FirstCarolinaCare INSURANCE COMPANY

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services
FirstHealth of the Carolinas: POS Plan Option

Coverage Period: Beginning on or after: 01/01/2022
Coverage for: Single & Family | **Plan Type:** POS

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, contact www.firstcarolinacare.com or call 1-866-267-5835. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call 1-866-267-5835 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**FirstHealth & In-network (contracted) provider**: $500 Single / $1,000 Family **Out-of-network (non-contracted) provider**: $5,000 Single / $15,000 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. - The following FirstHealth & in-network (contracted) provider services are not subject to deductible: prescription drugs, office & urgent care visits, preventive care, emergency services, home health care, rehabilitative therapy services, & chiropractic care. - The following out-of-network (non-contracted) provider services are not subject to deductible: emergency services, & urgent care visits.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**FirstHealth & In-network (contracted) provider**: $5,000 Single / $10,000 Family **Out-of-network (non-contracted) provider**: $15,000 Single / $30,000 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Charges over the maximum allowable charge, premiums, balance-billed charges, prior authorization penalties, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.firstcarolinacare.com or call 1-866-267-5835 for a list of network providers.	This plan does not use a provider network. You can receive covered services from any provider. You pay the least if you use a provider in the FirstHealth providers tier. You pay more if you use a provider in in-network (contracted) provider tier. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		FirstHealth Provider (You will pay the least)	In-Network (Contracted) Provider (You will pay more)	Out-of-Network (Non-Contracted) Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copayment per visit, deductible does not apply	$25 copayment per visit, deductible does not apply	40% coinsurance, after deductible	None
		Virtual visit/Telehealth			None
		- FirstHealth on the Go: No charge - Other providers: $25 copayment, deductible does not apply	- FirstHealth on the Go: No charge - Other providers: $25 copayment, deductible does not apply	40% coinsurance, after deductible	
	Specialist visit	$45 copayment per visit, deductible does not apply	$45 copayment per visit, deductible does not apply	40% coinsurance, after deductible	None
		Chiropractic care: $25 copayment per visit, deductible does not apply	Chiropractic care: $25 copayment per visit, deductible does not apply	Chiropractic care: 40% coinsurance, after deductible	Chiropractic care: Limited to 12 visits per covered person per benefit period – in-network (contracted) & out-of-network (non-contracted) providers combined.
	Preventive care/screening/ immunization	No charge	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance, after deductible	20% coinsurance, after deductible	40% coinsurance, after deductible	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance, after deductible	20% coinsurance, after deductible	40% coinsurance, after deductible	Prior authorization is required. Failure to ensure a prior authorization may result in the following penalty: 20% coinsurance per service.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		FirstHealth Provider (You will pay the least)	In-Network (Contracted) Provider (You will pay more)	Out-of-Network (Non-Contracted) Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.firstcarolinacare.com	Tier 1 (Preferred Generic)	No charge	No charge	Not covered	Deductible does not apply
	Tier 2 (Non-Preferred Generic)	- 30-day supply - $5 copayment per prescription - 90-day supply - $15 copayment per prescription	- 30-day supply - $15 copayment per prescription - 90-day supply - $45 copayment per prescription	Not covered	
	Tier 3 (Preferred Brand/Preferred Specialty)	- 30-day supply - $30 copayment per prescription - 90-day supply - $90 copayment per prescription	- 30-day supply - $60 copayment per prescription - 90-day supply - $180 copayment per prescription	Not covered	Deductible does not apply Specialty: Limited to 30-day supply
	Tier 4 (Preferred Brand/Preferred Specialty)	- 30-day supply - $60 copayment per prescription - 90-day supply - $180 copayment per prescription	- 30-day supply - $90 copayment per prescription - 90-day supply - $270 copayment per prescription	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance, after deductible	20% coinsurance, after deductible	40% coinsurance, after deductible	Prior authorization is required. Failure to ensure a prior authorization may result in in the following penalty: 20% coinsurance per service.
	Physician/surgeon fees	20% coinsurance, after deductible	20% coinsurance, after deductible	40% coinsurance, after deductible	
If you need immediate medical attention	Emergency room care	Facility: $150 copayment per visit, then 10% coinsurance, deductible does not apply FirstHealth provider/In-network (contracted) provider benefits apply			Copayment is waived if admitted.
		Physician: $45 copayment per visit, deductible does not apply FirstHealth provider/In-network (contracted) provider benefits apply			
	Emergency medical transportation	10% coinsurance, after deductible FirstHealth provider/In-network (contracted) provider benefits apply			Non-urgent ambulance: Prior authorization is required.
	Urgent care	FHC Convenient Care Center: $25 copayment per visit, deductible does not apply	Other urgent care facility: $75 copayment per visit, deductible does not apply FirstHealth provider/In-network (contracted) provider benefits apply		None

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		FirstHealth Provider (You will pay the least)	In-Network (Contracted) Provider (You will pay more)	Out-of-Network (Non-Contracted) Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance, after deductible	20% coinsurance, after deductible	40% coinsurance, after deductible	Prior authorization is required. Failure to ensure a prior authorization may result in in the following penalty: 20% coinsurance per service.
	Physician/surgeon fees	No charge	No charge	40% coinsurance, after deductible	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copayment per visit, deductible does not apply	$25 copayment per visit, deductible does not apply	40% coinsurance, after deductible	None
	Inpatient services	10% coinsurance, after deductible	10% coinsurance, after deductible	40% coinsurance, after deductible	Prior authorization is required. Failure to ensure a prior authorization may result in in the following penalty: 20% coinsurance per service.
If you are pregnant	Office visits	No charge	No charge	40% coinsurance, after deductible	None
	Childbirth/delivery professional services	No charge	No charge	40% coinsurance, after deductible	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery facility services	10% coinsurance, after deductible	20% coinsurance, after deductible	40% coinsurance, after deductible	Prior authorization is required. Failure to ensure a prior authorization may result in in the following penalty: 20% coinsurance per service.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		FirstHealth Provider (You will pay the least)	In-Network (Contracted) Provider (You will pay more)	Out-of-Network (Non-Contracted) Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	$25 copayment per visit, deductible does not apply	$25 copayment per visit, deductible does not apply	40% coinsurance, after deductible	Prior authorization is required. Failure to ensure a prior authorization may result in in the following penalty: 20% coinsurance per service. - Limited to 30 visits per covered person per benefit period – in-network (contracted) & out-of-network (non-contracted) providers combined.
	Rehabilitation services	$25 copayment per visit, deductible does not apply	$45 copayment per visit, deductible does not apply	40% coinsurance, after deductible	Prior authorization is required. Failure to ensure a prior authorization may result in in the following penalty: 20% coinsurance per service. - Inpatient: Limited to 45 days per covered person per benefit period – in-network (contracted) & out-of-network (non-contracted) providers combined. - Outpatient: Limited to 60 visits per covered person per benefit period – in-network (contracted) & out-of-network (non-contracted) providers combined.
	Habilitation services	Not covered	Not covered	Not covered	None
	Skilled nursing care	10% coinsurance, after deductible	20% coinsurance, after deductible	40% coinsurance, after deductible	Prior authorization is required. Failure to ensure a prior authorization may result in in the following penalty: 20% coinsurance per service. - Limited to 100 days per cause per covered person per benefit period – in-network (contracted) & out-of-network (non-contracted) providers combined.
	Durable medical equipment	10% coinsurance, after deductible	20% coinsurance, after deductible	40% coinsurance, after deductible	Prior authorization is required for select durable medical equipment. Failure to ensure a prior authorization may result in in the following penalty: 20% coinsurance per service.
	Hospice services	10% coinsurance, after deductible	20% coinsurance, after deductible	40% coinsurance, after deductible	Prior authorization is required. Failure to ensure a prior authorization may result in in the following penalty: 20% coinsurance per service.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		FirstHealth Provider (You will pay the least)	In-Network (Contracted) Provider (You will pay more)	Out-of-Network (Non-Contracted) Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	$25 copayment per visit, deductible does not apply	$25 copayment per visit, deductible does not apply	Not covered	- Vision screening for children 17 and under: Limited to one screening per year in a primary care providers office. - Visual impairment screening: Limited to children five and under.
	Children's glasses	Not covered	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery (FirstHealth & in-network (contracted) provider only) (Prior authorization is required.)
- Chiropractic care
- Hearing aids (Limited to covered persons under 22 years of age)
- Infertility treatment (Diagnostic only) (Prior authorization is required.)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Plan at 1-910-715-1357 or Department of Labor's Employee Benefits Security Administrations at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Plan at (for medical) 1-844-335-7097; (for prescription drugs) 1-866-267-5835 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) orwww.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact U.S. Department of Labor, Employee Benefits Security Administration at 1-866-487-2365 or visit www.dol.gov/ebsa/healthreform or visit http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/ or contact North Carolina Department of Insurance, 325 N Salisbury Street, Raleigh, NC 27603 or call 1-855-408-1212.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-267-5835.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-267-5835.
Chinese (中文): 如果需要中文的帮助， 请拨打这个号码1-866-267-5835.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-267-5835.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$500
Specialist *copayment*	$45
Hospital (facility) *coinsurance*	10%
Other *coinsurance*	10%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$10
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,570**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$500
Specialist *copayment*	$45
Hospital (facility) *coinsurance*	10%
Other *coinsurance*	10%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$500
Copayments	$1,000
Coinsurance	$70
What isn't covered	
Limits or exclusions	$100
The total Joe would pay is	**$1,670**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$500
Specialist *copayment*	$45
Hospital (facility) *coinsurance*	10%
Other *coinsurance*	10%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$200
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$900**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

IMPORTANT

Section 1557 of PPACA, a federal law, requires that you be provided this notice.

The notice does not change the terms of your coverage and/or benefits under your employer-sponsored health plan.

Please review the information and keep it with your plan materials.

NO FURTHER ACTION IS REQUIRED ON YOUR PART.

FirstCarolinaCare
INSURANCE COMPANY

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, 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, or sex, you can file a grievance with:

FirstCarolinaCare Insurance Company, FCC Civil Rights Coordinator
42 Memorial Drive
Pinehurst, NC 28374
Telephone: 1-800-481-1092 Fax number: 1-910-687-6506 Email: compliance@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.

Non-English Language Assistance

If you need assistance in a language other than English please call 1-866-267-5835.