



Appeals & Grievances

UPMC *for Life* Privacy Statement

Medicare Contract Disclaimer

Fraud and Abuse

Exclusions and Limitations

Utilization Management

Compensation Disclaimer

2009

UPMC *for Life*

UPMC Health Plan Medicare Program

TABLE OF CONTENTS

I. Appeals and Grievances 3

II. UPMC *for Life* Privacy Statement 11

III. Medicare Contract Disclaimer. 14

IV. Fraud and Abuse Information. 15

V. Exclusions and Limitations, UPMC *for Life* HMO. 16

VI. Exclusions and Limitations, UPMC *for Life* PPO. 18

VII. Exclusions and Limitations, UPMC *for Life* Specialty Plan 20

VIII. Utilization Management 22

IX. Compensation Disclaimer 23

APPEALS AND GRIEVANCES

WHAT TO DO IF YOU HAVE COMPLAINTS

Your comments are important to us. We continually work to improve the quality of care and service that you receive as a member of UPMC *for Life*. We encourage you to let us know right away if you have questions, concerns, or problems related to covered services or the care you receive while you are a member of UPMC *for Life* by calling Member Services at the following number:

UPMC *for Life* Specialty Plan (for individuals entitled to Medicare Part A and enrolled in Medicare Part B who have full Medical Assistance coverage)

If you are a current UPMC *for Life* Specialty Plan member, contact Member Services at 1-800-606-8648, from 8 a.m. to 8 p.m., seven days a week. TTY/TDD users should call 1-866-407-8762. From March 2 through November 14, you may receive a messaging service on weekends and holidays. Please leave a message and your call will be returned the next business day.

UPMC *for Life* Plans (for individuals entitled to Medicare Part A and enrolled in Medicare Part B)

If you are a current UPMC *for Life* member, contact UPMC *for Life* at 1-877-539-3080, from 8 a.m. to 8 p.m., seven days a week. TTY/TDD users should call 1-800-361-2629. From March 2 through November 14, you may receive a messaging service on weekends and holidays. Please leave a message and your call will be returned the next business day.

If at any point, you are not satisfied with the responses from UPMC *for Life* or the services that you received, you may file a complaint. If you make a complaint, we must be fair in how we handle it. You cannot be disenrolled from UPMC *for Life* or penalized in any way if you make a complaint.

WHAT ARE THE TYPES OF COMPLAINTS I CAN FILE ABOUT MY MEDICAL SERVICES?

What are the types of complaints I can file about my medical services?

You have the right to make a complaint if you have concerns or problems related to your medical coverage or care. Under the medical portion of your plan, you have the right to make “appeals” and “grievances.”

COMPLAINTS ABOUT A HOSPITAL DISCHARGE

What kind of complaint can I file if I disagree with my hospital discharge?

When you are hospitalized, you have the right to get all the hospital care covered by UPMC *for Life* that is necessary to diagnose and treat your illness or injury. The day you leave the hospital (your “discharge date”) is based on when your stay in the hospital is no longer medically necessary.

What information should I receive during my hospital stay?

When you are admitted to the hospital, someone at the hospital should give you a notice called the *Important Message from Medicare*. This notice explains:

- Your right to get all medically necessary hospital services covered.
- Your right to know about any decisions that the hospital, your doctor, or anyone else makes about your hospital stay, and who will pay for it.
- That your doctor or the hospital may arrange for services you will need after you leave the hospital.
- Your right to appeal a discharge decision.

You will also receive this notice within two (2) calendar days prior to your discharge if you are an inpatient for at least five (5) days. You (or someone you authorize) will be asked to sign and date this document to show that you received the notice. Signing the notice does not mean you agree that coverage should end – it only means that you received the notice.

If you think that you are being discharged too soon:

- You can talk to the hospital staff, your doctor, and UPMC *for Life* about your concerns.
- You also have the right to an appeal, that is, a review of your case by a Quality Improvement Organization (QIO). The QIO is an outside reviewer hired by Medicare to look at your case to decide whether you are ready to leave the hospital.
 - **If you want to appeal, you must contact the QIO no later than your planned discharge date and before you leave the hospital.**
 - If you do this, you will not have to pay for the services you receive during the appeal (except for charges like copayments and deductibles).
 - If you do not appeal, but decide to stay in the hospital past your planned discharge date, you may have to pay for any services you receive after that date.

How do I get a review of my hospital discharge?

If you think you are being discharged too soon and want to have your discharge reviewed, you must act quickly to contact the QIO. The *Important Message from Medicare* gives the name and telephone number of your QIO and tells you what you must do.

- You must ask the QIO for a “fast review” of whether you are ready to leave the hospital. This “fast review” is also called a “fast appeal” because you are appealing the discharge date that has been set for you.

How soon do I have to ask the QIO to review my coverage?

You must be sure that you have made your request to the QIO before you are discharged from the hospital. This deadline is very important. If you meet this deadline, you are allowed to stay in the hospital past your discharge date without paying for it yourself, while you wait to get the decision from the QIO.

What information should I receive after I ask QIO to review my coverage?

You will receive a detailed notice from the hospital or UPMC *for Life* that explains the reasons they think you are ready to be discharged.

What happens during the QIO review?

When the QIO reviews your discharge, it will first look at your medical information. Then it will give an opinion about whether it is medically appropriate for you to be discharged on the date that has been set for you. The QIO will make this decision within one full working day after it has received your request and all of the medical information it needs to make a decision.

Who pays for my hospital charges during the QIO review?

If the QIO decides that your discharge date was medically appropriate, you will not be responsible for paying the hospital charges until noon of the calendar day after the QIO gives you its decision.

If the QIO agrees with you, then we will continue to cover your hospital stay for as long as medically necessary.

Do I have to pay for charges if I stay past my discharge date?

If you stay in the hospital after your UPMC *for Life* approved discharge date and do not ask for immediate QIO review, you may be financially responsible for the cost of many of the services you receive. However, you can appeal any bills for hospital care you receive, using the appeals process.

Who pays for the hospital charges during a “fast appeal”?

Whether you have to pay or not depends on the decision we make.

- If we decide, based on the clinical information received from the hospital and your doctors, that you need to stay in the hospital, we will continue to cover your hospital care for as long as medically necessary.
- If we decide that you should not have stayed in the hospital beyond your discharge date, we will not cover any hospital care you received if you stayed in the hospital after the discharge date. If we uphold our original decision, we will forward our decision and case file to the Independent Review Entity (IRE) within 24 hours.

COMPLAINTS ABOUT SKILLED NURSING FACILITIES (SNF), HOME HEALTH AGENCIES (HHA) OR COMPREHENSIVE OUTPATIENT REHABILITATION FACILITIES (CORF)**What information will I receive during my SNF stay, or while receiving CORF or HHA services?**

If we decide to end coverage for your SNF, HHA, or CORF services, you will get a written advance notice called the “Notice of Medicare Non-Coverage” (NOMNC) either from us or your provider at least 2 calendar days before your coverage ends. You (or someone you authorize) will be asked to sign and date this document to show that you received the notice. Signing the notice does not mean that you agree that coverage should end – it only means that you received the notice.

How do I get a review of my coverage by the Quality Improvement Organization?

You have the right by law to ask for an appeal of our termination of your coverage. As will be explained in the notice you get from us or your provider, you can ask the Quality Improvement Organization (the “QIO”) to do an independent review of whether our terminating your coverage is medically appropriate.

How soon do I have to ask the QIO to review my coverage?

If you want to appeal the termination of your coverage, you must act quickly to contact the QIO. The written notice you got from us or your provider gives the name and telephone number of the QIO and tells you what you must do.

- If you get the notice 2 days before your coverage ends, you must be sure to make your request no later than noon of the day after you get the notice.
- If you get the notice and you have more than 2 days before your coverage ends, then you must make your request no later than noon the day before the date that your Medicare coverage ends.

What will happen during the review?

When the QIO reviews your case, the QIO will ask for your opinion about why you believe the services should continue. You do not have to prepare anything in writing, but you may do so if you wish. The QIO will also look at your medical information, talk to your doctor, and review other information that we have given to the QIO. You and the QIO will each get a copy of our explanation about why your services should not continue.

After reviewing all the information, the QIO will give an opinion about whether it is medically appropriate for your coverage to be terminated on the date that has been set for you. The QIO will make this decision within one full day after it receives the information it needs to make a decision.

What happens if the QIO decides in my favor?

If the QIO agrees with you, then we will continue to cover your SNF, HHA, or CORF services for as long as medically necessary.

What happens if the QIO denies my request?

If the QIO decides that our decision to terminate coverage was medically appropriate, you will be responsible for paying the SNF, HHA, or CORF charges after the termination date on the advance notice you got from us or your provider. Neither Original Medicare nor UPMC *for Life* will pay for these services. If you stop receiving services on or before the date given on the notice, you can avoid any financial liability. However, the QIO decision notification will explain how you can ask the QIO for a reconsideration.

What if you do not ask the QIO for a review in time?

You still have another option. If you do not ask the QIO for a “fast appeal” of your discharge or termination of coverage by the deadline, you can ask us for a “fast appeal” of your discharge or termination of coverage. If you ask us for a fast appeal of your termination and you continue getting services from the SNF, HHA, or CORF, you run the risk of having to pay for the care you receive past your termination date.

Who pays for my charges during a “fast appeal”?

Whether you have to pay or not depends on the decision we make.

- If we decide, based on the fast appeal, that you need to continue to get your services covered, then we will continue to cover your care for as long as medically necessary.
- If we decide that you should not have continued getting coverage for your care, then we will not cover any care you received if you stayed or continued to receive services after the termination date.

Do I have to pay if I stay past my discharge date or continue to receive services after the termination date? (The QIO does not decide in my favor.)

If you do not ask the QIO by noon after the day you are given written notice that we will be terminating coverage for your SNF, HHA, or CORF services, and if you stay in the SNF or continue to receive HHA or CORF after this date, you run the risk of having to pay for the SNF, HHA, or CORF care you receive on and after this date.

WHAT TO DO TO REQUEST AN EXCEPTION TO THE FORMULARY OR MAKE A COMPLAINT OR FILE AN APPEAL ABOUT A PART D PRESCRIPTION DRUG**How do I request an exception to UPMC *for Life*'s Formulary?**

You can ask us to make an exception to our coverage rules by calling Pharmacy Services at 1-800-396-4139, from 8 a.m. to 8 p.m., seven days a week. TTY/TDD users should call 1-800-250-5352. From March 2 through November 14, you may receive a messaging service on weekends and holidays. Please leave a message and your call will be returned the next business day. There are several types of exceptions that you can ask us to make.

- You can ask us to cover your drug even if it is not on our formulary.
- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, UPMC *for Life* limits the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover more.
- You can ask us to provide a higher level of coverage for your drug. For example, if your drug is usually considered a Brand drug, you can ask us to cover it as a Preferred Brand instead. This would lower the copayment amount you must pay for your drug.

Generally, UPMC *for Life* will only approve your request for an exception if the alternative drugs included on the plan's formulary or the lower-tiered drug would not be as effective in treating your condition and/or would cause you to have adverse medical effects. Once an exception request is approved, it is valid for the remainder of the plan year as long as your physician continues to prescribe the drug for you and it continues to be safe and effective for treating your condition.

What kind of complaints (appeals) can I make about UPMC *for Life* and my Part D drugs?

You have rights on what you can do if you have problems getting the prescription drugs you believe we should cover. We use the word "cover" in a general way to include such things as authorizing prescription drugs, paying for prescription drugs, or continuing to cover a Part D prescription drug that you have been getting. Problems getting a Part D prescription drug that you believe we should cover include the following situations:

- If you are not getting a prescription drug that you believe may be covered by UPMC *for Life*.
- If you have received a Part D prescription drug you believe may be covered by UPMC *for Life* while you were a member, but we have refused to pay for the drug.
- If we will not pay for a Part D prescription drug that your doctor has prescribed for you because it is not on our formulary.
- If you disagree with the amount that we require you to pay for a Part D prescription drug that your doctor has prescribed for you.
- If you are being told that coverage for a Part D prescription drug that you have been getting will be reduced or stopped.
- If there is a requirement that you try another drug before we pay for the drug your doctor prescribed, or if there is a limit on the quantity (or dose) of the drug and you disagree with the requirement or dosage limitation.

REQUESTING A PART D PRESCRIPTION DRUG BENEFIT, MEDICAL BENEFIT OR PAYMENT FROM UPMC *for Life***What are the steps for requesting a Part D benefit or payment from UPMC *for Life*?**

If you are having a problem getting care, Part D benefits, or payment for care or a prescription drug, there are six possible steps you can take to ask for the care, benefits, or payment you want from us. At each step, your request is considered and a decision is made. If you are unhappy with the decision, you may be able to take another step if you want to continue requesting the care, benefits, or payment.

- In Steps 1 and 2, you make your request directly to us. We review it and give you our decision.
- In Steps 3 through 6, people in organizations that are not connected to us make the decisions about your request. To keep the review independent and impartial, those who review the request and make the decision in Steps 3 through 6 are part of (or in some way connected to) the Medicare program or the federal court system.

The six possible steps are summarized below. The Evidence of Coverage provides additional information about each step. You may request the most recent UPMC *for Life* or UPMC *for Life* Specialty Plan Evidence of Coverage by calling the UPMC *for Life* Member Services at the number listed on the first page.

STEP 1: The initial decision or coverage determination by UPMC *for Life*

The starting point is when we make an “initial decision” about your medical care, Part D prescription drug, or about paying for medical care or a drug that you have already received. When we make an “initial decision,” we are giving our interpretation of how the services and benefits that are covered for members of UPMC *for Life* apply to your specific situation. You can ask for a “fast initial decision” if you have a request for medical care or Part D benefits that needs to be decided more quickly than the standard time frame.

STEP 2: Appealing the initial decision by UPMC *for Life*

If you disagree with the decision we make in Step 1, you may ask us to reconsider our decision. This is called an “appeal” or “request for redetermination.” You can ask for a “fast appeal” if your request for medical care or Part D benefit needs to be decided more quickly than the standard time frame. After reviewing your appeal, we will decide whether to stay with our original decision, or change this decision and give you some or all of the care, benefit, or payment you want.

To file a standard appeal, UPMC *for Life* members or an authorized representative may call Member Services at 1-877-539-3080, from 8 a.m. to 8 p.m., seven days a week. TTY/TDD users should call 1-800-361-2629. UPMC *for Life* Specialty Plan members or an authorized representative may call Member Services at 1-800-606-8648, from 8 a.m. to 8 p.m., seven days a week. TTY/TDD users should call 1-800-407-8762. From March through November 14, you may receive a messaging service on weekends and holidays. Please leave a message and your call will be returned the next business day. Your request must be made within 60 days of the initial decision.

You or your authorized representative can also file a standard appeal by mailing your request in writing within 60 days of the initial decision to UPMC Health Plan, Attn: Appeals and Grievances, P.O. BOX 2939, Pittsburgh, PA 15230-2939.

STEP 3: Review of your request by an Independent Review Organization

If we turn down part or your entire request for medical care in Step 2, we are required to send your request to an independent review organization that has a contract with the federal government and is not part of UPMC *for Life*. This organization will review your request and make a decision about whether we must give you the care or payment you want. If we turn down your request for a Part D prescription drug in Step 2, you may ask an independent review organization to review our decision. The independent review organization has a contract with the federal government and is not part of UPMC Health Plan. The independent review organization will review your request and make a decision about whether we must give you the benefit or payment you want.

STEP 4: Review by an Administrative Law Judge

If you are unhappy with the decision made by the independent review organization that reviews your case in Step 3, you may ask for an Administrative Law Judge to consider your case and make a decision. The Administrative Law Judge works for the federal government.

STEP 5: Review by a Medicare Appeals Council

If you or we are unhappy with the decision made in Step 4, either of us may be able to ask the Medicare Appeals Council (MAC) to review your case. The MAC is part of the federal department that runs the Medicare program.

STEP 6: Federal Court

If you or we are unhappy with the decision made by the MAC in Step 5, either of us may be able to take your case to a Federal Court.

COMPLAINTS (GRIEVANCES) ABOUT ANY OTHER TYPE OF PROBLEM YOU HAVE WITH UPMC *for Life* OR ONE OF OUR PLAN PROVIDERS**What is included in “all other types of problems”?**

Here are some examples of problems that are included in this category of “all other types of problems”:

- Problems with the quality of the medical care you receive, including quality of care during a hospital stay.
- If you feel that you are being encouraged to leave (disenroll from) UPMC *for Life*.
- Problems with the Member Service you receive.
- Problems with how long you have to spend waiting on the phone, in the waiting room, or in the exam room.
- Problems with getting appointments when you need them, or having to wait a long time for an appointment or to have your prescription filled.
- Disrespectful or rude behavior by pharmacists, doctors, nurses, receptionists, or other staff.
- Cleanliness or condition of pharmacies, doctor’s offices, clinics, or hospitals.

If you have one of these types of problems and want to make a complaint, it is called “filing a grievance.” In addition, you have the right to ask for a “fast grievance” if you disagree with our decision to not give you a “fast appeal” or if we take an extension on our initial decision or appeal.

What do I do if I have questions or concerns?

We will try to resolve any questions or concerns that you might have over the phone. If we cannot resolve your questions or concerns over the phone, we have a formal procedure to review your complaints. We call this formal procedure the UPMC *for Life* grievance procedure.

How do I file a grievance?

To use the UPMC *for Life* grievance procedure, ask a Member Services representative to document your concerns or send your grievance in writing to the Member Services Department at the following address:

UPMC Health Plan

Attn: Appeals and Grievances Coordinator

P.O. Box 2939

Pittsburgh, PA 15230-2939

When will UPMC *for Life* respond to me with a decision about my grievance?

We must notify you of our decision about your grievance as quickly as your case requires based on your health status, but no later than 30 calendar days after receiving your complaint. We may extend the time frame by up to 14 calendar days if you request the extension, or if we justify a need for additional information and the delay is in your best interest.

What happens during the grievance process?

Your complaint will be reviewed by an internal Grievance Review Committee, consisting of one or more employees of UPMC Health Plan. The Committee will investigate the details of your grievance. The committee will make a decision within 30 days of receipt of your complaint. You will receive written notification of the committee decision specifying the reasons for the decision. The Committee decision will be binding. You may authorize a representative to assist you in the grievance process.

For quality of care problems, you may also complain to the QIO.

If you are concerned about the quality of care you received, including care during a hospital stay, you can also complain to an independent organization called the QIO. You can contact Member Services to get information on how to contact the QIO. If you file a quality of care grievance, our decision letter will also include information on how to contact the QIO.

What if I want to designate someone to represent me during an appeal or grievance?

At any time during the grievance or appeal process, you may authorize a representative to assist you in the process. We must receive an authorization, in writing, from you to designate a representative. You can contact Member Services for additional information about designating a representative.

PRIVACY STATEMENT

That's right - your personal information is private and confidential. We at UPMC Health Plan want to take this opportunity to remind you that this is the trust that we establish with you. It is a pledge that we take seriously. Whether you are a prospective, current, or former member, living or deceased, we respect and safeguard the privacy and confidentiality of the information that we have about you on file.

Privacy is one of your rights as a consumer as well as a UPMC Health Plan member. It also is a right that you retain even when you are no longer a member of UPMC Health Plan.

But what does “private and confidential” really mean?

When you fill out your enrollment or renewal application form and sign it - you are doing two important things:

1. verifying the correctness and truthfulness of the information that you have provided to us
2. acknowledging that UPMC Health Plan can only use the information we collect or receive about you and your family for very well-defined routine purposes:
 - arranging for the provision of health care treatment and services to you and your family members that you are enrolling as dependents on your application.
 - making payment to doctors, hospitals, and other health care professionals for the treatment and services you and your family receive,
 - and performing certain health care operations that UPMC Health Plan uses to monitor the quality of the health care coverage and services that you have chosen for you and your family. These operations include measurement and review of all our data to see how many of our members receive certain services, such as childhood immunizations, mammograms, and other preventive health services. All these measurements are used so that we can assess how well we are doing in providing quality health care to all our members.

Your personal information covers a number of elements that all have one thing in common: they are all unique to you; they can be used to identify you. This means that any files containing information that includes such things as your name, address, social security number, and birth date are considered “protected health information.” And it is our responsibility to ensure the privacy of the protected health information of all our members - prospective, current, or former.

The files that a managed care organization collects or maintains are not things such as medical charts or records, but include things such as the claims we have received and paid for the services provided to you, or the health care premiums that you or your company have paid. So whether the protected health information we have is considered health information or non-public personal financial information - we only use the information we have in our files within our company and with our contracted providers, vendors, and agents for the purposes of your health care insurance.

Other than for the well-defined, routine purposes described above, or as required by law, the only one who has access to your personal information and records is you.

UPMC Health Plan does not share your protected health information with anyone else - including employers - unless you provide us with permission to do so. Any reports to employers about the services provided to their employees are based only on total employee group percentages and totals - and not on any individual member data or information.

Not only do all the physicians and providers in our network know that your information is private and confidential, but our Health Plan employees know that too. In fact, we have training programs for our employees to ensure that they know the procedures they need to follow to make sure that your information - whether in oral, written, or electronic format - is secure and safeguarded. We will not disclose information for any purposes beyond the provision of your health care coverage, unless authorized by you in writing or required to do so by law.

If we have any additional programs that we feel would be beneficial to you and that would require us to use your specific personal information in order to let you participate in the program, we would contact you and let you know all the details. We would request your permission and signed authorization before we would use your personal information for anything other than routine purposes that we have explained. If you decline such a request, your information will not be part of the special program enrollment.

You undoubtedly have heard a great deal about privacy in the news - especially as it concerns federal legislation about privacy of health information. In addition to any new legislation, all health insurance carriers and health care providers are dealing with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and several important sets of regulations that government agencies have recently issued for HIPAA implementation and compliance. In fact, because the HIPAA Privacy Regulations require doctors, hospitals, and health care insurers, as well as employee benefit plans, that are involved in your health care to have a "Notice of Privacy Practices," you will probably be receiving several of these notices.

So, in addition to this Privacy Statement, UPMC Health Plan's Notice of Privacy Practices will give you even more specific information and details about how we ensure the privacy of your protected health information. The Notice will also explain all the rights that you have concerning the privacy of your health information, and how you can exercise those rights.

UPMC Health Plan, through its Compliance Committee and Quality Improvement Committee, monitors all applicable laws and government regulations. We continually review our policies and procedures to ensure that we are meeting the needs of privacy laws and our commitment to our members. As new laws are passed and new regulations are issued or clarified, we will be providing you with revised information with any changes or updates.

If you have any questions concerning your right to the privacy and confidentiality of your personal information and data that have been entrusted to UPMC Health Plan, please contact our Member Services Department at the phone number on the back of your ID Card.

Contact Information:

Specific inquiries about this statement regarding HIPAA readiness and compliance should be directed to:

HIPAA Project Manager
One Chatham Center
112 Washington Place
Pittsburgh, PA 15219
e-mail: HealthPlanHIPAAOffice@msx.upmc.edu

MEDICARE CONTRACT DISCLAIMER

Important Note

UPMC Health Plan is required to renew its contract with the Centers for Medicare & Medicaid Services (CMS) on an annual basis. As a Medicare Advantage Plan, we are required by CMS to provide you with notification if we leave the service area or the Medicare program entirely.

What happens if UPMC *for Life* leaves the Medicare program or UPMC *for Life* leaves the area where you live?

If we leave the Medicare program or change our service area so that it no longer includes the area in which you live, we will tell you in advance in writing. If this happens, your membership in UPMC *for Life* will end. All of the benefits and rules will continue until your membership ends, which means that you must continue to get your medical care in the usual way through UPMC *for Life* until your membership ends.

Your choices as to how to get your Medicare benefits will always include Original Medicare and joining a Prescription Drug Plan to complement your Original Medicare coverage. Your choices may also include joining another Medicare Advantage plan or a private fee-for-service plan, if these plans are available in your area and are accepting new members. Once we have told you in writing that we are leaving the Medicare program or the area where you live, you will have a chance to change to another way of getting your Medicare benefits. If you decide to change from UPMC *for Life* to Original Medicare, you will have the right to buy a Medigap policy regardless of your health status.

UPMC *for Life* has a contract with the Centers for Medicare & Medicaid Services (CMS), the government agency that runs Medicare. This contract renews each year. At the end of each year, the contract is reviewed, and either UPMC *for Life* or CMS can decide to end it. You will get 90 days advance notice in this situation. It is also possible for our contract to end at some other time during the year, too. In these situations we will try to tell you 90 days in advance, but your advance notice may be as little as 30 or fewer days if CMS must end our contract in the middle of the year.

Whenever a Medicare health plan leaves the Medicare program or stops serving your area, you will be provided a special enrollment period (SEP) to make choices about how you get Medicare, including choosing a Medicare Prescription Drug Plan and guaranteed issue rights to a Medigap policy.

FRAUD AND ABUSE INFORMATION

Health care fraud, waste, and abuse is everybody's business...make it yours!

The following are examples of potential fraud or abuse regarding Medicare Part D:

- Someone asks you to pay to enroll in Medicare Part D.
- You are charged for a prescription you don't recall receiving.
- Someone offers you money to enroll in a prescription drug plan.
- You are contacted by someone representing himself or herself as an employee of a Medicare Part D organization who asks you to provide your name, date of birth, or, especially, your Social Security number, Medicare number, or credit card information.
- You are told that non-covered items are covered.
- You do not receive all the drugs you paid for.

If any of the above incidents have happened to you, or if you have noticed anything else you suspect may be fraud, waste, or abuse, contact our Fraud and Abuse hotline at **1-866-FRAUD-01**, 24 hours a day, 7 days a week. TTY/TDD users please call **1-800-361-2629**. Or, e-mail us at [**specialinvestigationsunit@upmc.edu**](mailto:specialinvestigationsunit@upmc.edu).

(Medical services that are not covered by UPMC *for Life* HMO – this does not apply to the stand-alone UPMC *for Life* Prescription Drug Plan)

1. Services that are not covered under Original Medicare.
2. Services that you get from non-plan providers, **except** for care for a medical emergency and urgently needed care, renal (kidney) dialysis services that you get when you are temporarily outside the plan's service area, and care from non-plan providers that is arranged or approved by a plan provider.
3. Services that you get without prior authorization, when prior authorization is required for getting that service.
4. Services that are not reasonable and necessary according to Original Medicare Plan standards, **unless** these services are otherwise listed by UPMC *for Life*.
5. Emergency facility services for non-authorized, routine conditions that do not appear to a reasonable person to be based on a medical emergency.
6. Experimental or investigational medical and surgical procedures, equipment and medications, **unless** covered by Original Medicare or under an approved clinical trial. Experimental procedures and items are those items and procedures determined by UPMC Health Plan and Original Medicare to not be generally accepted by the medical community.
7. Surgical treatment of morbid obesity **unless** medically necessary and covered under Original Medicare.
8. Private room in a hospital, **unless** medically necessary.
9. Private duty nurses.
10. Personal convenience items, such as a telephone or television in your room at a hospital or skilled nursing facility.
11. Nursing care on a full-time basis in your home.
12. Custodial care is not covered **unless** it is provided in conjunction with skilled nursing care and/or skilled rehabilitation services. "Custodial care" includes care that helps people with activities of daily living, like walking, getting in and out of bed, bathing, dressing, eating and using the bathroom, preparation of special diets, and supervision of medication that is usually self-administered.
13. Homemaker services.
14. Charges imposed by immediate relatives or members of your household.
15. Meals delivered to your home.
16. Unless medically necessary, elective or voluntary enhancement procedures, services, supplies and medications including but not limited to: weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance.
17. Cosmetic surgery or procedures, **unless** it is needed because of accidental injury or to improve the function of a malformed part of the body. Breast surgery and all stages of reconstruction for the breast on which a mastectomy was performed and, to produce a symmetrical appearance, surgery and reconstruction of the unaffected breast, is covered.
18. The following dental services (complex extractions, dentures, full mouth x-rays, orthodontics) are excluded. Certain dental services that you get when you are in the hospital will be covered.
19. Chiropractic care is generally not covered under the plan, (with the exception of the routine visits for manual manipulation of the spine) and is limited according to Medicare guidelines.
20. Routine foot care is generally not covered under the plan, (with the exception of the routine visits) and is limited according to Medicare guidelines.

21. Orthopedic shoes, **unless** they are part of a leg brace and are included in the cost of the leg brace. There is an exception: orthopedic or therapeutic shoes are covered for people with diabetic foot disease.
22. Supportive devices for the feet. **There is an exception:** orthopedic or therapeutic shoes are covered for people with diabetic foot disease.
23. Hearing aid batteries are not covered under the plan.
24. Radial keratotomy, LASIK surgery, vision therapy and other low vision aids and services.
25. Self-administered prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence, and anorgasmy or hyporgasmy.
26. Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies and devices.
27. Acupuncture.
28. Naturopaths' services.
29. Services provided to veterans in Veteran's Affairs (VA) facilities. However, in the case of emergency services received at a VA hospital, if the VA cost sharing is more than the cost sharing required under UPMC *for Life*, we will reimburse veterans for the difference.

(Medical services that are not covered by UPMC *for Life* PPO – this does not apply to the stand-alone UPMC *for Life* Prescription Drug Plan)

1. Services that are not covered under Original Medicare.
2. Services that are not part of your plan's Medicare-approved benefit package. If you obtain services from a provider who contracts with your plan, the service will be treated as an in-network covered service unless the provider advises you otherwise. However, if you obtain a service from a non-plan provider, you may want to confirm in advance with your plan that the service you obtain is medically necessary and a plan-covered service.
3. Even though you are not required to get prior authorization for services from non-plan providers, you can ask us for prior authorization to make sure that we agree that the services are covered and medically necessary. You may also obtain cost sharing reductions if you choose to obtain prior authorization for certain services you obtain from non-plan providers.
4. Services that are not reasonable and necessary according to Original Medicare Plan standards, **unless** these services are otherwise listed by UPMC *for Life*.
5. Emergency facility services for non-authorized, routine conditions that do not appear to a reasonable person to be based on a medical emergency.
6. Experimental or investigational medical and surgical procedures, equipment, and medications, **unless** covered by Original Medicare or under an approved clinical trial. Experimental procedures and items are those items and procedures determined by UPMC Health Plan and Original Medicare to not be generally accepted by the medical community.
7. Surgical treatment of morbid obesity **unless** medically necessary and covered under Original Medicare.
8. Private room in a hospital, **unless** medically necessary.
9. Private duty nurses.
10. Personal convenience items, such as a telephone or television in your room at a hospital or skilled nursing facility.
11. Nursing care on a full-time basis in your home.
12. Custodial care is not covered **unless** it is provided in conjunction with skilled nursing care and/or skilled rehabilitation services. "Custodial care" includes care that helps people with activities of daily living, like walking, getting in and out of bed, bathing, dressing, eating and using the bathroom, preparation of special diets, and supervision of medication that is usually self-administered.
13. Homemaker services.
14. Charges imposed by immediate relatives or members of your household.
15. Meals delivered to your home.
16. Unless medically necessary, elective or voluntary enhancement procedures, services, supplies and medications including, but not limited to: weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging, and mental performance.
17. Cosmetic surgery or procedures, **unless** it is needed because of accidental injury or to improve the function of a malformed part of the body. Breast surgery and all stages of reconstruction for the breast on which a mastectomy was performed and, to produce a symmetrical appearance, surgery and reconstruction of the unaffected breast, is covered.
18. The following dental services (complex extractions, dentures, full mouth x-rays, orthodontics) are excluded. Certain dental services that you get when you are in the hospital will be covered.

19. Chiropractic care is generally not covered under the plan, (with the exception of the routine visits for manual manipulation of the spine) and is limited according to Medicare guidelines.
20. Routine foot care is generally not covered under the plan, (with the exception of the routine visits) and is limited according to Medicare guidelines.
21. Orthopedic shoes **unless** they are part of a leg brace and are included in the cost of the leg brace. There is an exception: orthopedic or therapeutic shoes are covered for people with diabetic foot disease.
22. Supportive devices for the feet. **There is an exception:** orthopedic or therapeutic shoes are covered for people with diabetic foot disease.
23. Hearing aid batteries are not covered under the plan.
24. Radial keratotomy, LASIK surgery, vision therapy, and other low vision aids and services.
25. Self-administered prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence, and anorgasmy or hyporgasmy.
26. Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies and devices.
27. Acupuncture.
28. Naturopaths' services.
29. Services provided to veterans in Veteran's Affairs (VA) facilities. However, in the case of emergency services received at a VA hospital, if the VA cost sharing is more than the cost sharing required under UPMC *for Life*, we will reimburse veterans for the difference.

(Medical services that are not covered by UPMC *for Life* Specialty Plan – this does not apply to the stand-alone UPMC *for Life* Prescription Drug Plan)

1. Services that are not covered under Original Medicare.
2. Services that you get from non-plan providers, **except** for care for a medical emergency and urgently needed care, renal (kidney) dialysis services that you get when you are temporarily outside the plan's service area, and care from non-plan providers that is arranged or approved by a plan provider.
3. Services that you get without prior authorization, when prior authorization is required for getting that service.
4. Services that are not reasonable and necessary according to Original Medicare Plan standards, **unless** these services are otherwise listed by UPMC *for Life* Specialty Plan.
5. Emergency facility services for non-authorized, routine conditions that do not appear to a reasonable person to be based on a medical emergency.
6. Experimental or investigational medical and surgical procedures, equipment and medications, **unless** covered by Original Medicare or under an approved clinical trial. Experimental procedures and items are those items and procedures determined by UPMC Health Plan and Original Medicare to not be generally accepted by the medical community.
7. Surgical treatment of morbid obesity **unless** medically necessary and covered under Original Medicare.
8. Private room in a hospital, **unless** medically necessary.
9. Private duty nurses.
10. Personal convenience items, such as a telephone or television in your room at a hospital or skilled nursing facility.
11. Nursing care on a full-time basis in your home.
12. Custodial care is not covered **unless** it is provided in conjunction with skilled nursing care and/or skilled rehabilitation services. "Custodial care" includes care that helps people with activities of daily living, like walking, getting in and out of bed, bathing, dressing, eating and using the bathroom, preparation of special diets, and supervision of medication that is usually self-administered.
13. Homemaker services.
14. Charges imposed by immediate relatives or members of your household.
15. Meals delivered to your home.
16. Unless medically necessary, elective or voluntary enhancement procedures, services, supplies and medications including but not limited to: weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance.
17. Cosmetic surgery or procedures, **unless** it is needed because of accidental injury or to improve the function of a malformed part of the body. Breast surgery and all stages of reconstruction for the breast on which a mastectomy was performed and, to produce a symmetrical appearance, surgery and reconstruction of the unaffected breast, is covered.
18. Chiropractic care is generally not covered under the plan, (with the exception of manual manipulation of the spine) and is limited according to Medicare guidelines.
19. Routine foot care is generally not covered under the plan and is limited according to Medicare guidelines.
20. Orthopedic shoes, **unless** they are part of a leg brace and are included in the cost of the leg brace. There is an exception: Orthopedic or therapeutic shoes are covered for people with diabetic foot disease.

21. Supportive devices for the feet. **There is an exception:** orthopedic or therapeutic shoes are covered for people with diabetic foot disease.
22. Radial keratotomy, LASIK surgery, vision therapy, and other low vision aids and services.
23. Self-administered prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence, and anorgasmy or hyporgasmy.
24. Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies and devices. (Medically necessary services for infertility are covered according to Original Medicare guidelines.)
25. Acupuncture.
26. Naturopaths' services.
27. Services provided to veterans in Veteran's Affairs (VA) facilities. However, in the case of emergency services received at a VA hospital, if the VA cost sharing is more than the cost sharing required under UPMC *for Life* Specialty Plan, we will reimburse veterans for the difference.

UPMC Health Plan is committed to the delivery of appropriate care and does not use incentives to reward inappropriate restrictions of care. UPMC Health Plan affirms that:

- Utilization Management decision-making is based on reasonable clinical evidence, UPMC Health Plan policies, and nationally recognized utilization guidelines.
- UPMC Health Plan does not reward practitioners or other individuals conducting utilization review for issuing denials of coverage or service.
- No financial incentives are given to utilization management decision-makers to encourage decisions that result in under-utilization.
- Members have access to the utilization management process and decisions. UPMC Health Plan provides access for members to obtain information about the utilization process and authorization decisions.

The utilization management staff is available to provide information on how a decision was made. Members may obtain a copy of the criteria on which the decision was based by sending a request or contacting UPMC Health Plan by phone. If you are a current UPMC *for Life* member, inquiries can be made by calling Member Services at 1-877-539-3080, 8 a.m. to 8 p.m., 7 days a week. TTY/TDD users should call 1-800-361-2629. After business hours, you can leave a message and a representative will return your call on the next business day. Information about behavioral health utilization matters can be obtained by calling 1-888-251-0083. TTY/TDD users should call 1-877-877-3580.

If you are a current UPMC *for Life* Specialty Plan member, inquiries can be made by calling Member Services at 1-800-606-8648, 8 a.m. to 8 p.m., 7 days a week. TTY/TDD users should call 1-866-407-8762. After business hours, you can leave a message and a representative will return your call on the next business day.

Utilization Review Process

Our role as a financial and medical steward of your health care requires that UPMC Health Plan review and approve certain medical procedures and services before these procedures and services are provided. This review process is referred to as a pre-service review or prior authorization process, and is conducted by clinical staff in our Medical Management and Pharmacy departments. These staff members conduct Utilization Reviews (UR) to promote the appropriate use of health care resources. Their aim is to assess whether the proposed services, care, or medication requests meet medical necessity criteria and, consequently, whether the request for payment will be covered under your health benefits.

In addition to the prior authorization process, the utilization review process includes other types of reviews to determine reimbursement for medical services. These include concurrent reviews, retrospective (post-service) reviews, and discharge planning reviews. Concurrent reviews are performed when you or your provider request an extension of an ongoing course of treatment that has previously been approved. The request maybe for an extended period of time or an increase in the number of treatments. Retrospective reviews assess appropriateness of medical services after services have been provided. A discharge planning review includes a comprehensive evaluation of your health needs to assist in the planning of care following discharge from an inpatient setting. UPMC Health Plan's clinical staff will communicate with your health care providers about these review processes.

The person who is discussing plan options with you is either employed by or contracted with UPMC Health Plan. The person may be compensated based on your enrollment in a plan.

UPMC *for Life*

UPMC Health Plan Medicare Program

To find out if
UPMC *for Life*
is right for you,
call toll-free
1-877-381-3765

To find out if
UPMC *for Life* Specialty Plan
is right for you,
call toll-free
1-877-405-8762

TTY/TDD users should call
1-800-361-2629

From March 2 through November 14,
you may receive a messaging service
on weekends and holidays. Please
leave a message and your call will
be returned the next business day.

UPMC HEALTH PLAN **Where you belong.**

One Chatham Center
112 Washington Place
Pittsburgh, PA 15219

www.upmchealthplan.com/medicare