FirstMedicare Direct
FIRSTCAROLINACARE INSURANCE COMPANY

# 2020
# FirstMedicare Direct
# HMO Plus (HMO)
# H6306-011-003
# Summary of Benefits

**January 1, 2020– December 31, 2020**

**FirstMedicare Direct** HMO Plus is a Medicare Advantage HMO plan with a Medicare contract. Enrollment in the Plan depends on contract renewal.

The benefit information provided does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please request the "Evidence of Coverage."

To join **FirstMedicare Direct** HMO Plus, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. Our service area includes the following counties in North Carolina**: Buncombe, Henderson, Madison, McDowell, Transylvania and Yancey.**

Except in emergency situations, if you use the providers that are not in our network, we may not pay for these services.

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

This document is available in other formats such as Braille or large print.

For more information, please call us at
**1-877-279-1732**
(TTY users should call 711)
or
visit us at
www.FirstMedicare.com.

| FirstMedicare Direct<br>HMO Plus (HMO) | | |
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| **PREMIUM and BENEFITS** | **H6306-011-003** | **WHAT YOU SHOULD KNOW** |
| Monthly Plan Premium | YOU PAY $39 | You must continue to pay your Medicare Part B premium. |
| Part C Deductible | YOU PAY nothing | This plan does not have a medical deductible. |
| Maximum Out of Pocket | $3,400 annually | The most you pay for copayments, coinsurance, and other costs of medical services for the year. |
| ***SERVICES WITH A [1] MAY REQUIRE PRIOR AUTHORIZATION *** | | |
| Inpatient Hospital Care[1] | YOU PAY $275 copayment per day for days 1-6<br><br>YOU PAY $0 copayment per day for days 7-90 | The copayments for hospital and skilled nursing facility (SNF) benefits are based on benefit periods as defined by Medicare. |
| Outpatient Hospital Care<br>●Ambulatory Surgical Center<br>●Outpatient Surgery Hospital<br>●Other Outpatient Services<br>●Observation Services | <br>YOU PAY $200 copayment per visit<br>YOU PAY $250 copayment per visit<br>YOU PAY $0 copayment per visit<br>YOU PAY $0 copayment per visit | <br>One copayment for bilateral cataract surgery if both performed in the same year. |
| Doctor Visits<br>●Primary Care Physician<br>●Specialist | <br>YOU PAY $10 copayment per visit<br>YOU PAY $45 copayment per visit | |
| Preventive Care Services | YOU PAY $0 copayment per service | Includes but not limited to Medicare-covered: glaucoma screening, barium enemas, digital rectal exams, EKG following Welcome Visit. |
| Annual Physical Exam | YOU PAY $0 copayment per one annual visit | |

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| **PREMIUM and BENEFITS** | **H6306-011-003** | **WHAT YOU SHOULD KNOW** |
| Emergency Care | YOU PAY $120 copayment per visit | Copayment waived if admitted within 48 hours with the same condition. |
| Worldwide Emergency Coverage | YOU PAY $120 copayment per visit<br><br>YOU PAY $400 copayment per one way transportation (ground or air). | Co-payment is NOT waived if you are admitted to the hospital.<br><br>$10,000 lifetime limit for worldwide emergency coverage, including transportation outside of the United States. |
| Urgently Needed Services | YOU PAY $30 copayment per visit | Co-payment is NOT waived if you are admitted to the hospital. |
| Diagnostic Tests, Therapeutic Radiological Services and x-Rays[1] | YOU PAY 20% of the total cost | Medicare-covered services |
| Lab Services[1] | YOU PAY $5 copayment per visit | Medicare-covered lab services |
| Diagnostic Radiological Services | YOU PAY $120 copayment per visit | Medicare-care covered CT scans, MRI's, etc. |
| Hearing Services | | |
| ● Medicare Covered Hearing Exam | YOU PAY $45 copayment per visit | Medicare-covered exams to diagnose and treat hearing and balance issues. |
| ● Routine Hearing Exam* | YOU PAY $0 copayment per visit | ***At the beginning of the year, participants must communicate to FirstMedicare Direct their selection of one of two benefits: Hearing or Vision**<br><br>Supplemental hearing benefit limit of $1000. |
| ● Fitting/Evaluation for Hearing Aid* | YOU PAY $0 copayment per visit | |
| ● Hearing Aid* | YOU PAY $0 | |

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| **PREMIUM and BENEFITS** | **H6306-011-003** | **WHAT YOU SHOULD KNOW** |
| Dental Services<br>● Medicare-covered Services | YOU PAY $45 copayment per visit | Medicare-Covered dental services.<br>(this does not include services in connection with care, treatment, filling, removal, or replacement of teeth). |
| ● Preventive Services | YOU PAY $0 copayment per visit | Oral exam, cleaning, x-ray (1 each per year) |
| Vision Services<br>● Medicare-covered Eye Exam | YOU PAY $45 copayment per visit | Medicare-covered exams to diagnose and treat diseases of the eye. |
| ● Diabetic Retinopathy Eye Exam | YOU PAY $10 copayment per visit | |
| ● Medicare-covered Annual Glaucoma Exam | YOU PAY $0 copayment per visit | |
| ● Post Cataract Surgery Eyewear | YOU PAY 20% coinsurance of the total cost | |
| ● Routine Eye Exam and Eyewear* | YOU PAY $0 copayment per visit | ***At the beginning of the year, participants must communicate to FirstMedicare Direct their selection of one of two benefits: Hearing or Vision**<br><br>Supplemental annual vision benefit limit of $1000. |
| Outpatient Mental Health Services | YOU PAY $40 copayment per visit | Group or individual therapy visits. |

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| **PREMIUM and BENEFITS** | **H6306-011-003** | **WHAT YOU SHOULD KNOW** |
| Inpatient Mental Health Care[1] | YOU PAY $275 copayment per day for days 1-6<br><br>YOU PAY $0 copayment per day for days 7-90 | The copayments for hospital benefits are based on benefit periods as defined by Medicare. Covers up to 190 days in a lifetime in a psychiatric hospital. This limit does not apply to inpatient mental services provided in a general hospital. |
| Skilled Nursing Facility (SNF)[1] | YOU PAY $0 copayment per day for days 1-20<br>YOU PAY $150 copayment per day for days 21-100 | |
| Outpatient Rehabilitation Services | YOU PAY $30 copayment per visit | Occupational, physical, speech and language therapies. |
| Ambulance[1] | | Authorization required for non-emergency services. |
| • Ground Transportation Service | YOU PAY $250 copayment per one-way ground transportation | Medicare-covered ground ambulance services. |
| • Air Transportation Service | YOU PAY $400 copayment per one-way air transportation | Medicare-covered air transportation services. |
| Transportation (non-medical) | Not Covered | Non-medical transportation is not a covered service. |
| Medicare Part B Drugs[1] | YOU PAY 20% of the total cost | |
| Foot Care (podiatry services) | YOU PAY $45 copayment per visit | Medicare-covered services. |
| Durable Medical Equipment[1] | YOU PAY 20% of the total cost | Includes wheelchairs, oxygen, etc. |

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| **PREMIUM and BENEFITS** | **H6306-011-003** | **WHAT YOU SHOULD KNOW** |
| Cardiac and Pulmonary Rehabilitation | YOU PAY $0 copayment per visit | Medicare-covered Cardiac Rehabilitation Services; Medicare-covered Intensive Cardiac Rehabilitation Services; Medicare-covered Pulmonary Rehabilitation Services; Medicare-covered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services. |
| Chiropractic Care | YOU PAY $20 copayment per visit | Medicare-covered Chiropractic services. |
| Diabetes Supplies and Services | | |
| • Diabetes testing supplies from Retail Pharmacy | YOU PAY 0% of the total cost | |
| • Diabetes testing supplies from DME supplier | YOU PAY 20% of the total cost | |
| • Diabetes self-management training | YOU PAY 0% of the total cost | |
| • Therapeutic shoes or inserts | YOU PAY 20% of the total cost | Medicare-covered Diabetic Therapeutic Shoes or Inserts |
| Dialysis | YOU PAY 20% coinsurance of the total cost | |
| Home Health Care | YOU PAY 15% coinsurance of the total cost | |
| Prosthetic devices[1] | YOU PAY 20% of the total cost | Medicare-covered devices. |

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| **PREMIUM and BENEFITS** | **H6306-011-003** | **WHAT YOU SHOULD KNOW** |
| Fitness Center Membership | YOU PAY $0 for the membership | Full YMCA of Western NC membership included, $510 annual benefit. |
| Over the Counter (OTC) | YOU PAY $0 | Maximum Reimbursement is limited to $75.00 every three months<br>(not cumulative). |
| **PRESCRIPTION DRUGS** | | |
| **OUTPATIENT PRESCRIPTION DRUGS** | | |
| Part D Deductible | YOU PAY nothing | This plan does not have a Part D deductible. |
| **OUTPATIENT PRESCRIPTION DRUGS** | | |
| **TIERS** | **RETAIL COST** | **MAIL ORDER COST** |
| **One month (30 day) supply dispensed** | | |
| Tier 1<br>(Preferred Generic Drugs) | YOU PAY $6 copayment | YOU PAY $6 copayment |
| Tier 2<br>(Generic Drugs) | YOU PAY $18 copayment | YOU PAY $18 copayment |
| Tier 3<br>(Preferred Brand Drugs) | YOU PAY $45 copayment | YOU PAY $45 copayment |
| Tier 4<br>(Non-Preferred Drugs) | YOU PAY $100 copayment | YOU PAY $100 copayment |
| Tier 5<br>(Specialty Drugs) | YOU PAY 33% of the total cost | YOU PAY 33% of the total cost |
| Tier 6<br>(Select Care Drugs) | YOU PAY $6 copayment | YOU PAY $6 copayment |

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| **Long Term (90 day) supply dispensed** | | |
| Tier 1<br>(Preferred Generic Drugs) | YOU PAY $18 copayment | YOU PAY $0 copayment |
| Tier 2<br>(Generic Drugs) | YOU PAY $54 copayment | YOU PAY $45 copayment |
| Tier 3<br>(Preferred Brand Drugs) | YOU PAY $135 copayment | YOU PAY $112.50 copayment |
| Tier 4<br>(Non-Preferred Drugs) | YOU PAY $300 copayment | YOU PAY $250 copayment |
| Tier 5<br>(Specialty Drugs) | A long term supply is not available in Tier 5. | A long term supply is not available in Tier 5. |
| Tier 6<br>(Select Care Drugs) | YOU PAY $0 copayment | YOU PAY $0 copayment |
| **Long-Term Care Pharmacy** | | |
| **TIERS** | **RETAIL COST** | **MAIL ORDER COST** |
| Tier 1<br>(Preferred Generic Drugs) | YOU PAY $6 copay 31 day supply | |
| Tier 2<br>(Generic Drugs) | YOU PAY $18 copay 31 day supply | |
| Tier 3<br>(Preferred Brand Drugs) | YOU PAY $45 copay 31 day supply | |
| Tier 4<br>(Non-Preferred Drugs) | YOU PAY $100 copay 31 day supply | |
| Tier 5<br>(Specialty Drugs) | YOU PAY 33% coinsurance 31 day supply | |
| Tier 6<br>(Select Care Drugs) | YOU PAY $6 copay 31 day supply | |

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| **TIERS** | **RETAIL COST** | **MAIL ORDER COST** |
| Initial Coverage Limit | $4,020 | |
| Gap Coverage | Coverage through the gap<br>Tier 1: All Drugs<br>Tier 6: All Drugs | |
| Cost-sharing may change depending when you enter another phase of the Part D benefit. For more information on the phases of drug coverage, please call us or access our Evidence of Coverage, Chapter 6, at our website www.FirstMedicare.com. | | |
| **Optional Supplemental Benefits** | | |
| Comprehensive Dental - Premium (Optional Buy-Up Plan) | YOU PAY additional $26.00 per month<br><br>YOU PAY 50% coinsurance of total cost | Non-routine Services; Restorative; Endodontics; Periodontics; Extractions<br>(Maximum Annual Plan Benefit Coverage Amount $1,000) |