Dear Healthcare Provider,

Annual benefits changes for Medicare Advantage plan members will be effective January 1, 2011. The changes apply to members enrolled in Anthem Medicare Preferred Core (PPO). You can help members manage their healthcare costs by being aware of these changes.

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 2011 benefit changes and highlights by plan type.**

**Anthem Medicare Preferred Core (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.
- The inpatient hospital and inpatient mental health out-of-pocket maximum is being removed, however these services will apply to the $6,000 plan out-of-pocket maximum.
- Member cost shares are changing for certain outpatient labs, diagnostic tests, X-rays and radiology procedures for Anthem Medicare Preferred Core (PPO).
- Chiropractic cost share reduced to $10 copay for each in-network Medicare-covered visit.
- Reducing the plan Part D tier 1 and tier 6 copays from $7 to $0 for Anthem Medicare Preferred Core (PPO).
- Please check the member ID card for any identification and/or group number changes that may affect claim submissions.

**Anthem Medicare Preferred Core (PPO) plan highlights**
- Plan premium as low as $0.
- In-network primary care physician (PCP) copay is $0 and specialist copays is $40.
- Introducing a new plan Anthem Medicare Preferred Core (PPO) in 2011 in Clark and Washoe Counties with a $0 premium, $0 PCP copayment, and $0 copayment for Tier 1 generic drugs.
- Anthem Medicare Preferred Core (PPO) plan participates in reciprocal network sharing. This network sharing allows all Blue MA PPO members to obtain network-level benefits when traveling or living in the service area of any other participating 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 glaucoma tests.
- Anthem Medicare Preferred Core (PPO) plan includes the SilverSneakers® Fitness Program, a total health and fitness program that is beneficial for Medicare-eligible persons of all fitness levels. The program offers physical activity, health education and social events. Please remind members about the SilverSneakers fitness benefit included in their plan.
- In 2011, the Anthem Medicare Preferred Core (PPO) Medicare Advantage plan will introduce 3 new optional supplemental packages as a buy up benefit for members. Packages include a Preventive Dental package, a Comprehensive Dental and Vision package or a Combination package which includes dental, vision, 10 acupuncture visits and 10 routine chiropractic visits. Members will have the option of enrolling in the optional supplemental benefit packages up to 30 days from their plan effective date.

**SecurityChoice and Smart Value PFFS Non-Renewals**
Anthem Blue Cross and Blue Shield Individual Private Fee for Service plans: SecurityChoice Classic and Plus and SmartValue Classic and Plus, which are offered throughout the state of Nevada, have non-renewed all counties in the state of Nevada due to mandatory CMS 2011 deeming requirements for PFFS plans. Affected members have received a letter outlining their options for 2011. Members will be covered under their current plan until December 31, 2010, unless they choose to disenroll sooner.

Medicare Part D Prescription drug coverage changes (applicable to plans with Part D coverage)

- Initial Coverage Limit for Medicare Part D will increase from $2,830 to $2,840.
- When a member moves into the Coverage Gap: Members will pay the same copayments as in the ICL for Tier 1 and 6 drugs. Generics in tiers 2, 3, 4 and 5 the member will pay 93% of the cost-share. Brand-name drugs will be discounted.
- During the Catastrophic Coverage Phase: Members will pay 5% or $2.50 whichever is more for Tier 1 drugs, 5% or $6.30 for Tier 2 drugs, 5% or $3.25 for Tier 3 drugs, 5% or $6.30 for Tier 4 drugs, 5% or $6.30 for Tier 5 drugs, and the ICL copay for Tier 6 drugs.
- Individual Medicare Advantage plans with Part D will be moving to a 6 Tier system with the 6th tier being our Supplemental Drugs.

Employer Group Retiree changes

- Beginning January 1, 2011, Employer/Union Sponsored Medicare Advantage non-network PFFS plans will no longer be available in most areas. Many of our employer group members will be changing from PFFS to a MediBlue (PPO) plan. The reciprocal network sharing program will be available to these PPO plans.
- Employer Group Medicare Advantage plan benefits may vary from what is listed above. For Employer Group members, please refer to the members Evidence of Coverage or call Provider Services at the number on the back of the member ID card for more benefit detail.

CMS Changes Impacting Providers in 2011

Patient Protection and Affordable Care Act
The Patient Protection and Affordable Care Act (PPACA) was signed into law on March 23, 2010. CMS has made significant changes in policy as a result of the law and many of these changes apply to Medicare Advantage programs. Anthem Blue Cross and Blue Shield recognizes that these changes affect the physicians and practitioners who treat our members. On each of Anthem’s MA product pages within www.anthem.com there is a link titled Patient Protection and Affordable Care Act. Within that link Anthem has posted, and will continue to post going forward, CMS published material with a forward explaining Anthem’s role and responsibility in regards to the updated PPACA regulation. For complete details of CMS’s timeline and implementation of PPACA regulations please visit https://www.cms.gov/LegislativeUpdate/downloads/PPACA.pdf

Annual Wellness Exam/Visits
The Annual Wellness Exam / Visit is a $0 cost share in network benefit to Medicare Advantage members. The applicable G codes are not yet published by CMS but will be available for billing in 2011. Information will be provided when available at www.cms.gov

Clinical Research Study
According to Medicare Guidelines, charges related to clinical trials are to be billed on a claim separate from any other charges billed for the same Date of Service. The clinical trial claim should be submitted to Original Medicare, and the claim for all other services should be submitted to the member’s Medicare Advantage plan. If you are treating a Medicare Advantage member as part of a CMS approved study, Original Medicare is to be billed first for the Clinical Trial Services. After Medicare has paid on the claim than you may file with the Medicare Advantage plan for the difference in payment that would have been received if the member was not taking part in a CMS approved study.
Kidney Disease Training
This is a $0 in-network cost share benefit for Medicare-covered kidney disease education (KDE) services.

KDE services are designed to provide beneficiaries with comprehensive information regarding the management of comorbidities, including for purposes of delaying the need for dialysis; prevention of uremic complications; and each option for renal replacement therapy. This benefit is also designed to be tailored to individual needs and provide the beneficiary with the opportunity to actively participate in his/her choice of therapy. The Centers for Medicare & Medicaid Services (CMS) issued two new Healthcare Common Procedure Coding System (HCPCS) codes to be used to report covered KDE services: **G0420** (Face-to-face educational services related to the care of chronic kidney disease; individual, per session; per one hour) and **G0421** (Face-to-face educational services related to the care of chronic kidney disease; group, per session, per one hour).

Please refer to MM6557 MLN Matters article at www.cms.gov for additional information regarding this benefit.

Preventive Care Benefits
Network or PFFS plans offer preventive care benefits at no cost to the member. Coverage includes routine physical exams, bone mass measurement, colorectal screening, mammogram, breast exam, pap/pelvic, prostate screening, abdominal aortic aneurysm screening, HIV screening and preventive EKG screening as a result of a preventive physical or annual wellness exam.

Prior authorization updates for Medicare Advantage Plans
Several changes to our prior authorization requirements were filed with The Centers for Medicare and Medicaid Services (CMS) and will go into effect in calendar year 2011. A list of the 2011 prior authorization requirements will be posted in December to the Medicare Advantage Provider Portals. Please reference the document: *Medicare Advantage 2011 Precertification Requirements* for the list of precertification requirements.

Please visit our website at www.anthem.com 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.