Community HEALTH OPTIONS®

2020 Small Group Plan Designs

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

Having plan choices for small group employers is important. Our plans are designed to cover employees for routine and preventive care and to support them when they have to make informed decisions about when and where to seek care.

We also have plans that remove financial barriers for Members with specific chronic conditions. These plan designs help employees remain healthy so they can work and be productive.

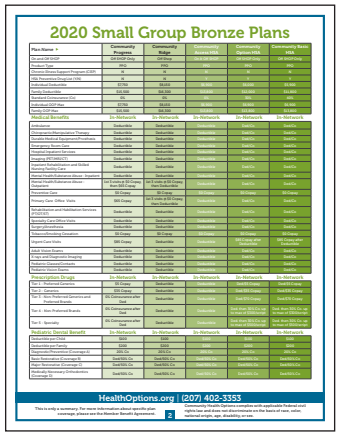
Our PPO plans offer varying embedded deductibles to meet a variety of individual needs.

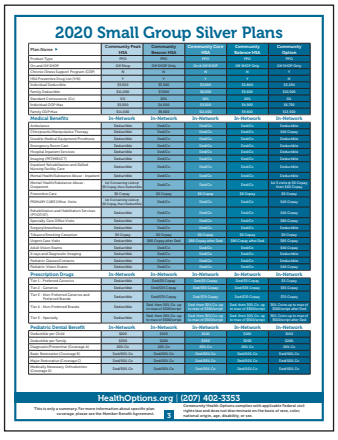
The Community Advantage, Prime, Flex, Merit, Preferred, Assure, Accord, Select, and Option **all include our Chronic Illness Support Program (CISP).** Medications that qualify for the Chronic Illness Support Program will be marked as CISP on the 2020 prescription drug formulary that can be found at HealthOptions.org by typing "formulary" in the search feature.

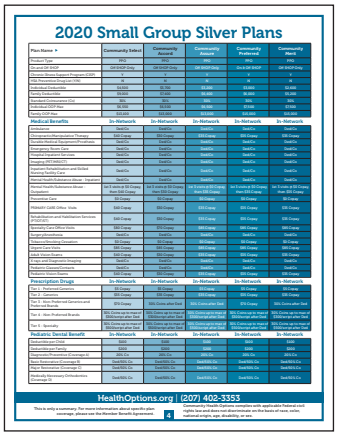
HSA Preventive Drug List

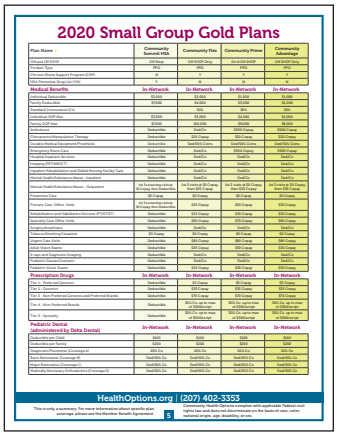
The Community Balance HSA, Peak HSA, Summit HSA, Core HSA, Beacon HSA, Basic HSA, Option HSA, and Access HSA **also include medications to help prevent chronic conditions and illnesses.**

Prescription drugs on this preventive drug list bypass the deductible, then the applicable coinsurance or copay will apply. These medications are also listed on the 2020 prescription drug formulary.


2020 Small Group Bronze Plans


2020 Small Group Silver Plans


2020 Small Group Silver Plans


2020 Small Group Gold Plans

SmallGroupPlans-11-110519-2

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2020 Small Group Bronze Plans

Plan Name ▶	Community Progress	Community Ridge	Community Access HSA	Community Option HSA	Community Basic HSA
On and Off SHOP	Off SHOP Only	Off Shop	On & Off SHOP	Off SHOP Only	Off SHOP Only
Product Type	PPO	PPO	PPO	PPO	PPO
Chronic Illness Support Program (CISP)	N	N	N	N	N
HSA Preventive Drug List (Y/N)	N	N	Y	Y	Y
Individual Deductible	$7,750	$8,150	$6,900	$6,000	$5,900
Family Deductible	$15,500	$16,300	$13,800	$12,000	$11,800
Standard Coinsurance (Co)	0%	0%	0%	30%	40%
Individual OOP Max	$7,750	$8,150	$6,900	$6,900	$6,900
Family OOP Max	$15,500	$16,300	$13,800	$13,800	$13,800
Medical Benefits	**In-Network**	**In-Network**	**In-Network**	**In-Network**	**In-Network**
Ambulance	Deductible	Deductible	Deductible	Ded/Co	Ded/Co
Chiropractic/Manipulative Therapy	Deductible	Deductible	Deductible	Ded/Co	Ded/Co
Durable Medical Equipment/Prosthesis	Deductible	Deductible	Deductible	Ded/Co	Ded/Co
Emergency Room Care	Deductible	Deductible	Deductible	Ded/Co	Ded/Co
Hospital Inpatient Services	Deductible	Deductible	Deductible	Ded/Co	Ded/Co
Imaging (PET/MRI/CT)	Deductible	Deductible	Deductible	Ded/Co	Ded/Co
Inpatient Rehabilitation and Skilled Nursing Facility Care	Deductible	Deductible	Deductible	Ded/Co	Ded/Co
Mental Health/Substance Abuse - Inpatient	Deductible	Deductible	Deductible	Ded/Co	Ded/Co
Mental Health/Substance Abuse - Outpatient	1st 3 visits @ $0 Copay, then $65 Copay	1st 3 visits @ $0 Copay, then Deductible	Deductible	Ded/Co	Ded/Co
Preventive Care	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay
Primary Care Office Visits	$65 Copay	1st 3 visits @ $0 Copay, then Deductible	Deductible	Ded/Co	Ded/Co
Rehabilitation and Habilitation Services (PT/OT/ST)	Deductible	Deductible	Deductible	Ded/Co	Ded/Co
Specialty Care Office Visits	Deductible	Deductible	Deductible	Ded/Co	Ded/Co
Surgery/Anesthesia	Deductible	Deductible	Deductible	Ded/Co	Ded/Co
Tobacco/Smoking Cessation	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay
Urgent Care Visits	$85 Copay	Deductible	Deductible	$85 Copay after Deductible	$85 Copay after Deductible
Adult Vision Exams	Deductible	Deductible	Deductible	Ded/Co	Ded/Co
X-rays and Diagnostic Imaging	Deductible	Deductible	Deductible	Ded/Co	Ded/Co
Pediatric Glasses/Contacts	Deductible	Deductible	Deductible	Ded/Co	Ded/Co
Pediatric Vision Exams	Deductible	Deductible	Deductible	Ded/Co	Ded/Co
Prescription Drugs	**In-Network**	**In-Network**	**In-Network**	**In-Network**	**In-Network**
Tier 1 - Preferred Generics	$5 Copay	Deductible	Deductible	Ded/$5 Copay	Ded/$5 Copay
Tier 2 - Generics	$35 Copay	Deductible	Deductible	Ded/$35 Copay	Ded/$35 Copay
Tier 3 - Non-Preferred Generics and Preferred Brands	0% Coinsurance after Ded	Deductible	Deductible	Ded/$70 Copay	Ded/$70 Copay
Tier 4 - Non-Preferred Brands	0% Coinsurance after Ded	Deductible	Deductible	Ded. then 30% Co. up to max of $300/script	Ded. then 30% Co. up to max of $300/script
Tier 5 - Specialty	0% Coinsurance after Ded	Deductible	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**	**In-Network**
Deductible per Child	$100	$100	$100	$100	$100
Deductible per Family	$200	$200	$200	$200	$200
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

2020 Small Group Silver Plans

Plan Name ▶	Community Peak HSA	Community Beacon HSA	Community Core HSA	Community Balance HSA	Community Option
Product Type	PPO	PPO	PPO	PPO	PPO
On and Off SHOP	Off Shop	Off SHOP Only	On & Off SHOP	Off SHOP Only	Off SHOP Only
Chronic Illness Support Program (CISP)	N	N	N	N	Y
HSA Preventive Drug List (Y/N)	Y	Y	Y	Y	N
Individual Deductible	$5,500	$3,500	$3,000	$2,800	$5,250
Family Deductible	$11,000	$7,000	$6,000	$5,600	$10,500
Standard Coinsurance (Co)	0%	20%	10%	20%	0%
Individual OOP Max	$5,500	$4,500	$5,500	$4,900	$6,750
Family OOP Max	$11,000	$9,000	$11,000	$9,800	$13,500
Medical Benefits	**In-Network**	**In-Network**	**In-Network**	**In-Network**	**In-Network**
Ambulance	Deductible	Ded/Co	Ded/Co	Ded/Co	Deductible
Chiropractic/Manipulative Therapy	Deductible	Ded/Co	Ded/Co	Ded/Co	$40 Copay
Durable Medical Equipment/Prosthesis	Deductible	Ded/Co	Ded/Co	Ded/Co	Deductible
Emergency Room Care	Deductible	Ded/Co	Ded/Co	Ded/Co	Deductible
Hospital Inpatient Services	Deductible	Ded/Co	Ded/Co	Ded/Co	Deductible
Imaging (PET/MRI/CT)	Deductible	Ded/Co	Ded/Co	Ded/Co	Deductible
Inpatient Rehabilitation and Skilled Nursing Facility Care	Deductible	Ded/Co	Ded/Co	Ded/Co	Deductible
Mental Health/Substance Abuse - Inpatient	Deductible	Ded/Co	Ded/Co	Ded/Co	Deductible
Mental Health/Substance Abuse - Outpatient	1st 3 screening visits @ $0 Copay, then Deductible	Ded/Co	Ded/Co	Ded/Co	1st 3 visits @ $0 Copay, then $40 Copay
Preventive Care	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay
PRIMARY CARE Office Visits	1st 3 screening visits @ $0 Copay, then Deductible	Ded/Co	Ded/Co	Ded/Co	$40 Copay
Rehabilitation and Habilitation Services (PT/OT/ST)	Deductible	Ded/Co	Ded/Co	Ded/Co	$40 Copay
Specialty Care Office Visits	Deductible	Ded/Co	Ded/Co	Ded/Co	$80 Copay
Surgery/Anesthesia	Deductible	Ded/Co	Ded/Co	Ded/Co	Deductible
Tobacco/Smoking Cessation	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay
Urgent Care Visits	Deductible	$85 Copay after Ded	$85 Copay after Ded	$85 Copay after Ded	$85 Copay
Adult Vision Exams	Deductible	Ded/Co	Ded/Co	Ded/Co	$40 Copay
X-rays and Diagnostic Imaging	Deductible	Ded/Co	Ded/Co	Ded/Co	Deductible
Pediatric Glasses/Contacts	Deductible	Ded/Co	Ded/Co	Ded/Co	Deductible
Pediatric Vision Exams	Deductible	Ded/Co	Ded/Co	Ded/Co	$40 Copay
Prescription Drugs	**In-Network**	**In-Network**	**In-Network**	**In-Network**	**In-Network**
Tier 1 - Preferred Generics	Deductible	Ded/$5 Copay	Ded/$5 Copay	Ded/$5 Copay	$5 Copay
Tier 2 - Generics	Deductible	Ded/$35 Copay	Ded/$35 Copay	Ded/$35 Copay	$35 Copay
Tier 3 - Non-Preferred Generics and Preferred Brands	Deductible	Ded/$70 Copay	Ded/$70 Copay	Ded/$70 Copay	$70 Copay
Tier 4 - Non-Preferred Brands	Deductible	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% Coins up to max of $300/script after Ded
Tier 5 - Specialty	Deductible	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% Coins up to max of $500/script after Ded
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
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

2020 Small Group Silver Plans

Plan Name ▶	Community Select	Community Accord	Community Assure	Community Preferred	Community Merit
Product Type	PPO	PPO	PPO	PPO	PPO
On and Off SHOP	Off SHOP Only	Off SHOP Only	Off SHOP Only	On & Off SHOP	Off SHOP Only
Chronic Illness Support Program (CISP)	Y	Y	Y	Y	Y
HSA Preventive Drug List (Y/N)	N	N	N	N	N
Individual Deductible	$4,500	$3,700	$3,200	$3,000	$2,600
Family Deductible	$9,000	$7,400	$6,400	$6,000	$5,200
Standard Coinsurance (Co)	30%	30%	30%	30%	30%
Individual OOP Max	$6,550	$6,500	$6,500	$7,500	$7,500
Family OOP Max	$13,100	$13,000	$13,000	$15,000	$15,000
Medical Benefits	**In-Network**	**In-Network**	**In-Network**	**In-Network**	**In-Network**
Ambulance	Ded/Co	Ded/Co	Ded/Co	Ded/Co	Ded/Co
Chiropractic/Manipulative Therapy	$40 Copay	$30 Copay	$35 Copay	$35 Copay	$35 Copay
Durable Medical Equipment/Prosthesis	Ded/Co	Ded/Co	Ded/Co	Ded/Co	Ded/Co
Emergency Room Care	Ded/Co	Ded/Co	Ded/Co	Ded/Co	Ded/Co
Hospital Inpatient Services	Ded/Co	Ded/Co	Ded/Co	Ded/Co	Ded/Co
Imaging (PET/MRI/CT)	Ded/Co	Ded/Co	Ded/Co	Ded/Co	Ded/Co
Inpatient Rehabilitation and Skilled Nursing Facility Care	Ded/Co	Ded/Co	Ded/Co	Ded/Co	Ded/Co
Mental Health/Substance Abuse - Inpatient	Ded/Co	Ded/Co	Ded/Co	Ded/Co	Ded/Co
Mental Health/Substance Abuse - Outpatient	1st 3 visits @ $0 Copay, then $40 Copay	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	$0 Copay
PRIMARY CARE Office Visits	$40 Copay	$30 Copay	$35 Copay	$35 Copay	$35 Copay
Rehabilitation and Habilitation Services (PT/OT/ST)	$40 Copay	$30 Copay	$35 Copay	$35 Copay	$35 Copay
Specialty Care Office Visits	$80 Copay	$70 Copay	$85 Copay	$85 Copay	$85 Copay
Surgery/Anesthesia	Ded/Co	Ded/Co	Ded/Co	Ded/Co	Ded/Co
Tobacco/Smoking Cessation	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay
Urgent Care Visits	$85 Copay	$85 Copay	$85 Copay	$85 Copay	$85 Copay
Adult Vision Exams	$40 Copay	$30 Copay	$35 Copay	$35 Copay	$35 Copay
X-rays and Diagnostic Imaging	Ded/Co	Ded/Co	Ded/Co	Ded/Co	Ded/Co
Pediatric Glasses/Contacts	Ded/Co	Ded/Co	Ded/Co	Ded/Co	Ded/Co
Pediatric Vision Exams	$40 Copay	$30 Copay	$35 Copay	$35 Copay	$35 Copay
Prescription Drugs	**In-Network**	**In-Network**	**In-Network**	**In-Network**	**In-Network**
Tier 1 - Preferred Generics	$5 Copay	$5 Copay	$5 Copay	$5 Copay	$5 Copay
Tier 2 - Generics	$35 Copay	$35 Copay	$35 Copay	$35 Copay	$35 Copay
Tier 3 - Non-Preferred Generics and Preferred Brands	$70 Copay	30% Coins after Ded	30% Coins after Ded	$70 Copay	30% Coins after Ded
Tier 4 - Non-Preferred Brands	30% Coins up to max of $300/script after Ded	30% Coins up to max of $300/script after Ded	30% Coins up to max of $300/script after Ded	30% Coins up to max of $300/script after Ded	30% Coins up to max of $300/script after Ded
Tier 5 - Specialty	30% Coins up to max of $500/script after Ded	30% Coins up to max of $500/script after Ded	30% Coins up to max of $500/script after Ded	30% Coins up to max of $500/script after Ded	30% Coins up to max of $500/script after Ded
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
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

2020 Small Group Gold Plans

Plan Name ▸	Community Summit HSA	Community Flex	Community Prime	Community Advantage
ON and Off SHOP	Off Shop	Off SHOP Only	On & Off SHOP	Off SHOP Only
Product Type	PPO	PPO	PPO	PPO
Chronic Illness Support Program (CISP)	N	Y	Y	Y
HSA Preventive Drug List (Y/N)	Y	N	N	N
Medical Benefits	**In-Network**	**In-Network**	**In-Network**	**In-Network**
Individual Deductible	$3,500	$2,000	$1,500	$1,000
Family Deductible	$7,000	$4,000	$3,000	$2,000
Standard Coinsurance (Co)		30%	30%	30%
Individual OOP Max	$3,500	$5,000	$4,500	$4,000
Family OOP Max	$7,000	$10,000	$9,000	$8,000
Ambulance	Deductible	Ded/Co	$500 Copay	$500 Copay
Chiropractic/Manipulative Therapy	Deductible	$25 Copay	$30 Copay	$30 Copay
Durable Medical Equipment/Prosthesis	Deductible	Ded/50% Coins	Ded/50% Coins	Ded/50% Coins
Emergency Room Care	Deductible	Ded/Co	$500 Copay	$500 Copay
Hospital Inpatient Services	Deductible	Ded/Co	Ded/Co	Ded/Co
Imaging (PET/MRI/CT)	Deductible	Ded/Co	Ded/Co	Ded/Co
Inpatient Rehabilitation and Skilled Nursing Facility Care	Deductible	Ded/Co	Ded/Co	Ded/Co
Mental Health/Substance Abuse - Inpatient	Deductible	Ded/Co	Ded/Co	Ded/Co
Mental Health/Substance Abuse - Outpatient	1st 3 screening visits @ $0 Copay, then Deductible	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	$0 Copay
Primary Care Office Visits	1st 3 screening visits @ $0 Copay, then Deductible	$25 Copay	$30 Copay	$30 Copay
Rehabilitation and Habilitation Services (PT/OT/ST)	Deductible	$25 Copay	$30 Copay	$30 Copay
Specialty Care Office Visits	Deductible	$60 Copay	$70 Copay	$80 Copay
Surgery/Anesthesia	Deductible	Ded/Co	Ded/Co	Ded/Co
Tobacco/Smoking Cessation	$0 Copay	$0 Copay	$0 Copay	$0 Copay
Urgent Care Visits	Deductible	$80 Copay	$80 Copay	$80 Copay
Adult Vision Exams	Deductible	$25 Copay	$30 Copay	$30 Copay
X-rays and Diagnostic Imaging	Deductible	Ded/Co	Ded/Co	Ded/Co
Pediatric Glasses/Contacts	Deductible	Ded/Co	Ded/Co	Ded/Co
Pediatric Vision Exams	Deductible	$25 Copay	$30 Copay	$30 Copay
Prescription Drugs	**In-Network**	**In-Network**	**In-Network**	**In-Network**
Tier 1 - Preferred Generics	Deductible	$5 Copay	$5 Copay	$5 Copay
Tier 2 - Generics	Deductible	$35 Copay	$35 Copay	$35 Copay
Tier 3 - Non-Preferred Generics and Preferred Brands	Deductible	$70 Copay	$70 Copay	$70 Copay
Tier 4 - Non-Preferred Brands	Deductible	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	Deductible	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**	**In-Network**
Deductible per Child	$100	$100	$100	$100
Deductible per Family	$200	$200	$200	$200
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