Anthem BlueCross BlueShield

2014 Virginia Medicare Advantage Plan Changes

Dear Healthcare Provider,

Annual benefits changes for Medicare Advantage plan members will be effective January 1, 2014. Each year, we renew our contract with the Centers for Medicare and Medicaid Services (CMS) and CMS re-evaluates and approves the benefits we’ll offer to our Medicare Advantage members for the upcoming year.

The below changes apply to members enrolled in Anthem Medicare Preferred Core (PPO) plans H4909-009 & H4909-010 and Anthem MediBlue (HMO and SNP) H3447-001, 003, 004, & 005. You can help members manage their health care costs by being aware of these changes. In addition, remember to check the MemberID card at the beginning of each calendar year, as the member may have changed plans. The bottom right hand corner of the current Member ID card reflects the contract and plan benefit package the member is enrolled in.

Notable 2014 benefits changes and highlights by plan type are listed below. Please note, the Anthem Medicare Preferred Core (PPO) plans, and Anthem MediBlue (HMO & SNP) plans have different diabetic supply coverage limitations. Additionally, Anthem Medicare Preferred Core (PPO) plans have an exclusive insulin arrangement that does not apply to Anthem MediBlue (HMO & SNP) plans.

Anthem Medicare Preferred Core (PPO) Plan Changes

- We will be offering the following plans in 2014:
  - H4909-009 - available in Roanoke City county, Virginia
  - H4909-010 - available in Mathews county, Virginia
- The following counties will no longer have the Anthem Medicare Preferred (PPO) plans available to them in 2014:
  - H4909-009 – James City, King & Queen, Lancaster, Richmond, Roanoke, Salem City, Suffolk City, Surry, Williamsburg City & York
  - H4909-010 – Gloucester & Hampton City
- In 2014 both Anthem Medicare Preferred Core (PPO) plans will have a Medical deductible amount of $700 that will apply to all out-of-network (OON) Medicare covered services. This deductible will have to be met before we pay towards the member’s OON medical bills.
- Members will see a premium increase in 2014.
- Instituting physician copayment and hospital inpatient copayment changes on some plans. The member ID card will reflect the change, if any.
- Member cost shares are changing for certain physician, hospital inpatient, outpatient labs, diagnostic tests, X-rays and radiology procedures.
- Diabetic shoes and inserts will be covered at a $0 copay when obtained in-network.
- The Visitor Travel Program now includes Montana, New Mexico and Oklahoma.
- 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

- Maintained MOOP max – Maintaining the member in-network and combined maximum-out-of-pocket limits for Individual Medicare Advantage plans in which all Medicare covered expenses apply.
- In-network Primary care physician (PCP) copays range from $10 to $15 and specialist copays are $35.
- 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 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 in-network Medicare-covered preventive care.

Group Sponsored Medicare Advantage Health Benefit Plans are not impacted by the changes described above for PPO plans. Our members in Group Sponsored Plans will continue to be covered through a national service area.

Diabetic Supplies for Anthem Medicare Preferred Core (PPO) Plans

Beginning January 1, 2014, our Anthem Individual Medicare Advantage Members will only cover LifeScan, Inc., OneTouch® or Roche Diagnostics, ACCU-CHEK® diabetic blood glucometers and blood glucose test strips for our Anthem Individual Medicare Advantage members. To be covered for a $0 copay, the members must purchase these supplies at an in-network: retail or mail-order pharmacy, or Durable Medical Equipment supplier.

Covered blood glucometers and blood glucose test strips in 2014:

- LifeScan, Inc., OneTouch®
- Roche Diagnostics, ACCU-CHEK®
- A limit of 100 blood glucose test strips per month

Other blood glucometer or blood glucose test strip brands or more than 100 test strips per month are not covered unless you as the doctor or provider tell us another brand or a larger quantity is medically necessary for the member’s treatment, no other brand or larger quantity limit will be covered.

- If our member is currently using OneTouch or ACCU-CHEK blood test strips or glucometer products, you don’t need to do anything!
- If our member is not using OneTouch or ACCU-CHEK blood test strips or glucometer products, then our member will need to get new prescriptions for the supplies by January 1st for these claims to be covered by us.
- You should discuss these coverage changes and possible new prescriptions with our member/your patient. If it is medically necessary for them to continue using a different brand of blood test strips or glucometer and/or more than 100 blood test strips per month, you will need to communicate this to us by requesting an exception. If your patient purchases their supplies through the pharmacy or the ESI mail-order service exceptions may be requested after December 1, 2013 by calling 1-800-338-6180. If your patient purchases their supplies through a Durable Medical Equipment supplier you will need to call the health plan.
The benefit and brand limitations described above generally do not apply to our Group Sponsored Medicare Advantage Health Benefit Plans. Please contact provider services for benefit information.

**Insulin Exclusivity for Anthem Medicare Preferred Core (PPO) Plans**

Effective January 1, 2014, select Anthem Individual MAPD plans will establish an insulin exclusivity contract with Eli Lilly, the manufacturer of Humulin and Humalog human insulins. Other insulin’s are considered non-formulary and are not eligible for coverage beginning January 1, 2014.

The following plans will be impacted by an insulin change Anthem Medicare Preferred Core (PPO). Please have members check their plan name on the left hand corner of their member ID card to see if they were impacted by this change. If members were impacted by this change the below formulary changes will apply:

The following chart provides the formulary covered insulin medications in 2014:

<table>
<thead>
<tr>
<th>Insulin Medication</th>
<th>Tier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Humalog pens</td>
<td>Tier 3</td>
</tr>
<tr>
<td>Humalog vials</td>
<td>Tier 3</td>
</tr>
<tr>
<td>Humulin 3 mL vials</td>
<td>Tier 3</td>
</tr>
<tr>
<td>Humulin pens</td>
<td>Tier 3</td>
</tr>
<tr>
<td>Humulin R u500 vials</td>
<td>Tier 3</td>
</tr>
<tr>
<td>Humulin vials</td>
<td>Tier 3</td>
</tr>
<tr>
<td>Relion vials / pens</td>
<td>Tier 3</td>
</tr>
</tbody>
</table>

**Note:** Novolin and Novolog vials and pens *and all other insulins* are considered non-formulary and not eligible for coverage.

The benefit and brand limitations described above generally do not apply to our Group Sponsored Medicare Advantage Health Benefit plans. Please contact provider services for benefit information.

**Optional Supplemental Benefits (OSB) for Anthem Medicare Preferred Core (PPO) Plans**

(Not available in HMO and HMO-SNP Plans)

For 2014, many of our Medicare Advantage plans will offer three Optional Supplemental Benefit (OSB) packages for an additional premium. OSB packages allow the Medicare Advantage plan to be tailored for additional dental, and vision coverage. **Please note, in 2014 OSB’s will no longer cover chiropractic and acupuncture benefits.**

Anthem will offer the below Optional Supplemental Benefit (OSB) packages on select plans. Members will have up to 90 days from their plan effective date to enroll in one of the below packages:

1.) Preventive Dental Package
2.) Dental and Vision Package
3.) Enhanced Dental and Vision Package

**New Year! New Formulary Changes for Anthem Medicare Preferred Core (PPO) Plans**

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 needed treatments at the most affordable cost.

Encourage your patients to review the 2014 formulary information within their Annual Notice of Change (ANOC) mailing, 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 need.

- Initial Coverage Limit (ICL) for Medicare Part D will decrease from $2,970 to $2,850.
- TROOP amount will decrease from $4,750 to $4,550.
- In 2014 we will offer daily fills for all MAPD plans. Daily fills give members an opportunity to try a high-priced drug for adverse reactions before purchasing an entire prescription.
- The pharmacy network includes preferred and other network retail pharmacies. You save more by paying a lower cost-sharing amount at preferred retail pharmacies. Our preferred retail pharmacies include Kroger Pharmacy, Rite Aid Pharmacy and Walmart. Kroger Co. participating preferred pharmacies include Kroger, FredMeyer, King Soopers, City Market, Fry's, Smith’s, Dillons, Ralphs, QFC, Baker's, Scott's, Owen's, Pay Less, Gerbes and JayC. Walmart participating preferred pharmacies include Walmart, Neighborhood Market and Sam’s Club. Members can fill a prescription at a network retail pharmacy, but their cost-sharing amount may be higher.

In 2014 Anthem Medicare Preferred Core (PPO) H4909-009 will have a Part D deductible amount of $125, and H4909-010 will have a Part D deductible amount of $145 that will apply to Tier 2: Nonpreferred Generic, Tier 3: Preferred Brand and Tier 4: Nonpreferred Brand drugs. This deductible will have to be met before that tier’s regular copays/coinsurance will apply.

- During the Catastrophic Coverage Phase: Members will pay 5% or $2.55 whichever is more for generic drugs, and members will pay 5% or $6.35 for brand drugs.

*Group Sponsored Medicare Advantage Health Benefit Plans are not impacted by the changes described above for Pharmacy plans*

**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.

Here is how this protection works - **Anthem Medicare Preferred Core (PPO) Plans**

- 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 obtained covered services from an out-of-network provider who participates with Medicare, then the member pays the coinsurance percentage multiplied by the Medicare payment rate for participating providers.

- If the member obtains 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 the 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.

Here is how this protection works - **Anthem MediBlue (HMO & SNP) Plans**

- If a member's cost sharing is a copayment (a set amount of dollars, for example, $15.00), then the member pays only that amount for any covered services from a network provider.

- If a member's cost sharing is a coinsurance (a percentage of the total charges), then you never pay more than that percentage. However, a member's cost depends on which type of provider you see:

- If a member receives the covered services from a network provider, members pay the coinsurance percentage multiplied by the plan's reimbursement rate (as determined in the contract between the provider and the plan).

- If a member receives the 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.

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**Anthem MediBlue HMO and HMO SNP (H3447-001, 003, 004 and 005) Plan Highlights**

Plans offered in 2014 include two MediBlue (HMO) plan options, “Anthem MediBlue Local” and the new “Anthem MediBlue Smart Fit”, plus two MediBlue (HMO-SNP) special needs plans designed to meet the needs of individuals who have diabetes (“Anthem MediBlue Diabetes”) and COPD (“Anthem MediBlue COPD). Featured benefits include:

- No monthly plan premium
- $0 copay for PCP visit, lab test and routine X-rays (Smart Fit has a $10 PCP copay)
- Preferred Generic drug copays of $0 to $5, plus partial drug coverage in the coverage gap, and no cost for insulin's in tier 6
- Exclusive access to CareMore Care Centers and the CareMore model of care including preventive medicine, disease management and health education services.
- Anthem MediBlue Smart Fit is an HMO open to general enrollment. Smart Fit features a Part B Rebate, which is a reduction to what Medicare beneficiaries must pay for their Part B coverage, of $49/month. The plan has slightly higher copays and includes SilverSneakers as a benefit. This plan is available to any Medicare Advantage eligible person and is best for individuals who are newer to Medicare or have more active lifestyles.

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**Anthem MediBlue HMO and HMO SNP (H3447-001, 003, 004 and 005) Plan Changes**
• H3447-002, Anthem MediBlue Care To You (HMO-ISNP) is not renewing in 2014. Members may continue to enjoy Care To You Program features if they re-enroll in one of our other HMO or HMO-SNP plans. Program features include support to those Members who require the same level of care as someone living in a nursing home but live in a plan-approved community such as a contracted skilled nursing facility, assisted living facility, board and care home, group home, and adult care home. The CareMore health care team includes a nurse practitioner and other care providers. The nurse practitioner will provide routine, preventive and personalized care right at their bedside. In this program, the nurse practitioner will work closely with the Member’s facility staff, family members, primary care physician and clinical team to support their care. The health care team travels to them so they do not have to worry about transportation or even getting out of bed.

Bedside services include:

- Comprehensive health assessment
- Weekly nurse practitioner visits
- Medication management
- On-site routine lab tests and X-rays
- Wound care management and supplies
- Clinical program management for chronic conditions.

• The service area is being expanded into additional zip codes in Henrico, Chesterfield, Goochland, Hanover and Powhatan counties with the following zip codes: 23059, 23113, 23223, 23224, 23225, 23226, 23231, 23238 and 23273.

• Member cost shares are changing for several benefits including inpatient hospital, SNF, outpatient hospital and ambulance.
• The physician specialist copay for office visits is increasing
• Dental is no longer offered as an Optional Supplemental Benefit.

Prescription Drug Coverage for HMO and HMO-SNP Plans

• The Part D prescription drug benefits will feature copay differences for preferred and network pharmacies under the continued administration by Express Scripts.
  - The pharmacy benefit will continue to feature 6 tiers; same as in 2013
  - For tiers 1-4, members will pay from $5-10 less at a preferred network pharmacy
  - Preferred pharmacies are Kroger’s, Rite-Aid and Wal-Mart.
  - Copays will be higher for network pharmacies

Diabetic Supplies for Anthem MediBlue HMO and HMO SNP Plans

Beginning January 1, 2014, these plans will only cover FreeStyle Lite, FreeStyle Freedom Lite, FreeStyle InsuLinx and Precision Xtra diabetic blood glucometers and blood glucose test strips for our Anthem Individual Medicare Advantage members. To be covered for a $0 copay, the members must purchase these supplies at an in-network: retail or mail-order pharmacy, or Durable Medical Equipment supplier.

Covered blood glucometers and blood glucose test strips in 2014:

- FreeStyle Lite
- FreeStyle Freedom Lite
- FreeStyle InsuLinx
- Precision Xtra
- A limit of 100 blood glucose test strips per month

Other blood glucometer or blood glucose test strip brands or more than 100 test strips per month are not covered unless you as the prescriber tell us another brand or a larger quantity is medically necessary for the member’s treatment, no other brand or larger quantity limit will be covered.
• If our member is currently using FreeStyle Lite, FreeStyle Freedom Lite, FreeStyle InsuLinx and Precision Xtra diabetic blood test strips or glucometer products, you don’t need to do anything!

• If our member is not using FreeStyle Lite, FreeStyle Freedom Lite, FreeStyle InsuLinx and Precision Xtra diabetic blood test strips or glucometer products, then our member will need to get new prescriptions for the supplies by January 1st for these claims to be covered by us.

• You should discuss these coverage changes and possible new prescriptions with our member/your patient. If it is medically necessary for them to continue using a different brand of blood test strips or glucometer and/or more than 100 blood test strips per month, you will need to communicate this to us by requesting an exception. If your patient purchases their supplies through the pharmacy or the ESI mail-order service exceptions may be requested after December 1, 2013 by calling 1-888-350-3381. If your patient purchases their supplies through a Durable Medical Equipment supplier you will need to contact the health plan.

Providers contracted with CareMore to provide services to members in these plans will receive specific information about plans, benefits, and programs.

To learn more about the CareMore Health Delivery System, visit www.getcaremore.com or call (888) 291-1358, Select Option 3, then Option 5.

**Employer Group Retiree Changes**

**Employer or Union Group Retiree Changes**

Group Sponsored Medicare Advantage Benefit Plan benefits vary from the the Anthem Medicare Preferred Core (PPO) and Anthem MediBlue (HMO & SNP) plans mentioned here. Employer or Union Group Plan names and benefit changes may be different than what is described above. For Group Sponsored Medicare Advantage Health Benefit Plan members, 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. Medicare Advantage member ID cards contain a CMS identifier in the lower right corner of the card. The number will be five characters (XXXXX) followed by three characters (XXX). The member is in a Group Sponsored Medicare Advantage Health Benefit Plan when the last three digits start with an eight (8XX).

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.

**What Does the Annual Wellness Visit Cover**

All of our 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.

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.

**Annual Wellness Visit**

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.**

Providers are required to periodically review and comply with the latest Medicare Advantage Prior Authorization requirements found at [www.anthem.com/medicareprovider](http://www.anthem.com/medicareprovider) on the document named: *Medicare Advantage Precertification Requirements*

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