

2010-11 Medical Benefits Comparison

Current Ferndale Plan compared to Most Similar to WEA Select Plans

BENEFITS	CURRENT PLAN Regence Engage 80	WEA Select Plan 2	WEA Select Plan 3
Copayments, Coinsurance, and Deductible Amounts Shown Represent the Amounts You Pay (Based on Allowable Charges)			
PROVIDER NETWORK	Regence Preferred / Participating / Non-Contracted	Heritage	Heritage
ANNUAL DEDUCTIBLE (An amount you pay before the plan pays benefits)	\$200 per person or \$600 per family per calendar year. Waived for office visits	\$100 per person or \$300 per family per calendar year. Waived for office visits and outpatient prescription drugs	\$200 per person or \$600 per family per calendar year. Waived for office visits and outpatient prescription drugs
COINSURANCE (portion you pay after deductible)	Preferred: 20% Participating: 20% Non-Contracted providers are subject to deductible and coinsurance	In-Network: 20% Out-of-Network: 40%	In-Network: 20% Out-of-Network: 40%
ANNUAL OUT OF POCKET EXPENSE LIMIT (After you reach this limit, the plan pays most benefits in full, unless otherwise specified)	Coinsurance maximum of: Individual: \$1,000 Family: \$2,000	A combined In and Out-of-Network coinsurance maximum: In-Network: \$1,375 Out-of-Network: \$3,667 (Deductible is not included in the annual out-of-pocket maximum.)	A combined In and Out-of-Network coinsurance maximum: In-Network: \$2,500 Out-of-Network: \$6,667 (Deductible is not included in the annual out-of-pocket maximum.)
PHYSICIAN OFFICE VISITS	Preferred: 20% after deductible Participating: 20% after deductible Acupuncture - 12 visit limit	Not subject to Deductible; In-Network: \$25 copayment Out-of-Network: \$30 copayment Acupuncture - 12 visit limit per calendar year	Not subject to Deductible; In-Network: \$30 copayment Out-of-Network: \$40 copayment Acupuncture - 12 visit limit per calendar year
PREVENTIVE CARE	Unlimited Benefit; Preferred: Paid in full, not subject to deductible Participating: Paid in full, not subject to deductible	Unlimited Benefit; In-Network: Paid in full, not subject to deductible Out-of-Network: 20% (A list of covered services is available online at www.premera.com/wea)	Unlimited Benefit; In-Network: Paid in full, not subject to deductible Out-of-Network: 20% (A list of covered services is available online at www.premera.com/wea)

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SPINAL MANIPULATIONS	After Deductible; Preferred: 20% Participating: 20% Limited to 12 visits per calendar year	Not subject to Deductible; In-Network: \$25 copayment Out-of-Network: \$30 copayment Unlimited visits	Not subject to Deductible; In-Network: \$30 copayment Out-of-Network: \$40 copayment Unlimited visits
LABORATORY / X-RAY SERVICES	Preferred: 20% after deductible. Deductible waived for a preventive mammogram and pap smear. Participating: 20% after deductible. Deductible waived for a preventive mammogram and pap smear.	After Deductible; In-Network: 20% Out-of-Network: 40%	After Deductible; In-Network: 20% Out-of-Network: 40%
EMERGENCY ROOM SERVICES (Copay waived if admitted directly from Emergency Room)	\$75 copayment per visit; Subject to deductible and coinsurance (preferred and participating)	\$75 copayment per visit; Subject to deductible and coinsurance	\$100 copayment per visit; Subject to deductible and coinsurance
HOSPITAL SERVICES: INPATIENT	After Deductible; Preferred: 20% Participating: 20%	After Deductible and Inpatient Copayment; In-Network: 20% Out-of-Network: 40% \$150 copayment per day to \$450 maximum per person per calendar year	After Deductible and Inpatient Copayment; In-Network: 20% Out-of-Network: 40% \$300 copayment per day to \$900 maximum per person per calendar year
OUTPATIENT SURGERY, AMBULATORY SURGERY CENTERS	After Deductible; Preferred: 20% Participating: 20%	After Deductible and Outpatient Surgery Copayment; In-Network: 20% Out-of-Network: 40% \$100 copayment	After Deductible and Outpatient Surgery Copayment; In-Network: 20% Out-of-Network: 40% \$150 copayment
MENTAL HEALTH CARE: INPATIENT (Unlimited Days)	After Deductible; Preferred: 20% Participating: 20%	After Deductible and Inpatient Copayment; In-Network: 20% Out-of-Network: 40%	After Deductible and Inpatient Copayment; In-Network: 20% Out-of-Network: 40%

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MENTAL HEALTH CARE: OUTPATIENT (Unlimited Visits)	After Deductible; Preferred: 20% Participating: 20%	Not subject to Deductible; In-Network: \$25 copayment Out-of-Network: \$30 copayment	Not subject to Deductible; In-Network: \$30 copayment Out-of-Network: \$40 copayment
PHYSICAL THERAPY	Unknown	Inpatient: See Rehabilitation Inpatient Benefit Outpatient: Deductible and Coinsurance - Unlimited Visits In-Network: 20% Out-of-Network: 40%	Inpatient: See Rehabilitation Inpatient Benefit Outpatient: Deductible and Coinsurance - Unlimited Visits In-Network: 20% Out-of-Network: 40%
REHABILITATION: INPATIENT	Unknown	After Deductible and Inpatient Copayment; In-Network: 20% Out-of-Network: 40% Up to 120 days per calendar year for Occupational, Speech, Massage and Physical Therapy	After Deductible and Inpatient Copayment; In-Network: 20% Out-of-Network: 40% Up to 30 days per calendar year for Occupational, Speech, Massage and Physical Therapy
REHABILITATION: OUTPATIENT	Unknown	Not subject to Deductible; In-Network: \$25 copayment Out-of-Network: \$30 copayment Up to 45 visits per calendar year for Occupational, Speech, and Massage Therapy.	Not subject to Deductible; In-Network: \$30 copayment Out-of-Network: \$40 copayment Up to 45 visits per calendar year for Occupational, Speech, and Massage Therapy.

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PRESCRIPTION DRUGS (Not subject to Deductible)	Retail Participating Pharmacy: Up to a 30-day supply - \$10 copayment - Generic \$15 copayment - Formulary Brand name \$30 copayment - Non-formulary Brand name Mail Order: Up to a 90-day supply \$20 copayment - Generic \$30 copayment - Formulary Brand name \$60 copayment - Non-formulary Brand name	Retail Participating Pharmacy: Up to a 34-day supply \$10 copayment - Generic \$20 copayment - Preferred Brand name \$35 copayment - Non-preferred Brand name Mail Order: Up to a 100-day supply \$10 copayment - Generic \$20 copayment - Preferred Brand name \$35 copayment - Nonpreferred Brand name Specialty Drugs: Limited to a 30-day supply, subject to retail pharmacy copayment.	Retail Participating Pharmacy: Up to a 34-day supply \$15 copayment - Generic \$25 copayment - Preferred Brand name \$40 copayment - Non-preferred Brand name Mail Order: Up to a 100-day supply \$15 copayment - Generic \$25 copayment - Preferred Brand name \$40 copayment - Nonpreferred Brand name Specialty Drugs: Limited to a 30-day supply, subject to retail pharmacy copayment.
LIFETIME MAXIMUM	Unlimited	Unlimited	Unlimited
LIFE INSURANCE	NA	\$20,000 decreasing term life and AD&D insurance for employee only	\$20,000 decreasing term life and AD&D insurance for employee only

This is a brief summary of benefits between the WEA Select Benefit programs and the plans offered in the Ferndale School District. This is a summary only and does not constitute a contract. Please refer to the specific plan booklets for complete information regarding benefits, exclusions and eligibility requirements. This comparison has not been reviewed by Regence.

Monthly Premium Rate Comparison (Before applying the state benefit allocation or pooling)

Gross Monthly Premium:	CURRENT PLAN Regence Engage 80	WEA Select Plan 2	WEA Select Plan 3
Employee	\$638.59	\$629.80	\$563.40
Employee & Spouse	\$1,222.68	\$1,219.85	\$1,091.50
Employee/Spouse/Child(ren)	\$1,479.94	\$1,469.85	\$1,315.30
Employee & Child(ren)	\$895.85	\$879.80	\$787.20
Gross Monthly Premium Difference Compared to Current Plan:			
Employee		(\$8.79)	(\$75.19)
Employee & Spouse		(\$2.83)	(\$131.18)
Employee/Spouse/Child(ren)		(\$10.09)	(\$164.64)
Employee & Child(ren)		(\$16.05)	(\$108.65)