BASIC MEDICAL BENEFITS COMPARISON 2011-12 (PIF: Paid in Full)

Blaine School District

SERVICE	GROUP HEALTH CO-OP TRADITIONAL 250 Managed Care	GROUP HEALTH CO-OP WELCOME 500 Managed Care	REGENCE / WEIC MODIFIED COPAY PLAN	REGENCE / WEIC ENGAGE 80 PLAN	REGENCE WEIC HIGH OPTION	REGENCE WEIC INNOVA 500	REGENCE K-12 HSA 2.0
Deductible	$250/person $750/family	$500/person $1,500/family	$200/person $600/family	$200/person $600/family	$200/person $600/family	$500/person $1,500/family	$1500/person $3000/family*
Coinsurance maximum	$2000/person $6000/family	$2000/person $6000/family	$2500/person $7500/family	$1000/person $2000/family	$1000/person $3000/family	$2500/person $7500/family	$5000/person $10000/family
Physicians	Primary Care Physician (PCP) referral needed for a specialist, except at GHC Specialty Centers in Seattle and Bellevue. Women may also self refer to a women's health care provider.	Primary Care Physician (PCP) referral needed for a specialist, except at GHC Specialty Centers in Seattle and Bellevue. Women may also self refer to a women's health care provider.	Preferred, participating, or non-contracted providers (Categories 1, 2 and 3 respectively) inside or outside the Regence Service area.	Preferred, participating, or non-contracted providers (Categories 1, 2 and 3 respectively) inside or outside the Regence Service area.	Preferred, participating, or non-contracted providers (Categories 1, 2 and 3 respectively) inside or outside the Regence Service area.	Preferred, participating, or non-contracted providers (Categories 1, 2 and 3 respectively) inside or outside the Regence Service area.	Preferred, participating, or non-contracted providers (Categories 1, 2 and 3 respectively) inside or outside the Regence Service area.
Change PCP	Anytime	Anytime	N/A	N/A	N/A	N/A	N/A
Physician's Office Visit	**80%** after $30 copay (Deductible waived)	Visits 1-4 100% after $20 copay, Visits 5+ subject to $20 copay, deductible; then covered at 80%	100% after $20 copay	80% after deductible	90% after $20 copay	All office visits subject to a $15 copay.	80% after deductible
X-Ray Laboratory	Covered at **80%**	Covered in full first $500 PCY. Deductible, then 80% thereafter	100%, deductible waived	80%. Deductible waived for mammogram and pap smear.	90%. Deductible waived.	Covered in full first $500 per calendar year. Deductible, then 80% thereafter.	80% after deductible
Prescriptions Pharmacy (30 Day Supply)	$15 copay generic. $30 copay brand.	$15 copay generic. $30 copay brand.	$5 copay generic formulary. $20 copay brand formulary. Non-form: $40.	$10 copay generic formulary. $15 copay brand formulary. Non-form: $30.	$5 copay generic formulary. $20 copay brand formulary. Non-form: $40.	$5 copay generic formulary. $20 copay brand formulary. Non-form: $40.	80% after deductible**
Prescriptions Mail Order (90 Day Supply)	$30 copay generic $60 copay brand per 90 day supply	$30 copay generic $60 copay brand per 90 day supply	$10 copay generic formulary. $20 copay brand formulary. Non-form: $80.	$20 copay generic formulary. $30 copay brand formulary. Non-form: $60.	$10 copay generic formulary. $40 copay brand formulary. Non- form: $80.	$10 copay generic formulary. $40 copay brand formulary. Non- form: $80.	80% after deductible**
Maternity	Dr. visits **80%** after $30 copay (ded waived); Delivery 80% after ded.	Covered at 80% after deductible.	90% after deductible	80% after deductible	90% after deductible	80% after deductible	80% after deductible
Preventive Care	Covered in full. No Annual Maximum	Covered in full. No Annual Maximum	Covered in full. No Annual Maximum	Covered in full. No Annual Maximum	Covered in full. No Annual Maximum	Covered in full. No Annual Maximum	Covered in full. No Annual Maximum
Emergency room (copay waived if admitted)	$100 copay, then ded & 80%	**$100** copay, then ded.& 80%.	$75 copay, then deductible and 90%;	$75 copay, then deductible and 80%;	$75 copay, then deductible and 90%;	$75 copay, then deductible and 80%;	80% after deductible
Hospital Inpatient	Covered 80% after annual deductible	Covered 80% after annual deductible.	90% after deductible	80% after deductible	90% after deductible.	80% after deductible.	80% after deductible.
Ambulance	80%	80%	90% after deductible	80% after deductible	90% after deductible	80% after deductible	80% after deductible

Please Note: All plan changes have been outlined in bold.

This benefits comparison provides general information only and is subject to plan limitations and restrictions. Refer to the plan booklets for specific coverage.

*HSA 2.0 :Prior to benefits being paid out for any family member, the deductible must be met. The family deductible applies with the subscriber and one or more dependents are enrolled.

*HSA 2.0: Deductible Waived for generic and formulary preventive drugs for asthma, diabetes, high blood pressure, high cholesterol and tobacco addiction.