

OptimaFit ON Exchange 2018 Plans

This summary is for comparison purposes only. For complete details, please view the product Summary of Benefits and Coverage (SBC) at www.optimahealth.com.

*Applies only if Rx deductible is separate from the medical deductible.

	OptimaFit Gold 1500 M	OptimaFit Silver 4600 20% M	OptimaFit Silver 2850 20% HSA M	OptimaFit Bronze 7200 20% M	OptimaFit Bronze 6000 HSA M	OptimaFit Catastrophic 7350 M
In-Network Deductible: Single / Family	\$1,500 Single / \$3,000 Family	\$4,600 Single / \$9,200 Family	\$2,850 Single / \$5,700 Family	\$7,200 Single / \$14,400 Family	\$6,000 Single / \$12,000 Family	\$7,350 Single / \$14,700 Family
Type of Deductible	Embedded	Embedded	Embedded	Embedded	Embedded	Embedded
In-Network Out-of-Pocket Max: Single / Family	\$7,350 Single / \$14,700 Family	\$7,350 Single / \$14,700 Family	\$5,600 Single / \$11,200 Family	\$7,350 Single / \$14,700 Family	\$6,550 Single / \$13,100 Family	\$7,350 Single / \$14,700 Family
Coinsurance	10%	20%	20%	20%	10%	0%
Office Visit: Primary Care Physician (PCP) <i>NOTE: Other office services subject to deductible and coinsurance</i>	\$35	\$30	20% AD	\$40 AD	10% AD	\$40 copay per visit for 3 office visits, then 0%
Virtual Visit: Primary Care Physician (PCP) <i>Note: Consultations provided by MDLIVE® physicians</i>	\$35	\$30	20% AD	\$40 AD	10% AD	\$40 copay per visit for 3 office visits, then 0%
Office Visit: Specialist	\$65	\$60	20% AD	\$60 AD	10% AD	0% AD
Preventive Care	0%	0%	0%	0%	0%	0%
Urgent Care	10% AD	20% AD	20% AD	20% AD	10% AD	0% AD
Emergency Room Care	30% AD	40% AD	40% AD	40% AD	30% AD	0% AD
Inpatient Care	10% AD	20% AD	20% AD	20% AD	10% AD	0% AD
Outpatient Diagnostic Tests (X-ray, EKG, etc.)	10% AD	20% AD	20% AD	20% AD	10% AD	0% AD
Outpatient Advanced Diagnostic Tests (MRI, CT Scan, etc.)	10% AD	20% AD	20% AD	20% AD	10% AD	0% AD
Outpatient Surgery	10% AD	20% AD	20% AD	20% AD	10% AD	0% AD
Pediatric Dental	10% AD	20% AD	20% AD	20% AD	10% AD	0% AD
Adult Vision	100% coverage 1 visit every 12 months. (OON claims reimbursed up to \$30 for eye exam only)	100% coverage 1 visit every 12 months. (OON claims reimbursed up to \$30 for eye exam only)	100% coverage 1 visit every 12 months. (OON claims reimbursed up to \$30 for eye exam only)	100% coverage 1 visit every 12 months. (OON claims reimbursed up to \$30 for eye exam only)	100% coverage 1 visit every 12 months. (OON claims reimbursed up to \$30 for eye exam only)	100% coverage 1 visit every 12 months.
Mental Health and Substance Abuse: Outpatient Facility & Services	\$35	\$30	20% AD	\$40 AD	10% AD	0% AD
Mental Health and Substance Abuse: Inpatient Hospital	10% AD	20% AD	20% AD	20% AD	10% AD	0% AD
Spinal Manipulation/Chiropractic Care	10% AD	20% AD	20% AD	20% AD	10% AD	0% AD
Physical and Occupational Therapy	10% AD	20% AD	20% AD	20% AD	10% AD	0% AD
Retail Pharmacy Deductible*	None	\$200 per covered person	None	None	None	None
Retail Pharmacy Tier 1	\$25	\$25 AD	\$25 AD	\$25	10% AD	0% AD
Retail Pharmacy Tier 2	\$50	\$50 AD	\$60 AD	\$45 AD	10% AD	0% AD
Retail Pharmacy Tier 3	35%	35% AD	35% AD	35% AD	10% AD	0% AD
Retail Pharmacy Tier 4	35%	35% AD	35% AD	35% AD	10% AD	0% AD

AD = After Deductible OON = Out Of Network

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