

March 15, 2010

[www.upmchealthplan.com](http://www.upmchealthplan.com)

Dear Provider:

UPMC *for You*, Inc., will introduce benefit design changes for some members, effective April 1, 2010. Some of the benefit design changes are similar to the benefit limitations adopted by the Department of Public Welfare (DPW). The benefits listed below represent specific revisions to the UPMC *for You* product at this time.

Based on the member's benefit category of assistance, he or she may have an eighteen (18) visit limit per year, six (6) prescription limit per calendar month, or copayments for some services.

- Limits do not apply to members under the age of 21.
- Copayments do not apply to members under the age of 18.
- Copayments and limits do not apply to pregnant women (including through the post-partum period), nursing facility residents, members who reside in an Intermediate Care Facility for the Mentally Retarded and Other Related Conditions, and recipients eligible under the Breast and Cervical Cancer Prevention and Treatment Programs, Title IV-B Foster Care and IV-E Foster Care, and Adoption Assistance.
- Pharmacy limits only apply to members in the General Assistance benefit category if they have not met one of the exceptions listed above.

Providers are required to collect applicable copayments for rendered services; however, providers may not deny services if the member cannot pay the copayment. The member is still liable for the copayment and the provider may attempt to collect the copayment by billing the member for the overdue amount. A provider may not waive the copayment requirement.

Some General Assistance (GA) members will have prescribed medications, including over-the-counter medications, covered up to a maximum of six (6) prescriptions, including originals and refills, per calendar month.

- Exceptions to the numerical limits on prescription may be granted if the member has a serious chronic systemic illness or other serious health conditions.
- The first month for these limits start April 1, 2010.

Some Medical Assistance (MA-Adult) and General Assistance (GA) members will have an 18-visit limit per year for certain routine office, clinic and home visits when performed by physicians, certified registered nurse practitioners (CRNP), podiatrists, optometrists, chiropractors, outpatient hospital clinics, outpatient medical clinics, Rural Health Clinics, or Federally Qualified Health Centers (FQHC).

- Visits to a primary care practitioner (PCP) or PCP-referred specialist that exceed the 18-visit limit are automatically approved for a benefit limit exception and do not require an additional request unless the visit is to a chiropractor or podiatrist.
- The first benefit year for these limits start April 1, 2010, and goes through June 30, 2010. After that, a new benefit year will start on July 1 of every year.

Providers may submit benefit limit exception requests to the Medical Management Department. See the UPMC Health Plan provider manual for complete instructions. The request may be submitted via telephone at 1-800-425-7800, via fax 412-454-2057, or via mail at the following address:

UPMC *for You*  
Attention: Medical Management  
One Chatham Center  
112 Washington Place  
Pittsburgh, PA 15219

An exception to the limit is reviewed by the Medical Director for medical necessity and can be granted if the member:

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

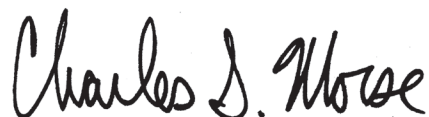
A provider may not bill a member for services that exceed the limits unless the following conditions are met:

- The provider has requested an exception to the limit and the request was denied.
- The provider advised the member, before the service was provided, that he or she will be responsible for payment if the exception is not granted.
- The provider advised the member, before the service was provided, that the member has exceeded the limits.
- The provider advised the member, before the service was provided, and documented the discussion in the medical record. The provider may have the member sign an advanced notification form.

Notification of these benefit changes and copayments has been mailed to UPMC *for You* members. Member notifications will be posted on our website at [www.upmchealthplan.com](http://www.upmchealthplan.com). Select "Member" and "Medical Assistance" to view the correspondence. As always, UPMC *for You* benefits can be reviewed within the provider portal at [www.upmchealthplan.com](http://www.upmchealthplan.com). If you have any questions regarding the benefit modifications noted below, please call Provider Services at 1-866-918-1595.

Thank you for your attention to these changes and your continued participation with UPMC *for You*.

Sincerely,



Charles S. Morse  
Sr. Manager, Network Management Dept

Attachment

<b>Copayments</b>	<b>MA (J07 &amp; J09)</b>	<b>GA (J08 &amp; J10)</b>
Ambulance (per trip)	\$0	\$0
Dental care	\$0	\$0
<b>Inpatient Hospital (Acute or Rehab)</b>		
Per day	\$3	\$6
Maximum with limits	\$21	\$42
<b>Medical Centers</b>		
Emergency Department (non-emergent visits)	\$3	\$6
Ambulatory Surgical Center	\$3	\$6
Federal Qualified Health Center/ Regional Health Center	\$0	\$0
Independent Medical/Surgical Center Convenience Care or Urgent Care Centers	\$2	\$4
Short Procedure Unit	\$3	\$6
<b>Medical Equipment</b>		
Purchase	\$0	\$0
Rental	\$0	\$0
<b>Medical Visits</b>		
Certified nurse practitioner	\$0	\$0
Chiropractor	\$2	\$4
Doctor (PCP, ob/gyn)	\$0	\$0
Optometrist	\$0	\$0
Podiatrist	\$2	\$4
Therapy (Occupational, Physical, Speech)	\$2	\$4
<b>Outpatient Hospital</b>		
Per visit	\$2	\$4
<b>Prescriptions</b>		
Generic	\$1	\$1
Brand	\$3	\$3
<b>Diagnostic Services (not performed in a doctor's office)</b>		
Medical diagnostic testing (per service)	\$1	\$2
Radiology diagnostic testing (per service)	\$1	\$2
Nuclear Medicine (per service)	\$1	\$2
Radiation Therapy (per service)	\$1	\$2
<b>Inpatient Hospital</b>		
	<b>Limits</b>	<b>Limits</b>
*Six-prescription limit per calendar month for new prescriptions and refills	n/a	Applies to adults over the age of 21
*18-visit limit per fiscal year (July 1 - June 30). *Visits over 18 to PCPs are exempt from the limit. *Visits over 18 to Specialists are exempt, if coordinated & referred by the PCP (except for podiatrists or chiropractors).	Applies to adults over the age of 21	Applies to adults over the age of 21