



The Board of Pensions
of the Presbyterian Church (U.S.A.)

Medical

Continuation

Program

A summary of the Medical Continuation Program of the
Benefits Plan of the Presbyterian Church (U.S.A.)

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The **Medical Continuation Program** booklet is a publication of The Board of Pensions of the Presbyterian Church (U.S.A.).

The Board of Pensions tries to ensure the accuracy of its publications. If any discrepancy exists between this booklet and the official Benefits Plan document, the official Benefits Plan document governs. Copies of the official plan document are available on Pensions.org or from the Board of Pensions.

For information, assistance, or to request a publication or form, please call the Board of Pensions at 800-773-7752 (800-PRESPLAN) or visit Pensions.org.

Introduction

When your coverage under the Medical Plan ends, you may be eligible for the Medical Continuation Program. You pay the subscription cost for this program. The coverage is the same as that provided through the Medical Plan except for the determination of the deductible and maximum copayment requirements. (See *Guide to Your Healthcare Benefits* for detailed information.)

The Medical Plan, administered by the Board of Pensions, protects you against financial loss due to medical expenses and is a PPO (Preferred Provider Organization) plan. The PPO plan offers its members a network of physicians, hospitals, and other health-care providers; the network exchanges discounted fees for increased volume and prompt payment.

Members and seminary students terminating from the Benefits Plan, members on the Transitional Participation Basis, retired members, and members for whom disability status ends and termination status begins may subscribe to the Medical Continuation Program. Surviving and divorced spouses may also subscribe. A spouse and eligible children may subscribe even if the member does not. (See the Eligibility and Duration chart for length of time you can subscribe, page 3.)

To subscribe for the Medical Continuation Program, please complete the Medical Continuation Subscription or Waiver form and send it with your initial payment to activate coverage **within 60 days of your active coverage ending** to:

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

To obtain the current subscription rates, forms, or additional information, please visit **Pensions.org** or call **800-773-7752 (800-PRESPLAN)**.

Members who are temporarily unemployed and actively seeking church service may first participate on the Transitional Participation Basis and, subsequently, if employment is not found, be eligible for the Medical Continuation Program. If they elect the Medical Continuation Program first, they will not be eligible later for coverage on the Transitional Participation Basis.

Medical Continuation

Eligibility and Duration

Subscription periods vary depending on your eligibility status.

You or your eligible dependents must subscribe for Medical Continuation coverage (within 60 days of the event that results in termination of your Traditional Program coverage under the Medical Plan) by submitting the Medical Continuation Subscription or Waiver form to the Board of Pensions. The Board must also receive the initial subscription payment with your subscription form. Your coverage begins immediately following any free coverage period that may be applicable. Dues for your Medical Plan coverage as an active plan member must have been paid in full at the time of enrollment in the Medical Continuation Program, and coverage must be continuous. If you choose not to subscribe now, you will not be eligible to subscribe at a future date unless you are now eligible and file for the Waiver of Continuous Coverage provision. (See page 4.)

When employment is terminated, members are eligible for 30 days of free medical coverage provided they have had one year of plan membership. (Seminary education is considered the equivalent of plan membership.) If coverage ends as a result of the participating member's death, the surviving eligible family receives 12 months of coverage under the Medical Plan at no charge. (See the Eligibility and Duration chart, page 3.)

Divorce

If you are divorced as an active member, your ex-spouse may continue coverage by paying the monthly subscription. He or she has 90 days of free coverage from the date of the divorce and must subscribe for Medical Continuation coverage before the free coverage expires. The Board must receive a copy of the divorce decree.

No free coverage is available to divorced spouses if the divorce occurs when the member is retired. The divorced spouse must subscribe for Medical Continuation or Medicare Supplement coverage within 60 days of the divorce.

If the divorced spouse does not subscribe within the 60-day time frame, the right to continue medical coverage is forfeited permanently. The subscription charge starts on the day the coverage becomes effective.

Family Members

Eligible family members can subscribe even if the member does not. Newborns or a child who is placed for adoption with a member covered under Medical Continuation may be added to that coverage during the subscription period.

Seminarians

Covered seminary students who leave the seminary for any reason other than graduation or who graduate and elect not to continue plan participation on the Transitional Participation Basis are eligible to subscribe for the Medical Continuation Program for 18 months.

Continuing Medical Coverage

Your benefits continue as long as you remain eligible for this coverage (See the Eligibility and Duration chart, page 3.) and you make timely subscription payments. If payments are not made on time, your coverage will terminate. Termination is effective on the date through which the premiums are paid. (See Subscription, page 4.)

You may cancel your coverage, but once you have done so, you cannot reinstate it. The Board must receive a written request from you at least one month in advance of the date you want your coverage to cease.

If you are a retired pensioner and die while covered under the Medical Continuation Program:

- Your surviving spouse and/or dependent(s) need to inform the Board of Pensions within 30 days of the date of death.
- Your surviving spouse and/or dependent(s) may continue coverage under Medical Continuation by paying the subscription charges.
- Your surviving spouse may subscribe to Medicare Supplement if he or she has maintained continuous medical coverage and is participating in Medicare Part A and Part B.

If your surviving spouse and/or dependent(s) were not covered under the Medical Continuation Program, they are not eligible to apply.

Continuous Coverage Requirement for Medicare Supplement Eligibility

Only eligible members, their spouses, former spouses, and dependents who have maintained continuous coverage or executed approved waivers may subscribe for Medicare Supplement coverage under the Benefits Plan. (See the Eligibility and Duration chart, page 3.)

Eligibility and Duration

Why was coverage under the Medical Plan lost?	Who is eligible?	How long is coverage available under the Medical Continuation Program?
Member's employment terminates before age 55 if vested or at any age if not vested.	Member	18 months (29 months if member is disabled during first 60 days of Medical Continuation coverage)
	Spouse	18 months (29 months if spouse is disabled during first 60 days of Medical Continuation coverage)
	Child	18 months (29 months if child is disabled during first 60 days of Medical Continuation coverage)
Member's disability status ends and termination status starts.	Member	18 months
	Spouse	18 months
	Child	18 months
Active member's death. (Surviving eligible family receives 12 months of coverage at no charge.)	Surviving spouse	Until eligible for Medicare and Medicare Supplement
	Child	Until loss of eligibility
Divorce. (Ex-spouse receives 90 days of coverage at no charge from divorce date.)	Ex-spouse	Until eligible for Medicare and Medicare Supplement
	Child	Until loss of eligibility
Employment terminates for vested member at age 55 or older who has at least five years of plan participation, and the sum of the years of plan participation and age at termination equals 70 or more (Rule of 70); retirement is deferred. (Eligible to waive the continuous coverage requirement with other employer-sponsored coverage.)	Member	Until eligible for Medicare and Medicare Supplement
	Spouse	Until eligible for Medicare and Medicare Supplement
	Child	Until loss of eligibility
Early retirement for vested member at age 55 or older who has at least five years of plan participation, and the sum of the years of plan participation and age at retirement equals 70 or more (Rule of 70). (Eligible to waive the continuous coverage requirement with other employer-sponsored coverage.)	Member	Until eligible for Medicare and Medicare Supplement
	Spouse	Until eligible for Medicare and Medicare Supplement
	Child	Until loss of eligibility
Early retirement for vested member at age 55 or older; fewer than five years' plan participation, or the sum of the years of plan participation and age at retirement does NOT equal 70 or more.	Member	18 months
	Spouse	18 months
	Child	18 months
Child loses eligibility because of age or other employer-sponsored healthcare coverage.	Child	36 months
Employer withdraws employment classification from plan participation.	No one	Not available

Waiver of Continuous Coverage

If you want to maintain eligibility for retiree medical coverage under the Benefits Plan, you must maintain continuous coverage through:

- the Medical Plan (active or Medical Continuation coverage), or
- other comparable employer group medical coverage (active or retired) resulting from employment, with an approved waiver of continuous coverage on file with the Board of Pensions if you are no longer covered as an active participant.

Terminated and retired members must meet the Rule of 70 to subscribe for Medical Continuation until eligible for Medicare Supplement or to qualify for a waiver. The Rule of 70 requires that the member be age 55 or older when active coverage ends, have at least five years of plan participation, and that the sum of the member's years of plan participation and the age when coverage ends equals 70 or more. Individuals who may waive the continuous coverage requirement include:

- a retired member with other comparable employer group medical coverage (as an individual or through spousal coverage) and that member's spouse, and
- a terminated vested member with other comparable employer group medical coverage (as an individual or through spousal coverage) and that member's spouse.

Also, a surviving or divorced spouse of a member may maintain continuous Medical Plan coverage through the Medical Continuation Program from the first day of his or her eligibility as a surviving or divorced spouse until eligibility for Medicare Parts A and B. The surviving or divorced spouse may also apply for a waiver of the continuous coverage requirement if other comparable employer group medical coverage is in effect.

The other coverage may be for active or retired employees.

You must complete and return the Medical Continuation Subscription or Waiver form, including the waiver section in which you certify that medical coverage is available through another employer.

If you lose that other coverage because your spouse retires, your employment is terminated, or the employer discontinues coverage, you and/or your spouse can enroll in the Medical Continuation Program if you have previously submitted a completed and approved waiver form. You must notify the Board within 90 days of the qualifying event. The Board does not require a health statement and places no limits on pre-existing conditions in these situations.

Subscription

You, together with your spouse and your eligible children, can purchase family coverage for a total of two subscriptions. If your subscription combines the Medical Continuation Program and Medicare Supplement, you will be charged for the cost of the member's subscription plus the cost of the coverage for either your spouse or children, whichever is higher. You can also elect not to subscribe for yourself and still have your children covered at a maximum cost of two subscriptions for two or more children.

For example, a retiring member is eligible to subscribe to Medicare Supplement, but the spouse is not Medicare-eligible and needs to subscribe to the Medical Continuation Program. The cost would be for two subscriptions: one Medicare Supplement and one Medical Continuation.

In another example, the retiring member and spouse may both be eligible to subscribe to the Medicare Supplement, but they have a child who needs to subscribe to the Medical Continuation Program. The cost would be for two subscriptions: one Medicare Supplement and one Medical Continuation.

If you receive a pension benefit, the Board of Pensions will deduct the monthly subscription cost from it. If your benefit does not fully cover the subscription cost (or you are not receiving a monthly benefit payment from the Board of Pensions), you will receive a monthly invoice.

If the Board invoices you directly, subscription costs are billed in advance, with payment being due by the last business day of the month prior to the month of coverage.

When you enroll, you must include an initial payment with the subscription form for the Board to establish eligibility for medical coverage. Payment activates eligibility; the Board can neither reimburse members for medical expenses incurred nor verify eligibility during a period for which the Board has not received payment.

When the Board receives your full monthly subscription cost, it extends eligibility for the period for which you paid. If the Board does not receive your payment by the due date, your coverage will be temporarily suspended. You can reinstate this coverage by paying the full account balance within 30 days of the due date. Members whose claims are denied during the period of non-payment may contact Highmark to reprocess those claims when coverage is reinstated. If the Board has not received your payment within that time period, the coverage will terminate with no option for reinstatement.

Visit [Pensions.org](https://www.pensions.org) or call 800-773-7752 (800-PRESPLAN) for current subscription dues.

Claim Year

The claim year is based on a calendar year, from January 1 through December 31.

Filing Deadline

Subscribers must submit all claims within 12 months of the date they are incurred.

Medical Plan Coverage Options

The Benefits Plan provides options for medical coverage depending on where you live. When enrolling in the Medical Continuation Program, most members are automatically covered by the BlueCard® PPO (Preferred Provider Organization) plan administered by Highmark Blue Cross Blue Shield (BC/BS). Triple-S, a Blue Shield program, serves members in Puerto Rico. Members residing within the geographic boundaries of the Mid-Kentucky Presbytery have an HMO (Health Maintenance Organization) option through Anthem Blue Cross Blue Shield, called Blue Preferred®.

Members served by the BlueCard PPO network also use the network providers of Cigna Behavioral Health, a company that coordinates mental health and substance abuse services.

In addition, they have ActiveHealth Management available to them, a company that coordinates medical services, and Express Scripts® Inc., the prescription drug benefit administrator.

Those arrangements do not apply to members covered by the Anthem HMO option or to members residing in Puerto Rico.

BlueCard PPO

The covered services under the Medical Continuation Program are the same as those for active members enrolled in the Medical Plan. The Medical Plan design continues to encourage you to use hospitals, physicians, and other medical providers who participate in the BlueCard PPO network for medical/surgical services.

You can see any provider in the PPO network without a referral from your primary care physician.

You live in a network, out-of-network, or non-network area depending on access to participating providers:

- Network medical costs are costs for services or supplies furnished by a provider who participates in the BlueCard program.
- Out-of-network medical costs are costs for services or supplies provided in a network area by an out-of-network provider, that is, a provider in a network area who does not participate in the networks offered through the BlueCard program.
- Non-network medical costs are costs for services or supplies furnished in an area designated as non-network. A non-network provider is one who provides services or supplies in a non-network area to a member or eligible family member and does not participate in the BlueCard program.

If you use network services, you can receive the care you need and save money for both yourself and the plan as a whole. You save money because your share of the medical expenses incurred is based on the lower fees that Blue Cross Blue Shield has negotiated with its participating providers.

For mental health and substance abuse services, contact Cigna for information about participating providers, the Employee Assistance Program, and work/life programs. Any service provided by a non-participating provider is an out-of-network service, regardless of where you live.

Refer to *Guide to Your Healthcare Benefits* for pre-certification requirements and detailed information regarding provisions, administrative requirements, and contact information.

Anthem Blue Preferred®

If you elect to subscribe to the Medical Continuation Program and reside within the boundaries of the Mid-Kentucky Presbytery, you may elect Blue Preferred (Anthem Blue Cross Blue Shield), the HMO available in that area. Regardless of your form of coverage, you must return a completed Medical Continuation Subscription or Waiver form and pay the current subscription charges.

If this is the first time you are electing the HMO option, you must complete both the Blue Preferred enrollment form and the Medical Continuation Subscription or Waiver form. You may request the HMO enrollment form from the Board of Pensions.

Blue Preferred coverage differs from that of the BlueCard PPO; please check with the Board to verify your eligibility to elect the Blue Preferred option.

When children reach age 26 under the active Medical Plan, they may subscribe to the Medical Benefits provisions or, if eligible, the Blue Preferred option under Medical Continuation.

An eligible spouse may elect the Blue Preferred option even if the member is age 65 and not eligible; the member may elect the option even if the spouse is age 65 and not eligible.

Your Share of the Costs

Medical/Surgical Costs

Your share is based on a percentage of the median salary for pastors serving churches. If you enroll your spouse and eligible children for coverage, together they must satisfy one additional annual medical deductible.

Each year, the plan pays the full amount of your eligible network medical expenses after you pay:

- **office copays** (other than preventive),
- costs (other than preventive) up to your **deductible**, and
- your **copayments** up to a maximum.

Office copays

Except for preventive care, whenever you visit the doctor's office, you pay a fixed copay amount — \$25 for visits to primary care physicians and \$45 for specialists — even if you have satisfied your deductible and copayment maximum.

Office copays do not count towards deductibles and copayment maximums.

Deductibles

Your deductible is the annual amount you pay before the plan pays its portion.

For families, individual deductibles and a family deductible apply. Individual deductibles apply to each family member until the family deductible is met. After that, the plan pays a portion and you pay a portion (your copayment) up to a specified maximum.

Copayments

Your copayment maximum is the annual out-of-pocket maximum costs you pay (not including office copays), after which the plan pays 100 percent. Until you reach that maximum, you are responsible for a defined percentage of the costs (20 percent of the cost for network care and 40 percent for out-of-network care) — your copayment. Only one copayment maximum applies per family.

Deductibles and copayment maximums are based on salaries (i.e., ability to pay). Different deductibles and copayment maximums apply for network and out-of-network care; network providers cost you less, out-of-network providers cost you more. If you live in a network area and choose to use an out-of-network provider, you are responsible for paying the difference between the physician's charge and the plan allowance, if any. That difference does not apply to your copayment maximum.

Preventive Care

Preventive care coverage is limited to preventive and screening services received from your primary care physician, including a pediatrician or gynecologist, unless the screening requires a specialist. If you go to your physician for the exams, tests, and immunizations specified for your age and gender without signs or symptoms of illness, this qualifies as a primary care preventive health visit. (Please consult the detailed preventive schedules of covered services for adults and children, available on Pensions.org.) If a health condition is discovered or diagnosed during the exam, the visit is still eligible under preventive healthcare coverage.

Plan Reimbursement

The plan covers 100% of the plan allowance for eligible preventive screening and immunization procedures according to the detailed preventive schedules. (The benefits are reimbursed based on the contracted rate, so members may be subject to billing if they go to an out-of-network provider and the charge is above the plan allowance.)

The member is responsible for all deductibles and copayments. Annual covered preventive care office visits are paid or reimbursed at the following levels:

- **Network using network providers.** Members pay \$0 copay for an office visit with a primary care physician or gynecologist.
- **Network using out-of-network providers.** Members pay 40% of the maximum charge determined by the BCBS contracted rate in that area. The deductible is waived.
- **Non-network.** Members pay \$0 copay for a visit with a primary care physician or gynecologist as long as the charge falls within 120% of the BCBS contracted rate for that area.

The prescription drug benefit is subject to different copayments and copayment maximums.

Members are encouraged to call Cigna Behavioral Health (866-640-2772) for guidance in selecting appropriate network providers for mental health and

substance abuse services.

In the calendar year that you transfer from active status to Medical Continuation, **the amounts you have paid towards your medical deductible and copayment maximums while active are credited to your Medical Continuation coverage requirements.** If you have already satisfied the deductible and/or copayment maximum before your transition to Medical Continuation, you will not be required to satisfy any additional amount.

Prescription Drug Program

Express Scripts, the Medical Plan's pharmacy benefits manager, administers the plan's Prescription Drug Program. Through this program, plan members can obtain the medications they require to treat an illness or ongoing condition. Express Scripts offers a network of participating providers (including a mail-service pharmacy), maintains a formulary of preferred prescription medications, and processes claims.

When a generic equivalent is available, the prescription drug program covers only the cost of the generic drug. If a plan member purchases a brand-name drug when a generic is available, he or she will pay the brand-name, non-formulary copay plus the full cost difference between the brand-name drug and the generic drug. The additional cost does not count towards the copayment limit.

Prescription Drug Program Overview					
Type of Pharmacy	When To Use	Maximum Fill	Your Cost per Prescription*		
			Generic	Formulary	Non-Formulary
Retail Pharmacy	You receive your first prescription for a maintenance (ongoing) medication or need a prescription for short-term use	Up to a 30-day supply	\$8	30% of cost; \$20 min. to \$100 max.	50% of cost; \$50 min. to \$150 max.
Mail-Order Service	You have an ongoing condition requiring continued use of the same medication	Up to a 90-day supply	\$20	30% of cost; \$50 min. to \$300 max.	50% of cost; \$125 min. to \$450 max.

* The maximum amount you pay each year in out-of-pocket prescription drug costs is \$2,500, except for non-formulary drugs or surcharges. Those do not count towards your copayment maximum.

Maintenance Prescription Medications

Maintenance medications are prescription drugs that a patient takes regularly. These medications are often used to treat ongoing conditions, such as diabetes, high cholesterol, and high blood pressure.

Under the maintenance medication program, plan members can fill a 30-day prescription at a local pharmacy up to two times before incurring additional copayments — \$5 for generic drugs, \$10 for brand-name formulary drugs, and \$15 for brand-name non-formulary drugs. Ordering maintenance medications through Express Scripts Home Delivery not only allows members to avoid these additional charges, but also provides them a 90-day supply of maintenance drugs, usually for a lower copay than would be charged at retail pharmacies for the same quantity.

Step Therapy

Step therapy is a program that can make prescription drugs more affordable for most plan members and their families. In step therapy, the covered prescription drugs are organized in a series of steps, beginning with proven, cost-effective drugs, usually generics. These drugs have been approved by the Food and Drug Administration (FDA) and have a history of successfully treating many medical conditions. More expensive drugs are then used only in the few situations where the generics fail to deliver the desired outcomes.

Prior Authorization

When prior authorization is required, it means that more clinical information is needed about a patient's particular medical condition before Express Scripts can confirm the medical necessity for the recommended prescription. A doctor or nurse can provide that information and request a prior authorization. The goal is to ensure patients receive appropriate medications for their diagnoses.

Specialty Medications

Specialty medications — typically used to treat complex conditions — often have product handling and distribution requirements and need to be filled by CuraScript, the plan's exclusive specialty pharmacy. High-cost injectable or oral medications are considered specialty medications. Call Express Scripts at 800-344-3896 for information.

Additional Information

For more information, members can call Express Scripts at 800-344-3896 or visit Express-scripts.com, where they can:

- make payments
- get statements
- order and track refills
- view a personal prescription history
- estimate out-of-pocket prescription drug costs
- review benefit details, including the formulary
- read health and drug information
- find a participating pharmacy
- learn about mail-order pharmacy services for maintenance drugs

Members may also learn more about their prescription drug benefit by visiting the Board of Pensions website at Pensions.org. Here, they can view the full formulary or learn about:

- step therapy
- prior authorization
- Rx updates
- plan limitations

The Prescription Drug Program has a three-tier design with differing copayments for generics, brand-name formulary drugs, and brand-name non-formulary drugs. By paying a higher copayment for a non-formulary drug (See chart on page 7.), you can obtain that drug without having to submit medical necessity documentation for prior approval (unless the drug has specific prior authorization requirements). With this approach, you can purchase a non-formulary drug if you believe it is worth the additional out-of-pocket expense.

A copayment for a non-formulary drug does not go towards satisfying the copayment maximum. When use of a non-formulary drug is demonstrated to be medically necessary, the Board grants approval for its use, and the copayment will be at the formulary rate and count towards the copayment maximum.

Upon the advice of Express Scripts, the Board also may set rules about the use of prescription drugs. For example, it may set drug-specific quantity limits or require pre-authorization for certain medications, including a requirement that other therapies are tried first. Call Express Scripts to find out if particular limitations apply to the medication you are prescribed.

Specialty medications that are typically used to treat complex conditions and often have product handling and distribution requirements need to be filled at a specialty pharmacy. These medications include high-cost injectable or oral medications. CuraScript (800-278-0980) is the plan's exclusive pharmacy for these specialty medications. Call Express Scripts at 800-344-3896 for information.

Express Scripts administers the prescription drug benefit by processing claims and maintaining a drug formulary of preferred medications to help reduce costs. The complete drug formulary contains 95% of FDA-approved drugs, including all generics.

The formulary helps your physician prescribe cost-effective, quality medications and is updated regularly to add newly approved brand-name and generic drugs. If your physician or pharmacist has questions, he or she may call Express Scripts at 800-344-3896. The Prescription Drug Program covers most prescription drugs, including injectables, approved for use by the FDA and prescribed by a licensed provider, dispensed by a licensed pharmacy, and deemed medically necessary by the plan.

The plan does not cover drugs/medications that:

- have no approved FDA indications,
- have over-the-counter equivalents, or
- are appetite suppressants, smoking cessation products, or drugs prescribed for cosmetic purposes only. (Note: Smoking cessation products may be covered if you are enrolled in the Mayo Clinic Tobacco Quitline.)

Durable medical equipment is not covered under the Prescription Drug Program but may be covered under your medical benefits. To confirm coverage, call 800-773-7752 (800-PRESPLAN).

FAQs

How can I make sure my prescription is covered?

If your physician is going to give you a prescription, ask him or her to write it according to the drug formulary so that you can be reimbursed. Remember to have it filled at a pharmacy participating in the Express Scripts network and show your Express Scripts card when you purchase the prescription.

How can I find out about participating pharmacies or what drugs are on the drug formulary?

Call Express Scripts at 800-344-3896 or visit Pensions.org.

What does my physician do if the drug he or she wants to prescribe is not on the formulary?

You may purchase the drug and pay the brand-name non-formulary cost, or you may ask your physician to submit information about the medical necessity for use of the brand-name non-formulary drug by calling Express Scripts at 800-344-3896.

If medical necessity is approved, you need only pay the brand-name formulary copayment. Check to make sure the drug is not subject to step therapy and/or preauthorization requirements.

What if my physician wants me to take a brand-name drug instead of a generic one?

If your physician believes that this is medically necessary, he or she should contact Express Scripts at 800-344-3896 and speak to the Prior Authorization Unit. The physician will receive an FDA form that asks for detailed information about the negative results experienced with use of the generic medication. You also have the option to obtain the brand name by paying the full difference in cost, plus the generic copayment amount.

What if my physician's request is denied?

Under the three-tier design, a member can pay a higher copayment for a non-formulary drug (provided it is not subject to prior authorization and/or step therapy limitations) without submitting medical necessity documentation for prior approval. With this approach, a member can purchase a non-formulary drug if he or she believes it is worth the additional out-of-pocket expense. As a plan member, you have the right to file an appeal.

Appeals Process

When presented with your claim, the service provider determines whether it is payable under the Medical Plan. If it is, the claim will be paid according to plan provisions. If it is not, you'll receive a written notice of the reason your claim, as submitted, cannot be paid.

The notice will include:

- the reasons for the denial and/or references to the Benefits Plan provisions on which the denial is based
- a description of any additional information needed to reconsider the claim
- an explanation of the appeals process, including the deadline by which you must file your appeal

If the notice you receive does not contain all of the information above, you may request further details from the Board of Pensions.

If your claim for a benefit under the Medical Plan is reduced or denied, you can appeal that decision to the service provider who made it, whether Highmark Blue Cross Blue Shield, ActiveHealth Management, Cigna Behavioral Health, or Express Scripts.

The procedures for filing an appeal and for its review are covered here.

1. You Appeal a Denied Claim

You should direct your appeal for a medical, prescription drug, or mental health/substance abuse claim to the service provider indicated on the denial. There are two requirements:

- You must make your appeal request, in writing, **within 180 days** of the date of the written claim denial.
- The request for an appeal must explain your reasons for appealing the decision and include any additional information that supports the appeal.

2. Service Provider Reconsiders Your Claim

When presented with your appeal, the service provider reviews your reasons, documents, and related information and reconsiders whether the claim is payable under the Medical Plan.

Timeframes

The timeframe within which the Medical Plan's service providers must decide your appeal depends on its type.

For Urgent Care

Your appeal of an adverse decision for an urgent care claim* will be decided **no later than 72 hours** after its receipt. If the service provider needs additional information to decide if benefits are payable, you'll be notified within 24 hours and be given at least 48 hours to provide that information. You'll be notified of the service provider's decision within 48 hours of their receiving the additional information.

A request that an ongoing course of treatment for urgent care be extended beyond the allowed period of time or number of treatments initially authorized will be decided as soon as possible. Provided the service provider receives your request at least 24 hours before the prescribed period of time or number of treatments ends, they'll notify you **within 24 hours**.

**An urgent care claim is one that must be expedited because, in the professional judgment of your physician, the normal process may seriously jeopardize your life, health, or ability to regain maximum function, or could subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.*

For Any Other Medical Service Denial or Reduction

Your appeal will be reviewed no later than **30 days** after it is received, although the service provider may have a 15-day extension, if necessary.

3. You Request an External Review

If you are not satisfied with the results of your first appeal decision, you may request a final review by an Independent Review Organization (IRO). You must do so **within four months** of the date the initial appeal was decided, and file your appeal with the service provider that advised you of the initial review decision.

IROs are state approved and accredited organizations that are independent of the Board of Pensions and the plan's service providers. The service provider will select an IRO from at least three IROs, randomly or by rotation, to review your appeal.

4. The IRO Reviews Your Claim

The IRO will make its decision and notify you in writing **within 45 days** after the service provider received your request for external review.

Once you have exhausted the appeals process, you have the right to challenge the decision in a court of law.

Plan Amendment or Termination

Although The Board of Pensions of the Presbyterian Church (U.S.A.) expects and intends to continue the Medical Continuation Program indefinitely, it reserves the right to modify, terminate, or suspend these provisions at any time and report such action to the General Assembly.



The Board of Pensions
of the Presbyterian Church (U.S.A.)

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