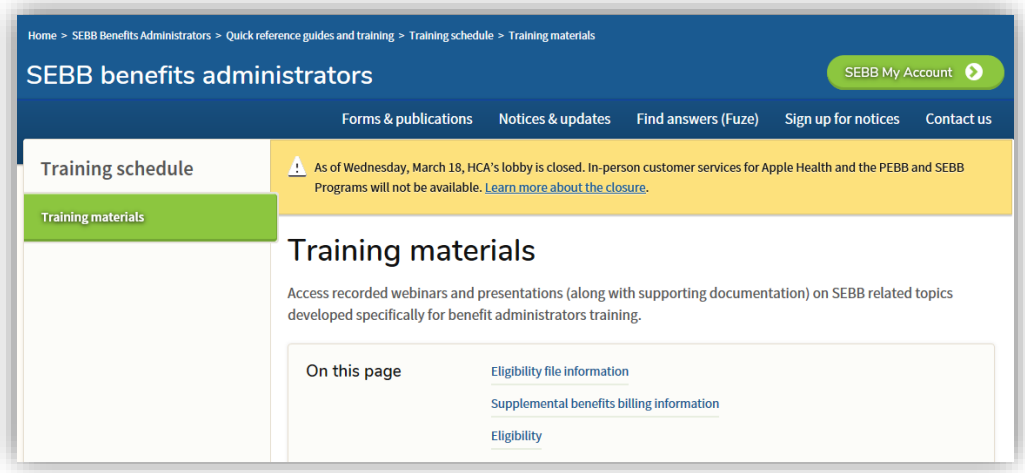
SEBB Program Appeals Process Webinar

Thank you for participating in today's webinar

The presentation will start around 10:05 a.m.

- All attendees will be muted. Please do not unmute yourself if the program allows you to.
- We can not assist with technical issues and apologize if they keep you from participating.
- This webinar will be recorded and posted on the Benefits Administrator website.



Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

hca.wa.gov/sebb-benefits-admins

SEBB Program Appeals Process Webinar

Addressing questions during the webinar

- Please use the “questions” feature to send questions throughout the webinar.
- We will address questions after the webinar via Email or FUZE.
- We also plan to add an FAQ on the Appeals website in the near future.

- **For urgent matters, contact Outreach & Training (O&T) at 1-800-700-1555**

Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

SEBB Program Appeals Process

School Employees Benefits

Outreach & Training

2020

Washington State Health Care Authority

SCHOOL EMPLOYEES BENEFITS BOARD

Timeline of upcoming events

October 26: Annual OE period for the 2021 plan year begins.

November 23: Last day to enroll or make changes

January 1, 2021: New plan year begins. New elections are effective

Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

Enrollment reminders

Employees can make enrollment decisions during:

- Initial enrollment window
  - 31 days from becoming eligible for benefits
- Annual Open Enrollment (OE)
  - Four-week period in the fall
  - Changes effective January 1 of the following year
- Special Open Enrollment (SOE) events
  - *Typically* a 60-day window
  - Effective dates are *generally* the later of the first of the month following the event or the date the form is received
  - See SEBB Policy 45-2A: SOE Matrix- Summary of permitted election changes

Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

Appealing a SEBB Program decision

Denial letters sent to subscribers from the SEBB Program will contain information on what the subscriber should include with their appeal:

- WAC 182-32-2070 provides what a written request for appeal should contain.
- The denial letter also explains that additional relevant documents should be included with their appeal.

Generally, subscribers will have **30 days** from the date of the denial letter to appeal.

- Appeals received after the deadline will be considered untimely.

Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

Appealing an Employer Decision

Employees have the right to appeal a specific decision or denial made by their SEBB organization regarding eligibility, enrollment or premium surcharges. WAC 182-32-2010 and WAC 182-32-2020

- Eligibility decisions address:
  - Whether a subscriber or dependent is entitled to SEBB benefits
- Enrollment decisions address:
  - Application for SEBB benefits, including, but not limited to:
    - Submission of proper documentation
    - Enrollment deadlines

Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

General guidance for SEBB organizations

WAC 182-31-030 – SEBB Organization obligations in the application of employee eligibility

SEBB Outreach and Training (O&T) staff are available to offer guidance, but **not** decision making.

- The SEBB Org's position must be in accordance with:
  - WAC Chapters 182-30, 182-31, and 182-32;
  - SEBB policies; and
  - RCW 41.05

Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

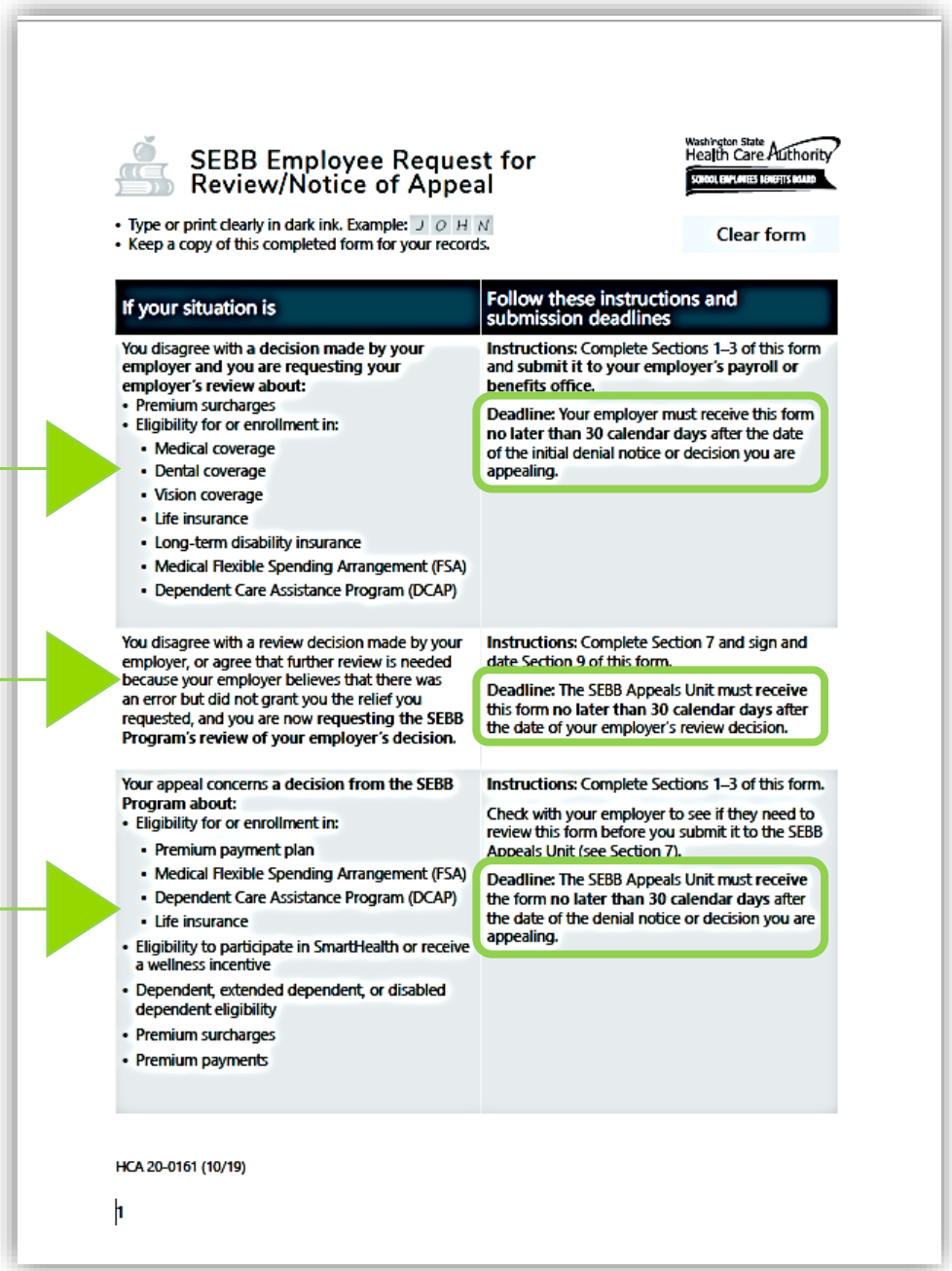
Review Process

SEBB Org denies eligibility/enrollment

Employee disagrees with SEBB Orgs decision and requests review by SEBB Org

Employee requests the SEBB Program's review of employer's decision

Employee disagrees with SEBB Programs decision



SEBB Employee Request for Review/Notice of Appeal

Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

- Type or print clearly in dark ink. Example: J O H N
- Keep a copy of this completed form for your records.

Clear form

If your situation is	Follow these instructions and submission deadlines

You disagree with **a decision made by your employer and you are requesting your employer's review about:**
• Premium surcharges
• Eligibility for or enrollment in:
  • Medical coverage
  • Dental coverage
  • Vision coverage
  • Life insurance
  • Long-term disability insurance
  • Medical Flexible Spending Arrangement (FSA)
  • Dependent Care Assistance Program (DCAP)
	Instructions: Complete Sections 1–3 of this form and **submit it to your employer's payroll or benefits office.**
	Deadline: Your employer must receive this form **no later than 30 calendar days** after the date of the initial denial notice or decision you are appealing.

You disagree with a review decision made by your employer, or agree that further review is needed because your employer believes that there was an error but did not grant you the relief you requested, and you are now **requesting the SEBB Program's review of your employer's decision.**	**Instructions:** Complete Section 7 and sign and date Section 9 of this form. **Deadline:** The SEBB Appeals Unit must **receive** this form **no later than 30 calendar days** after the date of your employer's review decision.

Your appeal concerns a decision from the SEBB Program about:
• Eligibility for or enrollment in:
  • Premium payment plan
  • Medical Flexible Spending Arrangement (FSA)
  • Dependent Care Assistance Program (DCAP)
  • Life insurance
• Eligibility to participate in SmartHealth or receive a wellness incentive
• Dependent, extended dependent, or disabled dependent eligibility
• Premium surcharges
• Premium payments
	Instructions: Complete Sections 1–3 of this form.
	Check with your employer to see if they need to review this form before you submit it to the SEBB Appeals Unit (see Section 7).
	Deadline: The SEBB Appeals Unit must **receive** the form **no later than 30 calendar days** after the date of the denial notice or decision you are appealing.

HCA 20-0161 (10/19)

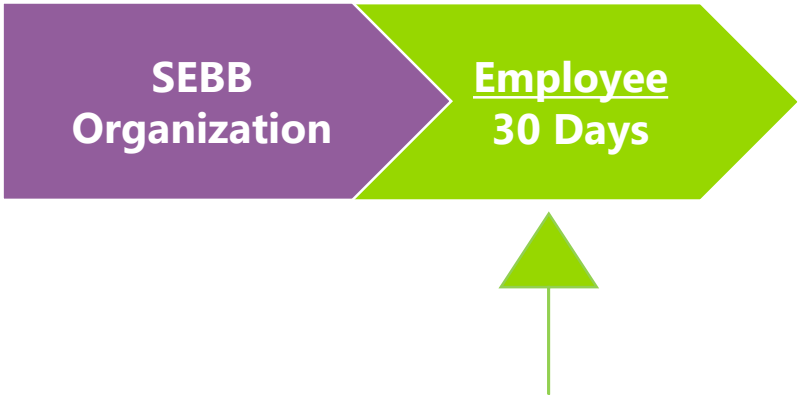
1

Page 1

hca.wa.gov/assets/pebb/20-0161-sebb-employee-request-for-review-notice-of-appeal.pdf

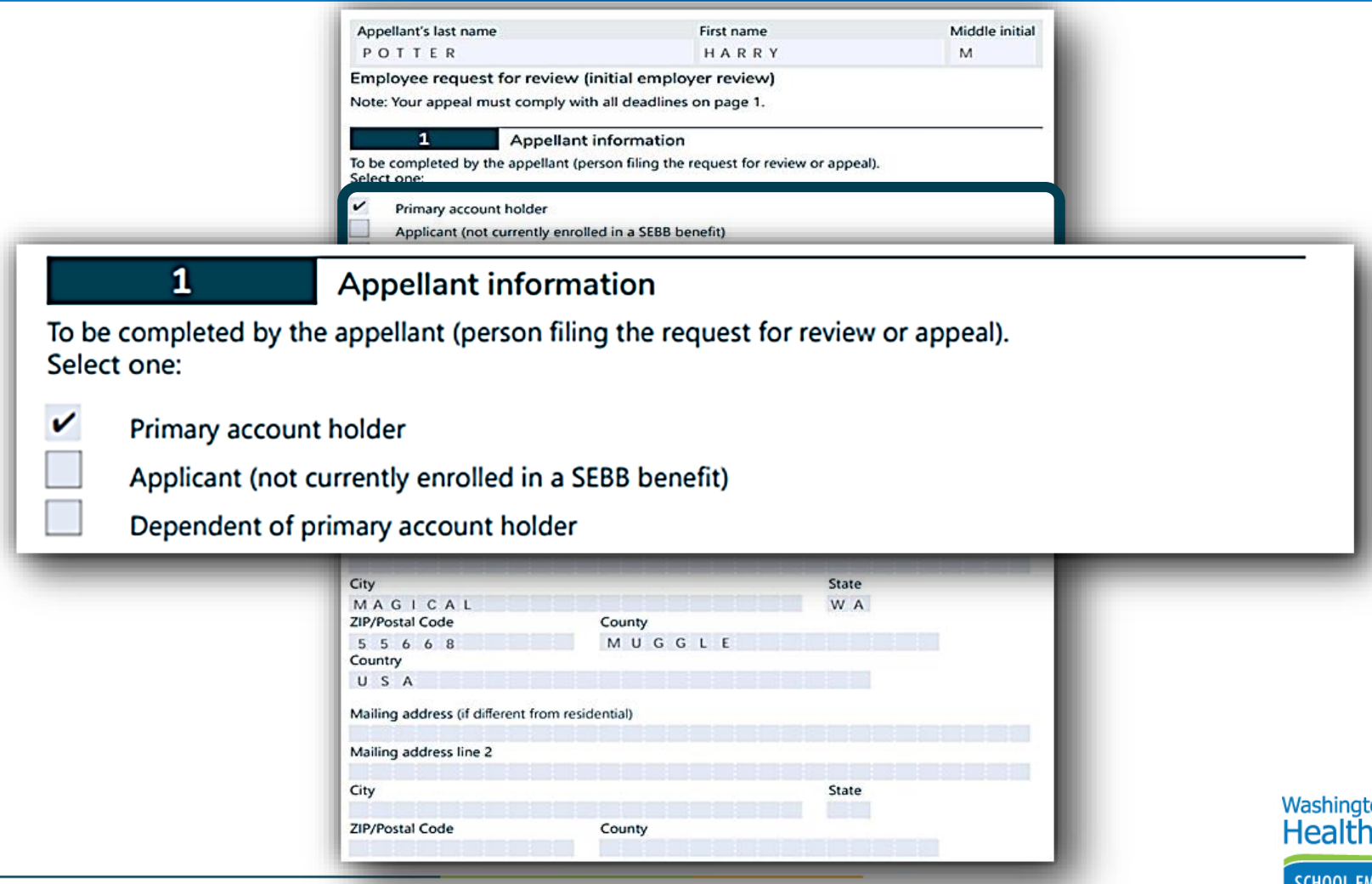
Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

Review Process



Employee will need to complete sections 1-3 of the *SEBB Employee Request for Review/Notice of Appeal* form within **30 calendar days** of denial and submit to their **SEBB Org**

Section 1
Appellant's Information

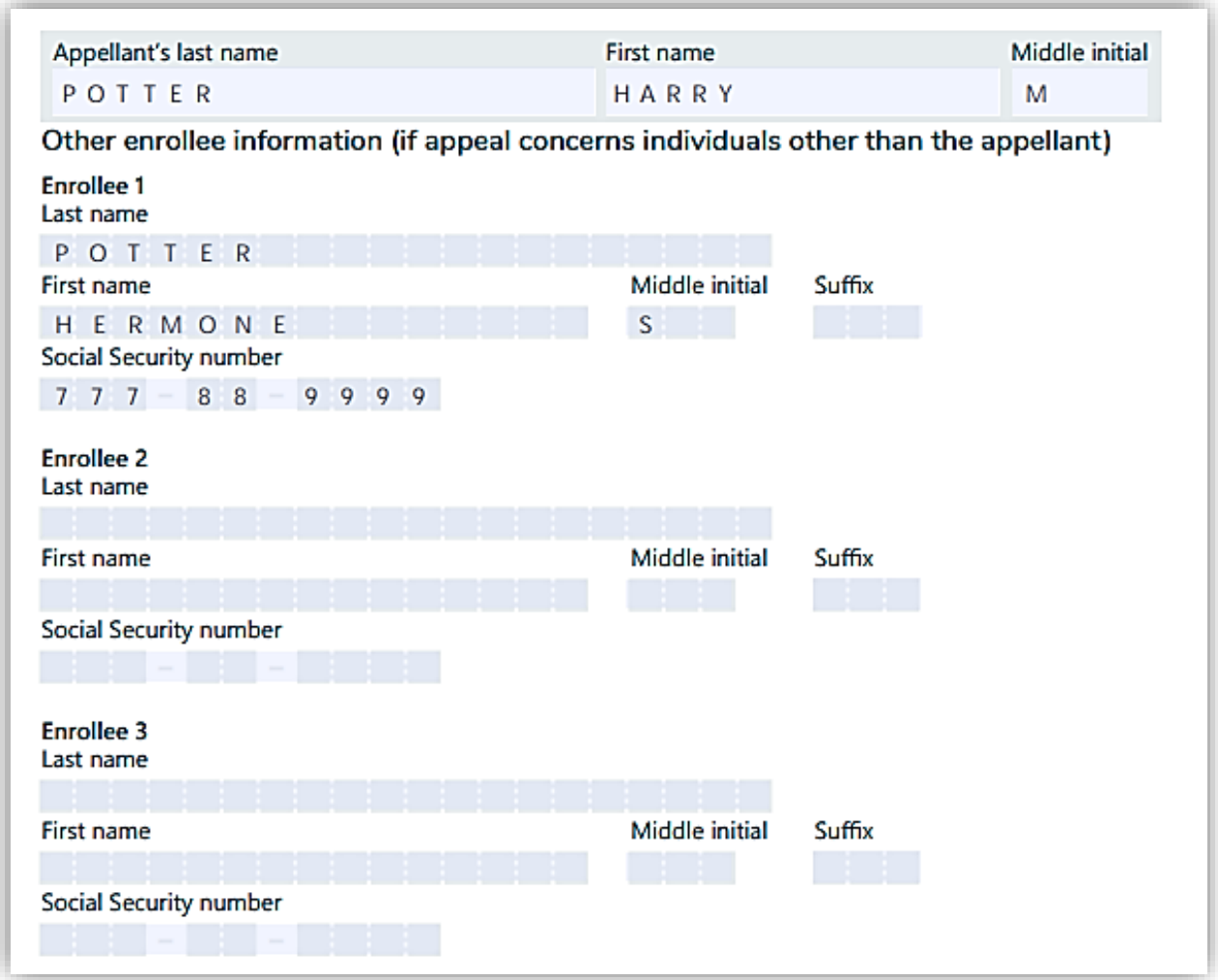


Page 2

hca.wa.gov/assets/pebb/20-0161-sebb-employee-request-for-review-notice-of-appeal.pdf

Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

Section 1
Other enrollee Information



Appellant's last name	First name	Middle initial
POTTER	HARRY	M

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

Enrollee 1
Last name: POTTER
First name: HERMONE | Middle initial: S | Suffix:
Social Security number: 777-88-9999

Enrollee 2
Last name:
First name: | Middle initial: | Suffix:
Social Security number:

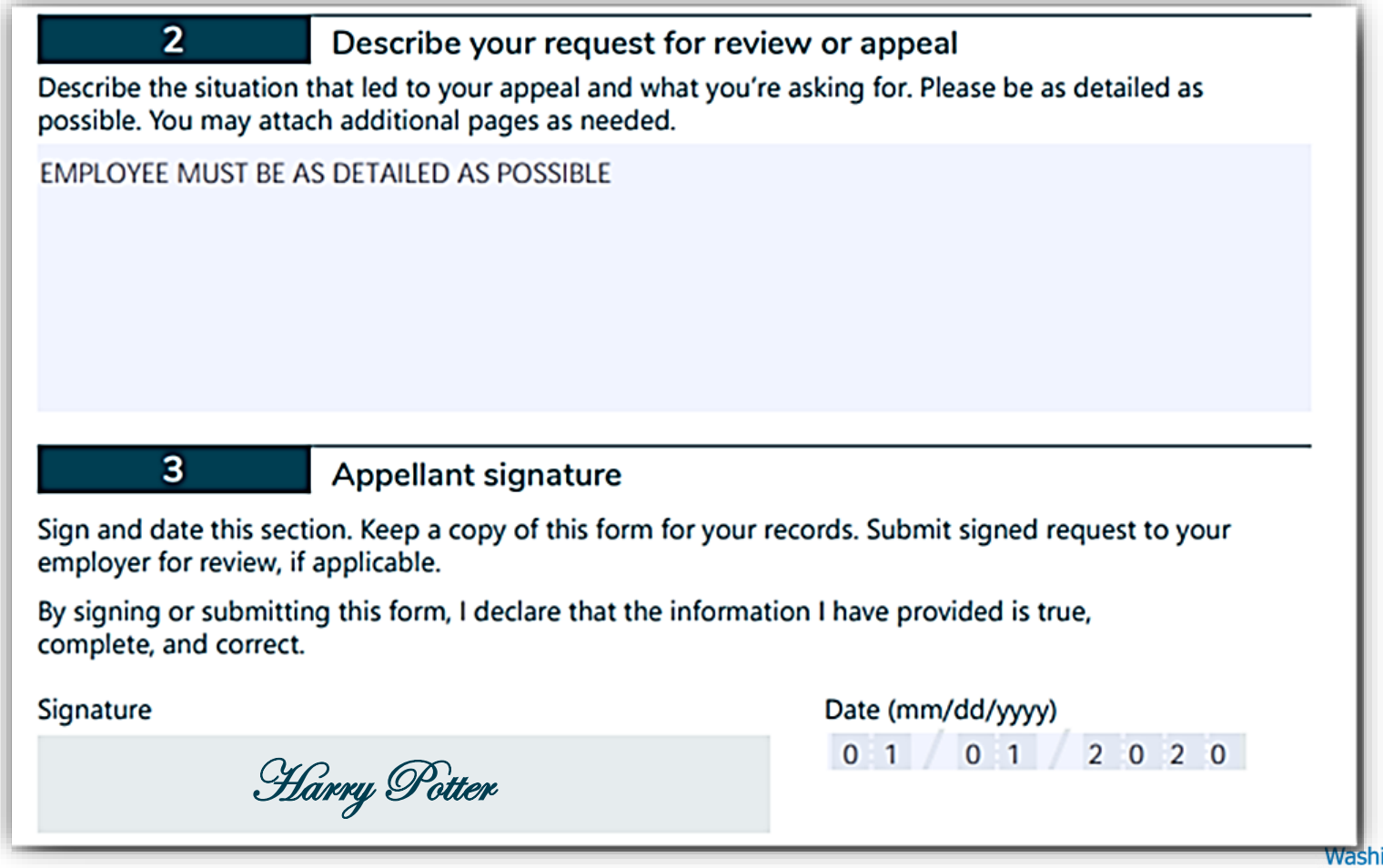
Enrollee 3
Last name:
First name: | Middle initial: | Suffix:
Social Security number:

Page 3

hca.wa.gov/assets/pebb/20-0161-sebb-employee-request-for-review-notice-of-appeal.pdf

Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

Sections 2-3
Description & Signature



2 **Describe your request for review or appeal**

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

EMPLOYEE MUST BE AS DETAILED AS POSSIBLE

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

Signature

Harry Potter

Date (mm/dd/yyyy)

0 1 / 0 1 / 2 0 2 0

Page 3

hca.wa.gov/assets/pebb/20-0161-sebb-employee-request-for-review-notice-of-appeal.pdf

Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

Review Process

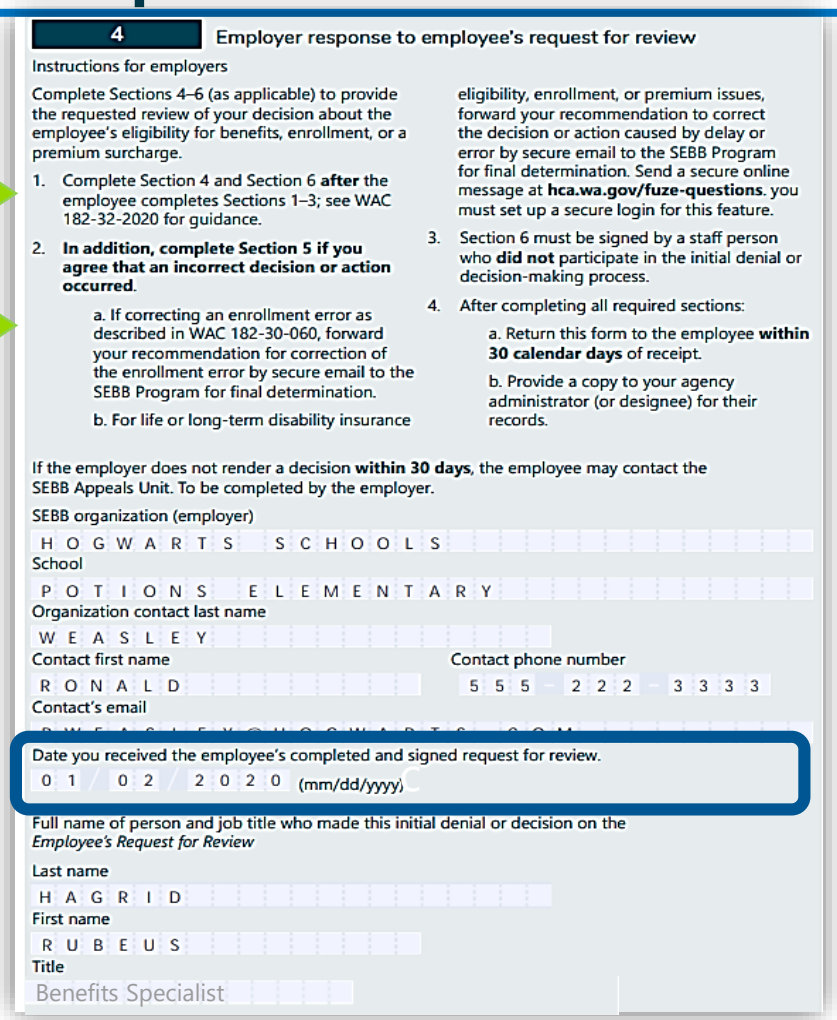
Reviewed by one or more staff *not involved* in the initial decision. **Employer** completes sections 4-6 (as applicable) within **30 calendar days** of the date of the request for review. A copy is provided to the **employee** and **SEBB Org administrator** or **designee.**

Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

Section 4
Employer's Response

Complete sections 4 and 6

Complete section 5 if necessary



4 Employer response to employee's request for review

Instructions for employers

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

1. Complete Section 4 and Section 6 **after** the employee completes Sections 1–3; see WAC 182-32-2020 for guidance.
2. **In addition, complete Section 5 if you agree that an incorrect decision or action occurred.**
   a. If correcting an enrollment error as described in WAC 182-30-060, forward your recommendation for correction of the enrollment error by secure email to the SEBB Program for final determination.
   b. For life or long-term disability insurance eligibility, enrollment, or premium issues, forward your recommendation to correct the decision or action caused by delay or error by secure email to the SEBB Program for final determination. Send a secure online message at **hca.wa.gov/fuze-questions**. you must set up a secure login for this feature.
3. Section 6 must be signed by a staff person who **did not** participate in the initial denial or decision-making process.
4. After completing all required sections:
   a. Return this form to the employee **within 30 calendar days** of receipt.
   b. Provide a copy to your agency administrator (or designee) for their records.

If the employer does not render a decision **within 30 days**, the employee may contact the SEBB Appeals Unit. To be completed by the employer.

SEBB organization (employer): HOGWARTS SCHOOLS
School: POTIONS ELEMENTARY
Organization contact last name: WEASLEY
Contact first name: RONALD
Contact phone number: 555 - 222 - 3333
Contact's email:
Date you received the employee's completed and signed request for review: 01 / 02 / 2020 (mm/dd/yyyy)
Full name of person and job title who made this initial denial or decision on the *Employee's Request for Review*
Last name: HAGRID
First name: RUBEUS
Title: Benefits Specialist

Staff person signs section 6

Provide copy to employee and one for the SEBB Org

Page 4

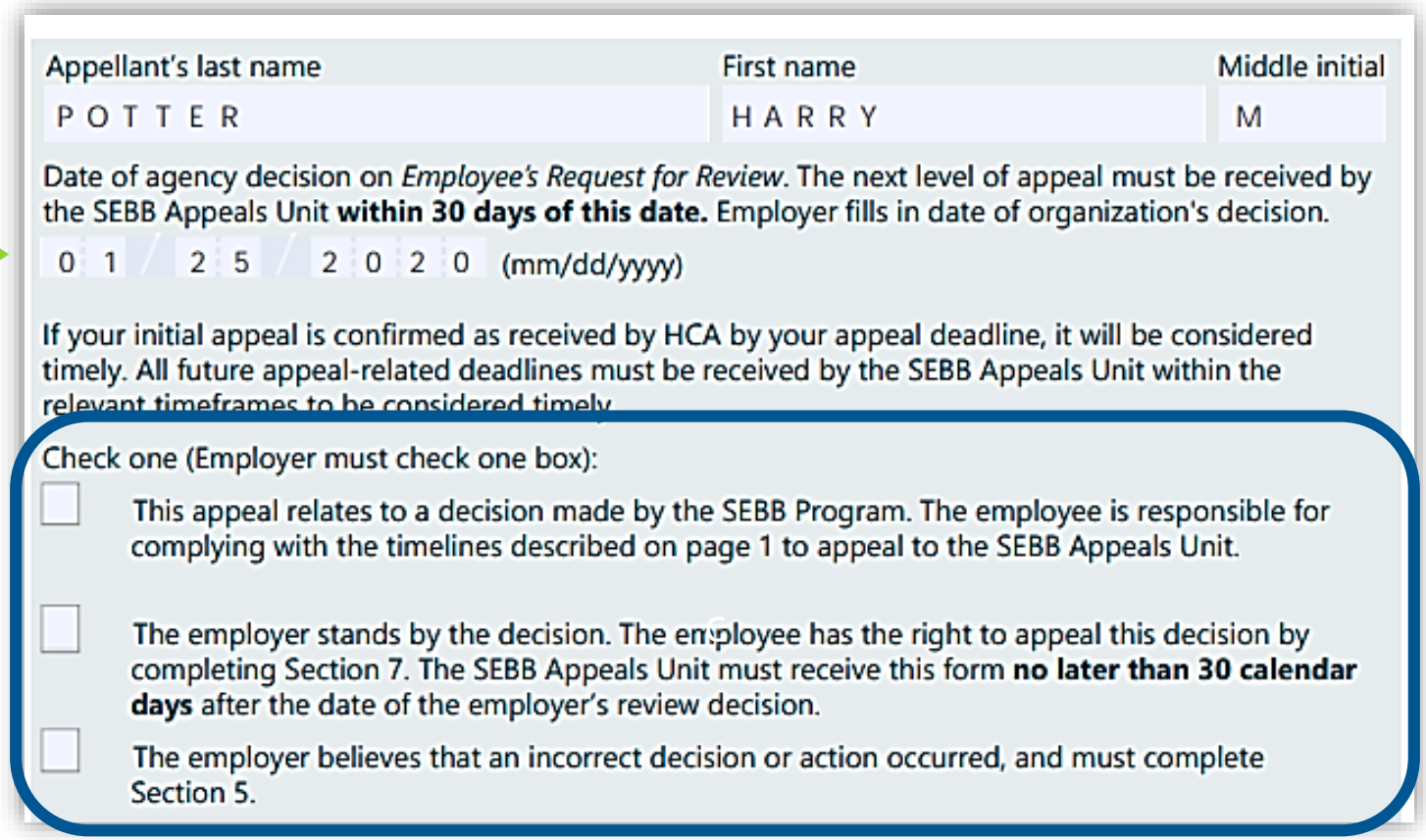
hca.wa.gov/assets/pebb/20-0161-sebb-employee-request-for-review-notice-of-appeal.pdf

Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

Section 4 (next page) Employer's Response

Enter the date of the organization's review decision

Select one of the decision options



Appellant's last name: POTTER | First name: HARRY | Middle initial: M

Date of agency decision on *Employee's Request for Review*. The next level of appeal must be received by the SEBB Appeals Unit **within 30 days of this date.** Employer fills in date of organization's decision.

01 / 25 / 2020 (mm/dd/yyyy)

If your initial appeal is confirmed as received by HCA by your appeal deadline, it will be considered timely. All future appeal-related deadlines must be received by the SEBB Appeals Unit within the relevant timeframes to be considered timely.

Check one (Employer must check one box):

- ☐ This appeal relates to a decision made by the SEBB Program. The employee is responsible for complying with the timelines described on page 1 to appeal to the SEBB Appeals Unit.
- ☐ The employer stands by the decision. The employee has the right to appeal this decision by completing Section 7. The SEBB Appeals Unit must receive this form **no later than 30 calendar days** after the date of the employer's review decision.
- ☐ The employer believes that an incorrect decision or action occurred, and must complete Section 5.

Page 5

hca.wa.gov/assets/pebb/20-0161-sebb-employee-request-for-review-notice-of-appeal.pdf

Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

How do SEBB Organizations Correct Enrollment Errors (WAC 182-30-060)(Policy 11-3)

A SEBB Organization that makes one or more of the following enrollment errors must correct the error as described in subsections (2) through (5) of WAC 182-30-060:

a) Failure to timely notify a school employee of their eligibility for SEBB benefits and the employer contribution as described in WAC 182-31-030;

b) Failure to enroll a school employee or their dependents in SEBB benefits as elected by the school employee, if the election was timely;

Continuation of Types of Enrollment Errors Qualifying for the Correction Process

c) Failure to enroll a school employee and their dependents in SEBB benefits as described in WAC 182-30-080(1)(b);

d) Failure to accurately reflect a school employee's premium surcharge attestation on the school employee's account;

e) Enrolling a school employee or their dependents in SEBB insurance coverage when they are not eligible as described in WAC 182-31-040 or 182-31-140, and it is clear there was no fraud or intentional misrepresentation by the school employee involved; or

f) Providing incorrect information, via a benefits administrator, regarding SEBB benefits to the employee that they relied upon.

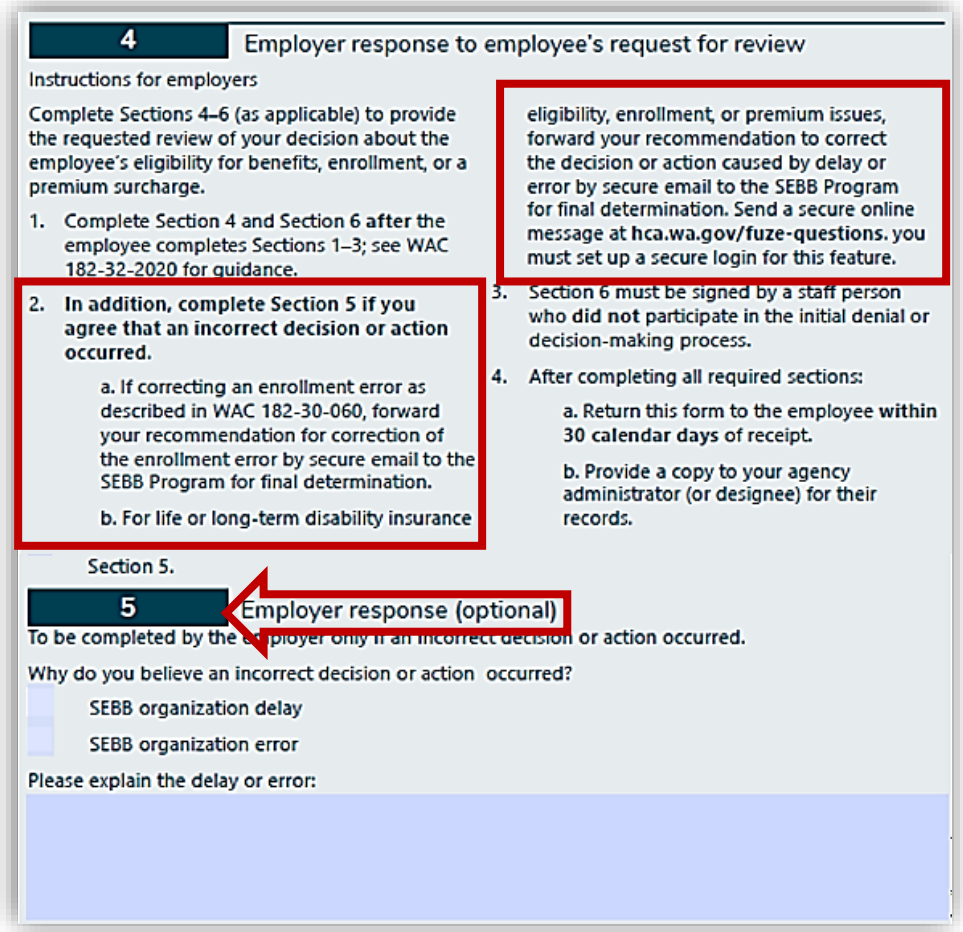
Correcting SEBB Organization and contracted vendor enrollment errors (Policy 11-3)

The SEBB Organization must:

- Enroll the school employee and the school employee's dependents, as elected, or terminate enrollment in SEBB benefits as described in WAC 182-30-060 subsection (3),
- Reconcile premium payments and applicable premium surcharges as described in WAC 182-30-060 subsection (4), and
- Provide recourse as described in WAC 182-30-060 subsection (5).

hca.wa.gov/assets/pebb/sebb-policy-11-3-correcting-enrollment-errors-2020.pdf

Actions to Take if the SEBB Organization Determines a Qualifying Error



4 Employer response to employee's request for review

Instructions for employers

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

1. Complete Section 4 and Section 6 after the employee completes Sections 1–3; see WAC 182-32-2020 for guidance.
2. **In addition, complete Section 5 if you agree that an incorrect decision or action occurred.**
   a. If correcting an enrollment error as described in WAC 182-30-060, forward your recommendation for correction of the enrollment error by secure email to the SEBB Program for final determination.
   b. For life or long-term disability insurance eligibility, enrollment, or premium issues, forward your recommendation to correct the decision or action caused by delay or error by secure email to the SEBB Program for final determination. Send a secure online message at **hca.wa.gov/fuze-questions**. you must set up a secure login for this feature.
3. Section 6 must be signed by a staff person who **did not** participate in the initial denial or decision-making process.
4. After completing all required sections:
   a. Return this form to the employee **within 30 calendar days** of receipt.
   b. Provide a copy to your agency administrator (or designee) for their records.

Section 5.

5 Employer response (optional)

To be completed by the employer only if an incorrect decision or action occurred.

Why do you believe an incorrect decision or action occurred?

SEBB organization delay

SEBB organization error

Please explain the delay or error:

If the SEBB Organization determines a qualifying error for correction, there are two avenues to correct the error:

1. The SEBB Organization agrees with the qualifying error and **it is within the lower limit:**
   - The SEBB Organization fixes the error.
2. The SEBB Organization agrees with the qualifying error and **it is beyond the lower limit:**
   - The SEBB Organization submits it for review and determination by the SEBB Program through FUZE addressed to O&T - Subject line: Possible Error Correction. ***(See Section 4, Subsection 2 of SEBB Request for Review, Notice of Appeal).***

hca.wa.gov/assets/pebb/20-0161-sebb-employee-request-for-review-notice-of-appeal.pdf

Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

Continued Actions to Take if the SEBB Organization Determines a Qualifying Error

There are two determinations SEBB Program's O&T can make:

1. If SEBB O&T determines that the error meets the standard for error correction under WAC 182-30-060, Outreach and Training will contact the SEBB Organization and begin the error correction process.
2. If SEBB O&T determines that the error does not meet the standard for error correction under WAC 182-30-060, O&T will notify the SEBB Organization of their decision.

The employee has the right to appeal this decision by completing Section 7 of the SEBB Request for Review, Notice of Appeal form.

Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

Scenario

"The employee was newly eligible on March 15th. Employee completed enrollment and physically handed dependent verification documents to BA. In August, I realize I never received a medical card for my dependent. I check in SEBB My Account and see the dependent is still pending verification."

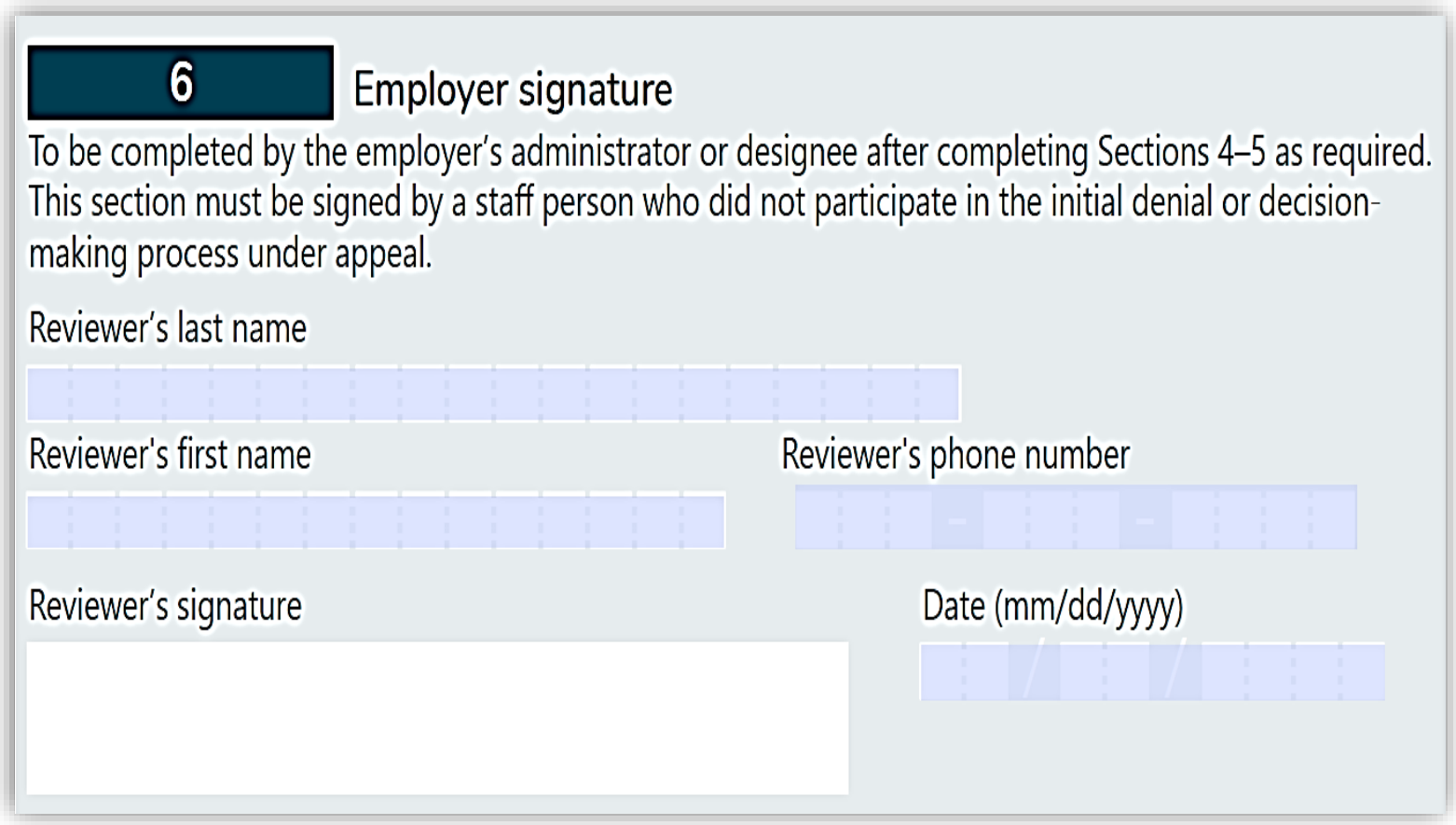
- The BA reviews the enrollment to see if an employer error occurred.
  - BA finds that dependent verification documents were submitted and never processed in SEBB My Account.
  - BA fixes the account if it is within the lower limit date.
  - If outside of the lower limit, the BA reaches out to O&T.

Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

Scenario

- If Employee feels that an error occurred, the Employee may submit a written Employee Request for Review/Appeal form for review.
  - The BA recognizes an enrollment error was made, and fills out sections 4 and 5 on the Request for Review/Notice of Appeal form.
  - A second reviewer (BA, administrator, or designee) reviews the decision and completes section 6.
  - BA then sends recommended correction through FUZE for SEBB Program's (O&T) final determination.

Employer's Signature



6 Employer signature

To be completed by the employer's administrator or designee after completing Sections 4–5 as required. This section must be signed by a staff person who did not participate in the initial denial or decision-making process under appeal.

Reviewer's last name

Reviewer's first name

Reviewer's phone number

Reviewer's signature

Date (mm/dd/yyyy)

hca.wa.gov/assets/pebb/20-0161-sebb-employee-request-for-review-notice-of-appeal.pdf

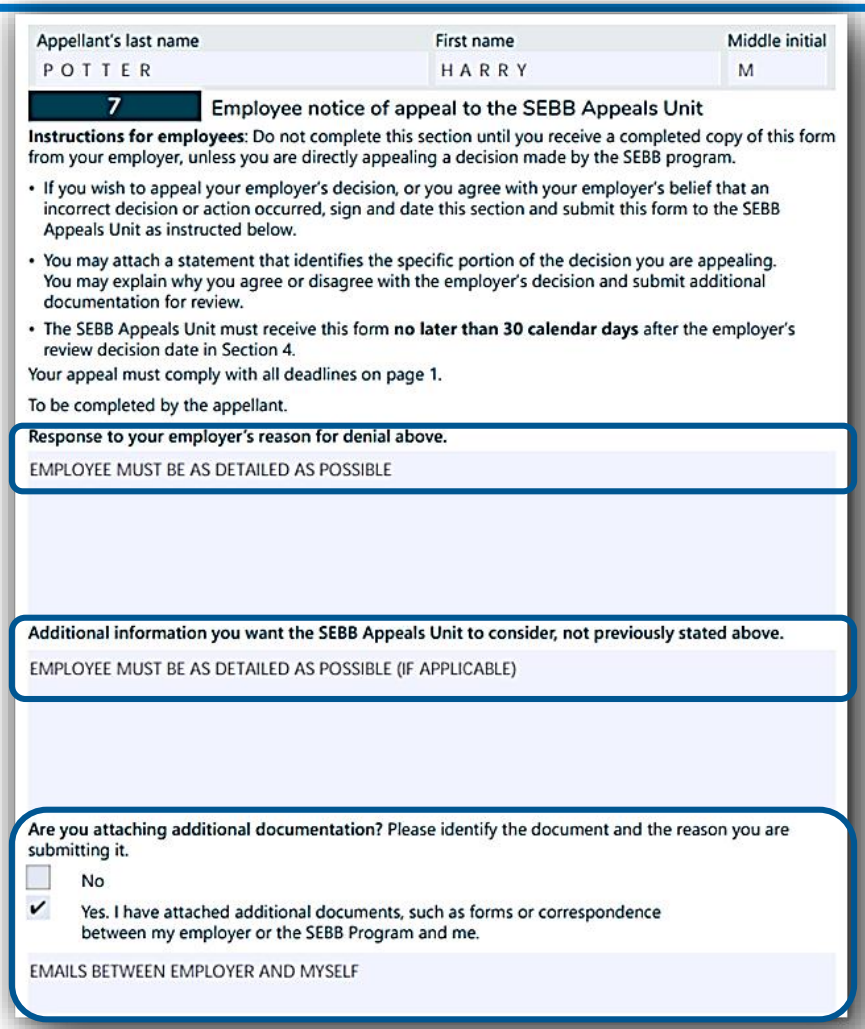
Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

Appeals Process

If the **employee** does not agree with the **SEBB org's** final decision, they have **30 calendar days** from the date of the **SEBB org's** decision to complete section 7-9 of the *Employee Request for Review/Notice of Appeal form* and submit it to the **SEBB Appeals Unit** *via fax or mail*.

Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

Section 7
Employee Notice of Appeal to SEBB Appeals Unit



Appellant's last name: POTTER | First name: HARRY | Middle initial: M

7 Employee notice of appeal to the SEBB Appeals Unit

Instructions for employees: Do not complete this section until you receive a completed copy of this form from your employer, unless you are directly appealing a decision made by the SEBB program.

- If you wish to appeal your employer's decision, or you agree with your employer's belief that an incorrect decision or action occurred, sign and date this section and submit this form to the SEBB Appeals Unit as instructed below.
- You may attach a statement that identifies the specific portion of the decision you are appealing. You may explain why you agree or disagree with the employer's decision and submit additional documentation for review.
- The SEBB Appeals Unit must receive this form **no later than 30 calendar days** after the employer's review decision date in Section 4.

Your appeal must comply with all deadlines on page 1.

To be completed by the appellant.

Response to your employer's reason for denial above.

EMPLOYEE MUST BE AS DETAILED AS POSSIBLE

Additional information you want the SEBB Appeals Unit to consider, not previously stated above.

EMPLOYEE MUST BE AS DETAILED AS POSSIBLE (IF APPLICABLE)

Are you attaching additional documentation? Please identify the document and the reason you are submitting it.

☐ No

☑ Yes. I have attached additional documents, such as forms or correspondence between my employer or the SEBB Program and me.

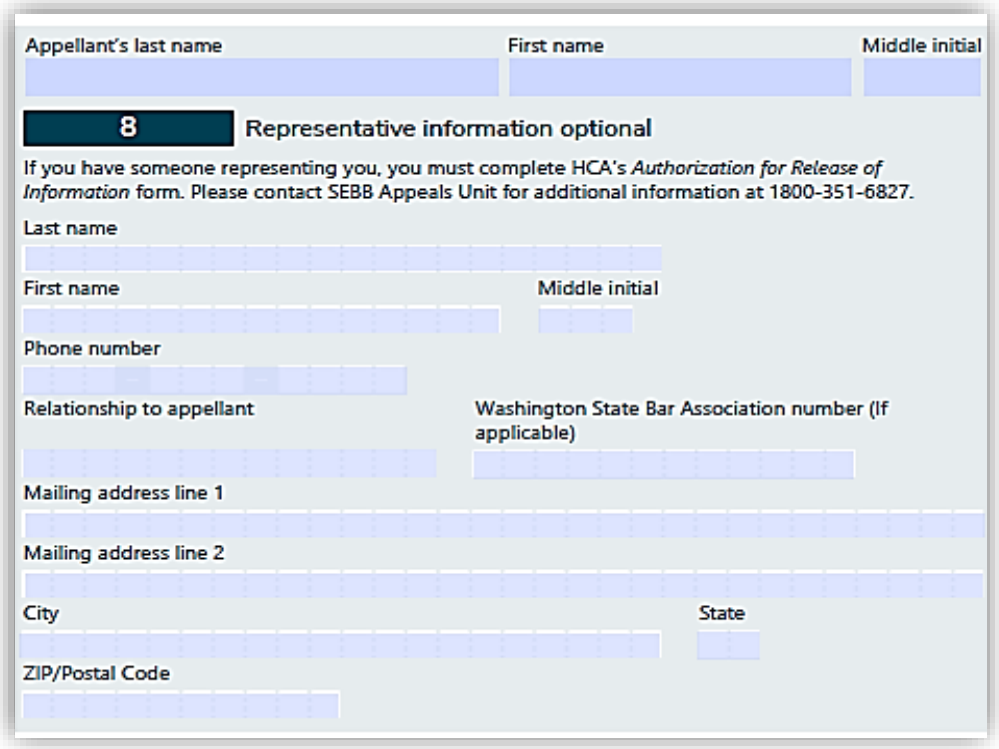
EMAILS BETWEEN EMPLOYER AND MYSELF

Page 6

hca.wa.gov/assets/pebb/20-0161-sebb-employee-request-for-review-notice-of-appeal.pdf

Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

Section 8-9
Representative & Appellant Information



Appellant's last name | First name | Middle initial

8 Representative information optional

If you have someone representing you, you must complete HCA's *Authorization for Release of Information* form. Please contact SEBB Appeals Unit for additional information at 1800-351-6827.

Last name

First name | Middle initial

Phone number

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

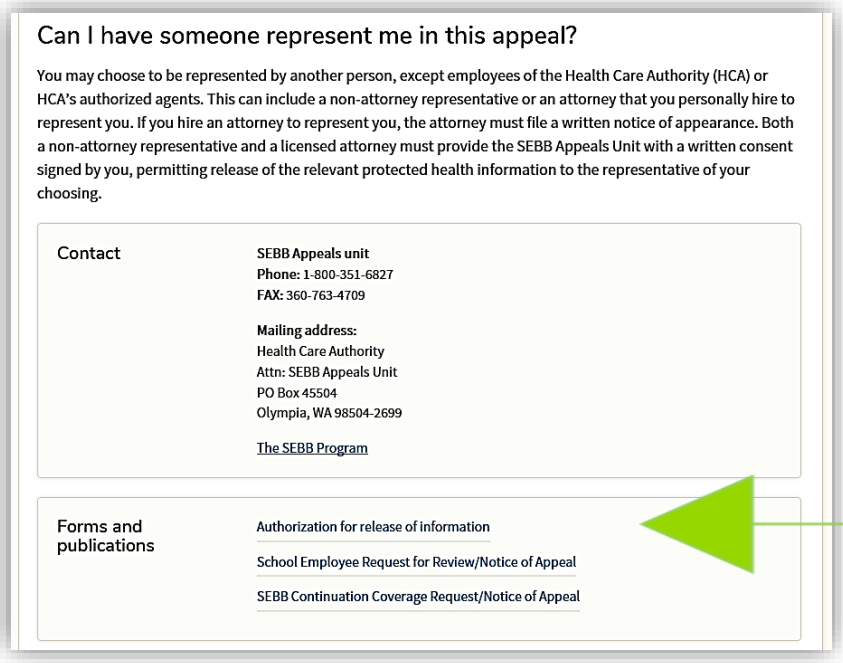
Mailing address line 1

Mailing address line 2

City | State

ZIP/Postal Code

If this section is filled out, this will Require the employer to include the "Authorization of Information" form.



Can I have someone represent me in this appeal?

You may choose to be represented by another person, except employees of the Health Care Authority (HCA) or HCA's authorized agents. This can include a non-attorney representative or an attorney that you personally hire to represent you. If you hire an attorney to represent you, the attorney must file a written notice of appearance. Both a non-attorney representative and a licensed attorney must provide the SEBB Appeals Unit with a written consent signed by you, permitting release of the relevant protected health information to the representative of your choosing.

Contact

SEBB Appeals unit
Phone: 1-800-351-6827
FAX: 360-763-4709

Mailing address:
Health Care Authority
Attn: SEBB Appeals Unit
PO Box 45504
Olympia, WA 98504-2699

The SEBB Program

Forms and publications

Authorization for release of information

School Employee Request for Review/Notice of Appeal

SEBB Continuation Coverage Request/Notice of Appeal

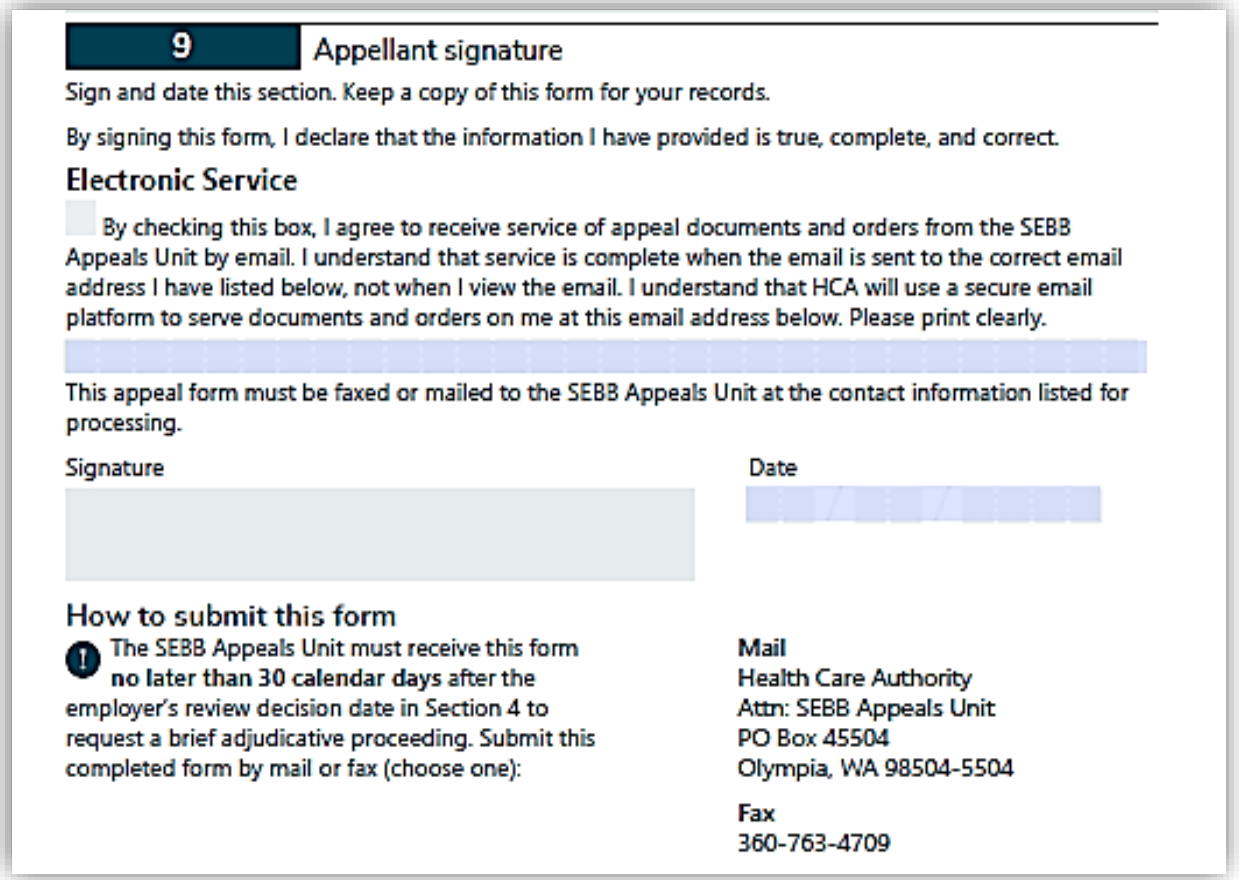
Release can be found here on the website. https://www.hca.wa.gov/about-hca/file-appeal-sebb

Page 7

hca.wa.gov/assets/pebb/20-0161-sebb-employee-request-for-review-notice-of-appeal.pdf

Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

Section 9
Appellant Information



9 Appellant signature

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

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

Electronic Service

☐ By checking this box, I agree to receive service of appeal documents and orders from the SEBB Appeals Unit by email. I understand that service is complete when the email is sent to the correct email address I have listed below, not when I view the email. I understand that HCA will use a secure email platform to serve documents and orders on me at this email address below. Please print clearly.

This appeal form must be faxed or mailed to the SEBB Appeals Unit at the contact information listed for processing.

Signature

Date

How to submit this form

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

Mail
Health Care Authority
Attn: SEBB Appeals Unit
PO Box 45504
Olympia, WA 98504-5504

Fax
360-763-4709

Electronic Service Option

The most current version of the form can be found here:
https://www.hca.wa.gov/about-hca/file-appeal-sebb

hca.wa.gov/assets/pebb/20-0161-sebb-employee-request-for-review-notice-of-appeal.pdf

Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

Appeals Process

The **SEBB Appeals Unit** must notify the appellant in writing when the request for brief adjudicative proceeding (BAP) has been received.

Presiding Officer authority WAC 182-32-2140

- The presiding officer is required by rule to decide the issue based on the information provided by the parties.
- The presiding officer is required to apply the WACs as the first rule of law.
- The Presiding officer does not have authority to decide that a rule is invalid or unenforceable.

SEBB Appeals Unit response

The SEBB appeals unit will send a request for documentation and information to the SEBB organization.

- The SEBB Org will then have **two business days** to respond and provide the requested material to the SEBB appeals unit and the appellant.

The BAP file will be reviewed by a presiding officer.

The presiding officer will issue a written initial order within **10 business days** of receiving the Request/Notice of Appeal form.

- A continuance (which may be up to **30 days**) may be granted.

Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

What is a submission of documents order?

- The Presiding Officer (PO) may need to request additional information from either the Appellant, the SEBB Organization, or the SEBB Program.
- To do this the PO issues a “Submission of Documents” (SOD) order, requesting the additional information/documentation, and a deadline for when the documents must be received by.
- If no documents are received, then the PO will have to make a decision based on what is in the Brief Adjudicative Proceeding (BAP) File, which could lead to a negative result.

Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

Converting to a Formal Hearing

WAC 182-32-2160- The Presiding officer or the review officer may convert a brief adjudicative proceeding to a formal administrative hearing.

What does this mean? What will happen?-

1. A hearing officer will send out a notice of hearing.
2. Telephonic hearing.
3. May need witnesses or declarations depending on the situation

Reading Initial Orders

STATE OF WASHINGTON
HEALTH CARE AUTHORITY
SCHOOL EMPLOYEES' BENEFITS BOARD PROGRAM

In the matter of:

APPELLLANT NAME,

Appellant

CASE NUMBER: XX-2020-SEB-XXXXX

INITIAL ORDER

1. Issue

Did the School Employees Benefits Board (SEBB) Organization properly deny Appellant's request to change her SEBB dental plan from DeltaCare to the Uniform Dental Plan?

2. Brief Adjudicative Proceeding

2.1. Presiding Officer: Officer Name

2.2. Documents Considered: The Brief Adjudicative Proceeding (BAP) File – consisting of 28 pages.

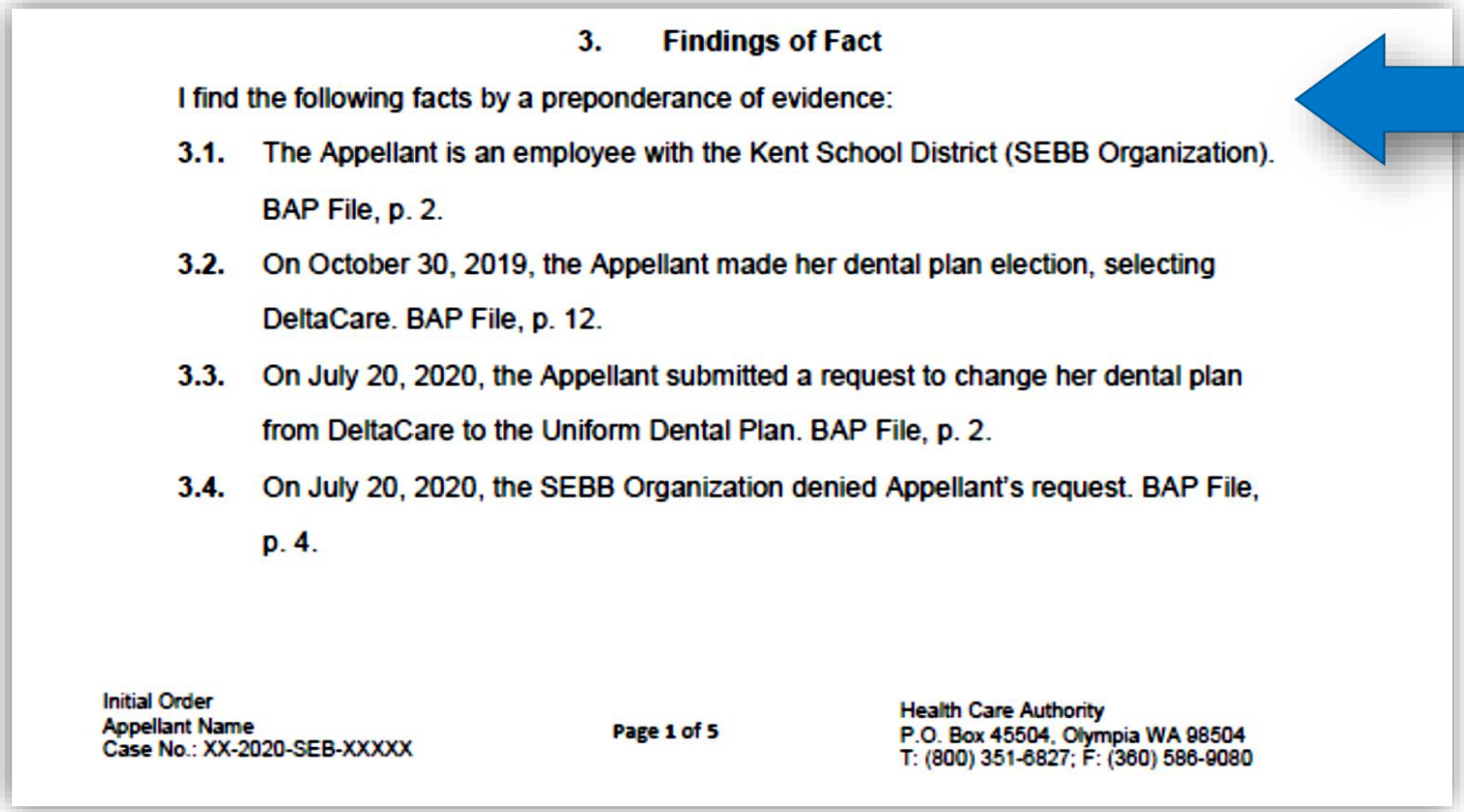
Case number and appellant name

Issue statement summarizes the Appellant's request the presiding officer is making a decision on

The BAP File is the evidence used to write the initial order

Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

Reading Initial Orders, cont.



3. Findings of Fact

I find the following facts by a preponderance of evidence:

3.1. The Appellant is an employee with the Kent School District (SEBB Organization). BAP File, p. 2.

3.2. On October 30, 2019, the Appellant made her dental plan election, selecting DeltaCare. BAP File, p. 12.

3.3. On July 20, 2020, the Appellant submitted a request to change her dental plan from DeltaCare to the Uniform Dental Plan. BAP File, p. 2.

3.4. On July 20, 2020, the SEBB Organization denied Appellant's request. BAP File, p. 4.

Initial Order
Appellant Name
Case No.: XX-2020-SEB-XXXXX

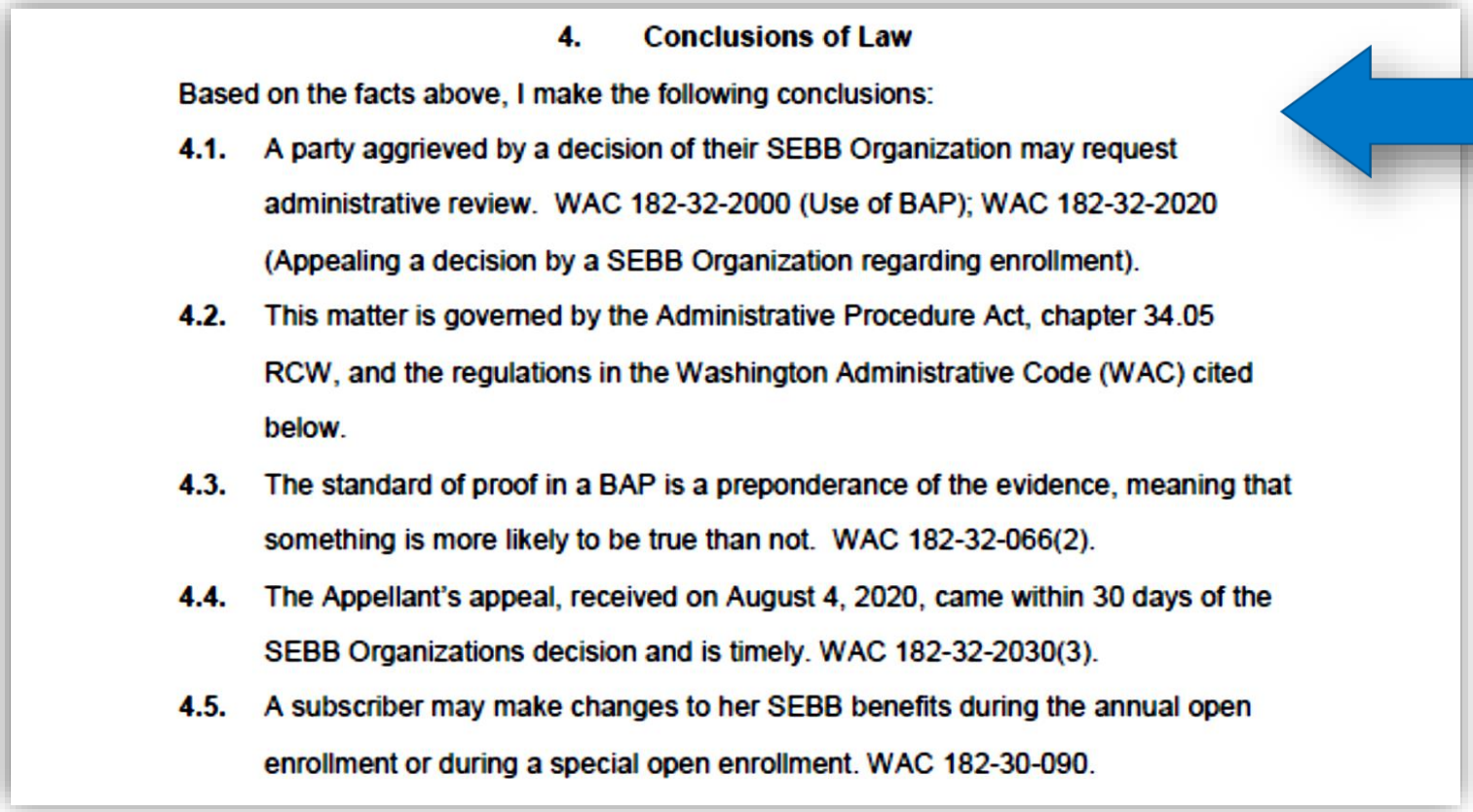
Page 1 of 5

Health Care Authority
P.O. Box 45504, Olympia WA 98504
T: (800) 351-6827; F: (360) 586-9080

Statement of facts relevant to the case and decision. All facts are found in the Brief Adjudicative Proceeding (BAP) File, and page number cited.

Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

Reading Initial Orders, cont.



4. Conclusions of Law

Based on the facts above, I make the following conclusions:

4.1. A party aggrieved by a decision of their SEBB Organization may request administrative review. WAC 182-32-2000 (Use of BAP); WAC 182-32-2020 (Appealing a decision by a SEBB Organization regarding enrollment).

4.2. This matter is governed by the Administrative Procedure Act, chapter 34.05 RCW, and the regulations in the Washington Administrative Code (WAC) cited below.

4.3. The standard of proof in a BAP is a preponderance of the evidence, meaning that something is more likely to be true than not. WAC 182-32-066(2).

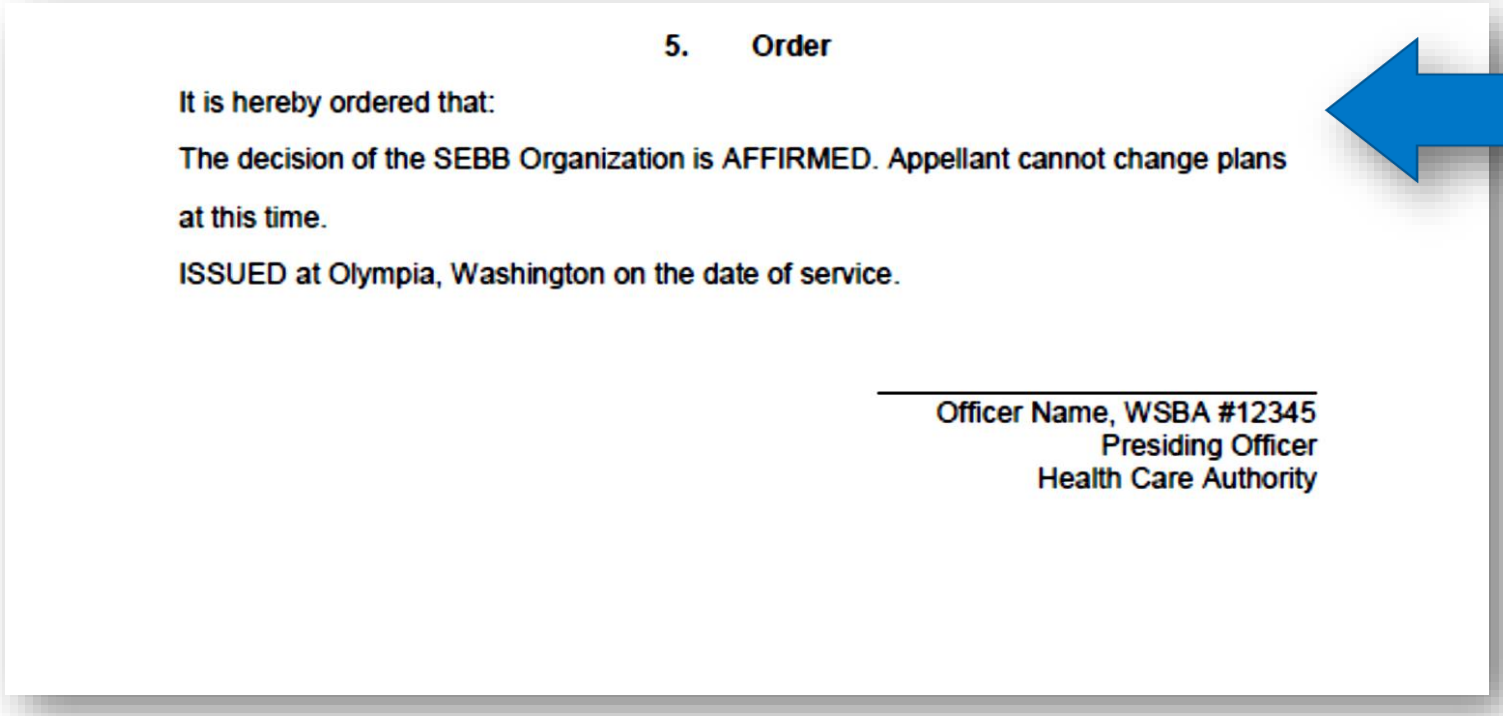
4.4. The Appellant's appeal, received on August 4, 2020, came within 30 days of the SEBB Organizations decision and is timely. WAC 182-32-2030(3).

4.5. A subscriber may make changes to her SEBB benefits during the annual open enrollment or during a special open enrollment. WAC 182-30-090.

State if laws and statutes Applied to the findings of Fact.

Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

Reading Initial Orders, cont.



5. Order

It is hereby ordered that:

The decision of the SEBB Organization is AFFIRMED. Appellant cannot change plans at this time.

ISSUED at Olympia, Washington on the date of service.

Officer Name, WSBA #12345
Presiding Officer
Health Care Authority

Presiding Officer's decision on the Employee's request and explanation of what the employee may or may not receive.

Understanding Judgements

Affirmed:

A finding that agrees with and confirms the SEBB Organization's or Program's decision.

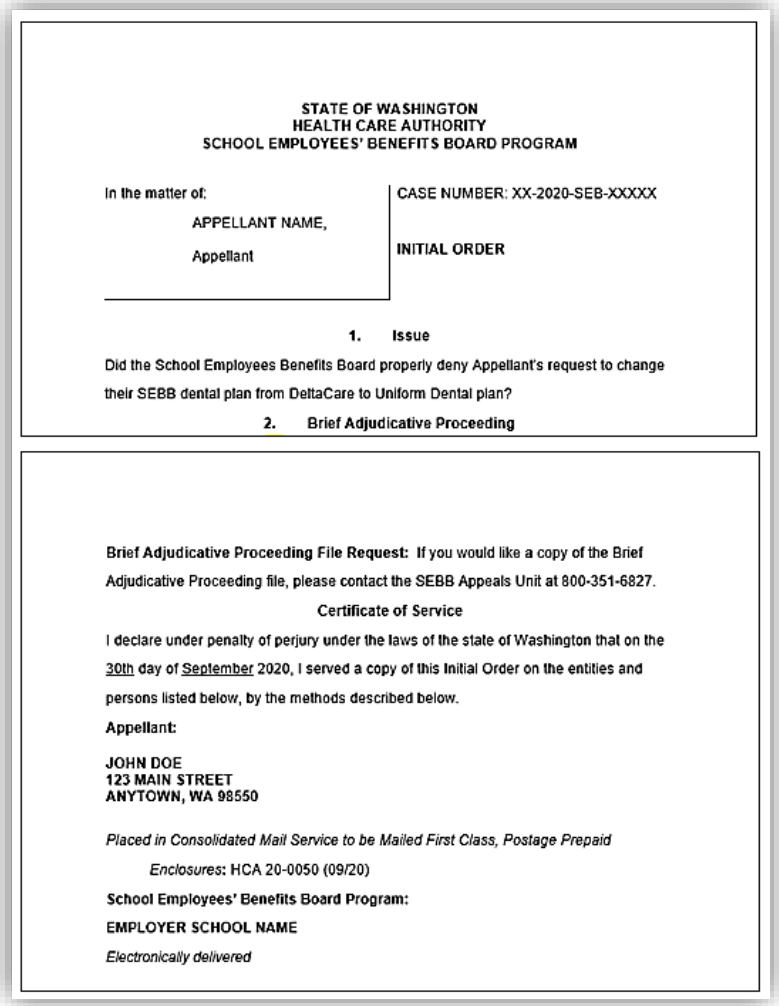
Overturned or Reversed:

A finding that the decision of the SEBB Organization or Program is incorrect.

In Part: A portion of the SEBB Organization or SEBB Program decision is affirmed or overturned.

Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

Employer Notification of Results



STATE OF WASHINGTON
HEALTH CARE AUTHORITY
SCHOOL EMPLOYEES' BENEFITS BOARD PROGRAM

In the matter of:
APPELLANT NAME,
Appellant

CASE NUMBER: XX-2020-SEB-XXXXX

INITIAL ORDER

1. Issue

Did the School Employees Benefits Board properly deny Appellant's request to change their SEBB dental plan from DeltaCare to Uniform Dental plan?

2. Brief Adjudicative Proceeding

Brief Adjudicative Proceeding File Request: If you would like a copy of the Brief Adjudicative Proceeding file, please contact the SEBB Appeals Unit at 800-351-6827.

Certificate of Service

I declare under penalty of perjury under the laws of the state of Washington that on the 30th day of September 2020, I served a copy of this Initial Order on the entities and persons listed below, by the methods described below.

Appellant:

JOHN DOE
123 MAIN STREET
ANYTOWN, WA 98550

Placed in Consolidated Mail Service to be Mailed First Class, Postage Prepaid

Enclosures: HCA 20-0050 (09/20)

School Employees' Benefits Board Program:

EMPLOYER SCHOOL NAME

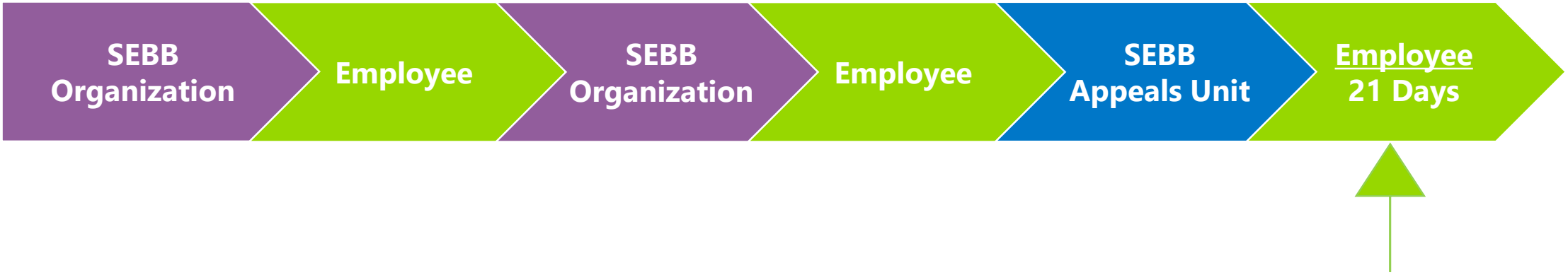
Electronically delivered

Once the Initial Order has been issued, an email with a courtesy copy of the order will be sent to the Benefits Administrator on file for your district.

Any questions regarding these results, should be directed toward 1-800-351-6827.

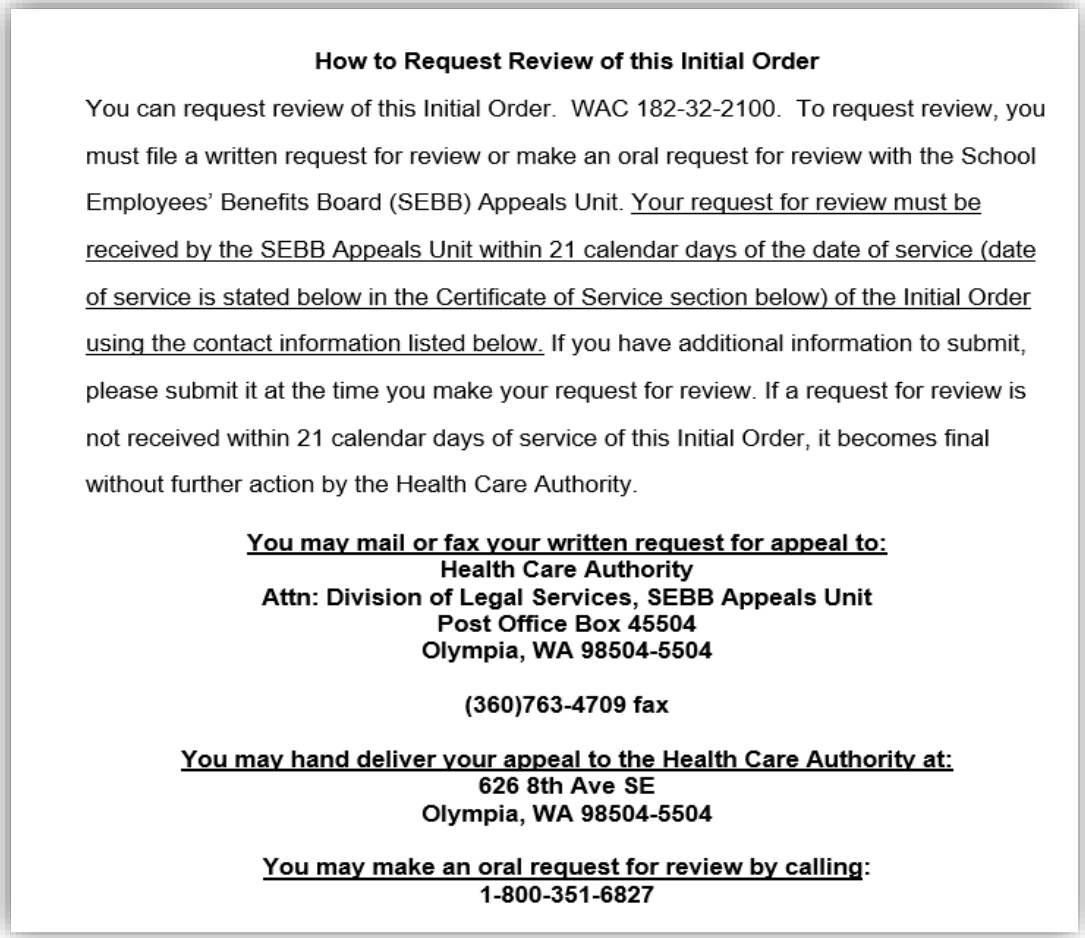
Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

Appeals Process



If the **employee** does not agree with the written initial order, they have **21 calendar days** from the date the initial order was issued to request further review by a review officer.

Appeals Process: Request for Review



How to Request Review of this Initial Order

You can request review of this Initial Order. WAC 182-32-2100. To request review, you must file a written request for review or make an oral request for review with the School Employees' Benefits Board (SEBB) Appeals Unit. Your request for review must be received by the SEBB Appeals Unit within 21 calendar days of the date of service (date of service is stated below in the Certificate of Service section below) of the Initial Order using the contact information listed below. If you have additional information to submit, please submit it at the time you make your request for review. If a request for review is not received within 21 calendar days of service of this Initial Order, it becomes final without further action by the Health Care Authority.

You may mail or fax your written request for appeal to:
Health Care Authority
Attn: Division of Legal Services, SEBB Appeals Unit
Post Office Box 45504
Olympia, WA 98504-5504

(360)763-4709 fax

You may hand deliver your appeal to the Health Care Authority at:
626 8th Ave SE
Olympia, WA 98504-5504

You may make an oral request for review by calling:
1-800-351-6827

The **employee** must file a written request for review or make an oral request for review with the SEBB Appeals Unit.

May submit request for review by:

- Mail or Fax
- Telephone number provided for requests for oral review

Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

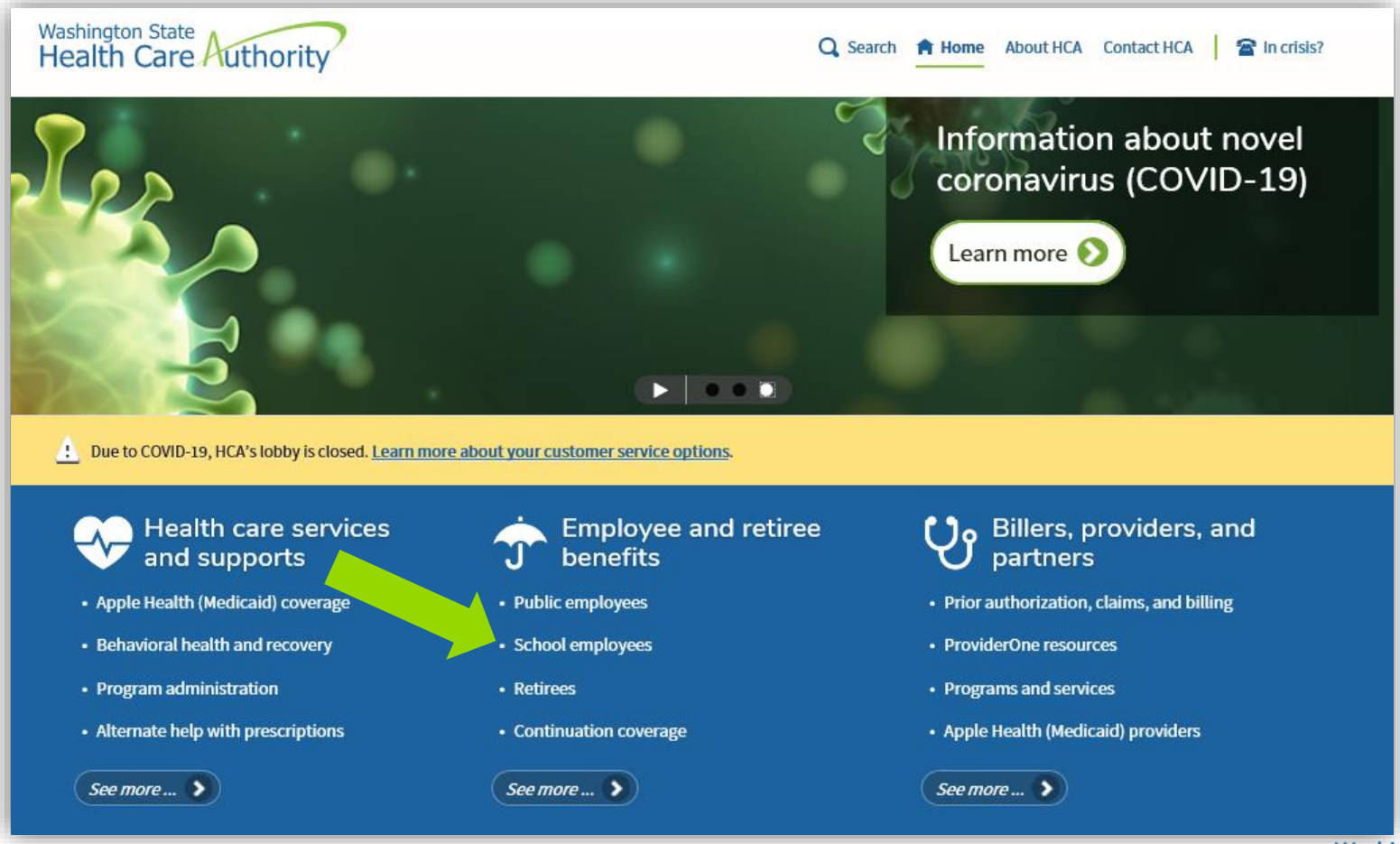
Appeals Process

The **SEBB review officer** will issue a final order within **20 calendar days** of the request for review. A copy of the final order is sent to all parties.

Appeals Process: Request for Judicial Review

- An **employee** may request judicial review of the final order.
- The employee must file a written petition for judicial review that meets the requirements of RCW 34.05.510 through 34.05.598.
- SEBB may not request judicial review of final orders.
- Judicial reviews are heard in Superior Court.

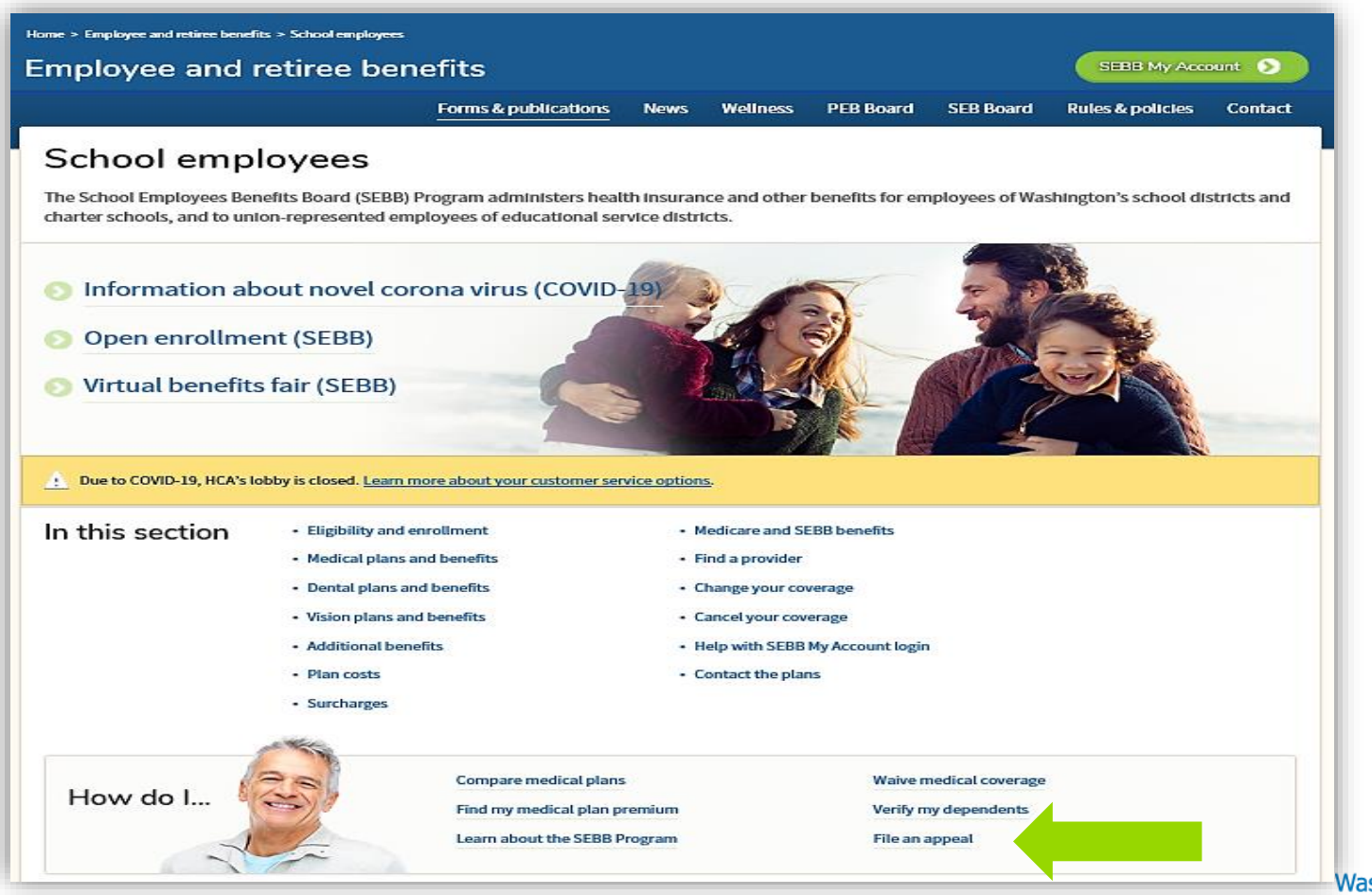
SEBB Employee Request for Review/ Notice of Appeal



Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

hca.wa.gov/

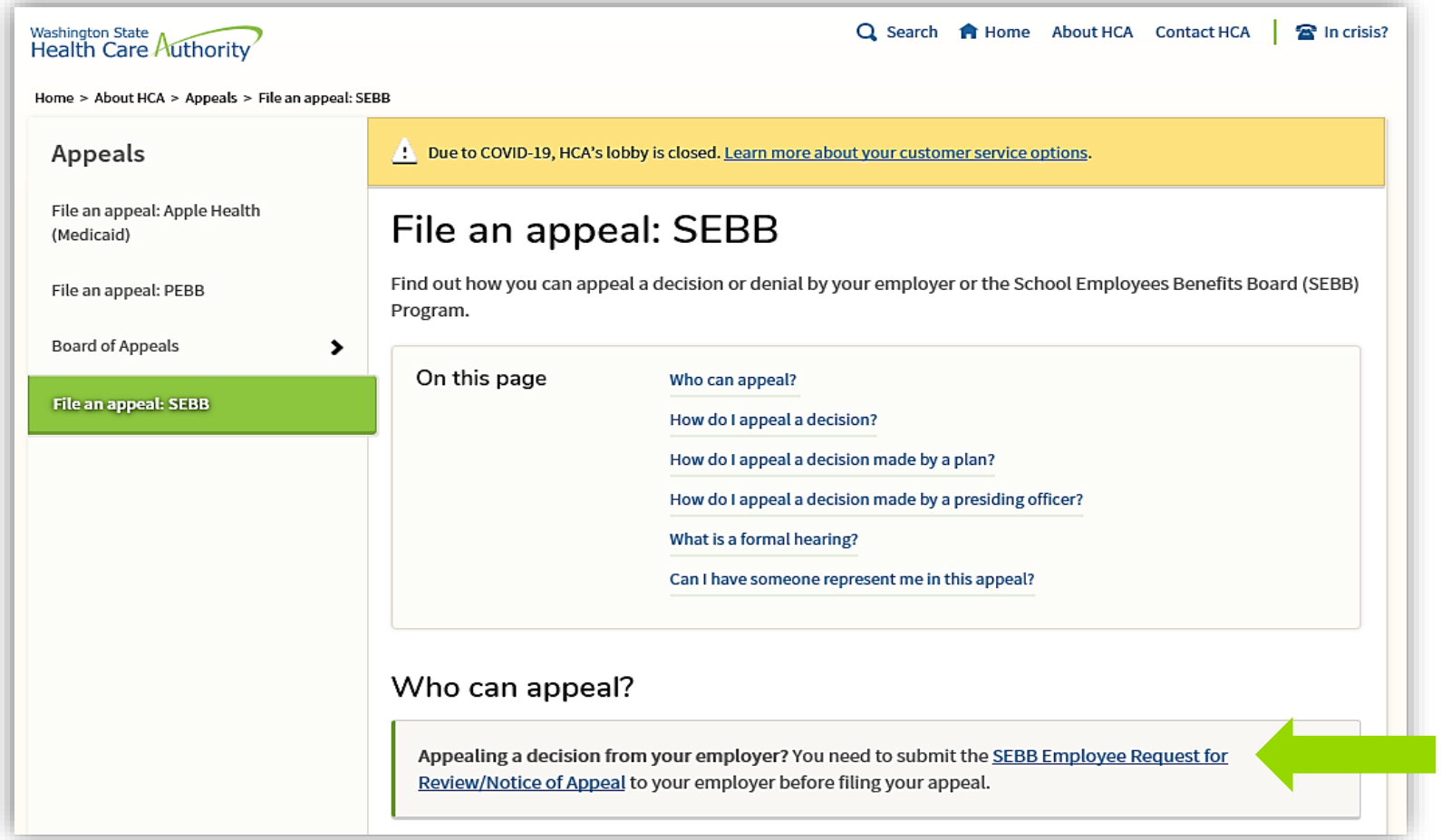
SEBB Employee Request for Review/ Notice of Appeal



Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

hca.wa.gov/employee-retiree-benefits/school-employees

SEBB Employee Request for Review/ Notice of Appeal



Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

hca.wa.gov/about-hca/file-appeal-sebb

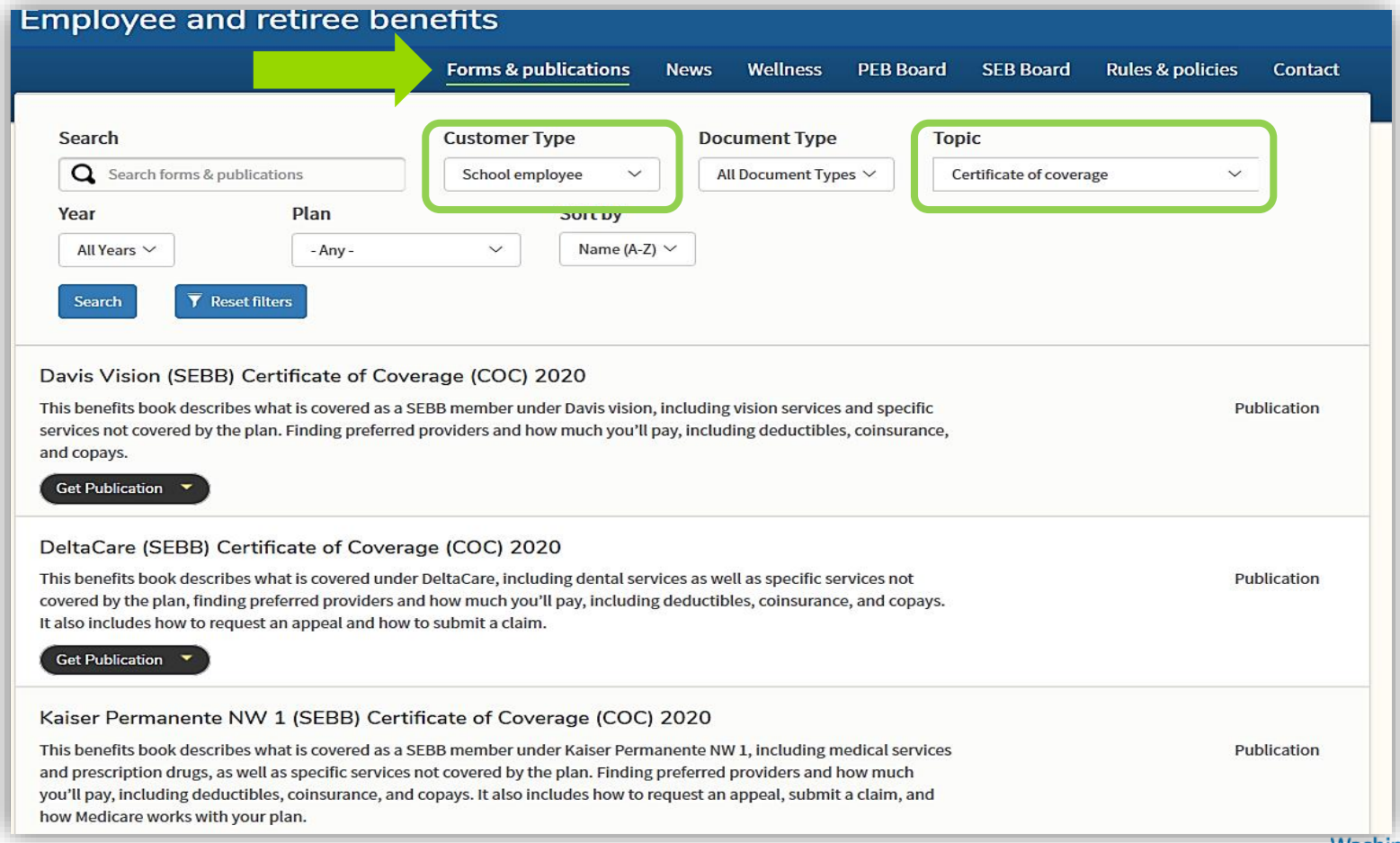
When to Appeal to your health plan

- A decision by your health plan regarding claims payment, processing, or reimbursement for services or supplies, or
- A preauthorization decision

More information is found in your plan's Certificate of Coverage

Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

Certificates of Coverage (COC's)



Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

hca.wa.gov/employee-retiree-benefits/forms-and-publications

SEBB Appeals

Where do employees or dependents appeal decisions?

Decision made by:	Appeal to:
SEBB Organization	SEBB Organization WAC 182-32-2020 *SEBB Employee Request for Review/Notice of Appeal*
SEBB Program	SEBB Appeals Unit WAC 182-32-2030
SEBB Health Plan or Insurance Carrier	Contact the Health Plan or Insurance Carrier *Certificate of Coverage (COC)*

Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

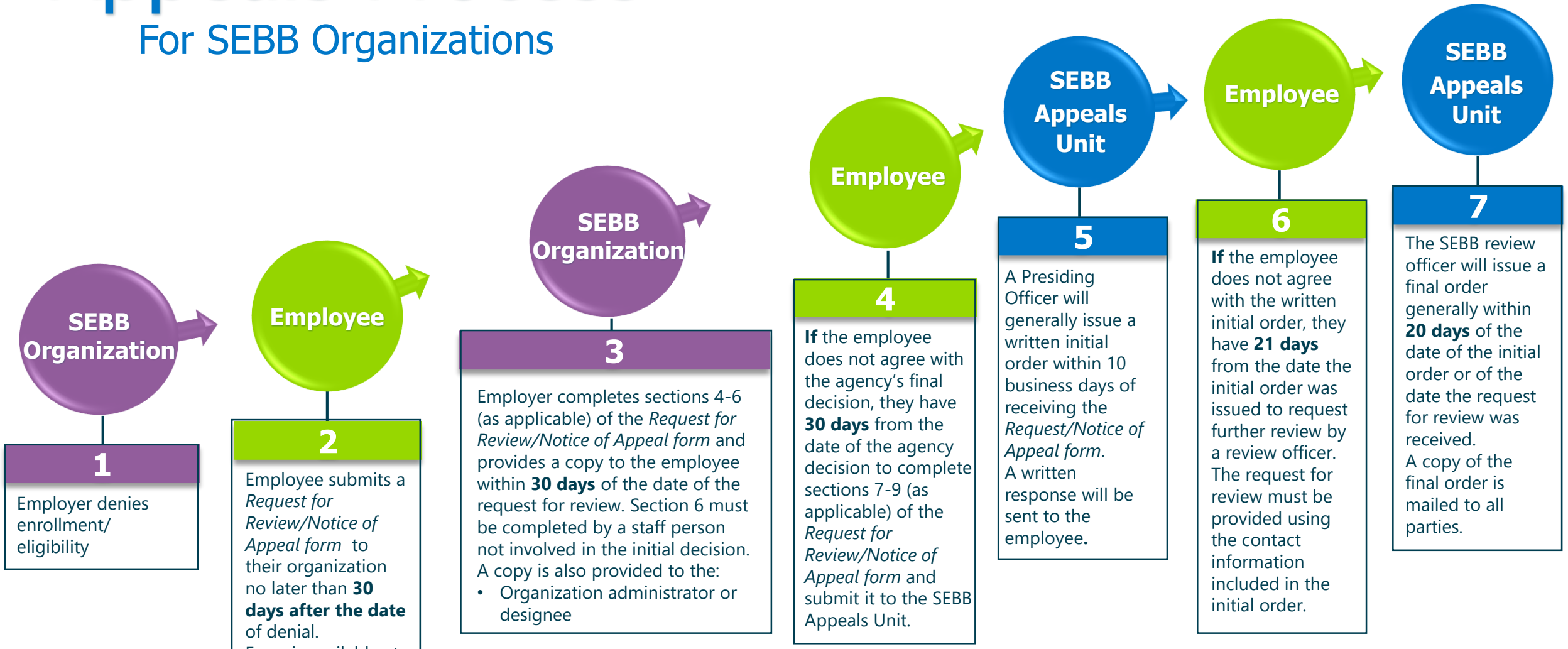
Review

- **Employee** has **30 calendar days** to file a request for review after the date of the denial notice
- The **SEBB Org** has **30 calendar days** after the date the request for review is received to conduct a review and provide a written response to the employee with a copy to the SEBB Org administrator
- **Employee** has **30 calendar days** after SEBB Org's final decision to appeal to the SEBB Appeals Unit
- **SEBB Appeals Unit** has **10 business days** from receiving the *Request/Notice of Appeal form* to provide employee with written initial order
- **Employee** has **21 calendar days** from the date the initial order was issued to request further review
- **SEBB review officer** has **20 calendar days** from the request for review to issue final order

Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

Appeals Process

For SEBB Organizations



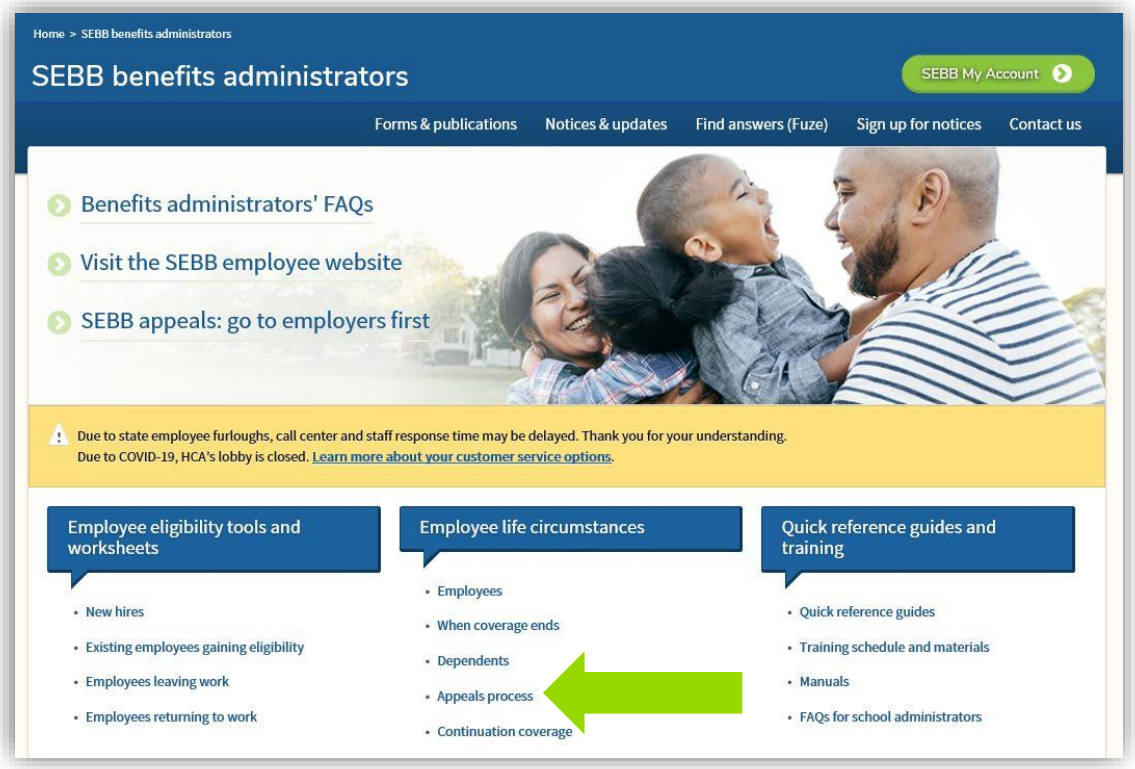
Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

hca.wa.gov/assets/perspay/SEBB-appeals-process-map.pdf

Resources

Outreach & Training for guidance

- 1-800-700-1555
- Online via FUZE secure messaging system



Contact us with employee's questions—employees should not contact us directly!

hca.wa.gov/sebb-benefits-admins

Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

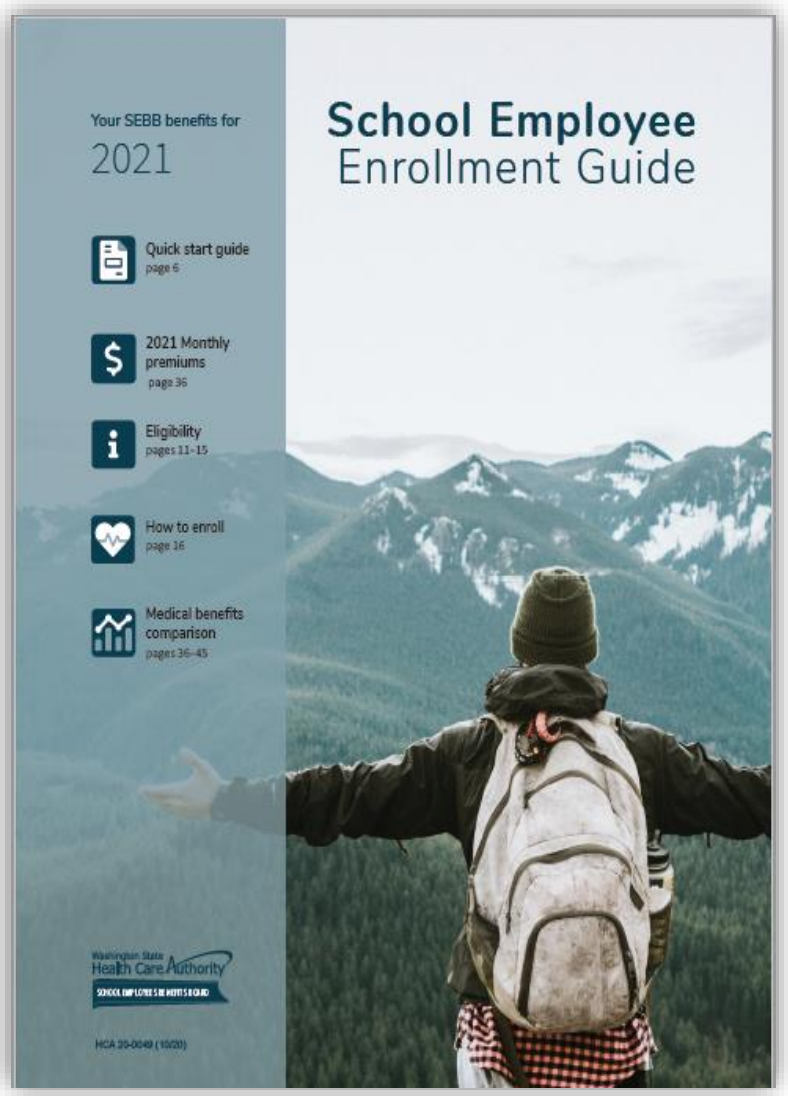
Resources

2021 School Employee Enrollment Guide

- Appeals
  - Pages 73-74

SEBB Appeals Unit

- Phone: 1-800-351-6827
- Fax: 1-360-763-4709



BA website/ Forms & publications

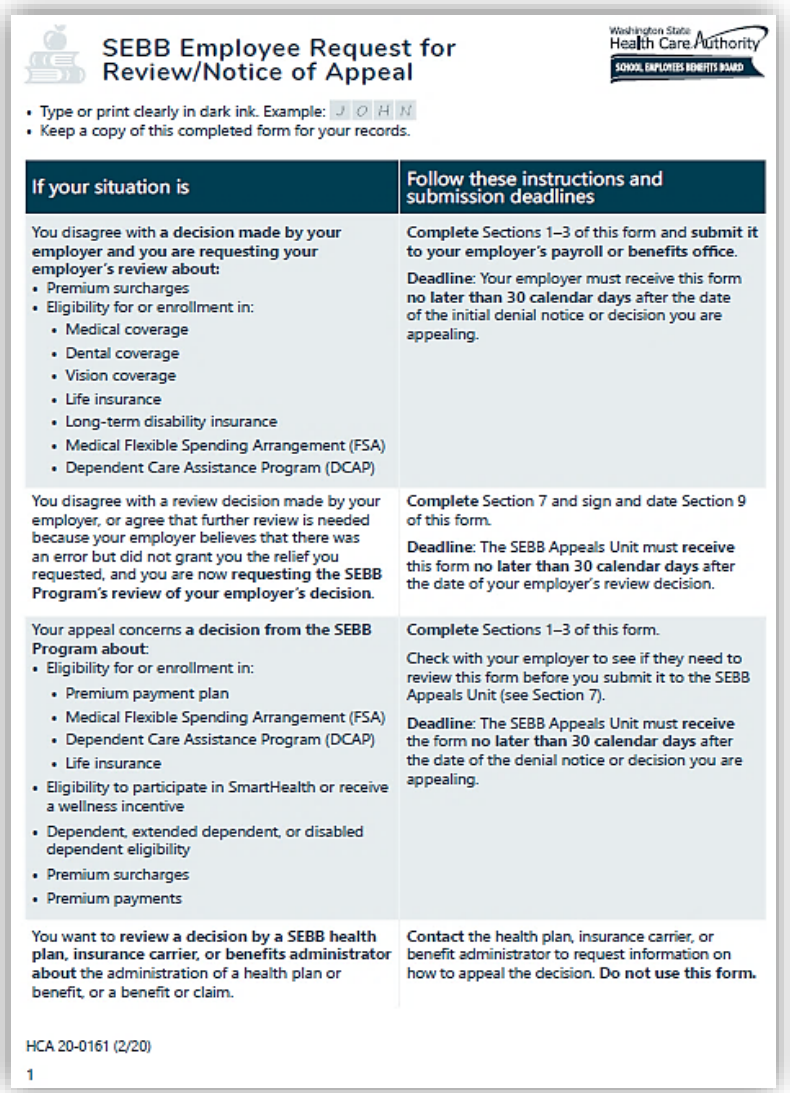
hca.wa.gov/assets/pebb/20-0049-school-employee-enrollment-guide-2021.pdf

Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

Reminder

Employees should submit appeals to HCA by fax or mail:

- **Contact:**
  - SEBB Appeals unit
  - Phone: 1-800-351-6827
  - **Fax:** 1-360-763-4709
- **Mailing address:**
  - Health Care Authority
  - Attn: SEBB Appeals Unit
  - PO Box 45504
  - Olympia, WA 98504-2699



SEBB Employee Request for Review/Notice of Appeal

Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

- Type or print clearly in dark ink. Example: J O H N
- Keep a copy of this completed form for your records.

If your situation is	Follow these instructions and submission deadlines

You disagree with **a decision made by your employer and you are requesting your employer's review about:**
• Premium surcharges
• Eligibility for or enrollment in:
  • Medical coverage
  • Dental coverage
  • Vision coverage
  • Life insurance
  • Long-term disability insurance
  • Medical Flexible Spending Arrangement (FSA)
  • Dependent Care Assistance Program (DCAP)
	Complete Sections 1–3 of this form and **submit it to your employer's payroll or benefits office.**
	Deadline: Your employer must receive this form **no later than 30 calendar days** after the date of the initial denial notice or decision you are appealing.

You disagree with a review decision made by your employer, or agree that further review is needed because your employer believes that there was an error but did not grant you the relief you requested, and you are now **requesting the SEBB Program's review of your employer's decision.**	**Complete** Section 7 and sign and date Section 9 of this form. **Deadline**: The SEBB Appeals Unit must **receive** this form **no later than 30 calendar days** after the date of your employer's review decision.

Your appeal concerns **a decision from the SEBB Program about**:
• Eligibility for or enrollment in:
  • Premium payment plan
  • Medical Flexible Spending Arrangement (FSA)
  • Dependent Care Assistance Program (DCAP)
  • Life insurance
• Eligibility to participate in SmartHealth or receive a wellness incentive
• Dependent, extended dependent, or disabled dependent eligibility
• Premium surcharges
• Premium payments
	Complete Sections 1–3 of this form.
	Check with your employer to see if they need to review this form before you submit it to the SEBB Appeals Unit (see Section 7).
	Deadline: The SEBB Appeals Unit must **receive** the form **no later than 30 calendar days** after the date of the denial notice or decision you are appealing.

You want to **review a decision by a SEBB health plan, insurance carrier, or benefits administrator about** the administration of a health plan or benefit, or a benefit or claim.	**Contact** the health plan, insurance carrier, or benefit administrator to request information on how to appeal the decision. **Do not use this form.**

HCA 20-0161 (2/20)

1

Please send appeal related **questions** through FUZE!

Please **do not** submit appeals through FUZE!

hca.wa.gov/assets/pebb/20-0161-sebb-employee-request-for-review-notice-of-appeal.pdf

Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

Upcoming Webinars

November 20: SEBB Data for Form 1095 Reporting

How to register: hca.wa.gov/sebb-benefits-admins/training-schedule

All past webinars are recorded and posted to the BA website.

Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

Thank you for your input!

Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD