# UPMC Individual ***Advantage***

Note: These Complaint and Grievance procedures apply only to UPMC Individual *Advantage* policy holders.

UPMC Individual *Advantage* is a product of UPMC Health Benefits, Inc., and is administered by UPMC Health Plan.

**Resolving Disputes with the Health Plan**

At times, you may not be satisfied with a decision that the Health Plan makes regarding your coverage or with the health care services you have received. As an insured of the Health Plan, you have the right to file a complaint or grievance.

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

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

**The Complaint Process**

A complaint is different from a grievance. See separate section on grievances.

If you have a dispute or objection regarding a provider, the coverage, operations, or management policies of the Health Plan, you may submit a complaint to the Health Plan. You may submit a complaint about issues, including, but not limited to, quality of care or services, benefits exclusions, claims denials, or coordination of benefits. You may file a complaint either verbally over the phone with the Member Services Department at **1-866-353-3598 (TTY: 1-800-361-2629)** or by sending a written complaint to:

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

You may also send any other written information that you have to support your complaint. You may indicate in the complaint the remedy, resolution, or corrective action that you seek from the Health Plan.

At any time during the complaint process, you may choose to designate a representative to act on your behalf. You must notify the Health Plan in writing that you are designating someone to represent you. Also, at any time during the complaint process, upon your request, the Health Plan can make available, at no charge, a Health Plan employee to assist you or your representative in preparing the complaint. This employee will not have previously participated in any of the Health Plan's decisions regarding your complaint.

You must submit your complaint within 180 days of the date on which the incident occurred. For example, if your complaint is regarding the fact that the Health Plan did not pay a claim to a provider on your behalf, you must file the complaint within 180 days of the date of the Explanation of Benefits document that you received. The Health Plan will send you a letter to let you know that we received the complaint. A Complaint Review Committee will investigate the allegations in your complaint. The committee will notify you of its decision in writing within 30 days of receipt of your complaint. The notification letter will explain the decision of the committee.

**The Grievance Process**

Sometimes the Health Plan will not cover a requested service because it is not Medically Necessary. If you have a dispute or objection regarding a service that was denied in full or in part because it was not Medically Necessary, you may file a grievance. A grievance is different from a complaint. A grievance may be filed by you, your designated representative, or a provider who has your written consent. We will refer to a provider who has your written consent to file a grievance as "your provider." You may file a grievance either verbally over the phone with the Member Services Department at **1-866-353-3598 (TTY: 1-800-361-2629)** or by sending a written grievance to:

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

You may also send any other written information to support your grievance. You may indicate in the grievance the remedy, resolution, or corrective action that you seek from the Health Plan. At any time during the grievance process, you may choose to designate a representative to act on your behalf. You must notify the Health Plan in writing that you are designating someone to represent you. Also, at any time during the grievance process, upon your request, the Health Plan can make available, at no charge, a Health Plan employee to assist you or your representative in preparing the grievance. This employee will not have previously participated in any of the Health Plan's decisions regarding your grievance.

You must submit your grievance within 180 days of the date on which the denial occurred. For example, if your grievance is regarding denial or pre-authorization for a service, you must file the grievance within 180 days of the date of the letter you received informing you of that denial. While it is preferable that you file a grievance in writing, you may call the Member Services Department to request assistance and file a grievance orally. The Health Plan will send you a letter to let you know that we received your grievance.

A Grievance Review Committee will investigate the allegations set forth in the grievance. The committee will seek input from a physician or, where appropriate, a licensed psychologist with experience in the same or similar specialty that typically manages or consults regarding the disputed health care service. We will refer to such personnel throughout as "qualified clinical personnel." The committee will notify you of its decision within 30 days of receipt of your grievance. The notification letter will explain the decision of the committee. A copy of the decision letter will be sent to you and/or your representative and/or your provider, as applicable.

**Important Information Regarding the Grievance Process**

- Your provider may request your written consent to pursue a grievance at the time of treatment — but not as a condition of providing that treatment.
- You and your provider cannot file separate grievances regarding the same treatment or service.
- Once you give written consent to a provider to file a grievance, the provider has 10 days from the receipt of denial notification to file the grievance. Your provider does not need to inform you if and when he/she/it files the grievance; however, your provider must inform you if he/she/it decided NOT to file the grievance.
- Your consent is automatically rescinded if your provider fails to file a grievance within the appropriate time frames.
- If you wish to file a grievance, but already gave written consent to your provider, you must rescind your consent in order to proceed with your grievance.

**The Expedited Grievance Review Process**

If you believe that your life, health, or ability to regain maximum function may be jeopardized due to the delay in the time frames for an internal grievance, you may request an expedited grievance review. To request an expedited grievance review, you should contact the Member Services Department at **1-866-353-3598 (TTY: 1-800-361-2629)** and explain the need for an expedited grievance review. You must obtain written certification from your treating provider that your life, health, or ability to regain maximum function would be placed in jeopardy by the delay inherent in the regular time frames of the internal grievance process. The certification must include a clinical rationale and facts to support your provider's position. You must provide any additional information for consideration in an expedited manner so we can comply with the requirements for an expedited review. The Health Plan then will arrange to have the grievance reviewed within 72 hours. The Health Plan will inform you of the decision orally and in writing within 72 hours of receipt of the request for review, accompanied by the provider certification.

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