



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. The procedures in this document apply only to appeals by the member or the member's authorized representative, on behalf of the member. As used in this document, "you" refers to the member or the member's authorized representative. UHA participating providers appealing UHA actions regarding their network status or professional competency or conduct or other disputes between the participating provider and UHA are required to follow appeal procedures in their Provider Handbook, not the procedures above.

Requesting Information Regarding Our Decision

The notice to you of our decision will include the date of service, the health care provider, and the claim amount. Upon request, we will also provide the treatment and diagnosis codes for the claim and their corresponding meanings. You may request this information by contacting UHA Customer Service at the phone numbers below.

Requesting Informal Reconsideration of an Adverse Decision

If for any reason you are dissatisfied with the services you receive under this plan or if you believe that we incorrectly denied a claim, paid an incorrect amount, incorrectly determined that a service is not a covered benefit or incorrectly rescinded your coverage, please call:

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

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

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

If you are dissatisfied with a denial that was based in whole or in part on a medical judgment, including determinations of whether a procedure was experimental or investigational, or whether it was medically necessary or appropriate, your informal reconsideration is limited to a peer-to-peer clinical review (telephonic, in person, or electronically) between UHA and the treating provider. For a peer-to-peer clinical review, please call:

UHA Health Care Services
808-532-4006
1-800-458-4600, extension 300, from the neighbor islands

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

Requesting a Formal Appeal

If you are not satisfied with our response to your concern, or do not wish to request informal reconsideration under the above procedure, you 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 decision you wish to appeal.
- You may appoint someone to represent you during the appeal process, such as a guardian or legal representative. This appointment must be made in writing.
- You or your representative are invited to submit written comments, documents, records, and other information relating to the claim for benefits or rescission of coverage, even if such information was not submitted in regard to the initial decision by UHA. At a minimum, your appeal should include the date of the request, your name, the date of service you believe we denied or paid in error, if any, 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.



- You 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 or rescission of coverage, as defined by federal ERISA rules, and any rule, guideline, or protocol we relied upon in making the decision at issue.
- If we need additional information to complete our review, we will notify you promptly and give you reasonable time to respond.
- If your appeal involves a decision by UHA regarding an ongoing course of treatment, we will continue coverage pending the outcome of the appeal to the extent required by applicable law.
- 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 representative relating to the claim, or considered as relevant by UHA, without regard to whether such information was submitted or considered in the initial benefit determination.
- If our initial decision 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.
- If we consider, rely upon or generate any new or additional evidence in our appeal review, we will provide you, free of charge, that evidence as soon as possible and sufficiently in advance of the date our decision on appeal is due to provide you a reasonable opportunity to respond prior to that date.
- If we intend to base our decision on appeal on a new or additional rationale, we will provide you, free of charge, the rationale as soon as possible and sufficiently in advance of the date our decision on appeal is due to provide you a reasonable opportunity to respond prior to that date.
- UHA 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 which was based in whole or in part on a medical judgment, including determinations of whether a procedure was experimental or investigational, or whether it was medically necessary or appropriate. We will notify you of our decision within 60 days of receipt of your written appeal for all other appeals.

Expedited Internal Appeals

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

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, you, your appointed representative, or a licensed health care provider with knowledge of your 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 your behalf by a licensed health care provider with knowledge of your condition, you need not submit written appointment for the health care provider's representation.

Expedited External Review With Expedited Internal Appeal

If you have requested an expedited internal appeal of an adverse benefit determination and: (1) the adverse benefit determination involves a medical condition for which the 72 hour time frame for completion of an expedited internal appeal would seriously jeopardize your life, health or ability to regain maximum functioning; or (2) would subject you to severe pain that cannot be adequately managed without the care or treatment requested, then you may request expedited external review.

The request for expedited external review must be in writing and must be received by the Commissioner within one-hundred thirty (130) days from the date you receive the letter notifying you of the decision by UHA. The request may be submitted by mail to:

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

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 (www.uhahealth.com) or by calling Customer Service at the number above. 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 ("IRO") and its physician reviewer if your request is approved.

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 include additional documentation from your treating physician. Please call UHA Customer Service at the number above for more information.

You will be notified by the Insurance Division when an 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.

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. Any request for external review must be made within one-hundred thirty (130) days of the date of receipt of the letter notifying you of the adverse benefit determination.

Additional Appeals Information

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