GOLD KIDNEY HEALTH PLAN

2023 GOLD KIDNEY HEALTH PLAN

SUMMARY OF BENEFITS

Gold Kidney of Arizona Dialysis Plus (HMO-POS C-SNP)
Gold Kidney of Arizona Dialysis Complete (HMO-POS C-SNP)

H4869_SOB Dialysis_Plus_Dialysis_Complete_0922M

Gold Kidney of Arizona Dialysis Plus and Gold Kidney of Arizona Dialysis Complete are HMO-POS C-SNP plans with a Medicare contract. Enrollment in the Gold Kidney of Arizona Dialysis Plus and Gold Kidney of Arizona Dialysis Complete Plans depends on contract renewal.

The benefit information provided does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please call us toll at free at 1-844-294-6535 (TTY 711) and request the "Evidence of Coverage" or access it online at www.goldkidney.com.

Does this plan cover my doctors and pharmacies?

Find out by searching our online directory at www.goldkidney.com. Or, give us a call. We can look up your doctors and pharmacies or mail you a directory.

Except in emergency situations, if you use the providers that are not in our network, we may not pay for these services.

To join Gold Kidney Dialysis Plus or Gold Kidney Dialysis Complete you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. Our service area includes the following counties in Arizona: Gila, Maricopa, Pima and Pinal.

You must also have End-Stage Renal Disease (ESRD) requiring dialysis to join our Dialysis Plus or Dialysis Complete Plans.

Does this plan cover my prescription drugs?

Find out by searching our online drug list at www.goldkidney.com. Or, give us a call. We can look up your medications or mail you our list of covered drugs (formulary).

For coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 7 days a week, 24 hours a day. TTY users should call 1-877-486-2048.

This document is available in other formats such as Braille, large print or audio, as well as Spanish.

FOR MORE INFORMATION:

Call us toll at free:

1-844-294-6535 (TTY 711)

Hours of Operation:

October 1st – March 31st
8am to 8pm local time
7 days a week

April 1st – September 30th
8am to 8pm local time
Monday-Friday

Or visit us at:

www.goldkidney.com

PREMIUMS AND BENEFITS

To view the complete list of benefits please refer to the Evidence of Coverage for Gold Kindney of Arizona Dailysis Plus (HMO-POS C-SNP) and Gold Kindney of Arizona Dailysis Complete (HMO-POS C-SNP) at www.goldkidney.com.

PREMIUMS AND BENEFITS	GOLD KIDNEY OF ARIZONA DIALYSIS PLUS (HMO-POS C-SNP)	GOLD KIDNEY OF ARIZONA DIALYSIS COMPLETE (HMO-POS C-SNP)*
Monthly Plan Premium (includes both medical and drugs)	You pay $0 You must continue to pay your Medicare Part B premium.	You pay $0-$42.60, depending on your level of "Extra Help". You must continue to pay your Medicare Part B premium.
Part B Buy Down	Not offered	Not offered
Deductible	This plan does not have a deductible.	$223 This is the 2022 Medicare amount. Costs may change for 2023. Gold Kidney will update this information once available at www.goldkidney.com. Based on your Medicaid eligibility, you may pay $0.
Pharmacy (Part D) Deductible	This plan does not have a deductible.	$505 Depending on your level of "Extra Help", this amount may be $0.
Maximum Out-of-Pocket Responsibility (does not include Part D prescription drugs)	**In-Network** $2,700 Includes copays and other costs for medical services for the year. This is the most you will pay for copays, coinsurance, and other costs for Medicare-covered medical services, supplies, and Part B covered medication for the plan year. What you pay out-of-pocket for Part D prescription drugs and certain supplemental benefits (dental, hearing aids) do not apply to this amount.	$8,300 Includes copays and other costs for medical services for the year. This is the most you will pay for copays, coinsurance, and other costs for Medicare-covered medical services, supplies, and Part B covered medication for the plan year. What you pay out-of-pocket for Part D prescription drugs and certain supplemental benefits (dental, hearing aids) do not apply to this amount.

PREMIUMS AND BENEFITS	GOLD KIDNEY OF ARIZONA DIALYSIS PLUS (HMO-POS C-SNP)	GOLD KIDNEY OF ARIZONA DIALYSIS COMPLETE (HMO-POS C-SNP)*
Inpatient Hospital *Prior Authorization is required.*	**In-Network and Out-of-Network/ Point-of-Sale (POS):** Days 1-7 $175 copay per day Days 8-90 $0 copay per day	**In-Network and Out-of-Network/ Point-of-Sale (POS):** You pay a $1,556 deductible per benefit period. You pay: • $0 for days 1-60 • $389 copay per day for days 61-90 • $778 copay per each “lifetime reserve day” after day 90 for each benefit period (up to 60 days over your lifetime) • 100% of all costs beyond the lifetime reserve days These are 2022 cost-sharing amounts and may change for 2023. Gold Kidney will update this information once available at www.goldkidney.com. If you have full Medicaid benefits, your costs could be less.
Outpatient Hospital Outpatient procedures/ surgery at an Outpatient Hospital *Prior Authorization is required.*	**In-Network and Out-of-Network/ Point-of-Sale (POS):** $0-$195 copay per visit	**In-Network and Out-of-Network/ Point-of-Sale (POS):** 20% coinsurance per visit
Ambulatory Surgical Center (ASC) *Prior Authorization is required.*	$100 copay per visit	20% coinsurance
Doctor Visits	**In-Network and Out-of-Network/ Point-of-Sale (POS):** Primary Care Provider (PCP) $0 copay per visit Specialists: Nephrologist, cardiologist, endocrinologist and cardiovascular specialists $0 copay per visit All other physician specialists $20 copay per visit	**In-Network and Out-of-Network/ Point-of-Sale (POS):** Primary Care Provider (PCP) 20% coinsurance per visit All other physician specialists 20% coinsurance per visit

PREMIUMS AND BENEFITS	GOLD KIDNEY OF ARIZONA DIALYSIS PLUS (HMO-POS C-SNP)	GOLD KIDNEY OF ARIZONA DIALYSIS COMPLETE (HMO-POS C-SNP)*
Preventive Care (e.g., flu vaccine, diabetic screenings) *Out-of-network preventive services require prior authorization.*	**In-Network and Out-of-Network/ Point-of-Sale (POS):** You pay $0 Other preventive services are available. There are some covered services that have a cost.	You pay $0 Other preventive services are available. There are some covered services that have a cost.
Emergency Care *In-network services require a referral.* *Out-of-network services require a prior authorization.*	**In-Network and Out-of-Network/ Point-of-Sale (POS):** You pay $120 copay per visit. Your copay is waived if you are admitted to the hospital within 24 hours.	**In-Network and Out-of-Network/ Point-of-Sale (POS):** You pay $95 copay per visit. Your copay is waived if you are admitted to the hospital within 24 hours.
Urgently Needed Services	**In-Network and Out-of-Network/ Point-of-Sale (POS):** $40 copay per visit	**In-Network and Out-of-Network/ Point-of-Sale (POS):** $60 copay per visit
Diagnostic Services, Labs and Imaging *Referral required for in-network services.* *Prior authorization required for out-of-network/POS services.*	**In-Network and Out-of-Network/ Point-of-Sale (POS):** Lab Services $0 copay Outpatient X-rays $0 copay Diagnostic Radiology Services $50 copay Diagnostic Tests and Procedures 20% coinsurance Therapeutic Radiology 20% copay	**In-Network and Out-of-Network/ Point-of-Sale (POS):** Lab Services 20% copay Outpatient X-rays 20% coinsurance Diagnostic Radiology 20% coinsurance Diagnostic Tests and Procedures 20% coinsurance Therapeutic Radiology 20% coinsurance
Hearing Services *Referral required for in-network hearing exams and hearing aids.*	**In-Network** Routine Hearing Exams $0 copay — 1 visit per year Hearing Aids $500 total allowance per ear for hearing aids every year *Referral required for in-network hearing exams and hearing aids.* **Out-of-Network/Point-of-Service (POS):** You pay $0 for hearing exams Hearing aid fittings/evaluation and Hearing aids are not covered *Prior authorization required for POS benefit.*	**In-Network** Routine Hearing Exams $0 copay — 1 visit per year Hearing Aids $500 total allowance per ear for hearing aids every year *Referral required for in-network hearing exams and hearing aids.* **Out-of-Network/Point-of-Service (POS):** You pay $0 for hearing exams Hearing aid fittings/evaluation and Hearing aids are not covered *Prior authorization required for POS benefit.*

PREMIUMS AND BENEFITS	GOLD KIDNEY OF ARIZONA DIALYSIS PLUS (HMO-POS C-SNP)	GOLD KIDNEY OF ARIZONA DIALYSIS COMPLETE (HMO-POS C-SNP)*
Preventive Dental Services *Limitations may apply.*	**In-Network** Periodic Oral Exams $0 copay Comprehensive Oral Evaluation $0 copay Cleanings $0 copay X-rays $0 copay **Out-of-Network/Point-of-Service (POS):** Preventive dental is not covered	**In-Network** Periodic Oral Exams $0 copay Comprehensive Oral Evaluation $0 copay Cleanings $0 copay X-rays $0 copay **Out-of-Network/Point-of-Service (POS):** Preventive dental is not covered
Comprehensive Dental Services *A Referral is required for In-Network Comprehensive Dental Services. Limitations may apply.*	**In-Network** Fillings $0 copay Root Planing & Scaling $0 copay Extractions $0 copay Full Mouth Debridement $0 copay Dentures $0 copay Root Canals $0 copay Crowns $0 copay Bridges $0 copay Combined maximum benefit coverage amount for preventive and comprehensive dental services: Dialysis Plus Plan $2,000 **Out-of-Network/Point-of-Service (POS):** You pay $0 for Medicare-covered services Other comprehensive benefits are not covered *Prior authorization is required for the POS benefit.*	**In-Network** Fillings $0 copay Root Planing & Scaling $0 copay Extractions $0 copay Full Mouth Debridement $0 copay Dentures $0 copay Root Canals $0 copay Crowns $0 copay Bridges $0 copay Combined maximum benefit coverage amount for preventive and comprehensive dental services: Dialysis Complete Plan $4,000 **Out-of-Network/Point-of-Service (POS):** You pay $0 for Medicare-covered services Other comprehensive benefits are not covered *Prior authorization is required for the POS benefit.*

PREMIUMS AND BENEFITS	GOLD KIDNEY OF ARIZONA DIALYSIS PLUS (HMO-POS C-SNP)	GOLD KIDNEY OF ARIZONA DIALYSIS COMPLETE (HMO-POS C-SNP)*
Routine Vision *Prior Authorization required for POS benefit.*	**In-Network** Routine Eye Exams: 2 every year $0 copay Eyewear $350 for Contact lenses, Eyeglasses (lenses and frames), Eyeglass lenses, Eyeglass frames and upgrades every 2 years. **Out-of-Network/Point-of-Service (POS):** You pay $0 for Medicare-covered eye exams and eyewear. All other routine vision services and eyewear are not covered.	**In-Network** Routine Eye Exams: 2 every year $0 copay Eyewear $400 for Contact lenses, Eyeglasses (lenses and frames), Eyeglass lenses, Eyeglass frames and upgrades every 2 years. **Out-of-Network/Point-of-Service (POS):** You pay $0 for Medicare-covered eye exams and eyewear. All other routine vision services and eyewear are not covered.
Mental Health Services Inpatient *Prior authorization is required for in-network and out-of-network/POS services.*	**In-Network and Out-of-Network/ Point-of-Service (POS):** In patient mental health care You pay the following per admission or per stay: Days 1-5 $225 copay per admission or stay Days 6-90 $0 copay per admission or stay Cost sharing is charged upon discharge from the hospital **Out-of-Network** Days 1-5 $100 Days 6-90 $0	**In-Network and Out-of-Network/ Point-of-Service (POS):** You pay a $1,556 deductible per benefit period. You pay: • $0 for days 1-60 • $389 copay per day for days 61-90 • $778 copay per each “lifetime reserve day” after day 90 for each benefit period (up to 60 days over your lifetime) • 100% of all costs beyond the lifetime reserve days These are 2022 cost-sharing amounts and may change for 2023. Gold Kidney will update this information once available at www.goldkidney.com. If you have full Medicaid benefits, your costs could be less.
Mental Health Services Outpatient	**In-Network** Outpatient mental health care – individual sessions $25 copay Outpatient mental health care – group sessions $10 copay *A referral is required* **Out-of-Network/Point-of-Service (POS):** Individual sessions are not covered *Prior Authorization required*	**In-Network and Out-of-Network/ Point-of-Service (POS):** Outpatient mental health care – individual sessions 20% coinsurance Outpatient mental health care – group sessions 20% coinsurance *Referral required for in-network mental health services.* *Prior Authorization required for POS benefit.*

PREMIUMS AND BENEFITS	GOLD KIDNEY OF ARIZONA DIALYSIS PLUS (HMO-POS C-SNP)	GOLD KIDNEY OF ARIZONA DIALYSIS COMPLETE (HMO-POS C-SNP)*
Skilled Nursing Facility *Prior Authorization is required.*	**In-Network and Out-of-Network/ Point-of-Service (POS):** Days 1-20 $0 copay per day Days 21-47 $100 copay per day Days 48-100 $0 copay per day	**In-Network and Out-of-Network/ Point-of-Service (POS):** You pay: • $0 for days 1-20 • $194.50 for days 21-100 • All costs for each day after day 100 of the benefit period. These are 2022 cost-sharing amounts and may change for 2023. Gold Kidney will update this information once available at www.goldkidney.com.
Physical Therapy	**In-Network** $20 copay *A referral is required.* **Out-of-Network/Point-of-Service (POS):** $20 copay per visit *Prior Authorization required for POS benefit.*	**In-Network and Out-of-Network/ Point-of-Service (POS):** 20% coinsurance *Referral is required for in-network services.* *Prior Authorization required for POS benefit.*
Ambulance *Prior authorization required for nonemergency Medicare services.*	**In-Network and Out-of-Network/ Point-of-Service (POS):** Ground Ambulance $200 copay Air Ambulance 20% coinsurance	**In-Network and Out-of-Network/ Point-of-Service (POS):** Ground Ambulance 20% copay Air Ambulance 20% coinsurance *Prior authorization required for POS benefit*
Transportation *Prior Authorization is required.*	**In-Network** Trips to any health-related location $0 copay – 104 one-way trips per year **Out-of-Network/Point-of-Service (POS):** Not covered	**In-Network** Trips to any health-related location $0 copay – 104 one-way trips per year **Out-of-Network/Point-of-Service (POS):** Not covered

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Medicare Part B Drugs *Prior Authorization is required.*	**In-Network and Out-of-Network/ Point-of-Service (POS):** Chemotherapy Drugs 20% coinsurance Other Part B Drugs 20% coinsurance	**In-Network and Out-of-Network/ Point-of-Service (POS):** Chemotherapy Drugs 20% coinsurance Other Part B Drugs 20% coinsurance
Over The Counter (OTC)	**In-Network** $50 per quarter You can use this benefit more than once, up to the limit per quarter, but unused amounts do not roll over. You can use this to purchase personal health care items and non-prescription OTC products like vitamins, sunscreen, pain relievers, cough/cold medicine, and bandages. **Out-of-Network/Point-of-Service (POS):** Not covered	**In-Network** $400 per quarter You can use this benefit more than once, up to the limit per quarter, but unused amounts do not roll over. You can use this to purchase personal health care items and non-prescription OTC products like vitamins, sunscreen, pain relievers, cough/cold medicine, and bandages. **Out-of-Network/Point-of-Service (POS):** Not covered
Podiatry *Prior authorization required for in-network and POS benefits.*	**In-Network and Out-of-Network/ Point-of-Service (POS):** $0 for Medicare-covered services	**In-Network** Routine Foot Care 20% coinsurance $0 copay for Medicare-covered services 20% coinsurance for unlimited routine podiatry services **Out-of-Network/Point-of-Service (POS):** $0 copay for Medicare-covered services
Durable Medical Equipment	**In-Network and Out-of-Network/ Point-of-Service (POS):** 20% coinsurance per item *Prior authorization required for in-network and POS benefits.*	**In-Network and Out-of-Network/ Point-of-Service (POS):** 20% coinsurance per item *Prior Authorization required for POS benefit.*

PREMIUMS AND BENEFITS	GOLD KIDNEY OF ARIZONA DIALYSIS PLUS (HMO-POS C-SNP)	GOLD KIDNEY OF ARIZONA DIALYSIS COMPLETE (HMO-POS C-SNP)*
Diabetes self-management training, diabetic services and supplies *For all people who have diabetes (insulin and non-insulin users). Covered services include:* *• Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors.* *• For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting.* *• Diabetes self-management training is covered under certain conditions.*	**In-Network** $0 copay for diabetes self-management training $0 copay for diabetic monitoring services and supplies $0 copay for diabetic shoes or therapeutic inserts *Referral required for in-network diabetes self-management training.* *Prior authorization required for POS benefit.*	**In-Network** $0 copay for diabetes self-management training $0 copay for diabetic monitoring services and supplies $0 copay for diabetic shoes or therapeutic inserts *Referral required for in-network diabetes self-management training.* *Prior authorization required for POS benefit.*
Home and Bathroom Safety Devices and Modifications *Members are eligible for receiving elevated toilet seats, safety frames and risers.*	**In-Network** $0 copay *Prior authorization required.* **Out-of-Network/Point-of-Service (POS):** Not covered	**In-Network** $0 copay *Prior authorization required.* **Out-of-Network/Point-of-Service (POS):** Not covered
Fitness *You have access to fitness locations that may include equipment, exercise classes, pools and other available amenities. Home-based fitness kits and online resources and supports are also available. This benefit is administrated by the* *Silver&Fit program by American Specialty Health.*	**In-Network** $0 copay *Prior authorization required.* **Out-of-Network/Point-of-Service (POS):** Not covered	**In-Network** $0 copay *Prior authorization required.* **Out-of-Network/Point-of-Service (POS):** Not covered
Telehealth	**In-Network** $0 copay **Out-of-Network/Point-of-Service (POS):** Not covered	**In-Network** 20% coinsurance **Out-of-Network/Point-of-Service (POS):** Not covered

PREMIUMS AND BENEFITS	GOLD KIDNEY OF ARIZONA DIALYSIS PLUS (HMO-POS C-SNP)	GOLD KIDNEY OF ARIZONA DIALYSIS COMPLETE (HMO-POS C-SNP)*
Meals The meal benefit is available to members immediately following surgery or inpatient hospitalization. Eligible members will receive up to 2 meals per day for up to 10 days. This benefit can be used up to 4 times per year.	**In-Network** You pay $0 *Prior authorization required.* **Out-of-Network/Point-of-Service (POS):** Not covered	**In-Network** You pay $0 *Prior authorization required.* **Out-of-Network/Point-of-Service (POS):** Not covered
Chiropractic services In-Network, routine covered services include: Routine Care: Up to 12 chiropractic visits per year *Prior authorization required for in-network and out-of-network/POS services.*	**In-Network** $20 copay per visit for Medicare-covered services $20 copay per visit for routine chiropractic services **Out-of-Network/Point-of-Service (POS):** $20 copay per visit for Medicare-covered services Routine chiropractic services are not covered.	**In-Network** 20% coinsurance per visit for Medicare-covered services $0 copay per visit for routine chiropractic services **Out-of-Network/Point-of-Service (POS):** 20% of the cost for Medicare-covered services Routine chiropractic services not covered.
Acupuncture Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as: Lasting 12 weeks or longer; Nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious, etc. disease) Not associated with surgery; and not associated with pregnancy *Prior authorization is required.*	**In-Network** $0 copay **Out-of-Network/Point-of-Service (POS):** Not covered	**In-Network** $0 copay **Out-of-Network/Point-of-Service (POS):** Not covered
		***Your medical cost-shares for Dialysis Complete (HMO C-SNP) may be less if you receive full Medicaid benefits.**

OUTPATIENT PRESCRIPTION DRUGS	GOLD KIDNEY OF ARIZONA DIALYSIS PLUS (HMO-POS C-SNP)		GOLD KIDNEY OF ARIZONA DIALYSIS COMPLETE (HMO-POS C-SNP)*	
Deductible	$0		$505 Depending on your level of "Extra Help", you may pay $0.	
	Standard Retail Rx 30-day supply	**Mail Order 90-day supply**	**Standard Retail Rx 30-day supply**	**Mail Order 90-day supply**
Initial Coverage			**Tiers 1-5:** 25% or $0-$10.35 if you receive "Extra Help" **Tier 6:** 15% or $0-$10.35 if you receive "Extra Help"	
Tier 1: Preferred Generic	You pay $0	You pay $0		
Tier 2: Generic **Select Insulins**	You pay $5 You pay $5	You pay $12 You pay $12		
Tier 3: Preferred Brand **Select Insulins**	You pay $45 You pay $35	You pay $112 You pay $105		
Tier 4: Non-Preferred Drug	You pay $100	You pay $250		
Tier 5: Specialty	You pay 33%	Not available		
Tier 6: Select Care Drugs	You pay $0	You pay $0		
Coverage Gap (after you or others on your behalf pay $4,660)	During this phase you will pay the same cost-shares for drugs on Tier 1 ($0) and Tier 2 ($5 for a 30-day supply; $12 for a 90-day supply). You pay no more than 25% of the cost for all other drugs.		No Gap Coverage	
Catastrophic Coverage (after you or others on your behalf pay $7,400) **Generic Drugs** **Brand Name Drugs**	Your share of the cost for a covered drug will be either coinsurance or a copay, whichever is the larger amount: • Either – coinsurance of 5% of the cost of the drug • or $4.15 for a generic drug or a drug that is treated like a generic and $10.35 for all other drugs.		Your share of the cost for a covered drug will be either coinsurance or a copay, whichever is the larger amount: • Either – coinsurance of 5% of the cost of the drug • or $4.15 for a generic drug or a drug that is treated like a generic and $10.35 for all other drugs.	
Important Message About What You Pay for Insulin	You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.		You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on, even if you haven't paid your deductible.	
Important Message About What You Pay for Vaccines	Our plan covers most Part D vaccines at no cost to you. Call Member Services for more information.			

GOLD KIDNEY HEALTH PLAN

At Gold Kidney, its important your treated fairly.

Gold Kidney Health Plan, Inc. does not discriminate or exclude people because of their race color, national origin; age, disability, sex, sexual orientation, intersex traits, pregnancy, or related conditions, gender, gender identity, ancestry, marital status, or religion. Discrimination is against the law. Gold Kidney complies with applicable Federal Civil Rights laws. If you believe that you have been discriminated against by Gold Kidney, there are ways to get help.

- You may file a complaint, also known as grievance, with:
  Gold Kidney Health Plan, INC. Attention: member services department.
  PO Box 14050 Scottsdale, AZ 85267.
  If you need help filing a grievance, call **1-844-294-6535 (TTY 711).** We are open 7 days a week, 8 a.m. to 8 p.m. local time, October through March. We are open 5 days a week, Monday through Friday 8 a.m. to 8 p.m. April through September. You may always leave a voicemail after hours, Saturdays, Sundays, and holidays and we will return your call within one business day.
- You can also file a civil rights compliant 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, SW, Room 509F, HHH Building, Washington, DC 20201, DC 20201, **1-800-368-1019, 1-800-537-7697 (TDD)**.

Complaint forms are available at **https://www.hhs.gov/ocr/office/file/index.html.**

Auxiliary aids and services, free of charge, are available to you **1-844-294-6535 (TTY 711).**

Gold Kidney provides free auxiliary aids and services, such as qualified sign language interpreters and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.

Language assistance services, free of charge are available to you
1-844-294-6535 (TTY 711).

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-844-294-6535 (TTY 711). Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-844-294-6535 (TTY 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Multi-language Interpreter Services

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此 译服务，请致电 1-844-294-6535 (TTY 711)。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-844-294-6535 (TTY 711)。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-844-294-6535 (TTY 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-844-294-6535 (TTY 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-844-294-6535 (TTY 711). sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits-und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-844-294-6535 (TTY 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-844-294-6535 (TTY 711). 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-844-294-6535 (TTY 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم بمساعدتك. هذه . سيقوم شخص ما يتحدث العربية 1-844-294-6535 (TTY 711) فوري، ليس عليك سوى الاتصال بنا على [خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-844-294-6535(TTY 711)पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Multi-language Interpreter Services

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il 1-844-294-6535 (TTY 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-844-294-6535 (TTY 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-844-294-6535 (TTY 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-844-294-6535 (TTY 711). Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、1-844-294-6535 (TTY 711). にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。す。これは無料のサー ビスです。