Washington*	*Cass, Dodge, Douglas, Sarpy and Washington*	*Cass, Dodge, Douglas, Sarpy and Washington*	*Cass, Dodge, Douglas, Sarpy and Washington*
Hospital Systems	CHI, NE-Med, MHS	CHI, NE-Med, MHS	CHI, NE-Med, MHS	CHI, NE-Med, MHS	CHI, NE-Med, MHS
Plan Overview					
Monthly Premium	$0	$19	$0 *(Part B Premium reduction $25)*	$0	$0
Medical Deductible	$0	$0	$0	$1,000* *(specific services*)	$0
Out-of-pocket Limit	$4,900	$3,900 in / $8,000 out	$6,700 in / $10,000 out	$6,100 in / $8,000 out	$5,900
Benefits and Costs					
Primary Doctor Copay	$5	$0	$10	$0	$0
Specialist Doctor Copay	$45	$35	$45	$35	$40
Urgent Care Copay	$30-$40	$30-$40	$30-$40	$65	$65
Labs/Test/X-rays Copay	$0 / $30 /$15	$0/ $30/$15	$0 / $30 /$15	$0 / $35 / $20	$0/ $40 / $15
Physical Therapy Copay	$40	$35	$40	$40	$40
Emergency Room Copay	$90	$90	$90	$90	$90
Ground Ambulance Copay	$250	$250	$250	$350	$350
Inpatient Hospital Copay	$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*	$295 per day for days 1– 6 $0 days 7-90+ *Potential Total = $1,770*	$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*
Outpatient Hospital Copay	$0 - $395 per visit	$0 - $395 per visit	$0-$295 per visit	$300 - $400 per visit*	$300 - $400 per visit
Skilled Nursing Facility Care Copay	$0/day 1-20, $184/day 21-47, $0/day 48-100	$0/day 1-20, $184/day 21-42, $0/day 43-100	$0/day 1-20, $184/day 21-57, $0/day 58-100	$0 day 1-20, $184 per day/days 21-100*	$0 day 1-20, $184 per day/days 21-100
Extra Benefits					
Dental Coverage	Yes - up to $1,000	Yes - up to $1,500	Yes - up to $1,500	Yes - up to $1,000	Yes - up to $1,300
Vision Coverage	Yes - up to $200	Yes - up to $300	Yes - up to $300	Yes - up to $310	Yes - up to $270
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*	Yes - *copays apply*	Yes - *copays apply*
Your Total Drug Cost	$_____	$_____	$_____	$_____	$_____

	Aetna Medicare Premier (PPO) ***H1608-012***	**Aetna Medicare Prime (HMO)** ***H7149-004***	**BlueCross Blue Shield MA Access (PPO)** ***H8181-001***	**BlueCross Blue Shield MA Choice (HMO-POS)** ***H3170-002***
Phone Number	855-275-6627	855-275-6627	844-899-6060	844-899-6060
Regional Counties Offered	*Cass, Dodge, Douglas, Sarpy and Washington*	*Douglas, Sarpy*	*Cass, Dodge, Douglas, Sarpy and Washington*	*Cass, Dodge, Douglas, Sarpy and Washington*
Hospital Systems	CHI, NE-Med, MHS	CHI	CHI, NE-Med, MHS	CHI, NE-Med, MHS
Plan Overview				
Monthly Premium	$33	$0	$26	$44
Medical Deductible	$0	$0	$0	$0
Out-of-pocket Limit	$6,100 in / $11,300 out	$5,000	$4,500 in / $6,900 out	$5,700 in / $6,700 out
Benefits and Costs				
Primary Doctor Copay	$15	$0	$5	$10
Specialist Doctor Copay	$40	$35	$30	$40
Urgent Care Copay	$65	$65	$65	$65
Labs/Test/X-rays Copay	$0/ $40 / $20	$0/ $35 / $10	$0/ $20-350 / $15-350	$10-350 / $20-350 / $20-350
Physical Therapy Copay	$40	$40	$40	$40
Emergency Room Copay	$90	$90	$90	$90
Ground Ambulance Copay	$350	$300	Not listed	$325
Inpatient Hospital Copay	$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*	$420 per day for days 1-4 $0 days 5-90+ *Potential Total = $1,680*	$420 per day for days 1-4 $0 days 5-100 *Potential Total = $1,680*
Outpatient Hospital Copay	$250 - $350 per visit	$250 - $350 per visit	$350 per visit	$200 per visit
Skilled Nursing Facility Care Copay	$0 day 1-20, $184 per day/days 21-100	$0 day 1-20, $184 per day/days 21-100	$0 day 1-20, $179 /day 21-46, $0/ day 47-100	$0 day 1-20, $184 /day 21-57, $0/ day 58-100
Extra Benefits				
Dental Coverage	Yes - up to $500	Yes - up to $1,000	Yes - up to $1,350	Yes - up to $700
Vision Coverage	Yes - up to $100	Yes - up to $100	Yes - up to $200	Yes - up to $100
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	$_____	$_____	$_____	$_____

	BlueCross Blue Shield MA Core (HMO) ***H3170-003-1***	**Bright Advantage (HMO)** ***H7853-007***	**Bright Advantage Choice Plus (PPO)** ***H5841-010***	**Bright Advantage Choice (PPO)** ***H5841-005***
Phone Number	844-899-6060	833-412-6737	833-412-6737	833-412-6737
Regional Counties Offered	*Cass, Dodge, Douglas, Sarpy and Washington*	*Dodge, Douglas, Sarpy*	*Dodge, Douglas, Sarpy*	*Dodge, Douglas, Sarpy*
Hospital Systems	CHI, NE-Med, MHS	NE-Med, MHS	NE-Med, MHS	NE-Med, MHS
Plan Overview				
Monthly Premium	$0	$0	$39	$0 *(Part B Premium Reduction $25)*
Medical Deductible	$0	$0	$0	$100
Out-of-pocket Limit	$6,250	$4,700	$4,500 in / $10,000 out	$4,500 in / $10,000 out
Benefits and Costs				
Primary Doctor Copay	$10	$0	$0	$0
Specialist Doctor Copay	$45	$10	$10	$30
Urgent Care Copay	$65	$35	$35	$35
Labs/Test/X-rays Copay	$10-395/$20-395/$20-395	$0 / $0-$100 / $0	$10 / $0-$125 / $20	$10 / $0-$125 / $20
Physical Therapy Copay	$40	$20	$20	$20
Emergency Room Copay	$90	$90	$90	$90
Ground Ambulance Copay	$325	$200	$225	$225
Inpatient Hospital Copay	$420 per day for days 1-4 $0 days 5-90 *Potential Total = $1,680*	$300 per day for days 1-6 $0 days 7-90+ *Potential Total = $1,800*	$350 per day for days 1-5 $0 days 6-90 *Potential Total = $1,750*	$250 per day for days 1-5 $0 days 6-90+ *Potential Total = $1,750*
Outpatient Hospital Copay	$395 per visit	$250 per visit	$325 per visit	$300
Skilled Nursing Facility Care Copay	$0 day 1-20, $184 /day 21-54, $0/ day 55-100	$0 day 1-20, $178 per day/days 21-100	$0 day 1-20, $178 per day/days 21-100	$0 day 1-20, $184 per day/days 21-100
Extra Benefits				
Dental Coverage	Yes - up to $650	Additional $18 premium	Yes - up to $1,500	Additional $22 premium
Vision Coverage	Yes - up to $100	Yes	Yes	Yes
Additional Benefits	Hearing, Fitness, OTC	Hearing, Fitness	Hearing, Fitness	Hearing, Fitness
Prescription Coverage				
Drug Coverage Included	Yes - *copays apply*	Yes - *copays apply*	Yes - *copays apply*	Yes - *copays apply*
Your Total Drug Cost	$_____	$_____	$_____	$_____

	Bright Advantage Plus (HMO) ***H7853-008***	**Humana Choice (PPO)** ***H5216-254***	**Humana Choice (PPO)** ***H5216-014***	**Humana Gold Plus (HMO)** ***H0028-011***
Phone Number	833-412-6737	800-833-2364	800-833-2364	800-833-2364
Regional Counties Offered	*Dodge, Douglas, Sarpy*	*Cass, Dodge, Douglas, Sarpy and Washington*	*Cass, Dodge, Douglas, Sarpy and Washington*	*Cass, Dodge, Douglas, Sarpy and Washington*
Hospital Systems	NE-Med, MHS	CHI, NE-Med, MHS	CHI, NE-Med, MHS	CHI, NE-Med, MHS
Plan Overview				
Monthly Premium	$39	$0	$59	$0
Medical Deductible	$0	$0	$0	$0
Out-of-pocket Limit	$3,900	$4,050 in / $6,700 out	$6,700 in / $10,000 out	$3,850
Benefits and Costs				
Primary Doctor Copay	$0	$0	$15	$0
Specialist Doctor Copay	$0	$45	$45	$45
Urgent Care Copay	$35	$0-$45	$15-$45	$0-$45
Labs/Test/X-rays Copay	$0 /$0-$100 / $0	$0-$45 / $0-$95 /$0-$95	$0-$40 / $0-$95 /$15-$95	$0-$25 / $0-$95 / $0-$95
Physical Therapy Copay	$20	$40	$40	$40
Emergency Room Copay	$90	$90	$90	$90
Ground Ambulance Copay	$200 per visit	$290	$290	$290
Inpatient Hospital Copay	$325 per day for days 1-5 $0 days 6-90 *Potential Total = $1,625*	$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*	$350 per day for days 1-5 $0 days 6-90+ *Potential Total = $1,750*
Outpatient Hospital Copay	$275	$45-$350 per visit	$45-$250 per visit	$45-$250 per visit
Skilled Nursing Facility Care Copay	$0 day 1-20, $178 per day/days 21-100	$0 day 1-20, $184 per day/days 21-100	$0 day 1-20, $184 per day/days 21-100	$0 day 1-20, $184 per day/days 21-100
Extra Benefits				
Dental Coverage	Yes - up to $1,500	Yes - up to $1,000	Additional premium	Yes - up to $1,000
Vision Coverage	Yes	Yes - up to $100	Additional premium	Yes - up to $100
Additional Benefits	Hearing, Fitness, OTC	Hearing, Fitness, OTC	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	$_____	$_____	$_____	$_____

	Humana Honor (PPO) ***H5216-086***	**Humana Value Plus (PPO)** ***H5216-171***	**Medica Advantage Solution (PPO)** ***H3632-001***	**Medica Advantage Solution (HMO)** ***HO798-001***
Phone Number	800-833-2364	800-833-2364	800-906-5432	800-906-5432
Regional Counties Offered	*Cass, Dodge, Douglas, Sarpy and Washington*	*Cass, Dodge, Sarpy and Washington*	*Cass, Dodge, Douglas, Sarpy and Washington*	*Cass, Dodge, Douglas, Sarpy and Washington*
Hospital Systems	CHI, NE-Med, MHS	CHI, NE-Med, MHS	CHI	CHI
Plan Overview				
Monthly Premium	$0 *(Part B Premium Reduction)*	$27.80	$39	$0
Medical Deductible	$0	Unavailable	$0	$0
Out-of-pocket Limit	$6,700 in / $10,000 out	$6,700 in/$10,000 out	$5,500 in /$7$10,000 out	$5,500
Benefits and Costs				
Primary Doctor Copay	$10	$20	$0	$0
Specialist Doctor Copay	$45	$50	$35	$50
Urgent Care Copay	$10-$45	$20-$50	$0-35	$0-$45
Labs/Test/X-rays Copay	$0-$40/ $0-$50 /$10-$50	$0/ $0-$50 / $20-$50	$0 / 15% / 15%	$0 / 20% / 20%
Physical Therapy Copay	$40	20% Coinsurance	$35	$40
Emergency Room Copay	$90	$90	$90	$90
Ground Ambulance Copay	$290	20% Coinsurance	$200	$200
Inpatient Hospital Copay	$295 per day for days 1-6 $0 days 7-90 + *Potential Total = $1,770*	*$2,019 per stay*	$325 per day for days 1-5 $0 days 6-90 *Potential Total = $1,625*	$350 per day for days 1-5 $0 days 6-90+ *Potential Total = $1,750*
Outpatient Hospital Copay	$45-$250 per visit	$50 or 20% per visit	$250 per visit	$295 per visist
Skilled Nursing Facility Care Copay	$0 day 1-20, $184 per day/days 21-100	$0 day 1-20, $184 per days 21-100	$0 day 1-20, $184 per day/days 21-100	$0 day 1-20, $184 per day/days 21-100
Extra Benefits				
Dental Coverage	Yes - up to $1,000	Yes - up to $2,000	Yes - up to $750	Yes - up to $400
Vision Coverage	Yes - up to $100	Yes - up to $100	Yes - up to $150	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	$_____	$_____	$_____	$_____