UNIVERSITY OF CALIFORNIA (PLAN)
PROCEDURES FOR A REQUEST FOR RETIREE HEALTH AND WELFARE APPEAL

A member, survivor, contingent annuitant, or beneficiary must submit a request to receive benefits or a distribution from the Plan. A request for Retiree Health and Welfare Benefits must be made in accordance with procedures established by the Plan Administrator. No Plan distribution will be made until an individual has submitted a formal request for benefits and has provided the required eligibility information regarding the request. If the Plan Administrator fails to act on the benefits request within 90 days, the claimant may assume that the request for benefits has been denied.

If a request for Plan benefits is denied in whole or in part, the UC Retirement Administration Service Center (RASC), on behalf of the Plan, will notify the individual in writing, explaining the reason for the denial.

Administrative Review

The individual may ask to have the denial of the benefit reviewed. The request must be in writing, accompanied by all relevant documentation supporting the claim, including the basis of the claim, the desired outcome, and why the claim should be granted.

Generally, the request goes through an Administrative Review process within 60 days of RASC receiving the request and any other required information. However, based on the complexity of the claim, the process may take up to 90 days.

The RASC will notify the claimant of its decision in writing. If the Administrative Review is denied, the RASC will explain the reason for denial in writing and notify the claimant that they may request an independent review of the denial by the Plan Administrator.

Appeal to Plan Administrator

The Appeal to Plan Administrator must be made within 60 days of receiving a written denial notice of the Administrative Review. The Appeal must be in writing, accompanied by any additional documentation supporting the claim. The written Appeal must:

(a) include an appeal watermark cover page;

(b) request a review of the application for benefits by the Plan Administrator;

(c) set forth all of the reasons upon which the request for review is based and any facts in support thereof; and

(d) set forth any issues or comments which the claimant deems relevant to the application.

Please send the appeal request for Plan Administrator review addressed to:

UC Retirement Administration Service Center
Attention: Administration Review and Appeals
University of California
1111 Franklin St.
Oakland, CA 94607

The claimant will receive a written response to the Appeal from the Plan Administrator within 120 days unless unusual circumstances are involved.

If, after exhausting these administrative claims procedures, the claimant still believes that a benefit has been improperly denied or paid, the claimant has the right to seek judicial review.

Appeal Related to Medicare Enrollment

There are different appeals processes based on Medicare enrollment. The appeals processes for Medicare Parts A and B differ if a beneficiary is enrolled in Original Medicare (Fee-For-Service Medicare) versus enrollment in a Medicare Advantage managed care plan.

For Original Medicare Enrollees

For disagreements with a coverage or payment decision by Original Medicare, your Medicare Advantage or other Medicare health plan, or your Medicare drug plan, the claimant must file an appeal directly to Medicare. For more information on Medicare's appeals process, including the right to a fast appeal, contact 1-800-MEDICARE (1-800-633-4227) or visit Medicare.gov/appeals.

For Medicare Advantage Enrollees

Beneficiaries enrolled in a Medicare Advantage (MA) plan can request an expedited review if the timeframe for a standard appeal could seriously jeopardize the member's health or ability to gain maximum function. This faster appeal process can be used to request medical care from the MA plan and to appeal an MA plan denial of service or termination of care. An MA plan member who wants an expedited review should contact the MA plan's member services department (the number is located on the back of your insurance card).