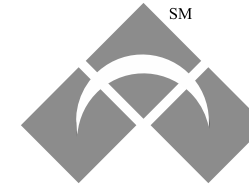
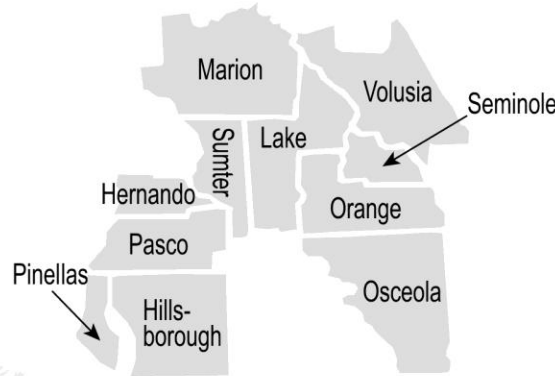
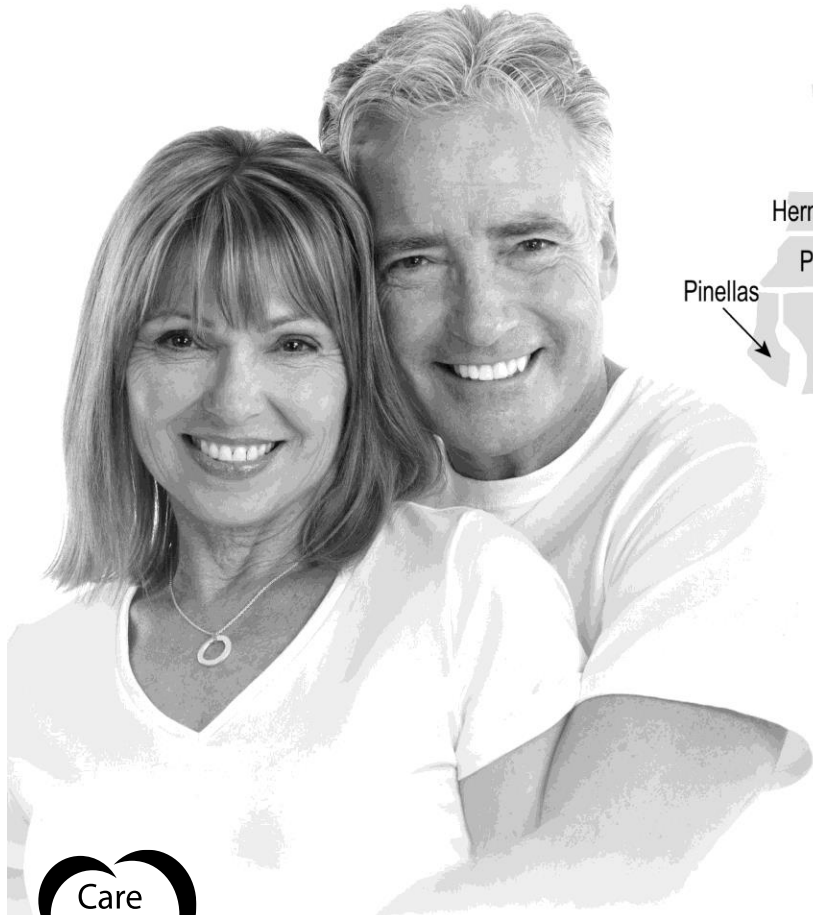


O20SBGOLD



OPTIMUM
HealthCare, Inc.



Broward

SB Combo 001 - 022 - 026 - 032

001 – Optimum Gold Rewards Plan (HMO)

Counties:
Broward, Hernando, Hillsborough, Pasco, Pinellas

022 – Optimum Gold Rewards Plan (HMO)

Counties:
Orange, Osceola, Seminole, Volusia

026 – Optimum Gold Rewards Plan (HMO)

Counties:
Lake, Marion, Sumter

032 – Optimum Gold Plus Plan (HMO)

Counties:
Hernando



H5594_2020_SB_001_022_026_032_M

2020 Summary of Benefits

Summary of Benefits

January 1, 2020 - December 31, 2020

Optimum Gold Rewards Plan (HMO) H5594_001

Optimum Gold Rewards Plan (HMO) H5594_022

Optimum Gold Rewards Plan (HMO) H5594_026

Optimum Gold Plus Plan (HMO) H5594_032

The purpose of the Summary of Benefits is to provide you with a summary of drug and health benefits covered by **Optimum Gold Rewards Plan (HMO) H5594_001, Optimum Gold Rewards Plan (HMO) H5594_022, Optimum Gold Rewards Plan (HMO) H5594_026** and **Optimum Gold Plus Plan (HMO) H5594_032**, which describes what we cover and what you pay. This information is not a complete description of benefits. Call 1-866-245-5360 (TTY: 711) for more information. Limitations, copayments and restrictions may apply. Benefits, premiums and/or co-payments/co-insurance may change on January 1 of each year.

Optimum HealthCare, Inc. is an HMO with a Medicare contract. Enrollment in Optimum HealthCare, Inc. depends on contract renewal.

To be eligible for **Optimum Gold Rewards Plan (HMO) H5594_001, Optimum Gold Rewards Plan (HMO) H5594_022, Optimum Gold Rewards Plan (HMO) H5594_026, and Optimum Gold Plus Plan (HMO) H5594_032**, you must have both Medicare Part A and Medicare Part B, and live in our service area.

Our service area includes the following counties in Florida:

Optimum Gold Rewards Plan (HMO) H5594_001:

Broward, Hernando, Hillsborough, Pasco and Pinellas

Optimum Gold Rewards Plan (HMO) H5594_026:

Lake, Marion and Sumter

Optimum Gold Rewards Plan (HMO) H5594_022:

Orange, Osceola, Seminole and Volusia

Optimum Gold Plus Plan (HMO) H5594_032:

Hernando

Optimum HealthCare, Inc. has a network of doctors, hospitals, pharmacies, and other providers. You must use plan providers to get your medical care and services except in emergency or urgent needed services when the network is not available, out-of-area dialysis services and in cases in which the plan authorizes use of out-of-network providers. If you obtain routine care from out-of-network providers neither Medicare nor Optimum HealthCare will be responsible for the costs. Out-of-network/non-contracted providers are under no obligation to treat Optimum HealthCare members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

Premiums and Benefits	Optimum Gold Rewards Plan (HMO)_001	Optimum Gold Rewards Plan (HMO)_022
Monthly Plan Premium	You pay \$0 Optimum HealthCare, Inc. will reduce your Medicare Part B premium by up to \$110	You pay \$0
Deductible	You pay \$0	You pay \$0
Maximum Out-of-Pocket Responsibility <i>(does not include prescription drugs)</i>	\$2,500 annually	\$3,400 annually
Inpatient Hospital Coverage	You pay \$150 copay each day for days 1 through 7 and \$0 copay each day for days 8 through 90 per admission	You pay \$195 copay each day for days 1 through 7 and \$0 copay each day for days 8 through 90 per admission
Outpatient Hospital Coverage	You pay \$200 copay per visit	You pay \$250 copay per visit
Doctor's Visits <ul style="list-style-type: none"> <li data-bbox="92 1263 264 1300">• Primary <li data-bbox="92 1354 310 1391">• Specialists 	You pay \$0 copay per visit You pay \$20 copay per visit	You pay \$0 copay per visit You pay \$35 copay per visit

Optimum Gold Rewards Plan (HMO)_026	Optimum Gold Plus Plan (HMO)_032	What you should know
You Pay \$0	You pay \$0 Optimum HealthCare, Inc. will reduce your Medicare Part B premium by up to \$110	You must continue to pay your Medicare Part B Premium unless your Part B Premium is paid for you by Medicaid or another third party.
You pay \$0	You pay \$0	This plan does not have a deductible
\$3,400 annually	\$2,500 annually	This is the most you pay for copays, coinsurance and other costs for medical services for the year. Contact the Plan for details on what is covered in the Maximum Out-of-Pocket.
You pay \$195 copay each day for days 1 through 7 and \$0 copay each day for days 8 through 90 per admission	You pay \$150 copay each day for days 1 through 7 and \$0 copay each day for days 8 through 90 per admission	Except in an emergency, you must get prior authorization in advance before you are admitted to the facility or your stay may not be covered.
You pay \$250 copay per visit	You pay \$150 copay per visit	Prior authorization is required for some services by your doctor or other network provider. Please contact the Plan for more information. Services include but are not limited to Medicare-covered outpatient hospital facility visits, clinic, outpatient treatment room, observation room, or outpatient surgery services.
You pay \$0 copay per visit You pay \$40 copay per visit	You pay \$0 copay per visit You pay \$20 copay per visit	Your primary care physician will coordinate the covered services you receive as a member of our plan. In order for you to see a specialist, you will need to have a referral from your PCP first. Separate copay may apply for each additional service received at an office visit.

Premiums and Benefits	Optimum Gold Rewards Plan (HMO)_001	Optimum Gold Rewards Plan (HMO)_022
Preventive Care	You pay \$0 copay	You pay \$0 copay
Emergency Care	You pay \$75 copay per visit	You pay \$75 copay per visit
Urgently Needed Services	You pay \$10 copay	You pay \$20 copay
Diagnostic Services/Labs/Imaging <ul style="list-style-type: none"> • Diagnostic Radiology service (e.g., MRI) • Lab services • Diagnostic Tests and procedures • Outpatient X-rays • Therapeutic Radiology 	<p>You pay \$25-\$200 copay depending on the service</p> <p>You pay \$0-\$50 copay depending on the place of service</p> <p>You pay \$0-\$200 copay or 20% coinsurance depending on the service</p> <p>You pay \$0-\$200 copay depending on the service</p> <p>You pay 20% coinsurance for Therapeutic Radiology</p>	<p>You pay \$25-\$250 copay depending on the service</p> <p>You pay \$0-\$50 copay depending on the place of service</p> <p>You pay \$0-\$250 copay or 20% coinsurance depending on the service</p> <p>You pay \$0-\$250 copay depending on the service</p> <p>You pay 20% coinsurance for Therapeutic Radiology</p>

Optimum Gold Rewards Plan (HMO)_026	Optimum Gold Plus Plan (HMO)_032	What you should know
You pay \$0 copay	You pay \$0 copay	Any additional preventive services approved by Medicare during the contract year will be covered. Preventive services in a hospital-based setting may require prior authorization.
You pay \$75 copay per visit	You pay \$75 copay per visit	\$500 copay for each emergency service, urgent service and emergency transportation outside the U.S. \$25,000 plan coverage limit for emergency services, urgent services and emergency transportation outside the U.S. every year. Contact the plan for details.
You pay \$20 copay	You pay \$10 copay	\$500 copay for each emergency service, urgent service and emergency transportation outside the U.S. \$25,000 plan coverage limit for emergency services, urgent services and emergency transportation outside the U.S. every year. Contact the plan for details.
<p>You pay \$25-\$250 copay depending on the service</p> <p>You pay \$0-\$50 copay depending on the place of service</p> <p>You pay \$0-\$250 copay or 20% coinsurance depending on the service</p> <p>You pay \$0-\$250 copay depending on the service</p> <p>You pay 20% coinsurance for Therapeutic Radiology</p>	<p>You pay \$25-\$150 copay depending on the service</p> <p>You pay \$0-\$50 copay depending on the place of service</p> <p>You pay \$0-\$150 copay or 20% coinsurance depending on the service</p> <p>You pay \$0-\$150 copay depending on the service</p> <p>You pay 20% coinsurance for Therapeutic Radiology</p>	Prior authorization is required for some services by your doctor or other network provider. Please contact the plan for more information.

Premiums and Benefits	Optimum Gold Rewards Plan (HMO)_001	Optimum Gold Rewards Plan (HMO)_022
<p>Hearing Services</p> <ul style="list-style-type: none"> • Hearing exam • Hearing aid 	<p>You pay \$0 copay for one routine hearing exam and one hearing aid fitting every year</p> <p>You pay \$0 copay for two hearing aids (1 per ear) per year</p>	<p>You pay \$0 copay for one routine hearing exam and one hearing aid fitting every year</p> <p>You pay \$0 copay for two hearing aids (1 per ear) per year</p>
<p>Dental Services</p> <ul style="list-style-type: none"> • Oral Exam & Cleaning • Fluoride Treatment • Dental X-rays • Extraction/Surgical Removal • Fillings • Debridement • Deep Cleaning (Scaling/Root Planing) 	<p>You pay \$0 copay for Oral exam, 2 per year, and \$0 copay for cleaning, 2 per year</p> <p>You pay \$0 copay for fluoride treatment, 2 per year</p> <p>You pay \$0 copay for Dental X-rays</p> <p>You pay \$0 copay for simple extraction OR surgical removal of erupted tooth, 1 procedure per year</p> <p>You pay \$0 copay for resin filling or restoration, 1 per year</p> <p>You pay \$0 copay for full mouth debridement, 1 per 2 years</p> <p>You pay \$0 copay for Scaling/Root Planing, 4 procedures per year and limited to 1 procedure per quadrant per year.</p>	<p>You pay \$0 copay for Oral exam, 2 per year, and \$0 copay for cleaning, 2 per year</p> <p>You pay \$0 copay for fluoride treatment, 2 per year</p> <p>You pay \$0 copay for Dental X-rays</p> <p>You pay \$0 copay for simple extraction OR surgical removal of erupted tooth, 1 procedure per year</p> <p>You pay \$0 copay for resin filling or restoration, 1 per year</p> <p>You pay \$0 copay for full mouth debridement, 1 per 2 years</p> <p>You pay \$0 copay for Scaling/Root Planing, 4 procedures per year and limited to 1 procedure per quadrant per year.</p>

Optimum Gold Rewards Plan (HMO)_026	Optimum Gold Plus Plan (HMO)_032	What you should know
<p>You pay \$0 copay for one routine hearing exam and one hearing aid fitting every year</p> <p>You pay \$0 copay for two hearing aids (1 per ear) per year</p>	<p>You pay \$0 copay for one routine hearing exam and one hearing aid fitting every year</p> <p>You pay \$0 copay for two hearing aids (1 per ear) per year</p>	<p>Our Plan pays up to a maximum of \$1,000 (\$500 per hearing aid) for hearing aid benefit every year.</p> <p>You are responsible for payment of any amount in excess of the maximum \$1,000 (\$500 per hearing aid)</p> <p>For all plans, you pay \$0 copay for Medicare-covered diagnostic hearing exam.</p>
<p>You pay \$0 copay for Oral exam, 2 per year, and \$0 copay for cleaning, 2 per year</p> <p>You pay \$0 copay for fluoride treatment, 2 per year</p> <p>You pay \$0 copay for Dental X-rays</p> <p>You pay \$0 copay for simple extraction OR surgical removal of erupted tooth, 1 procedure per year</p> <p>You pay \$0 copay for resin filling or restoration, 1 per year</p> <p>You pay \$0 copay for full mouth debridement, 1 per 2 years</p> <p>You pay \$0 copay for Scaling/Root Planing, 4 procedures per year and limited to 1 procedure per quadrant per year.</p>	<p>You pay \$0 copay for Oral exam, 2 per year, and \$0 copay for cleaning, 2 per year</p> <p>You pay \$0 copay for fluoride treatment, 2 per year</p> <p>You pay \$0 copay for Dental X-rays</p> <p>You pay \$0 copay for simple extraction OR surgical removal of erupted tooth, 1 procedure per year</p> <p>You pay \$0 copay for resin filling or restoration, 1 per year</p> <p>You pay \$0 copay for full mouth debridement, 1 per 2 years</p> <p>You pay \$0 copay for Scaling/Root Planing, 4 procedures per year and limited to 1 procedure per quadrant per year.</p>	<p>Dental services exclude periodontal maintenance. Prior Authorization may be required, and services must be performed by a participating dental provider.</p> <p>For more details or to get a complete list of services we cover, please refer to your Evidence of Coverage.</p> <p>For all plans, you pay \$0 copay for Medicare-covered dental benefit</p>

Premiums and Benefits	Optimum Gold Rewards Plan (HMO)_001	Optimum Gold Rewards Plan (HMO)_022
<p>Vision Services</p> <ul style="list-style-type: none"> • Routine Eye Exam • Eyeglasses (Frames and Lenses) 	<p>You pay \$0 copay for routine eye exam 1 every year by an optometrist</p> <p>You pay \$10 copay for the plan coverage limit for 1 pair of eyeglasses or contact lenses per year</p> <p>You pay \$0 copay for Medicare-covered eyewear (one pair of eyeglasses which includes frame and plastic lens or contact lenses) after cataract surgery</p> <p>You will be responsible for the \$10 copay and any amount over the plan benefit maximum of \$125 for eyewear benefit.</p>	<p>You pay \$0 copay for routine eye exam 1 every year by an optometrist</p> <p>You pay \$10 copay for the plan coverage limit for 1 pair of eyeglasses or contact lenses per year</p> <p>You pay \$0 copay for Medicare-covered eyewear (one pair of eyeglasses which includes frame and plastic lens or contact lenses) after cataract surgery</p> <p>You will be responsible for the \$10 copay and any amount over the plan benefit maximum of \$100 for eyewear benefit.</p>
<p>Mental Health Services</p> <ul style="list-style-type: none"> • Inpatient visit • Outpatient Group Therapy visit • Outpatient Individual Therapy visit 	<p>You pay \$150 copay each day for days 1-7 and \$0 copay each day for days 8-90 per admission</p> <p>You pay \$20 copay for outpatient group/individual therapy visit</p>	<p>You pay \$195 copay each day for days 1-7 and \$0 copay each day for days 8-90 per admission</p> <p>You pay \$35 copay for outpatient group/individual therapy visit</p>
<p>Skilled Nursing Facility</p>	<p>You pay \$0 copay each day for days 1-20</p> <p>You pay \$172 copay each day for days 21-100</p>	<p>You pay \$0 copay each day for days 1-5</p> <p>You pay \$20 copay each day for days 6-20</p> <p>You pay \$150 copay each day for days 21-100</p>

Optimum Gold Rewards Plan (HMO)_026	Optimum Gold Plus Plan (HMO)_032	What you should know
<p>You pay \$0 copay for routine eye exam 1 every year by an optometrist</p> <p>You pay \$10 copay for the plan coverage limit for 1 pair of eyeglasses or contact lenses per year</p> <p>You pay \$0 copay for Medicare-covered eyewear (one pair of eyeglasses which includes frame and plastic lens or contact lenses) after cataract surgery</p> <p>You will be responsible for the \$10 copay and any amount over the plan benefit maximum of \$100 for eyewear benefit.</p>	<p>You pay \$0 copay for routine eye exam 1 every year by an optometrist</p> <p>You pay \$10 copay for the plan coverage limit for 1 pair of eyeglasses or contact lenses per year</p> <p>You pay \$0 copay for Medicare-covered eyewear (one pair of eyeglasses which includes frame and plastic lens or contact lenses) after cataract surgery</p> <p>You will be responsible for the \$10 copay and any amount over the plan benefit maximum of \$125 for eyewear benefit.</p>	<p>Eye exams to diagnose and treat diseases and conditions of the eye by an Ophthalmologist are subject to the Specialist copay.</p> <p>Contact the Plan for additional supplemental benefits.</p> <p>You pay nothing for exams to diagnose and treat diseases and conditions of the eye by an Optometrist</p> <p>For plans 001 and 032, the coverage limit is \$125 for eyewear (eyeglasses or contact lenses) per benefit year.</p> <p>For plans 022 and 026, the coverage limit is \$100 for eyewear (eyeglasses or contact lenses) per benefit year.</p>
<p>You pay \$195 copay each day for days 1-7 and \$0 copay each day for days 8-90 per admission</p> <p>You pay \$40 copay for outpatient group/individual therapy visit</p>	<p>You pay \$150 copay each day for days 1-7 and \$0 copay each day for days 8-90 per admission</p> <p>You pay \$20 copay for outpatient group/individual therapy visit</p>	<p>Prior Authorization may be required. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>
<p>You pay \$0 copay each day for days 1-5</p> <p>You pay \$20 copay each day for days 6-20</p> <p>You pay \$150 copay each day for days 21-100</p>	<p>You pay \$0 copay each day for days 1-20</p> <p>You pay \$172 copay each day for days 21-100</p>	<p>Our plan covers up to 100 days in a SNF per benefit plan.</p> <p>You must get prior authorization in advance before you are admitted to the facility or your stay may not be covered.</p>

Premiums and Benefits	Optimum Gold Rewards Plan (HMO)_001	Optimum Gold Rewards Plan (HMO)_022
Physical Therapy (Rehabilitation Services) <ul style="list-style-type: none"> • Occupational Therapy visit • Physical Therapy and Speech Therapy and Language Therapy visit 	<p>You pay \$20 copay</p> <p>You pay \$20 copay</p>	<p>You pay \$35 copay</p> <p>You pay \$35 copay</p>
Ambulance	<p>You pay \$175 copay for Medicare-covered one-way ground ambulance benefit</p> <p>You pay 20% coinsurance for Medicare-covered one-way air ambulance benefit</p>	<p>You pay \$175 copay for Medicare-covered one-way ground ambulance benefit</p> <p>You pay 20% coinsurance for Medicare-covered one-way air ambulance benefit</p>
Transportation	<p>You pay \$0 copay for up to 20 one-way trips every year</p>	<p>You pay \$0 copay for up to 6 one-way trips every year</p>
Ambulatory Surgery Center	<p>You pay \$25 copay for each Medicare-covered ambulatory surgical center visit</p> <p>You pay \$200 copay for each Medicare-covered outpatient hospital facility visit</p>	<p>You pay \$25 copay for each Medicare-covered ambulatory surgical center visit</p> <p>You pay \$250 copay for each Medicare-covered outpatient hospital facility visit</p>
Medicare Part B Drugs	<p>You pay 20% of the cost for chemotherapy drugs</p> <p>You pay 20% of the cost for other Part B drugs</p>	<p>You pay 20% of the cost for chemotherapy drugs</p> <p>You pay 20% of the cost for other Part B drugs</p>

Optimum Gold Rewards Plan (HMO)_026	Optimum Gold Plus Plan (HMO)_032	What you should know
<p>You pay \$40 copay</p> <p>You pay \$40 copay</p>	<p>You pay \$20 copay</p> <p>You pay \$20 copay</p>	<p>For rehabilitative services, you will need a referral or authorization from your PCP first depending on the specific service.</p> <p>There may be limits on physical therapy, occupational therapy, and speech and language pathology services. Contact the plan for details.</p>
<p>You pay \$175 copay for Medicare-covered one-way ground ambulance benefit</p> <p>You pay 20% coinsurance for Medicare-covered one-way air ambulance benefit</p>	<p>You pay \$150 copay for Medicare-covered one-way ground ambulance benefit</p> <p>You pay 20% coinsurance for Medicare-covered one-way air ambulance benefit</p>	<p>Prior Authorization may be required. Contact the Plan for details.</p>
<p>You pay \$0 copay for up to 6 one-way trips every year</p>	<p>You pay \$0 copay for up to 20 one-way trips every year</p>	<p>Transportation is intended for rides to and/or from plan approved locations for medical appointments and health needs within your county.</p> <p>Call to schedule a ride at least 72 hours prior to scheduled medical appointment.</p>
<p>You pay \$25 copay for each Medicare-covered ambulatory surgical center visit</p> <p>You pay \$250 copay for each Medicare-covered outpatient hospital facility visit</p>	<p>You pay \$25 copay for each Medicare-covered ambulatory surgical center visit</p> <p>You pay \$150 copay for each Medicare-covered outpatient hospital facility visit</p>	<p>Prior authorization may be required. Contact the Plan for details.</p> <p>If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient.</p>
<p>You pay 20% of the cost for chemotherapy drugs</p> <p>You pay 20% of the cost for other Part B drugs</p>	<p>You pay 20% of the cost for chemotherapy drugs</p> <p>You pay 20% of the cost for other Part B drugs</p>	<p>The Plan may require authorization to determine whether certain drugs are covered by Medicare Part B or Medicare Part D.</p> <p>Please refer to your Evidence of Coverage for more details.</p>

Premiums and Benefits	Optimum Gold Rewards Plan (HMO)_001	Optimum Gold Rewards Plan (HMO)_022
Foot Care (<i>Podiatry Services</i>) <ul style="list-style-type: none"> • Foot exams and treatment 	You pay \$20 copay	You pay \$35 copay
Medical Equipment/Supplies <ul style="list-style-type: none"> • Durable Medical Equipment (<i>e.g., wheelchairs, oxygen</i>) • Prosthetics (<i>e.g., braces, artificial limits</i>) • Diabetes Supplies 	You pay 20% coinsurance You pay 20% coinsurance You pay 0-20% coinsurance	You pay 20% coinsurance You pay 20% coinsurance You pay 0-20% coinsurance
Wellness <ul style="list-style-type: none"> • Fitness • 24 Hour Nurse Advise Line 	You pay \$0 copay You pay \$0 copay	You pay \$0 copay You pay \$0 copay
Over The Counter (OTC)	\$50 Monthly Allowance <i>The plan doesn't allow you to roll over any remaining OTC allowance into the next month.</i>	\$30 Monthly Allowance <i>The plan doesn't allow you to roll over any remaining OTC allowance into the next month.</i>

Optimum Gold Rewards Plan (HMO)_026	Optimum Gold Plus Plan (HMO)_032	What you should know
You pay \$40 copay	You pay \$20 copay	<p>Covered podiatry benefits are for medically necessary foot care.</p> <p>You will need to have a referral or authorization from your PCP first depending on the service.</p>
<p>You pay 20% coinsurance</p> <p>You pay 20% coinsurance</p> <p>You pay 0-20% coinsurance</p>	<p>You pay 20% coinsurance</p> <p>You pay 20% coinsurance</p> <p>You pay 0-20% coinsurance</p>	<p>We cover all medically necessary durable medical equipment covered by Original Medicare.</p> <p>You will need to have a referral or authorization from your PCP first depending on the service.</p> <p>You pay \$0 for Diabetic Monitors, Lancets and Test Strips when ordered through the Plan's Mail Order Program. You pay 20% for all diabetic supplies from a retail pharmacy.</p>
<p>You pay \$0 copay</p> <p>You pay \$0 copay</p>	<p>You pay \$0 copay</p> <p>You pay \$0 copay</p>	<p>Health Club Memberships are limited to participating facilities.</p> <p>Health Advice from a nursing professional, available 24 hours a day, 7 days a week.</p>
<p>\$30 Monthly Allowance</p> <p><i>The plan doesn't allow you to roll over any remaining OTC allowance into the next month.</i></p>	<p>\$50 Monthly Allowance</p> <p><i>The plan doesn't allow you to roll over any remaining OTC allowance into the next month.</i></p>	<p>Please contact the plan or visit our website for specific instructions for using this benefit and our list of covered Over-the-Counter items.</p> <p>Call Member Services at 1-866-245-5360, TTY users call 711, or visit our website at http://www.YourOptimumHealthcare.com.</p>

Outpatient Prescription Drugs

Optimum Gold Rewards Plan (HMO) H5594_001

	Standard Retail Rx 30 – day Supply	Standard Mail Order 90 – day Supply	What you should know
<i>Deductible Stage</i>	This stage does not apply to you		
<i>Initial Coverage Stage</i>			<p>Cost Sharing may change depending on the pharmacy you choose and when you enter another phase of Part D benefit. You pay your cost share until your total yearly drug costs reach \$4,020. Not all drugs qualify for a 90-day supply. Some Tier 1 medications allow up to a 100-day supply. For more information please call us or access our Evidence of Coverage online.</p> <p>If you reside in a long-term care facility, you pay the same as a Standard Retail one-month supply for a 34-day supply.</p>
Tier 1: Preferred Generic	\$0 Copay	\$0 Copay	
Tier 2: Preferred Brand	\$35 Copay	\$70 Copay	
Tier 3: Non-Preferred Drug	\$85 Copay	\$170 Copay	
Tier 4: Specialty Tier	33% of the Cost	33% of the Cost	
<i>Coverage Gap Stage</i>			<p>For all other drugs, you pay 25% of the price for brand drugs and 25% of the price for all generic drugs (plus a portion of the dispensing fee). You stay in this stage until your out-of-pocket costs reach a total of \$6,350.</p>
Tier 1: Preferred Generic	\$0 Copay	\$0 Copay	
<i>Catastrophic Coverage Stage</i>	<p>You pay the greater of:</p> <ul style="list-style-type: none"> • 5% of the cost of the drug, or • \$3.60 copay for generic (including drugs treated as generic) and \$8.95 copay for all other drugs • Our Plan pays the rest of the cost 		<p>During this stage, the plan will pay most of the cost of your drugs for the rest of the calendar year.</p>

Outpatient Prescription Drugs

Optimum Gold Rewards Plan (HMO) H5594_022

	Standard Retail Rx 30 – day Supply	Standard Mail Order 90 – day Supply	What you should know
<i>Deductible Stage</i>	This stage does not apply to you		
<i>Initial Coverage Stage</i>			<p>Cost Sharing may change depending on the pharmacy you choose and when you enter another phase of Part D benefit. You pay your cost share until your total yearly drug costs reach \$4,020. Not all drugs qualify for a 90-day supply. Some Tier 1 medications allow up to a 100-day supply. For more information please call us or access our Evidence of Coverage online.</p> <p>If you reside in a long-term care facility, you pay the same as a Standard Retail one-month supply for a 34-day supply.</p>
Tier 1: Preferred Generic	\$0 Copay	\$0 Copay	
Tier 2: Preferred Brand	\$35 Copay	\$70 Copay	
Tier 3: Non-Preferred Drug	\$85 Copay	\$170 Copay	
Tier 4: Specialty Tier	33% of the Cost	33% of the Cost	
<i>Coverage Gap Stage</i>			<p>For all other drugs, you pay 25% of the price for brand drugs and 25% of the price for all generic drugs (plus a portion of the dispensing fee). You stay in this stage until your out-of-pocket costs reach a total of \$6,350.</p>
Tier 1: Preferred Generic	\$0 Copay	\$0 Copay	
<i>Catastrophic Coverage Stage</i>	<p>You pay the greater of:</p> <ul style="list-style-type: none"> • 5% of the cost of the drug, or • \$3.60 copay for generic (including drugs treated as generic) and \$8.95 copay for all other drugs • Our Plan pays the rest of the cost 		<p>During this stage, the plan will pay most of the cost of your drugs for the rest of the calendar year.</p>

Outpatient Prescription Drugs

Optimum Gold Rewards Plan (HMO) H5594_026

	Standard Retail Rx 30 – day Supply	Standard Mail Order 90 – day Supply	What you should know
<i>Deductible Stage</i>	This stage does not apply to you		
<i>Initial Coverage Stage</i>			<p>Cost Sharing may change depending on the pharmacy you choose and when you enter another phase of Part D benefit. You pay your cost share until your total yearly drug costs reach \$4,020. Not all drugs qualify for a 90-day supply. Some Tier 1 medications allow up to a 100-day supply. For more information please call us or access our Evidence of Coverage online.</p> <p>If you reside in a long-term care facility, you pay the same as a Standard Retail one-month supply for a 34-day supply.</p>
Tier 1: Preferred Generic	\$0 Copay	\$0 Copay	
Tier 2: Preferred Brand	\$35 Copay	\$70 Copay	
Tier 3: Non-Preferred Drug	\$85 Copay	\$170 Copay	
Tier 4: Specialty Tier	33% of the Cost	33% of the Cost	
<i>Coverage Gap Stage</i>			<p>For all other drugs, you pay 25% of the price for brand drugs and 25% of the price for all generic drugs (plus a portion of the dispensing fee). You stay in this stage until your out-of-pocket costs reach a total of \$6,350.</p>
Tier 1: Preferred Generic	\$0 Copay	\$0 Copay	
<i>Catastrophic Coverage Stage</i>	<p>You pay the greater of:</p> <ul style="list-style-type: none"> • 5% of the cost of the drug, or • \$3.60 copay for generic (including drugs treated as generic) and \$8.95 copay for all other drugs • Our Plan pays the rest of the cost 		<p>During this stage, the plan will pay most of the cost of your drugs for the rest of the calendar year.</p>

Outpatient Prescription Drugs

Optimum Gold Plus Plan (HMO) H5594_032

	Standard Retail Rx 30 – day Supply	Standard Mail Order 90 – day Supply	What you should know
<i>Deductible Stage</i>	This stage does not apply to you		
<i>Initial Coverage Stage</i>			<p>Cost Sharing may change depending on the pharmacy you choose and when you enter another phase of Part D benefit. You pay your cost share until your total yearly drug costs reach \$4,020. Not all drugs qualify for a 90-day supply. Some Tier 1 medications allow up to a 100-day supply. For more information please call us or access our Evidence of Coverage online.</p> <p>If you reside in a long-term care facility, you pay the same as a Standard Retail one-month supply for a 34-day supply.</p>
Tier 1: Preferred Generic	\$0 Copay	\$0 Copay	
Tier 2: Preferred Brand	\$20 Copay	\$40 Copay	
Tier 3: Non-Preferred Drug	\$60 Copay	\$120 Copay	
Tier 4: Specialty Tier	33% of the Cost	33% of the Cost	
<i>Coverage Gap Stage</i>			<p>For all other drugs, you pay 25% of the price for brand drugs and 25% of the price for all generic drugs (plus a portion of the dispensing fee). You stay in this stage until your out-of-pocket costs reach a total of \$6,350.</p>
Tier 1: Preferred Generic	\$0 Copay	\$0 Copay	
<i>Catastrophic Coverage Stage</i>	<p>You pay the greater of:</p> <ul style="list-style-type: none"> • 5% of the cost of the drug, or • \$3.60 copay for generic (including drugs treated as generic) and \$8.95 copay for all other drugs • Our Plan pays the rest of the cost 		<p>During this stage, the plan will pay most of the cost of your drugs for the rest of the calendar year.</p>

If you want to know more about the coverage and costs of Original Medicare, look in your current **"Medicare & You"** handbook. View it online at <http://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.

To get a complete list of services we cover, please review the "Evidence of Coverage" (EOC) online at <http://www.YourOptimumHealthcare.com> or get a copy by calling 1-866-245-5360 (TTY: 711).

This document is available in other formats such as Spanish and large print. For more information, please call us at the phone number below or visit us at <http://www.YourOptimumHealthcare.com>.

Please call our Member Services number at 1-866-245-5360 for additional information. TTY users should call 711. From October 1 to March 31, we are open 7 days a week from 8 a.m. to 8 p.m. EST. From April 1 to September 30, we are open Monday through Friday, 8 a.m. – 8 p.m. EST.

For accommodations of persons with special needs at meetings call 1-866-245-5360 (TTY: 711).

You can see our plan's provider and pharmacy directories at our website <http://www.YourOptimumHealthcare.com> or call us and we will send you a copy of the directories. The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

We cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider. You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website at <http://www.YourOptimumHealthcare.com>.

Optimum HealthCare, Inc. cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. Optimum HealthCare, Inc. konfòm ak lwa sou dwa sivil Federal ki aplikab yo e li pa fè diskriminasyon sou baz ras, koulè, peyi orijin, laj, enfimite oswa sèks.

Discrimination Is Against the Law

Notice Informing Individuals about Nondiscrimination and Accessibility Requirements

Optimum HealthCare, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Optimum HealthCare, Inc. does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Optimum HealthCare, Inc.:

- 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 the Optimum HealthCare Civil Rights Coordinator.

If you believe that Optimum HealthCare, Inc. has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Optimum HealthCare Civil Rights Coordinator
P.O. Box 152727
Tampa, FL 33684
Phone: 1-866-245-5360, TTY: 711
Fax: 813-506-6235

You can file a grievance by mail, fax, or phone. If you need help filing a grievance, the Optimum HealthCare Civil Rights Coordinator is available to help you.

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, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Multi-Language Insert / Inserción de varios idiomas

Multi-language Interpreter Services / Servicios de interpretación en varios idiomas

English: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-866-245-5360 (TTY: 711).

Español (Spanish): ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-245-5360 (TTY: 711).

Kreyòl Ayisyen (French Creole): ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-866-245-5360 (TTY: 711).

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-866-245-5360 (TTY: 711).

Português (Portuguese): ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-866-245-5360 (TTY: 711).

繁體中文 (Chinese): 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-866-245-5360 (TTY: 711)。

Français (French): ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-245-5360 (ATS: 711).

Tagalog (Tagalog – Filipino): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-866-245-5360 (TTY: 711).

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-245-5360 (телетайп: 711).

العربية (Arabic):

العربية ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-866-245-5360 (رقم هاتف الصم والبكم: 711).

Italiano (Italian): ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-866-245-5360 (TTY: 711).

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-866-245-5360 (TTY: 711).

한국어 (Korean): 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-245-5360 (TTY: 711) 번으로 전화해 주십시오.

Polski (Polish): UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-866-245-5360 (TTY: 711).

ગુજરાતી (Gujarati): સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-866-245-5360 (TTY: 711).

ภาษาไทย (Thai): เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-866-245-5360 (TTY: 711).

ΠΡΟΣΟΧΗ (Greek): Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-866-245-5360 (TTY: 711).

2020 Summary of Benefits



SB Combo 001 - 022 - 026 - 032

001 – Optimum Gold Rewards Plan (HMO)

Counties:

Broward, Hernando, Hillsborough, Pasco, Pinellas

022 – Optimum Gold Rewards Plan (HMO)

Counties:

Orange, Osceola, Seminole, Volusia

026 – Optimum Gold Rewards Plan (HMO)

Counties:

Lake, Marion, Sumter

032 – Optimum Gold Plus Plan (HMO)

Counties:

Hernando