OptimaFit ON Exchange 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

Metallic Tier → / Plan Name →	Gold OptimaFit Gold 1000 M	Silver OptimaFit Silver 4000 20% M	Silver OptimaFit Silver 2600 25 20% M	Bronze OptimaFit Bronze 6850 30 M
In-Network Deductible: Single / Family	$1,000 Single / $2,000 Family	$4,000 Single / $8,000 Family	$2,600 Single / $5,200 Family	$6,850 Single / $13,700 Family
Type of Deductible	Embedded	Embedded	Embedded	Embedded
In-Network Out-of-Pocket Max: Single / Family	$7,150 Single / $14,300 Family	$7,150 Single / $14,300 Family	$7,150 Single / $14,300 Family	$7,150 Single / $14,300 Family
Coinsurance	10%	20%	20%	20%
Office Visit: Primary Care Physician (PCP) *NOTE: Other office services subject to deductible and coinsurance*	$25	$25	$25 copay per visit for 3 office visits, then deductible and 20% coinsurance	$30 AD
Virtual Visit: Primary Care Physician (PCP) *Note: Consultations provided by MDLIVE® physicians*	$25	$25	$25 copay per visit for 3 office visits, then deductible and 20% coinsurance	$30 AD
Office Visit: Specialist	$50	$50	20% AD	$60 AD
Preventive Care	0	0	0	0
Urgent Care	10% AD	20% AD	20% AD	20% AD
Emergency Room Care	30% AD	40% AD	40% AD	40% AD
Inpatient Care	10% AD	20% AD	20% AD	20% AD
Outpatient Diagnostic Tests (X-ray, EKG, etc.)	10% AD	20% AD	20% AD	20% AD
Outpatient Advanced Diagnostic Tests (MRI, CT Scan, etc.)	10% AD	20% AD	20% AD	20% AD
Outpatient Surgery	10% AD	20% AD	20% AD	20% AD
Pediatric Dental	10% AD	20% AD	20% AD	20% 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)
Mental Health and Substance Abuse: Outpatient Facility & Services	$25	$25	$0 copay per visit for 3 office visits, then deductible and 20% coinsurance	$30 AD
Mental Health and Substance Abuse: Inpatient Hospital	10% AD	20% AD	20% AD	20% AD
Spinal Manipulation/Chiropractic Care	10% AD	20% AD	20% AD	20% AD
Physical and Occupational Therapy	10% AD	20% AD	20% AD	20% AD
Retail Pharmacy Deductible	None	$150 per covered person	$150 per covered person	None
Retail Pharmacy Tier 1	$15	$15 AD	$15	$15
Retail Pharmacy Tier 2	$45	$50 AD	$50 AD	$45
Retail Pharmacy Tier 3	35%	35% AD	35% AD	35%
Retail Pharmacy Tier 4	35%	35% AD	35% AD	35%

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