The Prudential Insurance Company of America
Individual Health Insurance
Utilization Review Procedures – Rhode Island Policyholders
Updated: November 2019

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 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 Rhode Island.

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 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, requesting an internal appeal 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.

(1) How We Review Your Claims

Claim Review Procedures. A claim examiner will review your claim. If the Company determines that the services and/or supplies in question were medically necessary and appropriate, the Company will calculate and pay the claim according to the terms of your policy. If it appears that the services and/or supplies may not have been medically necessary or appropriate, the Company will gather documents and information from you and/or your doctor that the Company needs in order to conduct a second, more detailed review of the claim. If you and/or your doctor do not provide the documents or information in a timely manner, the Company may deny your claim.

Once it collects all of the relevant documents and information, the Company will perform a detailed review of your claim. In this second review, qualified health care professionals and medical doctors will review the claim.

Length of the Review. The Company will normally decide your claim within thirty (30) days after receiving it. If, due to special circumstances, the Company cannot make a decision within this period, the Company will so notify you within the thirty (30) day period. If the Company requires additional time because of special circumstances, it will decide your claim within forty-five (45) days after receiving the claim.

Insufficient Information. If the Company does not have sufficient information to decide your claim, it will notify you what information is needed. You will have forty-five (45) calendar days from when you receive that notification to provide the requested information. If the Company requests additional information from you, the deadline for the Company to decide your claim will be paused after it requests this information, and will restart when you respond to the request.

Notice of a Denial. If the Company denies your claim, in whole or in part, it will send you written notice of the denial. The notice will include: (a) details concerning the claim, including the date of service, provider, amount, diagnosis code, and treatment code (as applicable); (b) the specific reason(s) for the denial; (c) reference(s) to any specific health benefit plan, provision, or guideline on which the Company based its decision; (d) the scientific or clinical judgment for the decision; (e) information about how you can obtain copies of any and all information relevant to the denied claim, free of charge; (f) information concerning the internal and external appeal processes; (g) notice that you have at least one hundred eighty (180) calendar days after receiving the notification to file an appeal; and (h) the clinical rationale in understandable terms.

(2) Internal Appeals

Your Right to Request Internal Appeal. If the Company denies your claim, you may appeal that decision by filing an appeal with the Company within one hundred eighty (180) days after you receive the decision.

Reconsideration Process. If you request an appeal, the Company may choose to reconsider its decision concerning your claim. If the Company denies reconsideration of your claim, it will notify you within fifteen (15) days. You may request an appeal of the reconsideration decision or submit additional information within forty-five (45) days after the Company notifies you of its reconsideration decision.

Submitting Information. Before the Company makes an internal appeal decision on your claim, you may review the entire adverse determination and appeal file within a reasonable period of time. You may also present evidence or additional information as part of the internal appeal process.

Length of the Review. For appeals of "administrative" decisions (which do not involve medical judgment or clinical criteria), the Company will notify you of its decision in writing within sixty (60) days after the Company receives your appeal.

For appeals of "non-administrative" decisions (which do involve medical judgment or clinical criteria), the Company will notify you of its decision in writing within thirty (30) days after the Company receives your appeal. If you request an extension of time to submit additional information for the appeal, or if the Company informs you that it requires additional information in order to make its appeal decision, this deadline may be extended to forty-five (45) calendar days after the Company receives the request for appeal.

(3) External Appeals

Your Right to Request an External Appeal. You may request that an external independent review organization (IRO) review adverse non-administrative decisions (meaning decisions that do involve medical judgment or clinical criteria). You must file a request for external appeal with the Company within four (4) months after you receive the internal appeal decision. In order to seek an external appeal, you must have first exhausted the internal claims and appeal process, unless (a) the Company failed to comply with the internal appeal process or (b) you applied for expedited external review at the same time you apply for expedited internal review.

Cost. The Company may charge you an external appeal fee of up to twenty-five dollars ($25.00). If you are unable to pay the fee, or if you have already paid seventy-five dollars ($75.00) in external appeal fees in the same year, the Company will waive the fee. If the adverse determination is reversed after the external appeal, the Company will refund your fee.

External Review Procedures. Within five (5) business days after you request an external appeal, the Company will notify you that your request has been sent to the IRO. In that notification, the Company will inform you about how to submit additional information to the IRO. Additional information must be submitted to the IRO within five (5) business days after you receive the Company's notification.

External Review Decision. The IRO will provide you with written notice of its external appeal decision within ten (10) days after it receives all of the information necessary to complete the review. This will be no later than forty-five (45) calendar days after the IRO receives your request for external review. The notice will include: (a) details of the claim that is being denied, including the date of service, provider name, amount of claim, diagnostic code, and treatment code; (b) the specific reason(s) for the external appeal decision; and (c) information about how you can obtain copies of any and all information relevant to the external appeal free, of charge. The IRO's decision is binding on you and the Company, subject to other remedies that may be available under federal or state law. If the IRO disagrees with the Company's decision, the Company will immediately approve the claim to the extent required by the IRO's decision.