HealthTeam Advantage Plan II (PPO) offered by Care N' Care Insurance Company of North Carolina

Annual Notice of Changes for 2020

You are currently enrolled as a member of HealthTeam Advantage Plan II (PPO). Next year, there will be some changes to the plan's costs and benefits. *This booklet tells about the changes.*

- **You have from October 15 until December 7 to make changes to your Medicare coverage for next year.**

What to do now

1. ASK: Which changes apply to you?

☐ Check the changes to our benefits and costs to see if they affect you.

- It's important to review your coverage now to make sure it will meet your needs next year.
- Do the changes affect the services you use?
- Look in Sections 1.1 and 1.5 for information about benefit and cost changes for our plan.

☐ Check the changes in the booklet to our prescription drug coverage to see if they affect you.

- Will your drugs be covered?
- Are your drugs in a different tier, with different cost sharing?
- Do any of your drugs have new restrictions, such as needing approval from us before you fill your prescription?
- Can you keep using the same pharmacies? Are there changes to the cost of using these pharmacies?
- Review the 2020 Drug List and look in Section 1.6 for information about changes to our drug coverage.
    - Your drug costs may have risen since last year. Talk to your doctor about lower-cost alternatives that may be available for you; this may save you in annual out-of-pocket costs throughout the year. To get additional information on drug prices visit https://go.medicare.gov/drugprices. These dashboards highlight which manufacturers have been increasing their prices and also show other year-to-year drug price information. Keep in mind that your plan benefits will determine exactly how much your own drug costs may change.

OMB Approval 0938-1051 (Expires: December 31, 2021)

☐ Check to see if your doctors and other providers will be in our network next year.

- Are your doctors, including specialists you see regularly, in our network?
- What about the hospitals or other providers you use?
- Look in Section 1.3 for information about our *Provider/Pharmacy Directory*.

☐ Think about your overall health care costs.

- How much will you spend out-of-pocket for the services and prescription drugs you use regularly?
- How much will you spend on your premium and deductibles?
- How do your total plan costs compare to other Medicare coverage options?

☐ Think about whether you are happy with our plan.

2. COMPARE: Learn about other plan choices.

☐ Check coverage and costs of plans in your area.

- Use the personalized search feature on the Medicare Plan Finder at https://www.medicare.gov website. Click "Find health & drug plans."
- Review the list in the back of your *Medicare & You* handbook.
- Look in Section 2.2 to learn more about your choices.

☐ Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan's website.

3. CHOOSE: Decide whether you want to change your plan.

- If you want to **keep** HealthTeam Advantage Plan II (PPO), you don't need to do anything. You will stay in HealthTeam Advantage Plan II (PPO).
- To change to a **different plan** that may better meet your needs, you can switch plans between October 15 and December 7.

4. ENROLL: To change plans, join a plan between **October 15** and **December 7, 2019.**

- If you **don't join another plan by December 7, 2019**, you will stay in HealthTeam Advantage Plan II (PPO).
- If you **join another plan by December 7, 2019**, your new coverage will start on **January 1, 2020**.

Additional Resources

- This information is also available in large print. Please call your Healthcare Concierge at 1-888-965-1965 (TTY users should call 711) if you need plan information in another format or language.

- **Coverage under this Plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at https://www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About HealthTeam Advantage Plan II (PPO)

- HealthTeam Advantage Plan II (PPO), 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 Plan II (PPO) depends on contract renewal.
- When this booklet says "we," "us," or "our," it means Care N' Care Insurance Company of North Carolina, Inc. When it says "plan" or "our plan," it means HealthTeam Advantage Plan II (PPO).

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Summary of Important Costs for 2020

The table below compares the 2019 costs and 2020 costs for HealthTeam Advantage Plan II (PPO) in several important areas. **Please note this is only a summary of changes**. A copy of the *Evidence of Coverage* is located on our website at www.HealthTeamAdvantage.com. You can also review the enclosed *Evidence of Coverage* to see if other benefit or cost changes affect you. You may also call your Healthcare Concierge to ask us to mail you an *Evidence of Coverage*.

Cost	2019 (this year)	2020 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 1.1 for details.	$60	$60
Maximum out-of-pocket amounts This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details.)	From in-network providers: $3,100 From in-network and out-of-network providers combined: $5,100	From in-network providers: $3,100 From in-network and out-of-network providers combined: $5,100
Doctor office visits	**In-network:** Primary care visits: $0 copay per visit Specialist visits: $15 copay per visit **Out-of-network:** Primary care visits: $45 copay per visit Specialist visits: $50 copay per visit	**In-network:** Primary care visits: $0 copay per visit Specialist visits: $20 copay per visit **Out-of-network:** Primary care visits: $45 copay per visit Specialist visits: $50 copay per visit

Cost	2019 (this year)	2020 (next year)
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.	**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	**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
Part D prescription drug coverage (See Section 1.6 for details.)	Deductible: $0 Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: $0 copay • Drug Tier 2: $12 copay • Drug Tier 3: $40 copay • Drug Tier 4: $80 copay • Drug Tier 5: 33% coinsurance	Deductible: $0 Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: $0 copay • Drug Tier 2: $12 copay • Drug Tier 3: $40 copay • Drug Tier 4: $80 copay • Drug Tier 5: 33% coinsurance

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SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2019 (this year)	2020 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$60	$60

- Your monthly plan premium will be *more* if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as "creditable coverage") for 63 days or more.
- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.
- Your monthly premium will be *less* if you are receiving "Extra Help" with your prescription drug costs.

Section 1.2 – Changes to Your Maximum Out-of-Pocket Amounts

To protect you, Medicare requires all health plans to limit how much you pay "out-of-pocket" during the year. These limits are called the "maximum out-of-pocket amounts." Once you reach this amount, you generally pay nothing for covered Part A and Part B services for the rest of the year.

Cost	2019 (this year)	2020 (next year)
In-network maximum out-of-pocket amount Your costs for covered medical services (such as copays) from in-network providers count toward your in-network maximum out-of-pocket amount. Your plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$3,100	$3,100 There are no changes to the in-network maximum out-of-pocket amount for 2020. Once you have paid $3,100 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services from in-network providers for the rest of the calendar year.
Combined maximum out-of-pocket amount Your costs for covered medical services (such as copays) from in-network and out-of-network providers count toward your combined maximum out-of-pocket amount. Your plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$5,100	$5,100 There are no changes to the combined maximum out-of-pocket amount for 2020. Once you have paid $5,100 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services from in-network or out-of-network providers for the rest of the calendar year.

Section 1.3 – Changes to the Provider Network

There are changes to our network of providers for next year. An updated *Provider/Pharmacy Directory* is located on our website at www.HealthTeamAdvantage.com. You may also call your Healthcare Concierge for updated provider information or to ask us to mail you a *Provider/Pharmacy Directory*. **Please review the 2020 *Provider/Pharmacy Directory* to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network**.

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan, but if your doctor or specialist does leave your plan you have certain rights and protections summarized below:

- Even though our network of providers may change during the year, we must furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider and managing your care.

Section 1.4 – Changes to the Pharmacy Network

Amounts you pay for your prescription drugs may depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered *only* if they are filled at one of our in-network pharmacies.

There are changes to our network of pharmacies for next year. An updated *Provider/Pharmacy Directory* is located on our website at www.HealthTeamAdvantage.com. You may also call your Healthcare Concierge for updated provider information or to ask us to mail you a *Provider/Pharmacy Directory*. **Please review the 2020 *Provider/Pharmacy Directory* to see which pharmacies are in our network**.

Section 1.5 – Changes to Benefits and Costs for Medical Services

We are changing our coverage for certain medical services next year. The information below describes these changes. For details about the coverage and costs for these services, see Chapter 4, *Medical Benefits Chart (what is covered and what you pay),* in your *2020 Evidence of Coverage.*

Cost	2019 (this year)	2020 (next year)
Cardiac rehabilitation services	**Out-of-network** You pay a $30 copay for Medicare-covered cardiac rehabilitation and intensive cardiac rehabilitation services.	**Out-of-network** You pay a $50 copay for Medicare-covered cardiac rehabilitation and intensive cardiac rehabilitation services.
Dental services (Comprehensive)	**In-Network** You pay a $25 copay for each Medicare-covered comprehensive dental service.	**In-Network** You pay a $20 copay for each Medicare-covered comprehensive dental service.
Dental services (Preventive)	**Out-of-network** You pay a $25 to $50 copay for routine (preventive) dental services. **In- and Out-of-network:** Comprehensive oral evaluations, D0150, are covered.	**Out-of-network** You pay a $25 copay for each routine (preventive) dental service. **In- and Out-of-network:** Comprehensive oral evaluations, D0150, are not covered.

Cost	2019 (this year)	2020 (next year)
Dental services (Preventive) (continued)	**Preventive Dental X-rays:** **In-network:** Intraoral, complete series of radiographic images, D0210, 1 every 3 years. Intraoral, periapical, first radiographic images, D0220, 2 every 12 months. Intraoral, periapical, each additional radiographic image, D0230, 2 every 12 months. Bitewing x-rays - up to 1 set per 12 months (single, two, three or four films). Limited to codes: D0270, D0272, D0273, D0274. Panoramic image, D0330, 1 every 3 years.	**Preventive Dental X-rays:** **In-network:** Intraoral, complete series including bitewing images, D0210, 1 set per year. Intraoral, panoramic images, D0330, 1 set per year.

Cost	2019 (this year)	2020 (next year)
Dental services (Preventive) (continued)	**Out-of-network:** You pay a $25 to $50 copay for preventive dental X-rays. Intraoral, complete series of radiographic images, D0210, 1 every 3 years. Intraoral, periapical, first radiographic images, D0220, 2 every 12 months. Intraoral, periapical, each additional radiographic image, D0230, 2 every 12 months. Bitewing x-rays - up to 1 set per 12 months (single, two, three or four films). Limited to codes: D0270, D0272, D0273, D0274. Panoramic image, D0330, 1 every 3 years.	**Out-of-network:** You pay a $25 copay for preventive dental X-rays. Intraoral, complete series including bitewing images, D0210, 1 set every 3 years. Intraoral, panoramic images, D0330, 1 set every 3 years.

Cost	2019 (this year)	2020 (next year)
Dental services (Preventive) (continued)	**Periodontics** **In- and Out-of-network** You pay a $25-$50 copay for periodontics. Periodontal scaling & root planing, 4 or more teeth per quadrant, D4341, $50, 4 quadrants every 2 years. Periodontal scaling & root planing, 1 to 3 teeth per quadrant, D4342, $25, 4 quadrants every 2 years. Full mouth debridement, D4355, $25, 1 every 2 years. Periodontal dental visits are covered as a mandatory plan benefit in 2019; no rider is required for periodontal services.	**Periodontics** **In- and Out-of-network** Periodontal dental visits are not covered as a mandatory plan benefit in 2020. They are available as part of the Optional Supplemental Package for an additional premium.
Hearing services	**In-network** You pay a $25 copay for Medicare-covered diagnostic hearing exams. You pay a $0 copay for one routine hearing exam per year. **In- and Out-of-network** You pay $499-$699 for hearing aids.	**In-network** You pay a $20 copay for Medicare-covered diagnostic hearing exams. You pay a $45 copay for one routine hearing exam per year. **In- and Out-of-network** You pay $499-$799 (per aid) for hearing aids. Premium hearing aids are available in rechargeable style options for an additional $75 per aid.

Cost	2019 (this year)	2020 (next year)
Opioid treatment program services	**In- and Out-of-network** Opioid treatment program services are not covered.	**In-network** You pay a $20 copay for Medicare-covered opioid treatment program services. **Out-of-network** You pay a $50 copay for Medicare-covered opioid treatment program services.
Outpatient hospital observation	**In-network** You pay a $150 copay for Medicare-covered observation services.	**In-network** You pay a $175 copay for Medicare-covered observation services.
Outpatient mental health care	**In-network** You pay a $40 copay for each Medicare-covered individual or group visit with a psychiatrist. You pay a $40 copay for each Medicare-covered individual or group visit with a different type of specialist.	**In-network** You pay a $20 copay for each Medicare-covered individual or group visit with a psychiatrist. You pay a $20 copay for each Medicare-covered individual or group visit with a different type of specialist.
Outpatient substance abuse services	**In-network** $40 copay for each Medicare-covered service in an individual or group setting.	**In-network** $20 copay for each Medicare-covered service in an individual or group setting.
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers	**In-network** You pay a $150 copay for Medicare-covered outpatient surgery services. You pay a $125 copay per day for each Medicare-covered ambulatory surgical center service.	**In-network** You pay a $175 copay for Medicare-covered outpatient surgery services. You pay a $175 copay per day for each Medicare-covered ambulatory surgical center service.

Cost	2019 (this year)	2020 (next year)
Physician/practitioner services, including doctor's office visits	**In-network** You pay a $15 copay for each Medicare-covered specialist visit. You pay a $7 copay for each Medicare-covered visit with other health care professionals.	**In-network** You pay a $20 copay for each Medicare-covered specialist visit. You pay a $20 copay for each Medicare-covered visit with other health care professionals.
Podiatry services	**In-network** You pay a $25 copay for each Medicare-covered podiatry service.	**In-network** You pay a $20 copay for each Medicare-covered podiatry service.
Pulmonary rehabilitation services	**Out-of-network** You pay a $30 copay for each Medicare-covered pulmonary rehab service.	**Out-of-network** You pay a $50 copay for each Medicare-covered pulmonary rehab service.
Services to treat kidney disease	**In-network** You pay a $25 copay for Medicare-covered dialysis services.	**In-network** You pay a $20 copay for Medicare-covered dialysis services.
Supervised Exercise Therapy (SET)	**Out-of-network** You pay a $30 copay for each Medicare-covered SET visit.	**Out-of-network** You pay a $50 copay for each Medicare-covered SET visit.
Urgently needed services	**In and Out-of-network** You pay a $30 copay for urgently needed services. Copayment for urgently needed services is not waived if you are admitted to the hospital for the same condition.	**In and Out-of-network** You pay a $15 copay for urgently needed services. 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.

Cost	2019 (this year)	2020 (next year)
Vision care (Medicare-covered)	**In-network** You pay a $25 copay for each Medicare-covered eye exam to diagnose and treat diseases and conditions of the eye. **Out-of-network** You pay a $0 copay for Medicare-covered eyeglasses or contact lenses after cataract surgery with a maximum benefit amount not to exceed $100.	**In-network** You pay a $0 copay for each Medicare-covered eye exam to diagnose and treat diseases and conditions of the eye; a refraction is covered. **Out-of-network** You pay a $50 copay for Medicare-covered eyeglasses or contact lenses after cataract surgery with a maximum benefit amount not to exceed $100.
Vision care (Routine)	**In-network** You pay $0-$50 for 1 pair of eyeglasses (lenses & frame) with CR-39 clear plastic single vision, lined bi-focal (FT28) or lined tri-focal (FT7x28) lenses, per year. Total Retail Benefit limit of $200.00 in eyewear value. Frame upgrade: Member is responsible for retail price less 15%. Lens upgrade: Member pays Coherent's rate. You pay a $50 copay for eye wear upgrades. $200 allowance per year for eyeglasses or contact lenses.	**In-network** $100 allowance per year for eyeglasses or contact lenses.

Cost	2019 (this year)	2020 (next year)
OPTIONAL SUPPLEMENTAL BENEFITS		
Comprehensive Dental Benefits (Optional Supplemental Benefit) ***These benefits only apply if you purchased the optional supplemental plan for an additional premium***	**In- and Out-of-network** Composite fillings posterior are covered as part of the Optional Supplemental Package for an additional premium.	**In- and Out-of-network** Composite fillings posterior are not covered as part of the Optional Supplemental Package.
	Resin-based fillings anterior are not covered.	You pay an $80 copay per filling for up to 4 fillings per year, including: • Resin-based, 1 surface, anterior, D2330 • Resin-based, 2 surfaces, anterior, D2331 • Resin-based, 3 surfaces, anterior, D2332
	Periodontal visits are covered as a mandatory plan benefit in 2019; no rider is required for periodontal services.	Periodontal dental visits are not covered as a mandatory plan benefit in 2020. They are available as part of the Optional Supplemental Package for an additional premium.

Cost	2019 (this year)	2020 (next year)
Comprehensive Dental Benefits (Optional Supplemental Benefit) (continued)	**In- and Out-of-network** You pay a $25-$50 copay for periodontics. Periodontal scaling & root planing, 4 or more teeth per quadrant, D4341, $50, 4 quadrants every 2 years. Periodontal scaling & root planing, 1 to 3 teeth per quadrant, D4342, $25, 4 quadrants every 2 years. Full mouth debridement, D4355, $25, 1 every 2 years.	**In- and Out-of-network** You pay a $50 copay per each service for: Periodontal scaling & root planing, 4 or more teeth per quadrant, D4341, 4 quadrants per 2 years Periodontal scaling & root planing, 1 to 3 teeth per quadrant, D4342, 4 quadrants per 2 years Full mouth debridement, D4355, 1 per 2 years.

Section 1.6 – Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a Formulary or "Drug List." A copy of our Drug List is in this envelope.

We made changes to our Drug List, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions.**

If you are affected by a change in drug coverage, you can:

- **Work with your doctor (or other prescriber) and ask the plan to make an exception** to cover the drug. **We encourage current members** to ask for an exception before next year.
    - To learn what you must do to ask for an exception, see Chapter 9 of your *Evidence of Coverage (What to do if you have a problem or complaint (coverage decisions, appeals, complaints))* or call your Healthcare Concierge.
- **Work with your doctor (or other prescriber) to find a different drug** that we cover. You can call your Healthcare Concierge to ask for a list of covered drugs that treat the same medical condition.

In some situations, we are required to cover a temporary supply of a non-formulary drug in the first 90 days of the plan year or the first 90 days of membership to avoid a gap in therapy.

If you are a current member and a drug you are taking will be removed from the formulary or restricted in some way for next year, we will allow you to request a formulary exception starting on December 15, 2019.

If you are taking a medication that required a coverage determination (i.e. prior authorization, step therapy, or quantity limit exception) in 2019, we will be extending the authorizations through December 31, 2020 provided you have a paid claim for the medication in the last four months of 2019.

Most of the changes in the Drug List are new for the beginning of each year. However, during the year, we might make other changes that are allowed by Medicare rules.

When we make these changes to the Drug List during the year, you can still work with your doctor (or other prescriber) and ask us to make an exception to cover the drug. We will also continue to update our online Drug List as scheduled and provide other required information to reflect drug changes. (To learn more about changes we may make to the Drug List, see Chapter 5, Section 6 of the *Evidence of Coverage*.)

Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs may not apply to you.** We sent you a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also called the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug costs. If you receive "Extra Help" and haven't received this insert by **October 15th**, please call your Healthcare Concierge and ask for the "LIS Rider." Phone numbers for your Healthcare Concierge are in Section 6.1 of this booklet.

There are four "drug payment stages." How much you pay for a Part D drug depends on which drug payment stage you are in. (You can look in Chapter 6, Section 2 of your *Evidence of Coverage* for more information about the stages.)

The information below shows the changes for next year to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage. To get information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in the *Evidence of Coverage* which is located on our website at www.HealthTeamAdvantage.com. You can also review the enclosed *Evidence of Coverage* to see if other benefit or cost changes affect you. You may also call your Healthcare Concierge to ask us to mail you an *Evidence of Coverage*.)

Changes to the Deductible Stage

Stage	2019 (this year)	2020 (next year)
Stage 1: Yearly Deductible Stage	Because we have no deductible, this payment stage does not apply to you.	Because we have no deductible, this payment stage does not apply to you.

Changes to Your Cost-sharing in the Initial Coverage Stage

To learn how copayments and coinsurance work, look at Chapter 6, Section 1.2, *Types of out-of-pocket costs you may pay for covered drugs* in your *Evidence of Coverage*.

Stage	2019 (this year)	2020 (next year)
Stage 2: Initial Coverage Stage During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost.**	Your cost for a one-month supply filled at an in-network pharmacy with standard cost-sharing:	Your cost for a one-month supply filled at an in-network pharmacy with standard cost-sharing:
The costs in this row are for a one-month (30-day) supply when you fill your prescription at an in-network pharmacy that provides standard cost-sharing.	**Preferred Generics:** You pay $0 per prescription.	**Preferred Generics:** You pay $0 per prescription.
For information about the costs for a long-term supply or for mail-order prescriptions, look in Chapter 6, Section 5 of your *Evidence of Coverage*.	**Generics:** You pay $12 per prescription.	**Generics:** You pay $12 per prescription.
We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.	**Preferred Brands:** You pay $40 per prescription.	**Preferred Brands:** You pay $40 per prescription.

Stage	2019 (this year)	2020 (next year)
Stage 2: Initial Coverage Stage (continued)	**Non-Preferred Drugs:** You pay $80 per prescription. **Specialty Tier:** You pay 33% of the total cost. Once your total drug costs have reached $3,820, you will move to the next stage (the Coverage Gap Stage).	**Non-Preferred Drugs:** You pay $80 per prescription. **Specialty Tier:** You pay 33% of the total cost. Once your total drug costs have reached $4,020, you will move to the next stage (the Coverage Gap Stage).

Changes to the Coverage Gap and Catastrophic Coverage Stages

The other two drug coverage stages – the Coverage Gap Stage and the Catastrophic Coverage Stage – are for people with high drug costs. **Most members do not reach the Coverage Gap Stage or the Catastrophic Coverage Stage**. For information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in your *Evidence of Coverage*.

SECTION 2 Deciding Which Plan to Choose

Section 2.1 – If you want to stay in HealthTeam Advantage Plan II (PPO)

To stay in our plan you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically stay enrolled as a member of our plan for 2020.

Section 2.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change for 2020 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan timely,

- – *OR*– You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan. If you do not enroll in a Medicare drug plan, please see Section 1.1 regarding a potential Part D late enrollment penalty.

To learn more about Original Medicare and the different types of Medicare plans, read *Medicare & You 2020*, call your State Health Insurance Assistance Program (see Section 4), or call Medicare (see Section 6.2).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to https://www.medicare.gov and click "Find health & drug plans." **Here, you can find information about costs, coverage, and quality ratings for Medicare plans.**

Step 2: Change your coverage

- To change **to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from HealthTeam Advantage Plan II (PPO).
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from HealthTeam Advantage Plan II (PPO).
- To **change to Original Medicare without a prescription drug plan**, you must either:
    - Send us a written request to disenroll. Contact your Healthcare Concierge if you need more information on how to do this (phone numbers are in Section 6.1 of this booklet).
    - – *OR* – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

SECTION 3 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7.** The change will take effect on January 1, 2020.

Are there other times of the year to make a change?

In certain situations, changes are also allowed at other times of the year. For example, people with Medicaid, those who get "Extra Help" paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area may be allowed to make a change at other times of the year. For more information, see Chapter 10, Section 2.3 of the *Evidence of Coverage.*

If you enrolled in a Medicare Advantage Plan for January 1, 2020, and don't like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2020. For more information, see Chapter 10, Section 2.2 of the *Evidence of Coverage*.

SECTION 4 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In North Carolina, the SHIP is called the North Carolina Seniors' Health Insurance Information Program (SHIIP).

The North Carolina Seniors' Health Insurance Information Program (SHIIP) is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. The SHIIP counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call SHIIP at 1-855-408-1212. You can learn more about SHIIP by visiting their website (www.ncdoi.com/SHIIP).

SECTION 5 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs. Below we list different kinds of help:

- **"Extra Help" from Medicare.** People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. Many people are eligible and don't even know it. To see if you qualify, call:
    - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
    - The Social Security Office at 1-800-772-1213 between 7 am and 7 pm, Monday through Friday. TTY users should call 1-800-325-0778 (applications); or
    - Your State Medicaid Office (applications).
- **Help from your state's pharmaceutical assistance program.** North Carolina has a program called North Carolina HIV State Pharmaceutical Assistance Program that helps people pay for prescription drugs based on their financial need, age, or medical condition. To learn more about the program, check with your State Health Insurance Assistance Program (the name and phone numbers for this organization are in Section 4 of this booklet).
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the North Carolina AIDS Drug Assistance Program. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call 1-877-466-2232.

SECTION 6 Questions?

Section 6.1 – Getting Help from HealthTeam Advantage Plan II (PPO)

Questions? We're here to help. Please call your Healthcare Concierge at 1-888-965-1965. (TTY only, call 711.) We are available October 1 – March 31, 8AM – 8PM Eastern, 7 days a week, April 1 – September 30, 8AM – 8PM Eastern, Monday through Friday. Calls to these numbers are free.

Read your 2020 *Evidence of Coverage* (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2020. For details, look in the 2020 *Evidence of Coverage* for HealthTeam Advantage Plan II (PPO). The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is located on our website at www.HealthTeamAdvantage.com. You can also review the enclosed *Evidence of Coverage* to see if other benefit or cost changes affect you. You may also call your Healthcare Concierge to ask us to mail you an *Evidence of Coverage*.

Visit our Website

You can also visit our website at www.HealthTeamAdvantage.com. As a reminder, our website has the most up-to-date information about our provider network (*Provider/Pharmacy Directory*) and our list of covered drugs (Formulary/Drug List).

Section 6.2 – Getting Help from Medicare

To get information directly from Medicare:

Call 1-800-MEDICARE (1-800-633-4227)

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Visit the Medicare Website

You can visit the Medicare website (https://www.medicare.gov). It has information about cost, coverage, and quality ratings to help you compare Medicare health plans. You can find information about plans available in your area by using the Medicare Plan Finder on the Medicare website. (To view the information about plans, go to https://www.medicare.gov and click on "Find health & drug plans.")

Read *Medicare & You 2020*

You can read *Medicare & You 2020* Handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (https://www.medicare.gov) or 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.