2010-11 Medical Benefits Comparison

Current Ferndale Plan compared to Most Similar to WEA Select Plans

BENEFITS	CURRENT PLAN Regence Modified Copay	WEA Select Plan 5	WEA Select Plan 2
Copayments, Coinsurance, and Deductible Amounts Shown Represent the Amounts You Pay (Based on Allowable Charges)			
PROVIDER NETWORK	Regence Preferred/ Participating/ Non-Contracted	Foundation	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 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	$100 per person or $300 per family per calendar year. Waived for 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:** Paid in full (100%) **Out-of-Network:** 30%	**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 $2,500 Family $7,500	**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.)	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.)
PHYSICIAN OFFICE VISITS	**Preferred**: $20 copayment, not subject to deductible **Participating**: $35 copayment, then 30% coinsurance, not subject to deductible Acupuncture - 12 visit limit	**In-Network**: $15 copayment per visit, not subject to deductible **Out-of-Network:** 30%; after deductible Acupuncture: unlimited visits	Not subject to Deductible; **In-Network**: $25 copayment **Out-of-Network**: $30 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:** Preventive screenings 30%, all other preventive care not covered (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**: 10% **Participating**: 30% Limited to 12 visits per calendar year	**In-Network:** $15 copayment per visit, not subject to deductible **Out-of-Network: 3**0%, after deductible Unlimited visits	Not subject to Deductible; **In-Network**: $25 copayment **Out-of-Network**: $30 copayment Unlimited visits
LABORATORY / X-RAY SERVICES	**Preferred**: Paid in full, deductible waived **Participating**: Paid in full, deductible waived	After Deductible; **In-Network:** Paid in full **Out-of-Network:** 30%	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, then 10% coinsurance (preferred and participating)	$50 copay per visit, Subject to deductible and coinsurance	$75 copayment per visit; Subject to deductible and coinsurance
HOSPITAL SERVICES: INPATIENT	After Deductible; **Preferred**: 10% **Participating**: 30%	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	After Deductible and Inpatient Copayment; **In-Network:** 20% **Out-of-Network:** 40% $150 copayment per day to $450 maximum per person per calendar year
OUTPATIENT SURGERY, AMBULATORY SURGERY CENTERS	After Deductible; **Preferred**: 10% **Participating**: 30%	After Deductible; **In-Network**: Paid in full **Out-of-Network**: 30%	After Deductible and Outpatient Surgery Copayment; **In-Network**: 20% **Out-of-Network**: 40% $100 copayment
MENTAL HEALTH CARE: INPATIENT (Unlimited Days)	After Deductible; **Preferred:** 10% **Participating:** 30%	After Deductible and Inpatient Copayment; **In-Network**: Paid in full **Out-of-Network**: 30%	After Deductible and Inpatient Copayment; **In-Network**: 20% **Out-of-Network**: 40%

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MENTAL HEALTH CARE: OUTPATIENT (Unlimited Visits)	**Preferred**: Paid in full, deductible waived **Participating**: Paid in full, deductible waived	**In-Network**: $15 copayment, not subject to deductible **Out-of-Network**: 30%; after deductible	Not subject to Deductible; **In-Network**: $25 copayment **Out-of-Network**: $30 copayment
PHYSICAL THERAPY	Unknown	See Rehabilitation Benefits	**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**: Paid in full **Out-of-Network**: 30% Up to 30 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 120 days per calendar year for Occupational, Speech, Massage and Physical Therapy
REHABILITATION: OUTPATIENT	Unknown	**In-Network**: $15 copayment, not subject to deductible **Out-of-Network**: 30% Up to 45 days per calendar year for Occupational, Speech, and Massage Therapy	Not subject to deductible; **In-Network**: $25 copayment **Out-of-Network**: $30 copayment Up to 45 visits per calendar year for o*ccupational, speech, and massage 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 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.	**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.
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 Modified Copay	WEA Select Plan 5	WEA Select Plan 2
Employee	$800.90	$645.75	$629.80
Employee & Spouse	$1,535.80	$1,309.90	$1,219.85
Employee/Spouse/Child(ren)	$1,860.71	$1,584.70	$1,469.85
Employee & Child(ren)	$1,125.81	$920.55	$879.80
Gross Monthly Premium Difference Compared to Current Plan:			
Employee		($155.15)	($171.10)
Employee & Spouse		($225.90)	($315.95)
Employee/Spouse/Child(ren)		($276.01)	($390.86)
Employee & Child(ren)		($205.26)	($246.01)