



# Enrollment Book 2026



Champion Plus (HMO C-SNP) H6170-010 for SPMI

For Fresno, Imperial, Kern,  
Los Angeles, Madera, Orange,  
Riverside, San Bernardino and  
San Diego Counties

# The Right Plan *for You!*

## Champion Plus

Champion Plus is a Chronic Care Special Needs Plan (HMO C-SNP) and is a great choice for Medicare beneficiaries with a diagnosis of Schizophrenia, Schizoaffective, Bipolar, Major Depressive or Paranoid Disorders. This plan reduces the cost of prescription drugs while adding additional services and benefits.

## Scope of Sales Appointment Confirmation Form

The Centers for Medicare and Medicaid Services requires licensed sales agents to document the scope of a marketing appointment prior to any individual 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 his/her authorized representative.

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

### **Medicare Advantage Plans (HMO, HMO-POS, HMO C-SNP):**

These Medicare Advantage Plans provide all Medicare Part A and Part B benefits, and all include Medicare Part D prescription drug coverage (MAPD). Some plans are designed for individuals with specific needs, such as those with chronic conditions (Chronic Condition Special Needs Plans, or C-SNPs).

**Medicare Advantage HMO (Health Maintenance Organization):** You must use doctors, hospitals, and other providers that are in the plan's network, except in emergencies. You must choose a primary care doctor and you may be required to obtain referrals to see specialists.

**Medicare Advantage POS (Point of Service) Plans (HMO-POS):** These plans combine features of HMO plans with some out-of-network coverage. You select a primary care physician within the network and can see out-of-network providers for specific services and coverages. You may have different cost shares when seeing out-of-network providers. Some C-SNPs include a POS option allowing some access to out-of-network providers. This option is only available for the Champion HMO-POS Plans associated with its CKD/ESRD C-SNPs.

**Chronic Condition Special Needs Plans (HMO C-SNP):** These plans are designed for people with specific chronic conditions, such as Chronic Kidney Disease (CKD) including End Stage Renal Disease (ESRD), diabetes, or heart disease, Chronic Heart Failure (CHF), Coronary Artery Disease (CAD), or cardiac arrhythmias, or behavioral health conditions like Schizophrenia, Schizoaffective disorder, Bipolar disorder, Major depressive disorder, or recurrent Paranoid and other psychotic disorders. They tailor benefits, provider choices, and drug formularies to best meet the specific needs of the group they serve. Some C-SNPs include a POS option allowing some access to out-of-network providers. You may have different cost shares when seeing out-of-network providers.

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## Scope of Sales Appointment Confirmation Form (Cont.)

By signing this form, you agree to a meeting with a licensed sales agent to discuss the types of products you initialed above. Please note, the person who will discuss the products 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.

<b>Beneficiary or Authorized Representative Signature and Signature Date:</b>	
Signature:	Signature Date:
<b>If you are the authorized representative, please sign above and print below:</b>	
Representative's Name:	
Your Relationship to the Beneficiary:	

**To be completed by Agent:**

Agent Name:	Agent NPN:
Agent Phone Number:	Agent Email:
Beneficiary Name:	Beneficiary Phone:
Beneficiary Address: <i>(optional)</i>	
Initial Method of Contact: <i>(Indicate here if candidate was a walk-in)</i>	
Agent Signature:	Date Appt. Completed:

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# Summary of *Benefits*

Champion Plus  
(HMO C-SNP) H6170-010

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For Fresno, Imperial, Kern, Los Angeles, Madera, Orange,  
Riverside, San Bernardino and San Diego counties

# 2026 Summary of *Benefits*

## Champion Health Plan

January 1, 2026 - December 31, 2026

**Champion Health Plan** is a Medicare Advantage HMO C-SNP with a Medicare contract. Enrollment in Champion Health Plan depends on contract renewal.

The benefit information provided is a summary of what we cover and what you can expect to pay. It doesn't list every service that we cover or list every limitation or exclusion. For a complete list of services, we cover, please access the "Evidence of Coverage" booklet at [championhmo.com](http://championhmo.com).

To join **Champion Plus (HMO C-SNP)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, live in our service area, and have a diagnosis of Schizophrenia, Schizoaffective, Bipolar, Major Depressive or Paranoid Disorders. This plan is designed to meet the needs of individuals who qualify for Medi-Cal and do not receive institutional-level type of care (long-term care). Our service area includes the following counties in California: Fresno, Imperial, Kern, Los Angeles, Madera, Orange, Riverside, San Bernardino and San Diego.

Except in emergency situations, if you use the providers that are not in our network, we may not pay for these services.

For coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View online at [medicare.gov](http://medicare.gov) or receive a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours, 7 days a week, including some federal holidays. TTY users should call 1-877-486-2048. This document is available in other formats such as Braille, large print or audio.

For more information, please call us toll free 1-800-885-8000 from October 1 - March 31, 7 days a week from 8 am to 8 pm pacific standard time (PST) and from April 1 - September 30, Monday through Friday from 8 am to 8 pm PST. You can also visit us at [championhmo.com](http://championhmo.com).

Plan Details	Champion Plus	Your Cost with Medicare and Medi-Cal
Monthly Premium	\$12	\$0 (with Extra Help)
Deductible	No Plan Deductible \$257 Part B Deductible (2025 cost sharing amounts and may change for 2026. Champion Health Plan will provide updated rates on its website when 2026 rates are released.)	No Deductible
Annual Maximum Out of Pocket (MOOP)	\$9,250	\$0

Plan Details	Champion Plus	Your Cost with Medicare and Medi-Cal
Inpatient Hospital	<p>\$1,676 deductible per benefit period</p> <p>\$0 for days 1 - 60</p> <p>\$419 Copay for days 61 - 90</p> <p>\$838 Copay for each lifetime reserve day after day 90 for each benefit period (up to 60 days over your lifetime)</p> <p>100% of all Costs beyond the lifetime reserve days</p> <p>*2025 Cost sharing amounts and may change for 2026. Champion Health Plan will provide updated rates on its website when 2026 rates are released.</p> <p>Services may require authorization and a referral.</p>	<p>\$0</p> <p>†If you have full Medi-Cal benefits, you may pay \$0 for your Medicare-covered services.</p> <p>Service may require authorization and referral.</p>
Outpatient Hospital and Ambulatory Surgery Centers (ASC)	<p>20% of the Cost for outpatient hospital services</p> <p>20% of the Cost for surgery in an Ambulatory Surgery Center</p> <p>20% of the Cost for outpatient hospital observation</p> <p>Services may require authorization and a referral.</p>	<p>\$0 Copay</p> <p>†If you have full Medi-Cal benefits, you may pay \$0 for your Medicare-covered services.</p> <p>Services may require authorization and referral.</p>
Primary Care Providers	\$0 Copay	\$0 Copay
Specialists	<p>20% of the Cost</p> <p>Authorization may be required for all services except nephrology.</p>	<p>\$0 Copay</p> <p>†If you have full Medi-Cal benefits, you may pay \$0 for your Medicare-covered services.</p> <p>Services may require authorization and referral.</p>
Preventive Services (Medicare Covered Screenings)	\$0 Copay	\$0 Copay

Plan Details	Champion Plus	Your Cost with Medicare and Medi-Cal
<p><b>Emergency Care (Hospital Emergency Department)</b></p> <p><b>Worldwide Emergency Care</b></p>	<p>\$115 Copay</p> <p>Copay is waived if admitted to hospital within 24 hours for related health event.</p> <p>\$0 Copay for up to \$100,000 maximum Worldwide benefit limit reimbursable by the plan not to exceed 60% of local Medicare rates. Combined with Worldwide Urgently Needed Care.</p>	<p>\$0 Copay</p> <p>†If you have full Medi-Cal benefits, you may pay \$0 for your Medicare-covered services.</p>
<p><b>Urgent Care Services (Non-hospital Urgent Care Center)</b></p> <p><b>Worldwide Urgently Needed Care</b></p>	<p>\$0 Copay</p> <p>\$0 Copay for up to \$100,000 maximum Worldwide benefit limit reimbursable by the plan not to exceed 60% of local Medicare rates. Combined with Worldwide Emergency Care.</p>	<p>\$0 Copay</p>
<p><b>Diagnostic Services/Labs/Imaging</b></p> <ul style="list-style-type: none"> <li>• Diagnostic tests and procedures</li> <li>• X-Rays</li> <li>• Lab Services</li> <li>• Diagnostic radiology services (such as MRI, CT Scans)</li> <li>• Therapeutic radiology services (such as radiation treatment for cancer)</li> </ul>	<p>\$0 Copay for lab services and X-rays</p> <p>20% of the Cost for all other services</p> <p>Diagnostic tests and procedures and lab services may require authorization and a referral.</p>	<p>\$0 Copay for lab services and X-rays</p> <p>\$0 Copay for all other services</p> <p>†If you have full Medi-Cal benefits, you may pay \$0 for your Medicare-covered services.</p> <p>Diagnostic tests and procedures and lab services may require authorization and a referral.</p>
<p><b>Hearing Services</b></p> <ul style="list-style-type: none"> <li>• Medicare-covered services</li> <li>• Routine hearing exam and fitting/evaluation for hearing aid</li> <li>• Hearing Aid</li> </ul>	<p>\$0 Copay for Medicare-covered services every year</p> <p>\$0 Copay for one routine exam and one fitting/evaluation for hearing aids every year</p> <p>\$149 Copay per hearing aid (all models) up to (2) aids every (3) years</p>	

Plan Details	Champion Plus	Your Cost with Medicare and Medi-Cal
<p><b>Dental Services</b></p>	<p>\$0 Copay for Preventive Dental Services and Medicare-covered dental services</p> <p>20% to 40% of the Cost for Comprehensive Dental Services</p> <p>\$3,000 yearly benefit coverage limit for preventive and comprehensive dental services combined</p> <p>Comprehensive dental services may require authorization and a referral.</p>	
<p><b>Vision Services</b></p> <ul style="list-style-type: none"> <li>• Medicare covered eye exam</li> <li>• Medicare covered frames and lenses or contacts</li> <li>• Routine eye exam</li> <li>• Frames and lenses, or contacts</li> </ul>	<p>\$0 Copay for a Medicare-covered exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening)</p> <p>\$0 Copay for (1) pair of Medicare-covered eyewear (eyeglasses or contact lenses) after a cataract surgery</p> <p>\$0 Copay for (1) routine eye exam, refraction up to (1) per year</p> <p>\$500 Allowance for frames and lenses and upgrades every year</p>	

Plan Details	Champion Plus	Your Cost with Medicare and Medi-Cal
<b>Mental Health Inpatient</b>	<p>\$1,676 deductible per benefit period</p> <p>\$0 for days 1 - 60</p> <p>\$419 Copay for days 61 - 90</p> <p>\$838 Copay for each lifetime reserve day after day 90 for each benefit period (up to 60 days over your lifetime)</p> <p>100% of all Costs beyond the lifetime reserve days</p> <p>*2025 Cost sharing amounts and may change for 2026. Champion Health Plan will provide updated rates on its website when 2026 rates are released.</p> <p>Services may require authorization and a referral.</p>	<p>\$0 Copay</p> <p>†If you have full Medi-Cal benefits, you may pay \$0 for your Medicare-covered services</p> <p>Services may require authorization and referral.</p>
<b>Mental Health Outpatient</b> (Medicare-covered individual and group sessions)	<p>\$0 Copay</p> <p>Services may require authorization and a referral.</p>	<p>\$0 Copay</p> <p>Services may require authorization and a referral.</p>
<b>Skilled Nursing Facility</b>	<p>\$0 Copay for days 1-20</p> <p>\$218 for days 21-100</p> <p>Services may require authorization and a referral.</p>	<p>\$0 Copay for days 1-100</p> <p>†If you have full Medi-Cal benefits, you may pay \$0 for your Medicare-covered services.</p> <p>Services may require authorization and a referral.</p>
<b>Outpatient Rehabilitation</b> <ul style="list-style-type: none"> <li>• Physical Therapy</li> <li>• Speech Therapy</li> <li>• Occupational Therapy</li> </ul>	<p>20% of the cost for physical and speech therapy services</p> <p>\$0 for occupational therapy services</p> <p>Services may require authorization and a referral.</p>	<p>\$0 Copay for physical, speech and occupational therapy sessions</p> <p>†If you have full Medi-Cal benefits, you may pay \$0 for your Medicare-covered services.</p> <p>Services may require authorization and a referral.</p>

Plan Details	Champion Plus	Your Cost with Medicare and Medi-Cal
Ambulance Services	<p>20% of the Cost for Medicare-covered air ambulance services</p> <p>0% to 20% of the Cost for Medicare-covered ground ambulance services, not to exceed \$125 copay</p> <p>Minimum cost share applies to non-emergency ground ambulance transport</p> <p>Authorization may be required for non-emergency services.</p>	<p>\$0 Copay</p> <p>†If you have full Medi-Cal benefits, you may pay \$0 for your Medicare-covered services.</p> <p>Authorization may be required for non-emergency services.</p>
Transportation	<p>\$0 Copay</p> <p>36 one-way plan-approved locations</p>	
Medicare Part B Drugs	<p>20% of the Cost</p> <p>You pay no more than \$35 for a 30-day supply of insulin</p>	<p>\$0 Copay</p> <p>†If you have full Medi-Cal benefits, you may pay \$0 for your Medicare-covered services.</p>
Dialysis	<p>20% of the Cost</p>	<p>\$0 Copay</p> <p>†If you have full Medi-Cal benefits, you may pay \$0 for your Medicare-covered services.</p>
Durable Medical Equipment (DME)	<p>DME, Prosthetics, &amp; Medical Supplies: \$0 for items \$100 or less</p> <p>20% of the Cost for items over \$100</p> <p>Services may require authorization.</p>	<p>\$0 Copay</p> <p>†If you have full Medi-Cal benefits, you may pay \$0 for your Medicare-covered services.</p> <p>Services may require authorization.</p>

Plan Details	Champion Plus	Your Cost with Medicare and Medi-Cal
<p><b>Healthy Foods / Over-the-Counter Items / Utilities Benefit</b></p>	<p>\$500 Allowance every (3) months</p> <p>\$0 Copay for quarterly allowance to use for healthy foods and produce, over-the-counter items, wellness products and/or assistance with utilities. Benefit does not rollover to the next period</p> <p>The benefits mentioned are a part of special supplemental program for the chronically ill. Qualifying conditions include Schizophrenia, Schizoaffective, Bipolar, Major Depressive or Paranoid Disorders. Please see your Evidence of Coverage, Chapter 4, Section 2's Medical Benefit Chart for Special Supplemental Benefits for more information</p>	
<p><b>Chiropractic</b></p> <ul style="list-style-type: none"> <li>• Medicare-covered chiropractic care</li> </ul>	<p>\$0 Copay</p> <p>Services may require authorization and a referral.</p>	<p>\$0 Copay</p> <p>Services may require authorization and a referral.</p>
<p><b>Silver&amp;Fit Fitness Benefit</b></p>	<p>\$0 Copay for receiving up to \$35 reimbursed each month on gym membership or fitness classes</p>	
<p><b>Podiatry Services</b> (Medicare-covered services only)</p>	<p>20% of the Cost</p> <p>Services may require authorization and a referral.</p>	<p>\$0 Copay</p> <p>†If you have full Medi-Cal benefits, you may pay \$0 for your Medicare-covered services.</p> <p>Services may require authorization.</p>
<p><b>Hospice</b></p>	<p>Covered by Original Medicare</p>	<p>Covered by Original Medicare</p>
<p><b>Personal Emergency Response System (PERS)</b></p>	<p>\$0 Copay</p>	

Plan Details	Champion Plus	Your Cost with Medicare and Medi-Cal
Annual Physical Exam	\$0 Copay for one (1) annual exam	
Home and Bathroom Safety Devices and Modifications	\$0 Copay for the provision of a shower chair	
Health Education	\$0 Copay	

## Prescription Drug Coverage

Plan Details	Champion Plus		Your Cost with Medicare and Medi-Cal or Extra Help	
Part D Deductible	\$615 (does not apply to Tier 1 and Tier 6)		\$0 Copay	
	<b>Participating Retail Pharmacy</b>	<b>Mail Order</b>	<b>Participating Retail Pharmacy</b>	<b>Mail Order</b>
Initial Coverage	Up to a 30-day supply	100-day supply	\$0 Copay	\$0 Copay
Tier 1: Preferred Generic	\$0 Copay	\$0 Copay	\$0 Copay	\$0 Copay
Tier 2: Generic	\$0 Copay	\$0 Copay	\$0 Copay	\$0 Copay
Tier 3: Preferred Brand	25% of the Cost	25% of the Cost	Generics: \$0 or \$4.80 or \$15.30 Copay Brands: \$0 or \$14.70 or \$37.95 Copay	Generics: \$0 or \$3.20 or \$10.20 Copay Brands: \$0 or \$9.80 or \$25.30 Copay
Tier 4: Non-Preferred Brand	25% of the Cost	25% of the Cost	Generics: \$0 or \$4.80 or \$15.30 Copay Brands: \$0 or \$14.70 or \$37.95 Copay	Generics: \$0 or \$3.20 or \$10.20 Copay Brands: \$0 or \$9.80 or \$25.30 Copay
Tier 5: Specialty Tier	25% of the Cost	A 100-day supply is not available in Tier 5	Generics: \$0 or \$4.80 or \$15.30 Copay Brands: \$0 or \$14.70 or \$37.95 Copay	A 100-day supply is not available in Tier 5
Tier 6: Select Care Drugs	\$0 Copay	\$0 Copay	\$0 Copay	\$0 Copay

## Prescription Drug Coverage

Plan Details	Champion Plus	Your Cost with Medicare and Medi-Cal or Extra Help
<b>Catastrophic Coverage</b> (after you or others on your behalf pay \$2,100)	During this stage, the plan pays the full cost for your covered Part D drugs.	
<b>Important Message About What You Pay for Insulin</b>	You won't pay more than \$20 for a one-month supply or \$60 for a three-month supply of each insulin product covered by our plan on Tiers 1, 2, 3, 4 and 6 and no more than \$35 for a one-month supply of insulin on Tier 5, even if you haven't paid your deductible.	Generics: \$0 or \$4.80 or \$15.30 Copay Brands: \$0 or \$14.70 or \$37.95 Copay
<b>Important Message About What You Pay for Vaccines</b>	Our plan covers most Part D vaccines at no cost to you. Call Member Services for more information.	
<b>*Extra Help Program</b>	If you meet federal low income limits, you qualify for the Extra Help program that assists individuals with Part D cost shares, including deductibles. You may pay \$0 for your Part D premium, deductible and no more than the low income subsidy amounts or all of your Part D drugs.	

# Resources for *Additional Benefits*

## Beyond Original Medicare



### Vision

Get routine vision care including exams and glasses through EyeMed.

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### Dental

Coverage through Delta Dental to keep you and your teeth healthy.

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### Transportation

Find out how to make the most of your transportation benefit.

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### Healthy Foods / Over-the-Counter Items / Utilities

You are eligible for health food delivery with participation in a care management program. You can also choose from products and utilities in the over-the-counter catalog that have been especially selected by a nephrologist to help you.

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### Telehealth

Champion Health Plan lets you connect with a doctor 24/7; a great option for urgent care, connecting with specialists and more.

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### Hearing

Most plans offer hearing exams and hearing aids through TruHearing.

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### Personal Alert

A Personal Emergency Response System provides help at the push of a button.

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### Fitness

Stay active with gym memberships and fitness class reimbursements offered by most plans through the Silver&Fit program.

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Benefits vary by plan. View your evidence of coverage for coverage.

## 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 customer service representative at 1-800-885-8000, TTY 711.

### Understanding the Benefits

- The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit [championhmo.com/member/plan-documents](http://championhmo.com/member/plan-documents) or call 1-800-885-8000, 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 medicine 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

- 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.
- Benefits, premiums and/or Copayments/co-insurance may change on January 1, 2027.
- 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).
- Your current health care coverage will end once your new Medicare coverage starts. For example, if you are in Tricare or a Medicare plan, you will no longer receive benefits from that plan once your new coverage starts.

### For Special Needs Plans Only

- This plan is a chronic condition special needs plan (C-SNP). Your ability to enroll will be based on verification that you have a qualifying specific severe or disabling chronic condition.

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## 2026 Enrollment Form

### 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:  
Champion Health Plan  
PO Box 15337  
Long Beach, CA 90815-9995  
Once they process your request to join, they'll contact you.

### How do I get help with this form?

Call Champion Health Plan at 1-800-885-8000. 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 Champion Health Plan al 1-800-885-8000. 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 (PO) 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.**

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

**SELECT THE PLAN YOU WANT TO JOIN:**

**CALIFORNIA**

**Champion Advantage  
(HMO-POS C-SNP) 001**

**\$0 premium per month**

**Champion Connect  
(HMO-POS C-SNP) 002**

**\$0 premium per month**

**Champion Select  
(HMO-POS C-SNP) 003**

**\$8.40 premium per month**

**Champion Ally (HMO) 007**

**\$0 premium per month**

**Champion Care (HMO C-SNP) 008**

**\$0 premium per month**

**Champion Choice (HMO C-SNP) 009**

**\$12 premium per month**

**Champion Plus (HMO C-SNP) 010**

**\$12 premium per month**

**FIRST Name**

**LAST Name**

**M.I. (Optional)**

**Birth Date (MM/DD/YYYY)**

**Sex**

**Male**

**Female**

**Phone Number**

**Mobile Number**

By providing your phone number, you agree to receive calls and/or text messages from Champion Health Plan for purposes related to your healthcare, including benefit information, care coordination, and health plan services. Message and data rates may apply. You may opt out at any time by replying STOP.

**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 (Optional)**

**State**

**ZIP Code**

**Mailing Address if different from your Permanent Address (PO Box Allowed)**

**Street Address**

**City**

**State**

**ZIP Code**

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## Your Medicare Information

**Medicare Number:**

**Medi-Cal Number:**

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### Answer these important questions:

1) Will you have other prescription drug coverage (like VA, TRICARE) in addition to Champion Health Plan?  Yes  No

**Name Of Other Coverage**

**Member Number For This Coverage**



**Group Number For This Coverage**

**THE FOLLOWING SECTION IS TO BE COMPLETED ONLY IF YOU ARE ELECTING A C-SNP PLAN.**

### Enrollment in some of the plans listed above requires that you have certain chronic conditions.

1) Do you require Dialysis services?  Yes  No

**Dialysis Center Name**

**Dialysis Center Address**



**Phone Number**

2) Have you been diagnosed with any of the following chronic conditions (check all that apply):

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Bipolar                      | <input type="checkbox"/> Congestive Heart Failure       | <input type="checkbox"/> Major Depressive   |
| <input type="checkbox"/> Cardiac Arrhythmias          | <input type="checkbox"/> Coronary Artery Disease (CAD)  | <input type="checkbox"/> Paranoid Disorders |
| <input type="checkbox"/> Cardiovascular Disease       | <input type="checkbox"/> Diabetes                       | <input type="checkbox"/> Schizoaffective    |
| <input type="checkbox"/> Chronic Heart Failure (CHF)  | <input type="checkbox"/> End Stage Renal Disease (ESRD) | <input type="checkbox"/> Schizophrenia      |
| <input type="checkbox"/> Chronic Kidney Disease (CKD) |   |   |

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## IMPORTANT: Read and sign below

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Champion Health Plan.
- By joining this Medicare Advantage, I acknowledge that Champion Health Plan 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 Champion Health Plan coverage begins, I must get all of my medical and prescription drug benefits from Champion Health Plan. Benefits and services provided by Champion Health Plan and contained in my Champion Health Plan “Evidence of Coverage” document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Champion Health Plan 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.

**Enrollee Signature**

**Today’s Date**



*If you are the authorized representative, you must sign above and fill out these fields:*

**Name**

**Address**



**Phone Number**

**Relationship To Enrollee**



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## Section 2 – All fields in this section are optional

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

**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 Champion Health Plan at 1-800-885-8000 if you need information in an accessible format other than what's listed above. Our office hours are 8 am to 8 pm, 7 days a week from October 1 - March 31 and 8 am to 8 pm, Monday through Friday from April 1 - September 30. 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:**

**For applicants applying for Champion Advantage 001, Champion Connect 002, Champion Select 003 please enter your Primary Treating Nephrologist. For applicants applying for Champion Plus 010 please enter your Primary Treating Psychiatrist:**

**I want to get the following materials via email. Select one or more.**

Evidence of Coverage (EOC)

Provider/Pharmacy Directory

Formulary

Email 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) 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. DON'T pay Champion Health Plan 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): \_\_\_\_\_

Name of staff member/broker (if assisted in enrollment): \_\_\_\_\_

Agent NPN: \_\_\_\_\_

Plan ID#: \_\_\_\_\_ Effective Date of Coverage: \_\_\_\_\_

AEP: \_\_\_\_\_ ICEP: \_\_\_\_\_ SEP (type): \_\_\_\_\_ Agent received date: \_\_\_\_\_

Licensed Sales Agent Signature (required): \_\_\_\_\_

**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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## Health Risk Assessment (HRA) Form

This information will help us understand your health needs. Your answers WILL NOT affect your benefits. We may share your information with your primary care provider(s). Direct questions about this form to 1-800-885-8000 or 711 for TTY.

Today's date: \_\_\_\_\_

### Personal Information

Name: \_\_\_\_\_

Address (City/State/ZIP): \_\_\_\_\_

Best Phone Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Medicare ID: \_\_\_\_\_

Medicaid (Medi-CAL) ID: \_\_\_\_\_

Champion Health Plan Member ID: \_\_\_\_\_

Person Completing this form: \_\_\_\_\_

Relationship to Member: \_\_\_\_\_

### Right to Consent or Decline

I  Accept/Opt In or  Decline/Opt Out to participate in Champion Health Plan's Health Risk Assessment (HRA)

### Physical Health Rating

1. What is your height \_\_\_\_\_(inches only)
2. What is your weight \_\_\_\_\_(pounds)
3. Are you concerned about your health?  Yes  No
4. Do you feel you get enough physical activity/exercise?  Yes  No
5. Do you feel that your diet supports a healthy lifestyle?  Yes  No

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## Health Risk Assessment (HRA) Form (Cont.)

### Activities of Daily Living

6. How much help do you need with the following?

Activity	No Help Needed	Some Help Needed	Can't Do at All
Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting out of bed or chair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Preparing meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Taking your medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Using the bathroom	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transportation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7. Where do you currently live?

- Private Home  
  Assisted Living  
  Nursing Home  
  Group Home  
 Apartment  
  Condo  
  Half-way House  
  Trailer/Mobile Home Park  
 Homeless  
  Other

8. If you need help, do you have someone close by or a caregiver who helps you?

- Family  
  Friend  
  Neighbor  
  Caregiver  
  No help  
 I prefer not to answer  
  Other

9. Medical Equipment (check all that apply)

- Walker  
  Wheelchair  
  Hospital Bed  
  Oxygen  
  Nebulizer  
 Portable Toilet  
  Shower Chair  
  C-pap/Bi-pap  
  Other

### Social Determinants of Health

10. Is there anything preventing you from taking steps to get the care you need?

- Yes  
  No  
  N/A

If yes, check all that apply

- Transportation  
  Cost of Medical Services  
  Cost of Medications  
 Access to Services  
  Care Giver Support  
  Language differences  
 Cultural differences  
  Hard of hearing  
  Visual difficulties  
  Family objections  
 Social issues: discrimination/distrust  
  Mental health issues/distrust some people  
 Domestic violence /abuse  
  Elder abuse  
  Other

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## Health Risk Assessment (HRA) Form (Cont.)

### Clinical Health History & Treatment

11. What is the name of your Primary Care Physician (PCP)? \_\_\_\_\_  
 \_\_\_\_\_
12. Do you need a PCP?  I need a new PCP  No
13. When did you last see your Primary Care Physician?  Less than 6 mo.  
 More than 6 mo.  12 mo. or greater
14. How many times were you admitted to the Hospital or Emergency Room in the past 12 months?  0  1 time  2 times  3 times  More than 3 times
15. Have you been in a post-acute facility (skilled nursing, rehabilitation, or long-term care) in the past 12 months?  0  1 time  2 times  3 times  
 More than 3 times
16. Please check Yes or No and include Treating Provider(s) for the following conditions:

Asthma or Chronic Bronchitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Provider name(s):
COPD or Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Provider name(s):
Shortness of Breath or Breathing Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Provider name(s):
Frequent Falls	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Provider name(s):
Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Provider name(s):
Osteoarthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Provider name(s):
Recent Fracture	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Provider name(s):
Parkinson's/ALS/MS/Lupus	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Provider name(s):
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Provider name(s):
HIV/AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Provider name(s):

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## Health Risk Assessment (HRA) Form (Cont.)

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Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Provider name(s):
Serious Mental Illness	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Provider name(s):
Eyes: Blindness or trouble seeing even when wearing glasses	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Provider name(s):
Ears: Deafness or trouble hearing even when wearing a hearing aid?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Provider name(s):
Stroke, Heart Attack, Chest Pain, or Blocked Arteries	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Provider name(s):
Congestive Heart Failure (CHF)	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Provider name(s):
Circulation Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Provider name(s):
High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Provider name(s):
Swelling (ankle or leg)	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Provider name(s):
Diabetes <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> Pre-Diabetes <input type="checkbox"/> Gestational	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Provider name(s):
Skin Ulcer, Non-Healing Wound, Sores	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Provider name(s):
Organ Transplant	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Provider name(s):
Memory Loss, Dementia, or Alzheimer's	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Provider name(s):
Urinary Incontinence or Bladder Control Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Provider name(s):

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## Health Risk Assessment (HRA) Form (Cont.)

Frequent Urinary Tract Infections	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Provider name(s):
Kidney Failure or End Stage Renal Disease (ESRD)	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Provider name(s):
Bowel Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Provider name(s):
Other	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Provider name(s):

### Life Planning Activities

17. Do you have or need the following: Advance Health Care Directive such as a Living Will or Physician Orders for Life-Sustaining Treatment (POLST)?
- Yes  No  I need one

### Preventive Health Maintenance

18. Do you get a flu vaccine/shot annually?  Yes  No
19. Have you received a Covid vaccine/shot in the year?  Yes  No
20. Have you had a colon cancer check /screening in the last 10 years?  Yes  No
21. Have you had a pap test in the past 2 years?  Yes  No  N/A
22. Have you had a mammogram in the past 2 years?  Yes  No  N/A
23. Do you use tobacco (smoke, chew, snuff, or in any other form)?  Yes  No
24. Does drinking alcohol interfere with your personal or work life?  Yes  No
25. Frequency of Pain in the past week?
- No pain  Pain some days  Pain every day
26. Pain Management medication or other therapies?  Yes  No

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## Health Risk Assessment (HRA) Form (Cont.)

### Behavioral & Mental Health

27. Over the past 2 weeks, how often have you been bothered by any of the following feelings?

Feeling down, depressed, hopeless	<input type="checkbox"/> Not at All <input type="checkbox"/> Several Days <input type="checkbox"/> More than Half the Days <input type="checkbox"/> Nearly Every Day
Little interest/pleasure in doing things	<input type="checkbox"/> Not at All <input type="checkbox"/> Several Days <input type="checkbox"/> More than Half the Days <input type="checkbox"/> Nearly Every Day
Crying Spells	<input type="checkbox"/> Not at All <input type="checkbox"/> Several Days <input type="checkbox"/> More than Half the Days <input type="checkbox"/> Nearly Every Day
Difficulty Sleeping	<input type="checkbox"/> Not at All <input type="checkbox"/> Several Days <input type="checkbox"/> More than Half the Days <input type="checkbox"/> Nearly Every Day
Nervousness / Anxious / Worried	<input type="checkbox"/> Not at All <input type="checkbox"/> Several Days <input type="checkbox"/> More than Half the Days <input type="checkbox"/> Nearly Every Day
Agitated / Irritable / Angry	<input type="checkbox"/> Not at All <input type="checkbox"/> Several Days <input type="checkbox"/> More than Half the Days <input type="checkbox"/> Nearly Every Day
Thought of hurting myself or others	<input type="checkbox"/> Not at All <input type="checkbox"/> Several Days <input type="checkbox"/> More than Half the Days <input type="checkbox"/> Nearly Every Day

28. Do personal or family health issues result in loss of work or daily activities?

Yes    No    Unsure    N/A

29. What stressors do you have at the moment (check all that apply)?

Relationships    Family    Children    Lack of Social Support    Occupation  
 General Physical Health    Financial    Other    N/A

### Cultural and Linguistic Needs

30. Do you identify with a religion or spiritual tradition?

Atheism/Agnosticism    Buddhism    Catholicism    Christianity  
 Christian Science    Hinduism    Islam    Jehovah's Witness    Judaism  
 Mormon    Other    None/Unaffiliated    I prefer not to answer

31. What is your primary language?

English    Spanish    Chinese    French Creole    Korean    Vietnamese  
 Tagalog    I prefer not to answer    Other

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## Health Risk Assessment (HRA) Form (Cont.)

32. How do you describe your ethnicity?

- White or Caucasian    Black or African American    Hispanic /Latino  
 Native American Indian/Alaskan Native    Asian  
 Pacific Islander/Native Hawaiian    Unknown  
 I prefer not to answer    Other

### Demographics

33. What gender do you identify?

- Male    Female    Intersex    Trans    Non-conforming    Personal  
 Eunuch    I prefer not to answer    Other \_\_\_\_\_

34. Who do you currently live with?

- Alone    Child(ren)    Extended Family    Friend(s)    Parent(s)  
 Roommate(s)    Sibling(s)    Spouse/Partner    Other \_\_\_\_\_

### Housing

35. Do you have the following problems (check all that apply)?

- Bugs    Rodents    Lead/Asbestos    Mold    Electric Issues  
 Heating Issues    Water Issues    House not safe  
 No issues    Other \_\_\_\_\_

36. Do you have internet access (check all that apply)?

- Computer    Phone    Tablet    Other \_\_\_\_\_

### Personal Goals

37. What is your main goal for your overall health? \_\_\_\_\_  
\_\_\_\_\_

38. As the caregiver, what is your main goal for your family member or client? \_\_\_\_\_  
\_\_\_\_\_

Thank you for your help. This information is crucial to deliver optimal care tailored to meet your requests and needs. Kindly send this completed form to:

### Champion Health Plan

PO Box 15337  
Long Beach, CA 90815-9995

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# What To Expect *Next?*

You've submitted your Champion Health Plan Enrollment Form — so now what happens?



## **Enrollment Forms Received**

Your enrollment is sent to Champion Health Plan by phone, mail, fax, agent, or via the internet. We will begin processing your application immediately.



## **Outbound Enrollment Verification (OEV) Letter**

This letter is to confirm your enrollment into the Plan. It will have information like your Member ID number and Part D Prescription information.



## **Your Champion Health Plan Member ID Card**

You will receive your Champion Health Plan Member ID in the mail. Make sure to place this card somewhere handy! You will need it when you visit your doctor, pharmacy, or hospital. Your Dental Plan card will be sent separately.



## **Welcome Packet**

You will receive a package containing important information on how to get the most out of your Champion Health Plan coverage.



## **Welcome Call or Visit**

A representative will call you to schedule some time to go over your Welcome Packet.



## **Help with Your Medicare Costs**

You may qualify for federal financial assistance, “Extra Help”. Many people qualify even if they do not have low income. To apply for this financial assistance with your medication cost, call Social Security at 1-800-772-1213, TTY 1-800-325-0778 or apply online at [SSA.gov](https://www.ssa.gov).

# Nondiscrimination Notice

Champion Health Plans-USA (Champion) and its subsidiaries, including Champion Health Plan of California, Inc.; Renal Payer Solutions, Inc.; Champion Payer Solutions, LLC. all comply with applicable federal civil rights laws. Champion Health Plan does not exclude individuals, deny benefits, or treat them differently on the basis of, or because of, race, color, national origin, age, disability, gender identity, sexual orientation, or religion.

Champion Health Plan provides free aids and services to individuals with disabilities to assist them in communicating effectively with the health plan. Such services may include but are not limited to qualified sign language interpreters, and written information in various formats such as: large print, audio, accessible electronic formats, and others.

Champion Health Plan provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services or believe that Champion Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or gender identity, contact **Champion Health Plan Member Services at:**

By Telephone: **Dial 1-800-885-8000**

By TTY: Dial "711"

By US Mail: **Champion Health Plan Grievance Department**

PO Box 15337

Long Beach, CA 90815-9995

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, or an appeal, Champion Health Plan Member Services is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

By Telephone: 1-800-368-1019 (TTY: 1-800-537-7697)

By Mail: U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, D.C. 20201

# Multi-language *Interpreter Services*

**English:** We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-885-8000. Someone who speaks English/Language can help you. This is a free service.

**Spanish:** Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-800-885-8000. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

**Chinese Mandarin:** 我們提供免費的翻譯服務，幫助解答關於健康或藥物保險的任何疑問。如果您需要此翻譯服務，請致電 1-800-885-8000。我們的中文工作人員很願意幫助。這是一項免費服務。

**Chinese Cantonese:** 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-800-885-8000。我們講中文的人員將樂意提供幫助。這是一項免費服務。

**Tagalog:** Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggagamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-800-885-8000. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

**French:** Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-800-885-8000. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

**Vietnamese:** Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quý vị cần thông dịch viên xin gọi 1-800-885-8000 sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.

**German:** Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-885-8000. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

**Korean:** 당사는 의료 보험 또는 약품 보험에 관한 질문에 대해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-885-8000 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

**Russian:** Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-800-885-8000. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

**Arabic:** لودج وأحصى لابل قلعتت قلىسأى أن ع قباجل إل ةيناجملا يروفلا مچرتملا تامدخ مدقن انن! ان يدل ةيودألا ىل ع انب لاصلتالا ىوس كىل ع سيل ، يروف مچرتم ىل ع لوصحلل . ان يدل ةيودألا ةيناجم ةمدخ هذہ . كتدعاسمب ةيبرعلا ثدحتي ام صخش موقسي .

**Hindi:** हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं। एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-800-885-8000 पर फोन करें। कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है। यह एक मुफ्त सेवा है।

**Italian:** È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-885-8000. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

**Portugués:** Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-800-885-8000. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

**French Creole:** Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-800-885-8000. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

**Polish:** Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-800-885-8000. Ta usługa jest bezpłatna.

**Japanese:** 社の健康 健康保と品 方プランに するご質問にお答えするために、無料の通ササービスがあります。通 をご用命になるには、1-800-885-8000 にお電話ください。日本語を話す人 者が支援いたします。これは無料のササービスです。





# For Questions *Call Toll-Free*

**1-800-885-8000, TTY 711**

April 1 - September 30:  
Monday - Friday, 8 am - 8 pm

October 1 - March 31:  
Monday - Sunday, 8 am - 8 pm

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