

WILLAMETTE UNIVERSITY

SCHEDULE OF BENEFITS

MEDICAL BENEFITS

| | | |
|--|----------------------------------|--------------------------------------|
| Maximum Benefit Per Covered Person While Covered By This Plan For: | | |
| Medical | \$2,000,000 | |
| <p>Notwithstanding any provision of this <i>Plan</i> to the contrary, all benefits received by an individual under any benefit option, package or coverage under the <i>Plan</i> shall be applied toward the maximum benefit paid by this <i>Plan</i> for any one <i>covered person</i> during the entire time he is covered by this <i>Plan</i>, such option, package or coverage under the <i>Plan</i>, and also toward the <i>maximum benefit</i> under any other options, packages or coverages under the <i>Plan</i> in which the individual may participate in the future.</p> | | |
| Deductible Per Calendar Year: | <i>Preferred Provider</i> | <i>Nonpreferred Provider</i> |
| Individual (Per Person) | \$250 | \$500 |
| Family (Aggregate) | \$750 | \$1,500 |
| <p>If two or more covered members of a family are injured in the same <i>accident</i> and, as a result of that <i>accident</i>, incur <i>covered expenses</i>, only one individual deductible amount will be deducted from the total <i>covered expenses</i> of all covered family members related to the <i>accident</i> for the remainder of the calendar year.</p> | | |
| Copays Per Admission or Occurrence: (Refer to <i>Medical Expense Benefit, Copay</i>) | <i>Preferred Provider</i> | <i>Nonpreferred Provider</i> |
| Each Physician's Office Visit | \$20 | Refer to Benefit Description Section |
| Each Office Visit for Well Woman Exam | \$15 | \$15 |
| Each Urgent Care Facility Visit | \$20 | \$20 |
| Each Emergency Room Visit (waived if admitted) | \$100 | \$100 |
| Out-of-Pocket Expense Limit Per Calendar Year: (excludes deductible) | <i>Preferred Provider</i> | <i>Nonpreferred Provider</i> |
| Individual (Per Person) | \$2,000 | \$6,000 |
| Family (Aggregate) | \$6,000 | \$18,000 |
| <p>Refer to <i>Medical Expense Benefit, Out-of-Pocket Expense Limit</i> for a listing of charges not applicable to the out-of-pocket expense limit. Amounts applied toward satisfaction of the <i>preferred provider</i> deductible and out-of-pocket expense limit may also be applied toward satisfaction of the <i>nonpreferred provider</i> deductible and out-of-pocket expense limit and vice versa.</p> | | |

Coinsurance:

The **Plan** pays the percentage listed on the following pages for **covered expenses incurred** by a **covered person** during a calendar year after the individual or family deductible has been satisfied and until the individual or family out-of-pocket expense limit has been reached. Thereafter, the **Plan** pays one hundred percent (100%) of **covered expenses** for the remainder of the calendar year or until the **maximum benefit** has been reached. Refer to **Medical Expense Benefit, Out-of-Pocket Expense Limit**, for a listing of charges not applicable to the one hundred percent (100%) **coinsurance**.

| BENEFIT DESCRIPTION | Preferred Provider (% of <i>negotiated rate</i> , if applicable, otherwise % of <i>customary and reasonable amount</i>) | Nonpreferred Provider (% of <i>customary and reasonable amount</i>) |
|---|--|--|
| Inpatient Hospital | 80% | 60% |
| Preadmission Testing | 80% | 60% |
| Outpatient Surgery/Ambulatory Surgical Center | 80% | 60% |
| Emergency Room Services (<i>copay</i> waived if admitted) | 80%* after \$100 <i>copay</i> | 80%* after \$100 <i>copay</i> |
| Urgent Care Facility | 100%* after \$20 <i>copay</i> | 100%* after \$20 <i>copay</i> |
| Ambulance Services | 80% | 80% after Preferred Provider deductible |
| Physician Services All Office Visits (Other than Well Woman Exams) (Copay applies to diagnostic lab and x-ray, injections, surgeries and basic supplies received during an office visit) | 100%* after \$20 <i>copay</i> | 60% |
| Diagnostic Lab and X-ray Services (other than during an office visit) | 80% | 60% |
| Routine Preventive Care Well Woman Exams (including Pap and mammogram) | 100%* after \$15 <i>copay</i> | 100%* after \$15 <i>copay</i> |
| All Other Routine Exams (Copay applies to diagnostic lab and x-ray, injections, surgeries and basic supplies received during an office visit) | 100%* after \$20 <i>copay</i> | 60% |
| Well Child Care | 100%* after \$20 <i>copay</i> | 60% |
| Immunizations | 100%* | 100%* |

* Deductible Waived

| BENEFIT DESCRIPTION | Preferred Provider (% of <i>negotiated rate</i> , if applicable, otherwise % of <i>customary and reasonable amount</i>) | Nonpreferred Provider (% of <i>customary and reasonable amount</i>) |
|---|--|--|
| Chemotherapy | 80% | 60% |
| Lab work associated with chemotherapy | 100%* after \$20 copay | 60% |
| Extended Care Facility Limitation: 100 days <i>maximum benefit</i> per calendar year | 80% | 60% |
| Home Health Care Limitation: 180 visits <i>maximum benefit</i> per calendar year | 80% | 60% |
| Hospice Care | 80% | 60% |
| Durable Medical Equipment | 80% | 60% |
| Chemical Dependency Care | | |
| Inpatient Services | 80% | 60% |
| Outpatient Services | 100%* after \$20 <i>copay</i> | 60% |
| Mental Health Treatment | | |
| Inpatient Services | 80% | 60% |
| Outpatient Services | 100%* after \$20 <i>copay</i> | 60% |
| Rehabilitation Therapy Services | 80% | 60% |
| Inpatient Services Limitation: 30 days <i>maximum benefit</i> per calendar year (increases to 60 days for head and spinal cord injuries or stroke) | | |
| Outpatient Services Limitation: 30 sessions <i>maximum benefit</i> per calendar year (increases to 60 days for head and spinal cord injuries or stroke) | 80% | 60% |

* Deductible Waived

| BENEFIT DESCRIPTION | <i>Preferred Provider</i> (% of <i>negotiated rate</i> , if applicable, otherwise % of <i>customary and reasonable amount</i>) | <i>Nonpreferred Provider</i> (% of <i>customary and reasonable amount</i>) |
|--|---|---|
| Nutritional Counseling Services Limitation: One (1) visit <i>maximum benefit</i> while covered by this <i>Plan</i> | 80% | 60% |
| Fertility Diagnosis Services | 50% | 50% |
| Temporomandibular Joint Disorder Expenses | 50% | 50% |
| All Other Covered Expenses | 80% | 60% |

Refer to *Medical Expense Benefit* for complete details.

PRESCRIPTION DRUG PROGRAM

Pharmacy Option

Prescription Drug Card

100% after *copay*

Copay

Generic: \$15 *copay*

Preferred Brand Name: \$35 *copay*

Limitation: 34 day supply

Non-Preferred Brand Name: \$55 *copay*

If the *covered person* purchases a brand name drug when the *physician* has indicated a *generic drug* can be dispensed, the *covered person* will be required to pay the difference between the cost of the *generic drug* and the brand name requested, plus the usual *copay*.

Mail Order Option

Mail Order Prescription

100% after *copay*

Copay

Generic: \$30 *copay*

Preferred Brand Name: \$70 *copay*

Limitation: 90 day supply

Non-Preferred Brand Name: \$110 *copay*

If the *covered person* purchases a brand name drug when the *physician* has indicated a *generic drug* can be dispensed, the *covered person* will be required to pay the difference between the cost of the *generic drug* and the brand name requested, plus the usual *copay*.

Refer to *Prescription Drug Program* for complete details.

DENTAL BENEFITS

| | |
|--|---------|
| Deductible Per Calendar Year: | |
| Individual (Per Person) | \$ 50 |
| Family (Aggregate) | \$150 |
| The deductible is waived for diagnostic & preventive dental services. | |
| If two or more covered members of a family are injured in the same <i>accident</i> and, as a result of that <i>accident</i> , incur <i>covered expenses</i> , only one individual deductible amount will be deducted from the total <i>covered expenses</i> of all covered family members related to the <i>accident</i> for the remainder of the calendar year. | |
| Maximum Benefit Per Covered Person For: | |
| Preventive, Basic and Major Dental services per calendar year Individual | \$1,500 |
| Family | \$4,500 |
| Orthodontic services while covered by this <i>Plan</i> | \$1,500 |
| Percentage of Customary and Reasonable Amount Payable For: | |
| Class I - Diagnostic & Preventive Dental Services | 100% |
| Class II - Basic Dental Services | 80% |
| Class III - Major Dental Services | 50% |
| Class IV - Orthodontic Services | 50% |

VISION BENEFITS

| | |
|---|--------------------------------|
| Examination/Maximum Benefit: Limitation: One (1) exam during any twelve (12) consecutive months. | 100% after a \$10 <i>copay</i> |
| Conventional Lenses/Maximum Benefit per twenty-four (24) month period: | |
| Single Vision | \$62 |
| Bi-focal | \$95 |
| Tri-focal | \$122 |
| Contacts (as an alternative to lenses and frames) Contact lenses are paid for in full if they are necessary after cataract surgery or if they are the only means to correct vision to 20/70 or better. | \$137 |
| Frames/Maximum Benefit: Limitation: One (1) pair during any twenty-four (24) consecutive months. | \$75 |

**ALTERNATIVE
CARE BENEFITS**

| | |
|--|----------------------------------|
| Office Visit * This <i>copay</i> does not accumulate towards the deductible and out-of-pocket amounts under the <i>Medical Expense Benefit</i> . | 100% after a \$20 <i>copay</i> * |
| Diagnostic X-rays (ordered by a Chiropractor) | 100% after a \$20 <i>copay</i> * |
| Annual Maximum Benefit | \$1,500 |

DENTAL EXPENSE BENEFIT

Subject to all the terms of the *Plan*, the *Plan* will pay a dental benefit for covered dental expenses. The dental benefit is a percentage of the *customary and reasonable amount* for covered dental expenses, as shown on the *Schedule of Benefits*.

DEDUCTIBLE

Individual Deductible

The individual deductible is the dollar amount of *covered expense* that each *covered person* must incur during each calendar year before the *Plan* pays applicable benefits. The individual deductible amount is shown on the *Schedule of Benefits*.

Family Deductible

If, in any calendar year, covered members of a family incur *covered expenses* that are subject to the deductible that are equal to or greater than the dollar amount of the family deductible shown on the *Schedule of Benefits*, then the family deductible will be considered satisfied for all family members for that calendar year. Any number of family members may help to meet the family deductible amount, but no more than each person's individual deductible amount may be applied toward satisfaction of the family deductible by any family member.

Common Accident

If two or more covered members of a family are *injured* in the same *accident* and, as a result of that *accident*, incur *covered expenses*, only one (1) individual deductible amount will be deducted from the total *covered expenses* of all covered family members related to the accident for the remainder of the calendar year.

COINSURANCE

The *Plan* pays a specified percentage of the *customary and reasonable amount* for *covered expenses*. That percentage is listed on the *Schedule of Benefits*. The *covered person* is responsible for the difference.

MAXIMUM BENEFIT

The maximum calendar year benefit payable on behalf of a *covered person* for covered dental expense is stated on the *Schedule of Benefits*. If the *covered person's* coverage under the *Plan* terminates and he subsequently returns to coverage under the *Plan* during the calendar year, the *maximum benefit* will be calculated on the sum of benefits paid by the *Plan*.

The *maximum benefit* for orthodontic treatment while a *covered person* is covered by this *Plan* is also specified on the *Schedule of Benefits*.

ALTERNATIVE TREATMENT

In the event the *dentist* recommends a particular course of treatment and a lower-cost alternative would be as effective, benefits shall be limited to the lower-cost alternative. Any balance remaining, as a result of the *covered person's* choice to obtain the higher-cost treatment will be the *covered person's* responsibility.

DENTAL INCURRED DATE

A dental procedure will be deemed to have commenced on the date the covered dental expense is ***incurred***, except as follows:

1. For installation of a prosthesis other than a bridge or crown, on the date the impression was made;
2. For a crown, bridge or gold restoration, on the date the tooth or teeth are first prepared;
3. For endodontic treatment, on the date the pulp chamber is opened.

There are times when one overall charge is made for all or part of a course of treatment. In this case the ***claims processor*** will apportion that overall charge to each of the separate visits or treatments. The pro rata charge will be considered to be ***incurred*** as each visit or treatment is completed.

COVERED DENTAL EXPENSES

Subject to the limitations and exclusions, covered dental expenses shall include the necessary services, supplies, or treatment listed below and on the following pages. No dental benefit will be paid for any dental service, supply or treatment that is not on the following list of covered dental expenses.

Class I Diagnostic and Preventive Dental Services

1. Routine oral examination: Initial or periodic, limited to twice per calendar year.
2. Prophylaxis: Scaling and cleaning of teeth, limited to twice per calendar year.
3. Dental x-rays as follows:
 - a. Supplementary bite-wing x-rays, limited to once per calendar year.
 - b. Panorex and/or full mouth series, limited to one (1) of each every five (5) years.
 - c. Other dental x-rays necessary for the diagnosis of a specific condition requiring treatment.
4. Topical application of fluoride for ***dependent*** children through the age of seventeen (17) limited to two (2) treatments per calendar year.
5. Space maintainers, fixed appliance (not made of precious metals), designed to preserve the space between teeth caused by the premature loss of a primary tooth (also called a baby tooth) including all adjustments within six (6) months of installation, limited to ***dependent*** children. This does not include space maintainers used in orthodontics to create a space between teeth.
6. Topical application of sealants to permanent posterior teeth for ***dependent*** children through the age of seventeen (17), limited to one (1) treatment per tooth every four (4) years.
7. ***Emergency*** palliative treatment primarily for relief of dental pain, not cure. Only paid as a separate benefit when no other treatment (except x-rays) is rendered during the visit. Benefit is limited to \$50 per incident.

Class II Basic Dental Services

1. Sedative fillings, covered as a separate procedure only if no other service (except x-rays) is rendered during the visit.
2. Restorations (fillings) to restore teeth to normal function, using amalgam, silicate, acrylic, synthetic, and composite filling materials to restore teeth broken down by decay or *injury*.
3. Periodontics as follows:
 - a. Gingivectomy/gingivoplasty, gingival curettage, gingival flap procedure or mucogingival surgery.
 - b. Scaling and root planing limited to twice per quadrant in any calendar year.
 - c. Pedicle and free soft tissue grafts, and vestibuloplasty.
 - d. Occlusal adjustment, excluding charges for TMJ.
 - e. Excision of pericoronal gingiva.
 - f. Periodontal prophylaxis limited to twice per calendar year.
 - g. Osseous surgery.
4. Endodontics as follows:
 - a. Direct pulp capping.
 - b. Pulpotomy.
 - c. Root canal therapy.
 - d. Apicoectomy.
 - e. Hemisection.
 - f. Retrograde fillings.
5. Oral surgery, including customary postoperative treatment furnished in connection with oral surgery, as follows:
 - a. Simple extraction of one (1) or more teeth.
 - b. Surgical extraction of erupted teeth and of soft tissue, partially bony, and completely bony impacted teeth.
 - c. Extraction of tooth root.
 - d. Incision and drainage of a tumor or a cyst.
 - e. Alveolectomy, alveoloplasty, and frenectomy.
 - f. Exostosis or hyperplastic tissue and excision of oral tissue for biopsy.
 - g. Re-implantation or transplantation of a natural tooth.
 - h. General anesthesia, only when provided in conjunction with a surgical procedure.
6. Therapeutic injections of antibiotics administered by a *dentist*.
7. Repairs and adjustments to full or partial dentures.
8. Relining of present dentures, but only if they were installed more than six (6) months earlier and if they have not been relined during the past twelve (12) months.
9. Rebased of present dentures, but only if they were installed more than six (6) months earlier and if they have not been rebased during the past thirty-six (36) months.
10. Denture adjustment once per twelve (12) consecutive months.
11. Repair or re-cementing of crowns, inlays, onlays or bridgework.

12. Specialist consultations and specialty examinations provided the **covered person** has been referred by a general **dentist**. These consultations and examinations are not restricted to the limitations for routine oral exams.

Class III Major Dental Services

1. Post and core on permanent teeth only.
2. Onlays: covered only when the tooth cannot be restored by basic restorations.
3. Porcelain Restorations: Covered only when the tooth cannot be restored by basic restorations. Restorations on teeth that are posterior to the first bicuspid are not covered.
4. Crowns: covered only when the tooth cannot be restored by basic restorations.
5. Initial installation of fixed bridge (including abutments) to replace one (1) or more natural teeth.
6. Removable bridge, partial or complete dentures to replace one (1) or more natural teeth.
7. Replacement of an existing partial or full removable denture or fixed bridge, or the addition of teeth to existing bridgework to replace extracted natural teeth. However, only replacement or additions that meet the "Prosthesis Replacement Rule" below will be covered.
8. Complete dentures.

Prosthesis Replacement Rule

The Prosthesis Replacement Rule requires that replacements for or additions to existing dentures or bridgework will be covered only if satisfactory evidence is furnished that the existing denture or bridge cannot be made serviceable and was installed at least seven (7) years prior to its replacement.

Covered expenses for both a temporary and permanent prosthesis will be limited to the charge for the permanent prosthesis.

Class IV Orthodontic Services

1. Any dental expense furnished in connection with the orthodontic treatment.
2. Surgical exposure of impacted or unerupted teeth in connection with orthodontic treatment, including routine x-rays, local anesthetics, and post-surgical care.
3. Active appliances, including diagnostic services, the treatment plan, the fitting, making and placing of the active appliance, and all related office visits including post-treatment stabilization.
4. Comprehensive full-banded and bracketed orthodontic treatment.

DENTAL EXCLUSIONS

In addition to the *Plan Exclusions*, no benefit will be provided under this **Plan** for dental expenses **incurred** by a **covered person** for the following:

1. Replacement of lost, missing or stolen appliances or prosthetic devices or duplicate appliances or prosthetic devices.
2. Charges for all services, supplies and treatment related to dental implants.

3. Inlays.
4. Any procedure not listed under *Covered Dental Expenses*.
5. Any procedure that began before the date the **covered person's** dental coverage started, to include a service that is:
 - a. An appliance, or modification of an appliance, for which an impression was made before such person became covered, or
 - b. A crown, bridge or gold restoration, for which a tooth was prepared before such person became covered, or
 - c. Root canal therapy, for which the pulp chamber was opened before such person became covered.

X-rays and prophylaxis shall not be deemed to start a dental procedure.

6. Services, supplies or treatment that is cosmetic in nature, including charges for personalization or characterization of dentures. Veneers or coverings placed on teeth except when used to return the tooth to normal form and function are considered cosmetic in nature.
7. Surgical services with respect to congenital or developmental malformations. These conditions include: cleft palate, mandibular prognathism, enamel hypoplasia, fluorosis, and anodontia.
8. Appliances, restoration or procedures for the purpose of altering vertical dimension, restoring or maintaining occlusion, splinting, or replacing tooth structure lost as a result of abrasion or attrition, except as provided under *Orthodontic Services*.
9. A service not furnished by a **dentist**, except:
 - a. Services performed by a licensed dental hygienist under a **dentist's** supervision;
 - b. X-rays ordered by a **dentist**; and
 - c. Denturist.
10. Charges for over-dentures, including related root canal therapy and supportive restorations.
11. Replacement of a prosthetic that in the **dentist's** opinion can be repaired or does not need replacement.
12. A posterior fixed prosthetic appliance when done in connection with a removable appliance in the same arch.
13. Charges in excess of the least costly plan of treatment when there is more than one accepted method of treatment for a dental condition.
14. Charges resulting from changing from one **dentist** to another while receiving treatment, or resulting from receiving care from more than one **dentist** for one dental procedure, to the extent that the total charges billed exceed the amount that would have been billed if one **dentist** had performed all the required dental services.
15. Charges for precision attachments, semi-precision attachments.
16. Charges for instruction in dental plaque control, dental hygienics, or nutritional counseling.
17. Charges for services or supplies related to diagnosis of, or treatment of temporomandibular joint syndrome, by whatever name called.
18. Charges for adjustments of new dentures within six (6) months of installation.

19. Charges for infection control (OSHA fees).
20. Charges for local anesthetic or analgesia including gas (nitrous oxide), charged separately from filings.
21. Charges for behavior management.

VISION BENEFITS

LIMITATIONS AND EXCLUSIONS

The following services and supplies are not covered:

1. Treatment of eyes or special procedures such as orthoptics and vision training.
2. Charges for fashion eyewear features such as flintglass, blended, coated, tinted (except tints #1 and #2), or oversize lenses.
3. Additional charges for partially covered frames.
4. Any extra charge for lenses with prisms, prism segs, slab-off and other special-purpose vision aids.
5. Replacement of lenses and frames at a time the *covered person* is not otherwise eligible for new lenses and frames.
6. The maximum allowances are subject to change without notice.

ALTERNATIVE CARE BENEFITS

The *Plan* will pay benefits for services when provided by licensed providers of chiropractic, acupuncture, naturopathic medicine and massage therapy.

LIMITATIONS AND EXCLUSIONS

The following Chiropractic services are not covered:

1. Minor surgery, proctology and OB-GYN services.

The following Acupuncture supplies are not covered:

1. Intradermal needles.
2. Non-FDA approved disposable needles.

The following Naturopathic services and supplies are not covered:

1. Hearing examinations for the purpose of prescribing hearing aids.
2. Infertility services and the reversal of sterilization.
3. Manipulative therapy provided for maintenance care.
4. The following tests:
 - a. EVA and electronic tests for diagnosis and allergy
 - b. Tryptophan load test
 - c. Zinc tolerancy test
 - d. Loomis 24-hour urine nutrient/enzyme analysis
 - e. Darkfield examination for toxicity or parasites
 - f. Comprehensive digestive stool analysis
 - g. Urine saliva pH
 - h. Cytotoxic food allergy test
 - i. Salivary caffeine clearance
 - j. Sulfate/creatine ratio
 - k. Urinary sodium benzoate
 - l. Fecal transient and retention time
 - m. Melatonin biorhythm challenge
 - n. Intestinal permeability
 - o. Henshaw tests
5. Dental services.

The following Massage Therapy services are not covered:

1. Any massage therapy outside the massage therapist's scope of license.
2. Educational programs, non-medical self-care, self-help training, or any related diagnosis training, except which occurs during the normal course of covered massage therapy treatment.

The following services of an Acupuncturist, Chiropractor, Naturopathic or Massage Therapist are not covered:

1. Any service provided for maintenance care, which is defined as any treatment program designed to maintain optimal health in the absence of symptoms.
2. Treatment of alcohol, drug or chemical dependency in a specialized inpatient or residential facility.
3. Any services in excess of those necessary for maximum improvement. This includes maintenance care and supportive care when physician dependence, somatization, illness behavior, or secondary gain exists.
4. Behavior training and modification, including but not limited to, biofeedback, hypnotherapy, play therapy, and sleep therapy.
5. Charges incurred as a result of a missed appointment or an appointment not cancelled.
6. Costs or charges incurred for which the *employee* is not legally required to pay for professional services rendered by a person who resides in the *employee's* home, or who is related to the *employee* by marriage or blood (including parents, children, sisters, brothers or foster children).
7. Cosmetics, dietary supplements, recreation, health or beauty classes, aids or equipment.
8. Devices or appliances, durable medical equipment, supplies, appliances or prosthetics.
9. Disorders connected to military service, any treatment or service to which the *employee* is legally entitled through the United States Government or for which facilities are available.
10. Expenses incurred for services provided before coverage begins or after coverage ends according to the terms of the Combined Benefit Plan.
11. Expenses incurred as a result of treatment or service for pre-employment, school entrance, or athletic physical examinations.
12. Experimental treatment including laboratory tests, x-rays, and services that are provided primarily for medical research purposes.
13. Over the counter drugs, medicines (prescription or non-prescription) including vitamins, minerals, nutritional or dietary supplements, or any other supply or product whether or not prescribed.
14. Personal or comfort items, environmental enhancements, modifications to dwellings, property or motor vehicles, adaptive equipment, and training in the use of the equipment, personal lodging, travel expenses or meals.
15. Physical exams, vocational rehabilitation, treatment of workers' compensation illnesses or injuries, evaluation and reports such as those for employment, licensing, schools, sports, premarital or required for court proceedings.
16. Preventive care, educational programs. Non-medical self-care, self-help training, or any related diagnostic training, except that which occurs during the normal course of covered treatment.
17. Public facility care in which services or care are required by federal, state or local law.
18. Radiological procedures performed on equipment not certified, registered or licensed by the State of Oregon, and/or radiological procedures that when reviewed by the health plan or its designee, are determined to be of such poor quality that they cannot safely be utilized in diagnosis or treatment.

19. Services considered experimental or investigational.
20. Services and charges for the condition under treatment from the time the patient refuses for personal reasons, to accept a recommended treatment or procedure after being advised that the treating provider believes no professionally acceptable alternative exists.
21. Services furnished by a facility which is primarily for rest, custodial care, a place for the aged, a nursing home or any facility of like character.
22. Services provided in an emergency room.
23. Services provided on an inpatient basis.
24. Services not provided in a participating provider's office and/or requiring anesthesia.
25. Services or costs exceeding the maximum allowable benefit for the contract year.
26. Services deemed not medically necessary by the health plan or its designee.
27. Thermography, hair analysis, heavy metal screening and mineral screenings.
28. Transportation services, including ambulances and care cars.
29. Treatment for purposes of obesity or weight control, to include any weight control supplies or products.
30. Treatment of accidental bodily injury or sickness that arises out of, or in the course of any employment including self-employment, or which is covered under any Workers' Compensation Act or Law.

ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATE

EMPLOYEE ELIGIBILITY/EFFECTIVE DATE

All regular full-time *employees*, in an eligible class, who normally work .6 FTE or one thousand two hundred forty eight (1,248) hours per year for the *employer* and full-time temporary *employees*, in an eligible class, who work at least one (1) full academic year (9 months) are eligible for the following coverage on the date of employment. A retired *employee* who is over age fifty-nine (59) and under age sixty-five (65) with twenty (20) years of service and who has entered into a special voluntary severance arrangement are also included.

DEPENDENT ELIGIBILITY

The following describes *dependent* eligibility requirements. The *employer* may require proof of *dependent* status.

1. The term "spouse" means the spouse of the *employee* under a legally valid existing marriage with a person of the opposite sex, unless court ordered separation exists.

Domestic partners and domestic partner's children are eligible for COBRA continuation. The term "domestic partner" means that the *dependent*:

- a. Is the same or opposite sex as the *employee*;
- b. Is at least eighteen (18) years of age and competent to enter into a contract;
- c. Is not legally married or the domestic partner of another individual;
- d. Is not related to the *employee* by blood closer than which would bar marriage in the state they reside in;
- e. Has allowed at least six (6) months to pass since the termination of any previous domestic partnership; and
- f. Has submitted documentation, as required by the *employer*, to verify the interdependent relationship with the *employee* including a joint affidavit with the *employee* that the relationship is an exclusive mutual commitment that is the functional equivalent of a marriage, that is, the domestic partner and *employee*:
 - i. Are jointly responsible for each other for the necessities of life including each others debts;
 - ii. Intend to remain in the relationship indefinitely; and
 - iii. Would enter into a legal marriage if the opportunity were available; and have agreed that in the event of dissolution of the domestic partnership there will be a substantially equal division of any earning acquired during the partnership and of property acquired with those earnings, i.e. there will be a division of property similar to that required of a married couple in the event of divorce.

2. The term "child" means the *employee's* natural children, foster children placed with a *covered employee*, adopted children or children placed with a *covered employee* in anticipation of adoption; the natural or adopted children of a domestic partner living in the same household as the *covered employee* and domestic partner, provided:

- a. The child is less than twenty-three (23) years of age, and qualifies as a tax dependent under IRC Section 152 (Dependent Defined), and;
- b. The child is unmarried, and;
- c. The child is principally dependent upon the *employee* for support and maintenance, and;
- d. The child is not regularly employed by one or more employers on a full-time basis, exclusive of scheduled vacation periods.

Step-children who reside in the *employee's* household may also be included as long as a natural parent remains married to the *employee* and also resides in the *employee's* household.

If a *covered employee* is the legal guardian of an unmarried child or children, these children may be enrolled in the Plan as *covered dependents*.

3. An eligible child shall also include any other child of an *employee* or their spouse who is recognized in a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) that has been issued by any court judgment, decree, or order as being entitled to enrollment for coverage under this *Plan*, even if the child is not residing in the *employee's* household. Such child shall be referred to as an *alternate recipient*. *Alternate recipients* are eligible for coverage only if the *employee* is also covered under this *Plan*. An application for enrollment must be submitted to the *employer* for coverage under this *Plan*. The *employer/plan administrator* shall establish written procedures for determining whether a medical child support order is a QMCSO or NMSN and for administering the provision of benefits under the *Plan* pursuant to a valid QMCSO or NMSN. Within a reasonable period after receipt of a medical child support order, the *employer/plan administrator* shall determine whether such order is a Qualified Medical Child Support Order (QMCSO), as defined in Section 609 of ERISA, or a National Medical Support Notice (NMSN), as defined in Section 401 of the Child Support Performance and Incentive Act of 1998.

The *employer/plan administrator* reserves the right, waivable at its discretion, to seek clarification with respect to the order from the court or administrative agency that issued the order, up to and including the right to seek a hearing before the court or agency.

4. Adopted children, who are less than eighteen (18) years of age at the time of adoption, shall be considered eligible from the date the child is *placed for adoption*.
5. A child who is unmarried, incapable of self-sustaining employment, and dependent upon the *employee* for support due to a mental and/or physical disability, and who was covered under the *Plan* prior to reaching the maximum age limit or due to other loss of *dependent's* eligibility and who lives with the *employee*, will remain eligible for coverage under this *Plan* beyond the date coverage would otherwise be lost.

Proof of incapacitation must be provided within thirty-one (31) days of the child's loss of eligibility and thereafter as requested by the *employer*, but not more than once every two (2) years. Eligibility may not be continued beyond the earliest of the following:

- a. Cessation of the mental and/or physical disability;
- b. Failure to furnish any required proof of mental and/or physical disability or to submit to any required examination.

Every eligible *employee* may enroll eligible *dependents*. If both the husband and wife are *employees*, each individual may be covered as either an *employee* or a *dependent* or both. Eligible children may be enrolled as *dependents* of one or both parents.