healthteam advantage℠

2024

Summary of Benefits

HealthTeam Advantage Plan I (PPO) H9808-004

HealthTeam Advantage Plan II (PPO) H9808-005

2024
Summary of Benefits

HealthTeam Advantage Plan I (PPO)
HealthTeam Advantage Plan II (PPO)

This is a summary of drug and health services covered by HealthTeam Advantage PPO.

January 1, 2024 - December 31, 2024.

The benefit information provided is a summary of what we 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 refer to your Evidence of Coverage booklet. You can request a copy from your Healthcare Concierge or view it on the website at www.HealthTeamAdvantage.com.

To join a HealthTeam Advantage PPO Health Plan, 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: Alamance, Caswell, Davidson, Davie, Forsyth, Guilford, Montgomery, Orange, Randolph, Rockingham, Stokes, and Yadkin.

HealthTeam Advantage has a network of doctors, hospitals, pharmacies and other providers. If you use the providers in our network, you may pay less for your covered services. You also have the option of using providers outside the network, however you will have higher costs associated with those visits and services.

For more information, contact the plan at 1-888-965-1965 (TTY: 711) from 8 a.m. to 8 p.m. Eastern, 7 days a week from October 1 – March 31, and 8 a.m. to 8 p.m. Eastern, Monday through Friday, April 1 – September 30, or visit us online at www.healthteamadvantage.com. HealthTeam Advantage, a product of Care N' Care Insurance Company of North Carolina, Inc., is a Medicare Advantage organization with a Medicare contract. Enrollment in HealthTeam Advantage depends on contract renewal.

Premiums and Benefits	HealthTeam Advantage Plan I (PPO)	HealthTeam Advantage Plan II (PPO)
Monthly Plan Premium	**$0**	**$50**
	You must continue to pay your Medicare Part B premium.	
Deductible	**$0**	**$0**
	These plans do not have a deductible for medical services.	
Maximum Out-of-Pocket Responsibility *(does not include prescription drugs)*	**In-Network: $3,200** annually **Out-of-Network: $5,750** annually	**In-Network: $3,000** annually **Out-of-Network: $5,500** annually
	The most you pay for copays, coinsurance, and other costs for medical services for the year.	
Inpatient Hospital Coverage		
	In-Network: **$295** copay per day for days 1 through 6 **$0** copay per day for days 7 through 90 **$0** copay for days 91 and beyond **Out-of-Network:** **$650** copay per day for days 1 through 6 **$0** copay per day for days 7 through 90 **$0** copay for days 91 and beyond	**In-Network:** **$200** copay per day for days 1 through 5 **$0** copay per day for days 6 through 90 **$0** copay for days 91 and beyond **Out-of-Network:** **$500** copay per day for days 1 through 6 **$0** copay per day for days 7 through 90 **$0** copay for days 91 and beyond
	Our plan covers an unlimited number of days for an inpatient hospital stay. Prior authorization may be required.	
Outpatient Hospital Coverage		
• Outpatient Hospital Facility	**In-Network: $250** copay **Out-of-Network: $350** copay	**In-Network: $200** copay **Out-of-Network: $300** copay
	Prior authorization may be required for some services. Please contact the plan for more information.	

Premiums and Benefits	HealthTeam Advantage Plan I (PPO)	HealthTeam Advantage Plan II (PPO)
Ambulatory Surgical Center		
	In-Network: **$200** copay per day **Out-of-Network:** **$250** copay per day Prior authorization may be required for some services. Please contact the plan for more information.	**In-Network:** **$100** copay per day **Out-of-Network:** **$200** copay per day
Doctor Visits		
• Primary Care Provider (PCP)	**In-Network: $0** copay **Out-of-Network: $50** copay	**In-Network: $0** copay **Out-of-Network: $30** copay
• Specialist	**In-Network: $20** copay **Out-of-Network: $75** copay	**In-Network: $10** copay **Out-of-Network: $50** copay
Preventive Care (e.g., flu vaccine, diabetic screenings)		
	In-Network: $0 copay **Out-of-Network: $30** copay Any additional preventive services approved by Medicare during the contract year will be covered. There are some items not covered at **$0** cost.	**In-Network: $0** copay **Out-of-Network: $30** copay
Emergency Care		
	In- and Out-of-Network: **$135** copay If you are admitted to the hospital for the same condition within 3 days, the emergency copay is waived.	**In- and Out-of-Network:** **$110** copay

Premiums and Benefits *(continued)*	HealthTeam Advantage Plan I (PPO)	HealthTeam Advantage Plan II (PPO)
Urgently-needed Services		
	In- and Out-of-Network: **$20** copay	**In- and Out-of-Network:** **$10** copay If you are admitted to the hospital within 1 calendar day for the same condition, you do not have to pay your share coinsurance for urgent care.
Diagnostic Services/Labs/Imaging		
• Diagnostic Radiology Services (such as MRIs, CT scans)	**In-Network: $0** to **$200** copay **Out-of-Network:** **$75** to **$250** copay	**In-Network: $0** to **$175** copay **Out-of-Network:** **$75** to **$200** copay
• Lab Services at a lab facility	**In-Network:** **$0** copay at a lab facility **Out-of-Network:** **$10** copay at a lab facility	**In-Network:** **$0** copay at a lab facility **Out-of-Network:** **$10** copay at a lab facility
• Lab Services at an outpatient hospital facility	**In-Network:** **$10** copay at an outpatient hospital facility **Out-of-Network:** **$25** copay at an outpatient hospital facility	**In-Network:** **$10** copay at an outpatient hospital facility **Out-of-Network:** **$25** copay at an outpatient hospital facility
• Diagnostic Tests and Procedures at a lab facility	**In-Network:** **$0** copay at a lab facility **Out-of-Network:** **$10** copay at a lab facility	**In-Network:** **$0** copay at a lab facility **Out-of-Network:** **$10** copay at a lab facility
• Diagnostic Tests and Procedures at an outpatient hospital facility	**In-Network:** **$5** copay at an outpatient hospital facility **Out-of-Network:** **$25** copay at an outpatient hospital facility	**In-Network:** **$5** copay at an outpatient hospital facility **Out-of-Network:** **$25** copay at an outpatient hospital facility
	Prior authorization may be required for some services. Please contact the plan for more information.	

Premiums and Benefits *(continued)*	HealthTeam Advantage Plan I (PPO)	HealthTeam Advantage Plan II (PPO)
Diagnostic Services/Labs/ Imaging *(continued)*		
• Outpatient X-rays included with physician visit	**In-Network:** **$5** copay for X-ray services included with a physician visit **Out-of-Network:** **$10** copay for X-ray services included with a physician visit	**In-Network:** **$0** copay for X-ray services included with a physician visit **Out-of-Network:** **$10** copay for X-ray services included with a physician visit
• Outpatient X-rays at an outpatient facility	**In-Network:** **$5** copay for X-ray services at an outpatient facility **Out-of-Network:** **$25** copay for X-ray services at an outpatient facility	**In-Network:** **$0** copay for X-ray services at an outpatient facility **Out-of-Network:** **$25** copay for X-ray services at an outpatient facility
Hearing Services		
• Medicare-covered Diagnostic Hearing Exam	**In-Network:** **$30** copay for a hearing exam **Out-of-Network:** **$45** copay for a hearing exam 1 per year	**In-Network:** **$20** copay for a hearing exam **Out-of-Network:** **$45** copay for a hearing exam
• Routine Assessment for Hearing Aids	**In-Network: $25** copay **Out-of-Network:** not covered 1 per year A TruHearing provider must be used for routine hearing benefits.	**In-Network: $0** copay **Out-of-Network:** not covered
• Fitting and Evaluation for Hearing Aid	**In-Network: $0** copay **Out-of-Network:** not covered Unlimited visits A TruHearing provider must be used for routine hearing benefits.	**In-Network: $0** copay **Out-of-Network:** not covered
• Hearing Aid	**In-Network:** **$299-$799** per hearing aid. Advanced and premium hearing aids are available in rechargeable style options for an additional **$50** per aid. **Out-of-Network:** Not covered Up to two TruHearing hearing aids every year (one per ear per year). A TruHearing provider must be used for hearing aid benefit.	**In-Network:** **$299-$799** per hearing aid. Advanced and premium hearing aids are available in rechargeable style options at no additional cost per aid. **Out-of-Network:** Not covered

Premiums and Benefits *(continued)*	HealthTeam Advantage Plan I (PPO)	HealthTeam Advantage Plan II (PPO)
In-Network Dental Services (Delta Dental NC Medicare Advantage or Delta Dental PPO network)		
	$3,000 allowance with annual deductible of **$50** for Comprehensive Services to include Basic and Major Services. Deductible does not apply for preventive services such as oral exams and cleanings.	
• Routine Dental/Preventive Services	Preventive oral exams, cleanings, X-rays, and routine dental services are covered at no cost to you. Maximum combined dental services allowance is **$3,000** annually.*	Preventive oral exams, cleanings, X-rays, and routine dental services are covered at no cost to you. Maximum combined dental services allowance is **$3,000** annually.*
• Non-Medicare Covered Comprehensive Dental Services	Comprehensive dental services such as fillings, dentures, crowns, extractions, implants, and periodontics procedures are covered. Maximum combined dental services allowance is **$3,000** annually.*[2]	Comprehensive dental services such as fillings, dentures, crowns, extractions, implants, and periodontics procedures are covered. Maximum combined dental services allowance is **$3,000** annually.*[2]
Out-of-Network		
	$500 maximum allowance (this amount is part of the overall $3,000 combined Maximum Dental Benefit Amount for both Routine Dental/Preventive and Comprehensive Dental non-Medicare covered services), with annual deductible of **$50** for Comprehensive Services to include Basic and Major Services. Deductible does not apply for preventive services such as oral exams and cleanings.	
• Routine Dental/Preventive Services	Preventive oral exams, cleanings, and routine dental services are covered at 50% coinsurance. X-rays are covered at 50% coinsurance. Maximum combined dental services allowance is **$500** annually.*	Preventive oral exams, cleanings, and routine dental services are covered at 50% coinsurance. X-rays are covered at 50% coinsurance. Maximum combined dental services allowance is **$500** annually.*
• Non-Medicare Covered Comprehensive Dental Services	Comprehensive dental services such as fillings, dentures, crowns, extractions, implants, and periodontics procedures are covered at 50% coinsurance. Maximum combined dental services allowance is **$500** annually.*[2]	Comprehensive dental services such as fillings, dentures, crowns, extractions, implants, and periodontics procedures are covered at 50% coinsurance. Maximum combined dental services allowance is **$500** annually.*[2]

** Frequency limits apply.*

[2] Covered in-network dental services will have a 0%-20% cost share. All out-of-network Routine Dental/Preventive and Comprehensive Services will have a 50% cost share.

Premiums and Benefits *(continued)*	HealthTeam Advantage Plan I (PPO)	HealthTeam Advantage Plan II (PPO)
Vision Services		
• Medicare-covered Diagnostic Eye Exam	**In-Network: $0** copay **Out-of-Network: $30** copay	**In-Network: $0** copay **Out-of-Network: $30** copay
• Medicare-covered Eye Wear	**In-Network:** **$0** copay for Medicare-covered frames or contact lenses after cataract surgery with a maximum benefit amount not to exceed **$100**. **Out-of-Network:** **$50** copay for Medicare-covered eyeglasses or contact lenses after cataract surgery with a maximum benefit amount not to exceed **$100**. 1 per year Materials covered up to Medicare-approved limits.	**In-Network:** **$0** copay for Medicare-covered eyeglasses or contact lenses after cataract surgery with a maximum benefit amount not to exceed **$100**. **Out-of-Network:** **$50** copay for Medicare-covered eyeglasses or contact lenses after cataract surgery with a maximum benefit amount not to exceed **$100**.
• Routine Eye Exam (non-Medicare covered)	**In-Network: $0** copay **Out-of-Network:** **$30** copay (One routine eye exam per year) Refraction included	**In-Network: $0** copay **Out-of-Network:** **$30** copay (One routine eye exam per year)
• Eyeglasses (lenses and frames) • Contact Lenses • Lens Enhancements	**In-Network:** Reimbursed up to **$200** towards eye wear, including contact lenses. Single vision, lined bifocals, lined trifocals, lenticular lenses, standard progressive lenses, and scratch-resistant coating are covered in full. **$60** contact lens fitting/evaluation **Out-of-Network:** Reimbursed up to **$50** for 1 pair of eyeglasses or 1 pair of contact lenses every year. Single vision, lined bifocals, lined trifocals, lenticular lenses, standard progressive lenses, and scratch-resistant coating are covered in full.	**In-Network:** Reimbursed up to **$200** towards eye wear, including contact lenses. Single vision, lined bifocals, lined trifocals, lenticular lenses, standard progressive lenses, and scratch-resistant coating are covered in full. **$60** contact lens fitting/evaluation **Out-of-Network:** Reimbursed up to **$50** for 1 pair of eyeglasses or 1 pair of contact lenses every year. Single vision, lined bifocals, lined trifocals, lenticular lenses, standard progressive lenses, and scratch-resistant coating are covered in full.

Premiums and Benefits *(continued)*	HealthTeam Advantage Plan I (PPO)	HealthTeam Advantage Plan II (PPO)
Mental Health Services		
Inpatient Visit	**In-Network:** **$295** copay per day for days 1 through 6 **$0** copay per day for days 7 through 90 **Out-of-Network:** 50% coinsurance Services require prior authorization.	**In-Network:** **$200** copay per day for days 1 through 5 **$0** copay per day for days 6 through 90 **Out-of-Network:** 35% coinsurance
Outpatient Individual Therapy Visit	**In-Network:** **$25** copay **Out-of-Network:** **$75** copay	**In-Network:** **$15** copay **Out-of-Network:** **$50** copay
Outpatient Group Therapy Visit	**In-Network:** **$25** copay **Out-of-Network:** **$75** copay	**In-Network:** **$15** copay **Out-of-Network:** **$50** copay
Skilled Nursing Facility		
	In-Network: **$0** copay per day for days 1 through 20 **$203** copay per day for days 21 through 100 **Out-of-Network:** **$50** copay per day for days 1 through 20 **$203** copay per day for days 21 through 100 Our plan covers up to 100 days in a SNF. Services require prior authorization.	**In-Network:** **$0** copay per day for days 1 through 20 **$203** copay per day for days 21 through 100 **Out-of-Network:** **$50** copay per day for days 1 through 20 **$203** copay per day for days 21 through 100

Premiums and Benefits *(continued)*	HealthTeam Advantage Plan I (PPO)	HealthTeam Advantage Plan II (PPO)
Rehabilitation Services		
• Physical Therapy Visit	**In-Network: $15** copay **Out-of-Network: $75** copay	**In-Network: $10** copay **Out-of-Network: $50** copay
• Speech and Language Therapy Visit	**In-Network: $15** copay **Out-of-Network: $75** copay	**In-Network: $10** copay **Out-of-Network: $50** copay
• Occupational Therapy Visit	**In-Network: $15** copay **Out-of-Network: $30** copay	**In-Network: $10** copay **Out-of-Network: $30** copay
Ambulance		
	In- and Out-of-Network: **$250** copay for Medicare-covered ambulance benefits per one-way trip. **$300** copay for Medicare-covered air ambulance benefits per one-way trip. Prior authorization required for non-emergency transportation.	**In- and Out-of-Network:** **$200** copay for Medicare-covered ambulance benefits per one-way trip. **$300** copay for Medicare-covered air ambulance benefits per one-way trip.
Transportation		
	Not covered.	Not covered.
Medicare Part B Drugs		
	In-Network: 20% coinsurance **Out-of-Network:** 30% coinsurance Prior authorization may be required.	**In-Network:** 20% coinsurance **Out-of-Network:** 30% coinsurance

Premiums and Benefits *(continued)*	**HealthTeam Advantage Plan I (PPO)**			
Outpatient Prescription Drugs				
Phase 1: Deductible	**$0** Because there is no prescription drug deductible for the plan, this payment phase does not apply to you. You begin in the Initial Coverage phase when you fill your first prescription of the year.			
Phase 2: Initial Coverage	**In-Network Retail** (After you pay your deductible, if applicable)			
	Preferred Pharmacies		**Other Retail Pharmacies**	
	30-day supply	**100-day supply**	**30-day supply**	**100-day supply**
Tier 1 - Preferred Generics	**$0** copay	**$0** copay	**$5** copay	**$10** copay
Tier 2 - Generics	**$5** copay	**$10** copay	**$15** copay	**$30** copay
Tier 3 - Preferred Brands	**$47** copay	**$94** copay	**$47** copay	**$94** copay
Tier 4 - Non-Preferred Drugs	**$100** copay	**$200** copay	**$100** copay	**$200** copay
Tier 5 - Specialty Drugs	33% coinsurance	33% coinsurance	33% coinsurance	33% coinsurance
	In-Network Mail Order (After you pay your deductible, if applicable)			
	Preferred* Mail Order		**Other Mail Order Pharmacies**	
	30-day supply	**100-day supply**	**30-day supply**	**100-day supply**
Tier 1 - Preferred Generics	**$0** copay	**$0** copay	**$5** copay	**$10** copay
Tier 2 - Generics	**$5** copay	**$10** copay	**$15** copay	**$30** copay
Tier 3 - Preferred Brands	**$47** copay	**$94** copay	**$47** copay	**$94** copay
Tier 4 - Non-Preferred Drugs	**$100** copay	**$200** copay	**$100** copay	**$200** copay
Tier 5 - Specialty Drugs	33% coinsurance	33% coinsurance	33% coinsurance	33% coinsurance
Phase 3: Coverage Gap (After the total amount for the prescription drugs you have filled and refilled reaches **$5,030**)	During this stage, you pay 25 percent of the total cost for brand name and generic drugs PLUS a portion of the dispensing fee. Tier 1 generics are covered at same copay as in the initial coverage stage (see EOC for details). You won't pay more than **$35** for a one-month supply of each covered insulin product regardless of the cost-sharing tier. **Once your out-of-pocket costs reach $8,000 (2024), you move to catastrophic coverage.**			
Phase 4: Catastrophic Coverage (After your out-of- pocket costs have reached the **$8,000** limit for the calendar year)	In this stage, the plan pays the full cost for your covered Part D drugs. You pay nothing. (See the EOC for details). **The plan and Medicare pay the rest until the end of the calendar year.**			

Premiums and Benefits *(continued)*	HealthTeam Advantage Plan II (PPO)			
Outpatient Prescription Drugs				
Phase 1: Deductible	**$0** Because there is no prescription drug deductible for the plan, this payment phase does not apply to you. You begin in the Initial Coverage phase when you fill your first prescription of the year.			
Phase 2: Initial Coverage	**In-Network Retail** (After you pay your deductible, if applicable)			
	Preferred Pharmacies		**Other Retail Pharmacies**	
	30-day supply	**100-day supply**	**30-day supply**	**100-day supply**
Tier 1 - Preferred Generics	**$0** copay	**$0** copay	**$0** copay	**$0** copay
Tier 2 - Generics	**$0** copay	**$0** copay	**$12** copay	**$24** copay
Tier 3 - Preferred Brands	**$47** copay	**$94** copay	**$47** copay	**$94** copay
Tier 4 - Non-Preferred Drugs	**$100** copay	**$200** copay	**$100** copay	**$200** copay
Tier 5 - Specialty Drugs	33% coinsurance	33% coinsurance	33% coinsurance	33% coinsurance
	In-Network Mail Order (After you pay your deductible, if applicable)			
	Preferred* Mail Order		**Other Mail Order Pharmacies**	
	30-day supply	**100-day supply**	**30-day supply**	**100-day supply**
Tier 1 - Preferred Generics	**$0** copay	**$0** copay	**$0** copay	**$0** copay
Tier 2 - Generics	**$0** copay	**$0** copay	**$12** copay	**$24** copay
Tier 3 - Preferred Brands	**$47** copay	**$94** copay	**$47** copay	**$94** copay
Tier 4 - Non-Preferred Drugs	**$100** copay	**$200** copay	**$100** copay	**$200** copay
Tier 5 - Specialty Drugs	33% coinsurance	33% coinsurance	33% coinsurance	33% coinsurance
Phase 3: Coverage Gap (After the total amount for the prescription drugs you have filled and refilled reaches **$5,030**)	During this stage, you pay 25 percent of the total cost for brand name and generic drugs PLUS a portion of the dispensing fee. Tier 1 generics are covered at same copay as in the initial coverage stage (see EOC for details). You won't pay more than **$35** for a one-month supply of each covered insulin product regardless of the cost-sharing tier. **Once your out-of-pocket costs reach $8,000 (2024), you move to catastrophic coverage.**			
Phase 4: Catastrophic Coverage (After your out-of- pocket costs have reached the **$8,000** limit for the calendar year)	In this stage, the plan pays the full cost for your covered Part D drugs. You pay nothing. (See the EOC for details). **The plan and Medicare pay the rest until the end of the calendar year.**			

** For more information regarding our 2024 preferred pharmacy locations, please see page 17 or your Evidence of Coverage.*

Premiums and Benefits *(continued)*	HealthTeam Advantage Plan I (PPO)	HealthTeam Advantage Plan II (PPO)
Over-the-Counter (OTC) Items		
	$40/Quarter	**$75**/Quarter
	Allowance per quarter for OTC items. Any unused portion can be carried forward to the next quarter. All funds must be used by 12/31/24.	
Foot Care (podiatry services)		
• Foot Exams and Treatment	**In-Network: $25** copay **Out-of-Network: $75** copay	**In-Network: $15** copay **Out-of-Network: $50** copay
Medical Equipment/Supplies		
• Durable Medical Equipment (e.g., wheelchairs, oxygen, braces)	**In-Network:** 20% coinsurance **Out-of-Network:** 50% coinsurance Services require prior authorization.	**In-Network:** 20% coinsurance **Out-of-Network:** 30% coinsurance
• Prosthetics (e.g., artificial limbs)	**In-Network:** 20% coinsurance **Out-of-Network:** 50% coinsurance Services require prior authorization.	**In-Network:** 20% coinsurance **Out-of-Network:** 30% coinsurance
• Diabetes Supplies	**In-Network:** **$0** copay for preferred and 20% coinsurance for non-preferred **Out-of-Network:** 20% coinsurance Diabetic Supplies and Services limited to those from the following manufacturers: - Blood Glucose Meter and testing supplies - One Touch - Continuous Glucose Monitor and supplies - FreeStyle Libre Authorization required for non-preferred. **$0** copay for one pair of Medicare-covered therapeutic shoes and up to two pairs of inserts.	**In-Network:** **$0** copay for preferred and 20% coinsurance for non-preferred **Out-of-Network:** 20% of the cost

Premiums and Benefits *(continued)*	HealthTeam Advantage Plan I (PPO)	HealthTeam Advantage Plan II (PPO)
Wellness Programs Health Club Membership		
	In-Network: $0 copay	**In-Network: $0** copay
	You must choose from a SilverSneakers® participating facility.	
Memory Fitness		
	$0 copay	**$0** copay
	Online program offered through BrainHQ with dozens of exercises to improve focus and memory.	
Custodial Care		
	In-Network: $0 copay	**In-Network: $0** copay
	Out-of-Network: **$30** copay per hour	**Out-of-Network:** **$30** copay per hour
	Up to 20 hours post-inpatient discharge or qualifying outpatient procedure, maximum of 60 hours annually.	
	Prior authorization is required for some services. Please contact the plan for more information.	
In-Home Support/Companion Services		
	In-Network: $0	**In-Network: $0**
	Up to 30 hours per year with Papa Pal companionship services.	
	No coverage for companionship services when not administered by Papa.	
Meal Delivery		
	2 meals per day for 14 days post discharge.	2 meals per day for 14 days post discharge.
Telehealth Services		
	In-Network: $0 copay	**In-Network: $0** copay
	Out-of-Network: **$0** copay	**Out-of-Network:** **$0** copay
	If you choose to receive services via telehealth, you must use a provider that currently offers the service via telehealth.	

If you want to know more about the coverage and costs of original Medicare, review your current "Medicare & You" handbook. View it online at www.medicare.gov or get a copy 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. This document is available in other formats such as braille, large print or other alternate formats.

You can access our Provider/Pharmacy Directory and the complete plan formulary (list of Part D prescription drugs) as well as any restrictions on our website, www.HealthTeamAdvantage.com.

We cover Part D drugs and Part B drugs (such as chemotherapy and some drugs administered by your provider).

HealthTeam Advantage complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATTENTION: If you speak Spanish or Chinese, language assistance services, free of charge, are available to you. Call 1-877-905-9216 (TTY:711).

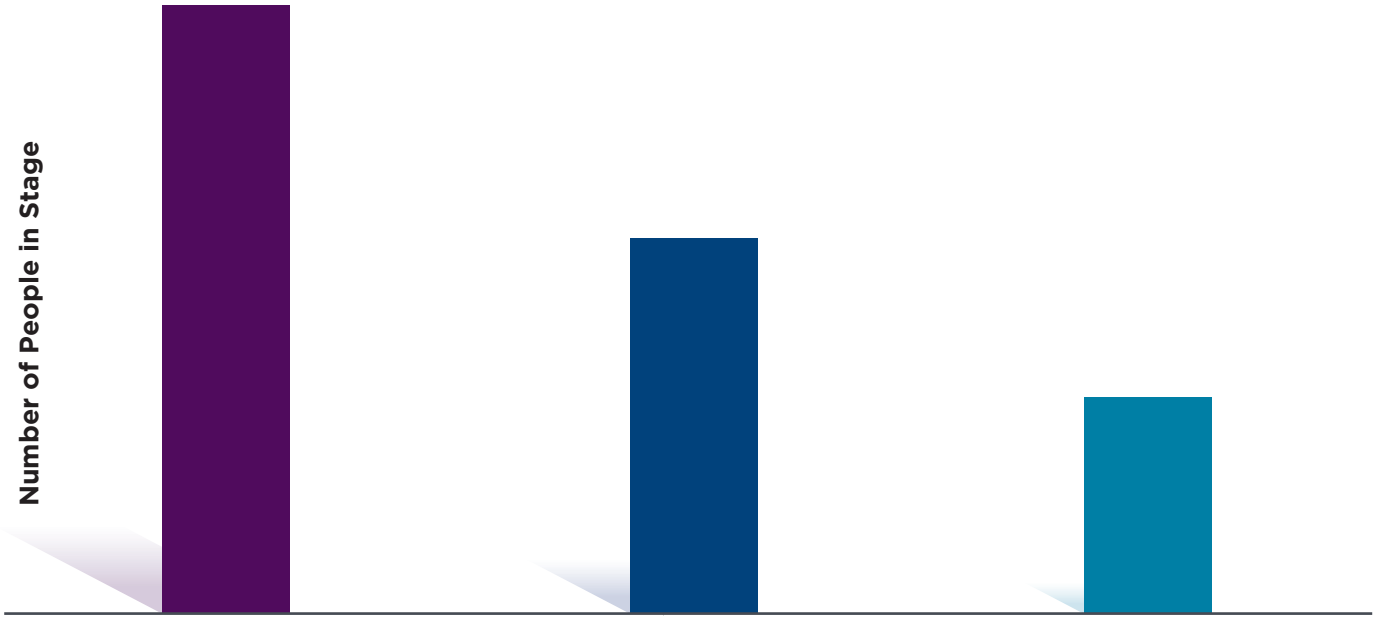
HealthTeam Advantage cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.

Llame al 1-877-905-9216 (TTY: 711). 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人。

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-905-9216 (TTY: 711)

Understanding Drug Payment Stages



Initial Coverage Stage

During this stage, you pay a flat fee (copay) or a percentage of a drug's total cost (coinsurance) for each prescription you fill.

You won't pay more than $35 for a one-month supply of each covered insulin product regardless of the cost-sharing tier.

The plan pays the rest until your total drug costs (paid by you and the plan) reach $5,030 (2024).

Coverage Gap Stage

During this stage, you pay 25 percent of the total cost for brand name and generic drugs PLUS a portion of the dispensing fee. Tier 1 generics are covered at same copay as in the initial coverage stage (see EOC for details).

You won't pay more than $35 for a one-month supply of each covered insulin product regardless of the cost-sharing tier

Once your out-of-pocket costs reach $8,000 (2024), you move to catastrophic coverage.

Catastrophic Coverage Stage

In this stage, the plan pays the full cost for your covered Part D drugs. You pay nothing. (See the EOC for details).

The plan and Medicare pay the rest until the end of the calendar year.

Non-Discrimination Notice

HealthTeam Advantage complies with applicable federal civil rights laws and does not discriminate based on race, color, national origin, age, disability, or sex. HealthTeam Advantage does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

HealthTeam Advantage:

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 your Healthcare Concierge at 888-965-1965 (TTY: 711) October 1-March 31, 8 a.m. to 8 p.m. ET, 7 days a week; April 1-September 30, 8 a.m. to 8 p.m. ET, Monday through Friday.

If you believe that HealthTeam Advantage has failed to provide these services or discriminated in another way based on race, color, national origin, age, disability, or sex, you can file a grievance with:

HealthTeam Advantage
Attn: Appeals and Grievances
300 East Wendover Ave, Suite 121
Greensboro, North Carolina, 27401
888-965-1965, (TTY 711), or via fax at 800-845-4104

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Appeals and Grievances Department 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/smartscreen/main.jsf, by email OCRMail@hhs.gov, by phone 1-888-368-1019, TDD: 1-800-537-7697, or by mail U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201.

Get Help in Other Languages

If you need help or speak a non-English language, call 888-965-1965 TTY: 711, and you will be connected to an interpreter who will assist you at no cost.

Non-Discrimination Notice

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llameal 1-888-965-1965 TTY: 711.

French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. **Appelez** le 1-888-965-1965 ATS: 711.

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen Verfügung. Rufnummer: 1-888-965-1965 TTY: 711.

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-965-1965 телетайп: 711.

Gujarati: સચના: જો તમે ગજરાતી બોલતા હો, તો નન:શલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો **1-888-965-1965 TTY711.**

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-965-1965 TTY711.

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-888-965-1965 TTY: 711.**。

Japanese: **注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。 1-888-965-1965 TTY: 711.** まで、お電話にてご連絡ください。

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1- 888-965-1965 TTY: 711** 번으로 전화해 주십시오.

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-965-1965 TTY: 711.

Hindi: ध्यान द:यदद आप ह दिी बोलते है तो आपके दलए मफ्ु त मे भाषा सहायता सेवाएं उपलब्ध है। **1-888-965-1965 TTY: 711** पर कॉल करे।

Laotian: ໂປດຊາບ: ຖ້າ ທ່ ານ ເວ ົ້ າພາສາ ລາວ, ການບໍລິການຊ່ ວຍເຫ ຼືອ ແນ ່ ໃ ສ ່ ຟ ຣ ີ ທ ່ ານ. ໂທ **1-888-965-1965 TTY: 711.** ຂ ້ າພພາສາ, ໂດຍບ ່ ສ ັ ງ ເ ,

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-888-965-1965 TTY: 711.

Cambodian: ប្រយ័ត្ន៖ បរើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, បសវាជំនួយខ្នកភាសា បយោយមិនគិតឈ្នួល គឺអាចមានសំរាំរបរើអ្នក។ ចូរ ទូរស័ព្ទ **1-888-965-1965 TTY: 711**។

(Arabic):
ب ر ق م ا ت ص ل. ب ا ل ا ج م ن ل ك ت اوت ف ا ر ل ل غ ي ة ا ل م س ع د خ د م ا ت ف إ ن ا ل ل غ ة، ذ ا ك ر ت ت ح ث ك
ن ت إ ذ ا :م ح ظ 1-888-965-1965 (711: TTY)

CONTACT INFORMATION

Online
Visit **HTANC.com**.

Address
300 East Wendover Ave, Suite 121
Greensboro, North Carolina, 27401

Sales
Prospective members call toll-free 877-905-9216 for questions related to our Medicare Advantage Plans.

October 1-March 31, 8 a.m. to 8 p.m. ET, seven days a week.
April 1-September 30, 8 a.m. to 8 p.m. ET, Monday through Friday.

TTY Users
TTY users call toll-free 711 for questions related to our Medicare Advantage Plans.

Prescription Drug Benefit
Prospective members call toll-free 877-905-9216 for questions related to our Part D Prescription Drug Benefit.

Medicare
For more information about Medicare, call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048. Or, visit Medicare.gov.

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