**Section 125.245 Appeals**

a) Any person who applies for or receives assistance under the Program shall have the right to appeal any of the following actions:

1) Refusal to accept an application.

2) Denial of an application or cancellation at the annual renewal, including denial based on failure to meet one or more of the eligibility requirements specified in this Part. If the denial or cancellation is not upheld on appeal, coverage under the Program shall be retroactive to the date the coverage would have commenced had the application or annual determination been approved. However, if the individual is eligible for All Kids Premium Level 1, it will be at the family's option whether coverage following a successful appeal shall be prospective only for the remainder of the 12-month period following application or retroactive to the date the coverage would have commenced had the application been approved. All premium and copayment requirements shall apply to the retroactive period.

3) Termination of coverage based on failure to continue to meet one or more of the eligibility requirements specified in this Part. If the termination is not upheld on appeal and benefits were not continued during the appeal, coverage under the Program shall be reinstated retroactive to the termination date. However, if an individual is eligible for All Kids Premium Level 1, it will be at the family's option whether coverage following a successful appeal shall be prospective only for the remainder of the 12-month period following application or retroactive to the date of termination. All premium and copayment requirements shall apply to any retroactive period.

4) Determination of the amount of the premium or copayments required. Coverage and any premium or copayment requirements, as determined by the Department, shall remain in force during the appeal process.

b) In addition to the actions that are appealable under subsection (a), individuals covered under the All Kids Health Plan shall have the right to appeal any of the following actions:

1) Termination of coverage due to non-payment of the required premium.

2) Denial of payment for a medical service or item that requires prior approval.

3) Decision granting prior approval for a lesser or different medical service or item than was originally requested.

c) The Department's decision to deny an application due to closing of enrollment for the Program shall not be appealable.

d) Individuals may initiate the appeal process by:

1) Filing a written, signed request for a hearing directed to the Department's Assistance Hearings Section;

2) Calling a toll free telephone number (800/435-0774, or as designated by the Department).

e) The request for a hearing may be filed by the individual affected by the action or by the individual's authorized representative.

f) For purposes of initiating the appeal process, a copy of a written, signed request for a hearing is considered the same as the original written, signed request.

g) The request for a hearing must be filed no later than 60 days after notice of the appealable action has been given.

h) If an appeal is initiated within 10 calendar days after the notice of intended Department action and the individual specifically requests that the benefits be continued, benefits shall be continued at the level in effect prior to the proposed action, pending the results of the fair hearing process. All copayment obligations, including premiums, must be met during the period.

i) The provisions of Subpart A of the Department's administrative rules at 89 Ill. Adm. Code 104 (Practice in Administrative Hearings) shall govern the handling of appeals and the conduct of hearings under the Program.

j) An individual can, prior to a decision being rendered on the appeal, reapply for the Program.

(Source: Amended at 38 Ill. Reg. 6006, effective February 26, 2014)