O26SBGOLDRW

HMO

2026 Summary of Benefits

SB Combo 001 - 022 - 026

001-Optimum Gold Rewards Plan (HMO)

Counties:
Broward, Citrus, 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

OPTIMUM HealthCare, Inc.

H5594_2026_SB_001_022_026_M
Y0114_26_3017175_0301_U_M

Summary of Benefits

January 1, 2026 - December 31, 2026

Optimum Gold Rewards Plan (HMO) H5594_001
Optimum Gold Rewards Plan (HMO) H5594_022
Optimum Gold Rewards Plan (HMO) H5594_026

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** and **Optimum Gold Rewards Plan (HMO) H5594_026**, 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. From October 1 to March 31, we are open 7 days a week from 8 a.m. to 8 p.m. ET. From April 1 to September 30, we are open Monday through Friday, 8 a.m. to 8 p.m. ET. Limitations, copayments and restrictions may apply. Benefits, premiums and/or copayments/coinsurance may change on January 1 of each year. Benefits vary by plan.

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**, and **Optimum Gold Rewards Plan (HMO) H5594_026** 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, Citrus, Hernando, Hillsborough, Pasco, and Pinellas

Optimum Gold Rewards Plan (HMO) H5594_022: Orange, Osceola, Seminole, and Volusia

Optimum Gold Rewards Plan (HMO) H5594_026: Lake, Marion, and Sumter

Optimum HealthCare, Inc. covers emergency care and urgently needed services from out-of-network providers. For routine care, you must use the Optimum HealthCare, Inc. network of providers, hospital, and pharmacies while in the plan's service area. Neither Medicare nor Optimum HealthCare, Inc. will be responsible for the costs incurred of routine care received from out-of-network providers. Out-of-network/non-contracted providers are under no obligation to treat Optimum HealthCare, Inc. members except in emergency situations. Please call our Member Services number or see your Evidence of Coverage for more information, including cost sharing that applies to out-of-network services.

Premiums and Benefits	Optimum Gold Rewards Plan (HMO)_001	Optimum Gold Rewards Plan (HMO)_022	Optimum Gold Rewards Plan (HMO)_026
Monthly Plan Premium	**$0.00**	**$0.00**	**$0.00**
Part B Premium Reduction 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.	Optimum HealthCare, Inc. will reduce your Medicare Part B premium by up to **$185.00**	Not available	Not available
Deductible These plans do not have a deductible.	**$0.00**	**$0.00**	**$0.00**
Maximum Out-of-Pocket Responsibility *(does not include Part D prescription drugs)* 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.	**$1,900.00** annually	**$4,200.00** annually	**$4,200.00** annually
Inpatient Hospital Coverage	**$95.00** copayment each day for days 1 to 5 and **$0.00** copayment each day for days 6 to 90 per admission. *Referral may be required.* *Prior authorization may be required.*	**$195.00** copayment each day for days 1 to 7 and **$0.00** copayment each day for days 8 to 90 per admission. *Referral may be required.* *Prior authorization may be required.*	**$195.00** copayment each day for days 1 to 7 and **$0.00** copayment each day for days 8 to 90 per admission. *Referral may be required.* *Prior authorization may be required.*

Premiums and Benefits	Optimum Gold Rewards Plan (HMO)_001	Optimum Gold Rewards Plan (HMO)_022	Optimum Gold Rewards Plan (HMO)_026
Outpatient Hospital Coverage Services include but are not limited to Medicare-covered outpatient hospital facility visits, clinic, outpatient treatment room, observation room, or outpatient surgery services.	**$95.00** copayment per visit. *Referral may be required.* *Prior authorization may be required.*	**$195.00** copayment per visit. *Referral may be required.* *Prior authorization may be required.*	**$195.00** copayment per visit. *Referral may be required.* *Prior authorization may be required.*
Ambulatory Surgical Center (ASC)	**$25.00** copayment for each Medicare-covered ambulatory surgical center visit. *Referral may be required.* *Prior authorization may be required.*	**$25.00** copayment for each Medicare-covered ambulatory surgical center visit. *Referral may be required.* *Prior authorization may be required.*	**$25.00** copayment for each Medicare-covered ambulatory surgical center visit. *Referral may be required.* *Prior authorization may be required.*
Doctor Visits • **Primary** Your Primary Care Physician (PCP) will coordinate the covered services you receive as a member of our plan.	**$0.00** copayment per visit.	**$0.00** copayment per visit.	**$0.00** copayment per visit.
• **Specialists** Separate copay may apply for each additional service received at an office visit.	**$10.00** copayment per visit. *Referral may be required.* *Prior authorization may be required.*	**$35.00** copayment per visit. *Referral may be required.* *Prior authorization may be required.*	**$40.00** copayment per visit. *Referral may be required.* *Prior authorization may be required.*

Premiums and Benefits	Optimum Gold Rewards Plan (HMO)_001	Optimum Gold Rewards Plan (HMO)_022	Optimum Gold Rewards Plan (HMO)_026
Preventive Care Please refer to your *Evidence of Coverage* for a list of covered preventive care services. Any additional preventive services approved by Medicare during the contract year will be covered.	**$0.00** copayment *Referral may be required.* *Prior authorization may be required.*	**$0.00** copayment *Referral may be required.* *Prior authorization may be required.*	**$0.00** copayment *Referral may be required.* *Prior authorization may be required.*
Emergency Care **$500.00** copayment for each emergency service, urgent service and emergency transportation outside the U.S. **$100,000.00** plan coverage limit for emergency services, urgent services and emergency transportation outside the U.S. every year. Contact the plan for details.	**$150.00** copayment	**$150.00** copayment	**$150.00** copayment
Urgently Needed Services **$500.00** copayment for each emergency service, urgent service and emergency transportation outside the U.S. **$100,000.00** plan coverage limit for emergency services, urgent services and emergency transportation outside the U.S. every year. Contact the plan for details.	**$10.00** copayment	**$20.00** copayment	**$20.00** copayment

Premiums and Benefits	Optimum Gold Rewards Plan (HMO)_001	Optimum Gold Rewards Plan (HMO)_022	Optimum Gold Rewards Plan (HMO)_026
Diagnostic Services/Labs/Imaging			
• **Diagnostic radiology services (e.g., ultrasound, MRI, CAT scan)**	**$25.00-$95.00** copayment depending on the service and location. *Referral may be required.* *Prior authorization may be required.*	**$25.00-$195.00** copayment depending on the service and location. *Referral may be required.* *Prior authorization may be required.*	**$25.00-$195.00** copayment depending on the service and location. *Referral may be required.* *Prior authorization may be required.*
• **Lab services**	**$0.00-$50.00** copayment depending on the location. *Referral may be required.* *Prior authorization may be required.*	**$0.00-$50.00** copayment depending on the location. *Referral may be required.* *Prior authorization may be required.*	**$0.00-$50.00** copayment depending on the location. *Referral may be required.* *Prior authorization may be required.*
• **Diagnostic tests and procedures**	**$0.00-$95.00** copayment or a **20%** coinsurance depending on the service and location. *Referral may be required.* *Prior authorization may be required.*	**$0.00-$195.00** copayment or a **20%** coinsurance depending on the service and location. *Referral may be required.* *Prior authorization may be required.*	**$0.00-$195.00** copayment or a **20%** coinsurance depending on the service and location. *Referral may be required.* *Prior authorization may be required.*

Premiums and Benefits	Optimum Gold Rewards Plan (HMO)_001	Optimum Gold Rewards Plan (HMO)_022	Optimum Gold Rewards Plan (HMO)_026
Diagnostic Services/Labs/Imaging			
• **Outpatient X-rays**	**$0.00-$95.00** copayment depending on the location. *Referral may be required.* *Prior authorization may be required.*	**$0.00-$195.00** copayment depending on the location. *Referral may be required.* *Prior authorization may be required.*	**$0.00-$195.00** copayment depending on the location. *Referral may be required.* *Prior authorization may be required.*
• **Therapeutic radiology**	**20%** coinsurance for Medicare-covered therapeutic radiology services. *Referral may be required.* *Prior authorization may be required.*	**20%** coinsurance for Medicare-covered therapeutic radiology services. *Referral may be required.* *Prior authorization may be required.*	**20%** coinsurance for Medicare-covered therapeutic radiology services. *Referral may be required.* *Prior authorization may be required.*

Premiums and Benefits	Optimum Gold Rewards Plan (HMO)_001	Optimum Gold Rewards Plan (HMO)_022	Optimum Gold Rewards Plan (HMO)_026
Hearing Services			
• **Hearing exam/hearing aid fitting-evaluation**	**$0.00** copayment for Medicare-covered diagnostic hearing exam. **$0.00** copayment for one routine hearing exam and one hearing aid fitting-evaluation every year.	**$0.00** copayment for Medicare-covered diagnostic hearing exam. **$0.00** copayment for one routine hearing exam and one hearing aid fitting-evaluation every year.	**$0.00** copayment for Medicare-covered diagnostic hearing exam. **$0.00** copayment for one routine hearing exam and one hearing aid fitting-evaluation every year.
• **Hearing aids**	**$0.00** copayment for two hearing aids (1 per ear) every year. Our plan pays up to a maximum of **$1,500.00 ($750.00 per hearing aid)** for hearing aid benefit every year. You are responsible for payment of any amount in excess of the maximum **$1,500.00 ($750.00 per hearing aid).**	**$0.00** copayment for two hearing aids (1 per ear) every year. Our plan pays up to a maximum of **$1,000.00 ($500.00 per hearing aid)** for hearing aid benefit every year. You are responsible for payment of any amount in excess of the maximum **$1,000.00 ($500.00 per hearing aid).**	**$0.00** copayment for two hearing aids (1 per ear) every year. Our plan pays up to a maximum of **$1,000.00 ($500.00 per hearing aid)** for hearing aid benefit every year. You are responsible for payment of any amount in excess of the maximum **$1,000.00 ($500.00 per hearing aid).**

Premiums and Benefits	Optimum Gold Rewards Plan (HMO)_001	Optimum Gold Rewards Plan (HMO)_022	Optimum Gold Rewards Plan (HMO)_026
Dental Services	**$0.00** copayment for Medicare-covered dental services. *Prior authorization may be required.*	**$0.00** copayment for Medicare-covered dental services. *Prior authorization may be required.*	**$0.00** copayment for Medicare-covered dental services. *Prior authorization may be required.*
• **Preventive dental services**	**$0.00** copayment This plan covers: 2 oral exams, 2 emergency exams, 2 prophylaxis cleanings, 2 fluoride treatments and dental X-rays every year.	**$0.00** copayment This plan covers: 2 oral exams, 2 emergency exams, 2 prophylaxis cleanings, 2 fluoride treatments and dental X-rays every year.	**$0.00** copayment This plan covers: 2 oral exams, 2 emergency exams, 2 prophylaxis cleanings, 2 fluoride treatments and dental X-rays every year.
• **Comprehensive dental services**	**$0.00** copayment This plan covers up to: 2 resin or amalgam fillings, 2 simple or surgical extractions (in 1 or more visits), 2 periodontal maintenance procedures, 1 periodontal scaling and root planing per quadrant every year, and 1 full mouth debridement every 2 years.	**$0.00** copayment This plan covers up to: 2 resin or amalgam fillings, 2 simple or surgical extractions (in 1 or more visits), 2 periodontal maintenance procedures, 1 periodontal scaling and root planing per quadrant every year, and 1 full mouth debridement every 2 years.	**$0.00** copayment This plan covers up to: 2 resin or amalgam fillings, 2 simple or surgical extractions (in 1 or more visits), 2 periodontal maintenance procedures, 1 periodontal scaling and root planing per quadrant every year, and 1 full mouth debridement every 2 years.

Premiums and Benefits	Optimum Gold Rewards Plan (HMO)_001	Optimum Gold Rewards Plan (HMO)_022	Optimum Gold Rewards Plan (HMO)_026
Vision Services • **Eye exam** Eye exams to diagnose and treat diseases and conditions of the eye by an Ophthalmologist are subject to the Specialist copay. Services must be performed by a participating Vision provider. You pay nothing for exams to diagnose and treat diseases and conditions of the eye by an Optometrist.	**$0.00** copayment for Medicare-covered eye exam. **$0.00** copayment for 1 routine eye exam every year by an optometrist.	**$0.00** copayment for Medicare-covered eye exam. **$0.00** copayment for 1 routine eye exam every year by an optometrist.	**$0.00** copayment for Medicare-covered eye exam. **$0.00** copayment for 1 routine eye exam every year by an optometrist.
Vision Services • **Eyeglasses (lenses and frames)**	**$0.00** copayment for Medicare-covered eyewear (one pair of eyeglasses which includes frame and plastic lens or contact lenses) after cataract surgery. **$0.00** copayment for the plan coverage limit of 1 pair of eyeglasses or contact lenses every year.	**$0.00** copayment for Medicare-covered eyewear (one pair of eyeglasses which includes frame and plastic lens or contact lenses) after cataract surgery. **$10.00** copayment for the plan coverage limit of 1 pair of eyeglasses or contact lenses every year.	**$0.00** copayment for Medicare-covered eyewear (one pair of eyeglasses which includes frame and plastic lens or contact lenses) after cataract surgery. **$10.00** copayment for the plan coverage limit of 1 pair of eyeglasses or contact lenses every year.

Premiums and Benefits	Optimum Gold Rewards Plan (HMO)_001	Optimum Gold Rewards Plan (HMO)_022	Optimum Gold Rewards Plan (HMO)_026
	$30.00 copayment for CR-39 lenses. The plan coverage limit is **$400.00** for 1 pair of eyeglasses or contact lenses every year. You will be responsible for any amount over the plan benefit maximum total retail cost of **$400.00** for 1 pair of eyeglasses or contact lenses every year.	**$30.00** copayment for CR-39 lenses. The plan coverage limit is **$100.00** for 1 pair of eyeglasses or contact lenses every year. You will be responsible for the **$10.00** copayment and any amount over the plan benefit maximum of **$100.00** for 1 pair of eyeglasses or contact lenses every year.	**$30.00** copayment for CR-39 lenses. The plan coverage limit is **$100.00** for 1 pair of eyeglasses or contact lenses every year. You will be responsible for the **$10.00** copayment and any amount over the plan benefit maximum of **$100.00** for 1 pair of eyeglasses or contact lenses every year.
Mental Health Services • **Inpatient visit**	**$95.00** copayment each day for days 1 to 5 and **$0.00** copayment each day for days 6 to 90 per admission. *Referral may be required.* *Prior authorization may be required.*	**$195.00** copayment each day for days 1 to 7 and **$0.00** copayment each day for days 8 to 90 per admission. *Referral may be required.* *Prior authorization may be required.*	**$195.00** copayment each day for days 1 to 7 and **$0.00** copayment each day for days 8 to 90 per admission. *Referral may be required.* *Prior authorization may be required.*

Premiums and Benefits	Optimum Gold Rewards Plan (HMO)_001	Optimum Gold Rewards Plan (HMO)_022	Optimum Gold Rewards Plan (HMO)_026
• **Outpatient group/individual therapy visit**	**$10.00** copayment for outpatient group/individual therapy visit. *Referral may be required.* *Prior authorization may be required.*	**$35.00** copayment for outpatient group/individual therapy visit. *Referral may be required.* *Prior authorization may be required.*	**$40.00** copayment for outpatient group/individual therapy visit. *Referral may be required.* *Prior authorization may be required.*
Skilled Nursing Facility (SNF) Care Our plan covers up to 100 days in a SNF per benefit period.	**$0.00** copayment each day for days 1 to 20. **$218.00** copayment each day for days 21 to 100. *Referral may be required.* *Prior authorization may be required.*	**$0.00** copayment each day for days 1 to 20. **$218.00** copayment each day for days 21 to 100. *Referral may be required.* *Prior authorization may be required.*	**$0.00** copayment each day for days 1 to 20. **$218.00** copayment each day for days 21 to 100. *Referral may be required.* *Prior authorization may be required.*

Premiums and Benefits	Optimum Gold Rewards Plan (HMO)_001	Optimum Gold Rewards Plan (HMO)_022	Optimum Gold Rewards Plan (HMO)_026
Rehabilitation Services There may be limits on physical therapy, occupational therapy, and speech and language pathology services. Contact the plan for details. • **Occupational therapy visit** • **Physical therapy visit** • **Speech therapy visit** • **Language therapy visit**	**$10.00** copayment *Referral may be required.* *Prior authorization may be required.*	**$35.00** copayment *Referral may be required.* *Prior authorization may be required.*	**$40.00** copayment *Referral may be required.* *Prior authorization may be required.*
Ambulance	**$200.00** copayment for Medicare-covered one-way ground ambulance services. *Prior authorization may be required.* **20%** coinsurance for Medicare-covered one-way air ambulance services. *Prior authorization may be required.*	**$200.00** copayment for Medicare-covered one-way ground ambulance services. *Prior authorization may be required.* **20%** coinsurance for Medicare-covered one-way air ambulance services. *Prior authorization may be required.*	**$200.00** copayment for Medicare-covered one-way ground ambulance services. *Prior authorization may be required.* **20%** coinsurance for Medicare-covered one-way air ambulance services. *Prior authorization may be required.*

Premiums and Benefits	Optimum Gold Rewards Plan (HMO)_001	Optimum Gold Rewards Plan (HMO)_022	Optimum Gold Rewards Plan (HMO)_026
Transportation Transportation is intended for rides to and/or from plan-approved locations for medical appointments and health needs. Trips are limited to 50 miles. Call to schedule a ride at least 48 hours (excluding weekends) prior to scheduled medical appointment.	**$0.00** copayment Routine transportation for up to 20 one-way trips every year.	**$0.00** copayment Routine transportation for up to 6 one-way trips every year.	**$0.00** copayment Routine transportation for up to 6 one-way trips every year.
Medicare Part B Prescription Drugs You may pay less for certain rebatable drugs. This list and the cost of each rebatable drug changes every quarter. Please refer to your *Evidence of Coverage* for more details.	**20%** coinsurance for chemotherapy drugs and for other Part B drugs. *Prior authorization may be required.* For Part B insulins, you pay **$35.00** for a one-month supply.	**20%** coinsurance for chemotherapy drugs and for other Part B drugs. *Prior authorization may be required.* For Part B insulins, you pay **$35.00** for a one-month supply.	**20%** coinsurance for chemotherapy drugs and for other Part B drugs. *Prior authorization may be required.* For Part B insulins, you pay **$35.00** for a one-month supply.
Additional Benefits			
Foot Care (Podiatry Services) • **Foot exams and treatment** Covered podiatry benefits are for medically necessary foot care.	**$10.00** copayment *Referral may be required.* *Prior authorization may be required.*	**$35.00** copayment *Referral may be required.* *Prior authorization may be required.*	**$40.00** copayment *Referral may be required.* *Prior authorization may be required.*

Premiums and Benefits	Optimum Gold Rewards Plan (HMO)_001	Optimum Gold Rewards Plan (HMO)_022	Optimum Gold Rewards Plan (HMO)_026
Medical Equipment/Supplies We cover all medically necessary durable medical equipment covered by Original Medicare.			
• **Durable medical equipment (e.g., wheelchairs, oxygen)**	**20%** coinsurance *Prior authorization may be required.*	**20%** coinsurance *Prior authorization may be required.*	**20%** coinsurance *Prior authorization may be required.*
• **Prosthetics (e.g., braces, artificial limbs)**	**20%** coinsurance *Prior authorization may be required.*	**20%** coinsurance *Prior authorization may be required.*	**20%** coinsurance *Prior authorization may be required.*
• **Diabetes supplies**	You pay **$0.00** copayment for diabetic monitors, lancets and test strips when ordered through the plan's mail order program. *Prior authorization may be required.* You pay **20%** coinsurance for all diabetic supplies from a retail pharmacy. *Prior authorization may be required.*	You pay **$0.00** copayment for diabetic monitors, lancets and test strips when ordered through the plan's mail order program. *Prior authorization may be required.* You pay **20%** coinsurance for all diabetic supplies from a retail pharmacy. *Prior authorization may be required.*	You pay **$0.00** copayment for diabetic monitors, lancets and test strips when ordered through the plan's mail order program. *Prior authorization may be required.* You pay **20%** coinsurance for all diabetic supplies from a retail pharmacy. *Prior authorization may be required.*

Premiums and Benefits	Optimum Gold Rewards Plan (HMO)_001	Optimum Gold Rewards Plan (HMO)_022	Optimum Gold Rewards Plan (HMO)_026
Wellness • **SilverSneakers® Fitness Program** Health club memberships are limited to participating facilities. • **24/7 Nurseline** Health advice from a nursing professional, available 24 hours a day, 7 days a week.	**$0.00** copayment **$0.00** copayment	**$0.00** copayment **$0.00** copayment	**$0.00** copayment **$0.00** copayment
Active Fitness This benefit provides a spending allowance on your Benefits Mastercard® Prepaid Card for the payment of access fees or lesson/clinic costs at sports facilities for golf, swimming, and tennis. The allowance cannot be applied to merchandise or other services. Unused amounts expire at the end of the plan year. For more information about this benefit please contact Member Services.	**$500.00** annual allowance	Not covered	Not covered

Premiums and Benefits	Optimum Gold Rewards Plan (HMO)_001	Optimum Gold Rewards Plan (HMO)_022	Optimum Gold Rewards Plan (HMO)_026
Over-the-Counter (OTC) Products Please contact the plan or visit our website for specific instructions for using this benefit and our list of covered over-the-counter items. Call Member Services at 1-866-245-5360, TTY users call 711, or visit our website at www.youroptimumhealthcare.com	This plan covers certain approved, non-prescription, over-the-counter drugs and health-related items, up to **$60.00** every month. *Unused OTC amounts expire at the end of each month.*	This plan covers certain approved, non-prescription, over-the-counter drugs and health-related items, up to **$50.00** every month. *Unused OTC amounts expire at the end of each month.*	This plan covers certain approved, non-prescription, over-the-counter drugs and health-related items, up to **$45.00** every month. *Unused OTC amounts expire at the end of each month.*

Outpatient Prescription Drugs			
	Optimum Gold Rewards Plan (HMO)_001	**Optimum Gold Rewards Plan (HMO)_022**	**Optimum Gold Rewards Plan (HMO)_026**
Important message about what you pay for vaccines and insulin - This plan covers most Part D vaccines at no cost to you and you won't pay more than **$35.00** for a one-month supply for any covered insulin.			
Stage 1: Yearly Deductible			
Deductible	This stage doesn't apply to you.	This stage doesn't apply to you.	This stage doesn't apply to you.
Stage 2: Initial Coverage			
Tier 1: Preferred Generic			
Preferred retail one-month supply	**$0.00** copayment	**$0.00** copayment	**$0.00** copayment
Standard retail one-month supply	**$0.00** copayment	**$0.00** copayment	**$0.00** copayment
Mail-order three-month supply	**$0.00** copayment	**$0.00** copayment	**$0.00** copayment
Tier 2: Preferred Brand			
Preferred retail one-month supply	**$30.00** copayment	**$10.00** copayment	**$10.00** copayment
Standard retail one-month supply	**$30.00** copayment	**$10.00** copayment	**$10.00** copayment
Mail-order three-month supply	**$60.00** copayment	**$20.00** copayment	**$20.00** copayment
Tier 3: Non-Preferred Drug			
Preferred retail one-month supply	**$70.00** copayment	**$70.00** copayment	**$50.00** copayment
Standard retail one-month supply	**$75.00** copayment	**$75.00** copayment	**$55.00** copayment
Mail-order three-month supply	**$140.00** copayment	**$140.00** copayment	**$100.00** copayment

Outpatient Prescription Drugs			
	Optimum Gold Rewards Plan (HMO)_001	**Optimum Gold Rewards Plan (HMO)_022**	**Optimum Gold Rewards Plan (HMO)_026**
Tier 4: Specialty Tier			
Preferred retail one-month supply	**33%** coinsurance	**33%** coinsurance	**33%** coinsurance
Standard retail one-month supply	**33%** coinsurance	**33%** coinsurance	**33%** coinsurance
Mail-order three-month supply	Not available	Not available	Not available
Stage 3: Catastrophic Coverage			
	During this stage, you pay nothing for your covered Part D drugs.	During this stage, you pay nothing for your covered Part D drugs.	During this stage, you pay nothing for your covered Part D drugs.
Cost sharing may change depending on the pharmacy you choose and when you enter another phase of Part D benefit. You pay the amounts listed in the table, until your total year-to-date out-of-pocket costs reach **$2,100.00**. 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. 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.			

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 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 www.youroptimumhealthcare.com or get a copy by calling 1-866-245-5360 (TTY: 711).

This document is available in alternate formats such as large print and Spanish. For more information, please call us at the phone number below or visit us at 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. ET. From April 1 to September 30, we are open Monday through Friday, 8 a.m. to 8 p.m. ET.

You can see our plan's provider and pharmacy directories at our website 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 www.youroptimumhealthcare.com.

The Benefits Mastercard® Prepaid Card is issued by The Bancorp Bank N.A., Member FDIC, pursuant to license by Mastercard International Incorporated and card can be used for eligible expenses wherever Mastercard is accepted. Valid only in the U.S. No cash access. This is not a gift card or gift certificate. You have received this card as a gratuity without the payment of any monetary value or consideration.

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. 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. 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).

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, Inc. 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, Inc. 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, Inc. 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/smartscreen/main.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/complaints/index.html.

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call **1-866-245-5360** (TTY: **711**) or speak to your provider. Hours of operation are 8 a.m. to 8 p.m. local time, seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30.

Spanish – ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia en otros idiomas. También puede obtener ayudas y servicios auxiliares adecuados gratuitos para proporcionar información en formatos accesibles. Llame al número de teléfono indicado anteriormente o hable con su proveedor. El horario de atención es de 8 a.m. a 8 p.m. hora local, los siete días de la semana (excepto el Día de Acción de Gracias y Navidad) desde el 1.º de octubre hasta el 31 de marzo, y de lunes a viernes (excepto los días feriados) desde el 1.º de abril hasta el 30 de septiembre.

Arabic - تنبيه: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية المجانية متاحة لك. كما تتوفر مساعدات وخدمات مساعدة مناسبة لتوفير المعلومات بأشكال يسهل الوصول إليها مجانا. اتصل برقم الهاتف المذكور أعلاه أو تحدث إلى مقدم الخدمة الخاص بك. ساعات العمل من الساعة 8 صباحًا حتى الساعة 8 مساءً على مدار الأسبوع (ما عدا أيام عيد الشكر وعيد الميلاد) بدايةً من 1 أكتوبر حتى 31 مارس، ومن الاثنين حتى الجمعة (ما عدا أيام العطلات) من 1 أبريل حتى 30 سبتمبر.

Chinese Simplified – 注意：如果您说简体中文，我们可以为您提供免费的语言协助服务。我们还免费提供适当的辅助工具和服务，以可访问的格式提供信息。请拨打上面列出的电话号码或与您的提供者交谈。营业时间：10 月 1 日至 3 月31 日，每周七天（感恩节和圣诞节除外），4 月 1 日至 9 月 30 日，周一至周五（节假日除外），当地时间上午 8 时至晚上 8 时。

Chinese Traditional – 注意：如果您說繁體中文，我們可以為您提供免費的語言協助服務。我們還免費提供適當的輔助工具和服務，以無障礙格式提供資訊。請撥打上面列出的電話號碼或與您的提供者交談。營業時間：10 月 1 日至 3 月31 日，每週七天（感恩節和耶誕節除外），4 月 1 日至 9 月 30 日，週一至週五（節假日除外），當地時間上午 8 時至晚上 8 時。

French – ATTENTION : Si vous parlez français, des services gratuits d'assistance linguistique sont disponibles. Des aides et services auxiliaires appropriés permettant de fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le numéro de téléphone mentionné ci-dessus ou appelez votre prestataire. Les heures d'ouverture sont de 8 a.m à 8 p.m., heure locale, sept jours sur sept (sauf Thanksgiving et Noël) du 1er octobre au 31 mars, et du lundi au vendredi (sauf jours fériés) du 1er avril au 30 septembre.

German – ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Dienste zur sprachlichen Unterstützung zur Verfügung. Außerdem sind kostenlose Hilfsmittel und Dienste verfügbar, um Informationen in zugänglichen Formaten bereitzustellen. Rufen Sie die oben aufgeführte Telefonnummer an oder wenden Sie sich an Ihren Anbieter. Die Geschäftszeiten sind 8 Uhr bis 20 Uhr lokaler Zeit an sieben Tagen in der Woche (außer Thanksgiving und Weihnachten) vom 1. Oktober bis zum 31. März, und Montag bis Freitag (außer an Feiertagen) vom 1. April bis zum 30. September.

Gujarati – ધ્યાન આપો: જો તમે ગુજરાતી બોલો છો, તો તમારા માટે વિના મૂલ્યે ભાષા સહાય સેવાઓ ઉપલબ્ધ છે. સુલભ ફોર્મેટમાં માહિતી પ્રદાન કરવા માટે યોગ્ય સહાયક સહાય અને સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. ઉપર દર્શાવેલ ફોન નંબર પર કૉલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો. કામકાજના કલાકો સ્થાનિક સમય મુજબ સવારે 8 વાગ્યાથી સાંજના 8 વાગ્યા સુધી, ઑક્ટોબર 1 થી માર્ચ 31 સુધી અઠવાડિયાના સાતેય દિવસ (થેંક્સગિવિંગ અને ક્રિસમસ સિવાય) અને સોમવારથી શુક્રવાર (રજાઓ સિવાય) એપ્રિલ 1 થી સપ્ટેમ્બર 30 સુધી છે.

Haitian Creole – ATANSYON: Si w pale kreyòl ayisyen, sèvis asistans lenguistik gratis disponib pou ou. Èd ak sèvis oksilyè apwopriye pou bay enfòmasyon nan fòma ki aksesib disponib tou san w p ap peye. Rele nimewo telefòn yo bay anwo a oswa pale ak founisè w la. Orè fonksyònman yo se 8 a.m. rive 8 p.m., sèt jou sou sèt (eksepte Jou Thanksgiving ak Nwèl) soti 1ye Oktòb rive 31 Mas, ak Lendi pou rive Vandredi (eksepte jou ferye) soti 1ye Avril rive 30 Septanm.

Hebrew –לתשומת לבך: אם הנך דובר/ת עברית, שירותי סיוע בשפה בחינם זמינים עבורך. אמצעי עזר ושירותים נלווים מתאימים, שנועדו לספק מידע בפורמטים נגישים, זמינים גם הם ללא תשלום. יש להתקשר למספר הטלפון המופיע למעלה או לדבר עם הספק שלכם. שעות הפעילות הן 8:00 עד 20:00 (שעון מקומי), שבעה ימים בשבוע (למעט חג ההודיה וחג המולד) מה-1 באוקטובר עד ה-31 במרץ, ובשאר השנה – ימי שני עד שישי (למעט חגים) מה-1 באפריל עד ה-30 בספטמבר.

Hindi – ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध हैं। पहुँच योग्य प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। ऊपर दिए गए फ़ोन नंबर पर कॉल करें या अपने प्रदाता से बात करें। कामकाज के घंटे, 1 अक्टूबर से 31 मार्च तक सप्ताह के सातों दिन (थैंक्सगिविंग और क्रिसमस को छोड़कर), और 1 अप्रैल से 30 सितंबर तक सोमवार से शुक्रवार (छुट्टियों को छोड़कर), स्थानीय समय अनुसार सुबह 8 बजे से रात 8 बजे तक हैं।

Italian – ATTENZIONE: sono disponibili servizi di assistenza linguistica gratuita in italiano. Sono inoltre disponibili gratuitamente adeguati supporti e servizi per ottenere informazioni in formato accessibile. Chiamare il numero di telefono riportato sopra o rivolgersi al proprio fornitore. Il servizio è attivo dalle 8.00 alle 20.00 ora locale, sette giorni su sette (eccetto il Giorno del Ringraziamento e Natale) dal 1º ottobre al 31 marzo, e dal lunedì al venerdì (eccetto i giorni festivi) dal 1º aprile al 30 settembre.

Korean – 주의: 한국어를 구사하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 대체 형식으로 정보를 제공하기 위한 적절한 보조 장치 및 서비스도 무료로 제공됩니다. 위의 전화 번호로 전화하시거나 담당 의료 제공자에게 문의해 주십시오. 운영 시간은 현지 시간 오전 8시부터 오후 8시까지이며 10월 1일부터 3월 31일까지는 주 7일(추수 감사절과 성탄절은 제외) 내내, 4월 1일부터 9월 30일까지는 월요일부터 금요일까지(휴일은 제외)입니다.

Polish – UWAGA: Jeśli mówisz po polsku, możesz skorzystać z bezpłatnych usług pomocy językowej. Dostępne są również nieodpłatnie odpowiednie pomoce i usługi zapewniające informacje w dostępnych formatach. Zadzwoń pod numer telefonu podany powyżej lub porozmawiaj ze swoim dostawcą. Czynne od 8:00 rano do 8:00 wieczorem czasu lokalnego, czasu lokalnego, siedem dni w tygodniu (oprócz Święta Dziękczynienia i Bożego Narodzenia) od 1 października do 31 marca oraz od poniedziałku do piątku (oprócz świąt) od 1 kwietnia do 30 września.

Portuguese – ATENÇÃO: Se fala português, tem à sua disposição serviços de assistência linguística gratuitos. Estão também disponíveis, a título gratuito, ajudas e serviços auxiliares adequados para fornecer informações em formatos acessíveis. Ligue para o número de telefone acima indicado ou fale com o seu fornecedor. Horário de expediente: das 8h às 20h, (hora local), sete dias por semana (exceto Dia de Ação de Graças e Natal) de 1 de outubro até 31 de março, e de segunda a sexta-feira (exceto feriados) de 1 de abril até 30 de setembro.

Russian – ВНИМАНИЕ: Если вы говорите на русском языке, вам могут предоставить бесплатные услуги переводчика. Также бесплатно предоставляются вспомогательные средства и услуги, позволяющие получать информацию в доступных форматах. Позвоните по вышеуказанному номеру телефона или обсудите этот вопрос с вашим поставщиком услуг. Часы работы: с 08:00 до 20:00 в любой день недели (кроме Дня благодарения и Рождества) с 1 октября по 31 марта и с понедельника по пятницу (кроме праздничных дней) с 1 апреля по 30 сентября.

Tagalog – PAUNAWA: Kung nagsasalita ka Tagalog, mayroong available na mga libreng serbisyo sa tulong sa wika para sa iyo. Ang naaangkop na mga karagdagang tulong at serbisyo para magbigay ng impormasyon sa mga naa-access na format ay available rin nang walang bayad. Tawagan ang numero ng telepono na nakalista sa itaas o makipag-usap sa iyong provider. Ang mga oras ng opisina ay 8 a.m. hanggang 8 p.m., lokal na oras, pitong araw sa isang linggo (maliban sa Thanksgiving at Pasko) mula Oktubre 1 hanggang Marso 31, at Lunes hanggang Biyernes (maliban sa mga holiday) mula Abril 1 hanggang Setyembre 30.

Thai – หมายเหตุ: หากคุณพูด ภาษาไทย เรามีบริการช่วยเหลือด้านภาษาฟรีสำหรับคุณ นอกจากนี้ยังมีความช่วยเหลือและบริการเสริมที่เหมาะสม เพื่อให้ข้อมูลในรูปแบบที่เข้าถึงได้โดยไม่เสียค่าใช้จ่ายอีกด้วย โทรไปยังหมายเลขโทรศัพท์ที่ระบุไว้ด้านบนหรือพูดคุยกับผู้ให้บริการของคุณ เวลาทำการคือ 08.00 น. ถึง 20.00 น. ตามเวลาท้องถิ่น เจ็ด วันต่อสัปดาห์ (ยกเว้นวันขอบคุณพระเจ้าและวันคริสต์มาส) ตั้งแต่วันที่ 1 ตุลาคม ถึง 31 มีนาคม และวันจันทร์ถึงวันศุกร์ (ยกเว้นวันหยุด) ตั้งแต่วันที่ 1 เมษายน ถึง 30 กันยายน.

Ukrainian – УВАГА. Якщо ви розмовляєте українською, вам доступні безкоштовні послуги мовної допомоги. Відповідні допоміжні засоби й послуги для надання інформації в доступних форматах також можна отримати безкоштовно. Зателефонуйте за вказаним вище номером або зверніться до свого постачальника. Графік роботи: з 08:00 до 20:00 за місцевим часом, без вихідних (крім Дня подяки й Різдва) з 1 жовтня по 31 березня, і з понеділка по п’ятницю (крім святкових днів) з 1 квітня по 30 вересня.

Vietnamese – CHÚ Ý: Nếu quý vị nói tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ miễn phí luôn sẵn sàng phục vụ quý vị. Các dịch vụ và hỗ trợ phụ trợ thích hợp cung cấp thông tin ở các định dạng có thể truy cập cũng được cung cấp miễn phí. Gọi số điện thoại nêu trên hoặc nói chuyện với nhà cung cấp của quý vị. Giờ làm việc từ 8 giờ sáng đến 8 giờ tối, giờ địa phương, bảy ngày một tuần (Trừ Lễ Tạ ơn và Giáng sinh) từ ngày 1 Tháng Mười đến 31 Tháng Ba, và Thứ Hai đến Thứ Sáu (trừ các ngày lễ), từ ngày 1 Tháng Tư đến 30 Tháng Chín.

Notes:

Notes:

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2026 Summary of Benefits

Optimum HealthCare, Inc.
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