



**The Episcopal Church Medical Trust**  
**Aetna National HMO Plan**  
**Association of Episcopal Seminaries**  
**Plan Year 8/1/2008-7/31/2009**

General Information	In-Network
Deductible	None
Out-of-Pocket Maximum (excluding deductible)	None
Lifetime Maximum	\$2,000,000
Dependent Eligibility	Spouse, children from birth to age 30 (restrictions apply)
<b>Primary Care Physician Visits</b>	\$20 copay
<b>Specialty Care</b>	
Office Visits	\$20 copay
Diagnostic Outpatient Laboratory/X-Ray Testing (at facility)	\$20 copay with PCP referral
Diagnostic Outpatient Laboratory/X-Ray Testing (at specialist)	Included in Specialist Office Visits copay for visit with PCP referral.
Outpatient Therapy (speech, physical, occupational) Limited to 60 visits per year.	\$20 copay
Outpatient Dialysis/Chemotherapy	\$20 copay
<b>Preventive Care</b>	
Routine Physicals	\$20 copay
Routine Child and Well Baby Care/Immunizations	\$20 copay
Routine GYN Care	\$20 copay. One routine GYN visit and pap smear/365 days. Direct access to participating providers.
Routine Mammography	\$20 copay, one annual mammogram age 40 and over.
Routine Eye Exam (Administered by EyeMed)	\$10 copay
Hearing Exam	\$20 copay. Routine hearing screenings.
Hearing Aids	Not covered
Chiropractic Care	\$20 Specialist copay, 20 visits per year with PCP referral.
<b>Hospital Care</b>	
Hospitalization (must be precertified)	Covered after \$150 copay per day; \$600 max per admission
Outpatient Surgery (must be precertified)	\$250 copay
<b>Emergency Care</b>	
Emergency Care	\$50 copay
Urgent Care Out-of-Area	\$50 copay
Ambulance	\$0 copay
<b>Other Benefits</b>	
Skilled Nursing Care (in lieu of hospitalization for medically necessary covered benefits)	Covered after \$150 copay per day ; \$600 maximum per admission



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Home Health Care/Hospice-Outpatient	\$0 copay
Hospice - Inpatient	Covered after \$150 copay per day ; \$600 maximum per admission
Private Duty or Special Duty Nursing	Not covered unless pre-authorized by HMO; \$0 copay when covered.
Family Planning/Reproductive Services	Covered with applicable specialist, outpatient surgery or inpatient hospital copay; Reversal of voluntary sterilization including related follow-up care and treatment of complications of such procedures is not covered.
Durable Medical Equipment	\$0 copay
Vision Corrective Lenses/Contacts Allowance (Administered by EyeMed Vision Care)	\$130 frame/contacts allowance every 12 months.
<b>Maternity</b>	
OB Visits	\$20 copay for initial visit only
Hospital (Includes Newborn Services)	Covered after \$150 copay per day ; \$600 maximum per admission
<b>Mental Health</b>	
Inpatient Mental Health Benefits (must be precertified)	Covered after \$150 copay per day ; \$600 maximum per admission; 30 days per calendar year.
Outpatient Mental Health Benefits	\$25 copay. 20 visits per calendar year through Aetna National HMO. Additional visits through the Medical Trust Mental Health/Substance Abuse Supplement.
Employee Assistance Program	Offered through CIGNA Behavioral Health. No copay.
<b>Substance Abuse Rehabilitation</b>	
Inpatient	Covered after \$150 copay per day ; \$600 maximum per admission; 30 days per calendar year.
Outpatient	\$20 Specialist copay, 20 visits per calendar year. Additional benefits available through the Medical Trust Mental Health/Substance Abuse Supplement.
<b>Prescription Plan Options</b>	
Individual Retail Deductible	\$50
Retail Copayments (Generic/Formulary/Non-formulary)	\$10/\$30/\$50
Mail Order Copayments	\$25/\$70/\$120
Generic or Pay the Difference	Applies to Retail and Mail Order
Maintenance Medication	Retail: 3 fills allowed (original script, 2 refills) Mail Order: mandatory after 3 <sup>rd</sup> retail fill

This benefit summary is provided for informational purposes, is not all-inclusive, and does not constitute an agreement. An applicable Summary of Benefits will