

2010-11 Medical Benefits Comparison

Current Ferndale Plan compared to Most Similar to WEA Select Plans

BENEFITS	CURRENT PLAN Group Health Traditional 250	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	Primary Care Physician (PCP) referral needed for specialist except for GHC Specialty Centers. Women may self refer to a women's health care provider.	Heritage Member directs own care	Heritage Member directs own care
ANNUAL DEDUCTIBLE (An amount you pay before the plan pays benefits)	\$250 per person or \$750 per family per calendar year. Waived for office visits and outpatient prescription drugs	\$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)	20%	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 \$2,000 Family \$6,000	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	Not subject to Deductible; subject to \$30 copay Self referral for acupuncture visits limited to 8 per condition per calendar year. Self referral for naturopathic visits limited to 3 per condition per calendar year.	Not subject to Deductible; In-Network: \$25 copayment Out-of-Network: \$30 copayment Acupuncture: limited to 12 visits per calendar year Naturopath: unlimited visits	Not subject to Deductible; In-Network: \$30 copayment Out-of-Network: \$40 copayment Acupuncture: limited to 12 visits per calendar year Naturopath: unlimited visits
PREVENTIVE CARE	Covered in full	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	Self referral to GHC contracted provider - 10 visit per calendar year maximum. \$30 copay per visit, deductible and coinsurance do not apply.	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	Outpatient: Covered at 100% for all covered services.	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)	\$100 copay per visit; subject to deductible and then 20% Non GHC ER - \$100 copay per visit, subject to deductible then 20%. Must notify GHC within 24 hours if admitted.	\$75 copayment per visit; Subject to deductible and coinsurance	\$100 copayment per visit; Subject to deductible and coinsurance
HOSPITAL SERVICES: INPATIENT	20% after deductible	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	\$30 copay, deductible and coinsurance do not apply.	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)	20% after deductible	After Deductible and Inpatient Copayment; In-Network: 20% Out-of-Network: 40%	After Deductible and Inpatient Copayment; In-Network: 20% Out-of-Network: 40%
MENTAL HEALTH CARE: OUTPATIENT (Unlimited Visits)	\$30 copay, deductible and coinsurance do not apply.	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

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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 - \$15 copayment - Generic \$30 copayment - Formulary Brand name Mail Order: Up to a 90-day supply \$30 copayment - Generic \$60 copayment - 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 Group Health.

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

Gross Monthly Premium:	CURRENT PLAN Group Health Traditional 250	WEA Select Plan 2	WEA Select Plan 3
Employee	\$720.14	\$629.80	\$563.40
Employee & Spouse	\$1,383.07	\$1,219.85	\$1,091.50
Employee/Spouse/Child(ren)	\$1,760.59	\$1,469.85	\$1,315.30
Employee & Child(ren)	\$1,098.85	\$879.80	\$787.20
Gross Monthly Premium Difference Compared to Current Plan:			
Employee		(\$90.34)	(\$156.74)
Employee & Spouse		(\$163.22)	(\$291.57)
Employee/Spouse/Child(ren)		(\$290.74)	(\$445.29)
Employee & Child(ren)		(\$219.05)	(\$311.65)