

Summary of Benefits

HealthTeam Advantage Plan I (PPO) H9808-004

HealthTeam Advantage Plan II (PPO) H9808-005



2026 Summary of Benefits

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

January 1, 2026 - December 31, 2026.

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 the Evidence of Coverage booklet. You can request a copy from HealthTeam Advantage or view it on our website at www.htanc.com/members/2026-plan-documents.

To join HealthTeam Advantage Plan I or Plan II, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. Our service area includes the following counties in North Carolina: **Alamance, Caswell, Davidson, Davie, Forsyth, Guilford, Montgomery, Orange, Randolph, Rockingham, Stokes, and Yadkin.**

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

For more information, contact HealthTeam Advantage at 1-877-905-9216 (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 from April 1 – September 30. Or visit www.htanc.com.

Cover image: Old Salem Coffee Pot, Winston-Salem.

Out-of-network/non-contracted providers are under no obligation to treat plan members, except in emergency situations. Please call our customer service number or see the Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

HealthTeam Advantage, a product of Care N' Care Insurance Company of North Carolina, Inc., is a PPO and HMO Medicare Advantage plan with a Medicare contract. Enrollment in HealthTeam Advantage depends on contract renewal. H9808_26004_M

Premiums and Benefits	HealthTeam Advantage Plan I (PPO)	HealthTeam Advantage Plan II (PPO)
Monthly Plan Premium	\$0 You must continue to pay your Medicare Part B premium.	\$40
Deductible (Medical)	\$0 These plans do not have a deductible for medical services.	\$0
Maximum Out-of-Pocket Responsibility (<i>does not include prescription drugs</i>)	In-Network: \$3,900 annually Out-of-Network: \$6,300 annually The most you pay for copays, coinsurance, and other costs for Medicare-covered medical services, supplies, and Part B-covered medication for the plan year you receive from in- and out-of-network providers. What you pay out-of-pocket for Part D prescription drugs and certain supplemental benefits (e.g., dental, vision, and hearing aids) does not apply to this amount.	In-Network: \$3,700 annually Out-of-Network: \$6,300 annually
Doctor Visits		
• Primary Care Provider (PCP)	In-Network: \$0 copay Out-of-Network: \$50 copay	In-Network: \$0 copay Out-of-Network: \$30 copay
• Specialist	In-Network: \$25 copay Out-of-Network: \$75 copay	In-Network: \$20 copay Out-of-Network: \$60 copay
Preventive Care (e.g., flu vaccine, diabetic screenings)		
	In-Network: \$0 copay Out-of-Network: \$30 copay Any additional preventive services approved by Medicare during the contract year will be covered. There are some items not covered at \$0 cost.	In-Network: \$0 copay Out-of-Network: \$30 copay
Urgent Care		
	In- and Out-of-Network: \$40 copay This copay is not waived if you are admitted to the hospital.	In- and Out-of-Network: \$30 copay This copay is not waived if you are admitted to the hospital.
Emergency Care		
	In- and Out-of-Network: \$150 copay If you are admitted to the hospital for the same condition within 3 days, the emergency care copay is waived.	In- and Out-of-Network: \$130 copay

Premiums and Benefits	HealthTeam Advantage Plan I (PPO)	HealthTeam Advantage Plan II (PPO)
Inpatient Hospital Coverage		
	In-Network: \$325 copay per day for days 1 through 6 \$0 copay per day for days 7 through 90 \$0 copay for days 91 and beyond Out-of-Network: 30% coinsurance Plan covers an unlimited number of days for an inpatient hospital stay. Prior authorization may be required.	In-Network: \$275 copay per day for days 1 through 5 \$0 copay per day for days 6 through 90 \$0 copay for days 91 and beyond Out-of-Network: 20% coinsurance
Outpatient Hospital Coverage		
	In-Network: \$350 copay Out-of-Network: 30% coinsurance Prior authorization may be required for some services.	In-Network: \$325 copay Out-of-Network: 20% coinsurance
Ambulatory Surgical Center (ASC)		
	In-Network: \$250 copay per day Out-of-Network: 30% coinsurance Prior authorization may be required for some services.	In-Network: \$200 copay per day Out-of-Network: 20% coinsurance

Premiums and Benefits (<i>continued</i>)	HealthTeam Advantage Plan I (PPO)	HealthTeam Advantage Plan II (PPO)
Diagnostic Services/Labs		
• Lab Services	In-Network: \$10 copay at a stand-alone lab facility \$20 copay at an outpatient hospital facility Out-of-Network: 30% coinsurance	In-Network: \$5 copay at a stand-alone lab facility \$10 copay at an outpatient hospital facility Out-of-Network: 20% coinsurance
• Diagnostic Tests and Procedures	In-Network: \$10 copay at a stand-alone facility \$20 copay at an outpatient hospital facility Out-of-Network: 30% coinsurance	In-Network: \$5 copay at a stand-alone facility \$10 copay at an outpatient hospital facility Out-of-Network: 20% coinsurance
• Sleep Studies	In-Network: \$50 copay at home \$100 copay for outpatient facility Out-of-Network: 30% coinsurance	In-Network: \$50 copay at home \$75 copay for outpatient facility Out-of-Network: 20% coinsurance
• Outpatient X-rays	In-Network: \$10 copay for X-ray services Out-of-Network: 30% coinsurance for X-ray services	In-Network: \$10 copay for X-ray services Out-of-Network: 20% coinsurance for X-ray services

Prior authorization may be required for some services.

Diagnostic Tests/Therapeutic Radiological Services

Diagnostic Radiological Services (Copay varies based on type of service.)

	In-Network	Out-of-Network	In-Network	Out-of-Network
• EKG Testing	\$0 copay	30% coinsurance	\$0 copay	20% coinsurance
• Ultrasound	\$75 copay	30% coinsurance	\$75 copay	20% coinsurance
• CT Scan	\$150 copay	30% coinsurance	\$125 copay	20% coinsurance
• MRI / MRA	\$225 copay	30% coinsurance	\$195 copay	20% coinsurance
• PET Scan	\$300 copay	30% coinsurance	\$275 copay	20% coinsurance
• Nuclear Stress Testing	\$225 copay	30% coinsurance	\$195 copay	20% coinsurance
• Echocardiography	\$75-\$150 copay	30% coinsurance	\$75-\$150 copay	20% coinsurance
• Other Diagnostic Radiological Services	\$225 copay	30% coinsurance	\$195 copay	20% coinsurance
Therapeutic Radiological Services	20% coinsurance	50% coinsurance	20% coinsurance	30% coinsurance

Premiums and Benefits (<i>continued</i>)	HealthTeam Advantage Plan I (PPO)	HealthTeam Advantage Plan II (PPO)
Hearing Services		
• Diagnostic Hearing Exam (Medicare covered)	In-Network: \$25 copay for a hearing exam Out-of-Network: \$75 copay for a hearing exam	In-Network: \$20 copay for a hearing exam Out-of-Network: \$60 copay for a hearing exam
• Routine Hearing Exam	In-Network: \$25 copay Out-of-Network: Not covered One exam visit per year A TruHearing provider must be used for routine hearing benefits.	In-Network: \$25 copay Out-of-Network: Not covered
• Fitting and Evaluation for Hearing Aid	In-Network: \$0 copay Out-of-Network: Not covered One year of provider follow-up visits for fitting and adjustments. A TruHearing provider must be used for hearing aid benefit.	In-Network: \$0 copay Out-of-Network: Not covered
• Hearing Aid	In-Network: \$299-\$799 per hearing aid. Advanced and Premium hearing aids are available in rechargeable style options for an additional \$50 per aid. Out-of-Network: Not covered Up to two TruHearing hearing aids every year (one per ear per year). OTC hearing aids not covered. A TruHearing provider must be used for hearing aid benefit.	In-Network: \$299-\$799 per hearing aid. Advanced and Premium hearing aids are available in rechargeable style options at no additional cost per aid. Out-of-Network: Not covered

Premiums and Benefits (<i>continued</i>)	HealthTeam Advantage Plan I (PPO)	HealthTeam Advantage Plan II (PPO)
Dental Services		
<ul style="list-style-type: none"> Diagnostic and Preventive Dental Services (Non-Medicare Covered) 	<p>Annual Benefit Maximum: No maximum plan coverage amount for Diagnostic and Preventive in- and out-of-network non-Medicare covered dental services.</p> <p>Annual Deductible: \$0</p> <p>Office Visit: \$0 copay</p> <p>In-Network: 0% coinsurance</p> <p>Out-of-Network: 50% coinsurance</p> <p>Diagnostic and Preventive dental services include cleanings, bitewing X-rays, periodic or comprehensive oral evaluations, re-evaluation - post-operative office visit, and tomographic survey.</p> <p>Must use a Dominion Dental participating dental provider for in-network coverage to apply. Frequency and visit limits apply.</p> <p>Refer to the <i>Dental Code Quick Reference Guide</i> for administrative coverage details, covered dental procedures and associated dental codes, and frequency and visit limits.</p>	<p>Annual Benefit Maximum: No maximum plan coverage amount for Diagnostic and Preventive in- and out-of-network non-Medicare covered dental services.</p> <p>Annual Deductible: \$0</p> <p>Office Visit: \$0 copay</p> <p>In-Network: 0% coinsurance</p> <p>Out-of-Network: 50% coinsurance</p> <p>Diagnostic and Preventive dental services include cleanings, bitewing X-rays, periodic or comprehensive oral evaluations, re-evaluation - post-operative office visit, and tomographic survey.</p> <p>Must use a Dominion Dental participating dental provider for in-network coverage to apply. Frequency and visit limits apply.</p> <p>Refer to the <i>Dental Code Quick Reference Guide</i> for administrative coverage details, covered dental procedures and associated dental codes, and frequency and visit limits.</p>
<ul style="list-style-type: none"> Comprehensive Dental Services (Non-Medicare Covered) 	<p>Annual Benefit Maximum: \$1,500 per year for all in- and out-of-network combined non-Medicare covered Comprehensive dental services.</p> <p>Note: There is no separate annual benefit maximum for out-of-network dental services.</p> <p>Annual Deductible: \$100 combined for all in- and out-of-network Comprehensive dental services.</p> <p>Office Visit: \$0 copay</p> <p>In-Network: 20%-50% coinsurance after Deductible is met for covered Comprehensive dental services.</p> <p>Out-of-Network: 50%-75% coinsurance after Deductible is met for covered Comprehensive dental services.</p> <p>Comprehensive dental services such as fillings, periodontal maintenance and simple extractions, crowns (including implant supported crowns), endodontics, periodontics, dentures and oral surgery.</p> <p>Must use a Dominion Dental participating dental provider for in-network coverage to apply. Frequency and visit limits apply.</p> <p>Refer to the <i>Dental Code Quick Reference Guide</i> for administrative coverage details, covered dental procedures and associated dental codes, and frequency and visit limits.</p>	<p>Annual Benefit Maximum: \$2,000 per year for all in- and out-of-network combined non-Medicare covered Comprehensive dental services.</p> <p>Note: There is no separate annual benefit maximum for out-of-network dental services.</p> <p>Annual Deductible: \$100 combined for all in- and out-of-network Comprehensive dental services.</p> <p>Office Visit: \$0 copay</p> <p>In-Network: 20%-50% coinsurance after Deductible is met for covered Comprehensive dental services.</p> <p>Out-of-Network: 50%-75% coinsurance after Deductible is met for covered Comprehensive dental services.</p> <p>Comprehensive dental services such as fillings, periodontal maintenance and simple extractions, crowns (including implant supported crowns), endodontics, periodontics, dentures and oral surgery.</p> <p>Must use a Dominion Dental participating dental provider for in-network coverage to apply. Frequency and visit limits apply.</p> <p>Refer to the <i>Dental Code Quick Reference Guide</i> for administrative coverage details, covered dental procedures and associated dental codes, and frequency and visit limits.</p>

Premiums and Benefits (<i>continued</i>)	HealthTeam Advantage Plan I (PPO)	HealthTeam Advantage Plan II (PPO)
Vision Services		
<ul style="list-style-type: none"> Diagnostic Eye Exam (Medicare covered) Eyewear (Medicare covered) 	<p>In-Network: \$25 copay Out-of-Network: \$75 copay</p> <p>In-Network: \$0 copay Out-of-Network: 30% coinsurance for Medicare-covered eyeglasses or contact lenses after cataract surgery. Materials covered up to Medicare-approved limits.</p>	<p>In-Network: \$20 copay Out-of-Network: \$60 copay</p> <p>In-Network: \$0 copay Out-of-Network: 20% coinsurance for Medicare-covered eyeglasses or contact lenses after cataract surgery.</p>
<ul style="list-style-type: none"> Routine Eye Exam (Non-Medicare covered) 	<p>In-Network: \$25 copay Out-of-Network: 30% coinsurance</p> <p>One routine eye exam per year. Refraction included.</p>	<p>In-Network: \$25 copay Out-of-Network: 20% coinsurance</p>
<ul style="list-style-type: none"> Eyeglasses (lenses and frames) Contact Lenses 	<p>In-Network: Reimbursed up to \$125 towards eyewear, including contact lenses, each year. Single vision lenses, lined bifocals, lined trifocals, and lenticular lenses covered in full.</p> <p>Vision allowance is limited to one pair of eyeglasses or contacts per year.</p>	<p>In-Network: Reimbursed up to \$125 towards eyewear, including contact lenses, each year. Single vision lenses, lined bifocals, lined trifocals, and lenticular lenses covered in full.</p>
<ul style="list-style-type: none"> Contact lens fitting/evaluation 	\$60 copay	\$60 copay
<ul style="list-style-type: none"> Lens Upgrades 	Standard progressive lenses and scratch-resistant coating are covered in full as an upgrade. No other upgrades are covered.	Standard progressive lenses and scratch-resistant coating are covered in full as an upgrade. No other upgrades are covered.

Premiums and Benefits <i>(continued)</i>	HealthTeam Advantage Plan I (PPO)	HealthTeam Advantage Plan II (PPO)
Mental Health Services		
• Inpatient Hospital	In-Network: \$325 copay per day for days 1 through 8 \$0 copay per day for days 9 through 90 Out-of-Network: 30% coinsurance Services require prior authorization.	In-Network: \$275 copay per day for days 1 through 8 \$0 copay per day for days 9 through 90 Out-of-Network: 20% coinsurance
• Outpatient Individual Therapy Visit	In-Network: \$25 copay Out-of-Network: 30% coinsurance	In-Network: \$20 copay Out-of-Network: 20% coinsurance
• Outpatient Group Therapy Visit	In-Network: \$25 copay Out-of-Network: 30% coinsurance	In-Network: \$20 copay Out-of-Network: 20% coinsurance
Skilled Nursing Facility (SNF)		
	In-Network: \$0 copay per day for days 1 through 20 \$218 copay per day for days 21 through 100 Out-of-Network: 30% coinsurance Plan covers up to 100 days in a SNF. Services require prior authorization.	In-Network: \$0 copay per day for days 1 through 20 \$218 copay per day for days 21 through 100 Out-of-Network: 20% coinsurance

Premiums and Benefits (<i>continued</i>)	HealthTeam Advantage Plan I (PPO)	HealthTeam Advantage Plan II (PPO)
Rehabilitation Services		
• Physical Therapy Visit	In-Network: \$25 copay Out-of-Network: 30% coinsurance	In-Network: \$20 copay Out-of-Network: 20% coinsurance
• Occupational Therapy Visit	In-Network: \$25 copay Out-of-Network: 30% coinsurance	In-Network: \$20 copay Out-of-Network: 20% coinsurance
• Speech and Language Therapy Visit	In-Network: \$25 copay Out-of-Network: 30% coinsurance	In-Network: \$20 copay Out-of-Network: 20% coinsurance
• Cardiac Rehabilitation Services	In-Network: \$25 copay Out-of-Network: 30% coinsurance	In-Network: \$20 copay Out-of-Network: 20% coinsurance
• Intensive Cardiac Rehabilitation Services	In-Network: \$25 copay Out-of-Network: 30% coinsurance	In-Network: \$20 copay Out-of-Network: 20% coinsurance
• Pulmonary Rehabilitation Services	In-Network: \$25 copay Out-of-Network: 30% coinsurance	In-Network: \$20 copay Out-of-Network: 20% coinsurance
Ambulance		
• Ground Ambulance (Medicare covered)	In- and Out-of-Network: \$250 copay per one-way trip	In- and Out-of-Network: \$200 copay per one-way trip
• Air Ambulance (Medicare covered)	\$350 copay per one-way trip	\$300 copay per one-way trip
Prior authorization required for non-emergency transportation. Copay is not waived if admitted to hospital.		
Medicare Part B Drugs		
	In-Network: 0% - 20% coinsurance Out-of-Network: 30% coinsurance	In-Network: 0% - 20% coinsurance Out-of-Network: 30% coinsurance
Prior authorization may be required. Does not include Part B insulin drugs.		

Premiums and Benefits <i>(continued)</i>		HealthTeam Advantage Plan I (PPO)			
Outpatient Prescription Drugs					
Phase 1: Deductible		\$250			
Deductible applies to Tier 4 and Tier 5 only.					
Phase 2: Initial Coverage	In-Network Retail (After you pay your deductible, if applicable)				
	Preferred Pharmacy		Standard Retail Pharmacy		
	30-day supply	100-day supply	30-day supply	100-day supply	
Tier 1 - Preferred Generic	\$0 copay	\$0 copay	\$10 copay	\$30 copay	
Tier 2 - Generic	\$3 copay	\$9 copay	\$15 copay	\$45 copay	
Tier 3 - Preferred Brand	20% coinsurance	20% coinsurance	25% coinsurance	25% coinsurance	
Tier 4 - Non-Preferred Drug	35% coinsurance	35% coinsurance	45% coinsurance	45% coinsurance	
Tier 5 - Specialty Tier (limited to a 30-day supply)	30% coinsurance	Not applicable	30% coinsurance	Not applicable	
	Mail Order (After you pay your deductible, if applicable)				
	Mail Order				
	30-day supply		100-day supply		
Tier 1 - Preferred Generic	\$0 copay		\$0 copay		
Tier 2 - Generic	\$3 copay		\$9 copay		
Tier 3 - Preferred Brand	20% coinsurance		20% coinsurance		
Tier 4 - Non-Preferred Drug	35% coinsurance		35% coinsurance		
Tier 5 - Specialty Tier (limited to a 30-day supply)	30% coinsurance		Not applicable		
		You won't pay more than \$35 or Tier coinsurance for a one-month supply of each covered insulin product.			
		Once your out-of-pocket costs reach \$2,100 (2026), you move to catastrophic coverage, Phase 3.			
Phase 3: Catastrophic Coverage (After your out-of-pocket costs have reached the \$2,100 limit for the calendar year)		In this stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.			
		The plan and Medicare pay the rest until the end of the calendar year.			

For more information regarding 2026 preferred pharmacy locations and the Part D drug stages, please refer to the Evidence of Coverage.

Premiums and Benefits <i>(continued)</i>		HealthTeam Advantage Plan II (PPO)			
Outpatient Prescription Drugs					
Phase 1: Deductible		\$150			
		Deductible applies to Tier 4 and Tier 5 only.			
Phase 2: Initial Coverage	In-Network Retail (After you pay your deductible, if applicable)				
	Preferred Pharmacy		Standard Retail Pharmacy		
	30-day supply	100-day supply	30-day supply	100-day supply	
Tier 1 - Preferred Generic	\$0 copay	\$0 copay	\$5 copay	\$15 copay	
Tier 2 - Generic	\$0 copay	\$0 copay	\$15 copay	\$45 copay	
Tier 3 - Preferred Brand	20% coinsurance	20% coinsurance	25% coinsurance	25% coinsurance	
Tier 4 - Non-Preferred Drug	35% coinsurance	35% coinsurance	45% coinsurance	45% coinsurance	
Tier 5 - Specialty Tier (limited to a 30-day supply)	31% coinsurance	Not applicable	31% coinsurance	Not applicable	
	Mail Order (After you pay your deductible, if applicable)				
	Mail Order				
	30-day supply		100-day supply		
Tier 1 - Preferred Generic	\$0 copay		\$0 copay		
Tier 2 - Generic	\$0 copay		\$0 copay		
Tier 3 - Preferred Brand	20% coinsurance		20% coinsurance		
Tier 4 - Non-Preferred Drug	35% coinsurance		35% coinsurance		
Tier 5 - Specialty Tier (limited to a 30-day supply)	31% coinsurance		Not applicable		
		You won't pay more than \$35 or Tier coinsurance for a one-month supply of each covered insulin product.			
		Once your out-of-pocket costs reach \$2,100 (2026), you move to catastrophic coverage, Phase 3.			
Phase 3: Catastrophic Coverage (After your out-of-pocket costs have reached the \$2,100 limit for the calendar year)		In this stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.			
		The plan and Medicare pay the rest until the end of the calendar year.			

For more information regarding 2026 preferred pharmacy locations and the Part D drug stages, please refer to the Evidence of Coverage.

Premiums and Benefits <i>(continued)</i>	HealthTeam Advantage Plan I (PPO)	HealthTeam Advantage Plan II (PPO)
Over-the-Counter (OTC) Items		
	\$60/Quarter Allowance is per quarter for qualifying OTC items, which can be purchased at participating retailers or through the NationsBenefits online store. Unused allowance amounts cannot be carried forward to the next quarter. Any unused benefit dollars will expire at the end of the year, 12/31/2026. Nicotine Replacement Therapy is not covered as part of the OTC benefit.	\$60/Quarter
Foot Care (podiatry services)		
• Foot Exams and Treatment (Medicare covered)	In-Network: \$25 copay Out-of-Network: \$75 copay	In-Network: \$20 copay Out-of-Network: \$60 copay
• Routine Foot Care	Not covered.	Not covered.
Medical Equipment/Supplies		
• Durable Medical Equipment (e.g., wheelchairs, oxygen, braces)	In-Network: 25% coinsurance Out-of-Network: 50% coinsurance	In-Network: 20% coinsurance Out-of-Network: 30% coinsurance
	Services require prior authorization.	
• Prosthetics (e.g., artificial limbs)	In-Network: 25% coinsurance Out-of-Network: 50% coinsurance	In-Network: 20% coinsurance Out-of-Network: 30% coinsurance
	Services require prior authorization.	
• Diabetic Supplies	In-Network: 0% coinsurance for preferred manufacturers 20% coinsurance for non-preferred manufacturers Out-of-Network: 30% coinsurance	In-Network: 0% coinsurance for preferred manufacturers 20% coinsurance for non-preferred manufacturers Out-of-Network: 20% coinsurance
	Diabetic Supplies and Services limited to those from the following preferred manufacturers: - Blood Glucose Meter and testing supplies - One Touch - Continuous Glucose Monitor and supplies - FreeStyle Libre Systems Prior authorization required for non-preferred diabetic supplies.	
• Diabetic Therapeutic Shoes / Inserts	In-Network: \$0 copay for one pair of Medicare-covered therapeutic shoes and up to two pairs of inserts Out-of-Network: 30% coinsurance	In-Network: \$0 copay for one pair of Medicare-covered therapeutic shoes and up to two pairs of inserts Out-of-Network: 20% coinsurance

Premiums and Benefits (<i>continued</i>)	HealthTeam Advantage Plan I (PPO)	HealthTeam Advantage Plan II (PPO)
Fitness Program		
<ul style="list-style-type: none"> SilverSneakers® 	<p>In-Network: \$0 copay</p> <p>HealthTeam Advantage covers the full cost of this benefit through participating SilverSneakers fitness locations. SilverSneakers fitness program offers unlimited visits with access to thousands of fitness locations nationwide, plus virtual resources and a mobile app.</p>	<p>In-Network: \$0 copay</p>
In-Home Support/Companion Services		
<ul style="list-style-type: none"> In-home or virtual assistance with non-medical services such as light house chores, technology assistance, transportation, and general companionship. 	<p>In-Network: \$0 copay</p> <p>Up to 30 hours per year with a Papa Pal for in-home support and companion services.</p>	<p>In-Network: \$0 copay</p> <p>Up to 60 hours per year with a Papa Pal for in-home support and companion services.</p>
Services must be provided by the plan's administrator, Papa.		
In-Home Meal Delivery		
	<p>In-Network: \$0 copay per meal</p> <p>Up to a total of 28 meals (2 meals per day over a 14-day period).</p> <p>Benefits may be used immediately following a qualifying event such as surgery or discharge from an inpatient hospital or skilled nursing stay.</p> <p>This benefit may be used for an unlimited number of times per calendar year based on a qualifying inpatient stay.</p> <p>You must use the plan's designated vendor for this benefit.</p>	<p>In-Network: \$0 copay per meal</p> <p>Up to a total of 28 meals (2 meals per day over a 14-day period).</p>
Telehealth Services		
	<p>\$0-\$25 copay based on provider type.</p> <p>If you choose to receive services via telehealth, you must use an in-network provider that currently offers the service via telehealth.</p> <p>This benefit may not be offered by all providers. Check directly with your providers about the availability of telehealth services.</p>	<p>\$0-\$20 copay based on provider type.</p>

Non-Discrimination Notice

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

HealthTeam Advantage:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- ◆ Qualified sign language interpreters
- ◆ Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- ◆ Qualified interpreters
- ◆ Information written in other languages

If you need these services, contact HealthTeam Advantage at 1-877-905-9216 (TTY 711) October 1-March 31, 8 a.m. to 8 p.m. ET, 7 days a week; April 1-September 30, 8 a.m. to 8 p.m. ET, Monday through Friday.

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

HealthTeam Advantage

Attn: Appeals and Grievances

300 East Wendover Avenue, Suite 121

Greensboro, NC 27401

1-877-905-9216, (TTY 711), or via fax at 800-845-4104

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Appeals and Grievances Department is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf>, by email OCRMail@hhs.gov, by phone 1-888-368-1019, TDD: 1-800-537-7697, or by mail U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201.

Get Help in Other Languages

If you need help or speak a non-English language, call 1-877-905-9216 TTY 711, and you will be connected to an interpreter who will assist you at no cost.

Notice of Availability

English: Free assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-877-905-9216 (TTY 711) or speak to your provider.

Spanish: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-877-905-9216 (TTY 711) o hable con su proveedor.

Simplified Chinese: 注意：如果您说[中文]，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 1-877-905-9216（文本电话：711）或咨询您的服务提供商。

Traditional Chinese: 注意：如果您說[台語]，我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務，以無障礙格式提供資訊。請致電 1-877-905-9216（TTY 711）或與您的提供者討論。

Tagalog: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyonang tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-877-905-9216 (TTY 711) o makipag-usap sa iyong provider.

French: Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-877-905-9216 (TTY 711) ou parlez à votre fournisseur.

Vietnamese: LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-877-905-9216 (Người khuyết tật: TTY 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.

German: UWenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzen zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-877-905-9216 (TTY 711) an oder sprechen Sie mit Ihrem Provider.

Korean: 주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-877-905-9216 (TTY 711) 번으로 전화하거나 서비스 제공업체에 문의하십시오.

Russian: ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-877-905-9216 (TTY 711) или обратитесь к своему поставщику услуг.

Arabic: تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 1-877-905-9216 (TTY 711) أو تحدث إلى مقدم الخدمة.

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-877-905-9216 (TTY 711) पर कॉल करें या अपने प्रदाता से बात करें।

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-877-905-9216 (TTY 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Se você fala [inserir idioma], serviços gratuitos de assistência linguística estão disponíveis para você. Auxílios e serviços auxiliares apropriados para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para 1-877-905-9216 (TTY 711) ou fale com seu provedor.

Polish: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 1-877-905-9216 (TTY 711) lub porozmawiaj ze swoim dostawcą.

We're Here for You!



Online

Visit htanc.com.



In Person

Local Benefit Center

5815 Samet Dr., Suite 107, High Point, NC 27265



By Phone

Prospective members call toll-free **877-905-9216**.

Current members call toll-free **888-965-1965**.

8 a.m.–8 p.m. | Oct. 1–March 31, 7 Days a Week
April 1–Sept. 30, Monday–Friday



TTY Users

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



Medicare

For more information about Medicare, call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week.

TTY users should call 1-877-486-2048. Or visit [Medicare.gov](https://www.Medicare.gov).

Connect with us



Out-of-network/non-contracted providers are under no obligation to treat plan members, except in emergency situations. Please call our customer service number or see the Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

HealthTeam Advantage, a product of Care N' Care Insurance Company of North Carolina, Inc., is a PPO and HMO Medicare Advantage plan with a Medicare contract. Enrollment in HealthTeam Advantage depends on contract renewal.

H9808_26004_M