Southern California Dairy Industry Security Fund

Administered By: Benefit Programs Administration
Telephone • (866) 481-5841 • (562) 463-5033 • Facsimile (562) 463-5894
www.scdairyfund.org

July 2022

Re: New Qualifying Payment Amounts and Claims and Appeals Procedures, including External Review Effective April 18, 2022
(Summary of Material Modifications)

This Summary of Material Modification (SMM) modifies some of the information contained in the Southern California Dairy Industry Security Fund (Fund). In the event of any discrepancy between this SMM and the SPD, the provisions of this SMM will govern.

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. This SMM must be read in conjunction with the SPD and all previous SMMs issued. If you need another copy of the SPD or these SMMs, contact the Trust Fund Office at (866) 481-5811.

I. UPDATES REGARDING QUALIFYING PAYMENT AMOUNTS

Effective June 1, 2022, new cost-sharing amounts are applicable for items and services within the scope of the surprise billing and cost-sharing protections for (1) out-of-network emergency services, (2) nonemergency services performed by nonparticipating providers at participating facilities, and (3) air ambulance services furnished by nonparticipating providers of air ambulance services.

If the expense falls into one of these three categories, then your share of the cost will be the same as if the services were obtained in-network, including co-payments and deductibles. In these circumstances, the provider payment for these items and services will be the Qualifying Payment Amount (QPA), which is the applicable median-contracted rate set by the provider network, rather than the "Allowable Charges" referenced in the current SPD.

II. UPDATED CLAIMS AND APPEALS PROCEDURES

Effective April 18, 2022, the Claims and Appeals Procedure under this Plan shall be as follows:

Claims and Appeals Procedures

The procedure for filing claims and appeals for the fee-for-service Medical is described in the following pages.

- If you are enrolled in one of the HMO Plans, please refer to the booklet or Evidence of Coverage (EOC) provided by your HMO for information on the HMO's claims and appeals procedures.

- If you are enrolled in the Indemnity Dental plan of the Joint Council of Teamsters No. 42 Welfare Trust Fund, please refer to its summary plan description for the claims and appeals procedures.

- If you are enrolled in one of the prepaid Dental plans, please refer to the provider brochure for the claims and appeals procedures.

- For the vision plan, please refer to the provider brochure for the claims and appeals procedures.

- For Life Insurance claims and appeals, please refer to the ULLICO Certificate of Group Insurance.

The Plan's claims procedures include administrative safeguards and processes designed to ensure and to verify that benefit claims determinations are made in accordance with governing Plan documents.

How to File Claims

Time of Notice

You must send written notice of a self-funded fee-for-service medical or dental claim to the Fund Administrator within ninety (90) days after an expense or loss occurs. If you cannot send notice within that time, you must send it as soon as reasonably possible.

Submit your self-funded fee-for-service Medical notice of a claim to the Fund Administrator. A claim will be considered to have been filed as soon as it is received at the Fund Administrator's office, provided it is complete, with all necessary documentation required by the notice of claim. If the notice is not complete, you or your authorized representative will be notified of the additional evidence required to establish whether or not a claim should be paid. The Fund Administrator may, for example, request supplementary documentation or the results of a physical examination or laboratory test in order to adjudicate a medical claim.

This notification will be provided to you or your authorized representative as soon as reasonably possible, but not later than five (5) days for a pre-service claim or 24 hours for an urgent care claim. For an urgent care claim, the notice may be provided to you or your representative orally, unless you or your representative requests a written notice.

If you fail to cooperate with such requests, your claim may be denied.

If your claim is denied, in whole or in part, a notice of an adverse benefit determination will be sent to you or your representative. "Adverse benefit determination" is defined as a denial, reduction, or termination of benefit, including the failure to pay a benefit due to the application of any utilization review, ineligibility, or a determination that it is experimental, not Medically Necessary, or appropriate.

Forms

When the Fund Administrator receives the notice of claim, they will send a claim form to you for filing proof of loss. If the Fund Administrator does not send the claim form within fifteen (15) days, you will be deemed to comply with the proof of loss requirements by sending written proof of loss as set forth below. Written proof must be submitted:

- To the Fund Administrator; and
- Within ninety (90) days after the end of each period for which the benefits are to be paid.

Claims should be filed ninety (90) days after you incur the medical expense. Claims will still be considered for payment when it is not possible to provide notification within ninety (90) days, but you should always file your claims as soon as possible.

Claims will not be paid if they are submitted more than twelve (12) months after the expense was incurred, except in the absence of legal capacity.

Proof of Loss

In case of a health claim for expense or loss for which a periodic benefit is paid while the loss continues, you must send written proof of loss:

- To the Fund Administrator; and
- Within ninety (90) days after the end of each period for which the benefits are to be paid.

In the case of a health claim for any other expense or loss, you must send written proof of loss to the Administrator within ninety (90) days after the date expense or loss is incurred. The Fund Administrator will not deny or reduce a claim due to the fact that you are not able to send the proof of loss within ninety (90) days, but for the lack of legal capacity. However, in no case will claims be honored more than one year after the date of service.

Claim Determinations

Claims for benefits under the Plan will be processed, and benefit determinations will be made, within the time frames allowed under the regulations depending on the type of claim submitted. There are four types of claims that may be filed under this Plan. A description of these claims and the Benefit determination time period are as follows:

1. Urgent Care Claim — any claim for medical care or treatment that must be determined promptly to avoid jeopardizing your life, health or ability to regain maximum function, or in the opinion of the attending Physician could subject you to severe pain if care or treatment is not received. If you require urgent care, you should seek immediate medical attention.

   You will be notified by the Plan of the benefit determination (whether adverse or not) not later than seventy-two (72) hours after receipt of your claim by the Plan.

2. Pre-Service Claim — any claim for a benefit that requires you to obtain approval before you receive medical care or treatment. This includes any prior authorization before you see a specialist or non-PPO provider, before any Hospitalization, or to obtain a higher benefit payment for an item or service.

You will be notified by the Plan of the benefit determination (whether adverse or not) not later than fifteen (15) days after receipt of your claim by the Plan.

3. Post-Service Claim — any claim for medical care or treatment that you have already received.

You will be notified of an adverse benefit determination no later than thirty (30) days after receipt of your claim by the Plan.

4. Concurrent Care Claim — any claim that results from the termination or reduction of previously granted benefits to be provided over a period of time. The Plan will notify you in advance of the termination or reduction to allow you time to appeal the decision and obtain a determination before the benefit is reduced or terminated.

Any request to extend a course of treatment is governed by the standards generally applicable to such claims.

5. Total Disability — any claim for extension of benefits resulting from Total Disability (the inability of a person to engage in any business, occupation, or employment for remuneration, profit or gain). You will be notified of the decision (whether adverse or not) not later than:

- Forty-Five (45) days from the receipt of your claim form, doctor's certification, copy of State Disability Insurance (SDI) or Worker's Compensation check stub certifying to the dates of disability; or
- Within an additional thirty (30) days if sufficient information has not been received and, therefore, a decision is not possible and is beyond the control of the Fund Administrator; or
- Within additional thirty (30) days after the first thirty (30) day extension if a decision has not been made because it is beyond the control of the Fund Administrator.

Notice will be given to you of each extension and the reasons thereof before the end of the first forty-five (45) days and again before the end of the first thirty (30) day extension and before the end of the last thirty (30) day extension.

To Whom Benefits Are Payable

Any health benefits payable for loss of your life will be paid to your designated beneficiary. Except as set forth below, any other benefits that have not been paid when you die may be paid either to your beneficiary or to your estate, at the option of the Fund Administrator. All other amounts will be paid to you.

Benefits Unpaid at Death — Incompetence

Benefits may be payable to any person or institution entitled to such payment, as much as $500 of any benefits, that:

- Are to be paid at the time of your death; or
- Are to be paid to a minor who is not able to execute a valid release, and for whom no guardian has been appointed.

To the extent of the payment, the Fund Administrator will have no more liability under the group Plan.

Physical Examination and Autopsy

The Fund Administrator shall have the right and opportunity to order the examination of a Participant by a Physician of its choice, to determine the extent of any sickness or injury for which a claim is made. This right may be used as often as it is reasonable to do so. If a Participant dies, an autopsy may be required (where the law does not forbid it). Such an examination or autopsy shall be made at the expense of the Administrator.

Extensions for Pre-Service And Post-Service Claims

The initial determination of benefits will be made as soon as possible, but not later than the period of time indicated above after the Plan receives your claim. The initial benefit determination period may be extended as follows:

1. Pre-Service Claim — the initial fifteen (15) days benefit determination period may be extended up to an additional fifteen (15) days if special circumstances beyond the control of the Plan require an extension of time to process the claim. If such an extension is required, you will be sent a written notice before the expiration of the initial fifteen (15) day period, stating the special circumstances requiring the extension and the date a decision on the claim can be expected.

2. Post-Service Claim — the initial thirty (30) day benefit determination period may be extended up to an additional fifteen (15) days if special circumstances beyond the control of the Plan require an extension of time to process the claim. If such an extension is required, you will be sent a written notice before the expiration of the initial thirty (30) day period, stating the special circumstances requiring the extension and the date a decision on the claim can be expected.

Incomplete Claims

If you fail to follow the filing procedures or do not provide sufficient information for a pre-service or post-service disability claim, you will be given at least forty-five (45) days to perfect your claim or provide any requested information. The time period for making a decision will be suspended from the date of the notification to the earlier of: (1) the date on which a response is received by the Plan, or (2) the date established by the Plan for furnishing the requested information (at least forty-five (45) days).

Notice of Claim Denial

If the Plan makes an adverse benefit determination, in whole or in part, you will be notified in writing of the determination and will be given the opportunity for a full and fair review of the benefit decision. The written notice of denial will include:

1. Information that fully identifies the claim, such as date of service, the healthcare provider, the claim amount, and a statement explaining that you may request a copy of the standard diagnosis and treatment codes and their corresponding meanings;

2. the specific reason or reasons for the denial;

3. reference to specific Plan provisions on which the denial is based;

4. a description of any additional material or information necessary for you to perfect your claim and an explanation of why that material is necessary;

5. a statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim; these relevant documents include any information that was relied upon, submitted, considered or generated in the course of making the benefit decision;

6. If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination, you will be provided with a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the determination and that a copy will be provided to you free of charge upon request;

7. If a medical necessity or experimental treatment or similar exclusion or limit was relied upon in making the adverse determination, you will be provided with a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, will be provided to you free of charge upon request; and

8. A description of the Plan's appeal procedures including a statement of your rights to bring a civil action under section 502 (a) of ERISA following an adverse determination on review, but only after you first exhaust the claims and appeals procedures as set forth herein.

9. In the case of Claims involving urgent care, a description of the expedited review process applicable to such Claims.

10. Denial of Disability Claims: If your claim is denied because the Plan determines that you were not disabled, you will receive a notice that includes (1) a discussion of the decision and the reason the Plan disagrees with any Social Security Administration disability determination or the views of any health care or vocational professionals presented by you or obtained by the Plan, (2) a statement that you are entitled to

receive, upon request and free of charge, reasonable access to and copies of all documents, records, or other information relating to your claim, and (3) a copy of the internal rule, guidelines, protocols, or similar rules of the Plan relied on in denying your claim or a statement that this information does not exist.

You may have the right to receive this notice in Spanish, depending on the number of Spanish-only speaking residents in your county.

Appeals Procedures

If you apply for benefits and your claim is denied, or if you believe you did not receive the full amount of benefits to which you are entitled, you have the right to petition the Plan for a review of the denial of your claim.

The petition must be in writing, state the reason or reasons for disputing the denial and must be accompanied by any pertinent material not already furnished to the Plan. You or your authorized representative must file the appeal with the Plan within one hundred eighty (180) days after you receive the notice of claim denial.

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).

The Plan will review all submitted comments, documents, records and other information related to the claim, regardless of whether the information was submitted or considered in the initial benefit determination. The Plan will not give deference to the initial adverse benefit determination.

If the adverse benefit determination is 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 Plan will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the judgment. The health care professional will be an individual who is neither the individual consulted in connection with the initial benefit determination nor the subordinate of such individual. The Plan will provide you with the identification of any medical

or vocational expert whose advice was obtained in connection with an adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

Appeals Determination Time Period

The time period for a benefit determination on review will begin at the time an appeal is filed under the Plan as instructed above, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. You must, therefore, make sure that your claims appeal is complete and any documentation or evidence is included with your claims when you file your appeal. You will be notified of the decision of the Plan in writing as follows:

1. Urgent Care Claims – For urgent care claims, you may make a request for an expedited appeal, orally or in writing, and all necessary information may be exchanged by telephone, facsimile or other expeditious method. Appeals for urgent care claims will be decided as soon as possible, but not later than 72 hours after receipt of the appeal.

2. Pre-Service Claim — You will be notified of the benefit determination not later than thirty (30) days after receipt by the Plan of your request for review of an adverse benefit determination.

3. Post-Service Claim* - A properly filed appeal will be reviewed by the Board of Trustees at its next regularly scheduled meeting. However, if the appeal is received within thirty (30) days prior to the meeting, the appeal may be reviewed at the second meeting following receipt of your appeal.

If special circumstances beyond the control of the Plan (such as the need to hold a hearing) require an extension of time, the Board of Trustees will render a decision at the third scheduled Board meeting following receipt of the appeal. The Plan will provide you, prior to the start of the extension, with a written notice of the extension describing the special circumstances and the date that the Board of Trustees will make its decision. A written notice of the decision on an appeal will be provided to you within five (5) calendar days following the Board of Trustees meeting

*In the event that you want or need additional time to present evidence in support of your petition for review, you may request such additional time in writing. The Trustees will grant your written request for additional time necessary to perfect a petition for review, provided the written request is received before the Trustees issue their decision. Requests for additional time and requests to submit additional information received after the Trustees' decision has been rendered will be denied, unless the Trustees, in their sole discretion, determine that the information is material to the petition and could not have been provided earlier.

3.Disability Claims — You will be notified if a claim is wholly or partially denied within forty-five (45) days of the date of receipt of the claims. You will have up to one hundred eighty (180) days from the receipt of the notice of denial to appeal the decision.

You will receive a response within forty-five (45) days from the date the appeal is received. This period may be extended for up to an additional forty-five (45) days if additional information is required and you will be notified for the special circumstances and the date that the Plan expects to render the benefit determination.

In the case of an adverse benefit determination on the appeal, the written denial will indicate:

1. The specific reasons for the denial;
2. Reference to the pertinent Plan provisions on which the denial is based;
3. A statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits;
4. A statement of your right to bring a civil action under section 502 (a) of ERISA;
5. If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination, you will be provided with a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the determination and that a copy will be provided to you free of charge upon request; and
6. If a medical necessity or experimental treatment or similar exclusion or limit was relied upon in making the adverse determination, you will be provided with a statement that the explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, will be provided free of charge upon request.
7. The appeal denial will also provide the following disclosure, as required by law: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

Denial of Disability Claims: If your appeal is denied because the Plan determines that you were not disabled, you will receive a notice that includes (1) a discussion of the decision and the reason the Plan disagrees with any Social Security Administration disability determination or the views of any health care or vocational professionals presented by you or obtained by the Plan, (2) a copy of the internal rule, guidelines, protocols, or similar rules of the Plan relied on in denying your claim or a statement that this information does not exist, and (3) a description of any contractual limitations period that applies to the claimant's right to bring an action under ERISA and the calendar date on which the limitations period expires.

Note that the additional procedures described above for disability benefits do not apply to claims or appeals for benefits, such as extended COBRA benefits for disabilities, where the determination of disability is based solely on a disability award from the Social Security Administration.

The failure to file an appeal within the one hundred eighty (180)-day period from the initial denial of your claim will constitute a waiver of your right to a review of the denial of your claim.

External Appeals Procedures

1. **In General** - You may have the right to appeal any adverse Claim decision to an independent third party after completing an "internal" appeal, as described above. An "external" review is handled by an independent review organization (IRO), which is independent from the Plan and is not bound to the Plan's findings, as described in this section.

External review is only available to: (a) Claims that involve medical judgment (including the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, effectiveness of a covered benefit, or the Plan's determination that a treatment is experimental or investigational); and (b) rescissions of coverage.

Effective June 1, 2022, external review is also applicable to adverse benefit determinations for items and services within the scope of the surprise billing and cost-sharing protections for (1) out-of-network emergency services, (2) nonemergency services performed by nonparticipating providers at participating facilities, and (3) air ambulance services furnished by nonparticipating providers of air ambulance services.

Generally, you must exhaust the internal claims and appeals procedure before an external review is available to you. However, in the event that completing an internal appeal would jeopardize your life, health, or ability to regain maximum function, you are entitled to apply for expedited external review.

If the IRO reverses the Plan's benefit denial, the Plan must immediately provide coverage and payment for the reversed Claim(s).

There are two types of external review: standard and expedited.

2. Standard External Review Procedures

a. Dates to Request - You may request external review within four months of receiving notice that your Claim has been denied. In the event that there is no corresponding date four months after the date of such receipt (for example, Feb. 30th), you must file by the first day of the fifth month following receipt of your Claim denial.

b. Initial Determination - Within five business days of receipt of the request, the Plan will make an initial determination whether you are eligible for Plan participation and have provided all the requisite paperwork for the appeal. Within one business day after completing the initial determination, the Administrator will notify you of the results. If your request is incomplete, the notice will state why it is incomplete and allow you to correct it within 48 hours or by the end of the four-month request period, whichever is later. If you are ineligible for Plan participation, the notice will state the reasons why you are ineligible and provide you contact information for the government agency that regulates plans like this one.

c. Referral - If your request is complete, it will be forwarded to an IRO. To combat any bias, the IRO will be one of at least three that the Plan rotates external review requests between, none of which are eligible for any financial incentives from the Plan to support a denial of benefits to you.

d. Review by IRO – The Plan's contract with the IROs that it refers requests for external review will provide that:

i. The IRO will utilize legal experts where appropriate to make coverage determinations under the Plan.

ii. The IRO will notify you of the request's eligibility and acceptance for review. That notice will inform you that you may submit additional information that the IRO must consider for the review within 10 days of receiving the notice; after 10 days, the IRO is allowed, but not required, to review the information you send it.

iii. The Plan will send the IRO all the documents and other information it considered for your Claim within five days of referring it the IRO. If the Plan fails to provide this information timely, the IRO may reverse the Claim denial. If that happens, it will notify you within one day.

iv. The IRO will consider the documentation and provide a written notice of its determination to you and the Plan within 45 of receiving the referral.

e. Notice from IRO – The IRO's notice will contain:

i. A general description of the request for review and information sufficient to identify the Claim (including dates of service, names of healthcare providers, the Claim amount (if applicable), diagnosis codes and their corresponding meanings, treatment codes and their corresponding meanings, and the reason for the previous denial),

ii. The date the IRO received the request for external review and the date of the IRO's decision,

iii. Reference to specific evidence or documentation considered in reaching its conclusion,

iv. A discussion of the reason(s) for its decision,

v. Notification that the determination is binding, except that other remedies may be available to you or the Plan in court (only if filed within 24 months of the date of the decision), and

vi. Contact information for the government agency that regulates plans like this one.

3. Expedited External Review Procedures

a. Availability - The Plan must provide for an expedited review if: (1) the time for a regular external review would seriously jeopardize your life or health or your ability to regain maximum function and you file a request for an expedited review, or (2) your Claim involves an admission, availability of care, continued stay or healthcare service for which you received emergency services but have not been discharged from a facility.

b. Initial Determination – Immediately after receiving the request, the Plan will make an initial determination whether you are eligible for Plan participation and have provided all the requisite paperwork for the appeal. The Plan must then immediately notify you of the results. If your request is incomplete, the notice will state why it is incomplete and allow you to correct it within 48 hours or by the end of the four month request period, whichever is later. If you are ineligible for Plan participation, the notice will state the reasons why you are ineligible and provide you contact information for the government agency that regulates plans like this one.

c. Referral - If your request is complete, it will be expeditiously forwarded to an IRO, along with any documentation regarding your Claim.

d. Review by IRO – Expedited review by the IRO has the same requirements as standard review, except that it must complete the review and provide its decision as expeditiously as possible, considering your medical needs. The process may not exceed 72 hours for notice in writing, or 48 hours if the notice is not in writing.

e. Notice from IRO – The content of the IRO notice must meet the same requirements for as standard review.

If you are not satisfied with the decision made on your appeal or after an external review by the IRO, you may file a lawsuit in federal court against the Plan. However, you must complete the appeal to the Trustees before you may file a lawsuit. You will waive your rights to file a lawsuit against the Trust, unless you do so within 24 months after you complete the appeals process and the Fund denies your claim.

Special Notes

Claims and Appeal Procedures for HMO Plans, prepaid Dental Plans, Prescription Drugs, Vision Plan and Life Benefits:

If the benefits involved are provided by an insurance company, insurance service, health maintenance organization, or other similar organization, that organization may be entitled to conduct the review and make the decision. Disputes concerning benefits provided by one of the HMO's, prepaid Dental or ULLICO for the Life benefits generally must be resolved using the appeal procedures established by that organization. See the applicable booklet or Evidence of Coverage (EOC) for details of the organization's claims and appeals procedures.

Authorizing a Representative

The claims and appeals procedures outlined above do not preclude your authorized representative from acting on your behalf in pursuing a benefit claim or appeal of an adverse benefit determination. In order to determine if an individual or firm has been duly designated by you, a form authorizing such entity to act as your representative must be completed and received by the Plan. However, if a claim involves urgent care, the Plan will permit a health care professional with knowledge of your medical condition (i.e., a Treating Physician) to act as your authorized representative.

If you have any questions regarding this notice, please contact the Administrative Office at (866) 481-5841. 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 the Administrative Office at (866) 481-5841.