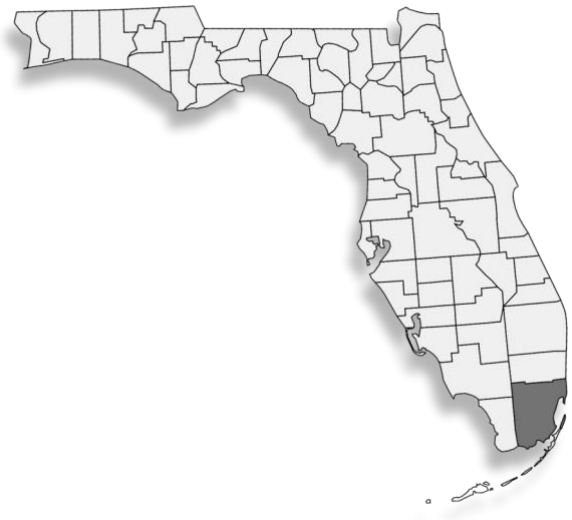
2026

Summary of Benefits

Gold Kidney of Florida Gold Dialysis & Kidney (HMO-POS C-SNP)



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

January 1 – December 31, 2026

Gold Kidney of Florida Gold Dialysis & Kidney (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 Dialysis & Kidney (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: Miami-Dade.

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

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 Florida Gold Dialysis & Kidney (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	$0 for medical benefits. $0 for Part D benefits.	
Maximum Out-of-Pocket Responsibility (does not include Part D prescription drugs)	$1,900 annually. Includes copays and other costs for in-network medical services for the year.	
Inpatient Hospital	In-Network $50 copay per day for days 1-7; $0 copay per day for days 8-90	Out-of-Network $50 copay per day for days 1-7; $0 copay per day for days 8-90
Outpatient Hospital	In-Network $50 copay per visit	Out-of-Network $50 copay per visit
Ambulatory Surgical Center (ASC)	In-Network $50 copay	Out-of-Network $50 copay
Doctor Visits Primary care provider Specialist	In-Network $0 copay $0 copay for nephrologists, cardiologists, and endocrinologists $5 copay for all other specialists	Out-of-Network $0 copay $5 copay
Preventive Care (e.g., flu vaccine, diabetic screenings)	In-Network $0 copay	Out-of-Network $0 copay
Emergency Care	$120 copay per visit. ER cost sharing is waived if you are admitted to the hospital within 24 hours for the same condition.	

Premiums and Benefits	Gold Kidney of Florida Gold Dialysis & Kidney (HMO-POS C-SNP)	
Urgently Needed Services	$0 copay per visit	
Diagnostic Services/Labs/ Imaging/Radiology	In-Network	Out-of-Network
Diagnostic tests and procedures	$0 to $10 copay	$10 copay
Lab services	$0 to $10 copay	$10 copay
MRIs, CAT scans	$0 to $150 copay	$150 copay
X-rays	$0 copay	$0 copay
Therapeutic radiology services	20% coinsurance	20% coinsurance
Hearing	In-Network	Out-of-Network
Supplemental routine hearing exam	$0 copay Limit one (1) Routine hearing exam per year	Not covered out-of-network
Fitting and evaluation for prescription hearing aids	$0 copay for unlimited visits every year	Not covered out-of-network
Hearing aids	$0 copay for Tier 1 $195 copay for Tier 2 $495 copay for Tier 3 $795 copay for Tier 4 $1,095 copay for Tier 5 $1,495 copay for Tier 6 Actual cost-share will depend on hearing aid selected	Not covered out-of-network
Gold Kidney contracts with a hearing services vendor to provide covered hearing benefits. Details and limits are available in the *Evidence of Coverage*.	3-year warranty, 3 years of follow-up provider visits, and 2 years of batteries Limit 1 hearing aid per ear per year	

Premiums and Benefits	Gold Kidney of Florida Gold Dialysis & Kidney (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 50% coinsurance for removable prosthodontics services $0 copay for oral and maxillofacial surgery services $0 copay for adjunctive general services $5,000 allowance per year for preventive and comprehensive dental services combined	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*.		

Premiums and Benefits	Gold Kidney of Florida Gold Dialysis & Kidney (HMO-POS C-SNP)	
Vision	In-Network	Out-of-Network
Supplemental routine eye exams	$0 copay	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 $25 copay for individual sessions $10 copay for group sessions	Out-of-Network $25 copay for individual sessions $10 copay for group sessions
Skilled Nursing Facility (SNF)	In-Network $0 copay per day for days 1-20; $214 copay per day for days 21-100	Out-of-Network $0 copay per day for days 1-20; $214 copay per day for days 21-100
Chiropractor	In-Network $20 copay for Medicare covered visits $20 copay for routine visits. Limit 12 visits per year	Out-of-Network $20 copay Not covered out-of-network
Ambulance	In-Network $220 copay for ground ambulance services. 20% coinsurance for air ambulance services.	Out-of-Network $220 copay for ground ambulance services. 20% coinsurance for air ambulance services.

Premiums and Benefits	Gold Kidney of Florida Gold Dialysis & Kidney (HMO-POS C-SNP)	
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 do not pay a deductible.

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:	$0	$0	$0	$0	$0
Tier 2 Generic:	$5	$12	$5	$5	$5
Tier 3 Preferred Brand:	$47	$117	$47	$47	$40
Tier 4 Non-Preferred Brand:	$100	$250	$100	$100	$250
Tier 5 Specialty Tier:	33%	N/A	33%	33%	N/A
Tier 6 Select Diabetic Drugs:	$0	$0	$0	$0	$0
Insulin drugs	$0	$0	$0	$0	$0

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
MA Uniformity Benefits for Chronic Conditions These benefits are available only to eligible members who are Chronic Kidney Disease (CKD) Stage 5 End-Stage Renal Disease (ESRD) on dialysis or kidney transplant.	**In-Home Support Services** 60-hour In-Home Support services per year. Services include home care tasks, transportation, light housekeeping, and support during light exercise. **Dialysis Transportation Services** Unlimited number of trips to and from dialysis centers for members diagnosed with ESRD on dialysis. 50-mile max one-way limit per trip. **ESRD & Transplant Additional Dental Max Limit** $1,000 additional allowance to max dental limit for ESRD members on dialysis. See Evidence of Coverage (EOC) for limits and prior authorization requirements. **Non-Medicare Covered In-Home Staff-Assisted Dialysis*** $0 Copay for Non-Medicare Covered In-Home Staff-Assisted Dialysis. Eligible End-Stage Renal Disease (ESRD) members undergoing dialysis may qualify for in-home Staff Assisted Dialysis services when deemed medically necessary by their physician or the health plan provider. These services are coordinated through case management, which will refer members to participating providers to ensure appropriate and continuous care in the home. Referral required.
Transportation	$0 copay for 24 one-way trips per year

Additional Benefits	
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.

Korean: 주의: 한국어를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-844-294-6535(TTY: 711)번으로 전화하거나 서비스 제공업체에 문의하십시오.