

UPMC Health Plan (Commercial)

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Employer Group Products at a Glance

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

- Health Maintenance Organization (HMO)
- Point-of-Service (POS)
- Preferred Provider Organization (PPO)
- Exclusive Provider Organization (EPO)
- UPMC Consumer *Advantage* (Consumer Directed Health Care Programs)

Each plan includes several standard options. These define the applicable deductible, copayments, coinsurance, and out-of-pocket maximums, as well as cover a standard set of health care services. Benefits for inpatient care, surgical procedures, professional provider services, and other medical treatments are included in every plan design.

Standard plan options are offered to all size employer groups but can be customized for larger employer groups upon request.

Here are the important aspects to know about these products:

- Cost shares will be displayed either on the Member's ID card or accessed online by visiting upmchealthplan.com.

These products will cover the following **10 Essential Health Benefits**:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care (care before and after the baby is born)
- Mental health and substance use disorder services, including behavioral health treatment, counseling, and psychotherapy
- Prescription drugs
- Rehabilitative and habilitative services and devices (services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills)
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

All plans will have an Actuarial value between **56 and 95 percent**.

- The Actuarial value will determine which metal level a plan design is—platinum, gold, silver, or bronze.
- Covered Benefits may vary based upon the plan metal level and plan design. A Member's specific benefits can be viewed by visiting the UPMC Health Plan website at upmchealthplan.com.
- Claims submissions will remain the same. Operations will not be impacted.

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



Closer Look at Additional Benefits for Individuals and Small Groups

UPMC Health Plan (Commercial) is required to provide the **10 Essential Health Benefits** and benchmark plan requirements as well as state-mandated benefits.



Alert — Prohibition on Discrimination

UPMC Health Plan does not discriminate and/or deny health care coverage based on a pre-existing condition. In addition, UPMC Health Plan (Commercial) benefit designs do not discriminate on the basis of the following:

- Age
- Life expectancy
- Present or predicted disability
- Degree of medical dependency
- Quality of life
- Other health condition

Health Maintenance Organization (HMO-Referral and Enhanced Access HMO)

UPMC Health Plan offers **two types** of Health Maintenance Organization (HMO) products: one that requires referrals for Members to seek specialty care (HMO-Referral) and another that does not (Enhanced Access HMO).

Both the HMO-Referral and the Enhanced Access HMO require all Members to select a participating primary care provider (PCP). HMO-Referral and Enhanced Access HMO Members must use a participating provider or hospital in their network for routine care.

The HMO-Referral product incorporates a referral requirement via a PCP for Members to access care to further encourage Member engagement with their PCP and coordination of care.

Some HMO-Referral products require Members to receive referrals from their PCP prior to seeking care from most specialists with the exception of pediatric specialists, ob-gyns, dermatologists through e-Dermatology, and behavioral health providers.

However, even for provider types exempt from a PCP referral, Members must utilize an in-network provider.

Members may use any in-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 nonemergency care is received outside the network appropriate to the Member's benefit plan, unless care has been authorized through Utilization Management before the services are received. Contact Utilization Management through **Provider OnLine** at upmchealthplan.com/providers.

Key Points

- A PCP is mandatory.
- In-network providers and facilities must be used.
- Most preventive services, including routine physical exams and many immunizations for both adults and children, are fully covered at no cost to Members when provided by an in-network PCP; copayments may apply for Member enrolled in a Grandfathered Plan.
- Certain plan designs may require a deductible and/or coinsurance.
- When Members reach the annual out-of-pocket maximum (in network), covered services are paid at **100 percent** of UPMC Health Plan’s contracted rate without Member cost share.
 - **Note:** Cost shares may still apply to Members enrolled in the Grandfathered Plan.
- Obstetricians/Gynecologists are credentialed for routine gynecological visits and mammogram screenings.

Emergency Services

Emergency services by any provider are covered if the health care services are provided to a Member after the sudden onset of a medical condition that manifests itself by acute symptoms of sufficient severity or severe pain such that a prudent layperson could reasonably expect the absence of immediate medical attention to result in **one or more** of the following:

- Placing the health of the Member (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

Urgent care by an in-network provider is covered if the health care services are provided to a Member who reasonably believes that delaying care until the Member can contact or see their personal physician may place the health of the Member in jeopardy.

- See *Nonemergency Services*, UPMC Health Plan Commercial, Chapter C.

Point-of-Service (POS)

The POS 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 UPMC Health Plan’s reasonable and customary allowance and the provider’s charge as well as the applicable deductible and coinsurance).

Members 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 POS 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.
- Most preventive services, including routine physical exams and many immunizations for both adults and children, are fully covered at no cost to Members when provided by a participating PCP; copayments may apply for Members enrolled in a Grandfathered Plan.

Self-Directed Out-of-Network Care

- Some preventive services may not be 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 UPMC Health Plan’s payment (reasonable and customary amount).
- When Members reach the annual out-of-pocket maximum, benefits are covered at **100 percent** of UPMC Health Plan’s reasonable and customary allowance.

Emergency Services

Emergency services by any provider are covered if the health care services are provided to a Member after the sudden onset of a medical condition that manifests itself by acute symptoms of sufficient severity or severe pain such that a prudent layperson could reasonably expect the absence of immediate medical attention to result in **one or more** of the following:

- Placing the health of the Member (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

Urgent care by an in-network provider is covered if the health care services are provided to a Member who reasonably believes that delaying care until the Member can contact or see their personal physician may place the health of the Member in jeopardy.

➤ See *Nonemergency Services*, UPMC Health Plan Commercial, Chapter C.

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 can access any specialists directly.

The Member's cost share is determined by the Member's use of in-network versus out-of-network providers, with a higher level of benefits awarded to those who use in-network providers.

Members have a combination of applicable deductibles, coinsurance, and copayments for both in-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

In-Network Care

- Members have lower copayments or coinsurance when using in-network providers and services.
- Certain plan designs may require a deductible and/or coinsurance.
- Most preventive services, including routine physical exams and many immunizations for both adults and children, are fully covered at **no cost** to Members when provided by a PCP; copayments may apply for Members enrolled in a Grandfathered Plan.
- When Members reach the annual out-of-pocket maximum (in network), covered services are paid at **100 percent** of UPMC Health Plan's contracted rate without Member cost share.
- Cost shares may still apply to Members enrolled in the Grandfathered Plan.
- When Members reach the annual out-of-pocket maximum (out of network), covered services are paid at **100 percent** of UPMC Health Plan's reasonable and customary allowance without Member cost share.

Out-of-Network Care

- Some preventive services may not be 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 UPMC Health Plan's payment (reasonable and customary allowance).

Emergency Services

Emergency services by any provider are covered if the health care services are provided to a Member after the sudden onset of a medical condition that manifests itself by acute symptoms of sufficient severity or severe pain such that a prudent layperson could reasonably expect the absence of immediate medical attention to result in **one or more** of the following:

- Placing the health of the Member (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

Urgent care by an in-network provider is covered if the health care services are provided to a Member who reasonably believes that delaying care until the Member can contact or see their personal physician may place the health of the Member in jeopardy.

➤ See *Nonemergency Services*, UPMC Health Plan Commercial, Chapter C.

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 in-network facility. But, like the HMO, the EPO plan requires Members to receive care from in-network providers and facilities to receive covered benefits.

There are no out-of-network benefits unless a Member's care has been authorized by Utilization Management before the services are received. Contact Utilization Management through **Provider OnLine** at upmchealthplan.com/providers.

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

- A PCP is not required, but one can be chosen to assist with coordinating care.
- Members may self-direct care to in-network providers.
- Copayments, deductibles, and/or coinsurance may apply.
- Most preventive services, including routine physical exams and many immunizations for both adults and children, are fully covered when provided by an in-network PCP.
- Copayments may apply for Members enrolled in a Grandfathered Plan.
- When Members reach the annual out-of-pocket maximum, in-network services are paid at **100 percent** of UPMC Health Plan's contracted rate without Member cost share.

Emergency Services

Emergency services by any provider are covered if the health care services are provided to a Member after the sudden onset of a medical condition that manifests itself by acute symptoms of sufficient severity or severe pain such that a prudent layperson could reasonably expect the absence of immediate medical attention to result in **one or more** of the following:

- Placing the health of the Member (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

Urgent care by an in-network provider is covered if the health care services are provided to a Member who reasonably believes that delaying care until the Member can contact or see their personal physician may place the health of the Member in jeopardy.

➤ See *Nonemergency Services*, UPMC Health Plan Commercial, Chapter C.

UPMC Consumer Advantage Consumer Directed Health Care Plans

At a Glance

UPMC Health Plan offers an array of consumer directed health care plans, 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 arrangement (HRA) or an employee-owned health savings account (HSA), which may be funded by the employee, employer, or both entities.

Key Points

In-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 deductibles and coinsurance apply to all HSA benefits.
- Annual deductibles and coinsurance apply to all HRA plan options, with the exception of preventive services and pharmacy.
- Most preventive services, including routine physical exams for adults and children, are fully covered; Copayments may apply for Members enrolled in a Grandfathered Plan.
- When Members reach the annual out-of-pocket maximum, benefits are covered at **100 percent** of UPMC Health Plan's reasonable and customary allowance.

Out-of-Network Care

- Some preventive services may not be 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 Services

Emergency services by any provider are covered if the health care services are provided to a Member after the sudden onset of a medical condition that manifests itself by acute symptoms of sufficient severity or severe pain such that a prudent layperson could reasonably expect the absence of immediate medical attention to result in **one or more** of the following:

- Placing the health of the Member (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

Urgent care by an in-network provider is covered if the health care services are provided to Member who reasonably believes that delaying care until the Member can contact or see their personal physician may place the health of the Member in jeopardy.

➤ See *Nonemergency Services*, UPMC Health Plan Commercial, Chapter C.

UPMC HealthyU

UPMC *HealthyU* is a unique health insurance product that provides the tax and consumerism advantages of a traditional CDHP with a wellness plan. UPMC *HealthyU* is designed to promote a higher level of consumerism and facilitate integrated health management. Members are able to earn funds in a Health Incentive Account (HIA) **each year** by participating in specific healthy activities based on the results of the Member's Health Risk Assessment. The funds they earn are then used to offset the costs of medical and pharmacy cost sharing.

The focus of these plan offerings is on health improvement and engagement. They have **three** core consumer-facing competencies to produce better outcomes and lower costs:

- *Understand* your health and care.
- *Improve* your health and care.
- *Partner* with your physician.

Each competency is supported by specific web tools, coaching programs, and care delivery innovations which are communicated, tracked, and incentivized with dollar amounts allocated to the HIA.

These plans follow the design of a high-deductible HSA/HRA but have an integrated health management focus rather than a strictly financial focus. They incorporate a health incentive account (HIA), which is an account into which funds are deposited by UPMC Health Plan as Members complete specific activities. The funds they earn are used to help offset the costs of health care by paying for medical deductibles, coinsurance, and copayments at the pharmacy. There are **more than 100** activities that Members can participate in to earn incentives.

UPMC Inside Advantage

UPMC Inside *Advantage* is a value network product for small and mid-sized employers and individuals in Clarion, Crawford, Elk, Erie, Forest, McKean, Mercer, Potter, Venango, and Warren counties. When Members choose to receive care at level-one facilities—quality hospitals in the Erie-Warren area—Members receive the same type of coverage as that provided by other UPMC Health Plan offerings, but at the lowest premium and out-of-pocket costs. **Tier two** provides slightly higher out-of-pocket costs and includes the remainder of the UPMC-contracted facilities within the UPMC network of more than **90** hospitals. **Tier three** includes non-contracted, out-of-network providers at higher out-of-pocket costs.

UPMC Inside *Advantage* Members may choose from all participating doctors. As detailed above, the **Level 1** and **Level 2** tiers are only applicable for facilities. For certain complex care issues that cannot be addressed at an Erie-Warren area hospital, UPMC Health Plan includes a domestic travel and care concierge benefit. A concierge will arrange for Members to come to Pittsburgh. The Member and their families will be reimbursed for hotel and travel expenses. In addition, the concierge will coordinate the care between their community physician and physicians in Pittsburgh.

Outlined below are the **Level 1** and **Level 2** facility providers. For searchable listings of both **Level 1** and **Level 2** facility providers, visit upmchealthplan.com.

| UPMC Network – Level 1 | UPMC Network – Level 2 |
|---------------------------|---|
| UPMC Hamot | Remainder of UPMC-contracted facilities |
| UPMC Kane | |
| UPMC Horizon | |
| UPMC Northwest | |
| All UPMC-owned facilities | |

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 UPMC 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
- 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

Nonemergency or routine transportation is not a covered benefit except for facility to facility nonemergent transfers, if medically necessary.

Ambulance transportation for previously scheduled and planned treatments and therapies is not a covered benefit (e.g., dialysis).

If the Member has no other means of transportation, a Case Manager can research alternative community-based resources that may assist the Member.



Alert — Emergency Transportation

Emergent ambulance transportation is a covered benefit. In the case of a life-threatening emergency, Members should dial **911** or call their local emergency service.

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 the following:

- Chiropractic care
- Diagnostic services (e.g., lab, x-ray), including special diagnostics
- Emergent ambulance services
- 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
- Nursing care at a licensed skilled nursing facility
- Orthotics and prosthetics
- 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, go to upmchealthplan.com.

In-Home Services

In-home services include the following:

- 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
- Respiratory equipment, including oxygen therapy



Closer Look at Specialized Equipment

If a Member requires specialized equipment or modifications, the ancillary provider must contact **Utilization Management** by submitting a request through **Provider OnLine** at upmchealthplan.com/providers. Utilization Management will be able to determine whether the equipment is covered and whether prior authorization is required.

Services Offered Outside the Home

A provider may refer a Member to a network hospital's outpatient department or freestanding facility as appropriate. For information regarding other network providers, visit the UPMC Health Plan website at 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 the following:

- 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 initial evaluation and 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 younger than **13 years old** should be treated by a chiropractor without prior authorization from UPMC Health Plan.

- See *Services Requiring Prior Authorization*, Utilization and Medical Management, Chapter G.
- See the *Policies and Procedures Manual* online at upmchealthplan.com.



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 by visiting the UPMC Health Plan website at upmchealthplan.com.

Dental Benefits

Dental Care

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

Many groups offer Essential Health Benefits that include pediatric dental benefits. These benefits include Diagnostic/Preventive, Class II Basic, Class III Major Services, and Orthodontia coverage. **UPMC Dental Advantage** will administer these benefits and questions can be directed to **1-877-648-9609**.

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 UPMC Health Plan when coordinated by a Member's PCP, if applicable, or network provider.



Alert – Temporomandibular Joint Disorder Joint Syndrome

Temporomandibular Joint Disorder and Temporomandibular Joint Syndrome (TMJ) typically are exclusions 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. Specific benefit designs can be viewed by visiting the UPMC Health Plan website at 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.

Some plan designs require a copayment, deductible, and/or coinsurance. The level of deductibles and coinsurance depends on the various plan options.



Closer Look at Laboratory Services

- Providers south of Interstate 80 should contact **Quest Diagnostics** at **1-800-920-9220**.
- Providers north of Interstate 80 should contact **Associated Clinical Labs** at **1-800-937-8028**.

Specific benefit designs can be viewed by visiting the UPMC Health Plan website at upmchealthplan.com.

Emergency Services

Emergency services by any provider are covered if the health care services are provided to a Member after the sudden onset of a medical condition that manifests itself by acute symptoms of sufficient severity or severe pain such that a prudent layperson could reasonably expect the absence of immediate medical attention to result in **one or more** of the following:

- Placing the health of the Member (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

Urgent care by an in-network provider is covered if the health care services are provided to Member who reasonably believes that delaying care until the member can contact or see their personal physician may place the health of the Member in jeopardy.

➤ See *Nonemergency Services*, UPMC Health Plan Commercial, Chapter C.

Emergency Admission

Emergency services, provided at an emergency department, typically require a copayment deductible and/or coinsurance, which are waived if the Member is admitted immediately. This emergency department copayment also will be waived if the Member is admitted **within three 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 **Utilization Management** by accessing **Provider OnLine** at upmchealthplan.com/providers **within 48 hours** or on the **next business day** following the emergency admission.

Hospital Admissions (including Labor & Delivery)

Admissions to network hospitals are covered at a higher level than out-of-network care; however, some plan designs do not cover nonemergency admissions to out-of-network hospitals. Hospital networks may vary according to a Member's particular plan. Members' benefits can be viewed by visiting the UPMC Health Plan website at upmchealthplan.com/providers or by calling **Provider Services** at **1-866-918-1595** to determine which hospitals serve a particular Member.

Hospitals are required to notify **Utilization Management** by accessing **Provider OnLine** at upmchealthplan.com/providers of an inpatient admission 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.

Some plan designs require a copayment, deductible and/or coinsurance, and the level of deductibles and coinsurance depends on the various plan options.

Behavioral Health and Substance Use Disorder

Behavioral health and substance use disorder benefits are managed through UPMC Health Plan. Urgent after-hours authorization requests are managed by Community Care Behavioral Health, which also provides Members with triage and referral for emergency services after hours. Providers can access **UPMC Health Plan’s Behavioral Health Services (BHS) 24 hours a day, seven days a week, 365 days a year** by calling **1-866-441-4185**. 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.



Alert – Behavioral Services

As with medical care, inpatient and outpatient behavioral health or substance use disorder services by network providers is covered at higher benefit levels than out-of-network care. Some plans may have copayments, deductible, and/or coinsurance. A Member’s individual plan can be viewed by visiting the UPMC Health Plan website at upmchealthplan.com. 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.

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 *Procedures Requiring Predetermination, Utilization and Medical Management*, Chapter G.



Alert — Copayment, Deductible, and/or Coinsurance

Some procedures may require a copayment deductible and/or coinsurance 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 may be 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. Some plan designs will require prior authorization for this service.

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, deductible and/or coinsurance 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 *UPMC Health Plan Commercial Pharmacy Program, Pharmacy Services, Chapter J.*
 - Your Choice Pharmacy Program
 - First Choice Pharmacy Program
 - Value Choice Pharmacy Program
 - Open choice Preferred Pharmacy Program

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 *When to Notify Utilization Management, Utilization and Medical Management, Chapter G.*



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, but may be subject to copayments, coinsurance, and/or deductibles and are subject to specific benefit limitations defined in the schedule of benefits.

- See *When to Notify Utilization Management*, Utilization and Medical Management, Chapter G.

Skilled Nursing Facility Care

Skilled nursing facility care is covered for medically necessary care **without a three-day waiting period (or a three-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 can be found online at upmchealthplan.com.



Closer Look at Skilled Nursing Facility Care

Providers should notify **Utilization Management** through **Provider OnLine** at upmchealthplan.com/providers 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 *When to Notify Utilization Management*, Utilization and Medical Management, Chapter G.

Vision Benefits

Routine eye care (such as glasses, contacts, and eye exams) is provided for certain employer groups through **UPMC Vision Care** at **1-877-262-7870** or **UPMC Vision Advantage** at **1-877-648-9621**. The levels of coverage vary by group. A Member's identification card does not indicate coverage, so providers should contact the appropriate vendor to determine benefits.

UPMC Vision Care is the administrator of pediatric vision benefits.

Many groups offer Essential Health Benefits that include pediatric vision benefits. These benefits include examinations, lenses, frames, and contact lenses (if deemed medically necessary).



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** as the coverage is provided through UPMC Health Plan.

Women’s Care

Non-maternity Care

Women in UPMC Health Plan’s 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 Member’s identification card. Copayment or coinsurance for sick visits or other care is the number listed after “specialist” on the identification card.

Maternity Care

Copayments, coinsurance and/or deductibles 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, coinsurance and/or deductibles 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 (Commercial) benefits. A Member's specific benefits can be viewed by visiting the UPMC Health Plan website at upmchealthplan.com.

- Alternative medicine, including but not limited to acupuncture, aromatherapy, ayurvedic medicine, guided imagery, herbal medicine, homeopathy, massage therapy naturopathy, relaxation therapy, transcendental meditation, and yoga
- Assisted fertilization, assisted fertilization services, unless the Member has an Infertility rider including, but not limited to GIFT, ZIFT, embryo transplants, and in vitro fertilization
- Cosmetic surgery
- Custodial care
- Court-ordered services
- Experimental or investigative procedures
- Genetic counseling
- Growth hormones
- Hearing aids and hearing examinations
- 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 accident 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, except when required by the Affordable Care Act
- 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. A Member's specific benefits may be viewed by visiting the UPMC Health Plan website at upmchealthplan.com.

- Acupuncture
- Bariatric and Metabolic Surgery
- Corrective appliances, when determined to be the standard to restore basic functions and/or necessitates due to injury or disease
- Dental care
- Home health care
- Durable medical equipment (DME)
- Nutritional counseling or supplements
- Oral surgery, is covered only for certain procedures in an outpatient setting or in an inpatient setting when such setting is determined to be Medically Necessary
- Podiatry services
- Private-duty nursing
- Rehabilitation/habilitation therapy services
- Reversal of voluntary sterilization procedures
- Sex transformation services and procedures
- Skilled nursing
- Therapeutic manipulation
- Transplants or organ donation
- Transportation, (routine or nonemergency)
- 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 UPMC 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 a Member may ask his or her provider to become 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 UPMC Health Plan. A complaint involves a dispute that has not been resolved by UPMC Health Plan and has been filed with UPMC Health Plan or the Pennsylvania Insurance Department.

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

- 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 a managed care plan or CRE reconsider a decision solely concerning the medical necessity and appropriateness of a health care service. If the managed care plan is unable to resolve the matter, a grievance may be filed regarding the decision that does any of the following:

- Disapproves full or partial payment for a requested health service
- Approves the provision of a requested health care service for a lesser scope or duration than requested
- Disapproves payment of the provision of a requested health care service but approves payment for the provision of an alternative health care service

Complaint Procedures

A UPMC Health Plan (Commercial) Member with a complaint about a network provider, coverage, operations, or UPMC Health Plan’s management policies should contact the **UPMC Health Plan Health Care Concierge team at 1-888-876-2756 (TTY: 711)**.

The Member may appoint in writing a representative to act on his or her behalf.

In addition, the Member or the Member’s representative may request the help of a UPMC 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 may be two steps in the internal complaint process depending on the Member’s plan:

- Initial Review
- Second-Level Review

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. Complaints may be submitted through the Member secure website via email or live chat.

All written complaints should be submitted to:

**UPMC Health Plan
Member Complaints/Grievances
PO Box 2939
Pittsburgh, PA 15230-2939**

2. UPMC Health Plan acknowledges the complaint.

UPMC Health Plan sends a letter to the Member **within five business days** of receipt of the complaint stating that it has received the complaint.

3. The Initial Complaint Review Committee investigates the complaint.

The committee, which consists of **one or more** UPMC Health Plan employees who were not involved in a prior decision to deny the complaint, investigates the complaint.

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

The committee makes a decision **within 30 calendar days** of receiving a complaint. The Member will be notified **within five business days** of the committee's decision. The notification states the reason for the decision 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 will be described in the response letter for the first level.

Second-Level Review (if applicable)

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 UPMC 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 UPMC Health Plan Members who are not employed by the UPMC Health Plan.

2. UPMC Health Plan acknowledges the appeal.

UPMC 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 30 calendar days** of the request. UPMC 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 based upon the Second-Level Review Committee hearing.

4. Second-Level Review Committee makes a decision.

The Second-Level Review Committee issues a written notification **within five business days** of making its decision, specifying its reasons. The decision letter includes information about how to file a complaint with a government agency.

Grievance Procedures

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

General Grievance Process

UPMC Health Plan (Commercial) Members with questions about UPMC Health Plan's complaint and grievance process should contact the **UPMC Health Plan Health Care Concierge team at 1-888-876-2756 (TTY: 711)**.

Written grievances should be addressed to:

**UPMC Health Plan
Member Complaints/Grievances
PO Box 2939
Pittsburgh, PA 15230-2939**

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 UPMC 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, and decides not to file a grievance, the provider has **10 days** from receipt of the standard written utilization review (UR) denial or receipt of the internal grievance review denial decision letter to notify the Member or the Member's legal representative.

- 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.

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 UPMC Health Plan’s identification number of the provider to whom the Member is providing the consent
- UPMC 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 the 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.
- 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:

- **Initial** Grievance Review
- **Second-Level** Grievance Review

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 UPMC Health Plan or calls the **UPMC Health Plan Health Care Concierge team at 1-888-876-2756 (TTY: 711)**.

UPMC Health Plan staff is available to document an oral grievance for Members with physical limitations or language barriers.

2. UPMC Health Plan acknowledges the grievance.

UPMC Health Plan sends a letter acknowledging receipt of the grievance **within five business days** of receipt of the grievance.

3. Initial Grievance Review Committee investigates the grievance.

The Initial Grievance Review Committee, consisting of **one or more** UPMC Health Plan employees and an independent consultant 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 a decision.

The committee makes a decision **within 10 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 of the decision. The Member will be notified **within five business days** of the committee's decision. In the letter the committee includes the reasons for its decision and the Member's appeal rights to UPMC Health Plan's Second-Level Grievance Review Committee.

Second-Level Grievance Review (if applicable)

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.

UPMC 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. UPMC Health Plan notifies the Member and/or the authorized representative with **15 calendar days’** advance written notice of the time scheduled for a post-service review of a **seven calendar-day** advance written notice for a pre-service review process, the format of the hearing, and the Member’s rights at such hearings. The hearing is completed **within 20 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 a decision.

The Second-Level Grievance Review Committee notifies the Member and/or an authorized representative, if any, of the decision **within five business days** of the committee’s decision or **within 20 calendar days** of the request for a second level appeal, whichever comes first. The notice will specify the reasons for its decision. The Member has **four months** to file an external appeal, if applicable for the Member’s benefit plan. The decision letter will include all necessary information about filing an external appeal.

➤ See *Internal Grievance Process*, UPMC Health Plan Commercial, Chapter C.



Alert — Expedited Internal Grievance

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 the **UPMC Health Plan Health Care Concierge team** at **1-888-876-2756 (TTY: 711)**.

The request for an expedited grievance must include evidence in writing from the provider that the Member's condition would be placed in jeopardy by the delay inherent in the typical grievance process. UPMC Health Plan's medical director will review the grievance **within 48 hours**. UPMC Health Plan will notify the Member, the Member's designated representative and the provider of the decision in writing along with information regarding the filing of an Expedited External Review. The member or provider filing on behalf of the member may request an Expedited External Review in conjunction with an expedited internal review or may wait until the expedited internal review is decided to file the Expedited External Review.

Members can contact UPMC Health Plan to request an external expedited grievance review at the same time they request an internal expedited grievance review. Members have **two business days** from receipt of the Expedited Internal Review decision to contact UPMC Health Plan with a request for an Expedited External Review to an independent review organization (IRO). The IRO issues a decision **within 72 hours**.

External Grievance Reviews

The steps for filing requests for External Grievance Reviews are described below.

1. The 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 **four months** from receipt of the decision by the Second-Level Grievance Review Committee to file a request to UPMC Health Plan for an External Grievance Review. Providers filing such a request must include the Member's written consent to file the grievance.

2. Preliminary Review

When the request for an External Grievance is received, UPMC Health Plan will complete a preliminary review of the request **within five business days**. The purpose of the preliminary review is to determine whether:

- The Member is or was covered at the time the service/item was requested.
- If the adverse benefit determination relates to the Member's failure to meet the requirements for coverage.
- The Member exhausted internal appeals.
- The Member provided all information and forms necessary to process the External Review.

After completion of the preliminary review, UPMC Health Plan will issue a notification in writing as to whether the grievance is eligible for an external review by an Independent Review Organization (IRO). If the grievance is eligible for external review the Member will be provided with information about the IRO's name, address, and phone number.

3. UPMC Health Plan sends written documentation to the IRO.

Within five business days of determining that a grievance is eligible for external review, UPMC Health Plan will forward a copy of all written documentation regarding the adverse benefit determination to the IRO. Documentation will include the correspondence concerning the decision, all reasonable supporting documentation, and a summary of the clinical rationale for the adverse determination.

4. UPMC Health Plan sends list of documents.

UPMC Health Plan will provide the Member, the Member's representative, or the provider with the list of documents that are being forwarded to the IRO for the external grievance review.

5. Member, Member representative, or provider sends additional information to IRO.

A Member, the Member's representative or the provider may supply additional information to the IRO to consider **within 15 business days** of receipt of notification that the external review was filed with the plan. If a provider supplies additional information to the IRO, the provider must simultaneously provide a copy of the same information to UPMC Health Plan.

6. IRO makes a decision.

The IRO will review all information provided by UPMC Health Plan, the Member, and the Member's representative or the provider. The IRO will make a determination under the terms of the benefit plan as established by UPMC Health Plan. The IRO will issue a decision **within 45 calendar days** of receipt of the external appeal. The decision will be issued in writing to the Member, the Member's representative or the provider, and UPMC Health Plan from the IRO. The decision notification will include the basis and clinical rationale for the decision, the credentials of the individual reviewer, and a list of information considered in the decision.



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 for the Fully insured groups.

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

**Pennsylvania Department of Health
Bureau of Managed Care
1311 Strawberry Square
Harrisburg, PA 17120-0701
1-888-466-2787**

**Pennsylvania Insurance Department
Bureau of Consumer Services
1209 Strawberry Square
Harrisburg, PA 17120
1-877-881-6388**

UPMC Individual Products

(Health Care Programs for Individuals and Their Families)

At a Glance

UPMC Health Plan offers an array of health care products that can be purchased directly by individuals and their families. These products comply with the Affordable Care Act and are available both on and off the Federally Facilitated Marketplace.

HMO

The HMO-R (HMO Referral) requires all Members to select a primary care provider (PCP) and use this provider for routine and preventive services. HMO Members must use a provider or hospital in their network and must access care by coordinating services with their PCP, with certain exceptions. Referrals are required from a PCP prior to seeking care from a specialist.

PPO

UPMC *Advantage* offers Preferred Provider Organization plan types. In the Preferred Provider Organization (PPO) plan, Members are **not required** to select a PCP or an ob-gyn. Their care, therefore, **is not** coordinated by any provider and Members can access any specialists directly.

EPO

UPMC *Advantage* plans offer network access through an Exclusive Provider Organization (EPO) network. An EPO plan blends elements of a traditional HMO with elements of a Preferred Provider Organization (PPO). Similar to a PPO, the EPO does not require Members to select a primary care physician (PCP) to act as a “gatekeeper.” But, like an HMO, the EPO does require Members to receive care from participating providers and facilities in order to qualify as a Covered Service.

Key Points

Network Care

- Members have direct and coordinated access to the renowned academic, advanced care, and specialty hospitals of UPMC, along with outstanding community hospitals, behavioral health centers, cancer centers, and physician practices.
- All plan designs require a copayment, deductible and/or coinsurance, and the level of copayment, deductibles and coinsurance depends on the various plan options.
- Annual deductibles and coinsurance apply to all HSA benefits, with the exception of preventive services.

- All preventive services, including routine physical exams for adults and children, are fully covered.
- In compliance with State and Federal regulations, all UPMC *Advantage* Members have a grace period after missing a premium payment.
 - **Members NOT receiving a Premium Tax Credit (APTC):**
A Member whose account is not in good standing due to a missed premium payment has **30 days** in which to pay the premium. If the Member does not bring the account current **within 30 days**, claims for dates of service within the grace period are not eligible for Health Plan payment.
 - **Members who DO receive a Premium Tax Credit (APTC):**
A Member whose account is not in good standing due to a missed premium payment has **90 days** in which to pay the premium. If the Member does not bring the account current **within 90 days**, claims for dates of service within **the last 60 days** of the grace period are not eligible for Health Plan payment. Pursuant to ACA regulations, the Health Plan will notify providers when a claim is received for a Member who is in **the last 60 days** of the grace period.
- UPMC Health Plan participates in the Federally Facilitated Marketplace. Here are the important aspects to know:
 - Cost shares will be displayed; either on the Member’s ID card or accessed online by visiting **upmchealthplan.com**.
 - These products will cover the following **10 Essential Health Benefits**:
 - Ambulatory patient services
 - Emergency services
 - Hospitalization
 - Maternity and newborn care
 - Mental health and substance use disorder services, including behavioral health treatment
 - Prescription drugs
 - Rehabilitative and habilitative services and devices
 - Laboratory services
 - Preventive and wellness services and chronic disease management
 - Pediatric services, including oral and vision care
 - All plans will have an Actuarial value between **56 and 95 percent**
 - The Actuarial value will determine which metal level a plan design- platinum, gold, silver, and bronze.
 - Claims submissions will remain the same. Operations will not be impacted.

Emergency Care

All Emergency Services provided by non-participating providers will be covered at the participating provider level. If the Member requires emergency health care services and cannot reasonably be attended to by a participating provider, UPMC Health Plan shall pay the emergency services so that the Member is not liable for a greater out-of-pocket expense than if the Member were attended to by a participating provider.

- Emergency services by any provider are covered if the health care services are provided to a Member after the sudden onset of a medical condition that manifests itself by acute symptoms of sufficient severity or severe pain such that a prudent layperson could reasonably expect the absence of immediate medical attention to result in **one or more** of the following:
 - Placing the health of the Member (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
 - Serious impairment to bodily functions
 - Serious dysfunction of any bodily organ or part
- Urgent care by an in-network provider is covered if the health care services are provided to a Member who reasonably believes that delaying care until the Member can contact or see their personal physician may place the health of the Member in jeopardy.

➤ See *Nonemergency Services*, UPMC Health Plan Commercial, Chapter C.

Covered Benefits

(For Individuals and Their Families)

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. Each UPMC *Advantage* plans has unique cost-sharing values and benefit designs and may require prior authorization. Members should refer to their Schedule of Benefits to determine the Covered Benefits associated with their plan.

A provider may bill a UPMC 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
- 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

Emergency transportation and related emergency services provided by a licensed ambulance service shall constitute an emergency service and be covered at the in-network level whether the service is provided by a participating or non-participating provider.



Alert — Emergency Transportation

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

Nonemergent services provided by a Non-Participating Provider will be covered at the non-participating provider level unless the services are authorized by UPMC Health Plan.

Dental Benefits

UPMC *Advantage* plans for Individuals and their families offer Essential Health Benefits that include pediatric dental benefits. These benefits include Diagnostic/Preventive, Class II Basic, Class III Major Services, and Orthodontia coverage. These dental benefits are covered through UPMC *Dental Advantage*.

Adult and pediatric dental care for accidental injury to sound and natural teeth is generally covered under UPMC Health Plan’s medical benefits; however, this benefit must be used **within 72 hours** of the particular injury.

The benefit plan covers dental services necessary to treat an accidental injury to sound, natural teeth when the services are obtained **within the first 72 hours** following the accidental injury. This coverage applies **only to** the emergency services rendered for and made necessary by the injury. These services include services obtained in an emergency room. Injury as a result of chewing or biting is not considered an accidental injury. The benefit plan does not provide coverage for any follow-up care related to the accidental injury, including, but not limited to, orthodontia, post-orthodontics, and restorative procedures. All other dental services are excluded, except as provided by a Dental Rider.



Alert — Benefit Limits and Initial Visits

The benefit period begins on the Member’s effective date. Copayments, deductibles, and visit limits are reset on Jan. 1 of each year.

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 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 three 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 **Utilization Management** by accessing **Provider OnLine** at upmchealthplan.com/providers **within 48 hours** or on the **next business day** following the emergency admission.

Hospital Admissions

Hospitals are required to notify **Utilization Management** by accessing **Provider OnLine** at upmchealthplan.com/providers of an inpatient admission by the **next business day**.

Vision Benefits

UPMC *Advantage* plans cover Essential Health Benefits that include pediatric vision benefits. These services are provided for individuals and their families' plans through **UPMC Vision Care**. These benefits include examinations, lenses, frames, and contact lenses (if deemed medically necessary).

Benefit Exclusions

(For Individuals and Their Families)

All of the benefits outlined in **Benefit Exclusions** are also excluded from the UPMC *Advantage* plan options.

- Bariatric Surgery
 - Pregnancy termination (Abortion). Abortion is not covered except for instances of rape, incest, or if the life of the mother is in jeopardy
 - Private duty nursing
- See the *Member's Policy/Certificate of Coverage* for a complete list of excluded services.

Complaints and Grievances

(For Individuals and Their Families)

There are two types of Member disputes—complaints and grievances. Although both are Member-driven, providers need to know about these procedures because a Member may ask his or her provider to become 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 UPMC Health Plan. A complaint involves a dispute that has not been resolved by UPMC Health Plan and has been filed with UPMC Health Plan 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 UPMC Health Plan reconsider a decision solely concerning the medical necessity and appropriateness of a health care service. If UPMC 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

(For Individuals and Their Families)

A UPMC Health Plan (Commercial) Member with a complaint about a network provider, coverage, operations, or UPMC Health Plan’s management policies should contact the **UPMC Health Plan Health Care Concierge team at 1-866-353-3598 (TTY: 711)**.

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 UPMC 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.

Complaint 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. Complaints may be submitted through the Member secure portal via email or live chat.

All written complaints should be submitted to:

**UPMC Health Plan
Member Complaints/Grievances
PO Box 2939
Pittsburgh, PA 15230-2939**

2. UPMC Health Plan acknowledges the complaint.

UPMC Health Plan sends a letter to the Member **within five business days** stating that it has received the complaint.

3. The Complaint Review Committee investigates the complaint.

The committee, which consists of **one or more** UPMC Health Plan employees who were not involved in a prior decision to deny the complaint, investigates the complaint.

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

The committee makes a decision and notifies the Member in writing **within 30 calendar days** of receiving a complaint. The Member will be notified **within five business days** of the committee’s decision. The notification states the reason for the decision and the Member’s appeal rights.

Grievance Procedures

(For Individuals and Their Families)

A grievance is a request by a Member, or a health care provider with the Member's written consent, to have UPMC 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 UPMC Health Plan's complaint and grievance process should contact the **UPMC Health Plan Health Care Concierge team** at **1-866-353-3598 (TTY: 711)**.

Written grievances should be addressed to:

**UPMC Health Plan
Member Complaints/Grievances
PO Box 2939
Pittsburgh, PA 15230-2939**

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 UPMC 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 and decides not to file a grievance, the provider has **10 days** from receipt of the standard written utilization review (UR) denial or receipt of the internal grievance review denial decision letter to notify the Member or the Member’s legal representative.
- 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.

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 UPMC Health Plan’s identification number of the provider to whom the Member is providing the consent
- UPMC 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.
- 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

Grievance Review Committee

1. Member or provider sends the grievance to UPMC Health Plan.

The Member or the provider (with Member's consent) sends a written letter of grievance to UPMC Health Plan or calls the **UPMC Health Plan Health Care Concierge team at 1-866-353-3598 (TTY: 711)**.

UPMC Health plan staff is available to document an oral grievance for Members with physical limitations or language barriers.

2. UPMC Health Plan acknowledges the grievance.

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

3. Grievance Review Committee investigates the grievance.

The Initial Grievance Review Committee, consisting of **one or more** UPMC 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. Grievance Review Committee makes a decision.

The committee makes a decision **within 10 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 of the decision. The Member will be notified **within five business days** of the committee's decision. In the letter the committee includes the reasons for its decision and the Member's external appeal right.

Expedited Internal Grievance

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 Member or his or her health care provider should call the **UPMC Health Plan Health Care Concierge team** at **1-866-353-3598 (TTY: 711)**. The request for an expedited grievance must include evidence in writing from the treating provider that the Member's condition would be placed in jeopardy by the delay inherent in the typical grievance process. UPMC Health Plan's medical director will review the grievance **within 48 hours**. UPMC Health Plan will notify the Member, the Member's designated representative and the provider of the decision along with information regarding the filing of an Expedited External Review.

Members can contact UPMC Health Plan to request an external expedited grievance review at the same time they request an internal expedited grievance review. Members have **two business days** from receipt of the Expedited Internal Review decision to contact UPMC Health Plan with a request for an Expedited External Review to an Independent Review Organization (IRO). The IRO issues a decision **within 72 hours**.

External Grievance Reviews

The steps for filing requests for External Grievance Reviews are described below.

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 **four months** from receipt of the decision by the Internal Grievance Review Committee to file a request to UPMC Health Plan for an External Grievance Review. Providers filing such a request must include the Member's written consent to file the grievance.

2. Preliminary Review.

When the request for an External Grievance is received, UPMC Health Plan will complete a preliminary review of the request **within five business days**. The purpose of the preliminary review is to determine whether:

- The Member is or was covered at the time the service/item was requested;
- If the adverse benefit determination relates to the Member's failure to meet the requirements for coverage;
- The Member exhausted internal appeals; and
- The Member provided all information and forms necessary to process the External Review.

After completion of the preliminary review, UPMC Health Plan will issue a notification in writing as to whether the grievance is eligible for an external review by an Independent Review Organization (IRO). If the grievance is eligible for external review UPMC Health Plan will include information about the IRO's name, address, and phone number.

3. UPMC Health Plan sends written documentation to the IRO.

Within five business days of receipt of determining that a grievance is eligible for external review, UPMC Health Plan will forward a copy of all written documentation regarding the adverse benefit determination to the IRO. Documentation will include the correspondence concerning the decision, all reasonable supporting documentation, and a summary of the clinical rationale for the adverse determination.

4. UPMC Health Plan sends list of documents.

UPMC Health Plan will provide the Member, the Member's representative, or the provider with the list of documents that are being forwarded to the IRO for the external grievance review.

5. Member, Member representative, or provider sends additional information to IRO.

A Member, the Member's representative or the provider may supply additional information to the IRO to consider **within 15 business days** of receipt of notification that the external review was filed with the plan. The IRO will then provide this information to UPMC Health Plan **within one day** so that UPMC Health Plan has an opportunity to consider the additional information as well.

6. IRO makes a decision.

The IRO will review all information provided by UPMC Health Plan, the Member, the Member's representative, or the provider. The IRO will make a determination under the terms of the benefit plan as established by UPMC Health Plan. The IRO will issue a decision **within 45 calendar days** of receipt of the external appeal. The decision will be issued in writing to the Member, the Member's representative or the provider, and UPMC Health Plan. The decision notification will include the basis and clinical rationale for the decision, the credentials of the individual reviewer, and a list of information considered in the decision.

Nonemergency & Routine Health Care Problems

Members **should not** go to an emergency department for routine health care. Members should call their PCP, (if applicable), for routine or nonemergency health care needs. They should call their PCP to schedule an appointment for routine health care needs.

Here are some examples of routine health care problems:

| | |
|----------------------------|-------------------------|
| Earache | Sore throat |
| Backache | Coughing or sneezing |
| Cuts, scrapes, and bruises | Minor skin rashes |
| Cold or flu | Sprained ankle or wrist |
| Physical exams | Toothache |

When Members have a minor illness or injury and need to receive care but cannot reach their PCP, an urgent care or convenience care center can be a very good alternative.

They can receive care at many participating urgent care or convenience care centers.

Urgent care centers have the capability to stitch wounds, take x-rays, and treat sprains. They treat earaches, back pain, dental pain, and sore throats. They care for minor rashes, burns, cuts, and scrapes.

Preventive Guidelines

Section 1001 of the Affordable Care Act “requires all health Plans to cover preventive services and immunizations recommended by the U.S. Preventive Services Task Force and the CDC, and certain child preventive services recommended by the Health Resources and Services Administration, without any Member cost-sharing.”

However, some Grandfathered groups may have cost-share associated with preventive services.

For additional information, visit [healthcare.gov](https://www.healthcare.gov).

Guidelines for Medical Record Documentation

UPMC Health Plan requires participating network physicians to maintain Member medical records in a manner that is accurate and timely, well-organized, readily accessible by authorized personnel, and confidential. Per UPMC Health Plan policy, all medical records must be retained for **10 years**. Consistent and complete documentation in the medical record is an essential component of quality patient care. Medical records should be maintained and organized in a manner that assists with communication among providers to facilitate coordination and continuity of patient care. UPMC Health Plan has adopted certain standards for medical record documentation, which are designed to promote efficient and effective treatment.

UPMC Health Plan reserves the right to obtain ongoing access to data, charts and medical record information related to UPMC Health Plan Members. The provider or provider group is required to allow UPMC Health Plan ongoing access to this information to comply with state, federal, and NCQA clinical, risk, and quality reporting requirements.

Accessing and Sharing Information

Nothing in the provider agreement, Provider Manual or UPMC Health Plan policies applicable to providers shall be construed as a gag clause that would directly or indirectly restrict UPMC Health Plan from:

- Sharing provider-specific cost or quality of care information or data, through a consumer engagement tool or any other means, with referring providers, plan sponsors, Members, or individuals eligible to become Members; or
- Electronically accessing de-identified claims and encounter information or data for each Member, upon request and consistent with the applicable federal and state privacy laws and regulations; or
- Sharing such information or data, or directing that such data be shared, with a business associate.

Providers may contact their physician account executive (PAE) or call **Provider Services** at **1-866-918-1595** to obtain additional information regarding public disclosure of price and quality data.