

2026

Annual Notice of Changes

HumanaChoice SNP-DE H5525-045 (PPO D-SNP)

This is a Highly Integrated Dual Eligible (HIDE) Special Needs Plan.

Kentucky

Humana[®]



It's time to review your HumanaChoice SNP-DE H5525-045 (PPO D-SNP) updates for 2026

Thank you for trusting Humana with your coverage needs for 2025. Inside, you'll find the Annual Notice of Change. This packet makes it easy to compare your plan benefits for 2025 and 2026, side by side. It shows you important changes, but keep in mind it does not include a full list of all plan benefits.

Humana is committed to offering plans that give you the benefits and services you rely on most. Our plans this year are no exception. Many of our members will see the same benefits on their plans this year. Some members may see enhanced benefits, too. Plus, we've made other changes to help make it easier to use your plan and get the care you need.



For example, your Dual Eligible Special Needs (D-SNP) plan includes dental, vision, hearing and prescription drug coverage. It also offers \$0 preventive care, including mammograms, colonoscopies and bone density screenings.

Here's how to make sure you're ready for 2026:



Please review the plan changes carefully. If you'd like to keep your current HumanaChoice SNP-DE H5525-045 (PPO D-SNP) plan, you don't need to do anything. It will automatically renew on January 1, 2026, and you can keep your current Humana member ID card.



If you have questions, you can find more information by logging in to www.Humana.com/PlanInformation.



**Beginning October 15, you can go to
www.Humana.com/PlanInformation or scan the QR code
to see a full list of your plan's benefits online in your 2026
Evidence of Coverage.**

Thank you for being a Humana member. We look forward to supporting your best health in 2026.

HumanaChoice SNP-DE H5525-045 (PPO D-SNP) offered by Humana Benefit Plan of Illinois, Inc.

Annual Notice of Change for 2026

You're enrolled as a member of HumanaChoice SNP-DE H5525-045 (PPO D-SNP).

This material describes changes to our plan's costs and benefits next year.

- **You have from October 15 - December 7 to make changes to your Medicare coverage for next year.** If you don't join another plan by December 7, 2025, you'll stay in HumanaChoice SNP-DE H5525-045 (PPO D-SNP).
- To change to a **different plan**, visit www.Medicare.gov or review the list in the back of your Medicare & You 2026 handbook.
- Note this is only a summary of changes. More information about costs, benefits, and rules is in the Evidence of Coverage. Get a copy at **Humana.com/PlanDocuments** or call Customer Care at 800-457-4708 (TTY users call 711) to get a copy by mail. You can also review the *Evidence of Coverage* to see if other benefit or cost changes affect you.

More Resources

- This material is available for free in Spanish.
- Call Customer Care at 800-457-4708 (TTY users call 711) for more information. Hours are 8 a.m. to 8 p.m. seven days a week from Oct. 1 – Mar. 31 and 8 a.m. to 8 p.m. Monday – Friday from Apr. 1 – Sept. 30. This call is free.
- This information is available in different formats, including braille, large print, and audio. Please call Customer Care at the number listed above if you need plan information in another format.
- **Coverage under this plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About HumanaChoice SNP-DE H5525-045 (PPO D-SNP)

- HumanaChoice SNP-DE H5525-045 (PPO D-SNP) is a Dual Eligible Special Needs PPO SNP plan with a Medicare contract and a contract with the Kentucky Medicaid program. Enrollment in this Humana plan depends on contract renewal. Our plan also has a written agreement with the Kentucky Medicaid program to coordinate your Medicaid benefits.

When this material says "we," "us," or "our," it means Humana Benefit Plan of Illinois, Inc. When it says "plan" or "our plan," it means HumanaChoice SNP-DE H5525-045 (PPO D-SNP).

- **If you do nothing by December 7, 2025, you'll automatically be enrolled in HumanaChoice SNP-DE H5525-045 (PPO D-SNP).** Starting January 1, 2026, you'll get your medical and drug coverage through HumanaChoice SNP-DE H5525-045 (PPO D-SNP). Go to Section 3 for more information about how to change plans and deadlines for making a change.

H5525_ANOC_MAPD_PPO_045000_2026_M

OMB Approval 0938-1051 (Expires: August 31, 2026)

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Lists the names, addresses, phone numbers, and other contact information for a variety of helpful resources in your state.

Summary of Important Costs for 2026

Cost	2025 (this year)		2026 (next year)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Monthly plan premium	\$0 or up to \$49.60		\$0 or up to \$38.40	
Deductible	\$0	\$0 or \$257 combined in-network and out-of-network except for insulin furnished through an item of durable medical equipment.	\$0	\$0 or you pay the same amount as you would with Original Medicare.
Maximum out-of-pocket amount This is the <u>most</u> you'll pay out of pocket for covered Part A and Part B services. (Go to Section 1.2 for details.)	From network providers: \$9,350 If you are eligible for Medicare cost-sharing help under Medicaid, you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.	From network and out-of-network providers combined: \$14,000 If you are eligible for Medicare cost-sharing help under Medicaid, you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.	From network providers: \$9,250 If you are eligible for Medicare cost-sharing help under Medicaid, you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.	From network and out-of-network providers combined: \$13,900 If you are eligible for Medicare cost-sharing help under Medicaid, you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.
Primary care office visits	\$0 copayment per visit	\$0 or 20% of the total cost per visit	\$0 copayment per visit	\$0 or 20% of the total cost per visit
Specialist office visits	\$0 copayment per visit	\$0 or 20% of the total cost per visit	\$0 copayment per visit	\$0 or 20% of the total cost per visit

Cost	2025 (this year)		2026 (next year)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you're formally admitted to the hospital with a doctor's order. The day before you're discharged is your last inpatient day.	\$0 copayment per stay	\$0 or \$2,185 copayment per stay	\$0 copayment per stay	\$0 or \$2,230 copayment per stay
Part D drug coverage deductible (Go to Section 1.7 for details)	\$590 except for covered insulin products and most adult Part D vaccines		\$615 except for covered insulin products and most adult Part D vaccines	
Part D drug coverage (Go to Section 1.7 for details, including Yearly Deductible, Initial Coverage, and Catastrophic Coverage Stages.) Not all tiers may include insulin. Please refer to your Prescription Drug Guide to confirm insulin coverage.	Coinsurance during the Initial Coverage Stage:		During this stage, you pay \$0 cost sharing for drugs on Tier 1, \$0 cost sharing for drugs on Tier 2 and the full cost of drugs on Tier 3, Tier 4, and Tier 5 until you have reached the yearly deductible. Copayment/Coinsurance during the Initial Coverage Stage:	

Cost	2025 (this year)		2026 (next year)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
	<p>For a 30-day supply from a retail pharmacy:</p> <ul style="list-style-type: none"> • All plan-covered Part D drugs: 25% You pay 25% per prescription except for each covered insulin product, you will pay \$35 per month supply. 		<p>For a 30-day supply from a retail pharmacy:</p> <ul style="list-style-type: none"> • Drug Tier 1: \$0 You pay 0% per month supply of each covered insulin product on this tier. • Drug Tier 2: \$0 You pay 0% per month supply of each covered insulin product on this tier. • Drug Tier 3: 25% You pay 25% up to \$35 per month supply of each covered insulin product on this tier. • Drug Tier 4: 25% You pay 25% up to \$35 per month supply of each covered insulin product on this tier. • Drug Tier 5: 25% You pay 25% up to \$35 per month supply of each covered insulin product on this tier. 	

Cost	2025 (this year)		2026 (next year)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
	<p>For a 90-day supply from a mail-order pharmacy with preferred cost-sharing:</p> <p>Not applicable</p>		<p>For a 100-day supply from a mail-order pharmacy with preferred cost-sharing:</p> <ul style="list-style-type: none"> • Drug Tier 1: \$0 • You pay 0% per 3-month supply of each covered insulin product on this tier. • Drug Tier 2: \$0 • You pay 0% per 3-month supply of each covered insulin product on this tier. • Drug Tier 3: 25% • You pay 25% up to \$105 per 3-month supply of each covered insulin product on this tier. • Drug Tier 4: 25% • You pay 25% up to \$105 per 3-month supply of each covered insulin product on this tier. • Drug Tier 5: Not available 	

Cost	2025 (this year)		2026 (next year)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
	<p>For a 90-day supply from a mail-order pharmacy with standard cost-sharing:</p> <ul style="list-style-type: none"> • All plan-covered Part D drugs: 25% <p>You pay 25% per prescription except for each covered insulin product, you will pay \$105 per 3-month supply.</p>		<p>For a 100-day supply from a mail-order pharmacy with standard cost-sharing:</p> <ul style="list-style-type: none"> • Drug Tier 1: \$30 <p>You pay 25% up to \$30 per 3-month supply of each covered insulin product on this tier.</p> <ul style="list-style-type: none"> • Drug Tier 2: \$60 <p>You pay 25% up to \$60 per 3-month supply of each covered insulin product on this tier.</p> <ul style="list-style-type: none"> • Drug Tier 3: 25% <p>You pay 25% up to \$105 per 3-month supply of each covered insulin product on this tier.</p> <ul style="list-style-type: none"> • Drug Tier 4: 25% <p>You pay 25% up to \$105 per 3-month supply of each covered insulin product on this tier.</p> <ul style="list-style-type: none"> • Drug Tier 5: Not available 	
	<p>Catastrophic Coverage:</p> <p>During this payment stage, you pay nothing for your covered Part D drugs</p>		<p>Catastrophic Coverage:</p> <p>During this payment stage, you pay nothing for your covered Part D drugs</p>	

SECTION 1 Changes to Benefits & Costs for Next Year

Section 1.1 Changes to the Monthly Plan Premium

Cost	2025 (this year)	2026 (next year)
Monthly plan premium (You must also continue to pay your Medicare Part B premium unless it is paid for you by Department for Medicaid Services (DMS).)	\$0 or up to \$49.60	\$0 or up to \$38.40 If you qualify for Extra Help with your prescription drug expenses, you may not have to pay a plan premium, or may pay a reduced amount.

Section 1.2 Changes to Your Maximum Out-of-Pocket Amount

Medicare requires all health plans to limit how much you pay out-of-pocket for the year. This limit is called the maximum out-of-pocket amount. Once you've paid this amount, you generally pay nothing for covered Part A and Part B services for the rest of the calendar year.

Cost	2025 (this year)		2026 (next year)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
In-network maximum out-of-pocket amount Because our members also get help from Department for Medicaid Services (DMS), very few members ever reach this out-of-pocket maximum. If you are eligible for Medicaid help with Part A and Part B copayments and deductibles, you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services. Your costs for covered medical services (such as copayments and deductibles) from network providers count toward your in-network maximum out-of-pocket amount. Our plan premium and your costs for prescription drugs don't count toward your maximum out-of-pocket amount. Combined maximum out-of-pocket amount Your costs for covered medical services (such as copayments and deductibles) from in-network and out-of-network providers count toward your combined maximum out-of-pocket amount. Our plan premium and your costs for outpatient prescription drugs don't count toward your maximum out-of-pocket amount for medical services.	\$9,350	\$14,000 combined in-network and out-of-network	\$9,250 Once you've paid \$9,250 out-of-pocket for covered Part A and Part B services, you'll pay nothing for your covered Part A and Part B services from network providers for the rest of the calendar year.	\$13,900 combined in-network and out-of-network Once you've paid \$13,900 out-of-pocket for covered Part A and Part B services, you'll pay nothing for your covered Part A and Part B services from in-network or out-of-network providers for the rest of the calendar year.

Section 1.3 Changes to the Provider Network

Our network of providers has changed for next year. Review the 2026 *Provider Directory* [**Humana.com/PlanDocuments**](#) to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network. Here's how to get an updated *Provider Directory*:

- Visit our website at [**Humana.com/PlanDocuments**](#).
- Call Customer Care at 800-457-4708 (TTY users should call 711) to get current provider information or to ask us to mail you a *Provider Directory*.

We can make changes to the hospitals, doctors, and specialists (providers) that are part of our plan during the year. If a mid-year change in our providers affects you, call Customer Care at 800-457-4708 (TTY users should call 711) for help. For more information on your rights when a network provider leaves our plan, go to Chapter 3, Section 2.3 of your *Evidence of Coverage*.

Section 1.4 Changes to the Pharmacy Network

Amounts you pay for your prescription drugs may depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered *only* if they are filled at one of our network pharmacies.

Our network of pharmacies has changed for next year. Review the 2026 *Provider Directory* [**Humana.com/PlanDocuments**](#) to see which pharmacies are in our network. Here's how to get an updated *Provider Directory*:

- Visit our website at [**Humana.com/PlanDocuments**](#).
- Call Customer Care at 800-457-4708 (TTY users should call 711) to get current pharmacy information or to ask us to mail you a *Provider Directory*.

We can make changes to the pharmacies that are part of our plan during the year. If a mid-year change in our pharmacies affects you, call Customer Care at 800-457-4708 (TTY users should call 711) for help.

Section 1.5 Changes to Benefits & Costs for Medical Services

The Annual Notice of Changes tells you about changes to your Medicare benefits and costs.

Services received at Rural Health Clinics, Federally Qualified Health Clinics, and Critical Access Hospitals may be subject to the Primary Care Physician or Specialist copay or coinsurance, as applicable, for 2026.

Cost	2025 (this year)		2026 (next year)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Ambulance services				
<ul style="list-style-type: none"> • For each Medicare-covered emergency transportation by ground, you pay: • For each Medicare-covered 	\$0 copayment per date of service	\$0 or \$315 copayment per date of service	No Change	\$0 or \$335 copayment per date of service

Cost	2025 (this year)		2026 (next year)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
<p>emergency transportation by air, you pay:</p> <ul style="list-style-type: none"> For each Medicare-covered non-emergency transportation by ground, you pay: For each Medicare-covered non-emergency transportation by air, you pay: 	<p>\$0 copayment per date of service</p> <p>\$0 copayment per date of service</p>	<p>\$0 or \$315 copayment per date of service</p> <p>\$0 or \$315 copayment per date of service</p>	No Change	<p>\$0 or \$335 copayment per date of service</p> <p>\$0 or \$335 copayment per date of service</p>
Dental services	DEN781 \$0 copayment for scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years. \$0 copayment for comprehensive oral evaluation or periodontal exam, occlusal adjustment, scaling for moderate inflammation up to 1 every 3 years. \$0 copayment for bridge recementation, bridges-pontic, complete dentures, crown recementation, panoramic film or diagnostic x-rays, partial dentures up to 1 every 5 years. \$0 copayment for bridges-crown up to 2 every 5 years. \$0 copayment for crown, other restorative services	DEN781 \$0 copayment for scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years. \$0 copayment for comprehensive oral evaluation or periodontal exam, occlusal adjustment, scaling for moderate inflammation up to 1 every 3 years. \$0 copayment for bridge recementation, bridges-pontic, complete dentures, crown recementation, panoramic film or diagnostic x-rays, partial dentures up to 1 every 5 years. \$0 copayment for bridges-crown up to 2 every 5 years. \$0 copayment for crown, other restorative services - core buildup and	DEN379 \$0 copayment for scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years. \$0 copayment for comprehensive oral evaluation or periodontal exam, occlusal adjustment, scaling for moderate inflammation up to 1 every 3 years. \$0 copayment for bridge recementation, bridges-pontic, crown recementation, panoramic film or diagnostic x-rays up to 1 every 5 years.	DEN379 \$0 copayment for scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years. \$0 copayment for comprehensive oral evaluation or periodontal exam, occlusal adjustment, scaling for moderate inflammation up to 1 every 3 years. \$0 copayment for bridge recementation, bridges-pontic, crown recementation, panoramic film or diagnostic x-rays up to 1 every 5 years.

Cost	2025 (this year)		2026 (next year)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
	<p>- core buildup and prefabricated post and core, restoration implant, root canal, root canal retreatment up to 1 per tooth per lifetime.</p> <p>\$0 copayment for bitewing x-rays, intraoral x-rays up to 1 set(s) per year.</p> <p>\$0 copayment for adjustments to dentures, denture rebase, denture reline, denture repair, emergency diagnostic exam, tissue conditioning up to 1 per year.</p> <p>\$0 copayment for emergency treatment for pain, oral surgery, periodic oral exam, prophylaxis (cleaning) up to 2 per year.</p> <p>\$0 copayment for periodontal maintenance up to 4 per year.</p> <p>\$0 copayment for amalgam and/or composite filling, necessary anesthesia with covered service, simple or surgical extraction up to unlimited per year.</p> <p>\$4,000 combined maximum benefit coverage amount per year for all diagnostic/preventive and comprehensive benefits.</p>	<p>- core buildup and prefabricated post and core, restoration implant, root canal, root canal retreatment up to 1 per tooth per lifetime.</p> <p>\$0 copayment for bitewing x-rays, intraoral x-rays up to 1 set(s) per year.</p> <p>\$0 copayment for adjustments to dentures, denture rebase, denture reline, denture repair, emergency diagnostic exam, tissue conditioning up to 1 per year.</p> <p>\$0 copayment for emergency treatment for pain, oral surgery, periodic oral exam, prophylaxis (cleaning) up to 2 per year.</p> <p>\$0 copayment for periodontal maintenance up to 4 per year.</p> <p>\$0 copayment for amalgam and/or composite filling, necessary anesthesia with covered service, simple or surgical extraction up to unlimited per year.</p> <p>\$4,000 combined maximum benefit coverage amount per year for all diagnostic/preventive and comprehensive benefits.</p>	<p>prefabricated post and core, root canal, root canal retreatment up to 1 per tooth per lifetime.</p> <p>\$0 copayment for bitewing x-rays, intraoral x-rays up to 1 set(s) per year.</p> <p>\$0 copayment for emergency diagnostic exam up to 1 per year.</p> <p>\$0 copayment for emergency treatment for pain, oral surgery, periodic oral exam, prophylaxis (cleaning) up to 2 per year.</p> <p>\$0 copayment for periodontal maintenance up to 4 per year.</p> <p>\$0 copayment for necessary anesthesia with covered service up to as needed with covered codes per year.</p> <p>\$0 copayment for amalgam and/or composite filling, simple or surgical extraction up to unlimited per year.</p> <p>\$2,000 combined maximum benefit coverage amount per year for all diagnostic/preventive and comprehensive benefits.</p>	<p>prefabricated post and core, root canal, root canal retreatment up to 1 per tooth per lifetime.</p> <p>\$0 copayment for bitewing x-rays, intraoral x-rays up to 1 set(s) per year.</p> <p>\$0 copayment for emergency diagnostic exam up to 1 per year.</p> <p>\$0 copayment for emergency treatment for pain, oral surgery, periodic oral exam, prophylaxis (cleaning) up to 2 per year.</p> <p>\$0 copayment for periodontal maintenance up to 4 per year.</p> <p>\$0 copayment for necessary anesthesia with covered service up to as needed with covered codes per year.</p> <p>\$0 copayment for amalgam and/or composite filling, simple or surgical extraction up to unlimited per year.</p> <p>\$2,000 combined maximum benefit coverage amount per year for all diagnostic/preventive and comprehensive benefits.</p>

Cost	2025 (this year)		2026 (next year)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
	ve and comprehensive benefits.	ve and comprehensive benefits. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.		Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
Emergency care				
• For each Medicare-covered emergency room visit, you pay:	\$0 copayment	\$0 or \$110 copayment	No Change	\$0 or \$115 copayment
Inpatient hospital care				
• For a Medicare-covered stay at a hospital, you pay:	\$0 copayment per stay	\$0 or \$2,185 copayment per stay	No Change	\$0 or \$2,230 copayment per stay
Inpatient mental health care				
• For a Medicare-covered stay at a hospital, you pay:	\$0 copayment per stay	\$0 or \$2,185 copayment per stay	No Change	\$0 or \$2,230 copayment per stay
• For a Medicare-covered stay at an inpatient psychiatric facility, you pay:	\$0 copayment per stay	\$0 or \$2,036 copayment per stay	No Change	\$0 or \$2,080 copayment per stay
Meal Program - Humana Well Dine®	\$0 copayment for Humana Well Dine® meal program. After your inpatient stay in either a hospital or a nursing facility, you may be eligible to receive 2 home delivered meals per day for 7 days (up to 14 meals). Meals must be requested within 30 days of discharge from your inpatient stay.	The in-network provider must be used for this service. If you choose to utilize another provider, you are responsible for all charges.	\$0 copayment for Humana Well Dine® meal program. After your inpatient stay in either a hospital or a nursing facility, you may be eligible to receive 2 home delivered meals per day for 7 days (up to 14 meals). Meals must be requested within 30 days of discharge from your inpatient stay.	No Change

Cost	2025 (this year)		2026 (next year)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
	Limited to 4 times per year.		Limited to 4 times per year. \$0 copayment for Humana Well Dine® meal program. Receive 2 meals per day for 10 days. Up to 20 meals delivered to member's home to assist in establishing a diet needed for diabetes mellitus with physician approval.	
Outpatient diagnostic tests, therapeutic services and supplies				
<ul style="list-style-type: none"> For advanced imaging services (MRI, MRA, PET, or CT Scan), you pay: <ul style="list-style-type: none"> at your primary care provider's office at a specialist's office at a freestanding radiology facility at a hospital facility as an outpatient 	\$0 copayment \$0 copayment \$0 copayment \$0 copayment	\$0 or \$165 copayment \$0 or \$165 copayment \$0 or \$165 copayment \$0 or \$325 copayment	No Change No Change No Change No Change	\$0 or \$200 copayment \$0 or \$280 copayment \$0 or \$200 copayment \$0 or \$335 copayment
Over-the-counter (OTC) items	\$30 quarterly allowance on a prepaid spending card to buy approved over-the-counter health and wellness products at participating retail locations or through the plan's approved OTC mail order vendor.	The in-network provider must be used for this service. If you choose to utilize another provider, you are responsible for all charges.	Not Covered	Not Covered

Cost	2025 (this year)		2026 (next year)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
	Unused amount expires at the end of the quarter.			
Skilled nursing facility (SNF) care <ul style="list-style-type: none">For a Medicare-covered stay at a skilled nursing facility, you pay:	\$0 copayment per day for days 1 - 20 \$0 copayment per day for days 21 - 100	\$0 copayment per day for days 1 - 20 \$0 or \$214 copayment per day for days 21 - 100	No Change	\$0 copayment per day for days 1 - 20 \$0 or \$218 copayment per day for days 21 - 100
Transportation	Covered	The in-network provider must be used for this service. If you choose to utilize another provider, you are responsible for all charges.	Not Covered	Not Covered
Vision care <ul style="list-style-type: none">Routine vision services:	VIS711 \$0 copayment for routine exam up to 1 per year. \$40 combined maximum benefit coverage amount per year for routine exam. \$300 maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames. OR \$350 maximum benefit coverage amount per year at PLUS Provider for contact lenses or eyeglasses-lenses	VIS711 \$0 copayment for routine exam up to 1 per year. \$40 combined maximum benefit coverage amount per year for routine exam. \$300 combined maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames. Eyeglass lens options may be available with the maximum benefit coverage amount	VIS704 \$0 copayment for routine exam up to 1 per year. \$40 combined maximum benefit coverage amount per year for routine exam. \$450 maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames. OR \$550 maximum benefit coverage amount per year at PLUS Provider for contact lenses or eyeglasses-lenses	VIS704 \$0 copayment for routine exam up to 1 per year. \$40 combined maximum benefit coverage amount per year for routine exam. \$450 combined maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames. Eyeglass lens options may be available with the maximum benefit coverage amount

Cost	2025 (this year)		2026 (next year)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
• Medically Necessary Contacts	and frames, fitting for eyeglasses-lenses and frames. Eyeglass lens options may be available with the maximum benefit coverage amount up to 1 pair per year. Maximum benefit coverage amount is limited to one time use per year.	up to 1 pair per year. Maximum benefit coverage amount is limited to one time use per year. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.	and frames, fitting for eyeglasses-lenses and frames. Eyeglass lens options may be available with the maximum benefit coverage amount up to 1 pair per year. Maximum benefit coverage amount is limited to one time use per year.	up to 1 pair per year. Maximum benefit coverage amount is limited to one time use per year. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
Worldwide coverage • For each emergency room visit, you pay:	\$0 copayment	Included as part of the out-of-network VIS711 allowance listed above.	Included as part of the VIS704 allowance listed above.	Included as part of the out-of-network VIS704 allowance listed above.

Section 1.6 Changes to Part D Drug Coverage

Changes to Our Drug Guide

Our list of covered drugs is called a Formulary or Drug Guide. A copy of our Drug Guide is provided electronically. The Drug List includes many—but not all—of the drugs that we'll cover next year. If you don't see your drug on this list, it might still be covered. **You can get the complete Drug Guide** by calling Customer Care at 800-457-4708 (TTY users should call 711) or visiting our website (Humana.com/PlanDocuments).

We made changes to our Drug Guide, which could include removing or adding drugs, changing the restrictions that apply to our coverage for certain drugs or moving them to a different cost-sharing tier. **Review the Drug Guide to make sure your drugs will be covered next year and to see if there will be any restrictions, or if your drug has been moved to a different cost-sharing tier.**

Most of the changes in the Drug Guide are new for the beginning of each year. However, we might make other changes that are allowed by Medicare rules that will affect you during the calendar year. We update our online Drug Guide at least monthly to provide the most up-to-date list of drugs. If we make a change that will affect your access to a drug you're taking, we'll send you a notice about the change.

If you're affected by a change in drug coverage at the beginning of the year or during the year, please review Chapter 9 of your *Evidence of Coverage* and talk to your prescriber to find out your options, such as asking for a temporary supply, applying for an exception, and/or working to find a new drug. Call Customer Care at 800-457-4708 (TTY users should call 711) for more information.

Section 1.7 Changes to Prescription Drug Benefits & Costs

Do you get Extra Help to pay for your drug coverage costs?

If you are in a program that helps pay for your drugs (Extra Help), **the information about costs for Part D Drugs may not apply to you.** We sent you a separate material, called the *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs*, which tells you about your drug costs. If you get Extra Help and don't get this material by September 30, call Customer Care at 800-457-4708 (TTY users should call 711) and ask for the *LIS Rider*.

Drug Payment Stages

There are **3 drug payment stages:** the Yearly Deductible Stage, the Initial Coverage Stage, and the Catastrophic Coverage Stage. The Coverage Gap Stage and the Coverage Gap Discount Program will no longer exist in the Part D benefit.

- ***Stage 1: Yearly Deductible***

You start in this payment stage each calendar year. During this stage, you pay the full cost of your Part D drugs until you've reached the yearly deductible.

- ***Stage 2: Initial Coverage***

Once you pay the yearly deductible, you move to the Initial Coverage Stage. In this stage, our plan pays its share of the cost of your drugs, and you pay your share of the cost. You generally stay in this stage until your year-to-date Out-of-Pocket costs reach **\$2,100 Out-of-Pocket threshold**.

- ***Stage 3: Catastrophic Coverage***

This is the third and final drug payment stage. In this stage, you pay nothing for your covered Part D drugs. You generally stay in this stage for the rest of the calendar year.

The Coverage Gap Discount Program has been replaced by the Manufacturer Discount Program. Under the Manufacturer Discount Program, drug manufacturers pay a portion of the plan's full cost for covered Part D brand name drugs and biologics during the Initial Coverage Stage and the Catastrophic Coverage Stage. Discounts paid by manufacturers under the Manufacturer Discount Program don't count toward out-of-pocket costs.

The table shows your cost per prescription during this stage.

Drug Costs in Stage 1: Yearly Deductible

Stage	2025 (this year)	2026 (next year)
Yearly Deductible	The deductible is \$590 except for covered insulin products and most adult Part D vaccines.	If you receive Extra Help, your deductible is \$0. Refer to your LIS Rider insert for your cost sharing amounts. If you do not receive Extra Help, the deductible is \$615 . The deductible is \$615 except for covered insulin products and most adult Part D vaccines.

Stage	2025 (this year)	2026 (next year)
		During this stage, you pay \$0 cost sharing for drugs on Tier 1, \$0 cost sharing for drugs on Tier 2 and the full cost of drugs on Tier 3, Tier 4, and Tier 5 until you've reached the yearly deductible.

Drug Costs in Stage 2: Initial Coverage

For drugs on Tier 1 – Preferred Generic, your cost-sharing in the Initial Coverage Stage is changing from coinsurance to a copayment. Go to the following table for the changes from 2025 to 2026.

For drugs on Tier 2 – Generic, your cost-sharing in the Initial Coverage Stage is changing from coinsurance to a copayment. Go to the following table for the changes from 2025 to 2026.

We changed the tier for some of the drugs on our Drug Guide. To see if your drugs will be in a different tier, look them up on the Drug Guide.

Not all tiers may include insulin. Please refer to your Prescription Drug Guide to confirm insulin coverage. The table shows your cost per prescription for a one-month supply filled at a network pharmacy with standard cost sharing.

Most adult Part D vaccines are covered at no cost to you. For more information about the costs of vaccines, or information about the costs for a long-term supply; or for mail-order prescriptions, go to Chapter 6 of your *Evidence of Coverage*.

Once you've paid **\$2,100** out of pocket for covered Part D drugs, you'll move to the next stage (the Catastrophic Coverage Stage).

	2025 (this year)	2026 (next year)
Tier 1: Preferred Generic:	All plan-covered Part D drugs: You pay 25% per prescription except for each covered insulin product, you will pay \$35 per month supply.	You pay \$0 per month supply at a retail pharmacy. You pay 0% per month supply of each covered insulin product at a retail pharmacy on this tier. Your cost for a one-month mail-order prescription is \$10 . You pay 25% up to \$10 per month supply of each covered insulin product for a mail-order prescription on this tier.

	2025 (this year)	2026 (next year)
Tier 2: Generic:	<p>All plan-covered Part D drugs: You pay 25% per prescription except for each covered insulin product, you will pay \$35 per month supply.</p>	<p>You pay \$0 per month supply at a retail pharmacy. You pay 0% per month supply of each covered insulin product at a retail pharmacy on this tier. Your cost for a one-month mail-order prescription is \$20. You pay 25% up to \$20 per month supply of each covered insulin product for a mail-order prescription on this tier.</p>
Tier 3: Preferred Brand:	<p>All plan-covered Part D drugs: You pay 25% per prescription except for each covered insulin product, you will pay \$35 per month supply.</p>	<p>You pay 25% per month supply at a retail pharmacy. You pay 25% up to \$35 per month supply of each covered insulin product at a retail pharmacy on this tier. Your cost for a one-month mail-order prescription is 25%. You pay 25% up to \$35 per month supply of each covered insulin product for a mail-order prescription on this tier.</p>
Tier 4: Non-Preferred Drug:	<p>All plan-covered Part D drugs: You pay 25% per prescription except for each covered insulin product, you will pay \$35 per month supply.</p>	<p>You pay 25% of the total cost per month supply at a retail pharmacy. You pay 25% up to \$35 per month supply of each covered insulin product at a retail pharmacy on this tier. Your cost for a one-month mail-order prescription is 25%. You pay 25% up to \$35 per month supply of each covered insulin product for a mail-order prescription on this tier.</p>
Tier 5: Specialty Tier:	<p>All plan-covered Part D drugs: You pay 25% per prescription except for each covered insulin product, you will pay \$35 per month supply.</p>	<p>You pay 25% of the total cost per month supply at a retail pharmacy. You pay 25% up to \$35 per month supply of each covered insulin product at a retail pharmacy on this tier. Your cost for a one-month mail-order prescription is 25%. You pay 25% up to \$35 per month supply of each covered insulin product for a mail-order prescription on this tier.</p>

Changes to the Catastrophic Coverage Stage

If you reach the Catastrophic Coverage Stage, you pay nothing for your covered Part D drugs.

For specific information about your costs in the Catastrophic Coverage Stage, go to Chapter 6, Section 6, in your

Evidence of Coverage.

SECTION 2 Administrative Changes

Description	2025 (this year)	2026 (next year)
Medicare Prescription Payment Plan	The Medicare Prescription Payment Plan is a payment option that began this year and can help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across the calendar year (January-December). You may be participating in this payment option.	If you're participating in the Medicare Prescription Payment Plan and stay in the same Part D plan, your participation will be automatically renewed for 2026. To learn more about this payment option, call us at 800-457-4708 (TTY users call 711) or visit http://www.Medicare.gov.

SECTION 3 How to Change Plans

To stay in HumanaChoice SNP-DE H5525-045 (PPO D-SNP), you don't need to do anything. Unless you sign up for a different plan or change to Original Medicare by December 7, you'll automatically be enrolled in our HumanaChoice SNP-DE H5525-045 (PPO D-SNP).

If you want to change plans for 2026 follow these steps:

- **To change to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from HumanaChoice SNP-DE H5525-045 (PPO D-SNP).
- **To change to Original Medicare with Medicare drug coverage**, enroll in the new Medicare drug plan. You will automatically be disenrolled from HumanaChoice SNP-DE H5525-045 (PPO D-SNP).
- **To change to Original Medicare without a drug plan**, you can send us a written request to disenroll or visit our website to disenroll online at www.humana.com/member/member-rights/disenrollment-and-cancellation. Call Customer Care at 800-457-4708 (TTY users call 711) for more information on how to do this. Or call **Medicare** at 1-800-MEDICARE (1-800-633-4227) and ask to be disenrolled. TTY users can call 1-877-486-2048. If you don't enroll in a Medicare drug plan, you may pay a Part D late enrollment penalty (go to Section 4).
- **To learn more about Original Medicare and the different types of Medicare plans**, visit www.Medicare.gov, check the Medicare & You 2026 handbook, call your State Health Insurance Assistance Program (go to Section 5), or call 1-800-MEDICARE (1-800-633-4227).

Section 3.1 Deadlines for Changing Plans

People with Medicare can make changes to their coverage from **October 15 – December 7** each year.

If you enrolled in a Medicare Advantage plan for January 1, 2026, and don't like your plan choice, you can switch to another Medicare health plan (with or without Medicare drug coverage) or switch to Original Medicare (with or without separate Medicare drug coverage) between January 1 – March 31, 2026.

Section 3.2 Are there other times of the year to make a change?

In certain situations, people may have other chances to change their coverage during the year. Examples include people who:

- Have Medicaid
- Get Extra Help paying for their drugs
- Have or are leaving employer coverage
- Move out of our plan's service area

Because you have Department for Medicaid Services (DMS), you can end your membership in our plan by choosing one of the following Medicare options in any month of the year:

- Original Medicare with a separate Medicare prescription drug plan,
- Original Medicare without a separate Medicare prescription drug plan (If you choose this option, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.), or
- If eligible, an integrated D-SNP that provides your Medicare and most or all of your Medicaid benefits and services in one plan.

If you recently moved into or currently live in an institution (like a skilled nursing facility or long-term care hospital), you can change your Medicare coverage **at any time**. You can change to any other Medicare health plan (with or without Medicare drug coverage) or switch to Original Medicare (with or without separate Medicare drug coverage) at any time. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for 2 full months after the month you move out.

SECTION 4 Get Help Paying for Prescription Drugs

You may qualify for help paying for prescription drugs. Different kinds of help are available:

- **Extra Help from Medicare.** People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75 % or more of your drug costs including monthly drug plan premiums, yearly deductibles and coinsurance. Also, people who qualify won't have a late enrollment penalty. To see if you qualify, call:
 - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day, 7 days a week.
 - Social Security at 1-800-772-1213 between 8 a.m. and 7 p.m., Monday - Friday for a representative. Automated messages are available 24 hours a day. TTY users should call 1-800-325-0778.
 - Your State Medicaid Office.
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible people living with HIV/AIDS have access to life-saving HIV medications. To be eligible for the ADAP operating in your state, you must meet certain criteria, including proof of state residence and HIV status, low income as defined by the state, and uninsured/under-insured.

status. Medicare Part D drugs that are also covered by ADAP qualify for prescription cost-sharing help through the ADAP program. For information on eligibility criteria, covered drugs, how to enroll in the program or if you are currently enrolled how to continue receiving help, call the ADAP program (the name and phone numbers for this organization are listed in “Exhibit A” in the back of this document). Be sure, when calling, to inform them of your Medicare Part D plan name or policy number.

- **The Medicare Prescription Payment Plan.** The Medicare Prescription Payment Plan is a payment option that works with your current drug coverage to help you manage your out-of-pocket drug costs, for drugs covered by our plan by spreading them across the calendar year (January – December). Anyone with a Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage plan with drug coverage) can use this payment option. **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs.**

Extra Help from Medicare and help from your ADAP, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan. All members are eligible to participate in the Medicare Prescription Payment Plan, regardless of income level. To learn more about this payment option, please call us at the Customer Care at 800-457-4708 (TTY users call 711) or visit Medicare.gov.

SECTION 5 Questions?

Get Help from HumanaChoice SNP-DE H5525-045 (PPO D-SNP)

Call Customer Care at 800-457-4708. (TTY users, call 711.)

We're available for phone calls from 8 a.m. to 8 p.m., seven days a week from Oct. 1 – Mar. 31 and 8 a.m. to 8 p.m. Monday – Friday from Apr. 1 – Sept. 30. Calls to these numbers are free.

Read your 2026 Evidence of Coverage

This Annual Notice of Changes gives you a summary of changes in your benefits and costs for 2026. For details, go to the 2026 Evidence of Coverage for HumanaChoice SNP-DE H5525-045 (PPO D-SNP). The Evidence of Coverage is the legal, detailed description of our plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. Get the Evidence of Coverage on our website at [Humana.com/PlanDocuments](#) or call Customer Care 800-457-4708 (TTY users call 711) to ask us to mail you a copy.

Visit [Humana.com/PlanDocuments](#)

Our website has the most up-to-date information about our provider network (*Provider Directory*) and our *List of Covered Drugs (formulary/Drug Guide)*.

Get Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is an independent government program with trained counselors in every state.

Call your state SHIP to get free personalized health insurance counseling. They can help you understand your Medicare and Medicaid plan choices and answer questions about switching plans. Contact information for your state SHIP is listed in “Exhibit A” in the back of this document.

Get Help from Medicare

- **Call 1-800-MEDICARE (1-800-633-4227)**

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

- **Chat live with www.Medicare.gov**

You can chat live at www.Medicare.gov/talk-to-someone.

- **Write to Medicare**

You can write to Medicare at PO Box 1270, Lawrence, KS 66044

- **Visit www.Medicare.gov**

The official Medicare website has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area.

- **Read *Medicare & You 2026***

The *Medicare & You 2026* handbook is mailed to people with Medicare every fall. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. Get a copy at www.Medicare.gov or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Get Help from Medicaid

Call Department for Medicaid Services (DMS) at the numbers listed in "Exhibit A" in the back of this document for help with Medicaid enrollment or benefit questions.

Exhibit A - State Agency Contact Information**Exhibit A- State Agency Contact Information**

This section provides the contact information for the state agencies referenced in this Annual Notice of Changes. If you have trouble locating the information you seek, please contact Customer Care at the phone number on the back cover of this booklet.

KENTUCKY	
SHIP Name and Contact Information	State Health Insurance Assistance Program (SHIP) 275 East Main Street, 3E-E Frankfort, KY 40621 877-293-7447 (toll free) 502-564-6930 (local) https://chfs.ky.gov/agencies/dail/Pages/ship.aspx
Quality Improvement Organization	Acentra Health 5201 W. Kennedy Blvd. Suite 900 Tampa, FL 33609 888-317-0751 711 (TTY) 844-878-7921 (Fax) www.acentraqio.com
State Medicaid Office	Department for Medicaid Services (DMS) 275 East Main Street 6EC Frankfort, KY 40621 800-635-2570 (toll free) 502-564-3852 (local) 711 (TTY) https://chfs.ky.gov/agencies/dms/Pages/default.aspx
AIDS Drug Assistance Program	Kentucky HIV/AIDS Care Coordinator Program (KHCCP) Kentucky Cabinet for Public Health and Family Services 275 E. Main St. HS2E-C Frankfort, KY 40621 866-510-0005 877-353-9380 (fax) 800-420-7431 502-564-9865 https://chfs.ky.gov/agencies/dph/dehp/hab/Pages/services.aspx

Insurance ACE

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The privacy of your personal and health information is important. You do not need to do anything unless you have a request or complaint.

This Notice of Privacy Practices applies to all entities that are part of the Insurance ACE, an Affiliated Covered Entity under HIPAA. The ACE is a group of legally separate covered entities that are affiliated and have designated themselves as a single covered entity for purposes of HIPAA. A complete list of the members of the ACE is available at <https://huma.na/insuranceace>.

We may change our privacy practices and the terms of this notice at any time, as allowed by law, including information we created or received before we made the changes. When we make a significant change in our privacy practices, we will change this notice and send the notice to our health plan subscribers.

What is nonpublic personal or health information?

Nonpublic personal or health information includes both medical information and personal information, like your name, address, telephone number, Social Security number, account numbers, payment information, or demographic information. The term “information” in this notice includes any nonpublic personal and health information. This includes information created or received by a healthcare provider or health plan. The information relates to your physical or mental health or condition, providing healthcare to you, or the payment for such healthcare.

How do we collect information about you?

We collect information about you and your family when you complete applications and forms. We also collect information from your dealings with us, our affiliates, or others. For example, we may receive information about you from participants in the healthcare system, such as your doctor or hospital, as well as from employers or plan administrators, credit bureaus, and the Medical Information Bureau.

What information do we receive about you?

The information we receive may include such items as your name, address, telephone number, date of birth, Social Security number, premium payment history, and your activity on our website. This also includes information regarding your medical benefit plan, your health benefits, and health risk assessments.

How do we protect your information?

We have a responsibility to protect the privacy of your information in all formats including electronic, and oral information. We have administrative, technical, and physical safeguards in place to protect your information in various ways including:

- Limiting who may see your information
- Limiting how we use or disclose your information
- Informing you of our legal duties about your information
- Training our employees about our privacy program and procedures

How do we use and disclose your information?

We use and disclose your information:

- To you or someone who has the legal right to act on your behalf
- To the Secretary of the Department of Health and Human Services

We have the right to use and disclose your information:

- To a doctor, a hospital, or other healthcare provider so you can receive medical care.

- For payment activities, including claims payment for covered services provided to you by healthcare providers and for health plan premium payments.
- For healthcare operation activities, including processing your enrollment, responding to your inquiries, coordinating your care, improving quality, and determining premiums.
- For performing underwriting activities. However, we will not use any results of genetic testing or ask questions regarding family history.
- To your plan sponsor to permit them to perform, plan administration functions such as eligibility, enrollment and disenrollment activities. We may share summary level health information about you with your plan sponsor in certain situations. For example, to allow your plan sponsor to obtain bids from other health plans. Your detailed health information will not be shared with your plan sponsor. We will ask your permission, or your plan sponsor must certify they agree to maintain the privacy of your information.
- To contact you with information about health-related benefits and services, appointment reminders, or treatment alternatives that may be of interest to you. If you have opted out, we will not contact you.
- To your family and friends if you are unavailable to communicate, such as in an emergency.
- To your family and friends, or any other person you identify. This applies if the information is directly relevant to their involvement with your health care or payment for that care. For example, if a family member or a caregiver calls us with prior knowledge of a claim, we may confirm if the claim has been received and paid.
- To provide payment information to the subscriber for Internal Revenue Service substantiation.
- To public health agencies, if we believe that there is a serious health or safety threat.
- To appropriate authorities when there are issues about abuse, neglect, or domestic violence.
- In response to a court or administrative order, subpoena, discovery request, or other lawful process.
- For law enforcement purposes, to military authorities and as otherwise required by law.
- To help with disaster relief efforts.
- For compliance programs and health oversight activities.
- To fulfill our obligations under any workers' compensation law or contract.
- To avert a serious and imminent threat to your health or safety or the health or safety of others.
- For research purposes in limited circumstances and provided that they have taken appropriate measures to protect your privacy.
- For procurement, banking, or transplantation of organs, eyes, or tissue.
- To a coroner, medical examiner, or funeral director.

Additional restriction on use and disclosure for specific types of information:

- Some federal and state laws may restrict the use and disclosure of certain sensitive health information such as: Substance Use Disorder; Biometric Information; Child or Adult Abuse or Neglect, including Sexual Assault; Communicable Diseases; Genetic Information; HIV/AIDS; Mental Health; Reproductive Health; and Sexually Transmitted Diseases.
- Reproductive Health Information: We will not use or disclose information to conduct an investigation into identifying (or the attempt to impose liability against) any person for the act of seeking, obtaining, providing, or facilitating lawful reproductive health care. In response to a government agency's (or other person's) request for information that might be related to reproductive health care, the person making the request must provide a signed attestation that the purpose of the request does not violate the prohibition on disclosing reproductive health care information.

Will we use your information for purposes not described in this notice?

We will not use or disclose your information for any reason that is not described in this notice, without your written permission. You may cancel your permission at any time by notifying us in writing.

The following uses and disclosures will require your written permission:

- Most uses and disclosures of psychotherapy notes
- Marketing purposes
- Sale of personal and health information

What do we do with your information when you are no longer a member?

Your information may continue to be used for purposes described in this notice. This includes when you do not obtain coverage through us. After the required legal retention period, we destroy the information following strict

procedures to maintain the confidentiality.

What are my rights concerning my information?

We are committed to responding to your rights request in a timely manner.

- Access - You have the right to review and obtain a copy of your information that may be used to make decisions about you. You also may receive a summary of this health information. As required under applicable law, we will make this personal information available to you or to your designated representative.
- Adverse Underwriting Decision - If we decline your application for insurance, you have the right to be provided a reason for the denial.
- Alternate Communications - To avoid a life-threatening situation, you have the right to receive your information in a different manner or at a different place. We will accommodate your request if it is reasonable.
- Amendment - You have the right to request correction of any of this personal information through amendment or deletion. Within 60 business days of receipt of your written request, we will notify you of our amendment or deletion of the information in dispute, or of our refusal to make such correction after further investigation.
- If we refuse to amend or delete the information in dispute, you have the right to submit to us a written statement of the reasons for your disagreement with our assessment of the information in dispute and what you consider to be the correct information. We shall make such a statement accessible to any and all parties reviewing the information in dispute.*
- Disclosure - You have the right to receive a listing of instances in which we or our business associates have disclosed your information. This does not apply to treatment, payment, health plan operations, and certain other activities. We maintain this information and make it available to you for six years. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee.
- Notice - You have the right to request and receive a written copy of this notice any time.
- Restriction - You have the right to ask to limit how your information is used or disclosed. We are not required to agree to the limit, but if we do, we will abide by our agreement. You also have the right to agree to or terminate a previously submitted limitation.

If I believe that my privacy has been violated, what should I do?

If you believe that your privacy has been violated you may file a complaint with us by calling us at 866-861-2762 any time.

You may also submit a written complaint to the U.S. Department of Health and Human Services, Office for Civil Rights (OCR). We will give you the appropriate OCR regional address on request. You can also e-mail your complaint to OCRComplaint@hhs.gov. If you elect to file a complaint, your benefits will not be affected and we will not punish or retaliate against you in any way.

We support your right to protect the privacy of your personal and health information.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

How do I exercise my rights or obtain a copy of this notice?

All of your privacy rights can be exercised by obtaining the applicable forms. You may obtain any of the forms by:

- Contacting us at 866-861-2762
- Accessing our website at Humana.com and going to the Privacy Practices link
- Send completed request form to:

Humana Inc.
Privacy Office 003/10911
101 E. Main Street
Louisville, KY 40202

* This right applies only to our Massachusetts residents in accordance with state regulations.

Notice of Non-Discrimination

Humana Inc. and its subsidiaries comply with applicable Federal civil rights laws and do not discriminate or exclude people because of their race, color, religion, gender, gender identity, sex, sexual orientation, age, disability, national origin, military status, veteran status, genetic information, ancestry, ethnicity, marital status, language, health status, or need for health services.

Humana Inc.:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
 - Qualified interpreters
 - Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids, or language assistance services contact **877-320-1235 (TTY: 711)**. Hours of operation: 8 a.m. - 8 p.m., Eastern time. If you believe that Humana Inc. has not provided these services or discriminated on the basis of race, color, religion, gender, gender identity, sex, sexual orientation, age, disability, national origin, military status, veteran status, genetic information, ancestry, ethnicity, marital status, language, health status, or need for health services, you can file a grievance in person or by mail or email with Humana Inc. Non-Discrimination Coordinator at P.O. Box 14618, Lexington, KY 40512-4618, **877-320-1235 (TTY: 711)**, or accessibility@humana.com. If you need help filing a grievance, Humana Inc. Non-Discrimination Coordinator can help you.

You can also file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

- U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building Washington, D.C. 20201. **800-368-1019, 800-537-7697 (TDD)**.

California members:

You can also file a civil rights complaint with the California Dept. of Health Care Services, Office of Civil rights by calling **916-440-7370 (TTY: 711)**, emailing Civilrights@dhcs.ca.gov, or by mail at: Deputy Director, Office of Civil Rights, Department of Health Care Services, P.O. Box 997413, MS 0009, Sacramento, CA 95899-7413. Complaint forms available at: http://www.dhcs.ca.gov/Pages/Language_Access.aspx.

Notice of Availability - Auxiliary Aids and Services Notice

English: Free language, auxiliary aid, and alternate format services are available. Call **877-320-1235 (TTY: 711)**.

العربية [Arabic]: تتوفر خدمات اللغة والمساعدة الإضافية والتنسيق البديل مجاناً. اتصل على الرقم **877-320-1235 (الهاتف النصي: 711)**.

Հայերեն [Armenian]: Հասանելի են անվճար լեզվական, աջակցման և այլընտրանքային ծևաչափի ծառայություններ: Չափահարեք **877-320-1235 (TTY: 711)**:

বাংলা [Bengali]: বিনামূল্যে ভাষা, আনুষঙ্গিক সহায়তা, এবং বিকল্প বিন্যাসে পরিষেবা উপলব্ধ। ফোন করুন **877-320-1235 (TTY: 711)** নম্বরে।

简体中文 [Simplified Chinese]: 我们可提供免费的语言、辅助设备以及其他格式版本服务。请致电**877-320-1235 (听障专线: 711)**。

繁體中文 [Traditional Chinese]: 我們可提供免費的語言、輔助設備以及其他格式版本服務。請致電**877-320-1235 (聽障專線: 711)**。

Kreyòl Ayisyen [Haitian Creole]: Lang gratis, èd oksilyè, ak lòt fòma sèvis disponib. Rele **877-320-1235 (TTY: 711)**.

Hrvatski [Croatian]: Dostupni su besplatni jezik, dodatna pomoć i usluge alternativnog formata. Nazovite **877-320-1235 (TTY: 711)**.

فارسی [Farsi]: خدمات زبان رایگان، کمک های اضافی و فرمت های جایگزین در دسترس است. با **1235-877-320-1235 (TTY: 711)** تماس بگیرید.

Français [French]: Des services gratuits linguistiques, d'aide auxiliaire et de mise au format sont disponibles. Appeler le **877-320-1235 (TTY: 711)**.

Deutsch [German]: Es stehen kostenlose unterstützende Hilfs- und Sprachdienste sowie alternative Dokumentformate zur Verfügung. Telefon: **877-320-1235 (TTY: 711)**.

Ελληνικά [Greek]: Διατίθενται δωρεάν γλωσσικές υπηρεσίες, βοηθήματα και υπηρεσίες σε εναλλακτικές προσβάσιμες μορφές. Καλέστε στο **877-320-1235 (TTY: 711)**.

ગુજરાતી [Gujarati]: નિઃશુલ્ક ભાષા, સહાયક સહાય અને વૈકલ્પિક ફોર્મેટ સેવાઓ ઉપલબ્ધ છે. **877-320-1235 (TTY: 711)** પર કોલ કરો.

עברית [Hebrew]: שירותים אלה זמינים בחינם: שירות תרגום, אביזרי עזר וטקסטים בפורמטים חלופיים. נא התקשר למספר **877-320-1235 (TTY: 711)**.

हिन्दी [Hindi]: निःशुल्क भाषा, सहायक मदद और वैकल्पिक प्रारूप सेवाएं उपलब्ध हैं। **877-320-1235 (TTY: 711)** पर काल करें।

Hmoob [Hmong]: Muaj kev pab txhais lus, pab kom hnov suab, thiab lwm tus qauv pab cuam. Hu **877-320-1235 (TTY: 711)**.

Italiano [Italian]: Sono disponibili servizi gratuiti di supporto linguistico, assistenza ausiliaria e formati alternativi. Chiama il numero **877-320-1235 (TTY: 711)**.

日本語 [Japanese]: 言語支援サービス、補助支援サービス、代替形式サービスを無料でご利用いただけます。877-320-1235 (TTY: 711)までお電話ください。

ភាសាខ្មែរ [Khmer]: សេវាកម្មផ្លូវការសារ ជំនួយ និង សេវាកម្មជាតិប្រចាំឆ្នាំដែលអាចប្រើបាន។ ទូរសព្ទទៅលេខ 877-320-1235 (TTY: 711)។

한국어 [Korean]: 무료 언어, 보조 지원 및 대체 형식 서비스를 이용하실 수 있습니다.

877-320-1235 (TTY: 711) 번으로 문의하십시오.

ພາສາລາວ [Lao]: ມີການບໍລິການດ້ານພາສາ, ອະນະກອນຂ່ວຍເຫຼືອ ເພື່ອ ລັບພະບາງວິທີ່ໄວ້ຝັກຕືກ. ໃຫ້ 877-320-1235 (TTY: 711).

Diné [Navajo]: Saad t'áá jiik'eh, t'áadoole'é binahjí' bee adahodoonílgíí diné bich'í' anídahazt'i'í, dóó lahgo át'éego bee hada'dilyaaígíí bee bika'aanída'awo'í dahóló. Kohjí' hodílnih 877-320-1235 (TTY: 711).

Polski [Polish]: Dostępne są bezpłatne usługi językowe, pomocnicze i alternatywne formaty. Zadzwoń pod numer 877-320-1235 (TTY: 711).

Português [Portuguese]: Estão disponíveis serviços gratuitos de ajuda linguística auxiliar e outros formatos alternativos. Ligue 877-320-1235 (TTY: 711).

ਪੰਜਾਬੀ [Punjabi]: ਮੁਫਤ ਭਾਸ਼ਾ, ਸਹਾਇਕ ਸਹਾਇਤਾ, ਅਤੇ ਵਿਕਲਪਿਕ ਢਾਰਮੈਟ ਸੇਵਾਵਾਂ ਉਪਲਬਧ ਹਨ। 877-320-1235 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

Русский [Russian]: Предоставляются бесплатные услуги языковой поддержки, вспомогательные средства и материалы в альтернативных форматах. Звоните по номеру 877-320-1235 (TTY: 711).

Español [Spanish]: Los servicios gratuitos de asistencia lingüística, ayuda auxiliar y servicios en otro formato están disponibles. Llame al 877-320-1235 (TTY: 711).

Tagalog [Tagalog]: Magagamit ang mga libreng serbisyon pangwika, serbisyo o device na pantulong, at kapalit na format. Tumawag sa 877-320-1235 (TTY: 711).

தமிழ் [Tamil]: இலவச மொழி, துணை உதவி மற்றும் மாற்று வடிவ சேவைகள் உள்ளன. 877-320-1235 (TTY: 711) ஜி அழைக்கவும்.

తెలుగు [Telugu]: ఉచిత భాష, సహాయక మర్యాదలు, మరియు ప్రత్యామ్రాదుల ఫార్మాట్ సేవలు అందుబాటులో గలవు. 877-320-1235 (TTY: 711) కి కాల్ చేయండి.

اردو [Urdu]: مفت زبان، معاون امداد، اور متبادل فارمیٹ کی خدمات دستیاب ہیں۔ کال 877-320-1235 (TTY: 711)

Tiếng Việt [Vietnamese]: Có sẵn các dịch vụ miễn phí về ngôn ngữ, hỗ trợ bổ sung và định dạng thay thế. Hãy gọi 877-320-1235 (TTY: 711).

አማርኛ [Amharic]: አዲስ አበባ ማዕከል አዲ አማራጭ ቅድሞ የለቻ አገልግሎቶችም ይገኘኝ:: በ 877-320-1235 (TTY: 711) ላይ ይደውሉ::

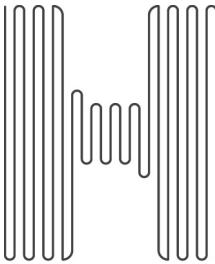
Băsăro [Bassa]: Wuqu-xwíníín-mú-zà-zà kùà, Hwòdq-fóńc-hyo, kè nyɔ-bɔ́nn-po-kà bě bé nyuee se wídqí pée-péè qò kò. 877-320-1235 (TTY: 711) qá.

Bekee [Igbo]: Asusụ n'efu, enyemaka nkwarụ, na ọru usoro ndị ọzo dị. Kpoo 877-320-1235 (TTY: 711).

Òyìnbó [Yoruba]: Àwọn işé àtiléhìn ìrànlówó èdè, àti ọnà kíkà míràn wà lárówótó. Pe 877-320-1235 (TTY: 711).

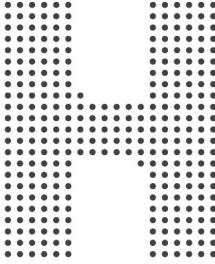
नेपाली [Nepali]: भाषासम्बन्धी निःशुल्क, सहायक साधन र वैकल्पिक फार्मेट (ढाँचा/व्यवस्था) सेवाहरू उपलब्ध छन् । 877-320-1235 (TTY: 711) मा कल गर्नुहोस् ।

Notes

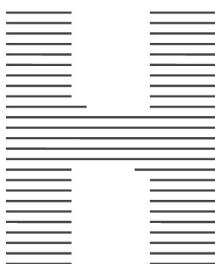


You can view these 2026 plan documents starting October 15, 2025 at **www.Humana.com/PlanDocuments**. Here you can see the most up-to-date information about your plan. It's easy to search, so you can find the information you are looking for quickly.

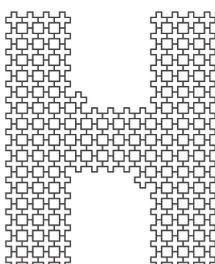
- See your Evidence of Coverage for your plan's specific details, benefits and costs.
- Review the Drug List which includes the drugs covered by your plan.
- View the Provider Directory to see a list of providers and specialists in your plan's network.



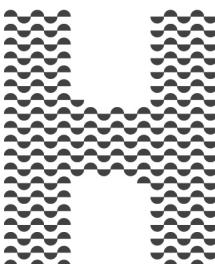
To get paper copies of these documents by mail, make your request online at the website above, or call **800-457-4708 (TTY: 711)**, 24 hours a day, seven days a week. Please have your Humana member ID card ready when you call. When asked for the reason you've called, say "Evidence of Coverage" "Drug List" and/or "Provider Directory." Please allow up to two weeks to receive the documents by mail.



We're here for you. If you need help using these online tools, please call the number on the back of your Humana member ID card for support.



As a Humana member, we may call you to offer other insurance-related products. You can opt out of those future calls by calling the Customer Care number on the back of your ID card.



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Important information about changes to your
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Here's a summary of your **HumanaChoice
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