

# **Willamette University Consolidated Welfare Benefits Plan**

## **Summary Plan Description**



**Original Effective Date:  
January 1, 2010**

**Restatement Effective Date:  
March 31, 2016**

**WILLAMETTE UNIVERSITY  
CONSOLIDATED WELFARE BENEFITS PLAN**

**SUMMARY PLAN DESCRIPTION  
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## **INTRODUCTION**

Willamette University ("Willamette") established the Willamette University Consolidated Welfare Benefits Plan (the "Plan"), effective January 1, 2010. The Plan was restated effective March 31, 2016. Although the purpose of this document is to summarize the more significant provisions of the Plan, the Plan document will prevail in the event of any inconsistency.

## **PURPOSE**

The purpose of the Plan is to combine Willamette's welfare benefit plans into a single Plan. The following welfare benefit plans of Willamette are subject to ERISA and incorporated into the Plan:

- Willamette University Group Medical Plan
- Willamette University Group Dental Plan
- Willamette University Group Life and AD&D Plan
- Willamette University Group Long Term Disability Plan
- Willamette University Group Business Travel Insurance Plan
- Willamette University Flexible Spending Account Plan
- Willamette University Employee Assistance Program

## **ADMINISTRATIVE INFORMATION**

The Plan Sponsor and Plan Administrator is Willamette University, EIN 93-0386972. Its address is 900 State Street, Salem, OR 97301 and phone number is (503) 370-6300.

The Plan is a welfare benefit plan which has been designated by the Plan Administrator as plan number is 512. The Plan's designated agent for service of legal process is the Associate Vice President of Human Resources. Any legal papers should be delivered to him or her at 900 State Street, Salem, OR 97301. The Plan year ends on December 31<sup>st</sup>.

## **FLEXIBLE SPENDING ACCOUNT SUMMARY PLAN DESCRIPTION**

If you are regularly scheduled to work at least 1,248 hours or more per year then you are eligible to participate in the Willamette University Flexible Spending Account Plan ("FSA Plan") after you have satisfied the service requirements for the Willamette University Group Medical Plan.

Benefits under the FSA Plan are purchased with pre-tax dollars as selected on an FSA Election Form provided by Willamette. The FSA Plan provides the following benefits:

- Medical Expense Reimbursement Account – This benefit permits you to pay certain uninsured and unreimbursed medical, dental, and vision expenses through the FSA Plan. A "Medical Expense Reimbursement Account" is set up for each employee choosing this benefit from which

eligible expenses are reimbursed. Reimbursements are limited to \$2,550 per year in 2016 (this limit may be adjusted in the future pursuant to IRS regulations).

- Dependent Care Reimbursement Account – This benefit enables you to pay certain expenses incurred for the care of an eligible dependent. A “Dependent Care Reimbursement Account” is set up for each employee choosing this benefit and eligible expenses are reimbursed as incurred. Reimbursements are limited to \$5,000 per year in 2016 (and future years until otherwise indicated on the FSA Election Form).
- Mass Transit Reimbursement Account – This benefit enables you to pay certain mass transit expenses through the Flexible Spending Account Plan. A “Mass Transit Reimbursement Account” is set up for each employee choosing this benefit and eligible expenses are reimbursed as incurred. Reimbursements are limited to \$230 per month in 2016 (and future years until otherwise indicated on the FSA Election Form).

In order to take advantage of the FSA Plan, several requirements must be satisfied. The requirements are:

1. In order to participate in the Flexible Spending Account Plan, you must complete an FSA Election Form prior to the date you first become eligible for the Plan or prior to the first day of the Plan Year.
2. Once the plan year or participation has begun you change your FSA Plan election for any reason other than a change in family status or other events specified in government regulations. Status change events include change in legal marital status, a change in number of dependents, or a change in employment status.
3. Any money placed in a reimbursement account becomes the employer's money and is paid to a participant only to reimburse eligible expenses. ANY AMOUNTS LEFT IN YOUR REIMBURSEMENT ACCOUNTS AT THE END OF THE PLAN YEAR AFTER ALL ELIGIBLE CLAIMS HAVE BEEN PROCESSED WILL BE FORFEITED.

#### **OTHER SUMMARY PLAN DESCRIPTIONS**

In the separate Summary Plan Descriptions and/or other plan-related documents, you will find information about fully-insured component welfare benefit plans. You are eligible to participate in this Plan on the date you are eligible to participate in one of the component welfare benefit plans. Your coverage under the Plan will terminate at the end of the month you terminate employment or cease to be an eligible employee under any of the component welfare benefit plans.

All benefits of this Plan are provided by the component welfare benefit plans. This Summary Plan Description incorporates the terms of the other Summary Plan Descriptions for each of the component welfare benefit plans.

## CLAIMS

### **Refunds and Indemnification**

You must immediately repay any excess payments or reimbursements. You must reimburse Willamette for any liability Willamette may incur for making such payments, including but not limited to, failure to withhold or pay payroll or withholding taxes from such payments or reimbursements. If you fail to timely repay an excess amount and/or make adequate indemnification, the Plan Administrator may: (i) to the extent permitted by applicable law, offset your salary or wages, and/or (ii) offset other benefits payable under this Plan.

### **Third Party Recovery**

If you are paid benefits from another welfare benefit plan the Plan may be entitled to reimbursement. In particular, the plan may be entitled to reimbursement for benefits which are related to medical expenses that are also payable under Workers' Compensation, any statute, any uninsured or underinsured motorist program, any no fault or school insurance program, any other insurance policy or any other plan of benefits, or when related medical expenses that arise through an act or omission of another person are paid by a third party, whether through legal action, settlement or for any other reason.

By participating in the Plan you and your covered dependents consent and agree that a constructive trust, lien or an equitable lien by agreement in favor of the Plan exists with regard to any settlement or recovery from a third person or party. In accordance, you and your covered dependents agree to cooperate with the Plan in reimbursing it for Plan costs and expenses. If you or your covered dependents have any reason to believe that the Plan may be entitled to recovery from any third party, you must notify the Plan. And, at that time, you (and your attorney, if applicable) must sign a subrogation/reimbursement agreement that confirms the prior acceptance of the Plan's subrogation rights and the Plan's right to be reimbursed for expenses arising from circumstances that entitle the Participant or covered dependent to any payment, amount or recovery from a third party.

You and your covered dependent consent and agree that you will not assign your rights to settlement or recovery against a third person or party to any other party, including your attorneys, without the Plan's consent. As such, the Plan's reimbursement will not be reduced by attorneys' fees and expenses without express written authorization from the Plan.

### **Claim Procedures - In General**

This section applies for any claim for benefits under a welfare benefit plan that is covered by ERISA unless the welfare benefit plan has a claims procedure that is compliant with ERISA section 503. If the welfare benefit plan has a claims procedure that is compliant with ERISA section 503, the claims procedure of the welfare benefit plan will apply. In general, this means that if the claims procedure of the welfare benefit plan has timeframes and procedures that are at least as favorable to you or more favorable than the deadlines provided below, the claims procedure of the welfare benefit plan will apply. In the case of a group health plan, any procedures for obtaining prior approval as a prerequisite for obtaining a benefit, such as preauthorization procedures or utilization review procedures are described in the relevant SPD for that plan and incorporated herein.

You or any other person entitled to benefits from the welfare benefit plan (a "Claimant") may apply for such benefits by completing and filing a claim with the applicable welfare benefit plan provider in accordance with the provider's claim filing guidelines. In general, claims must be filed in writing (except urgent care claims, which may be made orally) with the applicable welfare benefit plan provider. Any claim that does not relate to a specific benefit under the plan (for example, a general eligibility claim or a dispute involving a mid-year election change) must be filed with the welfare benefit plan's plan administrator. Any claim must include all information and evidence that the welfare benefit plan provider or plan administrator (the "Claim Reviewer") deems necessary to properly evaluate the merit of and to make any necessary determinations on a claim for benefits. If a claim is received, but there is not enough information to process the claim, you will be given an opportunity to provide the missing information.

A request for prior approval of a benefit or service where prior approval is not required under the Plan is not a "claim" under these rules. Similarly, a casual inquiry about benefits or the circumstances under which benefits might be paid under the Plan is not a "claim" under these rules, unless it is determined that your inquiry is an attempt to file a claim.

If you want to bring a claim for benefits under the Plan, you may designate an authorized representative to act on your behalf so long as you provide written notice of such designation to the applicable provider identifying such authorized representative. In the case of a claim for medical benefits involving urgent care, a health care professional who has knowledge of your medical condition may act as your authorized representative with or without prior notice.

### **Timing of Notice of Claim**

The Claim Reviewer will notify the Claimant of any benefit determination within a reasonable period of time but not later than the timeframe specified below depending on the type of claim.

#### ***Group Health Plan Claims***

Group health plan claims may involve urgent care, concurrent care claims, pre-service care claims or post-service claims. Each has different time-frames that may apply and is described below.

**Urgent Care.** The Claim Reviewer will notify the Claimant of the benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the plan, unless the Claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable. In the case of such a failure, the Claim Reviewer will notify the Claimant as soon as possible, but not later than 72 hours after receipt of the claim, of the specific information necessary to complete the claim. The Claimant will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Claim Reviewer will notify the Claimant of the determination as soon as possible, but in no case later than 48 hours after the earlier of (A) the plan's receipt of the specified information, or (B) the end of the period afforded the Claimant to provide the specified additional information.

Concurrent care (a group health plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments). The welfare benefit plan will notify a Claimant of any 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 at a time sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated. Any request by a Claimant to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care that will be decided as soon as possible, taking into account the medical exigencies, and the Claim Reviewer will notify the Claimant of the benefit determination, whether adverse or not, within 72 hours after receipt of the claim by the plan, provided that any such claim is made to the plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

Pre-service claims. The Claim Reviewer will notify the Claimant of the plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the plan. This period may be extended one time by the plan for up to 15 days, provided that the Claim Reviewer both determines that such an extension is necessary due to matters beyond the control of the plan and notifies the Claimant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Claim Reviewer expects to render a decision. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and the Claimant will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

Post-service claims. The Claim Reviewer will notify the Claimant, of an adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the plan for up to 15 days, provided that the Claim Reviewer both determines that such an extension is necessary due to matters beyond the control of the plan and notifies the Claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the plan expects to render a decision. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and the Claimant will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

### ***Disability Claims***

In the case of a claim for disability benefits, the Claim Reviewer will notify the Claimant, of the plan's adverse benefit determination within a reasonable period of time, but not later than 45 days after receipt of the claim by the plan. This period may be extended by the plan for up to 30 days, provided that the Claim Reviewer both determines that such an extension is necessary due to matters beyond the control of the plan and notifies the Claimant, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which the plan expects to render a decision. If, prior to the end of the first 30-day extension period, the administrator determines that, due to matters beyond the control of the plan, a decision cannot be rendered within that extension period, the period for making the

determination may be extended for up to an additional 30 days, provided that the Claim Reviewer notifies the Claimant, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the plan expects to render a decision. The notice of extension will specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and the Claimant will be afforded at least 45 days within which to provide the specified information.

### ***Other Claims***

The Claim Reviewer will notify the Claimant of any adverse benefit determination within a reasonable period of time, but not later than 90 days after receipt of the claim. This period may be extended one time by the Plan for up to 90 days, provided that the Claim Reviewer both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial review period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

### **Content of Notice of Denied Claim**

If a claim is wholly or partially denied, the Claim Reviewer will provide the Claimant with a notice identifying (1) the reason or reasons for such denial, (2) the pertinent Plan provisions on which the denial is based, (3) any material or information needed to grant the claim and an explanation of why the additional information is necessary, (4) an explanation of the steps that the Claimant must take if he wishes to appeal the denial including a statement that the Claimant may bring a civil action under ERISA.

In addition to the above information, if it is a group health plan or a plan providing disability benefits, the following information must be included with the notice described above:

(A) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Claimant upon request; or

(B) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

In addition, in the case of an adverse benefit determination by a group health plan concerning a claim involving urgent care, a description of the expedited review process applicable to such claims must be included with the notice described above and may be provided to the Claimant orally within the time frame described above, provided that a written or electronic notification is furnished to the Claimant not later than 3 days after the oral notification.

### **Appeal of Denied Claim**

If a Claimant wishes to appeal the denial of a claim, he must file an appeal with the Claim Reviewer on or before the 180th day (or the 60th day in the case of a claim other than a group health plan benefit or a disability benefit) after he receives the Claim Reviewer's notice that the claim has been wholly or partially denied. The appeal will identify both the grounds and specific Plan provisions upon which the appeal is based. The Claimant will be provided, upon request and free of charge, documents and other information relevant to his claim. An appeal may also include any comments, statements or documents that the Claimant may desire to provide. The Claim Reviewer will consider the merits of the Claimant's presentations, the merits of any facts or evidence in support of the denial of benefits, and such other facts and circumstances as the Claim Reviewer may deem relevant. The Claimant will lose the right to appeal if the appeal is not timely made.

In considering the appeal of a group health plan benefit or a disability benefit, the Claim Reviewer will:

(1) Provide for a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

(2) Provide that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

(3) Provide for the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

(4) Provide that the health care professional engaged for purposes of a consultation under Subsection (2) will be an individual 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.

(5) In addition, in the case of a claim involving urgent care, provide for an expedited review process pursuant to which (A) a request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the Claimant; and (B) all necessary information, including the plan's benefit determination on review, will be transmitted between the plan and the Claimant by telephone, facsimile, or other available similarly expeditious method.

### **Notice of Denied Appeal Review**

Except as provided below for group health urgent care, pre-service and post-service claims, the Claim Reviewer will notify the Claimant of the Plan's benefit determination on review within 60 days after receipt by the Plan of the Claimant's request for review of an adverse benefit determination (45 days in the case of a claim involving disability benefits). If the Claim Reviewer determines that an extension of time for processing is required, written notice of the extension will be furnished to the Claimant prior to the termination of the initial 60-day period (45 days in the case of a claim involving disability benefits).

In no event will such extension exceed a period of 60 days from the end of the initial period (45 days in the case of a claim involving disability benefits). The extension notice will indicate the special circumstances requiring an extension of time and the date by which the plan expects to render the determination on review.

Urgent care claims. In the case of a claim involving urgent care, the Claim Reviewer will notify the Claimant of the plan's benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the Claimant's request for review of an adverse benefit determination by the plan.

Pre-service claims. In the case of a pre-service claim, the Claim Reviewer will notify the Claimant, of the plan's benefit determination on review within a reasonable period of time appropriate to the medical circumstances. Such notification will be provided not later than 30 days after receipt by the plan of the Claimant's request for review of an adverse benefit determination.

Post-service claims. The Claim Reviewer will notify the Claimant of the plan's benefit determination on review within a reasonable period of time. Such notification will be provided not later than 60 days after receipt by the plan of the Claimant's request for review of an adverse benefit determination.

## **CONTINUATION RIGHTS**

### **Military Service**

If you serve in the United States Armed Forces and must miss work as a result of such service, you may be eligible to continue to receive benefits with respect to any qualified military service.

### **COBRA**

Under Federal law, you, your spouse, and your dependents may be entitled to COBRA continuation coverage in certain circumstances. Please see the "COBRA NOTICE" that is attached to the end of this Summary Plan Description for important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The COBRA NOTICE generally explains COBRA continuation coverage and when it may become available to you. The Plan Administrator will inform you of these rights, if any, when you terminate employment.

## **YOUR RIGHTS UNDER ERISA**

As a Participant, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). This federal law provides that you have the right to:

Examine, without charge, at the 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, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, 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 Participant with a copy of this summary annual report.

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.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage. (Certificates of creditable coverage are no longer required after December 31, 2014.)

In addition, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining your benefits or exercising your rights under ERISA.

If your claim for a 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 medical child support order, 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 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.

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.

## MISCELLANEOUS

### **Qualified Medical Child Support Orders**

In certain circumstances you may be able to enroll a child in the Plan if the Plan receives a Qualified Medical Child Support Order (QMCSO). You may obtain a copy of the QMCSO procedures from the Plan Administrator, free of charge.

### **Special Enrollment Rights**

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. If you or your dependents become ineligible for Medicaid or a state child health program (CHIP) or become eligible for premium assistance under Medicaid or a state child health program (CHIP), you must request enrollment within 60 days. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

### **Women's Health and Cancer Rights Act**

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for: All stages of reconstruction of the breast on which the mastectomy was performed; Surgery and reconstruction of the other breast to produce a symmetrical appearance; Protheses; and Treatment of physical complications of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your Plan Administrator at the number provided at the end of this Summary Plan Description.

### **Newborns' And Mothers' Health Protection**

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).

### **Loss of Benefit**

You may lose all or part of any payment due to you if we cannot locate you when your benefit becomes payable to you.

You may not alienate, anticipate, commute, pledge, encumber or assign any of the benefits or payments which you may expect to receive, contingently or otherwise, under the Plan, except that you may designate a Beneficiary.

### **Amendment and Termination**

Willamette may amend, terminate or merge the Plan at any time.

### **Administrator Discretion**

The Plan Administrator has the authority to make factual determinations, to construe and interpret the provisions of the Plan, to correct defects and resolve ambiguities in the Plan and to supply omissions to the Plan. Any construction, interpretation or application of the Plan by the Plan Administrator is final, conclusive and binding.

### **Taxation**

Willamette intends that all benefits provided under the Plan will not be taxable to you under federal tax law. However, Willamette does not represent or guarantee that any particular federal, state or local income, payroll, personal property or other tax consequence will result from participation in this Plan. You should consult with your professional tax advisor to determine the tax consequences of your participation in this Plan.

### **Privacy**

The Plan is required under federal law to take sufficient steps to protect any individually identifiable health information to the extent that such information must be kept confidential. The Plan Administrator will provide you with more information about the Plan's privacy practices.