



# 2018 Medicare Advantage Plans Terrebonne



Medicare Advantage Plans	Humana Gold Plus (HMO)	HumanaChoice(PPO)	HumanaChoice *(PPO)	HumanaChoice(PPO)
	800-833-2364	800-833-2364	800-833-2364	800-833-2364
Contract ID	H1951-047	R5826-011	R5826-068 *	R5826-078
Organization Name	Humana Health Benefit Plan of Louisiana Inc.	Humana Insurance Company	Humana Insurance Company	Humana Insurance Company
Type of Medicare Plan	Local HMO	Regional PPO	Regional PPO *	Regional PPO
Monthly Consolidated Premium	\$33	\$77	\$0	\$47
Health Plan Deductible	\$0	\$1,000 annual deductible	\$1,000 annual deductible	\$1,000 annual deductible
PCP Co-Pay	\$5	\$15	\$10 / \$35	\$15 / 30%
Specialist Co-Pay	\$5 - \$50	\$15 - 50	\$10 - \$35 / \$50	\$25 - \$50 / 30%
ER	\$75 per visit (always covered)	\$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%	\$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	\$150 per day (days 1-10) \$0 per day (days 11-90) \$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)	\$275 per day (days 1-7) \$0 per day (days 8-90) \$0 per day (days 91 & beyond)
Annual Drug Deductible	\$400 (only on certain Tiers)	\$400 (only on certain Tiers)	* NO drug coverage	\$400 (only on certain Tiers)
Additional Coverage in the Gap	Yes	Yes	* NO drug coverage	No Gap coverage
Chemo Drugs	20% (Part B)	20% (Part B)	20% / 30% (Part B)	20% / 30%
Out-of-Pocket Maximum	\$6,700	\$6,700 / \$10,000	\$6,700 / \$10,000	\$6,700 / \$10,000



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LOCAL HELP FOR PEOPLE WITH MEDICARE

Medicare Advantage Plans	Peoples Health Choices 65 #14 (HMO)	AAA4 Vantage Traditional Plus (HMO)	AAA0 Vantage Standard(HMO-POS)	AAA1 Vantage Premium (HMO-POS)
	866-301-8865	866-704-0109	866-704-0109	866-704-0109
Contract ID	H1961-014	H5576-008	H5576-017	H5576-018
Organization Name	Peoples Health	Vantage Health Plan Inc.	Vantage Health Plan Inc.	Vantage Health Plan Inc.
Type of Medicare Plan	Local HMO	HMO	HMO-POS	HMO-POS
Monthly Consolidated Premium	\$0	\$32.80	\$35	\$151
Health Plan Deductible	\$0	\$166 annual deductible	\$350 Out-of-Network deductible	\$350 Out-of-Network deductible
PCP Co-Pay	\$5	\$10 or 0-20%	\$15 or 0-20%   POS 50%	\$10 or 0-20%   POS 50%
Specialist Co-Pay	\$45	20% after \$166 deductible	\$45 or 0-20%   POS 50%	\$40 or 0-20%   POS 50%
ER	\$75 per visit (always covered)	20% per visit (always covered)	\$75 per visit (always covered)	\$75 per visit (always covered)
Ambulance	\$220	20% after \$166 deductible	\$250	20% after \$166 deductible
Skilled Nursing	\$0 per day (days 1-20) \$155 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 per day (days 21-100)	\$0 per day (days 1-20) \$164 per day (days 21-100)
Inpatient Hospital	\$85 per day (days 1-10) \$0 per day (days 11-90)	\$1,288 deductible (days 1-60) \$322 per day (days 61-90) \$644 per day (days 91-150)	\$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
Annual Drug Deductible	\$0 (No deductible)	\$400	\$0	\$0
Additional Coverage in the Gap	Yes	No Gap coverage	No Gap coverage	Yes
Chemo Drugs	20% (Part B)	20% (Part B)	20% (Part B)	20% (Part B)
Out of Pocket Maximum	\$6,700	\$6,700	\$5,900	\$3,600



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Medicare Advantage Plans	AAA8 Vantage Capitol(HMO-POS)
	866-704-0109
Contract ID	H5576-020
Organization Name	Vantage Health Plan Inc.
Type of Medicare Plan	HMO-POS
Monthly Consolidated Premium	\$0
Health Plan Deductible	\$350 Out-of-Network deductible
PCP Co-Pay	\$25 or 0-20%   POS 50%
Specialist Co-Pay	\$50 or 0-20%   POS 50%
ER	\$75 per visit (always covered)
Ambulance	\$250
Skilled Nursing	\$0 per day (days 1-20) \$164 per day (days 21-100)
Inpatient Hospital	\$360 per day (days 1-5) \$0 per day (days 6-90) Point-of-Service 50% per stay
Annual Drug Deductible	\$350 (only on certain Tiers)
Additional Coverage in the Gap	No Gap coverage
Chemo Drugs	20% (Part B)
Out-of-Pocket Maximum	\$6,700