

The Episcopal Church Medical Trust

Plan Document Handbook

HMO Plan

Presenting information at your fingertips.
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 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 Employee’s 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 Aetna Inc. (“Aetna”) National Health Maintenance Organization (HMO) Plan. 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 AETNA NETWORK— A SMART WAY TO GET HEALTH CARE

The Plan described in this Handbook is built around a network of health care providers available to you through Aetna, and the Aetna name appears on your ID card. 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 Aetna to provide services to members as part of the Aetna “network.” Because the contracted rate results in savings to both you and the plan, you are reimbursed at a higher level if you use network providers. The terms “non-network” or “out-of-network” refer to health care providers that do not participate in the Aetna network. Network providers include hospitals, physicians, outpatient facilities, and other ancillary health care providers.

Your Primary Care Physician: As a participant in the National HMO Plan, you must choose a Primary Care Physician (PCP). Consult your Primary Care Physician whenever you have questions about your health. He or she provides basic and routine care, and can refer you to specialists and facilities in the network, when medically necessary.

As a participant in the National HMO Plan, for all nonemergency services, you must use an Aetna provider to receive benefits under the plan.

The Plan is offered by the Medical Trust on a self-funded basis and all plan payments are paid from the ECCEBT. Aetna acts as the third-party administrator and is not financially responsible for any benefits under the Plan.

THE AETNA NETWORK ADVANTAGE

When you use the Aetna network for health care, you get:

- ⊗ A national network of doctors and hospitals.
- ⊗ 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 and 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 handbook 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 the 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”	1
What’s Covered	“Coverage”	17
Precertification and Health Information	“Clinical Management”	55
How to File a Claim, the Meaning of Health Care Terms, and Coordination of Benefits	“Details and Definitions”	58

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



Call Aetna for Precertification/ More Information



What’s Covered



What’s Not Covered



Remember



Tips

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GETTING ANSWERS

WHAT	WHY	WHERE
Member Services	For questions about your benefits, claims, or membership	www.aetna.com (877) 380-8584 (Monday through Friday, 8:00 a.m.–6:00 p.m. EST)
Aetna Network	Locate an Aetna provider	www.aetna.com (877) 380-8584 (Monday through Friday, 8:00 a.m.–6:00 p.m. EST)
Precertification	Preauthorization of hospital admissions and certain designated services	(800) 245-1206 (Monday through Friday, 8:00 a.m.–6:00 p.m. EST)
Informed Health® Line	Speak with a specially trained nurse to get health information	(800) 556-1555 (24 hours a day, 7 days a week)
Aetna Behavioral Health	Preauthorization of inpatient admissions or help finding a mental health or substance abuse provider	www.aetnabehavioralhealth.com (800) 755-2422
Medco	<ul style="list-style-type: none"> • Information about the program • Locate a participating retail pharmacy • Obtain a drug formulary list 	www.medco.com (800) 841-3361 (24 hours a day, 7 days a week)
Eyemed	<ul style="list-style-type: none"> • Information about vision benefits • Locate a participating vision provider • Obtain authorization to use non-network providers 	www.eyemedvisioncare.com (866) 723-0513 (Monday through Saturday, 8:00 a.m.–11:00 p.m., and Sunday, 11:00 a.m.–8:00 p.m.)
Episcopal Church Medical Trust	For questions about benefits, enrollment, or appeals	www.cpg.org (800) 480-9967 e-mail: medtrust@cp.org (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. Aetna 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.

CALL AETNA FOR PRECERTIFICATION/ MORE INFORMATION



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.

Providers in the Aetna 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 Aetna 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 Aetna 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 Aetna 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).

Please remember to precertify hospital and other facility admissions, maternity care, and other designated services 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.

USING THE PLAN TO YOUR BEST ADVANTAGE



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 Informed Health® Line—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. **Please note: Aetna nurses cannot diagnose, prescribe or give medical advice. All treatment decisions are between you and your doctor.**

Talk to your provider about your care, learn about your benefits and your options, and ask questions. Aetna is here to work with you and your provider to see that you get the best benefits.

KNOW THE BASICS

Plan participants have access to a network of participating Primary Care Physicians (PCPs), specialists and hospitals that meet Aetna's requirements for quality and service. These providers are independent physicians and facilities that are monitored for quality of care, patient satisfaction, cost-effectiveness of treatment, office standards and ongoing training.

YOUR PRIMARY CARE PHYSICIAN

As a participant in the HMO Plan, you will become a partner with your participating PCP in preventive medicine. Your PCP will provide your primary care and, when medically necessary, your PCP will refer you to other doctors or facilities for treatment. The referral is important because it is how your PCP arranges for you to receive necessary, appropriate care and follow-up treatment.

Your PCP can provide preventive care and treatment for illnesses and injuries. The Plans cover routine physical exams, well-baby care, immunizations and allergy shots provided by your PCP. You may also obtain routine vision exams and gynecological exams from participating providers without a referral from your PCP. You are responsible for the copayments shown in the "Schedules of Benefits".

SPECIALTY AND FACILITY CARE

Your PCP may refer you to a specialist or facility for treatment or for covered preventive care services, when medically necessary. Participating specialists are required to send reports back to your PCP to keep your PCP informed of any treatment plans ordered by the specialist.

Except for PCP, direct access and emergency services, **you must have a prior written or electronic referral from your PCP to receive coverage for all services and any necessary follow-up treatment.**

OUTPATIENT CARE

Although a specific service may be listed as a covered benefit, it may not be covered unless it is **medically necessary** for the prevention, diagnosis or treatment of your illness or condition. Refer to the “Glossary” section for the definition of “medically necessary”.

Certain services must be precertified by Aetna. Your participating provider is responsible for obtaining this approval. If you are a participant in the QPOS Plan and are seeking self-referred care, you are responsible for obtaining the necessary precertification.

WHAT'S COVERED



The following medical services are covered:

Office visits with your PCP during office hours and during non-office hours.

Home visits by your PCP.

Treatment for illness and injury.

Routine physical examinations, as recommended by your PCP.

Well-child care from birth, including immunizations and booster doses, as recommended by your PCP.

Health education counseling and information.

Annual prostate screening (PSA) and digital exam for males age 40 and over, and for males considered to be at high risk who are under age 40, as directed by physician.

Routine gynecological examinations and Pap smears performed by your PCP. You may also visit a participating gynecologist for a routine GYN exam and Pap smear without a referral.

Annual mammography screening for asymptomatic women age 40 and older. Annual screening is covered for younger women who are judged to be at high risk by their PCP. **NOTE:** Diagnostic mammography for women with signs or symptoms of breast disease is covered as medically necessary.

Routine immunizations (except those required for travel or work).

Flu shots.

Periodic eye examinations. You may see a participating provider as follows:

If you wear eyeglasses or contact lenses:

- age 1-18 years—one exam every 12 months.
- age 19 or over—one exam every 24 months

If you do not wear eyeglasses or contact lenses:

- age 1-45 years—one exam every 36 months.
- age 46 or over—one exam every 24 months.

TIPS FOR VISITING YOUR DOCTOR



- When you make your appointment, confirm that the doctor is a 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.aetna.com or call Member Services to confirm that the health care provider is a 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

Prescription lenses and frames, including contact lenses, subject to any allowances shown in the “Schedule of Benefits”.

Routine hearing screenings performed by your PCP as part of a routine physical examination.

Injections, including routine allergy desensitization injections.

WHAT'S NOT COVERED



The following medical services and supplies are not covered:

Ambulance services, when used as routine transportation to receive inpatient or outpatient services.

Any service in connection with, or required by, a procedure or benefit not covered by the Plan.

Any services or supplies that are not medically necessary, as determined by Aetna.

Biofeedback, except as specifically approved by Aetna.

Blood and blood plasma, including but not limited to, provision of blood, blood plasma, blood derivatives, synthetic blood or blood products other than blood derived clotting factors, 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, apheresis or plasmapheresis.

Breast augmentation and otoplasties, including treatment of gynecomastia.

Canceled office visits or missed appointments.

Care for conditions that, by state or local law, must be treated in a public facility, including mental illness commitments.

Care furnished to provide a safe surrounding, including the charges for providing a surrounding free from exposure that can worsen the disease or injury.

Cosmetic surgery or surgical procedures primarily for the purpose of changing the appearance of any part of the body to improve appearance or self-esteem. However, the Plan covers the following:

- reconstructive surgery to correct the results of an injury.
- surgery to treat congenital defects (such as cleft lip and cleft palate) to restore normal bodily function.
- surgery to reconstruct a breast after a mastectomy that was done to treat a disease, or as a continuation of a staged reconstructive procedure.

Court-ordered services and services required by court order as a condition of parole or probation, unless medically necessary and provided by participating providers upon referral from your PCP.

Custodial care and rest cures.

OUTPATIENT CARE

Dental care and treatment, including (but not limited to):

- care, filling, removal or replacement of teeth,
- dental services related to the gums,
- apicoectomy (dental root resection),
- orthodontics,
- root canal treatment,
- soft tissue impactions,
- alveolectomy,
- augmentation and vestibuloplasty treatment of periodontal disease,
- prosthetic restoration of dental implants, and
- dental implants.

However, the Plan does cover oral surgery as described under “Your Benefits”.

Educational services, special education, remedial education or job training. The Plan does not cover evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental and learning disorders, behavioral training or cognitive rehabilitation. Services, treatment, and educational testing and training related to behavioral (conduct) problems, learning disabilities and developmental delays are not covered by the Plan.

Expenses that are the legal responsibility of Medicare or a third party payor.

Experimental and investigational services and procedures; ineffective surgical, medical, psychiatric, or dental treatments or procedures; research studies; or other experimental or investigational health care procedures or pharmacological regimens, as determined by Aetna, unless approved by Aetna in advance. This exclusion will not apply to drugs:

- that have been granted treatment investigational new drug (IND) or Group c/treatment IND status,
- that are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute, or
- that Aetna has determined, based upon scientific evidence, demonstrate effectiveness or show promise of being effective for the disease.

Refer to the “Glossary” for a definition of “experimental or investigational”.

False teeth.

Hair analysis.

Health services, including those related to pregnancy, that are provided before your coverage is effective or after your coverage has been terminated.

Hearing aids, eyeglasses, or contact lenses or the fitting thereof, except as specified under “Your Benefits”.

Household equipment, including (but not limited to) the purchase or rental of exercise cycles, air purifiers, central or unit air conditioners, water purifiers, hypo-allergenic pillows, mattresses or waterbeds.

Improvements to your home or place of work, including (but not limited to) ramps, elevators, handrails, stair glides and swimming pools.

OUTPATIENT CARE

Hypnotherapy, except when approved in advance by Aetna.

Immunizations related to travel or work.

Implantable drugs.

Infertility services, except as described under “Your Benefits”. The Plan does not cover

- purchase of donor sperm and any charges for the storage of sperm.
- purchase of donor eggs, and any charges associated with care of the donor required for donor egg retrievals or transfers or gestational carriers.
- cryopreservation and storage of cryopreserved embryos.
- all charges associated with a gestational carrier program (surrogate parenting) for the Plan participant or the gestational carrier.
- drugs related to the treatment of non-covered benefits or related to the treatment of infertility that are not medically necessary.
- injectable infertility drugs.
- the cost for home ovulation prediction kits
- services for couples in which one of the partners has had a previous sterilization procedure, with or without reversal.
- services for females with FSH levels greater than 19 mIU/ml on day 3 of the menstrual cycle.

Oral and implantable contraceptive drugs and devices, except when prescribed to treat certain medical conditions; these may be covered under the Prescription Drug plan administered by Medco.

Orthoptics (a technique of eye exercises designed to correct the visual axes of eyes not properly coordinated for binocular vision).

Orthotics.

Outpatient supplies, including (but not limited to) outpatient medical consumable or disposable supplies such as syringes, incontinence pads, elastic stockings and reagent strips.

Personal comfort or convenience items, including services and supplies that are not directly related to medical care, such as guest meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, take-home supplies, and other similar items and services.

Prescription drugs and medicines, except those administered while you are an inpatient in a health care facility.

Private duty or special nursing care.

Radial keratotomy, including related procedures designed to surgically correct refractive errors.

Recreational, educational and sleep therapy, including any related diagnostic testing.

OUTPATIENT CARE

Religious, marital or sex counseling, including related services and treatment.

Reversal of voluntary sterilizations, including related follow-up care.

Routine hand and foot care services, including routine reduction of nails, calluses and corns.

Services not covered by the Plan, even when your PCP has issued a referral for those services.

Services or supplies covered by any automobile insurance policy, up to the policy's amount of coverage limitation.

Services provided by your close relative (your spouse, child, brother, sister, or the parent of you or your spouse) for which, in the absence of coverage, no charge would be made.

Services required by a third party, including (but not limited to) physical examinations, diagnostic services and immunizations in connection with:

- obtaining or continuing employment,
- obtaining or maintaining any license issued by a municipality, state or federal government,
- securing insurance coverage,
- travel, and
- school admissions or attendance, including examinations required to participate in athletics, unless the service is considered to be part of an appropriate schedule of wellness service.

Services and supplies that are not medically necessary.

Services you are not legally obligated to pay for in the absence of this coverage.

Special education, including lessons in sign language to instruct a Plan participant whose ability to speak has been lost or impaired to function without that ability.

Special medical reports, including those not directly related to the medical treatment of a Plan participant (such as employment or insurance physicals) and reports prepared in connection with litigation.

Specific injectable drugs, including:

- experimental drugs or medications, or drugs or medications that have not been proven safe and effective for a specific disease or approved for a mode of treatment by the FDA and the National Institutes of Health,
- needles, syringes and other injectable aids,
- drugs related to treatments not covered by the Plan, and
- drugs related to the treatment of infertility, contraception, and performance-enhancing steroids.

OUTPATIENT CARE

Specific non-standard allergy services and supplies, including (but not limited to):

- skin titration (wrinkle method),
- cytotoxicity testing (Bryan's Test),
- treatment of non-specific candida sensitivity, and
- urine autoinjections.

Speech therapy for treatment of delays in speech development, unless resulting from disease, injury, or congenital defects.

Surgical operations, procedures or treatment of obesity, except when approved in advance by Aetna.

Therapy or rehabilitation, including (but not limited to):

- primal therapy,
- chelation therapy,
- rolfing,
- psychodrama,
- megavitamin therapy,
- purging,
- bioenergetic therapy,
- vision perception training, and
- carbon dioxide therapy.

Thermograms and thermography.

Transsexual surgery, sex change or transformation. The Plan does not cover any procedure, treatment or related service designed to alter a Plan participant's physical characteristics from their biologically determined sex to those of another sex, regardless of any diagnosis of gender role or psychosexual orientation problems.

Treatment in a federal, state or governmental facility, including care and treatment provided in a nonparticipating hospital owned or operated by any federal, state or other governmental entity, except to the extent required by applicable laws.

Treatment, including therapy, supplies and counseling, for sexual dysfunctions or inadequacies that do not have a physiological or organic basis.

Treatment of diseases, injuries or disabilities related to military service for which you are entitled to receive treatment at government facilities that are reasonably available to you.

Treatment of injuries sustained while committing a felony.

Treatment of mental retardation, defects and deficiencies. This exclusion does not apply to mental health services or medical treatment of the retarded individual as described under "Your Benefits".

OUTPATIENT CARE

Treatment of sickness or injury covered by a worker's compensation act or occupational disease law, or by United States Longshoreman's and Harbor Worker's Compensation Act.

Treatment of temporomandibular joint (TMJ) syndrome, including (but not limited to):

- treatment performed by placing a prosthesis directly on the teeth,
- surgical and nonsurgical medical and dental services, and
- diagnostic or therapeutic services related to TMJ.

Weight reduction programs and dietary supplements.

LIMITATIONS

In the event there are two or more alternative medical services that, in the sole judgment of Aetna, are equivalent in quality of care, the Plan reserves the right to cover only the least costly services, as determined by Aetna, provided that Aetna approves coverage for the service or treatment in advance.

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 Aetna at (877) 380-8584.

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

CALL AETNA FOR PRECERTIFICATION/ MORE INFORMATION



An Aetna 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 Aetna at (877) 380-8584.

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 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.

External insulin infusion pumps, blood pressure/blood glucose monitoring devices, and self-management training for diabetes.

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

Jobst garments.

Wigs and artificial hairpieces.

Sterile surgical supplies after surgery.

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.

Eyeglasses.

Vision aids.

Hearing aids.

Communication aids.

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.

INPATIENT CARE

If you are hospitalized by a participating PCP or specialist (with prior referral except in emergencies), you are covered for the services and supplies listed below. See “Behavioral Health” for inpatient mental health and substance abuse benefits.

WHAT'S COVERED



Confinement in semi-private accommodations (or private room when medically necessary and certified by your PCP) while confined to an acute care facility.

Confinement in semi-private accommodations in an extended care/skilled nursing facility.

Confinement in semi-private accommodations in a hospice care facility for a Plan participant who is diagnosed as terminally ill.

Intensive or special care medical facilities when medically necessary.

Visits by your PCP while you are confined.

General nursing care.

Surgical, medical and obstetrical services provided by the participating hospital.

Use of operating rooms and related facilities.

Medical and surgical dressings, supplies, casts and splints.

Drugs and medications when necessary.

Intravenous injections and solutions.

Administration and processing of blood, processing fees and fees related to autologous blood donations. (The blood or blood product itself is not covered.)

Nuclear medicine.

Preoperative care and postoperative care.

Anesthesia and anesthesia services.

Oxygen and oxygen therapy.

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 may 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 reduced to 50% for all related hospital expenses, after any applicable deductible.

In addition, if you fail to follow the requirements to preauthorize or prenotify, and Clinical 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.

INPATIENT CARE

Inpatient physical and rehabilitation therapy, including cardiac rehabilitation and pulmonary rehabilitation.

X-rays (other than dental X-rays), laboratory testing and diagnostic services.

Magnetic resonance imaging.

Transplant services are covered if the transplant is not experimental or investigational and has been approved in advance by Aetna. Transplants must be performed in hospitals specifically approved and designated by Aetna to perform the procedure. The Institutes of Excellence (IOE) network is Aetna's network of providers for transplants and transplant-related services, including evaluation and follow-up care. Each facility has been selected to perform only certain types of transplants, based on their quality of care and successful clinical outcomes. A transplant will be covered only if performed in a facility that has been designated as an IOE facility for the type of transplant in question. Any facility that is not specified as an Institute of Excellence network facility is considered as an out-of-network facility for transplant-related services, even if the facility is considered as a participating facility for other types of services.

Surgical treatment of morbid obesity, limited to one procedure per lifetime, subject to the inpatient hospital copayment.

Maternity

The Plan covers physician and hospital care for mother and baby, including prenatal care, delivery and postpartum care. In accordance with the Newborn and Mothers Health Protection Act, you and your newly born child are covered for a minimum of 48 hours of inpatient care following a vaginal delivery (96 hours following a cesarean section). However, your provider may—**after consulting with you**—discharge you earlier than 48 hours after a vaginal delivery (96 hours following a cesarean section).

You do not need a referral from your PCP for visits to your participating obstetrician. A list of participating obstetricians can be found in your provider directory or on DocFind (see “Provider Information”).

Note: Your participating obstetrician is responsible for obtaining precertification from Aetna for all obstetrical care after your first visit. They must request approval (precertification) for any tests performed outside of their office and for visits to other specialists. Please verify that the necessary referral has been obtained before receiving such services.

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.

INPATIENT CARE

If you are pregnant at the time you join the Plan, you receive coverage for authorized care from participating providers **on and after your effective date**. There is no waiting period. Coverage for services incurred prior to your effective date with the Plan are your responsibility or that of your previous plan.

EMERGENCY CARE

If you need emergency care, you are covered 24 hours a day, 7 days a week, anywhere in the world. Aetna has adopted the following definition of an emergency medical condition from the Balanced Budget Act (BBA) of 1997:

An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson (including the parent of a minor child or the guardian of a disabled individual), who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- ⦿ Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- ⦿ Serious impairment to bodily function; or
- ⦿ Serious dysfunction of any bodily organ or part.

Some examples of emergencies are heart attack (or suspected heart attack), poisoning, severe shortness of breath, uncontrolled or severe bleeding, loss of consciousness, suspected overdose of medication, severe burns, and high fevers (especially in infants).

EMERGENCY GUIDELINES

Whether you are in or out of Aetna’s service area, we ask that you follow the guidelines below when you believe you may need emergency care:

- Call your PCP first, if possible. Your PCP is required to provide urgent care and emergency coverage 24 hours a day, including weekends and holidays. However, if a delay would be detrimental to your health, seek the nearest emergency facility, or dial 911 or your local emergency response service.
- After assessing and stabilizing your condition, the emergency facility should contact your PCP so they can assist the treating physician by supplying information about your medical history.
- If you are admitted to an inpatient facility, notify your PCP as soon as reasonably possible. The emergency room copayment will be waived if you are admitted to the hospital.
- All follow-up care should be coordinated by your PCP so you receive the Plan’s higher level of coverage.
- Services which do not qualify as an emergency under your referred benefits will be subject to the deductible, coinsurance and maximum benefit limits shown in the “Schedule of Benefits”.

REMEMBER



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

EMERGENCY CARE

FOLLOW-UP CARE
AFTER EMERGENCIES

Follow-up care following emergency treatment is covered by the Plan. You must have a referral from your PCP *and* approval from Aetna to receive follow-up care from a nonparticipating provider.

Suture removal, cast removal, x-rays, and clinic and emergency room revisits are some examples of follow-up care.

URGENT CARE

Treatment that you obtain outside of your service area for an urgent medical condition is covered if:

- The service is a covered benefit;
- You could not reasonably have anticipated the need for the care prior to leaving the network service area; and
- A delay in receiving care until you could return and obtain care from a participating network provider would have caused serious deterioration in your health.

Urgent care from participating providers within your service area is covered if your PCP is not reasonably available to provide services to you. You should first seek care through your PCP. Referrals to participating urgent care providers are not required, but the care must be urgent, nonpreventive or nonroutine.

Some examples of urgent medical conditions are: severe vomiting, earaches, sore throat, and fever.

Follow-up care provided by your PCP is covered, subject to the office visit copayment. Other follow-up care by participating specialists is fully covered with a **prior written or electronic referral** from your PCP, subject to the specialist copay shown in the “Schedule of Benefits”.

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 Aetna within 48 hours of admission. If the hospital does not participate in the network, you may need to file a claim.
- ⊙ If you have an emergency outside of the United States and need to visit a hospital, you are responsible for filing a claim with Aetna.

EMERGENCY CARE**WHAT TO DO OUTSIDE
YOUR AETNA SERVICE
AREA**

Plan participants who are traveling outside the service area, or students who are away at school and not within an Aetna service area, are covered for emergency care and treatment of urgent medical conditions. Urgent care may be obtained from a private practice physician, a walk-in clinic, or an urgent care center. An urgent medical condition that occurs outside your Aetna service area can be treated in any of the above settings. You should call your PCP as soon as possible after receiving treatment.

If, after reviewing information submitted to Aetna by the doctors who provided care, the nature of the urgent or emergency problem does not clearly qualify for coverage, it may be necessary to provide additional information. Aetna will send you an Emergency Room Notification Report or a customer service professional (CSP) can take this information over the telephone.

TRANSPLANT CARE*Aetna 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 Aetna National Transplant Program is a coordinated set of transplant services provided through a special network of transplant facilities by the National Medical Excellence Program®. 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 Aetna network hospitals are part of the Aetna National Transplant Program.

**CALL AETNA FOR
PRECERTIFICATION/
MORE INFORMATION**



To enroll in the Aetna National Transplant Program, you are required to call the National Medical Excellence Program® at (877) 212-8811 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.

**COVERED
TRANSPLANTS**

When all of the provisions of the Aetna National Transplant Program are satisfied, the Plan will provide benefits only for the services and supplies listed in this section.

Allogenic/autologous bone marrow.

Heart.

Heart/lung.

Lung.

Liver.

Kidney.

Kidney/pancreas.

Double lung.

Peripheral stem cell.

TRANSPLANT CARE

NATIONAL MEDICAL EXCELLENCE PROGRAM®

The National Medical Excellence Program® also coordinates all solid organ and bone marrow transplants and other specialized care that cannot be provided within a patient’s local geographic area. When care is directed to a facility more than 100 miles from the patient’s/donor’s home, the Plan will pay a benefit for travel and lodging expenses for the patient/donor and one other individual. Benefits also include travel to and from lodging near a designated transplant facility for the pre-transplant evaluation.

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 Aetna 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 Aetna 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, as outlined under the “National Medical Excellence Program®” section on the previous page. There is a \$50 per day maximum for lodging and a \$10,000 maximum per year for travel and lodging combined.

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 Clinical Management Program.

REMEMBER



Ⓞ When the required review procedures for the Aetna 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 an Aetna National Transplant Program facility or through a network 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 an Aetna National Transplant Program facility, you must still follow the Clinical 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 may 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.

BEHAVIORAL HEALTH

Your mental health/substance abuse benefits will be provided by participating behavioral health providers. You do not need a referral from your PCP to obtain care from participating mental health and substance abuse providers. Instead, when you need mental health or substance abuse treatment, call the behavioral health telephone number shown on your ID card. A clinical manager will assess your situation and refer you to participating providers, as needed.

WHAT'S COVERED**Mental Health Treatment**

Inpatient medical, nursing, counseling and therapeutic services in a hospital or non-hospital residential facility, appropriately licensed by the Department of Health or its equivalent.

Short-term evaluation and crisis intervention mental health services provided on an outpatient basis.

Treatment of Alcohol and Drug Abuse

Inpatient care for detoxification, including medical treatment and referral services for substance abuse or addiction.

Outpatient visits for substance abuse detoxification. Benefits include diagnosis, medical treatment and medical referral services by your PCP.

Outpatient visits to a participating behavioral health provider for diagnostic, medical or therapeutic rehabilitation services for substance abuse.

NOTE: Outpatient treatment for substance abuse or dependency must be provided in accordance with an individualized treatment plan.

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 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 Health 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.

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.

One cycle of 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. This is a result of the drug Claritin’s over the counter availability.

TIPS FOR USING YOUR PHARMACY BENEFITS



For questions about the Prescription Drug Program or to locate a participating pharmacy in your area, visit Medco at www.medco.com or call Medco’s toll-free number (800) 841-3361. Some medications may require medical necessity or prior authorization. Please call Medco for information on this process.

PHARMACY BENEFITS

DRUGS REQUIRING AUTHORIZATION

Some medications are covered only for specific medical conditions or for a specific quantity and duration. A Medco Health 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.

PHARMACY BENEFITS

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 retail pharmacy, you pay a copayment of \$10 for generic drugs, \$30 for formulary brand-name drugs, or \$50 for non-formulary brand-name drugs and non-sedating antihistamine drugs. There are no claim forms to file; you simply pay your portion at the pharmacy.

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" section of this Handbook.

USING THE MAIL-ORDER PHARMACY

The mail-order pharmacy should 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. When you use the mail-order pharmacy, you pay \$25 for generic medications, \$70 for formulary brand-name medications, and \$120 for non-formulary brand-name medications and non-sedating antihistamine medications.

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).

PHARMACY BENEFITS

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 Oph, 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.

PHARMACY BENEFITS**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 specific diseases (e.g., digestive health, cardiovascular health, respiratory health, diabetes, multiple sclerosis, and hepatitis C) 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 management program is appropriate for your condition.

SPECIAL PROGRAMS

ALTERNATIVE HEALTH CARE PROGRAMS

Aetna Natural Products and ServicesSM Program

You and your family can save on complementary health care products and professional services—not traditionally covered by your health benefit plan—through our Aetna Natural Products and Services program. All products and services are delivered through American Specialty Health Network, Inc., a recognized leader in this market.

You can access the following services from participating natural therapy professionals at reduced rates: acupuncture, chiropractic care, massage therapy and dietetic counseling. You can also purchase the following health-related products at a discount: over-the-counter vitamins, herbal and nutritional supplements, and natural products.

For more information or to locate participating natural therapy professionals, call the Member Services number on your ID card or visit the Aetna Natural Products and Services program page in Aetna Navigator by logging onto our secure member website at www.aetna.com.

FITNESS PROGRAMS

Aetna offers Plan participants access to discounted fitness services provided by GlobalFitTM. Plan participants can join the GlobalFit network and receive discounts on their health club membership rates. The Fitness Program offers Plan participants:

- Low or discounted membership rates at independent health clubs contracted with GlobalFit;
- Free guest passes to allow you to sample facilities before selecting a club** to join;
- Guest privileges at other participating GlobalFit clubs**; and
- Discounts on certain home exercise equipment.

To view a list of included clubs, visit the GlobalFit website at www.globalfit.com/fitness. If you would like to speak with a GlobalFit representative, you can call GlobalFit at (800) 298-7800.

** For current club members, participation under this program may not be available at all clubs.*

***Not available at all clubs.*

SPECIAL PROGRAMS**HEALTHY OUTLOOK®
PROGRAM-DISEASE
MANAGEMENT FOR THE
21ST CENTURY**

Aetna has five programs aimed at helping members and their physicians to better manage chronic disease.

Asthma Management Program (pediatric and adult)

The Asthma Management program integrates comprehensive asthma education and instruction in the use of asthma management equipment designed for home use.

Coronary Artery Disease—Secondary Prevention Program

This program focuses on prevention of secondary cardiac events associated with coronary artery disease.

Heart Failure Management Program

This program enables patients to receive certain intravenous drugs in the convenience of home and provides education to help them improve their lifestyle and reduce the risk of future hospitalizations.

Diabetes Management Program

The Diabetes Management Program combines member education with blood glucose self-monitoring to help achieve better blood sugar control and lessen the chance for the complications of diabetes to develop.

Low Back Pain Disease Management Program

This program provides access to educational materials to help prevent flare-ups of low back pain.

Additional information about Aetna's Disease Management Programs can be found on Aetna's website at www.aetna.com/products/extra/healthy_outlook.html.

SPECIAL PROGRAMS

If you have been diagnosed with coronary artery disease (CAD), we encourage you to take advantage of this personalized program that teaches you how to follow a healthy diet and keep your weight and blood pressure under control, helps you recognize the signs and symptoms of a heart attack, supports you and your doctor in working together to manage your condition, and provides free brochures and other CAD-related materials.

Caring for Diabetes

The Healthy Outlook Program Caring for Diabetes provides educational materials as well as access to a nurse case manager for certain high-risk members. Participation is voluntary.

The goal of the program is to help you or your family member(s) work with your physicians to improve your quality of life and reduce the symptoms and complications of diabetes.

The educational materials focus on increasing your understanding of diabetes, your understanding of and compliance with diet, the use of oral medications and insulin, your knowledge of sick-day management, and the use of blood glucose self-monitoring.

Low Back Pain Disease Management Program

This program provides access to educational materials to help prevent flare-ups of low back pain.

Additional information about Aetna's Disease Management Programs can be found on Aetna's website at www.aetna.com/products/extra/healthy_outlook.html

HEALTH EDUCATION PROGRAMS

The key to a long, healthy life is developing good health habits and sticking with them. Through the use of educational materials, Aetna's innovative Health Education Programs offer health education, preventive care and wellness programs to Plan participants. These programs provide materials that, in conjunction with care and advice from a physician, help promote a healthy lifestyle and good health.

To obtain information on Health Education Programs, call the toll-free number on your ID card or visit www.aetna.com/products/health_education.html.

SPECIAL PROGRAMS**Adolescent Immunization**

Adolescents need to see their doctors regularly for physical exams and screenings and to update immunizations. To reinforce the importance of protecting their children's health, parents of all 11- and 12-year-olds are sent a newsletter that includes an examination and immunization schedule recommended for these age groups. This reminder is in the form of a newsletter provided by Merck & Co., Inc.

Preventive Reminders

Influenza, pneumococcal pneumonia and colorectal cancer are serious health threats. Each year, Aetna sends a preventive health care reminder to households with a member who is particularly vulnerable to one or more of these diseases—adults who are age 50 and older, children ages 6-23 months, and people over age 2 with a chronic condition such as asthma, congestive heart failure, or chronic renal failure.

The reminder stresses the importance of receiving vaccines to prevent influenza and pneumococcal pneumonia, as well as completing appropriate colorectal cancer screenings.

CANCER SCREENING PROGRAMS

Early detection and treatment is important in helping our members lead longer, healthier lives. Health Education provides members with an important means of early detection.

Breast Cancer Screening

Beginning annually at age 40, each female Plan participant is sent information that stresses the importance of mammography, breast self-examination and annual gynecological exams. The mailer also includes information about menopause and heart disease. The mailer may also include information on participating mammography centers or information for women who have chosen a primary care physician with a capitated radiology office.

Cervical

Gynecological examinations and Pap smears are vital to women's health because they are often the first step in the detection and treatment of abnormalities. This program reminds female Plan participants, starting at 18 years of age, to get exams and Pap smears on a regular basis. Annually, women are sent information stressing the importance of annual gynecological exams and direct access to care.

SPECIAL PROGRAMS

Colorectal

The colorectal cancer cure rate can exceed 80% when detected early. We encourage you to discuss questions about colorectal cancer screening with your physician. Together you and your physician can choose the most appropriate method of colorectal cancer screening. Aetna sends annual reminders stressing the importance of completing appropriate colorectal cancer screening.

Childhood Immunization Program

Children need immunizations to protect them from a number of dangerous childhood diseases that could have very serious complications. Vaccines have been proven to be powerful tools for preventing certain diseases. It has been shown over time that the risks of serious illness from not vaccinating children far outweigh any risk of reaction to immunization. The common childhood diseases that vaccinations can guard against are:

- Measles
- Mumps
- Rubella
- Polio
- Pertussis (whooping cough)
- Diphtheria
- Tetanus
- Haemophilus influenzae type B
- Hepatitis B
- Varicella (chicken pox)

To promote good health through prevention, the Childhood Immunization Program sends immunization reminders to parents of children covered under this Plan.

An 18-month reminder is sent to families encouraging parents to schedule immunization visits with their pediatrician or family doctor if their child is not already fully immunized. This reminder contains a list of immunizations recommended at 18 months.* The objective of this reminder is to help promote timely childhood immunizations and to stress the importance of completing immunizations.

If you have questions about specific vaccinations, please call your pediatrician or your family doctor.

**Sources: Office of Prevention and Health Promotion, in cooperation with the agencies of Public Health Services, U.S. Department of Health and Human Services, Center for Disease Control and Prevention (CDC), American Association of Pediatrics (AAP), and Advisory Committee on Immunization Practices.*

SPECIAL PROGRAMS

**INFORMED HEALTH®
LINE**

Informed Health® Line provides eligible Plan participants with telephone access to registered nurses experienced in providing information on a variety of health topics. The nurses encourage informed health care decision making and optimal patient/provider relationships through information and support. However, the nurses do not diagnose, prescribe or give medical advice.

Informed Health Line is available to eligible members virtually 24 hours a day, 365 days a year from anywhere in the nation.

Backed by the Healthwise® Knowledgebase™ (a computerized database of over 1900 of the most common health problems) and an array of other online and desk references, the nurses help you understand health issues, treatment options, review specific questions to ask your provider, supply research analysis of treatments and diagnostic procedures, and explain the risks and benefits of various options. The nurses encourage patient/provider interaction by coaching you to give a clear medical history and information to providers and to ask clarifying questions.

**NUMBERS TO KNOW™—
HYPERTENSION AND
CHOLESTEROL
MANAGEMENT**

Aetna created *Numbers To Know*™ to promote blood pressure and cholesterol monitoring. The *Numbers To Know* mailer is sent to Plan participants who are targeted by selected diagnoses within specific age groups. The mailer includes helpful tips on blood pressure and cholesterol management; desirable goals for blood pressure and cholesterol; and a tri-fold wallet card to track blood pressure, total cholesterol, medication and dosage information.

WOMEN'S HEALTH CARE

Aetna is focused on the unique health care needs of women. They have designed a variety of benefits and programs to promote good health throughout each distinct life stage, and are committed to educating female Plan participants about lifelong benefits of preventive health care.

SUPPORT FOR WOMEN WITH BREAST CANCER

Aetna's Breast Health Education Center helps women make informed choices when they've been newly-diagnosed with breast cancer. A dedicated breast cancer nurse consultant provides the following services:

- Breast cancer information
- Second opinion options
- Information about community resources
- Benefit eligibility
- Help with accessing participating providers for wigs and lymphedema pumps

Call (888) 322-8742 to reach Aetna's Breast Health Education Center.

DIRECT ACCESS FOR OB/GYN VISITS

This program allows a female Plan participant to visit any participating gynecologist for one routine well-woman exam (including a Pap smear) per year, without a referral from her PCP. The Plan also covers additional visits for treatment of gynecological problems and follow-up care, without a PCP referral. Participating general gynecologists may also refer a woman directly for appropriate gynecological services without the patient having to go back to her participating PCP.

If your gynecologist is affiliated with an IDS or provider group, such as an independent practice association (IPA), you may be required to coordinate your care through that IDS or provider group.

INFERTILITY CASE MANAGEMENT AND EDUCATION

Infertility treatment can be an emotional experience for couples. Aetna's infertility case management unit provides Plan participants with educational materials and assistance with coordinating covered infertility care. A dedicated team of registered nurses and infertility coordinators staffs the unit.

MENOPAUSE EDUCATION

Beginning at age 40, each female Plan participant (who has selected a primary care physician) receives educational information about menopause with her annual mammography reminder. This includes a take-at-home osteoporosis self-evaluation, which she can complete and discuss with her provider.

WOMEN'S HEALTH CARE

MOMS-TO-BABIES MATERNITY MANAGEMENT PROGRAM™

The Moms-to-Babies™ maternity management program provides you with maternity health care information, and guides you through pregnancy. This program provides:

- Educational materials on prenatal care, labor and delivery, postpartum depression and breastfeeding.
- Specialized information for Dad or partner.
- Web-based materials and access to program services through Women's Health Online.
- Care coordination by trained obstetrical nurses
- Access to Smoke-free Moms-to-be® smoking cessation program for pregnant women.
- Preterm labor education
- Access to breastfeeding support services.

Under the program, all care during your pregnancy is coordinated by your participating obstetrical care provider and Moms-to-Babies case managers, so there is no need to return to your PCP for referrals. However, your obstetrician will need to request a referral from Aetna for any tests performed outside of the office. To ensure that you are covered, please make sure your obstetrician has obtained this referral before the tests are performed.

Another important feature, **Pregnancy Risk Assessment**, identifies women who may need more specialized prenatal and/or postnatal care due to medical history or present health status. If risk is identified, the program assists you and your physician in coordinating any specialty care that may be medically necessary.

REMEMBER



- ⊙ Use a network obstetrician/gynecologist and hospital to receive maternity care at the lowest cost.
- ⊙ Remember to enroll your newborn in your plan.

- ⊙ 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.

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.

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.

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.

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.

EXCLUSIONS AND LIMITATIONS

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.

Private-duty nursing in an inpatient setting.

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.

EXCLUSIONS AND LIMITATIONS

Hearing examinations, hearing aids, or related supplies, unless loss of hearing is due to a covered illness or accidental injury, except as specified in the “What’s Covered” section of this Handbook.

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 under a “What’s Covered” section of this Handbook.

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.

CLINICAL 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 Aetna 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.

Clinical Management services include a number of components explained in more detail below. These components include prior notification and certification requirements for inpatient services; case management services for serious or extended illnesses; voluntary maternity services; round-the-clock support through the Informed Health® Line; the Healthy Outlook Program; and Aetna's National Transplant Program and National Medical Excellence Program®.

PRIOR NOTIFICATION RECOMMENDATIONS

You are encouraged to call Aetna for the following:

Before selecting a specialist, to verify whether or not the provider is participating in the network. You are free to choose providers who are not participating in the network, but you will usually have the lowest out-of-pocket cost when network providers are used.

Before renting or purchasing any durable medical equipment.

Before receiving any home health care.

Before scheduling a Magnetic Resonance Angiography (MRA).

PRIOR NOTIFICATION REQUIREMENTS

You are required to call Aetna at (877) 380-8584 for the following:

All inpatient admissions, including any elective admission to a hospital.

Within 48 hours (2 working days) 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.

All inpatient mental health and/or substance abuse treatment must be authorized through Aetna Behavioral Health at (800) 755-2422. Please refer to the "Mental Health and Substance Abuse Care" section of this Handbook for details.

When you call Aetna, it will be necessary to provide your name, the patient's name, the name of the physician and hospital or facility, the reason for the hospitalization, and any other information needed to complete the review, as determined by Aetna. 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.

CLINICAL MANAGEMENT

CERTIFICATION AND
NONCERTIFICATION

Aetna 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 Notice of Certification. If services are proposed to extend beyond the period for which certification is given, Aetna 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. However, even if the confinement or other service is determined to be medically necessary, the preceding days of hospital confinement or other service may be penalized (including room and board, and certain other miscellaneous fees). 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 Aetna 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 Aetna 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, Aetna 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 Aetna at (877) 235-4005.

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 may 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 Clinical 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.

CLINICAL MANAGEMENT

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.

REDUCED BENEFITS FOR FAILURE TO FOLLOW REQUIRED NOTIFICATION PROCEDURES

If you or your dependent has a serious or extended care illness or injury, a case manager will 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.

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.

CASE MANAGEMENT

You may call Aetna's Informed Health® Line at (877) 380-8584 at any time, day or night, to obtain general health care information or have your questions about health care issues answered. A nurse 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.

ROUND-THE-CLOCK SUPPORT

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.

HEALTHY OUTLOOK PROGRAM

The Healthy Outlook Program is a voluntary program designed to help you manage a chronic condition successfully with outpatient treatment and avoid unnecessary emergency care or inpatient admissions. Examples of conditions that can be managed through this program include diabetes, coronary heart disease, lower back pain, asthma, and congestive heart failure.

Through interactions with you and your physician, or based on your pharmacy and/or medical claims data, you may be contacted by Aetna to participate in the program. A case manager will work closely with you to provide you with educational information about your condition, treatment plan, or medication support. As always, your final treatment plan will be decided between you and your physician. If you have a chronic condition and would like more information, or if you have questions about your current treatment, call Aetna at the toll-free number.

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

A service or supply is considered medically necessary if Aetna determines that it is appropriate for the diagnosis, care, or treatment of the covered illness or injury.

To be appropriate, the service or supply must:

- Be care or treatment, as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, to the illness or injury;
- Be a diagnostic procedure, indicated by the health status of the individual, and be as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, to the illness or injury; and
- As to diagnosis, care, and treatment, be no more costly than any alternative service or supply to meet the above conditions.

In determining if a service or supply is appropriate under the circumstances, Aetna will take into consideration:

- Information provided on the individual's health status;
- Reports in peer-reviewed medical literature;
- Reports and guidelines published by nationally recognized health care organizations that include supporting scientific data;
- Generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care, or treatment;
- The opinion of health professionals in the generally recognized health specialty involved; and
- Any other relevant information brought to Aetna's attention.

In no event will the following services or supplies be considered necessary. Those:

- That do not require the technical skills of a medical, mental health, or dental professional;
- Furnished mainly for the personal comfort or convenience of the individual, any individual who cares for him or her, any individual who is part of his or her family, or any health care provider or health care facility;
- Furnished solely because the individual is an inpatient on any day on which the individual's disease or injury could safely and adequately be diagnosed or treated while not confined; or
- Furnished solely because of the setting if the service or supply could safely and adequately be furnished in a physician's or a dentist's office or other less costly setting.

ABOUT YOUR BENEFITS

REASONABLE AND CUSTOMARY CHARGES

Only that part of a charge made by a physician or dentist which is reasonable is covered. The reasonable charge for a service or supply is the lowest of:

- The provider's usual charge for furnishing it;
- The charge Aetna determines to be appropriate, based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made; and
- The charge Aetna determines to be the prevailing charge level made for it in the geographic area where it is furnished.

In determining the reasonable charge for a service or supply that is:

- Unusual;
- Not often provided in the area; or
- Provided by only a small number of providers in the area;

Aetna may take into account factors such as:

- The complexity;
- The degree of skill needed;
- The type of specialty of the provider; and
- The prevailing charge in other areas.

In some circumstances, Aetna may have an agreement with a provider (either directly, or indirectly through a third party) that sets the rate Aetna will pay for a service or supply. In these instances, in spite of the methodology described above, the reasonable charge is the rate established in such an agreement.

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 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.

ABOUT YOUR BENEFITS

COPAYS

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 copays do not apply to your annual deductible or out-of-pocket maximum.

The copay 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.

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 employer or group plans and most government or tax-supported plans. Benefits will be coordinated with your other plan to prevent benefit overpayment.

Rules may vary as a result of specific situations, based on the coordination of benefits provisions of each plan and generally accepted insurance industry criteria. For persons eligible for Medicare, for example, Medical Trust benefits will generally be primary only as required by federal Medicare rules and regulations and will not be primary for any employee whose employment status has been terminated (such employees must enroll in Medicare Parts A and B as soon as they qualify; otherwise, benefits may be reduced).

The term “group health plan” also includes group insurance and subscriber contracts, such as union welfare plans and benefits provided under any group or individual automobile no-fault or fault-type policy or contract. Benefits are not coordinated with any individual insurance policy you might maintain.

COORDINATION OF BENEFITS

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 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.

RIGHT OF RECOVERY (SUBROGATION AND/OR REIMBURSEMENT)

If you or a covered family member receives benefits from this Plan as the result of an illness or injury caused by another person, the Plan has the right to be reimbursed for those benefits from any settlement or payment you receive or have the right to receive from the person who caused the illness or injury. This means the Plan may recover costs from all sources (including insurance coverage) potentially responsible for making any payment to you or your covered dependent as a result of an injury or illness, including:

- Uninsured motorist coverage;
- Underinsured motorist coverage;
- Personal Umbrella coverage;
- Med-pay coverage;
- Workers' Compensation coverage;
- No-fault automobile coverage; or
- Any first party insurance coverage.

WHAT YOU NEED TO KNOW

Here are some important points about the right of subrogation:

The Plan has a lien on any payments you receive.

The Plan automatically has a lien, to the extent of any benefits it has paid, on any payment you've received from a third party, his/her insurer or any other source. The lien is in the amount of benefits paid by Aetna under this Plan for treatment of the illness, injury or condition for which the other person is responsible.

Your cooperation is required.

You may not do anything to interfere or affect the Plan's subrogation rights.

OTHER IMPORTANT PLAN PROVISIONS

You also must fully cooperate with the Plan's efforts to recover benefits it has paid. This includes providing all information requested by the Claims Administrator or its representatives. As part of this process, Aetna may ask you to complete and submit certain applications or other forms or statements. If you fail to provide this information, it will be considered a breach of contract and may result in the termination of your health benefits or the instigation of legal action against you. You will assign to the Plan all rights of recovery against third parties to the extent of the benefits the Plan has provided for a sickness or injury caused by a third party.

You must notify Aetna.

If a lawsuit or any other claim is filed to recover damages due to injuries sustained by you or a covered family member, you must notify Aetna. This must be done within 30 days of the date the notice of the lawsuit or claim is given to a person, including an attorney.

The Plan is paid first.

The Plan's subrogation rights are a first priority claim against all potentially responsible person(s), and must be paid before any other claim for damages.

The Plan is entitled to full reimbursement.

The Plan is entitled to full reimbursement first from any payments made by any responsible person(s). This reimbursement must be made, even if the payment is not enough to compensate you or your covered family member in part or in whole for damages. The terms of this Plan provision apply and the Plan is entitled to full recovery whether or not any liability for payment is admitted by any potentially responsible person(s), and whether or not the settlement or judgment you receive identifies the medical benefits provided by the Plan. The Plan may be reimbursed from any and all settlements and judgments, even those for pain and suffering or non-economic damages only. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.

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.

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.

You may not accept any settlement that does not fully reimburse the Plan, without its prior written approval.

The Plan's rights will not be reduced due to your own negligence.

The Plan may file suit in your name and take appropriate action to assert its rights under this section. The plan is not required to pay you part of any recovery it may obtain from a third party, even if it files suit in your name.

OTHER IMPORTANT PLAN PROVISIONS

In case of your wrongful death, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs.

Benefits under the Plan are provided on the condition that the Plan has the right to recover from responsible third parties. As such, the Plan has the right to terminate your benefits, deny future benefits, take legal action against you, and/or set off from any future benefits the value of benefits the Plan has paid relating to any sickness or injury caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan.

Aetna chooses the court for any legal action.

Any legal action or proceeding with respect to this provision may be brought in any court of competent jurisdiction Aetna selects. When you receive benefits under this plan, you agree to this rule and waive whatever rights you have by reason of your present or future place of residence.

The Plan is not responsible for your attorneys' fees.

The Plan is not required to participate in or pay attorney fees to the attorney you hire to pursue your claim for damages.

Interpreting this provision.

If there is any question about the meaning or intent of this plan provision or any of its terms, the Plan will have the sole authority and discretion to resolve all disputes as to how this provision will be interpreted.

RECOVERY OF EXCESS PAYMENTS

Whenever payments have been made in excess of the amount necessary to satisfy the provisions of the 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.

OTHER IMPORTANT PLAN PROVISIONS

ALTERNATE PAYEE PROVISION

Under normal conditions, all network 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.

NO WAIVER

The failure of the Medical Trust to enforce strictly any term or provision of 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, the ECCEBT, 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 or UB-92 forms for medical expenses;
- ADA forms 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:

- Participant's name, Social Security number, and address;
- Patient's name, Social Security number, and address, if different from the participant's;
- Healthcare 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, or the claim of your dependent, 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:

Aetna
P.O. Box 14110
Lexington, KY 40512-4110

If you have any questions regarding your claim, please call (877) 235-4005.

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

FILING HEALTH CLAIMS UNDER THE PLAN

You may file claims for Plan benefits, and appeal adverse claim decisions, either yourself or through an authorized representative. If your claim is denied in whole or in part, you will receive a written notice of the denial from Aetna Life Insurance Company. The notice will explain the reason for the denial and the review procedures.

An “authorized representative” means a person you authorize, in writing, to act on your behalf. The Plan will also recognize a court order giving a person authority to submit claims on your behalf, except that in the case of a claim involving urgent care, a health care professional with knowledge of your condition may always act as your authorized representative.

Urgent Care Claims

If the Plan requires advance approval of a service, supply or procedure before a benefit will be payable, and if the Plan or your physician determines that it is an urgent care claim, you will be notified of the decision not later than 72 hours after the claim is received.

“A claim involving urgent care” is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or, in the opinion of a physician with knowledge of the claimant’s medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If there is not sufficient information to decide the claim, you will be notified of the information necessary to complete the claim as soon as possible, but not later than 24 hours after receipt of the claim. You will be given a reasonable additional amount of time, but not less than 48 hours, to provide the information, and you will be notified of the decision no later than 48 hours after the end of that additional time period (or after receipt of the information, if earlier).

Other Claims (Pre-Service and Post-Service)

If the Plan requires you to obtain advance approval of a service, supply or procedure before a benefit will be payable, a request for advance approval is considered a pre-service claim. You will be notified of the decision not later than 15 days after receipt of the pre-service claim.

For other claims (post-service claims), you will be notified of the decision not later than 30 days after receipt of the claim.

FILING A CLAIM

For either a pre-service or a post-service claim, these time periods may be extended up to an additional 15 days due to circumstances outside the Plan's control. In that case, you will be notified of the extension before the end of the initial 15 or 30 day period. For example, they may be extended because you have not submitted sufficient information, in which case you will be notified of the specific information necessary and given an additional period of at least 45 days after receiving the notice to furnish that information. You will be notified of the Plan's claim decision no later than 15 days after the end of that additional period (or after receipt of the information, if earlier).

For pre-service claims which name a specific claimant, medical condition, and service or supply for which approval is requested, and which are submitted to a Plan representative responsible for handling benefit matters, but which otherwise fail to follow the Plan's procedures for filing pre-service claims, you will be notified of the failure within 5 days (within 24 hours in the case of an urgent care claim) and of the proper procedures to be followed. The notice may be oral unless you request written notification.

Ongoing Course of Treatment

If you have received pre-authorization for an ongoing course of treatment, you will be notified in advance if the Plan intends to terminate or reduce benefits for the previously authorized course of treatment so that you will have an opportunity to appeal the decision and receive a decision on that appeal before the termination or reduction takes effect. If the course of treatment involves urgent care, and you request an extension of the course of treatment at least 24 hours before its expiration, you will be notified of the decision within 24 hours after receipt of the request.

HOW TO APPEAL A DENIAL OF BENEFITS

As a member of an Aetna Health Plan, you have the right to file an appeal about coverage for service(s) you have received from your health care provider or Aetna if you are not satisfied with the outcome of the initial determination and the appeal is regarding a change in the decision for the following:

- Certification of health care services;
- Claim payment;
- Plan interpretation;
- Benefit determination;
- Eligibility.

You may file an appeal in writing to Aetna. The denial notice will include the address where the appeal can be sent. If your appeal is of an urgent nature, you may call Aetna's Member Services Unit at the toll-free phone number on your ID card. Your request should include the group name (that is, your employer), your name, Social Security Number or other identifying information shown on the front of the Explanation of Benefits form, and any other comments, documents, records and other information you would like to have considered, whether or not submitted in connection with the initial claim.

FILING A CLAIM

Your appeal will be acknowledged within five working days of receipt. An Aetna representative may call you or your health care provider to obtain medical records and/or other pertinent information in order to respond to your appeal.

You will have 180 days following receipt of an adverse benefit decision to appeal the decision to Aetna. You will be notified of the decision not later than 15 days (for pre-service claims) or 30 days (for post-service claims) after the appeal is received. You may submit written comments, documents, records and other information relating to your claim, whether or not the comments, documents, records or other information were submitted in connection with the initial claim. A copy of the specific rule, guideline or protocol relied upon in the adverse benefit determination will be provided free of charge upon request by you or your authorized representative. You may also request that the Plan provide you, free of charge, copies of all documents, records and other information relevant to the claim.

If your claim involves urgent care, an expedited appeal may be initiated by a telephone call to Member Services. Aetna's Member Services telephone number is on your Identification Card. You or your authorized representative may appeal urgent care claim denials either orally or in writing. All necessary information, including the appeal decision, will be communicated between you or your authorized representative and the Plan by telephone, facsimile, or other similar method. You will be notified of the decision not later than 36 hours after the appeal is received.

If you are dissatisfied with the appeal decision on a claim involving urgent care, you may file a second level appeal with Aetna. You will be notified of the decision not later than 36 hours after the appeal is received.

If you are dissatisfied with a pre-service or post-service appeal decision, you may file a second level appeal with Aetna within 60 days of receipt of the level one appeal decision. Aetna will notify you of the decision not later than 15 days (for pre-service claims) or 30 days (for post-service claims) after the appeal is received.

All requests for a review of denied benefits should include a copy of the initial denial letter and any other pertinent information.

Send complete information to:

Aetna
Attn: National Account CRT
P.O. Box 14463
Lexington, KY 40512

Requests for appeal that do not comply with this procedure will not be considered, except in extraordinary circumstances.

GENERAL INFORMATION

Type of Plan

A benefit plan providing group medical and prescription drug benefits.

Name and Address of the Plan Sponsor and 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

Name and Address of the Third-Party Contract Administrator

Aetna
P.O. Box 981109
El Paso, TX 79998-1109

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.

SCHEDULE OF BENEFITS

HMO PLAN

PRESCRIPTION DRUG BENEFITS

VISION BENEFITS

SCHEDULE OF MEDICAL BENEFITS

AETNA

HMO PLAN

PLAN IS EFFECTIVE AS OF AUGUST 1, 2008

Inpatient Hospital Deductible

\$150 per day not to exceed a \$600 maximum.

Lifetime Benefit Maximum

(Includes All Other Maximums)

\$2 Million Individual

You must receive services only from health care providers participating in the Aetna network, or benefits will not be covered by the plan. Expenses for non-network providers will only be considered as specified in this Handbook.

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 "Clinical Management" section of this Handbook. Please refer to the text for additional Plan provisions that may affect your benefits.

Our Benefits: Although a specific service may be listed as a covered expense, it may not be covered unless it is medically necessary for the prevention, diagnosis or treatment of an illness or condition.

COVERED HEALTH SERVICE	YOUR COPAYMENT AMOUNT	ADDITIONAL LIMITATIONS AND EXPLANATIONS
Acupuncture Services	\$20 per visit	Limited to 12 visits per year.
Allergy Testing (Injections)	\$20 Per Visit	Benefit includes routine injections at PCP's office, with or without a physician encounter.
Ambulance Services - Emergency Only	\$0	No copay when medically necessary.
Diagnostic Tests/X-Ray and Laboratory Services	\$20	
Durable Medical Equipment (DME)	\$0	Must be precertified my Aetna.
Emergency Room Services	\$50 per visit	Your \$50 copay will be waived if you are admitted to the hospital.
Home Health Care	\$0	Limited to 210 days/visits per year.

SCHEDULE OF MEDICAL BENEFITS

AETNA

HMO PLAN

PLAN IS EFFECTIVE AS OF AUGUST 1, 2008

COVERED HEALTH SERVICE	YOUR COPAYMENT AMOUNT	ADDITIONAL LIMITATIONS AND EXPLANATIONS
Hospice Care	\$0	Admission into a facility covered after \$150 copay; \$600 maximum per admission.
Hospital Services (Inpatient)	\$150 per day copay; \$600 maximum per admission	Benefits include, but are not limited to, hospital semi-private room, miscellaneous fees, anesthesia, surgeons' fees, physician visits, x-ray, lab and therapy expenses. Follow the procedures required by the Clinical Management Program.
Hospital Services (Outpatient)	\$250 (for surgery)	Benefits include but are not limited to outpatient surgery, physician, anesthesiology, x-ray & laboratory, and therapy expenses in a hospital or ambulatory surgical center.
Maternity Services	\$20 for first visit only	
Mental Health/ Substance Abuse Services - Inpatient	\$150 copay per day; \$600 maximum per admission	Follow the procedures required by the Clinical Management Program.
Mental Health/ Substance Abuse Services - Outpatient	\$25 per visit	
Nutritional Counseling	\$20 per visit	Limited to 6 visits/sessions per calendar year.
Outpatient Therapy Services	\$20 per visit	Benefits include physical, occupational, and speech therapy. Limited to 60 visits each per year.
Physician's Office Services	\$20 per visit.	Your copay applies to the office visit only. To locate a network provider, contact Aetna via the toll-free number or check the web site.
Routine & Preventive Services Routine Exams Routine Exam X-Rays & Laboratory Services Well-Child Checkups Routine Colonoscopy Routine Sigmoidoscopy Other Routine Services	\$20 per visit.	Your copay applies to the office visit only. Benefits include the office visit and vaccinations, inoculations, and immunizations. Copay will be waived for immunizations if office visit is not billed. Well-Child checkups are limited to 7 exams 1st 12 months; 2 exams age 13 to 24 months; and 1 exam per year for children age 24 months to age 18. Adult exams are limited to 1 exam per year. Benefits include routine physicals, including gynecological exams, limited to 1 per year and digital rectal exam males age 40 and older, limited to 1 per year. X-Rays and laboratory tests related to the routine exam. One baseline mammogram age 35 to 40; annual mammograms age 40 and older; annual PAP tests and PSA screenings, males age 40 and older.

SCHEDULE OF MEDICAL BENEFITS

AETNA

HMO PLAN

PLAN IS EFFECTIVE AS OF AUGUST 1, 2008

COVERED HEALTH SERVICE	YOUR COPAYMENT AMOUNT	ADDITIONAL LIMITATIONS AND EXPLANATIONS
Skilled Nursing Facility	\$150 per day (\$600 maximum.)	Limited to 60 days per year
Smoking Cessation Program	0%	\$200 individual annual maximum. Benefits include hypnosis and counseling.
Spinal Treatment	\$20 per visit	Limited to 20 visits per year for spinal manipulation.
Surgical Treatment of Morbid Obesity	\$150 per day (\$600 maximum.)	Limited to 1 procedure per lifetime. Must be preauthorized by Aetna.
Urgent Care Services	\$50 per visit	Please see your regular physician or practitioner for routine care.

Additional Benefits

Routine Eye Exams	\$20	Direct access (no referral) to participating providers for periodic routine exams.
Eyeglasses/ Contact Lenses	\$0	\$100 per 24-month period. Discounts available through Vision One Discount Program.
Routine Hearing Exams	\$0	Covered when performed as part of a routine exam by PCP. Subject to office visit copay.
PCP After Hours/ Home Visits/ Emergency Visits	\$25	Covered when performed as part of a routine exam by PCP. Subject to office visit copay.
Infertility Services	\$20	Must be pre-authorized by Aetna. Limitations apply. Advanced reproductive technology not covered.

Clinical Management Program toll-free number: (877) 380-8584

Aetna Behavioral Health: (800) 755-2422

NOTES: The word “lifetime” refers to the period of time you or your eligible dependents participate in this plan or any other plan funded 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.

SCHEDULE OF BENEFITS

HMOPLAN
PRESCRIPTION DRUG BENEFITS
VISION BENEFITS

SCHEDULE OF PRESCRIPTION DRUG BENEFITS

EFFECTIVE AS OF AUGUST 1, 2008

For 2007, there are two prescription drug benefit plans: the Standard Plan and the Premium Plan. Your prescription plan is determined by your diocese or group and was noted on your personalized open enrollment form. If you are in the Premium Plan, it is also noted on your ID card.

Standard

	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 Oph, 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.

SCHEDULE OF VISION BENEFITS

EFFECTIVE AS OF AUGUST 1, 2008

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 UV Coating Tint (Solid and Gradient) Standard Scratch Resistance Standard Polycarbonate Standard Anti-Reflective Coating Standard Progressive (Add-On to Bifocal) Other Add-Ons and Services	You pay up to \$15 You pay up to \$15 You pay up to \$15 You pay \$0 You pay up to \$45 You pay up to \$65 20% off retail price	You are responsible for the cost of any lens options that you elect from out-of-network providers
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 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, or call EyeMed toll-free at (866) 723-0513.

As a participant in the Aetna National HMO Plan (the “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 will be 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	<p>www.cpg.org</p> <p>(800) 480-9967 e-mail: medtrust@cpg.org</p> <p>(Monday through Friday, except holidays, 8:30 a.m.– 5:30 p.m. EST)</p>
Aetna	<p>www.aetna.com</p> <p>(877) 380-8584 (Monday through Friday, 8:00 a.m. – 6:00 p.m. EST)</p>
Mental Health Benefit Program	<p>www.aetnabehavioralhealth.com</p> <p>(800) 755-2422 (Monday through Friday, except holidays, 8:00 a.m. – 5:00 p.m. EST)</p>
Medco Prescription Drug Program	<p>www.medco.com</p> <p>(800) 841-3361 (24 hours a day, 7 days a week)</p>
Eyemed	<p>www.eyemedvisioncare.com</p> <p>(866) 723-0513 (Monday through Saturday, 8:00 a.m. – 11:00 p.m., and Sunday, 11:00 a.m. – 8:00 p.m.)</p>

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.