Everett School Employee Benefit Trust
Claims and Appeals Procedures Policy

Policy Effective Date: *January 1, 2004*
Last Revised: *January 1, 2004*

General Information

Benefits under the Everett School Employee Benefit Trust ("Trust") will be paid only if the Trustees of the Trust ("Trustees") or their delegate decides, in their discretion, that participants and their dependents are entitled to them. 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." As an example, for participants in the PPO, the Claims Administrator is Healthcare Management Administrators, Inc.

In certain limited instances, however, the Trustees may also be a Claims Administrator. The Trustees are a Claims Administrator in the following circumstances:

1. 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 appeal of the benefit, enrollment or eligibility denial to the Trustees.

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 or summaries of plan benefits issued by third party administrators. If a participant or his or her dependent submits a claim ("claimant") and the claim is denied in full or in part, the 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 Trust has delegated the responsibility of administering and determining initial claims for benefits to the following Claims Administrators:

1. Healthcare Management Administrators, Inc.~~/PCN~~

2. Pharmaceutical Care Network (PCN)
3. Metropolitan Life Insurance Company (MetLife)
4. Unum Life Insurance Company of America
~~2.~~ 5. Group Health Cooperative of Puget Sound
~~3.~~ 6. PacifiCare of Washington
~~4.~~ 7. Washington Dental Service~~/~~ (WDS)
8. Willamette Dental
~~5. MetLife~~

Every effort will be made by the Claims Administrators to process claims as quickly as possible. The Claims Administrator will notify a 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 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 claimant has the right to appoint someone to pursue the claim on his or her behalf. ~~This can be a doctor, lawyer, or a friend or relative.~~ The claimant must notify the Claims Administrator in writing and give the Claims Administrator the name, address, and telephone number where the claimant's appointee can be reached.

If a 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 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 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 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 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 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 Claims Administrators listed in 1.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 or summaries of plan benefits issued by third party administrators. If the 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 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 or summaries of plan benefits issued by third party administrators.

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 ~~Trust's~~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 listed in 1.A. above, 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 participant communications, such as Certificates of Coverage issued by insurance carriers or summaries of plan benefits issued by third party administrators.

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.

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 ~~that is upheld~~ 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.

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Insertion	
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Split/Merged cell	
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