2022
ENROLLMENT BOOK

HealthTeam Advantage Plan I (PPO)
HealthTeam Advantage Plan II (PPO)

healthteam advantage℠

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2022 HealthTeam Advantage Enrollment Instructions

Who Can Use This Form?

People with Medicare who want to join a Medicare Advantage Plan. To join a plan you must be a United States citizen or be lawfully present in the U.S. and live in the plan's service area. You must also have Medicare Part A and Part B.

When Do I Use This Form?

You can join a plan between October 15 - December 7 each year (for coverage starting January 1); within three months of first getting Medicare; or in certain situations when you're allowed to join or switch plans (visit Medicare.gov to learn more about when you can sign up for a plan).

What You'll Need

- Your red, white, and blue Medicare insurance card
- Your health insurance information for any other insurance you have
- Your primary care provider's full name

Tips for Enrollment

- Each applicant must complete their own enrollment. Don't photocopy a form for reuse.
- Print neatly. You must complete all items.
- If you enroll outside the Annual Enrollment Period (AEP) timeframe, you must confirm your enrollment period (see Attestation page).
- Make a copy of the application for your records.
- We recommend you confirm your form was received if you fax or mail it (e.g. send certified mail).

How to Enroll in HealthTeam Advantage

Online: Visit HealthTeamAdvantage.com or the Centers for Medicare & Medicaid Services website at Medicare.gov.

Phone: Call one of our licensed sales agents at 877-905-9216 October 1–March 31, 8 a.m. to 8 p.m. ET, seven days a week, or April 1–September 30, 8 a.m. to 8 p.m. ET, Monday through Friday to enroll over the phone or to schedule a personal meeting.

Independent Agent: Contact your local insurance agent who is certified to sell HealthTeam Advantage plans.

Fax: Complete the enclosed Enrollment Form and fax to HealthTeam Advantage at 800-905-9131.

Mail: Complete the enclosed Enrollment Form and mail to HealthTeam Advantage in the provided post-paid envelope located at the end of this book.

Reminder: If you want to join a plan during AEP (October 15–December 7), the plan must get your completed form by December 7. Your plan will send a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

Once your request to join has been processed, HealthTeam Advantage will contact you.

Need Help?

Call 877-905-9216 October 1–March 31, 8 a.m. to 8 p.m. ET, seven days a week, or April 1–September 30, 8 a.m. to 8 p.m. ET, Monday through Friday.

Scope of Sales

Appointment Confirmation Form

The Centers for Medicare & Medicaid Services requires agents to document the scope of a marketing appointment prior to any face-to-face sales meeting to ensure understanding of what will be discussed between the agent and the Medicare beneficiary (or their authorized representative). All information provided on this form is confidential and should be completed by each person with Medicare or their authorized representative.

Please initial below beside the type of product(s) you want the agent to discuss.

	MEDICARE ADVANTAGE PLANS (PART C)

Medicare Preferred Provider Organization (PPO) Plan—A Medicare Advantage Plan provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. PPOs have network doctors and hospitals but you can also use out-of-network providers, usually at a higher cost.

By signing this form, you agree to a meeting with a sales agent to discuss the types of products you initialed above. Please note, the person who will discuss the product(s) is either employed or contracted by a Medicare plan. They do not work directly for the federal government. This individual may also be paid based on your enrollment in a plan.

Signing this form does NOT obligate you to enroll in a plan, affect your current enrollment, or enroll you in a Medicare plan.

Beneficiary or Authorized Representative Signature and Signature Date:

Signature: _____ Date: _____

If you are the representative, please sign above and print below:

Representative's Name: _____

Your Relationship to the Beneficiary:_____

Scope of Sales, continued

To be completed by Agent:

Plan(s) the agent represented during this meeting: _____

Agent Name: _____ Agent Phone:_____

Beneficiary Name:_____ Beneficiary Phone: _____

Beneficiary Address:_____
(optional)

Initial Method of Contact: *(Indicate here if beneficiary was a walk-in.)*

☐ Agent book of business ☐ Beneficiary referral ☐ Walk-in

☐ Agent contact ☐ Agent referral

Date Appointment Completed: _____

*Scope of Appointment documentation is subject to CMS record retention requirements.

Agents return this form to:

HealthTeam Advantage, 7800 McCloud Rd. Ste, 100, Greensboro, NC 27409, or by fax 800-905-9131

Individual Enrollment Application Form
2022 Plan Year

Important Information

Please check which plan you want to enroll in:

MA-PD Plans:

☐ HealthTeam Advantage Plan I PPO $0 per month

☐ HealthTeam Advantage Plan II PPO $75 per month

Optional Supplemental Benefits Riders:

☐ HealthTeam Advantage Comprehensive Dental Rider $25 per month

Last Name:	First Name:	Middle Initial:	☐ Mr. ☐ Mrs. ☐ Ms.

Birth Date: (_____ /_____ /_____) (MM/DD/YYYY)	Sex: ☐ M ☐ F	Race: ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Asian ☐ Black or African American ☐ White ☐ Some Other Race Ethnicity: ☐ Hispanic or Latin ☐ Not Hispanic or Latino

Home Phone Number: ( )	Cell Phone Number: ( )

Permanent Residence Street Address (P.O. Box is not allowed):

City:	County:	State:	ZIP Code:

Mailing Address (only if different from your Permanent Residence Address):
Street Address:

City:	County:	State:	ZIP Code:

Emergency Contact:	Phone Number:	Relationship to You:

Email Address:

Please Provide Your Medicare Insurance Information

Medicare Number: _____

Hospital (Part A) Effective Date: _____ Medical (Part B) Effective Date: _____

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

Individual Enrollment Application Form 2022 Plan Year, continued

Paying Your Plan Premium

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail, Electronic Funds Transfer (EFT), or credit card each month. **You can also choose to pay your premium by having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month.**

If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium. The amount is usually taken out of your Social Security benefit, or you may get a bill from Medicare (or the RRB). DON'T pay HealthTeam Advantage the Part D-IRMAA.

If you don't select a payment option below, you will get a bill each month.

Please select a premium payment option:

☐ Get a bill monthly

☐ Electronic funds transfer (EFT) from your bank account each month.
Please enclose a VOIDED check or provide the following:

Account Holder Name: _____

Bank Routing Number: _____

Bank Account Number: _____

Account type: ☐ Checking ☐ Savings

☐ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check.

I get monthly benefits from: ☐ Social Security ☐ RRB

*(The Social Security/RRB deduction **may take two or more months to begin** after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)*

Some individuals may have other drug coverage, including private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.

Will you have other prescription drug coverage in addition to the HealthTeam Advantage Plan? ☐ **Yes** ☐ **No**

If "yes", please list your other coverage and identification (ID) number(s) for this coverage:

Name of other coverage _____

ID # for this coverage _____

Group # for this coverage _____

Individual Enrollment Application Form 2022 Plan Year, continued

Important Information

Do you or your spouse work? ☐ **Yes** ☐ **No**

Please choose the name of a Primary Care Provider (PCP):

_____

Provider Phone: _____

Provider Address: _____

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in an accessible format: ☐ **Large Print** ☐ **Other**

Please contact HealthTeam Advantage at 888-965-1965, if you need information in another accessible format or language other than what is listed above. Our office hours are 8 a.m. to 8 p.m., seven days a week (ET) from October 1 to March 31, and 8 a.m. to 8 p.m. Monday through Friday, from April 1 to September 30. TTY users should call 711.

IMPORTANT: Read and sign below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in a HealthTeam Advantage plan.
- By joining this Medicare Advantage Plan, I acknowledge that HealthTeam Advantage will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by federal law that authorize the collection of this information (see Privacy Act Statement below).
- Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.
- I understand that people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.
- I understand that when my HealthTeam Advantage coverage begins, I must get all of my medical and prescription drug benefits from HealthTeam Advantage. Benefits and services provided by HealthTeam Advantage and contained in my HealthTeam Advantage Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor HealthTeam Advantage will pay for benefits or services that are not covered.
- If you currently have health coverage from an employer or union, joining HealthTeam Advantage could affect your employer or union health benefits. You could lose your employer or union health coverage if you join HealthTeam Advantage. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there isn't any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Individual Enrollment Application Form 2022 Plan Year, continued

- I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (as described above), this signature certifies that:

_____

Signature **Date**

If you're the authorized representative, sign and fill out these fields. This person is authorized under state law to complete this enrollment, and documentation of this authority is available upon request by Medicare.

Name: _____

Relationship to Enrollee: _____

Address: _____

_____

Phone Number: _____

Office Use Only:

_____

Name of agent/broker (if assisted in enrollment) NPN

_____

Plan ID# Effective Date of Coverage

Date Application Received by Agent: _____

ICEP/IEP: _____ AEP: _____ OEP: _____ SEP (type): _____ Not Eligible: _____

Attestation of Eligibility for an Enrollment Period

Individual Enrollment Application Form

Typically, you may enroll in a Medicare Advantage plan only during the Annual Enrollment Period (AEP) from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

- ☐ I am new to Medicare.
- ☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).
- ☐ I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on (insert date) _____.
- ☐ I recently was released from incarceration. I was released on (insert date) _____.
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) _____.
- ☐ I recently obtained lawful presence status in the United States. I got this status on (insert date) _____.
- ☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date) _____.
- ☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date) _____.
- ☐ I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.
- ☐ I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long term care facility). I moved/will move into/out of the facility on (insert date) _____.
- ☐ I recently left a PACE program on (insert date) _____.

Attestation of Eligibility for an Enrollment Period, continued

Individual Enrollment Application Form

- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date) _____.
- ☐ I am leaving employer or union coverage on (insert date) _____.
- ☐ I belong to a pharmacy assistance program provided by my state.
- ☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- ☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date) _____.
- ☐ I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date) _____.
- ☐ I was affected by a weather-related emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA). One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster.

If none of these statements apply to you or you're not sure, please contact HealthTeam Advantage at 877-905-9216 (TTY 711) to see if you are eligible to enroll. We are open October 1-March 31, 8 a.m. to 8 p.m. ET, seven days a week or April 1-September 30, 8 a.m. to 8 p.m. ET, Monday through Friday.

Application Checklist

Here's a quick check list to review your application and to keep for your records.

___ 1. The agent reviewed the HealthTeam Advantage Summary of Benefits for all HealthTeam Advantage plans.

___ 2. I selected the HealthTeam Advantage plan that best fits my current Medicare needs.

___ 3. I understand that the plan I have chosen is NOT a Medicare supplement (Medigap) plan.

___ 4. The agent explained the assistance a HealthTeam Advantage Healthcare Concierge can provide.

___ 5. The agent reviewed prescription drug (Rx) needs and identified the tiers and related co-pays using the Drug List. The agent explained the Rx benchmark, 2022 coverage gap, new changes once the coverage gap is reached, step therapy (if required), late enrollment penalty, and prior authorization.

___ 6. The agent explained I must continue to pay the Medicare Part B premium.

___ 7. The agent gave me the following materials:

A. HealthTeam Advantage Summary of Benefits C. Business Card

B. Multi-Language Insert

___ 8. I understand that the Primary Care Provider I have chosen is _____

and the physician is currently ☐ In-network ☐ Out-of-network

**Network participation may change*

___ 9. The payment method I have selected is ☐ Monthly Invoice ☐ SSA Deduct ☐ ACH

OPTIONAL SUPPLEMENTAL COVERAGE:

__ 10. The agent reviewed the HealthTeam Advantage Comprehensive Dental Rider with me. If selected, the agent explained that this optional coverage requires an additional $25 monthly premium.

Receipt

This receipt verifies that you completed an enrollment form with an agent who sells HealthTeam Advantage Medicare Advantage health plans.

Important Enrollment Information

Application Date: _____

Proposed Effective Date: _____

Medicare ID: _____

Plan Name: _____

Sales Agent Name: _____

Sales Agent Phone: _____

Sales Agent ID: _____

Thank You for Enrolling in HealthTeam Advantage!

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What's Next?

The following next steps will help you better understand what to expect on your way to becoming a HealthTeam Advantage Member.

The day you enroll…

- Receipt of completed enrollment form: The agent will provide a receipt that confirms you submitted an enrollment form. If you enroll online, you will receive a confirmation number and you will have the ability to print an electronic copy of your completed application for your files.

Within 10 days of submitting enrollment form…

- Letter confirming receipt of your enrollment and enrollment approval from Medicare to the HealthTeam Advantage plan you selected.

When you become a HealthTeam Advantage member…

- **HealthTeam Advantage Evidence of Coverage:** This book provides detailed coverage of your plan.
- **HealthTeam Advantage member identification cards:** You will receive a HealthTeam Advantage member identification card.
- **Personal Healthcare Concierge at your service:** If you would like assistance finding a provider, scheduling an appointment, have questions about your benefits, or need a replacement identification card, simply email your concierge at conciergehta@HealthTeamAdvantage.com, or call 888-965-1965 (TTY 711) October 1-March 31, 8 a.m. to 8 p.m. ET, seven days a week, or April 1-September 30, 8 a.m. to 8 p.m. ET, Monday through Friday.

CONTACT INFORMATION

Online
Visit **HealthTeamAdvantage.com**.

Address
7800 McCloud Road, Suite 100
Greensboro, North Carolina, 27409

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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