## 2010-11 Medical Benefits Comparison

## Current Ferndale Plan compared to Most Similar to WEA Select Plans

| BENEFITS | CURRENT PLAN Regence Innova 500 | WEA Select Plan 3 | WEA Select EasyChoice A | WEA Select EasyChoice B | WEA Select EasyChoice C |
|---|---|---|---|---|---|
| **Copayments, Coinsurance, and Deductible Amounts Shown Represent the Amounts You Pay (Based on Allowable Charges)** | | | | | |
| **PROVIDER NETWORK** | Regence Preferred / Participating / Non-Contracted | Heritage<br><br>Member directs own care | Heritage<br><br>Member directs own care | Heritage<br><br>Member directs own care | Foundation<br><br>Member directs own care |
| **ANNUAL DEDUCTIBLE** (An amount you pay before the plan pays benefits) | $500 per person or $1,500 per family per calendar year.<br><br>Waived for office visits, the first $500 of outpatient diagnostic lab and x-ray, and outpatient prescription drugs | $200 per person or $600 per family per calendar year.<br><br>Waived for office visits and outpatient prescription drugs | **In-Network:** $1,000 per person per calendar year; $3,000 per family per calendar year<br><br>**Out-of-Network:** $2,000 per person per calendar year; $6,000 per family per calendar year<br><br>Waived for in-network office visits | **In-Network:** $750 per person per calendar year; $2,250 per family per calendar year<br><br>**Out-of-Network:** $1,500 per person per calendar year; $4,500 per family per calendar year<br><br>Waived for in-network office visits | **In-Network:** $0 per person per calendar year; $0 per family per calendar year<br><br>**Out-of-Network:** $250 per person per calendar year; $750 per family per calendar year<br><br>Waived for in-network office visits |
| **COINSURANCE** (portion you pay after deductible) | **Preferred:** **Physicians/Hospitals**: 0% (office, home, hosp. outpat., and 1st $500 of lab and x-ray) **Other Professional Services:** 20%<br><br>**Participating**: 40%<br><br>**Non-Contracted** providers are subject to deductible and coinsurance | **In-Network**: 20%<br>**Out-of-Network**: 40% | **In-Network**: 20%<br>**Out-of-Network**: 50% | **In-Network**: 25%<br>**Out-of-Network**: 50% | **In-Network:** 35%<br>**Out-of-Network:** 50% |
| **ANNUAL OUT OF POCKET EXPENSE LIMIT**<br><br>(After you reach this limit, the plan pays most benefits in full, unless otherwise specified) | Coinsurance maximum of:<br><br>Individual $2,500<br>Family $7,500 | A combined In and Out-of-Network coinsurance maximum:<br><br>**In-Network**: $2,500<br>**Out-of-Network**: $6,667<br><br>(Deductible is not included in the annual out-of-pocket maximum.) | **In-Network:** $5,000 per person per calendar year / $15,000 per family per calendar year<br>**Out-of-Network:** None<br><br>(Deductible **is included** in the annual out-of-pocket maximum.) | **In-Network**: $4,000 per person per calendar year / $12,000 per family per calendar year<br>**Out-of-Network**: None<br><br>(Deductible **is included** in the annual out-of-pocket maximum.) | **In-Network:** $7,500 per person per calendar year / $22,500 per family per calendar year<br>**Out-of-Network:** None<br><br>(Deductible **is included** in the annual out-of-pocket maximum.) |

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|---|---|---|---|---|---|
| **Copayments, Coinsurance, and Deductible Amounts Shown Represent the Amounts You Pay (Based on Allowable Charges)** | | | | | |
| **PHYSICIAN OFFICE VISITS** | Not subject to Deductible<br><br>**Preferred**: $15 copayment<br>**Participating**: $30 copayment | Not subject to Deductible;<br><br>**In-Network**: $30 copayment<br>**Out-of-Network**: $40 copayment<br><br>Acupuncture: limited to 12 visits | **In-Network:** $15 copayment, not subject to the deductible<br>**Out-of-Network:** 50%; after deductible | **In-Network**: $30 copayment, not subject to the deductible<br>**Out-of-Network**: 50%; after deductible | **In-Network:** $35 copayment, not subject to the deductible<br>**Out-of-Network:** 50%; after deductible |
| **PREVENTIVE CARE (Unlimited)** | **Preferred**: Paid in full, not subject to deductible<br>**Participating**: Paid in full, not subject to deductible | Unlimited Benefit;<br><br>**In-Network**: Paid in full, not subject to deductible<br>**Out-of-Network**: 20%<br><br>(A list of covered services is available online at www.premera.com/wea) | Unlimited Benefit;<br><br>**In-Network:** Paid in full, not subject to deductible<br>**Out-of-Network:** Preventive screenings 50%, all other preventive care not covered<br><br>(A list of covered services is available online at www.premera.com/wea) | Unlimited Benefit;<br><br>**In-Network**: Paid in full, not subject to deductible<br>**Out-of-Network**: Preventive screenings 50%, all other preventive care not covered<br><br>(A list of covered services is available online at www.premera.com/wea) | Unlimited Benefit;<br><br>**In-Network:** Paid in full, not subject to deductible<br>**Out-of-Network:** Preventive screenings 50%, all other preventive care not covered<br><br>(A list of covered services is available online at www.premera.com/wea) |
| **SPINAL MANIPULATIONS** | After Deductible;<br><br>**Preferred**: 20%<br>**Participating**: 40%<br><br>Limited to 10 visits per calendar year | Not subject to Deductible;<br><br>**In-Network**: $30 copayment<br>**Out-of-Network**: $40 copayment<br><br>Unlimited visits | **In-Network:** $15 copayment, not subject to deductible<br>**Out-of-Network:** 50%; after deductible<br><br>12 visits per calendar year | **In-Network**: $30 copayment, not subject to deductible<br>**Out-of-Network**: 50%; after deductible<br><br>12 visits per calendar year | **In-Network:** $35 copayment, not subject to deductible<br>**Out-of-Network:** 50%; after deductible<br><br>12 visits per calendar year |
| **LABORATORY / X-RAY SERVICES** | The first $500 per calendar year covered in full (deductible waived) then;<br><br>**Preferred:** subject to deductible then covered at 20%<br><br>**Participating**: subject to deductible then covered at 40% | After Deductible;<br><br>**In-Network**: 20%<br>**Out-of-Network**: 40% | The first $1,000 per calendar year covered in full (deductible waived) then;<br><br>**In-Network:** 20%; after deductible<br><br>**Out-of-Network:** 50%; after deductible | After Deductible;<br><br>**In-Network**: 25%<br>**Out-of-Network**: 50% | After Deductible;<br><br>**In-Network:** 35%<br>**Out-of-Network:** 50% |
| **EMERGENCY ROOM SERVICES** (Copay waived if admitted directly from Emergency Room) | $75 copayment per visit;<br><br>Subject to deductible, then 20% coinsurance (preferred and participating) | $100 copayment per visit;<br><br>Subject to deductible and coinsurance | $100 copayment per visit;<br><br>Subject to deductible and coinsurance | $150 copayment per visit;<br><br>Subject to deductible and coinsurance | $200 copayment per visit;<br><br>Subject to deductible and coinsurance |

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|---|---|---|---|---|---|
| **Copayments, Coinsurance, and Deductible Amounts Shown Represent the Amounts You Pay (Based on Allowable Charges)** | | | | | |
| **HOSPITAL SERVICES: INPATIENT** | After Deductible;<br><br>**Preferred**: 20%<br>**Participating**: 40% | After Deductible and Inpatient Copayment;<br><br>**In-Network:** 20%<br>**Out-of-Network:** 40%<br><br>$300 copayment per day to $900 maximum per person per calendar year | After Deductible;<br><br>**In-Network:** 20%<br>**Out-of-Network:** 50% | After Deductible;<br><br>**In-Network:** 25%<br>**Out-of-Network:** 50% | After Deductible;<br><br>**In-Network:** 35%<br>**Out-of-Network:** 50% |
| **OUTPATIENT SURGERY, AMBULATORY SURGERY CENTERS** | After Deductible;<br><br>**Preferred**: 20%<br>**Participating**: 40% | After Deductible and Outpatient Surgery Copayment;<br><br>**In-Network**: 20%<br>**Out-of-Network**: 40%<br><br>$150 copayment | After Deductible;<br><br>**In-Network:** 20%<br>**Out-of-Network:** 50% | After Deductible;<br><br>**In-Network**: 25%<br>**Out-of-Network**: 50% | After Deductible;<br><br>**In-Network:** 35%<br>**Out-of-Network:** 50% |
| **MENTAL HEALTH CARE: INPATIENT** (Unlimited Days) | After Deductible;<br><br>**Preferred:** 20%<br>**Participating:** 40% | After Deductible and Inpatient Copayment;<br><br>**In-Network**: 20%<br>**Out-of-Network**: 40% | After Deductible;<br><br>**In-Network:** 20%<br>**Out-of-Network:** 50% | After Deductible;<br><br>**In-Network**: 25%<br>**Out-of-Network**: 50% | After Deductible;<br><br>**In-Network:** 35%<br>**Out-of-Network:** 50% |
| **MENTAL HEALTH CARE: OUTPATIENT** (Unlimited Visits) | After Deductible;<br><br>**Preferred**:20%<br>**Participating**: 40% | Not subject to Deductible;<br><br>**In-Network**: $30 copayment<br>**Out-of-Network**: $40 copayment | **In-Network:** $15 copayment, not subject to deductible<br>**Out-of-Network:** 50%; after deductible | **In-Network**: $30 copayment, not subject to deductible<br>**Out-of-Network**: 50%; after deductible | **In-Network:** $35 copayment, not subject to deductible<br>**Out-of-Network:** 50%; after deductible |
| **PHYSICAL THERAPY** | Unknown | **Inpatient**: See Rehabilitation Inpatient Benefit<br><br>**Outpatient**: Deductible and Coinsurance - Unlimited Visits<br><br>**In-Network**: 20%<br>**Out-of-Network**: 40% | See Rehabilitation Benefits | See Rehabilitation Benefits | See Rehabilitation Benefits |

**2010-11 Medical Benefits Comparison**

**Current Ferndale Plan compared to Most Similar to WEA Select Plans**

| BENEFITS | CURRENT PLAN<br>Regence Innova 500 | WEA Select Plan 3 | WEA Select EasyChoice A | WEA Select EasyChoice B | WEA Select EasyChoice C |
|---|---|---|---|---|---|
| **Copayments, Coinsurance, and Deductible Amounts Shown Represent the Amounts You Pay (Based on Allowable Charges)** | | | | | |
| **REHABILITATION: INPATIENT** | Unknown | After Deductible and Inpatient Copayment;<br><br>**In-Network**: 20%<br>**Out-of-Network**:40%<br><br>Up to 30 days per calendar year for Occupational, Speech, Massage and Physical Therapy | After Deductible,<br><br>**In-Network:** 20%<br>**Out-of-Network:** 50%<br><br>Up to 30 days per calendar year for Occupational, Speech, Massage and Physical Therapy | After Deductible,<br><br>**In-Network**: 25%<br>**Out-of-Network**:50%<br><br>Up to 45 days per calendar year for Occupational, Speech, Massage and Physical Therapy | After Deductible,<br><br>**In-Network:** 35%<br>**Out-of-Network:** 50%<br><br>Up to 45 days per calendar year for Occupational, Speech, Massage and Physical Therapy |
| **REHABILITATION: OUTPATIENT** | Unknown | Not subject to Deductible;<br>**In-Network**: $30 copayment<br>**Out-of-Network**: $40 copayment<br><br>Up to 45 visits per calendar year for Occupational, Speech, and Massage Therapy. | **In-Network:** $15 copayment, not subject to deductible<br>**Out-of-Network:** 50%; after deductible<br><br>Up to 30 visits per calendar year for Occupational, Speech, Massage and Physical Therapy. | **In-Network**: $30 copayment, not subject to deductible<br>**Out-of-Network**: 50%; after deductible<br><br>Up to 45 visits per calendar year for Occupational, Speech, Massage and Physical Therapy. | **In-Network:** $35 copayment, not subject to deductible<br>**Out-of-Network:** 50%; after deductible<br><br>Up to 45 visits per calendar year for Occupational, Speech, Massage and Physical Therapy. |
| **PRESCRIPTION DRUGS** | **Retail Participating Pharmacy:**<br>Up to a 30-day supply -<br>$5 copayment - Generic<br>$20 copayment - Formulary Brand name<br>$40 copayment - Non-formulary Brand name<br><br>**Mail Order:**<br>Up to a 90-day supply<br>$10 copayment - Generic<br>$40 copayment - Formulary Brand name<br>$80 copayment - Non-formulary Brand name | **Retail Participating Pharmacy:**<br>Up to a 34-day supply<br>$15 copayment - Generic<br>$25 copayment - Preferred Brand name<br>$40 copayment - Non-preferred Brand name<br><br>**Mail Order:**<br>Up to a 100-day supply<br>$15 copayment - Generic<br>$25 copayment - Preferred Brand name<br>$40 copayment - Nonpreferred Brand name<br><br>**Specialty Drugs:**<br>Limited to a 30-day supply, subject to retail pharmacy copayment. | **$500 RX Deductible (waived for generics)**<br>RX out-of-pocket max $5,000<br><br>**Retail Participating Pharmacy**:<br>Up to a 30-day supply<br>$0 copayment - Generic<br>*30%* copayment - Preferred Brand name<br>*30%* copayment - Non-preferred Brand name<br><br>**Mail Order**:<br>Up to a 90-day supply<br>$0 copayment - Generic<br>*25%* copayment - Preferred Brand name<br>*25%* copayment - Nonpreferred Brand name<br><br>**Specialty Drugs:**<br>Limited to a 30-day supply, 30% | **$250 RX Deductible (waived for generics)**<br>RX out-of-pocket max $5,000<br><br>**Retail Participating Pharmacy:**<br>Up to a 30-day supply<br>$0 copayment - Generic<br>$30 copayment - Preferred Brand name<br>$45 copayment - Non-preferred Brand name<br><br>**Mail Order:**<br>Up to a 90-day supply<br>$0 copayment - Generic<br>$75 copayment - Preferred Brand name<br>$112 copayment - Nonpreferred Brand name<br><br>**Specialty Drugs:**<br>Limited to a 30-day supply, 30% | **$500 RX Deductible (waived for generics)**<br>RX out-of-pocket max $5,000<br><br>**Retail Participating Pharmacy:**<br>Up to a 30-day supply<br>$0 copayment - Generic<br>$30 copayment - Preferred Brand name<br>$45 copayment - Non-preferred Brand name<br><br>**Mail Order:**<br>Up to a 90-day supply<br>$0 copayment - Generic<br>$75 copayment - Preferred Brand name<br>$112 copayment - Nonpreferred Brand name<br><br>**Specialty Drugs:**<br>Limited to a 30-day supply, 30% |

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|---|---|---|---|---|---|
| Copayments, Coinsurance, and Deductible Amounts Shown Represent the Amounts You Pay (Based on Allowable Charges) | | | | | |
| **LIFETIME MAXIMUM** | Unlimited | Unlimited | 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 | $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 Innova 500 | WEA Select Plan 3 | WEA Select EasyChoice A | WEA Select EasyChoice B | WEA Select EasyChoice C |
|---|---|---|---|---|---|
| Employee | $473.87 | $563.40 | $457.45 | $457.45 | $457.45 |
| Employee & Spouse | $909.65 | $1,091.50 | $885.85 | $885.85 | $885.85 |
| Employee/Spouse/Child(ren) | $1,174.35 | $1,315.30 | $1,067.30 | $1,067.30 | $1,067.30 |
| Employee & Child(ren) | $738.57 | $787.20 | $638.90 | $638.90 | $638.90 |
| **Gross Monthly Premium Difference Compared to Current Plan:** | | | | | |
| Employee | | $89.53 | ($16.42) | ($16.42) | ($16.42) |
| Employee & Spouse | | $181.85 | ($23.80) | ($23.80) | ($23.80) |
| Employee/Spouse/Child(ren) | | $140.95 | ($107.05) | ($107.05) | ($107.05) |
| Employee & Child(ren) | | $48.63 | ($99.67) | ($99.67) | ($99.67) |