Monongahela Valley Hospital

GROUP MEDICAL PLAN

(Also known as the Pennsylvania Health Care Plan, Southwestern Pennsylvania)

PLAN DOCUMENT / SUMMARY PLAN DESCRIPTION

– HOME HOST PLAN –

Administered by Vale-U-Health, Third Party Administrator

Restated: July 1, 2015
Intentionally blank
ESTABLISHMENT OF THE PLAN: ADOPTION OF THE SUMMARY PLAN DESCRIPTION

This SUMMARY PLAN DESCRIPTION (the “Summary Plan Description” or “SPD”), made by Monongahela Valley Hospital, Inc. (the “Hospital” or “Plan Sponsor”) as of July 1, 2015, hereby amends and restates the Monongahela Valley Hospital Group Medical Plan (also known as the Pennsylvania Health Care Plan, Southwestern Pennsylvania) (the “Plan”). The Plan was originally adopted by the Hospital effective January 1, 1986 for the Professional Staff Employees and July 1, 1987 for the Bargaining Unit Employees.

The Plan covers eligible employees of Monongahela Valley Hospital, Inc. and certain other subsidiaries of its parent company, Mon-Vale Health Resources, including the Center for Fitness and Health, Monongahela Medical Supply Company, Mon-Vale Professional Services, Inc., Residence at Hilltop and Vale-U-Health.

This Plan document and SPD applies to both Plan Number 509 (for Professional Staff Employees) and Plan Number 510 (for Bargaining Unit Employees).

Effective Date

This Summary Plan Description is effective as of July 1, 2015 (“Effective Date”), with certain amendments being effective as of the dates set forth herein.

Adoption of the Summary Plan Description

The Plan Sponsor, as the settlor of the Plan, hereby adopts this Summary Plan Description as the written description of the Plan. This Summary Plan Description amends and replaces any prior statement of the health care coverage contained in the Plan or any predecessor to the Plan and also serves as the Plan document.

The Plan is an employee welfare benefit plan as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974, as amended (“ERISA”). The terms and conditions of the benefits offered under the Plan are subject to various documents, agreements or administrative service contracts applicable to such benefits. The documents, agreements, and contracts, as amended from time to time, are incorporated herein by reference.

Benefits are provided under this Plan for employees covered by an agreement between the Hospital and United Steelworkers of America, Local #8041 of the International Union (designated collectively as the “Union”), pursuant to the terms of that agreement, as well as certain other individuals who are not covered by the agreement. A copy of the agreement between the Hospital and the Union may be obtained upon written request to the Plan Administrator and is available for examination at the Plan Sponsor’s principal office and at each establishment of the Plan Sponsor where at least 50 Employees covered by the Plan customarily work.

The Plan is self-insured, which means that the benefits are paid from the general assets of the Hospital.

Note that capitalized terms are defined in the “Definitions” section in the back of this document.

STATEMENT TO COVERED PERSONS

As an employee of the Hospital and other subsidiaries of parent company Mon-Vale Health Resources, you are provided with access to a complete system of quality medical care through the Plan, which is a Preferred Provider Organization (“PPO”) that contracts with physicians, hospitals, and allied health care facilities to form a health care network for you and your dependents.

This summary plan description gives you information you need to understand the health care benefits provided through your participating employer in accordance with the terms of the Plan. On the following pages, you will find a description of the benefits provided by the Home Host Plan option under the Plan. Please read this summary plan description carefully and use the following list to call with specific questions you may have:

Benefit coverage, claims and general inquiries, call:

For members of employer Monongahela Valley Hospital and other subsidiaries of its parent company Mon-Vale Health Resources, call Vale-U-Health at (724) 379-4011 Option #1 or toll free at 1-877-264-8258 (1-877-264-VALU) Option #1.


Pre-certification/Case Management requests or inquiries:

For members of employer Monongahela Valley Hospital and other subsidiaries of its parent company Mon-Vale Health Resources, call Vale-U-Health at (724) 379-4011 Option #2 or toll free at 1-877-264-8258 (1-877-264-VALU) Option #2;

For members of employer Vale-U-Health, call American Health Holdings at 1-800-641-5566.
For enrollment changes, changes in employment status or provider directories, call:
The Personnel Department at (724) 258-1094.

For all Prescription Drug Benefit Program inquiries, call:
The telephone number on the back of your Prescription Drug Benefit Program ID card.

Your medical coverage identification (ID) card
You will receive an additional card if you have one or more family members enrolled in the Plan. It is extremely important that you present the correct and most current ID card when receiving medical services.

Your Prescription Drug Benefit Program identification (ID) card
You will receive an additional card if you have one or more family members enrolled in the Plan. It is extremely important that you present the correct and most current ID card when purchasing prescription drugs.
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GENERAL PLAN INFORMATION

What is the purpose of the Plan?
The Plan Sponsor has established the Plan for your benefit, on the terms and conditions described herein. The Plan Sponsor’s purpose in establishing the Plan is to help offset, for you, the economic effects arising from an injury or illness. To accomplish this purpose, the Plan Sponsor must be cognizant of the necessity of containing health care costs through effective plan design and the Plan Administrator must abide by the terms of the Plan, as detailed in this document, to allow the Plan Sponsor to allocate the resources available to help those individuals participating in the Plan to the maximum feasible extent.

The purpose of this document is to set forth the terms and provisions of the Home Host Plan Option under the Plan that provide for the payment or reimbursement of all or a portion of certain medical expenses. This document is maintained by the Plan Administrator and may be inspected at any time during normal working hours by any covered person.

General Plan Information You Should Know

Participating Employers: Monongahela Valley Hospital, Inc., and other subsidiaries of Mon-Vale Health Resources and Vale-U-Health

Name of Plan: Monongahela Valley Hospital Group Medical Plan (also known as the “Pennsylvania Health Care Plan, Southwestern Pennsylvania”)

Plan Sponsor and ID # (EIN): Monongahela Valley Hospital, Inc. – 23-7218917
1163 Country Club Road
Monongahela, PA 15063-1095
(724) 258-1000

Plan Administrator: Vice President, Human Resources
Monongahela Valley Hospital, Inc.
1163 Country Club Road
Monongahela, PA 15063-1095
(724) 258-1132

Plan Option and Group Number Home Host Plan
Professional Staff Employees: 67945, 67946
Bargaining Unit Employees: 67955

Plan Year: July 1 through June 30

ERISA Plan Number: Professional Staff Employees: 509; Bargaining Unit Employees: 510

Plan Type: Medical and Prescription Drug

Third Party Administrator: Vale-U-Health
WillowPointe Plaza
800 Plaza Drive, Suite 230
Belle Vernon, PA 15012
(724) 379-4011
Toll Free: (877) 264-8258

For members of Vale-U-Health:
W.O. Comstock & Associates
5375 SW 7th Street Suite 600
Topeka, KS 66606
(866) 218-0617

Agent for Service of Process: Vice President, Human Resources
Monongahela Valley Hospital, Inc.
Plan Administrator
1163 Country Club Road
Monongahela, PA 15063-1095
(724) 258-1132
The Plan shall take effect on the effective date shown on the cover, unless a different date is set forth above. The Plan is a legal entity. Legal notice may be filed with and legal process served upon the Plan Administrator.

**Not a Contract**
This document and any amendments constitute the terms and provisions of coverage under this Plan. The document shall not be deemed to constitute a contract of any type between the Employer and any Covered Person or to be consideration for or an inducement or condition of the employment of any Employee. Nothing in this document shall be deemed to give any Employee the right to be retained in the service of the Employer or to interfere with the right of Employer to discharge any Employee at any time.

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**ELIGIBILITY FOR PARTICIPATION**

**Am I eligible to participate in the Plan?**
To protect employees against expenses incurred due to a non-occupational accident or illness, the Plan makes medical benefits available for all Regular Full-Time Employees and Temporary Full-Time Employees. Regular Part-Time Employees may participate subject to pro-rated premium contribution levels. Temporary Part-Time Employees, Seasonal Employees and Casual Employees are not eligible for coverage under this Plan, unless they meet the requirements below. Please refer to the “Definitions” section for the full definition of each of these classes of employees. You are also not eligible to participate if you are a leased employee or an independent contractor.

As a Regular Full-Time Employee, you are eligible for coverage when you begin active employment. Assignment to a work schedule is not a guarantee of any particular number of hours per day, week, pay period or year nor is it a promise of employment for any period of time.

As a Temporary Full-Time Employee, you are eligible for coverage when you complete your waiting period of 60 days of continuous active employment. At the end of the specified period of time, the Temporary Full-Time Employee’s employment is terminated.

As a Regular Part-Time Employee, you are eligible for coverage when you begin active employment.

Temporary Part-Time Employees, Seasonal Employees and Casual Employees are eligible for coverage during a payroll quarter if they work at least 30 hours per week, on average, during the previous payroll quarter. Payroll quarters are 13-week periods established by the Employer. Employees who qualify for coverage for a payroll quarter will remain eligible for the entire payroll quarter, irrespective of their hours, provided they remain employed.

**Active at Work Requirement**
You must actually begin work for the participating employer in order to be eligible. If you are unable to begin work as scheduled, then your coverage will become effective on the date when you begin work.

**Are my dependents eligible to participate in the Plan?**
Your Dependents will become eligible for coverage on the latest of the following dates:
- The date you become eligible for coverage;
- The date coverage for dependents first becomes available under the Plan; and
- The first date upon which you acquire a dependent.

**Please note: You must be covered under the Plan in order to cover any dependents.**

If your spouse also works for the Employer, your spouse cannot be added as a dependent on your coverage. Each spouse must be covered as an individual under the Plan. Your dependent children may be added as dependents under either your or your spouse’s coverage, but not both.

If your child under age 26 also works for the Employer, your child may either be added as a dependent on your coverage, or may be covered as an individual under the Plan, but not both.
When will we become covered persons in the plan?
Coverage will become effective at 12:01 A.M. (except for newborn children) on the date specified below, subject to the conditions of this section.

- Coverage will become effective on the first day of the month following the date you or your Dependents are eligible.
- For a dependent child who is born after the date your coverage becomes effective:
  - During the first thirty (30) days from the child’s birth, you should make written application to the Plan Administrator and agree to any required premium contributions. Coverage for the dependent child will then become effective from the moment of birth and no pre-existing condition limitation will apply.
  - If you acquire a dependent while you are eligible for coverage for dependents, coverage for the newly acquired dependent will be effective on the date the dependent becomes eligible. Within thirty (30) days of the date of eligibility for the dependent, you should make written application to the Plan Administrator and agree to make any required premium contributions.

What if I do not enroll during my original eligibility period and later decide to apply for coverage?
If you did not enroll during your original eligibility period and have now decided to apply for coverage, you may do so by making written application to the Plan Administrator. Likewise, if you declined to enroll any of your eligible dependents during the original enrollment period, you may apply for coverage for them at a later date in certain circumstances, such as during the next open enrollment period or if a change in status occurs. Coverage will be effective at 12:01 A.M. on the first day of the month following enrollment.

Open Enrollment
Each calendar year, there is an “Open Enrollment Period” for all eligible Employees to enroll in or change their plan option. Coverage for Covered Persons enrolling in a different plan option during an Open Enrollment Period will become effective with the first 12-month coverage period commencing after the Open Enrollment Period.

Are there any other exceptions for enrollment?

Special Enrollment Periods
This Plan provides three special enrollment periods that allow you to enroll in the Plan, even if you declined enrollment during your eligibility period. You must make written application to the Plan Administrator within the applicable timeframe upon the occurrence of any of the events detailed below.

Loss of Other Coverage
If you declined enrollment for yourself and/or your dependents because of other health coverage, you may enroll for coverage for yourself and/or your dependents, if the other health coverage is lost. You must make written application to the Plan Administrator for special enrollment within thirty (30) days of the date when the other health coverage was lost.

The following conditions apply to any eligible employee and dependents:

You may enroll during this special enrollment period:
- If you and/or your dependents are eligible for coverage under the terms of this Plan;
- You and/or your dependents are not currently enrolled under the Plan;
- When enrollment was previously offered, you declined because of coverage under another group health plan. You must have provided a written statement that other health coverage was the reason for declining enrollment under this Plan; and
- If the other coverage was terminated due to loss of eligibility for the coverage (including due to legal separation, divorce, death, termination of employment or reduction in the number of hours) or because premium contributions for the coverage were terminated.

If the conditions for special enrollment are satisfied, coverage for you and/or your dependents will be effective at 12:01 A.M. on the first day of the month beginning after the date the written request is received by the Plan.

New Dependent
If you acquire a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents during a special enrollment period. You must make written application to the Plan Administrator for special enrollment no later than thirty (30) days after you acquire the new dependent.
The following conditions apply to any eligible employee and dependents:

You may enroll during this special enrollment period if:
- You and/or your dependents are eligible for coverage under the terms of this Plan; and
- You have acquired a new dependent through marriage, birth, adoption or placement for adoption.

If the conditions for special enrollment are satisfied, coverage for you and/or your dependents will be effective at 12:01 A.M.:
- For a marriage, on the date of the marriage.
- For a birth, on the date of birth.
- For an adoption or placement for adoption, on the date of the adoption or placement for adoption.

**Change in Coverage Under the State Children’s Health Insurance Program (CHIP)**

If you and/or your dependents become eligible for CHIP Coverage or when such CHIP Coverage is terminated, you may be able to enroll yourself and/or your dependents during an additional special enrollment period. You must make written application for special enrollment to the Plan Administrator no later than sixty (60) days after the effective date of the CHIP Coverage’s termination or start of eligibility for CHIP coverage for you and/or your dependents.

The following conditions apply to any eligible employee and dependents:

You may enroll during this special enrollment period if:
- You or your dependents are eligible for coverage under the terms of the Plan; and
- Either you or your dependent
  - loses coverage under Medicaid or CHIP; or
  - becomes eligible for coverage under Medicaid or CHIP.

If the conditions for special enrollment are satisfied, coverage for you or your dependents will be effective at 12:01 A.M. on the following dates:
- If you or your dependent becomes eligible for CHIP Coverage, the date that you or your dependent is first eligible for CHIP Coverage or
- If you or your dependent loses CHIP Coverage, the date that you or your dependent loses CHIP Coverage.

**What if a court orders coverage for a child?**

The Plan will comply with any qualified medical child support order (“QMCSO”) issued by a court of competent jurisdiction or administrative body that requires the Plan to provide medical coverage to a Dependent child of an Employee. The Plan Administrator will establish reasonable procedures for determining whether a court order or administrative decree requiring medical coverage for a Dependent child meets the requirements for a QMCSO. Coverage under the Plan will end upon the expiration of the required coverage period as set forth in the QMCSO. The additional cost of such coverage, if any, will be borne by the Employee.

**Keeping Your Coverage Up-To-Date**

You must notify the Plan Administrator within thirty (30) days of a change in your personal status or dependent changes. Typical changes of this sort occur when:
- You marry;
- You have a child;
- You are no longer married;
- A covered child becomes ineligible;

As detailed above, you must notify the Plan Administrator within sixty (60) days of a change in your CHIP coverage.
Overview of PPO/Non-PPO Option

The Plan is a preferred provider organization (“PPO”) that has contracted with physicians, hospitals and allied health care facilities (called “In-Network Providers”) through Vale-U-Health and supplement provider networks to furnish covered persons with cost-effective medical care. In-Network providers have agreed not to charge you more than the approved contractual charge for covered expenses.

For covered services rendered outside the provider networks, referred to as Out-of-Network Providers, the Plan will pay a claim based upon the usual, customary and reasonable (“UCR”) fee for the service rendered. In some instances, the UCR fee may be less than the amount the out-of-network provider has actually charged you. If this occurs, you are responsible for any amount of the out-of-network provider’s charge that exceeds the determined UCR fee. **Amounts over and above the UCR fee are not covered in any manner.**

In-Network Provider Charges

The Plan is designed to pay benefits if in-network providers are utilized. All covered expenses, treatments and supplies rendered by an in-network provider will be subject to a deductible. Directories of the Vale-U-Health and supplemental networks’ in-network provider hospitals, physicians and allied health care facilities are available from the Plan Administrator or Vale-U-Health, free of charge, upon request.

To ensure that you have the most updated provider status, you should call the number that is printed on your ID card for Member Services. The Vale-U-Health Provider Directory is also available via the Internet at www.valeuhealth.com.

When you use an in-network provider, there are no forms to complete. Simply present your member identification card. Providers should submit claims to the address on the ID Card.

Out-of-Vale-U-Health Network Provider Charges

Except for obstetrical services, mental nervous services, substance abuse services, and life-threatening emergencies or with prior approval from the Plan, you and your dependents are restricted to using the services of Vale-U-Health Network providers, unless otherwise stated in the Plan. Prior approval from the Plan may be granted when services are not available within the Vale-U-Health and/or supplemental provider networks or when the condition is such that it is deemed medically necessary to go outside the provider networks.

**Please note that there are certain benefits listed in the “Schedule of Benefits” which are covered expenses only if provided by a network provider in the Vale-U-Health Network (i.e., Preventive Care Services).**

If you receive services by an out-of-Vale-U-Health Network provider, due to a life-threatening emergency or obtained plan authorization, the Plan will pay that percentage which would have been paid if you had received the services from a network provider, not to exceed the UCR fee. These services are subject to the same conditions as applied to covered services rendered by network providers.

When it appears that the non-emergency services you need are not available in the Vale-U-Health Network (excluding obstetrical, mental nervous or substance abuse services which can be provided by either the Vale-U-Health or the supplemental networks), you must call the number that is printed on your ID card for the Pre-certification/Case Management Department to request a non-Vale-U-Health Network provider authorization. If Plan authorization is not obtained, benefits will be reduced by 20% for in-network providers. If the service could not be performed in either the Vale-U-Health or supplemental provider networks and Plan authorization was not obtained, benefits will be reduced by 20% of the UCR fee for out-of-network providers.

**Responsibility for Vale-U-Health Network Providers**

Unless otherwise stated in the Plan, it is your responsibility to use Vale-U-Health Network providers, if you want to receive the benefits provided under this Plan.

If covered services are received from a non-Vale-U-Health Network provider, one of the following situations must apply for you to receive any benefits:

- You are in an emergency situation (accidental injury or life-threatening medical condition); or
- You require treatments, services or supplies **which are not available within the Vale-U-Health Network.** Plan authorization must be obtained for this to apply. To request Plan authorization prior to the services
being rendered, contact the number printed on your ID card for the Pre-certification/Case Management Department.

If your Vale-U-Health Network physician refers you to another physician or to a medical facility which is not in the Vale-U-Health Network for covered services, you must be sure one of the above circumstances applies or you will not receive the benefits available for the services rendered by non-Vale-U-Health Network providers.

Should you have any questions or concerns regarding your responsibility for use of Vale-U-Health Network providers, contact the number printed on your ID card for Member Services.

Patient Protections
You do not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Vale-U-Health or supplemental networks who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Plan Administrator.

Repatriation
In addition, if you are admitted to an out-of-network hospital due to an emergency or life-threatening emergency condition, the Plan reserves the right to require transfer to an in-network hospital once you have become medically stable, in order for benefits to continue to be available for covered services. If the Plan requires transfer to the in-network hospital, all costs associated with the transfer will be covered by the Plan.

The final choice to be transferred is at the sole discretion of the patient. However, if you are deemed medically stable and are requested by the Plan to transfer and do not elect to do so, all expenses incurred from that point on will be covered at the out-of-network level of benefits by the Plan.

Benefits While Traveling Outside the United States
If you are hospitalized and/or treated by a physician while traveling outside the United States or Puerto Rico, you will probably be required to pay the provider for such services, since hospitals and physicians in foreign countries generally do not honor insurance or Medicare identification cards. Be sure to obtain itemized receipts detailing the dates and types of services performed and the charges incurred. Such receipts are then to be submitted to the Plan for reimbursement on the same basis as if the expenses were incurred in the United States.

How Payments Are Made

Deductibles
A deductible will apply each calendar year to covered medical services rendered by In-Network and for Prescription Drugs. The deductible amounts are listed in the “Schedule of Benefits.” The deductible will be applied to covered services in the order in which claims are received. For covered medical services and prescription drugs, the deductible must be satisfied before anything is paid by the Plan.

Last Quarter Deductible Provision
Covered medical expenses that are incurred in October, November and December and that are applied to the Deductible (do not generate payment), will carry over to the following year’s Deductible.

Family Deductible Amount
If two or more members of a family incur covered medical expenses in a calendar year that are applied toward the individual deductible amounts in an amount that equals the family deductible amount listed in the “Schedule of Benefits,” all family members will have then satisfied the individual deductible amount for that calendar year.

Common Accident Deductibles
If two or more covered family members are injured in the same accident, those injured will be required to satisfy only one deductible for covered medical expenses related to the same accident for each plan year that such expenses related to that accident are incurred.

Copayments
The covered person is responsible for any specified copayment amount listed in the “Schedule of Benefits” section. The Plan will then pay the percentage, as listed in the “Schedule of Benefits,” of the in-network
provider’s or out-of-network provider’s charges.

**Payment of Benefits – In-Network Provider**
The Plan will make payment directly to the in-network provider.

**Payment of Benefits – Out-of-Network Provider**
No payment is made for out-of-network providers, unless otherwise stated in the Plan.

**Lifetime Maximum Payment**
There is no lifetime maximum amount for covered expenses.

### YOUR COSTS

You must pay for a certain portion of the cost of covered expenses under the Plan, including deductibles, copayments and the coinsurance percentage that is not paid by the Plan.

Deductibles, copayments and coinsurance percentages are shown in the “Schedule of Benefits.”

In addition, certain types of expenses may be limited to a certain number of visits in a given year. This information is also contained in the “Schedule of Benefits” section. Expenses in excess of these Plan limits will not be reimbursed.

The Plan will not reimburse any expense that is not a covered expense. In addition, you must pay any expenses to which you have agreed that are in excess of the UCR fees and any penalties for failure to comply with requirements of Pre-Certification or penalties that are otherwise stated in the Plan. None of these amounts will be eligible for reimbursement.

**Monthly Premium Contribution for Home Host Plan Coverage**
Regular Full-time Employees and Temporary Full-time Employees will be required to pay a premium contribution that is an amount determined by the Plan Sponsor which may be increased or decreased at the Plan Sponsor’s discretion.

Regular Part-time Employees, Temporary Part-time Employees, Seasonal Employees and Casual Employees, if eligible, shall be required to pay a premium contribution that is pro-rated based upon the average weekly hours worked in the preceding payroll quarter. The pro-rated premium contribution percentage decreases as the number of hours worked increases.
SCHEDULE OF BENEFITS

This schedule is provided as a convenience only and is not all-inclusive. Important information is contained in sections, “Medical Benefits” and “Exclusions and Limitations.” You may find the “Definitions” section helpful in understanding some of the terms used throughout this Summary Plan Description. In addition, the Plan has other requirements and provisions that may affect benefits, such as “Pre-certification Provisions,” and it is strongly recommended that you read the entire Summary Plan Description to ensure a complete understanding of the Plan provisions. You may also contact the third party administrator or the Plan Administrator for assistance.

<table>
<thead>
<tr>
<th>Deductible Amount for medical services, per calendar year</th>
<th>IN-NETWORK PROVIDERS</th>
<th>OUT-OF-NETWORK PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Individual - $100</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Family - $200</td>
<td></td>
</tr>
</tbody>
</table>

If you have family coverage, more than one individual can satisfy the family Deductible; however, no individual will satisfy more than individual Deductible.

A separate prescription drugs Deductible is described in the “Schedule of Benefits.”

**Annual Medical Maximum Out-of-Pocket**

The annual maximum out-of-pocket paid for Covered Medical Services is $500 for individual coverage and $1,000 for family coverage. This includes annual medical deductible amount, office visit copayments, and emergency room copayments. In addition, the following items do not apply to the annual medical maximum annual out-of-pocket expense:
- Monthly contributions for Home Host Plan Option coverage;
- Amounts that exceed the usual, customary and reasonable (UCR) fee;
- Penalties;
- Separate pharmacy Deductible; and
- Prescription drug Copayments.

**Annual Prescription Drugs Maximum Out-of-Pocket**

The annual maximum out-of-pocket paid for Prescription Drugs is $2,500 for individual coverage and $5,000 for family coverage. This includes annual prescriptions deductible amount and co-payment amounts. In addition, the following items do not apply to the annual prescription drugs maximum out-of-pocket expense for:
- The cost difference between the brand-name drug and its generic drug equivalent, when the brand-name is dispensed at the patient’s request.
<table>
<thead>
<tr>
<th><strong>INPATIENT HOSPITAL CHARGES</strong></th>
<th><strong>VALE-U-HEALTH PROVIDERS</strong></th>
<th><strong>NON-VALE-U-HEALTH PROVIDERS</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Semi-Private Room and Board</td>
<td>100% *</td>
<td>0%</td>
</tr>
<tr>
<td>Specialty Care, such as ICU, CCU or Isolation</td>
<td>100% *</td>
<td>0%</td>
</tr>
<tr>
<td>Emergency Accident/Medical Admissions</td>
<td>100% *</td>
<td>100% *</td>
</tr>
<tr>
<td>Ancillary Charges</td>
<td>100% *</td>
<td>0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>VALE-U-HEALTH or SUPPLEMENTAL NETWORK PROVIDERS</strong></th>
<th><strong>OUT-OF-NETWORK PROVIDERS</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternity and Newborn Admissions</td>
<td>100% *</td>
</tr>
<tr>
<td>Mental Nervous Disorder and Substance Abuse Admissions</td>
<td>100% *</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>OUTPATIENT HOSPITAL / FACILITY CHARGES</strong></th>
<th><strong>VALE-U-HEALTH PROVIDERS</strong></th>
<th><strong>NON-VALE-U-HEALTH PROVIDERS</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Room: Emergency Accident/Medical Services (Subject to a $40 per incident Copayment, waived if admitted or placed in Observation)</td>
<td>100%*</td>
<td>100%*</td>
</tr>
<tr>
<td>Cardiac Rehabilitation Services (subject to Precertification requirements)</td>
<td>100% * limited to 36 visits per year</td>
<td>0%</td>
</tr>
<tr>
<td>Diagnostic Services</td>
<td>100% *</td>
<td>0%</td>
</tr>
<tr>
<td>Obstetrical Services</td>
<td>100% *</td>
<td>0%</td>
</tr>
<tr>
<td>Outpatient Rehabilitation Services (such as Physical Therapy, Occupational Therapy, Speech Therapy, Hydrotherapy)</td>
<td>100% * limited to 20 visits per year **</td>
<td>0%</td>
</tr>
<tr>
<td>Outpatient Surgery</td>
<td>100% *</td>
<td>0%</td>
</tr>
<tr>
<td>Pre-admission Testing</td>
<td>100% *</td>
<td>0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>VALE-U-HEALTH or SUPPLEMENTAL NETWORK PROVIDERS</strong></th>
<th><strong>OUT-OF-NETWORK PROVIDERS</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Nervous Disorder and Substance Abuse Services</td>
<td>100% * limited to 120 visits per year</td>
</tr>
</tbody>
</table>

* Services subject to a Deductible

** Additional outpatient rehabilitation services must be medically necessary and requires pre-certification.
<table>
<thead>
<tr>
<th>PHYSICIAN / OTHER GENERAL CHARGES</th>
<th>VALE-U-HEALTH PROVIDERS</th>
<th>NON-VALE-U-HEALTH PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultations / Second Surgical Opinions</td>
<td>100% *</td>
<td>0%</td>
</tr>
<tr>
<td>Emergency Accident/Medical Services</td>
<td>100% *</td>
<td>100% of UCR fee *</td>
</tr>
<tr>
<td>Physician’s Home and Office Visits (Illness/Injury)</td>
<td>100% * with $30 Copayment</td>
<td>0%</td>
</tr>
<tr>
<td>Physician’s Inpatient Services</td>
<td>100% *</td>
<td>0%</td>
</tr>
<tr>
<td>Surgeon’s Services</td>
<td>100% *</td>
<td>0%</td>
</tr>
<tr>
<td>Ambulance Services: Emergency, Medically Necessary</td>
<td>100% *</td>
<td>100% *</td>
</tr>
<tr>
<td>Ambulance Services: Non-Emergency, Medically Necessary</td>
<td>100% *</td>
<td>0%</td>
</tr>
<tr>
<td>Ambulance Services: Non-Emergency, Not Medically Necessary</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Durable Medical Equipment / Prosthetic Appliances</td>
<td>100% *</td>
<td>0%</td>
</tr>
<tr>
<td>Extended Care Facilities</td>
<td>100% *</td>
<td>0%</td>
</tr>
<tr>
<td>Home Health Care and Hospice Care</td>
<td>100% *</td>
<td>0%</td>
</tr>
<tr>
<td>All other eligible services (such as Radiation Therapy, Allergy Testing, X-ray, Lab, Shock Therapy, Anesthesia, Chemotherapy, Dialysis)</td>
<td>100% *</td>
<td>0%</td>
</tr>
<tr>
<td>Mental Nervous Disorder and Substance Abuse Care</td>
<td>100% * with $30 Copayment</td>
<td>0%</td>
</tr>
<tr>
<td>Obstetrical Care (including Prenatal and Postnatal care)</td>
<td>100% *</td>
<td>0%</td>
</tr>
</tbody>
</table>

**PREVENTIVE CARE**

<table>
<thead>
<tr>
<th>VALE-U-HEALTH PROVIDERS</th>
<th>NON-VALE-U-HEALTH PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Routine Physical Exam</td>
<td>100%</td>
</tr>
<tr>
<td>Annual Routine Gynecological Exam</td>
<td>100%</td>
</tr>
<tr>
<td>Annual Routine Pap Smear</td>
<td>100%</td>
</tr>
<tr>
<td>Routine Mammogram (annually after age 40)</td>
<td>100%</td>
</tr>
<tr>
<td>Immunizations (As outlined in the PHCP Adult &amp; Pediatric Preventive Guidelines and for travel.)</td>
<td>100%</td>
</tr>
<tr>
<td>Well Baby Care (up to 19 months of age)</td>
<td>100%</td>
</tr>
<tr>
<td>Services listed in the PHCP Adult &amp; Pediatric Preventive Guidelines</td>
<td>100%</td>
</tr>
</tbody>
</table>

* Services subject to a Deductible
Prescription Drugs – Subject to a $50 annual deductible, per Covered Person

<table>
<thead>
<tr>
<th>Retail Providers – up to a 30-day supply</th>
<th>Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic and Preferred Brand</td>
<td>30% of cost, up to a maximum copayment of $100 per prescription</td>
</tr>
<tr>
<td>Non-Preferred Brand</td>
<td>35% of cost, up to a maximum copayment of $150 per prescription</td>
</tr>
<tr>
<td>Specialty</td>
<td>35% of cost, up to a maximum copayment of $200 per prescription</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mail Order – up to a 90-day supply</th>
<th>Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic and Preferred Brand</td>
<td>30% of cost, up to a maximum copayment of $200 per prescription</td>
</tr>
<tr>
<td>Non-Preferred Brand</td>
<td>35% of cost, up to a maximum copayment of $300 per prescription</td>
</tr>
<tr>
<td>Specialty</td>
<td>35% of cost, up to a maximum copayment of $400 per prescription</td>
</tr>
</tbody>
</table>

MEDICAL BENEFITS

The following services must be incurred while coverage is in force under this Plan. Please refer to the sections “Selection of Your Health Care Provider” and “Pre-Certification/Case Management” for important information concerning any requirements of the Plan that can affect how these services are covered. Reimbursement will be made according to the “Schedule of Benefits” and will be subject to all Plan maximums, limitations, exclusions and other provisions.

Hospital Inpatient Benefits

Inpatient Care
For medical or surgical care of an illness or injury, the Plan will reimburse covered expenses for semi-private room and board and necessary ancillary expenses. The Plan will cover the charge for a private room, if it is determined to be medically necessary and is certified as such by the attending physician.

Covered expenses will include cardiac care units and intensive care units, when appropriate for the covered person’s illness or injury.

Mental Nervous Disorder Inpatient Hospitalization
Covered expenses for inpatient care of a mental nervous disorder include semi-private room and board and necessary ancillary charges. Treatment must be rendered in a hospital or psychiatric treatment facility. The Plan will cover the charge for a private room, if it is determined to be medically necessary and is certified as such by the attending physician.

Substance Abuse Inpatient Hospitalization
Covered expenses for inpatient care of substance abuse include semi-private room and board and necessary ancillary charges. Treatment must be rendered in a hospital or substance abuse treatment facility. The Plan will cover the charge for a private room, if it is determined to be medically necessary and is certified as such by the attending physician.

Maternity Care

Under the Newborns’ and Mothers’ Health Protection Act of 1996, group health plans and health insurance issuers generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Benefits are payable in the same manner as for medical or surgical care of an illness, as shown in the “Schedule of Benefits” and this section and subject to the same maximums.

Newborn Care
Coverage for a newborn child will be available only if you have satisfied the requirements for coverage in the “Eligibility for Participation” section.
Covered expenses for newborn children include nursery and neo-natal intensive care room and board, necessary ancillary expenses and routine newborn care during the period of hospital confinement, including circumcision.

**Skilled Nursing (or Extended Care) Facilities Benefits**
Covered expenses for inpatient skilled nursing or (extended care) facilities include semi-private room and board accommodations and necessary ancillary charges. The confinement must be for continued treatment of an illness or injury.

**Physicians’ In-Hospital Services**

**In-Hospital Medical Services**
Covered expenses include professional services rendered by the attending physician while the covered person is hospitalized.

**In-Hospital Concurrent Medical Care**
Covered expenses include services rendered concurrently by a physician other than the attending physician when the covered person is being treated for multiple, unrelated illnesses or injuries or which require the skills of a physician specialist.

**In-Hospital Consultant Services**
Covered expenses include the services of a physician consultant when required for the diagnosis or treatment of an illness or injury.

**Mental Nervous Disorder or Substance Abuse In-Hospital Medical Care Services**
Covered expenses include professional services rendered by the attending physician while the covered person is hospitalized.

**Surgical Inpatient and Outpatient Services**

**Anesthesia Services**
Covered expenses include the administration of spinal, rectal or local anesthesia or a drug or other anesthetic agent by injection or inhalation, rendered by a licensed provider. Benefits are also payable for these services when rendered by a Certified Registered Nurse Anesthetist (CRNA). Covered expenses do not include anesthesia administered by the surgeon physician or a surgical assistant.

**Surgical Assistants**
Covered expenses include services by a licensed physician who actively assists the operating surgeon in the performance of surgical procedures when the condition of the patient and complexity of the surgery warrant such assistance. Benefits are also provided for these services when rendered by a licensed surgical physician’s assistant. Coverage will be provided for these services only when the hospital does not employ interns and residents qualified to perform the service.

**Diagnostic Testing**
Covered expenses include diagnostic testing (including pathology, radiology, ultrasound, nuclear medicine) performed in a physician’s office. In order for a covered person to have the highest level of benefits, these services must be billed for by the panel physician and, also, the interpretation must be done by a panel provider.

**Obstetrical Services**
Covered expenses include obstetrical services rendered by the physician in charge of the case, including services customarily rendered as prenatal and postnatal care. Benefits for obstetrical care will be based upon the Plan provisions in effect on the date the services are incurred.

**Surgical Services**
Covered expenses include surgical procedures, including treatment for fractures and dislocations and routine pre- and post-operative care.

When more than one surgical procedure is performed during the same operative session, the allowed expense is calculated according to the Centers for Medicare and Medicaid Services Claim Coding Guidelines and the National Correct Coding Initiatives.
Professional Interpretation Services Inpatient and Outpatient
Covered expenses include interpretation and reporting by a licensed radiologist or pathologist for covered diagnostic tests. Benefits are provided only for testing required for the diagnosis or treatment of an illness or injury, unless otherwise provided under “Preventive Care.”

Hospital Emergency Room Services
Covered expenses include:

- Emergency treatment of an accidental injury. Treatment must be rendered within 72 hours of the accident, in order for this benefit to be payable;
- Non-emergency use of emergency room facilities when medically necessary;
- Emergency treatment of an illness. Treatment must be rendered within 72 hours of the onset of acute symptoms of the illness, in order for this benefit to be payable.

Covered expenses also include physician’s charges and charges for radiology and pathology for emergency surgical or medical care rendered in the hospital emergency room.

Outpatient Facility Fees
Covered expenses include the following services when provided in an outpatient department of a hospital or other institution:

Mental Nervous Disorders
Covered expenses include outpatient services provided for mental nervous disorders by a licensed psychologist, psychiatrist or social worker, if the social worker’s services are under the direct supervision of a physician.

Substance Abuse Care
Covered expenses include outpatient substance abuse care by a licensed provider.

Outpatient Diagnostic Examinations
Benefits are provided for services such as X-ray and laboratory examinations, electrocardiograms (EKG), venous doppler studies, magnetic resonance imaging (MRI), computerized axial tomography (CAT scan), basal metabolism tests, and electroencephalograms (EEG), when the study is directed toward the diagnosis of an illness or injury.

Pre-Admission Testing
Benefits are provided for pre-admission testing for expenses incurred prior to the scheduled hospital admission and only when the testing is not duplicated on admission.

Outpatient Surgery/Ambulatory Surgery Center
Benefits are provided for charges by a hospital, ambulatory surgical center or in a physician’s office, for services required for a surgical procedure. The facility fees may include both services and supplies required for the surgery.

Biofeedback Services
Benefits are provided for biofeedback when certified as medically necessary by the attending physician in a treatment program that is appropriate for the covered person’s illness/injury.

Cardiac Rehabilitation
Benefits are provided for cardiac rehabilitation program services when certified as medically necessary by the attending physician in a treatment program that is appropriate for the covered person’s illness.

Chemotherapy Services
Benefits are provided for administration of chemotherapy treatment, including drugs and supplies used during the treatment.

Dialysis
Benefits are provided for kidney dialysis treatment, including the drugs and supplies used during the treatment. Charges for professional fees and services, supplies, medications, labs, and facility fees related to outpatient dialysis are covered expenses. These services include but are not limited to Hemodialysis, Home Hemodialysis, Peritoneal dialysis and Hemofiltration. For the first three months of outpatient dialysis, the plan will pay in
accordance with the major medical benefits contained in this plan, subject to HIPAA requirements. Benefits will be paid at the in-network benefit level.

Effective February 1, 2014, beginning with the fourth month of outpatient dialysis, the plan allowable for dialysis and the related services billed by the dialysis provider will be limited to 120% of the current year Medicare amount. The plan will pay 100% of the allowed amount (120% of current year Medicare) for 30 consecutive months of dialysis or until the plan is secondary to other coverage. Thereafter, standard coordination of benefits will apply. **Pre-certification is required.**

**Intravenous Therapy**
Benefits are provided for administration of intravenous therapy, including drugs and supplies used during the treatment.

**Occupational Therapy**
Benefits are provided for occupation therapy to restore a covered person to health or to social or economic independence. These services must be performed by a licensed occupational therapist, who evaluates the performance skills of well and disabled persons of all ages and who plans and implements programs designed to restore, develop, and maintain the covered person’s ability to accomplish satisfactorily normal daily tasks. Occupational therapy must be ordered by the attending physician as part of a treatment plan that is appropriate for the covered person’s illness or injury.

**Physical Therapy**
Benefits are provided for rehabilitation concerned with restoration of function and prevention of disability following illness, injury or loss of a body part. The services must be performed by a licensed physical therapist as part of a treatment program which is appropriate for the illness or injury and which is ordered by the attending physician.

**Radiation Therapy**
Benefits are provided for treatment by X-ray, radium, external radiation, or radioactive isotopes, including materials.

**Speech Therapy**
Benefits are provided for the evaluation and treatment of covered persons who have voice, speech, language, swallowing, cognitive or hearing disorders. These services must be performed by a licensed and certified speech therapist as part of a treatment program which is appropriate for the illness or injury and which is ordered by the attending physician.

**Respiratory and Pulmonary Therapy**
Benefits are provided for respiratory and pulmonary therapy when performed as an inpatient or an outpatient.

**Treatment by Physical Means**
Benefits are provided for treatment given to relieve pain, restore maximum function and to prevent disability following illness or injury, including respiratory therapy and pulmonary therapy, ultrasound therapy, physical treatments, hydrotherapy, heat or similar modalities, physical agents, hyperbaric therapy, biomechanical and neurophysiological principles and devices.

**Physician’s Office Services**
Covered expenses include the following services rendered in a physician’s office:

**Office Visits**
Benefits are provided for services given in a physician’s office which are required for the diagnosis or treatment of an illness or injury. Covered services include the services of a physician’s assistant ("P.A.") rendered under the supervision of the physician, and billed by the physician.

**Allergy Care**
Benefits are provided for allergy care, including injections, serums and extracts, given in a physician’s office.
**Chiropractic Care**  
Benefits are provided for medically necessary chiropractic care. Refer to Exclusions and Limitations regarding chiropractic care.

**Injections**  
Benefits are provided for therapeutic injections given in a physician’s office which are required for the treatment of an illness or injury. Benefits are also provided for immunizations given in a physician’s office as specified under “Preventive Care.”

**Diagnostic X-ray and Laboratory Services**  
Benefits are provided for diagnostic x-ray and laboratory services given in a physician’s office which are required for the diagnosis or treatment of an illness or injury.

**Outpatient Mental Nervous Disorder Care**  
Covered expenses include outpatient mental nervous disorder care by a licensed psychologist, psychiatrist or social worker, if the social worker services are under the direct supervision of a physician.

**Outpatient Substance Abuse Care**  
Covered expenses include outpatient substance abuse care by a licensed provider.

**Podiatric Care**  
Benefits are provided for medically necessary foot care. Also covered are “custom molded” orthotics (requiring casting of the feet) when medically necessary. Over the counter orthotics and/or shoe inserts are not covered under the Plan.

Routine care of the feet (i.e., reduction of corns and calluses, trimming of nails, treatment of fallen arches, etc.) is not covered by the Plan. However, if the patient has a medical condition (i.e., diabetes, PVD, etc.), these procedures may be deemed medically necessary and covered by the Plan.

**Preventive Care Services Benefit**  
Preventive care services covered under the Plan generally include evidence-based items or services with an A or B rating recommended by the United States Preventive Services Task Force (USPSTF); immunizations for routine use for children, adolescents, or adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) for infants, children, and adolescents; and other evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by HRSA for women.

Covered expenses include these listed services for preventive care for each covered person, subject to any limits described in the “Schedule of Benefits” section.

- Annual Routine Physical Exam;
- Annual Routine Gynecology Exam;
- Annual Routine Pap Smear;
- Annual Routine Mammogram (after age 40);
- Immunizations (as listed in the PHCP Adult and Pediatric Preventive Guidelines and required for travel);
- Services included in the PHCP Adult and Pediatric Preventive Guidelines; and
- Well Baby Care, up to 19-months of age.

In addition, the following services will be covered at 100% by the Plan when these services are provided by in-network providers:

- Abdominal Aortic Aneurysm one-time screening for men between the ages of 65-75 who have smoked;
- Alcohol Misuse screening and counseling;
- Aspirin therapy for men between the ages of 45 to 79 and women between the ages of 55 to 79
- Diet counseling for adults at higher risk for chronic disease
- Obesity screening and counseling
- Sexually Transmitted Infection prevention counseling for adolescents and adults at higher risk
- Tobacco use screening for all adults and cessation interventions for tobacco users
- BRCA counseling about genetic testing for women at higher risk
Breast cancer chemoprevention counseling for women at higher risk
Breastfeeding comprehensive support and counseling from trained providers
Contraception – FDA approved methods, sterilization procedures, and education/counseling, not including abortifacient drugs
Domestic and interpersonal violence screening and counseling for women
Folic Acid supplements for women who may become pregnant
Alcohol and drug use assessments for adolescents
Autism screening for children 18 and 24 months
Behavioral assessments for children, up to 18 years of age
Dyslipidemia screening for children at higher risk for lipid disorders, up to 18 years of age
Flouride supplements for children without flouride in their water source
Iron supplements for children ages 6 to 12 months at risk for anemia
Tuberculin testing for children at higher risk of tuberculosis, up to 18 years of age

Second Surgical Opinions
Covered expenses include a second opinion to determine the medical necessity for a recommended surgical procedure. The physician rendering the second opinion must not be affiliated with the physician who recommended the surgical procedure. A third opinion will be covered if the two opinions differ and if it is performed by a physician who is not affiliated with the physicians who have rendered opinions.

Other Covered Expenses

Ambulance Service
Covered expenses include local professional ambulance service required as a result of an accident or medical emergency or when medically necessary in a non-emergency situation. Air ambulance services will be covered when medically necessary to transport the covered person to the nearest institution capable of treating the illness or injury.

Clinical Trials
The Plan will cover an individual’s participation in an approved clinical trial according to the Plan’s benefits for in-network or out-of-network providers. The Plan’s Pre-certification requirement will apply.

An approved clinical trial is a Phase I, Phase II, Phase III, or Phase IV clinical trial conducted in relation to the prevention, detection or treatment of cancer or another life-threatening disease or condition that is likely to result in death, unless the course of the condition is interrupted. In addition, the clinical trial must be a study or investigation conducted under a new drug application reviewed by the Food and Drug Administration (or be exempt from having such an investigational new drug application) or the clinical trial must be approved or funded by specific government agencies.

Diabetic Meters and Supplies
Covered Expenses include diabetic meters and supplies, i.e. test strips, lancets and syringes, needed for the treatment of diabetes.

Durable Medical Equipment
Covered expenses include rental of durable medical equipment. The Plan may approve purchase of the equipment at the Plan Administrator’s discretion. Benefits for rental will not exceed the usual, customary and reasonable fee for purchase. The Plan will not pay for any repairs needed after equipment has been purchased.

Gastric Restrictive Procedures
Covered Expenses include services for lap band procedures and gastric bypass if the following applies:
- Patient is at least 100 lbs. over their ideal weight; or
- Has a Body Mass Index (BMI) exceeding 40; or
- Patient’s BMI is over 35 and has a clinically serious condition, such as obesity hypoventilation, sleep apnea, diabetes, hypertension, cardiomyopathy, musculoskeletal dysfunction, gastro esophageal reflux disease (GERD), coronary artery disease (CAD);
• Documented 2 year history of failure to lose weight despite compliance with a physician-supervised, multi-disciplinary, non-surgical program, including diet, supervised exercise, behavior modification, and group therapy. The 2 year history must include a minimum of 1 year participation in the Vale-U-Health Obesity Disease State Management Program;
• Documentation requirements include:
  ▪ A letter of medical necessity from the physician who supervised the above noted program;
  ▪ All office notes and/or progress notes from the above program;
  ▪ No specifically correctable cause for obesity (endocrine disorder);
  ▪ Be at least 18 years of age, but not older than 65 years of age;
  ▪ Patient is receiving treatment in a surgical program that is experienced in obesity surgery, characterized by experienced surgeons, and the patient obtains preoperative medical consultation and approval, preoperative psychiatric consultation and approval, nutritional counseling, exercise counseling, psychological counseling and support meetings.

**Home Health Care and Hospice Care**
Covered expenses include home health care and hospice care when rendered by a licensed and accredited home health care agency. These services must be provided through a formal, written home health care treatment plan, certified as medically necessary by the attending physician, and approved by the Plan. Benefits are provided for:
• Skilled nursing care as provided by a licensed practical nurse or registered nurse who does not ordinarily live in your home and who is not a member of your immediate family;
• Physical, occupational, and speech therapy;
• Medical and surgical supplies;
• Oxygen and its administration;
• Medical supplies and laboratory services to the extent that such services would have been covered if hospital confined.

Home health care benefits are **not** provided for:
• Transportation services;
• Dietician services;
• Homemaker services;
• Maintenance therapy;
• The services of a social worker;
• Purchase or rental of dialysis equipment;
• Food or home delivered meals;
• Treatments, services or supplies which are not specified in the home health care plan;
• The services of a person who ordinarily resides in your home; and
• Services for care which is primarily custodial.

On-going home health services will require re-certification by the attending physician and approval by the Plan, at the Plan Administrator’s discretion, in order to qualify for continued coverage.

**Other Covered Expenses Also Include:**
• **Blood transfusions and blood products**, to the extent not replaced. The Plan will cover expenses in connection with autologous blood acquisition and storage.
• **Chelation therapy** for a diagnosis of lead poisoning, or a diagnosis of anemia for a child.
• **Growth hormone therapy.** This is covered when it is part of a treatment program and approved by the Plan Administrator. Growth hormone therapy is not covered when used for the treatment of a growth hormone deficiency.
• **Kidney dialysis treatment** including drugs and supplies used during treatment, when provided in an outpatient department of a hospital, dialysis center, or in the home.
• **Non-surgical treatment of temperomandibular joint (TMJ) dysfunction.**
• **One set of lenses** (contact or frame-type) following surgery for cataracts.
• **Oral surgical procedures**, including:
  ▪ Excision of tumors and cysts of the jaws, cheeks, lips, tongues, roof and floor of the mouth.
  ▪ Emergency repair due to injury to sound natural teeth.
  ▪ Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.
• Excision of benign bony growths of the jaw and hard palate.
• External incision and drainage of cellulitis.
• Incision of sensory sinuses, salivary glands or ducts.
• Oxygen and its administration.
• Prosthetic devices and supplies, including initial purchase price, fitting, adjustment and repairs. Replacements of prosthetic devices are not covered unless due to a significant change in the covered person’s physical structure and the current device cannot be made serviceable.
• Reconstruction of a breast following a mastectomy, reconstruction of the other breast to produce a symmetrical appearance, and prosthesis and physical complications from all stages of a mastectomy, including lymphademas, in a manner determined in consultation with the attending physician and the covered person. Reimbursement will be made according to the “Schedule of Benefits” section by type of service. The Plan will also cover two mastectomy bras per plan year.
• R.N. and L.P.N. nursing services for outpatient care when medically necessary. Private duty nursing is not covered.
• Sterilization procedures, elective.
• Surgical dressings, splints, casts, and other devices used in the reduction of fractures and dislocations, as well as other similar items that serve only a medical purpose, excluding items usually stocked in the home, or that have a value in the absence of an illness or injury.
• Surgical extraction of bone-impacted wisdom teeth.
• Wigs. Following chemotherapy, the Plan will cover in-network providers at 100% for a wig or for out-of-network providers, the Plan will pay up to a maximum amount of $150.

Replacement of Organs/Tissues and Related Services
The Plan Administrator strongly recommends that any covered person who is a candidate for any transplant procedure contact Vale-U-Health before making arrangements for the procedure. This communication may identify certain types of procedures or expenses associated with the procedures, which will not be covered under the Plan, before the actual services are rendered.

In addition, the Plan Administrator has made arrangements with selected providers, called “Centers for Excellence”, where a covered person may receive care at a negotiated rate. Using a Center for Excellence will normally result in lower costs to the Plan and the covered person. Please contact Vale-U-Health for additional information about Centers for Excellence.

Covered expenses include the following types of transplants:

Solid Organs
Benefits are provided for the transplantation of solid human organs (with other human organs) and related services. This Plan excludes transplantation of non-human, mechanical or artificial organs.

Bone Marrow Transplants
Benefits are provided for medically necessary bone marrow transplantation procedures, including, but not limited to, synergic and allogenic/homologous bone marrow transplantation, as well as autologous bone marrow transplantation procedures.

Finding a donor who is an acceptable match for donation is important to the success of an allogenic/homologous bone marrow transplant. Because an immediate family member has the greatest chance of being a match, benefits for determining bone marrow matching are provided only for members of the immediate family and only if the proposed bone marrow transplantation is medically necessary and is not considered experimental or investigational. For purposes of this section, immediate family members include mother, father, biological children and biological siblings. If a donor match cannot be identified in the immediate family, the Plan will cover matching through a national registry.

Tissue Replacement
Benefits are provided for the replacement of human tissue (with human tissue or prosthetic devices). This Plan excludes transplantation of non-human tissue.
Other Benefits Related to Transplantation
Benefits are also provided for:

- The preparation, acquisition, transportation and storage of human organs, bone marrow or human tissue.
- Transportation of the covered person, if the organ recipient, to and from the site of the transplant procedure.

Specific rules apply as to the payment of benefits for the donor and recipient of the transplanted organ, bone marrow or tissue.

- When the transplant recipient and donor are both covered under this Plan, payment for covered expenses is provided for both, subject to each covered person’s respective benefit maximums.
- When the transplant recipient is covered under this Plan but the donor is not, payment for covered expenses is provided for both the recipient and the donor to the extent that charges for such services are not payable by any other source. Benefits payable on behalf of the donor are charged to the recipient’s claim and applied to the recipient’s maximums.
- When the transplant recipient is not covered under this Plan but the donor is covered, payment for covered expenses attributable to the donor is provided to the extent that charges for such services are not payable by any other source. Benefits are not provided for services attributable to the recipient.

EXCLUSIONS AND LIMITATIONS

Exclusions and Limitations – MEDICAL
This Plan will not reimburse any expense that is not a covered expense. This Plan does not cover any charge for the following:

- Abortion. That is incurred for elective/non-therapeutic abortion.
- Acupuncture. For charges relating directly or indirectly to acupuncture.
- Chiropractic care. For maintenance chiropractic care performed to allow the patient to remain in the optimal state of health.
- Cochlear implants. For cochlear implants.
- Corrective shoes. For corrective shoes.
- Counseling. Except as specifically the result of a mental nervous condition, counseling for:
  - Marital difficulties
  - Social maladjustment
  - Pastoral issues
  - Financial issues
  - Behavioral issues
  - Lack of discipline or other antisocial action.
- Custodial care. For custodial care of a covered person.
- Dental hospital admissions. Related to dental hospital admissions, unless determined to be medically necessary because of an accompanying medical condition.
- Dental prescriptions. For dental prescriptions (e.g., Peridex), except when medically necessary these can be obtained through the Prescription Drug Benefit Program.
- Dental. That is related to dental treatment, except as specifically provided in this Plan.
- Developmental delay. For developmental disorders, including learning disabilities, mental retardation or autism.
- Eating disorders. That is related to eating disorders (e.g., anorexia and bulimia). This does not apply to any care for an underlying mental or nervous condition.
- Educational. That is related to education or vocational training, except as specifically provided under the Plan.
  - This exclusion does not apply to educational services rendered for diabetic counseling, or any other educational service deemed to be medically necessary by the Plan.
- Excess over semi-private rate. That is in excess of the semi-private room rate, except as otherwise noted.
- Experimental. That is experimental.
  - In some cases, the application of an established procedure, as a course of treatment for a specific condition, may be considered experimental, and hence, not covered by this Plan.
- Excluded providers and facilities. That is rendered or provided by the following excluded providers or facilities:
  - Hypnotists;
  - Naturopaths;
- Rolfers; and
- Marriage counselors.

- **Eyeglasses, contact lenses, refractions.** For eyeglasses, contact lenses and refractions, or the examination for their prescription and fitting, except for the following: eye exams and refractions due to a medical condition; one pair of lenses following surgery for cataracts.

- **Eye exercises or training and orthoptics.** For eye exercises or training and orthoptics.
  - This exclusion does not apply to Aphakic patients.
  - This exclusion does not apply to soft lenses or sclera shells intended for use as corneal bandages.
  - This exclusion does not apply to one pair of lenses following cataract surgery.

- **Food supplements.** Related to food supplements or augmentation, in any form.

- **Foot care services, routine.** For routine foot care, including, but not limited to, fallen arches, cutting or removal of corns or calluses, the trimming of nails and other hygienic and preventive and maintenance care, performed in the absence of localized illness, injury or symptoms involving the foot.

- **Genetic counseling.** For genetic counseling.

- **Growth hormone therapy.** For the treatment of growth hormone deficiency.

- **Hearing aids.** For hearing aids or devices and/or the examination for their prescription and fitting.

- **Impotence; sexual dysfunction.** For impotence and sexual dysfunction treatment and medications, including, but not limited to, penile implants, sexual devices or any medications or drugs pertaining to sexual dysfunction or impotence.

- **Infertility treatment.** For infertility treatment, including, but not limited to, in vitro fertilization, gamete intrafallopian transfer (GIFT), fertility drugs, artificial insemination, zygote intrafallopian transfer (ZIFT), reversal of a sterilization procedure, surrogate mother or donor eggs.

- **Marital counseling.** For marital counseling.

- **Massage therapy.** For massage therapy, unless applied in conjunction with other active physical therapy modalities for a specific covered illness or injury, and approved as medically necessary by the Plan Administrator.

- **Medically unnecessary.** That is not medically necessary for the care and treatment of an injury or illness, except where otherwise specified, or is not accepted as standard practice by the American Medical Association or the Food and Drug Administration.

- **Non-prescription medicines and supplies.** That can be purchased without a prescription from a licensed physician.

- **Orthognathic surgery (jaw realignment surgery).** To correct retrognathia, apertognathia, prognathism, open bite malocclusion, or transverse skeletal deformities.

- **Patient convenience.** Related to the modification of homes, vehicles or personal property to accommodate patient convenience. This includes, but is not limited to, the installation of ramps, elevators, air conditioners, air purifiers, TDD/TTY communication devices, personal safety alert systems, exercise equipment and cervical pillows. This exclusion also applies to any services or supplies that are provided during a course of treatment for an illness or injury that are solely for the personal comfort and convenience of the patient.

- **Personal hygiene.** For personal hygiene or convenience items.

- **Preventive care when rendered by an out-of-network provider.**

- **Private Duty Nursing.**

- **Residential care facility.** Provided by or at a residential care facility or halfway house.

- **Sex change.** Expenses for all services and supplies in connection with sex change operations or procedures.

- **Smoking cessation.** For smoking cessation programs, nicorette gum, nicotine transdermal patches or other treatment of tobacco dependency. Notwithstanding the foregoing, the Plan will cover at 100% any FDA approved smoking cessation drugs that require a prescription under the Prescription Drug Benefit Program provided under the Plan with a coverage limitation of three (3) cycles per lifetime per drug.

- **Sterilization.** For the reversal of sterilization and all related expenses.

- **Therapy.** That is related to aversion therapy, hypnosis therapy, primal therapy, rolfing, psychodrama or megavitamin therapy.

- **Travel.** For travel, even though prescribed by a physician.

- **Trusses, corsets and other support devices.**

- **Vision correction.** For radial keratotomy, Lasik, keratomileusis or other vision correction procedures.

- **Without approval.** Furnished without recommendation and approval of a physician acting within the scope of his or her license.

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• **Work-related illness or injury.** Related to an illness or injury arising out of, or in the course of, any employment for wage or profit, including that of previous employers or while self-employed, without regard to whether such illness or injury entitles the covered person to workers’ compensation or similar benefits.

**Exclusions and Limitations – GENERAL**

This section applies to all benefits provided under any section of this summary plan description. This Plan does not cover any charge for the following:

- **Absence of coverage.** That would not have been made in the absence of coverage.
  - This includes charges that are submitted to the Plan equal to any amount for which the provider has discounted fees or has “written off” amounts due.

- **Civil insurrection or riot.** Resulting from injuries incurred or exacerbated while participating in a civil insurrection or riot.

- **Complications.** That result from complications arising from a non-covered illness or injury or from a non-covered procedure.

- **Cosmetic.** For cosmetic surgery or procedures, or aesthetic services (including complications arising there from).
  - This exclusion does not apply to procedures required as the result of an injury or if approved as medically necessary for a covered illness.
  - This exclusion does not apply to procedures to correct congenital anomalies for a dependent under age 14.
  - This exclusion does not apply to reconstruction of a breast following a mastectomy, reconstruction of the other breast to produce a symmetrical appearance, and prosthesis and physical complications from all stages of a mastectomy, including lymphadenomas, in a manner determined in consultation with the attending physician and the covered person.

- **Court-ordered services.** That are ordered by a court, unless determined by the Plan Administrator, in its discretion, to otherwise be appropriate and covered.

- **Deductibles, Copayments and Coinsurance.** That is not payable due to the application of any specified deductible, copayment or coinsurance provisions of the Plan.

- **Excess.** That is not payable under the Plan due to application of any Plan maximum or limit or because the charges are in excess of the Plan Administrator’s determination of the UCR fee for the particular service or supply.

- **Forms.** For the completion of medical reports, claim forms or itemized billings.

- **Government services.** To the extent paid or which the covered person is entitled to have paid or obtain without cost, by or through any government or division thereof, except a program for civilian employees of a government.

- **Hair Pieces.** Except as noted under Other Covered Expenses, wigs, artificial hair pieces, human or artificial hair transplants or any drug, prescription or otherwise, used to eliminate baldness.

- **Illegal act.** Related to injuries sustained, or an illness contracted, during the commission or attempted commission, of a felony.

- **Immediate relative.** Provided by an immediate relative.

- **Immunizations.** For administrative immunizations (for work or school) are not payable under the Plan, unless otherwise indicated as part of the PHCP Adult and Pediatric Preventive Guidelines, which are provided to covered persons on an annual basis.

- **Late Claims.** For which the claim is received by the Plan after the maximum period allowed under this Plan (12 months from date of service) for filing claims (twelve months from date of service) has expired.

- **Military service.** Resulting from, or prolonged as a result of, performing a duty as a member of the military service of any state or country.

- **Missed appointments.** Related to missed appointments.

- **No legal obligation.** That is provided to a covered person for which the provider customarily makes no direct charge or for which the covered person is not legally obligated to pay.

- **Not actually rendered.** That is not actually rendered.

- **Not eligible.** That were rendered or received prior to or after any period of coverage under this Plan, except as specifically provided for in this summary plan description.

- **Not medically necessary admissions.** Pre-admission testing performed as an inpatient is not covered, unless medically necessary.

- **Not specifically covered.** That is not specifically covered under the Plan.

- **Orthotics.** For orthotics which are not custom made through the casting of feet.
Outside of the U.S.A.  For any care, services, drugs or supplies incurred outside of the U.S.A., if the covered person traveled to such a location for the purpose of obtaining the care, services, drugs or supplies.

Penalties. That is related to failure to comply with any requirements for coverage under this Plan or for any copayment amounts identified as a “penalty” in this summary plan description.

Prohibited by law. For which the Plan is prohibited by law or regulation from providing benefits.

Self-inflicted. Resulting from any intentionally self-inflicted illness or injury, except when there is a history of a mental illness/condition.

Self-treatment. When a person renders treatment to themselves.

Subrogation. That is not payable under the Plan by virtue of its subrogation provisions.

Telephone consultations. For telephone consultations.

Usual, Customary and Reasonable (UCR) Fees. For amounts exceeding the UCR fees.

Vitamins. Vitamins, except for pre-natal vitamins.

War. Resulting from war or an act of war, whether declared or undeclared or any act of aggression and any complication there from. This exclusion does not apply to covered persons who are not members of the uniformed services.

With respect to any injury which is otherwise covered by the Plan, the Plan will not deny benefits provided for treatment of the injury, if the injury results from an act of domestic violence or a medical condition (including both physical and mental health conditions).

PRE-CERTIFICATION/CASE MANAGEMENT PROVISIONS

Pre-certification Inpatient Care
Inpatient care is normally the greatest part of the Plan’s expenses and can be the most critical part of your treatment. Through the Pre-certification/Case Management Department, it is possible to work with your attending physician to arrange for care in a setting that is more comfortable for you, such as your home and to save both you and the Plan unnecessary expense.

The Pre-certification process works by establishing a communication among you, your attending physician and the Utilization Review/Case Management Coordinator to discuss the proposed course of treatment and any options that may be available for your treatment. The Pre-certification process does not establish your eligibility for coverage under the Plan nor does it approve the services for coverage or reimbursement under the Plan.

Because communication is the basis for Pre-certification, the Plan requires that you contact the Pre-certification/Case Management Department at least five days before any non-emergency inpatient admission. The contact may be made by you, a friend or family member or your physician or facility; however, it is important that you understand that it is your responsibility to make sure that the contact has been made. Failure to contact the Pre-certification/Case Management Department within the time limits specified in this section will result in a penalty reducing the benefits otherwise payable.

Under the Newborns’ and Mothers’ Health Protection Act of 1996, group health plans and health insurance issuers generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). Notification is still encouraged at the time of admission and is required for any hospital stay that is in excess of the minimum length of stay. Failure to notify the Pre-certification/Case Management Department of any stay that is in excess of the minimum length of stay will result in application of a penalty to the hospital expenses for the excess days not certified.

Concurrent Inpatient Review
Once the inpatient setting has been pre-certified, the on-going review of the course of treatment becomes the focus of case management process. Working directly with your physician, the Pre-certification/Case Management Department will identify and approve the most appropriate and cost-effective setting for the treatment as it progresses.
Pre-Admission Testing
Tests are often required in conjunction with an elective (non-emergent) hospital admission. All necessary tests for an elective admission must be performed on an outpatient basis, prior to your admission. If pre-admission testing is performed on an inpatient basis and was not medically necessary to be done as an inpatient, the Plan will not cover the charges for the hospital room and board for the first day of your admission. This applies to in-network and out-of-network hospital charges.

Urgent Care or Emergency Admissions
Do not delay seeking medical care for any covered person who has a serious condition that may jeopardize their life or health because of the Pre-certification requirements. For urgent, emergency admissions, follow your physician’s instructions carefully and contact the Pre-certification/Case Management Department within 48 hours, or as soon thereafter as is reasonably possible of the admission. No penalty will be applied to your benefits if contact is made within this time period.

Since the Plan does not require you or a covered dependent to obtain approval of a medical service prior to getting treatment for an urgent care or emergency situation, there are no “pre-service urgent care claims” under the Plan. In an urgent care or emergency situation, you or a covered dependent simply follow the Plan’s procedures following the treatment and file the claim as a “post-service claim.”

Pre-certification for Outpatient Services
Certain outpatient services require Pre-certification. These typically are services that may not be covered expenses or that involve an on-going course of treatment on an outpatient basis. The purpose of pre-certifying these services is to identify non-covered expenses or Plan limitations, in advance of incurring the expenses.

The Plan requires that you contact the Pre-certification/Case Management Department at least one day before the commencement of non-emergency services of the types listed in this section. The contact may be made by you, a friend or family member or your physician or facility; however, it is important that you understand that it is your responsibility to make sure that the contact has been made. Failure to contact the Pre-certification/Case Management Department within the time limits specified in this section will result in a penalty reducing the benefits otherwise payable.

Urgent or Emergency Outpatient Care
Do not delay seeking medical care for any covered person who has a serious condition that may jeopardize their life or health because of the requirements of this Program. Pre-certification of outpatient emergency care is not recommended or required under these circumstances.

Since the Plan does not require you or a covered dependent to obtain approval of a medical service prior to getting treatment for an urgent care or emergency situation, there are no “pre-service urgent care claims” under the Plan. In an urgent care or emergency situation, you or a covered dependent simply follow the Plan’s procedures following the treatment and file the claim as a “post-service claim.”

Non-emergency outpatient care and services of the types listed below require pre-certification:
- Surgical procedures*
- CT scan diagnostic study
- MRA diagnostic study
- MRI diagnostic study
- PET scan diagnostic study

*Except wound care services when done in a wound care clinic of a hospital.

Pre-certification is also required for the types of outpatient care listed below:
- Chiropractic care
- Durable Medical Equipment/Supplies/Orthotics/Prosthetics rental or purchase
- Home Health Care
- Hospice Care
- Therapy (Occupational, Physical, Speech)

Pre-certification is not required when services are performed in a physician’s office or the wound care department of a hospital.
**Major Case Management**

In certain circumstances, especially in the case of a very serious illness or injury, the Plan may make available Major Case Management services to the covered person. This is strictly voluntary; no covered person is obligated to participate and benefits will not be adversely affected.

Major Case Management is administered by Vale-U-Health for members of Monongahela Valley Hospital and other subsidiaries of its parent company Mon-Vale Health Resources and by American Health Holdings for members of Vale-U-Health. Case managers are medical professionals who will work with your attending physician to identify alternate courses of treatment and an individualized plan of care. They can be of invaluable assistance in locating resources to assist in your recovery.

If you are selected as a candidate for Major Case Management, you will be contacted by a case manager who will then work with you and your physician throughout the course of treatment. For members of employer Monongahela Valley Hospital and other subsidiaries of its parent company Mon-Vale Health Resources, if you have any questions about Major Case Management, please contact Vale-U-Health at 724-379-4011 Option 2 or toll free at 877-264-8258, Option 2; for members of employer Vale-U-Health, contact American Health Holdings at 1-800-641-5566.

**The Pre-certification process will not interfere with your course of treatment or the physician-patient relationship. All decisions regarding treatment and use of facilities will be yours.**

**Penalty**

If you fail to notify the Pre-certification Program Administrator within the time periods described in this section, the benefits that otherwise would be available for the facility’s covered expenses under the Plan will be reduced by 20% for services by panel providers and for emergency services by in-network providers and by 50% (subject to deductible) for non-emergency services by out-of-network providers.

| A pre-certification or concurrent review determination will not be a guarantee of eligibility, coverage or benefits. All benefit determinations will be based upon the provisions of this Plan and the decision of the Plan Administrator in its sole discretion. |

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**DISEASE STATE MANAGEMENT**

**Diabetes Disease State Management**

Vale-U-Health’s Diabetes Disease State Management is a program offered to a covered person with a diagnosis of diabetes to assist them in managing their diabetes in hopes to prevent associated complications. The Utilization/Case Management Coordinator will work with the patient and their physician to assure the patient is following the doctor’s plan of care. The overall objective is to help reduce or eliminate the following: high blood pressure, hemoglobin A1C (HBGA1C), lipid abnormalities, renal failure, complications of neuropathy, hospital admissions and re-admissions, and emergency room admissions. The Utilization/Case Management Coordinator will also assist the patient in obtaining diabetic equipment, as needed.

**Obesity Disease State Management**

Vale-U-Health’s Obesity Disease State Management is a program offered to a covered person who has a body mass index (BMI) of 30 or greater. The goal is to help participants to get their weight under control and reduce the chances for potential complications associated with obesity. The Utilization/Case Management Coordinator will work with the patient and their physician to assure the patient is following the doctor’s plan of care for diet and exercise. In addition, to help participants in the program to reach their goals, the Plan will cover the following: Lifestyles of the Fit and Healthy and Center for Fitness and Health Memberships, all offered through Monongahela Valley Hospital.

For more information on either of these programs, contact Vale-U-Health at 724-379-4011 Option 2 or toll free at 877-264-8258 Option 2.
PRESCRIPTION DRUG BENEFIT PROGRAM

Upon enrollment in the Prescription Drug Benefit Program (the “prescription program”), you will receive a Prescription Drug Benefit Services booklet (“booklet”) from the Prescription Drug Benefit Program Administrator. This booklet will contain a Prescription Drug Benefit Program ID Card, which must be presented to the pharmacist. The pharmacist will submit your claim through the system, and inform you of the amount you are required to pay.

Virtually every large national pharmacy chain, as well as local independent pharmacies, participates in your prescription program.

The prescription program includes the use of a “formulary” which includes a full range of brand name drugs in each therapeutic category. It is hoped that your physician will feel that a particular medication within the formulary will be effective for you. If, however, a non-formulary drug is prescribed, it is still covered under the Plan, but will require a higher copayment.

Included in the booklet is a pamphlet which lists preferred medications within the formulary that are most cost effective for the Plan. Your physician and pharmacist may use this reference as a guide to prescribe medication.

Inquiries regarding participating pharmacies outside the local area or other drugs within the complete formulary that are not included in the booklet’s medication list can be answered by calling the phone number on your Prescription Drug Benefit Program ID card.

Prescription Benefits
The prescription program benefits require satisfaction of a deductible for each covered person (please refer to the “Schedule of Benefits” section) that can be met through retail purchase or the mail order program (see below). The covered person will pay the discounted wholesale price for each covered prescription filled until the deductible is met. The retail prescription benefit allows for a thirty (30) day supply of a covered drug or a ninety (90) day supply at the cost of a sixty (60) day supply of a covered drug.

Once the deductible has been satisfied, the covered person is then responsible for the applicable copayment for generic drugs, formulary brand-name drugs, and non-formulary brand-name drugs, as outlined in the “Schedule of Benefits” section.

YOUR PRESCRIPTION DRUG PROGRAM BENEFIT INCLUDES TWO (2) PROVISIONS, which will be administered as follows:

Dispense As Written (DAW) Provision
If YOU choose a brand name drug that has an FDA-approved generic drug equivalent, and your physician does not indicate “Dispense As Written” (meaning that substituting a generic drug is permissible in your case), you will be responsible for the cost difference between the brand-name drug and its generic drug equivalent, in addition to the appropriate copayment for formulary brand-name drug or non-formulary brand-name drug.

Please call the customer service number listed on the back of your Prescription Drug Benefit ID card if you have any questions regarding what you were charged for a prescription.

Step Therapy Provision
A Step Therapy Program is designed specifically for patients with certain conditions that require them to take medications regularly. It is the practice of beginning medication therapy for a medical condition with the most cost-effective medication and progressing to other more costly therapy(s) should the initial medication not provide adequate therapeutic benefit. In Step Therapy, medications are grouped into two (2) categories or steps:

Step 1 – First Line Medications – mostly generic medications proven to be safe, effective, and affordable. These medications should be tried first.

Step 2 – Second Line Medications – mostly higher costing brand name medications.

The Step Therapy Program asks that you try the First Line Medication before your Plan will cover a Second Line Medication. If your physician determines that a First Line Medication is not appropriate for you or is not effective in treating your condition, your prescription benefit medication benefit will cover a Second Line Medication, once certain criteria has been met. Your physician may write a letter of medical necessity to satisfy these criteria.
If your physician writes a new prescription for a medication that is part of the Step Therapy Program, your physician will need to write you a prescription for a First Line Medication. You may request that your pharmacist call the physician for you and ask to change to a First Line Medication. If you cannot take a First Line Medication, have your physician submit a prior authorization request for your current prescription. A prior authorization is a request by the physician to explain the need for a Second Line Medication when you cannot take the First Line Medication. You or your physician can begin the prior authorization process immediately by contacting the number on your Prescription Drug Benefit Program ID card.

Always talk to your physician before discontinuing or changing any medication. Ask you pharmacist or physician about First Line Medications and discuss the Step Therapy medications on your Prescription Drug Benefit Plan.

**Specialty Pharmacy Services**

Patients with complex chronic medical conditions need the necessary care management to monitor their conditions. Specialty Pharmacy Services is a program that provides that attention. The program provides a full complement of specialized drugs and services for patients with: Hepatitis C, Cancer, Growth Deficiency, Rheumatoid Arthritis, Crohn’s Disease, Multiple Sclerosis, RSV, Hemophilia, Organ Transplants, and HIV/AIDS. The program coordinator will work one on one with the patient, managing their treatment. If you are taking medications for one of the above conditions, Specialty Pharmacy Services will be your source to obtain your specialty drugs. Please call the customer service number on your pharmacy card for more details.

**Mail Order Option**

The mail order option of the prescription program is designed to be of benefit in the purchase of drugs prescribed on an ongoing or “maintenance” basis. You may obtain up to a 90-day supply of medication for the cost of a 60-day retail supply. If the prescription is written for less than a 90-day supply, the cost of a 60-day copayment will still be charged. Within your program booklet you will receive information regarding the mail order option along with an order envelope. Additional envelopes are available in the Personnel Department of your participating employer. Your physician may designate up to 3 refills under this program. A toll-free number is provided to contact the prescription program administrator.

**Exclusions:**

The following is a list of non-covered drugs and supplies under the prescription program:

- Allergy serums;
- Devices;
- Diabetic meters and supplies (See Medical Benefits, Other Covered Expenses);
- Diet medications, unless enrolled in the Vale-U-Health Obesity Disease State Management Program. Diet medications (anorexiants) can be purchased at a discount when the pharmacy card is used, with a 100% copayment (does not count towards deductible);
- Fertility agents;
- Impotence drugs;
- IV drugs; and
- Needles;
- Over the counter medicines, except for those as a part of a plan approved step therapy regimen or when deemed by the plan to be more cost effective than the Generic or Preferred Brand alternatives;
- Rogaine, Vaniga, Propecia (All cosmetic agents);
- Syringes (covered under medical);
- Vitamins, except pre-natal vitamins.

**National Drug Code (NDC) Limit Program**

The National Drug Code (NDC) Limit Program ensures that medications indicated for short-term use treatments are being used in a correct manner. Claims submitted for these medications for quantities greater than the limit will be rejected with a message to the pharmacist indicating the correct quantity and days supply. In order to have the quantity that has been prescribed and is in excess of the quantity recommended by the physician, a letter certifying medical necessity is required.
**Prior Approval**
This prescription program provides coverage for medications whose use is approved by the FDA Guidelines. This approval includes, but is not limited to, conditions for use, proper dosage and the length of time one can use a particular medication. These criteria are established based upon the Manufacturer’s Published Scientific Studies. Due to their uniqueness of therapy, some of these medications require prior approval. All prior approvals are handled by the Prescription Drug Benefit Program Administrator indicated on the back of your program ID card. Your physician will need to send a letter of medical necessity, describing the clinical rationale for the medication regarding your condition. Exceptions are not granted for non-formulary medications unless it is a life threatening condition.

Other situations in which prior approval is required include:
- Injectable medications; and
- Excluded drugs: Prior authorizations may be accepted for excluded drugs, with a letter of medical necessity, as long as they meet the required FDA approved usage.

To obtain further information regarding exclusions, the NDC Limit Program and the prior approval process, please call the phone number on the back of your Prescription Drug Benefit Program ID card.

**TERMINATION OF COVERAGE**

**When does my participation end?**
Your participation will end at 12:01 A.M. on the earliest of the following dates:
- The date the Plan terminates;
- The last day of the month for which you request that your coverage be terminated, provided your request is made on or before that date;
- If you fail to make any premium contribution when it is due, the last day of the period for which you made a premium contribution;
- The last day of the month in which you cease to be eligible for coverage under the Plan;
- For an early retiree who elected continuation of coverage as outlined in the Employer’s Retirement Policy, the date of Medicare eligibility;
- The last day of the month in which you terminate employment; or
- The date on which an employee or his dependent submits or has knowledge of the submission of a fraudulent claim or any fraudulent information to the Plan, including enrollment information.

**When does participation end for my dependents?**
The coverage for your dependents will end at 12:01 A.M. on the earliest of the following dates:
- The date the Plan terminates;
- The date on which the Plan discontinues coverage for dependents;
- The date your dependent becomes covered as an employee under the Plan;
- The last day of the month in which your coverage terminates;
- If you fail to make any premium contribution when it is due, the last day of the period for which you made a premium contribution for your dependents;
- In the case of a child for whom coverage is being continued due to mental or physical inability to earn his own living, the last day of the month in which earliest of the following events occurs:
  - Cessation of the inability;
  - Failure to furnish any required proof of the uninterrupted continuance of the inability or to submit to any required examination; or
  - Upon the child’s no longer being dependent on you for his support;
- The end of the month in which a dependent child reaches age 26.
- In the case of a spouse, the last day of the month in which a divorce becomes final; or
- The date on which an employee or his dependent submits or has knowledge of the submission of a fraudulent claim or any fraudulent information to the Plan, including enrollment information.

**Will the Plan provide evidence of coverage?**
The Plan generally will automatically provide a certificate of coverage to anyone who loses coverage in the Plan including individuals who become eligible for COBRA continuation coverage under the Plan. A certificate of coverage will be provided upon request within 24 months after the individual loses coverage under the Plan.
The Plan will make reasonable efforts to collect information applicable to any dependents and to include that information on the certificate of coverage, but the Plan will not issue an automatic certificate of coverage for dependents until the Plan has reason to know that a dependent has lost coverage under the Plan.

**Will my participating employer continue our coverage?**

Coverage will be continued for you and your dependents should the following occur:

- In the event of a layoff, coverage will continue for thirty (30) days following the date of layoff;
- In the event of a leave of absence due to total disability, coverage for Regular Full-Time Employees may be continued for up to four months following the month in which the leave began;
- In the event of a leave of absence due to total disability, coverage for Regular Full-Time Employees having 15 or more years of service with the participating employer may be continued during the fifth and sixth months following the month in which the leave began for 50% of the premium-equivalent cost;
- In the event of a leave of absence due to total disability, Regular Full-Time Employees are afforded the option to continue coverage at premium-equivalent cost for a period not to exceed the period of time that the employee is considered active by the Plan Administrator.

Please consult with the Plan Administrator for further details on any of the preceding provisions for continuation of coverage.

The period of continued coverage under this section will not reduce the maximum time for which you may elect to continue coverage under COBRA.

**May I continue participation during FMLA leave?**

The Plan will at all times comply with FMLA. During any leave taken under FMLA, you may maintain coverage under this Plan on the same conditions as if you had been continuously employed during the entire leave period. To continue your coverage, you must comply with the terms of the Plan, including election during the Plan’s annual enrollment period and pay your premium contributions, if any. Contact the Plan Administrator for information concerning your eligibility for FMLA and any requirements of the Plan.

**May I continue participation while I am absent under USERRA? Will my coverage be reinstated on return from USERRA leave?**

If you are absent from employment because you are in the uniformed service, you may elect to continue your coverage under this Plan for up to 24 months. To continue your coverage, you must comply with the terms of the Plan, including election during the Plan’s annual enrollment period and pay your premium contributions, if any. In addition, USERRA also requires that, regardless of whether you elected to continue your coverage under the Plan, your coverage and your dependents’ coverage be reinstated immediately upon your return to employment, so long as you meet certain requirements contained in USERRA. Contact the Plan Administrator for information concerning your eligibility for USERRA and any requirements of the Plan.

**Early Retiree Continuation Coverage**

Employees retiring prior to the age of Medicare eligibility are afforded the option to continue coverage at premium equivalent cost, until they attain Medicare eligibility. Early retirees who were not covered under the Plan on the date immediately before retirement will not be allowed to enter the Plan during the annual open enrollment period or as described in the section, “Special Enrollment Periods.” Retirees who are eligible for Medicare and their dependents are not included in this eligible class for coverage under the Plan.

Please consult with the Plan Administrator for further details.

**Disability Leave of Absence – Full Time Employees**

Coverage is continued for up to four months following the month in which the leave of absence began. Employees are afforded the option to continue coverage at premium equivalent cost for a period not to exceed the period of time that the employee is considered active by the Plan Administrator.

Please consult with the Plan Administrator for further details.

**COBRA Continuation Coverage**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (“COBRA”). COBRA continuation coverage can become available to you when you otherwise would lose your group health coverage. It also can become available to other members of your family who are covered under the Plan when they otherwise would lose their group health coverage. The entire cost
What is COBRA continuation coverage?
“COBRA continuation coverage” is a continuation of Plan coverage when coverage otherwise would end because of a life event known as a “qualifying event.” Life insurance, accidental death and dismemberment benefits and weekly income or long-term disability benefits (if a part of your participating employer’s plan) are not considered for continuation under COBRA.

What is a Qualifying Event?
A qualifying event is a specific defined event that results in a loss of coverage. Types of qualifying events are listed below. After a qualifying event, the Plan Sponsor must offer COBRA continuation coverage to each person who is a “qualified beneficiary.” You, your spouse and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event.

If you are a covered employee (meaning that you are an employee and are covered under the Plan), you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:
• Your hours of employment are reduced; or
• Your employment ends for any reason other than your gross misconduct.

If you are the spouse of a covered employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:
• Your spouse dies;
• Your spouse’s hours of employment are reduced;
• Your spouse’s employment ends for any reason other than his or her gross misconduct;
• Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
• You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:
• The parent-covered employee dies;
• The parent-covered employee’s hours of employment are reduced;
• The parent-covered employee’s employment ends for any reason other than his or her gross misconduct;
• The parent-covered employee becomes entitled to Medicare benefits (Part A, Part B, or both);
• The parents become divorced or legally separated; or
• The child stops being eligible for coverage under the plan as a “dependent child.”

Sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Monongahela Valley Hospital and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee’s spouse, surviving spouse and dependent children also will become qualified beneficiaries, if bankruptcy results in the loss of their coverage under the Plan.

The participating employer must give notice of some qualifying events
When the qualifying event is the end of employment, reduction of hours of employment, death of the covered employee, commencement of a proceeding in bankruptcy with respect to the employer or the covered employee’s becoming entitled to Medicare benefits (under Part A, Part B, or both), the participating employer must notify the Plan Administrator of the qualifying event.

You must give notice of some qualifying events
Each covered employee or qualified beneficiary is responsible for providing the Plan Administrator with the following notices, in writing, either by U.S. First Class Mail or hand delivery:
• Notice of the occurrence of a qualifying event that is a divorce or legal separation of a covered employee (or former employee) from his or her spouse;
• Notice of the occurrence of a qualifying event that is an individual’s ceasing to be eligible as a dependent under the terms of the Plan;
• Notice of the occurrence of a second qualifying event after a qualified beneficiary has become entitled to COBRA continuation coverage with a maximum duration of 18 (or 29) months;
• Notice that a qualified beneficiary entitled to receive COBRA continuation coverage with a maximum duration of 18 months has been determined by the Social Security Administration (“SSA”) to be disabled at any time during the first sixty (60) days of COBRA continuation coverage; and
• Notice that a qualified beneficiary, with respect to whom a notice described in the bulleted item above has been provided, has subsequently been determined by the SSA to no longer be disabled.

The Plan Administrator is:

Vice President, Human Resources
Monongahela Valley Hospital, Inc.
1163 Country Club Road
Monongahela, PA 15063-1095
(724) 258-1132

A form of notice is available, free of charge, from the Plan Administrator and must be used when providing the notice.

**Deadline for providing the notice**

For qualifying events described above, the notice must be furnished by the date that is sixty (60) days after the latest of:

• The date on which the relevant qualifying event occurs;
• The date on which the qualified beneficiary loses (or would lose) coverage under the Plan as a result of the qualifying event; or
• The date on which the qualified beneficiary is informed, through the furnishing of the Plan's summary plan description or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

For the disability determination described above, the notice must be furnished by the date that is sixty (60) days after the latest of:

• The date of the disability determination by the SSA;
• The date on which a qualifying event occurs;
• The date on which the qualified beneficiary loses (or would lose) coverage under the Plan as a result of the qualifying event; or
• The date on which the qualified beneficiary is informed, through the furnishing of the Plan’s summary plan description or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

In any event, this notice must be furnished before the end of the first 18 months of COBRA continuation coverage.

For a change in disability status described above, the notice must be furnished by the date that is thirty (30) days after the later of:

• The date of the final determination by the SSA that the qualified beneficiary is no longer disabled; or
• The date on which the qualified beneficiary is informed, through the furnishing of the Plan's summary plan description or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

The notice must be postmarked (if mailed), or received by the Plan Administrator (if hand delivered), by the deadline set forth above. If the notice is late, the opportunity to elect or extend COBRA continuation coverage is lost, and if you are electing COBRA continuation coverage, your coverage under the Plan will terminate on the last date for which you are eligible under the terms of the Plan, or if you are extending COBRA continuation coverage, such coverage will end on the last day of the initial 18-month COBRA continuation coverage period.

**Who can provide the notice?**

Any individual who is the covered employee (or former employee), a qualified beneficiary with respect to the qualifying event or any representative acting on behalf of the covered employee (or former employee) or qualified beneficiary, may provide the notice and the provision of notice by one individual shall satisfy any responsibility to provide notice on behalf of all related qualified beneficiaries with respect to the qualifying event.
**Required contents of the notice**
The notice must contain the following information:

- Name and address of the covered employee or former employee;
- If you already are receiving COBRA continuation coverage and wish to extend the maximum coverage period, identification of the initial qualifying event and its date of occurrence;
- A description of the qualifying event (for example, divorce, legal separation, cessation of dependent status, entitlement to Medicare by the covered employee or former employee, death of the covered employee or former employee, disability of a qualified beneficiary or loss of disability status);
- In the case of a qualifying event that is divorce or legal separation, name(s) and address(es) of spouse and dependent child(ren) covered under the Plan, date of divorce or legal separation and a copy of the decree of divorce or legal separation;
- In the case of a qualifying event that is Medicare entitlement of the covered employee or former employee, date of entitlement, and name(s) and address(es) of spouse and dependent child(ren) covered under the Plan;
- In the case of a qualifying event that is a dependent child’s cessation of dependent status under the Plan, name and address of the child, reason the child ceased to be an eligible dependent (for example, attained limiting age or other);
- In the case of a qualifying event that is disability of a qualified beneficiary, name and address of the disabled qualified beneficiary, name(s) and address(es) of other family members covered under the Plan, the date the disability began, the date of the SSA’s determination and a copy of the SSA’s determination;
- In the case of a qualifying event that is loss of disability status, name and address of the qualified beneficiary who is no longer disabled, name(s) and address(es) of other family members covered under the Plan, the date the disability ended and the date of the SSA’s determination; and
- A certification that the information is true and correct, including a signature and date.

If you cannot provide a copy of the decree of divorce or legal separation or the SSA’s determination by the deadline for providing the notice, complete and provide the notice, as instructed, by the deadline and submit the copy of the decree of divorce or legal separation or the SSA’s determination within thirty (30) days after the deadline. The notice will be timely if you do so. However, no COBRA continuation coverage, or extension of such coverage, will be available until the copy of the decree of divorce or legal separation or the SSA’s determination is provided.

If the notice does not contain all of the required information, the Plan Administrator may request additional information. If the individual fails to provide such information within the time period specified by the Plan Administrator in the request, the Plan Administrator may reject the notice if it does not contain enough information for the Plan Administrator to identify the plan, the covered employee (or former employee), the qualified beneficiaries, the qualifying event or disability and the date on which the qualifying event, if any, occurred.

**ELECTING COBRA CONTINUATION COVERAGE**
Complete instructions on how to elect COBRA continuation coverage will be provided by the Plan Administrator within fourteen (14) days of receiving the notice of your qualifying event. You then have sixty (60) days in which to elect COBRA continuation coverage. The sixty (60) day period is measured from the later of the date coverage terminates and the date of the notice containing the instructions. If COBRA continuation coverage is not elected in that sixty (60) day period, then the right to elect it ceases.

Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses and parents may elect COBRA continuation coverage on behalf of their children.

In the event that the Plan Administrator determines that the individual is not entitled to COBRA continuation coverage, the Plan Administrator will provide to the individual an explanation as to why he or she is not entitled to COBRA continuation coverage.

**How long does COBRA continuation coverage last?**
COBRA continuation coverage is generally available for up to 18 months beginning on the date you lose your coverage due to employment termination or reduction of hours or work. As detailed below, certain qualifying events or a second qualifying event during the initial 18 month period of COBRA continuation coverage, you may
be eligible to extend your COBRA continuation coverage in the case of Medicare entitlement or a determination of
disability by the SSA.

Multiple qualifying events which may be combined under COBRA will not continue coverage for more than 36
months beyond the date of the original qualifying event. When the qualifying event is “entitlement to Medicare,”
the 36 month continuation period is measured from the date of the original qualifying event. For all other qualifying
events, the continuation period is measured from the date of the qualifying event and not the date of loss of
coverage.

When the qualifying event is the death of the covered employee (or former employee), the covered employee’s (or
former employee’s) becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal
separation or a dependent child’s losing eligibility as a dependent child, COBRA continuation coverage lasts for up
to a total of 36 months.

When the qualifying event is the end of employment or reduction of the covered employee’s hours of employment,
and the covered employee became entitled to Medicare benefits less than 18 months before the qualifying event,
COBRA continuation coverage for qualified beneficiaries other than the covered employee (i.e. the covered
dependents or spouse) lasts until 36 months after the date of Medicare entitlement. For example, if a covered
employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA
continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement,
which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

Otherwise, when the qualifying event is the end of employment (for reasons other than gross misconduct) or
reduction of the covered employee’s hours of employment, COBRA continuation coverage generally lasts for only
up to a total of 18 months. There are two (2) ways in which this 18 month period of COBRA continuation coverage
can be extended.

**Disability extension of 18-month period of COBRA continuation coverage**
If you or anyone in your family covered under the Plan is determined by the SSA to be disabled and you notify the
Plan Administrator as set forth above, you and your entire family may be entitled to receive up to an additional 11
months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have
started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the
18-month period of COBRA continuation coverage. An extra fee may be charged for this extended COBRA
continuation coverage.

**Second qualifying event extension of 18-month period of COBRA continuation coverage**
If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage,
the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation
coverage, for a maximum of 36 months, if notice of the second qualifying event properly is given to the Plan as set
forth above. This extension may be available to the spouse and any dependent children receiving COBRA
continuation coverage if the covered employee or former employee dies, becomes entitled to Medicare benefits
(under Part A, Part B, or both), or gets divorced or legally separated or if the dependent child stops being eligible
under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose
coverage under the Plan had the first qualifying event not occurred. An extra fee will be charged for this extended
COBRA continuation coverage.

**Does COBRA continuation coverage ever end earlier than the maximum periods above?**
COBRA continuation coverage also may end before the end of the maximum period on the earliest of the following
dates:

- The date your participating employer ceases to provide a group health plan to any employee;
- The date on which coverage ceases by reason of the qualified beneficiary’s failure to make timely payment
  of any required premium;
- The date that the qualified beneficiary first becomes, after the date of election, covered under any other
  group health plan (as an employee or otherwise) or entitled to either Medicare Part A or Part B (whichever
  comes first) (except as stated under COBRA’s special bankruptcy rules). However, a qualified beneficiary
  who becomes covered under a group health plan which has a pre-existing condition limit must be allowed
  to continue COBRA continuation coverage for the length of a pre-existing condition or to the COBRA
  maximum time period, if less; or
• The first day of the month that begins more than thirty (30) days after the date of the SSA’s determination that the qualified beneficiary is no longer disabled, but in no event before the end of the maximum coverage period that applied without taking into consideration the disability extension.

Payment for COBRA continuation coverage
Once COBRA continuation coverage is elected, you must pay for the cost of the initial period of coverage within 45 days. Payments then are due on the first day of each month to continue coverage for that month. If a payment is not received within thirty (30) days of the due date, COBRA continuation coverage will be canceled and will not be reinstated.

Additional Information
Additional information about the Plan and COBRA continuation coverage is available from the Plan Administrator, who is:

Vice President, Human Resources
Monongahela Valley Hospital, Inc.
1163 Country Club Road
Monongahela, PA 15063-1095
(724) 258-1132

Current Addresses
In order to protect your family’s rights, you should keep the Plan Administrator (who is identified above) informed of any changes in the addresses of family members.

CLAIM PROCEDURES

You will receive a Plan identification (ID) card which will contain important information, including claim filing directions and contact information. Your ID card will show your PPO network and the Pre-certification/Case Management Administrator.

At the time you receive treatment, show your ID card to your provider of service. In most cases, your provider will file your claim for you. You may file the claim yourself by submitting the required information to the claims address on your ID card.

Most claims under the Plan will be “post service claims.” A “post service claim” is a claim for a benefit under the Plan after the services have been rendered. Post service claims must include the following information in order to be considered filed with the Plan:

A Form HCFA or Form UB92 completed by the provider of service, including:
• The name of the covered employee;
• The name of the patient;
• The name of the Plan;
• The date of service;
• The name, address, telephone number and tax identification number of the provider of the services or supplies;
• The place where the services were rendered;
• The diagnosis and procedure codes; and
• The amount of charges.

A call from a provider who wants to know if an individual is covered under the Plan or if a certain procedure or treatment is a covered expense before the treatment is rendered is not a “claim,” since an actual claim for benefits is not being filed with the Plan. Likewise, presentation of a prescription to a pharmacy does not constitute a claim.

Procedures for All Claims
The procedures outlined below must be followed by covered persons to obtain payment of health benefits under this Plan.
Health Claims
All claims and questions regarding health care benefits should be directed to the third party administrator. The Plan Administrator shall be ultimately and finally responsible for adjudicating such claims and for providing a full and fair review of the decision on such claims in accordance with the following provisions and with ERISA. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the covered person is entitled to them. While the responsibility to process claims in accordance with the summary plan description has been delegated to the third party administrator, the third party administrator is not a fiduciary of the Plan and does not have the authority to make decisions involving the use of discretion.

Each covered person claiming benefits under the Plan shall be responsible for supplying, at such times and in such manner as the Plan Administrator in its sole discretion may require, written proof that the expenses were incurred or that the benefit is covered under the Plan. If the Plan Administrator in its sole discretion shall determine that the covered person has not incurred a covered expense or that the benefit is not covered under the Plan or if the covered person shall fail to furnish such proof as is requested, no benefits shall be payable under the Plan.

Under the Plan, there are three types of claims: Pre-service (Non-urgent), Concurrent Care and Post-service.

• Pre-service Claims: A “pre-service claim” is a claim for a benefit under the Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

A “pre-service urgent care claim” is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the covered person or the covered person’s ability to regain maximum function or, in the opinion of a physician with knowledge of the covered person’s medical condition, would subject the covered person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

It is important to remember, if a covered person needs medical care for a condition which would seriously jeopardize their life, there is no need to contact the Plan for prior approval. The covered person should obtain such care without delay.

Further, if the Plan does not require the covered person to obtain approval of a specific medical service prior to getting treatment, then there is no pre-service claim. The covered person simply follows the Plan’s procedures with respect to any notice which may be required after receipt of treatment and files the claim as a post-service claim.

• Concurrent Claims: A “concurrent claim” arises when the Plan has approved an on-going course of treatment to be provided over a period of time or number of treatments and either:
  • The Plan Administrator determines that the course of treatment should be reduced or terminated; or
  • The covered person requests extension of the course of treatment beyond that which the Plan Administrator has approved.

Since the Plan does not require the covered person to obtain approval of a medical service in an emergency or urgent care situation prior to getting treatment, then there is no need to contact the Plan Administrator to request an extension of a course of treatment in an urgent care situation. The covered person simply follows the Plan’s procedures with respect to any notice which may be required after receipt of treatment and files the claim as a post-service claim.

• Post-service Claims: A “post-service claim” is a claim for a benefit under the Plan after the services have been rendered.

When Health Claims Must Be Filed
Post-service health claims must be filed with the third party administrator within 365 days of the date charges for the services were incurred. Claims filed later than that date shall be denied.

A pre-service claim (including a concurrent claim that also is a pre-service claim) is considered to be filed when the request for approval of treatment or services is made and received by the third party administrator in accordance with the Plan’s procedures.
Upon receipt of the required information, the claim will be deemed to be filed with the Plan. The third party administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested as provided herein. This additional information must be received by the third party administrator within fifteen (15) days from receipt by the covered person of the request for additional information. **Failure to do so may result in claims being declined or reduced.**

**Timing of Claim Decisions**
The Plan Administrator shall notify the covered person, in accordance with the provisions set forth below, of any adverse benefit determination (and, in the case of pre-service claims and concurrent claims, of decisions that a claim is payable in full) within the following timeframes:

- **Pre-service Non-urgent Care Claims:**
  - If the covered person has provided all of the information needed to process the claim, in a reasonable period of time appropriate to the medical circumstances, but not later than fifteen (15) days after receipt of the claim, unless an extension has been requested, then prior to the end of the fifteen (15) day extension period.
  - If the covered person has not provided all of the information needed to process the claim, then the covered person will be notified as to what specific information is needed as soon as possible, but not later than five (5) days after receipt of the claim. The covered person will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period) or by the date agreed to by the Plan Administrator and the covered person (if additional information was requested during the extension period).

- **Concurrent Claims:**
  - **Plan Notice of Reduction or Termination:** If the Plan Administrator is notifying the covered person of a reduction or termination of a course of treatment (other than by Plan amendment or termination), before the end of such period of time or number of treatments, the covered person will be notified sufficiently in advance of the reduction or termination to allow the covered person to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.
  - **Request by Covered Person Involving Non-urgent Care:** If the Plan Administrator receives a request from the covered person to extend the course of treatment beyond the period of time or number of treatments that is a claim not involving urgent care, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a pre-service non-urgent claim or a post-service claim).

- **Post-service Claims:**
  - If the covered person has provided all of the information needed to process the claim, in a reasonable period of time, but not later than thirty (30) days after receipt of the claim, unless an extension has been requested, then prior to the end of the fifteen (15) day extension period.
  - If the covered person has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the covered person will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then the covered person will be notified of the determination by a date agreed to by the Plan Administrator and the covered person.

- **Extensions – Pre-service Non-urgent Care Claims:** This period may be extended by the Plan for up to fifteen (15) days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the covered person, prior to the expiration of the initial fifteen (15) day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

- **Extensions – Post-service Claims:** This period may be extended by the Plan for up to fifteen (15) days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the covered person, prior to the expiration of the initial thirty (30) day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.
• Calculating Time Periods: The period of time within which a benefit determination is required to be made shall begin at the time a claim is deemed to be filed in accordance with the procedures of the Plan.

Notification of an Adverse Benefit Determination
The Plan Administrator shall provide a covered person with a notice, either in writing or electronically, containing the following information:

- A reference to the specific portion(s) of the summary plan description upon which a denial is based;
- Specific reason(s) for a denial;
- A description of any additional information necessary for the covered person to perfect the claim and an explanation of why such information is necessary;
- A description of the Plan’s review procedures and the time limits applicable to the procedures, including a statement of the covered person’s right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on final review;
- A statement that the covered person is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the covered person’s claim for benefits;
- The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);
- Any rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to the covered person, free of charge, upon request); and
- In the case of denials based upon a medical judgment (such as whether the treatment is medically necessary or experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the covered person’s medical circumstances, or a statement that such explanation will be provided to the covered person, free of charge, upon request.

Appeals of Adverse Benefit Determinations

Full and Fair Review of All Claims
In cases where a claim for benefits is denied, in whole or in part, and the covered person believes the claim has been denied wrongly, the covered person may appeal the denial and review pertinent documents. The Plan allows for three levels of appeal of an adverse benefit determination. Each appeal provides a covered person with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination in compliance with the Employee Retirement Income Security Act of 1974 (“ERISA”). More specifically, the Plan provides:

- Covered persons at least 180 days following receipt of a notification of an initial adverse benefit determination within which to appeal the determination, sixty (60) days to file a second appeal of an adverse benefit determination, and 120 days to file a third level of appeal of an adverse benefit determination;
- Covered persons the opportunity to submit written comments, documents, records and other information relating to the claim for benefits;
- For a review that does not afford deference to the previous adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan, who shall be neither the individual who made the adverse benefit determination that is the subject of the appeal nor the subordinate of such individual;
- For a review that takes into account all comments, documents, records and other information submitted by the covered person relating to the claim, without regard to whether such information was submitted or considered in any prior benefit determination;
- That, in deciding an appeal of any adverse benefit determination that is based in whole or in part upon a medical judgment, the Plan fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal nor the subordinate of any such individual;
- For the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice; and
- That a covered person will be provided, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the covered person’s claim for benefits in possession of the Plan Administrator or the third party administrator; information regarding any voluntary appeals procedures offered by the Plan; any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse determination; and an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the covered person’s medical circumstances.
First Level Appeal

Requirements for First Level Appeal
The covered person must file the first appeal in writing within 180 days following receipt of the notice of an adverse benefit determination. To file an appeal in writing, the covered person’s appeal must be addressed as follows and mailed or faxed as follows:

<table>
<thead>
<tr>
<th>For enrollees of employer Monongahela Valley Hospital and other subsidiaries of parent company Mon-Vale Health Resources, appeal should be sent to:</th>
<th>For enrollees of employer Vale-U-Health, appeal should be sent to:</th>
</tr>
</thead>
</table>
| Vale-U-Health  
Director of Operations  
800 Plaza Drive Suite 230  
Belle Vernon, PA 15012 | W.O. Comstock & Associates  
PO Box 5148  
Topeka, KS 66605 |

It shall be the responsibility of the covered person to submit proof that the claim for benefits is covered and payable under the provisions of the Plan. Any appeal must include:

- The name of the employee/covered person;
- The employee/covered person’s social security number;
- The group name or identification number;
- All facts and theories supporting the claim for benefits. **Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the covered person will lose the right to raise factual arguments and theories which support this claim if the covered person fails to include them in the appeal;**
- A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and
- Any material or information that the covered person has which indicates that the covered person is entitled to benefits under the Plan.

Timing of Notification of Benefit Determination on First Level Appeal
The Plan Administrator shall notify the covered person of the Plan’s benefit determination on review within the following timeframes:

- **Pre-service Non-urgent Care Claims:** Within a reasonable period of time appropriate to the medical circumstances, but not later than fifteen (15) days after receipt of the appeal.
- **Concurrent Claims:** The response will be made in the appropriate time period based upon the type of claim – pre-service non-urgent or post-service.
- **Post-service Claims:** Within a reasonable period of time, but not later than thirty (30) days after receipt of the appeal.
- **Calculating Time Periods:** The period of time within which the Plan’s determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

Manner and Content of Notification of Adverse Benefit Determination on First Level Appeal
The Plan Administrator shall provide a covered person with notification, in writing or electronically, of a Plan’s adverse benefit determination on review, setting forth:

- The specific reason or reasons for the denial;
- Reference to the specific portion(s) of the summary plan description on which the denial is based;
- The identity of any medical or vocational experts consulted in connection with the claim, even if the Plan did not rely upon their advice;
- A statement that the covered person is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the covered person’s claim for benefits;
- If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination, a statement that such rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol or other similar criterion will be provided, free of charge, to the covered person upon request;
• If the adverse benefit determination is based upon a medical judgment, a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the covered person’s medical circumstances, will be provided, free of charge, upon request;
• A description of any additional information necessary for the covered person to perfect the claim and an explanation of why such information is necessary;
• A description of the Plan’s review procedures and the time limits applicable to the procedures;
• A statement of the covered person’s right to bring an action under section 502(a) of ERISA, following an adverse benefit determination on final review; and
• The following statement: “You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency.”

**Furnishing Documents in the Event of an Adverse Determination**

In the case of an adverse benefit determination on review, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in items 3 through 6 of the section relating to “Manner and Content of Notification of Adverse Benefit Determination on First Level Appeal” as appropriate.

**Second Level Appeal**

**Adverse Decision on First Level Appeal; Requirements for Second Level Appeal**

Upon receipt of notice of the Plan’s adverse decision regarding the first appeal, the covered person has sixty (60) days to file a second appeal of the denial of benefits. The covered person again is entitled to a “full and fair review” (detailed above) of any denial made at the first appeal, which means the covered person has the same rights during the second appeal as he or she had during the first appeal. As with the first appeal, the covered person’s second appeal must be in writing and must include all of the items set forth in the section entitled “Requirements for First Level Appeal.”

**Timing of Notification of Benefit Determination on Second Level Appeal**

The Plan Administrator shall notify the covered person of the Plan’s benefit determination on review within the following timeframes:

- **Pre-service Non-urgent Care Claims:** Within a reasonable period of time appropriate to the medical circumstances, but not later than fifteen (15) days after receipt of the second appeal.
- **Concurrent Claims:** The response will be made in the appropriate time period based upon the type of claim – pre-service non-urgent or post-service.
- **Post-service Claims:** Within a reasonable period of time, but not later than thirty (30) days after receipt of the second appeal.
- **Calculating Time Periods:** The period of time within which the Plan’s determination is required to be made shall begin at the time the second appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

**Manner and Content of Notification of Adverse Benefit Determination on Second Level Appeal**

The same information must be included in the Plan’s response to a second appeal as a first appeal, except for:

• A description of any additional information necessary for the covered person to perfect the claim and an explanation of why such information is needed; and
• A description of the Plan’s review procedures and the time limits applicable to the procedures. See the section entitled “Manner and Content of Notification of Adverse Benefit Determination on First Appeal.”

**Furnishing Documents in the Event of an Adverse Determination**

In the case of an adverse benefit determination on the second appeal, the Plan Administrator shall provide such access to, and copies of, documents, records and other information described in items 3 through 6 of the section relating to “Manner and Content of Notification of Adverse Benefit Determination on First Appeal” as is appropriate.

**Decision on Second Level Appeal**

If, for any reason, the covered person does not receive a written response to the appeal within the appropriate time period set forth above, the covered person may assume that the appeal has been denied. The decision by the Plan Administrator or other appropriate named fiduciary of the Plan on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. All claim review procedures provided for in the Plan
must be exhausted before any legal action regarding the claim can be brought. Any legal action for the recovery of any benefits must be commenced within one year after the Plan’s claim review procedures have been exhausted.

**Third Level (External Review) Appeal**

**Adverse Decision on Second Appeal; Requirements for Third Appeal/External Review**
Upon receipt of a notice of the Plan’s adverse decision regarding the second appeal, the covered person/claimant has 120 calendar days to file a third appeal of the denial of benefits. As with the first and second appeals, the covered person’s third appeal must be in writing and must include all of the items set forth in the section entitled “Requirements for First Level Appeal.”

**Independent Review Organization**
The Plan will assign an independent review organization (IRO) that is certified by the Utilization Review Accreditation Commission to conduct the external review. The assigned IRO will notify the covered person in writing of the acceptance for external review. The covered person will then have ten business days following receipt of the notice to submit to the IRO additional information relevant to the appeal. Upon receipt of any information submitted by the covered person, the assigned IRO will within one business day forward the information to the Plan. Upon receipt of any such information, the Plan may reconsider its adverse benefit determination. Reconsideration by the Plan will not delay the external review. If, after reconsideration by the Plan, the Plan decides to reverse its adverse determination and provide payment, the external review will be terminated. Within one business day after making such a decision, the Plan must provide written notice of its decision to the covered person and the assigned IRO.

When conducting an external review, the IRO will review all of the submitted information. In reaching a decision, the assigned IRO will review the claim from the beginning and not be bound by any decisions reached during the Plan’s internal appeals process.

The assigned IRO will provide written notice of the final external review decision within 45 calendar days after receipt of the third appeal request. The IRO will provide the decision to both the covered person and the Plan. The final determination by the IRO is binding, except to the extent the covered person has the right to bring a civil action under section 502(a) of ERISA or other voluntary alternative dispute resolution options. To find out what may be available, contact the local U.S. Department of Labor Office or the state insurance regulatory agency.

**Appointment of Authorized Representative**
A covered person is permitted to appoint an authorized representative to act on his behalf with respect to a benefit claim or appeal of a denial. An assignment of benefits by a covered person to a provider will not constitute appointment of that provider as an authorized representative. To appoint such a representative, the covered person must complete a form which can be obtained from the Plan Administrator or the third party administrator. However, in connection with a claim involving urgent care, the Plan will permit a health care professional with knowledge of the covered person’s medical condition to act as the covered person’s authorized representative without completion of this form. In the event a covered person designates an authorized representative, all future communications from the Plan will be with the representative, rather than the covered person, unless the covered person directs the Plan Administrator, in writing, to the contrary.

**Physical Examinations**
The Plan reserves the right to have a physician of its own choosing examine any covered person whose illness or injury is the basis of a claim. All such examinations shall be at the expense of the Plan. This right may be exercised when and as often as the Plan Administrator may reasonably require during the pendency of a claim. The covered person must comply with this requirement as a necessary condition to coverage.

**Autopsy**
The Plan reserves the right to have an autopsy performed upon any deceased covered person whose illness or injury is the basis of a claim. This right may be exercised only where not prohibited by law.

**Payment of Benefits**
All benefits under this Plan are payable, in U.S. Dollars, to the covered employee whose illness or injury or whose covered dependent’s illness or injury, is the basis of a claim. In the event of the death or incapacity of a covered employee and in the absence of written evidence to this Plan of the qualification of a guardian for his estate, the Plan
Administrator may, in its sole discretion, make any and all such payments to the individual or institution which, in the opinion of the Plan Administrator, is or was providing the care and support of such employee.

Assignments
Benefits for medical expenses covered under this Plan may be assigned by a covered person to the provider; however, if those benefits are paid directly to the employee, the Plan shall be deemed to have fulfilled its obligations with respect to such benefits. The Plan will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned will be made directly to the assignee unless a written request not to honor the assignment, signed by the covered employee and the assignee, has been received before the proof of loss is submitted.

Non-U.S. Providers
Medical expenses for care, supplies or services which are rendered by a provider whose principal place of business or address for payment is located outside the United States (a “non-U.S. provider”) are payable under the Plan, subject to all Plan exclusions, limitations, maximums and other provisions, under the following conditions:
- Benefits may not be assigned to a non-U.S. provider;
- The covered person is responsible for making all payments to non-U.S. providers and submitting receipts to the Plan for reimbursement;
- Benefit payments will be determined by the Plan based upon the exchange rate in effect on the incurred date;
- The non-U.S. provider shall be subject to, and in compliance with, all U.S. and other applicable licensing requirements; and
- Claims for benefits must be submitted to the Plan in English.

Recovery of Payments
Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information or are not paid according to the Plan’s terms, conditions, limitations or exclusions. Whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan Administrator has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from the covered person or dependent on whose behalf such payment was made.

A covered person, dependent, provider, another benefit plan, insurer or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the Plan or on whose behalf such payment was made, shall return the amount of such erroneous payment to the Plan within thirty (30) days of discovery or demand. The Plan Administrator shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The Plan Administrator shall have the sole discretion to choose who will repay the Plan for an erroneous payment and whether such payment shall be reimbursed in a lump sum. When a covered person or other entity does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the covered person and to deny or reduce future benefits payable (including payment of future benefits for other injuries or illnesses) under the Plan by the amount due as reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other injuries or illnesses) under any other group benefits plan maintained by the Plan Sponsor or take any other steps it believes are appropriate to recover such amounts. The reductions will equal the amount of the required reimbursement.

Providers and any other person or entity accepting payment from the Plan, in consideration of such payments, agree to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict accordance with their state’s health care practice acts, ICD-9 or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator or insurer. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within thirty (30) days of discovery or demand or incur prejudgment interest of 1.5% per month. If the Plan must bring an action against a covered person, provider or other person or entity to enforce the provisions of this section, then that covered person, provider or other person or entity agrees to pay the Plan’s attorneys’ fees and costs, regardless of the action’s outcome.
Medicaid Coverage
A covered person’s eligibility for any state Medicaid benefits will not be taken into account in determining or making any payments for benefits to or on behalf of such covered person. Any such benefit payments will be subject to the state’s right to reimbursement for benefits it has paid on behalf of the covered person, as required by the state Medicaid program; and the Plan will honor any subrogation rights the state may have with respect to benefits which are payable under the Plan.

COORDINATION OF BENEFITS

Benefits Subject to This Provision
This provision applies to all benefits provided under any section of this Plan.

Spousal Coordination of Benefits Provision
This Plan will be secondary coverage for actively working spouses who have medical coverage available at any cost to them through their employer. This will begin on the first day of the month following the spouse’s plan’s first available Open Enrollment period, if necessary. If you have elected family coverage and your working spouse has not elected family coverage, this Plan will provide primary coverage to eligible children. If your spouse has family coverage, the Birthday Rule (described below) shall apply.

Other Plan
“Other plan” means any of the following plans, other than this Plan, providing benefits or services for medical or dental care or treatment:

- Group, blanket, or franchise insurance coverage;
- Blue Cross, Blue Shield, group practice, and other group prepayment coverage;
- Any coverage under labor-management trusted plans, union welfare plans, employer organization plans, school insurance, or employee benefit organization plans;
- Any coverage under governmental programs, and any coverage required or provided by statute; and
- Any mandatory automobile insurance (such as no-fault) providing benefits under a medical expense reimbursement provision for health care services because of injuries arising out of a motor vehicle accident, and any other medical and liability benefits received under any automobile policy.

If the “Other plan” is a High Deductible Health Plan that includes a Health Savings Account, this Plan is not permitted to coordinate benefits with that “Other plan.”

Allowable Expenses
“Allowable expenses” shall mean any medically necessary, usual, reasonable and customary item of expense, at least a portion of which is covered under this Plan. When some other plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be deemed to be the benefit.

It is important that you fulfill any requirements of other plan(s) for payment of benefits. If you fail to properly file for and receive payment by any other plan(s), this Plan will estimate the benefits that would otherwise have been payable and apply that amount, as though actually paid, to the “Application to Benefit Determination” calculation explained in this section.

In the case of HMO (Health Maintenance Organization) plans, this Plan will not consider any charges in excess of what an HMO provider has agreed to accept as payment in full. Further, when an HMO is primary and the covered person does not use an HMO provider, this Plan will not consider as allowable expenses any charge that would have been covered by the HMO had the covered person used the services of an HMO provider.

Effect on Benefits

Application to Benefit Determinations
The plan that pays first according to the rules in the section entitled “Order of Benefit Determination” will pay as if there were no other plan involved. If this Plan is a secondary or subsequent plan, this Plan will pay the balance due up to 100% of the total cumulative allowable expenses for that calendar year; however, in no event will this Plan pay more than it would have in the absence of any other plan(s). When there is a conflict in the order of benefit determination, this Plan will never pay more than 50% of allowable expenses.
When medical payments are available under automobile insurance, this Plan will always be considered the secondary carrier regardless of the individual’s election under personal injury protection (PIP) coverage with the automobile insurance carrier.

In certain instances, the benefits of the other plan will be ignored for the purposes of determining the benefits under this Plan. This is the case when:

- The other plan would, according to its rules, determine its benefits after the benefits of this Plan have been determined; and
- The rules in the section entitled “Order of Benefit Determination” would require this Plan to determine its benefits before the other plan.

**Order of Benefit Determination**

For the purposes of the section entitled “Application to Benefit Determinations,” the rules establishing the order of benefit determination are listed below. The Plan will consider these rules in the order in which they are listed and will apply the first rule that satisfies the circumstances of the claim.

- A plan without a coordinating provision will always be the primary plan;
- For a covered employee’s actively working spouse who has medical coverage available at any cost through his or her employer, this Plan will be secondary. Coverage through the spouse’s employer’s plan will be considered to be available on the earliest of:
  - The spouse’s original eligibility date under his or her employer’s plan, if that date is later than the covered employee’s eligibility date under this Plan;
  - The first day of the month following the first open enrollment period under the spouse’s employer’s plan; or
  - The first day on which coverage becomes available under the spouse’s employer’s plan because of a special enrollment event.
- The benefits of a plan which covers the person on whose expenses claim is based, other than as a dependent, will be determined before the benefits of a plan which covers such person as a dependent. If the person on whose expenses the claim is based is an inactive employee (e.g. retired or on layoff) or the dependent of an inactive employee, the benefits of the plan covering the person in an active status will be determined before the benefits of a plan covering the person in an inactive status;
- If the person for whom claim is made is a dependent child covered under both parents’ plans, the plan covering the parent whose birthday (month and day of birth, not year) falls earlier in the year will be primary (the “Birthday Rule”), except:
  - When the parents are separated (whether or not ever legally married) or divorced, and the parent with the custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody; or
  - When the parents are separated (whether or not ever legally married) or divorced and, the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent, and the benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

Notwithstanding the above provisions, if there is a court decree which would otherwise establish financial responsibility for the child’s health care expenses, the benefits of the plan which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other plan which covers the child as a dependent child; and

- When the rules above do not establish an order of benefit determination, the benefits of a plan which has covered the person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a plan which has covered such person the shorter period of time.

**Right to Receive and Release Necessary Information**

For the purpose of determining the applicability of and implementing the terms of this provision or any provision of similar purpose of any other plan, this Plan may, without the consent of or notice to any person, release to or obtain from any insurance company or other organization or individual, any information with respect to any person, which the Plan deems to be necessary for such purposes. Any person claiming benefits under this Plan shall furnish to the Plan such information as may be necessary to implement this provision.
**Facility of Payment**
Whenever payments which should have been made under this Plan in accordance with this provision have been made under any other plans, the Plan Administrator may, in its sole discretion, pay any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, this Plan shall be fully discharged from liability.

**Right of Recovery**
Whenever payments have been made by this Plan with respect to allowable expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, the Plan shall have the right to recover such payments, to the extent of such excess, in accordance with the Recovery of Payments provision of this Plan.

**Coordination of Benefits with Medicare**
If you are eligible for Medicare, and you are eligible for coverage under this Plan, you may choose to continue coverage under this Plan, and any Medicare benefits to which you are entitled may be used to supplement the benefits of this Plan. If, however, you choose to make Medicare your primary plan, you may not supplement your Medicare coverage with the benefits of this Plan.

In all cases, coordination of benefits with Medicare will conform with Federal law. When coordination of benefits with Medicare is permitted, each individual who is eligible for Medicare will be assumed to have full Medicare coverage whether or not the individual has enrolled for full coverage. Your benefits under this Plan will be coordinated to the extent allowed by Federal law.

**Coordination of Benefits with Medicaid**
In all cases, benefits available through a state or Federal Medicaid program will be secondary or subsequent to the benefits of this Plan.

**SUBROGATION, THIRD-PARTY RECOVERY AND REIMBURSEMENT**

The Plan has the right to recover the full amount of benefit payments made to or on behalf of you or your eligible dependents (including your spouse and eligible dependent children) if:

- Some other party (third-party) caused the injury, illness or condition for which Plan payments were made (for example, you are injured by another driver in an automobile accident and the Plan made payments for medical treatment you received arising from injuries you sustained in that accident); or
- An insurance carrier or self-insured party ("insurer") including, but not limited to, an insurer that provides medical payments, uninsured or underinsured motor vehicle insurance, or worker's compensation insurance, is responsible for making payments for the medical bills or wage replacement benefits that the Plan paid (for example, you slip and fall on a job site and the Plan made payments for wages you lost as a result of your fall).

The Plan's right to recover is called "subrogation." The Plan's subrogation rights also apply to your estate or your dependent's estate in the event that the estate receives or benefits from payments from the Plan. The Plan has the right to be "reimbursed" or paid back those monies paid to you or on your behalf.

The Plan's subrogation right allows the Plan or the Plan Administrator to take legal action in your name against the third-party or insurer. If you (or your dependent) take legal action against the third-party, the Plan or the Plan Administrator may, but has no duty to, intervene in that legal action.

The Plan's subrogation right becomes a lien on the proceeds of any claim against the third-party or insurer for the full amount of Plan benefits paid. This means that the Plan has the right to receive, before you, the full amount of Plan benefits paid. This lien applies regardless of whether you assert the claim yourself (or as a co-claimant with others) or whether the Plan or the Plan Administrator asserts the claim in your name. This lien applies to the proceeds of any claim, regardless of whether the proceeds are recovered as a result of a lawsuit, settlement, compromise and release, or otherwise.

At the option of the Trustees, the Plan's lien will not be reduced by any costs involved in the recovery of the proceeds such as attorneys' or experts' fees, legal costs, or other out-of-pocket expenses. In addition, the Plan's lien
will not be reduced by the failure of the recovery to make you (or your dependent) whole. For example, assume the Plan paid $50,000 for medical services you received in connection with injuries you sustained in a motor vehicle accident. You make a claim against the other driver for $125,000. Your $125,000 claim includes the $50,000 of medical expenses and $75,000 for lost wages. You recover $50,000. The Plan is entitled to the entire $50,000.00 even though you did not recover the full amount of your claim.

If you (or your dependent) assert a claim against a third-party or insurer on your own behalf (or as a co-claimant with others) and monies are recovered from the third-party or insurer, it will be conclusively presumed that the recovery is subject to the Plan's subrogation right regardless of how the recovery is allocated among the claimants, and no matter whether the payments are characterized in the same manner as described by the Plan. For example, assume you filed a lawsuit against a third-party who caused injuries to you in a motor vehicle accident. The Plan made payments in the amount of $75,000.00 for your medical bills. You settle with the third-party for $125,000. The manner in which the settlement is structured allocates $75,000.00 of the settlement proceeds to lost wages, $50,000 to your spouse for loss of consortium, and allocates nothing to medical expenses. The Plan has the right to be reimbursed for the $75,000 of medical benefits paid despite the fact that the settlement allocated no amount to medical expenses.

If you (or your dependents) receive any recovery from a third-party or insurer, you are obligated to immediately and fully reimburse the Plan from the proceeds to the full extent of the dollar amount of Plan benefits that are payable or paid. If the proceeds are less than the amount paid by the Plan, the Plan has the right to receive the entire amount of the proceeds.

The Plan may appoint an agent for purposes of these subrogation and reimbursement rights.

By accepting benefits from the Plan, you and your dependents:

- Grant the Plan a lien on the proceeds of any payment, settlement or judgment that is secured relating to the injuries that caused such benefits to be provided;
- Agree to sign and deliver any documents necessary to secure the Plan's subrogation and reimbursement rights;
- Agree to notify the Plan promptly of a claim against or settlement with any third-party or any insurer for benefits paid or that may be paid under the Plan;
- Will cooperate with the Plan with regard to and take no action to jeopardize the Plan's subrogation and reimbursement rights.

**Overpayments or Mistaken Payments**

1. In addition to, and without limiting those rights specified above under "Subrogation, Third-Party Recovery and Reimbursement,” the Plan has the right to recover from you, (or your dependent) any overpayments or mistaken benefit payments made to or on behalf of you (or your dependent), including but not limited to payment of such benefits pending approval or settlement of any workers’ compensation benefits. The Plan Administrator may act as the Plan's agent for purposes of recovery of such over or mistaken payment.

2. At the Plan Administrator's option, the Plan may also recoup such over or mistaken payments by: (1) reducing future payments due under the Plan to you (or your dependent) by the amount of such over or mistaken payment(s); and/or (2) by bringing a legal action to recover the over or mistaken payment(s).

**DEFINITIONS**

In this section you will find the definitions for words found throughout this summary plan description. There may be additional words or terms that have a meaning that pertains to a specific section and those definitions will be found in that section. **These definitions are not an indication that charges for particular care, supplies or services are eligible for payment under the Plan; please refer to the appropriate sections of this summary plan description for that information.**

“**Accident**” means a sudden and unforeseen event, definite as to time and place, or a deliberate act resulting in unforeseen consequences.
“Actively at Work” or “Active Employment” means performance by the employee of all the regular duties of his occupation at an established business location of the participating employer, or at another location to which he may be required to travel to perform the duties of his employment. An employee will be deemed actively at work if the employee is absent from work due to a health factor. In no event will an employee be considered actively at work if he has effectively terminated employment.

“ADA” means the American Dental Association.

“AHA” means the American Hospital Association.

“AMA” means the American Medical Association.

“Ambulatory Surgical Center” means any public or private state licensed and approved (whenever required by law) establishment with an organized medical staff of physicians, with permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures, with continuous physician services and registered professional nursing service whenever a patient is in the institution, and which does not provide service or other accommodations for patients to stay overnight.

“Brand Name Drug” means drugs produced and marketed exclusively by a particular manufacturer. These names are usually registered as trademarks with the Patent Office and confer upon the registrant certain legal rights with respect to their use.

“Cardiac Care Unit (CCU)” means a separate, clearly designated service area which is maintained within a hospital and which meets all the following requirements:

- It is solely for the treatment of patients who require special medical attention because of their critical condition;
- It provides within such area special nursing care and observation of a continuous and constant nature not available in the regular rooms and wards of the hospital;
- It provides a concentration of special lifesaving equipment immediately available at all times for the treatment of patients confined within such area;
- It contains at least two beds for the accommodation of critically ill patients; and
- It provides at least one professional registered nurse, who continuously and constantly attends the patient confined in such area on a 24-hour-a-day basis.

“Casual Employee” means an employee who works less than 40 hours per week or 80 hours per pay, who works an irregular schedule and does not meet the criteria for Regular Part-Time Employee. Employees in this category are normally scheduled or called to “fill-in” during peak work-loads or to replace call-offs, and are called at the complete discretion of the participating employer.

“Child Immunizations” means immunizations, including the immunizing agent, reimbursement for which shall not exceed 150% of the average wholesale price, which, as determined by the Department of Health, conform with the standards of the Advisory Committee on Immunization Practiced of the Center for Disease Control, the United States Department of Health and Human Services.

“Certificate of Coverage” means a written certification provided by any source that offers medical care coverage, including the Plan, for the purpose of confirming the duration and type of an individual’s previous coverage.

“Child(ren)” means, in addition to the employee’s own blood descendant of the first degree or lawfully adopted child, a child placed with the employee in anticipation of adoption, a child who is an alternate recipient under a QMCSO as required by the federal Omnibus Budget Reconciliation Act of 1993, any stepchild or any other child for whom the employee has obtained legal guardianship.

“Chiropractic Care” means the medical study diagnosing and treating back disorders through manual manipulation of the spine.

“COBRA” means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

“Coinsurance” means a specified percentage of a covered expense that must be paid by a covered person.
“**Copayment**” means an amount of money that must be paid by a covered person for a specific covered service before the Plan will reimburse additional covered expenses for the covered service.

“**Cosmetic**” or” **Cosmetic Surgery**” means any surgery, service, drug or supply designed to improve the appearance of an individual by alteration of a physical characteristic which is within the broad range of normal but which may be considered unpleasing or unsightly, except when necessitated by an injury.

“**Covered Expense**” means the cost of a medically necessary service or supply which is usual, customary and reasonable, and which is listed for coverage in this Plan.

“**Covered Person**” means a covered employee and his covered dependents that are eligible for benefits under the Plan.

“**Covered Service**” means a treatment, service or supply which is listed for coverage in this Plan.

“**Custodial Care**” means care or confinement provided primarily for the maintenance of the covered person, essentially designed to assist the covered person, whether or not totally disabled, in the activities of daily living, which could be rendered at home or by persons without professional skills or training. This care is not reasonably expected to improve the underlying medical condition, even though it may relieve symptoms or pain. Such care includes, but is not limited to, bathing, dressing, feeding, preparation of special diets, assistance in walking or getting in and out of bed, supervision over medication which can normally be self-administered and all domestic activities.

“**Deductible**” means an amount of money that must be paid by a covered person for covered expenses before the Plan will reimburse additional covered expenses incurred during that plan year.

“**Dentist**” means an individual holding a D.D.S. or D.M.D. degree, who is licensed to practice dentistry in the jurisdiction where such services are provided.

“**Dependent**” means one or more of the following person(s):

- An employee’s lawfully married spouse possessing a marriage license who is not divorced from the employee.
- An employee’s child who is less than 26 years of age; or
- An employee’s unmarried child, regardless of age, who is mentally or physically incapable of sustaining his own living, who has the same principal place of abode as the employee for more than one-half of the calendar year, and who does not provide more than one half of his or her own support for the calendar year in which the child is enrolled for coverage under the Plan. Such child must have been mentally or physically incapable of earning his own living prior to attaining the limiting age under the second and third bullets above. Written proof of such incapacity and dependency satisfactory to the Plan must be furnished and approved by the Plan within thirty (30) days after the date the child attains the limiting age under the second and third bullets above. The time limit for written proof of incapacity and dependency is thirty (30) days following the original eligibility date for a new or re-enrolling employee. The Plan may require, at reasonable intervals, subsequent proof satisfactory to the Plan during the next two years after such date. After such two-year period, the Plan may require such proof, but not more often than once each year.

“Dependent” does not include a spouse who is a member of the armed forces of any country or who is a resident of a country outside the United States.

The Plan reserves the right to require documentation, satisfactory to the Plan Administrator, which establishes a dependent relationship.

“**Detoxification**” means the process whereby an alcohol-intoxicated person, or person experiencing the symptoms of substance abuse, is assisted in a facility licensed by the Department of Health through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol, alcohol dependency factors or alcohol in combination with drugs as determined by a licensed physician, while keeping the physiological risk to the patient to a minimum.

“**Diagnostic Service**” means a test or procedure performed for specified symptoms to detect or to monitor an illness or injury. It must be ordered by a physician or other professional provider.
“Drug” means insulin and prescription legend drugs. A prescription legend drug is a Federal legend drug (any medicinal substance which bears the legend: “Caution: Federal law prohibits dispensing without a prescription”) or a state restricted drug (any medicinal substance which may be dispensed only by prescription, according to state law) and which, in either case, is legally obtained from a licensed drug dispenser only upon a prescription of a currently licensed physician.

“Durable Medical Equipment” means equipment which:

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

“Early Retiree” means a former employee who is not yet eligible for Medicare and who retired in accordance with the rules of the participating employer.

“Emergency” means a situation where necessary treatment is required as the result of a sudden and severe medical event, acute condition or trauma. An emergency includes poisoning, shock, hemorrhage, severe chest pain, difficulty in breathing, sudden onset of weakness or paralysis of a body part, severe burns, unconsciousness, partial or complete severing of a limb, and convulsions.

Other emergencies and acute conditions may be considered on receipt of proof, satisfactory to the Plan, that an emergency did exist.

“Employee” means a person who is a regular full-time employee or a temporary full-time employee of the participating employer, regularly scheduled to work for the participating employer in an employer-employee relationship. For purposes of medical plan benefits, such person must be scheduled to work at least 30 hours per week or at least 130 hours per month in order to be considered “full-time.” Also for purposes of medical plan benefits, Employee also means a regular part-time employee of the participating employer, regularly scheduled to work for the participating employer less than 30 hours per week or less than 130 hours per month. (Please see the definitions of “Regular Full-Time Employee,” “Regular Part-Time Employee,” “Temporary Full-Time Employee,” and “Temporary Part-Time Employee” for additional details regarding full-time and part-time status.) An employee is not a leased employee or an independent contractor. The term “Employee” also includes those individuals whose terms and conditions of employment are covered by the collective bargaining agreement between the employer Monongahela Valley Hospital and the Union.


“Experimental” means services, supplies, care, procedures, treatments or courses of treatment, which:

- Do not constitute accepted medical practice under the standards of the case and by the standards of a reasonable segment of the medical community or government oversight agencies at the time rendered; or
- Are rendered on a research basis as determined by the United States Food and Drug Administration and the AMA’s Council on Medical Specialty Societies. All phases of clinical trials shall be considered experimental.
- Drugs are considered experimental if they are not commercially available for purchase or are not approved by the Food and Drug Administration for general use.

“Family Unit” means the employee, his spouse and his dependent children.

“FMLA” means the Family and Medical Leave Act of 1993, as amended.

“FMLA Leave” means a leave of absence, which the Employer is required to extend to an employee under the provisions of the FMLA.

“Generic Drug” means drugs not protected by a trademark, usually descriptive of drug’s chemical structure.

“HIPAA” means the Health Insurance Portability and Accountability Act of 1996, as amended.
“Home Health Care” means certain services and supplies required for treatment of an illness or injury in the covered person’s home as part of a formal treatment plan certified by the attending physician and approved by the Plan Administrator.

“Home Health Care Agency” means an agency or organization which provides a program of home health care and which:

- Is approved as a home health agency under Medicare;
- Is established and operated in accordance with the applicable laws in the jurisdiction in which it is located and, where licensing is required, has been licensed and approved by the regulatory authority having the responsibility for licensing; or
- Meets all of the following requirements:
  - It is an agency which holds itself forth to the public as having the primary purpose of providing a home health care delivery system bringing supportive services to the home;
  - It has a full-time administrator;
  - It maintains written records of services provided to the patient;
  - Its staff includes at least one registered nurse (R.N.) or it has nursing care by a registered nurse (R.N.) available; and
  - Its employees are bonded and it provides malpractice insurance.

“Hospice Care Agency” means an agency which has the primary purpose of providing hospice services to hospice patients.

“Hospital” in certain statements throughout this document means Monongahela Valley Hospital, Inc. or an institution that meets all of the following requirements:

- It provides medical and surgical facilities for the treatment and care of injured or sick persons on an inpatient basis;
- It is under the supervision of a staff of physicians;
- It provides 24-hour-a-day nursing service by registered nurses;
- It is duly licensed as a hospital, except that this requirement will not apply in the case of a state tax-supported institution;
- It is not, other than incidentally, a place for rest, a place for the aged, a nursing home or a custodial or training-type institution, or an institution which is supported in whole or in part by a federal government fund; and
- It is accredited by the Joint Commission on Accreditation of Healthcare Organizations sponsored by the AMA and the AHA.

The requirement of surgical facilities shall not apply to a hospital specializing in the care and treatment of mentally ill patients, provided such institution is accredited as such an institution by the Joint Commission on Accreditation of Healthcare Organizations sponsored by the AMA and the AHA.

“Illness” means a condition, sickness or disease not resulting from trauma.

“Immediate Relative” means spouse, child, brother, sister or parent of the covered person, whether by birth, adoption or marriage.

“Impregnation and Infertility Treatment” means artificial insemination, fertility drugs, G.I.F.T. (Gamete Intrafallopian Transfer), impotency drugs such as Viagra™, in-vitro fertilization, sterilization and/or reversal of a sterilization operation, surrogate mother, donor eggs, or any type of artificial impregnation procedure, whether or not such procedure is successful.

“Incurred” means the date the service is rendered or the supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, expenses are incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered.

“Injury” means physical damage to the body, caused by an external force, and which is due directly and independently of all other causes, to an accident.
“Inpatient” means any person who, while confined to a hospital, is assigned to a bed in any department of the hospital other than its outpatient department and for whom a charge for room and board is made by the hospital.

“Institution” means a facility, operating within the scope of its license, whose purpose is to provide organized health care and treatment to individuals, such as a hospital, ambulatory surgical center, psychiatric hospital, community mental health center, residential treatment facility, psychiatric hospital, substance abuse treatment center, alternative birthing center, home health care center, or any other such facility that the Plan approves.

“Intensive Care Unit (ICU)” means a separate, clearly designated service area which is maintained within a hospital and which meets all the following requirements:

- It is solely for the treatment of patients who require special medical attention because of their critical condition;
- It provides within such area special nursing care and observation of a continuous and constant nature not available in the regular rooms and wards of the hospital;
- It provides a concentration of special lifesaving equipment immediately available at all times for the treatment of patients confined within such area;
- It contains at least two beds for the accommodation of critically ill patients; and
- It provides at least one professional registered nurse, who continuously and constantly attends the patient confined in such area on a 24-hour-a-day basis.

“Life-Threatening Medical Condition” means a condition which requires immediate treatment to avoid impairment to health and/or possible death, including loss of consciousness or respiratory function, severe convulsions, asphyxiation and similar conditions.

“Leave of Absence” means a leave of absence of an employee that has been approved by the participating employer, as provided for in the participating employer’s rules, policies, procedures and practices.

“Mastectomy” means the surgical removal of all or part of a breast.

“Medical Facility” means a facility, operating within the scope of its license, whose purpose is to provide organized health care and treatment to individuals, such as a hospital, ambulatory surgical center, psychiatric hospital, community mental health center, residential treatment facility, psychiatric hospital, substance abuse treatment center, alternative birthing center, home health care center, or any other such facility that the Plan approves.

“Medically Necessary” means services or supplies which are determined by the Plan Administrator to be:

- Appropriate and necessary for the symptoms, diagnosis or direct care and treatment of the medical condition, injury or illness;
- Provided for the diagnosis or direct care and treatment of the medical condition, injury or illness;
- Within standards of good medical practice within the organized medical community;
- Not primarily for the convenience of the covered person, the covered person’s physician or another provider; and
- The most appropriate supply or level of service which can safely be provided.

For hospital stays, this means that acute care as an inpatient is necessary due to the kind of services the covered person is receiving or the severity of the covered person’s condition, and that safe and adequate care cannot be received as an outpatient or in a less intensified medical setting. The mere fact that the service is furnished, prescribed or approved by a physician does not mean that it is “medically necessary.” In addition, the fact that certain services are excluded from coverage under this Plan because they are not “medically necessary” does not mean that any other services are deemed to be “medically necessary.”

“Medicare” means the program of health care for the aged established by Title XVIII of the Social Security Act of 1965, as amended.

“Mental Nervous Disorder” means any illness or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services; or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.
“Morbid obesity” means a diagnosed condition as defined by the Centers for Disease Control (CDC).

“Network” or “PPO Network” means the Preferred Provider Organization (PPO) network of providers offering discounted fees for services and supplies to covered persons. The network will be identified on the covered person’s Plan Identification Card.

“Network Provider” means any provider which is a member in the Vale-U-Health and supplemental PPO Provider Networks.

“Out-of-Pocket Expense” means the cost to the covered person for deductibles, coinsurance, copayments, penalties and non-covered expenses.

“Participating Employer” means Monongahela Valley Hospital or other subsidiaries of the parent company Mon-Vale Health Resources and Vale-U-Health.


“Plan” means the Monongahela Valley Hospital, Inc. Group Medical Plan, also known as the Pennsylvania Health Care Plan.

“Plan Administrator” means the Vice President, Human Resources of the Monongahela Valley Hospital, Inc. or his delegate.

“Plan Document” means this Plan Document and Summary Plan Description.

“Plan Sponsor” means Monongahela Valley Hospital, Inc.

“Pre-admission Tests” means those diagnostic services done before a scheduled hospital inpatient admission, provided that:
- The tests are required by the hospital and approved by the physician;
- The tests are performed on an outpatient basis prior to hospital admission;
- The tests are not duplicated on admission to the hospital; and
- The tests are performed at the hospital where the confinement is scheduled, or at a qualified facility approved by the hospital to perform the tests.

“Preferred Provider Organization” or “PPO” means a network of providers offering discounted fees for services and supplies to covered persons.

“Pregnancy” means carrying a child, resulting childbirth, miscarriage and non-elective abortion. The Plan considers pregnancy as an illness for the purpose of determining benefits.

“Privacy Standards” means the standards for privacy of individually identifiable health information, as enacted pursuant to HIPAA.

“Provider” means a physician, a licensed speech or occupational therapist, licensed professional physical therapist, physiotherapist, psychiatrist, audiologist, speech language pathologist, licensed professional counselor, certified nurse practitioner, certified psychiatric/mental health clinical nurse, certified midwife, or other practitioner or facility defined or listed herein, or approved by the Plan Administrator.

“Psychiatric Hospital” means an institution constituted, licensed, and operated as set forth in the laws that apply to hospitals, which meets all of the following requirements:
- It is primarily engaged in providing psychiatric services for the diagnosis and treatment of mentally ill persons either by, or under the supervision of, a physician;
- It maintains clinical records on all patients and keeps records as needed to determine the degree and intensity of treatment provided;
- It is licensed as a psychiatric hospital;
• It requires that every patient be under the care of a physician; and
• It provides 24-hour-a-day nursing service.

It does not include an institution, or that part of an institution, used mainly for nursing care, rest care, convalescent care, care of the aged, custodial care or educational care.

“Regular Full-Time Employee” means, for purposes of medical plan benefits, an employee of the participating employer who normally is assigned to a work schedule of 30 hours or more per week or 130 hours or more per month; for purposes of non-medical plan benefits, “Regular Full-Time Employee” means an employee of the participating employer who normally is assigned to a work schedule of 40 hours per week or 80 hours per pay period. Assignment to a work schedule is not a guarantee of any particular number of hours per day, week, pay period or year, nor is it a promise of employment for any period of time.

“Regular Part-Time Employee” means, for purposes of medical plan benefits, an employee of the participating employer who normally is assigned to a work schedule of less than 30 hours per week or less than 130 hours per month; for purposes of non-medical plan benefits, “Regular Part-Time Employee” means an employee of the participating employer who normally is assigned to a work schedule of less than 40 hours per week or less than 80 hours per pay period, but works at least 416 hours per calendar year. Assignment to a work schedule is not a guarantee of any particular number of hours per day, week, pay period or year, nor is it a promise of employment for any period of time.

“Rehabilitation Hospital” means an institution which mainly provides therapeutic and restorative services to sick or injured people. It is recognized as such if:
• It carries out its stated purpose under all relevant federal, state and local laws;
• It is accredited for its stated purpose by either the Joint Commission on Accreditation of Healthcare Organizations or the Commission on Accreditation for Rehabilitation Facilities; or
• It is approved for its stated purpose by Medicare.

“Room and Board” means an institution’s charge for:
• Room and linen service;
• Dietary service, including meals, special diets and nourishment;
• General nursing service; and
• Other conditions of occupancy which are medically necessary.

“Seasonal Employee” means an employee who is hired into a position for which the customary annual employment is six months or less and the period of work typically begins each calendar year in approximately the same part of the year, such as summer or winter.

“Significant Break in Coverage” means a period of 63 consecutive days during all of which an individual did not have any creditable coverage, but does not include waiting periods and affiliation periods.

“Substance Abuse” means any use of alcohol, any drug (whether obtained legally or illegally), any narcotic, or any hallucinogenic or other illegal substance, which produces a pattern of pathological use, causing impairment in social or occupational functioning, or which produces physiological dependency evidenced by physical tolerance or withdrawal.

“Substance Abuse Treatment Center” means an institution which provides a program for the treatment of substance abuse by means of a written treatment plan approved and monitored by a physician. This institution must be:
• Affiliated with a hospital under a contractual agreement with an established system for patient referral;
• Accredited as such a facility by the Joint Commission on Accreditation of Healthcare Organizations; or
• Licensed, certified or approved as an alcohol or substance abuse treatment program or center by a state agency having legal authority to do so.

“Summary Plan Description” means this plan document and summary plan description.
“Surgery” or “Surgical Procedure” means any of the following:

- The incision, excision, debridement or cauterization of any organ or part of the body, and the suturing of a wound;
- The manipulative reduction of a fracture or dislocation or the manipulation of a joint including application of cast or traction;
- The removal by endoscopic means of a stone or other foreign object from any part of the body or the diagnostic examination by endoscopic means of any part of the body;
- The induction of artificial pneumothorax and the injection of sclerosing solutions;
- Arthrodesis, paracentesis, arthrocentesis and all injections into the joints or bursa;
- Obstetrical delivery and dilation and curettage; or
- Biopsy.

“Temporary Full-Time Employee” means, for purposes of medical plan benefits, an employee of the participating employer who normally is assigned to a work schedule of 30 hours per week or 130 hours per month temporarily, for a specified period of time; for purposes of non-medical plan benefits, “Temporary Full-Time Employee” means an employee of the participating employer who normally is assigned to a work schedule of 40 hours per week or 80 hours per pay period temporarily, for a specified period of time. At the end of the specified period of time, the temporary full-time employee’s employment is terminated. This category will normally be used to complete a specific project or to replace a regular full-time employee who is on a leave of absence. Assignment to a work schedule is not a guarantee of any particular number of hours per day, week, pay period or year, nor is it a promise of employment for any period of time.

“Temporary Part-Time Employee” means, for purposes of medical plan benefits, an employee of the participating employer who is not regularly scheduled to work at least 30 hours per week or at least 130 hours per month and who is hired for a specific period of time; for purposes of non-medical plan benefits, “Temporary Part-Time Employee” means an employee of the participating employer who is not regularly scheduled to work at least 40 hours per week or 80 hours per pay period and who is hired for a specific period of time. At the end of the specific period of time, the Temporary Part-Time Employee’s employment is terminated. This category will normally be used to complete a specific project or to replace on a temporary basis a regular full-time employee who is absent due to illness, surgery, personal reasons, etc. Assignment to a work schedule is not a guarantee of any particular number of hours per day, week, pay period or year, nor is it a promise of employment for any period of time.

“Total Disability” or “Totally Disabled” means the inability of an employee to perform substantially all of the duties of his occupation due to an illness or injury. The Plan Administrator may, in its sole discretion, require satisfactory evidence of total disability.

“Uniformed Services” means the Armed Forces, the Army National Guard and the Air National Guard, when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or emergency.


“Usual, Customary and Reasonable” or “Usual, Customary and Reasonable Fees” (“UCR”) means services and supplies which are medically necessary for the care and treatment of illness or injury, but only to the extent that such fees are reasonable. Determination that a fee is reasonable will be made by the Plan Administrator, taking into consideration:

- The fee which the provider most frequently charges the majority of patients for the service or supply;
- The prevailing range of fees charged in the same “Area” by providers of similar training and experience for the service or supply; and
- Unusual circumstances or complications requiring additional time, skill and experience in connection with the particular service or supply.
  - “Area” means a metropolitan area, county or such greater area as is necessary to obtain a representative cross-section of providers rendering such services or furnishing such supplies.

“Waiting Period” means an interval of time during which the employee is in the continuous, active employment of his participating employer before he becomes eligible to participate in the Plan.
PLAN ADMINISTRATION

Who has the authority to make decisions in connection with the Plan?
The Plan is administered by the Plan Administrator in accordance with ERISA. The Plan Administrator has retained the services of the Third Party Administrator and delegated the authority to the Third Party Administrator to provide certain claims processing and other ministerial services. An individual or entity may be appointed by the Plan Sponsor to be Plan Administrator and serve at the convenience of the Plan Sponsor. If the Plan Administrator resigns, dies, is otherwise unable to perform, is dissolved, or is removed from the position, the Plan Sponsor will appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator will administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator will have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits (including the determination of what services, supplies, care and treatments are experimental), to decide disputes which may arise relative to a covered person’s rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator as to the facts related to any claim for benefits and the meaning and intent of any provision of the Plan, or its application to any claim, shall receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this Plan will be paid only if the Plan Administrator decides, in its discretion, that the covered person is entitled to them.

The duties of the Plan Administrator include the following:
- To administer the Plan in accordance with its terms;
- To determine all questions of eligibility, status and coverage under the Plan;
- To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms;
- To make factual findings;
- To decide disputes which may arise relative to a covered person’s rights;
- To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials;
- To keep and maintain the Plan documents and all other records pertaining to the Plan;
- To appoint and supervise a third party administrator to pay claims;
- To perform all necessary reporting as required by ERISA;
- To establish and communicate procedures to determine whether MCSOs and NMSNs are QMCSOs;
- To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate; and
- To perform each and every function necessary for or related to the Plan’s administration.

May changes be made to the Plan?
The Plan Sponsor expects to maintain this Plan indefinitely; however, the Plan Sponsor may, in its sole discretion, at any time, amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan.

Any such amendment, suspension or termination shall be enacted, if the Plan Sponsor is a corporation, by resolution of the Plan Sponsor’s directors and officers, which shall be acted upon as provided in the Plan Sponsor’s articles of incorporation or bylaws, as applicable, and in accordance with applicable federal and state law. Notice shall be provided as required by ERISA. In the event that the Plan Sponsor is a different type of entity, then such amendment, suspension or termination shall be taken and enacted in accordance with applicable federal and state law and any applicable governing documents.

If the Plan is terminated, the rights of covered persons are limited to expenses incurred before termination. All amendments to this Plan shall become effective as of a date established by the Plan Sponsor.
**Who pays the cost of the Plan?**
The Plan Sponsor is responsible for funding the Plan and will do so as required by law. To the extent permitted by law, the Plan Sponsor is free to determine the manner and means of funding the Plan. The amount of the covered person’s contribution (if any) will be determined from time to time by the Plan Sponsor, in its sole discretion.

**Will the Plan release my information to anyone?**
For the purpose of determining the applicability of and implementing the terms of these benefits, the Plan Administrator may, without the consent of or notice to any person, release or obtain any information necessary to determine the acceptability of any applicant or covered person for benefits under this Plan. In so acting, the Plan Administrator shall be free from any liability that may arise with regard to such action; however, the Plan Administrator at all times will comply with the privacy standards. Any covered person claiming benefits under this Plan shall furnish to the Plan Administrator such information as may be necessary to implement this provision.

**What if the Plan makes an error?**
Clerical errors made on the records of the Plan and delays in making entries on such records shall not invalidate coverage nor cause coverage to be in force or to continue in force. Rather, the effective dates of coverage shall be determined solely in accordance with the provisions of this Plan regardless of whether any contributions with respect to covered persons have been made or have failed to be made because of such errors or delays. Upon discovery of any such error or delay, an equitable adjustment of any such contributions will be made.

**Will the Plan conform with applicable laws?**
This Plan shall be deemed automatically to be amended to conform as required by any applicable law, regulation or the order or judgment of a court of competent jurisdiction governing provisions of this Plan, including, but not limited to, stated maximums, exclusions or limitations. In the event that any law, regulation or the order or judgment of a court of competent jurisdiction causes the Plan Administrator to pay claims that are otherwise limited or excluded under this Plan, such payments will be considered as being in accordance with the terms of this summary plan description. It is intended that the Plan will conform to the requirements of ERISA, as it applies to employee welfare plans, as well as any other applicable law.

**What constitutes a fraudulent claim?**
The following actions by you, or your knowledge of such actions being taken by another, constitute fraud and will result in immediate termination of all coverage under this Plan for the entire family unit of which you are a member:

- Attempting to submit a claim for benefits (which includes attempting to fill a prescription) for a person who is not a covered person in the Plan;
- Attempting to file a claim for a covered person for services that were not rendered or drugs or other items that were not provided;
- Providing false or misleading information in connection with enrollment in the Plan; or
- Providing any false or misleading information to the Plan.

**How will this document be interpreted?**
The use of masculine pronouns in this summary plan description shall apply to persons of both sexes unless the context clearly indicates otherwise. The headings used in this summary plan description are used for convenience of reference only. Covered persons are advised not to rely on any provision because of the heading.

The use of the words, “you” and “your” throughout this summary plan description applies to eligible or covered employees and, where appropriate in context, their covered dependents.

**How may a Plan provision be waived?**
No term, condition or provision of this Plan shall be deemed to have been waived, and there shall be no estoppel against the enforcement of any provision of this Plan, except by written instrument of the party charged with such waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless specifically stated therein, and each such waiver shall operate only as to the specific term or condition waived and shall not constitute a waiver of such term or condition for the future or as to any act other than the one specifically waived.

**Is this summary plan description a contract between the employer and covered persons?**
This summary plan description and any amendments constitute the terms and provisions of coverage under this Plan. The summary plan description shall not be deemed to constitute a contract of any type between the employer and
any covered person or to be consideration for, or an inducement or condition of, the employment of any employee. Nothing in this summary plan description shall be deemed to give any employee the right to be retained in the service of the employer or to interfere with the right of the employer to discharge any employee at any time.

**What if there is coverage through workers’ compensation?**
This Plan excludes coverage for any injury or illness that is eligible for coverage under any workers’ compensation policy or law regardless of the date of onset of such injury or illness. However, if benefits are paid by the Plan and it is later determined that you received or are eligible to receive workers’ compensation coverage for the same injury or illness, the Plan is entitled to full recovery for the benefits it has paid. This exclusion applies to past and future expenses for the injury or illness regardless of the amount or terms of any settlement you receive from workers’ compensation. The Plan will exercise its right to recover against you. The Plan reserves its right to exercise its rights under this section and the section entitled “Recovery of Payment” even though:

- The workers’ compensation benefits are in dispute or are made by means of settlement or compromise;
- No final determination is made that the injury or illness was sustained in the course of or resulted from your employment;
- The amount of workers’ compensation benefits due specifically to health care expense is not agreed upon or defined by you or the workers’ compensation carrier; or
- The health care expense is specifically excluded from the workers’ compensation settlement or compromise.

You are required to notify the Plan Administrator immediately when you file a claim for coverage under workers’ compensation if a claim for the same injury or illness is or has been filed with this Plan. Failure to do so, or to reimburse the Plan for any expenses it has paid for which coverage is available through workers’ compensation, will be considered a fraudulent claim and you will be subject to any and all remedies available to the Plan for recovery and disciplinary action.

**Will the Plan cover an alternate course of treatment?**
The Plan Administrator may, in its sole discretion, determine that a service or supply, not otherwise listed for coverage under this Plan, be included for coverage, if the service or supply is deemed appropriate and necessary and is in lieu of a more expensive, listed covered service or supply.

If a covered person, in cooperation with his provider, elect a course of treatment that is deemed by the Plan Administrator, in its sole discretion, to be more extensive or costly than is necessary to satisfactorily treat the illness or injury, this Plan will allow coverage for the usual, customary and reasonable value of the less costly or extensive course of treatment.

**HIPAA PRIVACY PRACTICES**

The following is a description of certain uses and disclosures that may be made by the Plan of your health information:

**Disclosure of Summary Health Information to the Plan Sponsor**
In accordance with HIPAA’s Standards for Privacy of Individually Identifiable Health Information (the “privacy standards”), the Plan may disclose summary health information to the Plan Sponsor, if the Plan Sponsor requests the summary health information for the purpose of:

- Obtaining premium bids from health plans for providing health insurance coverage under this Plan; or
- Modifying, amending or terminating the Plan.

“Summary health information” may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the Plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

**Disclosure of Protected Health Information (“PHI”) to the Plan Sponsor for Plan Administration Purposes**
In order that the Plan Sponsor may receive and use PHI for plan administration purposes, the Plan Sponsor agrees to:

- Not use or further disclose PHI other than as permitted or required by the Plan documents or as required by law (as defined in the privacy standards);
• Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
• Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the privacy standards;
• Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;
• Make available PHI in accordance with section 164.524 of the privacy standards (45 CFR 164.524);
• Make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the privacy standards (45 CFR 164.526);
• Make available the information required to provide an accounting of disclosures in accordance with section 164.528 of the privacy standards (45 CFR 164.528);
• Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with part 164, subpart E, of the privacy standards (45 CFR 164.500 et seq);
• If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and
• Ensure that adequate separation between the Plan and the Plan Sponsor, as required in section 164.504(f)(2)(iii) of the privacy standards (45 CFR 164.504(f)(2)(iii)), is established as follows:
  • The following employees, or classes of employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:
    
    Vice President of Human Resources
    Staff designated by Vice President of Human Resources
    Chief Financial Officer
    Staff designated by Chief Financial Officer
    Controller
    Staff designated by Controller

• The access to and use of PHI by the individuals described above shall be restricted to the plan administration functions that the Plan Sponsor performs for the Plan.
• In the event any of the individuals described above do not comply with the provisions of the Plan documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

“Plan administration” activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the Plan or solicit bids from prospective issuers. “Plan administration” functions include quality assurance, claims processing, auditing, monitoring and management of carve-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

The Plan shall disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that:
• The Plan documents have been amended to incorporate the above provisions; and
• The Plan Sponsor agrees to comply with such provisions.

Disclosure of Certain Enrollment Information to the Plan Sponsor
Pursuant to section 164.504(f)(1)(iii) of the privacy standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.
Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage
The Plan Sponsor hereby authorizes and directs the Plan, through the Plan Administrator or the third party administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing underwriters (“MGUs”) for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the privacy standards.

Other Disclosures and Uses of PHI
With respect to all other uses and disclosures of PHI, the Plan shall comply with the privacy standards.

HIPAA SECURITY PRACTICES

Disclosure of Electronic Protected Health Information (“Electronic PHI”) to the Plan Sponsor for Plan Administration Functions
To enable the Plan Sponsor to receive and use Electronic PHI for Plan Administration Functions (as defined in 45 CFR § 164.504(a)), the Plan Sponsor agrees to:
- Implement Administrative, Physical, and Technical Safeguards that reasonably and appropriately protect the Confidentiality, Integrity and Availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;
- Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate Security Measures;
- Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate Security Measures to protect the Electronic PHI; and
- Report to the Plan any Security Incident of which it becomes aware.

Any terms not otherwise defined in this section shall have the meanings set forth in the Security Standards.

STATEMENT OF ERISA RIGHTS

As a covered person in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all covered persons are entitled to:

Receive Information About Your Plan and Benefits
Examine, without charge, at the Plan Administrator’s office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts (if any) and copies 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 Administrator, 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 Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan’s annual financial report. The Plan Administrator is required by law to furnish each covered person with a copy of this summary annual report.

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

Prudent Actions by Plan Fiduciaries
In addition to creating rights for covered persons, ERISA imposes duties upon the people who are responsible for the operation of the 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 covered persons and beneficiaries. No one, including your
participating 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.

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator 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 Administrator. If you have a claim for benefits which 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’s decision or lack thereof concerning the qualified status of a domestic relations order, a medical child support order or a national medical support notice, you may file suit in Federal court. If it should happen that 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 a Federal court. The court will decide who would 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 the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest Office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.