Copy 2-Sided

SOUTHERN CALIFORNIA DRUG BENEFIT FUND
P.O. Box 27920
Los Angeles, CA 90027-0920
(323) 666-8910 ext. 503 Medical Benefits, ext. 501 Eligibility & Supplementary Benefits, ext. 500 Death Benefits

APPEAL FORM

Use this form to file an appeal of a claim for benefits that has been denied, in whole or in part. You must file your appeal within 60 days after you receive written notice of the denial of your claim, unless you are appealing the denial of a Health Claim or a claim for the Total and Permanent Disability Death Benefit, in which case you must file your appeal within 180 days after you receive written notice of the denial. To facilitate processing, please attach the written notice of denial to this form. For more information, see the back of this form.

Appellant Information

The Appellant is the person whose claim for benefits was denied. Fill out this section if the Appellant is not the enrolled Employee (for example, if the Appellant is the spouse of the Employee). Please print clearly.

Appellant's Last Name	First Name	Middle Initial	Relationship to Employee
Mailing Address	**City**	**State**	**Zip Code**

Employee Information

Fill out this section whether the appeal is for the Employee or a Dependent. Please print clearly.

Employee's Last Name	First Name	Middle Initial	Social Security or DF Number
Mailing Address	**City**	**State**	**Zip Code**
Home or Cell Phone Number	**Date of Birth**	☐ Male ☐ Female	☐ Married ☐ Single
Employer (if applicable)		**Work Phone Number (if applicable)**	

Parent/Guardian of Dependent Child

If the claim being appealed is for services provided to a dependent child, please complete this section. Please print clearly.

Parent's/Guardian's Last Name	First Name	M.I.	Date of Birth	Relationship to Child
Mailing Address (include City, State and Zip Code)				**Home or Cell Phone Number**

Type of Appeal

Please check one box only

☐ Medical	☐ Mental Health / Substance Abuse	☐ Supplementary Benefits
☐ Orthodontic	☐ Eligibility	☐ Death Benefit
☐ Vision	☐ COBRA (Eligibility)	☐ Other: _____
☐ Prescription	☐ Plan Change	

Reason for Appeal

Please provide an explanation of your appeal and describe why you think your appeal should be granted. Include any facts that you think establish your right to benefits. You may attach any documents, records or other information that supports your claim for benefits. Use a separate sheet of paper if necessary.

Appellant's Signature **Date**

SOUTHERN CALIFORNIA DRUG BENEFIT FUND
APPEALS PROCEDURE SUMMARY

1. **Application For Review (Appeal).** You or your Authorized Representative (someone you name to act for you) may request a review of the Southern California Drug Benefit Fund's decision not to provide or pay for a benefit or coverage (in whole or in part) by filing a written request for review (called an appeal). To designate an Authorized Representative, obtain an *Appointment of Authorized Representative Form* from the Fund Office or download the form at www.ufcwdrugtrust.org

2. **Deadline for Filing an Appeal.**

   a. ***For Health Claims and Claims for the Total and Permanent Disability Death Benefit ("Disability Claims")*:** Your appeal must be filed with the Fund within **180 days** after you receive written notice of the denial of your claim.

   b. ***For Standard Claims*:** Your appeal must be filed with the Fund within **60 days** after you receive written notice of the denial of your Claim. Standard Claims include claims for:

      - Eligibility for Fund coverage (including eligibilty for COBRA);
      - Supplementary Disability, Workers Compenation, or Unemployment benefits;
      - Death Benefits; and
      - Industry Vacation Benefits.

3. **Review Procedure.** The Board of Trustees (or the Appeals Committee) will give your appeal a full and fair review. As part of the appeals process:

   a. You may submit any written comments, documents, records, evidence, or other information that supports your claim, regardless of whether such information was submitted or considered in the initial review.

   b. You may request copies (free of charge) of all documents, records, and other information relevant to your claim.

   c. *For Health and Disability Claims only*: You may request the identity of any medical or vocational expert whose advice was obtained in connection with the claim denial.

   d. *For Health Claims only*: You may request procedure and diagnosis codes (free of charge), along with their corresponding meanings.

   e. You cannot appear personally before the Appeals Committee, unless it concludes that your appearance would be of value in enabling it to perform a full and fair review of your appeal.

4. **Notice of the Decision on Review.**

   a. Timing of Decision. Your appeal will generally be decided at the first Appeals Committee meeting that occurs at least thirty (30) days after your appeal is filed. If special circumstances require an extension of time, the decision will be made by the third Appeals Committee meeting after your appeal is filed, or later if you are asked to submit information necessary to decide the appeal. If special circumstances require an extension of time for processing, you will receive written notice before the extension begins. You will be notified in writing of the decision on your appeal within five (5) days after it is made.

   Exception: If you appeal a denied Pre-Service Claim for podiatry or orthodontic benefits, you will be notified in writing of the decision within 30 days after your appeal is filed.

   b. If Your Appeal Is Denied. If your appeal is denied or you do not receive a timely decision, you have the right to bring a civil action under ERISA Section 502(a). *You cannot file a civil action until you have exhausted the Fund's internal claims and appeals procedures.*

   For Health Claims only: If your appeal is denied, you may be able to request an external review of your claim by an independent third party. However, external review is available only for: (i) Health Claim denials that are based on medical judgment; and (ii) rescissions of coverage. If your claim is denied following external review, you can bring a civil action under ERISA section 502(a) at that time.

5. **Filing an Appeal.** Mail your appeal to the Board of Trustees at the Fund's address, as shown on the Appeal Form.

The Southern California Drug Benefit Fund complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-323-666-8910.
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-323-666-8910。