

Kaiser Permanente Dual Essential Plan 1 (HMO D-SNP) offered by Kaiser Foundation Health Plan of Georgia, Inc. (Dual Essential Plan 1)

Annual Notice of Change for 2026

You're enrolled as a member of Kaiser Permanente Dual Essential Plan 1.

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

- **You have from October 15 – December 7 to make changes to your Medicare coverage for next year.** If you don't join another plan by December 7, 2025, you'll stay in Kaiser Permanente Dual Essential Plan 1.
- 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 kp.org or call Member Services at 1-800-232-4404 (TTY users call 711) to get a copy by mail.

More Resources

- Call Member Services at 1-800-232-4404 (TTY users call 711) for more information. Hours are 8 a.m. to 8 p.m., 7 days a week. This call is free.
- This document is available in braille, large print, audio file, or data CD if you need it by calling Member Services.

About Kaiser Permanente Dual Essential Plan 1

- Kaiser Permanente is an HMO D-SNP plan with a Medicare contract and a contract with the state Medicaid program. Enrollment in Kaiser Permanente depends on contract renewal. Our plan also has a written agreement with the Georgia Medicaid program to coordinate your Medicaid benefits.
- When this material says "we," "us," or "our," it means Kaiser Foundation Health Plan of Georgia, Inc. (Health Plan). When it says "plan" or "our plan," it means Kaiser Permanente Dual Essential Plan 1 (Dual Essential).

- **If you do nothing by December 7, 2025, you'll automatically be enrolled in Kaiser Permanente Dual Essential Plan 1.** Starting January 1, 2026, you'll get your medical and drug coverage through Kaiser Permanente Dual Essential Plan 1. Go to Section 3 for more information about how to change plans and deadlines for making a change.

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Summary of Important Costs for 2026

	2025 (this year)	2026 (next year)
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 <u>most</u> you'll pay out of pocket for covered Part A and Part B services. (Go to Section 1.2 for details.)	\$8,850 If you are eligible for Medicare cost-sharing help under Medicaid, you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.	\$9,250 If you are eligible for Medicare cost-sharing help under Medicaid, you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.
Primary care office visits	\$0	\$0
Specialist office visits	\$0	\$0
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	Per admission, \$0 or \$2,000 per stay. If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay \$0 per visit.	Per admission, \$0 or \$2,000 per stay. If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay \$0 per visit.

	2025 (this year)	2026 (next year)
discharged is your last inpatient day.		
Part D drug coverage deductible (Go to Section 1.7 for details.)	\$400 (Tiers 3, 4, and 5), if you don't qualify for "Extra Help," except for covered insulin products and most adult Part D vaccines.	\$615 (Tiers 3, 4, and 5), if you don't qualify for "Extra Help," except for covered insulin products and most adult Part D vaccines.
Part D drug coverage (Go to Section 1.7 for details, including Yearly Deductible, Initial Coverage, and Catastrophic Coverage Stages.)	Cost-sharing during the Initial Coverage Stage if you don't qualify for "Extra Help": Drug Tier 1: \$0 Drug Tier 2: \$7 You pay \$0 per month supply of each covered insulin product on this tier. Drug Tier 3: \$47 You pay \$0 per month supply of each covered insulin product on this tier. Drug Tier 4: \$100 You pay \$0 per month supply of each covered insulin product on this tier. Drug Tier 5: 28% You pay \$0 per month supply of each covered insulin product on this tier. Drug Tier 6: \$0	Cost-sharing during the Initial Coverage Stage if you don't qualify for "Extra Help": Drug Tier 1: \$0 Drug Tier 2: \$0 Drug Tier 3: 10% You pay \$0 per month supply of each covered insulin product on this tier. Drug Tier 4: 25% You pay \$0 per month supply of each covered insulin product on this tier. Drug Tier 5: 25% You pay \$0 per month supply of each covered insulin product on this tier. Drug Tier 6: \$0

	2025 (this year)	2026 (next year)
	Catastrophic Coverage Stage: During this payment stage, you pay nothing for your covered Part D drugs.	Catastrophic Coverage Stage: During this payment stage, you pay nothing for your covered Part D drugs.

SECTION 1 Changes to Benefits & Costs for Next Year

Section 1.1 Changes to the Monthly Plan Premium

	2025 (this year)	2026 (next year)
Monthly plan premium without optional supplemental benefits (You must also continue to pay your Medicare Part B premium.)	\$0	\$0
Additional premium for optional supplemental benefits (Advantage Plus) If you've enrolled in an optional supplemental benefit package, you'll pay this premium in addition to the monthly plan premium above. (You must also continue to pay your Medicare Part B premium.)	\$12	Not Available

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

Medicare requires all health plans to limit how much you pay out of pocket for the year. This limit is called the maximum out-of-pocket amount. Once you've paid this amount, you generally pay nothing for covered Part A and Part B services (and other health services not covered by Medicare) for the rest of the calendar year.

	2025 (this year)	2026 (next year)
Maximum out-of-pocket amount Because our members also get help from Medicaid, very few members ever reach this out-of-pocket maximum. If you are eligible for Medicaid help with Part A and Part B copayments, you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services. Your costs for covered medical services (such as copayments) 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.	\$8,850	\$9,250 Once you've paid \$9,250 out of pocket for covered Part A and Part B services (and other health services not covered by Medicare), you'll pay nothing for your covered services 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* (kp.org/directory) 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 kp.org/directory.
- Call Member Services at 1-800-232-4404 (TTY users 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 Member Services

at 1-800-232-4404 (TTY users 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 can 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 *Pharmacy Directory* (kp.org/directory) to see which pharmacies are in our network. Here's how to get an updated *Pharmacy Directory*:

- Visit our website at kp.org/directory.
- Call Member Services at 1-800-232-4404 (TTY users call 711) to get current pharmacy information or to ask us to mail you a *Pharmacy Directory*.

We can make changes to the pharmacies that are part of our plan during the year. If a mid-year change in our pharmacies affects you, call Member Services at 1-800-232-4404 (TTY users call 711) for help.

Section 1.5 Changes to Benefits & Costs for Medical Services

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

	2025 (this year)	2026 (next year)
Chiropractic Services	You pay \$0 or 35% coinsurance. If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay \$0.	You pay \$0 or 20% coinsurance. If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay \$0.
Dental Preventive and Comprehensive Services		
• Preventive – Two oral exams, two teeth cleanings, two fluoride treatments, and one X-ray per calendar year.	You pay \$0 or 75% coinsurance for services provided by a specialist.	You pay \$0.
• Comprehensive		

	2025 (this year)	2026 (next year)
○ Restorative Services	You pay 75% coinsurance for services provided by a specialist. You pay \$28 to \$580, depending on the service.	You pay \$0.
○ Endodontics	Not Covered.	You pay \$0.
○ Periodontics	You pay 75% coinsurance for services provided by a specialist. You pay \$0 to \$400, depending on the service.	You pay \$0.
○ Prosthodontics, removable	You pay \$420 to \$480, depending on the service.	You pay \$0.
○ Prosthodontics, fixed	Not Covered.	You pay \$0.
○ Oral and Maxillofacial Surgery	You pay \$22 for one extraction per year or 75% coinsurance for services provided by a specialist.	You pay \$0.
○ Adjunctive General Services	You pay \$0 or 75% coinsurance for services provided by a specialist.	You pay \$0 for palliative treatment of dental pain.
Emergency Department	You pay \$0 or \$110 per visit. If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay \$0.	You pay \$0 or \$115 per visit. If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay \$0.
Hearing Aids - Prescription	You receive an allowance of up to \$500 per hearing aid, per ear that you can use toward the purchase of one hearing aid every 36 months. If the hearing aid(s) you purchase costs more than your	You receive an allowance of up to \$1,000 per hearing aid, per ear that you can use toward the purchase of one hearing aid every 36 months. If the hearing aid(s) you purchase costs

	2025 (this year)	2026 (next year)
	allowance, you pay the difference. Note: This hearing aid benefit may not be available next year.	more than your allowance, you pay the difference. Note: This hearing aid benefit may not be available next year.
Medicare Part B Drugs Up to a 30-day supply from a network pharmacy.	You pay \$0 or \$7 for generic drugs or \$0 or \$47 brand-name drugs per prescription, except you pay \$0 for Part B insulin drugs furnished through an item of DME. If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay \$0.	You pay \$0 or 20% of the total cost, except you pay \$0 for Part B insulin drugs furnished through an item of DME. If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay \$0.
Over-the-Counter (OTC)	We cover OTC items listed in our OTC catalog for free home delivery. You may order OTC items up to the \$150 quarterly benefit limit.	You will receive a preloaded healthy extras card with a quarterly benefit limit of \$100 to purchase eligible OTC items online and at participating retail stores. Your card will be reloaded on January 1, April 1, July 1, and October 1 on the 1st of each month. Any unused portion of the quarterly benefit limit doesn't roll over to the next quarter.

Prior authorization from our plan

Prior authorization must be obtained from our plan by your provider before you receive the following services:

	2025 (this year)	2026 (next year)
- Physical Therapy and Speech-Language Pathology Services - X-rays	Prior authorization is required.	Prior authorization is not required.
- Outpatient Blood Services - Preventive Services – Medicare-covered	Prior authorization is not required.	Prior authorization is required.

Referrals from your PCP

Referrals are needed from your PCP before you can get care for the following Medicare-covered services:

- Ambulatory Surgical Center Services - Home Health Services - Outpatient Blood Services	Referral not required.	Referral required.
X-rays	Referral required.	Referral not required.

Skilled Nursing Facility (SNF) Care

Per benefit period, you pay \$0 for days 1–20, and \$0 or \$214 per day for days 21–100. If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay \$0.	Per benefit period, you pay \$0 for days 1–20, and \$0 or \$218 per day for days 21–100. If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay \$0.
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Special Supplemental Benefits for the Chronically Ill (Healthy Food Card)

Eligible members with certain chronic conditions receive a preloaded healthy extras card with a quarterly allowance to buy approved foods, such as produce, online and at participating retail stores. See	Members who meet the criteria for this benefit will receive a preloaded card to purchase approved healthy foods with a quarterly \$245 allowance.	Members who meet the criteria for this benefit will receive a preloaded card to purchase approved healthy foods with a quarterly \$275 allowance.
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	2025 (this year)	2026 (next year)
<i>the Evidence of Coverage</i> for details.		
Transportation Services - Non-Emergency Medical Transportation not covered by Medicare We cover medically necessary, non-emergency transportation in a licensed stretcher/gurney van or wheelchair van to and from medical facilities within our service area, when ordered by a network provider.	Not Covered.	You pay \$60 per one-way trip for wheelchair van rides and \$125 per one-way trip for stretcher and gurney van rides.
Optional supplemental benefits (Advantage Plus) These changes only apply to members who have signed up for optional supplemental benefits, called Advantage Plus, for an additional monthly premium.		
Hearing aids	Covered.	Not covered. Advantage Plus is no longer available for this plan. Covered for all members as described in “Hearing Aids - Prescription” above.
Hearing exam for fitting and evaluation of hearing aids	Covered.	Not covered. Advantage Plus is no longer available for this plan. Covered for all members as described in the <i>Evidence of Coverage</i> .

	2025 (this year)	2026 (next year)
Dental care – comprehensive DeltaCare® USA Dental HMO Program	Covered.	Not covered. Advantage Plus is no longer available for this plan. Covered for all members as described in “Dental Preventive and Comprehensive Services” above.

Section 1.6 Changes to Part D Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a formulary or Drug List. A copy of our Drug List is provided electronically at kp.org/seniorrx.

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

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

If you're affected by a change in drug coverage at the beginning of the year or during the year, review Chapter 9 of your *Evidence of Coverage* and talk to your prescriber to find out your options, such as asking for a temporary supply, applying for an exception, and/or working to find a new drug. Call Member Services at 1-800-232-4404 (TTY users 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're in a program that helps pay for your drugs (Extra Help), **the information about costs for Part D drugs does not apply to you.** We sent you a separate material, called the *Evidence*

of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs, which tells about your drug costs. If you get Extra Help and you don't get this material by September 30, 2025, call Member Services at 1-800-232-4404 (TTY users 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 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 Tier 3 (Preferred brand-name), Tier 4 (Nonpreferred), and Tier 5 (Specialty-tier) drugs until you reach 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.

- **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 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.

The table shows your cost per prescription during this stage.

	2025 (this year)	2026 (next year)
Yearly Deductible	\$400, if you don't qualify for "Extra Help." During this stage, you pay \$0 for drugs on Tier 1 (Preferred generic), \$7 for drugs on Tier 2 (Generic), and \$0 for drugs on Tier 6 (Injectable Part D vaccines) and the full cost of drugs on Tier 3 (Preferred brand-name), Tier 4 (Nonpreferred), and Tier 5 (Specialty-tier) drugs until you've reached the yearly deductible.	\$615, if you don't qualify for "Extra Help." During this stage, you pay \$0 for drugs on Tier 1 (Preferred generic), Tier 2 (Generic), and Tier 6 (Injectable Part D vaccines) and the full cost of drugs on Tier 3 (Preferred brand-name), Tier 4 (Nonpreferred), and Tier 5 (Specialty-tier) drugs until you've reached the yearly deductible.

Drug Costs in Stage 2: Initial Coverage

For drugs on Tier 3 (Preferred brand-name), and Tier 4 (Nonpreferred), your cost sharing in the Initial Coverage Stage is changing from a copayment to coinsurance. Go to the following table for the changes from 2025 to 2026.

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 drugs:	You pay \$0 per prescription.	You pay \$0 per prescription.

	2025 (this year)	2026 (next year)
We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.		
Tier 2 – Generic drugs: We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.	You pay \$7 per prescription.	You pay \$0 per prescription.
Tier 3 – Preferred brand-name drugs: We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.	You pay \$47 per prescription. Your cost for a one-month mail-order prescription is \$47.	You pay 10% of the total cost. Your cost for a one-month mail-order prescription is 10% of the total cost.
Tier 4 – Nonpreferred drugs: We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.	You pay \$100 per prescription. Your cost for a one-month mail-order prescription is \$100.	You pay 25% of the total cost. Your cost for a one-month mail-order prescription is 25% of the total cost.
Tier 5 – Specialty-tier drugs: We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in	You pay 28% of the total cost. Your cost for a one-month mail-order prescription is 28% of the total cost.	You pay 25% of the total cost. Your cost for a one-month mail-order prescription is 25% of the total cost.

	2025 (this year)	2026 (next year)
a different tier, look them up on the Drug List.		
Tier 6 – Injectable Part D vaccines: We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.	You pay \$0 per prescription.	You pay \$0 per prescription.

Changes to the Catastrophic Coverage Stage

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

	2025 (this year)	2026 (next year)
Formulary exception for brand name drugs A type of coverage decision that, if approved, allows you to get a drug that is not on our formulary (a formulary exception). If we agree to cover a Part D drug not on our Drug List, you will need to pay the cost-sharing amount specified on the right. For more information about how to file a formulary exception, please see the <i>Evidence of Coverage</i>.	If you request and we agree to cover a Part D brand-name drug not on our Drug List, you will need to pay the cost-sharing amount that applies to drugs in Tier 4 for nonpreferred drugs.	If you request and we agree to cover a Part D brand-name drug not on our Drug List, you will need to pay the cost-sharing amount that applies to drugs in Tier 5 specialty tier drugs.
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 1-800-232-4404 (TTY users call 711) or visit www.Medicare.gov.

SECTION 3 How to Change Plans

To stay in Kaiser Permanente Dual Essential Plan 1, 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 Kaiser Permanente Dual Essential Plan 1.

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'll be automatically disenrolled from Kaiser Permanente Dual Essential Plan 1.
- **To change to Original Medicare with Medicare drug coverage**, enroll in the new Medicare drug plan. You'll be automatically disenrolled from Kaiser Permanente Dual Essential Plan 1.
- **To change to Original Medicare without a drug plan**, you can send us a written request to disenroll. Call Member Services at 1-800-232-4404 (TTY users call 711) for more information on how to do this. Or call **Medicare** at 1-800-MEDICARE (1-800-633-4227) and ask to be disenrolled. TTY users can call 1-877-486-2048. If you don't enroll in a Medicare drug plan, you may pay a Part D late enrollment penalty (go to Section 4)
- **To learn more about Original Medicare and the different types of Medicare plans**, visit www.Medicare.gov, check the *Medicare & You 2026* handbook, call your State Health Insurance Assistance Program (go to Section 5), or call 1-800-MEDICARE (1-800-633-4227). As a reminder, Kaiser Permanente offers other Medicare health plans. These other plans can differ in coverage, monthly plan premiums, and cost-sharing amounts.

Section 3.1 Deadlines for Changing Plans

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

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

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

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

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

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

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

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

SECTION 4 Get Help Paying for Prescription Drugs

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

- **Extra Help from Medicare.** People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs, including monthly drug plan premiums, yearly deductibles, and coinsurance. Also, people who qualify won't have a late enrollment penalty. To see if you qualify, call:
 - 1-800-MEDICARE (1-800-633-4227). TTY users can 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 Georgia AIDS Drug Assistance Program. For information on eligibility criteria, covered drugs, how to enroll in the program, or if you're currently enrolled, how to continue getting help, call 1-404-656-9805. 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 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, call us at 1-800-232-4404 (TTY users call 711) or visit www.Medicare.gov.

SECTION 5 Questions?

Get Help from Kaiser Permanente Dual Essential Plan 1

- **Call Member Services at 1-800-232-4404. (TTY users call 711.)**

We're available for phone calls 7 days a week, 8 a.m. to 8 p.m. Calls to these numbers are free.

- **Read your 2026 *Evidence of Coverage***

This *Annual Notice of Change* gives you a summary of changes in your benefits and costs for 2026. For details, go to the 2026 *Evidence of Coverage* for Kaiser Permanente Dual Essential Plan 1 plan. 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 kp.org/eocga or call Member Services at 1-800-232-4404 (TTY users call 711) to ask us to mail you a copy.

- **Visit kp.org**

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

Get Free Counseling about Medicare

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

Call Georgia 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. Call Georgia SHIP at 1-866-552-4464, option 4. Learn more about Georgia SHIP by visiting (www.aging.georgia.gov/georgia-ship).

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 can 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). TTY users can call 1-877-486-2048.

Get Help from Medicaid

To get information from Medicaid, you can call the Medicaid office in your county at the phone numbers listed below.

Georgia's Medicaid agencies by county – contact information

Cherokee County DFCS

1300 Univeter Road
Canton, GA 30115
Phone: 770-720-3610
Hours: Monday-Friday: 9 a.m. to 4 p.m.

Clayton County DFCS

877 Battlecreek Road
Jonesboro, GA 30236
Phone: 770-473-2339
Hours: Monday-Friday: 9 a.m. to 4 p.m.

Coweta County DFCS

533 Highway 29 North
Newnan, GA 30263
Phone: 770-254-7234
Hours: Monday-Friday: 9 a.m. to 4 p.m.

Cobb County DFCS

1090 Northchase Pkwy SE, Suite 200
Marietta, GA 30067
Phone: 770-528-7683
Hours: Monday-Friday: 9 a.m. to 4 p.m.

DeKalb County DFCS

2300 Parklane Drive NE
Atlanta, GA 30345
Phone: 404-370-5000
Hours: Monday-Friday: 9 a.m. to 4 p.m.

Forsyth County DFCS

6435 Shiloh Road, Suite C
Alpharetta, GA 30005
Phone: 770-781-6700
Hours: Monday-Friday: 9 a.m. to 4 p.m.

Fulton County DFCS

Northwest Service Center
1249 Donald Lee Hollowell Parkway
Atlanta, GA 30318
Phone: 404-206-5778
Hours: Monday-Friday: 9 a.m. to 4 p.m.

Fulton County DFCS

5710 Stonewall Tell Road
College Park, GA 30349
Phone: 404-206-5778
Hours: Monday-Friday: 9 a.m. to 4 p.m.

Gwinnett County DFCS

95 Constitution Blvd
Lawrenceville, GA 30046
Phone: 678-518-5500
Hours: Monday-Friday: 9 a.m. to 4 p.m.

Henry County DFCS

125 Henry Parkway
McDonough, GA 30253
Phone: 770-954-2014
Hours: Monday-Friday: 9 a.m. to 4 p.m.

Georgia's Medicaid agencies by county – contact information**Douglas County DFCS**

8473 Duralee Lane, Suite 100

Douglasville, GA 30134

Phone: 770-489-3000

Hours: Monday-Friday: 9 a.m. to 4 p.m.

Paulding County DFCS

1387 Industrial Blvd. North, Suite 101

Dallas, GA 30132

Phone: 770-443-7810

Hours: Monday-Friday: 9 a.m. to 4 p.m.

Fayette County DFCS

905 Highway 85 South

Fayetteville, GA 30215

Phone: 770-460-2555

Hours: Monday-Friday: 9 a.m. to 4 p.m.



Kaiser Permanente Dual Essential Member Services

Method	Member Services – Contact Information
Call	1-800-232-4404 Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m. Member Services 1-800-232-4404 (TTY users call 711) also has free language interpreter services available for non-English speakers.
TTY	711 Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m.
Write	Kaiser Permanente Member Services Nine Piedmont Center 3495 Piedmont Road, NE Atlanta, GA 30305-1736
Website	kp.org