Dear Healthcare Provider,

Annual benefits changes for Medicare Advantage plan members will be effective January 1, 2012. The changes apply to members enrolled in Anthem Medicare Preferred Standard (PPO) and Anthem Medicare Preferred Premier (PPO). You can help members manage their health care costs by being aware of these changes. In addition, it is important to check the Medical ID card at the beginning of each calendar year as the member may have changed plans.

Each year, we renew our contract with the Centers for Medicare and Medicaid Services (CMS). CMS re-evaluates and approves the benefits we’ll offer to our Medicare Advantage members for the upcoming year.

Notable 2012 benefit changes and highlights:

**Anthem Medicare Preferred (PPO) plan changes**
- Instituting network physician copayment and hospital inpatient copayment changes on some plans. The member ID card will reflect the change, if any.
- Reducing Out-of-Network outpatient and ambulatory surgery copayments to $150 for Anthem Medicare Preferred Premier.
- Member cost shares are changing for certain outpatient diagnostic tests, X-rays and radiology procedures for Anthem Medicare Preferred Standard and Anthem Medicare Preferred Premier.
- Routine Vision coverage will no longer be offered on the Anthem Medicare Preferred Premier plan; however, these members will now have access to vision coverage through Optional Supplemental Benefits.
- Routine Dental coverage will no longer be offered on the Anthem Medicare Preferred Premier plan; however, these members will now have access to dental coverage through Optional Supplemental Benefits. The member ID card will indicate whether the member has preventive dental benefits covered on their plan.
- Member cost shares are changing for Medicare-Covered Hearing Exam copayments for Anthem Medicare Preferred Standard and Anthem Medicare Preferred Premier.
- Member cost shares are changing for routine podiatry Anthem Medicare Preferred Standard and Anthem Medicare Preferred Premier.
- The Anthem Medicare Preferred Standard and Anthem Medicare Preferred Premier service area is expanding to the following counties: Albemarle, Charlottesville City, Fluvanna, Louisa, Montgomery, Northampton, Orange, Pulaski, Roanoke, Roanoke City, and Salem City.
- The Anthem Medicare Preferred Classic H4909-007 will be non-renewing for 2012.
- Please check the member ID card for any identification and/or group number changes that may affect claim submissions.

**Anthem Medicare Preferred (PPO) plan highlights**
- Plan premiums as low as $0 for Anthem Medicare Preferred Standard (PPO).
- Primary care physician (PCP) copays range from $0 to $15 and specialist copays range from $25 to $45.
- All of our Anthem Medicare Preferred plans participate in reciprocal network sharing. This network sharing allows all Blue Cross and Blue Shield MA PPO members to obtain network-level benefits when traveling or living in the service area of any other Blue MA PPO Plan as long as the member sees a contracted MA PPO provider. You can recognize a MA PPO member when their Blue Cross Blue Shield Member ID card has the “MA” in the suitcase, which indicates the member is covered under the MA PPO network sharing program.
- $0 copay for Medicare-covered Preventive Care.
- Maintaining the member maximum-out-of-pocket limits for Individual Medicare Advantage plans in which all Medicare covered expenses apply.

**Optional Supplemental Benefits (OSB)**
For 2012, many of our Medicare Advantage plans will be offering three Optional Supplemental Benefit (OSB) packages for an additional premium. These packages will allow the Medicare Advantage plan to be tailored to add additional dental, vision, chiropractic and acupuncture coverage by enrolling in an OSB package. Anthem will offer the following Optional Supplemental Benefit (OSB) packages on select plans in which members will have up to 90 days from their plan effective date to enroll.
- Preventive Dental Package
- Comprehensive Dental and Vision Package
- Combination Package (includes dental, vision, chiropractic, and acupuncture).

**Medicare Part D Prescription drug coverage changes (applicable to plans with Part D coverage)**
- Initial Coverage Limit (ICL) for Medicare Part D will increase from $2,840 to $2,930.
- In 2012, Anthem Medicare Preferred Standard and Anthem Medicare Preferred Premier will have a Part D deductible amount of $60 that will apply to its tier 2 and tier 3 drugs. This deductible will have to be met before those tier’s regular copays/coinsurance will apply.
- Starting January 1, 2012, we will be offering a Free First Fill program. This program is included to all members as part of their enrollment in our plan. Under this program, when a provider prescribes a patient/member any (brand or generic) covered osteoporosis drug, the patient/member will not pay any cost sharing for their first fill of that drug from any network pharmacy, regardless of which drug payment stage the patient/member is in (including if they are still in the deductible stage, if they have one).
- The patient/member can only benefit from the Free First Fill program once. For example, the benefit is not provided once per year. Also, if patient/member has already benefitted from the program, they will pay their normal cost-sharing amount for the fill of any additional osteoporosis drugs they are prescribed.
• **Anthem Medicare Preferred Standard** will no longer be offering enhanced coverage for its tier 1 and tier 6 drugs when the member reaches the gap. In previous years this plan allowed a member to continue to pay their pre-ICL copays during the gap for tiers 1 and 6. In 2012, when a member reaches the gap for this plan, they will be expected to pay a 86% coinsurance for all generics, or they will receive a 50% discount for their brand drugs until they reach the catastrophic phase.

• **For Anthem Medicare Preferred Premier**, when a member moves into the Coverage Gap: Members will pay the same copayments as in the Pre-ICL for Tier 1 and 6 drugs. Generics in tiers 2, 3, 4 and 5 the member will pay 86% of the cost-share. Brand-name drugs will be discounted by 50%.

• **During the Catastrophic Coverage Phase:** Members will pay 5% or $2.60 whichever is more for generic drugs, and members will pay 5% or $6.50 for brand drugs. Plans that have supplemental drug coverage of generic benzos and barbs will continue to pay their pre-ICL copay in the catastrophic stage.

**Help your patients get the best buy—each year—for their health care needs**

Each year we evaluate our benefits and formulary and may make changes to update them. Formulary changes in the upcoming year include: tier changes, drug removals, and new Prior Authorization, Step Therapy and Quantity Limit requirements. Your patients experiencing formulary changes will likely want to discuss their options with you. They will need your help to ensure they get their needed treatments at the most affordable cost.

Encourage your patients to review the 2012 formulary information within their Annual Notice of Change (ANOC) mailing, or to view the information online when it is available, beginning October 1, 2011. 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 meets their need.

We want to tell you about an important pharmacy network change that may affect your patients.

**Effective January 1, 2012, Walgreens and Walgreens-owned affiliates including Duane Reade, Happy Harry’s, OptionCare and Morton’s will no longer be part of our pharmacy network.**

If a patient currently fills prescriptions at Walgreens or a Walgreens-owned affiliate, they will need to change to a pharmacy that participates in our network.

Patients may move prescriptions to a new pharmacy by doing one of the following:

- Take their prescription bottle to a new pharmacy; they will call the old pharmacy.
- Call a new pharmacy and ask them to call their old pharmacy.
- Ask their doctor to call their new pharmacy with their prescription information.

Patients that have questions about this network update or would like additional information about participating pharmacies may call the Customer Service number on their ID card or on the front of their pharmacy directory.

**Balance Billing Reminder:**

The Centers for Medicare and Medicaid Services and our plan does not allow you to “balance bill” Medicare Advantage HMO and PPO members for Medicare covered services. CMS provides for 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 and includes charges that are in dispute.

Here is how this protection works.

- If the member cost sharing is a copayment (a set amount of dollars, for example, $15.00), then the member pays only that amount for any services from a network provider. Copayments may be higher for services performed by an out-of-network provider.
- If the member cost sharing is a coinsurance (a percentage of the total charges), then the member never pays more than that percentage. However, the cost depends on the type of provider:
  - If the member obtains covered services from a network provider, the member pays the coinsurance percentage multiplied by the plan’s reimbursement rate (as determined in the contract between the provider and the plan).
  - If the member obtains covered services from an out-of-network provider who participates with Medicare, the member pays the coinsurance percentage multiplied by the Medicare payment rate for participating providers.
  - If the member obtained covered services from an out-of-network provider who does not participate with Medicare, then the member pays the coinsurance amount multiplied by the Medicare payment rate for non-participating providers.
  - If a member obtains covered services from a provider who has opted out of Medicare, then the plan will not pay for these services, and depending upon the circumstances, the member may be liable for the entire amount.

Employer Group Retiree changes
Employer or Union Group Medicare Advantage plan benefits may vary from the Anthem Medicare Preferred (PPO) plan described above. For Employer or Union Group members, please refer to the members Evidence of Coverage or call Provider Services at the number on the member ID card for more benefit detail.

Providers should reference the member’s ID card for changes at every visit to help ensure proper billing. You can also assist your patients by passing on any ID card prefix or benefit change information to any ancillary providers who will be asked to serve your patient.

Medicare Advantage: The Annual Wellness Visit Frequently Asked Questions

What Providers Should Know
The Annual Wellness Visit (AWV) is a new benefit effective on all plans January 1, 2011. Beneficiaries new to Medicare will continue to be covered under the once in a lifetime “Welcome to Medicare” exam. However, now all beneficiaries are covered for the AWV every 12 months.

What codes are billed for the AWV?
For the first visit, providers should bill G0438 for the AWV which includes the Personalized Prevention Plan Service. Thereafter, providers should bill G0439 for the AWV and Personalized Prevention Plan Service, subsequent visit.

Routine Physical Exams and the Annual Wellness Visit
Medicare Advantage plans may offer extra supplement benefits that could include a routine physical exam. Providers should check with the plan to confirm if this is an extra benefit on the member’s plan before billing. The codes for the routine physical (under preventive services) include: CPT code range 99381 through 99397. These codes are not covered by original Medicare and may not be an extra benefit on the member’s plan.

However, all Medicare Advantage plans cover the AWV. Members are encouraged to use this annual benefit as one way to help assess current health status and future needs.

**What if additional services are provided at the same time as the AWV?**
If other evaluation and management services are provided in conjunction with the AWV, use CPT Modifier 25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) as appropriate.

**Prior authorization updates for Medicare Advantage Plans.**
A list of the 2012 prior authorization requirements will be posted in December to the Medicare Advantage Provider Portals. Please reference the document: [Medicare Advantage 2012 Precertification Requirements](www.anthem.com/medicareprovider); for the list of precertification requirements. The most current list of Precertification Requirements can be found at www.anthem.com/medicareprovider.

Please visit our website at [www.anthem.com/medicareprovider](www.anthem.com/medicareprovider) for more detailed product information or contact Provider Services at the number on the back of the member’s ID card. You can find important Medicare Advantage updates in the Plan & Administrative Changes/Update section. Contact your provider representative for participation details for our contracted plans.

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