SEBB Program Appeals Process

School Employees Benefits Board (SEBB)

Outreach & Training

2020

Washington State Health Care Authority

SCHOOL EMPLOYEES BENEFITS BOARD

Timeline of upcoming events

February 20: SEBB Health Plan coverage confirmation letters go out to school employees who enrolled in coverage outside of last year's OE period. (Nov 16, 2019 – current)

- This could result in employees submitting a request for review if they identify any issues related to their enrollment

Washington State Health Care Authority
School Employees Benefits Board
P.O. Box 42720 • Olympia, Washington 98504-2720
www.hca.wa.gov/sebb

<Date>

NAME
ADDRESS
ADDRESS
CITY STATE ZIP

Health plan info

Coverage effective:
Subscriber ID #:
Medical plan:
Medical plan phone #:
Dental plan:
Dental plan phone #:
Vision plan:
Vision plan phone #:

Confirmation of your SEBB Program health plan coverage

Dear Subscriber:

This letter confirms your School Employees Benefits Board (SEBB) Program health plan coverage (as listed at the top of this letter) for you and the following dependents, if any, effective **DATE**:

Dependent enrollment

Dependent name	Medical	Dental	Vision
Name 1	Yes/No	Yes/No	Yes/No
Name 2	Yes/No	Yes/No	Yes/No
Name 3	Yes/No	Yes/No	Yes/No
Name 4	Yes/No	Yes/No	Yes/No
Name 5	Yes/No	Yes/No	Yes/No
Name 6	Yes/No	Yes/No	Yes/No
Name 7	Yes/No	Yes/No	Yes/No
Name 8	Yes/No	Yes/No	Yes/No
Name 9	Yes/No	Yes/No	Yes/No
Name 10	Yes/No	Yes/No	Yes/No
Name 11	Yes/No	Yes/No	Yes/No
Name 12	Yes/No	Yes/No	Yes/No
Name 13	Yes/No	Yes/No	Yes/No
Name 14	Yes/No	Yes/No	Yes/No
Name 15	Yes/No	Yes/No	Yes/No

You can use this letter as your temporary health plan ID card until you receive plan ID cards (or until you can access ID card information on your plan's secure member website). Please note that Uniform Dental Plan and Willamette Dental Group do not issue ID cards.

If you or a covered dependent need health services, show this letter and your identification to the provider or pharmacist. You, your provider, or your pharmacist may call the medical, dental, or vision plan at the phone numbers listed above to check the enrollment shown in this letter. You may also need to share the first five digits of your Social Security number to complete the subscriber ID number shown above.

You may access your enrollment confirmation information and print a *Statement of Insurance* through SEBB My Account at **myaccount.hca.wa.gov**. You must register for SEBB My Account to

continued

view account information online. **Note:** If you are no longer eligible for SEBB health plan coverage, this letter does not apply.

Your monthly costs

Your medical coverage has monthly costs, called premiums. To see what your monthly premiums will be, visit **hca.wa.gov/erb**. You may also be subject to two premium surcharges.

The table below shows whether the premium surcharges will apply:

Surcharge	Applies to your account
$25 Tobacco use premium surcharge	Yes/No
$50 Spouse or state-registered domestic partner coverage premium surcharge	Yes/No

Surcharge status

If you are charged the premium surcharges, you either responded that they apply to your account (or if requested, your employer found that they apply) or you did not attest when you enrolled. Learn more about the surcharges at **hca.wa.gov/sebb-employee** under *Surcharges*.

If you have questions about this letter, or believe the information in this letter is incorrect, please contact your payroll or benefits office.

Sincerely,

SEBB Program

Timeline continued…

February 20: SEBB Health Plan coverage confirmation letters mailed

February 21: SEBB Appeals Webinar

February 29: Last day HCA/SEBB will accept ***new*** appeals from school employees. HCA/SEBB will continue to process any appeals ***received*** through Feb 29, 2020.

March 1: BA's will be expected to be the first level of review for all requests related to last year's OE, newly eligible employees, and subscribers who have a Special Open Enrollment (SOE) event.

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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

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SEBB Organization Obligations & Appeals

WAC 182-31-030

SEBB Organization obligations in the application of employee eligibility

WAC 182-32

Appeals practices and procedures

Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

Employer obligations

SEBB Organizations responsibilities include:

- Determining eligibility and providing notification to employees
- Routinely monitoring all school employee work hours
- Reviewing employer decisions when employees disagree with an eligibility, enrollment, or premium surcharge related decision
- Correcting errors made by the SEBB Organization through the process in WAC 182-30-060
- Supporting SEBB program auditing

Employer obligations

Mistakes are costly—to employer and employee

- Appeals
- Error correction and recourse
- Back premiums due
- Penalties
- Employee's (or dependent's) health may be compromised

SEBB Appeals

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

- 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
    - Meeting enrollment deadlines

General guidance for SEBB Org's

SEBB Outreach and Training staff are available to offer guidance, but not decision making.

An appeal is only necessary if the employee disagrees with the SEBB Org decision and wants to appeal that decision.

However:

- The SEBB Org's position must reflect:
  - RCW 41.05
  - WAC Chapters 182-30, 182-31, and 182-32
  - SEBB policies

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Correcting errors

The SEBB Org may only reverse eligibility, premium surcharges, or enrollment decisions as permitted by WAC 182-30-060 (1).

- Failure to provide notice of eligibility or accurately enroll in benefits:
  - The error is corrected prospectively with enrollment in benefits effective the first day of the month following the date the error is identified.
  - HCA approves all error correction actions and determines if additional recourse (such as retroactive enrollment) is warranted

Correcting errors

The SEBB org may only reverse eligibility, premium surcharges, or enrollment decisions as permitted by WAC 182-30-060 (2).

- SEBB Organization enrolls an employee or their dependents when they were not eligible.
- No fraud or intentional misrepresentation by the employee
  - Premiums and any applicable premium surcharges already paid by the employee will be refunded to the employee by the SEBB Org.
  - The correction is prospective with termination of benefits effective the first day of the month following the date the error is identified.

SEBB Appeals resources

Available resources for BA's and employees

- Employee Enrollment Guide (pgs. 74-75)
- SEBB website (hca.wa.gov/about-hca/file-appeal-sebb)
- BA website(hca.wa.gov/sebb-benefits-admins/appeals-process)

For questions, contact:

- O&T via **FUZE** or at 1-800-700-1555 (BA's only, not for employees)

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SCHOOL EMPLOYEES BENEFITS BOARD

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 Employee Request for Review/Notice of Appeal*
SEBB Health Plan or Insurance Carrier	Contact the Health Plan or Insurance Carrier *Certificate of Coverage (COC)*

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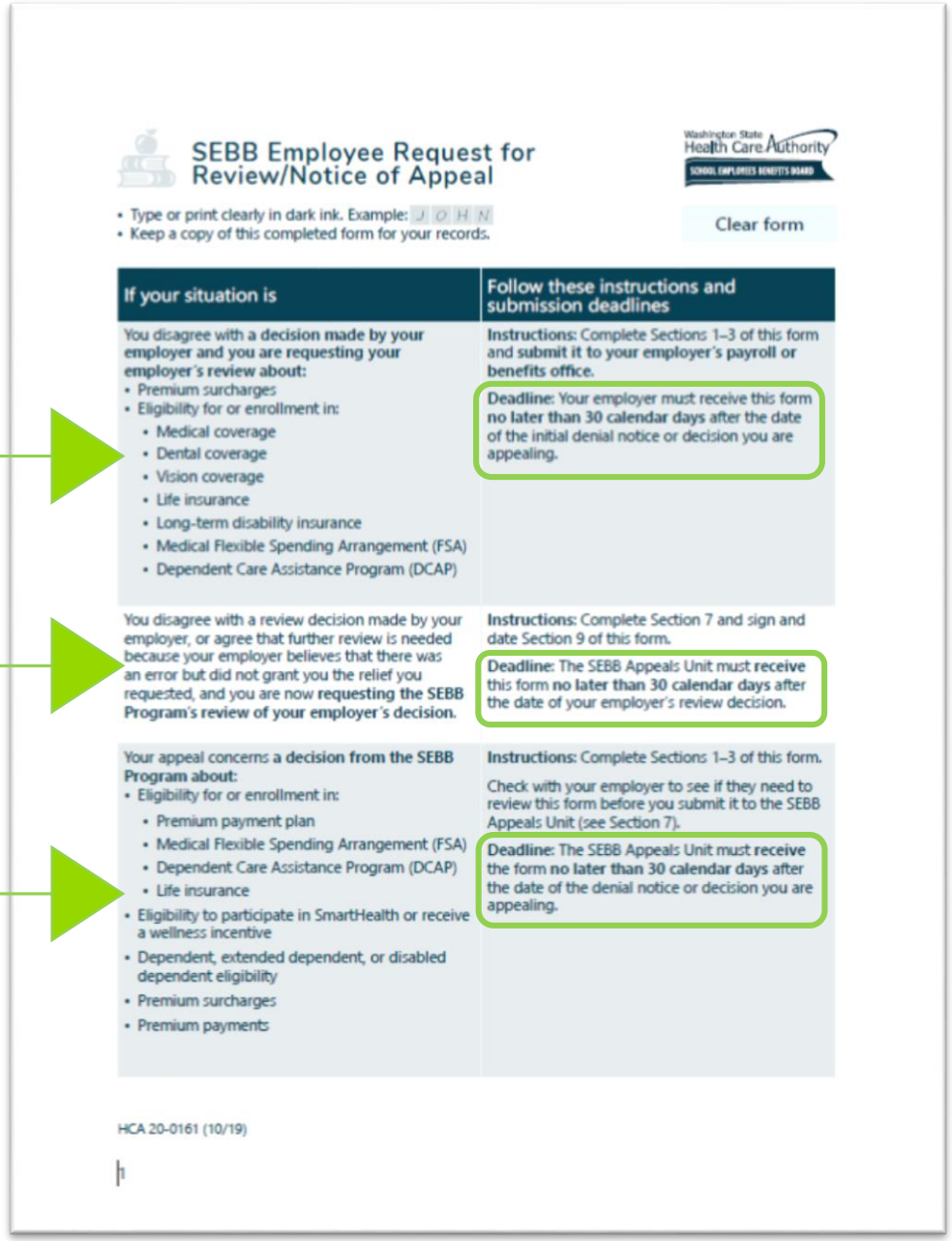
Employee disagrees with SEBB Orgs decision and requests review by SEBB Org

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)

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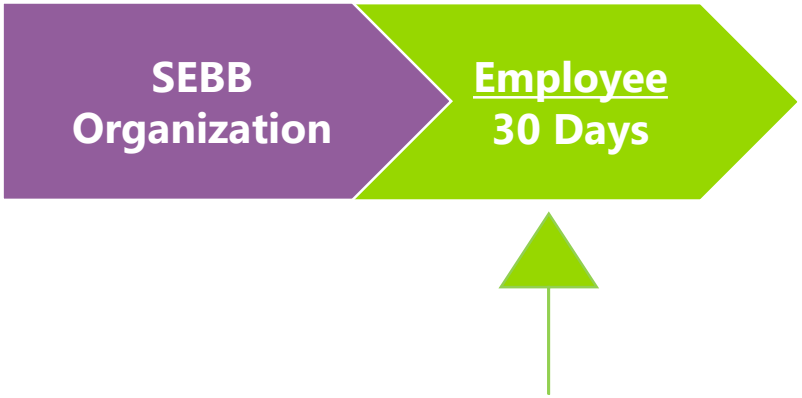
Review Process

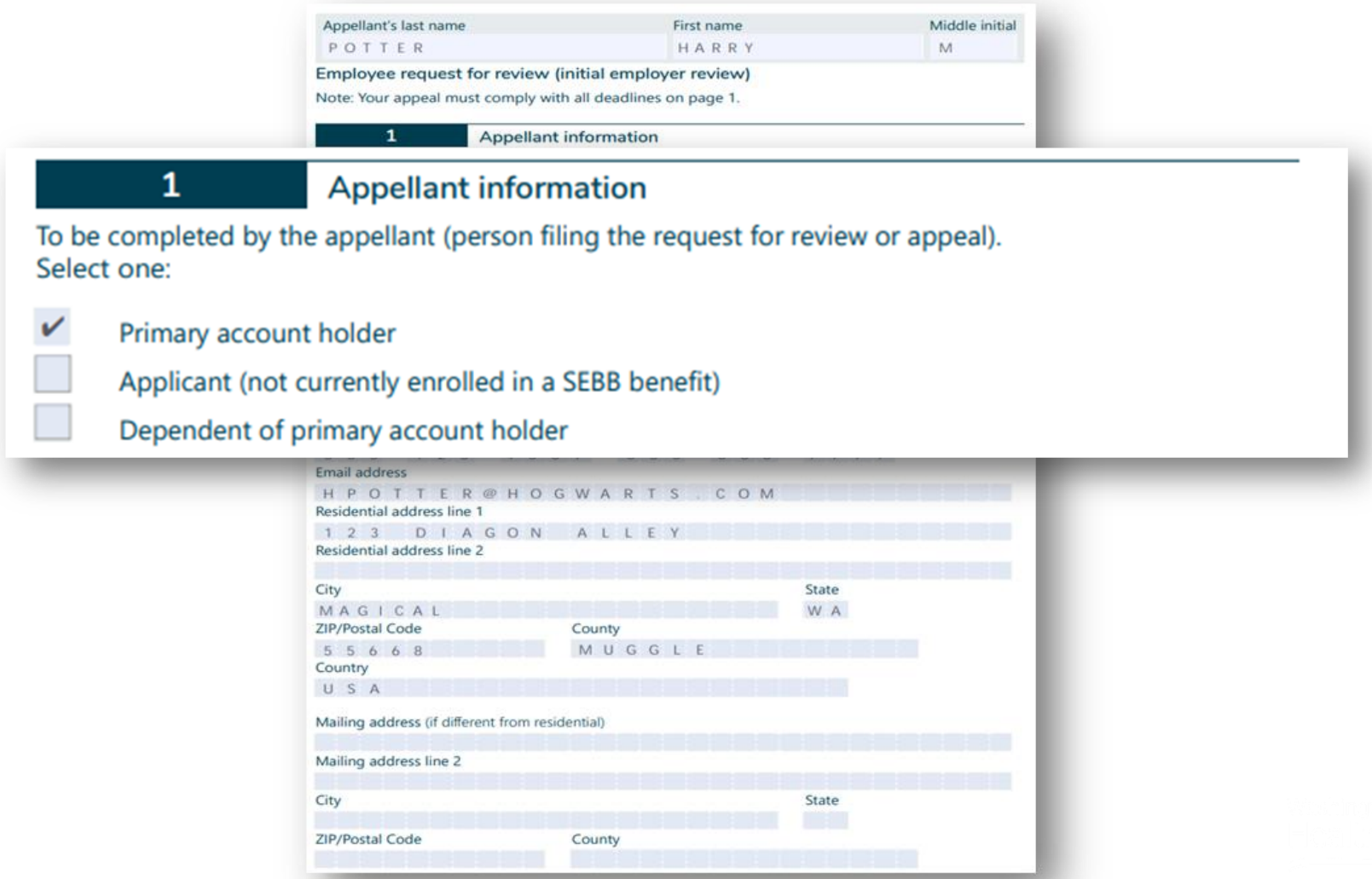
SEBB Org denies eligibility/enrollment

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



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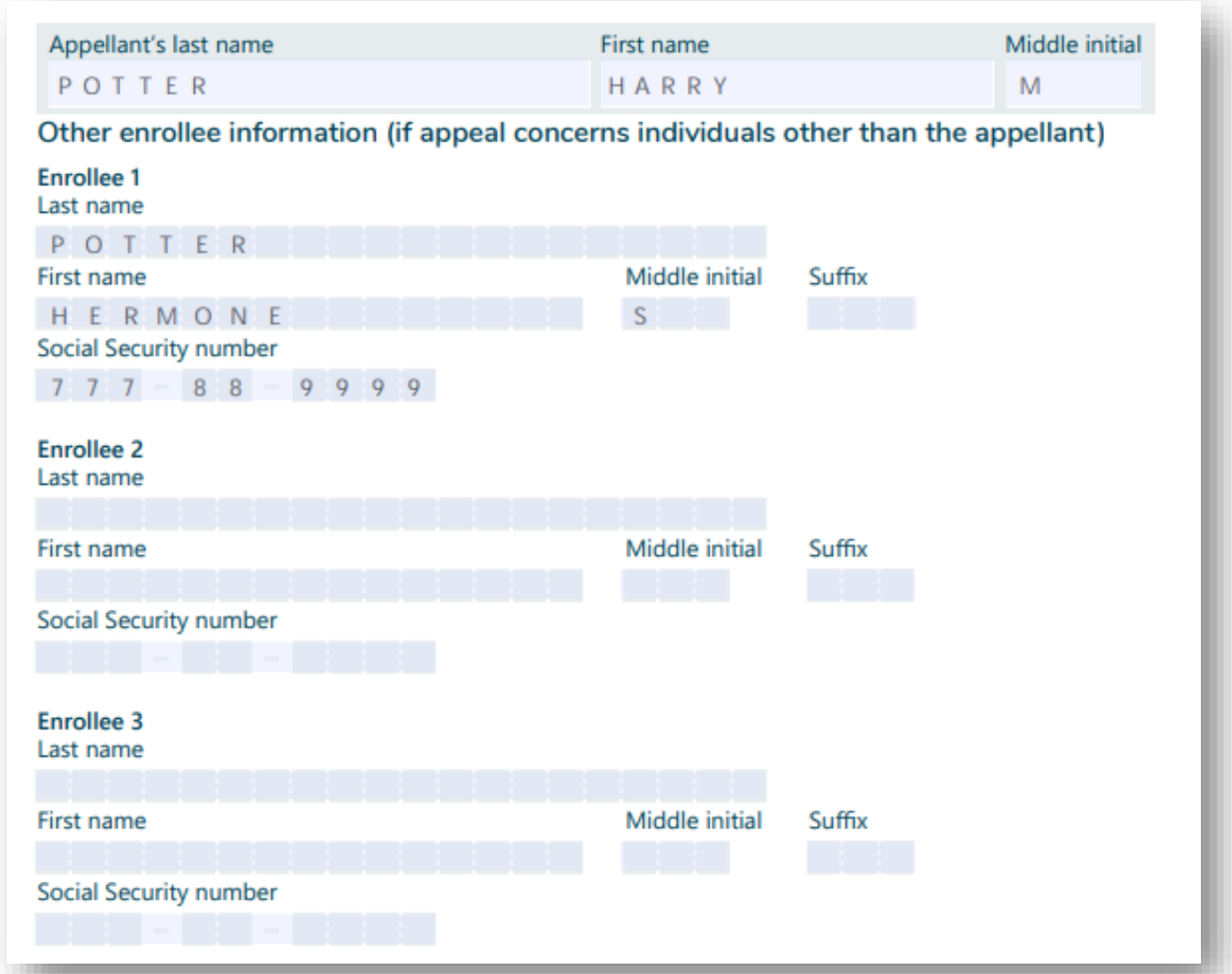
Section 1 Other enrollee Information



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: - -

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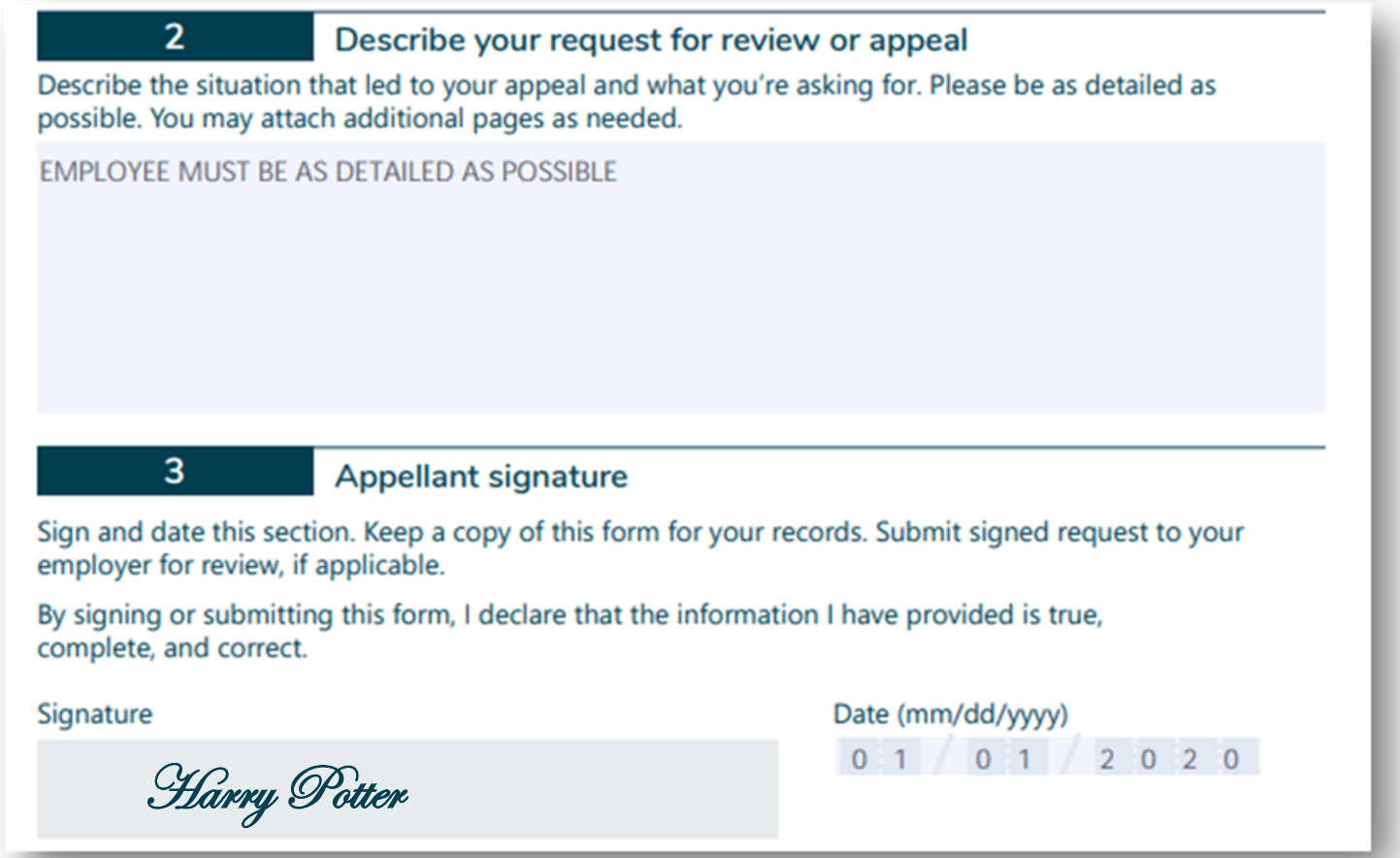
Sections 2-3 Description & Signature



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)

01 / 01 / 2020

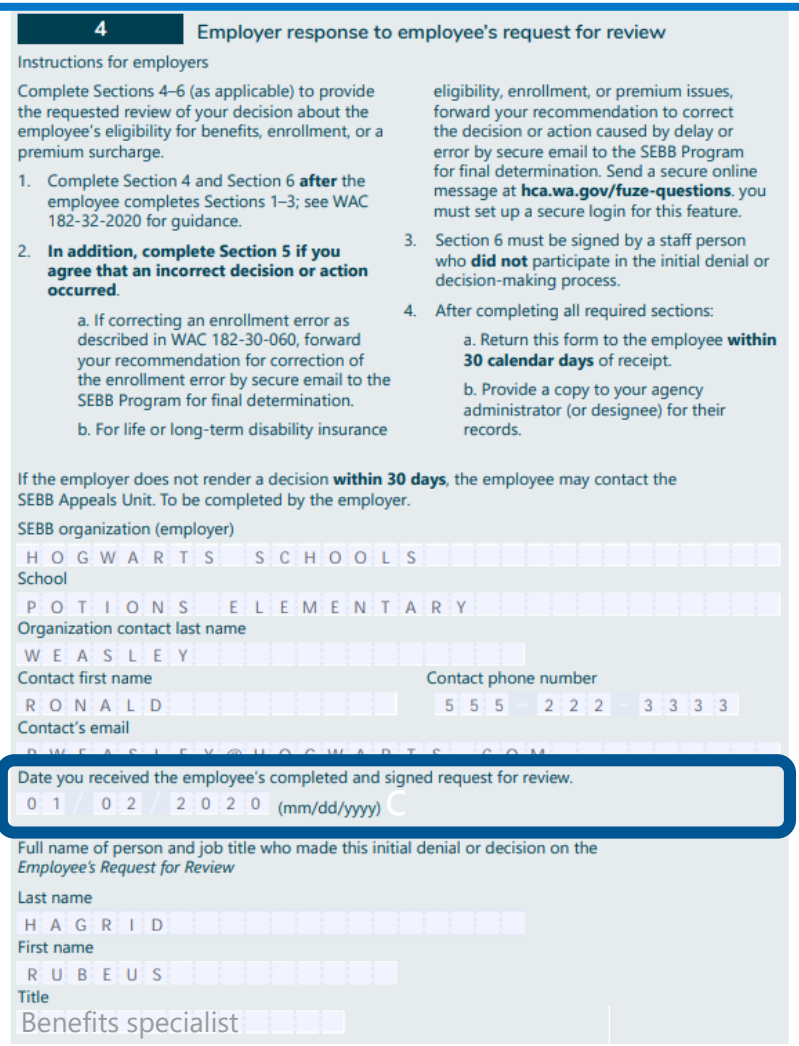
Review Process

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.**

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

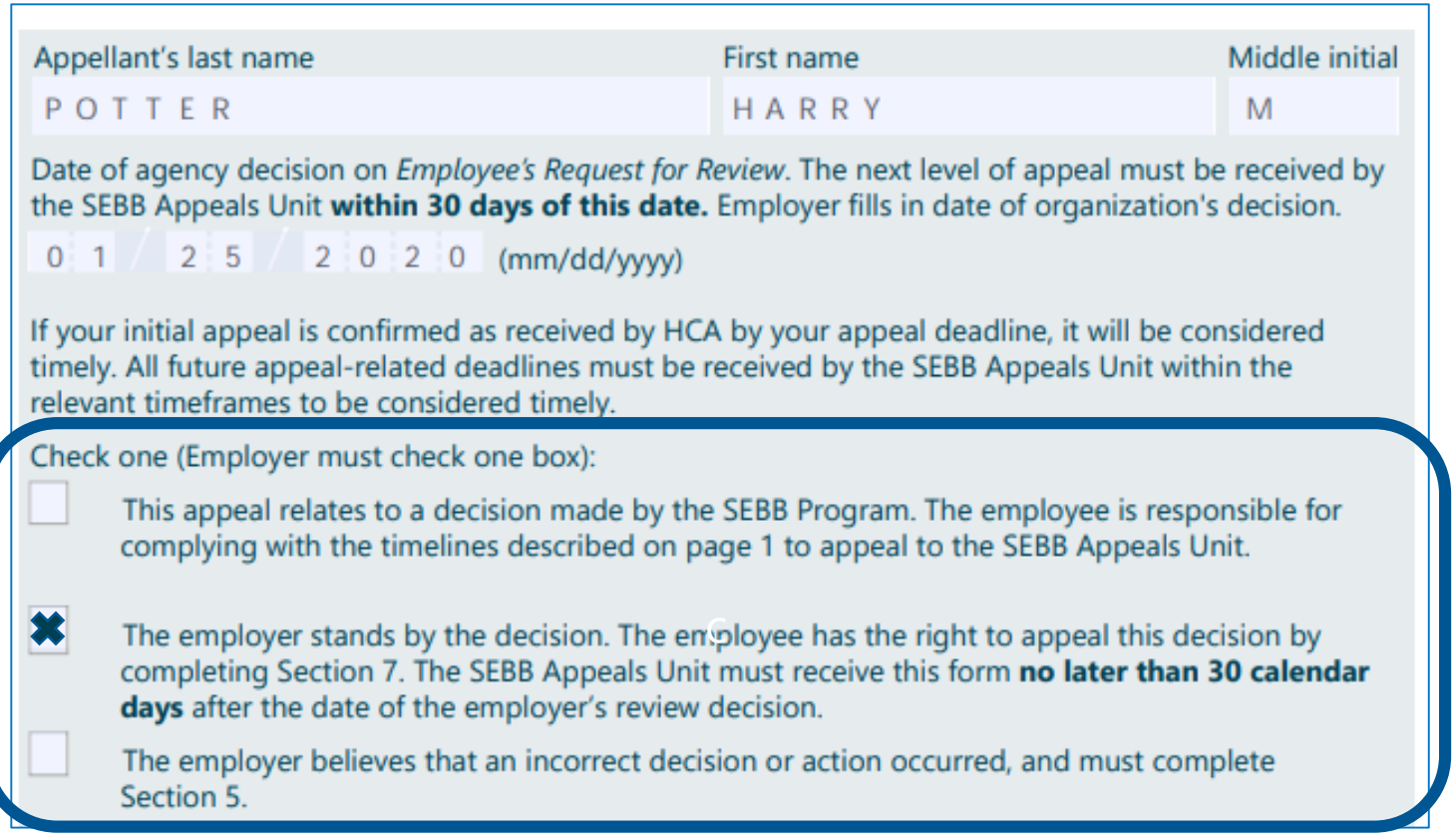
Staff person signs section 6

Provide copy to employee and one for the SEBB Org

Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

Section 4 Employer's Response

Enter the date of the organization's review decision



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.

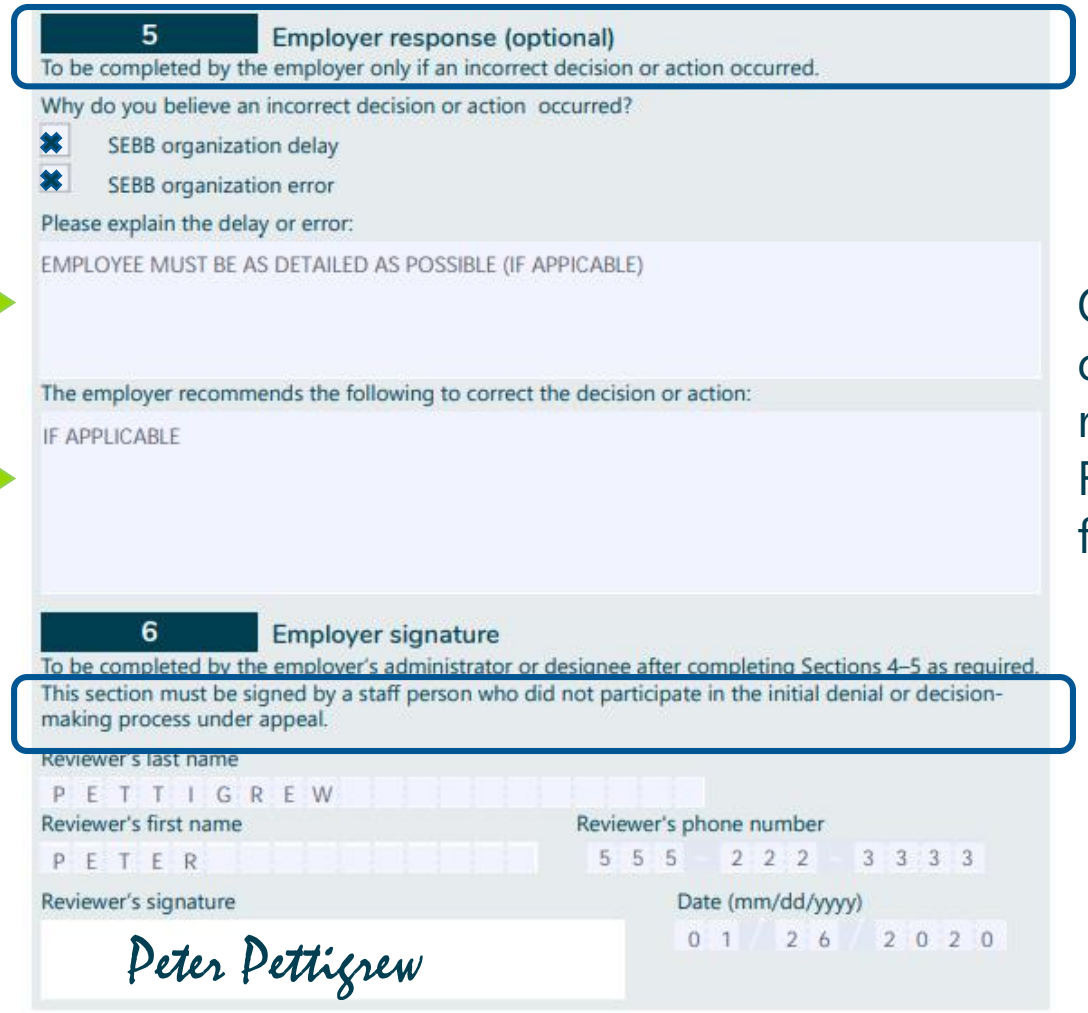
Check one (Employer must check one box):

- ☐ 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.

Sections 5-6 Employer's Response & Signature

Explain the delay or error

Recommendation to correct the decision or action



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:

EMPLOYEE MUST BE AS DETAILED AS POSSIBLE (IF APPICABLE)

The employer recommends the following to correct the decision or action:

IF APPLICABLE

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: P E T T I G R E W

Reviewer's first name: P E T E R

Reviewer's phone number: 5 5 5 - 2 2 2 - 3 3 3 3

Reviewer's signature: Peter Pettigrew

Date (mm/dd/yyyy): 0 1 / 2 6 / 2 0 2 0

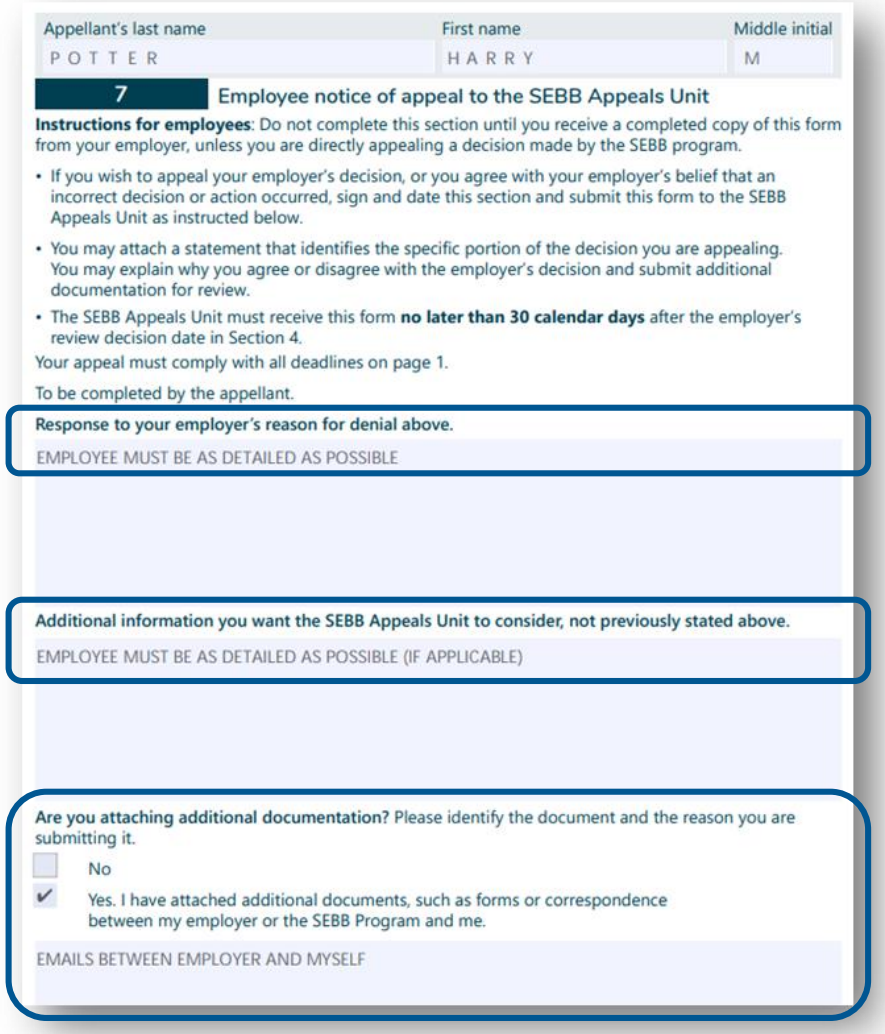
Once section 5 is completed, send recommendation through FUZE for SEBB Program's final determination

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.**

Section 7
Employee Notice of Appeal to SEBB Appeals Unit



Appellant's last name	First name	Middle initial
POTTER	HARRY	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

Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

Section 8-9
Representative Information & Appellant Information

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

8 Representative information (optional)

If you have someone representing you, you must complete HCA's *Authorization for Release of Information* form. Please contact the SEBB Appeals Unit for additional information at 1-800-351-6827.

Last name
First name
Middle initial
Phone number
Relationship to appellant applicable)
Washington State Bar Association number (If
Mailing address line 1
Mailing address line 2
City
State
ZIP/Postal Code

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.

Signature: *Harry Potter*
Date (mm/dd/yyyy): 02 / 15 / 2020

[Authorization for Release of Information form]

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 a brief adjudicative proceeding (BAP) has been received.

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 will be conducted by a presiding officer.

- Designated by the director

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.

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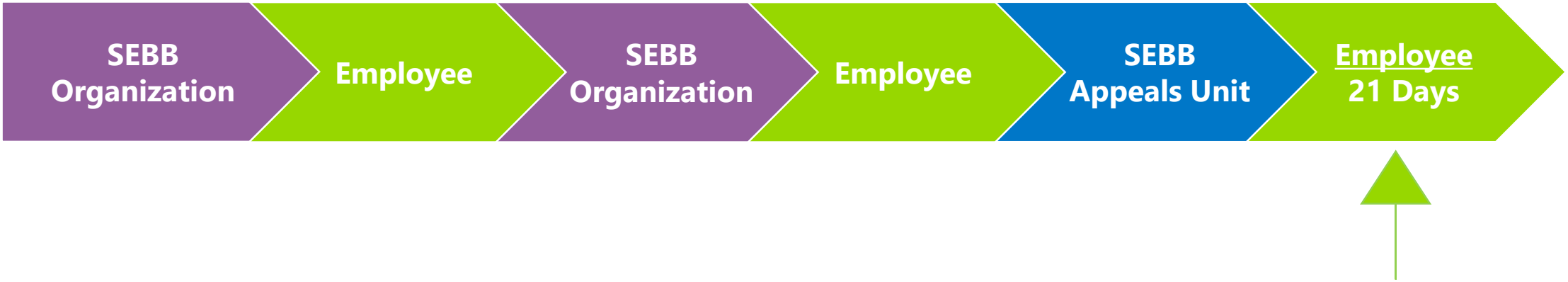
Appeals Process

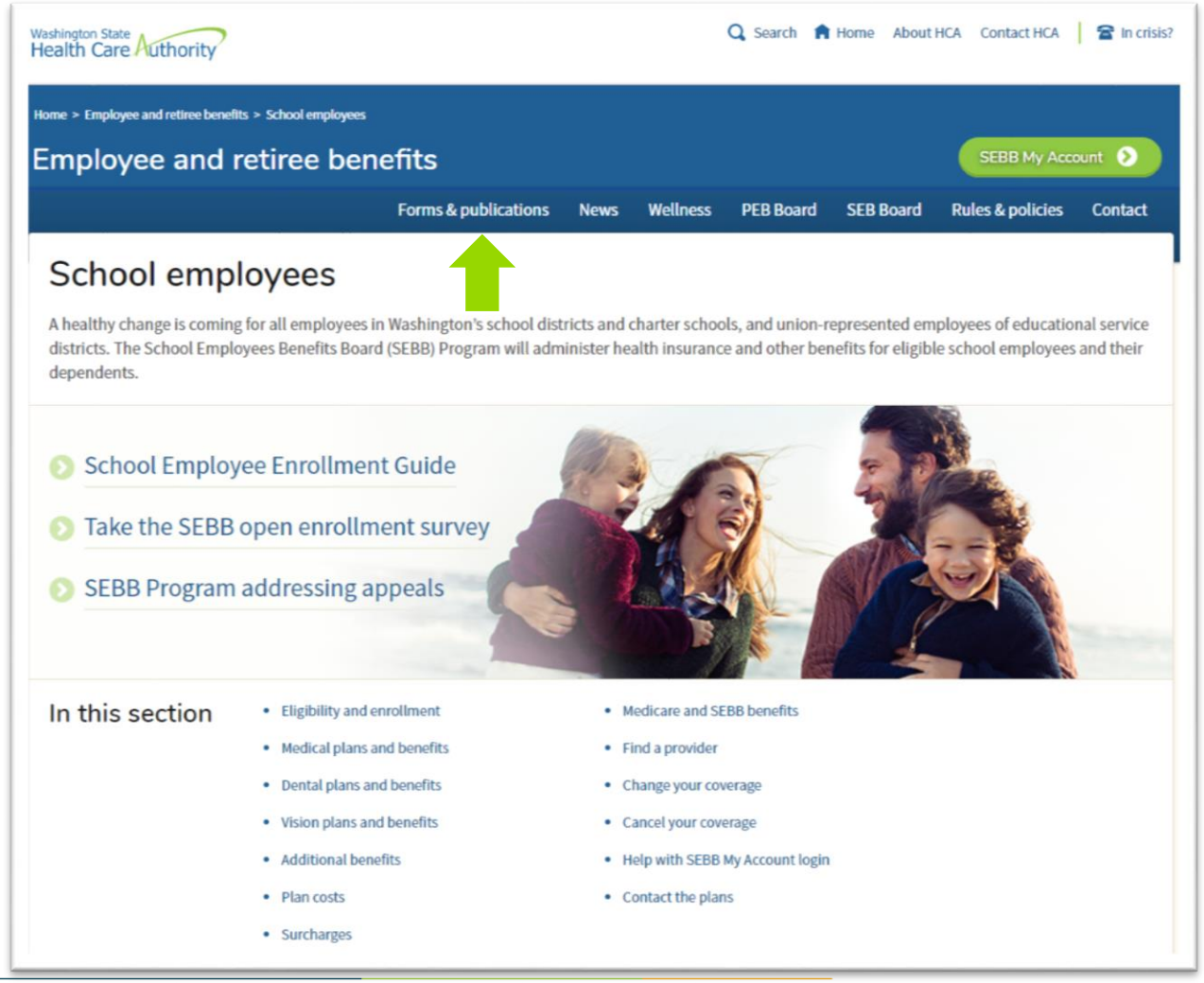


If the **employee** does not agree with the written initial order, they have **21 calendar days** from the date the initial order was issued to request further review by one or more review officers.

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 mailed to all parties.

SEBB Employee Request for Review/Notice of Appeal



https://www.hca.wa.gov/employee-retiree-benefits/school-employees

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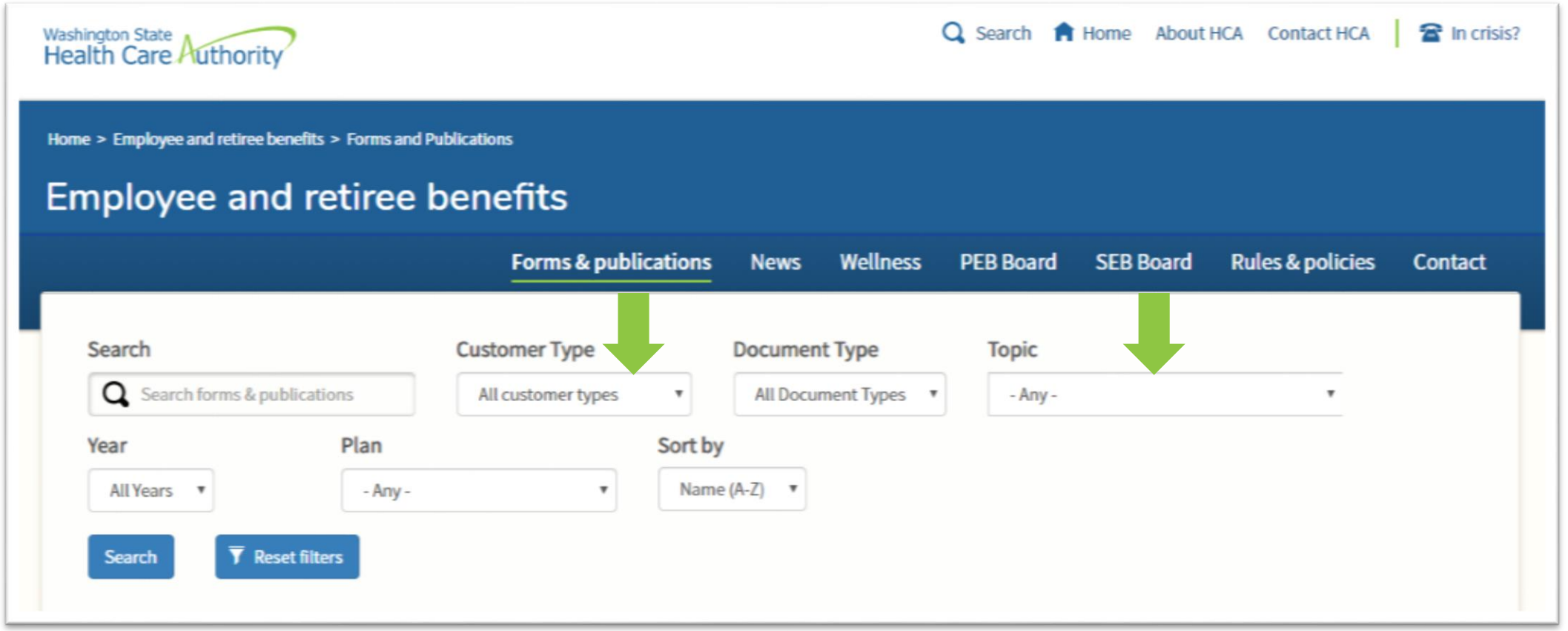
SEBB Employee Request for Review/Notice of Appeal



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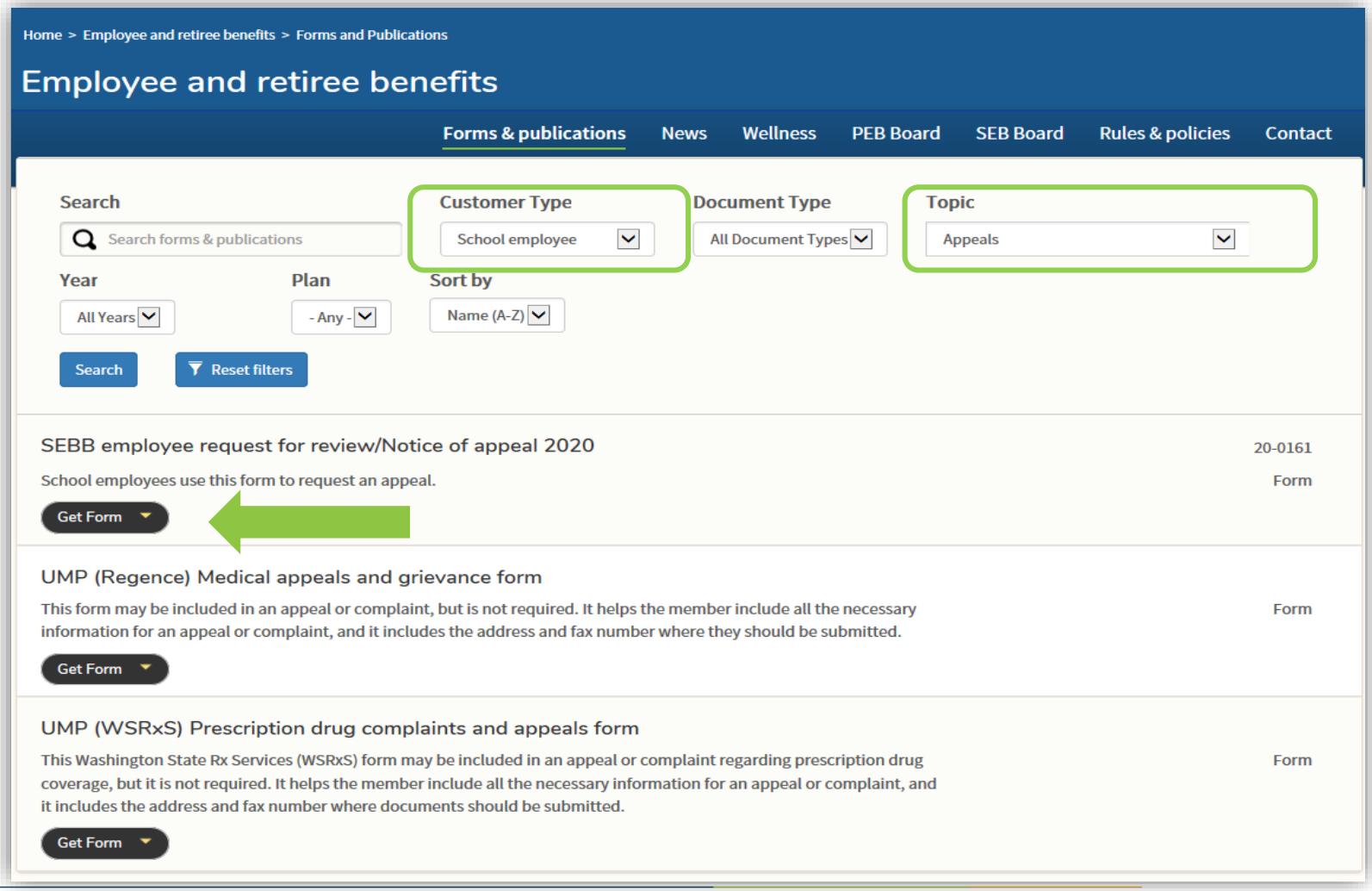
SCHOOL EMPLOYEES BENEFITS BOARD

SEBB Employee Request for Review/Notice of Appeal



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SCHOOL EMPLOYEES BENEFITS BOARD

KP WA Core 1 COC

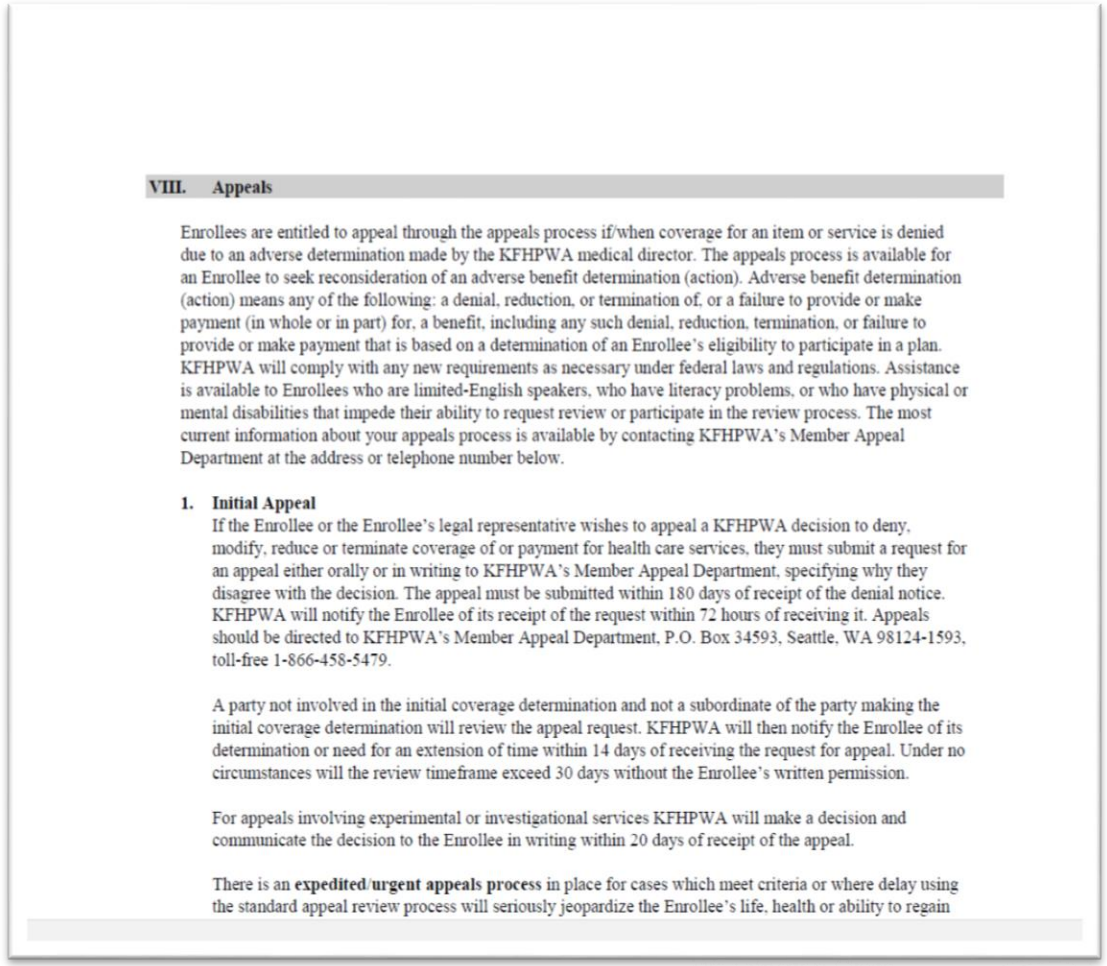
KAISER PERMANENTE®

Kaiser Foundation Health Plan of Washington

A nonprofit health maintenance organization

2020 Evidence of Coverage

School Employees (SEBB)
Core 1 ($1,250)



VIII. Appeals

Enrollees are entitled to appeal through the appeals process if/when coverage for an item or service is denied due to an adverse determination made by the KFHPWA medical director. The appeals process is available for an Enrollee to seek reconsideration of an adverse benefit determination (action). Adverse benefit determination (action) means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of an Enrollee's eligibility to participate in a plan. KFHPWA will comply with any new requirements as necessary under federal laws and regulations. Assistance is available to Enrollees who are limited-English speakers, who have literacy problems, or who have physical or mental disabilities that impede their ability to request review or participate in the review process. The most current information about your appeals process is available by contacting KFHPWA's Member Appeal Department at the address or telephone number below.

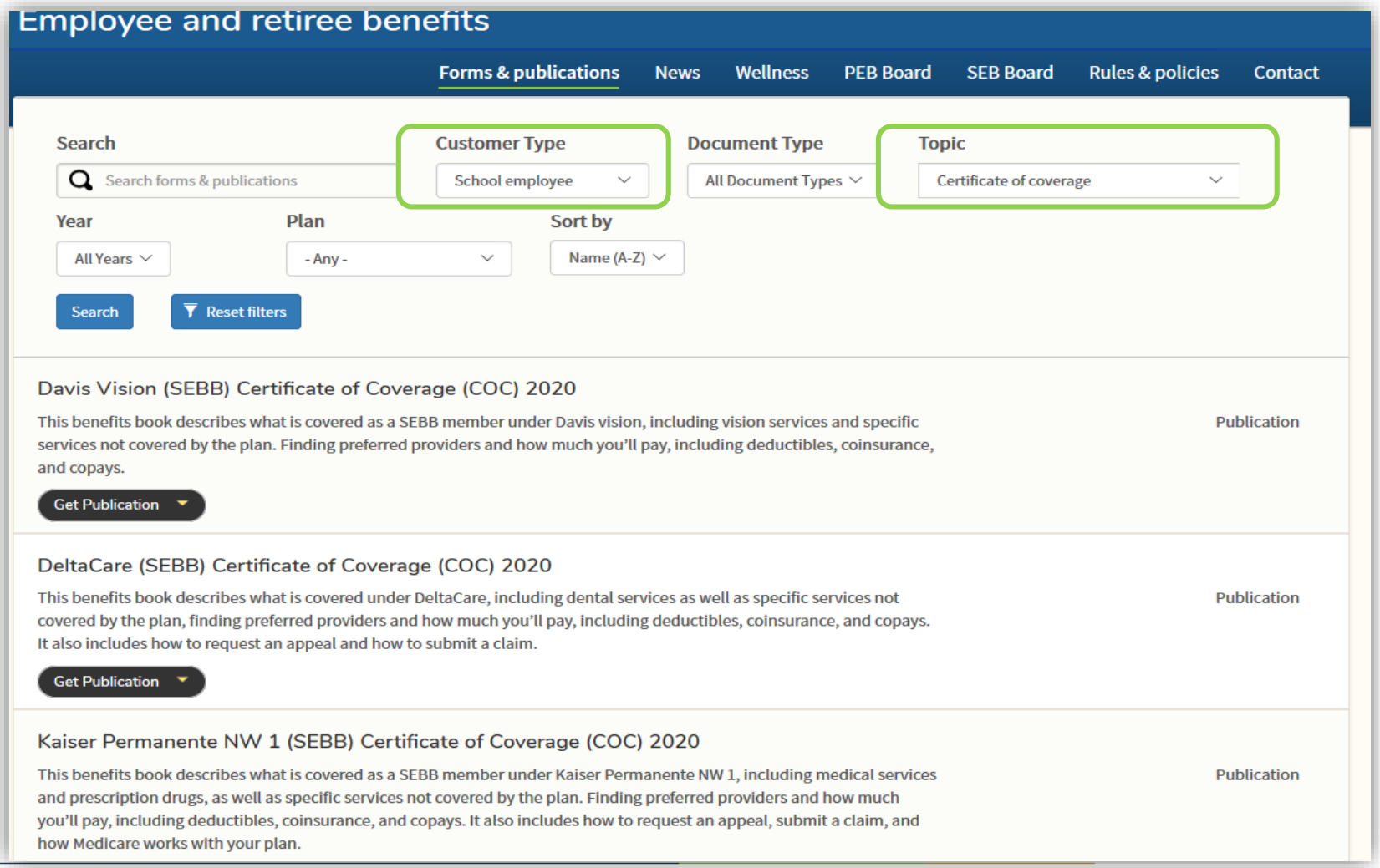
1. **Initial Appeal**
   If the Enrollee or the Enrollee's legal representative wishes to appeal a KFHPWA decision to deny, modify, reduce or terminate coverage of or payment for health care services, they must submit a request for an appeal either orally or in writing to KFHPWA's Member Appeal Department, specifying why they disagree with the decision. The appeal must be submitted within 180 days of receipt of the denial notice. KFHPWA will notify the Enrollee of its receipt of the request within 72 hours of receiving it. Appeals should be directed to KFHPWA's Member Appeal Department, P.O. Box 34593, Seattle, WA 98124-1593, toll-free 1-866-458-5479.

   A party not involved in the initial coverage determination and not a subordinate of the party making the initial coverage determination will review the appeal request. KFHPWA will then notify the Enrollee of its determination or need for an extension of time within 14 days of receiving the request for appeal. Under no circumstances will the review timeframe exceed 30 days without the Enrollee's written permission.

   For appeals involving experimental or investigational services KFHPWA will make a decision and communicate the decision to the Enrollee in writing within 20 days of receipt of the appeal.

   There is an **expedited/urgent appeals process** in place for cases which meet criteria or where delay using the standard appeal review process will seriously jeopardize the Enrollee's life, health or ability to regain

Certificates of Coverage (COC's)



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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

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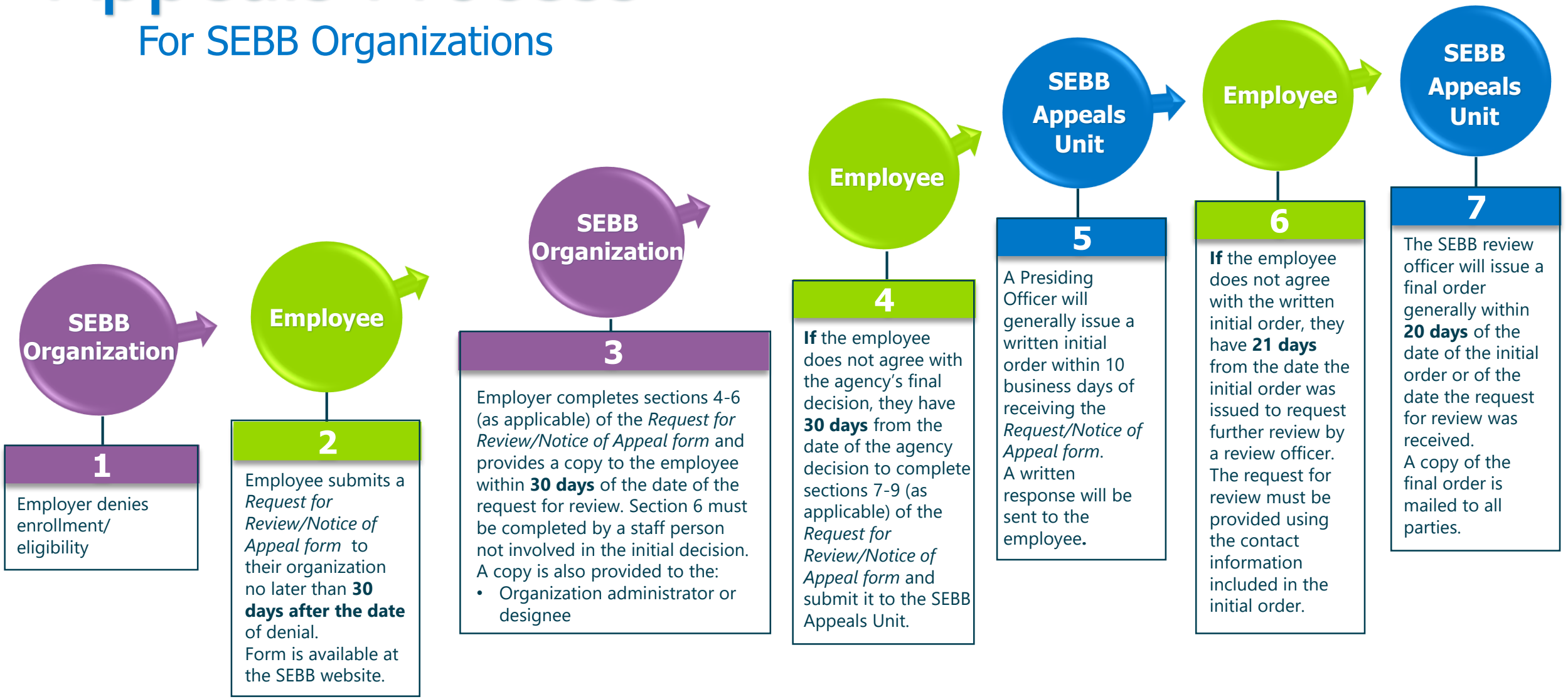
Appeals Process

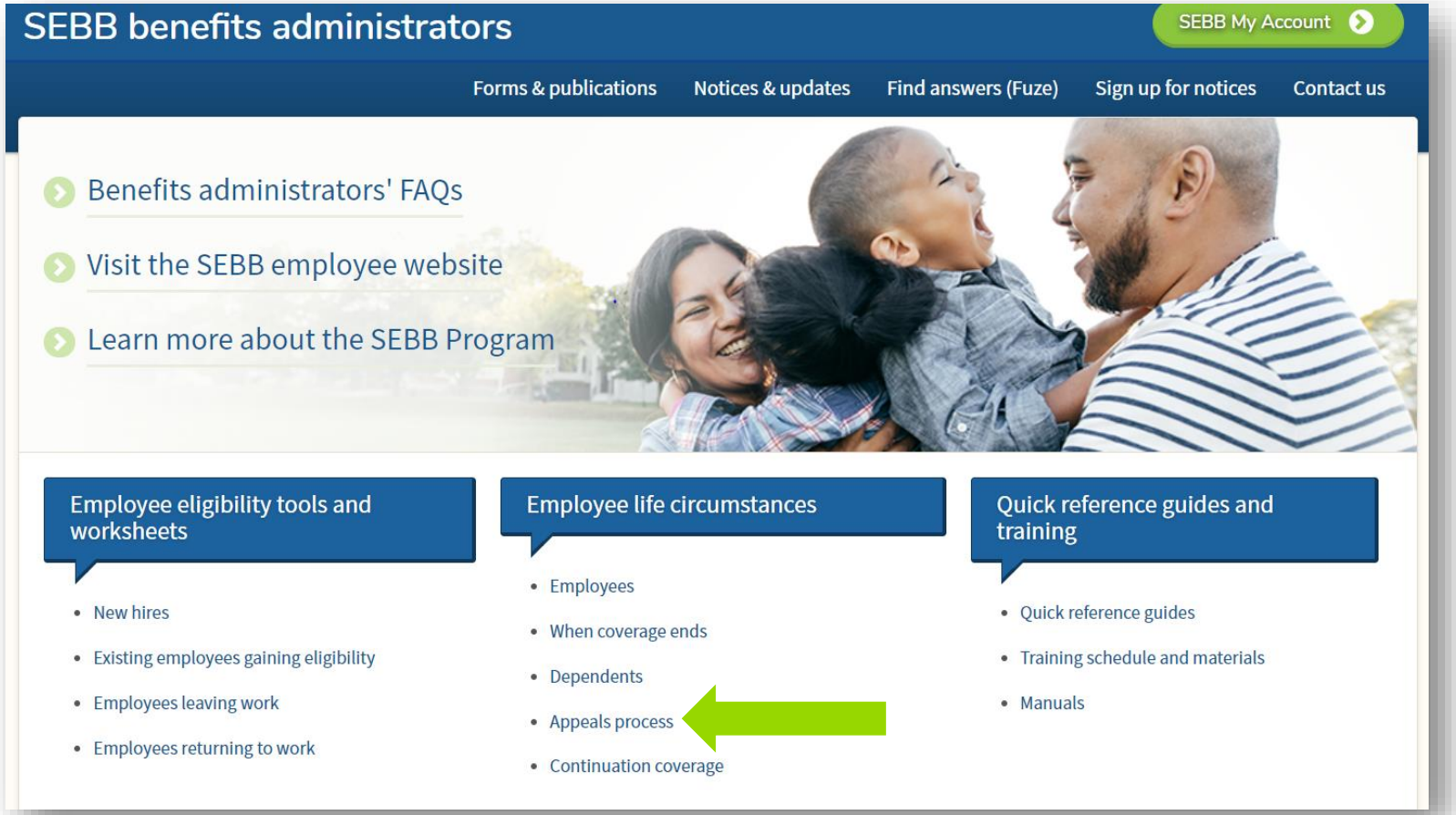
For SEBB Organizations



Resources

Outreach & Training for guidance

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



https://www.hca.wa.gov/sebb-benefits-admins

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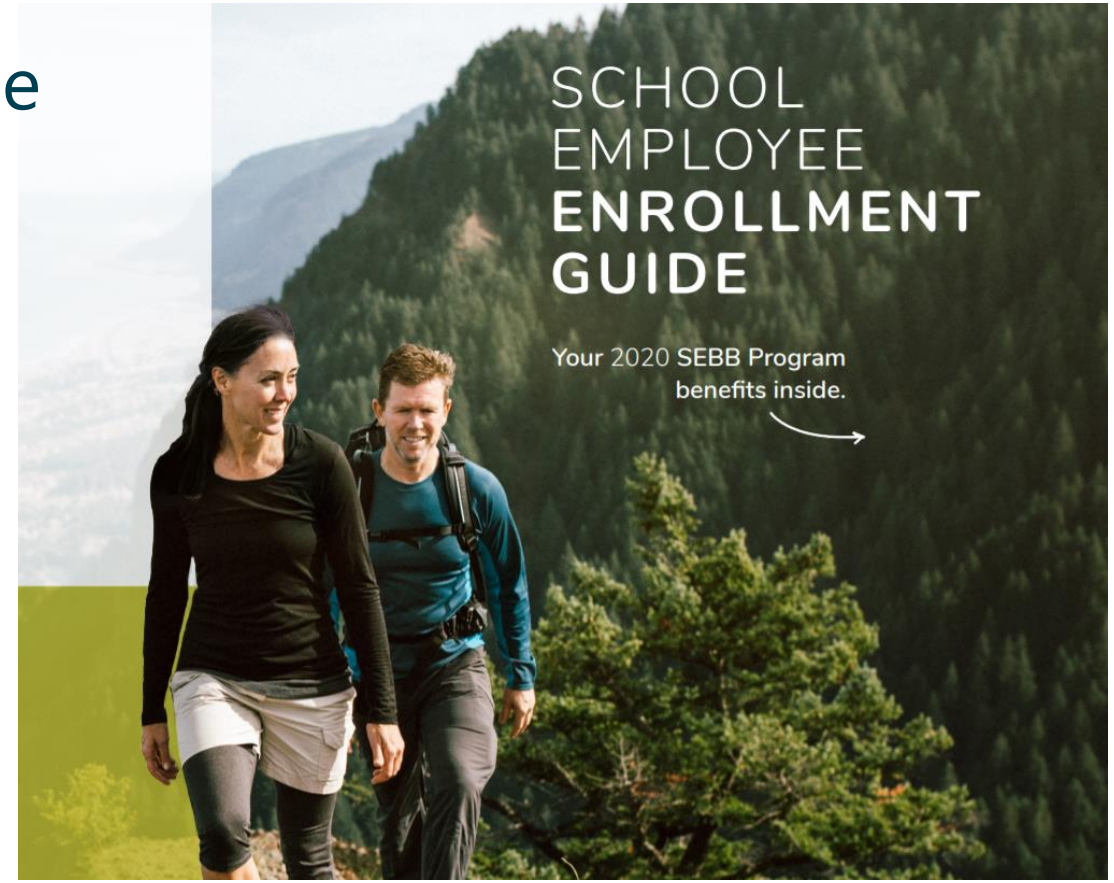
Resources continued…

School Employee Enrollment Guide

- Appeals
  - Pages 74-75

SEBB Appeals Unit

- 1-800-351-6827
- Fax: 360-586-9080



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Scenarios

"I'm newly eligible and enrolled in DeltaCare during my enrollment window (which is now closed). I thought I was enrolling in a PPO. A friend tells me that they were able to switch to Uniform Dental Plan (UDP), so I asked my BA to make this change."

- BA asks employee if they submitted an appeal to HCA prior to 2/29. If the appeal was submitted to HCA, employee will receive:
  - Notification that appeal was approved; OR
  - Information about next steps in the appeals process.
- If appeal was not submitted to HCA prior to 2/29, BA reviews the enrollment and provides initial decision to the employee.
  - Employee can then submit Employee Request for Review/Notice of Appeal

Scenarios

"I was newly eligible on March 15th. I completed my enrollment and physically handed my dependent verification documents to my BA. In May, 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.
- Employee submits written request 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 final determination.