2024 AEP Braven #5 – Week Ending December 1

General

1. **What is the cost sharing for a member being discharged from hospital to rehab facility?** Generally, inpatient rehab cost share follows the inpatient hospital cost share [i.e. $350/day, Days 1-5 for the original 8 county Choice plan]. However, if a member is readmitted to another facility within 3 days discharge from the previous facility, *the inpatient copay is waived*. This would also apply if the member is transferred from one facility to another. If the first facility applied a copay, the second facility will not apply a copay. So whether someone is readmitted to the same or a different facility within 3 days of discharge, even if they didn't fulfill the copay for the first 5 days, any subsequent cost sharing for the second admission is waived and they wouldn't have cost sharing again until their next readmission after the 60 day separation period.

Skilled nursing facility [Sub Acute Care]	Acute inpatient rehab hospital [Acute Care]
Length of stay	
The national average length of time spent at a skilled nursing facility rehab is 28 days.	The national average length of time spent at an acute inpatient rehab hospital is 16 days.
Amount (and intensity) of therapy	
In a skilled nursing facility you'll receive one or more therapies for an average of one to two hours per day. This includes physical, occupational, and speech therapy. The therapies are not considered intensive.	In an acute inpatient rehab hospital you'll receive a minimum of three hours per day, five days a week, of intensive physical, occupational, and speech therapy. Your therapy is provided by rehab specialists who incorporate advanced technologies and approaches into your regimen
Physician involvement	
An attending physician provides a comprehensive initial assessment within 30 days of your admission into a skilled nursing facility. An attending physician, physician assistant, or nurse practitioner is only required to visit you once every 30 days.	Physician care is provided 24 hours a day, seven days a week. A rehabilitation physician will visit you at least three times per week to assess your goals and progress.
Nursing care	
A registered nurse is required to be in the building and on duty for eight hours a day. More often, patients are seen by certified nurse aides. A registered nurse is available in the evening and off hours. The nurse-to-patient ratio is one nurse aide to 20 to 30 patients.	Nursing care is provided 24 hours a day, seven days a week, by registered nurses as well as Certified Rehabilitation Registered Nurses (CRRN). The nurse-to-patient ratio is one nurse to six or seven patients.
Treatment team	
In addition to a monthly visit from an attending physician, you may receive additional visits from a physician assistant, nurse practitioner, or clinical nurse specialist. Sub-acute teams include physical, occupational, and speech therapists, and a case manager.	Your highly trained, multidisciplinary personal rehab team, consisting of rehabilitation physicians, internal medicine physicians, nurses, therapists, care managers, dietitians, psychologists and family members, work together to help determine goals and the best individualized treatment approaches for you.

2. **If a member is enrolled in Medicare Advantage plan and needs to be hospitalized can they apply for Charity Care to help pay for their copayments?**
   In accordance with Charity Care guidelines, payment assistance is available to New Jersey resident patients whose household gross income is at or below 300% of the federal poverty guidelines and who:
   - Have no health coverage or have coverage that pays only for part of the bill; and
   - Are ineligible for any private or governmental sponsored coverage (such as Medicare and Medicaid); and
   - Meet both the income and assets eligibility criteria

3. **Member is switching from Humana to Braven for 1/1/2024 while still in a SNF. Would he begin a new benefit period, or would Braven just pick up where Humana left off? For example, if he used 20 days in the SNF under Humana then enrolls with Braven, would the day count be considered a continuation to Day 21, with applicable cost share under Braven, or would the day count reset back to Day 1 (i.e. $0 cost share) since it's new coverage?**
   If the member happens to be enrolled with Humana up to the 20th day of their SNF admission and switches over to Braven, the member would **not** pay the applicable Braven cost share for Days 21 on, etc. Humana would be responsible for coverage up to the member's discharge from the SNF and will continue paying up to their 100 day SNF benefit period. Braven will pick up any coverage for a new benefit period if applicable (i.e. after a 60 day separation). Braven will also be responsible for coverage of any non-SNF-related services after 1/1/24.
   In general, there is no coordination or continuity of cost share from one plan to the other. This includes their MOOP, which does NOT transfer from one carrier to the other. It would start over with Braven.

4. **If a member moves from one county to another but both are within the same region, is a new app needed? Or do they just need to notify service of their updated address?**
   They just need to notify customer service who will update all systems – no new app needed.

SMART CARD

1. **Can a BH member use the grocery benefit with InstaCart?**
   No, they can only use their OTC or grocery benefit with approved retailers.

2. **Would a pickle ball club be considered a fitness studio as it relates to the fitness benefit?**
   Yes, Pickle Ball clubs would be eligible. If the member uses a specific location we can have it added to the list of approved fitness locations.

3. **Regarding Noom, the online dieting app and the fitness benefit: member logs in each day to post her weight, food intake and exercise. The yearly cost is $90. Can this be reimbursed as part of the fitness benefit or any other way?**
   Unfortunately there is no reimbursement/allowance available for Noom under the Fitness or any other benefit.

PHARMACY / DIABETIC SUPPLIES

1. **I need more clarification on wearables. Are they 20% coinsurance or $0 copay from an In-network pharmacy like CVS, Walgreens, etc? Also, did we get confirmation that the Freestyle Libre 2 and Dexicom 7 covered? They are the newer models from the same suppliers.**
   Pharmacy can't speak to all wearables, but CGMs are covered at $0 from in network pharmacies. And yes, the new models of Freestyle and Dexcom are covered. There are limits to the number of sensors/transmitters a member can get over a period of time – 1 receiver per 365 days and 1 transmitter per 90 days and sensors limited to product labeling.

2024 AEP Braven #4 – Week Ending November 17

VISION

1. **An existing Braven member wants to see if his doctor is INN with Davis for 2024. I looked him up using the code and he does not come up. He does come up under the Braven doctor finder. However, the doctor is an ophthalmologist, not optometrist, which from the FAQ I understand would not be covered under Davis. So if the member goes to his ophthalmologist for his routine eye exam and he is INN with Braven- would this process as an INN routine eye exam, billed under Braven?**
   Beginning 1/1/24, Davis Vision is responsible for administering the **routine eye exam** benefit, and while routine eye exams are generally performed by optometrists, we have confirmed that coverage will include services rendered by Davis Vision network optometrists, as well as out-of-network optometrists ***or ophthalmologists*****.** So generally speaking, Davis Vision will reimburse the member 50% of the cost if he/she sees either an OON optometrist or ophthalmologist for the routine eye exam [ophthalmologists are always considered OON for the routine eye exam because we are not using Davis Vision's network ophthalmologists, *even when the ophthalmologist is in Braven/Horizon's network*.].

   So if this member sees their Braven network ophthalmologist for a routine eye exam and the diagnosis and procedure codes clearly indicate routine, the claim will be denied by Braven with instructions to the provider to collect 100% of fees up front. In order to receive 50% reimbursement of billed charges, the member will need to complete a reimbursement form found on bravenhealth.com, or submit a reimbursement request via the Davis Vision member portal.

   If this visit happened to be a diagnostic exam [as indicated by diagnosis and procedure codes], Braven/Horizon would process the claim under the diagnostic eye exam benefit.

   Bottom line: If this [or any] member prefers 100% coverage for their **routine eye exam**, they will need to see a **Davis Vision optometrist**.

2. **Are ALL ophthalmologists (both Braven and Davis) considered out-of-network for routine eye exams? When entering the Braven client code on the Davis Vision website and searching for routine eye exam, the search results do show ophthalmologists in the Davis network specifically under the Braven plan. So would we need to tell members to ignore any ophthalmologists they see in their search and only use optometrists?**

   Although Davis Vision has ophthalmologists in their network for some of their other MA clients, we are not using them. We are only utilizing Davis Vision's optometrist and eyewear retailer network. All ophthalmologists are considered OON for the routine vision exam, however they will sometimes appear in the provider search tool. There are two reasons: 1) optometrists also practice at that location; and/or 2) the ophthalmologist is explicitly contracted to provide the routine eye exam. The number of optometrists in the network is substantially larger than the number of ophthalmologists. Although we are utilizing Davis Vision's optometry network, it's possible that *one of their ophthalmologists might perform the routine eye exam.* In this scenario, *Davis Vision will pay the claim as INN under the same fee schedule as they do for optometrists performing the routine eye exam.* So even if a Davis Vision network ophthalmologist renders the routine eye exam, we have instructed them to allow these claims to process and pay to avoid potential access issues and member abrasion.

Ultimately we want to continue to encourage members to see a Davis Vision optometrist because: 1) that is the bulk of their network; and 2) ophthalmologists are generally seen for more complex medical issues that are treated during a diagnostic eye exam.

If a member happens to see a Davis Vision ophthalmologist for the routine eye exam, the service will be covered at $0 copay and the claim paid.

Again, remember that not all optometrists in the Braven Health network participate in the Davis Vision network, so please refer to the Davis Vision network of optometrists for routine eye exams.

Also confirming again that all Walmart and Visionworks locations are INN for the Davis Vision benefit.

GENERAL

3. **Does Braven Choice PPO cover a 3D Mammogram, also called a Tomography or Tomosynthesis?**

   Yes, 3D Tomography/Tomosynthesis is covered at $0 cost share, same as traditional mammo.

4. **Are Botox injections covered [J0585-J2]?**
   This procedure requires a prior authorization to meet medical necessity and the member would be responsible for 20% of the cost of the Medicare Part B drug. The administration in office, both in and out of network, is combined with the cost of the drug and does not apply a separate copay/coinsurance.

5. **How are eye injections to treat macular degeneration covered?**
   Eye injections for macular degeneration are considered a surgical procedure, so either the OV, ASC or OP surgical copay would apply, depending on place of service.

6. **What is the cost sharing for infusion therapy (i.e. for arthritis) rendered in OP dept or in a doctor's office? It's not spelled out in the SOB or EOC, only Home Infusion is addressed.**
   Infusion would fall under the Medicare Part B drugs/administration benefit. The bundled drug/admin cost would be 0-20%, depending on whether the drug happens to be on the Inflation Reduction Act drug list.

7. **If someone was on Medicare due to disability since 2009 without an Rx plan and is now turning 65 and wants to pick up Braven, would they potentially be subject to the LEP?**

   According to the **Medicare Prescription Drug Manual**, an individual who is entitled to Medicare prior to turning age 65 [e.g., those who were entitled based on disability], will have a new or subsequent Part D IEP when they become entitled to Medicare based on age. Therefore, *if this applicant never had a Part D plan in place and enrolls during their subsequent IEP, they will NOT be subject to an LEP. 9.*

   And in a situation where an applicant attains age 65 while enrolled in a Part D plan and paying an LEP, their LEP will end on the day before their subject IEP begins [i.e. three months prior to the month they turn 65, consistent with their Part B IEP].

8. **I was speaking with a prospective member and they mentioned therapeutic massage is no longer offer under the Flex benefit for 2024. I checked the summary of benefits and I don't see it. Is it no longer included next year?**
   That is correct. As discussed in the 2024 certification and our 2024 AEP educational sessions, therapeutic massage is no longer an included service under the Flex benefit for 2024.

9. **I have a customer that says she see her doctors sometimes virtually instead of going to the office if she is not feeling well. The doctors are all in network they are part of the Cooper group and I believe she said they do this on the Cooper app. Are those visits paid for just like a regular office visit? She is currently on Omnia and said they are covered normally under her current plan. If you could find some clarification that would be great.**
   Yes they are paid like a regular physical office visit, so PCP visit would be $0 cost share INN.

10. **A new Braven member is having arthroscopic knee surgery in early January. Can you give me an idea of the cost share and whether prior authorization will be required? If so, how would the provider go about obtaining that prior to 1/1?**
    Since this is a surgical procedure, either the ASC or OP surgical copay would apply, depending on place of service. It also appears this service does require prior authorization. We collaborate with TurningPoint Healthcare Solutions, LLC (TurningPoint) for the utilization management of certain specialized orthopedic services which may require the use of an implantable device. ID cards are mailed in early December, so once the member is officially assigned an ID number, their provider can consult Navinet or call their dedicated provider services number for clear instructions on how to initiate the prior authorization process with TurningPoint.

11. **A prospect is inquiring about the dental coverage. He stated he received a book on the dental coverage with covered codes. He stated even though the $1,000 benefit does not cover crowns, if he gets a specific service which he gave me the code of D2720 and he is being charged $1,200 by the dentist for that service, will he be entitled to pay the discounted amount which he mentioned was a bit over $400 if the dentist is in the Braven Medicare Advantage network?**
    That procedure code is for a crown – 3/4 resin-based composite (indirect). It appears the provider is trying to get the claim paid by using that code since it implies the crown is made mostly of "resin", as a covered filling might be. But as crowns, dentures, etc. are out of scope for this benefit, a claim with that code will still deny as not covered.

SMART CARD

12. **Will SSBCI HMO members transitioning over to a PPO plan need to requalify for Care Management under their new plan or will it carry over?**
    HMO members moving to PPO will keep their SSBCI eligibility and will **not** need to requalify.

13. **Can a Braven member use their fitness benefit at the YMCA vs. a fitness center?**
    Yes they can.

14. **A member asked if the Smart Card covers taxes because when the plan had the reimbursement for the extra benefits he was not reimbursed for the tax portion of his bills (i.e. bathroom safety devices, gym).**
    Yes, taxes charged for retail purchases are included in the total amount debited from the card (no taxes charged on catalog items).

15. **If someone enrolls in Braven in the middle of a quarter is their OTC allowance pro-rated?**
    No, none of the Smart Card benefits are pro-rated. The member would get the full amount to use within the remainder of the quarter. This is the same for TotalCare.

16. **A member stated he goes to Planet Fitness and was advised they don't accept the Smart card.**
    Workarounds were distributed for Smart Card issues identified earlier this year. Refer to the Fitness section of the Braven Smart Card document shared with this FAQ on 11/17 to review how Planet

Fitness is handled.

Please note: This workaround for Planet Fitness will stay in place into 2024, but as I indicated in a recent FAQ, **any other workarounds that involve reimbursements we honored due to Smart Card issues will only remain in place through 12/31/23.**

17. **A member's card didn't work at the place she usually goes to get her glasses. Is the same reimbursement workaround available in this case as it is for Walmart, fitness centers and other retailers where the card didn't work?**
Yes they can call into Braven Smart Card customer service and provide their proof of receipt, and they should be able to get reimbursed: **800-688-9140**

PHARMACY / DIABETIC SUPPLIES

18. **Is Tadalafil, the generic for Cialis, covered as one of the supplemental ED drugs?**
Only the generic for Viagra (sildenafil) is covered.

19. **I am getting many calls with extensive questions about Ozempic. It is on our formulary but it requires pre authorization and has quantity limit restrictions. Are we covering Ozempic for non- diabetic purposes and exactly how do quantity limits apply to this particular drug?**
We only cover Ozempic if the member has a diagnosis of Type 2 diabetes. As you're probably aware, Ozempic is being used for many other non-FDA approved conditions, we do not cover in those instances. Additionally, Medicare excludes weight loss drugs from coverage. We anticipate Medicare will start auditing us on appropriate payment for these drugs.
The quantity limit is 1 pen per 28 days. Ozempic is a weekly injection and each pen is good for 4 injections.
We did send letters to members about formulary changes. We continue to cover Ozempic next year, what's changing is the PA. Starting in 2024, that member will need to go through the PA process for Ozempic, we do accept prospective PA requests so if the member plans to stay with Braven they can start the PA request now and do not have to wait until 1/1/24.

20. **Broker has a prospective member who is NOT on insulin. They had an issue getting approval from their current plan for Freestyle Libre 2; seems an exception was made and he wants to ensure he can continue with that CGM on Braven before making the change. So, is the FreeStyle Libre 2 covered on Braven if they are *not* on insulin? Would special approval be necessary/available or how would that work?**
If he is diabetic but not on insulin, Medicare has specific policies around number of hypoglycemic events, etc. that would necessitate use of the CGM. It would need to go through Medical Policy review for final determination.
This will be the policy in effect 1/1/24: Article - Glucose Monitor - Policy Article (A52464)
https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleId=52464
Use this page to view details for the Local Coverage Article for Glucose Monitor - Policy Article.

21. **Can we confirm Freestyle Libre [specifically Freestyle Libre 2) and Dexicon 6 are still covered under Braven Health for 2024? Are the limits the same as last year for the wearable devices [including 4 transmitters/year and 1 sensor/day] as covered diabetic supplies under Part B at $0 cost share?**
Generally speaking, therapeutic continuous glucose monitors (CGMs) are limited to Dexcom (G5 and G6) and Freestyle Libre when obtained at the pharmacy. Continuous Glucose Monitoring (CGM) preferred products are Dexcom CG6 and Abbott Freestyle Libre. They are covered at $0 cost share in network.

Also, please revisit the following categories of diabetic supplies and how they are covered, to ensure understanding:

Diabetic Supply/Service	How Covered by Medicare / Braven
Testing equipment/supplies: blood glucose monitors [including continuous glucose monitors or CGMs such as Freestyle Libre and Dexicon], ***test strips, lancet devices, lancets	**Part B** – **requires script** and can be purchased at the pharmacy or through a DME supplier with appropriate cost sharing based on par status**** **[$0 cost share at in network Pharmacy/DME supplier; no coverage at out of network pharmacy/20% at out of network DME supplier]**
Therapeutic shoes, shoe inserts, insulin pumps, and the insulin the pump uses	**Part B** – **requires script** and can be purchased through a DME supplier with appropriate cost sharing based on par status **[$0 cost share at in network DME supplier; 20% at out of network DME supplier]**
Delivery equipment/supplies: needles, syringes, alcohol swabs, gauze, insulin inhalers and insulin [not administered through an insulin pump]	**Part D** – **requires script** and can be purchased at the pharmacy: **cost sharing based on Rx tier, just as any other covered medication would be**. **Note:** covered insulins would be **capped at $35 copay** in all coverage phases as part of the Inflation Reduction Act

***NOTE:** Remember, when purchased at the pharmacy, only **Contour** and **OneTouch** test strips are covered; all other test strips are not covered. If members obtain their test strips through a DME supplier, they are not limited to brand and the strips would be covered at $0 cost share using in network DME suppliers, and at 20% using out of network DME suppliers.

****NOTE**: Members obtaining supplies [diabetic or otherwise] from in-network DME suppliers must go through their primary care physician or specialist who will coordinate with that DME provider via CareCentrix. CareCentrix is responsible for ensuring that certain Care@Home services are medically necessary and appropriate through its utilization management activities, including:
– Durable medical equipment [including medical foods i.e. enteral]
– Orthotics and prosthetics
– Home infusion therapy
– Diabetic and other medical supplies

When a doctor refers a patient to a participating Care@Home ancillary services [DME] provider, that rendering provider will work with CareCentrix to ensure that the appropriate prior authorization/pre-service registration is performed. Referring/ordering doctors can also call CareCentrix directly to obtain approval and pricing estimates.

2024 AEP Braven #3 – October 27

SMART CARD

1. **If someone enrolls in Braven effective 11/1 will they receive the entire $70 quarterly OTC credit, or a pro-rated amount?**

   They will receive the entire $70 but will only have until 12/31 to use it.

GENERAL

2. **Reinforcing a previous Q&A to ensure understanding and that we are providing the correct information:**
   Does routine colonoscopy include polyp removal and biopsy if found during the procedure, also at $0 cost share, regardless of place of service?

   Yes, polyp removal and biopsy are included at $0 cost share, for both routine and diagnostic colonoscopy procedures. And confirming for 2024, it is $0 cost share *both in and out of network*, regardless of place of service.

3. **What about someone who has a dx colonoscopy every year because they have a condition? I see in the EOC it states, "…once every 24 months for high risk patients after a previous screening colonoscopy or barium enema". Would there be a cost share then if they need to do it annually vs. every other year?**

   The coverage is based on Medicare guidelines. We only cover what Original Medicare covers which is highlighted below.

   Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who are not at high risk for colorectal cancer, and once every 24 months for high risk patients after a previous screening colonoscopy or barium enema.

   So in this case it would be covered every 2 years and the member would be paying full cost for the years in between. We only cover the frequency limits established by CMS so it would only be covered every 24 months for high risk patients as described below.

4. **What is the specialist copay for the Telemed benefit?**
   The Telemed benefit is basically urgent care with general practitioners or BH, not specialists. So $0 for general primary care, N/A for specialist visit as it doesn't apply.

5. **Is cataract surgery covered via laser?**

   Yes it is covered via laser as well as using the traditional technique.

6. **Does the worldwide emergency coverage apply while on a cruise ship?**
   Yes it does.

7. **Is a dental device used for sleep apnea covered under Braven?**
   Yes it is covered under DME if determined to be medically necessary.

8. **UPDATED Q&A: I was asked by a prospect where our customer service call center is located. He currently has another MAPD plan and wants to make sure the customer service base is in Newark only. Also, he wants to make sure if he has any issues that he wants to resolve in person if he can do so at a local office. He doesn't want to speak to reps based in different states/regions and has had issues with this on his current plan.**

   Our customer service overflow is handled internally and by a vendor partner. All staff receive the same training and can assist with any inquiries. We no longer have a walk-up center following Covid.

9. **Confirming that if someone has a prior authorization from another carrier for a particular service and enrolls with Braven, they would need a new prior auth with us, correct?**

   Yes, that service would need to go through our utilization review and a new authorization added on file for that Braven member.

2024 AEP Braven #2 – Week Ending October 20

SMART CARD

10. I know that current Braven members are not receiving a new Smart Card, only newly enrolling members. Does this include terming HMO members who enroll in Braven Choice or Freedom?

Yes, all new Braven enrollees will receive a new Smart Card, including our terming HMO members who enroll in a Braven PPO plan.

VISION and HEARING BENEFIT

11. Will Davis Vision reimburse up to 50% of the total cost of eyeglass lenses, or up to a max or cap?

Davis Vision will reimburse the member 50% of billed charges (not allowed charges). There is no max for now.

12. I want to make sure I am quoting this benefit correctly. All non-Davis providers would be considered OON, even if they show as a participating provider on our Braven Directory? Or can we assume that the par provider in the Braven Directory is automatically in the Davis network? The broker asked the following questions and the "in network, non-Davis vision doctor" part from last week's FAQ is tripping me up. I quoted them the EOC, advising of the 50% coinsurance for OON.

Suppose someone sees their eye doctor for a non-routine visit, gets a prescription for new eyeglasses and then brings it to Davis Vision? Is that okay.

If they see their eye doctor for a diagnostic exam and receive a script for eyeglasses, the frames would fall under the $150 annual eyewear allowance applicable toward frames purchased at either a Davis Vision or a non-Davis Vision provider, so technically they could fill the script at their eye doctor's office or at Davis Vision.

The eyeglass lenses are $0 cost share for basic lenses (including tint and scratch resistant coating) if purchased at a Davis Vision provider, and reimbursable up to 50% of the cost if purchased at a non-Davis Vision provider.

Just so I understand. If someone sees an in network, non-Davis Vision doctor they will pay 50% of the exam?

1. The Davis Vision network and the Braven Managed Care network are **two different networks**, although there is some overlap between them.
2. When distinguishing who processes what type of claim, we have to look at the type of EXAM and the type of PROVIDER rendering the service.
    a. Routine eye exams are exams to determine if the patient is suffering from vision impairment and in need of prescription eyewear to correct that impairment. These exams are performed by optometrists. ***Beginning 1/1/24, claims for routine exams are always processed by Davis Vision, whether INN or OON. Braven will deny these claims and instruct the provider to route to Davis Vision.*** So members desiring an in-network routine eye exam can see a Davis Vision provider for $0 cost share, or a non-Davis vision provider of their choice for 50% reimbursement.

b. Diagnostic eye exams are performed by physicians, i.e. ophthalmologists. They are treated like any other kind of medical exam under Braven and should be rendered by a Braven provider (or an out of network provider if the member opts). Davis vision does not provide that kind of service, nor does it process that kind of claim. So members desiring an in-network diagnostic eye exam can see a Braven physician, or a non-par provider, for the appropriate in or out of network co-pay/coinsurance.

GENERAL

13. Does Braven cover TMJ treatment?

Yes it is a covered treatment.

14. We are hearing from a Braven member that CarePoint Hospitals are leaving our network. Is this accurate?

CarePoint as an employer group is terminating, **not** the hospitals in our provider network.

15. I am trying to confirm that St. Peter's Hospital in New Brunswick is in the Braven Managed Care network. Cannot find on the Provider Finder, only their Ambulatory Care Group, but I thought they were participating.

St. Peter's hospital IS participating in the Braven network but I've confirmed with our Provider Strategy team that there is an IT issue preventing the facility from being listed on the Provider Finder. They are looking into correcting this issue. But YES St. Peter's Hospital does participate with Braven. In the meantime, always remember to check PNO as a backup – the facility is showing as participating there.

16. I looked up a PT provider in the online directory and he isn't showing as par, however PNO shows him as par in certain locations, but not the one the prospect uses. What does this mean?

The member can see the provider at the in-network locations indicated in PNO. If the member sees the provider at one of the locations not listed in PNO then the service will be billed as out of network.

PRESCRIPTION

1. **I have a current Braven Health HMO member who takes Rybelsus which is currently covered and requires prior authorization. He enrolled in the Braven Health Choice PPO for 1/1 and would like to know if the prior authorization will carry-over or if he needs to do a new one.**

   Yes, just as is the case for Horizon Saver PDP members crosswalked to the Standard PDP, any Braven HMO member with an active authorization will carry it over when they enroll in Braven PPO.

2024 AEP Braven #1 – Week Ending October 13

SMART CARD

1. **Did the OTC catalog change or get smaller? A member says she received a new smaller catalog.**
   A catalog was mailed to members in September as a quarterly supplement that lists the top 150 eligible items for purchase. But members can continue to view the full list at Bravensmartcard.com or check their original catalog containing the full list of eligible items. We are researching this further with vendor to learn exactly what is communicated to members on these abbreviated versions.

2. **A couple months ago it was confirmed that we are no longer doing the workaround for Walmart, etc. where someone can pay up front and be reimbursed (i.e. for a treadmill, etc.) for 2024. Do we know if that is the case NOW thru the end of the year, or are we still doing the workaround until 12/31?**
   We are still doing the workaround through 12/31/23.

VISION and HEARING BENEFIT

1. **Confirming that the $150 eyewear allowance does not include non-prescription polarized sunglasses?**
   Correct, non-prescription polarized sunglasses would not be eligible for the eyewear allowance.

2. **Does the doctor performing cataract surgery have to be a Davis Vision provider?**
   No. Cataract surgery must be performed by a Braven network physician (usually an ophthalmologist in the case of cataract surgery), using their medical benefit. *Davis Vision will only be adjudicating claims from optometrists.* In general, we are not delegating any services performed by physicians, including ophthalmologists. So basically, Davis is handling optometry services only; Braven would handle cataracts since it is a medical procedure, so the ophthalmologist just needs to be INN with Braven, not Davis Vision.

3. **Member sees a Braven network participating ophthalmologist or optometrist for a Medicare covered eye exam and doctor also writes a script for eyewear. How is that handled?**

   Exams
   When we say "Medicare-covered eye exams", we mean 3 types of exams:
   - Exams to diagnose and treat diseases and injuries of the eye, including treatment for age-related macular degeneration. These exams can only be performed by physicians (e.g., ophthalmologists). Claims for these exams are always processed by Braven/NASCO, whether INN or OON.
   - Diabetic retinal exam, an exam that can be performed by optometrists or physicians to check for signs of diabetic retinopathy. Claims for these exams will be processed by both Braven/NASCO and Davis Vision. We expect that Davis Vision network optometrists will submit the claim to Davis Vision, and Braven Health network optometrists or network doctors will submit the claim to Braven/NASCO.
   - Glaucoma screening, a group of tests that help diagnose glaucoma that can be performed by optometrists or ophthalmologists. Claims for these exams will be processed by both Braven/NASCO and Davis Vision. We expect that Davis Vision network optometrists will submit the claim to Davis Vision, and Braven Health network optometrists or network doctors will submit the claim to Braven/NASCO.

In short: if a Medicare-covered exam can be rendered by an optometrist, both Davis Vision and Braven/NASCO will process the claim. If the Medicare-covered exam can only be rendered by a physician, Braven/NASCO will process the claim. *We do not delegate any physician services to Davis Vision.*

When we say "routine eye exams", we mean an exam to determine if the patient is suffering from vision impairment and in need of prescription eyewear to correct that impairment.

- Beginning 1/1/24, claims for these exams are always processed by Davis Vision, whether INN or OON. Braven/NASCO will deny these claims and instruct the provider to route to Davis Vision.

Eyewear

- Claims for routine eyewear (i.e., non-Medicare-covered eyewear), including prescription glasses and contact lenses, are always processed by Davis Vision.
- Claims for glasses required after cataract surgery (i.e., Medicare-covered eyewear) are always processed by Braven/NASCO.

4. Are the Davis Vision Providers included in the Provider directory that we can send out through Sales Force? If not, is there any way to have a directory sent to a member or even a prospect's physical address?

The printed provider directory that Braven mails to members will not include Davis Vision providers. We are currently working with Davis to see what our options are for getting printed lists to members, as currently it appears Davis will not fulfill requests for a printed directory.

To find Davis Vision Providers members can:

1. Call Davis Vision at 1-888-257-1267 (Monday – Friday: 8 a.m. to 11 p.m., ET, Saturday: 9 a.m. to 4 p.m., Sunday: noon to 4 p.m., ET)

2. Visit https://davisvision.com/. Click on Members, then Find an Eye Care Professional. Members can search by location and type of service (exam, eyewear).

3. Register for an account at https://davisvision.com/, click on Member Log In, and click Register new account. In addition to providing their full name and date of birth, members must provide their Braven Health member ID number and email address. Members must enter their member ID number beginning with "3HZN." The Davis Vision website does not recognize the three-digit prefix (e.g., B7U) at the beginning of the member ID number.

Note that only enrolled members will be able to log into the Davis portal. *Davis does have a provider search feature on their public website, but this is not reliable because it includes providers and retailers that may not be in their Medicare network.* We don't have an approximation of NJ providers yet but the latest roster has been requested and will shared as soon as we have it.

5. For hearing aids: the tiered co-pays - when we say "each year", we mean that they are eligible to purchase a new set of hearing aids each year, NOT that they have to repay this co-pay EACH year toward the hearing aids they purchased, like a renewal fee?
No renewal fees. If they purchase new hearing aids in 2024 and pay the co-pay, they wouldn't pay another co-pay the following year UNLESS they opt to purchase new hearing aids.

GENERAL

1. **Is GeoBlue available for Braven members?**
   No, GeoBlue is a commercial program. We feature the MA PPO Network for coverage outside NJ, and coverage for worldwide urgent/emergent care.

2. **Does Braven (Medicare) cover adult day care, or only Medicaid?**
   Only Medicaid covers adult day care.

3. **I was asked by a prospect where our customer service call center is located. He currently has another MAPD plan and wants to make sure the customer service base is in Newark only. Also, he wants to make sure if he has any issues that he wants to resolve in person if he can do so at a local office. He doesn't want to speak to reps based in different states/regions and has had issues with this on his current plan.**
   Our customer service overflow is outsourced [although they take a small percentage of calls] and we no longer have a walk-up center following Covid.

4. **A member's daughter called Braven and was told that the co-pay for a Nurse Practitioner visit is $20, even though her mom was seen by the NP in her PCP's absence. According to the plan, the $20 co-pay is for Specialists, and while a NP has the ability to write prescriptions, he/she is not a cardiologist etc.**
   Currently Nurse Practitioners are coded in our system as Specialists, so those NP visits in the PCP's office would charge a specialist co-pay. We are currently working to change that for 2024 or sooner, if possible.

5. **What is the updated guidance on Horizon/Braven Covid-related coverage (i.e. testing and vaccines) now that the Federal Emergency has been lifted?**
   Post PHE, vaccinations rendered by INN providers still are at no cost to the member. COVID tests are at member benefits, so a cost share could apply based on whether the test is done by an INN or OON provider. OTC home tests are not covered by Horizon/Braven but members can of course order them through the Federal website.
   Medicaid however is still waiving cost share on COVID tests because that was extended until 10/1/24.

   Important Update: Additional Policy Changes as PHE Ends - Horizon Blue Cross Blue Shield of New Jersey

   Some Benefits Changes as the PHE Ends - Horizon Blue Cross Blue Shield of New Jersey

   - Are vaccinations covered by in-network providers at a $0 copay? Covid-19 vaccines are covered at $0 INN/OON. There is no coinsurance, copayment, or deductible for the INN/OON pneumonia, influenza, Hepatitis B, and COVID-19 vaccines. Other vaccines have OON cost share.
   - What is the copay of a vaccination provided by OON provider? Some other vaccines have OON cost share. There is no coinsurance, copayment, or deductible for the INN/OON pneumonia, influenza, Hepatitis B, and COVID-19 vaccines. Other vaccines have OON cost share.
   - Can members go to participating pharmacies to get the vaccination? If "yes", I assume $0 copay? Yes, see above
   - What is the cost if they go to a non-participating pharmacy to get vaccinated? Depends on the plan.
   - Are COVID tests by an in-network provider covered? If "yes" what's the cost? Yes. See above
   - Are COVID tests by an OON provider covered? If "yes" what's the cost? Yes, see above
   - Can they get tested at a participating pharmacy or does it have to be to be a participating lab? Yes, this would follow the lab benefit.
   - If they can be tested at a pharmacy, does it have to be a participating pharmacy? Lab benefit
   - OTC home tests are not covered by Braven Health? Members need to go thru the Government to get home testing kits? Yes, correct no Braven coverage, but as of September 25, 2023, they can visit COVID.gov/tests to place an order of 4 free at-home tests per household.

6. **I received a call from a member today explaining that he spends about half the year in Florida. He has a blood disease. He is concerned that if he overstays the six months in Florida, due to illness, he would be dis-enrolled. Apparently the rule used to be 9 months and has been lowered to six months.**
   Assuming Mr. Mados is a Braven MA member and received notice, most likely via his ANOC, about the Visitor/Traveler benefit changing as follows:

   Members will continue to have access to the Blue Medicare Advantage PPO network of providers throughout the United States and pay the in-network cost sharing amount. However, they will be disenrolled from our Plan if they permanently reside outside of the plan's service area for longer than six months.

   According to our enrollment team, when we use our internal process to make a determination that someone is out of area, the IKA system will terminate them after 6 months if member does not contact us to advise that they are back in the service area.

   There are several ways we can be notified that member has left the service area. They are as follows:

   - Through a customer service call
   - Through CMS
   - Via returned mail

   For termination of member being out of the service area for more than 6 months, the countdown begins when we receive notification through one of the means referenced above. In his case if he ends up with a medical situation the communication may come up at the time the claim is received.

   Before we terminate a member we always send out notification. Once we put a member on the out of area process, a letter does go out at the start of the 6 month countdown. We also conduct outreach to confirm member's permanent address. In addition, a final letter is sent out once the 6 month is approaching to once again alert the member that if we do not hear from them we will proceed with termination. We would never terminate a member without proper communication going out.

7. **Is bloodwork is included with the routine physical supplement benefit?**
   We specify that an additional cost share applies for any additional services ordered, however blood work is $0 INN.

PRESCRIPTION

8. **A hubby and wife are saying they are sending $15.40 each to Braven every month in connection with their Rx plan. Any idea why?**
   That is their Part D Late Enrollment Penalty. They can also arrange to have it taken out of their SS check if they prefer.

9. **Does the $35 insulin max include pens?**
   Yes, but it includes certain insulin pens, i.e. Lantus Solostar, Toujeo Solostar, Toujeo Max Solostar and Humalog Kwikpen.

10. **Since the new Rx Supplemental meds for ED, cough and Vit D are excluded Medicare drugs, will their costs count toward the deductible, initial coverage limit or OOP in the Coverage Gap?**
    No, they will not count in any of the Part D phases.