2018 Medicare Advantage Plans
Pointe Coupee

Medicare Advantage Plans	Blue Advantage	Humana Gold Plus (HMO)	Humana Gold Plus * (HMO without Drug Coverage)	HumanaChoice (PPO)
	800-363-9152	800-833-2362	800-833-2363	800-833-2364
Contract ID	H6453-001	H1951-048	H1951-030 *	R0110-003
Organization Name	HMO Louisiana	Humana Health Benefit Plan of Louisiana Inc	Humana Insurance Company	Humana Insurance Company
Type of Medicare Plan	Local HMO	Local HMO	Local HMO *	Regional PPO
Monthly Consolidated Premium	$0	$24	$0	$87
Health Plan Deductible	$0	$0	$0	$1,000 annual deductible only for out-of-network
PCP Co-Pay	$0	$10	$5	$15
Specialist Co-Pay	$40	$50	$50	$50 $40-$60 Out-of-Network
ER	$80 per visit (always covered)	$80 per visit (always covered)	$80 per visit (always covered)	$80 per visit (always covered)
Ambulance	$245	$265 or 20%	$265 or 20%	$265 or 20%
Skilled Nursing	$0 for days 1-20 $165 for 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)	$0 per day (days 1-20) $164.50 per day (days 21-100)
Inpatient Hospital	$125 for days 1-10 $0 for days 11-90 $125 for days 91-100 $0 for days 101 & beyond	$150 per day (days 1-10) $0 per day (days 11-90) $0 for days 91 & beyond	$110 per day (days 1-10) $0 per day (days 11-90) $0 for days 91 & beyond	$275 per day (days 1-7) $0 per day (days 8-90) $0 for days 91 & beyond
Annual Drug Deductible	$0	$400 (only on certain Tiers)	* NO drug coverage	$400 (only on certain Tiers)
Additional Coverage in the Gap	Yes	No	* NO drug coverage	No
Chemo Drugs	20% (Part B)	20% (Part B)	20% (Part B)	20% (Part B)
Out-of-Pocket Maximum	$6,700	$6,700	$6,700	$6,700 / $10,000

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Medicare Advantage Plans	HumanaChoice * (PPO without Drug Coverage)	HumanaChoice (PPO)	Peoples Health Choices 65 #14 (HMO)	AAA4 Vantage Traditional Plus (HMO)
	800-833-2365	800-833-2365	866-301-8865	866-704-0108
Contract ID	R0110-001 *	R0110-002	H1961-014	H5576-008
Organization Name	Humana Insurance Company	Humana Insurance Company	Peoples Health	Vantage Health Plan
Type of Medicare Plan	Regional PPO *	Regional PPO	Local HMO	Local HMO
Monthly Consolidated Premium	$0	$53	$0	$30.90
Health Plan Deductible	$1,000 annual deductible only for out-of-network	$1,000 annual deductible only for out-of-network	$0	$183 per year
PCP Co-Pay	$10 / $35	$15 30% out-of-network	$5	$10 or 20% per visit
Specialist Co-Pay	$35 / $50	$50 $35 out-of-network	$35	20% per visit
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%	$235	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) $165 per day (days 21-100)	$0 for days 1 through 20 $167 per day (days 21-100)
Inpatient Hospital	$195 per day (days 1-6) $0 per day (days 7-90) $0 for days 91 & beyond	$275 per day (days 1-7) $0 per day (days 8-90) $0 for days 91 & beyond	$85 per day (days 1-10) $0 per day (days 11-90)	$1.316 deductible for days 1-60 $329 copay per day (61-90) $658 copay per day (91-150)
Annual Drug Deductible	* NO drug coverage	$300 (only on certain tiers)	$0	$405
Additional Coverage in the Gap	* NO drug coverage	No	Yes	No
Chemo Drugs	20% / 30% (Part B)	20% (Part B)	20% (Part B)	20% (Part B)
Out-of-Pocket Maximum	$6,700 / $10,000	$6,700 / $10,000	$6,700	$6,700

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Medicare Advantage Plans	AAA0 Vantage Standard	AAA1 Vantage Premium	AAA8 Vantage Basic	WellCare Value (HMO)
	866-704-0109	866-704-0109	866-704-0109	866-527-0056
Contract ID	H5576-017	H5576-018	H5576-020	H2491-007
Organization Name	Vantage Health Plan	Vantage Health Plan Inc	Vantage Health Plan	WellCare Health Plans
Type of Medicare Plan	Local HMO	HMO-POS	HMO-POS	HMO
Monthly Consolidated Premium	$59	$169	$0	$0
Health Plan Deductible	$500 Out-of network	$500 annual deductible only for out-of-network	$500 annual deductible only for out-of-network	$0
PCP Co-Pay	$20 / 0%- 20%/50%	$15 or 0-20% | POS 50%	$35 or 0-20% | POS 50%	$0
Specialist Co-Pay	$50 / 0%- 20%/50%	$40 or 0-20% | POS 50%	$50 0-20% | POS 50%	$35
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	$250
Skilled Nursing	$0 for days 1 through 20 $167 for days 21 through 100	$0 per day (days 1-20) $167 per day (days 21-100)	$0 per day (days 1-20) $167 per day (days 21-100)	$0 per day (days 1-20) $164.50 per day (days 21-100)
Inpatient Hospital	$325 for days 1 through 5 $0 for days 6 through 90	$275 per day (days 1-5) $0 per day (days 6-90) Point-of-Service 50% per stay	$360 per day (days 1-5) $0 per day (days 6-90) Point-of-Service 50% per stay	$195 per day (days 1-9) $0 per day (days 10-90)
Annual Drug Deductible	$250	$0	$380 (only on certain tiers)	$0
Additional Coverage in the Gap	Yes	Yes	No	No
Chemo Drugs	20%/50%	20% (Part B)	20% (Part B)	20% (Part B)
Out-of-Pocket Maximum	$5,500	$3,000	$6,700	$6,700