

Council of Independent Colleges in Virginia Benefits Consortium, Inc. Health and Welfare Plan

Wrap-Around Plan Document and Summary Plan Description

Restatement Effective January 1, 2012

This document, together with the Evidence of Coverage issued by the Council of Independent Colleges of Virginia Benefits Consortium, Inc., Anthem Blue Cross and Blue Shield or Delta Dental of Virginia, and attached hereto, constitutes the Plan Document and Summary Plan Description for each of the Component Benefit Programs listed specifically herein offered by the Council of Independent Colleges of Virginia Benefits Consortium, Inc. If the Evidence of Coverage is not attached, then this Plan Document and Summary Plan Description is not complete and the Participant should contact the Consortium for a complete copy.

The Council of Independent Colleges of Virginia Benefits Consortium, Inc. has amended this Wrap-Around Plan Document and Summary Plan Description (SPD) in good faith to comply with the requirements of a recent federal law entitled the Patient Protection and Affordable Care Act (PPACA). However, the regulations and other guidance under PPACA are interim, or in some cases, not yet promulgated. The Council of Independent Colleges of Virginia Benefits Consortium, Inc. reserves the right to amend this Plan Document and SPD, retroactively if deemed necessary, to comply with PPACA and the regulations and other guidance promulgated thereunder.



**Employee Welfare Benefits Plan for the
Employees of the Council of Independent Colleges in Virginia**

Wrap-Around Plan Document and Summary Plan Description

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Section 1 Introduction

1.1 Introduction

The Council of Independent Colleges in Virginia Benefits Consortium, Inc. (the Consortium) maintains the following Employee Welfare Benefits Plan for the Employees of the Council of Independent Colleges in Virginia (the Plan) for the exclusive benefit of the Council of Independent Colleges in Virginia (CICV) eligible employees and their eligible spouses and Dependents. Capitalized terms used in this Plan that are not otherwise defined shall have the meanings set forth in the Glossary.

Each of the Component Benefit Programs is summarized in a certificate, booklet or summary issued by Anthem Blue Cross and Blue Shield (Anthem) or Delta Dental of Virginia (Delta Dental), a summary plan description, or another governing document prepared by the Consortium. A copy of each certificate, booklet, summary or other document governing your benefit program is attached hereto.

The Consortium is providing this Wrap-Around Plan Document and Summary Plan Description (SPD) to give Participants an overview of the Plan to address certain information that may not be addressed in the Component Documents.

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

Health Plan Program Options:

- Anthem Vision Plan
- Anthem HealthKeepers Plan 9
- Anthem HealthKeepers Plan 10
- Anthem HealthKeepers Plan 11

Dental Plan Program 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

Read Both Documents. Each Participant must read this Wrap-Around Plan Document and Summary Plan Description along with the respective Component Document for each Component Benefit Program under which the Participant is covered to fully understand the benefits.

1.2 Purpose

The title of this document is Council of Independent Colleges in Virginia Benefits Consortium, Inc. Health and Welfare Plan Wrap-Around Plan Document and Summary Plan Description. The Company is

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

Read Both 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.

This document and the Component Documents constitute the Plan Document and Summary Plan Description (SPD) required by the Employee Retirement Income Security Act of 1974 (ERISA), for the Component Benefit Programs to which ERISA applies. This SPD 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. Except with regard to the Eligibility and Participation Requirements described in Section 3, if the terms of this Wrap-Around Plan Document and SPD conflict with the terms of the Component Documents, then the terms of the Component Documents will control, rather than the terms of this Wrap-Around Plan Document and SPD, unless otherwise required by law. However, this document is the controlling document for Eligibility and Participation Requirements which are described in Section 3, herein.

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.

1.3 Grandfathered Health Plan under the Patient Protection and Affordable Care Act

The Consortium believes that HealthKeepers Plan 9 and HealthKeepers Plan 10 are “grandfathered health plans” under the Patient Protection and Affordable Care Act (“PPACA”). As permitted by PPACA, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the Plan may not include certain consumer protections of PPACA that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in PPACA, for example, the elimination of lifetime limits with respect to essential health benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Tim Klopfenstein, Executive Director, Council of Independent Colleges in Virginia Benefits Consortium, Inc., 118 East Main Street, PO Box 1005, Bedford, Virginia 24523. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Section 2
General Plan Identifying Information

Name of the Plan	Council of Independent Colleges in Virginia Benefits Consortium, Inc. Health and Welfare Plan
Type of Plan	Health and Welfare Plan
Address of Plan	Council of Independent Colleges in Virginia Benefits Consortium, Inc. P.O. Box 1005 Bedford, VA 24523 (540) 586-1803
Plan Administrator and Agent for Service of Legal Process	Tim Klopfenstein Council of Independent Colleges in Virginia Benefits Consortium, Inc. P.O. Box 1005 Bedford, VA 24523 (540) 586-1803
Plan Numbers	501— Anthem Vision Plan 502— Anthem HealthKeepers Plan 9 502— Anthem HealthKeepers Plan 10 502— Anthem HealthKeepers Plan 11 101—Delta Dental Low Plan - Prevention First 101—Delta Dental High Plan - Prevention First 101—Delta Dental Low Voluntary Plan - Prevention First 101—Delta Dental High Voluntary Plan - Prevention First 101—Delta Dental Low Plan - MaxOver 101—Delta Dental High Plan - MaxOver
Plan Sponsor and its IRS Employer Identification Number	Council of Independent Colleges in Virginia Benefits Consortium, Inc. EIN: 27-1367957
Plan Effective Dates	January 1, 2010: Anthem Vision Plan January 1, 2010: Anthem HealthKeepers Plan 9 January 1, 2010: Anthem HealthKeepers Plan 10 January 1, 2012: Anthem HealthKeepers Plan 11 January 1, 2012: Delta Dental Low Plan - Prevention First January 1, 2012: Delta Dental High Plan - Prevention First January 1, 2012: Delta Dental Low Voluntary Plan - Prevention First January 1, 2012: Delta Dental High Voluntary Plan - Prevention First January 1, 2012: Delta Dental Low Plan - MaxOver January 1, 2012: Delta Dental High Plan - MaxOver

Plan Year End	December 31
Claims Administrator for the Health Plan Component Benefit Programs	<p>Anthem Blue Cross and Blue Shield 2015 Staples Mill Road Richmond, VA 23230</p> <p>HealthKeepers, Inc. P.O. Box 26623 Richmond, VA 23261-6623</p>
Claims Administrator for the Dental Component Benefit Programs	Delta Dental of Virginia 4818 Starkey Road Roanoke, VA 24018 (800) 237-6060
Named Fiduciary	The Board of Directors of the Council of Independent Colleges in Virginia Benefits Consortium, Inc.
Funding Medium and Type of Plan Administration	<p>The vision Component Benefit Program under the Plan is fully insured under a contract between the Consortium and Anthem. Anthem is responsible for administering the vision plan and for making claim payments.</p> <p>The health plan Component Benefit Programs under the Plan are self-funded under applicable contracts between the Consortium and Anthem. Anthem is responsible for paying claims and administering the health plan program options. The Consortium is responsible to fund the claim payments.</p> <p>The dental Component Benefit Programs under the Plan are self-funded under applicable contracts between the Consortium and Delta Dental. Delta Dental is responsible for paying claims and administering the dental plan program options. The Consortium is responsible to fund the claim payments.</p> <p>Plan contributions are paid in whole or in part by the Employers out of their general assets and in whole or in part by Employees' pre-tax payroll deductions. The Plan Administrator for the various Component Benefit Programs will provide a schedule of the applicable premiums during the initial and subsequent open enrollment periods and upon request for each of the Component Benefit Programs, as applicable.</p> <p>To further protect the self-funded Component Benefit Programs from catastrophic losses, the Consortium has purchased excess liability insurance in the form of a stop-loss insurance policy.</p>

Section 3
Eligibility and Participation Requirements

The following individuals are eligible for coverage:

PERSON	DEFINITION	WHEN ELIGIBLE
Employee	<p>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 1360 hours per year.</p> <p>A faculty member under an academic year contract for a minimum 75% of a full time teaching load, or equivalent, during the academic year with a Member;</p> <p>An employee that participates in either a “phased retirement” or “flexible retirement” program as defined by the employing Member institution;</p> <p>An employee on an Approved Leave of Absence;</p> <p>An employee on an Approved Sabbatical; or</p> <p>An employee on an Approved Disability Leave.</p>	<p>The Employee meets the requirements for eligibility and properly enrolls in the Plan; and</p> <p>Makes any 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.</p>
Part-Time Employee	<p>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</p> <p>A faculty member under an academic year contract 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.</p>	<p>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.</p>

PERSON	DEFINITION	WHEN ELIGIBLE
Eligible Retiree	An Employee who is a Participant in the Plan during the 3 month period immediately prior to retirement from a Member, was Actively at Work on the day prior to retirement, and meets both a minimum age of 55 years and has 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.	If a Participant becomes an Eligible Retiree, such Participant may continue as a Covered Person subject to any limitations contained herein; 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.
Medicare Eligible	Not Eligible.	Not Eligible.
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.	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.

PERSON	DEFINITION	WHEN ELIGIBLE
Dependent	<p>Child. A child up to the end of the Plan Year when such child attains age 26, who is:</p> <ul style="list-style-type: none"> ○ 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; ○ A child with proof of legal guardianship for whom the Participant or the Participant's spouse is the court-appointed legal guardian. <p>Such child shall be deemed a Dependent until the date in which he or she, at the end of the calendar year, reaches the attained age of 26; becomes a Participant; serves on extended active duty in the Armed Forces; or is no longer continuously incapable of self-support because of a disability, or is no longer dependent on the Participant for support and maintenance. The Participant must provide proof of such Disability within the 31 day period after the date the child would otherwise lose Dependent status.</p>	<p>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.</p> <p>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 in the Special Enrollee section. 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.</p>

PERSON	DEFINITION	WHEN ELIGIBLE
<p style="text-align: center;">Spouse and Dependents of Eligible Retiree</p>		<p>An Eligible Retiree may participate in the Plan as of the date of retirement from a Member, subject to the following and any other applicable terms and conditions set forth in this Plan Document:</p> <p>If a Participant becomes an Eligible Retiree, such Eligible Retiree may continue as a Covered Person until the date the Eligible Retiree becomes eligible for Medicare;</p> <p>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's may not thereafter become a Covered Person in the Plan unless the Dependent is a Special Enrollee (see Dependent portion of this Section 3) for more information;</p> <p>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 not be a Special Enrollee (see Dependent portion of this Section 3 for more information);</p> <p>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;</p>

		<p>Upon an Eligible Retiree's death or termination of participation due to eligibility for Medicare, any Covered Spouse and Covered Dependent may remain a Covered Dependent until the earlier of the date of such Covered Spouse's death or termination of participation due to Medicare eligibility. If the Covered Spouse terminates participation due to death or eligibility for Medicare, or if no spouse is covered at the time of the Eligible Retiree's termination of participation, any Covered Dependent may remain a Dependent for the applicable period of Continuation of Coverage as set forth under COBRA.</p> <p>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</p> <p>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.</p>
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PERSON	DEFINITION	WHEN ELIGIBLE
Special Enrollee	<p>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.</p> <p>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 60 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.</p> <p>Siblings and Other Dependents Upon Birth or Adoption. If a Participant's other Dependents are not Covered Persons, the Participant may enroll these other Dependents along with a newborn or adopted child as described in the subsection above. If the Participant enrolls the other Dependents within 60</p>	<p>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.</p>

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 due to any of the following:

Exhaustion of COBRA Continuation Coverage;

Loss of eligibility for such other coverage due to divorce, legal separation, death, termination of employment or reduction of hours of employment;

A Significant reduction in benefits, or a significant increase in premium, for such other coverage; or

Termination of employer contributions.

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 first day of the calendar month following the enrollment request. However, in the event that the Special Enrollee loses coverage on other than the last day of the month, the Effective

	<p>Date of the Special Enrollee's coverage shall be the later of the first day after the other coverage ends, or the first day after the date the enrollment request is received by the Plan Administrator.</p> <p>Employees and Dependents who are eligible but not enrolled for coverage when initially eligible may become a Special Enrollee in two additional circumstances:</p> <ul style="list-style-type: none">○ 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.	
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PERSON	DEFINITION	WHEN ELIGIBLE
Court Order	<p>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.</p>	

3.1 Change in Status

If the cost of benefits increases or decreases during a benefit period the Plan Administrator may automatically change the contribution amount.

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.

Participants may make a coverage election change if the Plan covering a spouse or Dependent:

- Incurs a change such as adding or deleting a benefit option;
- Allows election changes due to Special Enrollment, Change in Status, Court Order or Medicare Eligibility/Entitlement; or
- Allows election changes due to that Plan's annual Open Enrollment which does not coincide with this Plan's.

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).

If the Participant's coverage under this Plan ends, or a Dependent reaches the maximum age limit, the Plan will issue a Certificate of Creditable Coverage. The Plan will also issue a Certificate of Creditable Coverage upon request, if requested within 24 months after coverage ends.

All questions about Creditable Coverage, as well as requests for Creditable Coverage Certificates should be directed to Member Services.

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

If vision, health, prescription or dental coverage for the Participant, the Participant's eligible spouse, or eligible Dependents ceases because of certain "qualifying events" (e.g., termination of employment, reduction in hours, divorce, death, or a child's ceasing to meet the Plan's definition of Dependent) specified in a federal law called COBRA, then the Participant, the Participant's eligible spouse, or eligible Dependents may have the right to purchase continuing coverage under the Plan for a limited period of time. For more information, see the "COBRA" summary, a copy of which has been previously provided.

3.5 USERRA Continuation Coverage

Participant's 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 CICV Benefits Consortium. If any of the provisions concerning USERRA within this document conflict with the USERRA federal law, USERRA federal law shall govern.

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 are 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.

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 Company.

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; and
- Any preexisting condition exclusion shall not 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 SPD.

4.2 Newborns and Mothers Health Protection Act (NMHPA)

Under federal law, group health plans and health insurance issuers offering group health insurance, generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother of the newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the Plan may pay for a shorter stay if the attending Physician (e.g., the Participant's Physician, nurse or a physician assistant), after consultation with the mother, discharges the mother or newborn earlier. Also, under federal law, plans may not set the level of benefits for out of pocket costs so that any later portion of the 48 hour (or 96 hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a Plan may not, under federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours).

4.3 Reconstructive Surgery Following Mastectomy

On January 1, 1999, a new federal law, the Women's Health and Cancer Rights Act of 1998, (WHCRA) became effective for the Plan. The law requires group health plans to provide coverage for breast reconstruction, prostheses and complications following a mastectomy. The law mandates that a Participant or Dependent who is receiving benefits for a mastectomy and who elects breast reconstruction in connection with the mastectomy, will also receive coverage for:

- All stages of reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of all stages of mastectomies, including lymphedemas.

This coverage will be provided in a manner determined in consultation with the attending Physician and the patient, and will be subject to the same annual deductible, coinsurance and/or copayment provisions otherwise applicable under the Plan. If a Participant has any questions about coverages for mastectomies and post-operative reconstructive surgery, please contact the Plan Administrator.

4.4 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 4.4 may not be applicable due to PPACA'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 Employer 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;
- 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.

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

Vision and health benefits are provided under contracts entered into by the Consortium and Anthem. Anthem is responsible for (a) prescribing claims procedures to be followed and claims forms to be provided to Participants and (b) payment of all benefits under the vision and health plan Component Benefit Programs. The Consortium is responsible for determining eligibility under the individual vision and health plan Component Benefit Programs.

5.4 Power of Delta Dental of Virginia

Dental benefits are provided under contracts entered into by the Consortium and Delta Dental. Delta Dental is responsible for (a) prescribing claims procedures to be followed and claims forms to be provided to Participants and (b) payment of all benefits under the dental Component Benefit Programs. The Consortium is responsible for determining eligibility under the individual dental Component Benefit Programs.

5.5 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.

5.6 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 expressly provided in this Wrap-Around Plan Document and SPD or the Component Documents.

5.7 Questions

Questions regarding eligibility for, or the amount of, any benefits payable under a Component Benefit Program, should be directed to the Plan Administrator as provided in the Component Document.

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; or
- 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. 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 Employer 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 Employer 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.

Section 8
No Contract of Employment

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

Section 9 Claims Procedures

9.1 Claims

For purposes of determining the amount of, and entitlement to, benefits of a Component Benefit Program provided under a contract, the Consortium is the Named Fiduciary (as specified in Section 2) under the Plan. The Named Fiduciary has the full power to interpret and apply the terms of the Plan to the benefits provided under the applicable contract.

9.2 Anthem Claims Procedure

To obtain benefits from Anthem, the Participant must follow the claims procedures under the applicable contract, 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 any applicable provisions of ERISA. 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 PPACA. 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 or appeal.

9.3 Delta Dental Claims Procedure

To obtain benefits from Delta Dental, the Participant must follow the claims procedures under the applicable contract, 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 PPACA. 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.

9.4 Complaints and Appeals to Plan Administrator

The health and dental component documents provide for a complaint and appeals process. In addition to sending a complaint to Anthem and Delta Dental, Participants may also send written complaints to the Plan Administrator. Furthermore, in addition to filing an internal appeal with Anthem and Delta Dental, as set forth in the component documents, Participants may also file a written internal appeal, as described in the component documents, with the Plan Administrator. All requirements set forth in the component documents 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 can be sent to the Plan Administrator at the following address:

Tim Klopfenstein
CICV Benefits Consortium, Inc.
118 Main St.
P.O. Box 1005
Bedford, VA 24523

9.5 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.

9.6 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.

9.7 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 ERISA. ERISA provides that all plan Participants shall be entitled to the following rights:

10.2 Receive Information About Participant's Plan and Benefits

The Participant may examine without charge at the Consortium'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.

The Participant may obtain, upon written request to the Consortium, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated SPD. The Plan Administrator may make a reasonable charge for the copies.

The 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 Consortium, as Plan Administrator, is required by law to furnish each Participant with a copy of this summary annual report.

10.3 COBRA and HIPAA

The Participant may continue health care coverage for themselves, spouse, or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. The Participant, spouse, or Dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing Participant's COBRA continuation coverage rights.

The Participant should be provided with a certificate of creditable coverage, free of charge, from Anthem and/or Delta Dental when Participant loses coverage under the Plan, when the Participant becomes entitled to elect COBRA continuation coverage, when the Participant's COBRA continuation coverage ceases, if the Participant requests it before losing coverage, or if the Participant requests it up to 24 months after losing coverage. Without evidence of creditable coverage, the Participant may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after his or her enrollment date. Preexisting conditions shall not apply to a child under age 19, as more specifically set forth in the Component Benefit Programs.

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 benefits plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Participant and other Plan Participants and beneficiaries. No one, including Employer or any other person, may fire the Participant or otherwise discriminate against the Participant in any way to prevent the Participant from obtaining a Plan benefit or exercising his or her rights under ERISA.

10.5 Enforce Participant's Rights

If the Participant's claim for a welfare benefit is denied or ignored, in whole or in part, the Participant has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps that the Participant can take to enforce the above rights. For instance, if Participant requests a copy of Plan documents or the latest annual report (Form 5500), if any, from the Plan and do not receive them within 30 days, the Participant may file suit in a federal court. In such a case, the court may require the Employer, as Plan Administrator to provide the materials and pay the Participant up to \$110 per day until the Participant receives the materials unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If the Participant has a claim for benefits, which is denied or ignored in whole or in part, and if the Participant has exhausted the claims procedures available to the Participant under the Plan, then the Participant may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if the Participant is discriminated against for asserting their rights, the Participant may seek assistance from the U.S. Department of Labor, or the Participant may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the Participant is successful, the court may order the person the Participant sued to pay these costs and fees, if the Participant loses, the court may order the Participant to pay these costs and fees.

10.6 Evidence in Litigation

If the Participant files suit in a state or federal court, only evidence which was previously submitted during the claims or appeals process may be submitted. No new evidence may be submitted in court.

10.7 Assistance with Questions

If the Participant has any questions about the Plan, the Participant can contact Tim Klopfenstein at (540) 586-1803 or by mail at Council of Independent Colleges in Virginia Benefits Consortium, Inc., P.O. Box 1005, Bedford, VA 24523. If the Participant has any questions about this statement or about Participant's rights under ERISA, or if assistance is needed in obtaining documents from the Plan Administrator of the various Component Benefit Programs, the Participant should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor (listed in the Participant's 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. 20210. The Participant may also obtain certain publications about the 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 vision and health plan Component Benefit Programs are provided solely pursuant to contracts between the Consortium and Anthem, as set forth in the Component Document for such Component Benefit Program.

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

If the terms of this Wrap-Around Plan Document 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);
- Newborns' and Mothers' Health Protection Act of 1996 (NMHPA);
- Women's Health and Cancer Rights Act of 1998 (WHCRA);
- Genetic Information Nondiscrimination Act of 2008 (GINA);
- The Health Information Technology for Economic and Clinical Health Act (HITECH);
- Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA); and
- Patient Protection and Affordable Care Act (PPACA)

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 Employer, 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 (a) avoiding any penalties that may be imposed on the Participant or any other person or entity under the Internal Revenue Code or (b) 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.

IN WITNESS WHEREOF, the Council of Independent Colleges in Virginia Benefits Consortium, Inc. has caused this Wrap-Around Plan Document and Summary Plan Description to be executed, effective January 1, 2012.

Glossary

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

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

Component Benefit means the specific benefits contained within the Evidence of Coverage booklet 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 Anthem or Delta Dental.

Consortium means the Council of Independent Colleges of Virginia Benefits Consortium, Inc.

Dependent shall mean any person described below who is:

- **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.** Coverage will be extended for a child after the end of the Plan Year in which such child attains age 26, and who meet the eligibility requirements, are mentally or physically incapable of earning a living and who are chiefly Dependent upon the Participant or the Participant's spouse for Support and maintenance, provided that: the onset of such incapacity occurred prior to the end of the Plan Year in which such child attained age 26, proof of such incapacity is furnished to the Plan by the Participant upon enrollment of the Dependent or at the onset of the Dependent child's incapacity prior to the end of the Plan Year in which such child attains age 26 and from time to time as requested by the Plan.

This extension will continue until the earliest of:

- The date he or she ceases to be eligible for reasons other than age;
- The date he or she ceases to be incapacitated;
- The 31st day after failure to provide additional proof of his or her incapacity following a request from the Plan for such proof; or

- The date the Plan is terminated or discontinued for any or no reason , with or without notice.

In addition to the above limitations, Dependent does not include:

- The spouse or child if on active duty in the Armed Forces of any country;
- 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 an Employer, 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 an Employer, 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 1360 hours per year;
- A faculty member under an academic year contract for a minimum 75% of a full time teaching load, or equivalent, during the academic year with a Member;
- 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 employees 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;
- A student employee;
- Adjunct faculty; or
- Part time lecturer.

Employer means a Member of the Council of Independent Colleges of Virginia.

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, and who are approved for membership as set forth in the Articles of Incorporation and Bylaws. 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 CICV 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 CICV 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 CICV Benefits Consortium, to adopt the Plan.

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

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 under an academic year contract 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.

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;
- A student Employee;
- Adjunct faculty; or
- Part time lecturer.

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.

Plan means this Council of Independent Colleges in Virginia Welfare Benefits Plan.

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

Subscriber has the same meaning as Participant, above.