

**Medicare Advantage Plans
Benefits Comparison
Benefits effective January 1, 2019 - December 31, 2019**

	Blue Advantage HMO	Humana HMO	Peoples Health HMO-POS
	Network	Network	Network
	You Pay	You Pay	You Pay
Deductible			
You	\$0	\$0	\$0
You + 1 (Spouse)	\$0	\$0	\$0
You + Children	\$0	\$0	N/A
You + Family	\$0	\$0	N/A
Out-of-Pocket Maximum			
You	\$2,000 per member	\$2,500 per member	\$2,500 per member
You + 1 (Spouse or child)			
You + Children			
You + Family			
State Funding	The Plan Pays		
You	Not Available	Not Available	Not Available
You + 1 (Spouse or child)			
You + Children			
You + Family			
Physicians' Services	The Plan Pays		
Primary Care Physician or Specialist Office - Treatment of illness or injury	100% coverage after a \$5 PCP copayment or \$20 SPC copayment	PCP -100% after \$5 Copayment Specialist - 100% after \$20 Copayment	100% coverage after a \$5 PCP or \$10 SPC copayment per visit.
Preventative Care Primary Care Physician or Specialist Office or Clinic For a complete list of benefits, refer to the Preventive and Wellness/Routine Care in the Benefit Plan	100% coverage	100% coverage	100% coverage
Physician Services for Emergency Room Care	100% coverage	100% coverage	100% coverage
Allergy Shots and Serum	100% coverage after \$5 copay	PCP - 100% after \$5 Copayment Specialist - 100% after \$20 Copayment	95% coverage
Outpatient Surgery/Services when billed as office visits	100% coverage	PCP - 100% after \$5 Copayment Specialist - 100% after \$20 Copayment	100% coverage
Inpatient Services Inpatient care, delivery and inpatient short-term acute rehabilitation services	100% coverage after \$50 copayment per day (days 1-10)	100% after \$50 copayment per day (days 1 - 10)	100% coverage after \$50 copayment per day (days 1-10)
Outpatient Surgery/Services Hospital/Facility	100% coverage	100% coverage	100% coverage
Emergency Room Care - Hospital Treatment of an emergency medical condition or injury	100% coverage after \$50 copayment; waived if admitted	100% after \$50 copayment; waived if admitted within 24 hours	100% coverage after \$50 copayment per visit; waived if admitted

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Vantage Premium HMO-POS	Vantage Standard HMO-POS	Vantage Basic HMO-POS
Network	Network	Network
You Pay	You Pay	You Pay
Deductible		
\$0	\$0	\$0
\$0	\$0	\$0
\$0	\$0	\$0
\$0	\$0	\$0
Out-of-Pocket Maximum		
\$2,000 per member	\$3,000 per member	\$6,700 per member
The Plan Pays		The Plan Pays
Not Available	Not Available	Not Available
The Plan Pays		The Plan Pays
100% coverage after a \$5 or \$0 AHN PCP co-payment and \$20 or \$10 AHN SPC copayment per visit	100% coverage after a \$10 or \$0 AHN PCP copayment and \$40 or \$30 AHN SPC copayment per visit	100% coverage after a \$15 or \$5 AHN PCP co-payment and \$45 or \$35 AHN SPC copayment per visit
100% coverage	100% coverage	100% coverage
100% coverage	100% coverage	100% coverage
80% coverage	80% coverage	80% coverage
100% coverage	100% coverage	100% coverage
100% coverage after \$0 copay for day 1, \$100 /day for days 2-5 AHN or \$100/day for days 1-5	100% coverage after \$270/day or \$170/day AHN* for days 1-7	100% coverage after \$290/day or \$190/day AHN* for days 1-7
100% coverage	100% coverage after \$250 or \$150 AHN copayment per visit	100% coverage after \$350 or \$250 AHN copayment per visit
100% coverage after \$90 copayment per visit; waived if admitted	100% coverage after \$90 copayment per visit; waived if admitted	100% coverage after \$90 copayment per visit; waived if admitted

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Behavioral Health	The Plan Pays	The Plan Pays	The Plan Pays
Mental Health and Substance Abuse Inpatient Facility	100% after \$25 copayment days 1-5	100% after \$25 copayment per day (days 1 - 5) 190 day lifetime limit in a psychiatric facility	100% coverage after \$25 copay per day (days 1-5)
Mental Health and Substance Abuse Outpatient Visits - Professional	100% coverage after mental health outpatient \$10 copayment / substance abuse outpatient \$20 copayment	100% after \$20 copayment	100% coverage
Other Coverage	The Plan Pays	The Plan Pays	The Plan Pays
Outpatient Acute Short-Term Rehabilitation Services Physical Therapy, Speech Therapy, Occupational Therapy, Other short term rehabilitative services	100% coverage	100% at an Outpatient Hospital 100% after \$25 copayment at all other places of treatment	100% coverage; subject to Medicare maximum
Chiropractic Care	100% coverage after \$20 copayment	100% after \$20 copayment (Medicare Covered)	100% coverage after a \$10 copay per visit.
Vision Exam (routine)	100% coverage; one exam per year	Not Applicable	100% coverage after \$15 copay; 1 exam per year
Urgent Care Center	100% coverage after \$10 copayment	100% after \$10 copayment	100% coverage after \$10 copay per visit
Home Health Care Services	100% coverage	100% (Excludes Personal Home Care)	100% coverage
Skilled Nursing Facility Services	100% coverage after \$0 copay for days 1-20 and \$25 for days 21-100	100% per day (days 1 - 20); \$25 copayment per day (days 21 - 100); plan pays \$0 after 100 days	100% coverage after \$0 copay (days 1-20); \$25 copay per day (days 21+)
Hospice Care	Covered by Medicare	Covered by Medicare	Covered by Medicare
Durable Medical Equipment (DME) –Rental or Purchase	95% coverage	DME Provider - 95% coinsurance Pharmacy - 100% coinsurance	95% coverage
Transplant Services	100% coverage after \$50 copay per day (days 1-10)	See Inpatient Services; requires prior authorization	100% coverage after \$50 copay per day (days 1-10)
Pharmacy	You Pay	You Pay	You Pay
Tier 1 - Preferred Generic	\$5	Retail 30 Day - \$5/90 Day Retail - \$15/90 Day Mail Order - \$10	\$0 copay
Tier 2 - Generic	\$10	Retail 30 Day - \$25/90 Day Retail - \$75/90 Day Mail Order - \$50	\$0 copay
Tier 3 - Preferred Brand	\$25	Retail 30 Day - \$50/90 Day Retail - \$150/90 Day Mail Order - \$100	\$20 copay
Tier 4 - Non-Preferred Brand	\$50	Retail & Mail Order 30 Day - 25% Limited to a 30 day supply	\$40 copay
Tier 5 - Specialty	20%	Not Applicable	20% coinsurance

This comparison chart is a summary of plan features and is presented for general information only. It is not a guarantee of coverage.

The benefits outlined in this document were provided by Peoples Health and Vantage Health Plan. OGB is not responsible for the accuracy of this information.

NOTE: Prior authorizations, visit limits and age and/or time restrictions may apply to some benefits - refer to your official plan document for details.
All services are subject to deductibles/copays/coinsurance, if Medicare Deductibles have not been met

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Vantage Premium HMO-POS	Vantage Standard HMO-POS	Vantage Basic HMO-POS
Network	Network	Network
The Plan Pays	The Plan Pays	The Plan Pays
100% coverage after \$25 copay per day (days 1-5)	100% coverage after \$415 copay per day (days 1-4)	100% coverage after \$415 copay per day (days 1-4)
100% coverage after \$30 AHN copay or \$40 copay per visit	100% coverage after \$30 AHN copay or \$40 copay per visit	100% coverage after \$30 AHN copay or \$40 copay per visit
The Plan Pays	The Plan Pays	The Plan Pays
100% coverage after \$25 AHN/\$40 copay per visit, subject to Medicare maximum	100% coverage after \$25AHN/ \$40 copay per visit subject to Medicare maximum	100% coverage after \$25AHN/ \$40 copay per visit subject to Medicare maximum
100% coverage after a \$20 copay per visit	100% coverage after a \$20 copay per visit	100% coverage after a \$20 copay per visit.
100% coverage; 1 exam per year	100% coverage; 1 exam per year	100% coverage; 1 exam per year
100% coverage after \$20 copay per visit	100% coverage after \$65 copay per visit	100% coverage after \$65 copay per visit
100% coverage	100% coverage	100% coverage
100% coverage after \$0 copay (days 1-20); \$25 copay per day (days 21-100)	100% coverage after \$0 copay (days 1-20); \$172 copay per day (days 21-100)	100% coverage after \$0 copay (days 1-20); \$172 copay per day (days 21-100)
Covered by Medicare	Covered by Medicare	Covered by Medicare
95% coverage	80% coverage	80% coverage
100% coverage after \$0 copay for day 1, \$100/day for days 2 - 5 AHN, or \$100/day for days 1-5	100% coverage after \$270/day copay or \$170 AHN copay per day (days 1-7)	100% coverage after \$290/day copay or \$190 AHN copay per day (days 1-7)
You Pay	You Pay	You Pay
\$4 copay	\$4 copay	\$6 copay
\$10 copay	\$12 copay	\$15 copay
\$25 copay	\$47 copay	25% coinsurance; after \$310 deductible
\$50 copay	25% coinsurance; after \$250 deductible	25% coinsurance; after \$310 deductible
20% coinsurance	28% coinsurance; after \$250 deductible	25% coinsurance; after \$125 deductible 28% coinsurance; after \$250 deductible