



# 2018 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](http://HealthOptions.org) to view a copy of the 2018 prescription drug formulary. Medications that qualify for the Chronic Illness Support Program will be marked as CISP.

## HDHP Preventive Drugs

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

The Preventive drugs on the formulary are not subject to HSA plan deductible. Visit [HealthOptions.org](http://HealthOptions.org) to view a copy of the 2018 prescription drug formulary. Medications that qualify will be marked as HSA.

# 2018 Small Group Bronze Plans

Plan Name ▶	Community Progress	Community Access HSA	Community Relate HSA	Community Option HSA	Community Basic HSA
On and Off SHOP	Off SHOP Only	On & Off SHOP	Off SHOP Only	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	Y	Y	Y	Y
Individual Deductible	\$7,150	\$6,300	\$5,500	\$5,000	\$4,750
Family Deductible	\$14,300	\$12,600	\$11,000	\$10,000	\$9,500
Standard Coinsurance (Co)	0%	0%	30%	30%	40%
Individual OOP Max	\$7,150	\$6,550	\$6,550	\$6,550	\$6,550
Family OOP Max	\$14,300	\$13,100	\$13,100	\$13,100	\$13,100

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

Prescription Drugs	In-Network	In-Network	In-Network	In-Network	In-Network
Tier 1 - Preferred Generics	\$5 Copay	Ded/\$5 Copay	Ded/\$5 Copay	Ded/\$5 Copay	Ded/\$5 Copay
Tier 2 - Generics	\$35 Copay	Ded/\$35 Copay	Ded/\$35 Copay	Ded/\$35 Copay	Ded/\$35 Copay
Tier 3 - Non-Preferred Generics and Preferred Brands	\$70 Copay	Ded/\$70 Copay	Ded/\$70 Copay	Ded/\$70 Copay	Ded/\$70 Copay
Tier 4 - Non-Preferred Brands	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	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	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	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
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

# 2018 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	\$4,000
Family Deductible	\$7,000	\$6,000	\$5,400	\$10,000	\$8,000
Standard Coinsurance (Co)	20%	10%	20%	0%	20%
Individual OOP Max	\$4,500	\$5,500	\$4,600	\$6,500	\$5,500
Family OOP Max	\$9,000	\$11,000	\$9,200	\$13,000	\$11,000

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	Ded/Co	Ded/Co	Ded/Co	\$150 Copay	\$150 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

HealthOptions.org | (207) 402-3353

Community Health Options complies with applicable Federal civil rights law and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

# 2018 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	\$3,000	\$2,500	\$2,000
Family Deductible	\$7,400	\$6,000	\$5,000	\$4,000
Standard Coinsurance (Co)	30%	30%	30%	30%
Individual OOP Max	\$6,500	\$5,900	\$6,200	\$6,900
Family OOP Max	\$13,000	\$11,800	\$12,400	\$13,800

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	\$150 Copay	\$150 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

HealthOptions.org | (207) 402-3353

Community Health Options complies with applicable Federal civil rights law and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

# 2018 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	\$1,800	\$1,500	\$1,000
Family Deductible	\$3,600	\$3,000	\$2,000
Standard Coinsurance (Co)	30%	30%	30%
Individual OOP Max	\$4,500	\$4,200	\$4,000
Family OOP Max	\$9,000	\$8,400	\$8,000
Ambulance	Ded/Co	Ded/Co	Ded/Co
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	\$150 Copay	\$70 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