

The Prudential Insurance Company of America
Individual Health Insurance
Utilization Review and Grievances Document
California Policyholders
Updated: May 2024

The following policy describes the procedures that apply to claims you and other covered persons submit under individual health insurance policies issued by The Prudential Insurance Company of America (the “Company”) in California.

At the Company we welcome the opinions and suggestions that we receive from our policyholders, and we are always concerned when questions arise regarding the processing of claims. Most questions concern simple misunderstandings that can be resolved through open and frank discussions among the parties involved. For this reason, many questions are answered by contacting a claims representative, and we encourage you or your authorized representative to call to discuss any concern that you may have. Immediate and active assistance will be provided to resolve the problem or refer your concern to the appropriate area for resolution.

The Company does not conduct prospective or concurrent claim review or engage in pre-certification of claims for the individual health insurance policies. Only retrospective claim review – i.e., the review of benefits or services and supplies after such benefits or services have been provided to a covered person and a claim for reimbursement has been submitted, is conducted.

If you wish to contest the Company’s decision to deny a claim that you have submitted for payment or any other Company decision that affects you, you must follow the procedures explained in this document. This document describes the procedures that the Company will follow when a claim examiner raises a question whether a service or supply that has been provided to you was medically necessary (also known as “utilization review”). This document will also explain the procedures that you should follow to file a grievance with the Company.

Please note that a third-party administrator (“TPA”) or utilization review organization (“URO”) may be used to perform some of the services described below in connection with the review of claims. Where the terms “Company” or “we” appear in this document, it may include any such entity acting on behalf of the Company depending on the context.

I. Utilization Review

A claim examiner will review your claim. If it appears that the service and/or supply in question may not have been medically necessary or appropriate, the Company’s Medical Administration Processing Examiner will examine your claim. The Medical Administration Processing Examiner will ensure that all necessary materials have been provided and will examine the materials received, and, if the claim cannot be paid based on that information, the Medical Administration Processing Examiner will refer your claim to URO licensed in California. That organization will review your claim using criteria and guidelines developed with involvement from actively practicing health care providers. Upon request, the Company or the utilization review organization will provide you with a copy of the review guidelines.

Before transmitting a claim to the URO, the claim examiner and/or the Medical Administration Processing Examiner may ask you or your provider for information that the Company needs to review your claim. If you or your provider fail to submit this information in a timely manner, the Company may deny your claim.

The Company will provide you with notice of the utilization review decision within thirty (30) working days after it receives the information necessary to review your claim. If the Company fails to send you a decision within thirty (30) working days, you may submit a grievance to the Company concerning your claim.

If, however, the Company was not able to make a decision to approve or deny your request for payment within the thirty (30) working day period because the Company has not received all of the information reasonably necessary and requested, because the Company requires consultation by an expert reviewer, or because the Company has asked that an additional examination or test be performed upon you (provided that the examination or test is reasonable and consistent with good medical practice), the Company will, immediately upon the expiration of the thirty (30) working day period, or as soon as it becomes aware that it will not meet the timeframe, whichever occurs first, notify you and your provider, in writing, that the Company cannot make a decision concerning the request for payment within the required timeframe, and specify the information requested but not received, or the expert reviewer to be consulted, or the additional examinations or tests required. The Company will also notify you and your provider of the anticipated date on which a decision may be rendered. After the Company receives all information that is reasonably necessary and requested by the Company, the Company will approve or deny the request for payment within thirty (30) working days thereafter.

If the utilization review organization finds that the services or supplies for which you seek payment were medically necessary and covered under your policy, the Company will pay your claim according to the terms of your policy. If the Company has not paid your claim within thirty (30) working days after it received the information necessary to determine that your claim should be paid, interest will accrue and be payable at a rate of ten percent (10%) per annum beginning with the first calendar day after the thirty (30) working day period.

If the utilization review organization decides that the services or supplies for which you seek payment were not medically necessary, the Company will deny your claim. The Company will provide you with written notice of that decision. The notice will explain the reasons for the decision and describe the criteria or guidelines that the utilization review organization used to make the decision. The notice will also include information about how you can submit a grievance to the Company concerning the decision. If you so request, the Company will provide you with complaint forms and another copy of these grievance procedures. The notice will advise you and your provider that either of you may seek review by the Department of a claim that the Company contested or denied, and include the address, internet web site address, and telephone number of the unit within the Department that performs this review function.

Any written communication to a physician or provider of a denial of a request will include the name and direct telephone number of the health care professional responsible for

the denial and include information as to how you or your provider may file an appeal with the Company or seek Department review.

Note about utilization review of decisions concerning covered health care services and benefits for the diagnosis, prevention, and treatment of mental health and substance use disorders: Medical necessity determinations or utilization review criteria must be based on current generally accepted standards of mental health and substance use disorder care. Further, the Company must apply the most recent criteria and guidelines developed by the nonprofit professional association(s), or successor organization(s), for the relevant clinical specialty when conducting utilization review of treatment of mental health and substance use disorders.

If the Company delays, denies, or modifies a claim you submit concerning mental health and substance use disorders, the Company will notify you in writing outlining the basis for the delay, denial, or modification within five (5) calendar days of the decision for non-urgent care and within 72 hours for urgent care.

Note about utilization review of decisions concerning experimental or investigational therapies: If the Company delays, denies, or modifies a claim you submit concerning experimental or investigational therapies (and your claim meets the requirements below), you may elect to skip the Company’s grievance process set forth in section IV and request an Independent Medical Review as explained in section V. The Company will notify you in writing of your opportunity to request Independent Medical Review within five (5) days after making a decision to deny coverage if all of the following criteria are met:

- You have a life-threatening or seriously debilitating condition. “Life-threatening” means diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted and/or diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival. “Seriously debilitating” means diseases or conditions that cause major irreversible morbidity.
- Your physician certifies that you have a life-threatening or seriously debilitating condition for which standard therapies have not been effective or would not be medically appropriate, or there is no more beneficial standard therapy covered by the Company than the proposed therapy.
- Either your physician has recommended a drug, device, procedure, or other therapy that he or she certifies in writing is likely to be more beneficial to you than any available standard therapies, or you, or your licensed, board-certified or board-eligible physician qualified to practice in the area of practice appropriate to treat your condition, has requested a therapy that, based on two documents from the medical and scientific evidence is likely to be more beneficial for you than any available standard therapy. The physician certification must include a statement of the evidence relied upon by the physician in certifying his or her recommendation.

- The Company has denied you coverage for such a drug, device, procedure, or other therapy, unless coverage for the specific therapy has been excluded by the Company's contract.
- The specific recommended drug, device, procedure, or other therapy would be a covered service except for the Company's determination that the therapy is experimental or under investigation.

II. Claims Concerning Emergency Services

The Company will follow the following procedures to review any claims you submit for an emergency medical condition (as defined by Cal. Health & Safety Code 1317.1).

The Company will reimburse all complete claims as soon as practicable, but no later than thirty (30) working days after it receives your completed claim.

If the Company contests your claim, it will identify the portion of your claim that is contested, by revenue code, and the specific information needed from your provider to reconsider your claim.

If your claim is denied, the Company will notify you and your provider of that decision in writing. The notice will identify the portion of your claim that is denied, by revenue code, and the specific reasons for the denial, including the factual and legal basis known at that time by the Company for each reason. If the reason is based solely on facts or solely on law, the Company will provide only the factual or legal basis for its reason to deny your claim. The notice will also include a statement advising you and your provider that either may seek review by the Department of a claim that was contested or denied by the Company and the address, internet web site address, and telephone number of the unit within the Department that performs this review function.

If your complete claim, that is neither contested nor denied is not reimbursed by delivery to your address of record within the thirty (30) working day period after receipt by the Company, the Company will pay the greater of fifteen dollars (\$15) per year or interest at the rate of ten percent (10%) per annum beginning with the first calendar day after the thirty (30) working day period. The Company will automatically include the fifteen dollars (\$15) per year or interest due in your payment, without requiring you to request that such amounts be included.

For purposes of this section, a claim, or portion thereof, is reasonably contested if the Company has not received the completed claim. A paper claim from an institutional provider will be deemed complete upon submission of a legible emergency department report and a completed UB 92 or other format adopted by the National Uniform Billing Committee, and reasonable relevant information requested by the Company within thirty (30) working days of receipt of your claim. An electronic claim from an institutional provider will be deemed complete upon submission of an electronic equivalent to the UB 92 or other format adopted by the National Uniform Billing Committee, and reasonable relevant information requested by the Company within thirty (30) working days of receipt of your claim. However, if the Company

requests a copy of the emergency department report within the thirty (30) working days after receipt of the electronic claim from the institutional provider, the Company may also request additional reasonable relevant information within thirty (30) working days of receipt of the emergency department report, at which time your claim shall be deemed complete. A claim from a professional provider will be deemed complete upon submission of a completed HCFA 1500 or its electronic equivalent or other format adopted by the National Uniform Billing Committee, and reasonable relevant information requested by the Company within thirty (30) working days after it receives your claim. Your provider will provide the Company reasonable relevant information within fifteen (15) working days of receipt of a written request that is clear and specific regarding the information sought. If, as a result of reviewing the reasonable relevant information, the Company requires further information, the Company will have an additional fifteen (15) working days after it receives the reasonable relevant information to request the further information, notwithstanding any time limit to the contrary in this section, at which time your claim will be deemed complete.

These provisions do not apply to claims about which there is evidence of fraud and misrepresentation, to eligibility determinations, or where the Company has not been granted reasonable access to information under your provider's control. The Company will specify, in a written notice to your provider within thirty (30) working days after it receives your claim, which, if any, of these exceptions applies to your claim.

If your claim or portion thereof is contested on the basis that the Company has not received information reasonably necessary to determine your liability for the claim or portion thereof, then the Company will have thirty (30) working days after receipt of this additional information to complete reconsideration of your claim. If your claim, or portion thereof, undergoing reconsideration is not reimbursed by delivery to your address of record within the thirty (30) working days after receipt of the additional information, the Company will pay the greater of fifteen dollars (\$15) per year or interest at the rate of ten percent (10%) per annum beginning with the first calendar day after the thirty (30) working day period. The Company will automatically include the fifteen dollars (\$15) per year or interest due in your payment, without requiring you to request that such amounts be included.

The Company will not delay payment of your claim from your physician or other provider to await the submission of a claim from a hospital or other provider, without citing specific rationale as to why the delay was necessary and providing a monthly update regarding the status of your claim and the Company's actions to resolve your claim, to your provider that submitted your claim. The Company will not request or require that your provider waive its rights pursuant to this section.

III. Experimental Treatment Review For Individuals With Terminal Illnesses

A "terminal illness" is an incurable or irreversible condition that has a high probability of causing death within one year or less. If the Company denies you coverage for an experimental medical procedure or plan of treatment for a terminal illness, the Company will provide you or your representative a written notification that includes:

- the specific medical and scientific reasons for the denial and specific references to pertinent policy provisions upon which the denial was based;
- a description of the alternative medical procedures or treatments covered by your policy, if any; and
- copies of the Company's grievance procedures, which contain a description of the process by which you or your representative may exercise your right to appeal the denial and obtain and participate in a review of the denial. The review will not be limited to written communication and will be provided by the appropriate named fiduciary or his or her designee rendering the decision. The review will be provided to the you within 30 calendar days following the receipt of the request for review. However, the review will be held within five business days if your treating physician determines, in consultation with the Company's medical director, based on standard medical practice, that the effectiveness of either the proposed treatment, services, or supplies or any alternative treatment, services, or supplies covered by the policy, would be materially reduced if not provided at the earliest possible date.

IV. Grievances

If you submit a claim for payment and the Company denies that claim *for any reason*, you may submit a written grievance to the Company concerning that claim. *If you wish to file a grievance concerning a decision by the Company, you must do so within one hundred eighty (180) days after you receive notice of that decision.* Otherwise, you will have waived your right to file a grievance concerning that decision.

You or your provider may submit written materials for the Company to consider when it reviews your grievance. The individuals that review your grievance will not have been involved in making the original decision to deny the claim that is the subject of your grievance. Your grievance will be reviewed by a management or supervisory staff member responsible for the services or operations that are the subject of your grievance. If your grievance concerns a claim that the Company denied because the services or supplies were not medically necessary, the Company will forward your grievance to a utilization review organization, which will review your grievance using appropriately licensed personnel.

The Company will resolve your grievance within thirty (30) days after it receives the grievance. The Company will send you a written notice of its decision within the thirty (30) day period. The decision will include a clear and concise explanation of the reasons for the decision. If your grievance involved a clinical issue, the decision will (i) describe the criteria that the utilization review organization used to make the decision; (ii) state the clinical reasons for the decision (including all criteria and clinical reasons related to medical necessity); (iii) state that you may request a copy of the criteria, clinical guidelines, or medical policies used to reach the decision; (iv) provide the name of a Company representative or office, address, and telephone number from which the documents may be obtained; and (v) state that you or your provider may file a complaint with the Insurance Commissioner. The Company will also provide you with an application form that you may return to the Company to initiate an Independent Medical Review of your claim.

V. Independent Medical Review

If you believe that the Company has improperly denied, modified, or delayed health care services, you have the right to request an independent medical review from the California Department of Insurance. The Department's telephone number is 1-800-927-4357 and its Internet Web site is www.insurance.ca.gov. You may submit a request to the Department for Independent Medical Review after completing the Company's grievance process or participating in the process for at least thirty (30) days, or if your denied claim involves experimental or investigational therapies. You have six months to seek independent medical review after (a) you complete the Company's grievance process, (b) you participate in the Company's grievance process for 30 days and do not receive a response to your grievance, or (c) your claim for experimental or investigational therapies is denied.

VI. Complaints to Insurance Commissioner

You or your provider may file a written complaint with the Department with respect to the handling of a claim or other obligation under a health insurance policy issued by the Company or concerning alleged misconduct by the Company. The Insurance Commissioner will notify you of the receipt of your complaint within ten (10) business days of its receipt. The Insurance Commissioner will make a determination on your complaint within sixty (60) calendar days of the date of its receipt, unless the Insurance Commissioner, in his or her discretion, determines that additional time is reasonably necessary to fully and fairly evaluate your complaint. The Insurance Commissioner will notify you of the final action taken on your complaint within thirty (30) days of the final action. The notification will include a summary explaining the Insurance Commissioner's reasons for the final action.

VII. Further Assistance

If you have any questions about these procedures, or wish to file a grievance, please use the address and telephone number below to contact Prudential:

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