GOLD KIDNEY HEALTH PLAN

2025

Gold Kidney Health Plan

Annual Notice of Change

Gold Kidney of Arizona Gold Heart & Diabetes (HMO-POS C-SNP)

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Thank you for choosing Gold Kidney Health Plan!

We appreciate your continued trust in us for your healthcare needs. Gold Kidney is committed to providing benefits and services designed to help our members save money and live healthier lives.

This booklet compares your 2024 benefits to your 2025 benefits. Note that your plan name has changed from Gold Kidney of Arizona Super Plus (HMO-POS C-SNP) to Gold Kidney of Arizona Gold Heart & Diabetes (HMO-POS C-SNP). If you'd like to keep this plan, no action is required.

If you have questions, the information you need is just a click or a phone call away!

Starting October 15, 2024, you can find these 2025 documents online at www.goldkidney.com:

Evidence of Coverage
Complete details of your Gold Kidney of Arizona Gold Heart & Diabetes (HMO-POS C-SNP) plan, including benefits and costs.

Prescription Drug Guide (Drug List)
2025 Formulary

Provider Directory
List of doctors, specialists, and other providers in our network.

Pharmacy Directory
List of pharmacies in our network

If you have questions or prefer to have a printed copy of these documents mailed to you, please call Gold Kidney Member Services at (844) 294-6535 (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).

At Gold Kidney, we're dedicated to creating the gold standard of care, and we’re glad you’re continuing your healthcare journey with us.

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Gold Kidney of Arizona Gold Heart & Diabetes (HMO-POS C-SNP) offered by Gold Kidney Health Plan

Annual Notice of Changes for 2025

You are currently enrolled as a member of Gold Kidney of Arizona Super Plus (HMO-POS C-SNP). Next year, there will be changes to the plan's costs and benefits. ***Please see page 5 for a Summary of Important Costs, including Premium.***

This document tells about the changes to your plan. To get more information about costs, benefits, or rules please review the *Evidence of Coverage*, which is located on our website at www.goldkidney.com/evidence-of-coverage-2025-Arizona. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

- **You have from October 15 until December 7 to make changes to your Medicare coverage for next year.**

What to do now

1. ASK: Which changes apply to you

☐ Check the changes to our benefits and costs to see if they affect you.

- Review the changes to medical care costs (doctor, hospital).
- Review the changes to our drug coverage, including coverage restrictions and cost sharing.
- Think about how much you will spend on premiums, deductibles, and cost sharing.
- Check the changes in the 2025 "Drug List" to make sure the drugs you currently take are still covered.
- Compare the 2024 and 2025 plan information to see if any of these drugs are moving to a different cost-sharing tier or will be subject to different restrictions, such as prior authorization, step therapy, or a quantity limit, for 2025.

☐ Check to see if your primary care doctors, specialists, hospitals, and other providers, including pharmacies, will be in our network next year.

☐ Check if you qualify for help paying for prescription drugs. People with limited incomes may qualify for "Extra Help" from Medicare.

☐ Think about whether you are happy with our plan.

2. **COMPARE:** Learn about other plan choices

☐ Check coverage and costs of plans in your area. Use the Medicare Plan Finder at the www.medicare.gov/plan-compare website or review the list in the back of your *Medicare & You 2025* handbook. For additional support, contact your State Health Insurance Assistance Program (SHIP) to speak with a trained counselor.

☐ Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan's website.

3. **CHOOSE:** Decide whether you want to change your plan

- If you don't join another plan by December 7, 2024, you will stay in Gold Kidney of Arizona Gold Heart & Diabetes (HMO-POS C-SNP).
- To change to a **different plan**, you can switch plans between October 15 and December 7. Your new coverage will start on **January 1, 2025.** This will end your enrollment with Gold Kidney of Arizona Super Plus (HMO-POS C-SNP).
- If you recently moved into or currently live in an institution (like a skilled nursing facility or long-term care hospital), you can switch plans or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for two full months after the month you move out.

Additional Resources

- This document is available for free in Spanish.
- Please contact our Member Services number at 1-844-294-6535 for additional information. (TTY users should call 711.) Hours are October 1 – March 31: Live Customer Service Representatives (CSRs) are available seven days a week, from 8:00 a.m. to 8:00 p.m. local time for the regions in which they operate; and Interactive voice response system or similar technologies for Thanksgiving and Christmas Day (messages must be returned within one (1) business day) April 1 – September 30: Live CSRs available Monday through Friday, from 8:00 a.m. to 8:00 p.m. in all time zones for the regions in which they operate; and Interactive voice response system or similar technologies for Saturdays, Sundays and Federal Holidays (messages must be returned within one (1) business day. This call is free.
- This information is available in braille, large print, or other alternate formats.
- **Coverage under this plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About Gold Kidney of Arizona Gold Heart & Diabetes (HMO-POS C-SNP)

- 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.

- When this document says “we,” “us,” or “our,” it means Gold Kidney Health Plan. When it says “plan” or “our plan,” it means Gold Kidney of Arizona Gold Heart & Diabetes (HMO-POS C-SNP).

Annual Notice of Changes for 2025
Table of Contents

Summary of Important Costs for 2025

The table below compares the 2024 costs for Gold Kidney of Arizona Super Plus (HMO-POS C-SNP) and 2025 costs for Gold Kidney of Arizona Gold Heart & Diabetes (HMO-POS C-SNP) in several important areas. **Please note this is only a summary of costs**.

Cost	2024 (this year)	2025 (next year)
Monthly plan premium* * Your premium may be higher than this amount. See Section 2.1 for details.	$0	$0
Maximum out-of-pocket amount This is the most you will pay out of pocket for your covered Part A and Part B services. (See Section 2.2 for details.)	$3,000	$2,500
Doctor office visits	Primary care visits: $0 copay per visit Specialist visits: $0 copay for nephrologists, cardiologists, endocrinologists, cardiovascular surgeons and $10 copay for all other specialists per visit	Primary care visits: $0 copay per visit Specialist visits: $0 copay for nephrologists, cardiologists, endocrinologists, cardiovascular and vascular surgeons and $10 copay for all other specialists per visit
Inpatient hospital stays	$175 copay per day for days 1-5; $0 copay per day for days 6-90	$150 copay per day for days 1-5; $0 copay per day for days 6-90
Part D prescription drug coverage (See Section 2.5 for details.)	Deductible: $0	Deductible: $0

Cost	2024 (this year)	2025 (next year)
	Copayment during the Initial Coverage Stage: • Drug Tier 1: $0 copay • Drug Tier 2: $5 copay • Drug Tier 3: $40 copay You pay $35 copay per month supply of each covered insulin product on this tier. • Drug Tier 4: $100 copay • Drug Tier 5: 33% coinsurance • Drug Tier 6: $0 copay Catastrophic Coverage: • During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.	Copayment during the Initial Coverage Stage: • Drug Tier 1: $0 copay • Drug Tier 2: $0 copay • Drug Tier 3: $40 copay • Drug Tier 4: $100 copay • Drug Tier 5: 33% coinsurance • Drug Tier 6: $0 copay Catastrophic Coverage: • During this payment stage, you pay nothing for your covered Part D drugs.

SECTION 1 We Are Changing the Plan's Name

On January 1, 2025, our plan name will change from Gold Kidney of Arizona Super Plus (HMO-POS C-SNP) to Gold Kidney of Arizona Gold Heart & Diabetes (HMO-POS C-SNP).

You will receive a new ID card before January 1st. It will be updated with your new plan name, Gold Kidney of Arizona Gold Heart & Diabetes (HMO-POS C-SNP). Please remember, this new name will be present on any letters and materials sent by Gold Kidney Health Plan for 2025.

SECTION 2 Changes to Benefits and Costs for Next Year

Section 2.1 – Changes to the Monthly Premium

Cost	2024 (this year)	2025 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$0	$0
Monthly Part B premium reduction	$50	$0

- Your monthly plan premium will be *more* if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as creditable coverage) for 63 days or more.
- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.

Section 2.2 – Changes to Your Maximum Out-of-Pocket Amount

Medicare requires all health plans to limit how much you pay out of pocket for the year. This limit is called the maximum out-of-pocket amount. Once you reach this amount, you generally pay nothing for covered Part A and Part B services for the rest of the year.

Cost	2024 (this year)	2025 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount. Your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$3,000	$2,500 Once you have paid $2,500 out of pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year.

Section 2.3 – Changes to the Provider and Pharmacy Networks

Amounts you pay for your prescription drugs may depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Updated directories are located on our website at www.goldkidney.com. You may also call Member Services for updated provider and/or pharmacy information or to ask us to mail you a directory, which we will mail within three business days.

There are changes to our network of providers for next year. **Please review the 2025 *Provider Directory* at www.goldkidney.com/provider-search/ to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network**.

There are no changes to our network of pharmacies for next year.

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers), and pharmacies that are part of your plan during the year. If a mid-year change in our providers affects you, please contact Member Services so we may assist.

Section 2.4 – Changes to Benefits and Costs for Medical Services

We are making changes to costs and benefits for certain medical services next year. The information below describes these changes.

Cost	2024 (this year)	2025 (next year)
Referrals	Referrals are required for certain services.	Referrals are <u>not</u> required for any services.
Acupuncture	**<u>In-Network</u>** You pay $20 copay for each Medicare-covered visit. You pay $20 copay for each routine acupuncture visit (12 visits every year). **<u>Point-of-Service (POS)</u>** You pay $20 copay for each Medicare-covered visit. You pay $20 copay for each routine acupuncture visit (12 visits every year). Prior authorization is required for Medicare-covered acupuncture services. Prior authorization is required for routine acupuncture services.	**<u>In-Network</u>** You pay $10 copay for each Medicare-covered visit. You pay $10 copay for each routine acupuncture visit (12 visits every year). **<u>Point-of-Service (POS)</u>** You pay $10 copay for each Medicare-covered visit. You pay $10 copay for each routine acupuncture visit (12 visits every year). No prior authorization required for Medicare-covered acupuncture services. No prior authorization required for routine acupuncture services.
Chiropractic Services	**<u>In-Network</u>** You pay $20 copay for each Medicare-covered chiropractic services visit. You pay $20 copay for each routine chiropractic services visit (12 visits every year). **<u>Point-of-Service (POS)</u>** You pay $20 copay for each Medicare-covered chiropractic services visit. You pay $20 copay for each routine chiropractic services visit (12 visits every year).	**<u>In-Network</u>** You pay $10 copay for each Medicare-covered chiropractic services visit. You pay $10 copay for each routine chiropractic services visit (12 visits every year). **<u>Point-of-Service (POS)</u>** You pay $10 copay for each Medicare-covered chiropractic services visit. You pay $10 copay for each routine chiropractic services visit (12 visits every year).

Cost	2024 (this year)	2025 (next year)
Chiropractic Services continued	Prior authorization is required for Medicare-covered chiropractic care services. Prior authorization is required for routine chiropractic care services.	No prior authorization required for Medicare-covered chiropractic care services. No prior authorization required for routine chiropractic care services.
Dental: Combined Flexible Dental, Hearing and Vision Benefits	$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. You are responsible for all costs exceeding the combined benefit amount for the flexible benefits.	$1,000 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. You are responsible for all costs exceeding the combined benefit amount for the flexible benefits.
Fitness Benefit	Prior authorization is required for the fitness benefit.	No prior authorization required for the fitness benefit.
Gold Perks Plus The Gold Perks Plus 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 prepaid benefits card provided to you. **Indicates SSBCI benefit*	Gold Perks Plus combined services benefit is not offered.	Gold Perks Plus Package has a combined benefit of $25 maximum plan allowance amount every month for the following benefits:

Cost	2024 (this year)	2025 (next year)
Gold Perks Plus continued	Utilities Payment benefit is not covered.	Utilities Payment* Members may use the combined allowance to pay for utilities as General Supports for Daily Living. Unused allowance does not carry forward to the next month. Payment of utilities including electricity, water, sewer and trash, or natural/propane gas services required to sustain household operations. It does not include telephone, internet, or other cellular data services available through another plan benefit. Utility account information will be required for this benefit.
	Over-the-Counter (OTC) Supplies benefit is covered as a stand-alone benefit.	Over-the Counter (OTC) Supplies 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.

Cost	2024 (this year)	2025 (next year)
Gold Perks Plus continued	Therapeutic Massage is <u>not</u> covered.	<u>Therapeutic Massage</u> 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.
	Fitness Activity Allowance is <u>not</u> covered.	<u>Fitness Activity Allowance</u> 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&Fit gym membership. 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.

Cost	2024 (this year)	2025 (next year)
Gold Perks Plus continued	Pets Supplies & Services is not covered.	Pets Supplies & Services* Unused allowance does not carry forward to the next month. Members may use the combined allowance to pay for pet food, pet care supplies, and veterinary services. Does not include grooming or boarding services.
	Pest Control Services is not covered.	Pest Control Services* Unused allowance does not carry forward to the next month. Members may use the combined allowance to pay for pest control. Pest control services include pest eradication services that are necessary to ensure the health, welfare, and safety of the chronically ill member. Services may include pest control treatment(s) or products that may assist the member in the pest eradication (e.g., traps, pest control sprays, cleaning supplies). The health plan covers common pests such as bed bugs, rodents, roaches, etc. The plan will not cover termites or animal control services.

Cost	2024 (this year)	2025 (next year)
Gold Perks Plus continued	Indoor Air Quality Equipment and Services is not covered.	Indoor Air Quality Equipment and Services* Unused allowance does not carry forward to next month. Members may use the combined allowance to pay for indoor air quality equipment and services such as temporary or portable air conditioning units, humidifiers, dehumidifiers, High Efficiency Particulate Air filters and servicing of the equipment as part of the benefit.
	Personal Care Services is not covered.	Personal Care Services* Unused allowance does not carry forward to the next month. Members may use the combined allowance to purchase physical assistance services for the 6 basic activities of daily living including: bathing, continence, dressing, eating, toileting, or transferring. Services must be purchased from an entity licensed /certified to provide personal care services in accordance with state rules and regulations and able to accept payment via the plan payment card.

Cost	2024 (this year)	2025 (next year)
Gold Perks Plus continued	Home and bathroom safety devices benefit is covered as a stand-alone benefit.	Home and Bathroom Safety Devices 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.
Health and Wellness Education Programs	Prior authorization is required for health education services.	No prior authorization required for health education services.
Hearing: Combined Flexible Dental, Hearing and Vision Benefits	$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. You are responsible for all costs exceeding the combined benefit amount for the flexible benefits.	$1,000 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. You are responsible for all costs exceeding the combined benefit amount for the flexible benefits.
Home and Bathroom Safety Devices and Modifications (see Gold Perks Plus row)	**In-Network** You pay $0 copay for home and bathroom safety devices and modifications. **Point-of-Service (POS)** Home and bathroom safety devices and modifications benefit is not covered.	**In-Network** This benefit is covered as part of the Gold Perks Plus package. **Point-of-Service (POS)** This benefit is covered as part of the Gold Perks Plus package.

Cost	2024 (this year)	2025 (next year)
Home and Bathroom Safety Devices and Modifications (see Gold Perks Plus row) continued	No maximum plan coverage amount for the home and bathroom safety devices and modifications benefit. Prior authorization is required for the home and bathroom safety devices and modifications benefit.	No maximum plan coverage amount for the home and bathroom safety devices and modifications benefit. No prior authorization required for the home and bathroom safety devices and modifications benefit.
Home-based Palliative Care	**In-Network** You pay $0 copay for home-based palliative care. **Point-of-Service (POS)** You pay $0 copay for home-based palliative care.	**In-Network** Home-based palliative care benefit is not covered. **Point-of-Service (POS)** Home-based palliative care benefit is not covered.
In-home Safety Assessment Services	Prior authorization is required for the in-home safety assessment benefit.	No prior authorization required for the in-home safety assessment benefit.
In-home Support Services	Prior authorization is required for the in-home support services benefit.	No prior authorization required for the in-home support services benefit.
Inpatient Hospital Care	**In-Network** For Medicare-covered inpatient hospital stays, you pay $175 copay per day for days 1-5; $0 copay per day for days 6-90. **Point-of-Service (POS)** For Medicare-covered inpatient hospital stays, you pay $175 copay per day for days 1-5; $0 copay per day for days 6-90.	**In-Network** For Medicare-covered inpatient hospital stays, you pay $150 copay per day for days 1-5; $0 copay per day for days 6-90. **Point-of-Service (POS)** For Medicare-covered inpatient hospital stays, you pay $150 copay per day for days 1-5; $0 copay per day for days 6-90.

Cost	2024 (this year)	2025 (next year)
Inpatient Services in a Psychiatric Hospital	**In-Network** For Medicare-covered inpatient mental health stays, you pay $175 copay per day for days 1-7; $0 copay per day for days 8-90. **Point-of-Service (POS)** For Medicare-covered inpatient mental health stays, you pay $175 copay per day for days 1-7; $0 copay per day for days 8-90.	**In-Network** For Medicare-covered inpatient mental health stays, you pay $150 copay per day for days 1-5; $0 copay per day for days 6-90. **Point-of-Service (POS)** For Medicare-covered inpatient mental health stays, you pay $150 copay per day for days 1-5; $0 copay per day for days 6-90.
Meal Benefit	**In-Network** Prior authorization is required for the meal benefit.	**In-Network** No prior authorization required for the meal benefit.
Outpatient Blood Services	Prior authorization is required for outpatient blood services.	No prior authorization required for outpatient blood services.
Outpatient Diagnostic Tests and Therapeutic Services and Supplies	**In-Network** For Medicare-covered outpatient diagnostic procedures and tests, you pay $50 copay. **Point-of-Service (POS)** For Medicare-covered outpatient diagnostic procedures and tests, you pay $50 copay.	**In-Network** For Medicare-covered outpatient diagnostic procedures and tests, you pay $0 copay. **Point-of-Service (POS)** For Medicare-covered outpatient diagnostic procedures and tests, you pay $0 copay.
Outpatient Hospital Observation	**In-Network** You pay $175 copay per day for Medicare-covered outpatient hospital observation services.	**In-Network** You pay $150 copay per day for Medicare-covered outpatient hospital observation services.

Cost	2024 (this year)	2025 (next year)
Outpatient Hospital Observation continued	**Point-of-Service (POS)** You pay $175 copay for Medicare-covered outpatient hospital observation services.	**Point-of-Service (POS)** You pay $150 copay for Medicare-covered outpatient hospital observation services.
Outpatient Rehabilitation Services	**In-Network** You pay $10 copay for each Medicare-covered physical therapy or speech therapy visit. **Point-of-Service (POS)** You pay $10 copay for each Medicare-covered physical therapy or speech therapy visit. Prior authorization is required for Medicare-covered occupational therapy services.	**In-Network** You pay $15 copay for each Medicare-covered physical therapy or speech therapy visit. **Point-of-Service (POS)** You pay $15 copay for each Medicare-covered physical therapy or speech therapy visit. No prior authorization required for Medicare-covered occupational therapy services.
Outpatient Surgery	Includes services provided at hospital outpatient facilities and ambulatory surgical centers. **In-Network** For Medicare-covered services at an outpatient hospital facility, you pay $175 copay. For Medicare-covered services at an ambulatory surgical center, you pay $75 copay. **Point-of-Service (POS)** For Medicare-covered services at an outpatient hospital facility, you pay $175 copay.	**In-Network** For Medicare-covered services at an outpatient hospital facility, you pay $125 copay. For Medicare-covered services at an ambulatory surgical center, you pay $100 copay. **Point-of-Service (POS)** For Medicare-covered services at an outpatient hospital facility, you pay $125 copay.

Cost	2024 (this year)	2025 (next year)
Outpatient Surgery continued	For Medicare-covered services at an ambulatory surgical center, you pay $75 copay.	For Medicare-covered services at an ambulatory surgical center, you pay $100 copay.
Over-the-Counter Items (see Gold Perks Plus row)	**In-Network** You pay $0 copay for OTC items. $25 maximum plan coverage amount every month for OTC items. Unused portion does not carry over to the next period.	**In-Network** This benefit is covered as part of the Gold Perks Plus package. $25 maximum plan coverage amount every month for OTC items. This allowance is a combined amount for all services offered in the Gold Perks Plus combined benefit. Unused allowance does not carry forward to the next month.
Partial Hospitalization and Intensive Outpatient Services	**In-Network** You pay $70 copay for Medicare-covered partial hospitalization and intensive outpatient services. **Point-of-Service (POS)** You pay $70 copay for Medicare-covered partial hospitalization and intensive outpatient services.	**In-Network** You pay $80 copay for Medicare-covered partial hospitalization and intensive outpatient services. **Point-of-Service (POS)** You pay $80 copay for Medicare-covered partial hospitalization and intensive outpatient services.
Personal Emergency Response System (PERS) Benefit	Prior authorization is required for the personal emergency response system benefit.	No prior authorization required for the personal emergency response system benefit.

Cost	2024 (this year)	2025 (next year)
Physician/Practitioner Services, Including Doctor's Office Visits	**In-Network** For each Medicare-covered visit with other health care professionals (such as nurse practitioners and physician assistants), you pay $20 copay. **Point-of-Service (POS)** For each Medicare-covered visit with other health care professionals (such as nurse practitioners and physician assistants), you pay $20 copay.	**In-Network** For each Medicare-covered visit with other health care professionals (such as nurse practitioners and physician assistants), you pay $10 copay. **Point-of-Service (POS)** For each Medicare-covered visit with other health care professionals (such as nurse practitioners and physician assistants), you pay $10 copay.
Podiatry Services	**In-Network** You pay $0 copay for each Medicare-covered podiatry services visit. You pay $0 copay for each routine foot care visit (12 visits every year). **Point-of-Service (POS)** You pay $0 copay for each Medicare-covered podiatry services visit. You pay $0 copay for each routine foot care visit (12 visits every year). Prior authorization is required for Medicare-covered podiatry care services. Prior authorization is required for routine podiatry care services.	**In-Network** You pay $10 copay for each Medicare-covered podiatry services visit. You pay $10 copay for each routine foot care visit (12 visits every year). **Point-of-Service (POS)** You pay $10 copay for each Medicare-covered podiatry services visit. You pay $10 copay for each routine foot care visit (12 visits every year). No prior authorization required for Medicare-covered podiatry care services. No prior authorization required for routine podiatry care services.

Cost	2024 (this year)	2025 (next year)
Pulmonary Rehabilitation Services	**In-Network** You pay $10 copay for each Medicare-covered pulmonary rehabilitation services visit. **Point-of-Service (POS)** You pay $10 copay for each Medicare-covered pulmonary rehabilitation services visit.	**In-Network** You pay $15 copay for each Medicare-covered pulmonary rehabilitation services visit. **Point-of-Service (POS)** You pay $15 copay for each Medicare-covered pulmonary rehabilitation services visit.
Re-admission Prevention	**In-Network** You pay $0 copay for the re-admission prevention benefit. Covered benefits include In-Home Safety Assessment. **Point-of-Service (POS)** You pay $0 copay for the re-admission prevention benefit. Covered benefits include In-Home Safety Assessment.	**In-Network** You pay $0 copay for the re-admission prevention benefit. Covered benefits include PCP or In Home visit with Plan designated provider including post discharge health needs assessment. **Point-of-Service (POS)** You pay $0 copay for the re-admission prevention benefit. Covered benefits include PCP or In Home visit with Plan designated provider including post discharge health needs assessment.
Skilled Nursing Facility (SNF) Care	**In-Network** For Medicare-covered SNF stays, you pay $0 copay per day for days 1-20; $200 copay per day for days 21-36; $0 copay per day for days 37-100.	**In-Network** For Medicare-covered SNF stays, you pay $0 copay per day for days 1-20; $150 copay per day for days 21-36; $0 copay per day for days 37-100.

Cost	2024 (this year)	2025 (next year)
Skilled Nursing Facility (SNF) Care continued	**Point-of-Service (POS)** For Medicare-covered SNF stays, you pay $0 copay per day for days 1-20; $200 copay per day for days 21-36; $0 copay per day for days 37-100.	**Point-of-Service (POS)** For Medicare-covered SNF stays, you pay $0 copay per day for days 1-20; $150 copay per day for days 21-36; $0 copay per day for days 37-100.
Supervised Exercise Therapy (SET)	**In-Network** You pay $10 copay for each Medicare-covered SET visit for symptomatic peripheral artery disease (PAD). **Point-of-Service (POS)** You pay $10 copay for each Medicare-covered SET visit for symptomatic peripheral artery disease (PAD).	**In-Network** You pay $0 copay for each Medicare-covered SET visit for symptomatic peripheral artery disease (PAD). **Point-of-Service (POS)** You pay $0 copay for each Medicare-covered SET visit for symptomatic peripheral artery disease (PAD).
Supplemental Benefits for the Chronically Ill (SSBCI)	The benefits in this SSBCI package are only available 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. Not all will qualify. Utilities Payment, Personal Care Services, Pest Control Services, Indoor Air Quality Equipment and Services, and Pet Supplies & Services benefits are not covered.	Utilities Payment, Personal Care Services, Pest Control Services, Indoor Air Quality Equipment and Services, and Pet Supplies & Services benefits are covered. See Gold Perks Plus row in this chart for description.

Cost	2024 (this year)	2025 (next year)
Healthy Food & Produce Allowance (SSBCI)	A monthly allowance of $80 to be used for the purchase of healthy foods at participating Plan Merchants. Unused Allowance does not roll over to the next month.	A monthly allowance of $77 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.
Smart Phone & Cellular Data Plan (SSBCI)	Smart phone device and cellular data plan benefit is not covered.	Members are provided one smart phone device and cellular data plan from a contracted vendor.
Telehealth Benefits (additional)	**In-Network** For additional telehealth benefits, you pay $25 copay for primary care physician services and physician specialist services.	**In-Network** For additional telehealth benefits, you pay $15 copay for primary care physician services, physician specialist services, individual sessions for mental health specialty services, group sessions for mental health specialty services.
Telemonitoring Services	Prior authorization is required for telemonitoring services.	No prior authorization required for telemonitoring services.
Non-Emergency Transportation Services (routine)	**In-Network** You pay $0 copay for routine transportation services (36 one-way trips every year to health-related locations (50 miles max one way)) using rideshare services, van and medical transport a Plan designated provider. Prior authorization is required for routine transportation services.	**In-Network** You pay $0 copay for routine transportation services (24 one-way trips every year to health-related locations) using rideshare services, van and medical transport from a Plan designated provider. No prior authorization required for routine transportation services.

Cost	2024 (this year)	2025 (next year)
Urgently Needed Care Services	Urgently needed care services cost sharing is waived if you are admitted to the hospital within 24 hours for the same condition.	Urgently needed care services cost sharing is not waived if you are admitted to the hospital for the same condition.
Vision: Combined Flexible Dental, Hearing and Vision Benefits	$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. You are responsible for all costs exceeding the combined benefit amount for the flexible benefits.	$1,000 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. You are responsible for all costs exceeding the combined benefit amount for the flexible benefits.

Section 2.5 – Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a Formulary or Drug List. A copy of our Drug List is provided electronically.

We made changes to our Drug List, which could include removing or adding drugs, changing the restrictions that apply to our coverage for certain drugs or moving them to a different cost-sharing tier. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions, or if your drug has been moved to a different cost-sharing tier.**

Most of the changes in the Drug List are new for the beginning of each year. However, we might make other changes that are allowed by Medicare rules that will affect you during the plan year. We update our online Drug List at least monthly to provide the most up-to-date list of drugs. If we make a change that will affect your access to a drug you are taking, we will send you a notice about the change.

If you are affected by a change in drug coverage at the beginning of the year or during the year, please review Chapter 9 of your *Evidence of Coverage* and talk to your doctor to find out your options, such as asking for a temporary supply, applying for an exception, and/or working to find a new drug. You can also contact Member Services for more information.

We currently can immediately remove a brand name drug on our Drug List if we replace it with a new generic drug version on the same or a lower cost-sharing tier and with the same or fewer restrictions as the brand name drug it replaces. Also, when adding a new generic, we may also decide to keep the brand name drug on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions or both.

Starting in 2025, we can immediately replace original biological products with certain biosimilars. This means, for instance, if you are taking an original biological product that is being replaced by a biosimilar, you may not get notice of the change 30 days before we make it or get a month's supply of your original biological product at a network pharmacy. If you are taking the original biological product at the time we make the change, you will still get information on the specific change we made, but it may arrive after we make the change.

Some of these drug types may be new to you. For definitions of drug types, please see Chapter 12 of your *Evidence of Coverage*. The Food and Drug Administration (FDA) also provides consumer information on drugs. See FDA website: https://www.fda.gov/drugs/biosimilars/multimedia-education-materials-biosimilars#For%20Patients. You may also contact Member Services or ask your health care provider, prescriber, or pharmacist for more information.

Changes to Prescription Drug Benefits and Costs

Beginning in 2025, there are three **drug payment stages**: the Yearly Deductible Stage, the Initial Coverage Stage, and the Catastrophic Coverage Stage. The Coverage Gap Stage and the Coverage Gap Discount Program will no longer exist in the Part D benefit.

The Coverage Gap Discount Program will also be replaced by the Manufacturer Discount Program. Under the Manufacturer Discount Program, drug manufacturers pay a portion of the plan's full cost for covered Part D brand name drugs and biologics during the Initial Coverage Stage and the Catastrophic Coverage Stage. Discounts paid by manufacturers under the Manufacturer Discount Program do not count toward out-of-pocket costs.

Changes to the Deductible Stage

Stage	2024 (this year)	2025 (next year)
Stage 1: Yearly Deductible Stage	Because we have no deductible, this payment stage does not apply to you.	Because we have no deductible, this payment stage does not apply to you.

Changes to Your Cost Sharing in the Initial Coverage Stage

Stage	2024 (this year)	2025 (next year)
Stage 2: Initial Coverage Stage During this stage, the plan pays its share of the cost of your drugs, and **you pay your share of the cost.** The costs in this chart are for a one-month (30-day) supply when you fill your prescription at a network pharmacy that provides standard cost sharing. For information about the costs for a long-term supply, look in Chapter 6, Section 5 of your *Evidence of Coverage*.	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing is: **Tier 1 Preferred Generic:** You pay $0 copay per prescription. **Tier 2 Generic:** You pay $5 copay per prescription. You pay $5 copay per month supply of each covered insulin product on this tier. **Tier 3 Preferred Brand:** You pay $40 copay per prescription. You pay $35 copay per month supply of each covered insulin product on this tier.	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing is: **Tier 1 Preferred Generic:** You pay $0 copay per prescription. **Tier 2 Generic:** You pay $0 copay per prescription. Insulin products are not covered on this tier. **Tier 3 Preferred Brand:** You pay $40 copay per prescription. Insulin products are not covered on this tier.

Stage	2024 (this year)	2025 (next year)
Most adult Part D vaccines are covered at no cost to you.	**Tier 4 Non-Preferred Brand:** You pay $100 copay per prescription. **Tier 5 Specialty Tier:** You pay 33% coinsurance per prescription. **Tier 6 Select Diabetic Drugs:** You pay $0 copay per prescription.	**Tier 4 Non-Preferred Brand:** You pay $100 copay per prescription. **Tier 5 Specialty Tier:** You pay 33% coinsurance per prescription. **Tier 6 Select Diabetic Drugs:** You pay $0 copay per prescription.
	Once your total drug costs have reached $5,030, you will move to the next stage (the Coverage Gap Stage).	Once you have paid $2,000 out of pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).

Changes to the Catastrophic Coverage Stage

The Catastrophic Coverage Stage is the third and final stage. Beginning in 2025, drug manufacturers pay a portion of the plan's full cost for covered Part D brand name drugs and biologics during the Catastrophic Coverage Stage. Discounts paid by manufacturers under the Manufacturer Discount Program do not count toward out-of-pocket costs.

If you reach the Catastrophic Coverage Stage, you pay nothing for your covered Part D drugs.

For specific information about your costs in the Catastrophic Coverage Stage, look at Chapter 6, Section 6 in your *Evidence of Coverage*.

SECTION 3 Administrative Changes

Description	2024 (this year)	2025 (next year)
Medicare Prescription Payment Plan	Not applicable	The Medicare Prescription Payment Plan is a new payment option that works with your current drug coverage, and it can help you manage your drug costs by spreading them across **monthly payments that vary throughout the year** (January – December). To learn more about this payment option, please contact us at 1-844-294-6535 or visit Medicare.gov.

SECTION 4 Deciding Which Plan to Choose

Section 4.1 – If you want to stay in Gold Kidney of Arizona Gold Heart & Diabetes (HMO-POS C-SNP)

To stay in our plan, you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically be enrolled in our Gold Kidney of Arizona Gold Heart & Diabetes (HMO-POS C-SNP).

Section 4.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change plans for 2025 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- – *OR* – You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan. If you do not enroll in a Medicare drug plan, please see Section 2.1 regarding a potential Part D late enrollment penalty.

To learn more about Original Medicare and the different types of Medicare plans, use the Medicare Plan Finder (www.medicare.gov/plan-compare), read the *Medicare & You 2025* handbook, call your State Health Insurance Assistance Program (see Section 6), or call Medicare (see Section 8.2).

Step 2: Change your coverage

- To **change to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from Gold Kidney of Arizona Gold Heart & Diabetes (HMO-POS C-SNP).
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Gold Kidney of Arizona Gold Heart & Diabetes (HMO-POS C-SNP).
- To **change to Original Medicare without a prescription drug plan,** you must either:
    - Send us a written request to disenroll. Contact Member Services if you need more information on how to do so.
    - – *OR* – Contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

SECTION 5 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7.** The change will take effect on January 1, 2025.

Are there other times of the year to make a change?

In certain situations, changes are also allowed at other times of the year. Examples include people with Medicaid, those who get "Extra Help" paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area.

If you enrolled in a Medicare Advantage plan for January 1, 2025, and don't like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2025.

If you recently moved into or currently live in an institution (like a skilled nursing facility or long-term care hospital), you can change your Medicare coverage **at any time**. You can change to any other Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for two full months after the month you move out.

SECTION 6 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is an independent government program with trained counselors in every state. In Arizona, the SHIP is called Arizona State Health Insurance Assistance Program (SHIP).

It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. Arizona State Health Insurance Assistance Program (SHIP) counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call Arizona State Health Insurance Assistance Program (SHIP) at 1-602-542-4446 or 1-800-432-4040. You can learn more about Arizona State Health Insurance Assistance Program (SHIP) by visiting their website (https://des.az.gov/services/older-adults/medicare-assistance).

SECTION 7 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs.

- **"Extra Help" from Medicare.** People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, yearly deductibles, and coinsurance. Additionally, those who qualify will not have a late enrollment penalty. To see if you qualify, call:
    - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day, 7 days a week;
    - The Social Security Office at 1-800-772-1213 between 8 am and 7 pm, Monday through Friday for a representative. Automated messages are available 24 hours a day. TTY users should call 1-800-325-0778; or
    - Your State Medicaid Office.
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. To be eligible for the ADAP operating in your State, individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the Arizona AIDS Drugs Assistance Program (ADAP). For information on eligibility criteria, covered drugs, how to enroll in the program or if you are currently enrolled how to continue receiving assistance, call Arizona AIDS Drugs Assistance Program (ADAP) at 1-800-334-1540. Be sure, when calling, to inform them of your Medicare Part D plan name or policy number.
- **The Medicare Prescription Payment Plan.** The Medicare Prescription Payment Plan is a new payment option to help you manage your out-of-pocket drug costs, starting in 2025. This new payment option works with your current drug coverage, and it can help

you manage your drug costs by spreading them across **monthly payments that vary throughout the year** (January – December). **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs.**

"Extra Help" from Medicare and help from your SPAP and ADAP, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan. All members are eligible to participate in this payment option, regardless of income level, and all Medicare drug plans and Medicare health plans with drug coverage must offer this payment option. To learn more about this payment option, please contact us at 1 (844) 294-6535 or visit Medicare.gov.

SECTION 8 Questions?

Section 8.1 – Getting Help from Gold Kidney of Arizona Gold Heart & Diabetes (HMO-POS C-SNP)

Questions? We're here to help. Please call Member Services at 1-844-294-6535. (TTY only, call 711.) We are available for phone calls October 1 – March 31: Live Customer Service Representatives (CSRs) are available seven days a week, from 8:00 a.m. to 8:00 p.m. local time for the regions in which they operate; and Interactive voice response system or similar technologies for Thanksgiving and Christmas Day (messages must be returned within one (1) business day) April 1 – September 30: Live CSRs available Monday through Friday, from 8:00 a.m. to 8:00 p.m. in all time zones for the regions in which they operate; and Interactive voice response system or similar technologies for Saturdays, Sundays and Federal Holidays (messages must be returned within one (1) business day. Calls to these numbers are free.

Read your *2025 Evidence of Coverage* (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2025. For details, look in the *2025 Evidence of Coverage* for Gold Kidney of Arizona Gold Heart & Diabetes (HMO-POS C-SNP). The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is located on our website at www.goldkidney.com/evidence-of-coverage-2025-Arizona. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

Visit our Website

You can also visit our website at www.goldkidney.com. As a reminder, our website has the most up-to-date information about our provider network (*Provider Directory*) and our *List of Covered Drugs* (*Formulary/Drug List*).

Section 8.2 – Getting Help from Medicare

To get information directly from Medicare:

Call 1-800-MEDICARE (1-800-633-4227)

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Visit the Medicare Website

Visit the Medicare website (www.medicare.gov). It has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area. To view the information about plans, go to www.medicare.gov/plan-compare.

Read *Medicare & You 2025*

Read the *Medicare & You 2025* handbook. Every fall, this document is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this document, you can get it at the Medicare website (https://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf) or 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.

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 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) 294-6535번으로 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 294-6535 (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。

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: 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

Questions

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

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 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).

Point-of-Service (POS)/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 Point-of-Service (POS) 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) and participate in the Plan's case management program. Please note that a member 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.