COMMUNITY Health Options™

2021 Small Group Plan Design

*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. They offer varying embedded deductibles and rates to meet a variety of financial needs.

The Community Shield, Advantage, Prime, Flex, Preferred, Accord, and Option **all include our Chronic Illness Support Program (CISP).** With CISP, Members with **asthma, coronary artery disease (CAD), chronic obstructive pulmonary disease (COPD), diabetes, and hypertension,** who manage their conditions through office visits and prescriptions have access to savings on routine care. We reduce cost barriers to care by arranging lower out-of-pocket medical and pharmacy expenses when received by in-network providers and from the approved drug formulary via Express Scripts Inc. mail order. Medications that qualify for the Chronic Illness Support Program will be marked as CISP on the 2021 prescription drug formulary found at Health Options Medications

HSA Preventive Drug Coverage

All Small Group PPO/HSA Plans include a carefully created formulary containing medications to help prevent the development of and reduce the risk of complications due to chronic conditions and illnesses. These prescription drugs are identified on the formulary with an H.S.A notation. These drugs indicated as H.S.A. bypass the deductible. Members pay only the applicable co-insurance or co-payment amounts. Details on specific formulary coverage will be available in the Member portal.

Special Insulin Provision

Under Maine state law, Members pay a maximum of $35 for up to a 30-day supply of insulin, effective upon 2021 renewal.

COMMUNITY Health Options™

2021 Small Group Bronze Plans

Plan Name •	Community Progress	Community Access HSA	Community Shield	Community Option 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	Y	N
HSA Preventive Drug Coverage (Y/N)	N	Y	N	Y
Individual Deductible	$8,550	$7,000	$6,500	$6,200
Family Deductible	$17,100	$14,000	$13,000	$12,400
Standard Coinsurance (Co)	0%	0%	40%	30%
Individual OOP Max	$8,550	$7,000	$8,500	$7,000
Family OOP Max	$17,100	$14,000	$17,000	$14,000
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 waived for 1st 3 visits	Ded/Co
Preventive Care	$0 Copay	$0 Copay	$0 Copay	$0 Copay
Primary Care Office Visits	1st visit @ $0 Copay, then $65 Copay	Deductible	1st visit @$0, visits 2-3 $50 Copay, then 40% Coinsurance after Deductible	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	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/Co	Ded/$5 Copay
Tier 2 - Generics	$35 Copay	Deductible	Ded/Co	Ded/$35 Copay
Tier 3 - Preferred Brands	0% Coinsurance after Ded	Deductible	Ded/Co	Ded/$70 Copay
Tier 4 - Non-Preferred Brands	0% Coinsurance after Ded	Deductible	Ded/Co	Ded. then 30% Co. up to max of $300/script
Tier 5 - Specialty	0% Coinsurance after Ded	Deductible	Ded/Co	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
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

This is only a summary. For more information about specific plan coverage, please see the Schedule of Benefits.

COMMUNITY Health Options™

2021 Small Group Silver Plans

Plan Name •	Community Peak	Community Core HSA	Community Balance HSA	Community Option
Product Type	PPO	PPO	PPO	PPO
On and Off SHOP	Off Shop	On & Off SHOP	Off SHOP Only	Off SHOP Only
Chronic Illness Support Program (CISP)	N	N	N	Y
HSA Preventive Drug Coverage (Y/N)	N	Y	Y	N
Individual Deductible	$6,000	$3,000	$2,800	$5,000
Family Deductible	$12,000	$6,000	$5,600	$10,000
Standard Coinsurance (Co)	0%	10%	20%	10%
Individual OOP Max	$6,000	$7,000	$5,400	$8,500
Family OOP Max	$12,000	$14,000	$10,800	$17,000
Medical Benefits	**In-Network**	**In-Network**	**In-Network**	**In-Network**
Ambulance	Deductible	Ded/Co	Ded/Co	Ded/Co
Chiropractic/Manipulative Therapy	Deductible	Ded/Co	Ded/Co	$40 Copay
Durable Medical Equipment/Prosthesis	Deductible	Ded/Co	Ded/Co	Ded/Co
Emergency Room Care	Deductible	Ded/Co	Ded/Co	Ded/Co
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	Deductible waived 1st 3 visits	Ded/Co	Ded/Co	1st 3 visits @ $0 Copay, then $40 Copay
Preventive Care	$0 Copay	$0 Copay	$0 Copay	$0 Copay
PRIMARY CARE Office Visits	1st visit @$0, visits 2-3 $40 Copay, then 0% Coinsurance after Deductible	Ded/Co	Ded/Co	1st visit @ $0, then $40 Copay
Rehabilitation and Habilitation Services (PT/OT/ST)	Deductible	Ded/Co	Ded/Co	$40 Copay
Specialty Care Office Visits	Deductible	Ded/Co	Ded/Co	$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	$85 Copay after Ded	$85 Copay after Ded	$85 Copay
Adult Vision Exams	Deductible	Ded/Co	Ded/Co	$40 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	Ded/Co	Ded/Co	$40 Copay
Prescription Drugs	**In-Network**	**In-Network**	**In-Network**	**In-Network**
Tier 1 - Preferred Generics	Deductible	Ded/$5 Copay	Ded/$5 Copay	$5 Copay
Tier 2 - Generics	Deductible	Ded/$35 Copay	Ded/$35 Copay	$35 Copay
Tier 3 - Preferred Brands	Deductible	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	30% Coins up to max of $300/script Ded. does not apply
Tier 5 - Specialty	Deductible	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 $300/script Ded. does not apply
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
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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COMMUNITY Health Options™

2021 Small Group Silver Plans

Plan Name •	Community Accord	Community Preferred
Product Type	PPO	PPO
On and Off SHOP	Off SHOP Only	On & Off SHOP
Chronic Illness Support Program (CISP)	Y	Y
HSA Preventive Drug Coverage (Y/N)	N	N
Individual Deductible	$4,000	$3,000
Family Deductible	$8,000	$6,000
Standard Coinsurance (Co)	30%	30%
Individual OOP Max	$8,500	$8,400
Family OOP Max	$17,000	$16,800
Medical Benefits	**In Network**	**In Network**
Ambulance	Ded/Co	Ded/Co
Chiropractic/Manipulative Therapy	$35 Copay	$35 Copay
Durable Medical Equipment/Prosthesis	Ded/Co	Ded/Co
Emergency Room Care	Ded/Co	Ded/Co
Hospital Inpatient Services	Ded/Co	Ded/Co
Imaging (PET/MRI/CT)	Ded/Co	Ded/Co
Inpatient Rehabilitation and Skilled Nursing Facility Care	Ded/Co	Ded/Co
Mental Health/Substance Abuse - Inpatient	Ded/Co	Ded/Co
Mental Health/Substance Abuse - Outpatient	1st 3 visits @ $0 Copay, then $35 Copay	1st 3 visits @ $0 Copay, then $35 Copay
Preventive Care	$0 Copay	$0 Copay
PRIMARY CARE Office Visits	1st visit @ $0, then $35 Copay	1st visit @ $0, then $35 Copay
Rehabilitation and Habilitation Services (PT/OT/ST)	$35 Copay	$35 Copay
Specialty Care Office Visits	$70 Copay	$85 Copay
Surgery/Anesthesia	Ded/Co	Ded/Co
Tobacco/Smoking Cessation	$0 Copay	$0 Copay
Urgent Care Visits	$85 Copay	$85 Copay
Adult Vision Exams	$30 Copay	$35 Copay
X-rays and Diagnostic Imaging	Ded/Co	Ded/Co
Pediatric Glasses/Contacts	Ded/Co	Ded/Co
Pediatric Vision Exams	$35 Copay	$35 Copay
Prescription Drugs	**In Network**	**In Network**
Tier 1 - Preferred Generics	$5 Copay	$5 Copay
Tier 2 - Generics	$35 Copay	$35 Copay
Tier 3 - Non-Preferred Generics and Preferred Brands	$70 Copay	$70 Copay
Tier 4 - Non-Preferred Brands	30% Co. up to max of $300/script Deductible does not apply	30% Co. up to max of $300/script Deductible does not apply
Tier 5 - Specialty	30% Co. up to max of $500/script Deductible does not apply	30% Co. up to max of $500/script Deductible does not apply
Pediatric Dental Benefit	**In Network**	**In Network**
Deductible per Child	$100	$100
Deductible per Family	$200	$200
Diagnostic/Preventive (Coverage A)	20% Co	20% Co
Basic Restorative (Coverage B)	Ded/50% Co	Ded/50% Co
Major Restorative (Coverage C)	Ded/50% Co	Ded/50% Co
Medically Necessary Orthodontics (Coverage D)	Ded/50% Co	Ded/50% Co

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COMMUNITY Health Options™

2021 Small Group Gold Plans

Plan Name	Community Flex	Community Prime	Community Advantage
Product Type	PPO	PPO	PPO
ON and Off SHOP	Off SHOP Only	On & Off SHOP	Off SHOP Only
Chronic Illness Support Program (CISP)	Y	Y	Y
HSA Preventive Drug Coverage (Y/N)	N	N	N
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	$6,500	$6,000	$4,500
Family OOP Max	$13,000	$12,000	$9,000
Medical Benefits	**In-Network**	**In-Network**	**In-Network**
Ambulance	Ded/Co	$500 Copay	$500 Copay
Chiropractic/Manipulative Therapy	$30 Copay	$30 Copay	$30 Copay
Durable Medical Equipment/Prosthesis	Ded/50% Coins	Ded/50% Coins	Ded/50% Coins
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	$30 Copay Waived for 1st 3 visits	$30 Copay Waived for 1st 3 visits	$30 Copay Waived for 1st 3 visits
Preventive Care	$0 Copay	$0 Copay	$0 Copay
Primary Care Office Visits	1st visit @ $0, then $30 Copay	1st visit @ $0, then $30 Copay	1st visit @ $0, then $30 Copay
Rehabilitation and Habilitation Services (PT/OT/ST)	$30 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	$30 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	$30 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 - Preferred Brands	$70 Copay	$70 Copay	$70 Copay
Tier 4 - Non-Preferred Brands	30% Co. up to max of $300/script Deductible does not apply	30% Co. up to max of $300/script Deductible does not apply	30% Co. up to max of $300/script Deductible does not apply
Tier 5 - Specialty	30% Co. up to max of $500/script Deductible does not apply	30% Co. up to max of $500/script Deductible does not apply	30% Co. up to max of $500/script Deductible does not apply
Pediatric Dental (through Delta Dental)	**In-Network**	**In-Network**	**In-Network**
Deductible per Child	$100	$100	$100
Deductible per Family	$200	$200	$200
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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