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) *NOTE: Other office services subject to deductible and coinsurance*	$35	$30	20% AD	$40 AD	10% AD	$40 copay per visit for 3 office visits, then 0%
Virtual Visit: Primary Care Physician (PCP) *Note: Consultations provided by MDLIVE® physicians*	$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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