

OptimaFit ON Exchange Cost-Share Reduction (CSR) 2017 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.

AD = After Deductible OON = Out Of Network

	Core Plan				Core Plan			
Metallic Tier → Plan Name →	Silver OptimaFit Silver 4000 20% M	CSR 73% OptimaFit Silver 2500 M	CSR 87% OptimaFit Gold 600 M	CSR 93% OptimaFit Platinum 150 M	Silver OptimaFit Silver 2600 25 20% M	CSR 73% OptimaFit Silver 2000 25 M	CSR 87% OptimaFit Gold 800 20 M	CSR 93% OptimaFit Platinum 200 10 M
In-Network Deductible: Single / Family	\$4,000 Single / \$8,000 Family	\$2,500 Single / \$5,000 Family	\$600 Single / \$1,200 Family	\$150 Single / \$300 Family	\$2,600 Single / \$5,200 Family	\$2,000 Single / \$4,000 Family	\$800 Single / \$1,600 Family	\$200 Single / \$400 Family
Type of Deductible	Embedded	Embedded	Embedded	Embedded	Embedded	Embedded	Embedded	Embedded
In-Network Out-of-Pocket Max: Single / Family	\$7,150 Single / \$14,300 Family	\$5,700 Single / \$11,400 Family	\$2,300 Single / \$4,600 Family	\$900 Single / \$1,800 Family	\$7,150 Single / \$14,300 Family	\$5,700 Single / \$11,400 Family	\$2,000 Single / \$4,000 Family	\$900 Single / \$1,800 Family
Coinsurance	20%	20%	10%	10%	20%	20%	10%	10%
Office Visit: Primary Care Physician (PCP) <i>NOTE: Other office services subject to deductible and coinsurance</i>	\$25	\$25	\$20	\$10	\$25 copay per visit for 3 office visits, then deductible and 20% coinsurance	\$25 copay per visit for 3 office visits, then deductible and 20% coinsurance	\$20 copay per visit for 3 office visits, then deductible and 10% coinsurance	\$10 copay per visit for 3 office visits, then deductible and 10% coinsurance
Virtual Visit: Primary Care Physician (PCP) <i>Note: Consultations provided by MDLIVE® physicians</i>	\$25	\$25	\$20	\$10	\$25 copay per visit for 3 office visits, then deductible and 20% coinsurance	\$25 copay per visit for 3 office visits, then deductible and 20% coinsurance	\$20 copay per visit for 3 office visits, then deductible and 10% coinsurance	\$10 copay per visit for 3 office visits, then deductible and 10% coinsurance
Office Visit: Specialist	\$50	\$50	\$40	\$20	20% AD	20% AD	10% AD	10% AD
Preventive Care	0	0	0	0	0	0	0	0
Urgent Care	20% AD	20% AD	10% AD	10% AD	20% AD	20% AD	10% AD	10% AD
Emergency Room Care	40% AD	40% AD	30% AD	30% AD	40% AD	40% AD	30% AD	30% AD
Inpatient Care	20% AD	20% AD	10% AD	10% AD	20% AD	20% AD	10% AD	10% AD
Outpatient Diagnostic Tests (X-ray, EKG, etc.)	20% AD	20% AD	10% AD	10% AD	20% AD	20% AD	10% AD	10% AD
Outpatient Advanced Diagnostic Tests (MRI, CT Scan, etc.)	20% AD	20% AD	10% AD	10% AD	20% AD	20% AD	10% AD	10% AD
Outpatient Surgery	20% AD	20% AD	10% AD	10% AD	20% AD	20% AD	10% AD	10% AD
Pediatric Dental	20% AD	20% AD	10% AD	10% AD	20% AD	20% AD	10% AD	10% 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. (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)
Mental Health and Substance Abuse: Outpatient Facility & Services	\$25	\$25	\$20	\$10	\$0 copay per visit for 3 office visits, then deductible and 20% coinsurance	\$0 copay per visit for 3 office visits, then deductible and 20% coinsurance	\$0 copay per visit for 3 office visits, then deductible and 10% coinsurance	\$0 copay per visit for 3 office visits, then deductible and 10% coinsurance
Mental Health and Substance Abuse: Inpatient Hospital	20% AD	20% AD	10% AD	10% AD	20% AD	20% AD	10% AD	10% AD
Spinal Manipulation/Chiropractic Care	20% AD	20% AD	10% AD	10% AD	20% AD	20% AD	10% AD	10% AD
Physical and Occupational Therapy	20% AD	20% AD	10% AD	10% AD	20% AD	20% AD	10% AD	10% AD
Retail Pharmacy Deductible	\$150 per covered person	None	None	None	\$150 per covered person	None	None	None
Retail Pharmacy Tier 1	\$15 AD	\$15	\$15	\$10	\$15	\$15	\$15	\$10
Retail Pharmacy Tier 2	\$50 AD	\$40	\$35	\$25	\$50 AD	\$45	\$35	\$20
Retail Pharmacy Tier 3	35% AD	25%	10%	5%	35% AD	25%	10%	5%
Retail Pharmacy Tier 4	35% AD	25%	10%	5%	35% AD	25%	10%	5%

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