2018 Medicare Advantage Plans
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Medicare Advantage Plans	HumanaChoice	HumanaChoice	HumanaChoice	HumanaChoice
	800-833-2364	800-833-2364	800-833-2364	800-833-2364
Contract ID	R0110-001	R0110-002	R0110-003	H5525-015
Organization Name	Humana Insurance Company	Humana Insurance Company	Humana Insurance Company	Humana Benefit Plan of Illinois
Type of Medicare Plan	Regional PPO	Regional PPO	Regional PPO	Local PPO
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/$15	$5/30%
Specialist Co-Pay	$35/ $50	$50/ 30%	$50/$40-$60	$45/30%
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%	$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 for days 1 through 7 $0 for days 8 beyond
Annual Drug Deductible	Drugs not covered	$300	$400	$400
Additional Coverage in the Gap	Drugs not covered	No	No	No
Chemo Drugs	20%/30%	20%/30%	20%/17%-20%	20%/30%
Out-of-Pocket Maximum	$6700/$10,000	$6700/$10,000	$6700/$10,000	$6,700

2018 Medicare Advantage Plans
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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	$49	$169	$30.90
Health Plan Deductible	$500 Out-of-network	$500 Out-of-network	$500 Out-of-network	Contact Plan
PCP Co-Pay	$15- $35 0%- 20%	$0- $20 0%- 20%	$0- $15/0%-20%	$10 /20%
Specialist Co-Pay	$50 0%- 20%	$50 0%- 20%	$40 0%- 20%	20%
ER	$80 per visit (always covered)	$80 per visit (always covered)	$80 per visit (always covered)	$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	Contact Plan
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	Contact Plan
Annual Drug Deductible	$380	$250	$0	$405
Additional Coverage in the Gap	No	No	Yes	No
Chemo Drugs	20%/50%	20%/50%	20%/50%	20%
Out of Pocket Maximum	$6,700	$5,500	$3,000	$6,700