FirstMedicare Direct

FIRSTCAROLINACARE INSURANCE COMPANY

# FirstMedicare Direct POS Plus (HMO-POS) / FirstMedicare Direct POS Standard (HMO-POS)

## 2024 Summary of Benefits

**January 1, 2024 – December 31, 2024**

**Call toll-free 1-888-382-9781 daily from 8 a.m. to 8 p.m. local time. Voicemail is used on holidays and weekends from April 1 to September 30.**
**TTY 711**
**www.FirstMedicare.com**

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This booklet gives you a summary of what our plans cover and what you pay. It doesn't list every service we cover or every limitation or exclusion. For a complete list of covered services, call us and ask for the Evidence of Coverage.

**Options for Getting Medicare Benefits**

- Original Medicare (fee-for-service), which is run by the federal government
- Medicare Advantage through a private company, like FirstCarolinaCare Insurance Company

**Tips for Comparing Medicare Options**

This booklet allows you to compare costs and benefits for our plans.

- If you want to compare our plans with other Medicare Advantage plans, ask other plans for their Summary of Benefits booklets or use the Medicare Plan Finder at medicare.gov.
- If you want to know more about the coverage and costs of Original Medicare, look in your *Medicare and You* handbook. You can find it at medicare.gov. You can also 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.

**Booklet Sections**

- Things to Know
- Monthly Premium, Deductible and Limits on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits
- Prescription Drug Benefits
- Additional Covered Benefits
- About Us

This document is available in other formats, such as Braille and large print. For more information, call 1-877-210-9167 (TTY 711), daily from 8 a.m. to 8 p.m. local time. Voicemail is used on holidays and weekends from April 1 to September 30.

## THINGS TO KNOW

**Hours of Operation**

Call daily from 8 a.m. to 8 p.m. local time. Voicemail is used on holidays and weekends from April 1 to September 30.

**Contact Info**

- If you’re a current member: 1-877-210-9167 (TTY 711)
- If you’re not yet a member: 1-888-382-9781 (TTY 711)
- www.FirstMedicare.com

**Eligibility**
To join any of our Medicare Advantage plans, you must be entitled to Medicare Part A, enrolled in Medicare Part B and live in our service area.

Our service area includes these counties in North Carolina: Chatham, Cumberland, Harnett, Hoke, Johnston, Lee, Montgomery, Moore, Richmond, Robeson, Scotland and Wake

**Doctors, Hospitals and Pharmacies**
Our plans have a large network of doctors, hospitals, pharmacies, and other providers to choose from.

With our POS plans, we recommend having an in-network primary care provider (PCP) to oversee your care and, if applicable, refer you to specialists, but you also have the flexibility to see out-of-network providers.

You must use network pharmacies to fill your prescriptions in most cases.

You can see our provider directory and pharmacy directory at our website (www.FirstMedicare.com). You can call us, and we will send you a copy.

**What We Cover**
Like all Medicare Advantage plans, we cover everything Original Medicare covers, but we also cover more.

For some benefits, you may pay less in our plan than you would in Original Medicare, and for some, you may pay more. This booklet outlines many of our extra benefits and perks that Original Medicare doesn't cover.

We cover the prescriptions drugs listed in our formulary at www.FirstMedicare.com. You can read it online or call us for a copy.

**Determining Drug Costs**
Each of the drugs we cover is grouped into one of five tiers. The amount you pay depends on the drug's tier and what stage of the benefit you've reached (Initial Coverage, Coverage Gap or Catastrophic Coverage). You can find out what tier your drug is on in our formulary at www.FirstMedicare.com, and we discuss the benefit stages later in this booklet.

# Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at 1-888-382-9781 (TTY 711).

## Understanding the Benefits

- ☐ Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services that you routinely see a doctor. Visit www.FirstMedicare.com or call 1-888-382-9781 to view a copy of the EOC.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ☐ Review the formulary to make sure your drugs are covered.

## Understanding Important Rules

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2025.
- ☐ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situations, non-contracted providers may deny care. In addition, you may pay a higher co-pay for services received by non-contracted providers.
- ☐ Your current health care coverage will end once your new Medicare coverage starts. For example, if you are in Tricare or a Medicare plan, you will no longer receive benefits from that plan once your new coverage starts.

| | FirstMedicare Direct POS Plus (HMO-POS) | FirstMedicare Direct POS Standard (HMO-POS) |
|---|---|---|
| **MONTHLY PREMIUM, DEDUCTIBLE AND LIMITS ON HOW MUCH YOU PAY** | | |
| **Premium Each Month**<br>You must continue to pay your Medicare Part B premium. | **$35** | **$0** |
| *This plan includes prescription drug coverage. For information on non-Rx plans, contact your broker or FirstMedicare Direct.* | | |
| **Medical Deductible** | **$0** | **$0** |
| **Prescription Drugs Deductible** | **$0** | **$150** |
| **Maximum Out-of-Pocket Each Year**<br>The most you pay for copays, coinsurance and other costs for medical services for the year. You still need to pay your monthly premiums. | | |
| In-network providers | **$2,800** | **$3,200** |
| In-network and Out-of-network providers | **$5,450** | **$8,950** |
| **COVERED MEDICAL AND HOSPITAL BENEFITS** | | |
| **Inpatient Hospital Care** (may require prior authorization) | | |
| In-network: | **• $295 copay per day for days 1 through 6**<br>**• $0 copay per day for days 7 and beyond** | **• $325 copay per day for days 1 through 6**<br>**• $0 copay per day for days 7 and beyond** |
| Out-of-network: | **• $500 copay per day for days 1 through 6**<br>**• $0 copay per day for days 7 through 90** | **• $500 copay per day for days 1 through 6**<br>**• $0 copay per day for days 7 through 90** |
| **Outpatient Hospital Care** (may require prior authorization) | | |
| In-network: | **$250 copay** | **$300 copay** |
| Out-of-network: | **$400 copay** | **$450 copay** |
| **Outpatient Surgery at an Ambulatory Surgical Center** (may require prior authorization) | | |

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|---|---|---|
| In-network: | **$250 copay** | **$300 copay** |
| Out-of-network: | **$400 copay** | **$450 copay** |
| **DOCTOR VISITS** | | |
| **Primary Care Physician Office Visits** | | |
| In-network: | **$0 copay** | **$5 copay** |
| Out-of-network: | **$40 copay** | **$40 copay** |
| **Specialist Office Visits** | | |
| In-network: | **$25 copay** | **$30 copay** |
| Out-of-network: | **$65 copay** | **$65 copay** |
| **Virtual Visits for FirstHealth on the Go**<br>Our plan covers visits with a provider by phone or online, 24/7. Connect by phone or secure video through your Hally® account on the MyChart app or hally.com/. | | |
| In-network: | **$0 copay** | **$0 copay** |
| Out-of-network: | **$0 copay** | **$0 copay** |
| **Preventive Care**<br>Our plan covers many preventive services, including but not limited to:<br>• Abdominal aortic aneurysm screening • Annual “Wellness” visit • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease risk reduction visit • Cardiovascular disease testing • Cervical and vaginal cancer screening • Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy) • Depression screening • Diabetes screenings • HIV screening • Immunizations, including Flu shots, Hepatitis B shots, Pneumococcal shots • Obesity screening and therapy • Prostate cancer screenings (PSA) • Screening and counseling to reduce alcohol misuse • Screening for sexually transmitted infections (STIs) and counseling to prevent STIs • Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) • “Welcome to Medicare” preventive visit (one-time) | | |
| In-network: | **$0 copay** | **$0 copay** |

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|---|---|---|
| **EMERGENCY SERVICES** | | |
| **Emergency Care**<br>If you are admitted to the hospital within 48 hours, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs.<br>($10,000 lifetime limit for Worldwide urgent or emergency coverage, including transportation outside of the United States.) | | |
| In-network: | **$135 copay** | **$120 copay** |
| Out-of-network: | **$135 copay** | **$120 copay** |
| **Urgent Care Services** | | |
| In-network: | **$10 copay** | **$20 copay** |
| Out-of-network: | **$10 copay** | **$20 copay** |
| **DIAGNOSTIC SERVICES**<br>Costs for these services may vary based on place of service and may require prior authorization. | | |
| **Diagnostic Tests, Procedures and Lab Services** | | |
| In-network: | **$0 copay** | **$0 copay** |
| Out-of-network: | **$40 copay for A1C lab test, $40 copay for other services** | **$40 copay for A1C lab test, $40 copay for other services** |
| **Diagnostic Radiology** (such as MRIs, CT scans) | | |
| In-network: | **$250 copay** | **$275 copay** |
| Out-of-network: | **30% of the cost** | **30% of the cost** |
| **Outpatient X-rays** (such as x-rays and ultrasounds) | | |
| In-network: | **$0 copay** | **$0 copay** |

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|---|---|---|
| Out-of-network: | **30% of the cost** | **30% of the cost** |
| **HEARING, DENTAL AND VISION** | | |
| **Diagnostic Hearing Exam**<br>(Exam to diagnose and treat hearing and balance issues) | | |
| In-network: | **$35 copay** | **$35 copay** |
| Out-of-network: | **$65 copay** | **$65 copay** |
| **Routine Hearing Exam**<br>(Must be with a TruHearing® provider) (Copayment is not subject to the maximum out-of-pocket) (1 exam per year) | | |
| In-network: | **$0 copay** | **$0 copay** |
| Out-of-network: | **Not Covered** | **Not Covered** |
| **Hearing Aids**<br>Up to two TruHearing-branded® hearing aids every year (one per ear per year). Benefit is limited to the TruHearing-branded® Advanced and Premium hearing aids, which come in various styles and colors. You must see a TruHearing® provider to use this benefit. Premium hearing aids are available in rechargeable style options for an additional $50 per aid.<br>Limitations may apply. Copayment is not subject to the maximum out-of-pocket.<br><br>Hearing aid purchases include:<br>• Provider visits within first year of hearing aid purchase • 60-day trial period • 3-year extended warranty • 80 batteries per aid | | |
| Basic: (In-network) | **$495 copay** | **$495 copay** |
| Standard: (In-network) | **$895 copay** | **$895 copay** |
| Advanced: (In-network) | **$1,295 copay** | **$1,295 copay** |
| Premium: (In-network) | **$1,695 copay** | **$1,695 copay** |
| Out-of-Network | **Not Covered** | **Not Covered** |

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| **Medicare-covered Comprehensive Dental Services**<br>• Extractions of teeth to prepare jaw for radiation treatment of neoplastic disease • Non-covered procedures or services (e.g. tooth removal) if performed by a dentist incident to and as an integral part of an otherwise Medicare-covered procedure • Dental exams prior to kidney transplantation | | |
| In-network: | **$35 copay** | **$35 copay** |
| Out-of-network: | **$65 copay** | **$65 copay** |
| **Non-Medicare-covered Dental Services** (up to $3,000 in-network/$1,500 out-of-network per plan year)<br>These benefit options are included with your plan through FirstMedicare Direct in partnership with Delta Dental of North Carolina. Benefits Include: oral exam, cleaning, and X-rays. You will be responsible for any cost above the dental services maximum benefit limit. You or your dental provider can submit a claim directly to your plan utilizing the instructions on the back of your health plan ID card. For additional help, you can call member services listed on the back of your health plan ID card. | | |
| 2 Oral Exams, 2 Cleanings per Year, 1 set of x-rays per year: | **0% of the cost** | **0% of the cost** |
| **In-network Class 1:**<br>Diagnostic and Preventive Services<br>Emergency Palliative Treatment Radiographs | **0% Coinsurance for class 1 Dental.** | **0% Coinsurance for class 1 Dental.** |
| **Class 2:**<br>Oral Surgery Services<br>Endodontic<br>Periodontics<br>Restorative<br>Non-Routine Services | **0% Coinsurance for class 2 Dental.** | **0% Coinsurance for class 2 Dental.** |
| **Class 3:**<br>Prosthodontic<br>Dentures | **0% Coinsurance for class 3 Dental.** | **0% Coinsurance for class 3 Dental.** |

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|---|---|---|
| **Out-of-network:** | **Deductible: $50 Copay** | **Deductible: $50 Copay** |
| **Class 1:** | **0% Coinsurance for class 1 Dental.** | **0% Coinsurance for class 1 Dental.** |
| Diagnostic and Preventive Services | | |
| Emergency Palliative Treatment Radiographs | | |
| **Class 2:** | **20% Coinsurance for class 2 Dental.** | **20% Coinsurance for class 2 Dental.** |
| Oral Surgery Services | | |
| Endodontic | | |
| Periodontics | | |
| Restorative | | |
| Non-Routine Services | | |
| **Class 3:** | **40% Coinsurance for class 3 Dental.** | **40% Coinsurance for class 3 Dental.** |
| Prosthodontic | | |
| Dentures | | |
| **Medicare-covered Vision Services**<br>Exam to diagnose and treat diseases and conditions of the eye. | | |
| In-network: | **$0 copay** | **$0 copay** |
| Out-of-network: | **$0 copay** | **$0 copay** |
| **Eyewear After Cataract Surgery**<br>One pair of eyeglasses or contact lenses after each cataract surgery. | | |
| In-network: | **20% of the cost** | **20% of the cost** |
| Out-of-network: | **20% of the cost** | **20% of the cost** |
| **Eyewear (non-Medicare covered)** | Get access to vision services beyond what Original Medicare covers, including a routine vision exam with an in-network provider. Plus, use your Benefits Mastercard® Prepaid Card for a $200 | |

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|---|---|---|
| | allowance for eyewear, including contact lenses. Call member services located on the back of your health plan ID card regarding other methods of purchase. | |
| **Glaucoma Screening** | | |
| In-network: | **$0 copay** | **$0 copay** |
| Out-of-network: | **$0 copay** | **$0 copay** |
| **Routine Eye Exam** (1 exam per plan year) | | |
| In-network: | **$0 copay** | **$0 copay** |
| Out-of-network: | **Not Covered** | **Not Covered** |
| **MENTAL HEALTH CARE** | | |
| **Outpatient Individual Mental Health Therapy Visit** | | |
| In-network: | **$35 copay** | **$35 copay** |
| Out-of-network: | **$65 copay** | **$65 copay** |
| **Outpatient Group Mental Health Therapy Visit** | | |
| In-network: | **$35 copay** | **$35 copay** |
| Out-of-network: | **$65 copay** | **$65 copay** |
| **Inpatient Mental Health Visit**<br>Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital. Our plan also covers 60 “lifetime reserve days.” These are “extra” days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days. (may require prior authorization) | | |
| In-network: | • **$160 copay per day for days 1 through 10**<br>• **$0 copay per day for days 11 through 90** | • **$160 copay per day for days 1 through 10**<br>• **$0 copay per day for days 11 through 90** |

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| Out-of-network: | **• $400 copay per day for days 1 through 8<br>• $0 copay per day for days 9 through 60<br>• $150 copay per day for days 61 through 90** | **• $400 copay per day for days 1 through 8<br>• $0 copay per day for days 9 through 60<br>• $150 copay per day for days 61 through 90** |
| **SKILLED NURSING FACILITIES** | | |
| **Skilled Nursing Facility (SNF)**<br>Our plan covers up to 100 days in an SNF. (may require prior authorization and referral) | | |
| In-network: | **• $0 copay per day for days 1 through 20<br>• $203 copay per day for days 21 through 100** | **• $0 copay per day for days 1 through 20<br>• $203 copay per day for days 21 through 100** |
| Out-of-network: | **• $100 copay per day for days 1 through 20<br>• $225 copay per day for days 21 through 100** | **• $100 copay per day for days 1 through 20<br>• $225 copay per day for days 21 through 100** |
| **PHYSICAL THERAPY** | | |
| **Outpatient Physical Therapy**<br>(may require prior authorization) | | |
| In-network: | **$30 copay** | **$30 copay** |
| Out-of-network: | **$65 copay** | **$65 copay** |
| **TRANSPORTATION SERVICES** | | |
| **Ambulance**<br>Authorization for non-emergency transportation by ambulance is required. | | |
| In- and out-of-network emergent: | **$250 copay (Ground ambulance)<br>$400 copay (Air ambulance)** | **$350 copay (Ground ambulance)<br>$450 copay (Air ambulance)** |
| Out-of-network non-emergent: | **$250 copay (Ground ambulance)<br>$400 copay (Air ambulance)** | **$350 copay (Ground ambulance)<br>$450 copay (Air ambulance)** |

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|---|---|---|
| **Transportation** | **Not Covered** | **Not Covered** |
| **Worldwide Emergency Transportation** ($10,000 lifetime limit for worldwide urgent or emergency coverage, including transportation outside of the United States.) | **$250 copay (Ground Ambulance)**<br>**$400 copay (Air Ambulance)** | **$350 copay (Ground Ambulance)**<br>**$450 copay (Air Ambulance)** |
| **MEDICARE PART B DRUGS** | | |
| **Medicare Part B Drugs such as Chemotherapy Drugs** (may require prior authorization) | | |
| In-network: | **20% of the cost** | **20% of the cost** |
| Out-of-network: | **20% of the cost** | **20% of the cost** |
| **Other Medicare Part B Drugs** (may require prior authorization) | | |
| In-network: | **20% of the cost** | **20% of the cost** |
| Out-of-network: | **20% of the cost** | **20% of the cost** |

| | FirstMedicare Direct POS Plus (HMO-POS) | FirstMedicare Direct POS Standard (HMO-POS) |
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## PART D PRESCRIPTION DRUGS

You pay the following until your total yearly drug costs reach $5,030. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. Once you have reached this amount, you will move to the next stage (the Coverage Gap Stage).

Costs may differ based on pharmacy type or status (e.g., mail order, long-term care (LTC) or home infusion, and 30 or 90 day supply. You may get your drugs at network retail pharmacies and mail-order pharmacies. If you reside in a long-term care facility, you pay the same as at a retail pharmacy.

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.

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.

### Initial Coverage for Standard Retail Cost-Sharing

| | | |
|---|---|---|
| Tier 1 - Preferred Generic | | |
| 30-day supply: | **$2 copay** | **$5 copay** |
| 90-day supply: | **$6 copay** | **$15 copay** |
| Tier 2 - Generic | | |
| 30-day supply: | **$15 copay** | **$20 copay** |
| 90-day supply: | **$45 copay** | **$60 copay** |
| Tier 3 - Preferred Brand | | |
| 30-day supply: | **$47 copay** | **$47 copay** |
| 90-day supply: | **$141 copay** | **$141 copay** |
| Tier 4 - Non-Preferred Drug | | |
| 30-day supply: | **50% of the cost** | **$100 copay** |
| 90-day supply: | **50% of the cost** | **$300 copay** |
| Tier 5 - Specialty Tier | | |
| 30-day supply: | **33% of the cost** | **30% of the cost** |

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| 90-day supply: | **Not Covered** | **Not Covered** |

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|---|---|---|
| **Initial Coverage for Standard Mail-Order Cost-Sharing** | | |
| Tier 1 - Preferred Generic | | |
| 30-day supply: | **$2 copay** | **$5 copay** |
| 90-day supply: | **$0 copay** | **$0 copay** |
| Tier 2 - Generic | | |
| 30-day supply: | **$15 copay** | **$20 copay** |
| 90-day supply: | **$37.50 copay** | **$50 copay** |
| Tier 3 - Preferred Brand | | |
| 30-day supply: | **$47 copay** | **$47 copay** |
| 90-day supply: | **$117.50 copay** | **$117.50 copay** |
| Tier 4 - Non-Preferred Drug | | |
| 30-day supply: | **50% of the cost** | **$100 copay** |
| 90-day supply: | **50% of the cost** | **$250 copay** |
| Tier 5 - Specialty Tier | | |
| 30-day supply: | **33% of the cost** | **30% of the cost** |
| 90-day supply: | **Not Covered** | **Not Covered** |

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| **Coverage Gap** | | |
| Most Medicare drug plans have a coverage gap (also called the “donut hole”). This means that there’s a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $5,030.<br>After you enter the coverage gap, for Tier 1, you continue to pay your copay; for Tiers 2-5 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, which is the end of the coverage gap.<br>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.<br>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.<br>Not everyone will enter the coverage gap. | | |
| **Catastrophic Coverage** | | |
| After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $8,000, you enter a catastrophic coverage stage. During this stage, the plan pays full cost of covered Part D drugs. You pay nothing and will remain in this phase until the end of the plan year. | | |
| **ADDITIONAL BENEFITS** | | |
| **Chemotherapy**<br>For Part B chemotherapy drugs. (may require prior authorization) | | |
| In-network: | **20% of the cost** | **20% of the cost** |
| Out-of-network: | **20% of the cost** | **20% of the cost** |
| **Chiropractic Care**<br>Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position). (may require prior authorization) | | |
| In-network: | **$20 copay** | **$20 copay** |
| Out-of-network: | **$65 copay** | **$65 copay** |

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| **Durable Medical Equipment**<br>Wheelchairs, oxygen, etc. (may require prior authorization) | | |
| In-network: | **20% of the cost** | **20% of the cost** |
| Out-of-network: | **20% of the cost** | **20% of the cost** |
| **Diabetes Monitoring Supplies**<br>Manufacturer (Abbott Laboratories) limitations apply only to Blood Glucose Meters and Strips, and these items have a member coinsurance of 0% in-network. (may require prior authorization) | | |
| In-network: | **0%-20% of the cost, depending on the supply** | **0%-20% of the cost, depending on the supply** |
| Out-of-network: | **20% of the cost** | **20% of the cost** |
| **Diabetes Self-Management Training** | | |
| In-network: | **$0 copay** | **$0 copay** |
| Out-of-network: | **$0 copay** | **$0 copay** |
| **Foot Care (Podiatry Services)**<br>Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions. | | |
| In-network: | **$35 copay** | **$35 copay** |
| Out-of-network: | **$65 copay** | **$65 copay** |
| **Home Health Care** | | |
| In-network: | **$0 copay** | **$0 copay** |
| Out-of-network: | **30% of the cost** | **30% of the cost** |
| **Hospice**<br>$0 copay for hospice care from a Medicare-certified hospice. You may have to pay part of the costs for drugs and respite care. Hospice is | | |

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|---|---|---|
| covered by Original Medicare. Please contact us for more details. | | |
| In-network: | **$0 copay** | **$0 copay** |
| **Outpatient Cardiac Rehabilitation Service**<br>For a maximum of two one-hour sessions per day for up to 36 sessions up to 36 weeks. | | |
| In-network: | **$0 copay** | **$0 copay** |
| Out-of-network: | **30% of the cost** | **30% of the cost** |
| **Outpatient Occupational Therapy Visit**<br>(may require prior authorization) | | |
| In-network: | **$40 copay** | **$30 copay** |
| Out-of-network: | **$65 copay** | **$65 copay** |
| **Outpatient Speech and Language Therapy Visit**<br>(may require prior authorization) | | |
| In-network: | **$30 copay** | **$30 copay** |
| Out-of-network: | **$65 copay** | **$65 copay** |
| **Outpatient Substance Abuse Group Therapy Visit** | | |
| In-network: | **$35 copay** | **$35 copay** |
| Out-of-network: | **30% of the cost** | **30% of the cost** |
| **Outpatient Substance Abuse Individual Therapy Visit** | | |
| In-network: | **$35 copay** | **$35 copay** |
| Out-of-network: | **30% of the cost** | **30% of the cost** |
| **Outpatient Surgery at an Outpatient Hospital** | | |

| | FirstMedicare Direct POS Plus (HMO-POS) | FirstMedicare Direct POS Standard (HMO-POS) |
|---|---|---|
| (may require prior authorization) | | |
| In-network: | **$250 copay** | **$300 copay** |
| Out-of-network: | **$400 copay** | **$450 copay** |
| **Over-the-Counter Items**<br>Our plan covers up to $140 a year, $35 every three months, with no rollover allowance, while using your Benefits Mastercard® Prepaid Card for commonly used OTC products. You can use your card allowance to purchase products online and at participating retailers from many categories including but not limited to:<br>• Cold, flu and allergy.<br>• Dental and denture care.<br>• Diabetes care.<br>• Eye and ear care.<br>• First aid and medical supplies.<br>• Personal care.<br>• Sleep aids.<br>Visit FirstMedicareDirect.NationsBenefits.com to see a complete list of eligible OTC products available to order online. | | |
| **Prosthetic Devices and Related Medical Supplies**<br>Braces, Artificial Limbs, etc. (may require prior authorization) | | |
| In-network: | **20% of the cost** | **20% of the cost** |
| Out-of-network: | **20% of the cost** | **20% of the cost** |
| **Renal Dialysis** | | |
| In-network: | **20% of the cost** | **20% of the cost** |
| Out-of-network: | **20% of the cost** | **20% of the cost** |
| **Therapeutic Shoes or Inserts for Diabetics** | | |
| In-network: | **20% of the cost** | **20% of the cost** |

| | FirstMedicare Direct POS Plus (HMO-POS) | FirstMedicare Direct POS Standard (HMO-POS) |
|---|---|---|
| Out-of-network: | **20% of the cost** | **20% of the cost** |

## WELLNESS PROGRAMS

Members may use any FirstHealth Center for Health and Fitness, with no benefit limit.

***Be Fit* Fitness Benefit**
Get the most out of your fitness activities with Be Fit. You get to choose how you want to work out, and your $360-per-year Benefits Mastercard® Prepaid Card benefit will take care of the payment.

- Fitness class fees.
- Gym memberships.
- Online fitness subscriptions.
- Weight loss subscriptions.
- Ski memberships.
- Rowing.
- Golf.
- Bowling.
- Tennis.
- Pickleball.
- Recreational league fees.
- Pool exercise classes.
- 5k/10k race fees.

If your fees are more than $360 a year, you pay the difference. Be Fit doesn't cover fitness trackers or personal equipment.

FirstCarolinaCare Insurance Company's plans are HMO and PPO plans with a Medicare contract. Enrollment in FirstCarolinaCare Insurance Company depends on contract renewal.

Out-of-network/non-contracted providers are under no obligation to treat FirstMedicare Direct 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.

Other Pharmacies/Physicians/Providers are available in our network.

| | FirstMedicare Direct POS Plus (HMO-POS) | FirstMedicare Direct POS Standard (HMO-POS) |
|---|---|---|
| Plans may offer supplemental benefits in addition to Part C benefits and Part D benefits.<br><br>The Benefits Mastercard® Prepaid Card, is issued by The Bancorp Bank, N.A., Member FDIC, pursuant to license by Mastercard International Incorporated. Mastercard and the circles design are registered trademarks of Mastercard International Incorporated. Card can be used for eligible expenses wherever Mastercard is accepted. Valid only in the U.S. No cash access. | | |

## ABOUT US

FirstCarolinaCare Insurance Company has served North Carolina for over 20 years. We delight in working for our more than 21,000 members, serving Commercial and Medicare Advantage member needs.

**True Service with a Local Touch**

When you call, you speak with one of our helpful representatives who know our plans inside and out and can help you with the following:

- Answering questions
- Lead you to information available online at ***www.FirstMedicare.com***
- Arranging for someone to meet with you
- Guide you through the enrollment process and options

Our representatives are available weekdays from 8:30 a.m. to 5:00 p.m.

**Some of Our Many Extra Perks and Programs**

- Assist America global emergency services to help connect you to medical services while traveling, like helping replace lost prescriptions and getting you back home if you're sick. Keep these important numbers with you while traveling: Reference #: 01-AA-HAM-031003, U.S. Phone Number (800) 872-1414, Outside of U.S. Phone Number (609) 986-1234.
- Health coaching to help you set and reach your health goals. Contact by phone located on the back of your health plan ID card.
- 24-hour Nurse Advice Line to answer your health-related questions, day or night. Contact information 877-388-6501.
- Be Fit fitness benefit to pay you back up to $360 per year for fitness activities
- Care coordination to help you deal with chronic conditions. Contact by phone located on the back of your health plan ID card.
- Get a 10% discount code for a wide variety of competitively priced over-the-counter (OTC) products with OTC4Me. You can order online or by phone, and all orders are shipped directly to you. Shipping is free on orders over $25.
- Get up to 30 hours of in-home support yearly through Papa. Services include Companionship, transportation, technical support, light help around the house, light exercise and grocery shopping. You can receive in-home support services if you meet certain clinical criteria. An in-network doctor or licensed plan provider must request these services. Services are provided in two-hour increments.

Call 1-888-382-9781 (TTY 711), daily from 8 a.m. to 8 p.m. local time. Voicemail is used on holidays and weekends from April 1 to September 30.

FirstCarolinaCare
INSURANCE COMPANY

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OMB #0938-1421

## Multi-Language Insert

## Multi-Language Interpreter Services

**English:** We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at (877) 210-9167 (TTY: 711). Someone who speaks English/Language can help you. This is a free service.

**Spanish:** Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al (877) 210-9167 (TTY: 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

**Chinese Mandarin:** 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 (877) 210-9167 (TTY: 711)。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

**Chinese Cantonese:** 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 (877) 210-9167 (TTY: 711)。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

**Tagalog:** Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa (877) 210-9167 (TTY: 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

**French:** Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au (877) 210-9167 (TTY: 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

**Vietnamese:** Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi (877) 210-9167 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

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**German:** Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter (877) 210-9167 (TTY: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

**Korean:** 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 (877) 210-9167 (TTY: 711)번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

**Russian:** Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону (877) 210-9167 (TTY: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

**Arabic:** إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على (877-210-9167)TTY:711) . هذه خدمة مجانية. سيقوم شخص ما يتحدث العربية بمساعدتك.

**Hindi:** हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें (877) 210-9167 (TTY: 711) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

**Italian:** È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero (877) 210-9167 (TTY: 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

**Portugués:** Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número (877) 210-9167 (TTY: 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

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**French Creole:** Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan (877) 210-9167 (TTY: 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

**Polish:** Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer (877) 210-9167 (TTY: 711). Ta usługa jest bezpłatna.

**Japanese:** 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、(877) 210-9167 (TTY: 711)にお電話ください。日本語を話す人者 が支援いたします。これは無料のサー ビスです。

Form CMS-10802
(Expires 12/31/25)

FirstCarolinaCare
INSURANCE COMPANY

## Discrimination is Against the Law

FirstCarolinaCare Insurance Company complies with applicable Federal Civil Rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex (including pregnancy, sexual orientation and gender identity).
FirstCarolinaCare Insurance Company does not exclude people or treat them differently because of race, color, national origin, age, disability or sex (including pregnancy, sexual orientation and gender identity).

FirstCarolinaCare Insurance Company provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters.
- Written information in other formats (large print, audio, accessible electronic formats, other formats).

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters.
- Information written in other languages.

If you need these services, contact Customer Service. If you believe that FirstCarolinaCare Insurance Company has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex (including pregnancy, sexual orientation and gender identity), you can file a grievance with: FirstCarolinaCare Insurance Company, Customer Service, 3310 Fields South Drive, Champaign, Illinois 61822, telephone: (800) 481-1092, fax: (217) 902-9705, CustomerService@FirstCarolinaCare.com.

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, Customer Service is available to help you.

You can also file a Civil Rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at:
U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHS Building, Washington, DC 20201, (800) 368-1019, (800) 537-7697 (TDD). Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html.*

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