

THE PRUDENTIAL INSURANCE COMPANY OF AMERICA

Individual Health Insurance Claim and Grievance Review Procedures – Tennessee Policyholders Updated: October 2023

At The Prudential Insurance Company of America (the “Company”), we welcome your opinions and suggestions, 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 following policy describes the procedures that the Company will follow when you appeal a denial of a claim. These procedures apply to claims you submit under your individual health insurance policy issued by the Company in Tennessee.

Prudential does not conduct prospective claim review or engage in precertification of claims for individual health insurance policies. Only retrospective claim review is conducted — in other words, the review of services and supplies after such services and supplies has been provided to you and you submit a claim for reimbursement. Prudential’s Individual Health area is not a managed care entity.

The Company may employ a third-party administrator to perform some of the services in connection with reviewing claims. Where the terms “Company” appears in this document, it includes any third-party administrator acting on behalf of Prudential.

In certain circumstances, you may authorize another person to communicate with the Company on your behalf. This may be someone who is (a) appointed by you in writing, (b) authorized by law to act for you, or (c) your family member or your treating health care professional, if you are unable to provide consent. Your authorized representative may act on your behalf in filing a grievance concerning a claim or seeking an external review concerning a claim (as explained below). Where the terms “you” or “your” appear in this document, they include your authorized representative.

(1) Internal Grievance Review – First Level

If the Company does not pay a claim you submitted, or pays only a part of your claim, you may appeal that decision by filing a grievance with the Company within one hundred eighty (180) days after you receive notice of the decision.

You may submit written comments, documents, records, and other information for the Company to consider when it reviews your grievance. The Company will thoroughly investigate all grievances and will consider all relevant information that you or your doctor submit,

regardless of whether the information was considered when the Company first reviewed your claim.

Within five (5) days after the Company receives your grievance, the Company will send you a notice about your right to submit documents for consideration in the grievance process, and your right to receive free copies of documents relevant to your grievance.

The Company will make a decision on the grievance and send you written notice of the decision within sixty (60) days after it receives the grievance. The notice will include: (a) information about the people who reviewed your grievance, (b) the reason for the decision, and (c) a statement about the documents or evidence the reviewers relied on in making the decision. If the reviewers denied your grievance, the notice will explain your appeal options and how to request each type of appeal, and will include all the forms you need to request external review.

If your grievance is denied, you may request a free copy of any documents or information relating to the review of your claim.

(2) Your Further Appeal Options

If your first level grievance is denied, you may appeal the denial. If you appeal the denial, you may ask the Company for a second level review, or you may seek review by an external review organization.

To request a second level review by the Company, you must submit a written request for second level review to the Company within thirty (30) days after you receive notice that your first level grievance was denied.

To request a review by an external review organization, you must submit to the Company a request form and an authorization to release your medical records. You must do so within six (6) months after receiving notice that your first level grievance was denied.

(3) Internal Grievance Review – Second Level

If you submit a timely request for a second level review, the Company will send you a notice acknowledging your request within five (5) business days. The notice will explain your right to appear before the second level review panel chosen to review your claim, to submit additional documents or information to the panel, and to receive a free copy of documents and information relevant to the second level review.

The second level review panel will hold a hearing within sixty (60) days after the Company receives your request for a second level review. You will be notified of the date of the hearing at least fifteen (15) business days in advance. If you wish to appear at the hearing, you must submit a request within ten (10) business days of receiving the notice of the date of the hearing. If you wish to appear at the hearing but it is not practical for you to attend in person, the Company will arrange for you to attend by conference call or other means. You will receive fair consideration regardless of whether you choose to appear before the panel or not.

All members of the panel will have expertise appropriate to the subject of your claim. A majority of the panel will not have been involved in the first level review of your claim, and no panel member will have a direct financial interest in the outcome of the second level review.

The panel will make a decision within five (5) business days after completing its meeting, and the Company will provide you a notice of the decision. The notice will include: (a) information about the people who reviewed your second level grievance, (b) the reason for the decision, and (c) a statement about the documents or evidence the reviewers relied on in making the decision. If the reviewers denied your second level grievance, the notice will describe the process for seeking external review of the decision and will include an application for external review.

(4) External Grievance Review

For either a first or second level grievance, if the Company either denies your grievance, does not meet the deadline to decide your grievance, or agrees that you have exhausted the grievance process, you may request that an external review organization review the Company's decision, by filing a written request with the Company within six (6) months. You must include with the request a signed authorization for the Company to release copies of your medical records to the external reviewer.

The Company will review the request and decide whether the grievance is eligible for external review and whether any documents or information that are needed to review the claim are missing. The Company will make this decision within ten (10) business days. Once the Company makes a decision, it will notify you within three (3) business days. If the Company decides your grievance is not eligible for external review, the Commissioner of the Tennessee Department of Commerce and Insurance may overrule that decision. If your grievance is eligible for external review, the Company will assign an external review organization ("ERO") to review it. The Company will send you the contact information for the chosen ERO.

The Company will send the ERO copies of the documents and information that it considered when it denied your grievance. **You may send the ERO any documents or written explanation about your grievance that you want it to consider. The ERO will consider documents and information that you send it within six (6) business days after you are notified about the ERO. If you send documents or information to the ERO, the ERO may send copies to the Company.**

The ERO's written decision will explain the reasons for the decision and the documents and information the ERO considered in reaching the decision. The decision is binding on you and the Company, subject to other remedies that may be available under federal or state law. If the ERO disagrees with the Company's decision, the Company will immediately approve the claim to the extent required by the ERO's decision. Once the ERO has made a decision, you may not file a second request for external review about the same decision of the Company.

(5) Contact Information

You may contact the Commissioner of the Tennessee Department of Commerce and Insurance. The contact information for the Commissioner's office is:

State of Tennessee
Office of the Commissioner of the
Department of Commerce and Insurance
500 James Robertson Parkway
Davy Crockett Tower
Nashville, TN 37243-0565
Phone: 615-741-2241

If you have any questions about these procedures, please use the address and phone number below to contact Prudential:

The Prudential Insurance Company of America as
Administered by IBM Insurance Outsourcing Services
ATTN: Health Services Division
P.O. Box 64372
St. Paul, Minnesota 55164-0372
Phone: (800) 828-0153
Fax: (888) 478-2529