

Employee Medical Plan

SETON HEALTHCARE

January 1, 2012

Summary Plan Description

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Introduction

Seton Healthcare (the “Plan Sponsor”) established the Seton Healthcare Network Employee Health Plan (the “Plan”) to provide Eligible Employees (including eligible employees of participating affiliates) and their eligible Dependents access to the medical benefits described herein.

This summary plan description or “SPD” for the Plan is designed to summarize clearly and succinctly a complex benefits program provided under the Plan, without altering or modifying that program; therefore, if in our effort to make the Plan’s benefit program easy to understand any of the Plan’s provisions have been omitted or misstated in preparing this summary, the terms of the actual Plan will still apply. This SPD is effective January 1, 2012 and will be effective until another SPD is issued with a later effective date. This SPD may be modified from time to time by a Summary of Material Modifications (“SMM”) issued by the Plan Sponsor. To determine the actual benefits available under the Plan at any given time, it is necessary to consult the SPD (or Plan document) as it was in effect at that time.

Certain words in this SPD are capitalized, and these words are defined in the Glossary in the next section. You may find it helpful to consult the Glossary as you read the SPD.

Right to Amend or Discontinue the Plan

Seton Healthcare and the other Participating Employers expect and intend to continue the Plan. However, Seton Healthcare reserves the right to amend, modify or terminate the Plan, in whole or in part, or any benefits provided under the Plan at any time and for any reason and without prior notice. In addition, your eligibility and participation in the Plan described in this SPD should not be construed as an employment contract.

The official Plan document shall govern if there are any discrepancies between the information in this SPD and the Plan document.

Please retain this SPD with your important papers. Coverage is effective subject to the waiting period, enrollment in the Plan, and timely payment of your Premium Contribution.

Glossary

The following terms shall have the meanings provided below for purposes of this SPD unless the context clearly requires otherwise.

Benefit means a payment under the Plan for a Covered Health Service, subject to the terms and conditions of the Plan.

Benefit Maximum means the limitation on coverage for a specific medical benefit provided by the Plan during a specified period, usually a Plan Year. All claims above this aggregate amount are not covered under the Plan and are the financial responsibility of the Participant. The limitation may be expressed according to an aggregate dollar amount or an aggregate number of days, sessions, visits, etc. covered for the specific benefit.

Claims Administrator means Seton Health Plan, Inc.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA): a federal law that requires group health plans with 20 or more employees to offer continued health coverage for employees and their eligible dependents for 18 months after the employee leaves the job. Longer durations of continuance are available under certain circumstances.

Coinsurance is a cost-sharing arrangement between the member and the Plan in which the member is required to pay a percentage of the cost for the health care services received.

Co-payments are a predetermined fee that an individual pays for certain health care services. Co-payments are provided in Exhibit D, the 2012 Associate Medical Comparison Chart.

Covered Health Service is a health service or item that is expressly set out in Exhibit B, Medical Benefits, and that is partially or fully paid by the Plan.

Deductible is the portion of medical expense that the member pays for particular services prior to the Plan paying benefits each Plan Year.

Dependent is any individual described in paragraphs (a) through (c) of this definition:

- (a) the Eligible Employee's lawful spouse (according to Texas law) who is not the same sex as the Eligible Employee. In the event of any question by the Plan Sponsor as to an individual's status as lawful spouse, an Eligible Employee must provide a valid marriage license

showing date of marriage on or before date of enrollment or provide a valid Texas Declaration and Registration of Informal Marriage filed with the appropriate County clerk showing date of marriage on or before date of enrollment.

- (b) an unmarried child of the Eligible Employee of any age who is incapable of self support due to a physical or mental disability and who is expected to have the same principal place of abode as the Eligible Employee for more than one-half of the Plan Year and who will not provided over one-half of his own support for the Plan Year, provided the Eligible Employee submits proof of such condition at least 30 days prior to the date such child would otherwise loose coverage under the Plan.
- (c) an Eligible Employee's natural child, stepchild or legally adopted child, a child placed for adoption with the Eligible Employee, or a child for whom the Eligible Employee is the court-appointed legal guardian, with sole managing and possessory conservatorship if such individual has not attained the age of 26. For children over the age of 19, the Plan will cover those individuals who have not attained the age of 26 only if such individual is not eligible for any other employer-sponsored medical coverage (other than the Seton group health plan).
- (d) a Legally Domiciled Beneficiary (LDB) who meets all the following criteria:
1. The LDB resides in the same primary residence as the Eligible Employee and intends to remain a member of the Eligible Employee's household throughout the coverage period;
 2. The LDB has been a member of the Eligible Employee's household for at least six (6) months prior to effective date of benefit coverage;
 3. The LDB is not an employee (e.g., nanny, housekeeper, etc.) of the Eligible Employee;
 4. The LDB is not a spouse or eligible child of the Eligible Employee; and
 5. The LDB is not eligible for another employer-sponsored health plan.

An Eligible Employee is limited to **one LDB in lieu of a spouse**. Under no circumstance may an Employee have medical coverage for more than one LDB or for a Spouse and an LDB at any given time.

An Eligible Employee may only add an LDB as a dependent to the medical plan during the annual open enrollment or as a new hire. Legally Domiciled Beneficiaries are not entitled to COBRA Continuation of Coverage under any circumstances.

An Eligible Employee may not be covered as both an Eligible Employee and a Dependent. Eligible Dependents are eligible to participate solely through an Eligible Employee.

Eligible Employee means any employee of a Participating Employer who satisfies the eligibility requirements set out in Section 1 below and is eligible to participate in and receive benefits under the Plan.

Employer or Participating Employer means Seton Healthcare and any affiliated employer that participates in the Plan with the approval of Seton Healthcare including those listed in Section 10 under “Participating Employers”.

Emergency Care a medical condition of recent onset and severity, including, but not limited to severe pain, that would lead a prudent lay person, possessing an average knowledge of medicine and health, to believe that the member’s condition, sickness, or injury is of such a nature that failure to get immediate care could result in: (1) placing the member’s health in serious jeopardy; (2) serious impairment to bodily functions; (3) serious dysfunction of any bodily organ or part; (4) serious disfigurement; or (5) in the case of a pregnant member, serious jeopardy to the health of the fetus.

ERISA means the Employee Retirement Income Security Act of 1974, as amended.

Exclusive Provider Network (EPN) is defined as set forth in Section 5.

Exclusive Provider Network Expanded (EPNX) is defined as set forth in Section 5.

Institutional Review Board (IRB) is a committee/group that is given the responsibility by an institution to review research projects involving human subjects. The purpose and role of the IRB is to assure the protection and safety, rights and welfare of research participants.

Lifetime Maximum Benefit means a lifetime limitation on coverage for a benefit option provided under the Plan. All claims above this aggregate amount are not covered by the Plan and are the financial responsibility of the Participant. The

limitation may be expressed according to an aggregate dollar amount or an aggregate number of days, sessions, visits, etc.

Medically Necessary/Medically Necessary Services means that the use of services or supplies of a health care Provider is required to identify, treat, or avoid an illness or injury and is:

- (a) appropriate and necessary for the symptoms, diagnosis or treatment of a physical or behavioral health condition; and
- within recognized standards of medical or psychiatric practice; and
- not primarily for the convenience of a Participant or his or her family, physician or other Provider; and
- the most appropriate level and facility at which care can be safely provided to the Participant.

When specifically applied to an inpatient, the term “Medically Necessary” further means that the symptom or condition requires that the diagnosis or treatment cannot be safely provided to the Participant as an outpatient.

The term “Medically Necessary” does not include the use of services or supplies of a health care Provider to identify, treat, or avoid complications, symptoms or any other condition resulting from treatment that is not covered by the Plan.

Network Area means the counties of Bastrop, Bell, Burnet, Caldwell, Fayette, Hays, Lee, Llano, Travis, and Williamson located in the State of Texas.

Network Provider means a provider that is part of the Exclusive Provider Network (EPN). and/or the Exclusive Provider Network Expanded (EPNX).

Out-of-pocket Maximums is defined as set forth in Section 5.

Participant or “member” means (i) any Eligible Employee who elects to participate in the Plan in accordance with its terms and conditions and has enrolled, and has not for any reason become ineligible to participate, and (ii) any eligible Dependents of the Eligible Employee who are properly enrolled in the Plan and has not for any reason become ineligible to participate.

Plan means the Seton Healthcare Network Employee Health Plan.

Plan Administrator means Seton Health Plan, Inc.

Plan Year means a period of twelve months beginning each January 1 and ending December 31.

Pre-certification means approval by the Plan Administrator's Medical Management Team prior to certain services being rendered. Please see the Pre-certification chart in Exhibit A. Services requiring Pre-certification include but are not limited to non-emergent out of network services.

Premium Contribution or **Contribution** means the portion of the total cost of coverage under this Plan for a Participant and his or her eligible Dependents that is paid for by the Participant.

Provider means those physicians, hospitals, skilled nursing facilities, health professionals, health institutions, and other entities and persons who have directly or indirectly contracted with the Administrator to provide Covered Health Services to members.

Qualifying Event means an act or event of legal significance that is defined by the Internal Revenue Service and that triggers a change to, or a Participant's right to change, coverage under the Plan in accordance with guidance issued by the Internal Revenue Service. Such events may be the employment (or eligibility), termination, retirement, or death of the Participant, or a change in the family such as marriage, divorce or legal separation, among other events, as described in Section 2.

Section 1: Participating in the Plan

Who Is Eligible

Eligible Employees. You are eligible to participate in the Plan if you are a regular status employee of, and you are budgeted to work 16 hours or more per week for, an Employer.

Family Members. Your family members are eligible to participate in the Plan if they satisfy the requirements set forth in the definition of "Dependent" in the Glossary.

You must enroll yourself and your eligible family members. The Plan enrollment procedures are described in the enrollment materials and will be made available online when you become eligible and during open enrollment.

When Coverage Begins and Ends

Coverage begins coincident with or on the first day of the month following date of hire or when an Eligible Employee satisfies the Plan eligibility requirements

and properly enrolls. Coverage will begin the first of the month following a Qualifying Event with the exception of the birth of a child. If a child is enrolled within 30 days following birth, coverage will retroactively begin on the child's date of birth.

Elections made during the annual open enrollment period are effective the first day of the following calendar year. If you do not enroll during the 30 days after the date you become an Eligible Employee, you will have to wait until the next open enrollment period to enroll unless you experience a Qualifying Event.

If you enroll your eligible Dependents, their coverage begins coincident with or on the first day of the month following your date of hire.

Your coverage and that of your eligible Dependents ends on the earliest of the following:

- the date of your death;
- the end of the month during which you fail to make Premium Contributions when due;
- the end of the month during which you cease to be an Eligible Employee; and
- the date group health coverage is discontinued.

In addition, if you are a Dependent under the Plan, your coverage also can end on the earlier of the following:

- the end of the month during which you cease to be a Dependent, or
- the date on which coverage for the covered Eligible Employee ends.

Please refer to Section 6 of this SPD for information on portability and COBRA Continuation Coverage.

Your Cost for Coverage

The cost for coverage is provided annually during open enrollment and upon hire for newly Eligible Employees. The cost for coverage is also available on the Seton Intranet.

Premium Contribution rates are subject to change by the Plan Sponsor based on actual or expected group experience. If your benefits are modified at any time, your Premium Contributions may, at such time, be changed to reflect the change in benefits. Premium Contributions will not be changed due to your or your Dependents' age or your or your Dependents' use of Plan benefits. Changes will be made on a group basis, not for individual Participants.

Section 2: Election Changes Related to Qualifying Events

Once you enroll in the Plan, your benefit elections remain in effect for the entire Plan Year. You may change a benefit election during a Plan Year only if you experience a Qualifying Event that relates to your or your Dependent's eligibility to participate in the Plan. The change you make in your benefit election must be consistent with the Qualifying Event (for example, you cover your Spouse following your marriage, you terminate your Spouse's coverage at the time of your divorce, you cover your child following an adoption, etc.). Plan Participants may terminate coverage of an LDB only if: (i) they have a newly qualified dependent (spouse or child), (ii) the LDB becomes eligible for other medical coverage, or (iii) the LDB no longer meets the definition of an LDB as defined herein.

To change your benefit election as a result of a Qualifying Event you must enroll online within 30 days of the Qualifying Event. Information for online enrollment is available on the Human Resource website on the Seton Intranet. You will be required to retain and may be required to produce the appropriate legal documentation that evidences that you have incurred a Qualifying Event.

The following are considered Qualifying Events for purposes of the Plan:

- your marriage, divorce, legal separation or marriage annulment;
- the birth, adoption, placement for adoption or legal guardianship with sole managing and possessory conservatorship of a child;
- a change in your or your Dependent's employment affecting coverage or involuntary loss of health coverage under another employer's plan;
- loss of coverage due to the exhaustion of employer's COBRA benefits (if that employer is not affiliated with the Participating Employer), provided you were paying for premiums on a timely basis;
- the death of a Dependent;
- your Dependent child no longer qualifying as an eligible Dependent;
- a change in your or your Spouse's position or work schedule that impacts eligibility for health coverage;
- contributions are no longer paid by the employer (even if you or your eligible Dependent continues to receive coverage under the prior

plan and to pay the amounts previously paid by the employer);

- you or your eligible Dependent who were enrolled in an HMO no longer live or work in that HMO's service area and no other benefit option is available to you or your eligible Dependent;
- benefits are no longer offered by the Plan to a class of individuals that include you or your eligible Dependent;
- a strike or lockout involving you or your Spouse; or
- a court or administrative order.

The above list of Qualifying Events are not applicable to LDB's. LDB's may not be enrolled (or dropped) as a result of a Qualifying Event. LDB's may only be enrolled during Initial or Open enrollment periods and may only be dropped as described in the first paragraph of this Section above. If you fail to change your elections online within 30 days of the qualifying change in family status, you will need to wait until the next annual Open Enrollment to change your elections.

If you are not a Participant but are a benefit Eligible Employee and you experience a Qualifying Event, you will be eligible for enrollment for 30 days following the Qualifying Event.

Section 3: Special Enrollment Rules

When certain events occur, as described in more detail below, you may have a special right to enroll in the Plan during a period other than open enrollment.

Special Enrollment Due to Acquisition of a Dependent

If you are a Plan Participant and during the year you acquire a new Dependent by birth, marriage, adoption or placement for adoption, your Dependent will be eligible for special enrollment.

If you are not a Plan Participant, but you are an Eligible Employee, and during the year you acquire a new Dependent by birth, marriage, adoption or placement for adoption, you and your eligible Dependents will be eligible for special enrollment. You can enroll with or without enrolling your Dependents, or you and your qualifying spouse can enroll without enrolling your other eligible Dependents. However, your Dependents may not enroll unless you enroll.

You must enroll online within 30 days after the relevant birth, marriage, adoption or placement for

adoption. Enrollments following a birth, adoption or placement for adoption will be effective as of the date of the birth, adoption, or placement for adoption.

Special Enrollment Due to Loss of Other Medical Coverage

If you or your eligible Dependents have other medical coverage in place when you are initially eligible, you may decide not to enroll in the Plan at that time. If you later lose that other coverage, you may become eligible for a special enrollment right.

If your other coverage was Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage with a non-Seton entity, you will become eligible for special enrollment when your COBRA rights are exhausted. However, you will not become eligible if you lose COBRA coverage without exhausting your rights (for example, you stop paying premiums). If your other group medical coverage was non-COBRA coverage, you will become eligible for special enrollment if an employer that had been contributing to the cost of coverage stopped making those contributions or if your coverage terminated when you ceased to be eligible (for example, through legal separation, divorce or loss of dependent status).

You must enroll online within 30 days of the exhaustion of coverage or termination of coverage or employer contribution as described above.

Special Enrollment for Certain Changes in Medicaid or CHIP Coverage

If you or your eligible Dependent are eligible to enroll in the Plan but are not enrolled you or your Dependent will be entitled to enroll for coverage under the Plan if:

You or your eligible Dependent were covered under a Medicaid plan or under a State child health plan and that coverage was terminated because you or your eligible dependent lose eligibility for that coverage; or

You or your eligible Dependent become eligible under a Medicaid plan or under a State child health plan for assistance with your Premium Contributions under the Plan.

However, you must enroll in the Plan online not later than 60 days after the date of termination of the Medicaid plan or State child health plan coverage or the date you or your eligible Dependent is determined to be eligible for the assistance.

Section 4: Plan Benefits

Benefits / Exclusions and Limitations

Please see Exhibits A, B, C, and D for a detailed description of the benefits, exclusions and limitations under the Plan.

Premium Contributions

Premium Contribution for the benefits available under the Plan are available online at the Human Resource website on the Seton Intranet.

Payment of Benefits

Benefits generally are payable to the health care Network Provider from whom a Participant receives services, except under circumstances in which a Participant or other party pays the full cost of the services and receives a reimbursement under the Plan.

Section 5: How the Plan Works

Overview

To obtain a Benefit under the Plan, a member generally must receive the medical care, treatment, service or supply (that is, a Covered Health Service) from a Network Provider. Each Network Provider has contracted with the Administrator to participate in a network developed by the Administrator and available under the Plan. There are two types of networks available under the Plan, the “Exclusive Provider Network” (“EPN”) and the “Exclusive Provider Network Expanded” (“EPNX”).

A Benefit may be paid under the Plan for a Covered Health Service received from a provider that is not part of the EPN or EPNX for Emergency Care Service and for a service received outside the EPNX with the prior, written approval of the Plan Administrator’s Medical Management Team.

Exclusive Provider Network (EPN) Providers

The “Exclusive Provider Network” comprises Physicians who practice in the Network Area (that is, Bastrop, Bell, Burnet, Caldwell, Fayette, Hays, Lee, Llano, Travis, and Williamson counties in Texas) and participate in the EPN. A searchable Provider Directory is available online under the Provider Search tab on the Seton Health Plan website, www.setonhealthplan.com.

A Physician’s or other provider’s status as a participant in the EPN may change over time. To obtain, free of charge, a list of EPN Physicians and other Providers or to verify a provider’s status visit

the Provider Directory at www.setonhealthplan.com or call the customer service number provided on the back of your insurance ID card.

The EPN is designed to provide incentives to employees that utilize contracted Providers to provide members favorable pricing for certain Covered Health Services.

A member may be eligible to receive a Benefit under the Plan at the EPN level only if the member receives a Covered Health Service from a Physician or other Plan Provider that participates in the EPN. For facility services, these are Benefits for Covered Health Services that are provided at an EPN facility under the direction of a Physician or other provider that participates in and is a member of the EPN (but not a non-EPN provider). EPN Benefits include Physician services provided in an EPN facility by an anesthesiologist, emergency room Physician, consulting Physician, pathologist or radiologist only if that provider participates in and is a member of the EPN.

When you receive Covered Health Services from an EPN provider, you may pay less than you would if you receive the same care from an EPNX provider. Therefore, in most instances, your out-of-pocket expenses will be less if you use an EPN provider.

Emergency Care Services

A member may obtain Emergency Care services from any Physician or other health care professional. A member is not required to obtain Emergency Care services from a provider that participates in either the EPN or the EPNX in order to obtain a Benefit under the Plan for Emergency Care services.

Emergency Care services are described in Exhibit B. Please note that Emergency Care services do not include Urgent Care Services, which are described in Section 8. The Pre-Certification chart in Exhibit A identifies emergent services as well as services requiring Pre-certification.

Exclusive Provider Network Expanded (EPNX) Providers

A member is eligible to receive a Benefit under the Plan at the EPNX level if the member receives a Covered Health Service from a health care Provider that is not a Network Provider.

A member in the EPNX will generally pay a higher Premium Contribution and may pay a deductible due to the higher cost of providing a wider choice of Providers. In addition, members may be required to

satisfy a deductible prior to benefit payment. A member's cost will vary depending on whether Covered Health Services are provided by a Network Provider or a Provider who is not a Network Provider. The EPNX is designed for members who need the extra flexibility of contracted Providers outside of the EPN and/or outside the Network Area of Central Texas.

Out-of-Network Providers

Generally, a member in the EPN is not eligible to receive any Benefit under the Plan for any medical care, treatment, service or supply provided by a Physician or other health care professionals or provider if that Physician, professional or other provider is not part of the EPN. Exceptions for Emergency Care service are provided above and in Exhibits A and B. A limited exception for medical care, treatment, service or supply exists when that the Plan Administrator's Medical Management Team approves in writing as Medically Necessary and the Administrator approves and confirms in writing which Pre-certifies a member to receive services from a Physician or other health care professionals or provider that is not part of the EPN or the EPNX.

Qualifying Covered Health Service Obtained Outside the EPNX

A member who is enrolled in the EPNX is eligible to receive a Benefit under the Plan at the EPNX level if the Provider on behalf of and at the request of the member first obtains approval from the Plan Administrator's Medical Management Team and prior written approval and confirmation from the Administrator to receive a Covered Health Service at a health care facility or from a health care provider that does not participate in either the EPN or the EPNX.

A member must call the customer service number on the back of their membership card to obtain Pre-certification for medical care, treatment, service or supply, at the EPNX level, through contracted providers. Pre-certification from the Plan Administrator must be obtained before a member obtains the medical care, treatment, service or supply. Failure to obtain Pre-certification from the Plan Administrator's Medical Management Team for any medical care, treatment, service or supply from a provider may result in all claims with respect to such service being denied and nonpayment of the claims, other than claims for Emergency Care.

Members receiving Pre-certified care outside the Network Area by the Plan Administrator's Medical

Management Team are required to cooperate with the Medical Management Team.

Eligible Expenses

For EPNX members, the Plan will not pay certain Covered Health Services until the Annual Deductible has been met. For additional information, please see Exhibit D, the 2012 Associate Medical Comparison Chart. The Plan Administrator has the discretion and authority to decide whether any medical care, treatment, service or supply is a Covered Health Service and how the Eligible Expenses will be determined and otherwise covered under the Plan.

Annual Deductible

There is no annual deductible for EPN. For EPNX members, the "Annual Deductible" is the amount of Eligible Expenses you must pay each Plan Year for Covered Health Services before you are eligible to begin receiving Benefits. The amounts you pay toward each of your Annual Deductibles accumulate over the course of the Plan Year. Please remember that amounts you pay toward Annual Deductible do not accumulate for purposes of the following year's Annual Deductible.

Co-payment

A Co-payment (also referred to as a Co-pay) is the amount a member must pay each time the member receives certain Covered Health Services. The Co-payment is a flat dollar amount and is paid at the time of service or when billed by the provider. For EPN and EPNX members, only Inpatient Co-payments are applied toward the Inpatient Out-of-Pocket Maximum. For EPNX members, Co-payments do not count toward the Annual Deductible. If the Eligible Expense is less than the Co-payment, a member is only responsible for paying the Eligible Expense.

Coinsurance

Coinsurance is the percentage of Eligible Expenses that a member is responsible for paying. Coinsurance is a fixed percentage that applies to certain Covered Health Services after the member meets the Annual Deductible and applies only to the EPNX

Out-of-Pocket Maximum

An annual Inpatient Out-of-Pocket Maximum is a limit on the amount a person must generally pay for Inpatient Covered Health Services during a Plan Year. There are Inpatient Out-of-Pocket Maximums for both the EPN and EPNX plans.

If your eligible EPN and EPNX Inpatient hospital Co-payments in a Plan Year exceeds the respective annual Inpatient Out-of-Pocket Maximum, the Plan pays 100% of Eligible Expenses for Covered Health Services that are incurred after you reach that maximum through the end of the Plan Year. An EPNX member's coinsurance payment also applies to the Inpatient Out-of-Pocket Maximum. Inpatient Out-of-Pocket maximums do not include deductibles.

Please see Exhibit D, the 2012 Associate Medical Comparison Chart, for information regarding the Inpatient Out-of-Pocket Maximums.

Lifetime Maximum Benefit

A Lifetime Maximum Benefit is the maximum, aggregate amount of benefits that a medical plan will pay with respect to a Plan Participant. The Plan does not currently impose such a limit.

Section 6: COBRA Continuation Coverage

Introduction

As a Participant in the Plan you are entitled to certain rights under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"). Under COBRA Seton Healthcare must offer you and your qualifying family members the opportunity to temporarily extend medical coverage under the Plan, at group rates, in certain instances where that coverage would otherwise end (called "COBRA coverage"). **Legally Domiciled Beneficiaries (LDB's) are not entitled to COBRA continuation coverage under any circumstances.** Seton Healthcare has delegated to Ceridian Benefits Services ("Ceridian") the administration of COBRA coverage under the Plan. Your rights and obligations under COBRA are briefly summarized in this section.

COBRA coverage can become available to you, your Spouse and children who are covered under the Plan when you or your family member would otherwise lose group health coverage under the Plan. COBRA coverage is a temporary continuation of group health plan coverage when coverage would otherwise end because of a life event described below, referred to as a "COBRA qualifying event". To qualify to elect COBRA coverage, an individual must be covered under a group health plan on the day prior to a COBRA qualifying event; otherwise, the individual has no rights to elect COBRA coverage.

The information provided below summarizes your and your covered Spouse and children right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This**

information generally explains COBRA continuation coverage available under the Plan, when it may become available to you and your family, and what you need to do to protect the right to receive it.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed later in this Section. After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” An LBD is not a qualified beneficiary for purposes of COBRA. You, your Spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an Eligible Employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment or service are reduced, or
- Your employment or service ends for any reason other than your gross misconduct.

If you are the qualifying Spouse of an Eligible Employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your Spouse dies;
- Your Spouse's hours of employment or service are reduced;
- Your Spouse's employment or service ends for any reason other than his or her gross misconduct;
- Your Spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your Spouse.

Your covered children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

- The parent Eligible Employee dies;
- The parent Eligible Employee's hours of employment or service are reduced;

- The parent Eligible Employee's employment or service ends for any reason other than his or her gross misconduct;
- The parent Eligible Employee becomes entitled to Medicare benefits (under Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a Dependent.

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after Ceridian has been notified by Seton Healthcare (which notification must be made within 30 days of the event) that one of the following qualifying events has occurred:

- the end of employment or service;
- reduction of hours of employment or service,
- death of the Eligible Employee,
- commencement of a proceeding in bankruptcy with respect to Seton Healthcare, and
- or the Eligible Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

A Member Must Give Notice of Some Qualifying Events

For the other qualifying events, you must notify Ceridian no later than 60 days after the qualifying event occurs. These events are:

- divorce or legal separation of the Eligible Employee and Spouse; or
- a covered child's losing eligibility for coverage as a Dependent.

The notice must be in writing and must be signed and dated by the individual submitting the notice or by a parent or other authorized representative if the notice is submitted on behalf of a child. If the notice is being provided with respect to a divorce or legal separation, a copy of the divorce decree, legal separation order or similar court order, decree or document issued in connection with the divorce or legal separation must be provided along with the notice. The notice must be sent by first-class mail to the following address:

ATTN: Ceridian Benefits Services
3201 34th Street South
St. Petersburg, FL 33711-4099

The notice must be post-marked no later than the deadline for that notice set forth above. If you or your covered dependents fail to notify Ceridian of these events within the 60 day period, Seton Healthcare is not obligated to provide continued coverage to the affected qualified beneficiary.

If you have any questions about these requirements you can contact Ceridian by telephone at 1-800-877-7994 or by logging into Ceridian's website at www.ceridian-benefits.com. Ceridian's Interactive Voice Response system is available 24 hours a day, seven days a week. Ceridian's Customer Service Representatives are available from 8:00 a.m. to 8:00 p.m., Eastern time, Monday through Friday (other than national holidays).

How is COBRA Coverage Provided?

Once Ceridian receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered Eligible Employees may elect COBRA continuation coverage on behalf of their Spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the Eligible Employee, the Eligible Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a Dependent child losing eligibility as a Dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or service or reduction of the Eligible Employee's hours of employment or service, and the Eligible Employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the Eligible Employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered Eligible Employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his Spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or service or reduction of the Eligible Employee's hours of employment or service, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways

in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify Ceridian in a timely fashion, you and your qualifying Spouse and Dependent children may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18 month period of continuation coverage. You must provide notice of the disability to Ceridian before the end of the initial 18-month COBRA period. The notice must be in writing and must be signed and dated by the individual submitting the notice or by a parent or other authorized representative if the notice is submitted on behalf of a child. If the notice is being provided with respect to a determination by the Social Security Administration that a person is disabled, a copy of the determination notice issued by the Social Security Administration and any related documents must be provided along with the notice. The notice must be sent by first-class mail to the following address:

ATTN: Ceridian Benefits Services
3201 34th Street South
St. Petersburg, FL 33711-4099

The notice must be post-marked no later than the deadline for that notice set forth above. If you or your covered dependents fail to notify Ceridian of these events as provided above, Seton Healthcare is not obligated to provide additional continued coverage to the affected qualified beneficiary.

If you have any questions about these requirements you can contact Ceridian by telephone at 1-800-877-7994 or by logging into Ceridian's website at www.ceridian-benefits.com. Ceridian's Interactive Voice Response system is available 24 hours a day, seven days a week. Ceridian's Customer Service Representatives are available from 8:00 a.m. to 8:00 p.m., Eastern time, Monday through Friday (other than national holidays).

If you, your Spouse or Dependent child recovers from the disability and is determined by the Social Security Administration to no longer be disabled – you, your Spouse or Dependent child must notify Ceridian no later than 30 days after the date of the

determination. The notice must be in writing and must be signed and dated by the individual submitting the notice or by a parent or other authorized representative if the notice is submitted on behalf of a child. A copy of the determination notice issued by the Social Security Administration and any related documents must be provided along with the notice. The notice must be sent by first-class mail to the following address:

ATTN: Ceridian Benefits Services
3201 34th Street South
St. Petersburg, FL 33711-4099

The notice must be post-marked no later than the deadline for that notice set forth above. If you have any questions about these requirements you can contact Ceridian by telephone at 1-800-877-7994 or by logging into Ceridian's website at www.ceridian-benefits.com. Ceridian's Interactive Voice Response system is available 24 hours a day, seven days a week. Ceridian's Customer Service Representatives are available from 8:00 a.m. to 8:00 p.m., Eastern time, Monday through Friday (other than national holidays).

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, your Spouse and dependent children can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the Spouse and any dependent children receiving continuation coverage if the Eligible Employee or former Eligible Employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the Dependent child stops being eligible under the Plan as a Dependent child, but only if the event would have caused the Spouse or Dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If the notice is being provided with respect to a divorce or legal separation or a Dependent child's losing eligibility for coverage as a Dependent child, you must provide notice of that event as described above under "**A Member Must Give Notice of Some Qualifying Events**", of this Section 6. If you have any questions about the notice requirements for a second qualifying event you can contact Ceridian by telephone at 1-800-877-7994 or by logging into Ceridian's website at www.ceridian-benefits.com.

Ceridian's Interactive Voice Response system is available 24 hours a day, seven days a week. Ceridian's Customer Service Representatives are available from 8:00 a.m. to 8:00 p.m., Eastern time, Monday through Friday (other than national holidays).

Special Rules For FMLA Leave

Taking a leave under the Family and Medical Leave Act ("**FMLA**") is not a qualifying event under COBRA. However, a COBRA qualifying event will occur on the last day of the FMLA leave if:

- you are covered under the Plan on the day before your first day of FMLA leave; and
- you do not return to work with a Participating Employer when your FMLA leave ends; and
- in the absence of COBRA coverage, you would lose coverage under the Plan before the end of the maximum COBRA coverage period after your last day of FMLA leave.

If the above requirements are met, COBRA coverage for you would continue for up to 18 months from the last day of your FMLA leave. If you were covered under the Plan on the day before your FMLA leave but your coverage under the Plan lapses during your FMLA leave (for example, because you fail to pay your premiums) you will still be entitled to COBRA coverage if the three requirements listed above are satisfied.

If the above requirements are satisfied, your Spouse and your Dependent children will also be entitled to COBRA coverage if they were covered under the Plan on the day before the first day of your FMLA leave or they become covered under the Plan during your FMLA leave, and, in the absence of COBRA coverage, they would lose coverage under the Plan before the date that is 18 months after the last day of your FMLA leave.

Type of Coverage Available under COBRA

Continuation of coverage under the Plan that is available under COBRA is the same coverage that the person who is entitled to elect COBRA continuation coverage had on the day before the COBRA qualifying event. If coverage under the Plan is modified for any group of similarly situated persons covered under the Plan with respect to whom a COBRA qualifying event has not occurred, the COBRA coverage will also be modified in the same manner. During open enrollment periods, as long as you are entitled to COBRA coverage, you will have the same open enrollment period rights that similarly

situated active eligible employees have to add or eliminate coverage of family members.

If you terminate your employment with a Participating Employer and elect to continue your coverage under the Plan under COBRA at a time when you are entitled to Medicare coverage, Medicare will provide your primary coverage and the Plan will provide secondary coverage only, as allowed by applicable law.

How much does COBRA continuation coverage cost?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of continuation coverage due to a disability, 150 percent) of the cost to Seton Healthcare (including both employer and Eligible Employee contributions) for coverage of a similarly situated Plan Participant or beneficiary who is not receiving continuation coverage.

Timeline for Coverage Elections and Payments

Upon notification of a qualifying event Ceridian will mail to you, at the address Seton Healthcare then has on file for you, a notification of your right to elect COBRA coverage and the applicable election/enrollment forms for you to complete and return. The notification will give you detailed instructions for electing COBRA coverage and advise you of the monthly cost. You will have up to 60 days from the date your notification is mailed (determined by the postmark date) or 60 days from the date your coverage ends to elect COBRA coverage, whichever is later. You may make your election in one of three ways: (1) mail or send by fax to Ceridian a paper election form, (2) call Ceridian at 1-800-877-7994 and use Ceridian's Interactive Voice Response system to make your election or (3) log on to Ceridian's website at www.ceridian-benefits.com and access your account online to submit an election online (you will be provided the login information for your account as part of the COBRA election/enrollment forms package sent by Ceridian). From the date of your election (determined by the postmark date if the election is mailed, the date your fax is received if the election is sent by fax, the date you call Ceridian if you use Ceridian's Interactive Voice Response system or the date you submit your election through Ceridian's website) you will then have an additional 45 days to pay the cost of your COBRA coverage, retroactive to the date your Plan coverage ended.

After you make your first payment for continuation coverage, you will be required to pay for continuation coverage on a monthly basis for each subsequent month of coverage. You will pay your applicable coverage premiums on an after-tax basis. Under the Plan, these monthly periodic payments for continuation coverage are due on the first day of each month. If you make a periodic payment on or before its due date, your coverage under the Plan will continue for that coverage period without any break. Ceridian will mail an invoice on or about the 19th of each month for the following month's COBRA continuation coverage premium; however, it is your responsibility to make these payments in a timely manner irrespective of whether you receive the invoice. Periodic payments for continuation coverage should be made payable to Seton Healthcare and sent by mail to:

Ceridian Benefit Services
P.O. Box 534004
St. Petersburg, FL 33747

Please include your COBRA system ID on your check when remitting payment to ensure that your payment is correctly applied. Your COBRA system ID is provided on your invoice.

When you are a Participant under COBRA, you have the right to change your coverage election:

- During Open Enrollment Periods; and
- Following a change in family status, as described in Section 2.

You are solely responsible for ensuring that your continuation coverage payment is properly delivered to Ceridian. If Ceridian does not receive your continuation coverage payment you must be able to prove you timely mailed that payment or your continuation coverage will terminate. Your payment must be received before the first of the month to allow time for processing. Otherwise, your coverage will be suspended until your payment is received and processed. **Remember, payments received beyond the 30-day grace period described below will not be accepted and your coverage will terminate.**

Grace Periods For Periodic Payments

Although periodic payments are due on the first day of each month, you will be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment.

However, if you pay a periodic payment later than its due date but during its grace period, your continuation coverage under the Plan will be suspended as of the due date and then retroactively reinstated (going back to the due date) when the periodic payment is received. This means that any claim you submit (or that is submitted for you by a health care provider) for Benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated. If you fail to make a periodic payment before the end of the grace period for that coverage period, you will lose all rights to continuation coverage under the Plan.

Your first payment and all periodic payments for continuation coverage should be made payable to Seton Healthcare and sent mail to:

Ceridian Benefit Services
P.O. Box 534099
St. Petersburg, FL 33747

When Continuation Coverage Ends

Continuation coverage will be terminated before the end of the maximum period if any required premium is not paid in full on time, if a qualified beneficiary becomes covered, after electing COBRA continuation coverage, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary, if a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing COBRA continuation coverage, or if Seton Healthcare and its controlled group members cease to provide any group health plan for its employees. Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a Participant or beneficiary not receiving continuation coverage (such as fraud or intentional misrepresentation of material fact).

If You Have Questions

Questions concerning the Plan or your COBRA continuation coverage rights should be addressed in writing to

Ceridian Benefit Services
P.O. Box 534099
St. Petersburg, FL 33747

You may also contact Ceridian by telephone at 1-800-877-7994 or by logging into Ceridian's website at www.ceridian-benefits.com. Ceridian's Interactive Voice Response system is available 24 hours a day, seven days a week. Ceridian's Customer Service

Representatives are available from 8:00 a.m. to 8:00 p.m., Eastern time, Monday through Friday (other than national holidays).

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator and Ceridian informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Ceridian, the Plan Administrator or Seton Healthcare.

Section 7: Other Plan Provisions

The Plan Sponsor and the Plan believe the Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the "Affordable Care Act"). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Sponsor by mail at Seton Healthcare, 1345 Philomena Street, Austin, Texas 78723, or by telephone at (512) 324-1776.

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Privacy Practices

Your health information is highly personal, and the Plan is committed to safeguarding your privacy. For more information about how the Plan protects your privacy and its right to use and disclose your protected health information ("PHI"), refer to the Plan's Notice of Privacy Practices ("Notice"). The Notice also explains how you may (i) access and amend your PHI, (ii) request an accounting of disclosures of your PHI, (iii) request restrictions on disclosures of your PHI, and (iv) request confidential

communications of your PHI. Your Employer has previously provided you with a copy of the Notice. The Plan is required by the Health Insurance Portability and Accountability Act of 1996 to periodically advise you of the availability of the Notice adopted by the Plan and how to obtain a copy. If you would like another copy of the Notice, contact the Plan Sponsor by mail at Seton Healthcare, 1345 Philomena Street, Austin, Texas 78723, or by telephone at (512) 324-1776.

Maternity-Related Benefits

Under federal law, the Plan generally may not restrict benefits (or fail to provide reimbursement) for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's provider after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, if applicable). In any case, the Plan may not, under federal law, require that a Provider obtain Pre-certification from the Plan for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Mental Health Benefits

All benefits available under the Plan that are subject to the equal benefits requirements of the Mental Health Parity Act of 1996 and the Mental Health Parity and Addiction Equity Act of 2008, will be administered in accordance with the Act and any related regulations.

Breast Cancer Coverage

Under the Women's Health and Cancer Rights Act of 1998, the following notice must be provided to Participants. In the case of a Participant or Dependent who is receiving benefits under the Plan in connection with a mastectomy and elects breast reconstruction, coverage under the participating medical plan will be provided in a manner determined in consultation with the attending physician and the patient for the following:

- reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

Co-payments and Deductibles may still apply, but such co-payments and Deductibles must be consistent with those established for other medical benefits under the Plan.

Family and Medical Leave

In accordance with the Family and Medical Leave Act of 1993 ("FMLA"), you may continue your coverage under the Plan during a family or medical leave of absence, provided that you make arrangements with your Employer to pay your Plan Contributions during your leave or after you return to active employment with your Employer, as described below in the Continuation of Participation During Leave of Absence subsection.

Alternatively, you may discontinue coverage during your leave. When you return to work with your Employer following your leave, you may resume participation in the Plan. Your coverage will be effective the first day of the month following your return from leave, unless otherwise provided under a benefit option.

Qualified Military Leave

During an authorized leave due to qualified military service under the Uniformed Services Employment and Reemployment Rights Act ("USERRA"), you will be able to continue to participate in the Plan during your military leave in accordance with USERRA. If your military service does not exceed 31 days, you will continue to be covered by the Plan as a regular, active employee. If your military leave exceeds 31 days, you and your dependents will be entitled to continue coverage under the Plan during your leave for a period not exceeding 24 months from the date on which your absence began, or, if earlier the day after the date on which you fail to return to employment as required by USERRA or you lose your USERRA rights. If you return as an active employee after your military service, you and your dependents coverage will be immediately reinstated if you were covered under the Plan on the day before your military leave and your total leave did not exceed 5 years. Your period of coverage during an approved military leave will count against any COBRA continuation coverage. You must make arrangements with your Employer to pay your Contributions during your leave or after you return to active employment with your Employer.

Alternatively, you may discontinue coverage during your leave. When you return to work with your Employer following your leave, you may resume participation in the Plan. Your coverage will be

effective the first day of the month following your return from leave, unless otherwise provided under a benefit option.

Continuation of Participation During Leave of Absence

Your right to maintain coverage under the Plan (other than COBRA continuation coverage) while you are on a leave of absence, including leave under FMLA, is conditioned on your (i) continuing to have an employment relationship with an Employer, (ii) remaining eligible to participate in the Plan, and (iii) making the required Contributions, as provided below.

If you are on a paid leave of absence (including leave under FMLA), your Contributions will continue to be deducted from your paychecks. Any balance that is not covered by paid leave will be deducted from your first paycheck when you return, or in accordance with a payment schedule that you and your Employer agree on within 10 days after you return from leave.

If you take an unpaid leave of absence under FMLA but continue to participate in the Plan, your Contribution deductions will be suspended. When you return to work with your Employer, the amount of Contributions that would have been withheld from your paycheck if you had been paid during your leave will be deducted from your first paycheck, or in accordance with a payment schedule that you and your Employer agree on within 10 days after you return from leave. If you do not return to work with the Employer, you will be billed for such Contributions.

If you do not return to work with an Employer following a leave of absence, you may be eligible for COBRA continuation coverage.

Qualified Medical Child Support Orders

If you become divorced or separated, a state agency or court may issue a qualified medical child support order (“QMCSO”) that would require you to provide health coverage for your Dependent children (called “alternate recipients” under the order). As soon as you are aware of any court proceedings that may require you to provide health coverage to an alternate recipient, you should contact the Plan Sponsor.

After the Plan Sponsor receives a medical child support order, the Plan Sponsor will notify you, each of the alternate recipients, and the alternate recipients’ designated representatives (if any) of the order. When the Plan Sponsor receives notice of a medical child support order that may apply to your

benefits, the Plan Sponsor will provide you with a more detailed description of the medical child support order procedures. You may request, at any time and free of charge, a copy of the Plan’s procedures for determining whether a medical child support order is qualified by contacting the Plan Sponsor by mail at Seton Healthcare, 1345 Philomena Street, Austin, Texas 78723, or by telephone at (512) 324-1776.

Certificate of Creditable Coverage

The Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), among other things, protects workers who lose health coverage by providing better access to other group health plan coverage. Some employer group health plans do not cover pre-existing conditions, and HIPAA limits the time period of these restrictions so that most plans must cover an individual’s pre-existing conditions after 12 months. Under HIPAA, if you change jobs, a new employer’s plan will be required to give you credit for the length of time that you had continuous health coverage thereby reducing the 12-month exclusion period. If at the time you change jobs, you have had 12 months of continuous health coverage (without a break in coverage of 63 days or more); you will not have to start over with a new 12-month exclusion for any pre-existing conditions.

A new plan generally receives information about an individual’s creditable coverage from a certificate furnished by a prior plan or issuer, referred to as a “Certificate of Creditable Coverage” (if you do not have a Certificate of Creditable Coverage, you may present other evidence of creditable coverage).

HIPAA requires the Plan Sponsor to track and report your and your covered family members’ periods of Creditable Coverage under the Plan, including continuation of coverage under COBRA.

If you lose coverage under the Plan or become entitled to elect COBRA continuation coverage or your COBRA continuation coverage ceases, the Plan will automatically provide a Certificate of Creditable Coverage to you. If you make a request, the Plan will furnish a Certificate of Creditable Coverage to you before your coverage ceases or within 24 months of your losing coverage.

If you would like to request a Certificate of Creditable Coverage, contact the Plan Sponsor at (512) 421-5667 or toll-free at (866) 272-2507.

Use of Genetic Information

The Genetic Information Nondiscrimination Act of 2008 (“*GINA*”) generally prohibits group health plans such as the Plan from using the genetic information of Plan Participants to discriminate in providing coverage or benefits. The Plan is administered by the Plan Sponsor and the Plan Administrator to comply with the applicable requirements of *GINA*.

Keeping Your Health Information Private and Secure

Under the federal regulations of HIPAA, the Plan is required to secure and protect the confidentiality of a Participant’s private health information. The Plan, and the Plan Sponsor, will not use or disclose health information protected by HIPAA, except when such use or disclosure is necessary for treatment, payment, group health plan operations (collectively known as “*TPO*”), or as permitted or required by other state and federal law. All of the Plan’s business associates (organizations who have a contract with the Plan Sponsor to provide certain services, such as legal, actuarial, accounting, consulting, and data aggregation of financial circumstances) must also observe HIPAA’s privacy rules. Furthermore, the Plan will not use or disclose protected health information for employment-related actions and decisions (or in connection with any other Plan Sponsor employee benefit plan), unless it has obtained your written authorization for such use and disclosure.

Protected Health Information (“*PHI*”) is “individually identifiable” health information related to your physical or mental health or condition, services provided to you, or payments made for your care, which is created or received by a group health plan, a health care clearinghouse, or a health care provider and that is transmitted by electronic media or maintained in an electronic format, or transmitted or maintained in any other form or medium. Under HIPAA, a Participant has rights with respect to his or her protected health information, including:

- **Access:** A Participant has the right to inspect and receive a copy of his or her Protected Health Information, with limited exception (*e.g.*, psychotherapy notes).
- **Disclosure Accounting:** A Participant has the right to request an accounting of certain disclosures made by the Plan Sponsor or the Plan (however, a Participant is not entitled to an accounting of disclosures made for payment,

treatment or health care operations, or disclosures the Participant authorized in writing).

- **Restriction:** A Participant has the right to ask the Plan Sponsor and the Plan Administrator to restrict how the Participant’s Protected Health Information is used and disclosed for treatment, payment, and health care operations. A Participant may also ask the Plan Sponsor or the Plan Administrator to restrict disclosures to the Participant’s family members, relatives, friends, or other persons the Participant identifies who are involved in the Participant’s care or payment for the Participant’s care. The Plan Sponsor and the Plan Administrator are not, however, required to agree to such requests.
- **Confidential Communications:** A Participant has the right to request that the Participant receive his or her Protected Health Information by alternative means or at an alternative location if the Participant reasonably believes that other disclosure could pose a danger to the Participant. For example, a Participant may only want to have information sent by mail or to a work address.
- **Amendment:** A Participant has the right to amend or correct inaccurate Protected Health Information. A request for amendment may be denied in certain circumstances (*e.g.* if the Protected Health Information is accurate and correct as it is).
- **Right to a Paper Copy of the Notice:** If you agree to receive notice of your rights under HIPAA electronically, you have the right to request and obtain a paper copy of those rights from the Plan Sponsor or the Plan Administrator.

If a Participant believes that his or her rights under HIPAA have been violated, the Participant has the right to file a complaint with the Plan Administrator or with the Secretary of the U.S. Department of Health and Human Services. If a Participant wishes to file a HIPAA complaint with the Plan, please contact:

Privacy Officer – Employee Health Plan
Seton Healthcare
1345 Philomena Street
Austin, Texas 78723

The Plan maintains a privacy notice (*i.e.*, notice of privacy practices), which provides a complete description of a Participant’s rights under HIPAA’s privacy rules. If you would like a copy contact the

Plan Administrator at Seton Healthcare, 1345 Philomena Street, Austin, Texas 78723, or by telephone at (512)324-1776 or the Privacy Officer to obtain the privacy notice.

If you have questions about the privacy of your health information, please contact the Plan Sponsor's Privacy Officer.

The Plan and the Plan Sponsor are separate and independent entities, who must exchange information to coordinate a Participant's Plan coverage. For the purpose of obtaining summary health information from vendors and to report summary health information to the Plan Sponsor, the Plan will share data such as claim reports with a listing of diagnosis and treatment (no individual employee information is included in this kind of report) with the Plan Sponsor. PHI will only be shared with the Plan Sponsor if the Plan Sponsor has certified that it will:

- Not further use or disclose PHI other than as permitted, as required by the Plan documents, or as required by law;
- Ensure that anyone or any organization to which the Plan Sponsor provides PHI agrees to the same restrictions and conditions that apply to the Plan Sponsor;
- Not further use or disclose PHI for employment actions or decisions;
- Not further use or disclose PHI in connection with any the Plan Sponsor benefits;
- Report to the Plan any PHI use or disclosure that has not met HIPAA requirements;
- Make PHI available to an individual according to HIPAA's access requirements;
- Make PHI available for amendment, and incorporate amendments according to HIPAA's privacy rules;
- Make available any information required for an accounting of disclosures;
- Make available to the U.S. Department of Health and Human Services the Plan Sponsor's internal practices, books, and records relating to the use and disclosure of PHI from the Plan Sponsor to determine the Plan's compliance with HIPAA;

- Return or destroy PHI received from the Plan for the purposes for which the disclosure was made when no longer needed; and
- Ensure an adequate separation between the Plan and the Plan Sponsor and ensure such separation is supported by reasonable and appropriate security measures.

The Plan Sponsor has implemented administrative, physical and technical safeguards that reasonably and appropriately promote the confidentiality, integrity, and availability of electronic PHI that it creates, receives, maintains or transmits on behalf of the Plan and will report any security incident (as defined under HIPAA) that the Plan Sponsor becomes aware of to the Privacy Officer. The Plan sponsor will ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides electronic PHI which it received from the Plan agrees to implement reasonable and appropriate security measures to protect the information and shall comply with HIPAA's security breach notification requirements.

Termination of Coverage

Once an individual is enrolled and covered under the Plan the coverage of such individual under the Plan may not be rescinded retroactively unless (a) such individual was enrolled in the Plan either (1) as a result of an act, practice or omission by the individual (or other person who enrolled the individual in the Plan) that constitutes fraud or (2) as a result of an intentional misrepresentation of a material fact made by such individual, and (b) at least 30 days advance written notice is provided to each Participant who would be affected by recession of such individual's coverage.

Assignment of Benefits

No assignment of any kind will bind the Plan Sponsor without its written consent, except as otherwise required by law.

Facility of Payment

If a Participant is receiving benefits under the Plan and the Plan Sponsor determines that the Participant is not legally able to give a valid receipt and discharge of payment, the Plan Sponsor may pay the benefits to the Participant's legal representative.

Subrogation/Lien/Assignment/Reimbursement

If the Plan pays or provides medical benefits for an illness or injury that was caused by an act or omission of any person or organization, the Plan will

be **subrogated** to all rights of recovery of a Plan Participant, to the extent of such benefits provided or the reasonable value of services or benefits provided by the Plan. The Plan, once it has provided any benefits, is granted a **lien** on the proceeds of any payment, settlement, judgment, or other remuneration received by the Plan Participant from any of the sources identified herein, including but not limited to:

- a third party or any insurance company on behalf of a third party, including but not limited to premises, homeowners, professional, DRAM shop, or any other applicable liability or excess or insurance policy;
- underinsured/uninsured automobile insurance coverage regardless of the source;
- no fault insurance coverage, such as personal injury or medical payments protection regardless of the source;
- any award, settlement or benefit paid under any worker's compensation of law claim or award;
- any indemnity agreement or contract;
- any other payment designated, delineated, earmarked or intended to be paid to a Plan Participant as compensation, restitution, remuneration from injuries sustained or illness suffered as a result of the negligence or liability, including contractual, of any individual or entity;
- any source that reimburses, arranges, or pays for the cost of care.

Assignment

Upon being provided any benefits from the Plan, a Plan Participant is considered to have **assigned** his or her rights of recovery from any source including those listed herein to the Plan to the extent of the reasonable value of services as determined by the Plan or benefits provided by the Plan

Reimbursement

The Plan, by providing benefits, acquires the right to be reimbursed for the reasonable value of services or benefits provided to a Plan Participant, and this right is independent and separate and apart from the **subrogation**, **lien** and/or **assignment** rights acquired by the Plan and set forth herein.

The Plan is also entitled to recover from Plan Participant the value of services provided, arranged, or paid for, when Plan Participant was reimbursed for the cost of care by another party.

If a Plan Participant does not reimburse the Plan from any settlement, judgment, insurance proceeds or other source of payment, the Plan is entitled to reduce

current or future medical or expense benefits payable to or on behalf of a Plan Participant until the Plan has been fully reimbursed.

Plan's Actions

The Plan in furtherance of its rights obtained may:

- place a lien against a responsible party or insurance company to the extent benefits have been paid;
- bring an action on its own behalf, or on the Plan Participant's behalf, against the person, entity or insurance company;
- cease paying the Plan Participant's benefits until the Plan Participant provides the Plan Sponsor with the documents necessary for the Plan to exercise its rights and privileges; and
- the Plan may take any further action it deems necessary to protect its interest.

Obligations of the Plan Participant to the Plan

If a Plan Participant receives services or benefits under the Plan, the Plan Participant must immediately notify the Plan Sponsor of the name of any individual or entity against whom the Plan Participant might have a claim as a result of illness or injury (including any insurance company that provides coverage for any party to the claim) regardless of whether or not the Plan Participant intends to make a claim. For example, if a Plan Participant is injured in an automobile accident and the person who hit the Plan Participant was at fault, the person who hit the Plan Participant is a person whose act or omission has caused the Plan Participant's illness or injury.

A Plan Participant must also notify any third-party and any other individual or entity acting on behalf of the third-party of the Plan's rights of subrogation, lien, reimbursement and assignment.

A Plan Participant must cooperate with the Plan to provide information about the Plan Participant's illness or injury including, but not limited to providing information about all anticipated future treatment related to the subject injury or illness.

The Plan Participant authorizes the Plan and The Bratton Firm, to pursue, sue, compromise and/or settle any claims described herein, including but not limited to, subrogation, lien, assignment and reimbursement claims in the name of the Plan Participant and/or Plan. The Plan Participant agrees to fully cooperate with the Plan in the prosecution of such a claim. The Plan Participant agrees and fully authorizes the Plan and the Bratton Firm to obtain

and share medical information on the Plan Participant necessary to investigate, pursue, sue, compromise and/or settle the above-described claims. The Plan and The Bratton Firm specifically are granted by the Plan Participant the authorization to share this information with those individuals or entities responsible for reimbursing the Plan through claims of subrogation, lien, assignment or reimbursement in an effort to recoup those funds outlaid by the Plan related to the incident in question. This authorization includes, but is not be limited to, granting to the Plan and The Bratton Firm the right to discuss the Plan Participant's medical care and treatment and the cost of same with third and first-party insurance carriers responsible for the incident in question. Should a written medical authorization be required for the Plan to investigate, pursue, sue, compromise, prosecute and/or settle the above-described claims, the Plan Participant agrees to sign such medical authorization or any other necessary documents needed to protect the Plan's interests.

Additionally, should litigation ensue, the Plan Participant agrees to and is obligated to cooperate with the Plan and/or any and all representatives of the Plan, including subrogation counsel, in completing discovery, obtaining depositions and/or attending and/or cooperating in trial in order to effect the plans subrogation, assignment or reimbursement rights.

The Plan Participant agrees to obtain consent of the Plan before settling any claim or suit or releasing any party from liability for the payment of medical expenses resulting from an injury or illness. The Plan Participant also agrees to refrain from taking any action or making any statement to prejudice the Plan's recovery rights under these provisions.

Furthermore, it is prohibited for Plan Participant to settle a claim against a third party for elements of damages, by eliminating damages relating to medical expenses incurred. It is prohibited for a Plan Participant to waive a claim for medical expenses incurred by Plan Participants who are minors.

To the extent that a Plan Participant makes a claim individually or by or through an attorney for an injury or illness for which benefits were provided by the Plan, the Plan Participant agrees to keep the plan updated with the investigation and prosecution of said claim, including, but not limited to providing all correspondence transmitted by and between any potential defendant or source of payment; all demands for payment; all offers of compromise; accident/incident reports or investigation by any source; name, address, and telephone number of any

insurance adjuster involved in investigating the claim; and copies of all documents exchanged in litigation should a suit be filed.

Nothing in these provisions requires the Plan to pursue the Plan Participant's claim against any party for damages or claims or causes of action that the Plan Participant might have against such party as a result of injury or illness.

The Plan may designate a person, agency or organization to act for it in matters related to the Plan's rights described herein, and the Plan Participant agrees to cooperate with such designated person, agency, or organization the same as if dealing with the Plan itself.

Made Whole Doctrine

The Plan's right of subrogation, lien, assignment or reimbursement as set forth herein will not be affected, reduced or eliminated by the "made whole doctrine" and/or any other equitable doctrine or law which requires that the Plan Participant be "made whole" before the Plan's rights are allowed. The Plan has the right to be repaid first from any settlement, judgment, remuneration, insurance proceeds or other source of funds a Plan Participant receives. The Plan has the right to be reimbursed first whether or not a portion of the settlement, judgment, remuneration, insurance proceeds or other source of funds are identified as a reimbursement for medical expenses. The Plan has the right to be reimbursed first whether or not a Plan Participant makes a claim for medical expenses.

Attorneys' Fees

The Plan will not be responsible for any expenses, fees, costs or other monies incurred by the attorney for the Plan Participant and/or his or her beneficiaries, commonly known as the common fund doctrine. The Plan Participant is specifically prohibited from incurring any expenses, costs or fees on behalf of the Plan in pursuit of his rights of recovery against a third-party or Plan's subrogation, lien, assignment or reimbursement rights as set forth herein. No court cost, filing fees, experts' fees, attorneys' fees or other cost of a litigation nature may be deducted from the Plan's recovery without prior, express written consent of the Plan.

A Plan Participant must not reimburse their attorney for fees or expenses before the Plan has been paid in full. The Plan has the right to repaid first from any settlement, judgment, or insurance proceeds a Plan Participant receives. The Plan has a right to

reimbursement whether or not a portion of the settlement, judgment, insurance proceeds or any other source or payment was identified as a reimbursement of medical expenses.

Wrongful Death/Survivorship Claims

In the event that the Plan Participant dies as a result of his/her injuries and a wrongful death or survivorship claim is asserted the Plan Participant's obligations become the obligations of the Plan Participant's wrongful death beneficiaries, heirs and/or estate.

Death of Plan Participant

Should a Plan Participant die, all obligations set forth herein shall become the obligations of his heirs, survivors and/or estate.

Payment

The Plan Participant agrees to include the Plan's name as a co-payee on any and all settlement drafts or payments from any source.

Severability

In the event that any section of these provisions is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of the Plan. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the plan.

Incurred Benefits

The Plan reserves the right to reverse any decision associated with the reduction or waiver of charges related to services or benefits provided if and when the Plan discovers that the Plan Participant has been involved in an injury or accident and may be compensated by one of the sources set forth above.

Should this occur, the Plan Participant is deemed to have incurred the full billed charges or the full cost of the services rendered.

Non-exclusive Rights

The rights expressed in this document in favor of the Plan are cumulative and do not exclude any other rights or remedies available at law or in equity to the Plan or anyone in privity with the Plan.

The Provisions herein bind the Plan Participant, as well as the Plan Participant's spouse, dependants, or any members of the Plan Participant's family, who receives services or

benefits from the Plan individually or through the Plan Participant.

Coordination of Benefits

A Plan Participant must notify the Plan Administrator, within 31 days, if he or she is covered under another health plan and must also notify the Plan Administrator, within 31 days, when coverage under another health plan ends. If notification to the Plan Administrator of such other coverage or the loss of such other coverage is not provided in a timely manner, then claims may be denied. If an individual claiming benefits under the Plan is covered under two or more plans (including the Plan), benefits shall be determined as follows:

- (a) A plan that has no coordination of benefits provision always will be deemed to have primary benefit payment responsibility.
- (b) The plan covering the individual as an employee pays benefits first. The plan covering the individual as a dependent pays benefits second.
- (c) If no plan is determined to have primary benefit payment responsibility under (b), then the plan that has covered the individual for the longest period has the primary responsibility.
- (d) Except as otherwise provided in (e), the plan covering the parent of an eligible dependent pays first if that parent's birthday (month and day of birth, not year) falls earlier in the year. The plan covering the parent of an eligible dependent pays second if that parent's birthday falls later in the year.
- (e) If the parents of the eligible Dependent are divorced or separated, the following order of benefit determination applies:
 - The plan covering the parent with custody of the eligible Dependent pays benefits first.
 - If the parent with custody has not remarried, then the plan covering the parent without custody pays benefits second.
 - If the parent with custody has remarried, then the plan covering the step-parent pays benefits second and the plan covering the parent without custody pays benefits third.

However, if a divorce decree or other order of a court of competent jurisdiction places the financial responsibility for the child's health care expenses on one of the parents, then the plan covering that parent pays benefits first.

- (a) The plan covering an individual as an employee (or as the employee's Dependent) who is neither laid off nor retired pays benefits first. The plan covering that individual as a laid-off or retired employee (or as that individual's Dependent) pays benefits second.
- (b) The plan covering an individual as an employee (or as a Dependent of the employee) pays benefits first if such individual also is receiving COBRA continuation coverage under another plan, and such other plan pays benefits second for such an individual. Conversely, this Plan pays secondary benefits for any individual who receives COBRA continuation under this Plan and who also is covered simultaneously under another plan as an employee (or as a Dependent of an employee). In the event of conflicting coordination provisions between this Plan and any other plan, this Plan will pay primary benefits for an individual only if this Plan has provided coverage for a longer period of time.
- (c) Payments for benefits under the Plan will be reduced by any payments for the same benefits that are under Medicare. The reduction is the amount payable by Medicare whether or not the payment is actually made. Consequently, the payment for any benefits under the Plan will be determined by the Plan Administrator, and then reduced by the amount payable by Medicare. Coordination of Plan benefits with Medicare shall be determined in accordance with applicable federal regulations describing the order of benefit determination with respect to primary and secondary coverage.

Section 8: Claim and Appeal Procedures

Generally you will not pay for covered services. However, if you pay for a health service out of pocket or your provider does not file the claim for you and you wish to have the service considered for reimbursement under the Plan, you must submit a request for such benefit to the Claims Administrator listed in Section 10, Plan and Contact Information.

A "claim" under the Plan means an inquiry by an individual regarding benefits under the Plan that (a) consists of a communication by the individual or his or her authorized representative (including a care Provider) to the Claims Administrator and (b) identifies a specific claimant, condition or symptom and a specific treatment, service or product for which the individual (or his or her representative) requests approval or benefits.

A claim must (a) be in writing, (b) be submitted on the form designated by the Claims Administrator (which form will be provided by the Administrator, free of charge, within a reasonable period of time after the Administrator receives an oral or written request from the claimant for such form), (c) designate whether the benefit claim is an Urgent Care Claim and explain or describe whether, and what, medical exigencies or medical circumstances exist with respect to such claim, (d) be signed and dated by the claimant, and (e) be delivered to the Administrator at such address designated by the Administrator by first-class mail or by messenger delivery or such other means authorized by the Administrator.

Claims and appeals under the Plan will be processed by the Claims Administrator (identified in Section 10 of the SPD) in accordance with the claim and appeal procedures described in this section.

Coordination of Benefits Claims:

- Primary or secondary payor will be determined as outlined in Section 7.
- When the Plan is primary, it will pay benefits as if it were the only plan.
- When the Plan is secondary, its payment responsibility shall be limited to the Plan benefit guidelines and amount. Therefore, when the Plan payment is added to the payment of the primary payor it would not exceed the primary payor's benefit, or what the Plan would reimburse as primary.

If you (the "claimant") submit a claim under the Plan and the claim is denied in whole or in part, the claim and appeal procedures described in the following paragraphs will apply. For purposes of these procedures, if a care Provider submits a claim on your behalf and it results in an Adverse Benefit Determination, you will receive notice of the Adverse Benefit Determination and you may appeal the determination as described in this section.

Definition of Adverse Benefit Determination

For purposes of these claims procedures, an "Adverse Benefit Determination" is a denial, reduction or termination of a benefit or a failure to provide or make a benefit payment (in whole or in part). This includes a denial, reduction, termination or failure to provide or make payment based on a determination of ineligibility to participate in the Plan. An Adverse Benefit Determination also may include (i) a denial, reduction or termination of a benefit or a failure to provide a benefit or make payment (in whole or in

part) resulting from a utilization review or precertification; or (ii) a failure to cover a supply or service on the grounds that it is experimental, investigative, not Medically Necessary or appropriate, or not covered by the Plan.

Urgent Care Claim Procedures

An “Urgent Care Claim” is a claim for medical care or treatment where failure to act quickly (i) could seriously jeopardize your health or your ability to achieve a full recovery; or (ii) would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that could not be adequately managed without the care or treatment. If a physician with knowledge of your medical condition determines that a claim is an Urgent Care Claim, the claim will be treated as such under the Plan. Otherwise, the Claims Administrator will determine whether a claim is an Urgent Care Claim by applying the judgment of a prudent layperson with an average knowledge of health and medicine.

Once the Claims Administrator receives your Urgent Care Claim, the Administrator will notify you of the benefit determination as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the Administrator. If you do not provide sufficient information for the Claims Administrator to make a determination, the Claims Administrator will notify you, within 24 hours after the claim is filed, of the specific information necessary to complete the claim. You will have up to 48 hours to provide this information.

You may be notified of a benefit determination orally; however, you will be sent a written or electronic notice of the determination within 3 days after the oral notice is provided.

Pre-Service Claim Procedures

A “Pre-Service Claim” is any claim for benefits where the Plan conditions receipt of the benefit, in whole or in part, on advance approval of the benefit (for example, Pre-certification or utilization review procedures). After the Claims Administrator receives your Pre-Service Claim, the Administrator will notify you of the benefit determination within 15 days. Within that time, the Claims Administrator may notify you that it requires an extension (due to matters beyond the Plan’s control) of up to 15 days, indicating why an extension is necessary and the date the Administrator expects to issue its decision. If an extension is necessary because you have failed to submit the information necessary to make a benefit

determination, the notice will describe the specific information necessary to complete the claim. You will be given 45 days to provide this information.

If you attempt to file a Pre-Service Claim and your claim does not follow claim filing procedures, you will receive written, electronic or oral notice from the Claims Administrator within 5 days. The notice will explain the proper procedures to be followed in filing a claim. If the Pre-Service Claim is an Urgent Care Claim, the Claims Administrator will notify you within 24 hours that your claim has been improperly filed.

Post-Service Claim Procedures

A “Post-Service Claim” is any claim filed after you have received the medical services. A Post-Service Claim must be filed under the Plan not later than 90 days after the medical care, treatment, service or product relating to such claim has been received or, if the coverage under the Plan is secondary to another plan’s coverage, the claim must be filed under the Plan not later than 90 days after the date the Participant receives written notice of the other plan’s benefit determination with respect to the medical care, treatment, service or product in question; any claim filed under the Plan for such medical care, treatment, service or product after such date will be denied by the Claims Administrator, unless the Administrator determines there was reasonable cause for filing such benefit claim after such date. After the Claims Administrator receives your Post-Service Claim, the Administrator will notify you of the benefit determination within 30 days, unless an extension of up to 15 days is necessary. If an extension is needed (due to matters beyond the control of the Plan), the Claims Administrator will notify you during the initial 30-day period, indicating why an extension is necessary and the date on which the Administrator expects to issue its decision. If an extension is necessary because you did not submit the information necessary to make a benefit determination, the notice will describe the required information, and you will be given 45 days to provide the information.

Reducing or Terminating Benefits for an Ongoing Course of Treatment

If the Plan reduces or terminates benefits that you are receiving with respect to an ongoing course of treatment, the Claims Administrator will notify you well enough in advance to allow you to appeal before your benefit is actually reduced or terminated. If you would like to extend the course of treatment beyond the scheduled time or number of treatments and the

request is an Urgent Care Claim, you must file a claim and the Claims Administrator will notify you of its determination within 24 hours after receiving the claim. You must file the claim for extension at least 24 hours before the expiration of the scheduled time or at least 24 hours before the last of the permitted number of treatments.

Notice of an Adverse Benefit Determination

If the decision regarding your claim is an Adverse Benefit Determination, the Claims Administrator will send you a notice that will:

- be written in a manner designed for you to understand;
- include the specific reasons for the denial;
- refer to the Plan provisions on which the determination was based;
- describe any additional material or information necessary for you to perfect the claim and explain why the additional material is necessary;
- explain the Plan's review procedures and the applicable time limits;
- include a statement of your right to bring a civil action under ERISA after receiving a final Adverse Benefit Determination upon appeal;
- include a copy of any internal rule, protocol or criterion that was relied on in making the determination or indicate that a copy of such rule, protocol or criterion is available to you, free of charge, upon request;
- if the determination was based on medical necessity, experimental treatment or other similar exclusion or limit, either explain the scientific or clinical judgment made or indicate that such an explanation is available to you, free of charge, upon request; and
- if the Adverse Benefit Determination was made with respect to an Urgent Care Claim, describe the Plan's expedited review process.

Initial Appeal of an Adverse Benefit Determination

To appeal an initial Adverse Benefit Determination, you must, within 180 days after receiving the determination, notify the Claims Administrator of your request for review. The claimant must submit the request for review to the Claims Administrator. The appeal request must (a) be in writing, (b) include the information necessary to process the appeal request including the Eligible Employee's name, the patient's name and plan identification number (if any), the Provider's name, the date the service or product at issue was provided, an explanation of why the claimant believes the claim at issue should be paid or approved, and documentation and other

written information evidencing the amount or benefit requested in the claim, (c) be signed and dated by the claimant, and (iv) be delivered to the Claims Administrator at such address designated by the Administrator by first-class mail or messenger delivery or in such other manner as authorized by the Administrator, provided, however, that a request for an expedited appeal of an Adverse Benefit Determination of an Urgent Care Claim may be submitted orally or in writing by the claimant and all necessary information, including the Plan's determination regarding the appeal will be transmitted between the Administrator and the claimant by telephone, facsimile, or other available similarly expeditious method. You have the right to submit written comments, documents, records, and other pertinent information, and you may obtain, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim.

The appeal will be conducted by a named fiduciary (contracted by the Plan Administrator) who was neither the individual who made the initial Adverse Benefit Determination nor a subordinate of that individual. This reviewer will not defer to the initial Adverse Benefit Determination and will take into account all comments, documents, records, and other information that you submit relating to the claim, without regard to whether the information was submitted or considered in the initial Adverse Benefit Determination.

If the Adverse Benefit Determination was based on a medical judgment, the reviewer will consult with a health care professional who has appropriate training and experience in the medical field. This health care professional will not be an individual who was consulted in connection with the initial Adverse Benefit Determination or the subordinate of any such individual. The Plan will identify any medical or vocational experts whose advice was sought in making the initial Adverse Benefit Determination.

The appeal of Urgent Care Claims can be conducted on an expedited basis. If you desire an expedited appeal, you must notify the Claims Administrator. This will allow the Claims Administrator to transmit all information to you by methods such as telephone and facsimile. For Urgent Care Claims, the Claims Administrator will notify you of the determination as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt by the Administrator of your request for review. For Pre-Service Claims, the Claims Administrator will notify you of the determination within 15 days after

you file your request for review. For Post-Service Claims, the Claims Administrator will notify you of the determination within 30 days after you file your request for review.

Notice of Decision on Initial Appeal

If the decision on initial appeal is an Adverse Benefit Determination, notice of the Adverse Benefit Determination will:

- be written in a manner designed for you to understand;
- include the specific reasons for the Adverse Benefit Determination;
- refer to the Plan provisions on which the determination was based;
- inform you that, upon request and free of charge, you are entitled to reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits;
- explain the Plan's review procedures and the applicable time limits;
- include a statement of your right to bring a civil action under ERISA after receiving a final Adverse Benefit Determination upon appeal;
- include a copy of any internal rule, protocol or criterion that was relied on in making the determination or indicate that a copy of such rule, protocol or criterion is available, free of charge, upon request;
- if the determination was based on medical necessity, experimental treatment or similar exclusion or limit, either explain the scientific or clinical judgment made or indicate that such an explanation is available to you, free of charge, upon request; and
- if the determination was made with respect to an Urgent Care Claim, describe the Plan's expedited review process.

Unless a final appeal is filed (as described below), the Claims Administrator's decision on initial appeal is final and binding.

Final Appeal of an Adverse Benefit Determination

To request appeal of an Adverse Benefit Determination issued after an initial appeal, you must, within 90 days after receiving the determination, notify the Claims Administrator of your request for review. You have the right to submit written comments, documents, records, and other pertinent information, and you may obtain, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim.

The final appeal will be conducted by a named fiduciary (contracted by the Plan Administrator) who was neither the individual who made the Adverse Benefit Determination subject to the appeal nor a subordinate of that individual. This reviewer will not defer to the benefit determination subject to the appeal and will take into account all comments, documents, records, and other information that you submit relating to the claim, without regard to whether the information was submitted or considered in the benefit determination subject to the appeal.

You may address this reviewer in an appeal meeting and you may be accompanied by one person of your choice to an appeal meeting. The person who accompanies you (in person or by telephone) may not address this reviewer except in the following circumstance: If you are not an employee of the Participating Employer but you are a Dependent and spouse of an Eligible Employee, you may choose to designate your spouse to attend an appeal meeting in your place and to address the reviewer in your place. This designation must be made in writing and in advance of the appeal meeting. If both you and your spouse attend the appeal meeting, only one of you may address the appeal meeting.

If the Adverse Benefit Determination was based on a medical judgment, the reviewer will consult with a health care professional who has appropriate training and experience in the medical field. This health care professional will not be an individual who was consulted in connection with the benefit determination subject to the appeal or the subordinate of any such individual. The Plan will identify any medical or vocational experts whose advice was sought in making the Adverse Benefit Determination.

The final appeal of Urgent Care Claims can be conducted on an expedited basis. If you desire an expedited appeal, you must notify the Claims Administrator. This will allow the Claims Administrator to transmit all information to you by methods such as telephone and facsimile.

For Urgent Care Claims, the Claims Administrator will notify you of the determination as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt by the Administrator of your final appeal. For Pre-Service Claims, the Claims Administrator will notify you of the determination within 15 days after you file your final appeal. For Post-Service Claims, the Claims Administrator will notify you of the determination within 30 days after you file your final appeal.

Notice of Final Decision on Appeal of an Adverse Benefit Determination

If the decision on your final appeal is an Adverse Benefit Determination, notice of the Adverse Benefit Determination will:

- be written in a manner designed for you to understand;
- include the specific reasons for the Adverse Benefit Determination;
- refer to the Plan provisions on which the determination was based;
- inform you that, upon request and free of charge, you are entitled to reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits;
- notify you of your right to bring legal action under Section 502(a) of ERISA;
- include a copy of any internal rule, protocol or criterion that was relied on in making the determination or indicate that a copy of such rule, protocol or criterion is available, free of charge, upon request; and
- if the determination was based on medical necessity, experimental treatment or similar exclusion or limit, either explain the scientific or clinical judgment made or indicate that such an explanation is available to you, free of charge, upon request.

The Claims Administrator's decision on appeal is final and binding. No action in any court or agency may be brought prior to you exhausting these claims and appeals procedures.

Section 9: Your ERISA Rights

As a Participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). They are described below.

Information About Your Plan and Benefits

You have the right to:

- Examine, without charge, at the Plan Sponsor's office and other specified locations all documents governing the Plan, including insurance contracts, if any, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Sponsor, copies of documents governing the operation of

the Plan, including insurance contracts, if any, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Sponsor may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Sponsor is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

You may continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan for the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under the Plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your Employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforcing Your Rights

If your claim for welfare benefits is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the rights described above. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Sponsor to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Sponsor.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan Sponsor's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that the Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You also may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Section 10: Plan and Contact Information***Plan Information***

Official Plan Name	Seton Healthcare Network Employee Health Plan
Plan Sponsor's Employer Identification Number	74-1109643
Plan Number	501
Plan Year	January 1 through December 31
Plan Description	Group Health Plan
Plan Sponsor	Seton Healthcare 1345 Philomena Street Austin, Texas 78723
Plan Administrator	Seton Health Plan, Inc. PO Box 14545 Austin, TX 78761-4545 (512) 421-5667 or toll-free at 1 (866) 272-2507 www.setonhealthplan.com
COBRA Administrator	Ceridian Benefit Services P.O. Box 534099 St. Petersburg, FL 33747 1-800-877-7994 www.ceridian-benefits.com
Type of Administration	Plan benefits are administered by a third-party administrator.
Agent for Service of Legal Process	Senior Vice President of Legal Affairs Seton Healthcare 1345 Philomena Street Austin, Texas 78723 Service of legal process may be made on the Plan Administrator.
Type of Funding	Self-insured
Sources of Contributions	The Plan is funded with a combination of Employer and employee contributions. Benefits payable under the Plan are not guaranteed by or funded under any insurance policy.

Contact Information

TO FILE OR APPEAL A MEDICAL CLAIM

Claims Administrator

Seton Health Plan, Inc.
PO Box 14545
Austin, TX 78761-4545
Attention: Service Accountability Unit

(512) 421-5667 or toll-free at 1 (866) 272-2507
www.setonhealthplan.com

QUESTIONS ABOUT THE PLAN OR SPD

Plan Sponsor

Seton Healthcare
Human Resources Department
1345 Philomena Street
Austin, TX 78723

(512) 421-5667 or toll-free at 1 (800) 272-2507

Exhibit A

SETON Healthcare Employee Medical Plan Pre-certification Procedures

To be eligible to receive a Benefit for a medical treatment, service, supply or drug listed below you must complete the Plan's Pre-certification procedures that are described below. The Plan's Pre-certification procedures are conducted by the clinical staff in the Plan Administrator's Medical Management Department.

The Plan's Pre-certification procedures are initiated by the Provider on behalf of and at the request of the member. The individual initiating the Pre-certification procedures must provide the following information:

- Patient's full name
- Member ID number
- Anticipated date of admission or service
- Clinical history
- Diagnosis
- Procedure(s) or service(s) planned (CPT codes)
- Anticipated length of stay or frequency of services
- Type of admission (elective or emergency)
- Plan of treatment
- Name/phone number of admitting physician
- Facility
- Comorbid condition(s)
- Results of diagnostic testing and laboratory values, if applicable
- Caller name/phone number

When initiating the Plan's Pre-certification procedures by fax, the individual must complete the following information:

- Plan Administrator's Pre-certification form; and
- Clinical information that supports the requested service

Penalties for Failure to Obtain Pre-certification Required

All medical treatments, services, supplies and drugs for which you must obtain Pre-certification must be submitted to, and reviewed and approved in writing, by the clinical staff in the Plan Administrator's Medical Management Department before the medical treatment, service, supply or drug is provided to be eligible for a Benefit under the Plan. Failure to complete the Pre-certification procedure may result in no Benefit being paid under the Plan with respect to the medical treatment, service, supply or drug for which Pre-certification was not obtained.

Please do not schedule medical treatments, services, supplies or receipt of drugs for which you must obtain Pre-certification until approval in writing from the clinical staff in the Plan Administrator's Medical Management Department has been received.

Pre-certification is not a guarantee of a Benefit under the Plan because the ultimate payment of a Benefit under the Plan is subject to all of the terms of the Plan including eligibility of the member to receive the Benefit at the time the medical treatment, service, supply or drug service is provided.

Of course, the final decision as to whether you should receive proposed medical treatment, service, supply or drug must be made by the member and his or her attending Physician or other health care provider. The decision whether or not to receive any medical treatment, service, supply or drug for which you must obtain Pre-certification under the terms of the Plan is between the member and the member's Physician or other health care provider. The Plan's

Pre-certification procedures are merely provided for the limited purpose of assisting a member in maximizing any Benefit that can be obtained under the Plan.

Covered Health Services for which Pre-certification is Required

To be eligible to receive a Benefit for a medical treatment, service, supply or drug listed below you must complete the Plan’s Pre-certification procedures that are described above:

Pre-Certification Chart

Notes:	* Contact Member Service regarding annual benefit limit ** Subject to plan limitations *** Outpatient surgery/procedure performed in facility - not to include office procedure
Abbreviations	D - Direct access to in-plan contracted providers N - Notify the Health Plan of admission within 24 hours P - Plan approval required by phone/fax with medical information EL - Elective NB - Not a benefit ER -Emergency
Please refer to Exhibit D, 2012 Associate Medical Comparison Chart and the online Provider Directory, available at www.setonhealthplan.com, for network specific limitations and copayment requirements.	

Services	EPN EPNX	Notes
Acupuncture	**D	
Ambulance	D-ER P-EL	Ambulance/EMS services covered if pt. transported to hospital
Behavioral Health, Inpatient	P	Reference member ID card for phone number
Behavioral Health, Inpatient Substance Abuse	P	Reference member ID card for phone number
Behavioral Health, Outpatient - Office Visits for BH or Substance Abuse	D	Reference member ID card for phone number
Behavioral Health, Outpatient - Intensive Outpatient Program	P	Reference member ID card for phone number
Behavioral Health - Psychological Testing	See notes to right	EPN & EPN Expanded - when referred by in-network psychiatrist - Direct access up to 6 hours of testing. All other referrals require prior authorization.
Behavioral Health - ECT (Electroconvulsive Therapy)	P	
Biofeedback	**P	
Chemotherapy	D	
Chiropractic	**D	
Cognitive Training/Retraining	P	
Cosmetic Surgery	P/NB	Certain procedures are covered, prior auth required in all cases
Cyberknife	P	
Dental Trauma	P	

Services	EPN EPNX	Notes
Diabetes Disease Management Program - Living Well with Diabetes (Seton Family Facilities Only)	D	
Dialysis	P	
DME (quantity limits apply)	*D<\$500 P>\$500	Subject to plan limitations. EPN/EPN Expanded follow MCR guidelines
Disposable Supplies	*D<\$500 P>\$500	Subject to plan limitations. EPN/EPN Expanded follow MCR guidelines
Rental Items requiring auth regardless of dollar amount:		
Apnea Monitor	P	
Bedside Commode	D	
Bili lights (phototherapy)	P	
BIPAP	P	
Blood glucose monitor w/ voice synth	P	
Breast Pump	P**	
Compressors- high volume	P	
CPAP	P	
CPM; Dynamic splinting; PMD	P	
Enteral Therapy, supplies and formula	P	
Feeding pump (Enteral Therapy)	P	
Gastric suction pump	P	
Hospital Beds and Accessories	P	
Humidifier, w/ equipment	D	
Jaw motion rehab system (CPM)	P	
Oxygen and Related Respiratory Equip.	P	
Patient Lifts	P	
Powered air flotation bed/mattress (low air loss)	P	
Powered/Nonpowered overlay for mattress	P	
Pressure-relief pads, alternating; air; water mattress	P	
Pulse Oximeter	P	
Safety enclosure frame/canopy for use with hosp bed	P	
Suction Machine	P	
TENS; Neuromuscular and bone growth stimulators	P	
Wheelchairs	P	
Wound V.A.C. (Negative pressure wound therapy)	P	
Emergency Services	D	
Genetic Counseling	D	

Services	EPN EPNX	Notes
Genetic Testing	P	Majority require precertification except for the following: 1) Routine prenatal screening; 2) Routine inpatient newborn screenings; 3) Human leukocyte antigen (HLA) testing for transplant; 4) Chromosomal analysis for leukemia and lymphoma; 5) Infectious disease testing considered to be standard of care. NOT COVERED - APOE epsilon 4-(susceptibility to Alzheimer's)
Hearing Aids	P	EPN/EPN Expanded - Under age of 18. Subject to plan limitations: Up to \$2500/ear once every 2 years (\$5000 max benefit/year)
Health Education - (Asthma; Diabetes; nutrition)	**D	Seton facilities only
Home Health Care/ Home Infusion	P	
Hospice	**P	
Hospital Services		
Inpatient		
Scheduled (Elective)	P	
Rehab Facility	P	
Trauma/ER Admit	P/N	
Observation (Elective)	P	
Observation (Trauma/ER)	D	
Outpatient Surgery ***		
Scheduled (Elective)	P	
Biopsy - w/ or w/o image guided	D	
Port-a-cath insertion/removal	D	
Cataract removal w/ IOLens	P	
Infertility (diagnostic testing for definitive diagnosis)	P	
Infertility Treatment	NB	
Injectable Drugs Not Covered thru Pharmacy Benefit	P	Includes following drugs administered in physician office or outpt setting: Botox; Growth Hormones (including but not limited to Somatropin, Genotropin, Humatrope); Flolan; Bisphosphonates (Boniva,Zometa, Reclast, etc.); Osteoclast inhibitors (Prolia) Depo-Provera, IGG, Lupron Depot, Testosterone, DMAD (Remicade, Orencia; Humira, etc); Viscosupplements : (Supartz, Synvisc, Euflexxa, Hyalgan, Orthovisc, etc) Synagis, Tysabri, Xolair, Provenge; 17 Alpha hydroxyprogesterone caproate (17P)
Laser Assisted Uvulopalatoplasty	P	
Laser (Excimer) Treatment	P	
Lymphedema Mgmt/Therapy	P	
Neuropsychological Testing	P	
Orthotics (limited coverage)	**P/NB	>Contact Mbr Srv regarding benefits
Oral Surgery/ TMJ	P	
Orthodontia (pre & Post surgical)	NB	For Craniofacial Anomalies
Outpatient Therapeutic Studies		
Arthrogram	D	
Cardiac Catherization; EP studies	D	

Services	EPN EPNX	Notes
Colonoscopy; Sigmoidoscopy	D	
Doppler Study - Arterial/venous	D	
Echocardiogram; EKG; Holter Monitor	D	
EEG	D	
EGD	D	
Hysterosalpingography (HSG) / Sonohysterography (SIS)	P	
Stress Test - Cardiac (ETT)	D	
Visual Field Testing	D	
Pain Management	P	
Prolotherapy	P>6 vsts	
Prosthetics	P	
Radiology/Imaging		
Imaging Services Not Listed	D	
Anesthesia for imaging	D	
Angiography/Venography	D	
Barium Enema	D	
Bone Density Study (Dexa Scan)	D	
Ca Scoring (Heart Saver CT)	NB	
CT Scan	D	
CT Chest & Cardiac Angiography	D- Seton Facility	Not a benefit if provided at a non-Seton facility
Image guided biopsy	D	
IVP (Intravenous Pyelogram)	D	
Mammography	D	
Nuclear Medicine (NM)		
1) Bone Scan	D	
2) Nuclear Med Stress Test	D	
3) Perfusion Studies; spect	D	
4) Thyroid Scan/Uptake	D	
5) Other NM not listed	D	
MRA	D	
MRI	D	
MRI - Breast	P	
MRI - Open	D	
PET Scan	P	
Upper GI	D	
Radiation Therapy	D	
Referral to Specialist	D	
Referral to Specialty Clinic (Brackenridge/DCMCCT Clinics)	D	
Rehab Services		
Cardiac Rehab	D	
Pulmonary Rehab	D	

Services	EPN EPNX	Notes
PT, OT, ST	P	P>12 vsts @ SETON Network P>8 Other contracted facilities
Wound Care	D	
Sleep Study	D	
Skilled Nursing Facility	P	
Transplants	P	
Non Emergent Transportation/ Air Ambulance	P	
Varicose Vein Treatment	P	
Weight Management - Lifestyle Changes Program: 9 week session	D	
Weight Management - Lifestyle Changes Program: Outpatient Dietitian Visits @ Seton Family facilities only	D Max 6 vsts/plan yr	
Weight Management - Lifestyle Changes Program: Physician Directed Program - contracted providers only	P	Austin Bariatric Clinic 371-9885
Notes: <ul style="list-style-type: none"> * Contact Member Service regarding annual benefit limit ** Subject to plan limitations *** Outpatient surgery/procedure performed in facility - not to include office procedure 		
Abbreviations <ul style="list-style-type: none"> D - Direct access to in-plan contracted providers N - Notify the Health Plan of admission within 24 hours P - Plan approval required by phone/fax with medical information EL - Elective NB - Not a benefit ER-Emergency 		
Please refer to Exhibit D, 2012 Associate Medical Comparison Chart and the online Provider Directory, available at www.setonhealthplan.com , for network specific limitations and copayment requirements.		
General Instructions & Contact Information	SHP Precertification/Referral Telephone # (512) 324-3135; Fax # (512) 324-1936 SHP eligibility, benefits, provider network and claims status call - Local number (512) 421-5667 or toll free # 1-866-272-2507; Behavioral Health Services: Refer to the telephone # listed on the member's ID card	

Exhibit B

SETON Healthcare Employee Medical Plan Medical Benefits

The Plan will provide payments under the Plan for the following Medically Necessary Services as Covered Health Services, subject to the terms and conditions stated in the Plan.

Members and eligible Dependents that reside outside the service area must receive care from a Network Provider or facility unless they have received Pre-certification or receive Emergency Care Services. The only out of network benefit is Emergency Care services.

Co-payments, Coinsurance, Deductible and Benefit Maximums, which are summarized in the Exhibit D, the 2012 Associate Medical Comparison Chart, may apply to the benefits below. All limitations are per Participant for the Plan Year, except as specified.

A Provider Directory is available online at www.setonhealthplan.com or call the customer service number on the back of your insurance ID card.

(a) Physician Benefits

1. Primary Care Physician services

- Office visits for preventive medical care (“well-care”), which may include but is not limited to:
 - well-child care from birth
 - routine physical examination for adults
 - related lab expenses *
 - immunizations for children and adults
 - “well-woman” gynecological exam that may be performed either by an PCP or gynecologist
 - medically accepted cervical cancer screening, “pap” smear
 - routine screening mammography *
 - medically accepted bone mass measurement for the detection of low bone mass and to determine the person’s risk of osteoporosis and its associated risk of fractures *
 - prostate exam for the detection of prostate cancer and a prostate-specific antigen is covered (blood testing for prostate specific antigen*) colorectal screening examinations including but not limited to fecal occult blood test annually, flexible sigmoidoscopy or colonoscopy *.
 - Office visits for illness
 - Office diagnostic procedures (certain diagnostic procedures are allowed in the office*)
 - Office surgical procedures
 - Outpatient hospital diagnostic or surgical procedures*
 - Inpatient hospital diagnostic or surgical procedures
 - Hospital visits

2. Specialist Physician Care Services

- Office visits
- Office diagnostic procedures*
- Office surgical procedures
- Outpatient hospital diagnostic or surgical procedures*
- Inpatient diagnostic and surgical procedures
- Hospital visits

3. Other Physician Services

- Pre-certified allergy testing, sera, supplies, and related services, which may include allergy injections (subject to benefit limits).
- Office injectable medications subject to Plan Pre-certification guidelines.

Provider Directory available online at www.setonhealthplan.com or by calling the customer service number on the back of your insurance ID card.

(b) Diagnostic Services *

Professional and technical components of diagnostic laboratory and diagnostic and therapeutic radiological services in support of basic health services are covered, including:

- Outpatient skeletal or other plain film X-ray, mammogram, or lab associated with Physician office visit;
- Outpatient ultrasound, GI series and other diagnostic services per Plan guidelines, including contrast studies with no vascular injection;
- Major radiological procedures (e.g. Magnetic Resonance Imaging (“MRI”), Computed Tomography (“CT”), Positron Emission Tomography (“PET scan”) and invasive diagnostic services;

* A Provider Directory is available online at www.setonhealthplan.com or by calling the customer service number on the back of your insurance ID card

(c) Hospital and Related Services

Hospital and related services, and services of an approved chemical dependency treatment facility, except for the Hospital Services identified in Exhibit C Medical Benefits – Exclusions and Limitations, are covered, including:

Inpatient Services

When Pre-certified by the Plan, Medically Necessary inpatient, and twenty-four hour observation Hospital Services, will be covered. Services shall include:

- care and services in an intensive care unit when Medically Necessary;
- administered medications, including biologicals, fluids, and chemotherapy;
- special diets;
- dressings and casts;
- general nursing care;
- use of operating room and related facilities;
- blood, blood plasma and administration of blood transfusions;
- X-ray, laboratory and other diagnostic services;
- anesthesia and oxygen services;
- physical, occupational, and speech therapy services for an acute care need;
- inhalation therapy;
- radiation therapy; and
- such other Medically Necessary Services customarily provided in acute care hospitals.

Inpatient Rehabilitation Services

Medically Necessary inpatient physical, occupational, and speech therapy services for an acute care need are covered when Pre-certified by the Plan. The Maximum Benefit for inpatient rehabilitation is thirty (30) days per plan year.

Care in Skilled Nursing Facility

Medically Necessary care in a Skilled Nursing Facility is covered when Pre-certified by the Plan. The Maximum Benefit for the services in a Skilled Nursing facility is thirty (30) days per plan year, except as may relate to hospice care. Covered services will include but not be limited to:

- administered medications, including biologicals, fluids, and chemotherapy;
- special diets;
- dressings and casts;
- general nursing care;
- use of operating room and related facilities;
- blood, blood plasma and administration of blood transfusions;
- X-ray, laboratory and other diagnostic services;
- anesthesia and oxygen services;
- Physical, occupational, and speech therapy services for an acute need which cannot be provided in an outpatient setting;
- inhalation therapy;
- radiation therapy; and
- such other Medically Necessary Services customarily provided in skilled nursing facilities.

Outpatient Services and Supplies

Emergency Care Services provided on an outpatient basis by an in-network or out of network hospital are covered.

Emergency Care is defined as a medical condition of recent onset and severity, including, but not limited to severe pain, that would lead a prudent lay person, possessing an average knowledge of medicine and health, to believe that the member's condition, sickness, or injury is of such a nature that failure to get immediate care could result in: (1) placing the member's health in serious jeopardy; (2) serious impairment to bodily functions; (3) serious dysfunction of any bodily organ or part; (4) serious disfigurement, or (5) in the case of a pregnant member, serious jeopardy to the health of the fetus.

If a member receives Emergency Care, the Plan Administrator should be notified within 48 hours of the time Emergency Care is received or as soon as reasonably possible.

Notification must include full details of the care provided to the member.

If the member does not notify the Plan Administrator and care is determined not Medically Necessary, the member will be responsible for all charges incurred for the services received.

Pre-certified services and supplies for scheduled outpatient surgery provided under the direction of a physician at an in-network hospital or other approved health care facility are covered.

Pre-certified outpatient diagnostic tests provided under the direction of a participating in-network physician at an in-network hospital or other approved health care facility are covered.*

* Indicates a reference to see the Provider Directory, available online at www.setonhealthplan.com, for a list of plan eligible providers for these services.

(d) Diagnosis-Specific Benefits

Inpatient or outpatient hospital and physician services will be covered in the following circumstances:

Breast Related Conditions

Breast cancer

- Breast reconstruction following mastectomy will be covered;

- Surgery and reconstruction of the non-affected breast to achieve a symmetrical appearance is covered;
- Prostheses and treatment of physical complications, including lymphedemas, at all stages of mastectomy are covered;
- Inpatient stay following a mastectomy will be covered for a minimum of 48 hours postoperatively;
- Following a lymph node dissection for the treatment of breast cancer, inpatient stay will be covered for a minimum of 24 hours;
- If a Participant and the Participant's attending physician determine that a shorter period of inpatient care is appropriate following either a mastectomy or a lymph node dissection, the minimum hours of coverage will not apply;

Fibrocystic breast disease.

- Fibrocystic breast disease is treated as any other medical condition.

Breast hypertrophy (gigantomastia)

- Breast reduction surgery is not a Covered Health Service unless Plan Administrator's internal guidelines are met.

Reconstructive surgery

- Reconstructive surgery performed on a Dependent who is less than 18 years of age to improve the function of, or to attempt to create a normal appearance of a craniofacial abnormality; Reconstructive surgery to restore normal physiological functioning following an accident, injury, disease or surgery will be covered;
- Reconstructive surgery to correct congenital anomalies when required to restore normal physiological functioning (except as noted in Exhibit C, Medical Benefits – Exclusions and Limitations).

Diabetes

Diabetes equipment and supplies are covered when ordered by a contracted Provider, are Medically Necessary and meet the Plan Administrator's internal guidelines and is not subject to any Benefit Maximum.

- Diabetes self-management training is covered at the time of initial diagnosis, and when a change occurs in the Participant's condition which makes re-training Medically Necessary;
- Diabetes equipment is covered and not subject to the Benefit Maximum.
 - blood glucose monitors, including monitors designed to be used by blind individuals;
 - insulin pumps and associated supplies;
 - Therapeutic shoes along with inserts for members with any of the following complications:
 1. Peripheral neuropathy with evidence of callus formation; or
 2. History of pre-ulcerative calluses; or
 3. History of previous ulceration; or
 4. Foot deformity; or
 5. Previous amputation of the foot or part of the foot; or
 6. Poor circulation.

Therapeutic shoes and inserts limited to the following:

1. No more than one (1) pair of custom-molded shoes (including inserts provided with the shoes) and two (2) additional pairs of inserts; or
 2. No more than one (1) pair of depth shoes and three (3) pairs of inserts (not including the non-customized removable inserts provided with such shoes)
- Diabetes supplies are covered, including:
 - test strips for blood glucose monitors;

- visual reading and urine test strips;
- lancets and lancet devices;
- insulin and insulin analogs;
- injection aids;
- syringes;
- prescriptive and non-prescriptive oral agents for controlling blood sugar levels; and
- glucagon emergency kits.

Pregnancy

- Medically Necessary maternity-related physician, diagnostic, and Hospital Services ordered by an in-network physician, shall be provided when Pre-certified by the Plan;
- Coverage will be for a minimum of forty-eight (48) hours following an uncomplicated vaginal delivery and ninety-six (96) hours following an uncomplicated delivery by cesarean section, if the length of stay is determined to be Medically Necessary by an attending physician or is requested by the mother. The decision whether the delivery is complicated shall be made by the attending physician;

Acquired Brain Injury

- Medically Necessary cognitive rehabilitation therapy, cognitive communication therapy, neuro-cognitive therapy and rehabilitation, neuro-behavioral, neuro-physiological, neuro-feedback therapy, remediation, post acute transition services and community reintegration services are covered when Pre-certified by the Plan for Participants who have an acquired brain injury.

(e) Mental Health Services and Substance Use Disorders

The Plan provides benefits for the treatment of mental health and substance use disorders services. Expenses for the treatment of mental/behavioral health services are considered the same as any other illness and have equal deductible, benefit percentage, and out-of-pocket requirements. The mental/behavioral health service rendered must be based on an individual treatment plan. The individual treatment plan, and utilization review of services provided under such plan, shall be in compliance with applicable federal and state regulations for treatment. An order by a court or state agency for treatment is not an indication of Medical Necessity.

Outpatient Benefit

The Plan will cover individual or group therapy sessions for the Medically Necessary treatment of mental health and substance use disorders.

Intensive Outpatient Therapy Program

The Plan will cover intensive outpatient therapy individual or group sessions for the Medically Necessary treatment of mental health and substance use disorders.

Inpatient Benefit

When Pre-certified by the Plan, Medically Necessary mental/behavioral health services will be covered.

Residential Treatment

Mental Health Benefit

The Plan will reimburse up to sixty (60) days each calendar year for the Medically Necessary treatment of mental health conditions while confined in a residential treatment center (approved by the Plan) and are subject to the following restrictions:

- Covered individual must be 18 years of age or younger;
- Services must be based on an individual treatment plan; and
- Providers of services must be properly licensed and in-network

The residential treatment mental health benefit may only be used in situations in which the insured has a mental health condition which impairs the insured's thought, perception of reality, emotional process, or judgment or grossly impairs behavior as manifested by recent disturbed behavior.

Substance Use Disorders Benefit

The Plan will reimburse up to sixty (60) days each calendar year for the Medically Necessary treatment of substance use disorders while confined in a residential treatment center (approved by the Plan) and are subject to the following restrictions:

- Services must be based on an individual treatment plan; and
- Providers of services must be properly licensed and in-network

(f) Eating Disorders

Eating disorders are a subclass of complex biopsychosocial disorders characterized by severe disturbances in eating behavior. They include the diagnoses Anorexia Nervosa, Bulimia Nervosa and Eating Disorder NOS.

The Plan will reimburse up to ninety (90) days of treatment per calendar year at an inpatient, intensive outpatient program or residential treatment facility. Services require prior Pre-certification and must be provided at an in-network contracted eating disorder program.

Outpatient Benefit

The Plan will cover individual or group therapy sessions for the Medically Necessary treatment of an eating disorder.

On an outpatient basis, nutritional counseling is covered for eating disorders when it is prescribed by a physician and provided by an in-network provider.

Residential Benefit

Residential Treatment is a covered benefit when determined to be Medically Necessary for treatment of eating disorders and subject to the following restrictions:

- Subject to calendar year maximum days for Residential, Intensive Outpatient Program and Inpatient facility stays for eating disorders.
- Services must be based on an individual treatment plan; and
- Providers of services must be properly licensed and in-network

Inpatient Benefit

When Pre-certification by the Plan, Medically Necessary services will be covered. Subject to calendar year maximum days for Residential, Intensive Outpatient Program and Inpatient facility stays for eating disorders.

Intensive Outpatient Program Benefit

When Pre-certified by the Plan, Medically Necessary services will be covered. Subject to calendar year maximum days for Residential, Intensive Outpatient Program and Inpatient facility stays for eating disorders.

(g) Organ Transplant Services

Physician and Hospital Services for the following Medically Necessary organ transplants when Pre-certified by the Plan Administrator's Medical Management Team and meets the Plan Administrator's internal guidelines:

- kidney transplants

- heart transplants
- lung transplants
- liver transplants
- cornea transplants
- bone marrow transplants
- stem cell transplant
- digestive transplant
- pancreas transplant

Donor expenses are covered when the recipient of the transplant is a Participant.

(h) Ambulance Service

- A Participant is entitled to Medically Necessary ambulance service provided such ambulance service is Pre-certified by the Plan, or the use of such ambulance service is determined necessary for Emergency Care. Ambulance services are only covered when the Participant is transported.

(i) Home Health Services

Home health services provided by an in-network Provider are a Covered Health Service. Home health services are limited to the following:

- Speech, physical and occupational therapy
- Infusion therapy
- Skilled nursing visits provided on a part-time or intermittent level. The visits are not to exceed a two (2) hour block of time and are not intended to provide twenty-four (24) hour skilled nursing care. Skilled nursing visits are limited to sixty (60) visits per Plan Year.

(j) Prosthetics and Orthotics

If provided by or under the direction of a Plan physician, non-cosmetic internal prosthetic devices are a covered benefit when Medically Necessary. Such prosthetic items would include but not be limited to eyes, internal breast prostheses, internal cardiac pacemakers and joint replacements.

When Pre-certified in advance by the Plan Administrator's Medical Management Team and supplied by a Provider, initially required external prosthetic devices are covered. Such prosthetic items would include artificial limbs and external breast prostheses. The covered benefit shall be limited to the lowest cost prosthetic device which is functional, with the member being financially responsible for any cost differential for the prosthetic device chosen.

Payment may be made for the replacement of a prosthetic device or replacement part of a device if ordered by a Plan Provider and the following criteria are met:

- A change in the physiological condition of the patient;
- an irreparable change in the condition of the device, or in a part of the device; or
- the condition of the device, or the part of the device, requires repairs and the cost of such repairs would be more than sixty (60) percent of the cost of a replacement device; or, as the case may be, of the part being replaced; and
- replacement is supplied by a contracted Provider.

The DME maximum benefit limit is not applicable to external prosthetics.

Foot orthotic devices are not covered except under the following Medical Necessary conditions:

- If the shoe is an integral part of a leg brace and its expense is included as part of the cost of the brace;
- Therapeutic shoes along with inserts for diabetic members (See "Diagnosis-Specific Benefits" for Diabetes section, above);

- Rehabilitative foot orthotics prescribed following foot surgery for congenital foot deformities or foot trauma repair when the orthotics are a medically necessary part of the post surgical or cast care;
- Or as Prosthetic shoes.

(k) Durable Medical Equipment

Durable Medical Equipment is equipment which:

- can withstand repeated use;
- is primarily and customarily used to serve a medical purpose;
- is generally not useful to a person in the absence of illness or injury;
- is appropriate for use in the home.

Coverage of durable medical equipment, corrective appliances and supplies are Covered Health Services as defined by current federal Medicare guidelines or Plan Administrator's internal Pre-certification guidelines when ordered by an in-network physician and Medically Necessary as determined by the Plan. The Plan maintains the option of Pre-certifying any additional services, which are deemed to be of equal quality and more cost effective.

Rental of equipment for administration of oxygen, and mechanical equipment necessary for treatment of chronic or acute respiratory failure are covered, if provided under the direction of an in-network physician and Pre-certified in advance by the Plan.

Hearing aids for dependent children up to age 18, once every two years up to a total cost of \$2,500 per ear.

Disposable and consumable supplies are covered. The annual Benefit Maximum payable per Benefit Period, per Participant, on coverage under this is five thousand dollars and no cents (\$5000.00). The cost of hearing aids for dependent children up to age 18 are subject to the \$2,500 per ear once every two years maximum but are not included in, or subject to, the 5,000.00 Benefit Maximum

Note: Durable medical equipment which is covered under the "Diagnosis-Specific Benefits" for Diabetes (See "Diagnosis-Specific Benefits" for Diabetes section, above) are not subject to the Benefit Maximum.

(l) Rehabilitation Services and Therapies

Rehabilitation services and therapies that are performed or rendered on an inpatient or outpatient basis at a participating Plan hospital or other approved health care facility or program which is a Plan Provider, when determined to be Medically Necessary by a participating Plan physician and Pre-certified by the Plan Administrator are covered as long as they meet or exceed treatment goals for the Participant. Inpatient rehabilitation and skilled nursing unit are subject to the Plan's limitations as described in Section (c).

A care plan must be submitted by the Provider to document the medical necessity of the requested therapy. Clinical documentation needs to include at least the following: 1) The plan of care must be signed by the member's attending physician and therapist; 2) date of onset or exacerbation of the disorder/diagnosis; 3) specific statements of long-term and short-term goals; 4) quantitative objectives; 5) a reasonable estimate of when the goals will be reached; 6) specific treatment techniques and/or exercises to be used in treatment; and 7) frequency and duration of treatment.

(m) Dental Related Procedures/Oral Appliances

There is limited coverage for dental related services.

Restoration and correction of damage caused by external violent accidental injury to healthy sound natural teeth (healthy sound natural teeth is any tooth which is in good health and is free of any of the following:

root canal, crown, restoration (filling) involving three (3) or more surfaces, existing decay, periodontal disease) occurring while covered under the Plan and if treatment is initiated within 7 days of actual injury.

Cost of anesthesia and facility charges are covered if a Participant is unable to undergo dental treatment in an office setting or under local anesthesia due to a documented physical, mental, or medical reason as determined by the Participant's physician or the dentist providing the dental care and according to the Plan Administrator's internal guidelines.

Maxillofacial surgical procedure is limited to:

- excision of neoplasm, including benign, malignant and premalignant lesions, tumors, and nonodontogenic cysts;
- incision and drainage of cellulitis;
- surgical procedures involving accessory sinuses, salivary glands and ducts.

Temporomandibular Joint Dysfunction (TMJD) Treatment:

The Plan Administrator will determine medical necessity for treatment of TMJD utilizing the Plan Administrator's internal TMJD Coverage Guidelines. Coverage may include physical therapy and/or TMJ surgery. Bite splints, oral orthotic appliances, braces and orthodontic treatment of TMJD are considered dental therapy and are not eligible under medical benefits.

Obstructive Sleep Apnea:

Coverage of an oral appliance for treatment of obstructive sleep apnea according to the Plan Administrator's internal Pre-certification guidelines.

(n) Hospice Care

Care by an approved hospice is covered, not to exceed a Lifetime Maximum Benefit of 180 days.

(o) Health Education Services

The Plan may organize, sponsor or conduct programs in health education for the benefit of all Participants. Programs offered may include instructions in the appropriate use of health care services, information about the covered health services offered by the Plan and the generally accepted medical standards for the use and frequency of such health services, and/or instructions on the methods each Participant can use to improve or maintain their own health, such as nutritional education and counseling.

(p) Nutritional Counseling

Nutritional counseling is covered for chronic disease states in which dietary adjustment has a therapeutic role, when it is prescribed by a Plan Provider and provided only at a Seton Facility Clinical Nutrition Department. This benefit is subject to any Pre-certification requirements of the Plan.

Medical nutrition therapy provided by a registered dietitian involves the assessment of the person's overall nutritional status followed by the assignment of individualized diet, counseling, and/or specialized nutrition therapies to treat a chronic illness or condition. Medical nutrition therapy has been integrated into the treatment guidelines for a number of chronic diseases, including (1) cardiovascular disease, (2) diabetes mellitus, (3) hypertension, (4) kidney disease, (5) eating disorders, (6) gastrointestinal disorders, (7) seizures (i.e., ketogenic diet), (8) obesity and other conditions based on the efficacy of diet and lifestyle on the treatment of these diseased states. Registered dietitians, working in a coordinated, multidisciplinary team effort with the primary care physician, take into account a person's food intake, physical activity, course of any medical therapy including medications and other treatments, individual preferences, and other factors.

Nutritional counseling is not covered for conditions that have not been shown to be nutritionally related, including but not limited to chronic fatigue syndrome and attention-deficit hyperactivity disorder (ADHD).

(q) Chiropractic, Acupuncture, Biofeedback

Chiropractic, acupuncture and biofeedback services are benefits and may be subject to Pre-certification by the Plan and Plan Year Benefit Maximums (annual 20 visit maximum). Please see Exhibit D, the 2012 Associate Medical Comparison Chart.

Exhibit C

SETON Healthcare Employee Medical Plan Medical Benefits – Exclusions and Limitations

The Plan excludes or limits the following from coverage.

A. Routine Health Services – That are not covered

Assisted listening devices, hearing aids (including implanted bone conduction hearing aids) or testing and examinations for the prescribing or fitting of hearing aids, except for the limited coverage of hearing aids for dependent children under the age of 18 as described in Exhibit B, Section (k).

Vision examinations and routine eye refraction, eyeglasses, crystalens, contact lenses (including keratonconus contact lenses) and any other items or services for the correction of eye sight, including orthoptics, vision training, vision therapy, eye exercises and radial keratotomy and other refractive eye surgery.

Naturopathy, hypnotherapy, massage therapy, megavitamin therapy, psychosurgery, nutritional based therapy, IV chelation except for lead and mercury overdose.

Services and supplies for smoking cessation programs and the treatment of nicotine addiction unless provided at a Seton Healthcare facility

Marital counseling

Educational testing and therapy, treatment of learning disabilities, treatment of behavioral disorders or services that are educational in nature or are for vocational testing or training. Recreational therapy, play therapy, sand box therapy, hippotherapy and services for remedial reading and special education.

Applied Behavioral Analysis, also known as Lovaas Therapy is not covered.

Psychological testing and services for learning disabilities.

Shock-wave treatment for plantar fasciitis and other musculoskeletal conditions.

Under EPN, any care, treatment, services equipment or supplies received outside the service area and provided by a non-Network Provider unless care is Emergency Care or Pre-certification by the Plan Administrator.

Experimental or investigational or unproven drugs, devices, treatments or procedures. A drug, device treatment or procedure is considered experimental, investigational or unproven if:

- It cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration, and approval for marketing has not been given at the time it is provided; or
- It was reviewed and approved by the treating facility's Institutional Review Board or similar committee, or if federal law requires it to be reviewed and approved by that committee. This exclusion also applies if the informed consent form used with the drug, device, treatment or procedure was (or was required by federal law) to be reviewed and approved by that committee; or
- Reliable evidence show that the drug, device, treatment or procedure is the subject of ongoing Phase 1 or Phase 2 clinical trials; is the research, experimental study to determine its maximum tolerated dose, its toxicity, its safety its effectiveness, or its effectiveness compared to a standard method of treatment or diagnosis; or
- Reliable evidence shows that the prevailing opinion among experts is that further studies or clinical trials of the drug, device, treatment or procedure are needed to determine its maximum tolerated dose, its toxicity, its safety , its effectiveness, or its effectiveness compared to a standard method of treatment or diagnosis; or

- The fact that an experimental, investigational or unproven service, treatment device or pharmacological regimen is the only available treatment for a particular condition will not result in coverage if the procedure is considered to be experimental, investigational or unproven in the treatment of that particular condition.

("Reliable evidence" includes only published reports and articles in authoritative medical and scientific literature, and written protocols and informed consent forms used by the treating facility or by another facility studying substantially the same drug, device, treatment or procedure.)

Calcium scoring for evaluating coronary heart disease

Travel or transportation expenses except for an ambulance in a medical emergency or when it's been Pre-certified by the Plan Administrator. Ambulance/EMS services are only considered for coverage if the patient is transported.

Any service, supply or treatment connected with inpatient or outpatient custodial care. Custodial care is care that:

- Primarily helps with or supports daily living activities (such as bathing, dressing, eating and eliminating body wastes), exercising, moving patient, homemaking, giving medication, or acting as a companion or sitter; or
- Can be given by people other than trained medical personnel.

Care may be considered custodial even if it is prescribed by a physician or given by trained medical personnel, and even if it involves artificial methods such as feeding tube or catheters.

Personal and convenience items, such as special air conditioners, humidifiers, physical fitness equipment and other such devices, home modifications to accommodate handicaps; personal services or supplies, such as haircuts, wigs, hair pieces, hair implants, shampoos and sets, guest meals and radio/television rentals.

Personal or comfort items and private rooms unless Pre-certified by the Plan Administrator as necessary for isolation due to infectious disease or immune problem. Guest or incidental services/supplies including admission kits, television, telephone, "obstetrical coach," gowns, barber/beauty services, cots, maternity kits and paternity kits.

Volunteer mutual support groups and court-referred educational programs, including but not limited to alcohol educational programs.

Devices used specifically as safety items or to affect performance primarily in sports – related activities; all expenses related to physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility and diversion or general motivation.

Enrollment in a health, athletic, or similar club.

Physical, psychiatric or psychological examinations, testing, vaccinations, immunizations or treatments when such services are: (1) for purposes of obtaining, maintaining or otherwise relating to, education, sports or camp, travel, insurance, marriage or adoption; (2) relating to judicial or administrative proceedings or orders; or (3) conducted for purposes of medical research.

Social Security/Disability determination exams by Plan Providers are limited to one per Participant per lifetime.

Any fees relating to the selection of an Autologous Transfusion (AT) and Donor Directed Blood are excluded from the blood products provided under the Plan.

Post mortem services.

Routine care and treatment of feet. Includes but not limited to:

- weak, strained, flat, unstable or unbalanced feet, arch supports, heel wedges, lifts, the fitting or provision of orthotics or any orthopedic shoes, except for limited orthotic coverage listed in Medical Benefits, Exhibit B, section “Prosthetics and Orthotics” superficial lesions of the feet, such as corns, calluses or hyperkeratosis;
- tarsalgia, metatarsalgia or bunion, except surgery which involves exposure of bones, tendons or ligaments; or
- toenails, except removal of nail matrix.

Testing, treatment, or other services related to environmental sensitivity.

Services not covered under the Plan and any related services are also not covered. Related services include:

- Services provided in preparation for the non-covered service;
- Services provided in connection with the non-covered service including but not limited to complications; or
- Services that are usually provided following the non-covered service, such as follow-up care or therapy after surgery.

Expenses incurred for a midwife or free standing birthing center.

Services and supplies that are not provided and billed by a licensed Provider within the scope of his or her license.

Services and supplies that are not considered Medically Necessary for diagnosis and treatment.

Charges for telephone consultations, missed appointments, late payments, or after-hours charges.

B12 injections, except for treatment of pernicious anemia.

Room and board for a weekend hospital pre-admission testing on (Friday, Saturday, Sunday) unless surgery is performed on the day of admission or is the result of a medical emergency.

Services in a Long Term Acute Care (LTAC) facility.

B. Dental Services - That are not covered

General dental services including the care, treatment, filling, removal (unless removal is necessary for medical management of a current hazardous medical condition), replacement, or artificial restoration of the teeth or structures directly supporting the teeth, crowns, root canals, treatment of dental abscess or other oral conditions.

Dental implants or any treatment related in the preparation of the jaw for dentures, bridgework or implants.

Orthodontic appliances (except for limited coverage for treatment of obstructive sleep apnea. Refer to Exhibit B: Medical Benefits, section “Dental Related Procedures/Oral Appliances”), splints, and braces including the application and fitting regardless of Medical Necessity.

Dental x-rays, supplies, facility charges and all other expenses arising out of dental surgery.

Treatment of malocclusion, structural jaw abnormalities resulting in malocclusion and abnormalities is excluded except for limited coverage for treatment of TMJD. Refer to Exhibit B: Medical Benefits, section “Dental Related Procedures/Oral Appliances” for coverage information.

C. Transplant Services - That are not covered

Any and all transplant of organs, cells and other tissues are excluded, except for the list of transplants specifically covered in Exhibit B: Medical Benefits section, "Organ Transplant Services.". Such covered transplants must meet the following conditions:

- be Pre-certified by the Plan Administrator's Medical Management Team;
- not considered experimental, investigational or unproven;
- be provided by a Plan Provider and in-network facility.

Also excluded from coverage:

- an animal to human transplant;
- transplant services rendered at a non-designated transplant facility;
- artificial or mechanical devices designated to replace human organs;
- donor expenses if the transplant recipient is not a Participant in the Plan and service is not Medically Necessary for the Participant;
- national donor search .

D. Surgical Services - That are not covered

Cosmetic or other re-constructive procedures (including any related prostheses) unless a functional impairment is present. An objective functional impairment is defined as a direct measurable reduction of physical performance of an organ or body part. Surgery for psychological or emotional reasons are not covered. Among the procedures not covered are:

- Removing or altering sagging skin;
- Changing the appearance of any part of the body (such as enlargement, reduction or implantation);
- Treatment of gynecomastia (male breast enlargement);
- Hair transplants or removal;
- Treatment of keloid or other scar formation as a result of ear or other body part piercing;
- Peeling or abrasion of the skin associated with the removal of scars, tattoos, actinic changes, and/or which are performed as a treatment for acne;
- Any procedure that does not repair functional disorder;
- Any procedure primarily intended to improve physical appearance, whether for emotional, psychological or any other reasons;
- Vaginal rejuvenation procedures (reduction of labia minora, labia minor surgery, designer vaginoplasty, revirgination and G-spot amplification)
- Circumcision, except when the member or Dependent is less than one month old or is greater than one month old and Medically Necessary pursuant to the Plan Administrator's internal guidelines.

This exclusion does not apply to breast reconstruction following a mastectomy (see Exhibit B: Medical Benefits section, "Diagnosis-Specific Benefits." This exclusion also does not apply to re-constructive surgery performed on a Participant who is less than 18 years of age to improve function of or to attempt to create a normal appearance of a craniofacial abnormality (see Exhibit B: Medical Benefits section, "Diagnosis-Specific Benefits.")

Other surgical procedures not covered unless Plan Administrator's internal guidelines coverage criteria are met include:

- Breast reduction;
- Blepharoplasty (eyelid surgery);
- Surgical treatment of temporo-mandibular joint syndrome;
- Medical or surgical care for obesity or weight loss or the reversal of any prior surgical treatment for weight loss. Such excluded procedures include, but are not limited to, liposuction, gastric bypass, jejunal bypass, balloon procedures and jaw wiring.

E. Durable Medical Equipment - That are not covered

The services will only be provided in a Participant's home which is defined as their own dwelling, a relative's/friend's home, a home for the aged, or some other type of institution. However, an institution may not be considered a Participant's home if it:

- Meets the basic requirement in the definition of a hospital, i.e., it is primarily engaged in providing care by or under the supervision of physicians, to patients, injured, disabled, and sick, or rehabilitation services; or
- Meets the basic requirement in the definition of a skilled nursing facility.

Charges for services that are primarily and customarily used for a non-medical purpose or used for environmental control or enhancement (whether or not prescribed by a physician) including but not limited to air purifiers, vacuum cleaners, scooters/motorized transportation other than wheelchairs, escalators, elevators, ramps, waterbeds, hypoallergenic pillows or mattresses, cervical pillows, swimming pools, spas, exercise equipment (cycles), gravity lumbar reduction chairs, professional medical equipment including but not limited to blood pressure kits, PUVA lights, stethoscopes, and light treatments for S.A.D., personal computers and related equipment or other similar items or equipment, structural changes, modifications, or additions to cars, vans, living or working quarters to accommodate DME or transportation vehicles including patient ramps and patient lifts, communication devices, except after surgical removal of the larynx, or a diagnosis of permanent lack of function of the larynx.

Durable medical equipment may not be covered in every instance. Coverage is subject to the requirement that the equipment be necessary and reasonable for the treatment of an illness or injury, or to improve the functioning of a malformed body member. The Participant's diagnosis must warrant the type of equipment or supply being purchased or rented. In some instances the physician's prescription and other medical information available to the Plan is sufficient to establish that the equipment or supply is Medically Necessary. However, there are some durable medical equipment items that may require additional documentation, including but not limited to: Participant's diagnosis, the reason equipment is required, and the physician's estimate, in months, of the duration of its need. Length of time that the equipment is Medically Necessary will be determined by the Plan.

Disposable and consumable items shall be limited to the Medicare or the Plan Administrator's internal guidelines coverage and quantity guidelines pursuant to an order issued by a Plan Provider for treatment of a covered condition.

Maintenance and/or service charges for durable medical equipment covered under a manufacturer or supplier's warranty is not covered unless such charges are excluded from the warranty. In addition, since suppliers usually recover expenses incurred in maintaining equipment in working order from the rental charge, separately itemized charges for repair, maintenance, and the replacement of rented equipment are not covered.

Routine periodic servicing, such as testing, cleaning, regulating, and checking of the Participant's equipment is not covered.

Replacement, repair or maintenance of durable medical equipment or prosthetic devices unless due to a change in the Participant's condition, is supported by a current physician and approved in advance by the Plan Administrator's Medical Management Team.

Cases suggesting malicious damage, culpable neglect, or wrongful disposition of equipment will be investigated and denied when the Plan determines that it would be unreasonable to continue rental.

Separate charges for delivery of equipment and or supplies are generally not covered.

DME coverage excludes but is not limited to the following:

- Air cleaner (includes electrostatic machines, electric air cleaners);

- Air conditioners;
- Bathtub/shower seat, stool, lifts, bench, rails, or other bath/shower equipment;
- Bed accessories: board, table, over bed table or support device of any type;
- Bed baths (home type);
- Bed lifter (bed elevator);
- Bed boards;
- Bed lounge (power or manual);
- Bed, oscillating (e.g., Franklin, Clinitron or any special beds and/or specialized mattresses designed for the treatment and prevention of pressure sores or pain management);
- Blood glucose analyzer;
- Carefes;
- Dehumidifiers/humidifiers (room or central heating system type);
- Diathermy machines;
- Disposable sheets and bags;
- Disposable supplies/products which are not included with equipment;
- Elastic stockings, fabric supports, support hose, surgical stockings (e.g. TED, Jobst);
- Electrostimulation in the treatment of wounds;
- Emesis basin;
- Elevators;
- Esophageal dilator;
- Exercise equipment (e.g. weights, treadmill);
- Face masks;
- Gradient compression pumps and garments except in cases outlined in the Medicare coverage or Plan Administrator's internal guidelines;
- Grab bars;
- Heat and massage foam;
- Heating and cooling devices;
- Incontinent pads, Disposable under pads, all sizes (e.g. chux) and incontinence garment (e.g. brief, diaper);
- Insulin injectors;
- Jacuzzis or similar equipment;
- Leotards/pressure leotards;
- Lifts- patient lift bathroom or toilet (Kartop); Seat-lift chairs (except for mechanism);
- Message devices;
- Non-contact wound warming device;
- Orthotic devices, except as specified under Medical plan benefit;
- Paraffin bath units;
- Parallel bars;
- Portable nebulizer;
- Portable room heaters;
- Preset oxygen units;
- Pulse tachometer;
- Sauna baths;
- Seat lifts;
- Spare tanks of oxygen;
- Speech teaching machine;
- Stairway elevators;
- Telephone alert systems;
- Three (3) wheeled scooters;
- Toilet equipment: bidet toilet seat, raised toilet seat, toilet seat, grab bars;
- Ventilators;
- Waterbeds;
- Whirlpool baths;

- White cane.

F. Therapy Services – That are not covered

Speech Therapy (ST), Occupational Therapy (OT), or Physical Therapy (PT) unless it is determined that the member's condition is subject to improvement.

The primary diagnosis of the member is mental retardation, or a learning disability such as perceptual handicap, brain damage not caused by an accidental injury or illness, minimal brain dysfunction, dyslexia or developmental delay.

Maintenance therapy for a chronic disease or condition or a non-medical ancillary service such as vocational rehabilitation, driving evaluation and training programs, employment counseling or educational therapy.

Pulmonary rehabilitation programs provided in the home.

G. Reproductive Services – That are not covered

Devices or drugs used for the purpose of contraception

Infertility treatment (does not include diagnostic testing for infertility). Among the procedures not covered are:

- Drug therapy;
- Lab and radiology services and physician office visits related to infertility treatment;
- Artificial insemination;
- Costs associated with donation, preservation, preparation, analysis and storage of sperm, eggs or embryos;
- Embryo transplants;
- In vitro fertilization, including implantation of fertilized egg or embryo;
- Low tubal transfers;
- Gonadotropins and other drugs used to induce ovulation;
- Ultrasound monitoring for the evaluation or treatment of infertility;

Abortions by any technique, i.e. insertion of laminaria (except to initiate labor in case of intrauterine death of fetus), intra-amniotic injection for abortion of a living fetus, hysterotomy, dilatation and curettage of uterus, aspiration curettage of menstrual extraction or regulation, or any medical or surgical termination of an intact, intrauterine pregnancy prior to viability.

Expenses incurred for voluntary sterilization by any technique.

Reversal of sterilization procedures and concurrent or subsequent related expenses.

Any costs related to surrogate parenting.

Any assisted reproductive technology or related treatment that is not specified elsewhere in this Summary Plan Document.

Surgical procedures consisting of sex reassignment or sex change and related treatment including hormone therapy and medical or psychological counseling.

Amniocentesis for the sole purpose of fetal sex determination.

Care for sexual dysfunction unrelated to organic disease.

Any service that is in contravention to the Ethical and Religious Directives for Catholic HealthCare Services.

H. Work-Related Services – That are not covered

Health care services for any work-related injury or illness, if any other source of coverage or reimbursement is (or was) available may include the Participant's employer, a work-related benefit plan maintained by the Participant's employer, and any workers' compensations, occupational disease or similar program under local, state or federal law. A source of coverage or reimbursement will be considered available to the Participant even if the Participant waives the right to payment from that source.

I. Administrative Provisions – That are not covered

Services rendered or ordered by a Provider with the same legal residence or who is a family member of an eligible Participant, when such services are: (a) rendered or ordered outside of a formal Provider-patient relationship; (b) not appropriately documented in a medical or clinical record; or (c) a violation of the disciplinary guidelines of the Texas Medical Board.

All medical expenses incurred for a condition after a member leaves a program of in-patient care against medical advice of the member's physician.

Drugs that do not require a prescription are not FDA (U.S. Food and Drug Administration) approved or are considered investigational, obsolete or experimental. Specific drugs excluded from coverage include, but are not limited to:

- anorexiant and weight control medication unless an integral component of an approved physician supervised weight management program;
- nutritional programs and supplements;
- vitamins and over-the-counter medications;
- products used for cosmetic purposes;
- tobacco withdrawal or nicotine addiction medications beyond 90 days; and
- topical minoxidil used to initiate hair growth;
- drugs for contraceptive purpose.

Non-licensed professionals. Treatment for any illness or injury when not attended by a licensed physician, surgeon or non-Network Provider.

Care incurred for any conditions after the Plan terminates or Plan coverage terminates for any reason.

Services in excess of the maximum number of days or dollar amounts covered under the Plan.

Care for the conditions which federal, state or local law requires be treated in a public facility, or that would otherwise be covered under a government program.

Coverage for an otherwise eligible Participant who is on active military duty and receives care for any condition as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.

To the extent that a natural disaster, war, riot, civil insurrection, epidemic, act of God, or other emergency situation not within the control the Plan causes health or medical services, personnel, or financial resources of the Plan to be unavailable, benefits or services provided for, arranged by the Plan, or otherwise available under contract, may be unavailable. The Plan shall be responsible only for those covered services which are possible by the good-faith effort of the Plan under the circumstances of the event.

Services and supplies to any individual who is a resident or inmate in a public institution.

Exhibit D

2012 Associate Medical Comparison Chart

2012 Associate Medical Comparison Chart

Benefit Type	PLACE OF SERVICE	EPN		Expanded EPN		
		COPY	DED	Expanded EPN In-Network	Expanded EPN Out-of-Network	
Deductible	Deductible - Individual	None		\$500.00		
	Deductible - Family	None		\$1,000.00		
Outpatient Services	Maximum Inpatient Out-of-Pocket - Individual	\$1,500		\$1,500	\$10,000	
	Maximum Inpatient Out-of-Pocket - Family	\$3,000		\$3,000	\$25,000	
EXPANDED EPN SERVICES ARE SUBJECT TO DEDUCTIBLE UNLESS OTHERWISE INDICATED						
Outpatient Services	Primary Care Physician Office Visit	EPN DOCTOR	\$25	\$25		
	Specialist Physician Office Visit	SPHN	NA	\$25	40%	
		OUT of NETWORK	NA	NA	NA	40%
	Laboratory and radiology services in physician's office - office visit copay may apply if office visit billed by provider (1)	EPN DOCTOR	\$35	\$35		
		SPHN	NA	\$35		
	Skeletal or other plain film x-ray, mammogram, or lab.	OUT of NETWORK	NA	NA	\$20	40%
		EPN DOCTOR / SETON FACILITY	\$0	\$0		
	-Ultrasound, GI Series and other diagnostic services per plan guidelines, including contrast studies with no vascular injection	SPHN	NA	NA	\$25	40%
		OUT of NETWORK	NA	NA	NA	40%
	-Major radiological procedure (e.g. MRI, CT scan) and invasive diagnostic services per plan guidelines. (Listing of applicable services available upon request)	EPN DOCTOR / SETON FACILITY	\$0	\$0		
		SPHN	NA	NA	\$25	40%
	Surgical procedures in a physician's office, PCP or specialists	OUT of NETWORK	NA	NA	\$0	
		EPN DOCTOR	\$0	\$0		
	Prenatal and Postnatal obstetrical care obstetrics physician only.	SPHN	NA	NA	\$100	40%
		OUT of NETWORK	NA	NA	NA	40%
Rehabilitation therapies (speech, physical, occupational, cardiac) - Authorization is required after the first 12 visits per type of therapy service (i.e. speech, physical, occupational)	EPN DOCTOR	\$35	\$35			
	SPHN	NA	NA	\$35	40%	
	OUT of NETWORK	NA	NA	\$20	40%	
	EPN DOCTOR / SETON FACILITY	\$15	\$15			
	SPHN	NA	NA	\$20	40%	
	OUT of NETWORK	NA	NA	NA	40%	

Benefit Type	PLACE OF SERVICE	COPY	DED	COPY	COINSURANCE
Outpatient Services continued	Outpatient surgery physician charges (surgeon, anesthesia, pathology, radiology)	EPN DOCTOR		\$0	
		SPHN	Y	\$0	
		OUT of NETWORK	Y	NA	40%
	Outpatient surgery hospital charges	SETON OR JOINT VENTURE		\$0	
		SPHN	Y	\$0	
		OUT of NETWORK	Y	NA	40%
	Medical or Surgical Observation (scheduled, direct admission)	SETON OR JOINT VENTURE		\$0	
		SPHN	Y	\$0	
		OUT of NETWORK	Y	NA	40%
		EPN DOCTOR	Y	\$25	
Preventive Health Care Services	Check-ups, well-baby and well child care	EPN DOCTOR		\$25	
		SPHN	Y	\$25	
		OUT of NETWORK	Y	NA	40%
	Routine immunizations on or before child's 8th birthday	EPN DOCTOR		\$0	
		SPHN	Y	\$0	
		OUT of NETWORK	Y	NA	40%
	Other immunizations after age 8	EPN DOCTOR		\$25	
		SPHN	Y	\$25	
		OUT of NETWORK	Y	NA	40%
	Well-woman examination by PCP	EPN DOCTOR		\$25	
In-patient hospital services	Well-woman examination by OB/GYN	EPN DOCTOR		\$35	
		SPHN	Y	\$35	
		OUT of NETWORK	Y	NA	40%
	Facility charges (per admission)	SETON / JOINT VENTURE / CONTRACTED		\$100 per day	
	\$500.00 MAX PER ADMIT	SPHN	Y	NA	
		OUT of NETWORK	Y	NA	40%
	Physician charges	EPN DOCTOR		\$0	
		SPHN	Y	\$0	
		OUT of NETWORK	Y	NA	40%
	Maternity Services - Mother (per admission) hospital charges	SETON / JOINT VENTURE / CONTRACTED		\$100 per day	
	\$500.00 MAX PER ADMIT	SPHN	Y	NA	
		OUT of NETWORK	Y	NA	40%
	Physician charges	EPN DOCTOR		\$0	
		SPHN	Y	\$0	
		OUT of NETWORK	Y	NA	40%
	Maternity Services - Mother (per admission) physician charges	SETON / JOINT VENTURE / CONTRACTED		\$100 per day	
	\$500.00 MAX PER ADMIT	SPHN	Y	NA	
		OUT of NETWORK	Y	NA	40%
	Maternity Services MIDWIFE- Mother (per admission) hospital charges	SETON Facilities		\$100 per day	
	BIRTHING CENTERS NOT A BENEFIT	HOME	Y	\$0	
Maternity Services - Mother (per admission) physician charges	OUT of NETWORK	Y	\$0		
	EPN DOCTOR		\$0		
		SPHN	Y	\$0	
		OUT of NETWORK	Y	NA	40%
	Maternity Services MIDWIFE- Mother (per admission) physician charges	EPN DOCTOR		\$0	
		SPHN	Y	\$0	
		OUT of NETWORK	Y	NA	40%
		EPN DOCTOR		\$0	
		SPHN	Y	\$0	
		OUT of NETWORK	Y	NA	40%
		EPN DOCTOR		\$0	
		SPHN	Y	\$0	
	OUT of NETWORK	Y	NA	40%	

Benefit Type	PLACE OF SERVICE	COPAY	DED	COPAY	COINSURANCE
In-patient hospital services continued	Maternity Services - SICK Newborn (per admission) hospital charges	SETON / JOINT VENTURE / CONTRACTED		\$100 per day	
	Maternity Services - Newborn (per admission) physician charges	SPHN OUT of NETWORK EPN DOCTOR	Y Y	\$100 per day NA \$0	40%
Behavioral Health Services	Inpatient facility charges	SPHN OUT of NETWORK	Y Y	\$0 NA NA	40%
	\$500.00 MAX PER ADMIT	SETON / JOINT VENTURE / CONTRACTED		\$100 per day	
	Inpatient physician charges	SPHN OUT of NETWORK EPN DOCTOR	Y Y Y	\$100 per day NA \$0 \$0 NA	40%
	Outpatient physician charges	EPN DOCTOR / SETON FACILITY SPHN OUT of NETWORK	Y Y	\$35 NA NA NA	40%
	Chemical dependency inpatient facility charges	SETON / JOINT VENTURE / CONTRACTED	Y	\$100 per day	
	\$500.00 Copay MAX PER ADMIT	SPHN OUT of NETWORK	Y Y	NA NA	40%
	Chemical dependency inpatient physician charges	EPN DOCTOR SPHN OUT of NETWORK	Y Y	\$0 NA NA NA	40%
	Chemical dependency outpatient physician charges	SETON / JOINT VENTURE / CONTRACTED	Y	\$35	
	Inpatient facility charges - 90 days maximum	SPHN OUT of NETWORK	Y Y	NA NA	40%
	\$500.00 MAX PER ADMIT	SETON / JOINT VENTURE / CONTRACTED		\$100 per day	
Eating Disorders Medical criteria and Program limits apply	Inpatient physician charges	CONTRACTED DOCTOR SPHN OUT of NETWORK	Y Y	\$0 NA NA NA	40%
	Inpatient facility charges --60 days maximum	SETON / JOINT VENTURE / CONTRACTED	Y	\$0	
Residential Treatment Center under age 18 only Medical criteria and Program limits apply	Inpatient physician charges	CONTRACTED DOCTOR SPHN OUT of NETWORK	Y Y	\$0 NA NA NA	40%
	Inpatient facility charges	SETON / JOINT VENTURE / CONTRACTED	Y	\$0	
Other Health Care Services	Organ transplantation - transplant event (Note: physician and hospital services rendered pre and post transplant are subject to copays based on type of service rendered)	CONTRACTED	Y	\$100 per day	
	Home health care (per visit)	CONTRACTED OUT of NETWORK	Y Y	\$15 NA	40%

Benefit Type	PLACE OF SERVICE	COPAY	DED.	COPAY	COINSURANCE
Other Health Care Services continued					
Diabetic Supplies - Insulin, test strips, lancets and syringes 30 day supply	CONTRACTED	\$10		\$10	
Diabetic Equipment - blood glucose monitors -1 per year	OUT of NETWORK CONTRACTED	NA \$0	Y	NA \$0	40%
If additional is required \$15.00 copay	OUT of NETWORK	NA		NA	40%
Diabetic self management training (covered at Seton facilities only)	SETON FACILITY ONLY	\$15	Y	\$20	
Living Well with Diabetes Program: Team approach in managing diabetes; includes diabetic education, nutritional counseling, and diabetic educator support	OUT of NETWORK SETON FACILITY ONLY	NA \$0		NB \$0	NB
Life Style Changes Programs (Weight management options):		BELOW		BELOW	
1. Seton Weight to Health Program- 9 week session, \$20 workbook fee	SETON OR JOINT VENTURE only	\$20		\$30	NB
2. Seton Individual Nutritional Counseling Visits (max 6 visits/plan year)	SETON OR JOINT VENTURE only	\$20		\$30	NB
3. Physician Directed Program: comprehensive weight loss program	SETON OR JOINT VENTURE only	\$35		\$35	NB
4. Bariatric Surgery	SETON FACILITY ONLY	\$5,000 co-pay	Y	\$5,000 co-pay	NB
Coverage subject to member meeting SHP internal coverage guidelines for the coverage of Bariatric Surgery					
Acupuncture (Annual 20 visit maximum)	EPN DOCTOR	\$20		\$20	
Specialist copay applies on any office visit	SPHN OUT of NETWORK	NA NA	Y Y	NA NA	40%
Biofeedback (Annual 20 visit maximum and auth required for ALL visits)	EPN DOCTOR	\$20		\$30	
Specialist copay applies on any office visit	SPHN OUT of NETWORK	NA NA	Y Y	\$30 NA	40%
Chiropractic (Annual 20 visit maximum and No Auth required)	EPN DOCTOR	\$20		\$30	
Specialist copay applies on any office visit	SPHN OUT of NETWORK	NA NA	Y Y	\$30 NA	40%
Allergy testing and shots	EPN DOCTOR	\$15		\$20	
Allergy Serum (\$500 Maximum)	SPHN OUT of NETWORK EPN DOCTOR SPHN OUT of NETWORK	NA NA \$0 NA NA	Y Y Y Y	\$20 NA \$0 NA NA	40%
Durable medical equipment (\$5000 plan year maximum)	CONTRACTED PROVIDER	\$0		\$0	
Hearing Aides for Children up to age 18	OUT of NETWORK	NA	Y	NA	40%
Every 2 Years \$2500 per ear - total of \$5,000	CONTRACTED PROVIDER	\$0	Y	\$0	40%
Hospice services (180 days lifetime maximum)	CONTRACTED PROVIDER	\$0		\$0	
Emergency care	OUT of NETWORK SETON / JOINT VENTURE / CONTRACTED	NA \$125	Y	NA \$125	40%

Benefit Type	PLACE OF SERVICE	COPAY	DED	COPAY	COINSURANCE
Urgent Care	CONTRACTED FACILITY	\$125	Y	\$125	
	OUT of NETWORK	NA	Y	NA	40%
	SETON / JOINT VENTURE / CONTRACTED	\$125		\$125	
	CONTRACTED FACILITY	\$125	Y	\$125	40%
Emergency Care to Observation Care (overnight stays for observation care are not considered inpatient admissions)	OUT of NETWORK	NA	Y	NA	40%
	SETON / JOINT VENTURE / CONTRACTED	\$125		\$125	
	CONTRACTED FACILITY	\$125	Y	\$125	40%
	OUT of NETWORK	NA	Y	NA	40%
Emergency Care to Surgery then Observation Care (overnight stays for observation care are not considered inpatient admit).	CONTRACTED FACILITY	\$125	Y	\$125	40%
	OUT of NETWORK	NA	Y	NA	40%
	SETON FACILITY / Other Urgent Care list	\$45		\$45	
	OUT of NETWORK and Out of Area	\$45	Y	\$45	40%
Urgent care	OUT of NETWORK in service area	NA	Y	NA	40%
	CONTRACTED FACILITY	\$125	Y	\$125	40%
	OUT of NETWORK	NA	Y	NA	40%
	SETON FACILITY / Other Urgent Care list	\$45		\$45	
Prescription Drugs	OUT of NETWORK and Out of Area	\$45	Y	\$45	40%
	OUT of NETWORK in service area	NA	Y	NA	40%
	Generic	\$15.00		\$15	
	Preferred (see formulary)	\$30.00		\$30	
Non-preferred (see formulary)	\$60.00		\$60		
<p>Note: Members may receive a 3 month's supply of medication for 2 co-payments by the mail order program. Some drugs are subject to authorization and quantity limits. Please refer to the formulary for this information. If a generic drug is available and a name brand is filled the copay will be the generic copay plus the cost difference between the generic and name brand drug.</p>					
<p>(1) The specified physicians that provide lab and imaging are listed in http://setonhealthplan.com/provider_search/</p>					
<p>In network services must be received from in network participating providers and accessed according to the rules of the plan.</p>					
<p>All covered health services must be received from a licensed provider</p>					
<p>Expanded Out of Network - After meeting the annual deductible, the participant is responsible for charges in excess of usual, customary and reasonable (UCR)</p>					
<p>Information regarding your coverage is addressed in the information you receive from Seton human resources. If you have additional questions after reviewing the information please contact member services at 512/421-5667 or toll free 866/272-2507.</p>					
<p>Except when services are received at a Seton facility, Expanded annual deductible must be satisfied first before payment will be made to a provider by the plan. Once the deductible is satisfied you will be responsible for the copay/coinsurance only.</p>					
<p>Inpatient out of pocket individual and family maximums do not include deductible. Only inpatient hospital copays and coinsurance is applied to this maximum.</p>					
<p>Pharmacy is not subject to deductible</p>					
<p>Copays are applied when an office visit or other services subject to a copay are billed by a provider. When more than one service subject to a copay is provided on the same day same visit and by the same provider, then the plan will apply the highest copay to that visit. For EPNX members, Co-payments do not count toward the Annual Deductible.</p>					
<p>Limitations and exclusions are specified in the Summary Plan Description.</p>					
<p>REVISED AS OF 4/25/2012</p>					

This information is also available online on the Human Resource website on the Seton Intranet.