

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

General Information	In-Network	Out-of-Network
Annual Deductible	\$2,500 Individual / \$5,000 Family (Combined in and out-of-network)	
Out-of-Pocket Maximum per Plan Year (excluding deductible)	\$15,000 Individual / \$30,000 Family (Combined in and out-of-network)	
Calendar Year Maximum	\$500,000 combined in and out-of-network	
Lifetime Maximum	\$2,000,000 combined in and out-of-network	
Health Fund Account (1)	\$500 Individual / \$1,000 Family	
Hospital Care	In-Network	Out-of-Network
Inpatient Hospital Services (includes inpatient surgery expenses, room and board, physician expenses, and all other inpatient care including routine nursery care) (must be precertified)	80% after deductible	Not covered
Inpatient Mental Health/Substance Abuse Benefits (Provided by CIGNA Behavioral Health) (must be precertified)	100% after \$100 per day copay, not to exceed \$600 (CBH)	Not covered
Skilled Nursing Facility Limited to 60 days per calendar year*	100% after deductible	60% after deductible
Emergency Care	In-Network	Out-of-Network
Hospital Emergency Room	100% after deductible	100% after deductible
Urgent Care	100% after deductible	60% after deductible
Ambulance Service (non-emergency use of ambulance is not covered)	100% after deductible	100% after deductible
Outpatient Care	In-Network	Out-of-Network
Physicians' Office Visit	100% after deductible	60% after deductible
Outpatient Surgery Expenses (performed in a hospital, ambulatory surgical center or a doctor's office; includes all services performed with regard to that surgery on the day of the surgery, including physician's charges) (must be precertified)	100% after deductible	60% after deductible
Mental Health/Substance Abuse Treatment (Provided by CIGNA Behavioral Health)	100% after \$25 copay (CBH)	70% after deductible (CBH)
Diagnostic X-Rays, Lab Tests	100% after deductible	60% after deductible
Speech Therapy	100% after deductible	60% after deductible
Chiropractic Care	100% after deductible	60% after deductible

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Limited to 20 visits per year*		
<b>Outpatient Care, continued</b>	<b>In-Network</b>	<b>Out-of-Network</b>
Short Term Rehabilitation (outpatient physician's services and outpatient services of physical, speech or occupational therapists for treatment of acute conditions if such services will result in significant improvement in member's condition within a 60-day period.	100% after deductible	60% after deductible
<b>Preventive Care</b>	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Routine Physical Exams and Cancer Screenings</b> <ul style="list-style-type: none"> <li>• 1 exam per 24 months for adults and dependent children over age 18; includes routine immunizations; does not include hearing or eye exams</li> <li>• 1 routine exam and pap smear per plan year including related lab fees</li> <li>• 1 routine mammogram per plan year age 40 and over</li> <li>• 1 PSA and occult blood stool test during a 12 month period for males age 40 and over</li> </ul>	100% of first \$550 paid out of the PPO plan since no deductible applies. Health Fund is not used for these services. \$550 maximum for all preventive care expenses combined per calendar year.	60% of first \$550 paid out of the PPO plan since no deductible applies. Health Fund is not used for these services. \$550 maximum for all preventive care expenses combined per calendar year.
<b>Well Child Care/Immunizations</b> (Children to age 7: 6 visits in first year; 2 visits in second year; 1 visit per year thereafter until age 18; includes routine immunizations; does not include hearing or eye exams)	100% of first \$550 paid out of the PPO plan since no deductible applies. Health Fund is not used for these services. \$550 maximum for all preventive care expenses combined per calendar year.	60% of first \$550 paid out of the PPO plan since no deductible applies. Health Fund is not used for these services. \$550 maximum for all preventive care expenses combined per calendar year.
<b>Other</b>	<b>In-Network</b>	<b>Out-of-Network</b>
Home Health Care Limited to 120 visits per year*	100% after deductible	60% after deductible
Allergy Testing & Treatment	100% \$20 copay	60% after deductible
Hospice	Not covered	Not Covered
Durable Medical Equipment	Not covered	Not covered
Vision Care (provided through EyeMed)	\$10 copay for examination \$10 copay for lenses \$130 allowance for frames or contact lenses	Reimbursement varies. See Vision Benefits Schedule.



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Prescription Drugs Administered by Medco	Retail	Mail Order
Annual Benefit Maximum	\$1,000	Not applicable
Copayments (Generic/Formulary/Non-Formulary)	\$10/\$20/\$50	\$20 copay/You pay 100% of discounted rate/You pay 100% of discounted rate

(1) **Health Fund Account** – an amount of \$500 per individual/\$1,000 per family per plan year, which pays 100% of the first \$500/\$1,000 in covered health care costs that you and/or your family incur. You will be reimbursed for deductibles and co-payments up to \$500 for each individual and \$1,000 for a family of 2 or more.

\*Maximums are a combined limit for preferred and non-preferred services

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