Kaiser Permanente Senior Advantage Medicare Medicaid Plan 2 (HMO D-SNP)
Offered by Kaiser Foundation Health Plan of Georgia, Inc. (Medicare Medicaid Plan 2)

Annual Notice of Changes for 2024

You are currently enrolled as a member of Kaiser Permanente Senior Advantage Medicare Medicaid Plan 2. Next year, there will be changes to our plan's costs and benefits. **Please see page 4 for a summary of important costs, including premium**.

This document tells you about the changes to your plan. To get more information about costs, benefits, or rules, please review the **Evidence of Coverage**, which is located on our website at **kp.org**. You may also call Member Services to ask us to mail you an **Evidence of Coverage**.

What to do now

1. **Ask:** Which changes apply to you?
   - ☐ Check the changes to our benefits and costs to see if they affect you.
     - ♦ Review the changes to medical care costs (doctor, hospital).
     - ♦ Review the changes to our drug coverage, including authorization requirements and costs.
     - ♦ Think about how much you will spend on premiums, deductibles, and cost-sharing.
   - ☐ Check the changes in our 2024 "Drug List" to make sure the drugs you currently take are still covered.
   - ☐ Check to see if your primary care doctors, specialists, hospitals, and other providers, including pharmacies, will be in our network next year.
   - ☐ Think about whether you are happy with our plan.
2. **Compare:** Learn about other plan choices.
   - ☐ Check coverage and costs of plans in your area. Use the Medicare Plan Finder at the **www.medicare.gov/plan-compare** website or review the list in the back of your **Medicare & You** 2024 handbook.
   - ☐ Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan's website.
3. **Choose:** Decide whether you want to change your plan.

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- If you don't join another plan by December 7, 2023, you will stay in Senior Advantage Medicare Medicaid Plan 2.
- To **change to a different plan**, you can switch plans between **October 15 and December 7**. Your new coverage will start on January 1, 2024. This will end your enrollment with Senior Advantage Medicare Medicaid Plan 2.
- Look in Section 2, page 12, to learn more about your choices.
- If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can switch plans or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

Additional resources

- Please contact our Member Services number at **1-800-232-4404** for additional information. (TTY users should call **711**.) 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, or CD if you need it by calling Member Services.
- **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 Kaiser Permanente Senior Advantage Medicare Medicaid Plan 2

- 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.
- When this document 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 Senior Advantage Medicare Medicaid Plan 2 (Senior Advantage Medicare Medicaid).

Annual Notice of Changes for 2024

Table of Contents

Summary of important costs for 2024

The table below compares the 2023 costs and 2024 costs for Senior Advantage Medicare Medicaid Plan 2 in several important areas. **Please note this is only a summary of costs**.

Cost	2023 (this year)	2024 (next year)
Monthly plan premium* *Your premium may be higher or lower than this amount. (See Section 1.1 for details.)	**$0-$31** if you do not qualify for "Extra Help."*	**$0-$42.10** if you do not qualify for "Extra Help."*
Doctor office visits	Primary care visits: **$0** per visit. Specialist visits: **$0** per visit.	Primary care visits: **$0** per visit. Specialist visits: **$0** per visit.
Inpatient hospital stays	Per admission, **$0** or **$12** per admission. If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay **$0** per visit.	Per admission, **$0** or **$12** per admission. If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay **$0** per visit.
Part D prescription drug coverage (See Section 1.5 for details.)	Deductible: **$505** (Tiers 2, 3, 4, and 5) except for covered insulin products and most adult Part D vaccines. Cost-sharing during the **Initial Coverage Stage** (up to a 30-day supply): Drug Tier 1: **$0** Drug Tier 2: **$14** Drug Tier 3: **$47** You pay **$35** per month supply of	Deductible: **$545** (Tiers 2, 3, 4, and 5) except for covered insulin products and most adult Part D vaccines. Cost-sharing during the **Initial Coverage Stage** (up to a 30-day supply): Drug Tier 1: **$0** Drug Tier 2: **$14** Drug Tier 3: **$47** You pay **$35** per month supply of

Cost	2023 (this year)	2024 (next year)
	each covered insulin product on this tier. Drug Tier 4: **$100** You pay **$35** per month supply of each covered insulin product on this tier. Drug Tier 5: **25%** You pay **$35** per month supply of each covered insulin product on this tier. Drug Tier 6: **$0**	each covered insulin product on this tier. Drug Tier 4: **$100** You pay **$35** per month supply of each covered insulin product on this tier. Drug Tier 5: **25%** You pay **$35** per month supply of each covered insulin product on this tier. Drug Tier 6: **$0**
	Catastrophic Coverage: During this payment stage, our plan pays most of the cost for your covered drugs. For each prescription, you pay whichever of these is larger: a payment equal to **5%** of the cost of the drug (this is called coinsurance), or a copayment (**$4.15** for a generic drug or a drug that is treated like a generic, and **$10.35** for all other drugs).	**Catastrophic Coverage**: During this payment stage, our plan pays the full cost for your covered Part D drugs. **You pay nothing**.

Cost	2023 (this year)	2024 (next year)
Maximum out-of-pocket amount This is the **most** you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details.)	**$1,000** If you are eligible for Medicare cost-sharing assistance 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.	**$1,000** If you are eligible for Medicare cost-sharing assistance 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.

Section 1 — Changes to benefits and costs for next year

Section 1.1 – Changes to the monthly premium

Cost	2023 (this year)	2024 (next year)
Monthly premium without optional supplemental benefits (You must also continue to pay your Medicare Part B premium unless it is paid for you by Medicaid.) If you qualify for "Extra Help," your monthly premium will vary depending upon your level of Extra Help. For premium information, please refer to your "**Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs**" (also known as the "Low Income Subsidy Rider" or the "LIS Rider").	**$0-$31** if you do not qualify for "Extra Help."	**$0-$42.10** if you do not qualify for "Extra Help."
Additional monthly premium with optional supplemental benefits If you are enrolled in our optional supplemental benefits package (Advantage Plus) your plan premium above is increased each month by this amount.	**$9**	**$9**

Cost	2023 (this year)	2024 (next year)
(You must also continue to pay your Medicare Part B premium unless it is paid for you by Medicaid.)		

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 reach this amount, you generally pay nothing for covered Part A and Part B services (and other health care services not covered by Medicare as described in Chapter 4 of the **Evidence of Coverage**) for the rest of the year.

Cost	2023 (this year)	2024 (next year)
Maximum out-of-pocket amount **Because our members also get assistance from Medicaid, very few members ever reach this out-of-pocket maximum.** If you are eligible for **Medicaid** assistance with Part A and Part B copays, 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. Your plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	**$1,000**	**$1,000** Once you have paid $1,000 out-of-pocket for covered Part A and Part B services (and certain health care services not covered by Medicare), you will pay nothing for these covered services for the rest of the calendar year.

Section 1.3 – Changes to the provider and pharmacy networks

Updated directories are located on our website at **kp.org/directory.** You may also call Member Services for updated provider and/or pharmacy information or to ask us to mail you a directory, which we will mail within three business days.

There are changes to our network of providers for next year. **Please review the 2024 Provider Directory to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network**.

There are changes to our network of pharmacies for next year. **Please review the 2024 Pharmacy Directory to see which pharmacies are in our network**.

It is important that you know that we may make changes to the hospitals, doctors, and specialists (providers), and pharmacies that are a part of your plan during the year. If a midyear change in our providers affects you, please contact Member Services so we may assist.

Section 1.4 – Changes to benefits and costs for medical services

Please note that the **Annual Notice of Changes** tells you about changes to your Medicare benefits and costs.

We are making changes to costs and benefits for certain medical services next year. The information below describes these changes.

Cost	2023 (this year)	2024 (next year)
Dental services – comprehensive We cover certain comprehensive dental care through Delta Dental. Refer to the **Evidence of Coverage** for the full list of covered dental services:		
• Prosthodontics, other oral/maxillofacial surgery, and other services.	• You pay **$420** to **$480**, depending on the service.	• You pay **$0** to **$480**, depending on the service. or **75%** coinsurance when services are provided by a specialist.
Special Supplemental Benefits for the Chronically Ill (Healthy Food Card) • Eligible members with certain chronic conditions receive a quarterly allowance to purchase approved foods, such as produce. See the **Evidence of Coverage** for details.	Members who meet the criteria for this benefit will receive a pre-loaded debit card with a quarterly allowance of **$300** to purchase approved healthy foods.	Members who meet the criteria for this benefit will receive a pre-loaded debit card with a quarterly allowance of **$250** to purchase approved healthy foods.
Over-the-Counter (OTC) items	You receive a **$300** quarterly benefit amount to order OTC items listed in our catalog.	You receive a **$260** quarterly benefit amount to order OTC items listed in our catalog.

Cost	2023 (this year)	2024 (next year)
Prior authorization from our plan Prior authorization must be obtained from our plan by your provider before you receive the following services:		
• Physical Therapy and Speech-Language Pathology Services	Prior authorization is not required.	Prior authorization is required.
Optional supplemental benefits (Advantage Plus) – Dental services This change only applies to members who have signed up for optional supplemental benefits, called Advantage Plus. Refer to the **Evidence of Coverage** for the full list of covered dental services:		
• Non-routine services.	You pay **$0** to **$580**, depending on the service.	You pay **$0** to **$1,440**, depending on the service.
• Periodontics, such as gingivectomy or full mouth debridement.	You pay **$0** to **$320**, depending on the service.	You pay **$0** to **$331**, depending on the service.

Section 1.5 – Changes to Part D prescription 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 our "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 our "Drug List" are new for the beginning of each year. However, during the year, we might make other changes that are allowed by Medicare rules. For instance, we can immediately remove drugs considered unsafe by the FDA or withdrawn from the market by a

product manufacturer. We update our online "Drug List" to provide the most up-to-date list of drugs.

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

Changes to prescription drug costs

If you receive "Extra Help" to pay your Medicare prescription drugs, you may qualify for a reduction or elimination of your cost-sharing for Part D drugs. Some of the information described in this section may not apply to you. **Note**: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs does not apply to you**. We sent you a separate insert, called the **Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs** (also called the Low-Income Subsidy Rider or the LIS Rider), which tells you about your drug costs. If you receive "Extra Help" and you haven't received this insert by September 30, 2023, please call Member Services and ask for the LIS Rider.

There are four **drug payment stages**. The information below shows the changes to the first two stages—the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages—the Coverage Gap Stage or the Catastrophic Coverage Stage.)

Changes to the Deductible Stage

Stage	2023 (this year)	2024 (next year)
Stage 1: Yearly Deductible Stage During this stage, **you pay the full cost** of your **Tier 2** (generic), **Tier 3** (preferred brand-name), **Tier 4** (nonpreferred), and **Tier 5** (specialty) drugs until you have reached the yearly deductible. The deductible doesn't apply to covered insulin products and most adult Part D vaccines, including shingles, tetanus, and travel vaccines.	The deductible is **$505**, if you do not qualify for "Extra Help." During this stage, you pay the following cost-sharing for up to a 30-day supply: **$0** for drugs on **Tier 1** and **Tier 6**. You pay the full cost of drugs in **Tier 2** (generic), **Tier 3** (preferred brand-name), **Tier 4** (nonpreferred brand-name), and **Tier 5** (specialty) until you have reached the yearly deductible.	The deductible is **$545**, if you do not qualify for "Extra Help." During this stage, you pay the following cost-sharing for up to a 30-day supply: **$0** for drugs on **Tier 1** and **Tier 6**. You pay the full cost of drugs in **Tier 2** (generic), **Tier 3** (preferred brand-name), **Tier 4** (nonpreferred), and **Tier 5** (specialty) until you have reached the yearly deductible.

Changes to your cost-sharing in the Initial Coverage Stage

Stage	2023 (this year)	2024 (next year)
Stage 2: Initial Coverage Stage Once you pay the yearly deductible, you move to the Initial Coverage Stage. During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost**. The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy that provides standard cost-sharing. For information about the costs for a long-term supply or for mail-order prescriptions, look in Chapter 6, Section 5, of your **Evidence of Coverage**. 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 our "Drug List." Most adult Part D vaccines are covered at no cost to you.	Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing, if you do not qualify for "Extra Help": • Tier 1 – Preferred generic drugs: You pay **$0** per prescription. • Tier 2 – Generic drugs: You pay **$14** per prescription. • Tier 3 – Preferred brand-name drugs: You pay **$47** per prescription. You pay **$35** per month supply of each covered insulin product on this tier. • Tier 4 – Nonpreferred brand-name drugs: You pay **$100** per prescription. You pay **$35** per month supply of each covered insulin product on this tier. • Tier 5 – Specialty-tier drugs: You pay **25%** of the total cost. You pay **$35** per month supply of each covered insulin product on this tier. • Tier 6 – Injectable Part D vaccines: You pay **$0** per prescription. Once your total drug costs have reached **$4,660**, you will move to the next stage (the Coverage Gap Stage).	Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing, if you do not qualify for "Extra Help": • Tier 1 – Preferred generic drugs: You pay **$0** per prescription. • Tier 2 – Generic drugs: You pay **$14** per prescription. • Tier 3 – Preferred brand-name drugs: You pay **$47** per prescription. You pay **$35** per month supply of each covered insulin product on this tier. • Tier 4 – Nonpreferred drugs: You pay **$100** per prescription. You pay **$35** per month supply of each covered insulin product on this tier. • Tier 5 – Specialty-tier drugs: You pay **25%** of the total cost. You pay **$35** per month supply of each covered insulin product on this tier. • Tier 6 – Injectable Part D vaccines: You pay **$0** per prescription. Once your total drug costs have reached **$5,030**, you will move to the next stage (the Coverage Gap Stage).

Changes to the Coverage Gap and Catastrophic Coverage Stages

The other two drug coverage stages—the Coverage Gap Stage and the Catastrophic Coverage Stage—are for people with high drug costs. **Most members do not reach the Coverage Gap Stage or the Catastrophic Coverage Stage**.

Beginning in 2024, if you reach the Catastrophic Coverage Stage, you pay nothing for covered Part D drugs.

For specific information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in your **Evidence of Coverage**.

Section 2 — Deciding which plan to choose

Section 2.1 – If you want to stay in Senior Advantage Medicare Medicaid Plan 2

To stay in our plan, you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically be enrolled in our Senior Advantage Medicare Medicaid Plan 2.

Section 2.2 – If you want to change plans

We hope to keep you as a member next year, but if you want to change plans for 2024, follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan.
- Or you can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan.

To learn more about Original Medicare and the different types of Medicare plans, use the Medicare Plan Finder (**www.medicare.gov/plan-compare**), read the **Medicare & You** 2024 handbook, call your State Health Insurance Assistance Program (see Section 4), or call Medicare (see Section 6.2).

As a reminder, Kaiser Permanente offers other Medicare health plans. These other plans may differ in coverage, monthly premiums, and cost-sharing amounts.

Step 2: Change your coverage

- To **change to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from Senior Advantage Medicare Medicaid Plan 2.
- To **change to Original Medicare with a prescription drug plan**, enroll in the new drug plan. You will automatically be disenrolled from Senior Advantage Medicare Medicaid Plan 2.
- To **change to Original Medicare without a prescription drug plan**, you must either:
  - Send us a written request to disenroll. Contact Member Services if you need more information on how to do so.
  - Or contact **Medicare** at **1-800-MEDICARE** (**1-800-633-4227**), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call **1-877-486-2048**.

If you switch to Original Medicare and do **not** enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan unless you have opted out of automatic enrollment.

Section 3 — Changing plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7**. The change will take effect on January 1, 2024.

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

In certain situations, changes are also allowed at other times of the year. Examples include people with Medicaid, those who get "Extra Help" paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area.

Because you have Medicaid, you may be able to end your membership in our plan or switch to a different plan one time during each of the following **Special Enrollment Periods**:

- January to March
- April to June
- July to September

If you enrolled in a Medicare Advantage plan for January 1, 2024, and don't like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2024.

If you recently moved into, currently live in, or just moved out of 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 (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

Section 4 — Programs that offer free counseling about Medicare and Medicaid

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.

It is a state program that gets money from the federal government to give **free** local health insurance counseling to people with Medicare. Georgia SHIP counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call Georgia SHIP at **1-866-552-4464, option 4**.

You can learn more about Georgia SHIP by visiting their website (**https://aging.georgia.gov/georgia-ship**).

For questions about your Medicaid benefits, contact the Medicaid agency for your county listed in Section 6.3. Ask how joining another plan or returning to Original Medicare affects how you get your Medicaid coverage.

Section 5 — Programs that help pay for prescription drugs

You may qualify for help paying for prescription drugs. Below we list different kinds of help:

- **"Extra Help" from Medicare.** Because you have Medicaid, you are already enrolled in "Extra Help," also called the Low Income Subsidy. "Extra Help" pays some of your prescription drug premiums, annual deductibles, and coinsurance. Because you qualify, you do not have a coverage gap or late enrollment penalty. If you have questions about "Extra Help," call:
  - **1-800-MEDICARE** (**1-800-633-4227**). TTY users should call **1-877-486-2048**, 24 hours a day/7 days a week;
  - The Social Security office at **1-800-772-1213** between 8 a.m. and 7 p.m., Monday through Friday, for a representative. Automated messages are available 24 hours a day. TTY users should call **1-800-325-0778**; or
  - Your state Medicaid office (applications).
- **Prescription cost-sharing assistance for persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of state residence and HIV status, low income as defined by the state, and uninsured/underinsured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the **Georgia AIDS Drug Assistance Program**.

For information on eligibility criteria, covered drugs, or how to enroll in the program, please call **1-404-656-9805**.

Section 6 — Questions?

Section 6.1 – Getting help from our plan

Questions? We're here to help. Please call Member Services at **1-800-232-4404**. (TTY only, call **711**.) We are available for phone calls 7 days a week, 8 a.m. to 8 p.m. Calls to these numbers are free.

Read your 2024 Evidence of Coverage (it has details about next year's benefits and costs)

This **Annual Notice of Changes** gives you a summary of changes in your benefits and costs for 2024. For details, look in the 2024 **Evidence of Coverage** for our plan. The **Evidence of Coverage** is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of

the **Evidence of Coverage** is located on our website at **kp.org/eocga**. You may also call Member Services to ask us to mail you an **Evidence of Coverage**.

Visit our website

You can also visit our website at **kp.org**. As a reminder, our website has the most up-to-date information about our provider network (**Provider Directory**) and our list of covered drugs (Formulary/Drug List).

Section 6.2 – Getting help from Medicare

To get information directly 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**.

Visit the Medicare website

Visit the Medicare website (**www.medicare.gov**). It has information about cost, coverage, and quality star ratings to help you compare Medicare health plans in your area. To view the information about plans, go to **www.medicare.gov/plan-compare**.

Read Medicare & You 2024

Read the **Medicare & You** 2024 handbook. Every fall, this document is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this document, you can get it at the Medicare website (**https://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf**) 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**.

Section 6.3 – Getting 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	
Barrow County DFCS 63 Lays Drive, Suite 200 Winder, GA 30680 Phone: 770-868-4222 Hours: Monday-Friday: 8 a.m. to 5 p.m.	**Rockdale County DFCS** 975 Taylor Street Southwest Conyers, GA 30012 Phone: 770-388-5025 Hours: Monday-Friday: 8 a.m. to 5 p.m.
Butts County DFCS 178 Ernest Biles Drive Jackson, GA 30233 Phone: 770-504-2200 Hours: Monday-Friday: 8 a.m. to 5 p.m.	**Spalding County DFCS** 411 E Solomon Street Griffin, GA 30223 Phone: 770-228-1386 Hours: Monday-Friday: 8 a.m. to 5 p.m.

Georgia's Medicaid agencies by county – contact information	
Newton County DFCS 4117 Mill Street Covington, GA 30014 Phone: 770-784-2490 Hours: Monday-Friday: 8 a.m. to 5 p.m.	**Walton County DFCS** 300 Georgia Avenue, Suite 100 Monroe, GA 30655 Phone: 770-207-4176 Hours: Monday-Friday: 8 a.m. to 5 p.m.

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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 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**