2020
Summary of Benefits

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2020
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, 2020 - December 31, 2020.

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, Davidson, Davie, Forsyth, Guilford, Randolph, and Rockingham.

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 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.

Premiums and Benefits	HealthTeam Advantage Plan I (PPO)	HealthTeam Advantage Plan II (PPO)	What You Should Know
Monthly Plan Premium	$0	$60	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:** $3,400 annually **Out-of-Network:** $5,100 annually	**In-Network:** $3,100 annually **Out-of-Network:** $5,100 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 **Out-of-Network:** $500 copay per day for days 1 through 6 $0 copay per day for days 7 through 90	**In-Network:** $250 copay per day for day 1 $125 copay per day for days 2 through 6 $0 copay per day for days 7 through 90 **Out-of-Network:** $500 copay per day for days 1 through 6 $0 copay per day for days 7 through 90	Our plan covers an unlimited number of days for an inpatient hospital stay. Prior authorization may be required.
Outpatient Hospital Coverage			
• Outpatient Hospital Facility • Observation Services	**In-Network:** $225 copay **Out-of-Network:** $300 copay **In-Network:** $225 copay **Out-of-Network:** $300 copay	**In-Network:** $175 copay **Out-of-Network:** $300 copay **In-Network:** $175 copay **Out-of-Network:** $300 copay	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)	What You Should Know
Ambulatory Surgery Center			
	In-Network: $175 copay per day **Out-of-Network**: $225 copay per day	**In-Network:** $175 copay per day **Out-of-Network:** $200 copay per day	Prior authorization may be required for some services. Please contact the plan for more information.
Doctor Visits			
• Primary Care Physician (PCP)	**In-Network:** $0 copay **Out-of-Network:** $50 copay	**In-Network:** $0 copay **Out-of-Network:** $45 copay	
• Specialist	**In-Network:** $30 copay **Out-of-Network:** $50 copay	**In-Network:** $20 copay **Out-of-Network:** $50 copay	Specialist copays can vary for specific specialists. Please contact the plan for more information.
Preventive Care (e.g., flu vaccine, diabetic screenings)			
	In-Network: $0 copay **Out-of-Network:** $30 copay	**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.
Emergency Care			
	In- and Out-of-Network: $120 copay	**In- and Out-of-Network:** $100 copay	If you are admitted to the hospital for the same condition within 3 days, the emergency copay is waived.

Premiums and Benefits (continued)	HealthTeam Advantage Plan I (PPO)	HealthTeam Advantage Plan II (PPO)	What You Should Know
Urgently-needed Services			
	In- and Out-of-Network: $30 copay	**In- and Out-of-Network:** $15 copay	If you are admitted to the hospital within 1 calendar day for the same condition, you do not have to pay your share of the cost for urgent care.
Diagnostic Services/Labs/ Imaging			
• Diagnostic Radiology Services (such as MRIs, CT scans)	**In-Network:** $50-$200 copay **Out-of-Network:** $75-$250 copay	**In-Network:** $50-$175 copay **Out-of-Network:** $75-$200 copay	Prior authorization may be required for some services. Please contact the plan for more information.
• Lab Services - at a lab facility - at outpatient hospital facility	**In-Network:** $0 copay at a laboratory facility $10 copay at an outpatient hospital facility **Out-of-Network:** $10 copay at a laboratory facility $25 copay at an outpatient hospital facility	**In-Network:** $0 copay at a laboratory facility $10 copay at an outpatient hospital facility **Out-of-Network:** $10 copay at a laboratory facility $25 copay at an outpatient hospital facility	
• Diagnostic Tests and Procedures - at a lab facility - at outpatient hospital facility	**In-Network:** $0 copay at a laboratory facility $5 copay at an outpatient hospital facility **Out-of-Network:** $10 copay at a laboratory facility $25 copay at an outpatient hospital facility	**In-Network:** $0 copay at a laboratory facility $5 copay at an outpatient hospital facility **Out-of-Network:** $10 copay at a laboratory facility $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)	What You Should Know
Diagnostic Services/Labs/ Imaging *(continued)*			
• Outpatient X-rays - included with physician visit - at outpatient facility	**In-Network:** $5 copay for x-ray services included with a physician visit $5 copay for x-ray services at an outpatient facility **Out-of-Network:** $10 copay for x-ray services included with a physician visit $25 copay for x-ray services at an outpatient facility	**In-Network:** $0 copay for x-ray services included with a physician visit $0 copay for x-ray services at an outpatient facility **Out-of-Network:** $10 copay for x-ray services included with a physician visit $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	**In-Network:** $20 copay for a hearing exam **Out-of-Network:** $45 copay for a hearing exam	
• Routine Hearing Exam	**In-Network:** $45 copay (one routine hearing exam per year) **Out-of-Network:** $45 copay (one routine hearing exam per year)	**In-Network:** $45 copay (one routine hearing exam per year) **Out-of-Network:** $45 copay (one routine hearing exam per year)	1 per year
• Fitting and Evaluation for Hearing Aid	**In-Network:** $0 copay **Out-of-Network:** $45 copay	**In-Network:** $0 copay **Out-of-Network:** $45 copay	3 per year
• Hearing Aid	**In- and Out-of-Network:** $499-$799 per hearing aid. Premium hearing aids are available in rechargeable style options for an additional $75 per aid.	**In- and Out-of-Network:** $499-$799 per hearing aid. Premium hearing aids are available in rechargeable style options for an additional $75 per aid.	Up to two TruHearing hearing aids every year (one per ear per year). A TruHearing provider must be used for in- and out-of- network hearing aid benefit.

Premiums and Benefits (continued)	HealthTeam Advantage Plan I (PPO)	HealthTeam Advantage Plan II (PPO)	What You Should Know
Dental Services			
• Preventive Oral Exam & Cleaning	**In-Network:** $0 copay for a preventive dental exam and cleaning - Office visit—D9430, 1 per 6 months - Dental exams—periodic oral evaluation, D0120, 1 per 6 months - Dental cleanings—prophylaxis, D1110, 1 per 6 months **Out-of-Network:** $25 copay for a preventive dental exam and cleaning	**In-Network:** $0 copay for a preventive dental exam and cleaning - Office visit—D9430, 1 per 6 months - Dental exams—periodic oral evaluation, D0120, 1 per 6 months - Dental cleanings—prophylaxis, D1110, 1 per 6 months **Out-of-Network:** $25 copay for a preventive dental exam and cleaning	
• X-rays	- Intraoral, complete series including bitewing images, D0210, 1 set per year - Panoramic image, D0330, 1 set per year	- Intraoral, complete series including bitewing images, D0210, 1 set per year - Panoramic image, D0330, 1 set per year	
• Medicare-covered Dental	**In-Network:** $35 copay for each Medicare-covered dental exam **Out-of-Network:** $25 copay for a preventive dental exam and cleaning $50 copay for each Medicare-covered dental service	**In-Network:** $20 copay for each Medicare-covered dental exam **Out-of-Network:** $25 copay for a preventive dental exam and cleaning $45 copay for each Medicare-covered dental service	

Premiums and Benefits (continued)	HealthTeam Advantage Plan I (PPO)	HealthTeam Advantage Plan II (PPO)	What You Should Know
Vision Services			
• Routine Eye Exam	**In-Network:** $0 copay for one routine eye exam per year; includes one refraction per year. **Out-of-Network:** $30 copay (One routine eye exam per year)	**In-Network:** $0 copay for one routine eye exam per year; includes one refraction per year. **Out-of-Network:** $30 copay (One routine eye exam per year)	
• Eyeglasses (lenses and frames) • Contact Lenses	**In-Network:** Reimbursed up to $100 towards eye wear. **Out-of-Network:** Reimbursed up to $50 for eye wear per year.	**In-Network:** Reimbursed up to $100 towards routine eye wear. **Out-of-Network:** Reimbursed up to $50 for eye wear per year.	
Mental Health Services			
• Inpatient Visit	**In-Network:** $350 copay per day for days 1 through 5 $0 copay per day for days 6 through 90 **Out-of-Network:** 35% of the cost	**In-Network:** $300 copay per day for days 1 through 5 $0 copay per day for days 6 through 90 **Out-of-Network:** 35% of the cost	Services require prior authorization.
• Outpatient Individual Therapy Visit	**In-Network:** $30 copay **Out-of-Network:** $60 copay	**In-Network:** $20 copay **Out-of-Network:** $50 copay	
• Outpatient Group Therapy Visit	**In-Network:** $30 copay **Out-of-Network:** $60 copay	**In-Network:** $20 copay **Out-of-Network:** $50 copay	

Premiums and Benefits	HealthTeam Advantage Plan I (PPO)	HealthTeam Advantage Plan II (PPO)	What You Should Know
Skilled Nursing Facility			
	In-Network: $20 copay per day for days 1 through 20 $160 copay per day for days 21 through 100 **Out-of-Network:** $40 copay per day for days 1 through 20 $178 copay per day for days 21 through 100	**In-Network:** $10 copay per day for days 1 through 20 $160 copay per day for days 21 through 100 **Out-of-Network:** $50 copay per day for days 1 through 20 $160 copay per day for days 21 through 100	Our plan covers up to 100 days in a SNF. Services require prior authorization.
Rehabilitation Services			
• Physical Therapy Visit • Occupational Therapy Visit • Speech and Language 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.	**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.	Prior authorization required for non-emergency transportation.
Transportation			
	Not covered.	Not covered.	
Medicare Part B Drugs			
	In-Network: 20% of the cost **Out-of-Network**: 30% of the cost	**In-Network:** 20% of the cost **Out-of-Network:** 30% of the cost	Prior authorization may be required.

Premiums and Benefits (continued)	HealthTeam Advantage Plan I (PPO)		HealthTeam Advantage Plan II (PPO)		What You Should Know
Outpatient Prescription Drugs					
	Retail Rx 30-day supply	**Mail Order 90-day supply**	**Retail Rx 30-day supply**	**Mail Order 90-day supply**	
Phase 1: Initial Coverage *(After you pay your deductible, if applicable)*					
Tier 1: Preferred Generics	$5 copay	$10 copay	$0 copay	$0 copay	Cost-sharing may change depending on the pharmacy you choose and when you enter another phase of the Part D benefit. For more information on the additional pharmacy specific cost-sharing and the phases of the benefit, please call us or access our Evidence of Coverage online.
Tier 2: Generics	$ 15 copay	$30 copay	$12 copay	$24 copay	
Tier 3: Preferred Brand	$45 copay	$90 copay	$40 copay	$80 copay	
Tier 4: Non-Preferred Brand	$90 copay	$180 copay	$80 copay	$160 copay	
Tier 5: Specialty Drugs	33% coinsurance	33% coinsurance	33% coinsurance	33% coinsurance	
Phase 2: Coverage Gap (After the total amount for the prescription drugs you have filled and refilled reaches $4,020)	During this stage, you pay 25% of the price for brand name drugs (plus a portion of the dispensing fee) and 25% of the price for generic drugs. Tier 1 generics are covered at a $5 copay. You stay in this stage until your year- to-date out-of-pocket costs (your payments) reach a total of $6,350. During this stage, you pay 25% of the price for brand name drugs (plus a portion of the dispensing fee) and 25% of the price for generic drugs. Tier 1 generics are covered at a $0 copay. You stay in this stage until your year- to-date out-of-pocket costs (your payments) reach a total of $6,350.				
Phase 3: Catastrophic Coverage (After your out-of-pocket costs have reached the $6,350 limit for the calendar year)	During this stage, the plan will pay most of the cost of your drugs for the rest of the calendar year (through December 31, 2020). Your share of the cost for a covered drug will be either coinsurance or a copayment, whichever is the larger amount (either coinsurance for 5% of the cost of the drug, or $3.60 for a generic drug or a drug that is treated like a generic and $8.95 for all other drugs).				

Premiums and Benefits (continued)	HealthTeam Advantage Plan I (PPO)	HealthTeam Advantage Plan II (PPO)	What You Should Know
Foot Care *(podiatry services)*			
• Foot Exams and Treatment	**In-Network:** $30 copay **Out-of- Network**: $60 copay	**In-Network:** $20 copay **Out-of-Network:** $50 copay	
• Routine Foot Care	**In-Network:** Not covered. **Out-of-Network:** Not covered.	**In-Network:** Not covered. **Out-of-Network:** Not covered.	
Medical Equipment/Supplies			
• Durable Medical Equipment (e.g., wheelchairs, oxygen)	**In-Network:** 20% of the cost **Out-of-Network**: 30% of the cost	**In-Network:** 20% of the cost **Out-of-Network:** 30% of the cost	Services require prior authorization
• Prosthetics (e.g., braces, artificial limbs)	**In-Network:** 20% of the cost **Out-of-Network:** 30% of the cost	**In-Network:** 20% of the cost **Out-of-Network:** 30% of the cost	Services require prior authorization
• Diabetes Supplies	**In-Network:** $0 copay **Out-of-Network:** 20% of the cost	**In-Network:** $0 copay **Out-of-Network:** 20% of the cost	Limited to the following manufacturers: Freestyle, Precision, and One Touch.
Wellness Programs *(e.g., fitness)*			
	In-Network: $0 copay **Out-of-Network:** $0 copay	**In-Network:** $0 copay **Out-of-Network:** $0 copay	Access to SilverSneakers® network facilities.

Premiums and Benefits (continued)	HealthTeam Advantage Plan I and Plan II (PPO)	What You Should Know
Optional Supplemental Benefits—Dental Services Only		
Monthly Premium	$25	
Fillings • Amalgam Filling – 1 surface (D2140) • Amalgam Filling – 2 surfaces (D2150) • Amalgam Filling – 3 surfaces (D2160) • Resin-based Filling Anterior – 1 surface (D2330) • Resin-based Filling Anterior – 2 surfaces (D2331) • Resin-based Filling Anterior – 3 surfaces (D2332) - Composite-based Filling 1 surface (D2391) - Composite-based Filling Anterior – 2 surfaces (D2392) - Composite-based Filling Anterior – 3 surfaces (D2393)	$80 copay per service	Up to any 4 of these services per year (D2140, D2150, D2160, D2330, D2331, or D2332)
Denture Adjustment (D5410/D5411/D5421/D5422)	$30 copay	Adjustments are covered on new dentures for the first 3 months post-delivery
Dentures • Complete denture, maxillary (D5110) • Complete denture, mandibular (D5120) • Immediate denture, maxillary (D5130) • Immediate denture, mandibular (D5140) • Maxillary partial denture, resin-based (D5211) • Mandibular partial denture, resin- based (D5212) • Maxillary partial denture, cast metal, resin-based (D5213) • Mandibular partial denture, cast metal, resin-based (D5214)	$650 copay	1 set of full or partial dentures every 5 years
Extractions • Erupted Tooth (D7140) • Surgical (D7210)	$70 copay $90 copay	Up to 4 of these services per year (D7140 or D7210)

Premiums and Benefits (continued)	HealthTeam Advantage Plan I and Plan II (PPO)	What You Should Know
Optional Supplemental Benefits—Dental Services Only *(continued)*		
Crowns • Porcelain/Ceramic Substrate (D2740) • Porcelain Fused to High Nobel Metal (D2750) • Porcelain Fused to Base Metal (D2751) • Porcelain Fused to Noble Metal (D2752) • Full Cast Base Metal (D2791) • Full Cast Noble Metal (D2792)	$350 copay	Up to 2 of any of these services per year with 6-month waiting period (D2740, D2750, D2751, D2752, D2791, or D2792)
Periodontics • Scaling and Root Planing – 4 or more teeth per quadrant (D4341) • Scaling and Root Planing – 1-3 teeth per quadrant (D4342) • Full Mouth Debridement (D4355)	$50 copay $50 copay	4 quadrants per 2 years 1 per 2 years

If you want to know more about the coverage and costs of original Medicare, Review your current "Medicare & You" handbook. View it online at http://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).

HealthTeam Advantage 1-877-905-9216 (TTY: 711)

HealthTeam Advantage 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)