

SCHEDULE OF MEDICAL BENEFITS

UNITED HEALTHCARE

80/60 PPO PLAN

PLAN IS EFFECTIVE AS OF JANUARY 1, 2010

	Annual Deductibles		Annual Out-of-Pocket Maximums (Excludes Deductible)		Inpatient Hospital Copayment
Network	\$500 Individual	\$1,000 Family	\$1,500 Individual	\$3,000 Family	\$100 per day, not to exceed \$600 per admission
Non-Network	\$1,000 Individual	\$2,000 Family	\$4,500 Individual	\$9,000 Family	

Lifetime Benefit Maximum

(Includes All Other Maximums)

\$5 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.

COVERED HEALTH SERVICE	YOUR COPAYMENT AMOUNT	COPAY APPLY TO ANNUAL OOP MAX?	NEED TO MEET ANNUAL DEDUCTIBLE?	ADDITIONAL LIMITATIONS AND EXPLANATIONS
Acupuncture Services	Network 50%	No	No	Any combination of Network and Non-Network Benefits for pain therapy is limited to 12 visits per calendar year. Acupuncture services received on an inpatient basis are not covered.
	Non-Network 50%	Yes	Yes	
Allergy Testing (Injections)	Network \$25 per visit	No	No	Allergy treatment with no office visit billed is covered at 100%.
	Non-Network 40%	Yes	Yes	
Ambulance Services - Emergency Only	Network & Non-Network 20%	Yes	No	For facility/non-emergency services out-of-network, you will pay 40% and the annual deductible applies.
Diagnostic Tests/X-Ray and Laboratory Services	Network 20%	Yes	No	
	Non-Network 20%	Yes	No	
Durable Medical Equipment (DME)	Network 20%	No	No	
	Non-Network 20%	Yes	Yes	
Emergency Room Services	Network & Non-Network \$50 per visit	No	No	The \$50 copay will be waived if you are admitted to the hospital. Hospital admission must be precertified within 24 hours.

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Home Health Care	Network 20%	Yes	Yes	Limited to 200 visits per plan year; precertification is required.
	Non-Network 40%	Yes	Yes	
Hospice Care	Network 20%	Yes	Yes	Limited to one episode per lifetime. Benefits include bereavement counseling. Precertification is required.
	Non-Network 40%	Yes	Yes	
Hospital Services (Inpatient)	Network 20%. \$100 per day copay, \$600 maximum per inpatient stay	No	No	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.
	Non-network 40%	Yes	Yes	
Hospital Services (Outpatient)	Network 20%	Yes	Yes	
	Non-Network 40%	Yes	Yes	
Maternity Services Hospital Services	Network 20%. Subject to a \$100 copay per day, \$600 maximum per inpatient stay	No	No	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.
	Non-Network 40%	Yes	Yes	
Outpatient Services	Network \$25 for first visit only	No	No	Antepartum care only.
	Non-Network 30%	Yes	Yes	
Mental Health/ Substance Abuse Services - Inpatient	See CIGNA Behavioral Health Handbook			
Mental Health/ Substance Abuse Services - Outpatient	See CIGNA Behavioral Health Handbook			

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Nutritional Counseling	Network \$25 per visit	No	No	Limited to 6 sessions per calendar year.
	Non-Network 40%	No	No	
Outpatient Therapy Services	Network \$25 per visit	No	No	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.
	Non-Network 40%	Yes	Yes	
Physician's Office Services	Network \$25 per visit	No	No	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.
	Non-Network 40%	Yes	Yes	
Routine & Preventive Services	Network \$0 per visit	No	No	Benefits include routine physicals, including gynecological exams, limited to 1 per year; hearing exams performed by your physician during a routine physical, limited to 1 per year; and vaccinations, inoculations, and immunizations. Pap tests, limited to 1 per year; mammograms, limited to 1 per year age 40+, 1 age 35-39; PSA screenings, limited to 2 per year age 40+; and all related routine x-rays and laboratory services. Well-child checkups limited to 7 visits from birth to age 1, 6 visits from age 1 through age 5, 7 visits from age 5 through age 12, 6 visits from age 12 through age 18, and 2 visits age 18 up to the 19th birthday. Benefits include the office visit, vaccinations, inoculations, immunizations, and all related x-ray and laboratory services. Routine sigmoidoscopy limited to 1 every 2 years, age 40+. Routine colonoscopy limited to 1 every 10 years, age 50+.
	Non-Network 40%	Yes	Yes	
Skilled Nursing Facility/ Inpatient Rehabilitation Facility Services	Network 20%	Yes	Yes	Limited to 60 days per year.
	Non-Network 40%	Yes	Yes	
Smoking Cessation Program	Network 20%	No	No	Smoking cessation Benefits include hypnosis and counseling. Prescription smoking cessation drugs are excluded under the medical plan but are available through your prescription drug plan. Any combination of Network and Non-Network smoking cessation Benefits are limited to \$200 per covered person per calendar year.
	Non-Network 40%	No	No	
Spinal Treatment	Network \$25 per visit	No	No	Limited to 20 visits per year.
	Non-Network 40%	Yes	Yes	

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Surgical Treatment of Morbid Obesity	Network 20%	Yes	Yes	Limited to 1 procedure per lifetime.
	Non-Network 40%	Yes	Yes	
Urgent Care Services	Network 20%	Yes	Yes	
	Non-Network 40%	Yes	Yes	

Additional Benefits

Anesthesiology Services				
Professional	Network 20%	Yes	No	Benefits include Covered Health Services for organ and tissue transplants as specified in the Coverage section when ordered by a Network physician, when the transplant meets the definition of a Covered Health Service, and when the transplant is not an Experimental or Investigational Service or an unproven service. There are specific guidelines regarding Benefits for transplant services. Contact Personal Health Support for information about these guidelines. Your Network physician must notify Personal Health Support as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If Personal Health Support is not notified, and if the services are not performed at a Designated Facility, you will be responsible for paying all charges and Benefits will not be paid. See the Coverage section for more details.
	Non-Network 20%	No	No	
Facility	Network 20%	Yes	No	
	Non-Network 40%	Yes	Yes	
Organ Transplants	Network 20%	Yes	Yes	
	Non-Network Not available	Yes	Yes	
All Other Covered Medical Expenses	Network 20%	No	No	
	Non-Network 40%	Yes	Yes	

UnitedHealthcare Member Services toll-free number: (866) 204-8533

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 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.