INSERT AGENCY LETTERHEAD

MM/DD/YYYY

Dear EMPLOYEE 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 notice because we are unable to terminate your medical coverage retroactively; due to Federal rescission laws for termination of coverage (Policy 19-1, Addendum 19-1A). As a result, you remained enrolled in the current medical plan from MM/DD/YYYY through MM/DD/YYYY (WAC 182-12-187) and are not responsible for your employee medical premiums and any employee medical premiums collected in error will be refunded.

**Recourse options** may be considered for medical and dental for the period of MM/DD/YYYY to MM/DD/YYYY.

When correcting enrollment 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.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand my medical and dental coverage will end on MM/DD/YYYY due to the Federal rescission laws for termination of coverage. I agree to my employer covering medical premiums from MM/DD/YYYY to MM/DD/YYYY and any medical premiums collected in error will be refunded.

**Choose one:**

I do not choose to pursue any recourse.

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

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

Sincerely,

INSERT AGENCY SIGNATURE