FirstMedicare Direct
FIRSTCAROLINACARE INSURANCE COMPANY

2020

FirstMedicare Direct

HMO Prime (HMO)

H6306-010-000

Summary of Benefits

January 1, 2020– December 31, 2020

FirstMedicare Direct HMO Prime 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 Prime, 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.

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FirstMedicare Direct HMO Prime (HMO)		
PREMIUM and BENEFITS	**H6306-010**	**WHAT YOU SHOULD KNOW**
Monthly Plan Premium	YOU PAY $0	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	$6,700 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 $375 copayment per day for days 1-4 YOU PAY $0 copayment per day for days 5-90	The copayments for hospital and skilled nursing facility (SNF) benefits are based on benefit periods as defined by Medicare.
Outpatient Hospital Care ● Ambulatory Surgical Center	YOU PAY $300 copayment per visit	One copayment for bilateral cataract surgery if both performed in the same year.
● Outpatient Surgery Hospital	YOU PAY $350 copayment per visit	
● Other Outpatient Services	YOU PAY $0 copayment per visit	
● Observation Services	YOU PAY $0 copayment per visit	
Doctor Visits ● Primary Care Physician	YOU PAY $10 copayment per visit	
● Specialist	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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Emergency Care	YOU PAY $90 copayment per visit	Copayment waived if admitted within 48 hours with the same condition.
Worldwide Emergency Coverage	YOU PAY $90 copayment per visit YOU PAY $400 copayment per one way transportation (ground or air).	Co-payment is NOT waived if you are admitted to the hospital. $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[1]	YOU PAY $5 copayment per visit	Medicare-covered lab services
Diagnostic Radiological Services	YOU PAY $120 copayment per visit	Medicare-covered CT scans, MRI's, etc.

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PREMIUM and BENEFITS	H6306-010	WHAT YOU SHOULD KNOW
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**
● Fitting/Evaluation for Hearing Aid*	YOU PAY $0 copayment per visit	
● Hearing Aid*	YOU PAY $0	Plan has an annual allowance of $500 towards hearing aids (both ears combined).
Dental Services ● Medicare-covered Services	YOU PAY $45 copayment per visit	Medicare-Covered dental services. (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)

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PREMIUM and BENEFITS	**H6306-010**	**WHAT YOU SHOULD KNOW**
Vision Services ● 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** Supplemental annual vision benefit limit of $500.
Outpatient Mental Health Services	YOU PAY $40 copayment per visit	Group or individual therapy visits.
Inpatient Mental Health Care[1]	YOU PAY $375 copayment per day for days 1-4 YOU PAY $0 copayment per day for days 5-90	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 YOU PAY $160 copayment per day for days 21-100	

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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 $350 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	Only certain medications require authorization.
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.
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.

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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 $0 copayment per visit	
Prosthetic devices[1]	YOU PAY 20% of the total cost	Medicare-covered devices.
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 $50.00 every three months (not cumulative).
OUTPATIENT PRESCRIPTION DRUGS		
Part D Deductible	YOU PAY $200 deductible annually for Tiers 3-5.	Does not apply to Tiers 1, 2 & 6

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TIERS	**RETAIL COST**	**MAIL ORDER COST**
One month (30 day) supply dispensed		
Tier 1 (Preferred Generic Drugs)	YOU PAY $4 copayment	YOU PAY $4 copayment
Tier 2 (Generic Drugs)	YOU PAY $15 copayment	YOU PAY $15 copayment
Tier 3 (Preferred Brand Drugs)	YOU PAY $47 copayment	YOU PAY $47 copayment
Tier 4 (Non-Preferred Drugs)	YOU PAY $100 copayment	YOU PAY $100 copayment
Tier 5 (Specialty Drugs)	YOU PAY 29% of the total cost	YOU PAY 29% of the total cost
Tier 6 (Select Care Drugs)	YOU PAY $4 copayment	YOU PAY $4 copayment
Long Term (90 day) supply dispensed		
Tier 1 (Preferred Generic Drugs)	YOU PAY $12 copayment	YOU PAY $0 copayment
Tier 2 (Generic Drugs)	YOU PAY $45 copayment	YOU PAY $37.50 copayment
Tier 3 (Preferred Brand Drugs)	YOU PAY $141 copayment	YOU PAY $117.50 copayment
Tier 4 (Non-Preferred Drugs)	YOU PAY $300 copayment	YOU PAY $250 copayment
Tier 5 (Specialty Drugs)	A long term supply is not available in Tier 5.	A long term supply is not available in Tier 5.
Tier 6 (Select Care Drugs)	YOU PAY $0 copayment	YOU PAY $0 copayment

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Long-Term Care Pharmacy		
Tier 1 (Preferred Generic Drugs)	YOU PAY $4 copay 31 day supply	
Tier 2 (Generic Drugs)	YOU PAY $15 copay 31 day supply	
Tier 3 (Preferred Brand Drugs)	YOU PAY $47 copay 31 day supply	
Tier 4 (Non-Preferred Drugs)	YOU PAY $100 copay 31 day supply	
Tier 5 (Specialty Drugs)	YOU PAY 29% coinsurance 31 day supply	
Tier 6 (Select Care Drugs)	YOU PAY $4 copay 31 day supply	
Initial Coverage Limit	$4,020	
Gap Coverage	Coverage through the gap Tier 1: All Drugs 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 YOU PAY 50% coinsurance of total cost	Non-routine Services; Restorative; Endodontics; Periodontics; Extractions (Maximum Annual Plan Benefit Coverage Amount $1,000)

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This information is not a complete description of benefits. For more information, if you are a member, please call Member Services toll free at 1-844-201- 4957 (TTY users call 711). If you are not a member call us toll free at 1-877-279-1732. From October 1 to March 31, you can call 7 days a week from 8:00 a.m. to 8:00 p.m. Eastern. From April 1 to September 30, you can call Monday through Friday from 8:00 a.m. to 8:00 p.m. Eastern. Or you can visit us at www.FirstMedicare.com.

You can search our plan's provider and pharmacy directories on our website at www.FirstMedicare.com.

We cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider. You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website at www.FirstMedicare.com.

More information about your options under Medicare is available through the Medicare publication, "**Medicare and You**". You can get it at the Medicare website (https://www.medicare.gov) or 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.

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