

<b>2017 Summary of Benefits Table (West Feliciana Parish)</b>			
<b>Medicare Advantage Plans</b>	<b>Humana Gold Plus (HMO)</b>	<b>Humana Gold Plus * (HMO without Drug Coverage)</b>	<b>HumanaChoice (PPO)</b>
Contract ID/Plan ID	H1951-048	H1951-030 *	R5826-011
Organization/Company Name	Humana Health Benefit Plan of Louisiana Inc	Humana Insurance Co	Humana Insurance Co
Type of Medicare Plan	Local HMO	Local HMO *	Regional PPO
Monthly Consolidated Premium (includes part C & D)	\$36	\$0	\$77
Health Plan Deductible	\$0	\$0	\$1,000 annual deductible
Primary Care Provider Co-pay	\$10	\$5	\$15
Specialist Co-pay	\$10 - \$50	\$5 - \$50	\$15 - \$50
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	\$150 per day (days 1-10) \$0 per day (days 11-90) \$0 per day (days 91 & beyond)	\$110 per day (days 1-10) \$0 per day (days 11-90) \$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	Yes
Chemo Drugs	20% (Part B)	20% (Part B)	20% (Part B)
Out-of-Pocket Maximum	\$6,700	\$6,700	\$6,700 / \$10,000

<b>2017 Summary of Benefits Table (West Feliciana Parish)</b>			
<b>Medicare Advantage Plans</b>	<b>HumanaChoice * (PPO without Drug Coverage)</b>	<b>HumanaChoice (PPO)</b>	<b>Peoples Health Choices 65 #14 (HMO)</b>
Contract ID/Plan ID	R5826-068 *	R5826-078	H1961-014
Organization/Company Name	Humana Insurance Co	Humana Ins Co	Peoples Health
Type of Medicare Plan	Regional PPO *	Regional PPO	Local HMO
Monthly Consolidated Premium (includes part C & D)	\$0	\$47	\$0
Health Plan Deductible	\$1,000 annual deductible	\$1,000 annual deductible	\$0
Primary Care Provider Co-pay	\$10 / \$35	\$15 / 30%	\$5
Specialist Co-pay	\$10 - \$35 / \$50	\$25 - \$50 / 30%	\$45
ER	\$75 per visit (always covered)	\$75 per visit (always covered)	\$75 per visit (always covered)
Ambulance	\$265 or 20%	\$265 or 20%	\$220
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) \$155 per day (days 21-100)
Inpatient Hospital	\$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)	\$85 per day (days 1-10) \$0 per day (days 11-90)
Annual Drug Deductible	* NO drug coverage	\$400 (only on certain Tiers)	\$0 (No deductible)
Additional Coverage in Gap	* NO drug coverage	No Gap coverage	Yes
Chemo Drugs	20% / 30% (Part B)	20% / 30%	20% (Part B)
Out-of-Pocket Maximum	\$6,700 / \$10,000	\$6,700 / \$10,000	\$6,700

2017 Summary of Benefits Table (West Feliciana Parish)			
Medicare Advantage Plans	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