AMERICAN ARBITRATION ASSOCIATION

UPMC, Claimant, v. HIGHMARK INC. and KEYSTONE HEALTH PLAN WEST, INC., Respondents.	Case No. 01-15-0004-8523

UPMC-HIGHMARK SETTLEMENT AGREEMENT

Subject to the following terms, from January 1, 2016 to June 30, 2019, the continuation of care of a Highmark member in the midst of a course of treatment at UPMC shall be on an In-Network basis at In- Network rates:[1]

1. The need for a continuing course of treatment shall be determined, in the first instance, by the patient's treating physician, whether independent or UPMC employed, acting in consultation with and in accordance with the wishes of the patient or the patient's representative. To the extent that the patient's treating physician is an independent physician, the patient must have received service at UPMC for the condition based on a referral from the independent physician.

2. In-Network access for patients of either UPMC employed or independent physicians who were in a continuing course of treatment at UPMC in 2013, 2014, or 2015 shall be available to patients who have a chronic or persistent medical condition and shall include all care reasonably related to those condition(s). In-Network access shall specifically exclude, *inter alia*, routine wellness or routine preventive care. A Highmark member who was in a course of treatment at UPMC for a confirmed pregnancy on or before December 31, 2015, may continue to access UPMC on an In-Network basis for maternity care and delivery related to that pregnancy, as well as post-partum care related to that pregnancy.

3. The parties expect that it will be unusual that a person will be in a continuing course of treatment if a patient has not been seen by UPMC since 2012. In the event that UPMC believes that such a patient is entitled to continuity of care, UPMC will bear the burden of demonstrating that the patient was receiving care in accordance with recognized medical protocols and/or standards.

[1] All capitalized terms herein shall have the meanings given to them in the Consent Decrees.

4. While undergoing a continuing course of treatment with UPMC the services covered In-Network will include all services reasonably related to that treatment, including but not limited to testing and follow-up care.

5. UPMC will identify for Highmark the claims submitted for which the determination has been made that continuity of care status exists under the Consent Decrees. In the event that Highmark cannot identify prior claims history for a particular patient, UPMC will provide upon written request within 10 days:

   (a) previous date(s) of service
   (b) performing provider(s)
   (c) site of service
   (d) diagnosis and procedure codes
   (e) acquisition date of newly acquired UPMC provider and/or EPIC bill date
   (f) name of previous other insurance carrier.

6. If Highmark does not receive the information within the prescribed 10-day time period mentioned in paragraph 5, Highmark may at its option deem the claim to be Out-of-Network.

7. To the extent that Highmark disputes the In-Network status of a claim or deems the claim Out-of-Network under paragraph 6, either party, within 30 days of receiving a billed or denied claim, may invoke the following procedure.

   (a) Clinical Review. Highmark shall submit the claim(s) tied to the disputed care ("disputed claim") to teams of two clinicians, one designated by UPMC and the other by Highmark, who have the authority to determine for each party whether the claim qualifies as In-Network under the Continuity of Care provision. The Clinical Review will occur within 15 days of submission of the disputed claim to the clinicians for review. UPMC will provide the reviewing clinicians with appropriate supporting clinical information or documentation for the claim(s).

   (b) Submission to DOH. In the event that the designated clinicians cannot reach agreement, Highmark may, within 30 days of the completion of the Clinical Review, submit the disputed claim to the Pennsylvania Department of Health ("DOH"), or its designated representative, for a binding determination as to whether the claim is In-Network. If Highmark submits the disputed claim to DOH, Highmark must inform the affected Member or his/her legally authorized representative in writing that Highmark is disputing his/her claim(s) and that the Member has the right to participate in the DOH's determination of the disputed claim. Any costs incurred by the DOH or its designee will be paid by the losing party.

   (c) Payment of Disputed Claims Not Submitted to DOH. If Highmark does not submit the disputed claim to the DOH, Highmark shall pay the disputed claim within 30 days of the 30-day period described in section 7.b. above.

(d) Payments made at the conclusion of this process will be regarded as timely under any prompt payment requirement.

8. If the UPMC treating physician in consultation with the patient determines that the course of treatment for a prior condition is completed or does not qualify under this agreement, then that visit will be treated as In-Network and as a transition visit to assist the patient in transitioning care to an In-Network provider.