FirstCarolinaCare
INSURANCE COMPANY

FIRSTHEALTH OF THE CAROLINAS

SCHEDULE OF BENEFITS

PPO PLAN

1/1/2021

Lifetime Maximum Benefits	In-Network Providers/Out-of-Network Providers
Individual Lifetime Maximum Benefit	Unlimited

The term "Lifetime" refers to the time a person is actually a Beneficiary of a welfare benefit plan sponsored by the Group and is not intended to suggest benefits beyond an individual's termination date.

Calendar Year Maximum Benefits	In-Network Providers/Out-of-Network Providers
Skilled Nursing Care	100 days per cause
Inpatient Rehabilitative Therapy Services (Occupational, Speech and Physical Therapies)	45 days
Outpatient Rehabilitative Therapy Services (Occupational, Speech and Physical Therapies)	60 visits
Home Health Care	30 visits
Chiropractic Services	12 visits

The maximum benefits allowed for In-Network Providers and Out-of-Network Provider services are combined.

Calendar Year Deductibles (Medical)	In-Network Providers	Out-of-Network Providers
Individual	$500	$5,000
Family	$1,000	$15,000

Deductibles apply to all covered services except In-Network Provider Preventive services, Emergency Room Facility, Office visits and Prescription Drugs. A new Deductible will apply each Calendar Year. Family deductible is cumulative for all family members combined.

Deductible is Embedded. If two or more members are on the plan, they have separate individual deductibles embedded within the family deductible. This gives each member a chance to have his or her benefits start before the entire family meets the family deductible.

Calendar Year Out-of-Pocket Maximums	In-Network Providers	Out-of-Network Providers
Individual	$5,000	$15,000
Family	$10,000	$30,000

All Deductibles, Copayments and Coinsurance applies to the Out-of-Pocket Maximum. Premiums, prior authorization penalties, non-covered services and charges over Maximum Allowable Charge (MAC) do not apply to the Out-of-Pocket Maximum.

Out-of-Pocket Maximum is Embedded. If two or more members are on the plan, they have separate individual Out-of-Pocket Maximums embedded within the family Out-of-Pocket Maximum. This gives each member a chance to have his or her benefits start before the entire family meets the family Out-of-Pocket Maximum.

Prior Authorization Penalty	In-Network Providers/Out-of-Network Providers
Failure to Prior Authorize	20% coinsurance penalty will apply

Penalty for failure to obtain prior authorization applies to the following: Imaging (CT, PET scans, MRIs), Outpatient Surgery, Inpatient Hospital, Mental Health and Substance Abuse, Rehabilitation services, Skilled Nursing care, Durable Medical Equipment, Home Health Care and Hospice Services.

Inpatient Services/Benefits	You Pay In-Network Providers	You Pay Out-of-Network Providers
Physician Services	Plan pays 100% (Deductible waived)	40% coinsurance, after deductible
Hospital Care	10% coinsurance, after deductible	40% coinsurance, after deductible
Bariatric Surgery	10% coinsurance, after deductible	Not Covered
Inpatient Rehabilitation	10% coinsurance, after deductible	40% coinsurance, after deductible
Skilled Nursing Care	10% coinsurance, after deductible	40% coinsurance, after deductible
Human Organ Transplant	10% coinsurance, after deductible	Not Covered
Mental Health Care	10% coinsurance, after deductible	40% coinsurance, after deductible
Substance Use Treatment	10% coinsurance, after deductible	40% coinsurance, after deductible
Inpatient Hospice	10% coinsurance, after deductible	40% coinsurance, after deductible

Outpatient Services/Benefits	You Pay In-Network Providers	You Pay Out-of-Network Providers
Office Visit-Primary Care	$25 copayment (Deductible waived)	40% coinsurance, after deductible
Office Visit-Specialty Care	$45 copayment (Deductible waived)	40% coinsurance, after deductible
Routine Prenatal Care	Plan pays 100% (Deductible waived)	40% coinsurance, after deductible
Be Healthy Wellness Benefit Program	Plan pays 100% (Deductible waived)	Not Covered
Well Child Care	Plan pays 100% (Deductible waived)	Not Covered
Routine Eye Exams- Adult	Not Covered	Not Covered
Routine Eye Exams (Age 17 and under)	$25 copayment (Deductible waived)	Not Covered
Outpatient Surgery- Facility	10% coinsurance, after deductible	40% coinsurance, after deductible
Outpatient Surgery- Physician	10% coinsurance (Deductible waived)	40% coinsurance, after deductible
Diagnostic Testing (X-rays and laboratory services)	10% coinsurance, after deductible	40% coinsurance, after deductible
Mental Health Care	$25 copayment (Deductible waived)	40% coinsurance, after deductible
Substance Use Treatment	$25 copayment (Deductible waived)	40% coinsurance, after deductible
Home Health Care/Home Infusion	$25 copayment (Deductible waived)	40% coinsurance, after deductible
Hospice Care	10% coinsurance, after deductible	40% coinsurance, after deductible

Rehabilitative Therapy Services (Physical, Occupational, Speech Therapies)	$25 copayment (Deductible waived)	40% coinsurance, after deductible
Emergency Room- Facility	$150 copayment, then 10% coinsurance (Deductible waived)	$150 copayment, then 10% coinsurance (Deductible waived) (In-Network OOPM applies)
Emergency Room- Physician	$45 copayment (Deductible waived)	$45 copayment (Deductible waived) (In-Network OOPM applies)
Ambulance Services (must be medically necessary)	10% coinsurance, after deductible	10% coinsurance, after deductible (In-Network Benefits apply)
FHC Convenient Care Center (All inclusive)	$25 copayment (Deductible waived)	Not Applicable
Urgent Care Facility (All inclusive)	$75 copayment (Deductible waived)	$75 copayment (Deductible waived) (In-Network OOPM applies)
Durable Medical Equipment and Prosthetic Devices	10% coinsurance, after deductible	40% coinsurance, after deductible
Chiropractic Services	$25 copayment (Deductible waived)	40% coinsurance, after deductible
Infertility Services – Diagnostic	10% coinsurance, after deductible	40% coinsurance, after deductible
Temporomandibular Joint Disorders	10% coinsurance, after deductible	40% coinsurance, after deductible
Wisdom Teeth Removal	Not Covered	Not Covered
Other Covered Services	10% coinsurance, after deductible	40% coinsurance, after deductible

NOTES:
Participating Provider Coinsurance, if any, is based on the allowed or discounted amount.

Prescription Drugs	**You Pay FirstHealth Pharmacies**	**You Pay In-Network Pharmacies**	**You Pay Out-of-Network Pharmacies**
Retail Prescription Drugs (Limited to a maximum 30-day supply)	Tier 1: $0 Tier 2: $5 Tier 3: $30 Tier 4: $60	Tier 1: $0 Tier 2: $15 Tier 3: $60 Tier 4: $90	Tier 1: $20 Tier 2: $30 Tier 3: $120 Tier 4: $180
Retail Prescription Drugs (Limited to a maximum 90-day supply)	Tier 1: $0 Tier 2: $15 Tier 3: $90 Tier 4: $180	Tier 1: $0 Tier 2: $45 Tier 3: $180 Tier 4: $270	Not Covered