



UHA 3000

Preferred Provider Plan Medical Benefits Guide



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NOTICE OF PRIVACY PRACTICES

This Notice Describes How Medical Information About You May Be Used And Disclosed And How You Can Get Access To This Information

Please Review It Carefully

What Is This Notice?

This Notice tells you

- How UHA handles your health information;
- How UHA uses and gives out your health information;
- UHA's responsibilities in protecting your health information; and
- Your rights concerning your health information

UHA is required by law to maintain the privacy of protected health information and to provide you with this Notice and abide by its terms.

What Health Information Is Protected?

Protected Health Information is information that we have created or received regarding your health or payment for your health. It includes your medical record, health plan billing information, and personal information such as your name, address, social security number and telephone number. Information regarding mental health, drug and alcohol treatment, HIV+/AIDS, and some communicable diseases is subject to even more stringent privacy protections under Hawai'i law and may only be released with your specific authorization.

What Are UHA's Responsibilities To You About Your Protected Health Information?

Your health information is personal and UHA protects its privacy. We protect it in all places where we use it or store it. UHA uses the least amount of health information necessary to do our work and we have policies about physically and electronically safeguarding your information. These policies comply with state and federal laws.

How Do We Use Health Information About You?

UHA is permitted to use and disclose your health information in order to do our business. Information may also be shared with other health care businesses that give you care or that help us service your health plan benefits. This Notice describes some of the ways UHA uses and discloses information without authorization (special permission) from you.

HOW UHA USES YOUR HEALTH INFORMATION

Treatment Purposes

Treatment Facilitation

UHA uses your health information to decide which medical treatment(s) may be covered by your health plan.

Payment Purposes

Payment of Claims

Example A: The claim form your provider sends us contains health information so that we can pay for the services provided.

Example B: We send "Explanation of Benefits" statements to the health plan subscriber. These statements show the date(s) services were rendered, provider's name, submitted charges, eligible charges, and amounts for which the patient is responsible.

Health Care Operations Purposes

UHA and businesses we work with receive and give out health information for the following purposes:

- *Reviewing health care given or to be given to members*

Example A: Health Care Services. UHA may use your medical information to review services or approve authorizations for medical treatment. We may give out information to others for disease management and prevention programs.

Example B: Quality Assurance. UHA may use and give out health information to help providers improve the care they give you. This includes looking at and checking the treatment and services you receive.

- *Reviewing the use of benefits by members*

Example: Appeals. You or your provider may appeal a UHA decision. The information the Appeals Committee, our consultants, lawyers, and any outside review agency use to evaluate the appeal may include your medical records.

- *Risk Management Services*

Example: UHA may evaluate health information provided by you (sometimes through your employer or your employer's insurance broker) to determine applicable premium rates.

- *Business Operations*

Example A: UHA may use and disclose your health information to our business associates in order to administer our business operations. These may include providers of health care services, reinsurers, auditors, software vendors, and attorneys. For example, health information may be shared with our legal counsel to enable us to receive legal advice or to represent us in legal proceedings regarding our health care operations. Health information may also be shared in a potential merger or acquisition involving our business, to allow an informed business decision about any prospective transaction. We limit the information we share to the minimum necessary and to make sure that these entities protect the health information we do share.

Example B: UHA may disclose aggregated health information to your plan sponsor to explain the premium pricing. This information will not personally identify you.

Other Uses of Health Information

- When required or authorized by federal, state or local law. For example, releasing information in response to a court order, government investigation, or to a coroner.

- For reasons of public health or safety. For example, notifying authorities about communicable diseases or to avoid serious threat to your health or safety or that of others.

Uses and Disclosures of Your Protected Health Information by UHA That Require Us to Obtain Your Authorization

Except for the purposes listed above, we will use and disclose your Protected Health Information only with your written authorization.

If you sign an authorization you may revoke it in writing at any time, although a revocation may not affect persons who have already acted in reliance on your earlier authorization.

If you have questions about this Notice or would like UHA to disclose your Protected Health Information to someone you designate, please request an authorization form by calling UHA Member Services at 532.4000 from Oahu or 1.800.458.4600 (toll-free) from the Neighbor Islands, or by writing to:

Privacy Officer
UHA
700 Bishop Street, Suite 300
Honolulu, HI 96813

Your Rights Regarding Your Protected Health Information

UHA wants you to know your rights regarding your health information and your dependent's health information.

You have the right to the following:

- Request restrictions by asking that we limit the way we use or disclose your health information for treatment, payment, or health care operations. You may also ask that we limit the information we give to someone who is involved in your care, such as a family member or friend. For example, if you are a dependent on an account and do not wish your payment information in an "Explanation of Benefits" statement to be provided to the subscriber of the account, you may request that such information be restricted. Such restriction requests must be made in writing. Please note that we are not required to agree to your request. If we do agree, we will honor your limits, unless it is an emergency situation.
- Ask that we communicate with you in a certain way if you tell us that communication in another manner may endanger you. For example, if you want us to communicate to you by telephone and not in writing or at a different address, we can usually accommodate that request. We may ask that you make your request to us in writing.
- Look at or request a copy of your Protected Health Information. We may ask you to make this request in writing and we may charge you a reasonable fee for the cost of producing and mailing the copies. In certain situations, we may deny your request and will tell you why we are denying it. In some cases you may have the right to ask for a review of our denial.
- Ask UHA to amend certain Protected Health Information about you that you feel is incorrect or incomplete. Your request for amendment must be in writing and must provide the reason for your request. In certain cases, we may deny your request, in writing. You may respond by filing a written statement of disagreement with us and ask that the statement be included in your Protected Health Information.
- Seek an accounting of certain disclosures by asking UHA for a list of the times that we have disclosed your Protected Health Information. This list will not include disclosures you authorized or those made for treatment, payment, or health care operations. Your request must give us the specific information we need in order to respond to your request. You may request an accounting of disclosures made up to six years prior to your request. You may receive one list per year at no charge. We may charge you a reasonable fee for responding to additional requests.
- To file a complaint if you think your privacy rights have been violated or if you are dissatisfied with our breach notification policies or procedures, you may file a written complaint to the UHA Privacy Officer, 700 Bishop Street, Suite 300, Honolulu, HI 96813. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services. UHA will not retaliate if you file a complaint.

Changes To UHA's Privacy Practices

We reserve the right to change the terms of this Notice at any time. The revised Notice would apply to all the Protected Health Information that we maintain. If we change any of the practices described in this Notice, we will post the revised Notice on our Website. Member Groups will be provided a current copy upon contract renewal every year. You may request a paper copy to be faxed you or mailed you by UHA at any time.

About This Plan

UHA 3000 represents a major advance in health care coverage in Hawaii through its focus on keeping you healthy and well. For the first time, a health plan offers fully covered wellness services emphasizing the prevention and early detection of serious diseases such as cancer and heart disease, plus the identification and treatment of risk factors for life-threatening and disabling diseases.

In addition, the plan provides you with the following tools you need to get well and stay well:

- Nutritional counseling programs
- Smoking cessation program
- Diabetes and Asthma education programs
- Disease Management

These programs are offered to you at no cost—they're fully covered by the Plan. At the same time, you'll enjoy the traditional benefits, which protect you against financial loss from illness or injury.

UHA is committed to improving the quality of your life by improving your health. So please make sure to read our recommendations for using these benefits in "Better Health, Better Life: getting the most from your health plan."

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SECTION 1: GENERAL INFORMATION

About this Booklet	This booklet provides you with all the necessary information about your UHA health benefits plan. Please review it so you understand how your plan works and keep it handy for reference.
How to Contact UHA	<p>Should you ever have any questions about your plan, please contact us:</p> <p><u>By phone:</u> Please call Member Services at 532-4000 from Oahu or 1-800-458-4600 (toll-free) from the neighbor islands</p> <p><u>By fax:</u> (808) 522-8894</p> <p><u>By mail:</u> UHA Attn.: Member Services 700 Bishop Street, Suite 300 Honolulu, HI 96813</p> <p><u>On the web:</u> www.uhahealth.com for access to information on benefits and frequently asked questions, to look up the names and addresses of participating providers, or to submit a question to us</p>
Definitions	<p>Important terms used in this booklet will appear in bold the first time they are used. Definitions of these terms are included in the glossary at the end of the booklet for easy reference.</p> <p>We use the terms You and Your to mean you and your family Members who are eligible for coverage under this Agreement. We use the terms We, Us and Our to mean UHA.</p>
Your Comprehensive Medical Plan	Your UHA Plan is a Comprehensive Medical plan that provides flexibility in the way you obtain your medical Benefits. Your opportunity to take an active role in your health care decisions makes this coverage special. In general, you will experience the lowest out-of-pocket costs when you obtain services from a UHA Participating Provider .
Categories of Providers	<p>The payment made by this plan and the Copayment amount that you must pay depend on the category of provider from whom you receive services. A Provider may be “Participating” with UHA or “Non-Participating.”</p> <p>Participating means that a Physician, Hospital, or other licensed health care provider has signed a contract with UHA to provide Benefits under this plan. The contract requires that the provider collect only:</p> <ul style="list-style-type: none">(a) the Eligible Charge paid by UHA for the Covered Services delivered(b) the applicable copayment or Deductible(c) billed charges for non-covered services(d) the applicable state excise tax, based on the eligible charge <p>Participating Providers also agree to participate in and abide by UHA’s credentialing, quality improvement and utilization management programs.</p> <p>There are many Participating Providers throughout Hawaii. Please refer to the UHA Participating Physicians and Health Care Provider Directory for a listing. If you did not receive a Directory at the time of your enrollment, please call Member Services and we will send one to you without</p>

charge. This listing may have changed since the date of printing, therefore, it is always a good idea to check with the provider to make sure he or she is still participating with this plan. A Directory is also available on UHA's website at www.uhahealth.com.

It is also important to understand that a specific physician or other provider may be a Participating Provider at one office location, but be Non-Participating at another location. Additionally, a hospital may be a participating hospital, but some of the physicians or other individual licensed providers who practice at that hospital may not be participating providers with UHA. It is always a good idea to verify that each provider is participating with UHA before you receive services, in order to help minimize your health care costs.

Using Non-Participating Providers

A **Non-Participating Provider** is any health care provider who does not have a contract with us to participate with this plan, including out-of-state providers.

You may visit a provider that is not participating with UHA. UHA will pay you the eligible charge for covered services less your copayment or coinsurance, and the payment will be made directly to the subscriber. You will then pay the provider the total charge (which includes any difference between UHA's payment and the total Actual Charge) plus the applicable taxes for each service. UHA has no contract with Non-participating providers to guarantee the amount of charges you are assessed. UHA does not recognize assignment of benefits to non-participating providers. At our sole discretion, however, we will make payments directly to non-participating hospitals for **Inpatient services**.

Please note: Your participating provider may refer services to a non-participating provider and you may incur a higher out-of-pocket expense. For example, your participating provider may send you to a non-participating specialist for additional care. You can ask for your referral to be to a participating provider to help minimize your health care costs.

Referrals to Specialists

Remember, if you are referred to a specialist who is a UHA participating physician, your cost for the office visit will be the \$12 copayment, plus the applicable excise tax and charges for non-covered services. If the physician does not participate with UHA, UHA will pay the eligible charge for covered services less your applicable copayment or coinsurance and the payment will be made directly to you. You will also be responsible for any difference between the eligible charge and the amount charged by the specialist, plus the applicable taxes.

Services Outside the Service Area

The **Service Area** for this plan is the State of Hawaii.

UHA has a special arrangement with a mainland contractor to help you control your health care expenses in the event of a travel **Emergency**. A travel emergency is a medical emergency that occurs while you are traveling outside of the Service Area. For example, a member suffers a broken limb while vacationing in Las Vegas.

Please note: Providers with the special mainland contractor do not qualify as UHA Participating Providers for purposes of this plan. Except for travel emergencies, UHA will make payments for all mainland services, even services obtained from providers with the special mainland contractor, at non-participating provider benefit levels and members will be responsible for the provider's charges in excess of UHA's payment.

If you require medical services that are not available in Hawaii, your physician should contact us for an authorization for a referral to a mainland Provider. Please refer to [Section 7: Health Care Services Program](#) for Prior Authorization requirements.

Important Questions To Ask When You Receive Care

The benefits that this plan pays when you receive medical services depend on the answers to several questions. It is a good idea to keep these in mind when you seek medical care.

1. Is the service a Covered Service? To receive Benefits, the care you receive must be a covered service. Please refer to Section 5: Description of Benefits and to Section 6: Services Not Covered for information on what services are covered and not covered.
2. Is the provider a Participating Provider with this plan? The amount this plan pays and the amount you must pay depends on whether the provider of service is a participating provider. Please refer to the headings above about Participating and non-participating providers. You should always verify that the provider you see is a Participating Provider, in order to help minimize your health care costs.
3. Is the care Medically Necessary, is it a Covered Service, and does it meet our Payment Determination Criteria? Please refer to Section 7: Health Care Services Program for the definition of Medically Necessary and our payment determination criteria.
4. Is the service subject to Prior Authorization requirements? Some services require prior authorization by us and for those services you must obtain prior authorization. Please refer to Section 7: Health Care Services Program for information on prior authorization requirements.
5. Is the service subject to a Maximum Benefit Limit? Certain services may have a maximum limit on the dollar amount, the number of visits, or other limitation. Information on benefit maximums appears in Section 3: Payment Information and Section 5: Description of Benefits.
6. Is the provider of the service qualified and a recognized provider? To determine if a provider is qualified and recognized, we consider some or all of the following:
 - Is the provider appropriately licensed?
 - If a facility, is the provider accredited by a recognized accrediting agency?
 - Is the provider qualified under the requirements of the federal Medicare program?
 - Is the provider certified by the appropriate government authority?
 - Are the services rendered within the lawful scope of the provider's licensure, certification, or accreditation?
7. Did a provider order the care? To be covered, all services and supplies must be ordered by a recognized provider.

Our Agreement With You

The Agreement for coverage of medical services between you and us is contained in all of the following:

1. this "Medical Benefits Guide" booklet
2. any application form or enrollment form you submitted to us
3. the agreement between your employer or plan sponsor and us

We will interpret the provisions of this Agreement and determine all questions that arise under it. Our interpretations and determinations and its decisions on these matters are subject to de novo review by an impartial reviewer as provided in the Agreement or as allowed by law. If you disagree with us, you have the right to appeal (see Section 9: If You Disagree With our Decision).

No oral statement of any person shall modify or otherwise affect the benefits, limitations, exclusions, or other terms of this Agreement, convey or void any coverage, or increase or reduce any benefits under this Agreement.

Governing Law

To the extent not superseded by the laws of the United States, this coverage will be construed in accord with and governed by the laws of the State of Hawaii. Any action brought because of a claim against this coverage will be litigated in the state or federal courts located in the State of

Hawaii and no other.

Payment in Error

If for any reason we made a payment under this coverage in error, we may recover the amount we paid.

Non-Assignment of Benefits

Benefits for covered services under this Agreement cannot be transferred or assigned to anyone except as required by law. Any attempt to transfer or assign this coverage or rights to payment to anyone will be void.

SECTION 2: ELIGIBILITY AND ENROLLMENT

This Section contains information about your eligibility for coverage and how to enroll yourself and your Dependents.

Eligibility for Coverage	You may apply for coverage under this plan when you first become eligible for coverage through your employer. If you do not apply for coverage when you first become eligible, or by the first day of the month immediately following the first four consecutive weeks of employment, you must wait until the next open enrollment period. Open enrollment happens once each year. However, if you show us to our satisfaction that there was unusual and justifiable causes for submitting your application late, you may enroll sooner.
Categories of Enrollment	Depending on our agreement with your employer, you may enroll in one of the following categories of enrollment: <ul style="list-style-type: none">• single coverage, meaning that you are the only person covered• two-party coverage, meaning that you and one eligible dependent, such as your Spouse or dependent child, are covered• family coverage, meaning that you and two or more eligible dependents described below, such as your spouse and/or eligible dependent children, are covered
Initial Enrollment	You apply for coverage by completing and submitting an enrollment form to your employer. The enrollment form must include the names of any dependents you wish to include in this coverage. If you do not submit the names of your dependents on the enrollment form, you must wait until the next open enrollment period to enroll them.
Enrolling a New Spouse	If you marry during the plan year, you may enroll your spouse prior to the next open enrollment by notifying your employer within 31 days of the marriage. Your employer, in turn, will notify us. If you do not enroll your spouse within 31 days, you must wait for the next open enrollment period.
Enrolling Children	You may enroll a child if the child meets all of the following requirements: <ul style="list-style-type: none">• the child is your natural child, your legally adopted child, your stepchild, a child placed with you for adoption, or a child for whom you or your spouse are the court-appointed guardian• the child is under 19 years of age• the child is not married <p>Provisions for enrolling newborns, students age 19 and older, and children with special needs are described in the following sections.</p>
Enrolling Newborns or Newly Adopted Children	You may enroll a newborn or newly adopted child by notifying your employer within 31 days of the birth or adoption placement. Your employer, in turn, will notify us. If you do not enroll the child within 31 days of birth or adoption, you must wait for the next open enrollment period.
Children Who are Students	If your employer's agreement with us provides for coverage of students age 19 and over, you may enroll your child as a student if all of the following are true: <ul style="list-style-type: none">• the child is enrolled as a full-time student in an accredited school, college, or university• the child is not married• the child is a legal resident of Hawaii• the child is wholly dependent on you for support and maintenance• the child does not exceed the student age limit set forth in your employer's agreement with us

We may request documentation that all of the above conditions are met at the time you enroll your child as a student and at periodic intervals thereafter. You are responsible for notifying your employer when your child no longer meets these requirements for eligibility as a student. Your child will be terminated from coverage as soon as his or her student age limit is met.

Children With Special Needs

You may enroll your child who is age 19 or over if he or she is disabled by providing us with written documentation acceptable to us demonstrating that:

- the child is incapable of self-sustaining support because of a physical or mental disability
- the child's disability existed before the child turned 19 years of age
- the child relies primarily on you for support and maintenance as a result of his or her disability
- the child is enrolled with us under this coverage or other UHA coverage and has had continuous coverage with us since his or her 19th birthday

You must provide this documentation to us within 31 days of the child's 19th birthday and subsequently at our request, but not more than annually after the child reaches 21 years of age.

Qualified Medical Child Support Order

Any claim for benefits with respect to a child covered by a Qualified Medical Child Support Order ("QMCSO") may be made by the child or by the child's custodial parent or court-appointed guardian. Any benefits otherwise payable to the member with respect to any such claim shall be payable to the child's custodial parent or court-appointed guardian.

If you would like more information about how UHA handles QMCSOs, you may request a copy of UHA's procedures governing QMCSO determinations. A copy will be mailed to you without charge.

Identification Card

When you enroll with UHA, you will receive UHA Identification Cards for yourself and any dependents enrolled. It is a good idea to carry your UHA Identification Card at all times to ensure you have your health plan information in case of an emergency.

Each time you visit your doctor or other health care provider, you should present your I.D. card. It includes the following information:

- employer group name
- employer group number
- member name
- member identification number
- codes for your plan benefits

The provider requires this information to submit a Claim for payment to us.

When Your Coverage Begins

This coverage takes effect on your Effective Date as determined by your employer's rules, provided that you meet eligibility criteria set forth above and by your employer, and all of the following are met:

- your initial dues were paid by your employer
- we accepted your application by sending you an Identification Card

If you are confined in a hospital or other inpatient facility at the time this coverage begins and you had no other insurance or coverage immediately prior, then coverage for the hospitalization begins on the Effective Date of this coverage. If you had other insurance or coverage immediately prior, then coverage for the hospitalization begins either (a) on the effective date of this coverage or (b) on the day after your discharge from the hospital. We will work with your prior insurer or coverage to determine which option applies to you. This limitation does not apply to you if you had coverage with us prior to the effective date of this coverage.

When Coverage Ends

Your coverage will end on the last day of the month in which any of the following occurs:

- you choose to terminate this coverage; in this case you must notify your employer before the end of the month
- your employer fails to make payments to us when due
- your employer decides to discontinue this coverage
- we terminate our agreement with your employer by providing written notice to your employer 60 days prior to termination
- for you, the Subscriber, if you retire or otherwise terminate your employment
- for your spouse, if your coverage terminates or upon dissolution of the marriage
- for your children, if your coverage terminates, or if the child no longer meets the criteria described under the heading "Enrolling Children" and "Children who are Students"

However, coverage will not be cancelled unless the employer and Director of the Hawaii Department of Labor and Industrial Relations has received notice of the intent to cancel from us at least 10-days prior to the specified date of cancellation.

Notifying Us When Your Child's Eligibility Ends

You must inform your employer in writing if a child no longer meets the eligibility requirements. This notice must be made on or before the first day of the month following the month the child no longer meets the requirements. For example, if your child graduates from college on May 10, you must notify your employer by June 1.

If you fail to provide notice that your child is no longer eligible and we make payments for services on his or her behalf, you must reimburse us for the amount we paid.

Termination for Fraud

Your eligibility for coverage will terminate immediately if you use this coverage fraudulently or you misrepresent or conceal material facts in your application. If your coverage is terminated for fraud, misrepresentation, or the concealment of material facts:

- we will not pay for any services or supplies provided after the date the coverage is terminated
- you agree to reimburse us for any payments we made under this coverage
- we will retain our full legal rights. This includes the right to initiate a civil action based on fraud, concealment, or misrepresentation

If a person not eligible for enrollment is erroneously or fraudulently enrolled for UHA coverage, UHA reserves the right to cancel such enrollment immediately and seek repayment of any medical expenses paid on behalf of the ineligible person.

SECTION 3: PAYMENT INFORMATION

This section provides information about how we make payments under this plan and how your responsibility for payment is determined.

Annual Deductible This plan has an Annual Deductible of \$200 for the individual; \$600 for the family.

Here is an example of how your annual deductible works. Assume you have single coverage and your annual deductible for certain services is \$200 and you always utilize services from a Participating Provider:

- In January, you require oxygen and the rental of equipment for its administration. The eligible charge is \$150. You are responsible for the entire amount because these services are subject to the annual deductible and you have not met the annual deductible.
- In February, you require the rental of a wheelchair. The eligible charge is \$300. You owe \$50 to meet the remaining deductible balance, plus \$50 in coinsurance. (20% of the remaining \$250 balance).

Not all benefits are subject to the above deductible (see: [Section 5: Description of Benefits](#)).

Eligible Charge We determine our payment and your copayment based on the eligible charge for a covered service. The eligible charge for some services may be a per case, per treatment, or per day (per diem) fee, rather than an itemized amount (fee for service).

1. For participating providers, the eligible charge for covered services is a contracted rate with UHA.
2. For non-participating providers, the eligible charge for covered services will be the lesser of the following charges:
 - UHA's determination of an eligible charge for a covered service
 - the actual charge to you

Participating providers agree to accept the eligible charge for covered services. non-participating providers usually do not. Therefore, if you receive services from a non-participating provider, you are responsible for the amount of your copayment plus any difference between the eligible charge and the provider's actual charge.

The eligible charge does not include excise tax or any other tax. You are responsible for paying all taxes associated with the medical services you receive.

Example: Let's say you have a sore throat and go to a participating physician to have it checked.

- The physician's submitted or actual charge = \$100
- UHA's eligible charge = \$60
- Your copayment = \$12
- The difference between the submitted or actual charge and the eligible charge = \$40
- You owe \$12; Please note: If you went to a non-participating provider you would owe the copayment amount of \$12 plus the \$40 difference between the actual charge and the eligible charge, a combined total of \$52.

Copayment Copayment is the amount of the eligible charge you pay for a covered service. It can be a fixed dollar amount (for example, \$12 copayment for a visit to your Personal Physician) or a percentage of the eligible charge (for example, 20% of the eligible charge if you utilize services from a Participating hospital).

Please remember that when you receive services from a non-participating provider, you are responsible for the copayment amount plus any difference between the eligible charge and the provider's actual charge (plus any applicable taxes).

Annual and Lifetime Maximum Benefits

This plan will cover up to \$2,000,000 per member per Calendar Year. If you are covered under this Agreement and you were provided benefits under any other health plan of UHA, those Benefits shall be carried forward and applied to any Maximum Benefits available under this Agreement.

There is no lifetime maximum benefit.

Please note that certain benefits have annual maximums. For example, home health care is limited to 150 visits per Calendar Year.

Maximum Annual Copayment

When the total of your copayments reach \$2,500 per person or \$7,500 per family, in any calendar year, this plan pays 100% of the eligible charge for covered services rendered for the rest of that calendar year for medical care.

However, the following payments do not apply toward meeting the Maximum Annual Copayment:

- when you receive services from a non-participating provider, any difference you pay between the eligible charge and the provider's actual charge
- penalties for not obtaining prior authorization (see Section 7: Health Care Services Program for services subject to prior approval)
- your copayments for prescription drugs and vision benefits if your employer offers these additional benefits
- any copayments for contraceptives, diabetic drugs and supplies, insulin, and medical foods
- your copayments for Chiropractic and Acupuncture benefits
- if a service is subject to a maximum limitation and you have reached that maximum, any amounts that you pay after meeting the maximum (Benefit Maximums are listed in the benefits descriptions in Section 5: Description of Benefits)
- your payments for non-covered services

Services Outside the Service Area

For covered services rendered outside the Service Area (the State of Hawaii), we will pay Benefits as provided in this Agreement, but in no event will the eligible charge for such covered services exceed the eligible charge for similar services rendered in the State of Hawaii.

SECTION 4: SUMMARY OF BENEFITS AND PAYMENT OBLIGATIONS

This Section provides a summary of the Benefits available under this Agreement and identifies your payment obligations for the covered services depending on whether you receive them from a participating or non-participating provider. This summary of benefits below is subject to the description of benefits and related limitations of benefits in Section 5 and the exclusions in Section 6.

Prior Authorization is required for some services. From time to time, it is necessary to change our prior authorization requirements so that benefits remain current with the way therapies are delivered. Changes may occur any time during your plan year. Please call UHA's Health Care Services Department at 532-4006 (or 1-800-458-4600 from the Neighbor islands) to see if a service has been added or deleted from the list in this Guide.

Please remember that in addition to the payment amounts shown in this section, you are responsible for:

1. payment of all applicable taxes charged by the provider
2. if you see a non-participating provider, any difference between the eligible charge and the Actual Charge made by the provider, in addition to the copayment amount listed

A. PREVENTIVE CARE SERVICES <u>Preventive Care Benefits are available immediately.</u>	Annual Deductible Applies	Participating Provider YOU PAY	Non-Participating Provider YOU PAY
Well Child Care Physician Office Visits (Newborn to 5 years old)	No	No Copayment	No Copayment
All ACIP (Advisory Committee on Immunization) recommended Childhood Immunizations	No	No Copayment	No Copayment
Well Child Care Laboratory Tests (Newborn to 5 years old)	No	No Copayment	No Copayment
Preventive Medicine Office Visit (Ages 6 years old and greater)	No	No Copayment	No Copayment
Screening Laboratory Services	No	No Copayment	No Copayment
All ACIP recommended Adult Immunizations	No	No Copayment	No Copayment
Breast Cancer Screening (Mammography)	No	No Copayment	No Copayment
Cervical Cancer Screening (Pap Smear)	No	No Copayment	No Copayment
Chlamydia Screening	No	No Copayment	No Copayment
Osteoporosis Screening (Peripheral DEXA Scan or Ultrasound of the heel)	No	No Copayment	No Copayment
Tuberculin Skin Test	No	No Copayment	No Copayment
Colorectal Cancer Screening	No	No Copayment	No Copayment
Prostate Specific Antigen (PSA) Test	No	No Copayment	No Copayment

Summary of Benefits and Payment Obligations

Maternity Care and Delivery	No	No Copayment	No Copayment
Birthing Room	No	No Copayment	No Copayment
Newborn Nursery	No	No Copayment	No Copayment

B. DISEASE MANAGEMENT PROGRAMS Disease Management Benefits are available immediately.	Annual Deductible Applies	Participating Provider YOU PAY	Non-Participating Provider YOU PAY
Smoking Cessation Program Prior Authorization required	No	No Copayment	Not covered
Nutrition Counseling Programs Prior Authorization required	No	No Copayment	Not covered
Disease Education Programs Prior Authorization required	No	No Copayment	Not covered
Prenatal Program	No	No Copayment	Not covered

C. PHYSICIAN SERVICES	Annual Deductible Applies	Participating Provider YOU PAY	Non-Participating Provider YOU PAY
Anesthesia	Yes	20% of Eligible Charge	20% of Eligible Charge
Physician Visits: <ul style="list-style-type: none"> • Office • Hospital (inpatient or outpatient) • Emergency Room 	No	<ul style="list-style-type: none"> • \$12 Copayment • \$12 Copayment • \$12 Copayment 	<ul style="list-style-type: none"> • \$12 Copayment • \$12 Copayment • \$12 Copayment
Second Opinions Prior Authorization required for opinions rendered by out of state providers.	No	No Copayment	No Copayment
Consultations	No	\$12 Copayment	\$12 Copayment

D. SURGICAL SERVICES (Certain Surgical Services may require Prior Authorization)	Annual Deductible Applies	Participating Provider YOU PAY	Non-Participating Provider YOU PAY
Assistant Surgeon	Yes	20% of Eligible Charge	20% of Eligible Charge
Cutting and Non-Cutting Surgery, inpatient	Yes	20% of Eligible Charge	20% of Eligible Charge
Cutting and Non-Cutting Surgery, outpatient	Yes	20% of Eligible Charge	20% of Eligible Charge

Summary of Benefits and Payment Obligations

Surgical supplies	Yes	20% of Eligible Charge	20% of Eligible Charge
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E. HOSPITAL SERVICES	Annual Deductible Applies	Participating Provider YOU PAY	Non-Participating Provider YOU PAY
Ambulatory Surgical Center (ASC)	Yes	20% of Eligible Charge	20% of Eligible Charge
Hospital Room and Board	Yes	20% of Eligible Charge	20% of Eligible Charge
Special Care Units (such as coronary care, intensive care, telemetry, or isolation)	Yes	20% of Eligible Charge	20% of Eligible Charge
Ancillary Inpatient Services	Yes	20% of Eligible Charge	20% of Eligible Charge
Emergency Room For emergencies only	Yes	20% of Eligible Charge	20% of Eligible Charge

F. SKILLED NURSING FACILITY SERVICES	Annual Deductible Applies	Participating Provider YOU PAY	Non-Participating Provider YOU PAY
Room and Board (up to 120 days per calendar year) Prior Authorization required	Yes	20% of Eligible Charge	20% of Eligible Charge
Ancillary Services	Yes	20% of Eligible Charge	20% of Eligible Charge

G. HOME HEALTH CARE AND HOSPICE SERVICES	Annual Deductible Applies	Participating Provider YOU PAY	Non-Participating Provider YOU PAY
Home Health Care (up to 150 visits per calendar year) Prior Authorization required	Yes	20% of Eligible Charge	20% of Eligible Charge
Hospice Services	No	No Copayment	No Copayment

H. DIAGNOSTIC TESTING, LABORATORY AND RADIOLOGY SERVICES	Annual Deductible Applies	Participating Provider YOU PAY	Non-Participating Provider YOU PAY
Allergy testing – one testing series per calendar year	No	\$12 Copayment	\$12 Copayment
Diagnostic Testing – inpatient	Yes	20% of Eligible Charge	20% of Eligible Charge
Diagnostic Testing – outpatient	No	20% of Eligible Charge	20% of Eligible Charge

Summary of Benefits and Payment Obligations

Genetic Testing and Counseling Prior Authorization required	Yes	20% of Eligible Charge	20% of Eligible Charge
Laboratory and Pathology – inpatient	Yes	20% of Eligible Charge	20% of Eligible Charge
Laboratory and Pathology – outpatient	No	No Copayment	No Copayment
Radiology – inpatient	Yes	20% of Eligible Charge	20% of Eligible Charge
Radiology – outpatient Prior Authorization required for PET Scans	Yes	20% of Eligible Charge	20% of Eligible Charge

I. CHEMOTHERAPY AND RADIATION THERAPY SERVICES	Annual Deductible Applies	Participating Provider YOU PAY	Non-Participating Provider YOU PAY
Chemotherapy Prior Authorization required for certain treatments	Yes	20% of Eligible Charge	20% of Eligible Charge
Radiation therapy	Yes	20% of Eligible Charge	20% of Eligible Charge

J. ORGAN TRANSPLANT SERVICES	Annual Deductible Applies	Participating Provider YOU PAY	Non-Participating Provider YOU PAY
Transplant Evaluation Prior Authorization required	Yes	No Copayment	No Copayment
Corneal transplants	Yes	No Copayment	No Copayment
All other organ transplants Prior Authorization required	Yes	No Copayment	No Copayment
Organ donor services Prior Authorization required	Yes	20% of Eligible Charge	20% of Eligible Charge

K. MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES	Annual Deductible Applies	Participating Provider YOU PAY	Non-Participating Provider YOU PAY
Mental Health and Substance Abuse facility services	Yes	20% of Eligible Charge	20% of Eligible Charge
Mental Health and Substance Abuse Professional Services – inpatient	No	\$12 Copayment	\$12 Copayment
Mental Health and Substance Abuse Professional Services – outpatient	No	\$12 Copayment	\$12 Copayment

Summary of Benefits and Payment Obligations

Psychological Testing – inpatient	Yes	20% of Eligible Charge	20% of Eligible Charge
Psychological Testing – outpatient Prior Authorization required	No	20% of Eligible Charge	20% of Eligible Charge

L. SPECIFIC BENEFITS FOR CHILDREN	Annual Deductible Applies	Participating Provider YOU PAY	Non-Participating Provider YOU PAY
Newborn Circumcision	No	No Copayment	No Copayment
Newborn Care	Yes	20% of Eligible Charge	20% of Eligible Charge

M. SPECIFIC BENEFITS FOR WOMEN	Annual Deductible Applies	Participating Provider YOU PAY	Non-Participating Provider YOU PAY
Family Planning	Yes	20% of Eligible Charge	20% of Eligible Charge
Tubal Ligation	Yes	20% of Eligible Charge	20% of Eligible Charge
Termination of Pregnancy	Yes	20% of Eligible Charge	20% of Eligible Charge
Oral Contraceptives from pharmacy (30-day supply) Benefits under this plan apply only if you do not have a drug plan	No	<ul style="list-style-type: none"> • \$5 Copayment for Generic • \$15 Copayment for Preferred Brand • Not covered for Non-Preferred Brand 	Not covered
Oral Contraceptives by Mail Order (60-day supply for Preferred Brand and 90-day supply for Generic) Benefits under this plan apply only if you do not have a drug plan	No	<ul style="list-style-type: none"> • \$5 Copayment for Generic • \$15 Copayment for Preferred Brand • Not covered for Non-Preferred Brand 	Not covered
Emergency Contraceptives from pharmacy Benefits under this plan apply only if you do not have a drug plan	No	<ul style="list-style-type: none"> • \$5 Copayment for Generic • \$15 Copayment for Preferred Brand • Not covered for Non-Preferred Brand 	Not covered
Contraceptive Cervical Caps/ Diaphragms	No	No Copayment	No Copayment
Contraceptive Implants, Injections, IUDs	No	No Copayment	No Copayment

Summary of Benefits and Payment Obligations

N. SPECIFIC BENEFITS FOR MEN	Annual Deductible Applies	Participating Provider YOU PAY	Non-Participating Provider YOU PAY
Vasectomy	Yes	20% of Eligible Charge	20% of Eligible Charge
Erectile Dysfunction	Yes	20% of Eligible Charge	20% of Eligible Charge

O. SPECIFIC BENEFITS FOR MEMBER AND COVERED SPOUSE	Annual Deductible Applies	Participating Provider YOU PAY	Non-Participating Provider YOU PAY
In Vitro Fertilization Prior Authorization required	Yes	20% of Eligible Charge	20% of Eligible Charge

P. SPECIFIC BENEFITS FOR DIABETES	Annual Deductible Applies	Participating Provider YOU PAY	Non-Participating Provider YOU PAY
Diabetes drugs from pharmacy (limited to 30-day supply) Benefits under this plan apply only if you do not have a drug plan	No	<ul style="list-style-type: none"> • \$5 Copayment for Generic • \$15 Copayment for Preferred or Non-Preferred Brand 	Not covered
Diabetes drugs by mail order Benefits under this plan apply only if you do not have a drug plan	No	<ul style="list-style-type: none"> • \$10 Copayment for Generic (90-day supply) • \$35 Copayment for Preferred Brand (60-day supply) • \$60 Copayment for Non-Preferred Brand (60-day supply) 	Not covered
Insulin from pharmacy (limited to 30-day supply) Benefits under this plan apply only if you do not have a drug plan	No	<ul style="list-style-type: none"> • \$5 Copayment for Generic or Preferred Brand • \$15 Copayment for Non-Preferred Brand 	Not covered
Insulin by mail order Benefits under this plan apply only if you do not have a drug plan	No	<ul style="list-style-type: none"> • \$10 Copayment for Generic or Preferred Brand (90-day supply) • \$35 Copayment for Non-Preferred Brand (90-day supply) 	Not covered

Summary of Benefits and Payment Obligations

Diabetes supplies from pharmacy (limited to 30-day supply) Benefits under this plan apply only if you do not have a drug plan	No	<ul style="list-style-type: none"> No Copayment for Generic or Preferred Brand \$15 Copayment for Non-Preferred Brand 	Not covered
Diabetes supplies by mail order Benefits under this plan apply only if you do not have a drug plan	No	<ul style="list-style-type: none"> No Copayment for Generic or Preferred Brand (90-day supply) \$35 Copayment for Non-Preferred Brand (90-day supply) 	Not covered
Diabetes self-management education Prior Authorization required	No	No Copayment	Not covered

Q. COMPLEMENTARY ALTERNATIVE MEDICINE (Services provided by a Chiropractor or Acupuncturist for conditions limited to the neuromusculoskeletal system)	Annual Deductible Applies	Participating Provider YOU PAY	Non-Participating Provider YOU PAY
Office visit	No	\$10 Copayment	Plan pays up to \$20 per visit; you pay balance
First set of x-rays	No	50% of Eligible Charge	Not covered

R. OTHER MEDICAL SERVICES	Annual Deductible Applies	Participating Provider YOU PAY	Non-Participating Provider YOU PAY
Ambulance (ground or inter-island air) For emergencies only	Yes	20% of Eligible Charge	20% of Eligible Charge
Appliances and Durable Medical Equipment Prior Authorization required when cost is more than \$500	Yes	20% of Eligible Charge	20% of Eligible Charge
Asthma Education Prior Authorization required	No	No Copayment	Not covered
Bariatric Surgery Prior Authorization required	Yes	20% of Eligible Charge	20% of Eligible Charge
Blood, Blood Products, and Blood Bank Service Charges	Yes	20% of Eligible Charge	20% of Eligible Charge
Dialysis and Supplies	Yes	20% of Eligible Charge	20% of Eligible Charge

Summary of Benefits and Payment Obligations

Evaluations for Use of Hearing Aids	No	\$12 Copayment	\$12 Copayment
Growth Hormone Therapy Prior Authorization required	Yes	20% of Eligible Charge	20% of Eligible Charge
Home Infusion Therapy Prior Authorization required	Yes	20% of Eligible Charge	20% of Eligible Charge
Hyperbaric Treatment Prior Authorization required	Yes	20% of Eligible Charge	20% of Eligible Charge
Implants	Yes	20% of Eligible Charge	20% of Eligible Charge
Inhalation Therapy	Yes	20% of Eligible Charge	20% of Eligible Charge
Injectable Medications (Outpatient) Prior Authorization required for certain injectables	Yes	20% of Eligible Charge	20% of Eligible Charge
Medical Foods	Yes	20% of Eligible Charge	20% of Eligible Charge
Occupational Therapy Services Prior Authorization required	No	\$12 Copayment	\$12 Copayment
Orthotics Prior Authorization required	Yes	20% of Eligible Charge	20% of Eligible Charge
Physical Therapy Services Prior Authorization required	No	\$12 Copayment	\$12 Copayment
Prosthetics Prior Authorization required when cost is more than \$500	Yes	20% of Eligible Charge	20% of Eligible Charge
Speech Therapy Services Prior Authorization required	No	\$12 Copayment	\$12 Copayment

SECTION 5: DESCRIPTION OF BENEFITS

This Section describes the Benefits available to you under this Agreement, including any limitations.

A. PREVENTIVE CARE SERVICES

Preventive Care Benefits are not subject to the Annual Deductible and are available immediately. The attached "Better Health, Better Life" lists the recommended schedule for receiving certain Preventive Care Services.

Well Child Care Physician Office Visits Office visits for history, physical examinations, developmental assessments, anticipatory guidance, laboratory tests, and Immunizations are covered, according to the following schedule and limitations:

- birth to one year: six visits (one additional visit is covered when a newborn child is discharged within 48 hours of birth)
- age one to two years: two visits
- ages two to five years: one visit per year

If your child requires medical care for an illness or injury, benefits for physician visits, not Well Child Care, apply.

Well Child Immunizations Covered, in accord with Hawaii law and the guidelines set by the Advisory Committee on Immunization Practices (ACIP); copy of current guidelines is available upon request

Well Child Care Laboratory Tests The following laboratory tests are covered:

- urinalysis
- hematocrit
- hemoglobin

Preventive Medicine Office Visit (Ages 6 years and greater) Covered; one per calendar year for a preventive health examination

Screening Laboratory Services The following screening laboratory services are covered as part of the preventive medicine office visit:

- complete Blood Count
- basic metabolic panel
- lipid panel
- urinalysis
- TSH panel

Adult Immunizations Covered, for standard Immunizations (for cholera, diphtheria, hemophilus influenza, hepatitis, influenza, measles, mumps, pneumococcal disease, polio, smallpox, tetanus, typhoid, typhus, whooping cough, varicella and rubella) and for high risk conditions such as Hepatitis B and other vaccines in accord with the guidelines set by the Advisory Committee on Immunization Practices

Breast Cancer Screening Covered; one per calendar year

(Mammography) A woman of any age may receive a screening mammogram more often if she has a history of breast cancer or if her mother or sister has a history of breast cancer. Diagnostic mammography benefits are included in the heading "Diagnostic Testing, Laboratory and Radiology."

Cervical Cancer Screening (Pap Smear)	Covered; one per calendar year
Chlamydia Screening	Covered; one per calendar year
Osteoporosis Screening	Covered; one per calendar year for the Peripheral DEXA Scan or Ultrasound of the heel Central DEXA Scans are not covered for screening purposes and therefore, Prior Authorization is required for Central DEXA Scans for ages 64 and under.
Tuberculin Skin Test	Covered; for one tuberculin (TB) skin test per calendar year
Colorectal Cancer Screening	Covered for males and females over 50 years of age as follows: <ul style="list-style-type: none"> • one annual fecal occult blood testing • one fecal occult blood testing and flexible sigmoidoscopy every five years or • one colonoscopy every ten years
Prostate Specific Antigen (PSA) Test	Covered: one prostate specific antigen test per calendar year for men age 50 or older
Maternity Care and Delivery	Covered, including prenatal, false labor, delivery, and postnatal services provided by your physician or midwife The eligible charge for delivery includes prenatal and postnatal care. If payments for prenatal care are made separately prior to delivery, we will consider those payments advance payments and will deduct them from the maximum allowance for delivery. If a physician provides all or part of the antepartum and/or postpartum patient care but does not perform delivery, separate copayments may apply.
Birth Room	Covered, but only for labor and delivery
Maternity Length of Stay	Covered for at least: <ul style="list-style-type: none"> • 48 hours from the time of delivery for normal labor and delivery • 96 hours from the time of delivery for a cesarean birth
Newborn Nursery	Covered for at least: <ul style="list-style-type: none"> • 48 hours from the time of delivery for normal labor and delivery • 96 hours from the time of delivery for a cesarean birth

B. DISEASE MANAGEMENT PROGRAMS

Disease Management Benefits are not subject to the Annual Deductible and are available immediately.

Smoking Cessation Program	Covered, but only through UHA Participating Provider(s) and with Prior Authorization (see Section 7: Health Care Services Program)
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Nutrition Counseling	Covered, but only through UHA participating provider(s) and with Prior Authorization (see Section 7: Health Care Services Program)
Disease Education Programs	UHA provides fully covered Disease Education Programs for members with diabetes and asthma presently and expects to add others. Prior Authorization (see <u>Section 7: Health Care Services Program</u>) is required by us for these Programs. For information about these programs, please call our Health Care Services department. Information is also available on our website at www.uhahealth.com .
Prenatal Program	Covered, but only for UHA's special prenatal program This program is designed to improve outcomes, reduce complications of pregnancy, and improve quality of care. For information about this program, please call our Health Care Services department. Information is also available on our website at www.uhahealth.com .

C. PHYSICIAN SERVICES

Anesthesia	Covered, as required by the attending physician and when appropriate for your condition Covered services include general and regional Anesthesia. Conscious sedation is not covered unless it meets UHA's high-risk guidelines and Prior Authorized is obtained.
Physician Visits	Covered for the treatment of an illness or injury when you are an inpatient or are seen in a physician's office, clinic, Outpatient center, emergency room, or your home Home visits, or house calls, are covered only when provided within the Service Area, and only when your physician determines that necessary care can best be provided in the home. Services provided by Advanced Practice Registered Nurses and Physician Assistants are covered as Physician Services. <u>Physician Visits are not subject to the Annual Deductible.</u>
Physician Visits – Emergency Room	Covered, but only if a prudent layperson could reasonably expect that the absence of immediate medical attention would result in: <ul style="list-style-type: none">• serious jeopardy to the health of the individual, or, with respect to a pregnant woman, to the health of the woman and her unborn child• serious impairment to bodily function• serious dysfunction to any bodily organ or part Examples of an emergency include <ul style="list-style-type: none">• chest pain or other signs of a heart attack• shortness of breath and/or difficulty breathing• loss of consciousness, convulsions or seizures• sudden onset of a severe and unexplained headache• sudden weakness on one side of your body

- poisoning
- broken back, neck or other bones
- drug overdose
- significant loss of blood
- severe allergic reaction
- severe burn

Examples of non-emergencies are colds, flu, sore throat, medication refills, and using the emergency room for your convenience for medical conditions that could be treated in your doctor's office.

Physician Visits are not subject to the Annual Deductible.

Second Opinions Second opinions on the necessity of surgery or other treatment are fully covered without copayment.

Prior authorization is required for second opinions rendered by out of state providers.

Second Opinions are not subject to the Annual Deductible.

Consultations Covered, when requested by your attending physician. If you are hospitalized we will only pay for one Consultation for each specialty for each confinement

Follow-up visits by consultants are covered if we determine that additional visits are Medically Necessary.

Consultations are not subject to the Annual Deductible.

D. SURGICAL SERVICES

General Covered Surgical Services include operating room, surgical supplies, drugs, dressings, anesthesia services and supplies, oxygen, antibiotics, and blood transfusion services in an inpatient or outpatient facility

Assistant Surgeon Covered, but only when:

- assistance is Medically Necessary based on the complexity of the surgery; and
- the facility does not have a residency or training program; or
- the facility has a resident or training program, but a resident or intern on staff is not available to assist the surgeon

Cutting Surgery Covered, including pre-operative and post-operative care. Preoperative and postoperative care provided in connection with surgical procedures is included in the eligible charge for the surgery

If a physician charges separately for the preoperative and postoperative care in excess of this single eligible charge, we will not pay the excess charges.

Non-Cutting Surgery Covered

Examples of non-cutting surgical procedures include: diagnostic and endoscopic procedures; diagnostic and therapeutic injections; orthopedic castings; acne treatment; and destruction of localized lesions by chemotherapy (excluding silver nitrate), cryotherapy or electrosurgery.

Reconstructive Surgery

Covered, but only for corrective surgery required to restore or correct any bodily function that was lost, impaired or damaged as a result of an illness or injury

Reconstructive surgery to correct congenital anomalies (defects present from birth) is covered only if the anomaly severely impairs or impedes normal, essential bodily functions.

Reconstructive surgery requires **Prior Authorization**. Please refer to Section 7: Health Care Services Program for information on prior authorization.

Following mastectomy, reconstruction of the breast, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses are covered.

Reconstructive or plastic surgery that is intended to improve your appearance and is unrelated to an injury, illness, or physical or birth defect is considered cosmetic and is not covered. Services related to complications of non-covered reconstructive surgery are also not covered.

Additional Notes

- **Prior Authorization Requirements**

Certain surgical procedures must receive **Prior Authorization** from us before they are performed (see Section 7: Health Care Services Program)

- **Multiple Surgical Services**

When multiple surgical services are performed at the same time, we will pay full benefits for the primary surgical service. Benefits for the secondary surgical service will be paid only when UHA determines that the secondary surgical service was necessitated by the complexity and risk of the primary surgical service. If benefits are determined to be payable, allowances for the secondary Surgical Services will be based on the additional complexity and risk.

- **Oral Surgery**

Benefits are available for certain oral Surgical Services provided by a physician or a dentist.

Services of a dentist (D.D.S. or D.M.D.) are covered services only when:

- (a) the dentist is performing emergency service (for an accidental injury) or Surgical Services, and
- (b) these covered services could also be performed by Physicians (M.D. or D.O.)

Dental services that are generally done only by dentists and not physicians are not covered services. This includes services such as orthodontia; dental splints and other dental appliances; dental prostheses; osseointegration; removal of impacted teeth; and any other dental procedure involving the teeth, structures supporting the teeth, and gum tissues. In addition, any services in connection with the diagnosis or treatment of temporomandibular joint (TMJ) problems or malocclusion (misalignment of teeth or jaws) are not covered. These exclusions apply regardless of the symptoms or illnesses being treated.

Benefits are available if you have a medical problem, such as hemophilia, that makes hospitalization necessary for you to safely receive dental services or when the oral surgery itself requires hospitalization.

- **Payment Based**

If you choose to have a surgery as an inpatient in a hospital or other facility when it could have

on Appropriate Place for Surgery been done safely and effectively in a physician's office or in an outpatient surgical center, the Benefits we pay shall not exceed those for surgery in a physician's office or surgical center, whichever is most appropriate. Similarly, if you choose to have a surgery in a surgical center when it could have been done safely and effectively in a physician's office, the Benefits we pay shall not exceed those for surgery in a physician's office.

- "Stand By" Time The services of another physician may be necessary during a surgery so that the physician must "stand by" at the Hospital. In this case, Benefits will be paid for covered services that this physician actually provides, but no payment will be made for the waiting or "stand by" time.

E. HOSPITAL SERVICES

General Inpatient hospital services are covered up to 365 days per calendar year

Prior Notification When and if you require hospital care, the hospital facility and your participating physician have a responsibility to notify UHA of your admission. This is important as UHA's Health Care Services Department reviews all hospital admissions concurrently on your behalf to determine if the level of care being provided is appropriate, the quality of care you are receiving meets predetermined standards and to participate in discharge planning.

If you have elected to receive your care from a Non-Participating provider, you become primarily responsible for this prior notification to UHA.

Hospital Room and Board Covered, including:

- room and board based on the participating facility's semi-private medical/surgical room rate, unless a private room is authorized by UHA. If the facility does not have semi-private rooms, or is a non-participating facility, we will pay benefits based on our maximum allowable eligible charge for semi-private rooms. You will be responsible for your coinsurance on the eligible charge and any difference between our eligible charge for a semi-private room rate and the facility's room rate.
- special care units, such as intensive care, coronary care, isolation or intermediate telemetry unit
- operating room, labor room, delivery room and recovery room
- general nursing care

Hospital Ancillary Services Covered, including supplies, hospital anesthesia services and supplies, diagnostic and therapy services, dressings, oxygen, antibiotics and drugs including biologicals, special diets, and hospital blood transfusion services

Emergency Room Covered, but only if a prudent layperson could reasonably expect that the absence of immediate medical attention would result in:

- serious jeopardy to the health of the individual, or, with respect to a pregnant woman, to the health of the woman or her unborn child
- serious impairment to bodily function
- serious dysfunction to any bodily organ or part

Examples of an emergency include:

- chest pain or other signs of a heart attack
- shortness of breath and/or difficulty breathing

- loss of consciousness, convulsions or seizures
- sudden onset of a severe and unexplained headache
- sudden weakness on one side of your body
- poisoning
- broken back, neck or other bones
- drug overdose
- significant loss of blood
- severe allergic reaction
- severe burn

Examples of non-emergencies are colds, flu, sore throat, medication refills, and using the emergency room for your convenience for medical conditions that could be treated in your doctor's office.

If you require emergency services, you should call 911 or go to the nearest emergency room. Prior notification is not required.

If you are admitted to the hospital as an inpatient following a visit to the emergency room, hospital inpatient benefits apply, not emergency room benefits.

F. SKILLED NURSING FACILITY SERVICES

General	Skilled Nursing Facility services are covered up to 120 days per calendar year
Prior Authorization	If either a participating or a non-participating physician recommends that you be admitted to a skilled nursing facility, you or your physician must notify UHA's Health Care Services department and obtain Prior Authorization (see <u>Section 7: Health Care Services Program</u> for information on prior authorization)
Room and Board	Covered, but only at the eligible charge for a semi-private room
Ancillary Services	Covered, including routine supplies, prescribed drugs and medications, dressings, oxygen, diagnostic and therapeutic services
Limitations	Eligibility for skilled nursing facility services requires that all of the following be true: <ul style="list-style-type: none">• the facility meets Medicare standards• the admission is ordered by a physician• you need skilled nursing services and are under the care of a physician during the admission• we approve the admission• the admission is not primarily for comfort, convenience, a rest cure, or domiciliary care• if the stay exceeds 30 days, the attending physician submits a report showing the need for skilled nursing care at the end of each 30-day period• the confinement is not for custodial care

G. HOME HEALTH CARE AND HOSPICE SERVICES

Prior Authorization	Prior Authorization is required for home health care services (see <u>Section 7: Health Care Services Program</u> for information on prior authorization).
Home Health Care	<p>Covered, but only when all of the following statements are true:</p> <ul style="list-style-type: none">• home care services are prescribed in writing by a physician for the treatment of an illness or injury when you are homebound. Homebound means that due to an illness or an injury you are unable to leave home unless you use devices or have assistance from another person and you meet homebound standards defined by the federal Medicare program• part-time skilled health care services are required• home health care services are not more costly than other covered services that would be effective for the treatment of your condition• without home care, you would require inpatient hospital or skilled nursing facility care• if you need home health care services for more than 30 days, a physician certifies that there is further need for the services and provides a continuing plan of treatment at the end of each 30-day period of care• services do not exceed 150 visits per calendar year• services are provided by a qualified home care agency that meets Medicare requirements• we authorize home health care services
Hospice Services	<p>Covered, but only if services are received from a Medicare-approved Hospice program</p> <p>A hospice program provides care, generally in a home setting, for patients who are terminally ill and who have a life expectancy of six months or less. We follow Medicare guidelines in determining benefits, payment, level of care and eligibility for hospice services.</p> <p>Covered services include:</p> <ul style="list-style-type: none">• residential hospice room and board expenses directly related to the hospice care being provided• hospice referral visits during which a patient is advised of hospice care options, regardless of whether the referred person is eventually admitted to hospice care <p>The attending physician must certify in writing that the person is terminally ill and has a life expectancy of less than six months. While under hospice care, the terminally ill person is not eligible for benefits for the terminal condition except hospice services and attending physician office visits. The person is eligible for all covered benefits unrelated to the terminal condition.</p> <p><u>Hospice Services are not subject to the Annual Deductible.</u></p>

H. DIAGNOSTIC TESTING, LABORATORY AND RADIOLOGY SERVICES

Allergy Testing and Treatment Materials	<p>Covered, but for only one series of tests per calendar year</p> <p><u>Allergy Testing and Treatment Materials are not subject to the Annual Deductible.</u></p>
Diagnostic Testing	Covered, when related to an injury or illness

Examples of diagnostic testing include:

- electroencephalograms (EEG)
- electrocardiograms (ECG or EKG)
- Holter monitoring
- stress tests

Diagnostic Testing is not subject to the Annual Deductible.

Genetic Testing and Counseling Covered, but requires Prior Authorization (refer to Section 7: Health Care Services Program for information on prior authorization)

Laboratory and Pathology Covered, when related to an illness or injury. Additional benefits for routine and preventive laboratory tests are described in the “Specific Benefits” categories later in this Section

Outpatient Laboratory and Pathology are not subject to the Annual Deductible.

Radiology Covered, when related to an illness or injury. Additional benefits for routine and preventive radiology services are described in the “Specific Benefits” categories later in this section

Examples of radiology services are:

- computerized tomography scans (CT Scan)
- diagnostic mammography
- nuclear medicine procedures
- ultrasound
- x-rays

Some radiology services, such as PET scans, require Prior Authorization. Please refer to Section 7: Health Care Services Program for information on prior authorization.

I. CHEMOTHERAPY AND RADIATION THERAPY

Chemotherapy Covered

Prior Authorization is not required unless the recommended treatment plan does not conform to the current Compendia-Based Drug Bulletin. The Compendia-Based Drug Bulletin is published by the Association of Community Cancer Centers’ and is updated each February, May, August and November.

Radiation Therapy Covered

J. ORGAN TRANSPLANT SERVICES

Organ and Tissue Transplants Covered, but only as described in this Organ Transplant Services section

Prior Authorization is required for all transplants, except corneal.

In addition, transplant services must be provided by a facility that is under contract with us for that type of transplant and that facility must accept you as a candidate.

Benefits are not available for any of the following:

- artificial (mechanical) organs
- non-human organs
- organ or tissue transplants not listed in this Organ Transplant Services section

Transplant Evaluations

Covered, for transplants listed in this Guide, but only with our Prior Authorization

Transplant Evaluation means those procedures, including laboratory and diagnostic tests, consultations, and psychological evaluations that a facility uses in evaluating a potential transplant candidate.

Corneal Transplants

Covered

Bone Marrow Transplants

Covered, but only with our Prior Authorization (see Section 7: Health Care Services Program)

Benefits for bone marrow transplants are limited to autologous and allogeneic bone marrow transplants for the specified diseases or conditions listed in this Bone Marrow Transplants section. Benefits are not available for autologous and allogeneic bone marrow transplants for any other diseases or conditions.

The limited benefits specified for autologous and allogeneic bone marrow transplants are an exception to the exclusion for experimental or investigative procedures. This limited exception is not intended to, and does not operate as, a waiver of the exclusion for experimental or investigative procedures. This limited benefit is subject to all other conditions and provisions of this plan.

Autologous and Allogeneic Bone Marrow Transplants mean medical and/or surgical procedures composed of several steps or stages including, but not limited to:

- the harvest of stem cells from the blood or bone marrow of a third-party donor (“allogeneic”) or from the patient (“autologous”)
- processing and/or storage of the harvested stem cells
- the administration of high-dose chemotherapy and/or high-dose radiation therapy. **High-Dose Chemotherapy** and **High-Dose Radiation Therapy** are forms of therapy in which the dose and/or the manner of administration is expected to damage the patient’s bone marrow or suppress bone marrow function so that a bone marrow transplant is required or warranted.
- the infusion of harvested stem cells
- hospitalization, observation, and management of reasonably anticipated complications, such as graft versus host disease, infections, bleeding, organ or system toxicities, and low blood counts

This definition specifically includes transplants when the transplant component is derived from circulating blood instead of, or in addition to, harvest directly from the bone marrow. This definition further specifically includes all component parts of the procedure including, but not limited to, high-dose chemotherapy and/or high-dose radiation therapy.

Allogeneic bone marrow transplants are available only for treatment for the following conditions:

- acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia

- advanced stage Hodgkin’s disease
- advanced stage, intermediate-grade, or high-grade non-Hodgkin’s lymphoma
- advanced stage neuroblastoma
- chronic myelogenous leukemia that is in blast crisis or chronic phase
- gonadal germ cell tumors
- homozygous beta-thalassemia
- infantile malignant osteopetrosis
- lysosomal storage diseases
- myelodysplastic syndrome
- severe aplastic anemia
- severe combined immunodeficiency syndrome
- Wilm’s tumor
- Wiskott-Aldrich syndrome

Autologous bone marrow transplants are available only for treatment for the following conditions:

- acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia
- advanced stage Hodgkin’s disease
- advanced stage, intermediate-grade, or high-grade non-Hodgkin’s lymphoma
- advanced stage neuroblastoma
- gonadal germ cell tumors
- multiple myeloma
- Wilm’s tumor

Heart Transplants	Covered, but only with Prior Authorization (see Section 7: Health Care Services Program)
Heart and Lung Transplants	Covered, but only with Prior Authorization (see Section 7: Health Care Services Program)
Kidney Transplants	Covered, but only with Prior Authorization (see Section 7: Health Care Services Program)
Liver Transplants	<p>Covered, but only:</p> <ul style="list-style-type: none"> • with Prior Authorization (see Section 7: Health Care Services Program) • if contraindicators used by UHA are not present • the liver transplant is for a patient with end-stage liver disease due to (i) intrinsic disease of the liver, or (ii) disease caused by external agents, or (iii) systemic disease <p>Liver transplants for metastatic malignancies to the liver, or where Hepatitis B antigen or core antibody positive are present, are not covered.</p>
Lung Transplants	Covered, but only with Prior Authorization (see Section 7: Health Care Services Program)
Simultaneous Kidney/Pancreas Transplants	Covered, but only with Prior Authorization (see Section 7: Health Care Services Program)
Small Bowel and Multivisceral Transplants	Covered, but only with Prior Authorization (see Section 7: Health Care Services Program)

Organ Donor Services Covered, but only with **Prior Authorization** (see Section 7: Health Care Services Program) and when you are the recipient of the organ

No benefits are available under this plan if you are donating an organ to someone else.

This coverage is secondary and the living donor's coverage is primary in the situation when you are the recipient of an organ from a living donor and the donor's health coverage provides benefits for organ(s) donated by a living donor.

Benefits for the screening of donors are limited to the expenses of the actual donor. No benefits are available for screening expenses of candidates who do not become the actual donor.

K. MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

General

Mental health and substance abuse services are covered if all of the following are true:

- you are diagnosed with a condition listed within the current version of the Diagnostic and Statistical Manual of the American Psychiatric Association
- the services are provided under an individualized plan approved by us or our designee
- the services are provided by a licensed Psychiatrist, Psychologist, clinical social worker, mental health counselor, or advanced practice registered nurse
- you are physically present with the provider when the services are provided

Conditions such as epilepsy, senility, mental retardation, or other developmental disabilities, and addiction to and use of intoxicating substances, do not in and of themselves constitute a mental disorder. You are not covered for educational programs or other services performed by mutual self-help groups, even if you are referred to such groups by your provider or the judicial system.

Outpatient Mental Health or Substance Abuse Services

Covered, as follows:

- outpatient visits by a psychiatrist, psychologist, clinical social worker or advanced practice registered nurse for mental health or substance abuse conditions
- benefits for outpatient visits are limited to no more than 50 minutes per day. Outpatient psychological testing requires **Prior Authorization** (see Section 7: Health Care Services Program). Outpatient psychological testing & Physician Visits are not subject to the Annual Deductible.
- substance abuse services require **Prior Notification** (see Section 7: Health Care Services Program)

Inpatient Mental Health or Substance Abuse Services

Covered, as follows:

- facility days for mental health or substance abuse conditions. Inpatient care is limited to room and care and ancillary inpatient services. No additional benefits are available for intensive or special care psychiatric units.
- inpatient visits by a psychiatrist, psychologist, clinical social worker or advanced practice registered nurse for mental health or substance abuse conditions. Benefits are limited to no more than 50 minutes per day. Physician Visits are not subject to the Annual Deductible.
- substance abuse services require **Prior Notification** (see Section 7: Health Care Services Program)

Serious Mental Illness Services for serious mental illness, as defined by Hawaii law, such as schizophrenia, schizo-

affective disorder, bi-polar disorder, obsessive compulsive disorder, dissociative disorder, delusional disorder, and major depression are not subject to the mental health inpatient and outpatient limitations described above.

L. SPECIFIC BENEFITS FOR CHILDREN

Newborn Circumcision	Covered <u>Newborn Circumcision is not subject to the Annual Deductible.</u>
Newborn Care	Coverage is limited to the necessary services to treat medically diagnosed congenital defects and birth abnormalities of your newborn child Benefits for routine newborn care, nursery, circumcision, premature child care, and care for illness or injury are only available if you add your child to your coverage within 31 days of birth (see <u>Section 2: Eligibility and Enrollment</u>).

M. SPECIFIC BENEFITS FOR WOMEN

Family Planning Services	Covered, including abortion counseling and information on birth control
Tubal Ligation	Covered for only the initial surgery for tubal ligation. Reversal of a tubal ligation is not covered
Termination of Pregnancy	Covered
Contraceptives	Covered, for selected brands and generics determined by UHA in accordance with Hawaii law, but only when: <ul style="list-style-type: none">• prescribed by your physician (except for emergency contraceptives), and• you do not have a prescription drug plan <p>You may obtain a copy of UHA's Preferred Drug Listing by calling Member Services. The Listing also appears on our website at www.uhahealth.com.</p> <p>Benefit payment for contraceptives is limited to one contraceptive method per period of effectiveness. If you have a drug plan, there shall be no duplication or coordination of benefits between this plan and your drug plan.</p> <p>Copayments for contraceptives do not apply toward meeting the annual copayment maximum. Your UHA participating pharmacy or mail order copayment depends on which classification applies.</p> <p>You are not covered for contraceptive foams, creams, condoms, or other non-prescription substances or supplies used individually or in conjunction with any prescribed drug or device. If you have a drug plan, there shall be no duplication or coordination of benefits between this plan and your drug plan.</p>

Contraceptives are not subject to the Annual Deductible.

Emergency Contraceptives Covered, for selected brands and generics determined by UHA in accordance with Hawaii law, but only when obtained from a UHA participating pharmacy.

Emergency Contraceptives are not subject to the Annual Deductible.

N. SPECIFIC BENEFITS FOR MEN

Vasectomy Covered for only the initial surgery for a vasectomy. Reversal of a vasectomy is not covered

Erectile Dysfunction Covered for services, supplies, prosthetic devices, and injectables to treat erectile dysfunction

O. SPECIFIC BENEFITS FOR MEMBER AND COVERED SPOUSE

In Vitro Fertilization Covered to the extent required by Hawaii Law, but limited to one outpatient in vitro fertilization procedure while you are covered under any UHA medical benefit plan

Payment of benefits for an incomplete in vitro procedure counts as meeting the one-time only benefit limitation. In vitro fertilization services require Prior Authorization (See Section 7: Health Care Services Program).

In addition, the following limitations apply, subject to Hawaii law:

- (a) the in vitro fertilization is for you or your spouse
- (b) either of the following two statements is true:
 - you or your spouse has a history of infertility for at least five years
 - the infertility is associated with one of the following medical conditions: endometriosis; exposure in utero to diethylstilbesterol (DES); blockage of, or surgical removal of, one or both fallopian tubes (lateral or bilateral salpingectomy); or abnormal male factors contributing to the infertility
- (c) oocytes are fertilized with the spouse's sperm
- (d) you have been unable to attain a successful pregnancy through other infertility treatments
- (e) the in vitro fertilization procedures are performed at a medical facility that conforms to the American Society of Obstetrics and Gynecology guidelines for in vitro fertilization clinics or to the American Fertility Society minimum standards for programs of in vitro fertilization
- (f) hysterosalpingograms are not a covered benefit

P. SPECIFIC BENEFITS FOR DIABETES DRUGS, INSULIN AND SUPPLIES

Specific Benefits for Diabetes Drugs, Insulin and Supplies are not subject to the Annual Deductible and are available immediately.

Diabetes Drugs, Insulin, and Supplies Covered, but only when:

- prescribed by a health care professional authorized to prescribe the drug, insulin or supply,

and

- you do not have a prescription drug plan

If you have a drug plan, there shall be no duplication or coordination of benefits between this plan and your drug plan.

Diabetes drugs, insulin, and supplies can be Generic, Preferred Brand or Non-Preferred Brand. Your UHA participating pharmacy or mail order copayment depends on which classification applies.

Generic Drugs are drugs prescribed or dispensed under their generic (chemical) name rather than a brand name and which are not protected by a patent, or are drugs designated by us as generic. Generic drugs must be approved by the FDA as safe and effective.

Preferred Brand Drugs and insulin are brand name drugs or insulin identified as preferred by their inclusion in UHA's Preferred Drug Listing.

Non-Preferred Brand Drugs and insulin are brand name drugs and insulin that are not listed in the UHA Preferred Drug Listing.

You may obtain a copy of UHA's Preferred Drug Listing by calling Member Services. The Listing also appears on our website at www.uhahealth.com.

Covered diabetic supplies include lancets, syringes and needles, sugar test tablets, test strips, and blood glucose monitors.

Copayments for diabetic drugs, insulin or supplies do not count toward meeting your maximum annual copayment.

Diabetes Self-Management Education

Covered, through our Diabetes Education Program

Please contact the Health Care Services department for information about this program. Diabetes Self Management requires Prior Authorization (See Section 7: Health Care Services Program).

Diabetes Self Management Education is not subject to the Annual Deductible.

Q. COMPLEMENTARY ALTERNATIVE MEDICINE

Complementary Alternative Medicine Benefits are not subject to the Annual Deductible and are available immediately.

Services Provided by a Chiropractor or Acupuncturist

Covered, subject to the following:

- benefits are limited to treatment of conditions of the neuromusculoskeletal system
- providers of service must be licensed
- the plan pays 50% of the eligible charge for the first set of x-rays ordered by a participating Chiropractor. You are responsible for the balance of the eligible charge for the first set of x-rays and the full charge for any subsequent x-rays. The plan does not cover x-rays ordered by non-participating chiropractors.
- the total maximum benefit paid by the plan per calendar year is \$500 for combined services

provided by either participating or non-participating chiropractic and acupuncture providers

Complementary Alternative Medicine benefits are not subject to Annual Deductible requirements.

R. OTHER MEDICAL SERVICES

Ambulance

Covered, for ground and intra-island or inter-island air ambulance services to the nearest adequate hospital to treat your illness or injury, when all of the following apply:

- services to treat your illness or injury are not available in the hospital or skilled nursing facility where you are an inpatient
- transportation begins at the place where an injury or illness occurred or first required emergency care
- transportation ends at the nearest facility equipped to furnish emergency treatment
- transportation is for emergency treatment under circumstances where emergency room services would be covered (see Emergency Room section above)
- transportation takes you to the nearest facility equipped to furnish emergency treatment

Air ambulance Benefits are limited to inter-island and intra-island transportation within the State of Hawaii.

Appliances and Durable Medical Equipment

Covered, but only when prescribed by your physician and with **Prior Authorization** (see [Section 7: Health Care Services Program](#)) by us when cost is more than \$500. Examples include:

- hearing aids (one device per ear every five years)
- oxygen and rental of equipment for its administration
- rental of wheelchair and hospital-type bed
- charges for use of an artificial kidney machine, pulmonary resuscitator, and similar special mechanical equipment

Replacement appliances and equipment will be covered only when ordered by your physician, and when in our opinion the first or original one can no longer be used or repaired. UHA reserves the right to cover repair rather than replacement if in our opinion it is the more cost-effective option.

Benefit payment for the rental of appliances and medical equipment is limited to the amount it would cost to purchase the appliance or equipment.

Asthma Education

Covered, through our Asthma Education Program

Please contact the Health Care Services department for information about this program. Asthma Education requires **Prior Authorization** (See [Section 7: Health Care Services Program](#)).

Asthma Education is not subject to the Annual Deductible.

Bariatric Surgery

Covered, but requires **Prior Authorization** (see [Section 7: Health Care Services Program](#))

Blood and Blood Products

Covered, including blood costs, blood bank services, and blood processing

You are not covered for peripheral stem cell transplants except as described in this section under "Bone Marrow Transplants."

Dentists, Services of	<p>Covered, but only when the dentist is performing emergency or surgical services that could also be performed by a physician</p> <p>Refer also to the heading “Oral Surgery” under the category “Surgical Services” earlier in this Section.</p>
Dialysis and Dialysis Supplies	<p>Covered</p>
Evaluations for Hearing Aids	<p>Covered, but only when you receive the evaluation for the use of a hearing aid in the office of a physician or an audiologist</p> <p><u>Evaluations for Hearing Aids is not subject to the Annual Deductible.</u></p>
Growth Hormone Therapy	<p>Covered, subject to the limitations described below, but requires Prior Authorization (see <u>Section 7: Health Care Services Program</u>)</p> <p>Benefits are available only if human growth hormone therapy is replacement therapy for eligible persons up to age 18 to treat:</p> <ul style="list-style-type: none">• hypothalamic-pituitary axis damage caused by primary brain tumors, trauma, infection, or radiation therapy• Turner’s syndrome• growth failure secondary to chronic renal insufficiency awaiting renal transplantation• AIDS-wasting or cachexia without evidence of suspected or overt malignancy and where other modes of nutritional supplements (e.g., hyperalimentation, enteral therapy) have been tried• short stature due to growth hormone deficiency• neonatal hypoglycemia secondary to growth hormone deficiency• Prader-Willi Syndrome
Home Infusion Therapy	<p>Covered, for services and supplies for outpatient injections or intravenous administration of medication or nutrient solutions required for primary diet</p> <p><u>Home Infusion Therapy requires Prior Authorization (see Section 7: Health Care Services Program).</u></p>
Hyperbaric Treatment	<p>Covered, but only with Prior Authorization</p>
Implants	<p>Covered, for surgical implants like pacemakers, stents, and screws</p>
Inhalation Therapy	<p>Covered</p>
Injectable Medications	<p>Covered, for outpatient services and supplies for the injection or intravenous administration of medication or nutrient solutions required for primary diet, and travel immunizations in accord with the guidelines set by the Advisory Committee on Immunization Practices (ACIP)</p> <p>Some injections require Prior Authorization (see <u>Section 7: Health Care Services Program</u>).</p>
Medical Foods	<p>Medical foods and low protein modified food products are covered when prescribed for the</p>

treatment for an inborn error of metabolism in accord with Hawaii law.

Copayments for medical foods do not apply toward meeting the maximum annual copayment.

**Ophthalmologists,
Services of**

Services provided by ophthalmologists are divided into two categories:

- services for the treatment of medical conditions, such as glaucoma
- services for vision care, such as eye refraction examinations, aniseikonic studies and prescriptions, prescription eyeglasses or contact lenses

This medical plan covers services provided by Ophthalmologists only for medical conditions. Services for vision care are not covered by this plan. If your employer offers vision care benefits, please refer to your vision plan brochure for specific information about those additional benefits.

Orthotics

Covered, but only when prescribed by your physician. Foot orthotics are not covered except for certain diabetic conditions

Orthotics require Prior Authorization (see Section 7: Health Care Services Program).

**Physical and
Occupational Therapy**

Covered, but only when all of the following are true:

- the therapy is ordered by a Physician under an individual treatment plan
- the therapy is for restoration of musculoskeletal function that was lost or impaired by injury or illness
- the therapy can be reasonably expected to improve the patient's condition through short-term care. Long-term maintenance therapy and group exercise programs are not covered.
- the therapy is provided by a registered physical therapist (R.P.T.)
- the services receive **Prior Authorization** after the first 40 units (1 unit = 15 minutes) or 10 sessions (see Section 7: Health Care Services Program)

Group exercise programs are not covered.

Services of a registered occupational therapist (O.T.R.) are covered if the services could also be performed by a registered physical therapist (R.P.T.). Occupational therapy is limited to services to achieve and maintain improved self-care and other customary activities of daily living. Occupational therapy supplies are not covered.

Physical and Occupational Therapy is not subject to the Annual Deductible.

Prosthetics

Covered, but only when prescribed by your physician.

Examples of prosthetics are artificial limbs and eyes. Prosthetics require **Prior Authorization** (see Section 7: Health Care Services Program) by us when cost is more than \$500.

Vision appliances are covered subject to limitations for certain medical conditions, such as following cataract surgery.

Speech Therapy

Speech therapy is covered when all of the following are true:

- the therapy is ordered by a physician under an individualized treatment plan
- the therapy is necessary to restore speech or hearing function which was lost or impaired by illness or injury
- the therapy is received from a speech therapist holding a Certificate of Clinical Competence

- from the American Speech and Hearing Association
- the services are reasonably expected to improve the patient's condition through short-term care. (Long term maintenance programs are not covered.)
 - the therapy is not for a child with developmental learning disabilities or developmental delay
 - the services receive **Prior Authorization** (see Section 7: Health Care Services Program)

Speech Therapy is not subject to the Annual Deductible.

SECTION 6: SERVICES NOT COVERED

Your medical benefits plan does not provide benefits for those procedures, services or supplies that are listed in this section. Each of the procedures, services and supplies listed below are excluded from your plan.

Even if a service or supply is not specifically listed as an exclusion, it will not be covered unless it is described as a Covered Benefit in [Section 5: Description of Benefits](#) and it meets all of the criteria for payment listed in [Section 7: Health Care Services Program](#). If you have any questions about whether a specific procedure, service or supply is a Covered Benefit, please contact us (see Page 1) and we will assist you.

Experimental or Investigative Treatment

You are not covered for medical treatments, procedures, drugs, devices, or care, and all related services and supplies, which are experimental or investigational. Treatment is experimental or investigational if:

1. the drug or device cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration (FDA) and approval for marketing has not been given at the time the drug or device is furnished; or
2. the drug, device, medical treatment, or procedure, or the patient informed consent document utilized with the drug, device, treatment, or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review and approval; or
3. Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of ongoing phase I or phase II clinical trials, is for the research, experimental, study, or investigational arm of ongoing phase III clinical trials, or is otherwise not known to be safe and effective for treating your injury, illness or disease; or
4. reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety, efficacy or efficacy compared with a standard means of treatment or diagnosis.

Reliable evidence shall mean only:

- published reports and articles in authoritative medical and scientific literature
- the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure
- the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

You are also not covered for the diagnosis and treatment of any complications as a result of previous experimental or investigative services not covered under this Agreement, regardless of how long ago such services were performed.

Dental Services

You are not covered for dental services except those services listed in [Section 5: Description of Benefits](#) under the heading "Oral Surgery." This exclusion applies to dental services generally done only by dentists and not by physicians and includes:

- orthodontia
- dental splints and other dental appliances
- dental prostheses
- maxillary and mandibular implants (osseointegration) and all related services
- removal of impacted teeth
- any other procedures involving teeth, structures supporting the teeth, or gum tissues

- any services in connection with the diagnosis or treatment of temporomandibular joint (TMJ) problems or malocclusion of the teeth or jaw regardless of the reason.

Drugs

You are not covered for prescription drugs except as stated in Section 5: Description of Benefits.

**Vision Services,
Eyeglasses and Contacts**

You are not covered for vision services, including eyeglasses and contacts, except as stated in Section 5: Description of Benefits. You are not covered for:

- eyeglass and contact lenses
- sunglasses
- frames
- prescription inserts for diving masks or other protective eyewear
- non-prescription industrial safety goggles
- exams for a fitting or prescription, including eye refraction
- refractive eye surgery to correct visual acuity problems
- vision training
- aniseikonic studies and prescriptions
- reading problem studies or other procedures determined to be unusual

**Cosmetic or Reconstructive
Services, Supplies or
Procedures**

You are not covered for cosmetic or reconstructive services, supplies or procedures that are primarily intended to improve your natural appearance but do not restore or materially improve a physical function. This exclusion applies to cosmetic or reconstructive services for a psychological or psychiatric reason. You are not covered for reconstructive surgery or services to correct congenital abnormalities (defects present from birth), unless the anomaly severely impairs or impedes normal, essential bodily functions.

You are not covered for breast reduction surgery, breast implants (except following mastectomy for cancer), labioplasty, or rhinoplasty. You are not covered for excision of superficial benign tumors of the skin and subcutaneous tissue.

You are also not covered for the diagnosis and treatment of any complications as a result of previous cosmetic or reconstructive services not covered under this Agreement, regardless of how long ago such services were performed.

Counseling Services

You are not covered for any of the following counseling services:

- bereavement counseling or services of volunteers or clergy
- marriage or family counseling or other training services
- sexual identification counseling

Fertility/Infertility

You are not covered for services or supplies related to the diagnosis of infertility.

You are not covered for hysterosalpingography.

Except as described in Section 5: Description of Benefits under "Special Benefits for Member and Covered Spouse," you are not covered for services and supplies related to the treatment of infertility. This exclusion includes but is not limited to:

- collection, storage and processing of semen
- ovum transplants
- gamete intrafallopian transfer (GIFT)

- zygote intrafallopian transfer (ZIFT)
- services related to conception by artificial means

Reversal of Sterilization

You are not covered for reversal of sterilization.

Organ Transplant and Donor Services

You are not covered for:

- organ donor services if you are the organ donor
- any expenses of transporting a living donor
- mechanical or non-human organs and services related to them
- the purchase of any organ
- transplant services or supplies or related services or supplies except as described in Section 5: Description of Benefits under “Organ Transplants Services.” Related Transplant Supplies are those that would not meet payment criteria but for your receipt of the transplant, including and without limitation, all forms of bone marrow or peripheral stem cell transplants.

Exclusions by Type of Provider

You are not covered for services or supplies provided by the following types of providers:

- a provider who is a member of your immediate family, meaning a parent, child or spouse
- a private duty nurse
- a social worker (this exclusion does not apply to appropriately licensed clinical social workers providing covered mental health and substance abuse services)
- a massage therapist
- a naturopath

Emergency Room Visits for Non-Emergencies

You are not covered for any of the costs of care arising from an emergency room visit if your condition does not meet “emergency” standards as defined in Section 5: Emergency Room.

When Someone Else Is Responsible For Payment

You are not covered when someone else, including but not limited to any federal, state, territorial, municipal, or other government instrumentality or agency, has the legal obligation to pay for your care, and when, in the absence of this Agreement, you would not be charged.

You are not covered for treatment of illness or injury related to military service when you receive treatment in a facility operated by an agency of the United States government. You are not covered for services or supplies that are required to treat an illness or injury received while you were on active status in the military service.

You are not covered for services or supplies for an injury or illness for which you are entitled to receive disability benefits or compensation (or forfeit your rights thereto) under any Worker’s Compensation or Employer’s Liability Law, or entitled to receive Personal Injury Protection payment under a no-fault motor vehicle policy.

For more information on Third Party Liability, refer to Section 10: Coordination of Benefits and Third Party Liability.

Miscellaneous Exclusions

- Airline Oxygen
- Biofeedback

You are not covered for airline oxygen

You are not covered for biofeedback or any related diagnostic testing

- **Bionic Devices** You are not covered for Bionic Devices or related services
- **Complications of a Non-Covered Treatment or Procedure** You are not covered for complications of a non-covered treatment or procedure
- **Custodial Care** You are not covered for custodial care, sanatorium care, or rest cures provided in a hospital, skilled nursing facility, or other facility

Custodial care consists of training in personal hygiene, routine nursing services, and other forms of personal care, such as help in walking, getting in and out of bed, bathing, dressing, eating and taking medicine. Also excluded are supervising services by a physician or a nurse for a person who is not under specific medical, surgical, or psychiatric treatment to improve that person's condition and to live outside a facility providing this care.
- **Effective Date** You are not covered for services or supplies that you receive before the effective date of this coverage, or after the effective date of termination of this coverage
- **False Statements** You are not covered for services or supplies obtained due to a false statement or other misrepresentation made in an application for membership or in any claims for benefits

If we pay such Benefits to you or a provider before learning of any false statement or other misrepresentation, you are responsible for reimbursing us.
- **Hair Loss and Baldness** You are not covered for services and supplies, including hair transplants and topical medications, for the treatment of male and female pattern hair loss or baldness
- **Miscellaneous Supplies** You are not covered for miscellaneous supplies billed separately by your provider

This includes but is not limited to gauze, batteries, surgical trays, diapers, and tape.
- **Motor Vehicles** This plan does not cover the cost of purchase or rental of motor vehicles, such as cars or vans, or the equipment and costs associated with converting a motor vehicle to accommodate a disability.
- **Personal Convenience Items** You are not covered for personal convenience items, such as air conditioners, dehumidifiers, home remodeling, hot tubs, ramps, or swimming pools
- **Physical Examinations** Physical examinations specifically for job-related or sports program-related purposes are not covered
- **Self-Help or Self-Cure** You are not covered for self-help and self-cure programs and equipment
- **Sexual Transformation** You are not covered for services and supplies related to sexual transformation regardless of the reason. This includes but is not limited to sexual transformation surgery
- **Stand-by Time** You are not covered for a provider's waiting or stand-by time
- **Travel or Lodging Costs** You are not covered for the costs of travel or lodging

- Wigs You are not covered for wigs

SECTION 7: HEALTH CARE SERVICES PROGRAM

Payment Determination Criteria	<p>In order for us to pay for a covered service, all of the following payment determination criteria must be met</p> <ul style="list-style-type: none">• the service must be listed as a covered benefit and not be excluded as a benefit by this Agreement• the service must be medically necessary for the diagnosis or treatment of your illness or injury• the service must be provided in an appropriate setting and at an appropriate level of care• when required under this plan, the service must be Prior Authorized and consistent with our Guidelines for prior authorizations
The Health Care Services Department	<p>The fact that a physician or other provider may prescribe, order, recommend, or approve a service or supply does not in itself mean that the service or supply meets these payment criteria, even if the service or supply is listed as a covered service in this Agreement.</p> <p>It is the responsibility of the Health Care Services department to determine if a recommended service:</p> <ol style="list-style-type: none">1. is medically necessary, and2. is being provided in an appropriate setting and at an appropriate level of care
Medically Necessary	<p>This plan pays benefits for services that are covered benefits under the member's health plan and that are medically necessary.</p> <p>In making the determination of medical necessity, UHA follows the definition established in Hawaii Revised Statutes (sect. 432E-1.4):</p> <p>“(a) For contractual purposes, a health intervention shall be covered if it is an otherwise covered category of service, not specifically excluded, recommended by the treating licensed health care provider, and determined by the health plan's medical director to be medically necessary as defined in subsection (b). A health intervention may be medically indicated and not qualify as a covered benefit or meet the definition of medical necessity. A managed care plan may choose to cover health interventions that do not meet the definition of medical necessity.</p> <p>(b) A health intervention is medically necessary if it is recommended by the treating physician or treating licensed health care provider, is approved by the health plan's medical director or physician designee, and is:</p> <ol style="list-style-type: none">(1) For the purpose of treating a medical condition;(2) The most appropriate delivery or level of service, considering potential benefits and harms to the patient;(3) Known to be effective in improving health outcomes; provided that:<ol style="list-style-type: none">(A) Effectiveness is determined first by scientific evidence;(B) If no scientific evidence exists, then by professional standards of care; and(C) If no professional standards of care exist or if they exist but are outdated or contradictory, then by expert opinion; and(4) Cost-effective for the medical condition being treated compared to alternative health interventions, including no intervention. For purposes of this paragraph, cost-effective shall not necessarily mean the lowest price.”

Health Care Services Tools To assure to the extent possible that a recommended service is medically necessary and will be or has been provided at an appropriate site, UHA utilizes three levels of case review and management: concurrent review, **Prior Authorization** and retrospective review. All participating providers agree to cooperate with UHA in its efforts to make these determinations on your behalf. To be successful we need your cooperation.

Prior Notification of hospital admissions and concurrent review To work effectively, UHA must be aware of services recommended by your provider that require hospitalization, that are likely to require ongoing care after discharge and which may require services or supplies to facilitate discharge from the hospital.

Once UHA is made aware of a member's hospitalization, Health Care Services Nurses monitor your care, concurrently assisting with discharge planning and case management. In order for this review process to work for your benefit, UHA requires that you or your providers notify the Health Care Services Department:

- at least 72 hours in advance of elective admission to a hospital, skilled nursing facility, rehabilitation facility, or hospice program
- for provision of any Substance Abuse Services

If you are under the care of a non-participating provider, you are responsible for providing Prior Notification.

Prior Authorization Prior authorization is a special pre-approval process to ensure that certain treatments, procedures, or supplies are medically necessary covered services that will be provided in an appropriate setting.

In determining whether to provide prior authorization, we may use guidelines that include clinical standards, protocols, or criteria regarding treatment of specific conditions or providing certain services or supplies. If you are requesting prior authorization and want a copy of any Guidelines that we use for a particular condition or treatment, contact our Health Care Services department at the address below.

Those services that require prior authorization are listed below. If you are under the care of a UHA participating provider, he or she should obtain our prior authorization for you and he or she will accept any penalties for failure to obtain authorization. If you are under the care of a non-participating provider, you are responsible for obtaining prior authorization. If you do not obtain prior authorization, benefits may be denied.

Penalties for not obtaining prior authorization do not apply toward meeting the maximum annual copayment.

How to Obtain Prior Authorization Prior authorization may be requested by writing or faxing the request to UHA's Health Care Services department at:

UHA
Health Care Services Department
700 Bishop Street, Suite 300
Honolulu, HI 96813-4100

Phone: 532-4006 (or 1-800-458-4600, extension 300, from the neighbor islands)
Fax: (808) 535-5972

The Health Care Services department is open from 8:00 a.m. to 4:00 p.m. Monday through Friday.

Prior Authorization Request forms may be downloaded from our website:
www.uhahealth.com.

If you submit a request without use of this form, your request for prior authorization must include the following information:

- member name, address, birthdate, and UHA member number
- requesting provider's name, specialty, phone and fax numbers
- information about the member's other health insurance, if any
- name of the provider of requested service
- name of the facility where the requested service will be performed
- diagnoses, procedures, and supporting medical information
- information whether the member's condition is employment- or automobile-related
- if the prior authorization is for a drug override: the name of the drug and the reason for the override
- provider acknowledgment that the requested service meets the definition of Medically Necessary as specified in the glossary of this Guide

You must provide sufficient information to allow us to make a decision regarding your request. If you do not provide the information we request, or if the information you provide does not show entitlement to coverage under this Plan, your request may be denied.

If you want to designate a representative to make a request for prior authorization on your behalf, you may do so by filing an Authorization For Release of Information form with us. Contact us at the phone number above for an authorization form. If a healthcare provider with knowledge of your condition makes a request for an expedited decision on your behalf, we do not require an Authorization For Release of Information form from you.

Our Decision on your Request

We will make a decision on your request for prior authorization within 15 days of receipt of your request.

This period may be extended if you fail to submit information necessary for us to determine your request, and in that event we will tell you what additional information we need and will provide you at least 45 days after our notice to provide us the additional information. We may also extend this period one time for up to 15 days, if the extension is necessary for reasons beyond our control, and in that event we will notify you of the circumstances warranting extension and the date by which we plan to render a decision. If we denied the request or any part of it, we will provide an explanation, including the specific reason for denial and reference to the health plan terms on which our denial is based. If you disagree with our denial, you may file an appeal in accordance with the appeal procedures in Section 9.

If your health or ability to regain maximum function could be seriously harmed by waiting 15 days for a decision, then you or your provider may make a request for an expedited decision on prior authorization. If we find, or your treating physician states, that your health or ability to regain maximum function could be seriously harmed by waiting 15 days for a decision, then we will make a decision within 72 hours of receipt of your request for an expedited decision

and all required information.

You may make your request for an expedited review orally or in writing at the contact information listed above. The information we require to process your request includes the same information as required on our Prior Authorization Request form, as described above. If you qualify for an expedited decision but we do not have sufficient information on which to make an expedited decision, we will inform you within 24 hours of our receipt of your request and will provide you at least 48 hours to provide us the required information.

The following Table summarizes UHA’s prior authorization requirements. These requirements are subject to change. You may contact UHA’s Health Care Services department at 532-4006 (or 1-800-458-4600, extension 300, from the neighbor islands) for the most current list, or review the list on our website at www.uhahealth.com.

Note: Penalties for not obtaining Prior Authorization do not apply toward meeting the Maximum Annual Copayment.

Service Requiring Prior Authorization	Action Required
Ambulatory Surgery proposed to be done in an inpatient setting.	Notify UHA 72 hours in advance
Arthroscopic debridement & lavage of knee	Notify UHA 72 hours in advance
Asthma Self Management Education	Notify UHA 72 hours in advance
Bariatric Surgery	Notify UHA 72 hours in advance
Central Dexa Scans – for ages up to and including 64	Notify UHA 72 hours in advance
Diabetes Self Management Education	Notify UHA 72 hours in advance
Durable medical equipment with cost more than \$500 and all rentals	Notify UHA 72 hours in advance
Genetic Testing and Counseling	Notify UHA 72 hours in advance
Home Health Services (including infusion services)	Notify UHA 72 hours in advance
Hyperbaric Treatment	Notify UHA 72 hours in advance
In vitro Fertilization services	Notify UHA 72 hours in advance
Injectable Medications <ul style="list-style-type: none"> • Anti IgE Antibody including but not limited to Xolair • Anti-Tumor Necrosis Factor (TNF) including but not limited to: Enbrel, Humira, Raptiva, and Remicade • Anti-viral agents including but not limited to RespiGam, Synagis, and Fuzeon • Botulinum Toxin – Type A (Botox) • Erythrocyte and Granulocyte Stimulating Factors including but not limited to: Aranesp, Eprex, Epogen, Procrit, Neupogen, and Neulasta • Growth Hormone (Somatropin) including but not limited to Genotropin, 	Notify UHA 72 hours in advance

Service Requiring Prior Authorization	Action Required
<p>Genotropin Miniquick, Humatrope, Norditropin, Nutropin, Nutropin AQ, Nutropin Depot, Saizen, Serostim</p> <ul style="list-style-type: none"> • Leuprolide acetate (Lupron) • Oncological agents not listed in Compendia-Based Drug Bulletin as an indication for treatment of specific neoplasms. The Compendia-Based Drug Bulletin is published by the Association of Community Cancer Centers' and is updated each February, May, August and November. • Parathyroid hormone including but not limited to Forteo 	
Nutritional Programs	Notify UHA 72 hours in advance
Occupational Therapy (requires prior authorization after the first 40 units or 10 sessions: 1 unit = 15 minutes).	Notify UHA 72 hours in advance
Office Surgery proposed to be done in an Ambulatory (Outpatient) Surgery Center	Notify UHA 72 hours in advance
<p>Organ Transplantation services:</p> <ul style="list-style-type: none"> • Transplant evaluations • Organ donor services • Transplant procedures 	Notify UHA 72 hours in advance
Orthotics	Notify UHA 72 hours in advance
Out-of-State Referrals	Notify UHA at least 2 weeks in advance
Outpatient Psychological Testing	Notify UHA 72 hours in advance
PET scans	Notify UHA 72 hours in advance
Physical Therapy (requires prior authorization after first 40 units or 10 sessions: 1 unit = 15 minutes).	Notify UHA 72 hours in advance
Prosthetics with cost more than \$500.	Notify UHA 72 hours in advance
Reconstructive Surgery	Notify UHA 72 hours in advance
Second Opinions	Notify UHA 72 hours in advance
Skilled Nursing Facility – Room and Board	Notify UHA 72 hours in advance
Smoking Cessation Program	Notify UHA 72 hours in advance
Speech Therapy	Notify UHA 72 hours in advance
Stereotactic radiosurgery (e.g. gamma ray radiosurgery or gamma knife, X-knife)	Notify UHA 72 hours in advance

Service Requiring Prior Authorization	Action Required
Elective hospital admissions	Notify UHA 72 hours in advance
Pregnancies during first trimester	Notify UHA as soon as a pregnancy has been determined, and if the pregnancy is at high risk for complications
Chemical dependency/Substance abuse treatment	Notify UHA 72 hours in advance

Retrospective Review

All claims for reimbursement are subject to retrospective review to determine if the services provided were:

- covered benefits,
- medically Necessary, and
- provided in an appropriate setting at an appropriate cost, and
- for a person properly eligible to receive benefits under this Agreement.

This includes claims for services provided in an Emergency Department. To determine if these visits were appropriate UHA uses the “prudent lay person” standard as defined in Hawaii Revised Statutes (sect. 432E-1):

Emergency room visits are covered benefits if: “a prudent layperson could reasonably expect that the absence of immediate medical attention would result in:

- serious jeopardy to the health of the individual, or, with respect to a pregnant woman, to the health of the woman or her unborn child;
- serious impairment to bodily function; or
- serious dysfunction to any bodily organ or part.”

If it is determined that an emergency room visit does not meet this standard, payment for these benefits will be denied. In this circumstance, members may be billed by the provider for payment for those services.

Special Programs

UHA sponsors special programs designed to improve the health of members with chronic illnesses. These programs combine various components, including patient education and monitoring to assist with compliance with treatment programs. We currently provide special programs for members with diabetes or asthma.

UHA also offers expectant mothers an obstetrical management program designed to improve outcomes, reduce complications of pregnancy, and improve quality of care.

For information about these programs, please call our Health Care Services Department. Information is also available on our website at www.uhahealth.com.

We may add, change or terminate programs at any time.

SECTION 8: FILING CLAIMS FOR PAYMENT

Filing Claims

When you receive services from any provider, be sure to show them your UHA Identification Card.

When you visit a UHA Participating Provider, the provider will file a claim for payment on your behalf. We will send payment to the provider and we will send you an Explanation of Benefits (EOB).

When you visit a **Non-Participating Provider**, the provider may file a claim on your behalf or give you the claim to file with UHA. We will send payment to you along with an EOB. The provider of service must sign the claim form.

In no event will the amount we pay to a non-participating provider exceed the amount which we would pay to a comparable Participating Provider for like services rendered.

If we require any additional information, such as medical records or reports, in order to process the claim, we will request the information from the provider. We will not pay the claim unless we receive all necessary information.

We will not pay claims for services that are not Covered Benefits or were not actually received.

If you have any questions after reading this section, please contact your personnel department, or call us. Our telephone number appears in the front of this guide.

Payment Determination Criteria

In order for us to pay for a covered service, all of the following payment determination criteria must be met:

- the service must not be excluded as a benefit by this plan
- the service must be Medically Necessary for the diagnosis or treatment of your illness or injury
- the service must be provided in an appropriate setting and at an appropriate level of care
- when required under this plan, the service must be Prior Authorized

The fact that a physician or other provider may prescribe, order, recommend, or approve a service or supply does not in itself mean that the service or supply meets these payment criteria, even if the service or supply is listed as a covered service in this Agreement.

Information Required on a Claim

Any claim for services submitted to us for payment must include the following information:

- your subscriber number, which appears on your membership Identification Card
- the provider's full name and address
- the patient's name
- the date(s) services were received
- the date of injury or beginning of an illness
- the charge for each service (in U.S. currency)
- a description of each service (UHA uses the nationally accepted CPT-4 and HCPCS procedure codes)
- a diagnosis or type of illness or injury (UHA uses the nationally accepted ICD-9 diagnostic codes)
- the location where you received the service (office, outpatient center, hospital, etc.)

- if applicable, information about any other health coverage you have

The provider's signature must be on the claim. The claim must be in English. Receipts are not acceptable. We have a right to require that you provide sufficient information to allow us to make a decision regarding your claim. If you do not provide the information we request, or if the information you provide does not show entitlement to coverage under this Plan, your claim may be denied.

To be eligible for payment, service codes must conform to nationally accepted coding standards.

Where to Send Claims

Claims should be sent to:
UHA
700 Bishop Street, Suite 300
Honolulu, HI 96813

Late Claims

Claims should be submitted to us as soon as possible after the date of service. All claims for payment for services must be filed with UHA within one year of the date of service. We will not make payment on any claim received more than one year after the date on which you received the service.

Explanation of Benefits

We will mail you an Explanation of Benefits (EOB) after your claim has been processed. The EOB tells you how we processed the claim, including the services performed, the amount charged, our eligible charge, the amount we paid, and the amount, if any, that you owe. If we denied the claim or any part of it, the EOB will provide an explanation for the denial.

Be sure to keep your EOB for filing with your secondary insurance carrier when applicable.

If you have any questions about your EOB, or think that we made an error in paying a claim, please call or write to Member Services (see page 1). If after contacting Member Services you are not satisfied and think that we made an error in determining benefits or paying your claim, you may request a formal review by writing to us. Please refer to Section 9: If You Disagree With Our Decision for information on how to file an appeal.

SECTION 9: IF YOU DISAGREE WITH OUR DECISION

If You Are Dissatisfied or Believe We Made A Mistake If for any reason you are dissatisfied with the services you receive under this plan or if you believe that we incorrectly denied a claim, paid an incorrect amount, incorrectly determined that a service is not a Covered Benefit, contact Member Services and explain your concern (see page 1). We will investigate and attempt to respond to your concern fairly and promptly.

Requesting a Formal Appeal If you are not satisfied with the response you receive from Member Services, you may appeal the decision by writing to:

Appeals Coordinator
UHA
700 Bishop Street, Suite 300
Honolulu, HI 96813-4100

The appeal must be filed within one year of the date that UHA first informed you of the denial or limitation of the claim or coverage for any requested service. The appeal should include the following information:

- the date of the request
- your name
- the date of service we denied or paid in error
- a description of the facts related to the appeal and why you believe our decision was in error
- any other documents relating to your appeal you would like us to review

Upon your written request to the address above, you may be provided:

- a free copy of documents and information relevant to your claims for payment, request for prior authorization, or to your appeal
- any rule, guideline, or protocol we relied upon in denying a claim for payment or request for prior authorization
- the identity of experts whose advice was obtained by us in connection with our denial of your claim for payment, request for prior authorization, or appeal

Who May Request an Appeal You or your designated representative may request an appeal. Designated representatives include:

- a provider
- a court-appointed guardian or agent under a health care proxy, or other person whom you designate to us in writing to represent you on your appeal (you must provide us documentation of any representative capacity with your appeal)

Appeal of Our Prior Authorization Decision We will respond to your appeal as soon as possible given the medical circumstances of your case but not later than 30 days after we receive your appeal.

Appeal of Any Other Decision

We will respond to your appeal within 60 days of our receipt of your appeal.

Expedited Appeals

You may request an expedited appeal:

1. for an acute or urgent condition
2. if the standard time (60 days) for completing an appeal would
 - a) seriously jeopardize your life or health
 - b) seriously jeopardize your ability to regain maximum functioning
 - c) subject you to severe pain that cannot be adequately managed without the care or treatment requested

Expedited appeals are appropriate when a denial affects care that is in progress or to be initiated. Expedited appeals do not apply to payment denials for services already rendered.

You may make your request for expedited appeal in writing to the Appeals Coordinator whose address is given above. You may also orally submit your request for expedited appeal to UHA's Health Care Services department by calling 808-532-4006 (or 1-800-458-4600, extension 300, from the neighbor islands).

If a health care provider with knowledge of your condition makes a request for an expedited appeal on your behalf, we do not require a written authorization from you.

If we determine, or your health care provider states, that the above standards for expedited appeal are met, we will respond to your request for expedited appeal within 72 hours.

Appeals Committee

UHA's Appeals Committee will review your appeal request. When necessary, we will obtain the opinion of outside experts not affiliated with UHA to advise the committee. We will notify you in writing of the decision within the time frames specified above. If special circumstances arise requiring additional days, we will notify you that additional days are needed to complete the review.

Our review on appeal will consider all information submitted by you (whether or not that information was submitted in your initial claim for payment or request for prior authorization), will use a different reviewer than the person who decided your original request, and will not give deference to the initial decision.

If our appeal decision denies your request or any part of it, we will provide an explanation, including the specific reason for denial, reference to the health plan terms on which our decision is based, a statement of your external review rights, and other information regarding our denial.

If You Disagree with Our Appeals Decision Regarding Medical Necessity

If UHA's Appeals Committee has denied a request for coverage based on medical necessity and you disagree with the decision, you may request external review of the decision by a physician reviewer selected by an independent review organization. The request must be in writing and must be received by UHA within 60 days from the date of the decision of UHA's Appeals Committee. The request should be submitted to:

Appeals Coordinator
UHA
700 Bishop Street, Suite 300
Honolulu, HI 96813-4100

UHA will pay for the services of the independent review organization and its physician reviewer if you make a timely request. The physician reviewer will be provided all information considered by the UHA Appeals Committee (including any prior submissions by you), your request for external appeal and any accompanying documentation you provided with your request, and any other documentation deemed pertinent by us. The physician reviewer will render a decision within 60 days of receipt of all information needed for the reviewer's decision. The physician reviewer's decision shall be binding on you and us as the medical necessity of the service in question, but not as to other disputes that may exist between us. If you elect to have review by a Physician Reviewer, then the parties waive their right to an arbitration, Insurance Commissioner's review, court or jury trial on the issue of medical necessity for the services in question.

Other Procedures for External Review

If UHA's Appeals Committee's decision was based on a determination other than one of medical necessity and you disagree with the decision, or if the Committee's decision was based on medical necessity but you elected not to request review by a physician reviewer from an independent review organization, you must either 1) request binding arbitration before a mutually selected arbitrator, or 2) file a lawsuit against UHA. If you are not enrolled in an employer sponsored group plan subject to ERISA, you have the additional option of requesting a review by a panel appointed by the Hawaii State Insurance Commissioner.

If you select arbitration, you must submit a written request for arbitration to:

Appeals Coordinator
UHA
700 Bishop Street, Suite 300
Honolulu, HI 96813-4100

Arbitration

Your request for binding arbitration will not affect your rights to any other benefits under this plan. You must have complied with UHA's appeals procedures as described above and we must receive your request for arbitration within one year of the decision of UHA's Appeals Committee. In arbitration, one person (the arbitrator) reviews the positions of both parties and makes the final decision to resolve the disagreement. The arbitration is binding and the parties waive their right to a court trial and jury.

Before arbitration actually starts, both parties (you and we) must agree on the person to be arbitrator. If we both cannot agree within 30 days of your request for arbitration, either party may ask a court of appropriate jurisdiction to appoint an arbitrator. There shall be no consolidation of parties in arbitration.

The arbitration hearing shall be in Hawaii. The questions for the arbitrator shall be whether we were in violation of the law, or acted arbitrarily, capriciously, or in abuse of our discretion. The arbitration shall be conducted in accord with the Hawaii Arbitration Act, HRS Chapter 658A, and the arbitration rules of Dispute Prevention and Resolution, to the extent not inconsistent with that Act or this Agreement.

The arbitrator will make a decision and will give both parties a copy of this decision. The decision of the arbitrator is final and binding and no further appeal or court action can be taken except as provided under the Hawaii Arbitration Act.

UHA will pay the arbitrator's fee. You must pay your attorney's and witness's fees, if you have

any, and we must pay ours. The arbitrator will decide who will pay all the other costs of the arbitration.

UHA waives any right to assert that you have failed to exhaust administrative remedies because you did not select arbitration.

**Request for Review by
Insurance
Commissioner**

If you are not in an employer sponsored group plan subject to ERISA, you may request review by a panel selected by the Hawaii State Insurance Commissioner. Requests must be submitted within 60 days of the date of the decision of UHA's Appeals Committee to the Insurance Commissioner at:

Hawaii Insurance Division
ATTN: Health Insurance Branch – External Appeals
335 Merchant Street, Room 213
Honolulu, HI 96813
Telephone: (808) 586-2804

If your request for review is accepted by the Commissioner, the Commissioner will appoint a three member panel composed of a representative from another health plan, a provider not involved in your care, and a representative from the Commissioner's office. State law provides that a hearing will be conducted within 60 days and the panel will issue a decision within 30 days of the hearing.

You may request expedited review by the Insurance Commissioner if application of the above time frames may:

- seriously jeopardize your life or health;
- seriously jeopardize your ability to regain maximum functioning; or
- subject you to severe pain that cannot be adequately managed without the care or treatment requested.

ERISA Rights

See Section 11: ERISA Information for further information about your rights if you are enrolled in an employer group plan governed by ERISA.

SECTION 10: COORDINATION OF BENEFITS & THIRD PARTY LIABILITY

Coordination of Benefits	<p>If you have other insurance coverage, for example through your spouse or Medicare, that provides benefits similar to those of this plan, we will “coordinate” the benefits of the two plans. When benefits are coordinated, the benefits paid under this plan, when combined with the benefits paid under your other coverage, will not exceed the lesser of:</p> <ul style="list-style-type: none">• 100% of the eligible charge• the amount payable by your other coverage plus any deductible and copayment you would owe if the other coverage were your only coverage <p>Any deductible and copayment you owe under this plan will first be subtracted from the benefit payment. You remain responsible for the deductible and copayment owed under this plan, if any.</p>
Your Responsibility	<p>When you enroll, please let us know on the enrollment form if you or your dependents have other coverage, which might include other group benefit plans, Medicare, or other governmental benefits. You should also inform us if this information changes by calling Member Services (see page 1).</p> <p>When you receive services, please be sure to inform the provider of any other insurance you may have. This may include automobile insurance or other insurance if you are being treated as a result of an injury.</p> <p>We may send you a letter asking about other insurance coverage before we pay a claim. If you do not respond, your claims may be delayed or denied.</p>
Our Responsibility	<p>We will coordinate benefits for you based on the information you provide. There are certain rules we follow to determine which plan pays first when there is similar coverage.</p>
General Rules	<p>Some general rules governing coordination of benefits are:</p> <ul style="list-style-type: none">• the coverage you have as an employee pays first before any coverage you have as a spouse or dependent• the coverage you have as an active employee pays before coverage you have as a retiree or under which you are not actively employed• when both coverages are group-sponsored plans and one plan has no coordination of benefits rules and the other does, the plan without coordination of benefits rules pays first• when no other rule applied, the coverage with the earliest continuous effective date pays first <p>The coverage that pays first is called “primary” and the coverage that pays second is called “secondary.”</p>
Rules for Children	<p>For a child who is covered by both parents who are not separated or divorced, the “birthday rule” applies, that is, the coverage of the parent whose birthday occurs first in a calendar year pays first.</p> <p>If the child’s parents are separated or divorced and a court decree says which parent has health insurance responsibility, that coverage pays first.</p> <p>If the child’s parents are divorced or separated and there is no court decree stipulating which parent has health insurance responsibility, the coverage of the parent with custody pays first. The</p>

payment order for this dependent child is as follows:

1. custodial parent
2. spouse of custodial parent
3. other parent
4. spouse of other parent

If none of these rules apply, the parent's coverage with the earliest continuous effective date pays first.

Automobile Coverage

For injuries from an automobile accident, the automobile insurance will be considered primary for payment, and those benefits will be applied first before any benefits of this plan apply. This plan will begin paying benefits after the personal injury protection mandatory coverage amount as specified by state law has been exhausted, whether or not the member has complied with the duty to obtain that coverage.

You are responsible for any cost-sharing payments required under any motor vehicle insurance coverage. This plan does not cover any personal injury protection cost sharing arrangements.

Before we pay benefits under this coverage for any motor vehicle accident-related injury, you must provide us a list of expenses paid by the motor vehicle insurance. This list must include the date the services were provided, the provider of each service, and the amount paid for each service by motor vehicle insurance. We will verify that any motor vehicle coverages have been exhausted. Covered services you received which exceed the personal injury protection mandatory coverage amount may then be eligible for payment in accord with this coverage.

Medicare Coordination Rules

If you have both this group coverage and Medicare, federal rules determine which plan pays first. These rules apply to the working aged, the disabled, or patients with end stage renal disease (ESRD). For the working aged and disabled, these rules take into consideration the employment status of the employee covered by the employer group health plan as well as the number of part-time and full-time employees of the employer group plan.

If your employer or group employs 20 or more employees and you are 65 or older and eligible for Medicare only because of your age, this coverage will pay before Medicare, as long as your coverage is based on your status as a current active employee or the status of your spouse as an current active employee.

If you are under age 65 and eligible for Medicare only because of end-stage renal disease (ESRD), coverage under this plan will pay first before Medicare, but only for the first 30 months of your ESRD coverage. After 30 months, the amount that this plan pays will be reduced by the amount that Medicare pays for the same services.

If your employer or group employs 100 or more employees and if you are under 65 and eligible for Medicare only because of a disability (and not ESRD), this plan pays first before Medicare as long as your group coverage is based on your status as a current active employee, or the status of your spouse as a current active employee, or the current active employment status of the person for whom you are a dependent.

When Medicare is allowed by law to be the primary payer, coverage under this plan will be reduced by the amount paid by Medicare for the same covered services. Benefits under this plan will be paid up to either the Medicare-approved charge for services by a Medicare-participating provider, or the lesser of our eligible charge or the limiting charge (as defined by Medicare) for

services rendered by a provider who does not participate with Medicare.

If you are entitled to Medicare benefits, we will begin paying benefits after all Medicare benefits, including all lifetime reserve days, are exhausted.

If you have coverage under Medicare Part B only, we will pay inpatient benefits based on our eligible charge less any Medicare Part B benefits for inpatient diagnostic, laboratory and radiology services.

When services are rendered by a provider or facility that is not eligible or entitled to receive reimbursement from Medicare, and Medicare is entitled by law to be the primary payer, we will limit payment to the amount that would have been payable by Medicare had the provider or facility been eligible to receive such payments, regardless of whether or not Medicare benefits are paid.

**Benefit Payments
Under Coordination of
Benefits Rules**

When this plan is determined to be the primary payer, we will pay benefits in accordance with the provisions of this Agreement.

When this plan is determined to be the secondary payer, we will base our payment on the eligible charge, and deduct from our payment:

- any unpaid copayment or Deductible that you owe under this plan
- the benefit amount paid by the primary plan

We will not pay Benefits unless the service in question is a covered service. We also will not pay Benefits for the difference in cost between a private and a semiprivate hospital room, even if such private room is a benefit under the primary plan. Any payment by this plan as secondary will not exceed the amount that would have been paid for covered services you received had this plan been your only coverage. Any payment by this plan as secondary payer will count towards applicable Benefit Maximums of this plan. Even if no payment is made by this plan as secondary, the service for which payment is made by the primary plan shall count toward applicable service maximums of this plan.

**Third Party Liability
Rules**

Third party liability situations occur when you are injured or become ill and:

- the injury or illness is caused or alleged to have been caused by someone else and you have or may have the right to recover damages or receive payment in connection with the illness or injury
- you have or may have the right to recover damages or receive payment from someone else for your injury or illness, without regard to fault

When third party liability situations occur, UHA's Plan will provide benefits only as set forth in the following Rules.

If you have or may have coverage under workers' compensation insurance, such coverage will apply instead of the coverage under this Plan. Medical expenses arising from injury or illness covered under workers' compensation insurance are excluded from coverage under this Plan. If you have or may have coverage under motor vehicle personal injury protection (PIP) insurance, you must exhaust that coverage first, before the coverage under this Plan will apply. See Automobile Coverage terms under this Section 10 for conditions and procedures that apply.

In third party liability situations, you must cooperate with UHA by doing the following:

1. give UHA timely notice of each of the following, no later than 30 calendar days after their occurrence:
 - a. your knowledge of any actual or potential claim
 - b. any written claim or demand (including initiation of legal proceedings) made by you or on your behalf
 - c. any monetary recovery (including any settlement, judgment, award, insurance proceeds, or other payment) from any source of recovery in connection with your illness or injury
2. sign and deliver to UHA all papers it requires to secure its rights to repayment, including but not limited to a Reimbursement Agreement
3. provide UHA any information reasonably related to its investigation of liability for coverage and rights to repayment
4. do not release or otherwise impair UHA's rights to repayment, without UHA's express written consent
5. cooperate in protecting UHA's rights under this rules, including giving notice of our rights to repayment as part of any written claim or demand made against any other person or party or other source of recovery

Failure to comply with the Rules described above may result in delay in payment or denial of your claims, and will entitle UHA to reimbursement of its payments to the extent that your actions result in erroneous payment or prejudice UHA's rights to repayment. If UHA is entitled to reimbursement of payments under these Rules and does not promptly receive full reimbursement pursuant to its request, it shall have a right of set-off from any future benefits payable under this Plan.

Subject to the limitations and conditions described above, UHA will pay benefits in accordance with this Plan and these Rules. However, any benefits paid in third party liability situations must be repaid from any recovery received by you as a result of such injury or illness, even if the award does not specifically include medical expenses, or is described as general damages only, or is less than the total actual or alleged loss suffered by you due to the injury or illness. UHA shall have a first lien against any such recovery to the extent of its total payment of benefits. This lien will attach to and follow any recovery proceeds even if the proceeds are distributed to another person or entity. UHA may file notice of its lien with the court, the other person or party or other source of recovery, or any person or entity receiving the proceeds. You have a duty to authorize and direct any person or entity making any payment on account of any third party injury or illness to directly pay to UHA so much of such payment as is necessary to reimburse UHA for benefits paid.

If UHA is not reimbursed for its total payment of benefits in connection with your illness or injury, UHA shall have a right of subrogation (substituting UHA to the member's rights of recovery) for all causes of action and all rights of recovery you have against such other person or party or other source of recovery, to the extent of UHA's unreimbursed payments on your behalf.

UHA's rights of reimbursement, lien, and subrogation described above are in addition to all other rights of equitable subrogation, constructive trust, equitable lien and/or statutory lien UHA may have for repayment of benefits paid, all of which rights are preserved and may be pursued at UHA's option against you or any other appropriate person or entity.

No reductions for attorneys fees, costs, or other expenses may be made from the amounts owing to UHA under these Third Party Liability Rules, unless required by ERISA (the federal Employee Retirement Income Security Act).

Coordination of Benefits

For any payment made by UHA under these Rules, you will still be responsible for copayments, deductibles, timely submission of claims, and other duties under this Plan.

If you comply with the above requirements and if you have made reasonable efforts to obtain recovery for your illness or injury, but receive a final dismissal or denial of all your legal claim(s) without receiving any recovery for your illness or injury, then no reimbursement is owing to UHA for covered benefits paid for the illness or injury.

SECTION 11: OTHER PLAN PROVISIONS

Confidentiality	<p>Any information about you that we collect, including claims and medical record information, is confidential. By receiving benefits under this plan, you agree to provide to us, and to authorize your providers to provide to us, information about your medical condition and treatment necessary for us to fulfill our obligations under this Agreement for the purposes of determining benefits, paying claims, assuring quality, managing utilization, credentialing providers, complying with government regulations, and other responsibilities we have for administering this plan. We may use your information as needed for these and other activities described in our Notice of Privacy Practices.</p>
Dues Payment	<p>You or your employer must pay us the monthly premium due on or before the first of each month to which the premium applies.</p> <p>If you or your employer fails to make the monthly payments by the first of the month, we may terminate this Agreement as of the last day of the month for which dues were paid, unless all dues are brought current within 10 days of our written notice of default to your employer or group sponsor and the State of Hawaii Department of Labor and Industrial Relations.</p> <p>We are not liable for benefits for services received after the termination date of this Agreement. This includes benefits for services you receive if you are enrolled in this coverage under the provisions of the:</p> <ul style="list-style-type: none">• Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), or• Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)
Authority to Terminate Coverage	<p>Your employer has the authority to terminate this coverage by providing us 60 days written notice. If your employer terminates this coverage, you are not eligible to receive benefits under this coverage after the termination date.</p> <p>We have the authority to modify this Agreement provided that we give 60 days prior written notice to your employer.</p> <p>See also Section 3: When Your Coverage Ends, and Section 3: Termination for Fraud, for other circumstances of termination.</p>
Governing Law	<p>To the extent not superseded by the laws of the United States, this coverage will be construed in accord with and governed by the laws of the State of Hawaii. Any action brought because of a claim against this coverage will be litigated in the state or federal courts located in the State of Hawaii and in no other.</p>
Payment in Error	<p>If for any reason we make a payment under this coverage in error or due to any false claim or fraud, we may recover the amount we paid, and may offset any amounts we give to you by the amount of reimbursement you owe to us, as well as pursue any other remedies provided by law.</p>
Liability	<p>UHA is not an insurer against nor liable for the negligence or other wrongful act or omission of any Provider, Provider's employee, your employer, or plan sponsor or other person, or for any act or omission of any Eligible Person.</p>

No Guarantee	UHA does not guarantee the availability or quality of any services of any third party, including the availability of Participating Providers.
Continued Coverage Under Federal Law - COBRA	When your coverage ends under this Agreement, you may have the opportunity to continue your group coverage for a limited time under the Consolidated Omnibus Budget Reconciliation Act (COBRA). This Act only applies to employers with 20 or more employees.
Qualifying Events	<p>COBRA entitles you and your eligible dependents, if already covered, to continue this coverage if coverage is lost due to any of the following qualifying events:</p> <ul style="list-style-type: none">• employer or group sponsor from whom you retired files bankruptcy under federal law• death of the employee covered under this coverage• divorce or legal separation• child no longer meets our eligibility rules• enrollment in Medicare• termination of employment for reasons other than gross misconduct, or if your work hours are reduced to the point you are no longer eligible for coverage <p>Please note that dependents covered as domestic partners are not eligible for COBRA coverage.</p> <p>If you lose your coverage, contact your employer or group sponsor immediately. You are entitled to receive a COBRA election form within 44 days if the qualifying event is a termination of employment or reduction in hours. If the qualifying event is divorce, legal separation, or a child ceasing to be a dependent child, the form and notice must be provided to you within 14 days after you notify your employer of the event.</p> <p>Please note: You or your spouse is responsible for notifying your employer or group sponsor of your divorce or legal separation, or if a child loses eligibility status under our rules for coverage.</p> <p>If you or your spouse believes you have had a qualifying event and you have not received your COBRA election form on a timely basis, please contact your employer.</p>
Payment of COBRA Premiums	<p>If you or your dependents are entitled to and elect COBRA continuation coverage, you must pay UHA the premiums which may be up to 102% of group rates. In the case of a disabled individual whose coverage is being continued for 29 months, you or your dependents may be required to pay up to 150% of group rates for any month after the 18th month.</p> <p>Within 45 days of the date you elect COBRA coverage, you must pay an initial COBRA premium to cover the period between the date of your qualifying event and the date of your election. If you fail to make the initial payment or any subsequent payment in a timely manner (a 30 day grace period applies to late subsequent payments), your COBRA coverage will terminate.</p>
What You Must Do	<p>If you wish to elect COBRA, you must complete an election form and submit it to your employer within 60 days of the later date:</p> <ul style="list-style-type: none">• you are no longer covered, or• you are notified of the right to elect COBRA continuation coverage <p>You or your dependents must notify your employer in the following circumstances:</p> <ul style="list-style-type: none">• If coverage for you or your dependents is being continued for 18 months under COBRA and it is determined under Title XVI of the Social Security Act that you or your dependent was disabled on the date of, or within 60 days of, the event which would have caused coverage to

terminate, then you or your dependent must notify your employer of such determination. Notice must be provided within 60 days of the determination of disability. Notice must also be given within 30 days of any notice that you or your dependent is no longer disabled.

- If coverage for a dependent would terminate due to your divorce, a legal separation, or the dependent's ceasing to be a dependent under this plan, then you or your dependent must provide notice to your employer of the event. This notice must be given within 60 days after the later of the occurrence of the event or the date coverage would terminate due to the occurrence of the event.

If notice is not provided on time, COBRA coverage will not be available to you or your dependents.

Adding Your Child

If during the period of COBRA coverage, a child is born to you or placed with you for adoption and you are on COBRA because you terminated employment or had a reduction in hours, the child can be covered under COBRA and can have election rights of his or her own. Please be aware that dependent children of domestic partners are not eligible for COBRA continuation coverage.

Length of Coverage Under COBRA

Continuation coverage ends at the earliest of one of these events:

- the last day of the 18-, 29-, or 36-month maximum coverage period, whichever is applicable. If you or any of your dependents who have elected COBRA coverage are determined to be disabled under the Social Security Act during the first 60 days of continuation coverage, your COBRA coverage may continue for up to 29 months. The 29-month period will apply to you and your eligible dependents who elected COBRA coverage. You must provide notice of the disability determination to your employer within 60 days after the determination.
- the first day (including grace periods, if applicable) on which timely payment is not made by you
- the date on which the employer ceases to maintain any group health plan (including successor plans)
- the date the Qualified Beneficiary enrolls in Medicare benefits. Qualified Beneficiary means, with respect to a covered employee under a group health plan, any other individual who, on the day before the qualifying event for the employee, is a beneficiary under the plan (i) as a spouse of the covered employee, or (ii) as the dependent child of the covered employee
- the first day on which a beneficiary is actually covered by any other group plan. However, if the new group plan contains an exclusion or limitation relating to a preexisting condition of the beneficiary, then coverage will end on the earlier of the satisfaction of the waiting period for preexisting conditions contained in the new group plan, or the occurrence of any one of the other events stated in this section.

If the new group plan contains a preexisting condition exclusion, the preexisting condition exclusion period will be reduced by the qualified beneficiary's preceding aggregate periods of creditable coverage, if any. The creditable coverage is applicable to the qualified beneficiary as of the enrollment date in the new group health plan as long as there has been no interruption of coverage longer than 63 days. Creditable coverage means any of the following:

- a group health plan
- health insurance coverage
- Part A or B of Medicare
- Medicaid
- Chapter 55 of Title 10, United States Code
- a medical care program of the Indian Health Service or of a tribal organization
- a state health benefits risk pool

- a health plan offered under Chapter 89 of Title 5, United States Code
- a public health plan as defined in government regulations
- a health benefit plan under Section 5(e) of the Peace Corps Act

ERISA Information

The Employee Retirement Income Security Act of 1974 (ERISA) provides that you will be entitled to:

- examine all plan documents and copies of documents (such as annual reports) filed by the plan with the United States Department of Labor. You may examine these documents without charge at the plan administrator's office or at specified locations;
- obtain copies of plan documents from us upon written request (we may request a reasonable charge for the copies); or
- receive a summary of the plan's annual financial report if your employer or group sponsor has 100 or more participants in your plan. The plan administrator is required by law to furnish you with a copy of this summary annual report.

In addition to creating rights for you and other participants, ERISA imposes duties upon the people responsible for the operation of your employee benefit plan. The people responsible are called fiduciaries of the plan. Fiduciaries have a duty to operate your employee benefit plan prudently and in the interest of you and your family members. UHA and the plan administrator (your employer or group sponsor) are fiduciaries under this Agreement; however, UHA's duties are limited to those described in this Agreement, and the plan administrator is responsible for all other duties under ERISA. No one, including your employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a covered benefit or exercising your rights under ERISA. In general, federal law prohibits health plans from restricting benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a caesarian section. Plans may require authorization for lengths of stay in excess of these time parameters. If your claim for a covered benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to request an appeal and reconsideration of your claim. Under ERISA, there are steps you can take to enforce the above rights.

For instance, if you request plan documents from the plan administrator and do not receive them within 30 days, a federal court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the document, unless the document was not sent because of matters reasonably beyond the control of the plan administrator.

If you have a claim for benefits that is denied or ignored (in whole or in part), you may file suit in a state or federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person or entity you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous. If you have any questions about your plan, you should contact the plan administrator, i.e. your employer or group sponsor. If you have questions about this statement or about your rights under ERISA, you should contact the nearest Area Office of the Employee Benefits Security Administration, U.S. Department of Labor listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, D.C. 20010. You may also obtain certain publications about your rights and responsibilities under

ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Your plan administrator is your employer or group sponsor. Your plan is an employee welfare benefit plan for pre-paid health care, contributions for which are supplied by your employer in accordance with the Hawaii Prepaid Health Care Act, H.R.S. Chapter 393, and by the employee to the extent required by the employer's rules for contribution.

Your group health plan is designed to qualify as an employee group benefit plan under ERISA. However, ERISA law provides that any group is not ERISA-qualified if no employees are currently participants covered under the group's plan. For example, a group plan in which the only participants are non-employee partners of the company, is not an ERISA plan. Also, a plan in which the only participants are a person who wholly owns the company, or a person and his/her spouse who wholly own the company, is not an ERISA plan. However, if such group plan enrolls a qualifying employee, then the plan will become an ERISA plan.

GLOSSARY OF IMPORTANT TERMS

Actual Charge	means the amount a Provider actually bills for a service or supply.
Acupuncturist	means a licensed health care professional who practices stimulation of acupuncture points on the human body for the purpose of controlling and regulating the flow and balance of energy in the body.
Agreement	means this Medical Benefits Guide, any amendments or riders, any enrollment form or application form you submit to us, and the agreement between us and your employer or group sponsor.
Ambulatory Surgical Center	means a facility that provides Surgical Services on an outpatient basis for patients who do not need to occupy an inpatient hospital bed.
Ancillary Services	means charges by a facility for other than room and board. Examples are charges by a hospital for drugs, dressings, or medical supplies.
Anesthesia	means the administration of anesthetics to produce loss of feeling or consciousness, usually in conjunction with forms of medical treatment such as surgery.
Annual Deductible	means the fixed dollar amount you pay each calendar year before benefits become available for certain services.
Assistant Surgeon	means a physician who actively assists the physician in charge during a surgical procedure.
Benefit(s)	means those Medically Necessary Physician Services, Surgical Services, Hospital Services, Skilled Nursing Facility Services, Home Health Care and Hospice Services, Diagnostic Testing, Laboratory and Radiology Services, Chemotherapy and Radiation Therapy Services, Organ Transplant Services, Mental Health and Substance Abuse Services, Specific Benefits for Children, Women, Men, and Member and Covered Spouse, Complementary Alternative Medicine Services, and Other Medical Services that qualify for payment under the terms of this Agreement.
Bionic Devices	means electronic or electromechanical devices which replace missing body parts and/or which enhance one's existing strength and ability.
Calendar Year	means the period beginning January 1 and ending December 31 of any year. The first Calendar Year for a person covered under this plan begins on that person's Effective Date and ends on December 31 of the same year.
Chiropractor	means a licensed health care professional who practices the system of healing through spinal manipulation and specific adjustment of body structures.
Claim	means a written request for payment for Benefits for covered services.
Consultation	means a formal discussion (deliberation) between physicians on a case or its treatment.
Copayment	means the amount you pay as your share of the eligible charge for medical care.
Covered Services	means any Benefit that is Medically Necessary, is not specifically excluded by this plan, and meets our Payment Determination Criteria. Benefits are listed in <u>Section 5: Description of Benefits</u> .
Deductible	means the fixed dollar amount you pay each calendar year before benefits are payable by us.
Dependent	means a member's spouse and/or eligible child or children.
Effective Date	means the date on which you are first eligible to receive Benefits under this Agreement.
Eligible Charge	means the charge determined by UHA according to the terms of this Agreement and the charge used to calculate the Benefit payment and the amount of your copayment for a covered service.

Emergency	is defined as a situation when a prudent layperson could reasonably expect that the absence of immediate medical attention would result in: <ul style="list-style-type: none">• serious jeopardy to the health of the individual, or, with respect to a pregnant woman, to the health of the woman and her unborn child;• serious impairment to bodily function; or• serious dysfunction to any bodily organ or part.
ERISA	means the Employee Retirement Income Security Act of 1974, a federal law that governs this Agreement and protects your rights under this coverage.
Generic Drug	means drugs prescribed or dispensed under their generic (chemical) name rather than a brand name and which are not protected by a patent, or are drugs designated by us as generic. Generic drugs must be approved by the FDA as safe and effective.
Guidelines	means clinical standards, protocols, or criteria for treatment of specific conditions or for providing certain services and supplies, as often used in our prior authorization process.
Home Health Agency	means a licensed entity which provides skilled nursing care in your home.
Home Infusion Therapy	means treatment provided in the home involving the administration of drugs, nutrients and fluids intravenously or through a feeding tube.
Hospice	means a program that provides care in a comfortable setting, such as home, for patients who are terminally ill and have a life expectancy of six months or less.
Hospital	means an institution that provides inpatient acute care for the diagnosis and treatment of an illness or injury.
Immunization	means an injection with a specific antigen to promote antibody formation to make you immune to a disease or less susceptible to a contagious disease.
Inpatient Admission	means a stay, usually overnight, in a hospital, skilled nursing facility or other facility.
Maternity Care and Delivery	means routine obstetric care including antepartum care, delivery, and postpartum care in uncomplicated maternity cases.
Maximum Annual Copayment	means the maximum amount you pay for most covered services in a calendar year. For this plan, the maximum annual copayment is \$2,500 per individual and \$7,500 per family. The copayment maximum is reached from applicable deductible, copayments and coinsurance amounts you pay in any given calendar year.
Maximum Benefit	means the maximum benefit amount allowed for certain covered services. A Maximum Benefit may limit the dollar amount, the duration, or the number of visits for a covered service.
Medically Necessary	is defined in accordance with the definition established in Hawaii Revised Statutes (sect. 432E-1.4): <p>“(a) For contractual purposes, a health intervention shall be covered if it is an otherwise covered category of service, not specifically excluded, recommended by the treating licensed health care provider, and determined by the health plan's medical director to be medically necessary as defined in subsection (b). A health intervention may be medically indicated and not qualify as a covered benefit or meet the definition of medical necessity. A managed care plan may choose to cover health interventions that do not meet the definition of medical necessity.</p> <p>(b) A health intervention is medically necessary if it is recommended by the treating physician or treating licensed health care provider, is approved by the health plan's medical director or physician designee, and is:</p> <ol style="list-style-type: none">(1) For the purpose of treating a medical condition;(2) The most appropriate delivery or level of service, considering potential benefits and harms to the patient;(3) Known to be effective in improving health outcomes; provided that:<ol style="list-style-type: none">(A) Effectiveness is determined first by scientific evidence;

- (B) If no scientific evidence exists, then by professional standards of care; and
 (C) If no professional standards of care exist or if they exist but are outdated or contradictory, then by expert opinion; and
 (4) Cost-effective for the medical condition being treated compared to alternative health interventions, including no intervention. For purposes of this paragraph, cost-effective shall not necessarily mean the lowest price.”

Member	means the person who meets and maintains the eligibility requirements and executes the enrollment form that is accepted by us to become eligible for Benefits under this Agreement.
Non-Participating Provider	means a Provider who does not have a contract with UHA, for example an out-of-state provider.
Non-Preferred Brand Drugs	means brand name drugs that are not listed in the UHA Preferred Drug Listing.
Our	refers to UHA.
Outpatient	means care received in a practitioner’s office, the home, the outpatient department of a hospital, or an ambulatory surgical center.
Participating Provider	means that a physician, hospital, or other licensed health care provider has signed a contract with UHA to provide benefits under this plan, that requires that the provider collect only: <ul style="list-style-type: none"> • the eligible charge paid by UHA for the covered services delivered, • the applicable copayment, and • the applicable state excise tax, based on the eligible charge.
Payment Determination Criteria	means care, treatment, service, or supply that is a covered service and which is all of the following: <ul style="list-style-type: none"> • the service must be Medically Necessary for the diagnosis or treatment of your illness or injury • the service must not be primarily for your convenience or the convenience of your provider • the service must be the most appropriate supply or level of service that can be safely provided • the service must not be excluded as a benefit by this plan • when required under this plan, the service must be Prior Authorized
Physician	means a doctor of medicine (M.D.), doctor of osteopathy (D.O.), or doctor of podiatric medicine (D.P.M.), who is appropriately licensed to practice by the proper governmental authority and who renders services within the lawful scope of such license.
Physician Assistant	means a practitioner who provides care under the supervision of a physician.
Plan	means the Agreement between you and us regarding your health care coverage.
Preferred Brand Drug	means brand name drugs identified as preferred by their inclusion in UHA’s Preferred Drug Listing.
Prior Authorization	means a review process by which we determine if a service or supply is a Medically Necessary covered service that meets our Payment Determination Criteria, prior to the provision of the service or supply.
Provider	means a provider of health care services or supplies who is appropriately licensed or certified by the proper governmental authority to practice or provide such services, or dispense such supplies, and who renders services or dispenses supplies within the lawful scope of such license or certification.
Psychiatrist	means a Physician who is certified by or has at least three years of psychiatric training acceptable to the American Board of Psychiatry and Neurology, and whose practice is limited solely to psychiatry or psychiatry and neurology.
Psychologist	means a person who is appropriately certified and licensed to provide psychodiagnostic or psychotherapeutic services

by the proper governmental authority and who renders services within the lawful scope of such license.

Qualified Beneficiary	means, with respect to a covered employee under a group health plan, any other individual who, on the day before the qualifying event for that employee, is a beneficiary under the plan: <ul style="list-style-type: none">• as the spouse of the covered employee; or• as the dependent child of the covered employee.
Reliable evidence	means only: <ul style="list-style-type: none">• published reports and articles in authoritative peer-reviewed medical and scientific literature;• the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure; or• the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.
Service Area	means the State of Hawaii.
Skilled Nursing Facility	means an inpatient care facility which is licensed as such by the appropriate governmental authority, certified as such by the JCAHO, CARF or HCFA, recognized as such by UHA and under contract with or approved by UHA for the delivery of covered services.
Specialty Facility	means an inpatient or outpatient facility which is not a Hospital or Skilled Nursing Facility, but which provides specialized medical care, including, but not limited to, psychiatric hospitals, physical rehabilitation hospitals, sanitarium for the treatment of certain diseases, residential treatment facilities, free-standing urgent/emergent care centers, clinics, community health clinics, and ambulatory surgery centers, and is licensed as such by the appropriate governmental authority, certified as such by the JCAHO, CARF or HCFA, recognized as such by UHA and under contract with or approved by UHA for the delivery of covered services.
Spouse	means your husband or wife as a result of a marriage that is legally recognized in the State of Hawaii.
Surgical Services	means professional services necessarily and directly performed by a physician in treatment of an injury or illness requiring cutting; suturing; diagnostic and therapeutic endoscopic procedures; debridement of wounds including burns; surgical management or reduction of fractures and dislocations; orthopedic casting; manipulation of joints under general anesthesia; or destruction of localized surface lesions by chemotherapy (excluding silver nitrate), cryotherapy, or electrosurgery.
Third Party Liability	means our right to reimbursement when you or your family members receive medical services for an illness or injury and you have a lawful claim against another party or parties for compensation, damages, or other payment.
Transplant Evaluation	means those procedures, including laboratory and diagnostic tests, consultations, and psychological evaluations that a facility uses in evaluating a potential transplant candidate.
Us, We	means UHA.
You, Your	means you and your family members eligible for coverage under this Agreement.