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.)

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 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.

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.

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.

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.

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.

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.
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	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.
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.

If your group health plan has External Grievance Review rights, your second level grievance decision notification letter will explain how to file an external appeal. If your group health plan does not have External Grievance Review rights, the decision of the Second Level Grievance Review Committee is final.

External Grievance Process. If you and/or your provider still are dissatisfied with UPMC Health Plan's decision regarding your Grievance, you, your representative, or your provider may file a request with UPMC Health Plan for an External Grievance Review within four months of receipt of the decision of the Second Level Grievance Review Committee. External Grievances are reviewed by an Independent Review Organization (IRO). External Grievances should involve a question of medical necessity, appropriateness, health care setting, level of care, effectiveness of a covered benefit, or whether a treatment or service is experimental or investigational. 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.

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 (1) you are or were covered at the time the service/item was requested; (2) if the adverse benefit determination relates to your failure to meet the requirements for coverage; (3) you exhausted internal appeals; and (4) you provided all information and forms necessary to process the External Grievance Review.

Within one day after completion of the preliminary review, UPMC Health Plan will issue a notification to you in writing as to whether your grievance is eligible for an external review. We will tell you if we need additional information to determine eligibility for an external review. If we need additional information, we will tell you what we need and allow you to submit the additional information within the four-month filing period or within the 48-hour period following your receipt of notification, whichever is later. If your Grievance is eligible for external review, we will notify you of the IRO name, address, and phone number.

You, your representative, or your provider may supply additional information to the IRO to consider within five business days of notification that your grievance is eligible for external review. The IRO will then provide this information to UPMC Health Plan within one day so that the Health Plan has an opportunity to consider the additional information as well.

Within five business days of determining that your appeal 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. At the same time, UPMC Health Plan will provide you, your representative, or your provider with the list of documents that are being forwarded to the IRO for the External Grievance Review.

The IRO will review all information provided by UPMC Health Plan and you, your representative, or your provider. The IRO will make a determination under the terms of your 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 you or your representative 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.

Complaints to a Governing Agency. If you have a complaint, the Pennsylvania Department of Health or Pennsylvania Insurance Department may be able to help you resolve the dispute.

If you are dissatisfied with UPMC Health Plan's decision regarding your second level complaint, you may have the right to file an appeal of our decision with the Pennsylvania Department of Health or Pennsylvania Insurance Department. Your appeal must be filed within 15 calendar days after your receipt of our 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.

Generally, the Department of Health reviews appeals that concern quality of care or quality of service issues, whereas the Insurance Department reviews appeals that concern problems relating to contract exclusions, coverage disputes, and other insurance-related issues, such as subrogation.

The contact information for each department is below:

- Pennsylvania Department of Health, Bureau of Managed Care, P. O. Box 90, Harrisburg, PA 17108-0090 (Toll-Free Phone Number: 1-888-466-2787)
- Bureau of Consumer Services of the Pennsylvania Insurance Department, 1209 Strawberry Square, Harrisburg, PA 17120 (1-877-881-6388)

Your request for an appeal to a governing agency should be in writing, although each agency will make staff available to transcribe an oral appeal. Each agency requires that you provide the following information when requesting an appeal:

- Your name, address, and telephone number
- Name of the managed care plan
- Your identification number
- A brief description of the issue being appealed
- A copy of the adverse decision letter that we sent to you

You also need to let the agency know if you will be represented by an attorney.

ERISA Appeal Rights. You also may 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 as to your appeal rights under that plan. Remember that you must exhaust your administrative remedies with UPMC Health Plan prior to exercising your right to file a claim in a court of competent jurisdiction under ERISA. For questions about your rights, this notice, or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

SPANISH (Español): Para obtener asistencia en Español, llame al 1-888-876-2756.
TAGALOG (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa 1-888-876-2756.
CHINESE (**中文**): **如果需要中文的帮助**，请拨打这个号码 1-888-876-2756.
NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-876-2756.

This is a printable .pdf file, available as part of the Online Welcome Kit for new and renewing UPMC Health Plan members. If you have further questions, please contact UPMC Health Plan Member Services at the telephone number on the back of your member ID card.

In this document, the terms "UPMC Health Plan" and "the Health Plan" refer 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 services are covered.

UPMC Health Plan