2024 Sun Prairie Area School District - Dean Health Insurance Plan Comparison			
Benefit Description	**Traditional HMO In-Network Benefit**	**Alternative HMO In-Network Benefit**	**High Deductible HMO In-Network Benefit**
Medical Deductible			
Single	$750	$0	$3,000
Family	$1,500	$0	$6,000
Deductible / Coinsurance Limit (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	$1,500		$3,000
Family	$3,000		$6,000
Max. out of Pocket (includes any Ded, Coins, Med and Rx Copays)			Deductible / Coinsurance Limit is the Max Out of Pocket. No copays on this plan
Single	$3,000	$3,000	
Family	$6,000	$6,000	
Office Visits			
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
Urgent Care			
Facility Charge	$30 Copay	$20 Copay	0% coinsurance after deductible
Physicians Charges and Related Services	20% coinsurance after deductible to deductible/coinsurance limit	0% coinsurance after max out of pocket	0% coinsurance after deductible
Emergency Room			
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 max out of pocket	0% coinsurance after deductible
Inpatient			
Hospital Faciliy 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
Prescription Drugs			
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	30% coinsurance	$100 Copay	0% coinsurance after deductible
Durable Medical Equipment	20% coinsurance after deductible to deductible/coinsurance limit	$0 Copay	0% coinsurance after deductible
Diagnostic Services			
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
Therapies and Rehabilitation			
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
Behavioral Health			
Inpatient	Covered at 100%	$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