

***First*** Medicare Direct

FIRSTCAROLINACARE INSURANCE COMPANY

**FirstMedicare Direct SmartHMO (HMO)**

**2024 Summary of Benefits**

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

**Call toll-free 1-877-749-3356 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](http://www.FirstMedicare.com)**

H6306\_24\_113185\_M

This booklet gives you a summary of what our plan covers 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 plan

- If you want to compare our plan with other Medicare Advantage plans, ask other plans for their Summary of Benefits booklets or use the Medicare Plan Finder at [medicare.gov](http://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](http://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 1-844-499-5630 (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: 1-844-499-5630 (TTY 711)
- If you're not yet a member: 1-877-749-3356 (TTY 711)
- [www.FirstMedicare.com](http://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 this county in North Carolina: Wake

**Doctors, Hospitals and Pharmacies**

Our plan has a large network of doctors, hospitals, pharmacies, and other providers to choose from.

With our HMO plans, you must use in-network providers, unless it's for emergency or urgent care. But with such a broad network, chances are, you can keep seeing the doctors you already know and trust. You also must have a primary care provider (PCP) to oversee your care and refer you to the specialists.

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](http://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](http://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](http://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 1-877-749-3356.

### **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](http://www.FirstMedicare.com) or call 1-877-749-3356 to view a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ 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.
- ☐ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).
- ☐ 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.

**MONTHLY PREMIUM, DEDUCTIBLE AND LIMITS ON HOW MUCH YOU PAY****Premium Each Month**

You must continue to pay your Medicare Part B premium.

**\$0**

*This plan includes prescription drug coverage. For information on non-Rx plans, contact your broker or FirstMedicare Direct.*

**Medical Deductible****\$0****Prescription Drugs Deductible****\$0****Maximum Out-of-Pocket Each Year**

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

**\$2,400**

In-network and Out-of-network providers

**Not Applicable****COVERED MEDICAL AND HOSPITAL BENEFITS****Inpatient Hospital Care**

Our plan covers an unlimited number of days for an inpatient hospital stay. (may require referral and prior authorization)

In-network:

- **\$150 copay per day for days 1 through 5**
- **\$0 copay per day for days 6 through 90**

**Outpatient Hospital Care** (may require referral and prior authorization)

In-network:

**\$150 copay****Outpatient Surgery at an Ambulatory Surgical Center**

(may require referral and prior authorization)

In-network:

**\$100 copay**

**DOCTOR VISITS****Primary Care Physician Office Visits**In-network: **\$0 copay****Specialist Office Visits (may require referral and prior authorization)**In-network: **\$30 copay****Virtual Visits through FirstHealth on the Go**

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/](https://hally.com/).

In-network: **\$0 copay for Primary Care Physician**  
**\$30 copay for Specialist**  
**\$40 copay for Mental Health provider**

**Preventive Care**

Our plan covers many preventive services, including but not limited to:

- Abdominal aortic aneurysm screening • Annual “Wellness” visit • Barium enemas (may require prior authorization) • 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****EMERGENCY SERVICES****Emergency Care**

If you are admitted within 24 hours to the hospital, 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.

In- and Out-of-network: **\$80 copay**

**Urgent Care Services**

In- and Out-of-network: **\$0 copay**

**DIAGNOSTIC SERVICES**

Costs for these services may vary based on place of service and may require referral and prior authorization.

**Diagnostic Tests, Procedures and Lab Services**

In-network: **\$0 copay**

**Diagnostic Radiology** (such as MRIs, CT scans)

In-network: **\$0 copay**

**Outpatient X-rays** (such as x-rays and ultrasounds)

In-network: **\$0 copay**

**HEARING, DENTAL AND VISION**
**Diagnostic Hearing Exam** (may require referral and prior authorization)  
(Exam to diagnose and treat hearing and balance issues)

In-network: **\$0-\$45 copay**

**Medicare-covered Comprehensive Dental Services**

- 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: **\$0-\$425 copay**

**Non-Medicare-covered Dental Services**

Including, but not limited to: oral exam, cleaning, X-rays, fluoride treatment, fillings, dentures, denture adjustments and repairs, crowns, treatment for gum disease, bridge work, root canals, and extractions. 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.

First Medicare Direct SmartHMO (HMO)	
In-network:	<b>\$0-\$425 copay</b>
<b>Medicare-covered Vision Services</b> (may require prior authorization) Exam to diagnose and treat diseases and conditions of the eye.	
In-network:	<b>\$0 copay</b>
<b>Eyewear After Cataract Surgery</b> One pair of eyeglasses or contact lenses after each cataract surgery.	
In-network:	<b>\$0 copay</b>
<b>Eyewear</b> (non-Medicare covered) (may require prior authorization for non-contracted provider)	Get access to vision services beyond what Original Medicare covers, including a routine vision exam with an in-network provider. Plus, get a \$75 allowance for eyewear every two years.
<b>Glaucoma Screening</b>	
In-network:	<b>\$0 copay</b>
<b>Routine Eye Exam</b> (1 exam per plan year)	
In-network:	<b>\$0-\$45 copay</b>
<b>MENTAL HEALTH CARE</b> (may require referral and prior authorization)	
<b>Outpatient Individual Mental Health Therapy Visit</b>	
In-network:	<b>\$40 copay</b>
<b>Outpatient Group Mental Health Therapy Visit</b>	
In-network:	<b>\$40 copay</b>
<b>Inpatient Mental Health Visit</b> 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	



## FirstMedicare Direct SmartHMO (HMO)

extra 60 days, your inpatient hospital coverage will be limited to 90 days. (may require referral and prior authorization)

- |             |   |
|-------------|---|
| In-network: | <ul style="list-style-type: none"> <li>• <b>\$295 copay per day for days 1 through 5</b></li> <li>• <b>\$0 copay per day for days 6 through 90</b></li> </ul> |
|-------------|---|

### SKILLED NURSING FACILITIES

#### Skilled Nursing Facility (SNF)

Our plan covers up to 100 days in an SNF. (may require referral and prior authorization)

- |             |  |
|-------------|--|
| In-network: | <ul style="list-style-type: none"> <li>• <b>\$0 copay per day for days 1 through 20</b></li> <li>• <b>\$100 copay per day for days 21 through 100</b></li> </ul> |
|-------------|--|

### PHYSICAL THERAPY

#### Outpatient Physical Therapy

(may require referral and prior authorization)

- |             |                   |
|-------------|-------------------|
| In-network: | <b>\$10 copay</b> |
|-------------|-------------------|

### TRANSPORTATION SERVICES

#### Ambulance

(may require referral and prior authorization for non-emergency services)

- |                                  |  |
|----------------------------------|--|
| In- and out-of-network emergent: | <b>\$100 copay for ground transportation, \$400 copay for air transportation</b> |
|----------------------------------|--|

- |                              |  |
|------------------------------|--|
| Out-of-network non-emergent: | <b>\$100 copay for ground transportation, \$400 copay for air transportation</b> |
|------------------------------|--|

#### Transportation

(within the U.S. and its territories)  
(may require referral and prior authorization)

**24 one-way health-related trips with a 20-mile radius from your permanent residence to a plan approved location.**

### MEDICARE PART B DRUGS

#### Medicare Part B Drugs such as Chemotherapy Drugs

(may require prior authorization)

	FirstMedicare Direct SmartHMO (HMO)
In-network:	<b>20% of the cost</b>
<b>Other Medicare Part B Drugs</b> (may require prior authorization)	
In-network:	<b>20% of the cost</b>

## 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 day 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.

### Initial Coverage for Standard Retail Cost-Sharing

Tier 1 - Preferred Generic		
30-day supply:		<b>\$0 copay</b>
90-day supply:		<b>\$0 copay</b>
Tier 2 - Generic		
30-day supply:		<b>\$10 copay</b>
90-day supply:		<b>\$30 copay</b>
Tier 3 - Preferred Brand		
30-day supply:		<b>\$47 copay</b>
90-day supply:		<b>\$141 copay</b>
Tier 4 - Non-Preferred Drug		
30-day supply:		<b>\$100 copay</b>
90-day supply:		<b>\$300 copay</b>
Tier 5 - Specialty Tier		
30-day supply:		<b>33% of the cost</b>
90-day supply:		<b>Not covered</b>

## Initial Coverage for Standard Mail-Order Cost-Sharing

Tier 1 - Preferred Generic	
30-day supply:	<b>\$0 copay</b>
90-day supply:	<b>\$0 copay</b>
Tier 2 - Generic	
30-day supply:	<b>\$10 copay</b>
90-day supply:	<b>\$30 copay</b>
Tier 3 - Preferred Brand	
30-day supply:	<b>\$47 copay</b>
90-day supply:	<b>\$141 copay</b>
Tier 4 - Non-Preferred Drug	
30-day supply:	<b>\$100 copay</b>
90-day supply:	<b>\$300 copay</b>
Tier 5 - Specialty Tier	
30-day supply:	<b>33% of the cost</b>
90-day supply:	<b>Not covered</b>

## 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.

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.

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.

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

For Part B chemotherapy drugs. (may require prior authorization)

In-network:	<b>20% of the cost</b>
-------------	------------------------

### Chiropractic Care

Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position). (may require referral and prior authorization)

In-network:	<b>\$10 copay</b>
-------------	-------------------

### Durable Medical Equipment

Wheelchairs, oxygen, etc. (may require prior authorization)

In-network:	<b>20% of the cost</b>
-------------	------------------------

**Diabetes Monitoring Supplies**

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:	<b>0%-20% of the cost, depending on the supplier</b>
-------------	--

**Diabetes Self-Management Training**

In-network:	<b>\$0 copay</b>
-------------	------------------

**Medicare-Covered Foot Care (Podiatry Services) (may require referral and prior authorization)**

Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions.

In-network:	<b>\$30 copay</b> <b>Routine Foot Care: \$10 copay</b>
-------------	---

**Home Health Care (may require referral and prior authorization)**

In-network:	<b>\$0 copay</b>
-------------	------------------

**Hospice**

\$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 covered by Original Medicare. Please contact us for more details.

In-network:	<b>\$0 copay</b>
-------------	------------------

**Outpatient Cardiac Rehabilitation Service**

For a maximum of two one-hour sessions per day for up to 36 sessions up to 36 weeks.

In-network:	<b>\$10 copay</b>
-------------	-------------------

**Outpatient Occupational Therapy Visit**

(may require referral and prior authorization)

In-network:	<b>\$10 copay</b>
-------------	-------------------

**Outpatient Speech and Language Therapy Visit**

(may require referral and prior authorization)

FirstMedicare Direct SmartHMO (HMO)	
In-network:	<b>\$10 copay</b>
<b>Outpatient Substance Abuse Group Therapy Visit (may require referral and prior authorization)</b>	
In-network:	<b>\$40 copay</b>
<b>Outpatient Substance Abuse Individual Therapy Visit (may require referral and prior authorization)</b>	
In-network:	<b>\$40 copay</b>
<b>Outpatient Surgery at an Outpatient Hospital</b> (may require referral and prior authorization)	
In-network:	<b>\$150 copay</b>
<b>Prosthetic Devices and Related Medical Supplies</b> Braces, Artificial Limbs, etc. (may require prior authorization)	
In-network:	<b>20% of the cost</b>
<b>Renal Dialysis (may require referral and prior authorization)</b>	
In-network:	<b>\$30 copay</b>
<b>Therapeutic Shoes or Inserts for Diabetics</b>	
In-network:	<b>20% of the cost</b>
<b>WELLNESS PROGRAMS</b>	
<b>Fitness Benefit</b> Gym membership is offered with a Plan contracted gym.	
<b>Over-the-Counter Items (ACCESS on Demand)</b> Our plan covers up to \$75 every three months, with no rollover allowance, which allows you to purchase OTC products from a Catalog with hundreds of products to choose from.	
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.	

## FirstMedicare Direct SmartHMO (HMO)

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

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

Plans may offer supplemental benefits in addition to Part C benefits and Part D benefits.

Card can only be used for Qualified Purchases indicated by your plan provider everywhere Visa debit cards are accepted. Card is issued by Sutton Bank, pursuant to a license from Visa U.S.A. Inc. Please contact your Program Sponsor directly for a full list of Qualified Purchases. Visa is a registered trademark of Visa, U.S.A. Inc. All other trademarks and service marks belong to their respective owners. No Cash or ATM Access. Terms and conditions apply, contact your Plan Provider for details.



## 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

### Some of Our Many Extra Perks and Programs

- 24-hour ***Nurse Advice*** Line to answer your health-related questions, day or night. Contact information 844-323-2247
- Fitness benefit with a Plan contracted gym
- Care coordination to help you deal with chronic conditions. Contact by phone located on the back of your health plan ID card.
- Health coaching to help you set and reach your health goals. Contact by phone located on the back of your health plan ID card.

Call 1-877-749-3356 (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.

### 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 quý vị cần thông dịch viên xin gọi (877) 210-9167 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.



**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 대해 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 بمساعدتك. هذه خدمة مجانية على (877-210-9167)TTY:711. سيقوم شخص ما يتحدث العربية

**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.

**Português:** 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.

**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。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)

## 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](mailto: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>.