

SOUND HEALTH & WELLNESS TRUST PROCEDURES FOR FILING CLAIMS AND APPEALS

This Notice contains the Trust's procedures for filing claims for medical, dental, vision, and weekly disability (time loss) benefits and appeals of denied claims. These procedures are intended to comply with applicable U. S. Department of Labor regulations under Section 503 of ERISA. This notice should be kept with your current plan booklets. If you have any questions after reading through the information below, please call the Trust Office at **(206) 282-4500** in Seattle, or **(800) 225-7620** outside of Seattle.

Sound Health & Wellness Trust Benefit Claim Procedures

1. Effective Dates

These procedures are applicable to claims filed on or after January 1, 2003.

2. Statement of Purpose

These procedures summarize the requirements for filing a claim for benefits with the Trust, the time frames for making an initial determination on properly submitted claims, the contents of a denial of benefits, the procedures for filing an appeal, the Trust's appeal procedures, and the claimant's rights if an appeal is denied. These procedures are intended to help assure the consistent processing of claims and claim appeals.

The Trustees shall have the sole discretion, power and authority to interpret and apply the provisions of these procedures, or of their own motions, resolutions, and administrative rules and regulations, or of any contracts, instruments, or writings that they may have adopted or entered into with respect to these procedures. All such interpretations and applications shall be conclusive and binding on all parties.

3. Filing a Claim

To constitute a claim, the participant or beneficiary must comply with the procedures set forth below.

To be considered a claim, the participant or beneficiary must request that the Trust provide benefits for a specific service or supply. Claims must be submitted within one year from the date the services or supplies for which benefits are sought were received. Unless the participant or beneficiary can establish to the Trustees' satisfaction that it was not possible to file a claim within this one-year period, failure to submit a claim will result in a permanent denial of benefits. Subject to the special provisions dealing with urgent claims, claims must be submitted in writing by a participant or beneficiary and to the proper address.

The Trust may require additional information to process claims or to meet plan requirements. This may include inquiries related to eligibility, the nature of the services or supplies provided, coordination of benefits, other insurance, third party reimbursement requirements

or other plan provisions. Failure to provide this required information may result in the denial of a claim for benefits.

The Trustees have established the following requirements for filing claims:

a. Trust PPO and Sound Dental (formerly RCWT Schedule Dental) Benefits

Many providers will file claims for you if they have all of the needed information. If your provider does not submit a claim on your behalf, you will need to do the following:

- (1) Obtain a claim form from your employer, local union, the Trust Office, or by printing the form from the Trust's website at www.soundhealthwellness.com.
- (2) Complete all sections on the front of the form.
- (3) Attach a fully itemized bill from your provider of service. For dental services:
 - Have your dentist complete the provider section of the form. If continued treatment is needed, the dentist should send subsequent bills to the Trust Office.
 - If dental services are in connection with crowns, bridges, gold or porcelain inlays and onlays, gold restorations or dental implants, a dental treatment plan must be submitted in advance to the Trust Office for predetermination. The information must include current x-rays and records. (See your plan booklet for additional information about predetermination.)
- (4) If you have other medical or dental coverage and this plan is a secondary payer, submit the claim to the primary plan first. Once the primary plan pays, enclose a copy of their explanation of benefits and a fully itemized bill when you submit the claim to the Trust Office. (See your plan booklet for coordination of benefits rules.)
- (5) Mail the **fully** completed form and the enclosures to the address at the top of the form.
- (6) If you see a doctor for both vision care and medical treatment of the eye, you should submit the bill first to Vision Service Plan ("VSP") for reimbursement of expenses associated with the vision correction problem. Then send a copy of the bill – together with VSP's Explanation of Benefits – to the Trust Office for reimbursement of expenses covered by the Trust medical plan.
- (7) Remember, claims for injuries or accidents incurred on the job should be submitted to Workers' Compensation.
- (8) For claims assistance, contact the Trust Office at 206-282-4500 or 1-800-225-7620.

Note: Incomplete forms, and bills that are not itemized, will be returned to you for completion, which will delay payment of your claim. No claim will be accepted unless filed with the Trust Office within one year from the date the service or supply was received.

(b) Life Insurance and Accidental Death and Dismemberment Benefits

- (1) As soon as reasonably possible after the death of the insured person, notify the Trust Office, and, in the case of death, submit a certified copy of the death certificate.
- (2) Claims for Accidental Death and Dismemberment benefits must be made to the Trust Office no later than 90 days after the date of loss.
- (3) The Trust Office will forward all of the information to MetLife for processing.

(c) Weekly Disability Benefits (Time Loss)

- (1) Obtain a time loss claim form from your employer, local union, the Trust Office, or by printing the form from the Trust's website at www.soundhealthwellness.com.
- (2) Complete, sign, and date part 1 of the form.
- (3) Have your physician complete, sign, and date part 2 of the form.
- (4) Have your employer complete, sign, and date part 3 of the form.
- (5) Mail the **fully** completed form to the address at the top of the form.
- (6) Claims for Time Loss benefits must be filed within 12 months after the date the period of disability begins.

d. Vision Benefits (Trust PPO Plans)

The Trust has entered into an agreement with Vision Service Plan ("VSP") to provide vision benefits to you and your eligible dependents. Under this agreement, you can use any provider you wish. However, if you use a VSP provider, you may receive higher benefits, and the provider will automatically file claims for you.

To receive service from a VSP provider:

- (1) Choose a VSP provider from the provider directory. If you do not know if your provider is in the VSP network, or to obtain a directory, contact your local union office, the Trust Office, or VSP at 800-877-7195.
- (2) Make an appointment with your VSP provider. Prior to your visit they will verify your eligibility for benefits and the benefits available from the plan.
- (3) Pay a \$10 copayment.
- (4) The plan in most cases pays 100% for covered services.
- (5) There is no need to file a claim; the VSP provider will file the claim for you.

To receive service from a non-VSP provider:

- (1) Make an appointment with any provider
- (2) Pay the bill in full

- (3) File a claim for reimbursement. Write your name, Alternate ID number from your ID card, and the notation "Sound Health & Wellness Trust" on a copy of the receipt and send the copy to:

VSP
Out of Network Provider Claims
P.O. Box 997100
Sacramento, CA 95899-0001

- (4) The plan will reimburse you up to the scheduled amount (please refer to your plan booklet) less a \$10 copayment.
- (5) All claims must be filed within one year of the date services were received. Reimbursement is made directly to you and is not assignable to the provider.

4. Procedures for Processing Claims

Claims which are properly filed will be processed in accordance with the following guidelines:

a. Post-Service Health Claims

Any properly filed claim for health benefits that is not a pre-service, urgent care or concurrent care claim (as defined below) is processed as a postservice claim. If additional information is needed, the participant (or your dependent) will be notified and given 45 days from receipt of the notice to provide the required information. The time period for the Trust to make a benefit determination does not include the days from the date the information is requested until the earlier of the date the requested information is received or 45 after the request for information is mailed.

A post-service claim will ordinarily be processed within 30 days of receipt. This may be extended for an additional 15 days if the Trust Office determines that the extension is necessary due to matters beyond the control of the plan. In that case, you will receive a notice giving the reason the extension is necessary, including a statement of the unresolved issues and the information required to resolve these issues, within the initial 30-day period.

b. Pre-Service Health Claims

These procedures apply only to properly filed claims that must be preauthorized to receive full benefits from the Trust. All nonemergency inpatient stays must be preauthorized, except for maternity stays of 48 hours or less following a normal vaginal delivery and stays of 96 hours or less following a cesarean section delivery.

Claimants will be notified within five days if additional information is required to complete a preservice claim or to allow processing and will be advised of the specific information required. Claimants will be provided 45 days from receipt of the notice to submit any additional information requested. The time for the Trust to make a determination does not include the days from the date the information is requested

until the earlier of the date the requested information is received, or 45 days after the request for information is mailed.

A decision on a pre-service claim will ordinarily be made within 15 days. If additional time is necessary, the Trust Office may extend this 15-day period by an additional 15 days by providing notice to the claimant within the initial 15-day period giving the reason the extension is necessary, including a statement of the unresolved issues and the information required to resolve these issues.

If services which require preauthorization have been provided, the Trust will process the claim as a post-service health claim.

c. Urgent Care Health Claims

Urgent care claims are claims for services where following the normal claims processing timing rules could seriously jeopardize the claimant's health or ability to regain maximum function, or, in the opinion of a physician familiar with the claimant's medical condition, subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Urgent care claims may be filed orally or in writing. The claim may be filed by the claimant, or by a physician or other covered provider with knowledge of claimant's medical condition. Claimants will be informed within 24 hours after the claim is received if additional information is needed to process the claim and will be advised of the specific information required. The claim will be resolved no later than 48 hours after the earlier of the date the Trust Office receives the additional information or the end of the 48 hours the claimant has to provide the additional information. The determination of whether a claim is urgent will be made using the judgment of a prudent layperson with average knowledge of medicine or dentistry, as applicable.

If services which constitute urgent care have been provided, the Trust will process the claim as a post-service claim.

d. Concurrent Care Health Claims

Concurrent care claims are claims involving an ongoing course of treatment that has been authorized by First Choice as meeting the plan's medical necessity definition. While the approved treatment is continuing, the claimant or provider may ask to have additional or extended treatment approved. In addition, First Choice may issue notice that approval will be withdrawn before the full course of treatment is completed. The claimant will be notified of any denial or reduction at least 30 days in advance to allow the claimant sufficient time to appeal and obtain a determination on the appeal before the decision takes effect.

Any request to extend treatment that involves urgent care shall be decided as soon as reasonably practicable. The claimant will be notified of the determination within 24 hours of the time the Trust Office receives the claim, if it is received *at least* 24 hours prior to the expiration of the previously approved period of time or number of treatments.

Any appeal of a decision involving a concurrent care claim will be treated as either a pre-service, urgent care, or post-service claim appeal under these procedures, as appropriate.

e. Weekly Disability (Time Loss) Claims

A properly filed claim for weekly disability (time loss) benefits will ordinarily be processed within 45 days of receipt. This may be extended by an additional 30 days if a notice giving the reasons the extension is necessary and the date by which the Trust expects to issue a decision is provided to the claimant within the initial 45-day period. If, prior to the end of the first 30-day extension, the Trust determines that a further extension is necessary, the time may be extended for an additional 30 days, provided that the claimant is notified within the first 30-day extension period of the circumstances requiring the additional extension and the date by which the Trust expects to issue its decision. In the case of any extension of the time for processing a weekly disability (time loss) claim, the notice to the claimant will explain the applicable eligibility rules, the unresolved issues that made the extension necessary, and the additional information needed to resolve those issues. The claimant will be given at least 45 days within which to provide the specified information. The time period for the Trust to make a decision does not include the days from the date the information is requested to the earlier of the date the requested information is received or 45 days after the request for information is mailed.

f. Life Insurance Claims

A properly filed claim for life insurance benefits will normally be processed in 10 days with a written notice to the claimant. If additional information is needed from the claimant, follow-up letters will be sent to the claimant every 15 days. If, due to lack of information from the claimant, a decision cannot be made within 90 days, the claimant will be notified of an extension of 90 days until completion of the claim.

5. Notice of Denial

A denial of benefits will contain the following information:

- a. The reason for the denial.
- b. Reference to the plan provision(s) relied on.
- c. A description of any additional material or information needed for the claim, with an explanation of why it is necessary.
- d. Reference to any internal rule, guideline, or protocol used in denying the claim, with a statement that a copy of such rule, guideline or protocol is available without charge upon request.
- e. If the denial is based upon a medical necessity determination, because the service or supply is considered experimental or investigational in nature, or due to an equivalent exclusion, an explanation of the medical judgment applying the terms of the plan to the claimant's circumstances.

- f. An explanation of the Trust's appeal procedures, including applicable time limits.

The denial will be mailed to claimant at the last known address.

6. Appeal of Benefit Denial

Claimants have 180 days from the date of denial to appeal an adverse benefit determination. An appeal must be submitted in writing by the claimant or an authorized representative to the Trust Office. An appeal must identify the claim involved, as well as the reasons for the appeal, and provide any information the claimant believes is relevant. Except for urgent care claims, appeals will be accepted from an authorized representative only if accompanied by a written statement signed by the claimant (or parent or legal guardian where appropriate) naming the representative and authorizing them to seek benefits for the claimant. An assignment of benefits is not sufficient to make a provider an authorized representative.

Failure to file a claim appeal within 180 days of the denial will serve as a bar to any claim for benefits or for any other form of relief from the Trust.

7. Appeal Procedures

The procedures below shall be the exclusive procedures available to a claimant who is dissatisfied with an eligibility determination, benefit denial, or partial benefit award by the plan or its authorized claims payers. These procedures must be exhausted before a claimant may file suit under Section 502(a) of ERISA.

a. Information To Be Provided Upon Request

The claimant and/or authorized representative may, upon request and free of charge, have reasonable access to all documents relevant to the claim for benefits. Relevant documents shall include information relied upon, submitted, considered, or generated in making the benefit determination. They will also include internal guidelines, procedures, or protocols concerning the denied benefit claim, without regard to whether such document or advice was relied on in making the benefit determination. Absent a specific determination by the Trustees that disclosure is appropriate, relevant documents do not include any other individual's claim records or information specific to the resolution of other individuals' claims.

If a denial is based upon a medical necessity determination, an explanation of that determination and its application to the claimant's medical circumstances is also available upon request.

b. Review By Appeals Committee

Except for urgent care and pre-service claims, an appeal will be presented to the Trust's Appeals Committee at its next regularly scheduled meeting following receipt of the appeal. The Appeals Committee is appointed by the Trust's third party administrator and will not include any employee of the third party administrator who was involved in the initial processing of the claim. The Appeals Committee reviews

the administrative file, which contains all documents relevant to the claim, and all additional information submitted by the claimant. The review will be new and independent of the initial denial.

If the denial is based on medical or dental necessity, the Appeals Committee will consult with a medical or dental professional that has appropriate training and experience in the applicable field of medicine or dentistry. The Trust may have an individual with a different licensure review a matter if that individual is trained to deal with the condition involved. This professional will not be the individual who made the initial benefit determination or their subordinate. The Appeals Committee will identify by name any individuals consulted for medical or dental advice. The Appeals Committee will make its decision within 30 days of the date the appeal was received. The claimant will be notified of the Committee's decision as soon as reasonably practicable, but not later than five days after the decision is made.

c. Conduct of Review by Hearings Committee

If a claimant wishes to appeal a decision of the Appeals Committee, he or she may request a hearing before the Trustees' Hearings Committee, at which the claimant or his or her representative will be allowed to appear in person and present additional evidence or witnesses. These hearings are conducted according to the Trust's Hearing Procedures; copies of which may be obtained from the Trust Office. The Hearings Committee will consist of at least one Employer Trustee and one Labor Organization Trustee. The review by the Hearings Committee is new and independent from either the initial denial or the decision of the Appeals Committee. A request for a hearing must be made in writing and received by the Trust within 180 days of the date the claimant receives notice of the Appeals Committee's determination. Hearings will be held and decisions made within 30 days of the date the claimant's request for hearing was received unless the claimant agrees to a different schedule. The claimant will be notified of the Committee's decision as soon as practicable, but not later than five days after the decision is made.

d. Contents of Decision

If the Appeals Committee denies an appeal, the claimant will be notified of the specific reasons for the adverse decision and the specific plan provision(s) involved and advised that all information relevant to the claim is available without charge upon request. If the Committee relied on an internal rule, guideline, or protocol, its decision will identify the rule, guideline, or protocol involved and explain that a copy will be provided without charge upon request. If the Committee's decision was based on a medical judgment, its decision will explain the medical judgment, applying the terms of the plan to the claimant's circumstances. The claimant will also be notified of his or her rights under Section 502(a) of ERISA.

8. Modifications to the Appeal Procedures for Preservice and Urgent Care Claims

The following modifications will be made in the appeal procedures set forth in Section 6 for appeals involving pre-service or urgent care claims:

a. Pre-Service Claims

Pre-service claim appeals follow the above procedures with the following modifications:

- (1) There will be only one level of review, by the Appeals Committee; the Committee's decision is made within 30 days of the date the appeal is received, unless the claimant agrees to a different schedule. The claimant will be notified of the Appeals Committee's decision as soon as practicable, but not later than five days after the decision is made.
- (2) Appeals involving pre-service claims are reviewed by the Appeals Committee at its next scheduled meeting, time permitting, or by telephone conference call if necessary. The claimant or his authorized representative may participate, as authorized by the Committee, to the extent considered necessary for the Appeals Committee to develop an adequate record. If the claimant wishes to appear in person, he or she may elect to waive the 30-day time limit and schedule a formal hearing for a later meeting of the Committee.

b. Urgent Care Claims

Urgent care claim appeals follow the above procedures, with the following modifications:

- (1) An initial decision will be made within 72 hours if the initial claim was complete when submitted. If additional information is necessary to process the claim, the claimant or representative will be notified within 24 hours of the information needed. A decision on the appeal will be made no later than 48 hours after the earlier of the date the Trust receives the additional information or the end of the 48 hours the claimant has to provide the additional information.
- (2) An urgent care appeal may be made orally or in writing.
- (3) A medical or dental professional with knowledge of the claimant's condition may act as an authorized representative of the claimant without a prior written authorization.
- (4) Information may be provided to the claimant or authorized representative by phone, fax, or other expedited method. In any event, a written or electronic verification will be provided not more than 72 hours later.

9. Review of Denied Claims

The Trust does not provide any voluntary alternative dispute resolution procedures. If a claimant remains dissatisfied with the Trust's determination after exhausting the claim appeal procedures, he or she has the right to pursue a civil action under 29 U.S.C. § 1132(a) (i.e., section 502(a) of ERISA).

10. Ongoing Review of Policy

The Board of Trustees will annually review these procedures to ensure compliance with governing regulations. The Trustees will require the Trust's claims administrative agents to provide annual reports about their claims processing to document compliance with these procedures and to establish that claims are being processed consistently. A record of decisions on benefit claim appeals will be maintained.