healthteam advantage℠

2024

Summary of Benefits

HealthTeam Advantage Cardinal Plan (HMO) H2624-004

2024
Summary of Benefits

HealthTeam Advantage Cardinal (HMO) Plan

This is a summary of drug and health services covered by HealthTeam Advantage Cardinal Plan (HMO).

January 1, 2024 - December 31, 2024.

The benefit information provided is a summary of what we cover and what you pay. It doesn't list every service we cover or every limitation or exclusion. For a complete list of covered services refer to your Evidence of Coverage booklet. You can request a copy from your Healthcare Concierge or view it on the website at www.HealthTeamAdvantage.com.

To join a HealthTeam Advantage Cardinal (HMO) 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, Davidson, Davie, Forsyth, Guilford, Randolph, and Rockingham.

For more information, contact the plan at 1-888-965-1965 (TTY: 711) from 8 a.m. to 8 p.m. Eastern, 7 days a week from October 1 – March 31, and 8 a.m. to 8 p.m. Eastern, Monday through Friday, April 1 – September 30, or visit us online at 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 Cardinal Plan (HMO)
Monthly Plan Premium	**$0** You must continue to pay your Medicare Part B premium.
Deductible	**$0** These plans do not have a deductible for medical services.
Maximum Out-of-Pocket Responsibility *(does not include prescription drugs)*	**$2,900** annually The most you pay for copays, coinsurance, and other costs for medical services for the year.
Inpatient Hospital Coverage	
	$200 copay per day for days 1 through 5 **$0** copay per day for days 6 through 90 Our plan covers an unlimited number of days for an inpatient hospital stay. Prior authorization may be required.
Outpatient Hospital Coverage	
• Outpatient Hospital Facility	**$250** copay Prior authorization may be required for some services. Please contact the plan for more information.
Ambulatory Surgical Center	
	$150 copay per day Prior authorization may be required for some services. Please contact the plan for more information.
Doctor Visits	
• Primary Care Provider (PCP)	**$0** copay
• Specialist	**$0** copay
Preventive Care (e.g., flu vaccine, diabetic screenings)	
	$0 copay Any additional preventive services approved by Medicare during the contract year will be covered. There are some items not covered at **$0** cost.
Emergency Care	
	In-Network and Out-of-Network: $100 copay If you are admitted to the hospital for the same condition within 3 days, the emergency copay is waived.

Premiums and Benefits *(continued)*	HealthTeam Advantage Cardinal Plan (HMO)
Urgently-needed Services	
	In-Network and Out-of-Network: $10 copay
Diagnostic Services/Labs/Imaging	
• Diagnostic Radiology Services (such as MRIs, CT scans)	**$50** to **$175** copay
• Lab Services at a lab facility	**$0** copay at a lab facility
• Lab Services at an outpatient hospital facility	**$5** copay at an outpatient hospital facility
• Diagnostic Tests and Procedures at a lab facility	**$0** copay at a lab facility
• Diagnostic Tests and Procedures at an outpatient hospital facility	**$50** copay at an outpatient hospital facility Prior authorization may be required for some services. Please contact the plan for more information.
• Outpatient X-rays included with physician visit	**$0** copay for X-ray services included with a physician visit
• Outpatient X-rays at an outpatient facility	**$0** copay for X-ray services at an outpatient facility
Hearing Services	
	Flexible spending allowance of **$1,100** to use toward dental, vision and hearing expenses.
Dental Services	
	Flexible spending allowance of **$1,100** to use toward dental, vision and hearing expenses.
Vision Services	
	Flexible spending allowance of **$1,100** to use toward dental, vision and hearing expenses.

Premiums and Benefits *(continued)*	HealthTeam Advantage Cardinal Plan (HMO)
Mental Health Services	
Inpatient Visit	**$200** copay per day for days 1 through 5 **$0** copay per day for days 6 through 90 Services require prior authorization.
Outpatient Individual Therapy Visit	**$0** copay
Outpatient Group Therapy Visit	**$0** copay
Skilled Nursing Facility	
	$0 copay per day for days 1 through 20 **$203** copay per day for days 21 through 100 Our plan covers up to 100 days in a SNF. Services require prior authorization.
Rehabilitation Services	
• Physical Therapy Visit	**$0** copay
• Speech and Language Therapy Visit	**$0** copay
• Occupational Therapy Visit	**$0** copay
Ambulance	
	$200 copay for Medicare-covered ambulance benefits per one-way trip. **$300** copay for Medicare-covered air ambulance benefits per one-way trip. Prior authorization required for non-emergency transportation.

Premiums and Benefits *(continued)*	HealthTeam Advantage Cardinal Plan (HMO)			
Medicare Part B Drugs				
	20% coinsurance Prior authorization may be required.			
Outpatient Prescription Drugs				
Phase 1: Deductible	**$0** Because there is no prescription drug deductible for the plan, this payment phase does not apply to you. You begin in the Initial Coverage phase when you fill your first prescription of the year.			
Phase 2: Initial Coverage	**In-Network Retail** (After you pay your deductible, if applicable)			
	Preferred* Pharmacies		**Other Retail Pharmacies**	
	30-day supply	**100-day supply**	**30-day supply**	**100-day supply**
Tier 1 - Preferred Generics	**$0** copay	**$0** copay	**$10** copay	**$20** copay
Tier 2 - Generics	**$5** copay	**$10** copay	**$20** copay	**$40** copay
Tier 3 - Preferred Brands	**$47** copay	**$94** copay	**$47** copay	**$94** copay
Tier 4 - Non-Preferred Drugs	**$100** copay	**$200** copay	**$100** copay	**$200** copay
Tier 5 - Specialty Drugs	33% coinsurance	33% coinsurance	33% coinsurance	33% coinsurance
	In-Network Mail Order (After you pay your deductible, if applicable)			
	Preferred* Mail Order		**Other Mail Order Pharmacies**	
	30-day supply	**100-day supply**	**30-day supply**	**100-day supply**
Tier 1 - Preferred Generics	**$0** copay	**$0** copay	**$10** copay	**$20** copay
Tier 2 - Generics	**$5** copay	**$10** copay	**$20** copay	**$40** copay
Tier 3 - Preferred Brands	**$47** copay	**$94** copay	**$47** copay	**$94** copay
Tier 4 - Non-Preferred Drugs	**$100** copay	**$200** copay	**$100** copay	**$200** copay
Tier 5 - Specialty Drugs	33% coinsurance	33% coinsurance	33% coinsurance	33% coinsurance
Phase 3: Coverage Gap (After the total amount for the prescription drugs you have filled and refilled reaches **$5,030**)	During this stage, you pay 25 percent of the total cost for brand name and generic drugs PLUS a portion of the dispensing fee. Tier 1 generics are covered at same copay as in the initial coverage stage (see EOC for details). You won't pay more than **$35** for a one-month supply of each covered insulin product regardless of the cost-sharing tier. **Once your out-of-pocket costs reach $8,000 (2024), you move to catastrophic coverage.**			
Phase 4: Catastrophic Coverage (After your out-of- pocket costs have reached the **$8,000** limit for the calendar year)	In this stage, the plan pays the full cost for your covered Part D drugs. You pay nothing. (See the EOC for details). **The plan and Medicare pay the rest until the end of the calendar year.**			

** $0 copay applies to preferred pharmacy locations*

Premiums and Benefits *(continued)*	HealthTeam Advantage Cardinal Plan (HMO)
Over-the-Counter (OTC) Items	
	$175/Quarter Allowance per quarter for OTC items. Any unused portion can be carried forward to the next quarter. All funds must be used by 12/31/24.
Foot Care (podiatry services)	
• Foot Exams and Treatment	**$0** copay
Medical Equipment/Supplies	
• Durable Medical Equipment (e.g., wheelchairs, oxygen, braces)	20% coinsurance Services require prior authorization.
• Prosthetics (e.g., artificial limbs)	20% coinsurance Services require prior authorization.
• Diabetes Supplies	**$0** copay for preferred and 20% coinsurance for non-preferred
	Diabetic Supplies and Services limited to those from the following manufacturers: - Blood Glucose Meter and testing supplies - One Touch - Continuous Glucose Monitor and supplies - FreeStyle Libre **$0** coinsurance for preferred and 20% cost share for non-preferred. Authorization required for non-preferred. **$0** copay for one pair of Medicare-covered therapeutic shoes and up to two pairs of inserts.
Wellness Programs Health Club Membership	
	$0 copay You must choose from a SilverSneakers® participating facility.

Premiums and Benefits *(continued)*	HealthTeam Advantage Cardinal Plan (HMO)
Memory Fitness	
	$0 copay Online program offered through BrainHQ with dozens of exercises to improve focus and memory.
Custodial Care	
	$0 copay Up to 20 hours post-inpatient discharge or qualifying outpatient procedure, maximum of 60 hours annually. Prior authorization is required for some services. Please contact the plan for more information.
In-Home Support/Companion Services	
	$0 Up to 30 hours per year with Papa Pal companionship services. No coverage for companionship services when not administered by Papa.
Telehealth Services	
	$0 copay If you choose to receive services via telehealth, you must use a provider that currently offers the service via telehealth.

If you want to know more about the coverage and costs of original Medicare, review your current "Medicare & You" handbook. View it online at 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 access our Provider/Pharmacy Directory and the complete plan formulary (list of Part D prescription drugs) as well as any restrictions on our website, www.HealthTeamAdvantage.com.

We cover Part D drugs and Part B drugs (such as chemotherapy and some drugs administered by your provider).

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).

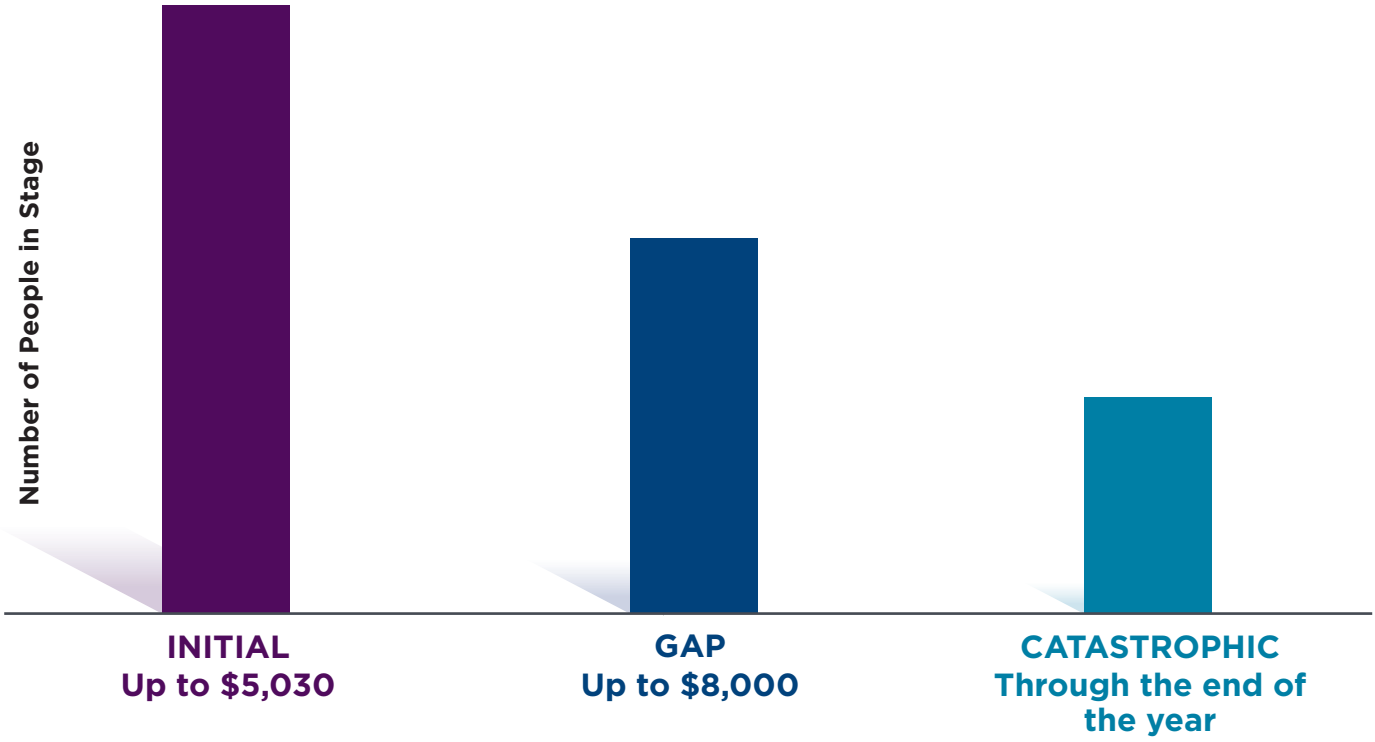
HealthTeam Advantage cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.

Llame al 1-877-905-9216 (TTY: 711). 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)

Understanding Drug Payment Stages



Initial Coverage Stage

During this stage, you pay a flat fee (copay) or a percentage of a drug's total cost (coinsurance) for each prescription you fill.

You won't pay more than $35 for a one-month supply of each covered insulin product regardless of the cost-sharing tier.

The plan pays the rest until your total drug costs (paid by you and the plan) reach $5,030 (2024).

Coverage Gap Stage

During this stage, you pay 25 percent of the total cost for brand name and generic drugs PLUS a portion of the dispensing fee. Tier 1 generics are covered at same copay as in the initial coverage stage (see EOC for details).

You won't pay more than $35 for a one-month supply of each covered insulin product regardless of the cost-sharing tier.

Once your out-of-pocket costs reach $8,000 (2024), you move to catastrophic coverage.

Catastrophic Coverage Stage

In this stage, the plan pays the full cost for your covered Part D drugs. You pay nothing. (See the EOC for details).

The plan and Medicare pay the rest until the end of the calendar year.

Non-Discrimination Notice

HealthTeam Advantage complies with applicable federal civil rights laws and does not discriminate based on race, color, national origin, age, disability, or sex. HealthTeam Advantage does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

HealthTeam Advantage:
Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact your Healthcare Concierge at 888-965-1965 (TTY: 711) October 1-March 31, 8 a.m. to 8 p.m. ET, 7 days a week; April 1-September 30, 8 a.m. to 8 p.m. ET, Monday through Friday.

If you believe that HealthTeam Advantage has failed to provide these services or discriminated in another way based on race, color, national origin, age, disability, or sex, you can file a grievance with:

HealthTeam Advantage
Attn: Appeals and Grievances
300 East Wendover Ave, Suite 121
Greensboro, North Carolina, 27401
888-965-1965, (TTY 711), or via fax at 800-845-4104

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Appeals and Grievances Department is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf, by email OCRMail@hhs.gov, by phone 1-888-368-1019, TDD: 1-800-537-7697, or by mail U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201.

Get Help in Other Languages
If you need help or speak a non-English language, call 888-965-1965 TTY: 711, and you will be connected to an interpreter who will assist you at no cost.

Non-Discrimination Notice

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llameal 1-888-965-1965 TTY: 711.

French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement.

Appelez le 1-888-965-1965 ATS: 711.

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen Verfügung. Rufnummer: 1-888-965-1965 TTY: 711.

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-965-1965 телетайп: 711.

Gujarati: સચના: જો તમે ગજરાતી બોલતા હો, તો નન:શલ્ ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો **1-888-965-1965 TTY711.**

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-965-1965 TTY711.

Chinese: 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 **1-888-965-1965 TTY: 711.**。

Japanese: **注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。 1-888-965-1965 TTY: 711.** まで、お電話にてご連絡ください。

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1- 888-965-1965 TTY: 711** 번으로 전화해 주십시오.

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-965-1965 TTY: 711.

Hindi: ध्यान द:यदद आप ह दिंा बोलते है तो आपके दलए मफु त मे भाषा सहायता सेवाएं उपलब्ध है। **1-888-965-1965 TTY: 711** पर कॉल करे।

Laotian: ໂປດຊາບ: ຖ້ າວ່ າ ທ່ ານເ ວົ້ າພາສາ ລາວ, ການບໍລິການຊ່ ວຍເຫຼືອເ ບນ ພ້ ອມໃຫ້ ທ່ ານ. ໂທຣ **1-888-965-1965 TTY: 711.** ອດ ້ ານພາສາ, ໂດຍບໍ່ເສັ ງຄ່ າ,

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-888-965-1965 TTY: 711.

Cambodian: ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, បសវាជំនួយខ្នកភាសា បោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ **1-888-965-1965 TTY: 711**។

(Arabic):
ك ث ح د ت ذكر ت ، غ ة ل ال ن إ ف ت خدمات دع ة سا م ال ة ي غو ل ال ر ف وات ت ك ل ن اج م ال ب. ل ص ت ا م ق ر ب
ن ت إذا :م ح و ل ظ ة 1-888-965-1965 (711: TTY)

CONTACT INFORMATION

Online
Visit **HTANC.com**.

Address
300 East Wendover Ave, Suite 121
Greensboro, North Carolina, 27401

Sales
Prospective members call toll-free 877-905-9216 for questions related to our Medicare Advantage Plans.

October 1-March 31, 8 a.m. to 8 p.m. ET, seven days a week.
April 1-September 30, 8 a.m. to 8 p.m. ET, Monday through Friday.

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

Prescription Drug Benefit
Prospective members call toll-free 877-905-9216 for questions related to our Part D Prescription Drug Benefit.

Medicare
For more information about Medicare, call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048. Or, visit Medicare.gov.

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