2026

Annual Notice of Changes

HumanaChoice Florida H5216-304 (PPO)

Central Florida PPO
Central Florida

Humana®

It’s time to review your HumanaChoice Florida H5216-304 (PPO) updates for 2026

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

Humana is committed to offering plans that give you the benefits and services you rely on most. Our plans this year are no exception. Many of our members will see that their plan benefits have either stayed the same or improved from last year. Plus, we’ve made other enhancements that make it easier to use your plan and get the care you need.

For example, your Medicare Advantage prescription drug (MAPD) plan includes dental, vision, hearing and prescription drug coverage. It also offers $0 primary care copays and $0 preventive care, including mammograms, colonoscopies and bone density screenings.

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

Please review the plan changes carefully. If you’d like to keep your current HumanaChoice Florida H5216-304 (PPO) plan, you don’t need to do anything. It will automatically renew on January 1, 2026, and you can keep your current Humana member ID card.

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

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

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

HumanaChoice Florida H5216-304 (PPO) offered by Humana Insurance Company

Annual Notice of Change for 2026

You're enrolled as a member of HumanaChoice Florida H5216-304 (PPO).

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

- **You have from October 15 - December 7 to make changes to your Medicare coverage for next year.** If you don't join another plan by December 7, 2025, you'll stay in HumanaChoice Florida H5216-304 (PPO).
- To change to a **different plan**, visit www.Medicare.gov or review the list in the back of your *Medicare & You 2026* handbook.
- Note this is only a summary of changes. More information about costs, benefits, and rules is in the Evidence of Coverage. Get a copy at **Humana.com/PlanDocuments** or call Customer Care 800-457-4708 (TTY users call 711) to get a copy by mail. You can also review the *Evidence of Coverage* to see if other benefit or cost changes affect you.

More Resources

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

About HumanaChoice Florida H5216-304 (PPO)

- HumanaChoice Florida H5216-304 (PPO) is a Medicare Advantage PPO organization with a Medicare contract. Enrollment in any Humana plan depends on contract renewal.
- When this material says "we," "us," or "our," it means Humana Insurance Company. When it says "plan" or "our plan," it means HumanaChoice Florida H5216-304 (PPO).
- Out-of-network/non-contracted providers are under no obligation to treat HumanaChoice Florida H5216-304 (PPO) members, except in emergency situations. Please call our Customer Care number or see your *Evidence of Coverage* for more information, including the cost-sharing that applies to out-of-network services.
- **If you do nothing by December 7, 2025, you'll automatically be enrolled in HumanaChoice Florida H5216-304 (PPO)**. Starting January 1, 2026, you'll get your medical and drug coverage through HumanaChoice Florida H5216-304 (PPO). 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)

Table of Contents

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* * Your premium can be higher than this amount. Go to Section 1.1 for details.	**$0**		**$0**	
Maximum out-of-pocket amount This is the most you'll pay out of pocket for covered Part A and Part B services. (Go to Section 1.2 for details.)	From network providers: **$4,700**	From network and out-of-network providers combined: **$8,900**	From network providers: **$4,700**	From network and out-of-network providers combined: **$8,900**
Primary care office visits	**$0** copayment per visit	**$55** copayment per visit	**$0** copayment per visit	**$55** copayment per visit
Specialist office visits	**$30** copayment per visit	**$65** copayment per visit	**$30** copayment per visit	**$65** copayment per visit
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.	**$275** copayment per day for days 1 – 4 **$0** copayment per day for days 5 – 90	**$495** copayment per day for days 1 – 27 **$0** copayment per day for days 28 – 90	**$425** copayment per day for days 1 – 4 **$0** copayment per day for days 5 – 90	**$495** copayment per day for days 1 – 27 **$0** copayment per day for days 28 – 90
Part D drug coverage deductible (Go to Section 1.7 for details)	**$300** 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
Part D drug coverage (Go to Section 1.7 for details, including Yearly Deductible, Initial Coverage, and Catastrophic Coverage Stages.) Not all tiers may include insulin. Please refer to your Prescription Drug Guide to confirm insulin coverage.	During this stage, you pay **$0** cost sharing for drugs on Tier 1, **$0** cost sharing for drugs on Tier 2 and the full cost of drugs on Tier 3, Tier 4, and Tier 5 until you have reached the yearly deductible. Copayment/Coinsurance during the Initial Coverage Stage:		During this stage, you pay **$0** cost sharing for drugs on Tier 1, **$5** cost sharing for drugs on Tier 2, **$47** cost sharing for drugs on Tier 3 and the full cost of drugs on Tier 4 and Tier 5 until you have reached the yearly deductible. Copayment/Coinsurance during the Initial Coverage Stage:	
	For a 30-day supply from a **retail pharmacy**: • Drug Tier 1: **$0** • Drug Tier 2: **$0** • Drug Tier 3: **$47** You pay **$35** per month supply of each covered insulin product on this tier. • Drug Tier 4: **35%** • Drug Tier 5: **29%** You pay **$35** per month supply of each covered insulin product on this tier.		For a 30-day supply from a **retail pharmacy**: • Drug Tier 1: **$0** You pay **0%** per month supply of each covered insulin product on this tier. • Drug Tier 2: **$5** You pay **25%** up to **$5** per month supply of each covered insulin product on this tier. • Drug Tier 3: **$47** You pay **25%** up to **$35** per month supply of each covered insulin product on this tier. • Drug Tier 4: **46%** You pay **25%** up to **$35** per month supply of each covered insulin product on this tier. • Drug Tier 5: **25%** You pay **25%** up to **$35** per month supply of each covered insulin product on this tier.	

Cost	2025 (this year)		2026 (next year)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
	For a 100-day supply from a **mail-order pharmacy** with preferred cost-sharing: • Drug Tier 1: **$0** • Drug Tier 2: **$0** • Drug Tier 3: **$131** You pay **$95** per 3-month supply of each covered insulin product on this tier. • Drug Tier 4: **35%** • Drug Tier 5: Not available		For a 100-day supply from a **mail-order pharmacy** with preferred cost-sharing: • 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: **$131** You pay **25%** up to **$95** per 3-month supply of each covered insulin product on this tier. • Drug Tier 4: **46%** 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
	For a 100-day supply from a **mail-order pharmacy** with standard cost-sharing: • Drug Tier 1: **$30** • Drug Tier 2: **$60** • Drug Tier 3: **$141** You pay **$105** per 3-month supply of each covered insulin product on this tier. • Drug Tier 4: **35%** • Drug Tier 5: Not available		For a 100-day supply from a **mail-order pharmacy** with standard cost-sharing: • Drug Tier 1: **$30** You pay **25%** up to **$30** per 3-month supply of each covered insulin product on this tier. • Drug Tier 2: **$60** You pay **25%** up to **$60** per 3-month supply of each covered insulin product on this tier. • Drug Tier 3: **$141** You pay **25%** up to **$105** per 3-month supply of each covered insulin product on this tier. • Drug Tier 4: **46%** You pay **25%** up to **$105** per 3-month supply of each covered insulin product on this tier. • Drug Tier 5: Not available	
	Catastrophic Coverage: During this payment stage, you pay nothing for your covered Part D drugs and for excluded drugs that are covered under our enhanced benefit.		Catastrophic Coverage: During this payment stage, you pay nothing for your covered Part D drugs and for excluded drugs that are covered under our enhanced benefit.	
Excluded Drug(s) Coverage	• Select Prescription Vitamins: Not Covered • Select Anti-Obesity drugs: Covered		• Select Prescription Vitamins are covered at a Tier 1 cost-share based on location. • Select Anti-Obesity drugs: Not Covered	

SECTION 1 Changes to Benefits and 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.)	**$0**	**$0**
Part B premium reduction This amount will be deducted from your Part B premium. This means you'll pay less for Part B.	**$2.50**	**$0**

Factors that could change your Part D Premium Amount

- Late Enrollment Penalty - Your monthly plan premium will be *more* if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as creditable coverage) for 63 days or more.
- Higher Income Surcharge - If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.

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

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

Cost	2025 (this year)		2026 (next year)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
In-network maximum out-of-pocket amount Your costs for covered medical services (such as copayments) from network providers **count** toward your in-network maximum out-of-pocket amount. Your costs for prescription drugs **don't count** toward your maximum out-of-pocket amount. **Combined maximum out-of-pocket amount** Your costs for covered medical services (such as copayments) from in-network and out-of-network providers **count** toward your combined maximum out-of-pocket amount. Your costs for outpatient prescription drugs **don't count** toward your maximum out-of-pocket amount for medical services.	**$4,700**	**$8,900** combined in-network and out-of-network	**$4,700** Once you've paid **$4,700** out-of-pocket for covered Part A and Part B services, you'll pay nothing for your covered Part A and Part B services from network providers for the rest of the calendar year.	**$8,900** combined in-network and out-of-network Once you've paid **$8,900** out-of-pocket for covered Part A and Part B services, you'll pay nothing for your covered Part A and Part B services from in-network or out-of-network providers for the rest of the calendar year.

Section 1.3 Changes to the Provider Network

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

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

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

Section 1.4 Changes to the Pharmacy Network

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

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

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

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

Section 1.5 Changes to Benefits & Costs for Medical Services

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

Cost	**2025** (this year)		**2026** (next year)	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Acupuncture for chronic low back pain	**$30** copayment for acupuncture for chronic low back pain visits up to 20 visit(s) per year.	**$30** copayment for acupuncture for chronic low back pain visits up to 20 visit(s) per year. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.	**$0** copayment for acupuncture for chronic low back pain visits up to 20 visit(s) per year.	**$0** copayment for acupuncture for chronic low back pain visits up to 20 visit(s) per year. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
Bone mass measurement				
– at a specialist's office	**$0** copayment	**50%** of the total cost	No Change	**$0** copayment
– at a freestanding radiology facility	**$0** copayment	**50%** of the total cost	No Change	**$0** copayment
– at a hospital facility as an outpatient	**$0** copayment	**50%** of the total cost	No Change	**$0** copayment
Breast cancer screening (mammograms)				

Cost	2025 (this year)		2026 (next year)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
– at a specialist's office	**$0** copayment	**50%** of the total cost	No Change	**$0** copayment
– at a freestanding radiology facility	**$0** copayment	**50%** of the total cost	No Change	**$0** copayment
– at a hospital facility as an outpatient	**$0** copayment	**50%** of the total cost	No Change	**$0** copayment
Chiropractic services				
• For each Medicare-covered visit (manual manipulation of the spine to correct subluxation), you pay:				
– at a specialist's office	**$20** copayment	**$65** copayment	**$15** copayment	No Change
Colorectal cancer screening				
– at a specialist's office	**$0** copayment	**50%** of the total cost	No Change	**$0** copayment
– at a hospital facility as an outpatient	**$0** copayment	**50%** of the total cost	No Change	**$0** copayment
– at an ambulatory surgical center	**$0** copayment	**50%** of the total cost	No Change	**$0** copayment
Dental services				
• Supplemental dental benefits:	**DENF09** Plan covers up to **$1,000** 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	**DENF09** Plan covers up to **$1,000** 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	**DENF62** Plan covers up to **$1,000** 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	**DENF62** Plan covers up to **$1,000** 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

Cost	2025 (this year)		2026 (next year)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
	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. **30%** coinsurance applies to dentures and bridges. Frequency limits may apply. Note: The allowance cannot be used on fluoride, cosmetic services and implants.	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. **30%** coinsurance applies to dentures and bridges. 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, limitations, and/or exclusions.	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. **30%** coinsurance applies to dentures. **30%** - **40%** coinsurance applies to bridges and crowns. Frequency limits may apply. Note: The allowance cannot be used on fluoride, cosmetic services and implants.	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. **30%** coinsurance applies to dentures. **30%** - **40%** coinsurance applies to bridges and crowns. 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, limitations, and/or exclusions.
Diabetes self-management training, diabetic services and supplies • For each Medicare-covered diabetic shoes and inserts, you pay:				
– at a durable medical equipment provider	**$10** copayment	**50%** of the total cost	**$5** copayment	No Change
– at a prosthetics provider	**$10** copayment	**50%** of the total cost	**$5** copayment	No Change
Emergency care				

Cost	**2025** (this year)		**2026** (next year)	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
• For each Medicare-covered emergency room visit, you pay:	**$125** copayment waived if admitted within 24 hours. When placed in observation, member pays observation cost-share instead of emergency room cost-share.	**$125** copayment waived if admitted within 24 hours. When placed in observation, member pays observation cost-share instead of emergency room cost-share.	**$130** copayment waived if admitted within 24 hours. When placed in observation, member pays observation cost-share instead of emergency room cost-share.	**$130** copayment waived if admitted within 24 hours. When placed in observation, member pays observation cost-share instead of emergency room cost-share.
Hearing services • Supplemental hearing benefits:	Not Covered	Not Covered	**HER833** **$0** copayment for fitting/evaluation, routine hearing exams up to 1 per year. **$1,000** combined maximum benefit coverage amount for both OTC hearing aids, prescription hearing aids (all types) up to 2 every 3 years.	**HER833** **25%** coinsurance for fitting/evaluation, routine hearing exams up to 1 per year. **$1,000** combined allowance amount with a **25%** reduction for out of network (**$750** out of network allowance) for both OTC hearing aids, prescription hearing aids (all types) up to 2 every 3 years. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
Inpatient hospital care • For a Medicare-covered stay at a hospital, you pay:	**$275** copayment per day for days 1 - 4 **$0** copayment per day for days 5 - 90	**$495** copayment per day for days 1 - 27 **$0** copayment per day for days 28 - 90	**$425** copayment per day for days 1 - 4 **$0** copayment per day for days 5 - 90	No Change
Inpatient mental health care				

Cost	**2025** (this year)		**2026** (next year)	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
• For a Medicare-covered stay at a hospital, you pay:	**$275** copayment per day for days 1 - 4 **$0** copayment per day for days 5 - 90	**$495** copayment per day for days 1 - 27 **$0** copayment per day for days 28 - 90	**$425** copayment per day for days 1 - 4 **$0** copayment per day for days 5 - 90	No Change
• For a Medicare-covered stay at an inpatient psychiatric facility, you pay:	**$275** copayment per day for days 1 - 4 **$0** copayment per day for days 5 - 90	**$495** copayment per day for days 1 - 27 **$0** copayment per day for days 28 - 90	**$425** copayment per day for days 1 - 4 **$0** copayment per day for days 5 - 90	No Change
Intensive Outpatient Services – at a hospital facility as an outpatient	**$40** copayment	**$65** copayment	**$35** copayment	**$140** copayment
Meal Program - Humana Well Dine®	Not Covered	Not Covered	**$0** copayment for Humana Well Dine® meal program. After your inpatient stay in either a hospital or a nursing facility, you may be eligible to receive 2 home delivered meals per day for 7 days (up to 14 meals). Meals must be requested within 30 days of discharge from your inpatient stay. Limited to 4 times per year. **$0** copayment for Humana Well Dine® meal program. Receive 2 meals per day for 10 days. Up to 20 meals delivered to member's home to assist in establishing a diet needed for diabetes	No Change

Cost	2025 (this year)		2026 (next year)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
			mellitus with physician approval. **$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. **$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 cardiovascular disorders with physician approval.	
Opioid treatment program services • For each Medicare-covered opioid treatment services visit, you pay: – at a hospital facility as an outpatient	**$50** copayment	**50%** of the total cost	**$35** copayment	No Change
Outpatient diagnostic tests, therapeutic services and supplies • For advanced imaging services (MRI, MRA, PET, or CT Scan), you pay:				

Cost	2025 (this year)		2026 (next year)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
– at your primary care provider's office	**$100** copayment	**50%** of the total cost	**$200** copayment	No Change
– at a specialist's office	**$100** copayment	**50%** of the total cost	**$200** copayment	No Change
– at a freestanding radiology facility	**$100** copayment	**50%** of the total cost	**$200** copayment	No Change
– at a hospital facility as an outpatient	**$225** copayment	**50%** of the total cost	**$335** copayment	No Change
• For diagnostic mammography, you pay:				
– at a specialist's office	**$0** copayment	**$65** copayment	No Change	**$0** copayment
– at a freestanding radiology facility	**$0** copayment	**$65** copayment	No Change	**$0** copayment
– at a hospital facility as an outpatient	**$0** copayment	**50%** of the total cost	No Change	**$0** copayment
• For nuclear medicine services, you pay:				
– at a hospital facility as an outpatient	**$225** copayment	**50%** of the total cost	**$325** copayment	No Change
• For diagnostic colonoscopy, you pay:				
– at an ambulatory surgical center	**$0** copayment	**50%** of the total cost	No Change	**$0** copayment
– at a hospital facility as an outpatient	**$0** copayment	**50%** of the total cost	No Change	**$0** copayment
Outpatient hospital observation				
• For each Medicare-covered observation services visit, you pay:				
– at a hospital facility as an outpatient	**$275** copayment	**$495** copayment	**$425** copayment	No Change
Outpatient mental health care				
• For each Medicare-covered individual/group therapy visit, you pay:				
– at a hospital facility as an outpatient	**$50** copayment	**50%** of the total cost	**$35** copayment	No Change

Cost	**2025** (this year)		**2026** (next year)	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Outpatient rehabilitation services				
• For Medicare-covered physical therapy, you pay:				
– at a specialist's office	**$10** copayment	**$65** copayment	No Change	**$55** copayment
– at a Comprehensive Outpatient Rehabilitation Facility (CORF)	**$10** copayment	**$65** copayment	No Change	**$55** copayment
• For Medicare-covered occupational therapy, you pay:				
– at a specialist's office	**$10** copayment	**$65** copayment	No Change	**$55** copayment
– at a Comprehensive Outpatient Rehabilitation Facility (CORF)	**$10** copayment	**$65** copayment	No Change	**$55** copayment
• For Medicare-covered speech/language therapy, you pay:				
– at a specialist's office	**$10** copayment	**$65** copayment	No Change	**$55** copayment
– at a Comprehensive Outpatient Rehabilitation Facility (CORF)	**$10** copayment	**$65** copayment	No Change	**$55** copayment
Outpatient substance abuse services				
• For each Medicare-covered individual/group therapy visit, you pay:				
– at a hospital facility as an outpatient	**$50** copayment	**50%** of the total cost	**$35** copayment	No Change
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers				
• For each Medicare-covered surgical services visit, you pay:				
– at an ambulatory surgical facility	**$150** copayment	**50%** of the total cost	**$125** copayment	No Change

Cost	2025 (this year)		2026 (next year)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Partial Hospitalization – at a hospital facility as an outpatient	**$40** copayment	**$65** copayment	**$35** copayment	**$140** copayment
Post-discharge personal home care	**$0** copayment for a minimum of 4 hours per day, up to a maximum of 44 hours per year for certain in-home support services following a discharge from a skilled nursing facility or from an inpatient hospitalization. Qualified aides can offer assistance performing activities of daily living (ADLs) Activities of daily living are activities related to personal care. They include bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet, and eating. When a member is receiving assistance with one or more Activities of Daily Living (ADLs), they may also receive assistance with Instrumental Activities of Daily living (IADLs) within the home by a qualified aide.	The in-network provider must be used for this service. If you choose to utilize another provider, you are responsible for all charges.	**$0** copayment for a minimum of 4 hours per day, up to a maximum of 44 hours per year for certain in-home support services following a discharge from a skilled nursing facility or from an inpatient hospitalization. Qualified aides can offer assistance performing activities of daily living (ADLs). Activities of daily living are activities related to personal care. They include bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet, and eating. Services must be initiated within 30 days of discharge event and utilized within 60 days of discharge for each qualifying event up to the maximum annual allowance. This benefit also allows Caregivers to take a break while the member continues to get	No Change

Cost	2025 (this year)		2026 (next year)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
	IADLs are activities related to independent living. They include preparing meals, pick up of pre-paid curbside/drive-thro ugh orders, performing light housework, laundry, dishes, and/or using a telephone. A member must be receiving assistance with a minimum of one ADL to receive assistance with any IADL. Services must be initiated within 30 days of discharge event and utilized within 60 days of discharge for each qualifying event up to the maximum annual allowance. This benefit also allows Caregivers to take a break while the member continues to get care in a safe environment.		care in a safe environment.	
Skilled nursing facility (SNF) care • For a Medicare-covered stay at a skilled nursing facility, you pay:	**$0** copayment per day for days 1 - 20 **$160** copayment per day for days 21 - 100	**$250** copayment per day for days 1 - 58 **$0** copayment per day for days 59 - 100	No Change	**$250** copayment per day for days 1 - 58 **$160** copayment per day for days 59 - 100
Vision care • Routine vision services:	**VIS694**	**VIS694**	**VIS751**	**VIS751**

Cost	**2025** (this year)		**2026** (next year)	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
	$0 copayment for routine exam up to 1 per year. **$75** combined maximum benefit coverage amount per year for routine exam. **$50** maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames. OR **$100** 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.	**$0** copayment for routine exam up to 1 per year. **$75** combined maximum benefit coverage amount per year for routine exam. **$50** 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. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.	**$0** copayment for routine exam up to 1 per year. **$75** combined maximum benefit coverage amount per year for routine exam. **$75** maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames. OR **$150** 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.	**$0** copayment for routine exam up to 1 per year. **$75** combined maximum benefit coverage amount per year for routine exam. **$75** combined maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames. Eyeglass lens options may be available with the maximum benefit coverage amount up to 1 pair per year. Maximum benefit coverage amount is limited to one time use per year. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
• Medically Necessary Contacts	**$0** copayment	Included as part of the out-of-network **VIS694** allowance listed above.	Included as part of the **VIS751** allowance listed above.	Included as part of the out-of-network **VIS751** allowance listed above.
Worldwide coverage • For each emergency room visit, you pay:	Not Applicable		Not Applicable	

Cost	2025 (this year)		2026 (next year)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
		$125 copayment waived if admitted within 24 hours.		**$130** copayment waived if admitted within 24 hours.

Section 1.6 Changes to Part D Drug Coverage

Changes to Our Drug Guide

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

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

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

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

Section 1.7 Changes to Prescription Drug Benefits & Costs

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

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

Drug Payment Stages

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

- ***Stage 1: Yearly Deductible***
  You start in this payment stage each calendar year. During this stage, you pay the full cost of your Part D drugs until you've reached the yearly deductible.

- ***Stage 2: Initial Coverage***
  Once you pay the yearly deductible, you move to the Initial Coverage Stage. In this stage, our plan pays its share of the cost of your drugs, and you pay your share of the cost. You generally stay in this stage until your year-to-date Out-of-Pocket costs reach **$2,100** *Out-of-Pocket threshold*.
- ***Stage 3: Catastrophic Coverage***
  This is the third and final drug payment stage. In this stage, you pay nothing for your covered Part D drugs. You generally stay in this stage for the rest of the calendar year.

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

Drug Costs in Stage 1: Yearly Deductible

The table shows your cost per prescription during this stage.

Stage	**2025** (this year)	**2026** (next year)
Yearly Deductible	The deductible is **$300** except for covered insulin products and most adult Part D vaccines. 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.	The deductible is **$615** except for covered insulin products and most adult Part D vaccines. During this stage, you pay **$0** cost sharing for drugs on Tier 1, **$5** cost sharing for drugs on Tier 2, **$47** cost sharing for drugs on Tier 3 and the full cost of drugs on Tier 4 and Tier 5 until you've reached the yearly deductible.

Drug Costs in Stage 2: Initial Coverage Stage

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

Not all tiers may include insulin. Please refer to your Prescription Drug Guide to confirm insulin coverage.

The table shows your cost per prescription for a one-month supply filled at a network pharmacy with standard cost sharing.

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

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

	2025 (this year)	**2026** (next year)
Tier 1: Preferred Generic:	You pay **$0**. Your cost for a one-month mail-order prescription is **$10**.	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.
Tier 2: Generic:	You pay **$0**. Your cost for a one-month mail-order prescription is **$20**.	You pay **$5** per month supply at a retail pharmacy. You pay **25%** up to a **$5** 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.
Tier 3: Preferred Brand:	You pay **$47**. You pay **$35** per month supply of each covered insulin product on this tier. Your cost for a one-month mail-order prescription is **$47**.	You pay **$47** 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 **$47**. You pay **25%** up to **$35** per month supply of each covered insulin product for a mail-order prescription on this tier.
Tier 4: Non-Preferred Drug:	You pay **35%** of the total cost. Your cost for a one-month mail-order prescription is **35%**.	You pay **46%** 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 **46%**. You pay **25%** up to **$35** per month supply of each covered insulin product for a mail-order prescription on this tier.

	2025 (this year)	**2026** (next year)
Tier 5: Specialty Tier:	You pay **29%** of the total cost. You pay **$35** per month supply of each covered insulin product on this tier. Your cost for a one-month mail-order prescription is **29%**.	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.

Changes to the Catastrophic Coverage Stage

If you reach the Catastrophic Coverage Stage, you pay nothing for your covered Part D drugs and for excluded drugs that are covered under our enhanced benefit.

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

SECTION 2 Administrative Changes

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

SECTION 3 How to Change Plans

To stay in HumanaChoice Florida H5216-304 (PPO), 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 plan HumanaChoice Florida H5216-304 (PPO).

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

- **To change to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from HumanaChoice Florida H5216-304 (PPO).

- **To change to Original Medicare with Medicare drug coverage,** enroll in the new Medicare drug plan. You will automatically be disenrolled from HumanaChoice Florida H5216-304 (PPO).
- **To change to Original Medicare without a drug plan,** you can send us a written request to disenroll or visit our website to disenroll online at www.humana.com/member/member-rights/disenrollment-and-cancellation. Call Customer Care at 800-457-4708 (TTY users call 711) for more information on how to do this. Or call **Medicare** at 1-800-MEDICARE (1-800-633-4227) and ask to be disenrolled. TTY users can call 1-877-486-2048. If you don't enroll in a Medicare drug plan, you may pay a Part D late enrollment penalty (go to Section 1.1).
- **To learn more about Original Medicare and the different types of Medicare plans,** visit www.Medicare.gov, check the *Medicare & You 2026* handbook, call your State Health Insurance Assistance Program (go to Section 5), or call 1-800-MEDICARE (1-800-633-4227).

Section 3.1 Deadlines for Changing Plans

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

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

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

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

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

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 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 can call 1-800-325-0778.

  - Your State Medicaid Office.

- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible people living with HIV/AIDS have access to life-saving HIV medications. To be eligible for the ADAP operating in your state, you must meet certain criteria, including proof of state residence and HIV status, low income as defined by the state, and uninsured/under-insured status. Medicare Part D drugs that are also covered by ADAP qualify for prescription cost-sharing help through the ADAP program. For information on eligibility criteria, covered drugs, how to enroll in the program or if you are currently enrolled how to continue receiving help, call the ADAP program (the name and phone numbers for this organization are listed in "Exhibit A" in the back of this document). Be sure, when calling, to inform them of your Medicare Part D plan name or policy number.

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

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

SECTION 5 Questions?

Get Help from HumanaChoice Florida H5216-304 (PPO)

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

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

Read your *2026 Evidence of Coverage*

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2026. For details, go to the 2026 *Evidence of Coverage* for HumanaChoice Florida H5216-304 (PPO). The *Evidence of Coverage* is the legal, detailed description of our plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. Get the *Evidence of Coverage* on our website at **Humana.com/PlanDocuments** or call Customer Care at 800-457-4708 (TTY users call 711) to ask us to mail you a copy.

Visit Humana.com/PlanDocuments

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

Get Free Counseling about Medicare

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

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

Get Help from Medicare

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

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

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

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

- **Write to Medicare**

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

- **Visit www.Medicare.gov**

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

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

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

Exhibit A- State Agency Contact Information

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

FLORIDA	
SHIP Name and Contact Information	Serving Health Insurance Needs of Elders (SHINE) Department of Elder Affairs 4040 Esplanade Way, Suite 270 Tallahassee, FL 32399-7000 800-963-5337 (toll free) 800-955-8770 (TTY) 850-414-2150 (fax) 800-963-5337 http://www.floridaSHINE.org
Quality Improvement Organization	Acentra Health 5201 W. Kennedy Blvd. Suite 900 Tampa, FL 33609 888-317-0751 711 (TTY) 844-878-7921 (Fax) www.acentraqio.com
State Medicaid Office	Florida Medicaid 2727 Mahan Drive Tallahassee, FL 32308-5407 888-419-3456 (toll free) 850-412-4000 (local) 850-922-2993 (fax) 800-955-8771 (TTY) https://ahca.myflorida.com
AIDS Drug Assistance Program	Florida AIDS Drug Assistance Program (ADAP) HIV/AIDS Section 4052 Bald Cypress Way Tallahassee, FL 32399 850-245-4422 1-800-545-7432 (1-800-545-SIDA) (Spanish) 1-800-2437-101 (1-800-AIDS-101) (Creole) 888-503-7118 (TTY) http://www.floridahealth.gov/diseases-and-conditions/aids/adap/index.html

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**.

This notice is available at **www.humana.com/legal/non-discrimination-disclosure**.
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Notice of Availability - Auxiliary Aids and Services Notice

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

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

Հայերեն [Armenian]: Հասանելի են անվճար լեզվական, աջակցման և այլընտրանքային ձևաչափի ծառայություններ: Զանգահարե՛ք՝ **877-320-1235 (TTY: 711)**:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

This notice is available at **https://www.humana.com/legal/multi-language-support**.

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

ភាសាខ្មែរ [Khmer]៖ សេវាកម្មផ្នែកភាសា ជំនួយ និង សេវាកម្មជាទម្រង់ផ្សេងជំនួសអាចរកបាន។ ទូរសព្ទទៅ លេខ **877-320-1235 (TTY: 711)**។

한국어 [Korean]: 무료 언어, 보조 지원 및 대체 형식 서비스를 이용하실 수 있습니다. **877-320-1235 (TTY: 711)**번으로 문의하십시오.

ພາສາລາວ [Lao] ມີການບໍລິການດ້ານພາສາ, ອຸປະກອນຊ່ວຍເຫຼືອ ແລະ ຮູບແບບທາງເລືອກອື່ນໃຫ້ໃຊ້ຟຣີ. ໂທ **877-320-1235 (TTY: 711)**.

Diné [Navajo]: Saad t’áá jiik’eh, t’áadoole’é binahjį’ bee adahodooníłígíí diné bich’į’ anídahazt’i’í, dóó łahgo át’éego bee hada’dilyaaígíí bee bika’aanída’awo’í dahólǫ. Kohjį’ hodíilnih **877-320-1235 (TTY: 711)**.

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

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

ਪੰਜਾਬੀ [Punjabi]: ਮੁਫ਼ਤ ਭਾਸ਼ਾ, ਸਹਾਇਕ ਸਹਾਇਤਾ, ਅਤੇ ਵਿਕਲਪਿਕ ਫਾਰਮੈਟ ਸੇਵਾਵਾਂ ਉਪਲਬਧ ਹਨ। **877-320-1235 (TTY: 711)** ‘ਤੇ ਕਾਲ ਕਰੋ।

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

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

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

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

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

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

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

አማርኛ [Amharic]፦ ቋንቋ፣ አጋዥ ማዳመጫ እና አማራጭ ቅርፀት ያላቸው አገልግሎቶችም ይገኛሉ። በ **877-320-1235 (TTY: 711)** ላይ ይደውሉ።

Bǎsɔ́ ̀[Bassa]: Wuɖu-xwíníín-mú-zà-zà kǔà, Hwòɖǒ-fɔńɔ-́nyɔ,́ kè nyɔ-bɔǔn-po-kà ɓě ɓé nyuɛɛ se wíɖí pɛ́ɛ̀-pɛ́ɛ̀ ɖò kɔ.̃ **877-320-1235 (TTY: 711)** ɖá.

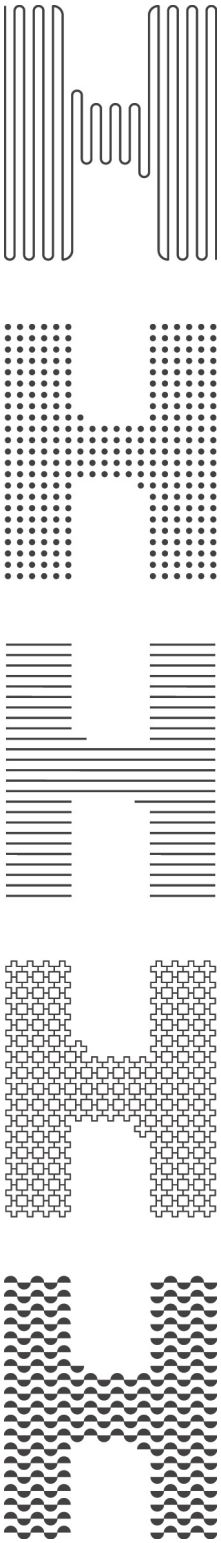
Bekee [Igbo]: Asụsụ n’efu, enyemaka nkwarụ, na ọrụ usoro ndị ọzọ dị. Kpọọ **877-320-1235 (TTY: 711)**.

Òyìnbó [Yoruba]: Àwọn iṣẹ́ àtìlẹhìn ìrànlọ́wọ́ èdè, àti ọ̀nà kíkà míràn wà lárọwọ́tó. Pe **877-320-1235 (TTY: 711)**.

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

Notes

Notes



Starting October 15, 2025, you can view and search these 2026 plan documents 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.
- View the Provider Directory to see a list of providers and specialists in your plan's network.
- Review the Drug List for a list of drugs covered in your plan.

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

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

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

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

H5216304000ANOC26

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

Look inside

Here's a summary of your **HumanaChoice Florida H5216-304 (PPO)** that takes effect on January 1, 2026.

Humana®

www.Humana.com
800-457-4708 (TTY: 711)