



**GOLD KIDNEY HEALTH PLAN**

# 2025

**Gold Kidney Health Plan**

**Annual Notice of Change**

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

## **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 Essential Care (HMO-POS) to Gold Kidney of Arizona Gold Loyalty (HMO-POS). 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](http://www.goldkidney.com):

### **Evidence of Coverage**

Complete details of your Gold Kidney of Arizona Gold Loyalty (HMO-POS), including benefits and costs.

### **Provider Directory**

List of doctors, specialists, and other providers 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 Loyalty (HMO-POS) offered by Gold Kidney Health Plan***

### **Annual Notice of Changes for 2025**

You are currently enrolled as a member of Gold Kidney of Arizona Essential Care (HMO-POS). Next year, there will be changes to the plan's costs and benefits. ***Please see page 4 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](http://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.**

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#### **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).
  - Think about how much you will spend on premiums, deductibles, and cost sharing.
- ☐ Check to see if your primary care doctors, specialists, hospitals and other providers will be in our network next year.
- ☐ 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](http://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 Loyalty (HMO-POS).

- 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 Essential Care (HMO-POS).
- 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](http://www.irs.gov/Affordable-Care-Act/Individuals-and-Families) for more information.

### About Gold Kidney of Arizona Gold Loyalty (HMO-POS)

- 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 Loyalty (HMO-POS).
- This plan does not include Medicare Part D prescription drug coverage and you cannot be enrolled in a separate Medicare Part D prescription drug plan and this plan at the same time. Note: If you do not have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), you may have to pay a late enrollment penalty if you enroll in Medicare prescription drug coverage in the future.

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***Annual Notice of Changes for 2025***  
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## Summary of Important Costs for 2025

The table below compares the 2024 costs for Gold Kidney of Arizona Essential Care (HMO-POS) and 2025 costs for Gold Kidney of Arizona Gold Loyalty (HMO-POS) in several important areas. **Please note this is only a summary of costs.**

Cost	2024 (this year)	2025 (next year)
<b>Monthly plan premium</b> (See Section 2.1 for details.)	\$0	\$0
<b>Maximum out-of-pocket amount</b> This is the <u>most</u> you will pay out of pocket for your covered Part A and Part B services. (See Section 2.2 for details.)	\$8,850	\$5,500
<b>Doctor office visits</b>	Primary care visits: 20% coinsurance per visit  Specialist visits: 20% coinsurance per visit	Primary care visits: \$0 copay per visit  Specialist visits: \$45 copay per visit
<b>Inpatient hospital stays</b>	Days 1-60: \$0 copay for each benefit period. Days 61-90: \$408 copay per day of each benefit period. Days 91 and beyond: \$816 copay for each “lifetime reserve day” after day 90 for each benefit period (up to 60 days over your lifetime). Beyond lifetime reserve days: all costs	\$300 copay per day for days 1-7; \$0 copay per day for days 8-90

## SECTION 1 We Are Changing the Plan's Name

On January 1, 2025, our plan name will change from Gold Kidney of Arizona Essential Care (HMO-POS) to Gold Kidney of Arizona Gold Loyalty (HMO-POS).

You will receive a new ID card before January 1<sup>st</sup>. It will be updated with your new plan name, Gold Kidney of Arizona Gold Loyalty (HMO-POS). 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)
<b>Monthly premium</b> (You must also continue to pay your Medicare Part B premium.)	\$0	\$0
<b>Monthly Part B premium reduction</b>	\$100	\$75

### 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)
<b>Maximum out-of-pocket amount</b> Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount.	\$8,850	\$5,500  Once you have paid \$5,500 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 Network

Updated directories are located on our website at [www.goldkidney.com](http://www.goldkidney.com). You may also call Member Services for updated provider 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/](http://www.goldkidney.com/provider-search/) to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network.**

It is important that you know that we may make changes to the hospitals, doctors, and specialists (providers) 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)
<b>Referrals</b>	Referrals are required for certain services.	Referrals are <u>not</u> required for any services.
<b>Acupuncture</b>	Prior authorization is required for Medicare-covered acupuncture services.	No prior authorization required for Medicare-covered acupuncture services.



Cost	2024 (this year)	2025 (next year)
<b>Ambulance Services</b>	<p><b><u>In-Network</u></b></p> <p>You pay 20% coinsurance for each one-way Medicare-covered ground ambulance service.</p> <p><b><u>Point-of-Service (POS)</u></b></p> <p>You pay 20% coinsurance for each one-way Medicare-covered ground ambulance service.</p>	<p><b><u>In-Network</u></b></p> <p>You pay \$250 copay for each one-way Medicare-covered ground ambulance service.</p> <p><b><u>Point-of-Service (POS)</u></b></p> <p>You pay \$250 copay for each one-way Medicare-covered ground ambulance service.</p>
<b>Annual Physical Exam (Non-Medicare-covered)</b>	<p><b><u>In-Network</u></b></p> <p>Annual physical exam is <u>not</u> covered.</p> <p><b><u>Point-of-Service (POS)</u></b></p> <p>Annual physical exam is <u>not</u> covered.</p>	<p><b><u>In-Network</u></b></p> <p>You pay \$0 copay for an annual physical exam.</p> <p><b><u>Point-of-Service (POS)</u></b></p> <p>You pay \$0 copay for an annual physical exam.</p>
<b>Chiropractic Services</b>	Prior authorization is required for Medicare-covered chiropractic care services.	No prior authorization required for Medicare-covered chiropractic care services.
<b>Dental: Combined Flexible Dental, Hearing and Vision Benefits</b>		<p>\$625 maximum plan coverage amount every 3 months for all preventive and comprehensive dental services. This combined flexible benefit is a quarterly allowance that may be used for dental, hearing and vision benefits. The unused balance will carry forward to the next period.</p> <p>You are responsible for all costs exceeding the combined benefit amount for the flexible benefits.</p>

Cost	2024 (this year)	2025 (next year)
<b>Dental: Combined Flexible Dental, Hearing and Vision Benefits continued</b>	<b><u>In-Network</u></b> You pay 20% coinsurance for each Medicare-covered visit.	<b><u>In-Network</u></b> You pay \$0 copay for each Medicare-covered visit.
<b>Preventive Dental Services</b>	Preventive dental benefits are <u>not</u> covered.	You pay \$0 copay for each preventive dental exam (unlimited oral exams every year).  You pay \$0 copay for each cleaning (unlimited cleanings every year).  You pay \$0 copay for each fluoride treatment (unlimited fluoride treatments every year).  You pay \$0 copay for X-rays (unlimited X-rays every year).
<b>Comprehensive Dental Services</b>	Comprehensive Dental services are <u>not</u> covered.	You pay \$0 copay for each restorative services visit (unlimited visits every year).  You pay \$0 copay for each endodontics services visit (unlimited visits every year).  You pay \$0 copay for each periodontics services visit (unlimited visits every year).  You pay \$0 copay for each removable prosthodontics services visit (unlimited visits every year).  You pay \$0 copay for each maxillofacial prosthetics services visit (unlimited visits every year).

Cost	2024 (this year)	2025 (next year)
<b>Comprehensive Dental Services continued</b>		<p>You pay \$0 copay for each implant services visit (unlimited visits every year).</p> <p>You pay \$0 copay for each fixed prosthodontics services visit (unlimited visits every year).</p> <p>You pay \$0 copay for each oral and maxillofacial surgery services visit (unlimited visits every year).</p> <p>You pay \$0 copay for each orthodontics services visit (unlimited visits every year).</p> <p>You pay \$0 copay for each adjunctive general services visit (unlimited visits every year).</p>
<b>Preventive Dental Services</b>	<p><b><u>Point-of-Service (POS)</u></b></p> <p>You pay 20% coinsurance for each Medicare-covered visit.</p> <p>Preventive dental services are <u>not</u> covered.</p>	<p><b><u>Point-of-Service (POS)</u></b></p> <p>You pay \$0 copay for each Medicare-covered visit.</p> <p>You pay \$0 copay for each preventive dental exam (unlimited oral exams every year).</p> <p>You pay \$0 copay for each cleaning (unlimited cleanings every year).</p> <p>You pay \$0 copay for each fluoride treatment (unlimited fluoride treatments every year).</p> <p>You pay \$0 copay for X-rays (unlimited X-rays every year).</p>

Cost	2024 (this year)	2025 (next year)
<b>Preventive Dental Services continued</b>		You pay \$0 copay for other diagnostic services (unlimited visits every year for other diagnostic dental services).
<b>Comprehensive Dental Services</b>	Comprehensive Dental services are <u>not</u> covered.	<p>You pay \$0 copay for each restorative services visit (unlimited visits every year).</p> <p>You pay \$0 copay for each endodontics services visit (unlimited visits every year).</p> <p>You pay \$0 copay for each periodontics services visit (unlimited visits every year).</p> <p>You pay \$0 copay for each removable prosthodontics services visit (unlimited visits every year).</p> <p>You pay \$0 copay for each maxillofacial prosthetics services visit (unlimited visits every year).</p> <p>You pay \$0 copay for each implant services visit (unlimited visits every year).</p> <p>You pay \$0 copay for each fixed prosthodontics services visit (unlimited visits every year).</p> <p>You pay \$0 copay for each oral and maxillofacial surgery services visit (unlimited visits every year).</p> <p>You pay \$0 copay for each orthodontics services visit (unlimited visits every year).</p>

Cost	2024 (this year)	2025 (next year)
		You pay \$0 copay for each adjunctive general services visit (unlimited visits every year).
<b>Emergency Care</b>	<p><b><u>In-Network and Out-of-Network</u></b></p> <p>You pay 20% coinsurance, up to a \$100 maximum for each visit for Medicare-covered emergency care services.</p> <p>ER cost sharing is waived if you are admitted to the hospital within 24 hours for the same condition.</p>	<p><b><u>In-Network and Point-of-Service (POS)</u></b></p> <p>You pay \$125 copay for each visit for Medicare-covered emergency care services.</p> <p>ER cost sharing is not waived if you are admitted to the hospital for the same condition.</p>
<b>Fitness Benefit</b>	<p><b><u>In-Network</u></b></p> <p>Fitness benefit is <u>not</u> covered.</p>	<p><b><u>In-Network</u></b></p> <p>You pay \$0 copay for Silver&amp;Fit gymnasium access. Additionally, members have a fitness activity fee allowance as part of their Gold Perks Package.</p>
<p><b>Gold Perks</b></p> <p>The Gold Perks Package is a new combined benefit package that offers you the flexibility to choose how to use your allowance funds to purchase select services that best suit your needs using the prepaid benefits card provided to you.</p>	Gold Perks is <u>not</u> covered.	Gold Perks has a combined \$50 maximum plan allowance amount every month for the following benefits:

Cost	2024 (this year)	2025 (next year)
<b>Gold Perks continued</b>	Over-the-Counter (OTC) Supplies benefit is <u>not</u> covered.	<u>Over-the-Counter (OTC) Supplies</u> 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.
	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.

Cost	2024 (this year)	2025 (next year)
<b>Gold Perks continued</b>	<p>Fitness Activity Allowance is <u>not</u> covered.</p> <p>Home and bathroom safety devices benefit is <u>not</u> covered.</p>	<p><u>Fitness Activity Allowance</u></p> <p>Unused allowance does not carry forward to the next month. Members may use the combined allowance to pay for fitness activity fees. This benefit is in addition to their Silver&amp;Fit gym membership. The fitness activity allowance is a benefit that provides a spending allowance that may be used for access fees required at sports facilities for dance, golf, swimming, tennis, or other fitness related activity. The allowance cannot be applied to merchandise, food, or sport leagues or club sport memberships, competitions, social programs, park fees or other services.</p> <p><u>Home and Bathroom Safety Devices</u></p> <p>Unused allowance does not carry forward to the next month. Members may use the combined allowance to purchase elevated toilet seats, safety frames and risers.</p>

Cost	2024 (this year)	2025 (next year)
<b>Hearing: Combined Flexible Dental, Hearing and Vision Benefits</b>	<p><b><u>In-Network</u></b></p> <p>You pay 20% coinsurance for each Medicare-covered hearing exam.</p> <p>Routine hearing aid fitting/evaluation benefit is <u>not</u> covered.</p> <p>Prescription hearing aids (all types) benefit is <u>not</u> covered.</p> <p><b><u>Point-of-Service (POS)</u></b></p> <p>You pay 20% coinsurance for each Medicare-covered hearing exam.</p> <p>Routine hearing aid fitting/evaluation benefit is <u>not</u> covered.</p>	<p>\$625 maximum plan coverage amount every 3 months for all routine hearing exams and prescription hearing aids. This combined flexible benefit is a quarterly allowance that may be used for dental, hearing and vision benefits. The unused balance will carry forward to the next period.</p> <p>You are responsible for all costs exceeding the combined benefit amount for the flexible benefits.</p> <p><b><u>In-Network</u></b></p> <p>You pay \$0 copay for each Medicare-covered hearing exam.</p> <p>You pay \$0 copay for each routine hearing aid fitting/evaluation visit (unlimited visits every year).</p> <p>You pay \$0 copay for prescription hearing aids – all types (unlimited hearing aids).</p> <p><b><u>Point-of-Service (POS)</u></b></p> <p>You pay \$0 copay for each Medicare-covered hearing exam.</p> <p>You pay \$0 copay for each routine hearing aid fitting/evaluation visit (unlimited visits every year).</p>



Cost	2024 (this year)	2025 (next year)
<b>Hearing: Combined Flexible Dental, Hearing and Vision Benefits continued</b>	Prescription hearing aids (all types) benefit is <u>not</u> covered.	You pay \$0 copay for prescription hearing aids – all types (unlimited hearing aids).
<b>Home and Bathroom Safety Devices and Modifications (see Gold Perks row)</b>	<p><b><u>In-Network</u></b></p> <p>Home and bathroom safety devices and modifications benefit is <u>not</u> covered.</p> <p><b><u>Point-of-Service (POS)</u></b></p> <p>Home and bathroom safety devices and modifications benefit is <u>not</u> covered.</p>	<p><b><u>In-Network</u></b></p> <p>This benefit is covered as part of the Gold Perks package.</p> <p><b><u>Point-of-Service (POS)</u></b></p> <p>This benefit is covered as part of the Gold Perks package.</p> <p>\$50 maximum plan coverage amount every month for the home and bathroom safety devices and modifications benefit. This allowance is a combined amount for all services offered in the Gold Perks combined benefit. Unused allowance does not carry forward to the next month.</p>
<b>In-home Safety Assessment Services</b>	<p><b><u>In-Network</u></b></p> <p>In-home safety assessment services benefit is <u>not</u> covered.</p> <p><b><u>Point-of-Service (POS)</u></b></p> <p>In-home safety assessment services benefit is <u>not</u> covered.</p>	<p><b><u>In-Network</u></b></p> <p>You pay \$0 copay for in-home safety assessment services.</p> <p><b><u>Point-of-Service (POS)</u></b></p> <p>You pay \$0 copay for in-home safety assessment services.</p>
<b>In-home Support Services</b>	<p><b><u>In-Network</u></b></p> <p>In-home support services benefit is <u>not</u> covered.</p>	<p><b><u>In-Network</u></b></p> <p>You pay \$0 copay for in-home support services.</p>

Cost	2024 (this year)	2025 (next year)
<b>Inpatient Hospital Care</b>	<p><b><u>In-Network</u></b></p> <p>For Medicare-covered inpatient hospital stays, you pay Days 1-60: \$0 copay for each benefit period. Days 61-90: \$408 copay per day of each benefit period. Days 91 and beyond: \$816 copay for each “lifetime reserve day” after day 90 for each benefit period (up to 60 days over your lifetime). Beyond lifetime reserve days: all costs</p> <p>For inpatient hospital stays, you pay \$816 copay for each lifetime reserve day</p> <p><b><u>Point-of-Service (POS)</u></b></p> <p>For Medicare-covered inpatient hospital stays, you pay Days 1-60: \$0 copay for each benefit period. Days 61-90: \$408 copay per day of each benefit period. Days 91 and beyond: \$816 copay for each “lifetime reserve day” after day 90 for each benefit period (up to 60 days over your lifetime). Beyond lifetime reserve days: all costs.</p> <p>\$1,612 combined deductible for inpatient hospital acute and inpatient psychiatric hospital stays.</p>	<p><b><u>In-Network</u></b></p> <p>For Medicare-covered inpatient hospital stays, you pay \$300 copay per day for days 1-7; \$0 copay per day for days 8-90</p> <p>For inpatient hospital stays, you pay \$0 copay for each lifetime reserve day</p> <p><b><u>Point-of-Service (POS)</u></b></p> <p>For Medicare-covered inpatient hospital stays, you pay \$300 copay per day for days 1-7; \$0 copay per day for days 8-90</p> <p>No deductible for inpatient hospital stays.</p>

Cost	2024 (this year)	2025 (next year)
<b>Inpatient Services in a Psychiatric Hospital</b>	<p><b><u>In-Network</u></b></p> <p>For Medicare-covered inpatient mental health stays, you pay Days 1-60: \$0 copay for each benefit period. Days 61-90: \$408 copay per day of each benefit period. Days 91 and beyond: \$816 copay for each “lifetime reserve day” after day 90 for each benefit period (up to 60 days over your lifetime). Beyond lifetime reserve days: all costs</p> <p>For inpatient mental health stays, you pay \$816 copay for each lifetime reserve day.</p> <p><b><u>Point-of-Service (POS)</u></b></p> <p>For Medicare-covered inpatient mental health stays, you pay Days 1-60: \$0 copay for each benefit period. Days 61-90: \$408 copay per day of each benefit period. Days 91 and beyond: \$816 copay for each “lifetime reserve day” after day 90 for each benefit period (up to 60 days over your lifetime). Beyond lifetime reserve days: all costs.</p> <p>\$1,612 combined deductible for inpatient hospital acute and inpatient psychiatric hospital stays.</p>	<p><b><u>In-Network</u></b></p> <p>For Medicare-covered inpatient mental health stays, you pay \$325 copay per day for days 1-7; \$0 copay per day for days 8-90</p> <p>For inpatient mental health stays, you pay \$0 copay for each lifetime reserve day.</p> <p><b><u>Point-of-Service (POS)</u></b></p> <p>For Medicare-covered inpatient mental health stays, you pay \$325 copay per day for days 1-7; \$0 copay per day for days 8-90.</p> <p>No deductible for inpatient mental health stays.</p>
<b>Kidney Disease Services</b>	<p><b><u>In-Network</u></b></p> <p>Kidney disease education services include four supplemental sessions.</p>	<p><b><u>In-Network</u></b></p> <p>Kidney disease education services include no supplemental sessions.</p>

Cost	2024 (this year)	2025 (next year)
<b>Kidney Disease Services continued</b>	You pay 20% coinsurance for Medicare-covered kidney disease education services.	You pay \$0 copay for Medicare-covered kidney disease education services.
<b>Opioid Treatment Program Services</b>	<p><b><u>In-Network</u></b></p> <p>You pay 20% coinsurance for Medicare-covered opioid treatment program services.</p> <p><b><u>Point-of-Service (POS)</u></b></p> <p>You pay 20% coinsurance for Medicare-covered opioid treatment program services.</p>	<p><b><u>In-Network</u></b></p> <p>You pay \$45 copay for Medicare-covered opioid treatment program services.</p> <p><b><u>Point-of-Service (POS)</u></b></p> <p>You pay \$45 copay for Medicare-covered opioid treatment program services.</p>
<b>Outpatient Blood Services</b>	Prior authorization is required for outpatient blood services.	No prior authorization required for outpatient blood services.
<b>Outpatient Hospital Observation</b>	<p><b><u>In-Network</u></b></p> <p>You pay 20% coinsurance for Medicare-covered outpatient hospital observation services.</p> <p><b><u>Point-of-Service (POS)</u></b></p> <p>You pay 20% coinsurance for Medicare-covered outpatient hospital observation services.</p>	<p><b><u>In-Network</u></b></p> <p>You pay \$300 copay per day for Medicare-covered outpatient hospital observation services.</p> <p><b><u>Point-of-Service (POS)</u></b></p> <p>You pay \$300 copay for Medicare-covered outpatient hospital observation services.</p>
<b>Outpatient Mental Health Care</b>	<p><b><u>In-Network</u></b></p> <p>You pay 20% coinsurance for each Medicare-covered individual therapy visit with a mental health care professional (non-psychiatrist).</p> <p>You pay 20% coinsurance for each Medicare-covered group therapy visit with a mental health care professional (non-psychiatrist).</p>	<p><b><u>In-Network</u></b></p> <p>You pay \$45 copay for each Medicare-covered individual therapy visit with a mental health care professional (non-psychiatrist).</p> <p>You pay \$45 copay for each Medicare-covered group therapy visit with a mental health care professional (non-psychiatrist).</p>

Cost	2024 (this year)	2025 (next year)
<b>Outpatient Mental Health Care continued</b>	<p>You pay 20% coinsurance for each Medicare-covered individual therapy visit with a psychiatrist.</p> <p>You pay 20% coinsurance for each Medicare-covered group therapy visit with a psychiatrist.</p> <p><b><u>Point-of-Service (POS)</u></b></p> <p>You pay 20% coinsurance for each Medicare-covered individual therapy visit with a mental health care professional (non-psychiatrist).</p> <p>You pay 20% coinsurance for each Medicare-covered group therapy visit with a mental health care professional (non-psychiatrist).</p> <p>You pay 20% coinsurance for each Medicare-covered individual therapy visit with a psychiatrist.</p> <p>You pay 20% coinsurance for each Medicare-covered group therapy visit with a psychiatrist.</p>	<p>You pay \$45 copay for each Medicare-covered individual therapy visit with a psychiatrist.</p> <p>You pay \$45 copay for each Medicare-covered group therapy visit with a psychiatrist.</p> <p><b><u>Point-of-Service (POS)</u></b></p> <p>You pay \$45 copay for each Medicare-covered individual therapy visit with a mental health care professional (non-psychiatrist).</p> <p>You pay \$45 copay for each Medicare-covered group therapy visit with a mental health care professional (non-psychiatrist).</p> <p>You pay \$45 copay for each Medicare-covered individual therapy visit with a psychiatrist.</p> <p>You pay \$45 copay for each Medicare-covered group therapy visit with a psychiatrist.</p>
<b>Outpatient Rehabilitation Services</b>	<p><b><u>In-Network</u></b></p> <p>You pay 20% coinsurance for each Medicare-covered occupational therapy visit.</p> <p>You pay 20% coinsurance for each Medicare-covered physical therapy or speech therapy visit.</p>	<p><b><u>In-Network</u></b></p> <p>You pay \$35 copay for each Medicare-covered occupational therapy visit.</p> <p>You pay \$35 copay for each Medicare-covered physical therapy or speech therapy visit.</p>

Cost	2024 (this year)	2025 (next year)
<b>Outpatient Rehabilitation Services continued</b>	<p><b><u>Point-of-Service (POS)</u></b></p> <p>You pay 20% coinsurance for each Medicare-covered occupational therapy visit.</p> <p>You pay 20% coinsurance for each Medicare-covered physical therapy or speech therapy visit.</p> <p>Prior authorization is required for Medicare-covered occupational therapy services.</p>	<p><b><u>Point-of-Service (POS)</u></b></p> <p>You pay \$35 copay for each Medicare-covered occupational therapy visit.</p> <p>You pay \$35 copay for each Medicare-covered physical therapy or speech therapy visit.</p> <p>No prior authorization required for Medicare-covered occupational therapy services.</p>
<b>Outpatient Surgery</b>	<p>Includes services provided at hospital outpatient facilities and ambulatory surgical centers.</p> <p><b><u>In-Network</u></b></p> <p>For Medicare-covered services at an outpatient hospital facility, you pay 20% coinsurance.</p> <p>For Medicare-covered services at an ambulatory surgical center, you pay 20% coinsurance.</p> <p><b><u>Point-of-Service (POS)</u></b></p> <p>For Medicare-covered services at an outpatient hospital facility, you pay 20% coinsurance.</p> <p>For Medicare-covered services at an ambulatory surgical center, you pay 20% coinsurance.</p>	<p><b><u>In-Network</u></b></p> <p>For Medicare-covered services at an outpatient hospital facility, you pay \$275 copay.</p> <p>For Medicare-covered services at an ambulatory surgical center, you pay \$250 copay.</p> <p><b><u>Point-of-Service (POS)</u></b></p> <p>For Medicare-covered services at an outpatient hospital facility, you pay \$275 copay.</p> <p>For Medicare-covered services at an ambulatory surgical center, you pay \$250 copay.</p>
<b>Over-the-Counter Items (see Gold Perks row)</b>	<p><b><u>In-Network</u></b></p> <p>OTC items benefit is <u>not</u> covered.</p>	<p><b><u>In-Network</u></b></p> <p>This benefit is covered as part of the Gold Perks package.</p>

Cost	2024 (this year)	2025 (next year)
<b>Over-the-Counter Items (see Gold Perks row) continued</b>		\$50 maximum plan coverage amount every month for OTC items. This allowance is a combined amount for all services offered in the Gold Perks combined benefit. Unused allowance does not carry forward to the next month.
<b>Partial Hospitalization and Intensive Outpatient Services</b>	<p><b><u>In-Network</u></b></p> <p>You pay 20% coinsurance for Medicare-covered partial hospitalization and intensive outpatient services.</p> <p><b><u>Point-of-Service (POS)</u></b></p> <p>You pay 20% coinsurance for Medicare-covered partial hospitalization and intensive outpatient services.</p>	<p><b><u>In-Network</u></b></p> <p>You pay \$80 copay for Medicare-covered partial hospitalization and intensive outpatient services.</p> <p><b><u>Point-of-Service (POS)</u></b></p> <p>You pay \$80 copay for Medicare-covered partial hospitalization and intensive outpatient services.</p>
<b>Personal Emergency Response System (PERS) Benefit</b>	<p><b><u>In-Network</u></b></p> <p>Personal emergency response system (PERS) benefit is <u>not</u> covered.</p>	<p><b><u>In-Network</u></b></p> <p>You pay \$0 copay for the personal emergency response system (PERS) benefit.</p>
<b>Physician/Practitioner Services, Including Doctor's Office Visits</b>	<p><b><u>In-Network</u></b></p> <p>You pay 20% coinsurance for each Medicare-covered primary care doctor visit.</p> <p>You pay 20% coinsurance for each Medicare-covered specialist visit.</p> <p>For each Medicare-covered visit with other health care professionals (such as nurse practitioners and physician assistants), you pay 20% coinsurance.</p>	<p><b><u>In-Network</u></b></p> <p>You pay \$0 copay for each Medicare-covered primary care doctor visit.</p> <p>You pay \$45 copay for each Medicare-covered specialist visit.</p> <p>For each Medicare-covered visit with other health care professionals (such as nurse practitioners and physician assistants), you pay \$45 copay.</p>

Cost	2024 (this year)	2025 (next year)
<b>Physician/Practitioner Services, Including Doctor's Office Visits continued</b>	<p><b><u>Point-of-Service (POS)</u></b></p> <p>You pay 20% coinsurance for each Medicare-covered primary care doctor visit.</p> <p>You pay 20% coinsurance for each Medicare-covered specialist visit.</p> <p>For each Medicare-covered visit with other health care professionals (such as nurse practitioners and physician assistants), you pay 20% coinsurance.</p>	<p><b><u>Point-of-Service (POS)</u></b></p> <p>You pay \$0 copay for each Medicare-covered primary care doctor visit.</p> <p>You pay \$45 copay for each Medicare-covered specialist visit.</p> <p>For each Medicare-covered visit with other health care professionals (such as nurse practitioners and physician assistants), you pay \$45 copay.</p>
<b>Podiatry Services</b>	<p><b><u>In-Network</u></b></p> <p>You pay 20% coinsurance for each Medicare-covered podiatry services visit.</p> <p>Routine foot care benefit is <u>not</u> covered.</p> <p><b><u>Point-of-Service (POS)</u></b></p> <p>You pay 20% coinsurance for each Medicare-covered podiatry services visit.</p> <p>Routine foot care benefit is <u>not</u> covered.</p> <p>Prior authorization is required for Medicare-covered podiatry care services.</p>	<p><b><u>In-Network</u></b></p> <p>You pay \$45 copay for each Medicare-covered podiatry services visit.</p> <p>You pay \$45 copay for each routine foot care visit (12 visits every year).</p> <p><b><u>Point-of-Service (POS)</u></b></p> <p>You pay \$45 copay for each Medicare-covered podiatry services visit.</p> <p>You pay \$45 copay for each routine foot care visit (12 visits every year).</p> <p>No prior authorization required for Medicare-covered podiatry care services.</p>
<b>Post Discharge In-home Medication Reconciliation</b>	<p><b><u>In-Network</u></b></p> <p>Post discharge in-home medication reconciliation services benefit is <u>not</u> covered.</p>	<p><b><u>In-Network</u></b></p> <p>You pay \$0 copay for post discharge in-home medication reconciliation services.</p>



Cost	2024 (this year)	2025 (next year)
<b>Post Discharge In-home Medication Reconciliation continued</b>	<p><b><u>Point-of-Service (POS)</u></b></p> <p>Post discharge in-home medication reconciliation services benefit is <u>not</u> covered.</p>	<p><b><u>Point-of-Service (POS)</u></b></p> <p>You pay \$0 copay for post discharge in-home medication reconciliation services.</p>
<b>Re-admission Prevention</b>	<p><b><u>In-Network</u></b></p> <p>Re-admission prevention benefit is <u>not</u> covered.</p> <p><b><u>Point-of-Service (POS)</u></b></p> <p>Re-admission prevention benefit is <u>not</u> covered.</p>	<p><b><u>In-Network</u></b></p> <p>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.</p> <p><b><u>Point-of-Service (POS)</u></b></p> <p>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.</p>
<b>Skilled Nursing Facility (SNF) Care</b>	<p><b><u>In-Network</u></b></p> <p>For Medicare-covered SNF stays, you pay Days 1-20: \$0 copay for each benefit period Days 21-100: \$204 copay per day of each benefit period Days 101 and beyond: all costs.</p> <p><b><u>Point-of-Service (POS)</u></b></p> <p>For Medicare-covered SNF stays, you pay Days 1-20: \$0 copay for each benefit period Days 21-100: \$204 copay per day of each benefit period Days 101 and beyond: all costs.</p>	<p><b><u>In-Network</u></b></p> <p>For Medicare-covered SNF stays, you pay \$0 copay per day for days 1-20; \$214 copay per day for days 21-100.</p> <p><b><u>Point-of-Service (POS)</u></b></p> <p>For Medicare-covered SNF stays, you pay \$0 copay per day for days 1-20; \$214 copay per day for days 21-100.</p>

Cost	2024 (this year)	2025 (next year)
<b>Supervised Exercise Therapy (SET)</b>	<p><b><u>In-Network</u></b></p> <p>You pay 20% coinsurance for each Medicare-covered SET visit for symptomatic peripheral artery disease (PAD).</p> <p><b><u>Point-of-Service (POS)</u></b></p> <p>You pay 20% coinsurance for each Medicare-covered SET visit for symptomatic peripheral artery disease (PAD).</p>	<p><b><u>In-Network</u></b></p> <p>You pay \$10 copay for each Medicare-covered SET visit for symptomatic peripheral artery disease (PAD).</p> <p><b><u>Point-of-Service (POS)</u></b></p> <p>You pay \$10 copay for each Medicare-covered SET visit for symptomatic peripheral artery disease (PAD).</p>
<b>Supplemental Benefits for the Chronically Ill (SSBCI)</b>	<p>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.</p>	
<b>Healthy Food &amp; Produce Allowance (SSBCI)</b>	<p>A monthly allowance of \$75 to be used for the purchase of healthy foods at participating Plan Merchants. Unused Allowance does not roll over to the next month.</p>	<p>Healthy food allowance is <u>not</u> covered.</p>
<b>Fuel Allowance (SSBCI)</b>	<p>A monthly allowance of \$75 to be used for the purchase of fuel at gas stations. Unused Allowance does not roll over to the next month.</p>	<p>Fuel allowance is <u>not</u> covered.</p>

Cost	2024 (this year)	2025 (next year)
<b>Telehealth Benefits (additional)</b>	<p><b><u>In-Network</u></b></p> <p>For additional telehealth benefits, you pay 20% coinsurance for primary care physician services and physician specialist services.</p>	<p><b><u>In-Network</u></b></p> <p>For additional telehealth benefits, you pay \$45 copay for primary care physician services, physician specialist services, individual sessions for mental health specialty services, group sessions for mental health specialty services.</p>
<b>Urgently Needed Care Services</b>	<p><b><u>In-Network and Point-of-Service (POS)</u></b></p> <p>You pay 20% coinsurance, up to a \$55 maximum for each visit for Medicare-covered urgently needed care services.</p> <p>Urgently needed care services cost sharing is waived if you are admitted to the hospital within 24 hours for the same condition.</p>	<p><b><u>In-Network and Point-of-Service (POS)</u></b></p> <p>You pay \$45 copay for each visit for Medicare-covered urgently needed care services.</p> <p>Urgently needed care services cost sharing is not waived if you are admitted to the hospital for the same condition.</p>
<b>Vision: Combined Flexible Dental, Hearing and Vision Benefits</b>		<p>\$625 maximum plan coverage amount every 3 months for all routine eye exams and eyewear. This combined flexible benefit is a quarterly allowance that may be used for dental, hearing and vision benefits. The unused balance will carry forward to the next period.</p> <p>You are responsible for all costs exceeding the combined benefit amount for the flexible benefits.</p>

Cost	2024 (this year)	2025 (next year)
<b>Vision: Combined Flexible Dental, Hearing and Vision Benefits continued</b>	<p><b><u>In-Network</u></b></p> <p>You pay 20% coinsurance for each Medicare-covered eye exam to diagnose and treat diseases and conditions of the eye.</p> <p>You pay 20% coinsurance for Medicare-covered eyewear (one pair of eyeglasses or contact lenses) after cataract surgery.</p> <p>Routine eyeglasses are <u>not</u> covered.</p>	<p><b><u>In-Network</u></b></p> <p>You pay \$0 copay for each Medicare-covered eye exam to diagnose and treat diseases and conditions of the eye.</p> <p>You pay \$0 copay for Medicare-covered eyewear (one pair of eyeglasses or contact lenses) after cataract surgery.</p> <p>You pay \$0 copay for routine eyeglasses (unlimited pairs every year).</p> <p>You pay \$0 copay for routine eyeglass lenses (unlimited pairs every year).</p> <p>You pay \$0 copay for routine eyeglass frames (unlimited pairs every year).</p> <p>You pay \$0 copay for routine contact lenses (unlimited pairs every year).</p> <p>You pay \$0 copay for upgrades.</p>
	<p><b><u>Point-of-Service (POS)</u></b></p> <p>You pay 20% coinsurance for each Medicare-covered eye exam to diagnose and treat diseases and conditions of the eye.</p> <p>You pay 20% coinsurance for Medicare-covered eyewear (one pair of eyeglasses or contact lenses) after cataract surgery.</p>	<p><b><u>Point-of-Service (POS)</u></b></p> <p>You pay \$0 copay for each Medicare-covered eye exam to diagnose and treat diseases and conditions of the eye.</p> <p>You pay \$0 copay for Medicare-covered eyewear (one pair of eyeglasses or contact lenses) after cataract surgery.</p>

Cost	2024 (this year)	2025 (next year)
<b>Vision: Combined Flexible Dental, Hearing and Vision Benefits continued</b>	Routine eyeglasses are <u>not</u> covered.	<p>You pay \$0 copay for routine eyeglasses (unlimited pairs every year).</p> <p>You pay \$0 copay for routine eyeglass lenses (unlimited pairs every year).</p> <p>You pay \$0 copay for routine eyeglass frames (unlimited pairs every year).</p> <p>You pay \$0 copay for routine contact lenses (unlimited pairs every year).</p> <p>You pay \$0 copay for upgrades.</p>

## SECTION 3 Deciding Which Plan to Choose

### Section 3.1 – If you want to stay in Gold Kidney of Arizona Gold Loyalty (HMO-POS)

**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 Loyalty (HMO-POS).

### Section 3.2 – 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, there may be 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](http://www.medicare.gov/plan-compare)), read the *Medicare & You 2025* handbook, call your State Health Insurance Assistance Program (SHIP) (see Section 5), or call Medicare (see Section 7.2).

## 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 Loyalty (HMO-POS).
- 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 Loyalty (HMO-POS).
- 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 4 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 5 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 6 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, annual 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.

## SECTION 7 Questions?

### Section 7.1 – Getting Help from Gold Kidney of Arizona Gold Loyalty (HMO-POS)

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 Loyalty (HMO-POS). 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](http://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](http://www.goldkidney.com). As a reminder, our website has the most up-to-date information about our provider network (*Provider Directory*).

### Section 7.2 – 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](http://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](http://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 quý vị cần thông dịch viên xin gọi (844) 294-6535 sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.

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

**Korean:** 당사는 의료 보험 또는 약품 보험에 관한 질문에 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 الترجمة الفورية لمجاليّتيّ الإجابة عن أيّ سؤالٍ تتعلّق بالصّحة أو جدول الأدوية لبلدك من أجل حصول على تّرجمة فوريّة، ليس عليك سوى التّصّال بالخطّ (844) 294-6535. سيقوم شخصٌ من فريقنا العربيّ بمساعدتك. هذه خدمة مجانية.

**Hindi:** हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं। एक दुभाषिया प्राप्त करने के लिए, बस हमें (844) 294-6535 पर फोन करें। कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है। यह एक मुफ्त सेवा है।

**Italian:** È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero (844) 294-6535. Un nostro incaricato che parla Italiano vi 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 ouwa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan (844) 294-6535. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

**Polish:** Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer (844) 294-6535. Ta usługa jest bezpłatna.

**Japanese:** 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがあります。通訳をご用命になるには、(844) 294-6535にお電話ください。日本語を話す人 者が支援いたします。これは無料のサービスです。

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

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



Gold Kidney Health Plan, Inc., is an HMO-POS and HMO-POS C-SNP with a Medicare contract. Enrollment in Gold Kidney Health Plan depends on contract renewal.

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

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.