**Section 2160.420 Appeals Process Responsibilities**

The Member shall be responsible for handling appeals concerning claims payments.

a) All correspondence concerning appeals must indicate the Unit in which the Member is enrolled in the Program.

b) If a Member believes that an error has been made in the benefit amount allowed or disallowed, the Member should contact the claims processing office of the self-funded managed care plan or the Administrative Service Organization within 180 days after denial of the initial claim determination.

c) Within 60 days after receiving the results of the review process by the self-funded managed care plan or Administrative Service Organization, the Member may submit a written request for review to the Department for a final determination of either an administrative or medical necessity appeal.

d) Administrative appeals are based on Plan exclusions and limitations and Plan design, and the Department's Group Insurance Division's decision is final and binding on all parties.

e) Within 60 days after receipt of the notice of the Department's Group Insurance Division's decision, a medical necessity appeal may be made to the Board. The Board will review the documentation and facts presented to the Department and make a recommendation to the Director, whose decision shall be final and binding on all parties. The Director's decision shall be in writing.

(Source: Amended at 32 Ill. Reg. 15994, effective September 11, 2008)