BENEFITS ELIGIBILITY APPEAL PROCEDURES FOR EMPLOYEES AND POSTDOCTORAL SCHOLARS

Appeal Procedures For Faculty/Staff and Postdoctoral Scholars

This appeal process is intended for situations in which denial of coverage is based on a determination that an individual did not meet the eligibility requirements of the GIRs. That is, benefits are denied because the individual is not eligible to participate in a plan, did not enroll in a timely fashion, did not properly complete the enrollment process, was enrolled in error, etc. A claimant with a request for an exception to GIRs policy or procedure must submit an appeal following the instructions below. No decision on the appeal will be made until an individual has submitted a written request and has provided pertinent information regarding the request as described below.

If the benefit claim of an individual who is eligible and properly enrolled in an insurance plan is denied by the plan carrier/administrator based on the plan's contractual provisions, the appeal should be addressed to the carrier/administrator.

First Level of Appeal – A claimant whose request has been denied, or his or her authorized representative, may ask for review by the UC Office of the President Appeals Committee for Health & Welfare Benefits.

Claimants should complete the Eligibility Appeal Form for Health & Welfare Benefits Plans (UBEN 177). The claimant or the claimant's authorized representative can submit this form to officially request an independent review of the claim for eligibility under the GIRs. The UBEN 177 form must be submitted within 60 days of the written notice of the denial.

Submit the appeal via email to: HealthAndWelfareBenefitsAppeal-L@ucop.edu

Submit the appeal via postal mail to:

Executive Director, Benefit Programs and Strategy
Human Resources, Health & Welfare Plan Administration
University of California
1111 Franklin St.
Oakland, CA 94607

In lieu of the UBEN 177 form, a written statement of appeal may be submitted that includes:

a. a request for a review of the denial;
b. statement of the reasons and supporting facts and documentation upon which the request for review is based; and
c. any issues or comments which the claimant deems relevant to the appeal.

Each appeal and any related written materials submitted by the claimant will receive a full and

fair review within 60 days after receipt of the request for review unless the circumstances determine that a longer period for review is required, which may include time to review additional information or documents reasonably requested from the claimant, the carrier, the campus/laboratory/medical center location, the provider, or other relevant party. If additional time for review is needed, the claimant will be notified in writing of the need, and the reason, for the extended review period.

If the written notice includes a request that the claimant provide additional information or documents, the claimant must submit such information or documents within 30 days after receipt of the notice. If the claimant and/or any other relevant party has been asked for additional information or documents, written notice of the decision shall be given within 60 days of receipt of all such information or documents. If the appeal is denied, the written notice of the decision to the claimant shall set forth the specific reasons for such denial and any specific references on which the decision is based.

Second Level of Appeal – If the first level of appeal sustained the decision to deny the decision, the claimant may ask the Plan Administrator to review the case by submitting a written statement of appeal to the Vice President, Human Resources, of the University of California within 60 days after receiving a written notice of denial.

A second level appeal should be directed to:

Vice President, Human Resources
ATTN: Health and Welfare Plan Appeals
University of California, Office of the President
1111 Franklin St.
Oakland, CA 94607

The decision of the Vice President, Human Resources shall be final and conclusive upon all persons. With the Vice President's decision, the claimant will have exhausted all administrative remedies under the plan. If after exhausting these administrative claims procedures, the claimant has the right to initiate legal proceedings.