CLAIMS AND REVIEW/APPEAL PROCEDURE (MEDICAL BENEFITS)

Your benefit program with the Northeast Pennsylvania School Districts (Health) Trust ("the Trust") maintains a claims procedure and a review and appeal procedure.

At any time during the appeal process, you may choose to designate a representative to participate in the appeal process on your behalf. You or your representative shall notify the Trust office in writing of the designation, with a copy sent to Highmark Blue Cross and Blue Shield ("Highmark BCBS").

For purposes of the appeal process, "you" includes designees, legal representatives and, in the case of a minor, parent(s) entitled or authorized to act on your behalf.

The Trust reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on your behalf. Such procedures as adopted by the Trust or its administrative service providers (including Highmark BCBS) shall, in the case of an urgent care claim, permit your physician or other provider of health care with knowledge of your medical condition to act as your representative.

CLAIMS PROCEDURE

You (the Participant) must first file all of the proper claims for your medical benefits with Highmark BCBS. If any portion of an initial claim submission is not paid, there is a denial of services in whole or in part, or you do not understand or agree with the handling of an initial claim determination or denial of services, there are several steps you can take.

Many questions can be answered quickly by calling the Customer Service number on your (the Participant's) Identification Card.

If you are not satisfied with the handling of the claim after this step, you may pursue the following procedures.

If you or your dependents have filed an initial claim for benefits and the claim is denied (in whole or in part), you will receive written notification from Highmark BCBS that includes the following:

- Specific reasons for the denial;
- Specific reference to any provisions of the Plan of Benefits on which the decision was based;
- Reference to the internal rule, guideline, protocol or other similar criterion that was relied upon in making the decision or a statement that a copy of the rule, guideline, protocol or other similar criterion is available upon request;
- A description of available internal appeal and external review procedures, including the time limits applicable to such procedures and information on how to initiate an appeal;

- The availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman to assist individuals with internal claims and appeals and external review procedures;

- A statement describing the opportunity to request the diagnosis and treatment codes (and their meanings) in all benefit denial notices; and

- In the case of a claim involving urgent care, a description of the expedited review process applicable to such claims.

If your claim is one in which a medical review is required, the written notification will also include:

- An explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances or a statement that such explanation will be provided free of charge upon request; and

- A description of any additional material or information needed to perfect the claim with an explanation of why it is needed.

This written notification is provided to you as an initial benefit determination. If your claim is denied at this stage, it is an adverse benefit determination. An adverse benefit determination includes coverage rescissions, defined as any retroactive termination of group health plan insurance coverage, except where an individual either: performed an act of fraud or made an intentional misrepresentation of a material fact. A retroactive termination of coverage is not a rescission when the termination is attributable to a failure to timely pay required premiums or contributions toward the cost of coverage.

Highmark BCBS will notify you of the initial benefit determination within the following timeframes:

- In the case of an urgent care claim, you will be notified as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by Highmark BCBS, unless you fail to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan, in which case, you will be notified of the specific information necessary to complete the claim and will be afforded at least 48 hours to provide the specified information and Highmark BCBS will then notify you of the initial benefit determination no later than 48 hours after the earlier of (a) Highmark BCBS's receipt of the specified information, or (b) the end of the period afforded you to provide the specified additional information.

- In the case of concurrent care decisions, which involve an approved ongoing course of treatment to be provided over time or a number of treatments, and where there is a reduction or termination of such course of treatment (other than by Plan amendment or termination), you will be notified at a time sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.

- In the case of pre-service claims, you will be notified of the benefit determination within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of your claim by Highmark BCBS, unless that period is extended by Highmark BCBS to up to 15 days and you are notified before the 15 day period expires of the circumstances requiring the time extension and the date by which Highmark BCBS expects to render a decision.

- In the case of post-service claims, you will be notified of the benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim by Highmark BCBS, unless that period is extended up to 15 days and you are notified before the 30-day period expires of the circumstances requiring the time extension and the date by which Highmark BCBS expects to render a decision.

In connection with your claim, you will be provided free of charge with any new or additional evidence that is considered, relied on or generated by, or at the direction of the Trust or Highmark BCBS in connection with the claim.

If you fail to follow the Plan's procedures for filing a pre-service claim, you will be notified of the failure and the proper procedures to be followed in filing a claim for benefits. This notification will be provided to you as soon as possible, but not later than 5 days (24 hours in the case of a failure to file a claim involving urgent care) following the failure and the notification may be oral unless you request written notification.

REVIEW/APPEAL PROCEDURE

You have the right to have your claim reviewed on appeal through the process described below. An internal review of your claim must be completed before you can institute an action in law or in equity in court.

Internal Review

If you receive notification that a claim has been denied by Highmark BCBS, in whole or in part, you may appeal the decision. Your appeal must be submitted to Highmark BCBS not later than 180 days from the date you received notice from Highmark BCBS of the initial adverse benefit determination.

Upon request to Highmark BCBS, you may review free of charge all documents, records and other information relevant to the claim which is the subject of your appeal and shall have the right to submit or present additional evidence or testimony, which includes any written or oral statements, comments and/or remarks, documents, records, information, data or other material in support of your appeal.

Highmark BCBS and the Trust will be involved in reviewing the appeal. The representatives of Highmark BCBS and of the Trust will be persons who were not involved in any previous adverse benefit determination regarding the claim that is the subject of your appeal and will not be the subordinate of any individual that was involved in any previous adverse benefit determination regarding

the claim that is the subject of your appeal.

In rendering a decision on your appeal, all evidence, comments, testimony, documents, records, and other information that you submit will be taken into account without regard to whether such information was previously submitted to or considered by Highmark BCBS or the Trust. Highmark BCBS and the Trust will also afford no deference to any previous adverse benefit determination on the claim that is the subject of your appeal.

In rendering a decision on an appeal that is based, in whole or in part, on medical judgment, including a determination of whether a requested benefit is medically necessary and appropriate or experimental/investigative, there will be consultation with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional will be a person who was not involved in any previous adverse benefit determination regarding the claim that is the subject of your appeal and will not be the subordinate of any person involved in a previous adverse benefit determination regarding the claim that is the subject of your appeal.

In cases of claims involving urgent care, you may submit a request for an expedited appeal either orally or in writing and all necessary information will be transmitted between Highmark BCBS or the Trust and you by telephone, facsimile or other available similarly expeditious method.

Your appeal will be promptly investigated and the Trust will provide you with written notification of the decision within the following time frames:

- When the appeal involves a non-urgent care pre-service claim, within a reasonable period of time appropriate to the medical circumstances not to exceed 30 days following receipt of your request for review/appeal;

- When the appeal involves an urgent care claim, as soon as possible taking into account the medical exigencies involved but not later than 72 hours following receipt of the appeal; or

- When the appeal involves a post-service claim, no later than 5 days after the next Board of Trustees meeting after the Trust's receipt of the appeal, unless the appeal is filed within 30 days preceding the date of such meeting, in which case, no later than 5 days after the second Board of Trustees meeting following the Trust's receipt of the appeal. If special circumstances require a time extension, the Trust will provide you with notification no later than 5 days after the third meeting of the Board of Trustees following the Trust's receipt of the appeal.

In the event the Trust renders an adverse benefit determination on your appeal, the notification shall include, among other items:

- The specific reason or reasons for the adverse benefit determination;

- Reference to the specific Plan provisions on which the benefit determination is based;

- A statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim for benefits;

- Reference to any internal rule, guideline, protocol or other similar criterion that was relied upon in making the decision or a statement that a copy of the rule, guideline, protocol or other similar criterion is available upon request;

- If the adverse benefit determination is based on a medical necessity or experimental or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances or a statement that such explanation will be provided free of charge upon request;

- If medical or vocational experts provided advice, the credentials of those individuals will be provided, and when required, they will be identified by name; and

- A statement regarding your right to request an external review or pursue a court action.

If the Trust's decision is a denial of your claim, in whole or in part, this is a final adverse benefit determination.

In connection with these procedures, upon your request, the Trust or Highmark BCBS will provide to you the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, associated with any adverse benefit determination or final internal adverse benefit determination.

External Review (Only applicable to non-grandfathered school districts or other public school entities)

These procedures for external review apply only to "non-grandfathered" (as defined under health care reform laws) school districts and public school entities.

Final adverse benefit determinations that involve medical judgment are eligible for external review. If you are a Participant associated with a "non-grandfathered" school district or other public school entity, you have four months from the date you receive notice of a final adverse benefit determination (except a determination that you failed to meet the eligibility requirements of your benefit program) to file a request for an external review with Highmark BCBS. This request must be in writing.

Preliminary Review

Highmark BCBS will conduct a preliminary review of your external review request within 5 business days following the date on which Highmark BCBS receives the request. Highmark BCBS's preliminary review will determine whether:

- You were covered by the Plan at all relevant times;

- The adverse benefit determination relates to your failure to meet the Plan's eligibility requirements;

- You exhausted the above-described appeal process; and

- You submitted all required information or forms necessary for processing the external review.

Highmark BCBS will notify you of the results of its preliminary review within one business day following its completion of the review. This will include reasons regarding the ineligibility of your request, if applicable. If your request is not complete, Highmark BCBS's notification will describe the information or materials needed to make the request complete. You will then have the balance of the

four month filing period or, if later, 48 hours from receipt of the notice, to perfect your request for external review, whichever is later.

Referral to an Independent Review Organization (IRO)

Highmark BCBS will, randomly or by rotation, select one of at least three IROs to perform an external review of your claim if your request is found acceptable after preliminary review. The IRO will be accredited by a nationally-recognized accrediting organization. Within 5 business days thereafter, Highmark BCBS will provide the IRO with documents and information considered when making the final adverse benefit determination. The IRO may reverse the Trust's final adverse benefit determination if the documents and information are not provided to the IRO within the five-day time frame.

Highmark BCBS will timely notify you in writing of your eligibility for the external review and will provide you with at least 5 business days following receipt of the notice to provide additional information.

The IRO will review all information and documents that are timely received. In reaching its decision, the IRO will review your claim de novo. In other words, the IRO will not be bound by any decisions or conclusions reached during the above-described appeal process.

The assigned IRO must provide written notice of its final external review decision within 45 days after the IRO received the request for the external review. The IRO will deliver its notice of final external review decision to you, Highmark BCBS and the Trust. The IRO's notice will inform you of:

- The date it received the assignment to conduct the review and the date of its decision;
- References to the evidence or documentation, including specific coverage provisions and evidence-based standards, considered in reaching its decision;
- A discussion of the principal reason(s) for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
- A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either you or your plan;
- A statement that judicial review may be available to you; and
- Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act.

Expedited External Review

You are entitled to the same procedural rights to an external review as described above on an expedited basis:

- If the final adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize your life or your health or would jeopardize your ability to regain maximum function and you filed a request for an expedited internal appeal; or
- For a final internal adverse benefit determination, if you have a medical condition where the time frame for completion of a standard external review would seriously jeopardize your life or

health or would jeopardize your ability to regain maximum function, or the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have not been discharged from the facility rendering the emergency services.

In the above circumstances, Highmark BCBS will immediately conduct a preliminary review and will immediately notify you of our reasons regarding the ineligibility of your request. If your request is not complete, Highmark BCBS's notification will describe the information or materials needed to make the request complete. You will then have 48 hours from receipt of the notice, to perfect your request for external review.

Referral to an Independent Review Organization (IRO)

Highmark BCBS will, randomly or by rotation, select one of at least three IROs to perform an external review of your claim if your request is found acceptable after preliminary review. The IRO will be accredited by a nationally-recognized accrediting organization. Thereafter, Highmark BCBS will immediately provide the IRO with documents and information considered when making the final adverse benefit determination via the most expeditious method (e.g., electronic, facsimile, etc.).

The IRO will review all information and documents that are timely received. In reaching its decision, the IRO will review your claim *de novo.* In other words, the IRO will not be bound by any decisions or conclusions reached during the above-described appeal process.

The assigned IRO must provide notice of its final external review decision as expeditiously as possible, but in no event more than 72 hours from the time the IRO received the request for the external review. The IRO must provide written notice of its final external review decision to you and to Highmark BCBS and the Trust, if not originally in writing, within 48 hours of its original decision. The IRO's written notice will inform you of:

- The date it received the assignment to conduct the review and the date of its decision;
- References to the evidence or documentation, including specific coverage provisions and evidence-based standards, considered in reaching its decision;
- A discussion of the principal reason(s) for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
- A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either you or your plan;
- A statement that judicial review may be available to you; and
- Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act.

Miscellaneous

When required, the Trust's Plan will provide continued coverage pending the outcome of the appeals process.

In connection with these claims and review/appeal procedures, you may be required to authorize the release of any medical records of the covered individual that may be required to be reviewed for the purpose of reaching a decision on review/appeal.

You may, at your own expense, have legal representation at any stage of these appeal procedures.

IF YOU HAVE ANY QUESTIONS ABOUT THESE CLAIMS AND APPEAL PROCEDURES PLEASE CONTACT THE TRUST OFFICE. The phone number is (570) 718-0433 or (570) 718-0353. You may also stop at the Trust office located at 38 Gateway Shopping Center, Edwardsville PA 18704. The office is open from 9:00 a.m. to 4:00 p.m. Monday through Friday.