

2026

Annual Notice of Changes

Humana Dual Fully Integrated H2875-001 (HMO-POS D-SNP)

This is a Fully Integrated Dual Eligible (FIDE) Special Needs Plan.

Virginia



Medicare and Medicaid Working Together



It's time to review your Humana Dual Fully Integrated H2875-001 (HMO-POS D-SNP) and Humana Healthy Horizons in VIRGINIA updates for 2026

Thank you for trusting Humana with your Medicare and Medicaid plan coverage needs for 2025. Inside, you'll find the Annual Notice of Change. This packet makes it easy to compare your Medicare and Medicaid plan 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 Humana Dual Fully Integrated H2875-001 (HMO-POS D-SNP) and Humana Healthy Horizons in VIRGINIA plans, 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.

Humana Dual Fully Integrated H2875-001 (HMO-POS D-SNP) offered by Humana WI Health Organization Insurance Corp

Annual Notice of Change for 2026

You're enrolled as a member of Humana Dual Fully Integrated H2875-001 (HMO-POS 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 Humana Dual Fully Integrated H2875-001 (HMO-POS 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 Member Services at 844-881-4482 (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, Korean, Vietnamese, Hindi, Chinese, Arabic, Amharic, Urdu, Tagalog, Farsi, French, Telegu, Nepali, Bengali and Russian.
- Call Member Services at 844-881-4482 (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 Member Services 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 Humana Dual Fully Integrated H2875-001 (HMO-POS D-SNP)

- Humana Dual Fully Integrated H2875-001 (HMO-POS D-SNP) is a Dual Eligible Special Needs HMO SNP plan with a Medicare contract and a contract with the Virginia Medicaid program. Enrollment in this Humana plan depends on contract renewal. Our plan also has a written agreement with the Virginia Medicaid program to coordinate your Medicaid benefits.

When this material says "we," "us," or "our," it means Humana WI Health Organization Insurance Corp. When it says "plan" or "our plan," it means Humana Dual Fully Integrated H2875-001 (HMO-POS D-SNP).

- **If you do nothing by December 7, 2025, you'll automatically be enrolled in Humana Dual Fully Integrated H2875-001 (HMO-POS D-SNP).** Starting January 1, 2026, you'll get your medical and drug coverage and your Cardinal Care Medicaid plan coverage through Humana Dual Fully Integrated H2875-001 (HMO-POS D-SNP). Go to Section 3 for more information about how to change plans and deadlines for making a change.

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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 \$30.70		\$0 or up to \$23.70	
Deductible	\$0	Not Applicable	\$0	Not Applicable
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.)	\$9,350 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.	Not Applicable	\$9,250 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.	Not Applicable
Primary care office visits	\$0 copayment per visit	Not Applicable	\$0 copayment per visit	Not Applicable
Specialist office visits	\$0 copayment per visit	Not Applicable	\$0 copayment per visit	Not Applicable
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	Not Applicable	\$0 copayment per stay	Not Applicable
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	

Cost	2025 (this year)		2026 (next year)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
<p>Part D drug coverage (Go to Section 1.7 for details, including Yearly Deductible, Initial Coverage, and Catastrophic Coverage Stages.)</p> <p>Not all tiers may include insulin. Please refer to your Drug List to confirm insulin coverage.</p>	<p>\$0 Rx Copay Benefit applies if you receive Extra Help. You will pay the following for all plan-covered Part D drugs for the entire calendar year:</p> <p>Deductible: \$0</p> <p>Copayment during the Initial Coverage Stage:</p> <ul style="list-style-type: none"> • All plan-covered Part D drugs: \$0 <p>\$0 Rx Copay Benefit does <u>not</u> apply if you <u>do not</u> receive Extra Help. You will pay the following:</p> <p>Coinurance during the Initial Coverage Stage:</p>	<p>\$0 Rx Copay Benefit is <u>not</u> available.</p> <p>If you receive Extra Help, the amount you pay depends on the level of Extra Help you receive. Refer to your LIS Rider insert for your cost sharing amounts.</p> <p>If you receive Extra Help, your deductible is \$0.</p> <p>If you do not receive Extra Help, you will pay the following:</p> <p>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.</p> <p>Copayment/Coinsurance during the Initial Coverage Stage:</p>		

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% <p>You pay 25% per prescription except for each covered insulin product, you will pay \$35 per month supply.</p>		<p>For a 30-day supply from a retail pharmacy:</p> <ul style="list-style-type: none"> • Drug Tier 1: \$0 <p>You pay 0% per month supply of each covered insulin product on this tier.</p> <ul style="list-style-type: none"> • Drug Tier 2: \$0 <p>You pay 0% per 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 \$35 per 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 \$35 per month supply of each covered insulin product on this tier.</p> <ul style="list-style-type: none"> • Drug Tier 5: 25% <p>You pay 25% up to \$35 per month supply of each covered insulin product on this tier.</p>	

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 Virginia Department of Medical Assistance Services (Medicaid).)	\$0 or up to \$30.70	\$0 or up to \$23.70 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
<p>Maximum out-of-pocket amount</p> <p>Because our members also get help from Virginia Department of Medical Assistance Services (Medicaid), very few members ever reach this out-of-pocket maximum.</p> <p>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.</p> <p>Your costs for covered medical services (such as copayments and deductibles) count toward your maximum out-of-pocket amount. Our plan premium and your costs for prescription drugs don't count toward your maximum out-of-pocket amount.</p>	\$9,350	Not Applicable	<p>\$9,250</p> <p>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 for the rest of the calendar year.</p>	Not Applicable

Section 1.3 Changes to the Provider Network

Our network of providers has changed for next year. Review the *2026 Provider and Pharmacy Directory* [Humana.com/PlanDocuments](https://www.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 and Pharmacy Directory*:

- Visit our website at [Humana.com/PlanDocuments](https://www.humana.com/PlanDocuments).
- Call Member Services at 844-881-4482 (TTY users should call 711) to get current provider information or to ask us to mail you a *Provider and Pharmacy 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 Member Services at 844-881-4482 (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 and Pharmacy Directory* [**Humana.com/PlanDocuments**](http://Humana.com/PlanDocuments) to see which pharmacies are in our network. Here's how to get an updated *Provider and Pharmacy Directory*:

- Visit our website at [**Humana.com/PlanDocuments**](http://Humana.com/PlanDocuments) .
- Call Member Services at 844-881-4482 (TTY users should call 711) to get current pharmacy information or to ask us to mail you a *Provider and Pharmacy 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 Member Services at 844-881-4482 (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.

This spending allowance and Chronic Condition Care Assistance are special program(s) for members with specific health conditions. Qualifying conditions include diabetes mellitus, cardiovascular disorders, chronic and disabling mental health conditions, chronic lung disorders, or chronic heart failure, among others. Some plans require at least two conditions and other requirements apply. See the plan's Evidence of Coverage for details. If you use this program for rent or utilities, Housing and Urban Development (HUD) requires it to be reported as income if you seek assistance. Contact your local HUD office if you have questions.

Cost	2025 (this year)		2026 (next year)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Special Supplemental Benefits for the Chronically Ill <ul style="list-style-type: none"> • Chronic Condition Care Assistance 	Chronic Condition Care Assistance is available to eligible members who demonstrate a need to receive additional assistance with a qualifying medical, primarily health related, or non-primarily health related expense that supports the member's care plan goals. Eligibility will be considered for members with	Not Covered	Chronic Condition Care Assistance is available to eligible members who demonstrate a need to receive additional assistance with a qualifying medical, primarily health related, or non-primarily health related expense that supports the member's care plan goals. Eligibility will be considered for members with	Not Covered

Cost	2025 (this year)		2026 (next year)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
	<p>certain qualifying chronic conditions, are currently participating in care management and meet the program criteria.</p> <p>Benefits are limited to \$500 per year and are coordinated by care management.</p> <p>There is no coinsurance, copayment, or deductible to participate.</p>		<p>certain qualifying chronic conditions, are currently participating in care management services and meet the program criteria.</p> <p>Benefits are limited to \$1,000 per year and are coordinated by care management.</p> <p>There is no coinsurance, copayment, or deductible to participate.</p>	
• Humana Healthy Options Allowance™	<p>See Value-based Insurance Design (VBID) Model below for Humana Healthy Options™ benefits for 2025.</p>	Not Covered	<p>\$315 monthly allowance on a prepaid spending card.</p> <p>All plan members receive this amount to buy approved over the counter (OTC) health and wellness products at participating retailers or through the plan's approved OTC mail order vendor.</p> <p>Plus, members may also use this money for eligible groceries, utilities, rent, and more if they have certain qualifying chronic condition(s) and meet other program criteria.</p> <p>Any unused amount rolls over each month and</p>	Not Covered

Cost	2025 (this year)		2026 (next year)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
			expires at the end of the plan year or upon disenrollment, whichever occurs first.	
Value-Based Insurance Design (VBID) Model				
<ul style="list-style-type: none"> Humana Healthy Options Allowance™ 	<p>\$225 monthly allowance on a prepaid card to use for essentials you need to support your health. This allowance can be used to buy approved products from participating retail locations (like groceries, over-the-counter health and wellness items, personal care items, home supplies, etc.) or pay for approved services (monthly living expenses like rent, non-medical transportation costs like a taxi, Uber, Lyft, etc.). Allowance amount cannot be combined with other allowances which may be on the Card. Unused funds will roll over to the next month and expire at the end of the plan year.</p>	<p>Not Covered</p>	<p>See Special Supplemental Benefits for the Chronically Ill above for Humana Healthy Option™ benefits for 2026.</p>	<p>Not Covered</p>
Dental services				

Cost	2025 (this year)		2026 (next year)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
<ul style="list-style-type: none"> Supplemental dental benefits: 	<p>DENE85 Plan covers up to \$4,000 allowance every year for non-Medicare covered preventive and comprehensive dental services. You are responsible for any amount above the dental coverage limit. Any amount unused at the end of the year will expire. Your benefit can be used for most dental treatments such as: Preventive dental services, such as exams, routine cleanings, etc. Basic dental services, such as fillings, extractions, etc. Major dental services, such as periodontal scaling, crowns, dentures, root canals, bridges etc. Frequency limits may apply. Note: The allowance cannot be used on fluoride, cosmetic services and implants.</p>	<p>DENE85 Plan covers up to \$4,000 allowance every year for non-Medicare covered preventive and comprehensive dental services. You are responsible for any amount above the dental coverage limit. Any amount unused at the end of the year will expire. Your benefit can be used for most dental treatments such as: Preventive dental services, such as exams, routine cleanings, etc. Basic dental services, such as fillings, extractions, etc. Major dental services, such as periodontal scaling, crowns, dentures, root canals, bridges etc. Frequency limits may apply. Note: The allowance cannot be used on fluoride, cosmetic services and implants. Benefits received out-of-network are subject to any in-network benefit maximums,</p>	<p>DEN447 Plan covers up to \$3,000 allowance every year for non-Medicare covered preventive and comprehensive dental services. You are responsible for any amount above the dental coverage limit. Any amount unused at the end of the year will expire. Your benefit can be used for most dental treatments such as: Preventive dental services, such as exams, routine cleanings, etc. Basic dental services, such as fillings, extractions, etc. Major dental services, such as periodontal scaling, crowns, dentures, root canals, bridges etc. Note: The allowance cannot be used on fluoride, cosmetic services and implants.</p>	<p>DEN447 Plan covers up to \$3,000 allowance every year for non-Medicare covered preventive and comprehensive dental services. You are responsible for any amount above the dental coverage limit. Any amount unused at the end of the year will expire. Your benefit can be used for most dental treatments such as: Preventive dental services, such as exams, routine cleanings, etc. Basic dental services, such as fillings, extractions, etc. Major dental services, such as periodontal scaling, crowns, dentures, root canals, bridges etc. Note: The allowance cannot be used on fluoride, cosmetic services and implants. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.</p>

Cost	2025 (this year)		2026 (next year)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
		limitations, and/or exclusions.		
HMO travel benefit	Members can receive in-network benefits when services are received from a participating HMO National Network provider during their travels to other states and Puerto Rico.	Not Covered	Members may receive in-network benefits when services are received from a participating HMO National Network provider when traveling to other states.	Not Covered
Meal Program - Humana Well Dine®	<p>\$0 copayment for Humana Well Dine® meal program.</p> <p>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).</p> <p>Meals must be requested within 30 days of discharge from your inpatient stay.</p> <p>Limited to 4 times per year.</p>	<p>The in-network provider must be used for this service.</p> <p>If you choose to utilize another provider, you are responsible for all charges.</p>	<p>\$0 copayment for Humana Well Dine® meal program.</p> <p>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).</p> <p>Meals must be requested within 30 days of discharge from your inpatient stay.</p> <p>Limited to 4 times per year.</p> <p>\$0 copayment for Humana Well Dine® meal program.</p> <p>Receive 2 meals per day for 10 days.</p> <p>Up to 20 meals delivered to member's home to assist in establishing a diet needed for diabetes mellitus with physician approval.</p>	<p>The in-network provider must be used for this service.</p> <p>If you choose to utilize another provider, you are responsible for all charges.</p> <p>The in-network provider must be used for this service.</p> <p>If you choose to utilize another provider, you are responsible for all charges.</p> <p>The in-network provider must be used for this service.</p> <p>If you choose to utilize another provider, you are responsible for all charges.</p>

Cost	2025 (this year)		2026 (next year)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
			\$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 chronic heart failure with physician approval.	
Vision care • Routine vision services:	VIS701 \$0 copayment for routine exam up to 1 per year. \$400 maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames. OR \$450 maximum benefit coverage amount per year at PLUS Provider 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 up to 1 pair per year.	Not Covered	VIS706 \$0 copayment for routine exam up to 1 per year. \$450 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 up to 1 pair per year. Maximum benefit coverage amount is limited to one time use per year.	Not Covered

Cost	2025 (this year)		2026 (next year)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
• Medically Necessary Contacts	Maximum benefit coverage amount is limited to one time use per year. \$0 copayment	Not Covered	Included as part of the VIS706 allowance listed above.	Not Covered

Section 1.6 Changes to Part D Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a Formulary or Drug List. A copy of our Drug List 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 List** by calling Member Services at 844-881-4482 (TTY users should call 711) or visiting our website (Humana.com/PlanDocuments).

We made changes to our Drug List, 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 List 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 List 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 List 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 Member Services at 844-881-4482 (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 does 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 Member Services at 844-881-4482 (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	<p>If you receive Extra Help, your deductible is \$0.</p> <p>During this stage, you pay \$0 for all plan-covered Part D drugs.</p> <p>If you do not receive Extra Help, the deductible is \$590.</p>	<p>If you receive Extra Help, your deductible is \$0. Refer to your LIS Rider insert for your cost sharing amounts.</p> <p>If you do not receive Extra Help, the deductible is \$615.</p> <p>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.</p>

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 List. To see if your drugs will be in a different tier, look them

up on the Drug List.

Not all tiers may include insulin. Please refer to your Prescription Drug List 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:	<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 \$10. You pay 25% up to \$10 per month supply of each covered insulin product for a mail-order prescription on this tier.</p>
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>

	2025 (this year)	2026 (next year)
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.</p> <p>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 your VBID Part D Benefit

Elimination of cost sharing for all Medicare Part D Drugs as part of the \$0 Rx Copay Benefit is **no** longer covered.

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	<p>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.</p>	<p>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.</p> <p>To learn more about this payment option, call us at 844-881-4482 (TTY users call 711) or visit http://www.Medicare.gov.</p>

SECTION 3 How to Change Plans

To stay in Humana Dual Fully Integrated H2875-001 (HMO-POS 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 Humana Dual Fully Integrated H2875-001 (HMO-POS 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 Humana Dual Fully Integrated H2875-001 (HMO-POS D-SNP). You will remain enrolled in Cardinal Care. If you also want to change your Cardinal Care plan carrier call Member Services at 844-881-4482 (TTY users call 711) for more information on how to do this.
- **To change to Original Medicare with Medicare drug coverage**, enroll in the new Medicare drug plan. You will automatically be disenrolled from Humana Dual Fully Integrated H2875-001 (HMO-POS D-SNP). You will remain enrolled in Cardinal Care. If you also want to change your Cardinal Care plan carrier call Member Services at 844-881-4482 (TTY users call 711) for more information on how to do this.
- **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 Member Services at 844-881-4482 (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). You will remain enrolled in Cardinal Care. If you also want to change your Cardinal Care plan carrier call Member Services at 844-881-4482 (TTY users call 711) for more information on how to do this.
- **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). If you also want to change your Cardinal Care plan carrier call Member Services at 844-881-4482 (TTY users call 711) for more information on how to do this.

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 Virginia Department of Medical Assistance Services (Medicaid), 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.

Virginia Medication Assistance Program (VA MAP), Address: Department of Health, 109 Governor Street, Richmond, VA 23219, **Phone:** 1-855-362-0658, 1-800-533-4148, **TTY:** 711,

Hours: Monday - Friday 8:00AM to 5:00PM, **Website:** vdh.virginia.gov/disease-prevention/disease-prevention/hiv-care-services/

- **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 SPAP and 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 Member Services at 844-881-4482 (TTY users call 711) or visit Medicare.gov.

SECTION 5 Questions?

Get Help from Humana Dual Fully Integrated H2875-001 (HMO-POS D-SNP)

Call Member Services at 844-881-4482. (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 Humana Dual Fully Integrated H2875-001 (HMO-POS 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 Member Services 844-881-4482 (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 and Pharmacy Directory) and our List of Covered Drugs (Formulary).

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 Virginia Department of Medical Assistance Services (Medicaid) 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

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 Member Services at the phone number on the back cover of this booklet.

VIRGINIA	
SHIP Name and Contact Information	Virginia Insurance Counseling and Assistance Program (VICAP) 1610 Forest Avenue Suite 100 Henrico, VA 23229 800-552-3402 (toll free) 804-662-9333 (local) 804-552-3402 (toll free TTY) http://www.vda.virginia.gov
Quality Improvement Organization	Commence Health BFCC-QIO Program 10820 Guilford Road Suite 202 Annapolis Junction, MD 20701 888-396-4646 888-985-2660 (TTY) 855-236-2423 (Fax) https://livantaqio.com/
State Medicaid Office	Virginia Department of Medical Assistance Services (Medicaid) 600 East Broad Street Suite 1300 Richmond, VA 23219 855-242-8282 (toll free) 804-786-7933 (local) 888-221-1590 (TTY) https://www.dmas.virginia.gov/for-members/
State Pharmacy Assistance Program(s)	Virginia State Pharmaceutical Assistance Program HCS Unit, 1st Floor James Madison Building 109 Governor Street Richmond, VA 23219 855-362-0658 (toll free) 804-864-8050 (fax) https://www.vdh.virginia.gov/disease-prevention/vamap/

VIRGINIA - Continued

AIDS Drug Assistance Program	VIRGINIA MEDICATION ASSISTANCE PROGRAM (VA MAP) Virginia Department of Health, HCS Unit 1st Floor, James Madison Building 109 Governor Street Richmond, VA 23219 855-362-0658 804-864-8050 800-533-4148 https://www.vdh.virginia.gov/disease-prevention/vamap/
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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.

Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-877-320-1235 (TTY: 711). Someone who speaks English can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-877-320-1235 (TTY: 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果 您需要此翻译服务， 请致电 1-877-320-1235 (听障专线: 711)。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如 需翻譯服務，請致電 1-877-320-1235 (聽障專線: 711)。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-877-320-1235 (TTY: 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-877-320-1235 (TTY: 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quý vị cần thông dịch viên xin gọi 1-877-320-1235 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-877-320-1235 (TTY: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-877-320-1235 (TTY: 711) 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными

услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-877-320-1235 (TTY: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي سؤال تتعلق بخطتنا الصحية أو خطة الأدوية الموصوفة لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-877-320-1235 (TTY: 711). سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुर्भाषिया सेवाएँ उपलब्ध हैं। एक दुर्भाषिया प्राप्त करने के लिए, बस हमें 1-877-320-1235 (TTY: 711) पर फोन करें। कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है। यह एक मुफ्त सेवा है।

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-877-320-1235 (TTY: 711). Un nostro incaricato che parla Italiano fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-877-320-1235 (TTY: 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-877-320-1235 (TTY: 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-877-320-1235 (TTY: 711). Ta usługa jest bezpłatna.

Japanese: 当社の健康保険と処方薬プランに関するご質問にお答えするために、無料の通訳サービスをご用意しています。通訳をご用命になるには、1-877-320-1235 (TTY: 711) にお電話ください。日本語を話す者が支援いたします。これは無料のサービスです。

Amharic: ከላ ጥና ወይም የሚደረኝት ዕቅናትና በተማለከት ማንኛውም የለቻሁን ተያችቃች ለማማለስ እና የአስተዳደርም አገልግሎቶች እናን፡ እስተዳደርም ለማግኘት፡ በ 1-877-320-1235 (TTY:- 711) የም፡አናን፡፡ እንዳለሁና የሚደገኝ ስም ለረዳምና ይችላል፡፡ ይህ እናግለሁና እም፡፡

Bengali: আমরা বিনামূলে একজন অনুবাদকের পরিষেবা প্রদান করি, যিনি আপনার স্বাস্থ্য ও ড্রাগ প্ল্যান সংক্রান্ত যেকোনো প্রশ্ন থাকলে তার উত্তর দেবেন। অনুবাদকের প্রয়োজন হলে অনুগ্রহ করে আমাদের 1-877-320-1235 (TTY: 711) নম্বরে কল করুন। বাংলা জানেন এমন একজন ব্যক্তি আপনার সাহায্য করবেন। এই পরিষেবাটি বিনামূলে উপলব্ধ।

Nepali: हाम्रो स्वास्थ्य वा औषधि योजनाका बारेमा तपाईंसँग हुन सक्ने कुनै पनि प्रश्नहरूको जवाफ दिन हामीसँग निःशुल्क दोभाषे सेवाहरू छन्। दोभाषे प्राप्त गर्न, हामीलाई 1-877-320-1235 (TTY: 711) मा फोन गर्नुहोस।

Farsi: ما خدمات مترجم رایگان جهت پاسخگویی به هر سؤالی که ممکن است شما در مورد طرح سلامت یا داروی خود داشته باشید داریم. به منظور دریافت مترجم، فقط از طریق شماره 1-877-320-1235 (TTY: 711) با ما تماس بگیرید. فردی که زبان انگلیسی صحبت می کند می تواند به شما کمک کند. این سرویس رایگان است.

Dari: جهت پاسخگویی به هر سوال که ممکن شما در مورد پلان صحی و ادویه جات ما داشته باشید ما برای ترجمانی خدمات رایگان داریم. به منظور دریافت ترجمان، فقط ذریعه این نمبر ذکر شده 1-877-320-1235 (TTY: 711) با ما تماس بگیرید. شخصی که انگلیسی صحبت میکند میتواند همراهی شما کمک کند. این یک خدمت رایگان میباشد.

Bassa: Dì gwèè bàhièl màhɔp inyùu holā wè i tìmbhè màmbadgà mɔŋ ma mā bèŋge mboo yɔŋ nì i bɛe ù nlama yɔŋ. Inyùu kòsnà hièl màhɔp, sèbel ndigi bɛs i nɔmbà 1-877-320-1235 (TTY: 711). Mùt wàdā nû ā pɔt ɔgisi ã nlà hola wê. Bā ñsaa bee maholā mā.

Igbo: Anyị nwere ọrụ ntụgharị okwu efu iji zaa ajụụ ọ bụla gi nwere ike ịnwe gbasara atumatụ ahụike ma ọ bụ ọgwụ anyị. Ichọ ịnweta onye ntụgharị okwu, naanị kpọọ anyị na 1-877-320-1235 (TTY: 711). Onye na-asụ asusụ Bekee nwere ike ịnyere gi aka. Nkea bụ ọrụ efu.

Telugu: మా ఆరోగ్యం లేదా ట్రడ్ ప్లాన్ గురించి మీకు ఏపైనా సందేహాలు ఉంటే వాటికి సమాధానమివ్వడానికి మా వద్ద ఉచిత వ్యాఖ్యాత సేవలు ఉన్నాయి. వ్యాఖ్యాతను పొందడానికి, 1-877-320-1235 (TTY: 711) వద్ద మాకు కాల్ చేయండి. ఇంగ్లీష్ మాట్లాడే ఎవరైనా మీకు సహాయం చేయగలరు. ఇది ఉచిత సేవ.

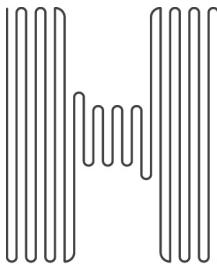
Urdu: بماریے صحت یا ادویات کے پلان کے بارے میں آپ کے کسی بھی سوال کا جواب دینے کے لیے ہمارے پاس مترجم کی مفت خدمات دستیاب ہیں۔ مترجم کی خدمات لینے کے لیے، بس ہمیں کال کریں 1-877-320-1235 (TTY: 711)۔ انگریزی بولنے والا کوئی شخص آپ کی مدد کر سکتا ہے۔ یہ ایک مفت سروس ہے۔

Yoruba: A ní àwọn isé ìtójú ògbifò lófèé láti dáhùn àwọn ìbéèrè yòówù tí o lè ní nípa ètò ìlera tàbí oògùn wa. Láti gba ògbifò kan, sá pè wá ní 1-877-320-1235 (TTY: 711). Ènìkan tí ó nsø èdè Gèéṣì lè ràn ó lówó. Isé ìtójú ọfè kan nìyí.

Notes

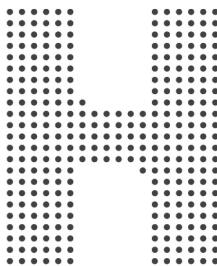
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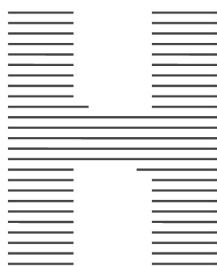


You can view these 2026 plan documents starting October 15, 2025 at **www.Humana.com/PlanDocuments**. Here you can see the most up-to-date information about your plan. It's easy to search, so you can find the information you are looking for quickly.

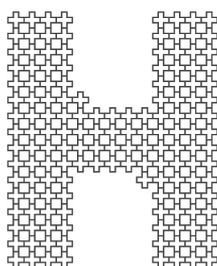
- See your Evidence of Coverage for your plan's specific details, benefits and costs.
- Review the Drug List which includes the drugs covered by your plan.
- View the Provider and Pharmacy Directory to see a list of providers and specialists in your plan's network.



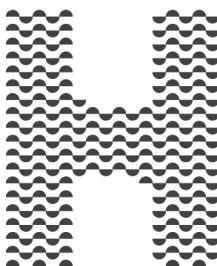
To get paper copies of these documents by mail, make your request online at the website above, or call **844-881-4482 (TTY: 711)**, 24 hours a day, seven days a week. Please have your Humana member ID card ready when you call. When asked for the reason you've called, say "Evidence of Coverage" "Drug 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 Member Services number on the back of your ID card.



Humana Inc.

P.O. Box 14168
Lexington, KY 40512-4168



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Important information about changes to your
Medicare Advantage and prescription drug plan



Look inside

Here's a summary of your **Humana Dual
Fully Integrated H2875-001 (HMO-POS
D-SNP)** that takes effect on January 1, 2026.

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