Summary of Benefits

Braven Medicare Choice (PPO)

January 1, 2023 – December 31, 2023

Service area for this plan includes: Bergen, Essex, Hudson, Middlesex, Monmouth, Ocean, Passaic and Union counties.

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This booklet gives you a summary of what we cover and what you pay. It doesn't list every service we cover or list every limitation or exclusion. To get a complete list of services, cost shares and exclusions, please refer to our Evidence of Coverage, which can be found online at BravenHealth.com/2023EOCChoice. Or, you can call us at 1-833-272-8360 (TTY **711**) to request a mailed copy. Hours of operation are: October 1 – March 31: Monday – Sunday, from 8:00 a.m. to 8:00 p.m., ET and April 1 – September 30: Monday – Friday, from 8:00 a.m. to 8:00 p.m., ET.

If you are a member of this plan, call toll-free 1-833-272-8360 (TTY **711**).

If you are not a member of this plan, call toll-free 1-833-713-1313 (TTY **711**).

About our plan

Braven Medicare Choice (PPO) is a Medicare Advantage PPO plan with a Medicare contract.

To join this plan, you must be entitled to Medicare Part A, be enrolled in Medicare Part B and live in one of the following counties: Bergen, Essex, Hudson, Middlesex, Monmouth, Ocean, Passaic or Union county.

Visit BravenHealth.com for more information.

Network providers and pharmacies

Braven Medicare Choice (PPO) has a network of doctors, hospitals, pharmacies and other providers. If you use the providers in our network, you may pay less for your covered services. But if you want to, you can also use providers that are not in our network. You can search for a network provider online at doctorfinder.bravenhealth.com.

You must generally use network pharmacies to fill your prescriptions for covered Part D Drugs. You can search for a network pharmacy online at bravenhealth.com/find-network-pharmacies.

You can always call us and we will send you a copy of the provider directory and pharmacy directories.

For coverage and costs of Original Medicare, look in your "**Medicare & You 2023**" handbook. View it online at www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Premiums and Benefits	Braven Medicare Choice (PPO)
Monthly Plan Premium	$0 per month In addition, you must keep paying your Medicare Part B premium.
Annual Medical Deductible	$0 per year
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	• $6,700 per year for services you receive from in-network providers. • $10,000 per year for services you receive from in-network and out-of-network providers combined. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay for the rest of the year. Our plan also has a benefit-specific coverage limit for select benefits. For coverage limit details, see Chapter 4, Medical Benefits Chart (what is covered and what you pay), in your 2023 Evidence of Coverage.
Covered Benefits NOTE: Services with a [1] may require prior authorization.	**Braven Medicare Choice (PPO)**
Inpatient Hospital Coverage[1]	Our plan covers an unlimited number of days for an inpatient hospital stay. In- and Out-of-network: • $335 copayment per day for days 1 through 5 • $0 copayment for days 6 and beyond
Outpatient Hospital and Observation Coverage[1]	In-network: • $295 copayment Out-of-network: • $395 copayment
Ambulatory Surgical Center[1]	• In-network: $250 copayment • Out-of-network: $350 copayment
Doctor Visits[1]	Primary Care Physician: • In-network: $0 copayment • Out-of-network: $10 copayment Specialists: • In-network: $20 copayment • Out-of-network: $30 copayment

Covered Benefits	Braven Medicare Choice (PPO)
NOTE: Services with a [1] may require prior authorization.	
Preventive Care	• In-network: $0 copayment • Out-of-network: $10 copayment Our plan covers many preventive services, including: • Abdominal aortic aneurysm screening • Alcohol misuse screening and counseling • Annual wellness visit • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease Intensive Behavioral Therapy (IBT) • Cardiovascular disease screenings • Cervical and vaginal cancer screening • Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy) • Depression screening • Diabetes screenings • Diabetes self-management training (DSMT) • Glaucoma screening • Hepatitis B and Hepatitis C virus screening • HIV screening • Lung cancer screening • Medicare Diabetes Prevention Program (MDPP) • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling • Smoking and Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Vaccines, including Pneumonia, Flu shots, Hepatitis B, COVID-19 and other vaccines • “Welcome to Medicare” preventive visit (one-time) Any additional preventive services approved by Medicare during the contract year will be covered. Flu shot, Hepatitis B, Pneumonia, and COVID-19 vaccines are $0 copayment in-and out-of-network. **Important Message About What You Pay for Vaccines** – Our plan covers most Part D vaccines at no cost to you even if you haven’t paid your deductible. Call Member Services for more information.

Covered Benefits	Braven Medicare Choice (PPO)
NOTE: Services with a [1] may require prior authorization.	
Emergency Care	$95 copayment (worldwide) Copayment waived if admitted to a hospital within 24 hours for the same condition. See the "Inpatient Hospital Coverage" section of this booklet for other costs.
Urgently Needed Services	• $40 copayment • $95 copayment for worldwide coverage Copayment waived if admitted to a hospital within 24 hours for the same condition. See the "Inpatient Hospital Coverage" section of this booklet for other costs.

Diagnostic Services/ Labs/ Imaging[1]	Diagnostic Colonoscopy:
	• In-network: $0 copayment
	• Out-of-network
	  ○ $50 copayment in an office or freestanding facility
	  ○ $110 copayment in an outpatient hospital
	Diagnostic Mammogram:
	• In-network: $0 copayment
	• Out-of-network:
	  ○ $60 copayment in an office or freestanding facility
	  ○ $175 copayment in an outpatient hospital
	Diagnostic radiology services (such as MRIs, CT scans):
	• In-network:
	  ○ $40 copayment in an office or freestanding facility
	  ○ $150 copayment in an outpatient hospital
	• Out-of-network:
	  ○ $60 copayment in an office or freestanding facility
	  ○ $175 copayment in an outpatient hospital
	Lab Services:
	• In-network:
	  ○ $0 copayment
	• Out-of-network:
	  ○ $20 copayment at an office
	  ○ $50 copayment at an outpatient hospital

Covered Benefits	Braven Medicare Choice (PPO)
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Diagnostic Services/ Labs/ Imaging[1]	Diagnostic tests and procedures:
	• In-network:
	  ○ $0 copayment at an office
	  ○ $30 copayment at a freestanding facility
	  ○ $50 copayment at an outpatient hospital
	• Out-of-network:
	  ○ $50 copayment at an office
	  ○ $110 copayment at an outpatient hospital
	Therapeutic Radiology:
	• In- and out-of-network: 20% of the cost
	X-Rays:
	• In-network:
	  ○ $0 copayment at an office
	  ○ $25 copayment at all other places of service
	• Out-of-network: $40 copayment

Hearing Services (continued on next page)	Exam to diagnose and treat hearing and balance issues: • In-network: $20 copayment • Out-of-network: $30 copayment Routine hearing exam (1 per year): • In-network: $0 copayment • Out-of-network: $30 copayment • Call HearUSA to schedule a visit with an in-network provider. Your provider must submit claims to HearUSA for any in-network and out-of-network routine hearing exams. Fitting/Evaluation for hearing aid (1 per year): • In-network: $0 copayment • Out-of-network: $30 copayment • Call HearUSA to schedule a visit with an in-network provider. Your provider must submit claims to HearUSA for any in-network and out-of-network fitting/evaluation for hearing aid. Our plan covers up to $1,250 every year for hearing aids. Plan covers $750 toward the purchase of a hearing aid for one ear and $500 toward the purchase of a hearing aid for the second ear. You are responsible for payment beyond the $1,250 coverage limit. One (1) year supply of batteries are included.

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Hearing Services	You can obtain hearing aids from any HearUSA in-network provider at a discount. If you obtain hearing aids from an out-of-network provider, submit your request to HearUSA for reimbursement up to a $1,250 coverage limit.

Dental Services	Routine dental services (preventive/diagnostic):
	• In- and Out-of-network:
	  ○ $0 copayment for cleaning (up to 3 per year)
	  ○ $0 copayment for fluoride treatment (1 every 6 months)
	  ○ $0 copayment for a full mouth x-ray (1 every 3 years)
	  ○ $0 copayment for bitewing x-ray (1 every 6 months)
	  ○ $0 copayment for oral exam (up to 3 per year)
	Comprehensive dental services (restorative, endodontics, periodontics and simple extractions):
	• In- and Out-of-network:
	  ○ 50% coinsurance
	  ○ $1,000 coverage maximum per year (coverage maximum does not apply to preventive and diagnostic services)
	Medicare-covered dental services:
	• In- and Out-of-network: 20% of the cost

Vision Services	Routine eye exam (1 every year): • In-network: $0 copayment • Out-of-network: $30 copayment Eyeglasses or contact lenses after cataract surgery • In- and Out-of-network: $0 copayment Glaucoma screening: • In-network: $0 copayment • Out-of-network: $10 copayment Exam to diagnose and treat diseases and conditions of the eye: • In-network: $20 copayment • Out-of-network: $30 copayment Diabetic retinal exam: • In-network: $0 copayment • Out-of-network: $30 copayment Our plan covers up to $200 every two years for eyeglasses or contact lenses not associated with cataract surgery. Available in- or out-of-network. Funds will be available on the Braven Health+ Smart Card. Member is responsible for payment beyond $200 coverage limit.

Covered Benefits	Braven Medicare Choice (PPO)
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Mental Health Services[1]	Inpatient:
	• In- and Out-of-network:
	  ○ $374 copayment per day for days 1 through 5
	  ○ $0 copayment for days 6 through 90
	• Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital.
	Outpatient individual or group therapy office visit:
	• In-network: $40 copayment
	• Out-of-network: $50 copayment

Skilled Nursing Facility (SNF)[1]	In-network: • $0 copayment for days 1 through 20 • $196 copayment for days 21 through 100 Out-of-network: • 20% of the cost per stay Our plan covers up to 100 days per benefit period. A new benefit period begins each time you have not been readmitted to a SNF for 60 consecutive days since your last discharge. Each benefit period begins with the Day 1 copayment or coinsurance listed above. There is no annual limit to the number of benefit periods.
Physical Therapy[1]	• In-network: $20 copayment per visit • Out-of-network: $30 copayment per visit
Ambulance[1]	In-network: • Ground ambulance (one way): $250 copayment • Air ambulance (one way): $250 copayment Out-of-network: • Emergency ground ambulance (one way): $250 copayment • Emergency air ambulance (one way): $250 copayment • Non-emergency ground/air ambulance (one way): 20% of the cost
Transportation	Non-Medicare covered transportation benefit offered as part of $275 Flex Benefit Allowance. Must use preferred vendor.
Medicare Part B Drugs[1]	For Part B drugs such as chemotherapy drugs or other drugs administered by a doctor: • In- and Out-of-network: 20% of the cost
Annual Physical Exam	• In-network: $0 copayment • Out-of-network: $10 copayment

Covered Benefits	Braven Medicare Choice (PPO)
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Cardiac Rehab	Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions during a 36-week period): • In-network: $15 copayment • Out-of-network: $25 copayment
Chiropractic Care	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): • In-network: $20 copayment • Out-of-network: $30 copayment
Fitness Benefit	Our plan covers up to $200 yearly towards a gym membership (also includes yoga studio), home fitness (virtual fitness programs) or fitness equipment (hand-held free weights, exercise bands or yoga mat). Funds will be available on the Braven Health+ Smart Card.
Flex Benefit	Our plan covers up to $275 yearly for the following items/services (combined): WW®(Weight Watchers), acupuncture visits, nutritional/dietary classes or counseling, bathroom safety devices, therapeutic massage, an activity tracker, additional hours of in-home support services (provided by Papa) and/or health-related transportation (Uber or Lyft). Funds will be available on the Braven Health+ Smart Card.
Foot Care (podiatry services)	For Medicare-covered foot exams and treatment: • In-network: $20 copayment • Out-of-network: $30 copayment
Home Health Care[1]	• In-network: $0 copayment • Out-of-network: $10 copayment
Hospice	$0 copayment for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care. Hospice is covered by Original Medicare, not our plan. Please contact us for more details.
In-Home Support Services	$0 copayment for in-home support services including, but not limited to: transportation for grocery shopping, medication pick up, and doctor's appointments, technical guidance, reminders, light house help, light exercise and activity. Limited to 36 hours per year. Additional hours can be purchased using the Flex Benefit allowance. Must use our preferred vendor, Papa.
Kidney Education Services	• In-network: $0 copayment • Out-of-network: $10 copayment
Meals – Home Delivered	$0 copayment for meals following any inpatient surgery or discharge from an inpatient hospital stay. Limited to 28 meals per surgery or discharge. Must be coordinated by a Braven Health Care Manager.

Covered Benefits	Braven Medicare Choice (PPO)
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Medical Equipment/ Supplies[1]	Durable Medical Equipment and related medical supplies (wheelchairs, oxygen equipment, etc.): • 20% of the cost Prosthetic devices (braces, artificial limbs, etc.): • 20% of the cost Diabetic supplies and services (test strips are limited to Ascensia and LifeScan products when obtained from the pharmacy): • In-network: $0 copayment • Out-of-network: 20% of the cost Diabetes self-management training: • In-network: $0 copayment • Out-of-network: $10 copayment
Nurse Line	$0 copayment for a 24/7 toll-free Nurse Line, a confidential service that enables the member to speak with a registered nurse to assist with health-related questions and concerns.
Outpatient Rehabilitation[1]	Occupational therapy office visit • In-network: $20 copayment • Out-of-network: $30 copayment Speech and language therapy office visit • In-network: $20 copayment • Out-of-network: $30 copayment
Outpatient Substance Use [1]	• In-network: $40 copayment for individual or group sessions • Out-of-network: $50 copayment for individual or group sessions
Over-the-Counter (OTC) Allowance	Our plan provides a $70 allowance every quarter (up to $280 annually) toward the purchase of personal health items from our participating retailers. The quarterly allowance does not carry over from quarter to quarter. Funds will be available on the Braven Health+ Smart Card.
Partial Hospitalization Services[1]	• In-network: $60 copayment • Out-of-network: $70 copayment
Pulmonary Rehabilitation	• In-network: $20 copayment • Out-of-network: $30 copayment
Renal Dialysis	• In-network: 20% of the cost • Out-of-network: 20% of the cost Cost sharing on laboratory services associated with dialysis in an outpatient hospital setting is waived.
Special Supplemental Benefit for Chronically lll (SSBCI)	For members with certain chronic conditions who are enrolled in a Braven Health Case Management program, our plan provides $75 per quarter to purchase groceries (food and produce) at participating retailers. Unused dollars do not carry over from quarter to quarter. Funds will be available on the Braven Health+ Smart Card. The benefits mentioned are a part of special supplemental program for the chronically ill. Not all members qualify.

Covered Benefits	Braven Medicare Choice (PPO)
NOTE: Services with a [1] may require prior authorization.	
Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD)	• In-network: $20 copayment • Out-of-network: $30 copayment
Telehealth	$0 copayment for urgently needed services and behavioral health. Must use our preferred vendor.

Prescription Drugs	Braven Medicare Choice (PPO)		
Deductible Phase	$0 per year for Tiers 1, 2 and 6. $150 per year for Tiers 3, 4 and 5 only.		
Initial Coverage Phase	Standard Pharmacy One-month supply	Preferred Mail Order Three-month supply	Standard Mail Order Three-month supply
Tier 1: Preferred Generic	$0 copayment	$0 copayment	$0 copayment
Tier 2: Generic	$8 copayment	$12 copayment	$24 copayment
Tier 3: Preferred Brand	$47 copayment	$141 copayment	$141 copayment
Tier 4: Non-Preferred Drug	$100 copayment	$300 copayment	$300 copayment
Tier 5: Specialty Tier	30% of the cost	Not offered	Not offered
Tier 6: Select Care Drugs	$0 copayment	$0 copayment	$0 copayment
If you reside in a long-term care facility, you will pay the same copayment as you would at a retail pharmacy for up to a one-month supply. You may get drugs from an out-of-network pharmacy. You will pay the same copayment as you would at a retail pharmacy for up to a one-month supply. Some of our network mail order pharmacies have preferred cost-sharing. Costs may differ based on mail order pharmacy type.			
Coverage Gap Phase	The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $4,660. After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and 25% of the plan's cost for covered generic drugs until your costs total $7,400.		
Catastrophic Coverage Phase	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reaches $7,400, you pay the greater of: • 5% of the cost, or • $4.15 copayment for generic (including brand drugs treated as generic) and a $10.35 copayment for all other drugs.		
Important Message About What You Pay for Insulin	You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on, even if you haven't paid your deductible.		
Part D Senior Savings Program	Our plan participates in the Part D Senior Savings Program. This means that, for insulins covered on Tier 3 or Tier 5 of our plan formulary, you pay no more than a $35 copayment for a one-month supply during the deductible, initial coverage, and coverage gap phases. Catastrophic coverage phase cost shares still apply.		

Out-of-network/non-contracted providers are under no obligation to treat plan members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

Braven Health has a Medicare contract to offer HMO and PPO Medicare Advantage and Medicare Advantage with Prescription Drug plans, including group Medicare Advantage and group Medicare Advantage with Prescription Drug plans. Enrollment in Braven Health's products depends on contract renewal. Products are provided by Braven Health, an independent licensee of the Blue Cross Blue Shield Association. The Blue Cross® and Blue Shield® names and symbols are registered marks of the Blue Cross Blue Shield Association. The Braven Health℠ name and symbols are service marks of Braven Health.
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