2017 Small Group Plan Designs

The Community Prime, Community Advantage, Community Option, Community Select, Community Assure, Community Preferred and Community Merit all include the **Chronic Illness Support Program**. Visit HealthOptions.org to view a copy of the 2017 prescription drug formulary and medications that qualify for the Chronic Illness Support Program will be marked as CISP.

HDHP Preventive Drug List ▸ HDHP Preventive Drug List – The Community Access HSA, Community Option HSA, Community Basic HSA, Community Core HSA, and Community Balance HSA include medications to help prevent chronic conditions and illnesses. The Preventive drugs on this list are not subject to your HSA plan deductible. For a copy of the medication list, see the HDHP Preventive Drug list. Visit HealthOptions.org to view a copy of the 2017 prescription drug formulary and medications that qualify will be marked as HSA.

2017 Group Plans: Gold

Plan Name ▸	Community Prime (On & Off SHOP)	Community Advantage (Off SHOP Only)
Medical		
Deductible - Individual (Ded)	$1,500	$1,000
Deductible - Family	$3,000	$2,000
Standard Plan Coinsurance (Co)	30%	20%
OOP Maximum - Individual	$3,500	$4,000
OOP Maximum - Family	$7,000	$8,000
Annual Maximum	Unlimited	Unlimited
Lifetime Maximum	Unlimited	Unlimited
Hospital	Ded/Co	Ded/Co
Skilled Nursing Facility	Ded/Co	Ded/Co
Mental Health/Substance Abuse Inpatient	Ded/Co	Ded/Co
Inpatient Physician and Surgical Services	Ded/Co	Ded/Co
Emergency Room	$500	$500
Outpatient Surgery	Ded/Co	Ded/Co
Outpatient Laboratory and Professional Services	Ded/Co	Ded/Co
Mental Health/Substance Abuse Outpatient	$20	$30
Imaging (PET, MRI, CT)	Ded/Co	Ded/Co
X-rays and Diagnostic Imaging	Ded/Co	Ded/Co
PT/ST/OT 60 visits per cal yr combined	$20	$30
Preventive Care	$0 Copay	$0 Copay
Office Visit-Primary Care	$20	$30
Office Visit-Specialty Care	$60	$80
Urgent Care Visits	$60	$80
Chiropractic Care 40 visits per year	$20	$30
Vision Exams - Pediatric, 1 visit annually, under 19	$20	$30
Vision Exams - Adult, 1 visit every 2 years after 19	$20	$30
Ambulance	Ded/Co	Ded/Co
Durable Medical Equipment/Prosthesis	Ded/Co	Ded/Co
Glasses/Contacts (Pediatric Only)	Ded/Co	Ded/Co
Prescription Drugs		
Tier 1: (Generics)	$5	$5
Tier 2: (Preferred Brands)	$35	$35
Tier 3: (Non-Preferred Brands)	$70	$70
Tier 4: (Specialty)	Ded/50% Co	Ded/50% Co
Tier 5: (Specialty)	Ded/50% Co	Ded/50% Co
Pediatric Dental (administered by Delta Dental)		
Deductible per child	$100	$100
Deductible per family	$200	$200
Diagnostic/Preventive	20% Coins	20% Coins
Basic Restorative	Ded/50% Co	Ded/50% Co
Major Restorative	Ded/50% Co	Ded/50% Co
Medically Necessary Orthodontics	Ded/50% Co	Ded/50% Co
Chronic Illness Support Program (CISP)	Yes	Yes
Preventive Drug list	No	No

Cost-sharing shown is when services are obtained in-network

2017 Group Plans: Silver

Plan Name ▸	Community Core HSA (On & Off SHOP)	Community Balance HSA (Off SHOP Only)	Community Option (Off SHOP Only)	Community Select (Off SHOP Only)
Medical				
Deductible - Individual (Ded)	$3,000	$2,600	$5,000	$4,000
Deductible - Family	$6,000	$5,200	$10,000	$8,000
Standard Plan Coinsurance (Co)	10%	20%	0%	20%
OOP Maximum - Individual	$5,500	$4,500	$6,500	$5,500
OOP Maximum - Family	$11,000	$9,000	$13,000	$11,000
Annual Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Hospital	Ded/Co	Ded/Co	Deductible	Ded/Co
Skilled Nursing Facility	Ded/Co	Ded/Co	Deductible	Ded/Co
Mental Health/Substance Abuse Inpatient	Ded/Co	Ded/Co	Deductible	Ded/Co
Inpatient Physician and Surgical Services	Ded/Co	Ded/Co	Deductible	Ded/Co
Emergency Room	Ded/Co	Ded/Co	Deductible	Ded/Co
Outpatient Surgery	Ded/Co	Ded/Co	Deductible	Ded/Co
Outpatient Laboratory and Professional Services	Ded/Co	Ded/Co	Deductible	Ded/Co
Mental Health/Substance Abuse Outpatient	Ded/Co	Ded/Co	$40	$40
Imaging (PET, MRI, CT)	Ded/Co	Ded/Co	Deductible	Ded/Co
X-rays and Diagnostic Imaging	Ded/Co	Ded/Co	Deductible	Ded/Co
PT/ST/OT 60 visits per cal yr combined	Ded/Co	Ded/Co	$40	$40
Preventive Care	$0 Copay	$0 Copay	$0 Copay	$0 Copay
Office Visit-Primary Care	Ded/Co	Ded/Co	$40	$40
Office Visit-Specialty Care	Ded/Co	Ded/Co	$80	$80
Urgent Care Visits	Ded/Co	Ded/Co	$150	$150
Chiropractic Care 40 visits per year	Ded/Co	Ded/Co	$40	$40
Vision Exams - Pediatric, 1 visit annually, under 19	Ded/Co	Ded/Co	$40	$40
Vision Exams - Adult, 1 visit every 2 years after 19	Ded/Co	Ded/Co	$40	$40
Ambulance	Ded/Co	Ded/Co	Deductible	Ded/Co
Durable Medical Equipment/Prosthesis	Ded/Co	Ded/Co	Deductible	Ded/Co
Glasses/Contacts (Pediatric Only)	Ded/Co	Ded/Co	Deductible	Ded/Co
Prescription Drugs				
Tier 1-Preferred Generics	Ded/Co	Ded/Co	$5	$5
Tier 2-Non-Preferred Generics	Ded/Co	Ded/Co	$35	$35
Tier 3-Preferred Brand	Ded/Co	Ded/Co	$70	$70
Tier 4-Non-Preferred Brand	Ded/50% Co	Ded/50% Co	Ded/50% Co	Ded/50% Co
Tier 5-Specialty	Ded/50% Co	Ded/50% Co	Ded/50% Co	Ded/50% Co
Pediatric Dental (administered by Delta Dental)				
Deductible per Child	$100	$100	$100	$100
Deductible per Family	$200	$200	$200	$200
Diagnostic/Preventive	20% Coins	20% Coins	20% Coins	20% Coins
Basic Dental Care - Child (Basic Restorative)	Ded/50% Co	Ded/50% Co	Ded/50% Co	Ded/50% Co
Medically Necessary Orthodontics	Ded/50% Co	Ded/50% Co	Ded/50% Co	Ded/50% Co
Major Dental Care - Child (Restorative)	Ded/50% Co	Ded/50% Co	Ded/50% Co	Ded/50% Co
Chronic Illness Support Program (CISP)	No	No	Yes	Yes
Preventive Drug list	Yes	Yes	No	No

Cost-sharing shown is when services are obtained in-network

2017 Group Plans: Silver

Plan Name ▸	Community Assure (Off SHOP only)	Community Preferred (On & Off SHOP)	Community Merit (Off SHOP only)
Medical			
Deductible - Individual (Ded)	$3,000	$2,500	$2,000
Deductible - Family	$6,000	$5,000	$4,000
Standard Plan Coinsurance (Co)	20%	20%	20%
OOP Maximum - Individual	$5,700	$6,000	$7,150
OOP Maximum - Family	$11,400	$12,000	$14,300
Annual Maximum	Unlimited	Unlimited	Unlimited
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Hospital	Ded/Co	Ded/Co	Ded/Co
Skilled Nursing Facility	Ded/Co	Ded/Co	Ded/Co
Mental Health/Substance Abuse Inpatient	Ded/Co	Ded/Co	Ded/Co
Inpatient Physician and Surgical Services	Ded/Co	Ded/Co	Ded/Co
Emergency Room	Ded/Co	Ded/Co	Ded/Co
Outpatient Surgery	Ded/Co	Ded/Co	Ded/Co
Outpatient Laboratory and Professional Services	Ded/Co	Ded/Co	Ded/Co
Mental Health/Substance Abuse Outpatient	$40	$30	$30
Imaging (PET, MRI, CT)	Ded/Co	Ded/Co	Ded/Co
X-rays and Diagnostic Imaging	Ded/Co	Ded/Co	Ded/Co
PT/ST/OT 60 visits per cal yr combined	$40	$30	$30
Preventive Care	$0 Copay	$0 Copay	$0 Copay
Office Visit-Primary Care	$40	$30	$30
Office Visit-Specialty Care	$80	$85	$85
Urgent Care Visits	$150	$85	$85
Chiropractic Care 40 visits per year	$40	$30	$30
Vision Exams - Pediatric, 1 visit annually, under 19	$40	$30	$30
Vision Exams - Adult, 1 visit every 2 years after 19	$40	$30	$30
Ambulance	Ded/Co	Ded/Co	Ded/Co
Durable Medical Equipment/Prosthesis	Ded/Co	Ded/Co	Ded/Co
Glasses/Contacts (Pediatric Only)	Ded/Co	Ded/Co	Ded/Co
Prescription Drugs			
Tier 1-Preferred Generics	$5	$5	$5
Tier 2-Non-Preferred Generics	$35	$35	$35
Tier 3-Preferred Brand	$70	$70	$70
Tier 4-Non-Preferred Brand	Ded/50% Co	Ded/50% Co	Ded/50% Co
Tier 5-Specialty	Ded/50% Co	Ded/50% Co	Ded/50% Co
Pediatric Dental (administered by Delta Dental)			
Deductible per Child	$100	$100	$100
Deductible per Family	$200	$200	$200
Diagnostic/Preventive	20% Coins	20% Coins	20% Coins
Basic Dental Care - Child (Basic Restorative)	Ded/50% Co	Ded/50% Co	Ded/50% Co
Medically Necessary Orthodontics	Ded/50% Co	Ded/50% Co	Ded/50% Co
Major Dental Care - Child (Restorative)	Ded/50% Co	Ded/50% Co	Ded/50% Co
Chronic Illness Support Program (CISP)	Yes	Yes	Yes
Preventive Drug list	No	No	No

Cost-sharing shown is when services are obtained in-network

2017 Group Plans: Bronze

Plan Name ▸	Community Progress (Off SHOP Only)	Community Access HSA (On & Off SHOP)	Community Option HSA (Off SHOP only)	Community Basic HSA (Off SHOP Only)
Medical				
Deductible - Individual (Ded)	$7,150	$6,300	$5,000	$4,800
Deductible - Family	$14,300	$12,600	$10,000	$9,600
Standard Plan Coinsurance (Co)	0%	20%	35%	40%
OOP Maximum - Individual	$7,150	$6,550	$6,550	$6,550
OOP Maximum - Family	$14,300	$13,100	$13,100	$13,100
Annual Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Hospital	Deductible	Ded/Co	Ded/Co	Ded/Co
Skilled Nursing Facility	Deductible	Ded/Co	Ded/Co	Ded/Co
Mental Health/Substance Abuse Inpatient	Deductible	Ded/Co	Ded/Co	Ded/Co
Inpatient Physician and Surgical Services	Deductible	Ded/Co	Ded/Co	Ded/Co
Emergency Room	Deductible	Ded/Co	Ded/Co	Ded/Co
Outpatient Surgery	Deductible	Ded/Co	Ded/Co	Ded/Co
Outpatient Laboratory and Professional Services	Deductible	Ded/Co	Ded/Co	Ded/Co
Mental Health/Substance Abuse Outpatient	$70	Ded/Co	Ded/Co	Ded/Co
Imaging (PET, MRI, CT)	Deductible	Ded/Co	Ded/Co	Ded/Co
X-rays and Diagnostic Imaging	Deductible	Ded/Co	Ded/Co	Ded/Co
PT/ST/OT 60 visits per cal yr combined	Deductible	Ded/Co	Ded/Co	Ded/Co
Preventive Care	$0 Copay	$0 Copay	$0 Copay	$0 Copay
Office Visit-Primary Care	$70	Ded/Co	Ded/Co	Ded/Co
Office Visit-Specialty Care	Deductible	Ded/Co	Ded/Co	Ded/Co
Urgent Care Visits	Deductible	Ded/Co	Ded/Co	Ded/Co
Chiropractic Care 40 visits per year	Deductible	Ded/Co	Ded/Co	Ded/Co
Vision Exams - Pediatric, 1 visit annually, under 19	Deductible	Ded/Co	Ded/Co	Ded/Co
Vision Exams - Adult, 1 visit every 2 years after 19	Deductible	Ded/Co	Ded/Co	Ded/Co
Ambulance	Deductible	Ded/Co	Ded/Co	Ded/Co
Durable Medical Equipment/Prosthesis	Deductible	Ded/Co	Ded/Co	Ded/Co
Glasses/Contacts (Pediatric Only)	Deductible	Ded/Co	Ded/Co	Ded/Co
Prescription Drugs				
Tier 1-Preferred Generics	$5	Ded/Co	Ded/Co	Ded/Co
Tier 2-Non-Preferred Generics	$35	Ded/Co	Ded/Co	Ded/Co
Tier 3-Preferred Brand	Deductible	Ded/Co	Ded/Co	Ded/Co
Tier 4-Non-Preferred Brand	Deductible	Ded/50% Co	Ded/50% Co	Ded/50% Co
Tier 5-Specialty	Deductible	Ded/50% Co	Ded/50% Co	Ded/50% Co
Pediatric Dental (administered by Delta Dental)				
Deductible per Child	$100	$100	$100	$100
Deductible per Family	$200	$200	$200	$200
Diagnostic/Preventive	20% Coins	20% Coins	20% Coins	20% Coins
Basic Dental Care - Child (Basic Restorative)	Ded/50% Co	Ded/50% Co	Ded/50% Co	Ded/50% Co
Medically Necessary Orthodontics	Ded/50% Co	Ded/50% Co	Ded/50% Co	Ded/50% Co
Major Dental Care - Child (Restorative)	Ded/50% Co	Ded/50% Co	Ded/50% Co	Ded/50% Co
Chronic Illness Support Program (CISP)	No	No	No	No
Preventive Drug list	No	Yes	Yes	Yes

Cost-sharing shown is when services are obtained in-network