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

Wrap-Around
Plan Document and
Summary Plan Description

Amended and Restated Effective January 1, 2023

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, (the "Consortium"). The attached documents include:

- x Anthem Vision Plan Group Policy;
- x UniView Vision / UNICARE Life & Health Insurance Company Certificate of Insurance;
- x Delta Dental Evidence of Coverage for either the (i) Low Plan - Prevention First, (ii) High Plan - Prevention First, (iii) Low Voluntary Plan - Prevention First, (iv) High Voluntary Plan - Prevention First, (v) Low Plan - Max Over, (vi) High Plan - Max over, (vii) EPO Plan; and
- x Wellness Plan Schedules of Coverage

The Consortium is providing this Wrap document to address certain information that may not 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.

Section 1
Introduction

1.1 Introduction

The Virginia Private Colleges Benefits Consortium, Inc. (the "Consortium") is effective January 1, 2023. 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. (the "Virginia Private Colleges Benefits Consortium") to provide Employee Retirement Income Security Act of 1974, as amended ("ERISA") benefits to eligible employees of the Consortium. The Virginia Private Colleges 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 Document

Section 3

PERSON	DEFINITION	WHEN ELIGIBLE
Spouse and Child(ren) of Eligible Retiree		/ (v o] P] o Z š] Œ [• ‰ v v š] • v } š } to the time the Participant becomes an Eligible Retiree, such Dependent may not thereafter become a Covered Person in the Plan unless Dependent is a Special Enrollee; A Dependent spouse acquired by marriage or domestic partner

PERSON	DEFINITION	WHEN ELIGIBLE
Special Enrollee	Later-Acquired Dependent. If a Participant, after initia enrollment, acquires a new eligible Dependent, t Participant may complete, sign and return application to the Plan Administrator within the perio set forth below. If the newly acquired Dependent(s) are enrolled within this period, the effective date of tha ‰ v v š [• } À Œ P] • š Z ( ] Œ • Dependent met the definition of Dependent. Spouse Upon Marriage. A spouse will be considered a eligible Dependent from the date of marriage, provided the spouse is properly enrolled as a Dependent wit 31 days of the date of marriage. Newborn or Adopted Children. Newborn and newly adopted children shall be covered for Injury or Illne from the moment of birth, adoption, or placement	

PERSON	DEFINITION	WHEN ELIGIBLE
Special Enrollee	Loss of eligibility for such other coverage due to divo legal separation, death, termination of employment reduction of hours of employment; Termination of Member contributions; or Reaching the lifetime limit on all benefits under the o] P] o u ‰ o } Ç [• } Œ ‰ v v š For a Disabled Child only, a significant cost increas š Z] • o Z] o [• } À Œ P š Z Œ will constitute a loss of coverage and thus a spe enrollment right for the Disabled Child, provided th the child meets the definition of a Disabled Child a satisfies the requirements for Special Enrollment o Disabled Child, both contained in the Glossary Individuals who lose coverage due to nonpayment of premiums or for cause (e.g. filing fraudulent claims) s not be Special Enrollees hereunder. Coverage f Special Enrollee hereunder shall begin as of the following loss of alternate health coverage, but r more than 31 days prior to the date the enrollment application is received by the Plan Administrator. Employees and Dependents who are eligible but enrolled for coverage when initially eligible may beco a Special Enrollee in two additional circumstances: o d Z u ‰ o } Ç [‰ } v Œ v š [• D]]	

- 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;
- h ‰ } v W Œ š]] ‰ v š [• š Z U v Ç } À Œ ‰ v v š u Ç Œ u 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

x Dependents. A Dependent may elect COBRA Continuation Coverage (at the ‰ v v š [• } Á v Æ ‰ v • ‰ o µ • î 9 u] v] • š Œ š] } v (•] (participation under the Plan would terminate as a result of one of the following qualifying events:

- o Death of a Participant;
- o A reduction in hours of a Participant;
- o Termination of Employment of a Participant, except for a termination due to gross misconduct;
- o Divorce or legal separation from a Participant;
- o 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

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

Notice Procedures: Any notice must be in writing. Oral notice, or notice 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
118 East Main Street
P.O. Box 1005
Bedford, VA 24523
tim@cicv.org

- 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 ‰ Œ } À] K Z o š] } v E } š] U µ •] v P š Z W o v [• o following the procedures specified on the Election Form;
  - Written notice of election must be provided to the Plan Administrator at the address pr } À] } v š Z W o v [• o š] } v & } Œ u X / (u] o U š Z 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 W Œ š] s] D ‰ u [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

W Œ š]] ‰ v š [• P Œ } µ ‰ Z o š Z } À Œ P v • X d Z
Special Enrollment rights at the end of Continuation Coverage if the Participant g
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 K Z } v š] v µ š] } v } À Œ P µ v Œ š Z W o v • Œ • µ o š 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 Continuati12 79212 01 12i>-333<0057016F>7<0102>9<

Period of Absence	Return to Work Requirement

Section 4
Plan Benefits Summary

4.1 Benefits

The Plan provides the Participant and the W Œ š]]‰eligible Dependent

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 Employer with respect to any and all factual matters dealing with the employment and eligibility of any 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 UniView Vision Component Benefit Programs, and fully insured Delta Dental Component Benefit Programs, as this is a power of the insurance carrier;
-

5.5 Power of Delta Dental of Virginia

Selffunded dental benefits are provided under contracts entered into by d into by d int p d nt p d

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

Section 6
Circumstances That May Affect Benefits

6.1 Denial, Recovery or Loss of Benefits

The W Œ š]]‰ benefits (and, except in some cases, in the event of the W Œ š]]‰ death, the benefits for the W Œ š]]‰ eligible spouse and eligible Dependent • • Á] o o • Á Z v µ W Œ š]]‰ participation]‰ v š [• in the Plan terminates. (See Section 3). The W Œ š]]‰ benefits [v 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, pract

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, 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 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 ‰ Œ • } v [• Œ] P Z š š } v ( ] š • (} Œ o] u •] v µ Œ Œ ‰ Œ] } 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 } v • } Œ š] 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 4(em)7(b)-4(er)] TJ ET Q q 0.00000

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[• (} Œ u X

Anthem will decide the W Œ š]] claim within a [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

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 Á Œ] š š v o] u } v o š v š o [• (} Œ u X

o š v š o Á] o o] š Z W Œ š]] ‰ v š [• o] u] v } Œ v Á] š Z

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 Œ P Œ] v P o š v š o [• o] u • ‰ Œ } µ Œ • X

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.
118 Main Street
P.O. Box 1005
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 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 • Œ] ‰ š] } v } (š Z W o v [• ‰ ‰ o ‰ Œ } µ Œ • v š Z š] u 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

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.
118 Main Street
P.O. Box 1005
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

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. 2022ì X W Œš]]‰ vš u Ç o•} } š]v Œš]v ‰µ o] š]}v• }µš W Œ 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 UniView Vision Component Benefit Program are provided solely pursuant to contracts between the Consortium and UNICARE Life & Health Insurance Company.

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

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 v i µ v š & µ o š Ç [• Z } µ Œ • } (• Œ À] X •
- An Employee š Z š ‰ Œ š]] ‰ š •] v] š Z Œ ^ ‰ Z • Œ š] Œ u v š _ 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 D u Œ [• } Œ } ( ] Œ š } Œ • U v } Á v Œ U ‰ Œ š v engaged in the conduct of the business on a full time basis;
- An independent contractor or consul n BT /-me1l3(or)6( )] TJ ET 1003>] TJ ET Q q 0.0000

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 Vision Plan Group Policy

Component Document 2: UniView Vision / UNICARE Life & Health Insurance Company Certificate of Insurance

Component Document 3: Delta Dental Evidence of Coverage for the:

- 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 4: Wellness Plan Schedules of Coverage

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