

The Prudential Insurance Company of America
Individual Health Insurance
Grievance Review Procedures – Indiana
Updated: June 2016

This document details the procedures the individual health area of The Prudential Insurance Company of America (the “Company”) will follow if a covered person or a covered person’s representative submits a grievance concerning a decision of the Company which affects that covered person.

For purposes of this document, a “grievance” is any dissatisfaction expressed by or on behalf of a covered person, for which the covered individual has a reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of the dissatisfaction, regarding:

- (A) a determination that a service or supply was not medically necessary or appropriate;
- (B) a determination that a service or supply was experimental or investigational;
- (C) the handling or payment of claims for health care services or supplies; or
- (D) matters pertaining to the contractual relationship between a covered person and the Company.

A third party administrator (“TPA”) and/or utilization review organization (“URO”) may be used to perform some of the services in connection with claim and/or grievance review. Where the term “Company” appears in this document, it may include any such entity acting on behalf of Prudential, depending on the context.

(1) Notices to Policyholders

If the Company denies a claim on the ground that a service or supply was not medically necessary or appropriate, was experimental or investigational, or was not covered under the terms of the covered person’s contract, the Company will provide the covered person, or his or her legal representative, with notice of:

- (A) these grievance procedures;
- (B) the procedure for external review of grievances;
- (C) information on how to file grievances and requests for external grievance review;
- (D) a toll-free telephone number through which a covered person may contact the Company to obtain information and to file a grievance; and
- (E) the address for the Internet website established by the Indiana Department of Insurance concerning internal and external grievance review procedures for accident and sickness insurance policies and HMOs (established by the department pursuant to IC § 27-1-3-33).

The Company will also prominently display on all notices to covered persons the toll free telephone number and the address at which a grievance or request for external grievance review may be filed.

(2) Filing of Grievances

A covered person may file a grievance with the Company either orally or in writing. Grievances are considered filed on the day and time they are first received orally or in writing by the Company. The covered person or the covered person's representative must file a grievance within forty-five (45) days after the Company notifies the covered person of the decision that forms the basis of the grievance. The Company will make available to covered persons a toll-free telephone number through which a grievance may be filed. The toll-free telephone number will be staffed by a qualified representative of the Company, be available for at least forty (40) hours per week during normal business hours, and accept grievances in the language of the major population groups served by the Company. A grievance is considered filed on the first date it is received by the Company, either by telephone or in writing.

Upon request, the Company will assist covered persons in filing grievances, including persons with literacy, language, physical, health, or other impediments. This assistance will include assisting the covered person in filling out any required forms, notifying the covered person about the information that the covered person must submit to enable the Company to properly review the grievance, and helping the covered person to comply with grievance review procedures. A covered person may also designate a representative to file a grievance on the covered person's behalf, and to represent the covered person during the grievance review process.

(3) Grievance Review Procedures

Within five (5) business days after the Company receives notice of an oral or written grievance, the Company will provide a written acknowledgment of the grievance to the covered person. The acknowledgment will include the name, address, and telephone number of an individual to contact regarding the grievance and the date the grievance was filed.

The Company will appoint at least one (1) individual to resolve each grievance. This individual will have sufficient experience, knowledge, and training to appropriately resolve the grievance. If the grievance involves a clinical matter, the Company may consult with a qualified utilization review agent to assist in the grievance review. The Company will investigate all grievances, including any aspect of a grievance that involves clinical care. The Company will document the substance of each grievance and any actions taken regarding the grievance, including notification, acknowledgment, investigation, and resolution.

The Company will resolve all grievances within twenty (20) business days after it receives the information that is reasonably necessary for the Company to complete the grievance review. The Company will render grievance decisions in less time if the clinical urgency of the situation so requires. The Company will provide the covered person with written notice of the grievance decision and the right to appeal the decision within five (5) business days after the Company makes the grievance decision. This notice will include: (a) a statement of the Company's understanding of the grievance; (b) a statement of the Company's grievance decision; (c) a statement in clear terms of the reasons, policies, evidence, documentation, and procedures that form the basis of the decision, including the contract basis or medical rationale for the decision stated in sufficient detail for the covered person to respond further to the Company's position; (d) notice of the covered person's right to appeal the decision; (e) information about how, when, and where to appeal the decision; (f) the department, address, and telephone number through which a covered person may contact a qualified representative of the Company to obtain additional information about the decision or the right to appeal; and (g) the right to further remedies allowed by law, in the case of an appeal of a grievance decision.

If the Company is unable to make a decision regarding a grievance within the twenty (20) day period due to circumstances beyond the Company's control, the Company will, before the twentieth (20th) business day, notify the covered person in writing of the reason for the delay and issue a written decision regarding the grievance within an additional ten (10) business days. "Circumstances beyond the Company's control" means (a) the failure of a provider to provide within fifteen (15) days of the filing of the grievance information that is requested by the Company and is necessary to adequately review and investigate the grievance, or (b) the failure of a covered person to provide additional information requested by the Company that is necessary to resolve the grievance within fifteen (15) days of the filing of the grievance.

(4) Appeals of Grievance Decisions

Within forty-five (45) days after the covered person receives the Company's grievance decision, the covered person may appeal that decision to the Company in writing. The Company will assist covered persons in filing appeals, including persons with literacy, language, physical, health, or other impediments. The Company will acknowledge receipt of a grievance appeal within five (5) business days after the appeal is filed.

The Company will investigate each grievance appeal, including any aspect of a grievance appeal that involves clinical care. If the appeal involves a clinical matter, the Company may consult with a qualified utilization review agent to assist in the appeal review. The Company will document the substance of each grievance appeal and the actions taken to review the appeal.

The Company will appoint one (1) or more qualified individuals to resolve each grievance appeal. If the appeal involves a clinical issue, the grievance appeal reviewers will include one (1) or more individuals who: (a) have knowledge in the medical condition,

procedure, or treatment at issue; (b) are licensed in the same profession and have a similar specialty as the provider who delivered the health care procedure, treatment, or service; (c) were not involved in the matter giving rise to the appeal or in the initial investigation of the grievance; and (d) do not have a direct business relationship with the covered person or the health care provider that delivered the health care procedure, treatment, or service giving rise to the grievance.

The panel will meet at a time during normal business hours and place convenient to a covered person who wishes to appear before or otherwise communicate with the panel, to the extent reasonably possible. The Company will provide the covered person with the opportunity to appear in person before the appeal reviewer(s) and, if the covered person is unable to appear in person, the Company will provide the covered person with the opportunity to otherwise appropriately communicate with the appeal reviewer(s). The Company will notify a covered person whose grievance is the subject of an appeal not less than seventy-two (72) hours prior to the meeting of the panel, unless the covered person waives this notice requirement.

The Company will resolve grievance appeals as expeditiously as possible. The Company will resolve all grievance appeals within forty-five (45) days after the Company receives the appeal. The Company will resolve appeals in a shorter period of time if the clinical urgency of the situation so requires.

The Company will notify a covered person in writing of the grievance appeal decision within five (5) business days after the Company completes the grievance appeal review. The grievance appeal decision will include: (a) a statement of the Company's decision; (b) a statement of the reasons, policies, and procedures that form the basis of the decision; (c) notice that the covered person may have the right to further remedies allowed by law, including the right to external grievance review by an independent review organization; and (d) the department, address, and telephone number through which the covered person may contact a qualified Company representative to obtain further information about the grievance appeal decision or the right to external grievance review.

(5) External Grievance Review

A grievance is eligible for external grievance review if:

- (A) the Company denied the claim at issue on the ground that a service or supply provided to a covered person (i) was not appropriately provided; (ii) was not medically necessary; or (iii) was experimental or investigational; and
- (B) the covered person has completed the Company's internal grievance and grievance appeal procedures detailed above; and
- (C) the covered person has not previously requested external grievance review concerning the grievance.

A covered person or a covered person's representative must file a request for external grievance review in writing not more than one hundred twenty (120) days after the Company notifies the covered person of the internal grievance appeal decision.

The Company will select a independent review organization for each external grievance from a list of independent review organizations certified by the Department of Insurance. The Company will rotate the choice of independent review organizations sequentially through the list of all certified independent review organizations maintained by the Department of Insurance on its website before repeating a selection.

The chosen independent review organization will assign a medical review professional who is board certified in the applicable specialty to resolve the external grievance. The independent review organization and medical review professional may not have a material professional, familial, financial, or other affiliation with: (1) the covered person; (2) the Company; (3) any officer, director, or management employee of the Company; (4) the relevant health care provider or the health care provider's medical group; (5) the facility at which the service was performed; or (6) the development or manufacture of the principal drug, device, procedure, or other therapy that has been provided to the covered person and is at issue during the external grievance review. The medical review professional may have an affiliation under which the medical review professional provides health care services to covered persons of the Company and may have an affiliation that is limited to staff privileges at the health facility, if the affiliation is disclosed to the covered person and the Company before commencing the review and neither the covered person nor the Company objects.

The Company will pay all costs associated with the services of the independent review organization.

The covered person may be assisted by other individuals, including health care providers, attorneys, friends, and family members throughout the external grievance review process.

The covered person will be permitted to submit additional information to the Company relating to the service or supply in question throughout the external grievance review process. If, at any time during the external review process, the covered person submits information to the Company that is relevant to the Company's resolution of the external grievance review and that information was not considered by the Company previously, the Company may reconsider its grievance appeal decision. If the Company chooses to reconsider its grievance appeal decision based on this new information, the independent review organization will cease the external review process until the reconsideration is completed. The Company will make this reconsideration decision based on the newly submitted information and notify the covered person of the Company's decision within fifteen (15) days after the covered person submits the information to the Company. If the reconsideration decision is adverse to the covered person,

the covered person may request that the independent review organization resume the external review process. If the Company chooses not to reconsider its grievance appeal decision based on this newly submitted information, the Company will forward the newly submitted information to the independent review organization not more than two (2) business days after the Company received the information.

The covered person has the obligation to provide any requested medical information to the independent review organization and to authorize the release of necessary medical information to the external grievance reviewer. Documents and other information created or received by the independent review organization or the medical review professional in connection with an external grievance review are not public records and the Company will treat that information in accordance with the Company's confidentiality policies and the confidentiality requirements of state and federal law.

The independent review organization will make a determination to uphold or reverse the Company's decision on the covered person's grievance within fifteen (15) business days after the external grievance review request is filed. The independent review organization will notify the Company and the covered person of the determination within seventy-two (72) hours after making the determination.

The decision of the independent review organization is binding on the Company.

(6) Expedited External Grievance Review

If a covered person has a grievance related to an illness, a disease, a condition, an injury, or a disability and the time frame for a standard review would seriously jeopardize his or her (a) life or health; or (b) ability to reach and maintain maximum function, the covered person may file a request for expedited external grievance review, subject to the procedures for standard reviews described above, if applicable. The independent review organization will make a determination to uphold or reverse the Company's decision on the grievance, and notify the Company and the covered person of the determination, within seventy-two (72) hours after the external grievance review request is filed.

(7) Annual Filings

On or before March 1 of each year, the Company will file electronically with the Insurance Commissioner a description of the Company's grievance procedures. This filing will include a grievance procedure report for the preceding calendar year on the form set forth in Exhibit 1 hereto.

On or before March 1 of each year, the Company will also file with the Commissioner a description of the Company's external grievance review procedures. This filing will include, for

each independent review organization: (a) the total number of external grievances handled by that independent review organization during the preceding calendar year; (b) a compilation of the causes underlying those grievances; and (c) a summary of the final disposition of those external grievance reviews. The Company will also submit any additional reports that the Commissioner requires.

The Company will include a copy of these grievance procedures, including any and all forms used in filing and reviewing grievances, with any application for a certificate of authority submitted to the department.

In addition, the Company will file with the Commissioner any material modifications to these grievance procedures not more than fifteen (15) days after the adoption of the modification.

(8) Record Maintenance

The Company will maintain written records documenting all grievances received during a calendar year (the “grievance register”). The grievance register will contain, at a minimum, the following information for each grievance: (a) a general description of the basis for the grievance using the categories in block 3 of the grievance procedures report (Exhibit 1 hereto); (b) date received; (c) date investigated or reviewed; (d) date resolved; (e) description of resolution; (f) date appeal, if any, was received; (g) date of appeals hearing or review; (h) date appeal was resolved; (i) description of resolution of the appeal; (j) name of covered person and covered person’s representative, if any, who filed, or upon whose behalf was filed, the grievance; and (k) names and titles of all persons who investigated, reviewed, and resolved the grievance.

The Company will retain each grievance register until the Commissioner has conducted an examination of the Company and adopted a final report of the examination that contains a review of the register for the calendar year covered by the grievance register.

(9) Toll-free Telephone Number

The Company will establish a toll-free telephone number through which grievances and appeals may be filed and information about grievance procedures obtained. An individual who is knowledgeable about the Company’s grievance procedures and any applicable state laws and regulations will be available to respond to calls received at the toll-free telephone number at least forty (40) normal business hours per week. The toll-free telephone number will be answered by an answering machine or similar device at all other times. Any messages left through the toll-free telephone number will be returned on the following business day by a qualified individual. The toll-free telephone number will accept grievances in English and the languages of the major population groups served by the Company.