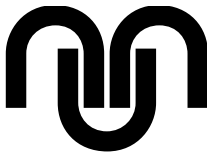


SOUTHERN CALIFORNIA
UNITED FOOD & COMMERCIAL WORKERS UNIONS AND
FOOD EMPLOYERS JOINT BENEFIT FUNDS ADMINISTRATION, LLC

CLAIMS & APPEALS
PROCEDURES
for
BENEFIT FUND
PENSION FUND



Summary of Material Modifications

Effective June 1, 2014

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Introduction

This booklet contains a summary of the Claims and Appeals procedures applicable to the benefits provided under the Benefit Fund and the Pension Fund. Unless expressly stated, this booklet does not describe the Claims and Appeals Procedures applicable to benefits provided by the Benefit Fund-sponsored HMOs (Kaiser and UnitedHealthcare) nor does it contain Claims and Appeals procedures applicable to the Prepaid Dental Plan. For Claims and Appeals Procedures applicable to those plans, please contact the Fund Office or review the HMO's Evidence of Coverage booklet.

Use of an Authorized Representative

You may designate someone as your Authorized Representative to be responsible for handling your claim, appeal, or request for external review, as applicable. Generally, your designation must be in writing, and you may obtain a form for this purpose from the Fund Office or your Union Local. In the case of Urgent Care Claims (defined at Section E. of Part I.), however, a health care professional with knowledge of your medical condition will be permitted to act as your Authorized Representative without your written designation.

BENEFIT FUND


SUMMARY DESCRIPTION OF CLAIMS AND APPEALS PROCEDURES

I. MEDICAL CLAIMS

This section applies to claims and appeals of denied claims for medical, dental, chiropractic and Employer/Member Assistance Program (“EMAP”) benefits that are pending as of, or submitted on or after, April 1, 2012. If you have any questions concerning your eligibility for these benefits, contact the Fund Office or your Union Local.

A. Filing Claims

1. PPO Providers and PPOC network podiatrists will submit claims for you. For other providers, a Claim form must be filed with the Fund Office for benefits for medical care, vision care, podiatric care, chiropractic care, acupuncture, dental care, or orthodontic care. You may also file a claim for prescription drugs if you are not satisfied after seeking benefits from a Participating Pharmacy. Claims submitted by your provider will be processed as if they were filed by you.
2. Claims must be filed in writing on forms acceptable to the Fund. You can request Medical or Dental Claim forms from the Fund Office or a Union Local.
3. Claims must be filed with the Fund Office (6425 Katella Avenue, Cypress, CA 90630-5238 or P.O. Box 6010, Cypress, CA 90630-0010) within one year after the date of service or they will be denied. If a PPO provider does not file a claim on time, the provider can bill



you only for the copayment or coinsurance you would have paid if the provider had filed on time.

4. Requests for information about plan benefits or eligibility are not considered claims, and the Fund Office's review of such requests will not be subject to the requirements and timelines described in this booklet.

5. See Section E. of this Part I for special rules for EMAP claims.

B. Processing Claims

1. Urgent care, concurrent care, and hospital stay claims are processed by Anthem and may require preauthorization to determine whether the proposed treatment is medically necessary. Anthem will process such claims and appeals in accordance with its own procedures, which are not discussed in this booklet. For a copy of Anthem's procedures, contact the Fund Office or Anthem. Call Anthem at 800-365-0609 if you have such a claim or appeal.

2. You will receive an Explanation of Benefits (EOB), which explains the Fund's payment of benefits, usually within 30 days after your claim is received. This may be extended an additional 15 days if necessary due to matters beyond the control of the Fund, or longer if you are asked to submit information necessary to process your claim. You will be notified of any extension before it is taken, the reason for it, and the date a decision is expected.

3. A rescission of coverage will be treated as a claim denial. A rescission of coverage is a cancellation or discontinuance of coverage

that has a retroactive effect, unless it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage. A rescission of coverage can occur even if it has no adverse effect on any particular benefit at that time.

4. If your claim is denied, in whole or in part, you will receive an EOB that:

- a. Identifies the claim involved and includes the date of service, the health care provider, and the claim amount (if applicable);
- b. States the specific reason(s) for the denial, the denial code (and its corresponding meaning), and a description of the Plan's standard(s), if any, that was used in denying the claim;
- c. Refers to the specific Plan provision(s) on which the denial is based;
- d. States that the Plan will provide you with the applicable diagnosis and treatment codes (and their meanings) if requested in writing;
- e. Describes any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary;
- f. Describes the Plan's internal review procedures, including the time limits applicable to such procedures and information on how to initiate an appeal;
- g. Describes the Plan's external review process and the time limits applicable to such process;
- h. Includes a statement of your right to bring a civil action under ERISA Section 502(a) following either the denial of a

claim on appeal or the denial of a claim under the Plan's external review process;


i. Includes a statement regarding the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under the Affordable Care Act to assist individuals with internal claims and appeals procedures and the external review processes;

j. States, if applicable, that an internal rule, guideline, protocol, or other similar criterion was relied upon in denying the claim and that a copy of such rule, guideline, protocol, or other criterion will be provided to you, free of charge and upon request; and

k. States, if applicable, that an explanation of the scientific or clinical judgment for the decision will be provided to you, free of charge and upon request, if the denial is based on a medical necessity or experimental treatment or similar exclusion or limit.

C. Filing an Appeal of a Claim Determination

1. If you are not satisfied with our determination of your claim, or you experience a rescission of coverage, **you have 180 days after receipt of our EOB to file an appeal.** Your appeal must be in writing and sent to the Fund Office, and it will be considered filed regardless of whether it contains all the information necessary to render a decision.



If your claim involves a Non-Preferred prescription drug for which benefits have been denied under the Market Priced Drug Program, you must file your appeal with OptumRx. OptumRx will process such appeals in accordance with its own procedures, which are not discussed in this booklet. For a copy of OptumRx's procedures, contact the Fund Office or OptumRx. Once the appeals process through OptumRx has been exhausted, if you are not satisfied with its determination, you may submit an Appeal to the Fund.

2. You will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim, including your claim file. In addition, you will be provided, automatically and free of charge: (i) any new or additional evidence considered, relied upon, or generated in connection with your claim; and (ii) any new or additional rationale for a denial at the internal appeals stage. This information will be provided to you as soon as possible, sufficiently before the decision on appeal is made, so that you will have a reasonable opportunity to respond before a final decision on appeal is rendered.

3. You may submit written comments, documents, records, evidence, testimony and other information relating to the claim, which will be considered on appeal regardless of whether such information was submitted or considered in the initial claims review.

4. Your appeal will receive full and fair review by the Board of Trustees or its designee, the Appeals Committee. The Board or Committee will make an independent determination and will not afford deference to the initial review.

5. If a denial was based in whole or in part on a medical judgment, including whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the Board or Committee will consult with a health care professional who has experience in the field of medicine involved in your claim. This health care professional will not be the individual who was consulted in connection with the initial claim denial, nor the subordinate of any such individual. If you request, we will identify any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the denial of the claim, even if the advice was not relied upon in denying the claim.

D. Processing Your Appeal

1. Your appeal will be decided by the Board of Trustees or its designee, the Appeals Committee, at its next regularly scheduled meeting that occurs at least 30 days following receipt of your appeal. If special circumstances require an extension of time for processing, the decision will be made by the third such meeting following receipt of your appeal, or later if you are asked to submit information necessary to process your appeal. You will be notified in writing of any extension before it is taken, the reason for it, and the date a decision is expected. You will be notified by mail within 5 days after the Board or Committee makes its decision.

2. If your appeal is denied, in whole or in part, you will receive a written denial notice that contains the following:

-
- a. Information sufficient to identify the claim involved, including the date of service, the health care provider, and the claim amount (if applicable).
 - b. A discussion of the specific reason(s) for the denial of the claim on appeal, the denial code (and its corresponding meaning), and a description of the Plan's standard(s), if any, that was used in denying the claim on appeal.
 - c. A statement of your right to receive, if requested, the applicable diagnosis and treatment codes (and their meanings).
 - d. The specific Plan provision(s) on which the denial on appeal is based.
 - e. 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 the claim.
 - f. A statement of your right to request an external review by an independent review organization, including a description of the external review process.
 - g. A statement regarding the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under the Affordable Care Act to assist individuals with the external review process.
 - h. A Statement of your right to bring an action under ERISA Section 502(a).
 - i. If applicable, a statement that an internal rule, guideline, protocol, or other similar criterion was relied upon in denying the appeal and that a copy of such specific rule, guideline, protocol or

other criterion will be provided to you, free of charge and upon request.

j. If the denial of a Medical Claim is based on a medical necessity or experimental treatment or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment for the decision will be provided to you, free of charge and upon request.

E. EMAP Claims

This information applies to individuals enrolled in the Indemnity PPO Medical Plan or United HealthCare (“UHC”) HMO. If you have any questions concerning eligibility for EMAP benefits, contact the Fund Office or your Union Local.

1. What is an Urgent Care Claim?

The term “Urgent Care Claim” means a claim where the usual time for processing a claim either (i) could seriously jeopardize your life, health or ability to regain maximum function or (ii) would subject you to severe pain that cannot be adequately managed without the care that is the subject of the claim. Your attending provider will determine whether a claim is an Urgent Care Claim, and HMC HealthWorks (“HMC”), the company that administers the EMAP, will defer to such determination.

2. Filing Claims:

a. You file a claim for EMAP benefits when you call HMC to request services.

b. If your EMAP claim is not properly filed but is received by the Fund Office or HMC and names you, a specific medical condition or symptom, and a specific treatment, service or product for which approval is requested, you will be notified of the proper procedures to follow. This notice will be provided within 5 days after receipt of the communication, or within 24 hours for an Urgent Care Claim. This notice may be oral, unless you request written notice.

3. Processing Claims:

a. HMC will process your claim within 15 days after it is received. HMC may extend this period for up to an additional 15 days if it determines that the extension is necessary due to matters beyond its control, or longer if you are asked to submit information necessary to process your claim. You will be notified of any extension before it is taken, the reason for it, and the date a decision is expected.

b. Urgent Care Claims. HMC will process your Urgent Care Claim within a reasonable time, but not later than 72 hours after receipt of the claim. Notice of the decision on an Urgent Care Claim may be provided orally, followed by a written notice within 3 days.

If HMC does not receive sufficient information to decide an Urgent Care Claim, it will notify you or your physician of such failure as soon as possible, but not later than 24 hours after receipt of the insufficient information. You will be afforded a reasonable amount of time, but

not less than 48 hours, to provide the specified information. After receipt of the specified information, HMC will provide its decision as soon as possible, but in no case later than 48 hours after the earlier of its receipt of the specified information, or the end of the period afforded you to provide the additional information.

c. **Concurrent Care Decisions.** If HMC has approved an ongoing course of treatment to be provided to you over a period of time or a number of treatments, a reduction or termination of the course of treatment before the end of such period of time or number of treatments (other than by amendment or plan termination) is a claim denial. HMC will notify you of such denial in advance of the reduction or termination and allow you to appeal and obtain a determination on appeal before the benefit is reduced or terminated.

If you request that a course of treatment be extended beyond the period of time or number of treatments initially approved and the request is an Urgent Care Claim, the request will be decided as soon as possible, and you will be notified of the decision not later than 24 hours after receipt of the request, but only if your request was made at least 24 hours before the expiration of the approved period of time or number of treatments. Otherwise, the decision will be made as soon as possible, but not later than 72 hours after your request is made.

d. If your claim is denied, in whole or in part, you will receive a notice that contains the information described in Section B.4. of this Part I. The notice

will also include a description of the expedited review process applicable to Urgent Care Claims, if applicable.

4. Appealing The Denial of EMAP Benefits

a. The procedures and time limits described at Section C. of this Part I. also apply to the appeal of EMAP claims, except that EMAP claims are submitted to and determined by HMC.

b. For appeals of denied Urgent Care Claims, HMC will accept oral or written requests for expedited review and will transmit all necessary information, including the determination on review, by telephone, facsimile, or other available expeditious method.

5. Processing an EMAP Benefits Appeal

a. HMC will notify you of its decision on your appeal:

(i) For Urgent Care Claims, as soon as possible, but not later than 72 hours after receipt of the appeal. Notice may be provided orally, by facsimile, or other similarly expeditious method, followed by a written notice within 3 days.

(ii) For non-Urgent Care Claims, within 30 days after receipt of the appeal. If the care was provided before the claim was submitted, the appeal will be decided within 60 days after receipt of the appeal. HMC may

extend this 60-day period a single time for up to an additional 60 days if it determines that special circumstances require an extension of time for processing the claim, and notifies you, before taking the extension, of the reason for the extension and the date a decision can be expected.

b. If your EMAP appeal is denied, in whole or in part, you will receive a denial notice containing the information described at Section D.2. of this Part I.

c. HMC has the discretionary authority and responsibility to determine all appeals of denied claims under the EMAP program. HMC also has the authority to interpret and construe all terms of the EMAP program and HMC determinations and instructions in such regard shall be final and binding, except in the limited circumstance that a claim or appeal is submitted to an IRO for external review under Section G. of this Part I., below, in which case the decision of the IRO will be final.

F. Recourse after a Medical Claim is Denied on Appeal

If your Medical Claim is denied on appeal, in whole or in part, you may:

1. Under two circumstances, submit the claim to external review (see Part I, Section G.), or
2. Bring an action under ERISA Section 502(a).

You may also bring an action under ERISA Section 502(a) after you have exhausted external review.

G. External Review (for Medical Claims Only)

Effective for requests for external review submitted on or after April 1, 2012.

1. General Rules

a. Eligibility for External Review: You may seek external review of your Medical Claim denial if all of the following requirements are satisfied:

(i) The denial either (a) involves a medical judgment (such as medical necessity, health care setting, level of care, or experimental treatment determinations), as determined by the external reviewer, or (b) concerns a rescission of coverage;

(ii) The denial was not based upon ineligibility for coverage;

(iii) You have exhausted (or are “deemed” to have exhausted, as discussed below in the second paragraph of Part III. below) the Plan’s internal claims and appeals procedures; and

(iv) You have provided all of the information and forms required to process an external review.

b. **Types of External Review:** There are two types of external review. (1) standard external review; and (2) expedited external review. There are special rules for expedited external review, including eligibility and timing requirements. These rules are shown below in Section G.3. of this Part I.

2. Standard External Review

a. Requesting External Review

(i) You may request an external review of your claim after your Medical Claim has been denied on appeal.

(ii) Your request for external review must be made in writing and must be submitted to the Fund Office within 4 months of the date of your appeal denial notice (see Section D.2. of this Part I.).

b. Preliminary Review by the Fund Office

(i) Within 5 business days of receiving your request, the Fund Office will determine whether your request is eligible for external review. The Fund Office will notify you of its decision in writing within one business day of making this determination.

(ii) If your request is not complete, the notice will describe the information or materials needed to complete the request, and provide with you instructions on completing your request.

c. External Review Procedure.

(i) An accredited independent review organization (IRO) will conduct the external review.

(ii) The IRO will notify you in writing that your request for external review has been granted.

(iii) You will have 10 business days after receiving the IRO's notice to submit additional written information regarding your claim to the IRO.

(iv) The Fund Office will provide the IRO with any documents and information that it considered in denying your claim within 5 business days after the request has been assigned to the IRO.

(v) The IRO will review all of the information and documents timely received. In addition, the IRO, to the extent the information or documents are available and appropriate, may consider additional information, including information from your medical records, recommendations or other information from your treating (attending) health care providers, other information from you or the Fund Office, reports from appropriate health care professionals, appropriate practice guidelines and applicable evidence-based standards, the Plan's applicable clinical review criteria, and/or the opinion of the IRO's clinical reviewer(s) and/or legal expert(s).

(vi) The IRO will review the claim de novo (as if it is new) and will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO decision is not contrary to such terms, unless the terms are inconsistent with applicable law. The IRO must also observe the Plan's requirements for benefits, including the Plan's standards for clinical review criteria, medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.

d. Notice of the IRO's Final External Review Decision.

(i) The IRO will notify you and the Fund Office of its final external review decision in writing within 45 days after the IRO receives your standard external review request.

(ii) The IRO's decision notice will contain the following:

(1) Information sufficient to identify the claim, including the date of service, the health care provider, and the claim amount (if applicable).

(2) The reason for the external review request and the reason for the previous denial.

(3) The date the IRO received the external review request.

(4) The date of the IRO's decision.

(5) References to the evidence or documentation considered in reaching its decision, including the specific coverage provisions and evidence-based standards.

(6) A discussion of the principal reason(s) for its decision, including the rationale for its decision and any evidence-based standards relied on in making its decision.

(7) A statement that the IRO's determination is binding, except to the extent that the dispute is submitted to binding arbitration pursuant to applicable State law.

(8) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Affordable Care Act to assist with external review processes.

3. Expedited External Review (Urgent Care Claims for EMAP benefits only)

- a. Eligibility: Expedited external review is only available for an Urgent Care Claim for EMAP benefits that has been denied at either: (i) the initial level, but only if an internal appeal has been filed in

accordance with Section E.4. of this Part I.; or (ii) on appeal. Expedited external review is also available for a Concurrent Claim that has been denied on appeal, if the denial concerns an admission, availability of care, continued stay, or health care item/service for which you received emergency services, but you have not yet been discharged from a facility.

b. Requesting External Review: Your request must be submitted to HMC within 4 months of the date that you receive the initial denial notice described in Section E.3.d. of this Part I. (or if applicable, the appeal denial notice described in Section E.5.b.).

c. Preliminary Review by HMC: Immediately after receiving your request, HMC will determine whether your request is eligible for expedited external review. HMC will notify you of its decision via telephone or fax immediately after making this determination.

d. External Review Procedure: An accredited independent review organization (IRO) will conduct the external review in accordance with the external review procedures described in Section G.2.c. of this Part I, except that HMC is required to provide the IRO with any documents and information that it considered in denying your claim expeditiously (i.e., via telephone, fax, courier, overnight delivery, etc.) after the request has been assigned to the IRO.

e. Notice of the IRO's Final External Review Decision.

- i. The IRO will notify you and HMC of its decision as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after it receives your expedited external review request. Notice may be oral, followed by a written notice within 48 hours.
- ii. The IRO's decision notice will contain the information described in Section G.2.d.ii. of this Part I.

4. Upon Completion of External Review

- a. If the IRO reverses the Plan's denial of your claim, the Fund Office must immediately cover or pay your claim.
- b. If the IRO upholds the Plan's denial, you may bring an action under ERISA Section 502(a) (see Section F.3. of this Part I., above).

II. DEATH BENEFIT AND INDUSTRY VACATION CLAIMS

This section is applicable to Claims for Industry Vacation and for Death Benefits and Retiree Death Benefits. If you have any questions concerning your eligibility for these benefits, contact the Fund Office or your Union Local.

A. Filing Claims

1. Claims for death benefits must be filed with the Fund Office within one year after the date of death.
2. Usually, you do not have to file a claim for Industry Vacation benefits. However, if you question the amount of Industry Vacation benefits paid by your Employer, you may file a claim with the Fund Office within one year from when your payment was due.

B. Processing Claims

1. Your claim will be processed within 90 days after it is received. This may be extended an additional 90 days if necessary due to matters beyond the control of the Fund, or longer if you are asked to submit additional information necessary to process your claim. You will be notified of any extension before it is taken, the reason for it, and the date a decision is expected.
2. If your claim is denied, in whole or in part, you will receive a written explanation that:
 - a. States the specific reason or reasons for the denial;

- b. Refers to the specific Plan provision(s) on which the denial is based;
- c. Describes any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary; and
- d. Describes the Plan's review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under ERISA Section 502(a) following a denial of a claim on appeal.

C. Filing an Appeal of a Claim Determination

1. If you are not satisfied with our determination of your claim, **you have 60 days after receipt of our determination to file an appeal.** Your appeal must be in writing and sent to the Fund Office.
2. You will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim. You may submit written comments, documents, records, and other information relating to the claim, which will be considered on appeal regardless of whether such information was submitted or considered in the initial claims review.

D. Processing Your Appeal

1. Your appeal will be decided by the Board of Trustees or its designee, the Appeals Committee, at its next regularly scheduled

meeting that occurs at least 30 days following receipt of your appeal. If special circumstances require an extension of time for processing, the decision shall be made by the third such meeting following receipt of your appeal, or later if you are asked to submit information necessary to process your appeal. You will be notified in writing of any extension before it is taken, the reason for it, and the date a decision is expected. You will be notified by mail within 5 days after the Board or Committee makes its decision.

2. If your appeal is denied, in whole or in part, you will be notified in writing of the following:

- a. The specific reason(s) for the denial of the claim on appeal.
- b. The specific Plan provision(s) on which the denial on appeal is based.
- c. 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 the claim.
- d. A statement of your right to bring an action under ERISA Section 502(a).

III. GENERAL RULES

The Board of Trustees of the Benefit Fund has full discretion and authority to resolve questions concerning the interpretation or administration of this Plan, and all benefits provided under the Benefit Fund, except for benefits provided by a Fund-sponsored HMO (Kaiser or UHC). The Board of Trustee's authority includes without limitation all questions relating to eligibility for benefits, and the determinations of the Board shall be conclusive and binding as to all persons and for all purposes, except in the limited circumstance that a disputed Medical Claim is submitted to an independent review organization ("IRO") for external review under Section G. of Part I., in which case the decision of the IRO will be final. The claimant shall have no right to appear personally before the reviewing group unless that group concludes that such an appearance would be of value in enabling it to perform its obligations.

If the Fund fails to follow these claims and appeals procedures, and it does not correct the error without prejudice to you, you will be deemed to have exhausted the administrative remedies available under the Plan and will be entitled to pursue any available remedies under ERISA Section 502(a). For Medical Claims, however, you have the option of first submitting your disputed claim to the external review process described in Section G. of Part I., before pursuing any available remedies under ERISA Section 502(a).

PENSION FUND

SUMMARY DESCRIPTION OF CLAIMS AND APPEALS PROCEDURES

This section applies to claims for Pension Benefits. If you have any questions concerning your retirement benefits, contact the Fund Office or your Union Local.

A. Filing Claims

1. To begin collecting retirement benefits, you must file a retirement application with the Fund Office or your Union Local. Retirement applications may be requested from the Fund Office or your Union Local.
2. You will be required to supply proof of age, your marriage certificate, and any other documentation necessary to complete your file and your application.

B. Processing Claims

1. Your application will usually be processed within 90 days after it is received. This may be extended an additional 90 days if necessary due to matters beyond the control of the Fund, or longer if you are asked to submit information necessary to process your claim. You will be notified of any extension before it is taken, the reason for it, and the date a decision is expected.
2. If your claim is denied in whole or in part, you will receive a notice that:

- a. States the specific reason or reasons for the denial;
- b. Refers to the specific Plan provision(s) on which the denial is based;
- c. Describes any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary; and
- d. Describes the Plan's review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under ERISA Section 502(a) following the denial of a claim on appeal.

C. Filing an Appeal of a Claim Determination

If you are not satisfied with our determination of your claim, **you have 60 days after receipt of our notice of determination to file an appeal.** Your appeal must be in writing and sent to the Fund Office.

You will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim. You may submit written comments, documents, records, and other information relating to the claim, which will be considered on appeal regardless of whether such information was submitted or considered in the initial claims review.

Your appeal will receive full and fair review by the Board of Trustees or its designee, the Appeals Committee.

D. Processing Your Appeal

1. Your appeal will be decided by the Board of Trustees or its designee, the Appeals Committee, at its next regularly scheduled meeting that occurs at least 30 days following receipt of your appeal. If special circumstances require an extension of time for processing, the decision will be made by the third such meeting following receipt of your appeal, or later if you are asked to submit information necessary to process your appeal. You will be notified in writing of any extension before it is taken, the reason for it, and the date a decision is expected.

You and your Authorized Representative do not have the right to appear personally before the Board or Committee, unless the Board or Committee concludes that your presence would be of value in rendering its determination.

You will be notified by mail within 5 days after the Board or Committee makes its decision.

2. If your appeal is denied, in whole or in part, you will be notified in writing of the following:
- a. The specific reason(s) for the denial of the claim on appeal.
 - b. The specific Plan provision(s) on which the denial on appeal is based.
 - c. 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 the claim.

d. A statement of your right to bring an action under ERISA Section 502(a).

E. Failure To Follow Procedures

If the Fund fails to follow these claims and appeals procedures, and it does not correct the error without prejudice to you, you will be deemed to have exhausted the administrative remedies available under the Plan and will be entitled to pursue any available remedies under ERISA Section 502(a).

Participating Union Locals

UFCW Local 8

Bakersfield – 661-391-5773 or 661-391-5770
900 Airport Drive, Bakersfield, CA 93308

UFCW Local 135

San Diego – Main Office – 619-298-7772 or 800-545-0135
2001 Camino Del Rio South, San Diego, CA 92108

San Marcos – 619-298-7772 or 800-545-0135
323-A South Rancho Santa Fe Road, San Marcos, CA 92078

UFCW Local 324

Buena Park – 714-995-4601 or 800-244-8329
8530 Stanton Avenue, Buena Park, CA 90620

UFCW Local 770

Los Angeles – Main Office – 213-487-7070 or 800-832-9770
630 Shatto Place, Los Angeles, CA 90005

Arroyo Grande – 805-481-5666
127 Bridge Street, Arroyo Grande, CA 93420

Camarillo – 805-383-3300
816 Camarillo Springs Road, Suite H, Camarillo, CA 93012

Harbor City – 310-784-5340
25949 Belle Porte Avenue, Harbor City, CA 90710

Huntington Park – 323-923-1510
5400 Pacific Boulevard, Huntington Park, CA 90255

Newhall – 661-259-9900
23030 Lyons Avenue, Suite 102, Newhall, CA 91321

Santa Barbara – 805-681-0770
4213 State Street Suite 201, Santa Barbara, CA 93110

UFCW Local 1167

Bloomington – 909-877-1110
855 West San Bernardino Avenue, Bloomington, CA 92316

UFCW Local 1428

Claremont – 909-626-6800
705 West Arrow Highway, Claremont, CA 91711

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Inglewood – 310-322-8329
9075 South La Cienega Boulevard, Inglewood, CA 90301

Administrative Office of the Fund

714-220-2297, 562-408-2715 or 877-284-2320,
6425 Katella Avenue Cypress, CA 90630-5238
P.O. Box 6010 Cypress, CA 90630-0010
scufcwfunds.com

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