**Section 2180.260 Appeals Process Responsibilities**

1. If a Participant believes that an error has been made in the benefit amount allowed or disallowed, the Participant should contact the claims processing office of the Plan Administrator pursuant to the Appeal Process as detailed in the Benefits Handbook. The Participant must utilize the Plan Administrator's review process to the fullest extent prior to contacting CMS. The Participant must contact the appropriate Plan Administrator within 180 days after the date of the initial claim determination.
2. If the Participant is not satisfied with the results of the review process by the Plan Administrator, the Participant may submit a written request for review to CMS, within 60 days after the date of the Initial Review determination for a Final Determination.
3. If the Participant is still not satisfied, an appeal of the determination may be made to an appeal committee, created by the Director, within 60 days after the Final Review by CMS. The findings of the appeal committee shall be final and binding on all parties.
4. The Participant will be notified in writing of every decision rendered during the Appeal Process.
5. The Participant retains all rights under Section 15(h) of the Group Insurance Act.
6. Appeal Committee members are appointed by the Director.