



2020 Medicare Advantage Plans

St. John the Baptist



Medicare Advantage Plans	Blue Advantage HMO	Blue Advantage PPO	HumanaChoice	Humana Honor
Phone Number	800-363-9152	800-363-9152	800-833-2364	800-833-2364
Contract ID	H6453-002-0	H1248-002-0	H5216-064	H5216-201
Medicare Plan Type	HMO Louisiana, HMO	Blue Cross Blue Shield of Louisiana, PPO	Humana, Regional PPO	Humana, Local PPO
Monthly Consolidated Premium	\$0	\$75	\$44.00	\$0
Health Plan Deductible	\$0	\$1000 Out-of-Network	\$1000 out of network	\$1000 Out-of Network
PCP Co-Pay	\$0	\$0	\$5.00	\$0
Specialist Co-Pay	\$35	\$35	\$45.00	\$35
ER	\$90	\$90	\$90.00	\$90
Ambulance	\$260	\$260	\$265.00	\$265
Inpatient Hospital	\$125 per day: Days 1-10	\$175 per day: Days 1-10	\$225 per day for days 1-7	\$195 per day: Days 1-6
Annual Drug Deductible	\$0	\$0	\$400.00	*No Drugs Covered
Additional Coverage in the Gap	Yes	Yes	No	
Out-of-Pocket Maximum	\$5,500 In-Network	\$3,500 In-Network; \$7,000 Combined	\$6,700 in network; \$10,000 combined	\$6,700 In-Network; \$10,000 Combined



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Medicare Advantage Plans	HumanaChoice	Humana Gold Plus	HumanaChoice (No Rx Coverage)	HumanaChoice
Phone Number	800-833-2364	800-833-2364	800-833-2364	800-833-2364
Contract ID	H5216-202	H1951-047-2	R0110-001	R0110-002
Medicare Plan Type	Humana, Local PPO	Humana, HMO	Humana, Regional PPO	Humana, Regional PPO
Monthly Consolidated Premium	\$78	\$21	\$0.00	\$82.00
Health Plan Deductible	\$1000 Out-of-Network	\$0	\$1000 out of network	\$1000 out of network
PCP Co-Pay	\$15	\$5	\$0 in network	\$15 in network
Specialist Co-Pay	\$50	\$50	\$35 in network	\$50 in network
ER	\$90	\$90	\$90.00	\$90.00
Ambulance	\$265	\$265	\$265.00	\$265.00
Inpatient Hospital	\$275 per day: Days 1-7	\$195 per day: Days 1-10	\$195 per day for days 1-6	\$275 per day for days 1-7
Annual Drug Deductible	\$400	\$0	No Drugs Covered	\$415.00
Additional Coverage in the Gap	No	No		No
Out-of-Pocket Maximum	\$6,700 In-Network; \$10,000 Combined	\$3,700	\$6,700 in network; \$10,000 combined	\$6,700 in network; \$10,000 combined



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Medicare Advantage Plans	HumanaChoice	Lasso Healthcare	Peoples Health Choices 65 #14	AAA0 Vantage Standard
Phone Number	800-833-2364	866-766-2583	800-536-3570	866-704-0109
Contract ID	R0110-003	H1924-001	H1961-014-1	H5576-017-2
Medicare Plan Type	Humana, Regional PPO	Medicare Saving Acct.	Peoples Health, HMO	Vantage Health Plan Inc, Local HMO
Monthly Consolidated Premium	\$110.00	\$0.00	\$0	\$69
Health Plan Deductible	\$1000 out of network	\$9,400	\$0	\$500 Out-of-Network
PCP Co-Pay	\$15 in network	Nothing until deductible	\$0	\$15
Specialist Co-Pay	\$50 in network	Nothing until deductible	\$30	\$45
ER	\$90.00	Nothing until deductible	\$90	\$90
Ambulance	\$265.00	Nothing until deductible	\$235	\$250
Inpatient Hospital	\$275 per day for days	Nothing until deductible	\$85 per day: Days 1-10	\$270 per day: Days 1-7 In-Network
Annual Drug Deductible	\$400.00	*No Drugs Covered	\$0	\$275
Additional Coverage in the Gap	No		Yes	No
Out-of-Pocket Maximum	\$6,700 in network; \$10,000 combined	\$9,400	\$6,700 In-Network	\$5,500



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Medicare Advantage Plans	AAA1 Vantage Premium	AAA4 Vantage Traditional Plus	AAA8 Vantage Basic	WellCare Value
Phone Number	866-704-0109	866-704-0109	866-704-0109	866-527-0056
Contract ID	H5576-018-2	H5576-008-0	H5576-020-2	H2491-007-0
Medicare Plan Type	Vantage Health Plan Inc, Local HMO	Vantage Health Plan Inc, Local HMO	Vantage Health Plan Inc, Local HMO	Wellcare Value HMO
Monthly Consolidated Premium	\$179	\$32.20	\$0	\$0
Health Plan Deductible	\$0	\$500 Out of Network	\$500 Out-of-Network	\$0
PCP Co-Pay	\$10	\$10 or 20%	\$15	\$0
Specialist Co-Pay	\$40	20% after Pt B	\$45	\$30
ER	\$90	\$90	\$90	\$125
Ambulance	\$250	20%	\$250	\$275
Inpatient Hospital	\$250 per day: Days 1-7	\$1364 per Benefit Period	\$290 per day: Days 1-7	\$225 per day: Days 1-9
Annual Drug Deductible	\$0	\$435	\$435	\$0
Additional Coverage in the Gap	Yes	No	No	Yes
Out-of-Pocket Maximum	\$3,000	\$6,700	\$6,700	\$3,400



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Medicare Advantage Plans	WellCare Compass
Phone Number	866-527-0056
Contract ID	H2491-010
Medicare Plan Type	WellCare, HMO
Monthly Consolidated Premium	\$17.90
Health Plan Deductible	\$0
PCP Co-Pay	\$0
Specialist Co-Pay	\$30
ER	\$120
Ambulance	\$275
Inpatient Hospital	\$175 per day: Days 1-9
Annual Drug Deductible	\$435
Additional Coverage in the Gap	No
Out-of-Pocket Maximum	\$3,400