Summary of Benefits

Braven Medicare Choice (PPO)

Braven Medicare Freedom (PPO)

January 1, 2024 – December 31, 2024

Service area for these plans includes:

- Braven Medicare Choice (PPO) Region 1 - Bergen, Essex, Hudson, Middlesex, Monmouth, Ocean, Passaic, and Union counties.
- Braven Medicare Choice (PPO) Region 2 - Mercer, Morris, and Somerset counties.
- Braven Medicare Freedom (PPO) - 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/2024EOCChoiceA or BravenHealth.com/2023EOCFreedom. 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 a plan, call toll-free 1-833-272-8360 (TTY **711**).

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

About our plans

Braven Health has a Medicare contract to offer PPO plans. Enrollment in Braven Health depends on contract renewal.

To join a plan, you must be entitled to Medicare Part A, be enrolled in Medicare Part B and live within our service area listed on the cover.

Visit BravenHealth.com for more information.

Network providers and pharmacies

Braven Medicare Choice (PPO) and Braven Medicare Freedom (PPO) have a network of doctors, hospitals, and other providers. If you use the providers in our network, you may pay less for your covered services. You can also use providers that are not in our network, though you may pay more for your covered services. You can search for a network provider online at DoctorFinder.BravenHealth.com.

Braven Medicare Choice (PPO) and Braven Medicare Freedom (PPO) have a network of pharmacies. 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/Rx.

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 2024**" 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) Region 1	**Braven Medicare Choice (PPO) Region 2**	**Braven Medicare Freedom (PPO)**
Service Area		
Bergen, Essex, Hudson, Middlesex, Monmouth, Ocean, Passaic and Union counties.	Mercer, Morris and Somerset counties.	Bergen, Essex, Hudson, Middlesex, Monmouth, Ocean, Passaic and Union counties.
Monthly Plan Premium		
$0 per month You must keep paying your Medicare Part B premium.	$0 per month You must keep paying your Medicare Part B premium.	$35 per month. This amount will be lower if you qualify for Extra Help with your prescription drug costs. In addition, you must keep paying your Medicare Part B premium.
Annual Medical Deductible		
$0 per year	$0 per year	$0 per year
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)		
• $7,050 per year for covered services you receive from in-network providers. • $11,500 per year for covered services you receive from in-network and out-of-network providers combined. Once you reach the limit on out-of-pocket costs, you pay nothing for covered hospital and medical services 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 2024 Evidence of Coverage.	• $7,300 per year for covered services you receive from in-network providers. • $12,000 per year for covered services you receive from in-network and out-of-network providers combined. Once you reach the limit on out-of-pocket costs, you pay nothing for covered hospital and medical services 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 2024 Evidence of Coverage.	• $6,825 per year for services you receive covered from in-network providers. • $9,500 per year for services you receive covered from in-network and out-of-network providers combined. Once you reach the limit on out-of-pocket costs, you pay noting for covered hospital and medical services 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 2024 Evidence of Coverage.

Covered Benefits NOTE: Services with a [1] may require prior authorization.		
Braven Medicare Choice (PPO) Region 1	**Braven Medicare Choice (PPO) Region 2**	**Braven Medicare Freedom (PPO)**
Inpatient Hospital Coverage[1]		

Our plan covers an unlimited number of days for an inpatient hospital stay.
You pay the following amounts both in- and out-of-network:
• $350 copayment each day for days 1 through 5
• $0 copayment each day for days 6 and beyond
	Our plan covers an unlimited number of days for an inpatient hospital stay.
	You pay the following amounts both in- and out-of-network:
	• $345 copayment each day for days 1 through 5
	• $0 copayment each day for days 6 and beyond
		Our plan covers an unlimited number of days for an inpatient hospital stay.
		• In-network:
		  ○ $325 copayment each day for days 1 through 5
		  ○ $0 copayment each day for days 6 and beyond
		• Out-of-network: 30% of the cost per stay

Outpatient Hospital and Observation Services Coverage[1]		
• In-network: $345 copayment • Out-of-network: $445 copayment	• In-network: $345 copayment • Out-of-network: $445 copayment	• In-network: $290 copayment • Out-of-network: 30% of the cost
Ambulatory Surgical Center[1]		
• In-network: $275 copayment • Out-of-network: $375 copayment	• In-network: $275 copayment • Out-of-network: $375 copayment	• In-network: $220 copayment • Out-of-network: 30% of the cost
Doctor Visits[1]		
Primary care doctor office visit: • In-network: $0 copayment • Out-of-network: $10 copayment Specialist office visit: • In-network: $30 copayment • Out-of-network: $40 copayment	Primary care doctor office visit: • In-network: $0 copayment • Out-of-network: $10 copayment Specialist office visit: • In-network: $30 copayment • Out-of-network: $45 copayment	Primary care doctor office visit: • In-network: $0 copayment • Out-of-network: 30% of the cost Specialist office visit: • In-network: $20 copayment • Out-of-network: 30% of the cost

Covered Benefits		
Braven Medicare Choice (PPO) Region 1	**Braven Medicare Choice (PPO) Region 2**	**Braven Medicare Freedom (PPO)**
Preventive Care (continued on next page)		
Our plan covers many preventive services, including those listed in this section. You pay a $0 copayment when you get the services listed below from an in-network provider, and a $10 copayment when you get these services from an out-of-network provider. • Abdominal aortic aneurysm screening • Alcohol misuse screening and counseling • Annual wellness visit • Bone mass measurement • Cardiovascular disease Intensive Behavioral Therapy (IBT) • Cardiovascular disease screenings • 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 • Sexually transmitted infections screening and counseling • Smoking and Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)	Our plan covers many preventive services, including those listed in this section. You pay a $0 copayment when you get the services listed below from an in-network provider, and a $10 copayment when you get these services from an out-of-network provider. • Abdominal aortic aneurysm screening • Alcohol misuse screening and counseling • Annual wellness visit • Bone mass measurement • Cardiovascular disease Intensive Behavioral Therapy (IBT) • Cardiovascular disease screenings • 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 • Sexually transmitted infections screening and counseling • Smoking and Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)	Our plan covers many preventive services, including those listed in this section. You pay a $0 copayment when you get the services listed below from an in-network provider, and 30% of the cost when you get these services from an out-of-network provider. • Abdominal aortic aneurysm screening • Alcohol misuse screening and counseling • Annual wellness visit • Bone mass measurement • Cardiovascular disease Intensive Behavioral Therapy (IBT) • Cardiovascular disease screenings • 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 • Sexually transmitted infections screening and counseling • Smoking and Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)

Preventive Care (continued)		
• Vaccines, including Pneumonia, Flu shots, Hepatitis B, COVID-19 and other vaccines • "Welcome to Medicare" preventive visit (one-time) You pay a $0 copayment when you receive the services listed below from either an in-network or out-of-network provider. • Breast cancer screening (mammogram) • Cervical and vaginal cancer screening (Pap smear, pelvic exam) • Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy) • Prostate cancer screenings (Prostate-Specific Antigen test) Any additional preventive services approved by Medicare during the contract year will be covered. **Important Message About What You Pay for Vaccines** – Our plan covers most Part D vaccines at no cost to you. Call Member Services for more information.	• Vaccines, including Pneumonia, Flu shots, Hepatitis B, COVID-19 and other vaccines • "Welcome to Medicare" preventive visit (one-time) You pay a $0 copayment when you receive the services listed below from either an in-network or out-of-network provider. • Breast cancer screening (mammogram) • Cervical and vaginal cancer screening (Pap smear, pelvic exam) • Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy) • Prostate cancer screenings (Prostate-Specific Antigen test) Any additional preventive services approved by Medicare during the contract year will be covered. **Important Message About What You Pay for Vaccines** – Our plan covers most Part D vaccines at no cost to you. Call Member Services for more information.	• Vaccines, including Pneumonia, Flu shots, Hepatitis B, COVID-19 and other vaccines • "Welcome to Medicare" preventive visit (one-time) You pay a $0 copayment when you receive the services listed below from either an in-network or out-of-network provider. • Breast cancer screening (mammogram) • Cervical and vaginal cancer screening (Pap smear, pelvic exam) • Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy) • Prostate cancer screenings (Prostate-Specific Antigen test) Any additional preventive services approved by Medicare during the contract year will be covered. **Important Message About What You Pay for Vaccines** – Our plan covers most Part D vaccines at no cost to you. Call Member Services for more information.
Emergency Care		
• $100 copayment in the U.S. and worldwide • We cover up to $100,000 of emergency and urgent care visits and emergency transportation (combined) received outside of the U.S. each year. Emergency visit 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.	• $100 copayment in the U.S. and worldwide • We cover up to $100,000 of emergency and urgent care visits and emergency transportation (combined) received outside of the U.S. each year. Emergency visit 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.	• $100 copayment in the U.S. and worldwide • We cover up to $100,000 of emergency and urgent care visits and emergency transportation (combined) received outside of the U.S. each year. Emergency visit 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.

Covered Benefits NOTE: Services with a [1] may require prior authorization.		
Braven Medicare Choice (PPO) Region 1	**Braven Medicare Choice (PPO) Region 2**	**Braven Medicare Freedom (PPO)**
Urgently Needed Services		
• $40 copayment in the U.S. • $100 copayment for urgent care received outside of the U.S. • We cover up to $100,000 of emergency and urgent care visits and emergency transportation (combined) received outside of the U.S. each year. Urgent care visit 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.	• $40 copayment in the U.S. • $100 copayment for urgent care received outside of the U.S. • We cover up to $100,000 of emergency and urgent care visits and emergency transportation (combined) received outside of the U.S. each year. Urgent care visit 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.	• $40 copayment in the U.S. • $100 copayment for urgent care received outside of the U.S. • We cover up to $100,000 of emergency and urgent care visits and emergency transportation (combined) received outside of the U.S. each year. Urgent care visit 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] (continued on next page)		
Diagnostic radiology services (such as MRIs, CT, PET scans): • In-network: ○ $40 copayment in a doctor's office or freestanding facility ○ $175 copayment in an outpatient hospital • Out-of-network: ○ $60 copayment in a doctor's office or freestanding facility ○ $200 copayment in an outpatient hospital Lab Services • In-network: ○ $0 copayment • Out-of-network: ○ $20 copayment in a doctor's office ○ $50 copayment at an outpatient hospital	Diagnostic radiology services (such as MRIs, CT, PET scans): • In-network: ○ $40 copayment in a doctor's office or freestanding facility ○ $200 copayment in an outpatient hospital • Out-of-network: ○ $60 copayment in a doctor's office or freestanding facility ○ $225 copayment in an outpatient hospital Lab Services • In-network: ○ $0 copayment • Out-of-network: ○ $20 copayment in a doctor's office ○ $50 copayment at an outpatient hospital	Diagnostic radiology services (such as MRIs, CT, PET scans): • In-network: ○ $40 copayment in a doctor's office or freestanding facility ○ $150 copayment in an outpatient hospital • Out-of-network: ○ 30% of the cost Lab Services: • In-network: ○ $0 copayment • Out-of-network: ○ 30% of the cost

Covered Benefits NOTE: Services with a [1] may require prior authorization.		
Braven Medicare Choice (PPO) Region 1	**Braven Medicare Choice (PPO) Region 2**	**Braven Medicare Freedom (PPO)**
Diagnostic Services/ Labs/ Imaging[1] (continued)		

Diagnostic tests and procedures
• In-network:
  ○ $0 copayment at a doctor's office
  ○ $30 copayment at a freestanding facility
  ○ $50 copayment at an outpatient hospital
• Out-of-network:
  ○ $50 copayment at a doctor's office or freestanding facility
  ○ $110 copayment at an outpatient hospital
	Diagnostic tests and procedures
	• In-network:
	  ○ $0 copayment at a doctor's office
	  ○ $30 copayment at a freestanding facility
	  ○ $50 copayment at an outpatient hospital
	• Out-of-network:
	  ○ $50 copayment at a doctor's office or freestanding facility
	  ○ $110 copayment at an outpatient hospital
		Diagnostic tests and procedures
		• In-network:
		  ○ $0 copayment at a doctor's office
		  ○ $30 copayment at a freestanding facility
		  ○ $50 copayment at an outpatient hospital
		• Out-of-network:
		  ○ 30% of the cost

Therapeutic radiology • In-and out-of-network: 20% of the cost	Therapeutic radiology • In-and out-of-network: 20% of the cost	Therapeutic radiology • In-network: 20% of the cost • Out-of-network: 30% of the cost

X-rays
• In-network:
  ○ $0 copayment at a doctor's office
  ○ $25 copayment at all other places of service
• Out-of-network: $40 copayment
	X-rays
	• In-network:
	  ○ $0 copayment at a doctor's office
	  ○ $25 copayment at all other places of service
	• Out-of-network: $40 copayment
		X-rays
		• In-network:
		  ○ $0 copayment at a doctor's office
		  ○ $25 copayment at all other places of service
		• Out-of-network: 30% of the cost

Covered Benefits NOTE: Services with a [1] may require prior authorization.		
Braven Medicare Choice (PPO) Region 1	**Braven Medicare Choice (PPO) Region 2**	**Braven Medicare Freedom (PPO)**
Hearing Services (continued on next page)		
Exam to diagnose and treat hearing and balance issues: • In-network: $30 copayment • Out-of-network: $40 copayment	Exam to diagnose and treat hearing and balance issues: • In-network: $30 copayment • Out-of-network: $45 copayment	Exam to diagnose and treat hearing and balance issues: • In-network: $20 copayment • Out-of-network: 30% of the cost
Routine hearing exam (1 per year): • In-network: $0 copayment • Out-of-network: $40 copayment • Call HearUSA to schedule a visit with an in-network provider for your routine hearing exam. Your provider must submit claims to HearUSA for any in-network and out-of-network routine hearing exams.	Routine hearing exam (1 per year): • In-network: $0 copayment • Out-of-network: $45 copayment • Call HearUSA to schedule a visit with an in-network provider for your routine hearing exam. Your provider must submit claims to HearUSA for any in-network and out-of-network routine hearing exams.	Routine hearing exam (1 per year): • In-network: $0 copayment • Out-of-network: 30% of the cost • Call HearUSA to schedule a visit with an in-network provider for your routine hearing exam. 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: $40 copayment • Call HearUSA to schedule a visit with an in-network provider for a fitting/evaluation for a hearing aid. Your provider must submit claims to HearUSA for any in-network and out-of-network fitting/evaluation for hearing aid.	Fitting/evaluation for hearing aid (1 per year): • In-network: $0 copayment • Out-of-network: $45 copayment • Call HearUSA to schedule a visit with an in-network provider for a fitting/evaluation for a hearing aid. Your provider must submit claims to HearUSA for any in-network and out-of-network fitting/evaluation for hearing aid.	Fitting/evaluation for hearing aid (1 per year): • In-network: $0 copayment • Out-of-network: 30% of the cost • Call HearUSA to schedule a visit with an in-network provider for a fitting/evaluation for a hearing aid. Your provider must submit claims to HearUSA for any in-network and out-of-network fitting/evaluation for hearing aid.

Covered Benefits NOTE: Services with a [1] may require prior authorization.		
Braven Medicare Choice (PPO) Region 1	**Braven Medicare Choice (PPO) Region 2**	**Braven Medicare Freedom (PPO)**
Hearing Services (continued)		
Hearing aids (Up to 1 per ear, per year): • In-network: ○ $299 copayment for a level 1 hearing aid ○ $599 copayment for a level 2 hearing aid ○ $1,199 for a level 3 hearing aid You must use a HearUSA network provider to obtain hearing aids.	Hearing aids (Up to 1 per ear, per year): • In-network: ○ $299 copayment for a level 1 hearing aid ○ $599 copayment for a level 2 hearing aid ○ $1,199 for a level 3 hearing aid You must use a HearUSA network provider to obtain hearing aids.	Hearing aids (Up to 1 per ear, per year): • In-network: ○ $299 copayment for a level 1 hearing aid ○ $599 copayment for a level 2 hearing aid ○ $1,199 for a level 3 hearing aid You must use a HearUSA network provider to obtain hearing aids.
Dental Services (continued on next page)		
Routine dental services (preventive/diagnostic): • $0 copayment for cleaning (up to 3 per year) • $0 copayment for oral exam (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) You may pay more if you receive covered dental services from an out-of-network provider.	Routine dental services (preventive/diagnostic): • $0 copayment for cleaning (up to 3 per year) • $0 copayment for oral exam (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) You may pay more if you receive covered dental services from an out-of-network provider.	Routine dental services (preventive/diagnostic): • $0 copayment for cleaning (up to 3 per year) • $0 copayment for oral exam (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) You may pay more if you receive covered dental services from an out-of-network provider.

Covered Benefits NOTE: Services with a [1] may require prior authorization.		
Braven Medicare Choice (PPO) Region 1	**Braven Medicare Choice (PPO) Region 2**	**Braven Medicare Freedom (PPO)**
Dental Services (continued)		
Comprehensive dental services (restorative, endodontics, periodontics* and extractions): • You will pay 50% of the allowed amount and we will pay the other 50% of the allowed amount. • We cover up to $1,000 per year towards covered comprehensive dental services. The coverage maximum does not apply to routine dental services. *Periodontal cleaning is limited to 1 every 6 months. You may pay more if you receive covered dental services from an out-of-network provider. Braven Health does not provide coverage for worldwide dental services. Medicare-covered dental services: • In-network: 20% of the cost • Out-of-network: 20% of the cost	Comprehensive dental services (restorative, endodontics, periodontics* and extractions): • You will pay 50% of the allowed amount and we will pay the other 50% of the allowed amount. • We cover up to $1,000 per year towards covered comprehensive dental services. The coverage maximum does not apply to routine dental services. *Periodontal cleaning is limited to 1 every 6 months. You may pay more if you receive covered dental services from an out-of-network provider. Braven Health does not provide coverage for worldwide dental services. Medicare-covered dental services: • In-network: 20% of the cost • Out-of-network: 20% of the cost	Comprehensive dental services (restorative, endodontics, periodontics* and extractions): • You will pay 50% of the allowed amount and we will pay the other 50% of the allowed amount. • We cover up to $1,000 per year towards covered comprehensive dental services. The coverage maximum does not apply to routine dental services. *Periodontal cleaning is limited to 1 every 6 months. You may pay more if you receive covered dental services from an out-of-network provider. Braven Health does not provide coverage for worldwide dental services. Medicare-covered dental services: • In-network: 20% of the cost • Out-of-network: 30% of the cost

Covered Benefits NOTE: Services with a [1] may require prior authorization.		
Braven Medicare Choice (PPO) Region 1	**Braven Medicare Choice (PPO) Region 2**	**Braven Medicare Freedom (PPO)**
Vision Services		
Routine eye exam (1 every year): • In-network through Davis Vision: $0 copayment • Out-of-network: 50% of the cost Eyeglass lenses (one pair per year) not associated with cataract surgery: • In-network through Davis Vision: $0 copayment • Out-of-network: 50% of the cost Frames or Contact Lenses: you have an allowance of $150 every year for frames or contact lenses not associated with cataract surgery. Available in- or out-of-network. You are responsible for costs beyond the $150 annual coverage limit. In addition, you are covered for the following: Eyeglasses or contact lenses after cataract surgery: • In- and Out-of-network: $0 copayment Exam to diagnose and treat diseases and conditions of the eye: • In-network: $30 copayment • Out-of-network: $40 copayment Diabetic Retinal Exam: • In- and Out-of-network: $0 copayment	Routine eye exam (1 every year): • In-network through Davis Vision: $0 copayment • Out-of-network: 50% of the cost Eyeglass lenses (one pair per year) not associated with cataract surgery: • In-network through Davis Vision: $0 copayment • Out-of-network: 50% of the cost Frames or Contact Lenses: you have an allowance of $150 every year for frames or contact lenses not associated with cataract surgery. Available in- or out-of-network. You are responsible for costs beyond the $150 annual coverage limit. In addition, you are covered for the following: Eyeglasses or contact lenses after cataract surgery: • In- and Out-of-network: $0 copayment Exam to diagnose and treat diseases and conditions of the eye: • In-network: $30 copayment • Out-of-network: $45 copayment Diabetic Retinal Exam: • In- and Out-of-network: $0 copayment	Routine eye exam (1 every year): • In-network through Davis Vision: $0 copayment • Out-of-network: 50% of the cost Eyeglass lenses (one pair per year) not associated with cataract surgery: • In-network through Davis Vision: $0 copayment • Out-of-network: 50% of the cost Frames or Contact Lenses: you have an allowance of $150 every year for frames or contact lenses not associated with cataract surgery. Available in- or out-of-network. You are responsible for costs beyond the $150 annual coverage limit. In addition, you are covered for the following: Eyeglasses or contact lenses after cataract surgery: • In- and Out-of-network: $0 copayment Exam to diagnose and treat diseases and conditions of the eye: • In-network: $20 copayment • Out-of-network: 30% of the cost Diabetic Retinal Exam: • In- and Out-of-network: $0 copayment

Covered Benefits NOTE: Services with a [1] may require prior authorization.		
Braven Medicare Choice (PPO) Region 1	**Braven Medicare Choice (PPO) Region 2**	**Braven Medicare Freedom (PPO)**
Mental Health Services[1]		

Inpatient:
• In- and Out-of-network
  ○ $385 copayment each 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
	Inpatient:
	• In- and Out-of-network
	  ○ $385 copayment each 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
		Inpatient:
		• In-network:
		  ○ $374 copayment each day for days 1 through 5
		  ○ $0 copayment for days 6 through 90
		• Out-of-network: 30% of the cost per stay
		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: 30% of the cost

Skilled Nursing Facility (SNF) [1]		
In-network: • $0 copayment for days 1 through 20 • $203 copayment each day 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.	In-network: • $0 copayment for days 1 through 20 • $203 copayment each day 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.	In-network: • $0 copayment for days 1 through 20 • $203 copayment each day for days 21 through 100 Out-of-network: • 30% 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.

Covered Benefits NOTE: Services with a [1] may require prior authorization.		
Braven Medicare Choice (PPO) Region 1	**Braven Medicare Choice (PPO) Region 2**	**Braven Medicare Freedom (PPO)**
Physical Therapy[1]		
• In-network: $20 copayment per visit • Out-of-network: $30 copayment per visit	• In-network: $20 copayment per visit • Out-of-network: $30 copayment per visit	• In-network: $20 copayment per visit • Out-of-network: 30% of the cost 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) in the U.S. and worldwide: $250 copayment • Emergency air ambulance (one way) in the U.S. and worldwide: $250 copayment • Non-emergency ground/air ambulance (one way) in the U.S.: 20% of the cost We cover up to $100,000 of emergency and urgent care visits and emergency transportation (combined) received outside of the U.S.	In-network: • Ground ambulance (one way): $250 copayment • Air ambulance (one way): $250 copayment Out-of-network: • Emergency ground ambulance (one way) in the U.S. and worldwide: $250 copayment • Emergency air ambulance (one way) in the U.S. and worldwide: $250 copayment • Non-emergency ground/air ambulance (one way): 20% of the cost We cover up to $100,000 of emergency and urgent care visits and emergency transportation (combined) received outside of the U.S.	In-network: • Ground ambulance (one way): $250 copayment • Air ambulance (one way): $250 copayment Out-of-network: • Emergency ground ambulance (one way) in the U.S. and worldwide: $250 copayment • Emergency air ambulance (one way) in the U.S. and worldwide: $250 copayment • Non-emergency ground/air ambulance (one way): 30% of the cost We cover up to $100,000 of emergency and urgent care visits and emergency transportation (combined) received outside of the U.S.
Transportation		
We cover rides to health-related locations as part the $275 Flex Benefit allowance. Must use Uber or Lyft.	We cover rides to health-related locations as part the $275 Flex Benefit allowance. Must use Uber or Lyft.	We cover rides to health-related locations as part the $275 Flex Benefit allowance. Must use Uber or Lyft.
Medicare Part B Drugs[1] (continued on next page)		
For Part B drugs such as chemotherapy drugs or other drugs administered by a doctor: • In-network: Up to 20% of the cost* • Out-of-network: 20% of the cost *You will usually pay 20% of the cost of Medicare Part B drugs in-network. You will pay less than 20% of the cost for certain drugs.	For Part B drugs such as chemotherapy drugs or other drugs administered by a doctor: • In-network: Up to 20% of the cost* • Out-of-network: 20% of the cost *You will usually pay 20% of the cost of Medicare Part B drugs in-network. You will pay less than 20% of the cost for certain drugs.	For Part B drugs such as chemotherapy drugs or other drugs administered by a doctor: • In-network: Up to 20% of the cost* • Out-of-network: 30% of the cost *You will usually pay 20% of the cost of Medicare Part B drugs in-network. You will pay less than 20% of the cost for certain drugs.

Covered Benefits NOTE: Services with a [1] may require prior authorization.		
Braven Medicare Choice (PPO) Region 1	**Braven Medicare Choice (PPO) Region 2**	**Braven Medicare Freedom (PPO)**
Medicare Part B Drugs[1] (continued)		
Call member services for more information about the cost of your Medicare Part B drug(s).	Call member services for more information about the cost of your Medicare Part B drug(s).	Call member services for more information about the cost of your Medicare Part B drug(s).
Annual Physical Exam		
• In-network: $0 copayment • Out-of-network: $10 copayment	• In-network: $0 copayment • Out-of-network: $10 copayment	• In-network: $0 copayment • Out-of-network: 30% of the cost
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	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	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: 30% of the cost
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: $15 copayment • Out-of-network: $30 copayment	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): • In-network: $15 copayment • Out-of-network: $30 copayment	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): • In-network: $15 copayment • Out-of-network: 30% of the cost
Fitness Benefit		
Our plan provides an allowance of $200 each year 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.	Our plan provides an allowance of $200 each year 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.	Our plan provides an allowance of $200 each year 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.

Covered Benefits NOTE: Services with a [1] may require prior authorization.		
Braven Medicare Choice (PPO) Region 1	**Braven Medicare Choice (PPO) Region 2**	**Braven Medicare Freedom (PPO)**
Flex Benefit		
Our plan provides an allowance of $275 each year for the following items/services (combined): WW®(Weight Watchers), acupuncture visits, nutritional/dietary classes or counseling, bathroom safety devices, 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.	Our plan provides an allowance of $275 each year for the following items/services (combined): WW®(Weight Watchers), acupuncture visits, nutritional/dietary classes or counseling, bathroom safety devices, 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.	Our plan provides an allowance of $275 each year for the following items/services (combined): WW®(Weight Watchers), acupuncture visits, nutritional/dietary classes or counseling, bathroom safety devices, 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: $30 copayment • Out-of-network: $40 copayment	For Medicare-covered foot exams and treatment: • In-network: $30 copayment • Out-of-network: $45 copayment	For Medicare-covered foot exams and treatment: • In-network: $20 copayment • Out-of-network: 30% of the cost
Home Health Care[1]		
• In-network: $0 copayment • Out-of-network: $10 copayment	• In-network: $0 copayment • Out-of-network: $10 copayment	• In-network: $0 copayment • Out-of-network: 30% of the cost
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.	$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.	$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 (continued on next page)		
$0 copayment for in-home support services including, but not limited to: transportation for grocery shopping and doctor's appointments, medication pick up, help with computers, light housekeeping, and light exercise and activity. Limited to 36 hours per year. Additional hours can be purchased using the Flex Benefit	$0 copayment for in-home support services including, but not limited to: transportation for grocery shopping and doctor's appointments, medication pick up, help with computers, light housekeeping, light exercise and activity. Limited to 36 hours per year. Additional hours can be purchased using the Flex Benefit	$0 copayment for in-home support services including, but not limited to: transportation for grocery shopping and doctor's appointments, medication pick up, help with computers, light housekeeping, light exercise and activity. Limited to 36 hours per year. Additional hours can be purchased using the Flex Benefit

Covered Benefits NOTE: Services with a [1] may require prior authorization.		
Braven Medicare Choice (PPO) Region 1	**Braven Medicare Choice (PPO) Region 2**	**Braven Medicare Freedom (PPO)**
In-Home Support Services (continued)		
allowance. Must use our preferred vendor, Papa.	allowance. Must use our preferred vendor, Papa.	allowance. Must use our preferred vendor, Papa.
Kidney Education Services		
• In-network: $0 copayment • Out-of-network: $10 copayment	• In-network: $0 copayment • Out-of-network: $10 copayment	• In-network: $0 copayment • Out-of-network: 30% of the cost
Meals – Home Delivered		
$0 copayment for meals following any inpatient surgery or discharge from an inpatient hospital or skilled nursing facility stay. Limited to 28 meals per surgery or discharge. Must be coordinated by a Braven Health Care Manager.	$0 copayment for meals following any inpatient surgery or discharge from an inpatient hospital or skilled nursing facility stay. Limited to 28 meals per surgery or discharge. Must be coordinated by a Braven Health Care Manager.	$0 copayment for meals following any inpatient surgery or discharge from an inpatient hospital or skilled nursing facility stay. Limited to 28 meals per surgery or discharge. Must be coordinated by a Braven Health Care Manager.
Medical Equipment/ Supplies[1]		
Durable Medical Equipment and related medical supplies (wheelchairs, oxygen equipment, etc.): • In-network: 20% of the cost • Out-of-network: 20% of the cost Prosthetic devices (braces, artificial limbs, etc.): • In-network: 20% of the cost • Out-of-network: 20% of the cost Diabetic supplies and services (test strips are limited to Ascensia (Contour) and LifeScan (OneTouch) products when obtained at a 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	Durable Medical Equipment and related medical supplies (wheelchairs, oxygen equipment, etc.): • In-network: 20% of the cost • Out-of-network: 20% of the cost Prosthetic devices (braces, artificial limbs, etc.): • In-network: 20% of the cost • Out-of-network: 20% of the cost Diabetic supplies and services (test strips are limited to Ascensia (Contour) and LifeScan (OneTouch) products when obtained at a 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	Durable Medical Equipment and related medical supplies (wheelchairs, oxygen equipment, etc.): • In-network: 20% of the cost • Out-of-network: 30% of the cost Prosthetic devices (braces, artificial limbs, etc.): • In-network: 20% of the cost • Out-of-network: 30% of the cost Diabetic supplies and services (test strips are limited to Ascensia (Contour) and LifeScan (OneTouch) products when obtained at a pharmacy): • In-network: $0 copayment • Out-of-network: 30% of the cost Diabetes self-management training: • In-network: $0 copayment • Out-of-network: 30% of the cost

Covered Benefits

NOTE: Services with a [1] may require prior authorization.

Braven Medicare Choice (PPO) Region 1	Braven Medicare Choice (PPO) Region 2	Braven Medicare Freedom (PPO)
Nurse Line		
$0 copayment for a 24/7 toll-free Nurse Line, a confidential service that enables you to speak with a registered nurse to assist with health-related questions and concerns.	$0 copayment for a 24/7 toll-free Nurse Line, a confidential service that enables you to speak with a registered nurse to assist with health-related questions and concerns.	$0 copayment for a 24/7 toll-free Nurse Line, a confidential service that enables you 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	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	Occupational therapy office visit: • In-network: $20 copayment • Out-of-network: 30% of the cost Speech and language therapy office visit: • In-network: $20 copayment • Out-of-network: 30% of the cost
Outpatient Substance Use[1]		
• In-network: $40 copayment for individual or group session • Out-of-network: $50 copayment for individual or group session	• In-network: $40 copayment for individual or group session • Out-of-network: $50 copayment for individual or group session	• In-network: $40 copayment for individual or group session • Out-of-network: 30% of the cost for individual or group session
Over-the-Counter (OTC) Allowance		
Our plan provides an allowance of $70 every calendar 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 or from year to year. Funds will be available on the Braven Health Smart Card.	Our plan provides an allowance of $70 every calendar 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 or from year to year. Funds will be available on the Braven Health Smart Card.	Our plan provides an allowance of $85 every calendar quarter (up to $340 annually) toward the purchase of personal health items from our participating retailers. The quarterly allowance does not carry over from quarter to quarter or from year to year. Funds will be available on the Braven Health Smart Card.
Partial Hospitalization Services[1]		
• In-network: $60 copayment • Out-of-network: $70 copayment	• In-network: $60 copayment • Out-of-network: $70 copayment	• In-network: $60 copayment • Out-of-network: 30% of the cost
Pulmonary Rehabilitation		
• In-network: $15 copayment • Out-of-network: $30 copayment	• In-network: $15 copayment • Out-of-network: $30 copayment	• In-network: $15 copayment • Out-of-network: 30% of the cost

Covered Benefits NOTE: Services with a [1] may require prior authorization.		
Braven Medicare Choice (PPO) Region 1	**Braven Medicare Choice (PPO) Region 2**	**Braven Medicare Freedom (PPO)**
Renal Dialysis		
• In-network: 20% of the cost • Out-of-network: 20% of the cost Cost sharing for laboratory services associated with dialysis in an outpatient hospital setting is waived.	• In-network: 20% of the cost • Out-of-network: 20% of the cost Cost sharing for laboratory services associated with dialysis in an outpatient hospital setting is waived.	• In-network: 20% of the cost • Out-of-network: 30% of the cost Cost sharing for laboratory services associatedwith dialysis in an outpatient hospital setting is waived.
Special Supplemental Benefit for Chronically lll (SSBCI)		
For members with diabetes, Congestive Heart Failure (CHF), and/or Chronic Obstructive Pulmonary Disorder (COPD), our plan provides an allowance of $85 every calendar quarter to purchase groceries (food and produce) at participating retailers. Unused dollars do not carry over from quarter to quarter or from year to year. 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.	For members with diabetes, Congestive Heart Failure (CHF), and/or Chronic Obstructive Pulmonary Disorder (COPD), our plan provides an allowance of $85 every calendar quarter to purchase groceries (food and produce) at participating retailers. Unused dollars do not carry over from quarter to quarter or from year to year. 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.	For members with diabetes, Congestive Heart Failure (CHF), and/or Chronic Obstructive Pulmonary Disorder (COPD), our plan provides an allowance of $85 every calendar quarter to purchase groceries (food and produce) at participating retailers. Unused dollars do not carry over from quarter to quarter or from year to year. 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.
Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD)		
• In-network: $20 copayment • Out-of-network: $30 copayment	• In-network: $20 copayment • Out-of-network: $30 copayment	• In-network: $20 copayment • Out-of-network: 30% of the cost
Telehealth		
$0 copayment for urgently needed services and behavioral health visits. Must use our preferred vendor, AmWell.	$0 copayment for urgently needed services and behavioral health visits. Must use our preferred vendor, AmWell.	$0 copayment for urgently needed services and behavioral health visits. Must use our preferred vendor, AmWell.

Prescription Drugs		
Braven Medicare Choice (PPO) Region 1	**Braven Medicare Choice (PPO) Region 2**	**Braven Medicare Freedom (PPO)**
Deductible		
$0 per year for drugs on Tiers 1, 2 and 6. $200 per year for drugs on Tiers 3, 4 and 5 only.	$0 per year for drugs on Tiers 1, 2 and 6. $200 per year for drugs on Tiers 3, 4 and 5 only.	$0 per year for drugs on Tiers 1, 2 and 6. $200 per year for drugs on Tiers 3, 4 and 5 only.
Initial Coverage (continued on next page)		
You will pay the following copayments for a one-month supply of medication when you visit an in-network pharmacy: • Tier 1 (Preferred Generic): $0 copayment • Tier 2 (Generic): $8 copayment • Tier 3 (Preferred Brand): $47 copayment • Tier 4 (Non-Preferred Drug): $100 copayment • Tier 5 (Specialty Tier): 30% of the cost • Tier 6 (Select Care Drugs): $0 copayment	You will pay the following copayments for a one-month supply of medication when you visit an in-network pharmacy: • Tier 1 (Preferred Generic): $0 copayment • Tier 2 (Generic): $8 copayment • Tier 3 (Preferred Brand): $47 copayment • Tier 4 (Non-Preferred Drug): $100 copayment • Tier 5 (Specialty Tier): 30% of the cost • Tier 6 (Select Care Drugs): $0 copayment	You will pay the following copayments for a one-month supply of medication when you visit an in-network pharmacy: • Tier 1 (Preferred Generic): $0 copayment • Tier 2 (Generic): $5 copayment • Tier 3 (Preferred Brand): $47 copayment • Tier 4 (Non-Preferred Drug): $100 copayment • Tier 5 (Specialty Tier): 30% of the cost • Tier 6 (Select Care Drugs): $0 copayment
You will pay the following copayments for a three-month supply of medication when you order from a preferred mail order pharmacy: • Tier 1 (Preferred Generic): $0 copayment • Tier 2 (Generic): $12 copayment • Tier 3 (Preferred Brand): $141 copayment • Tier 4 (Non-Preferred Drug): $300 copayment • Tier 5 (Specialty Tier): Not available by mail order • Tier 6 (Select Care Drugs): $0 copayment	You will pay the following copayments for a three-month supply of medication when you order from a preferred mail order pharmacy: • Tier 1 (Preferred Generic): $0 copayment • Tier 2 (Generic): $12 copayment • Tier 3 (Preferred Brand): $141 copayment • Tier 4 (Non-Preferred Drug): $300 copayment • Tier 5 (Specialty Tier): Not available by mail order • Tier 6 (Select Care Drugs): $0 copayment	You will pay the following copayments for a three-month supply of medication when you order from a preferred mail order pharmacy: • Tier 1 (Preferred Generic): $0 copayment • Tier 2 (Generic): $7.50 copayment • Tier 3 (Preferred Brand): $141 copayment • Tier 4 (Non-Preferred Drug): $300 copayment • Tier 5 (Specialty Tier): Not available by mail order • Tier 6 (Select Care Drugs): $0 copayment
You will pay the following copayments for a three-month supply of medication when you order from a non-preferred mail order pharmacy:	You will pay the following copayments for a three-month supply of medication when you order from a non-preferred mail order pharmacy:	You will pay the following copayments for a three-month supply of medication when you order from a non-preferred mail order pharmacy:

Prescription Drugs		
Braven Medicare Choice (PPO) Region 1	**Braven Medicare Choice (PPO) Region 2**	**Braven Medicare Freedom (PPO)**
Initial Coverage (continued)		
• Tier 1 (Preferred Generic): $0 copayment • Tier 2 (Generic): $24 copayment • Tier 3 (Preferred Brand): $141 copayment • Tier 4 (Non-Preferred Drug): $300 copayment • Tier 5 (Specialty Tier): Not available by mail order • Tier 6 (Select Care Drugs): $0 copayment	• Tier 1 (Preferred Generic): $0 copayment • Tier 2 (Generic): $24 copayment • Tier 3 (Preferred Brand): $141 copayment • Tier 4 (Non-Preferred Drug): $300 copayment • Tier 5 (Specialty Tier): Not available by mail order • Tier 6 (Select Care Drugs): $0 copayment	• Tier 1 (Preferred Generic): $0 copayment • Tier 2 (Generic): $15 copayment • Tier 3 (Preferred Brand): $141 copayment • Tier 4 (Non-Preferred Drug): $300 copayment • Tier 5 (Specialty Tier): Not available by mail order • Tier 6 (Select Care Drugs): $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.	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.	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 $5,030. 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 $8,000.	The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $5,030. 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 $8,000.	The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $5,030. 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 $8,000.

Prescription Drugs		
Braven Medicare Choice (PPO) Region 1	**Braven Medicare Choice (PPO) Region 2**	**Braven Medicare Freedom (PPO)**
Catastrophic Coverage Phase		
After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reaches $8,000, you pay $0 for covered prescription drugs.	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reaches $8,000, you pay $0 for covered prescription drugs.	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reaches $8,000, you pay $0 for covered prescription 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, during the deductible, initial coverage, and coverage gap phases.	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, during the deductible, initial coverage, and coverage gap phases.	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, during the deductible, initial coverage, and coverage gap phases.
Enhanced Prescription Drug Coverage		
We cover certain prescription drugs that are not usually covered under the Medicare Part D program, including prescription cough medicine and drugs to treat erectile dysfunction. You will pay the Tier 2 copayment for these drugs. Your 2024 list of covered drugs (formulary) includes information about coverage of these drugs.	We cover certain prescription drugs that are not usually covered under the Medicare Part D program, including prescription cough medicine and drugs to treat erectile dysfunction. You will pay the Tier 2 copayment for these drugs. Your 2024 list of covered drugs (formulary) includes information about coverage of these drugs.	We cover certain prescription drugs that are not usually covered under the Medicare Part D program, including prescription cough medicine and drugs to treat erectile dysfunction. You will pay the Tier 2 copayment for these drugs. Your 2024 list of covered drugs (formulary) includes information about coverage of these drugs.

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.

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