WPS HEALTH PLAN

Small Group HMO Plan Summary

Health Maintenance Organization (HMO) Plans		You Pay[3]											Drug Plan
Metal Tier	SBC Lookup[1]	Individual Deductible[2]	Coinsurance	Individual Annual Max Out of Pocket[2]	Emergency Room	Teladoc Visit	Retail Clinic Visit	PCP Visit	Specialty Visit	Outpatient Lab/X-ray	Outpatient Surgery	Hospital	
Platinum	84670WI1330101-00	$500	20%	$2,750	$450	$0	$10	$35	$70	20% after deductible			Plan 1
Gold	84670WI1330102-00	$1,000	20%	$6,650	$450	$0	$10	$35	$70	20% after deductible			Plan 1
Gold	84670WI1330104-00	$1,500	10%	$7,400	$450	$0	$10	$35	$70	10% after deductible			Plan 1
Gold	84670WI1330125-00	$2,000	20%	$7,900	$450	$0	$10	$35	$70	20% after deductible			Plan 1
Gold	84670WI1330126-00	$2,500	20%	$4,500	$450	$0	$10	$35	$70	20% after deductible			Plan 1
Silver	84670WI1330106-00	$3,200	20%	$8,550	$500	$0	$10	$45	$90	20% after deductible			Plan 2
Silver	84670WI1330107-00	$4,000	10%	$8,550	$500	$0	$10	$45	$90	10% after deductible			Plan 2
Silver	84670WI1330128-00	$4,500	20%	$7,000	$500	$0	$10	$45	$90	20% after deductible			Plan 2
Silver	84670WI1330136-00	$5,500	20%	$8,550	$500	$0	$10	$45	$90	20% after deductible			Plan 2
Silver	84670WI1330135-00	$6,250	0%	$6,250	$500	$0	$10	$45	$90	No charge after deductible			Plan 2
Silver	84670WI1330137-00	$6,500	30%	$8,550	$500	$0	$10	$45	$90	30% after deductible			Plan 2

Drug Plan 1: Preventive and Preferred Generics: $0; Non-Preferred Generics: $15; Preferred Brand: $40; Non-Preferred Brand: $70; Specialty Drugs: 30% coinsurance
Drug Plan 2: Preventive and Preferred Generics: $0; Non-Preferred Generics: $25; Preferred Brand: $60; Non-Preferred Brand: $100; Specialty Drugs: $750 deductible, then 40% coinsurance

Preventive drugs include specific supplements, contraceptives, immunizations, and other preventive drugs ranked A or B by the U.S. Preventive Services Task Force.

[1]wpshealth.com/resources/sbc

[2]Family deductibles and out-of-pocket limits are 2x the individual amounts.

[3]Out-of-network services are not covered under HMO plan options, except in emergency situations. See policy for details.

Unless otherwise noted, plans have an Embedded Deductible and Embedded Out-of-Pocket Limit: These plans feature an embedded deductible where an individual deductible must be satisfied before this plan will pay benefits for that individual. These plans feature an embedded out-of-pocket limit where the individual out-of-pocket limit must be satisfied before this plan will pay 100% of covered benefits for that individual. Deductibles and out-of-pocket maximums apply annually.

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Small Group HMO Plan Summary

Health Maintenance Organization (HMO) HSA-Qualified High-Deductible Health Plans		You Pay[3]											Drug Plan
Metal Tier	SBC Lookup[1]	Individual Deductible[2]	Coinsurance	Individual Annual Max Out of Pocket[2]	Emergency Room	Teladoc Visit	Retail Clinic Visit	PCP Visit	Specialty Visit	Outpatient Lab/X-ray	Outpatient Surgery	Hospital	
Gold[4]	84670WI1330114-00	$2,500	0%	$2,500	No charge after deductible								Plan 3
Gold	84670WI1330138-00	$3,000	0%	$3,000	No charge after deductible								Plan 3
Silver[5]	84670WI1330115-00	$1,850	30%	$7,000	30% after deductible								Plan 3
Silver[5]	84670WI1330116-00	$2,500	30%	$7,000	30% after deductible								Plan 3
Silver	84670WI1330117-00	$2,800	20%	$7,000	20% after deductible								Plan 3
Silver	84670WI1330139-00	$3,500	20%	$4,500	20% after deductible								Plan 3
Silver	84670WI1330120-00	$4,250	0%	$4,250	No charge after deductible								Plan 3
Silver	84670WI1330140-00	$5,000	0%	$5,000	No charge after deductible								Plan 3
Bronze	84670WI1330122-00	$6,000	30%	$7,000	30% after deductible								Plan 3
Bronze	84670WI1330123-00	$7,000	0%	$7,000	No charge after deductible								Plan 3
Drug Plan 3: Preventive: $0; All others: deductible and coinsurance													

Preventive drugs include specific supplements, contraceptives, immunizations, and other preventive drugs ranked A or B by the U.S. Preventive Services Task Force.

[1]wpshealth.com/resources/sbc

[2]Family deductibles and out-of-pocket limits are 2x the individual amounts.

[3]Out-of-network services are not covered under HMO plan options, except in emergency situations. See policy for details.

[4]Non-Embedded Deductible and Out-of-Pocket Limit: This plan features a non-embedded deductible and out-of-pocket limit. If an employee has family coverage, the family deductible must be satisfied before this plan will pay benefits. One person can satisfy the family deductible. If an employee has family coverage, the family out-of-pocket limit must be satisfied before this plan will pay 100% of covered benefits. One person can satisfy the family out-of-pocket limit. Deductibles and out-of-pocket maximums apply annually.

[5]Non-Embedded Deductible and Embedded Out-of-Pocket Limit: This plan features a non-embedded deductible. If an employee has family coverage, the family deductible must be satisfied before this plan will pay benefits. One person can satisfy the family deductible. This plan features an embedded out-of-pocket limit. The individual out-of-pocket limit must be satisfied before this plan will pay 100% of covered benefits for that individual. Deductibles and out-of-pocket maximums apply annually.

Unless otherwise noted, plans have an Embedded Deductible and Embedded Out-of-Pocket Limit: These plans feature an embedded deductible where an individual deductible must be satisfied before this plan will pay benefits for that individual. These plans feature an embedded out-of-pocket limit where the individual out-of-pocket limit must be satisfied before this plan will pay 100% of covered benefits, for that individual. Deductibles and out-of-pocket maximums apply annually.

WPS® HEALTH PLAN

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Small Group POS Plan Summary

Point-of-Service (POS) Plans		You Pay														Drug Plan
Metal Tier	SBC Lookup[1]	Individual Deductible[2]		Coinsurance		Individual Annual Max Out of Pocket[2]		At Participating Providers[3]								
		In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	Emergency Room	Teladoc Visit	Retail Clinic Visit	PCP Visit	Specialty Visit	Outpatient Lab/X-ray	Outpatient Surgery	Hospital	
Platinum	84670WI1350101-00	$500	$1,000	20%	50%	$2,750	$11,000	$450	$0	$10	$35	$70	20% after deductible			Plan 1
Gold	84670WI1350102-00	$1,000	$2,000	20%	50%	$6,650	$12,000	$450	$0	$10	$35	$70	20% after deductible			Plan 1
Gold	84670WI1350104-00	$1,500	$3,000	10%	40%	$7,400	$11,000	$450	$0	$10	$35	$70	10% after deductible			Plan 1
Gold	84670WI1350125-00	$2,000	$4,000	20%	50%	$7,900	$14,000	$450	$0	$10	$35	$70	20% after deductible			Plan 1
Gold	84670WI1350126-00	$2,500	$5,000	20%	50%	$4,500	$15,000	$450	$0	$10	$35	$70	20% after deductible			Plan 1
Silver	84670WI1350106-00	$3,200	$6,400	20%	50%	$8,550	$16,400	$500	$0	$10	$45	$90	20% after deductible			Plan 2
Silver	84670WI1350107-00	$4,000	$8,000	10%	40%	$8,550	$16,000	$500	$0	$10	$45	$90	10% after deductible			Plan 2
Silver	84670WI1350128-00	$4,500	$9,000	20%	50%	$7,000	$19,000	$500	$0	$10	$45	$90	20% after deductible			Plan 2
Silver	84670WI1350136-00	$5,500	$11,000	20%	50%	$8,550	$21,000	$500	$0	$10	$45	$90	20% after deductible			Plan 2
Silver	84670WI1350135-00	$6,250	$12,500	0%	30%	$6,250	$18,500	$500	$0	$10	$45	$90	No charge after deductible			Plan 2
Silver	84670WI1350137-00	$6,500	$13,000	30%	50%	$8,550	$23,000	$500	$0	$10	$45	$90	30% after deductible			Plan 2

Drug Plan 1: Preventive and Preferred Generics: $0; Non-Preferred Generics: $15; Preferred Brand: $40; Non-Preferred Brand: $70; Specialty Drugs: 30% coinsurance
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[3]Services performed out of network under the POS plan options are subject to the out-of-network deductible and coinsurance, except some emergency services. See policy for details.

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Silver	84670WI1350117-00	$2,800	$5,600	20%	50%	$7,000	$15,600	20% after deductible								Plan 3
Silver	84670WI1350139-00	$3,500	$7,000	20%	50%	$4,500	$17,000	20% after deductible								Plan 3
Silver	84670WI1350120-00	$4,250	$8,500	0%	30%	$4,250	$14,500	No charge after deductible								Plan 3
Silver	84670WI1350140-00	$5,000	$10,000	0%	30%	$5,000	$16,000	No charge after deductible								Plan 3
Bronze	84670WI1350122-00	$6,000	$12,000	30%	50%	$7,000	$22,000	30% after deductible								Plan 3
Bronze	84670WI1350123-00	$7,000	$14,000	0%	30%	$7,000	$20,000	No charge after deductible								Plan 3

Drug Plan 3: Preventive: $0; All others: deductible and coinsurance

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30034-085-2007