Washington State
Health Care Authority

PUBLIC EMPLOYEES BENEFITS BOARD

Employee Request for Review/Notice of Appeal

- Type or print clearly in dark ink.
- Keep a copy of this completed form for your records.

<table>
<tr><th>If you are...</th><th>And you...</th><th>Follow these instructions and submission deadlines:</th></tr>
<tr><td rowspan="3">A current or former state agency or higher-education employee (or their dependent)</td><td>Disagree with a decision made by your employer about your:
• Premium surcharges
• Eligibility for or enrollment in:
▸ Medical
▸ Dental
▸ Life and accidental death and dismemberment (AD&D) insurance
▸ Long-term disability insurance
▸ Medical Flexible Spending Arrangement (FSA)
▸ Dependent Care Assistance Program (DCAP)
And are requesting your employer's review.</td><td>Complete Sections 1 through 4 of this form and submit it to your employer's personnel, payroll, or benefits office.

Your employer must receive the form no later than 30 calendar days after the date of the initial denial notice or decision you are appealing.</td></tr>
<tr><td>Disagree with your employer's review decision, or agree with your employer that a wrong decision or action occurred, and you are now requesting the Public Employees Benefits Board (PEBB) Program's review of your employer's decision (see Section 5).</td><td>Sign and date Section 8 of this form.
The PEBB Appeals Unit must receive this form no later than 30 calendar days after your employer's written review decision date in Section 5.</td></tr>
<tr><td>Disagree with a decision from the PEBB Program about:
• Eligibility and enrollment in:
▸ Premium payment plan
▸ Medical FSA
▸ DCAP
▸ Life and AD&D insurance
• Eligibility to participate in SmartHealth or receive a wellness incentive
• Eligibility and enrollment of a dependent, extended dependent, or disabled dependent
• Premium surcharges
• Premium payments</td><td>Complete Sections 1 through 4 of this form.
Check with your employer to see if they need to review this form before you submit it to the PEBB Appeals Unit (see Section 8).
The PEBB Appeals Unit must receive this form no later than 30 calendar days after the date of the initial denial notice or decision you are appealing.</td></tr>
<tr><td rowspan="2">A current or former employer group employee (or their dependent) of:
• A county
• A municipality
• A political subdivision of the state
• A tribal government
• A school district
• An educational service district
• A charter school
• The Washington Health Benefit Exchange
• An employee organization representing state civil service employees</td><td>Disagree with a decision made by your employer about:
• Premium surcharges
• Eligibility for or enrollment in:
▸ Medical
▸ Dental</td><td>Do not use this form.
Contact your employer for information on how to appeal the decision or action.</td></tr>
<tr><td>Disagree with a decision made by your employer, a PEBB insurance carrier, or the PEBB Program about:
• Eligibility or enrollment in:
▸ Life and AD&D insurance
▸ Long-term disability insurance
• Eligibility to participate in SmartHealth or receive a wellness incentive</td><td>Complete Sections 1 through 4 of this form.
The PEBB Appeals Unit must receive this form no later than 30 calendar days after the date of the initial denial notice or decision you are appealing (see Section 8).</td></tr>
<tr><td>A current or former state agency or higher-education employee (or their dependent), or an employer group employee (or their dependent)</td><td>Are seeking review of a decision made by a PEBB health plan, insurance carrier, or benefit-administrator about:
• A benefit or claim
• Completion of Smarthealth requirements or request for a reasonable alternative to a SmartHealth requirement.
• Life insurance premium payments</td><td>Do not use this form.
Contact the health plan, insurance carrier, or benefit administrator to request information on how to appeal the decision.</td></tr>
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Appellant Request for Review/Notice of Appeal

Note: Your appeal must be received by the applicable deadline described on page 1.

Section 1: Appellant Information

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

Select one:
- ❑ State agency or higher-education employee (or former)
- ❑ Employer group employee (or former)
- ❑ Applicant (not currently enrolled in PEBB coverage)
- ❑ Dependent of state agency/higher-education employee
- ❑ Dependent of an employer group employee

Social Security number	Last name	First name	Middle initial

Street address	Apt./Unit	City	State	ZIP Code

Mailing address (if different from above)	Apt./Unit	City	State	ZIP Code

Email address (if available)	Home phone	Alternate phone
	( )	( )

Other Enrollee Information *(if appeal concerns individuals other than the appellant)*

Social Security number	Last name	First name	Middle initial
Social Security number	Last name	First name	Middle initial

Section 2: Describe Your Request for Review or Appeal

Please be as detailed as possible. You may attach additional pages as needed.

What was the date of the denial notice or decision?

What denial or decision do you want reviewed?

Why do you disagree with the denial or decision? Please give a detailed description of your situation and attach supporting documentation. Provide a statement identifying the specific portion of the denial or decision you are appealing and explain what you believe to be error.

What would you like done about the denial or decision?

Are you attaching additional documentation?

❑ No ❑ Yes. I have attached additional documents, such as forms or correspondence between my employer or the PEBB Program and me.

These documents show:

Section 3: Representative Information *(if you have someone representing you)*

Last name	First name	Middle initial	Phone number	Email address
			( )	

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

Mailing address	Apt./unit	City	State	ZIP Code

Section 4: Appellant Signature

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

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

Signature	Date

(continued on next page)

Appellant's last name	First name	Middle initial

Employer Response to Employee's Request for Review/Notice of Appeal

Instructions for employers: Complete Sections 5 through 7 (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 5 and Section 7 **after** the employee completes Sections 1 through 4; see WAC 182-16-2020 for guidance.
2. Complete Section 6 only if you agree that a wrong decision or action occurred.
   a. If correcting an enrollment error as described in WAC 182-08-187 and PEBB Policy 11-3, forward your recommendation for correction of the enrollment error by secure email to the PEBB Program for final determination.
   b. For life or long-term disability eligibility, enrollment, or premium issues, forward your recommendation to correct the decision or action caused by delay or error by secure email to the PEBB Program for final determination.
3. Section 7 must be completed by a staff person who **did not** participate in the initial denial or decision-making process.
4. After completing all sections:
   a. Return this form to the employee **within 30 calendar days** of receipt; and
   b. Provide a copy to your agency administrator (or designee) for their records.

Section 5: Employer Response to Employee's Request for Review

To be completed by the employer.

Agency number	Subagency number	Agency contact	Contact's email	Contact's phone number
				( )

1. **Date you received the employee's completed and signed request for review:** ____________________
2. **Full name of person in your agency who made the initial denial or decision on the employee's request for review based on PEBB rules and/or policy:** ____________________
3. **Identify the PEBB rule(s) the denial or decision was based on:** ____________________
4. **Date of agency decision on employee's request for review** *(next level of appeal must be received by the PEBB Appeals Unit **within 30 days** of this date)*: ____________________

Check one:

- ❑ This appeal relates to a decision made by the PEBB Program. The employee is responsible for complying with the timelines described on page 1 to appeal to the PEBB Appeals Unit.
- ❑ The employer cannot consider this request because it was received more than 30 calendar days after the initial denial notice, decision, or action.
- ❑ The employer stands by the original decision. No employer error or delay caused a wrong decision or action.
- ❑ The employee has the right to appeal this decision by completing Section 8. The PEBB Appeals Unit must receive this form **no later than 30 calendar days** after the date of the employer's review decision (see number 4 above).
- ❑ The employer agrees that a wrong decision or action occurred and must complete Section 6.

Section 6: Employer Response When the Employer Agrees a Wrong Decision or Action Occurred

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

1. Why did the wrong decision or action occur? ❑ Agency delay ❑ Agency error
   Please explain the delay or error:
2. What action will you take to correct the denial, decision, or action? *(Leave blank if an enrollment error per WAC 182-08-187.)*
3. For life or long-term disability eligibility, enrollment, or premium issues, submit your recommendation below.
   The employer recommends the following to correct the decision or action caused by delay or error:

(continued on next page)

Appellant's last name	First name	Middle initial

Section 7: Employer Signature

To be completed by the employer's administrator or designee after completing Sections 5 and 6 as required.

By signing this section, the employer agrees that the initial decision was reviewed by one or more staff who did not participate in the original decision or decision-making process under appeal.

Reviewer's name (print or type)	Reviewer's phone ( )
Reviewer's signature	

Section 8: Employee Appeal to the PEBB Appeals Unit

To be completed by the appellant.

Employees:

- Do not complete this section until you receive a completed copy of this form from your employer.
- If you wish to appeal your employer's decision, or you agree with your employer that a wrong decision or action occurred, sign and date this section 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 and submit additional documentation for review.
  - The PEBB Appeals Unit must receive this form **no later than 30 calendar days** after the employer's review decision date in Section 5.

Submit the completed form by mail or fax to:

Mail: Health Care Authority
PEBB Appeals
PO Box 42699
Olympia, WA 98504-2699

Fax: 360-725-0771

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

Appellant's signature	Date