FORMULA FOR THE FUTURE

vision

+

commitment

+

innovation

UPMC Health Plan Employer Brochure

VISION, COMMITMENT, INNOVATION…

Vision, commitment, innovation . . .

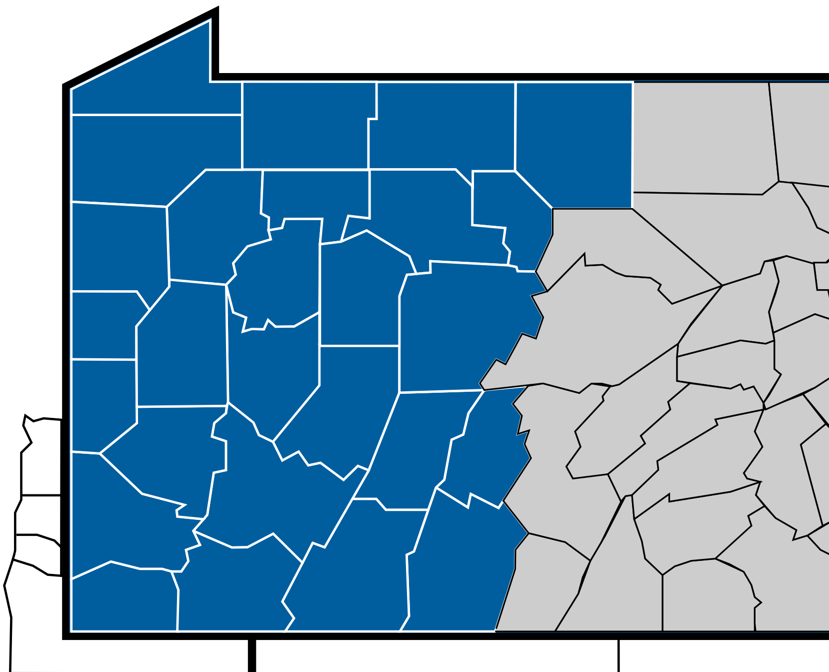
Vision, commitment, and innovation have always been more than just words to the people of western Pennsylvania — they are a way of life.

At UPMC Health Plan, we share these values with our partners: health care professionals, local communities, area residents, and you — the region's employers.

These values — vision, commitment, and innovation — are here to stay. And so is UPMC Health Plan.

As a locally grown and managed company, we understand the people of western Pennsylvania. We know what the region's businesses want. And we apply vision, commitment, and innovation every day to give our clients what they deserve —

Better health…better care… **a better way to do business.**



● UPMC Health Plan Commercial Service Area

QUALITY CARE AND SERVICE

Led by Physicians

UPMC Health Plan, unique in the western Pennsylvania region, was founded as a provider-led managed care organization. The Health Plan has never stood between doctor and patient. UPMC physicians are leaders in the quality of care they provide and in the wise use of health care resources. The Health Plan's network of over 6,000 physicians in 27 counties across the region also includes over 75 % of the area doctors named as the best in the nation by an independent consumer rating organization. That means hundreds of the "Best Doctors" in 30 specialty areas.[1] We work closely with these physicians to ensure that our members get regular preventive care and to determine the most effective health care protocols for members who need medical treatment.

Portal to the University of Pittsburgh Medical Center and Community Hospitals

The Health Plan's mission is to make high-quality, affordable health care available to the people of western Pennsylvania by serving as a gateway to the University of Pittsburgh Medical Center (UPMC) and to our other quality network medical facilities. Our affiliation with UPMC makes us one of the nation's few totally integrated health care delivery systems. This relationship gives us unique access to premier health care resources as well as to innovative medical studies not available to health insurance companies not associated with a medical center. Members are covered at topnotch community hospitals and the best medical centers from Altoona to Ohio and from Erie to West Virginia.

Best of the Best

For the five of the last six years, UPMC earned national recognition by making U.S. News & World Report's Honor Roll, which ranks the top hospitals of the more than 6,000 included in the magazine's study. UPMC is the only area health system to ever

[1] Best Doctors 2002 Assessment

have been placed on the Honor Roll, which recognizes hospitals that excel in multiple specialty areas and that demonstrate unusual breadth of excellence. In the magazine's 2004 listing, UPMC was recognized among the "Best of the Best" hospitals in America in 12 individual specialty areas: cancer, digestive disorders, ear, nose, and throat, geriatrics, gynecology, kidney disease, neurology and neurosurgery, orthopaedics, pediatrics, psychiatry, respiratory disorders, and rheumatology.[2]

Excellence Earned

No matter what service or product they're buying, consumers have one thing in common — they want the best and look for symbols of quality to find it.

In November 2003, UPMC Health Plan earned an important quality designation. In our very first comprehensive review of how well we deliver clinical care and satisfy members with our services and provider network, the National Committee for Quality Assurance (NCQA) gave the Health Plan a rating of "Excellent."

NCQA reserves this "Excellent" rating — the highest honor a managed care company can earn — for health plans that meet or exceed its rigorous requirements for consumer protection and quality improvement. Only 25 % of the more than 650 HMOs in the country have earned an "Excellent" rating.

This "Excellent" NCQA rating means that, compared against national and regional benchmarks, our clinical screening measures are in the upper range of national performance. In fact, the Health Plan scored above the national average in 12 critical areas of performance and ranked in the top 10 % nationally in nine areas.[3]

In addition, a member satisfaction survey conducted by the Consumer Assessment of Health Plans found that we rank more than 5% above the national average in the percentage of our members who believe they are getting the care they need.[4]

[2] U.S. News & World Report, July 12, 2004

[3] 2003 HEDIS (Health Plan Employer Data and Information Set) Quality Improvement Assessment

[4] 2003 HEDIS/CAHPS Member Satisfaction Survey

A BETTER WAY TO DO BUSINESS

State-of-the-art enrollment and claims software

UPMC Health Plan recently invested in new technology that operates our claims, enrollment, and customer service systems from a single software platform. The new software, which we began to use in the spring of 2004, offers our group clients easier report submission, improved response time, and lower administrative costs.

This technology allows group clients to play an active role in accessing and controlling Health Plan data about their accounts and their employees. In addition to submitting eligibility requirements, membership rosters, and demographics via a secure Internet connection, group clients can use online editing to review and make real-time changes to their data.

In addition, proactive claim audits help to ensure that claims are paid correctly the first time, with no need for the time, inconvenience, or expense of readjudication.

24-hour online client service

Employer OnLine, our Internet-based client service center, allows group clients to perform enrollment tasks at their convenience, from the comfort and privacy of home or office. Through Employer OnLine, clients can:

- add new hires as well as new contracts from open enrollment events;
- update members' phone numbers, mailing addresses, and information on spouses and dependents;
- change a member's primary care physician, request a duplicate member identification card, or generate a temporary replacement for a member's lost or damaged identification card
- confirm membership status and view up-to-date PCP, address, copayment, and coverage information on employees
- View historical coverage information on current Health Plan members, and up to a one-year history on terminated members

All data is hosted on a secure server that uses the most advanced security available. Clients' proprietary information is password-protected and seen only by those who are authorized to see it.

Employer OnLine experienced a 29% increase in registered users in 2003, and group clients used the system to process almost 30,000 new enrollment transactions and enrollment updates during that year.

Our **Broker OnLine** program continued to grow in 2003 and is now an integral part of the Health Plan's business relationship with brokers. Brokers get access they need to do their job. Employer groups' benefits are processed faster, which for brokers means fewer complaints from clients. The portal helps brokers organize their book of business, allows them to order supplies as needed instead of in bulk, and opens lines of communication between the Health Plan and brokerage houses. Broker OnLine automatically gives brokers answers they need to know.

We have sold more than 10,000 contracts through Broker OnLine. In 2004, an expanded rollout to more broker groups is scheduled.

WORLD-CLASS BENEFIT PLANS WITH WORLD-CLASS NETWORK

As members of UPMC Health Plan, you and your employees get the peace of mind that comes with having a provider network that includes the medical experts of the world-class University of Pittsburgh Medical Center (UPMC). In addition, members are able to go directly to the participating physicians of their choice — PCP, ob-gyn, or specialist — to receive covered services.

When we opened our doors in 1998, we set the health insurance standard in western Pennsylvania by not requiring members to get a referral in order to see a specialist. While many other insurance companies have followed our lead, the Health Plan's innovative "enhanced access" plans have always given members the flexibility to go directly to network specialists for covered services — without a referral and without waiting to see a PCP.

The Health Plan offers a wide range of benefit plans, making it easy for employers to offer their employees a choice.

Enhanced access HMO (Health Maintenance Organization)

- Based on coordination of care by a primary care physician (PCP)
- Allows self-directed care to network providers at a higher member cost
- Members must receive care from network providers and facilities

With our enhanced access HMO plans, members and their dependents each select a PCP from among the thousands of doctors who participate in the Health Plan's network. The goal of this PCP is to keep employees and their families healthy, not merely to treat them when they are sick.

HMO members may self-direct their care to participating specialists of their choosing (for the self-referral copayment) or have their PCPs coordinate their care (for the standard copayment) — the choice is up to the member.

For women's care, our enhanced access HMO plans allow female members to go to any obstetrician or gynecologist (ob-gyn) in the Health Plan's network for any female-related services, not just routine annual exams —without first having to obtain a referral. The plans cover in-network routine, non-routine, and self-directed gynecological care at 100% after the appropriate copayment.

Most in-network medical and surgical services are covered at 100% after the appropriate copayment. These benefits include

inpatient and outpatient hospital services, diagnostic services, rehabilitation therapy, medical therapy (such as radiation or dialysis), and other services prescribed by a participating physician, such as home health care or durable medical equipment and supplies.

And of course, the UPMC Health Plan enhanced access HMOs cover emergency department services at any medical facility — at 100% after copayment — whether that medical facility belongs to the Health Plan network or not.

EPO (Exclusive Provider Organization)

- Does not require members to coordinate care through a PCP
- Members must receive care from network providers and facilities

UPMC Health Plan's innovative EPO plans provide all the value and security of a traditional HMO without requiring that members coordinate their health care through a PCP. Members get the peace of mind that comes with having a provider network that includes the medical experts of the world-class University of Pittsburgh Medical Center (UPMC), but they are able to go directly to the participating physicians of their choice — PCP, ob-gyn, or specialist — to receive covered services.

While our EPO plans do not require members to officially select a PCP, the Health Plan still believes that PCPs play a vital role in managing care. We encourage each member to select a network general practitioner, internist, or pediatrician, and to build a long-term relationship with that physician. The goal for these doctors is to keep members healthy, not merely to treat you them when they are sick.

For women's care, our EPO plans allow female members to go directly to any obstetrician or gynecologist (ob-gyn) in the Health Plan's network for any female-related services, not just routine annual exams. The plans cover annual exams in full and other in-network routine, non-routine, and self-directed gynecological care at 90% to 100% (depending on plan design) after the appropriate copayment.

Office visits to network physicians for treatment of an illness or injury are covered in full after copayment. Most other in-network medical and surgical services are covered at 90% to 100% (once again depending on plan design) after the appropriate copayment. These benefits include inpatient and outpatient hospital services, diagnostic services, rehabilitation therapy, medical therapy (such as radiation or dialysis), and other services prescribed by a physician, such as home health care or durable medical equipment and supplies.

Enhanced access POS (Point of Service)

- Encourages members to coordinate care through a PCP
- Allows self-directed care to network providers at a higher member cost
- Members may choose out-of-network care for a higher out-of-pocket cost

UPMC Health Plan's enhanced access POS plans offer the best of both worlds: the peace of mind that comes with access to the medical experts of UPMC — and the flexibility of being able to choose out-of-network care.

EAPOS members may self-direct their care to participating specialists of their choosing (for the self-referral copayment) or have their PCPs coordinate their care (for the standard copayment) — the choice is up to the member.

For women's care, our EAPOS plans allow female members to go to any obstetrician or gynecologist (ob-gyn) in the Health Plan's network for any female-related services, not just routine annual exams —without first having to obtain a referral. The plans cover in-network routine, non-routine, and self-directed gynecological care at 100% after the appropriate copayment.

If a member prefers to see an ob-gyn who is not in the Health Plan network — no problem. Our EAPOS plans cover out-of-network routine and non-routine gynecological care after the member meets her deductible and coinsurance charges.

Most in-network medical and surgical services are covered at 100% after the appropriate copayment. Medical and surgical services are also covered out-of-network, but usually at a lower benefit level. These benefits include inpatient and outpatient hospital services, diagnostic services, rehabilitation therapy, medical therapy (such as radiation or dialysis), and other services prescribed by a physician, such as home health care or durable medical equipment and supplies.

And of course, the UPMC Health Plan enhanced access POS plans cover emergency department services at any medical facility — at 100% after copayment — whether that medical facility belongs to the Health Plan network or not.

PPO (Preferred Provider Organization)

- Does not require members to coordinate care through a PCP
- Allows members to receive care from the physicians and facilities of their choosing
- Members may choose out-of-network care for a higher out-of-pocket cost

We designed our PPO plans to give members the flexibility to go to the providers they want to see, whether those providers participate in our networks or not. Our PPO plans do not require that members coordinate their care through a PCP. Instead, they may go directly to the physician of their choice — PCP, ob-gyn, or specialist — to receive covered services.

PPO members incur lower out-of-pocket medical costs when they receive covered services from participating providers. If PPO members choose to receive those services from providers outside of our networks, they are still covered, but the member's out-of pocket costs will be higher.

UPMC Health Plan does require that members see our network providers for routine and preventive care services. We cover these services at 100% after copayment. Our PPO plans also cover annual gynecological exams, and physician office visits due to illness or injury, at 100% after the appropriate copayment.

Most in-network medical and surgical services are covered at 80% to 100% (depending on the plan design) after the appropriate copayment. These services are also covered out-of-network, but usually at a lower benefit level. Medical and surgical benefits include inpatient and outpatient hospital services, diagnostic services, rehabilitation therapy, medical therapy (such as radiation or dialysis), and other services prescribed by a physician, such as home health care or durable medical equipment and supplies.

And of course, our PPO plans cover emergency department services at any medical facility — at 100% after copayment — whether that medical facility belongs to the Health Plan network or not.

UNIQUE NO-COST PROGRAMS

UPMC Health Plan offers a variety of creative programs that safeguard and improve members' health. As members of the Health Plan, you and your employees have access to these unique programs and services at no additional charge:

Assist America, a global medical emergency assistance program for members who are traveling away from home. Assist America locates qualified doctors and hospitals, helps fill prescriptions forgotten at home, arranges emergency medical evacuations and transportation to be with injured relatives, and much more. UPMC Health Plan is the only health plan in western Pennsylvania to offer Assist America.

Health A to Z, an online collection of health materials that UPMC medical experts developed to keep you healthy and more informed about your medical care. Health A to Z includes:

- articles about the symptoms, causes, and treatments of diseases
- a list of prescription medications and their uses
- a set of health measurement tools that help you set proper diet and exercise goals
- patient education materials that describe common medical tests and procedures
- a calendar of regional health screenings, classes, and lectures
- a library of other consumer health information

Healthy Living Rewards, the program that offers Health Plan member discounts at hundreds of regional businesses that promote a healthy lifestyle: gyms, spas, salons, dance studios, martial arts schools, health food stores, sporting goods stores, and more.

Member OnLine, the Health Plan's easy-to-use Internet-based customer service center. With Member OnLine, you can change your primary care physician, update your contact information, request new ID cards, check your benefits, and confirm your eligibility for coverage, 24 hours a day, 7 days a week, from the privacy of your own home.

Health management programs that help members with chronic illnesses better understand and manage their medical conditions. We began providing such programs to members in 1999, with the launch of our diabetes management program. Since then we have added programs for asthma, CHF, and kidney disease. We have identified these chronic conditions because members with these diseases have been shown to respond well to care management.

Health insurance companies across the nation are beginning to recognize the value of such programs in fostering member health and reducing costs for health care systems as a whole. America's Health Insurance

Plans recently conducted a national survey of programs that health plans offer to members with chronic medical conditions. The survey found that diabetes, asthma, and congestive heart failure (CHF) programs, as well as programs for multiple chronic conditions, provide great value in terms of improved quality of life and conservation of health care resources.[5]

At the Health Plan, these programs involve the collaboration of on-staff nurses, network physicians, and members themselves. The results are hard to argue with — hospital admissions are down 29% for participants in our diabetes program and 44% for those in CHF. We see the same trend in emergency department visits: down 49% for diabetes, 13% for asthma, and 44% for CHF. Programs like these, which improve the quality of life for people with chronic conditions, also lead to improved employee morale and attendance — two areas with a great impact on a company's bottom line.

Outreach to members to remind them to get the preventive care they need. For example, we mail reminders to high-risk members to get flu shots, which we provide--at no cost to Health Plan members--at local grocery stores and through special UPMC mobile medical vans. We also send information to parents about immunizing their children. And we mail notices to female members to receive their annual mammogram and Pap smear, which can help detect breast and other cancers at early, and perhaps more treatable, stages.

Community outreach to promote wellness and help prevent illness in the local community. Maintaining and improving the health of our communities benefits all participants in the health care marketplace. It keeps members going strong at home and at work, frees providers' time to take care of patients, and conserves health care dollars by preventing doctor visits and, in some cases, emergency department visits and hospital admissions.

UPMC Health Plan also chairs annual fundraising and awareness-raising efforts for such events as the American Heart Association Heart Walk and the March of Dimes WalkAmerica. In addition, UPMC Health Plan is the title sponsor of Genesis of Pittsburgh's annual Riverside Run for Adoption. Backed by our parent company, UPMC, our annual contributions to these efforts help raise much-needed funding for these organizations, in addition to promoting the importance of physical activity.

[5] American Association of Health Plans/Health Insurance Association of America, November 2003

A PHARMACY PROGRAM THAT MEETS YOUR NEEDS

Your Choice pharmacy program

Good value and freedom of choice — UPMC Health Plan's three-tier Your Choice pharmacy program provides both of these by offering a variety of high-quality, effective generic and brand-name drugs. Unlike more traditional "closed formulary" pharmacy programs, the Your Choice program allows members and doctors to choose, for a higher copayment, drugs that were previously available only with special medical permission. This gives members and their physicians the freedom to choose from among multiple appropriate medications while allowing them to better budget health care dollars.

In-house management of pharmacy benefits

We have chosen to more closely manage our prescription drug costs by acting as our own pharmacy benefits manager. While we outsource pharmacy claims processing, all other functions of our pharmacy program are managed in-house, including direct contracting with pharmaceutical companies for rebate agreements and leveraging the purchasing power of the Health Plan and UPMC to negotiate more cost-effective network and reimbursement agreements.

Generic drugs

Another way in which the Health Plan is actively working to reduce pharmacy costs in order to minimize increases in health insurance premiums is by joining with consumer advocacy groups and government service organizations to advocate the use of generic drugs whenever appropriate. Generic drugs are a cost-effective way to lower company and member health care costs.

We encourage the use of generics through member brochures that reinforce the safety and cost-effectiveness of these drugs. In addition, the Your Choice pharmacy program has a mandatory generic policy. This means that if a drug has a generic equivalent, members must use the generic form. Our pharmacy copayment structure offers financial incentives for members to use generic drugs.

Generic drugs offer the same safety, quality, and active ingredients as their brand-name counterparts, and are usually priced significantly lower. According to published reports, the average price difference between a generic drug and its corresponding brand-name drug was $45.96. The use of generic drugs could save consumers between $8 billion and $10 billion per year at retail pharmacies alone.

Our pharmacy networks

The Health Plan's network of retail pharmacies includes hundreds of locations — independent pharmacies as well as multi-store chains — throughout the region. We also contract with a mail-order pharmacy fulfillment center to offer members the cost-savings and convenience of having prescriptions sent directly to their homes. And because the Health Plan uses a nationwide pharmacy benefits company to help manage the Your Choice pharmacy program, members' prescription needs are covered even when travelling outside of the western Pennsylvania area. Thousands of pharmacies across the country honor the UPMC Health Plan member ID card.

DENTAL AND VISION BENEFIT OPTIONS

VISION BENEFITS: CLEARLY MANAGED, CLEARLY FOCUSED

UPMC Health Plan offers vision benefits through an arrangement with Vision Benefits of America (VBA), a comprehensive nationwide network of eye care providers that has been managing group vision benefits for more than 35 years. Through its more than 12,000 participating optometrists, ophthalmologists, and retail optical facilities, VBA provides managed vision care to more than 1 million members across the country.

Standard vision benefit plans

UPMC Health Plan offers two standard VBA plan designs. The Exam Only plan includes a complete exam of the eyes and related structures to determine the presence of any vision problems. Adults and dependents age 19 or older are eligible for a vision exam once every 24 months, while juvenile dependents (younger than 19 years of age) are eligible for an exam every 12 months.

The Exam Plus plan adds a pair of clear, standard lenses and a $40 wholesale allowance toward eyeglass frames (approximately $90 to $110 retail value) to the basic vision exam described above.

VBA network versus out-of-network vision care

When members visit a VBA network provider, they incur no out-of-pocket costs for their vision exams. VBA does reimburse a certain dollar amount towards the cost of a vision exam by a non-participating provider, but the exams are covered at a lower level of benefits and the members will have higher out-of-pocket costs.

Using a VBA vision professional also ensures the quality of your employees' eye care. All of the providers in VBA's network have agreed to adhere to VBA's strict examination standards. Additionally, lenses ordered through a VBA provider are manufactured at one of VBA's more than 230 approved optical labs, where cost and quality are strictly controlled.

Dental Benefits from a Market Leader

When it came to choosing a partner to provide dental benefits, UPMC Health Plan chose the market leader: Guardian. Over 57,000 companies have selected Guardian to provide their employees' dental coverage — more than any other dental insurer.

The DentalGuard Preferred network

With more than 67,000 provider locations, Guardian's DentalGuard Preferred is already one of the largest PPO networks in the industry. Guardian is committed to the continued growth of its PPO network and, with high quality care remaining the foremost consideration, actively recruits more skilled dentists and specialists every day.

Guardian can generate comprehensive geographic access reports to illustrate how close to network dentists your employees live. And Guardian's online provider directory and toll-free 800 number make it easy for your employees to find nearby network dentists.

State-of-the-art claims processing

Guardian's claims turnaround is one of the fastest in the business. On average, Guardian processes and mails claims within five days from the time they are received.

Guardian's state-of-the-art claims software administers according to your group's specific plan provisions, and the system is able to issue a variety of periodic reports showing your company's actual claims activity. This allows you to analyze claims patterns and determine plan changes that may decrease your future premium costs.

Guardian also has a dedicated unit in place to identify and investigate possible service over-utilization and fraud. These sophisticated measures help promote cost-efficiency and premium savings which Guardian passes on to client companies and their employees.

Customer service

Guardian understands that service is a key element in client satisfaction and continues to make customer service its top priority.

Guardian's Customer Response Unit (CRU), which provides call-in customers with answers to billing and benefit questions, is specifically designed to support the ongoing service demands of brokers and employers. To ensure precise and prompt call resolutions, CRU team members are equipped with a comprehensive database of clients' benefits backgrounds and call histories. Guardian resolves more than 95% of questions and issues during the client's first call to the CRU.

UPMC *FOR LIFE* MEDICARE PLANS

UPMC Health Plan also offers group-sponsored UPMC for Life Medicare benefit plans to eligible subscribers:

- UPMC *for Life* Medicare Advantage HMO, which gives members a network of the area's best doctors and hospitals
- UPMC *for Life* Medicare Advantage PPO, which lets members visit any doctor and any hospital

Medicare premiums for eligible subscribers are determined based on the county in which the individual resides.

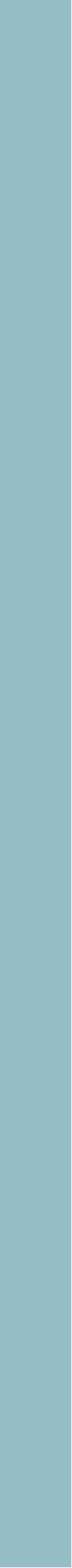
UPMC *for Life* Medicare Advantage HMO

UPMC *for Life* HMO expands on the benefits that traditional Medicare covers. Under UPMC *for Life* HMO, members do not have to pay an annual deductible. The 20% to 50% coinsurance that traditional Medicare coverage requires is also eliminated. Instead, members pay only a modest copayment when they visit a doctor or hospital in the UPMC *for Life* network. UPMC *for Life* HMO also offers an optional prescription drug plan.

UPMC *for Life* Medicare Advantage PPO

UPMC *for Life* PPO includes the same benefits as UPMC f*or Life* HMO, but offers even greater freedom and flexibility. As with UPMC *for Life* HMO, members are responsible for a small copayment each time they visit one of the many doctors or hospitals thatparticipate in the UPMC *for Life* network. Services rendered by network providers require no annual deductible or coinsurance payments.

In addition, UPMC *for Life* PPO also covers members when they visit a doctor or medical facility not included in the UPMC *for Life* network. After a $500 deductible, UPMC *for Life* PPO pays for 80 % of a member's covered benefits no matter what doctor or hospital the member chooses for treatment.



Utilization Management

Our role as financial and medical steward of your health care requires that UPMC Health Plan review and approve certain procedures prior to those services being completed. The Health Plan 's clinical staff will communicate with your physicians for these review processes. UPMC Health Plan 's key utilization management procedures include pre-authorization, concurrent review, retrospective review, and discharge planning.

Privacy & Confidentiality

At UPMC Health Plan,we respect and protect your personal information. Your name, address, social security number,and birth date are confidential – along with any other health information that could identify you personally, and any data we have about services that you have received or the premiums that you pay.

UPMC Health Plan uses your personal health and financial information internally and with our contracted agents or providers only. We use your personal information for the following three purposes:your health care treatment, the health care operations that are required to provide that treatment, and the payment of your health care claims. We do not share your personal information with your employers. We will not disclose your information for any purpose beyond the three described above,unless you authorize us or the law requires us to.

You have the right to access your medical records.You should contact your health care provider directly for these files since UPMC Health Plan does not create or maintain medical records. Your privacy rights include the rights to access, amend, restrict, request an alternate communication method for, and request an alternate communication location for the information the Health Plan maintains.You also have the right to know anytime the Health Plan discloses your personal health information beyond what is necessary for your treatment, the operations required to provide your treatment, or the payment of your claims.

UPMC Health Plan policies and procedures protect personal health information for current,former, and prospective members (living or deceased) in accordance with all applicable laws.These policies and procedures protect your information regardless of its format: oral, written, or electronic. UPMC Health Plan complies with all aspects of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and monitors issues related to HIPAA. The Health Plan has a Notice of Privacy Practices document that details our commitment to protecting your personal information. Prospective members may review the document on UPMC Health Plan 's website at www.upmchealthplan.com.

For questions concerning the privacy and confidentiality of your personal information, call UPMC Health Plan at 1-888-876-2756.

For questions concerning the confidentiality of behavioral health information, please contact Western Behavioral Health at 1-888-251-0083.

Now, more than ever,

UPMC Health Plan

One Chatham Center
112 Washington Place
Pittsburgh, PA 15219

www.upmchealthplan.com

If you have questions about UPMC Health Plan, please call our *Open Enrollment Information Line* at **1-800-644-1046**.

Our representatives are available:

Monday through Friday
8:00 a.m. to 5:30 p.m.

Saturday
8:00 a.m. to noon

UPMC Health Plan administers benefit plans underwritten by UPMC Health Network,Inc.

This managed care plan may not cover all your health care expenses.
Read your contract carefully to determine which health care services are covered.
UPMC Health Plan Member Services:1-888-876-2756
UPMC Health Benefits Member Services:1-877-381-3764