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

Annual Notice of Changes for 2018

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

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

What to do now

1. ASK: Which changes apply to you

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

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

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

- Will your drugs be covered?
- Are your drugs in a different tier, with different cost sharing?
- Do any of your drugs have new restrictions, such as needing approval from us before you fill your prescription?
- Can you keep using the same pharmacies? Are there changes to the cost of using this pharmacy?
- Review the 2018 Drug List and look in Section 1.6 for information about changes to our drug coverage.

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

- Are your doctors in our network?
- What about the hospitals or other providers you use?
- Look in Section 1.3 for information about our Provider Directory.

☐ Think about your overall health care costs.

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

☐ Think about whether you are happy with our plan.

2. COMPARE: Learn about other plan choices

☐ Check coverage and costs of plans in your area.

- Use the personalized search feature on the Medicare Plan Finder at https://www.medicare.gov website. Click "Find health & drug plans."
- Review the list in the back of your Medicare & You handbook.
- Look in Section 4.2 to learn more about your choices.

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

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

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

4. ENROLL: To change plans, join a plan between **October 15** and **December 7, 2017**

- If you **don't join by December 7, 2017**, you will stay in HealthTeam Advantage Plan II (PPO).
- If you **join by December 7, 2017**, your new coverage will start on January 1, 2018.

Additional Resources

- This information is available for free in other languages.
- Please contact your Healthcare Concierge at 1-888-965-1965 for additional information. (TTY users should call 711). Hours are October 1 - February 14, 8AM – 8PM Eastern, 7 days a week; February 15 - September 30, 8AM – 8PM Eastern, Monday through Friday.
- **Coverage under this Plan qualifies as minimum essential coverage (MEC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at https://www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About HealthTeam Advantage Plan II (PPO)

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

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Summary of Important Costs for 2018

The table below compares the 2017 costs and 2018 costs for HealthTeam Advantage Plan II (PPO) in several important areas. Please note this is only a summary of changes. It is important to read the rest of this ***Annual Notice of Changes*** and review the enclosed *Evidence of Coverage* to see if other benefit or cost changes affect you.

Cost	2017 (this year)	2018 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 1.1 for details.	$49	$57
Maximum out-of-pocket amounts This is the <u>most</u> you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details.)	From network providers: $3,100 From network and out-of-network providers combined: $5,100	From network providers: $3,100 From network and out-of-network providers combined: $5,100
Doctor office visits	Primary care visits: **In-Network** $5 per visit **Out-of-Network** $30 per visit Specialist visits: **In-Network** $15 per visit **Out-of-Network** $50 per visit	Primary care visits: **In-Network** $7 per visit **Out-of-Network** $40 per visit Specialist visits: **In-Network** $15 per visit **Out-of-Network** $50 per visit
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.	**In-Network** Days 1: $225 per day Days 2-5: $75 per day Days 6-90: $0 per day **Out-of-Network** Days 1-6: $425 per day Days 7-90: $0 per day	**In-Network** Days 1: $250 per day Days 2-6: $125 per day Days 7-90: $0 per day **Out-of-Network** Days 1-6: $425 per day Days 7-90: $0 per day

Cost	2017 (this year)	2018 (next year)
Part D prescription drug coverage (See Section 1.6 for details.)	Deductible: $0 Copayment for a 30-day supply during the Initial Coverage Stage: • Drug Tier 1: $0 copay • Drug Tier 2: $12 copay • Drug Tier 3: $40 copay • Drug Tier 4: $75 copay • Drug Tier 5: 33% coinsurance	Deductible: $0 Copayment for a 30-day supply during the Initial Coverage Stage: • Drug Tier 1: $0 copay • Drug Tier 2: $12 copay • Drug Tier 3: $40 copay • Drug Tier 4: $75 copay • Drug Tier 5: 33% coinsurance

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Annual Notice of Changes for 2018

Table of Contents

Summary of Important Costs for 2018 4

SECTION 1 Changes to Benefits and Costs for Next Year 8

Section 1.1 – Changes to the Monthly Premium 8

Section 1.2 – Changes to Your Maximum Out-of-Pocket Amounts 8

Section 1.3 – Changes to the Provider Network 9

Section 1.4 – Changes to the Pharmacy Network 10

Section 1.5 – Changes to Benefits and Costs for Medical Services....................................... 10

Section 1.6 – Changes to Part D Prescription Drug Coverage 12

SECTION 2 Deciding Which Plan to Choose 15

Section 2.1 – If you want to stay in HealthTeam Advantage Plan II (PPO) 15

Section 2.2 – If you want to change plans 15

SECTION 3 Deadline for Changing Plans...16

SECTION 4 Programs That Offer Free Counseling about Medicare 16

SECTION 5 Programs That Help Pay for Prescription Drugs............................16

SECTION 6 Questions?...18

Section 6.1 – Getting Help from HealthTeam Advantage Plan II (PPO)............................... 18

Section 6.2 – Getting Help from Medicare 18

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2017 (this year)	2018 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$49	$57

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

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

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

Cost	2017 (this year)	2018 (next year)
In-network maximum out-of-pocket amount Your costs for covered medical services (such as copays) from in-network providers count toward your network maximum out-of-pocket amount. Your plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$3,100	$3,100 Once you have paid $3,100 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services from in-network providers for the rest of the calendar year.

Cost	2017 (this year)	2018 (next year)
Combined maximum out-of-pocket amount Your costs for covered medical services (such as copays) from network and out-of-network providers count toward your combined maximum out-of-pocket amount. Your plan premium does not count toward your maximum out-of-pocket amount.	$5,100	$5,100 Once you have paid $5,100 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services from in-network or out-of-network providers for the rest of the calendar year.

Section 1.3 – Changes to the Provider Network

There are changes to our network of providers for next year. An updated Provider Directory is located on our website at www.healthteamadvantage.com. You may also call your Healthcare Concierge for updated provider information or to ask us to mail you a Provider Directory. **Please review the 2018 Provider Directory to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network**.

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

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

Section 1.4 – Changes to the Pharmacy Network

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

There are changes to our network of pharmacies for next year. An updated Pharmacy Directory is located on our website at http://www.healthteamadvantage.com. You may also call your Healthcare Concierge for updated provider information or to ask us to mail you a Pharmacy Directory. **Please review the 2018 Pharmacy Directory to see which pharmacies are in our network**.

Section 1.5 – Changes to Benefits and Costs for Medical Services

We are changing our coverage for certain medical services next year. The information below describes these changes. For details about the coverage and costs for these services, see Chapter 4, *Medical Benefits Chart (what is covered and what you pay)*, in your *2018 Evidence of Coverage.*

Cost	2017 (this year)	2018 (next year)
Inpatient Hospital	**In-Network** Days 1: $225 per day Days 2-5: $75 per day Days 6-90: $0 per day **Out-of-Network** Days 1-6: $425 per day Days 7-90: $0 per day	**In-Network** Days 1: $250 per day Days 2-6: $125 per day Days 7-90: $0 per day **Out-of-Network** Days 1-6: $425 per day Days 7-90: $0 per day
Emergency Care	You pay a $75 copay	You pay a $100 copay
Physician/Practitioner services, including doctor's office visits	**In-Network** You pay a $5 copay per visit to a Primary Care Physician **Out-of-Network** You pay a $30 copay per visit to a Primary Care Physician	**In-Network** You pay a $7 copay per visit to a Primary Care Physician **Out-of-Network** You pay a $40 copay per visit to a Primary Care Physician
Podiatry Services	**In-Network** You pay a $20 copay per visit **Out-of-Network** You pay a $50 copay per visit	**In-Network** You pay a $25 copay per visit **Out-of-Network** You pay a $60 copay per visit

Cost	2017 (this year)	2018 (next year)
Telemedicine Services	Not Covered	**In-Network** You pay a $0 copay per session with plan approved telemedicine service **Out-of-Network** You pay a $30 copay per session
Outpatient diagnostic tests and therapeutic services and supplies	**In-Network** You pay a $0 copay for laboratory tests at a provider office/laboratory facility You pay a $5 copay for laboratory tests at a outpatient hospital facility **Out-of-Network** You pay a $10 copay for laboratory tests at a provider office/laboratory facility You pay a $25 copay for laboratory tests at a outpatient hospital facility	**In-Network** You pay a $0 copay for laboratory tests at a provider office/laboratory facility You pay a $10 copay for laboratory tests at a outpatient hospital facility **Out-of-Network** You pay a $20 copay for laboratory tests at a provider office/laboratory facility You pay a $50 copay for laboratory tests at a outpatient hospital facility
Outpatient Surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers	**In-Network** You pay a $125 copay per day at an Outpatient Hospital Facility You pay a $100 copay per day at an Ambulatory Surgical Center **Out-of-Network** You pay a $225 copay per day at an Outpatient Hospital Facility You pay a $175 copay per day at an Ambulatory Surgical Center	**In-Network** You pay a $150 copay per day at an Outpatient Hospital Facility You pay a $125 copay per day at an Ambulatory Surgical Center **Out-of-Network** You pay a $300 copay per day at an Outpatient Hospital Facility You pay a $200 copay per day at an Ambulatory Surgical Center
Hearing Coverage	**In-Network** You pay a $0 copay for an annual routine hearing exam **Out-of-Network** You pay a $30 copay for an annual routine hearing exam	**In-Network** You pay a $5 copay for an annual routine hearing exam **Out-of-Network** You pay a $30 copay for an annual routine hearing exam

Cost	2017 (this year)	2018 (next year)
Vision Coverage	**In-Network** You pay a $0 copay for an annual routine eye exam **Out-of-Network** You pay a $30 copay for an annual routine eye exam	**In-Network** You pay a $5 copay for an annual routine eye exam **Out-of-Network** You pay a $30 copay for an annual routine eye exam
Ambulance services	**In-Network** You pay a $100 copay for Medicare-covered ambulance benefits per one-way trip. **Out-of-Network** You pay a $100 copay for Medicare-covered ambulance benefits per one-way trip. ***Referral is required for Non-Emergency transportation***	**In-Network** You pay a $200 copay for Medicare- covered ambulance benefits per one-way trip. **Out-of-Network** You pay a $200 copay for Medicare- covered ambulance benefits per one-way trip. ***Prior Authorization is required for Non-Emergency transportation***

Section 1.6 – Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a Formulary or "Drug List." A copy of our Drug List is in this envelope. The Drug List we included in this envelope includes many – *but not all* – of the drugs that we will cover next year. If you don't see your drug on this list, it might still be covered. **You can get the *complete* Drug List** by calling your Health Care Concierge (see the back cover) or visiting our website (http://www.healthteamadvantage.com).

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

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

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

- **Work with your doctor (or other prescriber) to find a different drug** that we cover. You can call Your Healthcare Concierge to ask for a list of covered drugs that treat the same medical condition.

In some situations, we are required to cover a **one-time**, temporary supply of a non-formulary in the first 90 days of coverage of the plan year or first 90 days of membership to avoid a gap in therapy. (To learn more about when you can get a temporary supply and how to ask for one, see Chapter 5, Section 5.2 of the *Evidence of Coverage.*) During the time when you are getting a temporary supply of a drug, you should talk with your doctor to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug.

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

If you are taking a medication that required a coverage determination in 2017, we will be extending the authorizations through 12/31/2018 provided you have a paid claim for the medication in the last four months of 2017.

Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs** may **not apply to you.** We sent you a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also called the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug costs. If you get "Extra Help" and haven't received this insert by September 30, 2017, please call your Healthcare Concierge and ask for the "LIS Rider." Phone numbers for your Healthcare Concierge are in Section 6.1 of this booklet.

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

The information below shows the changes for next year to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage. To get information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in the enclosed *Evidence of Coverage*.)

Changes to the Deductible Stage

Stage	2017 (this year)	2018 (next year)
Stage 1: Yearly Deductible Stage	Because we have no deductible, this payment stage does not apply to you.	Because we have no deductible, this payment stage does not apply to you.

Changes to Your Cost-sharing in the Initial Coverage Stage

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

Stage	2017 (this year)	2018 (next year)
Stage 2: Initial Coverage Stage During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost.** The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy that provides standard cost-sharing. For information about the costs for long-term supply or for mail-order prescriptions, look in Chapter 6, Section 5 of your *Evidence of Coverage*. We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.	Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing: **Preferred Generics:** You pay $0 per prescription **Generics:** You pay $12 per prescription **Preferred Brands:** You pay $40 per prescription **Non-Preferred Drugs:** You pay $75 per prescription **Specialty Tier:** You pay 33% of the total cost _______________ Once your total drug costs have reached $3,700, you will move to the next stage (the Coverage Gap Stage).	Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing: **Preferred Generics:** You pay $0 per prescription **Generics:** You pay $12 per prescription **Preferred Brands:** You pay $40 per prescription **Non-Preferred Drugs:** You pay $75 per prescription **Specialty Tier:** You pay 33% of the total cost _______________ Once your total drug costs have reached $3,750, you will move to the next stage (the Coverage Gap Stage).

Changes to the Coverage Gap and Catastrophic Coverage Stages

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

SECTION 2 Deciding Which Plan to Choose

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

To stay in our plan you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically stay enrolled as a member of our plan for 2018.

Section 2.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change for 2018 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- --*OR*-- You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan.

To learn more about Original Medicare and the different types of Medicare plans, read *Medicare & You 2018*, call your State Health Insurance Assistance Program (see Section 4), or call Medicare (see Section 6.2).

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

As a reminder, HealthTeam Advantage offers other Medicare health plans. These other plans may differ in coverage, monthly premiums, and cost-sharing amounts.

Step 2: Change your coverage

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

SECTION 3 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7.** The change will take effect on January 1, 2018.

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

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

If you enrolled in a Medicare Advantage plan for January 1, 2018, and don't like your plan choice, you can switch to Original Medicare between January 1 and February 14, 2018. For more information, see Chapter 10, Section 2.2 of the *Evidence of Coverage*.

SECTION 4 Programs That Offer Free Counseling about Medicare

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

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

SECTION 5 Programs That Help Pay for Prescription Drugs

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

- **"Extra Help" from Medicare.** People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. Many people are eligible and don't even know it. To see if you qualify, call:
- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
    - The Social Security Office at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY users should call, 1-800-325-0778 (applications);
    - Your State Medicaid Office (applications).

- **Help from your state's pharmaceutical assistance program.** Many states have State Pharmaceutical Assistance Programs that help some people pay for prescription drugs based on financial need, age, medical condition, or disabilities. Each state has different rules to provide drug coverage to its members. These programs provide limited income and medically needy seniors and individuals with disabilities financial help for prescription drugs. In North Carolina, the State Pharmaceutical Assistance Programs are the North Carolina HIV SPAP and North Carolina AIDS Drug Assistance Program.

Method	North Carolina HIV SPAP: (North Carolina State Pharmaceutical Assistance Program) – Contact Information
CALL	1-877-466-2232
WRITE	North Carolina HIV SPAP 1902 Mail Service Center Raleigh, NC 27699-2501
WEBSITE	http://www.epi.publichealth.nc.gov/cd/hiv/adap.html
	North Carolina AIDS Drug Assistance Program: (North Carolina State Pharmaceutical Assistance Program) – Contact Information
CALL	1-919-733-3419
WRITE	North Carolina AIDS Drug Assistance Program 225 N McDowell Street Raleigh, NC 27603
WEBSITE	http://www.epi.publichealth.nc.gov/cd/hiv/adap

- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by the ADAP qualify for prescription cost-sharing assistance through the North Carolina AIDS Drug Assistance Program. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call 1-877-466-2232.

SECTION 6 Questions?

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

Questions? We're here to help. Please call your Healthcare Concierge at 1-888-965-1965. (TTY only, call 711) We are available October 1 - February 14, 8AM – 8PM Central, 7 days a week; February 15 - September 30, 8AM – 8PM Central, Monday through Friday.

Read your 2018 *Evidence of Coverage* (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2018. For details, look in the 2018 *Evidence of Coverage* for HealthTeam Advantage Plan II (PPO). The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is included in this envelope.

Visit our Website

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

Section 6.2 – Getting Help from Medicare

To get information directly from Medicare:

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

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

Visit the Medicare Website

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

Read *Medicare & You 2018*

You can read *Medicare & You 2018* Handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (https://www.medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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