

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

BENEFITS	CURRENT PLAN Group Health (Deductible) Welcome 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	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	Heritage Member directs own care	Foundation 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. 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	In-Network: \$1,000 per person per calendar year; \$3,000 per family per calendar year Out-of-Network: \$2,000 per person per calendar year; \$6,000 per family per calendar year Waived for in-network office visits	In-Network: \$750 per person per calendar year; \$2,250 per family per calendar year Out-of-Network: \$1,500 per person per calendar year; \$4,500 per family per calendar year Waived for in-network office visits	In-Network: \$0 per person per calendar year; \$0 per family per calendar year Out-of-Network: \$250 per person per calendar year; \$750 per family per calendar year Waived for in-network office visits
COINSURANCE (portion you pay after deductible)	20%	In-Network: 20% Out-of-Network: 40%	In-Network: 20% Out-of-Network: 50%	In-Network: 25% Out-of-Network: 50%	In-Network: 35% Out-of-Network: 50%
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: \$2,500 Out-of-Network: \$6,667 (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 Out-of-Network: None (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 Out-of-Network: None (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 Out-of-Network: None (Deductible is included in the annual out-of-pocket maximum.)

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PHYSICIAN OFFICE VISITS	First Four visits 100% after \$20 copay, subsequent visits subject to deductible, \$20 copay, then 20% 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: \$30 copayment Out-of-Network: \$40 copayment Acupuncture: limited to 12 visits per calendar year Naturopath: Unlimited visits	In-Network: \$15 copayment, not subject to the deductible Out-of-Network: 50%; after deductible Acupuncture: limited to 12 visits per calendar year Naturopath: Unlimited visits	In-Network: \$30 copayment, not subject to the deductible Out-of-Network: 50%; after deductible Acupuncture: limited to 12 visits per calendar year Naturopath: Unlimited visits	In-Network: \$35 copayment, not subject to the deductible Out-of-Network: 50%; after deductible Acupuncture: limited to 12 visits per calendar year Naturopath: Unlimited visits
PREVENTIVE CARE (Unlimited)	Covered in full; unlimited benefit	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 50%, 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: Preventive screenings 50%, 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: Preventive screenings 50%, all other preventive care not covered (A list of covered services is available online at www.premera.com/wea)
SPINAL MANIPULATIONS	Self referral to GHC contracted provider - 10 visit per calendar year maximum. After deductible, \$20 copay then 20% per visit.	Not subject to Deductible; In-Network: \$30 copayment Out-of-Network: \$40 copayment Unlimited visits	In-Network: \$15 copayment, not subject to deductible Out-of-Network: 50%; after deductible 12 visits per calendar year	In-Network: \$30 copayment, not subject to deductible Out-of-Network: 50%; after deductible 12 visits per calendar year	In-Network: \$35 copayment, not subject to deductible Out-of-Network: 50%; after deductible 12 visits per calendar year
LABORATORY / X-RAY SERVICES	Covered in full for the first \$500 per calendar year, then 20% after deductible.	After Deductible; In-Network: 20% Out-of-Network: 40%	The first \$1,000 per calendar year covered in full (deductible waived) then; In-Network: 20%; after deductible Out-of-Network: 50%; after deductible	After Deductible; In-Network: 25% Out-of-Network: 50%	After Deductible; In-Network: 35% Out-of-Network: 50%

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EMERGENCY ROOM SERVICES (Copay waived if admitted directly from Emergency Room)	\$75 copay per visit subject to deductible, then 20% Non GHC ER - \$75 copay per visit subject to deductible then 20%. Must notify GHC within 24 hours if admitted.	\$100 copayment per visit; Subject to deductible and coinsurance	\$100 copayment per visit; Subject to deductible and coinsurance	\$150 copayment per visit; Subject to deductible and coinsurance	\$200 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% \$300 copayment per day to \$900 maximum per person per calendar year	After Deductible; In-Network: 20% Out-of-Network: 50%	After Deductible; In-Network: 25% Out-of-Network: 50%	After Deductible; In-Network: 35% Out-of-Network: 50%
OUTPATIENT SURGERY, AMBULATORY SURGERY CENTERS	\$20 copay then 20% after deductible	After Deductible and Outpatient Surgery Copayment; In-Network: 20% Out-of-Network: 40% \$150 copayment	After Deductible; In-Network: 20% Out-of-Network: 50%	After Deductible; In-Network: 25% Out-of-Network: 50%	After Deductible; In-Network: 35% Out-of-Network: 50%
MENTAL HEALTH CARE: INPATIENT (Unlimited Days)	20% after deductible	After Deductible and Inpatient Copayment; In-Network: 20% Out-of-Network: 40%	After Deductible; In-Network: 20% Out-of-Network: 50%	After Deductible; In-Network: 25% Out-of-Network: 50%	After Deductible; In-Network: 35% Out-of-Network: 50%
MENTAL HEALTH CARE: OUTPATIENT (Unlimited Visits)	After deductible, \$20 copay then 20%	Not subject to Deductible; In-Network: \$30 copayment Out-of-Network: \$40 copayment	In-Network: \$15 copayment , not subject to deductible Out-of-Network: 50% ; after deductible	In-Network: \$30 copayment , not subject to deductible Out-of-Network: 50% ; after deductible	In-Network: \$35 copayment , not subject to deductible Out-of-Network: 50% ; after deductible

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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%	See Rehabilitation Benefits	See Rehabilitation Benefits	See Rehabilitation Benefits
REHABILITATION: INPATIENT	Unknown	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	After Deductible, In-Network: 20% Out-of-Network: 50% Up to 30 days per calendar year for Occupational, Speech, Massage and Physical Therapy	After Deductible, In-Network: 25% Out-of-Network: 50% Up to 45 days per calendar year for Occupational, Speech, Massage and Physical Therapy	After Deductible, In-Network: 35% Out-of-Network: 50% Up to 45 days per calendar year for Occupational, Speech, Massage and Physical Therapy
REHABILITATION: OUTPATIENT	Unknown	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.	In-Network: \$15 copayment, not subject to deductible Out-of-Network: 50%; after deductible Up to 30 visits per calendar year for Occupational, Speech, Massage and Physical Therapy.	In-Network: \$30 copayment, not subject to deductible Out-of-Network: 50%; after deductible Up to 45 visits per calendar year for Occupational, Speech, Massage and Physical Therapy.	In-Network: \$35 copayment, not subject to deductible Out-of-Network: 50%; after deductible Up to 45 visits per calendar year for Occupational, Speech, Massage and Physical Therapy.

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PRESCRIPTION DRUGS	<p>Retail Participating Pharmacy: Up to a 30-day supply - \$15 copayment - Generic \$30 copayment - Formulary Brand name</p> <p>Mail Order: Up to a 90-day supply \$30 copayment - Generic \$60 copayment - Formulary Brand name</p>	<p>Retail Participating Pharmacy: Up to a 34-day supply \$15 copayment - Generic \$25 copayment - Preferred Brand name \$40 copayment - Non-preferred Brand name</p> <p>Mail Order: Up to a 100-day supply \$15 copayment - Generic \$25 copayment - Preferred Brand name \$40 copayment - Nonpreferred Brand name</p> <p>Specialty Drugs: Limited to a 30-day supply, subject to retail pharmacy copayment.</p>	<p>\$500 RX Deductible (waived for generics) RX out-of-pocket max \$5,000</p> <p>Retail Participating Pharmacy: Up to a 30-day supply \$0 copayment - Generic 30% copayment - Preferred Brand name 30% copayment - Non-preferred Brand name</p> <p>Mail Order: Up to a 90-day supply \$0 copayment - Generic 25% copayment - Preferred Brand name 25% copayment - Nonpreferred Brand name</p> <p>Specialty Drugs: Limited to a 30-day supply, 30%</p>	<p>\$250 RX Deductible (waived for generics) RX out-of-pocket max \$5,000</p> <p>Retail Participating Pharmacy: Up to a 30-day supply \$0 copayment - Generic \$30 copayment - Preferred Brand name \$45 copayment - Non-preferred Brand name</p> <p>Mail Order: Up to a 90-day supply \$0 copayment - Generic \$75 copayment - Preferred Brand name \$112 copayment - Nonpreferred Brand name</p> <p>Specialty Drugs: Limited to a 30-day supply, 30%</p>	<p>\$500 RX Deductible (waived for generics) RX out-of-pocket max \$5,000</p> <p>Retail Participating Pharmacy: Up to a 30-day supply \$0 copayment - Generic \$30 copayment - Preferred Brand name \$45 copayment - Non-preferred Brand name</p> <p>Mail Order: Up to a 90-day supply \$0 copayment - Generic \$75 copayment - Preferred Brand name \$112 copayment - Nonpreferred Brand name</p> <p>Specialty Drugs: Limited to a 30-day supply, 30%</p>

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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 Group Health.

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

Gross Monthly Premium:	CURRENT PLAN Group Health (Deductible) Welcome 500	WEA Select Plan 3	WEA Select EasyChoice A	WEA Select EasyChoice B	WEA Select EasyChoice C
Employee	\$498.18	\$563.40	\$457.45	\$457.45	\$457.45
Employee & Spouse	\$956.35	\$1,091.50	\$885.85	\$885.85	\$885.85
Employee/Spouse/Child(ren)	\$1,217.34	\$1,315.30	\$1,067.30	\$1,067.30	\$1,067.30
Employee & Child(ren)	\$759.94	\$787.20	\$638.90	\$638.90	\$638.90
Gross Monthly Premium Difference Compared to Current Plan:					
Employee		\$65.22	(\$40.73)	(\$40.73)	(\$40.73)
Employee & Spouse		\$135.15	(\$70.50)	(\$70.50)	(\$70.50)
Employee/Spouse/Child(ren)		\$97.96	(\$150.04)	(\$150.04)	(\$150.04)
Employee & Child(ren)		\$27.26	(\$121.04)	(\$121.04)	(\$121.04)