

2023 SUMMARY OF BENEFITS

HealthTeam Advantage Diabetes & Heart Care (HMO CSNP)

This is a summary of drug and health services covered by HealthTeam Advantage Diabetes & Heart Care (HMO CSNP).
January 1, 2023 - December 31, 2023.

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 HealthTeam Advantage Diabetes & Heart Care (HMO CSNP) Health Plan, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, live in our service area, and you must meet the special eligibility requirements of a diagnosis of Diabetes Mellitus and/or Chronic Heart Failure. Our service area includes the following counties in North Carolina: Alamance, Guilford, Randolph, and Rockingham.

As a member of the HealthTeam Advantage Diabetes & Heart Care (HMO CSNP), you must use the plan's network of doctors, hospitals, pharmacies, and other providers.

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 Diabetes & Heart Care (HMO CSNP)	What You Should Know
Monthly Plan Premium	\$0	You must continue to pay your Medicare Part B premium.
Deductible	\$0	This plan does not have a deductible for medical services.
Maximum Out-of-Pocket Responsibility <i>(does not include prescription drugs)</i>	\$5,000 annually	The most you pay for copays, coinsurance, and other costs for medical services for the year.
Inpatient Hospital Coverage	\$225 copay per day for days 1 through 6 \$0 copay per day for days 7 through 90 \$0 copay for days 91 and beyond	Our plan covers an unlimited number of days for an inpatient hospital stay. Prior authorization may be required.
Outpatient Hospital Coverage <ul style="list-style-type: none"> ○ Outpatient Hospital Facility ○ Observation Services 	\$225 copay \$225 copay per stay	Prior authorization may be required for some services. Please contact the plan for more information.
Ambulatory Surgery Center	\$225 copay per day	Prior authorization may be required for some services. Please contact the plan for more information.
Doctor Visits <ul style="list-style-type: none"> ○ Primary Care Provider (PCP) ○ Cardiologist ○ Endocrinologist ○ Podiatrist 	\$0 copay	

Premiums and Benefits	HealthTeam Advantage Diabetes & Heart Care (HMO CSNP)	What You Should Know
Doctor Visits (continued) <ul style="list-style-type: none"> ○ Other Specialists 	\$20 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	\$90 copay	If you are admitted to the hospital for the same condition within 3 days, the emergency copay is waived.
Urgently-needed Services	\$25 copay	
Diagnostic Services/Labs/ Imaging <ul style="list-style-type: none"> ○ Diagnostic Radiology Services (such as MRIs, CT scans) 	\$50 to \$175 copay	Prior authorization may be required for some services. Please contact the plan for more information.
<ul style="list-style-type: none"> ○ Lab Services <ul style="list-style-type: none"> ● at a lab facility ● at an outpatient hospital facility 	\$0 copay at a lab facility \$10 copay at an outpatient hospital facility	
<ul style="list-style-type: none"> ○ Diagnostic Tests and Procedures <ul style="list-style-type: none"> ● at a lab facility ● at an outpatient hospital facility 	\$0 copay at a lab facility \$10 copay at an outpatient hospital facility	
<ul style="list-style-type: none"> ○ Outpatient X-rays <ul style="list-style-type: none"> ● included with physician visit ● at an outpatient facility 	\$10 copay	

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Hearing Services <ul style="list-style-type: none"> ○ Medicare-covered Diagnostic Hearing Exam 	\$20 copay	1 per year
<ul style="list-style-type: none"> ○ Routine Assessment for Hearing Aids 	\$45 copay	1 per year A TruHearing provider must be used for routine hearing benefits.
<ul style="list-style-type: none"> ○ Fitting and Evaluation for Hearing Aid 	\$0 copay	Unlimited visits A TruHearing provider must be used for routine hearing benefits.
<ul style="list-style-type: none"> ○ Hearing Aid 	\$499-\$799 per hearing aid Premium hearing aids are available in rechargeable style options for an additional \$50 per aid.	Up to two TruHearing hearing aids every year (one per ear per year). A TruHearing provider must be used for hearing aid benefit.
Dental Services <ul style="list-style-type: none"> ○ Medicare-covered Dental Services 	\$0 copay for each Medicare-covered dental service	
<ul style="list-style-type: none"> ○ Non-Medicare-covered Routine Dental/Preventive Dental Services 	Preventive oral exams, cleanings, X-rays, and routine dental services are covered at no cost to you, up to \$750 maximum annually.	Limits apply. You must use in-network dentists for services. For a complete list of covered services, please refer to your Evidence of Coverage.

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<p>Dental Services (continued)</p> <ul style="list-style-type: none"> ○ Non-Medicare-covered Comprehensive Dental Services 	<p>Comprehensive dental services such as fillings, dentures, crowns, extractions, implants, and periodontics are covered at no cost to you, up to \$3,000 maximum annually.</p> <p>Annual maximum benefit applies to in-network services only. You must use a Delta Dental provider for any dental service. HealthTeam Advantage does not cover dental benefits received outside of the Delta Dental network of providers.</p>	<p>Limits apply.</p> <p>You must use in-network dentists for services.</p> <p>For a complete list of covered services, please refer to your Evidence of Coverage.</p>
<p>Vision Services</p> <ul style="list-style-type: none"> ○ Medicare-covered Diagnostic Exam ○ Medicare-covered Eye Wear 	<p>\$0 copay</p> <p>\$0 copay for Medicare-covered eyeglasses or contact lenses after cataract surgery with a maximum benefit amount not to exceed \$100.</p>	<p>1 per year</p> <p>Materials covered up to Medicare-approved limits.</p>
<ul style="list-style-type: none"> ○ Routine Eye Exam 	<p>\$0 copay</p>	<p>Refraction included</p>
<ul style="list-style-type: none"> ○ Eyeglasses (lenses and frames) ○ Contact Lenses 	<p>Reimbursed up to \$200 towards routine eye wear, including contact lenses. Single vision, lined bifocals, lined trifocals, and lenticular lenses are covered in full.</p>	

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Mental Health Services <ul style="list-style-type: none"> ○ Inpatient Visit 	\$225 copay per day for days 1 through 6 \$0 copay per day for days 7 through 90	Services require prior authorization.
<ul style="list-style-type: none"> ○ Outpatient Individual Therapy Visit 	\$0 copay	
<ul style="list-style-type: none"> ○ Outpatient Group Therapy Visit 	\$0 copay	
Skilled Nursing Facility	\$0 copay per day for days 1 through 20 \$184 copay per day for days 21 through 100	Our plan covers up to 100 days in a SNF. Services require prior authorization.
Rehabilitation Services <ul style="list-style-type: none"> ○ Physical Therapy Visit ○ Occupational Therapy Visit ○ Speech and Language Therapy Visit 	\$20 copay	
Ambulance	\$300 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.
Transportation	Not covered	
Medicare Part B Drugs	20% coinsurance	Prior authorization may be required.

Outpatient Prescription Drugs		
	HealthTeam Advantage Diabetes & Heart Care (HMO CSNP)	What You Should Know
Phase 1: Deductible	<p>\$95 for Tier 4 Non-Preferred Drug and Tier 5 Specialty Tier drugs</p> <p>During this stage, you pay the full cost of your Tier 4 Non-Preferred Drug and Tier 5 Specialty Tier drugs.</p> <p>During this stage, your out-of-pocket costs for Select Insulins will be \$0.</p>	You stay in this stage until you have paid \$95 for your Tier 4 Non-Preferred Drug and Tier 5 Specialty Tier drugs.

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Phase 2: Initial Coverage (After you pay your deductible, if applicable)	Retail Rx 30-day supply	Mail Order 90-day supply	
Tier 1: Preferred Generics	\$0 copay	\$0 copay	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.
Tier 2: Generics	\$15 copay	\$30 copay	
Tier 3: Preferred Brands	\$45 copay	\$90 copay	
Tier 4: Non-Preferred Drugs	\$100 copay	\$200 copay	
Tier 5: Specialty Drugs	31% coinsurance	31% coinsurance	

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Phase 2: Initial Coverage (After you pay your deductible, if applicable)	Retail Rx 30-day supply	Mail Order 90-day supply	
Tier 6: Select Care Drugs NOTE: This includes Select Insulins	\$0 copay	\$0 copay	The Select Insulins are formulary insulins that are covered in Tier 6 of our Drug List and are being used for a diagnosis covered under Part D. Please note that if your insulin is being administered through a Part B covered insulin pump then the insulin must be covered under Part B and will not be eligible for the Part D copay.

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Phase 3 Coverage Gap (After the total amount for the prescription drugs you have filled and refilled reaches \$4,660)	<p>During this stage, you pay 25% of the price for brand name drugs (plus a portion of the dispensing fee) and 25% of the price for generic drugs. Tier 1 and Tier 6 generics are covered at \$0 copay. You stay in this stage until your year-to-date out-of-pocket costs (your payments) reach a total of \$7,400.</p> <p>HealthTeam Advantage offers additional gap coverage for Select Insulins. During the Coverage Gap stage, your out-of-pocket costs for Select Insulins will be \$0. To find out which drugs are Select Insulins, review the most recent Drug List we sent you in the mail. If you have questions about the Drug List, you can also call your Healthcare Concierge.</p>		
Phase 4: Catastrophic Coverage (After your out-of-pocket costs have reached the \$7,400 limit for the calendar year)	<p>During this stage, the plan will pay most of the cost of your drugs for the rest of the calendar year (through December 31, 2023). 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 \$4.15 for a generic drug or a drug that is treated like a generic and \$10.35 for all other drugs).</p>		

Benefits (continued)	HealthTeam Advantage Diabetes & Heart Care (HMO CSNP)	What You Should Know
Foot Care (podiatry services) <ul style="list-style-type: none"> ○ Foot Exams and Treatment ○ Routine Foot Care 	\$0 copay \$0 copay	4 visits per year
Medical Equipment/Supplies <ul style="list-style-type: none"> ○ Durable Medical Equipment (e.g., wheelchairs, oxygen, braces) ○ Prosthetics (e.g. artificial limbs) ○ Diabetes Supplies 	20% coinsurance 20% coinsurance \$0 copay for preferred and 20% coinsurance for non-preferred	Services require prior authorization. Services require prior authorization. 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.

Benefits (continued)	HealthTeam Advantage Diabetes & Heart Care (HMO CSNP)	What You Should Know
Custodial Care	\$0 copay	<p>Up to 20 hours post-inpatient discharge or qualifying outpatient procedure, maximum of 60 hours annually.</p> <p>Prior authorization is required for some services. Please contact the plan for more information.</p>
Telehealth Services	\$0 copay	<p>If you choose to receive services via telehealth, then you must use a network provider that currently offers the service via telehealth.</p>
Over-the-Counter Items	<p>Our plan provides a \$45 allowance per quarter for OTC items and healthy foods. Any unused portion can be carried forward to the next quarter. This benefit ends on 12/31 of each year. Any unused portion cannot be carried forward to the new plan year.</p>	

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).

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)。