2018 Medicare Advantage Plans

St. Martin

Medicare Advantage Plans	Blue Advantage	Humana Gold Plus	HumanaChoice	HumanaChoice
	800-363-9152	800-833-2364	800-833-2364	800-833-2364
Contract ID	H6453-004	H1951-049	R0110-001	R0110-002
Organization Name	HMO LA	Humana Health Benefit Plan of LA	Humana Insurance Company	Humana Insurance Company
Type of Medicare Plan	Local HMO	Local HMO	Regional PPO	Regional PPO
Monthly Consolidated Premium	$0	$0	$0	$53
Health Plan Deductible	$0	$0	$1,000 annual deductible	$1,000 annual deductible
PCP Co-Pay	$0	$5	$10/ $35	$15/ 30%
Specialist Co-Pay	$40	40	$35/ $50	$50/30%
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 through 20 $165 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 $164.50 for days 21 through 100
Inpatient Hospital	$195 for days 1 through 10 $0 for days 11 through 90 $195 for days 91 through 100 $0 for days 101 and beyond	$215 for days 1 through 8 $0 for days 9 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
Annual Drug Deductible	$0	$200	Drugs not covered	$300
Additional Coverage in the Gap	Talk with Plan	Talk with Plan	Drugs not covered	Talk with Plan
Chemo Drugs	20%	20%	20%	20%/30%
Out-of-Pocket Maximum	$6,700	$6,700	$6,700/ $10,000	$6,700/ $10,000

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Medicare Advantage Plans	HumanaChoice	HumanaChoice(PPO)	Peoples Health Choices Gold (HMO)	AAA8 Vantage Basic
	800-833-2364	800-833-2364	866-301-8865	866-704-0109
Contract ID	R0110-003	H5216-064	H1961-017	H5576-020
Organization Name	Humana Insurance Company	Humana Insurance Company	Peoples Health	Vantage Health Plan
Type of Medicare Plan	Regional PPO	Local HMO	Local HMO	Local HMO
Monthly Consolidated Premium	$87	$47	$0	$0
Health Plan Deductible	$1,000 annual deductible	$1000 annual deductible	$0	$500 Out-of-network
PCP Co-Pay	$15/$15	$5/30%	$10	$35 0%- 20%
Specialist Co-Pay	$50/$40-$60	$45/30%	$35	$50 0%- 20%
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	$250
Skilled Nursing	$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)	$0 per day (days 1-20) $160 per day (days 21-100)	$0 for days 1 through 20 $167 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	$225 per day (days 1-7) $0 per day (days 8-90) $0 per day (days 91 & beyond)	$195 per day (days 1-7) $0 per day (days 8-90)	$360 for days 1 through 5 $0 for days 6 through 90
Annual Drug Deductible	$400	$400 (only on certain Tiers)	$0	$380
Additional Coverage in the Gap	Talk with Plan	Talk with Plan	Talk with Plan	Talk with Plan
Chemo Drugs	20%/17%-20%	20%/30% (Part B)	20% (Part B)	20%/50%
Out of Pocket Maximum	$6,700/ $10,000	$6,700 / $10,000	$6,700	$6,700

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Medicare Advantage Plans	AAA1 Vantage Premium	AAA0 Vantage Standard	AAA4 Vantage Traditional Plus	WellCare Value (HMO)
	866-704-0109	866-704-0109	866-704-0109	866-527-0056
Contract ID	H5576-018	H5576-017	H5576-008	H2491-007
Organization Name	Vantage Health Plan	Vantage Health Plan	Vantage Health Plan	WellCare Health Plans
Type of Medicare Plan	Local HMO	Local HMO	Local HMO	HMO
Monthly Consolidated Premium	$169	$59	$30.90	$0
Health Plan Deductible	$500 Out-of-network	$500 Out-of-network	Contact Plan	$0
PCP Co-Pay	$15 0%- 20%	$20 0%- 20%/50%	$10 or 20%	$0
Specialist Co-Pay	$40 0%- 20%	$50 0%- 20%/50%	20%	$35
ER	$80 per visit (always covered)	$80 per visit (always covered)	$80 per visit (always covered)	$80
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 per day (days 1-20) $164.50 per day (days 21-100)
Inpatient Hospital	$275 for days 1 through 5 $0 for days 6 through 90	$325 for days 1 through 5 $0 for days 6 through 90	$1,316 for days 1 through 60 $329 for days 61 through 90 $658 for days 91 through 150	$195 per day (days 1-9) $0 per day (days 8-90) $0 per day (days 91-150)
Annual Drug Deductible	0	$250	$405	$0
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% (Part B)
Out of Pocket Maximum	$3,000	$5,500	$6,700	$6,700