

SCHEDULE OF MEDICAL BENEFITS

EMPIRE BLUECROSS BLUESHIELD

90 EPO PLAN

PLAN IS EFFECTIVE AS OF JANUARY 1, 2010

Annual Deductibles

\$200 Individual
\$500 Family

Annual Out-of-Pocket Maximums

(Excludes Deductible)

\$1,000 Individual
\$2,000 Family

Lifetime Benefit Maximum

(Includes All Other Maximums)

\$5 Million Individual

You must receive services only from health care providers participating in the BlueCard PPO Network, or benefits will not be covered by the Plan. Expenses for non-network providers will only be considered as specified in the NOTES section of this schedule.

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	50%	Yes	No	Limited to 12 visits per calendar year. Acupuncture services received on an inpatient basis are not covered.
Allergy Testing (Injections)	\$25 per visit	Yes	Yes	Allergy treatment with no office visit billed is covered at 100%.
Ambulance Services - Emergency Only*	10%	Yes	No	
Diagnostic Tests/X-Ray and Laboratory Services	20%	Yes	No	
Durable Medical Equipment (DME)*	10%	Yes	No	
Emergency Room Services*	\$50 per visit	No	No	The \$50 copay will be waived if you are admitted to the hospital within 24 hours.
Home Health Care	10%	Yes	Yes	You should notify Empire by calling the toll-free number prior to receiving any home health care. Limited to 200 visits per plan year.
Hospice Care	10%	Yes	Yes	Limited to one episode per lifetime. Precertification is required.
Hospital Services (Inpatient)	10%	Yes	Yes	Precertification is required. 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.
Hospital Services (Outpatient)	10%	Yes	Yes	

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Maternity Services	10%	Yes	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.
Hospital Services				
Outpatient Services	\$25 for first visit only	Yes	Yes	Antepartum care only.
Mental Health/ Substance Abuse Services - Inpatient	See CIGNA Behavioral Health Handbook			
Mental Health/ Substance Abuse Services - Outpatient	See CIGNA Behavioral Health Handbook			
Nutritional Counseling	\$25 per visit	No	No	Limited to 6 sessions per calendar year.
Outpatient Therapy Services	\$25 per visit	No	No	Benefits include speech/hearing, physical, and occupational therapy. Limited to 60 visits per Plan year per each of the three types of therapy.
Physician's Office Services	\$25 per visit	No	No	
Routine & Preventive Services	\$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+.
Routine Exams				
Routine Exam X-Rays & Laboratory Services				
Well-Child Checkups				
Routine Colonoscopy				
Routine Sigmoidoscopy				
Other Routine Services				
Skilled Nursing Facility/ Inpatient Rehabilitation Facility Services	10%	Yes	Yes	Limited to 60 days per year. Precertification is required.
Smoking Cessation Program	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. Benefits are limited to \$200 per covered person per calendar year.

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Spinal Treatment	\$25 copay per visit	No	No	Limited to 20 visits per year.
Surgical Treatment of Morbid Obesity	10%	Yes	Yes	Limited to 1 procedure per lifetime.
Urgent Care Services	10%	Yes	Yes	

Additional Benefits

Anesthesiology Services	10%	Yes	Yes	
Organ Transplants	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.
All Other Covered Medical Expenses	10%	Yes	Yes	Benefits are provided for expenses listed in the "What's Covered" sections of this Handbook.

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

* You may visit non-network providers for these services, and eligible expenses will be considered as specified on this schedule. You will be responsible for any deductible, coinsurance, and amount over the "reasonable and customary" amount. Please refer to the individual provisions under "Additional Limitations and Explanations" to see if there are any prior notification or prior authorization requirements or other limitations. For assistance in locating providers who participate in the BlueCard PPO Network, contact Empire at the toll-free number (automated service is available 24 hours a day, 7 days a week; to speak with a representative, call between 8:30 a.m. and 8:00 p.m. EST, Monday through Friday).

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.