THE BOARD OF PENSIONS
OF THE PRESBYTERIAN CHURCH (U.S.A.)

Administrative Provisions

Administrative Rule 1801 Appeals

Benefits Plan Reference
Article XVIII Administration

Original Date
01/17

Replaces: Administrative Rule 1201

If a Benefits Plan member or beneficiary (*a claimant*) disagrees with a Benefits Plan claim or eligibility determination made by the Board of Pensions or its designated service provider (e.g., Aetna Dental, Highmark, OptumRx, or Lincoln Financial Group), the claimant may appeal. An appeal must be submitted within 180 days of the adverse claim decision. Other than for Medical Plan appeals, the process includes an initial internal review. If the initial review yields an adverse determination, the claimant may seek a final review by the Board of Pensions Appeals Board.

The Medical Plan's appeals process includes a review by an outside, independent review organization, as required by the federal healthcare reform law and regulations. The Board of Pensions Appeals Board is not part of that process.

Retirement Plans and Death and Disability Plan Appeals

An appeal involving the Pension Plan, Death and Disability Plan, or Retirement Savings Plan of the Presbyterian Church (U.S.A.) (RSP) must be submitted in writing. It must explain the reasons for the appeal and include any additional supporting information. The appeal must be submitted to the applicable plan representative within 180 days of the date of the initial adverse claim determination.

Appeals involving death and pension benefits and the RSP go to the following:

Vice President, Income Security
Board of Pensions of the Presbyterian Church (U.S.A.)
2000 Market Street
Philadelphia, PA 19103-3298

Appeals of disability claims go to the following:

Lincoln Financial Group
P.O. Box 7206
London, KY 40742-7206

Fax: 603-334-0401
The claimant will receive a written response to the appeal within 60 days. If the review cannot be completed within 60 days, the claimant will be notified of the reasons for the delay and when to expect a response.

Eligibility and Dues Appeals

In the case of an adverse eligibility or dues-related decision, or if a benefits claim cannot be considered as presented, the claimant will receive a written or electronic notice stating the reason for the decision no more than 90 days after the plan receives the claim. If additional time is needed to process the matter, the claimant will be notified before the initial, 90-day period expires that an extension is required. The extension will not exceed 90 days beyond the initial, 90-day period.

Eligibility appeals go to the following:

Director, Delivery and Administration
Board of Pensions of the Presbyterian Church (U.S.A.)
2000 Market Street
Philadelphia, PA 19103-3298

Dues appeals go to the following:

Senior Vice President, Plan Operations
Board of Pensions of the Presbyterian Church (U.S.A.)
2000 Market Street
Philadelphia, PA 19103-3298

A senior manager considers the appeal, makes a determination, and communicates the decision, in writing, within 60 days of receiving the appeal. If there will be a delay in responding or further information or reviews are necessary (e.g., a second opinion or an independent review), the claimant will be notified, by letter, of the reason for the delay and approximately when to expect a response.

Final Appeals to the Board of Pensions Appeals Board

The Board of Pensions Appeals Board decides final appeals, other than Medical Plan appeals. The Appeals Board comprises the President of the Board of Pensions and three senior managers who are not involved directly in Benefits Plan administration. At least three Appeals Board members must be available to review an appeal and render a decision. The Appeals Board strives to provide a thorough, impartial review and to administer plan provisions uniformly, consistently, and fairly to all plan members.

The Appeals Board Secretary coordinates final appeals. All final appeals should be submitted, in writing, within 60 days of receipt of the initial appeal decision. Final appeals will be acknowledged, promptly, in writing.

Final appeals go to the following:

Appeals Board Secretary

Board of Pensions of the Presbyterian Church (U.S.A.)
2000 Market Street
Philadelphia, PA 19103-3298
Fax: 215-587-6215

The Appeals Board Secretary or his or her designee will ensure that the record of the appeal includes all pertinent information and any additional information submitted for the final-level appeal. The senior officer responsible for the benefits involved will also review the file to ensure that no further information is necessary for Appeals Board consideration. The claimant will be advised if further information is required for the review to proceed. A claimant or his or her representative is entitled to review the claim file and present written evidence as part of the appeals process. Any comments, documents, records, or other information the claimant submits will be considered. A claimant is not entitled to appear and provide testimony.

Each Appeals Board member will receive a copy of the appeals record before meeting to review the appeal and render a decision. The Appeals Board will strive to render a decision within 45 days of the Appeals Board Secretary receiving the appeal. The claimant will be notified in writing of the decision immediately following the meeting or be notified if a decision cannot be rendered within 45 days.

The Appeals Board determination is final and binding. No further appeals or reviews are provided for by The Board of Pensions of the Presbyterian Church (U.S.A.). Once a claimant has exhausted the appeals process, he or she may pursue any remedies available under state or federal law.

Medical Plan Appeals[1]

For the most part, Medical Plan claims are adjudicated by Highmark (medical and behavioral health), OptumRx (prescription drugs), and Aetna Dental. The Board of Pensions has assigned the claims determination and internal appeal to these service providers. The second, and final, level of appeal involves an external review by an independent company under contract with the applicable provider.

The initial adverse claim determination notice will include

- the specific reason(s) the benefit is not payable as requested;
- a description of additional material or information, if any, needed to reconsider the claim and an explanation of why it is necessary;
- an explanation of the plan's appeals process and time limits; and
- information about state assistance that might be available to the claimant.

A claimant must file an appeal, in writing, within 180 days of the date of the initial adverse claim determination or explanation of benefits (EOB) notice.

Medical and behavioral appeals go to the following:

Highmark Blue Cross Blue Shield
Member Appeals

[1] Triple S and GeoBlue appeals should be directed to the appropriate vendor.

P.O. Box 535095
Pittsburgh, PA 15253-5095

Prescription drug appeals go to the following:

OptumRx Member Services
P.O. Box 3410
Lisle, IL 60532-8410

Dental appeals go to the following:

Aetna
Appeals Department
P.O. Box 14597
Lexington, KY 40512

A claimant is entitled to review the claim file and present evidence and testimony as part of the appeals process. Any comments, documents, records, or other information the claimant submits will be considered. If the plan or its service provider develops new or additional evidence in connection with the claim, the claimant will be advised as soon as possible, and sufficiently in advance of any appeals determination, to allow him or her reasonable opportunity to respond.

The Medical Plan service providers will render a decision on an appeal in accordance with the following time periods:

- Any request by a claimant to extend an ongoing course of treatment beyond the period of time or number of treatments that involved urgent care shall be decided as soon as possible. The service provider shall notify the claimant of the decision within 24 hours after receiving the request, provided that the request is made at least 24 hours before expiration of the prescribed time period or number of treatments.
- Non-urgent care claims will be reviewed no more than 30 days after the service provider receives the appeal, although the provider may receive a one-time extension of 15 days if necessary.

If a provider fails to meet the prescribed time periods, above, the claimant may consider the internal claim review process exhausted and initiate an external review. A claimant may also request an external review if he or she is dissatisfied with the result of the internal appeals process.

Urgent Care Claim

An urgent care claim is a claim that if handled in the normal process could seriously jeopardize the claimant's life, health, or ability to regain maximum function, or could subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the claim.

An urgent care claim will be decided no more than 72 hours after the service provider receives the claim. If more information is required, the service provider will notify the claimant within 24 hours, and the claimant will have a reasonable period of time (not less than 48 hours) to provide

the information. The service provider will notify the claimant of its decision within 48 hours of receiving the specified information.

An expedited external review (see below) is available for urgent claims on request.

External Review (Final Appeal of Medical Plan Claims)

If a claimant is dissatisfied with the result of an internal appeal, a final, external review by an Independent Review Organization (IRO) is available. IROs are state-approved and -accredited organizations that are independent of the Board of Pensions and the plan's service providers.

The claimant must file a request for an external review with the service provider that advised him or her of the internal appeal determination (Highmark Blue Cross Blue Shield, OptumRx, or Aetna Dental) within four months of the determination date. The final appeal will be conducted by an IRO under contract with the service provider. The provider will select the IRO from among at least three IROs, randomly or by rotation. The plan will pay the cost of the IRO.

If the appeal relates to an urgent care claim or an admission, availability of care, a continued stay, or healthcare services for which a claimant received emergency care and he or she has not been discharged, an expedited external review is available upon request.

The IRO must provide written notice to the plan and the claimant of its decision to uphold or reverse the adverse benefit determination within 45 days of receiving the external review request.

The IRO's decision is binding on the plan and on the claimant except to the extent that other remedies are available under state or federal law.