

HOOD COLLEGE HEALTH AND WELFARE BENEFITS PLAN

SUMMARY OF MATERIAL MODIFICATIONS

TO: Participants in the Hood College Health and Welfare Benefits Plan
FROM: Plan Administrator
DATE: December 2010
RE: Summary of Material Modifications

This Summary of Material Modifications ("SMM") amends certain provisions of your Summary Plan Description ("SPD") for the Hood College Health and Welfare Benefits Plan (the "Plan"). Please review this SMM carefully to familiarize yourself with the changes, and please attach this SMM to the front of your SPD. These changes are effective July 1, 2010, except as otherwise indicated below.

1. Effective June 1, 2010, the Section of your SPD titled "Dependent Eligibility" is revised by replacing the paragraphs that precede the definitions by the following:

For purposes of all benefits available under the Plan to dependents, your *spouse* or *domestic partner* is considered an eligible dependent (*spouse*, *domestic partner* and other *italicized* terms used in the section are defined below).

The Plan's dependent eligibility requirements for children of eligible employees have been changed to comply with federal health care reform requirements. Your *child* is eligible for coverage offered to dependents under the Plan based on the following rules:

- Medical Coverage for Children under Age 26. For purposes of medical benefits offered under the Plan, your eligible dependents include your *child* who is under age 26, regardless of the child's marital status, tax dependent status or student status and regardless of whether the child lives with you.
- Coverage for Children with Disabilities. For purposes of all coverage offered to dependents under the Plan, your unmarried *child* who is your *dependent for federal income tax purposes* for the applicable tax year is an eligible dependent if he or she is physically or mentally incapable of self-support, but only if the physical or mental incapacity commenced before the child reached age 25 (or before age 26 for purposes of medical coverage). (For purposes of medical coverage, a child under age 26 normally will be eligible under the first rule above, so this rule generally matters only for coverage other than medical coverage or if your child is over age 26.)
- For purposes of benefits other than medical coverage, your unmarried *child* who is your *dependent for federal income tax purposes* for the applicable tax year is your eligible dependent if he or she is under age 25.

2. Effective July 1, 2010, the following is added to the end of the Section of your SPD titled "Termination of Coverage":

Coverage under the Plan may also be terminated for any individual (or any employee or

dependent covered under the same family coverage as that individual) who engages in fraud or who makes a material misrepresentation of fact relating to the coverage. For example, if someone knowingly files a claim for benefits for medical services or supplies that were not actually provided, that would be considered fraud and would lead to termination of coverage. An example of a material misrepresentation of fact would include an employee signing an enrollment form indicating that an individual is eligible for coverage as a dependent at a time when the employee knows that the individual does not qualify as the employee's dependent. In such cases, coverage may be terminated retroactively, if appropriate, based on the details.

For medical coverage that is subject to the Affordable Care Act, effective July 1, 2011, a retroactive termination of coverage may occur in only two situations. First, as indicated above, if you fail to make any required contribution toward the cost of coverage by the applicable deadline, coverage would be terminated retroactive to the end of the period for which the required contributions were made. A retroactive termination also may occur if you or your dependent (or any person seeking coverage for you or your dependent) engages in fraud with respect to the Plan, or makes an intentional misrepresentation of a material fact. In that case, the Plan will provide at least 30 days advance written notice to any person who will be affected by the retroactive termination of coverage.

3. The following is added to the “Special Enrollment Periods for Employees and Dependents” section of your SPD:

Also, because of the new dependent coverage requirements for children under age 26 under the health care reform act, beginning on or before July 1, 2011, the Plan will provide a one-time special enrollment opportunity for any eligible child who is under age 26 on that date and who was previously excluded from the Plan’s medical/prescription drug coverage or whose coverage was dropped or who was previously ineligible for the Plan’s medical/prescription drug coverage because the child failed to satisfy the dependent eligibility requirements that applied under the Plan before this health care reform provision became applicable. This special enrollment period will last at least 30 days. Any employee who wishes to enroll such a child (and the employee if not already enrolled) may elect coverage for the child and the employee (if applicable) under any of the medical/prescription drug options available to the employee at that time. If elected, the coverage will be effective no later than July 1, 2011.

Finally, if you or an eligible dependent were previously excluded from any medical coverage under the Plan because you (or your eligible dependent) reached a lifetime limit on benefits that applied under that medical coverage, you and/or the affected eligible dependent may be eligible for a special enrollment opportunity in connection with the elimination of the Plan’s lifetime limit on medical benefits. This special enrollment period will last for a period of 30 days and will begin no later than July 1, 2011. If elected, the coverage will be effective no later than July 1, 2011.

4. Effective July 1, 2011, the following new section is added to your SPD:

Medical Coverage and Health Care Reform

The Plan offers four medical/prescription drug coverage options. The Employer believes that one of those options, the Plan’s High Deductible Health Plan/Health Savings Account option (the “HSA Plan”) is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, 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 your plan may not include certain consumer protections of the

Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on 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 the Plan Administrator at the address and phone number shown below. You may also contact the Employee Benefits Security Administration (EBSA), United States Department of Labor (DOL) by phone at 1-866-444-3272 or online at www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Note that the Plan's other medical coverage options besides the HSA Plan (the BlueChoice HMO, the BlueChoice Opt Out Plus Open Access and the Blue Preferred PPO plans) are not considered grandfathered health plans.

5. Effective July 1, 2011, for any medical coverage offered under the Plan, the Plan will not impose any preexisting condition exclusion on any person who is under age 19.

6. Effective January 1, 2011, otherwise reimbursable over-the-counter medicine (other than insulin) will not be eligible for reimbursement from your Health Care Flexible Spending Account unless you have a prescription.

7. Effective March 29, 2010, the Health Care Flexible Spending Account Section of your SPD is amended to replace the definition of "dependent" with the following:

For purposes of Health FSA reimbursements, "dependent" includes anyone who is your dependent for federal income tax purposes (using the same definition of "*dependent for federal income tax purposes*" that applies to medical/prescription drug benefits under the Dependent Eligibility section of this Summary. For expenses incurred after March 29, 2010, "Dependent" also includes your biological, adopted, step-child or eligible foster child if the child will be younger than 27 on the last day of the calendar year.

8. Effective July 1, 2011, the following new Section is added to your SPD:

Patient Protection Statement About Provider Designation (Applies to BlueChoice HMO)

For purposes of the BlueChoice HMO medical plan option, you (or your covered family members) generally are required to designate a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, the Plan designates one for you. For your covered child, you may designate a pediatrician as the primary care provider.

For information on how to select a primary care provider under the BlueChoice HMO, and for a list of the participating primary care providers, contact the insurer for your coverage at the address provided in this Summary.

For purposes of the Plan's BlueChoice HMO medical coverage option, you (or your covered family member) do not need prior authorization from the Plan or from any other person (including a

primary care provider) to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the insurer for your coverage at the address provided in your SPD.

9. Effective July 1, 2011, the Claims Procedures section of your SPD is replaced in its entirety as follows:

Claims Procedures

The following summary of the Plan's claims procedures is intended to reflect the Department of Labor's claims procedures regulations and for certain medical benefits, the applicable requirements of regulations issued under the federal health care reform law and should be interpreted accordingly. If there is any conflict between this summary and those regulations, the regulations will control. In addition, any changes in applicable law will apply to the Plan automatically effective on the date of those changes.

For any insured benefits, the insurer's claims procedures will apply instead of the claims procedures described in this Summary. The insurer's claims procedures are described in the benefits booklet that describes the specific benefit. If you have questions about claims procedures for any insured benefit, you should contact the insurer directly.

Note that, for any claim for a benefit under the Plan that is not subject to ERISA, the Department of Labor's regulations do not apply. For those claims, including claims for dependent care flexible spending account benefits, the claims procedures described in this section that apply for benefits other than health or disability benefits will apply, but any requirement that the Plan Administrator (or an insurer) provide notice to a claimant about any right under ERISA will not apply to such a claim. This claims procedure section does not apply to any Health Savings Account. Procedures for requesting and receiving payments from your Health Savings Account are established by the financial institution that administers the HSA.

To receive Plan benefits, you must follow the procedures established by the Plan Administrator and/or the insurance company which has the responsibility for making the particular benefit payments to you. If you do not follow the Plan's claims procedures, you may lose your right to a benefit under the Plan, including any right you may have to file a legal action for benefits.

Initial Claims

Initial claims for Plan benefits are made to the Plan Administrator or, if the benefit is insured, to the Insurer providing that benefit. The remainder of these procedures uses the term "Reviewer" to refer to either the Plan Administrator or the Insurer, whichever is responsible for reviewing a claim. All claims must be submitted, in writing (except to the extent that oral claims are permitted for urgent care claims, as described below), to the Reviewer. The Reviewer will review the claim itself or appoint an individual or an entity to review the claim, following the following procedures. (For purposes of these procedures, "health benefits" or "health claims" refers to benefits or claims involving medical, dental, vision or health care flexible spending account coverage.)

(a) Non-Health and Non-Disability Benefit Claims. For any claim that is not a health claim or a disability claim, the Claimant will be notified within 90 days after the claim is filed whether the claim is allowed or denied, unless the Claimant receives written notice from the Reviewer before the end of the 90-day period stating that circumstances require an extension of the time for decision, in which case the extension will not extend beyond 180 days after the day the claim is filed.

(b) Health Benefit Claims.

(i) Urgent Care Claims. If the Claimant's claim is for urgent care health benefits, the Reviewer will notify the Claimant of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the Plan receives the claim, unless the Claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. (For claims for benefits under a plan that is not a grandfathered plan under the Affordable Care Act, the 72 hour period in the preceding sentence is reduced to 24 hours.) In cases where the Claimant fails to provide sufficient information to decide the claim, the Reviewer will notify the Claimant as soon as possible, but not later than 24 hours after the Plan receives the claim, of the specific information necessary to complete the claim. The notification may be oral unless written notification is requested by the Claimant. The Claimant will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Reviewer will notify the Claimant of the Plan's determination as soon as possible, but in no case later than 48 hours after the earlier of (1) the Plan's receipt of the specified additional information or (2) the end of the period afforded the Claimant to provide the specified additional information.

A health benefits claim is considered an urgent care claim if applying the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function or, in the opinion of a physician with knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that could not be adequately managed without the care or treatment which is the subject of the claim.

(ii) Concurrent Care Claims. If the Plan has approved an ongoing course of health care treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of the previously approved course of treatment (other than by Plan amendment or termination) before the approved time period or number of treatments constitutes an adverse determination. In such a case, the Reviewer will notify the Claimant of the adverse determination at a time sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain a determination on review of that adverse determination before reduction or termination of the benefit.

Any request by a Claimant to extend a previously approved course of urgent care treatment beyond the approved period of time or number of treatments shall be decided as soon as possible, taking into account the medical exigencies, and the Reviewer will notify the Claimant of the benefit determination, whether adverse or not, within 24 hours after the Plan receives the claim, provided that any such claim is made to the Plan at least 24 hours before the expiration of the prescribed period of time or number of treatments.

(iii) Other Health Benefit Claims. For any health benefit claim not described above:

a. For any pre-service health benefit claim, the Reviewer will notify the Claimant of the Plan's benefit determination (whether adverse or not) within a reasonable period of time

appropriate to the medical circumstances, but not later than 15 days after the Plan receives the claim. If, due to special circumstances, the Reviewer needs additional time to process a claim, the Claimant will be notified, within 15 days after the Plan receives the claim, of those special circumstances and of when the Reviewer expects to make its decision. Under no circumstances may the Reviewer extend the time for making its decision beyond 30 days after receiving the claim. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension must specifically describe the required information, and the Claimant will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A health benefit claim is considered a pre-service claim if the claim requires approval, in part or in whole, in advance of obtaining the health care in question.

b. For any post-service health benefit claim, the Reviewer will notify the Claimant of the Plan's adverse determination within a reasonable period of time, but not later than 30 days after receipt of the claim. If, due to special circumstances, the Reviewer needs additional time to process a claim, the Claimant will be notified, within 30 days after the Plan receives the claim, of those special circumstances and of when the Reviewer expects to make its decision. Under no circumstances may the Reviewer extend the time for making its decision beyond 45 days after receiving the claim. If such an extension is necessary due to the failure of the Claimant to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and the Claimant will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A health benefit claim is considered a post-service claim if it is a request for payment of services which the Claimant has already received.

(c) Disability Benefit Claims. For any disability benefits claim, the Reviewer will notify the Claimant of the Plan's adverse determination within a reasonable period of time, but not later than 45 days after receipt of the claim. If, due to matters beyond the control of the Plan, the Reviewer needs additional time to process a claim, the Claimant will be notified, within 45 days after the Reviewer receives the claim, of those special circumstances and of when the Reviewer expects to make its decision but not beyond 75 days. If, before the end of the extension period, due to matters beyond the control of the Plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to 105 days, provided that the Reviewer notifies the Claimant of the circumstances requiring the extension and the date by which the Reviewer expects to render a decision. The extension notice will specifically explain the standards on which entitlement to a disability benefit is based, the unresolved issues that prevent a decision on the claim and the additional information needed from the Claimant to resolve those issues, and the Claimant shall be afforded at least 45 days within which to provide the specified information.

(d) Manner and Content of Denial of Initial Claims. If the Reviewer denies a claim, it will provide to the Claimant a written or electronic notice that includes:

- (i) A description of the specific reasons for the denial;
- (ii) A reference to any Plan provision or insurance contract provision upon which the denial is based;
- (iii) A description of any additional information that the Claimant must provide in

order to perfect the claim (including an explanation of why the information is needed);

(iv) Notice that the Claimant has a right to request a review of the claim denial and information on the steps to be taken if the Claimant wishes to request a review of the claim denial;

(v) A statement of the Claimant's right to bring a civil action under a Federal law called "ERISA" following any denial on review of the initial denial.

In addition, for a denial of health benefits or disability benefits, the following will be provided to the Claimant:

(i) A copy of any rule, guideline, protocol, or other similar criterion relied upon in making the adverse determination (or a statement that the same will be provided upon request by the Claimant and without charge); and

(ii) If the adverse determination is based on the Plan's medical necessity, experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment applying the exclusion or limit to the Claimant's medical circumstances (or a statement that the same will be provided upon request by the Claimant and without charge).

(For an adverse determination concerning a health claim involving urgent care, the information described in this Section may be provided to the Claimant orally within the permitted time frame, provided that a written or electronic notification in accordance with this Section is furnished not later than three days after the oral notification.)

Reviews of Initially Denied Claims

If you submit a claim for Plan benefits and it is initially denied under the procedures described above, you may request a review of that denial under the following procedures.

(a) Non-Health and Non-Disability Benefit Claims. For benefits other than health and disability benefits, a request for review of a denied claim must be made in writing to the Reviewer within 60 days after receiving notice of the initial denial of the claim. The decision on review will be made within 60 days after the Reviewer's receipt of a request for review, unless special circumstances require an extension of time for processing, in which case a decision will be rendered not later than 120 days after receipt of a request for review.

The Reviewer will provide the Claimant an opportunity to review and receive, without charge, all relevant documents, information and records and to submit issues and comments in writing to the Reviewer. The Reviewer will take into account all comments, documents, records and other information submitted by the Claimant relating to the claim regardless of whether the information was submitted or considered in the initial benefit determination.

(b) Health and Disability Benefit Claims. A Claimant whose initial claim for health or disability benefits is denied may request a review of that denial no later than 180 days after the Claimant receives the notice of an adverse determination. Except as provided below for an expedited review of a denied urgent care health claim, a request for review must be submitted to the Reviewer in writing.

A Claimant may request an expedited review of a denied initial urgent care health claim.

Such a request may be made to the Reviewer orally or in writing and all necessary information, including the Plan's determination on review, will be transmitted between the Plan and the Claimant by telephone, facsimile or other available similarly expeditious method.

In addition providing the right to review documents and submit comments as described in (a) above, a review will meet the following requirements:

(i) The Plan will provide a review that does not afford deference to the initial adverse determination and that is conducted by an appropriate named fiduciary of the Plan who did not make the initial determination that is the subject of the appeal, nor is a subordinate of the individual who made the determination.

(ii) The appropriate named fiduciary of the Plan will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment before making a decision on review of any adverse initial determination based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate. The professional engaged for purposes of a consultation in the preceding sentence shall be an individual who was neither an individual who was consulted in connection with the initial determination that is the subject of the appeal, nor the subordinate of any such individual.

(iii) The Plan will identify to the Claimant the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the review determination, without regard to whether the advice was relied upon in making the review determination.

(iv) For purposes of any medical coverage that is not part of a grandfathered plan under the Affordable Care Act, the Plan will allow a Claimant to review the claim file and to present evidence and testimony and will comply with the following additional requirements:

(A) The Plan will provide the Claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan in connection with the claim as soon as possible and sufficiently in advance of the Plan's deadline for providing notice of a final denial of a claim (as described in these claims procedures and applicable Regulations) to give the Claimant a reasonable opportunity to respond before that date; and

(B) Before the Plan issues a final decision on review based on a new or additional rationale, the Claimant will be provided, free of charge, with the rationale for the Plan's decision as soon as possible and sufficiently in advance of the Plan's deadline for providing notice of a final denial of a claim (as described in these claims procedures and applicable Regulations) to give the Claimant a reasonable opportunity to respond before that date.

(c) Deadline for Review Decisions.

(i) Urgent Health Benefit Claims. For urgent care health claims, the Reviewer will notify the Claimant of the Plan's determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the Plan receives the Claimant's request for review of the initial adverse determination by the Plan, unless the Claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan.

(ii) Other Health Benefit Claims.

a. For a pre-service health claim, the Reviewer will notify the Claimant of the Plan's determination on review within a reasonable period of time appropriate to the medical circumstances, but in no event later than 30 days after the Plan receives the Claimant's request for review of the initial adverse determination.

b. For a post-service health claim, the Reviewer will notify the Claimant of the Plan's benefit determination on review within a reasonable period of time, but in no event later than 60 days after the Plan receives the Claimant's request for review of the initial adverse determination.

(iii) Disability Benefit Claims. For disability claims, the decision on review will be made within 45 days after the Reviewer's receipt of a request for review, unless special circumstances require an extension of time for processing, in which case a decision will be rendered not later than 90 days after receipt of a request for review.

Additional Requirements for Non-Grandfathered Medical Plans

For any adverse determination involving medical coverage that is not provided under a plan that is a grandfathered plan under the Affordable Care Act, any notice of an adverse determination will be provided in a culturally and linguistically appropriate manner in accordance with applicable law regarding such notices and will include (in addition to other requirements described above):

(1) information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount (if applicable), the diagnosis code (and an explanation of its meaning) and the treatment code (and an explanation of its meaning);

(2) a discussion of the decision, as well as disclosure of any denial code used (and an explanation of its meaning) and a description of the Plan's standard, if any, that was used in denying the claim;

(3) a description of available internal appeals and external review processes, including information regarding how to initiate an appeal; and

(4) information (including contact information) about the availability of any applicable office of health insurance consumer assistance or ombudsmen established pursuant to the Affordable Care Act to assist individuals with internal claims and appeals and external review processes.

Also, for all claims involving coverage that is subject to the Affordable Care Act and is not a grandfathered plan under that Act, the Plan will ensure that claims and appeals are decided in a manner designed to ensure the independence and impartiality of individuals involved in claims decisions. Decisions regarding hiring, compensation, termination, promotion, or similar matters will not be made based on the likelihood that any person involved in making claims decisions will support the denial of benefits.

Calculation of Time Periods

For purposes of the time periods specified in this Claims Procedures section, the period during which a benefit determination must be made begins when a claim is filed in accordance with the Plan

procedures without regard to whether all the information necessary to make a decision accompanies the claim. If a time period is extended because a Claimant fails to submit all information necessary for a claim for non-urgent care health benefits or for disability benefits, the period for making the determination will be “frozen” from the date the notification requesting the additional information is sent to the Claimant until the day the Claimant responds or, if earlier, until 45 days from the date the Claimant receives (or was reasonably expected to receive) the notice requesting additional information.

Claimant’s Failure to Follow Procedures

A Claimant must follow the claims procedures described above to be entitled to file any legal action for benefits under the Plan (unless the Plan fails to follow those procedures).

Plan’s Failure to Follow Procedures

If the Plan fails to substantially follow the claims procedures described above, a Claimant will be deemed to have exhausted the administrative remedies available under the Plan and will be entitled to pursue any available remedy under ERISA on the basis that the Plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim. For any claim involving medical coverage that is not a grandfathered plan under the Affordable Care Act, a Claimant is deemed to have exhausted the Plan's internal claims and appeals process if the Plan does not strictly adhere to the applicable requirements of the U.S. Department of Labor's claims procedure regulations (or corresponding regulations issued by the Department of the Treasury or the Department of Health and Human Services). In such cases, in addition to the right to pursue any available remedy under ERISA, the Claimant will have the right to pursue any remedy under any available external review process provided under federal or State law in accordance with the Affordable Care Act.

For purposes of any coverage that is subject to the Affordable Care Act and is not a grandfathered plan, the Plan will comply with the applicable requirements of any external review process that applies under federal or State law. For any non-grandfathered coverage that is self-funded, the Plan will comply with the external review procedures set forth in Department of Labor Technical Release 2010-01 until those procedures are superseded by other guidance and the Plan will begin complying with any superseding guidance on or before the date that guidance becomes applicable to such coverage under the Plan. If you have any questions about those procedures, please contact the Plan Administrator for details.

If you have questions about these Plan changes, this SMM, or your SPD, please contact the Plan Administrator at the following address or phone number:

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