

# PLAN COMPARISON OVERVIEW

| Benefit / Cost Category   | Original Medicare Fee-For -Service <sup>‡</sup>  | Super Plus HMO C-SNP (H4869-001)   | Dialysis Plus HMO-POS C-SNP (H4869-003)                                      | Honest Care HMO (H4869-005)  | Super Complete HMO C-SNP (H4869-002)   | Dialysis Complete HMO-POS C-SNP (H4869-004)                                  |
|---|--|--|--|--|--|--|
| <b>MEMBER VALUE-ADDED ITEMS</b>   |  |  |  |  |  |  |
| Part B Premium Reduction (Buydown or Money back in their Social Security check)       | N/A  | \$25.00  | \$0  | \$25.00  | \$0  | \$0  |
| <b>MEMBER COST SHARES</b>   |  |  |  |  |  |  |
|   |  |  |  |  | <b>MEDICARE+MEDICAID / MEDICARE ONLY</b>                                     |  |
| Plan Premium  | N/A  | \$0  | \$0  | \$0  | \$0 / \$42.60  | \$0 / \$42.60  |
| Maximum out-of-pocket - MOOP  | N/A  | \$3,000  | \$2,700  | \$3,000  | \$8,300  | \$8,300  |
| Primary Care Physician - PCP  | 20%  | \$0  | \$0  | \$0  | 0% / 20%   | 0% / 20%   |
| Specialist (Nephrologist, Cardiologist, Endocrinologist, and Cardiovascular surgeons) | 20%  | \$0  | \$0  | \$20   | 0% / 20%   | 0% / 20%   |
| Specialist (all other)  | 20%  | \$20   | \$20   | \$20   | 0% / 20%   | 0% / 20%   |
| Urgent Care   | 20%  | \$0  | \$40   | \$20   | \$0 / \$60   | \$0 / \$60   |
| Emergency   | 20%  | \$90   | \$120  | \$90   | \$0 / \$95   | \$0 / \$95   |
| Inpatient Hospital  | <ul style="list-style-type: none"> <li>• \$1,556 deductible per benefit period</li> <li>• \$0 for the first 60 days of each benefit period</li> <li>• \$389 per day for days 61–90 of each benefit period</li> </ul> | \$100 for Days 1-7   | \$175 for Days 1-7   | \$175 for Days 1-7   | \$0 / Medicare cost shares   | \$0 / Medicare cost shares   |
| Outpatient Hospital   | 20%  | \$0 for diagnostic colonoscopy<br>\$195 per day for all other services       | \$0 for diagnostic colonoscopy<br>\$195 per day for all other services       | \$0 for diagnostic colonoscopy<br>\$225 per day for all other services       | 0% / 20%   | 0% / 20%   |
| Outpatient ASC  | 20%  | \$100 per visit  | \$100 per visit  | \$150 per visit  | 0% / 20%   | 0% / 20%   |
| Tests (Diagnostic Radiology)  | 20%  | \$50   | \$50   | \$50   | 0% / 20%   | 0% / 20%   |
| Lab Services  | 20%  | \$0  | \$0  | \$0  | \$0  | 0% / 20%   |
| Dialysis  | 20%  | 20%  | \$0  | 20%  | 0% / 20%   | 0% / 20%   |
| <b>EXTRA'S INCLUDED:</b>  |  |  |  |  |  |  |
| Dental  | Routine dental not covered   | Preventive & Comprehensive Services \$2,000 benefit coverage amount per year | Preventive & Comprehensive Services \$2,000 benefit coverage amount per year | Preventive & Comprehensive Services \$2,000 benefit coverage amount per year | Preventive & Comprehensive Services \$4,000 benefit coverage amount per year | Preventive & Comprehensive Services \$4,000 benefit coverage amount per year |
| Transportation  | Non-emergency transportation not covered**   | \$0 for 36 one-way trips per year  | \$0 for 104 one-way trips per year   | \$0 for 24 one-way trips per year  | \$0 for 54 one-way trips per year  | \$0 for 104 one-way trips per year   |
| Over-the-Counter  | Not covered  | \$50 quarterly allowance   | \$50 quarterly allowance   | \$50 quarterly allowance   | \$400 quarterly allowance  | \$400 quarterly allowance  |
| Fitness   | Not covered  | \$0 for Silver & Fit gym membership  | \$0 for Silver & Fit gym membership  | \$0 for Silver & Fit gym membership  | \$0 for Silver & Fit gym membership  | \$0 for Silver & Fit gym membership  |
| Companion Care  | Not covered  | \$0 for home-based care visits   | \$0 for home-based care visits   | \$0 for home-based care visits   | \$0 for home-based care visits   | \$0 for home-based care visits   |
| Prescription Drugs - 30-day supply at retail (Varies by Tier Level or Coverage Stage) | Not covered  | \$0   \$5   \$45   \$100   33%   \$0   | \$0   \$5   \$45   \$100   33%   \$0   | \$0   \$5   \$45   \$100   33%   \$0   | \$0 - \$10.35 / 25%   15%  | 25%   > of 5% of \$4.15   \$10.35  |
| Senior Savings Participation  | Not covered  | Yes  | Yes  | Yes  | No   | No   |

<sup>‡</sup>Cost share applies after deductible and any inpatient hospital copays that are required

\*\*Based on medical necessity; requires doctor order



## GOLD KIDNEY HEALTH PLAN

Toll Free: 1-844-294-6535 (TTY 711)

Local: 1-480-870-7007 (TTY 711)

### HOURS OF OPERATION:

October 1<sup>st</sup> – March 31<sup>st</sup>

8 a.m. to 8 p.m. local time (7 days a week)

April 1<sup>st</sup> – September 30<sup>th</sup>

8 a.m. to 8 p.m. local time (Monday-Friday)

Or scan the QR code with your  
smart phone to visit us online at:

[www.goldkidney.com](http://www.goldkidney.com)



Gold Kidney Health Plan is an HMO, HMO C-SNP, HMO-POS C-SNP with a Medicare contract. Enrollment in Gold Kidney Health Plan depends on contract renewal.



## GOLD KIDNEY HEALTH PLAN

PO Box 14050  
Scottsdale, AZ 85267

## PLAN COMPARISON OVERVIEW



## GOLD KIDNEY HEALTH PLAN

*Creating the gold standard for your care*