2018 Medicare Advantage Plans

Concordia

Medicare Advantage Plans	HumanaChoice	HumanaChoice	HumanaChoice	AAA8 Vantage Basic
	800-833-2364	800-833-2364	800-833-2364	866-704-0109
Contract ID	R0110-001	R0110-002	R0110-003	H5576-020
Organization Name	Humana Insurance Company	Humana Insurance Company	Humana Insurance Company	Vantage Health Plan
Type of Medicare Plan	Regional PPO	Regional PPO	Regional PPO	Local HMO
Monthly Consolidated Premium	$0	$53	$87	$0
Health Plan Deductible	$1,000 annual deductible	$1,000 annual deductible	$1,000 annual deductible	$500 Out-of network
PCP Co-Pay	$10/ $35	$15/ 30%	$15/$15	$35 or 0-20%
Specialist Co-Pay	$35/ $50	$50/ 30%	$50/$40-$60	$50 or 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%	$265 or 20%	$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 for days 1 through 20 $164.50 for days 21 through 100	$0 for days 1 through 20 $167 for days 21 through 103
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	$360 for days 1 through 5 $0 for days 6 through 90
Annual Drug Deductible	Drugs not covered	$300	$400	$380
Additional Coverage in the Gap	Drugs not covered	No	No	No
Chemo Drugs	20%/30%	20%/30%	20%/17%-20%	20%/50%
Out-of-Pocket Maximum	$6700/$10,000	$6700/$10,000	$6700/$10,000	$6,700

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Concordia

Medicare Advantage Plans	AAA0 Vantage Standard	AAA1 Vantage Premium	AAA4 Vantage Traditional Plus
	866-704-0109	866-704-0109	866-704-0109
Contract ID	H5576-017	H5576-018	H5576-008
Organization Name	Vantage Health Plan	Vantage Health Plan	Vantage Health Plan
Type of Medicare Plan	Local HMO	Local HMO	Local HMO
Monthly Consolidated Premium	$59	$169	$30.90
Health Plan Deductible	$500 Out-of network	$500 Out-of network	$183 per year
PCP Co-Pay	$20 or 0% 20%	$15 0%- 20%	$10 / 20%
Specialist Co-Pay	$50 or 0%- 20%	$40 0%- 20%	20%
ER	$80 per visit (always covered)	$80 per visit (always covered)	$80 per visit (always covered)
Ambulance	$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 101	$0 for days 1 through 20 $167 for days 21 through 102
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	$1,316 dedctable for days 1-60 $329 copay perday (61-90) $658 copay perday (91-150)
Annual Drug Deductible	$250	$0	$405
Additional Coverage in the Gap	No	Yes	No
Chemo Drugs	20%/50%	20%/50%	20%/50%
Out-of-Pocket Maximum	$5,500	$3,000	$6,700