

SCHEDULE OF MEDICAL BENEFITS

UNITEDHEALTHCARE

CHOICE 80 PLAN

PLAN IS EFFECTIVE AS OF JANUARY 1, 2012

**Annual Deductibles Annual Out-of-Pocket
Maximums**

(Excludes Deductible)

Individual	\$1,000	Individual	\$2,000
Family	\$2,000	Family	\$4,000

Lifetime Benefit Maximum

(Includes All Other Maximums)

None

You must receive all nonemergency services from healthcare providers participating in the UnitedHealthcare 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. Please refer to the Coverage chapter 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 COST SHARE	COPAY APPLY TO ANNUAL OOP MAX?	NEED TO MEET ANNUAL DEDUCTIBLE?	ADDITIONAL LIMITATIONS AND EXPLANATIONS
Acupuncture Services	\$25 per visit	No	No	Limited to 12 visits per calendar year. Acupuncture services received on an inpatient basis are not covered.
Allergy Testing (Injections)	\$25 per visit	No	No	Benefits are available for injections received in a physician's office when no other health service is received, for example, allergy immunotherapy. Benefits include serum for allergy care.
Ambulance Services - Emergency Only	Ground or Air Transportation 20%	Yes	No	Emergency ambulance transportation by a licensed ambulance service to the nearest hospital where emergency health services can be performed. Non-emergency ambulance services are not covered. Services must be provided at a designated facility. See the Coverage chapter for more details
Diagnostic Tests/X-Ray and Laboratory Services	20%	Yes	Yes	
Durable Medical Equipment (DME)	20%	Yes	Yes	

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Emergency Room Services	\$100	No	No	The \$100 copay will be waived if you are admitted to the hospital. Hospital admission must be precertified within 24 hours.
Home Health Care	20%	Yes	Yes	Benefits limited to 210 visits per calendar year, including private duty nursing. One visit equals 4 hours of skilled care services. See the Coverage chapter for more details.
Hospice Care	20%	Yes	Yes	
Hospital Services (Inpatient)	20%	Yes	Yes	Benefits are available for services and supplies received during the inpatient stay and room and board in a semi-private room (a room with two or more beds).
Hospital Services (Outpatient)	20%	Yes	Yes	Benefits include covered health services received on an outpatient basis at a hospital or alternate facility including: surgery and related services, lab and radiology/x-ray, mammography testing, and other diagnostic tests and therapeutic treatments (including cancer chemotherapy or intravenous infusion therapy). Benefits under this section include only the facility charge and the charge for required services, supplies, and equipment. Benefits for the professional fees related to outpatient surgery, diagnostic, and therapeutic services are described under Professional Fees for Surgical & Medical Services below. When these services are performed in a physician's office, benefits are described under Physician's Office Visits.
Maternity Services Hospital Services	20%	No	No	Benefits are the same as Professional Fees, Hospital-Inpatient Stay, Outpatient Surgery, and Diagnostic & Therapeutic Services. See the Coverage chapter for more information.
Outpatient Services	\$25 for visit to confirm pregnancy	No	No	

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Nutritional Counseling	\$25 per visit	No	No	Benefits include services provided by a registered dietician in an individual session. Limited to 6 sessions per calendar year. Copay and visit limit apply only to non-preventive services.
Outpatient Therapy Services	\$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.
Physician's Office Services	\$25 per visit	No	No	
Routine & Preventive Services Routine Exams Routine Exam X-Rays & Laboratory Services Well-Child Checkups Routine Colonoscopy Routine Sigmoidoscopy Other Routine Services	\$0	n/a	No	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.
Skilled Nursing Facility/ Inpatient Rehabilitation Facility Services	20%	Yes	Yes	Limited to 60 days per year. If you are transferred to a skilled nursing facility or inpatient rehabilitation facility directly from an acute facility, any combination of copayments required for the inpatient stay in a hospital and the inpatient stay in a skilled nursing facility or inpatient rehabilitation facility will apply to the stated maximum copayment per inpatient stay.

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Spinal Treatment	\$25 per visit	No	No	Limited to 20 visits per calendar year.
Surgical Treatment of Morbid Obesity	20%	Yes	Yes	Covered the same as Physician's Office Services, Hospital-Inpatient Stay, Outpatient Surgery, Diagnostic & Therapeutic Services, and Prosthetic Devices
Urgent Care Services	20%	Yes	Yes	Benefits include covered services received at an Urgent Care Center. When services to treat urgent healthcare needs are provided in a physician's office, benefits are available as Physician's Office Services.

Additional Benefits

Cancer Resource Services	\$25 per visit	Yes	Yes	Services must be provided at a designated facility. See the Coverage chapter for more information.
Dental (Accident or Oral Surgery Only)	\$50 per visit	Yes	Yes	You must notify Personal Health Support. See the Coverage chapter for more information
Eye Examinations	Refer to Routine and Preventive Care	No	No	Benefits include eye examinations received during routine physical examinations from a healthcare provider in the provider's office. Benefits are not available for charges connected to the purchase or fitting of eyeglasses or contact lenses such as refractive examinations to detect vision impairment, although these are available through the vision plan. See the Vision Schedule of Benefits for more information.
Foot Care	Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Surgery, Diagnostic & Therapeutic Services	Yes	Yes	Benefits include surgical treatment of diseases or illnesses of the foot. Non-surgical treatments are covered when required to treat metabolic or peripheral-vascular disease.
Hearing Care	Refer to Routine and Preventive Care	No	No	Benefits include hearing examinations and associated covered services received from a healthcare provider in the provider's office during routine physical examinations. Benefits are not available for charges connected to the purchase or fitting of hearing aids.

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Professional Fees for Surgical & Medical Services	20%	Yes	Yes	Benefits include professional fees for surgical procedures and other medical care received in a hospital, skilled nursing facility, inpatient rehabilitation facility, or alternate facility. When these services are performed in a physician's office, benefits are same as Physicians's Office Services.
Transplantation Services	20%	Yes	Yes	Benefits include covered health services for organ and tissue transplants as specified in the Coverage chapter 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 chapter for more details.
Congenital Heart Disease Services	20%	Yes	Yes	Benefits for Congenital Heart Disease (CHD) are covered when ordered by a physician. CHD services may be received at a Congenital Heart Disease Resource Services program. Benefits are available for the CHD services when the services meet the definition of a Covered Health Service, and is not an experimental or investigational service, or an unproven service. Personal Health Support notification is required for all CHD services, including outpatient diagnostic testing, in utero services, and evaluation.

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

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 UNITEDHEALTHCARE CHOICE 80 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	There is no annual limit.
	Out-of-Network 30%	
Inpatient Mental Health/ Substance Abuse	Network 20%	All admissions must be precertified. There is no annual limit. Emergency room, ambulance, and lab work charges are covered by your medical plan.
	Out-of-Network 30%	
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.

SCHEDULE OF PRESCRIPTION DRUG BENEFITS

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 Oph, 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 UV Coating Tint (Solid and Gradient) Standard Scratch Resistance Standard Polycarbonate Standard Anti-Reflective Coating Standard Progressive (Add-On to Bifocal) Other Add-Ons and Services	You pay up to \$15 You pay up to \$15 You pay up to \$15 You pay \$0 You pay up to \$45 You pay up to \$65 20% off retail price	You are responsible for the cost of any lens options that you elect from out-of-network providers
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.