

# 2024 Eastern Medicare Advantage and Cost Plans

*Below is a list of counties and the plans available in each county. The following pages contain the plan details for each plan.*

## Cass County

Aetna Medicare Premier (PPO)  
Aetna Medicare SmartFit (PPO)  
Aetna Medicare Premier (HMO-POS)  
Aetna Medicare Eagle (HMO-POS)  
Aetna Medicare Value Plus (HMO-POS)  
Aetna Medicare SmartFit (HMO-POS)  
Blue Cross Blue Shield Nebraska MA Core (HMO)  
Blue Cross Blue Shield Nebraska MA Access PPO (PPO)  
Blue Cross Blue Shield Nebraska MA Connect PPO (PPO)  
Humana Gold Plus H0028-053 (HMO)  
HumanaChoice H5216-014 (PPO)  
Humana Value Plus H5216-171 (PPO)  
HumanaChoice H5216-254 (PPO)  
Humana USAA Honor (PPO)  
Humana USAA Honor (PPO)  
Humana USAA Honor with Rx (PPO)  
Medica Advantage Solution H8889-009 (PPO)  
Medica Advantage Value (PPO)  
Medica Advantage Preferred (PPO)  
Medica Advantage Select (PPO)  
AARP Medicare Advantage from UHC NE-0001 (PPO)  
AARP Medicare Advantage Patriot No Rx NE-MA01 (PPO)  
AARP Medicare Advantage from UHC NE-0002 (PPO)  
AARP Medicare Advantage from UHC NE-0003 (HMO-POS)  
Wellcare No Premium (HMO)  
Wellcare Giveback (HMO)  
Wellcare No Premium Open (PPO)  
Wellcare Assist Open (PPO)

## Dodge County

Aetna Medicare Premier (PPO)  
Aetna Medicare SmartFit (PPO)  
Aetna Medicare Premier (HMO-POS)  
Aetna Medicare Eagle (HMO-POS)  
Aetna Medicare Value Plus (HMO-POS)  
Aetna Medicare SmartFit (HMO-POS)  
Blue Cross Blue Shield Nebraska MA Core (HMO)  
Blue Cross Blue Shield Nebraska MA Access PPO (PPO)  
Blue Cross Blue Shield Nebraska MA Connect PPO (PPO)  
Humana Gold Plus H0028-053 (HMO)  
HumanaChoice H5216-014 (PPO)  
Humana Value Plus H5216-171 (PPO)  
HumanaChoice H5216-254 (PPO)  
Humana USAA Honor (PPO)  
Humana USAA Honor (PPO)  
Humana USAA Honor with Rx (PPO)  
Medica Advantage Solution H8889-009 (PPO)  
Medica Advantage Value (PPO)  
Medica Advantage Preferred (PPO)  
Medica Advantage Select (PPO)  
AARP Medicare Advantage from UHC NE-0001 (PPO)  
AARP Medicare Advantage Patriot No Rx NE-MA01 (PPO)  
AARP Medicare Advantage from UHC NE-0002 (PPO)  
AARP Medicare Advantage from UHC NE-0003 (HMO-POS)  
Wellcare No Premium (HMO)  
Wellcare Giveback (HMO)  
Wellcare No Premium Open (PPO)  
Wellcare Assist Open (PPO)

## Douglas County

Aetna Medicare Premier (PPO)  
Aetna Medicare SmartFit (PPO)  
Aetna Medicare Premier (HMO-POS)  
Aetna Medicare Eagle (HMO-POS)  
Aetna Medicare Value Plus (HMO-POS)  
Aetna Medicare SmartFit (HMO-POS)  
Blue Cross Blue Shield Nebraska MA Core (HMO)  
Blue Cross Blue Shield Nebraska MA Access PPO (PPO)  
Blue Cross Blue Shield Nebraska MA Connect PPO (PPO)  
Humana Gold Plus H0028-053 (HMO)  
HumanaChoice H5216-014 (PPO)  
HumanaChoice H5216-254 (PPO)  
Humana USAA Honor (PPO)  
Humana USAA Honor (PPO)  
Humana USAA Honor with Rx (PPO)  
Medica Advantage Solution H8889-009 (PPO)  
Medica Advantage Value (PPO)  
Medica Advantage Preferred (PPO)  
Medica Advantage Select (PPO)  
AARP Medicare Advantage from UHC NE-0001 (PPO)  
AARP Medicare Advantage Patriot No Rx NE-MA01 (PPO)  
AARP Medicare Advantage from UHC NE-0002 (PPO)  
AARP Medicare Advantage from UHC NE-0003 (HMO-POS)  
Wellcare No Premium (HMO)  
Wellcare Giveback (HMO)  
Wellcare No Premium Open (PPO)  
Wellcare Assist Open (PPO)

*Below is a list of counties and the plans available in each county. The following pages contain the plan details for each plan.*

**Sarpy County**

Aetna Medicare Premier (PPO)  
Aetna Medicare SmartFit (PPO)  
Aetna Medicare Premier (HMO-POS)  
Aetna Medicare Eagle (HMO-POS)  
Aetna Medicare Value Plus (HMO-POS)  
Aetna Medicare SmartFit (HMO-POS)  
Blue Cross Blue Shield Nebraska MA Core (HMO)  
Blue Cross Blue Shield Nebraska MA Access PPO (PPO)  
Blue Cross Blue Shield Nebraska MA Connect PPO (PPO)  
Humana Gold Plus H0028-053 (HMO)  
HumanaChoice H5216-014 (PPO)  
Humana Value Plus H5216-171 (PPO)  
HumanaChoice H5216-254 (PPO)  
Humana USAA Honor (PPO)  
Humana USAA Honor (PPO)  
Humana USAA Honor with Rx (PPO)  
Medica Advantage Solution H8889-009 (PPO)  
Medica Advantage Value (PPO)  
Medica Advantage Preferred (PPO)  
Medica Advantage Select (PPO)  
AARP Medicare Advantage from UHC NE-0001 (PPO)  
AARP Medicare Advantage Patriot No Rx NE-MA01 (PPO)  
AARP Medicare Advantage from UHC NE-0002 (PPO)  
AARP Medicare Advantage from UHC NE-0003 (HMO-POS)  
Wellcare No Premium (HMO)  
Wellcare Giveback (HMO)  
Wellcare No Premium Open (PPO)  
Wellcare Assist Open (PPO)

**Washington County**

Aetna Medicare Premier (PPO)  
Aetna Medicare SmartFit (PPO)  
Aetna Medicare Premier (HMO-POS)  
Aetna Medicare Eagle (HMO-POS)  
Aetna Medicare Value Plus (HMO-POS)  
Aetna Medicare SmartFit (HMO-POS)  
Blue Cross Blue Shield Nebraska MA Core (HMO)  
Blue Cross Blue Shield Nebraska MA Access PPO (PPO)  
Blue Cross Blue Shield Nebraska MA Connect PPO (PPO)  
Humana Gold Plus H0028-053 (HMO)  
HumanaChoice H5216-014 (PPO)  
Humana Value Plus H5216-171 (PPO)  
HumanaChoice H5216-254 (PPO)  
Humana USAA Honor (PPO)  
Humana USAA Honor (PPO)  
Humana USAA Honor with Rx (PPO)  
Medica Advantage Solution H8889-009 (PPO)  
Medica Advantage Value (PPO)  
Medica Advantage Preferred (PPO)  
Medica Advantage Select (PPO)  
AARP Medicare Advantage from UHC NE-0001 (PPO)  
AARP Medicare Advantage Patriot No Rx NE-MA01 (PPO)  
AARP Medicare Advantage from UHC NE-0002 (PPO)  
AARP Medicare Advantage from UHC NE-0003 (HMO-POS)  
Wellcare No Premium (HMO)  
Wellcare Giveback (HMO)  
Wellcare No Premium Open (PPO)  
Wellcare Assist 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.

	<b>Nebraska Sample MA Plan (PPO) A1234-567</b>
<b>Phone Number</b>	555-555-555
<b>Regional Counties Offered</b>	Butler, Lancaster, Saline, Saunders, Seward
<b>Plan Overview</b>	
<b>Monthly Premium</b>	\$0
<b>Medical Deductible</b>	\$0
<b>Out-of-pocket Limit</b>	\$4,500
<b>Benefits and Costs</b>	
<b>Primary Doctor Copay</b>	\$5
<b>Specialist Doctor Copay</b>	\$45
<b>Urgent Care Copay</b>	\$30-\$40
<b>Labs/ Test/ X-rays Copay</b>	\$10/ \$30/ \$14
<b>Physical Therapy Copay</b>	\$40
<b>Emergency Room Copay</b>	\$90
<b>Ground Ambulance Copay</b>	\$225
<b>Inpatient Hospital Copay</b>	\$395 per day for days 1-4 \$0 days 5-90 <i>Potential Total = \$1,580</i>
<b>Outpatient Hospital Copay</b>	\$295 - 395
<b>Skilled Nursing Facility Care Copay</b>	\$0/day 1-20, \$160/day 21-51, \$0/day 52-100 <i>Out-of-pocket limit = \$4,900</i>
<b>Extra Benefits</b>	
<b>Dental Coverage</b>	Yes - up to \$1,500
<b>Vision Coverage</b>	Yes - up to \$200
<b>Additional Benefits</b>	Hearing, Fitness, OTC
<b>Prescription Coverage</b>	
<b>Drug Coverage Included</b>	Yes - <i>copays apply</i>
<b>Your Total Drug Cost</b>	\$ _____

## 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>AARP Medicare Advantage from UHC NE-0001 (PPO) H1278-001</b>	<b>AARP Medicare Advantage from UHC NE-0002 (PPO) H1278-020</b>	<b>AARP Medicare Advantage from UHC NE-0003 (HMO-POS) H2802-001</b>	<b>AARP Medicare Advantage Patriot No Rx NE-MA01 (PPO) H1278-018</b>
<b>Phone Number</b>	800-555-5757	800-555-5757	800-555-5757	800-555-5757
<b>Regional Counties Offered</b>	<i>See County List</i>	<i>See County List</i>	<i>See County List</i>	<i>See County List</i>
<b>Plan Overview</b>				
<b>Monthly Premium</b>	\$27	\$0	\$0	\$0 ( <i>Part B Premium Reduction up to \$125</i> )
<b>Medical Deductible</b>	\$0	\$0	\$0	\$0
<b>Out-of-pocket Limit</b>	\$3,800 in / \$5,750 out	\$4,500 in / \$9,550 out	\$3,800	\$6,700 in / \$8,000 out
<b>Benefits and Costs</b>				
<b>Primary Doctor Copay</b>	\$0	\$0	\$0	\$0
<b>Specialist Doctor Copay</b>	\$0 - 35	\$0 - 45	\$0 - 35	\$0 - 40
<b>Urgent Care Copay</b>	\$0 - 40	\$0 - 40	\$0 - 40	\$0 - 40
<b>Labs/ Test/ X-rays Copay</b>	\$0/ \$50/ \$15	\$0/ \$50/ \$15	\$0/ \$30/ \$15	\$0/ \$50/ \$25
<b>Physical Therapy Copay</b>	\$0 - 25	\$0 - 40	\$0 - 30	\$0 - 40
<b>Emergency Room Copay</b>	\$135	\$120	\$135	\$100
<b>Ground Ambulance Copay</b>	\$275	\$275	\$200	\$290
<b>Inpatient Hospital Copay</b>	\$350 per day for days 1-6 \$0 days 7-90+ <i>Potential Total = \$2,100</i>	\$395 per day for days 1-5 \$0 days 6-90+ <i>Potential Total = \$1,975</i>	\$350 per day for days 1-5 \$0 days 6-90+ <i>Potential Total = \$1,750</i>	\$295 per day for days 1- 6 \$0 days 7-90+ <i>Potential Total = \$1,770</i>
<b>Outpatient Hospital Copay</b>	\$0 - 350 per visit	\$0 - 395 per visit	\$0 - 350 per visit	\$0 - 295 per visit
<b>Skilled Nursing Facility Care Copay</b>	\$0/day 1-20, \$203/day 21-100	\$0/day 1-20, \$203/day 21-100	\$0/day 1-20, \$203/day 21-100	\$0/day 1-20, \$203/day 21-100
<b>Extra Benefits</b>				
<b>Dental Coverage</b>	Yes - up to \$1,250	Yes - up to \$750	Yes - up to \$1,750	Yes - up to \$2,000
<b>Vision Coverage</b>	Yes - up to \$250	Yes - up to \$150	Yes - up to \$300	Yes - up to \$300
<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>	<i>No prescription coverage</i>
<b>Your Total Drug Cost</b>	\$ _____	\$ _____	\$ _____	\$ _____

	<b>Aetna Medicare Eagle (HMO-POS) H7149-007</b>	<b>Aetna Medicare Premier (HMO- POS) H7149-001</b>	<b>Aetna Medicare Premier (PPO) H1608-012</b>	<b>Aetna Medicare SmartFit (HMO- POS) H7149-009</b>
<b>Phone Number</b>	833-859-6031	833-859-6031	833-859-6031	833-859-6031
<b>Regional Counties Offered</b>	<i>See County List</i>	<i>See County List</i>	<i>See County List</i>	<i>See County List</i>
<b>Plan Overview</b>				
<b>Monthly Premium</b>	\$0 ( <i>Part B Premium Reduction \$75</i> )	\$0	\$0	\$0
<b>Medical Deductible</b>	\$0	\$0	\$0	\$0
<b>Out-of-pocket Limit</b>	\$6,700	\$3,900	\$5,000 in / \$8,950 out	\$3,600
<b>Benefits and Costs</b>				
<b>Primary Doctor Copay</b>	\$0	\$0	\$0	\$0
<b>Specialist Doctor Copay</b>	\$40	\$30	\$50	\$20
<b>Urgent Care Copay</b>	\$50	\$50	\$50	\$50
<b>Labs/ Test/ X-rays Copay</b>	\$0/ \$0-20/ \$10	\$0/ \$0-20/ \$10	\$0/ \$0-20/ \$10	\$0/ \$0-20/ \$10
<b>Physical Therapy Copay</b>	\$40	\$30	\$40	\$20
<b>Emergency Room Copay</b>	\$100	\$120	\$120	\$120
<b>Ground Ambulance Copay</b>	\$320	\$335	\$315	\$335
<b>Inpatient Hospital Copay</b>	\$225 per day for days 1– 7 \$0 days 8-90 <i>Potential Total = \$1,575</i>	\$350 per day for days 1-5 \$0 days 6-90 <i>Potential Total = \$1,750</i>	\$350 per day for days 1-5 \$0 days 6-90 <i>Potential Total = \$1,750</i>	\$360 per day for days 1-5 \$0 days 6-90 <i>Potential Total = \$1,800</i>
<b>Outpatient Hospital Copay</b>	\$0 - 225 per visit	\$0 - 400 per visit	\$0 - 350 per visit	\$0 - 400 per visit
<b>Skilled Nursing Facility Care Copay</b>	\$0/day 1-20, \$184/day 21-100	\$0/day 1-20, \$184/day 21-100	\$0/day 1-20, \$184/day 21-100	\$0/day 1-20, \$184/day 21-100
<b>Extra Benefits</b>				
<b>Dental Coverage</b>	Yes - up to \$2,000	Yes - up to \$2,200	Yes - up to \$1,150	Yes - up to \$2,400
<b>Vision Coverage</b>	Yes - up to \$300	Yes - up to \$330	Yes - up to \$220	Yes - up to \$320
<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>	<i>Yes - copays apply</i>	<i>Yes - copays apply</i>	<i>Yes - copays apply</i>
<b>Your Total Drug Cost</b>	\$ _____	\$ _____	\$ _____	\$ _____

	<b>Aetna Medicare SmartFit (PPO) H1608-038</b>	<b>Aetna Medicare Value Plus (HMO- POS) H7149-008</b>	<b>Blue Cross Blue Shield Nebraska MA Access PPO (PPO) H8181-001</b>	<b>Blue Cross Blue Shield Nebraska MA Connect PPO (PPO) H8181-002</b>
<b>Phone Number</b>	833-589-6031	833-859-6031	844-899-6060	844-899-6060
<b>Regional Counties Offered</b>	<i>See County List</i>	<i>See County List</i>	<i>See County List</i>	<i>See County List</i>
<b>Plan Overview</b>				
<b>Monthly Premium</b>	\$0	\$36	\$25	\$0
<b>Medical Deductible</b>	\$0	\$0	\$0	\$0
<b>Out-of-pocket Limit</b>	\$4,500 in / \$8,000 out	\$3,900	\$3,900 in / \$8,000 out	\$4,500 in / \$8,000 out
<b>Benefits and Costs</b>				
<b>Primary Doctor Copay</b>	\$0	\$0	\$0	\$0
<b>Specialist Doctor Copay</b>	\$35	\$30	\$40	\$40
<b>Urgent Care Copay</b>	\$50	\$50	\$60	\$60
<b>Labs/ Test/ X-rays Copay</b>	\$0/ \$0-20/ \$10	\$0/ \$0-20/ \$10	\$0/ \$30-395/ \$20	\$0/ \$30-395/ \$25
<b>Physical Therapy Copay</b>	\$35	\$30	\$40	\$40
<b>Emergency Room Copay</b>	\$120	\$120	\$120	\$120
<b>Ground Ambulance Copay</b>	\$350	\$335	\$350	\$350
<b>Inpatient Hospital Copay</b>	\$360 per day for days 1-5 \$0 days 6-90 <i>Potential Total = \$1,800</i>	\$350 per day for days 1-5 \$0 days 6-90 <i>Potential Total = \$1,750</i>	\$375 per day for days 1-4 \$0 days 5-90 <i>Potential Total = \$1,500</i>	\$375 per day for days 1-4 \$0 days 5-90 <i>Potential Total = \$1,500</i>
<b>Outpatient Hospital Copay</b>	\$0-400 per visit	\$0-400 per visit	\$395 per visit	\$0-250 per visit
<b>Skilled Nursing Facility Care Copay</b>	\$0/day 1-20, \$184/day 21-100	\$0/day 1-20, \$184/day 21-100	\$0 day 1-20, \$196/day 21-50, \$0/day 51-100	\$0 day 1-20, \$196/day 21-50, \$0/day 51-100
<b>Extra Benefits</b>				
<b>Dental Coverage</b>	Yes - up to \$1,600	Yes - up to \$2,000	Yes - up to \$1,750	Yes - up to \$1,350
<b>Vision Coverage</b>	Yes - up to \$360	Yes - up to \$320	Yes - up to \$200	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>	Yes - <i>copays apply</i>	Yes - <i>copays apply</i>
<b>Your Total Drug Cost</b>	\$_____	\$_____	\$_____	\$_____

	<b>Blue Cross Blue Shield Nebraska MA Core (HMO) H3170-003</b>	<b>Humana Gold Plus H0028-053 (HMO) H0028-053</b>	<b>Humana USAA Honor (PPO) H5216-329</b>	<b>Humana USAA Honor (PPO) H5216-278</b>
<b>Phone Number</b>	844-899-6060	800-833-2364	800-833-2364	800-833-2364
<b>Regional Counties Offered</b>	<i>See County List</i>	<i>See County List</i>	<i>See County List</i>	<i>See County List</i>
<b>Plan Overview</b>				
<b>Monthly Premium</b>	\$0	\$0	\$0 <i>(Part B Premium Reduction up to \$100)</i>	\$0 <i>(Part B Premium Reduction up to \$70)</i>
<b>Medical Deductible</b>	\$0	\$0	\$0	\$0
<b>Out-of-pocket Limit</b>	\$3,900	\$3,850	\$6,700 in/\$8,950 out	\$4,900 in / \$8,950 out
<b>Benefits and Costs</b>				
<b>Primary Doctor Copay</b>	\$0	\$0	\$0	\$10
<b>Specialist Doctor Copay</b>	\$40	\$35	\$40	\$45
<b>Urgent Care Copay</b>	\$60	\$65	\$55	\$260
<b>Labs/ Test/ X-rays Copay</b>	\$0/ \$30-395/ \$25	\$0/ \$0-95/ \$0-125	\$0-35/ \$0-55 or 25%/ \$0-55	\$0-40/ \$0-60/ \$10-125
<b>Physical Therapy Copay</b>	\$40	\$30	\$35	\$40
<b>Emergency Room Copay</b>	\$120	\$135	\$100	\$120
<b>Ground Ambulance Copay</b>	\$350	\$300	\$265	\$300
<b>Inpatient Hospital Copay</b>	\$400 per day for days 1-4 \$0 days 7-90+ <i>Potential Total = \$1,600</i>	\$325 per day for days 1-6 \$0 days 7-90 <i>Potential Total = \$2,125</i>	\$425 per day for days 1-5 \$0 days 6-90+ <i>Potential Total = \$2,125</i>	\$295 per day for days 1-6 \$0 days 7-90+ <i>Potential Total = \$1,770</i>
<b>Outpatient Hospital Copay</b>	\$395 per visit	\$0-300 per visit	\$0-325 per visit	\$0-300 per visit
<b>Skilled Nursing Facility Care Copay</b>	\$0 day 1-20, \$196/day 21-53, \$0/day 54-100	\$0 day 1-20, \$203 per day/days 21-100	\$0 day 1-20, \$203 per days 21-100	\$10 day 1-20, \$ 203 per day/days 21-100
<b>Extra Benefits</b>				
<b>Dental Coverage</b>	Yes - up to \$1,425	Yes - up to \$1,000	Yes - up to \$1,000	Yes - up to \$2,500
<b>Vision Coverage</b>	Yes - up to \$200	Yes - up to \$200	Yes - up to \$75	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>Humana USAA Honor with Rx (PPO) H5216-340</b>	<b>Humana Value Plus H5216-171 (PPO) H5216-171</b>	<b>HumanaChoice H5216-014 (PPO) H5216-014</b>	<b>HumanaChoice H5216-254 (PPO) H5216-254</b>
<b>Phone Number</b>	800-833-2364	800-833-2364	800-833-2364	800-833-2364
<b>Regional Counties Offered</b>	<i>See County List</i>	<i>See County List</i>	<i>See County List</i>	<i>See County List</i>
<b>Plan Overview</b>				
<b>Monthly Premium</b>	\$0 <i>(Part B Premium Reduction up to \$84)</i>	\$42.20	\$41	\$0
<b>Medical Deductible</b>	\$450	\$0	\$0	\$0
<b>Out-of-pocket Limit</b>	\$5,900 in / \$9,550 out	\$6,700 in / \$13,300 out	\$6,700 in / \$10,000 out	\$3,900 in / \$9,550 out
<b>Benefits and Costs</b>				
<b>Primary Doctor Copay</b>	\$0	20%	\$5	\$0
<b>Specialist Doctor Copay</b>	\$50	20%	\$40	\$35
<b>Urgent Care Copay</b>	\$60	20%	\$55	\$60
<b>Labs/ Test/ X-rays Copay</b>	\$0-50/ \$0-100/ \$0-125	\$0-30/ \$0-20%/ \$50-20%	\$0 - 40/ \$0-95/ \$5 - 125	\$0/ \$0-95/ \$0-125
<b>Physical Therapy Copay</b>	\$40	20%	\$40	\$40
<b>Emergency Room Copay</b>	\$120	\$100	\$100	\$120
<b>Ground Ambulance Copay</b>	\$300	\$300	\$300	\$300
<b>Inpatient Hospital Copay</b>	\$425 per day for days 1-5 \$0 days 6-90+ <i>Potential Total = \$2,125</i>	\$2,080 per stay	\$360 per day for days 1-5 \$0 days 6-90 <i>Potential Total = \$1,800</i>	\$395 per day for days 1-7 \$0 days 8-90 <i>Potential Total = \$2,555</i>
<b>Outpatient Hospital Copay</b>	\$0-400 per visit	\$0 -20%	\$0 - 300 per visit	\$395 per visit
<b>Skilled Nursing Facility Care Copay</b>	\$10 day 1-20, \$ 203 per day/days 21-100	\$0 day 1-20, \$ 203 per day/days 21-100	\$0 day 1-20, \$203 per day/days 21-100	\$0 day 1-20, \$196 day/days 21-100
<b>Extra Benefits</b>				
<b>Dental Coverage</b>	Yes - up to \$4,000	Yes—up to \$2000	Yes - up to \$500	Yes - up to \$2,500
<b>Vision Coverage</b>	Yes - up to \$250	Yes - up to \$150	Yes - up to \$150	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>	Yes - <i>copays apply</i>	Yes - <i>copays apply</i>
<b>Your Total Drug Cost</b>	\$_____	\$_____	\$_____	\$_____



	<b>Medica Advantage Preferred (PPO) H8889-011</b>	<b>Medica Advantage Select (PPO) H8889-015</b>	<b>Medica Advantage Solution H8889-009 (PPO) H8889-009</b>	<b>Medica Advantage Value (PPO) H8889-010</b>
<b>Phone Number</b>	800-906-5432	800-906-5432	800-906-5432	800-906-5432
<b>Regional Counties Offered</b>	<i>See County List</i>	<i>See County List</i>	<i>See County List</i>	<i>See County List</i>
<b>Plan Overview</b>				
<b>Monthly Premium</b>	\$132	\$26	\$0	\$0
<b>Medical Deductible</b>	\$0	\$0	\$0	\$0
<b>Out-of-pocket Limit</b>	\$2,500 in /\$2,500 out	\$3,500 in /\$3,500 out	\$4,900 in /\$4,900 out	\$3,900 in /\$3,900 out
<b>Benefits and Costs</b>				
<b>Primary Doctor Copay</b>	\$0	\$0	\$0	\$0
<b>Specialist Doctor Copay</b>	\$10	\$35	\$30	\$35
<b>Urgent Care Copay</b>	\$0-10	\$0	\$0-45	\$0 - 50
<b>Labs/ Test/ X-rays Copay</b>	\$0/ \$0-50/ \$0	\$0/ \$0-75/ \$15	\$0/ \$0-70 /\$15	\$0/ \$0 - 100/ \$15
<b>Physical Therapy Copay</b>	\$10	\$35	\$30	\$35
<b>Emergency Room Copay</b>	\$120	\$120	\$120	\$120
<b>Ground Ambulance Copay</b>	\$100	\$250	\$265	\$250
<b>Inpatient Hospital Copay</b>	\$100 per stay	\$325 per day for days 1-5 \$0 days 6-90 <i>Potential Total = \$1,625</i>	\$245 per day for days 1-6 \$0 days 7-90 <i>Potential Total = \$1,470</i>	\$350/day for days 1-5, \$0/day for days 6-90 <i>Potential Total = \$1,750</i>
<b>Outpatient Hospital Copay</b>	\$0 -150 per visit	\$0 - 345 per visit	\$0 -250 per visit	\$0 - 375 per visit
<b>Skilled Nursing Facility Care Copay</b>	\$0 day 1-20, \$150 day/days 21-40, \$0 day/days 41-100	\$0 day 1-20, \$203 day/days 21-39, \$0 day/days 40-100	\$0/day 1-20, \$203/day 21-45 \$0/day 46-100	\$0/day 1-20, \$203/day 21-39 \$0/day 40-100
<b>Extra Benefits</b>				
<b>Dental Coverage</b>	Yes - up to \$1,500	Yes - up to \$700	Yes - up to \$1,000	Yes - up to \$600
<b>Vision Coverage</b>	Yes - up to \$300	Yes - up to \$200	Yes - up to \$200	Yes - up to \$150
<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>	Yes - <i>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>See County List</i>	<i>See County List</i>	<i>See County List</i>	<i>See County List</i>
<b>Plan Overview</b>				
<b>Monthly Premium</b>	\$24.70	\$0 <i>(Part B Premium Reduction up to \$86)</i>	\$0	\$0
<b>Medical Deductible</b>	\$0	\$0	\$0	\$0
<b>Out-of-pocket Limit</b>	\$4,500 in /\$8,950 out	\$8,850	\$3,600	\$3,900 in /\$8,950 out
<b>Benefits and Costs</b>				
<b>Primary Doctor Copay</b>	\$0	\$0	\$0	\$0
<b>Specialist Doctor Copay</b>	\$20	\$50	\$25	\$35
<b>Urgent Care Copay</b>	\$40	\$35	\$35	\$0 - 40
<b>Labs/ Test/ X-rays Copay</b>	\$0 - 50/ \$0-40/ \$0	\$0 - 50/ \$0 - 50/ \$15	\$0 - 50/ \$0 - 30/ \$0	\$0 - 50/ \$0 - 40/ \$0
<b>Physical Therapy Copay</b>	\$20	\$40	\$25	\$35
<b>Emergency Room Copay</b>	\$120	\$100	\$135	\$120
<b>Ground Ambulance Copay</b>	\$300	\$315	\$300	\$325
<b>Inpatient Hospital Copay</b>	\$225 per day for days 1-7 \$0 days 5-90 <i>Potential Total = \$1,575</i>	\$1,450 per stay	\$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>	\$0 - 300 per visit	\$0 - 350 per visit	\$0 - 250 per visit	\$0 - 300 per visit
<b>Skilled Nursing Facility Care Copay</b>	\$0/day 1-20, \$203/day 21-50 \$0/day 51-100	\$0/day 1-20, \$185/day 21-70 \$0/day 71-100	\$0/day 1-20, \$203/day 21-40 \$0/day 41-100	\$0/day 1-20, \$203/day 21-50 \$0/day 51-100
<b>Extra Benefits</b>				
<b>Dental Coverage</b>	Yes - up to \$2000	Yes. See Evidence of Coverage	Yes - up to \$2000	Yes - up to \$1,500
<b>Vision Coverage</b>	Yes - up to \$200	Yes - up to \$100	Yes - up to \$200	Yes - up to \$200
<b>Additional Benefits</b>	Hearing, Fitness, OTC	Hearing, Fitness	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>	\$_____	\$_____	\$_____	\$_____