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Honolulu, HI 96813.4100
T 808.532.4000
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How to Initiate an Appeal

UHA members have the right to express concerns about actions taken by UHA, to request a reconsideration of any decision made by UHA that adversely affects them, and to file a formal appeal of decisions made by UHA that relate to claim payments, benefit coverage, and member eligibility as stated in UHA's Medical Benefits Guide. UHA will attempt to resolve all concerns and appeals fairly and promptly. The procedures in this document apply only to appeals by the member or the member's authorized representative, on behalf of the member. As used in this document, "you" refers to the member or the member's authorized representative.

Requesting Information Regarding Our Decision
The notice to you of our decision will include the date of service, the health care provider, and the claim amount. Upon request, we will also provide the treatment and diagnosis codes for the claim and their corresponding meanings. You may request this information by contacting UHA Customer Service at 808-532-4000; 1-800-458-4600 from the neighbor islands.

Requesting Informal Reconsideration of an Adverse Decision
If 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denied a claim, paid an incorrect amount, incorrectly determined that a service is not a covered benefit or incorrectly rescinded your coverage, please call UHA Customer Services at the numbers listed above.

The Customer Services Representative will document the issue and attempt to resolve the concern on the telephone. If this is not possible, the Representative will refer the concern for informal reconsideration and inform you of the decision as promptly as possible.

Requests or referrals for an informal reconsideration must be made within one year of the date you were informed of the adverse decision.

If you are dissatisfied with a denial that was based in whole or in part on a medical judgment, including determinations of whether a procedure was experimental or investigational, or whether it was medically necessary or appropriate, your informal reconsideration is limited to a peer-to-peer clinical review (telephonic, in person, or electronically) between UHA and the treating provider. For a peer-to-peer clinical review, please call UHA Health Care Services at 808-532-4006; 1-800-458-4600, extension 300, from the neighbor islands.

Requests for a peer-to-peer clinical review must be made within one month of the date you were informed of the adverse decision.

Requesting a Formal Appeal
If you are not satisfied with our response to your concern, or do not wish to request informal reconsideration under the above procedure, you must ask for an appeal. Your request must be in writing unless you are asking for an expedited appeal (see Expedited Internal Appeals below).

- Appeals must be submitted in writing to: UHA Appeals Coordinator
  700 Bishop Street, Suite 300
  Honolulu, HI 96813
- We must receive your written appeal within one year of the date UHA informed you of the decision you wish to appeal.
- You may appoint someone to represent you during the appeal process, such as a court-appointed guardian, legal representative or any person you authorize to act on your behalf as long as you follow our procedures. This appointment must be made in writing. This includes filing a form with UHA; the "Authorized Representative Form" is available on our website at uhahealth.com under "Member Forms".
- Your appeal should include the following information: the date of your request, your name and member identification number from your identification card, the date of service you believe we denied or paid in error, provider name, a description of the facts related to your appeal and why you believe our action or decision was in error, and any other details about your appeal, including written comments, documents, and records relating to your appeal that you would like us to review. You should keep a copy of the request for your records. It will not be returned to you
- You shall be provided, upon request and free of charge, copies of all documents, records, and other information relevant to the claim for benefits or rescission of coverage, as defined by federal ERISA rules, and any rule, guideline, or protocol we relied upon in making the decision at issue.

- Your appeal will be reviewed by staff not involved in the original decision (nor a subordinate to the original decision maker) and will not give deference to the initial decision. If the appeal concerns a matter of medical judgment about an otherwise covered category of service that is not expressly excluded by the member's plan, it will be reviewed by an independent licensed practitioner with appropriate expertise and experience in the field of medicine involved in the medical judgment, and who was not previously consulted in connection with the original decision. The review will take into account all comments, documents, records, and other information submitted by you or your authorized representative relating to the claim, or considered as relevant by UHA, without regard to whether such information was submitted or considered in the initial benefit determination.
- If our appeal decision denies your request or any part of it, we will provide an explanation, including an identification of the claim or service denied, 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. The notice to you of our decision will also include the date of service, the health care provider, and the claim amount. Upon request, we will also provide the treatment and diagnosis codes for the claim and their corresponding meanings. You may request this information by contacting Customer Services.
- If we consider, rely upon or generate any new or additional evidence in our appeal review, we will provide you, free of charge, that evidence as soon as possible and sufficiently in advance of the date our decision on appeal is due to provide you a reasonable opportunity to respond prior to that date.
- If we intend to base our decision on appeal on a new or additional rationale, we will provide you, free of charge, the rationale as soon as possible and sufficiently in advance of the date our decision on appeal is due to provide you a reasonable opportunity to respond prior to that date.
- UHA's final internal decision will be made by UHA's Appeals Committee. We will notify you of our decision within 30 days of receipt of your written appeal if your appeal concerns a UHA denial which was based in whole or in part on a medical judgment, including determinations of whether a procedure was experimental or investigational, or whether it was medically necessary or appropriate. We will notify you of our decision within 60 days of receipt of your written appeal for all other appeals.

Expedited Internal Appeals
A member, a member's authorized representative, or a health care provider with knowledge of the member's medical condition can request an expedited internal appeal (72-hour response time for UHA's final internal determination) if the standard time (30 or 60 days, as set forth above) for completing an appeal would:

- seriously jeopardize the member's life or health;
- seriously jeopardize the member's ability to gain maximum functioning; or
- subject the member to severe pain that cannot be adequately managed without the care or treatment requested.

To request an expedited appeal, you, your authorized representative, or a licensed health care provider with knowledge of your medical condition, should call UHA Health Care Services at 808-532-4006; 1-800-458-4600, extension 300, from the neighbor islands.

If the request for expedited appeal is made on your behalf by a health care provider with knowledge of your condition, you need not submit written appointment for the health care provider's representation.

Expedited External Review with Expedited Internal Appeal
If you have requested an expedited internal appeal of an adverse benefit determination and: (1) the adverse benefit determination involves a medical condition for which the 72 hour time frame for completion of an expedited internal appeal would seriously jeopardize your life, health or ability to regain maximum functioning; or (2) would subject you to severe pain that cannot be adequately managed without the care or treatment requested, then you may request expedited external review. For more information about requesting an external expedited review, please refer to the "If You Disagree with our Final Appeals Decision" document on our website at uhahealth.com under "Member Forms".

Additional Appeals Information
For other details regarding your appeal rights, consult UHA's Medical Benefits Guide. If you are not satisfied with the final decision of the UHA Appeals Committee, you have the right to request external review by an independent review organization (IRO) of a decision regarding medical necessity or whether a service is experimental or investigational, to bring a civil claim under ERISA or to elect binding arbitration, in accordance with your UHA plan terms.