
UPMC HEALTH PLAN (Commercial)



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Products at a Glance

UPMC Health Plan offers five basic medical plan designs, which are distinguished mainly by varying levels of provider-coordinated vs. self-directed care and the use of network vs. out-of-network providers:

- Enhanced Access Health Maintenance Organization (EAHMO)
- Enhanced Access Point-of-Service (EAPOS)
- Preferred Provider Organization (PPO)
- Exclusive Provider Organization (EPO)
- UPMC *Consumer Advantage* (Consumer Directed Health Care Programs)

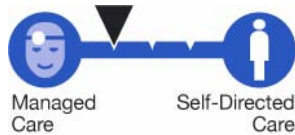
Each plan includes several standard options, which define the applicable deductible, copayments, coinsurance, and out-of-pocket maximums.

UPMC Health Plan also customizes benefit options for employer groups and covers a standard set of health care services in each plan. Benefits for inpatient care, surgical procedures, professional provider services, and other medical treatments are included in every plan design.

The Health Plan offers standard plan designs for smaller employer groups and customizes benefits for employer groups with more than 200 employees. Standard plans offer similar standardized benefit plans for smaller employers. The differences are related to applicable cost sharing levels such as, copayments, deductible and coinsurance levels, choice of benefit levels, and out-of-pocket expenses, if applicable.

Some plans may change over time due to employer benefit changes, regulatory requirements, or policy requirements. For the latest updates and variations, please visit our website at www.upmchealthplan.com or call Provider Services at 1-866-918-1595 from 8 a.m. to 5 p.m., Monday through Friday.

Enhanced Access Health Maintenance Organization (EAHMO)



The Enhanced Access HMO requires all participants to select a primary care provider (PCP) and use this provider for routine and preventive services. EAHMO members may use a provider or hospital in their benefit plan network and may access care by coordinating services with their PCP.

Women may use any network ob-gyn to provide or coordinate all covered gynecological/obstetric care, and there is no requirement to designate a specific gynecologist for routine and preventive services.

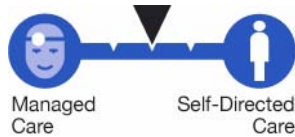
No benefits are paid if routine or non-emergent care is received outside the network appropriate to the member's benefit plan, unless care has been coordinated through Case Management before the services are received.



Key Points

- PCP is mandatory.
- Network providers and facilities must be used.
- Preventive care is covered only if provided by PCPs (or specialists who are credentialed as PCPs).
- Routine physical exams and immunizations for both adults and children (ages birth to 18) are covered (refer to member's benefit plan for immunization coverage), although copayments may apply.
- Most preventive services are fully covered; copayments may apply.
- Obstetricians/gynecologists are credentialed for routine gynecological visits and mammogram screenings, even when not credentialed as PCPs.
- Emergent care by any provider is covered if the member believes that their health is in serious danger. Urgent care by any provider is covered if the member believes that if untreated, his or her condition could rapidly become a medical emergency.

Enhanced Access Point-of-Service (EAPOS)



The EAPOS plan offers two levels of health care benefits. Members are encouraged to use a primary care provider (PCP) for medical care; however, they also may self-direct their care within their network or outside their network. Out-of-network care has applicable deductibles, coinsurance, and higher costs, e.g., the difference between the Health Plan's reasonable and customary allowance and the provider's charge as well as the applicable deductible and coinsurance.

Women may use any network ob-gyn to provide or coordinate all covered gynecological/obstetric care, but there is no requirement to designate a specific gynecologist for routine and preventive services.

The EAPOS plans may include a combination of deductible requirements, coinsurance, and copayments even when care is received in network.



Key Points

Coordinated Care or Self-Directed Care within Network:

- Members should designate a PCP for preventive services and to coordinate specialized services.
- Certain plan designs may require a deductible and/or coinsurance.
- Routine physical exams and immunizations for both adults and children are covered only when performed by a PCP. A copayment may apply.
- Most preventive services are fully covered.

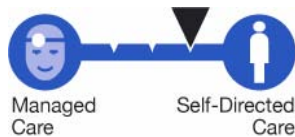
Self-Directed Out-of-Network Care:

- Routine preventive care is not covered.
- Members have higher payments for out-of-network providers or benefits.
- Coinsurance and annual deductibles may apply.
- Members may be responsible for the difference between the provider's charges and the Health Plan's payment (reasonable and customary amount).
- When members reach the annual out-of-pocket maximum, benefits are covered at 100 percent of the Health Plan's reasonable and customary allowance until the lifetime maximum is met for out-of-network care.

Emergency Care:

- Emergent care by any provider is covered if the member believes that their health is in serious danger. Urgent care by any provider is covered if the member believes that if untreated, his or her condition could rapidly become a medical emergency.

Preferred Provider Organization (PPO)



In the Preferred Provider Organization (PPO) plan, members are not required to select a PCP or an ob-gyn. The member's care, therefore, is not coordinated by any provider, and members access specialists directly.

Benefits are largely determined by the member's use of network vs. out-of-network providers, with higher benefits awarded to those who use network providers.

Members have a combination of applicable deductibles, coinsurance, and copayments for both network and out-of-network benefits. A combination of deductible and coinsurance applies for out-of-network care, and members are responsible for higher costs when care is received out-of-network.



Key Points

Network Care:

- Members have lower copayments or coinsurance when using network providers and services.
- Certain plan designs may require a deductible and/or coinsurance.
- Most preventive services, including routine physical exams for adults and children, are fully covered. A copayment may apply.

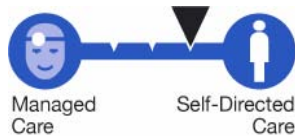
Out-of-Network Care:

- Preventive services are not covered.
- Members have higher payments for out-of-network providers or services.
- Annual deductibles and coinsurance apply.
- Members may be responsible for the difference between the provider's charges and the Health Plan's payment (the Health Plan's reasonable and customary allowance).

Emergency Care:

- Emergent care by any provider is covered if the member believes that their health is in serious danger. Urgent care by any provider is covered if the member believes that if untreated, his or her condition could rapidly become a medical emergency.

Exclusive Provider Organization (EPO)



UPMC Health Plan offers an Exclusive Provider Organization (EPO) plan, which blends elements of a traditional HMO with the elements of a PPO.

Similar to a PPO plan, members are not required to select a PCP or ob-gyn. They may receive treatment from any network provider or at any network facility. But, like the EAHMO, the EPO plan requires members to receive care from network providers and facilities to receive covered benefits.

There are no out-of-network benefits unless a member's care has been coordinated through Medical Management at 1-800-425-7800 from 8 a.m. to 6:00 p.m. Monday through Friday before the services are received.

Members may be responsible for a copayment, an annual deductible, and/or coinsurance up to an annual out-of-pocket maximum. Copayments depend on the medical care received, such as preventive services or sick care. Copayments also may be tiered for drug coverage.



Key Points

- PCP is not required.
- Copayments, deductibles, and/or coinsurance may apply.
- Most preventive services, including routine physical exams for adults and children, are fully covered when performed by a provider credentialed as a PCP. A copayment may apply.
- Members must self-direct care to network providers.
- Emergent care by any provider is covered if the member believes that their health is in serious danger. Urgent care by any provider is covered if the member believes that if untreated, his or her condition could rapidly become a medical emergency.

UPMC Consumer Advantage (Consumer Directed Health Care Programs)

At a Glance

UPMC Health Plan offers an array of consumer directed health care products, complete with health promotional programs and online tools to engage members in a consumer-focused health benefits environment.

A consumer directed health plan consists of a high-deductible health plan (HDHP) coupled with a financial (funding) and investment arrangement to fund the plan's deductible. The funding source may be either an employer-funded and owned Health Reimbursement Account (HRA) or an employee-owned Health Savings Account (HSA), which may be funded by the employee, employer, or both entities. UPMC Health Plan offers six HRA and HSA options.

HDHPs offer a benefit structure that is almost identical to traditional PPO plans. Members do not select a primary care physician or ob-gyn and may receive treatment from an in-network or out-of-network provider. The member's care is not coordinated by any provider, and the member can access any specialists directly.



Key Points

Network Care:

- Members have lower copayments or coinsurance when using network providers and services.
- All plan designs require a deductible and/or coinsurance, and the level of deductibles and coinsurance depends on the various plan options.
- Annual up-front deductibles and coinsurance apply to all HSA benefits.
- Annual up-front deductibles and coinsurance apply to all HRA plan options, with the exception of preventive services and pharmacy.
- All preventive services, including routine physical exams for adults and children, are fully covered.

Out-of-Network Care:

- Preventive services are not covered.
- All plan designs require a deductible and/or coinsurance, and the level of deductibles and coinsurance depends on the various plan options.
- Annual up-front deductibles and coinsurance apply to all out-of-network benefits.

Emergency Care:

- Emergent care by any provider is covered if the member believes that their health is in serious danger. Urgent care by any provider is covered if the member believes that if untreated, his or her condition could rapidly become a medical emergency.

Covered Benefits

At a Glance

UPMC Health Plan network PCPs, specialists, therapists, chiropractors, podiatrists, nursing homes, hospices, hospitals, and rehabilitation centers provide a variety of medical benefits, some of which are itemized in the following section.

Benefit exclusions and services that may be covered with some restrictions are listed at the end of this chapter.

A provider may bill a Health Plan member for a non-covered service or item only if the provider, before performing the service, informs the member:

- of the nature of the service;
- that the service is not covered by UPMC Health Plan; and
- of the estimated cost to the member for the service.

The member must agree in writing that he or she will be financially responsible for the service. For specific information not covered in this manual, contact Provider Services at 1-866-918-1595 from 8 a.m. to 5 p.m., Monday through Friday.

Ambulance

Non-emergency medical transportation may be covered, depending on the member's benefit plan and medical necessity, if coordinated through UPMC Medical Transportation at 1-877-521-RIDE (7433).



Alert—Emergency Transportation

In the case of a life-threatening emergency, members should dial 911 or their local emergency service.

All requests for non-emergency medical transportation must be coordinated for the following:

- Air ambulance
- Ground ambulance
- Invalid coach (i.e., stretcher van)
- Wheelchair van transportation

Ancillary Services

Ancillary services include a wide range of outpatient support services that may be available at a provider's office/location, a hospital outpatient department, or a member's home.

Ancillary service benefits include, but are not limited to:

- Ambulance
- Chiropractic care
- Diagnostic services (e.g., lab, x-ray), including special diagnostics
- Home health care (including skilled/intermittent nursing; physical, speech, and occupational therapy; medical social services; home health aides; and registered dietitian services)
- Home infusion therapy
- Home medical equipment (HME), including specialty wheelchairs and scooters known as Power Mobility Devices (PMD).
- Hospice care
- Laboratory services
- Non-emergency ambulance
- Nursing care at a licensed skilled nursing facility
- Orthotics and prosthetics
- Private duty nursing in the home
- Respiratory equipment, including oxygen therapy

Ancillary services are covered when care is performed by network providers and coordinated by a member's PCP (when applicable) ob-gyn, or network specialist, through a prescription or by telephone. Prior authorization may be required and copayments may apply to certain benefits. To find a network provider for a particular service or location, please go to www.upmchealthplan.com.

In-Home Services

In-home services include:

- Home health care (including skilled/intermittent nursing; physical, speech, and occupational therapy; medical social services; home health aides; and registered dietitian services)
- Home infusion therapy
- Home medical equipment (HME), including specialty wheelchairs and scooters known as Power Mobility Devices (PMDs).
- Hospice care
- Private duty nursing
- Respiratory equipment, including oxygen therapy



Closer Look at Specialized Equipment

If a member requires specialized equipment or modifications, the ancillary provider should contact Medical Management at 1-800-425-7800. Medical Management will be able to determine whether the equipment is covered, and whether prior authorization is required. Please refer to the Quick Reference Guide to determine which equipment requires prior authorization.

Services Offered Outside the Home

A provider may refer a member to a network hospital's outpatient department or network free-standing facility as appropriate. For information regarding other network providers, please go to www.upmchealthplan.com or call Provider Services at 1-866-918-1595 from 8 a.m. to 5 p.m., Monday through Friday.

Ancillary network providers should determine member and benefit eligibility before rendering the service, whenever possible.

Services that must be coordinated by a member's PCP include but are not limited to:

- Ambulatory surgery centers
- Audiology
- Dialysis
- Laboratory services
- MRI
- Orthotics and prosthetics
- Outpatient rehabilitation services
- Radiology
- Skilled nursing facilities
- Special diagnostics, such as cardiac event monitors
- Specialty medical supplies, including, but not limited to, bone stimulators, insulin pumps, mastectomy products, therapy vests, and compression garments

Chiropractic Care

Chiropractic services do not have to be coordinated by a member's PCP, but they must be performed by a network chiropractor to be covered. Chiropractic care typically requires a higher copayment for the first visit (for the evaluation and initial management visit) and lower copayments for subsequent visits (for the treatment). In addition, the number of treatments per benefit period usually is limited.

It is the position of UPMC Health Plan that chiropractic services are not always appropriate for children. Therefore, no child under the age of 13 should be treated by a chiropractor without prior authorization from UPMC Health Plan.



Alert—Benefit Limits and Initial Visits

The benefit period begins on the member's effective date, which starts on the first day of the month in which the member's employer renews coverage. Copayments, deductibles, and visit limits are reset on the policy's renewal date.

If treatment overlaps the renewal date, a member may have to pay the higher first-visit copayment again and/or satisfy another deductible. Specific information on each member's benefits may be found at www.upmchealthplan.com.

Dental Benefits

Dental Care

Dental care for accidental injury to sound and natural teeth is generally covered under the Health Plan medical benefits; however, this benefit must be used within 72 hours of the particular injury. Routine dental care may be covered under a supplemental dental rider that is separate from the Health Plan's medical coverage. Members who have dental coverage sometimes are given a separate ID card.

Oral Surgery

Oral surgery, consisting of removal of impacted teeth that are partially or totally covered by bone as well as the related anesthesia, is a medical benefit under the Health Plan when coordinated by a member's PCP, if applicable, or network provider.



Alert

Temporomandibular Joint Disorder (TMJ) typically is an exclusion under most benefit plan designs. However, several plans have different levels of coverage for services related to TMJ – ranging from coverage of only the office visit to full coverage for all services, including surgery and pharmaceuticals. Please review specific benefit designs at www.upmchealthplan.com.

Diagnostic Services

Diagnostic services include radiology procedures, magnetic resonance imaging (MRI), ultrasound, and nuclear medicine; pathology testing consisting of laboratory and pathology tests; medical procedures consisting of ECG, EEG, and other electronic diagnostic medical procedures and physiological medical testing; and allergy testing consisting of percutaneous, intracutaneous, and patch tests.

Copayments fall into three categories.

- Most services are covered in full, but some members may have a copayment.
- Copayments for these services do not apply in the inpatient settings or the emergency department.
- Copayments may be limited for a specific number of services per year, and then the services are paid at 100%.

Providers south of Interstate 80 should call Quest Diagnostics at 1-800-920-9220.

Providers north of Interstate 80 should contact Associated Clinical Labs at 1-800-937-8028.

Please review specific benefit designs at www.upmchealthplan.com.

Emergency Services

Emergency services typically require a copayment at an emergency department, which is waived if the member is admitted immediately. This emergency department copayment also will be waived if the member is admitted within 3 days for the same condition, even if not admitted directly from the emergency department.

For members who have identified a PCP, the admitting physician or facility should notify that PCP within 24 hours or as soon as reasonably possible.



Closer Look at Emergency Admissions

The hospital or facility must notify Medical Management at 1-800-425-7800 within 48 hours or on the next business day following the emergency admission.

Hospital Admissions

Admissions to network hospitals are covered at higher level than out-of-network care; however, some plan designs do not cover non-emergent admissions to out-of-network hospitals. Also, hospital networks may vary according to a member's particular plan. Refer to www.upmchealthplan.com and review a member's benefits online or call Provider Services at 1-866-918-1595 to determine which hospitals serve a particular member.

Hospitals are required to notify Medical Management of inpatient admissions at 1-800-425-7800 by the next business day.

Labor, Delivery, and Postnatal Services

These services are covered at the highest benefit level when coordinated and delivered by a network ob-gyn or nurse midwife.

If there is an inpatient copayment listed for medical services, this copayment will apply. Several plans waive copayments for delivery only, though this variation will be noted in the member's particular plan, located at www.upmchealthplan.com.

Mental Health and Substance Abuse Benefits

Mental health and substance abuse benefits are managed through UPMC Health Plan Behavioral Health Services, the commercial component of Community Care Behavioral Health that provides triage and referral for emergency services 24 hours a day. Providers can access UPMC Health Plan Behavioral Health Services (BHS) by calling 1-888-251-2224. Members may call 1-888-251-0083.

Behavioral health providers must coordinate a member's care directly by calling the number listed on the member's identification card. Annual and lifetime maximums may apply for treatment of substance abuse and general mental illness.



Alert

As with medical care, inpatient care for behavioral health or substance abuse by network providers is covered at higher benefit levels with a limit on the number of days per year. Some plans may have an inpatient copayment. (Please check a member's individual plan at www.upmchealthplan.com.) Outpatient care by network providers may have possible copayments and annual visit limits, depending on the plan. Members may self-direct care to a behavioral health provider. Behavioral health providers are encouraged to communicate with other treating providers about the member's care, as applicable. Members do not have to obtain a referral from their PCP.



Closer Look at Directly Coordinating a Member's Care

Behavioral health practitioners are given a separate provider manual.

Call 1-888-251-2224 to request a manual or visit www.ccbh.com/providers.

Outpatient Surgery

Outpatient surgery is covered at the highest benefit level allowed by the particular plan design as long as the surgery is medically necessary and the PCP (when applicable), ob-gyn, or network specialist coordinates it. Some procedures may require prior authorization.

- ▶ See *Medical Management* chapter, *Procedures Requiring Predetermination*, chapter G.



Alert

Some procedures may require a copayment if the member receives services at particular locations, such as ambulatory surgical centers or outpatient clinics in a facility setting.

Podiatry

Routine podiatry care (e.g., treatment of bunions, corns, and calluses) and supportive orthotic devices are covered when the member has severe circulatory insufficiency and/or areas of desensitization in the legs or feet caused by diabetes mellitus, peripheral vascular disease, peripheral neuropathy, or severe collagen vascular diseases.

Prescription Drug Coverage

Coverage for prescription drugs varies by product and employer group. While most formularies are similar, it is important to always check the specific pharmacy rider applicable for individual members, as coverage for the same employer may have variations. Copayments may be listed in a two-tier or a three-tier structure, and the network may vary by design.



Alert—Prescription Formularies and Copayments

Each medical plan may be paired with one of many different pharmaceutical riders. Due to this customization option, providers need to verify the formulary, copayment structure, prior authorization requirements, and quantity limits for each member.

- ▶ See *Pharmacy Services* chapter, *Your Choice Pharmacy Program*.
 - ▶ See *Pharmacy Services* chapter, *First Choice Pharmacy Program*.
 - ▶ See *Pharmacy Services* chapter, *Value Choice Pharmacy Program*.
 - ▶ See *Pharmacy Services* chapter, *Open Choice Pharmacy Program*.
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Rehabilitative Therapy

Rehabilitative therapy (cardiac, occupational, respiratory, physical, and speech) is covered at higher benefit levels when coordinated through a network PCP (when applicable), ob-gyn, or network specialist. A copayment will apply to these services and is frequently the amount of the specialist copayment.

Benefit limits per episode or per year may apply for some members for each type of therapy. Coverage is subject to medical review and medical necessity.

- ▶ See *Medical Management* chapter, *When to Notify Medical Management*, chapter G.
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Alert—Difference Between Rehabilitation Therapy and Medical Therapy Services

Medical therapy services include chemotherapy, radiation therapy, dialysis treatment, and infusion therapy. These services typically are covered at 100 percent with possible copayments and are subject to specific benefit limitations defined in the schedule of benefits.

- ▶ See *Medical Management* chapter, *When to Notify Medical Management*, chapter G.
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Skilled Nursing Facility Care

Skilled nursing facility care is covered for medically necessary care without a 3-day waiting period (or a 3-day inpatient stay). Members needing skilled nursing care may be admitted to a skilled nursing facility directly from a hospital emergency department or from home, if appropriate.

Standard coverage for skilled medical care may not exceed 100 days per benefit period, and standard coverage for inpatient rehabilitation may not exceed 60 days per benefit period. Other benefit limits may apply and will be listed in the member's benefit description or at www.upmchealthplan.com.



Closer Look at Skilled Nursing Facility Care

Providers should notify Medical Management at 1-800-425-7800 to determine whether skilled nursing facility care is medically necessary. Custodial or respite care is not typically a covered benefit. Providers should verify the member's benefits for clarification.

- ▶ See *Medical Management* chapter, *When to Notify Medical Management*, chapter G.
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Vision Benefits

Routine eye care (such as glasses, contacts, and eye exams) is provided for certain employer groups through Vision Benefits of America (VBA) at 1-800-432-4966. The levels of coverage vary by group. A member's identification card does not indicate coverage, so providers should contact VBA to determine benefits.



Closer Look at Vision Benefits

UPMC Health Plan covers diabetic retinal screening exams and any eye treatments related to a medical condition.



Alert—Another Close Look at Vision Benefits

For post-cataract surgery, corrective lenses – either contacts or eyeglasses – may be necessary. In this instance, corrective lenses are a medical benefit, and questions should be directed to Provider Services at 1-866-918-1595 rather than VBA, as the coverage is provided through UPMC Health Plan.

Women's Care

Non-maternity care

Women in commercial plans do not have to select an ob-gyn. Copayment for routine annual exams is the first number listed after “physician” or “PCP” on the identification card. Copayment for sick visits or other care is the number listed after “specialist” on the identification card.

Maternity care

Copayments are waived for maternity care up to the time of delivery, including any copayments that may apply for diagnostic services.



Closer Look at Copayments for Delivery

Depending on the member's plan, a copayment may apply for delivery in an acute facility. If a pregnant woman is admitted for another illness, even if related to her maternity status, the inpatient copayment still applies.

Benefit Exclusions

The following is a partial list of the products, services, and procedures that are generally excluded from UPMC Health Plan benefits. Please check a member's specific benefits by going to www.upmchealthplan.com.

- Acupressure
- Alternative Medicine, including but not limited to: acupuncture and acupressure, aromatherapy, ayurvedic medicine, guided imagery, herbal medicine, homeopathy, massage therapy, naturopathy, relaxation therapy, transcendental meditation and yoga, and equestrian therapy.
- Comfort or convenience items such as air conditioners, television rental, or humidifiers
- Cosmetic surgery
- Court-ordered services
- Custodial care
- Experimental or investigative procedures
- Genetic counseling
- Growth hormones
- Hearing aids and routine hearing examinations and services
- Immunizations required for foreign travel
- Medically unnecessary services
- Military service-connected disabilities and conditions
- Miscellaneous services, supplies, or treatments not specifically listed in the Certificate of Coverage as covered benefits, services, supplies, or treatments
- Motor vehicle insurance or workers' compensation-covered services
- Non-covered services or any services related to or necessitated by an excluded item or non-covered service
- Over-the-counter drugs
- Physical examinations per third-party request, including but not limited to attorneys, employers, insurers, schools, camps, and driver's licensing bureaus
- Smoking cessation programs or products, unless specifically listed as a covered benefit in the benefit rider.
- Surrogate motherhood
- Weight reduction programs or drugs

Services That May Be Covered with Certain Restrictions

The following is a partial list of the products, services, and procedures that some members' benefit plans may cover under certain conditions. Limitations and restrictions may apply. Please check a specific member's benefits by going to www.upmchealthplan.com.

- Assisted fertilization, including but not limited to GIFT, ZIFT, embryo transplants, and in-vitro fertilization, when specifically covered by an infertility rider.
- Acupuncture
- Behavioral health services
- Corrective appliances, when determined to be the standard to restore basic functions and/or necessitates due to injury or disease
- Home medical equipment (**HME**)
- Dental care
- Home care
- Nutritional counseling or supplements
- Oral surgery
- Private-duty nursing
- Podiatry services
- Rehabilitation therapy services
- Reversal of voluntary sterilization procedures
- Sex transformation services and procedures
- Skilled nursing
- Therapeutic manipulation
- Transplants or organ donation
- Transportation, routine or non-emergency
- Vision care

Complaints and Grievances

Under the provisions of the Quality Health Care Accountability and Protection Act and regulations of the Pennsylvania Department of Health and the Pennsylvania Insurance Department, UPMC Health Plan has implemented formal procedures for members who are dissatisfied with the Health Plan or a network provider.

This chapter covers two types of disputes—complaints and grievances. Although both are member-driven, providers need to know about these procedures because members may ask them to get involved.

Complaints

A complaint is a dispute or objection by a member regarding a participating health care provider or the coverage, operations, or management policies of the Health Plan. A complaint involves a dispute that has not been resolved by the Health Plan and has been filed with the Health Plan, the Pennsylvania Department of Health, or the Pennsylvania Insurance Department.

Complaints may concern many different issues, including, but not limited to:

- Benefit exclusions
- Claim denials
- Coordination of benefits
- Pharmacy
- Quality of care or service

Grievances

A grievance is a request by a member—or a health care provider with the written consent of the member—to have the Health Plan or utilization review entity reconsider a decision solely concerning the medical necessity and appropriateness of a health care service. If the Health Plan is unable to resolve the matter to the member's satisfaction, the member or provider may file a grievance challenging a decision to:

- Fully or partially deny payment for a requested health care service
- Approve a requested health care service at a lesser scope or duration than requested
- Disapprove payment of a requested health care service but approve payment of an alternative health care service

Complaint Procedures

A commercial member with a complaint about a network provider, coverage, operations, or the Health Plan's management policies should contact Member Services at 1-888-876-2756. TTY users should call 1-800-361-2629.

The member may appoint in writing a representative to act on the member's behalf.

In addition, the member or the member's representative may request the help of a Health Plan employee who has not taken part in the decision to deny coverage or the issue in dispute. That employee will assist the member in preparing the complaint at no charge to the member. Appeals must be filed with UPMC Health Plan within 180 days from notification of the occurrence.

There are two steps in the internal complaint process—the Initial Review and the Second-Level Review. Each of these steps is described in this section and a diagram of the process also is included.

▶ [See *Member Complaint Procedures*, chapter C.](#)

Initial Review

1. Member files complaint.

Complaints may be verbal or in writing and may include documentation. The complaint should indicate the remedy or corrective action being sought. For example, a complaint may deal with a claim denial, and the remedy being sought is payment of the claim.

All written complaints should be submitted to:

UPMC Health Plan
Member Complaints/Grievances
P.O. Box 2939
Pittsburgh, PA 15219

2. UPMC Health Plan acknowledges the complaint.

The Health Plan sends a letter to the member within 5 calendar days stating that it has received the complaint.

3. The Initial Complaint Review Committee investigates the complaint.

The committee, which consists of one or more Health Plan employees, investigates the complaint.

4. The committee makes a decision and notifies the member.

The committee makes a decision within 15 calendar days of receiving a complaint for a pre-service denial or within 30 calendar days of receiving a complaint for a post-service denial. The committee notifies the member in writing within 5 business days of making its decision, giving its reasons and the member's appeal rights.

If a member accepts the decision of the Initial Complaint Review Committee, no further action is required; however, if the member appeals the decision, the complaint procedures continue with the Second-Level Review.

Second-Level Review

1. Member appeals the decision of the Initial Review Committee.

Within 60 calendar days of the decision of the Initial Complaint Review Committee, a member may file an appeal verbally as well as in writing to the Health Plan's Second-Level Review Committee. This committee consists of three or more people who did not participate in the matter under review. At least one-third of the committee is made up of Health Plan members who are not employed by the Health Plan.

2. UPMC Health Plan acknowledges the appeal.

The Health Plan sends a letter to the member stating that it has received the appeal.

3. UPMC Health Plan schedules a Second-Level Review Committee hearing.

The member has the right, but is not required, to attend the Second-Level Review Committee hearing, which will be held within 15 calendar days of a request for review of a pre-service denial or within 30 calendar days of a request for review of a post-service denial. The Health Plan notifies the member in writing 15 calendar days before the date scheduled for the review and provides details of the review process and how the hearing is conducted, including the member's rights at the hearing. The committee makes a decision as part of the Second-level Review Committee hearing.

4. Second-Level Review Committee makes decision.

The Second-Level Review Committee issues a written notification within 5 business days of making its decision, specifying its reasons. The member has 15 calendar days to file an external appeal. The decision letter will include all necessary information about how to file an external appeal.

Initial Review



Second-Level Review



External Appeal



Grievance Procedures

A grievance is a request by a member, or a health care provider with the member's written consent, to have the Health Plan reconsider a decision solely concerning the medical necessity and appropriateness of a health care service.

General Grievance Process

Commercial members with questions about the Health Plan's complaint and grievance process should contact Member Services at 1-888-876-2756.

Written grievances should be addressed to:

UPMC Health Plan Member Complaints/Grievances
P.O. Box 2939 Pittsburgh, PA 15219

At any time, the member may appoint in writing a representative to act on his or her behalf. The member or the member's representative also may request the aid of a Health Plan employee who has not taken part in the decision to deny coverage for the issue in dispute. That employee is to assist the member in preparing the grievance at no charge.



Key Points

If the provider initiates a grievance with the member's consent:

- The provider may ask the member for his or her written consent to pursue a grievance at the time of treatment or service—but not as a condition of providing that treatment or service.
- The provider must notify the member if the provider decides not to file the grievance.
- The provider may not bill the member for services that are the subject of the grievance until the external grievance review has been completed or member consent has been rescinded.
- The member cannot file a separate grievance for the same denied treatment or service. If a member wishes to do so, the member must first rescind consent to the provider.
- If the provider has obtained consent from the member or the member's legal representative to file a grievance, the provider has 10 days from receipt of the standard written UR denial and any decision letter from a first, second, or external review that upholds the Health Plan's denial to notify the member or the member's legal representative if the provider decides not to file a grievance.

- The member retains the right to rescind the consent at any time during the grievance process, and the member may continue with the grievance at the point at which the consent was rescinded.
- The member's consent is automatically rescinded if the provider fails to file a grievance or fails to continue to prosecute the grievance through the second level of the grievance process.
- If the provider files an external grievance, the non-prevailing party pays all fees and costs related to the filing of that grievance. The provider and the Health Plan shall each place in escrow an amount equal to half of the estimated costs of the external grievance process.
- If the member files the external grievance and the Health Plan prevails, the Health Plan shall pay the fees and costs.

Member's Written Consent Guidelines

If a member requests that a provider file a grievance, the member must complete a consent form or write a letter. The consent form or letter of consent must include certain information, statements, and signatures that are required by the Pennsylvania Department of Health.

Required Information

The following general information is required in the letter of consent or on the consent form:

- The name and address of the member and of the policyholder (if they are different), the member's date of birth, and the member's identification number
- If the member is a minor or is legally incompetent, the name and relationship to the member of the person who signs the consent
- The name, address, and Health Plan identification number of the provider to whom the member is providing the consent
- The Health Plan's name and address
- A description of the specific service for which coverage was provided or denied

Required Statements

The following statements are required in the letter of consent or on a consent form:

- The member or member's representative may not submit a grievance concerning the services listed in this letter of consent or consent form unless the member or member's representative rescinds consent in writing. The member or member's representative has the right to rescind consent at any time during the grievance process.
- The consent of the member or member's representative shall be automatically rescinded if the provider fails to file a grievance or fails to continue to prosecute the grievance through the Second-Level Review process.
- The member or member's representative has read this consent form and has had it explained to his or her satisfaction.

Required Signatures

The following signatures are required in the letter of consent or on a consent form:

- The dated signature of the member or the member's representative
- The dated signature of a witness

Internal Grievance Reviews

There are two steps in the internal grievance process—the Initial Grievance Review and the Second-Level Grievance Review. Each of these steps is described in this section and a diagram of the process is also included.

▶ See *Internal Grievance Process*, chapter C.

Initial Grievance Review Committee

1. Member or provider sends grievance to UPMC Health Plan

The member or the provider (with member's consent) sends a written letter of grievance to the Health Plan or calls Member Services at 1-888-876-2756.

2. UPMC Health Plan acknowledges the grievance.

The Health Plan sends a letter acknowledging receipt of the grievance.

3. Initial Grievance Review Committee investigates the grievance.

The Initial Grievance Review Committee, consisting of one or more Health Plan employees who did not take part in the decision to deny payment for the health care service under dispute, investigates the grievance.

4. Initial Grievance Review Committee makes decision.

The committee makes a decision within 15 calendar days of receiving a grievance for a pre-service denial or 30 calendar days of receiving a grievance for a post-service denial. The committee includes input from a licensed physician who has experience in the same or a similar specialty and who typically manages or consults on the health care service under dispute.

5. Member and provider receive notification of the decision.

The committee notifies the member and provider, if appropriate, in writing within 5 business days of making the decision. In the letter the committee includes the reasons for its decision and the member's appeal rights to the Health Plan's Second-Level Grievance Review Committee.

Second-Level Grievance Review

1. Member or provider sends appeal to UPMC Health Plan's Second-Level Grievance Review Committee within 60 calendar days.

This committee consists of three or more people who did not participate in the matter under review. The committee includes input from a licensed physician who has experience in the same or

a similar specialty and who typically manages or consults on the health care service under dispute.

2. UPMC Health Plan acknowledges the grievance.

The Health Plan sends a letter acknowledging receipt of the grievance.

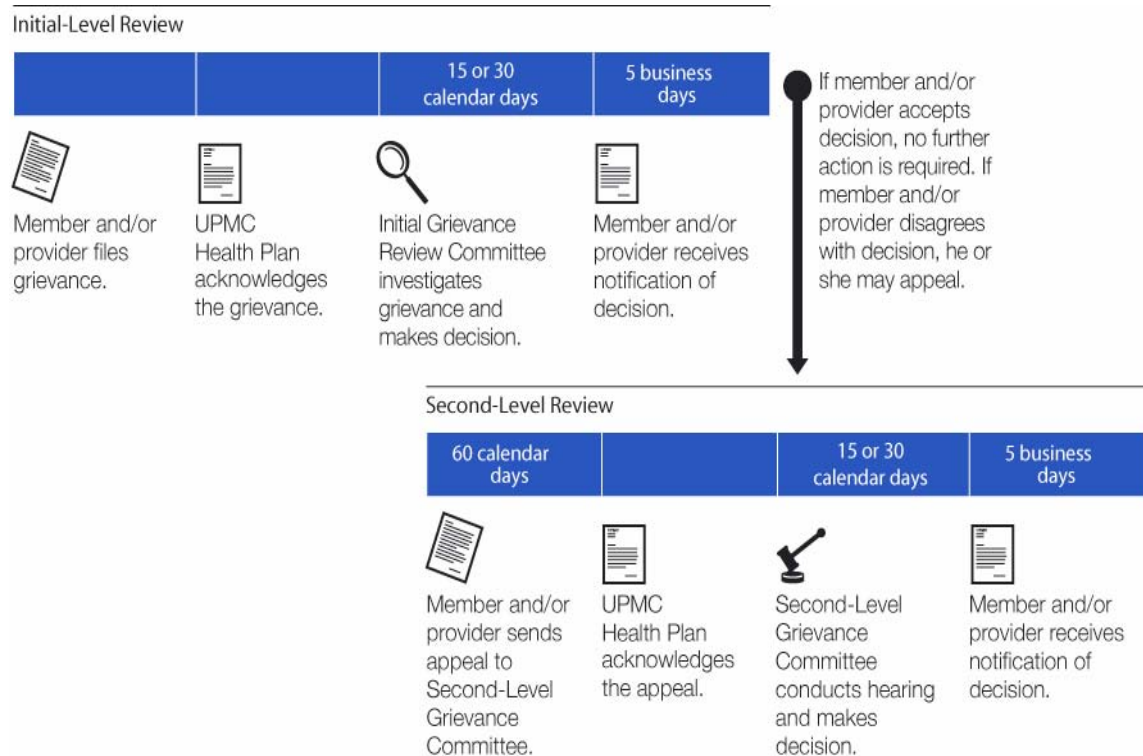
3. UPMC Health Plan schedules a Second-Level Grievance Review Committee hearing.

The member and/or provider has the right, but is not required, to attend the Second-Level Grievance Review Committee hearing. The Health Plan notifies the member and/or provider in writing 15 calendar days before the scheduled hearing date, along with details of the review process, the format of the hearing, and the member's rights at such hearings. The hearing is completed within 15 calendar days of the request for a review of the pre-service denial or 30 calendar days of the request for a review of the post-service denial.

4. Second-Level Grievance Review Committee makes decision.

The Second-Level Grievance Review Committee issues a decision to the member within 5 business days of the hearing, specifying the reasons for its decision. The member has 15 calendar days to file an external appeal. The decision letter will include all necessary information about filing an external appeal.

▶ See *Internal Grievance Process*, chapter C.



Expedited Internal Grievance



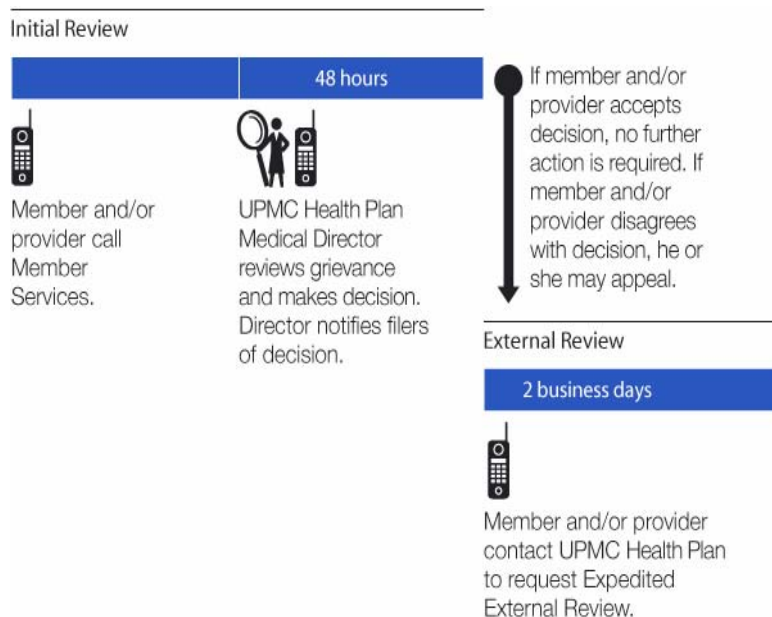
Alert

An Expedited Internal Grievance may be filed if the member believes his or her life, health, or ability to regain maximum function is in immediate jeopardy. The process follows all the requirements of a Second-Level Grievance Review, with shortened periods.

The member or his or her health care provider should call Member Services at 1-888-876-2756 and offer evidence in writing that the member's condition would be placed in jeopardy by the delay inherent in the typical grievance process. The Health Plan's medical director will review the grievance within 48 hours and inform the member in writing of the decision, along with information regarding the filing of an Expedited External Review.

Members have 2 business days from receipt of the Expedited Internal Review decision to contact the Health Plan with a request for an Expedited External Review to a certified review entity (CRE). The CRE issues a decision within 2 business days.

Figure C3: Expedited Internal Grievance Process



External Grievance Reviews

The steps for filing requests for External Grievance Reviews are described below and a diagram of the process is also included.

1. Member, member representative, or provider files a request for External Grievance Review.

The member, the member's representative, or the health care provider who filed the grievance has 15 calendar days from receipt of the decision by the Second-Level Grievance Review Committee to file a request to the Health Plan for an External Grievance Review. Providers filing such a request must include the member's written consent to file the grievance.

2. UPMC Health Plan sends notification.

Within 5 business days of receiving the external grievance, the Health Plan will notify the Pennsylvania Department of Health, the member, and/or the provider that a request for an External Grievance Review has been filed.

3. Department of Health assigns a certified review entity (CRE).

Within 2 business days of receiving the external grievance, the Pennsylvania Department of Health assigns a CRE to conduct the External Grievance Review.

4. UPMC Health Plan sends written documentation to the CRE.

Within 15 calendar days of receipt of the request for an External Grievance Review, the Health Plan will forward written documentation regarding the denial to a CRE assigned by the Pennsylvania Department of Health to perform the External Grievance Review, including the following:

- The decision
- All necessary supporting information
- A summary of applicable issues
- The contractual language supporting the denial, including the plan's definition of "medical necessity" used in the Internal Grievance Reviews

5. UPMC Health Plan sends list of documents.

Within the same 15-day period, the Health Plan will provide the member, the member's representative, and/or the provider with the list of documents being forwarded to the CRE.

6. Member, member representative, or provider sends additional information to CRE.

Also within that 15-day period, the member, the member's representative, and/or the provider may supply additional information to the CRE for consideration in the External Grievance Review. Copies of any additional information must also be supplied to the Health Plan so that it has an opportunity to consider the additional information.

7. CRE makes decision.

The decision of the CRE is issued in writing, within 60 business days of receipt of the filing, to the Health Plan, the member, the Pennsylvania Department of Health, and the provider, including the clinical rationale and basis of the decision. The External Grievance Review decision is subject to appeal to a court of competent jurisdiction within 60 business days of receipt of notice of the External Grievance Review decision. There is a rebuttal presumption in favor of the decision of the certified review entity.

Figure C4: External Grievance Review



Closer Look at Monitoring Complaint and Grievance Procedures

The Bureau of Managed Care in the Pennsylvania Department of Health and the Bureau of Consumer Services in the Pennsylvania Insurance Department are responsible for monitoring HMO compliance with the complaint and grievance procedures.

These agencies can be reached at the following addresses and phone numbers:

Pennsylvania Department of Health
 Bureau of Managed Care
 Health and Welfare Building, Room 912
 7th and Forster Street Harrisburg, PA 17120
 888-466-2787

Pennsylvania Insurance Department
 Bureau of Consumer Services
 1209 Strawberry Square Harrisburg, PA 17120
 877-881-6388

Quick Reference Guide

The quick reference guides are available in the Reference Library on Provider OnLine at www.upmchealthplan.com.

Hard copies are available upon request. Please contact Provider Services at 1-866-918-1595.