

SCHOOL DISTRICT OF WISCONSIN DELLS

Effective Date: 07/01/2021

Product Type: HMO
Plan Code: HMO05557/PHA02613

	Effective Date: 07/01/2021	Plan Code: HMO05557/PHA02613
Plan Overview	Plan Providers - You Pay	Non-Plan Providers - You Pay
Deductible	\$1,000 single / 2000 family	Not Covered
Coinsurance	0% coinsurance after deductible	Not Covered
Office Visit Charge (Primary/Specialist)	\$0 copay	Not Covered
Office Visit and Related Services	0% coinsurance after deductible	Not Covered
Preventive Services	\$0 copay	Not Covered
Deductible and Coinsurance Limit	\$1,000 single / \$2,000 family	Not Covered
Maximum Out-of-Pocket (Deductible and Coinsurance Limit plus Medical and Prescription Copays unless otherwise noted)	\$2,000 single / \$4,000 family	Not Covered
Prescription Drugs, Insulin & Disposable Diabetic Supplies	Unless otherwise indicated, generic or brand name drugs can be found in any formulary tier)	
Tier 1	\$10 copay	Not Covered
Tier 2	\$25 copay	Not Covered
Tier 3	\$50 copay	Not Covered
Tier 4	Not Covered	Not Covered
Diagnostic Services		
Diagnostic Services (Xrays/Labs)	0% coinsurance after deductible / 0% coinsurance after deductible	Not Covered / Not Covered
CAT Scans/MRI/MRA	0% coinsurance after deductible	Not Covered
Hospital & Surgical Center	THE STREET STREET	
Inpatient Hospital	0% coinsurance after deductible	Not Covered
Outpatient Hospital	0% coinsurance after deductible	Not Covered
Emergency Services		
Urgent Care	\$0 copay and/or 0%coinsurance after deductible	\$0 copay and/or 0%coinsurance after in- network deductible
Emergency Room Services (Copay is waived if admitted)	\$150 copay and/or 0%coinsurance after deductible	\$150 copay and/or 0%coinsurance after in- network deductible
Ambulance	0% coinsurance after deductible	0% coinsurance after deductible
Other Services	被告诉的信息的	
Mental Health Inpatient	0% coinsurance after deductible	Not Covered
Mental Health Day Treatment Programs	0% coinsurance after deductible	Not Covered
Mental Health Outpatient	\$0 copay	Not Covered
Durable Medical Equipment	0% coinsurance after deductible	Not Covered
Physical, Speech & Occupational Therapy	\$0 copay per therapy type per day	Not Covered
Plan Special Features		

Product Type: POS



SCHOOL DISTRICT OF WISCONSIN DELLS

Effective Date: 07/01/2021 Plan Code: POS04323/PHA02614

	Effective Date: 07/01/2021	Plan Code: POS04323/PHA02614
Plan Overview	Plan Providers - You Pay	Non-Plan Providers - You Pay
Deductible	\$1,000 single / 2000 family	\$2,000 single / \$4,000 family
Coinsurance	0% coinsurance after deductible	20% coinsurance after deductible
Office Visit Charge (Primary/Specialist)	\$0 copay	20% coinsurance after deductible
Office Visit and Related Services	0% coinsurance after deductible	20% coinsurance after deductible
Preventive Services	\$0 copay	20% coinsurance after deductible
Deductible and Coinsurance Limit	\$1,000 single / \$2,000 family	Not Applicable
Maximum Out-of-Pocket (Deductible and Coinsurance Limit plus Medical and Prescription Copays unless otherwise noted)	\$2,000 single / \$4,000 family	\$4,000 single / \$8,000 family
Prescription Drugs, Insulin & Disposable Diabetic Supplies	Unless otherwise indicated, generic or brand name drugs can be found in any formulary tier)	
Tier 1	\$10 copay	50% coinsurance
Tier 2	\$25 copay	50% coinsurance
Tier 3	\$50 copay	Not Covered
Tier 4	Not Covered	Not Covered
Diagnostic Services		
Diagnostic Services (Xrays/Labs)	0% coinsurance after deductible / 0% coinsurance after deductible	20% coinsurance after deductible / 20% coinsurance after deductible
CAT Scans/MRI/MRA	0% coinsurance after deductible	20% coinsurance after deductible
Hospital & Surgical Center		
Inpatient Hospital	0% coinsurance after deductible	20% coinsurance after deductible
Outpatient Hospital	0% coinsurance after deductible	20% coinsurance after deductible
Emergency Services		
Urgent Care	\$0 copay and/or 0% coinsurance after deductible	\$0 copay and/or 0% coinsurance after in- network deductible
Emergency Room Services (Copay is waived if admitted)	\$150 copay and/or 0% coinsurance after deductible	\$150 copay and/or 0% coinsurance after in- network deductible
Ambulance	0% coinsurance after deductible	0% coinsurance after in-network deductible
Other Services		
Mental Health Inpatient	0% coinsurance after deductible	20% coinsurance after deductible
Mental Health Day Treatment Programs	0% coinsurance after deductible	20% coinsurance after deductible
Mental Health Outpatient	\$0 copay	20% coinsurance after deductible
Durable Medical Equipment	0% coinsurance after deductible	20% coinsurance after deductible
Physical, Speech & Occupational Therapy	\$0 copay per therapy type per day	20% coinsurance after deductible
Plan Special Features		

Product Type: PPO



SCHOOL DISTRICT OF WISCONSIN

DELLS

Effective Date: 07/01/2021 Plan Code: PPO03958/PHA02614

Maximum Out-of-Pocket (Deductible and Coinsurance Limit plus Medical and Prescription Copays unless otherwise noted) Prescription Drugs, Insulin & Disposable Diabetic Supplies Tier 1 \$10 copay \$25 copay \$50% coinsurance Tier 2 \$50 copay \$50% coinsurance Tier 3 \$50 copay \$50% coinsurance Tier 4 Not Covered 20% coinsurance after deductible 20% coinsurance after deductible 20% coinsurance after deductible Note Coinsurance after deductible Not		Elicotivo Bato. 0170 II EUE	
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Office Visit Charge (Primary/Specialist) Office Visit and Related Services Office Visit and Related Services Office Visit and Related Services 30 coppy 20% coinsurance after deductible 20% coinsurance after deductible 20% coinsurance after deductible S1,000 single / \$2,000 family Not Applicable Maximum Out-of-Pocket (Deductible and Coinsurance Limit plus Medical and Prescription Coppys unless otherwise noted) Prescription Drugs, Insulin & Disposable Diabetic Supplies Tier 1 \$10 coppy S2,000 single / \$4,000 family \$4,000 single / \$8,000 family \$4,000 single / \$8,000 family Prescription Drugs, Insulin & Disposable Diabetic Supplies Tier 2 \$10 coppy S0% coinsurance Tier 3 \$10 coppy Not Covered Not Cover	Deductible	\$1,000 single / 2000 family	\$2,000 single / \$4,000 family
Office Visit and Related Services 10 copsy 20% coinsurance after deductible 31.000 single / \$2,000 family Not Applicable Maximum Out-of-Pocket (Deductible and Coinsurance Limit plus Maximum Out-of-Pocket (Deductible and Coinsurance Limit plus Maximum Out-of-Pocket (Deductible and Coinsurance Limit plus 82,000 single / \$4,000 family \$4,000 single / \$6,000 family Prescription Drugs, Insulin & Disposable Diabetic Supplies Unleas otherwise indicated, generic or brand name drugs can be found in any formularly ter) Tier 1 \$10 copsy 50% coinsurance \$10 copsy 50% coinsurance Tier 2 \$25 copsy Not Covered Not Co	Coinsurance	0% coinsurance after deductible	20% coinsurance after deductible
Preventive Services \$0 copay 20% coinsurance after deductible Deductible and Coinsurance Limit \$1,000 single / \$2,000 family Maximum Out-of-Pocket (Deductible and Coinsurance Limit plus Medical and Prescription Copays unless otherwise noted) Prescription Drugs, Insulin & Disposable Diabetic Supplies Tier 1 \$10 copay \$50% coinsurance Tier 2 \$25 copay \$50% coinsurance Tier 3 \$50 copay Not Covered Not Cov	Office Visit Charge (Primary/Specialist)	\$0 copay	20% coinsurance after deductible
Deductible and Coinsurance Limit S1,000 single / \$2,000 family Maximum Out-of-Pocket (Deductible and Coinsurance Limit plus Medical and Prescription Copays unless otherwise noted) Prescription Drugs, Insulin & Disposable Diabetic Supplies Unless otherwise indicated, generic or brand name drugs can be found in any formulary tier) Tier 1 \$10 copay 50% coinsurance \$150 copay Not Covered	Office Visit and Related Services	0% coinsurance after deductible	20% coinsurance after deductible
Maximum Out-of-Pocket (Deductible and Coinsurance Limit plus Medical and Prescription Copays unless otherwise noted) Prescription Drugs, Insulin & Disposable Diabetic Supplies Tier 1 \$10 copay \$25 copay \$50% coinsurance Tier 2 \$50 copay \$50% coinsurance Tier 3 \$50 copay \$50% coinsurance Tier 4 Not Covered 20% coinsurance after deductible 20% coinsurance after deductible 20% coinsurance after deductible Note Coinsurance after deductible Not	Preventive Services	\$0 copay	20% coinsurance after deductible
Medical and Prescription Copays unless otherwise noted) Prescription Drugs, Insulin & Disposable Diabetic Supplies Tier 1 \$10 copay \$50% coinsurance Tier 2 \$50 copay \$50% coinsurance Tier 3 \$50 copay Not Covered Not	Deductible and Coinsurance Limit	\$1,000 single / \$2,000 family	Not Applicable
Tier 1 \$10 copay \$60% coinsurance Tier 2 \$25 copay \$60% coinsurance Tier 3 \$50 copay Not Covered Not Cover	Maximum Out-of-Pocket (Deductible and Coinsurance Limit plus Medical and Prescription Copays unless otherwise noted)	\$2,000 single / \$4,000 family	\$4,000 single / \$8,000 family
Tier 2 \$25 copay \$25 copay Not Covered N	Prescription Drugs, Insulin & Disposable Diabetic Supplies		
Tier 3 \$50 copay Not Covered Tier 4 Not Covered Not Cov	Tier 1	\$10 copay	50% coinsurance
Tier 4 Diagnostic Services Diagnostic Services Diagnostic Services (Xrays/Labs) Officinsurance after deductible / 0% coinsurance after deductible / 20% coinsurance after in-network deductible / 20% coinsurance after deductible	Tier 2	\$25 copay	50% coinsurance
Diagnostic Services Diagnostic Services (Xrays/Labs) Diagnostic Services (Xrays/Labs) Diagnostic Services (Xrays/Labs) Diagnostic Services (Xrays/Labs) O''' coinsurance after deductible O''' coinsurance after deductible D''' coinsurance after deductible	Tier 3	\$50 copay	Not Covered
Diagnostic Services (Xrays/Labs) 0% coinsurance after deductible / 0% coinsurance after deductible / 20% coinsurance after in-network deductible / 20% coinsurance after deductible / 2	Tier 4	Not Covered	Not Covered
coinsurance after deductible CAT Scans/MRI/MRA 0% coinsurance after deductible 20% coinsurance after deductible Hospital & Surgical Center Inpatient Hospital 0% coinsurance after deductible 20% coinsurance after deductible Emergency Services Urgent Care \$0 copay and/or 0% coinsurance after deductible \$150 copay and/or 0% coinsurance after innetwork deductible Emergency Room Services (Copay is waived if admitted) \$150 copay and/or 0% coinsurance after deductible \$150 copay and/or 0% coinsurance after innetwork deductible 0% coinsurance after deductible 0% coinsurance after deductible 20% coinsurance after deductible 20% coinsurance after deductible 20% coinsurance after deductible 20% coinsurance after deductible Durable Medical Equipment 0% coinsurance after deductible 20% coinsurance after deductible	Diagnostic Services		
Inpatient Hospital & Surgical Center Outpatient Hospital 0% coinsurance after deductible 20% coinsurance after deductible Emergency Services Urgent Care \$0 copay and/or 0% coinsurance after deductible \$150 copay and/or 0% coinsurance after deductible Emergency Room Services (Copay is waived if admitted) \$150 copay and/or 0% coinsurance after deductible \$150 copay and/or 0% coinsurance after deductible \$150 copay and/or 0% coinsurance after innetwork deductible Ambulance 0% coinsurance after deductible 0% coinsurance after innetwork deductible Other Services Mental Health Inpatient 0% coinsurance after deductible 20% coinsurance after deductible Mental Health Day Treatment Programs 0% coinsurance after deductible 20% coinsurance after deductible Mental Health Outpatient \$0 copay 20% coinsurance after deductible Durable Medical Equipment 0% coinsurance after deductible 20% coinsurance after deductible Physical, Speech & Occupational Therapy \$0 copay per therapy type per day 20% coinsurance after deductible	Diagnostic Services (Xrays/Labs)		
Inpatient Hospital 0% coinsurance after deductible 20% coinsurance after deductible Outpatient Hospital 0% coinsurance after deductible 20% coinsurance after deductible Emergency Services Urgent Care \$0 copay and/or 0% coinsurance after deductible \$0 copay and/or 0% coinsurance after in-network deductible Emergency Room Services (Copay is waived if admitted) \$150 copay and/or 0% coinsurance after in-network deductible Ambulance 0% coinsurance after deductible 0% coinsurance after in-network deductible Other Services Mental Health Inpatient 0% coinsurance after deductible 20% coinsurance after deductible Mental Health Day Treatment Programs 0% coinsurance after deductible 20% coinsurance after deductible Durable Medical Equipment 0% coinsurance after deductible 20% coinsurance after deductible Physical, Speech & Occupational Therapy \$0 copay per therapy type per day 20% coinsurance after deductible	CAT Scans/MRI/MRA	0% coinsurance after deductible	20% coinsurance after deductible
Outpatient Hospital O's coinsurance after deductible Emergency Services Urgent Care \$0 copay and/or 0% coinsurance after deductible \$150 copay and/or 0% coinsurance after innetwork deductible Emergency Room Services (Copay is waived if admitted) Ambulance O's coinsurance after deductible	Hospital & Surgical Center		
Urgent Care \$0 copay and/or 0% coinsurance after deductible \$150 copay and/or 0% coinsurance after innetwork deductible 0% coinsurance after deductible 0% coinsurance after innetwork deductible Other Services Mental Health Inpatient 0% coinsurance after deductible 20% coinsurance after deductible 20% coinsurance after deductible Mental Health Day Treatment Programs 0% coinsurance after deductible 20% coinsurance after deductible Durable Medical Equipment 0% coinsurance after deductible 20% coinsurance after deductible	Inpatient Hospital	0% coinsurance after deductible	20% coinsurance after deductible
Urgent Care \$0 copay and/or 0% coinsurance after deductible \$150 copay and/or 0% coinsurance after innetwork deductible 0% coinsurance after deductible 0% coinsurance after innetwork deductible Other Services Wental Health Inpatient 0% coinsurance after deductible 20% coinsurance after deductible Mental Health Day Treatment Programs 0% coinsurance after deductible 20% coinsurance after deductible Durable Medical Equipment 0% coinsurance after deductible 20% coinsurance after deductible	Outpatient Hospital	0% coinsurance after deductible	20% coinsurance after deductible
deductible network deductible Emergency Room Services (Copay is waived if admitted) \$150 copay and/or 0% coinsurance after deductible \$150 copay and/or 0% coinsurance after innetwork deductible 0% coinsurance after deductible 0% coinsurance after innetwork deductible Other Services Mental Health Inpatient 0% coinsurance after deductible 20% coinsurance after deductible Mental Health Day Treatment Programs 0% coinsurance after deductible 20% coinsurance after deductible Mental Health Outpatient \$0 copay 20% coinsurance after deductible Durable Medical Equipment 0% coinsurance after deductible 20% coinsurance after deductible	Emergency Services		
Ambulance 0% coinsurance after deductible 0% coinsurance after in-network deductible Other Services Mental Health Inpatient 0% coinsurance after deductible 20% coinsurance after deductible Mental Health Day Treatment Programs 0% coinsurance after deductible 20% coinsurance after deductible Mental Health Outpatient \$0 copay 20% coinsurance after deductible Durable Medical Equipment 0% coinsurance after deductible 20% coinsurance after deductible Physical, Speech & Occupational Therapy \$0 copay per therapy type per day 20% coinsurance after deductible	Urgent Care		
Mental Health Inpatient O% coinsurance after deductible	Emergency Room Services (Copay is waived if admitted)		\$150 copay and/or 0% coinsurance after in- network deductible
Mental Health Inpatient 0% coinsurance after deductible 20% coinsurance after deductible	Ambulance	0% coinsurance after deductible	0% coinsurance after in-network deductible
Mental Health Day Treatment Programs 0% coinsurance after deductible 20% coinsurance after deductible	Other Services	多是是这种种种的。	等是是否的证明是否对于
Mental Health Outpatient \$0 copay 20% coinsurance after deductible Durable Medical Equipment 0% coinsurance after deductible 20% coinsurance after deductible Physical, Speech & Occupational Therapy \$0 copay per therapy type per day 20% coinsurance after deductible	Mental Health Inpatient	0% coinsurance after deductible	20% coinsurance after deductible
Durable Medical Equipment 0% coinsurance after deductible 20% coinsurance after deductible Physical, Speech & Occupational Therapy \$0 copay per therapy type per day 20% coinsurance after deductible	Mental Health Day Treatment Programs	0% coinsurance after deductible	20% coinsurance after deductible
Physical, Speech & Occupational Therapy \$0 copay per therapy type per day 20% coinsurance after deductible	Mental Health Outpatient	\$0 copay	20% coinsurance after deductible
	Durable Medical Equipment	0% coinsurance after deductible	20% coinsurance after deductible
Plan Special Features	Physical, Speech & Occupational Therapy	\$0 copay per therapy type per day	20% coinsurance after deductible
	Plan Special Features		