**Section 5430.40 Health Carrier Obligations**

a) Each health carrier shall maintain written records in the aggregate, by state, and for each type of health benefit plan offered by the health carrier on all requests for external review for which the health carrier received notice from the Director for each calendar year. The health carrier shall submit, electronically, a report to the Director in the format specified by the Director by March 1 of each year.

b) A health carrier must file with the Director for approval sample copies of:

1) All notices and forms that carriers must provide to covered persons under Sections 20, 25, 35, 40 and 42 of the Act. In addition to those statutory requirements, the following information must be included on notices sent to members in response to member appeals:

A) All notices and forms must prominently display the name, address, toll-free phone number, fax number and appeal email address of the carrier or administrator that handles appeals;

B) All notices and forms shall be specific and limited to information regarding appeals and external review procedures for the member's plan;

C) All notices shall state the number of levels of appeals available (no more than two levels for group and one level for individual) under the plan and will state which level of appeal is applicable to the adverse determination within the notice;

D) All notices shall include the date, including month, day and year, of the adverse determination and, if applicable, the date of the final adverse determination, including month, day and year;

E) All notices shall inform covered persons that the deadlines for filing an appeal or external review request are not postponed or delayed by health care provider appeals unless the health care provider is acting as an authorized representative for the covered person; i.e., the covered person should be filing internal appeals independently and concurrently unless the health care provider has been designated in writing as the authorized representative;

F) All notices shall indicate whether the adverse determination relates to a member appeal (filed by the member or authorized representative who may be the health care provider) or a provider appeal (pursuant to the provider contract) and shall explain timeframes from the date of the adverse determination for the member to appeal and to file an external review regardless of the status of a provider appeal;

G) Upon exhaustion of provider appeals, the notice (which is copied to the member) shall specify timeframes from the date of the final adverse determination for the member to file an appeal or file an external review;

H) Upon exhaustion of internal appeals by the member, the final adverse determination notice shall clearly state that it is the final adverse determination, that all internal appeals have been exhausted, and that the member has 4 months from the date of the letter to file an external review;

I) All notices shall include the following contact information for the Department of Insurance:

Illinois Departments of Insurance

Office of Consumer Health Insurance

External Review Unit

320 W. Washington Street

Springfield IL 62767

Toll-free Telephone: (877) 850-4740

Fax: (217) 557-8495

Email: doi.externalreview@illinois.gov

Website: https://mc.insurance.illinois.gov/messagecenter.nsf

2) Descriptions for both the required standard external review and expedited external review procedures as set forth within Section 20 of the Act.

3) Statements informing the covered person and any authorized representative that a standard external review request deemed to be ineligible for review by the plan or its representative may be appealed to the Director by filing a complaint with the Director. The health carrier shall use the following address and provide the following contact information when directing the covered person or authorized representative to appeal initial determinations of ineligibility for standard external review:

The Illinois Department of Insurance

Office of Consumer Health Insurance

External Review Unit

320 West Washington Street

Springfield IL 62767

Toll-free Telephone: (877) 527-9431

Fax: (217) 557-8495

Email: doi.externalreview@illinois.gov

Website: https://mc.insurance.illinois.gov/messagecenter.nsf

4) Statements informing the covered person and any authorized representative that an expedited external review request deemed to be ineligible for review by the plan or its representative may be appealed to the Director by filing a complaint with the Director. The health carrier shall use the following address when directing the covered person or authorized representative to appeal initial determinations of ineligibility for expedited external review:

The Illinois Department of Insurance

Office of Consumer Health Insurance

External Review Unit

320 West Washington Street

Springfield IL 62767

Toll-free Telephone: (877) 850-4740

Fax: (217) 557-8495

Email: doi.externalreview@illinois.gov

Website: https://mc.insurance.illinois.gov/messagecenter.nsf

5) Special Rules for Multi-State Plans Under the Marketplace

Pursuant to the U.S. Office of Personnel Management's (OPM) Multi‑State Plan Program regulation at 45 CFR 800.5023, OPM administers the External Review Process for disputed adverse benefit determinations submitted by enrollees in Multi-State Plan health insurance options.

(Source: Amended at 39 Ill. Reg. 12577, effective September 1, 2015)