The Episcopal Church Medical Trust

Plan Document Handbook

PPO 75/50 Plan

Presenting information at your fingertips 24 hours a day, 7 days a week. A complete staff of professionals is ready to assist you with:

- General health questions.
- Health care resources.
- Current provider information.
- Benefit plan inquiries.

Benefits effective as of August 1, 2008

ABOUT US

The Episcopal Church Medical Trust (the "Medical Trust"*) maintains a series of benefit plans for the employees (and their dependents) of the Protestant Episcopal Church in the United States of America (hereinafter referred to as "the Church"). We serve only ecclesiastical societies, dioceses, missionary districts, or other bodies subject to the authority of the church. The benefit plans maintained by the Medical Trust are intended to qualify as "church plans" within the meaning of Section 414(e) of the Internal Revenue Code, and are exempt from the requirements of the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

The Medical Trust funds certain of its benefit plans through a trust fund, the Episcopal Church Clergy and Employees' Benefit Trust ("ECCEBT"), that is intended to qualify as a voluntary employees' beneficiary association (VEBA) under Section 501(c)(9) of the Internal Revenue Code. The purpose of the ECCEBT is to provide benefits to eligible employees, former employees, and/or their dependents in the event of illness or expenses for various types of medical care and treatment.

SERVING THE CHURCH

The mission of the Medical Trust is to "balance compassionate Christian care with financial stewardship." This is a unique mission in the world of health care benefits, and we believe that our experience and mission to serve the church offer a level of expertise that is unparalleled.

ENROLL NOW

If you have questions about any of our plans, please don't hesitate to contact us. We're looking forward to serving you.

For more information, please visit our web site at www.cpg.org. Or you may call our Member Service Call Center at (800) 480-9967.

* Church Pension Group Services Corporation is the sponsor of this program and is doing business under the name "The Episcopal Church Medical Trust."

ABOUT THIS HANDBOOK

The Medical Trust has prepared this Handbook to help you understand your benefits under the PPO 75/50 Plan administered by Empire BlueCross BlueShield ("Empire"). Please read it carefully. Your benefits are affected by certain limitations and conditions that require you to be a wise consumer of health services and to use only those services you need. Also, benefits are not provided for certain kinds of treatments or services, even if your health care provider recommends them.

THE BLUECARD® PPO NETWORK— A SMART WAY TO GET HEALTH CARE

The Medical Trust health plans described in this Handbook are built around a network of health care providers available to you through the BlueCross and BlueShield Associations BlueCard® Preferred Provider Organization (PPO). The suitcase logo on your ID card indicates that you are a member of the BlueCard PPO Program. A PPO is a group of health care providers that have agreed to provide medical care services at a contracted rate through the PPO. If you think about your town, it includes doctors, hospitals, laboratories, and other medical facilities that provide health care services—that's what we mean by health care "providers."

Some health care providers contract with Empire or other BlueCross and/or BlueShield networks to provide services to members as part of the BlueCard PPO Network. Because the contracted rate results in savings to both you and the Plan, you are reimbursed at a higher level if you use PPO providers. PPO providers are also referred to as a "network" or "network providers." The terms "non-network" or "out-of-network" refer to health care providers that do not participate in the BlueCard PPO Network. Network providers include hospitals, physicians, outpatient facilities, and other ancillary health care providers.

If you are enrolled in a PPO Plan, when you need health care services, you have a choice. For many medically necessary health care services, you are free to get care from providers participating in the BlueCard PPO Network, or you can choose to use non-network providers.

THE BLUECARD PPO NETWORK ADVANTAGE

When you use the BlueCard PPO Network for health care, you get:

- Access to a network of doctors and hospitals across the country.
- Minimal out-of-pocket costs for preventive care and a wide variety of hospital and medical services.
- Ease of use—no claim forms to file.
- Coverage for yourself and your family when traveling or temporarily living outside of your service area.

HOW TO USE THIS HANDBOOK

As used in this Handbook, the word “year” refers to the plan year, which is the 12-month period beginning August 1 and ending July 31. All annual benefit maximums and deductibles accumulate during the plan year. The word “lifetime,” as used in this Handbook, refers to the period of time you or your eligible dependents participate in this Plan or any other plan maintained by the Medical Trust.

Any amount you or your eligible dependents have accumulated toward the benefit maximum amounts of any previous Medical Trust plan will be counted toward the benefit maximum amounts of this Plan.

The Medical Trust intends the Plan to be permanent, but since future conditions affecting the Medical Trust or your employer cannot be anticipated or foreseen, the Medical Trust reserves the right to amend, modify, or terminate the Plan in any manner, at any time, which may result in the termination or modification of your coverage. If the Plan is terminated, any Plan assets will be used to pay for eligible expenses incurred prior to the Plan’s termination, and such expenses will be paid as provided under the terms of the Plan prior to its termination.

This handbook contains only a partial, general description of the Plan. This book is provided for informational purposes only and should not be viewed as a contract, an offer of coverage, or investment, tax, medical or other advice. There are additional sources of information, such as medical policy, that will be used in making benefit determinations. In the event of a conflict between this handbook and other official Plan documents, the official Plan documents will govern.

Benefits described in this Handbook are effective as of August 1, 2008.

You’ll find the information you need divided into sections.
Here’s a quick reference:

IF YOU ARE LOOKING FOR…	YOU’LL FIND IT IN…	BEGINNING ON PAGE
How the Plan Works	“Using the Plan”	2
What’s Covered	“Coverage”	4
Precertification and Health Information	“Medical Management”	37
How to File a Claim, the Meaning of Health Care Terms, and Coordination of Benefits	“Details and Definitions”	41

Throughout this Handbook, we’ve posted signs along the way to help you out:

Empire’s Medical Management Program

What’s Covered

What’s Not Covered

Remember

Tips

TABLE OF CONTENTS

INTRODUCTION	**1**
Getting Answers	1
USING THE PLAN	**3**
COVERAGE	**4**
Outpatient Care	4
Healthy Living Programs	7
Maternity Care	9
Emergency Care	11
Hospital Care	13
Transplant Care	19
Durable Medical Equipment and Supplies	21
Home Health Care	23
Skilled Nursing and Hospice Care	24
Mental Health and Substance Abuse Care	26
Pharmacy Benefits	27
Exclusions and Limitations	34
MEDICAL MANAGEMENT	**37**
DETAILS AND DEFINITIONS	**41**
About Your Benefits	41
Coordination of Benefits	43
Other Important Plan Provisions	46
Filing a Claim	50
General Information	54
SCHEDULE OF BENEFITS	**56**
75/50 PPO Plan	56
Prescription Drug Benefits	60
Vision Benefits	62
YOUR PRIVACY RIGHTS	**63**

GETTING ANSWERS

WHAT	WHY	WHERE
Empire BlueCross/BlueShield Member Services	For questions about your benefits, claims, or membership	(800) 352-3152 (Monday through Friday, 8:30 a.m.–8:00 p.m. EST)
BlueCard PPO Network	Locate a provider	**www.empireblue.com/medicaltrust** (800) 352-3152
Medical Management Program	Preauthorization of hospital admissions and certain designated services	(800) 352-3152 (Monday through Friday, 8:30 a.m.–5:00 p.m. EST)
Empire Nurse Access	Speak with a specially trained nurse to get health information	(877) TALK-2RN ((877) 825-5276) (24 hours a day, 7 days a week)
BlueCard Worldwide Program	Locate a licensed health care professional who participates in an international network, when you need emergency services when traveling outside the United States	(877) 352-3152 (Monday through Friday, 8:30 a.m.–5:00 p.m. EST)
CIGNA Behavioral Health	Preauthorization of inpatient admissions or help finding a mental health or substance abuse provider	**www.cignabehavioral.com** (866) 395-7794 24 hours a day, 7 days a week
Medco	For questions about the program, to locate a participating retail pharmacy, or to obtain a drug formulary list.	**www.medco.com** (800) 841-3361 (24 hours a day, 7 days a week)
EyeMed Vision Care	For questions about vision benefits, to locate a participating provider, or to obtain authorization to use non-network providers.	**www.eyemedvisioncare.com** (866) 723-0513 (Monday through Saturday, 8:00 a.m.–11:00 p.m. EST, and Sunday, 11:00 a.m.–11:00 p.m. EST)
The Medical Trust	For questions about benefits, enrollment, or appeals	**www.medicaltrust.org** (800) 480-9967 (Monday through Friday, except holidays, 8:30 a.m.–5:30 p.m. EST)

USING THE PLAN TO YOUR BEST ADVANTAGE

Your health is valuable. Knowing how to use your benefits to your best advantage will help ensure that you receive high-quality health care—with maximum benefits. Here are three ways to get the most from your coverage.

Be sure you know what's covered by the Plan.

That way, you and your doctor are better able to make decisions about your health care. The BlueCard PPO Network will work with you and your doctor so that you can take advantage of your health care options and are aware of limits the Plan applies to certain types of care.

EMPIRE'S MEDICAL MANAGEMENT PROGRAM

When seeking health care, please note that the Plan is structured so that you have the lowest out-of-pocket cost for your health care coverage when you use network providers. You have the flexibility of seeking care directly from any type of network provider, including specialists. For most visits, simply choose the network physician you prefer and make an appointment when care is needed. You may also seek care from a non-network provider. However, it is important to note that when using a non-network provider, your out-of-pocket expenses may be higher, as outlined on the Schedule of Medical Benefits. The final choice of health care providers is always up to you. Some Plan benefits may be offered only through the PPO. Please refer to the "Medical Management" section of this Handbook to determine if you need to give prior notification of services before seeing your provider.

Providers in the BlueCard PPO Network will maintain traditional health care provider/patient relationships with you and/or your dependent(s) for the provision of hospital and other medical services. Such relationships include the right of providers in the BlueCard PPO Network to commence or terminate treatment in accordance with generally accepted principles of medical practice and treatment. Nothing contained in this Plan will require a provider in the BlueCard PPO Network to commence or continue medical treatment for you or your dependent(s), and nothing contained in this Plan will require you or your dependent(s) to commence or continue medical treatment with a particular provider in the BlueCard PPO Network. Furthermore, nothing in this Plan will limit or otherwise restrict a physician's medical judgment with respect to his/her ultimate responsibility for patient care in the provision of medical services to you and/or your dependent(s).

USING THE PLAN TO YOUR BEST ADVANTAGE

Please remember to precertify hospital and other facility admissions, maternity care, and other designated services requiring preauthorization in order to ensure maximum benefits.

You'll recognize these services when you see the blue telephone sign. Precertification gives you and your doctor an opportunity to learn what the Plan will cover and identify treatment alternatives and the proper setting for care—for instance, a hospital or your home. Knowing these things in advance can help you save time and money. If you fail to precertify when necessary, your benefits may be reduced or denied.

Ask questions about your health care options and coverage.

To find answers, you can:

Read this Handbook.

Call Member Services when you have questions about your Plan benefits in general or your benefits for a specific medical service or supply.

Call Empire Nurse Access®—available to members 24 hours a day to get recorded general health information or to speak to a nurse to discuss health care options and more.

Talk to your provider about your care, learn about your benefits and your options, and ask questions. The BlueCard PPO Network is here to work with you and your provider to see that you get the best benefits while receiving the quality health care you need.

OUTPATIENT CARE

When you need to visit your health care provider, the Plan makes it easy. In-network, you pay only a small copayment for the office visit. There are no claim forms to fill out, and in some of our Plans, there are no additional charges for x-rays, blood tests, or other diagnostic procedures. Remember, any services performed during the visit will be paid as outlined on the Schedule of Medical Benefits at the back of this Handbook.

When you visit an out-of-network provider or use an out-of-network facility for diagnostic tests, you pay the deductible and coinsurance, plus any amount above the allowed amount, which is defined as the "reasonable and customary charge." (The reasonable and customary charge is the charge most frequently made to the majority of patients for the same service or procedure in the geographic area where services or supplies are provided.)

WHAT'S COVERED

The following medical services are covered:

Physician home and office visits.

Second and third surgical opinions.

Termination of pregnancy.

Dental services received after an accidental injury to teeth. This includes replacement of teeth and any related x-rays.

Chiropractic services. Benefits are limited as outlined on the Schedule of Medical Benefits.

Radiation therapy. However, there is no coverage provided for high-dose radiotherapy in connection with autologous bone marrow transplantation, stem cell rescue, or other hematopoietic support procedures for any symptom, disease, or condition, except as specified in the "Transplant Care" section of this Handbook.

Chemotherapy. However, there is no coverage provided for high-dose chemotherapy in connection with autologous bone marrow transplantation, stem cell rescue, or other hematopoietic support procedures for any symptom, disease, or condition, except as specified in the "Transplant Care" section of this Handbook.

Dialysis.

Cardiac therapy.

Acupuncture. Benefits are limited as outlined in the Schedule of Medical Benefits.

Nutritional counseling. Benefits are limited as outlined in the Schedule of Medical Benefits.

TIPS FOR VISITING YOUR DOCTOR

- When you make your appointment, confirm that the doctor is a PPO network provider.
- Arrange ahead of time to have pertinent medical records and test results sent to the doctor.
- If the doctor sends you to a lab or radiologist for tests or x-rays, please visit **www.empireblue.com/medicaltrust** or call Member Services to confirm that the health care provider is a PPO network provider. This will ensure that you receive maximum benefits.
- Ask about a second opinion anytime you are unsure about surgery or a cancer diagnosis.

OUTPATIENT CARE

Smoking cessation, including counseling and hypnosis. Benefits are limited as outlined in the Schedule of Medical Benefits.

Consultation requested by the attending physician for advice on an illness or injury.

Diabetes supplies prescribed by an authorized provider:

- Blood glucose monitors for the legally blind.
- Testing strips.
- Insulin, syringes, injection aids, cartridges for the legally blind, insulin pumps and appurtenances, and insulin infusion devices.
- Oral agents for controlling blood sugar.
- Data management systems.

Diabetes self-management education and diet information, including:

- Education by a physician, certified nurse practitioner, or member of their staff:
  - At the time of diagnosis;
  - When the patient's condition changes significantly; and
  - When medically necessary.
- Education by a certified diabetes nurse educator, certified nutritionist, certified dietitian when referred by a physician, or certified nurse practitioner. This benefit may be limited to a group setting when appropriate.

Medically necessary treatment of the feet, including treatment of metabolic or peripheral-vascular disease.

Diagnostic charges for x-rays.

Diagnostic charges for laboratory services.

Preadmission testing (PAT).

Ultrasounds, including routine pregnancy-related ultrasounds.

Allergy testing.

Magnetic Resonance Imaging (MRI), including Magnetic Resonance Angiography (MRA).

Venipuncture.

Occupational, speech, physical, or hearing therapy, or any combination of these on an outpatient basis, up to the Plan maximums, if:

- Prescribed by a physician or in conjunction with a physician's services;
- Given by skilled medical personnel at home, in a therapist's office, or in an outpatient facility; and
- Performed by a licensed speech/language pathologist, audiologist, or other therapist qualified to perform the services rendered.

OUTPATIENT CARE

WHAT'S NOT COVERED

Treatment of or related to sleep disorders.

The following medical services and supplies are not covered:

Routine foot care, including, but not limited to, care of corns, bunions, calluses, toenails, flat feet, fallen arches, weak feet, and chronic foot strain.

Symptomatic complaints of the feet, except capsular or bone surgery related to bunions and hammertoes.

Foot orthotics.

Hearing aids and the examination for their fitting.

Services given by an unlicensed health care provider or performed outside the scope of the provider's license.

Services such as laboratory x-ray and imaging, and pharmacy services as required by law, from a facility in which the referring physician or his/her immediate family member has a financial interest or relationship.

Nonsurgical treatment for, or prevention of, temporomandibular joint (TMJ) dysfunction, craniomandibular disorder, and other conditions of the joint linking the jawbone and skull, and the muscles, nerves, and other tissues related to that joint.

Hypnosis (unless part of smoking cessation).

Treatment, instructions, activities, or drugs (including diet pills) for weight reduction or control, except as specified for nutritional counseling under What's Covered.

Infertility testing.

Genetic testing.

Rolfing.

HEALTHY LIVING PROGRAMS

Preventive care is an important and valuable part of your health care. Regular physical checkups and appropriate screenings can help you and your doctor detect illness early. When you treat an illness or condition early, you minimize the risk of a serious health problem and reduce the risk of incurring greater costs. That's why the Plan provides benefits for many preventive care services at no cost to you or for only a small copayment when you use providers participating in the BlueCard PPO Network.

WHAT'S COVERED

Benefits are limited as outlined on the Schedule of Medical Benefits. The following preventive care services are covered:

Well-woman care visits to a gynecologist/obstetrician, including Pap tests.

Well-child care visits (through age 19) to a pediatrician, nurse, or licensed nurse practitioner, including a physical examination, medical history, developmental assessment, guidance on normal childhood development, and laboratory tests. The tests may be performed in the office or a laboratory. The number of visits covered per year depends on your child's age.

Well-child care immunizations as listed:

- DPT (diphtheria, pertussis, and tetanus)
- Polio
- MMR (measles, mumps, and rubella)
- Varicella (chicken pox)
- Hepatitis B
- Hemophilus
- Tetanus-diphtheria
- Pneumococcal
- Meningococcal Tetramune

PSA tests.

Mammograms.

Physicals, including all related x-rays and laboratory services.

Vision exams performed by your physician during a routine physical. Additional benefits are available through EyeMed VisionCare.

Hearing exams performed by your physician during a routine physical.

EKGs performed by your primary care physician as part of a routine physical.

Sigmoidoscopy. Benefits are limited as outlined on the Schedule of Medical benefits.

Colonoscopy. Benefits are limited as outlined on the Schedule of Medical benefits.

Flu shots.

TIPS FOR USING PREVENTIVE CARE

- Visit your doctor once a year for a checkup. Take the screening tests appropriate for your gender and age to help identify illness or the risk of serious illness.
- Get routine mammograms, especially if you are a woman age 35 and over and/or if you have a family history of breast cancer.
- Keep your children healthy by getting routine checkups and preventive care, including certain immunizations.

HEALTHY LIVING PROGRAMS

WHAT'S NOT COVERED

These preventive care services are not covered:

Screening tests done at your place of work at no cost to you.

Free screening services offered by a government health department.

Tests done by a mobile screening unit, unless a doctor not affiliated with the mobile unit prescribes the tests.

Flu vaccines supplied by a government agency, or otherwise provided at no cost to you.

MATERNITY CARE

The primary objective of the specialized maternity program is to identify high-risk pregnancies to promote positive outcomes for the mother and baby, and to assist in coordinating cost-effective care. You are encouraged to call the Medical Management Program's toll-free number at (800) 352-3152 during the first trimester of your pregnancy; however, you may call at any time during your pregnancy. When you call, a *nurse* will ask you questions about your general health and medical history. This information may be provided to your *physician* or *practitioner* and will help determine whether a nurse can provide you with additional support during and/or after your pregnancy.

If appropriate, a case manager will follow your case and coordinate communication among you and all *health care providers* involved in your care.

The specialized maternity program is an optional service provided for your benefit. The Plan's coinsurance will not be reduced if you choose not to participate in the program.

There are no out-of-pocket expenses for office visits, except the initial office visit copayment for maternity and newborn care, when you use providers participating in the BlueCard PPO Network.

For out-of-network maternity services, you pay the deductible, coinsurance, and any amount above the allowed amount.

EMPIRE'S MEDICAL MANAGEMENT PROGRAM

Whether services are provided in-network or out-of-network, call the Medical Management Program at (800) 352-3152 within the first three months of a pregnancy and again within 24 hours after delivery of the baby. This will ensure that you receive maximum benefits.

Our specially trained nurses are available to support you during and after your pregnancy. Call with questions or to get information during normal business hours. A nurse will work with you and your doctor to identify high-risk pregnancies and, if necessary, will refer you to network specialists who are trained to deal with complicated pregnancies and home care. You can participate in this program as soon as you call the Medical Management Program to let them know you are pregnant.

REMEMBER

- Use a network obstetrician/gynecologist and hospital to receive maternity care at the lowest cost.
- Obstetrical care in the hospital or birthing center is covered up to 48 hours after a normal vaginal birth and 96 hours after a Cesarean section.

MATERNITY CARE

WHAT'S COVERED

The Schedule of Medical Benefits provides information on what is covered. The following are additional covered services and limitations:

Services of a certified nurse-midwife affiliated with a licensed facility. The nurse-midwife's services must be provided under the direction of a physician.

Parent education, and assistance and training in breast or bottle feeding, if available.

Amniocentesis, including the associated genetic counseling and genetic testing.

Ultrasounds.

Circumcision of newborn males.

Special care for the baby if the baby stays in the hospital longer than the mother. Call the Medical Management Program to precertify the hospital stay if the newborn's stay is expected to be more than 48 hours following a normal delivery or 96 hours after a Cesarean section.

Semiprivate room.

Home care with precertification.

WHAT'S NOT COVERED

These maternity care services are not covered:

Days in the hospital that are not medically necessary (beyond the 48-hour/ 96-hour limits).

Services that are not medically necessary.

Private room charges in excess of the cost of a semiprivate room.

Out-of-network birthing center facilities.

Private-duty nursing.

Cold blood storage.

Should you need emergency care, your Plan is there to cover you. Emergency care is covered in the hospital emergency room. To be covered as emergency care, the condition must be one in which a prudent layperson, who has an average knowledge of medicine and health, could reasonably expect that without emergency care, the condition would:

- Place your health in serious jeopardy
- Cause serious problems with your body functions, organs, or parts
- Cause serious disfigurement
- In the case of behavioral health, place you or others in serious jeopardy

Sometimes you have a need for medical care that is not an emergency (e.g., bronchitis, high fever, sprained ankle), but can't wait for a regular appointment. If you need urgent care, call your physician or your physician's backup. You can also call the Empire Nurse Access at (877) TALK2RN ((877) 825-5276) for advice, 24 hours a day, 7 days a week.

EMERGENCY ASSISTANCE

In an emergency, call 911 for an ambulance or go directly to the nearest emergency room. If possible, go to the emergency room of a hospital in the BlueCard PPO Network. However, your benefits will be the same regardless of whether you are treated in an emergency room participating in the network or not.

You pay only a copayment for a visit to an emergency room. This copayment is waived if you are admitted to the hospital within 24 hours. Admission to the hospital through the ER must be precertified within 24 hours. If you make an emergency visit to your doctor's office, you pay the same copayment as for an office visit.

Benefits for treatment in a hospital emergency room are limited to the initial visit for an emergency condition. If a physician or practitioner in the network provides all follow-up care, you will receive maximum benefits.

WHAT'S COVERED

These emergency services are covered:

Treatment in a hospital emergency room or other emergency care facility for a condition that can be classified as a medical emergency.

Ground or air transportation provided by a professional ambulance service to a hospital or emergency care facility that is equipped to treat a condition that can be classified as a medical emergency.

Treatment of an accident in a hospital or other emergency care facility.

REMEMBER

Show your Empire ID card when entering the emergency room or before discharge.

EMERGENCY CARE

WHAT'S NOT COVERED

These emergency services are not covered:

Use of the emergency room:

- To treat routine ailments
- Because you have no regular physician
- Because it is late at night (and the need for treatment is not sudden and serious)

TIPS

- If time permits, speak to your physician to direct you to the best place for treatment.
- Be sure to show your ID card at the emergency room, and if you are admitted, notify Medical Management within 24 hours of admission. If the hospital does not participate in the PPO network, you may need to file a claim.
- If you have an emergency outside of the United States and need to visit a hospital that participates in the BlueCard Worldwide Program, simply show your ID card. The hospital will submit its bill through the BlueCard Worldwide Program. If the hospital does not participate in the BlueCard Worldwide Program, you will need to file a claim.

HOSPITAL CARE

IF YOU NEED TO VISIT A HOSPITAL

The Plan covers most or all of the cost of your medically necessary care when you stay at a network hospital for surgery or treatment of an illness or injury. When you use an out-of-network hospital or facility, you pay the deductible and coinsurance, plus any amount above the allowed amount. If it is not a planned admission, Medical Management needs to be called within 24 hours or a reduction in benefits may occur.

WHEN OUTPATIENT HOSPITAL CARE IS COVERED

You are also covered for same-day (outpatient) hospital services, such as chemotherapy or radiation therapy, cardiac rehabilitation, and kidney dialysis. Same-day surgery services are surgical or invasive diagnostic procedures that:

- Are performed in a same-day or hospital outpatient surgical facility
- Require the use of both surgical operating and postoperative recovery rooms
- Require either local or general anesthesia
- Do not require inpatient hospital admission because it is not appropriate or medically necessary
- Would justify an inpatient hospital admission in the absence of a same-day surgery program

EMPIRE'S MEDICAL MANAGEMENT PROGRAM

Remember to call the Medical Management Program at (800) 352-3152 at least two weeks prior to any planned surgery or hospital admission. For an emergency admission, call Medical Management within 24 hours or as soon as reasonably possible. Otherwise, your benefits may be reduced to 50% for each hospital admission or surgery that is not precertified.

The medical necessity and length of any hospital stay are subject to Medical Management Program guidelines. If Medical Management determines that the admission or surgery is not medically necessary, no benefits will be paid. See the "Medical Management" section of this Handbook for additional information.

If surgery is performed in a network hospital, you will receive in-network benefits for the anesthesiologist, whether or not the anesthesiologist is in the network.

REMEMBER

If you follow the notification and certification requirements outlined above, your benefits will be unaffected, and you and the Plan avoid expenses related to unnecessary health care. However, if you do not follow the procedures required by this Plan, the Plan's coinsurance will be reduced to 50% for all related covered hospital expenses, after any applicable deductible. If you do not preauthorize all inpatient mental health and substance abuse treatment through the Mental Health Benefit Program, benefits will be denied.

In addition, if you fail to follow the requirements to preauthorize or prenotify, and Medical Management retrospectively reviews the treatment and/or services you received and determines they were not medically necessary, benefits will be denied, and you will be responsible for all noncovered expenses.

The penalty assessed when you do not follow the notification and certification procedures required by the Plan does not apply toward your out-of-pocket maximum.

HOSPITAL CARE

WHAT'S COVERED
Inpatient and Outpatient Hospital Care

When all of the provisions of this Plan are satisfied, the Plan will provide benefits as outlined on the Schedule of Medical Benefits for the services and supplies listed in this section. This list is intended to give you a general description of services and supplies covered by the Plan.

The following are covered services and limitations for both inpatient and outpatient (same-day) care:

Diagnostic charges for x-rays.

Diagnostic charges for laboratory services and other diagnostic tests such as EKGs, EEGs, or endoscopics.

Preadmission testing (PAT).

Amniocentesis, including the associated genetic counseling and genetic testing.

Ultrasounds, including routine pregnancy-related ultrasounds.

Allergy testing.

Magnetic Resonance Imaging (MRI), including Magnetic Resonance Angiography (MRA).

Venipuncture.

Oxygen and anesthesia (including equipment for administration).

Anesthesiologist, including one consultation before surgery and services during and after surgery.

Blood and/or plasma and the equipment for its administration, except the collection or storage of blood plasma; blood banking (including the collection, testing and storage of cord blood); the cost of receiving the services of professional blood donors; aphaeresis; or plasmapheresis, with the exception of any of these services that might be required as part of a Plan participant's stem cell or bone marrow transplant.

Physical therapy, physical medicine, or rehabilitation services, or any combination of these on an inpatient or outpatient basis, up to the Plan maximums, if:

- Prescribed by a physician
- Designed to improve or restore physical functioning within a reasonable period of time
- Approved by Empire

TIPS FOR GETTING HOSPITAL CARE

- If your doctor prescribes presurgical testing, have your tests done within seven days prior to surgery at the hospital where surgery will be performed.
- If you are having same-day surgery, often the hospital or outpatient facility requires that someone meet you after the surgery to take you home. Ask about their policy and make arrangements for transportation before you go in for surgery.

HOSPITAL CARE

WHAT'S COVERED
Inpatient Hospital Care

The following are additional covered services for inpatient care:

Semiprivate room and board when:

- The patient is under the care of a physician
- A hospital stay is medically necessary. Coverage is for unlimited days, subject to Medical Management Program review, unless otherwise specified

Private room and board expenses, limited to the cost of a semiprivate room.

Intensive care unit and coronary care unit charges.

Operating and recovery rooms.

Special diet and nutritional services while in the hospital.

Cardiac care unit.

Services of a licensed physician or surgeon employed by the hospital.

Care related to surgery.

Miscellaneous hospital services and supplies required for treatment during a hospital confinement.

Hospital confinement expenses for dental services if hospitalization is necessary to safeguard the health of the patient.

Breast cancer surgery (lumpectomy, mastectomy), including:

- Reconstruction following surgery.
- Surgery on the other breast to produce a symmetrical appearance.
- Prostheses.
- Treatment of physical complications at any stage of a mastectomy, including lymphedemas.

The patient has the right to decide, in consultation with the physician, the length of hospital stay following mastectomy surgery.

Use of cardiographic equipment.

Drugs, dressings, and other medically necessary supplies.

Social, psychological, and pastoral services.

Reconstructive surgery associated with injuries unrelated to cosmetic surgery.

Reconstructive surgery for a functional defect that is present from birth.

Physical, occupational, speech/hearing therapy, including facilities, services, supplies, and equipment.

WHAT'S COVERED

Surgical Care

The following are additional covered surgical services:

Surgeon's expenses for the performance of a surgical procedure.

Assistant surgeon's expenses, not to exceed 20% of the reasonable and customary charge of the surgical procedure.

Two or more surgical procedures performed during the same session. The amount eligible for consideration is the sum of reasonable and customary charges for the largest amount billed for one procedure plus 50% of the sum of reasonable and customary charges billed for all other procedures performed.

Anesthetic services when performed by a licensed anesthesiologist or certified registered nurse anesthetist in connection with a surgical procedure.

Oral surgery, limited to:

- Treatment of an accidental injury to teeth;
- Removal of cysts or tumors, including radicular dentigerous cysts;
- Cutting operations of the periodontium;
- Surgical extractions;
- Treatment for malignancy or disease of the oral cavity;
- Frenectomy or frenotomy; and
- Biopsies.

Benefits include general anesthesia, even when administered by the surgeon performing the procedure. If you have elected medical and dental coverage, covered expenses will be considered under the medical plan only.

Reconstructive surgery when needed to correct damage caused by a birth defect resulting in the malformation or absence of a body part or an accidental injury.

Breast reconstruction following a total or partial mastectomy. Benefits include prostheses and reconstruction of the non-diseased breast to restore symmetry.

Medically necessary removal of breast or other prosthetic implants, only if they were not inserted in connection with cosmetic surgery.

Surgical treatment of morbid obesity. Benefits are limited as outlined on the Schedule of Medical Benefits.

Surgical reproductive sterilization.

Human organ and tissue transplants. Please refer to the "Transplant Care" section of this Handbook for further information.

Circumcision, for newborns only.

Outpatient surgery.

Surgical treatment of temporomandibular joint (TMJ) dysfunction.

Penile prosthetic implants.

Orthognathic surgery.

Podiatry surgery.

WHAT'S COVERED
Outpatient Hospital Care

The following are additional covered services for same-day care:

Same-day and hospital outpatient surgical facilities.

Surgeons.

Surgical assistant if:

- None are available in the hospital or facility where the surgery is performed; and
- The surgical assistant is not a hospital employee.

Chemotherapy and radiation therapy, including medications, in a hospital outpatient department, doctor's office, or facility. Medications that are part of outpatient hospital treatment are covered if they are prescribed by the hospital and filled by the hospital pharmacy.

Kidney dialysis treatment (including hemodialysis and peritoneal dialysis) is covered in the following settings until the patient becomes eligible for end-stage renal disease dialysis benefits under Medicare:

- At home, when provided, supervised, and arranged by a physician and the patient has registered with an approved kidney disease treatment center (professional assistance to perform dialysis and any furniture, electrical, plumbing, or other fixtures needed in the home to permit home dialysis treatment are not covered); and
- In a hospital-based or free-standing facility.

Diabetic nutritional counseling.

WHAT'S NOT COVERED
Inpatient Hospital Care

These inpatient services are not covered:

Private duty nursing.

Private room. If you use a private room, you need to pay the difference between the cost for the private room and the hospital's average charge for a semiprivate room. The additional cost cannot be applied to your deductible or coinsurance.

Diagnostic inpatient stays, unless connected with specific symptoms that, if not treated on an inpatient basis, could result in serious bodily harm or risk to life.

Services performed in the following:

- Nursing or convalescent homes.
- Institutions primarily for rest or for the aged.
- Rehabilitation facilities (except for physical therapy).
- Spas.
- Sanitariums.
- Infirmaries at schools, colleges, or camps.

Any part of a hospital stay that is primarily custodial.

Elective cosmetic surgery or any related complications.

Hospital services received in clinic settings that do not meet Empire's definition of a hospital or other covered facility.

WHAT'S NOT COVERED
Outpatient Hospital Care

These outpatient services are not covered:

Routine medical care, including, but not limited to:

- Inoculation or vaccination.
- Drug administration or injection, excluding chemotherapy.
- Blood collection.

Collection or storage of your own blood, blood products, semen, or bone marrow.

TRANSPLANT CARE

BlueCross BlueShield (BCBS) National Transplant Program

We wish to provide you and your family with a human organ and tissue transplant benefit that helps you obtain quality care and financially protects you from significant health care expenses. The BCBS National Transplant Program is a coordinated set of transplant services provided through a special network of transplant facilities. It is designed to help you obtain the transplant services that are appropriate for you and eligible for reimbursement under this Plan. It includes case management and some services not otherwise covered by this Plan. The medical professionals who conduct the program focus their review on the appropriateness of the proposed transplant procedures. Only those procedures that are covered and certified as medically necessary will be eligible under the Plan.

Please note that because transplantation is a highly specialized area, not all BlueCard PPO Network hospitals are part of the BCBS National Transplant Program.

EMPIRE'S MEDICAL MANAGEMENT PROGRAM

To enroll in the BCBS National Transplant Program, you are required to call Empire's Medical Management Program at (800) 352-3152 as soon as the possibility of a transplant is discussed with your physician. When you call, it will be necessary to provide the program with all the information needed to complete the review. In order to receive the highest level of benefits, you must choose one facility within the special network of transplant facilities. Transplant-related services must be received at the facility you choose in order to be covered under the National Transplant Program benefit. All transplant benefits, including pre-transplant evaluation expenses (even if the transplant does not occur), will be provided by the Plan as outlined on the Schedule of Medical Benefits.

COVERED TRANSPLANTS

When all of the provisions of the BCBS National Transplant Program are satisfied, the Plan will provide benefits as outlined on the Schedule of Medical Benefits only for the services and supplies listed in this section.

Allogenic/autologous bone marrow.

Heart.

Heart/lung.

Lung.

Double lung.

Liver.

Kidney.

Kidney/pancreas.

TRANSPLANT CARE

BlueCross BlueShield (BCBS) National Transplant Program

WHAT'S COVERED

Pre-transplant evaluation.

Organ procurement.

Transplant procedures and associated hospitalization.

Transplant-related follow-up care provided by the designated transplant facility for up to one year.

Pharmacy supplies and services provided by the BCBS National Transplant Program facility for immunosuppressant and other transplant-related medications while hospitalized.

Donor expenses, if not covered under any other plan.

Transplant-related services provided by the BCBS National Transplant Program facility that are associated with the transplant events listed on the previous page, including laboratory and other diagnostic services.

Physician services related to the transplant events listed on the previous page.

Travel and lodging expenses for the patient/donor and one other individual if the patient/donor lives at least 100 miles from the designated facility. If the patient is a minor, the Plan will consider expenses for two individuals to accompany the patient. Benefits also include travel to and from lodging near a designated transplant facility for the pre-transplant evaluation.

WHAT'S NOT COVERED

Services, supplies, drugs, and aftercare for, or related to, artificial or nonhuman organ implants or transplants.

Services that are considered experimental/investigational or not medically necessary.

Expenses for services that are specifically excluded under the "Exclusions and Limitations" section of this Handbook, unless a part of a treatment plan approved through the Medical Management Program.

REMEMBER

- When the required review procedures for the BCBS National Transplant Program are followed and you use one of the designated transplant facilities, your benefits will be unaffected, and you and the Plan avoid unnecessary expenses. However, if a transplant procedure is not performed at a BCBS National Transplant Program facility or through a PPO facility, the plan will not cover any transplant-related expenses, including, but not limited to, organ donor costs or travel, lodging, and meal expenses.
- If you choose not to have a transplant performed at a BCBS National Transplant Program facility, you must still follow the Medical Management Program prior notification and certification requirements outlined in the previous section. If you do not follow the procedures required by this Plan, the Plan's coinsurance will be reduced to 50% for all related covered hospital expenses, after any applicable deductible.
- The penalty assessed when you do not follow the notification and certification procedures required by the Plan does not apply toward your out-of-pocket maximum.

DURABLE MEDICAL EQUIPMENT AND SUPPLIES

The Plan covers medically necessary prosthetics, and durable medical equipment. Please see the Schedule of Medical Benefits for the level of coverage. Before ordering equipment and supplies, contact Empire's Medical Management Program at (800) 352-3152.

Disposable medical supplies, such as syringes, are covered whether you obtain them in-network or out-of-network.

EMPIRE'S MEDICAL MANAGEMENT PROGRAM

Empire's Medical Management case manager can help locate a durable medical equipment supplier for you and coordinate communication among you and all health care providers involved in arranging and obtaining medical supplies. You can arrange for a case manager by calling Empire's Medical Management Program at (800) 352-3152.

WHAT'S COVERED

Durable medical equipment, including expenses related to necessary repairs and maintenance. A statement is required from the prescribing physician describing how long the equipment is expected to be necessary. This statement will determine whether the equipment will be rented or purchased. Replacement equipment will be covered if the replacement equipment is required due to a change in the patient's physical condition, or if purchase of new equipment will be less expensive than repair of existing equipment.

Artificial limbs and eyes and replacement of artificial limbs and eyes if required due to a change in the patient's physical condition, or if a replacement is less expensive than repair of existing equipment.

Original fitting, adjustment, and placement of orthopedic braces, casts, splints, crutches, cervical collars, head halters, traction apparatus, or prosthetic appliances to replace lost body parts or to aid in their function when impaired. Replacement of such devices only will be covered if the replacement is necessary due to a change in the patient's physical condition.

Orthopedic or corrective shoes and other supportive appliances for the feet, only in connection with the treatment of diabetes.

Oxygen and rental of equipment required for its use, not to exceed the purchase price of such equipment.

Blood and/or plasma and the equipment for its administration.

Allergy injections, including the serum.

DURABLE MEDICAL EQUIPMENT AND SUPPLIES

Contraceptive devices, including diaphragms, IUDs, and Norplant implants.

Depo-Provera injections. Contraceptive injectables dispensed at a pharmacy may be available through the Prescription Drug Program.

Insulin infusion pumps.

Initial prescription contact lenses or eyeglasses, including the examination and fitting of the lenses, to replace the human lens lost through intraocular surgery.

Wigs and artificial hairpieces, only after chemotherapy or radiation therapy. Benefits are limited as outlined on the Schedule of Medical Benefits.

Sterile surgical supplies after surgery.

Compression garments. Benefits are limited as outlined on the Schedule of Medical Benefits.

WHAT'S NOT COVERED

The following equipment is not covered:

Air conditioners or purifiers.

Humidifiers or dehumidifiers.

Exercise equipment.

Swimming pools or hot tubs.

False teeth.

Hearing aids.

Foot orthotics.

Heating pads or hot water bottles.

Waterbeds.

Clothing or equipment that could be used in the absence of an illness or injury.

Electric chairlifts or any other modifications to a home or residence.

Breast pumps.

HOME HEALTH CARE

If you or your dependents have a serious or extended care illness or injury, a Medical Management case manager can assist in identifying and coordinating cost-effective medical care alternatives. Home health care can be one such alternative to an extended stay in a hospital or a stay in a skilled nursing facility. You receive full coverage when you use an in-network provider. Out-of-network agencies must be certified by your state. Home infusion therapy is available in-network only.

EMPIRE'S MEDICAL MANAGEMENT PROGRAM

The Medical Management Program case manager can help locate a home health care provider for you and coordinate communication among you and all health care providers involved in arranging and obtaining home health care services. You can arrange for a case manager by calling Empire's Medical Management Program at (800) 352-3152.

WHAT'S COVERED

The following are covered services and limitations:

Home health care visits, combined in- and out-of-network. A visit is defined as up to four hours of care. Your physician must certify home health care as medically necessary and approve a written treatment plan. Home health care services include:

- Part-time services by a registered nurse (RN) or licensed practical nurse (LPN).
- Part-time home health aide services (skilled nursing care).
- Physical, speech, or occupational therapy, if restorative.
- Medications, medical equipment, and supplies prescribed by a doctor.
- Laboratory tests.

WHAT'S NOT COVERED

The following home health care services are not covered:

Custodial services, including bathing, feeding, changing, or other services that do not require skilled care.

Services or supplies that are not part of the home health care plan.

Services of a person who usually lives with you or who is a member of your or your spouse's family.

Transportation.

SKILLED NURSING AND HOSPICE CARE

The Plan provides benefits for both skilled nursing and hospice care. The Medical Management case manager can assist you in arranging and obtaining these services, should they be necessary for you or your dependents.

EMPIRE'S MEDICAL MANAGEMENT PROGRAM

The Medical Management case manager can help locate a skilled nursing facility or hospice provider for you and coordinate communication among you and all health care providers involved in arranging and obtaining these services. You can reach a case manager by calling Empire's Medical Management Program at (800) 352-3152.

WHAT'S COVERED
for Skilled Nursing Care

You are covered for up to 60 inpatient days per calendar year in a skilled nursing facility if you need medical care, nursing care, or rehabilitation services.

Services are covered if the doctor provides:

- A written treatment plan
- A projected length of stay
- An explanation of the services the patient needs
- The intended benefits of care

Care is under the direct supervision of a physician, registered nurse (RN), physical therapist, or other health care professional.

WHAT'S NOT COVERED
for Skilled Nursing & Hospice Care

The following skilled nursing care services are not covered:

Skilled nursing facilities that primarily:

- Give assistance with daily living activities
- Are for rest or for the aged
- Treat drug addiction or alcoholism
- Convalescent care
- Sanitarium-type care
- Rest cures

SKILLED NURSING AND HOSPICE CARE

WHAT'S COVERED
for Hospice Care

The Plan covers hospice care once in a covered person's lifetime. Hospices provide medical and supportive care to patients who have been certified by their physician as having a life expectancy of six months or less. Hospice care can be provided in a hospice, in the hospice area of a network hospital, or at home, as long as it is provided by a network hospice agency.

The following are covered services and limitations:

Hospice care services, including:

- Up to 12 hours of intermittent care each day by a registered nurse (RN) or licensed practical nurse (LPN).
- Medical care given by the hospice doctor.
- Drugs and medications prescribed by the patient's doctor that are not experimental and are approved for use by the most recent Physicians' Desk Reference.
- Physical, occupational, speech, and respiratory therapy when required for control of symptoms.
- Laboratory tests, x-rays, chemotherapy, and radiation therapy.
- Social and counseling services for the patient's family, including bereavement counseling visits until one year after death.
- Transportation between home and hospital or hospice when medically necessary.
- Medical supplies and rental of durable medical equipment.

MENTAL HEALTH AND SUBSTANCE ABUSE CARE

Mental Health Benefit Program

MENTAL HEALTH/ SUBSTANCE ABUSE SERVICES

CIGNA Behavioral Health administers the inpatient and outpatient mental health benefits for members enrolled in the Empire 75/50 PPO Plan. CIGNA Behavioral Health's nationwide network of providers includes more than 47,000 independent psychiatrists, psychologists, pastoral counselors and clinical social workers and more than 4,000 facilities and clinics. To find a network provider, or to learn more about your benefits, you may call CIGNA Behavioral Health toll-free at (866) 395-7794, 24 hours a day, seven days a week.

Employee Assistance Program (EAP)

The Employee Assistance Program (EAP) is managed by CIGNA Behavioral Health and covers a vast array of family and personal services. The program is designed to assist our members with information, educational materials, resources, referrals, and ongoing support.

EAP services are available 24 hours a day, 7 days a week through the CIGNA Behavioral Health website or by phone. All services are free and confidential. Equipped with many tools, the EAP staff members are trained to provide you with a multitude of services including: help finding daycare services for your children, support for managing stress, information on adoption, assistance in researching nursing homes, etc.

To access the CIGNA EAP services, visit the EAP website at **www.cignabehavioral.com** or call (866) 395-7794.

REMEMBER

- Participants are required to call CIGNA's Behavioral Health toll-free number (866) 395-7794 before any inpatient mental health and substance abuse treatment. When you call, you should provide the following: the name of the covered employee and the name of the patient; the name, address, and telephone number of the hospital; and the scheduled date of admission.
- If you do not have a mental health/substance abuse provider and need assistance in selecting one, CIGNA Behavioral Health can assist you with a referral. For emergency admissions (including evenings and weekends), you or your provider must contact CIGNA Behavioral Health at the time of the admission.
- If you follow the notification requirements outlined above, your benefits will be unaffected, and you and the plan avoid expenses related to unnecessary care. However, if you do not preauthorize all inpatient mental health and substance abuse treatment through CIGNA Behavioral Health, benefits may be reduced to 50%.

PHARMACY BENEFITS

YOUR PHARMACY BENEFITS PROGRAM

Your Plan has selected Medco as its Prescription Drug Program. The program is administered separately from the other components of your Medical Plan. There are three ways to fill your prescriptions under the Prescription Drug Program. You can use one of the 55,000 participating retail pharmacies nationwide, the mail-order pharmacy (for long-term needs), or any nonparticipating retail pharmacy.

You will receive the highest possible benefit under the Prescription Drug Program when you purchase medications at a participating retail pharmacy (you must present your ID card) or through the mail-order pharmacy. Additional information about the Prescription Drug Program, including the location of participating pharmacies in your area, is available through the Medco web site at **www.medco.com** or the member services department at (800) 841-3361.

You must present your ID card when receiving drugs and services from a network pharmacy. The network pharmacy will verify eligibility. You will be required to pay any applicable deductibles or copayments at the time the prescription is obtained. The pharmacist should notify you if a generic drug is available; however, it is in your best interest to also ask the pharmacist about generic equivalents that may be available. To obtain maximum benefits from the program, you should usually choose Tier 1 generic drugs when available.

DRUG FORMULARY

Medco includes a Formulary Management Program designed to control costs for you and the Plan. The formulary includes all U.S. Food and Drug Administration (FDA)-approved drugs that have been placed in tiers based on their clinical effectiveness, safety, and cost. Tier 1 includes primarily generic drugs; Tier 2 includes formulary brand-name drugs; and Tier 3 includes non-formulary brand-name drugs and non-sedating antihistamines.

You should share the formulary with your physician or practitioner when the physician or practitioner prescribes a drug, and encourage the physician or practitioner to prescribe a Tier 1 or Tier 2 drug if possible. By choosing Tier 1 generic or Tier 2 formulary brand-name drugs, you may decrease your out-of-pocket expenses. While all currently FDA-approved drugs are included on the formulary list, your Plan may elect to exclude some drugs. Please review the provisions of your Plan for specific drug exclusions. See "What's Covered" and "What's Not Covered" in this section for further information.

It is always up to you and your doctor to decide which prescriptions are best for you. You are never required to use generic drugs or drugs that are on the Medco formulary list. If you prefer, you can use non-formulary brand-name drugs and pay a higher copayment.

It is also important to note that drugs included on the formulary list are routinely updated. To find the most up-to-date list of covered drugs, visit Medco at **www.medco.com**, or call their member services department at 1-(800) 841-3361. It should be noted that all drugs listed on the formulary may not be covered due to Plan exclusions and limitations.

PHARMACY BENEFITS

GENERIC MEDICATIONS

Generic medications and their brand-name counterparts have the same active ingredients and are manufactured according to the same strict federal regulations.

Generic drugs may differ in color, size, or shape, but the FDA requires that the active ingredients have the same strength, purity, and quality as their brand-name counterparts.

For this reason, the Plan will cover the cost of the generic equivalent if you purchase a brand-name medication when there is a generic available. You will be charged the generic copayment and the cost difference between the brand-name and the generic medication.

If you have questions or concerns about generic medication, speak to your physician or your pharmacist, and he or she will be able to help you.

WHAT'S COVERED

This section is intended to provide a general description of covered drugs and supplies under the retail and mail-order pharmacy programs. All FDA-approved drugs requiring a prescription to dispense are covered, unless specifically excluded under this Plan:

Federal legend drugs (all drugs approved by the FDA and that require a prescription), except those listed under "What's Not Covered" in this section.

State-restricted drugs.

Compounded medications of which at least one is a legend drug.

Insulin.

Needles and syringes.

Diabetic supplies.

Legend contraceptive medications—oral, injectable, patch, ring.

Over-the-counter and legend prenatal vitamins.

Legend smoking cessation treatment.

Brand non-sedating antihistamine drugs will be paid as Tier 3, regardless of the drug's formulary status as preferred or non-preferred.

TIPS FOR USING YOUR PHARMACY BENEFITS

For questions about the Prescription Drug Program or to locate a participating pharmacy in your area, call Medco Health's toll-free number ((800) 841-3361, 24 hours a day, 7 days a week). Some medications may require medical necessity or prior authorization. Please call Medco Health for information on this process.

DRUGS REQUIRING AUTHORIZATION

Some medications are covered only for specific medical conditions or for a specific quantity and duration. A Medco pharmacist, in cooperation with your physician, determines coverage based on clinical guidelines and the manufacturer's specifications to review the appropriateness of the medication, dosage, and duration prescribed for certain conditions. Examples of medications that may require review are:

Drugs to treat impotency for males only (except Yohimbine), drugs for treatment of impotence related to diabetes, peripheral vascular disease or side effects of the medications to treat it, post-prostatectomy/orchiectomy, post-radiation therapy related to treatment of prostate cancer, and syndromes affecting sexual functioning. Limited to six tablets per month.

Myeloid stimulants.

Neumega.

Erythroid stimulants.

Interferons (i.e., Alpha, Beta, Gamma, Pegasys).

Multiple Sclerosis therapy (i.e., Avonex, Copaxone, Betaseron).

Retin-A (tretinoin) (co-brands—cream only).

Reganex Gel.

Penlac solution.

Panrentin Gel.

Targretin Gel.

Protopic Ointment.

Elidel.

Lupron 1 mg.

Alzheimer's therapy (i.e., Cognex, Aricept, Exelon, Reminyl).

Botox/Myobloc.

Gleevec.

Hespera.

Lotronex for females only.

Xolair.

Migraine Agents (i.e., Imitrex, Zomig, Maxalt).

COX II Medications (i.e., Bextra, Celebrex).

If your prescription requires review or authorization, Medco will work with you, your pharmacist, and your physician to determine if the medication, as prescribed by your physician, is covered under the Prescription Drug Program. If you have any questions regarding coverage of a specific drug, please check the Medco web site or call the member services department.

PHARMACY BENEFITS

WHAT'S NOT COVERED

The Plan will not provide benefits for any of the items listed in this section, regardless of medical necessity or a prescription from a health care provider:

Non-federal legend drugs.

Medication for which the cost is recoverable under any Workers' Compensation or occupational disease law, or from any state or governmental agency.

Medication for which there is no legal obligation to pay, or medication furnished by a drug or medical service for which no charge is made to the individual.

Medication that is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended care facility, skilled nursing facility, convalescent hospital, nursing home, or similar institution that operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals.

Any prescription refilled in excess of the number of refills specified by the physician or practitioner, or any refill dispensed after one year from the physician's or practitioner's original order.

Drugs whose sole purpose is to promote or stimulate hair growth (e.g., Rogaine or Propecia) or for cosmetic purposes only (e.g., Renova or Vaniqa).

Drugs labeled "Caution: Limited by federal law to investigational use" or other experimental/investigational drugs, even though a charge is made to the individual.

Immunization agents.

Blood products.

Immune globulins.

Topical dental fluorides.

Therapeutic devices or appliances.

Mifeprex.

Contraceptive devices.

Drugs to treat impotency for females only.

Yohimbine.

Accutane.

Human Growth Hormones.

Fertility Agents.

Appetite suppressants and weight-loss agents.

Lamisil.

Seasonale at a retail pharmacy.

USING A RETAIL PHARMACY

When you need a drug for a limited time, use a participating retail pharmacy to maximize your benefits. **The retail pharmacy program allows for a total of three fills of a maintenance medication at a retail pharmacy (one original fill and two refills). Additional fills will not be covered by the Plan. Each fill can be for no more than a 30-day supply. Note that you are allowed a total of three fills, even if each is for less than 30 days.**

The amount you pay for prescription drugs depends on whether you use a Medco participating retail pharmacy or a nonparticipating pharmacy. At a participating pharmacy, there are no claim forms to file; you simply pay your portion at the pharmacy. Please refer to the Schedule of Pharmacy Benefits for details about retail copayments.

At a nonparticipating pharmacy, you must pay in full for your prescription and submit a claim for reimbursement. If the pharmacy charges you more than the allowable amount (based on pricing at a participating pharmacy), you will be reimbursed based on the allowable amount minus the copayment. You should mail your claims for reimbursement to the address on the form.

Any reimbursement will be sent directly to you and made according to the Plan's prescription drug benefit, as outlined on the Schedule of Prescription Drug Benefits. If any request for reimbursement is denied or reduced other than for copayments, please refer to the appeal provisions in the "How to Appeal a Denial of Benefits or Clinical Noncertification" section of this Handbook.

USING THE MAIL-ORDER PHARMACY

The mail-order pharmacy must be used for maintenance medications. You can receive up to a 90-day supply of medication for one copayment. Prescriptions must be filled as prescribed by your physician—refills cannot be combined to equal a 90-day supply. Please refer to the Schedule of Prescription Drug Benefits for details about mail-order copayments.

The Prescription Drug Program will maintain a retail refill limit policy. The retail refill limit requires that you use the mail-order pharmacy if you are prescribed a maintenance medication, rather than refilling multiple prescriptions for the same drug at a retail pharmacy. If you or a covered dependent receives a prescription for a maintenance medication and you do not use the mail-order pharmacy, your prescriptions may not be covered.

In some circumstances, you may not be required to use the mail-order pharmacy. For example, there are several categories of medications that are uniquely appropriate for multiple refills at your local pharmacy (and are therefore exempt from the retail refill limit provision, as outlined above).

If you have a prescription for any of the following medications, the Medco Prescription Drug Program allows you to receive multiple refills at your local retail pharmacy:

- Anti-infectives, including antibiotics (Amoxicillin, Biaxin), antivirals (Zovirax, Famvir), antifungals (Diflucan), and drops used in the eyes and ears (Polsporin Opth, Cipro Otic). Please note that drops must be prescribed specifically to treat infection. For example, glaucoma drops are not covered.
- Prescription cough medications, including Phenergan with Codeine, Tessalon, and Tussionex.
- Medications to treat acute pain, both narcotic (Vicodin, Percodan, etc.) and non-narcotic (Darvocet). Please note that long-term pain medications, such as NSAIDs, do not meet the necessary retail requirements.
- Medications that require a new written prescription each time you need them, as refills are prohibited by federal law (e.g., Percodan, Ritalin, and Nembutal).
- Medications used to treat both attention deficit disorder (Ritalin, Cylert) and narcolepsy (Dexedrine).
- Medications whose sole use is to treat cancer.

To order medications from the mail-order pharmacy, simply log on to the Medco web site to request that the pharmacist contact your physician (to order prescriptions, you must be a registered member for security reasons). You will need to confirm your information and provide the contact information for your physician. If you prefer, you can have your physician call (888) 327-9791 for instructions to fax your prescription. You will receive your medication in approximately seven to ten days. If you have a written prescription to mail in, you will need to complete an order form (available from the Medco web site or by calling their member services department) to include with your prescription. The prescription and order form should be mailed to the address on the form.

Once you have initiated your prescription delivery through mail-order, you can request refills online or via the member services department. Refills requested by 12:00 noon are filled and shipped the same day.

DRUG UTILIZATION REVIEW (DUR)

When you have your prescription filled, the pharmacist and/or Medco may access information about previous prescriptions electronically and check pharmacy records for drugs that conflict or interact with the medicine being dispensed. If there is a question, the pharmacist will work with you and your physician before dispensing the medication. This is an automatic feature available only with prescriptions purchased through a participating pharmacy and the mail-order pharmacy.

SPECIAL PRESCRIPTION PROGRAM SERVICES

Emergency Pharmacist Consultation

Access to pharmacists is available 24 hours a day, 7 days a week, for emergency consultation.

Pharmacy Locator

A voice-activated system for locating participating retail pharmacies within specific ZIP codes; call the member services department at (800) 841-3361. This information is also available via the web site at **www.medco.com**.

Telecommunications for the Deaf

Call (800) 759-1089. Service is available Sunday through Friday, from 8:00 a.m. to 12:00 midnight EST, and on Saturday, from 8:00 a.m. to 6:00 p.m. EST.

Printed Materials for the Visually Impaired

Large-print or Braille labels are available upon request for prescriptions purchased through the mail-order pharmacy.

Health Education Programs

These programs, based on medical practices, promote good health care for cardiovascular health, respiratory health, and diabetes by providing in-depth education and support tools to members in order to improve their self-management skills.

The programs are designed to enhance communication between patients and physicians, decrease the rates of short-term and long-term disease complications, improve overall health outcomes (including quality of life), and improve patient satisfaction with medical care.

You will be contacted by Medco if participation in a health education program is appropriate for your condition.

EXCLUSIONS AND LIMITATIONS

The Plan will not provide benefits for any of the items listed in this section, regardless of medical necessity or recommendation of a health care provider. This list is intended to give you a description of services and supplies not covered by the Plan.

Expenses exceeding the reasonable and customary charge for the geographic area in which services are rendered, except as specified on the Schedule of Medical Benefits.

Treatment not prescribed or recommended by a health care provider.

Services, supplies, or treatment that is not medically necessary.

Services or supplies for which there is no legal obligation to pay, or expenses that would not be made except for the availability of benefits under this Plan.

Dental services, including, but not limited to:

- Cavities and extractions.
- Care of gums.
- Bones supporting the teeth or periodontal abscess.
- Orthodontia.
- False teeth.
- Treatment of TMJ that is dental in nature.
- Orthagnathic surgery.

However, the Plan does cover:

- Surgical removal of impacted teeth; and
- Treatment of sound natural teeth injured by accident, if treated within 12 months of the injury.

Experimental/investigational equipment, services, or supplies.

Complications arising from any noncovered surgery or treatment.

Services furnished by or for the United States government or any other government, unless payment is legally required.

Services performed at home, except for those services specifically noted elsewhere in this Handbook as available either at home or as an emergency.

Services usually given without charge, even if charges are billed.

Services performed by hospital or institutional staff that are billed separately from other hospital or institutional services, except as specified.

Any condition, disability, or expense sustained as a result of being engaged in an illegal occupation or the commission or attempted commission of an illegal or criminal act.

Any condition, disability, or expense sustained as a result of duty as a member of the armed forces of any state or country; engaging in a war or act of war, whether declared or undeclared; participation in a civil revolution or riot; or an intentional or accidental atomic explosion or other release of nuclear energy, whether in peacetime or wartime.

Any condition or disability sustained as a result of being engaged in any activity primarily for wage, profit, or gain, and that could entitle the covered person to a benefit under a Workers' Compensation Act or similar legislation.

EXCLUSIONS AND LIMITATIONS

Educational, vocational, or training services and supplies.

Expenses for copying or preparing medical reports, itemized bills, or claim forms.

Mailing and/or shipping and handling expenses.

Expenses for broken appointments or telephone calls.

Charges in connection with telephonic or other electronic consultations.

Services or supplies furnished, paid for, or for which benefits are provided or required by reason of past or present service of any covered family member in the armed forces of a government.

Travel expenses of a physician or a covered person, except as specified in the "Transplant Care" section of this Handbook.

Any services received from a Health Maintenance Organization (HMO) if the individual is a participant in the HMO.

Sanitarium, rest, or custodial care.

Maintenance care.

Professional services performed by a person who ordinarily resides in your household or is related to the covered person, such as a spouse, parent, child, brother, sister, or in-law.

Expenses eligible for consideration under any other plan of the employer.

Sales tax.

Elective hospital admissions on Saturday or Sunday.

Personal comfort or service items while confined in a hospital, such as, but not limited to, radio, television, telephone, and guest meals.

Expenses relating to, or incurred in connection with, autologous hematopoietic support (e.g., autologous bone marrow transplantation or stem cell rescue), including expenses for high-dose chemotherapy or radiotherapy, for any symptom, disease, or condition, except as specified in the "Transplant Care" section of this Handbook.

Cosmetic surgery.

Kerato-refractive eye surgery (surgery to improve nearsightedness, farsightedness, and/or astigmatism by changing the shape of the cornea, including, but not limited to, radial keratotomy and keratomileusis surgery).

Reversal of any reproductive sterilization procedure.

Surgical impregnation procedures, including, but not limited to, artificial insemination, in vitro fertilization, and fetal and embryo implants.

Surgical treatment for the correction of infertility.

Sex-change surgery.

Expenses related to insertion or maintenance of an artificial heart.

Genetic counseling, except as specified in a "What's Covered" section of this Handbook.

EXCLUSIONS AND LIMITATIONS

Private-duty nursing.

Rolfing.

Eye examinations for the diagnosis or treatment of a refractive error, including the fitting of eyeglasses or lenses, orthoptics, vision therapy, or supplies, except as specified in a "What's Covered" section of this Handbook. Benefits are provided by EyeMed Vision Care.

Hearing examinations, except as specified in the "What's Covered" section.

Hearing aids, or related supplies, unless loss of hearing is due to a covered illness or accidental injury.

Expenses for education and educational testing, counseling, job training, or care for learning disorders, whether or not services are rendered in a facility that also provides medical and/or mental health treatment.

Adoption expenses.

Surrogate expenses.

Biofeedback.

Nonsurgical treatment of morbid obesity.

Nonsurgical treatment for the correction of infertility.

Nonsurgical treatment for, or prevention of, temporomandibular joint (TMJ) dysfunction, craniomandibular disorder, and other conditions of the joint linking the jawbone and skull, and the muscles, nerves, and other tissues related to that joint.

Expenses incurred for nonsurgical treatment of the feet, including treatment of corns, calluses, and toenails, or other routine foot care, except as specified in a "What's Covered" section of this Handbook.

Hypnosis, except as specified in a "What's Covered" section of this Handbook.

Treatment, instructions, activities, or drugs (including diet pills) for weight reduction or control.

Infertility testing.

Genetic testing, except as specified in a "What's Covered" section of this Handbook.

Foot orthotics.

Prescription drugs and medicines, including vitamins and nutritional supplements (including prenatal vitamins), oral impotence medications (e.g., Viagra), oral contraceptives, and insulin and insulin syringes. See "Pharmacy Benefits" for a description of your prescription drug benefits.

Drugs, medicines, or supplies that do not require a physician's prescription.

Equipment such as air conditioners, air purifiers, dehumidifiers, heating pads, hot water bottles, water beds, swimming pools, hot tubs, and any other clothing or equipment that could be used in the absence of an illness or injury.

Electric chairlifts or any other modifications to a home or residence.

MEDICAL MANAGEMENT

We wish to provide you and your family with a health care benefit plan that financially protects you from significant health care expenses while helping you obtain quality care. While part of increasing health care costs results from new technology and important medical advances, another significant cause is the way health care services are used.

The Medical Trust has contracted with Empire to identify and assist individuals with conditions requiring extensive or long-term care. The program is not intended to diagnose or treat medical conditions, guarantee benefits, make payments, or validate eligibility for Plan coverage. The program focuses on making recommendations regarding the appropriateness and medical necessity of specified health services. The final medical decisions regarding treatment are always made between you and your treating physician.

Medical Management services include a number of components explained in more detail below. These components include prior notification and certification requirements for inpatient services and case management services for serious or extended illnesses through the Medical Management Program, voluntary maternity services, round-the-clock support through Empire HealthLine, and the BCBS National Transplant Program.

PRIOR NOTIFICATION REQUIREMENTS

You are required to call the Medical Management Program's toll-free number (800) 352-3152 for the following:

All inpatient admissions, including any elective admission to a hospital or skilled nursing or acute rehabilitation facility.

Within 24 hours of any emergency situation.

When a maternity stay extends beyond 48 hours following a normal vaginal delivery or 96 hours following a Cesarean section delivery.

All human organ and tissue transplants prior to selecting a transplant facility or scheduling a pre-transplant evaluation.

Home health care services.

Home infusion therapy.

All inpatient mental health disorder and/or substance abuse treatment must be authorized through the Medical Trust Mental Health Benefit Program at (800) 806-0478. Please refer to the "Mental Health and Substance Abuse Care" section of this Handbook for details.

Hospice services.

MEDICAL MANAGEMENT

When you call the Medical Management Program, it will be necessary to provide your name, birth date, sex, address, telephone number, ID card number, name and address of the hospital/facility, name and telephone number of the admitting doctor, and the reason for admission and nature of the services to be performed. You will be advised if certification of medical necessity is required for the proposed services. If so, the certification process described in the following section will be started immediately. It is your responsibility to obtain the cooperation of the physician in the program.

CERTIFICATION AND NONCERTIFICATION

The Medical Management Program may review a proposed service and evaluate whether it is medically necessary. If it is determined to be medically necessary, you and your providers will receive a written statement of approval or denial of certification. If services are proposed to extend beyond the period for which certification is given, the Medical Management Program will initiate further medical necessity review prior to the receipt of additional services.

If you or your dependent is hospitalized or receives other health care services without meeting the notification requirements, notification may be made during the hospital confinement or delivery of other services. If the confinement or other service is determined to be medically necessary, the preceding days of hospital confinement or other service will not be penalized. Remaining days of hospital confinement or other services, if certified, will not be penalized if the confinement or other service is deemed medically necessary.

If the Medical Management Program does not recommend that the proposed services are medically necessary, you and your physician will receive a Notice of Clinical Noncertification. The notice will describe why the proposed services were noncertified and will describe how to appeal the noncertification.

If the Medical Management Program does not receive adequate information to properly evaluate whether the proposed services are medically necessary, you and your physician will receive a Notice of Administrative Noncertification. This notice will describe how to appeal the noncertification.

- The decision whether to receive a proposed health care service is always yours, in consultation with your physician. However, if you receive a service that is not covered under this Plan, you will be responsible for paying the full cost of that service.
- Prior to payment of benefits, the Medical Management Program may retrospectively review for medical necessity any services provided but not previously certified or reviewed.
- Certification is not a guarantee that benefits are payable by this Plan. Also, certification does not substitute for filing a claim with the Plan, if necessary. Payment of benefits is subject to all Plan provisions, limitations, and exclusions. In addition, verification of coverage does not fulfill certification requirements, nor does it guarantee payment of benefits. If you are uncertain about whether certification is required for proposed services, please call Empire at (800) 352-3152.

MEDICAL MANAGEMENT

REDUCED BENEFITS FOR FAILURE TO FOLLOW REQUIRED NOTIFICATION PROCEDURES

If you follow the notification and certification requirements outlined on the previous pages, your benefits will be unaffected, and you and the Plan avoid expenses related to unnecessary health care. However, if you do not follow the procedures required by this Plan, the Plan's coinsurance will be reduced to 50% for all related covered hospital expenses, including all inpatient mental health and substance abuse treatment, after any applicable deductible. This will not apply to situations where a medical emergency results in your inability to follow the notification and certification requirements prior to receiving care. You, your dependent, or the physician should provide notification as soon thereafter as possible. In addition, if you fail to follow the requirements to preauthorize or prenotify, and Medical Management retrospectively reviews the treatment and/or services you received and determines they were not medically necessary, benefits will be denied, and you will be responsible for all noncovered expenses.

The penalty assessed when you do not follow the notification and certification procedures required by the Plan does not apply toward your out-of-pocket maximum.

CASE MANAGEMENT

If you or your dependent has a serious or extended care illness or injury, a case manager can assist you or your dependent in identifying and coordinating cost-effective medical care alternatives. The case manager will also coordinate communication among you and all health care providers involved in your or your dependent's care. Case management can help with cases such as cancer, stroke, AIDS, chronic illness, hemophilia, and spinal cord and other traumatic injuries.

Benefits may be modified by the Medical Trust to permit a method of treatment not expressly provided for, but not prohibited by law, rules, or public policy, if the Medical Trust determines that such modification is medically necessary and is more cost-effective than continuing a benefit to which you or your eligible dependents may otherwise be entitled. The Medical Trust also reserves the right to limit payment for services to those amounts that would have been charged had the services been provided in the safest and most cost-effective setting available.

If you would like case management's assistance following an illness or surgery, contact the Medical Management Program at (800) 352-3152.

MEDICAL MANAGEMENT

ROUND-THE-CLOCK SUPPORT

You may call the Empire Nurse Access toll-free number, (877) TALK2RN ((877) 825-5276), at any time, day or night, to obtain health information and advice; assess symptoms; or understand a medical condition, procedure, prescription, or diagnosis and discharge from a hospital. A nurse (or an audiotape message) will provide you with information about your condition and self-care and, if necessary, suggest the names of network providers from whom you may seek health care.

This 24/7 service is a benefit to you, allowing you to be informed about your health care options. There is no penalty for not using it. This service is not meant to replace physician care. If you require medical care, please be sure to see your physician or practitioner.

ABOUT YOUR BENEFITS

All benefits provided under this Plan must satisfy some basic conditions. The following conditions are commonly included in health benefit plans, but are often overlooked or misunderstood.

MEDICAL NECESSITY

"Medically Necessary" or "Medical Necessity" shall mean health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are: (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and (c) not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of physicians practicing in relevant clinical areas and any other relevant factors.

REASONABLE AND CUSTOMARY CHARGES

The Plan provides benefits only for covered expenses that are equal to or less than the reasonable and customary charge in the geographic area where services or supplies are provided. Any amounts that exceed the reasonable and customary charge are not recognized by the Plan for any purpose.

HEALTH CARE PROVIDERS

The Plan provides benefits only for covered services and supplies rendered by a physician, practitioner, nurse, hospital, or specialized treatment facility.

CUSTODIAL CARE

The Plan does not provide benefits for services and supplies that are furnished primarily to assist an individual in the activities of daily living. Activities of daily living include such things as bathing, feeding, administration of oral medicines, or other services that can be provided by persons without the training of a health care provider.

PLAN YEAR

The word "year", as used in this Handbook, refers to the benefit year, which is the 12-month period beginning August 1 and ending July 31. All annual benefit maximums and deductibles accumulate during the plan year.

NON-PPO DEDUCTIBLES

A non-PPO ("non-network") deductible is the amount of covered non-network expenses each covered individual must pay during each year before the Plan will consider expenses for reimbursement. The individual deductible applies separately to each covered person. The family deductible applies collectively to all covered persons in the same family. When the family deductible is satisfied, no further deductible will be applied for any covered family member during the remainder of that year. The annual individual and family non-network deductible amounts are shown on the Schedule of Medical Benefits.

ABOUT YOUR BENEFITS

COINSURANCE

Coinsurance represents the portion of covered expenses paid by the Plan after you have satisfied any applicable deductible. These percentages apply only to covered expenses that do not exceed reasonable and customary charges. You are responsible for all remaining covered and noncovered expenses, including any amount that exceeds the reasonable and customary charge for covered expenses.

Use of the term “coinsurance” in this Handbook does not imply that the Plan is insured. The Plan is offered by the Medical Trust on a self-funded basis, and all Plan payments are paid from ECCEBT. Empire BlueCross BlueShield acts as the third-party administrator and is not financially responsible for any benefits under the Plan.

The coinsurance amounts are shown on the Schedule of Medical Benefits.

COPAYMENTS

Copayments (“copays”) are the first-dollar amounts you must pay for certain covered services under the Plan that are usually paid at the time the service is performed (e.g., physician office visits or emergency room visits). These copayments do not apply to your annual deductible or out-of-pocket maximum.

The copayment amounts are shown on the Schedule of Medical Benefits.

OUT-OF-POCKET MAXIMUMS

An out-of-pocket maximum is the maximum amount of covered expenses you must pay during a year, excluding the deductible, before the coinsurance percentage of the Plan increases. The individual out-of-pocket maximum applies separately to each covered person. When a covered person reaches the annual out-of-pocket maximum, the Plan will pay 100% of additional covered expenses for that individual during the remainder of that year.

The family out-of-pocket maximum applies collectively to all covered persons in the same family. When the annual family out-of-pocket maximum is reached, the Plan will pay 100% of covered expenses for any covered family member during the remainder of that year.

However, expenses for services that do not apply to the out-of-pocket maximum will never be paid at 100%.

The annual individual and family out-of-pocket maximum amounts are shown on the Schedule of Medical Benefits.

BENEFIT MAXIMUMS

Total Plan payments for each covered person are limited to certain maximum benefit amounts. A benefit maximum can apply to specific benefit categories or to all benefits. A benefit maximum amount also applies to a specific time period, such as annual or lifetime. Whenever the word “lifetime” appears in this plan in reference to benefit maximums, it refers to the period of time you or your eligible dependents participate in this plan or any other plan maintained by the Medical Trust.

The benefit maximums applicable to this Plan are shown on the Schedule of Medical Benefits.

COORDINATION OF BENEFITS

GENERAL PROVISION

When you and/or your dependents are covered under more than one group health plan, the primary plan will determine benefits first, without regard to benefits provided under any other group health plan.

When this Plan is the secondary payor, the Plan will coordinate payment with the primary plan in such a way that when this Plan's payment is combined with the primary plan's payment, the total does not exceed the amount this Plan would have paid if it were primary.

GOVERNMENT PROGRAMS AND OTHER GROUP HEALTH PLANS

The term "group health plan," as it relates to coordination of benefits, includes the government programs Medicare, Medicaid, and TRICARE. The regulations governing these programs take precedence over the determination of benefits under this plan. For example, in determining the benefits payable under the Plan, the Plan will not take into account the fact that you or any eligible dependent(s) are eligible for or receive benefits under a Medicaid Plan.

The term "group health plan" also includes all group insurance and group subscriber contracts, such as union welfare plans, and benefits provided under any group or individual automobile no-fault or fault-type policy or contract. Individual policies or contracts are not included.

AUTOMOBILE INSURANCE

This Plan provides benefits relating to medical expenses incurred as a result of an automobile accident on a secondary basis only. Benefits payable under this Plan will be coordinated with and secondary to benefits provided or required by any no-fault automobile insurance statute, whether or not a no-fault policy is in effect, and/or any other automobile insurance.

Any benefits provided by this Plan will be subject to the Plan's reimbursement and/or subrogation provisions.

RIGHT TO MAKE PAYMENTS TO OTHER ORGANIZATIONS

Whenever payments that should have been made by this Plan have been made by any other plan(s), this Plan has the right to pay the other plan(s) any amount necessary to satisfy the terms of this coordination of benefits provision. Amounts paid will be considered benefits paid under this Plan, and, to the extent of such payments, the Plan will be fully released from any liability regarding the person for whom payment was made.

COORDINATION OF BENEFITS

ORDER OF PAYMENT WHEN COORDINATING WITH OTHER GROUP HEALTH PLANS

Any group health plan that does not contain a coordination of benefits provision will be considered primary.

When all plans covering you and/or your dependents contain a coordination of benefits provision, the first of the following rules that describes which plan will pay benefits before another plan is the rule to follow:

1) The plan covering an individual other than as a dependent (for example, as an active employee or retiree) will be primary to a plan covering the same individual as a dependent. However, if the individual is covered by two group health plans and Medicare, and under federal law, Medicare is secondary to the plan covering the individual as a dependent and primary to the plan covering the individual as other than a dependent (for example, a retiree), then the order of payment is reversed so the plan covering the individual as an employee or retiree is secondary, and the other plan is primary.

2) If a dependent child is covered under more than one plan, the primary plan is the plan of the parent whose birthday (month and day) is earlier in the calendar year if:

- The parents are married;
- The parents are not separated (regardless of whether they ever have been married); or
- A court decree awards joint custody without specifying that one parent has the responsibility to provide health care coverage.

If both parents have the same birthday (month and day), the plan that has covered either of the parents longer is primary.

If the specific terms of a court decree state that one of the parents is responsible for the child's health care coverage or expenses and the plan of that parent has knowledge of the decree, that plan is primary. If the parent designated by the decree has no coverage for the child, but that parent's spouse does, the spouse's plan is primary.

If the parents are not married, are separated (regardless of whether they were ever married), or are divorced and there is no court decree allocating responsibility for the child's health care coverage or expenses, the order of benefit determination among the plans of the parents and the parents' spouses (if any) is:

- The plan of the custodial parent;
- The plan of the spouse of the custodial parent;
- The plan of the noncustodial parent; then
- The plan of the spouse of the noncustodial parent.

COORDINATION OF BENEFITS

3) The plan that covers an individual as an employee who is neither laid-off nor retired (or as that employee's dependent) is primary. However, the order of benefit determination for an individual covered both as a retiree and as a dependent of that individual's spouse will be determined under section No. 1 on the previous page.

4) The plan covering the individual as an employee or retiree (or as that individual's dependent) will be primary to the plan providing continuation coverage under federal (COBRA) or state law.

5) The plan that has covered the individual for the longer period of time will be considered primary.

6) If none of the above rules determine the primary plan, the allowable expenses will be shared equally between the plans.

OTHER IMPORTANT PLAN PROVISIONS

ASSIGNMENT OF BENEFITS

All PPO (“network”) benefits payable by the Plan are automatically assigned to the provider of services or supplies, unless evidence of previous payment is submitted with the claim. All other benefits payable by the Plan may be assigned to the provider of services or supplies at your option. Payments made in accordance with an assignment are made in good faith and release the Plan’s obligation to the extent of the payment. Payments will also be made in accordance with any assignment of rights required by a state Medicaid plan.

SPECIAL ELECTION FOR EMPLOYEES AND SPOUSES AGE 65 AND OVER

If you remain actively employed after reaching age 65, you or your spouse may choose to remain covered under this Plan without reduction for Medicare benefits. You may also choose to end coverage under this Plan and enroll only in Medicare; however, benefits that are payable under this Plan may not be covered by Medicare. If you choose to remain covered under this Plan, this Plan will be the primary payor of benefits, and Medicare will be secondary.

If you are under age 65 and your spouse is over age 65, he or she can make his or her own choice.

REIMBURSEMENT TO THE PLAN

This section applies whenever another party (including your own insurer under an automobile or other policy) is legally responsible or agrees to compensate you or your dependent, by settlement, verdict, or otherwise, for an illness or injury. In that case, you or your dependent (or the legal representatives, estate, or heirs of either you or your dependent) must promptly reimburse the Plan for any benefits it paid relating to that illness or injury, up to the full amount of the compensation received from the other party (regardless of how that compensation may be characterized and regardless of whether you or your dependent has been made whole). If the Plan has not yet paid benefits relating to that illness or injury, the Plan may reduce or deny future benefits on the basis of the compensation received or constructively received by you, your dependent or representative.

In order to secure the rights of the Plan under this section, you or your dependent hereby (1) grant to the Plan a first-priority equitable lien against the proceeds of any full or partial settlement, verdict, or other amounts received by you or your dependent no matter how those proceeds are captioned or characterized; (2) assign to the Plan any benefits you or your dependent may have under any automobile policy or other coverage, to the extent of the Plan’s claim for reimbursement; and (3) agree that you, your dependent, or representative will hold any compensation in constructive trust for the benefit of the Plan and all its participants who have contributed to the funding of the Plan. No so-called “Fund Doctrine” or “Common Fund Doctrine” or “Attorney’s Fund Doctrine” shall defeat the Plan’s rights. The Plan has a first priority to any recovery from a third party to the extent that benefits have been paid or are payable under the Plan. This means that the Plan’s claim to reimbursement must be paid before any other claim against amounts received from the third party.

You or your dependent must cooperate with the Plan and its agents and must sign and deliver such documents in a timely manner as the Plan or its agents reasonably request to protect the Plan’s right of reimbursement. You or your dependent must also provide any relevant information and take such actions as the Plan or its agents reasonably request to assist the Plan in making a full recovery of the reasonable value of the benefits provided. You or your dependent must not take

any action that prejudices the Plan's right of reimbursement. If you receive payment as part of a settlement or judgment from any third party as a result of a sickness or injury, and the Plan alleges some or all of those funds are due and owed to it, you agree to hold those settlement funds in trust, either in a separate bank account in your name or in your attorney's trust account. You agree that you will serve as a trustee over those funds to the extent of the benefits the Plan has paid. The Plan may reduce or deny future benefits on the basis that you or your dependents have refused to sign and deliver such documents as the Plan or its agents reasonably request to protect the Plan's right of reimbursement.

The reimbursement required under this provision will not be reduced to reflect any costs or attorneys' fees incurred in obtaining compensation, unless separately agreed to, in writing, by the Medical Trust, in the exercise of its sole discretion. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you.

SUBROGATION

This section applies whenever another party (including your own insurer, under an automobile or other policy) is legally responsible or agrees to compensate you or your dependent for your or your dependent's illness or injury and the Plan has paid benefits related to that illness or injury.

The Plan is subrogated to all of the rights of you or your dependent against any party liable for your or your dependent's illness or injury, to the extent of the reasonable value of the benefits provided to you or your dependent under the Plan. The Plan may assert this right independently of you or your dependent.

You or your dependent is obligated to cooperate with the Plan and its agents in order to protect the plan's subrogation rights. "Cooperation" means providing the Plan or its agents in a timely manner with any relevant information requested by them, signing and delivering such documents as the Plan or its agents reasonably request to secure the Plan's subrogation claim, and obtaining the consent of the Plan or its agents before releasing any party from liability for payment of medical expenses.

If you or your dependent enters into litigation or settlement negotiations regarding the obligations of other parties, you or your dependent must not prejudice, in any way, the subrogation rights of the Plan under this section.

The costs of legal representation of the Plan in matters related to subrogation will be borne solely by the Plan. The costs of legal representation of you or your dependent must be borne solely by you or your dependent.

RECOVERY OF EXCESS PAYMENTS

Whenever payments have been made in excess of the amount necessary to satisfy the provisions of this Plan, the Plan has the right to recover these excess payments from any individual (including yourself), insurance company, or other organization to whom the excess payments were made, or to withhold payment, if necessary, on future benefits until the overpayment is recovered.

If excess payments were made for services rendered to your dependent(s), the

Plan has the right to withhold payment on your future benefits until the overpayment is recovered.

Furthermore, whenever payments have been made based on fraudulent information provided by you, the plan will exercise all available legal rights, including its right to withhold payment on future benefits, until the overpayment is recovered.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

Consistent with any applicable privacy requirements under the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA") and other applicable law, the Plan may, without the consent of or notice to any person, release to or obtain from any organization or person information needed to implement Plan provisions, including medical information. When you request benefits, you must either furnish or authorize the release of all the information required to implement Plan provisions. Your failure to fully cooperate will result in a denial of the requested benefits, and the Plan will have no further liability for such benefits.

ALTERNATE PAYEE PROVISION

Under normal conditions, all PPO benefits are payable to the provider of services or supplies. All other benefits are payable to you and can only be paid directly to another party upon signed authorization from you. If conditions exist under which a valid release or assignment cannot be obtained, the Plan may make payment to any individual or organization that has assumed the care or principal support for you and is equitably entitled to payment. The Plan may choose to make payments to your separated/divorced spouse, state child support agencies, or Medicaid agencies if required by a qualified medical child support order (QMCSO) or state Medicaid law.

The Plan may also honor benefit assignments made prior to your death in relation to remaining benefits payable by the Plan.

Any payment made by the Plan in accordance with this provision will fully release the Plan of its liability to you.

RELIANCE ON DOCUMENTS AND INFORMATION

Information required by the Medical Trust may be provided in any form or document that the Medical Trust considers acceptable and reliable. The Medical Trust relies on the information provided by you and others when evaluating coverage and benefits under the Plan. All such information, therefore, must be accurate, truthful, and complete. The Medical Trust is entitled to conclusively rely upon, and will be protected for any action taken in good faith in relying upon, any information provided to the Medical Trust. In addition, any fraudulent statement, omission or concealment of facts, misrepresentation, or incorrect information may result in the denial of the claim, cancellation or rescission of coverage, or any other legal remedy available to the Plan.

The failure of the Medical Trust to enforce strictly any term or provision of

OTHER IMPORTANT PLAN PROVISIONS

NO WAIVER

this Plan will not be construed as a waiver of such term or provision. The Medical Trust reserves the right to enforce strictly any term or provision of this Plan at any time.

PHYSICIAN/PATIENT RELATIONSHIP

This Plan is not intended to disturb the physician/patient relationship. Physicians and other health care providers are not agents or delegates of the employer, the Medical Trust, or the third-party contract administrator. Nothing contained in this Plan will require you or your dependent to commence or continue medical treatment by a particular provider. Furthermore, nothing in this Plan will limit or otherwise restrict a physician's judgment with respect to the physician's ultimate responsibility for patient care in the provision of medical services to you or your dependent.

THE PLAN IS NOT A CONTRACT OF EMPLOYMENT

Nothing contained in this Plan will be construed as a contract or condition of employment between the employer and any employee. All employees are subject to discharge to the same extent as if this Plan had never been adopted.

RIGHT TO AMEND OR TERMINATE THE PLAN

The Medical Trust reserves the right to amend, modify, or terminate the Plan in any manner, for any reason, at any time, and without prior notification.

FILING A CLAIM

Your health care provider should file claims for you. Electronically submitted claims are processed most efficiently. If unable to file electronically, your health care provider may submit the following:

- HCFA-1500 (revision 12/90 and later) or UB-92 forms for medical expenses;
- ADA forms (revision 1990 and later) for dental expenses; and
- Prescription submittal forms and vision care submittal forms.

These are the only appropriate forms for requesting Plan payment. If your health care provider is unable to file one of these forms for you, you are responsible for completing and submitting it. These forms are available from either your health care provider or your employer. Include the following information:

- Plan participant's name, Social Security number, and address;
- Patient's name, Social Security number, and address, if different from the participant's;
- Provider's name, tax identification number, address, degree, and signature;
- Date(s) of service;
- Diagnosis;
- Procedure codes (describes the treatment or services rendered);
- Signed assignment of benefits (if payment is to be made to the provider);
- Signed release of information statement; and
- Explanation of benefits (EOB) if another plan is the primary payor.

You should submit claims for each individual. Please do not attach or staple claims together. If additional information is needed to process your claim, you or your health care provider will be notified. If you receive a letter regarding your claim, prompt completion and return of the letter with any requested attachments will expedite processing of the claim.

Send complete information to:

Empire BlueCross BlueShield
P.O. Box 5009
Middletown, NY 10940-9009

If you have any questions regarding your claim, please call (800) 352-3152.

All claims must be received by the Plan within 180 days following the end of the year in which expenses were incurred.

FILING A CLAIM

HOW TO APPEAL A DENIAL OF BENEFITS

An appeal is a request to review and change an adverse determination (i.e., a benefit denial or reduction) made by Empire's Medical Management Program or the Mental Health Benefit Program. There are two types of appeals:

- Appeals to overturn a decision that was made prior to or during your medical service, which is referred to as a pre-service appeal.
- Appeals to overturn a decision on a claim that was made after a service was provided, which is referred to as a post-service appeal.

The Empire Medical Management Program or the Medical Trust (for the Mental Health Benefit Program) will notify you in writing whenever your benefits will be reduced or denied. You may appeal this decision if:

- You believe extenuating circumstances prevented you from complying with Empire Medical Management's opinion as to the appropriate setting or type of care.
- You followed the treating doctor's recommendation even though it was contrary to Empire Medical Management's opinion as to the appropriate setting or type of care.
- You believe that benefits were otherwise incorrectly reduced by the Empire Medical Management Program.

LEVEL 1 APPEALS

A Level 1 Appeal is your first request for review of the initial reduction or denial of benefits. You have 180 calendar days from the date on the notification letter or Explanation of Benefits to file an appeal. An appeal submitted beyond the 180-calendar-day limit will not be accepted for review.

A physician of a same or similar discipline that did not participate in the orignal decision will review your appeal. A same or similar discipline physician is a physician that typically treats or provides the treatment under review. Empire will advise you, the attending doctor, and the hospital of the decision within:

- Fifteen calendar days for pre-service appeals. Appeal outcome notification occurs verbally and in writing.
- Thirty calendar days for post-service appeals. Appeal outcome notification occurs in writing.

REMEMBER

An appeal submitted beyond the 60-calendar-day or 180-calendar-day limit will not be accepted for review.

EXPEDITED LEVEL 1 APPEALS

You can file an expedited Level 1 Appeal and receive a quicker response if:

- You want to continue health care services, procedures, or treatments that have already started.
- You need additional care during an ongoing course of treatment.
- Your provider believes an immediate appeal is warranted because delay in treatment would pose an imminent or serious threat to your health.

Please note that appeals of claims decisions cannot be expedited.

When you file an expedited appeal, the following time frames apply:

- You or your provider will have reasonable access to our clinical reviewer within one business day of Empire's receipt of the request.
- Empire will make a decision within two business days following receipt of all necessary information about the case.
- Empire will notify you immediately of the decision by telephone, and within two business days in writing.

After an expedited appeal is completed, your appeal options with Empire are exhausted.

LEVEL 2 APPEALS AND TIME FRAMES

If you are dissatisfied with the outcome of your Level 1 Appeal, you may file a Level 2 Appeal with Empire within 60 calendar days from the date on the letter denying your Level 1 Appeal. A specialty-matched physician reviews a Level 2 Appeal, which is the same specialty of the physician that recommended your care. This physician will have not participated in the original decision or the Level 1 Appeal review. An appeal submitted beyond the 60-calendar-day limit will not be accepted for review.

LEVEL 1 GRIEVANCES

A grievance is a request to review an adverse determination concerning an administrative decision not related to medical necessity (for example, a claim was denied because your child exceeded the age limits of the contract). A Level 1 Grievance is your first request for review of the initial reduction or denial of benefits. You have 180 calendar days from the date on the notification letter to file a grievance. A grievance submitted beyond the 180-calendar-day limit will not be accepted for review. Empire will acknowledge your grievance in writing within 15 calendar days from the date Empire received your grievance and will advise you of the decision in writing within 30 calendar days from the initial receipt date. If additional information is necessary to make a decision, a detailed explanation of the needed information will be requested in writing. The final decision (either upheld or overturned) will be made within 45 business days from the date Empire received your grievance, based upon the available information.

If you are not satisfied with the outcome of your Level 1 Grievance, you can file a Level 2 Grievance within 60 calendar days of the date on the letter denying your Level 1 Grievance. A different representative will review the grievance and make a decision within 30 business days from the date the Level 2 Grievance was received. A grievance submitted beyond the

60-calendar-day limit will not be accepted for review. To submit an appeal or grievance, call Member Services at (800) 352-3152, or write to one of the following addresses with the reason why you believe the coverage request was improperly denied or the claim was improperly paid. Please submit any data to support your request and include your member ID number and, if applicable, claim number and date of service.

LEVEL 3 APPEALS

If after a Level 2 Appeal, Empire continues to deny your care, you may file an appeal with the Medical Trust. Your appeal should be filed within 60 calendar days from the date of your Level 2 appeal denial letter.

How to File an Appeal or Grievance

The address for filing a grievance or Medical Management appeal is:

Empire BlueCross BlueShield

Appeal & Grievance Dept
P.O. Box 5078
Middletown, NY 10940-5078

The address for filing a Level 3 or Mental Health Benefit Program appeal is:

The Episcopal Church Medical Trust
445 Fifth Avenue
New York, NY 10016

Attn: Clinical Department

GENERAL INFORMATION

Type of Plan

A benefit plan providing group medical and prescription drug benefits.

Name and Address of the Plan Sponsor and Plan Administrator

The Episcopal Church Medical Trust
445 Fifth Avenue
New York, NY 10016
(212) 592-1800

Name and Address of the Designated Agent for Service of Legal Process

The Episcopal Church Medical Trust
445 Fifth Avenue
New York, NY 10016
(212) 592-1800

Internal Revenue Service Identification Number

The corporate tax identification number assigned by the Internal Revenue Service to Church Pension Group Services Corporation is 75-3089458.

Name and Address of the Third-Party Contract Administrator

Empire BlueCross BlueShield
P.O. Box 5009
Middletown, NY 10940-9009

Plan Year

The plan year is the 12-month period beginning August 1 and ending July 31.

Method of Funding Benefits

Health benefits are self-funded by the Medical Trust from accumulated assets and are provided directly from the Episcopal Church Clergy and Employees' Benefit Trust ("ECCEBT").

Payments out of the Plan to health care providers on behalf of the covered person will be based on the provisions of the Plan.

EMPIRE BLUECROSS BLUESHIELD | 75/50 PPO PLAN

PLAN IS EFFECTIVE AS OF AUGUST 1, 2008

	Annual Deductibles		Annual Out-of-Pocket Maximums (Excludes Deductible)		Inpatient Hospital Copayment
Network	$900 $1,800	Individual Family	$2,700 $5,400	Individual Family	$100 per day, not to exceed $600 per admission
Non-Network	$1,800 $3,600	Individual Family	$5,400 $10,800	Individual 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
Acupuncture Services	**Network** 50% **Non-Network** 50%	No Yes	No Yes	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.
Allergy Testing (Injections)	**Network** $35 Per Visit w/ PCP $45 w/ specialist **Non-Network** 50%	No Yes	No Yes	Allergy treatment with no office visit billed is covered at 100%.
Ambulance Services - Emergency Only	**Network & Non-Network** 25%	Yes	No	For facility/non-emergency services out-of-network, you will pay 40% and the annual deductible applies.
Diagnostic Tests/X-Ray and Laboratory Services	**Network** 25% **Non-Network** 25%	Yes Yes	No No	
Durable Medical Equipment (DME)	**Network** 25% **Non-Network** 25%	No Yes	No Yes	
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.

PLAN IS EFFECTIVE AS OF AUGUST 1, 2008

COVERED HEALTH SERVICE	YOUR COPAYMENT AMOUNT	COPAY APPLY TO ANNUAL OOP MAX?	NEED TO MEET ANNUAL DEDUCTIBLE?	ADDITIONAL LIMITATIONS AND EXPLANATIONS
Home Health Care	**Network** 25%	Yes	Yes	Limited to 200 visits per plan year; precertification is required.
	Non-Network 50%	Yes	Yes	
Hospice Care	**Network** 25%	Yes	Yes	Limited to one episode per lifetime. Benefits include bereavement counseling. Precertification is required.
	Non-Network 50%	Yes	Yes	
Hospital Services (Inpatient)	**Network** 25%. $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.
	Non-network 50%	Yes	Yes	
Hospital Services (Outpatient)	**Network** 25%	Yes	Yes	
	Non-Network 50%	Yes	Yes	
Maternity Services Hospital Services	**Network** 25%. 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.
	Non-Network 50%	Yes	Yes	
Outpatient Services	**Network** $35 for first visit only with PCP/$45 with specialist.	No	No	Antepartum care only.
	Non-Network 50%	Yes	Yes	
Mental Health/ Substance Abuse Services - Inpatient	See Cigna Behavioral Health Schedule			

EMPIRE BLUECROSS BLUESHIELD | 75/50 PPO PLAN

PLAN IS EFFECTIVE AS OF AUGUST 1, 2008

COVERED HEALTH SERVICE	YOUR COPAYMENT AMOUNT	COPAY APPLY TO ANNUAL OOP MAX?	NEED TO MEET ANNUAL DEDUCTIBLE?	ADDITIONAL LIMITATIONS AND EXPLANATIONS
Mental Health/ Substance Abuse Services - Outpatient	See Cigna Behavioral Health Schedule			
Nutritional Counseling	**Network** $35 w/ PCP $45 w/ specialist **Non-Network** 50%	No No	No No	Limited to 6 sessions per calendar year.
Outpatient Therapy Services	**Network** $35 w/ PCP $45 w/ specialist **Non-Network** 50%	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.
Physician's Office Services	**Network** $35 w/ PCP $45 w/ specialist **Non-Network** 50%	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.
Routine & Preventive Services **Routine Exams** **Routine Exam X-Rays & Laboratory Services** **Well-Child Checkups** **Routine Colonoscopy** **Routine Sigmoidoscopy** **Other Routine Services**	**Network** $35 w/ PCP $45 w/ specialist **Non-Network** 50%	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+.
Skilled Nursing Facility/ Inpatient Rehabilitation Facility Services	**Network** 25% **Non-Network** 50%	Yes Yes	Yes Yes	Limited to 60 days per year.
Smoking Cessation Program	**Network** 25% **Non-Network** 50%	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.
Spinal Treatment	**Network** $35 w/ PCP $45 w/ specialist **Non-Network** 50%	No Yes	No Yes	Limited to 20 visits per year.

EMPIRE BLUECROSS BLUESHIELD | **75/50 PPO PLAN**

PLAN IS EFFECTIVE AS OF AUGUST 1, 2008

COVERED HEALTH SERVICE	YOUR COPAYMENT AMOUNT	COPAY APPLY TO ANNUAL OOP MAX?	NEED TO MEET ANNUAL DEDUCTIBLE?	ADDITIONAL LIMITATIONS AND EXPLANATIONS
Surgical Treatment of Morbid Obesity	**Network** 25%	Yes	Yes	Limited to 1 procedure per lifetime.
	Non-Network 50%	Yes	Yes	
Urgent Care Services	**Network** 25%	Yes	Yes	
	Non-Network 50%	Yes	Yes	
Additional Benefits				
Anesthesiology Services				
Professional	**Network** 25%	Yes	No	
	Non-Network 25%	No	No	
Facility	**Network** 25%	Yes	No	
	Non-Network 50%	Yes	Yes	
Organ Transplants	**Network** 25%	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 50%	Yes	Yes	
All Other Covered Medical Expenses	**Network** 25%	No	No	Benefits are provided for expenses listed in the “What’s Covered” sections of this Handbook.
	Non-Network 50%	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.

	RETAIL PRESCRIPTION DRUGS	MAIL-ORDER PRESCRIPTION DRUGS
Annual Prescription Deductible	$50 per individual	N/A
Tier 1: Generic	You pay up to $10.	You pay up to $25.
Tier 2: Formulary Brand-Name	You pay up to $30.	You pay up to $70.
Tier 3: Non-Formulary Brand-Name and Brand Non-Sedating Antihistamines	You pay up to $50.	You pay up to $120.
Dispensing Limits Per Copayment	Up to a 30-day supply.	Up to a 90-day supply
Prescription Smoking Cessation Drugs Annual Maximum	1 cycle of therapy per individual.	

Coverage of Non-Sedating Antihistamines

The non-sedating antihistamine drug category has the highest copayment, regardless of the drug's formulary status. This change is a result of the drug Claritin now being available over the counter. For example, if you prefer to take the medication Clarinex rather than buying Claritin over the counter, you pay the third-tier copayment.

Generic Substitution Requirement

Generic medications and their brand-name counterparts have the same active ingredients and are manufactured according to the same strict federal regulations. Generic drugs may differ in color, size, or shape, but the U.S. Food and Drug Administration (FDA) requires that the active ingredients have the same strength, purity, and quality as their brand-name counterparts. **For this reason, the Plan will cover the cost of the generic equivalent if you purchase a brand-name medication when there is a generic available. You will be charged the generic copayment and the cost difference between the brand-name and the generic medication.** If you have questions or concerns about generic medication, speak to your physician or your pharmacist, and he or she will be able to help you.

Prescriptions Filled At A Nonparticipating Pharmacy

If you go to a retail pharmacy that is not part of the Medco network, you must pay the full cost of the prescription and then submit a direct reimbursement claim form to Medco. You will be reimbursed for the amount the medication would have cost your Plan at a participating pharmacy minus the copayment you would have paid.

Keep in mind, the retail pharmacy program allows for a total of three fills of a maintenance medication at a retail pharmacy (one original fill and two refills). Additional fills will not be covered by the Plan. Each fill can be for no more than a 30-day supply. Note that you are allowed a total of three fills, even if each is for less than 30 days.

Retail Refill Limit

The Prescription Drug Program will maintain a Retail Refill Limit policy. The retail refill limit requires that you use the mail-order pharmacy if you are prescribed a maintenance medication, rather than refilling multiple prescriptions for the same drug at a retail pharmacy. If you or a covered dependent receives a prescription for a maintenance medication and you do not use the mail-order pharmacy, your prescriptions may not be covered.

In some circumstances, you may not be required to use the mail-order pharmacy. For example, there are several categories of medications that are uniquely appropriate for multiple refills at your local pharmacy (and are therefore exempt from the mandatory mail-order provision, as outlined above). If you have a prescription for any of the following medications, the Prescription Drug Program allows you to receive multiple refills at your local retail pharmacy:

- Anti-infectives, including antibiotics (Amoxicillin, Biaxin), antivirals (Zovirax, Famvir), antifungals (Diflucan), and drops used in the eyes and ears (Polsporin Opth, Cipro Otic). Please note that drops must be prescribed specifically to treat infection. For example, glaucoma drops are not covered.
- Prescription cough medications, including Phenergan with Codeine, Tessalon, and Tussionex.
- Medications to treat acute pain, both narcotic (Vicodin, Percodan, etc.) and non-narcotic (Darvocet). Please note that long-term pain medications, such as NSAIDs, do not meet the necessary retail requirements.
- Medications that require a new written prescription each time you need them, as refills are prohibited by federal law (e.g., Percodan, Ritalin, and Nembutal).
- Medications used to treat both attention deficit disorder (Ritalin, Cylert) and narcolepsy (Dexedrine).
- Medications whose sole use is to treat cancer.

Refilling Mail-Order Prescriptions

Since your medication can take 7 to 11 days to be delivered, you should have at least a 14-day supply of that medication on hand to hold you over. If you do not have enough medication, you may need to ask your doctor for another prescription for a 14-day supply that you can fill at your local retail network pharmacy.

Your Plan May Have Coverage Limits

Your Plan may have certain coverage limits. For example, prescription drugs used for cosmetic purposes may not be covered, or a medication might be limited to a certain amount (such as the number of pills or total dosage) within a specific time period.

If you submit a prescription for a drug that has coverage limits, your pharmacist will tell you that approval is needed before the prescription can be filled. The pharmacist will give you or your doctor a toll-free number to call. If you use *Medco By Mail*, your doctor will be contacted directly.

When a coverage limit is triggered, more information is needed to determine whether your use of the medication meets your Plan's coverage conditions. We will notify you and your doctor of the decision in writing. If coverage is approved, the letter will indicate the amount of time for which coverage is valid. If coverage is denied, an explanation will be provided, along with instructions on how to submit an appeal.

Additional Information

It is always up to you and your doctor to decide which prescriptions are best for you. You are never required to use generic drugs or drugs that are on the Medco formulary list. If you prefer, you can use non-formulary brand-name drugs and pay a higher copayment.

It is also important to note that drugs included on the formulary list are routinely updated. To find the most up-to-date list of covered drugs, visit Medco at **www.medco.com**, or call their member services department at (800) 841-3361. It should be noted that all drugs listed on the formulary may not be covered due to Plan exclusions and limitations. You can also use Medco's Web site or member services telephone number to locate the retail pharmacy nearest you.

Paper Claims Reimbursement

You must pay the full price at the pharmacy and file a claim for reimbursement. You will be reimbursed according to what the Plan would have paid at a participating pharmacy, less your applicable copayment. See the "Pharmacy Benefits" section of your Plan Handbook for more information about filing claims for reimbursement for prescription drugs purchased at retail pharmacies.

Medco toll-free number: (800) 841-3361

NOTES: Some prescriptions may require prior authorization. Please refer to the "Pharmacy Benefits" section of this Handbook for further information.

Prescription deductibles and copayments do not apply to the medical plan deductibles or out-of-pocket maximums.

EYEMED VISION CARE

Services	Copayments for Benefits
Exam	$10
Eye Glass Lenses	$10

Benefit Description	Network	Out-of-Network
Eye Examinations	You pay $10	Plan pays up to $30 for ophthalmologists or optometrists
Lenses*	You pay $10 for single, bifocal or trifocal	Plan pays up to: $32—single vision $46—bifocal $57—trifocal
Lens Options		You are responsible for the cost of any lens options that you elect from out-of-network providers
UV Coating	You pay up to $15	
Tint (Solid and Gradient)	You pay up to $15	
Standard Scratch Resistance	You pay up to $15	
Standard Polycarbonate	You pay $0	
Standard Anti-Reflective Coating	You pay up to $45	
Standard Progressive (Add-On to Bifocal)	You pay up to $65	
Other Add-Ons and Services	20% off retail price	
Frames*	$130 allowance, 20% off balance over $130	Plan pays up to $47
Contact Lenses*		
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

** You are eligible to receive lenses and frames* **or** *contact lenses once per calendar year.*

When you use EyeMed network providers, you will not need to submit a claim. Your EyeMed provider will submit claims on your behalf. You will pay the copayment and also pay for any noncovered expenses at the time you receive services.

For More Information

For more information about EyeMed, and to see a list of EyeMed providers, please visit **www.eyemedvisioncare.com**, or call EyeMed toll-free at (866) 723-0513.

As a participant in an Episcopal Church Medical Trust Health Plan, you are entitled to certain rights concerning your protected health information under the Health Insurance Portability and Accountability Act (HIPAA). The following describes how health information about you may be used and disclosed and how you may access this information.

The plan is permitted to make certain types of uses and disclosures of protected health information under applicable law for treatment, payment, and health care operations purposes.

USE AND DISCLOSURE OF INFORMATION TO AND FROM CHURCH PENSION GROUP SERVICES CORPORATION

The plan may disclose protected health information to Church Pension Group Services Corporation (the "plan sponsor") under limited circumstances. The plan will disclose protected health information to the plan sponsor only upon receipt of a certification by the plan sponsor that the plan documents have been amended to incorporate and to abide by these privacy provisions.

The plan may disclose summary health information to the plan sponsor for the purposes of obtaining premium bids, insurance coverage, or modifying, amending, or terminating the plan.

The plan may disclose protected health information to carry out plan administration functions that are consistent under applicable law. The plan may not disclose protected health information to the plan sponsor for the purpose of employment-related actions or decisions or in connection with other benefits or employee benefit plans of the plan sponsor.

A limited number of employees of the plan sponsor will have access to protected health information for the purposes of carrying out plan administration functions in the ordinary course of business. These employees are in the following areas: Human Resources, Information Services, Mailroom/Fax Delivery, Legal Department, Medical Trust Member Services, and Medical Trust Plan Administration.

These employees will only use protected health information for plan administration functions, consistent with the plan's Privacy Policies and Procedures, the Standards for Privacy of Individually Identifiable Health Information, other applicable federal or state privacy law, and the departments' privacy policies. Should an employee of the plan sponsor not comply with the plan's Privacy Policies and Procedures, the Standards for Privacy of Individually Identifiable Health Information, or other federal or state privacy law, the employee will be subject to corrective action. The plan sponsor will promptly implement the contingency plans to mitigate any deleterious effect of improper use or disclosure of protected health information by Church Pension Group Services Corporation employees or the plan's business associates.

If feasible, the plan sponsor must return or destroy all protected health information received from the plan that the plan sponsor maintains in any form. The plan sponsor cannot retain copies of such information when it is no longer needed for the purpose for which disclosure was made. If the return or destruction of protected health information is not feasible, the plan sponsor will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible. The plan sponsor has an obligation under the law to retain records for its plan administrative functions, and will retain the required records, which may or may not contain protected health information, as required under the law. The plan sponsor must report to the plan any use or disclosure of protected information that is inconsistent with the uses or disclosures provided for of which the plan sponsor becomes aware.

The plan sponsor must make its internal practices, books, and records relating to the use and disclosure of protected health information received from the plan available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance with the Standards for Privacy of Individually Identifiable Health Information.

USE AND DISCLOSURE OF HEALTH INFORMATION BY THE PLAN

The plan will not use or disclose protected health information other than as permitted or required by the plan documents or as required by law. For instance, the plan is permitted to disclose minimum necessary protected health information without your authorization for public health activities, health oversight activities, research, and judicial and administrative proceedings. The plan is permitted to disclose protected health information to law enforcement officials as required by law. The plan is also required to disclose protected health information to you or your personal representative to the extent that you have a right of access to the information and to the U.S. Department of Health and Human Services on request for complaint investigation or compliance review.

The plan's business associates are permitted to use protected health information received from the plan for the specific activities for which those business associates are contracted. Before receiving your protected health information, the plan's business associates must agree to the same restrictions and conditions that apply to the plan and plan sponsor under the Standards for Privacy of Individually Identifiable Health Information and other applicable federal or state privacy laws. The third-party administrator is considered a business associate of the plan.

ACCESS, AMENDMENT, AND ACCOUNTING OF HEALTH INFORMATION

You have a right to request access to inspect and obtain a copy of your protected health information that the plan and the plan's business associates maintain in a designated record set. The plan has established procedures in its Privacy Policies and Procedures to grant access to your protected health information. The plan has a right to deny your request for access, and you have the right to request a review of that denial under certain circumstances, pursuant to the provisions of 45 CFR § 164.524.

The designated record set that the plan maintains includes documentation about enrollment, payment, claims adjudication, or case/medical management. To request access to your protected health information, contact the plan sponsor.

You have a right to request that the plan amend your protected health information that the plan and the plan's business associates maintain in a designated record set. The plan has established procedures in its Privacy Policies and Procedures to allow amendment to your protected health information. The plan has a right to deny your request for amendment, and you have the right to attach a statement of disagreement, pursuant to the provisions of 45 CFR § 164.526. To request an amendment to your protected health information, contact the plan sponsor.

Pursuant to 45 CFR § 164.528, you have a right to request an accounting of disclosures of your protected health information made by the plan six years prior to the date on which the accounting is requested, beginning with the effective date of the Standards for Privacy of Individually Identifiable Health Information, which is April 14, 2003.

Example 1: You request an accounting on September 14, 2003. The plan is obligated to account for disclosures made from April 14, 2003 through September 14, 2003.

Example 2: You request an accounting on September 14, 2010. The plan is obligated to account for disclosures made from September 14, 2004 through September 14, 2010.

The plan does not have to account for disclosures made:

- To you;
- To carry out treatment, payment, and health care operations;
- Pursuant to your authorization;
- Incident to a use or disclosure otherwise permitted under the Standards for Privacy of Individually Identifiable Health Information;
- For national security or intelligence purposes;
- As part of a limited data set;
- Prior to April 14, 2003; or
- For other reasons listed in 45 CFR § 164.528.

To request an accounting of disclosures of your protected health information, contact the plan sponsor.

COMPLAINTS

If you believe your privacy rights have been violated, you may complain to the Chief Privacy Officer at Church Pension Group Services Corporation; 445 Fifth Avenue; New York, NY 10016. You also may complain to the Secretary of the Department of Health and Human Services at Hubert H. Humphrey Building; 200 Independence Ave., SW; Washington, D.C. 20201. You will not be retaliated against for filing a complaint.

YOUR HEALTH INFORMATION AND PRIVACY

Your health information is confidential, and your privacy will be protected. Medical information obtained through administrative services, including medical claims and pharmacy claims, may be used to help identify the appropriate level of case management or other programs available to you, as described in the plan. You may receive prescription drug refill reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Your health information also may be used for quality assessment and improvement activities related to your medical benefits. Medical information obtained through these administrative services will not be used to make employment and personnel decisions.

NOTE: The following terms, as used in this section, are defined in the Standards for Privacy of Individually Identifiable Health Information (45 CFR Parts 160 and 164): "protected health information," "summary health information," "business associates," "personal representative," "designated record set," and "limited data set."

SECURITY

On April 21, 2005, the final rule implementing the Security Standards ("Security Rule") under the Health Insurance Portability and Accountability Act of 1996 became effective. To comply with the Security Rule, the plan sponsor must implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic protected health information that it creates, receives, maintains or transmits. The Plan's business associates must agree to implement reasonable and appropriate security measures to protect health information received from the Plan or plan sponsor. A limited number of employees of the plan sponsor will have access to protected health information for the purposes of carrying out plan administration functions in the ordinary course of business, and there are reasonable and appropriate security measures in place to ensure that only these employees will have access to information. The plan sponsor will report to the Plan any security incident of which it becomes aware.

FOR MORE INFORMATION

Here are some additional resources, should you have any questions after reviewing all of the information in this Handbook.

FOR QUESTIONS ABOUT…	YOU SHOULD CONTACT…
The Episcopal Church Medical Trust	www.cpg.org Active Employees (800) 480-9967 e-mail: medtrust@cpg.org Retired Employees (866) 273-4545 e-mail: mtmedsupp@cpg.org (Monday through Friday, except holidays, 8:30 a.m.– 5:30 p.m. EST)
Empire BlueCross BlueShield	www.empireblue.com/medicaltrust (800) 352-3152 (Monday through Friday, 8:30 a.m. - 8:00 p.m. EST)
Mental Health Benefit Program	www.cignabehavioral.com (866) 395-7794 (24 hours a day, 7 days a week)
Medco	www.medco.com (800) 841-3361 (24 hours a day, 7 days a week)
EyeMed Vision Care	www.eyemedvisioncare.com (866) 723-0513 (Monday through Saturday, 8:00 a.m. – 11:00 p.m. EST, and Sunday, 11:00 a.m. – 8:00 p.m. EST)

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, 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 its affiliates, including but not limited to the Medical Trust, CPGSC and ECCEBT (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, the Travel Protection Benefit and the Hearing Aid Benefit, 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.

If you are a Plan participant, call the number on your ID card for more information about the Plan in which you are enrolled. All other individuals should call (800) 480-9967.

THE EPISCOPAL CHURCH MEDICAL TRUST

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