2025

- New Hanover Health Advantage Select HMO-POS (MAPD)
- New Hanover Health Advantage Platinum HMO-POS (MAPD)
- New Hanover Health Advantage Freedom HMO-POS (MA Only)

New Hanover Health Advantage

SUMMARY OF BENEFITS

2025 Summary of Benefits

Jan. 1, 2025 – Dec. 31, 2025

New Hanover Health Advantage Select (HMO-POS) (MAPD)
New Hanover Health Advantage Platinum (HMO-POS) (MAPD)
New Hanover Health Advantage Freedom (HMO-POS) (MA Only)

Call 888-384-4842 daily from 8 a.m. to 8 p.m. local time.

Voicemail is used on holidays and weekends from April 1 to Sept. 30.
TTY 711
FirstCarolinaCare.com/NHHA

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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 800-MEDICARE (800-633-4227), 24 hours a day, 7 days a week. TTY users should call 877-486-2048.

Booklet sections

- 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 855-291-9336 (TTY 711), daily from 8 a.m. to 8 p.m. local time. Voicemail is used on holidays and weekends from April 1 to Sept. 30.

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 Sept. 30.

Contact info

- If you're a current member: 855-291-9336 (TTY 711)
- If you're not yet a member: 888-384-4842 (TTY 711)
- FirstCarolinaCare.com/NHHA

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: **Brunswick, New Hanover** and **Pender**.

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 a primary care physician (PCP) in network to oversee your care. You generally pay less to stay in-network.

You must use network pharmacies to fill your prescriptions in most cases.

You can see our provider directory and pharmacy directory at our website (FirstCarolinaCare.com/NHHA). 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.

For plans with drug coverage, we cover the prescriptions drugs listed in our formulary at FirstCarolinaCare.com/NHHA. 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 or Catastrophic Coverage). You can find out what tier your drug is on in our formulary at FirstCarolinaCare.com/NHHA, 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, call 910-667-NHHA(6442) to speak with a local, licensed agent, or 888-384-4842 to speak with a FirstCarolinaCare representative. Hearing impaired persons can call TTY 711.

Understanding the benefits

- ☐ The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit FirstCarolinaCare.com/NHHA or call 888-384-4842 to view a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ 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 (if applicable), 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 co-payment/co-insurance may change on Jan. 1, 2026.
- ☐ Our plan allows you to see providers outside of our network (noncontracted providers). However, while we will pay for covered services provided, the provider must agree to treat you. Except in an emergency or urgent situations, noncontracted providers may deny care. In addition, you may pay a higher co-pay for services received by noncontracted providers.
- ☐ Your current healthcare coverage will end once your new Medicare coverage starts. For example, if you are in Tricare or a Medicare plan, you will no longer receive benefits from that plan once your new coverage starts.

	NEW HANOVER HEALTH ADVANTAGE SELECT (HMO-POS)	NEW HANOVER HEALTH ADVANTAGE PLATINUM (HMO-POS)	NEW HANOVER HEALTH ADVANTAGE FREEDOM (HMO-POS) (MA only)
MONTHLY PREMIUM, DEDUCTIBLE AND LIMITS ON HOW MUCH YOU PAY			
Premium each month You must continue to pay your Medicare Part B premium.	$0	$53	$0
Medicare Part B premium reduction	N/A	N/A	$75 (credit) per month
New Hanover Health Advantage Select and Platinum HMO-POS plans include prescription drug coverage. The New Hanover Health Advantage Freedom HMO-POS plan does not include prescription drug coverage. For more information about how these plans compare, contact your broker or New Hanover Health Advantage.			
Medical deductible	$0	$0	$0
Prescription drugs deductible	$100 (Does not apply to Tier 1 and Tier 2 drugs)	$0	N/A
Maximum out-of-pocket each year The most you pay for co-pays, co-insurance and other costs for medical services for the year. You still need to pay your monthly premiums (does not include Part D prescription drugs).			
In-network providers	$3,350	$2,900	$3,600
In-network and out-of-network providers	$8,950	$7,900	$8,950
COVERED MEDICAL AND HOSPITAL BENEFITS			
Inpatient hospital care (may require prior authorization)			
In-network:	$295 co-pay per day for days 1 through 6 $0 co-pay per day for days 7 and beyond	$275 co-pay per day for days 1 through 6 $0 co-pay per day for days 7 and beyond	$300 co-pay per day for days 1 through 6 $0 co-pay per day for days 7 and beyond
Out-of-network:	$450 co-pay per day for days 1 through 6 $0 co-pay per day for days 7 through 90	$400 co-pay per day for days 1 through 6 $0 co-pay per day for days 7 through 90	$450 co-pay per day for days 1 through 6 $0 co-pay per day for days 7 through 90
Outpatient hospital care (may require prior authorization)			
In-network:	$265 co-pay for outpatient surgery	$250 co-pay for outpatient surgery	$300 co-pay for outpatient surgery
Out-of-network:	$450 co-pay for outpatient surgery	$350 co-pay for outpatient surgery	$450 co-pay for outpatient surgery

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Outpatient surgery at an ambulatory surgical center (may require prior authorization)			
In-network:	$215 co-pay	$175 co-pay	$250 co-pay
Out-of-network:	$350 co-pay	$350 co-pay	$350 co-pay
DOCTOR VISITS			
Primary care physician office visits			
In-network:	$0 co-pay	$0 co-pay	$0 co-pay
Out-of-network:	$0 co-pay	$0 co-pay	$0 co-pay
Physician specialist services			
In-network:	$15 co-pay	$0 co-pay	$35 co-pay
Out-of-network:	$50 co-pay	$40 co-pay	$50 co-pay
Cardiac rehabilitation services			
In-network:	$20 co-pay	$0 co-pay	$20 co-pay
Out-of-network:	$50 co-pay	$15 co-pay	$50 co-pay
Intensive cardiac rehabilitation services			
In-network:	$50 co-pay	$0 co-pay	$50 co-pay
Out-of-network:	$65 co-pay	$15 co-pay	$65 co-pay
Pulmonary rehabilitation services			
In-network:	$15 co-pay	$15 co-pay	$15 co-pay
Out-of-network:	$50 co-pay	$15 co-pay	$50 co-pay
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 FirstCarolinaCare.com/NHHA or your Evidence of Coverage for more information.			
In-network:	$0 co-pay	$0 co-pay	$0 co-pay
Out-of-network:	No coverage	No coverage	No coverage

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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, Cologuard fecal occult blood test, flexible sigmoidoscopy) • Depression screening • Diabetes screenings • HIV screening • Immunizations, including Covid-19, Respiratory syncytial virus (RSV), Flu shots, Hepatitis B shots, Pneumococcal shots and shingles 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 co-pay	$0 co-pay	$0 co-pay
Out-of-network:	$0 co-pay	$0 co-pay	$0 co-pay
EMERGENCY SERVICES			
Emergency care If you are admitted to the hospital, you do not have to pay your share of cost for emergency care. See the “Inpatient Hospital Care” section of this booklet for other costs.			
In-network:	$140 co-pay	$140 co-pay	$140 co-pay
Out-of-network:	$140 co-pay	$140 co-pay	$140 co-pay
Worldwide emergency care*	$140 co-pay	$140 co-pay	$140 co-pay
*10,000 annual limit for worldwide urgent or emergency coverage, including transportation outside the United States and its territories			
URGENT CARE SERVICES			
In-network:	$40 co-pay	$40 co-pay	$40 co-pay
Out-of-network:	$40 co-pay	$40 co-pay	$40 co-pay
Wordwide urgent care*	$40 co-pay	$40 co-pay	$40 co-pay
*10,000 annual limit for worldwide urgent or emergency coverage, including transportation outside the United States and its territories			
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 - $85 co-pay	$0 - $85 co-pay	$0 - $85 co-pay
Out-of-network:	40% of cost	40% of cost	40% of cost
Diagnostic radiology (such as MRIs, CT scans)			
In-network:	$0 - $275 co-pay	$0 - $275 co-pay	$0 - $275 co-pay
Out-of-network:	40% of cost	40% of cost	40% of cost

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Outpatient X-rays (such as X-rays and ultrasounds)			
In-network:	$0 - $100 co-pay	$0 - $100 co-pay	$0 - $100 co-pay
Out-of-network:	30% of cost	30% of cost	30% of cost
HEARING, DENTAL AND VISION			
Diagnostic hearing exam Exam to diagnose and treat hearing and balance issues.			
In-network:	$35 co-pay	$0 co-pay	$35 co-pay
Out-of-network:	$50 co-pay	$40 co-pay	$50 co-pay
Routine hearing exam (This is the non-Medicare covered exam to evaluate for hearing aid purchase.)	$0 co-pay	$0 co-pay	$0 co-pay
Hearing aids			
In-network:	$750 allowance per ear	$750 allowance per ear	$750 allowance per ear
Out-of-network:	No coverage	No coverage	No coverage
Medicare-covered 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 co-pay	$35 co-pay	$35 co-pay
Out-of-network:	$35 co-pay	$35 co-pay	$35 co-pay
Non-Medicare-covered dental services (up to $3,000 per plan year) These benefit options are included with your plan through New Hanover Health Advantage 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.			
Preventative dental services	2 oral exams, 2 cleanings per year, 1 set of X-rays per year: $0 co-pay	2 oral exams, 2 cleanings per year, 1 set of X-rays per year: $0 co-pay	2 oral exams, 2 cleanings per year, 1 set of X-rays per year: $0 co-pay
	Plan pays for covered services up to annual max benefit of $3,000; excluding members co-pay and co-insurance as applicable.		
Exam and cleaning			
In-network:	$0 co-pay	$0 co-pay	$0 co-pay
Out-of-network:	$0 co-pay	$0 co-pay	$0 co-pay

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Bitewing radiographs			
In-network:	$0 co-pay	$0 co-pay	$0 co-pay
Out-of-network:	$0 co-pay	$0 co-pay	$0 co-pay
Minor services Oral and maxillofacial surgery services, endodontics, periodontics, restorative, non-routine services			
In-network:	$35 co-pay plus 30%-50% co-insurance for minor dental services	$35 co-pay plus 30%-50% co-insurance for minor dental services	$35 co-pay plus 30%-50% co-insurance for minor dental services
Out-of-network:	$35 co-pay plus 30%-50% co-insurance for minor dental services	$35 co-pay plus 30%-50% co-insurance for minor dental services	$35 co-pay plus 30%-50% co-insurance for minor dental services
Major services Prosthodontics (fixed and removed), dentures, maxillofacial prosthetics, implant services, adjunctive general services			
In-network:	$35 co-pay plus 50% co-insurance for major dental services	$35 co-pay plus 50% co-insurance for major dental services	$35 co-pay plus 50% co-insurance for major dental services
Out-of-network:	$35 co-pay plus 50% co-insurance for major dental services	$35 co-pay plus 50% co-insurance for major dental services	$35 co-pay plus 50% co-insurance for major dental services
Eyewear after cataract surgery One pair of eyeglasses or contact lenses after cataract surgery.			
In-network:	20% of cost	20% of cost	20% of cost
Out-of-network:	20% of cost	20% of cost	20% of 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.			
Frames and lenses	$300 annual allowance	$300 annual allowance	$300 annual allowance
Glaucoma screening			
In-network:	$0 co-pay	$0 co-pay	$0 co-pay
Out-of-network:	$0 co-pay	$0 co-pay	$0 co-pay
Vision exam routine (1 exam per plan year)			
In-network:	$0 co-pay	$0 co-pay	$0 co-pay
Out-of-network:	Not covered	Not covered	Not covered
Vision exam (Medicare-covered)			
In-network:	$0 - $35 co-pay	$0 - $35 co-pay	$0 - $35 co-pay
Out-of-network:	$50 co-pay	$40 co-pay	$50 co-pay

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MENTAL HEALTH CARE			
Outpatient individual mental health therapy visit			
In-network:	$35 co-pay	$25 co-pay	$35 co-pay
Out-of-network:	$50 co-pay	$40 co-pay	$50 co-pay
Outpatient group mental health therapy visit			
In-network:	$35 co-pay	$25 co-pay	$35 co-pay
Out-of-network:	$50 co-pay	$40 co-pay	$50 co-pay
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 co-pay per day for days 1 through 10 $0 co-pay per day for days 11 through 90	$160 co-pay per day for days 1 through 10 $0 co-pay per day for days 11 through 90	$160 co-pay per day for days 1 through 10 $0 co-pay per day for days 11 through 90
Out-of-network:	$400 co-pay per day for days 1 through 8 $0 co-pay per day for days 9 through 90	$400 co-pay per day for days 1 through 8 $0 co-pay per day for days 9 through 90	$400 co-pay per day for days 1 through 8 $0 co-pay per day for days 9 through 90
SKILLED NURSING FACILITIES			
Skilled nursing facility (SNF) Our plan covers up to 100 days in an SNF (may require prior authorization).			
In-network:	$0 co-pay per day for days 1 through 20 $214 co-pay per day for days 21 through 41 $0 co-pay per day for days 42 through 100	$0 co-pay per day for days 1 through 20 $214 co-pay per day for days 21 through 41 $0 co-pay per day for days 42 through 100	$0 co-pay per day for days 1 through 20 $214 co-pay per day for days 21 through 41 $0 co-pay per day for days 42 through 100
Out-of-network:	$0 co-pay per day for days 1 through 20 $214 co-pay per day for days 21 through 41 $0 co-pay per day for days 42 through 100	$0 co-pay per day for days 1 through 20 $214 co-pay per day for days 21 through 41 $0 co-pay per day for days 42 through 100	$0 co-pay per day for days 1 through 20 $214 co-pay per day for days 21 through 41 $0 co-pay per day for days 42 through 100
PHYSICAL THERAPY			
Outpatient physical therapy (may require prior authorization)			
In-network:	$30 co-pay	$25 co-pay	$35 co-pay
Out-of-network:	$50 co-pay	$40 co-pay	$50 co-pay

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TRANSPORTATION SERVICES			
Ambulance, ground or air (Authorization required for non-emergency transportation by ambulance for same cost share.)			
In-network:	$265 co-pay	$265 co-pay	$265 co-pay
Out-of-network:	$265 co-pay	$265 co-pay	$265 co-pay
Transportation (within the U.S. and its territories)	26 one-way health-related trips, 25 miles from your permanent residence to an in-network location: $0 co-pay	26 one-way health-related trips, 25 miles from your permanent residence to an in-network location $0 co-pay	26 one-way health-related trips, 25 miles from your permanent residence to an in-network location: $0 co-pay
Worldwide emergency transportation *	$265 co-pay	$265 co-pay	$265 co-pay
*$10,000 annual limit for worldwide urgent or emergency coverage, including transportation outside the United States and its territories			
MEDICARE PART B DRUGS			
Medicare Part B drugs such as chemotherapy drugs (may require prior authorization)			
In-network:	0% - 20% of cost	0% - 20% of cost	0% - 20% of cost
Out-of-network:	20% of cost	20% of cost	20% of cost
Other Medicare Part B drugs (may require prior authorization)			
In-network:	0% - 20% of cost	0% - 20% of cost	0% - 20% of cost
Out-of-network:	20% of cost	20% of cost	20% of cost
PART D PRESCRIPTION DRUGS			
Catastrophic coverage			
After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $2,000, you enter the catastrophic coverage stage. During this stage, the plan pays the full cost of covered Part D drugs. You pay nothing and will remain in this phase until the end of the plan year.			
Costs may differ based on pharmacy type or status (e.g., mail order, long-term care [LTC] or home infusion, and 30, 60, 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.			
Important message about what you pay for vaccines — 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. **Important message about what you pay for insulin** — 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]*.			

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Initial coverage for standard retail cost-sharing						
	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network
Part D deductible	$100 (does not apply to Tier 1 and Tier 2)	$100 (does not apply to Tier 1 and Tier 2)	$0 deductible	$0 deductible	N/A	N/A
Tier 1 – preferred generic						
30-day supply	$0 co-pay	$0 co-pay	$0 co-pay	$0 co-pay	N/A	N/A
60-day supply	$0 co-pay	$0 co-pay	$0 co-pay	$0 co-pay	N/A	N/A
90-day supply	$0 co-pay	$0 co-pay	$0 co-pay	$0 co-pay	N/A	N/A
Tier 2 – generic						
30-day supply	$0 co-pay	$0 co-pay	$0 co-pay	$0 co-pay	N/A	N/A
60-day supply	$0 co-pay	$0 co-pay	$0 co-pay	$0 co-pay	N/A	N/A
90-day supply	$0 co-pay	$0 co-pay	$0 co-pay	$0 co-pay	N/A	N/A
Tier 3 – preferred brand						
30-day supply	25% of cost *(after deductible)*	25% of cost *(after deductible)*	25% of cost	25% of cost	N/A	N/A
60-day supply	25% of cost *(after deductible)*	25% of cost *(after deductible)*	25% of cost	25% of cost	N/A	N/A
90-day supply	25% of cost *(after deductible)*	25% of cost *(after deductible)*	25% of cost	25% of cost	N/A	N/A
Tier 4 – non-preferred drug						
30-day supply	50% of cost *(after deductible)*	50% of cost *(after deductible)*	50% of cost	50% of cost	N/A	N/A
60-day supply	50% of cost *(after deductible)*	50% of cost *(after deductible)*	50% of cost	50% of cost	N/A	N/A
90-day supply	50% of cost *(after deductible)*	50% of cost *(after deductible)*	50% of cost	50% of cost	N/A	N/A
Tier 5 – specialty tier						
30-day supply	31% of cost *(after deductible)*	31% of cost *(after deductible)*	33% of cost	33% of cost	N/A	N/A
Vaccine Tier						
In-network:	$0 co-pay	$0 co-pay	$0 co-pay	$0 co-pay	N/A	N/A
Out-of-network:	$0 co-pay	$0 co-pay	$0 co-pay	$0 co-pay	N/A	N/A

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Initial coverage for standard mail-order cost-sharing						
	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network
Tier 1 – preferred generic						
30-day supply	$2 co-pay		$5 co-pay		N/A	N/A
60-day supply	$4 co-pay		$10 co-pay			
90-day supply	$0 co-pay		$0 co-pay			
Tier 2 – generic						
30-day supply	$8 co-pay		$10 co-pay		N/A	N/A
60-day supply	$20 co-pay		$20 co-pay			
90-day supply	$0 co-pay		$0 co-pay			
Tier 3 – preferred brand						
30-day supply	25% of cost *(after deductible)*		25% of cost		N/A	N/A
60-day supply						
90-day supply						
Tier 4 – non-preferred drug						
30-day supply	50% of cost *(after deductible)*		50% of cost		N/A	N/A
60-day supply						
90-day supply						
Tier 5 – specialty tier						
30-day supply	31% of cost *(after deductible)*		33% of cost		N/A	N/A

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ADDITIONAL BENEFITS			
Acupuncture (Medicare covered)			
In-network:	$35 co-pay	$0 co-pay	$35 co-pay
Out-of-network:	$35 co-pay	$0 co-pay	$35 co-pay
Acupuncture (non-Medicare covered)			
In-network:	$35 co-pay	$0 co-pay	$35 co-pay
Out-of-network:	$35 co-pay	$0 co-pay	$35 co-pay
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 co-pay	$20 co-pay	$20 co-pay
Out-of-network:	$50 co-pay	$40 co-pay	$50 co-pay
Durable medical equipment Wheelchairs, oxygen, etc. (may require prior authorization)			
In-network:	20% of cost	20% of cost	20% of cost
Out-of-network:	20% of cost	20% of cost	20% of 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.			
In-network:	0%-20% of cost, depending on the supplier	0%-20% of cost, depending on the supplier	0%-20% of cost, depending on the supplier
Out-of-network:	20% of cost	20% of cost	20% of cost
Diabetes self-management training			
In-network:	$0 co-pay	$0 co-pay	$0 co-pay
Out-of-network:	$0 co-pay	$0 co-pay	$0 co-pay
Foot care (podiatry services) Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions.			
In-network:	$35 co-pay Routine foot care: not covered	$25 co-pay Routine foot care: not covered	$35 co-pay Routine foot care: not covered
Out-of-network:	$50 co-pay	$40 co-pay	$50 co-pay

	NEW HANOVER HEALTH ADVANTAGE SELECT (HMO-POS)	NEW HANOVER HEALTH ADVANTAGE PLATINUM (HMO-POS)	NEW HANOVER HEALTH ADVANTAGE FREEDOM (HMO-POS) (MA only)
Home health care			
In-network:	$0 co-pay	$0 co-pay	$0 co-pay
Out-of-network:	$0 co-pay	$0 co-pay	$0 co-pay
Hospice $0 co-pay for hospice care from a Medicare-certified hospice. You may have to pay part of costs for drugs and respite care. Hospice is covered by Original Medicare. Please contact us for more details.			
In-network:	$0 co-pay	$0 co-pay	$0 co-pay
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:	$20 co-pay	$0 co-pay	$20 co-pay
Out-of-network:	$50 co-pay	$15 co-pay	$50 co-pay
Outpatient occupational therapy visit (may require prior authorization)			
In-network:	$35 co-pay	$30 co-pay	$40 co-pay
Out-of-network:	$55 co-pay	$45 co-pay	$55 co-pay
Outpatient speech and language therapy visit (may require prior authorization)			
In-network:	$30 co-pay	$25 co-pay	$35 co-pay
Out-of-network:	$50 co-pay	$40 co-pay	$50 co-pay
Outpatient substance abuse group therapy visit			
In-network:	$35 co-pay	$25 co-pay	$35 co-pay
Out-of-network:	$50 co-pay	$40 co-pay	$50 co-pay
Outpatient substance abuse individual therapy visit			
In-network:	$35 co-pay	$25 co-pay	$35 co-pay
Out-of-network:	$50 co-pay	$40 co-pay	$50 co-pay
Outpatient surgery at an outpatient hospital (may require prior authorization)			
In-network:	$265 co-pay	$250 co-pay	$300 co-pay
Out-of-network:	$450 co-pay	$350 co-pay	$450 co-pay

	NEW HANOVER HEALTH ADVANTAGE SELECT (HMO-POS)	NEW HANOVER HEALTH ADVANTAGE PLATINUM (HMO-POS)	NEW HANOVER HEALTH ADVANTAGE FREEDOM (HMO-POS) (MA only)
Prosthetic devices and related medical supplies Braces, artificial limbs, etc. (may require prior authorization)			
In-network:	20% of cost	20% of cost	20% of cost
Out-of-network:	20% of cost	20% of cost	20% of cost
Renal dialysis			
In-network:	20% of cost	20% of cost	20% of cost
Out-of-network:	20% of cost	20% of cost	20% of cost
Therapeutic shoes or inserts for diabetics			
In-network:	20% of cost	20% of cost	20% of cost
Out-of-network:	20% of cost	20% of cost	20% of cost
EXTRAS			
Over-the-counter items Our plan covers a quarterly over-the-counter (OTC) benefit, which allows you to purchase OTC products. OTC quarterly limits do not carry forward. This allowance can be spent on a variety of brand-name and generic health and wellness products. You may qualify for up to an additional $50 in over-the-counter benefits upon completion of an Annual Wellness Visit and Health Risk Assessment.			
	$100 quarterly	$120 quarterly	$90 quarterly
Post-hospitalization meals	Plan provides the meal benefit post-discharge to any congestive heart failure member, diabetes member, or any member with 2 or more of the top 5 chronic conditions (asthma, CHF, COPD, diabetes, vascular) who has an inpatient stay for any reason or is discharged from a skilled nursing facility, or discharged from an inpatient hospital with Home Care. Plan provides up to 2 home delivered meals per day, for up to 14 days. Up to 3 instances.		

FirstCarolinaCare Insurance Company's plans are HMO and PPO plans with a Medicare contract. Enrollment in a FirstCarolinaCare plan depends on contract renewal.

Out-of-network/non-contracted providers are under no obligation to treat New Hanover Health Advantage 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.

FirstCarolinaCare
INSURANCE COMPANY

Form Approved
OMB #0938-1421

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 .

Form CMS-10802
(Expires 12/31/25)

FirstCarolinaCare
INSURANCE COMPANY

Form Approved
OMB #0938-1421

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 على (877-210-9167(TTY:711 . سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

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。

Form CMS-10802
(Expires 12/31/25)

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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 (including discrimination on the basis of sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity; and sex stereotypes).
FirstCarolinaCare Insurance Company does not exclude people or treat them differently because of race, color, national origin, age, disability or sex (including discrimination on the basis of sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity; and sex stereotypes).

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 Customer Service. 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 (including discrimination on the basis of sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity; and sex stereotypes), you can file a grievance with: FirstCarolinaCare Insurance Company, Customer Service, 3310 Fields South Drive, Champaign, Illinois 61822, telephone: (800) 481-1092, fax: (217) 902-9705, CustomerService@FirstCarolinaCare.com.

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

NewHanoverHealthAdvantage.com

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