

The Prudential Insurance Company of America

Individual Health Insurance Internal and External Appeals New Jersey Policyholders Updated: October 2023

At The Prudential Insurance Company of America (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 following policy describes the procedures that the Company will follow when you submit a claim, including the procedures for appealing decisions that the Company makes. These procedures apply to claims you submit under your individual health insurance policy issued by the Company in New Jersey.

The Company 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 have 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 or utilization review organization to perform some of the services described below in connection with reviewing claims. Where the terms “Company” or “we” appears in this document, it may include any third-party administrator or utilization review organization acting on behalf of Prudential depending on the context.

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 claim, filing a grievance concerning a claim, or seeking an independent external review concerning a claim (as explained below). Where the terms “you” or “your” appear in this document, they include your authorized representative.

Your Prudential policy does not cover services or supplies that are not medically necessary. The Company will follow the procedures set forth in this document if you appeal a decision finding that a service or supply was not medically necessary.

I. DEFINITIONS

As used in this document, the term “Adverse Benefit Determination” means a failure to make payment (in whole or in part) for a benefit, including a failure to provide or make payment (in whole or in part) for a benefit resulting from application of any utilization review, as well as a failure to make payment for an item or service for which benefits are otherwise provided because the Company determines the item or service to be experimental or investigational, cosmetic, dental rather than medical, excluded as pre-existing condition, or because the Company has rescinded the coverage.

Also, the term “Final Internal Adverse Benefit Determination” means (a) an Adverse Benefit Determination that the Company upholds after the internal appeal process is completed, (b) an Adverse Benefit Determination where the Company waived its right to conduct an internal appeal, or (c) an Adverse Benefit Determination where the Company failed to comply with the internal appeal deadlines.

II. INTERNAL APPEALS

You or your provider (with your consent) may ask the Company to conduct an immediate review of any decision, policy, or action of the Company that affects you. You may seek such a review by phone. Your right to appeal includes appeals from Adverse Benefit Determinations¹ where the Company has denied payment because the services and/or supplies at issue were not medically necessary or appropriate. Appeals of Adverse Benefit Determinations must be filed within 180 days after you receive the Adverse Benefit Determination.

The Company will provide you with any new or additional evidence or rationale that the Company intends to rely on, consider, or use in connection with the appeal. Any new or additional evidence will be provided free of charge and will be provided as soon as possible and sufficiently in advance of the date on which the Final Internal Adverse Benefit Determination is required to be provided in order to give you or your provider a reasonable opportunity to respond prior to that date.

During an appeal of an Adverse Benefit Determination, you or your designated provider may ask to speak with the Medical Administration Processing Examiner² who made the Adverse Benefit Determination.

All internal appeals will be concluded within 10 calendar days after you requested the review.

¹ All notices of Adverse Benefit Determination will be culturally and linguistically appropriate pursuant to 45 CFR 147.136(e).

² The Company’s Medical Administration Processing Examiner is a licensed practical nurse (LPN). After you submit a claim for payment, the Company may refer your claim to its designated independent utilization review organization, American Health Holdings, where a Medical Director, who is a licensed physician, will review and decide your claim.

If your appeal involves an Adverse Benefit Determination, and the Company denies your appeal, then the Company will issue a Final Internal Adverse Benefit Determination³ that will include the following:

- Information sufficient to identify the claim involved, including date of service, health care provider, claim amount (if applicable) and a statement describing the availability, upon request, of the diagnosis and treatment codes (and their corresponding meanings) (Note: The Company will respond as soon as practicable to any request for diagnosis and treatment information. Such a request is not considered a request for an internal appeal.);
- The reason(s) for the Adverse Benefit Determination, including the denial codes and their corresponding meanings, and a description of the standard used by the Company in making the denial;
- A detailed, written description of the Company's appeal process;
- A written explanation of your right to file an appeal with the Independent Health Care Appeals Program, including the limits for filing the appeal; and
- Information regarding the availability and contact information for the consumer assistance program at the New Jersey Department of Banking and Insurance (the "Department"), which can assist you with claims, internal appeals, and external appeals, including the following address and telephone number:

Department of Banking and Insurance
Consumer Protection Services
Office of Managed Care
PO Box 329
Trenton, New Jersey 08625-0329
(888) 393-1062

The form that you must use to submit an appeal to the Independent Health Care Appeals Program will also be included with the Company's notice to you.

The Company will provide continued coverage of an ongoing course of treatment pending the outcome of the internal appeals process and the external appeals process (described below).

III. INDEPENDENT HEALTH CARE APPEALS PROCESS

Eligibility for Independent Appeal

³ All notices of Final Internal Adverse Benefit Determination will be culturally and linguistically appropriate pursuant to 45 CFR 147.136(e).

You or your provider (with your consent), may appeal a Final Internal Adverse Benefit Determination through the Independent Health Care Appeals Program, except where the decision was based on eligibility, including rescission, or the application of a contract exclusion or limitation not related to medical necessity.

External appeals will be conducted by an Independent Utilization Review Organization (IURO). You may seek an external appeal only if you fully comply with the Internal Appeals process set forth above, unless one of the two situations below applies:

- If the Company fails to comply with any of the deadlines for completion of an internal Adverse Benefit Determination appeal, unless the Company's violation does not cause, and is not likely to cause, prejudice or harm to you, so long as the Company demonstrates that the violation was for good cause or due to matters beyond the control of the Company and that the violation occurred in the context of an ongoing, good faith exchange of information between the Company and you, and is not reflective of a pattern or practice of non-compliance by the Company.
 - You may ask the Company to provide you a written explanation for its failure to comply with any of the deadlines for completion of an internal Adverse Benefit Determination appeal. The Company will provide that explanation to you within 10 days. The explanation will include a specific description of its bases, if any, for asserting that the Company's violation should not cause the internal claims and appeals process to be deemed completed.
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 - If an external reviewer or a court rejects your request for immediate review because the Company met the standards for the exception, you have the right to resubmit and pursue the internal appeal of the claim. In such a case, within 10 days after the external reviewer or court rejects the claim for immediate review, the Company will notify you of your opportunity to resubmit and pursue the internal appeal. The time period for refiling the claim will begin to run after you receive such notice.
- If the Company expressly waives its rights to an internal review of any appeal.

Initiating External Appeals

To initiate an external appeal, you must file a written request directly with the Department's IURO, Maximus Federal Services, within 4 months after you receive the Company's Final Internal Adverse Benefit Determination. Requests must include the Final Internal Adverse Benefit Determination, a release of all relevant medical records, and a copy of all medical records and correspondence.

You may complete your request and submit all required documents to the IURO online by creating an account through the IURO's portal at <https://njihcap.maximus.com>.

If you are unable to submit your request online, you may submit a written request by mail or fax. You may also submit a PDF copy of your written request by email. All written requests must be filed on the IHCAP application form provided to you with the notice of Final Internal Adverse Benefit Determination or on a form downloaded from the IURO's website above. You may also contact the IURO and ask them to send the form to you by regular mail and/or by fax. A completed form and all required documents can be mailed, faxed, or emailed to the IURO as set forth below:

Maximus Federal Services
Attn: State Appeals - NJ IHCAP
3750 Monroe Avenue, Suite 705
Pittsford, New York 14534
Fax: (585) 425 – 5296
[Email: stateappealseast@maximus.com](mailto:stateappealseast@maximus.com)

Instructions regarding the external appeal request process are available on the IURO's website at <https://njihcap.maximus.com>. Questions about how to request an appeal may also be directed to the IURO by calling (888) 866 - 6205 or e-mailing stateappealseast@maximus.com.

The external appeal request filing fee for all methods of filing has been suspended at this time pursuant to COVID-19 emergency Bulletin No 20-08. Once this emergency Bulletin is no longer in effect, you may be billed a \$25.00 filing fee. Instructions on how to remit payment will be included with the invoice/bill for the filing fee when applicable. You will receive a refund of any paid filing fee if the Final Internal Adverse Benefit Determination at issue is reversed. The filing fee may be waived if you have a financial hardship. You may demonstrate a financial hardship through evidence that one or more members of your household is receiving assistance or benefits under the Pharmaceutical Assistance to the Aged and Disabled, Medicaid, NJ Family Care, General Assistance, SSI, or New Jersey Unemployment Assistance. If you file more than one external appeal in a given calendar year, you are only responsible for up to \$75.00 in filing fees for that calendar year.

Review of External Appeals by the IURO

After the IURO receives your appeal, it will conduct a preliminary review of the appeal and accept it for processing if:

- You were covered by a policy issued by the Company;
- The service that is the subject of the appeal reasonably appears to be a service covered under the terms of your contract or policy for which some level of benefit is payable; and
- You have provided all information required by the IURO and the Department to make a preliminary decision, including the appeal form and a copy of any information

provided by the Company regarding its Final Internal Adverse Benefit Determination, and a fully-executed release to obtain any necessary medical records from the Company and any relevant provider.

After the IURO completes the preliminary review, it will immediately notify you in writing as to whether the appeal has been accepted for processing, and if not, the reasons why it was not accepted. If the IURO accepts your appeal for processing, it will notify you that you have the right to submit in writing, within 5 business days from the date you receive the IURO's notice of acceptance, additional information to be considered by the IURO (which the IURO will provide to the Company).

If your appeal is accepted for processing, the IURO will conduct a full review to determine whether the Company properly denied your claim, considering:

- All pertinent medical records, consulting physician reports, and other documents submitted by you and the Company;
- Applicable generally accepted practice guidelines developed by the Federal government, national or professional medical societies, boards and associations; and
- Applicable clinical protocols and/or practice guidelines developed or used by the Company, if any.

The IURO will refer all cases for full review to an expert physician in the same specialty or area of practice that generally would manage the type of treatment that is the subject of the appeal. But the IURO will not render a final recommendation except with the approval of the IURO's medical director, who will be a physician licensed to practice in New Jersey.

The IURO will complete its review and issue its decision in writing as soon as possible, but no later than 45 days after it receives the request for external review.

External Appeal Decisions

The IURO will provide its written decision to you, the Company, and the Department.

The IURO's decision will be binding on you and the Company, unless you or the Company have other available remedies under State or Federal law. If the decision is to reverse a decision of the Company and require payment to you, the Company will pay the claim without delay, and no later than ten (10) business days after it receives the IURO's determination, even if the Company intends to seek judicial review of the decision (unless there is a judicial decision stating otherwise). The Company will provide benefits to comply with the IURO decision sooner if the medical exigencies of the case warrant a more rapid response.

IV. FURTHER ASSISTANCE

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

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