



## 2023 Summary of Benefits

### Blue Medicare Freedom+<sup>SM</sup> (PPO)

This is a summary of health services that are covered under Blue Medicare Freedom+ (PPO) for **January 1, 2023 – December 31, 2023**.

#### Plan: Blue Medicare Freedom+ (PPO) H3404-004

##### Notes:

- The benefits information provided is a summary of what we cover and what you pay. This information is not a complete description of benefits. Visit [Medicare.BlueCrossNC.com/medicare/forms-library](https://www.Medicare.BlueCrossNC.com/medicare/forms-library) and click on the Evidence of Coverage tab.
- To join Blue Medicare Freedom+, you must have both Medicare Part A and Medicare Part B and live in our service area.
- Blue Medicare Freedom+ has a network of doctors, hospitals, pharmacies and other providers. You'll get your health care at lower prices by using in-network providers.
- Out-of-network/non-contracted providers are under no obligation to treat Blue Cross and Blue Shield of North Carolina (Blue Cross NC) 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.
- Plan may offer supplemental benefits in addition to Part C benefits.
- Blue Cross and Blue Shield of North Carolina is a PPO plan with a Medicare contract. Enrollment in Blue Cross and Blue Shield of North Carolina depends on contract renewal.
- For more information about Original Medicare, or to request the *Medicare & You* handbook from Medicare, call 1-800-MEDICARE (1-800-633-4227), TTY: 1-877-486-2048, 7 days a week, 24 hours a day. Or visit [Medicare.gov](https://www.Medicare.gov)
- For more details, call **1-888-790-6412** (TTY: 711), visit [Medicare.BlueCrossNC.com/FreedomPlus](https://www.Medicare.BlueCrossNC.com/FreedomPlus) or contact your Blue Cross NC Authorized Independent Agent.

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# Summary of Benefits

## Plan Offering and Premium

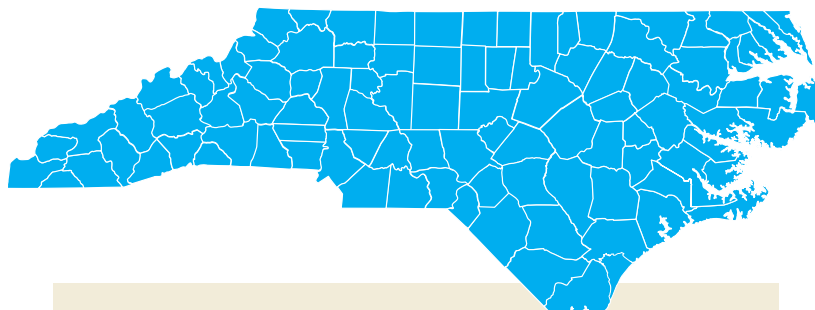
Blue Medicare Freedom+ (PPO) is available in all 100 North Carolina counties.

**Blue Medicare Freedom+**™ (PPO)

H3404-004

**Monthly Premium: \$0**

Alamance	Catawba	Franklin	Jones	Pamlico	Surry
Alexander	Chatham	Gaston	Lee	Pasquotank	Swain
Alleghany	Cherokee	Gates	Lenoir	Pender	Transylvania
Anson	Chowan	Graham	Lincoln	Perquimans	Tyrrell
Ashe	Clay	Granville	Macon	Person	Union
Avery	Cleveland	Greene	Madison	Pitt	Vance
Beaufort	Columbus	Guilford	Martin	Polk	Wake
Bertie	Craven	Halifax	McDowell	Randolph	Warren
Bladen	Cumberland	Harnett	Mecklenburg	Richmond	Washington
Brunswick	Currituck	Haywood	Mitchell	Robeson	Watauga
Buncombe	Dare	Henderson	Montgomery	Rockingham	Wayne
Burke	Davidson	Hertford	Moore	Rowan	Wilkes
Cabarrus	Davie	Hoke	Nash	Rutherford	Wilson
Caldwell	Duplin	Hyde	New Hanover	Sampson	Yadkin
Camden	Durham	Iredell	Northampton	Scotland	Yancey
Carteret	Edgecombe	Jackson	Onslow	Stanly	
Caswell	Forsyth	Johnston	Orange	Stokes	



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**Please note:** To join Blue Medicare Freedom+ , you must have both Medicare Part A and Medicare Part B and live in our service area.

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<b>Blue Medicare Freedom+™ (PPO)</b>		H3404-004
<b>Monthly Premium:</b>	You must also continue to pay your Medicare Part B premium.	\$0
<b>Part B Premium Reduction:</b>	Paid monthly.	\$100
<b>Deductible:</b>	This plan has no medical deductible.	\$0

Benefit	What You Should Know	In-Network	Out-of-Network
<b>Annual Maximum Out-of-Pocket Amount:</b>	Does not include prescription drugs.	\$8,300	\$12,450
<b>Inpatient Hospital Care:*</b> (Benefit period applied per admission.)	<b>Days 1–90:</b>	\$2,050 per stay	40% of cost
	<b>Days 91–150:</b>	\$778 per day	40% of cost
<b>Outpatient Services:*</b>	<b>Outpatient Hospital:</b> Per stay.	20% of cost	40% of cost
	<b>Ambulatory Surgical Center:</b>	20% of cost	40% of cost
<b>Doctor Visit:</b>	<b>Primary:</b>	20% of cost	40% of cost
	<b>Specialist:</b>	20% of cost	40% of cost
<b>Preventive Care:</b>	Any additional preventive services approved by Medicare during the contract year will be covered.	\$0 copay	\$0 copay
<b>Emergency Care:</b>		\$95 copay	\$95 copay
<b>Urgently Needed Services:</b>		\$60 copay	\$60 copay
<b>Diagnostic Services/ Labs/Imaging:</b>	Diagnostic tests, labs, radiology services* and X-rays.	20% of cost	40% of cost

\*May require prior authorization.

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**Blue** Medicare Freedom+™ (PPO)

H3404-004

Benefit		What You Should Know	In-Network	Out-of-Network
<b>Hearing Services:</b>	<b>Medicare-Covered Hearing Exam:</b>	Exam to diagnose and treat hearing and balance issues.	20% of cost	40% of cost
<b>Dental Services:</b>	<b>Medicare-Covered Dental Services:</b>	Medicare may pay for certain services when you're in a hospital and need emergency or complicated dental procedures.	20% of cost	40% of cost
<b>Vision Services:</b>	<b>Medicare-Covered Eye Exam:</b>	For the diagnosis and treatment of illnesses and injuries of the eye.	20% of cost	40% of cost
	<b>Eyewear After Cataract Surgery:</b>	One pair of eyeglasses or one pair of contact lenses.	20% of cost	40% of cost
<b>Mental Health Services:</b>	<b>Inpatient:*</b> (Benefit period applied per admission.)	<b>Days 1–90:</b>	\$1,871 copay per stay	40% of cost
		<b>Days 91–150:</b>	\$778 copay per day	40% of cost
	<b>Outpatient:</b> (Mental health* and substance use.)	Individual and group sessions.	20% of cost	40% of cost
<b>Skilled Nursing Facility:*</b>	(Cost share applies per day. Benefit period applied per admission.)	<b>Days 1–20:</b>	\$0 copay	40% of cost
		<b>Days 21–60:</b>	\$196 copay	40% of cost
		<b>Days 61–100:</b>	\$0 copay	40% of cost
<b>Outpatient Rehabilitation Services:</b>		<b>Occupational, Physical and Speech Language Therapy:</b>	\$40 copay	40% of cost
		<b>Cardiac Rehab Services:</b>	\$40 copay	40% of cost
		<b>Pulmonary Rehab Services:</b>	\$20 copay	40% of cost
<b>Ambulance Services:*</b>		Covers medically necessary ground and air ambulance services.	20% of cost	40% of cost
<b>Transportation:</b>		24 one-way rides to health-related locations. Must use designated providers.	\$0 copay	Not covered
<b>Medicare Part B Drugs:*</b>		Part D drugs not covered.	20% of cost	40% of cost

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<b>Blue Medicare Freedom+™ (PPO)</b>		H3404-004	
<b>Other Covered Benefits</b>		<b>In-Network</b>	<b>Out-of-Network</b>
<b>Podiatry Services:</b>	Foot care.	20% of cost	40% of cost
<b>Medical Equipment and Supplies:</b>	<b>Durable Medical Equipment and Supplies:*</b>	20% of cost	40% of cost
	<b>Diabetic Shoes or Inserts:</b>	20% of cost	40% of cost
	<b>Diabetes Supplies:*</b>	20% of cost	40% of cost
<b>Healthy Aging and Exercise Program:</b>	Must use participating facilities.	\$0 copay**	Not covered
<b>PPO Travel Program:</b>	Extended network in the U.S.	Included	Not covered
<b>Meals Benefit:</b>	Two meals per day for 14 days post-discharge.	\$0 copay	Not covered
<b>Support for Caregivers:</b>	Support and resources for non-professional caregivers.	\$0 copay	Not covered
<b>In-Home Assistance:</b>	60 hours per year.	\$0 copay	Not covered
<b>Personal Emergency Response System:</b>	Wearable device with fast access to emergency services.	\$0 copay	Not covered

\*May require prior authorization.

\*\* This program includes the Standard network. Premium network may have monthly costs.