

## 2023 Sun Prairie Area School District - Dean Health Insurance Plan Comparison

| Benefit Description  | Traditional HMO<br>In-Network Benefit                            | Alternative HMO<br>In-Network Benefit   | High Deductible HMO<br>In-Network Benefit                                       |
|--|--|---|---|
| <b>Medical Deductible</b>  |  |   |   |
| Single   | \$200  | \$0   | \$3,000   |
| Family   | \$400  | \$0   | \$6,000   |
| <b>Deductible / Coinsurance Limit</b><br>(does not include any medical or Rx copays) |  | N/A - No Deductibles on this plan. All copays count towards the Max Out of Pocket |   |
| Single   | \$400  |   | \$3,000   |
| Family   | \$800  |   | \$6,000   |
| <b>Max. out of Pocket</b> (includes any Ded, Coins, Med and Rx Copays)               |  |   | Deductible / Coinsurance Limit is the Max Out of Pocket. No copays on this plan |
| Single   | \$7,150  | \$3,000   |   |
| Family   | \$14,300   | \$6,000   |   |
| <b>Office Visits</b>   |  |   |   |
| Office Visit   | \$30 Copay   | \$20 Copay  | 0% coinsurance after deductible   |
| Specialist Visit   | \$30 Copay   | \$40 Copay  | 0% coinsurance after deductible   |
| Chiropractic   | \$30 Copay   | \$40 Copay  | 0% coinsurance after deductible   |
| Routine Vision Exam  | \$30 Copay   | \$20 Copay  | 0% coinsurance after deductible   |
| Acupuncture  | \$30 Copay   | \$20 Copay  | 0% coinsurance after deductible   |
| <b>Urgent Care</b>   |  |   |   |
| Facility Charge  | \$30 Copay   | \$80 Copay  | 0% coinsurance after deductible   |
| Physicians Charges and Related Services  | 20% coinsurance after deductible to deductible/coinsurance limit | 0% coinsurance after deductible   | 0% coinsurance after deductible   |
| <b>Emergency Room</b>  |  |   |   |
| Facility Charge  | \$250 Copay  | \$150 Copay   | 0% coinsurance after deductible   |
| Physicians Charges and Related Services  | 20% coinsurance after deductible to deductible/coinsurance limit | 0% coinsurance after deductible   | 0% coinsurance after deductible   |
| <b>Inpatient</b>   |  |   |   |
| Hospital Facility Charge   | 20% coinsurance after deductible to deductible/coinsurance limit | \$1,000 per day up to the annual Max. out of Pocket                               | 0% coinsurance after deductible   |
| <b>Prescription Drugs</b>  |  |   |   |
| Tier 1   | \$10 Copay   | \$10 Copay  | 0% coinsurance after deductible   |
| Tier 2   | \$25 Copay   | \$35 Copay  | 0% coinsurance after deductible   |
| Tier 3   | \$50 Copay   | \$60 Copay  | 0% coinsurance after deductible   |
| Tier 4   | \$50 Copay   | \$100 Copay   | 0% coinsurance after deductible   |
| <b>Durable Medical Equipment</b>   | 20% coinsurance after deductible to deductible/coinsurance limit | \$0 Copay   | 0% coinsurance after deductible   |
| <b>Diagnostic Services</b>   |  |   |   |
| X-Rays and Readings  | 20% coinsurance after deductible to deductible/coinsurance limit | \$0 Copay   | 0% coinsurance after deductible   |
| Laboratory Services and Readings   | 20% coinsurance after deductible to deductible/coinsurance limit | \$0 Copay   | 0% coinsurance after deductible   |
| MRI/MRA  | 20% coinsurance after deductible to deductible/coinsurance limit | \$240 Copay   | 0% coinsurance after deductible   |
| CT Scan  | 20% coinsurance after deductible to deductible/coinsurance limit | \$240 Copay   | 0% coinsurance after deductible   |
| PET Scan   | 20% coinsurance after deductible to deductible/coinsurance limit | \$240 Copay   | 0% coinsurance after deductible   |
| <b>Therapies and Rehabilitation</b>  |  |   |   |
| Autism   | \$30 copay per therapy type per day                              | \$40 copay per therapy type per day   | 0% coinsurance after deductible   |
| PT/OT/ST   | \$30 copay per therapy type per day                              | \$40 copay per therapy type per day   | 0% coinsurance after deductible   |
| Habilitative Services  | \$30 copay per therapy type per day                              | \$40 copay per therapy type per day   | 0% coinsurance after deductible   |
| <b>Behavioral Health</b>   |  |   |   |
| Inpatient  | 20% coinsurance after deductible to deductible/coinsurance limit | \$1,000 per day up to the annual Max. out of Pocket                               | 0% coinsurance after deductible   |
| Outpatient   | \$30 Copay   | \$20 Copay  | 0% coinsurance after deductible   |