EVERETT SCHOOL EMPLOYEE BENEFIT TRUST
NOTICE OF APPEAL DENIAL

TO: _____ Date:_____

_____

_____

[insert name and address of claimant or authorized representative]

RE: Everett School Employee Benefit Trust **[insert patient's name]** – Benefit claim of **[insert date]** re coverage of **[insert description of medical service, treatment or product]**

Dear **[claimant or authorized representative name]**:

This letter responds to your request for review of the benefit denial that was made on **[insert date]** with respect to benefits requested under **[insert self-funded medical plan name]** funded by Everett School Employee Benefit Trust ("Trust"). The Trust received your request for review on **[insert date]**. You requested coverage of **[insert description of medical service, treatment or product]** for **[insert patient's name]**. We have carefully considered the information provided and applied the terms of the plan that apply to your request for review. For the reason(s) set out below, we have determined that the benefits being requested are not covered by the health plan, and accordingly, the decision following review is that your request for plan benefits must be denied.

1. **Specific Reason for Denial**

   The specific reason(s) for denial of benefits and the Trust's agreement with that denial is **[insert description or reason]**.

2. **Applicable Plan Provisions**

   The provisions(s) in the plan document on which the denial is based is **[insert citation to section]** found on page(s) [**insert page number]**. The cited provision(s) states:

   [insert quote from relevant provision(s)]

This decision on review is the Trust's final decision.

Sincerely,

_____
Trustee(s)
Everett School Employee Benefit Trust