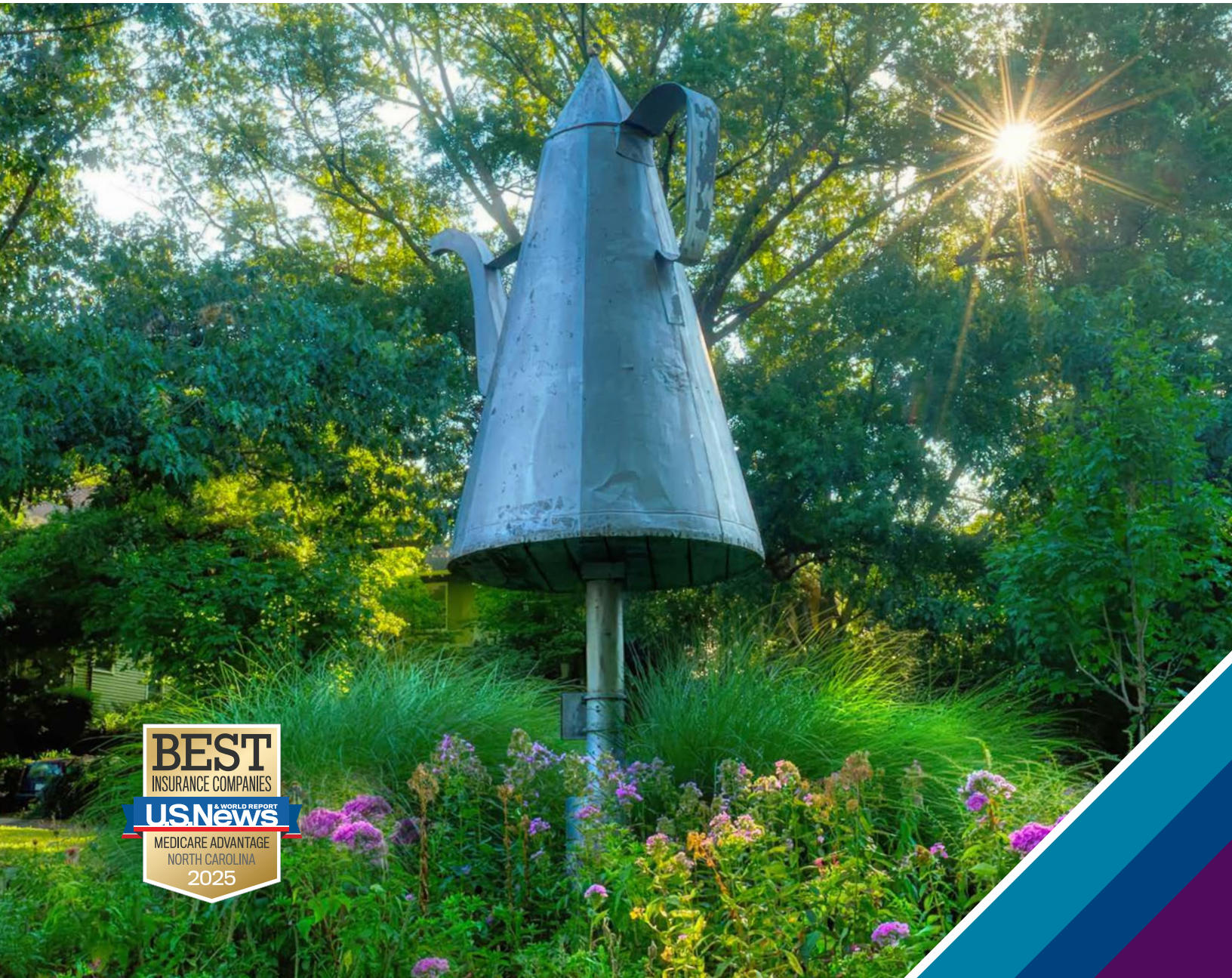
healthteam advantage℠

2026

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 1-888-965-1965 (TTY 711) from 8 a.m. to 8 p.m. Eastern, 7 days a week from October 1 – March 31, and 8 a.m. to 8 p.m. Eastern, Monday through Friday 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

2026
Plan I (PPO) and Plan II (PPO)

Premiums and Benefits	HealthTeam Advantage Plan I (PPO)	HealthTeam Advantage Plan II (PPO)
Monthly Plan Premium	**$0**	**$40**
	You must continue to pay your Medicare Part B premium.	
Deductible (Medical)	**$0**	**$0**
	These plans **do not** have a deductible for medical services.	
Maximum Out-of-Pocket Responsibility *(does not include prescription drugs)*	**In-Network: $3,900** annually **Out-of-Network: $6,300** annually	**In-Network: $$3,700** 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.	
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	**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.	
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	**In- and Out-of-Network:** **$130** copay
	If you are admitted to the hospital for the same condition within 3 days, the emergency care copay is waived.	

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	**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
	Plan covers an unlimited number of days for an inpatient hospital stay. Prior authorization may be required.	
Outpatient Hospital Coverage		
	In-Network: $350 copay **Out-of-Network:** **30%** coinsurance	**In-Network: $325** copay **Out-of-Network:** **20%** coinsurance
	Prior authorization may be required for some services.	
Ambulatory Surgical Center (ASC)		
	In-Network: **$250** copay per day **Out-of-Network:** **30%** coinsurance	**In-Network:** **$200** copay per day **Out-of-Network:** **20%** coinsurance
	Prior authorization may be required for some services.	

Premiums and Benefits *(continued)*	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 *(continued)*	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 *(continued)*	HealthTeam Advantage Plan I (PPO)	HealthTeam Advantage Plan II (PPO)
Dental Services		
• Diagnostic and Preventive Dental Services (Non-Medicare Covered)	**Annual Benefit Maximum:** No maximum plan coverage amount for Diagnostic and Preventive in- and out-of-network non-Medicare covered dental services. **Annual Deductible: $0** **Office Visit: $0** copay **In-Network: 0%** coinsurance **Out-of-Network: 50%** coinsurance Diagnostic and Preventive dental services include cleanings, bitewing X-rays, periodic or comprehensive oral evaluations, re-evaluation - post-operative office visit, and tomographic survey. Must use a Dominion Dental participating dental provider for in-network coverage to apply. Frequency and visit limits apply. **Refer to the *Dental Code Quick Reference Guide* for administrative coverage details, covered dental procedures and associated dental codes, and frequency and visit limits.**	**Annual Benefit Maximum:** No maximum plan coverage amount for Diagnostic and Preventive in- and out-of-network non-Medicare covered dental services. **Annual Deductible: $0** **Office Visit: $0** copay **In-Network: 0%** coinsurance **Out-of-Network: 50%** coinsurance
• Comprehensive Dental Services (Non-Medicare Covered)	**Annual Benefit Maximum: $1,500** per year for all in- and out-of-network combined non-Medicare covered Comprehensive dental services. **Note:** There is no separate annual benefit maximum for out-of-network dental services. **Annual Deductible: $100** combined for all in- and out-of-network Comprehensive dental services. **Office Visit: $0** copay **In-Network: 20%-50%** coinsurance after Deductible is met for covered Comprehensive dental services. **Out-of-Network: 50%-75%** coinsurance after Deductible is met for covered Comprehensive dental services. Comprehensive dental services such as fillings, periodontal maintenance and simple extractions, crowns (including implant supported crowns), endodontics, periodontics, dentures and oral surgery. Must use a Dominion Dental participating dental provider for in-network coverage to apply. Frequency and visit limits apply. **Refer to the *Dental Code Quick Reference Guide* for administrative coverage details, covered dental procedures and associated dental codes, and frequency and visit limits.**	**Annual Benefit Maximum: $2,000** per year for all in- and out-of-network combined non-Medicare covered Comprehensive dental services. **Note:** There is no separate annual benefit maximum for out-of-network dental services. **Annual Deductible: $100** combined for all in- and out-of-network Comprehensive dental services. **Office Visit: $0** copay **In-Network: 20%-50%** coinsurance after Deductible is met for covered Comprehensive dental services. **Out-of-Network: 50%-75%** coinsurance after Deductible is met for covered Comprehensive dental services.

Premiums and Benefits *(continued)*	HealthTeam Advantage Plan I (PPO)	HealthTeam Advantage Plan II (PPO)
Vision Services		
• Diagnostic Eye Exam (Medicare covered)	**In-Network: $25** copay **Out-of-Network: $75** copay	**In-Network: $20** copay **Out-of-Network: $60** copay
• Eyewear (Medicare covered)	**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.	**In-Network: $0** copay **Out-of-Network:** **20%** coinsurance for Medicare-covered eyeglasses or contact lenses after cataract surgery.
• Routine Eye Exam (Non-Medicare covered)	**In-Network: $25** copay **Out-of-Network:** **30%** coinsurance One routine eye exam per year. Refraction included.	**In-Network: $25** copay **Out-of-Network:** **20%** coinsurance
• Eyeglasses (lenses and frames) • Contact Lenses	**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. Vision allowance is limited to one pair of eyeglasses or contacts per year.	**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.
• Contact lens fitting/ evaluation	**$60** copay	**$60** copay
• 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 *(continued)*	**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 *(continued)*	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) • Air Ambulance (Medicare covered)	**In- and Out-of-Network:** **$250** copay per one-way trip **$350** copay per one-way trip **Prior authorization required for non-emergency transportation.** Copay is not waived if admitted to hospital.	**In- and Out-of-Network:** **$200** copay per one-way trip **$300** copay per one-way trip
Medicare Part B Drugs		
	In-Network: 0% - 20% coinsurance **Out-of-Network: 30%** coinsurance Prior authorization may be required. Does not include Part B insulin drugs.	**In-Network: 0% - 20%** coinsurance **Out-of-Network: 30%** coinsurance

Premiums and Benefits *(continued)*	**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 *(continued)*	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 *(continued)*	HealthTeam Advantage Plan I (PPO)	HealthTeam Advantage Plan II (PPO)
Over-the-Counter (OTC) Items		
	$60/Quarter	**$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.	
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 **Services require prior authorization.**	**In-Network: 20%** coinsurance **Out-of-Network: 30%** coinsurance
• Prosthetics (e.g., artificial limbs)	**In-Network: 25%** coinsurance **Out-of-Network: 50%** coinsurance **Services require prior authorization.**	**In-Network: 20%** coinsurance **Out-of-Network: 30%** coinsurance
• Diabetic Supplies	**In-Network:** **0%** coinsurance for preferred manufacturers **20%** coinsurance for non-preferred manufacturers **Out-of-Network: 30%** coinsurance Diabetic Supplies and Services limited to those from our preferred manufacturers for: • Blood Glucose Meter and testing supplies. • Continuous Glucose Monitor and supplies. **Prior authorization required for non-preferred diabetic supplies.**	**In-Network:** **0%** coinsurance for preferred manufacturers **20%** coinsurance for non-preferred manufacturers **Out-of-Network: 20%** coinsurance
• 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 *(continued)*	HealthTeam Advantage Plan I (PPO)	HealthTeam Advantage Plan II (PPO)
Fitness Program		
• SilverSneakers®	**In-Network: $0** copay	**In-Network: $0** copay
	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.	
In-Home Support/Companion Services		
• In-home or virtual assistance with non-medical services such as light house chores, technology assistance, transportation, and general companionship.	**In-Network: $0** copay Up to 30 hours per year with a Papa Pal for in-home support and companion services.	**In-Network: $0** copay Up to 60 hours per year with a Papa Pal for in-home support and companion services.
	Services must be provided by the plan's administrator, Papa.	
In-Home Meal Delivery		
	In-Network: $0 copay per meal Up to a total of 28 meals (2 meals per day over a 14-day period).	**In-Network: $0** copay per meal Up to a total of 28 meals (2 meals per day over a 14-day period).
	Benefits may be used immediately following a qualifying event such as surgery or discharge from an inpatient hospital or skilled nursing stay. This benefit may be used for an unlimited number of times per calendar year based on a qualifying inpatient stay. **You must use the plan's designated vendor for this benefit.**	
Telehealth Services		
	$0-$25 copay based on provider type.	**$0-$20** copay based on provider type.
	If you choose to receive services via telehealth, you **must use an in-network provider** that currently offers the service via telehealth. This benefit may not be offered by all providers. Check directly with your providers about the availability of telehealth services.	

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

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

HealthTeam Advantage
Attn: Appeals and Grievances
300 East Wendover Avenue, Suite 121
Greensboro, NC 27401
1-888-965-1965, (TTY 711), or via fax at 800-845-4104

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

Get Help in Other Languages

If you need help or speak a non-English language, call 1-888-965-1965 (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 1-888-965-1965 (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 1-888-965-1965 (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 1-888-965-1965（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 1-888-965-1965（TTY 711）或與您的提供者討論。

Tagalog: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong 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 1-888-965-1965 (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 1-888-965-1965 (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 1-888-965-1965 (Người khuyết tật: TTY 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.

German: UWenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-888-965-1965 (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.1-888-965-1965 (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 1-888-965-1965 (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 1-888-965-1965 (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। 1-888-965-1965 (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 1-888-965-1965 (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 1-888-965-1965 (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 1-888-965-1965 (TTY 711) lub porozmawiaj ze swoim dostawcą.

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

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TTY users should call 1-877-486-2048. Or visit Medicare.gov.

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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.

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