

2017 Summary of Benefits Table (Ouachita Parish)			
Medicare Advantage Plans	Humana Gold Plus (HMO)	HumanaChoice (PPO)	HumanaChoice * (PPO without Drug Coverage)
Contract ID/Plan ID	H1951-042	R5826-011	R5826-068 *
Organization/Company Name	Humana Health Benefit Plan of LA Inc	Humana Ins Co	Humana Ins Co
Type of Medicare Plan	HMO	Regional PPO	Regional PPO *
Monthly Consolidated Premium (includes part C & D)	\$0	\$77	\$0
Health Plan Deductible	\$0	\$1,000 annual deductible	\$1,000 annual deductible
Primary Care Provider Co-pay	\$15	\$15	\$10 / \$35
Specialist Co-pay	\$15 - \$45	\$15 - 50	\$10 - \$35 / \$50
ER	\$75 per visit (always covered)	\$75 per visit (always covered)	\$75 per visit (always covered)
Ambulance	\$265 or 20%	\$265 or 20%	\$265 or 20%
Skilled Nursing	\$0 per day (days 1-20) \$164.50 per day (days 21-100)	\$0 per day (days 1-20) \$164.50 per day (days 21-100)	\$0 per day (days 1-20) \$164.50 per day (days 21-100)
Inpatient Hospital	\$215 per day (days 1-8) \$0 per day (days 9-90) \$0 per day (days 91 & beyond)	\$275 per day (days 1-7) \$0 per day (days 8-90) \$0 per day (days 91 & beyond)	\$195 per day (days 1-6) \$0 per day (days 7-90) \$0 per day (days 91 & beyond)
Annual Drug Deductible	\$200 (only on certain Tiers)	\$400 (only on certain Tiers)	* NO drug coverage
Additional Coverage in Gap	Yes	Yes	* NO drug coverage
Chemo Drugs	20% (Part B)	20% (Part B)	20% / 30% (Part B)
Out-of-Pocket Maximum	\$6,700	\$6,700 / \$10,000	\$6,700 / \$10,000

2017 Summary of Benefits Table (Ouachita Parish)			
Medicare Advantage Plans	HumanaChoice (PPO)	HumanaChoice (PPO)	AAA4 Vantage Traditional Plus (HMO)
Contract ID/Plan ID	R5826-078	H6609-104	H5576-008
Organization/Company Name	Humana Ins Co	Humana Insurance Co	Vantage Health Plan Inc
Type of Medicare Plan	Regional PPO	Local PPO	HMO
Monthly Consolidated Premium (includes part C & D)	\$47	\$47	\$32.80
Health Plan Deductible	\$1,000 annual deductible	\$750 annual deductible	\$166 annual deductible
Primary Care Provider Co-pay	\$15 / 30%	\$5	\$10
Specialist Co-pay	\$25 - \$50 / 30%	\$5 - \$50	20% after \$166 deductible
ER	\$75 per visit (always covered)	\$75 per visit (always covered)	20% per visit (always covered)
Ambulance	\$265 or 20%	\$265 or 20%	20% after \$166 deductible
Skilled Nursing	\$0 per day (days 1-20) \$164.50 per day (days 21-100)	\$0 per day (days 1-20) \$164.50 per day (days 21-100)	\$0 per day (days 1-20) \$164.50 per day (days 21-100)
Inpatient Hospital	\$275 per day (days 1-7) \$0 per day (days 8-90) \$0 per day (days 91 & beyond)	\$225 per day (days 1-7) \$0 per day (days 8-90) \$0 per day (days 91 & beyond)	\$1,288 deductible for days 1-60 \$322 per day (days 61-90) \$644 per day (days 91-150)
Annual Drug Deductible	\$400 (only on certain Tiers)	\$400 (only on certain Tiers)	\$400
Additional Coverage in Gap	No Gap coverage	Yes	No Gap coverage
Chemo Drugs	20% (Part B)	20% (Part B)	20% (Part B)
Out-of-Pocket Maximum	\$6,700 / \$10,000	\$6,700 / \$10,000	\$6,700

2017 Summary of Benefits Table (Ouachita Parish)			
Medicare Advantage Plans	AAA0 Vantage Standard (HMO-POS)	AAA6 Vantage Premium (HMO-POS)	AAA8 Vantage Basic (HMO-POS)
Contract ID/Plan ID	H5576-017	H5576-018	H5576-020
Organization/Company Name	Vantage Health Plan Inc	Vantage Health Plan Inc	Vantage Health Plan Inc
Type of Medicare Plan	HMO-POS	HMO-POS	HMO-POS
Monthly Consolidated Premium (includes part C & D)	\$27	\$152	\$0.00
Health Plan Deductible	\$350 Out-of-Network deductible	\$350 Out-of-Network deductible	\$350 Out-of-Network deductible
Primary Care Provider Co-pay	\$0 - \$15 or 0-20%	\$0 - \$10 or 0-20%	\$10 - \$25 or 0-20%
Specialist Co-pay	\$45 or 0-20%	\$40 or 0-20%	\$50 or 0-20%
ER	\$75 per visit (always covered)	\$75 per visit (always covered)	\$75 per visit (always covered)
Ambulance	\$250	\$250	\$250
Skilled Nursing	\$0 per day (days 1-20) \$164 per day (days 21-100)	\$0 per day (days 1-20) \$164 per day (days 21-100)	\$0 per day (days 1-20) \$164 per day (days 21-100)
Inpatient Hospital	\$325 per day (days 1-5) \$0 per day (days 6-90) Point-of-Service 50% per stay	\$275 per day (days 1-5) \$0 per day (days 6-90) Point-of-Service 50% per stay	\$360 per day (days 1-5) \$0 per day (days 6-90) Point-of-Service 50% per stay
Annual Drug Deductible	\$0 (No deductible)	\$0 (No deductible)	\$350 (only on certain Tiers)
Additional Coverage in Gap	No Gap coverage	Yes	No Gap coverage
Chemo Drugs	20% (Part B)	20% (Part B)	20% (Part B)
Out-of-Pocket Maximum	\$5,900	\$3,600	\$6,700