2024 INDIVIDUAL AND FAMILY BENEFIT PLAN DESIGNS

On-Exchange Bronze & Catastrophic Plans

Adult Vision Exam benefits are available for additional premium with these On-Exchange Bronze plans **except** for the CGHC Bronze Standard $7500 plan. These additional benefits are not available with the On-Exchange Catastrophic plan.

	Calendar Year Deductible	Out-of-Pocket Maximum		Provider Visits In-Network Copays / Coinsurance					Rx Calendar Year Deductible	Prescription Drugs			
Envision 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 Copay Bronze $0 Ded / $2250 Rx Ded Plan ID: 87416WI003000301 Plan ID: 87416WI006002301 [4] Plan ID: 87416WI007002301	$0 / $0	$9,450 / $18,900	50%	$30	$40	$100	$1,800	$200	$2,250 / $4,500	$35	$140	D/C[3]	D/C[3]
CGHC Bronze $6000 Plan ID: 87416WI003003501 Plan ID: 87416WI006001701	$6,000 / $12,000	$9,450 / $18,900	40%	$25	$35 after Ded	D/C[3]	$1,500 after Ded	D/C[3]	Not Applicable	$25	D/C[3]	D/C[3]	D/C[3]
CGHC Bronze Standard $7500 Plan ID: 87416WI003004101	$7,500 / $15,000	$9,400 / $18,800	50%	$30	$50	$100	D/C[3]	$75	Not Applicable	$25	$50 after Ded	$100 after Ded	$500 after Ded
CGHC HSA Bronze $7500 Plan ID: 87416WI003003101 Plan ID: 87416WI006001801	$7,500 / $15,000	$7,500 / $15,000	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 Bronze $9450 ($35 PCP Copay) Plan ID: 87416WI003002701 Plan ID: 87416WI006001501	$9,450 / $18,900	$9,450 / $18,900	0%	$25	$35	D/C[3]	D/C[3]	D/C[3]	Not Applicable	D/C[3]	D/C[3]	D/C[3]	D/C[3]
CGHC Catastrophic $9450 Plan ID: 87416WI003002601	$9,450 / $18,900	$9,450 / $18,900	0%	D/C[3]	$0	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.

4 **Preventive Dental** is available for additional premium in the following counties: Kenosha, Milwaukee, Ozaukee, Racine, Washington, and Waukesha only. If you purchased a plan that includes dental coverage, preventive dental services include: 2 exams per year, 2 cleanings per year, x-rays (one full mouth, one bite wing), fluoride with cleanings (up to age 14, limit 2 per year), and sealants (up to age 14 on permanent molars only).

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 INDIVIDUAL AND FAMILY BENEFIT PLAN DESIGNS

On-Exchange Limited
Cost Share - Bronze Plans

Adult Vision Exam benefits are available for additional premium with these On-Exchange Bronze plans **except** for the CGHC Bronze Standard $7500 LCS plan.

	Calendar Year Deductible	Out-of-Pocket Maximum		Provider Visits In-Network Copays / Coinsurance					Rx Calendar Year Deductible	Prescription Drugs			
Envision 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 Copay Bronze $0 Ded / $2250 Rx Ded LCS Plan ID: 87416WI003000303 Plan ID: 87416WI006002303 [4] Plan ID: 87416WI007002303	$0 / $0	$9,450 / $18,900	50%	$30	$40	$100	$1,800	$200	$2,250 / $4,500	$35	$140	D/C[3]	D/C[3]
CGHC Bronze $6000 LCS Plan ID: 87416WI003003503 Plan ID: 87416WI006001703	$6,000 / $12,000	$9,450 / $18,900	40%	$25	$35 after Ded	D/C[3]	$1,500 after Ded	D/C[3]	Not Applicable	$25	D/C[3]	D/C[3]	D/C[3]
CGHC Bronze Standard $7500 LCS Plan ID: 87416WI003004103	$7,500 / $15,000	$9,400 / $18,800	50%	$30	$50	$100	D/C[3]	$75	Not Applicable	$25	$50 after Ded	$100 after Ded	$500 after Ded
CGHC Bronze $7500 LCS Plan ID: 87416WI003003103 Plan ID: 87416WI006001803	$7,500 / $15,000	$7,500 / $15,000	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 Bronze $9450 ($35 PCP Copay) LCS Plan ID: 87416WI003002703 Plan ID: 87416WI006001503	$9,450 / $18,900	$9,450 / $18,900	0%	$25	$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 plans offer 10 Virtuwell visits for $0 except the CGHC Bronze $7500 LCS plan.

For the CGHC Bronze $7500 LCS plan, 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.

4 **Preventive Dental** is available for additional premium in the following counties: Kenosha, Milwaukee, Ozaukee, Racine, Washington, and Waukesha only. If you purchased a plan that includes dental coverage, preventive dental services include: 2 exams per year, 2 cleanings per year, x-rays (one full mouth, one bite wing), fluoride with cleanings (up to age 14, limit 2 per year), and sealants (up to age 14 on permanent molars only).

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 INDIVIDUAL AND FAMILY BENEFIT PLAN DESIGNS

On-Exchange No Cost Share - Bronze Plans

Adult Vision Exam benefits are available for additional premium with these On-Exchange Bronze plans **except** for the CGHC Bronze Standard $7500 NCS plan.

	Calendar Year Deductible	Out-of-Pocket Maximum		Provider Visits In-Network Copays / Coinsurance					Rx Calendar Year Deductible	Prescription Drugs			
Envision 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 Copay Bronze $0 Ded / $2250 Rx Ded NCS Plan ID: 87416WI003000302 Plan ID: 87416WI006002302 [4] Plan ID: 87416WI007002302	$0 / $0	$0 / $0	0%	$0	$0	$0	$0	$0	Not Applicable	$0	$0	$0	$0
CGHC Bronze $6000 NCS Plan ID: 87416WI003003502 Plan ID: 87416WI006001702	$0 / $0	$0 / $0	0%	$0	$0	$0	$0	$0	Not Applicable	$0	$0	$0	$0
CGHC Bronze Standard $7500 NCS Plan ID: 87416WI003004102	$0 / $0	$0 / $0	0%	$0	$0	$0	$0	$0	Not Applicable	$0	$0	$0	$0
CGHC Bronze $7500 NCS Plan ID: 87416WI003003102 Plan ID: 87416WI006001802	$0 / $0	$0 / $0	0%	$0	$0	$0	$0	$0	Not Applicable	$0	$0	$0	$0
CGHC Bronze $9450 NCS Plan ID: 87416WI003002702 Plan ID: 87416WI006001502	$0 / $0	$0 / $0	0%	$0	$0	$0	$0	$0	Not Applicable	$0	$0	$0	$0

All plans offer preventive health benefits for $0. 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.

4 **Preventive Dental** is available for additional premium in the following counties: Kenosha, Milwaukee, Ozaukee, Racine, Washington, and Waukesha only. If you purchased a plan that includes dental coverage, preventive dental services include: 2 exams per year, 2 cleanings per year, x-rays (one full mouth, one bite wing), fluoride with cleanings (up to age 14, limit 2 per year), and sealants (up to age 14 on permanent molars only).

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 INDIVIDUAL AND FAMILY BENEFIT PLAN DESIGNS

On-Exchange Gold Plans

Adult Vision Exam benefits are available for additional premium with these On-Exchange Gold plans **except** for the CGHC Gold Standard $1500 plan.

	Calendar Year Deductible	Out-of-Pocket Maximum		Provider Visits In-Network Copays / Coinsurance					Rx Calendar Year Deductible	Prescription Drugs			
Envision 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 Copay Gold $0 Ded Plan ID: 87416WI003000501 Plan ID: 87416WI006002501	$0 / $0	$8,500 / $17,000	20%	$25	$35	$75	$500	$75	Not Applicable	$20	$55	30% after Ded	30% after Ded
CGHC Gold Standard $1500 Plan ID: 87416WI003004301	$1,500 / $3,000	$8,700 / $17,400	25%	$20	$30	$60	D/C[3]	$45	Not Applicable	$15	$30	$60	$250
CGHC Gold $1800 Plan ID: 87416WI003001901 Plan ID: 87416WI006000401	$1,800 / $3,600	$6,600 / $13,200	20%	$15	$25	$50	$300	$75	Not Applicable	$10	$50	$100 after Ded	30% after Ded
CGHC Gold $3000 Plan ID: 87416WI003001701 Plan ID: 87416WI006000601	$3,000 / $6,000	$9,300 / $18,600	20%	$10	$20	$50	$300	$75	Not Applicable	$10	$50	$100 after Ded	30% after Ded
CGHC HSA Gold $3200 Plan ID: 87416WI003003201 Plan ID: 87416WI006002001	$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 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.

2024 INDIVIDUAL AND FAMILY BENEFIT PLAN DESIGNS

On-Exchange Limited
Cost Share - Gold Plans

Adult Vision Exam benefits are available for additional premium with these On-Exchange Gold plans **except** for the CGHC Gold Standard $1500 LCS plan.

	Calendar Year Deductible	Out-of-Pocket Maximum		Provider Visits In-Network Copays / Coinsurance					Rx Calendar Year Deductible	Prescription Drugs			
Envision 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 Copay Gold $0 Ded LCS Plan ID: 87416WI003000503 Plan ID: 87416WI006002503	$0 / $0	$8,500 / $17,000	20%	$25	$35	$75	$500	$75	Not Applicable	$20	$55	30% after Ded	30% after Ded
CGHC Gold Standard $1500 LCS Plan ID: 87416WI003004303	$1,500 / $3,000	$8,700 / $17,400	25%	$20	$30	$60	D/C[3]	$45	Not Applicable	$15	$30	$60	$250
CGHC Gold $1800 LCS Plan ID: 87416WI003001903 Plan ID: 87416WI006000403	$1,800 / $3,600	$6,600 / $13,200	20%	$15	$25	$50	$300	$75	Not Applicable	$10	$50	$100 after Ded	30% after Ded
CGHC Gold $3000 LCS Plan ID: 87416WI003001703 Plan ID: 87416WI006000603	$3,000 / $6,000	$9,300 / $18,600	20%	$10	$20	$50	$300	$75	Not Applicable	$10	$50	$100 after Ded	30% after Ded
CGHC Gold $3200 LCS Plan ID: 87416WI003003203 Plan ID: 87416WI006002003	$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 plans offer 10 Virtuwell visits for $0 except the Gold $3200 LCS plan. For the Gold $3200 LCS plan, Virtuwell applies 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 INDIVIDUAL AND FAMILY BENEFIT PLAN DESIGNS

On-Exchange No Cost Share - Gold Plans

Adult Vision Exam benefits are available for additional premium with these On-Exchange Gold plans **except** for the CGHC Gold Standard $1500 NCS plan.

	Calendar Year Deductible	Out-of-Pocket Maximum		Provider Visits In-Network Copays / Coinsurance					Rx Calendar Year Deductible	Prescription Drugs			
Envision 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 Copay Gold $0 Ded NCS Plan ID: 87416WI003000502 Plan ID: 87416WI006002502	$0 / $0	$0 / $0	0%	$0	$0	$0	$0	$0	Not Applicable	$0	$0	$0	$0
CGHC Gold Standard $1500 NCS Plan ID: 87416WI003004302	$0 / $0	$0 / $0	0%	$0	$0	$0	$0	$0	Not Applicable	$0	$0	$0	$0
CGHC Gold $1800 NCS Plan ID: 87416WI003001902 Plan ID: 87416WI006000402	$0 / $0	$0 / $0	0%	$0	$0	$0	$0	$0	Not Applicable	$0	$0	$0	$0
CGHC Gold $3000 NCS Plan ID: 87416WI003001702 Plan ID: 87416WI006000602	$0 / $0	$0 / $0	0%	$0	$0	$0	$0	$0	Not Applicable	$0	$0	$0	$0
CGHC Gold $3200 NCS Plan ID: 87416WI003003202 Plan ID: 87416WI006002002	$0 / $0	$0 / $0	0%	$0	$0	$0	$0	$0	Not Applicable	$0	$0	$0	$0

All plans offer preventive health benefits for $0. 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 INDIVIDUAL AND FAMILY BENEFIT PLAN DESIGNS

On-Exchange Cost Share Reduction 73% - Silver Plans

Adult Vision Exam benefits are available for additional premium with these On-Exchange Silver plans **except** for the CGHC Silver Standard $5700 CSR 73% plan.

	Calendar Year Deductible	Out-of-Pocket Maximum		Provider Visits In-Network Copays / Coinsurance					Rx Calendar Year Deductible	Prescription Drugs			
Envision 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 Silver $2850 CSR 73% Plan ID: 87416WI003003304 Plan ID: 87416WI006001904	$2,850 / $5,700	$6,600 / $13,200	15%	D/C[3]	$15 after Ded	$30 after Ded	D/C[3]	D/C[3]	Not Applicable	$15 after Ded	D/C[3]	D/C[3]	D/C[3]
CGHC Silver $3600 CSR 73% Plan ID: 87416WI003002104 Plan ID: 87416WI006000904	$3,600 / $7,200	$7,250 / $14,500	25%	$25	$35	$80	D/C[3]	$75	Not Applicable	$20	$75	D/C[3]	30% after Ded
CGHC Silver $4000 CSR 73% Plan ID: 87416WI003002304 Plan ID: 87416WI006001204 [4] Plan ID: 87416WI007001204	$4,000 / $8,000	$7,550 / $15,100	30%	$30	$60	$115	$250	D/C[3]	Not Applicable	$15	$100	D/C[3]	40% after Ded
CGHC Silver $4050 CSR 73% Plan ID: 87416WI003004704 Plan ID: 87416WI006001104 [4] Plan ID: 87416WI007001104	$4,050 / $8,100	$7,550 / $15,100	30%	$30	$40	$75	D/C[3]	D/C[3]	Not Applicable	$10	$90	D/C[3]	40% after Ded
CGHC Silver Standard $5700 CSR 73% Plan ID: 87416WI003004204	$5,700 / $11,400	$7,200 / $14,400	40%	$30	$40	$80	D/C[3]	$60	Not Applicable	$20	$40	$80 after Ded	$350 after Ded

All plans offer preventive health benefits for $0. All plans offer a $15 tier 2 insulin benefit. All plans offer 10 Virtuwell visits for $0 except the CGHC Silver $2850 CSR 73% plan. For the CGHC Silver $2850 CSR 73% plan, 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.

4 **Preventive Dental** is available for additional premium in the following counties: Kenosha, Milwaukee, Ozaukee, Racine, Washington, and Waukesha only. If you purchased a plan that includes dental coverage, preventive dental services include: 2 exams per year, 2 cleanings per year, x-rays (one full mouth, one bite wing), fluoride with cleanings (up to age 14, limit 2 per year), and sealants (up to age 14 on permanent molars only).

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 INDIVIDUAL AND FAMILY BENEFIT PLAN DESIGNS

On-Exchange Cost Share Reduction 87% - Silver Plans

Adult Vision Exam benefits are available for additional premium with these On-Exchange Silver plans **except** for the CGHC Silver Standard $700 CSR 87% plan.

	Calendar Year Deductible	Out-of-Pocket Maximum		Provider Visits In-Network Copays / Coinsurance					Rx Calendar Year Deductible	Prescription Drugs			
Envision 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 Silver $600 CSR 87% ($25 PCP Copay) Plan ID: 87416WI003004705 Plan ID: 87416WI006001105[4] Plan ID: 87416WI007001105	$600 / $1,200	$3,140 / $6,280	25%	$15	$25	$55	D/C[3]	D/C[3]	Not Applicable	$5	$50	D/C[3]	40% after Ded
CGHC Silver $600 CSR 87% Plan ID: 87416WI003002305 Plan ID: 87416WI006001205[4] Plan ID: 87416WI007001205	$600 / $1,200	$3,150 / $6,300	25%	$20	$30	$70	$100	D/C[3]	Not Applicable	$5	$50	20% after Ded	40% after Ded
CGHC Silver $700 CSR 87% Plan ID: 87416WI003002105 Plan ID: 87416WI006000905	$700 / $1,400	$3,000 / $6,000	20%	$10	$20	$40	D/C[3]	$60	Not Applicable	$10	$50	D/C[3]	30% after Ded
CGHC Silver Standard $700 CSR 87% Plan ID: 87416WI003004205	$700 / $1,400	$3,000 / $6,000	30%	$10	$20	$40	D/C[3]	$30	Not Applicable	$10	$20	$60 after Ded	$250 after Ded
CGHC Silver $850 CSR 87% Plan ID: 87416WI003003305 Plan ID: 87416WI006001905	$850 / $1,700	$2,800 / $5,600	10%	D/C[3]	$15 after Ded	$30 after Ded	D/C[3]	D/C[3]	Not Applicable	$15 after Ded	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 plans offer 10 Virtuwell visits for $0 except the CGHC Silver $850 CSR 87% plan. For the CGHC Silver $850 CSR 87% plan, 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.

4 **Preventive Dental** is available for additional premium in the following counties: Kenosha, Milwaukee, Ozaukee, Racine, Washington, and Waukesha only. If you purchased a plan that includes dental coverage, preventive dental services include: 2 exams per year, 2 cleanings per year, x-rays (one full mouth, one bite wing), fluoride with cleanings (up to age 14, limit 2 per year), and sealants (up to age 14 on permanent molars only).

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 INDIVIDUAL AND FAMILY BENEFIT PLAN DESIGNS

On-Exchange Cost Share Reduction 94% - Silver Plans

Adult Vision Exam benefits are available for additional premium with these On-Exchange Silver plans **except** for the CGHC Silver Standard $0 CSR 94% plan.

	Calendar Year Deductible	Out-of-Pocket Maximum		Provider Visits In-Network Copays / Coinsurance					Rx Calendar Year Deductible	Prescription Drugs			
Envision 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 Silver Standard $0 CSR 94% Plan ID: 87416WI003004206	$0 / $0	$1,800 / $3,600	25%	$0	$0	$10	D/C[3]	$5	Not Applicable	$0	$15	$50	$150
CGHC Silver $0 CSR 94% ($0 PCP Copay) Plan ID: 87416WI003004706 [4] Plan ID: 87416WI006001106 Plan ID: 87416WI007001106	$0 / $0	$3,000 / $6,000	15%	$0	$0	$10	D/C[3]	D/C[3]	Not Applicable	$0	$15	D/C[3]	40% after Ded
CGHC Silver $0 CSR 94% Plan ID: 87416WI003002306 [4] Plan ID: 87416WI006001206 Plan ID: 87416WI007001206	$0 / $0	$3,150 / $6,300	15%	$0	$5	$25	$55	D/C[3]	Not Applicable	$0	$20	20% after Ded	40% after Ded
CGHC Silver $150 CSR 94% Plan ID: 87416WI003002106 Plan ID: 87416WI006000906	$150 / $300	$2,500 / $5,000	10%	$0	$0	$10	D/C[3]	$30	Not Applicable	$0	$25	D/C[3]	30% after Ded
CGHC Silver $250 CSR 94% Plan ID: 87416WI003003306 Plan ID: 87416WI006001906	$250 / $500	$950 / $1,900	10%	D/C[3]	$5 after Ded	$20 after Ded	D/C[3]	D/C[3]	Not Applicable	$5 after Ded	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 plans offer 10 Virtuwell visits for $0 except the CGHC Silver $250 CSR 94% plan. For the CGHC Silver $250 CSR 94% plan, 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.

4 **Preventive Dental** is available for additional premium in the following counties: Kenosha, Milwaukee, Ozaukee, Racine, Washington, and Waukesha only. If you purchased a plan that includes dental coverage, preventive dental services include: 2 exams per year, 2 cleanings per year, x-rays (one full mouth, one bite wing), fluoride with cleanings (up to age 14, limit 2 per year), and sealants (up to age 14 on permanent molars only).

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 INDIVIDUAL AND FAMILY BENEFIT PLAN DESIGNS

On-Exchange Silver Plans

Adult Vision Exam benefits are available for additional premium with these On-Exchange Silver plans **except** for the CGHC Silver Standard $5900 plan.

	Calendar Year Deductible	Out-of-Pocket Maximum		Provider Visits In-Network Copays / Coinsurance					Rx Calendar Year Deductible	Prescription Drugs			
Envision 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 HSA Silver $3200 Plan ID: 87416WI003003301 Plan ID: 87416WI006001901	$3,200 / $6,400	$8,000 / $16,000	15%	D/C[3]	$15 after Ded	$35 after Ded	D/C[3]	D/C[3]	Not Applicable	$15 after Ded	D/C[3]	D/C[3]	D/C[3]
CGHC Silver $4000 Plan ID: 87416WI003002101 Plan ID: 87416WI006000901	$4,000 / $8,000	$9,450 / $18,900	25%	$30	$40	$80	D/C[3]	$100	Not Applicable	$20	$75	D/C[3]	30% after Ded
CGHC Silver $5000 Ded / $5000 Rx Ded Plan ID: 87416WI003002301 Plan ID: 87416WI006001201[4] Plan ID: 87416WI007001201	$5,000 / $10,000	$9,450 / $18,900	30%	$30	$70	$115	$250	D/C[3]	$5,000 / $10,000	$20	$100	D/C[3]	40% after Ded
CGHC Silver $5650 Ded / $6000 Rx Ded Plan ID: 87416WI003004701 Plan ID: 87416WI006001101[4] Plan ID: 87416WI007001101	$5,650 / $11,300	$9,450 / $18,900	30%	$30	$50	$90	D/C[3]	D/C[3]	$6,000 / $12,000	$15	$90	D/C[3]	40% after Ded
CGHC Silver Standard $5900 Plan ID: 87416WI003004201	$5,900 / $11,800	$9,100 / $18,200	40%	$30	$40	$80	D/C[3]	$60	Not Applicable	$20	$40	$80 after Ded	$350 after Ded

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

4 **Preventive Dental** is available for additional premium in the following counties: Kenosha, Milwaukee, Ozaukee, Racine, Washington, and Waukesha only. If you purchased a plan that includes dental coverage, preventive dental services include: 2 exams per year, 2 cleanings per year, x-rays (one full mouth, one bite wing), fluoride with cleanings (up to age 14, limit 2 per year), and sealants (up to age 14 on permanent molars only).

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 INDIVIDUAL AND FAMILY BENEFIT PLAN DESIGNS

On-Exchange Limited
Cost Share - Silver Plans

Adult Vision Exam benefits are available for additional premium with these On-Exchange Silver plans **except** for the CGHC Silver Standard $5900 LCS plan.

	Calendar Year Deductible	Out-of-Pocket Maximum		Provider Visits In-Network Copays / Coinsurance					Rx Calendar Year Deductible	Prescription Drugs			
Envision 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 Silver $3200 LCS Plan ID: 87416WI003003303 Plan ID: 87416WI006001903	$3,200 / $6,400	$8,000 / $16,000	15%	D/C[3]	$15 after Ded	$35 after Ded	D/C[3]	D/C[3]	Not Applicable	$15 after Ded	D/C[3]	D/C[3]	D/C[3]
CGHC Silver $4000 LCS Plan ID: 87416WI003002103 Plan ID: 87416WI006000903	$4,000 / $8,000	$9,450 / $18,900	25%	$30	$40	$80	D/C[3]	$100	Not Applicable	$20	$75	D/C[3]	30% after Ded
CGHC Silver $5000 Ded / $5000 Rx Ded LCS Plan ID: 87416WI003002303 Plan ID: 87416WI006001203[4] Plan ID: 87416WI007001203	$5,000 / $10,000	$9,450 / $18,900	30%	$30	$70	$115	$250	D/C[3]	$5,000 / $10,000	$20	$100	D/C[3]	40% after Ded
CGHC Silver $5650 Ded / $6000 Rx Ded LCS Plan ID: 87416WI003004703 Plan ID: 87416WI006001103[4] Plan ID: 87416WI007001103	$5,650 / $11,300	$9,450 / $18,900	30%	$30	$50	$90	D/C[3]	D/C[3]	$6,000 / $12,000	$15	$90	D/C[3]	40% after Ded
CGHC Silver Standard $5900 LCS Plan ID: 87416WI003004203	$5,900 / $11,800	$9,100 / $18,200	40%	$30	$40	$80	D/C[3]	$60	Not Applicable	$20	$40	$80 after Ded	$350 after Ded

All plans offer preventive health benefits for $0. All plans offer a $15 tier 2 insulin benefit. All plans offer 10 Virtuwell visits for $0 except the Silver $3200 LCS plan. For the Silver $3200 LCS plan, 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.

4 **Preventive Dental** is available for additional premium in the following counties: Kenosha, Milwaukee, Ozaukee, Racine, Washington, and Waukesha only. If you purchased a plan that includes dental coverage, preventive dental services include: 2 exams per year, 2 cleanings per year, x-rays (one full mouth, one bite wing), fluoride with cleanings (up to age 14, limit 2 per year), and sealants (up to age 14 on permanent molars only).

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 INDIVIDUAL AND FAMILY BENEFIT PLAN DESIGNS

On-Exchange No Cost Share - Silver Plans

Adult Vision Exam benefits are available for additional premium with these On-Exchange Silver plans **except** for the CGHC Silver Standard $5900 NCS plan.

	Calendar Year Deductible	Out-of-Pocket Maximum		Provider Visits In-Network Copays / Coinsurance					Rx Calendar Year Deductible	Prescription Drugs			
Envision 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 Silver $3200 NCS Plan ID: 87416WI003003302 Plan ID: 87416WI006001902	$0 / $0	$0 / $0	0%	$0	$0	$0	$0	$0	Not Applicable	$0	$0	$0	$0
CGHC Silver $4000 NCS Plan ID: 87416WI003002102 Plan ID: 87416WI006000902	$0 / $0	$0 / $0	0%	$0	$0	$0	$0	$0	Not Applicable	$0	$0	$0	$0
CGHC Silver $5000 Ded / $5000 Rx Ded NCS Plan ID: 87416WI003002302 Plan ID: 87416WI006001202[4] Plan ID: 87416WI007001202	$0 / $0	$0 / $0	0%	$0	$0	$0	$0	$0	Not Applicable	$0	$0	$0	$0
CGHC Silver $5650 Ded / $6000 Rx Ded NCS Plan ID: 87416WI003004702 Plan ID: 87416WI006001102[4] Plan ID: 87416WI007001102	$0 / $0	$0 / $0	0%	$0	$0	$0	$0	$0	Not Applicable	$0	$0	$0	$0
CGHC Silver Standard $5900 NCS Plan ID: 87416WI003004202	$0 / $0	$0 / $0	0%	$0	$0	$0	$0	$0	Not Applicable	$0	$0	$0	$0

All plans offer preventive health benefits for $0. 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).

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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.