2022 Small Group Plan Design

COMMUNITY Health Options™

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, Option, Preferred, Flex, Premier, Elite, Prime, and Advantage **all include our Chronic Illness Support Program (CISP).** With CISP, Members with **asthma, coronary artery disease, chronic obstructive pulmonary disease, 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 2022 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 2022 renewal.

COMMUNITY Health Options™

2022 Small Group New England Plans

Plan Name	Community Progress New England	Community Preferred New England	Community Elite New England
On and Off SHOP	Off SHOP Only	Off SHOP Only	Off SHOP Only
Product Type	PPO	PPO	PPO
Chronic Illness Support Program (CISP)	N	N	N
HSA Preventive Drug Coverage (Y/N)	N	N	N
Individual Deductible	$8,700	$3,400	$1,500
Family Deductible	$17,400	$6,800	$3,000
Standard Co-insurance (Co)	0%	30%	25%
Individual Out of Pocket Maximum (OOPM)	$8,700	$8,600	$7,900
Family Out of Pocket Maximum (OOPM)	$17,400	$17,200	$15,800
Medical Benefits			
Ambulance	Deductible	Ded/Co	Ded/Co
Chiropractic/Manipulative Therapy	Deductible	$45 Copay	$35 Copay
Durable Medical Equipment/Prosthesis	Deductible	Ded/Co	Ded/Co
Emergency Room Care	Deductible	Ded/Co	Ded/Co
Hospital Inpatient Services	Deductible	Ded/Co	Ded/Co
Imaging (PET/MRI/CT)	Deductible	Ded/Co	Ded/Co
Inpatient Rehabilitation and Skilled Nursing Facility Care	Deductible	Ded/Co	Ded/Co
Mental Health/Substance Use - Inpatient	Deductible	Ded/Co	Ded/Co
Mental Health/Substance Use - Outpatient	1st 3 Visits @ $0 Co-pay, then $65 Co-pay	1st 3 Visits @ $0 Co-pay, then $45 Co-pay	1st Visit @ $0 Co-pay, then $35 Co-pay – Co-pay for Visits 2-3 apply to Deductible
Preventive Care	$0 Co-pay	$0 Co-pay	$0 Co-pay
Primary Care Visits	1st Visit @ $0 Co-pay, then $65 Co-pay – Co-pay for Visits 2-3 apply to Deductible	1st Visit @ $0 Co-pay, then $45 Co-pay – Co-pay for Visits 2-3 apply to Deductible	1st Visit @ $0 Co-pay, then $35 Co-pay – Co-pay for Visits 2-3 apply to Deductible
Rehabilitation and habilitation Services (PT/OT/ST)	Deductible	$45 Co-pay	$35 Co-pay
Specialty Care Office Visits	Deductible	$85 Co-pay	$85 Co-pay
Surgery/Anesthesia	Deductible	Ded/Co	Ded/Co
Tobacco/Smoking Cessation	$0 Co-pay	$0 Co-pay	$0 Co-pay
Urgent Care Visits	$85 Co-pay	$85 Co-pay	$85 Co-pay
Urgent Care Visits via Amwell Telehealth	$0 Co-pay	$0 Co-pay	$0 Co-pay
Adult Vision Exams	Not Covered	$45 Co-pay	$35 Co-pay
X-rays and Diagnostic Imaging	Deductible	Ded/Co	Ded/Co
Pediatric Glasses/Contacts	Deductible	Ded/Co	Ded/Co
Pediatric Vision Exams	Deductible	$45 Co-pay	$35 Co-pay
Prescription Drugs			
Tier 1 - Preferred Generics	$5 Co-pay	$5 Co-pay	$5 Co-pay
Tier 2 - Generics	$35 Co-pay	$35 Co-pay	$35 Co-pay
Tier 3 - Preferred Brands	0% Co. after Ded	$70 Co-pay	$70 Co-pay
Tier 4 - Non-Preferred Brands	0% Co. after Ded	30% Co up to max of $300/script. Ded does not apply	30% Co up to max of $300/script. Ded does not apply
Tier 5 - Specialty	0% Co. after Ded	30% Co. up to max of $500/script. Ded does not apply	30% Co. up to max of $500/script. Ded does not apply
Pediatric Dental			
Deductible per Child	Not Covered	Not Covered	Not Covered
Deductible per Family	Not Covered	Not Covered	Not Covered
Diagnostic/Preventive (Coverage A)	Not Covered	Not Covered	Not Covered
Basic Restorative (Coverage B)	Not Covered	Not Covered	Not Covered
Major Restorative (Coverage C)	Not Covered	Not Covered	Not Covered
Medically Necessary Orthodontics (Coverage D)	Not Covered	Not Covered	Not Covered

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

COMMUNITY Health Options™

2022 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	$8,700	$7,000	$6,500	$6,200
Family Deductible	$17,400	$14,000	$13,000	$12,400
Standard Co-insurance (Co)	0%	0%	40%	30%
Individual Out of Pocket Maximum (OOPM)	$8,700	$7,000	$8,500	$7,000
Family Out of Pocket Maximum (OOPM)	$17,400	$14,000	$17,000	$14,000
Medical Benefits				
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 Use - Inpatient	Deductible	Deductible	Ded/Co	Ded/Co
Mental Health/Substance Use - Outpatient	1st 3 Visits @ $0 Co-pay, then $65 Co-pay	Deductible	1st 3 Visits @ $0 Co-pay, then Ded/Co	Ded/Co
Preventive Care	$0 Co-pay	$0 Co-pay	$0 Co-pay	$0 Co-pay
Primary Care Visits	1st Visit @ $0 Co-pay, then $65 Co-pay – Co-pay for Visits 2-3 apply to Deductible	Deductible	1st Visit @ $0 Co-pay, Visits 2-3 $50 Co-pay, then 40% Co. after Ded – Co-pay for Visits 2-3 apply to 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 Co-pay	$0 Co-pay	$0 Co-pay	Ded/Co
Urgent Care Visits	$85 Co-pay	Deductible	Ded/Co	$85 Co-pay after Ded
Urgent Care Visits via Amwell Telehealth	$0 Co-pay	$0 Co-pay	$0 Co-pay	$0 Co-pay after Ded
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				
Tier 1 - Preferred Generics	$5 Co-pay	Deductible	Ded/Co	Ded/$5 Co-pay
Tier 2 - Generics	$35 Co-pay	Deductible	Ded/Co	Ded/$35 Co-pay
Tier 3 - Preferred Brands	0% Co. after Ded	Deductible	Ded/Co	Ded/$70 Co-pay
Tier 4 - Non-Preferred Brands	0% Co. after Ded	Deductible	Ded/Co	Ded then 30% Co. up to max of $300/script
Tier 5 - Specialty	0% Co. after Ded	Deductible	Ded/Co	Ded then 30 % Co. up to max of $500/script
Pediatric Dental				
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™

2022 Small Group Silver Plans

Plan Name	Community Peak	Community Core HSA	Community Balance HSA
On and Off SHOP	Off SHOP Only	On & Off SHOP	Off SHOP Only
Product Type	PPO	PPO	PPO
Chronic Illness Support Program (CISP)	N	N	N
HSA Preventive Drug Coverage (Y/N)	N	Y	Y
Individual Deductible	$6,200	$3,000	$2,800
Family Deductible	$12,400	$6,000	$5,600
Standard Coinsurance (Co)	0%	10%	20%
Individual Out of Pocket Maximum (OOPM)	$6,200	$7,000	$5,400
Family Out of Pocket Maximum (OOPM)	$12,400	$14,000	$10,800
Medical Benefits			
Ambulance	Deductible	Ded/Co	Ded/Co
Chiropractic/Manipulative Therapy	Deductible	Ded/Co	Ded/Co
Durable Medical Equipment/Prosthesis	Deductible	Ded/Co	Ded/Co
Emergency Room Care	Deductible	Ded/Co	Ded/Co
Hospital Inpatient Services	Deductible	Ded/Co	Ded/Co
Imaging (PET/MRI/CT)	Deductible	Ded/Co	Ded/Co
Inpatient Rehabilitation and Skilled Nursing Facility Care	Deductible	Ded/Co	Ded/Co
Mental Health/Substance Use - Inpatient	Deductible	Ded/Co	Ded/Co
Mental Health/Substance Use - Outpatient	Deductible waived for 1st 3 Visits	Ded/Co	Ded/co
Preventive Care	$0 Co-pay	$0 Co-pay	$0 Co-pay
Primary Care Visits	1st Visit @ $0 Co-pay, Visits 2-3 $40 Co-pay, then 0% Co. after Ded – Co-pay for Visits 2-3 apply to Deductible	Ded/Co	Ded/Co
Rehabilitation and habilitation Services (PT/OT/ST)	Deductible	Ded/Co	Ded/Co
Specialty Care Office Visits	Deductible	Ded/Co	Ded/Co
Surgery/Anesthesia	Deductible	Ded/Co	Ded/Co
Tobacco/Smoking Cessation	$0 Co-pay	$0 Co-pay	$0 Co-pay
Urgent Care Visits	Deductible	$85 Co-pay after Ded	$85 Co-pay after Ded
Urgent Care Visits via Amwell Telehealth	$0 Co-pay	$0 Co-pay after Ded	$0 Co-pay after Ded
Adult Vision Exams	Deductible	Ded/Co	Ded/Co
X-rays and Diagnostic Imaging	Deductible	Ded/Co	Ded/Co
Pediatric Glasses/Contacts	Deductible	Ded/Co	Ded/Co
Pediatric Vision Exams	Deductible	Ded/Co	Ded/Co
Prescription Drugs			
Tier 1 - Preferred Generics	Deductible	Ded/$5 Co-pay	Ded/$5 Co-pay
Tier 2 - Generics	Deductible	Ded/$35 Co-pay	Ded/$35 Co-pay
Tier 3 - Preferred Brands	Deductible	Ded/$70 Co-pay	Ded/$70 Co-pay
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
Tier 5 - Specialty	Deductible	Ded then 30% Co. up to max of $500/script	Ded then 30% Co. up to max of $500/script
Pediatric Dental			
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

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

COMMUNITY Health Options™

2022 Small Group Silver Plans Continued

Plan Name	Community Option	Community Accord	Community Preferred
On and Off SHOP	Off SHOP Only	Off SHOP Only	On & Off SHOP
Product Type	PPO	PPO	PPO
Chronic Illness Support Program (CISP)	Y	Y	Y
HSA Preventive Drug Coverage (Y/N)	N	N	N
Individual Deductible	$5,000	$4,000	$3,000
Family Deductible	$10,000	$8,000	$6,000
Standard Co-insurance (Co)	10%	30%	30%
Individual Out of Pocket Maximum (OOPM)	$8,500	$8,500	$8,400
Family Out of Pocket Maximum (OOPM)	$17,000	$17,000	$16,800
Medical Benefits			
Ambulance	Ded/Co	Ded/Co	Ded/ 40% Co
Chiropractic/Manipulative Therapy	$40 Co-pay	$35 Co-pay	$35 Co-pay
Durable Medical Equipment/Prosthesis	Ded/Co	Ded/Co	Ded/Co
Emergency Room Care	Ded/Co	Ded/Co	Ded/Co
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 Use - Inpatient	Ded/Co	Ded/Co	Ded/Co
Mental Health/Substance Use - Outpatient	1st 3 Visits @ $0 Co-pay, then $40 Co-pay	1st 3 Visits @ $0 Co-pay, then $35 Co-pay	1st 3 Visits @ $0 Co-pay, then $35 Co-pay
Preventive Care	$0 Copay	$0 Copay	$0 Copay
Primary Care Visits	1st Visit @ $0 Co-pay, then $40 Co-pay – Co-pay for Visits 2-3 apply to Deductible	1st Visit @ $0 Co-pay, then $35 Co-pay – Co-pay for Visits 2-3 apply to Deductible	1st Visit @ $0 Co-pay, then $35 Co-pay – Co-pay for Visits 2-3 apply to Deductible
Rehabilitation and habilitation Services (PT/OT/ST)	$40 Co-pay	$35 Co-pay	$35 Co-pay
Specialty Care Office Visits	$80 Co-pay	$70 Co-pay	$85 Co-pay
Surgery/Anesthesia	Ded/Co	Ded/Co	Ded/Co
Tobacco/Smoking Cessation	$0 Co-pay	$0 Co-pay	$0 Co-pay
Urgent Care Visits	$85 Co-pay	$85 Co-pay	$85 Co-pay
Urgent Care Visits via Amwell Telehealth	$0 Co-pay	$0 Co-pay	$0 Co-pay
Adult Vision Exams	$40 Co-pay	$35 Co-pay	$35 Co-pay
X-rays and Diagnostic Imaging	Ded/Co	Ded/Co	Ded/Co
Pediatric Glasses/Contacts	Ded/Co	Ded/Co	Ded/Co
Pediatric Vision Exams	$40 Co-pay	$35 Co-pay	$35 Co-pay
Prescription Drugs			
Tier 1 - Preferred Generics	$5 Co-pay	$5 Co-pay	$5 Co-pay
Tier 2 - Generics	$35 Co-pay	$35 Co-pay	$35 Co-pay
Tier 3 - Preferred Brands	$70 Co-pay	$70 Co-pay	$70 Co-pay
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			
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

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

COMMUNITY Health Options™

2022 Small Group Gold Plans

Plan Name	Community Flex	Community Premier	Community Elite
On and Off SHOP	Off SHOP Only	Off SHOP Only	Off SHOP Only
Product Type	PPO	PPO	PPO
Chronic Illness Support Program (CISP)	Y	Y	Y
HSA Preventive Drug Coverage (Y/N)	N	N	N
Individual Deductible	$2,000	$2,000	$1,500
Family Deductible	$4,000	$4,000	$3,000
Standard Co-insurance (Co)	30%	20%	25%
Individual Out of Pocket Maximum (OOPM)	$6,500	$5,500	$7,900
Family Out of Pocket Maximum (OOPM)	$13,000	$11,000	$15,800
Medical Benefits			
Ambulance	Ded/Co	Ded/Co	Ded/Co
Chiropractic/Manipulative Therapy	$30 Co-pay	$30 Co-pay	$35 Co-pay
Durable Medical Equipment/Prosthesis	Ded/Co	Ded/Co	Ded/Co
Emergency Room Care	Ded/Co	Ded/$300 Co-pay	Ded/Co
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 Use - Inpatient	Ded/Co	Ded/Co	Ded/Co
Mental Health/Substance Use - Outpatient	1st 3 Visits @ $0 Co-pay, then $30 Co-pay	1st 3 Visits at $0 Co-pay, then $30 Co-pay	1st Visit @ $0 Co-pay, then $35 Co-pay – Co-pay for Visits 2-3 apply to Deductible
Preventive Care	$0 Co-pay	$0 Co-pay	$0 Co-pay
Primary Care Visits	1st Visit @ $0 Co-pay, then $30 Co-pay – Co-pay for Visits 2-3 apply to Deductible	1st Visit @ $0 Co-pay, then $30 Co-pay – Co-pay for Visits 2-3 apply to Deductible	1st Visit @ $0 Co-pay, then $35 Co-pay – Co-pay for Visits 2-3 apply to Deductible
Rehabilitation and habilitation Services (PT/OT/ST)	$30 Co-pay	$30 Co-pay	$35 Co-pay
Specialty Care Office Visits	$60 Co-pay	$60 Co-pay	$85 Co-pay
Surgery/Anesthesia	Ded/Co	Ded/Co	Ded/Co
Tobacco/Smoking Cessation	$0 Co-pay	$0 Co-pay	$0 Co-pay
Urgent Care Visits	$80 Co-pay	$30 Co-pay	$85 Co-pay
Urgent Care Visits via Amwell Telehealth	$0 Co-pay	$0 Co-pay	$0 Co-pay
Adult Vision Exams	$30 Co-pay	$30 Co-pay	$35 Co-pay
X-rays and Diagnostic Imaging	Ded/Co	Ded/Co	Ded/Co
Pediatric Glasses/Contacts	Ded/Co	Ded/Co	Ded/Co
Pediatric Vision Exams	$30 Co-pay	$30 Co-pay	$35 Co-pay
Prescription Drugs			
Tier 1 - Preferred Generics	$5 Co-pay	$5 Co-pay	$5 Co-pay
Tier 2 - Generics	$35 Co-pay	$35 Co-pay	$35 Co-pay
Tier 3 - Preferred Brands	$70 Co-pay	$70 Co-pay	$70 Co-pay
Tier 4 - Non-Preferred Brands	30% Co. up to max of $300/script. Deductible does not apply	30% Co. up to max of $300/sciript. 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			
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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COMMUNITY Health Options™

2022 Small Group Gold Plans Continued

Plan Name	Community Prime	Community Advantage
On and Off SHOP	On & Off SHOP	Off SHOP Only
Product Type	PPO	PPO
Chronic Illness Support Program (CISP)	Y	Y
HSA Preventive Drug Coverage (Y/N)	N	N
Individual Deductible	$1,500	$1,000
Family Deductible	$3,000	$2,000
Standard Co-insurance (Co)	30%	30%
Individual Out of Pocket Maximum (OOPM)	$6,000	$4,500
Family Out of Pocket Maximum (OOPM)	$12,000	$9,000
Medical Benefits		
Ambulance	$500 Co-pay	$500 Co-pay
Chiropractic/Manipulative Therapy	$30 Co-pay	$30 Co-pay
Durable Medical Equipment/Prosthesis	Ded/Co	Ded/Co
Emergency Room Care	$500 Co-pay	$500 Co-pay
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 Use - Inpatient	Ded/Co	Ded/Co
Mental Health/Substance Use - Outpatient	1st 3 Visits @ $0 Co-pay, then $30 Co-pay	1st 3 Visits @ $0 Co-pay, then $30 Co-pay
Preventive Care	$0 Co-pay	$0 Co-pay
Primary Care Visits	1st Visit @ $0 Co-pay, then $30 Co-pay – Co-pay for Visits 2-3 apply to Deductible	1st Visit @ $0 Co-pay, then $30 Co-pay – Co-pay for Visits 2-3 apply to Deductible
Rehabilitation and habilitation Services (PT/OT/ST)	$30 Co-pay	$30 Co-pay
Specialty Care Office Visits	$70 Co-pay	$80 Co-pay
Surgery/Anesthesia	Ded/Co	Ded/Co
Tobacco/Smoking Cessation	$0 Co-pay	$0 Co-pay
Urgent Care Visits	$80 Co-pay	$80 Co-pay
Urgent Care Visits via Amwell Telehealth	$0 Co-pay	$0 Co-pay
Adult Vision Exams	$30 Co-pay	$30 Co-pay
X-rays and Diagnostic Imaging	Ded/Co	Ded/Co
Pediatric Glasses/Contacts	Ded/Co	Ded/Co
Pediatric Vision Exams	$30 Co-pay	$30 Co-pay
Prescription Drugs		
Tier 1 - Preferred Generics	$5 Co-pay	$5 Co-pay
Tier 2 - Generics	$35 Co-pay	$35 Co-pay
Tier 3 - Preferred Brands	$70 Co-pay	$70 Co-pay
Tier 4 - Non-Preferred Brands	30% Co. up to max of $300/script. Deductible does not apply	Ded then 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		
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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