

SCHEDULE OF MEDICAL BENEFITS

AETNA

SELECT EPO PLAN

PLAN IS EFFECTIVE AS JANUARY 1, 2006

Annual Deductibles Annual Out-of-Pocket Maximums

(Excludes Deductible)

\$100 Individual \$1,000 Individual
 \$250 Family \$2,000 Family

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 the NOTES section of this schedule.

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.

BENEFIT DESCRIPTION	PLAN PAYS	ADDITIONAL LIMITATIONS AND EXPLANATIONS
Ambulance Services	90%	Not subject to annual deductible.
Emergency Room Services Facility Physician	100% 100%	You must pay the first \$50 per ER visit. Your \$50 copay will be waived if you are admitted to the hospital within 24 hours. Not subject to annual deductible.
Urgent Care Facility Services Facility Physician	100% 100%	You must pay the first \$25 per visit. Please see your regular physician or practitioner for routine care. Not subject to annual deductible.
Diagnostic X-Ray and Laboratory Services	80%	Benefit for services performed in an independent lab facility or doctor's office not related to a routine exam. Subject to annual deductible.
Inpatient Hospital Services	90%	Subject to the annual deductible. Benefits include but are not limited to hospital semi-private room, miscellaneous fees, anesthesia, surgeon's fees, physician visits, x-ray, laboratory and therapy expenses. Follow the procedures required by the Clinical Management Program. Subject to annual deductible.
Outpatient Hospital Services	90%	Subject to the annual deductible. Benefits include but are not limited to outpatient surgery, physician, anesthesiology, x-ray and laboratory, and therapy expenses in a hospital or ambulatory surgical center. Subject to annual deductible.
Smoking Cessation Program	100%	\$200 individual annual maximum. Benefits include hypnosis and counseling. Not subject to annual deductible.
Routine and Preventive Services Routine Exams	100%	You must pay the first \$25 for 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. Not subject to annual deductible. Well-Child checkups are limited to 6 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 exams males age 40 and older, limited to 1 per year.
Routine Exam X-Rays & Laboratory Services	100%	X-Rays and laboratory tests related to the routine exam.
Other Routine Services	100%	One baseline mammogram age 35 to 40; annual mammograms age 40 and older; annual PAP tests; and PSA screenings, males age 40 and older.
Acupuncture	50%	Limited to 12 visits per year. Benefits are not subject to reduction for usual and customary charges or annual deductible.

SCHEDULE OF MEDICAL BENEFITS

AETNA

OPEN CHOICE EPO PLAN

PLAN IS EFFECTIVE AS JANUARY 1, 2006

BENEFIT DESCRIPTION	PLAN PAYS	ADDITIONAL LIMITATIONS AND EXPLANATIONS
Nutritional Counseling	100%	You may the first \$25 per visit. Limited to 6 sessions per year. Not subject to annual deductible.
Routine Sigmoidoscopy	100%	Age 50 and over, limited to 1 every 5 years. Not subject to annual deductible.
Routine Colonoscopy	100%	Age 50 and over, limited to 1 every 10 years. Not subject to annual deductible.
Home Health Care	90%	You should notify Aetna by calling the toll-free number prior to receiving any home health care. Limited to 200 visits per calendar year. Subject to annual deductible.
Hospice Facility/Home Hospice	90%	Limited to 210 combined hospice facility/home hospice days per lifetime. Subject to annual deductible.
Skilled Nursing Facility	90%	Limited to 60 days per year. Subject to annual deductible.
Outpatient Therapy Services	100%	You must pay the first \$25 per visit. Includes physical, speech, and occupational therapy. Limited to 60 visits each per year. Not subject to annual deductible.
Chiropractor Services	100%	You must pay the first \$25 per visit. Limited to 20 visits per year for spinal manipulation. Not subject to annual deductible.
Physician Home and Office Visits	100%	You must pay the first \$25 per visit. Your \$25 copay applies to the home or office visit only. Not subject to annual deductible.
Durable Medical Equipment/ Prosthetics	90%	You should notify Aetna by calling the toll-free number prior to renting or purchasing any durable medical equipment. Subject to annual deductible.
Inpatient Mental Health/ Substance Abuse Treatment	90%	Limited to 30 mental health/substance abuse days per year. The plan will not consider benefits for any services that have not been preauthorized through the Mental Health Benefit Program. You will be solely responsible for all expenses incurred for services that have not been preauthorized. Subject to annual deductible.
Outpatient Mental Health/ Substance Abuse atment	90%	Limited to 20 mental health/substance abuse visits per year. Subject to annual deductible.
Allergy Services	100%	Benefit includes allergy injections/serum and physician allergy testing/treatment. You must pay a \$25 copay per visit if professional services charged in addition to the injection for serum preparation or physician supervision. Not subject to the annual deductible.
Surgical Treatment of Morbid Obesity	90%	Limited to 1 procedure per lifetime. Must be preauthorized by Aetna. Subject to the annaul deductible.
All Other Covered Medical Expenses	90%	Benefits are provided for expenses listed in a "What's Covered" section of this Handbook. Subject to annual deductible.

Clinical Management Program toll-free number: (877) 235-4005

Mental Health Benefit Program toll-free number: (800) 806-0478

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.