

SCHEDULE OF MEDICAL BENEFITS

EMPIRE BLUECROSS BLUESHIELD

90 EPO PLAN

PLAN IS EFFECTIVE AS OF JANUARY 1, 2006

Annual Deductibles

\$100 Individual
\$250 Family

Annual Out-of-Pocket Maximums

(Excludes Deductible)

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

Lifetime Benefit Maximum

(Includes All Other Maximums)

\$2 Million Individual

You must receive services only from health care providers participating in the BlueCard PPO Network, or benefits will not be covered by the plan. Expenses for non-network providers will only be considered as specified in the NOTES section of this schedule.

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.

BENEFIT DESCRIPTION	PLAN PAYS	ADDITIONAL LIMITATIONS AND EXPLANATIONS
Ambulance Services*		
Facility	90%	Not subject to annual deductible.
Professional	90%	
Emergency Room Services*		
Facility	100%	You must pay a \$50 copay per ER or urgent care facility visit. Your \$50 copay will be waived if you are admitted to the hospital within 24 hours.
Physician	100%	
Anesthesiology Services	90%	
Diagnostic X-Ray and Laboratory Services*	80%	Not subject to annual deductible.
Inpatient Hospital Services	90%	Precertification is required. 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.
Outpatient Surgery	90%	
Surgical Treatment of Morbid Obesity	90%	Limited to 1 procedure per lifetime.
Well-Child Checkups	100%	You must pay a \$25 copay per office visit. Limited to 6 visits from birth to age 1, 3 visits from age 1 through age 2, 4 visits from age 3 through age 6, and 6 visits from age 7 through age 19. Benefits include the office visit, vaccinations, inoculations, immunizations, and all related x-ray and laboratory services.
Routine and Preventive Services		
Routine Exams	100%	You must pay a \$25 copay per visit. 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.
Other Routine Services	100%	
Routine Sigmoidoscopy	100%	Age 40 and over, 1 every 2 years.
Routine Colonoscopy	100%	Age 50 and over, 1 every 10 years.

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BENEFIT DESCRIPTION	PLAN PAYS	ADDITIONAL LIMITATIONS AND EXPLANATIONS
Organ Transplants	90%	Must use the BCBS National Transplant Network. Precertification is required. There is a \$10,000 travel and lodging limit.
Home Health Care	90%	You should notify Empire by calling the toll-free number prior to receiving any home health care. Limited to 200 visits per plan year.
Hospice Facility	90%	Limited to 210 days per lifetime. Precertification is required.
Skilled Nursing Facility	90%	Limited to 60 days per year. Precertification is required.
Outpatient Therapy Services	100%	You must pay a \$25 copay per visit. Benefits include speech/hearing, physical, and occupational therapy. Limited to 60 visits per plan year per each of the three types of therapy.
Chiropractic Services	100%	You must pay a \$25 copay per visit. Limited to 20 visits per year.
Physician Office Visits	100%	You must pay a \$25 copay per visit.
Allergy Testing	100%	You must pay a \$25 copay per visit. Allergy treatment with no office visit billed is covered at 100%.
Wigs/Hairpieces	90%	Benefit limited to synthetic wigs or hairpieces.
Durable Medical Equipment*/ Prosthetics*	90%	
Inpatient Mental Health/ Substance Abuse Treatment	90%	Limited to 30 mental health/substance abuse 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.
Outpatient Mental Health/ Substance Abuse Treatment	90%	Limited to 20 visits per year, combined facility and office.
All Other Covered Medical Expenses	90%	Benefits are provided for expenses listed in the "What's Covered" sections of this Handbook.

Medical Management Program toll-free number: (800) 352-3152

Mental Health Benefit Program toll-free number: (800) 806-0478

* You may visit non-network providers for these services, and eligible expenses will be considered as specified on this schedule. You will be responsible for any deductible, coinsurance, and amount over the "reasonable and customary" amount. Please refer to the individual provisions under "Additional Limitations and Explanations" to see if there are any prior notification or prior authorization requirements or other limitations. For assistance in locating providers who participate in the BlueCard PPO Network, contact Empire at the toll-free number (automated service is available 24 hours a day, 7 days a week; to speak with a representative, call between 8:30 a.m. and 5:00 p.m. EST, Monday through Friday).

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 Church Pension Group Services Corporation.

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.