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2025

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

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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 discuss HealthTeam Advantage Medicare Advantage Plans. The person that will be discussing plan options with you is either employed or contracted by a Medicare health plan that is not the federal government, and they may be compensated based on your enrollment in a plan.

You are under no obligation to enroll. Signing this form does NOT affect your current or future enrollment status, nor will it automatically enroll you in a Medicare Advantage plan, prescription drug plan or other Medicare plan.

Beneficiary or legally authorized representative signature and signature date:

Signature: _____

Date and time of form completion: ___/___/___ ___:___ ❑ A.M. ❑ P.M.

PLEASE STOP HERE. YOUR SALES AGENT WILL COMPLETE 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:

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.

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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

- ☐ 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.
- ☐ **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 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.
- ☐ Benefits, premiums and/or copayments/co-insurance may change next calendar year.
- ☐ 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).
- ☐ 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.

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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.

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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.

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OMB No. 0938-1378
Expires:6/30/2026

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.

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Section 1 – All fields on this page are required (unless marked optional)

Select the plan you want to join:

- ❑ **Plan I** (PPO) H9808-004 **$0 per m onth**
- ❑ **Plan II** (PPO) H9808-005 **$44 per month**
- ❑ **Eagle Plan** (PPO) H9808-009 **$0 per month**
- ❑ **Vitality Plan** (PPO) H9808-10 **$0 per month**
  - ❑ **Dental Rider $40 per month**
- ❑ **Diabetes & Heart Care** (HMO CSNP) H2624-001 **$0 per month**
- ❑ **Cardinal Plan** (HMO) H2624-004 **$0 per month**

FIRST Name:	LAST Name:	[Optional: Middle Initial]:
Birth Date: (MM/DD/YYYY) (_____/_____/_____)	Sex: ❑ Male ❑ Female	Phone Number: ( )

Permanent Residence Street Address (Don't enter a PO Box. Note: For individuals experiencing homelessness, a PO Box may be considered your permanent residence address.):

City:	County:	State:	ZIP Code:
Mailing address, if different from your permanent address (PO Box allowed): Street Address:	City:	State:	ZIP Code:

Your Medicare Information

Medicare Number: ___ ___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___

Answer these important questions:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to HealthTeam Advantage? ❑ Yes ❑ No

Name of other coverage: _____ Member number for this coverage: _____ Group number for this coverage: _____

If you are signing up for the HMO CSNP plan, please complete the **Chronic Condition Verification Form.**

IMPORTANT: Read and sign below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in HealthTeam Advantage.
- 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.
- I understand that I can be enrolled in only one MA plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA PFFS, MA MSA plans).
- 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.
- 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 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:
  1) This person is authorized under State law to complete this enrollment, and
  2) Documentation of this authority is available upon request by Medicare.

Signature: _____ **Today's date:** _____

If you're the authorized representative, sign above and fill out these fields:

Name: _____ Address: _____

Phone number: _____ Relationship to enrollee: _____

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Section 2 – All fields on this page are optional

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Are you of Hispanic, Latino/a, or Spanish origin? Select all that apply.

- ❑ No, not of Hispanic, Latino/a, or Spanish origin
- ❑ Yes, Puerto Rican
- ❑ Yes, another Hispanic, Latino/a, or Spanish origin
- ❑ Yes, Mexican, Mexican American, Chicano/a
- ❑ Yes, Cuban
- ❑ **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 language other than English.

- ❑ Spanish

Select one if you want us to send you information in an accessible format.

❑ Braille ❑ Large print ❑ Audio CD ❑ Data CD

Please contact HealthTeam Advantage at 888-965-1965 (TTY 711) if you need information in an accessible format other than what's listed above. Our office hours are 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. TTY users can call 711.

Do you work? ❑ Yes ❑ No Does your spouse work? ❑ Yes ❑ No

List your Primary Care Physician (PCP), clinic, or health center: _____

I want to get the following materials via email.

- ❑ Evidence of Coverage
- ❑ Provider Directory
- ❑ Comprehensive Formulary
- ❑ Member Newsletters/Alerts

E-mail address: _____

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Paying Your Plan Premiums

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail, or Electronic Funds Transfer (EFT) 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.**

Please select a plan premium and/or late enrollment payment option:

❑ Get a bill each month.

❑ 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.*

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. DON'T pay HealthTeam Advantage the Part D-IRMAA.

For individuals helping enrollee with completing this form only

Complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, family members, or other third parties) helping an enrollee fill out this form.

_____

Name Relationship to enrollee

_____

Signature National Producer Number (Agents/Brokers Only)

AGENTS/BROKERS ONLY:

Date Application Received by Agent: _____

Plan ID #: _____ Effective Date of Coverage _____

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.

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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 ☐ In-network ☐ 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.

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This document is required for Diabetes & Heart Care (HMO C-SNP) applicants.

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.

Release of Information

By joining HealthTeam Advantage Diabetes & Heart Care (HMO C-SNP), a Medicare Advantage Special Needs Plan for Chronic Conditions, I acknowledge that I have one or more of the following conditions:

☐ **Diabetes** ☐ **Chronic Heart Failure**

I authorize and direct _____ (Care Provider/Specialist) 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.

Application Use and Disclosure Authorization

APPLICANT, please complete if applicable.

Print Name of Applicant/Authorized Representative: _____

Medicare ID Number or Date of Birth: _____

Signature of Applicant/Authorized Representative: _____ Date: _____

If you are the authorized representative of the applicant, provide the following information:

Relationship to Applicant: _____ Phone Number: _____

Provider Confirmation of Chronic Condition

PROVIDER, please complete.

I, _____ (Provider)

hereby certify that _____ (Applicant)

has the following health condition(s):

☐ **Diabetes** ☐ **Chronic Heart Failure**

Provider: _____ **Date:** _____

Provider Address: _____

_____ **Provider Phone:** _____

Fax this completed form to: 800-820-0774

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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Department of Veterans Affairs

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.

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 INDIVIDUAL

☐ 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)*

NOTE: If signed by someone other than the individual, indicate the authority (e.g. guardianship or power of attorney) under which request is made.

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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.

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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.

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 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.

4 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.

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Connect with us on Facebook and YouTube

MULTI-PLAN_25144_M