

2026

Annual Notice of Changes

Humana Dual Integrated (HMO D-SNP) H1396-001

South Carolina

Humana®

Humana Dual Integrated (HMO D-SNP) offered by Humana

Annual Notice of Change for 2026

Introduction

You're currently enrolled as a member of our plan. Next year, there will be some changes to our benefits, coverage, rules, and costs. This *Annual Notice of Change* tells you about the changes and where to find more information about them. To get more information about costs, benefits, or rules please review the *Member Handbook*, which is located on our website at **Humana.com**. Call Member Services at the number at the bottom of the page to get a copy by mail. Key terms and their definitions appear in alphabetical order in the last chapter of your *Member Handbook*.

Additional resources

- This document is available for free in Spanish.
- You can get this Annual Notice of Change for free in other formats, such as large print, braille, or audio. Call Member Services at 866-432-0001, TTY 711, between 8 am to 8 pm EST seven days a week, Oct. 1 - March 31 and Monday - Friday, April 1 - Sept. 30. The call is free.
- If you prefer to receive your written communications in an alternate format such as braille, large font, audio, or another language please contact Member Services at 866-432-0001, TTY 711, between 8 am to 8 pm EST seven days a week, Oct. 1 - March 31 and Monday - Friday, April 1 - Sept. 30. The call is free.
- Once we receive your request, all future state mandated communications will be provided in your chosen format. If we are unable to provide printed materials within your requested format, then the member will receive those communications over the phone with an interpreter.
- If a member chooses to change their standing request, members can call Member Services to have their request updated at 866-432-0001, TTY 711, between 8 am to 8 pm EST seven days a week, Oct. 1 - March 31 and Monday - Friday, April 1 - Sept. 30. The call is free.

OMB Approval 0938-1444 (Expires: June 30, 2026)



If you have questions, please call Humana Dual Integrated (HMO D-SNP) at 866-432-0001, TTY 711, between 8 am to 8 pm EST seven days a week, Oct. 1 - March 31 and Monday - Friday, April 1 - Sept. 30. The call is free. **For more information**, visit **Humana.com**.

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A. Disclaimers

Humana Dual Integrated (HMO D-SNP) H1396-001 is a Dual Eligible Special Needs HMO SNP plan with a Medicare contract and a contract with the state Medicaid program. Enrollment in this Humana plan depends on contract renewal.

B. Reviewing your Medicare and South Carolina Healthy Connections Medicaid coverage for next year

It's important to review your coverage now to make sure it will still meet your needs next year. If it doesn't meet your needs, you may be able to leave our plan. Refer to **Section E** for more information on changes to your benefits for next year.

New members to Humana Dual Integrated (HMO D-SNP) H1396-001: In most instances you'll be enrolled in Humana Dual Integrated (HMO D-SNP) H1396-001 for your Medicare benefits the 1st day of the month after you request to be enrolled in Humana Dual Integrated (HMO D-SNP) H1396-001. You may still receive your South Carolina Healthy Connections Medicaid from your previous South Carolina Healthy Connections Medicaid health plan for one additional month. After that, you'll receive your South Carolina Healthy Connections Medicaid services through Humana Dual Integrated (HMO D-SNP) H1396-001. There will be no gap in your South Carolina Healthy Connections Medicaid coverage. Please call us at the number at the bottom of the page if you have any questions.

If you choose to leave our plan, your Medicare membership will end on the last day of the month in which your request was made. You'll still be in the Medicare and Healthy Connections Medicaid programs as long as you're eligible.

If you leave our plan, you can get information about your:

- Medicare options in the table in **Section G2**.
- Healthy Connections Medicaid options in **Section G2**.

B1. Information about Humana Dual Integrated (HMO D-SNP)

- Humana Dual Integrated (HMO D-SNP) is a health plan that contracts with both Medicare and Healthy Connections Medicaid to provide benefits of both programs to members.
- When this *Annual Notice of Change* says "we," "us," "our," or "our plan," it means Humana Dual Integrated (HMO D-SNP).

B2. Important things to do

- **Check if there are any changes to our benefits and costs that may affect you.**
 - Are there any changes that affect the services you use?



If you have questions, please call Humana Dual Integrated (HMO D-SNP) at 866-432-0001, TTY 711, between 8 am to 8 pm EST seven days a week, Oct. 1 - March 31 and Monday - Friday, April 1 - Sept. 30. The call is free. **For more information, visit [Humana.com](https://www.humana.com).**

- Review benefit and cost changes to make sure they'll work for you next year.
- Refer to **Section E1** for information about benefit changes for our plan.
- **Check if there are any changes to our drug coverage that may affect you.**
 - Will your drugs be covered? Are they in a different cost-sharing tier? Can you use the same pharmacies? Will there be any changes such as prior authorization, step therapy or quantity limits?
 - Review changes to make sure our drug coverage will work for you next year.
 - Refer to **Section E2** for information about changes to our drug coverage.
 - Your drug costs may have risen since last year.
 - Talk to your doctor about lower cost alternatives that may be available for you; this may save you in annual out-of-pocket costs throughout the year.
 - Keep in mind that your plan benefits determine exactly how much your own drug costs may change.
- **Check if your providers and pharmacies will be in our network next year.**
 - Are your doctors, including your specialists, in our network? What about your pharmacy? What about the hospitals or other providers you use?
 - Refer to **Section D** for information about our *Provider and Pharmacy Directory*.
- **Think about your overall costs in the plan.**
 - How much will you spend out-of-pocket for the services and drugs you use regularly?
 - How do the total costs compare to other coverage options?
- **Think about whether you're happy with our plan.**

If you decide to stay with Humana Dual Integrated (HMO D-SNP):

If you want to stay with us next year, it's easy – you don't need to do anything. If you don't make a change, you automatically stay enrolled in Humana Dual Integrated (HMO D-SNP).

If you decide to change plans:

If you decide other coverage will better meet your needs, you may be able to switch plans (refer to **Section G2** for more information). If you enroll in a new plan, or change to Original Medicare, your new coverage will begin on the first day of the following month.

C. Changes to our plan name

On January 1, 2026, our plan name changes from Humana Gold Plus SNP-DE (HMO D-SNP) to Humana Dual Integrated (HMO D-SNP).



If you have questions, please call Humana Dual Integrated (HMO D-SNP) at 866-432-0001, TTY 711, between 8 am to 8 pm EST seven days a week, Oct. 1 - March 31 and Monday - Friday, April 1 - Sept. 30. The call is free. **For more information**, visit [Humana.com](https://www.humana.com).

You will receive a new ID card in the mail and with the new Humana plan name prior to your effective date. Any plan documents you receive after January 1, 2026 will use the new plan name.

D. Changes to our network providers and pharmacies

Amounts you pay for your drugs depend on which pharmacy you use. Our plan has a network of pharmacies. In most cases, your prescriptions are covered *only* if they're filled at one of our network pharmacies. Our network includes pharmacies with preferred cost sharing, which may offer you lower cost sharing than the standard cost sharing offered by other network pharmacies for some drugs.

Our provider and pharmacy networks have changed for 2026.

Please review the 2026 Provider and Pharmacy Directory to find out if your providers (primary care provider, specialists, hospitals, etc.) or pharmacy are in our network. An updated *Provider Directory* is located on our website at **Humana.com/PlanDocuments**. You may also call Member Services at the numbers at the bottom of the page for updated provider information or to ask us to mail you a *Provider and Pharmacy Directory*.

It's important that you know that we may also make changes to our network during the year. If your provider leaves our plan, you have certain rights and protections. For more information, refer to **Chapter 3** of your *Member Handbook* or call Member Services at the number at the bottom of the page for help.

E. Changes to benefits and costs for next year

E1. Changes to benefits for medical services

We're changing our coverage for certain medical services next year. The table below describes these changes.



If you have questions, please call Humana Dual Integrated (HMO D-SNP) at 866-432-0001, TTY 711, between 8 am to 8 pm EST seven days a week, Oct. 1 - March 31 and Monday - Friday, April 1 - Sept. 30. The call is free. **For more information**, visit **Humana.com**.

Cost	2025 (this year)	2026 (next year)
Maximum out-of-pocket amount Because our members also get help from South Carolina Department of Health and Human Services Healthy Connections Medicaid 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 or Part B services. 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.	\$9,350	\$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 for the rest of the calendar year.

Cost	2025 (this year)	2026 (next year)
Dental care Routine dental services:	DEN286 • \$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 complete dentures, crown recementation, panoramic film or diagnostic x-rays, partial dentures up to 1 every 5 years. • \$0 copayment for crown, other restorative services - core buildup and prefabricated post and core, root canal, root canal retreatment up to 1 per tooth per lifetime. • \$0 copayment for bitewing x-rays, intraoral x-rays up to 1 set(s) per year. • \$0 copayment for adjustments to dentures, denture rebase, denture relines, denture repair, emergency diagnostic exam, tissue conditioning up to 1 per year. • \$0 copayment for emergency treatment for pain, oral surgery, periodic oral exam, prophylaxis (cleaning) up to 2 per year. • \$0 copayment for periodontal maintenance up to 4 per year.	DEN284: • \$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 complete dentures, crown recementation, panoramic film or diagnostic x-rays, partial dentures up to 1 every 5 years. • \$0 copayment for crown, other restorative services - core buildup and prefabricated post and core, root canal, root canal retreatment up to 1 per tooth per lifetime. • \$0 copayment for bitewing x-rays, intraoral x-rays up to 1 set(s) per year. • \$0 copayment for adjustments to dentures, denture rebase, denture relines, denture repair, emergency diagnostic exam, tissue conditioning up to 1 per year. • \$0 copayment for emergency treatment for pain, oral surgery, periodic oral exam, prophylaxis (cleaning) up to 2 per year. • \$0 copayment for periodontal maintenance up to 4 per year.

Cost	2025 (this year)	2026 (next year)
Dental care Routine dental services: (continued)	• \$0 copayment for amalgam and/or composite filling, necessary anesthesia with covered service, simple or surgical extraction up to unlimited per year. • \$2,000 maximum benefit coverage amount per year for all diagnostic/preventive and comprehensive benefits.	• \$0 copayment for necessary anesthesia with covered service up to as needed with covered codes per year. • \$0 copayment for amalgam and/or composite filling, simple or surgical extraction up to unlimited per year. • \$1,500 maximum benefit coverage amount per year for all diagnostic/preventive and comprehensive benefits.
Over-The-Counter (OTC) Allowance (MSB) [Over-The-Counter (OTC) Allowance (Medicaid)]	Over-The-Counter (OTC) Allowance isn't covered [\$30 per quarter (Medicaid)]	See Humana Healthy Options Allowance™ benefit in this chart [\$65 per quarter (Medicaid)]



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Cost	2025 (this year)	2026 (next year)
*Special Supplemental Benefit for the Chronically Ill (SSBCI) Humana Healthy Options Allowance™	Humana Healthy Options Allowance™ isn't covered	\$280 monthly allowance on a prepaid spending card. 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. 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. Any unused amount rolls over each month and expires at the end of the plan year or upon disenrollment, whichever occurs first. *This spending allowance is a special program 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 Member Handbook 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)
Value Based Insurance Design (VBID) VBID Healthy Options Card	• \$175 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.	VBID Healthy Options Card isn't covered
VBID \$0 Rx Copay	\$0 for all Plan-Covered Part D Drugs on your formulary for the entire calendar year. To qualify, members must be eligible for "Extra Help".	VBID \$0 Rx Copay isn't covered

Cost	2025 (this year)	2026 (next year)
Vision care Routine vision services:	VIS787 • \$0 copayment for routine exam up to 1 per year. • \$500 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 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.	VIS602: • \$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.
Medically necessary contacts	\$0 copayment	Included as part of the VIS602 allowance listed above.

E2. Changes to drug coverage

Changes to our Drug List

An updated *List of Covered Drugs* is located on our website at **Humana.com/PlanDocuments**. You may also call Member Services at the numbers at the bottom of the page for updated drug information or to ask us to mail you a *List of Covered Drugs*.

The *List of Covered Drugs* is also called the *Drug List*.

We made changes to our *Drug List*, which could include removing or adding drugs, changing drugs we cover and changes to the restrictions that apply to our coverage for certain drugs or moving them to a different cost-sharing tier.



If you have questions, please call Humana Dual Integrated (HMO D-SNP) at 866-432-0001, TTY 711, between 8 am to 8 pm EST seven days a week, Oct. 1 - March 31 and Monday - Friday, April 1 - Sept. 30. The call is free. **For more information**, visit **Humana.com**.

Review the *Drug List* to **make sure your drugs will be covered next year** and to find out if there are 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 are allowed by Medicare and/or the state 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 a drug you're taking, we'll send you a notice about the change.

If you're affected by a change in drug coverage, we encourage you to:

- Work with your doctor (or other prescriber) to find a different drug that we cover.
 - You can call Member Services at the numbers at the bottom of the page or contact your care coordinator to ask for a *List of Covered Drugs* that treat the same condition.
 - This list can help your provider find a covered drug that might work for you.
- Ask us to cover a temporary supply of the drug.
 - In some situations, we cover a **temporary** supply of the drug during the first 90 days of the calendar year.
 - This temporary supply is for up to 30 or 31 days. (To learn more about when you can get a temporary supply and how to ask for one, refer to **Chapter 5** of your *Member Handbook*.)
 - When you get a temporary supply of a drug, talk with your doctor about what to do when your temporary supply runs out. You can either switch to a different drug our plan covers or ask us to make an exception for you and cover your current drug.

If you are affected by a change in drug coverage at the beginning of the year or during the year, please review **Chapter 9** of your *Member Handbook* and talk to your doctor to find out your options, such as asking for a temporary supply, applying for an exception, and/or working to find a new drug. You can also contact Customer Care for more information.

If a drug isn't covered in the way you'd like it to be covered, you can ask us to make an exception. An exception is a type of coverage decision.

If we approve your request for an exception, our approval usually is valid until the end of our plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.

Changes to drug costs

There are two payment stages for your Medicare Part D drug coverage under our plan. How much you pay depends on which stage you're in when you get a prescription filled or refilled. These are the two stages:



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Stage 1 Initial Coverage Stage	Stage 2 Catastrophic Coverage Stage
During this stage, our plan pays part of the costs of your drugs, and you pay your share. Your share is called the copay. You begin this stage when you fill your first prescription of the year.	During this stage, the plan pays all of the costs of your drugs through December 31, 2026. You begin this stage after you pay a certain amount of out-of-pocket costs.

The Initial Coverage Stage ends when your total out-of-pocket costs for drugs reaches **\$2,100**. At that point, the Catastrophic Coverage Stage begins. Our plan covers all of your drug costs from then until the end of the year. Refer to **Chapter 6** of your *Member Handbook* for more information on how much you'll pay for drugs.

Under the Manufacturer Discount Program, drug manufacturers pay a portion of our 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.

E3. Stage 1: "Initial Coverage Stage"

During the Initial Coverage Stage, our plan pays a share of the cost of your covered drugs, and you pay your share. Your share is called the copay. The copay depends on what cost-sharing tier the drug is in and where you get it. You pay a copay each time you fill a prescription. If your covered drug costs less than the copay, you pay the lower price.

We moved some of the drugs on our Drug List to a lower or higher drug tier. If your drugs move from tier to tier, this could affect your copay. To find out if your drugs are in a different tier, look them up in our *Drug List*.

The following table shows your costs for a one-month supply filled at a network pharmacy with standard copays in each of our 5 drug tiers. These amounts apply **only** during the time when you're in the Initial Coverage Stage.

Most adult Part D vaccines are covered at no cost to you.

For information about the costs for a long-term supply; or at a network pharmacy that offers preferred cost sharing; or for mail-order prescriptions go to **Chapter 6, Section D** of your *Member Handbook*.

	2025 (this year)	2026 (next year)
Drugs in Tier 1 Preferred Generic Cost for a one-month supply of a drug in Tier 1 that's filled at a network pharmacy	Your copay for a one-month (30-day) supply is \$0 . Your copay for a one-month (30-day) mail-order prescription is \$0.	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. If you do not receive Extra Help, your copay for a one-month (30-day) supply is \$0 . Your copay for a one-month (30-day) preferred mail-order prescription is \$0.
Drugs in Tier 2 Generic Cost for a one-month supply of a drug in Tier 2 that's filled at a network pharmacy	Your copay for a one-month (30-day) supply is \$0 . Your copay for a one-month (30-day) mail-order prescription is \$0.	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. If you do not receive Extra Help, your copay for a one-month (30-day) supply is \$0 . Your copay for a one-month (30-day) preferred mail-order prescription is \$0.
Drugs in Tier 3 Preferred Brand Cost for a one-month supply of a drug in Tier 3 that's filled at a network pharmacy	Your copay for a one-month (30-day) supply is \$0 . Your copay for a one-month (30-day) mail-order prescription is \$0 .	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. If you do not receive Extra Help, your coinsurance for a one-month (30-day) supply is 25% . Your coinsurance for a one-month (30-day) preferred mail-order prescription is 25% .

	2025 (this year)	2026 (next year)
Drugs in Tier 4 Non-Preferred Drug Cost for a one-month supply of a drug in Tier 4 that's filled at a network pharmacy	Your copay for a one-month (30-day) supply is \$0 . Your copay for a one-month (30-day) mail-order prescription is \$0 .	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. If you do not receive Extra Help, your coinsurance for a one-month (30-day) supply is 25% . Your coinsurance for a one-month (30-day) preferred mail-order prescription is 25% .
Drugs in Tier 5 Specialty Tier Cost for a one-month supply of a drug in Tier 5 that's filled at a network pharmacy	Your copay for a one-month (30-day) supply is \$0 . Your copay for a one-month (30-day) mail-order prescription is \$0 .	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. If you do not receive Extra Help, your coinsurance for a one-month (30-day) supply is 25% . Your coinsurance for a one-month (30-day) preferred mail-order prescription is 25% .

The Initial Coverage Stage ends when your total out-of-pocket costs reach **\$2,100**. At that point the Catastrophic Coverage Stage begins. The plan covers all of your drug costs from then until the end of the year. Refer to **Chapter 6** of your *Member Handbook* for more information about how much you pay for drugs.

E4. Stage 2: "Catastrophic Coverage Stage"

When you reach the out-of-pocket limit **\$2,100** for your drugs, the Catastrophic Coverage Stage begins and you pay nothing for your covered Part D drugs. You stay in the Catastrophic Coverage Stage until the end of the calendar year.

For more information about your costs in the Catastrophic Coverage stage, refer to **Chapter 6** of your *Member Handbook*.

F. Administrative changes

	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 drug costs by spreading them out during the calendar year (January-December).	The Medicare Prescription Payment Plan may help you manage your drug costs by spreading them out during the year as monthly payments. To learn more about this program, please contact us at the number at the bottom of the page or visit www.medicare.gov .

G. Choosing a plan

G1. Staying in our plan

We hope to keep you as a plan member. You don't have to do anything to stay in our plan. Unless you sign up for a different Medicare plan or change to Original Medicare, you'll automatically stay enrolled as a member of our plan for 2026.

G2. Changing plans

Most people with Medicare can end their membership during certain times of the year. Because you have Healthy Connections Medicaid, you can end your membership in our plan any month of the year.

In addition, you may end your membership in our plan during the following periods:

- The **Open Enrollment Period**, which lasts from October 15 to December 7. If you choose a new plan during this period, your membership in our plan ends on December 31 and your membership in the new plan starts on January 1.
- The **Medicare Advantage (MA) Open Enrollment Period**, which lasts from January 1 to March 31. If you choose a new plan during this period, your membership in the new plan starts the first day of the next month.

There may be other situations when you're eligible to make a change to your enrollment. For example, when:

- you moved out of our service area,
- your eligibility for Healthy Connections Medicaid or Extra Help changed, **or**
- you recently moved into or are currently getting care in an institution (like a skilled nursing facility or a long-term care hospital). If you recently moved out of an institution, you can change plans or change to Original Medicare for two full months after the month you move out.

 **If you have questions**, please call Humana Dual Integrated (HMO D-SNP) at 866-432-0001, TTY 711, between 8 am to 8 pm EST seven days a week, Oct. 1 - March 31 and Monday - Friday, April 1 - Sept. 30. The call is free. **For more information**, visit Humana.com.

Your Medicare services

You have three options for getting your Medicare services listed below any month of the year. You have an additional option listed below during certain times of the year including the **Open Enrollment Period** and the **Medicare Advantage Open Enrollment Period** or other situations described in **Section G2**. By choosing one of these options, you automatically end your membership in our plan.

1. You can change to: Another plan that provides your Medicare and most or all of your Medicaid benefits and services in one plan, also known as an integrated dual-eligible special needs plan (D-SNP) or a Program of All-inclusive Care for the Elderly (PACE) plan, if you qualify.	Here is what to do: Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. For information about Program of All-inclusive Care for the Elderly (PACE), call Healthy Connections Medicaid at 1-888-549-0820. This call is free. TTY users should call 1-888-842-3620. You can also go to www.scdhhs.gov/providers/managed-care/program-all-inclusive-care-elderly-pace/members If you need help or more information: • After you contact Medicare about changing plans, Medicare will work with Healthy Connections Medicaid to make the change. For more information about this process, you can call South Carolina Healthy Connections Choices at 1-877-552-4642, Monday through Friday from 8 a.m. to 6 p.m. TTY users should call 1-877-552-4670. • Call the SHIP program, I-CARE, at 1-800-868-9095, Monday through Friday from 8:30 a.m. to 5 p.m. TTY users should call 711 OR Enroll in a new integrated D-SNP. You'll automatically be disenrolled from our plan when your new plan's coverage begins.
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If you have questions, please call Humana Dual Integrated (HMO D-SNP) at 866-432-0001, TTY 711, between 8 am to 8 pm EST seven days a week, Oct. 1 - March 31 and Monday - Friday, April 1 - Sept. 30. The call is free. **For more information**, visit Humana.com.

2. You can change to: Original Medicare with a separate Medicare drug plan	Here is what to do: Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. If you need help or more information: • Call the State Health Insurance Assistance Program (SHIP) at 1-800-868-9095, Monday through Friday from 8:30 a.m. to 5 p.m. TTY users should call 711. In South Carolina, the SHIP is called the Insurance Counseling Assistance and Referrals for Elders (I-CARE) program. For more information, please visit www.aging.sc.gov. OR Enroll in a new Medicare drug plan. You'll automatically be disenrolled from our plan when your Original Medicare coverage begins.
3. You can change to: Original Medicare without a separate Medicare drug plan NOTE: If you switch to Original Medicare and don't enroll in a separate Medicare drug plan, Medicare may enroll you in a drug plan, unless you tell Medicare you don't want to join. You should only drop drug coverage if you have drug coverage from another source, such as an employer or union. If you have questions about whether you need drug coverage, call Insurance Counseling Assistance and Referrals for Elders (I-CARE) at 1-800-868-9095, Monday through Friday from 8:30 a.m. to 5 p.m. TTY users should call 711. For more information, please visit www.aging.sc.gov.	Here is what to do: Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. If you need help or more information: • Call the State Health Insurance Assistance Program (SHIP) at 1-800-868-9095, Monday through Friday from 8:30 a.m. to 5 p.m. TTY users should call 711. In South Carolina, the SHIP is called the Insurance Counseling Assistance and Referrals for Elders (I-CARE) program. For more information, please visit www.aging.sc.gov. You'll automatically be disenrolled from our plan when your Original Medicare coverage begins.

4. You can change to: Any Medicare health plan during certain times of the year including the Open Enrollment Period and the Medicare Advantage Open Enrollment Period or other situations described in Section A.	Here is what to do: Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. For information about Program of All-inclusive Care for the Elderly (PACE), call Healthy Connections Medicaid at 1-888-549-0820. This call is free. TTY users should call 1-888-842-3620. You can also go to www.scdhhs.gov/providers/managed-care/program-all-inclusive-care-elderly-pace/members If you need help or more information: • Call the State Health Insurance Assistance Program (SHIP) at 1-800-868-9095, Monday through Friday from 8:30 a.m. to 5 p.m. TTY users should call 711. In South Carolina, the SHIP is called the Insurance Counseling Assistance and Referrals for Elders (I-CARE) program. For more information, please visit www.aging.sc.gov. OR Enroll in a new Medicare plan. You're automatically disenrolled from our Medicare plan when your new plan's coverage begins.
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Your Healthy Connections Medicaid services

For questions about how to get your Healthy Connections Medicaid services after you leave our plan, contact South Carolina Healthy Connections Choices at 1-877-552-4642, Monday through Friday from 8 a.m. to 6 p.m. TTY users should call 1-877-552-4670. You can also visit www.scchoices.com. Ask how joining another plan or returning to Original Medicare affects how you get your Healthy Connections Medicaid coverage.

H. Getting help

H1. Our plan

We're here to help if you have any questions. Call Member Services at the numbers at the bottom of the page during the days and hours of operation listed. These calls are toll-free.

Read your Member Handbook

Your *Member Handbook* is a legal, detailed description of our plan's benefits. It has details about benefits and

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costs for 2026. It explains your rights and the rules to follow to get services and drugs we cover.

The *Member Handbook* for 2026 will be available by October 15. An up-to-date copy of the *Member Handbook* is available on our website at **Humana.com/PlanDocuments**. You may also call Member Services at the numbers at the bottom of the page to ask us to mail you a *Member Handbook* for 2026.

Our website

You can visit our website at **Humana.com/PlanDocuments**. As a reminder, our website has the most up-to-date information about our provider and pharmacy network (*Provider and Pharmacy Directory*) and our *Drug List (List of Covered Drugs)*.

H2. The state enrollment broker, South Carolina Healthy Connections Choices

The enrollment broker helps people choose between different Healthy Connections Medicaid health plans, enroll, change plans, or disenroll. The enrollment broker is called South Carolina Healthy Connections Choices, and it isn't connected with any insurance company or health plan. You can call South Carolina Healthy Connections Choices at 1-877-552-4642, Monday through Friday from 8 a.m. to 6 p.m. TTY users should call 1-877-552-4670. For more information, please visit www.scchoices.com.

H3. Getting help from the State Health Insurance Assistance Program (SHIP)

You can also call the State Health Insurance Assistance Program (SHIP). In South Carolina, the SHIP is called the Insurance Counseling Assistance and Referrals for Elders (I-CARE) program. I-CARE counselors can help you understand your plan choices and answer questions about switching plans. I-CARE isn't connected with any insurance company or health plan. The I-CARE phone number is 1-800-868-9095. TTY users should call 711.

H4. Medicare

To get information directly from Medicare:

- call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- chat live at www.Medicare.gov/talk-to-someone
- write to Medicare at PO Box 1270, Lawrence, KS 66044.

Medicare's Website

You can visit the Medicare website (www.medicare.gov). If you choose to disenroll from our plan and enroll in another Medicare plan, the Medicare website has information about costs, coverage, and quality ratings to help you compare plans.

You can find information about Medicare plans available in your area by using Medicare Plan Finder on Medicare's website. (For information about plans, refer to www.medicare.gov and click on "Find plans.")



If you have questions, please call Humana Dual Integrated (HMO D-SNP) at 866-432-0001, TTY 711, between 8 am to 8 pm EST seven days a week, Oct. 1 - March 31 and Monday - Friday, April 1 - Sept. 30. The call is free. **For more information**, visit **Humana.com**.

Medicare & You 2026

You can read the *Medicare & You 2026* handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. This handbook is also available in Spanish, Chinese, and Vietnamese.

If you don't have a copy of this booklet, you can get it at the Medicare website (www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf) or by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

H5. Healthy Connections Medicaid

The phone number for Healthy Connections Medicaid is 1-888-549-0820. This call is free. TTY users should call 1-888-842-3620. Healthy Connections Medicaid can help or direct you to someone who can help you.

H6. The Medicare Prescription Payment Plan

The Medicare Prescription Payment Plan is a payment option that may help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across the calendar year (January-December) as monthly payments. This program doesn't save you money or lower your drug costs.

"Extra Help" from Medicare and help from your state's pharmaceutical assistance program (SPAP) and the AIDS Drug Assistance Program (ADAP), for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan alone. All members are eligible to participate in this program, regardless of income level. To learn more about this program please contact us at the phone number at the bottom of this page or visit www.Medicare.gov.

H7. Additional Resources

Aids Drug Assistance Program (ADAP)

The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. To be eligible for the ADAP operating in your State, individuals 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 prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance 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 assistance, call the ADAP program (the contact information for this organization are listed below). Be sure, when calling, to inform them of your Medicare Part D plan name or policy number.

South Carolina AIDS Drug Assistance Program (ADAP)

Address:

DHEC Constituent Services



If you have questions, please call Humana Dual Integrated (HMO D-SNP) at 866-432-0001, TTY 711, between 8 am to 8 pm EST seven days a week, Oct. 1 - March 31 and Monday - Friday, April 1 - Sept. 30. The call is free. For more information, visit Humana.com.

2600 Bull Street

Columbia, SC 29211

Phone Number: 800-856-9954

Website: <https://dph.sc.gov/diseases-conditions/infectious-diseases/hiv aids/aids-drug-assistance-program>



If you have questions, please call Humana Dual Integrated (HMO D-SNP) at 866-432-0001, TTY 711, between 8 am to 8 pm EST seven days a week, Oct. 1 - March 31 and Monday - Friday, April 1 - Sept. 30. The call is free. **For more information,** visit **Humana.com**.

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 **866-432-0001 (TTY: 711)**, Monday through Friday, from 8:00 a.m. to 8:00 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.'s Non-Discrimination Coordinator at P.O. Box 14618, Lexington, KY 40512-4618, **866-432-0001 (TTY: 711)**, or **accessibility@humana.com**. If you need help filing a grievance, Humana Inc.'s 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)**.
- You can also file a civil rights complaint with the South Carolina Department of Health and Human Services, Civil Rights Division, 1801 Main Street, P.O. Box 8206, Columbia, South Carolina 29202, **888-808-4238, TTY: 888-842-3620, civilrights@scdhhs.gov**. Complaint form is available at **https://www.scdhhs.gov/sites/default/files/SCDHHS%20Civil%20Rights%20Discrimination%20Complaint_0.pdf**.

This notice is available at **[Humana.com/SouthCarolinaDocuments](https://www.humana.com/SouthCarolinaDocuments)**.

Humana Healthy Horizons in South Carolina is a Medicaid product of Humana Benefit Plan of South Carolina, Inc.

Auxiliary aids and services, free of charge, are available to you.
866-432-0001 (TTY: 711), Monday through Friday,
from 8:00 a.m. to 8:00 p.m., Eastern time.

Humana Inc. and its subsidiaries comply with Section 1557 by providing free auxiliary aids and services to people with disabilities when auxiliary aids and services are necessary to ensure an equal opportunity to participate. Services include qualified sign language interpreters, video remote interpretation, and written information in other formats.

English: Call the number above to receive free language assistance services.

Español (Spanish): Llame al número que se indica arriba para recibir servicios gratuitos de asistencia lingüística.

繁體中文 (Chinese): 您可以撥打上面的電話號碼以獲得免費的語言協助服務。

Tiếng Việt (Vietnamese): Gọi số điện thoại ở trên để nhận các dịch vụ hỗ trợ ngôn ngữ miễn phí.

한국어 (Korean): 무료 언어 지원 서비스를 받으려면 위 번호로 전화하십시오.

Français (French): Appelez le numéro ci-dessus pour recevoir des services gratuits d'assistance linguistique.

Tagalog (Tagalog – Filipino): Tawagan ang numero sa itaas para makatanggap ng mga libheng serbisyo sa tulong sa wika.

Русский (Russian): Позвоните по вышеуказанному номеру, чтобы получить бесплатную языковую поддержку.

Deutsch (German): Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.

ગુજરાતી (Gujarati): મફત ભાષા સહાય સેવાઓ મેળવવા માટે ઉપર આપેલા નંબર પર કોલ કરો.

العربية (Arabic): اتصل برقم الهاتف أعلاه للحصول على خدمات المساعدة اللغوية المجانية.

Português (Portuguese): Ligue para o número acima para receber serviços gratuitos de assistência no idioma.

日本語 (Japanese): 無料の言語支援サービスを受けるには、上記の番号までお電話ください。

Українська (Ukrainian): Зателефонуйте за вказаним вище номером для отримання безкоштовної мовної підтримки.

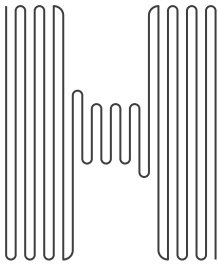
हिंदी (Hindi): भाषा सहायता सेवाएं मुफ्त में प्राप्त करने के लिए ऊपर के नंबर पर कॉल करें।

ខ្មែរ (Cambodian): ហៅមកលេខទូរស័ព្ទខាងលើ ដើម្បីទទួលបានសេវាភាសាឥតគិតថ្លៃ។

This notice is available at **[Humana.com/SouthCarolinaDocuments](https://www.humana.com/SouthCarolinaDocuments)**.

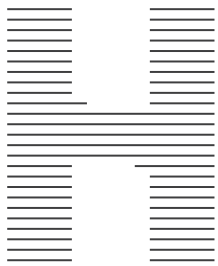
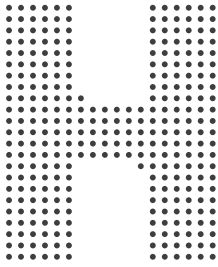
Humana Healthy Horizons in South Carolina is a Medicaid product of Humana Benefit Plan of South Carolina, Inc.

SCHMEDVEN_Approved

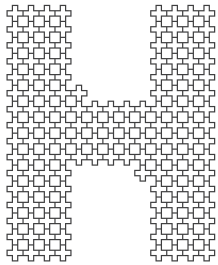


You can view these 2026 plan documents starting October 15, 2025 at www.Humana.com/PlanDocuments. Here you can see the most up-to-date information about your plan. It's easy to search, so you can find what you are looking for quickly.

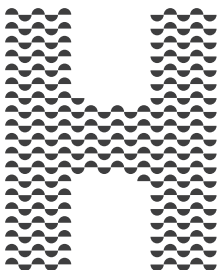
- See your *Member Handbook* for your plan's specific details, benefits and costs.
- Review the *Drug List* which includes the drugs covered by your plan.
- View the *Provider and Pharmacy Directory* to see a list of providers and specialists in your plan's network.



To get paper copies of these documents by mail, make your request online at the website above, or call **866-432-0001 (TTY: 711)**, 24 hours a day, seven days a week. Please have your Humana member ID card ready when you call. When asked why you've called, say "Member Handbook," "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.

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

