

OptimaFit Select OFF Exchange 2017 Plans **Select Network**

Metallic Tier → Plan Name →	Gold OptimaFit Gold 1400 Select	Silver OptimaFit Silver 4000 20% Select	Bronze OptimaFit Bronze 6000 HSA Select
In-Network Deductible: Single / Family	\$1,400 Single / \$2,800 Family	\$4,000 Single / \$8,000 Family	\$6,000 Single / \$12,000 Family
Type of Deductible	Embedded	Embedded	Embedded
In-Network Out-of-Pocket Max: Single / Family	\$4,000 Single / \$8,000 Family	\$7,150 Single / \$14,300 Family	\$6,550 Single / \$13,100 Family
Coinsurance	20%	20%	0%
Office Visit: Primary Care Physician (PCP) <i>NOTE: Other office services subject to deductible and coinsurance</i>	\$30	\$25	10% AD
Virtual Visit: Primary Care Physician (PCP) <i>Note: Consultations provided by MDLIVE® physicians</i>	\$30	\$25	10% AD
Office Visit: Specialist	20% AD	\$50	10% AD
Preventive Care	0	0	0
Urgent Care	20% AD	20% AD	10% AD
Emergency Room Care	40% AD	40% AD	30% AD
Inpatient Care	20% AD	20% AD	10% AD
Outpatient Diagnostic Tests (X-ray, EKG, etc.)	20% AD	20% AD	10% AD
Outpatient Advanced Diagnostic Tests (MRI, CT Scan, etc.)	20% AD	20% AD	10% AD
Outpatient Surgery	20% AD	20% AD	10% AD
Pediatric Dental	20% AD	20% 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)
Mental Health and Substance Abuse: Outpatient Facility & Services	0	\$25	10% AD
Mental Health and Substance Abuse: Inpatient Hospital	20% AD	20% AD	10% AD
Spinal Manipulation/Chiropractic Care	20% AD	20% AD	10% AD
Physical and Occupational Therapy	20% AD	20% AD	10% AD
Retail Pharmacy Deductible	None	None	None
Retail Pharmacy Tier 1	\$15	\$15	10% AD
Retail Pharmacy Tier 2	\$50 AD	\$50	10% AD
Retail Pharmacy Tier 3	20% AD	35%	10% AD
Retail Pharmacy Tier 4	20% AD	35%	10% AD

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OptimaFit Select ON Exchange 2017 Plans **Select Network**

Gold OptimaFit Gold 1000 M Select	Bronze OptimaFit Bronze 6850 30 M Select
\$1,000 Single / \$2,000 Family	\$6,850 Single / \$13,700 Family
Embedded	Embedded
\$7,150 Single / \$14,300 Family	\$7,150 Single / \$14,300 Family
10%	20%
\$25	\$30 AD
\$25	\$30 AD
\$50	\$60 AD
0	0
10% AD	20% AD
30% AD	40% AD
10% AD	20% AD
10% AD	20% AD
10% AD	20% AD
10% AD	20% AD
10% AD	20% AD
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)
\$25	\$30 AD
10% AD	20% AD
10% AD	20% AD
10% AD	20% AD
None	None
\$15	\$15
\$45	\$45
35%	35%
35%	35%

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

OptimaFit Select plans are only available for individuals residing in zip codes within the cities of Virginia Beach, Chesapeake, Norfolk, and Portsmouth.

OptimaFit Select 2017 Plans – Both OFF and ON Exchange