2018 Medicare Advantage Plans
Tensas

Medicare Advantage Plans	Humana Gold Plus (HMO)	HumanaChoice	HumanaChoice	HumanaChoice
	800-833-2364	800-833-2364	800-833-2364	800-833-2364
Contract ID	H1951-049	R0110-001	R0110-002	R0110-003
Organization Name	Humana Health Benefit Planof LA Inc	Humana Insurance Company	Humana Insurance Company	Humana Insurance Company
Type of Medicare Plan	HMO	Regional PPO	Regional PPO	Regional PPO
Monthly Consolidated Premium	$0	$0	$53	$87
Health Plan Deductible	$0	$1,000 annual deductible	$1,000 annual deductible	$1,000 annual deductible
PCP Co-Pay	$15	$10/$35	$15/30%	$15
Specialist Co-Pay	$45	$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	$215 per day (days 1-8) $0 per day (days 9-90) $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	$200	Drugs not covered	$300	$400
Additional Coverage in the Gap	Talk with Plan	Drugs not covered	Talk with Plan	Talk with Plan
Chemo Drugs	20%	20%/30%	20%- 30%	20%/ 17%-20%
Out-of-Pocket Maximum	$6,700	$6,700/ $10,000	$6,700/ $10,000	$6,700/ $10,000

2018 Medicare Advantage Plans

Tensas

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 0%- 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	$0 for days 1 through 20 $167 for days 21 through 100	$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	$1,316 for days 1 through 60 $329 for days 61 thorugh 90 $658 for days 91 through 150	$360 for days 1 through 5 $0 for days 6 through 90
Annual Drug Deductible	$250	$0	$405	$380
Additional Coverage in the Gap	Talk with Plan	Talk with Plan	Talk with Plan	Talk with Plan
Chemo Drugs	20%/50%	20% / 50%	20%	20% / 50%
Out of Pocket Maximum	$5,500	$3,000	$6,700	$6,700