The Episcopal Trust Medical Trust
Empire BlueCross BlueShield 75/50 PPO Plan
Association of Episcopal Seminaries
Plan Year 8/1/2008 – 7/31/2009

General Information	In-Network[1]	Out-of-Network[2,3]
Deductible	$900 Individual; $1,800 Family	$1,800 Individual; $3,600 Family
Out-of-Pocket Maximum	$2,700 Individual; $5,400 Family (excludes deductible)	$5,400 Individual; $10,800 Family (excludes deductible)
Lifetime Maximum	$2,000,000 combined in and out of network	
Dependent Eligibility	Spouse and unmarried children up to age 30 (restrictions apply)	
Hospital Care[4]	**In-Network[1]**	**Out-of-Network[2,3]**
Inpatient Hospital Services (**must be precertified**)	Covered at 75% after $100 per day deductible; $600 maximum per admission **Not subject to annual deductible**	Covered at 50% after the deductible
Physicians' & Surgeons' Services	Covered at 75% after the annual deductible	Covered at 50% after the deductible
Newborn Nursery Care	Covered at 75% after the annual deductible	Covered at 50% after the deductible (Included with maternity benefit)
Inpatient mental health/substance abuse treatment[5] (must be precertified)	$100 per day deductible; $600 maximum per admission **Must be pre-authorized by CBH**	Not Covered
Skilled Nursing Facility Limited to 60 days per calendar year[7]	Covered at 75% after the annual deductible	Covered at 50% after the deductible
Hospice Facility/Home Hospice[4] Limited to 200 days/visits per lifetime[7]	Covered at 75% after the annual deductible	Covered at 50% after the deductible
Emergency Care	**In-Network[1]**	**Out-of-Network[2,3]**
Hospital Emergency Room	$50 copay; waived if admitted within 24 hours	$50 co-pay; waived if admitted within 24 hours
Ambulance Service (ground transportation)	Covered at 75% Not subject to annual deductible	Covered at 75% Not subject to deductible
Outpatient Care	**In-Network[1]**	**Out-of-Network[2,3]**
Outpatient: ambulatory surgery (**must be precertified**)	Covered at 75% after the annual deductible	Covered at 50% after the deductible
Physicians' Charges	$35 copay (PCP) $45 copay (specialist)	Covered at 50% after the deductible
Outpatient Mental Health/Substance Abuse Treatment[5]	$25 copay (CBH)	Covered at 70% after the deductible (CBH)
Maternity Care (ante partum care only)	$35 copay first visit only; covered thereafter	Covered at 50% after the deductible
Diagnostic X-Rays, Lab Tests, and Procedures (non-routine)	Covered at 75%	Covered at 75%
Physical/Speech/Occupational/Vision therapies; visit limitations apply	$35 copay (PCP) $45 copay (specialist)	Covered at 50% after the deductible
Chiropractic Care Limited to 20 visits per calendar year[7]	$35 copay (PCP) $45 copay (specialist)	Covered at 50% after the deductible

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Preventive Care	In-Network[1]	Out-of-Network[2,3]
Routine Physical[8]	$35 copay (PCP) $45 copay (specialist)	Covered at 50% after the deductible
Well-Child Checkups	$35 copay (PCP) $45 copay (specialist)	Covered at 50% after the deductible (Subject to visit limitations by age)
Immunizations[8]	$35 copay (PCP) $45 copay (specialist)	Covered at 50% after the deductible
Routine GYN Exam[8]	$35 copay (PCP) $45 copay (specialist)	Covered at 50% after the deductible
Routine Eye Exam (Administered by EyeMed Vision Care)	$10 co-pay, direct access to participating providers, Frequency schedules apply	Partial reimbursement according to schedule of benefits
Vision–Corrective Lenses/Contacts Allowance (Administered by EyeMed Vision Care)	$130 Allowance for frames/contact lenses every 12 months	Reimbursement varies (See detailed Vision Benefits Schedule)
Routine X-Ray and Laboratory Services[8]	Covered at 100%	Covered at 50%
Mammography (routine) [8]	Covered at 100%	Covered at 100%
Other	**In-Network[1]**	**Out-of-Network[2,3]**
Durable medical equipment (Must call First Health before purchase or rental)	Covered at 75% after the annual deductible	Covered at 50% after the deductible
All Other Covered Medical Expenses	Covered at 75% after the annual deductible	Covered at 50% after the deductible
Prescription Drugs	**Retail**	**Mail Order**
Individual Retail Deductible	$50	None
Retail Copayments (Generic/Formulary/Non-formulary)	$10/$30/$50	$25/$70/$120
Generic or Pay the Difference	Applies to Retail and Mail Order	
Maintenance Medications	3 fills allowed (original script, 2 refills)	Mandatory after 3rd retail fill

1 Network provider renders care.
2 The member is responsible for any deductible, coinsurance and amount above the R&C allowed amount where applied. (This also applies to any claim that receives the in-network reimbursement level for a non-participating provider, for example Durable Medical equipment.)
3 Out-of-network services are those from a provider that does not participate.
4 The plan's copayment for hospital expenses will be reduced to 50% if you do not follow the procedures required by the clinical management program. This penalty does not apply to the out-of-pocket maximum.
5 All mental health benefits are provided through CIGNA Behavioral Health.
7 Visit/day maximum limits are combined for both in and out of network services.
8 $550 individual annual maximum.

Failure to comply with our Clinical Management Program could result in benefit reductions and/or denial of services.

This benefit summary is provided for informational purposes, is not all-inclusive, and does not constitute an agreement. This summary is subject to the terms, conditions, limitations and exclusions set for in the contract. An applicable Summary of Benefits will be issued to eligible, enrolled members. The Medical Trust reserves the right to alter the benefits outlined herein without notice.