

# **Enrollment Book**

HealthTeam Advantage Plan I (PPO) H9808-004

HealthTeam Advantage Plan II (PPO) H9808-005

HealthTeam Advantage Eagle Plan (PPO) H9808-009

HealthTeam Advantage Vitality Plan (PPO) H9808-010

HealthTeam Advantage Diabetes & Heart Care (HMO C-SNP) H2624-001

HealthTeam Advantage Cardinal Plan (HMO) H2624-004





# **Scope of Appointment Form**

By signing this form, I'm agreeing to meet with a sales agent to discuss:

# **HealthTeam Advantage Medicare Advantage Plans**

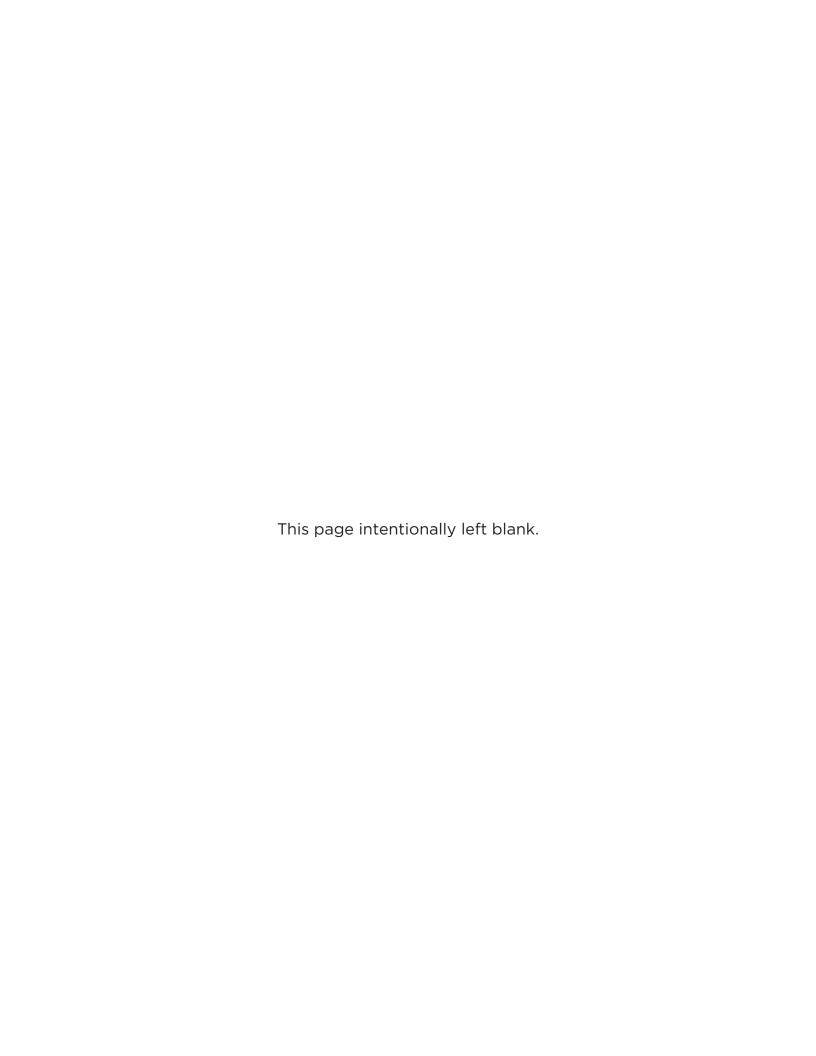
Name:	Phone:
Address (street, city, state, zip code):	
Relationship to enrollee:	Medicare ID number (optional):
By signing this form, you are agreeing to a sales meeting with a sales agent to d Advantage Plans. The person that will be discussing plan options with you is eith health plan that is not the federal government, and they may be compensated b You are under no obligation to enroll. Signing this form does NOT affect your cuit automatically enroll you in a Medicare Advantage plan, prescription drug plan Beneficiary or legally authorized representative signature and signature date:	ner employed or contracted by a Medicare lased on your enrollment in a plan. rrent or future enrollment status, nor will
Signature:	Date and time of form completion:
	//: \_ A.M. \_ P.M
PLEASE STOP HERE. YOUR SALES AGENT WILL COMPLET	TE THE REST OF THE FORM.
Agent Name:	Agent Phone:
Agent Email:	National Producer Number (NPN):
Date and time of scheduled appointment:// : A.M. □ P.M.	Initial method of contact:
Indicate which of the CMS-approved exceptions to the 48-hour rule apply IF the appointment is scheduled less than 48-hours after the signature:  Occurred during last 4 days of a valid election period for the beneficiary  Walk-in meeting initiated by beneficiary  In-bound call initiated by beneficiary	Agent, please mail this form to: HealthTeam Advantage - Enrollment 300 E. Wendover Avenue, Suite 121 Greensboro, North Carolina 27401 or fax to: 866-790-4173
Agent Signature:	
Agent signature date (mm/dd/yyyy):	Date appointment completed:
1	

Scope of appointment (SOA) is subject to Medicare Record Retention Requirements.

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. To file a complaint with HealthTeam Advantage, call us at 877-905-9216 (TTY 711). To file a complaint with Medicare,

call 1-800-MEDICARE (TTY 1-877-486-2048), 24 hours a day/7 days a week. If your complaint involves a broker or agent, be sure to include their name when you file your complaint.

MULTI-PLAN 25129 M



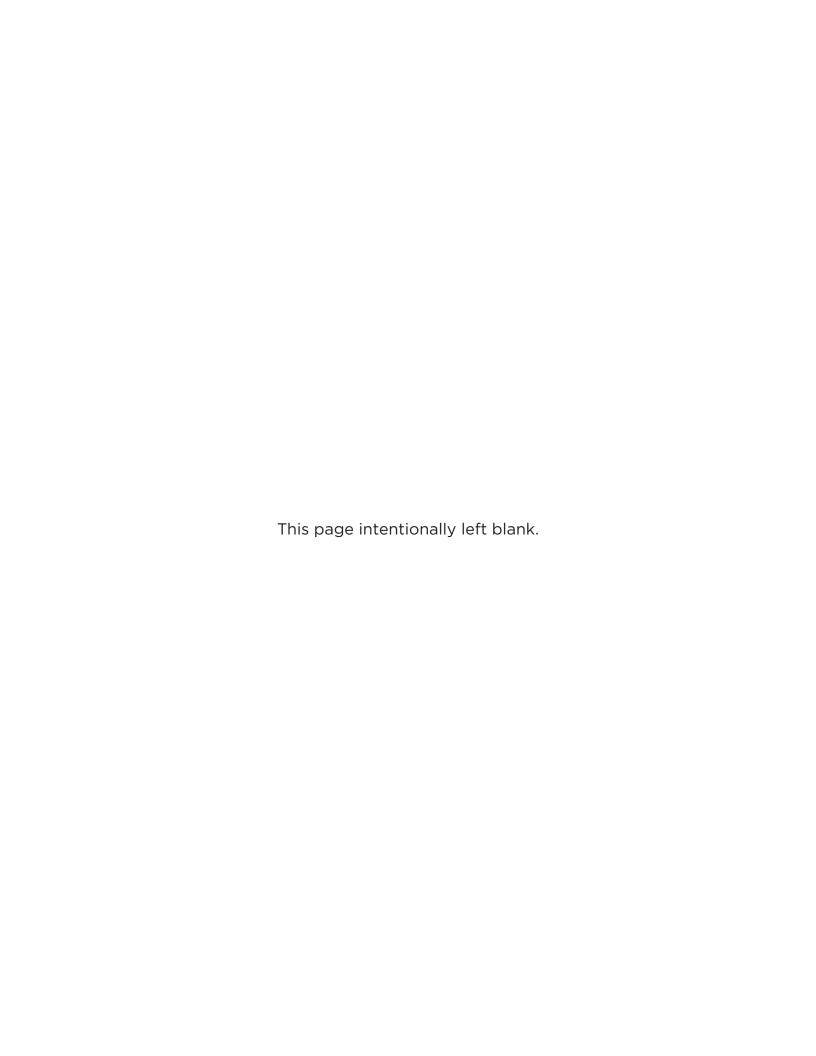


# Pre-enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a local Medicare Expert at 877-905-9216.

Understanding the Benefits
Review the full list of benefits found in the Evidence of Coverage (EOC), especially those services for which you routinely see a doctor. Visit www.htanc.com or call 877-905-9216 (TTY 711) to view a copy of the EOC.
Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
Review the formulary to make sure your drugs are covered.
Understanding Important Rules
<ul> <li>If you select a plan with a monthly premium then in addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.</li> <li>Effect on Current Coverage. If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage healthcare coverage will end once your new Medicare Advantage coverage starts. If you have Tricare, your coverage may be</li> </ul>
affected once your new Medicare Advantage coverage starts. Please contact Tricare for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.
<ul> <li>Benefits, premiums and/or copayments/co-insurance may change next calendar year.</li> <li>Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).</li> </ul>
Our HealthTeam Advantage PPO Plans allow you to see out-of-network (non-contracted) providers outside of the plans service area. However, while we pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in emergency or urgent situations, non-contracted providers may deny care.
For our HealthTeam Advantage HMO and C-SNP plans, you must use network providers except in emergency or urgent care situations or for out-of-area renal dialysis or other services. If you obtain routine care from out-of-network providers, neither Medicare nor HealthTeam Advantage will be responsible for the cost.

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.





# Attestation of Eligibility for an Enrollment Period

### **Individual Enrollment Application Form**

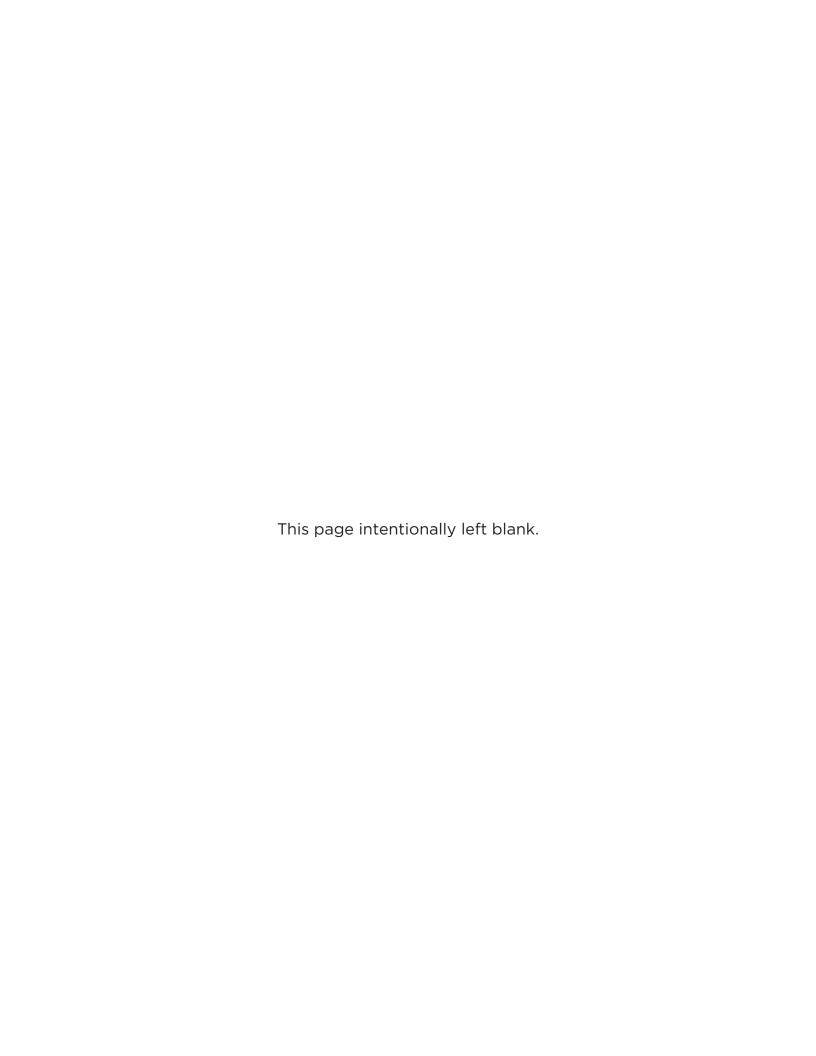
Typically, you may enroll in a Medicare Advantage plan only during the Annual Enrollment Period (AEP) from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

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) \_\_\_\_\_\_ .

I qualify for a Special Needs Plan.



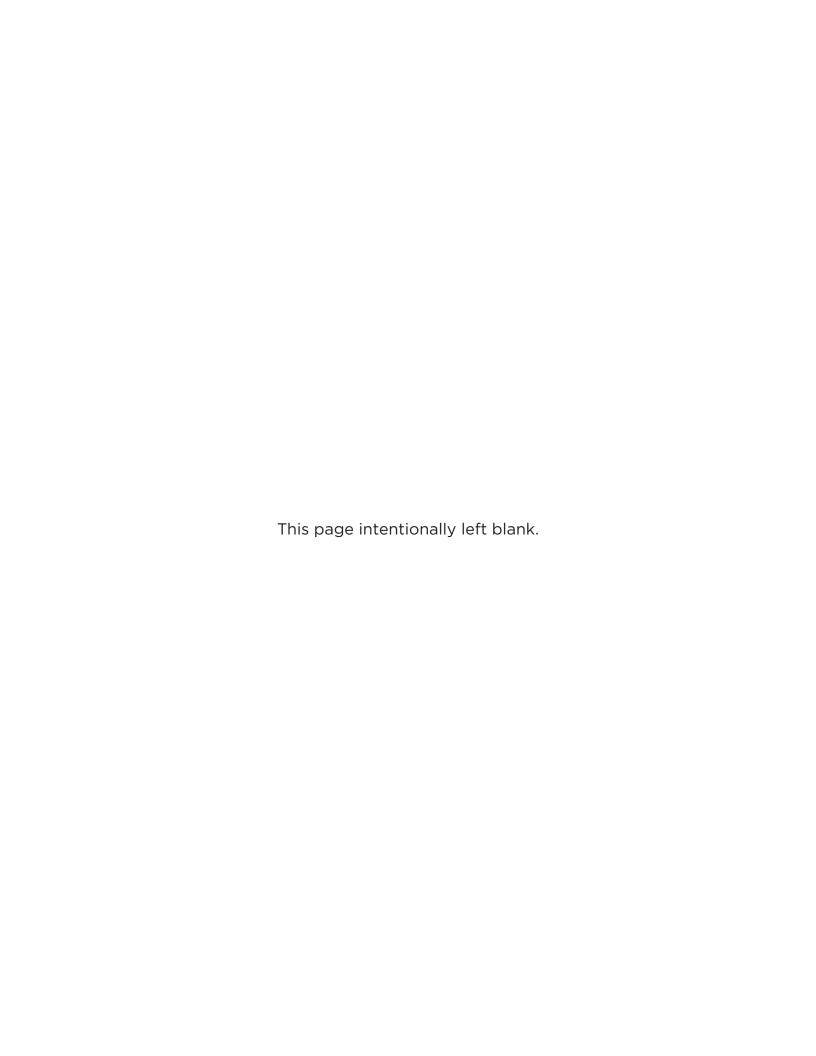


# Attestation of Eligibility for an Enrollment Period, continued

## **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.
There is a 5-Star Medicare Advantage plan in my area.
There are exceptional circumstances beyond my control.

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.





# INDIVIDUAL ENROLLMENT REQUEST FORM TO ENROLL IN A MEDICARE ADVANTAGE PLAN (PART C)

### 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.
- Live in the plan's service area

**Important:** To join a Medicare Advantage Plan, you must also have both:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)

### When Do I Use This Form?

You can join a plan:

- Between October 15-December 7 each year (for coverage starting January 1)
- Within 3 months of first getting Medicare
- In certain situations where you're allowed to join or switch plans

Visit **Medicare.gov** to learn more about when you can sign up for a plan.

# What Do I Need to Complete This Form?

- Your Medicare Number (the number on your red, white, and blue Medicare card)
- Your permanent address and phone number

**Note:** You must complete all items in Section 1. The items in Section 2 are optional — you

can't be denied coverage because you don't fill them out.

### **Reminders:**

- If you want to join a plan during fall open enrollment (October 15-December 7), the plan must get your completed form by December 7.
- Your plan will send you 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.

### What Happens Next?

Send your completed and signed form to: HealthTeam Advantage 300 East Wendover Ave, Suite 121 Greensboro, NC 27401 Once they process your request to join, they'll contact you.

### **How Do I Get Help With This Form?**

Call HealthTeam Advantage at **877-905-9216**. TTY users can call **711**.

Or, call Medicare at **1-800-MEDICARE (1-800-633-4227)**. TTY users can call 1-877-486-2048.

En español: Llame a HealthTeam Advantage al |877-905-9216/TTY 711 o a Medicare gratis al 1-800-633-4227 y oprima el 8 para asistencia en español y un representante estará disponible para asistirle.

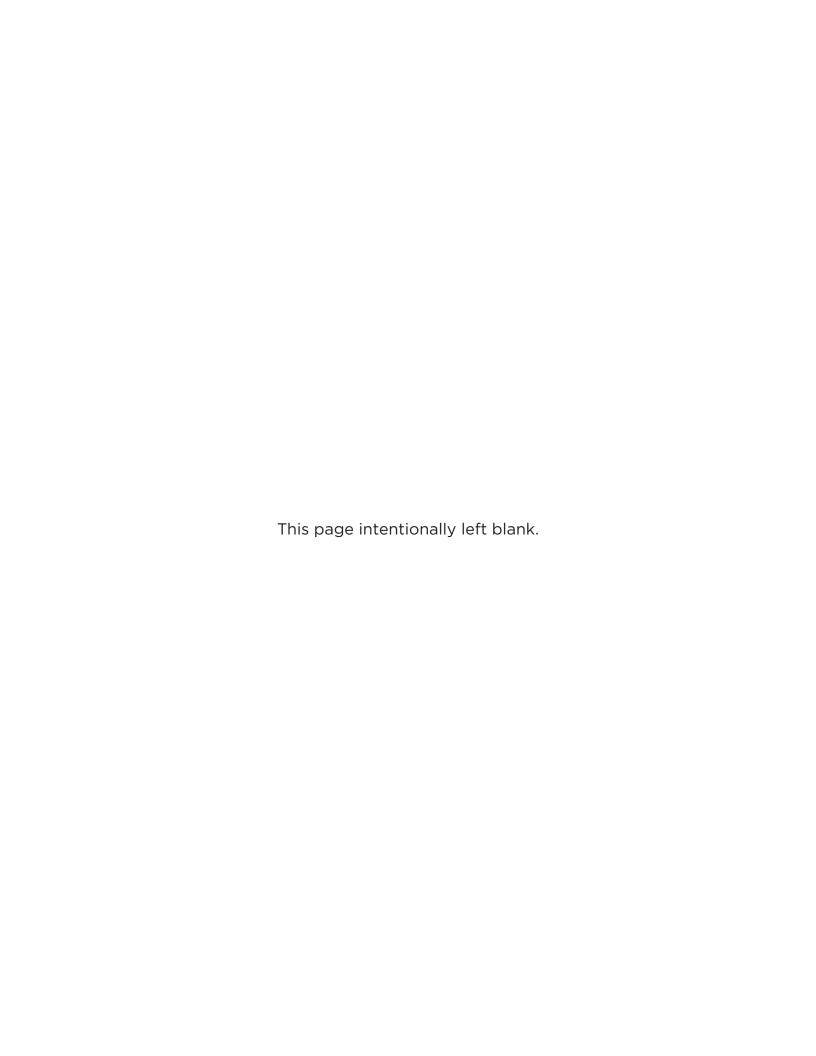
# **Individuals Experiencing Homelessness**

 If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g., social security checks) may be considered your permanent residence address.

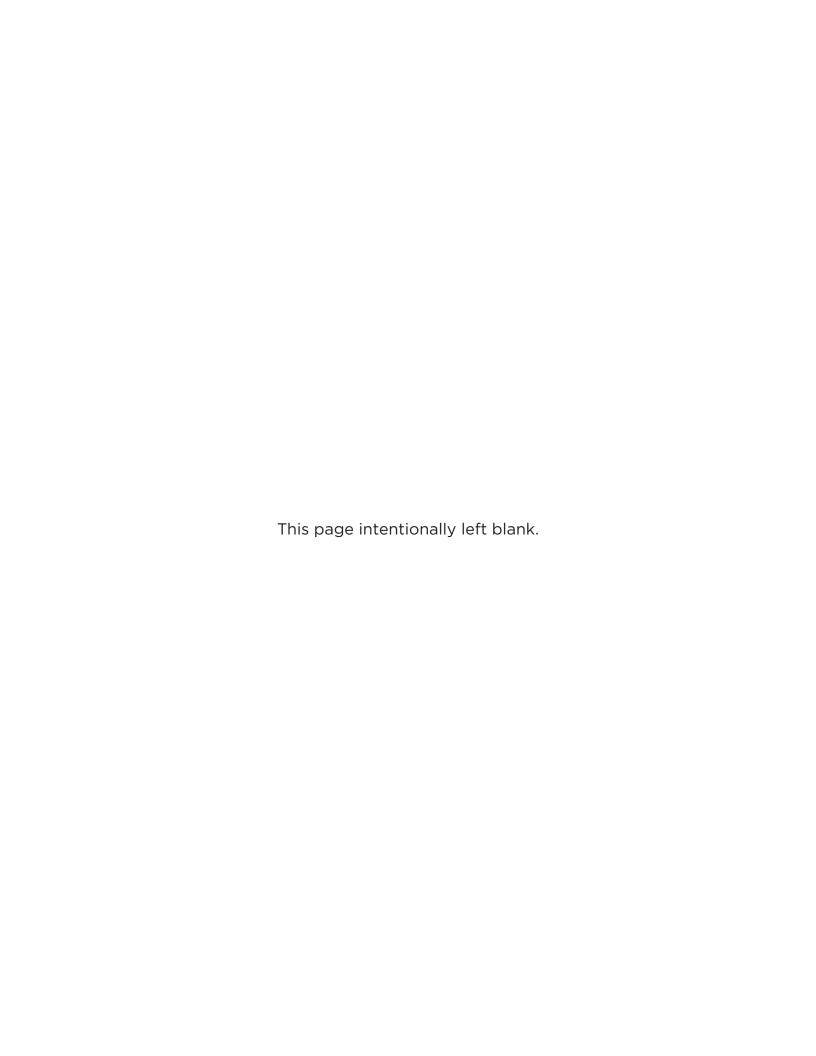
According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1378. The time required to complete this information is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

#### **IMPORTANT**

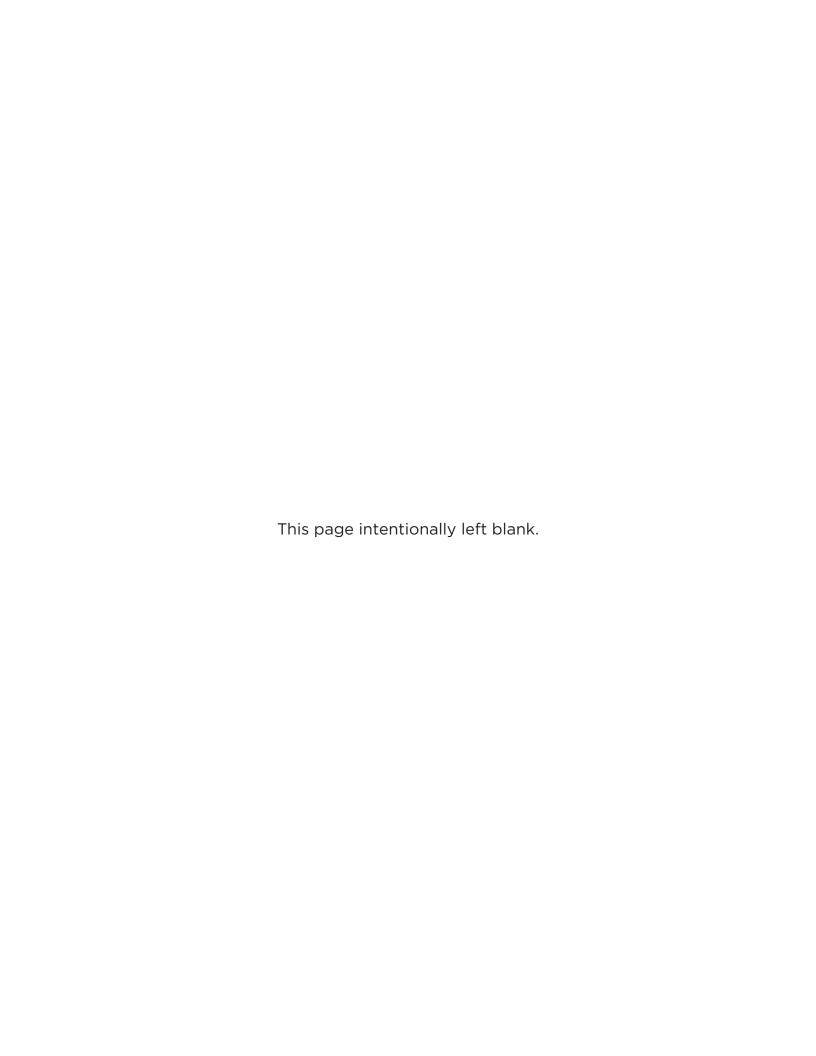
Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan. See "What happens next?" on this page to send your completed form to the plan.



Sec	tion 1 – All fields on th	is page are require	d (uı	nless mark	ed o	ptional)
Select the plan you want to join:	☐ Plan I (PPO) H9808-004 \$0 p☐ Plan II (PPO) H9808-005 \$44☐ Eagle Plan (PPO) H9808-005	4 per month De	ental R etes &	n (PPO) H9808-1 tider <b>\$40 per m</b> <b>Heart Care</b> (HM an (HMO) H2624	onth 10 CSN	NP) H2624-001 <b>\$0 per month</b>
FIRST Name:		LAST Name:				[Optional: Middle Initial]:
Birth Date: (MM/D	D/YYYY)	Sex:	Pho	ne Number:		
(/_	)	☐ Male ☐ Female	(	)		
	ce Street Address (Don't enter permanent residence address.		vidual	s experiencing	hom	elessness, a PO Box may
City:		County:		State:	ZIP	Code:
Mailing address, if o Street Address:	lifferent from your permanent	City:	•	State:	ZIP	Code:
	You	ır Medicare Informa	ition	1		
	Medicare Number:					
	Answer	these important qu	uesti	ions:		
Name of othe	prescription drug coverage (lil r coverage: Member o for the HMO CSNP plan, plea	er number for this covera	ge:	Group ———	num	nber for this coverage:
	IMPOR1	TANT: Read and sig	n be	low:		
<ul> <li>By joining this Me Medicare, who makedicare, who maked that authorize voluntary. However I understand that end my enrollme</li> <li>I understand that drug benefits from in my HealthTean agreement) will knot covered.</li> <li>The information of provide false info</li> <li>I understand that application mean representative (and 1) This person is a second to me and the second that application is a second to me and the second that application is a second to me and the second that application is a second to me and the second that application is a second to me and the second that a second that a</li></ul>	Hospital (Part A) and Medical edicare Advantage plan, I acknow use it to track my enrollment the collection of this information and the collection of this information and the enrolled in only one of the collection of this information and the manage of the covered and the enrollment form is controlled in this enrollment form is controlled in this enrollment form is controlled in this enrollment form, I will be a manage on this enrollment form, I will be a managed the signature of the signature of the signature of the signature of this authority is available on of this authority is available on of this authority is available or the signature of this authority is available or the signature of this authority is available or the signature of this authority is available or the collection of the collec	knowledge that HealthTe ent, to make payments, nation (see Privacy Act Sifect enrollment in the place MA plan at a time – and ptions apply for MA PFFS ntage coverage begins, lenefits and services provoverage" document (also enor HealthTeam Advant encet to the best of my killed disenrolled from the place of the person legally estand the contents of this ature certifies that:	am A and for tatem an. d that i, MA must vided know age v nowle an. autho s app	dvantage will or other purporent below). You enrollment in MSA plans). It get all of my by HealthTeal or as a member will pay for belowing to act of act of act of alication. If signification.	share oses a our re this med m Ac oer co nefits tand n my	allowed by Federal esponse to this form is plan will automatically lical and prescription elvantage and contained portract or subscriber sor services that are that if I intentionally behalf) on this
Signature:				-		e:
	re the authorized rep					
	A			ationship to a	nrall	ee:
Phone number:			Kel	ationsilib to e	IIO II I	tt



Section 2 - All fields on the Answering these questions is your choice. You can't be	
Are you of Hispanic, Latino/a, or Spanish origin? Select No., not of Hispanic, Latino/a, or Spanish origin Yes, Puerto Rican Yes, another Hispanic, Latino/a, or Spanish origin I choose not to answer.	
What's your race? Select all that apply.  American Indian or Alaska Native  Asian:  Asian Indian  Chinese  Filipino  Japanese  Korean  Vietnamese  Other Asian	☐ Black or African American Native Hawaiian and Pacific Islander: ☐ Guamanian or Chamorro ☐ Native Hawaiian ☐ Samoan ☐ Other Pacific Islander ☐ White ☐ I choose not to answer.
Select one if you want us to send you information in a la	nguage other than English.
Select one if you want us to send you information in an a Braille Large print Audio CD Data Please contact HealthTeam Advantage at 888-965-1965 format other than what's listed above. Our office hours a seven days a week, or April 1-September 30, 8 a.m. to can call 711.	a CD 5 (TTY 711) if you need information in an accessible are October 1-March 31, 8 a.m. to 8 p.m. ET,
Do you work?  Yes  No Does your spouse	e work? 🔲 Yes 🔲 No
List your Primary Care Physician (PCP), clinic, or health o	center:
I want to get the following materials via email.  □ Evidence of Coverage □ Comprehensive Formulary □ Member Newsletters E-mail address:	s/Alerts

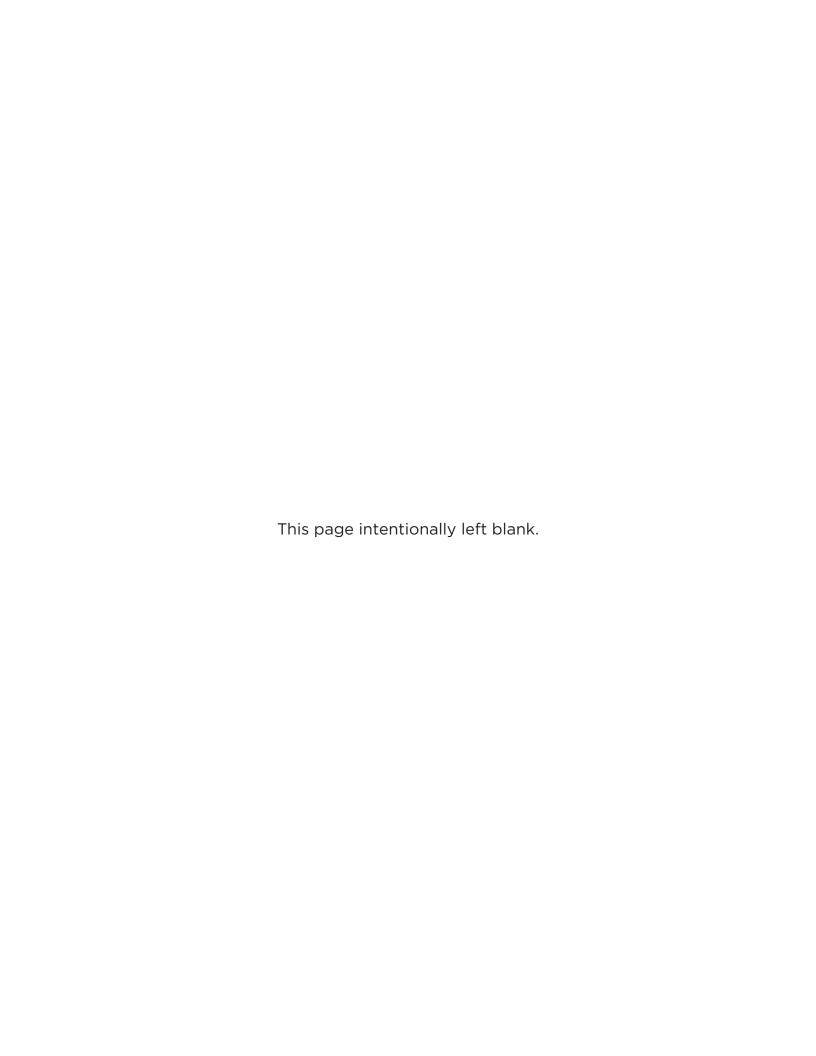




	Paying Yo	ur Plan Premiums	
or may owe) by mail, or	Electronic Funds Transfe Itomatically taken out on Ith.	ing any late enrollment penalty the (EFT) each month. You can also of your Social Security or Railroad	choose to pay your
	DED check or provide the		
Bank Routi	ng Number:		
Bank Acco	unt Number:		
☐ Automatic deduction fr	•	avings Security or Railroad Retirement Boar Social Security	d (RRB) benefit check.
or RRB approves the deautomatic deduction, to premiums due from your RRB does not appromonthly premiums.	eduction. In most cases, in the first deduction from your enrollment effective of the your request for autor	yo or more months to begin after Sif Social Security or RRB accepts your Social Security or RRB benefit of late up to the point withholding begin atic deduction, we will send you a southly Adjustment Amount (Part	ur request for check will include all nins. If Social Security paper bill for your
		<b>n premium.</b> DON'T pay HealthTea	
		ollee with completing this for	
or other third parties) h	•	i.e. agents, brokers, SHIP counse out this form.	elors, family members,
Name		Relationship to enr	ollee
Signature		National Producer Number (Age	ents/Brokers Only)
AGENTS/BROKERS ON	LY:		
Date Application Receiv	ed by Agent:		
Plan ID #:		Effective Date of Coverag	e
ICEP/IEP: /	AEP: OEP: _	SEP (type):	Not Eligible:

PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 of the Social Security Act and 42 CFR §§ 422.50 and 422.60 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARX)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

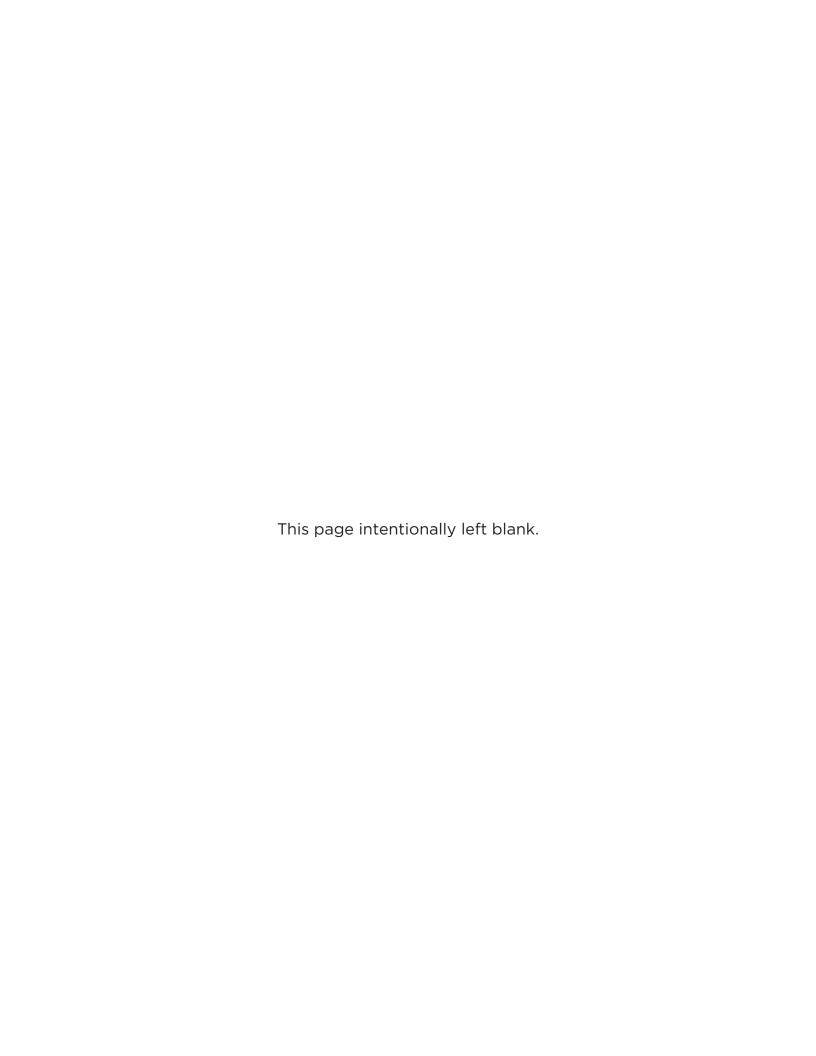




# **Application Checklist**

# Here's a quick checklist to review your application and to keep for your records.

 1.	The agent reviewed the 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 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, 2025 drug payment stages, 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. Summary of Benefits B. Multi-Language Insert C. Medicare Star Ratings Sheet D. Business Card
 8.	I understand that the Primary Care Provider I have chosen is
	and the physician is currently \square In-network \square Out-of-network *Network participation may change
 9.	The payment method I have selected is Monthly Invoice SSA Deduct ACH
 10.	I understand that I need to complete the Health Risk Assessment (HRA).
 11.	I understand that I must complete the Chronic Condition Verification form if I have signed up for the Diabetes & Heart Care (HMO CSNP) (H2624-001).
 12.	If I selected the Eagle Plan (H9808-009), I need to complete VA Form 10-5345a.





# **Chronic Condition Verification Form**

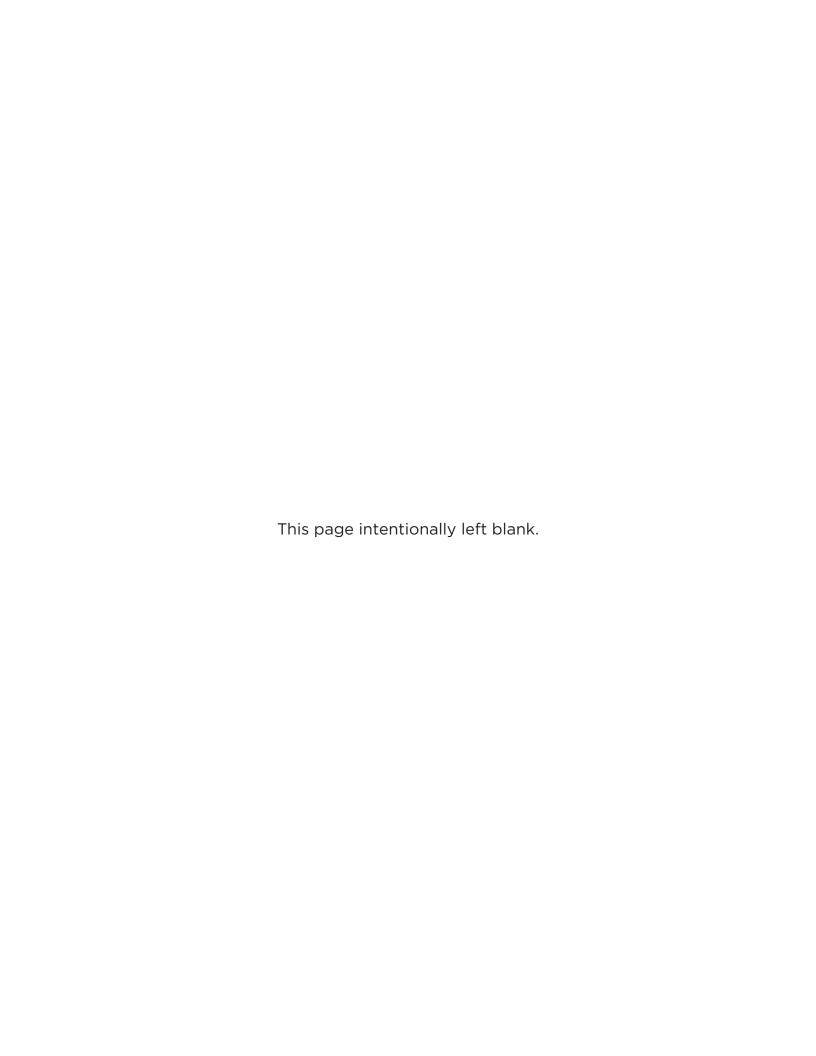
Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with federal law concerning the privacy of such information.

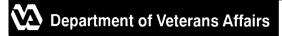
Provider Address:	
Provider:Date:	
☐ Diabetes ☐ Chronic Heart Failure	
has the following health condition(s):	
hereby certify that	(Applicant)
l,	(Provider)
PROVIDER, please complete.	
Provider Confirmation of Chronic Condition	
Relationship to Applicant:Phone Number:	
If you are the authorized representative of the applicant, provide the following information:	
Signature of Applicant/Authorized Representative: Date: _	
Medicare ID Number or Date of Birth:	
Print Name of Applicant/Authorized Representative:	
APPLICANT, please complete if applicable.	
Application Use and Disclosure Authorization	
I authorize and direct(Care Provo to confirm my chronic condition and disclose my medical records to HealthTeam Advantage. This authorization shall be effective until I am no longer enrolled in HealthTeam Advantage.	vider/Specialist) e.
☐ Diabetes ☐ Chronic Heart Failure	
By joining HealthTeam Advantage Diabetes & Heart Care (HMO C-SNP), a Medicare Advanta Needs Plan for Chronic Conditions, I acknowledge that I have one or more of the following of	•

Fax this completed form to: 800-820-0//4

**Mail this form to: HealthTeam Advantage**, 300 E. Wendover Ave., Suite 121, Greensboro, NC 27401 If you have any questions, please call: 877-905-9216, TTY 711, Monday—Friday, 8:00 a.m.—5:00 p.m.

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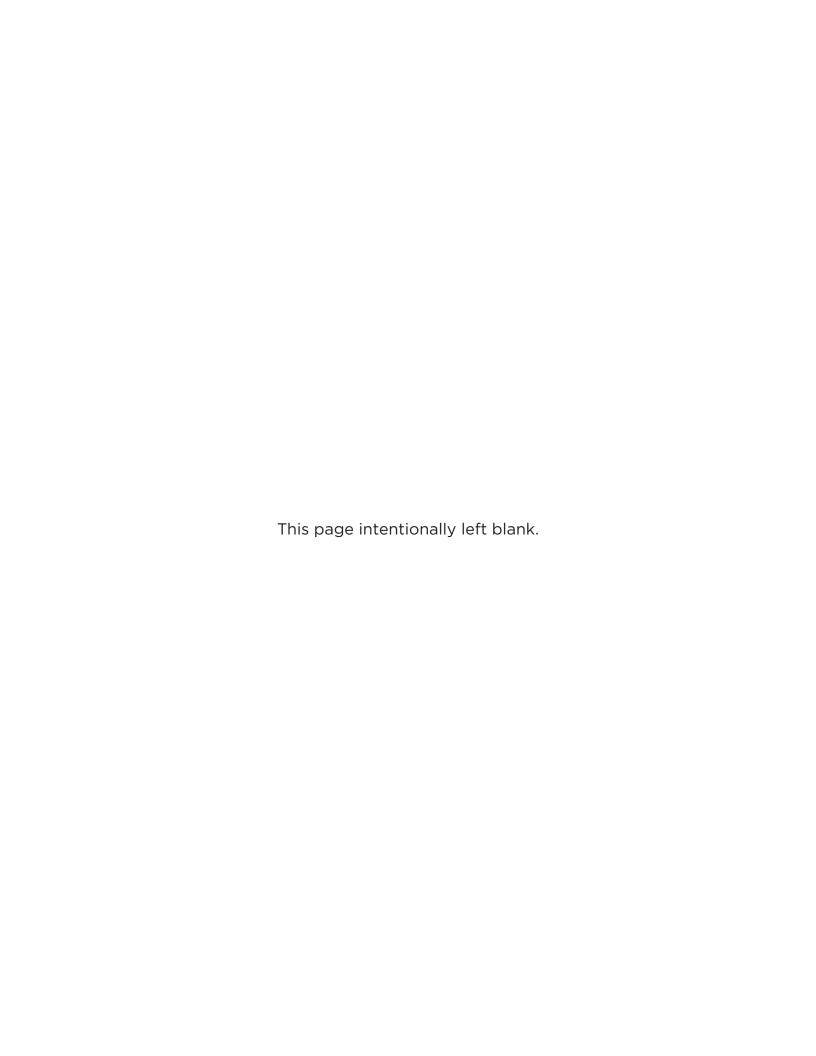
# INDIVIDUALS' REQUEST FOR A COPY OF THEIR OWN HEALTH INFORMATION

### PRIVACY ACT INFORMATION

The purpose of this form is to provide an individual the means to make a written request for a copy of their information maintained by the Department of Veteran Affairs (VA) in accordance with 38 CFR 1.577. The information on this form is requested under Title 38 U.S.C. Your disclosure of the information requested on this form is voluntary. However, if information needed to locate records for release is not furnished completely and accurately, VA will be unable to comply with the request. Failure to furnish the information will not have any effect on any other benefits to which you may be entitled.

the request. Failure to furnish the information will not have any effect on any other benefits to which you may be entitled.	tery, VII will be unable to comply with
TO: DEPARTMENT OF VETERANS AFFAIRS (Name and Location of the VA Health Care Facility)	
LAST NAME- FIRST NAME- MIDDLE NAME	DATE OF BIRTH (mm/dd/yyyy)
PATIENT'S MAILING ADDRESS (including City, State and Zip Code)	
DESCRIPTION OF INFORMATION REQUESTED	
Check applicable box(es) and state the extent or nature of information to be provided:	
HEALTH SUMMARY (Prior 2 Years)	
INPATIENT DISCHARGE SUMMARY (Dates):	
PROGRESS NOTES:	
SPECIFIC CLINICS (Name & Date Range):	
SPECIFIC PROVIDERS (Name & Date Range):	
DATE RANGE:	
OPERATIVE/CLINICAL PROCEDURES (Name & Date):	
LAB RESULTS:	
SPECIFIC TESTS (Name & Date):	
DATE RANGE:	
RADIOLOGY REPORTS (Name & Date):	
LIST OF ACTIVE MEDICATIONS	
VACCINATION (Dose, Lot Number, Date & Location):	
LEGAL HEALTH RECORDS FOR TORTS:	
OTHER (Describe):	
COPY OF HEALTH INFORMATION IS TO BE DELIVERED TO THE IND	IVIDUAL
PAPER CD-ROM OTHER:	
IN-PERSON PICK-UP, PROVIDE CONTACT PHONE NUMBER:	
MAIL TO: SAME ADDRESS AS ABOVE NEW ADDRESS BELOW	
PATIENT SIGNATURE (Sign in ink)	DATE (mm/dd/yyyy)
(28,)	(
NOTE: If signed by someone other than the individual, indicate the authority (e.g. guardianship or power of	attorney) under which request is
made.	attorney) under which request is

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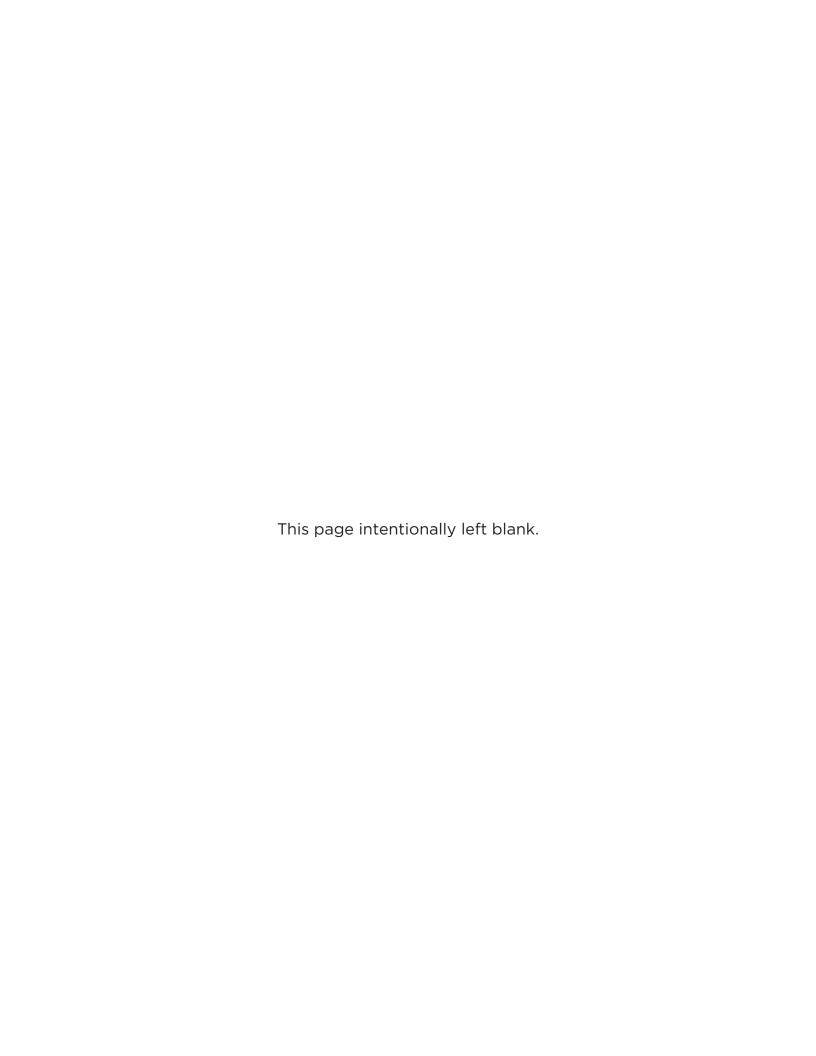
# **Enrollment Receipt**

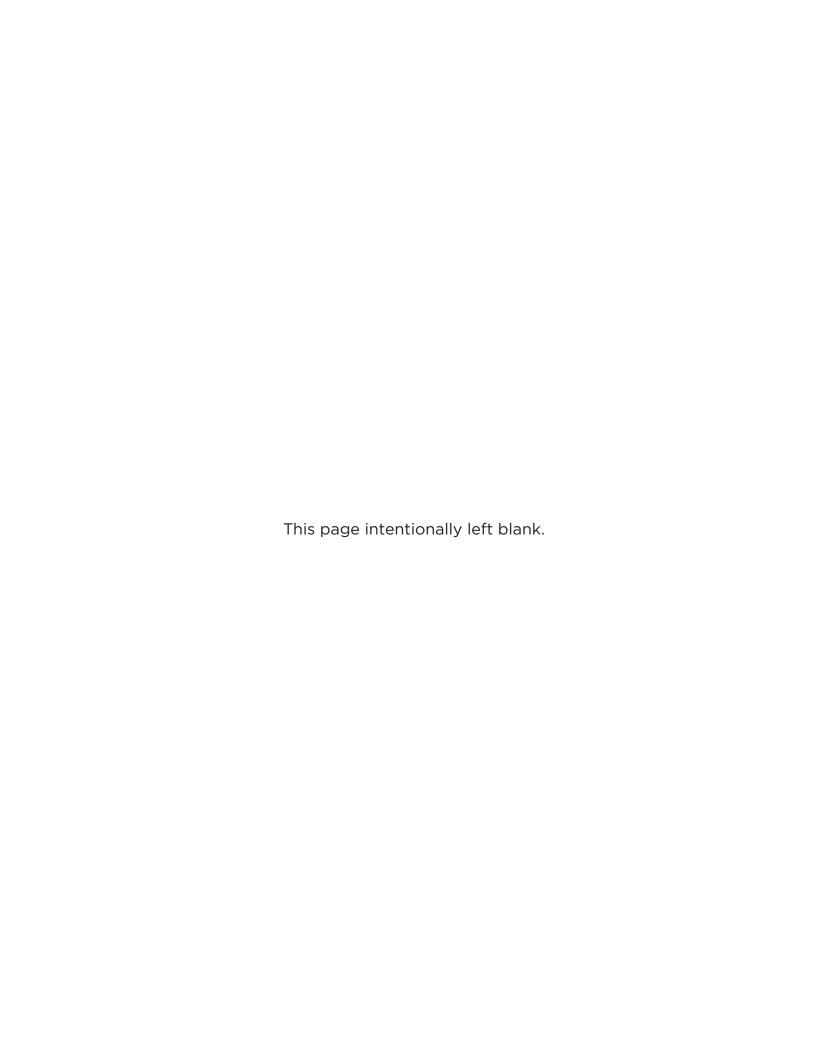
Complete if enrolling with a licensed agent.

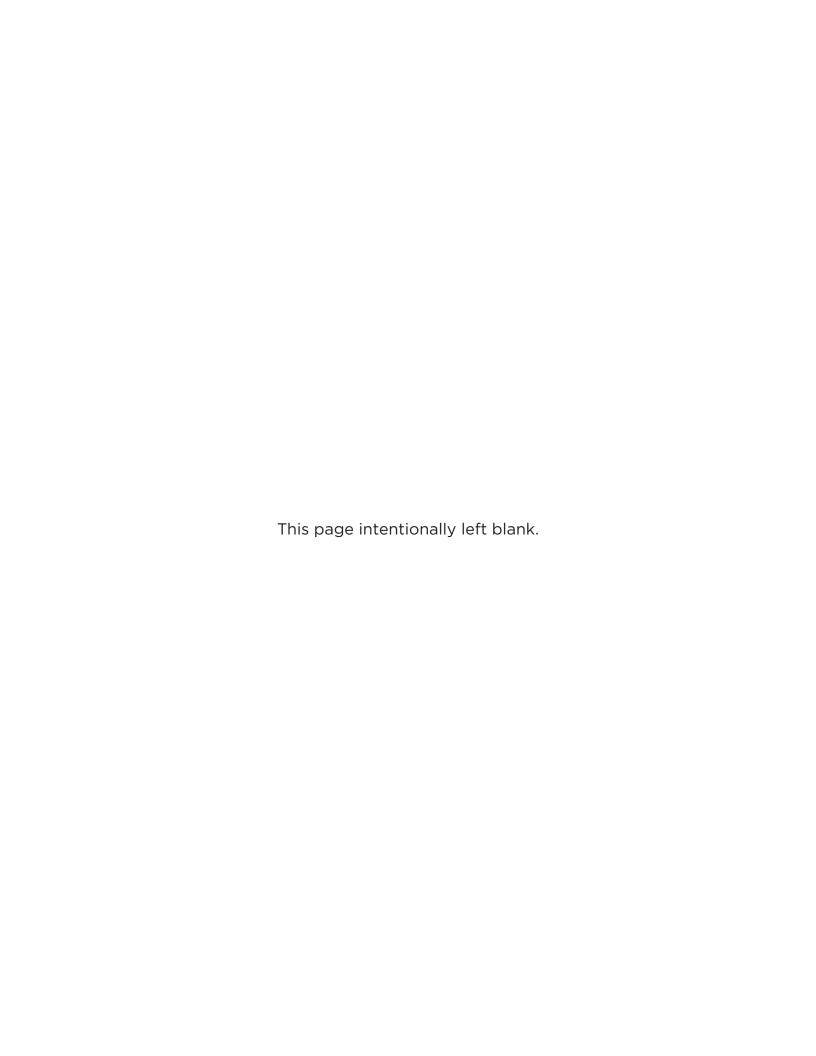
Application Date:
Proposed Effective Date:
Medicare ID:
Plan Name:
Agent Name:
Agent Phone:
Agent NPN Number:

This receipt verifies that you completed an enrollment form with a licensed agent who sells HealthTeam Advantage Medicare Advantage plans. Use this as your temporary proof of coverage until Medicare has confirmed your enrollment.

If you have questions about your enrollment, call your licensed agent or call a HealthTeam Advantage local expert at the number listed on the back of this booklet.









# What's Next?

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

- 1 Enrollment Receipt
  - 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.
- 2 Confirmation Letter
  Within 10 days of submitting your enrollment form, and Medica

Within 10 days of submitting your enrollment form, and Medicare has approved your enrollment, you will receive a letter from HealthTeam Advantage confirming your approval by Medicare to the plan.

- **3** Welcome Call
  - Your Healthcare Concierge will call to welcome you to HealthTeam Advantage and confirm the information provided on the enrollment form, such as your home address and primary care physician. They can also assist you with any questions you may have.
- HealthTeam Advantage Welcome Kit

  Your Welcome Kit will include your Evidence of Coverage (EOC) booklet which provides detailed coverage information.
- 5 Identification (ID) Card

Members will receive two ID cards. ID Cards will be mailed separately from any other materials provided by HealthTeam Advantage. Use your HealthTeam Advantage ID card when visiting your doctor, pharmacy, or hospital.

6 Welcome to HealthTeam Advantage!



# We're Here for You!



# **Online**

Visit HTANC.com.



# **In-Person**

Local Benefit Center 5815 Samet Dr., Suite 107, High Point, NC 27265



# Call Us

Prospective members call toll-free 877-905-9216

8 a.m.-8 p.m. Oct.1-March 31, 7 Days a Week April 1-Sept. 30, Monday-Friday



## **TTY Users**

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



# **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.

health**team**advantage\*

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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.