

# 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](http://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](http://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	<p><b>\$0</b></p> <p>You must continue to pay your Medicare Part B premium.</p>
Deductible	<p><b>\$0</b></p> <p>These plans do not have a deductible for medical services.</p>
Maximum Out-of-Pocket Responsibility ( <i>does not include prescription drugs</i> )	<p><b>\$2,900</b> annually</p> <p>The most you pay for copays, coinsurance, and other costs for medical services for the year.</p>
<b>Inpatient Hospital Coverage</b>	
	<p><b>\$200</b> copay per day for days 1 through 5</p> <p><b>\$0</b> copay per day for days 6 through 90</p> <p>Our plan covers an unlimited number of days for an inpatient hospital stay. Prior authorization may be required.</p>
<b>Outpatient Hospital Coverage</b>	
<ul style="list-style-type: none"> <li>• Outpatient Hospital Facility</li> </ul>	<p><b>\$250</b> copay</p> <p>Prior authorization may be required for some services. Please contact the plan for more information.</p>
<b>Ambulatory Surgical Center</b>	
	<p><b>\$150</b> copay per day</p> <p>Prior authorization may be required for some services. Please contact the plan for more information.</p>
<b>Doctor Visits</b>	
<ul style="list-style-type: none"> <li>• Primary Care Provider (PCP)</li> <li>• Specialist</li> </ul>	<p><b>\$0</b> copay</p> <p><b>\$0</b> copay</p>
<b>Preventive Care (e.g., flu vaccine, diabetic screenings)</b>	
	<p><b>\$0</b> copay</p> <p>Any additional preventive services approved by Medicare during the contract year will be covered. There are some items not covered at <b>\$0</b> cost.</p>
<b>Emergency Care</b>	
	<p><b>In-Network and Out-of-Network: \$100</b> copay</p> <p>If you are admitted to the hospital for the same condition within 3 days, the emergency copay is waived.</p>

**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.

	<b>In-Network Retail</b> (After you pay your deductible, if applicable)			
	<b>Preferred* Pharmacies</b>		<b>Other Retail Pharmacies</b>	
	<b>30-day supply</b>	<b>100-day supply</b>	<b>30-day supply</b>	<b>100-day supply</b>
<b>Tier 1 - Preferred Generics</b>	<b>\$0</b> copay	<b>\$0</b> copay	<b>\$10</b> copay	<b>\$20</b> copay
<b>Tier 2 - Generics</b>	<b>\$5</b> copay	<b>\$10</b> copay	<b>\$20</b> copay	<b>\$40</b> copay
<b>Tier 3 - Preferred Brands</b>	<b>\$47</b> copay	<b>\$94</b> copay	<b>\$47</b> copay	<b>\$94</b> copay
<b>Tier 4 - Non-Preferred Drugs</b>	<b>\$100</b> copay	<b>\$200</b> copay	<b>\$100</b> copay	<b>\$200</b> copay
<b>Tier 5 - Specialty Drugs</b>	33% coinsurance	33% coinsurance	33% coinsurance	33% coinsurance
	<b>In-Network Mail Order</b> (After you pay your deductible, if applicable)			
	<b>Mail Order</b>			
	<b>30-day supply</b>		<b>100-day supply</b>	
<b>Tier 1 - Preferred Generics</b>	<b>\$0</b> copay		<b>\$0</b> copay	
<b>Tier 2 - Generics</b>	<b>\$5</b> copay		<b>\$10</b> copay	
<b>Tier 3 - Preferred Brands</b>	<b>\$47</b> copay		<b>\$94</b> copay	
<b>Tier 4 - Non-Preferred Drugs</b>	<b>\$100</b> copay		<b>\$200</b> copay	
<b>Tier 5 - Specialty Drugs</b>	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](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 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](http://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).

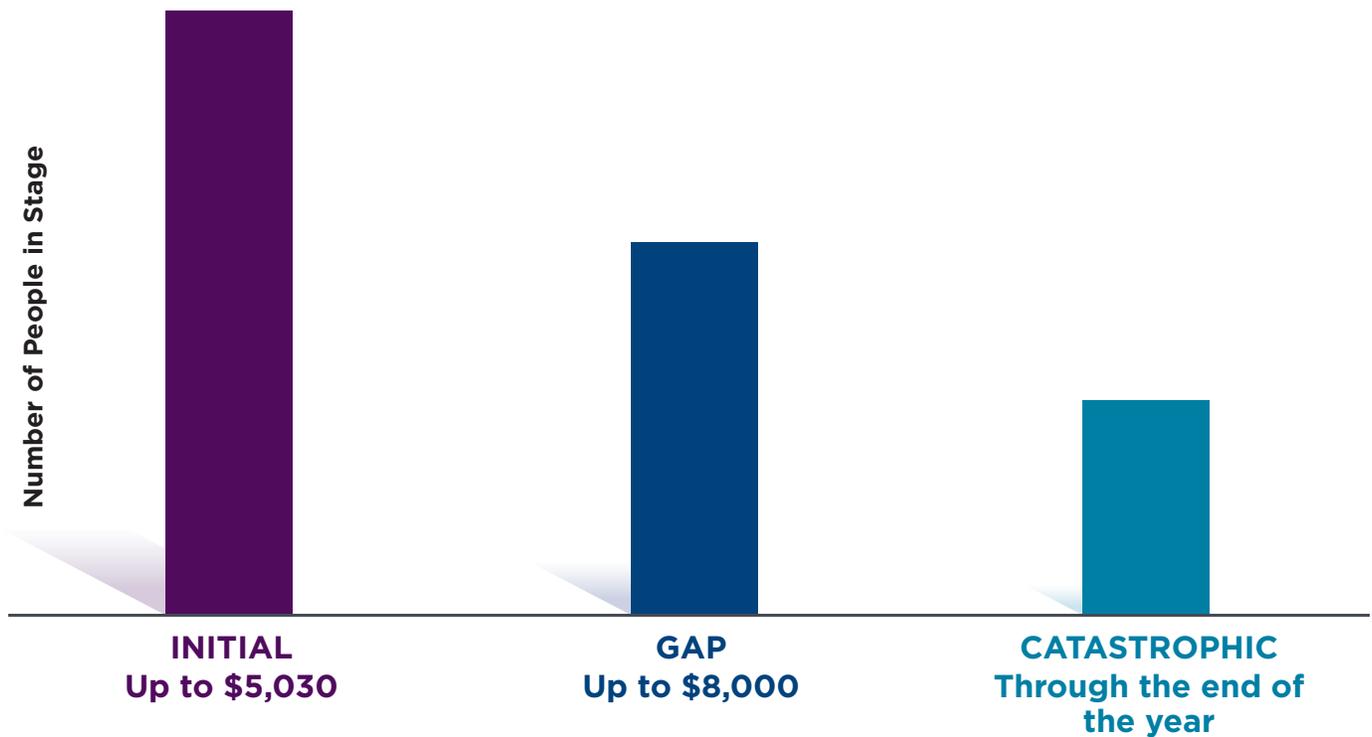
HealthTeam Advantage cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

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](mailto: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. Llame al 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 दःयदद आप ह दि बोलते है तो आपके दलए मफू त मे भाषा सहायता सेवाएं उपलब्ध है | 1-888-965-1965 TTY: 711 पर कॉल करे।

**Laotian:** ໂປດຂາບ: ຖ້າ ຈ່ວ ຈ ທ່ ານໄວ້ ຈາສາ ລາວ, ການບໍລິການຊ່ ອຍເໝັ ມມີ ພ້ ອມໃຫ້ ທ່ ານ. ໂທ 1-888-965-1965 TTY: 711. ອດ້ 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៖ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ, បេសវាជំនួយខុសនកភាសា បណ្តាមិនគិតថ្លៃឡើយ គឺអាចមានសំរាប់ប្រើប្រាស់។ ចូរ ទូរស័ព្ទ 1-888-965-1965 TTY: 711។

(Arabic):

ك ت دحت ت ركذا، غ ل ل ل ن إ ف ت ادخ ة دع اس م ل ا ي و غ ل ل ا ر ف اوت ت ك ل ن ا جم ل ا ب. ل ص ت ا م قرب  
ن اذ ن م: وح ل م: 1-888-965-1965 (711: TTY)



## CONTACT INFORMATION



### Online

Visit [HTANC.com](https://www.htanc.com).



### Corporate Office

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



### Healthcare Concierge

Contact your Healthcare Concierge if you have any questions about your plan or benefits. Call 888-965-1965 or email [conciergeHTA@htanc.com](mailto:conciergeHTA@htanc.com).

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

Contact your Healthcare Concierge for questions related to your HealthTeam Advantage 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](https://www.Medicare.gov).



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HealthTeam Advantage, a product of Care N' Care Insurance Company of North Carolina, Inc., is a PPO and HMO Medicare Advantage plan with a Medicare contract. Enrollment in HealthTeam Advantage depends on contract renewal.

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