2027 Eastern Nebraska Medicare Advantage Plans

Cass County

AARP Medicare Advantage Essentials from UHC NE-3 (HMO-POS)
AARP Medicare Advantage Extras from UHC NE-5 (HMO-POS)
AARP Medicare Advantage from UHC NE-0002 (PPO)
AARP Medicare Advantage Patriot No Rx NE-MA01 (PPO)
AARP Medicare Advantage Patriot No Rx NE-MA2 (HMO-POS)
Aetna Medicare Eagle (HMO-POS)
Aetna Medicare Enhanced Classic Extra (PPO)
Aetna Medicare Enhanced Extra (PPO)
Aetna Medicare Signature (HMO-POS)
Aetna Medicare Signature (PPO)
Aetna Medicare Signature Classic (PPO)
Aetna Medicare Signature Classic Extra (PPO)
Blue Cross and Blue Shield of Nebraska MA Assure (HMO-POS)
Blue Cross and Blue Shield of Nebraska MA Connect (PPO)
Blue Cross and Blue Shield of Nebraska MA Protect (PPO)
DEVOTED CHOICE 001 NE (PPO)
DEVOTED CHOICE GIVEBACK 002 NE (PPO)
DEVOTED CHOICE GIVEBACK EXTRAS 011 NE (PPO)
Humana Gold Plus H0028-053 (HMO)
Humana USAA Honor Giveback (PPO)
HumanaChoice Giveback H5216-340 (PPO)
HumanaChoice H5216-014 (PPO)
MyAdvocate Medicare Advantage GOLD (HMO-POS)
MyAdvocate Medicare Advantage SILVER (HMO-POS)
Wellcare Giveback (HMO-POS)
Wellcare Simple (HMO-POS)

Dodge County

AARP Medicare Advantage Patriot No Rx NE-MA2 (HMO-POS)
Aetna Medicare Eagle (HMO-POS)
Aetna Medicare Enhanced Classic Extra (PPO)
Aetna Medicare Enhanced Extra (PPO)
Aetna Medicare Signature (PPO)
Aetna Medicare Signature Classic (PPO)
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Wellcare Simple (HMO-POS)

Douglas County

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Sarpy County

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Washington County

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Wellcare Simple (HMO-POS)

Understanding Medicare Advantage Plan Benefits

Plan Overview

Monthly Premium - The dollaramount you owe monthly in addition to the Part B premium to be a plan member.

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 & Cost

Copays - A set amount that you pay for 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.

Costs shown are in-network values unless noted as 'out'. Out-of-network costs may be higher.

Prescription Coverage

Medicare Advantage plansmay include drug coverage. Deductibles, copays and coinsurance will apply to prescriptions and do not count towards the Health Deductible or out-of-pocket limit.

	Nebraska Sample MA Plan (HMO)
Phone Number	800-555-5555
Contract & Plan ID	*H5555-055*
Evidence of Coverage Link	Click for more details
Plan Overview	
Monthly Premium	$0
Health Deductible	$0 $7,150
Maximum Out-of-Pocket	in
Benefits & Costs	
Primary Doctor Visit	$0
Specialist Visit	$0 - 70
Labs / Tests / X-rays	$0 / $45 / $30
Emergency Room	$130
Urgent Care	$0 - 50
Inpatient Hospital Care	$445 per day for days 1-6 $0 days 7-90 *Potential Total = $2,670*
Outpatient Hospital Care	$0 - 445 per visit
Skilled Nursing Facility Care	$0/day 1-20, $218/day 21-100
Ground Ambulance	$290
Physical Therapy	$50
Prescription Coverage	
Drug Deductible	No Drug Coverage
Extra Benefits	
Dental Coverage	Yes - up to $1,000
Vision Coverage	Yes - up to $200
Additional Benefits	Hearing, Fitness, OTC—$65/qtr., & other benefits. See Plan materials

Plan Name and Type

HMO - This type of plan has a network of providers. 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 in-network and out-of-network providers. Enrollees who use in-network providers may pay less out-of-pocket. Enrolleess who use out-of-network providers may pay more out-of-pocket.

Cost - This type of plan has a network of providers. Enrollees who use in-network providers may pay less out-of-pocket. If an out-of-network provider is used, standard Medicare Part A and B costs apply.

SNP - This type of plan has a network of providers. Enrolleess must meet specific requiremwents to enroll into a Special Needs Plan (SNP). Costs will vary.

Extra Benefits

Dental/Vision Coverage - The amount listed is the total the plan will pay for care in the calendar year. Some plans require the use of network providers, others offer reimbursement for any provider. Contact the 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. Check the plan's Evidence of Coverage or contact the plan for a full list of their specific additional benefits.

	Aetna Medicare Enhanced Classic Extra (PPO)	*Aetna Medicare Signature Classic Extra (PPO)*	*Aetna Medicare Signature Classic (PPO)*	*Aetna Medicare Enhanced Extra (PPO)*
Phone Number	844-509-6254	844-509-6254	844-509-6254	844-509-6254
Contract & Plan ID	*H1608-118*	*H1608-012*	*H1608-038*	*H5521-755*
Evidence of Coverage Link	Click for more details	Click for more details	Click for more details	Click for more details
Plan Overview				
Monthly Premium	$62	$0	$0	$72
Health Deductible	$0	$0	$0	$0
Maximum Out-of-Pocket	$6,500 in / $10,750 out	$5,000 in / $10,750 out	$7,150 in / $10,750 out	$7,150 in / $10,750 out
Benefits & Costs				
Primary Doctor Visit	$0 in / $35 out	$0 in / 40% out	$0 in / 50% out	$0 in / $35 out
Specialist Visit	$35 in / $65 out	$35 in / 40% out	$50 in / 50% out	$35 in / $65 out
Labs / Tests / X-rays	$0 / $0-20 / $10	$0 / $0-20 / $10	$0 / $0-25 / $15	$0 / $0-20 / $10
Emergency Room	$130	$130	$130	$130
Urgent Care	$50	$50	$50	$50
Inpatient Hospital Care	$275 per day for days 1-5 $0 days 6-90 *Potential Total = $1,375*	$300 per day for days 1-5 $0 days 6-90 *Potential Total = $1,500*	$335 per day for days 1-5 $0 days 6-90 *Potential Total = $1,675*	$325 per day for days 1-5 $0 days 6-90 *Potential Total = $1,625*
Outpatient Hospital Care	$0 - 275 per visit	$0 - 300 per visit	$0 - 335 per visit	$0 - 325 per visit
Skilled Nursing Facility Care	$0/day 1-20, $221/day 21-100	$0/day 1-20, $221/day 21-100	$0/day 1-20, $221/day 21-100	$0/day 1-20, $221/day 21-100
Ground Ambulance Physical	$245	$315	$315	$245
Therapy Prescription	$35	$40	$60	$35
Coverage				
Drug Deductible	$500	$500	$700	$700
Extra Benefits				
Dental Coverage	Yes - up to $2,000	Yes - up to $750	Yes - Preventive only	Yes - up to $2,000
Vision Coverage	Yes - up to $100	Yes - up to $100	Yes - up to $100	Yes - up to $250
Additional Benefits	Hearing, Fitness, OTC—$50/qtr., & other benefits. See Plan materials	Hearing, Fitness, & other benefits. See Plan materials	Hearing, Fitness, & other benefits. See Plan materials	Hearing, Fitness, & other benefits. See Plan materials

	Aetna Medicare Signature (PPO)	*Aetna Medicare Eagle (HMO-POS)*	*Aetna Medicare Signature (HMO-POS)*	*Blue Cross Blue Shield of Nebraska MA Assure (HMO-POS)*
Phone Number	844-509-6254	844-509-6254	844-509-6254	844-899-6060
Contract & Plan ID	*H5521-754*	*H7149-007*	*H7149-001*	*H3170-004*
Evidence of Coverage Link	Click for more details	Click for more details	Click for more details	Click for more details
Plan Overview				
Monthly Premium	$0	$0 (Part B giveback $95)	$0	$0
Health Deductible	$0	$0	$0 $4,450	$0 $5,900
Maximum Out-of-Pocket	$7,150 in / $10,750 out	$6,750 in	in	in
Benefits & Costs				
Primary Doctor Visit	$0 in / 40% out	$0	$0	$0
Specialist Visit	$45 in / 40% out	$40	$40	$45
Labs / Tests / X-rays	$0 / $0-30 / $30	$0 / $0-20 / $10	$0 / $0-20 / $15	$0 / $0-525 / $40
Emergency Room	$130	$130	$150	$130
Urgent Care	$50	$50	$50	$40
Inpatient Hospital Care	$405 per day for days 1-5 $0 days 6-90 *Potential Total = $2,025*	$325 per day for days 1-5 $0 days 6-90 *Potential Total = $1,625*	$375 per day for days 1-5 $0 days 6-90 *Potential Total = $1,875*	$525 per day for days 1-5 $0 days 6-90 *Potential Total = $2,625*
Outpatient Hospital Care	$0 - 405 per visit	$0 - 325 per visit	$0 - 375 per visit	$525 per visit
Skilled Nursing Facility Care	$0/day 1-20, $221/day 21-100	$0/day 1-20, $221/day 21-100	$0/day 1-20, $221/day 21-100	$0/day 1-10, $10/day 11-20, $218/day 21-100
Ground Ambulance	$315	$320	$320	$325
Physical Therapy	$45	$40	$40	$45
Prescription Coverage				
Drug Deductible	$500	No Drug Coverage	$700	$400
Extra Benefits				
Dental Coverage	Yes - up to $1,000	Yes - up to $1,500	Yes - up to $1,000	Yes - up to $500
Vision Coverage	Yes - up to $100	Yes - up to $200	Yes - up to $200	Yes - up to $150
Additional Benefits	Hearing, Fitness, & other benefits. See Plan materials	Hearing, Fitness, OTC—$90/qtr., & other benefits. See Plan materials	Hearing, Fitness, & other benefits. See Plan materials	Hearing, Fitness, OTC—$20/qtr., & other benefits. See Plan materials

	Blue Cross Blue Shield of Nebraska MA Connect (PPO)	***Blue Cross Blue Shield of Nebraska MA Protect (PPO)***	***Devoted Choice 001 NE (PPO)***	***Devoted Choice Giveback 002 NE (PPO)***
Phone Number	844-899-6060	844-899-6060	844-978-2770	844-978-2770
Contract & Plan ID	*H8181-002*	*H8181-004*	*H9802-001*	*H9802-002*
Evidence of Coverage Link	Click for more details	Click for more details	Click for more details	Click for more details
Plan Overview				
Monthly Premium	$0	$48	$0	$0 (Part B giveback $159.80)
Health Deductible	$0	$0	$0	$0
Maximum Out-of-Pocket	$6,650 in / $9,000 out	$5,700 in / $8,000 out	$4,800 in / $6,800 out	$9,850 in / $14,500 out
Benefits & Costs				
Primary Doctor Visit	$0 in / $15 out	$0 in / $15 out	$0 in / $5 out	$0 in / $5 out
Specialist Visit	$50 in / 40% out	$45 in / 40% out	$5-40 in/out	55 in/out
Labs / Tests / X-rays	$0 / $0-550 / $50	$0 / $0-500 / $30	$0-40 / $0-95 / $0-75	$0-55 / $0-95 / $0-75
Emergency Room	$130	$130	$130	$115
Urgent Care	$50	$40	$0-45	$0-40
Inpatient Hospital Care	$550 per day for days 1-5 $0 days 6-90 *Potential Total = $2,750*	$500 per day for days 1-5 $0 days 6-90 *Potential Total = $2,500*	$395 per day for days 1-6 $0 days 7-90 *Potential Total = $2,370*	$475 per day for days 1-5 $0 days 6-90 *Potential Total = $2,375*
Outpatient Hospital Care	$550 per visit	$500 per visit	$0 - 495 per visit	$0 - 500 per visit
Skilled Nursing Facility Care	$0/day 1-10, $10/day 11-20, $218/day 21-100	$0/day 1-10, $10/day 11-20, $218/day 21-100	$10/day 1-20, $221/day 21-100	$0/day 1-20, $218/day 21-100
Ground Ambulance Physical	$400	$350	$0-350	$0-325
Therapy Prescription	$50	$35	$20-50	$55
Coverage				
Drug Deductible	$400	$400	$650	$461
Extra Benefits				
Dental Coverage	Yes - up to $250	Yes - up to $600	Yes - up to $3,000	Yes - up to $250
Vision Coverage	Yes - up to $100	Yes - up to $200	Yes - up to $350	Yes - up to $200
Additional Benefits	Hearing, Fitness, & other benefits. See Plan materials	Hearing, Fitness, OTC—$45/qtr., & other benefits. See Plan materials	Hearing, Fitness, OTC-$62/qtr., & other benefits. See Plan materials	Hearing, Fitness & other benefits. See Plan materials

	Devoted Choice Giveback Extras 011 NE (PPO)	***Humana Gold Plus H0028-053 (HMO)***	***HumanaChoice Giveback H5216-340 (PPO)***	***HumanaChoice H5216-014 (PPO)***
Phone Number	844-978-2770	888-873-0686	888-873-0686	888-873-0686
Contract & Plan ID	*H9802-011*	*H0028-053-3*	*H5216-340*	*H5216-014*
Evidence of Coverage Link	Click for more details	Click for more details	Click for more details	Click for more details
Plan Overview				
Monthly Premium	$0 (Part B giveback $75)	$0	$0 (Part B giveback up to $63)	$51
Health Deductible	$150	$150	$500	$0
Maximum Out-of-Pocket	$7,250 in / $10,600 out	$4,400 in	$5,000 in / $10,100 out	$7,500 in / $12,000 out
Benefits & Costs				
Primary Doctor Visit	$0 in / $5 out	$0	$0 in / 50% out	0 in/out
Specialist Visit	50 in/out	$55	$45 in / 50% out	40 in/out
Labs / Tests / X-rays	$0-50 / $0-95 / $0-75	$0 / $0-100 / $0-145	$0 / $0-100 / $0-145	$0 / $0-100 / $0-145
Emergency Room	$115	$150	$130	$115
Urgent Care	$0-40	$65	$50	$40
Inpatient Hospital Care	$490 per day for days 1-5 $0 days 6-90 *Potential Total = $2,450*	$500 per day for days 1-6 $0 days 7-90 *Potential Total = $3,000*	$440 per day for days 1-5 $0 days 6-90 *Potential Total = $2,200*	$360 per day for days 1-6 $0 days 7-90 *Potential Total = $2,160*
Outpatient Hospital Care	$0 - 550 per visit	$0 - 400 per visit	$0 - 400 per visit	$0 - 400 per visit
Skilled Nursing Facility Care	$0/day 1-20, $221/day 21-100	$10/day 1-20, $221/day 21-100	$10/day 1-20, $221/day 21-100	$0/day 1-20, $221/day 21-100
Ground Ambulance	$0-345	$325	$325	$325
Physical Therapy	$50	$40	$40	$35
Prescription Coverage				
Drug Deductible	$700	$700	$700	$700
Extra Benefits				
Dental Coverage	Yes - up to $3,250	Yes - $0 copay for select services	Yes - up to $4,000	Yes - up to $2,500
Vision Coverage	Yes - up to $400	Yes - up to $100	Yes - up to $100	Yes - up to $100
Additional Benefits	Hearing, Fitness, OTC-$71/qtr., & other benefits. See Plan materials	Hearing, Fitness, OTC-$50/qtr., & other benefits. See Plan materials	Hearing, Fitness, OTC-$25/qtr., & other benefits. See Plan materials	Hearing, Fitness, OTC-$50/qtr., & other benefits. See Plan materials

	Humana USAA Honor Giveback (PPO)	***MyAdvocate Medicare Advantage GOLD (HMO-POS)***	***MyAdvocate Medicare Advantage SILVER (HMO-POS)***	**AARP Medicare Advantage from UHC NE-0002 (PPO)**
Phone Number	888-873-0686	888-960-5788	888-960-5788	800-555-5757
Contract & Plan ID	*H5216-278-1*	*H0816-001*	*H0816-002*	*H1278-020*
Evidence of Coverage Link	Click for more details	Click for more details	Click for more details	Click for more details
Plan Overview				
Monthly Premium	$0 (Part B giveback up to $150)	$82	$0	$61
Health Deductible	$0	$0	$0	$1,000
Maximum Out-of-Pocket	$4,700 in / $10,100 out	$5,500 in / $8,500 out	$6,900 in / $9,900 out	$7,150 in / $10,750 out
Benefits & Costs				
Primary Doctor Visit	$0 in / 50% out	$0 in / 50% out	$0 in / 50% out	0 in/out
Specialist Visit	$55 in / 50% out	$35 in / 50% out	$40 in / 50% out	$0 - 70 in / $100 out
Labs / Tests / X-rays	$0 / $0-100 / $0-145	$0 / $25 / $20	$0 / $35 / $25	$0 / $5 / $5
Emergency Room	$130	$120	$130	$130
Urgent Care	$50	$0 - 35	$0 - 40	$0 - 50
Inpatient Hospital Care	$375 per day for days 1-7 $0 days 8-90 *Potential Total = $2,625*	$400 per day for days 1-5 $0 days 6-90 *Potential Total = $2,000*	$400 per day for days 1-5 $0 days 6-90 *Potential Total = $2,000*	$685 per day for days 1-4 $0 days 5-90 *Potential Total = $2,740*
Outpatient Hospital Care	$0 - 400 per visit	$0 - 350 per visit	$0 - 375 per visit	$0 - 685 per visit
Skilled Nursing Facility Care	$10/day 1-20, $221/day 21-100	$0/day 1-20, $221/day 21-100	$0/day 1-20, $221/day 21-100	$0/day 1-20, $221/day 21-100
Ground Ambulance Physical	$325	$275	$325	$215
Therapy Prescription	$30	$40	$50	$30
Coverage				
Drug Deductible	No Drug Coverage	$250	$400	$685
Extra Benefits				
Dental Coverage	Yes - up to $1,500	Yes - Preventive only	Yes - up to $500	$0 cost for limited services, Optional Rider @ $54/mo. ($1,500 max.)
Vision Coverage	Yes - up to $200	Yes - up to $300	Yes - up to $300	Yes - Routine Eye Exam Only
Additional Benefits	Hearing, Fitness, OTC-$100/qtr., & other benefits. See Plan materials	Hearing, Fitness, OTC-$95/qtr., & other benefits. See Plan materials	Hearing, Fitness, OTC-$60/qtr., & other benefits. See Plan materials	Hearing, Fitness, & other benefits. See Plan materials

	AARP Medicare Advantage Patriot No Rx NE-MA01 (PPO)	AARP Medicare Advantage Patriot No Rx NE-MA2 (HMO-POS)	AARP Medicare Advantage Essentials from UHC NE-3 (HMO-POS)	AARP Medicare Advantage Extras from UHC NE-5 (HMO-POS)
Phone Number	800-555-5757	800-555-5757	800-555-5757	800-555-5757
Contract & Plan ID	*H1278-018*	*H2802-084*	H2802-001	*H2802-074*
Evidence of Coverage Link	Click for more details	Click for more details	Click for more details	Click for more details
Plan Overview				
Monthly Premium	$0 (Part B giveback $160)	$0 (Part B giveback up to $170)	$0	$0
Health Deductible	$0	$0	$0 $6,400	$0 $7,150
Maximum Out-of-Pocket	$7,150 in / $10,750 out	$7,150 in	in	in
Benefits & Costs				
Primary Doctor Visit	0 in/out	$0	$0	$0
Specialist Visit	$0-70 in / $90 out	$0 - 70 in	$0 - 70	$0 - 70
Labs / Tests / X-rays	$0/$50 / $30	$0 / $50 / $30	$0 / $10 / $5	$0 / $5 / $5
Emergency Room	$130	$130	$130	$130
Urgent Care	$0 - 50	$0 - 50	$0 - 50	$0 - 50
Inpatient Hospital Care	$685per day for days 1-4 $0 days 5-90 *Potential Total = $2,740*	$685 per day for days 1-4 $0 days 5-90 *Potential Total = $2,740*	$550 per day for days 1-5 $0 days 6-90 *Potential Total = $2,750*	$685 per day for days 1-4 $0 days 5-90 *Potential Total = $2,740*
Outpatient Hospital Care	$0 - 685 per visit	$0 - 685 per visit	$0 - 550 per visit	$0 - 685 per visit
Skilled Nursing Facility Care	$0/day 1-20, $221/day 21-100	$0/day 1-20, $221/day 21-100	$0/day 1-20, $221/day 21-100	$0/day 1-20, $221/day 21-100
Ground Ambulance Physical	$350	$350	$300	$150
Therapy Prescription	$70	$70	$60	$70
Coverage				
Drug Deductible	No Drug Coverage	No Drug Coverage	$685	$685
Extra Benefits				
Dental Coverage	Yes - up to $2,500	Yes - up to $3,000	$0 cost for limited services, Optional Rider @ $54/mo.. ($1,500 max.)	Yes - up to $2,000
Vision Coverage	Yes - up to $250	Yes - up to $250	Yes - up to $150	Yes - up to $200
Additional Benefits	Hearing, Fitness, OTC—$50/qtr., & other benefits. See Plan materials	Hearing, Fitness, OTC—$50/qtr., & other benefits. See Plan materials	Hearing, Fitness, & other benefits. See Plan materials	Hearing, Fitness, & other benefits. See Plan materials

	Wellcare Giveback (HMO-POS)	***Wellcare Simple (HMO-POS)***
Phone Number	844-480-0680	844-480-0680
Contract & Plan ID	*H1215-003*	*H1215-005*
Evidence of Coverage Link	Click for more details	Click for more details
Plan Overview		
Monthly Premium	$0 (Part B giveback $20)	$0
Health Deductible	$375	$250
Maximum Out-of-Pocket	$8,850 in	$7,100 in
Benefits & Costs		
Primary Doctor Visit	$0	$0
Specialist Visit	$55	$50
Labs / Tests / X-rays	$0-50 / $0-50 / $50	$0-50 / $0-50 / $25
Emergency Room	$115	$130
Urgent Care	$35	$50
Inpatient Hospital Care	$1,450 per stay	$500 per day for days 1-5 $0 days 6-90 *Potential Total = $2,500*
Outpatient Hospital Care	$0 - 450 per visit	$0 - 500 per visit
Skilled Nursing Facility Care	$0/day 1-20, $221/day 21-70, $0/day 71-100	$0/day 1-20, $221/day 21-60, $0/day 61-100
Ground Ambulance	$315	$350
Physical Therapy	$35	$35
Prescription Coverage		
Drug Deductible	$700	$700
Extra Benefits		
Dental Coverage	Yes - See Plan materials	Yes - See Plan materials
Vision Coverage	Not Covered	Not Covered
Additional Benefits	Hearing, Fitness, & other benefits. See Plan materials	Fitness, & other benefits. See Plan materials