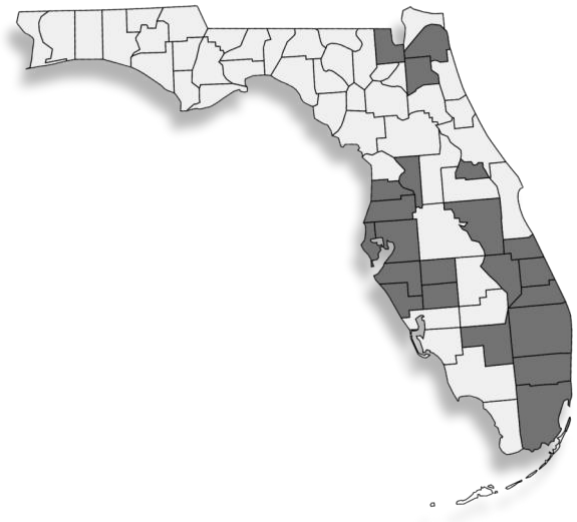
2026

Summary of Benefits

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



This is a summary of Medicare health care and prescription drug coverage for Gold Kidney of Florida Gold Heart & Diabetes Complete (HMO-POS C-SNP).

January 1 – December 31, 2026

Gold Kidney of Florida Gold Heart & Diabetes Complete (HMO-POS C-SNP) is a Medicare Advantage HMO-POS Chronic Special Needs Plan (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 Florida Gold Heart & Diabetes Complete (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 Florida: Broward, Clay, Duval, Hernando, Manatee, Palm Beach, Pasco, Pinellas, Sarasota, Baker, DeSoto, Hardee, Hendry, Hillsborough, Indian River, Martin, Miami-Dade, Okeechobee, Osceola, Seminole, St. Lucie and Sumter.

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

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

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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.

*Your medical cost-shares may be less if you receive full Medicaid benefits.

Premiums and Benefits	Gold Kidney of Florida Gold Heart & Diabetes Complete (HMO-POS C-SNP)	
Monthly Plan Premium (includes both medical and drugs)	You pay $0 each month. You must continue to pay your Medicare Part B premium.	
Deductible	$288 for medical benefits. $615 for Part D benefits.	
Maximum Out-of-Pocket Responsibility (does not include Part D prescription drugs)	$9,250 annually. Includes copays and other costs for in-network medical services for the year.	
Inpatient Hospital	In-Network Days 1-60: $0 copay for each benefit period. Days 61-90: $419 copay per day of each benefit period. Days 91 and beyond: $838 copay for each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime). Beyond lifetime reserve days: all costs. $1,676 deductible for each benefit period. These are 2025 cost-sharing amounts and may change for 2026.	Out-of-Network Days 1-60: $0 copay for each benefit period. Days 61-90: $419 copay per day of each benefit period. Days 91 and beyond: $838 copay for each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime). Beyond lifetime reserve days: all costs. $1,676 deductible for each benefit period. These are 2025 cost-sharing amounts and may change for 2026.
Outpatient Hospital	In-Network 20% coinsurance per visit	Out-of-Network 20% coinsurance per visit
Ambulatory Surgical Center (ASC)	In-Network 20% coinsurance	Out-of-Network 20% coinsurance

Premiums and Benefits	Gold Kidney of Florida Gold Heart & Diabetes Complete (HMO-POS C-SNP)	
Doctor Visits Primary care provider Specialist	In-Network 20% coinsurance 20% coinsurance	Out-of-Network 20% coinsurance 20% coinsurance
Preventive Care (e.g., flu vaccine, diabetic screenings)	In-Network $0 copay	Out-of-Network 20% coinsurance
Emergency Care	20% coinsurance, up to a $115 maximum per visit. ER cost sharing is waived if you are admitted to the hospital within 24 hours for the same condition.	
Urgently Needed Services	20% coinsurance, up to a $40 maximum per visit	
Diagnostic Services/Labs/ Imaging/Radiology Diagnostic tests and procedures Lab services MRIs, CAT scans X-rays Therapeutic radiology services	In-Network 20% coinsurance 20% coinsurance 20% coinsurance 20% coinsurance 20% coinsurance	Out-of-Network 20% coinsurance 20% coinsurance 20% coinsurance 20% coinsurance 20% coinsurance
Hearing Supplemental routine hearing exam Fitting and evaluation for prescription hearing aids Hearing aids Gold Kidney contracts with a hearing services vendor to provide covered hearing benefits. Details and limits are available in the *Evidence of Coverage*.	In-Network $0 copay Limit one (1) Routine hearing exam per year $0 copay for unlimited visits every year $1,500 maximum plan coverage amount every year for routine hearing exams. This amount is combined with the prescription hearing aids benefit. 3-year warranty, 3 years of follow-up provider visits, and 2 years of batteries Limit 1 hearing aid per ear per year	Out-of-Network Not covered out-of-network Not covered out-of-network Not covered out-of-network

Premiums and Benefits	Gold Kidney of Florida Gold Heart & Diabetes Complete (HMO-POS C-SNP)	
Dental	In-Network	Out-of-Network
Preventive dental services	$0 copay for preventive dental exams $0 copay for cleanings $0 copay for fluoride treatments $0 copay for X-rays $0 copay for other preventive dental services received	Not covered out-of-network
Comprehensive dental services	$0 copay for restorative services $0 copay for endodontics services $0 copay for periodontics services $0 copay for oral and maxillofacial surgery services $0 copay for adjunctive general services	Not covered out-of-network
Gold Kidney contracts with a dental services vendor to provide covered dental benefits. Details and limits are available in the Evidence of Coverage.	$4,000 allowance per year for preventive and comprehensive dental services combined	

Premiums and Benefits	Gold Kidney of Florida Gold Heart & Diabetes Complete (HMO-POS C-SNP)	
Vision Supplemental routine eye exams	In-Network $0 copay	Out-of-Network Not covered out-of-network
Routine eyewear	$300 maximum coverage amount every year for routine eyewear, including lenses, frames, or lenses and frames combined	Not covered out-of-network
Gold Kidney contracts with a vision services vendor to provide covered vision benefits. Details and limits are available in the Evidence of Coverage.	OR $115 every year for contact lenses (in lieu of glasses). The contact lens allowance applies to lens fitting/evaluation and contact lenses.	
Mental Health Outpatient group therapy / individual therapy visit	In-Network 20% coinsurance for individual sessions 20% coinsurance for group sessions	Out-of-Network 20% coinsurance for individual sessions 20% coinsurance for group sessions
Skilled Nursing Facility (SNF)	In-Network Days 1-20: $0 copay for each benefit period Days 21-100: $209.50 copay per day of each benefit period Days 101 and beyond: all costs These are 2025 cost-sharing amounts and may change for 2026. Gold Kidney of Florida will provide updated rates as soon as they are available.	Out-of-Network Days 1-20: $0 copay for each benefit period. Days 21-100: $209.50 copay per day of each benefit period. Days 101 and beyond: all costs. These are 2025 cost-sharing amounts and may change for 2026. Gold Kidney of Florida will provide updated rates as soon as they are available.

Premiums and Benefits	Gold Kidney of Florida Gold Heart & Diabetes Complete (HMO-POS C-SNP)	
Chiropractor	In-Network 20% coinsurance for Medicare covered visits 20% coinsurance for routine visits. Limit 12 visits per year	Out-of-Network 20% coinsurance Not covered out-of-network
Ambulance	In-Network 20% coinsurance for ground ambulance services. 20% coinsurance for air ambulance services.	Out-of-Network 20% coinsurance for ground ambulance services. 20% coinsurance for air ambulance services.
Medicare Part B Drugs	In-Network $35 copay for Medicare Part B insulin drugs. 0% to 20% coinsurance for Medicare Part B chemotherapy and radiation drugs. 0% to 20% coinsurance for other Medicare Part B drugs.	Out-of-Network 20% coinsurance for Medicare Part B insulin drugs. 20% coinsurance for Medicare Part B chemotherapy and radiation drugs. 20% coinsurance for other Medicare Part B drugs.

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 $615. **You must pay the full cost of your drugs** until you reach this amount.

Initial Coverage Stage

You stay in the Initial Coverage Stage until you have paid $2,100 out of pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).

	Standard Retail Rx		Long-term Care Rx	Out-of-Network Rx	Mail-Order Rx
Day Supply	30-day	100-day	31-day	30-day	100-day
Tier 1 Preferred Generic:	24%	24%	24%	24%	24%
Tier 2 Generic:	24%	24%	24%	24%	24%
Tier 3 Preferred Brand:	24%	24%	24%	24%	24%
Tier 4 Non-Preferred Brand:	26%	26%	26%	26%	26%
Tier 5 Specialty Tier:	25%	N/A	25%	25%	N/A
Tier 6 Select Diabetic Drugs:	15%	15%	15%	15%	15%
Insulin drugs	15%	15%	15%	15%	15%

Catastrophic Coverage Stage

You enter the Catastrophic Coverage Stage when your out-of-pocket costs have reached the $2,100 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.

During this stage, you pay nothing for Part D drugs.

Additional Benefits

For more information on limits and benefit details, see the *Evidence of Coverage* on our website at www.goldkidney.com.

Additional Benefits	
Durable Medical Equipment (DME)	20% coinsurance for Medicare-covered DME
Transportation	$0 copay for 22 one-way trips per year
Supplemental Benefits for the Chronically Ill (SSBCI) 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.	**Monthly Healthy Food and Produce Allowance*** $200 monthly allowance to be used for the purchase of healthy foods / produce or prepared meals from participating Plan Merchants. Unused allowance does not roll over to the next month. **Smartphone & Data Plan*** $0 copay for smartphone and unlimited talk, text, and data package for eligible members who agree to participate in care management services provided by the health plan and its partners. First 10GB of mobile data at high speed; speeds reduced to 128 kbps after 10GB. **Quarterly OTC and Utilities Allowance*** $100 quarterly allowance to be used for the purchase of over-the-counter (OTC) items and/or paying utilities. Unused allowance does not roll over to the next quarter. Utility account information required.

Gold Kidney Health Plan, Inc.®, is an 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, or sex (including pregnancy, sexual orientation, and gender identity).

*Special Supplemental Benefits for the Chronically Ill (SSBCI) are available to eligible members with qualifying chronic conditions, including diabetes, chronic heart failure, cardiovascular disorders, and chronic kidney disease (stage 3b or higher), and are offered based upon Gold Kidney Health Plan eligibility criteria. SSBCI benefits are not guaranteed and may change each year. For full details, including eligibility requirements and available services, please contact Gold Kidney Health Plan or review your plan’s Evidence of Coverage.

Notice of Availability

English: ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-844-294-6535 (TTY: 711) or speak to your provider.

Spanish: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-844-294-6535 (TTY: 711) o hable con su proveedor.

Navajo: SHOOH: Diné bee yáníłti'gogo, saad bee aná'awo' bee áka'anída'awo'ít'áá jiik'eh ná hóló. Bee ahił hane'go bee nida'anishí t'áá ákodaat'éhígíí dóó bee áka'anída'wo'í áko bee baa hane'í bee hadadilyaa bich'į' ahoot'i'ígíí éí t'áá jiik'eh hóló. Kohjį' 1-844-294-6535 (TTY: 711) hodíilnih doodago nika'análwo'í bich'į' hanidziih.

Haitian: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd aladispozisyon w gratis pou lang ou pale a. Èd ak sèvis siplemantè apwopriye pou bay enfòmasyon nan fòma aksesib yo disponib gratis tou. Rele nan 1-844-294-6535 (TTY: 711) oswa pale avèk founisè w la.

French: ATTENTION: Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-844-294-6535 (TTY : 711) ou parlez à votre fournisseur.

Portuguese: ATENÇÃO: Se você fala português, serviços gratuitos de assistência linguística estão disponíveis para você. Auxílios e serviços auxiliares apropriados para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para 1-844-294-6535 (TTY: 711) ou fale com seu provedor.

Simplified Chinese: 注意：如果您说中文，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 1-844-294-6535（文本电话：711）或咨询您的服务提供商。

Tagalog: PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-844-294-6535 (TTY: 711) o makipag-usap sa iyong provider.

Vietnamese: LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-844-294-6535 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.

Arabic: تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 1-844-294-6535 (711) أو تحدث إلى مقدم الخدمة.

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-844-294-6535 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-844-294-6535 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।

Russian: ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-844-294-6535 (TTY: 711) или обратитесь к своему поставщику услуг.

Italian: ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l'1-844-294-6535 (tty: 711) o parla con il tuo fornitore.

Gujarati: ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઑક્ઝિલરી સહાય અને ઍક્સેસિબલ ફૉર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 1-844-295-6535 (TTY: 711) પર કૉલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.

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