

SCHEDULE OF MEDICAL BENEFITS

EMPIRE BLUECROSS BLUESHIELD

90/70 PPO PLAN

PLAN IS EFFECTIVE AS OF JANUARY 1, 2010

	Annual Deductibles		Annual Out-of-Pocket Maximums (Excludes Deductible)		Inpatient Hospital Copayment
Network	\$250 Individual \$500 Family		\$1,000 Individual \$2,000 Family		\$100 per day, not to exceed \$600 per admission
Non-Network	\$500 Individual \$1,000 Family		\$3,000 Individual \$6,000 Family		

Lifetime Benefit Maximum

(Includes All Other Maximums)

\$5 Million Individual

The following schedule summarizes coinsurance amounts paid by the Plan, benefit maximums, and any additional explanation needed for your benefits. The Plan's coinsurance will be reduced if you do not follow the procedures outlined in the "Medical Management" section of this Handbook. Please refer to the text for additional Plan provisions that may affect your benefits.

COVERED HEALTH SERVICE	YOUR COPAYMENT AMOUNT	COPAY APPLY TO ANNUAL OOP MAX?	NEED TO MEET ANNUAL DEDUCTIBLE?	ADDITIONAL LIMITATIONS AND EXPLANATIONS
Acupuncture Services	Network 50%	No	No	Any combination of Network and Non-Network Benefits for pain therapy is limited to 12 visits per calendar year. Acupuncture services received on an inpatient basis are not covered.
	Non-Network 50%	Yes	Yes	
Allergy Testing (Injections)	Network \$25 per visit	No	No	Allergy treatment with no office visit billed is covered at 100%.
	Non-Network 30%	Yes	Yes	
Ambulance Services - Emergency Only	Network & Non-Network 10%	Yes	No	For facility/non-emergency services out-of-network, you will pay 30% and the annual deductible applies.
Diagnostic Tests/X-Ray and Laboratory Services	Network 20%	Yes	No	
	Non-Network 20%	Yes	Yes	
Durable Medical Equipment (DME)	Network 10%	Yes	No	
	Non-Network 10%	Yes	Yes	

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Emergency Room Services	Network & Non-Network \$50 per visit	No	No	The \$50 copay will be waived if you are admitted to the hospital. Hospital admission must be precertified within 24 hours.
Home Health Care	Network 10% Non-Network 30%	Yes Yes	Yes Yes	Limited to 200 visits per plan year; precertification is required.
Hospice Care	Network 10% Non-Network 30%	Yes Yes	Yes Yes	Limited to one episode per lifetime. Benefits include bereavement counseling. Precertification is required.
Hospital Services (Inpatient)	Network 10%. \$100 per day copay, \$600 maximum per inpatient stay Non-Network 30%	No Yes	No Yes	The Plan's coinsurance for hospital expenses will be reduced to 50% if you do not follow the procedures required by the Medical Management Program. This penalty does not apply to the out-of-pocket maximum.
Hospital Services (Outpatient)	Network 10% Non-network 30%	Yes Yes	Yes Yes	
Maternity Services Hospital Services	Network 10%. Subject to a \$100 copay per day, \$600 maximum per inpatient stay Non-Network 30%	No Yes	No Yes	The Plan's coinsurance for hospital expenses will be reduced to 50% if you do not follow the procedures required by the Medical Management Program. This penalty does not apply to the out-of-pocket maximum. Well-newborn care is also covered, but is not subject to the inpatient hospital deductible.
Outpatient Services	Network \$25 for first visit only Non-Network 30%	No Yes	No Yes	Antepartum care only.

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Mental Health/ Substance Abuse Services - Inpatient		See CIGNA Behavioral Health Handbook		
Mental Health/ Substance Abuse Services - Outpatient		See CIGNA Behavioral Health Handbook		
Nutritional Counseling	Network \$25 per visit	No	No	Limited to 6 visits/sessions per calendar year.
	Non-Network 30%	No	No	
Outpatient Therapy Services	Network \$25 per visit	No	No	Benefits include hearing/speech, physical and occupational therapy. Limited to 60 visits per Plan year, combined facility and office, per each of the three therapies.
	Non-Network 30%	Yes	Yes	
Physician's Office Services	Network \$25 per visit	No	No	You pay one copay to the provider for all services performed during the visit. If the provider sends you to a radiology/laboratory to have a diagnostic test, you are responsible to pay that charge at the radiology/laboratory diagnostic benefit level.
	Non-Network 30%	Yes	Yes	
Routine & Preventive Services Routine Exams Routine Exam X-Rays & Laboratory Services Well-Child Checkups Routine Colonoscopy Routine Sigmoidoscopy Other Routine Services	Network \$0 per visit	No	No	Benefits include routine physicals, including gynecological exams, limited to 1 per year; hearing exams performed by your physician during a routine physical, limited to 1 per year; and vaccinations, inoculations, and immunizations. Pap tests, limited to 1 per year; mammograms, limited to 1 per year age 40+, 1 age 35-39; PSA screenings, limited to 2 per year age 40+; and all related routine x-rays and laboratory services. Well-child checkups limited to 7 visits from birth to age 1, 6 visits from age 1 through age 5, 7 visits from age 5 through age 12, 6 visits from age 12 through age 18, and 2 visits age 18 up to the 19th birthday. Benefits include the office visit, vaccinations, inoculations, immunizations, and all related x-ray and laboratory services. Routine sigmoidoscopy limited to 1 every 2 years, age 40+. Routine colonoscopy limited to 1 every 10 years, age 50+.
	Non-Network 30%	Yes	Yes	
Skilled Nursing Facility/ Inpatient Rehabilitation Facility Services	Network 10%	Yes	Yes	Limited to 60 days per year.
	Non-Network 30%	Yes	Yes	

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Smoking Cessation Program	Network 10%	No	No	Smoking cessation Benefits include hypnosis and counseling. Prescription smoking cessation drugs are excluded under the medical plan but are available through your prescription drug plan. Any combination of Network and Non-Network smoking cessation Benefits are limited to \$200 per covered person per calendar year.
	Non-Network 30%	No	No	
Spinal Treatment	Network \$25 per visit	No	No	Limited to 20 visits per year.
	Non-Network 30%	Yes	Yes	
Surgical Treatment of Morbid Obesity	Network 10%	Yes	Yes	Limited to 1 procedure per lifetime.
	Non-Network 30%	Yes	Yes	
Urgent Care Services	Network 10%	Yes	Yes	
	Non-Network 30%	Yes	Yes	
Additional Benefits				
Anesthesiology Services Professional	Network 10%	Yes	No	
	Non-Network 10%	No	No	
Facility	Network 10%	Yes	No	
	Non-Network 30%	Yes	Yes	
Organ Transplants	Network 10%	Yes	Yes	For this benefit, "network plan" refers to the BCBS National Transplant Network. Precertification required. There is a \$10,000 travel and lodging limit.
	Non-Network 30%	Yes	Yes	
All Other Covered Medical Expenses	Network 10%	No	No	Benefits are provided for expenses listed in the "What's Covered" sections of this Handbook.
	Non-Network 30%	Yes	Yes	

Medical Management Program toll-free number: (800) 352-3152

NOTES: The word "lifetime" refers to the period of time you or your eligible dependents participate in this plan or any other plan sponsored by the Medical Trust.

This benefit summary is provided for informational purposes, is not all-inclusive, and does not constitute an agreement. Additional limitations and explanations, including specific benefit maximums will be provided to eligible, enrolled members in the Plan Document Handbook. In the event of a conflict between this document and the official plan documents, the official plan documents will govern. The Episcopal Church Medical Trust retains the right to amend, terminate or modify the terms of the plan at any time, without notice and for any reason.