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) *NOTE: Other office services subject to deductible and coinsurance*	$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) *Note: Consultations provided by MDLIVE® physicians*	$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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