

## 2019 Medicare Advantage plan changes

Annual benefit changes for Medicare Advantage plan members will be effective January 1, 2019. The following is a summary of these changes. Complete details can be found in the member's evidence of coverage. Please visit [anthem.com/ca/medicareprovider](http://anthem.com/ca/medicareprovider) for 2019 evidence of coverage, formularies and benefit summaries or contact Provider Services at the number on the back of the member's ID card. Plans may include changes to medical and Part D benefits, copayments and/or coinsurance, deductibles, formulary coverage, pharmacy network, premiums and out-of-pocket maximums.

Some group-sponsored Medicare Advantage plan benefits vary from the Medicare Advantage plans offered to individuals. Please refer to the member's evidence of coverage or call Provider Services at the number on the member ID card for more benefit detail.

### 2019 highlights (vary by plan)

- **Medicare community resource support:** This telephone-based service staffed by a community resource outreach team will offer:
  - Community resource research and education
  - Condition/disease-state education and how to access community support and services
  - Outreach to programs to connect members to information and services
- Tiered skilled nursing facility (SNF) network (excluding Dual Special Needs Plans) with lower copayments for preferred SNFs. Members will have access to higher-quality care and lower costs with preferred SNF providers. Preferred SNF providers will be identified in provider directories.
- \$0 labs for A1C, urine protein, fecal occult blood test and diabetic eye exam.

### Medicare Advantage PPO

- Our PPO plans include coverage for services rendered by out-of-network providers. While out-of-network services do not need approval in advance, the member or member's provider can ask us to make a coverage decision in advance so the member can be made aware if the service is covered under their plan prior to services being rendered. Members are responsible for verifying that this has been completed. All services will be reviewed for coverage and medical necessity in accordance with Medicare guidelines once a claim is received. Medical records may be requested. If the member uses an out-of-network provider, their share of the cost for the covered services will be as shown in the benefits chart for out-of-network care. The member is responsible for the out-of-network cost sharing even if directed to an out-of-network provider by an in-network provider. **If the member has a National Access Plus plan, the member's share of the cost is the same whether the doctor is in our network or not. The doctor must be approved by Medicare.** If a provider requests a coverage determination because there is no contracted network provider available to provide the service/treatment

within our plan's service area, and this request was approved for that reason, the member will only pay the in-network cost share associated with that service.

**Medicare Advantage HMO:**

- **Anthem MediBlue Dual Plus (HMO SNP)** will be a new plan in Fresno, Kings, Madera, Tulare, Kern, Sacramento, San Francisco, and Ventura counties.
- **Anthem MediBlue Extra (HMO)** will be offered in Los Angeles County.
- **Anthem MediBlue Select (HMO)** will be offered in San Diego County.

**Frequently Offered Supplemental Benefits** (Complete details can be found in the member's evidence of coverage.)

- \$0 annual exam
- Preventive dental
- Vision exam
- SilverSneakers — fitness
- Hearing aid allowance
- Over-the-counter allowances for OTC medications and health-related items at Walmart's 4,700 stores or other retailers and online
- Over-the-counter allowances
- LiveHealth Online — convenient access to a doctor via live, two-way video on a computer or mobile device. Members logon to [www.livehealthonline.com](http://www.livehealthonline.com)
- Nursing hotline
- Acupuncture and chiropractic care
- Post-discharge meals
- Worldwide coverage
- Personal Emergency Response System (PERS) --The Emergency Response System is intended to help people maintain independence in their own homes who might otherwise need to live in an assisted living facility. Monthly monitoring and testing is included.

**Formulary and pharmacy**

For plans that have a 5-tier structure, more than 600 drugs and strengths will move from Tiers 3 and 4 to a lower copay tier on Tiers 1 and 2 in 2019.

Your patients will have formulary changes and will need your help to ensure they get their prescriptions at the most affordable cost.

Please encourage your patients to review the 2019 formulary information within their Annual Notice of Change (ANOC) mailing or their new member kit, or online. Ask them if the coverage for any of their prescriptions has been changed, and consider alternative medications in a lower cost-sharing tier that may meet their needs.

Individual MAPD plans have a pharmacy network that includes preferred and standard network retail pharmacies. Members save more by paying a lower cost-sharing amount at preferred cost-sharing pharmacies. Our preferred cost-sharing pharmacies include **CVS/pharmacy, Giant**

**Eagle, Kroger, Target, Sam's Club and Walmart. Additional independent pharmacies have been added to the cost-sharing network for 2019.**

Members can fill a prescription at a network retail pharmacy, but their cost-sharing amount may be higher. In some of our plans, members will also see additional savings through mail order, which we have moved from 3 times the preferred retail copay to 2 times the preferred retail copay.

Some of our plans have added coverage of Erectile Dysfunction drugs. Please refer to the formulary or evidence of coverage for more details.

**Balance billing reminder:**

CMS and Anthem do not allow you to balance bill Medicare Advantage HMO and PPO members for Medicare-covered services. CMS provides an important protection for Medicare beneficiaries and our members such that, after our members have met any plan deductibles, they only have to pay the plan's cost-sharing amount for services covered by our plan. As a Medicare provider and/or a plan provider, you are not allowed to balance bill members for an amount greater than their cost share amount. This includes situations where we pay you less than the charges you bill for a service. This also includes charges that are in dispute.

**Prior authorization for Medicare Advantage plans:**

Detailed prior authorization requirements are available to contracted providers by accessing the Provider Self-Service Tool at [www.Availity.com](http://www.Availity.com). Contracted and non-contracted providers who are unable to access Availity may call our Provider Services at the phone number on the back of the member's ID card for prior authorization requirements.

Please check the member ID card for any identification and/or group number changes that may affect claim submissions. Sample 2019 member ID cards will be available at [anthem.com/ca/medicareprovider](http://anthem.com/ca/medicareprovider).

**New provider service number for individual Medicare Advantage**

Effective January 1, 2019, providers should call 844-421-5654 for individual Medicare Advantage provider service.

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