



**GOLD KIDNEY HEALTH PLAN**

2025

## Enrollment Guide

**Gold Kidney of Arizona Gold Advantage (HMO-POS)**

**Gold Kidney of Arizona Gold Loyalty (HMO-POS)**

**For the residents of the following Arizona counties:** Cochise, Coconino, Gila, Graham, Maricopa, Navajo, Pima, and Pinal



# Gold Kidney Health Plan: Your Partner for Better Health

Thank you for considering a Gold Kidney health plan. We are confident you'll find our Medicare Advantage plans to be designed for your unique healthcare needs. Our goal is to take the hassle out of healthcare and keep you and your doctors at the center of your care decisions. Gold Kidney is here to simplify your life and support your health.

We offer plans that help you live your best life no matter where you are along your healthcare journey. You will find that our standard Medicare Advantage plans allow you to get more out of your Medicare coverage. Our Chronic Special Needs Plans (C-SNPs) have benefits uniquely designed for people with diabetes, heart and cardiovascular problems, and/or end-stage renal disease (ESRD).

**Enjoy more, pay less.** Gold Kidney plans are filled with benefits that ease the burden of large copays and out-of-pocket costs. You have more choices of doctors, specialists, and hospitals with the flexibility of no referrals and few pre-authorizations required.

**Benefits beyond Medicare for the extras you need in life.** Our supplemental benefits include a wide array of useful options that help you live your best life. From flexible dental, hearing, and vision allowances to fitness and wellness programs, to healthy meals and companionship when you need it. We're not just a health plan; we're your partners in wellness.

**Ready to experience the difference?** Learn more about how Gold Kidney can improve your life and help you get the best possible care and support. Enroll today and start your journey to better health!



Dave Firdaus  
Chief Executive Officer (CEO)  
Gold Kidney Health Plan

# Table of Contents

**Gold Kidney Health Plan** 02

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**Gold Kidney puts you at the center of  
your healthcare journey** 03

---

**Make prevention a priority** 04

---

**Services for you** 05

---

**Which plan is right for you?** 06

---

**How to enroll** 07

---

**What happens next?** 08

---

**Important forms and documents** 10

---

# Gold Kidney Health Plan

Our story began with listening to patients with chronic diseases. Often these individuals end up with high copays for treatments needed to manage their chronic conditions. This often limits care options and makes medications unaffordable. But, at Gold Kidney, we are changing that.

Our Medicare Advantage plans are designed with our members' health in mind! We offer low-to-no-member cost for doctor visits and many medications, lowering out-of-pocket expenses, while also reducing the barriers to obtaining quality care.

Gold Kidney health plans are uniquely designed to support our members health and wellness through affordable coverage, simplified access to care, and comprehensive benefits that improve quality of life.

Your care is tailored to you. This team works together to create a personalized plan based on your specific needs and preferences. You will also have access to:

- A 24/7 nurse advice line
- Telehealth services
- Wellness programs
- and more!

**Gold Kidney is more than just a health plan. We are a partner in your healthcare journey.**



# Gold Kidney puts you at the center of your healthcare journey

Our mission is to enhance our members' lives through access to **high-quality, affordable healthcare**. Some of the benefits offered include:

- \$0 monthly premiums
- \$0 copays for primary care physicians
- \$0 deductible on prescription drugs
- \$0 or low copays for many medications, including insulin
- Convenient 100-day mail order prescription supply for the same copay as a 30-day retail supply

With our **Gold Perks** program, you get even more support. Use your monthly allowance for everyday living expenses, including:

- Over-the-counter items
- Therapeutic massages
- Fitness activity fees
- Home and bathroom safety devices

We also have you covered with **extra benefits** that support your well-being:

- Dental, vision, and hearing allowance
- In-home companion care to help you with daily activities like light housekeeping, yardwork, and technology support
- Personal Emergency Response System (PERS) device
- Silver&Fit® fitness benefits for gym memberships, virtual fitness classes, and home fitness kits

## Quarterly dental, hearing, and vision flex allowance

You're in control with our flex allowance program

- You choose which dental, hearing, and vision services you need, which providers to use, and how much of your allowance to spend
- Your quarterly flex allowance rolls over so you can save up for more costly services and devices
- You have the entire calendar year to use your allowance

*Your quarterly allowance is loaded to your Alivi® Gold Kidney Prepaid Visa® card. Flex Allowance amounts vary by plan. Benefits may vary by plan. Please refer to your plan's Summary of Benefits included in this booklet for details.*

# Make prevention a priority

## Earn healthy rewards

We make it easy to stay healthy with Gold Kidney Rewards & Incentives. As a member, you are eligible to earn rewards for completing healthy activities. You can be rewarded if you complete activities such as:

- Fill out and submit your Health Risk Assessment within 90 days of enrollment
- Visit your doctor for your annual wellness visit
- Get your flu or COVID vaccine
- Have a mammogram or a colorectal cancer screening
- Complete a medication reconciliation visit with your PCP within 14 days of an inpatient discharge
- Sign up for the Gold Kidney member portal
- Participate in periodic surveys through the member portal

Rewards are added to your Alivi® Gold Kidney Prepaid Visa® card and can be spent on additional OTC items, healthy food and produce, and more to meet your healthcare needs.

## Rely on your partners in care

At Gold Kidney, we take the hassle out of getting the care you need. As a Gold Kidney plan member, we keep your doctors at the center of your care decisions and provide you with the resources you need, including:

- No referrals and few pre-authorizations required
- Access to providers with no network constraints
- Nurse line available 24/7
- Member services

With Gold Kidney, you will have the peace of mind that comes with knowing that you have a trusted partner in your health care journey.



# Services for you

## Medicare Prescription Payment Plan

The Medicare Prescription Payment Plan is a new program that will help people with Medicare prescription drug coverage (Part D) who have high out-of-pocket expenses. Individuals can spread out their medication costs in the form of monthly payments over the course of the plan year.

Anyone with Part D is eligible to use the Medicare Prescription Payment Plan. To find more information and to opt-in to use the program, please see your enrollment form attached to this booklet.

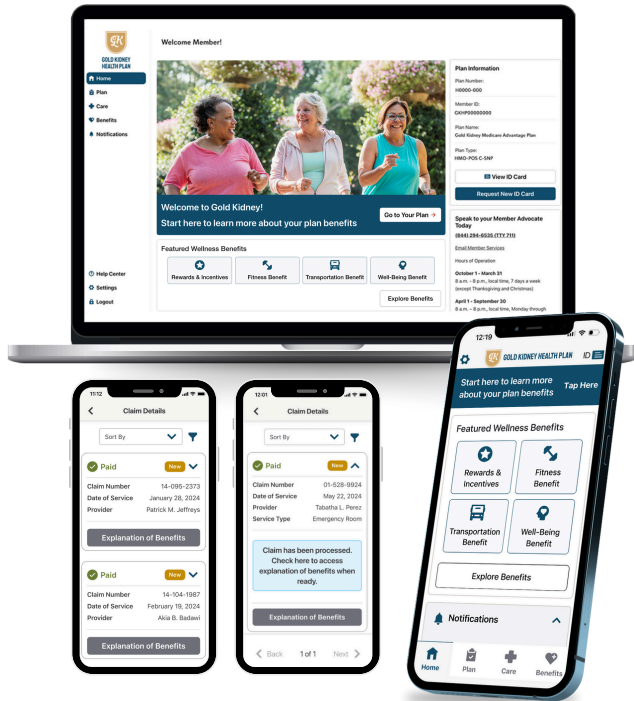
## Personalized Support and Services

We take pride in supporting our members on their personal journey to better health. In addition to exceptional support for all members, enrollees of Gold Kidney Medicare Advantage plans enjoy access to our member concierge service. Our member advocates are available to answer your benefit questions, help you coordinate care when you need it, and much more.

It's another benefit you can count on when you trust Gold Kidney to create the gold standard of care.

## Gold Kidney Member Portal

Our members can easily view their plan and benefit information in one convenient place. The online member portal and mobile app allow members to track claims status and track their out-of-pocket costs, quickly access their pharmacy benefit manager with single sign-on, use their digital member ID card, and much more.





# Which plan is right for you?

**We offer two standard Medicare Advantage health plans in your county.**

**Gold Advantage**  
**(HMO-POS MA-PD) H4869-005**

For those who are Medicare-eligible who do not qualify for our chronic special needs plans

**Gold Loyalty**  
**(HMO-POS MA) H4869-009**

For those who are Medicare-eligible and do not need prescription drug coverage



# How to enroll

It's easy. You can choose to...



## COMPLETE YOUR APPLICATION ONLINE

- Visit [goldkidney.com/how-to-enroll](http://goldkidney.com/how-to-enroll)
- Under Enroll Online select “Enroll Now”
- Fill in the applicant information
- Complete your Medicare Advantage Enrollment Eligibility form
- Choose a Primary Care Provider
- Provide your email address to receive updates and notifications (you can opt-out any time)



## ENROLL BY PHONE

If you would like to enroll over the phone, one of our licensed agents will be happy to assist you. Simply call us at (888) 376-6188 (TTY 711). We are available October 1 through March 31 from 8:00 a.m. to 8:00 p.m., local time, 7 days a week (except holidays), and April 1 through September 30 from 8:00 a.m. to 8:00 p.m., local time, Monday through Friday (except holidays).



## SCHEDULE AN IN-PERSON APPOINTMENT

If you're more of a face-to-face person, we can schedule an appointment with one of our licensed agents. Give us a call at (888) 376-6188 (TTY 711). We are available October 1 through March 31 from 8:00 a.m. to 8:00 p.m. local time, 7 days a week (except holidays), and April 1 through September 30 from 8:00 a.m. to 8:00 p.m. local time, Monday through Friday (except holidays).



## MAIL OR FAX YOUR FORM

- Fill out the enclosed pre-qualification assessment tool and the enrollment form and return them in the enclosed self-addressed envelope. Or, to use your own envelope, you can send your completed forms to us at:

Gold Kidney Health Plan  
Attn: Sales Operations  
PO Box 285  
Portsmouth, New Hampshire 03802

- You can fax your completed documents to (866) 370-0078.

# What happens next?

Once your enrollment is received by Gold Kidney, we will begin processing your enrollment into the Medicare Advantage plan you have selected.

## ✓ Acknowledgement

Once your enrollment application is received, Gold Kidney will send you an acknowledgement letter that details next steps and how to reach us if you have questions.

## ✓ Confirmation

Within 10 days of enrollment, you will receive a confirmation of enrollment letter. This letter will also serve as confirmation that Medicare has approved your enrollment.

## ✓ Enrollment verification notice

Within 15 days of enrollment, you will receive a notification by mail or phone. This is to confirm your enrollment and make sure the Medicare Advantage plan was explained to you clearly and thoroughly. It is also to ensure that it is your intent to enroll in the plan. This is called “Outbound Enrollment and Verification” requirements.

## ✓ Member ID card

Within 10 days of your confirmed enrollment or by the last day of the month prior to your effective date, you will receive your member ID card. Bring your new Gold Kidney Health Plan member ID card with you to all your doctor, hospital, and pharmacy visits.

## ✓ Welcome to your new health plan

You will receive an envelope containing important plan documents. The envelope will include information on how to access or request your Evidence of Coverage and Provider and Pharmacy directories online or by mail.

## ✓ Extra help

If you qualify for “Extra Help” from the state for your prescription drug costs, you will receive a Low-Income Subsidy (LIS) letter within 10 days of verified enrollment.

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# Scope of appointment form

The Centers for Medicare and Medicaid Services requires agents to document the scope of a marketing appointment prior to any individual sales meeting to ensure understanding of what will be discussed between the agent and the Medicare beneficiary (or their authorized representative). All information provided on this form is confidential and should be completed by each person with Medicare or his/her authorized representative.

**Please initial below beside the type of product(s) you want the agent to discuss.**

(Refer to page 2 for product type descriptions.)

- |  |  |
|--|--|
| <input type="checkbox"/> <b>Stand-alone Medicare Prescription Drug Plans</b> | <input type="checkbox"/> <b>Dental/Vision/Hearing Products</b>         |
| <input type="checkbox"/> <b>Medicare Advantage Plans (Part C) Cost Plans</b> | <input type="checkbox"/> <b>Medicare Supplement (Medigap) Products</b> |

**By signing this form, you agree to a meeting with a sales agent to discuss the types of products you initialed above.** Please note, the person who will discuss the products is either employed or contracted by a Medicare plan. They do not work directly for the Federal government. This individual may also be paid based on your enrollment in a plan. Signing this form does NOT obligate you to enroll in a plan, affect your current or future enrollment, or enroll you in a Medicare plan.

### Beneficiary or Authorized Representative Signature and Signature Date:

Signature:

Signature Date:

### If you are the authorized representative, please sign above and print below:

Representative's Name:

Your Relationship to the Beneficiary:

### To be completed by Agent:

Agent Name:

Agent Phone:

Beneficiary Name:

Beneficiary Phone:

Beneficiary Address:

Initial Method of Contact: *(Indicate here if beneficiary was a walk-in.)*

Agent's Signature:

Plan(s) the agent represented during this meeting:

Date Appointment Completed:

### Plan use only

Agent, if the form was signed by the beneficiary at time of appointment, provide explanation why SOA was not documented prior to meeting:

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## Stand-alone Medicare Prescription Drug Plans (Part D)

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**Medicare Prescription Drug Plan (PDP):** A stand-alone drug plan that adds prescription drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private-Fee-for-Service Plans, and Medicare Medical Savings Account Plans.

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## Medicare Advantage Plans (Part C) and Cost Plans

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**Medicare Health Maintenance Organization (HMO):** A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. In most HMOs, you can only get your care from doctors or hospitals in the plan's network (except in emergencies).

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**Medicare Preferred Provider Organization (PPO) Plan:** A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. PPOs have network doctors and hospitals but you can also use out-of-network providers, usually at a higher cost.

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**Medicare Private Fee-For-Service (PFFS) Plan:** A Medicare Advantage Plan in which you may go to any Medicare-approved doctor, hospital and provider that accepts the plan's payment, terms and conditions and agrees to treat you — not all providers will. If you join a PFFS Plan that has a network, you can see any of the network providers who have agreed to always treat plan members. You will usually pay more to see out-of-network providers.

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**Medicare Point of Service (POS) Plan:** A type of Medicare Advantage Plan available in a local or regional area which combines the best features of an HMO with an out-of-network same cost-share benefit. Like the HMO, members are required to designate a physician to be the primary health care provider.

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**Medicare Special Needs Plan (SNP):** A Medicare Advantage Plan that has a benefit package designed for with special health care needs. Examples of the specific groups served include people who have both Medicare and Medicaid, people who reside in nursing homes, and people who have certain chronic medical conditions.

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**Medicare Medical Savings Account (MSA) Plan:** MSA Plans combine a high deductible health plan with a bank account. The plan deposits money from Medicare into the account. You can use it to pay your medical expenses until your deductible is met.

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**Medicare Cost Plan:** In a Medicare Cost Plan, you can go to providers both in and out of network. If you get services outside of the plan's network, your Medicare-covered services will be paid for under Original Medicare but you will be responsible for Medicare coinsurance and deductibles.

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**Medicare Medicaid Plan (MMP):** An MMP is a private health plan designed to provide integrated and coordinated Medicare and Medicaid benefits for dual eligible Medicare beneficiaries.

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## Dental/Vision/Hearing Products

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Plans offering additional benefits for consumers who are looking to cover needs for dental, vision or hearing. These plans are not affiliated or connected to Medicare.

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## Supplemental Health Products

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Plans offering additional benefits; payable to consumers based upon their medical utilization; sometimes used to defray copays/coinsurance. These plans are not affiliated or connected to Medicare.

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## Medicare Supplemental (Medigap) Products

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Plans offering a supplemental policy to fill "gaps" in Original Medicare coverage. A Medigap policy typically pays some or all of the deductible and coinsurance amounts applicable to Medicare-covered services, and sometimes covers items and services that are not covered by Medicare, such as care outside of the country. These plans are not affiliated or connected to Medicare.

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Scope of Appointment documentation is subject to CMS record retention requirements.

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**GOLD KIDNEY HEALTH PLAN**

**2025**

**Gold Kidney Health Plan**

**Summary of Benefits**

**Gold Kidney of Arizona Gold Advantage (HMO-POS)**

**Gold Kidney of Arizona Gold Loyalty (HMO-POS)**

# 2025 Summary of Benefits

## Gold Kidney of Arizona Gold Advantage (HMO-POS) and Gold Kidney of Arizona Gold Loyalty (HMO-POS)

This is a summary of Medicare health care and prescription drug coverage for Gold Kidney of Arizona Gold Advantage (HMO-POS) and Medicare health care coverage for Gold Kidney of Arizona Gold Loyalty (HMO-POS).

January 1 – December 31, 2025

**Gold Kidney of Arizona Gold Advantage (HMO-POS) and Gold Kidney of Arizona Gold Loyalty (HMO-POS)** are Medicare Advantage HMO-POS plans with a Medicare contract. Enrollment in these 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 1-844-294-6535 (TTY 711) and request the “Evidence of Coverage” or access it online at [www.goldkidney.com](http://www.goldkidney.com).

To join Gold Kidney of Arizona Gold Advantage (HMO-POS) or Gold Kidney of Arizona Gold Loyalty (HMO-POS), you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. Our service area includes these counties in Arizona: Gila, Maricopa, Pima, Pinal, Cochise, Coconino, Graham and Navajo.

### **Does this plan cover my doctors and pharmacies?**

You can search our directory online at [www.goldkidney.com](http://www.goldkidney.com) or give us a call. We can look up your doctors and pharmacies or mail you a directory.

Gold Kidney offers you the value that comes with our integrated system of physicians, hospitals, and health plan — all working together to keep you healthy. With our HMO-POS plans, you enjoy more benefits than Original Medicare (Part A and Part B) and many services at low to no cost to you.

Our HMO-POS plans allow you to see out-of-network providers at the same copay as in-network providers. While we pay for covered services, the provider must agree to treat you.

### **Does this plan cover my prescription drugs?**

Gold Kidney of Arizona Gold Advantage (HMO-POS): You can search our drug list online at [www.goldkidney.com](http://www.goldkidney.com) or give us a call. We can look up your medications or mail you the list of drugs covered in your plan (formulary).

Gold Kidney of Arizona Gold Loyalty (HMO-POS): No, this plan does not provide Part D coverage.

For coverage and costs of Original Medicare, look in your current “Medicare & You” handbook. View it online at [www.medicare.gov](http://www.medicare.gov) or get a copy 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.

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



**For more information:**

- **CALL US AT**  
1 (844) 294-6535 (TTY 711)
- **HOURS OF OPERATION**  
October 1 – March 31  
8 a.m. to 8 p.m., local time, 7 days a week (except holidays)  
  
April 1 – September 30  
8 a.m. to 8 p.m., local time, Monday – Friday (except holidays)
- **VISIT US AT**  
[www.goldkidney.com](http://www.goldkidney.com)

# Premiums and Benefits

This is a short list of benefits and cost sharing for our plans. For a complete list, see the *Evidence of Coverage* on our website at [www.goldkidney.com](http://www.goldkidney.com).

Premiums and Benefits	Gold Kidney of Arizona Gold Advantage (HMO-POS)	Gold Kidney of Arizona Gold Loyalty (HMO-POS)
<b>Monthly Plan Premium</b> (includes both medical and drugs)	You pay \$0 each month. You must continue to pay your Medicare Part B premium.	You pay \$0 each month. You must continue to pay your Medicare Part B premium.
<b>Part B Premium Buy-down</b>	Our plan will reduce your monthly Medicare Part B premium by \$55.	Our plan will reduce your monthly Medicare Part B premium by \$75.
<b>Deductible</b>	You pay \$0 for medical benefits. You pay \$0 for Part D benefits.	You pay \$0 for medical benefits.
<b>Maximum Out-of-Pocket Responsibility</b>	You pay no more than \$3,400 annually. Includes copays and other costs for in-network medical services for the year.	You pay no more than \$5,500 annually. Includes copays and other costs for in-network medical services for the year.
<b>Inpatient Hospital</b>	For in-network inpatient hospital stays, you pay: \$195 copay per day for days 1-7; \$0 copay per day for days 8-90 For out-of-network stays, you pay:  \$195 copay per day for days 1-7; \$0 copay per day for days 8-90	For in-network inpatient hospital stays, you pay: \$300 copay per day for days 1-7; \$0 copay per day for days 8-90 For out-of-network stays, you pay:  \$300 copay per day for days 1-7; \$0 copay per day for days 8-90
<b>Outpatient Hospital</b>	For services at an in-network outpatient hospital, you pay \$225 copay per visit For services at an out-of-network outpatient hospital, you pay \$225 copay per visit.	For services at an in-network outpatient hospital, you pay \$275 copay per visit For services at an out-of-network outpatient hospital, you pay \$275 copay per visit.

Premiums and Benefits	Gold Kidney of Arizona Gold Advantage (HMO-POS)	Gold Kidney of Arizona Gold Loyalty (HMO-POS)
<b>Ambulatory Surgical Center (ASC)</b>	You pay \$150 copay in-network. You pay \$150 copay out-of-network.	You pay \$250 copay in-network. You pay \$250 copay out-of-network.
<b>Doctor Visits</b> <ul style="list-style-type: none"> <li>• Primary care provider</li> <li>• Specialists</li> </ul>	<p>You pay \$0 copay in-network. You pay \$0 copay out-of-network.</p> <p>You pay \$15 copay in-network. You pay \$15 copay out-of-network.</p>	<p>You pay \$0 copay in-network. You pay \$0 copay out-of-network.</p> <p>You pay \$45 copay in-network. You pay \$45 copay out-of-network.</p>
<b>Preventive Care</b> (e.g., flu vaccine, diabetic screenings)	You pay nothing in-network. You pay \$0 copay out-of-network.	You pay nothing in-network. You pay \$0 copay out-of-network.
<b>Emergency Care</b>	You pay \$135 copay per visit. ER cost sharing is waived if you are admitted to the hospital within 24 hours for the same condition.	You pay \$125 copay per visit.
<b>Urgently Needed Services</b>	You pay \$45 copay per visit.	You pay \$45 copay per visit.
<b>Diagnostic Services/ Labs/Imaging/ Radiology</b> <ul style="list-style-type: none"> <li>• Diagnostic tests and procedures</li> <li>• Lab services</li> </ul>	<p>You pay \$0 copay in-network. You pay \$0 copay out-of-network.</p> <p>You pay \$0 copay in-network. You pay \$0 copay out-of-network.</p>	<p>You pay 20% coinsurance in-network. You pay 20% coinsurance out-of-network.</p> <p>You pay 20% coinsurance in-network. You pay 20% coinsurance out-of-network.</p>

<b>Premiums and Benefits</b>	<b>Gold Kidney of Arizona Gold Advantage (HMO-POS)</b>	<b>Gold Kidney of Arizona Gold Loyalty (HMO-POS)</b>
<ul style="list-style-type: none"> <li>• MRIs, CAT scans</li>   <li>• X-rays</li>   <li>• Therapeutic radiology services</li> </ul>	<p>You pay \$95 copay in-network. You pay \$95 copay out-of-network.</p> <p>You pay \$0 copay in-network. You pay \$0 copay out-of-network.</p> <p>You pay 20% coinsurance in-network. You pay 20% coinsurance out-of-network.</p>	<p>You pay 20% coinsurance in-network. You pay 20% coinsurance out-of-network.</p> <p>You pay 20% coinsurance in-network. You pay 20% coinsurance out-of-network.</p> <p>You pay 20% coinsurance in-network. You pay 20% coinsurance out-of-network.</p>
<p><b>Hearing: Combined Flexible Dental, Hearing and Vision Benefits</b></p> <ul style="list-style-type: none"> <li>• Medicare-covered hearing exam</li> </ul> <p><b>Combined flexible dental, hearing and vision benefits allowance</b></p>	<p>You pay \$0 copay in-network. You pay \$0 copay out-of-network.</p> <p>\$525 maximum plan coverage amount every 3 months for all routine hearing exams and prescription hearing aids. This combined flexible benefit is a quarterly allowance that may be used for dental, hearing and vision benefits. The unused balance will carry forward to the next period.</p> <p>You are responsible for all costs exceeding the combined benefit amount for the flexible benefits.</p>	<p>You pay \$0 copay in-network. You pay \$0 copay out-of-network.</p> <p>\$625 maximum plan coverage amount every 3 months for all routine hearing exams and prescription hearing aids. This combined flexible benefit is a quarterly allowance that may be used for dental, hearing and vision benefits. The unused balance will carry forward to the next period.</p> <p>You are responsible for all costs exceeding the combined benefit amount for the flexible benefits.</p>

<b>Premiums and Benefits</b>	<b>Gold Kidney of Arizona Gold Advantage (HMO-POS)</b>	<b>Gold Kidney of Arizona Gold Loyalty (HMO-POS)</b>
<ul style="list-style-type: none"> <li>• Routine hearing exam</li> <li>• Fitting and evaluation for prescription hearing aids</li> <li>• Hearing aids</li> </ul>	<p>You pay \$0 copay in-network (unlimited exams every year). You pay \$0 copay out-of-network.</p> <p>You pay \$0 copay in-network (unlimited visits every year). You pay \$0 copay out-of-network.</p> <p>You pay \$0 copay in-network for prescription hearing aids – all types (unlimited hearing aids). You pay \$0 copay out-of-network.</p>	<p>You pay \$0 copay in-network (unlimited exams every year). You pay \$0 copay out-of-network.</p> <p>You pay \$0 copay in-network (unlimited visits every year). You pay \$0 copay out-of-network.</p> <p>You pay \$0 copay in-network for prescription hearing aids – all types (unlimited hearing aids). You pay \$0 copay out-of-network.</p>
<p><b>Dental: Combined Flexible Dental, Hearing and Vision Benefits</b></p> <ul style="list-style-type: none"> <li>• Medicare-covered dental services</li> </ul> <p><b>Combined flexible dental, hearing and vision benefits allowance</b></p>	<p>You pay \$0 copay in-network. You pay \$0 copay out-of-network.</p> <p>\$525 maximum plan coverage amount every 3 months for all preventive and comprehensive dental services. This combined flexible benefit is a quarterly allowance that may be used for dental, hearing and vision benefits. The unused balance will carry forward to the next period.</p> <p>You are responsible for all costs exceeding the combined benefit amount for the flexible benefits.</p>	<p>You pay \$0 copay in-network. You pay \$0 copay out-of-network.</p> <p>\$625 maximum plan coverage amount every 3 months for all preventive and comprehensive dental services. This combined flexible benefit is a quarterly allowance that may be used for dental, hearing and vision benefits. The unused balance will carry forward to the next period.</p> <p>You are responsible for all costs exceeding the combined benefit amount for the flexible benefits.</p>

<b>Premiums and Benefits</b>	<b>Gold Kidney of Arizona Gold Advantage (HMO-POS)</b>	<b>Gold Kidney of Arizona Gold Loyalty (HMO-POS)</b>
<ul style="list-style-type: none"> <li>• Preventive dental services               <ul style="list-style-type: none"> <li>○ unlimited oral exams every year</li> <li>○ unlimited cleanings every year</li> <li>○ unlimited fluoride treatments every year</li> <li>○ unlimited X-rays every year</li> <li>○ unlimited visits every year for other diagnostic dental services</li> <li>○ unlimited visits every year for other preventive dental services</li> </ul> </li> </ul>	<p>You pay \$0 copay in-network for preventive dental exams.</p> <p>You pay \$0 copay out-of-network.</p> <p>You pay \$0 copay in-network for cleanings.</p> <p>You pay \$0 copay out-of-network.</p> <p>You pay \$0 copay in-network for fluoride treatments.</p> <p>You pay \$0 copay out-of-network.</p> <p>You pay \$0 copay in-network for X-rays.</p> <p>You pay \$0 copay out-of-network.</p> <p>You pay \$0 copay in-network for other diagnostic services received.</p> <p>You pay \$0 copay out-of-network.</p> <p>You pay \$0 copay in-network for other preventive dental services received.</p> <p>You pay \$0 copay out-of-network.</p>	<p>You pay \$0 copay in-network for preventive dental exams.</p> <p>You pay \$0 copay out-of-network.</p> <p>You pay \$0 copay in-network for cleanings.</p> <p>You pay \$0 copay out-of-network.</p> <p>You pay \$0 copay in-network for fluoride treatments.</p> <p>You pay \$0 copay out-of-network.</p> <p>You pay \$0 copay in-network for X-rays.</p> <p>You pay \$0 copay out-of-network.</p> <p>You pay \$0 copay in-network for other diagnostic services received.</p> <p>You pay \$0 copay out-of-network.</p> <p>You pay \$0 copay in-network for other preventive dental services received.</p> <p>You pay \$0 copay out-of-network.</p>

<b>Premiums and Benefits</b>	<b>Gold Kidney of Arizona Gold Advantage (HMO-POS)</b>	<b>Gold Kidney of Arizona Gold Loyalty (HMO-POS)</b>
<ul style="list-style-type: none"> <li>Comprehensive dental services:</li> </ul>	<p>You pay \$0 copay in-network for restorative services (unlimited visits every year).</p> <p>You pay \$0 copay out-of-network.</p> <p>You pay \$0 copay in-network for endodontics services (unlimited visits every year).</p> <p>You pay \$0 copay out-of-network.</p> <p>You pay \$0 copay in-network for periodontics services (unlimited visits every year).</p> <p>You pay \$0 copay out-of-network.</p> <p>You pay \$0 copay in-network for removable prosthodontics services (unlimited visits every year).</p> <p>You pay \$0 copay out-of-network.</p> <p>You pay \$0 copay in-network for maxillofacial prosthetics services (unlimited visits every year).</p> <p>You pay \$0 copay out-of-network.</p> <p>You pay \$0 copay in-network for implant services (unlimited visits every year).</p> <p>You pay \$0 copay out-of-network.</p>	<p>You pay \$0 copay in-network for restorative services (unlimited visits every year).</p> <p>You pay \$0 copay out-of-network.</p> <p>You pay \$0 copay in-network for endodontics services (unlimited visits every year).</p> <p>You pay \$0 copay out-of-network.</p> <p>You pay \$0 copay in-network for periodontics services (unlimited visits every year).</p> <p>You pay \$0 copay out-of-network.</p> <p>You pay \$0 copay in-network for removable prosthodontics services (unlimited visits every year).</p> <p>You pay \$0 copay out-of-network.</p> <p>You pay \$0 copay in-network for maxillofacial prosthetics services (unlimited visits every year).</p> <p>You pay \$0 copay out-of-network.</p> <p>You pay \$0 copay in-network for implant services (unlimited visits every year).</p> <p>You pay \$0 copay out-of-network.</p>

<b>Premiums and Benefits</b>	<b>Gold Kidney of Arizona Gold Advantage (HMO-POS)</b>	<b>Gold Kidney of Arizona Gold Loyalty (HMO-POS)</b>
	<p>You pay \$0 copay in-network for fixed prosthodontics services (unlimited visits every year).</p> <p>You pay \$0 copay out-of-network.</p> <p>You pay \$0 copay in-network for oral and maxillofacial surgery services (unlimited visits every year).</p> <p>You pay \$0 copay out-of-network.</p> <p>You pay \$0 copay in-network for orthodontics services (unlimited visits every year).</p> <p>You pay \$0 copay out-of-network.</p> <p>You pay \$0 copay in-network for adjunctive general services (unlimited visits every year).</p> <p>You pay \$0 copay out-of-network.</p>	<p>You pay \$0 copay in-network for fixed prosthodontics services (unlimited visits every year).</p> <p>You pay \$0 copay out-of-network.</p> <p>You pay \$0 copay in-network for oral and maxillofacial surgery services (unlimited visits every year).</p> <p>You pay \$0 copay out-of-network.</p> <p>You pay \$0 copay in-network for orthodontics services (unlimited visits every year).</p> <p>You pay \$0 copay out-of-network.</p> <p>You pay \$0 copay in-network for adjunctive general services (unlimited visits every year).</p> <p>You pay \$0 copay out-of-network.</p>
<p><b>Vision: Combined Flexible Dental, Hearing and Vision Benefits</b></p> <ul style="list-style-type: none"> <li>• Medicare-covered benefits</li> </ul>	<p>You pay \$0 copay in-network for an eye exam to diagnose and treat diseases and conditions of the eye.</p> <p>You pay \$0 copay out-of-network.</p> <p>You pay \$0 copay in-network for one pair of eyeglasses or contact lenses after cataract surgery.</p> <p>You pay \$0 copay out-of-network.</p>	<p>You pay \$0 copay in-network for an eye exam to diagnose and treat diseases and conditions of the eye.</p> <p>You pay \$0 copay out-of-network.</p> <p>You pay \$0 copay in-network for one pair of eyeglasses or contact lenses after cataract surgery.</p> <p>You pay \$0 copay out-of-network.</p>



<b>Premiums and Benefits</b>	<b>Gold Kidney of Arizona Gold Advantage (HMO-POS)</b>	<b>Gold Kidney of Arizona Gold Loyalty (HMO-POS)</b>
<p><b>Combined flexible dental, hearing and vision benefits allowance</b></p> <ul style="list-style-type: none"> <li>Routine eye exams</li> </ul>	<p>\$525 maximum plan coverage amount every 3 months for all routine eye exams and eyewear. This combined flexible benefit is a quarterly allowance that may be used for dental, hearing and vision benefits. The unused balance will carry forward to the next period.</p> <p>You are responsible for all costs exceeding the combined benefit amount for the flexible benefits.</p> <p>You pay \$0 copay in-network (unlimited exams every year).</p> <p>You pay \$0 copay out-of-network.</p>	<p>\$625 maximum plan coverage amount every 3 months for all routine eye exams and eyewear. This combined flexible benefit is a quarterly allowance that may be used for dental, hearing and vision benefits. The unused balance will carry forward to the next period.</p> <p>You are responsible for all costs exceeding the combined benefit amount for the flexible benefits.</p> <p>You pay \$0 copay in-network (unlimited exams every year).</p> <p>You pay \$0 copay out-of-network.</p>

<b>Premiums and Benefits</b>	<b>Gold Kidney of Arizona Gold Advantage (HMO-POS)</b>	<b>Gold Kidney of Arizona Gold Loyalty (HMO-POS)</b>
<ul style="list-style-type: none"> <li>Routine eyewear</li> </ul>	<p>You pay \$0 copay in-network for eyeglasses (unlimited pairs every year).</p> <p>You pay \$0 copay out-of-network.</p> <p>You pay \$0 copay in-network for eyeglass lenses (unlimited pairs every year).</p> <p>You pay \$0 copay out-of-network.</p> <p>You pay \$0 copay in-network for eyeglass frames (unlimited pairs every year).</p> <p>You pay \$0 copay out-of-network.</p> <p>You pay \$0 copay in-network for contact lenses (unlimited pairs every year).</p> <p>You pay \$0 copay out-of-network.</p> <p>You pay \$0 copay in-network for upgrades.</p> <p>You pay \$0 copay out-of-network.</p>	<p>You pay \$0 copay in-network for eyeglasses (unlimited pairs every year).</p> <p>You pay \$0 copay out-of-network.</p> <p>You pay \$0 copay in-network for eyeglass lenses (unlimited pairs every year).</p> <p>You pay \$0 copay out-of-network.</p> <p>You pay \$0 copay in-network for eyeglass frames (unlimited pairs every year).</p> <p>You pay \$0 copay out-of-network.</p> <p>You pay \$0 copay in-network for contact lenses (unlimited pairs every year).</p> <p>You pay \$0 copay out-of-network.</p> <p>You pay \$0 copay in-network for upgrades.</p> <p>You pay \$0 copay out-of-network.</p>

Premiums and Benefits	Gold Kidney of Arizona Gold Advantage (HMO-POS)	Gold Kidney of Arizona Gold Loyalty (HMO-POS)
<p><b>Mental Health Services</b></p> <ul style="list-style-type: none"> <li>Outpatient therapy with a psychiatrist</li> <li>Outpatient therapy with a mental health care professional (non-psychiatrist)</li> </ul>	<p>You pay \$25 copay in-network for individual sessions.  You pay \$25 copay out-of-network.  You pay \$25 copay in-network for group sessions.  You pay \$25 copay out-of-network.</p> <p>You pay \$25 copay in-network for individual sessions.  You pay \$25 copay out-of-network.  You pay \$10 copay in-network for group sessions.  You pay \$10 copay out-of-network.</p>	<p>You pay \$45 copay in-network for individual sessions.  You pay \$45 copay out-of-network.  You pay \$45 copay in-network for group sessions.  You pay \$45 copay out-of-network.</p> <p>You pay \$45 copay in-network for individual sessions.  You pay \$45 copay out-of-network.  You pay \$45 copay in-network for group sessions.  You pay \$45 copay out-of-network.</p>
<p><b>Skilled Nursing Facility (SNF)</b></p>	<p>Inpatient hospital stay is not required prior to admission.</p> <p>For in-network SNF stays, you pay:  \$0 copay per day for days 1-20;  \$214 copay per day for days 21-100</p> <p>For out-of-network stays, you pay:  \$0 copay per day for days 1-20;  \$214 copay per day for days 21-100</p>	<p>Inpatient hospital stay is not required prior to admission.</p> <p>For in-network SNF stays, you pay:  \$0 copay per day for days 1-20;  \$214 copay per day for days 21-100</p> <p>For out-of-network stays, you pay:  \$0 copay per day for days 1-20;  \$214 copay per day for days 21-100</p>
<p><b>Physical Therapy</b></p>	<p>You pay \$35 copay in-network.  You pay \$35 copay out-of-network.</p>	<p>You pay \$35 copay in-network.  You pay \$35 copay out-of-network.</p>

<b>Premiums and Benefits</b>	<b>Gold Kidney of Arizona Gold Advantage (HMO-POS)</b>	<b>Gold Kidney of Arizona Gold Loyalty (HMO-POS)</b>
<b>Ambulance</b>	<p>You pay \$200 copay in-network for ground ambulance services.</p> <p>You pay \$200 copay out-of-network.</p> <p>You pay 20% coinsurance in-network for air ambulance services.</p> <p>You pay 20% coinsurance out-of-network.</p>	<p>You pay \$250 copay in-network for ground ambulance services.</p> <p>You pay \$250 copay out-of-network.</p> <p>You pay 20% coinsurance in-network for air ambulance services.</p> <p>You pay 20% coinsurance out-of-network.</p>
<b>Transportation</b>	<p>Not covered.</p>	<p>Not covered.</p>
<b>Medicare Part B Drugs</b>	<p>You pay \$35 copay in-network for Medicare Part B insulin drugs.</p> <p>You pay \$35 maximum copay out-of-network.</p> <p>You pay 0% to 20% coinsurance in-network for Medicare Part B chemotherapy and radiation drugs.</p> <p>You pay 0% to 20% coinsurance out-of-network.</p> <p>You pay 0% to 20% coinsurance in-network for other Medicare Part B drugs.</p> <p>You pay 0% to 20% coinsurance out-of-network.</p>	<p>You pay \$35 copay in-network for Medicare Part B insulin drugs.</p> <p>You pay \$35 maximum copay out-of-network.</p> <p>You pay 0% to 20% coinsurance in-network for Medicare Part B chemotherapy and radiation drugs.</p> <p>You pay 0% to 20% coinsurance out-of-network.</p> <p>You pay 0% to 20% coinsurance in-network for other Medicare Part B drugs.</p> <p>You pay 0% to 20% coinsurance out-of-network.</p>

# Prescription Drugs

This is a summary of prescription drug coverage and cost sharing for our plans. For more information, see the *Evidence of Coverage* on our website at [www.goldkidney.com](http://www.goldkidney.com).

	Gold Kidney of Arizona Gold Advantage (HMO-POS)			Gold Kidney of Arizona Gold Loyalty (HMO-POS)
<b>Deductible Stage</b>	You do not pay a deductible.			Does not include Part D prescription drugs.
<b>Initial Coverage Stage (one-month supply)</b>	You stay in the Initial Coverage Stage until you have paid \$2,000 out of pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).			
	<b>Standard Retail Rx</b> 30-day supply	<b>Long-term Care Rx</b> 31-day supply	<b>Out-of-network Rx</b> 30-day supply	
Tier 1 Preferred Generic:	\$0 copay	\$0 copay	\$0 copay	
Tier 2 Generic:	\$5 copay	\$5 copay	\$5 copay	
<i>Insulin drugs</i>	\$5 copay			
Tier 3 Preferred Brand:	\$47 copay	\$47 copay	\$47 copay	
<i>Insulin drugs</i>	\$35 copay			
Tier 4 Non-Preferred Brand:	\$100 copay	\$100 copay	\$100 copay	
Tier 5 Specialty Tier:	33% coinsurance	33% coinsurance	33% coinsurance	
<b>Initial Coverage Stage (long-term supply)</b>	You stay in the Initial Coverage Stage until you have paid \$2,000 out of pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).			
	<b>Standard Retail Rx</b> 100-day supply	<b>Mail Order Rx</b> 100-day supply		
Tier 1 Preferred Generic:	\$0 copay	\$0 copay		
Tier 2 Generic:	\$12 copay	\$5 copay		
<i>Insulin drugs</i>	\$12 copay			
Tier 3 Preferred Brand:	\$117 copay	\$40 copay		
<i>Insulin drugs</i>	\$105 copay			
Tier 4 Non-Preferred Brand:	\$250 copay	\$250 copay		
Tier 5 Specialty Tier:	A long-term supply is not available for drugs in Tier 5.	Mail order is not available for drugs in Tier 5.		

	<b>Gold Kidney of Arizona Gold Advantage (HMO-POS)</b>	<b>Gold Kidney of Arizona Gold Loyalty (HMO-POS)</b>
<b>Catastrophic Coverage Stage</b>	<p>You enter the Catastrophic Coverage Stage when your out-of-pocket costs have reached the \$2,000 limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year.</p> <p>During this stage, you pay nothing for Part D drugs.</p>	Does not include Part D prescription drugs.

## Additional Benefits

These plans provide additional benefits. For more information, see the *Evidence of Coverage* on our website at [www.goldkidney.com](http://www.goldkidney.com).

<b>Additional Benefits</b>	<b>Gold Kidney of Arizona Gold Advantage (HMO-POS)</b>	<b>Gold Kidney of Arizona Gold Loyalty (HMO-POS)</b>
<b>Companionship (In-Home Support Services)</b>	<p>\$0 copay in-network for companionship services rendered by nonclinical personal caregivers. Light housekeeping, light yard work, technology assistance up to 60 hours.</p> <p>Not covered out-of-network.</p>	<p>\$0 copay in-network for companionship services rendered by nonclinical personal caregivers. Light housekeeping, light yard work, technology assistance up to 60 hours.</p> <p>Not covered out-of-network.</p>
<b>Dialysis Services</b>	20% coinsurance in- and out-of-network for Medicare-covered dialysis services.	20% coinsurance in- and out-of-network for Medicare-covered dialysis services.

<b>Additional Benefits</b>	<b>Gold Kidney of Arizona Gold Advantage (HMO-POS)</b>	<b>Gold Kidney of Arizona Gold Loyalty (HMO-POS)</b>
<p><b>Fitness</b></p> <p>You have access to fitness locations that may include equipment, exercise classes, pools and other available amenities.</p> <p>Home-based fitness kits and online resources and supports are also available. This benefit is administrated by the Silver&amp;Fit program by American Specialty Health.</p>	<p>\$0 copay for Silver&amp;Fit gymnasium access in-network.</p> <p>Fitness benefit is not covered out-of-network.</p>	<p>\$0 copay for Silver&amp;Fit gymnasium access in-network.</p> <p>Fitness benefit is not covered out-of-network.</p>

Additional Benefits	Gold Kidney of Arizona Gold Advantage (HMO-POS)	Gold Kidney of Arizona Gold Loyalty (HMO-POS)
<p><b>Gold Perks</b></p> <p>The Gold Perks Package is a new combined benefit package that offers you the flexibility to choose how to use your allowance funds to purchase select services that best suit your needs using the pre-paid benefits card provided to you.</p>	<p>Gold Perks Package has a combined benefit of \$50 maximum plan allowance amount every month for the following benefits:</p> <p><u>Over-the Counter (OTC) Supplies</u></p> <p>Unused allowance does not carry forward to the next month. Members may use the combined allowance to purchase a variety of commonly used products to support and maintain your general health. OTC items may be purchased only for the member. This benefit consists of Medicare approved over-the-counter (OTC) items and includes protein shakes, vitamins and minerals. These benefits are limited to OTC items available from the plan's OTC vendor marketplace or participating plan merchants.</p> <p><u>Therapeutic Massage</u></p> <p>Unused allowance does not carry forward to the next month. Members may use the combined allowance to purchase therapeutic massage services from an entity licensed/certified to provide therapeutic massage services in accordance with state rules and regulations and able to accept payment via the plan payment card.</p> <p><u>Fitness Activity Allowance</u></p> <p>Unused allowance does not carry forward to the next month. Members may use the combined allowance to pay for fitness activity fees. This benefit is in addition to their Silver&amp;Fit gym membership.</p>	<p>Gold Perks Package has a combined benefit of \$50 maximum plan allowance amount every month for the following benefits:</p> <p><u>Over-the Counter (OTC) Supplies</u></p> <p>Unused allowance does not carry forward to the next month. Members may use the combined allowance to purchase a variety of commonly used products to support and maintain your general health. OTC items may be purchased only for the member. This benefit consists of Medicare approved over-the-counter (OTC) items and includes protein shakes, vitamins and minerals. These benefits are limited to OTC items available from the plan's OTC vendor marketplace or participating plan merchants.</p> <p><u>Therapeutic Massage</u></p> <p>Unused allowance does not carry forward to the next month. Members may use the combined allowance to purchase therapeutic massage services from an entity licensed/certified to provide therapeutic massage services in accordance with state rules and regulations and able to accept payment via the plan payment card.</p> <p><u>Fitness Activity Allowance</u></p> <p>Unused allowance does not carry forward to the next month. Members may use the combined allowance to pay for fitness activity fees. This benefit is in addition to their Silver&amp;Fit gym membership.</p>



Additional Benefits	Gold Kidney of Arizona Gold Advantage (HMO-POS)	Gold Kidney of Arizona Gold Loyalty (HMO-POS)
<b>Gold Perks continued</b>	<p>The fitness activity allowance is a benefit that provides a spending allowance that may be used for access fees required at sports facilities for dance, golf, swimming, tennis, or other fitness related activity. The allowance cannot be applied to merchandise, food, or sport leagues or club sport memberships, competitions, social programs, park fees or other services.</p> <p><u>Home and Bathroom Safety Devices</u></p> <p>Unused allowance does not carry forward to the next month. Members may use the combined allowance to purchase elevated toilet seats, safety frames and risers.</p>	<p>The fitness activity allowance is a benefit that provides a spending allowance that may be used for access fees required at sports facilities for dance, golf, swimming, tennis, or other fitness related activity. The allowance cannot be applied to merchandise, food, or sport leagues or club sport memberships, competitions, social programs, park fees or other services.</p> <p><u>Home and Bathroom Safety Devices</u></p> <p>Unused allowance does not carry forward to the next month. Members may use the combined allowance to purchase elevated toilet seats, safety frames and risers.</p>
<b>Personal Emergency Response System (PERS) benefit</b>	<p>PERS is a medical alert system, that provides continuous in-home and mobile monitoring. You receive a mobile PERS device with GPS, fall detection, and links to other Plan services, as well as access to trained professionals to assess the nature of the call and coordinate the assistance 24 hours/day, 7 days/week, 365 days/year monitoring.</p> <p>\$0 copay in-network for the personal emergency response system (PERS) benefit.</p> <p>Not covered out-of-network.</p>	<p>PERS is a medical alert system, that provides continuous in-home and mobile monitoring. You receive a mobile PERS device with GPS, fall detection, and links to other Plan services, as well as access to trained professionals to assess the nature of the call and coordinate the assistance 24 hours/day, 7 days/week, 365 days/year monitoring.</p> <p>\$0 copay in-network for the personal emergency response system (PERS) benefit.</p> <p>Not covered out-of-network.</p>

Additional Benefits	Gold Kidney of Arizona Gold Advantage (HMO-POS)	Gold Kidney of Arizona Gold Loyalty (HMO-POS)
<p><b>Preventive Rewards &amp; Incentives</b></p> <p>Your benefit allows you to earn extra rewards for completing preventive services and participating in plan surveys.</p> <p>Reward funds may be used for purchases at participating vendors.</p>	<p>Earn up to a total of \$300 for the completion of various plan preventive activities and surveys.</p> <p>Completion of:</p> <ul style="list-style-type: none"> <li>• Member Portal Registration</li> <li>• Health Risk Assessment</li> <li>• Annual Wellness Visit</li> <li>• Flu/Covid Vaccine</li> <li>• Diabetes Eye Exam</li> <li>• Fall Risk Assessment</li> <li>• Bladder Control Assessment</li> <li>• 2 HbA1c tests</li> <li>• Post-Inpatient Medication Reconciliation in 14 days</li> <li>• Post-ER PCP visit in 7 days</li> <li>• Cancer Screenings: <ul style="list-style-type: none"> <li>○ Colon</li> <li>○ Prostate</li> <li>○ Cervical</li> <li>○ Mammogram</li> </ul> </li> <li>• Plan Surveys: <ul style="list-style-type: none"> <li>○ PCP Visit Survey</li> <li>○ Mock CAHPS Survey</li> </ul> </li> </ul>	<p>Earn up to a total of \$300 for the completion of various plan preventive activities and surveys.</p> <p>Completion of:</p> <ul style="list-style-type: none"> <li>• Member Portal Registration</li> <li>• Health Risk Assessment</li> <li>• Annual Wellness Visit</li> <li>• Flu/Covid Vaccine</li> <li>• Diabetes Eye Exam</li> <li>• Fall Risk Assessment</li> <li>• Bladder Control Assessment</li> <li>• 2 HbA1c tests</li> <li>• Post-Inpatient Medication Reconciliation in 14 days</li> <li>• Post-ER PCP visit in 7 days</li> <li>• Cancer Screenings: <ul style="list-style-type: none"> <li>○ Colon</li> <li>○ Prostate</li> <li>○ Cervical</li> <li>○ Mammogram</li> </ul> </li> <li>• Plan Surveys: <ul style="list-style-type: none"> <li>○ PCP Visit Survey</li> <li>○ Mock CAHPS Survey</li> </ul> </li> </ul>

# Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at 1 (844) 294-6535 (TTY 711).

## HOURS OF OPERATION

October 1 through March 31: 8 a.m.–8 p.m., 7 days a week (except holidays)

April 1 through September 30: 8 a.m.–8 p.m., Monday through Friday (except holidays)

## Understanding the Benefits

- The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit [Goldkidney.com](http://Goldkidney.com) or call **1 (844) 294-6535 (TTY 711)** to view a copy of the EOC.
- Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- Review the pharmacy directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- Review the formulary to make sure your drugs are covered.

## Understanding Important Rules

- Effect on Current Coverage:** If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage healthcare coverage will end once your new Medicare Advantage coverage starts. If you have Tricare, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact Tricare for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.
- Medicare Part B:** In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- Chronic Special Needs Plan (C-SNP):** This plan is a chronic condition special needs plan (C-SNP). Your ability to enroll will be based on verification that you have a qualifying specific severe or disabling chronic condition.
- HMO-POS:** Our plan allows you to see providers outside of our network (non-contracted providers). However, while we pay for covered services, the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care.

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## LET'S CHECK IF YOU CAN JOIN A PLAN RIGHT NOW

Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes, you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

- I am enrolling during the annual enrollment period from October 15 through December 7.
- I am new to Medicare (Turning 65 in the next 3 months or reaching 24th month of disability).
- I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).
- I recently moved outside of the service area for my current plan, or I recently moved, and this plan is a new option for me. I moved on (insert date) \_\_\_\_\_.
- I recently was released from incarceration. I was released on (insert date) \_\_\_\_\_.
- I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) \_\_\_\_\_.
- I recently obtained lawful presence status in the United States. I got this status on (insert date) \_\_\_\_\_.
- I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date) \_\_\_\_\_.
- I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date) \_\_\_\_\_.
- I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.
- I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long-term care facility). I moved/will move into/out of the facility on (insert date) \_\_\_\_\_.
- I recently left a PACE program on (insert date) \_\_\_\_\_.
- I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date) \_\_\_\_\_.
- I am leaving employer or union coverage on (insert date) \_\_\_\_\_.
- I belong to a pharmacy assistance program provided by my state.
- My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date) \_\_\_\_\_.
- I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date) \_\_\_\_\_.
- I was affected by a weather-related emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA)). One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster.

If none of these statements applies to you or you're not sure, please contact Gold Kidney Health Plan at (888) 376-6188 (TTY 711) to see if you are eligible to enroll. We are available October 1 through March 31 from 8:00 a.m. to 8:00 p.m. local time, 7 days a week (except holidays), and from April 1 through September 30 from 8:00 a.m. to 8:00 p.m. local time, Monday through Friday (except holidays).

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## INDIVIDUAL ENROLLMENT REQUEST FORM TO ENROLL IN A MEDICARE ADVANTAGE PLAN (PART C)

### Who can use this form?

People with Medicare who want to join a Medicare Advantage Plan

### To join a plan, you must:

- Be a United States citizen or be
- lawfully present in the U.S.
- Live in the plan's service area

**Important:** To join a Medicare Advantage Plan, you must also have both:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)

### When do I use this form?

You can join a plan:

- Between October 15–December 7 each year (for coverage starting January 1)
- Within 3 months of first getting Medicare
- In certain situations where you're allowed to join or switch plans

Visit [Medicare.gov](http://Medicare.gov) to learn more about when you can sign up for a plan.

### What do I need to complete this form?

- Your Medicare Number (the number on your red, white, and blue Medicare card)
- Your permanent address and phone number

**Note:** You must complete all items in Section 1. The items in Section 2 are optional — you can't be denied coverage because you don't fill them out.

### Reminders:

- If you want to join a plan during fall open enrollment (October 15–December 7), the plan must get your completed form by December 7.
- Your plan will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

### What happens next?

Send your completed and signed form to:

Gold Kidney Health Plan Attn: Enrollment  
P.O. Box 285 Portsmouth, NH 03802

Or, fax the completed form to (866) 370-0078.

Once they process your request to join, they'll contact you.

### How do I get help with this form?

Call Gold Kidney Health Plan at 844-294-6535. TTY users can call 711. Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

**En español:** Llame a Gold Kidney Health Plan al 844-294-6535/TTY 711 o a Medicare gratis al 1-800-633-4227 y oprima el 8 para asistencia en español y un representante estará disponible para asistirle.

### Individuals experiencing homelessness

If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g., social security checks) may be considered our permanent residence address.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1378. The time required to complete this information is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

#### IMPORTANT

**Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan. See "What happens next?" on this page to send your completed form to the plan.**

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**Section 1 – All fields on this page are required (unless marked optional)**

**Select the plan you want to join:**

Counties: Cochise, Coconino, Gila, Graham, Maricopa, Navajo, Pima, Pinal

**Gold Advantage**  
**(HMO-POS MA-PD) H4869-005**  
\$0 per month

**Gold Loyalty**  
**(HMO-POS MA) H4869-009**  
\$0 per month

First Name:

Last Name:

Middle Initial (Optional):

Birth Date: (MM/DD/YYYY)

( \_\_\_/\_\_\_/\_\_\_\_ )

Sex:

Male  Female

Phone Number:

( \_\_\_ ) \_\_\_ - \_\_\_\_

Permanent residence street address (don't enter a P.O. Box. Note: For individuals experiencing homelessness, a PO Box may be considered your permanent residence address.):

City:

County (Optional):

State:

ZIP Code:

Mailing address, if different from your permanent address (PO Box allowed):

Street address:

City:

State:

ZIP Code:

**Your Medicare information**

Medicare Number:

\_\_\_\_ - \_\_\_\_ - \_\_\_\_

**Answer these important questions:**

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Gold Kidney Health Plan?  Yes  No

Name of other coverage:

Member number for this coverage:

Group number for this coverage:

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**IMPORTANT: Read and sign below:**

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Gold Kidney Health Plan.
- By joining this Medicare Advantage plan, I acknowledge that Gold Kidney Health Plan will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below). Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- I understand that I can be enrolled in only one MA plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA PFFS, MA MSA plans).
- I understand that when my Gold Kidney Health Plan coverage begins, I must get all of my medical and prescription drug benefits from Gold Kidney Health Plan. Benefits and services provided by Gold Kidney Health Plan and contained in my Gold Kidney Health Plan “Evidence of Coverage” document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Gold Kidney Health Plan will pay for benefits or services that are not covered.
- The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.
- I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (as described above), this signature certifies that:
  - 1) This person is authorized under State law to complete this enrollment, and
  - 2) Documentation of this authority is available upon request by Medicare.

<b>Signature</b>	<b>Today’s date:</b>
------------------	----------------------

**If you’re the authorized representative, sign above and fill out these fields:**

Name:	
Address:	
Phone number:	Relationship to enrollee:

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## Section 2 – All fields in this section are optional

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

- |   |  |
|---|--|
| <input type="checkbox"/> No, not of Hispanic, Latino/a, or Spanish origin   | <input type="checkbox"/> Yes, Mexican, Mexican American, Chicano/a |
| <input type="checkbox"/> Yes, Puerto Rican                                  | <input type="checkbox"/> Yes, Cuban                                |
| <input type="checkbox"/> Yes, another Hispanic, Latino/a, or Spanish origin | <input type="checkbox"/> <b>I choose not to answer.</b>            |

What's your race? Select all that apply.

- |   |   |
|---|---|
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Black or African American      |
| Asian:  | Native Hawaiian and Pacific Islander:                   |
| <input type="checkbox"/> Asian Indian                     | <input type="checkbox"/> Guamanian or Chamorro          |
| <input type="checkbox"/> Chinese                          | <input type="checkbox"/> Native Hawaiian                |
| <input type="checkbox"/> Filipino                         | <input type="checkbox"/> Samoan                         |
| <input type="checkbox"/> Japanese                         | <input type="checkbox"/> Other Pacific Islander         |
| <input type="checkbox"/> Korean                           | <input type="checkbox"/> White                          |
| <input type="checkbox"/> Vietnamese                       | <input type="checkbox"/> <b>I choose not to answer.</b> |
| <input type="checkbox"/> Other Asian                      |   |

What is your gender? Select one.

- |                                     |  |
|-------------------------------------|--|
| <input type="checkbox"/> Woman      | <input type="checkbox"/> I use a different term: _____ |
| <input type="checkbox"/> Man        | <input type="checkbox"/> <b>I choose not to answer</b> |
| <input type="checkbox"/> Non-binary |  |

Which of the following best represents how you think of yourself? Select one.

- |  |  |
|--|--|
| <input type="checkbox"/> Lesbian or gay                        | <input type="checkbox"/> I use a different term: _____ |
| <input type="checkbox"/> Straight, that is, not gay or lesbian | <input type="checkbox"/> Not sure                      |
| <input type="checkbox"/> Bisexual                              | <input type="checkbox"/> <b>I choose not to answer</b> |

Select one if you want us to send you information in a language other than English.

- Spanish

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Select one if you want us to send you information in an accessible format.

- Braille     Large print     Audio CD     Data CD

Please contact Gold Kidney Health Plan Member Services at (844) 294-6535 if you need information in an accessible format other than what's listed above. Our office hours are 8:00 am to 8:00 pm from October 1 through March 31, 7 days a week; and from April 1 through September 30, 8:00 am to 8:00 pm, Monday through Friday. TTY users can call 711.

Do you work?     Yes     No

Does your spouse work?     Yes     No

List your Primary Care Physician (PCP), clinic, or health center:

I want to get the following materials via email. Select one or more.

- Summary of Benefits     Evidence of Coverage     Annual Notice of Change  
 Required Operational Documents     General Member Correspondence

E-mail Address:

I want to receive SMS / Text messaging from Gold Kidney Health Plan for general member correspondence and alerts.

Phone Number:    ( \_\_\_ \_\_\_ ) \_\_\_ \_\_\_ - \_\_\_ \_\_\_

*Your carrier may charge for SMS messages. You can opt-out of SMS messaging at any time by calling us at (844) 294-6535 (TTY 711).*

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## Paying your plan premiums

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail or “Electronic Funds Transfer (EFT)” or “credit card” each month. **You can also choose to pay your premium by having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month.**

**If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium. DON'T pay Gold Kidney Health Plan the Part D-IRMAA.**

### Please select a premium payment option

- Monthly Invoice**
- Automatic deduction from your monthly Social Security (SSA) or Railroad Retirement Board (RRB) check.**

The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.

- Credit Card Payment**
- Electronic funds transfer (EFT) from your bank account each month.**

## For individuals helping enrollee with completing this form only

Complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, family members, or other third parties) helping an enrollee fill out this form.

Name:	Relationship to enrollee:
Signature:	National Producer Number (Agents/Brokers only):

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**GOLD KIDNEY HEALTH PLAN ADMINISTRATIVE SECTION**  
*(Licensed Agent Use Only)*

Plan ID #	Effective Date of Coverage:
<b>Licensed Sales Agent received date:</b>	
<b>Licensed Sales Agent signature (required):</b>	

**PRIVACY ACT STATEMENT**

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 of the Social Security Act and 42 CFR §§ 422.50 and 422.60 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

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PLEASE ANSWER ALL QUESTIONS

Contact Information	
First Name	Last Name
Phone Number	Date of Birth
MBI	Gold Kidney ID Number
INTERNAL USE ONLY Type of assessment (to be completed by case manager) <input type="checkbox"/> Initial <input type="checkbox"/> Annual <input type="checkbox"/> TOC	
Language / Cultural	
<p>1. Do you have a language preference other than English?</p> <p><input type="checkbox"/> Yes    <input type="checkbox"/> No    <input type="checkbox"/> Unable to assess    <input type="checkbox"/> Declined to answer</p> <p>If yes, which language?</p> <p><input type="checkbox"/> Arabic   <input type="checkbox"/> Chinese    <input type="checkbox"/> French    <input type="checkbox"/> German    <input type="checkbox"/> Hindi</p> <p><input type="checkbox"/> Korean   <input type="checkbox"/> Navajo    <input type="checkbox"/> Spanish    <input type="checkbox"/> Tagalog    <input type="checkbox"/> Vietnamese</p> <p><input type="checkbox"/> Other _____</p>	
<p>2. Are there any specific cultural or religious beliefs that may affect your health care?</p> <p><input type="checkbox"/> Yes    <input type="checkbox"/> No    <input type="checkbox"/> Unable to assess    <input type="checkbox"/> Declined to answer</p> <p>If yes, which of the following?</p> <p><input type="checkbox"/> Amish   <input type="checkbox"/> Baha'i    <input type="checkbox"/> Buddhism   <input type="checkbox"/> Christianity   <input type="checkbox"/> Hindu</p> <p><input type="checkbox"/> Jehovah's Witness    <input type="checkbox"/> Judaism    <input type="checkbox"/> Muslim    <input type="checkbox"/> Seventh-day Adventist</p> <p><input type="checkbox"/> Sikh    <input type="checkbox"/> Other _____</p> <p>If any of the above boxes are marked, what are the specifics of those beliefs?</p> <p>_____</p>	



**3. What is your race?**

- |   |   |
|---|---|
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Native Hawaiian      |
| <input type="checkbox"/> Asian Indian                     | <input type="checkbox"/> Samoan               |
| <input type="checkbox"/> Black or African American        | <input type="checkbox"/> Vietnamese           |
| <input type="checkbox"/> Chinese                          | <input type="checkbox"/> White                |
| <input type="checkbox"/> Filipino                         | <input type="checkbox"/> Other Asian Other    |
| <input type="checkbox"/> Guamanian or Chamorro            | <input type="checkbox"/> Pacific Islander     |
| <input type="checkbox"/> Japanese                         | <input type="checkbox"/> Prefer not to answer |
| <input type="checkbox"/> Korean                           |   |

**4. What is your ethnicity?**

- |  |   |
|--|---|
| <input type="checkbox"/> Not of Hispanic, Latino/a or Spanish origin | <input type="checkbox"/> Another Hispanic, Latino or Spanish origin |
| <input type="checkbox"/> Puerto Rican                                | <input type="checkbox"/> Prefer not to answer                       |
| <input type="checkbox"/> Mexican, Mexican American, Chicano/a        |   |
| <input type="checkbox"/> Cuban                                       |   |

**5. What is the highest level of education you have completed?**

- |  |  |
|--|--|
| <input type="checkbox"/> 8th grade or less           | <input type="checkbox"/> College Degree  |
| <input type="checkbox"/> High School Graduate or GED | <input type="checkbox"/> Advanced Degree |
| <input type="checkbox"/> Some College                |  |

**General**

**6. In general, how would you rate your current health?**

- |   |   |                               |                               |                               |
|---|---|-------------------------------|-------------------------------|-------------------------------|
| <input type="checkbox"/> Excellent        | <input type="checkbox"/> Very good          | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor |
| <input type="checkbox"/> Unable to assess | <input type="checkbox"/> Declined to answer |                               |                               |                               |

Are there specific reasons that made you answer the question the way you did?

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**Activity / Exercise**

7. How is your current activity level?

- Same as 3 months ago
- Better than 3 months ago
- Worse than 3 months ago
- Unable to assess
- Declined to answer

8. Do you use any of the following assistive devices in your home?

- Cane
- Walker
- Crutches
- Manual Wheelchair
- Scooter
- Powered Wheelchair
- None
- Other \_\_\_\_\_

**Substance Use**

9. How often do you use alcohol?

- Never
- Sometimes
- Often
- Very often
- Unable to assess
- Declined to answer

10. Do you use illegal substances or medications not prescribed to you?

- Yes
- No
- Unable to assess
- Declined to answer

If yes, do you want to quit using illegal substances or medications not prescribed to you?

- Yes
- No
- Unable to assess
- Declined to answer

11. Do you use tobacco / nicotine products such as e-cigarettes / vape or dip / chew?

- Yes
- No
- Unable to assess
- Declined to answer

If yes, do you want to quit smoking or using tobacco / nicotine products?

- Yes
- No
- Unable to assess
- Declined to answer

**Mental Health**

12. Over the past 2 weeks, how often have you had little interest or pleasure in doing things?

- Not at all (0)
- Several days (1)
- More than half the days (2)
- Nearly every day (3)

13. Over the past 2 weeks, how often have you been feeling down, depressed, or hopeless?

- Not at all (0)
- Several days (1)
- More than half the days (2)
- Nearly every day (3)

*(Note: If the total score for these PHQ-2 questions is 3 or greater than 3, it should auto-trigger additional PHQ-9 questions with potential case management referral.)*



**Vaccination**

14. Have you had a flu shot / vaccine?

- Yes     No     Unable to assess     Declined to answer

If so, when was your last flu shot / vaccine? Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

15. Have you had a Td/Tdap shot / vaccine in the last 9 years?

- Yes     No     Unable to assess     Declined to answer

16. If over the age of 50, have you had a shingle shot / vaccine any time after you turned 50?

- Yes     No     Unable to assess     Declined to answer

17. Have you had a pneumococcal shot / vaccine?

- Yes     No     Unable to assess     Declined to answer

If yes, how many?

- 1st dose     2nd dose     Booster     Unable to assess

- Declined to answer

18. Have you had a Hepatitis immunization shot?

If yes, how many?

- One dose     Two doses     Three doses     Unable to assess

- Declined to answer

If yes, when was your last Hepatitis immunization shot? Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Chronic Conditions**

19. Has a doctor ever told you that you have the following?

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Diabetes or Prediabetes | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Kidney disease  |
| <input type="checkbox"/> Heart disease           | <input type="checkbox"/> Asthma              | <input type="checkbox"/> COPD            |
| <input type="checkbox"/> HIV / AIDS              | <input type="checkbox"/> Stroke              | <input type="checkbox"/> Cancer          |
| <input type="checkbox"/> Bipolar disorder        | <input type="checkbox"/> Depression          | <input type="checkbox"/> Schizophrenia   |
| <input type="checkbox"/> Dementia                | <input type="checkbox"/> Hearing problems    | <input type="checkbox"/> Vision problems |
| <input type="checkbox"/> None                    | <input type="checkbox"/> Other _____         |  |

*(Note: Specific assessments should auto-trigger for diabetes, kidney disease, heart disease, and lung disease if they are marked in the above question.)*





**Current Care**

20. Do you have a primary care doctor (regular doctor) that you can easily see on a routine basis?

- Yes
- No
- Unable to assess
- Declined to answer

If yes, what is the name and contact information of your primary care doctor?

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21. Do you have other doctors / specialists that you see?

- Yes
- No
- Unable to assess
- Declined to answer

If yes, what is the name and contact information of your specialist as well as what type of doctor are they?

---

22. In the past 3 months, have you visited the emergency room and / or stayed overnight in the hospital?

- Yes
- No
- Unable to assess
- Declined to answer

If yes, how many times and for what reasons?

---

23. Do you use any of the following medical devices in your home?

- Oxygen
- CPAP/BiPAP
- Wound vac
- Insulin pump
- Hospital bed
- None
- Other \_\_\_\_\_

**Activities of Daily Living (ADLs)**

24. Do you need help from others to perform everyday activities such as eating, getting dressed, grooming, getting in and out of chairs, bathing, walking, or using the toilet?

- Yes
- No

If yes, do you get the help you need?

- Yes
- No



**Instrumental Activities of Daily Living (IADLs)**

25. Do you need help from others to take care of things such as laundry and housekeeping, shopping for groceries, using the telephone, cooking or meal preparation, driving or using public transportation, home repair, or taking your own medications?

- Yes  No

If yes, do you get the help you need?

- Yes  No

**Fall**

26. Have you fallen more than once in the past 6 months? (A fall is when your body goes to the ground without being pushed.)

- Yes  No  Unable to assess  Declined to answer

**Living Situation**

If someone chooses the underlined answers, they might have an unmet health-related social need.

27. What is your living situation today?

- I have a steady place to live
- I have a place to live today, but I am worried about losing it in the future
- I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus, or train station, or in a park)
- Other \_\_\_\_\_

28. Think about the place where you live. Do you have problems with any of the following?

CHOOSE ALL THAT APPLY

- Pests such as bugs, ants, or mice
- Mold
- Lead paint or pipes
- Lack of heat
- Oven or stove not working
- Smoke detectors missing or not working
- Water leaks
- None of the above
- Other \_\_\_\_\_



**Food**

Some people have made the following statements about their food situation. Please answer whether the statements were **OFTEN**, **SOMETIMES**, or **NEVER** true for you and your household in the last 12 months.

29. Within the past 12 months, you worried that your food would run out before you got money to buy more.

- Often True                       Sometimes True                       Never True

30. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.

- Often True                       Sometimes True                       Never True

**Transportation**

31. In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?

- Yes             No

**Medication**

32. Do you have any difficulty getting your medications?

- Yes             No

If yes, what is your difficulty in getting your medications?

\_\_\_\_\_

33. Do you understand your medications and how to take them?

- Yes             No                       Unable to assess                       Declined to answer

If no, what is it that you do not understand?

\_\_\_\_\_

**Pain**

**(If a member scores positive, please immediately refer to Case Management)**

34. In the past 7 days, how much pain have you felt?

- None             Some                       A lot

If you have been in pain, specify the location or the cause of the pain.

\_\_\_\_\_



35. Do you have an advance directive? *(An advance directive is a written document expressing your medical care wishes should you be unable to speak for yourself.)*

- Yes       No       Unable to assess       Declined to answer

If no, can we provide you with information regarding advance directives?

- Yes       No       Unable to assess       Declined to answer

**Reporting**

36. Assessment Status:       Pending       Completed       Refused

Completion Date: \_\_\_\_\_

Who completed the form?     Member       Spouse       Family Member or Friend

Please mail the completed form to:

Gold Kidney Health Plan  
Attention: Enrollment Department  
P.O. Box 285  
Portsmouth, NH 03802

# Notice of Non-Discrimination

Gold Kidney Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity). Gold Kidney Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity).

## GOLD KIDNEY HEALTH PLAN

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Customer Service at 1 (844) 294-6535 (TTY 711)

If you believe that Gold Kidney Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity), you can file a grievance with:

Gold Kidney Health Plan – Appeals & Grievances  
P.O. Box 285, Portsmouth, NH 03802  
1 (844) 294-6535 (TTY 711)

Fax: 1 (866) 515-7869

Attention: Gold Kidney Appeals & Grievances Department

You can file a grievance in person, by mail, or fax. If you need help filing a grievance, call 1 (844) 294-6535 (TTY 711).

You can also file a civil rights complaint 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, D.C. 20201  
1 (800) 368-1019, 1 (800) 537-7697 (TDD)

Complaint forms are available at <https://www.hhs.gov/ocr/index.html>

Y0171\_NonDiscrimination\_0824C

## Multi-Language Insert 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 **(844) 294-6535**. 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 **(844) 294-6535**. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

**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。如果您需要此翻译服务，请致电 **(844) 294-6535**。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 **(844) 294-6535**。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 **(844) 294-6535**. 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 **(844) 294-6535**. 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 quý vị cần thông dịch viên xin gọi **(844) 294-6535** sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.

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

**Korean:** 당사는 의료 보험 또는 약품 보험에 관한 질문에 대해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 **(844) 294-6535**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 **(844) 294-6535**. 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 فوري، ليس عليك سوى الاتصال بنا على **(844) 294-6535**. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه 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 **(844) 294-6535** पर फोन करें। कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है। यह एक मुफ्त सेवा है।

**Italian:** È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero **(844) 294-6535**. Un nostro incaricato che parla Italiano 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 **(844) 294-6535**. 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 **(844) 294-6535**. 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 **(844) 294-6535**. 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。通訳をご用命になるには、**(844) 294-6535** 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。

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## Questions

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

**1 (888) 376-6188 (TTY 711)**

## Hours of operation

### **OCTOBER 1 – MARCH 31**

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

### **APRIL 1 – SEPTEMBER 30**

8 a.m. to 8 p.m., local time, Monday through Friday  
(except holidays)

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

Gold Kidney Health Plan, P.O. Box 285, Portsmouth, NH 03802



Gold Kidney Health Plan, Inc., is an HMO-POS and HMO-POS C-SNP with a Medicare contract.

Enrollment in Gold Kidney Health Plan depends on contract renewal.

Gold Kidney Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity).

Out-of-network/non-contracted providers are under no obligation to treat Plan members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.