

Plan	Empire BCBS PPO 90/70		Empire BCBS PPO 80/60		Empire BCBS PPO 75/50		Empire BCBS EPO 90	Empire BCBS EPO 80	Empire BCBS HDHP/HSA	
	Network	Out-of-Network	Network	Out-of-Network	Network	Out-of-Network	Network	Network Only	Network	Out-of-Network
Annual Medical Deductible	\$250 per person \$500 per family	\$500 per person \$1,000 per family	\$500 per person \$1,000 per family	\$1,000 per person \$2,000 per family	\$900 per person \$1,800 per family	\$1,800 per person \$3,600 per family	\$200 per person \$500 per family	\$350 per person \$700 per family	\$2,700 per person \$5,450 per family (deductible includes medical & prescriptions)	\$3,000 per person \$6,000 per family (deductible includes medical & prescriptions)
Annual Out-of-Pocket Maximum (excludes deductible)	\$1,500 per person \$3,000 per family	\$4,000 per person \$8,000 per family	\$2,000 per person \$4,000 per family	\$5,500 per person \$11,000 per family	\$3,200 per person \$6,400 per family	\$6,400 per person \$12,800 per family	\$1,500 per person \$3,000 per family	\$2,000 per person \$4,000 per family	\$1,500 per person \$3,000 per family	\$4,000 per person \$7,000 per family
<b>Preventive Care</b>										
Routine and Preventive Services  Preventive Care based on guidelines from the U. S. Preventive Services Task Force, American Cancer Society, the Advisory Committee on Immunization Practices (ACIP), and the American Academy of Pediatrics. Coverage for child immunizations is based on the published guidelines of the American Academy of Pediatrics.	\$0 copay	You pay 30%	\$0 copay	You pay 40%	\$0 copay (both PCP and specialist)	You pay 50%	\$0 copay	\$0 copay	\$0 copay	You pay 45%
Well-Child Care  Preventive Care based on guidelines from the U. S. Preventive Services Task Force, American Cancer Society, the Advisory Committee on Immunization Practices (ACIP), and the American Academy of Pediatrics. Coverage for child immunizations is based on the published guidelines of the American Academy of Pediatrics.	\$0 copay	You pay 30%	\$0 copay	You pay 40%	\$0 copay (both PCP and specialist)	You pay 50%	\$0 copay	\$0 copay	\$0 copay	You pay 45%
<b>Physician Services</b>										
Office Visit	\$25 copay	You pay 30%	\$25 copay	You pay 40%	\$35 copay	You pay 50%	\$25 copay	\$25 copay	You pay 20%	You pay 45%
Diagnostic Services	You pay 20%	You pay 20%	You pay 20%	You pay 20%	You pay 25%	You pay 25%	You pay 20%	You pay 20%	You pay 20%	You pay 45%
Specialist Care	\$25 copay	You pay 30%	\$25 copay	You pay 40%	\$45 copay	You pay 50%	\$25 copay	\$25 copay	You pay 20%	You pay 45%
<b>Hospital Services</b>										
Inpatient Services	Copay of \$100 per day not to exceed \$600 per admission, then you pay 10%	You pay 30%	Copay of \$100 per day not to exceed \$600 per admission, then you pay 20%	You pay 40%	Copay of \$100 per day not to exceed \$600, then you pay 25%	You pay 50%	You pay 10%	You pay 20%	You pay 20%	You pay 45%
Emergency Room Care	\$100 copay (waived if admitted within 24 hours)	\$100 copay (waived if admitted within 24 hours)	\$100 copay (waived if admitted within 24 hours)	\$100 copay (waived if admitted within 24 hours)	\$100 copay (waived if admitted within 24 hours)	\$100 copay (waived if admitted within 24 hours)	\$100 copay (waived if admitted within 24 hours)	\$100 copay (waived if admitted within 24 hours)	You pay 20%	You pay 20%
Outpatient Surgery	You pay 10%	You pay 30%	You pay 20%	You pay 40%	You pay 25%	You pay 50%	You pay 10%	You pay 20%	You pay 20%	You pay 45%
Organ Transplants	You pay 10%	You pay 30%	You pay 20%	You pay 40%	You pay 25%	You pay 50%	You pay 10%	You pay 20%	You pay 20%	You pay 45%
Ambulance Services	You pay 10%	You pay 10%	You pay 20%	You pay 20%	You pay 25%	You pay 25%	You pay 10%	You pay 20%	You pay 20%	You pay 45%
<b>Maternity Services</b>										
Prenatal Care (copay applies only to visit to confirm pregnancy)	\$25 copay	You pay 30%	\$25 copay	You pay 40%	\$35 copay	You pay 50%	\$25 copay	\$25 copay	You pay 20%	You pay 45%
Inpatient Services	Copay of \$100 per day not to exceed \$600 per admission, then you pay 10%	You pay 30%	Copay of \$100 per day not to exceed \$600 per admission, then you pay 20%	You pay 40%	Copay of \$100 per day not to exceed \$600, then you pay 25%	You pay 50%	You pay 10%	You pay 20%	You pay 20%	You pay 45%

Plan	Empire BCBS PPO 90/70		Empire BCBS PPO 80/60		Empire BCBS PPO 75/50		Empire BCBS EPO 90	Empire BCBS EPO 80	Empire BCBS HDHP/HSA	
	Network	Out-of-Network	Network	Out-of-Network	Network	Out-of-Network	Network	Network Only	Network	Out-of-Network
<b>Mental Health/Substance Abuse</b>										
Outpatient Services	\$20 copay (services provided only through CIGNA Behavioral Health, not through Empire)	You pay 30% (services provided only through CIGNA Behavioral Health, not through Empire)	\$20 copay (services provided only through CIGNA Behavioral Health, not through Empire)	You pay 30% (services provided only through CIGNA Behavioral Health, not through Empire)	\$20 copay (services provided only through CIGNA Behavioral Health, not through Empire)	You pay 30% (services provided only through CIGNA Behavioral Health, not through Empire)	Network - \$20 copay (services provided through CIGNA Behavioral Health, not through Empire)  Out-of-Network - You pay 30% (services provided only through CIGNA Behavioral Health, not through Empire)	Network - \$20 copay (services provided through CIGNA Behavioral Health, not through Empire)  Out-of-Network - You pay 30% (services provided only through CIGNA Behavioral Health, not through Empire)	You pay 20%	You pay 45%
Inpatient Services	Covered at 100% after \$100 per day copay/\$600 maximum (services provided through CIGNA Behavioral Health, not through Empire)	You pay 30% (services provided only through CIGNA Behavioral Health, not through Empire)	Covered at 100% after \$100 per day copay/\$600 maximum (services provided through CIGNA Behavioral Health, not through Empire)	You pay 30% (services provided only through CIGNA Behavioral Health, not through Empire)	Covered at 100% after \$100 per day copay/\$600 maximum (services provided through CIGNA Behavioral Health, not through Empire)	You pay 30% (services provided only through CIGNA Behavioral Health, not through Empire)	Network - You pay 10% (services provided only through CIGNA Behavioral Health, not through Empire)  Out-of-Network - You pay 30% (services provided only through CIGNA Behavioral Health, not through Empire)	Network - You pay 20% (services provided through CIGNA Behavioral Health, not through Empire)  Out-of-Network - You pay 30% (services provided only through CIGNA Behavioral Health, not through Empire)	You pay 20%	You pay 45%
<b>Other Medical Services</b>										
Acupuncture (12 visits per year)	You pay 50%	You pay 50%	You pay 50%	You pay 50%	You pay 50%	You pay 50%	You pay 50%	You pay 50%	You pay 20%	You pay 20%
Allergy Testing (Injections)	\$25 copay	You pay 30%	\$25 copay	You pay 40%	\$35 copay (PCP) \$45 copay (Specialist)	You pay 50%	\$25 copay	\$25 copay	You pay 20%	You pay 45%
Durable Medical Equipment (DME)	You pay 10%	You pay 10%	You pay 20%	You pay 20%	You pay 25%	You pay 25%	You pay 10%	You pay 20%	You pay 20%	You pay 20%
Home Health Care (limits are combined in- and out-of-network)	You pay 10% (200 visits per year)	You pay 30% (200 visits per year)	You pay 20% (200 visits per year)	You pay 40% (200 visits per year)	You pay 25% (200 visits per year)	You pay 50% (200 visits per year)	You pay 10% (200 visits per year)	You pay 20% (200 visits per year)	You pay 20% (200 visits per year)	You pay 45% (200 visits per year)
Hospice Care	You pay 10%	You pay 30%	You pay 20%	You pay 40%	You pay 25%	You pay 50%	You pay 10%	You pay 20%	You pay 20%	You pay 45%
Nutritional Counseling (6 sessions per year)	\$25 copay	You pay 30%	\$25 copay	You pay 40%	\$35 copay (PCP) \$45 copay (Specialist)	You pay 50%	\$25 copay	\$25 copay	You pay 20%	You pay 45%
Outpatient Therapy (limits are combined in- and out-of-network)	\$25 copay (includes hearing/speech, physical, and occupational) (60 visits per year per each type of therapy)	You pay 30% (includes hearing/speech, physical, and occupational) (60 visits per year per each type of therapy)	\$25 copay (includes hearing/speech, physical, and occupational) (60 visits per year per each type of therapy)	You pay 40% (includes hearing/speech, physical, and occupational) (60 visits per year per each type of therapy)	\$35 copay (PCP) \$45 copay (specialist) (includes hearing/speech, physical, and occupational) (60 visits per year per each type of therapy)	You pay 50% (includes hearing/speech, physical, and occupational) (60 visits per year per each type of therapy)	\$25 copay (includes hearing/speech, physical, and occupational) (60 visits per year per each type of therapy)	\$25 copay (includes hearing/speech, physical, and occupational) (60 visits per year per each type of therapy)	You pay 20% (includes hearing/speech, physical, and occupational) (60 visits per year per each type of therapy)	You pay 45% (includes hearing/speech, physical, and occupational) (60 visits per year per each type of therapy)
Skilled Nursing Facility (60 days per year)	You pay 10%	You pay 30%	You pay 20%	You pay 40%	You pay 25%	You pay 50%	You pay 10%	You pay 20%	You pay 20%	You pay 45%
Smoking Cessation Program	You pay 10%	You pay 30%	You pay 20%	You pay 40%	You pay 25%	You pay 50%	You pay 10%	You pay 20%	You pay 20%	You pay 45%
Spinal Treatment (20 visits per year)	\$25 copay	You pay 30%	\$25 copay	You pay 40%	\$35 copay (PCP) \$45 copay (Specialist)	You pay 50%	\$25 copay	\$25 copay	You pay 20%	You pay 45%
Surgical Treatment of Morbid Obesity (See Schedules of Benefits for limitations)	You pay 10%	You pay 30%	You pay 20%	You pay 40%	You pay 25%	You pay 50%	You pay 10%	You pay 20%	You pay 20%	You pay 45%
Urgent Care Services	You pay 10%	You pay 30%	You pay 20%	You pay 40%	You pay 25%	You pay 50%	You pay 10%	You pay 20%	You pay 20%	You pay 45%



**THE EPISCOPAL CHURCH  
MEDICAL TRUST**

Prescription Drug Benefits			
	Medco		
	Standard		HDHP/HSA
	Retail	Mail Order	Retail & Mail Order
Annual Prescription Deductible	\$50 per person	None	\$2,700 per person \$5,450 per family (combined with medical deductible)
Tier 1: Generic	Up to a \$10 copay	Up to a \$25 copay	You pay 15% after deductible
Tier 2: Formulary Brand Name	Up to a \$35 copay	Up to a \$90 copay	You pay 25% after deductible
Tier 3: Non-Formulary Brand Name and Brand Non-Sedating Antihistamines	Up to a \$60 copay	Up to a \$150 copay	You pay 50% after deductible
Dispensing Limits Per Copayment	Up to a 30-day supply	Up to a 90-day supply	Up to a 30-day supply (retail) or 90-day supply (mail order)

This chart is a general description and is provided for informational purposes only. It should not be viewed as an offer of coverage. In the event of a conflict between this chart and the official Plan documents, the official Plan documents will govern.



Vision Benefits		
	EyeMed	
	Network	Out-of-Network
Eye Examinations	\$0 copay	Plan pays up to \$30 for ophthalmologists or optometrists
Lenses (eligible once every calendar year)	\$10 copay	Plan pays up to: \$32 for single vision \$46 for bifocal \$57 for trifocal
Lens Options		You are responsible for the cost of any lens options that you elect from out-of-network providers
UV Coating	up to \$15 copay	
Tint (solid and Gradient)	up to \$15 copay	
Standard Scratch Resistance	up to \$15 copay	
Standard Polycarbonate	\$0 copay	
Standard Anti-Reflective Coating	up to \$45 copay	
Standard Progressive (add-on to bifocal)	Up to \$65 copay	
Disposable	20% off retail price	
Frames (eligible once every calendar year)	\$130 allowance, 20% off balance over \$130	Plan pays up to \$47
Contact Lenses (eligible once every calendar year)		
Conventional	\$130 allowance, 15% off balance over \$130	Plan pays up to \$100
Disposable	\$130 allowance, then you pay balance over \$130	Plan pays up to \$100

This chart is a general description and is provided for informational purposes only. It should not be viewed as an offer of coverage. In the event of a conflict between this chart and the official Plan documents, the official Plan documents will govern.



Dental Benefits			
	CIGNA Dental		
	Dental & Orthodontia PPO Plan	Basic Dental PPO Plan	Preventive Dental PPO Plan
Annual Non-Network Deductible	\$25 per person \$75 per family	\$50 per person \$150 per family	None
Preventive & Diagnostic Services (e.g., oral exams, cleanings, x-rays, emergency care to relieve pain)	You pay \$0  (not subject to annual deductible)	You pay \$0  (not subject to annual deductible)	You pay \$0
Basic Restorative Care	You pay 15% Includes fillings, root canal therapy, periodontal scaling and root planing, denture adjustments and repairs, extractions, and anesthetics	You pay 15% Includes fillings, root canal therapy, periodontal scaling and root planing, denture adjustments and repairs, extractions, and anesthetics	You pay 20% Includes only fillings, denture adjustments and repairs
Major Restorative Services	You pay 15% Includes crowns, dentures, oral surgery, osseous surgery, and bridges	You pay 50% Includes crowns, dentures, oral surgery, osseous surgery, and bridges	You pay 99% Includes crowns, dentures, oral surgery, osseous surgery, and bridges, root canal therapy
Orthodontia	You pay 50% (\$1,500 individual lifetime maximum)	Not covered	You pay 99%
Annual Benefit Maximum	\$1,500	\$1,500	\$1,500

This chart is a general description and is provided for informational purposes only. It should not be viewed as an offer of coverage. In the event of a conflict between this chart and the official Plan documents, the official Plan documents will govern.

The Plans described in this document (collectively, the "Plans") are sponsored and administered by the Church Pension Group Services Corporation ("CPGSC"), also known as the Episcopal Church Medical Trust (the "Medical Trust"). The Plans that are self-funded are funded by the Episcopal Church Clergy and Employees' Benefit Trust ("ECCEBT"), which is a voluntary employees' beneficiary association within the meaning of section 501(c)(9) of the Internal Revenue Code.

This document contains only a partial, general description of the Plans. It is provided for informational purposes only and should not be viewed as a contract, an offer of coverage, a confirmation of eligibility, or investment, tax, medical, or other advice. In the event of a conflict between this document and the official Plan documents (schedule of benefits, summary Plan description, booklet, booklet-certificate), the official Plan documents will govern. The Church Pension Fund and CPGSC (collectively, "CPG"), retain the right to amend, terminate, or modify the terms of the Plans, as well as any post-retirement health subsidy, at any time, without notice and for any reason.

The Plans are church Plans within the meaning of section 3(33) of the Employee Retirement Income Security Act and section 414(e) of the Internal Revenue Code. Not all Plans are available in all areas of the United States, and not all Plans are available on both a self-funded and fully insured basis. The Plans do not cover all health care expenses, and Plan participants should read the official Plan documents carefully to determine which benefits are covered, as well as any applicable exclusions, limitations, and procedures.

All benefits under the Plans are subject to applicable laws, regulations, and policies.

Except for the Preventive Dental PPO Plan, all such benefits are subject to coordination of benefits. The Plans are subrogated to all of the rights of a Plan participant against any party liable for such participant's illness or injury, to the extent of the reasonable value of the benefits provided to such participant under the Plans. The Plans may assert this right independently of a Plan participant, and such participant is obligated to cooperate with the Medical Trust in order to protect the Plans' subrogation rights.

CPG does not provide any health care services and therefore cannot guarantee any results or outcomes. Health care providers and vendors are independent contractors in private practice and are neither employees nor agents of CPG. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change.

Due to the interim final rules published February 2, 2010 to implement the Paul Wellstone and Peter Domenici Mental Health Parity and Addiction Equity Act of 2008 (the "MHPAEA"), mental health and substance abuse benefits under the Plans are subject to change effective January 1, 2011.