

SCHEDULE OF MEDICAL BENEFITS

AETNA

CHOICE POS II PLAN

PLAN IS EFFECTIVE AS JANUARY 1, 2006

	Annual Deductibles		Annual Out-of-Pocket Maximums (Excludes Deductible)		Inpatient Hospital Deductible
Network	\$250	Individual	\$1,000	Individual	\$100 per day, not to exceed \$600 per admission
	\$500	Family	\$2,000	Family	
Non-Network	\$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 "Clinical 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
Emergency Room Services				You must pay the first \$50 per ER or urgent care facility visit. Your \$50 copay will be waived if you are admitted to the hospital.
Facility	NO	100%	100%	
Physician	NO	100%	100%	
Smoking Cessation Program	NO	100%	100%	\$200 individual annual maximum. Benefits include hypnosis and counseling. Prescription smoking cessation drugs are excluded under the medical plan, but are available through Medco. Please refer to Acupuncture for a description of your acupuncture benefits.
Physician Office Visits				You must pay the first \$25 per network office visit. Your copay applies to the office visit only. All services performed during the visit will be considered as "All Other Covered Medical Expenses" or according to regular plan provisions. To locate a network provider, contact Aetna via the toll-free number or check the web site.
Network	NO	100%	—	
Non-Network	YES	—	70%	
Network	NO	100%	—	
Non-Network	YES	—	70%	
Maternity Care				You must pay a \$25 copayment upon your first visit only.
Network	NO	100%	—	
Non-Network	YES	—	70%	

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Outpatient Therapy Network Non-Network	NO YES	100% —	— 70%	You must pay a \$25 copay per visit to a network provider. Benefits include physical, occupational, and speech therapy. Limited to 60 visits each per year.
Chiropractor Services Network Non-Network	NO YES	100% —	— 70%	You must pay a \$25 copay per visit to a network provider. Limited to 20 visits per year for spinal manipulation.
Nutritional Counseling	NO	100%	100%	You must pay the first \$25 per visit. Limited to 6 sessions per year.
Routine & Preventive Services Routine Exams Network Non-Network	NO YES	100% —	— 70%	You must pay the first \$25 per visit to a network provider. Your copay applies to the office visit only. Benefits include the office visit and vaccinations, inoculations, and immunizations. Copay will be waived for immunizations if office visit is not billed. Well-Child checkups are limited to 6 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.
Routine Exam X-Rays & Laboratory Services	NO	100%	100%	X-rays and laboratory tests related to the routine exams.
Other Routine Services	NO	100%	100%	One baseline mammogram age 35 to 40; annual mammograms age 40 and older; annual PAP tests and PSA screenings, males age 40 and over.

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Routine Sigmoidoscopy	NO	100%	100%	Age 50 and over, limited to 1 every 5 years.
Routine Colonoscopy	NO	100%	100%	Age 50 and over, limited to 1 every 10 years.
Diagnostic X-Ray & Laboratory Services	NO	80%	80%	Benefit for services performed in an independent lab facility or doctor's office not related to a routine exam.
Ambulance Services	NO	90%	90%	
Home Health Care	YES	90%	70%	Limited to 200 visits per year. You should notify Aetna by calling the toll-free number prior to receiving any home health care.
Acupuncture	NO	50%	50%	Limited to 12 visits per year. Benefits are not subject to reduction for usual and customary charges.
Hospice Facility/ Home Hospice	YES	90%	70%	Limited to 210 days/visits per lifetime.
Durable Medical Equipment	YES	90%	70%	You should notify Aetna by calling the toll-free number prior to purchasing or renting any durable medical equipment.
Inpatient Hospital Services				Subject to a \$100 per day deductible, \$600 maximum per admission for in-network services.* The plan's coinsurance for hospital expenses will be reduced to 50% if you do not follow the procedures required by the Clinical Management Program. This penalty does not apply to the out-of-pocket maximum.
Network	NO	90%	—	
Non-Network	YES	—	70%	
*Benefits include, but are not limited to, hospital semi-private room, miscellaneous fees, anesthesia, surgeons' fees, physician visits, x-ray, lab and therapy expenses.				
Skilled Nursing Facility	YES	90%	70%	Limited to 60 days per year.
Outpatient Mental Health/ Substance Abuse Treatment	YES	90%	70%	Limited to 20 visits per year.

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Allergy Services				
Network	NO	100%	—	Benefit includes allergy injections/serum and physician allergy testing/treatment. You must pay a \$25 copay per visit to a network provider if professional services charged in addition to the injection for serum preparation or physician supervision.
Non-Network	YES	—	70%	
Outpatient Hospital Services				
Network	YES	90%	—	Benefits include but not limited to outpatient surgery, physician, anesthesiology, x-ray & laboratory, and therapy expenses in a hospital or ambulatory surgical center.
Non-Network	YES	—	70%	
Inpatient Mental Health/ Substance Abuse Treatment				
Network	NO	90%	—	Subject to a \$100 per day deductible, \$600 maximum per admission for in-network services. 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.
Non-Network	YES	—	70%	
Surgical Treatment of Morbid Obesity	YES	90%	70%	Limited to 1 procedure per lifetime. Must be preauthorized by Aetna.
All Other Covered Medical Expenses	YES	90%	70%	Benefits are provided for expenses listed in a "What's Covered" section of this Handbook.

Clinical Management Program toll-free number: (877) 235-4005

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 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.