WILLAMETTE UNIVERSITY

CONSOLIDATED WELFARE BENEFITS PLAN

EFFECTIVE DATE
01/01/2010

This document, together with the attached documents listed on the final page, constitutes the written plan document required by ERISA § 402
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ATTACHMENTS
ARTICLE 1
DEFINITIONS

1.1 Definitions

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


d. “Company” means Willamette University or any successor thereto.

e. “DCAP” means the dependent care assistance program established by the Company under a separate document. The DCAP is a component benefit program under the Plan.


g. “Employee” means any employee of the Company who satisfies the eligibility provisions of Section 3 and who is not excluded from participation by the terms of an applicable component benefit program.


i. “FMLA” means the Family and Medical Leave Act of 1993.

j. “FSA Plan” means the flexible spending account plan established by the Company. The FSA Plan has two component parts: the Health FSA Plan and the DCAP.

k. “Health FSA Plan” means the health flexible spending arrangement plan established by the Company under a separate document. The Health FSA plan is a component benefit program under the Plan.


m. “MHPA” means the Mental Health Parity Act.

n. “NMHPA” means the Newborns’ and Mothers’ Health Protection Act of 1996, as amended.

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

p. “Plan Administrator” means Willamette University.

q. “Plan Sponsor” means Willamette University.


ARTICLE 2
INTRODUCTION

2.1 Introduction
The Company as Plan Sponsor has established the Plan for the exclusive benefit of its employees and their spouses and dependents, effective as of the Effective Date. The Plan provides benefits through the following component benefit programs:

- Willamette University PPO Medical Plan (Attachment #1);
- Willamette University FFS Dental Plan (Attachment #1);
- Willamette University HMO Medical Plan (Attachment #2);
- Willamette University HMO Dental Plan (Attachment #3);
- Willamette University Flexible Spending Account Plan (Attachment #4);
- Willamette University Group Life Insurance Plan and ADD-Basic and Voluntary (Attachment #5);
- Willamette University Long Term Disability Plan (Attachment #6);
- Willamette University Transportation Fringe Benefit Plan (Attachment #7);
- Willamette University Business Travel Accident Insurance Plan (Attachment #8); and,
- Willamette University Employee Assistance Plan (Attachment #9).

Each of these component benefit programs is summarized in an insurance contract, trust document, a plan document, or another governing document prepared by the Company. When the Plan refers to an insurance contract or trust document, it also refers to any attachments to such contract or document, as well as documents incorporated by reference into such contract or document (such as the application and the certificate of insurance booklet). A copy of each contract (including the booklet), trust document, plan document, or other governing document is attached to this document in Attachments #1 to #9 as noted above.

This document and its Attachments constitute the plan document required by ERISA § 402. The Employer has designated this Plan as Plan #512.

ARTICLE 3
ELIGIBILITY AND PARTICIPATION REQUIREMENTS

3.1 Eligibility and Participation
An eligible employee with respect to the Plan will be any employee of the Company who is eligible to participate in and receive benefits under one or more of the component benefit programs. Certain component benefit programs 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 benefit program in accordance with the terms and conditions established for that program.

3.2 Termination of Participation
An employee’s benefits (and the benefits of his or her eligible family members) will cease when the employee’s participation in the Plan terminates.

Benefits will also cease upon termination of the 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 an employee has a preexisting condition and incurs 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 Attachments provide additional information.

3.3 Continuation Coverage Under COBRA
If medical or dental coverage for an employee or his or her eligible family members ceases because of certain “qualifying events” specified in COBRA (such as termination of employment, reduction in hours, divorce, death or a child’s ceasing to meet the definition of dependent), then the employee and his or her 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 in the applicable Attachments provide additional information regarding COBRA rights under the Plan.

If an employee or his or her eligible family members qualify for such continuation coverage, then the medical and dental plans will be treated as a single plan for purposes of COBRA and the Health FSA will be treated as a separate plan. Accordingly, if an active employee had both medical and dental coverage and then elected COBRA, then he or she must pay the applicable premium for both medical and dental coverage. He or she cannot elect medical-only or dental-only coverage.

ARTICLE 4
PLAN BENEFITS

4.1 Benefits and Contributions
The Plan provides employees and their eligible dependents with medical, dental, FSA, group term life insurance and ADD, group long term disability, transportation fringe benefits, business travel accident insurance, and employee assistance. A summary of each benefit provided under the Plan is set forth in the attached insurance contracts (including the certificate of insurance booklet), trust document, plan documents, or other governing documents.

The cost of the benefits provided through the component benefit programs will be funded in part by Company contributions and in part by employee contributions. The Company will determine and periodically communicate the employee’s share of the cost of the benefits provided through each component benefit program, and it may change that determination at any time.

The Company will make its contributions in an amount that (in the Company’s sole discretion) is at least sufficient to fund the benefits or a portion of the benefits that are not otherwise funded by employee contributions. The Company will pay its contribution and employee contributions to an insurance carrier, to a trust, or with respect to benefits that are self-insured, will use these contributions to pay benefits directly to or on behalf of employees or their eligible family members from the Company’s general assets. Employee contributions toward the cost of a particular benefit will be used in their entirety prior to using Company contributions to pay for the cost of such benefit.

4.2 Qualified Medical Child Support Orders
With respect to component benefit plans that are group health plans, the Plan will also provide benefits as required by any qualified medical child support order (QMCSO) (defined in ERISA § 609(a)). The Plan has procedures for determining whether an order qualifies as a QMCSO. Participants and beneficiaries can obtain, without charge, a copy of such procedures from the Plan Administrator.

ARTICLE 5
PLAN ADMINISTRATION

5.1 Plan Administration
The administration of the Plan is under the supervision of the Company as Plan Administrator. The Human Resource Office of the Company 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 may delegate any of these administrative duties among one or more persons or entities, provided that such delegation is in writing, expressly identifies the delegate(s) and expressly describes the nature and scope of the delegated responsibility.

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 any benefits under the Plan.
The Company will bear its incidental costs of administering the Plan.

5.2 **Power and Authority of Insurance Company and Health Trust**

Certain benefits under the Plan are fully insured. Other benefits are part of a multiple employer welfare arrangement (“MEWA”) and are paid from a trust.

Group insurance contracts provide for the following benefits: Medical and Dental, Life, ADD, Long Term Disability and Business Travel Accident.

Health trust (MEWA) assets provide for the following benefits: 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 benefit plans; and (2) prescribing claims procedures to be followed and the claims forms to be used by employees pursuant to the their respective component benefit plans.

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

Insurance premiums and health trust contributions for employees and their eligible family members are paid in part by the Company out of its general assets and in part by employees’ payroll deductions. The Plan Administrator provides a schedule of the applicable premiums and health trust contributions during the initial and subsequent open enrollment periods and on request for each of the component benefit programs, as applicable. Contributions for the self-insured component benefit program are also made in part by the Company and in part by employees’ payroll deductions.

The Health FSA Plan, the DCAP, and the Transportation Fringe Benefit Plan are self-funded. Benefits under these component benefit programs are paid from the Company’s general assets.

**ARTICLE 6**

**CIRCUMSTANCES THAT MAY AFFECT BENEFITS**

6.1 **Denial or Loss of Benefits**

An employee’s benefits (and the benefits of his or her eligible family members) will cease when the employee’s participation in one or more of the component benefit programs terminates.

Benefits will also cease upon termination of this Plan or a component benefit program.

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 an employee has a preexisting condition and incurs 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 Attachments provide additional information.

**ARTICLE 7**

**AMENDMENT OR TERMINATION OF THE PLAN**

7.1 **Amendment or Termination**

The Company, as Plan Sponsor, has the right to amend or terminate the Plan at any time. The Plan may be amended or terminated by a written instrument duly adopted by the Company or any of its delegates.

The Company’s Director of Human Resources may sign insurance contracts or trust documents for this Plan on behalf of the Company, including amendments to those contracts or documents, and may adopt (by a written instrument) amendments to the Plan that he or she considers to be administrative in nature or advisable to comply with applicable law.
ARTICLE 8
CLAIMS PROCEDURES

8.1 Claims for Fully-Insured Benefits or Benefits Paid from Trust

For purposes of determination of the amount of, and entitlement to, benefits of the component benefit programs provided 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 benefit program or from a trust, the participant must follow the claims procedures under the applicable insurance contract or trust, which may require the participant 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 a participant’s claim in accordance with its reasonable 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 the participant will receive a written notification setting forth the reason(s) for the denial.

If a claim is denied, the participant 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 reasonable claims procedures, as required by ERISA. If the participant does not appeal on time, then he or she will lose his or her right to file suit in a state or federal court, as he or she will not have exhausted his or her internal administrative appeal rights (which generally is a prerequisite to bringing a suit in state or federal court).

The attached 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.

8.2 Claims for Self-Funded Benefits

For purposes of determining the amount of, and entitlement to, benefits under the component benefit programs provided through the Company’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, the participant must complete, execute and submit to the Plan Administrator a written claim on the 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 a participant’s claim in accordance with reasonable claims procedures, as required by ERISA. If the Plan Administrator denies a claim in whole or in part, then the participant will receive a written notification setting forth the reason(s) for the denial.

If a claim is denied, the participant 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 the participant does not appeal on time, then the participant will lose his or her right to file suit in a state or federal court, because he or she will not have exhausted the internal administrative appeal rights (which generally is a prerequisite to bringing a suit in state or federal court).

The attached Summary Plan Descriptions contain more information about how to file a claim and details regarding the Plan’s appeal procedures.
ARTICLE 9
GENERAL INFORMATION ABOUT THE PLAN

9.1 No Contract of Employment
The Plan is not intended to be, and may not be construed as constituting, a contract or other arrangement between any individual and the Company to the effect that the individual will be employed for any specific period of time.

9.2 Compliance With State and Federal Mandates
With respect to component benefit plans, the Plan will comply, to the extent applicable, with the requirements of all applicable laws, such as USERRA, COBRA, HIPAA, NMHPA (and the state version of NMHPA), WHCRA, MHPA and FMLA.

9.3 Insurance Contract or Governing Document Controls
Benefits are provided under the Plan pursuant to an insurance contract or trust or pursuant to a governing plan document adopted by the Company. If the terms of this document conflict with the terms of such insurance contract, trust, or governing plan document, then the terms of the insurance contract, trust, or governing plan document will control, rather than this document, unless otherwise required by law.

9.4 Third Party Recovery / Reimbursement
Certain Benefits provided under the Plan may be subject to third party recovery and/or reimbursement rights. The rules and regulations governing such rights are contained in the terms of the individual component benefit plan(s) to which they apply.

IN WITNESS WHEREOF, the undersigned has caused this Plan to be executed, effective as of January 01, 2010

WILLAMETTE UNIVERSITY

Keith A. Grimm, Director of Human Resources