2026 MEDICARE ADVANTAGE COMPARISON CHART

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

	Humana Passive (National)		Humana Traditional (National)		Humana $0 Premium (Miami-Dade)	UnitedHealthcare Passive		UnitedHealthcare Differential	
	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	PPO		PPO		HMO	PPO		PPO	
Drug Plan Type	100% Part D		100% Part D		100% Part D	100% Part D		100% Part D	
PCP Required	No		No		Yes	No		No	
Annual Deductible	$0		$0		$0	$0		$0	
Annual Maximum Out-of-Pocket (OOP)	$2,500		$4,500	$8,950	$500	$2,500		$4,500	$10,000
OOP Exclusions	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	$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	$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 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	20%
Doctor Office Visits - Primary Care	$5	$5	$10	$35	$0	$5	$5	$10	$35
Doctor Office Visits - Specialist	$15	$15	$40	$60	$0	$15	$15	$40	$60

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	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Emergency Care	$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	$35	$35	$35	$35	$0 copay	$35	$35	$35	$35
Chiropractic Services	$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
Podiatry Services	$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	$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	$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	$50	$50	20%	40%	$25	$50	$50	20%	40%
Outpatient Surgery - Ambulatory Surgical Center	$25	$25	20%	40%	$0	$50	$50	20%	40%
Professional Fees for Outpatient Surgeries - Outpatient Hospital	$0	$0	10%	40%	$0	included in $50 copay	Included in $50 copay	Included in 20%	Included in 40%
Ambulance Services	$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	$20	10%	40%	$0	$20	$20	10%	40%

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	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Durable Medical Equipment	20%	20%	20%	40%	$0	20%	20%	20%	40%
Prosthetic Devices	20%	20%	20%	40%	$0	20%	20%	20%	40%
Diabetes Monitoring Supplies	20%	20%	20%	40%	$0	$0	$0	$0	$0
Diagnostic - Outpatient Hospital	$20	$20	10%	40%	$0	$50	$50	20%	40%
Diagnostic - Freestanding Facility	$20	$20	10%	40%	$0	$50	$50	20%	40%
Diagnostic Radiology Services	$20	$20	10%	40%	$25	$20	$20	10%	40%
Lab Services	$0	$0	$13	$13	$0	$0	$0	$13	$13
Medicare Part B Drugs	20%	20%	20%	40%	$0	20%	20%	20%	40%
Preventive Services	$0	$0	$0	$0	$0	$0	$0	$0	40% /Immunizations $0/ Smoking Cessation $0
Wellness Visits	$0	$0	$0	$0	$0	$0	$0	$0	$0
Wellness Services	$0	$0	$0	$0	$0	$0	$0	$0	$0
Dental Services (Medicare Covered Services)	$15	$15	$40	$60	$0	$15	$15	$40	$60
- Exam	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	N/A	N/A	N/A	N/A		N/A	N/A	N/A	N/A
- X-Ray	N/A	N/A	N/A	N/A		N/A	N/A	N/A	N/A

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	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Hearing Services (Hearing Loss Exam)	$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)	$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	Non-Pref	Pref	Non-Pref	Pref	Pref	Standard	Pref	Standard
Deductible	$0	N/A	$0	N/A	N/A	N/A	N/A	$0	N/A
Network	Local and Chain Pharmacies	N/A	Local and Chain Pharmacies	N/A	Local and Chain Pharmacies	Major Chains	N/A	Major Chains	N/A
Drug Usage Management	Yes		Yes		Yes				
INITIAL COVERAGE PERIOD									
Initial Coverage Limit	N/A	N/A	N/A	N/A	N/A	$2,100		$2,100	
Tier 1	$5	N/A	$0	N/A	$0	$5	N/A	$0	N/A
Tier 2	$30	N/A	$47	N/A	$0	$30	N/A	$15	N/A
Tier 3	$60	N/A	$100	N/A	$5	$60	N/A	$47	N/A
Tier 4	$80	N/A	$100	N/A	33%	$80	N/A	$100	N/A
Tier 5	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$100	N/A
Tier 6	N/A	N/A	N/A	N/A	N/A			N/A	N/A

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CATASTROPHIC COVERAGE									
Catastrophic Coverage Limit	$2,100		$2,100		$2,100	$2,100		$2,100	
Tier 1	$0	N/A	$0	N/A	$0	$0	N/A	$0	N/A
Tier 2	$0	N/A	$0	N/A	$0	$0	N/A	$0	N/A
Tier 3	$0	N/A	$0	N/A	$0	$0	N/A	$0	N/A
Tier 4	$0	N/A	$0	N/A	$0	$0	N/A	$0	N/A
Tier 5	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$0	N/A
MAIL ORDER	90 DAY SUPPLY								
Tier 1	$10	N/A	$0	N/A	$0	$10	N/A	$0	N/A
Tier 2	$60	N/A	$94	N/A	$0	$60	N/A	$30	N/A
Tier 3	$120	N/A	$200	N/A	$5	$120	N/A	$94	N/A
Tier 4	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	$200	N/A
STANDARD RETAIL	90 DAY SUPPLY								
Tier 1	$15	N/A	$0	N/A	$0	$10	N/A	$0	N/A
Tier 2	$90	N/A	$141	N/A	$0	$60	N/A	$30	N/A
Tier 3	$180	N/A	$300	N/A	$15	$120	N/A	$94	N/A
Tier 4	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	$200	N/A
PREMIUM									
Monthly Premium	$478.91		$338.91		$0	$392.38		$267.53	