Plan Comparison Overview

Benefits and premiums	Original Medicare Fee-For -Service[1]	Super Plus (HMO-POS C-SNP)	Super Complete[2] (HMO-POS C-SNP)	Dialysis Plus (HMO-POS C-SNP)	Dialysis Complete[2] (HMO-POS C-SNP)
MEMBER VALUE ADDED SERVICES					
Part B premium reduction (Buydown or money back in their Social Security check)	N/A	**$150**	N/A	N/A	N/A
MONTHLY PREMIUM			**MEDICARE & MEDICAID / MEDICARE ONLY**		**MEDICARE & MEDICAID / MEDICARE ONLY**
Monthly premium	N/A	**$0**	**$0 / $25.80**	**$0**	**$0 / $36.30**
Maximum Out of Pocket (MOOP)	N/A	**$3,000**	**$8,850**	**$2,700**	**$8,850**
BENEFITS AND PREMIUMS			**MEDICARE & MEDICAID / MEDICARE ONLY**		**MEDICARE & MEDICAID / MEDICARE ONLY**
Primary care physician	**20%**	**$0**	**0% / 20%**	**$0**	**0% / 20%**
Specialist (cardiologist, nephrologist, endorcrinologist and CV surgeon)	**20%**	**$0**	**0% / 20%**	**$0**	**0% / 20%**
Specialist (all other)	**20%**	**$10**	**0% / 20%**	**$10**	**0% / 20%**
Urgent care	**20%**	**$10**	**$0 / $10**	**$40**	**$0 / $55**
Emergency	**20%**	**$90**	**$0 / $90**	**$120**	**$0 / $75**
Inpatient hospitalization	Medicare Part A deductible applies; **$0** Days 1–60; Medicare allowable says 61–90 each benefit period	Days 1–5: **$175** Days 6–90: **$0**	Medicare Part A deductible applies; **$0** Days 1–60; Medicare allowable days 61–90 each benefit period	Days 1–5: **$175** Days 6–90: **$0**	Medicare Part A deductible applies; **$0** Days 1–60; Medicare allowable days 61–90 each benefit period
Outpatient hospital	**20%**	**$175**	**0% / 20%**	**$175**	**0% / 20%**
Outpatient ambulatory surgical center	**20%**	**$75**	**0% / 20%**	**$75**	**0% / 20%**
Tests (diagnostic radiology)	**20%**	**$50**	**0% / 20%**	**$50**	**0% / 20%**
Lab services	**20%**	**$0**	**$0**	**$0**	**0% / 20%**
Dialysis	**20%**	**20%**	**0% / 20%**	**$0**	**0% / 20%**
EXTRAS					
Dental, Vision & Hearing[3]	Routine dental not covered; Dental not covered	**$625** limit per 3 mos Combined **$2,500** annual Flex allowance	**$875** limit per 3 mos Combined **$3,500** annual Flex allowance	**$625** limit per 3 mos Combined **$2,500** annual Flex allowance	**$875** limit per 3 mos Combined **$3,500** annual Flex Allowance
Special Supplemental Benefits for the Chronically Ill (SSBCI)[4]	Not covered	Healthy groceries allowance: **$80**/month	Healthy groceries allowance: **$35**/month	Healthy groceries allowance: **$75**/month	Healthy groceries allowance: **$35**/month
Transportation — Non-emergency	Non-emergency transportation not covered[5]	**$0** for 36 one-way trips[6]	**$0** for 54 one-way trips per year[6]	**$0** for unlimited trips[6]	**$0** for unlimited[6]
Over-the-Counter[7]	Not covered	**$25**/month, up to **$300** per year	**$135**/month, up to **$1,620** per year	**$25**/month; up to **$300** per year	**$135**/month add up to **$1,620** per year
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
Companion eare[8]	Not covered	**$0** for in-home support	**$0** for in-home support	**$0** for in-home support	**$0** for in-home support
Preventive rewards and incentives	N/A	Preventive rewards and incentives: Up to **$300** per year[9]	Preventive rewards and incentives: Up to **$300** per year[9]	Preventive rewards and incentives: Up to **$300** per year[9]	Preventive rewards and incentives: Up to **$300** per year[9]
Prescription drugs — 30/100-day supply at retail[10]	Not covered	**$0 / $5 / $40 / $100 / 33% / $0**	**25% / 25% / 25% / 25% / 25% / 25%**	**$0 / $5 / $40 / $100 / 33% / $0**	**25% / 25% / 25% / 25% / 25% / 25%**

FOOTNOTES

1 Cost share applies after deductible and any inpatient hospital coinsurance that are required.
2 If you receive Medicaid benefits your premium and coinsurance will be paid by the programs.
3 New combined flexible allowance lets you choose how much can be used towards covered dental, vision and hearing services and where you get your care — no network required. Spend up to the Plan FLEX allowance each quarter. Allowance does not rollover to the next quarter. All costs in excess of the plan allowance are paid by the member.
4 You must have one of the listed chronic conditions and participate in case management. Not everyone will qualify.
5 Based on medical necessity; requires doctor order.
6 Maximum distance is 50 miles.
7 Includes coverage of protein shakes for nutrition therapy like Glucerna and Nepro. No rollover.
8 Includes in-home support for light housekeeping, yardwork or technology support; up to 60 hr.
9 For completion of preventive activities.
10 Varies by tier, level or coverage stage.

Questions

For questions about our plans, or to enroll, please call:

1 (844) 294-6535 (TYY 711)

Hours of operation

OCTOBER 1–MARCH 31

8 a.m.–8 p.m., Monday–Friday; 8 a.m.–1 p.m. Saturdays (except Thanksgiving and Christmas)

APRIL 1–SEPTEMBER 30

8 a.m.–8 p.m., Monday–Friday (except holidays)

www.goldkidney.com

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GOLD KIDNEY HEALTH PLAN

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Florida C-SNP Plans

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