

# SCHEDULE OF MEDICAL BENEFITS

**EMPIRE BLUECROSS BLUESHIELD**

**80/60 PPO PLAN**

**PLAN IS EFFECTIVE AS OF JANUARY 1, 2008**

	Annual Deductibles		Annual Out-of-Pocket Maximums (Excludes Deductible)		Inpatient Hospital Copayment
<b>Network</b>	\$350	Individual	\$1,500	Individual	\$100 per day, not to exceed \$600 per admission
	\$700	Family	\$3,000	Family	
<b>Non-Network</b>	\$700	Individual	\$4,500	Individual	
	\$1,400	Family	\$9,000	Family	

## Lifetime Benefit Maximum

(Includes All Other Maximums)

\$2 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
<b>Acupuncture Services</b>	<b>Network</b> 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.
	<b>Non-Network</b> 50%	Yes	Yes	
<b>Allergy Testing (Injections)</b>	<b>Network</b> \$25 Per Visit	No	No	Allergy treatment with no office visit billed is covered at 100%.
	<b>Non-Network</b> 40%	Yes	Yes	
<b>Ambulance Services - Emergency Only</b>	<b>Network &amp; Non-Network</b> 20%	Yes	No	For facility/non-emergency services out-of-network, you will pay 40% and the annual deductible applies.
<b>Diagnostic Tests/X-Ray and Laboratory Services</b>	<b>Network</b> 20%	Yes	No	
	<b>Non-Network</b> 20%	Yes	No	
<b>Durable Medical Equipment (DME)</b>	<b>Network</b> 20%	No	No	
	<b>Non-Network</b> 20%	Yes	Yes	
<b>Emergency Room Services</b>	<b>Network &amp; Non-Network</b> \$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.

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<b>Home Health Care</b>	<b>Network</b> 20%	Yes	Yes	Limited to 200 visits per plan year; precertification is required.
	<b>Non-Network</b> 40%	Yes	Yes	
<b>Hospice Care</b>	<b>Network</b> 20%	Yes	Yes	Limited to one episode per lifetime. Benefits include bereavement counseling. Precertification is required.
	<b>Non-Network</b> 40%	Yes	Yes	
<b>Hospital Services (Inpatient)</b>	<b>Network</b> 20%. \$100 per day copay, \$600 maximum per inpatient stay.	No	No	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.
	<b>Non-network</b> 40%.	Yes	Yes	
<b>Hospital Services (Outpatient)</b>	<b>Network</b> 20%	Yes	Yes	
	<b>Non-Network</b> 40%	Yes	Yes	
<b>Maternity Services Hospital Services</b>	<b>Network</b> 20%. Subject to a \$100 copay per day, \$600 maximum per inpatient stay.	No	No	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.
	<b>Non-Network</b> 40%.	Yes	Yes	
<b>Outpatient Services</b>	<b>Network</b> \$25 for first visit only.	No	No	Antepartum care only.
	<b>Non-Network</b> 30%.	Yes	Yes	
<b>Mental Health/ Substance Abuse Services - Inpatient</b>	See Cigna Behavioral Health Schedule			

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<b>Mental Health/ Substance Abuse Services - Outpatient</b>	See Cigna Behavioral Health Schedule			
<b>Nutritional Counseling</b>	<b>Network</b> \$25 per visit <b>Non-Network</b> 40%	No  No	No  No	Limited to 6 sessions per calendar year.
<b>Outpatient Therapy Services</b>	<b>Network</b> \$25 per visit <b>Non-Network</b> 40%	No  Yes	No  Yes	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.
<b>Physician's Office Services</b>	<b>Network</b> \$25 per visit. <b>Non-Network</b> 40%	No  Yes	No  Yes	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.
<b>Routine &amp; Preventive Services</b> <b>Routine Exams</b> <b>Routine Exam X-Rays &amp; Laboratory Services</b> <b>Well-Child Checkups</b> <b>Routine Colonoscopy</b> <b>Routine Sigmoidoscopy</b> <b>Other Routine Services</b>	<b>Network</b> \$25 per visit. <b>Non-Network</b> 40%	No  Yes	No  Yes	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+.
<b>Skilled Nursing Facility/ Inpatient Rehabilitation Facility Services</b>	<b>Network</b> 20% <b>Non-Network</b> 40%	Yes  Yes	Yes  Yes	Limited to 60 days per year.
<b>Smoking Cessation Program</b>	<b>Network</b> 20% <b>Non-Network</b> 40%	No  No	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.
<b>Spinal Treatment</b>	<b>Network</b> \$25 per visit <b>Non-Network</b> 40%	No  Yes	No  Yes	Limited to 20 visits per year.

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<b>Surgical Treatment of Morbid Obesity</b>	<b>Network</b> 20%	Yes	Yes	Limited to 1 procedure per lifetime.
	<b>Non-Network</b> 40%	Yes	Yes	
<b>Urgent Care Services</b>	<b>Network</b> 20%	Yes	Yes	
	<b>Non-Network</b> 40%	Yes	Yes	

## Additional Benefits

<b>Anesthesiology Services</b>				
<b>Professional</b>	<b>Network</b> 20%	Yes	No	
	<b>Non-Network</b> 20%	No	No	
<b>Facility</b>	<b>Network</b> 20%	Yes	No	
	<b>Non-Network</b> 40%	Yes	Yes	
<b>Organ Transplants</b>	<b>Network</b> 20%	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.
	<b>Non-Network</b> 40%	Yes	Yes	
<b>All Other Covered Medical Expenses</b>	<b>Network</b> 20%	No	No	Benefits are provided for expenses listed in the “What’s Covered” sections of this Handbook.
	<b>Non-Network</b> 40%	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.