SUMMARY PLAN DESCRIPTION FOR THE
Willamette University
Consolidated Welfare Benefits Plan
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INTRODUCTION

TYPE OF PLAN
Willamette University (the “University”) has established, effective January 1, 2010, the Consolidated Welfare Benefits Plan (the "Plan"). The Plan is for the exclusive benefit of the University’s employees and, in certain cases, for their spouses and dependents. The Plan provides benefits through several component welfare benefit plans, as further described below.

PLAN SPONSOR
The Plan is sponsored by Willamette University, which will sometimes be referred to in this summary as the "Employer," "we," "us" or "our." Our address is 900 State Street, Salem OR 97301. Our federal tax identification number is 93-0386972.

PURPOSE OF THE PLAN
Provided you have satisfied any applicable eligibility requirements, the Plan permits you to participate in one or more employee welfare benefit plans, which are further described below. These plans provide you, your spouses and/or your dependents with medical and dental benefits, group disability insurance, opportunities to participate in flexible spending arrangements, and other fringe benefits.

This Plan encompasses several different types of employee welfare benefit plans, each of which may be referred to in this Summary as a "Component Plan." The following are the Component Plans contained within this Plan:
• Willamette University PPO Medical Plan

• Willamette University FFS Dental Plan

• Willamette University HMO Medical Plan

• Willamette University HMO Dental Plan

• Willamette University Flexible Spending Account Plan (which includes a Health FSA and DCAP)

• Willamette University Group Life Insurance Plan and ADD-Basic and Voluntary

• Willamette University Long Term Disability Plan

• Willamette University Transportation Fringe Benefit Plan

• Willamette University Business Travel Accident Insurance Plan

• Willamette University Employee Assistance Plan

**PURPOSE OF THIS SUMMARY**

This Summary describes highlights of the Plan and of the benefits provided by this Plan through its Component Plans, but is not intended to be a complete description of either the Plan or of any of the Component Plans. If there is a conflict between this Summary and the Plan or any of the Component Plans, the provisions of the Plan or Component Plans control.
Also, no provision of the Plan or of this Summary is intended to give you the right to continued employment, or to prohibit changes in the terms or conditions of your employment.

**Plan Administration**

**Plan Administrator**
The administration of the Plan is under the supervision of the University as Plan Administrator. The Human Resource Office of the University has been designated to act on behalf of the Plan Administrator.

The principal duty of the Plan Administrator is to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan. The administrative duties of the Plan Administrator include, but are not limited to interpreting the Plan prescribing applicable procedures, determining eligibility for and the amount of benefits, authorizing benefit payments, and gathering information necessary for administering the Plan.

The Plan Administrator has the discretionary authority to interpret the Plan in order to make eligibility and benefit determinations as it may determine in its sole discretion. The Plan Administrator also has the discretionary authority to make factual determinations as to whether any individual is entitled to receive benefits under the Plan.

The University will bear the incidental costs of administering the Plan.
CONTRIBUTIONS AND FUNDING
The cost of the benefits provided by the Plan and the Component Plans are funded in some cases by the University, in some cases by employee contributions, and in some cases by a combination of contributions by the University and contributions by the employees. This section provides a general description of the funding sources for the Component Plans. For individual Component Plans that require employee contributions, including but not limited to premium payments, you will be provided with a description of the specific cost of the particular benefit. Generally, the funding source for each benefit is as follows:

**Employer-Funded Component Plans**
- Long Term Disability Plan
- Business Travel Accident Insurance Plan
- Employee Assistance Plan

**Employee-Funded Component Plans**
- Flexible Spending Account Plan (including the Health FSA and the DCAP)
- Transportation Fringe Benefit Plan

**Employer and Employee-Funded Component Plans**
- PPO Medical & FFS Dental Plan
- HMO Medical & HMO Dental Plan
- Life, ADD-Basic & ADD-Voluntary Plans

**INSURANCE COMPANY AND HEALTH TRUST**
In addition to the Plan funding described above, certain benefits under the Plan are fully insured, while other benefits
are part of a multiple employer welfare arrangement ("MEWA") and are paid from a trust. At present, group insurance contracts with Kaiser Permanente, Sun Life Assurance Company, and Gerber Life Insurance Company provide for the following benefits:

**Kaiser Permanente**  
Medical and Dental

**Sun Life Assurance Company**  
Life, ADD and Long Term Disability

**Gerber Life Insurance Company**  
Business Travel Accident

Health trust (MEWA) assets provide for the following benefits:

**Pioneer Educators Health Trust**  
Medical and Dental

The insurance companies and/or health trust are responsible for: (1) determining eligibility for and the amount of any benefits payable under their respective Component Plans; and (2) prescribing claims procedures to be followed and the claims forms to be used by employees pursuant to the their respective Component Plans.

The insurance companies and health trust, not the University, are responsible for paying claims with respect to these programs. The University shares responsibility with the
insurance companies and health trust for administering these program benefits.

**OTHER INFORMATION**
We have assigned number 512 to the Plan. The accounting year of the Plan, called the Plan Year, begins January 1st and ends December 31st. Legal process can be served on the Administrator. Some Component Plans may have a different Plan Year. Please contact the Administrator for further information.

**PLAN DEFINITIONS**

Many terms are used in this Summary, but most of them are defined only in the section in which they are actually used. The following defined terms, however, have broader application and are used throughout the Summary:

“**ADD**” means accidental death and dismemberment insurance.

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

“**DCAP**” means the dependent care assistance program established by the University under a separate document. The DCAP is a Component Plan under the Plan, but for the purposes of this Summary it is considered to be a component benefit program contained within the Flexible Spending Account Plan.
“Effective Date” means January 1, 2010.

“Employee” means any employee of the University who satisfies the eligibility provisions of the Plan and who is not excluded from participation by the terms of an applicable Component Plan.


“FSA Plan” or “Flexible Spending Account Plan” means the flexible spending account plan established by the University. The FSA Plan has two component parts: the Health FSA Plan and the DCAP.

“Health FSA Plan” means the health flexible spending arrangement plan established by the University under a separate document. The Health FSA Plan is a Component Plan under the Plan, but for the purposes of this Summary it is considered to be a component benefit program contained within the FSA Plan.

“HIPAA” means the Health Insurance Portability and Accountability Act of 1996, as amended.

“Plan” means the Willamette University Consolidated Welfare Benefits Plan.

“Plan Administrator” means Willamette University for purposes of all uninsured Component Plans. It means the
insurance company or health trust for purposes of all insured Component Plans.

“Plan Sponsor” means Willamette University.

**Eligibility Requirements**

**General Eligibility Requirements**
Any employee of the University who is eligible to participate in or receive benefits under one or more of the Component Plans is considered an Eligible Employee for this Plan. Certain Component Plans require an annual election to enroll for coverage. An eligible employee may begin participating in the Plan upon his or her election to participate in a Component Plan, in accordance with its established terms and conditions.

**Component Plan Eligibility Requirements**
This section describes the general eligibility requirements for each of the Component Plans. This is not a full description of the eligibility requirements for any of the Component Plans. You should refer to the individual Component Plan or contact the Administrator for further details.

You will become eligible to participate in the following Component Plans if you are a full-time Employee scheduled to work 30 or more hours per week (i.e., .75 FTE):
1. Group Life Insurance Plan and ADD—Basic and Voluntary
2. Long-Term Disability Plan
3. Business Travel Accident Insurance Plan

You will become eligible to participate in the following Component Plans if you are a full-time Employee scheduled to work 1,248 hours or more per year (i.e., .60 FTE):

1. Flexible Spending Account (including the Health FSA and the DCAP)
2. PPO Medical and FFS Dental Plan
3. HMO Medical and HMO Dental Plan
4. Employee Assistance Plan

ENTRY DATES
For some of the Component Plans, you will be eligible to participate in the Plan on the date you begin employment with the University, provided that you meet the other eligibility requirements for those plans. Some of the Component Plans provide that you satisfy a waiting period before you can begin receiving benefits.

DENIAL OR LOSS OF BENEFITS
Your benefits (and the benefits of your eligible family members) will generally cease when your participation in one or more of the Component Plans terminates.

Benefits will also cease upon termination of this Plan or of a Component Plan. Other circumstances can result in the termination, reduction or denial of benefits. For example,
benefits may be denied under the medical or dental benefit programs if you or your eligible family member has a preexisting condition and incur costs within the exclusionary period. The insurance contracts (including the certificate of insurance booklets) trust document, plan documents, and other governing documents in the applicable Component Plans provide additional information.

**Plan Benefits**

**General Benefit Description**
The Plan provides employees and their eligible dependents with medical, dental, FSA, group life insurance and ADD, group long term disability, transportation fringe benefits, business travel accident insurance, and employee assistance through participation in each of the Component Plans. This Summary provides a brief description of the particular benefits provided by each of the Component Plans. A more detailed summary of each benefit provided under Component Plans is set forth in the appropriate insurance contracts (including the certificate of insurance booklet), trust document, plan documents, or other governing documents.

**Willamette University PPO Medical & FFS Dental Plan**
This Component Plan provides for medical, dental, prescription medication and vision benefits for you, your spouse and/or your dependents. This plan allows you to pay a premium to participate in group health insurance through the University’s participation in a MEWA, as defined above. Generally, this
Component Plan allows you to receive the benefits described above through a medical provider of your choice. The amount of the premium you pay to participate in this Component Plan depends upon your personal circumstances. The Plan Administrator will provide you with information which shows how much the premiums will cost you in order to participate in this plan.

**Willamette University HMO Medical Plan**
This Component Plan is an alternative to the Willamette University PPO Medical Plan and provides for medical, prescription medication and vision benefits for you, your spouse and/or your dependents. The primary difference between this plan and the PPO medical plan is that under this plan, you can obtain medical care only through medical care providers approved by the HMO. The Plan Administrator will provide you with information showing the cost of the premiums to participate in this Component Plan.

**Willamette University HMO Dental Plan**
This Component Plan is similar to the HMO medical plan except that it provides dental benefits rather than medical benefits. Like the HMO medical plan described above, you can obtain dental care only through dental care providers approved by the HMO. The Plan Administrator will inform you of the cost of dental premiums under this Component Plan.

**Willamette University Flexible Spending Account Plan**
This Component Plan provides you with the ability to reduce your wages on a pre-tax basis to pay for group health insurance
premiums, uninsured health expense reimbursements, dependent care assistance, group life and disability insurance premiums, health savings account contributions and certain other health and non-health insurance premiums. The Flexible Spending Account Plan consists of two other Component Plans which are governed by their own documents: the Health FSA and the DCAP.

The Health FSA allows you to reduce your wages every payroll period by a certain amount (up to the University established maximum of $5,000 per Plan Year). You can then use the money you’ve set aside to pay for certain qualifying medical expenses. The effect of participating in the Health FSA is that you can pay for the qualified medical expenses on a pre-tax basis. However, once you’ve elected to set aside your wages to participate in the Health FSA, the amount set aside must be used for qualifying medical expenses within the Plan Year and any applicable grace period that may follow the Plan Year. (This is referred to as the “use it or lose it” rule.)

The DCAP works similarly to the Health FSA, except that you are setting aside wages that allow you to pay for qualifying dependent care expenses on a pre-tax basis. The annual limit on DCAP contributions is $5,000. The Flexible Spending Account Plan (including the Health FSA and the DCAP) is funded only through employee contributions. The University does not fund this Component Plan.

Please refer to the documents provided by the Plan Administrator for a more particular description of how this
Plan operates and for definitions of what constitutes qualifying medical and dependant care costs.

**Willamette University Group Life Insurance Plan and ADD-Basic and Voluntary**
This Component Plan provides for group life and ADD insurance equal to two times your salary, as well as optional Life and ADD insurance. Once you’ve met the eligibility requirements of this Component Plan, the University will pay for basic life and ADD insurance in the amount described above. If you wish to obtain coverage in an additional amount (up to the plan-established maximum), you may elect to pay for extra insurance. Any amounts you pay as premiums for the voluntary portion of this Component Plan can be paid on a pre-tax basis through your participation in the Flexible Spending Account Plan.

**Willamette University Long Term Disability Plan**
In the event of your long-term Partial or Total Disability, this Component Plan provides for income replacement in the amount of 60% of total monthly earnings, subject to a maximum monthly benefit of $6,000. The cost of the premiums for this Component Plan is paid entirely by the University. The Long Term Disability Plan has specific definitions of “Partial Disability” and “Total Disability” which must be met before you begin receiving benefits under this Component Plan. You should refer to the plan document for more details.
**Willamette University Transportation Fringe Benefit Plan**

This Component Plan provides you with certain transportation and/or parking benefits on a pre-tax basis. Provided you meet the eligibility requirements for the Transportation Fringe Benefit Plan, you may exclude from your gross income the cost of a Commuter Highway Vehicle Benefit, a Transit Pass Benefit or a Qualified Parking Benefit. The Plan Administrator will provide you with a *Plan Information Sheet* which will explain further details about participation in this plan.

**Willamette University Business Travel Accident Insurance Plan**

This Component Plan provides insurance in the event of accidental injury or death while traveling on business for the University. Generally, in the event of your death while traveling on University business, this plan will pay your designated beneficiary the sum of $250,000. If you are injured while traveling on business, this plan will pay you a benefit. You should refer to the summary plan description for the Business Travel Accident Insurance Plan to determine what type of injury qualifies for a benefit and more particular details about the death benefit.

**Willamette University Employee Assistance Plan**

This Component Plan provides free counseling for you and your family members. The plan will pay for up to five counseling sessions per incident per year. The Plan Administrator will provide you with a *Plan Information Sheet* which will explain further details about participation in this plan.
COBRA COVERAGE
If medical, dental or Employee Assistance coverage for you or your family members ceases because of certain “qualifying events” specified under COBRA (such as termination of employment, reduction in hours, divorce, death, or a child’s ceasing to meet the definition of dependent), then you and your eligible family members may have the right to purchase continuation coverage for a temporary period of time. The insurance contracts (including the certificate of insurance booklets) trust document, plan documents, and other governing documents for the Component Plans provide additional information regarding COBRA rights under the Plan.

If you or your eligible family members qualify for such continuation coverage, then the medical, dental and Employee Assistance plans will be treated as separate plans for purposes of COBRA. For example, if you had both medical and dental coverage and then experienced a qualifying event, you can elect whether to continue medical-only coverage, dental-only coverage, or both.

ELECTING COBRA COVERAGE
Once the Plan Administrator receives notice and satisfactory proof that a qualifying event has occurred, COBRA coverage will be offered to each qualified beneficiary who loses group health, dental or Employee Assistance coverage because of the qualifying event. You will receive information about electing COBRA, and you should follow the instructions given. Each qualified beneficiary will have an independent right to elect COBRA coverage. Covered employees and spouses (if the spouse is a qualified beneficiary) may elect
COBRA on behalf of all of the qualified beneficiaries. Also, a parent or legal guardian may elect COBRA on behalf of their minor dependent children. To elect COBRA, you must complete the election form that will be provided to you and timely return it as instructed. Under federal law, you have 60 days to elect COBRA Coverage. The 60-day period is measured from the later of the date coverage is lost under the terms of the Component Plan or the date of the COBRA election notice.

MORE INFORMATION
Specific questions about any of the Component Plans may be addressed in a separate summary description given to you by the Administrator for the Plan. For more information about your rights under ERISA, COBRA, HIPAA, or any other laws affecting health and welfare benefit plans, contact the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. Addresses and phone numbers for regional and district EBSA offices are available through EBSA’s website.

KEEP THE PLAN INFORMED OF ADDRESS CHANGES
In order to protect your and your family’s rights, you should provide the Administrator with an update of any changes in your address or the addresses of family members. Updates should be mailed to the Plan Administrator whose name and address are provided at the beginning of the Summary.
CLAIMS PROCEDURES

CLAIMS FOR FULLY-INSURED BENEFITS OR BENEFITS PAID FROM TRUST
For purposes of determining the amount of, or entitlement to, benefits of the Component Plans that are funded under insurance contracts or from a trust, the respective insurer or individuals acting on behalf of the trust are the named fiduciaries under the Plan, with the full power to interpret and apply the terms of the Plan as they relate to the benefits provided under the applicable insurance contract or trust.

To obtain benefits from the insurer of a Component Plan or from a trust, you must follow the claims procedures under the applicable insurance contract or trust, which may require you to complete, sign and submit a written claim on the insurance company’s or trust’s form.

The insurance company or individuals acting on behalf of the trust will decide your claim in accordance with its claims procedures, as required by ERISA. The insurance company or trust has the right to secure independent medical advice and to require such other evidence as it deems necessary in order to decide a claim. If the insurance company or trust denies a claim in whole or in part, then you will receive a written notification setting forth the reason(s) for the denial.

If a claim is denied, you may appeal to the insurance company or trust for a review of the denied claim. The insurance company or trust will decide the appeal in accordance with its
claims procedures, as required by ERISA. If you do not appeal on time, then you may lose your right to file suit in a state or federal court, as you will not have exhausted your internal administrative appeal rights (which generally is a prerequisite to bringing a suit in state or federal court).

The applicable insurance contract (including the certificate of insurance) and trust provide more information about how to file a claim and details regarding the insurance company’s or trust’s claims procedures.

**Claims for Self-Funded Benefits**

For purposes of determining the amount of, or entitlement to, benefits under the Component Plans funded through the University’s general assets, the Plan Administrator is the named fiduciary under the Plan, with the full power to make factual determinations and to interpret and apply the terms of the Plan as they relate to the benefits provided through a self-funded arrangement.

To obtain benefits from a self-funded arrangement, you must complete, execute and submit to the Plan Administrator a written claim on a form available from the Plan Administrator. The Plan Administrator has the right to secure independent medical advice and to require such other evidence as it deems necessary to decide a claim.

The Plan Administrator will decide your claim in accordance with reasonable claims procedures, as required by ERISA. If the Plan Administrator denies a claim in whole or in part, then
you will receive a written notification setting forth the reason(s) for the denial.

If a claim is denied, you may appeal to the Plan Administrator for a review of the denied claim. The Plan Administrator will decide the appeal in accordance with reasonable claims procedures, as required by ERISA. If you do not appeal on time, then you may lose your right to file suit in a state or federal court, because you will not have exhausted the internal administrative appeal rights (which generally is a prerequisite to bringing a suit in state or federal court).

CLAIMS AND REVIEW PROCEDURE
Information about how to file a claim is described above under “Claims Procedures.” If you think you are not receiving benefits to which you are entitled, you may request a review. The procedures that apply to the Component Plans will be reviewed in accordance with procedures contained in the policies for such Component Plans and/or in the applicable summary plan descriptions.

OTHER INFORMATION

AMENDMENT AND TERMINATION
We have established the Plan with the expectation that it will be continued indefinitely, but the University can amend or terminate the Plan at any time. The University also has the right, without notice to or consent from any employee, to amend or terminate any other benefit plan we maintain.
ERISA RIGHTS
You are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA) with respect to the Plan. ERISA provides that all Plan participants are entitled to:

*Receive Information About Your Plan and Benefits*
Examine, without charge, at your Plan Administrator’s office and at other specified locations such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, if any, and a copy of any latest annual report (Form 5500) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Upon written request to the Plan Administrator, obtain copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of any latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

*Prudent Actions by Plan Fiduciaries*
In addition to creating rights for Plan participants, ERISA imposes obligations 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 plan participants and beneficiaries. No one, including the University, your union, or any other person, may fire you or otherwise discriminate
against you in any way to prevent you from obtaining a benefit from a plan covered by ERISA or from exercising your rights under ERISA.

*Enforce Your Rights*

If your claim for a benefit under this Plan 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 any 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 to 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 medical child support order, you may file suit in a Federal court (participants and beneficiaries can obtain, without charge, a copy of the applicable procedures governing qualified medical child support orders). If it should happen that plan fiduciaries misuse the Plan’s money (if the Plan is considered to have 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 should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example if it finds your claim is frivolous.

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

Newborns’ and Mothers’ Health Protection Act of 1996
Group health plans and health insurance issuers generally may not, under federal law, 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).