2018

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_18_41 Accepted

healthteam advantage

2018

SUMMARY OF BENEFITS

HEALTHTEAM ADVANTAGE PLAN I (PPO)
HEALTHTEAM ADVANTAGE PLAN II (PPO)

This is a summary of drug and health services covered by HealthTeam Advantage Health Plan (PPO) January 1, 2018 - December 31, 2018.

The benefit information provided is a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of covered services, please call us to request the "Evidence of Coverage." You can contact us at the numbers listed below or find the Evidence of Coverage on our website at https://www.healthteamadvantage.com.

To join a HealthTeam Advantage PPO Health Plan, 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, Rockingham.

HealthTeam Advantage has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers in our network, you may pay less for your covered services. But if you want to, you can also use providers that are not in our network.

For questions, you can contact the plan at 1-877-905-9216 (TTY:711) from 8 a.m. to 8 p.m. (EST), 7 days a week. You can also find more information on our website at https://www.healthteamadvantage.com

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.

PREMIUMS AND BENEFITS	HEALTHTEAM ADVANTAGE PLAN I		WHAT YOU SHOULD KNOW
Monthly Plan Premium	$0 monthly		You must continue to pay your Medicare Part B premium.
Deductible	$0		This plan does not have a deductible.
	IN-NETWORK	OUT-OF-NETWORK	
Maximum Out of Pocket Responsibility (does not include prescription drugs)	$3,400	$5,100	The most you pay for copays, coinsurance, and other costs for medical services for the year.
Inpatient Hospital Coverage	Days 1-6: $250 copay per day Days 7-90: $0 copay per day	Days 1-7: $400 copay per day Days 8-90: $0 copay per day	Our plan covers an unlimited number of days for an inpatient hospital stay. Prior Authorization may be required.
Outpatient Hospital Coverage • Outpatient Hospital Facility • Ambulatory Surgical Center	 $190 copay per day $175 copay per day	 $300 copay per day $225 copay per day	Prior authorization may be required for some services. Please contact the plan for more information.
DOCTOR VISITS			
• Primary Care Physician (PCP) • Specialist	$10 copay $20 copay	$45 copay $50 copay	
Preventive Care	$0 copay	$30 copay	
Emergency Care	$100 copay	$100 copay	If you are admitted to the hospital for the same condition within 3 days, the emergency copay is waived.
Urgently Needed Services	$30 copay	$30 copay	
DIAGNOSTIC SERVICES/LABS/IMAGING			
• Diagnostic Radiology Service (e.g., MRI) • Lab Services ◦ at a lab facility ◦ at outpatient hospital facility • Diagnostic Tests and Procedures ◦ at a lab facility ◦ at outpatient hospital facility • Outpatient X-Rays ◦ included with physician visit ◦ at outpatient facility	$50 - $200 copay $0 copay $10 copay $0 copay $5 copay $5 copay $5 copay	$75 - $250 copay $10 copay $25 copay $10 copay $25 copay $10 copay $25 copay	Prior authorization may be required for some services. Please contact the plan for more information.

PREMIUMS AND BENEFITS	HEALTHTEAM ADVANTAGE PLAN I		WHAT YOU SHOULD KNOW
HEARING SERVICES	IN-NETWORK	OUT-OF-NETWORK	
• Medicare Covered Diagnostic Hearing Exam • Hearing Aid • Routine Hearing Exam	$35 copay Not Covered $5 copay	$50 copay Not Covered $30 copay	 1 per year
DENTAL SERVICES			
• Oral Exam & Cleaning • Fillings • Complete Dentures	Not Covered Not Covered Not Covered	Not Covered Not Covered Not Covered	
VISION SERVICES			
• Medicare Covered Diagnostic Exam • Routine Eye Exam • Eyeglasses (lenses and frames)/Contact Lenses after Cataract Surgery	$35 copay $5 copay $0 copay	$50 copay $30 copay 50% of the cost	 1 per year. Materials covered up to Medicare approved limits.
MENTAL HEALTH SERVICES			
• Inpatient Visit • Outpatient Group Therapy Visit • Outpatient Individual Therapy Visit	Days 1-5: $350 copay per day Days 6-90: $0 copay per day $40 copay $40 copay	35% of the cost $60 copay $60 copay	Services require prior authorization.
Skilled Nursing Facility (SNF)	Days 1-20: $0 copay per day Days 21-100: $150 copay per day	Days 1-20: $40 copay per day Days 21-100: $160 copay per day	Our plan covers up to 100 days in a SNF. Services require prior authorization.
REHABILITATION SERVICES			
• Occupational Therapy Visit • Physical Therapy and Speech and Language Therapy Visit	$15 copay $15 copay	$40 copay $40 copay	
Ambulance	$225 copay	$225 copay	Prior Authorization required for non-emergency transportation.
Transportation	Not Covered	Not Covered	
Medicare Part B Drugs	20% of the cost	30% of the cost	Prior authorization may be required
FOOT CARE (PODIATRY SERVICES)			
• Foot Exams and Treatment • Routine Foot Care	$35 copay Not Covered	$60 copay Not Covered	

PREMIUMS AND BENEFITS	HEALTHTEAM ADVANTAGE PLAN I		WHAT YOU SHOULD KNOW
MEDICAL EQUIPMENT/SUPPLIES	IN-NETWORK	OUT-OF-NETWORK	
• Durable Medical Equipment (e.g., wheelchairs, oxygen)	20% of the cost	30% of the cost	Services require prior authorization
• Prosthetics (e.g., braces, artificial limbs)	20% of the cost	30% of the cost	Services require prior authorization
• Diabetes Supplies	$0 copay	20% of the cost	Limited to the following manufacturers: Freestyle, Precision, and One Touch.
Wellness Programs (e.g., fitness)	$0 copay	$30 copay	Access to Silver and Fit network facilities. Members can change locations once per month.
OUTPATIENT PRESCRIPTION DRUGS			
	Retail Rx 30-day supply	Mail Order 90-day supply	
PHASE 1: INITIAL COVERAGE			
During the Initial Coverage Stage, you pay the following amount until your “total drug costs” (the amount paid by both you and the plan) reaches $3,750.			
• Tier 1: Preferred Generics • Tier 2: Generics • Tier 3: Preferred Brand • Tier 4: Non-Preferred Drugs • Tier 5: Specialty Drugs	$5 copay $15 copay $45 copay $85 copay 33% of the cost	$10 copay $30 copay $90 copay $170 copay 33% of the cost	Cost-Sharing may change depending on the pharmacy you choose and when you enter another phase of the Part D benefit. For more information on the additional pharmacy specific cost-sharing and the phases of the benefit, please call us or access our Evidence of Coverage online.
PHASE 2: COVERAGE GAP			
For Tier 1 generic drugs, you pay either your Tier 1 copayment or 44% of the costs, whichever is lower. For all other covered generic drugs, you pay 44% of the costs. For covered brand name drugs, you pay 35% of the price (plus a portion of the dispensing fee). You stay in this stage until your year-to-date “out-of-pocket costs” (your payments) reach a total of $5,000. This amount and rules for counting costs toward this amount have been set by Medicare.			
PHASE 3: CATASTROPHIC COVERAGE			
During this stage, the plan will pay most of the cost of your drugs for the rest of the calendar year (through December 31, 2018). Your share of the cost for a covered drug will be either coinsurance or a copayment, whichever is the larger amount (either coinsurance for 5% of the cost of the drug, or $3.35 for a generic drug or a drug that is reated like a generic and $8.35 for all other drugs).			

PREMIUMS AND BENEFITS	HEALTHTEAM ADVANTAGE PLAN I	WHAT YOU SHOULD KNOW
OPTIONAL SUPPLEMENTAL BENEFITS		
DENTAL SERVICES ONLY		
• Monthly Premium	$25 monthly	
ORAL EXAMS		
• Recall Exam (D0120) • Comprehensive Exam (D0150) • Routine Cleaning (D1110)	$0 copay $0 copay $0 copay	Up to 2 per year. 1 per year; New Patients Only; Limited to 1 every 3 years. Up to 2 per year.
X-RAYS - (CHOOSE ONE OF THE FOLLOWING CATEGORIES EACH YEAR)		
• Bitewing X-Rays (D0270/ D0272/D0273/D0274) • Full Mouth X-Rays (D0210)	$0 copay $0 copay	1 set per year. 1 set per year; Allowed once every year.
FILLINGS		
• Amalgam Filling - 1 surface (D2140) • Amalgam Filling - 2 surfaces (D2150) • Amalgam Filling - 3 surfaces (D2160) • Resin-Based Composite Filling Anterior - 1 surface (D2330) • Resin-Based Composite Filling Anterior - 2 surfaces (D2331) • Resin-Based Composite Filling Anterior - 3 surfaces (D2332)	$35 copay $45 copay $55 copay $50 copay $65 copay $80 copay	Up to 4 total fillings per year.
Scaling and Root Planing (D4341)	$50 copay per quadrant	Up to 2 quadrants per year.
Denture Adjustment (D5410/ D5411)	$0 copay	Total of 2 per year.
EXTRACTIONS		
• Erupted Tooth (D7140) • Surgical (D7210)	$40 copay $75 copay	Up to 2 per year.
CROWNS		
• Porcelain Fused to Base Metal (D2751) • Porcelain Fused to Noble Metal (D2752) • Full Cast Base Metal (D2791) • Full Cast Noble Metal (D2792)	$305 copay $320 copay $307 copay $305 copay	Total of 2 per year. Crowns have a 6 month waiting period.

PREMIUMS AND BENEFITS	HEALTHTEAM ADVANTAGE PLAN I	WHAT YOU SHOULD KNOW
DENTAL, VISION AND HEARING SERVICES		
• Monthly Premium	$40 monthly	
DENTAL SERVICES		
ORAL EXAMS		
• Recall Exam (D0120) • Comprehensive Exam (D0150) • Routine Cleaning (D1110)	$0 copay $0 copay $0 copay	Up to 2 per year. 1 per year; New Patients Only; Limited to 1 every 3 years. Up to 2 per year.
X-RAYS - (CHOOSE ONE OF THE FOLLOWING CATEGORIES EACH YEAR)		
• Bitewing X-Rays (D0270/ D0272/D0273/D0274) • Full Mouth X-Rays (D0210)	$0 copay $0 copay	Limit 1 set per year. 1 set per year; Allowed once every 3 years.
FILLINGS		
• Amalgam Filling - 1 surface (D2140) • Amalgam Filling - 2 surfaces (D2150) • Amalgam Filling - 3 surfaces (D2160) • Resin-Based Composite Filling Anterior - 1 surface (D2330) • Resin-Based Composite Filling Anterior - 2 surfaces (D2331) • Resin-Based Composite Filling Anterior - 3 surfaces (D2332)	$35 copay $45 copay $55 copay $50 copay $65 copay $80 copay	Up to 4 total fillings per year.
Scaling and Root Planing (D4341)	$50 copay per quadrant	Up to 2 quadrants per year.
Denture Adjustment (D5410/ D5411)	$0 copay	Total of 2 per year.
EXTRACTIONS		
• Erupted Tooth (D7140) • Surgical (D7210)	$40 copay $75 copay	Up to 2 per year.
CROWNS		
• Porcelain Fused to Base Metal (D2751) • Porcelain Fused to Noble Metal (D2752) • Full Cast Base Metal (D2791) • Full Cast Noble Metal (D2792)	$305 copay $320 copay $307 copay $305 copay	Total of 2 per year. Crowns have a 6 month waiting period.

PREMIUMS AND BENEFITS	HEALTHTEAM ADVANTAGE PLAN I	WHAT YOU SHOULD KNOW
VISION SERVICES		
• Routine Eye Exam • Frames & Lenses OR Contacts	$0 copay $0 copay	1 per year. $200 coverage limit per year. Excludes any in-store or in-office provider specials.
HEARING SERVICES		
• Routine Hearing Screening Test • Hearing Aid Fitting Evaluation • Hearing Aids	$0 copay $0 copay $0 copay	Limited to 1 per year. Up to 1 every 3 years. $800 coverage limit every 3 years; for both ears.

PREMIUMS AND BENEFITS	HEALTHTEAM ADVANTAGE PLAN II		WHAT YOU SHOULD KNOW
Monthly Plan Premium	$57 monthly		You must continue to pay your Medicare Part B premium.
Deductible	$0		This plan does not have a deductible.
	IN-NETWORK	OUT-OF-NETWORK	
Maximum Out of Pocket Responsibility (does not include prescription drugs)	$3,100	$5,100	The most you pay for copays, coinsurance, and other costs for medical services for the year.
Inpatient Hospital Coverage	Day 1: $250 copay Days 2-6: $125 copay per day Days 7-90: $0 copay per day	Days 1-6: $425 copay per day Days 7-90: $0 copay per day	Our plan covers an unlimited number of days for an inpatient hospital stay. Prior Authorization may be required.
Outpatient Hospital Coverage • Outpatient Hospital Facility • Ambulatory Surgical Center	 $150 copay per day $125 copay per day	 $300 copay per day $200 copay per day	Prior authorization may be required for some services. Please contact the plan for more information.
DOCTOR VISITS			
• Primary Care Physician (PCP) • Specialist	$7 copay $15 copay	$40 copay $50 copay	
Preventive Care	$0 copay	$30 copay	
Emergency Care	$100 copay	$100 copay	If you are admitted to the hospital for the same condition within 3 days, the emergency copay is waived.
Urgently Needed Services	$30 copay	$30 copay	
DIAGNOSTIC SERVICES/LABS/IMAGING			
• Diagnostic Radiology Service (e.g., MRI) • Lab Services ◦ at a lab facility ◦ at outpatient hospital facility • Diagnostic Tests and Procedures ◦ at a lab facility ◦ at outpatient hospital facility • Outpatient X-Rays ◦ included with physician visit ◦ at outpatient facility	$50 - $175 copay $0 copay $10 copay $0 copay $5 copay $0 copay $0 copay	$75 - $200 copay $20 copay $50 copay $10 copay $25 copay $10 copay $25 copay	Prior authorization may be required for some services. Please contact the plan for more information.

PREMIUMS AND BENEFITS	HEALTHTEAM ADVANTAGE PLAN II		WHAT YOU SHOULD KNOW
HEARING SERVICES	IN-NETWORK	OUT-OF-NETWORK	
• Medicare Covered Diagnostic Hearing Exam • Hearing Aid • Routine Hearing Exam	$25 copay Not Covered $5 copay	$40 copay Not Covered $30 copay	 1 per year.
DENTAL SERVICES			
• Oral Exam & Cleaning • Fillings • Complete Dentures	Not Covered Not Covered Not Covered	Not Covered Not Covered Not Covered	
VISION SERVICES			
• Medicare Covered Diagnostic Exam • Routine Eye Exam • Eyeglasses (lenses and frames)/Contact Lenses	$25 copay $5 copay $0 copay	$40 copay $30 copay 50% of the cost	 1 per year. Maximum benefit of $100.
MENTAL HEALTH SERVICES			
• Inpatient Visit • Outpatient Group Therapy Visit • Outpatient Individual Therapy Visit	Days 1-5: $300 copay per day Days 6-90: $0 copay per day $40 copay $40 copay	35% of the cost $55 copay $55 copay	Services require prior authorization.
Skilled Nursing Facility (SNF)	Days 1-20: $0 copay per day Days 21-100: $140 copay per day	Days 1-20: $40 copay per day Days 21-100: $160 copay per day	Our plan covers up to 100 days in a SNF. Services require prior authorization.
REHABILITATION SERVICES			
• Occupational Therapy Visit • Physical Therapy and Speech and Language Therapy Visit	$10 copay $10 copay	$30 copay $30 copay	
Ambulance	$200 copay	$200 copay	Prior Authorization required for non-emergency transportation.
Transportation	Not Covered	Not Covered	
Medicare Part B Drugs	20% of the cost	30% of the cost	Prior authorization may be required.
FOOT CARE (PODIATRY SERVICES)			
• Foot Exams and Treatment • Routine Foot Care	$25 copay Not Covered	$60 copay Not Covered	

PREMIUMS AND BENEFITS	HEALTHTEAM ADVANTAGE PLAN II		WHAT YOU SHOULD KNOW
MEDICAL EQUIPMENT/SUPPLIES			
• Durable Medical Equipment (e.g., wheelchairs, oxygen)	20% of the cost	30% of the cost	Services require prior authorization.
• Prosthetics (e.g., braces, artificial limbs)	20% of the cost	30% of the cost	Services require prior authorization.
• Diabetes Supplies	$0 copay	20% of the cost	Limited to the following manufacturers: Freestyle, Precision, and One Touch.
Wellness Programs (e.g., fitness)	$0 copay	$30 copay	Access to Silver and Fit network facilities. Members can change locations once per month.
OUTPATIENT PRESCRIPTION DRUGS			
	Retail Rx 30-day supply	Mail Order 90-day supply	
PHASE 1: INITIAL COVERAGE			
During the Initial Coverage Stage, you pay the following amount until your "total drug costs" (the amount paid by both you and the plan) reaches $3,750.			
• Tier 1: Preferred Generics • Tier 2: Generics • Tier 3: Preferred Brand • Tier 4: Non-Preferred Drugs • Tier 5: Specialty Drugs	$0 copay $12 copay $40 copay $75 copay 33% of the cost	$0 copay $24 copay $80 copay $150 copay 33% of the cost	Cost-Sharing may change depending on the pharmacy you choose and when you enter another phase of the Part D benefit. For more information on the additional pharmacy specific cost-sharing and the phases of the benefit, please call us or access our Evidence of Coverage online.
PHASE 2: COVERAGE GAP			
For Tier 1 generic drugs, you pay either your Tier 1 copayment or 44% of the costs, whichever is lower. For all other covered generic drugs, you pay 44% of the costs. For covered brand name drugs, you pay 35% of the price (plus a portion of the dispensing fee). You stay in this stage until your year-to-date "out-of-pocket costs" (your payments) reach a total of $5,000. This amount and rules for counting costs toward this amount have been set by Medicare.			
PHASE 3: CATASTROPHIC COVERAGE			
During this stage, the plan will pay most of the cost of your drugs for the rest of the calendar year (through December 31, 2018). Your share of the cost for a covered drug will be either coinsurance or a copayment, whichever is the larger amount (either coinsurance for 5% of the cost of the drug, or $3.35 for a generic drug or a drug that is reated like a generic and $8.35 for all other drugs).			

PREMIUMS AND BENEFITS	HEALTHTEAM ADVANTAGE PLAN II	WHAT YOU SHOULD KNOW
OPTIONAL SUPPLEMENTAL BENEFITS		
DENTAL SERVICES ONLY		
• Monthly Premium	$25 monthly	
ORAL EXAMS		
• Recall Exam (D0120) • Comprehensive Exam (D0150) • Routine Cleaning (D1110)	$0 copay $0 copay $0 copay	Up to 2 per year. 1 per year; New Patients Only; Limited to 1 every 3 years. Up to 2 per year.
X-RAYS - (CHOOSE ONE OF THE FOLLOWING CATEGORIES EACH YEAR)		
• Bitewing X-Rays (D0270/ D0272/D0273/D0274) • Full Mouth X-Rays (D0210)	$0 copay $0 copay	1 set per year. 1 set per year; Allowed once every year.
FILLINGS		
• Amalgam Filling - 1 surface (D2140) • Amalgam Filling - 2 surfaces (D2150) • Amalgam Filling - 3 surfaces (D2160) • Resin-Based Composite Filling Anterior - 1 surface (D2330) • Resin-Based Composite Filling Anterior - 2 surfaces (D2331) • Resin-Based Composite Filling Anterior - 3 surfaces (D2332)	$35 copay $45 copay $55 copay $50 copay $65 copay $80 copay	Up to 4 total fillings per year.
Scaling and Root Planing (D4341)	$50 copay per quadrant	Up to 2 quadrants per year.
Denture Adjustment (D5410/ D5411)	$0 copay	Total of 2 per year.
EXTRACTIONS		
• Erupted Tooth (D7140) • Surgical (D7210)	$40 copay $75 copay	Up to 2 per year.
CROWNS		
• Porcelain Fused to Base Metal (D2751) • Porcelain Fused to Noble Metal (D2752) • Full Cast Base Metal (D2791) • Full Cast Noble Metal (D2792)	$305 copay $320 copay $307 copay $305 copay	Total of 2 per year. Crowns have a 6 month waiting period.

PREMIUMS AND BENEFITS	HEALTHTEAM ADVANTAGE PLAN II	WHAT YOU SHOULD KNOW
DENTAL, VISION AND HEARING SERVICES		
• Monthly Premium	$40 monthly	
DENTAL SERVICES		
ORAL EXAMS		
• Recall Exam (D0120) • Comprehensive Exam (D0150) • Routine Cleaning (D1110)	$0 copay $0 copay $0 copay	Up to 2 per year. 1 per year; New Patients Only; Limited to 1 every 3 years. Up to 2 per year.
X-RAYS - (CHOOSE ONE OF THE FOLLOWING CATEGORIES EACH YEAR)		
• Bitewing X-Rays (D0270/ D0272/D0273/D0274) • Full Mouth X-Rays (D0210)	$0 copay $0 copay	1 set per year. 1 set per year; Allowed once every 3 years.
FILLINGS		
• Amalgam Filling - 1 surface (D2140) • Amalgam Filling - 2 surfaces (D2150) • Amalgam Filling - 3 surfaces (D2160) • Resin-Based Composite Filling Anterior - 1 surface (D2330) • Resin-Based Composite Filling Anterior - 2 surfaces (D2331) • Resin-Based Composite Filling Anterior - 3 surfaces (D2332)	$35 copay $45 copay $55 copay $50 copay $65 copay $80 copay	Up to 4 total fillings per year.
Scaling and Root Planing (D4341)	$50 copay per quadrant	Up to 2 quadrants per year.
Denture Adjustment (D5410/ D5411)	$0 copay	Total of 2 per year.
EXTRACTIONS		
• Erupted Tooth (D7140) • Surgical (D7210)	$40 copay $75 copay	Up to 2 per year.
CROWNS		
• Porcelain Fused to Base Metal (D2751) • Porcelain Fused to Noble Metal (D2752) • Full Cast Base Metal (D2791) • Full Cast Noble Metal (D2792)	$305 copay $320 copay $307 copay $305 copay	Total of 2 per year. Crowns have a 6 month waiting period.

VISION SERVICES		
• Routine Eye Exam • Frames & Lenses OR Contacts	$0 copay $0 copay	1 per year. $200 coverage limit per year. Excludes any in-store or in-office provider specials.
HEARING SERVICES		
• Routine Hearing Screening Test • Hearing Aid Fitting Evaluation • Hearing Aids	$0 copay $0 copay $0 copay	1 per year. Up to 1 every 3 years. $800 coverage limit every 3 years; for both ears.

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. This document is available in other formats such as Braille,
large print or other alternate formats.

You can see our plan’s provider directory at our website at www.healthteamadvantage.com.
You can see our plan’s pharmacy directory at our website at www.healthteamadvantage.com.
We cover Part D drugs. 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 at www.healthteamadvantage.com.

HealthTeam Advantage complies with applicable Federal civil rights laws and does not
discriminate on the basis of race, color, national origin, age, disability, or sex.

ATTENTION: If you speak Spanish or Chinese, language assistance services, free of charge,
are available to you. Call 1-877-905-9216 (TTY:711).

HealthTeam Advantage cumple con las leyes federales de derechos civiles aplicables
y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.
Llame al 1-877-905-9216 (TTY: 711).

HealthTeam Advantage 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、
年齡、殘障或性別而歧視任何人。

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-905-9216（TTY: 711）。

HEALTHTEAM ADVANTAGE HEALTH PLAN

CONTACT INFORMATION

WEB ADDRESS
Visit HealthTeam Advantage at www.healthteamadvantage.com.

SALES INFORMATION
Prospective members call toll-free 1-877-905-9216 for questions related to HealthTeam Advantage Medicare Advantage Plans from 8am - 8pm, EST, seven days a week.

HEALTHCARE CONCIERGE
Current HealthTeam Advantage members call your Healthcare Concierge toll-free at 1-888-965-1965 for questions related to your HealthTeam Advantage Medicare Advantage Plan, October 1 - February 14, 8am to 8pm, CST, seven days a week or February 15 - September 30, 8am to 8pm, EST, Monday through Friday.

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

PRESCRIPTION DRUG BENEFIT
Current HealthTeam Advantage members call toll-free 1-888-965-1965 for questions related to your HealthTeam Advantage Part D Prescription Drug Benefit. Prospective members call toll-free 1-877-905-9216 for questions related to the HealthTeam Advantage Part D Prescription Drug Benefit.

MEDICARE INFORMATION
For more information about Medicare, call Medicare at 1-800-Medicare (1-800-633-4227). TTY users should call 1-877-486-2048. You can call 24 hours a day, seven days a week or, visit https://www.medicare.gov.