

# SCHEDULE OF MEDICAL BENEFITS

## AETNA

## HMO PLAN

PLAN IS EFFECTIVE AS OF JANUARY 1, 2010

### Inpatient Hospital Deductible

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

### Lifetime Benefit Maximum

(Includes All Other Maximums)

\$5 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	\$0	No copay when medically necessary. Non-emergency ambulance services must be pre-authorized by Aetna.
Diagnostic Tests/X-Ray and Laboratory Services	\$20	
Durable Medical Equipment (DME)	\$0	Must be precertified by 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.

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COVERED HEALTH SERVICE	YOUR COPAYMENT AMOUNT	ADDITIONAL LIMITATIONS AND EXPLANATIONS
<b>Hospice Care</b>	\$0	Admission into a facility covered after \$150 copay; \$600 maximum per admission.
<b>Hospital Services (Inpatient)</b>	\$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.
<b>Hospital Services (Outpatient)</b>	\$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.
<b>Maternity Services</b>		
<b>Outpatient Services</b>	\$20 for first visit only	
<b>Hospital Services</b>	\$150 copay per day; \$600 maximum per admission	
<b>Mental Health/ Substance Abuse Services - Inpatient</b>	See the CIGNA Behavioral Health Handbook	
<b>Mental Health/ Substance Abuse Services - Outpatient</b>	See the CIGNA Behavioral Health Handbook	
<b>Nutritional Counseling</b>	\$20 per visit	Limited to 6 visits/sessions per calendar year.
<b>Outpatient Therapy Services</b>	\$20 per visit	Benefits include physical, occupational, and speech therapy. Limited to 60 visits each per year.
<b>Physician's Office Services</b>	\$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.
<b>Routine &amp; Preventive Services</b>	\$0 per visit	Benefits include the office visit and vaccinations, inoculations, and immunizations. 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.
<b>Routine Exams</b>		
<b>Routine Exam X-Rays &amp; Laboratory Services</b>		
<b>Well-Child Checkups</b>		
<b>Routine Colonoscopy</b>		
<b>Routine Sigmoidoscopy</b>		
<b>Other Routine Services</b>		

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COVERED HEALTH SERVICE	YOUR COPAYMENT AMOUNT	ADDITIONAL LIMITATIONS AND EXPLANATIONS
Skilled Nursing Facility	\$150 per day (\$600 maximum)	Limited to 60 days per year
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	\$0	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.