QualChoice® HEALTH INSURANCE

Disabled Dependent Request for Extension of Coverage

Use this form to request an extension of coverage for a disabled dependent child who is currently covered by QualChoice but has reached the maximum age limit.

Decision Process

Our Medical Director will review the information received from the Subscriber, the treating doctor, and the Social Security Administration (SSA). If more information is needed, the Subscriber or treating doctor is contacted. If we find that the disability began **before** the dependent child was covered by QualChoice or another health plan, the child will not be approved for an extension of coverage. If the Subscriber does not agree with the finding made, he or she may ask for an appeal.

Eligibility Rules

A disabled dependent who has reached the maximum age limit allowed on the Subscriber's plan can be covered if **all** these rules are met:

1. The child became disabled **before** reaching the maximum dependent age limit.
2. The child was covered by QualChoice or another group health plan when the disability began.
3. The child is not able to support him/herself financially due to continuous developmental or physical incapacity.
4. The child is a dependent on the Subscriber's most recent federal income tax return.
5. The child has a qualifying diagnosis and statement from a doctor (or the SSA) which verifies that the disability occurred before reaching the maximum dependent age limit.

Required Documents for Submission

1. The Subscriber must complete Section I and the treating doctor must complete Section II of this form.
2. The Subscriber's most recent federal income tax return indicating the child is an eligible dependent must be included.
3. If the child has Social Security benefits, the Social Security Income (SSI) award letter must be included.

Time Frame for Submission

This form and proof of disability must be sent to QualChoice within the time frames below.

Within 90 days	***before*** the date your covered dependent reaches the maximum age for a dependent child
Within 90 days	***before*** the expiration date of your dependent child's *current* disabled dependent coverage
During initial enrollment period	***If*** you are a new member
During group's open enrollment period	***If*** you are a current employee

NOTE: Since the dependent's disability must have occurred **before** reaching the maximum age limit, a dependent cannot be added back onto plan if the disability occurred **after** being dropped due to reaching the maximum age limit.

To determine the maximum age limit for a disabled dependent, please check your policy. You can also call Customer Service at 501.228.7111 or 800.235.7111 for assistance.

Disabled Dependent Request for Extension of Coverage

Section I. Subscriber to Complete - *all information must be answered completely for application to be processed*

Subscriber Name *(First, Last, MI)*		QualChoice ID No. or Social Security No.	
Address ☐ Home ☐ Mailing	City	State	Zip
Legal Name of Dependent Child *(First, Last, MI)*	Relationship to Subscriber	Date of Birth (MM/DD/YYYY)	
Dependent's Address *(only if different from Subscriber)*	City	State	Zip

What age was your dependent child when the disability was first noticed? Age: _____

		YES	NO
1.	Is the dependent listed above under the maximum age limit as stated in your policy?		
2.	Is the dependent listed above your son, daughter, stepson, stepdaughter, an individual legally adopted by you or your spouse, an individual lawfully placed with you for legal adoption (a foster child is not eligible), or an individual for whom you or your spouse are the legal guardian?		
3.	Does this disability prevent this dependent from being able to work and support him- or herself?		
4.	Has this dependent applied for supplemental security income (SSI) or social security disability insurance (SSDI)? If **YES**, date of application: _____		
5.	Has this dependent been found eligible as disabled by supplemental security income (SSI) or social security disability insurance (SSDI)? If **YES,** provide eligibility documentation. For example: The SSI Notice of Award letter.		
6.	Has this dependent previously been under the care of a doctor? If **YES**, the treating doctor must complete Section II.If **NO**, please make an appointment with your dependent's primary doctor for an evaluation. This doctor must complete Section II of this form.		
7.	Has this dependent been previously covered by QualChoice or another insurance carrier under an extension of coverage due to this disability? If **YES:** Name of insurance carrier: _____ Date of Coverage: _____		
8.	Have you ever applied for and been denied a disability waiver for this dependent? If **YES:** Name of insurance carrier: _____ Date of Denial: _____		

Describe the nature of this dependent's disability

SIGNATURE. I understand and agree to the following:

- The above named disabled dependent lives with me or his/her care is provided by me, and I am responsible for his/her care or support
- The statements and responses I've provided are true, complete and accurate
- it is my responsibility to let QualChoice know in writing of any change in the status of the above named disabled dependent
- QualChoice has the right to require recertification as to eligibility for continuation of coverage as a disabled dependent
- That my signature authorizes any hospital or doctor who has treated this dependent to release any medical information to QualChoice

Any person who knowingly gives a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance, is guilty of a crime and may be subject to fines and confinement in prison.

Subscriber's Signature	Date Signed (MM/DD/YYYY)	Phone No. ☐ Home ☐ Work ☐ Cell
X		

Disabled Dependent Request for Extension of Coverage

Section II. Certification of Treating Doctor- *all information must be completed by treating doctor*

Patient's Name		Date of Birth (MM/DD/YYYY)
Date of first visit with the patient (MM/DD/YYYY)	Date of last visit with the patient (MM/DD/YYYY)	Date patient became disabled (MM/DD/YYYY)

Primary diagnosis *(ICD Code that is the handicapping condition)*	Secondary diagnosis *(if applicable)*

Describe nature and extent of incapacity. Please provide complete diagnosis. You may attach a narrative summary relative to the diagnosis/prognosis. Include functional limitations (i.e., what assistance does the patient require, number of people required to assist with ADLs, etc.)

Is the patient described above, physically or mentally capable of returning to school or any type of work? ☐ Yes ☐ No

- If **YES:** How many hours per week: _____ What type of work: _____
- If **NO:** Please attach any relevant medical documentation including office notes, progress reports, and treatment plans that supports disability status and incapability of financial self-support.

Is the disability: ☐ Permanent ☐ Temporary

- If **temporary**, what is the estimated time frame for the disability? _____
- If **permanent**, provide rationale for that status.

Treating Doctor's Name (print)	Degree	Specialty Board Certification
Doctor's Signature *(form not valid without doctor's signature and date)* **X**		Date Signed (MM/DD/YYYY)

Office Address	City	State
Phone	Fax	

Please mail or fax *page 2 and 3* **only to:**
QualChoice
Attn: Care Management Department
P.O. Box 25610
Little Rock, AR 72221

Fax:501.228.9413 or 800.228.9413

Non-Discrimination and Accessibility Notice

QualChoice complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. QualChoice does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

QualChoice:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Customer Service at (501) 228-7111. If you believe that QualChoice has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

QualChoice Civil Rights Coordinator
QualChoice
P.O. Box 25610
Little Rock, AR 72221-5610
(501) 228-7111
Fax #: 501-707-6729
QCA_COE@qualchoice.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the QualChoice Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-868-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Notice of Discrimination Grievance Procedures

It is the policy of QualChoice not to discriminate on the basis of race, color, national origin, sex, age or disability. QualChoice has adopted an internal grievance procedure providing for prompt and equitable resolution of complaints alleging any action prohibited by Section 1557 of the Affordable Care Act (42 U.S.C. 18116) and its implementing regulations at 45 CFR part 92, issued by the U.S. Department of Health and Human Services. Section 1557 prohibits discrimination on the basis of race, color, national origin, sex, age or disability in certain health programs and activities. Section 1557 and its implementing regulations may be examined in the office of the QualChoice Civil Rights Coordinator, who has been designated to coordinate the efforts of QualChoice to comply with Section 1557 (the "Section 1557 Coordinator"):

QualChoice Civil Rights Coordinator
QualChoice
P.O. Box 25610
Little Rock, AR 72221-5610
(501) 228-7111
Fax #: 501-707-6729
QCA_COE@qualchoice.com

Any person who believes someone has been subjected to discrimination on the basis of race, color, national origin, sex, age or disability may file a grievance under this procedure. It is against the law for QualChoice to retaliate against anyone who opposes discrimination, files a grievance, or participates in the investigation of a grievance.

Procedure:

- Grievances must be submitted to the Section 1557 Coordinator within sixty (60) days of the date the person filing the grievance becomes aware of the alleged discriminatory action.
- A complaint must be in writing, containing the name and address of the person filing it. The complaint must state the problem or action alleged to be discriminatory and the remedy or relief sought.
- The Section 1557 Coordinator (or her/his designee) shall conduct an investigation of the complaint. This investigation may be informal, but it will be thorough, affording all interested persons an opportunity to submit evidence relevant to the complaint. The Section 1557 Coordinator will maintain the files and records of QualChoice relating to such grievances. To the extent possible, and in accordance with applicable law, the Section 1557 Coordinator will take appropriate steps to preserve the confidentiality of files and records relating to grievances and will share them only with those who have a need to know.
- The Section 1557 Coordinator will issue a written decision on the grievance, based on a preponderance of the evidence, no later than thirty (30) days after its filing, including a notice to the complainant of their right to pursue further administrative or legal remedies.
- The person filing the grievance may appeal the decision of the Section 1557 Coordinator by writing to the Vice President Corporate Responsibility within fifteen (15) days of receiving the Section 1557 Coordinator's decision. The Vice President Corporate Responsibility shall issue a written decision in response to the appeal no later than thirty (30) days after its filing.

The availability and use of this grievance procedure does not prevent a person from pursuing other legal or administrative remedies, including filing a complaint of discrimination on the basis of race, color, national origin, sex, age or disability in court or with the U.S. Department of Health and Human Services, Office for Civil Rights. A person can file a complaint of discrimination electronically through the Office for Civil Rights Complaint Portal, which is available at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf , or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201.

Complaint forms are available at: http://www.hhs.gov/ocr/office/file/index.html. Such complaints must be filed within 180 days of the date of the alleged discrimination. QualChoice will make appropriate arrangements to ensure that individuals with disabilities and individuals with limited English proficiency are provided auxiliary aids and services or language assistance services, respectively, if needed to participate in this grievance process. Such arrangements may include, but are not limited to, providing qualified interpreters, providing taped cassettes of material for individuals with low vision, or assuring a barrier-free location for the proceedings. The Section 1557 Coordinator will be responsible for such arrangements.

QualChoice offers help for members with limited English proficiency (LEP). The following statement is printed in the top languages used in Arkansas, as required by the Federal government. ***ATTENTION: If you speak [insert language], language assistance services, free of charge, are available to you. Call 1-800-235-7111 (TTY: 711).***

Spanish
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-235-7111 (TTY: 711).

Vietnamese
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-235-7111 (TTY: 711).

Marshallese
LALE: Ñe kwōj kōnono Kajin Ṃajōḷ, kwomaroñ bōk jerbal in jipañ ilo kajin ṇe aṃ ejjeḷọk wōṇāān. Kaalọk 1-800-235-7111 (TTY: 711).

Chinese
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-235-7111 (TTY: 711).

Lao
ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-800-235-7111 (TTY: 711).

Tagalog
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-235-7111 (TTY: 711).

Arabic
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-532-1117 (رقمهاتف الصم والبكم: 117).

German
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-235-7111 (TTY: 711).

French
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-235-7111 (ATS: 711).

Hmong
LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-235-7111 (TTY: 711).

Korean
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-235-7111 (TTY: 711) 번으로 전화해 주십시오.

Portuguese
ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-235-7111 (TTY: 711).

Japanese
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-235-7111 (TTY: 711) まで、お電話にてご連絡ください。

Hindi
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-235-7111 (TTY: 711) पर कॉल करें।

Gujarati
સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-235-7111 (TTY: 711).