2025 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.

	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: 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 Plan ID: 87416WI006000101	$1,500 / $3,000	$7,800 / $15,600	25%	$20	$30	$60	D/C[3]	$45	Not Applicable	$15	$30	$60	$250
CGHC Gold $3000 Plan ID: 87416WI003001701 Plan ID: 87416WI006000601	$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

On-Exchange Limited
Cost Share - Gold Plans

Adult Vision Exam benefits are available for additional premium with these On-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 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 Plan ID: 87416WI006000103	$1,500 / $3,000	$7,800 / $15,600	25%	$20	$30	$60	D/C[3]	$45	Not Applicable	$15	$30	$60	$250
CGHC Gold $3000 LCS Plan ID: 87416WI003001703 Plan ID: 87416WI006000603	$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

On-Exchange No Cost Share - Gold Plans

Adult Vision Exam benefits are available for additional premium with these On-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 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 Plan ID: 87416WI006000102	$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

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

On-Exchange Silver Plans

Adult Vision Exam benefits are available for additional premium with these On-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 Silver $4200 Ded / $5000 Rx Ded Plan ID: 87416WI003002301 Plan ID: 87416WI006001201	$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: 87416WI003004701 Plan ID: 87416WI006001101	$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
CGHC Silver Standard $5000 Plan ID: 87416WI003004201 Plan ID: 87416WI006000201	$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

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

On-Exchange Limited
Cost Share - Silver Plans

Adult Vision Exam benefits are available for additional premium with these On-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 Silver $4200 Ded / $5000 Rx Ded LCS Plan ID: 87416WI003002303 Plan ID: 87416WI006001203	$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 LCS Plan ID: 87416WI003004703 Plan ID: 87416WI006001103	$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
CGHC Silver Standard $5000 LCS Plan ID: 87416WI003004203 Plan ID: 87416WI006000203	$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

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

On-Exchange No Cost Share - Silver Plans

Adult Vision Exam benefits are available for additional premium with these On-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 Silver $4200 NCS Plan ID: 87416WI003002302 Plan ID: 87416WI006001202	$0 / $0	$0 / $0	0%	$0	$0	$0	$0	$0	Not Applicable	$0	$0	$0	$0
CGHC Silver $4700 NCS Plan ID: 87416WI003004702 Plan ID: 87416WI006001102	$0 / $0	$0 / $0	0%	$0	$0	$0	$0	$0	Not Applicable	$0	$0	$0	$0
CGHC Silver Standard $5000 NCS Plan ID: 87416WI003004202 Plan ID: 87416WI006000202	$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 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

On-Exchange Cost Share Reduction 73% - Silver Plans

Adult Vision Exam benefits are available for additional premium with these On-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 Silver $4000 CSR 73% Plan ID: 87416WI003002304 Plan ID: 87416WI006001204	$4,000 / $8,000	$7,350 / $14,700	30%	$30	$45	$90	$250	D/C[3]	Not Applicable	$10	$80	D/C[3]	40% after Ded
CGHC Silver $4100 CSR 73% Plan ID: 87416WI003004704 Plan ID: 87416WI006001104	$4,100 / $8,200	$7,350 / $14,700	30%	$20	$30	$60	D/C[3]	D/C[3]	Not Applicable	$10	$80	D/C[3]	40% after Ded
CGHC Silver Standard $3000 CSR 73% Plan ID: 87416WI003004204 Plan ID: 87416WI006000204	$3,000 / $6,000	$6,400 / $12,800	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 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

On-Exchange Cost Share Reduction 87% - Silver Plans

Adult Vision Exam benefits are available for additional premium with these On-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 Silver $700 CSR 87% ($20 PCP Copay) Plan ID: 87416WI003004705 Plan ID: 87416WI006001105	$700 / $1,400	$3,050 / $6,100	25%	$10	$20	$40	D/C[3]	D/C[3]	Not Applicable	$5	$50	D/C[3]	40% after Ded
CGHC Silver $700 CSR 87% Plan ID: 87416WI003002305 Plan ID: 87416WI006001205	$700 / $1,400	$3,050 / $6,100	25%	$15	$25	$50	$150	D/C[3]	Not Applicable	$5	$50	D/C[3]	40% after Ded
CGHC Silver Standard $500 CSR 87% Plan ID: 87416WI003004205 Plan ID: 87416WI006000205	$500 / $1,000	$3,000 / $6,000	30%	$10	$20	$40	D/C[3]	$30	Not Applicable	$10	$20	$60 after Ded	$250 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

On-Exchange Cost Share Reduction 94% - Silver Plans

Adult Vision Exam benefits are available for additional premium with these On-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 Silver Standard $0 CSR 94% Plan ID: 87416WI003004206 Plan ID: 87416WI006000206	$0 / $0	$2,000 / $4,000	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 Plan ID: 87416WI006001106	$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 Plan ID: 87416WI006001206	$0 / $0	$3,050 / $6,100	15%	$0	$5	$20	$55	D/C[3]	Not Applicable	$0	$20	D/C[3]	40% 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

On-Exchange Bronze & Catastrophic Plans

Adult Vision Exam benefits are available for additional premium with these On-Exchange Bronze plans. 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 Bronze $0 Ded / $2250 Rx Ded Plan ID: 87416WI003000301 Plan ID: 87416WI006002301	$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: 87416WI003004101 Plan ID: 87416WI006000301	$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 Bronze $9200 ($40 PCP Copay) Plan ID: 87416WI003002701 Plan ID: 87416WI006001501	$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: 87416WI003002601	$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 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

On-Exchange Limited
Cost Share - Bronze Plans

Adult Vision Exam benefits are available for additional premium with these On-Exchange Bronze 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 LCS Plan ID: 87416WI003000303 Plan ID: 87416WI006002303	$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 LCS Plan ID: 87416WI003004103 Plan ID: 87416WI006000303	$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 Bronze $9200 LCS ($40 PCP Copay) Plan ID: 87416WI003002703 Plan ID: 87416WI006001503	$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]

All plans offer preventive health benefits for $0. 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

On-Exchange No Cost Share - Bronze Plans

Adult Vision Exam benefits are available for additional premium with these On-Exchange Bronze 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 NCS Plan ID: 87416WI003000302 Plan ID: 87416WI006002302	$0 / $0	$0 / $0	0%	$0	$0	$0	$0	$0	Not Applicable	$0	$0	$0	$0
CGHC Bronze Standard $7500 NCS Plan ID: 87416WI003004102 Plan ID: 87416WI006000302	$0 / $0	$0 / $0	0%	$0	$0	$0	$0	$0	Not Applicable	$0	$0	$0	$0
CGHC Bronze $9200 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 Tealdoc 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.

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