Virginia 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/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)

- **Essential Extras**: These new Medicare Advantage flexible benefits may help your patients with meals, caregiver relief, mobility and more. Prior authorization and/or recommendation from a licensed clinician may be required for some of these benefits. Members may choose one of the following benefits per calendar year:
  - **Transportation**: Trips may be covered for getting to and from medical visits, SilverSneakers locations and visits to a pharmacy to pick up prescriptions. Stops at a pharmacy after a covered medical service are covered as long as the stop does not exceed 20 minutes. Trips must be scheduled 48 hours in advance.
  - **Personal home helper**: Assistance services to provide in-home support for caregiver respite, home-based chores and activities of daily living (ADL) to address needs while recovering from injury or illness. Covers up to 124 hours of care (four hours per day for 31 days) in a calendar year. Prior authorization required. Anthem will call the member’s physician to confirm the member’s eligibility for this benefit based on the criteria above.
  - **Assistive devices**: A $500 allowance toward the purchase of assistive or safety devices, such as ADA toilet seats, shower stools, hand-held shower heads, reaching devices and temporary wheelchair ramps.
  - **Alternative medicine**: Covers up to a combined total of twenty-four (24) medically necessary acupuncture and/or therapeutic massage visits each calendar year.
  - **Healthy meal delivery**: Meals to prevent or treat a health-related issue and to avoid health-related complications. Covers up to 16 meals per qualifying event, allows up to four (4) events each calendar year (64 meals in total). A qualifying event includes post-hospital discharge or other event if member has a BMI higher than 25 and/or an A1C higher than 9.0. The member must get prior approval from the health plan and a nutritional assessment or support by a health care provider may be required.
  - **Day center visits**: This benefit includes one visit per week, less than or equal to eight (8) hours, and includes transportation to and from the adult day care location. To qualify, members must get prior approval from the health plan, need help with at least two (2)
activities of daily living (ADLs) and must be recommended by a clinician. The member must submit a request reimbursement for a plan-approved, licensed facility (maximum reimbursement of $80 per day). Anthem will call the member’s physician to confirm the member’s eligibility for this benefit based on the criteria above.

- **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

- **Togetherness Program**: This program addresses senior loneliness as a treatable condition by focusing on members’ psychological, social and physical health. Togetherness connectors and social workers stay in contact with members via phone or in-person visits. Members are identified through Healthy Start assessments and referrals. No authorizations or referrals are required. The Togetherness Program is available to members in Anthem MediBlue Local (HMO), Anthem MediBlue Diabetes (HMO SNP), Anthem MediBlue COPD (HMO SNP), Anthem MediBlue SmartFit (HMO) and Anthem MediBlue Care On Site (HMO SNP) plans.

- 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.

- **Anthem MediBlue Access (PPO)** will continue to be available in Mathews County.
Medicare Advantage HMO:

- **Anthem MediBlue Dual Advantage (HMO SNP)** will be available in all Virginia counties except Accomack and Lee.

- **Anthem MediBlue Local (HMO), Anthem MediBlue SmartFit (HMO), Anthem MediBlue Diabetes (HMO SNP), Anthem MediBlue COPD (HMO SNP) and Anthem MediBlue ESRD (HMO SNP)** will continue to be available in central Virginia, including Chesterfield, Hanover, Goochland, Henrico and Powhatan counties and the cities of Richmond, Hopewell, Petersburg and Colonial Heights.

- **Anthem MediBlue Plus (HMO)** will continue to be available in James City County and the cities of Chesapeake, Hampton, Newport News, Norfolk, Portsmouth, Suffolk, and Virginia Beach in Tidewater Virginia and the city Alexandria and counties of Arlington, Fairfax, Loudoun and Prince William in northern Virginia.

- **Anthem MediBlue ESRD (HMO POS SNP)** is a new plan that will be available in the cities of Chesapeake, Hampton, Newport News, Norfolk, Portsmouth, Suffolk and Virginia Beach in Tidewater Virginia.

- **Anthem MediBlue Care On Site (HMO SNP)** will continue to be available in the central Virginia counties of Chesterfield, Hanover, Goochland, Henrico, Powhatan and cities of Richmond, Hopewell, Petersburg and Colonial Heights. This plan is designed for Medicare beneficiaries living in a nursing home, in a community or assisted living facility requiring the same level of care as someone in a nursing home. It offers benefits, services and care designed to enhance the overall health and well-being of nursing home residents.

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/medicareprovider.

**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
- LiveHealth Online — convenient access to a doctor via live, two-way video on a computer or mobile device; members log on to www.livehealthonline.com
- Nursing hotline
- Postdischarge meals
- Worldwide coverage
- Personal Emergency Response System (PERS) (PERS 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.)
- Podiatry services
Formulary and pharmacy
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 online or within their Annual Notice of Change (ANOC) mailing or their new member kit. 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 Medicare Advantage Part D 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.

Note: Some of our plans have added coverage for 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 updates for Medicare Advantage plans
Detailed prior authorization requirements are available to contracted providers by accessing the Provider Self-Service Tool at www.availity.com. Contracted and noncontracted providers who are unable to access Availity may call Provider Services at the phone number on the back of the member’s ID card for prior authorization requirements.

New provider service number for individual Medicare Advantage
Effective January 1, 2019, providers should call 844-421-5662 for individual Medicare Advantage provider service.
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