2025 INDIVIDUAL AND FAMILY BENEFIT PLAN DESIGNS

Off-Exchange Gold Plans

Adult Vision Exam and Allergy Testing benefits are included with these Off-Exchange Gold plans.

	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 Gold $0 Ded Plan ID: 87416WI005002500	$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: 87416WI005001300	$1,500 / $3,000	$7,800 / $15,600	25%	$20	$30	$60	D/C[3]	$45	Not Applicable	$15	$30	$60	$250
CGHC Gold $1800 Plan ID: 87416WI005000100	$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: 87416WI005001000	$3,000 / $6,000	$8,000 / $16,000	20%	$10	$20	$50	$300	$75	Not Applicable	$10	$50	$100 after Ded	30% after Ded

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

All plans offer 10 Teladoc 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.

2025 INDIVIDUAL AND FAMILY BENEFIT PLAN DESIGNS

Off-Exchange Silver Plans

Adult Vision Exam and Allergy Testing benefits are included with these Off-Exchange Silver plans.

	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: 87416WI005001900	$3,200 / $6,400	$8,050 / $16,100	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 Standard $5000 Plan ID: 87416WI005001800	$5,000 / $10,000	$8,000 / $16,000	40%	$30	$40	$80	D/C[3]	$60	Not Applicable	$20	$40	$80 after Ded	$350 after Ded
CGHC Silver $4200 Ded / $5000 Rx Ded Plan ID: 87416WI005001200	$4,200 / $8,400	$9,200 / $18,400	30%	$30	$55	$110	$250	D/C[3]	$5,000 / $10,000	$10	$80	D/C[3]	40% after Ded
CGHC Silver $4700 Ded / $6000 Rx Ded Plan ID: 87416WI005000500	$4,700 / $9,400	$9,200 / $18,400	30%	$30	$40	$80	D/C[3]	D/C[3]	$6,000 / $12,000	$10	$80	D/C[3]	40% 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 Teladoc visits for $0.

For HSA plans, Teladoc 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.

2025 INDIVIDUAL AND FAMILY BENEFIT PLAN DESIGNS

Off-Exchange Bronze & Catastrophic Plans

Adult Vision Exam and Allergy Testing benefits are included with these Off-Exchange Bronze and Catastrophic plans.

	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 Bronze $0 Ded / $2250 Rx Ded Plan ID: 87416WI005002300	$0 / $0	$9,200 / $18,400	50%	$30	$40	$100	$1,850	$200	$2,250 / $4,500	$35	$140	D/C[3]	D/C[3]
CGHC Bronze Standard $7500 Plan ID: 87416WI005002100	$7,500 / $15,000	$9,200 / $18,400	50%	$30	$50	$100	D/C[3]	$75	Not Applicable	$25	$50 after Ded	$100 after Ded	$500 after Ded
CGHC HSA Bronze $8050 Plan ID: 87416WI005000700	$8,050 / $16,100	$8,050 / $16,100	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 $9200 ($40 PCP Copay) Plan ID: 87416WI005000600	$9,200 / $18,400	$9,200 / $18,400	0%	$30	$40	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 $9200 Plan ID: 87416WI005000900	$9,200 / $18,400	$9,200 / $18,400	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 Teladoc visits for $0.

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

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

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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.