

WPS HEALTH INSURANCE | 2021 Small Group Plan Summary

Preferred Provider Organization (PPO) Plans		You Pay														Drug Plan
Metal Tier	SBC Lookup ¹	Individual Deductible ²		Coinsurance		Individual Annual Max Out of Pocket ²		At Preferred 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	81974WI1930002-00	\$500	\$1,000	20%	50%	\$2,750	\$11,000	\$450	\$0	\$10	\$35	\$70	20% after deductible ⁴			Plan 1
Gold	81974WI1930009-00	\$1,000	\$2,000	20%	50%	\$6,650	\$12,000	\$450	\$0	\$10	\$35	\$70	20% after deductible ⁴			Plan 1
Gold	81974WI1930040-00	\$1,500	\$3,000	10%	40%	\$7,400	\$11,000	\$450	\$0	\$10	\$35	\$70	10% after deductible ⁴			Plan 1
Gold	81974WI1930041-00	\$2,000	\$4,000	20%	50%	\$7,900	\$14,000	\$450	\$0	\$10	\$35	\$70	20% after deductible ⁴			Plan 1
Gold	81974WI1930042-00	\$2,500	\$5,000	20%	50%	\$4,500	\$15,000	\$450	\$0	\$10	\$35	\$70	20% after deductible ⁴			Plan 1
Silver	81974WI1930033-00	\$3,200	\$6,400	20%	50%	\$8,550	\$16,400	\$500	\$0	\$10	\$45	\$90	20% after deductible ⁴			Plan 2
Silver	81974WI1930032-00	\$4,000	\$8,000	10%	40%	\$8,550	\$16,000	\$500	\$0	\$10	\$45	\$90	10% after deductible ⁴			Plan 2
Silver	81974WI1930044-00	\$4,500	\$9,000	20%	50%	\$7,000	\$19,000	\$500	\$0	\$10	\$45	\$90	20% after deductible ⁴			Plan 2
Silver	81974WI1930047-00	\$5,500	\$11,000	20%	50%	\$8,550	\$21,000	\$500	\$0	\$10	\$45	\$90	20% after deductible ⁴			Plan 2
Silver	81974WI1930046-00	\$6,250	\$12,500	0%	30%	\$6,250	\$18,500	\$500	\$0	\$10	\$45	\$90	No charge after deductible			Plan 2
Silver	81974WI1930048-00	\$6,500	\$13,000	30%	50%	\$8,550	\$23,000	\$500	\$0	\$10	\$45	\$90	30% after deductible ⁴			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 care services include routine exams, screenings, immunizations, and other services ranked A or B by the U.S. Preventive Services Task Force. Preventive drugs include specific supplements, contraceptives, immunizations, and other preventive drugs ranked A or B by the U.S. Preventive Services Task Force.

¹wpshealth.com/resources/sbc

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

³Preferred providers are in this plan's network. All other providers are out of network. Services performed out of network are subject to the out-of-network deductible and coinsurance, except some emergency services. See policy for details.

⁴Until maximum out-of-pocket limit is met.

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Preferred Provider Organization (PPO) High-Deductible Health Plans		You Pay														Drug Plan
Metal Tier	SBC Lookup ¹	Individual Deductible ²		Coinsurance		Individual Annual Max Out of Pocket ²		At Preferred 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	
Gold ⁴	81974WI1930022-00	\$2,500	\$5,000	0%	30%	\$2,500	\$11,000	No charge after deductible								Plan 3
Gold	81974WI1930049-00	\$3,000	\$6,000	0%	30%	\$3,000	\$12,000	No charge after deductible								Plan 3
Silver ⁵	81974WI1930025-00	\$1,850	\$3,700	30%	50%	\$7,000	\$13,700	30% after deductible ⁶								Plan 3
Silver ⁵	81974WI1930023-00	\$2,500	\$5,000	30%	50%	\$7,000	\$15,000	30% after deductible ⁶								Plan 3
Silver	81974WI1930035-00	\$2,800	\$5,600	20%	50%	\$7,000	\$15,600	20% after deductible ⁶								Plan 3
Silver	81974WI1930050-00	\$3,500	\$7,000	20%	50%	\$4,500	\$17,000	20% after deductible ⁶								Plan 3
Silver	81974WI1930037-00	\$4,250	\$8,500	0%	30%	\$4,250	\$14,500	No charge after deductible								Plan 3
Silver	81974WI1930051-00	\$5,000	\$10,000	0%	30%	\$5,000	\$16,000	No charge after deductible								Plan 3
Bronze	81974WI1930027-00	\$6,000	\$12,000	30%	50%	\$7,000	\$22,000	30% after deductible ⁶								Plan 3
Bronze	81974WI1930026-00	\$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

Preventive care services include routine exams, screenings, immunizations, and other services ranked A or B by the U.S. Preventive Services Task Force.

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

¹wpshealth.com/resources/sbc

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

³Preferred providers are in this plan's network. All other providers are out of network. Services performed out of network are subject to the out-of-network deductible and coinsurance, except some emergency services. See policy for details.

⁴Non-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.

⁵Non-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.

⁶Until maximum out-of-pocket limit is met.

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.

