2017 Medicare Advantage Plans	Summary of Benefits Table (Evangeline Parish)			
	HumanaChoice	HumanaChoice	HumanaChoice	Peoples Health Choices Gold
Contract ID/Plan ID	R5826-011	R5826-068	R5826-078	H1961-017
Organization Name	Humana Insurance Company	Humana Insurance Company	Humana Insurance Company	Peoples Health
Type of Medicare Plan	Regional PPO	Regional PPO	Regional PPO	Local HMO
Monthly Consolidated Premium (includes part C & D)	$77	$0	$47	$0
Health Plan Deductible	$1,000 annual deductible	$1,000 annual deductible	$1,000 annual deductible	$0
PCP Co-pay	$15	$10/ $35	$15/ 30%	$10
Specialist Co-pay	$15- $50	$10- $35/ $50	$25- $50/ 30%	$40
ER	$75 per visit (always covered)	$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%	$220
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 for days 1 through 20 $160 for days 21 through 100
Inpatient Hospital	$275 for days 1 through 7 $0 for days 8 through 90 $0 for days 91 and 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	$195 for days 1 through 7 $0 for days 8 through 90
Annual Drug Deductible	$400	Drugs not covered	$400	$0
Additional Coverage Offered in the Gap	$6- $100 and/or 25%- 51%	Drugs not covered	40%- 51%	$0- $15 and/or 40%- 51%
Chemo Drugs	20%/ 19%- 25%	20%- 30%	20%/ 30%	20%
Out-of-Pocket Maximum	$6,700/ $10,000	$6,700/ $10,000	$6,700/ $10,000	$6,700

Summary of Benefits Table (Evangeline Parish)				
Medicare Advantage Plans	AAA0 Vantage Standard	AAA1 Vantage Premium	AAA4 Vantage Traditional Plus	AAA8 Vantage Basic
Contract ID/Plan ID	H5576-017	H5576-018	H5576-008	H5576-020
Organization Name	Vantage Health	Vantage Health Plan	Vantage Health Plan	Vantage Health Plan
Type of Medicare Plan	Local HMO	Local HMO	Local HMO	Local HMO
Monthly Consolidated Premium (includes part C & D)	$35	$151	$32.80	$0
Health Plan Deductible	$350 Out-of-network	$350 Out-of-network		$350 Out-of-network
PCP Co-pay	$15 0%- 20%	$10 0%- 20%	$10 0%- 20%	$25 0%- 20%
Specialist Co-pay	$45 0%- 20%	$40 0%- 20%	20%	$50 0%- 20%
ER	$75 per visit (always covered)	$75 per visit (always covered)	20% per visit (always covered)	$75 per visit (always covered)
Ambulance	$250	$250	20%	$250
Skilled nursing	$0 for days 1 through 20 $164 for days 21 through 100	$0 for days 1 through 20 $164 for days 21 through 100		0 for days 1 through 20 $164 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		360 for days 1 through 5 $0 for days 6 through 90
Annual Drug Deductible	$0	$0	$400	$350
Additional Coverage Offered in the Gap	40%- 51%	$0- $4 and/or 40%- 51%	40%- 51%	40%- 51%
Chemo Drugs	20%	20%	20%	20%
Out-of-Pocket Maximum	$5,900	$3,600	$6,700	$6,700