Virginia Private Colleges Benefits Consortium, Inc.
Health and Welfare Plan

Wrap-Around
Plan Document and
Summary Plan Description

Amended and Restated Effective January 1, 2025

This document and the attached documents constitute the Plan Document and Summary Plan Description required by ERISA for each of the Component Benefit Programs described herein and offered by the Virginia Private Colleges Benefits Consortium, Inc. (the "Consortium"). The attached documents include:

- Anthem Blue View Vision Plan Document(s);
- Delta Dental Plan Document(s);
- Employee Assistance Program Plan Document(s); and
- Wellness Plan Document and Schedules of Coverage.

The Consortium is providing this Wrap document to address certain information that may not be addressed in the attached documents. If any of these documents are not attached, then this Plan Document and Summary Plan Description is not complete, and the Participant should contact the Consortium for a complete copy.

Virginia Private Colleges Benefits Consortium, Inc.
Wrap-Around Plan Document and Summary Plan Description
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Section 1
Introduction

1.1 Introduction

The Virginia Private Colleges Benefits Consortium, Inc. Health Plan (the "Plan") shall be effective January 1, 2025. The Plan may be amended at any time, in whole or in part, by the Board of Directors.

The Plan has been approved by the Board of Directors of the Virginia Private Colleges Benefits Consortium, Inc. ("VPC Benefits Consortium"). The Plan is intended to meet the requirements of the Employee Retirement Income Security Act of 1974 ("ERISA"), and Section 501(c)(9) of the Internal Revenue Code of 1986 ("Code") and the Regulations promulgated thereunder, as amended from time to time ("Section 501(c)(9)"). The VPC Benefits Consortium is authorized by Section 23.1-106 of the Code of Virginia, which allows certain institutions of higher education in the Commonwealth of Virginia to form a higher education benefits consortium.

This Wrap-Around Plan Document and any amendments and the attached Component Documents constitute the governing document of the Plan. This Plan is a multiple employer plan, designed and administered exclusively for the members of the VPC Benefits Consortium. Employees are entitled to this coverage if the provisions in the Plan have been satisfied. This Plan is void if Participant ceases to be entitled to coverage. No clerical error shall invalidate such coverage if otherwise validly in force.

The Board of Directors intends to maintain the Plan indefinitely. However, the Board of Directors has the right to modify the Plan at any time, and for any reason, as to any part or in its entirety, without advance notice. Likewise, the Board of Directors has the right to terminate the Plan at any time, and for any reason, upon 90 days' notice to the Members. If the Plan is amended or terminated, the Participant may not receive benefits described in the Plan after the Effective Date of such amendment or termination. Any such amendment or termination shall not affect Participant's right to benefits for claims incurred prior to such amendment or termination. If the Plan is amended, a Participant may be entitled to receive different benefits or benefits under different conditions. However, if the Plan is terminated, all benefit coverage will end, including COBRA benefits. This may happen at any time. If this Plan is terminated, the Participant will not be entitled to any vested rights under the Plan.

The Plan makes the following Component Benefit Programs available to its Members:

Vision Plan Program Options:

- Anthem Blue View Vision Plan (Component Document 1)

Dental Plan Program Options: (Component Document 2)

- Delta Dental Low Plan - Prevention First
- Delta Dental High Plan - Prevention First
- Delta Dental Low Voluntary Plan - Prevention First
- Delta Dental High Voluntary Plan - Prevention First
- Delta Dental Low Plan - MaxOver
- Delta Dental High Plan - MaxOver
- Delta Dental EPO Plan

Employee Assistance Program Option: (Component Benefit Document 3)

Wellness Plan Program Option: (Component Document 4)

Each of the Component Benefit Programs is summarized in this document and in the attached Component Documents. Please contact the Plan Administrator if you need an additional copy of any of the Component Documents.

1.2 Purpose

The Consortium is providing this document to give you an overview of the Plan and to address certain information concerning the Component Benefit Programs that may not be addressed in the attached Component Documents.

Read All Documents. You must read this document along with the respective attached Component Document for each Component Benefit Program in which you participate to fully understand your benefits. Should the terms of this Wrap-Around Plan Document and Summary Plan Description conflict with the terms of the Component Document, the terms of the Component Document will control, unless superseded by applicable law.

This document and the Component Documents constitute the Plan Document and Summary Plan Description required by the Employee Retirement Income Security Act of 1974 (ERISA), for the Component Benefit Programs to which ERISA applies. This document is not intended to give Participants any substantive rights to benefits that are not already provided by the Component Documents.

Component Benefit Programs hereunder are provided pursuant to an insurance contract or pursuant to a governing plan document adopted by the Consortium. This document, however, is the controlling document for Eligibility and Participation Requirements, which are described in Section 3.

The terms of this document are designed to incorporate important differences between the fully insured and self-funded Component Benefit Programs. Nothing in this document or any of the Component Documents shall be construed as to change the funding nature of any Component Benefit Program, such as transferring a fully insured Component Benefit Program into a self-funded Component Benefit Program.

You must enroll to receive benefits. You must actually enroll to receive benefits under this Plan, as explained in Article 3 on Eligibility. Some of these Component Benefit Programs require you to make an annual election to enroll for coverage. The details of such annual election are described in the Component Documents.

Section 2
General Plan Identifying Information

Name of the Plan	Virginia Private Colleges Benefits Consortium, Inc. Health and Welfare Benefits Plan
Type of Plan	Health and Welfare Plan
Address of Plan	Virginia Private Colleges Benefits Consortium, Inc. 1 Cedar Hill Court, Suite D Bedford, VA 24523 (540) 525-9693
Plan Administrator and Agent for Service of Legal Process	Tim Klopfenstein Virginia Private Colleges Benefits Consortium, Inc. 1 Cedar Hill Court, Suite D Bedford, VA 24523 (540) 525-9693
Named Fiduciary **Board of Directors**	The Board of Directors of the Virginia Private Colleges Benefits Consortium, Inc. **Chair:** Ken Copeland **Vice Chair:** Rob Young **Secretary:** Kim Harper **Treasurer:** Holli Harman **Executive Director:** Tim Klopfenstein
Plan Number	501
Plan Sponsor and its IRS Employer Identification Number	Virginia Private Colleges Benefits Consortium, Inc. EIN: 27-1367957
Plan Effective Date	January 1, 2010
Amended and Restated Effective Date	January 1, 2025
Plan Year End	December 31

Blue View Vision Component Benefit Program – Fully Insured (Component Document 1)	
Original Effective Date	January 1, 2016
Plan Administrator	Tim Klopfenstein Virginia Private Colleges Benefits Consortium, Inc. 1 Cedar Hill Court, Suite D Bedford, VA 24523 (540) 525-9693
Named Fiduciary	Anthem Blue View Vision P.O. Box 8504 Mason, OH 45040-7111
Claims Administrator	Anthem Blue View Vision P.O. Box 8504 Mason, OH 45040-7111 (866) 723-0515
Funding Medium and Type of Plan Administration	The Anthem Blue View Vision Component Benefit Program is fully insured under a contract between the Consortium and Anthem. Anthem is responsible for administering the Anthem Blue View Vision Plan and for making claim payments. Anthem is responsible for funding claims. Plan contributions are paid in whole or in part by the Members out of their general assets and in whole or in part by Employees' pre-tax payroll deductions. The Plan Administrator will provide a schedule of the applicable premiums during the initial and subsequent open enrollment periods and upon request, as applicable.

Dental Component Benefit Program – Fully Insured & Self-Funded (Component Document 2)	
Dental Benefit Options	Delta Dental Low Plan - Prevention First Delta Dental High Plan - Prevention First Delta Dental Low Voluntary Plan - Prevention First Delta Dental High Voluntary Plan - Prevention First Delta Dental Low Plan - MaxOver Delta Dental High Plan - MaxOver Delta Dental EPO Plan

Original Effective Date **Plan Administrator**	January 1, 2012 Tim Klopfenstein Virginia Private Colleges Benefits Consortium, Inc. 1 Cedar Hill Court, Suite D Bedford, VA 24523 (540) 525-9693
Named Fiduciary	The Board of Directors of the Virginia Private Colleges Benefits Consortium, Inc.
Claims Administrator	Delta Dental of Virginia 4818 Starkey Road Roanoke, VA 24018 (800) 237-6060
Funding Medium and Type of Plan Administration	The following Dental Component Benefit Programs are self-funded under applicable contracts between the Consortium and Delta Dental: Delta Dental Low Plan – Prevention First Delta Dental High Plan – Prevention First Delta Dental Low Voluntary Plan – Prevention First Delta Dental High Voluntary Plan – Prevention First Delta Dental Low Plan – MaxOver Delta Dental High Plan – MaxOver For the self-funded Dental Component Benefit Programs, Delta Dental is responsible for making claim payments and administering the dental plan program options. The Consortium is responsible for funding claims. The following Dental Component Benefit Programs are fully insured under a contract between the Consortium and Delta Dental: Delta Dental EPO Plan For the fully insured Dental Component Benefit Programs, Delta Dental is responsible for administering the dental plans, funding claims, and making claim payments. Plan contributions are paid in whole or in part by the Members out of their general assets and in whole or in part by Employees' pre-tax payroll deductions.

	For each of the Dental Component Benefit Programs, the Plan Administrator will provide a schedule of the applicable premiums during the initial and subsequent open enrollment periods and upon request, as applicable.

Employee Assistance Program Plan Option – Fully Insured (Component Document 3)	
Original Effective Date	January 1, 2025
Plan Administrator	Tim Klopfenstein Virginia Private Colleges Benefits Consortium, Inc. 1 Cedar Hill Court, Suite D Bedford, VA 24523 (540) 525-9693
Named Fiduciary	Anthem Blue Cross and Blue Shield 2015 Staples Mill Rd. Richmond, VA 23230
Claims Administrator	Anthem Blue Cross and Blue Shield P.O. box 27401 Richmond, VA 23279
Funding Medium and Type of Plan Administration	The Anthem Blue Cross and Blue Shield Employee Assistance Component Benefit Program is fully insured under a contract between the Consortium and Anthem Blue Cross and Blue Shield. Anthem Blue Cross and Blue Shield is responsible for administering the Employee Assistance Program and for making claim payments. Anthem Blue Cross and Blue Shield is responsible for funding claims.

Wellness Plan Option – Self-Funded (Component Document 4)	
Original Effective Date	January 1, 2012
Plan Administrator	Virginia Private Colleges Benefits Consortium, Inc. Respective Member Colleges (See Wellness Program Schedules for more information).

Named Fiduciary	The Board of Directors of the Virginia Private Colleges Benefits Consortium, Inc.
Funding Medium and Type of Plan Administration	The Wellness Component Benefit Program is self-funded. The Plan Administrator is responsible for funding claims, making claim payments, and administering Wellness Program options.

Section 3
Eligibility and Participation Requirements

The eligibility and participation requirements for the Component Benefit Programs are set forth below. The following individuals are eligible for coverage in the Component Benefit Programs:

PERSON	DEFINITION	WHEN ELIGIBLE
Full-Time Employee	*See Glossary Definition*	The Employee meets the requirements for eligibility and properly enrolls in the Plan; and Continuously meets the requirements for eligibility; and Makes the required Contributions toward the cost of coverage for the Participant and any Covered Dependent(s). The formula used for allocating the required Contributions between the Member and its Employees must be approved by the Board of Directors. The amount of the respective Contributions shall be set forth in notices from the Plan Administrator and may be changed from time to time by the Board of Directors.
Part Time Employee	*See Glossary Definition*	A Part Time Employee must properly enroll in the Plan, continuously meet the requirements for eligibility and pay the required contributions on a timely basis, as described in this Section on Eligibility and Enrollment.
Eligible Retiree	*See Glossary Definition*	If a Participant becomes an Eligible Retiree, such Participant may continue as a Covered Person subject to any limitations contained herein; An Eligible Retiree may continue as a Covered Person until the date the Eligible Retiree becomes eligible for Medicare; If an Eligible Retiree or an Eligible Retiree's Dependent spouse who was a Covered Person terminates participation in the Plan, such person may not become a Covered Person thereafter.
Spouse	*See Glossary Definition of "Dependent"*	A Spouse will be considered an eligible Dependent from the date of marriage, provided the Spouse is properly enrolled as a Dependent within 31 days of the date of marriage.
Child(ren)	*See Glossary Definition of "Dependent"*	**Initial Enrollment.** If the child satisfies the definition of a "Dependent" in the Glossary, and if a Participant properly enrolls the child within 31 days of the date of hire, the child's Effective Date shall be the same day as the Participant's Effective Date. A Disabled Child must meet the definition of a Disabled Child and satisfy the requirements for Initial Enrollment of a Disabled Child, both contained in the Glossary. **Later-Acquired Child.** If a Participant, after initial enrollment, acquires a new, eligible child, the Participant may complete, sign and return an application to the Plan Administrator within the period set forth in the Special Enrollee section. If the newly acquired child is enrolled within this period, the effective date of that child's coverage is the first date in which the child met the definition of an eligible Dependent.

PERSON	DEFINITION	WHEN ELIGIBLE
Spouse and Child(ren) of Eligible Retiree		If an Eligible Retiree's Dependent is not a Covered Person on the day prior to the time the Participant becomes an Eligible Retiree, such Dependent may not thereafter become a Covered Person in the Plan unless the Dependent is a Special Enrollee; A Dependent spouse acquired by marriage or domestic partnership (where the Member has executed a Rider affording domestic partner coverage) after a Participant becomes an Eligible Retiree may become a Covered Person in the Plan as a Special Enrollee (see Dependent Enrollment for further information); If an Eligible Retiree or an Eligible Retiree's Dependent who was a Covered Person terminates participation in the Plan, such person may not thereafter become a Covered Person in the Plan unless the Dependent is a Special Enrollee (see Dependent Enrollment for further information); Upon an Eligible Retiree's death or termination of participation due to eligibility for Medicare, any Covered Spouse and Covered child may remain a Covered Dependent until the earlier of the date of such Covered Spouse's death, termination of participation due to Medicare eligibility, or remarriage. An Eligible Retiree's Dependent who is eligible for Medicare may not be a Covered Person in the Plan. Upon an Eligible Retiree's death or termination of participation due to eligibility for Medicare, any Covered Spouse and Covered child may elect to cancel or reduce their dental or vision coverage at that time; Upon the death or retirement of a Participant who is Medicare eligible and who, except for such eligibility for Medicare, would qualify as an Eligible Retiree, any Covered Dependents may remain a Covered Dependent on the same basis as the Covered Dependents of an Early Retiree who is terminating due to death or eligibility for Medicare; and If an Eligible Retiree terminates participation in the Plan for any reason other than for death or eligibility for Medicare, the Covered Dependents of such Eligible Retiree shall terminate participation in the Plan as of the Eligible Retiree's termination of participation, at which time no Continuation of Coverage shall be offered.

PERSON	DEFINITION	WHEN ELIGIBLE
Special Enrollee	**Later-Acquired Dependent.** If a Participant, after initial enrollment, acquires a new eligible Dependent, the Participant may complete, sign and return an application to the Plan Administrator within the period set forth below. If the newly acquired Dependent(s) are enrolled within this period, the effective date of that Dependent's coverage is the first date in which the Dependent met the definition of Dependent. **Spouse Upon Marriage.** A spouse will be considered an eligible Dependent from the date of marriage, provided the spouse is properly enrolled as a Dependent within **31 days** of the date of marriage. **Newborn or Adopted Children.** Newborn and newly adopted children shall be covered for Injury or Illness from the moment of birth, adoption, or placement for adoption. Covered Expenses include the necessary care or treatment of medically diagnosed Congenital Defects, birth abnormalities or prematurity, provided the child is properly enrolled as a Dependent within **30 days** of the child's date of birth, adoption or placement for adoption. This provision shall not apply to or in any way affect the maternity coverage applicable to the mother. **Siblings and Other Dependents Upon Birth or Adoption.** If a Participant's other children are not Covered Persons, the Participant may enroll these other children along with a newborn or adopted child as described in the subsection above. If the Participant enrolls the other children within **30 days**, the Special Enrollment Date and coverage shall become effective on the child's date of birth, adoption, or upon placement for adoption. **Loss of Alternate Health Coverage.** A Participant or a Dependent who was previously eligible for coverage, but did not enroll because of alternate health coverage, may complete, sign and return an application to the Plan Administrator within the 31 day Special Enrollment Period following the Participant or Dependent's loss of such other coverage (including coverage through the Marketplace) due to any of the following: Exhaustion of COBRA Continuation Coverage;	**Initial Enrollment.** If a Participant enrolls a Dependent within 31 days of the date of hire, the Dependent's Effective Date shall be the same day as the Participant's Effective Date.

PERSON	DEFINITION	WHEN ELIGIBLE
Special Enrollee	Loss of eligibility for such other coverage due to divorce, legal separation, death, termination of employment or reduction of hours of employment; Termination of Member contributions; or Reaching the lifetime limit on all benefits under the Eligible Employee's or Dependent's prior plan. For a Disabled Child only, a significant cost increase of the Disabled Child's coverage through the Marketplace will constitute a loss of coverage and thus a special enrollment right for the Disabled Child, provided that the child meets the definition of a Disabled Child and satisfies the requirements for Special Enrollment of a Disabled Child, both contained in the Glossary. Individuals who lose coverage due to nonpayment of premiums or for cause (e.g. filing fraudulent claims) shall not be Special Enrollees hereunder. Coverage for a Special Enrollee hereunder shall begin as of the day following loss of alternate health coverage, but not more than 31 days prior to the date the enrollment application is received by the Plan Administrator. Employees and Dependents who are eligible but not enrolled for coverage when initially eligible may become a Special Enrollee in two additional circumstances: ○ The Employee's or Dependent's Medicaid or CHIP coverage is terminated as a result of loss of eligibility and the Employee requests coverage under the Plan within 60 days after the termination; or ○ The Employee or Dependent become eligible for a premium assistance subsidy under Medicaid or CHIP, and the Employee requests coverage under the Plan within 60 days after eligibility is determined. **Court Order or Decree.** If a Dependent is acquired through a court order, decree, or marriage, that Dependent will be considered a Dependent from the date of such court order, decree, or marriage, provided that this new Dependent is properly enrolled within **31 days** of the court order, decree, or marriage.	

PERSON	DEFINITION	WHEN ELIGIBLE
Special Enrollee	**Qualified Medical Child Support Order.** A child may become eligible for coverage as set forth in a Qualified Medical Child Support Order (QMCSO). The Plan Administrator will establish written procedures for determining (and have sole discretion to determine) whether a medical child support order is qualified and for administering the provisions of benefits under the Plan pursuant to a QMCSO. The Plan Administrator may seek clarification and modification of the order, up to and including the right to seek a hearing before the court or agency which issued the order.	

3.1 Change in Status

The Plan allows election changes outside of Open Enrollment based on certain change in status events. The cafeteria plan of the Member governs whether a corresponding mid-year change is allowed to a Participant's pre-tax salary reduction election. Participants should refer to the Member's Plan document governing the cafeteria plan to determine whether pre-tax salary reduction elections can be changed for the following change in status events allowed under this Plan:

- When a change in contribution is significant, a Participant may either increase the contributions or change to a less costly coverage election.
- When a new benefit option is added, a Participant may change to elect the new benefit option.
- When a significant overall reduction is made to a benefit option, a Participant may elect another available benefit option.
- A Participant may make a coverage election change if the spouse or Dependent is covered as an Employee or Dependent under another employer plan and that plan incurs a change such as adding or deleting a benefit option; and
    - Allows a permitted mid-year election change; or
    - Allows election changes due to that Plan's annual Open Enrollment, which does not coincide with this Plan's annual Open Enrollment.

3.2 Participant's and Dependent's Termination of Participation

A Participant and Dependent's participation under the Plan shall terminate on the earlier of the following occurrences:

- The end of the month in which the Participant Terminates Employment with a Member; unless the Member is obligated to continue to make contributions on behalf of such Participant by terms of the employment agreement between the Member and the Participant including the Member's personnel manual;
- The end of the month in which the Participant loses his status as a Participant, or the Dependent loses his status as a Covered Dependent;

- The Plan terminates;
- While on an Approved Leave of Absence or Approved Sabbatical, the Participant becomes employed full time by another employer and is eligible for health benefits;
- The failure to pay required contributions. In such case coverage shall terminate on the last date for which the required contributions were paid, as determined by the Plan Administrator;
- Upon a Participant's death, any Covered Dependent may remain a Dependent for the applicable period of Continuation Coverage set forth in the Continuation of Coverage Section, provided that the Covered Dependent complies with the conditions therein; or
- For cause (i.e. fraudulent claims).

3.3 Open Enrollment

The Plan shall conduct Open Enrollment each Calendar Year. During Open Enrollment, Participants may make any of the following changes regarding participation in the Plan, subject to the other governing provisions of this Plan Document.

- Add Dependents not able to enroll during the Calendar Year as Special Enrollees or remove existing Dependents from coverage; and
- Change Plan options or such other changes as permitted by this Plan Document.

3.4 COBRA Continuation Coverage

COBRA Continuation Coverage is a temporary extension of group health coverage under the Plan. The right to COBRA Continuation Coverage was created by the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). COBRA Continuation Coverage can become available to Qualified Beneficiaries when group health coverage under the Plan ends. The following benefits qualify as group health coverage under the Plan:

- Anthem Blue View Vision Plan
- Delta Dental Plans
- Employee Assistance Program
- Wellness Plan

This Section explains COBRA Continuation Coverage, when it may become available and what the Participants need to do to protect the right to receive it.

For additional information about the Participant's rights and obligations under the Plan and under Federal law, the Participant should contact the Plan Administrator.

COBRA Continuation Coverage is available to "Qualified Beneficiaries," who are Covered Persons whose coverage would otherwise be lost because of a "qualifying event," as described below:

- **Participants.** A Participant may elect COBRA Continuation Coverage, (at the Participant's own expense plus a 2% administration fee) if the Participant's participation under the Plan terminates as a result of Termination of Employment or reduction of hours with a Member.

- **Gross Misconduct.** The Plan Administrator will not offer COBRA Continuation Coverage for the Participant or any of the Participant's Dependents where the Plan Administrator determines that the Termination of Employment was due to gross misconduct.
- **Dependents.** A Dependent may elect COBRA Continuation Coverage (at the Dependent's own expense plus a 2% administration fee) if the Dependent's participation under the Plan would terminate as a result of one of the following qualifying events:
    - Death of a Participant;
    - A reduction in hours of a Participant;
    - Termination of Employment of a Participant, except for a termination due to gross misconduct;
    - Divorce or legal separation from a Participant;
    - If the Participant cancels coverage for his or her spouse in anticipation of a divorce or legal separation, and the divorce or legal separation later occurs, then the divorce or legal separation will be considered a qualifying event even though the ex-spouse lost coverage earlier. If the ex-spouse notifies the Plan Administrator within 60 days after the divorce or legal separation and can establish that coverage was cancelled earlier in anticipation of the divorce or legal separation, then COBRA coverage may be available for the period after the divorce or legal separation;
    - A Dependent child ceases to qualify as a Dependent under the Plan; or
    - A Participant becomes entitled to Medicare.

    Other individuals who may qualify for COBRA Continuation Coverage:

    - **Recipients under Qualified Medical Child Support Orders**. A child of the Participant who is receiving benefits under the Plan pursuant to a Qualified Medical Child Support Order received by the Plan Administrator during the Participant's period of employment with Member is entitled to the same rights under COBRA as a Dependent child of the Participant, regardless of whether that child would otherwise be considered a Dependent.
    - **Children Born To or Placed for Adoption During COBRA Period.** A child born to, adopted by or placed for adoption with a Participant during a period of Continuation Coverage is considered to be a Qualified Beneficiary provided that, the Participant has elected Continuation Coverage for himself or herself. The child's COBRA coverage begins when the child is enrolled in the Plan, whether through Special Enrollment or Open Enrollment, and lasts for as long as COBRA coverage for other Qualified Beneficiaries of the Participant. To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan requirements.
    - **Participants and Dependents after FMLA**. If a Participant takes leave under FMLA and does not return to work at the end of that leave, the Participant and any Dependents will be entitled to elect COBRA if:

- They were covered under the Plan on the day before the FMLA leave began (or became covered during the FMLA leave); or
- They will lose Plan Coverage within 18 months because of the Participant's failure to return to work at the end of the leave.

COBRA Continuation Coverage elected in these circumstances will begin on the last day of FMLA leave.

COBRA Continuation Coverage is the same coverage that the Plan gives to other Participants and their Dependents under the Plan that are not receiving COBRA Continuation Coverage. Each Qualified Beneficiary who elects COBRA will have the same rights under the Plan as other Participants or Dependents covered under the Plan, including Open Enrollment and Special Enrollment rights.

- **Duty to Notify Plan Administrator of Qualifying Events.** The Plan Administrator must be timely notified in writing that a qualifying event has occurred in order to be eligible for COBRA Continuation Coverage.
  - Notice must be given by the Member within **30 days** of the following qualifying events:
    - Termination of Employment of a Participant;
    - Reduction of hours of a Participant;
    - Death of a Participant;
    - Participant becoming entitled to Medicare; or
    - Bankruptcy of Member.
  - Notice must be given within **60 days** by the Qualified Beneficiary or its representative, for all other qualifying events not previously mentioned, following either:
    - The date of the qualifying event; or
    - The date on which the Qualified Beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event.
  - If the Covered Person provides written notice that does not contain all of the information and documentation required, such notice will nevertheless be considered timely **if all of the following conditions are met**:
    - Notice is mailed or hand delivered by the deadline;
    - The Plan Administrator is able to determine the identity of the Member, Participant and Qualified Beneficiaries, and the qualifying event from the Notice; and
    - The Notice is supplemented with the requested additional information and documentation to meet the Plan's requirements within 15 business days after a written or oral request from the Plan Administrator.

If any of the above conditions are not met, the incomplete Notice will be rejected and COBRA will not be offered.

Caution: If these procedures are not followed or if written notice is not provided to the Plan Administrator within the specified time period, any Participant or Dependent who loses coverage will not be offered the option to elect Continuation Coverage.

***Notice Procedures*:** Any notice must be in writing. Oral notice, or notice by telephone, is not accepted. Participant must mail, e-mail or hand-deliver their notice to the Plan Administrator at this address:

Virginia Private Colleges Benefits Consortium, Inc.

Attn: Tim Klopfenstein
1 Cedar Hill Court, Suite D
Bedford, VA 24523
tim@cicv.org

If mailed, the Participant's notice must be postmarked no later than the last day of the specified time period. Any notice provided must state the name of the Plan *(*Virginia Private Colleges Benefits Consortium, Inc. Health Plan), the name and address of the Participant covered under the Plan, and the name(s) and address(es) of the Dependent(s) who lost coverage. Participant's notice must also state the qualifying event and the date it happened.

Forms: The Plan's Notice of Qualifying Event Form should be used to notify the Plan Administrator of a qualifying event. (A copy of this form can be obtained from the Plan Administrator.) If the qualifying event is a divorce, the notice must include a copy of the divorce decree.

The Plan's Notice of a Second Qualifying Event (a copy of the form can be obtained from the Plan Administrator) must also state the event and the date it happened. If the qualifying event is a divorce, the notice must include a copy of the divorce decree.

The Participant's Notice of Disability must also include the name of the disabled qualified Dependent, the date when the Dependent became disabled, the date the Social Security Administration made its determination. Participant's Notice of Disability must include a copy of the Social Security Administration's determination, and a statement as to whether or not the Social Security Administration has subsequently determined that the Qualified Beneficiary is no longer disabled (a copy of this form can be obtained from the Plan Administrator).

- **Electing COBRA Continuation Coverage.** The following rules apply to COBRA election:
  - COBRA Continuation Coverage will begin on the date of the qualifying event for each Qualified Beneficiary who timely elects COBRA Continuation Coverage;
  - Each Qualified Beneficiary has an independent right to elect Continuation Coverage;
  - A Qualified Beneficiary must elect coverage in writing within 60 days of being provided a COBRA Election Notice, using the Plan's Election Form and following the procedures specified on the Election Form;
  - Written notice of election must be provided to the Plan Administrator at the address provided on the Plan's Election Form. If mailed, the election must be postmarked no later than the 60th day of the election time period;
  - A Participant or Dependent may change a prior rejection of Continuation Coverage at any time during the specified time period by providing the Notice of Election;
  - A Participant or Dependent who fails to elect Continuation Coverage within the specified time period will lose his or her right to elect Continuation Coverage; and
  - Unless otherwise indicated, an affirmative election of COBRA Continuation Coverage by a Participant shall be deemed to be an election for that Participant's Dependents who would otherwise lose coverage under the Plan.

The Participant (i.e. the Employee or former Employee who is or was covered under the Plan), a Qualified Beneficiary with respect to the qualifying event, or a representative acting on behalf of either may provide the Notice of Election on behalf of all Qualified Beneficiaries who lost coverage due to the qualifying event described in the Notice.

Note Regarding Failure to Elect. In considering whether to elect Continuation Coverage, Participant should take into account that a failure to continue their group health coverage will affect Participant's future rights under federal law.

First, the Participant can lose the right to avoid having preexisting condition exclusions applied to Participant by other group health plans if the Participant has a gap of 63 days or more in health coverage. Election of Continuation Coverage may help Participant avoid such a gap.

Second, the Participant will lose the guaranteed right to purchase individual health insurance policies that do not impose such preexisting condition exclusions if the Participant does not get Continuation Coverage for the maximum time available to the Participant.

Finally, the Participant should take into account that they have Special Enrollment rights under federal law. The Participant has the right to request Special Enrollment in another group health plan for which the Participant is otherwise eligible (such as a plan sponsored by the Participants spouse's employer) within 30 days after the

Participant's group health coverage ends. The Participant will also have the same Special Enrollment rights at the end of Continuation Coverage if the Participant gets Continuation Coverage for the maximum time available to Participant.

- **Length of Continuation Coverage.** COBRA Continuation Coverage is a temporary continuation of coverage. The COBRA Continuation Coverage periods described below are maximum coverage periods.
- **Period of Continuation Coverage for Participants.** A Participant, who qualifies for COBRA Continuation Coverage as a result of Termination of Employment or reduction in hours of employment, may elect COBRA Continuation Coverage for up to 18 months measured from the date of the qualifying event.

  Coverage under this Section may not continue beyond:

  - The date on which the Member ceases to maintain a group health plan;
  - The last day of the month for which the required contributions have been made;
  - The date the Participant becomes entitled to Medicare; or
  - The first day after the COBRA Continuation Coverage election, when the Participant is covered under any other group health plan that is not maintained by VPC Benefits Consortium, provided the new group plan does not have a preexisting condition limitation that affects the Participant.
  - COBRA Continuation Coverage may also be terminated for any reason the Plan would terminate coverage of a Covered Person not receiving COBRA Continuation Coverage (*i.e.* filing fraudulent claims).
- **Period of COBRA Continuation Coverage for Dependents.** If a Dependent elects COBRA Continuation Coverage under the Plan as a result of the Participant's Termination of Employment or reduction in hours of employment as described above, Continuation Coverage may be continued for up to 18 months measured from the date of the qualifying event. COBRA Continuation Coverage for all other qualifying events may continue for up to 36 months.

  In addition to maximum periods discussed immediately above, Continuation Coverage under this subsection may not continue beyond:

  - The last day of the month for which required contributions have been made;
  - The date the Dependent becomes entitled to Medicare;
  - The date which the Member ceases to maintain a group health plan; or
  - The first day after the COBRA Continuation Coverage election, when the Participant is covered under any other group health plan that is not maintained by the VPC Benefits Consortium provided that the new group plan does not have a preexisting condition limitation that affects the Dependent.

3.5 USERRA Continuation Coverage

Participants Have Rights Under Both COBRA and USERRA. Participant's rights under COBRA and USERRA are similar but not identical. Any election that Participant makes pursuant to COBRA will also be an election under USERRA. COBRA and USERRA will both apply with respect to the Continuation Coverage elected. If COBRA or USERRA gives Covered Persons different rights or protections, the law that provides the greater benefit will apply. The administrative policies and procedures for COBRA also apply to USERRA coverage, unless compliance with the procedures is precluded by military necessity or is otherwise impossible or unreasonable under the circumstances.

The Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") established requirements that employers must meet for certain Employees who are involved in the Uniformed Services. In addition to the rights that Participant has under COBRA, Participant is entitled under USERRA to continue the coverage Covered Persons had under the VPC Benefits Consortium.

Uniformed Services means the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full time National Guard duty pursuant to orders issued under federal law, and the commissioned corps of the Public Health Service and any other category of persons designated by the President in time of War or national Emergency.

Service in the Uniformed Services or Service means the performance of duty on a voluntary or involuntary basis in the Uniformed Services under competent authority, including active duty, active duty for training, initial active duty for training, inactive duty training, full time National Guard duty, the time necessary for a person to be absent from employment for an examination to determine the fitness of the person to perform any of these duties, and a period for which a person is absent from employment to perform certain funeral honors duty. It also includes certain duty and training by intermittent disaster response personnel of the National Disaster Medical System.

- **Duration of USERRA Coverage.**
    - **General rule 24 months maximum.** When a Participant takes a leave for service in the Uniformed Services, USERRA coverage for the Participant (and Covered Dependents for whom coverage is elected) begin the day after the Participant (and Covered Dependents) lose coverage under the Plan, and it may continue for up to 24 months. However, USERRA coverage will end earlier if one of the following events takes place:
        - Participant fails to make a premium payment within the required time;
        - Participant fails to return to work within the time frame required under USERRA (see below) following the completion of Participant's service in the Uniformed Services; or
        - Participant loses rights under USERRA as a result of a dishonorable discharge or other conduct specified in USERRA.
    - **Returning to Work.** Participant's right to continue coverage under USERRA will end if Participant does not notify the Employer of the intent to return to work within the time frame required under USERRA following the completion of Participant's service in the Uniformed Services by either reporting to work (when absence was for less than 31 days) or applying for reemployment (if absence was for more than 30 days). The time for returning to work depends on the length of the absence, as follows:

Period of Absence	Return to Work Requirement
Less than 31 days	Report to work at the beginning of the first regularly scheduled work period following the end of service plus 8 hours or as soon as possible thereafter if satisfying the deadline is unreasonable or impossible through no fault of the Employee.
More than 30 days but less than 181 days	Submit an application for employment not later than 14 days after the completion of the service, or as soon as possible thereafter if satisfying the deadline is unreasonable or impossible through no fault of the Employee.
More than 180 days	Submit an application for employment not later than 90 days after the completion of the service.
Any period, if the absence was for purposes of an examination for fitness to perform service	Report to work at the beginning of the first regularly-scheduled work period following the end of service plus 8 hours, or as soon as possible thereafter if satisfying the deadline is unreasonable or impossible through no fault of the Employee.
Any period if Participant was Hospitalized for or is convalescing from an Injury or Illness incurred or aggravated as a result of Participant's service	Apply for work or submit application as described above (depending on length of absence) when recovery is over, but recovery time is limited to two years. The 2-year period is extended by any minimum time required to accommodate circumstances beyond the Employee's control that make compliance with these deadlines unreasonable or impossible.

- **Concurrent.** COBRA coverage and USERRA coverage begin at the same time and run concurrently. However, COBRA coverage can continue longer, depending on the qualifying event, and is subject to different early termination provisions. In contrast, USERRA coverage can continue for up to 24 months, as described earlier in this Section.
- **Premium Payments for USERRA Continuation Coverage.** If Participant elects to continue health coverage pursuant to USERRA, the Participant will be required to pay 102% of the full premium for the coverage elected (the same rate as COBRA). However, if Participant's Uniformed Services leave of absence is less than 31 days, Participant is not required to pay more than the amount that Participant would pay as an active Employee for that coverage.

3.6 Family and Medical Leave

If a Participant is on a leave of absence under the Family and Medical Leave Act (FMLA), the Participant may continue coverage under a Component Benefit Program that is a health plan. Such coverage is subject to the FMLA and to the terms of the Component Benefit Program. Such coverage is also subject to the following conditions:

- The Participant must pay any required employee contribution; and
- The Participant must obtain written approval of leave from the Member.

Coverage will be continued for up to the greater of:

- The leave period required by the FMLA; or
- The leave period required by a similar state law.

If coverage is not continued during an FMLA absence, when the Participant returns to actively at work status, no new waiting period will apply.

Section 4
Plan Benefits Summary

4.1 Benefits

The Plan provides the Participant and the Participant's eligible Dependents with benefits under the Component Benefit Programs as set forth in Section 1 of this Wrap-Around Plan Document and Summary Plan Description.

4.2 Michelle's Law

A Dependent will not lose status as a Dependent while on a Medically Necessary Leave of Absence. A "Medically Necessary Leave of Absence" is a leave of absence from a post-secondary educational institution that:

- Commences while the Dependent is suffering from a severe illness or injury;
- Is medically necessary (as certified by the Dependent's physician); and
- Causes the Dependent to lose full time student status under the Plan.

Coverage may not terminate due to the Medically Necessary Leave of Absence until the earlier of:

- One year after the first day of the Medically Necessary Leave of Absence; or
- The date the coverage would otherwise terminate under the Plan.

(Section 4.2 may not be applicable due to ACA's age 26 Dependent coverage mandate.)

Section 5
Plan Administration

5.1 Plan Administrator

The Plan Administrator for the Component Benefit Programs of the Plan is identified in Section 2.

5.2 Power of Plan Administrator

Subject to the limitations of the Plan and any Component Document, the Plan Administrator will from time to time establish rules for the administration of the various Component Benefit Programs of the Plan and transaction of its business. The Plan Administrator will rely on the records of the Member with respect to any and all factual matters dealing with the employment and eligibility of an employee. The Plan Administrator will resolve any factual dispute, giving due weight to all evidence available to it. The Plan Administrator shall have such powers and duties as may be necessary to discharge its functions hereunder, including but not limited to, the sole and absolute discretion to:

- Construe and interpret the various Component Benefit Programs of the Plan, except for the fully insured Anthem and Anthem Blue View Vision Component Benefit Programs, and fully insured Delta Dental Component Benefit Program, as this is a power of the insurance carrier;
- Decide questions of eligibility to participate in the various Component Benefit Programs of the Plan; and
- Determine the amount, manner and time of payment of any benefit to any covered person, except for the fully insured Anthem and Anthem Blue View Vision Component Benefit Programs, and fully insured Delta Dental Component Benefit Program, as this is a power of the insurance carrier.

The Plan Administrator will have final discretionary authority to make such decisions and all such determinations shall be final, conclusive and binding.

5.3 Power of Anthem

Anthem vision benefits are provided under contracts entered into by the Consortium and Anthem. Anthem is responsible for:

- Prescribing claims procedures to be followed;
- The claims forms to be provided to Participants; and
- Payment of all benefits under the Vision Component Benefit Program.

The Consortium is responsible for determining eligibility under the individual Anthem Vision Component Benefit Program.

5.4 Power of Anthem Blue View Vision

Anthem Blue View Vision vision benefits are provided under contracts entered into by the Consortium and Anthem Blue View Vision. Anthem Blue View Vision is responsible for paying claims and administering the Anthem Blue View Vision vision program option. Anthem Blue View Vision is responsible for funding claim payments. The Consortium is responsible for determining eligibility under the Anthem Blue View Vision Component Benefit Program.

5.5 Power of Delta Dental of Virginia

Self-funded dental benefits are provided under contracts entered into by the Consortium and Delta Dental. Delta Dental is responsible for:

- Prescribing claims procedures to be followed;
- The claims forms to be provided to Participants; and
- Payment of all benefits under the Dental Component Benefit Programs.

The Consortium is responsible for funding claims and determining eligibility under the individual Dental Component Benefit Programs.

Fully insured dental benefits are provided under a contract entered into by the Consortium and Delta Dental. Delta Dental is responsible for:

- Prescribing claims procedures to be followed;
- The claims forms to be provided to Participants; and
- Payment of all benefits under the Dental Component Benefit Programs.

The Consortium is responsible for determining eligibility under the individual Dental Component Benefit Programs.

5.6 Power of Members

Wellness Program Benefits are provided under the Schedules referenced in Appendix B. Members, as Plan Administrators, are responsible for:

- Determining eligibility criteria for the Wellness Program;
- Designing the Wellness Program, including any incentives to be offered, and submitting design to Consortium for approval;
- Selecting participating vendors from approved list of vendors provided by the Consortium; and
- Administering any incentive programs provided under the Wellness Program.

The Consortium, as Plan Sponsor, is responsible for:

- Selecting and contracting with Wellness Program vendors;
- Reviewing Member College Wellness Program designs;
- Reviewing and approving Member Wellness Program budget proposals; and
- Prescribing applicable claims and appeals procedures as described in Section 9.

5.7 Outside Assistance

The Board of Directors and/or Plan Administrator may employ such counsel, accountants, claims administrators, consultants, actuaries and other person or persons as the Board of Directors and/or Plan Administrator shall deem advisable. The various Component Benefit Programs of the Plan shall pay the compensation of such counsel, accountants, and other person or persons and any other reasonable expenses incurred by the Plan Administrator in the administration of the various Component Benefit Programs of the Plan.

5.8 Delegation of Powers

In accordance with the provisions hereof, the Board of Directors and/or Plan Administrator has been delegated certain administrative functions relating to the various Component Benefit Programs of the Plan with all powers necessary to enable the Board of Directors and/or Plan Administrator properly to carry out such duties. The Board of Directors and/or Plan Administrator as such shall have no power in any way to modify, alter, add to, or subtract from any provisions of the various Component Benefit Programs of the Plan other than as expressly provided in this Wrap-Around Plan Document and Summary Plan Description or the Component Documents.

5.9 Questions

Questions regarding eligibility for benefits under a Component Benefit Program should be directed to the Plan Administrator. Questions regarding the amount of any benefits payable under the self-funded Dental Component Benefit Program or Wellness Program Benefit should be directed to the Plan Administrator. Questions regarding the amount of any benefits payable under the fully insured Anthem and Anthem Blue View Vision Component Benefit Programs should be directed to Anthem or Anthem Blue View Vision, as provided in the Anthem and Anthem Blue View Vision Component Documents. Questions regarding the amount of any benefits payable under the fully insured Delta Dental Component Benefit Program should be directed to Delta Dental, as provided in the Delta Dental Component Documents.

Section 6
Circumstances That May Affect Benefits

6.1 Denial, Recovery or Loss of Benefits

The Participant's benefits (and, except in some cases in the event of the Participant's death, the benefits for the Participant's eligible spouse and eligible Dependents) will cease when Participant's participation in the Plan terminates. (See Section 3). The Participant's benefits will also cease upon termination of the Plan.

6.2 Rescission of Coverage

The Plan Administrator reserves the right to rescind coverage under the Plan if an employee, spouse or child becomes covered under this Plan or receives Plan benefits as a result of an act, practice or omission that constitute fraud or is due to the intentional misrepresentation of a material fact, both of which are prohibited by this Plan. Rescission is a cancellation and discontinuance of coverage, retroactive to the date the employee, spouse or child became covered or received a Plan benefit as a result of fraud or the intentional misrepresentation of a material fact. The Plan Administrator will provide at least 30 days advance notice to an employee, spouse or child of its intent to rescind coverage with an explanation of the reason for the intended rescission. The rescission shall not apply to benefits paid more than one year before the date of such advance notice. A cancellation or discontinuance of coverage is not a rescission if:

- The cancellation or discontinuance of coverage only has a prospective effect;
- The cancellation or discontinuance of coverage is only retroactive to the extent it is attributable to the timely failure to pay Premiums (including COBRA Premiums) toward the cost of coverage; or
- The cancellation or discontinuance of coverage is initiated by an employee, spouse or child (or the employee, spouse or child's personal representative).

A rescission is subject to the claims payment and appeal procedures described in Section 9.

Section 7
Amendment or Termination of the Plan

7.1 Right to Amend, Merge or Consolidate

The Consortium reserves the right to make any amendment or restatement to the Plan or any individual Component Benefit Program from time to time, including those which are retroactive in effect. Such amendments may be applicable to any covered person. Any amendment or restatement shall be deemed to be duly executed by the Consortium when signed by its authorized representative.

7.2 Right to Terminate

The Plan and its individual Component Benefit Programs are intended to be permanent, but the Consortium may at any time and without notice terminate the Plan or any individual Component Benefit Program in whole or in part.

7.3 Effect on Benefits

Except as may otherwise be provided by applicable law or the Component Documents, if the Plan or any individual Component Benefit Program is amended or terminated, the Participant may not receive benefits described in the Plan or in any individual Component Benefit Program after the effective date of such amendment or termination. Any such amendment or termination shall not affect a covered person's right to benefits for claims incurred prior to such amendment or termination. If the Plan or any individual Component Benefit Program is amended, covered persons may be entitled to receive different benefits or benefits under different conditions. However, if the Plan is terminated, all benefit coverage will end, including COBRA or other continuation benefits. This may happen at any time. If the Plan is terminated, covered persons will not be entitled to any vested rights under the Plan. For information regarding the distribution of assets upon termination, refer to the Consortium's Articles of Incorporation and Bylaws.

Section 8
No Contract of Employment

Nothing contained in this Wrap-Around Plan Document and Summary Plan Description, or the Component Documents shall be construed as a contract of employment with a Member, or as a right to be continued in the employment of a Member, or as a limitation of the right of a Member to discharge any Participants, with or without cause.

Section 9
Claims Procedures

9.1 Claims for the Fully Insured Anthem Vision Component Benefit Program

To obtain benefits from Anthem, the Participant must follow the claims procedures under the applicable Component Document, which may require the Participant to complete, sign, and submit a written claim on Anthem's form.

Anthem will decide the Participant's claim in accordance with its reasonable claims procedures, as required by law. Anthem 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 Anthem 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 must follow the appeals procedures under the applicable contract. Anthem will handle the appeal in accordance with its reasonable appeals procedures, as required by any applicable provisions of ERISA and ACA. 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, as internal administrative appeal rights will not have been exhausted. Exhaustion of internal administrative appeal rights is generally a prerequisite to bringing suit in state or federal court.

The Anthem Component Document provides more information about how to file a claim or appeal.

9.2 Claims for the Fully Insured Anthem Blue View Vision Component Benefit Program

To obtain benefits from Anthem Blue View Vision, the Participant must follow the claims procedures under the applicable Component Document, which may require the Participant to complete, sign, and submit a written claim on Anthem Blue View Vision's form.

Anthem Blue View Vision will decide the Participant's claim in accordance with its reasonable claims procedures, as required by law. Anthem Blue View Vision 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 Anthem Blue View Vision 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 Anthem Blue View Vision for a review of the denied claim. Anthem Blue View Vision will handle the appeal in accordance with its reasonable claim procedures, as required by any applicable provisions of ERISA and ACA. 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, as internal administrative appeal rights will not have been exhausted. Exhaustion of internal administrative appeal rights is generally a prerequisite to bringing suit in federal court.

The Anthem Blue View Vision Component Document provides more information about how to file a claim or appeal.

9.3 Claims for the Fully Insured Dental Component Benefit Program

To obtain benefits from Delta Dental, the Participant must follow the claims procedures under the applicable Component Document, which may require the Participant to complete, sign, and submit a written claim on Delta Dental's form.

Delta Dental will decide the Participant's claim in accordance with its reasonable claims procedures, as required by law. Delta Dental 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 Delta Dental 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 Delta Dental for a review of the denied claim. Delta Dental will handle the appeal in accordance with its reasonable claim procedures, as required by any applicable provisions of ERISA and ACA. 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, as internal administrative appeal rights will not have been exhausted. Exhaustion of internal administrative appeal rights is generally a prerequisite to bringing suit in federal court.

The Delta Dental Component Document provides more information about how to file a claim or appeal.

9.4 Claims for the Self-Funded Dental Component Benefit Program

To obtain benefits from Delta Dental, the Participant must follow the claims procedures under the applicable Component Document, which may require the Participant to complete, sign, and submit a written claim on Delta Dental's form.

Delta Dental will decide the Participant's claim in accordance with its reasonable claims procedures, as required by law. Delta Dental 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 Delta Dental 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 Delta Dental for a review of the denied claim. Delta Dental will handle the appeal in accordance with its reasonable claims procedures, as required by ERISA and ACA. 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, as internal administrative appeal rights will not have been exhausted. Exhaustion of internal administrative appeal rights is generally a prerequisite to bringing suit in state or federal court.

The applicable Component Document provides more information about how to file a claim and details regarding Delta Dental's claims procedures.

9.5 Complaints and Appeals to Plan Administrator for the Self-Funded Dental Component Benefit Program

The Delta Dental Component Documents provide for a complaint and appeals process. In addition to sending a complaint to Delta Dental, Participants may also send written complaints to the Plan Administrator. Furthermore, in addition to filing an internal appeal with Delta Dental, Participants may also file a written internal appeal with the Plan Administrator, as described in the Delta Dental Component Document. All requirements set forth in the Delta Dental Component Document concerning the complaint and appeal process also apply when a Participant sends a complaint or internal appeal directly to the Plan Administrator.

The written complaints and internal appeals for the Dental Component Benefit Program can be sent to the Plan Administrator at the following address:

Tim Klopfenstein
Virginia Private Colleges Benefits Consortium, Inc.
1 Cedar Hill Court, Suite D
Bedford, VA 24523

9.6 Claims and Appeals Procedures for the Self-Funded Wellness Program

The Plan Sponsor has established the following claims review procedures in the event a claim is denied under the Wellness Program.

Step 1: *Notice is received from Plan Administrator*. If a claim is denied, the Participant will receive written notice from the Plan Administrator that the claim is denied as soon as reasonably possible, but no later than 30 days after receipt of the claim. For reasons beyond the control of the Plan Administrator, the Plan Administrator may take up to an additional 15 days to review the claim. The Participant will be provided written notice of the need for additional time prior to the end of the 30-day period. If the reason for the additional time is that the Participant needs to provide additional information, the Participant will have 45 days from the notice of the extension to obtain that information. The time period during which the Plan Administrator must make a decision will be suspended until the earlier of the date that the Participant provides the information or the end of the 45-day period.

Step 2: *Review the notice carefully*. Once the Participant has received notice from the Plan Administrator, the Participant should review it carefully. The notice will contain:

- The reason(s) for the denial and the Plan provisions on which the denial is based;
- A description of any additional information necessary for the Participant to perfect the claim, why the information is necessary, and the time limit for submitting the information;
- A description of the Plan's appeal procedures and the time limits applicable to such procedures; and
- A right to request all documentation relevant to the claim.

Step 3: *If Participant disagrees with the decision, Participant files an Appeal*. If the Participant does not agree with the decision of the Plan Administrator and wishes to appeal, the Participant must file the appeal no later than 180 days after receipt of the notice described in Step 1. The Participant should submit all information identified in the notice of denial as necessary to perfect the claim and any additional information that the Participant believes would support the claim. If the Participant fails to appeal on time, the Participant will lose the right to file suit in a state or federal court, as internal administrative appeal rights will not have been exhausted.

Step 4: *Notice of Denial is received from the Plan Administrator*. If the claim is again denied, the Participant will be notified in writing as soon as possible but no later than 30 days after receipt of the appeal by the Plan Administrator.

Step 5: *Review the notice carefully*. The Participant should take the same action taken in Step 2 described above. The notice will contain the same type of information that is provided in the first notice of denial provided by the Plan Administrator.

Step 6: *If Participant still disagrees with the Plan Administrator decision, Participant files a 2nd Level Appeal with the Plan Administrator*. If the Participant still does not agree with the Plan Administrator's decision and wishes to appeal, the Participant must file a written appeal with the Plan Administrator within the time period set forth in the first level appeal denial notice from the Plan Administrator. The Participant should gather any additional information that is identified in the notice as necessary to perfect the claim and any other information that the Participant believes would support the claim.

If the Plan Administrator denies the 2nd Level Appeal, the Participant will receive notice within 30 days after the Plan Administrator receives the claim. The notice will contain the same type of information that was referenced in Step 2 above.

Important Information

Other important information regarding appeals:

- Each level of appeal will be independent from the previous level (i.e., the same person(s) or subordinates of the same person(s) involved in a prior level of appeal will not be involved in the appeal);
- On each level of appeal, the claims reviewer will review relevant information that the Participant submits even if it is new information; and
- The Participant cannot file suit in state or federal court until the Participant has exhausted these appeals procedures.

9.7 Complaints and Appeals to Plan Sponsor for the Self-Funded Wellness Program

In addition to sending a complaint to the Plan Administrator, Participants may also send written complaints to the Plan Sponsor. Furthermore, in addition to filing an internal appeal with the Plan Administrator, Participants may also file a written internal appeal with the Plan Sponsor. All requirements set forth herein concerning the complaint and appeal process also apply when a Participant sends a complaint or internal appeal directly to the Plan Sponsor.

The written complaints and internal appeals for the Wellness Program Component Benefit can be sent to the Plan Sponsor at the following address:

Tim Klopfenstein
Virginia Private Colleges Benefits Consortium, Inc.
1 Cedar Hill Court, Suite D
Bedford, VA 24523

9.8 Administrative Exhaustion Requirement

All claim review procedures provided for in the applicable Component Documents must be exhausted before any legal action is brought including a claim for benefits or for breach of fiduciary duty.

9.9 Limitation on Actions

To the extent not otherwise specified in the applicable Component Document, any legal action for the recovery of any benefits or breach of fiduciary duty must be commenced within one year after the applicable Claims Administrator's claim review procedures have been exhausted.

9.10 Failure to File a Request

If the Participant fails to file a request for review in accordance with the claims procedures outlined herein and in the Component Documents, the Participant shall have no right of review and shall have no right to bring action in any court. The denial of the claim shall become final and binding on all persons for all purposes.

Section 10
Statement of ERISA Rights

10.1 Participant's Rights

Participants are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all Participants shall be entitled to:

10.2 Receive Information About Participant's Plan and Benefits

Participants may examine, without charge, at the Plan's principal office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series), if any, filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Participants may obtain, upon written request to Tim Klopfenstein, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The VPC Benefits Consortium may make a reasonable charge for the copies.

Participant may receive a summary of the Plan's annual Form 5500, if any is required by ERISA to be prepared, in which case the VPC Benefits Consortium is required by law to furnish each Participant with a copy of this summary annual report.

10.3 Enforce Participant's Rights

If Participant's claim is denied or ignored, in whole or in part, Participant has the 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 a Covered Person can take to enforce his or her rights. For instance, if a request for Plan documents is made to the Plan Administrator and such requested information is not received within 30 days, Participant may file a suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay up to $110 a day until such requested information is received by the requesting Covered Person, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. Additionally, if a claim for benefits is denied or ignored, in whole or in part, and if Participant has exhausted the claims procedures available to Participant under the Plan as described in Section 12, Participant may file suit in federal court.

10.4 Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The individuals who operate the Participant's Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of Participant and other Plan Participants and beneficiaries. No one, including a Member or any other person, may fire a Participant or otherwise discriminate against a Participant in any way to prevent a Participant from obtaining a Plan benefit or exercising a Participant's rights under ERISA.

If it should happen that Plan fiduciaries misuse the Plan's money, or if a Participant is discriminated against for asserting his or her rights, then such Participant may seek assistance from the U.S. Department of Labor, or file suit in federal court. The court will decide who should pay court costs and legal fees. If a Covered Person is successful, the court may order the person sued to pay these costs and

fees. If the Covered Person loses, the court may order such Covered Persons to pay these costs and fees, for example, if the court finds the claim is frivolous.

10.5 Questions

If Participant has any questions about the Plan, Participant should contact the VPC Benefits Consortium. If Participant has any questions about this statement, or about their ERISA rights, or if they need assistance in obtaining documents from the Plan Administrator, Participant should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory, or contact the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20220. Participant may also obtain certain publications about Participant's rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Section 11
Plan Information

11.1 Component Benefit Contracts Control

Benefits under the Anthem Vision Component Benefit Program are provided solely pursuant to contracts between the Consortium and Anthem, as set forth in the Anthem Component Document.

Benefits under the Anthem Blue View Vision Component Benefit Program are provided solely pursuant to contracts between the Consortium and Anthem Blue View Vision, as set forth in the Anthem Blue View Vision Component Document.

Benefits under the Dental Component Benefit Programs are provided solely pursuant to contracts between the Consortium and Delta Dental, as set forth in the Delta Dental Component Document.

Except for Section 3 of this document on eligibility, if the terms of this Wrap-Around Plan Document and Summary Plan Description conflict with the terms of the Component Document, the terms of the Component Document will control, unless superseded by applicable law.

11.2 Compliance with Federal Mandates

To the extent applicable, the Plan will provide benefits in accordance with the requirements of all applicable laws and as described in the Component Documents, including the following:

- Employee Retirement Income Security Act of 1974 (ERISA);
- Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA);
- Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA);
- Health Insurance Portability and Accountability Act of 1996 (HIPAA);
- Americans with Disabilities Act of 1990 (ADA);
- Genetic Information Nondiscrimination Act of 2008 (GINA);
- The Health Information Technology for Economic and Clinical Health Act (HITECH); and
- Affordable Care Act (ACA)

11.3 Verification

The Plan Administrator for the various Component Benefit Programs shall be entitled to require reasonable information to verify any claim or the status of any person as an Employee or Dependent. If the Employee or Dependent does not supply the requested information within the applicable time limits or provide a release for such information, such Employee or Dependent shall not be entitled to benefits under the Plan.

11.4 Limitation of Rights

Nothing appearing in or done pursuant to the Plan shall be held or construed:

- To give any person any legal or equitable right against the Member, any of its employees, or persons connected therewith, except as provided by law; or

- To give any person any legal or equitable right to any assets of the Plan or any related trust, except as expressly provide herein or as provided by law.

11.5 Governing Law

The Plan is intended to be construed, and all rights and duties hereunder are to be governed, in accordance with the laws of the Commonwealth of Virginia, except to the extent such laws are preempted by ERISA or other federal law.

11.6 Severability

If any provision of the Plan is held invalid or unenforceable, its validity or unenforceability shall not affect any other provision of the Plan, and the Plan shall be construed and enforced as if such provision had not been included herein.

11.7 Caption

The captions contained herein are inserted only as a matter of convenience and for reference and in no way define, limit, enlarge or describe the scope or intent of the Plan nor in any way shall affect the Plan or the construction of any provision thereof.

11.8 Federal Tax Disclaimer

To ensure compliance with requirements imposed by the Internal Revenue Service, we inform each Participant that to the extent this communication (including any of the Component Documents) contains advice relating to a Federal tax issue, it is not intended or written to be used, and it may not be used, for the purpose of:

- Avoiding any penalties that may be imposed on the Participant or any other person or entity under the Internal Revenue Code; or
- Promoting, marketing or recommending to another party any transaction or matter addressed herein.

If the Participant is not the original addressee of this communication, the Participant should seek advice from an independent advisor based on the particular circumstances.

Glossary

Capitalized terms used in this Plan Document have the following meanings:

Approved Disability Leave shall mean an approved leave for purposes of Disability for the period of time approved and designated by the Member as a short-term disability leave for the Employee for a period not to exceed one year. For purposes of this Section, the term "Disability" shall mean that the Employee is not able to perform the duties of the Employee's regular occupation with the Member, as determined in the sole discretion of the Plan Administrator.

Approved Leave of Absence shall mean an Approved Leave of Absence for a period not to exceed 12 consecutive months, with the stated intention of returning to full time employment with the Member. For purposes of this document the term Approved Leave of Absence shall not refer to leave under the Family and Medical Leave Act.

Approved Sabbatical shall mean an approved paid sabbatical or fellowship for a period not to exceed 12 consecutive months. Participant must be covered prior to Effective Date of Leave.

Code means the Internal Revenue Code of 1986, as amended.

Component Benefit means the specific benefits contained within a certificate, booklet, summary or other governing document in which an Employee participates.

Component Benefit Program means the program under which the specific Component Benefits are held.

Component Document means a certificate, booklet or summary issued by an insurance company or another governing document prepared by the Plan summarizing the Component Benefit Programs.

Consortium means the Virginia Private Colleges Benefits Consortium, Inc.

Dependent shall mean any person described below who is a:

- Spouse. The legally recognized spouse of a Participant, provided that a spouse that is legally separated or divorced from the Participant shall not be a Dependent, except for purposes of COBRA Continuation Coverage.
- Child. A child up to the end of the Plan Year when such child attains age 26, who is:
  - A natural child;
  - A legally adopted child, which shall be defined as a child adopted or placed for adoption with the Participant or the Participant's spouse. The child's placement for adoption ends upon the termination of the legal obligation;
  - A stepchild;
  - A child of a Participant required to be covered in accordance with applicable requirements of any Qualified Medical Child Support Order as defined by ERISA Section 609; or
  - A child with proof of legal guardianship for whom the Participant or the Participant's spouse is the court-appointed legal guardian.
- Disabled Child. A child, as defined above, regardless of age, who is incapable of self-sustaining employment due to a severe physical or mental condition that is expected to last indefinitely and who is dependent on a Participant or a Participant's Spouse for support and maintenance. If written proof of such incapacity and dependency

satisfactory to the Plan is furnished to and approved by the Plan within thirty-one (31) days after the date the Disabled Child's coverage would otherwise terminate due to attaining age 26, the Disabled Child will remain a Covered Dependent and coverage will continue beyond that date the Disabled Child attains age 26, provided that the child continues to qualify as a Disabled Child and a Dependent. The Plan may require, at reasonable intervals, subsequent proof satisfactory to the Plan. A Disabled Child who terminates his/her coverage under the Plan will not be able to re-enroll unless the Disabled Child qualifies as a Special Enrollee and provides the required documentation to the Plan.

- **Requirements for Initial or Special Enrollment of Disabled Child.** A Disabled Child may be enrolled in the Plan after attaining age 26, due to an initial or special enrollment, provided that within thirty-one (31) days of the date of hire of the Employee or within the 31-day special enrollment period, the following are furnished to and approved by the Plan:
  - Satisfactory written proof that such incapacity and dependency existed as of the date the Disabled Child attained age 26; and
  - Satisfactory written proof that the Disabled Child was covered under a major medical insurance plan (such as coverage through the Marketplace, an individual health insurance plan, or other group health plan coverage) immediately prior to the date of hire of the Employee or special enrollment period and did not experience a break in coverage of more than sixty (60) days.

The Disabled Child will remain a Covered Dependent provided that the child continues to qualify as a Disabled Child and a Dependent. The Plan may require, at reasonable intervals, subsequent proof of incapacity and dependency satisfactory to the Plan.

- Dependent Limitations. In addition to the above limitations, Dependent does not include:
  - The Spouse if on active duty in the Armed Forces of any country, unless such Spouse is considered a TRICARE eligible employee, as defined under 10 U.S.C. § 1086;
  - A grandchild of the Participant or the Participant's Spouse, unless either is named the legal guardian of the child.

For purposes of coverage under this Plan, if both parents are Participants, a Dependent shall only be covered as a Dependent under this Plan by one parent.

Eligible Retiree shall mean each Employee who is a Participant in the Plan during the three month period immediately prior to retirement from a Member, was Actively at Work on the day prior to retirement, meets both a minimum age of 55 years and a minimum service of 10 years of continuous service as an Employee with a Member, and the sum of such Employee's age and years of service is at least 70.

Employee shall mean:

- An Employee regularly scheduled to work at a position for a minimum of 75% of a full time Employee load as defined by the Member **and** shall not be less than 30 hours per week or 1560 hours per year;
- A faculty member teaching a minimum 75% of a full time teaching load, or equivalent, during the academic year with a Member;

  (For purposes of this calculation, Adjunct Faculty will be calculated with (a) 2.25 hours of service per week for each hour of teaching or classroom time, which represents a combination of teaching or classroom time and time performing related tasks such as class preparation and grading of examinations or papers, and, separately, (b) an hour of service per week for each additional hour outside of the classroom the faculty member spends performing duties he or she is required to perform, such as required office hours or required attendance at faculty meetings. The Member colleges may also use an alternate reasonable method that can be considered consistent with the above method, to calculate an Adjunct Faculty's hours of service.)
- An Employee that participates in either a "phased retirement" or "flexible retirement" program as defined by the employing Member institution;
- An Employee on an Approved Leave of Absence;
- An Employee on an Approved Sabbatical; or
- An Employee on an Approved Disability Leave.

The term **Employee** shall not include

- Leased employees;
- Collectively bargained employees, unless an agreement between the Member and the collectively bargained group specifies coverage for such individuals;
- Temporary employees;
- A member of the Member's board of directors, an owner, partner or officer unless engaged in the conduct of the business on a full time basis;
- An independent contractor or consultant who is paid on other than a regular wage or salary by the Member; or
- A student employee that is not paid or who is not entitled to pay or who is engaged in a federal work study program or similar program of a state or a political subdivision of a state.

Group Administrator has the same meaning as Plan Administrator, below.

Member shall mean the independently governed and operated institutions of higher education in the Commonwealth of Virginia who are Members of the Council of Independent Colleges in Virginia, operating as Virginia Private Colleges, and who are approved for membership as set forth in the Articles of Incorporation and Bylaws of the VPC Benefits Consortium. The term Member shall also mean any affiliated foundation or other entity associated with such institutions, and any other entity adopting the Plan with the approval of its governing body and the VPC Benefits Consortium as set forth in its Articles of Association. If a Member merges or is otherwise consolidated with any affiliate, the successor shall,

as to the group of Members covered by the Plan immediately before such merger or consolidation, be the Member as defined hereunder, unless the VPC Benefits Consortium specifies to the contrary. In the case of any other merger or consolidation, the successor shall not be the Member except to the extent that it acts, with the approval of the VPC Benefits Consortium, to adopt the Plan.

Part Time Employee shall mean:

- An Employee regularly scheduled to work at a position for a minimum of 1000 hours per year or equivalent, but less than the required number of hours to meet the definition of an Employee; or
- A faculty member teaching at least 50% of a full teaching load, or equivalent, but less than the required teaching load to meet the definition of an Employee, as determined by the Member Institution.

  (For purposes of this calculation, Adjunct Faculty will be calculated with (a) 2.25 hours of service per week for each hour of teaching or classroom time, which represents a combination of teaching or classroom time and time performing related tasks such as class preparation and grading of examinations or papers, and, separately, (b) an hour of service per week for each additional hour outside of the classroom the faculty member spends performing duties he or she is required to perform, such as required office hours or required attendance at faculty meetings. The Member colleges may also use an alternate reasonable method that can be considered consistent with the above method, to calculate an Adjunct Faculty's hours of service.)

The term Part Time Employee shall not include:

- Leased Employees;
- Collectively bargained Employees, unless an agreement between the Member and the collectively bargained group specifies coverage for such individuals;
- Temporary Employees;
- A member of the Member's board of directors, an owner, partner or officer unless engaged in the conduct of the business on a full time basis;
- An independent contractor or consultant who is paid on other than a regular wage or salary by the Member; or
- A student employee that is not paid or who is not entitled to pay or who is engaged in a federal work study program or similar program of a state or a political subdivision of a state.

A Part Time Employee must properly enroll in the Plan, continuously meet the requirements for eligibility and pay the required contributions on a timely basis, as described in the Enrollment Contributions Section.

Participant means a person who is an Eligible Employee and who is participating in this Plan in accordance with the provisions of Section 3.

Plan means this Virginia Private Colleges Benefits Consortium, Inc. Health and Welfare Benefits Plan

Plan Administrator means the entity identified as the Plan Administrator in Section 2, unless otherwise specified.

Plan Sponsor means the entity identified as the Plan Sponsor in Section 2.

Subscriber has the same meaning as Participant, above.

Appendix A
Component Benefit Programs

The following documents are attached to the Wrap-Around Plan Document and Summary Plan Description and explain the Component Benefit Programs:

Component Document 1: Anthem Blue View Vision Plan

Component Document 2: Delta Dental Plans

- Low Plan - Prevention First
- High Plan - Prevention First
- Low Voluntary Plan - Prevention First
- High Voluntary Plan - Prevention First
- Low Plan - Max Over
- High Plan - Max Over
- EPO Plan

Component Document 3: Employee Assistance Program

Component Document 4: Wellness Plan

Appendix B
Wellness Plan Schedules

The following documents are attached to the Wrap-Around Plan Document and Summary Plan Description and explain the wellness plan designs for the Member Colleges.

Schedule A: Appalachian College of Pharmacy Wellness Program

Schedule B: Appalachian School of Law Wellness Program

Schedule C: Averett University Wellness Program

Schedule D: Bluefield University Wellness Program

Schedule E: Bridgewater College Wellness Program

Schedule F: Council of Independent Colleges in Virginia Wellness Program

Schedule G: Emory & Henry College Wellness Program

Schedule H: Ferrum College Wellness Program

Schedule I: Hampden-Sydney College Wellness Program

Schedule J: Hollins University Wellness Program

Schedule K: University of Lynchburg Wellness Program

Schedule L: Mary Baldwin University Wellness Program

Schedule M: Randolph-Macon College Wellness Program

Schedule N: Roanoke College Wellness Program

Schedule O: Southern Virginia University Wellness Program

Schedule P: Sweet Briar College Wellness Program

Schedule Q: Virginia Union University Wellness Program

Schedule R: Virginia Wesleyan University Wellness Program