

Employee Health Plan

SETON Healthcare Network

January 1, 2007

Summary Plan Description

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Introduction

Seton Healthcare Network (the “Plan Sponsor”) established the Seton Healthcare Network Employee Health Plan (the “Plan”) to provide Eligible Employees (and employees of participating affiliates) and their eligible Dependents access to the medical benefits. Other benefits available to Seton employees are described in different plans and summary plan descriptions. Regardless of the number and types of benefits incorporated in this Plan, the Plan is a single welfare benefit plan under the Employee Retirement Income Security Act (“ERISA”). The Plan is intended to satisfy all of the applicable requirements of ERISA and the regulations issued thereunder.

This summary plan description or “SPD” for the Plan is designed to summarize clearly and succinctly a complex benefits program, without altering or modifying that program; therefore, if any mistakes were made in preparing this summary, the terms of the actual Plan will still apply. This SPD is effective January 1, 2007 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 proper benefits at any given time, it is necessary to consult the SPD (or Plan document) as it was in effect at that time.

The SPD refers in several places to the Seton Healthcare Network “Benefits Guide.” The Benefits Guide is the booklet Seton Healthcare Network distributes at open enrollment and to new hires to provide information about its benefit programs. The Benefits Guide and this SPD are designed to work together to describe the medical benefits available under the Plan, so please consult the Benefits Guide for more information whenever you see a reference to it in this SPD. For information about other Seton benefits, please see the appropriate summary plan description.

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

The Plan is based on current tax laws. Seton Healthcare Network and the Participating Employers expect and intend to continue the Plan and its benefits as described in this SPD. However, Seton Healthcare Network reserves the right to amend, modify or terminate the Plan or any benefits provided under the Plan at any time and for any reason. In addition, your eligibility and participation in the Plan described in this SPD should not be construed as an employment contract.

The Plan Sponsor intends for the official Plan documents to govern if there are any discrepancies between the information in this SPD (or the Benefits Guide) and the Plan documents.

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

Glossary

The following terms may help you in reading and understanding the provisions of this SPD.

Authorization approval by the plan received prior to certain services being rendered, including but not limited to non-emergent out of network services.

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.

Benefits Guide descriptive guide of all benefits published on an annual basis by the employer.

Claims Administrator means, with respect to a particular benefit option, the person(s) or entity(ies) appointed by the Plan Sponsor to serve as the claims administrator for such benefit. The Claims Administrator for insured benefits will be the relevant insurance company or HMO. The Claims Administrator for self-funded benefits will be the Plan Sponsor or a third party administrator designated by the Plan Sponsor.

Consolidated Omnibus Budget Reconciliation Act (COBRA): act of 1985, requires group health plans with 20 or more employees to offer continued health coverage for employees and their 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, in addition to what health insurance covers, that an individual pays for health care services.

Covered Benefit is a health service or item that is included in the Plan, 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 benefits paying each Plan Year.

Dependent (based on recent legislative changes) is any individual described in paragraphs (a) through (d) of this definition:

(a) the Eligible Employee's lawful spouse (according to Texas law). 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 complete, sign and return an Affidavit of Informal Marriage provided by the Plan Sponsor.

(b) a child of the Eligible Employee with respect to whom a qualified medical child support order is in effect;

(c) an unmarried child of any age who is incapable of self support due to a physical or mental disability and who has the same principal place of abode as the Eligible Employee for more than one-half of the Plan Year and who has 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 lose coverage.

(d) an Eligible Employee's dependent child, stepchild or legally adopted child, a child placed for adoption with the Participant, a child for whom the Eligible Employee is the legal guardian, or a descendant of any of the children listed in this paragraph who satisfies the requirements of either sub-paragraph (1) or sub-paragraph (2) of this paragraph (d):

(1) Any individual named above in paragraph (d) of this definition shall be a dependent of the Eligible Employee if such individual: (A) has not attained the age of 19 (age 24 in the case of a student as defined in Internal Revenue Code Section 152(f)(2)); and (B) has the same principal place of abode as the Eligible Employee for more than one-half of the Plan Year; and (C) has not provided over one-half of this or her own support during the Plan Year.

(2) Any individual named above in paragraph (d) of this definition shall be a dependent of the Eligible Employee if: (A) such individual is not described in paragraph (d)(1) of this definition; and (B) such individual has not attained age 25; and (C) the Eligible Employee provides over one-half of the support of such individual during the Plan Year.

(e) an Eligible Employee may not be covered as both an Employee and a Dependent

Eligible Employee means any employee or former employee of an Employer who is eligible to participate in and receive benefits under the Plan. The term "Eligible Employee" includes any employee or former employee who is not

participating in the Plan solely because he or she has not made a required election or has not completed a required waiting period. Dependents are eligible to participate solely through an Eligible Employee.

Employer or Participating Employer means Seton Healthcare Network and any affiliated employer that participates in the Plan with the approval of Seton Healthcare Network.

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.

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.

Medical Director is the health Plan physician executive who is responsible for the quality and cost-effectiveness of the medical care delivered by the plan's providers.

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:

- 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.

Participant means (i) any Eligible Employee who elects to participate in the Plan in accordance with its terms and conditions, 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.

Plan means the Seton Healthcare Network Employee Health Plan as set forth in this document, including any amendments, and the Participating Programs incorporated by reference in Supplement A

Plan Sponsor is the entity responsible for establishing and maintaining the plan

Plan Year means a period of twelve months beginning each January 1 and ending December 31 (except that the first Plan Year is a short year beginning July 1 and ending December 31).

Premium means the total periodic payments, including self-insured Plan costs, necessary to keep coverage in force under this Plan.

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

Qualifying Event means an act or event of legal significance that triggers a change to, or a Participant's right to change, coverage under the Plan. Such events may be the employment 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 3.

Serious Mental Illness includes: bipolar disorders (hypomaniac, manic depressive, and mixed); depression in childhood and adolescence: major depressive disorders (single episode or recurrent); obsessive-compulsive disorders; paranoid and other psychotic disorders; pervasive developmental disorders; schizo-affective disorders (bipolar or depressive); and schizophrenia.

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, you are budgeted to work 16 hours or more per week for an

Employer, and you enroll in the Plan, unless another eligibility standard is specified for a benefit option.

Family Members. Your family members are eligible to participate in the Plan if you, the Eligible Employee, enroll and cover them as Dependents.

The Plan enrollment procedures are described in the Benefits Guide.

When Coverage Begins and Ends

Generally, coverage will begin the first of the month following a 30-day waiting period, at the time an Eligible Employee satisfies the Plan eligibility requirements, or each year during open enrollment, except as otherwise provided for a benefit option. If you do not enroll during the 30 days after the date you become an Eligible Employee, you may have to wait until the next open enrollment period unless you experience a Qualifying Event that allows you to change your election.

If you enroll your spouse and/or children, their coverage begins on the first of the month following a 30-day waiting period.

Your coverage and that of your 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 5 of this SPD for information on portability and continuation of coverage.

Your Cost for Coverage

The cost for coverage is provided to you in the enrollment materials.

Premiums are subject to change by the Plan Sponsor or insurance carrier, as applicable, based on actual or expected group experience. However, 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 family members' age or your or your family members' 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 generally 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 makes you or your Dependent eligible or ineligible to participate in the Plan. The Qualifying Event election change rules and procedures are described in the Benefits Guide.

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 Dependents will be eligible for special enrollment. You can enroll without enrolling your Dependents, or you and your spouse can enroll without enrolling your other Dependents. However, your spouse and other Dependents may not enroll unless you enroll.

You must request special enrollment 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. Any other enrollment will be effective as of the date you submit the enrollment form.

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 this 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, 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).

Section 4: Plan Benefits

Benefits / Exclusions and Limitations

Please see Exhibit A for an overview of the benefits, exclusions and limitations under the Plan.

Premium Contributions

Premiums for the benefits available under the Plan are printed on your enrollment worksheet.

Payment of Benefits

Benefits generally are payable to the health care 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: COBRA Continuation Coverage

Under COBRA you and your enrolled Dependents will have the opportunity to extend medical health COBRA coverage temporarily at group rates after health coverage under the Plan would otherwise end or if costs increase due to specific events. The COBRA continuation coverage rules and procedures are described in the Benefits Guide.

Section 6: Other Plan Provisions

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. If you would like another copy of the Notice, contact the Plan Sponsor.

Maternity-Related Benefits

Under federal law, the Plan 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 fewer than 48 hours following a normal vaginal delivery, or fewer than 96 hours following a cesarean section, or require Authorization from the participating medical plan to prescribe a length of stay that does not exceed the periods described above, subject to plan guidelines. However, federal law does not prohibit an attending Provider of the mother or newborn, after consulting with the mother, from discharging the mother or her

newborn before 48 hours (or 96 hours, if applicable) have passed.

Mental Health Benefits

All benefit options available under the Plan that are subject to the equal benefits requirements of the Mental Health Parity Act 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 first month that begins 30 days after your status change, 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 under COBRA for up to 18 months after the end of the month in which you otherwise lose coverage (or, if earlier, until the day after the date you are required to apply or return to active employment with your

Employer). You must make arrangements with your Employer to pay your COBRA Contributions during your leave or after you return to active employment with your Employer, as described in the Benefits Guide.

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 first month that begins 30 days after your status change, 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 take any other unpaid leave of absence, including leave under USERRA, your right to maintain coverage under the Plan is as described in Section 5 and the Benefits Guide under COBRA continuation coverage.

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.

Assignment of Benefits

No assignment of any kind will bind the Plan Sponsor or any insurance carrier 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 or insurance carrier, as applicable, determines that the Participant is not legally able to give a valid receipt and discharge of payment, the Plan Sponsor or insurance carrier may pay the benefits to the Participant’s legal representative.

Subrogation

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 of your rights of recovery, to the extent of such benefits provided or the reasonable value of services or benefits provided by the Plan, including those rights of recovery against underinsured/uninsured automobile insurance coverage or no fault insurance coverage, such as personal injury or medical payments protection. Upon receiving any benefits from the Plan, you are considered to have assigned your rights of recovery to the Plan to the extent of such benefits. If you have retained an attorney to pursue your rights of recovery, the Plan is not responsible for paying any portions of your attorney’s fees or costs.

If you receive benefits under the Plan, you must immediately notify the Plan Sponsor of the name of any individual or organization against whom you might have a claim as a result of your illness or injury (including any insurance company that provides coverage for you). For example, if you are injured in an automobile accident and the person who hit you was at fault, the person who hit you (and his insurance company) is a person whose act or

omission has caused your illness or injury. You must cooperate with the Plan to provide information about your illness or injury and you must agree to sign any necessary document for the Plan and provide all requested information sought by the Plan in furtherance of the Plan's right to subrogate your claim. The Plan may:

- place a lien against a third party or insurance company to the extent benefits have been paid;
- bring an action on its own behalf, or on your behalf, against the person, organization or insurance company; and
- cease paying you benefits until you provide the Plan Sponsor with the documents necessary for the Plan to exercise its rights and privileges of subrogation.

Reimbursement

If the Plan pays or provides you medical benefits for an illness or injury that was caused by an act or omission of an individual or organization, and/or if you have sought recovery from no fault insurance, the Plan has the right to be repaid first for any medical benefits from any settlement, judgment, or insurance proceeds you receive. The Plan has a right to reimbursement whether or not a portion of the settlement, judgment, or insurance proceeds was identified as a reimbursement of medical expenses. You agree, by accepting benefits under the Plan, to provide the Plan with a lien, to the extent the Plan has paid medical benefits, to be filed with the responsible party or insurance company.

If you do not reimburse the Plan from any settlement, judgment, or insurance proceeds, the Plan is entitled to reduce current or future medical or expense benefits payable to you or payable on your behalf until the plan has been fully reimbursed.

Coordination of Benefits

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.
- (f) 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.
- (g) 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.
- (h) Payments for benefits under the Plan will be reduced by any payments for the same benefits 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 applicable Claims 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 7: Claim and Appeal Procedures

A “claim” under the Plan means an inquiry by an individual regarding benefits under the Plan that (i) consists of a communication by the individual or his or her authorized representative (including a care Provider) to the Plan Sponsor, a Claims Administrator or any other individual or organization that handles benefit matters for the Plan Sponsor and (ii) 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.

Claims and appeals under the Plan will be processed by the appropriate Claims Administrator (identified in Section 9 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 6.
- 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. 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 Claims Administrator will notify you of the benefit determination within 72 hours. 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.

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 Claims 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 of up to 15 days, indicating why an extension is necessary and the date the Claims 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. After the Claims Administrator receives your Post-Service Claim, the Claims 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, the Claims Administrator will notify you during the initial 30-day period, indicating why an extension is necessary and the date on which the Claims 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 through 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 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 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 make available such a statement of explanation; 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 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 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 (such as the Claims 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 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 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 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 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 within 72 hours after you file 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 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 make available such a statement of explanation; and
- if the determination was made with respect to an Urgent Care Claim, describe the Plan's expedited review process.

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 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 (such as the Claims 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 Plan Sponsor but you are a dependent and spouse of a Participant, 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 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 within 72 hours after you file your appeal. For Pre-Service Claims, the Claims Administrator will notify you of the determination within 15 days after you file your appeal. For Post-Service Claims, the Claims Administrator will notify you of the determination within 30 days after you file your appeal.

Notice of Final Decision on Appeal of an Adverse Benefit Determination

If the decision on 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 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 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 make available such a statement of explanation.

The Claims Administrator's decision on appeal is final and binding.

Section 8: Your ERISA Rights

As a Participant in this 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.

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 Employee benefit plan. The people who operate your 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 are 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 documents from the Plan Sponsor 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 Sponsor. 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 Sponsor, 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 9: Plan and Contact Information*Plan Information*

Official Plan Name	Seton Healthcare Network Employee Health Plan
Employer Identification Number	74-1109643
Plan Number	501
Plan Year	January 1 through December 31
Plan Description	Group Health Plan
Plan Sponsor and Administrator	Seton Healthcare Network 1201 West 38th Street Austin, Texas 78705
Claims Administrator	The Claims Administrators for the various benefit options are identified below in the Contact Information section.
Type of Administration	Self-funded benefit options are administered by a third-party administrator. Insured benefit options are administered by the insurer.
Participating Employers	<ul style="list-style-type: none"> • Ascension Health – Austin Employees • Children’s Hospital Foundation of Austin • CTMF, Inc., d/b/a Austin Medical Education Programs • Daughters of Charity Health Services of Austin, d/b/a Seton Healthcare Network • Healthy Achievements, Inc. • Seton Fund of the Daughters of Charity of St. Vincent de Paul, Inc. • Seton Health Plan, Inc. • Seton Medical Group • Seton Physician Hospital Network • ‘Specially for Children’ Children’s Hospital Subspecialists of Central Texas • The Seton Cove • Topfer Building Condominium Association
Agent for Service of Legal Process	Seton Healthcare Network 1201 West 38th Street Austin, Texas 78705 Attn: Vice President of Legal Affairs
Type of Funding	Some of the benefit options available under the Plan are self-insured and some are fully insured. The Plan is funded with a combination of Employer and employee Contributions.

Contact Information

TO FILE OR APPEAL A CLAIM	Claims Administrator
<ul style="list-style-type: none"> • Medical 	Seton Health Benefits Administrator PO Box 14545 Austin, TX 78761-4545
QUESTIONS ABOUT THE PLAN OR SPD	Plan Sponsor
	Seton Healthcare Network Human Resources Department 1201 West 38th Street Austin, TX 78705

Exhibit A

Medical Benefits and Exclusions and Limitations

SETON Healthcare Network Employee Health Plan

SETON Healthcare Network Employee Health Plan Medical Benefits

The Plan will provide the following Medically Necessary Services as Covered Benefits, subject to the terms and conditions stated in the SPD.

Members or Dependents that reside outside the service area must receive care from an in-network Provider or facility. The only out of network benefit is Emergency Care services.

Co-payments, Coinsurance, Deductible and Benefit Maximums, which are summarized in the Benefits Guide, may apply to the benefits below. All limitations are per Participant for the Plan Year, except as specified.

A. Physician Benefits

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 in-network 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

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

Other Physician Services

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

EPN members must use SETON Healthcare Network facilities for this service.

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;

EPN members must use SETON Healthcare Network facilities for this service.

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 "General Exclusions", are covered, including:

Inpatient Services

When authorized by the Plan, Medically Necessary inpatient, twenty-four hour observation Hospital Services, and acute inpatient rehabilitation 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;
- acute rehabilitation services and physical therapy, which cannot be provided on an outpatient basis;
- inhalation therapy;
- radiation therapy; and
- such other Medically Necessary Services customarily provided in acute care hospitals.

Inpatient Rehabilitation Services

Medically Necessary inpatient rehabilitation services are covered. The Maximum Benefit for inpatient rehabilitation services is thirty (30) days per plan year.

Care in Skilled Nursing Facility

Medically Necessary care in a Skilled Nursing Facility is covered when prior authorized by the Plan. The Maximum Benefit for 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;
- acute rehabilitation services and physical therapy, which cannot be provided on an outpatient basis;
- 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 at an out of network facility, the Claims 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 Claims Administrator and care is determined not Medically Necessary, the member will be responsible for all charges incurred for the services received.

Authorized 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.

Authorized 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.*

*EPN members must use SETON Healthcare Network facilities for this service.

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 Benefit unless internal guidelines are met.

Reconstructive surgery

- Reconstructive surgery for craniofacial abnormalities in Dependent children to improve the function of, or to attempt to create a normal appearance of, an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease will be covered;
- 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 General Exclusions).

Diabetes

Diabetes equipment and supplies are covered when ordered by a contracted Provider, are Medically Necessary and meet the Claims Administrator's internal guidelines.

- 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 if authorized not subject to any Benefit Maximum, including:
 - blood glucose monitors, including monitors designed to be used by blind individuals;
 - insulin pumps and associated supplies;
 - podiatric appliances not to exceed two pairs of therapeutic footwear per year, for the prevention of complications associated with diabetes;
- 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 authorized 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 authorized by the Plan for Participants who have an acquired brain injury.

E. Mental Health Services

The Plan provides benefits for the treatment of mental/behavioral health conditions. Expenses for the treatment of mental/behavioral health conditions are considered the same as any other illness for the Plan's deductible, benefit percentage, and out of pocket requirements. An order by a court or state agency for treatment is not an indication of medical necessity.

Outpatient Benefit

The Plan will reimburse up to twenty (20) individual or group therapy sessions (outpatient visits per calendar year) for the medically necessary treatment of a behavioral health condition. The Plan will reimburse sixty (60) individual or group therapy sessions (outpatient visits per calendar year) for the medically necessary treatment of a serious mental illness (SMI see section F). Outpatient visits for the purpose of medication management are covered under the same terms and conditions as outpatient visits for treatment of physical illness, and are not counted toward the annual visit limit.

Intensive Outpatient Therapy Program

Intensive outpatient therapy individual or group sessions will accumulate to the outpatient visit benefit calendar year maximum of twenty (20) visits and sixty (60) for SMI.

Inpatient Benefit

The Plan will reimburse up to thirty (30) inpatient days each calendar year for the medically necessary treatment of behavioral health conditions. The Plan will reimburse up to forty-five (45) inpatient days each calendar year for the medically necessary treatment of SMI (see section F).

Day Treatment/Partial Hospitalization

Each day of treatment in a psychiatric day treatment program or partial hospitalization at a psychiatric facility will be considered equal to one-half (1/2) of one day of treatment in a hospital or inpatient program for the purpose of determining the Benefit Maximums.

F. Serious Mental Illness

The term “Serious Mental Illness” mean the following psychiatric illnesses as defined by the American Psychiatric Association in the latest version of the Diagnostic and Statistical Manual (DSM):

1. bipolar disorders (hypomaniac, manic, depressive, and mixed);
2. depression in childhood and adolescence;
3. major depressive disorders (single episode or recurrent);
4. obsessive compulsive disorders (OCD);
5. paranoid and other psychotic disorders;
6. pervasive developmental disorders including autism;
7. schizo-affective disorders (bipolar or depressive); and
8. schizophrenia.

Outpatient Benefit

The Plan will reimburse up to sixty (60) individual or group therapy sessions (outpatient visits per calendar year) based on Medical Necessity. Outpatient visits for the purpose of medication management are covered under the same terms and conditions as outpatient visits for treatment of physical illness, and are not counted toward the annual sixty (60) visits.

Inpatient Benefit

The Plan will reimburse up to forty-five (45) inpatient days each calendar year for the medically necessary treatment of SMI.

Day Treatment/Partial Hospitalization

Each day of treatment in a psychiatric day treatment program or partial hospitalization at a psychiatric facility will be considered equal to one-half (1/2) of one day of treatment in a hospital or inpatient program for the purpose of determining the Benefit Maximums.

Residential Treatment – Children and Adolescents ONLY

The Plan will reimburse up to sixty (60) days each calendar year for the medically necessary treatment of behavioral 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;
- Covered individual must have a behavioral health condition which would otherwise necessitate hospital confinement;
- Services must be based on an individual treatment plan; and
- Providers of services must be properly licensed and in-network

The benefit may only be used in situations in which the insured has a Serious Mental Illness which substantially impairs the person’s thought, perception of reality, emotional process, or judgment or grossly impairs behavior as manifested by recent disturbed behavior and which would otherwise necessitate confinement in a hospital if such care and treatment were not available.

G. Eating Disorders

The Plan will reimburse up to ninety (90) days of treatment per calendar year at either an inpatient or residential treatment facility. Services must be provided at an in-network contracted eating disorder program.

Outpatient Benefit

The Plan will reimburse up to sixty (60) individual or group therapy sessions (outpatient visits per calendar year) for the medically necessary treatment of an eating disorder.

Intensive Outpatient Therapy Program

Intensive outpatient therapy individual or group sessions will accumulate to the outpatient visit benefit calendar year maximum of sixty (60) visits.

H. Chemical Dependency and Detoxification Treatment

Coverage for chemical dependency treatment is available on the same basis as physical illness generally under the Plan, subject to the limitations and definitions of this subsection. Expenses for the treatment of chemical dependency have a lifetime maximum of three (3) separate series of treatments. A chemical dependency treatment series is a planned and organized program to promote chemical free status which may include different facilities or treatment modalities and is complete when the Participant is discharged on medical advice from inpatient detoxification, inpatient rehabilitation, partial hospitalization, or intensive outpatient therapy, or alternatively, when there is a lapse in treatment of, or failure to materially comply with the treatment plan for a period of thirty (30) days. The services rendered must be based on an individual treatment plan, and approved by the Plan. An order by a court or state agency is not an indication of medical necessity. The individual treatment plan, and utilization review of services provided under such plan, shall be in compliance with applicable federal and state regulations for detoxification, chemical dependency treatment and chemical dependency treatment centers.

Inpatient Benefit

Inpatient benefit is subject to the physical illness benefit limitations of the Plan.

Residential Treatment

Residential Treatment is a covered benefit when determined to be medically necessary for treatment of chemical dependency and 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

I. Organ Transplant Services

Physician and Hospital Services for the following Medically Necessary organ transplants when pre-approved by the Plan's Medical Director and meets internal guidelines:

- kidney transplants
- heart transplants

- lung transplants
- liver transplants
- cornea transplants
- bone marrow transplants

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

J. Ambulance Service

- A Participant is entitled to Medically Necessary ambulance service provided such ambulance service is authorized 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.

K. Home Health Services

Home health services provided by an in-network Provider are a Covered Benefit. 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/Plan Year.

L. Prosthetics and Orthotics

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 furnished to selected diabetic Participants (section D 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 casting care;
- Or as Prosthetic shoes.

M. 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 Benefits as defined by current federal Medicare guidelines when ordered by an in-network physician and medically indicated as determined by the Plan. The Plan maintains the option of providing 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 authorized in advance by the Plan and are included in the DME Benefit Maximum.

Disposable and consumable supplies are covered. The annual Benefit Maximum payable per Benefit Period, per Participant, on coverage under this rider is five thousand dollars and no cents (\$5000.00). Coverage is provided for durable medical equipment, subject to requirements of the Plan.

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

N. 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 authorized in advance by the Claims Administrator are covered as long as they meet or exceed treatment goals for the Participant.

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.

O. Dental Related Procedures

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 Plan 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 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.

P. Hospice Care

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

Q. 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.

R. Nutritional Counseling

Nutritional counseling is covered for chronic disease states in which dietary adjustment has a therapeutic role, when it is prescribed by a physician and provided only at a Seton Facility Clinical Nutrition Department. This benefit is subject to any pre-Authorization 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).

S. Chiropractic, Acupuncture, Biofeedback

Chiropractic, acupuncture and biofeedback services are benefits and may be subject to Authorization by the Plan and Plan Year Benefit Maximums (annual 20 visit maximum).

**SETON Healthcare Network Employee Health Plan
Medical Benefits – Exclusions and Limitations**

The Plan excludes or limits the following from coverage.

A. Routine Health Services

Assisted listening devices, hearing aids (including implanted bone conduction hearing aids) or testing and examinations for the prescribing or fitting of hearing aids.

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.

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, services for remedial reading and special education.

Psychological testing and services for learning disabilities.

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

Any care, treatment, services equipment or supplies received outside the service area and provided by a non-participating Provider unless care is Emergency Care or prior authorized by the Claims 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-approved by the Claims 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 conditioner, 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 authorized by the Claims 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.

Disability determinations 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 Benefit 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 K;
- 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.

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

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

Services not covered under the Plan and any related services are non-covered also. 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

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.

The application of fitting of orthodontic appliances, splints, and braces 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 the Medical Section O for TMJD coverage information).

C. Transplant Services

Any and all transplant of organs, cells and other tissues are excluded, except for the list of transplants specifically covered in Medical Benefits H. Such covered transplants must meet the following conditions:

- be pre-approved by the Claims Administrator's Medical Director;
- not considered experimental, investigational or unproven;
- be provided by a contracted physician and 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

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;

This exclusion does not apply to breast reconstruction following a mastectomy (see Medical Benefits, D). 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 Medical Benefits, D)

Other surgical procedures not covered unless internal criteria are met include:

- Breast reduction;
- Blepharoplasty;
- 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

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 coverage and quantity guidelines pursuant to an order issued by an in-network physician 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 Medical Director.

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 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 dialator;
- Exercise equipment (e.g. weights, treadmill);
- Face masks;
- Garments for gradient compression pumps (lymphadema pump) except for treatment of lymphadema secondary to neoplasms;
- Grab bars;
- Heat and massage foam;
- Heating and cooling plants;
- 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 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

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. Mental Health Services

Long-term psychological conditions or behavioral disorders that the Claims Administrator's Medical Director determines are not amenable to improvement by short-term treatment are excluded, except as may be necessary for Serious Mental Illness.

Marital counseling.

H. Reproductive Services

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 agreement.

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.

I. Work-Related Services

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.

J. Administrative Provisions

Services rendered by a Provider with the same legal residence or who is a family member of an eligible Participant.

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 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 addition medications; 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-participating Provider.

Care incurred for any conditions after the Plan 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.