FirstMedicare Direct

FIRSTCAROLINACARE INSURANCE COMPANY

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

2023 Summary of Benefits

January 1, 2023 – December 31, 2023

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: Buncombe, Henderson, Madison, McDowell, Transylvania and Yancey.

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.

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, 2024.
- ☐ 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.

	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 You must continue to pay your Medicare Part B premium.	**$39**	**$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 (Does not apply to Tier 1 or Tier 2 Drugs)**
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	**$3,300**	**$5,250**
In-network and Out-of-network providers	**$5,450**	**$8,950**
COVERED MEDICAL AND HOSPITAL BENEFITS		
Inpatient Hospital Care Our plan covers an unlimited number of days for an inpatient hospital stay. (may require prior authorization)		
In-network:	**• $295 copay per day for days 1 through 6** **• $0 copay per day for days 7 through 90**	**• $325 copay per day for days 1 through 6** **• $0 copay per day for days 7 through 90**
Out-of-network:	**30% of the cost**	**30% of the cost**
Outpatient Hospital Care (may require prior authorization)		
In-network:	**$250 copay**	**$300 copay**
Out-of-network:	**30% of the cost**	**30% of the cost**
DOCTOR VISITS		

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Primary Care Physician Office Visits		
In-network:	**$0 copay**	**$5 copay**
Out-of-network:	**30% of the cost**	**30% of the cost**
Specialist Office Visits		
In-network:	**$35 copay**	**$35 copay**
Out-of-network:	**$65 copay**	**$65 copay**
Virtual Visits through FirstHealth on the Go Our plan covers visits with a provider by phone or online, 24/7. You must use FirstHealth on the Go to obtain in-network benefits for these services. Go to www.FirstMedicare.com or your Evidence of Coverage for more information.		
In-network:	**$0 copay**	**$0 copay**
Out-of-network:	**$0 copay**	**$0 copay**
Preventive Care Our plan covers many preventive services, including but not limited to: • 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**
Out-of-network:	**$0 copay**	**$0 copay**
EMERGENCY SERVICES		
Emergency Care 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		

	FirstMedicare Direct POS Plus (HMO-POS)	FirstMedicare Direct POS Standard (HMO-POS)
Hospital Care" section of this booklet for other costs.		
In-network:	**$125 copay**	**$110 copay**
Out-of-network:	**$125 copay**	**$110 copay**
Urgent Care Services		
In-network:	**$10 copay**	**$20 copay**
Out-of-network:	**$10 copay**	**$20 copay**
DIAGNOSTIC SERVICES 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:	**30% of the cost**	**30% of the cost**
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**
Out-of-network:	**30% of the cost**	**30% of the cost**
HEARING, DENTAL AND VISION		
Diagnostic Hearing Exam (Exam to diagnose and treat hearing and balance issues)		

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In-network:	**$35 copay**	**$35 copay**
Out-of-network:	**$65 copay**	**$65 copay**
Routine Hearing Exam (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 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. Limitations may apply. Copayment is not subject to the maximum out-of-pocket. Hearing aid purchases include: • 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**
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:	**$35 copay**	**$35 copay**

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Out-of-network:	**$65 copay**	**$65 copay**
Non-Medicare-covered Dental Services (up to $3,000 per plan year) 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.		
	$0 copay	**$0 copay**
Medicare-covered Vision Services 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 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, get a $130 allowance for eyewear.	
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:	**$0 copay**	**$0 copay**

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MENTAL HEALTH CARE		
Outpatient Individual Mental Health Therapy Visit		
In-network:	**$35 copay**	**$35 copay**
Out-of-network:	**30% of the cost**	**30% of the cost**
Outpatient Group Mental Health Therapy Visit		
In-network:	**$35 copay**	**$35 copay**
Out-of-network:	**30% of the cost**	**30% of the cost**
Inpatient Mental Health Visit 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** **• $0 copay per day for days 11 through 90**	**• $160 copay per day for days 1 through 10** **• $0 copay per day for days 11 through 90**
Out-of-network:	**30% of the cost**	**30% of the cost**
SKILLED NURSING FACILITIES		
Skilled Nursing Facility (SNF) Our plan covers up to 100 days in an SNF. (may require prior authorization)		
In-network:	**• $0 copay per day for days 1 through 20** **• $196 copay per day for days 21 through 100**	**• $0 copay per day for days 1 through 20** **• $196 copay per day for days 21 through 100**
Out-of-network:	**30% of the cost**	**30% of the cost**

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PHYSICAL THERAPY		
Outpatient Physical Therapy (may require prior authorization)		
In-network:	**$30 copay**	**$30 copay**
Out-of-network:	**30% of the cost**	**30% of the cost**
TRANSPORTATION SERVICES		
Ambulance Authorization for non-emergency transportation by ambulance is required.		
In- and out-of-network emergent:	**$250 copay**	**$350 copay**
Out-of-network non-emergent:	**$250 copay**	**$350 copay**
Transportation (within the U.S. and it's territories)	**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**	**$350 copay**
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**

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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)

PART D PRESCRIPTION DRUGS

You pay the following until your total yearly drug costs reach $4,660. 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:	**33% of the cost**	**30% of the cost**

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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:	**33% of the cost**	**30% of the cost**

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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 $4,660. 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 $7,400, which is the end of the coverage gap. Our plan offers additional coverage through the gap for select insulins. During the Coverage Gap stage, your out-of-pocket costs for select insulins will be $15 - $35 per month on FirstMedicare Direct POS Plus and $20 - $35 per month on FirstMedicare Direct POS Standard. 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. 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 $7,400, you pay the greater of: 5% of the cost, or $4.15 copay for generic (including brand drugs treated as generic) and a $10.35 copayment for all other drugs.		
ADDITIONAL BENEFITS		
Chemotherapy 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 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**

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Out-of-network:	**30% of the cost**	**30% of the cost**
Durable Medical Equipment 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 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 supplier**	**0%-20% of the cost, depending on the supplier**
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**
Medicare-covered Foot Care (Podiatry Services) 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		

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$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:	**$0 copay**	**$0 copay**
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:	**$0 copay**	**$0 copay**
Out-of-network:	**30% of the cost**	**30% of the cost**
Outpatient Occupational Therapy Visit (may require prior authorization)		
In-network:	**$30 copay**	**$30 copay**
Out-of-network:	**30% of the cost**	**30% of the cost**
Outpatient Speech and Language Therapy Visit (may require prior authorization)		
In-network:	**$30 copay**	**$30 copay**
Out-of-network:	**30% of the cost**	**30% of the cost**
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**

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Outpatient Surgery at an Ambulatory Surgical Center (may require prior authorization)		
In-network:	**$250 copay**	**$300 copay**
Out-of-network:	**30% of the cost**	**30% of the cost**
Outpatient Surgery at an Outpatient Hospital (may require prior authorization)		
In-network:	**$250 copay**	**$300 copay**
Out-of-network:	**30% of the cost**	**30% of the cost**
Prosthetic Devices and Related Medical Supplies 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**
Out-of-network:	**20% of the cost**	**20% of the cost**
WELLNESS PROGRAMS		
Fitness Benefit Members will be reimbursed up to $360 per year towards fitness activities.		

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FirstCarolinaCare Insurance Company is a health plan with a Medicare contract. Enrollment in a FirstMedicare Direct plan 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. Plans may offer supplemental benefits in addition to Part C benefits and Part D benefits.		

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

- 24-hour Nurse Advice Line to answer your health-related questions, day or night
- Fitness benefit
- Care coordination to help you deal with chronic conditions
- 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

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 بمساعدتك. هذه خدمة مجانية على (TTY:711)877-210-9167 . 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.

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。

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FirstCarolinaCare
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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, sexual orientation, gender identity or sex.
FirstCarolinaCare Insurance Company does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

- 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 the Civil Rights Coordinator for FirstCarolinaCare Insurance Company. 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, sexual orientation, gender identity or sex, you can file a grievance with:

FCC Civil Rights Coordinator FirstCarolinaCare Insurance Company 42 Memorial Drive
Pinehurst, NC 28374
Telephone: 1-877-210-9167
Fax number: 1-910-235-7854
Email: FCCCompliance@firstcarolinacare.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the FCC Civil Rights Coordinator 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, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html.*

Y0094_23_109493_C FCC Approved 07/13/2022