



How To Initiate An Appeal

UHA customers (members, employer groups, and providers) have the right to express concerns about actions taken by UHA, to request a reconsideration of any decision made by UHA that adversely affects them, and to file a formal appeal of decisions made by UHA that relate to claim payments, benefit coverage, and member eligibility as stated in UHA's Medical Benefits Guides, employer group contracts, and provider contracts. UHA will attempt to resolve all concerns and appeals fairly and promptly.

Requesting Informal Reconsideration of an Adverse Decision

If you disagree with a decision made by UHA about any matter, please call:

UHA Member Services
808-532-4000
1-800-458-4600 from the neighbor islands

The Member Services Representative will document the issue and attempt to resolve the concern on the telephone. If this is not possible, 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.

Requesting a Formal Appeal

If you are not satisfied with our response to your concern, or do not wish to request informal reconsideration under the above procedure, you may file a formal appeal of our decision.

- Appeals must be submitted in writing to:

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

- We must receive your written appeal within one year of the date UHA informed you of the denial or limitation of the claim.
- Customers may appoint someone to represent them during the appeal process, such as a guardian or legal representative. This appointment must be made in writing.
- Customers are invited to submit written comments, documents, records, and other information relating to the claim for benefits, even if such information was not submitted in regard the initial claim determination. At a minimum, your appeal should include the date of the request, your name, the date of service we denied or paid in error, a description of the facts related to the appeal and why you believe our decision was in error, and any documentation you have relating to your appeal that you would like us to review.
- Customers shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits, as defined by federal ERISA rules, and any rule, guideline, or protocol we relied upon in denying a claim for payment or request for prior authorization.
- If we need additional information to complete our review, we will notify you promptly and give you reasonable time to respond.
- 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 benefit determination. 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 the customer relating to the claim, or considered as relevant by UHA, without regard to whether such information was submitted or considered in the initial benefit determination.
- If the initial basis for denial of your claim 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, an



explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to your medical circumstances, will be provided free of charge upon request.

- UHA will identify any medical or vocational experts whose advice was obtained by UHA in connection with the initial adverse benefits determination, without regard to whether the advice was relied upon in making the benefit determination.
- UHA's final internal decision will be made by UHA's Appeals Committee. We will notify you of our decision within 30 days of receipt of your written appeal if your appeal concerns a UHA denial of a prior authorization request, or a UHA denial which was based in whole or in part on a medical judgment, including determinations of whether a procedure was experimental or investigational, or whether it was medically necessary or appropriate. We will notify you of our decision within 60 days of receipt of your written appeal for all other appeals.

Expedited Appeals

A member, a member's legal representative, or a licensed health care provider with knowledge of the member's medical condition can request an expedited appeal (72-hour response time for UHA's final internal determination):

1. For an acute or urgent condition; or
2. If the standard time (30 or 60 days, as set forth above) for completing an appeal would
 - seriously jeopardize the member's life or health;
 - seriously jeopardize the member's ability to gain maximum functioning; or
 - in the opinion of a physician with knowledge of the appellant's medical condition, subject the member to severe pain that cannot be adequately managed without the care or treatment requested.

To request an expedited appeal, a member, member's representative, or a licensed health care provider with knowledge of the member's medical condition, should call:

UHA Health Care Services
808-532-4006
1-800-458-4600, extension 300, from the neighbor islands
or fax the request to 866-572-4384

All necessary information regarding such urgent appeal may be submitted by telephone, facsimile, or other expeditious means. If the request for expedited appeal is made on a member's behalf by a licensed health care provider with knowledge of the member's condition, the member need not submit written appointment for the health care provider's representation.

Additional Appeals Information

For other details regarding a member's appeal rights, consult UHA's Medical Benefits Guide. If the member is not satisfied with the final decision of the UHA Appeals Committee, the member has the right to bring a civil claim under ERISA, to elect binding arbitration, or to request binding external review of any decision regarding medical necessity by a physician reviewer selected by an independent review organization, in accordance with the member's UHA plan terms.

Note: UHA participating providers appealing UHA actions regarding their network status or professional competency or conduct are required to follow appeal procedures in their Provider Handbook, not the procedures above.