



SUMMARY OF BENEFITS

HEALTHTEAM ADVANTAGE PLAN I (PPO)
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.

H9808_16_06 Accepted

Summary of Benefits

January 1, 2016 – December 31, 2016

This booklet gives you a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call us and ask for the "Evidence of Coverage."

You have choices about how to get your Medicare benefits

- One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government.
- Another choice is to get your Medicare benefits by joining a Medicare health plan (such as HealthTeam Advantage Plan I (PPO) or HealthTeam Advantage Plan II (PPO)).

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what HealthTeam Advantage Plan I (PPO) or HealthTeam Advantage Plan II (PPO) covers and what you pay.

- If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on <http://www.medicare.gov>.
- If you want to know more about the coverage and costs of Original Medicare, look in your current "**Medicare & You**" handbook. View it online at <http://www.medicare.gov> or get a copy 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.

Sections in this booklet

- Things to Know About HealthTeam Advantage Health Plan I (PPO) and HealthTeam Advantage Plan II (PPO)
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits
- Prescription Drug Benefits
- Optional Benefits (you must pay an extra premium for these benefits)

This document is available in other formats such as Braille and large print.

This document may be available in a non-English language. For additional information, call us at 1-877-905-9216.

Este documento esta disponible en otros formatos como Braille y en letra grande.

Este documento puede ser disponible en un idioma que no sea Ingles. Para obtener mas informacion, llame al 1-877-905-9216.

Things to Know About HealthTeam Advantage Plan I (PPO) and HealthTeam Advantage Plan II (PPO).

Hours of Operation

You can call us 7 days a week from 8:00 am to 8:00 pm eastern standard time.

HealthTeam Advantage Plan I (PPO) and HealthTeam Advantage Plan II (PPO) Phone Numbers and Website

- If you are a member of this plan, call toll-free 1-800-222-CARE.
- If you are not a member of this plan, call toll-free 1-877-905-9216.
- Our website: <http://www.healthteamadvantage.com>

Who can join?

To join HealthTeam Advantage Plan I (PPO) and HealthTeam Advantage Plan II (PPO), you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

Our service area includes the following counties in North Carolina: Alamance, Guilford, Randolph and Rockingham.

Which doctors, hospitals, and pharmacies can I use?

HealthTeam Advantage Plan I (PPO) and HealthTeam Advantage Plan II (PPO) have 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. But if you want to, you can also use providers that are not in our network.

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs. You can see our plan's provider and pharmacy directory at our website (<http://www.healthteamadvantage.com>). Or, call us and we will send you a copy of the provider and pharmacy directories.

What do we cover?

Like all Medicare health plans, we cover everything that Original Medicare covers - and *more*.

- **Our plan members get *all* of the benefits covered by Original Medicare. For some of these benefits, you may pay more in our plan than you would in Original Medicare.** For others, you may pay less.
- **Our plan members also get *more than what is* covered by Original Medicare.** Some of the extra benefits are outlined in this booklet.

We cover Part D drugs for HealthTeam Advantage Plan I (PPO) and HealthTeam Advantage Plan II (PPO). In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider.

- You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, <http://www.healthteamadvantage.com>.
- Or, call us and we will send you a copy of the formulary.

How will I determine my drug costs?

Our plan groups each medication into one of five "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the benefit stages that occur: Initial Coverage, Coverage Gap, and Catastrophic Coverage.

Summary of Benefits

January 1, 2016 – December 31, 2016

MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES

| | HealthTeam Advantage Plan I (PPO) | HealthTeam Advantage Plan II (PPO) |
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| How much is the monthly premium? | \$0 per month. In addition, you must keep paying your Medicare Part B premium. | \$57 per month. In addition, you must keep paying your Medicare Part B premium. |
| How much is the deductible? | This plan does not have a deductible. | This plan does not have a deductible. |
| Is there any limit on how much I will pay for my covered services? | <p>Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care.</p> <p>Your yearly limit(s) in this plan:</p> <ul style="list-style-type: none"> • 3,400 for services you receive from in-network providers. • \$5,100 for services you receive from any provider. Your limit for services received from in-network providers will count toward this limit. <p>If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year.</p> <p>Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.</p> | <p>Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care.</p> <p>Your yearly limit(s) in this plan:</p> <ul style="list-style-type: none"> • \$3,100 for services you receive from in-network providers. • \$5,100 for services you receive from any provider. Your limit for services received from in-network providers will count toward this limit. <p>If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year.</p> <p>Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.</p> |
| Is there a limit on how much the plan will pay? | No. there are no limits on how much our plan will pay. | Our plan has a coverage limit every year for certain in-network benefits. Contact us for the services that apply. |

Covered Medical and Hospital Benefits

Note:

- Services with a ¹ may require prior authorization.
- Services with a ² may require a referral from your doctor.

OUTPATIENT CARE AND SERVICES

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| Acupuncture | Not covered | Not covered |
| Ambulance | In-network: \$200 copay Out-of-network: \$200 copay | In-network: \$100 copay Out-of-network: \$100 copay |

| | HealthTeam Advantage Plan I (PPO) | HealthTeam Advantage Plan II (PPO) |
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| Chiropractic Care | <p>Manipulation of the spine to correct a subluxation (when 1 or more of the ones of your spine move out of position):</p> <p>In-network: \$15 copay Out-of-network: \$20 copay</p> | <p>Manipulation of the spine to correct a subluxation (when 1 or more of the ones of your spine move out of position):</p> <p>In-network: \$10 copay Out-of-network: \$20 copay</p> |
| Dental Services | <p>Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth):</p> <p>In-network: \$35 copay Out-of-network: \$50 copay</p> | <p>Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth):</p> <p>In-network: \$25 copay Out-of-network: \$40 copay</p> |
| Diabetes Supplies and Services | <p>Diabetes monitoring supplies:</p> <p>In-network: You pay nothing Out-of-network: 20% of the cost</p> <p>Diabetes self-management training:</p> <p>In-network: You pay nothing Out-of-network: 20% of the cost</p> <p>Therapeutic shoes or inserts:</p> <p>In-network: You pay nothing Out-of-network: 20% of the cost</p> | <p>Diabetes monitoring supplies:</p> <p>In-network: You pay nothing Out-of-network: 20% of the cost</p> <p>Diabetes self-management training:</p> <p>In-network: You pay nothing Out-of-network: 20% of the cost</p> <p>Therapeutic shoes or inserts:</p> <p>In-network: You pay nothing Out-of-network: 20% of the cost</p> |
| Diagnostic Tests, Lab and Radiology Services, and X-Rays (costs for these services may vary based on the place of service)¹ | <p>Dianostic radiology services (such as MRIs, CT scans):</p> <p>In-network: \$50-\$200 copay, depending on the service Out-of-network: \$75-\$250 copay, depending on the service</p> <p>Diagnostic tests and procedures:</p> <p>In-network: \$0-\$5 copay, depending on the service Out-of-network: \$10-\$25 copay, depending on the service</p> <p>Lab services:</p> <p>In-network: \$0-\$5 copay, depending on the service Out-of-network: \$10-\$25 copay, depending on the service</p> | <p>Dianostic radiology services (such as MRIs, CT scans):</p> <p>In-network: \$50-\$175 copay, depending on the service Out-of-network: \$75-\$200 copay, depending on the service</p> <p>Diagnostic tests and procedures:</p> <p>In-network: \$0-\$5 copay, depending on the service Out-of-network: \$10-\$25 copay, depending on the service</p> <p>Lab services:</p> <p>In-network: \$0-\$5 copay, depending on the service Out-of-network: \$10-\$25 copay, depending on the service</p> |

| | HealthTeam Advantage Plan I (PPO) | HealthTeam Advantage Plan II (PPO) |
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| Diagnostic Tests, Lab and Radiology Services, and X-Rays¹ (cont'd) | <p>Outpatient x-rays:</p> <p>In-network: \$10 copay Out-of-network: \$10-\$25 copay, depending on the service</p> <p>Therapeutic radiology services (such as radiation treatment for cancer):</p> <p>In-network: 20% of the cost Out-of-network: 30% of the cost</p> | <p>Outpatient x-rays:</p> <p>In-network: You pay nothing Out-of-network: \$10-\$25 copay, depending on the service</p> <p>Therapeutic radiology services (such as radiation treatment for cancer):</p> <p>In-network: 20% of the cost Out-of-network: 30% of the cost</p> |
| Doctor's Office Visits | <p>Primary care physician visit:</p> <p>In-network: \$15 copay Out-of-network: \$40 copay</p> <p>Specialist visit:</p> <p>In-network: \$30 copay Out-of-network: \$50 copay</p> | <p>Primary care physician visit:</p> <p>In-network: \$10 copay Out-of-network: \$30 copay</p> <p>Specialist visit:</p> <p>In-network: \$20 copay Out-of-network: \$50 copay</p> |
| Durable Medical Equipment (wheelchairs oxygen, etc.)¹ | <p>In-network: 20% of the cost Out-of-network: 30% of the cost</p> | <p>In-network: 20% of the cost Out-of-network: 30% of the cost</p> |
| Emergency Care | <p>\$75 copay</p> <p>If you are admitted to the hospital within 3 days, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs.</p> | <p>\$75 copay</p> <p>If you are admitted to the hospital within 3 days, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs.</p> |
| Foot Care (podiatry services) | <p>Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions:</p> <p>In-network: \$30 copay Out-of-network: \$50 copay</p> | <p>Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions:</p> <p>In-network: \$20 copay Out-of-network: \$50 copay</p> |
| Hearing Services | <p>Exam to diagnose and treat hearing and balance issues:</p> <p>In-network: \$35 copay Out-of-network: \$50 copay</p> | <p>Exam to diagnose and treat hearing and balance issues:</p> <p>In-network: \$25 copay Out-of-network: \$40 copay</p> |
| Home Health Care¹ | <p>In-network: \$25 copay Out-of-network: \$45 copay</p> | <p>In-network: \$10 copay Out-of-network: \$40 copay</p> |
| Mental Health Care¹ | <p>Inpatient visit: Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital.</p> | <p>Inpatient visit: Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital.</p> |

| | HealthTeam Advantage Plan I (PPO) | HealthTeam Advantage Plan II (PPO) |
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| Mental Health Care¹ (cont'd) | <p>The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you have not received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There's no limit to the number of benefit periods.</p> <p>Our plan covers 90 days for an inpatient hospital stay.</p> <p>Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days.</p> <p style="text-align: center;">In-network: \$350 copay per day for days 1 through 5</p> <p style="text-align: center;">You pay nothing per day for days 6 through 90</p> <p>Out-of-network: 35% of the cost per stay</p> <p>Outpatient group therapy visit:</p> <p style="text-align: center;">In-network: \$40 copay Out-of-network: \$60 copay</p> <p>Outpatient individual therapy visit:</p> <p style="text-align: center;">In-network: \$40 copay Out-of-network: \$60 copay</p> | <p>The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you have not received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There's no limit to the number of benefit periods.</p> <p>Our plan covers 90 days for an inpatient hospital stay.</p> <p>Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days.</p> <p style="text-align: center;">In-network: \$300 copay per day for days 1 through 5</p> <p style="text-align: center;">You pay nothing per day for days 6 through 90</p> <p>Out-of-network: 35% of the cost per stay</p> <p>Outpatient group therapy visit:</p> <p style="text-align: center;">In-network: \$40 copay Out-of-network: \$55 copay</p> <p>Outpatient individual therapy visit:</p> <p style="text-align: center;">In-network: \$40 copay Out-of-network: \$55 copay</p> |
| Outpatient Rehabilitation¹ | <p>Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks):</p> <p style="text-align: center;">In-network: \$15 copay Out-of-network: \$25 copay</p> | <p>Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks):</p> <p style="text-align: center;">In-network: \$10 copay Out-of-network: \$20 copay</p> |

| | HealthTeam Advantage Plan I (PPO) | HealthTeam Advantage Plan II (PPO) |
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| Outpatient Rehabilitation¹ <i>(cont'd)</i> | Occupational therapy visit: In-network: \$15 copay Out-of-network: \$40 copay Physical therapy and speech and language therapy visit: In-network: \$15 copay Out-of-network: \$40 copay | Occupational therapy visit: In-network: \$10 copay Out-of-network: \$30 copay Physical therapy and speech and language therapy visit: In-network: \$10 copay Out-of-network: \$30 copay |
| Outpatient Substance Abuse | Group therapy visit: In-network: \$45 copay Out-of-network: \$60 copay Individual therapy visit: In-network: \$45 copay Out-of-network: \$60 copay | Group therapy visit: In-network: \$40 copay Out-of-network: \$55 copay Individual therapy visit: In-network: \$40 copay Out-of-network: \$55 copay |
| Outpatient Surgery¹ | Ambulatory surgical center: In-network: \$150 copay Out-of-network: \$200 copay Outpatient hospital: In-network: \$170 copay Out-of-network: \$250 copay | Ambulatory surgical center: In-network: \$100 copay Out-of-network: \$175 copay Outpatient hospital: In-network: \$125 copay Out-of-network: \$225 copay |
| Over-the-Counter Items | Not Covered | Not Covered |
| Prosthetic Devices <i>(braces, artificial limbs, etc.)¹</i> | Prosthetic devices: In-network: 20% of the cost Out-of-network: 30% of the cost Related medical supplies: In-network: 20% of the cost Out-of-network: 30% of the cost | Prosthetic devices: In-network: 20% of the cost Out-of-network: 30% of the cost Related medical supplies: In-network: 20% of the cost Out-of-network: 30% of the cost |
| Renal Dialysis | In-network: \$30 copay Out-of-network: \$60 copay | In-network: \$25 copay Out-of-network: \$55 copay |
| Transportation | Not Covered | Not Covered |
| Urgently Needed Services | \$30 copay | \$30 copay |

| | HealthTeam Advantage Plan I (PPO) | HealthTeam Advantage Plan II (PPO) |
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| Vision Services | <p>Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening):</p> <p style="text-align: center;">In-network: \$0-\$35 copay, depending on the service Out-of-network: \$50 copay</p> <p>Eyeglasses or contact lenses after cataract surgery:</p> <p style="text-align: center;">In-network: You pay nothing Out-of-network: 50% of the cost</p> | <p>Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening):</p> <p style="text-align: center;">In-network: \$0-\$25 copay, depending on the service Out-of-network: \$40 copay</p> <p>Routine eye exam (for up to 1 every year):</p> <p style="text-align: center;">In-network: \$25 copay Out-of-network: \$40 copay</p> <p>Contact lenses:</p> <p style="text-align: center;">In-network: \$0 copay Out-of-network: 50% of the cost</p> <p>Eyeglasses (frames and lenses):</p> <p style="text-align: center;">In-network: \$0 copay Out-of-network: 50% of the cost</p> <p>Eyeglass frames:</p> <p style="text-align: center;">In-network: \$0 copay Out-of-network: 50% of the cost</p> <p>Eyeglass lenses:</p> <p style="text-align: center;">In-network: \$0 copay Out-of-network: 50% of the cost</p> <p>Eyeglasses or contact lenses after cataract surgery:</p> <p style="text-align: center;">In-network: \$0 copay Out-of-network: 50% of the cost</p> <p>Our plan pays up to \$100 every year for eyewear from any provider.</p> |
| Preventive Care | <p style="text-align: center;">In-network: You pay nothing Out-of-network: \$30 copay</p> <p>Our plan covers many preventive services, including:</p> <ul style="list-style-type: none"> • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screening | <p style="text-align: center;">In-network: You pay nothing Out-of-network: \$30 copay</p> <p>Our plan covers many preventive services, including:</p> <ul style="list-style-type: none"> • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screening |

| | HealthTeam Advantage Plan I (PPO) | HealthTeam Advantage Plan II (PPO) |
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| Preventive Care (cont'd) | <ul style="list-style-type: none"> • Colorectal cancer screenings (colonoscopy, Fecal occult blood test, flexible sigmoidoscopy) • Depression screening • Diabetes screenings • HIV screening • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots • "Welcome to Medicare" preventive visit (one-time) • Yearly "Wellness" visit <p>Any additional preventive services approved by Medicare during the contract year will be covered.</p> | <ul style="list-style-type: none"> • Colorectal cancer screenings (colonoscopy, Fecal occult blood test, flexible sigmoidoscopy) • Depression screening • Diabetes screenings • HIV screening • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots • "Welcome to Medicare" preventive visit (one-time) • Yearly "Wellness" visit <p>Any additional preventive services approved by Medicare during the contract year will be covered.</p> |
| Hospice | You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details. | You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details. |
| INPATIENT CARE | | |
| Inpatient Hospital Care¹ | <p>The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you have not received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There's no limit to the number of benefit periods.</p> <p>Our plan covers 90 days for an inpatient hospital stay.</p> | <p>The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you have not received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There's no limit to the number of benefit periods.</p> <p>Our plan covers an unlimited number of days for an inpatient hospital stay.</p> |

| | HealthTeam Advantage Plan I (PPO) | HealthTeam Advantage Plan II (PPO) |
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| Inpatient Hospital Care¹ (cont'd) | <p>Our plan also covers 60 “lifetime reserve days.” These are “extra” days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days.</p> <p style="text-align: center;">In-network: \$275 copay per day for days 1 through 7 You pay nothing per day for days 8 through 90</p> <p style="text-align: center;">Out-of-network: \$400 copay per day for days 1 through 7 You pay nothing per day for days 8 through 90</p> | <p style="text-align: center;">In-network: \$225 copay per day for days 1 \$75 copay per day for days 2 through 5 You pay nothing per day for days 6 through 90</p> <p style="text-align: center;">Out-of-network: \$425 copay per day for days 1 through 6 You pay nothing per day for days 7 through 90 You pay nothing per day for days 91 and beyond</p> |
| Inpatient Mental Health Care | For inpatient mental health care, see the "Mental Health Care" section of this booklet. | For inpatient mental health care, see the "Mental Health Care" section of this booklet. |
| Skilled Nursing Facility (SNF)¹ | <p>Our plan covers an unlimited number of days in a SNF.</p> <p style="text-align: center;">In-network: You pay nothing per day for days 1-20 \$150 copay per day for days 21-100 You pay nothing per day for days 101 and beyond</p> <p style="text-align: center;">Out-of-network: \$40 copay per day for days 1-20 \$160 copay per day for days 21-100</p> | <p>Our plan covers an unlimited number of days in a SNF.</p> <p style="text-align: center;">In-network: You pay nothing per day for days 1-20 \$140 copay per day for days 21-100 You pay nothing per day for days 101 and beyond</p> <p style="text-align: center;">Out-of-network: \$40 copay per day for days 1-20 \$160 copay per day for days 21-100</p> |
| PRESCRIPTION DRUG BENEFITS | | |
| How much do I pay? | <p>For Part B drugs such as chemotherapy drugs:</p> <p style="text-align: center;">In-network: 20% of the cost Out-of-network: 30% of the cost</p> <p>Other Part B drugs:</p> <p style="text-align: center;">In-network: 20% of the cost Out-of-network: 30% of the cost</p> | <p>For Part B drugs such as chemotherapy drugs:</p> <p style="text-align: center;">In-network: 20% of the cost Out-of-network: 30% of the cost</p> <p>Other Part B drugs:</p> <p style="text-align: center;">In-network: 20% of the cost Out-of-network: 30% of the cost</p> |

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| <p>Initial Coverage</p> | <p>You pay the following until your total yearly drug costs reach \$3,310. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.</p> <p>You may get your drugs at network retail pharmacies and mail order pharmacies.</p> <p>Standard Retail Cost-Sharing</p> <p>Tier 1 (Preferred Generic) 1-month: \$4 2-month: \$8 3-month: \$12</p> <p>Tier 2: (Generic) 1-month: \$15 2-month: \$30 3-month: \$45</p> <p>Tier 3: (Preferred Brand) 1-month: \$45 2-month: \$90 3-month: \$135</p> <p>Tier 4: (Non-Preferred Brand) 1-month: \$85 2-month: \$170 3-month: \$255</p> <p>Tier 5: (Specialty Tier) 1-month: 33% of the cost 2-month: 33% of the cost 3-month: 33% of the cost</p> <p>Standard Mail Order Cost-Sharing</p> <p>Tier 1: (Preferred Generic) 1-month: \$4 2-month: \$8 3-month: \$12</p> <p>Tier 2: (Generic) 1-month: \$15 copay 2-month: \$30 copay 3-month: \$45 copay</p> <p>Tier 3: (Preferred Brand) 1-month: \$45 copay 2-month: \$90 copay 3-month: \$135 copay</p> <p>Tier 4: (Non-Preferred Brand) 1-month: \$85 copay 2-month: \$170 copay 3-month: \$255 copay</p> | <p>You pay the following until your total yearly drug costs reach \$3,310. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.</p> <p>You may get your drugs at network retail pharmacies and mail order pharmacies.</p> <p>Standard Retail Cost-Sharing</p> <p>Tier 1: (Preferred Generic) 1-month: \$0 2-month: \$0 3-month: \$0</p> <p>Tier 2: (Generic) 1-month: \$12 2-month: \$24 3-month: \$36</p> <p>Tier 3: (Preferred Brand) 1-month: \$40 2-month: \$80 3-month: \$120</p> <p>Tier 4: (Non-Preferred Brand) 1-month: \$75 2-month: \$150 3-month: \$225</p> <p>Tier 5: (Specialty Tier) 1-month: 33% of the cost 2-month: 33% of the cost 3-month: 33% of the cost</p> <p>Standard Mail Order Cost-Sharing</p> <p>Tier 1: (Preferred Generic) 1-month: \$0 2-month: \$0 3-month: \$0</p> <p>Tier 2: (Generic) 1-month: \$12 copay 2-month: \$24 copay 3-month: \$36 copay</p> <p>Tier 3: (Preferred Brand) 1-month: \$40 copay 2-month: \$80 copay 3-month: \$120 copay</p> <p>Tier 4: (Non-Preferred Brand) 1-month: \$75 copay 2-month: \$150 copay 3-month: \$225 copay</p> |
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| | HealthTeam Advantage Plan I (PPO) | HealthTeam Advantage Plan II (PPO) |
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| Initial Coverage (cont'd) | <p>Tier 5: (Specialty Tier) 1-month: 33% of the cost 2-month: 33% of the cost 3-month: 33% of the cost If you reside in a long-term care facility, you pay the same as at a retail pharmacy.</p> <p>You may get drugs from an out-of-network pharmacy and pay the same as an in-network pharmacy, but you will get less of the drug.</p> | <p>Tier 5: (Specialty Tier) 1-month: 33% of the cost 2-month: 33% of the cost 3-month: 33% of the cost If you reside in a long-term care facility, you pay the same as at a retail pharmacy.</p> <p>You may get drugs from an out-of-network pharmacy and pay the same as an in-network pharmacy, but you will get less of the drugs.</p> |
| Coverage Gap | <p>Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches \$3,310.</p> <p>After you enter the coverage gap, you pay 45% of the plan's cost for covered brand name drugs and 58% of the plan's cost for covered generic drugs until your costs total \$4,850, which is the end of the coverage gap. Not everyone will enter the coverage gap.</p> | <p>Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches \$3,310.</p> <p>After you enter the coverage gap, you pay 45% of the plan's cost for covered brand name drugs and 58% of the plan's cost for covered generic drugs until your costs total \$4,850, which is the end of the coverage gap. Not everyone will enter the coverage gap.</p> |
| Coverage Gap (cont'd) | <p>Under this plan, you may pay even less for the brand and generic drugs on the formulary. Your cost varies by tier. You will need to use your formulary to locate your drug's tier. See the chart that follows to find out how much it will cost you.</p> <p>Standard Retail Cost-Sharing Tier 1 (Preferred Generic) Drugs covered: All 1-month Supply: \$4 2-month Supply: \$8 3-month Supply: \$12</p> <p>Standard Mail Order Cost-Sharing Tier 1 (Preferred Generic) Drugs covered: All 1-month Supply: \$4 2-month Supply: \$8 3-month Supply: \$12</p> | <p>Under this plan, you may pay even less for the brand and generic drugs on the formulary. Your cost varies by tier. You will need to use your formulary to locate your drug's tier. See the chart that follows to find out how much it will cost you.</p> <p>Standard Retail Cost-Sharing Tier 1 (Preferred Generic) Drugs covered: All 1-month Supply:\$0 2-month Supply:\$0 3-month Supply:\$0</p> <p>Standard Mail Order Cost-Sharing Tier 1 (Preferred Generic) Drugs covered: All 1-month Supply:\$0 2-month Supply:\$0 3-month Supply:\$0</p> |

| | HealthTeam Advantage Plan I (PPO) | HealthTeam Advantage Plan II (PPO) |
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| Catastrophic Coverage | <p>After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$4,850, you pay the greater of:</p> <ul style="list-style-type: none"> • 5% of the cost, or • \$2.95 copay for generic (including brand drugs treated as generic) and a \$7.40 copayment for all other drugs. | <p>After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$4,850, you pay the greater of:</p> <ul style="list-style-type: none"> • 5% of the cost, or • \$2.95 copay for generic (including brand drugs treated as generic) and a \$7.40 copayment for all other drugs. |
| Optional Benefits (you must pay an extra premium each month for these benefits) | | |
| <p>Package 1: Dental Rider</p> <p>How much is the monthly premium?</p> <p>How much is the deductible?</p> <p>Is there a limit on how much the plan will pay?</p> | <p>Benefits include:</p> <ul style="list-style-type: none"> • Preventive Dental • Comprehensive Dental <p>Additional \$20 per month. You must keep paying your Medicare Part B premium and your \$0 monthly plan premium.</p> <p>This package does not have a deductible.</p> <p>No. There is no limit to how much our plan will pay for benefits in this package.</p> | <p>Benefits include:</p> <ul style="list-style-type: none"> • Preventive Dental • Comprehensive Dental <p>Additional \$20 per month. You must keep paying your Medicare Part B premium and your \$57 monthly plan premium.</p> <p>This package does not have a deductible.</p> <p>No. There is no limit to how much our plan will pay for benefits in this package.</p> |
| <p>Package 2: Combination Rider (Dental, Hearing, Vision)</p> <p>How much is the monthly premium?</p> <p>How much is the deductible?</p> <p>Is there a limit on how much the plan will pay?</p> | <p>Benefits include:</p> <ul style="list-style-type: none"> • Preventive Dental • Comprehensive Dental • Eye Exams • Eyewear • Hearing Exams • Hearing Aids <p>Additional \$35 per month. You must keep paying your Medicare Part B premium and your \$0 monthly plan premium.</p> <p>This package does not have a deductible.</p> <p>Our plan has a coverage limit for certain benefits.</p> | <p>Benefits include:</p> <ul style="list-style-type: none"> • Preventive Dental • Comprehensive Dental • Hearing Exams • Hearing Aids • Eye Exams • Eyewear <p>Additional \$35 per month. You must keep paying your Medicare Part B premium and your \$57 monthly plan premium.</p> <p>This package does not have a deductible.</p> <p>Our plan has a coverage limit for certain benefits.</p> |

Multi-language Interpreter Services

English:

We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-877-905-9216. Someone who speaks English/Language can help you. This is a free service.

Spanish:

Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-877-905-9216. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin:

我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-877-905-9215。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese:

您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-877-905-9216。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog:

Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggagamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-877-905-9216. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French:

Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-877-905-9216. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese:

Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quý vị cần thông dịch viên xin gọi 1-877-905-9216. sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.

German:

Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-877-905-9216. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean:

당사는 의료 보험 또는 약품 보험에 관한 질문에 대해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-877-905-9216 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian:

Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-877-905-9216. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic:

إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-877-905-9216. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi:

हमारे सवास्थय या दवा की योजना के बारे में आपके किसी भी परथन के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया परथपथ करने के लिए, बस हमें 1-877-905-9216 पर फोन करें. कोई वथकथकत जो हिनथदी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

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. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués:

Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-877-905-9216. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole:

Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-877-905-9216. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish:

Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-877-905-9216. Ta usługa jest bezpłatna.

Japanese:

当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがあります。通訳をご用命になるには、**1-877-905-9216** にお電話ください。日本語を話す人者が支援いたします。これは無料のサービスです。