Anthem BlueCross BlueShield

2014 Kentucky 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 Senior Advantage (HMO), Anthem Medicare Preferred (PPO) and Blue Medicare Access (Regional PPO). You can help members manage their health care costs by being aware of these changes. In addition, remember to check the Member ID card at the beginning of each calendar year, as the member may have changed plans.

Notable 2014 benefits changes and highlights by plan type.

Anthem Medicare Preferred Standard (PPO) Plan Changes

- The in-network maximum-out-of-pocket for Anthem Medicare Preferred Standard (PPO) will be increasing for 2014 from $5,200 to $5,900 and the combined maximum out-of-pocket will be increasing for 2014 from $5,200 to $6,900.
- In 2014, Anthem Medicare Preferred Standard (PPO) will have a Medical deductible amount of $500 that will apply to all OON Medicare covered services. This deductible will have to be met before we pay towards the member’s OON medical bills.
- The following counties Ballard, Hancock, Jessamine, Mason, Menifee, Pendleton, Scott, Shelby and Trimble will no longer have the Anthem Medicare Preferred Standard (PPO) available to them in 2014. Members will stay have access to the Blue Medicare Access Value (Regional PPO) plan.
- Anthem Medicare Preferred Standard (PPO) members will see a premium increase in 2014.
- Instituting network physician copayment and hospital inpatient copayment changes on some plans. The member ID card will reflect the change, if any.
- In 2014, the in-network copayment for Skilled Nursing Facility days will decrease to $25 for days 1-20 and increase to $145 for days 21-100.
- The routine hearing exam copay increased from $35 to $40 for in-network and $45 to $50 for out-of-network. The routine hearing limit increased from $50 to $75.
- If a member is admitted to the hospital within 72 hours for the same condition the emergency care copay will not be waived in 2014.
- 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 Standard (PPO) Plan Highlights

- In-network Primary care physician (PCP) copays are $20 and specialist copays are $40.
- Anthem Medicare Preferred Standard (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 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.

**Blue Medicare Access Value (Regional PPO) Plan Changes**

- The combined maximum out-of-pocket for Blue Medicare Access Value (Regional PPO) will be increasing for 2014 from $6,500 to $7,500.
- In 2014, Blue Medicare Access Value (Regional PPO) will have a Medical deductible amount of $500 that will apply to all OON Medicare covered services. This deductible will have to be met before we pay towards the member’s OON medical bills.
- Blue Medicare Access Value (Regional PPO) members will see a premium increase in 2014.
- Instituting network physician copayment and hospital inpatient copayment changes on some plans. The member ID card will reflect the change, if any.
- In 2014 the in-network copayment for Skilled Nursing Facility days will decrease to $25 for days 1-20 and increase to $105 for days 21-100.
- Worldwide coverage for urgent and emergency care has been removed in 2014.
- If a member is admitted to the hospital within 72 hours for the same condition the emergency care copay will not be waived in 2014.
- 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.

**Blue Medicare Access Value (Regional PPO) Plan Highlights**

- Maintained MOOP max – Maintaining the member in-network maximum-out-of-pocket limits for Individual Medicare Advantage plans in which all Medicare covered expenses apply.
- In-network Primary care physician (PCP) copays are $20 and specialist copays are $40.
- Blue Medicare Access Value (Regional PPO) plans participate 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 Medicare-covered preventive care.

**Anthem Medicare Preferred Select (PPO) Plan Changes**

- The Anthem Medicare Preferred Select (PPO) H5530-004 will be non-renewing for 2014. Members will have access to the Blue Medicare Access Value (Regional PPO) plan in all counties and Anthem Medicare Preferred Standard (PPO) in most counties.

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

**Anthem Senior Advantage Value (HMO) Plan Changes**

- The maximum-out-of-pocket for Anthem Senior Advantage Value (HMO) will be increasing for 2014 from $3,400 to $4,900.
- Anthem Senior Advantage Value (HMO) members will see a premium increase in 2014.
- In 2014, the in-network copayment for Skilled Nursing Facility days will decrease to $25 for days 1-20 and increase to $135 for days 21-100.
- Instituting network 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 outpatient labs for Anthem Senior Advantage Value (HMO).
• If a member is admitted to the hospital within 72 hours for the same condition the emergency care copay will not be waived in 2014.
• Please check the member ID card for any identification and/or group number changes that may affect claim submissions.

Anthem Senior Advantage Value (HMO) Plan Highlights
• Primary care physician (PCP) copays are $20 and specialist copays are $45.
• $0 copay for Medicare-covered preventive care.

Anthem Senior Advantage Complete (HMO) Plan Changes
• The Anthem Senior Advantage Complete (HMO) H1849-016 will be non-renewing for 2014. Members will have access to the Anthem Senior Advantage Value (HMO) and Blue Medicare Access Value (Regional PPO) plan in all counties and the Anthem Medicare Preferred Standard (PPO) in most counties.

Group/Union Sponsored Plans are not impacted by the changes described above for HMO plans. Our members in Group/Union Sponsored Plans will continue to be covered through the same counties in the 2013 service area.

Optional Supplemental Benefits (OSB)

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.

We 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!

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 meets 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.

Deductible

In 2014, Anthem Medicare Preferred Standard (PPO) will have a Part D deductible amount of $135 that will apply to its NonPreferred Generic, Preferred Brand and NonPreferred Brand tier drugs. This deductible will have to be met before those tier’s regular copays/coinsurance will apply.

In 2014, Blue Medicare Access Value Regional (PPO) will have a Part D deductible amount of $100 that will apply to its NonPreferred Generic, Preferred Brand and NonPreferred Brand tier drugs. This deductible will have to be met before those tiers’ regular copays/coinsurance will apply.

In 2014 Anthem Senior Advantage Value (HMO) will have a Part D deductible amount of $150 that will apply to its tier NonPreferred Generic, Preferred Brand and NonPreferred Brand tier drugs. This deductible will have to be met before those 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/Union Sponsored Plans are not impacted by the changes described above for Pharmacy plans

Diabetic Supplies

Beginning January 1, 2014, our 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 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 quantities of 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 LifeScan, Inc, OneTouch® or Roche Diagnostics, ACCU-CHEK® blood test strips or glucometer products, you don’t need to do anything!
- If our member is not using LifeScan, Inc, OneTouch® or Roche Diagnostics, 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.
• To receive a pre-cert for a member’s diabetic brand glucometer or QLL on test strips fax pre-certs to 1-800-959-1537 or call 1-866-797-9884 and press option 1 for preauthorization, then press option 3 for all other services.

**The benefit and brand limitations described above generally do not apply to our employer or union group plans. Please contact provider services for benefit information.**

**Insulin Exclusivity**

Effective January 1, 2014, select 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 Standard (PPO) and Anthem Senior Advantage Value (HMO). 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 employer or union group plans. Please contact provider services for benefit information.**

**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 for Anthem Medicare Preferred Standard (PPO) and Blue Medicare Access Value (Regional PPO).

• 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:

  o 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).

  o 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.

  o 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.

  o 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 for Anthem Senior Advantage (HMO) plans:

  o If a members 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.

  o If a members cost sharing is a coinsurance (a percentage of the total charges), then the member never pays more than that percentage. However, a members cost depends on which type of provider the member sees.

  o 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).

  o 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.

**Employer Group Retiree Changes**

Employer or Union Group Medicare Advantage plan benefits vary from the Anthem Medicare Preferred (PPO), Blue Medicare Access Value (Regional PPO) and Anthem Senior Advantage (HMO) plans mentioned here. **Employer Group Plan names and benefit changes may be different than what is described above.** For Employer or Union Group 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 an employer or union sponsored 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 (updated 10/01/2013).*

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