2024 SMALL EMPLOYER BENEFIT PLAN DESIGNS

Platinum Plans

All Platinum plans listed are available with the **Envision** network. The **Rise** network is available for all Platinum plans in the following counties: Kenosha, Milwaukee, Ozaukee, Racine, Washington, and Waukesha only.

	Calendar Year Deductible	Out-of-Pocket Maximum		Provider Visits In-Network Copays / Coinsurance					Rx Calendar Year Deductible	Prescription Drugs			
EPO Plan Name	Single / Family	Single / Family	Coinsurance	Quick / Fast Care	PCP[1]	Specialist	Emergency[2]	Urgent	Single / Family	Tier 1	Tier 2	Tier 3	Specialty
CGHC EPO Platinum $500 Deductible/10% Plan ID: 87416WI004003300 Plan ID: 87416WI004006200	$500 / $1,000	$1,500 / $3,000	10%	$15	$25	$50	$150	$100	Not Applicable	$10	$35	$70	D/C[3]
CGHC EPO Platinum $500 Deductible/20% Plan ID: 87416WI004003200 Plan ID: 87416WI004006100	$500 / $1,000	$1,500 / $3,000	20%	$15	$25	$50	$150	$100	Not Applicable	$10	$35	$70	D/C[3]

All plans offer preventive health benefits for $0. All plans offer a $15 tier 2 insulin benefit. All plans offer Virtuwell visits for $0.

Urgent = Urgent Care Services. **Emergency** (ER) = Emergency Room Care services. **Ded** = Deductible**.**

1 **PCP** = Primary Care Provider (includes general pediatrics, internal medicine, obstetrics/gynecology, family practice, general medicine, and geriatrics).

2 **Services that meet our definition of Emergency Care** are paid at the in-network rate even when care is provided by an out-of-network provider or facility. We recommend members to go to the nearest Emergency Room in a life-threatening emergency. The plan copay applies to the facility charge only. All other charges related to ER visits are subject to additional copayment or deductible/coinsurance.

3 **D/C** refers to Deductible/Coinsurance.

Our Deductibles Explained: All plans have a 12-month deductible. All deductibles, coinsurance and copayments accumulate toward the out-of-pocket maximum. All plans noted above have embedded deductibles for family coverage. This means that if you are enrolled in a 2-person or family plan, an individual family member only has to satisfy the individual deductible before the plan begins to pay for covered services for that family member.

2024 SMALL EMPLOYER BENEFIT PLAN DESIGNS

Gold Plans

All Gold plans listed are available with the **Envision** network. The **Rise** network is available for all Gold plans in the following counties: Kenosha, Milwaukee, Ozaukee, Racine, Washington, and Waukesha only.

	Calendar Year Deductible	Out-of-Pocket Maximum		Provider Visits In-Network Copays / Coinsurance					Rx Calendar Year Deductible	Prescription Drugs			
EPO Plan Name	Single / Family	Single / Family	Coinsurance	Quick / Fast Care	PCP[1]	Specialist	Emergency[2]	Urgent	Single / Family	Tier 1	Tier 2	Tier 3	Specialty
CGHC EPO Gold $0 Deductible/20% Plan ID: 87416WI004003400 Plan ID: 87416WI004006300	$0 / $0	$8,000 / $16,000	20%	$15	$35	$70	$300	$100	Not Applicable	$10	$40	$70	D/C[3]
CGHC EPO Gold $800 Deductible/20% Plan ID: 87416WI004003500 Plan ID: 87416WI004006400	$800 / $1,600	$8,350 / $16,700	20%	$15	$35	$70	$300	$100	Not Applicable	$15	$40	$80	D/C[3]
CGHC EPO Gold $1500 Deductible/20% Plan ID: 87416WI004003700 Plan ID: 87416WI004006500	$1,500 / $3,000	$6,000 / $12,000	20%	$15	$35	$70	$300	$100	Not Applicable	$15	$40	$80	D/C[3]
CGHC EPO Gold $2000 Deductible/20% Plan ID: 87416WI004003900 Plan ID: 87416WI004006600	$2,000 / $4,000	$7,500 / $15,000	20%	$15	$30	$60	D/C[3]	$100	Not Applicable	$15	$40	$80	D/C[3]
CGHC EPO Gold $2200 Deductible/20% Plan ID: 87416WI004004100 Plan ID: 87416WI004006700	$2,200 / $4,400	$6,500 / $13,000	20%	$15	$35	$70	$300	$100	Not Applicable	$15	$40	$80	D/C[3]
CGHC EPO Gold $2600 Deductible/15% Plan ID: 87416WI004004200 Plan ID: 87416WI004006800	$2,600 / $5,200	$8,500 / $17,000	15%	$15	$20	$60	D/C[3]	$100	Not Applicable	$10	$40	$70	D/C[3]
CGHC EPO Gold $2750 Deductible/15% - ER Copay Plan ID: 87416WI004004300 Plan ID: 87416WI004006900	$2,750 / $5,500	$8,550 / $17,100	15%	$15	$35	$70	$300	$100	Not Applicable	$10	$40	$70	D/C[3]
CGHC EPO HSA Gold $3200 Deductible/0% Plan ID: 87416WI004005400 Plan ID: 87416WI004007600	$3,200 / $6,400	$3,200 / $6,400	0%	D/C[3]	D/C[3]	D/C[3]	D/C[3]	D/C[3]	Not Applicable	D/C[3]	D/C[3]	D/C[3]	D/C[3]

All plans offer preventive health benefits for $0. All plans offer a $15 tier 2 insulin benefit. All non-HSA plans offer Virtuwell visits for $0.

For HSA plans, Virtuwell visits apply to deductible / coinsurance.

Urgent = Urgent Care Services. **Emergency** (ER) = Emergency Room Care services. **Ded** = Deductible**.**

1 **PCP** = Primary Care Provider (includes general pediatrics, internal medicine, obstetrics/gynecology, family practice, general medicine, and geriatrics).

2 **Services that meet our definition of Emergency Care** are paid at the in-network rate even when care is provided by an out-of-network provider or facility. We recommend members to go to the nearest Emergency Room in a life-threatening emergency. The plan copay applies to the facility charge only. All other charges related to ER visits are subject to additional copayment or deductible/coinsurance.

3 **D/C** refers to Deductible/Coinsurance.

Our Deductibles Explained: All plans have a 12-month deductible. All deductibles, coinsurance and copayments accumulate toward the out-of-pocket maximum. All plans noted above have embedded deductibles for family coverage. This means that if you are enrolled in a 2-person or family plan, an individual family member only has to satisfy the individual deductible before the plan begins to pay for covered services for that family member.

2024 SMALL EMPLOYER BENEFIT PLAN DESIGNS

Silver Plans

All Silver plans listed are available with the **Envision** network. The **Rise** network is available for all Silver plans in the following counties: Kenosha, Milwaukee, Ozaukee, Racine, Washington, and Waukesha only.

	Calendar Year Deductible	Out-of-Pocket Maximum		Provider Visits In-Network Copays / Coinsurance					Rx Calendar Year Deductible	Prescription Drugs			
EPO Plan Name	Single / Family	Single / Family	Coinsurance	Quick / Fast Care	PCP[1]	Specialist	Emergency[2]	Urgent	Single / Family	Tier 1	Tier 2	Tier 3	Specialty
CGHC EPO HSA Silver $3200 Deductible/20% Plan ID: 87416WI004005600 Plan ID: 87416WI004007700	$3,200 / $6,400	$7,000 / $14,000	20%	D/C[3]	D/C[3]	D/C[3]	D/C[3]	D/C[3]	Not Applicable	D/C[3]	D/C[3]	D/C[3]	D/C[3]
CGHC EPO Silver $4000 Deductible/20% Plan ID: 87416WI004004400 Plan ID: 87416WI004007000	$4,000 / $8,000	$8,500 / $17,000	20%	$15	$40	$80	D/C[3]	$150	Not Applicable	$30	$50	$90	D/C[3]
CGHC EPO Silver $5000 Deductible/20% Plan ID: 87416WI004004600 Plan ID: 87416WI004007100	$5,000 / $10,000	$7,750 / $15,500	20%	$15	$40	$80	D/C[3]	$150	Not Applicable	$25	$50	$90	D/C[3]
CGHC EPO HSA Silver $5100 Deductible/0% Plan ID: 87416WI004005700 Plan ID: 87416WI004007800	$5,100 / $10,200	$5,100 / $10,200	0%	D/C[3]	D/C[3]	D/C[3]	D/C[3]	D/C[3]	Not Applicable	D/C[3]	D/C[3]	D/C[3]	D/C[3]
CGHC EPO Silver $5500 Deductible/20% Plan ID: 87416WI004004800 Plan ID: 87416WI004007200	$5,500 / $11,000	$8,000 / $16,000	20%	$15	$40	$80	D/C[3]	$150	Not Applicable	$25	$50	$100	D/C[3]
CGHC EPO Silver $6000 Deductible/20% Plan ID: 87416WI004004900 Plan ID: 87416WI004007300	$6,000 / $12,000	$8,500 / $17,000	20%	$15	$50	$100	D/C[3]	$150	Not Applicable	$20	$40	$100	D/C[3]

All plans offer preventive health benefits for $0. All plans offer a $15 tier 2 insulin benefit. All non-HSA plans offer Virtuwell visits for $0.

For HSA plans, Virtuwell visits apply to deductible / coinsurance.

Urgent = Urgent Care Services. **Emergency** (ER) = Emergency Room Care services. **Ded** = Deductible**.**

1 **PCP** = Primary Care Provider (includes general pediatrics, internal medicine, obstetrics/gynecology, family practice, general medicine, and geriatrics).

2 **Services that meet our definition of Emergency Care** are paid at the in-network rate even when care is provided by an out-of-network provider or facility. We recommend members to go to the nearest Emergency Room in a life-threatening emergency. The plan copay applies to the facility charge only. All other charges related to ER visits are subject to additional copayment or deductible/coinsurance.

3 **D/C** refers to Deductible/Coinsurance.

Our Deductibles Explained: All plans have a 12-month deductible. All deductibles, coinsurance and copayments accumulate toward the out-of-pocket maximum. All plans noted above have embedded deductibles for family coverage. This means that if you are enrolled in a 2-person or family plan, an individual family member only has to satisfy the individual deductible before the plan begins to pay for covered services for that family member.

2024 SMALL EMPLOYER BENEFIT PLAN DESIGNS

Bronze Plans

All Bronze plans listed are available with the **Envision** network. The **Rise** network is available for all Bronze plans in the following counties: Kenosha, Milwaukee, Ozaukee, Racine, Washington, and Waukesha only.

	Calendar Year Deductible	Out-of-Pocket Maximum		Provider Visits In-Network Copays / Coinsurance					Rx Calendar Year Deductible	Prescription Drugs			
EPO Plan Name	Single / Family	Single / Family	Coinsurance	Quick / Fast Care	PCP[1]	Specialist	Emergency[2]	Urgent	Single / Family	Tier 1	Tier 2	Tier 3	Specialty
CGHC EPO Bronze $5500 Deductible/30% Plan ID: 87416WI004005000 Plan ID: 87416WI004007400	$5,500 / $11,000	$8,250 / $16,500	30%	$15	$75	$150	D/C[3]	D/C[3]	Not Applicable	D/C[3]	D/C[3]	D/C[3]	D/C[3]
CGHC EPO HSA Bronze $7100 Deductible/0% Plan ID: 87416WI004005900 Plan ID: 87416WI004007900	$7,100 / $14,200	$7,100 / $14,200	0%	D/C[3]	D/C[3]	D/C[3]	D/C[3]	D/C[3]	Not Applicable	D/C[3]	D/C[3]	D/C[3]	D/C[3]
CGHC EPO Bronze $8550 Deductible/0% Plan ID: 87416WI004005200 Plan ID: 87416WI004007500	$8,550 / $17,100	$8,550 / $17,100	0%	$15	$35	D/C[3]	D/C[3]	D/C[3]	Not Applicable	D/C[3]	D/C[3]	D/C[3]	D/C[3]

All plans offer preventive health benefits for $0. All non-HSA plans offer 10 Virtuwell visits for $0.

For HSA plans, Virtuwell visits apply to deductible / coinsurance.

Urgent = Urgent Care Services. **Emergency** (ER) = Emergency Room Care services. **Ded** = Deductible**.**

1 **PCP** = Primary Care Provider (includes general pediatrics, internal medicine, obstetrics/gynecology, family practice, general medicine, and geriatrics).

2 **Services that meet our definition of Emergency Care** are paid at the in-network rate even when care is provided by an out-of-network provider or facility. We recommend members to go to the nearest Emergency Room in a life-threatening emergency. The plan copay applies to the facility charge only. All other charges related to ER visits are subject to additional copayment or deductible/coinsurance.

3 **D/C** refers to Deductible/Coinsurance.

Our Deductibles Explained: All plans have a 12-month deductible. All deductibles, coinsurance and copayments accumulate toward the out-of-pocket maximum. All plans noted above have embedded deductibles for family coverage. This means that if you are enrolled in a 2-person or family plan, an individual family member only has to satisfy the individual deductible before the plan begins to pay for covered services for that family member.