

SCHEDULE OF MEDICAL BENEFITS

COVENTRY HEALTH CARE (FORMERLY FIRST HEALTH)

CONFIDENT CARE SELECT 80 EPO PLAN PLAN IS EFFECTIVE AS OF JANUARY 1, 2007

Annual Deductibles Annual Out-of-Pocket Maximums (Excludes Deductible)

\$200 Individual \$1,500 Individual
\$500 Family \$3,000 Family

Lifetime Benefit Maximum

(Includes All Other Maximums)

\$2 Million Individual

You must receive services only from health care providers participating in The **Coventry Health Care 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 "Health Care 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*	50%	Yes	Yes	Limited to 12 visits per calendar year.
Allergy Testing (Injections)	\$25 Per Visit	Yes	Yes	Allergy treatment with no office visit billed is covered at 100%.
Ambulance Services - Emergency Only*	20%	Yes	No	
Diagnostic Tests/X-Ray and Laboratory Services*	20%	Yes	No	Call Coventry for prior authorization before scheduling any Magnetic Resonance Angiography (MRA). If you use Quest Diagnostics for your laboratory services, eligible expenses may be considered at 100%, no deductible.
Durable Medical Equipment (DME)*	20%	Yes	Yes	Notify Coventry prior to renting, purchasing, or ordering any durable medical equipment or prosthetics.
Emergency Room Services*	\$50 per visit	No	No	The \$50 copay will be waived if you are admitted to the hospital within 24 hours.
Home Health Care*	20%	Yes	Yes	Limited to 200 visits per year. The plan's coinsurance for hospital expenses will be reduced to 50% if you do not follow the procedures required by the health care management program.
Hospice Care*	20%	Yes	Yes	Benefits include bereavement counseling. Notify Coventry prior to receiving any hospice care.
Hospital Services (Inpatient)	20%	Yes	Yes	The plan's coinsurance for hospital expenses will be reduced to 50% if you do not follow the procedures required by the health care management program. This penalty does not apply to the out-of-pocket maximum.
Hospital Services (Outpatient)	20%	Yes	Yes	
Mental Health/ Substance Abuse Services	See Cigna Behavioral Health Schedule			

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Maternity Services Hospital/Physician Services	0%	No	No	Benefits include obstetrical visits, routine or diagnostic testing performed during the visit, delivery, and facility charges. If you do not participate in the specialized maternity program, benefits for pregnancy-related care will be considered as any other physician or hospital service. For inpatient stays, the plan's coinsurance for hospital expenses will be reduced to 50% if you do not follow the procedures required by the health care management program. This penalty does not apply to the out-of-pocket maximum. Eligible expenses for x-rays, labs, tests, and anesthesiology services will be considered whether in- or out-of-network.
Office Visits	\$25 for first visit only	No	No	
Nutritional Counseling*	\$25 per visit	No	No	Limited to 6 sessions per calendar year.
Outpatient Therapy Services	\$25 per visit	No	No	Limited to 60 visits of each per year: physical, occupational, speech, and hearing. Speech therapy benefits include screening, but exclude speaking aids or any training for the use of such aids. Hearing therapy benefits include hearing exams and rehabilitative services necessary to treat hearing loss related to a medical condition or injury, but excludes hearing aids and any related services or supplies, or lessons in sign language. See Routine And Preventive Services for routine hearing exams.
Physician's Office Services	\$25 per visit	No	No	Your copay applies to the office visit only. All covered services performed during the visit will be considered as "All Other Covered Medical Expenses" or according to regular plan provisions. Call Coventry to locate a network provider.
Routine & Preventive Services Routine Exams Routine Exam X-Rays & Laboratory Services Well-Child Checkups Routine Colonoscopy Routine Sigmoidoscopy Other Routine Services	\$25 copay for office visit	Yes	Yes	<p>\$550 annual routine and preventive maximum per person. Benefits include routine physicals, including gynecological exams, limited to 1 each per year; routine EKGs performed during the routine physical exam; hearing and vision exams performed by your physician during a routine physical, limited to 1 each per year; and vaccinations, inoculations and immunizations.</p> <p>The following benefits do not require a copay for network or non-network providers and are not subject to reduction for usual and customary charges: PAP tests, mammograms, PSA screenings, limited to 1 each per year; and routine x-rays and laboratory services.</p> <p>The following benefits are not subject to the \$550 annual routine and preventive maximum and do not require a copay for network or non-network providers: routine sigmoidoscopies, limited to 1 every 5 years; and routine colonoscopies, limited to 1 every 10 years, age 50+</p> <p>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.</p> <p>Well-Child Checkups: Limited to 7 visits from birth to age 1; 3 visits from age 1 through age 2; 4 visits from age 3 through age 6 and 1 visit per year from age 7 through 19. Benefits include the office visit, all related x-rays and laboratory tests and vaccinations, inoculations and immunizations. Labs and x-rays are not subject to reduction for usual and customary charges.</p>

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Skilled Nursing Facility*/ Inpatient Rehabilitation Facility Services	20%	Yes	Yes	Limited to 60 days per year. Notify Coventry prior to receiving any skilled nursing facility care.
Smoking Cessation Program	20%	Yes	No	\$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.
Spinal Treatment	\$25 copay per visit	No	No	Limited to 20 visits per year.
Surgical Treatment of Morbid Obesity	20%	Yes	Yes	Limited to 1 procedure per lifetime. Contact Coventry before selecting a surgeon for assistance with locating network providers.
Urgent Care Services*	\$25 copay per visit	No	No	Benefits include diagnostic services performed during the visit, except x-rays and laboratory services. Diagnostic x-rays, labs, and tests performed during the visit will be considered as any other "Diagnostic Tests/X-Ray and Laboratory Services".

Additional Benefits

Anesthesiology Services*	20%	Yes	Yes	
Jobst Garments*	20%	Yes	Yes	Limited to 2 pairs per year. Notify Coventry prior to receiving any Jobst garments for assistance locating network providers.
Wigs/Hairpieces After Radiation Therapy or Chemotherapy*	20%	Yes	Yes	Limited to 1 per episode of illness.
All Other Covered Medical Expenses	20%	Yes	Yes	Benefits are provided for expenses listed in the "What's Covered" sections of this Handbook.

* You may utilize non-network providers for these services, and eligible expenses will be considered as specified on this schedule. 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 **Coventry Health Care** Network, contact Coventry at the toll-free number anytime, 24 hours a day, 7 days a week.

Coventry toll-free number: (800) 410-7989

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 Church Pension Group Services Corporation.

Specialists Not Available in Network: If you live within The **Coventry Health Care** Network service area, and no network specialty providers are available within 30 miles of your home address, you may visit a non-network provider for your specialty care and have your eligible expenses considered as specified on this schedule. To qualify, you must contact Coventry at the toll-free number prior to receiving any specialty care.

Non-Network Emergency Hospital Admission: If you are admitted to a non-network hospital due to a medical emergency, benefits will be considered at the network level until the plan notifies you or your health care provider that it considers your condition to be stable. Once your condition has stabilized, Coventry will help you locate a network hospital and arrange for a safe and timely transfer. The plan will cover reasonable transportation costs related to the transfer. However, if you choose to remain in the non-network hospital after your condition has stabilized, expenses will be considered at the non-network level of benefits beginning the day after you are considered stable.

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The following schedule summarizes coinsurance amounts paid by the plan, benefit maximums, and any additional explanations needed for your transplant benefits. Please refer to the First Health® National Transplant Program section for additional plan provisions that may affect your benefits.

Human Organ and Tissue Transplants

BENEFIT DESCRIPTION	COVENTRY NATIONAL TRANSPLANT PROGRAM PAYS	COVENTRY NETWORK (PPO) HOSPITAL PAYS*	NON-NETWORK HOSPITAL PAYS*	ADDITIONAL LIMITATIONS AND EXPLANATIONS
Plan Pays	80%	Not Covered	Not Covered	Benefits are paid after satisfying the annual deductible. The travel, lodging, and meals allowance is for the transplant recipient and his or her immediate family travel companion (both parents, if patient is under age 19). Transplants performed outside the National Transplant Program will not be covered, including any donor expenses or travel, lodging and meals related to the transplant.
Copay Per Transplant	N/A	Not Covered	Not Covered	
Organ Donor Costs Per Transplant	\$100,000	Not Covered	Not Covered	
Travel, Lodging, and Meals Allowance Per Transplant	\$10,000	Not Covered	Not Covered	
Individual Lifetime Benefit Maximum	\$2 Million	Not Covered	Not Covered	

Coventry National Transplant Program toll-free number: (800) 410-7989

* Benefits when not using a participating **Coventry** National Transplant program facility. Contact Coventry, as outlined in the “Transplant Care” section of this Handbook, for assistance in locating a network facility and for information about the program.

NOTES: Non-EPO ancillary service providers (anesthesiologists, radiologists, and pathologists) will be considered when you are treated at a network facility, as outlined on the Schedule of Medical Benefits.

All maximums apply to the medical plan lifetime benefit maximum.

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.