INSERT AGENCY LETTERHEAD

MM/DD/YYYY

Dear NAME,

During a retrospective review of your eligibility for PEBB Program insurance, it was discovered that you became ineligible for PEBB benefits on a MM/DD/YYYY and we failed to end coverage timely. We are providing you with this notification because we are unable to terminate your medical coverage retroactively due to Federal termination rescission laws (Policy 19-1, Addendum 19-1A).

As a result, you will remain enrolled in the current medical plan from MM/DD/YYYY through MM/DD/YYYY (WAC 182-12-187). You are not responsible for the employee medical premiums during this time period and we did not collect any employee medical premiums after MM/DD/YYYY.

**Recourse options** may be considered for medical and dental for the period of MM/DD/YYYY to MM/DD/YYYY. When correcting termination errors, the employer must work with the employee and the Health Care Authority to implement insurance coverage within the following parameters:

* Retroactive enrollment in a PEBB Program health plan;
* Reimbursement of claims paid;
* Reimbursement of amounts paid for medical and dental premiums; or
* Other recourse, upon approval by the Health Care Authority

**Recourse** must not contradict a specific provision of federal law or statute and does not apply to requests for non-covered services or in the case of an individual who is not eligible for PEBB Program benefits.

**An employee** who does not agree with a recourse decision of the employing agency or the Health Care Authority may appeal the decision by submitting an appeal within 30 days as outlined in WAC 182-16.

**Failure to respond** no later than 31 days from the date of this notice, will result in automatic refund of medical premiums collected in error with no future opportunity for recourse.

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I understand my medical and dental coverage ended on MM/DD/YYYY, due to the Federal termination rescission laws. I understand my employer paid medical premiums from MM/DD/YYYY to MM/DD/YYYY and did not collect any employee medical premiums after MM/DD/YYYY.

**Choose one:**

[ ]  I do not choose to pursue additional recourse.

[ ]  I choose to pursue the following recourse: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Employee Signature: Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sincerely,

INSERT AGENCY

SIGNATURE BLOCK