**Section 4520.70 Health Care Services, Appeals, Complaints and External Independent Reviews**

a) A plan shall implement an effective appeals process for appeals of coverage determinations and claims, under which the health care plan shall, at a minimum:

1) have in effect an internal claims appeal process;

2) provide notice to enrollees, in a culturally and linguistically appropriate manner, of available internal and external appeals processes, and the availability of Department consumer assistance to assist enrollees with the appeals processes; and

3) allow an enrollee to review his or her file, to present evidence and testimony as part of the appeals process, and to receive continued coverage pending the outcome of the appeals process. (Section 2719 of the Public Health Service Act; 42 USC 201 et seq.)

b) A plan shall affirm or deny liability on claims within a reasonable time and shall offer payment within 30 days after affirmation of liability, if the amount of the claim is determined and not in dispute. For those portions of the claim that are not in dispute and the payee is known, the plan shall tender payment within the 30 days.

c) If a settlement of a claim is less than the amount claimed, or if the claim is denied, the plan shall provide to the insured a reasonable written explanation of the basis of the lower offer or denial within 30 days after the investigation and determination of liability is completed. This explanation shall clearly set forth the policy definition, limitation, exclusion or condition upon which denial was based. The explanation shall clearly inform the enrollee of the right to appeal the claim reduction or denial, the process by which the enrollee (or the enrollee's designee or guardian) may initiate the appeal process and the plan's phone number to call to receive more information concerning the appeal process. Notice of Availability of the Department shall accompany this explanation.

d) A health plan shall ensure that an enrollee (or the enrollee's designee or guardian) has a period of not less than 180 days after the date of the explanation of a denial of a claim for benefits in which to appeal the denial under this Section. The only exception to this requirement is those complaints that are handled by the Department of Healthcare and Family Services (HFS), consistent with the requirements of Section 4520.80(a).

 (Source: Amended at 38 Ill. Reg. 2253, effective January 2, 2014)