FirstMedicare Direct
FIRSTCAROLINACARE INSURANCE COMPANY

2020
FirstMedicare Direct
PPO Plus (PPO)
H8064-002-000
Summary of Benefits

January 1, 2020– December 31, 2020

FirstMedicare Direct PPO Plus is a Medicare Advantage PPO 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** PPO 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**: Chatham, Hoke, Lee, Montgomery, Moore, Richmond, and Scotland**.

FirstMedicare Direct PPO Plus has a network of doctors, hospitals, pharmacies and other providers. If you use the providers that are not in our network, your share of the cost may be higher than if you use network providers.

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 PPO Plus (PPO) H8064-002-000			
PREMIUM and BENEFITS	**IN NETWORK**	**OUT-OF-NETWORK**	**WHAT YOU SHOULD KNOW**
Monthly Plan Premium	YOU PAY $73		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	$5,500 In-Network annually	$10,000 combined In and Out-of-Network 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 $310 copayment per day for days 1-6 YOU PAY $0 copayment per day for days 7-90	YOU PAY 20% of the total cost per stay	The copayments for hospital benefits are based on benefit periods as defined by Medicare.
Outpatient Hospital Care ●Outpatient Surgery and/or Ambulatory Surgery Center Services	YOU PAY $275 copayment per visit	YOU PAY 20% of the total cost	One copayment applies for bilateral cataract surgery if both performed in the same calendar year.
●Other Outpatient Services	YOU PAY $0 copayment per visit	YOU PAY 20% of the total cost	
●Observation Services	YOU PAY $0 copayment per visit	YOU PAY 20% of the total cost	
Doctor Visits ●Primary Care Physician	YOU PAY $10 copayment per visit	YOU PAY 20% of the total cost	
●Specialist	YOU PAY $45 copayment per visit	YOU PAY 20% of the total cost	

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PREMIUM and BENEFITS	**IN NETWORK**	**OUT-OF-NETWORK**	**WHAT YOU SHOULD KNOW**
Preventive Care Services Annual Physical Exam	YOU PAY $0 copayment per service YOU PAY $0 copayment per one annual visit		Includes but not limited to Medicare-covered: glaucoma screening, barium enemas, digital rectal exams, and EKG following Welcome Visit.
Emergency Care	YOU PAY $90 copayment per visit		Copayment is waived if admitted within 48 hours.
Worldwide Emergency Coverage	YOU PAY $90 copayment per visit YOU PAY $500 copayment per one-way transportation (ground or air)		Copayment 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 $10 copayment per visit		Copayment is NOT waived if you are admitted to the hospital.
Diagnostic Tests, Lab, Therapeutic Radiology Services and x-rays[1]	YOU PAY 20% of the total cost	YOU PAY 30% of the total cost	Such as MRIs, CT scans, outpatient x-rays.
Hearing Services	YOU PAY $45 copayment per visit	YOU PAY 20% of the total cost	Medicare-covered exams to diagnose and treat hearing and balance issues.
Dental Services ●Medicare-covered Services	YOU PAY $45 copayment per visit	YOU PAY 20% of the total cost	Medicare-covered dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth).

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PREMIUM and BENEFITS	**IN NETWORK**	**OUT-OF-NETWORK**	**WHAT YOU SHOULD KNOW**
●Preventive Services	YOU PAY $0 copayment per annual visit		One oral exam; cleaning; and dental x-rays per year.
Vision Services ●Eye exam, Medicare-covered ●Eye exam, Diabetic Retinopathy	YOU PAY $45 copayment per visit YOU PAY $10 copayment per visit	YOU PAY 20% of the total cost YOU PAY 20% of the total cost	Diagnose and treat diseases and conditions of the eye.
●Medicare-covered Annual Glaucoma Test	YOU PAY $0 copayment per visit		
●Post Cataract Surgery Eyewear ●Eye Exam, Routine	YOU PAY 20% of the total cost YOU PAY $45 copayment per visit	YOU PAY 20% of the total cost YOU PAY 20% of the total cost	One pair of eyeglasses or contact lenses after cataract surgery. Routine eye exam annual $130 limit.
Outpatient Mental Health Services	YOU PAY $40 copayment per visit	YOU PAY 20% of the total cost	Group or individual therapy visits.
Inpatient Mental Health Care[1]	YOU PAY $160 copayment per day for days 1-10 YOU PAY $0 copayment per day for days 11-90	YOU PAY 20% of the total cost per stay	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 $178 copayment per day for days 21-100	YOU PAY 20% of the total cost per stay	This plan covers 100 days per cause.
Outpatient Rehabilitation Services	YOU PAY $30 copayment per visit	YOU PAY 20% of the total cost	Occupational, physical, speech and language therapies.

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PREMIUM and BENEFITS	**IN NETWORK**	**OUT-OF-NETWORK**	**WHAT YOU SHOULD KNOW**
Ambulance[1] ●Ground Transportation Service	YOU PAY $350 copayment per one-way ground transportation		Authorization required for non- emergency services.
· ●Air Transportation Service	YOU PAY $500 copayment per one-way air transportation		Medically necessary Medicare- covered ground or air medical transportation.
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	YOU PAY 20% of the total cost	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions.
Durable Medical Equipment (DME)[1]	YOU PAY 20% of the total cost	YOU PAY 20% of the total cost	Includes wheelchairs, oxygen, etc.
Cardiac and Pulmonary Rehabilitation	YOU PAY $15 copayment per visit	YOU PAY 20% of the total cost	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	YOU PAY 20% of the total cost	Medicare-covered services only.

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Diabetes Supplies and Services ●Diabetes testing supplies from Retail Pharmacy	YOU PAY 0% of the total cost	YOU PAY 20% of the total cost	
●Diabetes testing supplies from DME supplier	YOU PAY 20% of the total cost	YOU PAY 20% of the total cost	
●Diabetes self-management training	YOU PAY 0% of the total cost	YOU PAY 0% of the total cost	
●Therapeutic shoes or inserts	YOU PAY 20% of the total cost	YOU PAY 20% of the total cost	Medicare-covered Diabetic Therapeutic Shoes or Inserts
Dialysis	YOU PAY 20% of the total cost for each Medicare-covered dialysis service.	YOU PAY 20% of the total cost for each Medicare-covered dialysis service.	
Home Health Care	YOU PAY $0 copayment per visit	YOU PAY 15% of the total cost	
Prosthetic Devices [1]	YOU PAY 20% of the total cost	YOU PAY 20% of the total cost	Braces, artificial limbs, etc.
Fitness Center Membership	YOU PAY $0		Applies to fitness membership at any FirstHealth Center for Health and Fitness. A member may use another plan approved fitness center and be reimbursed up to $300 annually for fees. Reimbursements are made on a quarterly basis and will not be paid in advance.

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OUTPATIENT PRESCRIPTION DRUGS			
Part D Deductible	YOU PAY nothing		This plan does not have a Part D deductible.
TIERS	**RETAIL COST**	**MAIL ORDER COST**	
One month (30 day) supply dispensed			
Tier 1 (Preferred Generic Drugs)	YOU PAY $8 copayment	YOU PAY $8 copayment	
Tier 2 (Generic Drugs)	YOU PAY $18 copayment	YOU PAY $18 copayment	
Tier 3 (Preferred Brand Drugs)	YOU PAY $45 copayment	YOU PAY $45 copayment	
Tier 4 (Non-Preferred Drugs)	YOU PAY $100 copayment	YOU PAY $100 copayment	
Tier 5 (Specialty Drugs)	YOU PAY 33% of the total cost	YOU PAY 33% of the total cost	
Tier 6 (Select Care Drugs)	YOU PAY $8 copayment	YOU PAY $8 copayment	
Long Term (90 day) supply dispensed			
TIERS	**RETAIL COST**	**MAIL ORDER COST**	
Tier 1 (Preferred Generic Drugs)	YOU PAY $24 copayment	YOU PAY $0 copayment	
Tier 2 (Generic Drugs)	YOU PAY $54 copayment	YOU PAY $45 copayment	
Tier 3 (Preferred Brand Drugs)	YOU PAY $135 copayment	YOU PAY $112.50 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	
Long-Term Care Pharmacy			
Tier 1(Preferred Generic Drugs)	YOU PAY $8 copay 31 day supply		
Tier 2 (Generic Drugs)	YOU PAY $18 copay 31 day supply		
Tier 3 (Preferred Brand Drugs)	YOU PAY $45 copay 31 day supply		
Tier 4 (Non-Preferred Drugs)	YOU PAY $100 copay 31 day supply		
Tier 5 (Specialty Drugs)	YOU PAY 33% coinsurance 31 day supply		
Tier 6 (Select Care Drugs)	YOU PAY $8 copay 31 day supply		

FirstMedicare Direct PPO Plus (PPO) H8064-002-000	
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			
PREMIUM and BENEFITS	**IN NETWORK**	**OUT-OF-NETWORK**	**WHAT YOU SHOULD KNOW**
Comprehensive Dental - Premium (Optional Buy-Up Plan)	YOU PAY an additional $26.00 per month		Non-routine Services; Restorative; Endodontics; Periodontics; Extractions
	YOU PAY 50% coinsurance of the total cost		(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.