UHA HEALTH INSURANCE
Better Health. Better Life.

Medical Benefits Guide
Preferred Provider Plan

UHA One Plan℠

January 2025

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SECTION 1: GENERAL INFORMATION

About this Plan

One Plan represents a major advance in health care coverage in Hawaii through its focus on keeping you healthy and well. Many wellness services are covered at little or no cost to you, emphasizing the prevention and early detection of serious diseases such as cancer and heart disease, plus 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 for disease management
- Smoking cessation program
- Diabetes self-management training and education
- Asthma education program

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.

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

Should you ever have any questions about your Plan, please contact us:

By phone: Please call Customer Services at 808-532-4000 from Oahu or 1-800-458-4600 (toll-free) from the neighbor islands

By fax: (866) 572-4393

By mail: UHA
Attn.: Customer Services
700 Bishop Street, Suite 300
Honolulu, HI 96813

On the web: 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

Definitions

Important terms used in this booklet will appear capitalized throughout, and 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.

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.

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

The payment made by this Plan and the **Co-payment** or **Coinsurance** 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."

Participating means that a **Physician, Hospital**, or other accredited and/or certified, licensed health care provider has signed a contract with UHA to provide Benefits under this Plan. The contract requires that the provider collect only:

- the **Eligible Charge** paid by UHA for the **Covered Services** delivered
- the applicable Co-payment or Coinsurance
- billed charges for non-covered services
- the applicable state excise tax, based on the Eligible Charge

Participating Providers also agree to participate in and abide by UHA's credentialing, quality improvement and utilization management programs.

There are many Participating Providers throughout Hawaii. Please refer to the UHA Participating Physicians and Health Care Provider Directory for a listing. If you need a copy, please call Customer Services and we will send one to you without 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 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.

When you see a provider that is not participating with UHA, you will owe any Co-payment, Coinsurance and applicable taxes that apply to Covered Services plus potentially the difference between UHA's payment for Covered Services and the provider's **Actual Charge**. Also, Non-Participating Providers have not agreed to UHA's payment policies and can bill you for services or other charges that UHA does not cover.

Please note: Your Participating Provider may refer services to a Non-Participating Provider and you may incur a higher out-of-pocket cost. For example, your Participating Provider may send a blood sample to a non-participating lab to analyze, or refer 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.

UHA's payment is usually the Eligible Charge for Covered Services but in certain situations with Non-Participating Providers we may use other payment methods, such as billed charges, the highest Eligible Charge of an identical Participating Provider, a qualifying payment amount, or a special negotiated payment.

Payments for covered emergency services, including certain **Post-Stabilization Care** services that qualify as emergency services (under applicable federal law), provided by Non-Participating Providers are a "reasonable amount" as defined by federal law. Federal law also governs payments for emergency services and air ambulance, and certain non-emergent services, including ancillary services, provided by Non-Participating Providers. For such services protected under federal law, participating benefit levels apply.

In general, payment for services provided by Non-Participating Providers will be made directly to the subscriber of the Plan. Payment for emergency services will be made directly to Non-Participating Provider in accordance with federal and state law. At our sole discretion or as required under the federal No Surprises Act of 2021, however, we may make payments directly to Non-Participating Providers for non-emergent services. UHA does not recognize assignment of benefits to Non-Participating Providers.

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 Co-payment, plus applicable taxes 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 Co-payment or Coinsurance and the payment may be made directly to the subscriber of the Plan. You may also be responsible for any difference between the Eligible Charge and provider's Actual Charge, plus applicable taxes.

Services Outside the Service Area

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

UHA has an agreement 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. Treatment for a condition which occurred or was diagnosed before your trip will be subject to the same **Prior Authorization** requirements as any non-emergent treatment outside of the State of Hawaii.

UHA reserves the right to modify the agreement with the mainland contractor which may affect coverage for services. Please check with UHA before you travel to determine the extent of coverage through the mainland contractor in the area you are visiting. Note that the agreement between UHA and the mainland contractor does not include coverage for Vision, Chiropractors and Acupuncturists.

The agreement between UHA and the mainland contractor also covers medical care, subject to certain conditions and limitations, provided on the mainland to:

- your **Dependent** children less than 26 years of age who reside on the mainland; or
- you and your qualified Dependents if your employer requires that you reside on the mainland while working; or
- you and your qualified Dependents who reside on the mainland during any period of continued coverage under COBRA if one of the above items was in effect prior to selecting COBRA.

The conditions and limitations which can affect coverage of medical care on the mainland include:

1. If you have two addresses, UHA will only recognize the Hawaii address for coverage in Hawaii, which is the Plan's Service Area. Generally, this condition usually applies to elective services.
2. The following require Prior Authorization (Section 7: Health Care Services Program):

- If you are a Hawaii resident and require medical services that are not available in Hawaii, your physician should contact us for an authorization for a referral to a mainland provider
- Hawaii residents seeking any services, procedures or medical care on the mainland when clinically similar services, procedures or medical care are performed and available in Hawaii
- Mainland residents seeking elective ASC or hospital based procedures, or any advanced imaging

3. If it is reasonable for you to receive elective services, procedures or medical care in Hawaii, but you elect to have the services, procedures or medical care performed on the mainland, then services, procedures or medical care obtained from providers participating with the mainland contractor may be paid at the Non-Participating Provider benefit level, and you will be responsible for the provider's charges in excess of UHA's payment. Please refer to UHA's "Out-of-State Referrals for Medical Services" policy on UHA's website for more information, and please be aware that generally UHA requires two weeks' advance notice for Prior Authorizations.

Services received beyond the mainland, such as in a foreign country, are not covered except in the event of a travel emergency.

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

Your employer or plan sponsor has agreed to act as your agent for dues payments and for sending and receiving health plan notices to and from UHA. If you do not agree with your employer or plan sponsor acting as your agent, please contact Customer Services (see page 1).

We will interpret the provisions of this Agreement and determine all questions that arise under it. Our interpretations, determinations and 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 RULES

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

When You Are Eligible for Coverage

You may enroll in this coverage when you are first eligible according to the Hawaii Prepaid Health Care Act (Hawaii Revised Statutes chapter 393) and the rules for eligibility described in our agreement with your employer. If you do not enroll in this coverage when you first become eligible or by the first day of the month immediately following the first four consecutive weeks of employment, you will not be eligible to enroll until the next open enrollment period. Open enrollment happens once each year. However, if we agree that there was unusual and justifiable cause for submitting your enrollment form 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:

- 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 **Civil Union Partner,** or Dependent child, are covered
- family coverage, meaning that you and two or more eligible Dependents described below, such as your Spouse or Civil Union Partner and/or eligible Dependent children, are covered

Enrollment Process

You must enroll your Dependents by naming them on the enrollment form and submitting it within 31 days of the date the Dependents become eligible. If you do not enroll within this time frame, you may enroll at the next open enrollment period. Open enrollment takes place once a year.

If you decline enrollment in this Plan for yourself or your Dependents (including your Spouse or Civil Union Partner) because of other health plan coverage, you may be able to enroll yourself or your Dependents in this Plan at a later date if you or your Dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your Dependents' other coverage). You must enroll by complying with our usual enrollment process within 31 days after the other coverage ends (or after the employer stops contributing toward the other coverage).

Enrolling a New Spouse or Civil Union Partner

If you marry or enter into a Civil Union partnership during the plan year, you may enroll your Spouse or Civil Union Partner prior to the next open enrollment by notifying your employer within 31 days of the marriage or Civil Union partnership. Your employer, in turn, must promptly notify us. If you do not enroll your Spouse or Civil Union Partner 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:

- 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 or Civil Union Partner are the court-appointed guardian
- the child is under 26 years of age

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 With Special Needs

You may enroll your child who is age 26 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 26 years of age
- the child relies primarily on parent or legal guardian, who is a UHA member, for support and maintenance as a result of his or her disability
- the child is enrolled with us under this coverage or another qualified health insurance coverage, and has had no break in health insurance coverage since before child's 26th birthday.

The documentation must be provided to us within 31 days of the child's 26th birthday and subsequently at our request, but not more frequently than annually.

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 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 our Agreement with your employer, provided that you meet eligibility criteria set forth above 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 or Civil Union Partner, if your coverage terminates or upon dissolution of the marriage or Civil Union partnership
- for your children, if your coverage terminates, or if the child no longer meets the criteria described under the heading "Enrolling Children"

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.

See also provisions below regarding Termination for Fraud and Eligibility and Termination Rules for **Member Groups**.

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. Your employer must promptly notify us.

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 end if you or your employer use this coverage fraudulently or intentionally misrepresent or conceal material facts on your enrollment form or in any claim for benefits.

If we determine that you or your employer has committed fraud or made an intentional misrepresentation or concealment of material facts, we will provide you written notice 30 days prior to prospective or retrospective termination of coverage. You have the right to appeal our determination; please refer to Section 9: If you Disagree with our Decision for information about the appeals process.

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 and seek repayment of any medical expenses paid on behalf of the ineligible person.

Eligibility and Termination Rules for Member Groups

Member Groups must:

1. engage in business in Hawaii;
2. have a General Excise Tax License and Department of Labor number; and
3. deduct FICA taxes from enrolled employees.

A Member Group who fails to maintain such eligibility requirements at any time during the term of this Agreement shall be deemed ineligible and terminated from enrollment in the Health Plan at the end of the month in which such ineligibility occurs.

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 no **Annual Deductible**.

Eligible Charge

We determine our payment and your Co-payment or Coinsurance 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

The base amount on which your Co-payment or Coinsurance is calculated for emergency, certain Post-Stabilization Care services and air ambulance services from Non-Participating Providers, as well as certain non-emergent services provided by Non-Participating Providers in Participating Provider facilities is calculated in accordance with federal law.

Participating Providers agree to accept the Eligible Charge for Covered Services; Non-Participating Providers usually do not. Therefore, for most medical services, except for emergency and air ambulance services, received from a Non-Participating Provider, you are responsible for the amount of your Co-payment or Coinsurance plus any difference between the Eligible Charge and the provider's Actual Charge. For certain non-participating services included in the federal No Surprises Act of 2021, you will not have to pay the difference between the Eligible Charge and the provider's Actual Charge.

The Eligible Charge does not include state 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 Co-payment = $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 Co-payment amount of $12 plus the $40 difference between the actual charge and the Eligible Charge, a combined total of $52.

Coinsurance

Coinsurance is the amount of the Eligible Charge you pay for a Covered Service, calculated as a percentage (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 Coinsurance amount and applicable taxes that apply to Covered Services plus potentially the difference between UHA's payment and the provider's Actual Charge.

Co-payment

Co-payment is the amount of the Eligible Charge you pay for a Covered Service, represented as a fixed dollar amount (for example, $12 Co-payment for a visit to your Personal Physician).

Please remember that when you receive services from a Non-Participating Provider, you are responsible for the Co-payment amount and applicable taxes that apply to Covered Services plus potentially the difference between UHA's payment and the provider's Actual Charge.

Maximum Benefits

Please note that certain benefits have annual maximums. For example, home health care is limited to 150 visits per **Calendar Year**. There are no annual or lifetime maximum benefits for this Plan.

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.

Annual Maximum Out-of-Pocket

When the total of your Co-payments and Coinsurance amounts 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 **Annual Maximum Out-of-Pocket**:

(a) when you receive services from a Non-Participating Provider, any difference you pay between the Eligible Charge and the provider's actual charge
(b) penalties for not obtaining Prior Authorization (see Section 7: Health Care Services Program for services subject to Prior Authorization)
(c) your Co-payments or Coinsurance for prescription drugs and vision benefits if your employer offers these additional benefits
(d) your Co-payments for Chiropractic and Acupuncture benefits
(e) 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)
(f) 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.

If you receive care on the mainland, your Plan coverage may be significantly less than if you receive care within Hawaii. This may result in high out-of-pocket costs to you. Please contact the Health Care Services Department at 808-532-4006 (or 1-800-458-4600, extension 300, from the Neighbor islands) for questions about out-of-state care.

Services received beyond the mainland are not covered except in the event of a travel emergency.

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 808-532-4006 (or 1-800-458-4600, extension 300, from the Neighbor islands) to see if a service has been added to or deleted from the list, which is also available on our website at uhahealh.com under "Member Forms."

As stated previously in Section 1 of this document, the Service Area for this Plan is the State of Hawaii and the following require Prior Authorization (Section 7: Health Care Services Program):

- If you are a Hawaii resident and require medical services that are not available in Hawaii, your physician should contact us for an authorization for a referral to a mainland provider
- Hawaii residents seeking services, procedures or medical care on the mainland when clinically similar services, procedures or medical care are performed and available in Hawaii
- Mainland residents seeking elective ASC or hospital based procedures, or any advanced imaging

If it is reasonable for you to receive elective services, procedures or medical care in Hawaii, but you elect to have the services, procedures or medical care performed on the mainland, then services, procedures or medical care obtained from providers participating with the mainland contractor may be paid at the Non-Participating Provider benefit level, and you will be responsible for the provider's charges in excess of UHA's payment. Please refer to UHA's "Out-of-State Referrals for Medical Services" policy on UHA's website for more information, and please be aware that generally UHA requires two weeks' advance notice for Prior Authorizations.

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

1. payment of all applicable taxes and non-covered services charged by the provider, in addition to the Co-payment or Coinsurance amount listed
2. if you see a Non-Participating Provider, any difference between the Eligible Charge and the Non-Participating Provider's Actual Charge, unless prohibited under federal law

A. PREVENTIVE CARE SERVICES	**Participating Provider Co-payment/Coinsurance**	**Non-Participating Provider Co-payment/Coinsurance**
Well Child Care Physician Office Visits	None	None
All ACIP (Advisory Committee on Immunization Practices) recommended Childhood Immunizations	None	None
Well Child Care Laboratory Tests (Newborn through 5 years old)	None	None
Preventive Medicine Office Visit	None	None
Well Woman Exam	None	None
Screening Laboratory Services	None	None

All ACIP recommended Adult Immunizations	None	None
Mammography for Breast Cancer Screening	None	None
Cervical Cancer Screening (Pap Smear)	None	None
Chlamydia Screening	None	None
Osteoporosis Screening (Peripheral DEXA Scan or Ultrasound of the heel)	None	None
Colorectal Cancer Screening	None	None
Diabetes Prevention Program	None	20% of Eligible Charge
Gonorrhea Screening	None	None

B. DISEASE MANAGEMENT PROGRAMS	**Participating Provider Co-payment/Coinsurance**	**Non-Participating Provider Co-payment/Coinsurance**
Smoking Cessation Program	None	None
Nutritional Counseling Programs	None	None
Asthma Education Program	None	None
Diabetes Self-Management Training and Education Program	None	None

C. PHYSICIAN SERVICES	**Participating Provider Co-payment/Coinsurance**	**Non-Participating Provider Co-payment/Coinsurance**
Anesthesia	20% of Eligible Charge	20% of Eligible Charge
Physician Visits: • Office • Hospital (inpatient or outpatient) • Emergency Room	• $12 Co-payment • $12 Co-payment • $12 Co-payment	• $12 Co-payment • $12 Co-payment • $12 Co-payment
Second Opinions **Prior Authorization required for opinions rendered by out-of-state providers.**	$12 Co-payment	$12 Co-payment
Consultations	$12 Co-payment	$12 Co-payment

D. SURGICAL SERVICES (Certain Surgical Services may require Prior Authorization)	**Participating Provider Co-payment/Coinsurance**	**Non-Participating Provider Co-payment/Coinsurance**
Assistant Surgeon	20% of Eligible Charge	20% of Eligible Charge
Cutting and Non-Cutting Surgery, inpatient	20% of Eligible Charge	20% of Eligible Charge
Cutting and Non-Cutting Surgery, outpatient	20% of Eligible Charge	20% of Eligible Charge
Surgical supplies	20% of Eligible Charge	20% of Eligible Charge

E. HOSPITAL SERVICES	**Participating Provider Co-payment/Coinsurance**	**Non-Participating Provider Co-payment/Coinsurance**
Ambulatory Surgical Center (ASC)	20% of Eligible Charge	20% of Eligible Charge
Hospital Room and Board	20% of Eligible Charge	20% of Eligible Charge
Special Care Units (such as coronary care, intensive care, telemetry, or isolation)	20% of Eligible Charge	20% of Eligible Charge
Hospital Ancillary Services	20% of Eligible Charge	20% of Eligible Charge
Emergency Room **For emergencies only**	20% of Eligible Charge	20% of Eligible Charge

F. SKILLED NURSING FACILITY SERVICES	**Participating Provider Co-payment/Coinsurance**	**Non-Participating Provider Co-payment/Coinsurance**
Room and Board (up to 120 days per calendar year)	20% of Eligible Charge	20% of Eligible Charge
Ancillary Services	20% of Eligible Charge	20% of Eligible Charge

G. HOSPICE / CONCURRENT CARE SERVICES	**Participating Provider Co-payment/Coinsurance**	**Non-Participating Provider Co-payment/Coinsurance**
Hospice / Concurrent Care Services **Prior Authorization required after initial 14 days**	None	None

H. DIAGNOSTIC TESTING, LABORATORY AND RADIOLOGY SERVICES	**Participating Provider Co-payment/Coinsurance**	**Non-Participating Provider Co-payment/Coinsurance**
Allergy testing	20% of Eligible Charge	20% of Eligible Charge
Diagnostic Mammography	None	None
Diagnostic Testing – inpatient	20% of Eligible Charge	20% of Eligible Charge
Diagnostic Testing – outpatient	20% of Eligible Charge	20% of Eligible Charge

Genetic Testing and Counseling **Prior Authorization required for testing**	20% of Eligible Charge	20% of Eligible Charge
Genetic Testing and Counseling Related to Breast Cancer (BRCA) Screening **Prior Authorization required**	None	None
Laboratory and Pathology – inpatient	20% of Eligible Charge	20% of Eligible Charge
Laboratory and Pathology – outpatient	20% of Eligible Charge	20% of Eligible Charge
Radiology – inpatient	20% of Eligible Charge	20% of Eligible Charge
Radiology – outpatient **Prior Authorization required for PET Scans and CTCA**	20% of Eligible Charge	20% of Eligible Charge
Tuberculin Test	None	None

I. CHEMOTHERAPY AND RADIATION THERAPY SERVICES	**Participating Provider Co-payment/Coinsurance**	**Non-Participating Provider Co-payment/Coinsurance**
Chemotherapy **Prior Authorization required for certain treatments**	20% of Eligible Charge	20% of Eligible Charge
Oral Chemotherapy **Prior Authorization required for certain drugs** **Benefits are available for these drugs under this Plan only if you do not have a drug plan which provides coverage for oral chemotherapy**	None	Not covered
Oral Chemotherapy by Mail Order (limited to a 30-day supply) **Prior Authorization required for certain drugs** **Benefits are available for these drugs under this Plan only if you do not have a drug plan which provides coverage for oral chemotherapy**	None	Not covered
Radiation therapy **Prior Authorization required for certain treatments**	20% of Eligible Charge	20% of Eligible Charge

J. ORGAN TRANSPLANT SERVICES	**Participating Provider Co-payment/Coinsurance**	**Non-Participating Provider Co-payment/Coinsurance**
Transplant Evaluation **Prior Authorization required for evaluations rendered by out-of-state providers**	None	None

Corneal transplants	None	None
All other organ transplants **Prior Authorization required**	None	None
Organ donor services **Prior Authorization required**	20% of Eligible Charge	20% of Eligible Charge

K. MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES	**Participating Provider Co-payment/Coinsurance**	**Non-Participating Provider Co-payment/Coinsurance**
Mental Health and Substance Abuse facility services	20% of Eligible Charge	20% of Eligible Charge
Mental Health and Substance Abuse Professional Services – inpatient	$12 Co-payment	$12 Co-payment
Mental Health and Substance Abuse Professional Services – outpatient	$12 Co-payment	$12 Co-payment
Psychological Testing – inpatient	20% of Eligible Charge	20% of Eligible Charge
Psychological Testing – outpatient **Prior Authorization required**	20% of Eligible Charge	20% of Eligible Charge

L. SPECIFIC BENEFITS FOR CHILDREN	**Participating Provider Co-payment/Coinsurance**	**Non-Participating Provider Co-payment/Coinsurance**
Newborn Circumcision	None	None
Newborn Nursery Care	None	None
Well Child Care Physician Office Visits	None	None

M. SPECIFIC BENEFITS FOR WOMEN	**Participating Provider Co-payment/Coinsurance**	**Non-Participating Provider Co-payment/Coinsurance**
Birthing Room	None	None
Cervical Cancer Screening (Pap Smear)	None	None
Family Planning	None	None
Gonorrhea Screening	None	None
Mammography for Breast Cancer Screening	None	None
Maternity Care	None	None
Tubal Ligation	None	None

Termination of Pregnancy	None	None
Well Woman Exam	None	None
Oral Contraceptives from pharmacy (30-day supply) **Benefits are available for these Contraceptives under this Plan only if you do not have a drug plan which provides coverage for contraceptives**	None (Generic, Preferred & Non-Preferred Brands)	None (Generic, Preferred & Non-Preferred Brands)
Oral Contraceptives by Mail Order & Maintenance Retail (60-day supply for Brand and 90-day supply for Generic) **Benefits are available for these Contraceptives under this Plan only if you do not have a drug plan which provides coverage for contraceptives**	None (Generic, Preferred & Non-Preferred Brands)	Not covered
Over-the-counter (OTC) Contraceptives from pharmacy **Benefits are available for these Contraceptives under this Plan only if you do not have a drug plan which provides coverage for contraceptives**	None (Generic, Preferred & Non-Preferred Brands)	None (Generic, Preferred & Non-Preferred Brands)
Contraceptive Cervical Caps/ Diaphragms	None	None
Contraceptive Implants, Injections, IUDs	None	None

N. SPECIFIC BENEFITS FOR MEN	**Participating Provider Co-payment/Coinsurance**	**Non-Participating Provider Co-payment/Coinsurance**
Prostate Specific Antigen (PSA) Test	None	None
Vasectomy	None	None
Erectile Dysfunction	20% of Eligible Charge	20% of Eligible Charge

O. SPECIFIC BENEFITS FOR MEMBER AND SPOUSE OR CIVIL UNION PARTNER	**Participating Provider Co-payment/Coinsurance**	**Non-Participating Provider Co-payment/Coinsurance**
Artificial Insemination	20% of Eligible Charge	Not Covered
In Vitro Fertilization **Prior Authorization required**	20% of Eligible Charge	20% of Eligible Charge

P. SPECIFIC BENEFITS FOR DIABETES	**Participating Provider Co-payment/Coinsurance**	**Non-Participating Provider Co-payment/Coinsurance**
Diabetes drugs from pharmacy (limited to 30-day supply) **Benefits are available for these drugs under this Plan only if you do not have a drug plan which provides coverage for diabetes drugs**	None (Generic, Preferred & Non-Preferred Brands)	None (Generic, Preferred & Non-Preferred Brands)
Diabetes drugs by Mail Order & Maintenance Retail (90-day supply) **Benefits are available for these drugs under this Plan only if you do not have a drug plan which provides coverage for diabetes drugs**	None (Generic, Preferred & Non-Preferred Brands)	Not covered
Insulin from pharmacy (limited to 30-day supply) **Benefits are available for insulin under this Plan only if you do not have a drug plan which provides coverage for insulin**	None (Preferred & Non-Preferred Brands)	None (Preferred & Non-Preferred Brands)
Insulin by Mail Order & Maintenance Retail (90-day supply) **Benefits are available for insulin under this Plan only if you do not have a drug plan which provides coverage for insulin**	None (Preferred & Non-Preferred Brands)	Not covered
Diabetes supplies from pharmacy (limited to 30-day supply) **Benefits are available for these supplies under this Plan only if you do not have a drug plan which provides coverage for diabetes supplies**	None (Preferred & Non-Preferred Brands)	None (Preferred & Non-Preferred Brands)
Diabetes supplies by Mail Order & Maintenance Retail (90-day supply) **Benefits are available for these supplies under this Plan only if you do not have a drug plan which provides coverage for diabetes supplies**	None (Preferred & Non-Preferred Brands)	Not covered
Diabetes Self-Management Training and Education Program	None	None

Q. COMPLEMENTARY ALTERNATIVE MEDICINE (Services provided by a Chiropractor or **Acupuncturist** for conditions limited to the neuromusculoskeletal system)	**Participating Provider Co-payment/Coinsurance**	**Non-Participating Provider Co-payment/Coinsurance**
Office visit	$10 Co-payment	Plan pays up to $20 per visit; you pay balance
First set of x-rays	50% of Eligible Charge	Not covered

Other imaging services	Not covered	Not covered

R. OTHER MEDICAL SERVICES	**Participating Provider Co-payment/Coinsurance**	**Non-Participating Provider Co-payment/Coinsurance**
Advance Care Planning	None	None
Ambulance (ground or inter-island air) **For emergencies only**	20% of Eligible Charge	20% of Eligible Charge
Applied Behavioral Analysis for Autism Spectrum Disorders **Prior Authorization required**	$12 Co-payment	$12 Co-payment
Bariatric Surgery	20% of Eligible Charge	Not Covered
Blood, Blood Products, and Blood Bank Service Charges	20% of Eligible Charge	20% of Eligible Charge
Dialysis and Supplies	20% of Eligible Charge	20% of Eligible Charge
Evaluations for Use of Hearing Aids	$12 Co-payment	$12 Co-payment
Growth Hormone Therapy **Prior Authorization required**	20% of Eligible Charge	20% of Eligible Charge
Home Health Care (up to 150 visits per calendar year) **Prior Authorization required after first 12 visits**	20% of Eligible Charge	20% of Eligible Charge
Home Infusion Therapy **Prior Authorization required for Adult Home TPN services**	20% of Eligible Charge	20% of Eligible Charge
Hyperbaric Oxygen Treatment **Prior Authorization required**	20% of Eligible Charge	20% of Eligible Charge
Implants	20% of Eligible Charge	20% of Eligible Charge
Inhalation Therapy	20% of Eligible Charge	20% of Eligible Charge
Injectable Medications (Outpatient) **Prior Authorization required for certain injectables**	20% of Eligible Charge	20% of Eligible Charge
Medical Equipment and Appliances **Prior Authorization required when purchase is greater than $500 or rental is greater than $100/month**	20% of Eligible Charge	20% of Eligible Charge
Medical Foods	20% of Eligible Charge	20% of Eligible Charge
Orthotics	20% of Eligible Charge	20% of Eligible Charge

Physical and Occupational Therapy Services **Prior Authorization required following 32 units (1 unit = 15 minutes)**	$12 Co-payment	$12 Co-payment
Prosthetics **Prior Authorization required when cost is more than $500**	20% of Eligible Charge	20% of Eligible Charge
Pulmonary Rehabilitation – Outpatient	20% of Eligible Charge	20% of Eligible Charge
Speech Therapy Services **Prior Authorization required**	$12 Co-payment	$12 Co-payment
Telehealth Services	Your Co-payment/Coinsurance amounts vary depending on the type of service or supply. See Co-payment/Coinsurance amounts listed in this chart for the service or supply you receive	

SECTION 5: DESCRIPTION OF BENEFITS

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

Additional Coverage Mandated by Law	As may be required by law, including without limitation in response to State and/or Federal emergency declarations, this plan may provide expanded benefits and coverage policies not described in this Guide. Up-to-date information related to such circumstances, including emergency declarations, will be posted on our website at uhahealth.com.

A. PREVENTIVE CARE SERVICES

UHA covers all U.S. Preventive Services Task Force (USPSTF) A and B recommended screening services at 100% as required under the provisions of the Affordable Care Act (ACA).

Well Child Care Physician Office Visits	Covered, including routine sensory screening, and developmental/behavioral assessments according to the American Academy of Pediatrics Periodicity Schedule of the Bright Futures Recommendations for Preventive Pediatric Health Care: • birth to one year: seven visits • age one year: three visits • age two years: two visits • ages three years through twenty-one 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 national CDC Advisory Committee on Immunization Practices (ACIP)
Well Child Care Laboratory Tests	Covered, UHA clinical preventive services guidelines are derived from the clinical recommendations of the USPSTF and Bright Futures. USPSTF guidelines are evidence-based and rely on current scientific studies, and are the basis for the guidelines in the ACA. Bright Futures guidelines represent a consensus by the American Academy of Pediatrics (AAP).
Preventive Medicine Office Visit	Covered, one per calendar year for a preventive health examination for members who are 22 and older. This benefit is in addition to the Well Woman Exam Benefit described below.
Well Woman Exam	Covered, for one annual health assessment per calendar year. The assessment should include screening, evaluation and counseling, and immunizations based on age and risk factors. Please refer to the Cervical Cancer Screening (Pap Smear) language below for specific benefit information.
Screening Laboratory Services	Covered, UHA clinical preventive services guidelines are derived from the clinical recommendations of the USPSTF. USPSTF guidelines are evidence-based and rely on current scientific studies, and are the basis for the guidelines in the ACA.
Adult Immunizations	Covered, for standard Immunizations 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

Mammography for Breast Cancer Screening	Covered, one per calendar year for women ages 40 and older. Annual screening for women under 40 is allowed with a physician's order for women with a personal history of breast cancer, a history of chest irradiation, a family history of breast cancer in a first degree relative or a known genetic predisposition to breast cancer. Each member's frequency of testing should be determined after consultation with her physician to assure that current recommendations and personal risk factors are considered. Please note: mammograms that are not done for breast cancer screening fall under your diagnostic mammography benefits, which are included in the heading "Diagnostic Testing, Laboratory and Radiology Services."
Cervical Cancer Screening (Pap Smear)	Covered, one every three years for women ages 21 to 65.
Chlamydia Screening	Covered, one per calendar year
Osteoporosis Screening	Covered, coverage for initial screening and repeat testing interval is based on age and risk factors per USPSTF and National Osteoporosis Foundation guidelines.
Colorectal Cancer Screening	Covered, based on age and risk factors in compliance with current USPSTF guidelines.
Diabetes Prevention Program	The Diabetes Prevention Program is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle. Coverage is limited to one program per lifetime. If you receive benefits for this program under a UHA Plan, you will not be eligible for benefits for the program under any other UHA Plan.
Gonorrhea Screening	Covered, one per calendar year

B. DISEASE MANAGEMENT PROGRAMS

Smoking Cessation Program	Covered
Nutritional Counseling Programs	Covered, but only when counseling is provided: • by a Registered Dietician (RD), Certified Nutrition Specialist (CNS), or Certified Diabetes Educator (CDE); and • for the treatment of eating disorders, convulsions/seizures, cardiovascular disease, hypertension, renal disease (chronic kidney disease and end stage renal disease), Crohn's disease, gastrointestinal disorders, gout, obesity in adults (BMI ≥ 30 kg/m2), loss of weight, pediatric overweight and obesity (BMI > 95%), pancreatitis, pre- and post-bariatric surgery, pre-natal diet regulation, obstructive sleep apnea, squamous cell – oropharynx, or diabetes

Asthma Education	Covered, through our Asthma Education Program Please contact the Health Care Services department for information about this program.
Diabetes Self-Management Training and Education	Covered, through our Diabetes Education Program, but only through a Certified Diabetes Educator (CDE), Registered Dietician (RD), or Certified Nutrition Specialist (CNS). Please contact the Health Care Services department for information about this program.
Disease Education Programs	UHA provides Disease Education Programs for members with diabetes and asthma. For information about these programs, please call our Health Care Services department. Information is also available on our website at 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** and Conscious sedation. Please note*:* Anesthesia for dental services are covered in accord with our medical payment policy and requires Prior Authorization.
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.
Physician Visits – Emergency Room	Covered, but only if the services provided are: (1) **Emergency Services** as defined in accordance with the definition established in Hawaii Revised Statutes (sect. 432E-1) as services provided to an individual when the individual has symptoms of sufficient severity, including severe pain, such that a layperson could reasonably expect, in the absence of medical treatment, to result in placing the individual's health or condition in serious jeopardy, serious impairment of bodily functions, serious dysfunction of any bodily organ or part, or death; (2) with respect to a pregnant woman, a layperson could reasonably expect the absence of medical treatment to result in serious jeopardy to the health of the woman and her unborn child, or (3) Emergency Services provided to an individual when the individual has symptoms of sufficient severity, severe pain, or acute symptoms, including a mental health condition or substance use disorder, as defined in accordance with federal law (the federal Affordable Care Act and the federal No Surprises Act of 2021). 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 • severe pain • 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, earaches, sore throat, medication refills, and using the emergency room for your convenience or during normal physician office hours for medical conditions that could be treated in your doctor's office.

Once your condition is stabilized, generally, Covered Services that you receive are Post-Stabilization Care. The exception is when you receive Emergency Services from Non-Participating Providers and federal law requires coverage of your Post-Stabilization Care as Emergency Services.

Second Opinions Covered, second opinions on the necessity of surgery or other treatment.

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

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.

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 preoperative and postoperative 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; destruction of localized lesions by chemotherapy (excluding silver nitrate); cryotherapy or electrosurgery; and acne treatment.

Nonsurgical interventional treatment for subacute and chronic spinal pain requires Prior Authorization (see Section 7: Health Care Services Program).

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 or plastic surgery that is primarily intended to improve your natural appearance and does not restore or materially improve a physical function is considered cosmetic and is not covered. Services related to complications of non-covered reconstructive surgery are also not covered.

Women's Health and Cancer Rights Act of 1998

Following a mastectomy, reconstruction of the breast on which the mastectomy is performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, prostheses and treatment of physical complications of the mastectomy, including lymphedema, in a manner determined in consultation with the attending physician and the patient, **are covered** as provided for in the Women's Health and Cancer Rights Act of 1998 **and do not require Prior Authorization**. Such coverage is subject to Co-payments or Coinsurance that are consistent with those established for other benefits under this Plan. Please refer to Section 4 for information on Co-payments or Coinsurance.

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**

  Covered, but only for certain oral Surgical Services provided by a physician or a dentist. Services of a dentist (DDS or DMD) are Covered Services only when:
  - the dentist is performing emergency service (for an accidental injury) or Surgical Services, and
  - these Covered Services could also be performed by Physicians (MD or DO)

  Coverage is limited to: the removal of tumors and cysts; surgery to correct injuries; cutting and draining of cellulitis; cutting of sinuses, salivary glands, or ducts; and reduction of dislocations. These services, including those anticipated to require hospitalization if you have a serious medical problem, require Prior Authorization (see Section 7: Health Care Services Program).

- **Payment Based on Appropriate Place for Surgery**

  If you choose to have a surgery as an inpatient in a hospital or other facility when it could have 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. The hospital facility must hold current national accreditation with either the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the Commission on Accreditation of Rehabilitation Facilities (CARF) for any level of care including acute inpatient, residential, partial hospitalization, or intensive outpatient programs.

Ambulatory Surgical Center (ASC)

Covered, including operating rooms, surgical supplies, drugs, dressing, anesthesia services and supplies, oxygen, antibiotics, blood transfusion services, routine lab and x-ray related to surgery. An ASC is an outpatient facility that provides surgical services without an overnight stay. This facility may be in a hospital or it may be a separate independent facility.

Please note: Anesthesia for dental services are covered in accord with our medical payment policy and requires Prior Authorization.

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.

72 hours advance notification is required for elective hospital admissions (including skilled nursing facilities and rehabilitation facilities) when possible. UHA requires notification of emergency and non-elective admissions within two (2) business days of admission.

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 Provider'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 Provider, 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 surgical supplies, hospital anesthesia services and supplies, diagnostic and therapy services, drugs, dressings, oxygen, antibiotics, and hospital blood transfusion services.

Please note*:* Anesthesia for dental services are covered in accord with our medical payment policy and requires Prior Authorization.

Emergency Room

Covered, but only if the services provided are: (1) Emergency Services as defined in accordance with the definition established in Hawaii Revised Statutes (sect. 432E-1) as services provided to an individual when the individual has symptoms of sufficient severity, including severe pain, such that a layperson could reasonably expect, in the absence of medical treatment, to result in placing the individual's health or condition in serious jeopardy, serious impairment of bodily functions, serious dysfunction of any bodily organ or part, or death; (2) with respect to a pregnant woman, a layperson could reasonably expect the absence of medical treatment to result in serious jeopardy to the health of the woman and her unborn child; or (3) Emergency Services provided to an individual when the individual has symptoms of sufficient severity, severe pain, or acute symptoms, including a mental health condition or substance use disorder, as defined in accordance with federal law (the federal Affordable Care Act and the federal No Surprises Act of 2021).

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
- severe pain
- 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, earaches, sore throat, medication refills, and using the emergency room for your convenience or during normal physician office hours 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, generally, hospital inpatient benefits apply and not emergency room benefits. The exception is when federal law requires coverage of your Post-Stabilization Care and other certain services as Emergency Services.

F. SKILLED NURSING FACILITY SERVICES

General

Skilled Nursing Facility services are covered up to 120 days per calendar year

Notification of Admission

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 within 72 hours of your admission.

Room and Board	Covered, but only at the Eligible Charge for a semi-private room
Ancillary Services	Covered, including routine surgical supplies, drugs, dressings, oxygen, antibiotics, blood transfusion services, and diagnostic and therapy services
Limitations	Eligibility for skilled nursing facility services requires that all of the following be true: • you meet the Medicare skilled nursing criteria • 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. HOSPICE / CONCURRENT CARE SERVICES

Hospice / Concurrent Care Services

Covered, but only if services are received from a Medicare-approved **Hospice** program.

Prior Authorization is required for hospice/concurrent care services after the initial 14 days to allow for the development of a descriptive and analytic care plan (see Section 7: Health Care Services Program for information on Prior Authorization).

Covered Services include:

- 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

UHA endorses an "open access" model of hospice care in which palliative care can involve radiation, chemotherapeutic and surgical therapies alongside typical palliative interventions including pain and other symptom management. Open access/concurrent care services are covered when the following criteria are met:

- Services are prescribed in writing by an attending physician with intimate knowledge of the disease process(es)
- Services are provided by a Medicare-certified hospice under contract with UHA
- The patient carries the diagnosis of a disease which is active, progressive and irreversible (end-stage), and which has resulted in a greatly reduced life expectancy for which palliative and supportive interventions are medically necessary
- Services are for the FINAL stages of a terminal disease process and are NOT custodial care
- Interdisciplinary hospice care team management is ongoing, medically necessary and appropriately documented

Please refer to the specific benefits and UHA's Hospice: An Open Access Model of Concurrent Care medical payment policy for more information on services.

A certification/attestation of life expectancy of less than or equal to six months is NOT required.

H. DIAGNOSTIC TESTING, LABORATORY AND RADIOLOGY SERVICES

Allergy Testing and Treatment Materials

Covered

Diagnostic Testing

Covered, when related to an injury, illness, or maternity care. Examples of diagnostic testing include:

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

Genetic Testing and Counseling

Covered, but genetic testing 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, injury, or maternity care. Additional benefits for routine and preventive laboratory tests are described in the "Specific Benefits" categories later in this section

Radiology

Covered, when related to an illness, injury, or maternity care. 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 and CTCA require Prior Authorization. Please refer to Section 7: Health Care Services Program for information on Prior Authorization.

Tuberculin Test

Covered, for one tuberculin (TB) test per calendar year

I. CHEMOTHERAPY AND RADIATION THERAPY

Chemotherapy

Covered

Prior Authorization is not required unless the recommended treatment plan does not conform to one of the nationally recognized oncology compendia.

Oral chemotherapy drugs are covered, but only when you do not have a prescription drug plan which provides coverage for oral chemotherapy. If you have coverage for oral chemotherapy drugs under a drug plan, there shall be no duplication of benefits between this Plan and your drug plan and this Plan will pay secondary to the more specific coverage afforded by your drug plan.

Radiation Therapy

Covered

Prior Authorization is required for certain treatments. Please refer to Section 7: Health Care Services Program for information on Prior Authorization.

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, except for artificial hearts when used as a bridge to a permanent heart transplant
- non-human organs
- the purchase of organs
- organ or tissue transplants not listed in this Organ Transplant Services section

Transplant Evaluations

Covered, for transplants listed in this Guide. Prior Authorization is required for transplant evaluations rendered by out-of-state providers.

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 if you meet UHA's criteria and obtain Prior Authorization (see Section 7: Health Care Services Program)

Heart Transplants

Covered, but only if you meet UHA's criteria and obtain Prior Authorization (see Section 7: Health Care Services Program)

Heart and Lung Transplants

Covered, but only if you meet UHA's criteria and obtain Prior Authorization (see Section 7: Health Care Services Program)

Kidney Transplants

Covered, but only if you meet UHA's criteria and obtain Prior Authorization (see Section 7: Health Care Services Program)

Liver Transplants

Covered, but only if you meet UHA's criteria and obtain Prior Authorization (see Section 7: Health Care Services Program)

Lung Transplants

Covered, but only if you meet UHA's criteria and obtain Prior Authorization (see Section 7: Health Care Services Program)

Pancreas Transplants

Covered, but only if you meet UHA's criteria and obtain Prior Authorization (see Section 7: Health Care Services Program)

Simultaneous Kidney/Pancreas Transplants	Covered, but only if you meet UHA's criteria and obtain Prior Authorization (see Section 7: Health Care Services Program)
Small Bowel and Multivisceral Transplants	Covered, but only if you meet UHA's criteria and obtain 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. If you are donating an organ to someone else, then no benefits are available under this Plan. If 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, then this coverage is secondary and the living donor's coverage is primary. No benefits are available under this Plan to the living donor for post-transplant donor services. 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 treatment plan subject to review and approval by UHA or our designee
- the services are provided by a licensed physician, **psychiatrist, psychologist**, clinical social worker, mental health counselor, marriage and family therapist, or advanced practice registered nurse. Nutritional counseling services for the treatment of eating disorders is covered, but only when the services are provided by a Registered Dietician (RD) or Certified Nutrition Specialist (CNS)
- except for telehealth interactions as defined by Hawaii law and family psychotherapy sessions as discussed below, you are physically present with the provider when the services are provided. Standard telephone contacts, facsimile transmissions, or email text, in combination or by itself, do not constitute a telehealth service
- each family psychotherapy session may only be billed to one family member, even if the provider is seeing multiple members of the same family. Coverage will be provided for family psychotherapy without the patient present
- the services are certified as medically or psychologically necessary at the least restrictive appropriate level of care in accordance with Hawaii law

Conditions such as epilepsy, senility, intellectual disability, 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.

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 covered for treatment provided by a marriage and family therapist but only for treatment of mental illness or substance or drug abuse. You are not otherwise covered for services rendered by a marriage and family therapist.

Outpatient Mental Health or Substance Abuse Services

Covered, as follows:

- outpatient visits by a licensed physician, psychiatrist, psychologist, clinical social worker, mental health counselor, marriage and family therapist, or advanced practice registered nurse for mental health or substance abuse conditions. Nutritional counseling services for the treatment of eating disorders is covered, but only when the services are provided by a Registered Dietician (RD) or Certified Nutrition Specialist (CNS)
- outpatient psychological testing requires Prior Authorization (see Section 7: Health Care Services Program).
- residential chemical dependency/substance abuse treatment requires 72 hours advance notification

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, medically necessary care, and hospital ancillary services.
- inpatient visits by a licensed physician, psychiatrist, psychologist, clinical social worker, mental health counselor, marriage and family therapist, or advanced practice registered nurse for mental health or substance abuse conditions. Nutritional counseling services for the treatment of eating disorders is covered, but only when the services are provided by a Registered Dietician (RD) or Certified Nutrition Specialist (CNS).
- Chemical dependency/substance abuse treatment requires 72 hours advance notification.

L. SPECIFIC BENEFITS FOR CHILDREN

Newborn Circumcision

Covered

Newborn Nursery Care

Newborn nursery length of stay, covered for up to:

- 48 hours from the time of delivery for normal labor and delivery; or
- 96 hours from the time of delivery for a cesarean birth

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 Section 2: Eligibility and Enrollment).

Newborns with congenital defects and birth abnormalities are covered for the first 31 days of birth to the extent required by Hawaii law. These newborns are covered after 31 days of birth only if added to your coverage within 31 days of birth.

Well Child Care Physician Office Visits

Please refer to Section 5.A: Preventive Care Services for more information.

M. SPECIFIC BENEFITS FOR WOMEN

Birthing Room	Covered, but only for labor and delivery
Cervical Cancer Screening (Pap Smear)	Please refer to Section 5.A: Preventive Care Services for more information.
Family Planning Services	Covered, including abortion counseling and information on birth control
Gonorrhea Screening	Covered, one per calendar year
Mammography for Breast Cancer Screening	Please refer to Section 5.A: Preventive Care Services for more information.
Maternity Care	Covered, including prenatal, false labor, delivery, and postnatal services provided by your physician or **Certified Nurse Midwife**. Maternity care does not include related services such as nursery care, labor room, hospital room and board, diagnostic testing, and other lab work and radiology. Please refer to the specific benefits for more information on those services. The Eligible Charge is a global fee related to a bundle of maternity care, which 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 Co-payments or Coinsurance may apply. Maternity length of stay, covered for up to: • 48 hours from the time of delivery for normal labor and delivery; or • 96 hours from the time of delivery for a cesarean birth
Prenatal Program	UHA may contract with vendors to reduce complications of pregnancy and improve quality of care for expectant mothers with diabetes. For information about our current programs, please call our Health Care Services department.
Tubal Ligation	Covered, for only the initial surgery for tubal ligation. Reversal of a tubal ligation is not covered
Termination of Pregnancy	Covered
Well Woman Exam	Please refer to Section 5.A: Preventive Care Services for more information.
Contraceptive Services and Supplies	Covered, for selected brands and generics determined by UHA in accordance with Hawaii law, but only when: • prescribed by your physician (except for emergency contraceptives); • approved by the Food and Drug Administration; and • you do not have a prescription drug plan which provides coverage for contraceptives.

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

Benefit payment for contraceptives is limited to one contraceptive method per period of effectiveness. If you have coverage for contraceptives under a drug plan, there shall be no duplication of benefits between this Plan and your drug plan and this Plan will pay secondary to the more specific coverage afforded by your drug plan.

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.

Over-the-counter (OTC) Contraceptives — Covered, for selected brands and generics determined by UHA in accordance with Hawaii law, but only when you receive a written prescription and when obtained from a licensed pharmacist.

N. SPECIFIC BENEFITS FOR MEN

Prostate Specific Antigen (PSA) Test — Covered, for one screening prostate specific antigen test per calendar year for men age 50 or older.

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 due to organic cause as defined by UHA or as described in this section under Section 5.R: Other Medical Services; Gender Identity Services.

O. SPECIFIC BENEFITS FOR MEMBER AND SPOUSE OR CIVIL UNION PARTNER

Artificial Insemination — Covered. Please refer to the specific benefits for more information about coverage for other related services such as office visits, labs, and radiology.

In Vitro Fertilization — Covered, to the extent required by Hawaii Law if the in vitro fertilization is for you and your Spouse or Civil Union Partner. Coverage is limited to a one-time only benefit for one outpatient in vitro fertilization procedure while you are a UHA member. If you receive benefits for in vitro fertilization services under a UHA Plan, you will not be eligible for in vitro fertilization benefits under any other UHA Plan.

One complete in vitro procedure is covered. 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 vitro fertilization services are not covered when a surrogate is used. The in vitro procedures must be performed at a medical facility that conforms to the American College of Obstetrics and Gynecology guidelines for in vitro fertilization clinics or to the American Society for Reproductive Medicine minimum standards for programs of in vitro fertilization.

Covered for you and your Spouse or Civil Union Partner if all of the following criteria are met:

1. For female-male couples:

(a) You and your Spouse or Civil Union Partner have a five-year history of infertility or infertility is related to one or more 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.

(b) You and your male Spouse or Civil Union Partner have been unable to attain a successful pregnancy through other infertility treatments

(c) Oocytes are fertilized with the Spouse or Civil Union Partner's sperm

2. For female-female couples:
   (a) You are not known to be otherwise infertile, and
   (b) You have failed to achieve pregnancy following three cycles of physician-directed, appropriately timed intrauterine insemination

P. SPECIFIC BENEFITS FOR DIABETES

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 which provides coverage for diabetes drugs, insulin and supplies.

If you have a drug plan which provides coverage for diabetes drugs, insulin and supplies, there shall be no duplication of benefits between this Plan and your drug plan and this Plan will pay secondary to the more specific coverage afforded by your drug plan.

Diabetes drugs, insulin, and supplies can be **Generic**, **Preferred Brand** or **Non-Preferred Brand**.

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 List.

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

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

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

Diabetes Self-Management Training and Education	Covered, through our Diabetes Education Program, but only through a Certified Diabetes Educator (CDE), Registered Dietician (RD), or Certified Nutrition Specialist (CNS). Please contact the Health Care Services department for information about this program.
Prenatal Program	UHA may contract with vendors to reduce complications of pregnancy and improve quality of care for expectant mothers with diabetes. For information about our current programs, please call our Health Care Services department.

Q. COMPLEMENTARY ALTERNATIVE MEDICINE

Services Provided by a Chiropractor or Acupuncturist

Covered, subject to the following:

- benefits are limited to treatment of conditions of the neuromusculoskeletal system, which consists of the nerves, muscles and bones
- the service is provided by a qualified provider of chiropractic or acupuncture services. A qualified provider is an individual who is licensed appropriately, performs within the scope of his/her licensure and is recognized by UHA
- 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 other imaging services ordered or performed by participating or 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

R. OTHER MEDICAL SERVICES

Advance Care Planning	Covered
Ambulance	Covered, for ground and intra-island or inter-island air ambulance services to the nearest hospital equipped 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 or in the emergency department where you are initially seen • 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 services to the continental United States (US) is covered in certain situations when treatment for critical care is not available in Hawaii and air ambulance transportation to the continental US with life supporting equipment and/or a medical support team is needed. Services are covered in accord with UHA's medical payment policy and require Prior Authorization (see Section 7: Health Care Services Program). Exclusions or limitations may apply, see Section 6: Services Not Covered.

Applied Behavioral Analysis for Autism Spectrum Disorders

Treatment and therapeutic care for members with clearly diagnosed autism is covered in accordance with Hawaii law. These services require Prior Authorization (Section 7: Health Care Services Program) with a defined and personalized treatment plan after the diagnosis is made. Services must be provided by licensed or certified providers as defined by the Hawaii Revised Statutes. Medical necessity determinations rest upon complex diagnostic criteria and the early involvement of pediatric psychiatrists and/or psychologists in making diagnoses and originating treatment plans can simplify this process.

Bariatric Surgery

Covered

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."

Dialysis and Dialysis Supplies

Covered

Evaluations for Hearing Aids

Covered, but only when you receive the evaluation for the use of a hearing aid in the office of a physician or an audiologist

Gender Identity Services

Covered, subject to the limitations described in our medical payment policy. Certain services require Prior Authorization (see Section 7: Health Care Services Program); exclusions may apply (see Section 6: Services Not Covered).

The services listed below are covered, but only when deemed medically necessary to treat gender dysphoria. Your Co-payments and Coinsurance may vary depending on the type of service or supply you receive (see Section 4: Summary of Benefits and Payment Obligations). Additional benefit information about the service or supply you receive can be found in other areas of this section.

- Gender reassignment/confirmation surgery
- Hospital room and board
- Hormone replacement therapy
- Laboratory monitoring
- Other gender reassignment/confirmation surgery related services and supplies which are medically necessary and not excluded. These include but are not limited to sexual identification counseling, pre-surgery consultations and post-surgery follow-up visits
- Otherwise Covered Services deemed medically necessary to treat gender dysphoria

Growth Hormone Therapy

Covered, subject to the limitations described in our medical payment policy, but requires Prior Authorization (see Section 7: Health Care Services Program)

Benefits for human growth hormone therapy are available for eligible persons based on medical necessity

Home Health Care

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

- 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

Prior Authorization is required for home health care services after the first 12 visits (see Section 7: Health Care Services Program for information on Prior Authorization).

Home Infusion Therapy

Covered, for services and supplies for outpatient injections or intravenous administration of medication or nutrient solutions required for primary diet

Home total parenteral nutrition (TPN) for adults requires Prior Authorization (see Section 7: Health Care Services Program).

Hyperbaric Oxygen Treatment

Covered, but only with Prior Authorization

Implants

Covered, for surgical implants like pacemakers, stents, and screws

Inhalation Therapy

Covered

Injectable Medications

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)

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

Medical Equipment and Appliances

Covered, up to the Eligible Charge, only when ordered by your physician and subject to the following conditions:
Prior Authorization is required (see Section 7: Health Care Services Program) when the purchase price for the item is greater than $500, or the rental fee for the item is greater than $100/month. Examples include, but are not limited to: humidifiers, ambulatory infusion pumps, vacuum drainage collection units, wheelchairs and hospital-type beds.

Hearing aids are covered up to the Eligible Charge for one device per ear, every five years. You may be responsible for paying the provider the difference between UHA's payment and the total actual charge. You are not covered for the replacement of hearing aids lost or broken within five years from the date of purchase.

Benefit payment for the rental of appliances and medical equipment is limited to the Eligible Charge to purchase the appliance or equipment.

Replacement appliances and medical 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. To "repair" means to fix or mend and put equipment back into good condition after damage or wear, and includes reasonable charges for parts and labor.

Repairs and maintenance of appliances and medical equipment

- Prior Authorization is required (Section 7: Health Care Services Program)
- You are not covered for routine maintenance of any medical equipment or appliance, including periodic servicing (such as testing, cleaning, adjusting, regulating and checking of equipment); unless you establish that you are unable due to illness, injury or disability to perform the periodic servicing. More extensive maintenance is covered when, based on manufacturer's recommendations, it should be performed by authorized technicians.
- There is no coverage for repair or maintenance to the extent parts and/or labor is covered by a manufacturer's or supplier's warranty or by the rental contract.
- If there is no coverage for the equipment or appliance under this section, then there is no coverage for repair or maintenance of the equipment or appliance.
- You are not covered for battery replacements or recharging related to any appliances or medical equipment.

Medical Foods

Medical foods and low protein modified food products are covered when prescribed for the treatment for an inborn error of metabolism in accord with Hawaii law.

Ophthalmologists, Services of

Services provided by ophthalmologists are only covered for treatment of medical conditions, such as glaucoma and cataracts. Corrective lenses prescribed as part of the post-operative care following surgery to correct a medical condition are covered under this section.

Services for vision care without a medical diagnosis, such as aniseikonic studies and prescriptions, prescription eyeglasses or contact lenses 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.

Orthodontic Treatment for Orofacial Anomalies

Covered, for medically necessary orthodontic services for the treatment of orofacial anomalies resulting from birth defects or birth defect syndromes to the extent required by Hawaii law only if you meet UHA's criteria and obtain Prior Authorization (Section 7: Health Care Services Program).

Benefits are limited to a maximum of $6,927 per treatment phase.

Orthotics

Covered, when prescribed by your physician. Foot orthotics are only covered for diabetic conditions and fractures.

You are not covered for orthotics management and training. Coverage for orthotics fitting and fabrication is included in the reimbursement for the orthotic itself.

Physical and Occupational Therapy

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

- the therapy is ordered by a Provider practicing within the scope of their license 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 qualified provider of physical or occupational therapy services. A qualified provider is an individual who is licensed appropriately, performs within the scope of his/her licensure and is recognized by UHA

Prior Authorization is required following 32 units (1 unit = 15 minutes) or 8 one hour sessions per calendar year. **Payment is limited to 4 units/session** (see Section 7: Health Care Services Program)

Group exercise programs are not covered.

When you receive both occupational and physical therapies, the therapies should provide different treatments and not duplicate the same treatment. 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.

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.

Pulmonary Rehabilitation

Pulmonary rehabilitation is a multidisciplinary approach to reducing symptoms and improving quality of life in patients with compromised lung function.

Benefits are not provided for maintenance programs.

Participants must meet UHA's eligibility criteria and guidelines. Pulmonary rehabilitation requires Prior Authorization (see Section 7: Health Care Services Program).

Routine Care Associated with Clinical Trials

Covered, in compliance with the Affordable Care Act. If you are eligible to participate in an approved clinical trial, you are covered for all routine patient costs while enrolled in the trial. Routine patient costs are all items and services that would be covered under your UHA Plan if you were not participating in the clinical trial.

Speech Therapy

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

- the therapy is ordered by a Provider practicing within the scope of their license 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 provided by a qualified provider of speech therapy services. A qualified provider is an individual who is licensed appropriately, performs within the scope of his/her licensure and is recognized by UHA
- the services are reasonably expected to improve the patient's condition through short-term care. (Long term maintenance programs are not covered.)
- the services require Prior Authorization (see Section 7: Health Care Services Program)

Telehealth

Health services received via telecommunications (integrated electronic transfer of medical data, including but not limited to real-time video conferencing-based communication, secure interactive and non-interactive web-based communication, and secure asynchronous information exchange) are covered in accordance with Hawaii law, if they are for otherwise Covered Services under this Agreement and are provided in accordance with generally accepted health care practices and standards prevailing in the applicable professional community in Hawaii. Covered at level applicable to service provided. Standard telephone contacts, facsimile transmissions, or email text, in combination or by itself, do not constitute telehealth services.

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, drugs, devices, or care, and all related services and supplies, which cannot be designated as being reasonably necessary for your care relative to other well established available services or equipment, or when the potential therapeutic benefit of such treatments are judged to be of a degree insufficient to offset the risk to patient safety and cost. The Prior Authorization process for experimental and investigative treatments is designed to define and address these issues with consideration for each member's individual circumstances.

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.

Non-Routine Care Associated with Clinical Trials

You are not covered for any items and services associated with clinical trials except as stated in Section 5: Description of Benefits. Non-routine patient costs include the investigational item, device, or service itself; items solely for data collection; or services clearly inconsistent with accepted standard of care. These non-covered items and services are usually provided without cost by the clinical trial.

FDA Approval Not Obtained

You are not covered for any service or supply that (i) cannot be legally marketed in the United States without the approval of the Food and Drug Administration (FDA) and such approval has not been granted; or (ii) is the subject of a current new drug or new device application on file with the FDA, that has not yet been approved by the FDA.

Dental Services

You are not covered for dental services except those services listed in Section 5: Description of Benefits under the headings "Oral Surgery" and "Orthodontic Treatment for Orofacial Anomalies." The following exclusions apply regardless of the symptoms or illnesses being treated:

- orthodontia
- dental splints and other dental appliances
- dental prostheses
- dental anesthesia except as described in Section 5: Description of Benefits; Physician Services under "Anesthesia"
- maxillary and mandibular implants (osseointegration) and all related services
- removal of impacted teeth
- any other dental procedures involving teeth, structures supporting the teeth, or gum tissues
- any services in connection with the treatment of temporomandibular joint (TMJ) problems or malocclusion of the teeth or jaw, except for limited medical services related to the initial diagnosis of TMJ or malocclusion.

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
- contact lens fitting, repair or replacement of frame parts and accessories, and contact lenses which are required after cataract surgery
- non-prescription eyeglasses and lenses, including sunglasses, reading glasses, blue light filtering lenses, and magnification lenses
- inserts for diving masks, non-prescription industrial safety goggles, and coating or tinting of lenses
- 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 and 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 implants (except following mastectomy as described in Section 5: Description of Benefits), labiaplasty, or rhinoplasty. You are not covered for excision of superficial benign tumors of the skin and subcutaneous tissue.

UHA maintains a list of procedures which are determined to be cosmetic in most cases. For the most current list of cosmetic procedures, visit our website at uhahealth.com under "Member Forms". The list is not exclusive, and UHA will deny coverage for any procedure determined to be cosmetic, whether or not it is on the list.

Counseling Services

Except as described in Section 5: Description of Benefits, you are not covered for any counseling services, including, but not limited to the following:

- bereavement counseling or services of volunteers or clergy
- marriage, couples, or family counseling
- parent, or other, training services

You are not covered for nutritional counseling services, except as stated in Section 5: Description of Benefits.

Autism Services

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

- Care that is custodial in nature
- Services and supplies that are not clinically appropriate
- Services provided by family or household members
- Treatments considered experimental

- Services provided outside of the State of Hawaii

Infertility Treatment

Except as described in Section 5: Description of Benefits under "Specific Benefits for Member and Spouse or Civil Union Partner," 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
- cryopreservation of oocytes, sperm and embryos
- cost of donor oocytes and donor sperm
- any donor-related services, including, but not limited to collection, storage and processing of donor oocytes and donor sperm
- ovum transplants
- gamete intrafallopian transfer (GIFT)
- zygote intrafallopian transfer (ZIFT)
- services related to conception by artificial means including drugs and supplies related to services except as described in Section 5: Description of Benefits under "Specific Benefits for Member and Spouse or Civil Union Partner"
- hysterosalpingography
- in vitro fertilization benefits when services of a surrogate or gestational carrier are used

Reversal of Sterilization

You are not covered for reversal of sterilization.

Reversal of Vasectomy

You are not covered for reversal of vasectomy.

Growth Hormone Therapy

You are not covered for human growth hormone therapy except as stated in Section 5: Description of Benefits.

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 except for artificial hearts as a bridge awaiting heart transplant
- the purchase of any organ
- services rendered to the living donor for post-transplant donor services
- transplant services or supplies or related services or supplies except as described in Section 5: Description of Benefits under "Organ Transplants Services." Related Transplant Services or Supplies are those that would not meet payment criteria but for your receipt of the transplant.

Exclusion by Type of Provider

You are not covered for services or supplies provided by a provider who is a member of your immediate family, meaning a parent, child, Spouse, Civil Union Partner, or yourself

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.

You are not covered for services or supplies for an injury or illness that is a Third Party Liability situation, except as stated in Section 10: Coordination of Benefits & Third Party Liability. We have the right to deny coverage for any claim in a Third Party Liability situation if you fail to provide us with timely notice of the potential claim.

Miscellaneous Exclusions

- **Airline Oxygen** — You are not covered for airline oxygen

- **Air Ambulance** — You are not covered for air ambulance services except as described in Section 5: Description of Benefits. The following air ambulance services are not covered:
  - Transportation from the continental US to Hawaii
  - Transportation within the continental US
  - Transportation for patients whose condition allows for transportation via commercial airline
  - Transportation on a commercial airline

- **Biofeedback** — 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 the diagnosis and treatment of any complications of a treatment or procedure which is excluded from coverage under this Agreement, regardless of how long ago such services were performed and regardless of whether you were eligible for coverage under this Agreement at the time the services were performed. This exclusion applies to complications related to every category of excluded services under this Agreement.

- **Complementary and Alternative Medicine** — You are not covered for complementary and alternative medicine except as stated in Section 5: Description of Benefits. You are not covered for other imaging services ordered or performed by participating or non-participating chiropractors.

- **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.

- **Duplicate Item** — You are not covered for duplicate medical equipment, appliances, and supplies, orthotics and external prosthetics, and vision and hearing appliances that are intended to be used as a

back-up device, for multiple residences, or for traveling, e.g., a second wheeled mobility device specifically for work or school use or a back-up manual wheelchair when a power wheelchair is the primary means of mobility.

- **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

- **Erectile Dysfunction** — You are not covered for services and supplies (including prosthetic devices) related to erectile dysfunction except if due to an organic cause or to treat gender dysphoria as described in Section 5: Description of Benefits; Gender Identity Services. This includes, but is not limited to, penile implants. You are not covered for drug therapies related to erectile dysfunction except certain injectables approved by us to treat erectile dysfunction due to an organic cause or to treat gender dysphoria as described in Section 5: Description of Benefits; Gender Identity Services.

- **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.

- **Foot Orthotics** — You are not covered for foot orthotics except for diabetic conditions and fractures

- **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

- **Home Health and Hospice** — You are not covered for home health and hospice services except as stated in Section 5: Description of Benefits

- **Massage Therapy** — You are not covered for massage therapy services except when provided within the course of rehabilitative services as defined in Section 5: Description of Benefits; Physical and Occupational Therapy.

- **Medical Equipment and Appliances** — You are not covered for equipment and appliances that are not primarily medical in nature such as environment control equipment or supplies (e.g. air conditioners, humidifiers, dehumidifiers, air purifiers or sterilizers, water purifiers, vacuum cleaners, supplies such as filters, vacuum cleaner bags and dust mite covers); hygienic equipment; exercise equipment; items primarily for participation in sports or leisure activities, and education equipment except as stated in Section 5: Description of Benefits

- **Medical Foods** — You are not covered for medical foods and low protein modified food products except as stated in Section 5: Description of Benefits

- **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 Vehicle Accident** — You are not covered for injuries or illness due to a motor vehicle accident (including arising from operation, maintenance or use of a motor vehicle), except for medical costs exceeding the personal injury protection mandatory coverage amount specified by state law, as described in Section 10: Coordination of Benefits & Third Party Liability

- **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.
- **Naturopathy** — You are not covered for medical treatments, drugs, devices, care, or ancillary services (to include laboratory testing and imaging) that are not the most appropriate delivery or level of service, or are not known to be effective in improving health outcomes
- **Non-Related Items Exclusion** — You are not covered for any service, procedure, or supply that is directly or indirectly related to a non-covered service, procedure, or supply
- **Orthotics** — You are not covered for orthotics management and training
- **Personal Convenience Items** — You are not covered for treatments, services or supplies that are prescribed, ordered or recommended primarily for your comfort or convenience, or the comfort or convenience of your provider or caregiver. Such items may include home remodeling, hot tubs, ramps, swimming pools, or personal supplies such as surgical stockings and disposable underpads
- **Physical Examinations or Preventive Screening Services** — Physical examinations, any associated screening procedures, or preventive screening services in connection with third party requests or requirements, such as those for: employment, participation in employee programs, sports, camp, insurance, disability licensing, or on court order for parole or probation are not covered. This limitation is not intended to affect coverage of physical examinations, associated screening procedures, or preventive screening services that would otherwise have been covered, and that have separately and incidentally been requested or required by a third party.
- **Physical and Occupational Therapy** — You are not covered for physical and occupational therapy except as stated in Section 5: Description of Benefits. You are not covered for occupational therapy supplies
- **Preventive Care** — You are not covered for preventive care services except as stated in Section 5: Description of Benefits
- **Private Duty Nursing** — You are not covered for private duty nursing services
- **Repair/Replacement** — You are not covered for the replacement of hearing aids lost or broken within five years from the date of purchase. You are not covered for replacement, or repairs and maintenance of medical equipment and appliances except as stated in Section 5: Description of Benefits
- **Reversal of Gender Reassignment Surgery** — You are not covered for reversal of gender reassignment surgery, except in the case of a serious medical barrier to completing gender reassignment or the development of a serious medical condition requiring a reversal
- **Self-Help or Self-Cure** — You are not covered for self-help and self-cure programs and equipment. You are not covered for the 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.
- **Skilled Nursing** — You are not covered for skilled nursing services except as stated in Section 5: Description of Benefits

- **Social Work Services** — You are not covered for treatment provided by a social worker except as defined in Section 5: Description of Benefits; Mental Health and Substance Abuse Services
- **Speech Therapy** — You are not covered for speech therapy except as stated in Section 5: Description of Benefits
- **Stand-by Time** — You are not covered for a provider's waiting or stand-by time
- **Third Party Liability** — You are not covered for services or supplies for an injury or illness that is a Third Party Liability situation, except as stated in Section 10: Coordination of Benefits & Third Party Liability. We have the right to deny coverage for any claim in a Third Party Liability situation if you fail to provide us with timely notice of the potential claim.
- **Travel or Lodging Costs** — You are not covered for the costs of travel or lodging
- **Weight Reduction Programs** — You are not covered for weight reduction programs and supplies (including dietary supplements, food, equipment, laboratory testing, examinations, and drugs), whether or not weight reduction is medically appropriate.
- **Wigs** — You are not covered for wigs

SECTION 7: HEALTH CARE SERVICES PROGRAM

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 be listed as a covered benefit and 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.

Medical Payment Policies

Additional and more clinically specific information about your coverage may be obtained by reviewing our Medical Payment Policies with your healthcare provider. They may be found on our website at uhahealth.com.

The Health Care Services Department

It is the responsibility of the Health Care Services department to determine if a recommended service is medically necessary

Medically Necessary

This Plan pays benefits for services that are covered benefits under the member's health plan and that are medically necessary.

In making the determination of medical necessity, UHA follows the definition established in Hawaii Revised Statutes (sect. 432E-1.4):

"(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.

(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:

(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:

(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, 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:

- 72 hours in advance of elective hospital admissions (including skilled nursing facilities and rehabilitation facilities) when possible. UHA requires notification of emergency and non-elective admissions within two (2) business days of admission
- for provision of any Substance Abuse treatment

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.

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.

A few common examples of things you must obtain Prior Authorization for:

Lab, X-ray & Other Diagnostic Tests such as genetic testing, polysomnography and sleep studies, computed tomography (CT), and PET scans.

Surgeries such as organ and tissue transplants and varicose veins treatment.

Treatment Therapies such as applied behavioral analysis, physical, occupational and speech therapies, in vitro fertilization, growth hormone therapy, home IV therapy, drugs such as oral chemotherapy agents, infusibles and injectables, new drug to market (specialty medical drugs), and off-label drug use.

Medical Equipment & Appliances & Supplies, Prosthetic Devices such as wheelchairs, positive airway pressure and oral devices for the treatment of obstructive sleep apnea.

The list of services and medications requiring Prior Authorization may change periodically. To ensure your treatment or procedure is covered, contact UHA's Health Care Services department at 808-532-4006 (or 1-800-458-4600, extension 300, from the neighbor islands) for the most current list, or review the list on our website at uhahealth.com. UHA requires that all Participating Providers participate with its Prior Authorization, concurrent, and retrospective review activities.

As stated previously in Section 1 of this document, the Service Area for this Plan is the State of Hawaii and the following require Prior Authorization (Section 7: Health Care Services Program):

- If you are a Hawaii resident and require medical services that are not available in Hawaii, your physician should contact us for an authorization for a referral to a mainland provider
- Hawaii residents seeking services, procedures or medical care on the mainland when clinically similar services, procedures or medical care are performed and available in Hawaii
- Mainland residents seeking elective ASC or hospital based procedures, or any advanced imaging

If it is reasonable for you to receive elective services, procedures or medical care in Hawaii, but you elect to have the services, procedures or medical care performed on the mainland, then services, procedures or medical care obtained from providers participating with the mainland contractor may be paid at the Non-Participating Provider benefit level, and you will be responsible for the provider's charges in excess of UHA's payment. Please refer to UHA's "Out-of-State Referrals for Medical Services" policy on UHA's website for more information, and please be aware that generally UHA requires two weeks' advance notice for Prior Authorizations.

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 annual maximum out-of-pocket.

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: 808-532-4006 (or 1-800-458-4600, extension 300, from the neighbor islands)
Fax: (866) 572-4384

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: 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 must file an appeal in accordance with the appeal procedures in Section 9: If You Disagree With Our Decision.

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.

Retrospective Review

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

- covered benefits, and
- 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 are covered, UHA uses the definition of Emergency Services provided in Hawaii Revised Statutes (sect. 432E-1), the federal No Surprises Act of 2021, and in the Glossary of this document.

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.

SECTION 8: FILING CLAIMS FOR PAYMENT

Filing Claims

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

UHA Participating Providers will file a claim for payment on your behalf; Non-Participating Providers may file a claim on your behalf or give you an itemized bill or receipt which lists the services you received.

If we require any additional information, such as medical records or reports, in order to process the claim, we will request the information from you or your provider. If you or your provider do not provide the information we request, or if the information provided does not show entitlement to coverage under this Plan, your claim may be denied.

We will not pay claims for services that are not Covered Services or were not actually received. For more information on Covered Services and payment determination criteria, please refer to Section 7: Health Care Services.

File a separate claim for each covered family member and each provider. You should follow the same procedures for filing a claim for services received in- or out-of-state.

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.

Information Required on a Claim

Any claim for services submitted to us for payment must be in English and include the following information:

- your member identification number from your identification card; if not available, patient's date of birth is required
- the provider's full name and address
- the patient's name and address
- the date(s) services were received
- 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-10 diagnostic codes)
- if applicable, information about any other health coverage you have

The above information must be from your provider (statements you prepare, cash register receipts, receipt of payment notices or balance due notices cannot be accepted). Without the required information, claims are not eligible for benefits.

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 or itemized bill or receipt received more than one year after the date on which you received the service.

Explanation of Benefits

Explanation of Benefits (EOB) are generated after your claim has been processed. You have access to them via our member portal, which is through our website at uhahealth.com. You will receive an email notification when an EOB is available on the member portal. 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 under the Plan. 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 would like your EOBs mailed to you, have any questions or find inaccuracies within the EOB, or think that we made an error in paying a claim, please call or write to Customer Services (see page 1). If after contacting Customer Services you are not satisfied and think that we made an error in determining benefits or paying your claim, you must 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.

Remittance Advice

Participating Providers will receive a Remittance Advice (RA) with each payment of claims made by UHA. The RA tells how we processed the claim, including the services performed, the amount charged, our Eligible Charge, and other information. For payment of certain services rendered by Non-Participating Providers, a check and RA may be sent directly to the subscriber of the Plan. The check should be cashed or deposited before its expiration date.

SECTION 9: IF YOU DISAGREE WITH OUR DECISION

Requesting Informal Reconsideration of an Adverse Determination

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 under this Plan, you may contact Customer Services and explain your concern (see page 1). If we cannot resolve your concern on the telephone, the Representative will refer it 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 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, 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, you may contact UHA's Health Care Services department.

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 the 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 Appeals in this section). Send written requests to:

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

We must receive your written appeal within one year of the date that UHA informed you of the decision you wish to appeal. The 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, or the date of the contested action or decision
- provider name
- a description of the facts related to your appeal and why you believe our action or decision was in error
- any other details about your appeal. This may include written comments, documents, and records relating to your appeal you would like us to review

You should keep a copy of the request for your records. It will not be returned to you.

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

- a free copy of all documents, records, and information relevant to your claims for benefits, or rescission of coverage, as defined by federal ERISA rules
- any rule, guideline, or protocol we relied upon in making the decision at issue

Who May Request an Appeal

You or your authorized representative may request an appeal. Authorized representatives include:

- any person you authorize to act on your behalf as long as you follow our procedures. This includes filing a form with us. To get a form to authorize a person to act on your behalf, please call Customer Services. (Requests for appeal from an authorized representative who is a provider must be in writing unless you are asking for an expedited appeal)
- a court-appointed guardian or agent under a health care proxy
- a person authorized by law to provide substituted consent for you or to make health care decisions on your behalf
- a family member or your treating health care professional if you are unable to provide consent

Appeal of Our Decisions

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 respond within 30 days of our receipt of your appeal. We will respond to your appeal within 60 days of our receipt of your appeal for all other appeals.

Unless you qualify for expedited external review of our initial decision, before requesting external review, you must have exhausted UHA's internal appeals process or show that UHA violated federal rules related to claims and appeals unless the violation was 1) de minimis; 2) non-prejudicial; 3) attributable to good cause or matters beyond UHA's control; 4) in the context of an ongoing good-faith exchange of information; and 5) not reflective of a pattern or practice of non-compliance.

Expedited Appeals

You may request an expedited appeal if the standard time (30 or 60 days, as set forth above) for completing an appeal would

- 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

Expedited appeals are only 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 by calling UHA's Health Care Services department at 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.

You may request expedited external review of our initial decision if you have requested an expedited internal appeal and the adverse benefit determination involves a medical condition for which the completion of an expedited internal appeal would meet the requirements above.

The process for requesting an expedited external review is discussed below.

Appeals Committee

UHA's Appeals Committee will review your appeal request. We will notify you in writing of the decision within the time frames specified above.

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.

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.

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 You Disagree with Our Appeals Decision Regarding Medical Necessity and Experimental or Investigational Services

If UHA has denied a request for coverage based on medical necessity, appropriateness, health care setting, level of care or effectiveness, or on the basis that the service requested is experimental or investigational, or involves consideration of whether UHA is complying with state or federal laws, 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 the Insurance Commissioner of the State of Hawaii within 130 days from the date of the letter notifying you of UHA's decision. The request should be submitted to:

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

Unless you qualify for expedited external review of our appeal decision, before requesting review, you must have exhausted UHA's internal appeals process or show that UHA violated federal rules related to claims and appeals unless the violation was 1) de minimis; 2) non-prejudicial; 3)

attributable to good cause or matters beyond UHA's control; 4) in the context of an ongoing good-faith exchange of information; and 5) not reflective of a pattern or practice of noncompliance.

Your request for external review must include: (1) a copy of the adverse benefit determination you wish to have reviewed; (2) a signed authorization for release of your medical records relevant to the review; (3) a disclosure for conflicts of interest; and (4) a filing fee of $15, which will be reimbursed if the decision is reversed on external review. The authorization and disclosure forms are available on UHA's website (uhahealth.com) or by calling Customer Service (see page 1). The Commissioner may waive the filing fee if payment of the fee would impose a financial hardship. You are not required to pay more than $60 in any plan year.

UHA will pay for the services of the independent review organization and its physician reviewer if you make a timely request.

If the decision that is the subject of the external review is based on a determination by UHA that the service is experimental or investigational, your request for external review must also include a written certification from your treating physician that standard health care services or treatments have not been effective in improving your medical condition or are not medically appropriate for you, or that there is no available standard health care service or treatment covered by UHA that is more beneficial than the service or treatment that is the subject of the external review. Your treating physician must certify in writing that the service recommended is likely to be more beneficial to you, in the physician's opinion, than any available standard health care service or treatment, or your licensed, board certified or board eligible physician must certify in writing that scientifically valid studies using accepted protocols demonstrate the service that is the subject of the external review is likely to be more beneficial to you than any available standard health care services or treatment.

You will be notified by the Insurance Division when an independent review organization ("IRO") is assigned your external review. You may submit additional written information to the IRO at the address provided in the notice. The IRO shall consider any additional information submitted within five (5) business days after you receive the notice, and may consider additional information received after that date. If any additional information is submitted, it will be shared with UHA in order to give UHA an opportunity to reconsider its denial.

The IRO will be provided all information considered by UHA (including any prior submissions by you) in making the decision that is the subject of the external review, your request for external appeal and any accompanying documentation you provided with your request, and any other documentation deemed pertinent by us. The IRO will render a decision within 45 days of its receipt of the request for external review.

Expedited External Review of Decisions Based on Medical Necessity or Experimental or Investigational Services

You may request expedited external review by the IRO of a final adverse determination involving issues of medical necessity: (1) if you have a medical condition for which the completion of a standard external review would seriously jeopardize your life, health or ability to regain maximum functioning, or would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the external review; or (2) if the final adverse determination concerns an admission, availability of care, continued stay, or health care services for which you received emergency services, provided you have not been discharged from a facility for health care services related to the emergency services.

If the decision that is the subject of the external review is based on a determination by UHA that the service is experimental or investigational, you may request expedited external review if your

treating physician certifies, in writing, that the health care service or treatment that is the subject of the request would be significantly less effective if not promptly initiated. You may make your request orally, but it must be followed promptly by your treating physician's written certification.

Immediately upon being notified of a request for expedited external review, UHA and the Commissioner will review the request and determine whether you are eligible for expedited external review. If you are not eligible for expedited external review, the Commissioner will notify you and us as soon as possible. If the external review is accepted as an expedited review, UHA will provide the IRO with all documents and information it considered in making the decision that is the subject of the expedited external review. The IRO will provide notice of the final external review decision as soon as the medical circumstances require but not more than 72 hours after the external reviewer receives the request for expedited external review of a medical necessity determination or not more than 7 days for a decision regarding experimental or investigational services. The notice of the external review decision may initially be provided orally but must be confirmed in writing by the reviewer within 48 hours of the oral notice.

The IRO's decision regarding the issue in the external review shall be binding on you and us except to the extent that the other remedies may be available to either you or us under applicable State or Federal law. If you elect to have a review by an IRO, then the parties waive their right to an arbitration for the services in question.

Other Procedures for External Review

If UHA's decision was based on a determination other than one of medical necessity, appropriateness, health care setting, level of care or effectiveness, or on the basis that the service requested is experimental or investigational, and you disagree with the decision, or if UHA's decision was based on medical necessity or on the basis that the service is experimental or investigational but you elected not to request review by an IRO, you may either 1) request binding arbitration before a mutually selected arbitrator, or 2) file a lawsuit against UHA under section 502(a) of ERISA. If you do not know whether your Plan is subject to ERISA, contact your plan administrator.

Arbitration

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

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 date of the letter notifying you of UHA's decision. 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 UHA) must agree on the person to be arbitrator. The arbitration will be administered by Dispute Prevention and Resolution, and the arbitrator will be selected from its panel of neutrals. 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.

The arbitrator's fees and costs will be shared, with UHA to pay two-thirds and member to pay one-third. You must pay your attorney's and witnesses' fees, if you have any, and we must pay ours. The arbitrator will decide who will pay any 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.

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

If you have other insurance coverage, for example through your Spouse, Civil Union Partner, 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:

- 100% of the Eligible Charge
- the amount payable by your other coverage plus any Deductible and Co-payment or Coinsurance you would owe if the other coverage were your only coverage

Your Responsibility

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 Customer Services (see page 1).

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.

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.

Our Responsibility

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.

General Rules

Some general rules governing coordination of benefits are:

- the coverage you have as an employee pays first before any coverage you have as a Spouse, Civil Union Partner, 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 employer-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

The coverage that pays first is called "primary" and the coverage that pays second is called "secondary."

Rules for Children

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.

If the child's parents are separated or divorced and a court decree says which parent has health insurance responsibility, that coverage pays first.

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 payment order for this dependent child is as follows:

1. custodial parent
2. Spouse or Civil Union Partner of custodial parent

3. other parent
4. Spouse or Civil Union Partner of other parent

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

Motor Vehicle Accident Coverage

For injuries or illness due to a motor vehicle accident (including arising from operation, maintenance or use of a motor vehicle), any motor vehicle insurance will be considered primary for payment, and those benefits will be applied first before any benefits of this Plan apply. No benefits are payable under this Plan until after the motor vehicle personal injury protection mandatory coverage amount as specified by state law has been exhausted. Only amounts incurred in excess of that mandatory amount are payable as benefits under this Plan (and any other motor vehicle insurance benefits available in excess of the mandatory amount must be applied first before any benefits of this Plan apply). The exhaustion of the mandatory amount may be calculated by UHA in accordance with the fee schedule applicable to HRS chapter 431, article 10C.

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

Before we pay benefits under this coverage for any motor vehicle accident-related injury, you must provide us a list of expenses paid by any 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 or Civil Union Partner as a 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 or Civil Union Partner 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 Co-payment or Coinsurance 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 injury or illness
- 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 and applicable laws.

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 are in a motor vehicle accident, you must exhaust the motor vehicle personal injury protection

mandatory coverage amount specified by state law first, before the coverage under this Plan will apply. See Motor Vehicle Accident 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 potential claim or source of recovery related to your injury or illness
   b. any written claim or demand (including initiation of legal proceedings) made by you or on your behalf
   c. any monetary proceeds recovery (including any settlement, judgment, award, insurance proceeds, or other payment) whether or not confidential from any source of recovery in connection with your injury or illness, including the amount and source of any recovery
2. sign and deliver to UHA all liens, assignments, and other documents it requires to secure its rights to recover payments;
3. provide UHA any information reasonably related to its investigation of liability for coverage and rights to repayment, including medical records and documents related to any legal claims;
4. do not release or otherwise impair UHA's rights to repayment, without UHA's express written consent; and
5. cooperate in protecting UHA's rights under these 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

Any notice required by these Rules must be sent to:

TPL Administrator
UHA
700 Bishop Street, Suite 300
Honolulu, HI 96813-4100

Failure to sign and submit to UHA documents to secure UHA's reimbursement rights and provide information reasonably related to UHA's investigation of its liability for coverage may result in delay in payment or denial of your claims, and may 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 you know or reasonably should know that you may have a third party claim for recovery of damages and you fail to provide timely notice to UHA of your potential claim as specified in these Rules, UHA may limit your coverage under this plan for the third party injury or illness. Coverage limitations may include UHA's recovery of any past benefits paid for the third party injury or illness and to refuse to reimburse any past, present or future medical expenses arising from the third party injury or illness.

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 proceeds received by you, your estate, a family member, special needs trust, or any other person or party, arising from or related to such injury or illness, out of the amount of the corresponding special damages recovered by the judgement or settlement. UHA shall have a first lien against any such recovery to the extent of its total payment of benefits related to the injury or illness until the amount of its reimbursement is decided. 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, including your attorney. You must inform any attorney representing you of these Rules, as your attorney may be subject to professional disciplinary action and liability to UHA if your attorney does not comply with these Rules.

Should the recovery proceeds cover only general damages, whether or not the recovery is confidential, you must still cooperate with UHA as described above to allow UHA to determine whether to petition a court of competent jurisdiction for the validity and amount of its lien, under HRS § 663-10. In addition, if UHA's lien is not resolved, then it is possible that UHA's lien may still exist and remain unresolved.

For any payment made by UHA under these Rules, you will still be responsible for Co-payments, Coinsurance, 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 injury or illness, but receive a final dismissal or denial of all your legal claim(s) without receiving any recovery for your injury or illness, then no reimbursement is owing to UHA for covered benefits paid for the injury or illness.

SECTION 11: OTHER PLAN PROVISIONS

Confidentiality

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.

Dues Payment

Your employer or plan sponsor when they act as your agent for dues payment, or you must pay us the monthly premium due on or before the first of each month to which the premium applies.

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 plan sponsor and the State of Hawaii Department of Labor and Industrial Relations.

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:

- Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), or
- Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

Authority to Terminate or Amend Coverage

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. Other circumstances of termination and ineligibility of coverage for You and your Group are described in Section 2, see particularly sections on When Coverage Ends, Termination for Fraud, and Eligibility and Termination Rules for Member Groups.

We also have the authority to modify this Agreement provided that we give 60 days prior written notice to your employer.

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 court action brought because of a claim regarding this coverage or arising out of this Plan, will be litigated in the state or federal courts located in the State of Hawaii and in no other.

Payment in Error

If for any reason we make a payment under this coverage in error or due to any false statement, 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.

Severability

If any court or arbitrator rules that any part or term of our Agreement is illegal, invalid or unenforceable, then the validity of the remaining portions of this Agreement shall remain valid and binding as if the Agreement did not contain the part or term held to be unenforceable.

Liability

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.

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

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:

- employer or plan 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

Please note that Dependents covered as domestic partners are not eligible for COBRA coverage.

If you have a qualifying event, contact your employer or plan sponsor immediately. Generally, you are entitled to receive a COBRA election form within 14 days after you notify your employer of the event.

Please note: You or your spouse is responsible for notifying your employer or plan sponsor of your divorce or legal separation, or if a child loses eligibility status under our rules for coverage.

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.

Payment of COBRA Premiums

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 (unless you or your Dependents qualify for COBRA premium subsidy from the federal government as described below). 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.

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.

What You Must Do

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:

- you are no longer covered, or
- you are notified of the right to elect COBRA continuation coverage

You or your Dependents must notify your employer in the following circumstances:

- 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 or Civil Union Partner of the covered employee, or (ii) as the Dependent child of the covered employee
- the first day on which a Qualified 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 Qualified 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

You may request a certificate of creditable coverage by calling Customer Services (see page 1).

ERISA Information

Your Plan is designed, established and maintained as a Plan governed by the Employee Retirement Income Security Act of 1974 (ERISA), unless otherwise stated in your employer's agreement with UHA. Your plan administrator under ERISA is your employer (or plan sponsor). As a participant in your Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all plan participants shall be entitled to:

- Receive Information About Your Plan and Benefits
  Examine, without charge, at the plan administrator's office, all documents governing the plan, including any insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

  Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including any insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The plan administrator may make a reasonable charge for the copies.

  Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

- Continue Group Health Plan Coverage
  Continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the plan as a result of a qualifying event and your employer is of a size to trigger COBRA rights. You or your Dependents may have to pay for such coverage. Review this Medical Benefits Guide and the documents governing the Plan on the rules governing COBRA continuation coverage rights.

- Prudent Actions by Plan Fiduciaries
  In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of your health plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan benefit or exercising your rights under ERISA.

- Enforce Your Rights
  If your claim for a Plan benefit is denied or ignored, in whole or in part, you have a right to

know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan administrator and do not receive them within 30 days, you may file suit against the plan administrator in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the plan administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in 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 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.

- Assistance with Your Questions
  If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest 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 N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

- Maternity and Newborn Infant Coverage Law
  Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a caesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Your Plan is an ERISA employee welfare benefit plan for pre-paid health care, contributions for which are supplied by your employer and by the employee to the extent required by the employer’s rules for contribution. This Plan is also governed by the Hawaii Prepaid Health Care Act, H.R.S. Chapter 393.

GLOSSARY OF IMPORTANT TERMS

Actual Charge	The amount a Provider actually bills for a service or supply.
Acupuncturist	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.
Advance Care Planning	The process of reflection, discussion, and communication that enables members to plan for when they're no longer able to make or communicate their decisions about medical treatment and other care
Agreement	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 plan sponsor.
Ambulatory Surgical Center	A facility that provides Surgical Services on an outpatient basis for patients who do not need to occupy an inpatient hospital bed.
Ancillary Services	Charges by a facility for other than room and board. Examples are charges by a hospital for drugs, dressings, or surgical supplies.
Anesthesia	The administration of anesthetics to produce loss of feeling or consciousness, usually in conjunction with forms of medical treatment such as surgery.
Annual Maximum Out-of-Pocket	The maximum amount you pay for most Covered Services in a calendar year. The out-of-pocket maximum is reached from applicable Co-payments and Coinsurance amounts you pay in any given calendar year.
Assistant Surgeon	A physician who actively assists the physician in charge during a surgical procedure.
Benefit(s)	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	Electronic or electromechanical devices which replace missing body parts and/or which enhance one's existing strength and ability.
Calendar Year	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.
Certified Nurse Midwife	A registered nurse licensed in the State of Hawaii who is appropriately certified and licensed to provide midwifery services by the proper governmental authority and who renders services within the lawful scope of such license
Chiropractor	A licensed health care professional who practices the system of healing through spinal manipulation and specific adjustment of body structures.
Civil Union	A civil union between two individuals that is legally recognized by Chapter 572B, Hawaii Revised Statutes
Civil Union Partner	An individual who is a party to a civil union established pursuant to Chapter 572B, Hawaii Revised Statues
Claim	A written request for payment for Benefits for Covered Services.
Coinsurance	The amount you pay as your share of the Eligible Charge for medical care, calculated as a percent.
Consultation	A formal discussion (deliberation) between physicians on a case or its treatment.

Co-payment	The amount you pay as your share of the Eligible Charge for medical care.
Cosmetic Services	Services primarily intended to improve your natural appearance and which do not restore or materially improve physical function
Covered Services	Any Benefit that is Medically Necessary, is not specifically excluded by this Plan, and meets our Payment Determination Criteria. Benefits are listed in Section 5: Description of Benefits.
Dependent	A member's Spouse, Civil Union Partner, and/or eligible child or children.
Effective Date	The date on which you are first eligible to receive Benefits under this Agreement.
Eligible Charge	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 Co-payment or Coinsurance for a covered service.
Emergency Services	Is defined (1) in accordance with the definition established in Hawaii Revised Statutes (sect. 432E-1) as services provided to an individual when the individual has symptoms of sufficient severity, including severe pain, such that a layperson could reasonably expect, in the absence of medical treatment, to result in placing the individual's health or condition in serious jeopardy, serious impairment of bodily functions, serious dysfunction of any bodily organ or part, or death; (2) with respect to a pregnant woman, a layperson could reasonably expect the absence of medical treatment to result in serious jeopardy to the health of the woman and her unborn child; or (3) Emergency Services provided to an individual when the individual has symptoms of sufficient severity, severe pain, or acute symptoms, including a mental health condition or substance use disorder, as defined in accordance with federal law (the federal Affordable Care Act and the federal No Surprises Act of 2021).
ERISA	The Employee Retirement Income Security Act of 1974, a federal law that governs this Agreement and protects your rights under this coverage.
Gender Identity	A person's internal sense of being male, female, a gender different from the gender assigned at birth, a transgender person, or neither male nor female
Gender Dysphoria	The distress experienced when a person's gender assigned at birth does not match their gender identity
Gender Transition	The process of a person changing the person's outward appearance or sex characteristics, to accord with the person's actual gender identity
Generic Drug	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	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	A licensed entity which provides skilled nursing care in your home.
Home Infusion Therapy	Treatment provided in the home involving the administration of drugs, nutrients and fluids intravenously or through a feeding tube.
Hospice	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	An institution that provides inpatient acute care for the diagnosis and treatment of an illness or injury.
Immunization	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 — A stay, usually overnight, in a hospital, skilled nursing facility or other facility.

Maternity Care — Routine obstetric care including antepartum care, delivery, and postpartum care in uncomplicated maternity cases.

Maximum Benefit — 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):
"(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.
(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:
(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:
(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 — 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 — A Provider who does not have a contract with UHA, for example an out-of-state provider.

Member Group — An employer or plan sponsor of the Plan, which meets the Eligibility and Termination Rules for Member Groups set forth in Section 2 of this Guide

Non-Preferred Brand Drugs — Brand name drugs that are not listed in the UHA Preferred Drug List.

Our — Refers to UHA.

Outpatient — Care received in a practitioner's office, the home, the outpatient department of a hospital, or an ambulatory surgical center.

Participating Provider — That a physician, hospital, or other accredited and/or certified, licensed health care provider has signed a contract with UHA to provide benefits under this Plan, that requires that the provider collect only:
- the Eligible Charge paid by UHA for the Covered Services delivered,
- the applicable Co-payment or Coinsurance, and
- the applicable state excise tax, based on the Eligible Charge.

Partner — An individual who is a party to a civil union established pursuant to Chapter 572B, Hawaii Revised Statutes

Payment Determination Criteria — Care, treatment, service, or supply that is a covered service and which is all of the following:
- the service must be listed as a covered benefit and 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

Physician A doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is appropriately licensed to practice by the proper governmental authority and who renders services within the lawful scope of such license.

Physician Assistant A nationally certified and state-licensed medical professional who provides care under the supervision of a physician.

Plan The Agreement between you and us regarding your health care coverage.

Post-Stabilization Care Services you receive after the acute episode of an emergency medical condition is stabilized, as defined under section 1867(e)(3) of the Social Security Act

Preferred Brand Drug Brand name drugs identified as preferred by their inclusion in UHA's Preferred Drug List.

Prior Authorization 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 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 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 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 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:
- as the Spouse or Civil Union Partner of the covered employee; or
- as the Dependent child of the covered employee.

Repair To fix or mend and put equipment back into good condition after damage or wear, and includes reasonable charge for parts and labor

Service Area The State of Hawaii.

Sexual Identification Counseling Psychotherapy for a person with gender dysphoria

Sexual Orientation Counseling Treatment of an enduring pattern of emotional, romantic and/or sexual attractions to men, women or both sexes. Sexual orientation also refers to a person's sense of identity based on those attractions, related behaviors and membership in a community of others who share those attractions

Skilled Nursing Facility 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 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, sanitaria 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 Your husband or wife as a result of a marriage that is legally recognized in the State of Hawaii.

Surgical Services	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	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.
Transgender Person	A person who has gender dysphoria, has received health care services related to gender transition, or otherwise identifies as a gender different from the gender assigned to that person at birth.
Us, We	UHA.
You, Your	You and your family members eligible for coverage under this Agreement.

NOTES

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