Dear Healthcare Provider,

Annual benefits changes for Medicare Advantage plan members will be effective January 1, 2016. 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 our 2016 Individual Medicare Advantage plans. You can help members manage their health care costs by being aware of these changes.

Group Sponsored Medicare Advantage Health Benefit Plan benefits vary from the Medicare Advantage plans offered to individuals. **Group Sponsored names and benefit changes may be different than what is described in this letter.** 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 (eg H4909) followed by a three digit number with an 8 in the first position (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.

**Notable 2016 benefits changes and highlights by plan type.**

**Medicare Advantage PPO Highlighted Changes**

- In 2016, the Medicare Preferred Core (PPO) will be renamed Anthem MediBlue Access (PPO).
- The 2016 Plan 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](http://www.anthem.com/medicareprovider) or calling provider services on 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, and Part B drugs.
- For 2016, we will no longer apply different cost share for diagnostic procedures and tests based on the level of complexity (or tier) for in-network services. However, cost share for these services may vary if performed in the office, free standing radiological facility or hospital.
- Our plan may use an independent network of providers for “routine” dental and vision care. If you have questions on whether you are eligible to be reimbursed for providing these services, please call provider services on the number on the back of the member’s ID card.
• Our plan offers a telehealth benefit that uses LiveHealth Online. LiveHealth Online provides members with convenient access to a doctor via live, two-way video on a computer or mobile device.
  o Members logon to [www.livehealthonline.com](http://www.livehealthonline.com) to access care.
  o LiveHealth Online is available for conditions such as colds and flu, infections, rashes and allergies.
  o For 2016, we are adding coverage for limited behavioral health conditions to assist members with feelings of depression, stress or anxiousness (mood).

• Our PPO plan includes 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 doctor 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 and 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. However, if you requested a coverage determination due to the fact that 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.

• Please check the member ID card for any identification and/or group number changes that may affect claim submissions.

• There are no changes to our Medicare Advantage PPO service area in 2016.

**Optional Supplemental Benefits (OSB)**

For 2016, our Medicare Advantage PPO plan 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.

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

**Diabetic Supplies:**

Effective January 1, 2016, all of our individual Medicare Advantage plans will only cover certain lancets if they are purchased at one of our network pharmacies or through our mail-order service. Lancets will be limited to the following manufacturers: Lifescan / Delica, Roche, Kroger and its affiliates which include Fred Meyer, King Soopers, City Market, Fry’s Food Stores, Smith’s Food and Drug Centers, Dillon Companies, Ralph, Quality Food Centers, Baker, Scott’s, Owen, Payless, Gerbes, Jay-C, Prodigy, and Good Neighbor.

Up to 100 lancets per month will be covered.

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.
PM insert for plans with capitated arrangements: As a reminder, providers that participate in a delegated arrangement with the health plan are responsible for the provision of services as indicated in the Division of Financial Responsibility (DOFR) section of the provider group’s contract or services agreement. If your provider group participates in a delegated arrangement, please remember that diabetic test strips and Part B drugs must be supplied at the provider’s office and not through a retail pharmacy or mail-order service.

**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 2016 formulary information within their Annual Notice of Change (ANOC) mailing or their new member kit, 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 2016:**

Individual MAPD plans have a pharmacy network that includes preferred and standard network retail pharmacies. Member’s save more by paying a lower cost-sharing amount at preferred cost-sharing pharmacies. Our preferred cost-sharing pharmacies include **CVS/pharmacy, Target, Sam’s Club, Walmart and some independent pharmacies within specific geographical areas.**

- CVS/pharmacy participating pharmacies include CVS/pharmacy, Longs Drug Stores and Navarro Discount Pharmacies.
- Walmart participating 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.

**Enhanced Benefits:**
Individual MAPD plans have select care drugs at a $0 cost share for the following conditions: high blood pressure, high cholesterol and diabetes. The following drugs will be on the $0 cost share tier:

- **ENAMELAPRIL MALEATE**
- **PRAVASTATIN SODIUM**
- **LOSARTAN POTASSIUM/HYDROCHLOROTHIAZIDE**
- **LISINOPRIL**
- **LOVASTATIN**
- **METFORMIN HCL**
- **BENAZEPRIUL HCL**
- **ENAMELAPRIL MALEATE/HYDROCHLOROTHIAZIDE**
- **GLIPIZIDE**
- **GLIMEPIRIDE**
- **ATORVASTATIN CALCIUM**
Most Group Sponsored MAPD plans have a similar benefit for select generics at a $0 to low cost share. Select generic drugs include 36 generic drugs used to treat high blood pressure, high cholesterol, diabetes, depression, osteoporosis, and smoking cessation. The list of select generic drugs is provided in the member’s formulary document. The list is similar to the one used on the Individual MAPD plans, but not exactly the same. In addition to covering some generics not covered on the Individual plan’s $0 copay list, Group Sponsored MAPD plans cover all drugs listed above at $0 except for LOSARTAN POTASSIUM.

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.

Annual Wellness Visit (AWV):
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 Does the AWV Cover?
All of our Individual and Group sponsored 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 for subsequent visits.

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 on the document named: Medicare Advantage Precertification Requirements.

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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