QualChoice HEALTH INSURANCE

Right to Appeal Notice

Group Plan Members

This is important information about your appeal rights. Please keep a copy.

If QualChoice denies coverage or payment of a claim (in whole or in part), you have the right to ask us to change that decision. This is called an *appeal*.

What is an adverse benefit determination?

- When we decline to pay a claim (in whole or in part), it is called an *adverse benefit determination* or a *denial.* We will send you an *Explanation of Benefits (EOB)* or a letter explaining why the claim was denied.

What if I need help understanding an adverse benefit determination?

To learn more about diagnosis and treatment codes and their meaning, or for other help, please call us. We are happy to help!

Customer Service
Monday through
Friday – 8:00 a.m.
to 5:00 p.m.
800.235.7111 or
501.228.7111

What if I don't agree with the denial?

If you don't agree, you may file an appeal. It must be received in writing.

How do I file an appeal?

You are encouraged to complete the *Member Appeal Request Form** or send a letter explaining your appeal. We must receive it within **180 days** of the date you received your *EOB* or denial letter.

Who can file an appeal?

You may file an appeal on your own. You may also approve someone to act on your behalf. This person is called an *authorized representative*. If you approve someone else to act on your behalf, you must let us know on the *Member Appeal Request Form**.

Can I provide additional information for review of my claim?

You, your doctor or another healthcare expert can send us additional facts. This might help us change our decision. Be sure to send a copy of any added information with your written request.

Can I request a copy of the information used in denying my claim?

You are entitled to receive, on request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits. Simply call or complete the *Request for Access to Personal Health Information** form and send it in with your request.

Phone	**Mail**
Customer Service 800.235.7111 or 501.228.7111 Monday-Friday, 8:00 a.m. to 5:00 p.m.	QualChoice ATTN: Appeals and Grievance Coordinator P.O. Box 25610 Little Rock, AR 72221-5610

*Forms are located at QualChoice.com, select *Already a Member?*, then *Find a Form or Document*. Or call us at 800.235.7111 or 501.228.7111 and ask for a copy to be mailed to you.

How long will it be before QualChoice makes a decision?

Pre-service (care not yet received) request: within **30 days** of your appeal *Post-service* (care already received) appeal: within **60 days** of your appeal

What if my health issue is urgent?

An *urgent* care claim is when you or your doctor feel that:

- Your health, life or recovery is at high risk, or
- You are having a high level of pain.

In this case, you or your doctor acting on your behalf may ask for an *expedited* internal appeal. If your issue may be defined as *urgent*
under the law, we will respond within **72 hours**.

What if I don't agree with the decision?

External Review Request
You have the right to an external review by an outside third party, for medical necessity or experimental/investigational procedures, if:

- We still deny your claims for coverage or service, or
- You did not get a timely decision from us (60 days for post-service claims and 30 days for pre-service requests)

If you qualify for a standard external review, your appeal must be filed within 4 months after the date you receive this notice. *As part of the external review process, you have the opportunity to submit additional information to QualChoice related to the Claim for consideration by the external review organization*.

Please write or call:

Attn: External Appeals

Arkansas Department of Insurance
Consumer Services Division
1 Commerce Way Suite 102
Little Rock, AR 72202-2083
Phone: 501-371-2640
Toll free: 1-800-852-5494
Fax: 501-371-2749
insurance.arkansas.gov

You also have the right to request an expedited external review.

You or your authorized representative may file a request for an expedited external review if:

- You have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function.

- The determination concerns:
  - An admission, availability of care, continued stay or health care service for which you received emergency services, but have not been discharged from a facility; or
  - A denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational, or if your doctor certifies in writing that the recommended or requested health care service or treatment that is the subject of the request would be significantly less effective if not promptly initiated.

You will not be held responsible for the cost of the External Review.

What other help is available?

You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.

Arkansas Insurance Department	**U.S. Dept. of Labor**
Consumer Services Division 1200 West Third St Little Rock AR 72201 P: 800.852.5494 Email: insurance.consumers@arkansas.gov	Employee Benefits Security Administration (EBSA) P: 866.444.EBSA (3272) www.askebsa.dol.gov

Arkansas Department of Health	**Arkansas State Medical Board**
4815 W Markham Little Rock AR 72205 P: 800.462.0599 www.healthy.arkansas.gov	1401 W Capitol Ave, Suite 340 Little Rock AR 72201 P: 501.296.1802 Email: support@armedicalboard.org