



Summary of Benefits

**HealthTeam Advantage
Plan I (PPO) H9808-004**

**HealthTeam Advantage
Plan II (PPO) H9808-005**

2027 Summary of Benefits

HealthTeam Advantage Plan I (PPO)

HealthTeam Advantage Plan II (PPO)

January 1, 2027 - December 31, 2027.

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/2027-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.

HealthTeam Advantage Plan I (PPO) and HealthTeam Advantage Plan II (PPO) Service Area:

- ◆ Alamance ◆ Davidson ◆ Forsyth ◆ Montgomery ◆ Randolph ◆ Stokes
- ◆ Caswell ◆ Davie ◆ Guilford ◆ Orange ◆ Rockingham ◆ 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.

SCAN HERE



Plan
Documents



HealthTeam
Advantage

For more information, contact HealthTeam Advantage at 1-877-905-9216 (TTY 711).

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

Or visit www.htanc.com.

2027 Plan I (PPO) and Plan II (PPO)

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.	\$34
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: \$4,900 annually Combined In- and Out-of-Network: \$8,500 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: \$4,700 annually Combined In- and Out-of-Network: \$7,500 annually
Doctor Visits		
• Primary Care Provider (PCP)	In-Network: \$0 copay Out-of-Network: 50% coinsurance	In-Network: \$0 copay Out-of-Network: 30% coinsurance
• Specialist	In-Network: \$40 copay Out-of-Network: 50% coinsurance	In-Network: \$35 copay Out-of-Network: 30% coinsurance
Preventive Care		
• Original Medicare Preventive Services (e.g., flu vaccine, diabetic screenings)	In-Network: \$0 copay Out-of-Network: 50% coinsurance	In-Network: \$0 copay Out-of-Network: 30% coinsurance
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: \$45 copay This copay is not waived if you are admitted to the hospital.	In- and Out-of-Network: \$40 copay This copay is not waived if you are admitted to the hospital.
Emergency Care		
	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.	In- and Out-of-Network: \$130 copay

Premiums and Benefits	HealthTeam Advantage Plan I (PPO)	HealthTeam Advantage Plan II (PPO)
Worldwide Travel Coverage		
	Annual Maximum Benefit: \$50,000 Worldwide Emergency Care: \$130 copay If you are admitted to the hospital for the same condition within 3 days, the emergency copay is waived. Worldwide Urgent Care: \$45 copay Copay is not waived if admitted to the hospital.	Annual Maximum Benefit: \$75,000 Worldwide Emergency Care: \$130 copay If you are admitted to the hospital for the same condition within 3 days, the emergency copay is waived. Worldwide Urgent Care: \$40 copay Copay is not waived if admitted to the hospital.
Inpatient Hospital Coverage		
	In-Network: \$350 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: 50% coinsurance Plan covers an unlimited number of days for an inpatient hospital stay. Prior authorization may be required.	In-Network: \$300 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: 30% coinsurance
Outpatient Hospital Coverage		
• Outpatient Hospital Facility	In-Network: \$200 copay per visit (non-surgical) or \$350 per visit (surgical) Out-of-Network: 50% coinsurance Prior authorization may be required for some services.	In-Network: \$175 copay per visit (non-surgical) or \$325 per visit (surgical) Out-of-Network: 30% coinsurance
Ambulatory Surgical Center (ASC)		
	In-Network: \$125 copay per visit (non-surgical) or \$200 per visit (surgical) Out-of-Network: 50% coinsurance Prior authorization may be required for some services.	In-Network: \$100 copay per visit (non-surgical) or \$175 per visit (surgical) Out-of-Network: 30% coinsurance

2027 Plan I (PPO) and Plan II (PPO)

Premiums and Benefits	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: 50% coinsurance	In-Network: \$5 copay at a stand-alone lab facility \$15 copay at an outpatient hospital facility Out-of-Network: 30% coinsurance
• Diagnostic Tests and Procedures	In-Network: \$10 copay at a stand-alone facility \$20 copay at an outpatient hospital facility Out-of-Network: 50% coinsurance	In-Network: \$5 copay at a stand-alone facility \$10 copay at an outpatient hospital facility Out-of-Network: 30% coinsurance
• Sleep Studies	In-Network: \$50 copay at home \$200 copay for outpatient facility Out-of-Network: 50% coinsurance	In-Network: \$50 copay at home \$200 copay for outpatient facility Out-of-Network: 30% coinsurance
• Outpatient X-rays	In-Network: \$20 copay for X-ray services Out-of-Network: 50% coinsurance for X-ray services	In-Network: \$10 copay for X-ray services Out-of-Network: 30% coinsurance for X-ray services
Prior authorization may be required for some diagnostic services, labs and procedures.		

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	50% coinsurance	\$0 copay	30% coinsurance
• Ultrasound	\$75-\$125 copay	50% coinsurance	\$75-\$125 copay	30% coinsurance
• CT Scan	\$150-\$200 copay	50% coinsurance	\$150-\$200 copay	30% coinsurance
• MRI / MRA	\$225-\$400 copay	50% coinsurance	\$225-\$350 copay	30% coinsurance
• PET Scan	\$400 copay	50% coinsurance	\$350 copay	30% coinsurance
• Nuclear Stress Testing	\$350 copay	50% coinsurance	\$300 copay	30% coinsurance
• Echocardiography	\$75-\$150 copay	50% coinsurance	\$75-\$150 copay	30% coinsurance
Therapeutic Radiological Services	20% coinsurance	50% coinsurance	20% coinsurance	30% coinsurance

Premiums and Benefits	HealthTeam Advantage Plan I (PPO)	HealthTeam Advantage Plan II (PPO)
Hearing Services		
• Diagnostic Hearing Exam (Medicare covered)	In-Network: \$40 copay Out-of-Network: 50% coinsurance	In-Network: \$35 copay Out-of-Network: 30% coinsurance
• Routine Hearing Exam	In-Network: \$0 copay Out-of-Network: 75% coinsurance One routine hearing exam per year (in- or out-of-network).	In-Network: \$0 copay Out-of-Network: 75% coinsurance
• Fitting and Evaluation for Hearing Aid	In-Network: \$0 copay Unlimited follow-up provider visits for fitting and adjustments for 12 months following a hearing aid purchase from TruHearing. Out-of-Network: 75% coinsurance	In-Network: \$0 copay Unlimited follow-up provider visits for fitting and adjustments for 12 months following a hearing aid purchase from TruHearing. Out-of-Network: 75% coinsurance
• Hearing Aid	In-Network: \$499-\$999 per hearing aid. Advanced and Premium hearing aids are available in rechargeable style options for an additional \$50 per aid. A TruHearing provider must be used for in-network hearing aid benefit. Out-of-Network: 75% coinsurance per hearing aid. Rechargeable style options are covered for an additional 75% coinsurance per hearing aid. You can purchase up to two hearing aids every year (one per ear per year) — combined in- and out-of-network. OTC hearing aids not covered.	In-Network: \$399-\$899 per hearing aid. Advanced and Premium hearing aids are available in rechargeable style options for an additional \$50 per aid. A TruHearing provider must be used for in-network hearing aid benefit. Out-of-Network: 75% coinsurance per hearing aid. Rechargeable style options are covered for an additional 75% coinsurance per hearing aid.

2027 Plan I (PPO) and Plan II (PPO)

Premiums and Benefits	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 copay Out-of-Network: 50% coinsurance Routine Preventive dental services include oral exams, routine cleanings, and basic X-rays. Fluoride treatment is not a covered service. Frequency and visit limits apply. Must use an FCL Dental participating dental provider for in-network coverage to apply.	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 copay Out-of-Network: 50% coinsurance Routine Preventive dental services include oral exams, routine cleanings, and basic X-rays. Fluoride treatment is not a covered service. Frequency and visit limits apply. Must use an FCL Dental participating dental provider for in-network coverage to apply.
Comprehensive Dental Services (Non-Medicare Covered)	Annual Benefit Maximum: \$750 per year for all in- and out-of-network combined 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: 50% coinsurance after deductible is met for covered Comprehensive dental services. Out-of-Network: 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 are covered. Surgical placement of implants is not a covered service. Must use an FCL Dental participating dental provider for in-network coverage to apply. Frequency and visit limits apply.	Annual Benefit Maximum: \$1,500 per year for all in- and out-of-network combined 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: 50% coinsurance after deductible is met for covered Comprehensive dental services. Out-of-Network: 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 are covered. Surgical placement of implants is not a covered service. Must use an FCL Dental participating dental provider for in-network coverage to apply. Frequency and visit limits apply.

Premiums and Benefits	HealthTeam Advantage Plan I (PPO)	HealthTeam Advantage Plan II (PPO)
Vision Services		
- Diagnostic Eye Exam (Medicare covered) - Eyewear after Cataract Surgery (Medicare covered)	In-Network: \$40 copay Out-of-Network: 50% coinsurance In-Network: \$0 copay for Medicare-covered eyeglasses or contact lenses after cataract surgery. Out-of-Network: 50% coinsurance for Medicare-covered eyeglasses or contact lenses after cataract surgery. Materials covered up to Medicare-approved limits.	In-Network: \$35 copay Out-of-Network: 30% coinsurance In-Network: \$0 copay for Medicare-covered eyeglasses or contact lenses after cataract surgery. Out-of-Network: 30% coinsurance for Medicare-covered eyeglasses or contact lenses after cataract surgery.
Routine Eye Exam (Non-Medicare covered)	In-Network: \$0 copay Out-of-Network: 75% coinsurance One routine eye exam per year (in- or out-of-network). Refraction included.	In-Network: \$0 copay Out-of-Network: 75% coinsurance
- Routine Eyewear - Eyeglasses (lenses and frames) - Contact Lenses	In-Network: Allowance of \$100 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- or out-of-network).	In-Network: Allowance of \$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 - Lens Upgrades	In-Network: \$60 copay Out-of-Network: 75% coinsurance In-Network: \$0 copay Out-of-Network: 75% coinsurance Lens upgrades include standard progressive lenses and scratch-resistant coating only.	In-Network: \$60 copay Out-of-Network: 75% coinsurance In-Network: \$0 copay Out-of-Network: 75% coinsurance Lens upgrades include standard progressive lenses and scratch-resistant coating only.

2027 Plan I (PPO) and Plan II (PPO)

Premiums and Benefits	HealthTeam Advantage Plan I (PPO)	HealthTeam Advantage Plan II (PPO)
Mental Health Services		
• Inpatient Hospital	In-Network: \$350 copay per day for days 1 through 6 \$0 copay per day for days 7 through 90 Out-of-Network: 50% coinsurance Services require prior authorization.	In-Network: \$300 copay per day for days 1 through 5 \$0 copay per day for days 6 through 90 Out-of-Network: 30% coinsurance
• Outpatient Individual Therapy Visit	In-Network: \$40 copay Out-of-Network: 50% coinsurance	In-Network: \$35 copay Out-of-Network: 30% coinsurance
• Outpatient Group Therapy Visit	In-Network: \$20 copay Out-of-Network: 50% coinsurance	In-Network: \$15 copay Out-of-Network: 30% coinsurance
Skilled Nursing Facility (SNF)		
	In-Network: \$0 copay per day for days 1 through 20 \$221 copay per day for days 21 through 100 Out-of-Network: 50% 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 \$221 copay per day for days 21 through 100 Out-of-Network: 30% coinsurance

Premiums and Benefits	HealthTeam Advantage Plan I (PPO)	HealthTeam Advantage Plan II (PPO)
Outpatient Rehabilitation Services		
• Physical Therapy Visit	In-Network: \$25 copay Out-of-Network: 50% coinsurance	In-Network: \$20 copay Out-of-Network: 30% coinsurance
• Occupational Therapy Visit	In-Network: \$40 copay Out-of-Network: 50% coinsurance	In-Network: \$35 copay Out-of-Network: 30% coinsurance
• Speech and Language Therapy Visit	In-Network: \$40 copay Out-of-Network: 50% coinsurance	In-Network: \$35 copay Out-of-Network: 30% coinsurance
• Cardiac Rehabilitation Services	In-Network: \$40 copay Out-of-Network: 50% coinsurance	In-Network: \$40 copay Out-of-Network: 30% coinsurance
• Intensive Cardiac Rehabilitation Services	In-Network: \$50 copay Out-of-Network: 50% coinsurance	In-Network: \$50 copay Out-of-Network: 30% coinsurance
• Pulmonary Rehabilitation Services	In-Network: \$35 copay Out-of-Network: 50% coinsurance	In-Network: \$35 copay Out-of-Network: 30% coinsurance
Prior authorization may be required for some outpatient rehabilitation services.		
Ambulance		
• Ground Ambulance (Medicare covered)	In- and Out-of-Network: \$300 copay per one-way trip	In- and Out-of-Network: \$200 copay per one-way trip
• Air Ambulance (Medicare covered)	In- and Out-of-Network: \$400 copay per one-way trip	In- and Out-of-Network: \$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		
• Chemotherapy/Radiation Drugs	In-Network: 0-20% coinsurance Out-of-Network: 50% coinsurance	In-Network: 0-20% coinsurance Out-of-Network: 30% coinsurance
• Other Part B Drugs	Prior authorization may be required. Does not include Part B insulin drugs. Part B drugs may be subject to Step Therapy.	
• Part B Insulin Drugs	In- and Out-of-Network: \$35 copay	In- and Out-of-Network: \$35 copay

2027 Plan I (PPO) and Plan II (PPO)

Premiums and Benefits		HealthTeam Advantage Plan I (PPO)			
Outpatient Prescription Drugs					
Phase 1: Deductible		\$595			
		Deductible applies to Tiers 3, 4, and 5 only.			
Phase 2: Initial Coverage		In-Network Retail & Mail Order (After you pay your deductible, if applicable)			
		Preferred Pharmacy & Mail Order		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		26% coinsurance	26% coinsurance	31% coinsurance	31% coinsurance
Tier 5 - Specialty Tier (limited to a 30-day supply)		27% coinsurance	Not applicable	27% 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 \$2,400, you move to catastrophic coverage, Phase 3.			
Phase 3: Catastrophic Coverage (After your out-of-pocket costs have reached the \$2,400 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 2027 preferred pharmacy locations and the Part D drug stages, please refer to the Evidence of Coverage.

Premiums and Benefits	HealthTeam Advantage Plan II (PPO)
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Outpatient Prescription Drugs

Phase 1: Deductible **\$550**

Deductible applies to Tiers 3, 4, and 5 only.

Phase 2: Initial Coverage

In-Network Retail & Mail Order

(After you pay your deductible, if applicable)

Preferred Pharmacy & Mail Order

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

28% coinsurance

28% coinsurance

33% coinsurance

33% coinsurance

Tier 5 - Specialty Tier
(limited to a
30-day supply)

27% coinsurance

Not applicable

27% 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 **\$2,400**, you move to catastrophic coverage, Phase 3.

Phase 3: Catastrophic Coverage

(After your out-of-pocket costs have reached the **\$2,400** 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 2027 preferred pharmacy locations and the Part D drug stages, please refer to the Evidence of Coverage.

2027 Plan I (PPO) and Plan II (PPO)

Premiums and Benefits	HealthTeam Advantage Plan I (PPO)	HealthTeam Advantage Plan II (PPO)
Foot Care (podiatry services)		
• Foot Exams and Treatment (Medicare covered)	In-Network: \$40 copay Out-of-Network: 50% coinsurance	In-Network: \$35 copay Out-of-Network: 30% coinsurance
• Routine Foot Care	Not covered.	Not covered.
Medical Equipment/Supplies		
• Durable Medical Equipment (e.g., wheelchairs, oxygen, braces)	In-Network: 20% coinsurance Out-of-Network: 50% coinsurance	In-Network: 20% coinsurance Out-of-Network: 50% coinsurance
Services require prior authorization.		
• Prosthetics (e.g., artificial limbs)	In-Network: 20% coinsurance Out-of-Network: 50% coinsurance	In-Network: 20% coinsurance Out-of-Network: 50% coinsurance
Services require prior authorization.		
• Diabetic Monitors	In-Network: 0% coinsurance for preferred manufacturers 25% coinsurance for non-preferred manufacturers	In-Network: 0% coinsurance for preferred manufacturers 25% coinsurance for non-preferred manufacturers
• Diabetic Supplies	Out-of-Network: 40% coinsurance for preferred 50% coinsurance for non-preferred	Out-of-Network: 30% coinsurance for preferred 50% coinsurance for non-preferred
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.		
• Diabetic Therapeutic Shoes/ Inserts	In-Network: 25% coinsurance for one pair of Medicare-covered therapeutic shoes and up to two pairs of inserts Out-of-Network: 50% coinsurance	In-Network: 25% coinsurance for one pair of Medicare-covered therapeutic shoes and up to two pairs of inserts Out-of-Network: 50% coinsurance

Premiums and Benefits	HealthTeam Advantage Plan I (PPO)	HealthTeam Advantage Plan II (PPO)
Fitness Benefit		
Physical Fitness Program	In-Network: \$0 copay The fitness program benefit helps you to stay active and connected at participating SilverSneakers® fitness locations at home or in your community. It's available at no additional cost when staying in-network and includes: - Access to a large network of participating SilverSneakers fitness locations - Unlimited gym visits - On-demand workout videos and live-streaming fitness classes Out-of-Network: 75% coinsurance	In-Network: \$0 copay The fitness program benefit helps you to stay active and connected at participating SilverSneakers® fitness locations at home or in your community. It's available at no additional cost when staying in-network and includes: - Access to a large network of participating SilverSneakers fitness locations - Unlimited gym visits - On-demand workout videos and live-streaming fitness classes Out-of-Network: 75% coinsurance
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 Out-of-Network: 75% coinsurance Benefit may be used up to 30 hours per year (combined in- and out-of-network). In-network services must be provided by the plan's administrator.	In-Network: \$0 copay Out-of-Network: 75% coinsurance Benefit may be used up to 60 hours per year (combined in- and out-of-network).
In-Home Meal Delivery		
	In-Network: \$0 copay per meal Out-of-Network: 75% coinsurance Up to a total of 14 meals (2 meals per day over a 7-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 two times per calendar year (combined in- and out-of-network) based on a qualifying inpatient stay.	In-Network: \$0 copay per meal Out-of-Network: 75% coinsurance Up to a total of 28 meals (2 meals per day over a 14-day period).
Routine Acupuncture		
Routine acupuncture services for the treatment or diagnosis of neuromusculoskeletal and related disorders, nausea, or pain.	Not covered.	In-Network: \$35 copay Out-of-Network: 30% coinsurance Limited to 30 visits per year.
Telehealth Services		
	\$0-\$40 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.	\$0-\$35 copay based on provider type.

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 Sprachassistentendienste 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.

2027 Plan I (PPO) and Plan II (PPO)

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 Italiani 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!



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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).

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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.

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.

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