

	Optima Health Equity 3000/0%		Optima Health Vantage 35/50	Optima Health POS 1000/40/30%	
Benefits Coverage	In-Network Benefits	Out-of-Network Benefits	In-Network Only	In-Network Benefits	Out-of-Network Benefits
<b>Annual Deductible</b>					
Individual	\$3,000	\$3,000	\$0	\$1,000	\$3,000
Family	\$6,000	\$6,000	\$0	\$2,000	\$6,000
Coinsurance	0%	30%	10% (complex radiology)	30%	40%
<b>Maximum Out-of-Pocket*</b>					
Individual	\$4,000	\$6,000	\$4,750	\$4,750	\$6,000
Family	\$8,000	\$12,000	\$9,000	\$9,000	\$12,000
<b>Physician Office Visit</b>					
Primary Care	0% after deductible	30% after deductible	\$35 copay	\$40 copay	40% after deductible
Specialty Care	0% after deductible	30% after deductible	\$50 copay	\$60 copay	40% after deductible
<b>Preventive Care</b>					
Adult Periodic Exams	Covered at 100%	30% after deductible	Covered at 100%	Covered at 100%	40% after deductible
Well-Child Care	Covered at 100%	30% after deductible	Covered at 100%	Covered at 100%	40% after deductible
<b>Diagnostic Services</b>					
X-ray and Lab Tests	0% after deductible	30% after deductible	\$50 copay	30% after deductible	40% after deductible
Complex Radiology	0% after deductible	30% after deductible	10% after deductible	30% after deductible	40% after deductible
Urgent Care Facility	0% after deductible	30% after deductible	\$50 copay	\$60 copay	40% after deductible
Emergency Room Facility Charges*	0% after deductible	0% after deductible	\$500 copay	30% after deductible	30% after deductible
Facility Charges					
Inpatient Facility Charges	0% after deductible	30% after deductible	\$350 copay per day	30% after deductible	40% after deductible
Outpatient Facility and Surgical Charges	0% after deductible	30% after deductible	\$500 copay	30% after deductible	40% after deductible
Skilled Nursing	0% after deductible, limit 100 days	30% after deductible	20% coinsurance, limited to 100 days per year	30% after deductible, limited to 100 days per yr.	40% after deductible
<b>Maternity Care</b>					
Pre/Post Natal Care	0% after deductible	30% after deductible	\$400 copay global	\$500 copay global	40% after deductible
Inpatient Hospital Delivery Charges	0% after deductible	30% after deductible	\$350 copay per day	30% after deductible	50% after deductible

	Optima Health Equity 3000/0%		Optima Health Vantage 35/50	Optima Health POS 1000/40/30%	
Benefits Coverage	In-Network Benefits	Out-of-Network Benefits	In-Network Only	In-Network Benefits	Out-of-Network Benefits
<b>Mental Health &amp; Substance Abuse</b>					
<b>Inpatient</b>	0% after deductible	30% after deductible	\$350 copay per day	30% after deductible	50% after deductible
<b>Outpatient</b>	0% after deductible	30% after deductible	\$35 copay	\$40 copay	50% after deductible
<b>Other Services</b>					
<b>Ambulance</b>	0% after deductible	30% after deductible	\$100 per transport	30% after deductible	40% after deductible
<b>Vision Benefits (exam only) every 12 months through EyeMed</b>	No charge	Reimbursed up to \$30	No charge	No charge	Reimbursed up to \$30
<b>Durable Medical Equipment</b>	30% after deductible	30% after deductible	No charge	30% after deductible	40% after deductible
<b>Chiropractic</b>	0% after deductible; 30 visits per year	30% after deductible; 30 visits per year	\$35 copay	30% after deductible; 30 visits per year	40% after deductible; 30 visits per year
<b>Retail Pharmacy (30 Day Supply)</b>					
<b>Generic (Tier 1)</b>	\$10 copay	\$10 copay	\$15 copay	\$15 copay	\$15 copay
<b>Preferred (Tier 2)</b>	\$30 copay	\$30 copay	\$40 copay	\$40 copay	\$40 copay
<b>Non-Preferred (Tier 3)</b>	\$50 copay	\$50 copay	\$75 copay	\$75 copay	\$75 copay
<b>Mail Order Pharmacy (90 Day Supply)</b>					
<b>Generic (Tier 1)</b>	\$20 copay	Not covered	\$30 copay	\$30 copay	Not covered
<b>Preferred (Tier 2)</b>	\$60 copay	Not covered	\$80 copay	\$80 copay	Not covered
<b>Non-Preferred (Tier 3)</b>	\$100 copay	Not covered	\$150 copay	\$150 copay	Not covered