2017 Medicare Advantage Plans	Summary of Benefits Table (St. Bernard Parish)		
	HumanaChoice (PPO)	HumanaChoice * (PPO without Drug Coverage)	HumanaChoice (PPO)
Contract ID/Plan ID	R5826-011	R5826-068 *	R5826-078
Organization/Company Name	Humana Insurance Co	Humana Insurance Co	Humana Ins Co
Type of Medicare Plan	Regional PPO	Regional PPO *	Regional PPO
Monthly Consolidated Premium (includes part C & D)	$77	$0	$47
Health Plan Deductible	$1,000 annual deductible	$1,000 annual deductible	$1,000 annual deductible
Primary Care Provider Co-pay	$15	$10 / $35	$15 / 30%
Specialist Co-pay	$15 - 50	$10 - $35 / $50	$25 - $50 / 30%
ER	$75 per visit (always covered)	$75 per visit (always covered)	$75 per visit (always covered)
Ambulance	$265 or 20%	$265 or 20%	$265 or 20%
Skilled Nursing	$0 per day (days 1-20) $164.50 per day (days 21-100)	$0 per day (days 1-20) $164.50 per day (days 21-100)	$0 per day (days 1-20) $164.50 per day (days 21-100)
Inpatient Hospital	$275 per day (days 1-7) $0 per day (days 8-90) $0 per day (days 91 & beyond)	$195 per day (days 1-6) $0 per day (days 7-90) $0 per day (days 91 & beyond)	$275 per day (days 1-7) $0 per day (days 8-90) $0 per day (days 91 & beyond)
Annual Drug Deductible	$400 (only on certain Tiers)	* NO drug coverage	$400 (only on certain Tiers)
Additional Coverage in Gap	Yes	* NO drug coverage	No Gap coverage
Chemo Drugs	20% (Part B)	20% / 30% (Part B)	20% / 30%
Out-of-Pocket Maximum	$6,700 / $10,000	$6,700 / $10,000	$6,700 / $10,000

2017 Medicare Advantage Plans	Summary of Benefits Table (St. Bernard Parish)		
	AAA4 Vantage Traditional Plus (HMO)	AAA9 Vantage Capitol (HMO-POS)	WellCare Value (HMO)
Contract ID/Plan ID	H5576-008	H5576-021	H2491-007
Organization/Company Name	Vantage Health Plan Inc	Vantage Health Plan Inc	WellCare Health Plans
Type of Medicare Plan	HMO	HMO-POS	HMO
Monthly Consolidated Premium (includes part C & D)	$32.80	$0	$0
Health Plan Deductible	$166 annual deductible	$350 Out-of-Network deductible	$0
Primary Care Provider Co-pay	$10	$25 or 0-20% | POS 50%	$5
Specialist Co-pay	20% after $166 deductible	$50 or 0-20% | POS 50%	$35
ER	20% per visit (always covered)	$75 per visit (always covered)	$75
Ambulance	20% after $166 deductible	$250	$250
Skilled Nursing	$0 per day (days 1-20) $164.50 per day (days 21-100)	$0 per day (days 1-20) $164 per day (days 21-100)	$0 per day (days 1-20) $164.50 per day (days 21-100)
Inpatient Hospital	$1,288 deductible (days 1-60) $322 per day (days 61-90) $644 per day (days 91-150)	$335 per day (days 1-5) $0 per day (days 6-90) Point-of-Service 50% per stay	$250 per day (days 1-7) $0 per day (days 8-90)
Annual Drug Deductible	$400	$350 (only on certain Tiers)	$0
Additional Coverage in Gap	No Gap coverage	No Gap coverage	No Gap coverage
Chemo Drugs	20% (Part B)	20% (Part B)	20% (Part B)
Out-of-Pocket Maximum	$6,700	$6,700	$6,700