Southern California Dairy Industry Security Fund

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Southern California Dairy Industry Security Fund
Benefit Changes for the Fee-for-service Health Plan
(Summary of Material Modifications)

The purpose of this notice is to inform you that both the active and retiree plans available through the Fund are no longer considered "grandfathered" plans under PPACA and of changes to your health, prescription drug and vision coverage available through the Southern California Dairy Industry Security Fund's (Fund's) Fee-for-service Plan (Plan) effective **December 1, 2014**.

The Board of Trustees of the Fund recently approved a number of material modifications to the plan of benefits. This Summary of Material Modifications (SMM) notes changes to the benefits set forth in the Fund's Summary Plan Description (SPD) effective as of December 1, 2014. This SMM must be read in conjunction with the SPD.

Substantially all of the modifications to the Fund's existing benefits are being made to assure that all of the benefits available to you meet or exceed the minimum essential benefits and minimum value requirements of the Patient Protection and Affordable Care Act (PPACA), the healthcare reform law. These changes make changes in the way you pay for and obtain approval of health care, prescription drugs and vision benefits. No changes are being made to your dental benefits at this time.

Outline of Benefits, Limitations and Exclusions

Enclosed with this SMM is a Summary of Benefits and Coverage (SBC). The SBC outlines in detail, by type of service, the basic benefits, limitations and exclusions of the revised plan of benefits. The SBC is an integral part of this summary and the details there are incorporated here by reference. Remember that, by law, this is a summary description. If you need more details, you can contact the Fund office at 1 (866) 481-5841.

Limits on What the Plan Pays

While there is no annual limit on what the plan pays, there remain limits for certain types of services, as well as deductibles, copayments and other costs.

Preventive Care, Screening, and Immunization

Subject to some limitations, the Plan will now cover 100% of certain in-network preventive services. These services include routine examinations, screenings, tests, education, and immunizations administered with the intent of preventing future disease, illness, or injury.

Services are considered preventive if you have no current symptoms or prior history of a medical condition associated with that screening or service.

Because the exact services covered can change over time, you may want to contact the Fund office at 1 (800) 524-8687 to see if a service is considered preventive.

Subject to some limitations, the Plan will now cover 100% of certain in-network preventive services. For more information about which services are covered as preventive services, a requirement governed by federal and state law, you can review the following sources:

- Services with an "A" or "B" rating from the U.S. Preventive Services Task Force;
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- Preventive care and screenings for infants, children, and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
- Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration.

You may also refer to the following websites that are maintained by the U.S. Department of Health and Human Services:

https://www.healthcare.gov/what-are-my-preventive-care-benefits/

http://www.cdc.gov/vaccines/acip/index.html

Emergency Services

You are covered for so-called emergency services whether you obtain treatment at a PPO or non-PPO facility. The Plan will now cover out-of-network emergency services (that is, emergency services provided at a non-PPO facility) if provided in connection with an emergency medical condition as though those services were provided in-network. This means that the services you receive are subject to the same deductibles and coinsurance as apply at a PPO facility. Emergency room visits should be restricted to true emergency medical conditions and the emergency room should not necessarily be your first stop when the unexpected happens. Unnecessary emergency room visits will cost you time and money. Non-emergency services received at the emergency room will be paid at a lower rate. If your symptoms are not severe or life threatening but require immediate attention, use an urgent care facility. Normally, urgent care facilities are open for extended hours and available on a first-come, first-served basis. The Administrative Office can provide or refer to you a list of network urgent care facilities.

Supplemental Appeals Procedures and New External Review Process

If your claim for benefits is denied in whole or in part, you have the right to request an appeal of the denied claim, which will be considered by the Board of Trustees. The process for that initial appeal, except in circumstances in which expedited external review is

authorized, is largely unchanged. As part of the internal review process, you are entitled to review the claim file and to present relevant evidence and testimony in support of your claim. Additionally, during any internal appeal, you will be entitled, free of charge, to:

(1) Be provided with any new or additional evidence considered, relied upon, or generated by the Plan in connection with your claim sufficiently in advance of the date on which notice of any final internal adverse determination is due; you will also be provided a reasonable opportunity to respond to that new evidence.
(2) Be provided with any new or additional rationale for a final internal adverse determination before such new or additional rationale is included in the final internal adverse determination sufficiently in advance of the date on which notice of any final internal adverse determination is due; you will also be provided a reasonable opportunity to respond.

You will be provided with additional notices in connection with any adverse or benefit determination or final internal adverse determination as required by 26 C.F.R. Section 54.9815-2719T(b)(2)(ii)(E).

In addition, if your appeal to the Board of Trustees is denied, you may now have the right to request an external review of certain denied claims to an independent review organization (IRO). The IRO will provide a medical professional qualified to determine whether the denial of coverage was correct under the terms of the Plan or not. The IRO and the professionals they provide have no material affiliation or interest in the Plan. To promote fairness and eliminate bias in the external review process, the Plan will use a rotating panel of at least three IROs. In the event the IRO determines the claim should have not been denied by the Trustees, the Plan will promptly pay the claim. However, the claim may still result in legal action after the IRO renders its decision by either you or the Plan.

In the event you have a medical condition that could seriously jeopardize your life or health and are denied coverage, there is a new process for expedited external review.
A more detailed description of the IRO process and expedited review process are included in the attached document entitled, “Changes to the Claims and Appeal Procedures.”

Approved Clinical Drug Trials

Prescription drug benefits now cover participation in approved clinical drug trials for life-threatening diseases or conditions, as defined in the Public Service Health Act, Section 2709.

Utilization of Podiatrists and Chiropractors

Utilization of podiatrists and chiropractors is now limited to medically necessary services and procedures that are performed within the scope of a provider’s license.

Further Information Contained In the Summary of Benefits and Coverage

Please see the Plan’s SBC for additional details of the plan and how it works. Always remember to get the required pre-authorization and/or approval of the treatment plan for non-emergency medical expenses.

Questions?

Questions regarding these changes can be directed to the Administrative Office at **1-800-524-8687**. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at (866) 444-3272 or www.dol.gov/ebsa/healthreform.

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: 1-800-524-8687.

SPANISH (Español): Para obtener asistencia en Español, llame al 1-800-524-8687.

Changes to the Claims and Appeal Procedures

Overview of the "New" External Review Procedures

Effective for claims incurred on and after January 1, 2014, the Fund's claims and appeals procedures have been changed pursuant to PPACA. Most notably, the Fund is implementing an external review appeal process. If, after exhausting the Fund's internal appeals procedure, you are not satisfied with the final determination, you may choose to participate in the external review program. This program only applies if the adverse benefit determination is based on:

- Clinical reasons,
- The exclusions for Experimental or Investigational Services or Unproven Services, or
- As otherwise required by applicable law.

This external review program offers an independent review process to review the denial of a requested service or procedure or the denial of payment for a service or procedure. The process is available at no charge to you after exhausting the Fund's internal appeals process and receiving a final adverse benefit determination from the Fund on your internal appeal (your "internal appeal denial"). You may request an external review by an independent review organization (IRO) within four (4) months of the notice of the internal appeal denial.

The Fund's internal appeal denial notice will inform you of your right to request an external review appeal, your external review rights and your right to file suit in federal court under the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended. See the SPD for details regarding the internal appeals process.

The external review will be performed by an independent Physician, or by a Physician who is qualified to decide whether the requested service or procedure is a covered health service under the Fund. The IRO has been contracted by the Fund and has no material affiliation with or interest in the Fund. The Fund will choose the IRO based on a rotating list of approved IROs. In certain cases, the independent review may be performed by a panel of Physicians, as deemed appropriate by the IRO. Within applicable timeframes of the Fund's receipt of a request for independent review, the request will be forwarded to the IRO, together with:

- all relevant medical records;
- all other documents relied upon by the Fund in making a decision on the case; and
- all other information or evidence that you/or your Physician have already submitted to the Fund.

If there is any information or evidence you or your Physician wish to submit in support of the request that was not previously provided, you may include this information with the request for an independent review, and the Fund will include it with the documents forwarded to the IRO. A decision will be made within applicable timeframes. If the reviewer needs additional information to make a decision, this time period may be extended. The

independent review process will be expedited if you meet the criteria for an expedited external review as defined by applicable law.

Preliminary Review by the Fund

Within five (5) business days following the date of the Fund's receipt of your request for an external review, the Claims Administrator will complete a preliminary review to determine whether your request is complete and eligible for an external review. Specifically, that preliminary review will determine whether:

i. you were covered under the Fund at the time the health care item or service was requested or, in the case of a retrospective review, provided;
ii. the final denial of your appeal relates to your failure to meet the Fund's eligibility requirements;
iii. you exhausted the Fund's internal appeal process (or are not required to exhaust the process); and
iv. you have provided all the information and forms required by the Fund to process an external review.

Within one (1) business day after the Claims Administrator completes its preliminary review, it will issue you a written notification of its determination. If your request is complete, but not eligible for external review, the notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration. If your request is not complete, the notification will describe the information or materials needed to make the request complete and you will be allowed to perfect your request for an external review within the original four-month filing period or, if later, the 48-hour period following your receipt of the notification.

Review by the IRO

If the Claims Administrator approves your request for an external review, the Fund will assign a qualified IRO to conduct it. Within five (5) business days after making the assignment, the Fund will provide the assigned IRO with the documents and information that the Claims Administrator considered in making its final adverse benefit determination. The Fund will also notify you of this assignment. Upon receiving such notice, you will have ten (10) business days to submit additional information to the IRO. If you submit additional information, within one (1) day after receiving such information, the IRO will send such information to the Fund so that it may reconsider its determination. If the Fund decides to reverse its decision based on its review of this new information, it will provide a written notice of its decision to you and the IRO within one (1) business day after reaching that favorable decision; and the IRO will terminate the external review upon receipt of the Fund's notice. If, however, the Fund does not reverse its determination, the IRO will conduct a de novo review of all of the information and documents that it received from the Fund or you, and will not be bound by any decisions or conclusions reached by the Claims Administrator during the Fund's internal claim and appeal process. The IRO, at its discretion, may also consider the following in reaching its decision: your medical records; the attending health care professional's recommendation; reports from the appropriate health care professionals and other documents submitted by the Claims Administrator, you or your treating provider; the terms of the Fund, to ensure that the IRO's decision is not contrary to the terms of the Fund; appropriate practice guidelines; any applicable clinical

review criteria developed and used by the Fund; and the opinion of the IRO's clinical reviewer(s).

The IRO will provide written notice to you and the Claims Administrator of the final external review decision within 45 days after the IRO receives the request for the external review. The IRO's notice will contain, to the extent required by law, the following information:

i. a general description of the reason for the request for external review including, if applicable, information sufficient to identify the claim, the amount of the claim, the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning and the reason for the previous denial;
ii. the date the IRO received the assignment from the Fund to conduct the external review and the date of the IRO's decision;
iii. references to the evidence or documentation considered in reaching its decision, including the specific coverage provisions and evidence-based standards;
iv. a discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
v. a statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Fund or you;
vi. a statement that judicial review may be available to you; and
vii. if applicable, the current contact information for any applicable office of health insurance consumer assistance or ombudsman.

Overview of the "New" Expedited External Review Procedures

Under the following circumstances, you may be eligible to file for an expedited external review:

i. If you receive an adverse benefit determination that involves a medical condition for which the timeframe for completion of an expedited internal appeal with the Claims Administrator would seriously jeopardize your life or health, or that would jeopardize your ability to regain maximum function, and you have filed a request for an expedited internal appeal; or
ii. If you receive a final adverse benefit determination from the Claims Administrator and
    - you have a medical condition for which the timeframe for completion of a standard external appeal would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function; or
    - if the final adverse benefit determination concerns an admission, availability of care, continued stay, or a health care item or service for which you have received emergency services but have not been discharged from a facility.

Preliminary Review by the Fund

Immediately upon receipt of the request for an expedited external review, the Claims Administrator will conduct a preliminary review of your request and determine whether you are eligible for such a review. Immediately after completion of this preliminary review, the Claims Administrator will issue you a written notification of its determination. If your request is complete but is not found to be eligible for an expedited external review, the

notice will include the reasons for ineligibility. If your request is incomplete, the notice will describe the information or materials needed to perfect the request.

Review by the IRO

Upon a determination that a request is eligible for an expedited external review, the Claims Administrator will assign an IRO to review it and will transmit all necessary documents and information to the IRO in accordance with the above-discussed "standard" external review rules. The IRO will provide a written notice of its final decision to you and the Claims Administrator as expeditiously as possible, but in no event later than 72 hours (24 hours for reviews involving urgent claims) after the IRO receives the request for the expedited external review. If notice is not in writing, within 48 hours of providing that notice, the IRO shall provide written notice to you and the Claims Administrator of its final decision.

Overview of Other Changes to the Fund's Current Claims and Appeal Procedures

In addition to the new standard and expedited external review procedures, the Fund's existing claims and appeal procedures are amended and/or clarified to reflect the following:

- The scope of an adverse benefit determination or claim will include rescissions (within the meaning of PPACA) of coverage whether or not there is an immediate adverse effect on any particular benefit. As a result, rescissions of coverage are subject to the Fund's claims and appeal rules.
- The Fund will notify you of its decision for urgent care claims as soon as possible but no later than 24 hours after the receipt of such claim, provided that you provide the Fund with sufficient information for it to determine whether and to what extent benefits are covered under the Fund under such circumstances. If the Fund requires additional information from you in order to make a determination for an urgent care claim, you will have no less than 48 hours to provide the Fund with the requested information.

This summary is intended to satisfy the requirement for issuance of a SMM under ERISA. You should take the time to read this SMM carefully and keep it with the SPD that was previously provided to you.