AETNA

HMO PLAN

PLAN IS EFFECTIVE AS OF JANUARY 1, 2012

Inpatient Hospital Copayment

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

Lifetime Benefit Maximum

(Includes All Other Maximums)

None

You must receive all nonemergency services from healthcare providers participating in the Aetna network, or benefits will not be covered by the plan.

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	$25 per visit	Limited to 12 visits per year.
Allergy Testing (Injections)	$25 per visit	Benefit includes routine injections at PCP's office, with or without a physician encounter. Benefit is covered at 100% if no office visit is charged.
Ambulance Services - Emergency Only	$0	No copay when medically necessary.
Diagnostic Tests/X-Ray and Laboratory Services	$25	
Durable Medical Equipment (DME)	$0	
Emergency Room Services *	$100 per visit	Your $100 copay will be waived if you are admitted to the hospital.
Home Health Care	$0	Limited to 210 visits per year.

SCHEDULE OF MEDICAL BENEFITS

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COVERED HEALTH SERVICE	YOUR COPAYMENT AMOUNT	ADDITIONAL LIMITATIONS AND EXPLANATIONS
Hospice Care	$0	Admission into a facility covered after $150 copay; $600 maximum per admission.
Hospital Services (Inpatient)	$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.
Hospital Services (Outpatient)	$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.
Hypnosis	$25 per visit	Limited to 6 visits per calendar year.
Maternity Services		
Outpatient Services	$25 to confirm pregnancy	
Hospital Services	$150 copay per day; $600 maximum per admisssion	
Nutritional Counseling	$25 per visit	Limited to 6 visits per calendar year.
Outpatient Therapy Services	$25 per visit	Benefits include physical, occupational, and speech therapy. Limited to 60 visits each per year.
Physician's Office Services	$25 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.
Routine & Preventive Services **Routine Exams** **Routine Exam X-Rays & Laboratory Services** **Well-Child Checkups** **Routine Colonoscopy** **Routine Sigmoidoscopy** **Other Routine Services**	$0 per visit	Preventive care is based on guidelines from the U.S. Preventive Services Task Force, American Cancer Society, The Advisory Committee on Immunization Practices (ACIP), and the American Academy of Pediatrics. Coverage for child immunizations is based on the published guidelines of the American Academy of Pediatrics.

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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	$25 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	

Clinical Management Program toll-free number: (877) 380-8584

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.

SCHEDULE OF MENTAL HEALTH/SUBSTANCE ABUSE BENEFITS

CIGNA BEHAVIORAL HEALTH

PLAN IS EFFECTIVE AS OF JANUARY 1, 2012

FOR MEMBERS ENROLLED IN THE AETNA HMO PLAN

The following schedule summarizes your mental health and substance abuse benefits, coinsurance amounts, benefit maximums, and any additional explanation needed for your benefits. Please refer to the Mental Health/Substance Abuse chapter for additional Plan provisions. **All coinsurances apply to your health plan's out-of-pocket maximums.**

COVERED HEALTH SERVICE	YOUR COST SHARE	ADDITIONAL LIMITATIONS AND EXPLANATIONS
Outpatient Mental Health/ Substance Abuse	**Network** $20 per visit **Out-of-Network** 30%	There is no annual limit.
Inpatient Mental Health/ Substance Abuse	**Network** $150 per day, not to exceed $600 per admission **Out-of-Network** 30%	All admissions must be precertified. There is no annual limit. Emergency room, ambulance, and lab work charges are covered by your medical plan.
Intensive Outpatient Mental Health/Substance Abuse	**Network** $150 per program, payable at admission **Out-of-Network** 30%	All programs must be precertified. There is no annual limit.
Employee Assistance Program (EAP)	**Network** $0 **Out-of-Network** N/A	Benefits include (but are not limited to) unlimited telephonic and work/life services, crisis intervention, referrals to community resources, legal consultations, and a large online resource library. You may also receive up to 10 face-to-face counseling sessions per issue, but they must be precertified by CIGNA Behavioral.
Colleague Groups		Benefit is limited to 24 90-minute sessions per calendar year. Up to 12 of the 24 sessions may be used for individual consultation. The Plan will reimburse 70% up to $40.

CIGNA Behavioral Health Member Services Toll-Free Number: (866) 395-7794

Everything you discuss with your counselor or care provider is kept in the strictest confidence in accordance with applicable state and federal laws. Your employer is not notified of your visits or given specific information about your treatment without your written permission. The general health privacy and security standards of the Episcopal Church Medical Trust apply.

SCHEDULE OF PRESCRIPTION DRUG BENEFITS

PLAN IS EFFECTIVE AS OF JANUARY 1, 2012

There are two prescription drug benefit plans: the Standard Plan and the Premium Plan. Your prescription plan is determined by your diocese or group and was noted on your personalized open enrollment form. If you are in the Premium Plan, it is also noted on your ID card.

Standard

	RETAIL PRESCRIPTION DRUGS	MAIL-ORDER PRESCRIPTION DRUGS
Annual Prescription Deductible	$50 per individual	N/A
Tier 1: Generic	You pay up to $10	You pay up to $25
Tier 2: Formulary Brand-Name	You pay up to $35	You pay up to $90
Tier 3: Non-Formulary Brand-Name and Brand Non-Sedating Antihistamines	You pay up to $60	You pay up to $150
Dispensing Limits Per Copayment	Up to a 30-day supply	Up to a 90-day supply

Premium

	RETAIL PRESCRIPTION DRUGS	MAIL-ORDER PRESCRIPTION DRUGS
Annual Prescription Deductible	$50 individual	N/A
Tier 1: Generic	You pay up to $5	You pay up to $12
Tier 2: Formulary Brand-Name	You pay up to $25	You pay up to $70
Tier 3: Non-Formulary Brand-Name and Brand Non-Sedating Antihistamines	You pay up to $45	You pay up to $110
Dispensing Limits Per Copayment	Up to a 30-day supply	Up to a 90-day supply

Coverage of Non-Sedating Antihistamines

The non-sedating antihistamine drug category has the highest copayment, regardless of the drug's formulary status. This change is a result of the drug Claritin now being available over the counter. For example, if you prefer to take the medication Clarinex rather than buying Claritin over the counter, you pay the third-tier copayment.

Generic Substitution Requirement

Generic medications and their brand-name counterparts have the same active ingredients and are manufactured according to the same strict federal regulations. Generic drugs may differ in color, size, or shape, but the U.S. Food and Drug Administration (FDA) requires that the active ingredients have the same strength, purity, and quality as their brand-name counterparts. **For this reason, the Plan will cover the cost of the generic equivalent if you purchase a brand-name medication when there is a generic available. You will be charged the generic copayment and the cost difference between the brand-name and the generic medication.** If you have questions or concerns about generic medication, speak to your physician or your pharmacist, and he or she will be able to help you.

Prescriptions Filled At A Nonparticipating Pharmacy

If you go to a retail pharmacy that is not part of the Medco network, you must pay the full cost of the prescription and then submit a direct reimbursement claim form to Medco. You will be reimbursed for the amount the medication would have cost your Plan at a participating pharmacy minus the copayment you would have paid.

Keep in mind, the retail pharmacy program allows for a total of three fills of a maintenance medication at a retail pharmacy (one original fill and two refills). Additional fills will not be covered by the Plan. Each fill can be for no more than a 30-day supply. Note that you are allowed a total of three fills, even if each is for less than 30 days.

Retail Refill Limit

The Prescription Drug Program will maintain a Retail Refill Limit policy. The retail refill limit requires that you use the mail-order pharmacy if you are prescribed a maintenance medication, rather than refilling multiple prescriptions for the same drug at a retail pharmacy. If you or a covered dependent receives a prescription for a maintenance medication and you do not use the mail-order pharmacy, your prescriptions may not be covered.

In some circumstances, you may not be required to use the mail-order pharmacy. For example, there are several categories of medications that are uniquely appropriate for multiple refills at your local pharmacy (and are therefore exempt from the mandatory mail-order provision, as outlined above). If you have a prescription for any of the following medications, the Prescription Drug Program allows you to receive multiple refills at your local retail pharmacy:

- Anti-infectives, including antibiotics (Amoxicillin, Biaxin), antivirals (Zovirax, Famvir), antifungals (Diflucan), and drops used in the eyes and ears (Polsporin Opth, Cipro Otic). Please note that drops must be prescribed specifically to treat infection. For example, glaucoma drops are not covered.
- Prescription cough medications, including Phenergan with Codeine, Tessalon, and Tussionex.
- Medications to treat acute pain, both narcotic (Vicodin, Percodan, etc.) and non-narcotic (Darvocet). Please note that long-term pain medications, such as NSAIDs, do not meet the necessary retail requirements.
- Medications that require a new written prescription each time you need them, as refills are prohibited by federal law (e.g., Percodan, Ritalin, and Nembutal).
- Medications used to treat both attention deficit disorder (Ritalin, Cylert) and narcolepsy (Dexedrine).
- Medications whose sole use is to treat cancer.

Refilling Mail-Order Prescriptions

Since your medication can take 7 to 11 days to be delivered, you should have at least a 14-day supply of that medication on hand to hold you over. If you do not have enough medication, you may need to ask your doctor for another prescription for a 14-day supply that you can fill at your local retail network pharmacy.

Your Plan May Have Coverage Limits

Your Plan may have certain coverage limits. For example, prescription drugs used for cosmetic purposes may not be covered, or a medication might be limited to a certain amount (such as the number of pills or total dosage) within a specific time period.

If you submit a prescription for a drug that has coverage limits, your pharmacist will tell you that approval is needed before the prescription can be filled. The pharmacist will give you or your doctor a toll-free number to call. If you use *Medco By Mail*, your doctor will be contacted directly.

When a coverage limit is triggered, more information is needed to determine whether your use of the medication meets your Plan's coverage conditions. We will notify you and your doctor of the decision in writing. If coverage is approved, the letter will indicate the amount of time for which coverage is valid. If coverage is denied, an explanation will be provided, along with instructions on how to submit an appeal.

Additional Information

It is always up to you and your doctor to decide which prescriptions are best for you. You are never required to use generic drugs or drugs that are on the Medco formulary list. If you prefer, you can use non-formulary brand-name drugs and pay a higher copayment.

It is also important to note that drugs included on the formulary list are routinely updated. To find the most up-to-date list of covered drugs, visit Medco at **www.medco.com**, or call their member services department at (800) 841-3361. It should be noted that all drugs listed on the formulary may not be covered due to Plan exclusions and limitations. You can also use Medco's Web site or member services telephone number to locate the retail pharmacy nearest you.

Paper Claims Reimbursement

You must pay the full price at the pharmacy and file a claim for reimbursement. You will be reimbursed according to what the Plan would have paid at a participating pharmacy, less your applicable copayment. See the "Pharmacy Benefits" section of your Plan Handbook for more information about filing claims for reimbursement for prescription drugs purchased at retail pharmacies.

Medco toll-free number: (800) 841-3361

NOTES: Some prescriptions may require prior authorization. Please refer to the "Pharmacy Benefits" section of this Handbook for further information.

Prescription deductibles and copayments do not apply to the medical plan deductibles or out-of-pocket maximums.

SCHEDULE OF VISION BENEFITS

EYEMED VISION CARE

PLAN IS EFFECTIVE AS OF JANUARY 1, 2012

Services	Copayments for Benefits
Exam	$0
Eye Glass Lenses	$10

Benefit Description	Network	Out-of-Network
Eye Examinations	You pay $0	Plan pays up to $30 for ophthalmologists or optometrists
Lenses*	You pay $10 for single, bifocal or trifocal	Plan pays up to: $32—single vision $46—bifocal $57—trifocal
Lens Options		You are responsible for the cost of any lens options that you elect from out-of-network providers
UV Coating	You pay up to $15	
Tint (Solid and Gradient)	You pay up to $15	
Standard Scratch Resistance	You pay up to $15	
Standard Polycarbonate	You pay $0	
Standard Anti-Reflective Coating	You pay up to $45	
Standard Progressive (Add-On to Bifocal)	You pay up to $65	
Other Add-Ons and Services	20% off retail price	
Frames*	$130 allowance, 20% off balance over $130	Plan pays up to $47
Contact Lenses*		
Conventional	$130 allowance, 15% off balance over $130	Plan pays up to $100
Disposable	$130 allowance, then you pay balance over $130	Plan pays up to $100

** You are eligible to receive lenses and frames* **or** *contact lenses once per calendar year.*

When you use EyeMed network providers, you will not need to submit a claim. Your EyeMed provider will submit claims on your behalf. You will pay the copayment and for any noncovered expenses at the time you receive services.

For More Information

For more information about EyeMed, and to see a list of EyeMed providers, please visit **www.eyemedvisioncare**, or call EyeMed toll-free at (866) 723-0513.