

# SCHEDULE OF MEDICAL BENEFITS

**EMPIRE BLUECROSS BLUESHIELD**

**90/70 PPO PLAN**

**PLAN IS EFFECTIVE AS OF JANUARY 1, 2006**

	Annual Deductibles		Annual Out-of-Pocket Maximums (Excludes Deductible)		Inpatient Hospital Copayment
<b>Network</b>	\$250	Individual	\$1,000	Individual	\$100 per day, not to exceed \$600 per admission
	\$500	Family	\$2,000	Family	
<b>Non-Network</b>	\$500	Individual	\$3,000	Individual	
	\$1,000	Family	\$6,000	Family	

## Lifetime Benefit Maximum

(Includes All Other Maximums)

\$2 Million Individual

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

BENEFIT DESCRIPTION	ANNUAL DEDUCTIBLE	NETWORK PLAN PAYS	NON-NETWORK PLAN PAYS	ADDITIONAL LIMITATIONS AND EXPLANATIONS
<b>Emergency Room Services</b>				You must pay a \$50 copay per ER or urgent care facility visit. The \$50 copay will be waived if you are admitted to the hospital. Hospital admission must be precertified within 24 hours.
<b>Facility</b>	<b>NO</b>	<b>100%</b>	<b>100%</b>	
<b>Physician</b>	<b>NO</b>	<b>100%</b>	<b>100%</b>	
<b>Physician Office Visits</b>				You must pay a \$25 copay per network office visit. You pay one copay to the provider for all services performed during the visit. If the provider sends you to a radiology/laboratory to have a diagnostic test, you are responsible to pay that charge at the radiology/laboratory diagnostic benefit level.
<b>Network</b>	<b>NO</b>	<b>100%</b>	<b>-</b>	
<b>Non-Network</b>	<b>YES</b>	<b>-</b>	<b>70%</b>	
<b>Outpatient Therapy Visits</b>				You must pay a \$25 copay per visit to a network provider. Benefits include hearing/speech, physical and occupational therapy. Limited to 60 visits per plan year, combined facility and office, per each of the three therapies.
<b>Network</b>	<b>NO</b>	<b>100%</b>	<b>-</b>	
<b>Non-Network</b>	<b>YES</b>	<b>-</b>	<b>70%</b>	

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<b>Chiropractic Services</b>				
<b>Network</b>	<b>NO</b>	<b>100%</b>	<b>-</b>	You must pay a \$25 copay per visit to a network provider. Limited to 20 visits per year.
<b>Non-Network</b>	<b>YES</b>	<b>-</b>	<b>70%</b>	
<b>Maternity Care</b>				
<b>Hospital Services</b>				Subject to a \$100 copay per day, \$600 maximum per in-network admission. The plan's coinsurance for hospital expenses will be reduced to 50% if you do not follow the procedures required by the Medical Management Program. This penalty does not apply to the out-of-pocket maximum. Well-newborn care is also covered, but is not subject to the inpatient hospital deductible.
<b>Network</b>	<b>NO</b>	<b>90%</b>	<b>-</b>	
<b>Non-Network</b>	<b>YES</b>	<b>-</b>	<b>70%</b>	
<b>Outpatient Services</b>				
<b>Network</b>	<b>NO</b>	<b>100%</b>	<b>-</b>	Antepartum care only. You must pay a \$25 copay to a network provider for the first visit only.
<b>Non-Network</b>	<b>YES</b>	<b>-</b>	<b>70%</b>	
<b>Well-Child Checkups</b>				
<b>Routine Exams</b>				You must pay a \$25 copay per office visit to a network provider. Your copay applies to the office visit only. Limited to 6 visits from birth to age 1, 3 visits from age 1 through age 2, 4 visits from age 3 through age 6, and 6 visits from age 7 through age 19. Benefits include the office visit; all related x-rays and laboratory tests; and vaccinations, inoculations, and immunizations.
<b>Network</b>	<b>NO</b>	<b>100%</b>	<b>-</b>	
<b>Non-Network</b>	<b>YES</b>	<b>-</b>	<b>70%</b>	
<b>Routine X-Rays &amp; Laboratory Services</b>				
<b>Network</b>	<b>NO</b>	<b>100%</b>	<b>-</b>	
<b>Non-Network</b>	<b>YES</b>	<b>-</b>	<b>70%</b>	
<b>Routine &amp; Preventive Services</b>				
<b>Routine Exams</b>				You must pay a \$25 copay per annual visit to a network provider. Benefits include routine physicals, including gynecological exams, limited to 1 per year; hearing and vision exams performed by your physician during a routine physical, limited to 1 each per year; and vaccinations, inoculations, and immunizations.
<b>Network</b>	<b>NO</b>	<b>100%</b>	<b>-</b>	
<b>Non-Network</b>	<b>YES</b>	<b>-</b>	<b>70%</b>	

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<b>Routine &amp; Preventive Services (continued)</b>				Benefits include Pap tests, limited to 1 per year; mammograms, limited to 1 per year age 40+, 1 age 35-39; PSA screening, limited to 2 per year age 40+; and routine x-rays and laboratory services.
<b>Other Routine Services</b>				
<b>Network</b>	<b>NO</b>	<b>100%</b>	<b>--</b>	
<b>Non-Network</b>	<b>YES</b>	<b>--</b>	<b>70%</b>	
<b>Routine Colonoscopy</b>	<b>NO</b>	<b>100%</b>	<b>100%</b>	Age 50 and over, 1 every 10 years.
<b>Routine Sigmoidoscopy</b>	<b>NO</b>	<b>100%</b>	<b>100%</b>	Age 40 and over, 1 every 2 years.
<b>Anesthesiology Services</b>				
<b>Professional</b>	<b>NO</b>	<b>90%</b>	<b>90%</b>	
<b>Facility</b>	<b>YES</b>	<b>90%</b>	<b>70%</b>	
<b>Diagnostic X-Ray &amp; Laboratory Services</b>				
<b>Outpatient</b>	<b>NO</b>	<b>80%</b>	<b>80%</b>	
<b>Inpatient</b>	<b>YES</b>	<b>80%</b>	<b>80%</b>	
<b>Ambulance Services</b>				
<b>Facility</b>	<b>YES</b>	<b>90%</b>	<b>70%</b>	
<b>Professional</b>	<b>NO</b>	<b>90%</b>	<b>90%</b>	
<b>Home Health Care</b>	<b>YES</b>	<b>90%</b>	<b>70%</b>	Limited to 200 visits per plan year; precertification is required.
<b>Hospice Facility</b>	<b>YES</b>	<b>90%</b>	<b>70%</b>	Limited to 210 days/visits per lifetime. Benefits include bereavement counseling. Precertification is required.
<b>Durable Medical Equipment</b>				
<b>Facility</b>	<b>YES</b>	<b>90%</b>	<b>70%</b>	
<b>Professional</b>	<b>NO</b>	<b>90%</b>	<b>90%</b>	
<b>Wigs/Hairpieces</b>	<b>NO</b>	<b>90%</b>	<b>90%</b>	Benefit limited to synthetic wigs/hairpieces.
<b>Inpatient Hospital Services</b>				Subject to a \$100 copay per day, \$600 maximum per in-network admission. The plan's coinsurance for hospital expenses will be reduced to 50% if you do not follow the procedures required by the Medical Management Program. This penalty does not apply to the out-of-pocket maximum.
<b>Network</b>	<b>NO</b>	<b>90%</b>	<b>-</b>	
<b>Non-Network</b>	<b>YES</b>	<b>-</b>	<b>70%</b>	

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Surgical Treatment of Morbid Obesity	YES	90%	70%	Limited to 1 procedure per lifetime.
Skilled Nursing Facility	YES	90%	70%	Limited to 60 days per year.
Organ Transplants	YES	90%	70%	For this benefit, "network plan" refers to the BCBS National Transplant Network. Precertification required. There is a \$10,000 travel and lodging limit.
Outpatient Mental Health/Substance Abuse Treatment	YES	90%	70%	Limited to 20 visits per year.
Inpatient Mental Health/Substance Abuse Treatment	YES	90%	70%	Subject to \$100 copay per day, \$600 maximum per in-network admission. Limited to 30 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. Your coinsurance does not apply to the out-of-pocket maximum, and coverage is subject to the inpatient hospital deductible.
Allergy Testing				
Network	NO	100%	--	You must pay a \$25 copay per visit. Allergy treatment with no office visit billed is covered at 100%.
Non-Network	YES	--	70%	
All Other Covered Medical Expenses	YES	90%	70%	Benefits are provided for expenses listed in the "What's Covered" sections of this Handbook.

**Medical Management Program toll-free number: (800) 352-3152**

**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 sponsored by Church Pension Group Services Corporation.

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.