WPS HEALTH INSURANCE | 2025 Small Group Plan Summary

Preferred Provider Organization (PPO) Plans		You Pay														
Metal Tier	SBC Lookup[1]	Individual Deductible[2]		Coinsurance		Individual Annual Max Out of Pocket[2]		At Preferred Providers[3]								Drug Plan
		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%	$1,700	$11,000	$500	$0	$10	$35	$70	20% after deductible[4]			Plan 1
Gold	81974WI1930009-00	$1,000	$2,000	20%	50%	$7,350	$12,000	$500	$0	$10	$35	$70	20% after deductible[4]			Plan 1
Gold	81974WI1930040-00	$1,500	$3,000	10%	50%	$6,750	$13,000	$500	$0	$10	$35	$70	10% after deductible[4]			Plan 1
Gold	81974WI1930041-00	$2,000	$4,000	20%	50%	$5,950	$14,000	$500	$0	$10	$35	$70	20% after deductible[4]			Plan 1
Gold	81974WI1930042-00	$2,500	$5,000	20%	50%	$5,800	$15,000	$500	$0	$10	$35	$70	20% after deductible[4]			Plan 1
Silver	81974WI1930033-00	$5,000	$10,000	25%	50%	$9,200	$20,000	$750	$0	$10	$50	$100	25% after deductible[4]			Plan 2
Silver	81974WI1930047-00	$5,500	$11,000	25%	50%	$9,200	$21,000	$750	$0	$10	$50	$100	25% after deductible[4]			Plan 2
Silver	81974WI1930032-00	$5,700	$11,400	15%	50%	$9,200	$21,400	$750	$0	$10	$50	$100	15% after deductible[4]			Plan 2
Silver	81974WI1930044-00	$6,000	$12,000	25%	50%	$9,000	$22,000	$750	$0	$10	$50	$100	25% after deductible[4]			Plan 2
Silver	81974WI1930048-00	$6,500	$13,000	35%	50%	$9,200	$23,000	$750	$0	$10	$50	$100	35% after deductible[4]			Plan 2
Silver	81974WI1930046-00	$9,000	$18,000	0%	30%	$9,000	$24,000	$750	$0	$10	$50	$100	No charge after deductible			Plan 2

Drug Plan 1: Preventive: $0; Preferred Generics: $10; Non-Preferred Generics: $25; Preferred Brand: $50; Non-Preferred Brand: $90; Specialty Drugs: Plan deductible and coinsurance
Drug Plan 2: Preventive: $0; Preferred Generics: $20; Non-Preferred Generics: $40; Preferred Brand: $80; Non-Preferred Brand: $125; Specialty Drugs: Plan 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.

[1]wpshealth.com/resources/sbc

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

[3]Preferred 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 for limited situations such as emergency services and other select services. See policy for details.

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

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Preferred Provider Organization (PPO) High-Deductible Health Plans		You Pay														
Metal Tier	SBC Lookup[1]	Individual Deductible[2]		Coinsurance		Individual Annual Max Out of Pocket[2]		At Preferred Providers[3]								Drug Plan
		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	$3,000	$6,000	0%	30%	$3,000	$12,000	No charge after deductible								Plan 1
Gold	81974WI1930049-00	$3,750	$7,500	0%	30%	$3,750	$13,500	No charge after deductible								Plan 1
Silver[5]	81974WI1930023-00	$2,500	$5,000	30%	50%	$8,000	$15,000	30% after deductible[6]								Plan 1
Silver	81974WI1930035-00	$3,300	$6,600	20%	50%	$8,300	$16,600	20% after deductible[6]								Plan 1
Silver	81974WI1930050-00	$3,500	$7,000	20%	50%	$8,300	$17,000	20% after deductible[6]								Plan 1
Silver	81974WI1930025-00	$4,000	$8,000	30%	50%	$7,500	$18,000	30% after deductible[6]								Plan 1
Silver	81974WI1930037-00	$5,100	$10,200	0%	30%	$5,100	$16,200	No charge after deductible								Plan 1
Silver	81974WI1930051-00	$6,000	$12,000	0%	30%	$6,000	$18,000	No charge after deductible								Plan 1
Ex. Bronze	81974WI1930027-00	$6,500	$13,000	30%	50%	$8,300	$23,000	30% after deductible[6]								Plan 1
Bronze	81974WI1930026-00	$8,300	$16,600	0%	30%	$8,300	$22,600	No charge after deductible								Plan 1
Drug Plan 1: 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.

[1]wpshealth.com/resources/sbc

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

[3]Preferred 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 for limited situations such as emergency services and other select services. 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.

[6]Until 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.

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