~~410.1P~~

Claims ~~Procedure~~and Appeals

Claims Determinations

The Trustees or their delegate shall make such determinations as may be required from time to time in the administration of the Trust and shall have the sole authority and responsibility to determine all factual and legal questions under the Trust, including but not limited to interpreting and administering the terms and conditions of Trust benefits, deciding all questions concerning the eligibility of any persons to participate in Trust benefits, granting or denying Trust benefits including the resolution of disputed facts, construing any ambiguous provision of the Trust or Trust benefit document, correcting any defect, supplying any omission, or reconciling any inconsistency as the Trustees or their delegate, in its discretion, may determine.

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.

~~Where a third party administrator, insurance company, health care services contractor or HMO is in place with respect to a certain benefit, such third party has been delegated the responsibility for administering and determining initial claims and reviewing and reconsidering benefit, enrollment or eligibility denials if appealed ("appeals"). The entities that are responsible for administering and determining initial claims and appeals are called "Claims Administrators."~~

Claims and Appeals Procedure
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; 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, then the procedures in Section 2719 of the PHSA shall apply.

~~In~~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, ~~however,~~ the Trustees may also be a ~~Claims Administrator.~~"claims administrator." The Trustees are ~~a~~the Claims Administrator ~~in the following circumstances:1. If~~if the Everett School District ("District") denies a request for enrollment in or eligibility for a benefit ~~plan~~ offered through the Trust~~, the employee can appeal the denial to the Trustees~~.~~2. If a participant in a self-funded benefit offered through the Trust exhausts a third party administrator's appeal process, the participant can submit a final~~ The Claimant can appeal ~~of the benefit, enrollment or eligibility~~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 participant communications, such as Certificates of Coverage issued by ~~insurance carriers~~Insurers or summaries of plan benefits issued by third party administrators. If a ~~participant or his or her dependent~~Claimant submits a claim ~~("claimant")~~ and the claim is denied in full or in part, the ~~c~~Claimant will be notified in writing.

Claims for benefits are considered filed when the Claims Administrator receives the claim.

I. Initial Claim Determinations

A. Benefit Denials

The following 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 ~~and insurance carriers~~:

1. ~~Premara (the Washington Education Association (WEA) Premera Medical Plans)~~Aetna (medical insurance benefits)
2. ~~Washington Dental Service (~~Delta Dental of ~~Washigton)~~Washington (the WEA Delta Dental of Washington Plan (dental insurance benefits))
3. Willamette Dental (the WEA Willamette Dental Plan (dental insurance benefits))
4. ~~Premera (the WEA Vision Plans)~~MetLife (vision insurance benefits)
5. Group Health Cooperative (~~Medical Plan~~medical insurance benefits)
6. ~~Metropolitan Life Insurance Company (Life and Accidental Death & Dismemberment Insurance Plans)~~MetLife (life and accidental death & dismemberment insurance benefits)
7. ~~The Standard (Voluntary Short-Term and Long-Term Disability Plans)~~MetLife (voluntary short-term and long-term disability insurance benefits)

8. Magellan (~~E~~employee ~~A~~assistance ~~Plan~~benefits)

Every effort will be made by the Claims Administrators to process claims as quickly as possible. The Claims Administrator will notify a ~~c~~Claimant in writing if all or part of the claim will be denied within the time frames outlined in participant communications, such as Certificates of Coverage issued by ~~insurance carriers~~Insurers or summaries of plan benefits issued by third party administrators.

~~The Claims Administrator may secure independent medical or other advice and require such other evidence as it deems necessary to decide claims.~~

At any time, a ~~c~~Claimant has the right to appoint someone to pursue the claim on his or her behalf. ~~The claimant~~In such an instance, the Claimant must notify the Claims Administrator in writing and give the Claims Administrator the name, address, and telephone number where the ~~c~~Claimant's appointee can be reached.

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

B. Eligibility or Enrollment Denials

If a ~~c~~Claimant submits a claim to the Trustees rather than to the applicable Claims Administrator regarding eligibility for or enrollment in a benefit plan offered through the Trust, the Trustees will refer the ~~c~~Claimant to the ~~Everett School~~ District ~~("District")~~ or to the appropriate Claims Administrator listed in I.A. above.

C. Notification of Denial

If the Claims Administrator issues a benefit denial, the ~~c~~Claimant will be notified of the denial in writing. 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 ~~c~~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 ~~c~~Claimant or his or her authorized representative may appeal a benefit denial. Appeals of benefit denials must be made to the Claims Administrators listed in I.A.

above. Such appeal must be made in writing and submitted within the time frames outlined in participant communications, such as Certificates of Coverage issued by ~~insurance carriers~~Insurers or summaries of plan benefits issued by third party administrators.

If the ~~e~~Claimant does not follow the Claims Administrator's proscribed procedures, he or she loses the right to appeal the denial.

B. Appealing Eligibility or Enrollment Denials

The ~~e~~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 participant communications, such as Certificates of Coverage issued by ~~insurance carriers~~Insurers or summaries of plan benefits issued by third party administrators.

If the eligibility or enrollment denial was made by the District, the ~~e~~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 ~~e~~Claimant loses the right to appeal.

C. Notification of Appeal Denial

If the ~~e~~Claimant appeals a benefit, eligibility or enrollment denial made by a Claims Administrator listed in I.A. above, and if the decision on appeal affirms the initial claim denial, the ~~e~~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 participant communications, such as Certificates of Coverage issued by ~~insurance carriers~~Insurers or summaries of plan benefits issued by third party administrators.

If the ~~e~~Claimant appeals an eligibility or enrollment denial made by the District, the Trustees will review and render a written decision on the ~~e~~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.

~~**III. Final Appeal for Self-Funded Benefits**~~

~~For insured benefits, any claim or appeal determination made by the insurance carrier is final and cannot be appealed to the Trustees. For benefits that are funded directly by the Trust and not through a contract of insurance between the Trust and an insurance carrier, once a participant exhausts the third party administrator's appeal process, the participant may submit a final appeal to the Trust. The appeal must be made on the Trust's Final Appeal Form within 180 days of the third party administrator's notification of a benefit denial on appeal or else the claimant loses the right to appeal to the Trustees. For insured benefits, any claim or appeal determination made by the insurance carrier is final and cannot be appealed to the Trustees.~~

~~The Trustees will review and render a written decision on the claimant's final 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 Benefit 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

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