Dear Healthcare Provider,

Annual benefits changes for Medicare Advantage plan members will be effective January 1, 2015. 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 MediBlue Select (HMO), Medicare Preferred Core (PPO), Medicare Preferred Standard (PPO) or BCBSHP Dual Advantage (HMO SNP). You can help members manage their health care costs by being aware of these changes. In addition, remember to check the Member identification card at the beginning of each calendar year, as the member may have changed plans.

Notable 2015 benefits changes and highlights by plan type.

Medicare Preferred Core and Medicare Preferred Standard (PPOs) Highlighted Plan Changes

- 2015 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. Please check the member’s benefits for the new Plan year changes, by visiting our website at www.anthem.com/medicareprovider or calling Provider Services at the number on the back of the member’s ID card.
- If members receive two or more services from the same provider during the same visit and/or on the same day, members will be responsible to pay the copay for each applicable service. This includes but is not limited to lab services, diagnostic procedures and test, X-rays, Radiology, Part B drugs.
- Our plan will no longer cover unlimited inpatient days for acute care illness or injury.
- These plans will offer a new benefit called LiveHealth Online. LiveHealth Online provides convenient access for members to interact with a doctor via live, two-way video on a computer or mobile device.
- These plans will offer one routine physical exam in addition to the Medicare-covered “Welcome to Medicare” exam or Annual Wellness Exam. The examination for this visit is multi-system, and the exact content and extent of the exam is based on the patient’s age, gender, and identified risk factors; face-to-face visit. The comprehensive history obtained as part of the preventive medicine E/M service is not problem-oriented and does not involve a chief complaint or present illness. It does, however, include a comprehensive system review and comprehensive or interval past, family, and social history as well as a comprehensive assessment/history of pertinent risk factors. It also includes clinical laboratory tests. Providers should bill 99381-99397 (Preventive Medicine Services) for the routine physical exam. When the routine physical is completed by an in-network provider, there are no out-of-pocket costs for the member.
Physicals completed by out-of-network providers will be subject to member co-pay as applicable by the member’s plan.

- Preventive dental consisting of 1 exam and 1 cleaning and preventive vision consisting of 1 eye exam are new covered benefits in 2015. Members have the option of purchasing an optional supplemental benefit package beyond this coverage.
- Please check the member ID card for any identification and/or group number changes that may affect claim submissions.

New Plans and Service Area Changes:
- Members in Milwaukee and Waukesha Counties will no longer have the Medicare Preferred Standard (PPO) available to them in 2015. A HMO plan is available to these members.

Group Sponsored Medicare Advantage Health Benefit Plans are not impacted by the service area changes described above for PPO plans.

MediBlue Select (HMO) Highlighted Plan Changes
- 2015 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. Please check the member’s benefits for the new Plan year changes, by visiting our website at www.anthem.com/medicareprovider or calling Provider Services at the number on the back of the member’s ID card.
- If members receive two or more services from the same provider during the same visit and/or on the same day, members will be responsible to pay the copay for each applicable service.
- Our plan will no longer cover unlimited inpatient days for acute care illness or injury.
- These plans will offer a new benefit called LiveHealth Online. LiveHealth Online provides convenient access for members to interact with a doctor via live, two-way video on a computer or mobile device.
- These plans will offer one routine physical exam in addition to the Medicare-covered “Welcome to Medicare” exam or Annual Wellness Exam. The examination for this visit is multi-system, and the exact content and extent of the exam is based on the patient’s age, gender, and identified risk factors; face-to-face visit. The comprehensive history obtained as part of the preventive medicine E/M service is not problem-oriented and does not involve a chief complaint or present illness. It does, however, include a comprehensive system review and comprehensive or interval past, family, and social history as well as a comprehensive assessment/history of pertinent risk factors. It also includes clinical laboratory tests. Providers should bill 99381-99397 (Preventive Medicine Services) for the routine physical exam. When the routine physical is completed by an in-network provider, there are no out-of-pocket costs for the member. Physicals completed by out-of-network providers will be subject to member co-pay as applicable by the member’s plan.
- Preventive dental consisting of 1 exam and 1 cleaning and preventive vision consisting of 1 eye exam are new covered benefits in 2015. Members have the option of purchasing an optional supplemental benefit package beyond this coverage.
• Please check the member ID card for any identification and/or group number changes that may affect claim submissions.

New Plans and Service Area Changes:
• Members in Racine County will no longer have the MediBlue Select (HMO) available to them in 2015.

New for 2015: Anthem Dual Advantage (HMO SNP):
• A Dual Eligible Special Needs Plan for beneficiaries with Medicare and Medicaid serving select counties
• Preventive dental exam, cleaning and x-rays
• Hearing exam and hearing aids
• Vision exam with glasses/contact benefit
• Limited OTC coverage

Group Sponsored Medicare Advantage Health Benefit Plans are not impacted by the service area changes described above for HMO plans.

Optional Supplemental Benefits (OSB)
For 2015, 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.

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

Diabetic Supplies:
Effective January 1, 2015, all of our individual Medicare Advantage plans will only cover certain diabetic supplies if they are purchased at one of our network pharmacies or through our mail-order service. Durable Medical Equipment (DME) providers as well as physicians will no longer be able to bill for these supplies.

HCPC codes that will no longer be covered when purchased through a DME provider or other physicians:
• A4253 blood glucose test strips
• E0607 home blood glucose monitor
• E2100 blood glucose monitor with integrated voice synthesizer
• E2101 blood glucose monitor with integrated lancing/blood sample
Members impacted by this change will be notified in October through their Annual Notice of Change and Evidence of Coverage plan benefit materials.

To be covered for a $0 copay, the members must purchase these supplies at an in-network retail or mail-order pharmacy supplier.

**Covered blood glucometers and blood glucose test strips in 2015:**

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 and using an in-network retail or mail-order pharmacy supplier, 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 or using an in-network retail or mail-order pharmacy supplier, 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 by calling 1-800-338-6180.

**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:**
As a reminder for 2015 Individual MAPD plans have an insulin exclusivity contract with Eli Lilly, the manufacturer of Humulin and Humalog human insulins. Other insulins are considered non-formulary and are not eligible for coverage.

**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.

Please encourage your patients to review the 2015 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 needs.

Pharmacy Benefit Changes for 2015:

- Tier 6 has select care drugs at a $0 for the following conditions: high blood pressure, high cholesterol and diabetes and will have the following drugs on it: GLIPIZIDE, LISINOPRIL, LOSARTAN POTASSIUM, METFORMIN HCL, and SIMVASTATIN.

- The pharmacy network includes preferred and other 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 (participating pharmacies include CVS and Longs Drugs), Giant Eagle Pharmacy, Hannaford Brothers (participating pharmacies include Hannaford and Food Lion), Harris Teeter Supermarkets, Kroger (Kroger Co. participating preferred pharmacies include Kroger, Fred Meyer, King Soopers, City Market, Fry’s, Smith’s, Dillons, Ralph’s, QFC, Baker’s, Scott’s, Owen’s, Pay Less, Gerbes and JayC), Target and Wal-Mart (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.) Please note: Rite Aid will no longer offered preferred cost sharing for member, but will continue as part of the standard retail network.

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.

Claim payment guidelines for BCBSHP Dual Advantage (HMO SNP):
To fulfill state and federal contractual requirements, this plan applies the Medicare statutory amounts to Medicare covered services. The remaining Medicare Advantage deductible, coinsurance or copayment amounts are then applied to the member’s Medicaid benefits; those claims are processed subject to Medicaid processing guidelines.

Under Medicaid, additional payment may be available dependent upon the Medicaid rate of reimbursement. If the Medicaid rate of reimbursement is more than the filed Medicare benefit, the difference will be paid to the provider. If the Medicaid rate is less than what the filed
Medicare benefit has already paid on that claim, no additional payment will be made. Providers are prohibited from balance billing members for any portion of that Medicare cost share that is deemed not covered under their Medicaid benefit.

**Employer or Union Group Retiree Changes:**
Group Sponsored Medicare Advantage Benefit Plan benefits vary from the **Medicare Preferred Core (PPO)**, **BlueValue Basic (HMO)**, and **BCBSHP Dual Advantage (HMO SNP)** 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 (updated 10/01/2014)**

**Referral Process Updates for Individual Medicare Advantage Plans:**
In most situations, our members may need to receive a referral from their PCP before they can use specialists in the Plan’s network. Examples of specialists include Cardiologists, Dermatologists, Orthopedic Surgeons, Oncologists and Urologists. However, referrals from a PCP are not required for emergency care or urgently needed care. There are also other kinds of care members can obtain without having approval in advance from their PCP.

Please visit our website at www.anthem.com/medicareprovider 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.

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