2024 Sun Prairie Area School District - Dean Health Insurance Plan Comparison			
	Traditional HMO	Alternative HMO	High Deductible HMO
Benefit Description	In-Network Benefit	In-Network Benefit	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	
Single	\$1,500	copays count towards the Max Out of	\$3,000
Family	\$3,000	Pocket	\$6,000
Max. out of Pocket (includes any			
Ded, Coins, Med and Rx Copays)			Dodustible / Coincurance Limit is the
Single	\$3,000	\$3,000	Deductible / Coinsurance Limit is the
Family	\$6,000	\$6,000	Max Out of Pocket. No copays on this plan
Office Visits	\$0,000	\$0,000	pian
Office Visits	\$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		\$40 Copay \$20 Copay	0% coinsurance after deductible
	\$30 Copay		
Acupuncture	\$30 Copay	\$20 Copay	0% coinsurance after deductible
Urgent Care	420.0	420.0	00/ : 5: 1 1 ::11
Facility Charge Physicians Charges and Related	\$30 Copay 20% coinsurance after deductible to	\$20 Copay 0% coinsurance after max out of	0% coinsurance after deductible
Services	deductible/coinsurance limit	pocket	0% coinsurance after deductible
Emergency Room	deddetible/comsdrance innic	pocket	0% comsurance after deductible
	\$3E0 Conny	\$1E0 Coppy	0% coinsurance after deductible
Facility Charge Physicians Charges and Related	\$250 Copay 20% coinsurance after deductible to	\$150 Copay 0% coinsurance after max out of	0% comsurance after deductible
Services	deductible/coinsurance limit	pocket	0% coinsurance after deductible
Inpatient	•	·	
	20% coinsurance after deductible to	\$1,000 per day up to the annual Max.	
Hospital Faciliy Charge	deductible/coinsurance limit	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
	20% coinsurance after deductible to		
Durable Medical Equipment	deductible/coinsurance limit	\$0 Copay	0% coinsurance after deductible
Diagnostic Services			
	20% coinsurance after deductible to		
X-Rays and Readings	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
Laboratory Services and Readings	20% coinsurance after deductible to	30 сорау	0% comsurance after deductible
MRI/MRA	deductible/coinsurance limit	\$240 Copay	0% coinsurance after deductible
,	20% coinsurance after deductible to	φ2.0 σοραγ	o/s comparance area academone
CT Scan	deductible/coinsurance limit	\$240 Copay	0% coinsurance after deductible
DET C	20% coinsurance after deductible to	6340 Camari	OO/ coincurate after the destable
PET Scan	deductible/coinsurance limit	\$240 Copay	0% coinsurance after deductible
Therapies and Rehabilitation	420	A40	201
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		\$1,000 per day up to the applied Man	
lanationt	Covered at 100%	\$1,000 per day up to the annual Max. out of Pocket	0% coinsurance after deductible
Inpatient Outpatient	\$30 Copay	\$20 Copay	0% coinsurance after deductible
Outpatient	230 Copay	220 Copay	070 comsurance after deductible