Title: Continuation Coverage and Retiree Insurance Coverage Reinstatement for Subscribers with Mental or Physical Impairment or Incapacitation

PEBB Program Administrative Policy 56-1

Contact:	Rules Specialist, ERB Division	**Effective:**	January 1, 2019
		Rescinded:	
Associated RCW:		**Supersedes:**	
Associated WAC:	182-08-180		
Assoc. fed law/reg:		**Owner:**	Policy, Rules, & Compliance Manager, ERB Division
Associated Procedures:			
Associated Forms & Communication		**Approved by:**	
		Position:	Director of the PEBB Program
		Date approved:	11/29/2018

Purpose:

This policy applies whenever a subscriber (or another party acting on behalf of the subscriber) requests reinstatement of continuation coverage or retiree insurance coverage due to non-payment of premiums, or applicable premium surcharges, for reason of mental or physical impairment or incapacitation.

This policy establishes the methodology that the PEBB Program will use to make a determination of mental or physical impairment or incapacitation for the purpose of reinstatement of coverage terminated due to non-payment of premiums, or applicable premium surcharges.

This policy provides timing requirements for requesting reinstatement due to non-payment of premiums, or applicable premium surcharges, for reason of mental or physical impairment or incapacity.

Policy:

1. Reinstatement Eligibility: The subscriber, and anyone who is permitted to pay premiums on behalf of the subscriber (i.e., spouse, state registered domestic partner, dependent, legal representative, hospital administration, etc.), may request reinstatement of continuation coverage or retiree insurance coverage due to the mental or physical impairment or incapacitation of the subscriber.

2. A determination of the subscriber's mental or physical impairment or incapacitation shall be made by the subscriber's physician. A written note from the subscriber's physician will

be sufficient proof of the subscriber's impairment or incapacitation if it includes the following information:

a. The condition that renders the subscriber mentally or physically impaired or incapacitated; and

b. The date that the subscriber's mental or physical impairment or incapacitation began, and if it has ended, the date the period of impairment or incapacitation ended.

3. If the subscriber, or a party acting on behalf of the subscriber, is not able to provide a note from the subscriber's physician, the Health Care Authority's (HCA) Clinical Quality and Care Transformation (CQCT) Division will make a determination of impairment or incapacitation based upon supporting documents submitted on behalf of the subscriber. The supporting documents must clearly state the condition that renders the subscriber mentally or physical impaired or incapacitated, and the date the impairment or incapacitation began and if the impairment or incapacitation has ended, the date it ended.

4. A request for reinstatement due to the mental or physical impairment or incapacitation of the subscriber must be made in writing and received by the PEBB Program no later than 120 days after the date on the termination letter sent by the HCA. A written note from the subscriber's physician as described in section 2 above, or supporting documentation as described in section 3 must be submitted with the reinstatement request.

5. If the request for reinstatement is approved, coverage will be reinstated retroactive to the date of termination for non-payment of premiums, or applicable premium surcharges, and is contingent upon the subscriber or another party acting on behalf of the subscriber making the payment of any unpaid premiums and unpaid applicable premium surcharges.

6. If the request for reinstatement is denied, the subscriber's coverage will remain terminated. The subscriber or another party acting on behalf of the subscriber may appeal the denial to the PEBB Appeals Unit by following the process described in WAC 182-16-2030.