

# 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: July 1, 2011  
RE: Summary of Material Modifications

This Summary of Material Modifications ("SMM") amends 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 change and please attach this SMM to the front of your SPD. These changes are effective July 22, 2011, except as otherwise indicated below.

1. Effective July 1, 2011, no participant will be permitted to use pre-tax salary deferral elections to pay for COBRA coverage.
2. The following is added to the end of the first paragraph of the "*Initial Claims*" subsection of the Claims Procedures section of your SPD:

Unless a different deadline expressly applies in this Summary or under a benefits booklet or insurance contract, no initial claim for any benefit will be accepted, processed or paid for any expense if the initial claim is submitted later than one year after the date the expense was incurred.

3. Any reference in your SPD to a 24-hour deadline for the Plan to notify a Claimant of its decision on an initial urgent care claim is no longer applicable and part (b)(i) of the "*Initial Claims*" subsection of the Claims Procedures section of your SPD is replaced with the following:

(i) Urgent Care Claims. If the 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. 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. For any claim for benefits under coverage that is subject to the Affordable Care Act and is not part of a

grandfathered medical option, the Plan will defer to a determination, if any, by a qualified attending provider that a claim qualifies as an urgent care claim based on the definition summarized in the preceding sentence.

4. The “*Additional Requirements for Non-Grandfathered Medical Plans*” subsection of the Claims Procedures section of your SPD is replaced with the following:

*Additional Requirements for Non-Grandfathered Medical Plans*

For any adverse determination involving medical coverage that is provided under an option that is not 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 and the claim amount (if applicable);

(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;

(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; and

(5) a statement describing the availability, upon request, of any applicable diagnosis code (and an explanation of its meaning) and any applicable treatment code (and an explanation of its meaning).

The Plan will make reasonable good faith efforts to comply with requirements (1) through (4) above. However, the plan will not be treated as in violation of any requirement of the Plan’s claims procedures because a notice fails to satisfy all of those requirements, to the extent that an enforcement grace period applies under Department of Labor Technical Release 2011-01 (or any later guidance that extends that enforcement grace period). Under Technical Release 2011-01, an enforcement grace period currently applies until the first Plan Year that begins on or after July 1, 2011 for those requirements.

Also, for all claims involving coverage that is subject to the Affordable Care Act and that is not a grandfathered medical option 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.

5. The “*Calculation of Time Periods*” subsection of the Claims Procedures section of your SPD is replaced with the following:

*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 or appeal 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 an initial claim for health benefits (other than urgent care benefits) or for disability benefits, the period for making the determination will be “frozen” from the date the notice requesting additional information is sent to the Claimant until the day the Claimant responds. Also, if a time period is extended because a Claimant fails to submit all information necessary for an appeal of an adverse determination for benefits other than health benefits, the period for making the determination on appeal will be “frozen” from the date the notice requesting additional information is sent to the Claimant until the day the Claimant responds.

6. The “*Plan’s Failure to Follow Procedures*” subsection of the Claims Procedures section of your SPD is replaced with the following:

*Plan’s Failure to Follow Procedures*

If the Plan fails to substantially follow the claims procedures described above, you 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 for benefits under coverage that is subject to the Affordable Care Act and that is not part of a grandfathered medical option under that Act, effective starting with the Plan Year that begins in 2012, you are deemed to have exhausted the Plan’s internal claims and appeals process if the Plan fails to 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), except for certain minor violations. For this purpose, the Plan’s failure to comply with the claims procedure regulations is considered a minor violation if (i) the violation does not cause, and is not likely to cause, prejudice or harm to you, (ii) the violation was for good cause or due to matters beyond the control of the Plan, (iii) the violation occurred as part of an ongoing, good faith exchange of information between the Plan and you and (iv) the violation is not part of a pattern or practice of violations by the Plan. If an issue arises regarding whether this “minor violation” exception applies, you may request a written explanation of the violation from the Plan and the Plan will provide the explanation within 10 days, including a specific description of its reasons, if any, for asserting that the violation should not cause the Plan’s internal claims and appeals process to be deemed exhausted. If an external reviewer or a court rejects your request for immediate review on the basis that the Plan met the standards for the minor violation exception, you will be permitted to resubmit and pursue the internal appeal of the claim. In such a case, within a reasonable time after the external reviewer or court rejects the claim for immediate review (not to exceed 10 days), the Plan will provide you with notice of the opportunity to resubmit and pursue the internal appeal of the claim. Time periods for re-filing the claim will begin to run upon Claimant’s receipt of the notice.

In cases where you are deemed to have exhausted the Plan’s internal claim procedures, you have the right to pursue any available remedy under ERISA and, if the claim involves coverage that is subject to the Affordable Care Act and that is not part of a grandfathered medical option under that Act, you 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.

7. The paragraph in your SPD concerning external review is deleted and the following is added to

the end of the Claims Procedures section of your SPD:

*External Review*

For purposes of any medical coverage that is subject to the Affordable Care Act and that is not provided under a grandfathered medical option, certain claims that have been denied by the Plan may be submitted for external review. For any insured medical coverage, the insurance carrier that provides the benefits is responsible for complying with the external review requirements of applicable federal or state law. If you have questions about the external review process for any insured medical coverage, see the Benefits Booklet for that medical coverage or contact the insurance carrier for that coverage.

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:

Hood College  
401 Rosemont Avenue  
Frederick, MD 21701-8575  
(301) 696-3592