

## The Episcopal Church Medical Trust - 2010 Health Plan Comparison Chart

Plan	Empire BCBS PPO 90/70		Empire BCBS PPO 80/60		Empire BCBS EPO 90	Empire BCBS EPO 80	Empire BCBS HDHP/HSA	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network Only	In-Network Only	In-Network	Out-of-Network
Annual 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	\$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)	\$1,000 per person \$2,000 per family	\$3,000 per person \$6,000 per family	\$1,500 per person \$3,000 per family	\$4,500 per person \$9,000 per family	\$1,000 per person \$2,000 per family	\$1,500 per person \$3,000 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 (includes routine physicals, gynecological exams (1 per year), hearing exams performed by your physician during a routine physical (1 per year), and vaccinations, inoculations, and immunizations. Pap tests (1 per year), mammograms (1 per year age 40+, 1 age 35-39), PSA screenings (2 per year age 40+), and all related routine x-rays and laboratory services. Routine sigmoidoscopy (1 every 2 years, age 40+), routine colonoscopy (1 every 10 years, age 50+)	\$0 copay	You pay 30%	\$0 copay	You pay 40%	\$0 copay	\$0 copay	No copay	You pay 45%
Well-Child Care (includes 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.	\$0 copay	You pay 30%	\$0 copay	You pay 40%	\$0 copay	\$0 copay	No copay	You pay 45%
<b>Physician Services</b>								
Office Visit	\$25 copay	You pay 30%	\$25 copay	You pay 40%	\$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 20%	You pay 20%	You pay 20%	You pay 45%
Specialist Care	\$25 copay	You pay 30%	\$25 copay	You pay 40%	\$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%	You pay 10%	You pay 20%	You pay 20%	You pay 45%

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 Episcopal Church Medical Trust - 2010 Health Plan Comparison Chart

Plan	Empire BCBS PPO 90/70		Empire BCBS PPO 80/60		Empire BCBS EPO 90	Empire BCBS EPO 80	Empire BCBS HDHP/HSA	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network Only	In-Network Only	In-Network	Out-of-Network
Emergency Room Care	\$50 copay (waived if admitted within 24 hours)	\$50 copay (waived if admitted within 24 hours)	\$50 copay (waived if admitted within 24 hours)	\$50 copay (waived if admitted within 24 hours)	\$50 copay (waived if admitted within 24 hours)	\$50 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 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 10%	You pay 20%	You pay 20%	You pay 45%
Anesthesiology Services	You pay 10%	You pay 10%	You pay 20%	You pay 40%	You pay 10%	You pay 20%	You pay 20%	You pay 20%
Ambulance Services (emergency only)	You pay 10%	You pay 10%	You pay 20%	You pay 20%	You pay 10%	You pay 20%	You pay 20%	You pay 45%
<b>Maternity Services</b>								
Prenatal Care	\$25 copay for first office visit only	You pay 30%	\$25 copay for first office visit only	You pay 40%	\$25 copay for first office visit only	\$25 copay for first visit only	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%	You pay 10%	You pay 20%	You pay 20%	You pay 45%
<b>Mental Health/Substance Abuse</b>								
Outpatient Services	\$25 copay (services provided only through CIGNA Behavioral Health, not through Empire)	You pay 30% (services provided only through CIGNA Behavioral Health, not through Empire)	\$25 copay (services provided only through CIGNA Behavioral Health, not through Empire)	You pay 30% (services provided only through CIGNA Behavioral Health, not through Empire)	\$25 copay (services provided through CIGNA Behavioral Health) You pay 30% for out-of-network services (services provided only through CIGNA Behavioral Health, not through Empire)	\$25 copay (services provided only through CIGNA Behavioral Health, not through Empire) You pay 30% for out-of-network services (services provided only through CIGNA Behavioral Health, not through Empire)	You pay 20%	You pay 45%
Inpatient Services	Copay of \$100 per day not to exceed \$600 (services provided only through CIGNA Behavioral Health, not through Empire)	No out-of-network benefit available	Copay of \$100 per day not to exceed \$600 (services provided only through CIGNA Behavioral Health, not through Empire)	No out-of-network benefit available	Copay of \$100 per day not to exceed \$600 (services provided only through CIGNA Behavioral Health, not through Empire)	Copay of \$100 per day not to exceed \$600 (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 20%	You pay 20%
Allergy Testing (Injections)	\$25 copay	You pay 30%	\$25 copay	You pay 40%	\$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 10%	You pay 20%	You pay 20%	You pay 45%
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 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)

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 Episcopal Church Medical Trust - 2010 Health Plan Comparison Chart

Plan	Empire BCBS PPO 90/70		Empire BCBS PPO 80/60		Empire BCBS EPO 90	Empire BCBS EPO 80	Empire BCBS HDHP/HSA	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network Only	In-Network Only	In-Network	Out-of-Network
Hospice Care (1 episode per lifetime)	You pay 10%	You pay 30%	You pay 20%	You pay 40%	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%	\$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)	\$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 10%	You pay 20%	You pay 20%	You pay 45%
Smoking Cessation Program (\$200 per person per year maximum)	You pay 10%	You pay 30%	You pay 20%	You pay 40%	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%	\$25 copay	\$25 copay	You pay 20%	You pay 45%
Surgical Treatment of Morbid Obesity (1 procedure per lifetime)	You pay 10%	You pay 30%	You pay 20%	You pay 40%	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 10%	You pay 20%	You pay 20%	You pay 45%

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.