

In-Network Benefits **Member Responsibility**
when a FirstHealth hospital / entity is used

Deductible
Individual / Family..... \$0 / \$0
Maximum Coinsurance Out-of-Pocket/yr \$2,500 / \$5,000
Unlimited Lifetime Maximum

Outpatient Services

Diagnostic Testing & Procedures (*office or outpatient*)
Category I 10% co-ins.
(Limited to plain film, X-ray, Ultrasound, EKG, Spirometry, Laboratory, Holter Monitor, Bone Density & Infusion services)
Category II..... 10% co-ins.
(Includes all other diagnostics such as MRI, CT, PET scan Cardiac Cath, Nuclear Medicine, Sleep Lab, Colonoscopy, etc.)
Surgery (*in an outpatient setting*)\$100 copay +10% co-ins*
Physical, Occupational & Speech Therapy \$20 per visit
(60 combined visits max /yr)
Physician Services 20% co-ins.
Other outpatient services not subject to a copay 10% co-ins.
Other outpatient services subject to a copay see In-Network Benefits

Inpatient Services

Hospital Services.....\$200 per admission +10% co-ins*
Maternity Care - Hospital Services..... \$200 per admission +10% co-ins*
Skilled Nursing (*up to 100 days per cause*).....\$200 per admission +10% co-ins*
Acute Rehab Services\$200 per admission +10% co-ins*
(45 days max / yr)
Gastric Bypass Surgery\$200 per admission +10% co-ins*
(maximum one surgery per lifetime)

Behavioral Health Services

(Obtain an authorization prior to seeking services)
Mental/Nervous Disorder
Inpatient (*30 day max/yr*) \$200 per admission +10% co-ins*
Outpatient (*20 visits max/yr*) \$35 per visit
Chemical Dependency
Inpatient \$200 per admission +10% co-ins*
(max. \$8,000 / yr - \$16,000 / lifetime)
Outpatient (*See Summary Plan Document for details*)\$35 per visit

Ambulance - Emergency \$0

Emergency Services\$75 Facility copay +10% co-ins*
& \$35 Provider copay / visit

SEE IN-NETWORK BENEFITS FOR ANY SERVICES NOT LISTED ABOVE.

Prescription Drugs **Member Responsibility**

In-Network Retail Pharmacy
Generic/Preferred Brand /Non-preferred Brand.....\$8/\$35/\$55
Out-of-Network PharmacyNot Covered
Home Delivery Pharmacy\$24 /\$105 /\$165
(90 day supply for chronic conditions)

If a generic is available but not chosen, non-preferred brand co-pay applies plus cost difference.

* AFTER COPAY

In-Network Benefits **Member Responsibility**

Deductible
Individual / Family.....\$0 / \$0
Maximum Coinsurance Out-of-Pocket/yr\$2,500 /\$5,000
Unlimited Lifetime Maximum

Physician Services

Office Visits /Primary Care Provider\$20 per visit
Office Visits /Specialist.....\$35 per visit
Allergy Testing & Treatment.....\$35 per visit
Maternity (*prenatal physician visits*)\$20 first visit only
Surgery (*during an office visit*).....\$20 /\$35 per visit
Preventive Services\$20 per visit
Physical Exams, Routine Gyn Exams, Well Child Care
Immunizations and Injections\$0

Outpatient Services

Diagnostic Testing & Procedures (*office or outpatient*)
Category I 10% co-ins
(Limited to plain film, X-ray, Ultrasound, EKG, Spirometry, Laboratory, Holter Monitor, Bone Density & Infusion services)
Category II 20% co-ins
(Includes all other diagnostics such as MRI, CT, PET scan Cardiac Cath, Nuclear Medicine, Sleep Lab, Colonoscopy, etc.)
Surgery (*in an outpatient setting*)\$100 copay + 20% co-ins
Physical, Occupational & Speech Therapy \$35 per visit
(60 combined visits max /yr)
Chiropractic Care (*12 visits max /yr*) \$20 per visit
Dialysis & Chemotherapy 20% co-ins
Home Health (*30 visits max/yr*) \$20 per visit
Home Medical Equipment..... 20% co-ins
Hospice (*Limited to 6 months*)..... \$0
Other Outpatient Services..... 20% co-ins
Physician Services 20% co-ins.

Inpatient Services

Hospital Services.....\$200 per admission + 20% co-ins*
Physician Services..... \$0 per visit
Maternity Care - Hospital Services \$200 per admission + 20% co-ins*
Maternity Care - Physician Services \$0 per visit
Skilled Nursing (*up to 100 days per cause*)\$200 per admission + 20% co-ins*
Acute Rehab Services\$200 per admission + 20% co-ins*
(45 days max /yr)
Gastric Bypass Surgery\$200 per admission + 20% co-ins*
(maximum one surgery per lifetime)

Behavioral Health Services

(Obtain an authorization prior to seeking services)
Mental/Nervous Disorder
Inpatient (*30 day max/yr*) \$200 per admission +10% co-ins*
Outpatient (*See Summary Plan Document for details*) \$35 per visit
Chemical Dependency
Inpatient..... \$200 per admission +10% co-ins*
(max. \$8,000 /yr - \$16,000 /lifetime)
Outpatient (*See Summary Plan Document for details*)\$35 per visit

Ambulance - Emergency \$0

Emergency Services\$75 Facility copay /10% co-ins (after copay)
& \$35 Provider copay /visit

Out-of-Network Benefits **Member Responsibility**

Deductible
Individual / Family.....\$1,500 /\$4,500
Max. Coinsurance & Deductible Out-of-Pocket/yr\$8,000 /\$16,000
\$2,000,000 Lifetime Maximum

Physician Services

Office Visits /Primary Care Provider All Services
Office Visits /Specialist 40% of MAP** +
Allergy Testing & Treatment amount over MAP
Maternity (*prenatal physician visits*)
Surgery (*during an office visit*)
Preventive Services Not Covered
Physical Exams, Routine Gyn Exams
Well Child Care, Mammograms, PSA,
Vision Screening
Immunizations and Injections Not Covered

Outpatient Services

Diagnostic Testing & Procedures All Services
Surgery (*in an outpatient setting*) 40% of MAP** +
Physical, Occupational & Speech Therapy amount over MAP
(60 combined visits max /yr)
Chiropractic Care (*12 visits max /yr*)
Dialysis & Chemotherapy
Home Health (*30 visits max/yr*)
Home Medical Equipment
Hospice (*limited to 6 months*)

Inpatient Services

Hospital Services All Services
Physician Services 40% of MAP** +
Maternity Care - Hospital Services amount over MAP
Maternity Care - Physician Services
Skilled Nursing (*up to 100 days per cause*)
Acute Rehab Services (*45 days max /yr*)
Gastric Bypass Surgery Not Covered

Behavioral Health Services

Mental/Nervous Disorder40% of MAP** +
Inpatient (*30 days max/yr*) amount over MAP
Outpatient (*See Summary Plan Document for details*)
Chemical Dependency40% of MAP** +
Inpatient amount over MAP
(max. \$8,000 /yr - \$16,000 /lifetime)
Outpatient (*See Summary Plan Document for details*)

Ambulance - Emergency \$0

Emergency Services\$75 Facility copay /10% co-ins (after copay)
& \$35 Provider copay /visit

** MAP = Maximum Allowable Payment.

NOTICE: Your actual expenses for covered services may exceed the stated coinsurance percentage because actual provider charges may not be used to determine Plan and Member payment obligations.

Some services subject to medical review and/or precertification.

The information above is a summary of your medical benefit plan. Please refer to your Summary Plan Document for a more detailed and comprehensive explanation of covered services and exclusions.

HOW TO GET THE MOST FROM YOUR HEALTH PLAN

- **Whenever possible, ask your medical provider if the service you need can be provided at a FirstHealth hospital.**
- Choose a Primary Care Provider (PCP) from the Provider Directory. Although you do not need a referral from your PCP to receive covered services from a participating Specialist, we recommend you access your PCP's expertise in coordinating your health care needs.
- Precertification is required on certain covered services. **If precertification is not completed prior to service, your benefits will be reduced by 20 percent.** You should call Member services if you have any questions on Precertification requirements.
- You can lower your Pharmacy Copayment by choosing a Generic Drug instead of a Brand Name Drug. Make sure you discuss your options with your Provider.
- A Nurse HelpLine is available to you 24 hours a day, 365 days a year to provide personal health care advice and support as well as general health information.
- If you have any questions about your benefits, call FirstCarolinaCare Member Services at (800) 811-3298.
- For additional information, please visit our Web site at www.firstcarolinacare.com

IMPORTANT TELEPHONE NUMBERS

Member Services(800) 811-3298

Questions concerning:

- Claims
- Benefits
- Issues or Concerns
- Eligibility

Pharmacy Benefits(800) 788-2949

Behavioral Services(800) 574-8556

& Chemical Dependency

Precertification(800) 574-8556

Provider Relations(910) 715-8115

Questions concerning a physician
not in the Provider Directory

Nurse HelpLine.....(800) 336-2121

FirstCarolinaCare.....(910) 715-8100

or (800) 574-8556

Plan administered by
FirstCarolinaCare Insurance Company,
a wholly-owned subsidiary of



www.firstcarolinacare.com



POS Benefits Summary

Employee Medical Benefit Plan 2009

