2018 Medicare Advantage Plans

La Salle

Medicare Advantage Plans	HumanaChoice	HumanaChoice	HumanaChoice	HumanaChoice(PPO)
	800-833-2364	800-833-2364	800-833-2364	800-833-2364
Contract ID	R0110-003	R0110-001	R0110-002	H5216-064
Organization Name	Humana Insurance Company	Humana Insurance Company	Humana Insurance Company	Humana Insurance Company
Type of Medicare Plan	Regional PPO	Regional PPO	Regional PPO	Local HMO
Monthly Consolidated Premium	$87	$0	$53	$47
Health Plan Deductible	$1,000 annual deductible	$1,000 annual deductible	$1,000 annual deductible	$1000 annual deductible
PCP Co-Pay	$15	$10/ $35	$15/ 30%	$5 30%
Specialist Co-Pay	$50 $40-$60	$35/ $50	$50/ 30%	$45 30%
ER	$80 per visit (always covered)	$80 per visit (always covered)	$80 per visit (always covered)	$80 per visit (always covered)
Ambulance	$265 or 20%	$265 or 20%	$265 or 20%	$265 or 20%
Skilled Nursing	$0 for days 1 through 20 $164.50 for days 21 through 100	$0 for days 1 through 20 $164.50 for days 21 through 100	$0 for days 1 through 20 $164.50 for days 21 through 100	$0 per day (days 1-20) $164.50 per day (days 21-100)
Inpatient Hospital	$275 for days 1 through 7 $0 for days 8 through 90 $0 for days 91 and beyond	$195 for days 1 through 6 $0 for days 7 through 90 $0 for days 91 and beyond	$275 for days 1 through 7 $0 for days 8 through 90 $0 for days 91 and beyond	$225 per day (days 1-7) $0 per day (days 8-90) $0 per day (days 91 & beyond)
Annual Drug Deductible	$400	Drugs not covered	$300	$400
Additional Coverage in the Gap	No	Drugs not covered	No	No
Chemo Drugs	20% 17%-20%	20% 30%	20% 30%	20% 30%
Out-of-Pocket Maximum	$6,700/ $10,000	$6,700/ $10,000	$6,700/ $10,000	$6,700 / $10,000

2018 Medicare Advantage Plans

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Medicare Advantage Plans	AAA8 Vantage Basic	AAA Vantage Standard	AAA1 Vantage Premium	AAA4 Vantage Traditional Plus
	866-704-0109	866-704-0109	866-704-0109	866-704-0109
Contract ID	H5576-020	H5576-017	H5576-018	H5576-008
Organization Name	Vantage Health Plan	Vantage Health Plan	Vantage Health Plan	Vantage Health Plan
Type of Medicare Plan	Local HMO	Local HMO	Local HMO	Local HMO
Monthly Consolidated Premium	$0	$59	$169	$31.00
Health Plan Deductible	$500 Out-of-network	$500 Out-of-network	$500 Out-of-network	Contact Plan
PCP Co-Pay	$35 or 0%-20% 50%	$20 or 0%-20% 50%	$15 or 0%-20% 50%	$10 or 20%
Specialist Co-Pay	$50 or 0%-20% 50%	$50 or 0%-20% 50%	$40 or 0%-20% 50%	20%
ER	$80 per visit (always covered)	$80 per visit (always covered)	$80 per visit (always covered)	$80 per visit (always covered)
Ambulance	$250	$250	$250	20%
Skilled Nursing	$0 for days 1 through 20 $167 for days 21 through 100	$0 for days 1 through 20 $167 for days 21 through 100	$0 for days 1 through 20 $167 for days 21 through 100	Contact Plan
Inpatient Hospital	$360 for days 1 through 5 $0 for days 6 through 90	$325 for days 1 through 5 $0 for days 6 through 90	$275 for days 1 through 5 $0 for days 6 through 90	Contact Plan
Annual Drug Deductible	$380	$250	$0	$405
Additional Coverage in the Gap	No	No	Yes	No
Chemo Drugs	20% 50%	20%	20% 50%	20%
Out of Pocket Maximum	$6,700	$5,500	$3,000	$6,700