2018 Medicare Advantage Plans

Tangipahoa

Medicare Advantage Plans	Alwell (HMO)	Blue Advantage	Humana Gold Plus (HMO)	HumanaChoice
	855-766-1572	800-363-9152	800-833-2364	800-833-2364
Contract ID	H5117-001	H6453-003	H1951-024	R0110-001
Organization Name	Allwell Medicare	HMO Louisiana	Humana Health Benefit Plan of Louisiana Inc.	Humana Insurance Company
Type of Medicare Plan	Local HMO	Local HMO	Local HMO	Regional PPO
Monthly Consolidated Premium	$0	$0	$59	$0
Health Plan Deductible	$0	$0	$0	$1,000 annual deductible
PCP Co-Pay	$0	$0	$5	$10/$35
Specialist Co-Pay	$40	$40	$45	$35/$50
ER	$80 per visit (always covered)	$80 per visit (always covered)	$80 per visit (always covered)	$80 per visit (always covered)
Ambulance	$250	$245	$265 or 20%	$265 or 20%
Skilled Nursing	$0 for days 1 through 20 $160 for days 21 through 100	$0 for 1 through 20 $165 for days 21 through 100	$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
Inpatient Hospital	$199 for days 1 through 10 $0 for days 11 through 90	$195 for days 1 through 10 $0 for days 11 through 60 $195 for days 91 through 100 $0 for days 101 and beyond	TIER 1: $200 per day (days 1-7) $0 per day (days 8 & beyond) TIER 2: $275 per day (days 1-7) $0 per day (days 91 & beyond)	$195 for days 1 through 6 $0 for days 7 through 90 $0 for days 91 and beyond
Annual Drug Deductible	$300	$0	$320	Drugs not covered
Additional Coverage in the Gap	Yes	Yes	Yes	Drugs not covered
Chemo Drugs	20%	20%	20% (Part B)	20%/30%
Out-of-Pocket Maximum	$6,700	$6,700	$6,700	$6,700/ $10,000

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Medicare Advantage Plans	HumanaChoice	HumanaChoice	Peoples Health Choices Select (HMO)	AAA0 Vantage Standard
	800-833-2364	800-833-2364	866-301-8865	866-704-0109
Contract ID	R0110-002	R0110-003	H1961-007	H5576-017
Organization Name	Humana Insurance Company	Humana Insurance Company	Peoples Health	Vantage Health Plan Inc
Type of Medicare Plan	Regional PPO	Regional PPO	Local HMO	HMO-POS
Monthly Consolidated Premium	$53	$87	$ 62.50	$49
Health Plan Deductible	$1,000 annual deductible	$1,000 annual deductible	$0	$500 Out-of -Network
PCP Co-Pay	$15/30%	$15	$5	$20 or 0-20% /50%
Specialist Co-Pay	$50/30%	$50/$40-$60	$40	$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%	$265 or 20%	$235	$250
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 per day (days 1-20) $155 per day (days 21-100)	$0 per day (days 1-20) $167 per day (days 21-100)
Inpatient Hospital	$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	$185 per day (days 1-10) $0 per day (days 11-90)	$325 per day (days 1-5) $0 per day (days 6-90) Point-of-Service 50% per stay
Annual Drug Deductible	$300	$400	$0	$250
Additional Coverage in the Gap	Yes	Yes	Yes	Yes
Chemo Drugs	20%- 30%	20%/ 17%-20%	20% (Part B)	20% /50%(Part B)
Out-of-Pocket Maximum	$6,700/ $10,000	$6,700/ $10,000	$6,700	$5,500

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Medicare Advantage Plans	AAA1 Vantage Premium	AAA4 Vantage Traditional Plus	AAA8Vantage Basic
	866-704-0109	866-704-0109	866-704-0109
Contract ID	H5576-018	H5576-008	H5576-020
Organization Name	Vantage Health Plan Inc	Vantage Health Plan	Vantage Health Plan
Type of Medicare Plan	HMO-POS	Local HMO	HMO-POS
Monthly Consolidated Premium	$169	$30.90	$0
Health Plan Deductible	$500 Out-of-Network	$183 per year	$500 Out of Network
PCP Co-Pay	$15 or 0-20% | POS 50%	$10 0%- 20%	$15 -$35 0-20%/50%
Specialist Co-Pay	$40 or 0-20% | POS 50%	20% per visit	$50 0-20%/50%
ER	$80 per visit (always covered)	$80 per visit (always covered)	$80 per visit (always covered)
Ambulance	$250	20%	$250
Skilled Nursing	$0 per day (days 1-20) $167 per day (days 21-100)	$0 for days 1 through 20 $167 for days 21 through 100	$0 per day (days 1-20) $167 per day (days 21-100)
Inpatient Hospital	$275 per day (days 1-5) $0 per day (days 6-90) Point-of-Service 50% per stay	$1.316 deductible for days 1-60 $329 copay per day (61-90) $658 copay per day (91-150)	$360 per day (days 1-5) $0 per day (days 6-90) Point-of-Service 50% per stay
Annual Drug Deductible	$0	$405	$380
Additional Coverage in the Gap	Yes	Yes	Yes
Chemo Drugs	20% (Part B)	20%	20%
Out-of-Pocket Maximum	$3,000	$6,700	$6,700