



# 2018 Medicare Advantage Plans

## Beauregard



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	H5216-135
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 HMO
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%	\$15/30%	\$5
Specialist Co-Pay	\$35/ \$50	\$25- \$50/ 30%	\$50/30%	\$45
ER	\$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 for days 1 through 20 \$164.50 for days 21 through 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	Talk with Plan	Talk with Plan	Talk with Plan
Chemo Drugs	20%	20%	20%	20%
Out-of-Pocket Maximum	\$6700/\$10,000	\$6700/\$10,000	\$6700/\$10,000	\$6,700



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Medicare Advantage Plans	AAA8 Vantage Basic	AAA0 Vantage Standard	AAA1 Vantage Premium	AAA4 Vantage Traditional Plus
	866-704-0109	866-704-0109	866-704-0109	866-704-0109
Contract ID	H5576-020	H5576-017	H5576-018	H5576-008
Organization Name	Vantage Health Plan	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	\$59	\$169	\$31
Health Plan Deductible	\$500 Out- of network	\$500 Out- of network	\$500 Out- of network	\$183 per year
PCP Co-Pay	\$35 0%- 20%	\$20 0%- 20%	\$15 0%- 20%	\$10 0%- 20%
Specialist Co-Pay	\$50 0%- 20%	\$50 0%- 20%	\$40 0%- 20%	20%
ER	\$80 per visit (always covered)			
Ambulance	\$250	\$250	\$250	20%
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 for days 1 through 20 \$167 for days 21 through 100
Inpatient Hospital	\$360 for days 1 through 5 \$0 for days 6 through 90	\$325 for days 1 through 5 \$0 for days 6 through 90	\$275 for days 1 through 5 \$0 for days 6 through 90	\$1,316 dedctable for days 1-60 \$329 copay perday (61-90) \$658 copay perday (91-150)
Annual Drug Deductible	\$380	\$250	\$0	\$405
Additional Coverage in the Gap	Talk with Plan	Talk with Plan	Talk with Plan	Talk with Plan
Chemo Drugs	20%	20%	20%	20%
Out of Pocket Maximum	\$6,700	\$5,500	\$3,000	\$6,700