



## 2018 Medicare Advantage Plans Natchitoches



Medicare Advantage Plans	HumanaChoice	HumanaChoice	HumanaChoice	HumanaChoice
	800-833-2364	800-833-2364	800-833-2364	800-833-2364
Contract ID	H5525-015	R0110-001	R0110-002	R0110-003
Organization Name	Humana Benefit Plan of Illinois Inc.	Humana Insurance Company	Humana Insurance Company	Humana Insurance Company
Type of Medicare Plan	Local PPO	Regional PPO	Regional PPO	Regional PPO
Monthly Consolidated Premium	\$47	\$0	\$53	\$87
Health Plan Deductible	\$1,000 Out-of-Network	\$1,000 annual deductible	\$1,000 annual deductible	\$1,000 annual deductible
PCP Co-Pay	\$5/30%	\$10/\$35	\$15/30%	\$15
Specialist Co-Pay	\$45/30%	\$35/\$50	\$50/30%	\$50/\$40-\$60
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 per day (days 1-20) \$164.50 per day (days 21-100)	\$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 for days 1 through 20 \$164.50 for days 21 through 100
Inpatient Hospital	\$225 per day (days 1-7) \$0 per day (days 8-90) \$0 per day (days 91 & 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	\$275 for days 1 through 7 \$0 for days 8 through 90 \$0 for days 91 and beyond
Annual Drug Deductible	\$400	Drugs not covered	\$300	\$400
Additional Coverage in the Gap	No	Drugs not covered	No	No
Chemo Drugs	20%/30%	20%/30%	20%/ 30%	20%/ 17%-20%
Out-of-Pocket Maximum	\$6,700 / \$10,000	\$6,700/ \$10,000	\$6,700/ \$10,000	\$6,700/ \$10,000



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Medicare Advantage Plans	AAA0 Vantage Standard	AAA1 Vantage Premium	AAA4 Vantage Traditional Plus	AAA8 Vantage Basic
	866-704-0109	866-704-0109	866-704-0109	866-704-0109
Contract ID	H5576-017	H5576-018	H5576-008	H5576-020
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	\$59	\$169	\$31.00	\$0
Health Plan Deductible	\$500 Out of network	\$500 Out-of network	Contact Plan	\$500 Out-of network
PCP Co-Pay	\$20 or 0%- 20% 50%	\$15 or 0%- 20% 50%	\$10 or 20%	\$35 or 0-20% 50%
Specialist Co-Pay	\$50 or 0%- 20% 50%	\$40 or 0%- 20% 50%	20% per visit	\$50 or 0-20% 50%
ER	\$80 per visit ( always covered)	\$80 per visit ( always covered)	\$80 per visit (always covered)	\$80 per visit ( always covered)
Ambulance	\$250	\$250	20%	\$250
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	Contact Plan	\$0 for days 1 through 20 \$167 for days 21 through 100
Inpatient Hospital	\$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	\$360 for days 1 through 5 \$0 for days 6 through 90
Annual Drug Deductible	\$250	\$0	\$405	\$380
Additional Coverage in the Gap	No	Yes	No	No
Chemo Drugs	20%/50%	20% / 50%	20%	20% / 50%
Out of Pocket Maximum	\$5,500	\$3,000	\$6,700	\$6,700