



2019 Small Group Plan Designs

-choose the plan that's best for your employees-

The Community Advantage, Prime, Flex, Merit, Preferred, Assure, Accord, Select, and Option **all include our Chronic Illness Support Program (CISP)**. Visit HealthOptions.org to view a copy of the 2019 prescription drug formulary. Medications that qualify for the Chronic Illness Support Program will be marked as CISP.

HSA Preventive Drug List

The Community Balance HSA, Core HSA, Beacon HSA, Basic HSA, Option HSA, and Access HSA **include medications to help prevent chronic conditions and illnesses**.

Prescription drugs on this preventive drug list bypass the deductible, then the applicable coinsurance or copay will apply. Visit HealthOptions.org to view a copy of the 2019 prescription drug formulary.

2019 Small Group Bronze Plans

| Plan Name ▶ | Community Progress | Community Access HSA | Community Option HSA | Community Basic HSA |
|----------------------------------------|--------------------|----------------------|----------------------|---------------------|
| On and Off SHOP | Off SHOP Only | On & Off SHOP | Off SHOP Only | Off SHOP Only |
| Product Type | PPO | PPO | PPO | PPO |
| Chronic Illness Support Program (CISP) | N | N | N | N |
| HSA Preventive Drug List (Y/N) | N | Y | Y | Y |
| Individual Deductible | \$7,750 | \$6,650 | \$5,700 | \$5,600 |
| Family Deductible | \$15,500 | \$13,300 | \$11,400 | \$11,200 |
| Standard Coinsurance (Co) | 0% | 0% | 30% | 40% |
| Individual OOP Max | \$7,750 | \$6,650 | \$6,600 | \$6,600 |
| Family OOP Max | \$15,500 | \$13,300 | \$13,200 | \$13,200 |

| Medical Benefits | In-Network | In-Network | In-Network | In-Network |
|------------------------------------------------------------|-------------------------------------------|------------|-----------------------------|-----------------------------|
| Ambulance | Deductible | Deductible | Ded/Co | Ded/Co |
| Chiropractic/Manipulative Therapy | Deductible | Deductible | Ded/Co | Ded/Co |
| Durable Medical Equipment/Prosthesis | Deductible | Deductible | Ded/Co | Ded/Co |
| Emergency Room Care | Deductible | Deductible | Ded/Co | Ded/Co |
| Hospital Inpatient Services | Deductible | Deductible | Ded/Co | Ded/Co |
| Imaging (PET/MRI/CT) | Deductible | Deductible | Ded/Co | Ded/Co |
| Inpatient Rehabilitation and Skilled Nursing Facility Care | Deductible | Deductible | Ded/Co | Ded/Co |
| Mental Health/Substance Abuse - Inpatient | Deductible | Deductible | Ded/Co | Ded/Co |
| Mental Health/Substance Abuse - Outpatient | 1st 3 visits @ \$0 Copay, then \$65 Copay | Deductible | Ded/Co | Ded/Co |
| Preventive Care | \$0 Copay | \$0 Copay | \$0 Copay | \$0 Copay |
| Primary Care Office Visits | \$65 Copay | Deductible | Ded/Co | Ded/Co |
| Rehabilitation and Habilitation Services (PT/OT/ST) | Deductible | Deductible | Ded/Co | Ded/Co |
| Specialty Care Office Visits | Deductible | Deductible | Ded/Co | Ded/Co |
| Surgery/Anesthesia | Deductible | Deductible | Ded/Co | Ded/Co |
| Tobacco/Smoking Cessation | \$0 Copay | \$0 Copay | \$0 Copay | \$0 Copay |
| Urgent Care Visits | \$85 Copay | Deductible | \$85 Copay after Deductible | \$85 Copay after Deductible |
| Adult Vision Exams | Deductible | Deductible | Ded/Co | Ded/Co |
| X-rays and Diagnostic Imaging | Deductible | Deductible | Ded/Co | Ded/Co |
| Pediatric Glasses/Contacts | Deductible | Deductible | Ded/Co | Ded/Co |
| Pediatric Vision Exams | Deductible | Deductible | Ded/Co | Ded/Co |

| Prescription Drugs | In-Network | In-Network | In-Network | In-Network |
|------------------------------------------------------|-----------------------------------|------------|---------------------------------------------|---------------------------------------------|
| Tier 1 - Preferred Generics | \$5 Copay | Deductible | Ded/\$5 Copay | Ded/\$5 Copay |
| Tier 2 - Generics | \$35 Copay | Deductible | Ded/\$35 Copay | Ded/\$35 Copay |
| Tier 3 - Non-Preferred Generics and Preferred Brands | \$70 Copay | Deductible | Ded/\$70 Copay | Ded/\$70 Copay |
| Tier 4 - Non-Preferred Brands | 30% Co. up to max of \$300/script | Deductible | Ded. then 30% Co. up to max of \$300/script | Ded. then 30% Co. up to max of \$300/script |
| Tier 5 - Specialty | 30% Co. up to max of \$500/script | Deductible | Ded. then 30% Co. up to max of \$500/script | Ded. then 30% Co. up to max of \$500/script |

| Pediatric Dental Benefit | In-Network | In-Network | In-Network | In-Network |
|-----------------------------------------------|------------|------------|------------|------------|
| Deductible per Child | \$100 | \$100 | \$100 | \$100 |
| Deductible per Family | \$200 | \$200 | \$200 | \$200 |
| Office Visit Copay | \$0 Copay | \$0 Copay | \$0 Copay | \$0 Copay |
| Diagnostic/Preventive (Coverage A) | 20% Co | 20% Co | 20% Co | 20% Co |
| Basic Restorative (Coverage B) | Ded/50% Co | Ded/50% Co | Ded/50% Co | Ded/50% Co |
| Major Restorative (Coverage C) | Ded/50% Co | Ded/50% Co | Ded/50% Co | Ded/50% Co |
| Medically Necessary Orthodontics (Coverage D) | Ded/50% Co | Ded/50% Co | Ded/50% Co | Ded/50% Co |

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2019 Small Group Silver Plans

| Plan Name ▶ | Community Beacon HSA | Community Core HSA | Community Balance HSA | Community Option | Community Select |
|----------------------------------------|----------------------|--------------------|-----------------------|------------------|------------------|
| Product Type | PPO | PPO | PPO | PPO | PPO |
| On and Off SHOP | Off SHOP Only | On & Off SHOP | Off SHOP Only | Off SHOP Only | Off SHOP Only |
| Chronic Illness Support Program (CISP) | N | N | N | Y | Y |
| HSA Preventive Drug List (Y/N) | Y | Y | Y | N | N |
| Individual Deductible | \$3,500 | \$3,000 | \$2,700 | \$5,000 | \$4,200 |
| Family Deductible | \$7,000 | \$6,000 | \$5,400 | \$10,000 | \$8,400 |
| Standard Coinsurance (Co) | 20% | 10% | 20% | 0% | 30% |
| Individual OOP Max | \$4,500 | \$5,500 | \$4,600 | \$6,500 | \$6,000 |
| Family OOP Max | \$9,000 | \$11,000 | \$9,200 | \$13,000 | \$12,000 |

| Medical Benefits | In-Network | In-Network | In-Network | In-Network | In-Network |
|------------------------------------------------------------|----------------------|----------------------|----------------------|-------------------------------------------|-------------------------------------------|
| Ambulance | Ded/Co | Ded/Co | Ded/Co | Deductible | Ded/Co |
| Chiropractic/Manipulative Therapy | Ded/Co | Ded/Co | Ded/Co | \$40 Copay | \$40 Copay |
| Durable Medical Equipment/Prosthesis | Ded/Co | Ded/Co | Ded/Co | Deductible | Ded/Co |
| Emergency Room Care | Ded/Co | Ded/Co | Ded/Co | Deductible | Ded/Co |
| Hospital Inpatient Services | Ded/Co | Ded/Co | Ded/Co | Deductible | Ded/Co |
| Imaging (PET/MRI/CT) | Ded/Co | Ded/Co | Ded/Co | Deductible | Ded/Co |
| Inpatient Rehabilitation and Skilled Nursing Facility Care | Ded/Co | Ded/Co | Ded/Co | Deductible | Ded/Co |
| Mental Health/Substance Abuse - Inpatient | Ded/Co | Ded/Co | Ded/Co | Deductible | Ded/Co |
| Mental Health/Substance Abuse - Outpatient | Ded/Co | Ded/Co | Ded/Co | 1st 3 visits @ \$0 Copay, then \$40 Copay | 1st 3 visits @ \$0 Copay, then \$40 Copay |
| Preventive Care | \$0 Copay | \$0 Copay | \$0 Copay | \$0 Copay | \$0 Copay |
| PRIMARY CARE Office Visits | Ded/Co | Ded/Co | Ded/Co | \$40 Copay | \$40 Copay |
| Rehabilitation and Habilitation Services (PT/OT/ST) | Ded/Co | Ded/Co | Ded/Co | \$40 Copay | \$40 Copay |
| Specialty Care Office Visits | Ded/Co | Ded/Co | Ded/Co | \$80 Copay | \$80 Copay |
| Surgery/Anesthesia | Ded/Co | Ded/Co | Ded/Co | Deductible | Ded/Co |
| Tobacco/Smoking Cessation | \$0 Copay | \$0 Copay | \$0 Copay | \$0 Copay | \$0 Copay |
| Urgent Care Visits | \$85 Copay after Ded | \$85 Copay after Ded | \$85 Copay after Ded | \$85 Copay | \$85 Copay |
| Adult Vision Exams | Ded/Co | Ded/Co | Ded/Co | \$40 Copay | \$40 Copay |
| X-rays and Diagnostic Imaging | Ded/Co | Ded/Co | Ded/Co | Deductible | Ded/Co |
| Pediatric Glasses/Contacts | Ded/Co | Ded/Co | Ded/Co | Deductible | Ded/Co |
| Pediatric Vision Exams | Ded/Co | Ded/Co | Ded/Co | \$40 Copay | \$40 Copay |

| Prescription Drugs | In-Network | In-Network | In-Network | In-Network | In-Network |
|------------------------------------------------------|---------------------------------------------|---------------------------------------------|---------------------------------------------|-----------------------------------|-----------------------------------|
| Tier 1 - Preferred Generics | Ded/\$5 Copay | Ded/\$5 Copay | Ded/\$5 Copay | \$5 Copay | \$5 Copay |
| Tier 2 - Generics | Ded/\$35 Copay | Ded/\$35 Copay | Ded/\$35 Copay | \$35 Copay | \$35 Copay |
| Tier 3 - Non-Preferred Generics and Preferred Brands | Ded/\$70 Copay | Ded/\$70 Copay | Ded/\$70 Copay | \$70 Copay | \$70 Copay |
| Tier 4 - Non-Preferred Brands | Ded. then 30% Co. up to max of \$300/script | Ded. then 30% Co. up to max of \$300/script | Ded. then 30% Co. up to max of \$300/script | 30% Co. up to max of \$300/script | 30% Co. up to max of \$300/script |
| Tier 5 - Specialty | Ded. then 30% Co. up to max of \$500/script | Ded. then 30% Co. up to max of \$500/script | Ded. then 30% Co. up to max of \$500/script | 30% Co. up to max of \$500/script | 30% Co. up to max of \$500/script |

| Pediatric Dental Benefit | In-Network | In-Network | In-Network | In-Network | In-Network |
|-----------------------------------------------|------------|------------|------------|------------|------------|
| Deductible per Child | \$100 | \$100 | \$100 | \$100 | \$100 |
| Deductible per Family | \$200 | \$200 | \$200 | \$200 | \$200 |
| Office Visit Copay | \$0 Copay | \$0 Copay | \$0 Copay | \$0 Copay | \$0 Copay |
| Diagnostic/Preventive (Coverage A) | 20% Co | 20% Co | 20% Co | 20% Co | 20% Co |
| Basic Restorative (Coverage B) | Ded/50% Co | Ded/50% Co | Ded/50% Co | Ded/50% Co | Ded/50% Co |
| Major Restorative (Coverage C) | Ded/50% Co | Ded/50% Co | Ded/50% Co | Ded/50% Co | Ded/50% Co |
| Medically Necessary Orthodontics (Coverage D) | Ded/50% Co | Ded/50% Co | Ded/50% Co | Ded/50% Co | Ded/50% Co |

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2019 Small Group Silver Plans

| Plan Name ▶ | Community Accord | Community Assure | Community Preferred | Community Merit |
|----------------------------------------|------------------|------------------|---------------------|-----------------|
| Product Type | PPO | PPO | PPO | PPO |
| On and Off SHOP | Off SHOP Only | Off SHOP Only | On & Off SHOP | Off SHOP Only |
| Chronic Illness Support Program (CISP) | Y | Y | Y | Y |
| HSA Preventive Drug List (Y/N) | N | N | N | N |
| Individual Deductible | \$3,700 | \$3,200 | \$2,600 | \$2,500 |
| Family Deductible | \$7,400 | \$6,400 | \$5,200 | \$5,000 |
| Standard Coinsurance (Co) | 30% | 30% | 30% | 30% |
| Individual OOP Max | \$6,500 | \$6,500 | \$7,000 | \$7,400 |
| Family OOP Max | \$13,000 | \$13,000 | \$14,000 | \$14,800 |

| Medical Benefits | In-Network | In-Network | In-Network | In-Network |
|------------------------------------------------------------|-------------------------------------------|-------------------------------------------|-------------------------------------------|-------------------------------------------|
| Ambulance | Ded/Co | Ded/Co | Ded/Co | Ded/Co |
| Chiropractic/Manipulative Therapy | \$30 Copay | \$35 Copay | \$35 Copay | \$35 Copay |
| Durable Medical Equipment/Prosthesis | Ded/Co | Ded/Co | Ded/Co | Ded/Co |
| Emergency Room Care | Ded/Co | Ded/Co | Ded/Co | Ded/Co |
| Hospital Inpatient Services | Ded/Co | Ded/Co | Ded/Co | Ded/Co |
| Imaging (PET/MRI/CT) | Ded/Co | Ded/Co | Ded/Co | Ded/Co |
| Inpatient Rehabilitation and Skilled Nursing Facility Care | Ded/Co | Ded/Co | Ded/Co | Ded/Co |
| Mental Health/Substance Abuse - Inpatient | Ded/Co | Ded/Co | Ded/Co | Ded/Co |
| Mental Health/Substance Abuse - Outpatient | 1st 3 visits @ \$0 Copay, then \$30 Copay | 1st 3 visits @ \$0 Copay, then \$35 Copay | 1st 3 visits @ \$0 Copay, then \$35 Copay | 1st 3 visits @ \$0 Copay, then \$35 Copay |
| Preventive Care | \$0 Copay | \$0 Copay | \$0 Copay | \$0 Copay |
| PRIMARY CARE Office Visits | \$30 Copay | \$35 Copay | \$35 Copay | \$35 Copay |
| Rehabilitation and Habilitation Services (PT/OT/ST) | \$30 Copay | \$35 Copay | \$35 Copay | \$35 Copay |
| Specialty Care Office Visits | \$70 Copay | \$85 Copay | \$85 Copay | \$85 Copay |
| Surgery/Anesthesia | Ded/Co | Ded/Co | Ded/Co | Ded/Co |
| Tobacco/Smoking Cessation | \$0 Copay | \$0 Copay | \$0 Copay | \$0 Copay |
| Urgent Care Visits | \$85 Copay | \$85 Copay | \$85 Copay | \$85 Copay |
| Adult Vision Exams | \$30 Copay | \$35 Copay | \$35 Copay | \$35 Copay |
| X-rays and Diagnostic Imaging | Ded/Co | Ded/Co | Ded/Co | Ded/Co |
| Pediatric Glasses/Contacts | Ded/Co | Ded/Co | Ded/Co | Ded/Co |
| Pediatric Vision Exams | \$30 Copay | \$35 Copay | \$35 Copay | \$35 Copay |

| Prescription Drugs | In-Network | In-Network | In-Network | In-Network |
|------------------------------------------------------|-----------------------------------|-----------------------------------|-----------------------------------|-----------------------------------|
| Tier 1 - Preferred Generics | \$5 Copay | \$5 Copay | \$5 Copay | \$5 Copay |
| Tier 2 - Generics | \$35 Copay | \$35 Copay | \$35 Copay | \$35 Copay |
| Tier 3 - Non-Preferred Generics and Preferred Brands | \$70 Copay | \$70 Copay | \$70 Copay | \$70 Copay |
| Tier 4 - Non-Preferred Brands | 30% Co. up to max of \$300/script | 30% Co. up to max of \$300/script | 30% Co. up to max of \$300/script | 30% Co. up to max of \$300/script |
| Tier 5 - Specialty | 30% Co. up to max of \$500/script | 30% Co. up to max of \$500/script | 30% Co. up to max of \$500/script | 30% Co. up to max of \$500/script |

| Pediatric Dental Benefit | In-Network | In-Network | In-Network | In-Network |
|-----------------------------------------------|------------|------------|------------|------------|
| Deductible per Child | \$100 | \$100 | \$100 | \$100 |
| Deductible per Family | \$200 | \$200 | \$200 | \$200 |
| Office Visit Copay | \$0 Copay | \$0 Copay | \$0 Copay | \$0 Copay |
| Diagnostic/Preventive (Coverage A) | 20% Co | 20% Co | 20% Co | 20% Co |
| Basic Restorative (Coverage B) | Ded/50% Co | Ded/50% Co | Ded/50% Co | Ded/50% Co |
| Major Restorative (Coverage C) | Ded/50% Co | Ded/50% Co | Ded/50% Co | Ded/50% Co |
| Medically Necessary Orthodontics (Coverage D) | Ded/50% Co | Ded/50% Co | Ded/50% Co | Ded/50% Co |

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2019 Small Group Gold Plans

| Plan Name ▶ | Community Flex | Community Prime | Community Advantage |
|----------------------------------------|----------------|-----------------|---------------------|
| ON and Off SHOP | Off SHOP Only | On & Off SHOP | Off SHOP Only |
| Product Type | PPO | PPO | PPO |
| Chronic Illness Support Program (CISP) | Y | Y | Y |
| HSA Preventive Drug List (Y/N) | N | N | N |

| Medical Benefits | In-Network | In-Network | In-Network |
|------------------------------------------------------------|-------------------------------------------|-------------------------------------------|-------------------------------------------|
| Individual Deductible | \$2,000 | \$1,500 | \$1,000 |
| Family Deductible | \$4,000 | \$3,000 | \$2,000 |
| Standard Coinsurance (Co) | 30% | 30% | 30% |
| Individual OOP Max | \$5,000 | \$4,500 | \$4,000 |
| Family OOP Max | \$10,000 | \$9,000 | \$8,000 |
| Ambulance | Ded/Co | \$500 Copay | \$500 Copay |
| Chiropractic/Manipulative Therapy | \$25 Copay | \$30 Copay | \$30 Copay |
| Durable Medical Equipment/Prosthesis | Ded/Co | Ded/Co | Ded/Co |
| Emergency Room Care | Ded/Co | \$500 Copay | \$500 Copay |
| Hospital Inpatient Services | Ded/Co | Ded/Co | Ded/Co |
| Imaging (PET/MRI/CT) | Ded/Co | Ded/Co | Ded/Co |
| Inpatient Rehabilitation and Skilled Nursing Facility Care | Ded/Co | Ded/Co | Ded/Co |
| Mental Health/Substance Abuse - Inpatient | Ded/Co | Ded/Co | Ded/Co |
| Mental Health/Substance Abuse - Outpatient | 1st 3 visits @ \$0 Copay, then \$25 Copay | 1st 3 visits @ \$0 Copay, then \$30 Copay | 1st 3 visits @ \$0 Copay, then \$30 Copay |
| Preventive Care | \$0 Copay | \$0 Copay | \$0 Copay |
| Primary Care Office Visits | \$25 Copay | \$30 Copay | \$30 Copay |
| Rehabilitation and Habilitation Services (PT/OT/ST) | \$25 Copay | \$30 Copay | \$30 Copay |
| Specialty Care Office Visits | \$60 Copay | \$70 Copay | \$80 Copay |
| Surgery/Anesthesia | Ded/Co | Ded/Co | Ded/Co |
| Tobacco/Smoking Cessation | \$0 Copay | \$0 Copay | \$0 Copay |
| Urgent Care Visits | \$80 Copay | \$80 Copay | \$80 Copay |
| Adult Vision Exams | \$25 Copay | \$30 Copay | \$30 Copay |
| X-rays and Diagnostic Imaging | Ded/Co | Ded/Co | Ded/Co |
| Pediatric Glasses/Contacts | Ded/Co | Ded/Co | Ded/Co |
| Pediatric Vision Exams | \$25 Copay | \$30 Copay | \$30 Copay |

| Prescription Drugs | In-Network | In-Network | In-Network |
|------------------------------------------------------|-----------------------------------|-----------------------------------|-----------------------------------|
| Tier 1 - Preferred Generics | \$5 Copay | \$5 Copay | \$5 Copay |
| Tier 2 - Generics | \$35 Copay | \$35 Copay | \$35 Copay |
| Tier 3 - Non-Preferred Generics and Preferred Brands | \$70 Copay | \$70 Copay | \$70 Copay |
| Tier 4 - Non-Preferred Brands | 30% Co. up to max of \$300/script | 30% Co. up to max of \$300/script | 30% Co. up to max of \$300/script |
| Tier 5 - Specialty | 30% Co. up to max of \$500/script | 30% Co. up to max of \$500/script | 30% Co. up to max of \$500/script |

| Pediatric Dental (administered by Delta Dental) | In-Network | In-Network | In-Network |
|-------------------------------------------------|------------|------------|------------|
| Deductible per Child | \$100 | \$100 | \$100 |
| Deductible per Family | \$200 | \$200 | \$200 |
| Office Visit Copay | \$0 Copay | \$0 Copay | \$0 Copay |
| Diagnostic/Preventive (Coverage A) | 20% Co | 20% Co | 20% Co |
| Basic Restorative (Coverage B) | Ded/50% Co | Ded/50% Co | Ded/50% Co |
| Major Restorative (Coverage C) | Ded/50% Co | Ded/50% Co | Ded/50% Co |
| Medically Necessary Orthodontics (Coverage D) | Ded/50% Co | Ded/50% Co | Ded/50% Co |

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