

## **COMPLIANCE AND RISK MANAGEMENT**

### **Claims and Appeals**

Any Trust participant or covered dependent or beneficiary claiming a benefit or questioning an interpretation, ruling or provision under any Trust benefit option (“claimant”) shall follow the procedure specified in the applicable document listed in Appendix I of the Trust agreement; if the document does not include claims procedures or they include procedures that do not satisfy the minimum requirements of Section 2719 of the PHSA (defined below), then the procedures in Section 2719 of the PHSA shall apply.

The entities that are responsible for administering and determining claims and appeals are the Insurers, or claims administrators for non-insured benefits (“Claims Administrators”), and in certain limited instances, the Trustees may also be a “claims administrator.” The Trustees are the Claims Administrator if the Everett School District (“district”) denies a request for enrollment in or eligibility for a benefit offered through the Trust. The claimant can appeal the denial to the Trustees. The Trustees are also the Claims Administrator for wellness benefits.

The Claims Administrator generally will make decisions on a claim within the time frames outlined in the applicable document listed in Appendix I of the Trust agreement. If a claimant submits a claim and the claim is denied in full or in part, the claimant will be notified in writing.

### **Insurance Benefits**

For each insured benefit provided by the Trust, the Insurer (defined below) will have the sole authority, discretion and responsibility to interpret and apply the terms of the insured benefit document(s) and to determine all factual and legal questions under such documents, including the amount of benefits to be paid under the Insurance Contract (defined below). Each Insurer is responsible for the payment of all benefits it insures. The liability of the Trust is limited to the payment of premiums to the applicable Insurer. No claimant (defined below) shall have any claim or cause of action against the Trust as to the payment of any benefits under any Insurance Contract. Each claimant entitled to payment of benefits under an Insurance Contract shall look solely to the applicable Insurance Contract, and not to the district, the Association, or the Trust for payment of such insured benefits. For each insured benefit provided under an Insurance Contract and offered by the Trust, the Insurer, and not the Trust, is responsible to comply with the internal claims and appeals and external review standards set forth in Section 2719 of the Public Health Services Act and interpreting regulations and subregulatory guidance, including without limitation 29 C.F.R. 2560.503-1 and 29 C.F.R. 2590.715-2719 (“Section 2719 of the PHSA”).

“Insurer” means an insurance company, insurance service or insurance organization that is licensed to engage in the business of insurance in a state and is subject to state law that regulates insurance. “Insurer” also includes a health maintenance organization (“HMO”) that is either a federally qualified HMO, an organization recognized as an HMO under state law, or a similar organization regulated for solvency under state law in the same manner and to the same extent as such an HMO. “Insurance Contract” means each applicable insurance, health maintenance organization contract or other similar policy or contract, any amendments thereto and any replacement or successor contract between the Trust and an Insurer.

**I. Initial Claim Determinations**

**A. Benefit Denials**

Insurers are responsible for administering and determining initial insured claims and the Trust has delegated the responsibility of administering and determining initial non-insured claims for benefits to the following third-party administrators. The Insurers and third-party administrators are identified in the documents listed on Appendix I of the Trust Agreement.

If a claimant submits an initial claim for benefits directly to the Trust rather than to the applicable Claims Administrator, the Trustees will direct the claimant to the appropriate above-listed Claims Administrator as soon as is reasonably possible.

**B. Eligibility or Enrollment Denials**

If a claimant submits a claim or request regarding eligibility for or enrollment in a benefit offered through the Trust to the Trustees, the Trustees will refer the claimant to the district or to the appropriate Claims Administrator. A claim or request regarding eligibility for or enrollment in a benefit offered through the Trust will be considered “filed” when the district receives the written request or claim.

**C. Notification of Denial**

If the Claims Administrator issues a benefit denial, the claimant will be notified of the denial in writing and pursuant to the Claims Administrator’s procedures. Except due to Trust amendment or termination, a “benefit denial” is a denial or reduction of benefits, failure to provide benefits, termination of benefits (in whole or in part). The notification of denial will be in the standard written format used by the Claims Administrator.

If the district or a Claims Administrator issues an eligibility or enrollment denial, the claimant will be notified of the determination either orally or in writing. An “eligibility or enrollment denial” is a denial of enrollment in or eligibility for a benefit plan offered through the Trust. If the denial is in writing, the notification of denial will be in the standard written format used by the district or the Claims Administrator.

**II. Appealing Denied Claims**

**A. Appealing Benefit Denials**

The claimant or his or her authorized representative may appeal a benefit denial. Appeals of benefit denials must be made to the appropriate Claims Administrator. Such appeal must be made in writing and submitted within the time frames outlined in the applicable document listed in Appendix I of the Trust agreement.

**B. Appealing Eligibility or Enrollment Denials**

The claimant or his or her authorized representative may appeal an eligibility or enrollment denial. If the eligibility or enrollment denial was made by a Claims Administrator, the appeal must be made to the Claims Administrator. Such appeal must be in writing and submitted within the time frames outlined in the applicable document listed in Appendix I of the Trust Agreement.

If the eligibility or enrollment denial was made by the district, the claimant may appeal the denial to the Trustees by using the Final Appeal Form. In this instance, the appeal must be made on the Final Appeal Form within 180 days of the district's notification of denial or else the claimant loses the right to appeal.

**C. Notification of Appeal Denial**

If the claimant appeals a benefit, eligibility or enrollment denial made by a Claims Administrator, and if the decision on appeal affirms the initial claim denial, the claimant will be notified of the decision upon appeal in writing. Such notification will be in the standard written format used by the Claims Administrator and be provided by the Claims Administrator within the time frames outlined in the documents listed in Appendix I of the Trust Agreement.

If the claimant appeals an eligibility or enrollment denial made by the district, the Trustees will review and render a written decision on the claimant's appeal, adverse or not, no later than 120 days after the Trustees received the appeal. Such notification will be on the Everett School Employee Benefit Trust Notice of Eligibility/Enrollment Appeal Denial form.

Cross Reference:     [Trust Policy 410](#)

Claims and Appeals

Legal Reference:     [WAC 200-110-120](#)

(Applies only if the Trust self-insures any Trust benefits.) Standards for claims management—Claims administration

Adopted: January 1, 2004  
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