

2010-11 Medical Benefits Comparison
Current Ferndale Plan compared to Most Similar to WEA Select Plans

| BENEFITS | CURRENT PLAN Regence High Option | WEA Select Plan 1 | WEA Select Plan 5 |
|--|--|--|---|
| Copayments, Coinsurance, and Deductible Amounts Shown Represent the Amounts You Pay (Based on Allowable Charges) | | | |
| PROVIDER NETWORK | Regence Preferred / Participating / Non-Contracted | Heritage | Foundation |
| 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 | \$50 per person or \$150 per family per calendar year. Waived for office visits and outpatient prescription drugs | In-Network: \$100 per person or \$300 per family per calendar year Out-of-Network: \$250 per person per calendar year Waived for in-network office visits and outpatient prescription drugs |
| COINSURANCE (portion you pay after deductible) | Preferred: 10% Participating: 30% Non-Contracted providers are subject to deductible and coinsurance | In-Network: 10% Out-of-Network: 30% | In-Network: Paid in full (100%) Out-of-Network: 30% |
| 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 \$3,000 | A combined In and Out-of-Network coinsurance maximum: In-Network: \$444 Out-of-Network: \$1,714 (Deductible is not included in the annual out-of-pocket maximum.) | In Network: \$0; in-network services paid at 100% of allowable charges Out-of-Network: There is no out-of-pocket maximum for out-of-network providers (Deductible is not included in the annual out-of-pocket maximum.) |
| PHYSICIAN OFFICE VISITS | Not subject to Deductible; Preferred: \$20 copayment, then 10% coinsurance Participating: \$35 copayment, then 30% coinsurance | Not subject to Deductible; In-Network: \$20 copayment Out-of-Network: \$25 copayment | In-Network: \$15 copayment per visit, not subject to deductible Out-of-Network: 30%; after deductible |
| 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: Preventive screenings 30%, all other preventive care not covered (A list of covered services is available online at www.premera.com/wea) |

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| SPINAL MANIPULATIONS | After Deductible; Preferred: 10% Participating: 30% Limited to 10 visits per calendar year | Not subject to Deductible; In-Network: \$20 copayment Out-of-Network: \$25 copayment Unlimited visits | In-Network: \$15 copayment per visit, not subject to deductible Out-of-Network: 30%, after deductible Unlimited visits |
| LABORATORY / X-RAY SERVICES | Not subject to Deductible; Preferred: 10% Participating: 30% | After Deductible; In-Network: 10% Out-of-Network: 30% | After Deductible; In-Network: Paid in full Out-of-Network: 30% |
| EMERGENCY ROOM SERVICES (Copay waived if admitted directly from Emergency Room) | \$75 copayment per visit; Subject to deductible for preferred and participating providers | \$75 copayment per visit; Subject to deductible and coinsurance | \$50 copay per visit, Subject to deductible and coinsurance |
| HOSPITAL SERVICES: INPATIENT | After Deductible; Preferred: 10% Participating: 30% | After Deductible and Inpatient Copayment; In-Network: 10% Out-of-Network: 30% \$100 copayment per day to \$300 maximum per person per calendar year | After Deductible and Inpatient Copayment; In-Network: Paid in full Out-of-Network: 30% \$200 copayment per admission up to \$600 per person/\$1,000 per family max per calendar year |
| OUTPATIENT SURGERY, AMBULATORY SURGERY CENTERS | After Deductible; Preferred: 10% Participating: 30% | After Deductible and Outpatient Surgery Copayment; In-Network: 10% Out-of-Network: 30% \$50 copayment | After Deductible; In-Network: Paid in full Out-of-Network: 30% |
| MENTAL HEALTH CARE: INPATIENT (Unlimited Days) | After Deductible; Preferred: 10% Participating: 30% | After Deductible and Inpatient Copayment; In-Network: 10% Out-of-Network: 30% | After Deductible and Inpatient Copayment; In-Network: Paid in full Out-of-Network: 30% |
| MENTAL HEALTH CARE: OUTPATIENT (Unlimited Visits) | Not subject to Deductible; Preferred: 10% Participating: 30% | Not subject to Deductible; In-Network: \$20 copayment Out-of-Network: \$30 copayment | In-Network: \$15 copayment, not subject to deductible Out-of-Network: 30%; after deductible |

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| PHYSICAL THERAPY | Unknown | Inpatient: See Rehabilitation Inpatient Benefit Outpatient: Deductible and Coinsurance - Unlimited Visits In-Network: 10% Out-of-Network: 30% | See Rehabilitation Benefits |
| REHABILITATION: INPATIENT | Unknown | After Deductible and Inpatient Copayment; In-Network: 10% Out-of-Network: 30% Up to 120 days per calendar year for Occupational, Speech, Massage and Physical Therapy | After Deductible and Inpatient Copayment; In-Network: Paid in full Out-of-Network: 30% Up to 30 days per calendar year for Occupational, Speech, Massage and Physical Therapy |
| REHABILITATION: OUTPATIENT | Unknown | Not subject to Deductible; In-Network: \$20 copayment Out-of-Network: \$25 copayment Up to 45 visits per calendar year for Occupational, Speech, and Massage Therapy | In-Network: \$15 copayment, not subject to deductible Out-of-Network: 30% Up to 45 days per calendar year for Occupational, Speech, Massage and Physical Therapy |

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| PRESCRIPTION DRUGS (Not subject to Deductible) | Retail Participating Pharmacy: Up to a 30-day supply - \$5 copayment - Generic \$20 copayment - Formulary Brand name \$40 copayment - Non-formulary Brand name Mail Order: Up to a 90-day supply \$10 copayment - Generic \$40 copayment - Formulary Brand name \$80 copayment - Non-formulary Brand name | Retail Participating Pharmacy: Up to a 34-day supply \$10 copayment - Generic \$15 copayment - Preferred Brand name \$30 copayment - Non-preferred Brand name Mail Order: Up to a 100-day supply \$10 copayment - Generic \$15 copayment - Preferred Brand name \$30 copayment - Nonpreferred Brand name Specialty Drugs: Limited to a 30-day supply, subject to retail pharmacy copayment. | Retail Participating Pharmacy: Up to a 30-day supply \$10 copayment - Generic \$15 copayment - Preferred Brand name \$30 copayment - Non-preferred Brand name Mail Order: Up to a 90-day supply \$10 copayment - Generic \$30 copayment - Preferred Brand name \$60 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 High Option | WEA Select Plan 1 | WEA Select Plan 5 |
|---|-------------------------------------|-------------------|-------------------|
| Employee | \$706.40 | \$719.80 | \$645.75 |
| Employee & Spouse | \$1,354.45 | \$1,398.45 | \$1,309.90 |
| Employee/Spouse/Child(ren) | \$1,641.02 | \$1,685.80 | \$1,584.70 |
| Employee & Child(ren) | \$992.97 | \$1,007.15 | \$920.55 |
| Gross Monthly Premium Difference Compared to Current Plan: | | | |
| Employee | | \$13.40 | (\$60.65) |
| Employee & Spouse | | \$44.00 | (\$44.55) |
| Employee/Spouse/Child(ren) | | \$44.78 | (\$56.32) |
| Employee & Child(ren) | | \$14.18 | (\$72.42) |