HealthTeam Advantage Plan II (PPO) offered by Care N' Care Insurance Company of North Carolina, Inc. (d/b/a HealthTeam Advantage)

Annual Notice of Change for 2026

You're enrolled as a member of HealthTeam Advantage Plan II (PPO).

This material describes changes to our plan's costs and benefits next year.

- **You have from October 15 – December 7 to make changes to your Medicare coverage for next year.** If you don't join another plan by December 7, 2025, you'll stay in HealthTeam Advantage Plan II (PPO).
- To change to a **different plan**, visit www.Medicare.gov or review the list in the back of your *Medicare & You 2026* handbook.
- Note this is only a summary of changes. More information about costs, benefits, and rules is in the *Evidence of Coverage*. Get a copy at https://htanc.com/members/2026-plan-documents or call your Healthcare Concierge at 1-888-965-1965 (TTY users call 711) to get a copy by mail.

More Resources

- Call your Healthcare Concierge at 1-888-965-1965 (TTY users call 711). Hours are October 1 – March 31, 8AM – 8PM Eastern, 7 days a week; April 1 – September 30, 8AM – 8PM Eastern, Monday through Friday. This call is free.
- This information is available in Large Print. Please call your Healthcare Concierge at 1-888-965-1965 if you need plan information in another format or language.

About HealthTeam Advantage Plan II (PPO)

- 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.
- When this material 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).
- **If you do nothing by December 7, 2025, you'll automatically be enrolled in HealthTeam Advantage Plan II (PPO).** Starting January 1, 2026, you'll get your medical

and drug coverage through HealthTeam Advantage Plan II (PPO). Go to Section 3 for more information about how to change plans and deadlines for making a change.

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Summary of Important Costs for 2026

	2025 (this year)	2026 (next year)
Monthly plan premium* * Your premium can be higher or lower than this amount. Go to Section 1.1 for details.	$44	**$40**
Maximum out-of-pocket amount This is the most you'll pay out of pocket for covered Part A and Part B services. (Go to Section 1.2 for details.)	From network providers: $3,200 From network and out-of-network providers combined: $5,950	**From network providers: $3,700** **From network and out-of-network providers combined: $6,300**
Primary care office visits	In-Network $0 copayment per visit. Out-Of-Network $30 copayment per visit.	**In-Network** **$0 copayment per visit.** **Out-Of-Network** **$30 copayment per visit.**
Specialist office visits	In-Network $15 copayment per visit. Out-Of-Network $60 copayment per visit.	**In-Network** **$20 copayment per visit.** **Out-Of-Network** **$60 copayment per visit.**
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the	In-Network $250 copayment per day for days 1-5; $0 copayment per day for days 6–90.	**In-Network** **$275 copayment per day for days 1-5; $0 copayment per day for days 6–90.**

	2025 (this year)	2026 (next year)
day you're formally admitted to the hospital with a doctor's order. The day before you're discharged is your last inpatient day.	For additional days after reaching the benefit limit, you pay $0 copayment per day for days 91 and beyond. Out-Of-Network 20% coinsurance per stay.	**For additional days after reaching the benefit limit, you pay $0 copayment per day for days 91 and beyond.** **Out-Of-Network** **20% coinsurance per stay.**
Part D drug coverage deductible (Go to Section 1.7 for details.)	$0	**$150 on Tiers 4 and 5 except for covered insulin products and most adult Part D vaccines.**
Part D drug coverage (Go to Section 1.7 for details, including Yearly Deductible, Initial Coverage, and Catastrophic Coverage Stages.)	Copayment/Coinsurance during the Initial Coverage Stage: Drug Tier 1: $0 copayment at a preferred network pharmacy. $0 copayment at a network pharmacy.	**Copayment/Coinsurance during the Initial Coverage Stage:** **Drug Tier 1:** **$0 copayment at a preferred network pharmacy.** **$5 copayment at a network pharmacy.**
	Drug Tier 2: $0 copayment at a preferred network pharmacy. $12 copayment at a network pharmacy.	**Drug Tier 2:** **$0 copayment at a preferred network pharmacy.** **$15 copayment at a network pharmacy.**

	2025 (this year)	2026 (next year)
Part D drug coverage (continued)	Drug Tier 3: $47 copayment at a preferred network pharmacy. $47 copayment at a network pharmacy. You pay $35 per month supply of each covered insulin product on this tier.	**Drug Tier 3:** **20% coinsurance at a preferred network pharmacy.** **25% coinsurance at a network pharmacy.** **You pay the lesser of Tier 3 coinsurance or $35 per month supply of each covered insulin product on this tier.**
	Drug Tier 4: $100 copayment at a preferred network pharmacy. $100 copayment at a network pharmacy. You pay $35 per month supply of each covered insulin product on this tier.	**Drug Tier4:** **35% coinsurance at a preferred network pharmacy.** **45% coinsurance at a network pharmacy.** **You pay the lesser of Tier 4 coinsurance or $35 per month supply of each covered insulin product on this tier.**
	Drug Tier 5: 33% coinsurance at a preferred network pharmacy. 33% coinsurance at a network pharmacy.	**Drug Tier 5:** **31% coinsurance at a preferred network pharmacy.** **31% coinsurance at a network pharmacy.**

	2025 (this year)	2026 (next year)
Part D drug coverage (continued)	Catastrophic Coverage Stage: During this payment stage, you pay nothing for your covered Part D drugs and for excluded drugs that are covered under our enhanced benefit.	**Catastrophic Coverage Stage: During this payment stage, you pay nothing for your covered Part D drugs and for excluded drugs that are covered under our enhanced benefit.**

SECTION 1 Changes to Benefits & Costs for Next Year

Section 1.1 Changes to the Monthly Plan Premium

	2025 (this year)	2026 (next year)
Monthly plan premium (You must also continue to pay your Medicare Part B premium.)	$44	**$40**

Factors that could change your Part D Premium Amount

- Late Enrollment Penalty - Your monthly plan premium will be *more* if you're required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that's at least as good as Medicare drug coverage (also referred to as creditable coverage) for 63 days or more.
- Higher Income Surcharge - If you have a higher income, you may have to pay an additional amount each month directly to the government for Medicare drug coverage.
- Extra Help – Your monthly plan premium will be less if you get Extra Help with your drug costs. Go to Section 4 for more information about Extra Help from Medicare.

Section 1.2 Changes to Your Maximum Out-of-Pocket Amount

Medicare requires all health plans to limit how much you pay out of pocket for the year. This limit is called the maximum out-of-pocket amount. Once you've paid this amount, you generally pay nothing for covered Part A and Part B services for the rest of the calendar year.

	2025 (this year)	2026 (next year)
In-network maximum out-of-pocket amount Your costs for covered medical services (such as copayments from network providers **count** toward your in-network maximum out-of-pocket amount. Our plan premium and your costs for prescription drugs **don't count** toward your maximum out-of-pocket amount.	$3,200	**$3,700** **Once you've paid $3,700 out of pocket for covered Part A and Part B services, you'll pay nothing for your covered Part A and Part B services from network providers for the rest of the calendar year.**
Combined maximum out-of-pocket amount Your costs for covered medical services (such as copayments from in-network and out-of-network providers **count** toward your combined maximum out-of-pocket amount. Your plan premium and your costs for outpatient prescription drugs **don't count** toward your maximum out-of-pocket amount for medical services.	$5,950	**$6,300** **Once you've $6,300 out of pocket for covered Part A and Part B services, you'll pay nothing for your covered Part A and Part B services from network or out-of-network providers for the rest of the calendar year.**

Section 1.3 Changes to the Provider Network

Our network of providers has changed for next year. Review the 2026 *Provider Directory* https://htanc.com/find-a-provider-2026/ to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network. Here's how to get an updated *Provider Directory*:

- Visit our website at https://htanc.com/find-a-provider-2026/.
- Call your Healthcare Concierge at 1-888-965-1965 (TTY users call 711) to get current provider information or to ask us to mail you a *Provider Directory*.

We can make changes to the hospitals, doctors, and specialists (providers) that are part of our plan during the year. If a mid-year change in our providers affects you, call your Healthcare Concierge at 1-888-965-1965 (TTY users call711) for help.

Section 1.4 Changes to the Pharmacy Network

Amounts you pay for your prescription drugs can 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 network pharmacies. Our network includes pharmacies with preferred cost sharing, which may offer you lower cost sharing than the standard cost sharing offered by other network pharmacies for some drugs.

Our network of pharmacies has changed for next year. Review the 2026 *Pharmacy Directory* https://htanc.com/find-a-pharmacy-2026/ to see which pharmacies are in our network. Here's how to get an updated *Pharmacy Directory*:

- Visit our website at https://htanc.com/find-a-pharmacy-2026/
- Call your Healthcare Concierge at 1-888-965-1965 (TTY users call 711) to get current pharmacy information or to ask us to mail you a *Pharmacy Directory*.

We can make changes to the pharmacies that are part of our plan during the year. If a mid-year change in our pharmacies affects you, call your Healthcare Concierge at 1-888-965-1965 (TTY users call 711) for help.

Section 1.5 Changes to Benefits & Costs for Medical Services

	2025 (this year)	2026 (next year)
Acupuncture for chronic low back pain	In-Network $15 copayment for each Medicare-covered acupuncture visit.	**In-Network** **$20 copayment for each Medicare-covered acupuncture visit.**
Acupuncture – Supplemental (Non-Medicare-covered)	This benefit includes up to 30 routine acupuncture visits per year. In-Network $15 copayment per routine acupuncture visit. Out-of-Network $30 copayment per routine acupuncture visits.	**This benefit includes up to 30 routine acupuncture visits per year.** **In-Network** **$20 copayment per routine acupuncture visit.** **Out-of-Network** **$60 copayment per routine acupuncture visits.**
Cardiac Rehabilitation Services	In-Network $15 copayment for each Medicare-covered cardiac rehabilitation service visit. $15 copayment for each Medicare-covered intensive cardiac rehabilitation service visit.	**In-Network** **$20 copayment for each Medicare-covered cardiac rehabilitation service visit.** **$20 copayment for each Medicare-covered intensive cardiac rehabilitation service visit.**

	2025 (this year)	2026 (next year)
Chiropractic Services	In-Network $10 copayment for each Medicare-covered chiropractic service visit.	**In-Network** **$20 copayment for each Medicare-covered chiropractic service visit.**
Dental Services	In-Network $15 copayment for each Medicare-covered dental visit.	**In-Network** **$20 copayment for each Medicare-covered dental visit.**
Dental Services – Supplemental (Non-Medicare-covered)	Deductible $0 Deductible for most Diagnostic and Preventive dental services. $50 Deductible for some Diagnostic and Preventive dental services and all Comprehensive in- and out-of-network dental services.	**Deductible** **$0 Deductible for Diagnostic and Preventive dental services.** **$100 Deductible for all Comprehensive in- and out-of-network dental services.**
	Annual Benefit Maximum Diagnostic and Preventive Dental Services No maximum plan coverage amount for most Diagnostic and Preventive in- and out-of-network non-Medicare covered dental services.	**Annual Benefit Maximum** **Diagnostic and Preventive Dental Services** **No maximum plan coverage amount for Diagnostic and Preventive in- and out-of-network non-Medicare covered dental services.**

	2025 (this year)	2026 (next year)
Dental Services – Supplemental (Non-Medicare-covered) – (continued)	Diagnostic and Preventive services with no annual benefit maximum include: prophylaxis (cleaning), bitewing x-rays, periodic oral evaluation – new or established patient, re-evaluation – post-operative office visit, and tomographic survey. Diagnostic and Preventive services that apply to the annual benefit maximum include: comprehensive series of radiographic images, panoramic radiographic images, periapical radiographic images, intraoral-occlusal radiographic images, extra-oral – 2D projection radiographic images, limited oral evaluation – problem focused, detailed and extensive oral evaluation – problem-focused, re-evaluation – limited, problem-focused, comprehensive periodontal evaluation – new or established patient, and diagnostic cast.	

	2025 (this year)	2026 (next year)
Dental Services – Supplemental (Non-Medicare-covered) – (continued)	Annual Maximum Benefit Comprehensive Dental Services $3,000 maximum plan coverage amount every year for some Diagnostic and Preventive in- and out-of-network non-Medicare-covered dental services and all in- and out-of-network Comprehensive dental services. There is no separate plan benefit maximum for out-of-network dental services.	**Annual Maximum Benefit** **Comprehensive Dental Services** **$2,000 maximum plan coverage amount every year for all in- and out-of-network Comprehensive dental services. There is no separate plan benefit maximum for out-of-network dental services.**
	In-Network Preventive and Diagnostic Dental Services 0% to 20% of the total cost for dental X-rays. 0% to 20% of the total cost for other diagnostic dental services. *Frequency, visit limits, and alternate benefits may apply to Diagnostic and Preventive and Comprehensive Dental Services.*	**In-Network** **Preventive and Diagnostic Dental Services** **0% of the total cost for dental X-rays.** **0% of the total cost for other diagnostic dental services.** ***Frequency, visit limits, and alternate benefits may apply to Diagnostic and Preventive and Comprehensive Dental Services.***

	2025 (this year)	2026 (next year)
Hearing Services	In-Network $15 copayment for each Medicare-covered hearing exam.	**In-Network** **$20 copayment for each Medicare-covered hearing exam**.
Home-Based Palliative Care and In-Home Custodial Care	$0 copayment for up to 20 hours of care after a qualifying event, maximum of 60 hours annually (combined for In-Network and Out-of-Network) for both Palliative Care and In-Home Custodial Care. Hours do not carry forward to the next calendar year.	**$0 copayment for up to 20 hours of care after a qualifying event, maximum of 60 hours annually for Palliative Care.** **Hours do not carry forward to the next calendar year.** **In-Home Custodial Care is not covered.**
Inpatient Hospital Care	In-Network For Medicare-covered inpatient hospital stays, you pay a $250 copayment per day for days 1–5; and $0 copayment per day for days 6-90. For additional days after reaching the benefit limit, you pay $0 copayment per day for days 91 and beyond.	**In-Network** **For Medicare-covered inpatient hospital stays, you pay a $275 copayment per day for days 1–5; and $0 copayment per day for days 6-90.** **For additional days after reaching the benefit limit, you pay $0 copayment per day for days 91 and beyond.**

	2025 (this year)	2026 (next year)
Inpatient Services in a Psychiatric Hospital	In Network For Medicare-covered inpatient mental health stays, you pay a $250 copayment per day for days 1–8; and $0 copayment per day for days 9-90.	**In-Network** **For Medicare-covered inpatient mental health stays, you pay a $275 copayment per day for days 1–8; and $0 copayment per day for days 9-90.**
Meal Benefit	$0 copayment per meal. You are eligible to receive up to 28 meals (2 meals per day) over a 14-day period immediately following a qualifying event such as surgery, discharge from an inpatient hospital stay or skilled nursing facility or once per year for an initial diagnosis of a qualifying chronic condition - chronic heart failure, diabetes, and/or chronic lung disease. There is no limit as to the number of times you can access this meal benefit for post discharge purposes.	**$0 copayment per meal.** **You are eligible to receive up to 28 meals (2 meals per day) over a 14-day period following a qualifying event such as surgery or discharge from an inpatient hospital stay or skilled nursing facility.** **There is no limit as to the number of times you can access this meal benefit for post discharge purposes.** **Meal benefit when initially diagnosed with a chronic illness/condition is not covered.**
Memory Fitness	Memory fitness is covered.	**Memory fitness is not covered.**

	2025 (this year)	2026 (next year)
Opioid Treatment Program Services	In-Network $15 copayment for Medicare-covered opioid treatment program services.	**In-Network** **$20 copayment for Medicare-covered opioid treatment program services.**
Other Health Care Professional Services	In-Network $15 copayment for each Medicare-covered other health care professional services (e.g., nurse practitioners and physician assistants) visit.	**In-Network** **$20 copayment for each Medicare-covered other health care professional services (e.g., nurse practitioners and physician assistants) visit.**
Outpatient Mental Health Care, including psychiatric services	In-Network $15 copayment for each Medicare-covered individual or group therapy visit with a mental health care professional (non-psychiatrist) or psychiatrist.	**In-Network** **$20 copayment for each Medicare-covered individual or group therapy visit with a mental health care professional (non-psychiatrist) or psychiatrist.**
Outpatient Rehabilitation Services	In-Network $15 copayment for each Medicare-covered occupational, physical or speech-language therapy visit.	**In-Network** **$20 copay for each Medicare-covered occupational, physical or speech-language therapy visit.**

	2025 (this year)	2026 (next year)
Outpatient Substance Use Disorder Services	In-Network $15 copayment for each Medicare-covered individual or group therapy visit.	**In-Network** **$20 copayment for each Medicare-covered individual or group therapy visit.**
Over-the-Counter (OTC) Items	$60 allowance every quarter (3 months). Unused allowance amount can be carried forward to the next quarterly (3-month) benefit period.	**$60 allowance every quarter (3 months).** **Unused allowance amounts do not carry forward to the next quarterly (3-month) benefit period.**
Podiatry Services	In-Network $15 copayment for every Medicare-covered Podiatry visit.	**In-Network** **$20 copayment for every Medicare-covered Podiatry visit.**
Pulmonary Rehabilitation Services	In-Network $15 copayment for each Medicare-covered pulmonary rehabilitation services visit.	**In-Network** **$20 copayment for each Medicare-covered pulmonary rehabilitation services visit.**
Skilled Nursing Facility (SNF) Care	In-Network For Medicare-covered SNF stays, $0 copayment per day for days 1–20; and $214 copayment per day for days 21-100.	**In-Network** **For Medicare-covered SNF stays, $0 copayment per day for days 1–20; and $218 copayment per day for days 21–100.**

	2025 (this year)	2026 (next year)
Specialist Doctor Office Visits	In-Network $15 copayment per visit.	**In-Network** **$20 copayment per visit.**
Supervised Exercise Therapy (SET)	In-Network $15 copayment for every Medicare-covered SET visit for Symptomatic Peripheral Artery Disease (PAD) services.	**In-Network** **$20 copayment for every Medicare-covered SET visit for Symptomatic Peripheral Artery Disease (PAD) services.**
Telehealth Benefits (additional)	In-Network For additional telehealth benefits you pay a $0 - $15 copayment for primary care physician services, physician specialist services, other health care professionals, individual sessions for mental health specialty services, individual sessions for psychiatric services group sessions for psychiatric services, opioid treatment program services, individual sessions for outpatient substance abuse, group sessions for outpatient substance abuse. Copayment based on provider type.	**In-Network** **For additional telehealth benefits you pay a $0 - $20 copayment for primary care physician services, physician specialist services, other health care professionals, individual sessions for mental health specialty services, individual sessions for psychiatric services group sessions for psychiatric services, opioid treatment program services, individual sessions for outpatient substance abuse, group sessions for outpatient substance abuse.** **Copayment based on provider type.**

	2025 (this year)	2026 (next year)
Urgently Needed Services	$20 copayment for each Medicare-covered urgent care visit.	**$30 copayment for each Medicare-covered urgent care visit.**
Vision Care	In-Network $15 copayment for each Medicare-covered eye exam to diagnose and treat diseases and conditions of the eye.	**In-Network** **$20 copayment for each Medicare-covered eye exam to diagnose and treat diseases and conditions of the eye.**
Vision Eyewear	$150 maximum plan coverage amount every year for all in- and out-of-network non-Medicare-covered eyewear.	**$125 maximum plan coverage amount every year for all in- and out-of-network non-Medicare-covered eyewear.**

Section 1.6 Changes to Part D 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 provided electronically.

We made changes to our Drug List, which could include removing or adding drugs, changing the restrictions that apply to our coverage for certain drugs, or moving them to a different cost-sharing tier. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions, or if your drug has been moved to a different cost-sharing tier.**

Most of the changes in the Drug List are new for the beginning of each year. However, we might make other changes that are allowed by Medicare rules that will affect you during the calendar year. We update our online Drug List at least monthly to provide the most up-to-date list of drugs. If we make a change that will affect your access to a drug you're taking, we'll send you a notice about the change.

If you're affected by a change in drug coverage at the beginning of the year or during the year, review Chapter 9 of your *Evidence of Coverage* and talk to your prescriber to find out your options, such as asking for a temporary supply, applying for an exception, and/or working to find a new drug. Call your Healthcare Concierge at 1-888-965-1965 (TTY users call 711) for more information.

Section 1.7 Changes to Prescription Drug Benefits & Costs

Do you get Extra Help to pay for your drug coverage costs?

If you're in a program that helps pay for your drugs (Extra Help), **the information about costs for Part D drugs may not apply to you**. We sent you a separate material, called the *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs*, which tells about your drug costs. If you get Extra Help and you don't get this material by September 30th, call your Healthcare Concierge 1-888-965-1965 (TTY users call 711) and ask for the *LIS Rider*.

Drug Payment Stages

There are **3 drug payment stages:** the Yearly Deductible Stage, the Initial Coverage Stage, and the Catastrophic Coverage Stage. The Coverage Gap Stage and the Coverage Gap Discount Program no longer exist in the Part D benefit.

- ***Stage 1: Yearly Deductible***

  You start in this payment stage each calendar year. During this stage, you pay the full cost of your Tier 4 – Non-Preferred Drug and Tier 5 - Specialty drugs until you reach the yearly deductible.

- ***Stage 2: Initial Coverage***

  Once you pay the yearly deductible, you move to the Initial Coverage Stage. In this stage, our plan pays its share of the cost of your drugs, and you pay your share of the cost. You generally stay in this stage until your year-to-date total Out-of-Pocket costs reach $2,100.

- ***Stage 3: Catastrophic Coverage***

  This is the third and final drug payment stage. In this stage, you pay nothing for your covered Part D drugs. You generally stay in this stage for the rest of the calendar year.

The Coverage Gap Discount Program has been replaced by the Manufacturer Discount Program. Under the Manufacturer Discount Program, drug manufacturers pay a portion of our plan's full cost for covered Part D brand name drugs and biologics during the Initial Coverage Stage and the Catastrophic Coverage Stage. Discounts paid by manufacturers under the Manufacturer Discount Program don't count toward out-of-pocket costs.

Drug Costs in Stage 1: Yearly Deductible

The table shows your cost per prescription during this stage

	2025 (this year)	2026 (next year)
Yearly Deductible	Because we have no deductible, this payment stage doesn't apply to you.	**$150** **During this stage, you pay $0- $5 cost sharing for drugs on Tier 1 – Preferred Generic drugs, $0 - $15 cost sharing on Tier 2 – Generic drugs, and 20% - 25% of the total cost for Tier 3 - Preferred Brand drugs and the full cost of drugs on Tier 4 – Non-Preferred drugs and Tier 5 – Specialty drugs until you've reached the yearly deductible.** **In addition, you will pay the lesser of the Tier coinsurance or $35 per month supply of insulin.**

Drug Costs in Stage 2: Initial Coverage

For drugs on Tier 3 – Preferred Brand drugs and Tier 4 – Non-Preferred drugs, your cost sharing in the Initial Coverage Stage is changing from a copayment to coinsurance. Go to the following table for the changes from 2025 to 2026.

The table shows your cost per prescription for a one-month (30-day) supply filled at a network pharmacy with standard and preferred cost sharing.

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. Most adult Part D vaccines are covered at no cost to

you. For more information about the costs of vaccines, or information about the costs for mail-order prescriptions, go to Chapter 6 of your *Evidence of Coverage*.

Once you've paid $2,100 out of pocket for covered Part D drugs, you'll move to the next stage (the Catastrophic Coverage Stage).

	2025 (this year)	**2026 (next year)**
Tier 1 - Preferred Generic: 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.	*Standard cost sharing:* You pay $0 copayment per prescription. Your cost for a one-month (30 days) mail-order prescription is $0 copayment. *Preferred cost sharing:* You pay $0 copayment per prescription.	***Standard cost sharing:*** **You pay $5 copayment per prescription.** **Your cost for a one-month (30 days) mail-order prescription is $0 copayment.** ***Preferred cost sharing:*** **You pay $0 copayment per prescription.**
Tier 2 - Generic: 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.	*Standard cost sharing:* You pay $12 copayment per prescription. Your cost for a one-month (30 days) mail-order prescription is $0 copayment. *Preferred cost sharing:* You pay $0 copayment per prescription.	***Standard cost sharing:*** **You pay $15 copayment per prescription.** **Your cost for a one-month (30 days) mail-order prescription is $0 copayment.** ***Preferred cost sharing:*** **You pay $0 copayment per prescription.**

	2025 (this year)	2026 (next year)
Tier 3 - Preferred Brand: 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.	*Standard cost sharing:* You pay $47 copayment per prescription. Your cost for a one-month (30 days) mail-order prescription is $47 copayment. *Preferred cost sharing:* You pay $47 copayment per prescription. You pay $35 per month supply of each covered insulin product on this tier.	***Standard cost sharing:*** **You pay 25% of the total cost** **Your cost for a one-month (30 days) mail-order prescription is 20% of the total cost** ***Preferred cost sharing:*** **You pay 20% of the total cost** **You pay the lesser of the Tier 3 coinsurance or $35 per month supply of each covered insulin product on this tier.**
Tier 4 - Non-Preferred Drug: 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.	*Standard cost sharing:* You pay $100 copayment per prescription. Your cost for a one-month (30 days) mail-order prescription is $100 copayment. *Preferred cost sharing:* You pay $100 copayment per prescription. You pay $35 per month supply of each covered insulin product on this tier.	***Standard cost sharing:*** **You pay 45% of the total cost.** **Your cost for a one-month (30 days) mail-order prescription is 35% of the total cost.** ***Preferred cost sharing:*** **You pay 35% of the total cost.** **You pay the lesser of the Tier 4 coinsurance or $35 per month supply of each covered insulin product on this tier.**

	2025 (this year)	2026 (next year)
Tier 5 - Specialty Tier*:* 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.	*Standard cost sharing:* You pay 33% of the total cost. Your cost for a one-month (30 days) mail-order prescription is 33% of the total cost. *Preferred cost sharing:* You pay 33% of the total cost.	***Standard cost sharing:*** **You pay 31% of the total cost.** **Your cost for a one-month (30 days) mail-order prescription is 31% of the total cost.** ***Preferred cost sharing:*** **You pay 31% of the total cost.**

Changes to the Catastrophic Coverage Stage

If you reach the Catastrophic Coverage Stage, you pay nothing for your covered Part D drugs and for excluded drugs that are covered under our enhanced benefit.

For specific information about your costs in the Catastrophic Coverage Stage, go to Chapter 6, Section 6 in your *Evidence of Coverage*.

SECTION 2 Administrative Changes

	2025 (this year)	2026 (next year)
Medicare Prescription Payment Plan	The Medicare Prescription Payment Plan is a payment option that began this year and can help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across the calendar year (January-December). You may be participating in this payment option.	**If you're participating in the Medicare Prescription Payment Plan and stay in the same Part D plan, your participation will be automatically renewed for 2026.** **To learn more about this payment option, call us at 1-888-965-1965 (TTY users call 711) or visit www.Medicare.gov.**
Organization Marketing Name	CARE N' CARE INSURANCE COMPANY OF NORTH CAROLINA	**HealthTeam Advantage**

SECTION 3 How to Change Plans

To stay in HealthTeam Advantage Plan II (PPO), you don't need to do anything. Unless you sign up for a different plan or change to Original Medicare by December 7, 2025, you'll automatically be enrolled in our HealthTeam Advantage Plan II (PPO).

If you want to change plans for 2026, follow these steps:

- **To change to a different Medicare health plan**, enroll in the new plan. You'll be automatically disenrolled from HealthTeam Advantage Plan II (PPO).
- **To change to Original Medicare with Medicare drug coverage,** enroll in the new Medicare drug plan. You'll be automatically disenrolled from HealthTeam Advantage Plan II (PPO).

- **To change to Original Medicare without a drug plan,** you can send us a written request to disenroll. Call your Healthcare Concierge at 1-888-965-1965 (TTY users call 711) for more information on how to do this. Or call **Medicare** at 1-800-MEDICARE (1-800-633-4227) and ask to be disenrolled. TTY users can call 1-877-486-2048. If you don't enroll in a Medicare drug plan, you may pay a Part D late enrollment penalty (Go to Section 1.1).

- **To learn more about Original Medicare and the different types of Medicare plans**, visit www.Medicare.gov, check the *Medicare & You 2026* handbook, call your State Health Insurance Assistance Program (go to Section 5), or call 1-800-MEDICARE (1-800-633-4227). Section 3.1 Deadlines for Changing Plans

Section 3.1 Deadlines for Changing Plans

People with Medicare can make changes to their coverage from **October 15 – December 7** each year.

If you enrolled in a Medicare Advantage plan for January 1, 2026, and don't like your plan choice, you can switch to another Medicare health plan (with or without Medicare drug coverage) or switch to Original Medicare (with or without separate Medicare drug coverage) between January 1 – March 31, 2026.

Section 3.2 Are there other times of the year to make a change?

In certain situations, people can have other chances to change their coverage during the year. Examples include people who:

- Have Medicaid
- Get Extra Help paying for their drugs
- Have or are leaving employer coverage
- Move out of our plan's service area

If you recently moved into or currently live in, an institution (like a skilled nursing facility or long-term care hospital), you can change your Medicare coverage **at any time**. You can change to any other Medicare health plan (with or without separate Medicare drug coverage) or switch to Original Medicare (with or without Medicare drug coverage) at any time. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for 2 full months after the month you move out.

SECTION 4 Get Help Paying for Prescription Drugs

You can qualify for help paying for prescription drugs. Different kinds of help are available:

- **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 drug plan premiums, yearly deductibles, and coinsurance. Also, people who qualify won't have a late enrollment penalty. To see if you qualify, call:
  - 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048, 24 hours a day, 7 days a week.
  - Social Security at 1-800-772-1213 between 8 a.m. and 7 p.m., Monday -Friday for a representative. Automated messages are available 24 hours a day. TTY users call 1-800-325-0778.
  - Your State Medicaid Office.
- **Help from your state's pharmaceutical assistance program (SPAP).** North Carolina has a program called NC MedAssist 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 (SHIP). To get the phone number for your state, visit shiphelp.org, or call 1-800-MEDICARE.
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible people living with HIV/AIDS have access to life-saving HIV medications. To be eligible for the ADAP operating in your state, you 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 drugs that are also covered by ADAP qualify for prescription cost-sharing help through the North Carolina HIV Medication Assistance Program (HMAP). For information on eligibility criteria, covered drugs, how to enroll in the program, or, if you're currently enrolled, how to continue getting help, call 1-877-466-2232. Be sure, when calling, to inform them of your Medicare Part D plan name or policy number.
- **The Medicare Prescription Payment Plan.** The Medicare Prescription Payment Plan is a payment option that works with your current drug coverage to help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across the calendar year (January – December). Anyone with a Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage plan with drug coverage) can use this payment option. **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs.**

Extra Help from Medicare and help from your SPAP and ADAP, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan. All members are eligible to participate in the Medicare Prescription Payment Plan. To learn more about this payment option, call us at 1-888-965-1965 (TTY users should call *711*) or visit www.Medicare.gov.

SECTION 5 Questions?

Get Help from HealthTeam Advantage Plan II (PPO)

- **Call your Healthcare Concierge at 1-888-965-1965 (TTY users call 711.)**

  We're available for phone calls 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 2026 *Evidence of Coverage*

  This *Annual Notice of Change* gives you a summary of changes in your benefits and costs for 2026. For details, go to the 2026 *Evidence of Coverage* for HealthTeam Advantage Plan II (PPO). The *Evidence of Coverage* is the legal, detailed description of our plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. Get the *Evidence of Coverage* on our website at https://htanc.com/members/2026-plan-documents or call your Healthcare Concierge 1-888-965-1965 (TTY users call 711) to ask us to mail you a copy.

- **Visit https://htanc.com/members/2026-plan-documents**

  Our website has the most up-to-date information about our provider network (*Provider Directory/Pharmacy Directory*) and our *List of Covered Drugs* (formulary/Drug List).

Get Free Counseling about Medicare

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

Call North Carolina Seniors' Health Insurance Information Program (SHIIP) to get free personalized health insurance counseling. They can help you understand your Medicare plan choices and answer questions about switching plans. Call North Carolina Seniors' Health Insurance Information Program (SHIIP) at 1-855-408-1212. Learn more about North Carolina Seniors' Health Insurance Information Program (SHIIP) by visiting (www.ncdoi.gov/SHIIP/).

Get Help 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 can call 1-877-486-2048.

- **Chat live with www.Medicare.gov**

  You can chat live at www.Medicare.gov/talk-to-someone.

- **Write to Medicare**

  You can write to Medicare at PO Box 1270, Lawrence, KS 66044

- **Visit www.Medicare.gov**

  The official Medicare website has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area.

- **Read *Medicare & You* 2026**

  The *Medicare & You 2026* handbook is mailed to people with Medicare every fall. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. Get a copy at www.Medicare.gov or by calling 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.