PEBB Employee Request for Employer Review/Notice of Appeal

HCA | Health Care Authority
Public Employees Benefits Board

Type or print clearly in dark ink and use all capital, block lettering in the spaces provided. Example: J O H N
Keep a copy of your completed form for your records.

Follow the instructions under the heading that describes your situation.

If you are a current or former state agency or higher-education employee (or their dependent), and you disagree with **a decision made by the employer,** and you are requesting the employer's review about premium surcharges or eligibility for or enrollment in:

- A premium payment plan
- Medical coverage
- Dental coverage
- Vision coverage
- Life insurance
- Accidental death and dismemberment (AD&D) insurance
- Long-term disability (LTD) insurance
- Flexible Spending Arrangement (FSA) or Limited Purpose FSA
- Dependent Care Assistance Program (DCAP)

Complete Sections 1 through 3 of this form and submit it to the employer's payroll or benefits office.

The employer must receive this form **no later than 30 days** after the date on the denial notice regarding the decision you are appealing.

If you are a current or former state agency or higher-education employee (or their dependent), and you disagree with **a review decision made by the employer**, and you are now requesting the PEBB Appeals Unit review of the employer's decision:

Complete Section 7, sign and date Section 9 of this form, and submit it to the PEBB Appeals Unit.

The PEBB Appeals Unit must receive this form **no later than 30 days** after the employer's written review decision date in Section 4.

If you are a current or former state agency or higher-education employee or their dependent, and you disagree with **a decision made by a PEBB medical, dental , or vision plan, insurance carrier, or contracted vendor** about:

- A benefit or claim
- Completion of SmartHealth requirements or request for a reasonable alternative to a SmartHealth requirement
- Life insurance and AD&D insurance premium payments

Do not use this form.
Contact the medical, dental, or vision plan, insurance carrier, or contracted vendor to request information on how to appeal the decision.

If you are a current or former state agency or higher-education employee (or their dependent) and you disagree with **a decision from the PEBB Program** about:

- Eligibility or enrollment in:
  - A premium payment plan
  - Medical FSA or Limited Purpose FSA
  - DCAP
  - Life insurance
  - AD&D insurance
  - LTD insurance
- Eligibility to participate in SmartHealth or receive a wellness incentive
- Eligibility and enrollment for a dependent, extended dependent, or dependent child with a disability
- Premium surcharges
- Premium payments

Do not use this form.
Follow the appeal instructions on the decision letter you received from the PEBB Program.

See next page for employer group instructions.

If you are a current or former PEBB participating employer group employee (or their dependent) of:

- A county
- A municipality
- A political subdivision of the state
- A tribal government
- An educational service district
- The Washington Health Benefit Exchange
- An employee organization representing state civil service employees

and you disagree with **a decision made by the employer or the PEBB Program about:**

- Eligibility or enrollment in:
  - Life insurance
  - AD&D insurance
  - LTD insurance
  - Eligibility and enrollment for a dependent, extended dependent, or dependent child with a disability
- Eligibility to participate in SmartHealth or receive a wellness incentive

Complete Sections 1 through 3 of this form, or submit a letter to the PEBB Appeals Unit as described in the denial letter from the PEBB Program.

The PEBB Appeals Unit must receive this form **no later than 30 days** after the date of the initial denial notice or decision you are appealing (see Section 7).

If you are a current or former PEBB participating employer group employee (see list on the left) or their dependent and you disagree with **a decision made by a PEBB health plan or contracted vendor** about:

- A benefit or claim
- Completion of SmartHealth requirements or request for a reasonable alternative to a SmartHealth requirement
- Life insurance and AD&D insurance premium payments

Do not use this form.
Contact your employer for information on how to appeal the decision.

If you are a current or former employer group employee (see list on far left) or their dependent and you disagree with **a decision made by your employer** about:

- Premium surcharges
- Eligibility for or enrollment in medical, dental, or vision coverage

Do not use this form.
Contact your employer for information on how to appeal the decision or action.

Appellant's last name Last 4 digits of Social Security number

Request for initial employer review

Employees, former employees, or dependents may appeal. Your appeal must comply with all applicable deadlines on pages 1 and 2.

1 Appellant information

To be completed by the person filing the request for review or appeal (the appellant).

Select one:

Employee or former employee

Dependent of employee or former employee

Employer name

Social Security number Date of birth

Last name

First name Middle initial

Street address

Address line 2

City State

ZIP/Postal code

Mailing address (if different from above)

Address line 2

City State

ZIP/Postal code

Phone number Alternate phone number

Email address

Appellant's last name Last 4 digits of Social Security number

Other enrollee information (if appeal concerns people other than the appellant)

Enrollee 1

Last name Middle initial

First name Social Security Number

Enrollee 2

Last name Middle initial

First name Social Security Number

2 Describe your request for review or appeal

Describe the situation that led to your appeal and what you are asking for. Please be as detailed as possible. You may attach additional pages as needed.

3 Appellant signature

Sign and date this section. Keep a copy of this form for your records. Submit the signed request to the employer for review, if applicable.

By submitting this form, I declare that the information I have provided is true, complete, and correct.

Appellant's signature Date

4 Employer response to appellant's request for review

Instructions for employers

Complete Sections 4 through 6 (as applicable) to provide the requested review of your decision about the employee's or dependent's eligibility for benefits, enrollment, or a premium surcharge.

1. Complete Section 4 and Section 6 after the appellant completes Sections 1 through 3; see WAC 182-16-2020 for guidance.
2. **In addition, complete Section 5:**
   - If the Employer believes the Employing Agency committed an enrollment error.
   - If correcting an enrollment error as described in WAC 182-08-187 and PEBB Program Administrative Policy 11-3, forward your recommendation for correction of the enrollment error to the PEBB Program Outreach and Training Unit for final approval by secure message through HCA Support at **support.hca.wa.gov**. You must set up a secure login for this option.
   - For life, AD&D, or LTD insurance eligibility, enrollment, or premium issues, forward your recommendation to correct the decision or action caused by delay or error by secure message through HCA Support to the PEBB Program Outreach and Training Unit for a final approval.
3. Section 6 must be completed by a staff person who did not participate in the initial denial or decision-making process.
4. After completing all required sections:
   - Return this form to the appellant within 30 days of receipt.
   - Provide a copy to your agency administrator (or designee).

If the employer does not make a decision within 30 days, the appellant may appeal to the PEBB Appeals Unit.

To be completed by the employer.

Employer name

Agency/sub-agency code

Agency contact's last name

First name

Contact's phone number

Contact's email address

Date you received the appellant's completed and signed request for review

Full name and job title of the person who made this initial denial or decision on the appellant's request for review.

Last name

First name

Middle initial

Job title

List the PEBB Program rule(s) the denial or decision was based on, if known:

Appellant's last name

Last 4 digits of Social Security number

Date of employer's review decision on employee's request for review. The next level of appeal must be received by the PEBB Appeals Unit **no later than 30 days** after this date. If the PEBB Appeals Unit receives your appeal by the deadline, it will be considered timely.

Employer must check only one box.

The employer stands by the denial. The appellant has the right to appeal this decision by completing Section 7. The PEBB Appeals Unit must receive this form **no later than 30 days** after the date of the employer's review decision noted above.

The employer believes that an enrollment error occurred by the employing agency and must complete Section 5.

If the appeal relates to a decision made by the PEBB Program, the appellant is responsible for complying with the timelines described on the decision letter. (This form is not required if the PEBB Program has already sent a decision letter.)

5 Employer response (if applicable)

To be completed by the employer only when the employer agrees a wrong decision or action occurred.

Why do you believe a wrong decision or action occurred? Employing agency delay Employing agency error

Please explain the delay or error:

What do you recommend to correct the decision or action?

6 Employer signature

To be completed by a staff person who did not participate in the initial denial or decision-making process under appeal, such as the employer's administrator or a designee. Complete this section after the employer completes Section 4 (and Section 5 if applicable).

Reviewer's last name

First name

Phone number

Reviewer's signature

Date

Appellant's last name Last 4 digits of Social Security number

7 Employee notice of appeal to the PEBB Appeals Unit

To be completed by the appellant. Your appeal must comply with all applicable deadlines on page 1.

Instructions for appellant:

- Do not complete this section until you receive a completed copy of this form from the employer, unless you are directly appealing a decision made by the PEBB Program.
- If you wish to appeal the employer's decision, or you agree with the employer that a wrong decision or action occurred, complete this section, sign and date Section 9, and submit this form to the PEBB Appeals Unit as instructed below.
- You may attach a statement that identifies the specific portion of the decision you are appealing and explains why you agree or disagree with the employer's decision. You can also submit additional documentation for review.
- The PEBB Appeals Unit must receive this form **no later than 30 days** after the employer's review decision date in Section 4.
- If the employer does not make a decision within 30 days, the appellant may contact the PEBB Appeals Unit.

Response to the employer's reason for denial listed in Section 4, if applicable.

Additional information you want the PEBB Appeals Unit to consider that was not mentioned before.

Are you attaching additional documentation?

No.

Yes. I have attached additional documents, such as forms or correspondence between the employer or the PEBB Program and me. (Please identify the document and the reason you are submitting it.)

Appellant's last name | Last 4 digits of Social Security number

8 Representative information (if applicable)

If you have someone representing you, you must submit the *Authorization for Release of Information,* available on the PEBB Appeals webpage at **hca.wa.gov/pebb-appeals**. Or, you may submit a power of attorney document. Please contact the PEBB Appeals Unit for more information at 1-800-351-6827.

Representative's last name

First name | Middle initial

Mailing address

Address line 2

City | State

ZIP/Postal code

Phone number | Alternate phone number

Email address

Relationship to appellant | Washington State Bar Association number (if applicable)

9 Appellant signature and electronic service option

Sign and date this section. Keep a copy of this form for your records.

By signing and providing my email address below, I agree to receive service of appeal documents and orders from the PEBB Appeals Unit by secure message. I understand that the PEBB Appeals Unit will use secure messages to serve documents and orders on me at the email address below. I understand that service is complete when the PEBB Appeals Unit sends the email, not when I view it. (Please print clearly.)

Email address

By signing this form, I declare that the information I have provided is true, complete, and correct.

Appellant's signature | Date

How to submit this form

The PEBB Appeals Unit must receive this form **no later than 30 days** after the employer's review decision date in Section 4 to request a brief adjudicative proceeding. Submit this form by mail or fax.

Mail
Health Care Authority
PEBB Appeals Unit
PO Box 45504
Olympia, WA 98504

Fax
360-763-4709