Benefit Comparison
Plan Year 2003

	HealthSelect	CIGNA				
		A. HMO	B. POS		C. PPO	
	In-Network	In-Network	In-Network	Out-of Network	In-Network	Out-of Network
Standard Benefit Coverage						
Deductible						
Individual	None	None	None	$300	$250	$750
Family	None	None	None	$600	$500	$1,500
Standard Coinsurance Percentage Covered by Plan		100%	100%	70% after deductible	80% after deductible	60% after deductible
Out of Pocket Maximum for specific services						
Individual		$1,000 OOP Max	$1,000 OOP Max	$3,000 OOP Max	$2,000 OOP Max	$4,000 OOP Max
Family		$2,000 OOP Max	$2,000 OOP Max	$6,000 OOP Max	$6,000 OOP Max	$12,000 OOP Max
Lifetime Maximum Benefit		Unlimited	Unlimited	$5,000,000	Unlimited	$5,000,000
Pre-existing Conditions	None	None	None	12 Months Waiting Period, waived if covered 1/01/03	None	12 Months Waiting period, waived if covered 1/01/03
General Services						
Preventive Care	$5 Copay	$10 Copay	$15 Copay	Covered In-Network Only	$20 Copay	Covered In-Network Only
Primary Care Physician Services	$5 Copay	$10 Copay	$15 Copay	70% after deductible	$20 Copay	60% after deductible
Specialty Care Physician Services	$5 Copay	$10 Copay	$25 Copay	70% after deductible	$30 Copay	60% after deductible
Urgent Care Facility (Participating)	$5 Copay	$35 Copay	$50 Copay	70% after deductible	$50 Copay	60% after deductible
Out-patient Lab and X-Ray	No Copay	No Copay for lab or X-Ray $50 Copay for MRI & CAT	No Copay for lab or X-Ray $50 Copay for MRI & CAT	70% after deductible	80% after deductible	60% after deductible
In-patient Coverage						
Facility Charges	No Copay	No Copay	$100 Copay (reimbursed by County)	70% (Precertification Required)* after deductible	80% after deductible	60% (Precertification Required)* after deductible
Physician & Surgeon's Services	No Copay	No Copay	No Copay	70% (Precertification Required)* after deductible	80% after deductible	60% (Precertification Required)* after deductible
Outpatient Surgery	No Copay	No Copay	$50 Copay	70% (Precertification Required)* after deductible	80% after deductible	60% (Precertification Required)* after deductible
Non-certification Penalty	NA	NA	NA	$400 Penalty	$400 Penalty	$400 Penalty
Maternity						
Pre & Postnatal Exams(after pregnancy has been determined)	Copay waived after 1st visit	Copay waived after 1st visit	Copay waived after 1st visit	70% after deductible	Copay waived after 1st visit	60% after deductible
Delivery	No Copay	No Copay	$100 In-Patient Copay (reimbursed by County)	70% after deductible	80% after deductible	60% after deductible
Emergency Care (Defined by Plan)						
Emergency Room-Copay Waived @ Admit	$50 Copay	$75 Copay	$100 Copay	$100 Copay if emergency, otherwise 70%	$100 Copay	$100 Copay if emergency, otherwise 60%
Ambulance	No Copay	No Copay	No Copay	No Copay	90% after deductible	90% after deductible
Equipment & Devices						
Durable Medical Equipment	No Copay	No Copay ($3500 Max)	No Copay ($3500 Max)	Covered In-Network Only	80% after ded. ($700 max.)	60% ($700 max.)
External Prosthetics & Orthotics	No Copay	No Copay ($1000 Max)	No Copay ($1000 Max)	Covered In-Network Only	80% after $200 ded. ($1,000 max.)	60% after $200 ded, ($1000 max.)
Outpatient Rehabilitation						
Physical, Speech, and Occupational						
Therapy	$5 Copay	$10 Copay	$10 Copay	70% after deductible	$20 Copay	60%
Chiropractic Services Open Access; No referral required; visit limit is per year	$10 Copay 12 Visits	$10 Copay 20 visits	$10 Copay 20 Visits	Covered In-Network Only	$20 Copay Unlimited (subject to benefit max.)	60% after deductible Unlimited (subject to benefit max.)
Maximum Therapy & Chiropractic visits combined per year	60 Visits/Days	60 Visits	60 Visits Combined		60 Visits Combined	
Ancillary Benefits						
Vision & Hearing Screening	$5 Copay, $500 per year	$10 Copay	$15 Copay	Covered In-Network Only	$20 Copay	Covered In-Network Only
Other Healthcare Facilities						
Skilled Nursing Facilities						
Subscriber Payment	No Copay	No Copay	No Copay	70% after deductible	80%	60%
Limit per Contract Year	20 days per illness	90 Days Combined	90 Days Combined	90 Days Combined	90 Days Combined	90 Days Combined
Home Health Care	No Copay when medically necessary (Unlimited)	No Copay when medically necessary (Unlimited)	No Copay when medically necessary (Unlimited)	70% ded. up to 40 Days per Year	80% after deductible (Unlimited)	60% after ded. up to 40 Days per Year
Family Planning						
Sterilization						
Vasectomy	Place of Service Copay	Place of Service Copay	Place of Service Copay	70% after deductible	80% after deductible	60% after deductible
Tubal Ligation	Place of Service Copay	Place of Service Copay	Place of Service Copay	70% after deductible	80% after deductible	60% after deductible
Infertility Treatment	Not Covered	Diagnostic Services and Corrective Treatment Only	Diagnostic Services and Corrective Treatment Only	Covered In-Network Only	Diagnostic Services and Corrective Treatment Only	Covered In-Network Only
Dependent Children						

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Unmarried and legally dependent upon employee and/or spouse	Covered to Age 19 Unless Full Time Student and Then Covered to Age 25 (Includes Missionaries)	Covered to Age 19 Unless Full Time Student and Then Covered to Age 25-(Includes Missionaries)	Covered to Age 19 Unless Full Time Student and Then Covered to Age 25 (Includes Missionaries)		Covered to Age 19 Unless Full Time Student and Then Covered to Age 25 (Includes Missionaries)		
Pharmacy Benefit	**HealthSelect**	**Walgreens Health Initiatives**	**Walgreens Health Initiatives**		**Walgreens Health Initiatives**		
	RETAIL:	THREE LEVEL PLAN:	THREE LEVEL PLAN:		THREE LEVEL PLAN:		
	$5.00 Copay for Generics	Generics:	Generics:		Generics:		
	$15.00 Copay for Brand	25% Coinsurance	25% Coinsurance		25% Coinsurance		
	MAIL ORDER:	Min Cost $2.00, Max Cost $10.00	Min Cost $2.00, Max Cost $10.00		Min Cost $2.00, Max Cost $10.00		
	$15 Copay for Generics	Brand On:	Brand On:		Brand On:		
	$30 Copay for Brand	30% Coinsurance	30% Coinsurance		30% Coinsurance		
		Min Cost $5.00, Max Cost $25.00	Min Cost $5.00, Max Cost $25.00		Min Cost $5.00, Max Cost $25.00		
	90-day supply	Brand Off:	Brand Off:		Brand Off:		
		30% Coinsurance	30% Coinsurance		30% Coinsurance		
		Min Cost $20.00, Max Cost $50.00	Min Cost $20.00, Max Cost $50.00		Min Cost $20.00, Max Cost $50.00		
		Annual Out-of-Pocket Maximum	Annual Out-of-Pocket Maximum		Annual Out-of-Pocket Maximum		
		$1500 - Single/$3,000 Family	$1500 - Single/$3,000 Family		$1500 - Single/$3,000 Family		
Behavioral Health Benefit	**United Behavioral Health**	**United Behavioral Health**	**United Behavioral Health**		**United Behavioral Health**		
Vision Benefit	**AVESIS Vision Plan**	**AVESIS Vision Plan**	**AVESIS Vision Plan**		**AVESIS Vision Plan**		

Note: Lifetime Maximum and Visits per year for Out of Network Services, cross-accumulates with In-Network.

The detailed benefit summaries provide a more comprehensive summary of benefits.

Revised 09/13/02