Review and Appeals

If a plan participant disagrees with a benefit or eligibility determination made by the PSC-CUNY Welfare Fund or parties contracting with the Fund to administer components of the program, there is a process to request pursue review.

Type of Review

If the adverse determination involves **eligibility** for benefits, the review should be requested of the Fund Office. The request must be in writing and filed within 60 days of the initial determination. The request should include any new information or documented extenuating conditions that will impact the course of the review.

A decision will be made about a claim of eligibility and notice rendered in writing of that decision within 90 days. Under special circumstances, another 90 days may be needed to review a claim, and the participant will be duly notified of the extension.

If a claim of eligibility is denied, in whole or in part, the following will be noted:

- the specific reasons for the denial;
- the plan provision(s) on which the decision was based
- what additional information may relevant, and
- which procedures should be followed to get further review or file an appeal.

If the adverse determination involves **provision of or payment for benefits** , the review should be directed to the appropriate contract vendor or insurance carrier, according to the type of benefit. The request must be in writing and filed within 30 days of the determination or receipt of notice of the determination. The request should include any new information, medical data or documented extenuating conditions that may impact the course of the review.

Type of Appeal

In the event that a review is negative, the decision may be appealed.

- An appeal of a **negative eligibility decision** (except declination of coverage by a carrier related to medical suitability) must be directed to the PSC-CUNY Welfare Fund Board of Trustees within 60 days of the completion of the initial review.
- An appeal of a **negative benefits decision** related a non-insured product (CVS Prescription Drugs, Guardian Dental, GHI Extended Medical, all Vision Care, hearing aids, death and wellness) must by directed to the PSC-CUNY Welfare Fund Board of Trustees within 60 days of the completion of the initial review.
- An appeal of a **negative benefits decision** related an insured product (Standard Life Disability, Delta Dental HMO, certain HIP or Aetna Drug Riders, Hancock Long-Term Care, AIG Catastrophic Medical) must be directed to the carrier. The carrier is obligated to inform the participant of the appeals process, which will typically extend as far as the State

Insurance Department. These matters are not subject to review by the PSC-CUNY Welfare Fund Board of Trustees. The Fund office may cooperate with provision of any available materials or with clarification of terms, but is not a party to the process.

An Appeal to the Board of Trustees must be in writing and should include any new information or arguments that you feel will affect the proceedings. In the event of a review regarding a non-insured benefit, this must include the negative determination letter from the vendor/carrier. Appeals are reviewed by a committee of the Board which convenes as necessary. A decision will be made about an appeal within 90 days of its receipt by the Fund Office and determination that necessary information is provided. Under special circumstances, another 90 days may be required, and the participant will be duly notified.

If an Appeal is denied, in whole or in part, it will be noted:

- the specific reasons for the denial;
- the plan provision(s) on which the decision was based.