2018 Medicare Advantage Plans

Sabine

Medicare Advantage Plans	HumanaChoice	HumanaChoice	HumanaChoice	HumanaChoice
	800-833-2364	800-833-2364	800-833-2364	800-833-2364
Contract ID	H5525-015	R0110-001	R0110-002	R0110-003
Organization Name	Humana Benefit Planof Illinois Inc	Humana Insurance Company	Humana Insurance Company	Humana Insurance Company
Type of Medicare Plan	Local PPO	Regional PPO	Regional PPO	Regional PPO
Monthly Consolidated Premium	$47	$0	$53	$87
Health Plan Deductible	$1,000 annual deductible	$1,000 annual deductible	$1,000 annual deductible	$1,000 annual deductible
PCP Co-Pay	$5/30%	$10/$35	$15 / 30%	$15 /$15
Specialist Co-Pay	$45/30%	$35/$50	$50 / 30%	$50 $40-$60
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 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)	$0 per day (days 1-20) $164.50 per day (days 21-100)
Inpatient Hospital	$225 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)	$275 per day (days 1-7) $0 per day (days 8-90) $0 per day (days 91 & beyond)	$275 per day (days 1-7) $0 per day (days 8-90) $0 per day (days 91 & beyond)
Annual Drug Deductible	$400	$0	$300	$400
Additional Coverage in the Gap	Talk with Plan	Talk with Plan	Talk with Plan	Talk with Plan
Chemo Drugs	20% 30%	20% 30%	20% 30%	20% 17%-20%
Out-of-Pocket Maximum	$6,700 / $10,000	$6,700 / $10,000	$6,700 / $10,000	$6,700 / $10,000

2018 Medicare Advantage Plans

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Medicare Advantage Plans	AAA0 Vantage Standard	AAA6 Vantage Premium	AAA4 Vantage Traditional Plus	AAA8 Vantage Basic
	866-704-0109	866-704-0109	866-704-0109	866-704-0109
Contract ID	H5576-017	H5576-018	H5576-008	H5576-020
Organization Name	Vantage Health Plan Inc.	Vantage Health Plan Inc.	Vantage Health Plan Inc.	Vantage Health Plan Inc.
Type of Medicare Plan	HMO-POS	HMO-POS	HMO	HMO-POS
Monthly Consolidated Premium	$59	$169	$31.00	$0
Health Plan Deductible	$500 Out-of-Network	$500 Out-of-Network	Contact Plan	$500 Out-of-Network
PCP Co-Pay	$20 or 0%-20% 50%	$15 or 0%-20% 50%	$10 or 20%	$35 or 0% - 20% 50%
Specialist Co-Pay	$50 or 0%-20% 50%	$40 or 0%-20% 50%	20%	$50 or 0% - 20% 50%
ER	$80 per visit (always covered)	$80 per visit (always covered)	20% per visit (always covered)	$80 per visit (always covered)
Ambulance	$250	$250	20%	$250
Skilled Nursing	$0 per day (days 1-20) $167 per day (days 21-100)	$0 per day (days 1-20) $167 per day (days 21-100)	$0 per day (days 1-20) $167 per day (days 21-100)	$0 per day (days 1-20) $167 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	$1,316 for days 1 through 60 $329 for days 61 through 90 $658 for days 91 through 150	$360 per day (days 1-5) $0 per day (days 6-90) Point-of-Service 50% per stay
Annual Drug Deductible	$250	$0	$405	$380
Additional Coverage in the Gap	Talk with Plan	Talk with Plan	Talk with Plan	Talk with Plan
Chemo Drugs	20% 50%	20% 50%	20%	20% 50%
Out of Pocket Maximum	$5,500	$3,000	$6,700	$6,700