

2012 MEMBER Handbook

Introduction

We prepared this booklet for you, whether you are an existing or a renewing member. While you need to read your Certificate of Coverage or Summary Plan Description carefully to learn the details of your covered benefits, this booklet provides a brief overview of your rights and responsibilities as well as general information about benefits and services that will help you understand your health benefits.

We want to assure you that you are important to us and we have established high standards for the quality of health care coverage we deliver to you.

Please take time to review this information.

If you need information on how to get materials in an alternate format or language, contact us and we will work with you to meet your needs. Just call the number on the back of your member ID card. Member Advocates are available Monday through Friday from 7 a.m. to 7 p.m. and Saturday from 8 a.m. to 3 p.m. at **1-888-876-2756**. TTY users should call **1-800-361-2629**.

Visit our website at **www.upmchealthplan.com** to find doctors who speak languages other than English. Click on the "Find a Doctor" link and use the language tab to pick the language you prefer. You can also call our Member Advocates for this information.

We offer a variety of health insurance products through several companies, including UPMC Health Plan, Inc., and UPMC Health Network, Inc. UPMC Health Plan, Inc., also administers self-funded group health plans for various employers. Please note that throughout this document, we use the terms "UPMC Health Plan" and "the Health Plan" to refer to UPMC Health Network, Inc., as well as to UPMC Health Plan, Inc.

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OUR APPROACH TO COVERAGE

UPMC Health Plan is a provider-led health plan. That means that we support health care providers in giving you the best care possible. In many cases, depending on your benefit plan, you may have to visit a personal physician for your care. All of UPMC Health Plan's coverage plans encourage you to establish a relationship with a personal physician, while also providing easy access to specialists.

Check Your Benefit Plan

If you do not know which UPMC Health Plan benefit plan design you have — health maintenance organization (HMO), point-of-service (POS), preferred provider organization (PPO), exclusive provider organization (EPO), or *HealthyU*—please check with your employer or check your Certificate of Coverage or Summary Plan Description. A table on page 5 explains where to find benefit information.

Depending on your coverage, your benefits will be more fully described in a Certificate of Coverage or a Summary Plan Description. A **Certificate of Coverage** is a description of your contract with UPMC Health Plan. It describes your health care coverage in detail. The Member Handbook you are reading provides a general overview of coverage, but you should always refer to your Certificate of Coverage for detailed descriptions of your specific health care benefits. A **Summary Plan Description** is similar to a Certificate of Coverage. It provides detailed information about your specific health care benefits. The Summary Plan Description is provided to members by their plan sponsor.

Product Descriptions

HMO members: If you are a member of an HMO plan, we require you to select a personal physician for your preventive or routine care. This personal physician can also direct your non-routine care to specialists. You may

self-direct your care to a network specialist without a specific referral from a personal physician. HMO members must receive their care from UPMC Health Plan network providers for services to be covered. For more information about personal physicians, see page 16.

If you did not select a personal physician at the time of your enrollment, you should have received a printed notice along with your member ID card asking you to contact the Member Services Department at **1-888-876-2756** to select a personal physician. TTY users should call **1-800-361-2629**.

As a member of an HMO, you must see a network physician for your routine and preventive care.

POS members: If you are a member of a POS plan, we encourage you to select a personal physician to provide your preventive care. This personal physician also can coordinate your non-routine and specialist care. Your self-directed specialist care will be covered by your plan but you may incur a higher out-of-pocket cost when you seek specialist care without coordinating with your personal physician.

A POS plan allows you to use facilities and physicians that are not in the UPMC Health Plan network, but you will realize the highest benefit level when you use network facilities and health care providers.

PPO members: If you are a member of a PPO plan, you do not have to select a personal physician because PPOs are plans in which you coordinate your own physician visits and specialist care. However, we encourage you to select a personal physician to assist you with coordinating your care. You may receive preventive services or seek treatment from any network physician or facility.

PPO members have a choice of two levels of health care benefits. You will realize the highest benefit level when you use facilities and doctors within your designated PPO network, although your plan also allows you (at a higher out-of-pocket cost) to use facilities and physicians that are not in your designated PPO network.

EPO members: If you are a member of an EPO plan, you do not have to select a personal physician because EPOs are plans in which you coordinate your own physician visits and specialist care. However, we encourage you to select a personal physician to assist you with coordinating your care. You may receive preventive care or seek treatment from any network physician or facility. EPO members must receive their care from UPMC Health Plan network providers for services to be covered.

UPMC HealthyU: If you are a UPMC *HealthyU* member, your employer chose either a PPO or EPO coverage plan. You do not have to select a personal physician because you coordinate your own physician visits and specialist care. However, we encourage you to select a personal physician to assist you with coordinating your care. You may receive preventive services or seek treatment from any physician, but your costs are reduced when you use network physicians. UPMC *HealthyU* members have high deductibles and spending accounts from which they can pay their health care expenses.

Group Conversion Policyholders

Group conversion coverage may be available to you and your eligible dependents through UPMC Health Plan if you:

- Formerly had group health coverage through your employer and
- Have exhausted — or are ineligible for — COBRA benefits.

Eligible dependents include your spouse, qualified disabled dependents, and children younger than age 26.

If you purchased a group conversion policy, you have received this handbook as part of your benefit materials. Your policy will fall into one of two categories: PPO or HMO. PPO and HMO plans are detailed in the Product Descriptions section of this handbook.

Check your Group Conversion Policy for detailed information about your coverage.

Behavioral Health Services

Many UPMC Health Plan benefit packages include behavioral health benefits for members who need help with mental health or substance abuse problems. If you have behavioral health benefits through UPMC Health Plan, those benefits are managed through UPMC Health Plan Behavioral Health Services, which offers an extensive network of behavioral health specialists to provide services for our members. Not all plans include behavioral health benefits; check your Certificate of Coverage or Summary Plan Description for this information.

Staff members will ask you a series of questions about your specific needs and preferences, including the geographical area where you prefer the clinician's office to be located. UPMC Health Plan will provide you with the names and numbers of clinicians to choose from. All telephone representatives are specially trained and all calls are kept confidential. Please note that you are not required to call. You may self-refer to a network provider. You do not need to obtain a referral for behavioral health services.

Some benefit plans require that all behavioral health care be provided by network clinicians, except in special situations approved in advance by UPMC Health Plan Behavioral Health Services. Certain benefit plans allow you to go out-of-network for services, but the highest level of benefits and least cost to you will apply when you use network clinicians. You are responsible for any copayments or coinsurance required by your benefit plan. Also, your plan may include annual limits or lifetime maximum benefit amounts. Please consult your Schedule of Benefits for details.

If your benefit plan provides behavioral health services managed through UPMC Health Plan Behavioral Health Services, you may call our toll-free number at **1-888-251-0083 (TTY: 1-877-877-3580)** for behavioral health referral assistance or for information about behavioral health care.

Pharmacy, Dental, and Vision Benefits

Not all plans include pharmacy, dental, or vision coverage. Talk to your employer or check your member materials to find out if you have one or more of these benefits. If you do, you will have received brochures, riders, and handbooks on each of these programs. For your convenience, we have provided contact information for our mail-order pharmacy and our vision and dental providers on page 31 in this handbook.

You and Your Benefits

This member handbook contains general information that you can use regardless of the type of coverage you have selected.

You can find more specific information about your plan in other materials that you received. You may also have received materials if you recently changed from one type of coverage to another.

These materials contain one or more of the documents on page 5, which specify your coverage as well as your out-of-pocket costs.

If you have misplaced your Certificate of Coverage, a rider, or your Schedule of Benefits, please contact Member Services at the telephone number on the back of your member ID card, and we will send a new one to you. If you misplaced your Summary Plan Description, please contact your employer for an additional copy.

Our Member Services staff is available to assist you Monday through Friday from 7 a.m. to 7 p.m. and Saturday from 8 a.m. to 3 p.m. The Member Services telephone number is on the back of your member ID card. If you have not received your member ID card, or if you cannot locate it, call us at **1-888-876-2756**. TTY users should call **1-800-361-2629**.

You can also learn more about your benefits by visiting the UPMC Health Plan website at **www.upmchealthplan.com**.

Member Advocate Program

UPMC Health Plan's Member Advocate program offers members personal assistance.

This service offers regular contact with one specific advocate who understands your health history and who can offer assistance specific to your needs.

The Member Advocate program offers:

- Advice on any health topic related to your coverage
- Telephone contact with your own advocate
- Help getting involved in programs such as smoking cessation
- Telephone calls to offer preventive care reminders

The Member Advocate program, which is free, can help members navigate the sometimes complex details of health care benefits. You can start a relationship with your advocate by calling **1-888-876-2756 (TTY: 1-800-361-2629)** Monday through Friday from 7 a.m. to 7 p.m. and Saturday from 8 a.m. to 3 p.m.

Documents that Describe Your Benefits			
Name	Delivery to you	Description	Notes
Certificate of Coverage	In your member materials	The Certificate of Coverage is the contract between you and UPMC Health Plan, and it describes your health benefits, the provider network, your appeal rights, how to file a claim, and other information. Copayment, coinsurance, or deductible amounts are included on the Schedule of Benefits.	<p>If your health benefits change, we will send you a new Certificate of Coverage and/or Schedule of Benefits.</p> <p>If your employer is self-insured, you may receive a Summary Plan Description from your employer instead of the Certificate of Coverage.</p> <p>If you have purchased individual coverage through group conversion, you will receive a Conversion Policy instead of a Certificate of Coverage.</p>
Schedule of Benefits	In your member materials	The Schedule of Benefits contains details of any copayment, coinsurance, and deductible amounts you might be responsible for under your plan design, as well as benefit limits.	If your health benefits change, we will send you a new Schedule of Benefits.
Summary Plan Description	Sent by your employer	The Summary Plan Description contains benefit information and details on copayment, coinsurance, and deductible amounts.	If you have any questions on this document, please contact your employer.
Riders	In your member materials	Riders are amendments to your contract that modify and/or expand the scope of your benefits set forth in your Certificate of Coverage or Summary Plan Description.	Riders may be issued for some of the following: benefit modification, dependent eligibility, dental, vision, and pharmacy.

Should any conflict arise between this Member Handbook and the COC and Schedule of Benefits, the COC and Schedule of Benefits govern.



Explanation of Benefits

After you receive medical services, UPMC Health Plan will mail you an Explanation of Benefits (EOB), which will tell you if you are responsible for a copayment, deductible, or coinsurance. We will also send you an EOB if we deny your claim. Turn to page 5 for information on documents that explain copayments and other member responsibilities.

The EOB details the cost of your care, what your benefit plan covers, and any charges that are your responsibility. The EOB also shows you, in the column marked “Billed Amount,” the actual cost of the health care you received. This figure indicates the amount you would have to pay if you did not have health insurance coverage. The EOB also indicates whether your claim was denied and the reason(s) your claim was denied.

The EOB is not a bill. To avoid any confusion, the following statement appears on your EOB: “This is not a bill.”

Your doctor, hospital, or other health care provider will bill you separately for any copayment, deductible, or coinsurance amounts that you owe to them.

EOB tutorials are available online. For more information about your EOB, visit www.upmchealthplan.com/EOB/index.html.



Online Services

At www.upmchealthplan.com you can find benefits information and quickly complete tasks at any time by letting your computer do some of the work for you.

Visitors to the UPMC Health Plan website can access these convenient online services:

- View an online directory of health care providers
- Refill mail-order prescriptions online
- Access member newsletters
- Check quality and privacy guidelines
- Find and use common member forms

In addition to our public website, UPMC Health Plan provides information that only members can access. As a UPMC Health Plan member, you have 24-hour access to your specific benefit information through our Web-based customer service center — MyHealth OnLine.

Using MyHealth OnLine, you can:

- Request a new or replacement member ID card and print a temporary member ID card
- Change your selected personal physician
- Update your own or a dependent's contact information
- Confirm your benefits, copayments, and eligibility
- Access health promotion tools and information
- Live chat or e-mail with a Member Services representative

To access MyHealth OnLine, go to www.upmchealthplan.com. Enter your user ID and password, or follow the "New User Registration" link to sign up for MyHealth OnLine.

What to Do in an Emergency

Medical emergencies can be frightening. It is not easy to think clearly at such times. We recommend that you understand what to do before an emergency arises, so that you can receive the maximum benefits for the medical care you need.

Emergency care. If you feel you need emergency care, you should attempt to call your personal physician (if you have a personal physician) to explain the symptoms and provide any other information necessary to help determine the appropriate action.

You should go to the nearest emergency facility in the following situations:

- If your personal physician tells you to
- If you believe that your health is in jeopardy

If you are out of the UPMC Health Plan service area at the time you need emergency care, you should seek emergency care immediately.

As a member of UPMC Health Plan, you have the right to summon emergency help by calling 911, any other emergency telephone number, or a licensed ambulance service without getting prior approval.

UPMC Health Plan will cover care for an emergency medical condition with symptoms of such severity that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of medical attention to result in serious jeopardy to his or her health.

After you receive emergency room treatment, you should contact your personal physician within a reasonable amount of time to coordinate any necessary follow-up care.

Urgent care. Urgent care is defined as care that is needed not for an emergency, but rather for a situation in which delaying care until the member can contact his or her personal physician might jeopardize the member's health or life.

When you are in the UPMC Health Plan service area, you should contact your personal physician if you have an urgent medical need. UPMC Health Plan encourages its network physicians to make same-day appointments available to patients who call with an urgent need that does not rise to the level of an emergency room need.

If you are unable to contact your personal physician and you believe you need care immediately, you should seek immediate medical attention. After such treatment, you should contact your personal physician to coordinate any necessary follow-up care.

If you are out of the UPMC Health Plan service area at the time you need urgent care, you should seek the medical attention that you need. After either emergency care or urgent care, you should contact your personal physician within a reasonable period of time.

What to Do When Traveling

UPMC Health Plan members who need help with medical services when they are more than 100 miles from home have access to Assist America® — the nation's largest provider of global emergency medical services for travelers. All members receive an Assist America brochure in the member materials they receive after enrollment.

Your membership in Assist America is included at no additional charge as part of your UPMC Health Plan coverage. If you become ill or injured, Assist America will help you to locate proper medical care anywhere in the world.

To contact Assist America for more details about this benefit, please call **1-800-872-1414** if you are within the United States, or **1-609-986-1234** if you are outside of the country.* These numbers are not on your UPMC Health Plan member ID card and you may want to make a note and carry them with you when you travel. You can also call Member Services at the telephone number on the back of your member ID card and a representative will provide you with the Assist America telephone and reference numbers. All services must be arranged and provided by Assist America.

* The Assist America reference number for UPMC Health Plan members is **01-AA-UP-156243**.

Dependent Coverage

Your eligible dependents are entitled to share the benefits of your UPMC Health Plan membership. Your employer determines who is an eligible dependent, but typical dependents would include spouses, children up to the age of 26, and unmarried children over the age of 26 who cannot support themselves financially due to a physical disability, mental retardation, or a mental impairment which can be expected to result in death or to be of indefinite duration. To qualify as a disabled dependent other criteria must also be met.

Please check with your employer (or with the sponsor of your group coverage) for details about who is an eligible dependent. This information is also available in your Certificate of Coverage and, if applicable, your Dependent Eligibility Rider.

We automatically provide coverage for a newborn dependent up to a maximum of 31 days from the date of birth. In order for your newborn to be covered after 31 days, you must contact your employer prior to the end of the 31-day period and fill out the paperwork your employer requires to add a dependent to your health care coverage.

Depending on the size of the employer group, standard coverage may or may not include a spouse 65 years of age or older who has chosen to enroll in a Medicare program instead of obtaining health coverage through an employer group.

Once your children reach a certain age, they are no longer considered to be dependents. A letter will be mailed to you 30 days prior to your dependent's coverage being terminated. Please refer to your Certificate of Coverage or, if applicable, your Dependent Eligibility Rider for the age limits that apply to your dependents.

Coverage for Dependent Students

You should try to schedule your dependents' appointments for health care services while they are at home for holidays and breaks. Non-emergency services obtained while your dependent is outside of the UPMC Health Plan service area may require prior authorization. In a true emergency, your dependent should go to the nearest hospital. For specific questions or additional information about your dependents' coverage while away at school, please contact Member Services at the number on the back of your member ID card.

Coordination of Benefits

In addition to your UPMC Health Plan insurance, you may have additional health insurance coverage through your spouse, another employer, or a government-sponsored program such as Medicare or Medical Assistance. If you have insurance coverage from more than one source, your insurance carriers must coordinate the benefits from these different sources and determine which insurance company is your primary carrier. We do this to ensure that no one makes duplicate payments for the same medical services.

We follow standard health insurance industry guidelines to determine which of your insurance carriers is responsible for your primary coverage. The following are standard guidelines:

- The coverage that you have through your employer is your primary coverage, even if you have additional coverage through your spouse. The coverage that your spouse provides is secondary.
- If you have multiple active insurance plans through multiple employers, the plan that has been active the longest is your primary carrier.

- If you have both Medical Assistance and commercial health insurance coverage, your commercial insurance is always your primary carrier.
- If you have a baby, your newborn is covered under the mother's benefits for the first 31 days of the baby's life. If the mother does not have health insurance, then the baby is covered under the father's health insurance for the first 31 days of the baby's life. Prior to the 31st day, the child must be added to the policy.
- If your child is covered under the insurance of more than one parent or guardian, your child's primary carrier is the insurance company of the parent or guardian whose birth date falls earliest in the calendar year.
- If you and your spouse are divorced or separated, and your child is covered under both of your insurance policies, your child's primary carrier is the insurance company of the parent who has custody of the child, unless the judicial system has issued a court order stating otherwise.

Privacy and Confidentiality

You retain the right to have all your personal information and records safeguarded and kept private and confidential whether you are a prospective member, an existing member, or a former member of UPMC Health Plan. We at UPMC Health Plan want to remind you that this is a right we take seriously.

But what does "private and confidential" really mean? When you complete your enrollment or renewal application form, you are doing two very important things:

1. Verifying the correctness and truthfulness of the information you have provided to us
2. Acknowledging that UPMC Health Plan may use the information we collect or receive only for very well-defined routine purposes:
 - Arranging for the provision of health care treatment and services to you and your family
 - Making payment for the treatment and services you and your family receive
 - Performing those health care operations required to provide you and your family with the quality health care coverage that you have purchased

Your right to confidentiality extends to all information that is unique to you. For a managed care organization, this means information that can be used to identify you, such as your name, address, Social Security number, and birth date, along with any data we have about the services you have received or the premiums you pay.

Health care operations. We use your personal health and financial information within UPMC Health Plan and with our contracted providers or agents for the purposes of your health care treatment and the health care operations required to provide that treatment. These health care operations include UPMC Health Plan's monitoring of the quality of the services that are provided and the payments made to the physicians and professionals who provide the services.

Additionally, we measure and review all our data to see how many of our members receive certain services, such as childhood immunizations, mammograms, and other preventive health services. These measurements are necessary so that we can assess how well we are providing quality health care to all our members.

More information on Healthcare Effectiveness Data and Information Set (HEDIS) measures to help you compare health care plans can be found on page 14.

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

UPMC Health Plan protects your personal information and does not share the data with others — including employers. Any reports to employers about the services provided to their employees in a contract year are based only on total employee group percentages and totals — and not on any individual member information.

Not only do all our practitioners and providers know that your information is private and confidential, but our UPMC Health Plan employees know that as well. In fact, we have training programs for our employees to ensure that they know the procedures they need to follow to make sure your information is secure in their particular section or area. Information will be protected whether in oral, written, or electronic format.

We will not disclose information for any purpose beyond the provision of your health care coverage, unless authorized by you or required to do so by law.

Health care programs. At times we may want to let you know about special health care programs that we feel would be beneficial to you. See page 11 for more information on health care programs.

We may need to use your specific personal information in order to let you participate in a program. In such a case, we will request your permission and signed approval before we use your personal information. If you decline such a request, your information will not be part of the special program enrollment.

UPMC Health Plan compliance. All health insurance carriers must comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and several important sets of regulations that government agencies have issued for HIPAA implementation and compliance. In fact, any doctor, hospital, or insurer involved in your health care will be providing you with a "Notice of Privacy Practices." This is a HIPAA-required document and you will probably receive several of these notices.

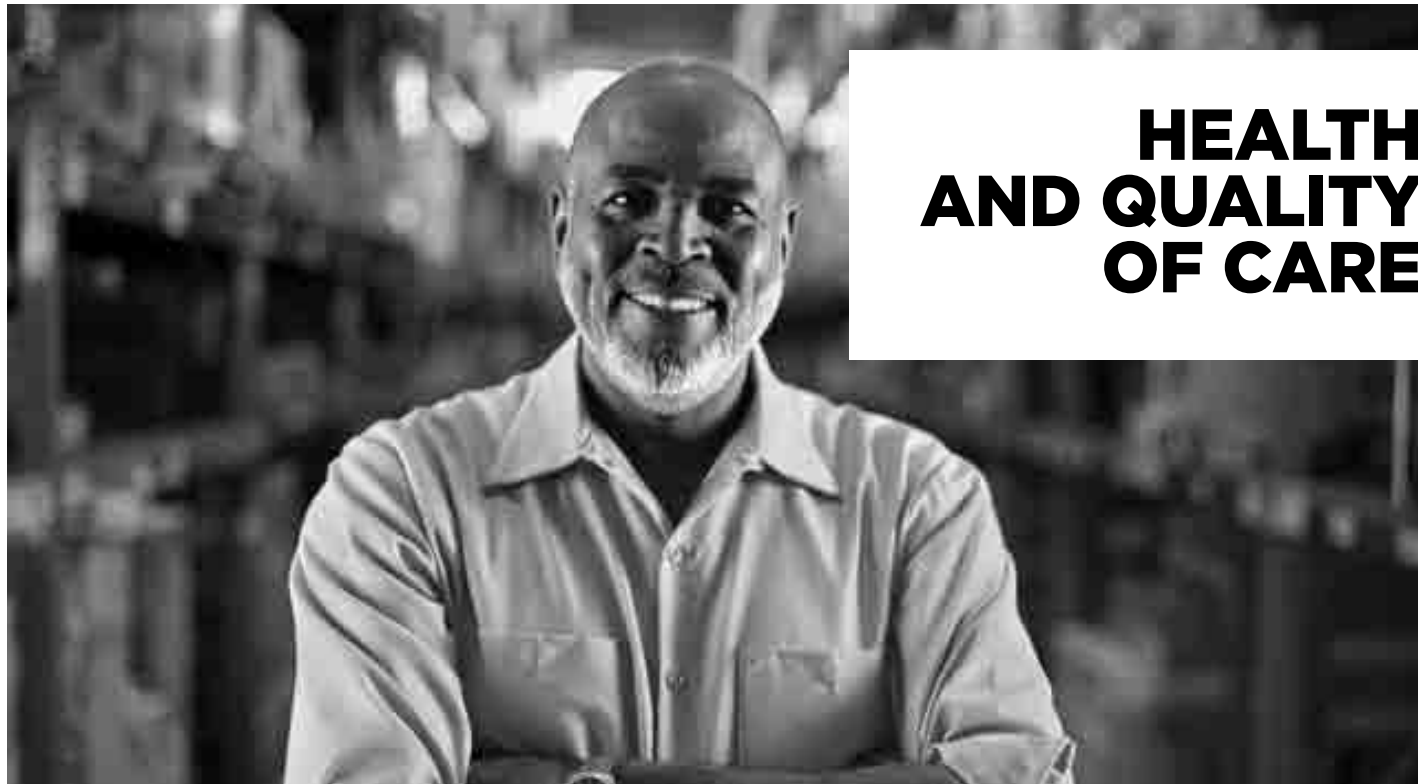
Our "Notice of Privacy Practices" will give you more specific information about how UPMC Health Plan ensures the privacy of your protected health information. You can find additional information about UPMC Health Plan's privacy policies, including the complete Privacy Statement and electronic versions of the Notice of Privacy Practices and other HIPAA forms, on the UPMC Health Plan website at www.upmchealthplan.com. You will find the link to this HIPAA information at the bottom of our homepage.

For a complete statement about the protections we give to your privacy when you visit our website, select Terms and Conditions at the bottom of the homepage, then select Privacy Considerations.

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

You have a right to privacy and confidentiality concerning the personal information about you that has been entrusted to UPMC Health Plan. Your right to privacy and confidentiality also extends to those companies that contract with us to assist in providing your health care services.

If you have any questions concerning the confidentiality of your personal information and data, please contact us at **1-888-876-2756 (TTY: 1-800-361-2629)**.



Health Management Programs

UPMC Health Plan operates health management programs for members who have been diagnosed with diabetes, respiratory problems, heart disease, depression, or low back pain. Based on the kinds of treatment you receive, we may contact you and suggest that you would benefit from one of these programs.

Through our health management programs we offer education, support, and other information that can help you manage your condition.

Certainly, the benefits of such programs depend on your individual state of health, but studies indicate that the total populations of people involved in health management programs have fewer and less serious hospitalizations and a higher quality of life.

We can contact your physician and other clinicians to help coordinate your care. We will send out notices to remind you about routine physicals, lab tests, and other care.

Our goal is to help you follow your physician's plan to maintain your health, help you to better understand and manage your medical condition, and help prevent complications.

Your physician may call us and recommend that you participate in one of these programs, or you may call our Health Management Department directly at **1-866-778-6073 (TTY: 1-800-361-2629)** if you are interested in participating. Health Management staff members are available Monday through Friday from 8 a.m. to 5:30 p.m. If you call outside these hours, you can leave a message and we will return your call on the next business day.

Your participation is voluntary. At any time, you may choose not to participate by calling our Health Management Department at the number above.

HEALTH AND QUALITY OF CARE

Online Health Promotion

Your health is our priority. So is empowering you to actively manage your health care. That's why UPMC Health Plan's MyHealth program offers an interactive health and wellness tool called MyHealth OnLine.

MyHealth OnLine will help you take steps to lead a healthier lifestyle. When you access this information through **www.upmchealthplan.com**, you will find useful tools such as the MyHealth Record, which will allow you to better manage your health care information. You will also have access to resources to help you manage your weight, quit smoking, become more active, and take surveys to determine your health risks. Many parts of the website provide interactive information about health and wellness.

- You can do all of the following through MyHealth OnLine:
- View spending account activity, if applicable
 - View detailed benefit information, including claim status
 - View covered services
 - Compare health care costs and quality
 - Research prescription drug costs and order prescription drugs and refills, if applicable
 - Access your medical history
 - Access tools and multimedia to manage chronic conditions
 - View easy-to-understand electronic Explanations of Benefit
 - Access discount programs
 - Customize healthy activities to earn incentives
 - Live chat or e-mail with a health coach or Member Services representative
 - Replace an ID card
 - Change a personal physician

UPMC Health Plan's online health promotion site uses the latest technology to make sure personal information is kept secure and confidential. You can access these health promotion tools by logging in to **www.upmchealthplan.com**.

MyHealth Advice Line

In the middle of the day or the middle of the night, UPMC Health Plan's MyHealth Advice Line is available to provide members with health advice. Whether you are calling to seek general health information or information regarding a specific issue, experienced registered nurses are available to provide prompt and efficient service. The MyHealth Advice Line number is **1-866-918-1591**.

You can also contact a registered nurse who will answer your health-related questions within 24 hours. At **www.upmchealthplan.com**, log in to MyHealth OnLine and visit our secure Member Message Center.

Interactive Health Information

UPMC Health Plan offers a free, computer-based program developed by Emmi[®] Solutions that can answer many of the questions you may have about specific health conditions.

The Emmi service offers information about hypertension, asthma, diabetes, and coronary artery disease. The program can help you better understand the risks and potential outcomes associated with your condition.

To access this program, you will need a computer with an Internet connection and sound capability. Go to **www.upmchealthplan.com** and enter your user ID and password to log in to MyHealth OnLine. Select MyHealth Central. Then select the Health Tools tab and click on the WebMD Tools box. In WebMD Interactives, click on any of the links or tabs.

MyHealth Community

As a UPMC Health Plan member, you are eligible for discounts and other benefits from participating local businesses, including fitness centers, sporting goods stores, and much more.

MyHealth Community enhances the UPMC Health Plan healthy lifestyle programs by offering, in many cases, significant savings when you take steps to improve your health.

To take advantage of MyHealth Community, you can access our full network of businesses and organizations online. It's easy to get started:

- Go to **www.upmchealthplan.com/MyHealthCommunity**
- Type in your ZIP code

The MyHealth Community tool uses Google search technology to find our business partners. When you enter your address or ZIP code into the MyHealth Community website, the online tool searches its network for nearby businesses that have a relationship with UPMC Health Plan. The online tool will display a map and information for various organizations in your area.

You will want to return to MyHealth Community often to search for discounts and stay updated on healthy lifestyle opportunities.

Direct Access to Women's Care

Coverage under UPMC Health Plan is designed to simplify women's care. With UPMC Health Plan, benefits for preventive women's care include an annual Pap smear, pelvic examination, clinical breast examination, and mammogram according to your Certificate of Coverage. You may also go to your network ob-gyn for all other medically appropriate covered obstetrical and gynecological care, including outpatient services and inpatient admissions. You should choose a gynecologist as soon as you become a UPMC Health Plan member, so that he or she can keep you healthy — not just treat you when you are sick.

Women's Health and Cancer Rights Act

Since October 1998, federal law has required insurance companies to provide certain specific benefits for reconstructive surgery after mastectomy. UPMC Health Plan has always covered reconstructive surgery following mastectomy. We provide coverage for:

- Reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the other breast to produce symmetrical appearance
- Prostheses and treatment of physical complications at all stages of mastectomy, including lymphedemas
- Coverage for inpatient care following a mastectomy for the length of stay determined by the attending physician

Additionally, Pennsylvania law mandates that coverage for mastectomy shall include the following:

- Home health care visit within 48 hours of discharge when the discharge occurs within 48 hours of the admission for the mastectomy

The patient and the attending physician must collaborate in making decisions concerning these procedures. The coverage will be subject to annual deductibles, copayments, and coinsurance provisions that apply to other benefits under the plan.

HEDIS

The Healthcare Effectiveness Data and Information Set (HEDIS) is a set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA). The measures are designed to ensure that consumers have access to reliable data for comparing the quality of managed care organizations.

Employers are interested in HEDIS for collecting data relevant to their employees, evaluating and comparing health plans, and setting performance targets and ensuring quality of health care for their employees.

We use the HEDIS measures to evaluate the effectiveness of programs and make quality improvements in care and service. HEDIS ratings are reported annually and are included in member and provider publications annually.

HEDIS includes measures that range from the percentage of children receiving all recommended immunizations to the percentage of diabetics receiving recommended services. The Consumer Assessment of Health Plans and Systems (CAHPS) member satisfaction survey is also part of the annual HEDIS evaluation.

HEDIS and CAHPS are registered trademarks of NCQA.

For a complete listing of all HEDIS measures, contact the UPMC Health Plan Member Services Department at **1-888-876-2756**.

Quality Improvement Program

High-quality health care is a priority at UPMC Health Plan. Our Quality Improvement Program, in collaboration with practitioners in the UPMC Health Plan network, operates according to guidelines, standards, and regulations of the following regulatory agencies/accrediting bodies: Pennsylvania Department of Health (DOH), Pennsylvania Department of Public Welfare (DPW), Centers for Medicare and Medicaid Services (CMS), and the National Committee for Quality Assurance (NCQA).

Areas of focus include quality management and improvement, credentialing and recredentialing of practitioners, utilization management, member rights and responsibilities, and preventive health care.

If you would like additional information regarding our Quality Improvement Program, we will provide you with a description of the program as well as an update on our progress toward meeting our goals.

If you have suggestions for our Quality Improvement Program or would like additional information, contact the Quality Improvement Department at the following address:
**Quality Improvement
UPMC Health Plan
One Chatham Center
112 Washington Place
Pittsburgh, PA 15219-9533**

You may contact us by e-mail as well. Send an e-mail to **upmchp@upmc.edu** and include "Quality Improvement Program" in the subject line of your message.



NETWORK AND PHYSICIAN SERVICES

Our Networks

UPMC Health Plan's provider network includes more than 9,800 health care professionals. We encourage all of our members to receive their medical services from the doctors and hospitals in this network because this ensures that you will receive the highest level of benefits.

You can refer to our provider index and our provider directory to determine whether your health care providers are in our network. A Web-based provider directory tool is available to you at www.upmchealthplan.com. Select the "Find a Doctor" link and use this tool to obtain information such as a provider's name, office location(s), telephone number(s), board certification, specialty, hospital affiliation, medical group affiliation (if any), gender, languages spoken, and acceptance of new patients. You can also find information about hospitals such as their locations and accreditation status. For members who do not have access to the Internet, call Member Services using the telephone number on the back of your member ID card. If you have not received your member ID card, call us at **1-888-876-2756**. TTY users can call **1-800-361-2629**.

The Benefits of Having a Personal Physician

Your personal physician's goal is to keep you healthy, not merely to treat you when you are sick. You should visit a personal physician for routine and preventive care and establish a relationship with him or her before you need serious medical attention.

A personal physician is the key to maximizing efficient and effective care while minimizing out-of-pocket expenses.

A personal physician may be:

- A family practitioner
- A general practitioner
- An internist
- A pediatrician (for a child)

Note: Women may self-refer to a network ob-gyn for preventive and routine as well as non-routine women's care.

Your personal physician coordinates your care by:

- Studying your medical history
- Monitoring your health, and reviewing records from any other doctors you visit
- Making referrals to specialists, when necessary
- Arranging for hospital admissions
- Ensuring that you get all appropriate tests

Physician Referrals

Here are some key terms regarding referrals to physician specialists:

Network vs. out-of-network care. HMO and EPO members must use network physicians and services to receive any benefits (except for emergency care or urgent care when your personal physician is not available, or very specialized care that is not available in our network; we must first authorize any services for specialized care not available in our network). POS and PPO members may use network or out-of-network physicians or services. Remember that network care is covered at a higher benefit level than out-of-network care.

Open Patient Dialogue Encouraged

Your personal physician (or an associate) must provide access by telephone 24 hours a day, seven days a week, so that you can reach him or her whenever you are in need of medical care.

You may change your personal physician at any time by contacting our Member Services Department at the telephone number on the back of your member ID card. Personal physician changes processed by the Member Services Department are effective immediately.

Member Services will arrange for a new member ID card to be printed and mailed to you, reflecting your personal physician change. You can also change your personal physician and generate your own temporary member ID card through the UPMC Health Plan Internet-based customer service center — MyHealth OnLine. If, for any reason, your personal physician's participation in the UPMC Health Plan network ends, we will notify you of the situation and help you to select a new personal physician.

For more information about MyHealth OnLine, refer to information on page 7 in this handbook, or visit our website at www.upmchealthplan.com.

Coordinated care. This is care that is performed by either your personal physician or a specialist who has been referred by your personal physician. Your coordinated care may be in-network or out-of-network, depending on the kind of plan you have with us. Some plan types may offer the highest level of benefit coverage and lower cost sharing if the specialist care is coordinated through your personal physician.

You can also obtain health care services from specialists on a self-directed basis, without a referral from your personal physician. While you can self-direct your specialist care, UPMC Health Plan encourages you to coordinate your care through your personal physician.

To find out the actual dollar amounts of any copayments, coinsurances, or deductibles you may need to pay, refer to your Schedule of Benefits for more information.

UPMC Health Plan supports open communication between a patient and his or her health care provider regarding all appropriate treatment alternatives and will not penalize health care providers for discussing medically necessary or appropriate care with a patient.

Coordination of Care Between Medical and Behavioral Health

To promote better health outcomes and to protect member safety, UPMC Health Plan encourages personal physicians to coordinate care with other specialists who are also seeing the member.

It is important that your personal physician and your behavioral health care provider communicate with each other to effectively coordinate your care, especially if either provider is prescribing medication as part of your treatment plan.

Either your personal physician or your behavioral health care provider may ask you to sign a consent form. At that time, you may agree to have the provider send information about your treatment to the other provider who is seeing you. Or you can elect not to share information.

If you agree that information may be shared, your provider will send your information confidentially to the other provider and will keep a copy. Please note that providers are required by law to protect patient medical information.

Out-of-Area Claims

Occasionally, you might receive urgent or emergency care outside of UPMC Health Plan's service area from a doctor or other health care professional who is not part of the network appropriate to your plan. This is considered out-of-area care.

Health care providers or hospitals that are out of the service area and not in our network might ask you to pay for their services up front. If this occurs and you are required to render payment at the time of service, here is what to do afterward: Please notify us of the situation by filling out and submitting an Out-of-Network Care Claim form.

We must receive the Out-of-Network Care Claim form within one year (365 days) from the time that the health care facility or professional performed the health care services for you or your dependent.

You may also download and print a copy of the Out-of-Network Care Claim form from our website at www.upmchealthplan.com.

You can request an Out-of-Network Care Claim form from the Member Services Department. The telephone number is listed on the back of your member ID card.

To make sure that the claims process moves quickly, you must answer each of the questions on the claim form accurately and completely. Along with your Out-of-Network Care Claim form, you must submit itemized bills that show:

- The name of the member who received care from the out-of-network health care professional
- The member's relationship to you

- The name of the out-of-network health care professional who provided the service or supply
- The type of health care service(s) received
- The date that the out-of-network health care professional provided the service
- The amount of the bill

Keep your original bills; UPMC Health Plan does not return paperwork submitted with claims.

After you complete the Out-of-Network Care Claim form, attach the itemized bill(s) that you want UPMC Health Plan to consider paying, and send all of the paperwork to:

Claims Department
UPMC Health Plan
P.O. Box 2999
Pittsburgh, PA 15230-2999

Our Claims Department will review the form and the itemized bill. If everything is properly filled out and submitted, you will be reimbursed to the benefit level detailed in your Schedule of Benefits.

If the form is incorrect or any documentation is missing, we will deny the claim and send you an Explanation of Benefits (EOB) telling you why. (Read about "Explanation of Benefits" on page 6 in this publication.) You may resubmit the claim to us for consideration. You must make sure you fill out the form properly and include all the requested information.

If we deny your claim and you do not know what was incorrect or what was missing, you may call Member Services at the telephone number on the back of your member ID card. The Member Services representative will tell you what you need to do to resubmit the claim.

Transition of Care

If a new member joins UPMC Health Plan while receiving active, ongoing treatment by a health care provider who is not in the UPMC Health Plan network, that member may request what is known as "transition of care." We may, in certain situations, cover that active, ongoing treatment with the doctor at the member's highest available level of benefits.

This transition of care period may last up to 60 days, effective from the date of enrollment. UPMC Health Plan will consult with the member and the member's health care provider and may extend this transition of care period if clinically appropriate. If you are a woman in the second or third trimester of pregnancy as of the effective date of your enrollment in UPMC Health Plan, we will extend

the transition of care period through the postpartum care related to your delivery.

Please note that transition of care is not automatic. If either of the situations above apply to you and you wish to apply for transition of care, you must complete and return a UPMC Health Plan Transition of Care Request form within 15 days of enrollment in UPMC Health Plan. You should have received the "Member Health Survey and Transition of Care Application" in your open enrollment book. You can also request this form by calling our Member Services Department at the telephone number on the back of your member ID card or call **1-888-876-2756**. TTY users should call **1-800-361-2629**. See page 31 of this booklet for frequently used phone numbers.

Accessibility of Providers

All UPMC Health Plan health care providers have contractually agreed to the following timeliness standards for appointments and requirements concerning their office practice and procedures:

Office hours and accessibility. Participating personal physicians must have a minimum of 20 office hours per week and all physicians must be accessible to members with disabilities.

24-hour on-call coverage. Personal physicians and ob-gyns are required to provide 24-hour on-call coverage and be available 7 days a week. If a physician delegates this responsibility, the covering physician must be participating with UPMC Health Plan and also be available 24 hours a day, 7 days a week.

Coverage for providers on extended leave. While on leave, a participating physician must arrange for coverage by another UPMC Health Plan physician. If the practice is going on an extended leave, the practice must notify UPMC Health Plan's Provider Services Department.

If you are having difficulty accessing your personal physician or a physician in UPMC Health Plan network, contact our Member Services Department at **1-888-876-2756**. TTY users should call **1-800-361-2629**.

Network personal physicians, specialists, and ob-gyns are accessible to you within the time frames established by UPMC Health Plan. You may schedule appointments with network physicians based on the time frame that is appropriate for your type of appointment.

Accessibility of Behavioral Health Providers

All network behavioral health care providers have contractually agreed to these timeliness standards for appointments, as well as to the following requirements concerning their office practice and procedures:

Office hours and accessibility. Behavioral health providers' offices are accessible to members with disabilities.

24-hour on-call coverage. Behavioral health providers are required to provide 24-hour on-call coverage. If a provider delegates this responsibility, the covering provider should be participating with the network affiliated with UPMC Health Plan. Also, the covering provider must be available 24 hours a day, 7 days a week.

Extended leave coverage. If your provider is unable to meet the access standards or is planning an extended leave, your practitioner is responsible for notifying UPMC Health Plan Behavioral Health Services. You may then either call UPMC Health Plan Behavioral Health Services for another referral or self-refer to another provider in our network. If you are having difficulty accessing your behavioral health provider in the UPMC Health Plan Behavioral Health Services network, contact Member Services at **1-888-251-0083**. TTY users should call **1-877-877-3580**.

Type of Appointment	Scheduling Time Frame
Personal Physician	
Preventive care	Within 3 weeks of the request
Regular and routine care	Within 10 business days of the request
Urgent	Within 24 hours of the request
Emergency	Immediately or referred to an emergency room
Ob-Gyn	
Annual well-woman exam	Within 3 weeks of the request
Prenatal Care	
Initial visit in first trimester	Within 10 business days of the request
Second trimester	Within 5 business days of the request
Third trimester	Within 4 business days of the request
High risk	Within 24 hours of identification of high risk to maternity care provider, or immediately if an emergency exists
Emergency	Immediately or referred to an emergency room
Specialist	
Routine care	Within 10 business days of the request
Urgent care	Within 24 hours of the request
Emergency	Immediately or referred to an emergency room

Accessibility of Behavioral Health Services

Behavioral health care providers are accessible to you within time periods established by UPMC Health Plan for the various appointment categories. You may schedule appointments with network behavioral health care providers based on the time frame that is applicable to the type of appointment you need.

Type of Appointment	Scheduling Time Frame
Behavioral Health Services	
Routine office visit	Within 7 calendar days of the request
Urgent	Within 24 hours of the request
Non-life-threatening emergency	Within 1 hour of the request
Emergency	Immediately or referred to an emergency room

Utilization Management

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 only on appropriateness of care and service.
- UPMC Health Plan does not reward health care providers 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 underutilization.

Member Access to Utilization Management

UPMC Health Plan provides access for members to obtain information about the utilization process and authorization decisions. 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 by contacting UPMC Health Plan.

Inquiries can be made by calling our Member Services Department at **1-888-876-2756** during normal business hours, as noted on the back of your member ID card. TTY users should call **1-800-361-2629**.

After business hours, you can leave a message on the UPMC Health Plan voicemail system, 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 users should call **1-877-877-3580**.

Evaluation of New Technology

UPMC Health Plan is committed to ensuring that our members have access to safe and effective care. Our Technology Assessment Committee evaluates new health care services, medical and behavioral health procedures, devices, and pharmacological treatments to determine whether they should be included in the UPMC Health Plan's benefit packages.

Professionals with related expertise participate in the evaluation of each new technology and the creation of criteria for its application.

To be considered for coverage, the new technology must meet the following criteria:

- The technology must have final approval from the appropriate government regulatory bodies, such as the Food and Drug Administration (FDA).
- There must be published scientific evidence that the technology has therapeutic value.
- The technology's beneficial effects on health outcomes should outweigh any harmful effects or risks.
- The technology should improve the health outcomes as much as or more than current alternatives.



MEMBER RIGHTS AND PROBLEM RESOLUTION

Rights of Members

- To receive information about UPMC Health Plan, its services, its programs, its health care providers, and your rights and responsibilities
- To be treated with respect and recognition of your dignity and right to privacy
- To participate with health care providers in decision-making regarding your health care
- To receive clear and complete information from your health care provider about your health condition and treatment
- To participate in a candid discussion of appropriate or medically necessary treatment options for your condition, regardless of cost or benefit coverage
- To voice complaints, grievances, or appeals about UPMC Health Plan, the care provided, or your health care provider
- To choose your own health care provider from the list of network providers and to receive timely care in an emergency
- To see your medical records, to keep copies for yourself, and to ask to have corrections made, if needed
- To have your medical information kept confidential whether it is in written, oral, or electronic format
- To make decisions about your treatment, including the right not to participate in research, and to refuse treatment as long as you understand that by refusing you may cause your health problem to get worse or possibly become fatal
- To execute a living will and/or a durable power of attorney that tells how decisions about your treatment will be made if you are unable to make decisions for yourself
- To be represented by parents, guardians, family members, or other conservators if unable to fully participate in your treatment decisions
- To make recommendations regarding the UPMC Health Plan members' rights and responsibilities policy
- To access, amend, restrict, request alternate communication (method or location), and receive an accounting of any disclosures of personal health information made to persons or organizations other than yourself, and for purposes other than treatment, payment, and operations

Responsibilities of Members

- To provide, to the extent possible, information that UPMC Health Plan and its health care providers need in order to care for you
- To follow plans and instructions for care that you have agreed on with your health care providers
- To treat your health care provider and other health care workers with dignity and respect, which includes being on time for appointments and calling ahead if you need to cancel an appointment
- To tell your health care provider as much about your medical history as you know
- To follow your health care provider's directions, such as taking the right amount of medication at the right times if you agreed to do so
- To ask questions about how to access health care services appropriately
- To participate, to the extent possible, in understanding any health or behavioral health problems you may have and developing mutually agreed upon treatment goals
- To provide a safe environment for services rendered in your place of residence
- To pay applicable copayments, coinsurances, deductibles, and fees

In keeping with established regulations, UPMC Health Plan will update all members on any changes.

Complaint and Grievance Process

The complaint and grievance process for fully insured employer groups may differ from the standard complaint and grievance process for self-insured groups. Always check your Certificate of Coverage or Summary Plan Description or ask your employer. These processes, and the differences between them, are noted in the following text.

Please contact your Human Resources or Benefits Department to determine whether you are a member of a fully insured group or a self-insured group.

Self-insured groups may also customize their complaint and grievance process. If you are a member of a self-insured group, contact your Human Resources or Benefits Department to confirm that the group follows the standard complaint and grievance processes outlined in the following pages.

If you have any questions or concerns regarding UPMC Health Plan's complaint and grievance process, you should call our Member Services Department at **1-888-876-2756**. Your comments are important to us as we strive to improve the quality of the care and service we provide.

When you call the Member Services Department at either UPMC Health Plan or UPMC Health Plan Behavioral Health Services, a representative will try to answer your questions or respond to your concerns. At any point in the process, if you are not satisfied with the response, you may ask to file a complaint or grievance through the UPMC Health Plan complaint and grievance process.

UPMC Health Plan has established a set of formal procedures that you may use if you are in any way dissatisfied with UPMC Health Plan or a participating provider.

The following is a brief overview of the UPMC Health Plan complaint and grievance process.

Complaints. If you have a dispute or objection regarding a provider or the coverage, operations, or management policies of UPMC Health Plan, you should contact our Member Services Department.

Complaints can involve many different issues, including, but not limited to, the quality of care or services, benefits exclusions, claim denials, rescission of coverage, or coordination of benefits.

A complaint is different from a grievance. (See separate section on Grievances, beginning on page 24.)

General information about complaints. You may file a complaint over the telephone with a Member Services Department representative by calling **1-888-876-2756**. Or you may send a written complaint or written information to support a complaint to:

**UPMC Health Plan
P.O. Box 2939
Pittsburgh, PA 15230-2939**

You must file a complaint within 180 days of the date you receive a claim denial or within 180 days of the event that is prompting your complaint.

At any time during the course of the complaint process, you may choose to designate a representative to participate in the complaint process on your behalf. You must notify UPMC Health Plan in writing of this designation. You can contact our Member Services Department for the Personal Representative Designation Form. Just call the number on the back of your member ID card. If you wish to designate a representative, you must complete and return the Personal Representative Designation Form.

Member Advocates are available Monday through Friday from 7 a.m. to 7 p.m. and Saturday from 8 a.m. to 3 p.m. TTY users should call **1-800-361-2629**.

You can also visit our website at **www.upmchealthplan.com** and select the Commonly used forms link under the Members heading. Then click on the Personal Representative Designation Form link and download the form. Return your completed form to the address or fax number listed below:

UPMC Health Plan
P.O. Box 2965
Pittsburgh, Pennsylvania 15230-2965
Fax: 412-454-7829

The complaint process consists of a two-step internal process as well as an external appeal process, should you remain dissatisfied with the internal complaint process results. The complaint process is summarized in the chart below.

The Internal Complaint Process

First Level Complaint Review Process

What	When	Details
Acknowledgment Letter	Upon receipt of your oral or written complaint	UPMC Health Plan will provide you or your representative with written confirmation of receipt of the complaint.
First Complaint Review Process	Within 30 days of receipt of the complaint	The First Complaint Review Committee (consisting of one or more employees of UPMC Health Plan who have not been involved in a prior decision on the issue under dispute) will investigate the details of the complaint. The Committee will make a decision within 30 days of receipt of the complaint.
New Information	Within 5 calendar days of receipt of new information	If the Committee receives any new evidence or rationale regarding your complaint, we will provide you or your representative with a copy of this information before issuing a decision.
First Complaint Review Committee Decision Letter	Within 5 business days of the decision	UPMC Health Plan will send you or your representative written notification of the First Complaint Review Committee decision within 5 business days.
Request for Second Level Review	Within 60 days of receipt of the first complaint decision letter	If you or your representative request a Second Level Complaint Review of the First Complaint Review decision, the complaint will go to UPMC Health Plan's Second Level Complaint Review Committee.

Second Level Complaint Review Process

What	When	Details
Acknowledgment Letter	Upon receipt of your oral or written request for a second level review	Upon receipt of your request for a Second Level Complaint Review, UPMC Health Plan will provide written confirmation to you or your representative. This letter will also advise you or your representative that you have the right to appear before the Second Level Complaint Review Committee and that UPMC Health Plan will provide you and your representative with 15 days' advance written notice of the date and time scheduled for that review.

Second Level Complaint Review Process (Continued)

What	When	Details
Second Level Complaint Review	Within 30 days of receipt of the complaint	The Second Level Complaint Review Committee consists of three or more individuals who did not previously participate in the matter under review. At least one-third of the committee is made up of members who are not employed by UPMC Health Plan or a related subsidiary or affiliate. The members of the committee have the duty to be impartial in their review of the information and decision. You or your representative have the right, but are not required, to attend the Second Level Complaint Review Committee meeting. When arranging the meeting, UPMC Health Plan will notify you or your representative in writing 15 days in advance of the date scheduled for the Second Level Complaint Review. UPMC Health Plan will also provide details of the review process and how the meeting will be conducted, including your rights at such meetings. If you or your representative cannot appear in person at the Second Level Review, UPMC Health Plan will provide you or your representative with the opportunity to communicate with the Committee by telephone or other appropriate means. The Second Level Complaint Review Committee will complete its review and will base its decision solely upon the materials and testimony presented at the review.
New Information	Within 5 calendar days of receipt of new information	If the Committee receives any new evidence or rationale regarding your complaint, we will provide you or your representative with a copy of this information before issuing a decision.
Second Level Complaint Review Committee Decision Letter	Within 5 business days of the decision	UPMC Health Plan will send you or your representative written notification of the Second Level Complaint Review Committee's decision.

Grievances. A grievance is different from a complaint. A grievance is a request on the part of a member, a member's representative, or a health care provider (with written member consent) to have a managed care plan reconsider a decision solely concerning the medical necessity and appropriateness of a health care service.

A grievance may be filed regarding decisions to fully or partially deny payment for a requested health service, to approve provision of a requested health care service at a lesser level or duration than requested, or to disapprove payment for the provision of a requested service but approve payment for the provision of an alternative health care service.

You must file a grievance within 180 days of the date you receive a denial or within 180 days of the event that is prompting your grievance.

General information about grievances. You may send a written grievance or written information to support a grievance to:

UPMC Health Plan
P.O. Box 2939
Pittsburgh, PA 15230-2939

While it is generally preferable that you file a grievance in writing, you or your representative may call our Member Services Department at **1-888-876-2756** to request assistance and file a grievance orally.

Your health care provider may request your consent (in writing) to pursue a grievance at the time of treatment or service, but not as a condition of providing that treatment or service.

- Once you give a health care provider consent to file the grievance, the provider has 10 days from the receipt of the UPMC Health Plan denial to file the grievance. The provider needs to inform you only in the event he or she decides not to file the grievance.
- Your consent is automatically rescinded if the health care provider fails to file a grievance or fails to follow

the grievance through the Second Level of the grievance process.

- If you or your representative wish to file a grievance, but have already given your provider written consent, you or your representative must rescind the consent to your provider in order for you or your representative to proceed with the filing of the grievance.
- You and your health care provider cannot file separate grievances for the same denied treatment or service.
- We have instructed all our providers on the required format for written member consents.

As with the complaint process, the grievance process also consists of a two-step internal process as well as an external grievance appeal, should you remain dissatisfied with the results of the internal grievance process decisions. The grievance process is summarized in the chart below.

The Internal Grievance Process

First Level Grievance Review Process

What	When	Details
Acknowledgment Letter	Upon receipt of your oral or written grievance	UPMC Health Plan will provide written confirmation of receipt to you or your representative, if one has been designated, and the health care provider, if the health care provider filed the grievance with written member consent.
First Grievance Review Process	Within 30 days of receipt of your grievance	The First Grievance Review Committee (consisting of one or more employees of UPMC Health Plan who did not previously participate in the decision to deny payment for the health care service under dispute) will investigate the details of the grievance. This committee will include input from qualified personnel (for example, a licensed physician or, where appropriate, an approved licensed psychologist) with experience in the same or a similar specialty that typically manages or consults on the health care service under dispute.
New Information	Within 5 calendar days of receipt of new information	If the Committee receives any new evidence or rationale regarding your grievance, we will provide you or your representative with a copy of this information before issuing a decision.
First Grievance Review Committee Decision Letter	Within 5 business days of the decision	UPMC Health Plan will send you or your representative written notification of the First Level Grievance Committee decision, within 5 business days.
Request for Second Level Review	Within 60 days of receipt of the first grievance decision letter	If you, your representative, or the health care provider with written member consent, requests a Second Level Grievance Review of the decision of the First Grievance Review Committee, the grievance will go to UPMC Health Plan's Second Level Grievance Review Committee.

Second Level Grievance Review Process

What	When	Details
Acknowledgement Letter	Upon receipt of your oral or written request for a second level review	Upon receipt of the request for the Second Level Grievance Review, UPMC Health Plan will provide written confirmation to you or your representative. This letter will also advise you or your representative that you have the right to appear before the Second Level Grievance Review Committee and that UPMC Health Plan will provide you or your representative with 15 days' advance written notice of the date and time scheduled for that review.
Second Level Grievance Review	Within 30 days of receipt of your grievance	The Second Level Grievance Review Committee consists of three or more individuals who did not previously participate in any decision to deny payment for the health care service under dispute. This committee will review input from qualified personnel (for example, a licensed physician or, where appropriate, an approved licensed psychologist) with experience in the same or a similar specialty that typically manages or consults on the health care service under dispute. You or your representative or the health care provider have the right, but are not required, to attend the Second Level Grievance Review Committee hearing. When arranging the review, UPMC Health Plan will notify you, your representative, or health care provider in writing at least 15 days in advance of the date scheduled for the Second Level Grievance Review. UPMC Health Plan will also provide details of how the review will be conducted, including your rights at such meetings. If you, your representative or health care provider cannot appear in person at the Second Level Grievance Review, UPMC Health Plan will provide you or your representative with the opportunity to communicate with the Committee by telephone or other appropriate means. The Second Level Grievance Review Committee will complete its review and shall base its decision solely upon the materials and testimony presented at the review.
New Information	Within 5 calendar days of receipt of new information	If the Committee receives any new evidence or rationale regarding your grievance, we will provide you or your representative with a copy of this information before issuing a decision.
Second Level Grievance Review Committee Decision Letter	Within 5 business days of the decision	UPMC Health Plan will send you or your representative written notification of the Second Level Grievance Review Committee decision within 5 business days. If it is applicable to your group health plan , information on how to file an external grievance will also be provided in the event that you are dissatisfied with the results of the internal grievance decision.

Expedited internal grievance process. If you feel that your life, health, or ability to regain maximum function are in jeopardy because of any delay that the time frame for an internal grievance might cause, or feel that UPMC Health Plan failed to provide medically necessary and appropriate covered services, you may request an expedited review.

In such cases, please call the Member Services Department to request an expedited review. You or your representative must have certification in writing from your physician that your condition would be placed in jeopardy by the delay inherent in the regular time frame of the internal grievance process. The certification must include a clinical rationale and facts to support your provider's position. UPMC Health Plan will arrange to have expedited grievances reviewed by the UPMC Health Plan Medical Director within 48 hours of receipt.

The Complaints and Grievances Department will send you or your representative a letter explaining the decision within 48 hours. A reasonable attempt will be made to verbally notify you or your representative of this decision as well.

The Expedited Internal Review decision letter will advise you if you have the right to file an Expedited External Grievance Review. If applicable, you have 2 business days from the receipt of the Expedited Internal Grievance Decision letter to contact UPMC Health Plan and request an Expedited External Grievance Review.

External grievance review process. Members should contact their employer or check their Certificate of Coverage or Summary Plan Description to determine if they have external grievance rights.

If you have the right to file an external appeal, and you or your representative still are dissatisfied with UPMC Health Plan's decision regarding your grievance, you or your representative may file a request for an External Grievance Review with UPMC Health Plan within 4 months of receipt of the decision of UPMC Health Plan's Second Level Grievance Review Committee. If your provider is filing the request for an External Grievance Review, your provider must submit a copy of your written consent. The request must contain any materials, supporting information, or necessary justification for the external grievance. For more information regarding the External Grievance Review process, see your Certificate of Coverage or Summary Plan Description.

When a request for an External Grievance is received, UPMC Health Plan will assign an Independent Review Organization (IRO) to conduct the external grievance. UPMC Health Plan will advise you or your representative of the name, address, and phone number of the IRO within 2 business days.

UPMC Health Plan will forward a copy of all written documentation regarding the denial to the IRO conducting the External Grievance Review within 15 days of receipt of notice that the External Grievance was filed. This written documentation will include the correspondence concerning the decision, as well as all reasonable supporting documentation and a summary of the clinical rationale for the decision. At the same time, UPMC Health Plan will provide you or your representative with the list of documents that are being forwarded to the IRO for the External Grievance Review.

You or your representative may supply additional information for consideration in the External Grievance Review. You must also send a copy of any additional information to UPMC Health Plan at the same time for consideration.

The IRO will review all information provided by UPMC Health Plan and you or your representative. The IRO will determine whether the service in question is/was medically necessary under the terms established by UPMC Health Plan. The IRO will issue a decision within 45 days of receipt of the External Grievance. The decision will be issued in writing to UPMC Health Plan. The decision notification will include the basis and clinical rationale for the decision, the credentials of the individual reviewer, a list of information considered in the decision, and a statement that you or your representative has 60 days from the receipt of the decision to appeal to a court of competent jurisdiction.

Appeal of a decision to a governing agency. The following information is for fully insured HMO and POS members only. If you are still dissatisfied with UPMC Health Plan's decision, you may have the right to file an appeal with the Pennsylvania Department of Health or Pennsylvania Insurance Department.

The appeal to a governing agency must be filed within 15 days after your receipt of UPMC Health Plan's Second Level Complaint Review Committee's decision. The Second Level Complaint Review decision letter will contain the contact information for both the Department of Health and the Insurance Department. For more information regarding this appeal process, see your Certificate of Coverage or Summary Plan Description.

ERISA appeal rights. You or your representative may also have appeal rights under section 502 (a) of the Employee Retirement Income Security Act (ERISA), if your benefit plan is an ERISA plan.

You should contact your employer or plan sponsor to determine if your benefit plan is an ERISA plan and to inquire about your appeal rights under that plan.

Remember that you must exhaust the Complaint or Grievance process with UPMC Health Plan prior to exercising your right to file an appeal with ERISA. If still dissatisfied after the ERISA appeal review, you or your representative may file a claim in a court of competent jurisdiction if all processes have been followed.



ADDITIONAL INFORMATION

Health Care Fraud and Identity Theft

Health care fraud hurts everyone by driving up costs and creating the risk that you may receive inappropriate care. Health care identity theft is the use — by someone pretending to be you — of your personal and health insurance information to get medical treatment or prescription drugs. Identity theft is a type of health care fraud. Fraudulent claims may become part of your permanent medical record and could later result in the wrong treatment or medication being provided.

Take steps to minimize your risk of identity theft:

- Protect your medical insurance card and ID number.
- Shred documents and paperwork that contain personal information before you discard them.
- Do not provide personal information on the phone, through the mail, or over the Internet unless you know who is requesting it.
- Do not let a family member or friend “borrow” your medical insurance card to obtain prescription drugs or medical services.
- Call the UPMC Health Plan Special Investigations Unit immediately if your personal information has been compromised.

The UPMC Health Plan Special Investigations Unit (SIU) is committed to the detection, prevention, and investigation of suspected insurance fraud and abuse. Our SIU will investigate all allegations of fraud or abuse committed by providers, members, employees, or any other entity doing business with UPMC Health Plan.

To report possible fraud:*

- Send an e-mail to specialinvestigationsunit@upmc.edu
- Call the Fraud Hotline at **1-866-FRAUD-01**
- Send a referral by U.S. mail:
UPMC Health Plan — Special Investigations Unit
Personal and Confidential (Do Not Open in Mail Room)
P.O. Box 2968
Pittsburgh, PA 15230

*Persons making referrals to the SIU may remain anonymous.

Information Available upon Written Request

To obtain information about UPMC Health Plan or to ask any questions about coverage that you could not locate in this Member Handbook or other member documents, send written correspondence to:

UPMC Health Plan Member Services
U.S. Steel Tower, 23rd Floor
600 Grant Street
Pittsburgh, PA 15219
upmchp@upmc.edu

Or, you may want to try our secure Message Center, where you can send messages directly to our staff. Just go to www.upmchealthplan.com and log in to MyHealth OnLine. Under the We're Here to Help! heading, select the Member Services link. Click on the Send a Secure Message link and compose your message.

You may contact us by e-mail as well. Send an e-mail to upmchp@upmc.edu and include “Additional Information Request” in the subject line of your message.

The following information is available upon written request:

- List of names, business addresses, and official positions of members of the Board of Directors or officers of UPMC Health Plan
- UPMC Health Plan procedures to protect confidentiality of medical records and other enrollee information
- Description of credentialing process for providers
- List of participating health care providers affiliated with participating hospitals, as well as instructions on how to obtain additional information concerning the practitioners
- List detailing which benefits and services are included and which are excluded from coverage
- List detailing whether specifically identified drugs are included or excluded from coverage

- Description of copayments and charges for which members are responsible
- Description of restrictions of benefits that apply to services obtained out-of-network or out of the service area
- Instructions on how to obtain primary care, specialty care, behavioral health services, and hospital services
- Instructions on how to obtain emergency care, care after normal office hours, and care out of the service area when needed
- Description of process by which a practitioner can prescribe specific drugs, drugs used for off-label purposes, biologicals and medications not included in the drug formulary for prescription drugs, or biologicals when the formulary equivalent has been ineffective in treatment of enrollee's disease or if a drug causes or is suspected of causing harmful reactions to enrollee
- Description of procedures followed by UPMC Health Plan to make decisions about the experimental nature of individual drugs, medical devices, or treatments
- Description of how UPMC Health Plan evaluates new technology for inclusion as a covered benefit
- Instructions on submitting a claim for covered services
- Summary of methodologies used by UPMC Health Plan to reimburse for health care services (Note: UPMC Health Plan will not disclose information about individual contracts or specific details of financial arrangements between UPMC Health Plan and providers.)
- Information on your right to file a complaint, grievance, or appeal concerning an adverse decision related to coverage and benefits, quality of care, or service issues
- Description of procedures used by the UPMC Health Plan Quality Improvement Program

Important Contact Information

The following list includes important telephone numbers, fax numbers, e-mail addresses, and websites that you might need as a UPMC Health Plan member. For your convenience, have your member ID card (or number) handy before you contact these numbers or sites.

Service	Contact	Notes
UPMC Health Plan Member Services	1-888-876-2756 www.upmchealthplan.com upmchp@upmc.edu MyHealth OnLine Message Center	Your benefit plan may direct you to use a different, specific number. Please refer to the back of your member ID card.
Express Scripts Mail-order Pharmacy	1-877-787-6279 www.upmchealthplan.com	Drugs delivered to your door at a reduced copayment.
UPMC Health Plan Health Management	1-866-778-6073 www.upmchealthplan.com	Specialized programs to improve the health of members.
UPMC Health Plan Behavioral Health Services	1-888-251-0083 (TTY: 1-877-877-3580) www.ccbh.com	Your benefit plan may direct you to use a different, specific number. Please refer to the back of your member ID card.
Assist America	1-800-872-1414 (toll-free within the U.S.) 1-609-986-1234 (outside of the U.S.) www.assistamerica.com	Travel assistance for urgent or emergency medical care.
Vision Benefits of America	1-800-432-4966 www.visionbenefits.com	Your benefit plan may not cover vision.
OptiCare Managed Vision Discount Network	1-866-918-1597 www.opticare.com/upmcdiscount	Your benefit plan may not cover vision.
UPMC Dental <i>Advantage</i> Member Services	1-877-648-9640	Your benefit plan may not cover dental.
DenteMax	1-877-648-9609	Your benefit plan may not cover dental.
UPMC Vision <i>Advantage</i>	1-888-499-6914	Your benefit plan may not cover vision.

In this document, the term "UPMC Health Plan" refers to benefit plans offered by UPMC Health Network, Inc., as well as to plans offered by UPMC Health Plan Inc.

This managed care plan may not cover all your health care expenses. Read your contract carefully to determine which health care services are covered.

UPMC Health Plan Member Services: **1-888-876-2756**
TTY Services: **1-800-361-2629**