

FirstMedicare Direct Healthy State HMO Prime (HMO)

2018 Summary of Benefits

This is a summary of drug and health services covered January 1, 2018-December 31, 2018 by the FirstMedicare Direct Healthy State HMO Prime.

The benefit information provided is a summary of what we cover and what you pay. It does not list every service that is covered 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 Healthy State 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.

FirstMedicare Direct Healthy State HMO Prime has a network of doctors, hospitals, pharmacies and other providers. If you use the providers that are not in our network, the plan may not pay for these services.



PREMIUM and BENEFITS	First Medicare Direct Healthy State HMO Prime	WHAT YOU SHOULD KNOW
Monthly Plan Premium	YOU PAY \$17	You must continue to pay your Medicare Part B premium.
Part C Deductible	YOU PAY nothing	This plan does not have a deductible.
Maximum Out of Pocket	\$6,700 annually	The most you pay for copayments, coinsurance, and other costs of medical services for the year.
<p>• SERVICES WITH A * MAY REQUIRE PRIOR AUTHORIZATION •</p>		
Inpatient Hospital Care*	YOU PAY \$350 Copayment per day for days 1 through 4; YOU PAY \$0 for days 5 through 90	The copayments for hospital and skilled nursing facility (SNF) benefits are based on Medicare defined benefit periods.
Outpatient Hospital Services	YOU PAY \$300 Copayment	Includes outpatient hospital or ambulatory surgery services. One copayment for bilateral cataract surgery if both performed in same calendar year.
Doctor Visits ▪ Primary Care Providers ▪ Specialists	YOU PAY \$10 Copayment YOU PAY \$45 Copayment	
Preventive Care	YOU PAY \$0	Includes but is not limited to: bone mass measurement; mammogram; cardiovascular screenings; cervical/vaginal screening; diabetes screening; PSA; vaccinations; annual wellness visit.
Emergency Care	YOU PAY \$80 Copayment	Copayment is waived if admitted within 48 hours. \$10,000 lifetime limit for worldwide emergency coverage outside of the United States.
Urgently Needed Services	YOU PAY \$30 Copayment	
Diagnostic Tests, Lab, Therapeutic Radiology Services and X-rays*	YOU PAY 20% Coinsurance	Such as MRIs, CT scans, outpatient X-rays. Authorization required for genetic testing.
Hearing Services	YOU PAY \$45 Copayment	Exam to diagnose and treat hearing and balance issues.
Dental Services	YOU PAY \$45 Copayment	Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth).
Vision Services ▪ Medicare Covered Eye Exam ▪ Medicare Covered Annual Glaucoma Test	YOU PAY \$45 Copayment YOU PAY \$0	Diagnose and treat diseases and conditions of the eye.

PREMIUM and BENEFITS	FirstMedicare Direct Healthy State HMO Prime	WHAT YOU SHOULD KNOW
▪Post Cataract Surgery Eyewear	YOU PAY 20% Coinsurance	
Outpatient Mental Health Services	YOU PAY \$40 Copayment	Group or individual therapy visit.
Inpatient Mental Health Care*	YOU PAY \$350 Copayment per day for days 1 through 4; YOU PAY \$0 for days 5 through 90	Inpatient psychiatric care 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)*	YOU PAY \$0 Copayment per day for days 1 through 20; YOU PAY \$160 per day for days 21 through 100	This plan covers 100 days per cause.
Outpatient Rehabilitation Services	YOU PAY \$30 Copayment	Occupational, physical, speech and language therapies.
Ambulance*	YOU PAY \$350 Copayment	Medically necessary ground or air medical transportation. Authorization required for non-emergency services.
Transportation (non-medical)	NOT COVERED	Non-medical transportation is not a covered service.
Medicare Part B Drugs*	YOU PAY 20% Coinsurance	Only certain medications require authorization.
Foot Care (podiatry services)	YOU PAY \$45 Copayment	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions.
Durable Medical Equipment*	YOU PAY 20% Coinsurance	Includes wheelchairs, oxygen, etc.
Cardiac Rehabilitation	YOU PAY \$0	
Chiropractic Care	YOU PAY \$20 Copayment	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position).
Diabetes Supplies and Services	YOU PAY 0% - 20% Coinsurance	
Dialysis	YOU PAY 20% Coinsurance	
Home Health Care	YOU PAY 0% Coinsurance	
Prosthetic devices (braces, artificial limbs, etc.)*	YOU PAY 20% Coinsurance	Includes related medical supplies.
SUPPLEMENTAL BENEFITS		
Routine Eye Exam	YOU PAY \$25 Copayment	\$100 annual limit.

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Annual Physical Exam	YOU PAY \$0	
Fitness Benefit	YOU PAY \$0	Members must use YMCA of Western NC facilities. May be reimbursed a maximum of \$510 annually. Payment receipts required.
PRESCRIPTION DRUGS		
Part D Deductible	YOU PAY \$200 annually	
TIERS	RETAIL COST	MAIL ORDER COST
One month (30 day) supply dispensed		
Tier 1 (Preferred Generic Drugs)	YOU PAY \$6	YOU PAY \$6
Tier 2 (Generic Drugs)	YOU PAY \$20	YOU PAY \$20
Tier 3 (Preferred Brand Drugs)	YOU PAY \$45	YOU PAY \$45
Tier 4 (Non-Preferred Drugs)	YOU PAY \$90	YOU PAY \$90
Tier 5 (Specialty Drugs)	YOU PAY 29% of the cost	YOU PAY 29% of the cost
Tier 6 (Select Care Drugs)	YOU PAY \$6	YOU PAY \$6
Two month (60 day) supply dispensed		
Tier 1 (Preferred Generic Drugs)	YOU PAY \$12	YOU PAY \$0
Tier 2 (Generic Drugs)	YOU PAY \$40	YOU PAY \$40
Tier 3 (Preferred Brand Drugs)	YOU PAY \$90	YOU PAY \$90
Tier 4 (Non-Preferred Drugs)	YOU PAY \$180	YOU PAY \$180
Tier 5 (Specialty Drugs)	Not Offered	Not Offered
Tier 6 (Select Care Drugs)	YOU PAY \$6	YOU PAY \$6
Long term (90 day) supply dispensed		
Tier 1 (Preferred Generic Drugs)	YOU PAY \$18	YOU PAY \$0
Tier 2 (Generic Drugs)	YOU PAY \$60	YOU PAY \$50
Tier 3 (Preferred Brand Drugs)	YOU PAY \$135	YOU PAY \$112.50
Tier 4 (Non-Preferred Drugs)	YOU PAY \$270	YOU PAY \$225
Tier 5 (Specialty Drugs)	Not Offered	Not Offered
Tier 6 (Select Care Drugs)	YOU PAY \$0	YOU PAY \$0
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 .		



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 February 14, you can call 7 days a week from 8:00 a.m. to 8:00 p.m. Eastern. From February 15 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.