2018 Medicare Advantage Plans

Lafayette

Medicare Advantage Plans	HumanaChoice	HumanaChoice	HumanaChoice	HumanaChoice(PPO)
	800-833-2364	800-833-2364	800-833-2364	800-833-2364
Contract ID	R0110-001	R0110-002	R0110-003	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 PPO
Monthly Consolidated Premium	$0	$53	$87	$47
Health Plan Deductible	$1,000 annual deductible	$1,000 annual deductible	$1,000 annual deductible	$1000 annual deductible
PCP Co-Pay	$10 $35	$15 30%	$15	$5 30%
Specialist Co-Pay	$35 $50	$50 30%	$50 $40-$60	$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	$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	$225 per day (days 1-7) $0 per day (days 8-90) $0 per day (days 91 & beyond)
Annual Drug Deductible	Drugs not covered	$300	$400	$400
Additional Coverage in the Gap	Drugs not covered	No	No	No
Chemo Drugs	20% 30%	20% 30%	20% 17%-20%	20% 30%
Out-of-Pocket Maximum	$6,700/ $10,000	$6,700/ $10,000	$6,700/ $10,000	$6,700 / $10,000

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Lafayette

Medicare Advantage Plans	Humana Gold Plus	AAA8 Vantage Basic	AAA1 Vantage Premium	AAA0 Vantage Standard
	800-833-2364	866-704-0109	866-704-0109	866-704-0109
Contract ID	H1951-049	H5576-020	H5576-018	H5576-017
Organization Name	Humana Health Benefit Plan of LA	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	$0	$169	$59
Health Plan Deductible	$0	$500 Out-of-network	$500 Out-of-network	$500 Out-of-network
PCP Co-Pay	$5	$35 or 0%- 20% 50%	$15 or 0%- 20% 50%	$20 or 0%-20% 50%
Specialist Co-Pay	$40	$50 or 0%- 20% 50%	$40 or 0%- 20% 50%	$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	$265 or 20%	$250	$250	$250
Skilled Nursing	$0 for days 1 through 20 $164.50 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	$215 for days 1 through 7 $0 for days 8 through 90 $0 for days 91 and beyond	$360 for days 1 through 5 $0 for days 6 through 90	$275 for days 1 through 5 $0 for days 6 through 90	$325 for days 1 through 5 $0 for days 6 through 90
Annual Drug Deductible	$200	$380.00	0	$250
Additional Coverage in the Gap	No	No	Yes	No
Chemo Drugs	20%	20% 50%	20% 50%	20% 50%
Out-of-Pocket Maximum	$6,700	$6,700	$3,000	$5,500

2018 Medicare Advantage Plans
Lafayette

Medicare Advantage Plans	AAA4 Vantage Traditional Plus	Blue Advantage	Peoples Health Choices Gold	WellCare Value
	866-704-0109	800-363-9152	Peoples Health Choices Gold	866-527-0056
Contract ID	H5576-008	H6453-004	H1961-017	H2491-007
Organization Name	Vantage Health Plan	HMO LA	Peoples Health	WellCare Health
Type of Medicare Plan	Local HMO	Local HMO	Local HMO	Local HMO
Monthly Consolidated Premium	$31.00	$0	$0	$0
Health Plan Deductible	Contact Plan	$0	$0	$0
PCP Co-Pay	$10 or 20%	$0	$10	$0
Specialist Co-Pay	20%	$40	$35	$35
ER	$80 per visit (always covered)	$80 per visit (always covered)	$80 per visit (always covered)	$80 per visit (always covered)
Ambulance	20%	$245	$235	$250
Skilled Nursing	$0 for days 1 through 20 $167 for days 21 through 99	$0 for days 1 through 20 $165 for days 21 through 100	$0 for days 1 through 20 $160 for days 21 through 100	$0 for days 1 through 20 $164.50 for days 21 through 100
Inpatient Hospital	$1,316 deductible for days 1-60 $329 copay perday (61-90) $658 copay perday (91-150)	$195 for days 1 through 10 $0 for days 11 through 90 $195 for days 91 through 100 $0 for days 101 and beyond	$195 for days 1 through 7 $0 for days 8 through 90	$195 for days 1 through 9 $0 for days 10 through 90
Annual Drug Deductible	$405	$0	$0	$0
Additional Coverage in the Gap	No	No	Yes	No
Chemo Drugs	20%	20%	20%	20%
Out-of-Pocket Maximum	$6,700	$6,700	$6,700	$6,700