UPMC *for You*

Affiliate of UPMC Health Plan

2009 Member Handbook

Member Services 1-800-286-4242
TTY Services 1-800-361-2629

upmchealthplan.com

Translation services are available by calling UPMC *for You* at 1-800-286-4242/TTY 1-800-361-2629.

请拨电UPMC for You（电话：1-800-286-4242），可提供翻译服务。

[illegible] UPMC for You [illegible] 1-800-286-4242 ។

Вы можете воспользоваться услугами переводчика, позвонив в службу «UPMC *для Вас*» по телефону 1-800-286-4242.

Servicios de traducción UPMC *para Usted* están disponibles llamando al 1-800-286-4242.

Có dịch vụ thông dịch bằng cách liên lạc với UPMC *for You* tại số 1-800-286-4242.

Important Phone Numbers

IMPORTANT TELEPHONE NUMBERS AT A GLANCE

UPMC *for You* Member Services 1-800-286-4242
UPMC *for You* Member Services
TTY Line 1-800-361-2629
HealthChoices Hotline 1-800-440-3989
HealthChoices TTY Line 1-800-618-4225
MA Provider Compliance Hotline
(includes TTY services) 1-866-379-8477
UPMC Health Plan
Fraud and Abuse Hotline 1-866-372-8301
Maternity Program
(UPMC *for a New Beginning*) 1-866-778-6073
Option 5, then Option 3
UPMC *for You* Health
Management Programs 1-866-778-6073
Option 1- asthma
Option 2- diabetes
Option 4- heart disease
Voluntary Counties Hotline 1-800-485-5998
Voluntary Counties TTY Line 1-800-654-5988
Department of Public Welfare Hotline 1-800-426-2090
Department of Public Welfare Hotline
TTY Line 1-877-202-3021
UPMC *My*Health Advice Line 1-866-918-1591

Behavioral Health Services

Community Care Behavioral Health
Allegheny County 1-800-553-7499

Value Behavioral Health

Armstrong County 1-877-688-5969
Beaver County 1-877-688-5970
Bedford 1-866-773-7891
Butler County 1-877-688-5971
Cambria 1-866-404-4562
Clearfield 1-866-878-6046

Crawford	1-866-404-4561
Erie	1-866-404-4560
Fayette County	1-877-688-5972
Greene County	1-877-688-5973
Indiana County	1-877-688-5974
Lawrence County	1-877-688-5975
Mercer	1-866-404-4561
Venango	1-866-404-4561
Washington County	1-877-688-5976
Westmoreland County	1-877-688-5977

Medical Assistance Transportation Program (MATP) Offices

Allegheny County	1-888-547-6287
Armstrong County	1-800-468-7771
Beaver County	1-800-262-0343
Bedford County	1-888-338-1335
Butler County	1-866-638-0598
Clearfield County	1-800-822-2610
Crawford County	1-800-210-6226
Fayette County	1-800-321-7433
Greene County	1-877-360-7433
Indiana County	1-888-526-6060
Lawrence County	1-888-252-5104
Mercer County	1-800-570-6222
Washington County	1-800-331-5058
Westmoreland County	1-800-242-2706
Westmoreland County (Urgent Care Line for rides)	724-832-2703

Emergency Numbers

Police: _____

PCP: _____

Ambulance: _____

Pediatrician: _____

Pharmacy: _____

Poison Control: _____

Fire: _____

Emergency: **911**

Reminder

If your address changes, please call your caseworker.

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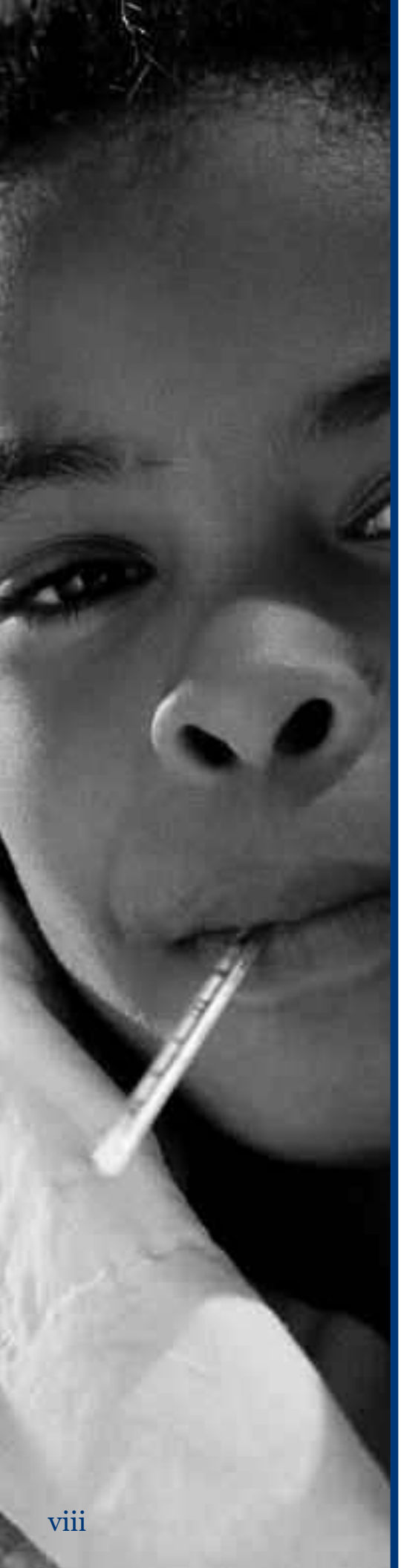


Section 7

Section 1

Section 1 Welcome

Welcome to UPMC *for You*

We would like to thank you for choosing UPMC *for You* as your health plan. This member handbook will tell you about services you can get and how to reach us. Some of these services will help to keep you healthy. Other services will help you when you have a health problem. Please use this handbook to help answer your questions as they arise.

Facts about UPMC *for You*

UPMC *for You* is a Managed Care Organization (MCO) licensed by the Pennsylvania Department of Health and the Pennsylvania Insurance Department. Through contracts with the Department of Public Welfare (DPW), UPMC *for You* offers coverage to eligible Medical Assistance recipients living in 14 counties in Western Pennsylvania.

UPMC *for You* follows the federal and state laws that affect members, such as the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the Americans with Disabilities Act (ADA).

Sign up through the Department of Public Welfare

A caseworker at your Department of Public Welfare County Assistance Office will tell you if you are able to receive Medical Assistance. UPMC *for You* does not decide if you can receive Medical Assistance. UPMC *for You* also does not decide what benefits will be covered under Medical Assistance. DPW determines whether you qualify for Medical Assistance and what benefits you and/or your family members receive. You must continue to sign up and be eligible to get Medical Assistance to stay enrolled in UPMC *for You*.

Your enrollment depends on where you live.

HealthChoices - If you live in Allegheny, Armstrong, Beaver, Butler, Fayette, Greene, Indiana, Lawrence, Washington, or Westmoreland counties, you are enrolled in the HealthChoices program.

What is HealthChoices?

HealthChoices is the name of the mandatory Medical Assistance managed care program. It is for most Medical Assistance recipients who live in one of the 10 counties listed in the previous paragraph. These recipients must enroll in one of the Department of Public Welfare's approved physical health managed care plans.

What if I don't live in one of the HealthChoices counties?

If you do not live in one of the HealthChoices counties, you have a choice of health insurance. If your county has a Voluntary physical health managed care plan, you may join it or stay on ACCESS Plus. UPMC *for You* currently services Bedford, Clearfield, Crawford, and Mercer counties.

How do I enroll?

Enrollment is completed through Affiliated Computer Services, Incorporated (ACS, Inc.), an independent enrollment assistance program. ACS, Inc., can explain what health plans are available for you to join, tell you how to choose a primary care practitioner (PCP), list behavioral health benefits and explain how to get them, and note any special needs you might have. If you live in a HealthChoices county and would like to enroll, call 1-800-440-3989. TTY users should call toll-free 1-800-618-4225. If you live in one of the voluntary counties listed in the previous paragraph, call 1-800-485-5998. TTY users should call toll-free 1-800-654-5988.

Will I get a UPMC *for You* ID card?

You will get a UPMC *for You* identification (ID) card for each member of your family who has picked UPMC *for You*. Show this ID card and any other medical insurance cards to UPMC *for You* participating providers when you get services. You still need to keep your yellow or greenish-blue ACCESS card. Do not throw it away. You may need to use your ACCESS card for other Medical Assistance services.

The UPMC *for You* ID card is a plastic card. When you get it in the mail, punch out the UPMC *for You* ID card and keep it in your wallet with your ACCESS card. See pages 53-54 for more information about your card.

How can I contact UPMC *for You*?

Just call 1-800-286-4242 and a Member Services representative will help you with your questions. TTY users should call toll-free 1-800-361-2629. Member Services representatives are available Monday through Friday from 8 a.m. to 8 p.m. and Saturday from 8 a.m. to 3 p.m.

See pages 53-55 for more information on Member Services.

What does the Web portal offer?

Staying healthy is a 24/7 task. UPMC *for You* understands there are plenty of questions when it comes to health resources, questions that can happen at any time of day or any day of the week. Our website upmchealthplan.com is designed to be your answer to these questions, to be your go-to site for health needs at all times. With a collection of online tools such as a personal health record, interactive wellness programs, and customizable searches and listings, you're just a click away from health information that's both practical and precise. User-friendly pages with health tools make our site an interesting place to visit, and explore.

Section 1 Providers

What is a primary care practitioner (PCP)?

A primary care practitioner (PCP) is your personal doctor or Certified Registered Nurse Practitioner (CRNP) who will provide or arrange all of your health care needs. Your PCP will help manage your health care needs and act as your advocate. You and your family members who are enrolled in UPMC *for You* can all have the same PCP, or you can choose different PCPs.

A PCP may be a family and general practice doctor, a pediatrician, an internal medicine doctor, or a CRNP. Family and general practice doctors treat all family members. Most pediatricians treat children and most internal medicine doctors treat adults. A CRNP is a registered nurse with advanced training in a specialty area, certified by the boards in that specialty area. A CRNP may diagnose a condition or prescribe medicine under the direction of a doctor.

Some PCP offices have other caregivers to help them. You may see a caregiver other than your PCP. Your PCP is still responsible for your care. Examples of other caregivers are nurse practitioners and physician assistants. A physician assistant (PA) is a health professional who is trained to practice medicine with physician supervision. A PA may perform physical exams, order and read lab tests, diagnose and treat illness, prescribe medicine, and counsel patients.

How do I choose a PCP?

When you joined UPMC *for You*, the person you talked to gave you information on choosing a PCP. If you did not choose a PCP when you signed up, call UPMC *for You* Member Services at 1-800-286-4242 to help you choose a PCP. TTY users should call toll-free 1-800-361-2629. Member Services representatives are available Monday through Friday from 8 a.m. to 8 p.m. and Saturday from 8 a.m. to 3 p.m. We can also give you a list of providers to help you choose the one that is right for you. Some PCPs limit the patients they treat in their office. For example, they may see only children or may no longer take new patients. A UPMC *for You* Member Services representative can tell you if a PCP has limitations.

What if I want to change my PCP?

The relationship you have with your PCP is very important. If you feel your PCP is not right for you, you can pick another PCP. Call Member Services at 1-800-286-4242 and we will help you pick a new PCP. TTY users should call toll-free 1-800-361-2629. Member Services representatives are available Monday through Friday from 8 a.m. to 8 p.m. and Saturday from 8 a.m. to 3 p.m.

When can I see my new PCP?

You can contact your new PCP immediately after calling a UPMC *for You* Member Services representative. We will send you a new UPMC *for You* ID card with the name and phone number of your new PCP. Keep your current UPMC *for You* ID card until you get your new one.

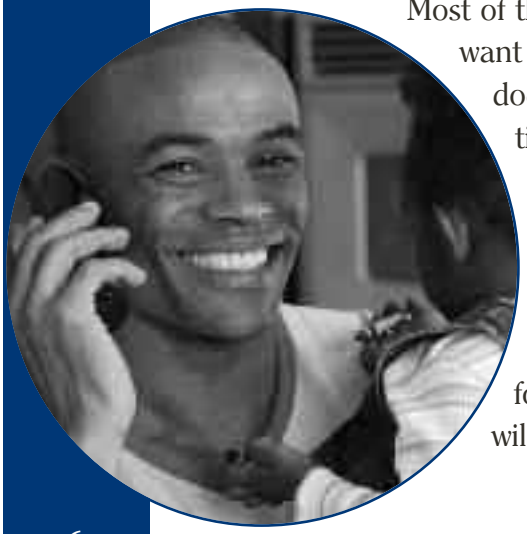
Here are some of the things your PCP can do to help manage your health care:

- Help you 24 hours a day, seven days a week, including weekends and holidays, either in person or by telephone. Your PCP will make plans for you to be able to contact him or her after hours.
- Give you checkups, shots that help prevent diseases, and treatment for most common health problems.
- Order tests and treatments.
- Refer you to a specialist.
- Coordinate other services, such as hospital admission, services in your home, or medical equipment.
- Teach you about your health problems and how to take care of yourself.

Your PCP is always the first person you should call for a routine or non-emergency health care needs. See page 10 for emergency care.

It is important that you get to know your PCP. Call and make an appointment for a visit soon after you become a member. When you make the appointment, tell your PCP if you have any medical insurance in addition to UPMC *for You*. You should give your PCP as much information as possible about your health. This includes family history, past illnesses, medicines you are taking, and any current health problems or concerns you may have. When you have to make a decision about your health care, your PCP tells you about the choices you have and helps you make the choice that is right for you.

What if I need to see a specialist?



Most of the time, you will need to see only your PCP. Sometimes your PCP may want you to see a provider who has special skills, such as a cardiologist (a doctor for heart conditions) or a dermatologist (a doctor for skin conditions). Your PCP will refer you to a UPMC *for You* participating specialist who can best treat your needs. The PCP and specialist will work together to coordinate your health care. If your health condition meets certain qualifications, you may ask your PCP to give you an ongoing referral to a specialist. If UPMC *for You* does not have a choice of at least two of the types of specialists you need in our network, arrangements will be made for you to see a non-participating specialist at no cost to you. Your PCP will contact UPMC *for You* if this happens.

Can I have a specialist as a PCP?

Yes. UPMC *for You* knows that in some cases a member's health care needs may be better met if the member has a specialist as a PCP. If you have an ongoing health condition and want a specialist to be your PCP, we can help. Call UPMC *for You* Special Needs Department at 1-800-286-4242 option 2, then option 2 again. TTY users should call toll-free 1-800-361-2629.The Special Needs staff are available Monday through Friday from 8 a.m. to 4:30 p.m.

Staff from the Special Needs Department will ask you questions about your health. Your information and request will be sent to the specialist. If the specialist agrees to be your PCP, this doctor will need to be approved as a UPMC *for You* participating PCP. Until UPMC *for You* approves the specialist as your PCP, you will have to select and use another PCP. In the meantime, we will work with you to ensure your health care needs are met.

What if I need to see an obstetrician-gynecologist (ob-gyn)?

Sometimes your PCP may want you to see a provider who specializes in women's care. An obstetrician-gynecologist (ob-gyn) is a doctor who cares for pregnant women, delivers babies, and provides women's health services such as Pap smears, annual checkups, and family planning services. An ob-gyn can also perform surgical procedures such as a D&C (removal of uterus tissue lining) or a hysterectomy (removal of uterus).

It is important for women to have an annual gynecological exam. It is also very important to see an obstetrician as soon as you think that you are pregnant. You should keep seeing your obstetrician the whole time you are pregnant and after the baby is born. You should try not to change your health coverage while you are pregnant, so you can keep seeing the same provider until you deliver your baby.

Your PCP may also want you to see an ob-gyn if you are having other health problems. You can see an ob-gyn without a referral from your PCP:

- When you are pregnant or think you are pregnant. You should see your provider or ob-gyn as soon as you can.
- When you need a yearly gynecological exam, which includes a Pap smear and a breast exam.
- For family planning services. You can see any provider, such as an ob-gyn or Planned Parenthood provider, including a provider who is not participating with UPMC *for You*, for family planning services.
- If you are having any women's health problems (i.e., infection, bleeding, sexually transmitted diseases (STD).

Your UPMC for *You* participating ob-gyn will coordinate care with your PCP as needed. See pages 35-37 for more information on services for women.

Are providers free to speak openly with me about treatment options?

UPMC *for You* supports open communication between participating providers and our members. We want our providers to talk with you about your health care options regardless of your benefit coverage limitations.

What if I want a second opinion?

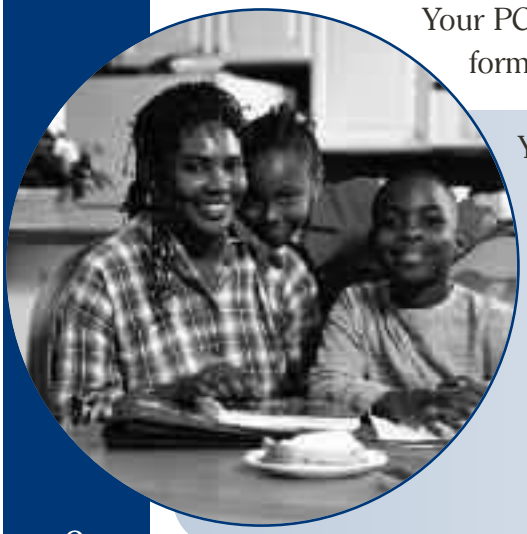
If your PCP sends you to a specialist or other provider for evaluation or treatment and you are not satisfied, you can ask for a second opinion. You have a right to a second opinion. You should call your PCP and let him or her know of your concern. Your PCP can refer you to another UPMC *for You* participating provider. If a participating provider is unable to meet your needs, you can obtain a second opinion from an out-of-network provider at no cost to you. You must contact Member Services to let UPMC *for You* know that you want to see an out-of-network provider. Please call Member Services at 1-800-286-4242. TTY users should call toll-free1-800-361-2629. Member Services representatives are available Monday through Friday from 8 a.m. to 8 p.m. and Saturday from 8 a.m. to 3 p.m.

When do I need a referral?

You need a referral from your PCP to use these services:

- Specialists, such as a cardiologist (a doctor for heart conditions), dermatologist (a doctor for skin conditions), allergist (a doctor for allergies), or surgeon
- Ophthalmologist for eye problems
- Outpatient therapy, such as physical therapy, occupational therapy, or speech therapy
- Diagnostic testing such as x-rays
- Emergency room visit for non-emergent care
- Non-participating provider

Your PCP will give you a referral to see a specialist. You will not receive a referral form. There is no cost to you when you have a referral from your PCP.



You do NOT need a referral from your PCP to see certain providers. You can self-refer. To self-refer means you can call directly to make an appointment with these types of participating providers:

- Gynecologist - for your annual well-woman exam, which includes a Pap smear, a clinical breast exam, and, depending on how old you are, a routine mammogram
- Obstetrician - if you are pregnant or think you are pregnant
- Family planning provider - you can see participating and non-participating providers for family planning services

- Chiropractor
- Dentist
- Vision provider - for routine eye exam
- Mental health or substance abuse provider

Will my PCP need to coordinate my care with other providers?

UPMC *for You* encourages your primary care practitioner (PCP) to coordinate care with other providers who are also seeing members. It is also important that your PCP and your behavioral health care provider communicate with each other to coordinate your care, especially if either provider is prescribing medication for you.

Your providers may ask you for permission to communicate with one another. Your PCP or other providers, including behavioral health providers, may ask you to sign a consent form. At that time, you may or may not agree to have your provider send information about your treatment to other providers who are seeing you. If you agree that information may be shared, your provider will send your information confidentially to the other provider and will keep a copy. Sharing your information with other providers you are seeing only helps your provider give you better, more accurate care. Please note that providers are required by law to protect medical and personal information.

Can I continue care with an out-of-network provider?

Yes. This is called Transition of Care (TOC). TOC is a process used in special circumstances to approve a member's coverage for continuing care by an out-of-network provider for a short period of time. To apply for a TOC, members must complete a Transition of Care Request Form and a Transition of Care Consent Letter. If the member is less than 18 years of age, the member or parent/guardian must initiate and sign all forms. Members can obtain these forms and receive assistance in this process by calling the Special Needs Department at 1-800-286-4242 and selecting option 2, then 2 again. TTY users should call toll-free 1-800-361-2629. The Special Needs staff is available Monday through Friday from 8 a.m. to 4:30 p.m.

What if I need emergency care?

If you have an emergency, go to the nearest emergency room, call 911, or call the local ambulance service.

What is an emergency?

A medical condition is considered an emergency when the symptoms or situation is so severe that the average person who does not have medical training could reasonably expect that not having immediate medical attention could result in: (a) serious danger to the member's health or the health of the member's unborn child, (b) loss of normal body functions, or (c) serious injury to an organ or body part.

Here are some examples of emergencies:

- Heart attack
- Severe headache (a possible sign of stroke)
- Unconsciousness
- Sudden loss of feeling or not being able to move
- Severe pain
- Chest pain
- Severe bleeding
- Poisoning
- Strong feeling that you may kill yourself or another person

The emergency room will perform an appropriate initial screening examination, at no cost to you, to determine if an emergency condition exists. If an emergency exists, the hospital will conduct additional examinations and treatments to stabilize your medical condition. If the hospital determines that you need to be transferred to another facility, they will advise you of the risks and benefits and obtain your written consent and authorization from UPMC *for You*.

You must call your PCP for any follow-up care needed after your visit to the emergency room. If you need help arranging care, please call Member Services at 1-800-286-4242. TTY users should call toll-free 1-800-361-2629. Member Services representatives are available Monday through Friday from 8 a.m. to 8 p.m. and Saturday from 8 a.m. to 3 p.m.

If you get follow-up care with someone other than your PCP without a referral, UPMC *for You* may not pay the bill. If you have questions about a bill, please call Member Services at 1-800-286-4242. TTY users should call toll-free 1-800-361-2629. Member Services representatives are available Monday through Friday from 8 a.m. to 8 p.m. and Saturday from 8 a.m. to 3 p.m.

What if I get admitted to the hospital because of an emergency?

If you have an emergency and need to be admitted to the hospital, you should let your PCP know. You should call within two days or as soon as you or your family can call. If you are admitted to a hospital that does not accept UPMC *for You* members, you may be moved to a UPMC *for You* participating hospital. You will be moved only when you are strong enough to be moved. UPMC *for You* does not cover non-emergency care in an emergency room.

You should not go to an emergency room for routine health care. Call your PCP to schedule an appointment for routine health care needs.

Here are some examples of routine health care problems:

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

Call your PCP for routine or non-emergency health care needs. If you do not go to your PCP for routine or non-emergency health care, UPMC *for You* may not pay the bill. You may be responsible for the bill. If you have any questions about a bill, please call Member Services at 1-800-286-4242. TTY users should call toll-free 1-800-361-2629. Member Services representatives are available Monday through Friday from 8 a.m. to 8 p.m. and Saturday from 8 a.m. to 3 p.m.

What if I need medical care while I am outside the UPMC *for You* service area?

If you are outside the service area and need non-emergency care, you should call your PCP. Your PCP will then get approval for any services that are medically necessary.

If you are out of the area and need emergency care, go to the nearest emergency room, call 911, or call the local ambulance service.

What if I have a non-emergency admission to the hospital?

If you need to be admitted to a hospital, it will be arranged through your PCP or specialist. UPMC *for You* must approve the admission to the hospital before you go.

There are times when you do not need an approval to be admitted. These are:

- Emergency admissions
- Admissions to a UPMC *for You* participating hospital for a routine delivery of a baby

What can I expect when I make an appointment?

PCPs and ob-gyns	
Emergency cases	must be seen immediately or referred to an emergency room
Urgent medical conditions	must be scheduled within 24 hours of request
Routine checkup	must be scheduled within 10 business days of request
Wellness (physical, wellness exam, well-child exam)	must be scheduled within 3 weeks of request
Well-woman exams	must be scheduled within 3 weeks of request
Maternity care	prenatal care appointments must be scheduled: • first trimester - within 10 business days of request • second trimester - within 5 business days of request • third trimester - within 4 business days of request • high-risk pregnancies - within 24 hours of notifying the provider of the high risk, or immediately, if an emergency exists

Your PCP and ob-gyn must be available to you 24 hours a day, 7 days a week, every day of the year. They may have an answering service or paging system that will contact them after their office has closed. Leave a phone number where the PCP or ob-gyn can call you back.

Specialists	
Emergency cases	must be seen immediately or referred to an emergency room
Urgent medical conditions	must be scheduled within 24 hours of request
Routine checkup	must be scheduled within 10 business days of request

New Members	
First examination	**For your first examination, you must be seen by:**
Members with HIV/AIDS	PCP or specialist no later than 7 days after you have become a member of UPMC *for You* unless you are already being treated by a PCP or specialist
Members who receive Supplemental Security Income (SSI)	PCP or specialist no later than 45 days after you have become a member of UPMC *for You*, unless you are already being treated by a PCP or specialist
Members under the age of 21	PCP for an EPSDT (Early and Periodic Screening, Diagnosis, and Treatment) screen no later than 45 days after you have become a member of UPMC *for You*, unless you are already being treated by a PCP or specialist and are current with screens and immunizations
All other members	PCP no later than 3 weeks after you have become a member of UPMC *for You*

If you are unable to get an appointment within the standard time frames listed above, you can file a complaint. You must file a complaint within 45 days of the date you should have had the appointment. For information about how to file a complaint, see pages 73-77.

UPMC *for You* wants to be sure you are getting health care when you need it. That is why we have standards for appointments at the provider's office. Your health care needs determine the kinds of visits you need and how soon providers should see you.

What are my appointment time frames?
How many hours per week will my PCP's office be open?

PCPs and ob-gyns must have at least 20 office hours per week.

How long will I have to wait in the office to see my PCP?

The expected waiting time is 20 minutes or up to one hour if the provider receives an unexpected urgent visit or is treating someone with a difficult medical need.

Will my provider's office be accessible for people with disabilities?

All provider offices must be accessible to people with disabilities.

Will my provider be on call?

PCPs and ob-gyns must be available 24 hours a day, 7 days a week for urgent and emergency care and to provide appropriate treatment or referrals for treatment. If a provider arranges for coverage by another participating provider, the covering provider must participate with UPMC *for You* and be available 24 hours a day, 7 days a week, as noted above for PCPs and ob-gyns.

What if my PCP takes an extended leave?

While on an extended leave, a provider must arrange for coverage by another participating provider. If the provider goes on leave for 30 days or longer, the provider must notify UPMC *for You*.

If your provider leaves our network, UPMC *for You* will try to inform you within 15 calendar days of the termination.

If you are having difficulty contacting your PCP or a provider in the UPMC *for You* network, please contact UPMC *for You* Member Services at 1-800-286-4242. TTY users should call toll-free 1-800-361-2629. Member Services representatives are available Monday through Friday from 8 a.m. to 8 p.m. and Saturday from 8 a.m. to 3 p.m.

UPMC *for You* has a large network of physicians, hospitals, and other health care providers. Our members should receive services from a participating provider, unless it is an emergency or there is an urgent need for care while out of the service area. You can find information on participating providers in the following ways:

1. Call Member Services at 1-800-286-4242, Monday through Friday, 8 a.m. to 8 p.m., and Saturday, 8 a.m. to 3 p.m. TTY users can call toll-free at 1-800-361-2629. Member Services will give you the names of a few providers in your area.

2. Or look in your UPMC *for You* provider directory to find a complete listing of providers near you. Call Member Services with your choice.

3. Or visit upmchealthplan.com. Select "Find a Provider," then select the "UPMC *for You* HMO" link to search for a provider in your area.

Section 1 Provider Directory

You can find useful information about a UPMC *for You* physician in the provider directory. This directory lists the providers' names, medical group affiliation, office addresses, phone numbers, any limitations (for example, if the physician only sees children of specific ages), hospitals the physician uses for admissions, his or her specialty, board certification, languages spoken, handicap accessibility, gender of the physician, and acceptance of new patients. You can also find information about hospitals such as their locations and accreditation status.

You can obtain assistance to receive this information in alternate format at no cost to you. See page 58 for more information.

Section 1 Utilization Management

What is utilization management?

UPMC *for You* is committed to giving appropriate care. "Utilization management" is the process of deciding what is medically necessary.

UPMC *for You* promises that:

- All decisions are based on the medical need and benefit coverage for the service requested.
- UPMC *for You* does not reward our providers or other staff who deny coverage or medical services.
- There are no financial incentives for UPMC *for You* to deny requests for medical care.

UPMC *for You* believes that no one should be limited in his or her access to necessary medical care.

Please call Member Services at 1-800-286-4242 if you have any questions. TTY users should call toll-free 1-800-361-2629. Member Services representatives are available Monday through Friday from 8 a.m. to 8 p.m. and Saturday from 8 a.m. to 3 p.m.

Do some services have to be approved by UPMC *for You*?

Yes. Some services do have to be approved by UPMC *for You* before you have the service. This is called prior authorization. You need to work with your provider to make sure that the services that may be recommended are covered and authorized.

What services must have prior authorization?

The services that must have prior authorization (approval) from UPMC *for You* are:

- Abdominoplasty/panniculectomy
- Bone growth stimulator, non-invasive
- Breast reduction (female only, excluding reconstruction for breast cancer)
- Carotid angioplasty with stenting
- Chiropractic services (members under age 13)
- Dental Anesthesia
- Endovascular Stent for Abdominal aortic aneurysm
- Enteral/parenteral feedings and nutritional supplements
- Lymphedema pumps and appliances
- Microprocessor knee (C Leg)
- Negative pressure wound therapy
- Out-of-network services
- Power-operated vehicles (purchase)

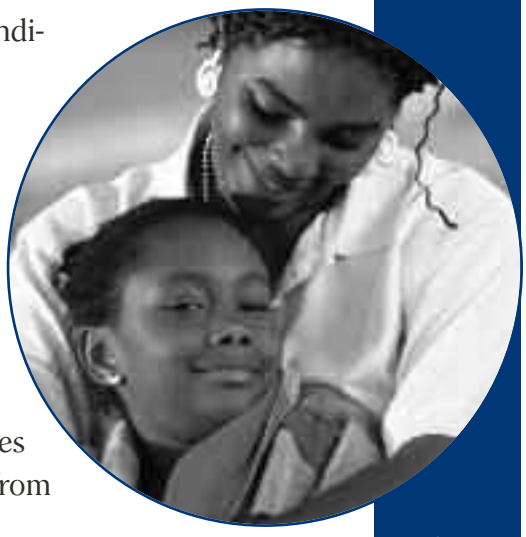
- Power wheelchairs (purchase)
- Private duty nursing (under 21)
- Prophylactic Oophorectomy
- Rhinoplasty (operation to change shape of the nose) or septoplasty (operation to correct a deformity in the nasal cavity)
- ThAIRapy Vest™
- Transplants (except corneal, which is an operation to replace clear surface on front of eye)
    - Bone marrow
    - Stem cell
    - Solid organ
- Weight-reduction surgery
- Wheelchair accessories, seating, repairs, replacement
- Hospital admissions (elective and acute; excludes deliveries)
- Rehab facility admissions
- Skilled nursing facility (SNF) admissions

The above list may not include all services that require a prior authorization. You can call our Member Services Department at 1-800-286-4242 to check on a service. TTY users should call toll-free 1-800-361-2629. Member Services representatives are available Monday through Friday from 8 a.m. to 8 p.m. and Saturday from 8 a.m. to 3 p.m. We will send you a copy of the prior authorization list upon request.

Your PCP or other provider must contact the UPMC *for You* Utilization Management Department to get prior authorization for any of these services. If you do not have approval from UPMC *for You* before getting these services, you may have to pay the bill.

How does UPMC *for You* make prior authorization decisions?

The service your provider is asking for is reviewed for medical necessity. This means we need to understand why the service is needed to treat your specific condition. All requests for service are reviewed by UPMC *for You* Utilization Management Department. If we deny any care your provider is asking for, we will send you a letter.



What if I disagree with a decision?
UPMC *for You* will send you a letter explaining why the service was denied. The letter will also tell you how to file a grievance if you are not satisfied with the decision. If you have any questions about a decision, you can call our Member Services Department at 1-800-286-4242. TTY users should call toll-free 1-800-361-2629. Member Services representatives are available Monday through Friday from 8 a.m. to 8 p.m. and Saturday from 8 a.m. to 3 p.m.

How do I contact UPMC *for You* staff with questions about the decision-making process for my care?

The Utilization Management staff is available to discuss the utilization management process and how a decision was made. Upon request, UPMC *for You* will provide the criteria used to make the decision. Inquiries can be made by calling Member Services at 1-800-286-4242, as noted on the back of your member ID card. TTY users should call toll-free 1-800-361-2629. Member Services representatives are available Monday through Friday from 8 a.m. to 8 p.m. and Saturday from 8 a.m. to 3 p.m. After normal business hours, you can leave a message on the UPMC *for You* voice mail system, and a representative will return your call on the next business day.

What if the UPMC *for You* Utilization Management Department does not respond in time to meet my needs?

The Department of Public Welfare operates a hotline to assist managed care consumers with navigating the managed care process. The Department of Public Welfare's Hotline does not provide emergency medical interventions and cannot approve or deny services. The hotline staff can be reached by calling 1-800-426-2090, Monday through Friday from 9 a.m. to 5 p.m. TTY users should call toll-free at 1-877-202-3021. See page 86 for an additional explanation of the hotline.

Will UPMC *for You* authorize care that involves new technology?

UPMC *for You* is committed to making sure that our members have access to safe and effective care. UPMC *for You* has providers and pharmacists who review new technologies, including health services, medical procedures, medical equipment, and medication treatments. These experts look at the new technologies and determine the standards for use.

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

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

If you would like more information on this matter, please contact UPMC *for You* Member Services at 1-800-286-4242. TTY users should call toll-free 1-800-361-2629. Member Services representatives are available Monday through Friday from 8 a.m. to 8 p.m. and Saturday from 8 a.m. to 3 p.m. Depending on the Medical Assistance benefit package, some members have prescription benefits and some members do not have prescription benefits.

Section 1 Prescriptions

Please see the booklet, "Your Prescription Drug Program," to get all of the details of the program. If you would like a copy, contact Member Services at 1-800-286-4242. TTY users should call toll-free 1-800-361-2629. Member Services representatives are available Monday through Friday from 8 a.m. to 8 p.m. and Saturday from 8 a.m. to 3 p.m. You can also find the booklet on our website, upmchealthplan.com. The booklet includes a formulary, which is a list of drugs that UPMC *for You* covers. The booklet also marks the drugs that require prior authorization.

Your pharmacy benefits are based on age and benefit category, which are determined by the Department of Public Welfare. You can find a brief description of prescription benefits on page 45. There is information to help you to find participating pharmacies on page 24.

Section 2

Section 2 Other Health Care Providers

Who are they and how do I get care?

Dentists

Dental benefits are administered through Doral Dental Services of Pennsylvania. These benefits are provided by a network of general dentists and dentists who provide special dental care.

A dentist is a health professional who specializes in caring for teeth, gums, and other tissues in the mouth. You can self-refer to a participating dentist for routine dental care. Specialist dentists include those who treat children and members with special needs.

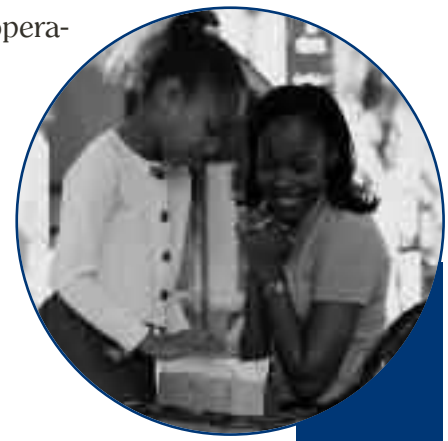
You can call Doral Dental Member Services at 1-800-508-6775 to get a dentist's name or to see what dental benefits you have. TTY users should call toll-free 1-800-466-7566. You can also get this information if you call UPMC *for You* Member Services at 1-800-286-4242 and select the number for "dental." TTY users should call toll-free 1-800-361-2629. Member Services representatives are available Monday through Friday from 8 a.m. to 8 p.m. and Saturday from 8 a.m. to 3 p.m.

Eye care providers

Vision benefits are administered through OptiCare Managed Vision. You can visit an optometrist or an ophthalmologist for care.

An optometrist performs eye examinations and can fit you for eyeglasses or contact lenses. Many optometrists also treat eye problems, (i.e. chronic eye conditions such as cataracts or glaucoma) and write prescriptions. An ophthalmologist is a medical doctor who treats eye problems and diseases. Many ophthalmologists can perform surgery and write prescriptions.

An ophthalmologist can also give eye exams and fit you for eyeglasses and contact lenses. You can self-refer to a participating optometrist or ophthalmologist for a routine eye exam. If you need to see an ophthalmologist for a problem, you need to get a referral from your PCP. If you need help finding an eye care provider or have questions about your vision benefit, call OptiCare Member Services at 1-866-458-2138. OptiCare's Member Services department hours of operation are 8 a.m. to 7 p.m. EST Monday through Friday. Members can also access provider information online at www.opticare-ehn.com/upmchealthplans/, 24 hours a day/7 days a week. You can also get this information if you call UPMC *for You* Member Services at 1-800-286-4242 and select the number for "vision." TTY users should call toll-free 1-800-361-2629. Member Services representatives are available Monday through Friday from 8 a.m. to 8 p.m. and Saturday from 8 a.m. to 3 p.m. TTY users should call toll-free 1-800-361-2629.



Home health care providers

Home health care providers are health care professionals who provide health care services to you in your home. These include nurses, home health aides, physical therapists, speech therapists, occupational therapists, and social workers.

When are services provided in my home?

Your PCP, specialist, or other provider may want you to have service in your home because this is the best way to help you get better or to help keep you from getting sicker. Your PCP or a UPMC *for You* participating specialist must order all home care services. All home care must be coordinated through your PCP and be medically necessary.

Here are some examples of when you may need home care:

- You come home from the hospital and need a nurse to teach you or a family member how to change a bandage.
- You come home from the hospital and need some physical therapy to help you become stronger.

Home care services have to be provided by a UPMC *for You* participating provider. Your UPMC *for You* participating provider will make plans for you to get these services. UPMC *for You* does not cover any personal care services such as helping you to get dressed, cleaning your house, or cooking.

Home medical equipment and supplies

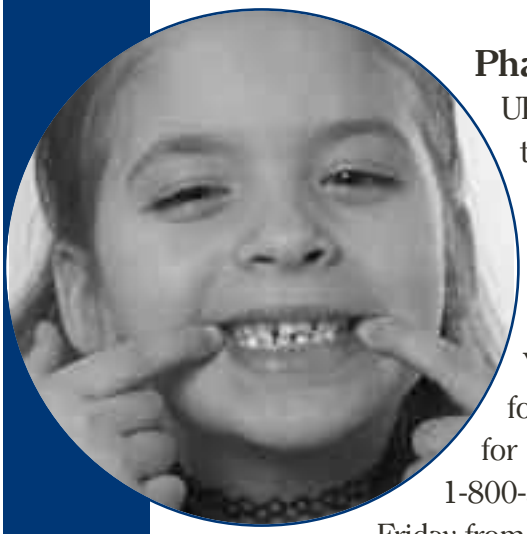
What are home medical equipment and supplies?

There is medical equipment that can be reused and supplies that are medically necessary. They help you to get better or help you to function in your everyday activities. They have to be ordered by your PCP or other providers.

Some examples of home medical equipment and supplies are:

- Hospital bed
- Walker
- Wheelchair
- Bandages

Home medical equipment and supplies have to be provided by a UPMC *for You* participating provider and be medically necessary. Your provider will make plans for you to receive these services.



Pharmacies for prescriptions

UPMC *for You* has many participating pharmacies that can fill your prescriptions. You will have pharmacy benefit coverage if the Department of Public Welfare has determined that you are eligible for this coverage. Some over-the-counter medications are covered by UPMC *for You*. See pages 45-47, for more information on pharmacy benefits.

You can call Member Services at 1-800-286-4242 and select the number for "pharmacy" to find a participating pharmacy close to you as well as for information on pharmacy benefits. TTY users should call toll-free 1-800-361-2629. Member Services representatives are available Monday through Friday from 8 a.m. to 8 p.m. and Saturday from 8 a.m. to 3 p.m.

Behavioral Health Services

Who provides behavioral health services?

UPMC *for You* does not manage your behavioral health benefits. These services are managed by a behavioral health managed care organization.

Behavioral Health – Managed Care Organizations

If you live in one of the following counties, you have behavioral health coverage with the specified behavioral health managed care organization

Community Care Behavioral Health:

Allegheny County	1-800-553-7499
TTY users	1-877-877-3580

Value Behavioral Health:

Armstrong County	1-877-688-5969
Beaver County	1-877-688-5970
Bedford County	1-866-773-7891
Butler County	1-877-688-5971
Cambria County	1-866-404-4562
Clearfield County	1-866-878-6046
Crawford County	1-866-404-4561
Erie County	1-866-404-4560
Fayette County	1-877-688-5972
Greene County	1-877-688-5973
Indiana County	1-877-688-5974
Lawrence County	1-877-688-5975
Mercer County	1-866-404-4561
Venango County	1-866-404-4561
Washington County	1-877-688-5976
Westmoreland County	1-877-688-5977
TTY users	1-877-615-8502 for all counties managed by Value Behavioral Health.

What services are provided?

Services that are covered by your behavioral health managed care organization include:

- Inpatient mental health and/or substance abuse care, including detoxification and rehabilitation
- Outpatient mental health and/or substance abuse care
- Partial hospitalization
- Drug and alcohol counseling
- Residential treatment
- Community-based services such as case management, crisis services, and in-home treatment

Depending on your county of residence, additional supplemental services may also be covered. Check with your provider or behavioral health managed care organization's member services department for details.

Some behavioral health services you may need are covered by UPMC *for You*. They are:

- Emergency care
- Consults by a medical provider while you are in a behavioral health hospital
- Emergency and medically necessary ambulance services
- Home care related to a behavioral health need
- Prescriptions written by a behavioral health provider, if you have prescription coverage
- A few specific medically necessary services not covered by Medical Assistance for members age 20 and under (see Early and Periodic Screening, Diagnosis and Treatment Services [EPSDT] on pages 31-32)

Your PCP does NOT need to give you a referral for these behavioral health services. Your PCP and behavioral health provider will coordinate your care when needed.

How do I get behavioral health services?

Call the behavioral health managed care organization listed for the county in which you live (see page 25). The behavioral health managed care organization is responsible for managing your behavioral health benefits. They can help you make an appointment and can give you a list of the providers you can see.

UPMC *for You* can work with your behavioral health managed care organization to coordinate your care.

Section 3

Section 3 Managing Your Health

UPMC *for You* is very interested in helping you be as healthy as you can. There are many routine services and tests for children and adults that are important to have on a regular basis to help keep you healthy or to identify problems early. For our members with ongoing medical conditions such as asthma, diabetes, or heart conditions, there are routine tests and treatments that can help you manage your condition. UPMC *for You* has programs that can help you manage your health care. In the sections below please find more information on routine preventive services and care management programs that can help you maintain good health.

Preventive services

What are preventive services?

Preventive services can help keep you well. Preventive services include more than just seeing your PCP once a year for a checkup. They also include immunization (shots), lab tests, and other tests that can help your PCP or other provider know that you may have a problem.

Where do I go for preventive services?

Go to your PCP for preventive services. Women can also go to a UPMC *for You* participating ob-gyn for their yearly Pap smear, pelvic exam, and mammogram. Routine physical appointments usually take longer to schedule. Call far enough in advance of the time you would like to schedule an appointment that is convenient for you. The standards for getting appointments are listed on pages 12-13.

The following are some important preventive services you should know about.

Physical exam

See your PCP at least once a year. When you go for a physical exam, your PCP will ask you questions about your medical history and your family's medical history. This is important because sometimes you may have a greater risk of having a disease if someone in your family had it. Your PCP will also check your height, weight, and blood pressure.

You can help your PCP by making a list before your appointment. The list should include:

- Any serious health conditions someone in your family has or had – this includes high blood pressure, cancer, diabetes, kidney disease, or heart disease.
- Any past surgery you have had and when it was performed.
- Any serious health condition you have or had; give dates if you can remember them.
- The names of any other providers you are seeing now.
- If you have just changed your PCP, the name, address, and phone number of your other PCP; your new PCP will need a copy of your medical records to plan the best treatment for you.

- Any prolonged feelings of sadness, depression, or anxiety.
- Any medications you are taking now. Don't forget any over-the-counter medicines or herbs. Write down the name of the medications, the dosage, and how often you take them. If you have trouble reading the label, bring your prescription bottles to your appointment with you.
- Any immunizations (or shots) you have had and the dates if you know them. If you are bringing your child to see your PCP, bring the child's immunization (shot) record or baby book.
- Any other medical insurance coverage you have.
- The date of your most recent Pap smear, mammogram, or colonoscopy exam.
- Any allergies you have to drugs, foods, or other things such as pets.
- Any important health care concerns you have that you want to talk to your PCP about during your appointment.

Blood work and other tests

Based on your age, medical history, and the results of your physical exam, your PCP or other providers may order some tests. This might be blood work to check your cholesterol level or blood sugar, a cardiogram (EKG) to check your heart, or other tests.

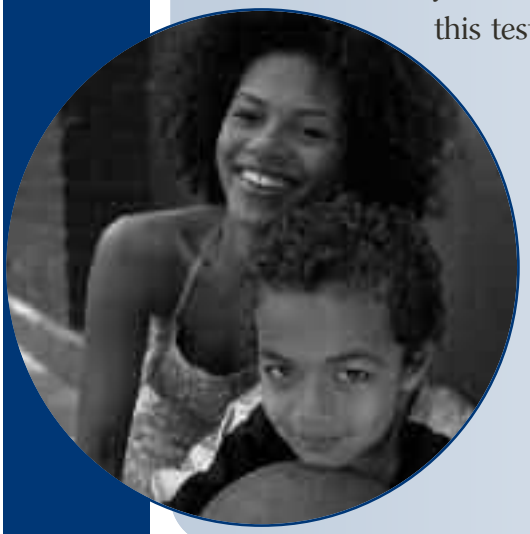
Preventive screening tests can help you and your PCP find out early if you have a disease or health condition. Sometimes early treatment can save your life. Here are some examples of preventive screening tests:

For Children

- Lead screening blood test. This test helps to identify children who may have a high lead level in their blood. If children have too much lead in their blood, it can stop them from growing and developing. A child should have a blood lead screening test by the time the child is one year old and again before the age of two years old.

For Women

- Pap smear and pelvic exam. This test helps to identify cancer of the cervix in women. Women should get a Pap smear at least every one to three years starting at age 18 or when they become sexually active. Ask your PCP when and how often you should have this test.



- Mammogram. This test helps to identify breast cancer. Women should get a mammogram every year starting at age 40.
- Chlamydia screening. Chlamydia infection is a curable sexually transmitted disease (STD). Because a Chlamydia infection does not make most people sick, you can have it and not know it. The infection may move inside the body if it is not treated, where it can cause very serious illnesses. All pregnant women should be tested for Chlamydia. All sexually active females who are 25 or younger should have a yearly screening. Women older than 25 should also have a screening done once a year if they have one or more of the following risk factors:

- New or multiple sex partners
- Prior history of cervical ectopy
- Inconsistent or no use of barrier contraceptives
- Prior history of sexually transmitted disease

For Men and Women

- Cholesterol blood test. This test tells you your risk for heart disease. You should have this test every five years after the age of 20 years old. Your doctor may want you to have it more often if you are a high risk.
- Colonoscopy. This test helps to detect colon cancer. You should have this test if you are age 50 or older. You may need to have this done earlier if you have a family history of colon cancer or are at a high risk. Ask your PCP when and how often you should have this test.
- Fecal occult blood screening. This is a test for hidden blood in the stool. The presence of such blood could be a sign of cancer. You should have this test annually if you are at high risk for colon cancer. If you are at average risk for colon cancer, you should have this test annually, beginning at age 50. Talk to your PCP to find out when you should have this screening.
- Sigmoidoscopy. This test helps detect colon cancer. If you are at high risk for colon cancer, you should have this test. If you are at average risk for colon cancer, a sigmoidoscopy is recommended beginning at age 50. Your PCP may recommend a colonoscopy instead of the sigmoidoscopy. Discuss with your provider which option is better for you. If you are age 65 or older, a colonoscopy is recommended.

Immunizations

Immunizations are shots that your PCP can give adults and children to help protect them from diseases or from getting sick. Some shots are for measles, mumps, pneumonia, or the flu.
It is very important for all children to get all their shots even though they are feeling fine. Some immunizations (shots) need to be given only once. Others need to be given at certain times as your child grows. Talk to your PCP to find out which immunizations (shots) your child may need.

Services for children and young adults from birth to age 20

What is an Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) exam?

An EPSDT exam is a comprehensive physical exam along with tests. Members from birth up to and including the age of 20 can get these services. The exam will help in the early identification of any physical or behavioral health care problems. It also looks at growth and development, dental care, vision, immunizations (shots), and lab tests that may be needed.

Your PCP will do the following during the EPSDT exam:

- Perform an unclothed physical exam and take a medical history
- Check eyes for vision problems and to determine if glasses are needed
- Check oral health and take a dental history. Check teeth for any dental problems and refer the child to a dentist
- Check ears for hearing problems
- Measure height, weight, and BMI to see if the child is growing and developing properly and to screen for obesity
- Check blood pressure on older children
- Check for any medical or psychosocial/behavioral health problems and perform Autism and Developmental screenings
- Give the child immunizations (shots) they may not have had or need
- Order blood tests to be sure the child is healthy, including testing for anemia, dyslipidemia, and blood lead screenings to test if the child has too much lead in his or her blood
- Refer the child to a specialist, if needed, for conditions such as sexually transmitted diseases, sickle-cell anemia, and other blood diseases
- Order any special equipment, services, or other testing, if needed
- Schedule another visit to follow up with the PCP, if needed
- Screen and/or counsel for tobacco, alcohol, and substance abuse starting at age 14
- Perform a urinalysis screening, if needed
- Perform a tuberculosis (TB) screening

How often should an EPSDT exam be done?

A child should have EPSDT exams regularly based on his or her age. Babies need to go several times in one year. Children ages 6 to 20 need to go once a year. Your PCP will tell you when your children need to come in for another EPSDT exam.

Who does an EPSDT exam?

Your PCP or other provider will do an EPSDT exam. Call your PCP or other provider to schedule an EPSDT exam for any UPMC *for You* member in your family who is 20 years old or younger.

How can I remember when to have an EPSDT exam?

To help remind you that an EPSDT exam is due, UPMC *for You* representatives may call or send you a letter letting you know to schedule an EPSDT exam. They can help you make an appointment with your PCP or other provider. If you have any questions about EPSDT, call UPMC *for You* Member Services at 1-800-286-4242. TTY users should call toll-free 1-800-361-2629. Member Services representatives are available Monday through Friday from 8 a.m. to 8 p.m. and Saturday from 8 a.m. to 3 p.m.

Expanded Services

What are expanded services?

Expanded services are services that are medically necessary to treat you but may not be covered under Medical Assistance. Examples of expanded services are some special equipment items, private duty nursing, and nutritional supplements.

Who can get expanded services?

Any member from birth up to the age of 20 is able to get expanded services.

How do I get expanded services?

If you or your child is age 20 or younger, your PCP or other provider must call the UPMC *for You* Utilization Management Department at 1-800-242-3544. TTY users should call toll-free 1-800-361-2629. The Medical Review Department is open from 8 a.m. to 4:30 p.m., Monday through Friday. The provider will give UPMC *for You* information about the service needed. The provider needs to tell us why the service is medically necessary. If the service is medically necessary, our staff will work with you and help you get the services you need. See pages 16-17 for more information about prior authorization.

Early Intervention Program

What is the Early Intervention Program?

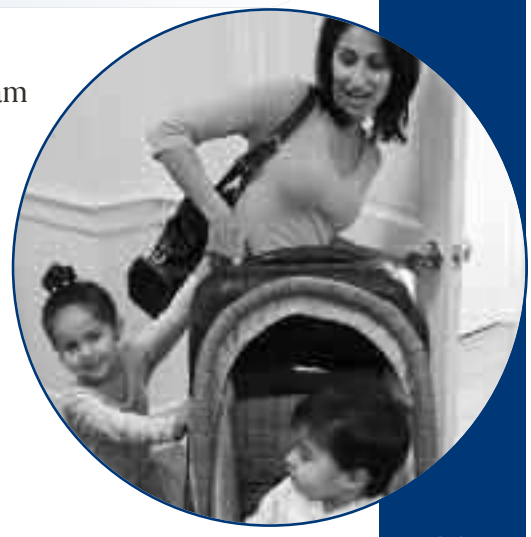
The Early Intervention Program is for children from birth to five (5) years of age who have high-risk health problems. The Early Intervention Program helps children to grow and develop.

Examples of children who are high-risk and could be helped by Early Intervention services are:

- Babies who are born small or early and need special care
- A child up to the age of three (3) who is not growing or developing as quickly as he or she should
- Children who have high levels of lead in their blood

How do I get Early Intervention services?

Your PCP or other provider can refer you to the Early Intervention Program through an agency called CONNECT. If you have any questions or think the Early Intervention Program can help your child, call the UPMC *for You* Member Services Department at 1-800-286-4242 and select the "special needs" prompt. TTY users should call toll-free 1-800-361-2629. Member Services representatives are available Monday through Friday from 8 a.m. to 8 p.m. and Saturday from 8 a.m. to 3 p.m. Staff of the Special Needs Department can explain the Early Intervention Program and assist you with enrolling if needed.



Health Management Programs

What is a health management program?

A health management program helps people with a certain disease or condition manage their health care. A nurse can help educate you on how to take better care of yourself and to understand your disease or condition. By following your provider's plan of care and learning about your disease or condition, you can stay healthier.

Does UPMC *for You* have any health management programs?

Yes. UPMC *for You* has several health management programs.

They are:

- Asthma
- Cardiovascular heart disease (high cholesterol, coronary artery disease, high blood pressure, and congestive heart failure)
- Diabetes
- Maternity

A member can be enrolled in a health management program without a referral from his or her PCP or other provider. The UPMC *for You* health management programs are reviewed and approved by a committee of UPMC *for You* participating providers. These providers are experts in health care.

How can I learn more about a health management program?

Call the Health Management Department at 1-866-778-6073 Monday through Friday from 8:00 a.m. to 4:30 p.m. TTY users should call toll-free 1-800-361-2629. The staff will be happy to answer your questions.

Quit Smoking Programs

Cigarette smoking can lead to health problems such as asthma and other lung problems, heart attacks, strokes, and cancer. Babies whose mothers smoke while pregnant may be born less healthy than babies whose mothers did not. Breathing secondhand smoke is also not healthy for infants and young children. If you smoke and are ready to quit, UPMC *for You* can help.

Smoking cessation aids, with the exception of Zyban, are available to all members. Medicines such as the nicotine patch and nicotine gum help reduce withdrawal symptoms. Other medicines can also help make quitting easier. Call your PCP or other provider to learn more about them. Members may also attend free smoking cessation classes at Giant Eagle. Enroll in a class near your home by calling 1-800-804-0950. TTY users should call toll-free 1-877-345-7948. Other help is available. Pennsylvania's toll-free Quitline (1-877-724-1090) gives information and telephone counseling that can help smokers quit. TTY users should call toll-free1-866-228-4327. The

Quitline is available 24 hours a day, 7 days a week. If you have Internet access, type in http://www.dsf.health.state.pa.us/health/cwp/view.asp?A=174&Q=236582 to get a list of programs in your county at no cost to you.

Women's Care

UPMC *for You* covers many services for women. It is very important for women to get yearly checkups. Women should see an obstetrician as soon as they think they are pregnant, regularly during the pregnancy, and after the baby is born. Some of the services available to women are described below.

Family Planning Services

What are family planning services?

These are services that help you to plan your family. It is important for women to talk to a health care provider who can help them decide how to plan their family. A visit to a family planning provider will include a health exam. You and your provider will decide which method of birth control is best for you. You may be given a prescription for birth control. If you have pharmacy coverage, you can take your prescription to any UPMC *for You* participating pharmacy.

Where can I go for family planning services?

You can see participating or non-participating providers for family planning services. You do not need a referral to see a family planning provider. Just call and make an appointment. This is one service for which you can use a non-participating provider without prior authorization from UPMC *for You*.

If you need help finding a UPMC *for You* participating provider for family planning services, call Member Services at 1-800-286-4242. TTY users should call toll-free 1-800-361-2629. Member Services representatives are available Monday through Friday from 8 a.m. to 8 p.m. and Saturday from 8 a.m. to 3 p.m.

Care When Pregnant

What do I do if I am pregnant or think I am pregnant?

UPMC *for You* wants every woman to have a healthy baby. Seeing an obstetrician as soon as you think you are pregnant and staying with the same obstetrician once your pregnancy has been confirmed are very important. These are the first and most important steps to having a healthy baby. You do not need a referral to see an obstetrician. Just call and make an appointment with a UPMC *for You* participating obstetrician.

If you need help finding an obstetrician, call UPMC *for You* Member Services at 1-800-286-4242. TTY users should call toll-free 1-800-361-2629. A Member Services representative can help you.

How often do I need to see the obstetrician?
Your obstetrician will tell you how often you need to come in for prenatal care. The number of visits may be different for each woman depending on the pregnancy.

You should be seen at least at the following times during your pregnancy:

- First trimester (first three months) - at least one time
- Second trimester (months four to six) - every month
- Third trimester (months seven to delivery) - every one to two weeks
- After delivery - six weeks after your baby is born

Keeping appointments helps your provider tell how you and your baby are doing. Sometimes you may need to be seen more often. It is important to keep all of your appointments. This will help you have a healthy baby.

Are there any special services for pregnant women?
Yes. To help you during your pregnancy and to help you have a healthy baby, certain special services are covered.

Here are some of those services:

- Childbirth (Lamaze) classes
- Childbirth refresher class
- Breastfeeding (lactation) class
- Breast pump (after delivery)
- Prenatal parenting class
- Prenatal exercise class
- Stop smoking class
- Home visit by a nurse to check on you during your pregnancy
- Home visit by a nurse to check on you and your baby after you come home from the hospital
- Maternity health management program
- UPMC *for a New Beginning* Car Seat program

Is there a special program for pregnant women?
Yes. UPMC *for You* has a maternity program, UPMC *for a New Beginning*, for pregnant women. The program has nurses who will call you and help you get the care and services you need. They will also answer questions about your pregnancy. The nurses will work with your obstetrician if you are having any problems with your pregnancy. If you are pregnant, you can call 1-866-778-6073 and select option 5. A nurse can tell you more about the program. TTY users should call toll-free 1-800-361-2629. The Maternity Health Management Department is open Monday through Friday from 8 a.m. to 4:30 p.m.

Direct Access to Women's Care

One of the goals of UPMC *for You* is to make women's care easier for our female members. Women can go directly to a participating ob-gyn for an exam. UPMC *for You* will pay for a woman to get a Pap smear, pelvic exam, breast exam, and mammogram according to her benefits. You can also see your ob-gyn if you have any other women's care needs throughout the year. It is important for you to have a good relationship with your ob-gyn. Your ob-gyn can help keep you healthy, as well as provide treatment when you are sick.

Women's Health and Cancer Rights Act

Since October 1998, federal law has required that insurance companies give benefits for reconstructive surgery after a mastectomy. This law allows members who have a mastectomy to have breast reconstruction. UPMC *for You* pays for reconstruction after a mastectomy.

Examples of these procedures are:

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

Pennsylvania law requires that coverage for a mastectomy include home visits by a health care provider within 48 hours of being sent home from the hospital, when this occurs less than 48 hours from the admission.

These arrangements must be made between the member and her provider.

Women, Infants, and Children Program (WIC)

What is WIC?

WIC is a program that provides certain foods for pregnant women and for young children under age five (5). Pregnant women and their young children can receive milk, formula, cereal, bread, juice, eggs, and cheese at no cost to them. Eating right during your pregnancy is very important to having a healthy baby. WIC can also help you get healthy food for other young children you may have.

How do I get WIC?

You need to fill out a WIC application and have your provider sign it. You can ask your obstetrician about a WIC application at your visit. You can also ask a UPMC *for You* maternity program nurse or call Member Services at 1-800-286-4242 and select the "special needs" prompt. TTY users should call toll-free 1-800-361-2629. Member Services representatives are available Monday through Friday from 8 a.m. to 8 p.m. and Saturday from 8 a.m. to 3 p.m.

HIV/AIDS Services

Are there special services for HIV/AIDS?

Yes. Members with HIV/AIDS may need some extra services in their home or in the community to help them. These services are called AIDS Waiver services. Any member with AIDS or symptomatic HIV is eligible for AIDS Waiver services.

Examples of these services are:

- Skilled nursing visits above what is covered by regular Medical Assistance
- Home health aide above what is covered by regular Medical Assistance
- Homemaker services, which are non-medical services to help you if you cannot do many of the things needed every day due to your illness, for example, bathing, dressing, light housekeeping, preparing meals, doing dishes, or grocery shopping
- Supplies and nutritional supplements
- Nutritional education with a registered dietitian

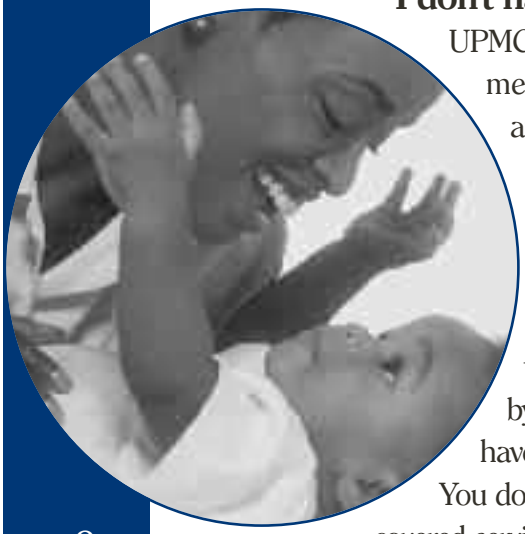
How do I get AIDS Waiver services?

Your PCP or other provider can order AIDS Waiver services for you. A UPMC *for You* participating provider will perform the services. Nutritional supplements and homemaker services must have prior authorization by UPMC *for You*. Your PCP or other provider will call the UPMC *for You* Medical Review Department to request an authorization for nutritional supplements or homemaker services for you.

Are there specialists who are trained to treat HIV/AIDS?

Yes. Your PCP can evaluate and treat you for HIV/AIDS. Your PCP may refer you to a specialist who can also help treat you. You can talk to your PCP about a specialist who may meet your needs. You can also call UPMC *for You* Member Services at 1-800-286-4242 for information on participating HIV/AIDS specialists. TTY users should call toll-free 1-800-361-2629. Member Services representatives are available Monday through Friday from 8 a.m. to 8 p.m. and Saturday from 8 a.m. to 3 p.m.

Routine Transportation for Appointments



I don't have my own transportation. How do I get to my appointment?

UPMC *for You* knows it is very important for you to get to health care appointments. It is important for you to receive the care you need in the right place at the right time.

You should arrange for routine transportation for health care services through the Medical Assistance Transportation Program (MATP). The MATP program has several ways to help you get routine transportation to services that are covered by UPMC *for You*. This includes bus fare, paying you or a family member to drive to your appointment, or sharing a ride with others in a vehicle provided by MATP. MATP may provide door-to-door transportation for people who do not have a car or who are physically or emotionally unable to use public transportation. You do not need to pay for MATP transportation to medical offices and providers' covered services. UPMC *for You* does not cover transportation to other places.

How can I get MATP services?

You must register with the MATP office in your county in order to get transportation. It can take up to 10 days to register, so plan ahead. Call the MATP office in your county to register. Telephone numbers are listed on the next page. You may also call UPMC *for You* Member Services at 1-800-286-4242 to get more information on MATP or other transportation means. TTY users should call toll-free 1-800-361-2629. Member Services representatives are available Monday through Friday from 8 a.m. to 8 p.m. and Saturday from 8 a.m. to 3 p.m.

Medical Assistance Transportation Program (MATP)

County	Telephone Number	County	Telephone Number
Allegheny County	1-888-547-6287	Fayette County	1-800-321-7433
Armstrong County	1-800-468-7771	Greene County	1-877-360-7433
Beaver County	1-800-262-0343	Indiana County	1-888-526-6060
Bedford County	1-888-338-1335	Lawrence County	1-888-252-5104
Butler County	1-866-638-0598	Mercer County	1-800-570-6222
Clearfield County	1-800-822-2610	Washington County	1-800-331-5058
Crawford County	1-800-210-6226	Westmoreland County	1-800-242-2706
Urgent Care Line for rides	724-832-2703		

Does UPMC *for You* cover any transportation?

UPMC *for You* covers only medically necessary transportation.

Examples are:

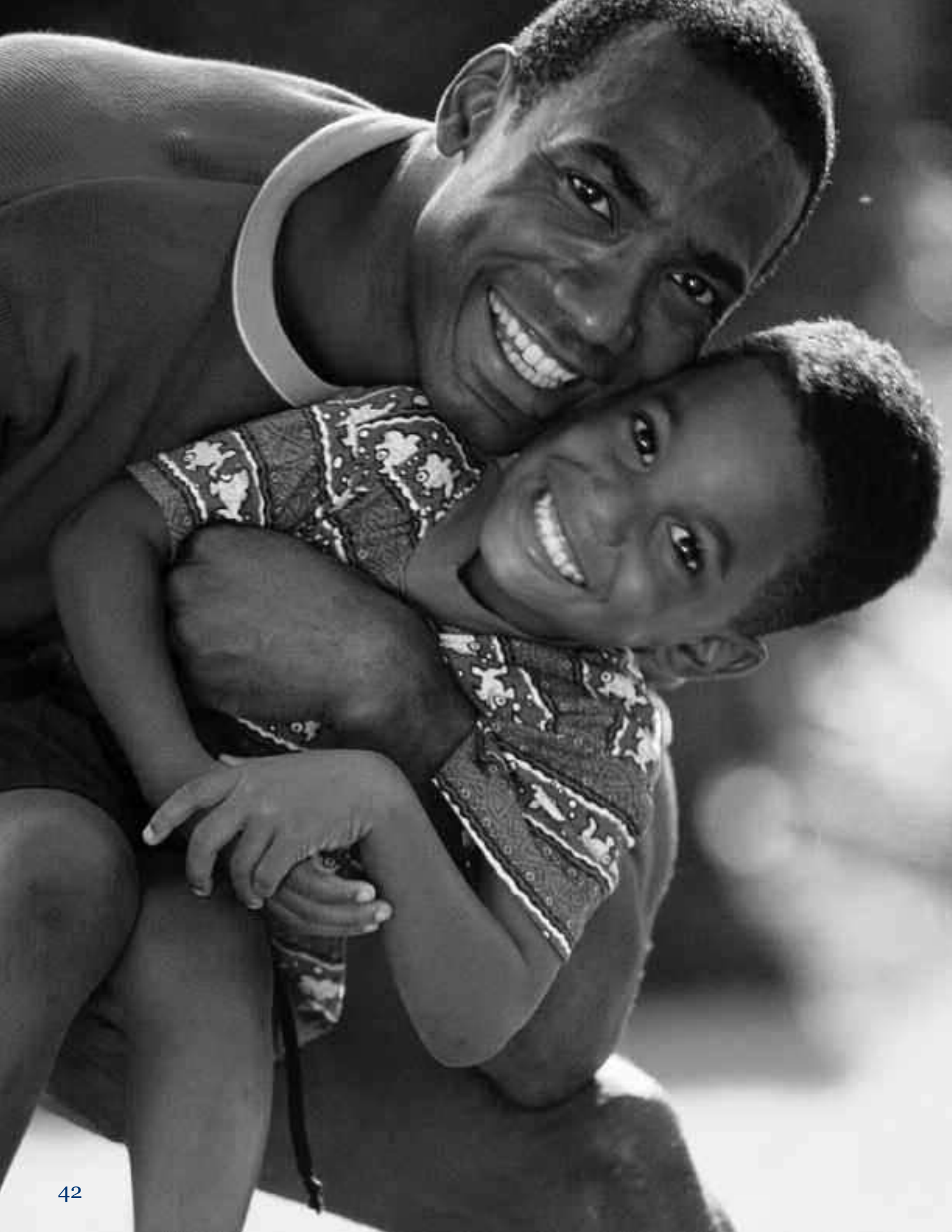
- Transporting you from one hospital to another
- Transporting you from an emergency room to another hospital because you need services that another hospital has to provide

Your UPMC *for You* participating provider or behavioral health provider will coordinate this medically necessary transportation for you.

Is emergency transportation covered?

Yes. If you have an emergency, go to the nearest emergency room, call 911, or call the local ambulance service. In case of an emergency, UPMC *for You* covers the ambulance.

Section 4



Section 4 Benefits

What benefits do I have as a UPMC *for You* member?

As a member of UPMC *for You*, you receive all the medical benefits covered by your ACCESS card. Your health care benefits are based on age and benefit category, which are determined by the Department of Public Welfare. UPMC *for You* members pay no copayments and submit no claim forms for medical benefits; however, members may have pharmacy copayments (see page 46).
If you receive a bill for service or have questions about a bill, please call Member Services at 1-800-286-4242. TTY users should call toll-free 1-800-361-2629. Member Services representatives are available Monday through Friday from 8 a.m. to 8 p.m. and Saturday from 8 a.m. to 3 p.m.

What services are covered?

Listed below are some of the services that are covered:

Medical services

- Visits to your PCP or other provider's office
- Visits to a specialist's office with a referral from your PCP
- Services while you are in the hospital
- Yearly physical exam
- Well-child exam, including regular checkups and immunizations (shots)
- Allergy tests and shots
- Laboratory tests, x-rays, cardiograms, and other diagnostic tests
- Physical therapy
- Occupational and speech therapy
- Cancer treatments
- Kidney dialysis
- Home health care services when ordered by your provider
- Medical equipment and supplies
- Chiropractic services
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) – medically necessary expanded services for children age 20 and under
- Hearing aids for children age 20 and under

Emergency services

- Care in emergency room both in and out of the service area
- Admission to the hospital due to an emergency condition, in and out of the service area

Hospital services

- Hospitalization, including a semi-private room (a private room is covered if called for by a medical condition), inpatient drugs, and physician services
- Outpatient surgery
- Inpatient and outpatient anesthesia

Skilled nursing services

- Medically necessary services provided in a skilled nursing facility (If you need these services for more than 30 days, the Fee-for-Service (ACCESS) program will pay for these services.)
- Diagnostic tests and therapies

Dental services

A member's dental coverage includes, but is not limited to, the following:

Full Benefits:

- Two (2) routine exams per year, including x-rays
- Two (2) cleanings per year
- Emergency care
- Fillings
- Extractions
- Dental Anesthsia - requires prior authorization
- Dentures – requires prior authorization
- Root canals/crowns/periodontal work – requires prior authorization
- Braces (for those under the age of 21 who qualify) – requires prior authorization

Partial (limited) Benefits:

- Two (2) routine exams per year, including x-rays
- Two (2) cleanings per year
- Dental Anesthsia - requires prior authorization
- Emergency care
- Fillings
- Extractions (teeth cannot be impacted and must be fully erupted)

To find out if you have full or partial (limited) dental benefits, please contact Member Services at 1-800-286-4242. TTY users should call toll-free 1-800-361-2629. Member Services representatives are available Monday through Friday from 8 a.m. to 8 p.m. and Saturday from 8 a.m. to 3 p.m.

Vision services

For members age 21 and older:

- Routine vision exam once a year
- $100 toward frames and lenses or toward contact lenses per year
- Glasses or contact lenses to treat cataracts or aphakia (medical condition)
- Specialist eye exam with referral from PCP

For members age 20 and younger:

- Routine vision exams twice a year
- $100 toward frames and lenses (2 frames and 4 lenses per year) or toward contact lenses
- Replacement of eyeglasses or contact lenses if they are broken or lost or if prescription changes, provided written documentation of the necessity of the service is submitted by the provider
- Glasses or contact lenses to treat cataracts or aphakia (medical conditions)
- Eyeglasses and all other vision services deemed medically necessary, provided written documentation of the necessity of the service is submitted by the provider

Pharmacy services

Members who receive full pharmacy coverage as part of their Medical Assistance benefit package will receive:

- Prescription drugs, including birth control pills/family planning supplies
- Some over-the-counter medicines with a provider's prescription
- Over-the-counter vitamins with a provider's prescription

Members who recieve partial (limited) pharmacy coverage as part of their Medical Assistance benefit package will receive:

- Some over-the-counter medicines with a provider's prescription
- Over-the-counter vitamins with a provider's prescription
- Family planning supplies/birth control pills

Do some prescription drugs have to be approved by UPMC *for You*?

Yes. Some prescription drugs have to be approved by UPMC *for You*. This is called "prior authorization." Decisions to approve or deny will be made within 24 hours.

If a decision cannot be made, you will receive one of the following:

- A 15-day supply of medication if your prescription qualifies as an ongoing medication
- A 72-hour supply of medication if you have an immediate need for it

If your PCP or other provider prescribes a drug for you, you can get it filled at any UPMC *for You* participating pharmacy. Take the prescription form and your UPMC *for You* ID card to the pharmacy. If you need help in locating the nearest participating pharmacy, finding out whether your prescription requires prior authorization, or obtaining more information on pharmacy benefits, call Member Services toll-free at 1-800-286-4242 and select the number for pharmacy services. TTY users should call toll-free 1-800-361-2629.

Please see the UPMC *for You* booklet, "Your Prescription Drug Program," for more information on your prescription drug program and coverage. The booklet includes a formulary, which is a list of drugs that UPMC *for You* covers, and marks the drugs that require prior authorization. If you would like a copy, contact Member Services at 1-800-286-4242. TTY users should call toll-free 1-800-361-2629. Member Services representatives are available Monday through Friday from 8 a.m. to 8 p.m. and Saturday from 8 a.m. to 3 p.m. You can also find the "Your Prescription Drug Program" booklet on our website at upmchealthplan.com.

Using a computer connected to the Internet, take these steps:

① Go to upmchealthplan.com.
② Select "Members" at the top of the page.
③ Select "Medical Assistance."
④ Select "Benefits Information" on the left side of the page.
⑤ Select "Pharmacy."

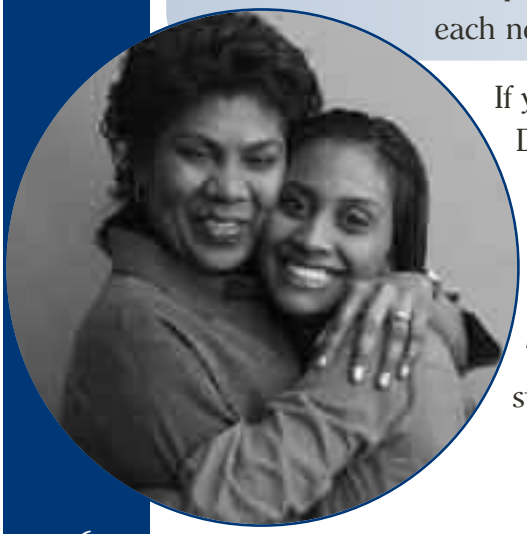
What pharmacy copayments do I have as a UPMC *for You* member?

If you have pharmacy benefits, some drugs have a copayment. A copayment is an amount that you pay to the pharmacist when you receive your prescription or over-the-counter drugs.

Pharmacy copayments do not apply to pregnant women, recipients under the age of 18, nursing facility residents, members who reside in an Intermediate Care Facilities for the Mentally Retarded and Other Related Conditions (ICF/MR/ORCs). Pharmacy copayments also do not apply to emergency supplies, family planning supplies, and recipients eligible under the Breast and Cervical Cancer Prevention and Treatment Program, Title IV-B Foster Care and IV-E Foster Care and Adoption Assistance.

Information for members in the General Assistance Benefit category with pharmacy benefits:

- Brand-name prescription drugs and brand-name over-the-counter drugs are $3 for each new prescription or refill.
- Generic prescription drugs and generic over-the-counter drugs are $1 for each new prescription or refill.



If your copayments between January and June or between July and December are more than $180, UPMC *for You* will automatically refund the amount that is over $180. You will receive a rebate check from UPMC *for You* for the amount that is over $180. Rebate checks will be mailed within four (4) to six (6) weeks after each six-month period. You cannot be denied a prescription drug if you cannot pay the copayment. Tell your pharmacist if you cannot afford to pay. Your pharmacist can still try to collect the copayment.

Information for members in the Adult Benefit category with pharmacy benefits:

- Brand-name prescription drugs and brand-name over-the-counter drugs are $3 for each new prescription or refill.
- Generic prescription drugs and generic over-the-counter drugs are $1 for each new prescription or refill.

You do not have to pay a copayment for certain drugs, such as anti-hypertensives (high blood pressure drugs), anti-neoplastics (cancer drugs), anti-diabetics (diabetes drugs), anti-convulsants (epilepsy drugs), cardiovascular preparations (heart disease drugs), anti-Parkinson's agents (Parkinson's disease drugs), AIDS-specific agents, anti-glaucoma agents (glaucoma drugs), anti-psychotics (drugs for psychosis), and anti-depressants (drugs for depression). Drugs, including immunization (shots), dispensed by a physician, are excluded from copayments.

If your copayments between January and June or between July and December are more than $90, UPMC *for You* will automatically refund the amount that is over $90. You will receive a rebate check from UPMC *for You* for the amount that is over $90. Rebate checks will be mailed within four (4) to six (6) weeks after each six-month period.

You cannot be denied a prescription drug if you cannot pay the copayment. Tell your pharmacist if you cannot afford to pay. Your pharmacist can still try to collect the copayment.

If you have questions about these copayments, call Member Services at 1-800-286-4242. TTY users should call toll-free 1-800-361-2629. Member Services representatives are available Monday through Friday from 8 a.m. to 8 p.m. and Saturday from 8 a.m. to 3 p.m.

What are the service limits for each benefit year?

Service limits are set for each benefit year. A benefit year begins July 1 of the current year and ends June 30 of the following year. If you are under the age of 21, pregnant, or in a nursing facility, you do not have any service limits.

Benefit limits for members in the General Assistance Benefit category:

- One (1) inpatient medical hospital stay
- One (1) inpatient medical rehabilitation hospital stay

Benefit limits for members in the Adult Benefit category:

- One (1) inpatient medical rehabilitation hospital stay

Are there exceptions to service limits?

You or your provider can ask UPMC *for You* to approve services above these limits. This is called an exception.

An exception to the limit can be granted if:

- You have a serious chronic illness or other serious health condition and without the additional service your life would be in danger; or
- You have a serious chronic illness or other serious health condition and without the additional service your health would get much worse; or
- You would need more costly service if the exception is not granted; or
- You would have to go into a nursing home or institution if the exception is not granted.

To ask for an exception:

- You can call the Special Needs Department at 1-800-286-4242 and select option 2 and option 2 again. Staff is available Monday through Friday from 8 a.m. to 4:30 p.m. TTY users should call toll-free 1-800-361-2629.
- Your provider can call the Provider Prior Authorization Line at 1-800-425-7800.
- You or your provider can mail or fax a written request to:
  UPMC *for You*
  Attn: Medical Management Department
  One Chatham Center
  112 Washington Place
  Pittsburgh, PA 15219
  Fax: 412-454-2057

You or your provider must submit the following information to request an exception:

- Your name, address, and telephone number
- Your UPMC *for You* member ID number
- A description of the service for which you are requesting an exception
- The reason you think the exception is necessary
- Your provider's name and telephone number

A request for an exception may be made before or after you receive the service.

For an exception request made before you receive the service, UPMC *for You* will make a decision:

- Within 21 days after we receive the request
- Within 48 hours after we receive the request, when the provider indicates an urgent need for a quick response

For an exception request made after you received the service, UPMC *for You* will make a decision:

- Within 30 days after we receive the request

An exception request made after the service has been delivered must be submitted no later than 60 days from the date UPMC *for You* rejects the claim because the service is over the benefit limit. Exception requests made after 60 days from the claim rejection date will be denied.

Both you and your provider will receive written notice of the approval or denial of the exception request. For exception requests made before you receive the service, if you or your provider is not notified of the decision within 21 days of the date the request is received, the exception will be automatically granted.

If you have exceeded a service limit, your provider may not bill you for services unless both of the following are met:

- The provider requested an exception to the limit and UPMC *for You* denied the exception.
- The provider told you before the service was provided that you will have to pay for the service if the exception is denied.

What is my right to appeal and to a Fair Hearing?

You can file an appeal with DPW and ask for a Fair Hearing:

- If you think that your General Assistance category assignment is wrong and that General Assistance limits should not apply to you.

The benefit limitations for General Assistance categories are set by the state law. You cannot appeal the law.

You can file a complaint with UPMC *for You* or ask for a Fair Hearing from DPW if:

- UPMC *for You* denies a service and you think you have not reached the limit.
- You or your provider asks for a benefit exception and the exception is denied.
  See pages 73-86, for complete details about Complaints, Grievances, and Fair Hearings.

If you have questions about which benefit you are eligible for, call Member Services at 1-800-286-4242. TTY users should call toll-free 1-800-361-2629. Member Services representatives are available Monday through Friday from 8 a.m. to 8 p.m. and Saturday from 8 a.m. to 3 p.m.

What happens to my benefits if I have other insurance or Medicare?

If you have Medicare, you can get care from any Medicare provider. The provider does not have to be participating with UPMC *for You*. You also do not have to get prior authorization or referrals from your Medicare provider to get specialty care. UPMC *for You* will coordinate payment with Medicare. If you need a service that is not covered by Medicare, a UPMC *for You* participating provider must provide the service. A participating Pennsylvania Medical Assistance provider that is in the network of UPMC *for You* cannot charge you for services or balances that are covered by your UPMC *for You* plan. If you have insurance other than Medicare, payment for the services will be coordinated with your other insurance company. Remember to tell your PCP or other provider's office

and UPMC *for You* of any medical insurance you have in addition to UPMC *for You*. If you get a bill that you do not think you owe, call Member Services at 1-800-286-4242. TTY users should call toll-free 1-800-361-2629. Member Services representatives are available Monday through Friday from 8 a.m. to 8 p.m. and Saturday from 8 a.m. to 3 p.m. You will need to have the bill handy so we can help solve your problem.

What services are not covered?

Listed below are some of the services not covered by UPMC *for You:*

- Non-emergency inpatient and outpatient medical and surgical treatment services provided out of the service area, unless approved by UPMC *for You*
- Services by providers who are not participating with UPMC *for You*, except as noted in covered services on pages 43-45, unless approved by UPMC *for You* as described on pages 16-17
- Experimental or investigative organ transplants that are not approved by the Department of Public Welfare
- Cosmetic surgery, except when performed in order to improve the functioning of a malformed body part, or as post-mastectomy breast reconstruction
- Barber, beauty, telephone, and TV service provided during an inpatient stay
- Surgical procedures, medical care, and medication provided in connection with sex-change operations
- Acupuncture, medically unnecessary surgery, and other procedures that are experimental or are not in accordance with customary standards of medical practice
- Reversal of voluntary sterilization
- Infertility services
- Any service found to be medically unnecessary or inappropriate
- Sunglasses
- Services available through other public agencies or private insurance plans
- Services and procedures not covered on the Department of Public Welfare's Medical Assistance fee schedule
- Services and procedures not covered under the EPSDT enhanced benefits program or through waiver programs for which UPMC *for You* is responsible

If you have any questions about what is covered by UPMC *for You*, contact Member Services at 1-800-286-4242. TTY users should call toll-free 1-800-361-2629. Member Services representatives are available Monday through Friday from 8 a.m. to 8 p.m. and Saturday from 8 a.m. to 3 p.m.

Please note: Benefit limitations and most exclusions do not apply to members under the age of 21.

Section 5

Section 5 Member Services

How do I contact the Member Services Department?

Call the UPMC *for You* Member Services Department at 1-800-286-4242. TTY users should call toll-free 1-800-361-2629. Member Services representatives can help answer your questions. Member Services representatives are available Monday through Friday from 8 a.m. to 8 p.m. and Saturday from 8 a.m. to 3 p.m.

For questions related to dental services, please call Doral Dental at 1-800-508-6775 Monday through Friday from 8 a.m. to 5 p.m. TTY users should call toll-free 1-800-466-7566.

For questions related to vision services, please call OptiCare Managed Vision at 1-866-458-2138 Monday through Friday from 8 a.m. to 7 p.m.

What can the Member Services Department do to help me?

Give you information on UPMC *for You* providers

Our representatives can give you information about participating PCPs, specialists, hospitals, and other providers. You may also request a copy of the most recent provider directory or view the provider directory on the UPMC *for You* website (www.upmchealthplan.com). Call UPMC *for You* Member Services at 1-800-286-4242. TTY users should call toll-free 1-800-361-2629. Member Services representatives are available Monday through Friday from 8 a.m. to 8 p.m. and Saturday from 8 a.m. to 3 p.m.

Help you change your PCP

If you are a new member or have recently moved and need a PCP, we can help you find a PCP that will best meet your needs and your family's needs. If you decide that the PCP you selected does not meet your needs after you have had an appointment with him or her, call us and we can help you find a new PCP.

Send you an ID card

As a new member, if you have not received one already, a UPMC *for You* ID card will be sent to you soon. Punch out the UPMC *for You* ID card and keep it in your wallet with your yellow or greenish-blue ACCESS card. Your UPMC *for You* ID card does not replace your ACCESS card, so you should carry both cards with you. Your UPMC *for You* ID card is good as long as you stay in our plan. Whenever you make an appointment, go to your PCP or other provider, or use any UPMC *for You* medical facilities, inform your PCP's or other provider's office of all the medical insurance you have. Show your UPMC *for You* ID card, ACCESS card, and any other additional insurance cards whenever you go to your PCP or other provider or use any UPMC *for You* medical facilities.

Printed on your ID card are:

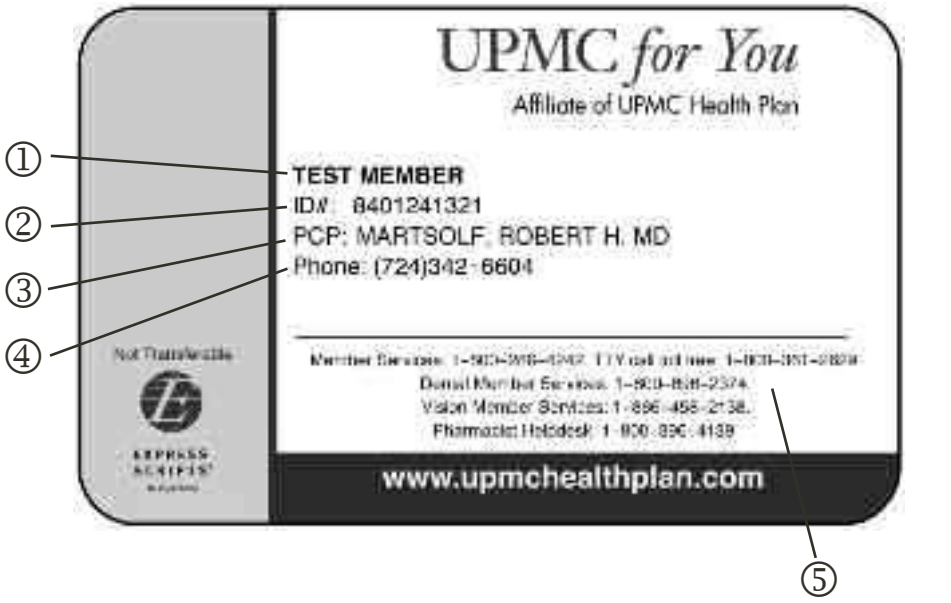
① Your name

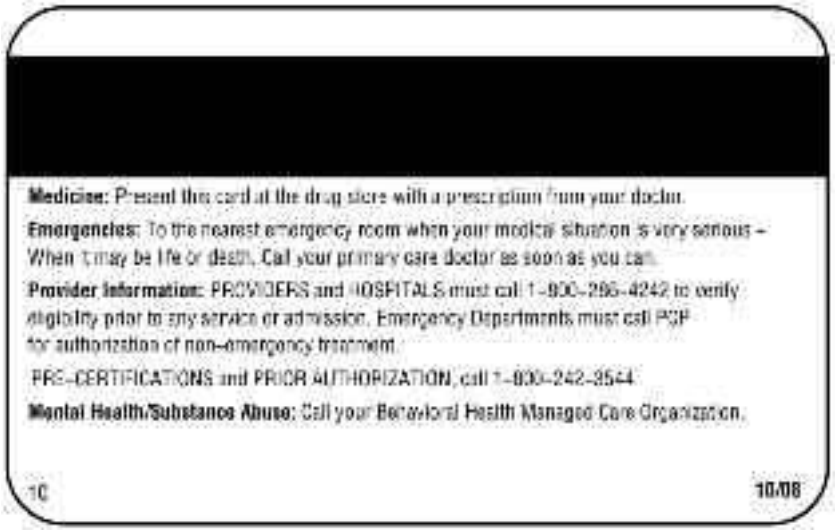
② Your UPMC *for You* ID number

③ Your PCP's name

④ Telephone number of the group in which your PCP practices

⑤ Telephone number for UPMC *for You* Member Services





If you lose your UPMC *for You* ID card, call Member Services at 1-800-286-4242. TTY users should call toll-free 1-800-361-2629. Member Services representatives are available Monday through Friday from 8 a.m. to 8 p.m. and Saturday from 8 a.m. to 3 p.m. We will send you a new ID card. If you do not have your card and need services, you can use your ACCESS card for the provider to verify that you are a member of UPMC *for You*. If you lose your ACCESS card, call your caseworker at your County Assistance Office.

Tell you what is covered or not covered and how to get services

If you have any questions about what is covered by UPMC *for You*, call Member Services at 1-800-286-4242. TTY users should call toll-free 1-800-361-2629. Member Services representatives are available Monday through Friday from 8 a.m. to 8 p.m. and Saturday from 8 a.m. to 3 p.m. A representative can answer your questions.

Answer questions about your bill.

A participating Pennsylvania Medical Assistance provider that is in the network of UPMC *for You* cannot charge you for services or balances that are covered by your UPMC *for You* plan. You are not responsible for a bill if the network provider does not receive payment for your covered services.

As a member of UPMC *for You,* and based on your age and benefit category, you may receive a bill if:

- You did not go to a participating provider
- You received services that are not a covered benefit
- You have exceeded your inpatient benefit limits
- You have a pharmacy copayment
- You did not obtain a referral from your PCP or other provider, when a referral was needed
- Your provider did not obtain prior authorization if one was required

Remember to show your UPMC *for You* member ID card as well as any other medical insurance cards you have when you go for your visits. This will help us pay your claim. If you get a bill that you do not think you owe, call Member Services at 1-800-286-4242. TTY users should call toll-free 1-800-361-2629. Member Services representatives are available Monday through Friday from 8 a.m. to 8 p.m. and Saturday from 8 a.m. to 3 p.m. You will need to have the bill handy so we can help solve your problem.

Help you with other services

Our Member Services representatives can help in other ways, too.

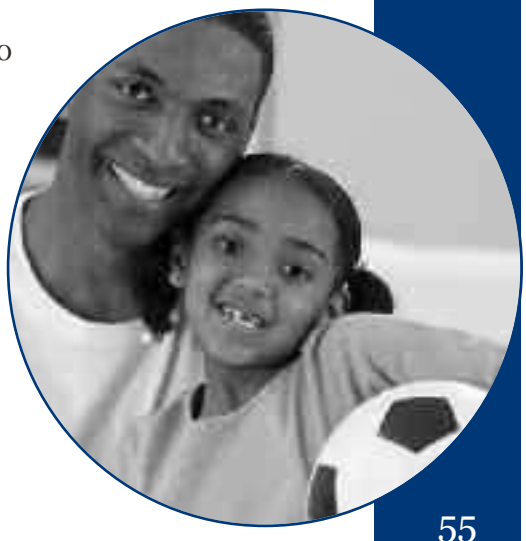
They can:

- Help you schedule a visit with your PCP or other provider
- Explain what you can do and what to expect when filing a complaint or grievance
- Help arrange the medical care and services you need
- Help you get copies of utilization review and clinical practice guidelines

What can the UPMC *My*Health Advice Line do for me?

24 hours a day/7 days a week the UPMC *My*Health Advice Line* is open to answer your health care questions. Call 1-866-918-1591 and a registered nurse can help you. TTY users should call toll-free 1-800-361-2629.

*Note: This advice line is not a substitue for medical care. If you need emergency care, go to the nearest emergency room, call 911 or the local ambulance service.



What is the UPMC *for You* Member Advocate Program?

To help you ease your way through the complex world of health care, your UPMC *for You* Member Advocate will provide personal assistance and service when and where you need it. Through this no cost program, advisors will help you make important decisions about your medical, vision, dental, and pharmacy benefits.

To learn more about our UPMC *for You* Member Advocate Program please call 1-800-286-4242. TTY users should call toll-free 1-800-361-2629. Member Services representatives are available Monday through Friday from 8 a.m. to 8 p.m. and Saturday from 8 a.m. to 3 p.m.

Section 5 Special Needs

What is a special need?

A special need is when any UPMC *for You* member needs some extra help. This may be because you have:

- Physical health problems
- Behavioral health problems (UPMC *for You* is not responsible for all of your behavioral health services. The Special Needs staff can help coordinate your physical health and behavioral health care.)
- Trouble getting health care services
- Special communication needs because you have a vision or hearing-impairment or you do not speak English
- A need for services in your community
- Handicaps or disabilities

How can the Special Needs Department help me?

The Special Needs Department has trained nurses, social workers, and other staff who can help UPMC *for You* members who have special needs.

How do I contact the Special Needs Department?

The Special Needs Department can be reached by calling 1-800-286-4242, option 2, then 2 again. TTY users should call toll-free 1-800-361-2629. The Special Needs staff are available Monday throughFriday from 8 a.m. to 4:30 p.m.

Who can call the Special Needs Department?

Anyone can call the Special Needs Department to ask for help for a UPMC *for You* member or for information.

This includes:

- UPMC *for You* members
- Members' family or friends
- Hospital, PCP, or other providers
- Community agencies
- Any other person helping you

If someone else calls for you, the Special Needs Department will contact you to see how they may help. The Special Needs Department will keep your information confidential.

What services does the Special Needs Department provide?

The Special Needs Department helps UPMC *for You* members understand how to get covered services. They also help identify services in the community that may help you and your family.

Some of the things the Special Needs Department can do to help you are:

- Educate you on what benefits you have as a UPMC *for You* member.
- Help you get the health care services you need.
- Identify UPMC *for You* participating providers, including specialists.
- Tell you which UPMC *for You* participating providers speak languages other than English and whether a provider's office is wheelchair-accessible.
- Direct you to your behavioral health provider if you need behavioral health services.
- Assist you in getting language interpreter services if needed.
- Help identify community agencies that can provide services not covered by UPMC *for You*.
- Help coordinate your health care with UPMC *for You* participating providers and other community agencies that may be helping you.
- Tell you about UPMC *for You* programs that may help you, for example, the health management program or the maternity program if you are pregnant.
- Coordinate services for children who are in the custody of the Office of Children, Youth and Families or a Juvenile Probation Office.
- Assist you in arranging for medical transportation.
- Help you file a complaint or grievance with UPMC *for You*.
- Provide case management for members who have many needs.

How can I get information from UPMC *for You* if I have a disability or speak a language other than English?

- Members with hearing and/or vision impairments can obtain information in large print, Braille, or audio format at no cost by calling the Special Needs Department at 1-800-286-4242, Option 2, then Option 2 again. TTY users should call toll-free 1-800-361-2629.
- For members who do not speak English, the Special Needs Department can use a special translation telephone service. Staff from Special Needs can contact an interpreter who speaks your language. The interpreter will talk with you and the Special Needs staff so you can tell us what we can do to help you.
- Providers may arrange for an interpreter for members who do not speak English or who communicate through American Sign Language or other forms of visional/gestural communication. The Special Needs Department can help you and your UPMC *for You* participating provider find a translator who can communicate for you at your appointments.

Can the Special Needs Department help me get services not covered by UPMC *for You*?

UPMC *for You* understands that you or your family may need services that are not covered by UPMC *for You*. The Special Needs Department knows about many services provided in your community. Staff will work with you and your family to help identify which community services will meet your needs.

Some community services not covered by UPMC *for You* are:

- Support groups
- Routine transportation to your doctor appointments through the Medical Assistance Transportation Program - see pages 38-39 for more information
- Homemaker services (except for members with AIDS or symptomatic HIV)

The Special Needs Department may not be able to help you get everything that you need, but they will work to help find you the services that may be available in your community.

Section 6

Section 6 Rights and Responsibilities

Do I have rights and responsibilities as a member of UPMC *for You*?

Yes. You have both rights and responsibilities. These are very important in managing your health care needs.

What are my rights?

It is very important for you as a UPMC *for You* member to know your rights. These rights will help you know what you can do to better manage your health care decisions.

You have a right to receive medical services at no cost and:

- Be treated with respect, recognizing your dignity and right to privacy
- Have your identity protected
- Know about UPMC *for You*, its programs, its services, its providers, and members' rights and responsibilities
- Ask for UPMC *for You* utilization review guidelines and clinical practice guidelines
- Choose your own participating PCP or other provider
- Participate in decisions regarding your health, including the right to refuse treatment
- Not participate in research and to stop treatment as long as you understand that by stopping treatment your condition may get worse or possibly become fatal
- Exercise your rights and be assured that exercising those rights will not adversely affect the way UPMC *for You* or our providers treat you
- Access, inspect, and receive a copy of most of your protected health information (PHI) that UPMC *for You* has in our files. Your PHI includes personal information such as your health benefit records with your address and your Social Security number
- Request an amendment to your PHI
- Request restrictions to the use and disclosures of your PHI
- At no cost to you, you can request alternative methods of communications regarding your PHI
- Receive an accounting of certain types of disclosures of your PHI as specified in the Health Insurance Portability and Accountability Act (HIPAA) regulations
- Have a Living Will and/or a Durable Power of Attorney that tells how decisions about your treatment will be made if you cannot decide for yourself
- Get a second opinion
- Talk about medically necessary treatment options for your condition, regardless of cost or benefit coverage
- Make a complaint or file a grievance about UPMC *for You* and/or your PCP or other provider

- Request a Department of Public Welfare (DPW) Fair Hearing at any time during the complaint or grievance process
- Provide written authorization telling UPMC *for You* if you decide to have someone (family member, friend, lawyer or other person you know) represent or act on your behalf during the complaint or grievance process
- Select a personal representative to act on your behalf during the complaint and grievance process
- Make recommendations about UPMC *for You* members' rights and responsibilities policy
- Know that UPMC *for You* staff and UPMC *for You* providers are required to follow state and federal laws related to your care and your rights as a member
- Be free from any form of restraint or seclusion; restraint or seclusion may not be used as a means of harassment, discipline, convenience, or retaliation

You also have the right to:

- Receive clear and complete information from your PCP or other providers about your health condition and treatment options and alternatives
- Request a change to another managed care health plan following DPW guidelines
- Request and receive a provider directory that includes a list of network providers and the non-English languages they speak (if applicable)

What are my responsibilities?

UPMC *for You* participating providers need help from you in managing your health care. You have to give them information about your health and follow their directions. This is important for you to stay healthy or to treat your health care needs.

As a UPMC *for You* member, your responsibilities are to:

- Treat your PCP or other provider and other health care workers with dignity and respect
- Tell your PCP or other provider as much about your medical history as you know
- Follow your PCP or other provider's directions, such as taking the right amount of a medicine at the right times, if you agreed to do so
- Report your symptoms and problems to your PCP or other provider and ask questions
- Be on time for your visits and call if you will be late or must cancel a visit
- Ask questions about and understand how to access health care services
- Talk to and work with your PCP or other provider about behavioral health problems
- Provide a safe home environment for those services rendered in your place of residence

- Understand your health problems and, whenever possible, participate with your PCP or other provider in the development of treatment goals that you and your provider have agreed upon
- Consent to the proper use of your health information
- Be represented by parents, guardians, family members, or other custodians of your choice, if you are unable to fully participate in your treatment decisions
- Carry your UPMC *for You*, fee-for-service (ACCESS), and any other medical insurance cards with you at all times and present them to providers when scheduling and receiving medical services
- Tell your PCP or other provider's office and UPMC *for You* of any medical insurance you have in addition to UPMC *for You*
- Tell your case worker if you move or if you plan to be out of the area for a period of over 30 days
- Call your PCP or ob-gyn if you think you are pregnant
- Do not share your UPMC *for You* ID card with anyone, including other members

Do I have a self-determination right?

Yes. In Pennsylvania, there is a law called the Patient Self-Determination Act which states that you have the right to decide to accept, refuse, or stop medical treatment. If you do not wish to have a certain procedure or to receive a certain type of treatment, you have the right to tell your PCP or other provider. In order to protect this right, you must put your wishes in writing. The document that states your wishes is called an Advance Directive for health care. This document tells others what care you would like to receive or not receive if you become unable to share your wishes. Some conditions that would keep you from telling a PCP or other provider what you want are permanent brain damage, terminal illness, or permanent coma. There is no law that guarantees that a health care provider will follow your wishes in every case. The Patient Self-Determination Act does say that a provider needs to let you know if he or she cannot follow your wishes. UPMC *for You* will notify you within 90 days of any changes in this law.

Advance Directives

There are two kinds of Advance Directives:

Living Will
This document tells the kind of life-sustaining treatment you want or do not want if you are unable to tell your doctor. Examples of life-sustaining treatment include cardiopulmonary resuscitation (CPR), intravenous (IV) therapy, feeding tubes, respirators, pain relief, and dialysis.

Durable Power of Attorney
This document lets you name a person (proxy) to make medical decisions for you if you become unable to do so. This person can authorize your admission to a medical, nursing, residential, or other facility. This person can enter into medical agreements for your care and can agree to medical and surgical procedures.

Important facts about Advance Directives

- You may have both a Living Will and a Durable Power of Attorney.
- Before you write down your wishes, discuss them with your PCP or other provider, family, friends, or other people who need to know your wishes.
- Give your written instructions to your health care providers, your proxy, and those who should be notified in case of an emergency. Keep them with your other important papers.
- Review these documents as needed. You can change your mind at any time either in writing or verbally. Make sure you rewrite your instructions and give them to anyone who had a copy of the old instructions.
- UPMC *for You* does not limit Advance Directives.
- UPMC *for You* will honor your Advance Directives to the fullest extent allowed by law.
- UPMC *for You* will tell you how to file a complaint about Advance Directives with UPMC *for You* or with the Department of Health.
- The time frame for notifying the member of any changes in applicable state law is as soon as possible, but no later than 90 days after the effective date of the change.

If you would like some help with making an Advance Directive or filing a complaint, call UPMC *for You* Member Services at 1-800-286-4242. TTY users should call toll-free 1-800-361-2629. Member Services representatives are available Monday through Friday from 8 a.m. to 8 p.m. and Saturday from 8 a.m. to 3 p.m.

Privacy and Confidentiality

It is very important to us that what you tell us is kept private. When you enroll with UPMC *for You*, you are doing two important things:

- Giving us correct and honest information
- Allowing us to use your information to provide health care and to pay the providers who have treated you

The only people who may see this information are:

- Our staff members who need to coordinate your health care or measure the quality of your care
- Your providers or the medical facility staff and administration where you receive care
- The Department of Public Welfare (DPW)

UPMC *for You* protects your personal and financial information. Any reports that we produce will not have individual information. Our providers, medical facilities, and UPMC *for You* employees know and understand that your information is private. We train our employees to make sure that they handle your private information the right way. This includes information that is spoken, written, or electronic. We will not give information for any reason beyond the requirements of your treatment, payment for services, and our health care operations.

The only other ways we would release your information would be if you wanted us to, or if required to by law. Personal information (such as your name, address, Social Security number, birth date, and services that you have received) is kept private for UPMC *for You* current and former members (living or deceased). We only use your information for your treatment, payment of your health care providers, and required business activities. If we have a program that we think will benefit you, we will get in touch with you and let you know about it. We will need your permission and signature before we use your personal information. If you do not want to join our programs, we will not use your personal information.

You may have heard about federal laws regarding privacy of health information in the news. All health insurance carriers follow the Health Insurance Portability and Accountability Act of 1996 (HIPAA). In fact, the HIPAA Privacy Regulations require providers, medical facilities, and health care insurers that are involved in your health care to have a Notice of Privacy Practices. You probably receive these notices when you visit your providers and your pharmacy. You do not need to respond to these documents. They are for your information only.

UPMC *for You*'s Compliance Committee and Quality Improvement Committee make sure that we follow all government rules and regulations. We are always reviewing our policies and procedures to make sure we are following the law. We make periodic announcements when any changes are made to laws or regulations.

The following Notice of Privacy Practices gives you even more specific information and details about how UPMC *for You* ensures the privacy of your protected health information. If you have any questions about your right to privacy and the confidentiality of your personal information, please contact UPMC *for You* Member Services at 1-800-286-4242. TTY users should call toll-free 1-800-361-2629. Member Services representatives are available Monday through Friday from 8 a.m. to 8 p.m. and Saturday from 8 a.m. to 3 p.m.

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. **PLEASE REVIEW IT CAREFULLY**.

We at UPMC *for You* will protect your health information. The law requires us to maintain the privacy of your health information and to send you this notice.

This notice explains how we use information about you. It also explains when we can share that information with others. The notice tells you about your health information rights and how you can use those rights. We talk about "information" and "health information" in this notice. That means information we receive in claims from your providers or in our files that can identify you. Any records that UPMC *for You* has that contain things like your name, your address, Social Security number, and date of birth would be protected health information. UPMC *for You* is committed to making sure that this information is kept private.

How UPMC *for You* uses or shares information

The following are ways we may use information about you:

- We may use or share the information to help pay your medical bills that providers and medical facilities have submitted to us for payment.
- We may share your information with your providers and medical facilities to help them provide medical care to you. For example, if you are in a medical facility, we may show them medical records sent to us by your provider.
- We may use or share your information with others to help manage your health care. For example, we might talk to your provider to suggest a program that could help improve your health.
- We may share your information with others who help us conduct our business, including other health insurance carriers.
- We will not share your information with these outside groups unless they agree to protect it.
- We may use or share your information with public health agencies for certain types of public health or disaster relief efforts, if we believe there is a serious health or safety threat.
- We may use or share your information to send you a reminder about an appointment with your PCP or other provider.
- We may use or share your information so you can benefit from special health programs. For example, we might send you information about a program that could help you to stop smoking.

State and federal laws may require us to release your health information to others. The reasons include:

- We may report information to state and federal agencies that regulate us. These agencies include the U.S. Department of Health and Human Services and the Pennsylvania Department of Public Welfare.
- We may share information for public health activities. For example, we may report information to the Food and Drug Administration for investigating a potential problem with a prescription medication.

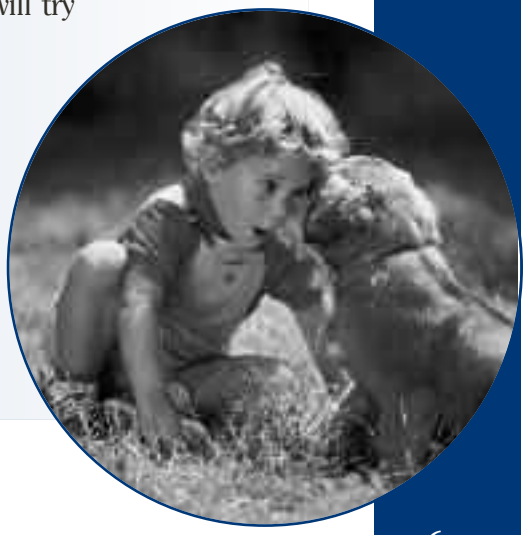
- We may share information with a health oversight agency. The reasons may include audits, inspections, licensure, and disciplinary actions.
- We may provide information to a court or administrative agency. The reasons may include court orders and search warrants.
- We may report information for law enforcement purposes. For example, we may give information to a law enforcement official so he or she may identify a suspect or missing person.
- We may report information to a government authority regarding child abuse, neglect, or domestic violence.
- We may share information with a coroner or medical examiner to identify someone who has died, to determine a cause of death, or as authorized by law. We may also share information with funeral directors so they can perform their duties.
- We may use or share information for obtaining, banking, or transplanting of organs, eyes, or tissue.
- We may share information needed for some government functions. These functions may include military and veteran activities, national security and intelligence activities, and the protective services for the president and others.
- We may report information on job-related injuries because of requirements of your state workers' compensation laws.

For any other reason, we must get your written permission to use or disclose your health information. If you give us written permission and change your mind, you may cancel your written permission at any time.

What are your privacy rights?

The following are your rights. Call the Member Services Department if you want to do any of these things:

- You have the right to ask us to restrict how we use or disclose your information for treatment, payment, or health care operations. If any family member or someone else is involved in your health care decisions or payment, you also have the right to ask us to restrict information that we may share with them. We will try to honor your request, but we are not required to agree to these restrictions.
- You have the right to ask to receive communications confidentially. For example, if mailing health information to your address would be harmful, you can ask us to send the information to another address or some other way, for example, by fax. We will take care of your reasonable requests as explained above.
- You have the right to inspect and obtain a copy of certain information about yourself.



- You do not have the right to access certain types of information.
  We may decide not to provide you with copies of the following information:
  - Psychotherapy notes
  - Information for civil, criminal, or administrative proceedings
  - Information related to federal laws on biological products and clinical laboratories

Sometimes we may deny your request to inspect or obtain a copy of your information. We will notify you in writing if your request is denied. You may request to have the denial reviewed. If we deny this request, we will give you an explanation.

- You have the right to ask us to make changes to information we have about you. We may ask you to put your request in writing and tell us why you are making the request.
  - We will respond to your request no later than 60 days after we receive it. In some cases we may extend that time by no more than an additional 30 days. If we need to extend this time, we will tell you when we can complete your request.
  - We will notify you when a change is made. We will provide the change to any person who has previously received your health information. We will also provide the change to others identified by you.
  - We will write to you to tell you about any denial. The denial will explain your right to file a written statement of disagreement. We have a right to respond to your statement. You have the right to request that your written request, our written denial, and your statement of disagreement be included with your information for any future disclosures.

- You have the right to ask us what we disclosed about you during the six years before your request. We are not required to give you information:
  - For disclosures before April 14, 2003
  - Disclosed or used for treatment, payment, and health care operations
  - Disclosed to you or based on your authorization
  - That relates to a permitted use or disclosure
  - Disclosed to any person involved in your care based on your agreement or during an emergency
  - Disclosed for national security or intelligence purposes
  - Disclosed to correctional institutions, law enforcement officials, or health oversight agencies
  - Disclosed or used for limited research, public health, or health care operations

We may require that your request be in writing. We will act on your request within 60 days. We may need additional time to act on your request. If so, we may take up to an additional 30 days. Your first request will be free. We will continue to provide you with one free request every 12 months. If you make a second request within 12 months, we may charge you a fee. We will inform you in advance of the fee and provide you with an opportunity to withdraw or change your request.

Exercising Your Privacy Rights

You have a right to receive a copy of this notice whenever you ask. If any of our privacy practices change, we have the right to change the terms of this notice. We have the right to make the new notice apply to all protected health information we maintain. We will mail the new notice to you after we revise it.

You may have questions about this notice or wish to file a complaint with UPMC Health Plan's Privacy Officer if you feel that your privacy rights have not been respected. You also may want to obtain the contact information for the Secretary of Health and Human Services. If you want to do this, you may write or call as follows:

UPMC Health Plan Privacy Officer
One Chatham Center, Suite 900
112 Washington Place
Pittsburgh, Pennsylvania 15219
Telephone: 1-877-574-5517 (toll-free)
TTY users, call 1-800-361-2629 (toll-free).

Section 6 Complaints, Grievances, and Fair Hearings

What do I do if I am unhappy about a service, how I was treated, or a decision made by UPMC *for You*?

If a provider or UPMC *for You* does something that you are unhappy about or do not agree with, you can tell UPMC *for You* or the Department of Public Welfare that you are unhappy or that you disagree with what the provider or UPMC *for You* has done. This section describes what you can do and what will happen.

Complaints

What is a complaint?

A complaint is when you, or your personal representative acting on your behalf, tells us that you are unhappy with UPMC *for You* or with your provider or that you do not agree with a decision by UPMC *for You*. Your provider can file a complaint on your behalf with your consent. We will not take any action against you for filing a complaint.

Some things you may complain about are:

- You are unhappy with the care you are getting.
- You cannot get the service or item you want because it is not a covered service or item.
- You have not received services that UPMC *for You* has approved.

What should I do if I have a complaint?

First Level Complaint

To file a complaint, you, your provider, or your personal representative acting on your behalf, can do one of the following:

- Call UPMC *for You* at 1-800-286-4242 and tell us your complaint. TTY users should call toll-free 1-800-361-2629. Member Services representatives are available Monday through Friday from 8 a.m. to 8 p.m. and Saturday from 8 a.m. to 3 p.m.

OR

- Write down your complaint and send it to us at:
  UPMC *for You*
  Complaints, Grievances and Appeals
  P.O. Box 2939
  Pittsburgh, PA 15230-2939

When should I file a First Level Complaint?

You must file a complaint within 45 days of getting a denial letter.

Examples of denial letters are:

- UPMC *for You* has decided that you cannot get a service or item you want because it is not a covered benefit; or
- UPMC *for You* will not pay a provider for a service or item after the service was received because it is not a covered service or item; or
- UPMC *for You* did not decide a complaint or grievance you told us about within the proper time frames; or
- UPMC *for You* will not pay for a service or item you received from a provider not enrolled in the Pennsylvania Medical Assistance Program unless the service or item was authorized by the Health Plan; or
- You are unable to get an appointment within standard time frames. (Standard time frames are listed on pages 12-13.)

You may file all other complaints at any time.

What happens after I file a First Level Complaint?

After you file your complaint, you will get a letter from UPMC *for You* telling you that we have received your complaint and providing information about the First Level Complaint review process.

You may ask to see any information UPMC *for You* has about your complaint. You can also send the Health Plan information that may help with your complaint. You or your personal representative acting on your behalf may attend the complaint review if you wish.

You may come to our offices at:
One Chatham Center
112 Washington Place
Pittsburgh, PA 15219

Or, you may attend by phone. If you decide that you do not want to attend the complaint review, it will not affect our decision.

A committee of one or more UPMC *for You* staff who have not been involved in the issue you filed your complaint about will review your complaint and make a decision. Your complaint will be decided no later than 30 days after we receive your complaint.

If your complaint involves a clinical issue, the First Level Complaint review committee will include a licensed physician. The licensed physician will be in the same or a similar specialty as the one that typically manages the service or item in question. The physician may consult with other health care professionals if needed, but the licensed physician will decide the complaint.

A decision letter will be mailed to you within 5 business days after the decision has been made. This letter will tell you all the reasons for the decision and what you can do if you don't agree with the decision.

If your PCP or other provider believes that the usual time frames for deciding your complaint or grievance will harm your health, you, your PCP, or other provider can call UPMC *for You* at 1-800-286-4242 and request that your complaint or grievance be decided faster. See page 81 for additional information. TTY users should call toll-free 1-800-361-2629. Member Services representatives are available Monday through Friday from 8 a.m. to 8 p.m. and Saturday from 8 a.m. to 3 p.m. You will need to have a signed letter from your PCP or other provider faxed to 412-454-7920 within 48 hours of your request explaining how the usual time frame for deciding your complaint or grievance will harm your health.

If you need more information about getting help during the complaint process, please contact UPMC *for You* at 1-800-286-4242. TTY users should call toll-free 1-800-361-2629. Member Services representatives are available Monday through Friday from 8 a.m. to 8 p.m. and Saturday from 8 a.m. to 3 p.m.

What can I do to continue receiving services?

If you have been receiving services or items that are being reduced, changed, or stopped, and you file a complaint that is hand-delivered or postmarked within 10 days of the mail date on the letter (notice) telling you that the services or items you have been receiving are not covered services or items for you, the service or items will continue until a decision is made.

What if I don't like UPMC *for You's* decision?

Second Level Complaint

If you do not agree with our First Level Complaint decision, you may file a Second Level Complaint with UPMC *for You*.

When should I file a Second Level Complaint?

You must file your Second Level Complaint within 45 days of the date you receive the First Level Complaint decision letter. You may send it to the same address or phone number you used to file your First Level Complaint.

What happens after I file a Second Level Complaint?

You will receive a letter from UPMC *for You* telling you that we have received your complaint and providing information about the Second Level Complaint review process. You may ask to see any information UPMC *for You* has about your complaint. You may also send information that may help with your complaint to UPMC *for You*.

You may attend the complaint review if you want to. You may come to our offices at:

One Chatham Center
112 Washington Place
Pittsburgh, PA 15219

Or, you may attend by phone. If you decide that you do not want to attend the complaint review, it will not affect our decision.

A committee made up of three or more people who have not been involved in the issue about which you filed your First Level Complaint will review your Second Level Complaint and make a decision. At least one-third of the second level review committee may not be employees of UPMC *for You* or of a related subsidiary or affiliate. Your complaint will be decided no later than 30 days after we receive your complaint.

A decision letter will be mailed to you within 5 business days after the decision has been made. This letter will tell you all the reasons for the decision and what you can do if you don't like the decision.

If your PCP or other provider believes that the usual time frames for deciding your complaint or grievance will harm your health, you, your PCP, or other provider can call UPMC *for You* at 1-800-286-4242 and ask that your complaint or grievance be decided faster. See page 81 for more details. TTY users should call toll-free 1-800-361-2629. Member Services representatives are available Monday through Friday from 8 a.m. to 8 p.m. and Saturday from 8 a.m. to 3 p.m. You will need to have a signed letter from your PCP or other provider faxed to 412-454-7920 within 48 hours of your request explaining how the usual time frame for deciding your complaint or grievance will harm your health.

If you need more information about getting help during the complaint process, see page 83. You can also contact UPMC *for You* at 1-800-286-4242. TTY users should call toll-free 1-800-361-2629. Member Services representatives are available Monday through Friday from 8 a.m. to 8 p.m and Saturday from 8 a.m. to 3 p.m.

What can I do to continue receiving services?

If you have been receiving services or items that are being reduced, changed, or stopped because they are not covered services or items for you, and you file a Second Level Complaint that is hand-delivered or postmarked within 10 days of the mail date on the First Level Complaint decision letter, the services or items will continue until a decision is made.

What can I do if I still don't agree with UPMC *for You*'s decision?

External Complaint Review

If you do not agree with UPMC *for You*'s Second Level Complaint decision, you may ask for an External Complaint review by either the Pennsylvania Department of Health or the Pennsylvania Insurance Department. The Department of Health and the Insurance Department work together to decide which agency should review the complaint.

You must ask for an external review within 15 days of the date you received the Second Level Complaint decision letter. If you ask, the Department of Health will help you put your complaint in writing.

You must send your request for External Complaint review in writing to either of the following addresses:

Pennsylvania Department of Health
Bureau of Managed Care
Health and Welfare Building, Room 912
7th and Forster Streets
Harrisburg, Pennsylvania 17120
Telephone Number: 1-888-466-2787
TTY: 1-800-654-5984
Hours: 8 a.m. to 4:30 p.m.
Monday through Friday

Pennsylvania Insurance Department
Bureau of Consumer Services
1209 Strawberry Square
Harrisburg, Pennsylvania 17120
Telephone Number: 1-877-881-6388
Hours: 8 a.m. to 5 p.m.
Monday through Friday

If you send your request for external review to the wrong department, it will be sent to the correct department.

The Department of Health or the Insurance Department will request your file from UPMC *for You*. You may also send any other information that may help with the external review of your complaint.

You may be represented by an attorney or another person during the external review. A decision letter will be sent to you after the decision is made. This letter will tell you all the reasons for the decision and what you can do if you don't agree with the decision.

What can I do to continue receiving services?

If you have been receiving services or items that are being reduced, changed, or stopped because they are not covered services or items for you, and you file a request for an External Complaint review that is hand-delivered or postmarked within 10 days of the mail date on the Second Level Complaint decision letter, the services or items will continue until a decision is made.

Grievances

What is a grievance?

When UPMC *for You* denies, decreases, or approves a service or item different from the service or item you requested because it is not medically necessary, you will get a letter (notice) telling you UPMC *for You*'s decision.

A grievance is when you tell us you disagree with UPMC *for You*'s decision.

What should I do if I have a grievance?

First Level Grievance

To file a grievance, you can do one of the following:

- Call UPMC *for You* at 1-800-286-4242 and tell us your grievance. TTY users should call toll-free 1-800-361-2629. Member Services representatives are available Monday through Friday from 8 a.m. to 8 p.m. and Saturday from 8 a.m. to 3 p.m.
  OR
- Write down your grievance and send it to us at:
  UPMC *for You*
  Complaints, Grievances and Appeals
  P.O. Box 2939
  Pittsburgh, PA 15230-2939
  OR
- Your provider can file a grievance for you if you give the provider your consent in writing to do so.

NOTE: If your provider files a grievance for you, you cannot file a separate grievance on your own.

When should I file a First Level Grievance?

You must file a grievance within 45 days of getting a denial letter (notice) that tells you about the denial, decrease, or approval of a different service or item to file your grievance.

What happens after I file a First Level Grievance?

After you file your grievance, you will get a letter from UPMC *for You* telling you that we have received your grievance and providing information about the First Level Grievance review process. You may ask UPMC *for You* to see any information we have about your grievance. You can also send information that may help with your grievance to UPMC *for You*.

You may attend the grievance review if you want to. You may come to our offices at:

One Chatham Center
112 Washington Place
Pittsburgh, PA 15219

Or you may attend by phone. If you decide that you do not want to attend the grievance review, it will not affect our decision.

A committee of one or more UPMC *for You* staff, including a licensed physician, will review your grievance and make a decision. The licensed physician will be in the same or a similar specialty as the one that typically manages or consults on the service or item in question. The licensed physician will decide the grievance. None of the committee members will have been previously involved in the grievance issue. Your grievance will be decided no later than 30 days after we receive your grievance.

A decision letter will be mailed to you within 5 business days after the decision has been made. This letter will tell you all the reasons for the decision and what you can do if you don't agree with the decision.

If your PCP or other provider believes that the usual time frames for deciding your complaint or grievance will harm your health, you, your PCP, or other provider can call UPMC *for You* at 1-800-286-4242 and request that your complaint or grievance be decided faster. See page 81 for more details. TTY users should call toll-free 1-800-361-2629. Member Services representatives are available Monday through Friday from 8 a.m. to 8 p.m. and Saturday from 8 a.m. to 3 p.m. You will need to have a signed letter from your PCP or other provider faxed to 412-454-7920 within 48 hours of your request explaining how the usual time frame for deciding your complaint or grievance will harm your health.

If you need more information about getting help during the grievance process, see page 83. You can also contact UPMC *for You* at 1-800-286-4242. TTY users should call toll-free 1-800-361-2629. Member Services representatives are available Monday through Friday from 8 a.m. to 8 p.m. and Saturday from 8 a.m. to 3 p.m.

What can I do to continue getting services?

If you have been receiving services or items that are being reduced, changed, or stopped, and you file a grievance that is hand-delivered or postmarked within 10 days of the mail date on the letter (notice) telling you that the services or items you have been receiving are being reduced, changed, or stopped, the services or items will continue until a decision is made.

What if I don't like UPMC *for You*'s decision?

Second Level Grievance

If you do not agree with our First Level Grievance decision, you may file a Second Level Grievance with UPMC *for You*.

When should I file a Second Level Grievance?

You must file your Second Level Grievance within 45 days of the mail date you receive the First Level Grievance decision letter. Use the same address or phone number you used to file your First Level Grievance.

What happens after I file a Second Level Grievance?

You will receive a letter from UPMC *for You* telling you that we have received your grievance and providing information about the Second Level Grievance review process. You may ask UPMC *for You* to see any information we have about your grievance. You can also send information that may help with your grievance to UPMC *for You*.

You may attend the grievance review if you want to. You may come to our offices at:

One Chatham Center
112 Washington Place
Pittsburgh, PA 15219

Or, you may attend by phone. If you decide that you do not want to attend the grievance review, it will not affect our decision.

A committee of three or more people will review your grievance and make a decision. The committee will include a licensed physician. At least one-third of the second level review committee may not be employees of the UPMC *for You* or of a related subsidiary or affiliate. None of the committee members will have been previously involved in the grievance issue. Your grievance will be decided no later than 30 days after we receive your grievance.

If your PCP or other provider believes that the usual time frames for deciding your complaint or grievance will harm your health, you, your PCP, or other provider can call UPMC *for You* at 1-800-286-4242 and ask that your complaint or grievance be decided faster. See page 81 for more details. TTY users should call toll-free 1-800-361-2629. Member Services representatives are available Monday through Friday from 8 a.m. to 8 p.m. and Saturday from 8 a.m. to 3 p.m. You will need to have a signed letter from your PCP or other provider faxed to 412-454-7920 within 48 hours of your request explaining how the usual time frame for deciding your complaint or grievance will harm your health.

A decision letter will be mailed to you within 5 business days after the decision has been made. This letter will tell you all the reasons for the decision and what you can do if you don't like the decision.

If you need more information about getting help during the grievance process, see page 83. You can also contact UPMC *for You* at 1-800-286-4242. TTY users should call toll-free 1-800-361-2629. Member Services representatives are available Monday through Friday from 8 a.m. to 8 p.m. and Saturday from 8 a.m. to 3 p.m.

What can I do to continue getting services?

If you have been receiving services or items that are being reduced, changed, or stopped, and you file a Second Level Grievance that is hand-delivered or postmarked within 10 days of the mail date on the First Level Grievance decision letter, the services or items will continue until a decision is made.

What can I do if I still don't agree with UPMC *for You*'s decision?

External Grievance Review

If you do not agree with UPMC *for You*'s Second Level Grievance decision, you may ask for an External Grievance Review. You must call or send a letter to UPMC *for You* asking for an External Grievance Review

within 15 days of the mail date you received our grievance decision letter. Use the same address and phone number you used to file your First Level Grievance.

We will send your request to the Pennsylvania Department of Health. UPMC *for You* will notify you of the External Grievance reviewer's name, address, and phone number. You will also be given information about the external review process.

UPMC *for You* will send your grievance file to the reviewer. You can provide the reviewer with additional information that may help with the external review of your grievance within 15 days of filing the request for an External Grievance Review.

You will receive a decision letter within 60 days of the date you asked for an External Grievance Review. This letter will tell you the reason(s) for the decision and what you can do if you don't agree with the decision.

What can I do to continue receiving services?

If you have been receiving services or items that are being reduced, changed, or stopped, and you file a request for an External Grievance Review that is hand-delivered or postmarked within 10 days of the mail date on the Second Level Grievance decision letter, the services or items will continue until a decision is made.

You may call the UPMC *for You* Member Services at 1-800-286-4242 if you need help or have questions about complaints and grievances. TTY users should call toll-free 1-800-361-2629. Member Services representatives are available Monday through Friday from 8 a.m. to 8 p.m. and Saturday from 8 a.m. to 3 p.m.

You can also contact the Pennsylvania Legal Services Office at 1-800-322-7572 (www.palegalservices.org) or call the Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org).

Expedited Complaints and Grievances

What can I do if my health is at immediate risk?

If your PCP or other provider believes that the usual time frames for deciding your complaint or grievance will harm your health, you, your PCP, or other provider can call UPMC *for You* at 1-800-286-4242 and ask that your complaint or grievance be decided faster. TTY users should call toll-free 1-800-361-2629. Member Services representatives are available Monday through Friday from 8 a.m. to 8 p.m. and Saturday from 8 a.m. to 3 p.m. You will need to have a signed letter from your PCP or other provider faxed to 412-454-7920 within 48 hours of your request explaining how the usual time frame for deciding your complaint or grievance will harm your health.

If your PCP or other provider does not fax this letter to UPMC *for You* within 48 hours of your request, your complaint or grievance will be decided within the usual time frames.

Expedited Complaint

The Expedited Complaint will be decided by a licensed physician who has not been involved in the issue you filed your complaint about. The licensed physician will be in the same or a similar specialty as the one that typically manages the service or item in question.

UPMC *for You* will call you within 48 hours of when we receive your request for an expedited (faster) complaint review with our decision. You will also receive a letter telling you the reason(s) for the decision. If you do not agree with the decision, you may file a request for a Department of Public Welfare (DPW) Fair Hearing. For information on how to file a request for a DPW Fair Hearing see page 84.

You may request an expedited review at any time prior to a second-level decision on the same issue. An Expedited Complaint decision may not be requested after a Second Level Complaint decision has been made on the same issue.

Expedited External Complaint

If you want to ask for an Expedited External Complaint review by the Department of Health, you must call UPMC *for You* at 1-800-286-4242 within 2 business days from the date you get the Expedited Complaint decision. TTY users should call toll-free 1-800-361-2629. Member Services representatives are available Monday through Friday from 8 a.m. to 8 p.m. and Saturday from 8 a.m. to 3 p.m. UPMC *for You* will send your request to the Department of Health within 24 hours after receiving your request.

Expedited Grievance

A committee including a licensed physician will review your Expedited Grievance. The licensed physician will be in the same or a similar specialty as the one that typically manages the service or item in question. The licensed physician will decide your Expedited Grievance. No one on the committee will have been previously involved in the grievance issue.

UPMC *for You* will call you within 48 hours of when we receive your request for an Expedited (faster) Grievance review with our decision. You will also receive a letter telling you the reason for the decision. The letter will tell you that you can ask for an Expedited External Grievance Review if you don't agree with the decision.

An Expedited Grievance decision may not be requested after a Second Level Grievance decision has been made on the same issue.

Expedited External Grievance

If you want to ask for an Expedited External Grievance Review by the Department of Health, you must call UPMC *for You* at 1-800-286-4242 within 2 business days from the date you get the Expedited Grievance decision. TTY users should call toll-free 1-800-361-2629. Member Services representatives are available Monday through Friday from 8 a.m. to 8 p.m. and Saturday from 8 a.m. to 3 p.m. UPMC *for You* will send your request to the Department of Health within 24 hours after receiving your request.

What kind of help can I have with the complaints and grievances processes?

If you need help filing your complaint or grievance, a staff member of UPMC *for You* will assist you during this process. You do not have to pay for the help of the staff member. This staff member will not have been involved in any decision about your complaint or grievance. You may also have a family member, friend, lawyer, or other person help you file your complaint or grievance. This person can also help you if you would like to appear at the complaint or grievance review. For legal assistance, you can contact the Pennsylvania Legal Services Office at 1-800-322-7572 (www.palegalservices.org).

At any time during the complaint or grievance process, you can have someone you know represent you or act on your behalf. If you decide to have someone represent or act for you, tell UPMC *for You,* in writing, the name of that person and how we can reach him or her. You or the person you choose to represent you may ask UPMC *for You* to see any information we have about your complaint or grievance.

Persons whose primary language is not English

If you ask for language interpreter services, UPMC *for You* will provide the services at no cost to you.

Persons with disabilities

UPMC *for You* will provide persons with disabilities with the following help in presenting complaints or grievances at no cost, if needed:

- Sign language interpreters.
- Information submitted by UPMC *for You* at the complaint or grievance review in an alternative format. The alternative format version will be given to you before the review, i.e., Braille, audio tapes or computer diskettes.
- Someone to help copy and present information.

You can contact UPMC *for You* for help at 1-800-286-4242. TTY users should call toll-free 1-800-361-2629. Member Services representatives are available Monday through Friday from 8 a.m. to 8 p.m. and Saturday from 8 a.m. to 3 p.m.

When can I request a DPW Fair Hearing?

For some issues you can request a Fair Hearing from the Department of Public Welfare in addition to or instead of filing a complaint or grievance with UPMC *for You*.

See below for the reasons for which you can request a Fair Hearing.

Department of Public Welfare Fair Hearings

In some cases you can ask the Department of Public Welfare to hold a hearing because you are unhappy about or do not agree with something UPMC *for You* did or did not do. These hearings are called "Fair Hearings." You can ask for a Fair Hearing at the same time you file a complaint or grievance, or you can ask for a Fair Hearing after UPMC *for You* decides your First or Second Level Complaint or Grievance.

What kinds of things can I request a Fair Hearing about, and by when do I have to ask for my Fair Hearing?

If you are unhappy because:

- UPMC *for You* decided to deny a service or item because it is not a covered service or item, you must ask for a Fair Hearing within:
  - 30 days of getting a letter from UPMC *for You* telling you of this decision
- UPMC *for You* decided not to pay a provider for a service or item you received and the provider can bill you for the service or item, you must ask for a Fair Hearing within:
  - 30 days of getting a letter from UPMC *for You* telling you of this decision
- UPMC *for You* did not make a decision about your complaint or grievance within 30 days of receiving the complaint or grievance, you must ask for a Fair Hearing within:
  - 30 days of getting a letter from UPMC *for You* telling you that we did not decide your complaint or grievance within the time we were supposed to
- UPMC *for You* decided to deny or decrease a service or item, or to approve a service or item different than the service or item you requested, because it was not medically necessary, you must ask for a Fair Hearing within:
  - 30 days of getting a letter from UPMC *for You* telling you of this decision, or within 30 days of getting a letter from UPMC *for You* telling you its decision after you filed a complaint or grievance about this issue
- UPMC *for You* did not provide a service or item by the time you should have received it (the time by which you should have received a service or item is listed on page 86), you must ask for a Fair Hearing within:
  - 30 days from the date you should have received the service or item

How do I ask for a Fair Hearing?

You must ask for a Fair Hearing in writing and send it to:

Department of Public Welfare
Office of Medical Assistance Programs
HealthChoices Program
Complaint, Grievance and Fair Hearings
P.O. Box 2675
Harrisburg, PA 17105-2675

Your request for a Fair Hearing should include the following information:

- Member name
- Member Social Security number and date of birth
- Telephone number where you can be reached during the day
- If you want to have the Fair Hearing in person or by telephone
- A copy of the decision letter you received about the issue for which you are requesting your Fair Hearing

What happens after I ask for a Fair Hearing?

You will get a letter from the Department of Public Welfare's Bureau of Hearings and Appeals telling you where the hearing will be held and the date and time for the hearing. You will receive this letter at least 10 days before the date of the hearing.

You may come to where the Fair Hearing will be held or attend by phone. A family member, friend, lawyer, or other person may help you during the Fair Hearing.

UPMC *for You* will also go to your Fair Hearing to explain why we made the decision or explain what happened.

UPMC *for You* must give you (at no cost to you) any records, reports, and other information we have that are relevant to the issue for which you requested your Fair Hearing.

You can contact UPMC *for You* at 1-800-286-4242. TTY users should call toll-free 1-800-361-2629. Member Services representatives are available Monday through Friday from 8 a.m. to 8 p.m. and Saturday from 8 a.m. to 3 p.m.

When will the Fair Hearing be decided?

If you ask for a Fair Hearing after a First Level Complaint or First Level Grievance decision, the Fair Hearing will be decided no more than 60 days after the Department of Public Welfare receives your request.
If you ask for a Fair Hearing and did not file a First Level Complaint or First Level Grievance, or if you ask for a Fair Hearing after a Second Level Complaint or Second Level Grievance decision, the Fair Hearing will be decided within 90 days from when the Department of Public Welfare gets your request. If your appeal is not decided within 90 days from the date that the Department of Public Welfare receives your request, you may be able to get assistance until the decision is made.

What can I do to continue receiving services?

If you have been receiving services or items that are being reduced, changed, or stopped, and your request for a Fair Hearing is hand-delivered or postmarked within 10 days of the mail date on the letter (notice) telling you that UPMC *for You* has reduced, changed, or denied your services or items, or telling you UPMC *for You*'s decision about your First or Second Level Complaint or Grievance, your services or items will continue until a decision is made.

Expedited Fair Hearing

What can I do if my health is at immediate risk?

If your PCP, other provider, or dentist believes that using the usual time frames to decide your Fair Hearing will harm your health, you, your PCP, other provider, or dentist can call the Department of Public Welfare at 1-800-798-2339 and ask that your Fair Hearing be decided faster. This is called an Expedited Fair Hearing. You will need to have a signed letter from your provider faxed to 1-717-772-6328 explaining why using the usual time frames to decide your Fair Hearing will harm your Health. If your PCP, other provider, or dentist does not send a written statement, your PCP, other provider, or dentist may testify at the Fair Hearing to explain why using the usual time frames to decide your Fair Hearing will harm your health.

The Bureau of Hearings and Appeals will contact you to schedule the Expedited Fair Hearing. The Expedited Fair Hearing will be held by telephone within three (3) business days after you ask for the Fair Hearing.

If your PCP, other provider, or dentist does not send a written statement and does not testify at the Fair Hearing, the Fair Hearing decision will not be expedited. Another hearing will be scheduled, and the time frame for the Fair Hearing decision will be based on the date you asked for the Fair Hearing.

If your PCP, other provider, or dentist sent a written statement or testifies at the hearing, the decision will be made within 3 business days after you asked for the Fair Hearing. You may call the UPMC *for You* Member Services at 1-800-286-4242 if you need help or have questions about Fair Hearings. TTY users should call toll-free 1-800-361-2629. You can contact the Pennsylvania Legal Service Office at 1-800-322-7572 (www.palegalservices.org), or you can call the Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org).

What can I do if UPMC *for You* is not responding to me quickly enough?

The Department of Public Welfare developed a hotline to ensure that the HealthChoices managed care organizations (MCOs) and behavioral health plans honor your right to a timely response to your request for medically necessary care. If you need help, call the Department of Public Welfare's Hotline at 1-800-426-2090. The hotline operates Monday through Friday between 9 a.m. and 5 p.m. TTY users should call toll-free 1-877-202-3021.

Fraud and Abuse Hotline

If you think your HMO, provider or anyone else is committing health care fraud and/or abuse, the Department of Public Welfare has a hotline to report a medical provider (for example, a PCP, other provider, dentist, therapist, hospital) or business (for example, medical supplier).

Here are some common examples of health care fraud and abuse:

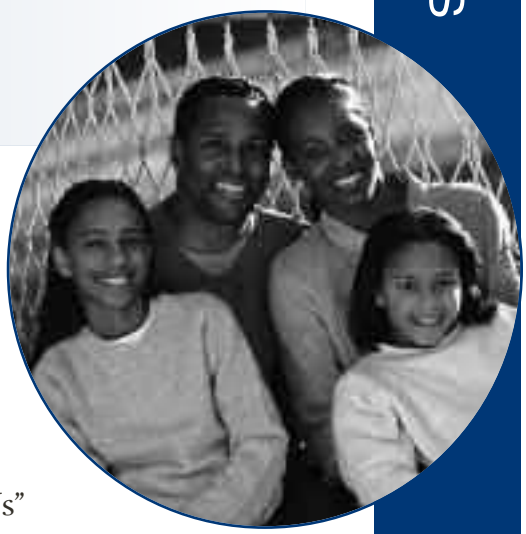
- A provider billing or charging you for services that your health plan covers
- Being offered gift, prescription or prescription medications, or money by medical staff to receive treatment or services
- Being offered free services, prescription or prescription medications, equipment, or supplies in exchange for your UPMC *for You* or ACCESS card insurance information
- Being offered or given treatments or services that you do not need
- Physical, mental, or sexual abuse by medical staff
- Being offered prescription or prescription medications without being seen or treated by the prescribing doctor.
- A UPMC *for You* member who visits an unusually high number of doctors to attain narcotic drugs
- A person who commits identity theft by using someone else's health insurance cards

For suspected fraud or abuse call the Office of Medical Assistance Programs (OMAP) MA Provider Compliance Hotline at 1-866-379-8477 (1-866-DPW-TIPS) Monday through Friday from 8:30 a.m. to 3:30 p.m. This number can also be used for TTY services and to contact non-English-speaking interpreters. You may also call the UPMC Health Plan Fraud and Abuse Hotline at 1-866-372-8301 (1-866-FRAUD-01). Members with hearing impairments or who do not speak English should call the OMAP Hotline. You do not have to leave your name when you call either hotline; however, you will need to leave a detailed message.

All complaint information will be kept confidential. You can contact UPMC Health Plan by mail at:

UPMC Health Plan Corporate Special Investigations Unit
Personal and Confidential (Do Not Open in Mail Room)
P.O. Box 2968
Pittsburgh, PA 15230

To report any other health care fraud, call the Office of Inspector General fraud tip line at 1-800-932-0582.



You can also report suspected fraud and/or abuse by using the following websites:

- OMAP – http://www.dpw.state.pa.us/omap (http://www.dpw.state.pa.us/Business/FraudAbuse/003673491.htm) or send an e-mail to omaptips@state.pa.us
- UPMC Health Plan website – upmchealthplan.com - click on "About Us" and access "Fraud and Abuse" or send an e-mail to specialinvestigationsunit@upmc.edu

MA Provider Compliance Hotline

The MA Provider Compliance Hotline was created by the Department of Public Welfare (DPW) to provide easy access for reporting suspected fraudulent and abusive practices by providers in fee-for-service and managed care plans. The hotline is staffed Monday through Friday from 8:30 a.m. to 3:30 p.m. A voice messaging service is available at other hours. Callers are not required to identify themselves.

If you have knowledge of suspected MA provider noncompliance or of substandard quality of care by a provider, please contact the hotline at 1-866-379-8477 (includes TTY services) or fax information to 1-717- 772-4655 - Attention: MA Provider Compliance Hotline.

You can also mail information to:

Bureau of Program Integrity
MA Provider Compliance Hotline
P.O. Box 2675
Harrisburg, PA 17105-2675

Recipient Restrictions

UPMC *for You* and the Department of Public Welfare (DPW) have the right to restrict members to specific providers or pharmacies when DPW has determined a member has overused and/or misused medical services.

UPMC *for You* will send notification to the member by mail with information regarding DPW's approved restriction. Members or providers may request in writing that the designated provider be changed. Within 30 days from the date the request was received, UPMC *for You* will make the requested change.

Written requests should be mailed to:
UPMC *for You*
One Chatham Center, 6th Floor
112 Washington Place
Pittsburgh, Pennsylvania 15219

Or written requests should be faxed to: 412-454-2933.

A complaint or grievance may not be filed with UPMC *for You* regarding this restriction. The member has the right to appeal the restriction by requesting a DPW Fair Hearing.

A request for a DPW Fair Hearing must be in writing, signed by the member, and sent to:

Department of Public Welfare
Office of Medical Assistance Programs
Bureau of Program Integrity
Division of Program and Provider Compliance
Recipient Restriction Section
P.O. Box 2675
Harrisburg, PA 17110

Phone Number: 1-717-772-4627

Section 7


SOLD

Section 7 Moving and Adding Family Members

What do I do if I move?

If you move, you need to call your caseworker at the County Assistance Office and UPMC *for You* Member Services Department at 1-800-286-4242. TTY users should call toll-free 1-800-361-2629.

Your caseworker must change your address. UPMC *for You* gets this information from the Department of Public Welfare (DPW). It is very important to keep your address up to date so you can receive information from UPMC *for You*.

If you move out of the county in which you currently live, move out of state, or will be out of the service area for more than 30 days, you must notify your caseworker at the County Assistance Office. If you move out of the service area covered by UPMC *for You*, your PCP will not be able to coordinate your care. Depending on where you move, you may need to disenroll from UPMC *for You*. Depending on the county you move to, you may be able to return to the Medical Assistance ACCESS program, or you may need to enroll in another managed care plan. See page 95 for more information on disenrollment.

What do I have to do if I have a new family or household member?

If you have a baby while you are a UPMC *for You* member, you need to call your caseworker at the County Assistance Office to have the baby added to your case. Your baby will be covered by UPMC *for You* from the date he or she is born if the mother is a UPMC *for You* member. Please call the UPMC *for You* Member Services Department at 1-800-286-4242, soon after you have your baby so we can help you select a PCP for your baby. TTY users call toll-free 1-800-361-2629. Member Services representatives are available Monday through Friday from 8 a.m. to 8 p.m. and Saturday from 8 a.m. to 3 p.m. After you select a PCP for your baby, you will receive a UPMC *for You* ID card for your baby. Refer to pages 3-4 for enrollment information.

Anytime you add someone to your family or household, you need to call your caseworker at the County Assistance Office. Your caseworker must determine Medical Assistance eligibility for your new family or household member and add him or her to your case. Once he or she is eligible, the new family or household member can be added to UPMC *for You*. See pages 3-4 for information on enrollment. Enrollment will be different if you live in a HealthChoices county or a Voluntary county.

Section 7 Changing Plans

What if I want to change my health plan?

If you live in a HealthChoices county:
If you live in a HealthChoices county, call the HealthChoices Hotline at 1-800-440-3989. TTY users should call toll-free 1-800-618-4225. A HealthChoices Enrollment Specialist will help you select a new managed care plan. You will have to disenroll from UPMC *for You*.

You are still a UPMC *for You* member until the disenrollment is effective. Continue to use your UPMC *for You* ID card until you are enrolled in your new managed care plan.

The HealthChoices counties are Allegheny, Armstrong, Beaver, Butler, Fayette, Greene, Indiana, Lawrence, Washington, and Westmoreland.

If you do not live in a HealthChoices county:
If you live in the counties of Bedford, Clearfield, Crawford, or Mercer, call the Enrollment Specialist at 1-800-485-5998. TTY users should call toll-free 1-800-654-5988.

Section 7 Additional Information

Quality Improvement Program

High-quality health care is a top priority at UPMC *for You*. The Pennsylvania Department of Health (DOH), Department of Public Welfare (DPW), Centers for Medicare & Medicaid Services (CMS), and National Committee for Quality Assurance (NCQA) set guidelines that we use to guide our Quality Improvement Program.

We pay special attention to:

- Quality management and improvement
- The process that makes sure our providers have the right education and qualifications
- The types of services members are using
- Member rights and responsibilities
- Preventive health care

Section 7 Additional Information

Quality Improvement Program (continued)

If you need information or have any comments that would help us improve our Quality Improvement Program, please write us at this address:

Quality Improvement
UPMC *for You*
One Chatham Center
112 Washington Place
Pittsburgh, PA 15219

HEDIS/CAHPS

The Healthcare Effectiveness Data and Information Set (HEDIS)

HEDIS is a set of standardized measures developed by the National Committee for Quality Assurance (NCQA). The measures were developed to make sure that consumers are able to get reliable answers to compare the quality of health insurance companies. We use the HEDIS measures to evaluate our programs and to make quality improvements in care and service. HEDIS rates are submitted every June, for the previous year. HEDIS information is included in member and provider materials each year.

HEDIS reports many different types of information, including the percentage of children receiving all recommended immunizations (shots) and the percentage of diabetics receiving recommended services.

The Consumer Assessment of Healthcare Providers and Systems (CAHPS)

The CAHPS member satisfaction survey is also part of the annual HEDIS evaluation. As a UPMC *for You* member, you may be asked to complete an adult version of the CAHPS Survey for yourself or a child's version for a dependent child.

For a complete listing of all HEDIS measures, please contact the UPMC *for You* Member Services Department at 1-800-286-4242. TTY users should call toll-free 1-800-361-2629. Member Services representatives are available Monday through Friday from 8 a.m. to 8 p.m. and Saturday from 8 a.m. to 3 p.m.

HEDIS® and CAHPS® are registered trademarks of the National Committee for Quality Assurance (NCQA).

Section 7 Additional Information

Requesting Information

If you need more information or have any questions about UPMC *for You,* call Member Services at 1-800-286-4242. TTY users call toll-free 1-800-361-2629. Member Services representatives are available Monday through Friday from 8 a.m. to 8 p.m. and Saturday from 8 a.m. to 3 p.m. or write to:

Member Services Department
UPMC *for You*
One Chatham Center
112 Washington Place
Pittsburgh, PA 15219

The following information is available upon request:

- A list of names, business addresses, and official positions of members of the Board of Directors or officers of UPMC Health Plan/UPMC *for You*
- The methods UPMC *for You* uses to protect your medical records and other private information
- A description of how we check our providers' qualifications
- A list of providers who practice at our medical facilities
- A list of which drugs are covered
- What you or your provider can do if you need a medication that is not included on the list of covered drugs or when similar formulary medications have not been effective in the treatment of your condition or cause or are suspected of causing a reaction that is harmful to you
- How we decide what experimental drugs, medical devices, or treatments are covered
- How we decide what new treatments are covered
- A summary of how we pay the providers and medical facilities when you use our services
  (**Note:** We will not disclose information about individual contracts or specific details of financial arrangements between UPMC *for You* and providers.)

UPMC *for You*

Affiliate of UPMC Health Plan

One Chatham Center
112 Washington Place
Pittsburgh, PA 15219

upmchealthplan.com

This managed care plan may not cover all your health care expenses.
If you have questions, please call UPMC *for You* Member Services at 1-800-286-4242.
TTY Services: 1-800-361-2629.

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