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

Annual Notice of Changes for 2019

You are currently enrolled as a member of HealthTeam Advantage Plan I (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 2019 Drug List and look in Section 1.6 for information about changes to our drug coverage.
- Your drug costs may have risen since last year. Talk to your doctor about lower cost alternatives that may be available for you; this may save you in annual out-of-pocket costs throughout the year. To get additional information on drug prices visit https://go.medicare.gov/drugprices. These dashboards highlight which manufacturers have been increasing their prices and also show other year-to-year drug price information. Keep in mind that your plan benefits will determine exactly how much your own drug costs may change.

☐ 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/Pharmacy 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 3.2 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 I (PPO), you don't need to do anything. You will stay in HealthTeam Advantage Plan I (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, 2018**

- If you **don't join another plan by December 7, 2018**, you will stay in HealthTeam Advantage Plan I (PPO).
- If you **join another plan by December 7, 2018**, your new coverage will start on January 1, 2019.

Additional Resources

- This information is also available in large print. Please call your Healthcare Concierge at 1-888-965-1965 (TTY users should call 711) if you need plan information in another format or language.

- **Coverage under this Plan qualifies as Qualifying Health Coverage (QHC)** 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 I (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 I (PPO).

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Summary of Important Costs for 2019

The table below compares the 2018 costs and 2019 costs for HealthTeam Advantage Plan I (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	2018 (this year)	2019 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 1.1 for details.	$0	$0
Maximum out-of-pocket amounts This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details.)	From network providers: $3,400 From network and out-of-network providers combined: $5,100	From network providers: $3,400 From network and out-of-network providers combined: $5,100
Doctor office visits	**In-network:** Primary care visits: $10 copay per visit Specialist visits: $20 copay per visit **Out-of-network:** Primary care visits: $45 copay per visit Specialist visits: $50 copay per visit	**In-network:** Primary care visits: $0 copay per visit Specialist visits: $20 copay per visit **Out-of-network:** Primary care visits: $50 copay per visit Specialist visits: $50 copay per visit

Cost	2018 (this year)	2019 (next year)
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:** $250 copay per day for days 1 through 6 $0 copay per day for days 7 through 90 **Out-of-network:** $400 copay per day for days 1 through 7 $0 copay per day for days 8 through 90	**In-network:** $295 copay per day for days 1 through 6 $0 copay per day for days 7 through 90 **Out-of-network:** $500 copay per day for days 1 through 6 $0 copay per day for days 7 through 90
Part D prescription drug coverage (See Section 1.6 for details.)	Deductible: $0 Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: $5 copay • Drug Tier 2: $15 copay • Drug Tier 3: $45 copay • Drug Tier 4: $85 copay • Drug Tier 5: 33% coinsurance	Deductible: $0 Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: $5 copay • Drug Tier 2: $15 copay • Drug Tier 3: $45 copay • Drug Tier 4: $90 copay • Drug Tier 5: 33% coinsurance

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SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2018 (this year)	2019 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$0	$0

- 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 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	2018 (this year)	2019 (next year)
In-network maximum out-of-pocket amount Your costs for covered medical services (such as copays) from network providers count toward your in-network maximum out-of-pocket amount. Your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$3,400	$3,400 There are no changes to the in-network maximum out-of-pocket amount for 2019. Once you have paid $3,400 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 network providers for the rest of the calendar year.
Combined maximum out-of-pocket amount Your costs for covered medical services (such as copays) from in-network and out-of-network providers count toward your combined maximum out-of-pocket amount.	$5,100	$5,100 There are no changes to the combined maximum out-of-pocket amount for 2019. 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 network or out-of-network providers for the rest of the calendar year.

Section 1.3 – Changes to the Provider Network

Our network has changed more than usual for 2019. An updated *Provider/Pharmacy 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/Pharmacy Directory*. **We strongly suggest that you review our current *Provider/Pharmacy Directory* to see if your providers (primary care provider, specialists, hospitals, etc.) are still in our network.**

It is important that you know that we may make changes to the hospitals, doctors and specialists (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 *Provider/Pharmacy 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/Pharmacy Directory*. **Please review the 2019 *Provider/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 *2019 Evidence of Coverage.*

Cost	2018 (this year)	2019 (next year)
Ambulance Services	**In and Out-of-Network** Air ambulance services not covered in 2018.	**In and Out-of-Network** You pay a $300 copay for Medicare-covered air ambulance benefits per one-way trip.
Annual Physical Exam	**Out-of-Network** You pay a $20 copay for one comprehensive preventive medical examination per year.	**Out-of-Network** You pay a $30 copay for one comprehensive preventive medical examination per year.
Cardiac rehabilitation services	**Out-of-Network** You pay a $25 copay for Medicare-covered cardiac rehabilitation and intensive cardiac rehabilitation services.	**Out-of-Network** You pay a $30 copay for Medicare-covered cardiac rehabilitation and intensive cardiac rehabilitation services.
Chiropractic Services	**Out-of-Network** You pay a $20 copay for Medicare-covered chiropractic services.	**Out-of-Network** You pay a $30 copay for Medicare-covered chiropractic services.
Colorectal cancer screening	**In-Network** You pay a $5 copay for each Medicare-covered barium enema. **Out-of- Network** You pay a $25 copay for each Medicare-covered barium enema.	**In-Network** You pay a $0 copay for each Medicare-covered barium enema. **Out-of- Network** You pay 20% of the cost for each Medicare-covered barium enema.

Cost	2018 (this year)	2019 (next year)
Dental Services	Routine (preventive) dental services are not covered. Periodontics not covered in 2018.	**In-Network** You pay a $0 copay for routine (preventive) dental services. **Out-of-Network** You pay a $25 to $50 copay for a routine (preventive) dental services. **In and Out-of-Network** Office Visit, D9430, 1 per 6 months. Periodic oral evaluation, D0120, 1 per 6 months. Limited oral evaluation, D0140, 1 per 6 months. Comprehensive oral evaluation, D0150, 1 per 3 years. Re-evaluation, limited, problem focused, D0170, 1 per 6 months. Intraoral, complete series of radiographic images, D0210, 1 per 3 years.

Cost	2018 (this year)	2019 (next year)
Dental Services (*continued*)		**In and Out-of-Network** Intraoral, periapical, first radiographic images, D0220, 2 per 12 months. Intraoral, periapical, first radiographic images, D0230, 2 per 12 months. Bitewing, single radiographic image, D0270, 4 per 12 months. Bitewings, two radiographic images, D0272, 2 per 12 months. Bitewings, three radiographic images, D0273, 1 per 12 months. Bitewings, four radiographic images, D0274, 1 per 12 months. Panoramic image, D0330, 1 per 3 years. You pay a $25-$50 copay for periodontics.
Emergency Care	**In and Out-of-Network** You pay a $100 copay for each Medicare-covered emergency care visit.	**In and Out-of-Network** You pay a $120 copay for each Medicare-covered emergency care visit.

Cost	2018 (this year)	2019 (next year)
Hearing Services	**Out-of-Network** You pay a $50 copay for Medicare-covered hearing exam. You pay a $30 copay for one routine hearing exam per year. Exams to fit and evaluate hearing aids are not covered in 2018. **In and Out-of-Network** Hearing aids are not covered in 2018.	**Out-of-Network** You pay a $45 copay for Medicare-covered hearing exam. You pay a $45 copay for one routine hearing exam per year. You pay a $45 copay for exams to fit and evaluate hearing aids. **In and Out-of-Network** You pay $499-$699 for hearing aids. TruHearing provider must be used for in- and out-of-network hearing aid benefit.
Home Health Services	**In-Network** You pay a $25 copay for Medicare-covered home health services. **Out-of-Network** You pay a $45 copay for Medicare-covered home health services.	**In-Network** You pay a $0 copay for Medicare-covered home health services. **Out-of-Network** You pay a $50 copay for Medicare-covered home health services.

Cost	2018 (this year)	2019 (next year)
Inpatient Hospital Care	**In-Network** You pay a $250 copay per day for days 1 through 6 $0 copay per day for days 7 through 90 for Medicare-covered inpatient hospital stays. **Out-of-Network** You pay a $400 copay per day for days 1 through 7 $0 copay per day for days 8 through 90 for Medicare-covered inpatient hospital stays.	**In-Network** You pay a $295 copay per day for days 1 through 6 $0 copay per day for days 7 through 90 for Medicare-covered inpatient hospital stays. **Out-of-Network** You pay a $500 copay per day for days 1 through 6 $0 copay per day for days 7 through 90 for Medicare-covered inpatient hospital stays.
Outpatient Hospital Services	**In-Network** You pay a $190 copay for Medicare-covered outpatient hospital and observation services.	**In-Network** You pay a $225 copay Medicare-covered outpatient hospital and observation services.
Outpatient Rehabilitative Services	**Out-of-Network** You pay a $40 copay for occupational, physical, and speech language therapy visits.	**Out-of-Network** You pay a $30 copay for occupational, physical, and speech language therapy visits.
Prostate cancer screening exams	**In-Network** You pay a $10 PCP copay or a $20 specialist copay for an annual digital rectal exam. **Out-of- Network** You pay a $45 PCP copay or a $50 specialist copay for an annual digital rectal exam.	**In-Network** You pay a $0 copay for an annual digital rectal exam. **Out-of- Network** You pay 20% of the cost for an annual digital rectal exam.

Cost	2018 (this year)	2019 (next year)
Pulmonary rehabilitation services	**Out-of-Network** You pay a $25 copay	**Out-of-Network** You pay a $30 copay
Skilled Nursing Facility (SNF) Care	**In-Network** You pay a $0 copay per day for days 1 through 20 $150 copay per day for days 21 through 100 for Medicare-covered stays at a Skilled Nursing Facility.	**In-Network** You pay a $20 copay per day for days 1 through 20 $160 copay per day for days 21 through 100 for Medicare-covered stays at a Skilled Nursing Facility.
Vision Services	**Out-of-Network** You pay 50% of the cost for Medicare-covered eyeglasses or contact lenses after cataract surgery with a maximum benefit amount not to exceed $175. **In and Out-of-Network** Routine eyewear is not covered in 2018.	**Out-of-Network** You pay a $0 copay for Medicare-covered eyeglasses or contact lenses after cataract surgery with a maximum benefit amount not to exceed $100. **In-Network** You pay a $10 to $50 copay for 1 pair of eyeglasses every year (with single-vision, lined bifocal, trifocal or lenticular lenses only) or 1 pair of contact lenses every year. There is a $200 maximum allowed benefit for in-network eyewear. **Out-of-Network** You are reimbursed up to $50 for 1 pair of eyeglasses every year (with single-vision, lined bifocal, trifocal or lenticular lenses only) or 1 pair of contact lenses.

Cost	2018 (this year)	2019 (next year)
Welcome Visit-EKG	**In-Network** You pay a $0-$5 copay for an EKG following Welcome Visit. **Out-of-Network** You pay a $30 copay for an EKG following Welcome Visit.	**In-Network** You pay a $0 copay for an EKG following Welcome Visit. **Out-of-Network** You pay 20% of the cost for an EKG following Welcome Visit.
OPTIONAL SUPPLEMENTAL BENEFITS		
Comprehensive Dental Benefits (Optional Supplemental Benefit) *These benefits only apply if you purchased the optional supplemental plan for an additional premium*	**In and Out-of-Network** You pay a $35 copay for amalgam filling 1 surface. $45 copay for amalgam filling 2 surfaces. $55 copay for amalgam filling 3 surfaces. $50 copay for composite filling anterior 1 surface. $65 copay for composite filling anterior 2 surfaces. Composite filling posterior surface 1 is not covered. Composite filling posterior 2 surfaces is not covered. Composite filling posterior 3 surfaces is not covered. $40 copay for extraction, erupted tooth. $75 copay for extraction, surgical.	**In and Out-of-Network** You pay a $80 copay for amalgam filling 1 surface. $80 copay for amalgam filling 2 surfaces. $80 copay for amalgam filling 3 surfaces. $80 copay for composite filling anterior 1 surface. $80 copay for composite filling anterior 2 surfaces. $80 copay for composite filling posterior surface 1. $80 copay for composite filling posterior 2 surfaces. $80 copay for composite filling posterior 3 surfaces. $70 copay for extraction, erupted tooth. $90 copay for extraction, surgical.

Cost	2018 (this year)	2019 (next year)
Comprehensive Dental Benefits (Optional Supplemental Benefit) (*continued*)	$0 copay for denture adjustment. Complete denture, maxillary is not covered. Complete denture, mandibular is not covered. Immediate denture, maxillary is not covered. Immediate denture, mandibular is not covered. Partial denture, maxillary is not covered. Partial denture, mandibular is not covered. Partial denture, maxillary-cast metal is not covered. Partial denture, mandibular-cast metal is not covered. Crown-Porcelain/Ceramic substrate is not covered. Crown-Porcelain Fused to High Noble Metal is not covered. $305 copay for Crown - Porcelain Fused to Base Metal.	$30 copay for denture adjustment. $650 copay for complete denture, maxillary $650 copay for complete denture, mandibular. $650 copay for immediate denture, maxillary. $650 copay for immediate denture, mandibular. $650 copay for partial denture, maxillary. $650 copay for partial denture, mandibular $650 copay for partial denture, maxillary-cast metal. $650 copay for partial denture, mandibular-cast metal. $350 copay for Crown-Porcelain/Ceramic substrate. $350 copay for Crown-Porcelain Fused to High Noble Metal. $350 copay for Crown - Porcelain Fused to Base Metal.

Cost	2018 (this year)	2019 (next year)
Comprehensive Dental Benefits (Optional Supplemental Benefit) (*continued*)	$320 copay for Crown - Porcelain Fused to Noble Metal. $307 copay for Crown – Full Cast Base Metal. $305 copay for Crown – Full Cast Noble Metal. Periodontics covered as an optional supplemental benefit in 2018.	$350 copay for Crown - Porcelain Fused to Noble Metal. $350 copay for Crown – Full Cast Base Metal $350 copay for Crown – Full Cast Noble Metal. Periodontics not covered as an optional supplemental benefit in 2019. Periodontics are covered as a plan benefit in 2019; no rider is required for periodontics.
Hearing Services (Optional Supplemental Benefit) *These benefits only apply if you purchased the optional supplemental plan for an additional premium.*	Optional Supplemental Package is available with this plan in 2018.	Optional Supplemental Package for routine hearing exams and hearing aid fittings/evaluations services is not available in 2019. Hearing Services are covered as a mandatory plan benefit in 2019; no rider is required for hearing services.
Preventive Dental Benefits (Optional Supplemental Benefit) *These benefits only apply if you purchased the optional supplemental plan for an additional premium.*	Optional Supplemental Package is available with this plan in 2018.	Optional Supplemental Package is not available in 2019. Preventive Dental Services are covered as a plan benefit in 2019; no rider is required for preventive dental services.

Cost	2018 (this year)	2019 (next year)
Vision Services (Optional Supplemental Benefit) *These benefits only apply if you purchased the optional supplemental plan for an additional premium.*	Optional Supplemental Package is available with this plan in 2018.	Optional Supplemental Package for routine vision services and eye wear is not available in 2019. Routine Vision Services are covered as a plan benefit in 2019; no rider is required for routine vision services.

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.

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 temporary supply of a non-formulary drug in the first 90 days of the plan year or the first 90 days of membership to avoid a gap in therapy. For 2019, members in long term care (LTC) facilities will now receive a temporary supply that is the same amount of temporary days supply provided in all other cases: 30-day supply of medication rather than the amount provided in 2018 (up to a 98 day supply of medication). (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 2018, we will be extending the authorizations through 12/31/2019 provided you have a paid claim for the medication in the last four months of 2018.

Most of the changes in the Drug List are new for the beginning of each year. However, during the year, we might make other changes that are allowed by Medicare rules.

Starting in 2019, we may immediately remove a brand name drug on our Drug List if, at the same time, we replace it with a new generic drug on the same or lower cost sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the brand name drug on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions. This means if you are taking the brand name drug that is being replaced by the new generic (or the tier or restriction on the brand name drug changes), you will no longer always get notice of the change 60 days before we make it or get a 60-day refill of your brand name drug at a network pharmacy. If you are taking the brand name drug, you will still get information on the specific change we made, but it may arrive after the change is made.

Also, starting in 2019, before we make other changes during the year to our Drug List that require us to provide you with advance notice if you are taking a drug, we will provide you with notice 30, rather than 60, days before we make the change. Or we will give you a 30-day, rather than a 60-day, refill of your brand name drug at a network pharmacy.

When we make these changes to the Drug List during the year, you can still work with your doctor (or other prescriber) and ask us to make an exception to cover the drug. We will also continue to update our online Drug List as scheduled and provide other required information to reflect drug changes. (To learn more about the changes we may make to the Drug List, see Chapter 5, Section 6 of the Evidence of Coverage.)

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 receive "Extra Help" and haven't received this insert by **October 15th**, please call your Healthcare Concierge and ask for the "LIS Rider." Phone numbers for your Healthcare Concierge are in Section 7.1 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	2018 (this year)	2019 (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	2018 (this year)	2019 (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 a 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 $5 per prescription **Generics:** You pay $15 per prescription **Preferred Brands:** You pay $45 per prescription **Non-Preferred Drugs:** You pay $85 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).	Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing: **Preferred Generics:** You pay $5 per prescription **Generics:** You pay $15 per prescription **Preferred Brands:** You pay $45 per prescription **Non-Preferred Drugs:** You pay $90 per prescription **Specialty Tier:** You pay 33% of the total cost Once your total drug costs have reached $3,820, 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 Administrative Changes

In an effort to serve you better, HealthTeam Advantage has changed our claims and enrollment system, as well as our supplemental benefit vendors.

Process	2018 (this year)	2019 (next year)
Fitness benefit vendor	For 2018, the fitness benefit vendor for HealthTeam Advantage is Silver & Fit.	For 2019, the fitness benefit vendor for HealthTeam Advantage is Silver Sneakers.
Claims processing vendor	For 2018, the claims processing vendor for HealthTeam Advantage is SilverBack TPA.	For 2019, the claims processing vendor for HealthTeam Advantage is Beacon Health Solutions.
Dental benefit vendor	For 2018, the dental benefit vendor for HealthTeam Advantage is Avesis.	For 2019, the dental benefit vendor for HealthTeam Advantage is Argus Dental.
Vision benefit vendor	For 2018, the vision benefit vendor for HealthTeam Advantage is Avesis.	For 2019, the vision benefit vendor for HealthTeam Advantage is Coherent Vision.
Hearing benefit vendor	For 2018, the hearing benefit vendor for HealthTeam Advantage is Avesis.	For 2019, the hearing benefit vendor for HealthTeam Advantage is TruHearing.
Service Area	For 2018, the service area is: Alamance, Guilford, Randolph, and Rockingham counties.	For 2019, the service area is: Alamance, Forsyth, Guilford, Randolph, and Rockingham counties.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in HealthTeam Advantage Plan I (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 2019.

Section 3.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change for 2019 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 2019*, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2).

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.**

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 I (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 I (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 7.1 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 4 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, 2019.

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, those who have or are leaving employer coverage, and those who move out of the service area may be 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, 2019, and don't like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2019. For more information, see Chapter 10, Section 2.2 of the *Evidence of Coverage*.

SECTION 5 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 North Carolina Seniors' Health Insurance Information Program (SHIIP).

The North Carolina 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 SHIIP 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 SHIIP at 855-408-1212. You can learn more about SHIIP by visiting their website (www.ncdoi.com/SHIIP/).

SECTION 6 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 am and 7 pm, Monday through Friday. TTY users should call 1-800-325-0778 (applications); or
  - Your State Medicaid Office (applications).

- **Help from your state's pharmaceutical assistance program.** North Carolina has a program called North Carolina State Pharmaceutical Assistance Program that helps people pay for prescription drugs based on their financial need, age, or medical condition, To learn more about the program, check with your State Health Insurance Assistance Program (the name and phone numbers for this organization are in Section 5 of this booklet).
- **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 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 7 Questions?

Section 7.1 – Getting Help from HealthTeam Advantage Plan I (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 – March 31, 8AM – 8PM Central, 7 days a week, April 1 – September 30, 8AM – 8PM Central, Monday through Friday. Calls to these numbers are free.

Read your 2019 *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 2019. For details, look in the 2019 *Evidence of Coverage* for HealthTeam Advantage Plan I (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 www.healthteamadvantage.com. As a reminder, our website has the most up-to-date information about our provider network (*Provider/Pharmacy Directory*) and our list of covered drugs (Formulary/Drug List).

Section 7.2 – 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 2019*

You can read *Medicare & You 2019* 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.