Anthem Blue Cross and Blue Shield

2018 New Hampshire Medicare Advantage Plan Changes

Annual benefits changes for Medicare Advantage plan members will be effective Jan. 1, 2018. Each year, we renew our contract with the Centers for Medicare & Medicaid Services (CMS) and CMS re-evaluates and approves the benefits we offer to our Medicare Advantage members for the upcoming year.

This is a summary. Complete details can be found in the member’s evidence of coverage. Please visit our website at www.anthem.com/medicareprovider for 2018 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, premium and out-of-pocket maximums.

Some group-sponsored Medicare Advantage health 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. Additional information about prior authorizations and utilization management for new group-sponsored Medicare Advantage members in 2018 is available at Important Medicare Advantage Updates at anthem.com/medicareprovider.

2018 highlights

Global Medical Benefits
- Tiered Skilled Nursing Facility network (excluding Dual Special Needs Plans) with lower copayments for preferred SNFs. Members will have access to higher quality care and lower cost with preferred SNF providers. Preferred SNF providers will be identified in the provider directory.
- Reduced Urgent Care copayments
- $0 Labs for A1C, Urine Protein, FOBT and Diabetic Eye Exam
- Increased ER copay to new maximums of $80. These copays were changed to encourage members to select the most appropriate site of care, such as an urgent care or primary care setting. In 2018, ER Copay limits are $80 for plans with a Maximum Out of Pocket (MOOP) greater than $3,400.

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 doctor 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 and 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. However, if you requested 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.

- Please check the member ID card for any identification and/or group number changes that may affect claim submissions. Sample 2018 member ID cards can be found at anthem.com/medicareprovider.
- Anthem MediBlue Access (PPO) will continue to be available in Cheshire, Hillsborough, Merrimack, Rockingham and Strafford counties.

Medicare Advantage HMO:
- Anthem MediBlue Plus (HMO) will continue to be available in Cheshire, Hillsborough, Merrimack, Rockingham and Strafford counties.
- Anthem MediBlue Coordination Plus (HMO) will continue to be offered in Cheshire, Grafton, Hillsborough, Merrimack, Rockingham and Strafford counties.

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
- LiveHealth Online — convenient access to a doctor via live, two-way video on a computer or mobile device. Members logon to www.livehealthonline.com
- Nursing hotline
- Worldwide coverage
- Urgent Care – copay set $10 below specialist in all plans except for Anthem MediBlue Coordination Plus (HMO)

Formulary and Pharmacy
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 and Quantity Limit requirements.

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 2018 formulary information within their Annual Notice of Change (ANOC) mailing or their new member kit, or to view the information online when it is available, beginning October 1. 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 2018.
Members can fill a prescription at a network retail pharmacy, but their cost-sharing amount may be higher.

Part D benefits on all Medicare Advantage Part D plans include an expanded $0 Tier 6 and will continue to cover Tier 6 through the gap at both preferred and non-preferred pharmacies.

**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. This also includes charges that are in dispute.

**Prior Authorization Updates for Medicare Advantage Plans:**
Providers are required to periodically review and comply with the latest Medicare Advantage Prior Authorization requirements found at [www.anthem.com/medicare(provider)] at the Important Medicare Advantage Updates page or on the document named: *Medicare Advantage Precertification Requirements.*

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