GOLD KIDNEY HEALTH PLAN

# 2025

# Enrollment Guide

**Gold Kidney of Arizona Gold Circle Dialysis** (HMO-POS C-SNP)

H4869_PEK_DY_AZ_0824M

# 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

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# Gold Kidney Health Plan

Our story began by partnering with and listening to doctors and individuals eligible for Medicare struggling to manage their chronic health conditions. Often these individuals end up with high copays for needed treatments to manage their health. This can limit care options and make medications unaffordable. But, at Gold Kidney, we are changing that.

Our Medicare Advantage Chronic Special Needs Plans (C-SNPs) are designed with our members' health in mind! We offer low-to-no-member cost for treatments needed to manage chronic conditions, lowering out-of-pocket expenses, while also reducing the barriers to obtaining quality care.

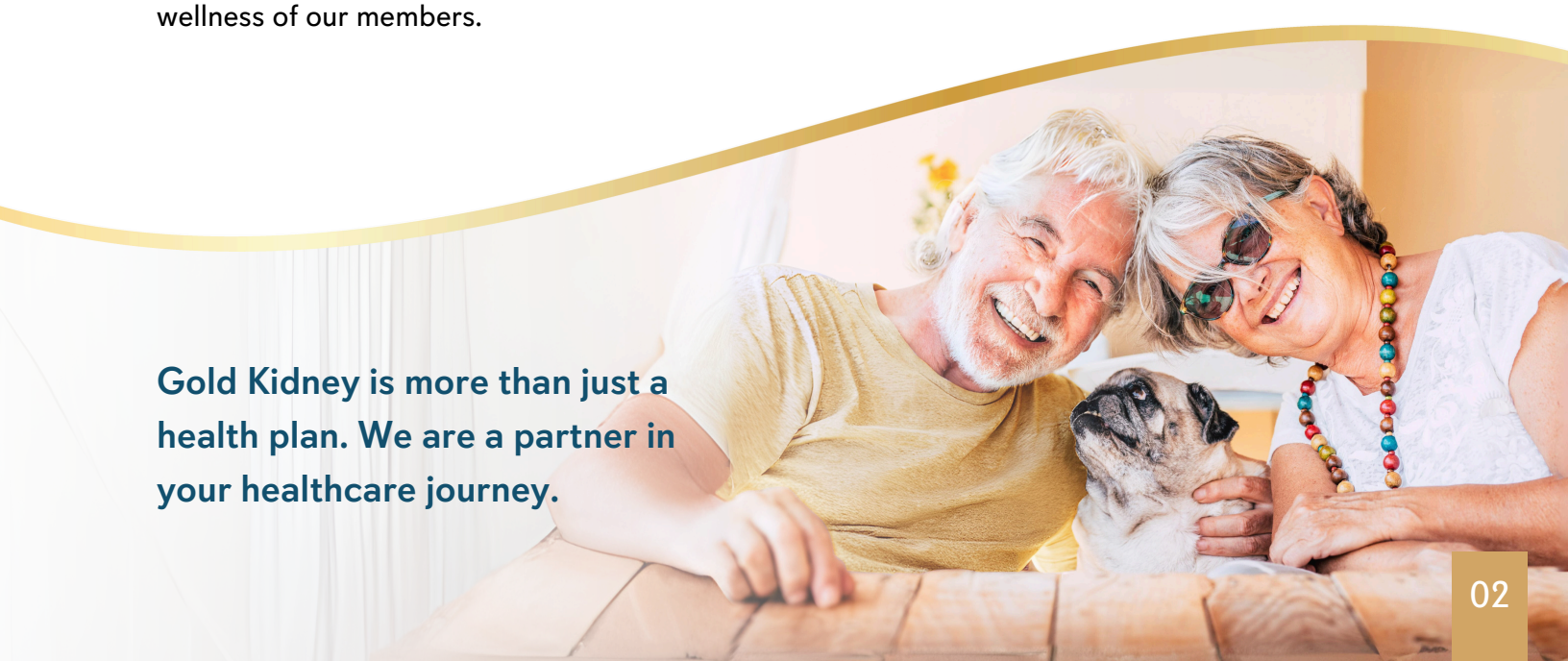
Gold Kidney C-SNP plans are uniquely designed for those living with end-stage renal disease (ESRD), as well as diabetes, cardiovascular disorders, and chronic heart failure (CHF), which can lead to kidney function loss and eventually progress to ESRD. Our goal is to slow the progression of these diseases and improve the health and wellness of our members.

As a Gold Kidney C-SNP member, you will have access to a dedicated care team that includes a:

- Primary care provider
- Specialists for your chronic condition (nephrologist, endocrinologist, cardiologist)
- Nurse care manager
- Pharmacist

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:

- Telehealth services
- Thrive Mobile® smartphone program
- Health education 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
- 4G smartphone with unlimited talk, text, and data*
- Fuel and rideshare* allowances
- Healthy food and produce* allowances
- Allowances for alternative therapy services of a medicine man from a Native American or Indigenous tribe

*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 C-SNP plan member, you have a team of healthcare professionals to assist you based on your unique needs and preferences. Whether you need help coordinating appointments, finding a specialist in your area, or planning for surgery, your care team is right by your side. Your team is comprised of:

- Your primary care provider and specialists
- Nurse care manager
- Pharmacist
- Care coordinator
- 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.

# Special Supplemental Benefits for the Chronically Ill

If you have one or more complex chronic conditions that affect your daily life and health, you may need more care and support than what original Medicare covers. That's why Gold Kidney Health Plan offers Special Supplemental Benefits for the Chronically Ill (SSBCI) for Medicare Advantage C-SNP members who meet certain criteria.

These benefits provide extra services and resources to help you manage your condition and improve your quality of life. To qualify, you must have at least one of the following conditions covered by Gold Kidney Health Plan:

- Cardiovascular disorder
- Chronic heart failure
- Diabetes mellitus
- End-stage renal disease (ESRD)

Please note that an enrollee with one or more of the chronic conditions listed above may not necessarily receive the benefit. To qualify, the member must have at least one qualifying chronic condition listed above and participate in case management. Not all members will qualify.

Gold Kidney members who are eligible for SSBCI are provided with extra benefits including:

### THRIVE MOBILE SMARTPHONE

Stay connected with the Thrive Mobile smartphone brought to you by Gold Kidney. The phone comes with an unlimited talk, text, and 4G cellular data plan, and is pre-loaded with the Gold Kidney Member Portal and health apps to make it easier for you to access health-related care.

### HEALTHY FOOD AND PRODUCE ALLOWANCE*

Make healthy eating easier with a monthly allowance for healthy food and produce items from participating vendors. The allowance can also be used for prepared meals delivered to your home.

### FUEL AND RIDESHARE ALLOWANCE*

Alleviate the burden of transportation costs with a monthly allowance for fuel purchases and rideshare services from participating vendors.

**Purchases must be made using the Alivi Gold Kidney Prepaid Visa® Card.*

# Thrive Smartphone Program*

Gold Kidney C-SNP members with qualifying conditions are eligible for a unique Medicare Advantage benefit. The Thrive 4G smartphone from Gold Kidney will help you stay connected and make accessing healthcare easier.

Thrive Mobile® is our trusted partner for mobile service and devices with unlimited talk, text, and data at no additional cost to you. Your premium smartphone helps you stay connected with your doctors and care team and makes it easier to access helpful information about your coverage and benefits.

After a simple enrollment process through the Thrive Assistant team, the phone arrives with Gold Kidney resources preloaded for one-touch access. The phone uses the T-Mobile cellular network that covers 99% of Americans including our members in Arizona and Florida.

## Ready to enroll in our Thrive Smartphone program? It's easy as 1-2-3:


STEP 1

Call Gold Kidney Member Services at (844) 294-6535 to determine your eligibility

STEP 2

Complete your 10-minute Thrive Mobile enrollment process with a Thrive Assistant

STEP 3

Unbox and start using your phone to access Gold Kidney benefits and partners

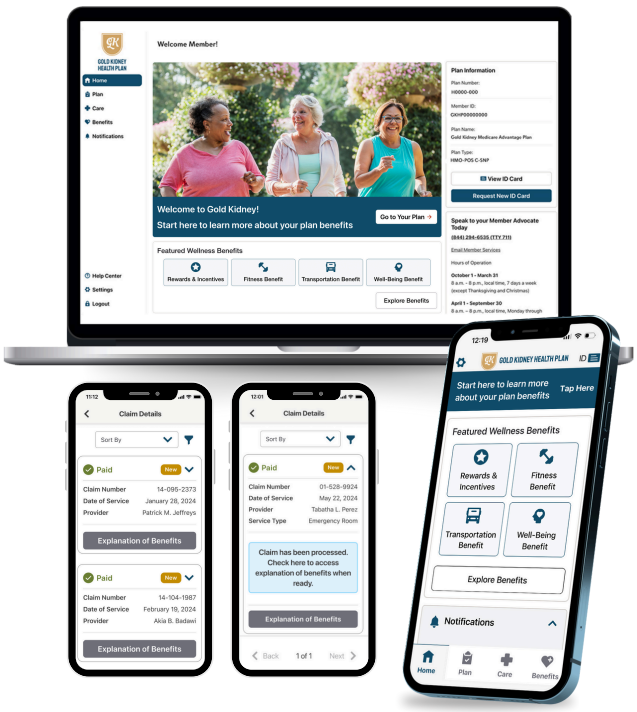
*Not all C-SNP Medicare Advantage members will qualify*

# 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 a Gold Kidney C-SNP Medicare Advantage plan enjoy exclusive 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 six chronic condition Medicare Advantage health plans in your county.**

### Gold Heart & Diabetes (HMO-POS C-SNP) H4869-001 / H4869-011

For those who are Medicare-eligible with cardiovascular disorders, chronic heart failure, and/or diabetes.

### Gold Dialysis (HMO-POS C-SNP) H4869-003 / H4869-013

For those who are Medicare-eligible and have end-stage renal disease (ESRD), generally requiring dialysis.

### Gold Circle Heart & Diabetes (HMO-POS C-SNP) H4869-010

For those with heart and diabetes conditions who have access to other forms of coverage but want a traditional Medicare plan plus additional benefits.

### Gold Circle Dialysis (HMO-POS C-SNP) H4869-012

For those Medicare-eligible who are on dialysis and have access to other forms of coverage.

### Gold Heart & Diabetes Complete (HMO-POS C-SNP) H4869-002

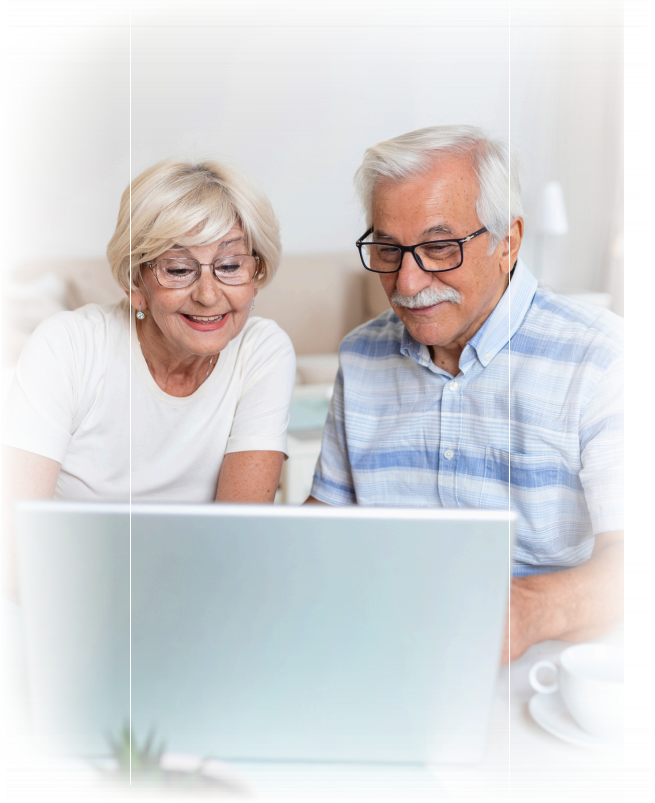
For those who are Medicare- and Medicaid-eligible with cardiovascular disorders, chronic heart failure, and/or diabetes.

### Gold Dialysis Complete (HMO-POS C-SNP) H4869-004

For those who are Medicare- and Medicaid-eligible with end-stage renal disease (ESRD), generally requiring dialysis.

# How to enroll

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



## COMPLETE YOUR APPLICATION ONLINE

- Visit 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
  P.O. 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

Once your enrollment is confirmed by the Center for Medicare and Medicaid Services (CMS), you will receive a member ID card in the mail from Gold Kidney. 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.)

- ☐ **Stand-alone Medicare Prescription Drug Plans**
- ☐ **Medicare Advantage Plans (Part C) Cost Plans**
- ☐ **Dental/Vision/Hearing Products**
- ☐ **Medicare Supplement (Medigap) Products**

**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:** | |

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

**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.

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

**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).

**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.

**Medicare Private Fee-For-Service (PFFS) Plan:** A Medicare Advantage Plan in which you may go to anyMedicare-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.

**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.

**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.

**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.

**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.

**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.

## Dental/Vision/Hearing Products

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.

## Supplemental Health Products

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.

## Medicare Supplemental (Medigap) Products

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.

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

GOLD KIDNEY HEALTH PLAN

# 2025

# Gold Kidney Health Plan

## Summary of Benefits

**Gold Kidney of Arizona Gold Circle Dialysis (HMO-POS C-SNP)**

H4869_SBpbp012AZgcdy_0824M

# 2025 Summary of Benefits

## Gold Kidney of Arizona Gold Circle Dialysis (HMO-POS C-SNP)

**This is a summary of Medicare health care and prescription drug coverage for Gold Kidney of Arizona Gold Circle Dialysis (HMO-POS C-SNP).**

**January 1 – December 31, 2025**

**Gold Kidney of Arizona Gold Circle Dialysis (HMO-POS C-SNP)** is a Medicare Advantage HMO-POS C-SNP plan with a Medicare contract. Enrollment in the Plan 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.

To join Gold Kidney of Arizona Gold Circle Dialysis (HMO-POS C-SNP), 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 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?**

You can search our drug list online at 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).

For coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 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

# Premiums and Benefits

This is a short list of benefits and cost sharing for our plan. For a complete list, see the *Evidence of Coverage* on our website at www.goldkidney.com.

| Premiums and Benefits | Gold Kidney of Arizona Gold Circle Dialysis (HMO-POS C-SNP) |
|---|---|
| **Monthly Plan Premium** (includes both medical and drugs) | You pay $0 each month.<br>You must continue to pay your Medicare Part B premium. |
| **Deductible** | You pay $240 for medical benefits. This is the 2024 amount and may change for 2025. Gold Kidney of Arizona Gold Circle Dialysis (HMO-POS C-SNP) will provide updated amount as soon as it is released.<br>You pay $590 for Part D benefits. |
| **Maximum Out-of-Pocket Responsibility** (does not include Part D prescription drugs) | You pay no more than $9,350 annually.<br>Includes copays and other costs for in-network medical services for the year. |

| Premiums and Benefits | Gold Kidney of Arizona Gold Circle Dialysis (HMO-POS C-SNP) |
|---|---|
| **Inpatient Hospital** | For in-network inpatient hospital stays, you pay:<br>Days 1-60: $0 copay for each benefit period.<br>Days 61-90: $408 copay per day of each benefit period.<br>Days 91 and beyond: $816 copay for each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime).<br>Beyond lifetime reserve days: all costs<br>These are 2024 cost-sharing amounts and may change for 2025.<br>Gold Kidney of Arizona Gold Circle Dialysis (HMO-POS C-SNP) will provide updated rates on www.goldkidney.com as soon as they are available.<br>For out-of-network stays, you pay:<br>$1,712 combined deductible for inpatient hospital acute and inpatient psychiatric hospital stays.<br>Days 1-60: $0 copay for each benefit period.<br>Days 61-90: $408 copay per day of each benefit period.<br>Days 91 and beyond: $816 copay for each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime).<br>Beyond lifetime reserve days: all costs<br>These are 2024 cost-sharing amounts and may change for 2025.<br>Gold Kidney of Arizona Gold Circle Dialysis (HMO-POS C-SNP) will provide updated rates on www.goldkidney.com as soon as they are available. |
| **Outpatient Hospital** | For services at an in-network outpatient hospital, you pay 20% coinsurance per visit<br>For services at an out-of-network outpatient hospital, you pay 20% coinsurance per visit. |
| **Ambulatory Surgical Center (ASC)** | You pay 20% coinsurance in-network.<br>You pay 20% coinsurance out-of-network. |
| **Doctor Visits**<br>• Primary care provider | You pay 20% coinsurance in-network.<br>You pay 20% coinsurance out-of-network. |

| Premiums and Benefits | Gold Kidney of Arizona Gold Circle Dialysis (HMO-POS C-SNP) |
|---|---|
| • Specialists | You pay 20% coinsurance in-network.<br>You pay 20% coinsurance out-of-network. |
| **Preventive Care**<br>(e.g., flu vaccine, diabetic screenings) | You pay nothing in-network.<br>You pay $0 copay out-of-network. |
| **Emergency Care** | You pay 20% coinsurance, up to a $110 maximum per visit.<br>ER cost sharing is waived if you are admitted to the hospital within 24 hours for the same condition. |
| **Urgently Needed Services** | You pay 20% coinsurance, up to a $45 maximum per visit. |
| **Diagnostic Services /Labs /Imaging /Radiology** | |
| • Diagnostic tests and procedures | You pay 20% coinsurance in-network.<br>You pay 20% coinsurance out-of-network. |
| • Lab services | You pay 20% coinsurance in-network.<br>You pay 20% coinsurance out-of-network. |
| • MRIs, CAT scans | You pay 20% coinsurance in-network.<br>You pay 20% coinsurance out-of-network. |
| • X-rays | You pay 20% coinsurance in-network.<br>You pay 20% coinsurance out-of-network. |
| • Therapeutic radiology services | You pay 20% coinsurance in-network.<br>You pay 20% coinsurance out-of-network. |
| **Hearing Services** | |
| • Medicare-covered hearing exam | You pay 20% coinsurance in-network.<br>You pay 20% coinsurance out-of-network. |

| Premiums and Benefits | Gold Kidney of Arizona Gold Circle Dialysis (HMO-POS C-SNP) |
|---|---|
| **Dental Services** | |
| • Medicare-covered dental services | You pay 20% coinsurance in-network.<br>You pay 20% coinsurance out-of-network. |
| • Transplant assistance services | Additional coverage will be offered for kidney transplant candidates needing additional dental care to be eligible for the transplant. |
| **Vision Services** | |
| • Medicare-covered benefits | You pay 20% coinsurance in-network for an eye exam to diagnose and treat diseases and conditions of the eye.<br>You pay 20% coinsurance out-of-network.<br>You pay 20% coinsurance in-network for one pair of eyeglasses or contact lenses after cataract surgery.<br>You pay 20% coinsurance out-of-network. |
| **Mental Health Services** | |
| • Outpatient therapy with a psychiatrist | You pay 20% coinsurance in-network for individual sessions.<br>You pay 20% coinsurance out-of-network.<br>You pay 20% coinsurance in-network for group sessions.<br>You pay 20% coinsurance out-of-network. |
| • Outpatient therapy with a mental health care professional (non-psychiatrist) | You pay 20% coinsurance in-network for individual sessions.<br>You pay 20% coinsurance out-of-network.<br>You pay 20% coinsurance in-network for group sessions.<br>You pay 20% coinsurance out-of-network. |

| Premiums and Benefits | Gold Kidney of Arizona Gold Circle Dialysis (HMO-POS C-SNP) |
|---|---|
| **Skilled Nursing Facility (SNF)** | Inpatient hospital stay is not required prior to admission.<br>For in-network SNF stays, you pay:<br>Days 1-20: $0 copay for each benefit period<br>Days 21-100: $204 copay per day of each benefit period<br>Days 101 and beyond: all costs<br>These are 2024 cost-sharing amounts and may change for 2025.<br>Gold Kidney of Arizona Gold Circle Dialysis (HMO-POS C-SNP) will provide updated rates on www.goldkidney.com as soon as they are available.<br>For out-of-network stays, you pay:<br>Days 1-20: $0 copay for each benefit period<br>Days 21-100: $204 copay per day of each benefit period<br>Days 101 and beyond: all costs<br>These are 2024 cost-sharing amounts and may change for 2025.<br>Gold Kidney of Arizona Gold Circle Dialysis (HMO-POS C-SNP) will provide updated rates on www.goldkidney.com as soon as they are available. |
| **Physical Therapy** | You pay 20% coinsurance in-network.<br>You pay 20% coinsurance out-of-network. |
| **Ambulance** | You pay 20% coinsurance in-network for ground ambulance services.<br>You pay 20% coinsurance out-of-network.<br>You pay 20% coinsurance in-network for air ambulance services.<br>You pay 20% coinsurance out-of-network. |
| **Transportation** | Not covered. |

| Premiums and Benefits | Gold Kidney of Arizona Gold Circle Dialysis (HMO-POS C-SNP) |
|---|---|
| **Medicare Part B Drugs** | You pay $35 copay in-network for Medicare Part B insulin drugs.<br>You pay $35 maximum copay out-of-network.<br>You pay 0% to 20% coinsurance in-network for Medicare Part B chemotherapy and radiation drugs.<br>You pay 0% to 20% coinsurance out-of-network.<br>You pay 0% to 20% coinsurance in-network for other Medicare Part B drugs.<br>You pay 0% to 20% coinsurance out-of-network. |

# Prescription Drugs

This is a summary of prescription drug coverage and cost sharing for our plan. For more information, see the *Evidence of Coverage* on our website at www.goldkidney.com.

| Deductible Stage |
|---|
| You pay $590. **You must pay the full cost of your drugs** until you reach this amount. |

| Initial Coverage Stage (one-month supply) | | | |
|---|---|---|---|
| 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). | | | |
| **Cost Sharing for a one-month supply** | **Standard Retail Rx** 30-day supply | **Long-term Care Rx** 31-day supply | **Out-of-network Rx** 30-day supply |
| Tier 1 Preferred Generic: | 25% coinsurance | 25% coinsurance | 25% coinsurance |
| *Insulin drugs* | the lesser of 25% coinsurance or $35 copay | | |

| Initial Coverage Stage (long-term supply) | | |
|---|---|---|
| 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). | | |
| **Cost Sharing for a long-term supply** | **Standard Retail Rx**<br>100-day supply | **Mail Order Rx**<br>100-day supply |
| Tier 1 Preferred Generic: | 25% coinsurance | 25% coinsurance |
| *Insulin drugs* | the lesser of 25% coinsurance or $105 copay | |

| Catastrophic Coverage Stage |
|---|
| 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.<br><br>During this stage, you pay nothing for Part D drugs. |

# Additional Benefits

This plan provides additional benefits. For more information, see the *Evidence of Coverage* on our website at www.goldkidney.com.

| Additional Benefits | |
|---|---|
| **Alternative Therapies Benefit** | Includes the services of a medicine man (a man or woman) from a Native American or Indigenous tribe that is thought to have the ability to heal physical and mental ailments. Benefit includes a debit card in the amount of $50 per quarter for the services. |
| **Dialysis Services** | 20% coinsurance in- and out-of-network for Medicare-covered dialysis services. |
| **Meals Benefit** | You pay $0 copay per meal from a participating plan provider.<br>Immediately following surgery or an in-patient hospitalization, you will receive 2 meals per day for 14 days. This benefit can be used up to 4 times per year. |

| Additional Benefits | |
|---|---|
| **Preventive Rewards & Incentives**<br>Your benefit allows you to earn extra rewards for completing preventive services and participating in plan surveys.<br>Reward funds may be used for purchases at participating vendors. | Earn up to a total of $300 for the completion of various plan preventive activities and surveys.<br>Completion of:<br>• Member Portal Registration<br>• Health Risk Assessment<br>• Annual Wellness Visit<br>• Flu/Covid Vaccine<br>• Diabetes Eye Exam<br>• Fall Risk Assessment<br>• Bladder Control Assessment<br>• 2 HbA1c tests<br>• Post-Inpatient Medication Reconciliation in 14 days<br>• Post-ER PCP visit in 7 days<br>• Cancer Screenings:<br>  o Colon<br>  o Prostate<br>  o Cervical<br>  o Mammogram<br>• Plan Surveys:<br>  o PCP Visit Survey<br>  o Mock CAHPS Survey |
| **Supplemental Benefits for the Chronically Ill (SSBCI)**<br>These benefits are available only to eligible chronically ill members where the specific benefit has been determined to meet the reasonable expectation to improve the health or overall function of the member. Members must have a chronic illness and participate in the Plan's case management programs to receive these benefits. | **Healthy Food and Produce Allowance:** A monthly allowance of $100 to be used for the purchase of healthy foods / produce or prepared meals at participating Plan Merchants. Unused Allowance does not roll over to the next month.<br>The benefit includes a plan payment card that may be used to purchase items such as (but not limited to) produce, frozen foods, and canned goods from participating plan vendors. Tobacco and alcohol purchases are not permitted.<br>**Fuel / Ride Share Allowance for Non-emergency Transportation:** A monthly allowance of $100 to be used for the purchase of fuel at gas stations and for ride sharing trips from a plan participating vendor. Unused Allowance does not roll over to the next month.<br>**Smart Phone & Cellular Data Plan:** Members are provided one smart phone device and cellular data plan from a contracted vendor. |

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GOLD KIDNEY HEALTH PLAN
GOLD KIDNEY HEALTH PLAN

# 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 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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GOLD KIDNEY HEALTH PLAN

# 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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GOLD KIDNEY HEALTH PLAN

# Pre-Enrollment Qualification Assessment Tool for Gold Kidney Dialysis Plans

**IMPORTANT: Complete this section IF you are enrolling in a Chronic Condition Special Needs Plan (HMO-POS C-SNP)**

Gold Kidney Health Plan offers Chronic Special Needs Plans (C-SNP) for individuals with certain chronic health conditions. To enroll in this plan, Medicare requires that Gold Kidney Health Plan verify your chronic condition. This is a two-step process:

**Step One**
Please complete this form and return it to us with your completed enrollment application. If you can answer "yes" to at least one of the chronic condition questions, you may pre-qualify for enrollment in a Gold Kidney Health Plan Chronic Special Needs Plan (C-SNP).

**Step Two**
This information will be used to verify your chronic condition within two months of your enrollment. Medicare requires Gold Kidney Health Plan to verify your chronic condition as part of the enrollment process. It is important to give us contact information for a doctor or clinic that can verify your condition.

**Note: If we are unable to verify your chronic condition, we must disenroll you from the C-SNP plan at the end of your second month of enrollment.**

## Applicant Information

| Last Name: | First Name: | Middle Initial (Optional): |
|---|---|---|
| | | |

| Birth Date: (MM/DD/YYYY)<br>(__ __/__ __/__ __ __ __) | Medicare Number:<br>__ __ __ __ - __ __ __ - __ __ __ __ |
|---|---|
| Phone Number:<br>(__ __ __) __ __ __ - __ __ __ __ | Alternate Phone Number (cell):<br>(__ __ __) __ __ __ - __ __ __ __ |

GOLD KIDNEY HEALTH PLAN

## Qualifying for Gold Kidney Dialysis Plans

You must answer "yes" to at least one of the dialysis questions below to qualify for any Gold Kidney dialysis plan

| | |
|---|---|
| Are you currently receiving regularly scheduled dialysis? (Either in-home or in-center) | ☐ Yes ☐ No |
| Do you have end-stage renal disease (ESRD) / end-stage kidney disease (ESKD)? | ☐ Yes ☐ No |

Are you currently taking any of the following types of medications?

| | | | |
|---|---|---|---|
| Blood pressure | ☐ Yes ☐ No | Diabetes (sugar disease) | ☐ Yes ☐ No |
| Blood thinners | ☐ Yes ☐ No | Heart disease | ☐ Yes ☐ No |
| Chest pain | ☐ Yes ☐ No | Other | ☐ Yes ☐ No |

## List doctors, clinics, and other healthcare providers who can verify your "Yes" answers

| | | |
|---|---|---|
| Primary Nephrologist Name (required) | Phone Number (__ __ __) __ __ __ - __ __ __ __ | City |
| Provider #1 (Physician Name) | Specialty | City |
| Phone Number (__ __ __) __ __ __ - __ __ __ __ | Fax Number (__ __ __) __ __ __ - __ __ __ __ | |
| Provider #2 (Physician Name) | Specialty | City |
| Phone Number (__ __ __) __ __ __ - __ __ __ __ | Fax Number (__ __ __) __ __ __ - __ __ __ __ | |

## Release of Information

Completion of this document authorizes the disclosure and use of individually identifiable information, as set forth below, consistent with Federal Law concerning the privacy of such information.

☐ I herewith authorize and direct Gold Kidney to confirm my chronic conditions and obtain my medical records until I am no longer enrolled in the Gold Kidney Health Plan.
**(Box must be checked for C-SNP applications)**

| | |
|---|---|
| Applicant Name (printed): | Date: |
| Applicant/Authorized Representative Signature: | |

GOLD KIDNEY HEALTH PLAN

OMB No. 0938-1378
Expires: 6/30/2026

# 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 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.

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GOLD KIDNEY HEALTH PLAN

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

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

Counties: Gila, Maricopa, Pima, Pinal

- ☐ **Gold Heart & Diabetes (HMO-POS C-SNP)** H4869-001
  $0 per month
- ☐ **Gold Heart & Diabetes Complete (HMO-POS C-SNP)** H4869-002
  $10.90 per month
  $0 premium with full Medicaid
- ☐ **Gold Dialysis (HMO-POS C-SNP)** H4869-003
  $0 per month
- ☐ **Gold Dialysis Complete (HMO-POS C-SNP)** H4869-004
  $30.10 per month
  $0 premium with full Medicaid
- ☐ **Gold Circle Heart & Diabetes (HMO-POS C-SNP)** H4869-010
  $0 per month
- ☐ **Gold Circle Dialysis (HMO-POS C-SNP)** H4869-012
  $0 per month

Counties: Cochise, Coconino, Graham, Navajo

- ☐ **Gold Heart & Diabetes (HMO-POS C-SNP)** H4869-011
  $0 per month
- ☐ **Gold Dialysis (HMO-POS C-SNP)** H4869-013
  $0 per month
- ☐ **Gold Circle Heart & Diabetes (HMO-POS C-SNP)** H4869-010
  $0 per month
- ☐ **Gold Circle Dialysis (HMO-POS C-SNP)** H4869-012
  $0 per month

| First Name: | Last Name: | Middle Initial (Optional): |
|---|---|---|
| | | |

| Birth Date: (MM/DD/YYYY) | Sex: | Phone Number: |
|---|---|---|
| (__ __/__ __/__ __ __ __) | ☐ Male ☐ Female | ( __ __ __ ) __ __ __ - __ __ __ __ |

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: |
|---|---|---|---|
| | | | |

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GOLD KIDNEY HEALTH PLAN

## 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: |
|---|---|---|
| | | |

To qualify for a Heart & Diabetes Chronic Condition Special Needs Plan (C-SNP), you must have one or more of the below chronic conditions.

Have you been diagnosed with one of the following? Please check all that apply.

☐ Congestive heart failure (CHF)
☐ Diabetes mellitus (DM)
☐ Cardiovascular disease (CVD)

**Please also complete the Pre-Enrollment Qualification Assessment Tool (PQAT) included with this form before submitting your application. The PQAT must be submitted with your enrollment form.**

To qualify for a Dialysis Chronic Condition Special Needs Plan (C-SNP), you must be undergoing one or more of the below services.

☐ Dialysis
☐ Dialysis Services

**Please also complete the Pre-Enrollment Qualification Assessment Tool (PQAT) included with this form before submitting your application. The PQAT must be submitted with your enrollment form.**

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GOLD KIDNEY HEALTH PLAN

## 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.

| **Signature** | **Today's date:** |
|---|---|
| | |

## If you're the authorized representative, sign above and fill out these fields:

| Name: | |
|---|---|
| Address: | |
| Phone number: | Relationship to enrollee: |

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GOLD KIDNEY HEALTH PLAN

## 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.

- ☐ No, not of Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Puerto Rican
- ☐ Yes, another Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Mexican, Mexican American, Chicano/a
- ☐ Yes, Cuban
- ☐ **I choose not to answer.**

What's your race? Select all that apply.

- ☐ American Indian or Alaska Native

Asian:

- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian

- ☐ Black or African American

Native Hawaiian and Pacific Islander:

- ☐ Guamanian or Chamorro
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Other Pacific Islander

- ☐ White
- ☐ **I choose not to answer.**

What is your gender? Select one.

- ☐ Woman
- ☐ Man
- ☐ Non-binary
- ☐ I use a different term: _____
- ☐ **I choose not to answer**

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

- ☐ Lesbian or gay
- ☐ Straight, that is, not gay or lesbian
- ☐ Bisexual
- ☐ I use a different term: _____
- ☐ Not sure
- ☐ **I choose not to answer**

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

- ☐ Spanish

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GOLD KIDNEY HEALTH PLAN

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).*

## Thrive® Smartphone Program

Gold Kidney Health Plan offers a smartphone with unlimited talk, text, and data as a supplemental benefit to members who meet certain criteria. There is no monthly charge associated with the smartphone while you are enrolled with Gold Kidney Health Plan. To qualify for this benefit, you must be enrolled in a C-SNP plan **and** qualify for Special Supplemental Benefits for the Chronically Ill (SSBCI).

If you opt-in for this benefit, a representative will contact you after Gold Kidney plan enrollment to enroll in the smartphone program and activate the smartphone.

☐ I want to opt-in for the Thrive smartphone program brought to you by Gold Kidney Health Plan

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The benefits mentioned are part of a special supplemental benefit program for the chronically ill. To qualify, members must have at least one of the following chronic conditions: cardiovascular disorder; chronic heart failure; diabetes mellitus; end-stage renal disease (ESRD); chronic kidney disease (CKD).

Please note that an enrollee with one or more of the chronic conditions listed above may not necessarily receive the benefit. To qualify, the member must meet all five of the following requirements: 1) have at least one qualifying chronic condition (see above) **and** 2) be enrolled in a Gold Kidney chronic special needs plan (C-SNP); refer to the plan's Summary of Benefits for specific benefits and coverage amounts **and** 3) be at a high risk for hospitalization or other adverse health outcome **and** 4) require intensive care coordination **and** 5) participate in case management.

Not all members will qualify.

## 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.**

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GOLD KIDNEY HEALTH PLAN

| 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): |
| **GOLD KIDNEY HEALTH PLAN ADMINISTRATIVE SECTION** *(Licensed Agent Use Only)* | |
| Plan ID # | Effective Date of Coverage: |
| **Licensed Sales Agent received date:** | |
| **Licensed Sales Agent signature (required):** | |

**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<br>Type of assessment *(to be completed by case manager)* ☐ Initial ☐ Annual ☐ TOC | |

## Language / Cultural

1. Do you have a language preference other than English?
   ☐ Yes ☐ No ☐ Unable to assess ☐ Declined to answer

   If yes, which language?
   ☐ Arabic ☐ Chinese ☐ French ☐ German ☐ Hindi
   ☐ Korean ☐ Navajo ☐ Spanish ☐ Tagalog ☐ Vietnamese
   ☐ Other _____

2. Are there any specific cultural or religious beliefs that may affect your health care?
   ☐ Yes ☐ No ☐ Unable to assess ☐ Declined to answer

   If yes, which of the following?
   ☐ Amish ☐ Baha'i ☐ Buddhism ☐ Christianity ☐ Hindu
   ☐ Jehovah's Witness ☐ Judaism ☐ Muslim ☐ Seventh-day Adventist
   ☐ Sikh ☐ Other _____

   If any of the above boxes are marked, what are the specifics of those beliefs?

   _____

3. What is your race?

- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Black or African American
- ☐ Chinese
- ☐ Filipino
- ☐ Guamanian or Chamorro
- ☐ Japanese
- ☐ Korean
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Vietnamese
- ☐ White
- ☐ Other Asian Other
- ☐ Pacific Islander
- ☐ Prefer not to answer

4. What is your ethnicity?

- ☐ Not of Hispanic, Latino/a or Spanish origin
- ☐ Puerto Rican
- ☐ Mexican, Mexican American, Chicano/a
- ☐ Cuban
- ☐ Another Hispanic, Latino or Spanish origin
- ☐ Prefer not to answer

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

- ☐ 8th grade or less
- ☐ High School Graduate or GED
- ☐ Some College
- ☐ College Degree
- ☐ Advanced Degree

## General

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

□ Excellent □ Very good □ Good □ Fair □ Poor

□ Unable to assess □ Declined to answer

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

_____

_____

_____

## 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?

| | | |
|---|---|---|
| □ Diabetes or Prediabetes | □ High blood pressure | □ Kidney disease |
| □ Heart disease | □ Asthma | □ COPD |
| □ HIV / AIDS | □ Stroke | □ Cancer |
| □ Bipolar disorder | □ Depression | □ Schizophrenia |
| □ Dementia | □ Hearing problems | □ Vision problems |
| □ None | □ 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?

_____

_____

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

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

Form Approved
OMB# 0938-1421

# 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'assurancemédicaments. 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 quí vị cần thông dịch viên xin gọi **(844) 294-6535** sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

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

**Korean:** 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 **(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 6535-294 (844). 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 Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

**Portuguese:** Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número **(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ございます。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

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.
*The benefits mentioned are part of a special supplemental benefit program for members with one or more complex chronic conditions. To qualify, members must have at least one of the following chronic conditions: cardiovascular disorder; chronic heart failure; diabetes mellitus; end-stage renal disease (ESRD); chronic kidney disease (CKD). Please note that an enrollee with one or more of the chronic conditions listed above may not necessarily receive the benefit. To qualify, the member must have at least one qualifying chronic condition (see above) and participate in case management. Not all members will qualify.