2025 MEDICARE ADVANTAGE COMPARISON CHART

This comparison chart is a side-by-side representation of services offered through the AvMed, UHC, and Humana Medicare Advantage Plans for both in-network and out-of-network providers.

	AvMed Medicare Circle		AvMed Medicare Choice		AvMed Medicare Access		AvMed Medicare One		Humana Passive (National)		Humana Traditional (National)		Humana $0 Premium (Miami-Dade)	UnitedHealthcare Passive		UnitedHealthcare Differential	
	Miami-Dade	Broward	Miami-Dade	Broward	Miami-Dade	Broward	Miami-Dade	Broward	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Medical Plan Type	HMO	HMO	HMO	HMO	HMO-POS	HMO-POS	HMO	HMO	PPO		PPO		HMO	PPO		PPO	
Drug Plan Type	100% Part D	100% Part D	100% Part D	100% Part D	100% Part D	100% Part D	100% Part D	100% Part D	100% Part D		100% Part D		100% Part D	100% Part D		100% Part D	
PCP Required	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No		No		Yes	No		No	
Annual Deductible	0	0	$0	$0	$0	$0	0	0	$0		$0		$0	$0		$0	
Annual Maximum Out-of-Pocket (OOP)	$2,500	$2,500	$3,000	$3,400	$3,400	$3,400	$1,000	$1,500	$2,500		$4,500	$8,950	$500	$2,500		$4,500	$10,000
OOP Exclusions	Dental and Part D Medication		Dental and Part D Medication		Dental and Part D Medication		Dental and Part D Medication		Exclusions: Part D Pharmacy, Chiropractic Services (Routine), Hearing Services (Routine), Vision Services (Routine), Podiatry Services (Routine), Wigs (medically necessary), Extra Services, Worldwide Coverage, and the Plan Premium.				Part D Drugs	Prescription Drugs and the Plan Premium		Prescription Drugs and the Plan Premium	
MEDICAL BENEFITS																	
Inpatient Hospital Care	$50 copay for days 1 to 5; $0 copay for days 6 to 90	$50 copay for days 1 to 5; $0 copay for days 6 to 90	$75 copay for days 1 to 5; $0 copay for days 6 to 90	$65 copay for days 1 to 5; $0 copay for days 6 to 90	$0 days 1 to 5 $40 days 6 to 20 $0 days 21 to 90		$0	$0	$175 copay per Admission		$275 copay per day (days 1-6)	40% per admission	$0 copay per admission	$175 copay per Admission		$275/Day for Days 1-6; $0/Day for Days 7 and Beyond	40%
Inpatient Mental Health Care	$150 days 1 to 9 $0 days 10 to 90	$0	$150 days 1 to 9 $0 days 10 to 90		$150 days 1 to 9 $0 days 10 to 90		$0 days 0 to 90	$0 days 0 to 90	$175 copay per Admission (190 Days lifetime limit)		$175 copay per Day (days 1-8) (190 Days lifetime limit)	40% per admission (190 Days lifetime limit)	$0 copay per admission (190 Days lifetime limit in psychiatric facility)	$175 copay per Admission (190 Days lifetime limit)		$175/Day for Days 1-8; $0/Day for Days 9-190 (190 days lifetime limit)	40%
Skilled Nursing Facility (SNF)	$0 days 1 to 20 $160 days 21 to 62 $0 days 63 to 100	$0 days 1 to 20 $135 days 21 to 62 $0 days 63 to 100	$0 days 1 to 20 $160 days 21 to 100	$0 days 1 to 20 $135 days 21 to 100	$0 days 1 to 20 $135 days 21 to 100	$0 days 1 to 20 $135 days 21 to 100	$0 days 1 to 20 $160 days 21 to 62 $0 days 63 to 100	$0 days 1 to 20 $135 days 21 to 62 $0 days 63 to 100	$0 copay days 1-20; $50 copay days 21-100; plan pays $0 after day 100	$0 copay days 1-20; $50 copay days 21-100; plan pays $0 after day 100	$0 copay days 1-20; $172 copay days 21-100; plan pays $0 after day 100	$175 copay days 1-100; plan pays $0 after day 100	$0 copay (days 1-20); $50 copay per day (days 21-100); plan pays $0 after day 100	$0/Day for Days 1-20; $50/Day for Days 21-100	$0/Day for Days 1-20; $50/Day for Days 21-100	$0/Day for Days 1-20; $172/Day for Days 21-100	$175/Day for Days 1-100
Home Health Care	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	20%
Doctor Office Visits - Primary Care	$0	$0	$0	$0	$0	$0	$0	$0	$5	$5	$10	$35	$0	$5	$5	$10	$35
Doctor Office Visits - Specialist	$0	$0	$5	$5	$15 No Referral	$15 No Referral	$0 No Referral	$0 No Referral	$15	$15	$40	$60	$0	$15	$15	$40	$60
Emergency Care	$100	$100	$100	$100	$120	$120	$100	$100	$65 copay; waived if admitted within 24 hours	$65 copay; waived if admitted within 24 hours	$90 copay; waived if admitted within 24 hours	$90 copay; waived if admitted within 24 hours	$40 copay; waived if admitted within 24 hours	$65 copay (waived if admitted)	$65 copay (waived if admitted)	$90 copay (waived if admitted)	$90 copay (waived if admitted)
Urgently Needed Care	$0	$0	$10	$10	$20-$50	$20-$50	$0	$0	$35	$35	$35	$35	$0 copay	$35	$35	$35	$35
Chiropractic Services	$5	$5	$5	$5	$5	$5	$5	$5	$15 for Medicare Covered and $10 Routine Services	$15 for Medicare Covered and $10 Routine Services	$10 for Medicare Covered and Routine Services	$15 for Medicare Covered and $10 Routine Services	$0 for Medicare Covered Services	$15	$15	$10	$15

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	AvMed Medicare Circle		AvMed Medicare Choice		AvMed Medicare Access		AvMed Medicare One		Humana Passive (National)		Humana Traditional (National)		Humana $0 Premium (Miami-Dade)	UnitedHealthcare Passive		UnitedHealthcare Differential	
	Miami-Dade	Broward	Miami-Dade	Broward	Miami-Dade	Broward	Miami-Dade	Broward	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Podiatry Services	$5	$5	$5	$5	$5	$5	$5	$5	$15 for Medicare Covered and Routine Services	$15 for Medicare Covered and Routine Services	$40 for Medicare Covered and Routine Services	$60 for Medicare Covered and $40 Routine Services	$0 for Medicare Covered and Routine Services	$15 copay (No visits limit)	$15 copay (No visits limit)	$40 (No visits limit)	$60 (No visits limit)
Outpatient Mental Health Care	$15 visit Group or Individual Therapy	$15 visit Group or Individual Therapy	$15/visit Group or Individual therapy	$15/visit Group or Individual therapy	$15/visit Group or Individual therapy	$15/visit Group or Individual therapy	$15 visit Group or Individual Therapy	$15 visit Group or Individual Therapy	$15	$15	$40	$60	$0	$15	$15	"Indiv-$40/ Visit; Group-$10/ Visit; Partial Hosp-$55/ Day"	"Indiv-$60/ Visit; Group-$35/ Visit; Partial Hosp-$55/ Day"
Outpatient Substance Abuse	$15 visit Group or Individual Therapy	$15 visit Group or Individual Therapy	$15/visit Group or Individual therapy	$15/visit Group or Individual therapy	$15/visit Group or Individual therapy	$15/visit Group or Individual therapy	$15 visit Group or Individual Therapy	$15 visit Group or Individual Therapy	$15	$15	$40	$60	$0	$15	$15	"Indiv-$40/ Visit; Group-$10/ Visit; Partial Hosp-$55/ Day"	"Indiv-$60/ Visit; Group-$35/ Visit; Partial Hosp-$55/ Day"
Outpatient Surgery - Outpatient Hospital	$150	$100	$175	$200	$175	$200	$100	$100	$50	$50	20%	40%	$25	$50	$50	20%	40%
Outpatient Surgery - Ambulatory Surgical Center	$50	$75	$50	$75	$75	$75	$25	$25	$25	$25	20%	40%	$0	$50	$50	20%	40%
Professional Fees for Outpatient Surgeries - Outpatient Hospital	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	10%	40%	$0	included in $50 copay	Included in $50 copay	Included in 20%	Included in 40%
Ambulance Services	$145	$180	$165	$180	$165	$165	$145	$180	$50 for Medicare covered services	$50 for Medicare covered services	$150 for Medicare covered services	$150 for Medicare covered services	$75 for Medicare-covered services	$50	$50	$150	$150
Outpatient Rehabilitation	$20/visit	$20/visit	$20/visit	$15/visit	$15/visit	$15/visit	$10/visit	$15/visit	$20	$20	10%	40%	$0	$20	$20	10%	40%
Durable Medical Equipment	20%	20%	20%	20%	20%	20%	10%	10%	20%	20%	20%	40%	$0	20%	20%	20%	40%
Prosthetic Devices	$0	$0	$0	$0	$0	$0	$0	$0	20%	20%	20%	40%	$0	20%	20%	20%	40%
Diabetes Monitoring Supplies	0% coinsurance 90 strips per month (or 3 strips per day)		0% coinsurance 90 strips per month (or 3 strips per day)		0% coinsurance 90 strips per month (or 3 strips per day)		0% coinsurance 90 strips per month (or 3 strips per day)		20%	20%	20%	40%	$0	$0	$0	$0	$0
Diagnostic - Outpatient Hospital	$15	$0-$25	$0-$25	$25	$25	$25	$15	$25	$20	$20	10%	40%	$0	$50	$50	20%	40%
Diagnostic - Freestanding Facility	$5	$5	$5	$5	$5	$5	$0-$5	$0-$5	$20	$20	10%	40%	$0	$50	$50	20%	40%
Diagnostic Radiology Services	$0	$25-$50	$50-$200 or 20%	$75-$100	$50-$100	$50-$100	$0	$25-$50	$20	$20	10%	40%	$25	$20	$20	10%	40%
Lab Services	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$13	$13	$0	$0	$0	$13	$13
Medicare Part B Drugs	10%-20%	10%-20%	10-20%	10-20%	10-20%	10-20%	10%-20%	10%-20%	20%	20%	20%	40%	$0	20%	20%	20%	40%
Preventive Services	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	40% / Immunizations $0/ Smoking Cessation $0

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	Miami-Dade	Broward	Miami-Dade	Broward	Miami-Dade	Broward	Miami-Dade	Broward	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Wellness Visits	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Wellness Services	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Dental Services (Medicare Covered Services)	$0-$150	$0-$150	$5-$200	$10-$200	$10-$175	$0-$175	$0-$175	$0-$175	$15	$15	$40	$60	$0	$15	$15	$40	$60
- Exam	$0	$0	$0	$0	$0-$25	$0-$25	$0	$0	N/A	N/A	N/A	N/A	$5,000 allowance per year for non-Medicare covered preventive and comprehensive dental services.	N/A	N/A	N/A	N/A
- Cleaning	$0	$0	$0	$0	$0	$0	$0	$0	N/A	N/A	N/A	N/A		N/A	N/A	N/A	N/A
- X-Ray	$0	$0	$0	$0	$0-$35	$0-$35	$0	$0	N/A	N/A	N/A	N/A		N/A	N/A	N/A	N/A
Hearing Services (Hearing Loss Exam)	$0 Hearing Exam $1,500 Hearing Aid allowance per ear every two years	$0 Hearing Exam $1,500 Hearing Aid allowance per ear every two years	$0 Hearing Exam $1,200 Hearing Aid allowance per ear every two years	$0 Hearing Exam $1,200 Hearing Aid allowance per ear every two years	$0 Hearing Exam $1,200 Hearing Aid allowance per ear every two years	$0 Hearing Exam $1,200 Hearing Aid allowance per ear every two years	$0 Hearing Exam $1,500 Hearing Aid allowance per ear every two years	$0 Hearing Exam $1,500 Hearing Aid allowance per ear every two years	$15 copay Medicare-covered; see Humana plan benefit grid for routine hearing coverage.	$15 copay Medicare-covered; see Humana plan benefit grid for routine hearing coverage.	$40 copay Medicare-covered; see Humana plan benefit grid for routine hearing coverage.	$60 copay Medicare-covered; see Humana plan benefit grid for routine hearing coverage.	$0; see Humana plan benefit grid for routine hearing coverage.	$15	$15	$40	$60
Vision Services (Medicare Covered Eye Exam)	$0 Vision exam $450 eyewear/ contacts allowance	$0 Vision exam $450 eyewear/ contacts allowance	$0 Vision exam $350 eyewear/ contacts allowance	$0 Vision exam $350 eyewear/ contacts allowance	$0 Vision exam	$0 Vision exam	$0 Vision exam $450 eyewear/ contacts allowance	$0 Vision exam $450 eyewear/ contacts allowance	$15 copay Medicare-covered; see Humana plan benefit grid for routine vision coverage.	$15 copay Medicare-covered; see Humana plan benefit grid for routine vision coverage.	$40 copay Medicare-covered; see Humana plan benefit grid for routine vision coverage.	$60 copay Medicare-covered; see Humana plan benefit grid for routine vision coverage.	$0; see Humana plan benefit grid for routine vision coverage.	$15	$15	$40	$60
PHARMACY BENEFITS																	
Type of Pharmacy	Pref	Std	Pref	Std	Pref	Standard	Pref	Standard	Pref	Standard	Pref	Standard	Pref	Pref	Standard	Pref	Standard
Deductible	$0		$0		$0		$0		$0		$0		$0	N/A		$0	
Network	Major Chains		Major Chains		Major Chains		Major Chains		Major Chains		Major Chains		Major Chains	Major Chains		Major Chains	
Drug Usage Management	Yes		Yes		Yes		Yes		Yes		Yes		Yes				
INITIAL COVERAGE PERIOD																	
Initial Coverage Limit	$2,000		$2,000		$2,000		$2,000		$2,000		$2,000		$2,000	$2,000		$2,000	
Tier 1	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Tier 2	$0	$15	$0	$15	$0	$15	$0	$15	$0	$15	$0	$15	$0	$15	$0	$15	$0
Tier 3	$0	$47	$10	$47	$25	$47	$30	$47	$30	$47	$30	$40	$0	$47	$10	$47	$0
Tier 4	$35	$100	$65	$100	$35	$100	$65	$100	$75	$100	$75	$100	$35	$100	$65	$100	$0
Tier 5	33%	33%	33%	33%	33%	33%	33%	33%	33%	33%	33%	33%	33%	33%	33%	33%	33%
Tier 6	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
									$80	$100	$100	33%		$100		$100	
									N/A	N/A	N/A	N/A		N/A		N/A	
									N/A	N/A	N/A	N/A		N/A		N/A	

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	Miami-Dade	Broward	Miami-Dade	Broward	Miami-Dade	Broward	Miami-Dade	Broward	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
CATASTROPHIC COVERAGE																	
Catastrophic Coverage Limit	$8,000	$8,000	$8,000	$8,000	$8,000	$8,000	$8,000	$8,000	$2,000		$2,000		$8,000	$2,000		$2,000	
Tier 1	$0	$0	$0	$0	$0	$0	$0	$0	$0	N/A	$0	N/A	$0	$0	N/A	$0	N/A
Tier 2	$0	$0	$0	$0	$0	$0	$0	$0	$0	N/A	$0	N/A	$0	$0	N/A	$0	N/A
Tier 3	$0	$0	$0	$0	$0	$0	$0	$0	$0	N/A	$0	N/A	$0	$0	N/A	$0	N/A
Tier 4	$0	$0	$0	$0	$0	$0	$0	$0	$0	N/A	$0	N/A	$0	$0	N/A	$0	N/A
Tier 5	$0	$0	$0	$0	$0	$0	$0	$0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$0	N/A
MAIL ORDER	100 DAY SUPPLY								90 DAY SUPPLY								
Tier 1	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$10	N/A	$0	N/A
Tier 2	$0	$30	$0	$30	$0	$30	$0	$30	$0	$30	$0	$30	$0	$30	$0	$30	$60	N/A	$94	N/A	$0	$60	N/A	$30	N/A
Tier 3	$0	$75	$25	$90	$62.50	$105	$75	$120	$75	$120	$75	$120	$0	$75	$25	$90	$120	N/A	$200	N/A	$5	$120	N/A	$94	N/A
Tier 4	$87.50	$87.50	$162.50	$162.50	$87.50	$87.50	$162.50	$162.50	$187.50	$300	$187.50	$300	$87.50	$87.50	$162.50	$162.50	N/A	N/A	N/A	N/A	N/A	$160	N/A	$200	N/A
Tier 5	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$200	N/A
PREMIUM																	
Monthly Premium	$0		$0		$0		$0		$0		$0		$0	$410.82		$270.82		$0		$392.38		$267.53	