CHAMPION HEALTH PLAN

Enrollment Book 2026



Champion Ally (HMO) H6170-007

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

CHAMPION HEALTH PLAN

The Right Plan *for You!*

Champion Ally

This plan is a great choice for Medicare beneficiaries that don't qualify for a Chronic Condition Special Needs plan (C-SNP). This plan reduces the cost of prescription drugs while adding additional services and benefits.

CHAMPION HEALTH PLAN

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.

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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.

Beneficiary or Authorized Representative Signature and Signature Date:	
Signature:	Signature Date:
If you are the authorized representative, please sign above and print below:	
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: *(optional)*	
Initial Method of Contact: *(Indicate here if candidate was a walk-in)*	
Agent Signature:	Date Appt. Completed:

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CHAMPION HEALTH PLAN



Summary of *Benefits*

Champion Ally
(HMO) H6170-007

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 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.

To join **Champion Ally (HMO)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. 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 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.

Plan Details	Champion Ally
Monthly Premium	$0
Annual Plan Deductible	No Deductible
Annual Maximum Out of Pocket (MOOP)	$199
Inpatient Hospital	$0 Per Stay Services may require authorization and a referral.
Outpatient Hospital and Ambulatory Surgery Centers (ASC)	$100 Copay for outpatient hospital services $0 Copay for surgery in an Ambulatory Surgery Center $0 Copay for outpatient hospital observation Services may require authorization and a referral.

Plan Details	Champion Ally
Primary Care Providers	$0 Copay
Specialists	$0 Copay Authorization may be required for all services except nephrology.
Preventive Services (Medicare Covered Screenings)	$0 Copay
Emergency Care (Hospital Emergency Department)	$70 Copay Copay is waived if admitted to hospital within 24 hours for related health event.
Worldwide Emergency Care	$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.
Urgent Care Services (Non-hospital Urgent Care Center)	$0 Copay
Worldwide Urgently Needed Care	$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.
Diagnostic Services/Labs/Imaging • Diagnostic tests and procedures • X-Rays • Lab Services • Diagnostic radiology services (such as MRI, CT Scans) • Therapeutic radiology services (such as radiation treatment for cancer)	$0 Copay Diagnostic tests and procedures and lab services may require authorization and a referral.
Hearing Services • Medicare-covered services • Routine hearing exam and fitting/ evaluation for hearing aid • Hearing Aid	$0 Copay for Medicare-covered services every year $0 Copay for one routine exam and one fitting/ evaluation for hearing aids every year $149 Copay per hearing aid (all models) up to (2) aids every (3) years

Plan Details	Champion Ally
Dental Services	$0 Copay for Preventive Dental Services and Medicare-covered dental services 20% to 40% of the Cost for Comprehensive Dental Services. Limitations may apply. $3,000 yearly benefit coverage limit for preventive and comprehensive dental services combined Comprehensive dental services may require authorization and a referral.
Vision Services	
• Medicare covered eye exam	$0 Copay for a Medicare-covered exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening)
• Medicare covered frames and lenses or contacts	$0 Copay for (1) pair of Medicare covered eyewear (eyeglasses or contact lenses) after a cataract surgery
• Routine eye exam	$0 Copay for (1) routine eye exam, refraction up to (1) per year
• Eyeglasses (lenses and frames) and upgrades	$335 Allowance for eyeglasses (lenses and frames) and upgrades every year
Mental Health Inpatient	$100 Copay for days 1-10 $0 Copay for days 11-90 Services may require authorization and a referral.
Mental Health Outpatient (Medicare-covered individual and group sessions)	$0 Copay Services may require authorization and a referral.
Skilled Nursing Facility	$0 Copay for days 1-20 $218 per day for days 21-100 Services may require authorization and a referral.
Outpatient Rehabilitation • Physical Therapy • Speech Therapy • Occupational Therapy	$0 Copay Services may require authorization and a referral.
Ambulance Services	20% of the Cost for Medicare-covered air ambulance services $0 or $125 of the Cost for Medicare-covered ground ambulance services Minimum cost share applies to non-emergency air and ground ambulance transport. Authorization may be required for non-emergency services.

Plan Details	Champion Ally
Transportation	$0 Copay 24 one-way plan-approved health-related locations
Medicare Part B Drugs	0% to 20% of the Cost $0 to $24 Copay for 30-day supply Part B insulins. Prior authorization may be required.
Dialysis	20% of the Cost
Durable Medical Equipment (DME)	DME, Prosthetics, & Medical Supplies: $0 for items $100 or less 20% of the Cost for items over $100 Services may require authorization.
Healthy Foods / Over-the-Counter Items / Utilities Benefit	$330 Allowance every (3) months $0 Copay for quarterly allowance to use for healthy foods and produce, over-the-counter items, wellness products and/or assistance with utilities. The benefits mentioned are a part of special supplemental program for the chronically ill. Not all members qualify. Qualifying conditions include diabetes, cardiovascular disorders, stroke, overweight/obesity/metabolic syndrome, and cancer. This is not a full listing of eligible conditions. Please see your Evidence of Coverage, Chapter 4, Section 2's Medical Benefit Chart for Special Supplemental Benefits for the Chronically Ill for a full listing of qualifying conditions.
Acupuncture • Medicare-covered acupuncture • Routine acupuncture	 $0 Copay $0 Copay for up to 50 visits every year
Chiropractic • Medicare-covered chiropractic care • Routine chiropractic care	 $0 Copay $0 Copay for up to 20 visits every year
Silver&Fit Fitness Benefit	$0 Copay for receiving up to $35 reimbursed each month on gym membership or fitness classes
Podiatry Services (Medicare-covered services only)	$0 Copay Services may require authorization and a referral.
Hospice	Covered by Original Medicare

Plan Details	Champion Ally
Home / Bathroom Safety Devices / Modifications	$0 Copay for the provision of a shower chair
Personal Emergency Response System (PERS)	$0 Copay
Annual Physical Exam	$0 Copay
Health Education	$0 Copay

Prescription Drug Coverage		
Plan Details	**Champion Ally**	
Part D Deductible	No Deductible	No Deductible
	Participating Retail Pharmacy	**Mail Order**
Initial Coverage	Up to a 30-day supply	100-day supply
Tier 1: Preferred Generic	$0 Copay	$0 Copay
Tier 2: Generic	$3 Copay	$6 Copay
Tier 3: Preferred Brand	$47 Copay	$94 Copay
Tier 4: Non-Preferred Brand	$100 Copay	$200 Copay
Tier 5: Specialty Tier	33% of the Cost	A 100-day supply is not available in Tier 5
Tier 6: Select Care Drugs	$0 Copay	$0 Copay
Catastrophic Coverage (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.	
Important Message About What You Pay for Insulin	At retail pharmacy locations, 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. You will not pay more than $35 for a one-month supply of insulin on Tier 5. For mail order, you won't pay more than $40 for a three month supply of each insulin product covered by our plan on Tiers 1, 2, 3, 4 and 6. Long term supplies of insulins in Tier 5 are not available through mail order.	
Important Message About What You Pay for Vaccines	Our plan covers most Part D vaccines at no cost to you. Call Member Services for more information.	
Extra Help from Medicare	Medicare and Social Security have a program called Extra Help that can help pay drug costs for people with limited income and resources. If you qualify, you get help paying for your Medicare drug plan's monthly plan premium, yearly deductible, and copayments. Extra Help also counts toward your out-of-pocket costs.	

Resources for *Additional Benefits*

Beyond Original Medicare

Vision
Get routine vision care including exams and glasses through EyeMed.

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

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

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.

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

Hearing
Most plans offer hearing exams and hearing aids through TruHearing.

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

Acupuncture and Chiropractic
Many plans include access to acupuncture and chiropractic care through American Specialty Health to help support overall wellness.

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

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

CHAMPION HEALTH PLAN

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.

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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 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.

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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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CHAMPION HEALTH PLAN

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

2026 Enrollment Form

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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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CHAMPION HEALTH PLAN

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

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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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CHAMPION HEALTH PLAN

Your Medicare Information

Medicare Number:

__ __ __ __ – __ __ __ – __ __ __ __

Medi-Cal Number:

__ __ __ __ __ __ __ __ __ __ __ __ __ __

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):

- ☐ Bipolar
- ☐ Cardiac Arrhythmias
- ☐ Cardiovascular Disease
- ☐ Chronic Heart Failure (CHF)
- ☐ Chronic Kidney Disease (CKD)
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Disease (CAD)
- ☐ Diabetes
- ☐ End Stage Renal Disease (ESRD)
- ☐ Major Depressive
- ☐ Paranoid Disorders
- ☐ Schizoaffective
- ☐ Schizophrenia

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CHAMPION
HEALTH PLAN

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.

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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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CHAMPION HEALTH PLAN

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, or 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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CHAMPION HEALTH PLAN

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, 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.

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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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CHAMPION HEALTH PLAN

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:_____

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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

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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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CHAMPION HEALTH PLAN

Health Risk Assessment (HRA) Form (Cont.)

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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	☐	☐	☐
Dressing	☐	☐	☐
Eating	☐	☐	☐
Getting out of bed or chair	☐	☐	☐
Preparing meals	☐	☐	☐
Taking your medicine	☐	☐	☐
Using the bathroom	☐	☐	☐
Walking	☐	☐	☐
Transportation	☐	☐	☐

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

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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

FOLD - HOLD - TEAR

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CHAMPION HEALTH PLAN

Health Risk Assessment (HRA) Form (Cont.)

FOLD - HOLD - TEAR

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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	☐ Yes ☐ No	If Yes, Provider name(s):
COPD or Emphysema	☐ Yes ☐ No	If Yes, Provider name(s):
Shortness of Breath or Breathing Problems	☐ Yes ☐ No	If Yes, Provider name(s):
Frequent Falls	☐ Yes ☐ No	If Yes, Provider name(s):
Osteoporosis	☐ Yes ☐ No	If Yes, Provider name(s):
Osteoarthritis	☐ Yes ☐ No	If Yes, Provider name(s):
Recent Fracture	☐ Yes ☐ No	If Yes, Provider name(s):
Parkinson's/ALS/MS/ Lupus	☐ Yes ☐ No	If Yes, Provider name(s):
Cancer	☐ Yes ☐ No	If Yes, Provider name(s):
HIV/AIDS	☐ Yes ☐ No	If Yes, Provider name(s):

FOLD - HOLD - TEAR

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CHAMPION HEALTH PLAN

Health Risk Assessment (HRA) Form (Cont.)

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

FOLD - HOLD - TEAR

FOLD - HOLD - TEAR

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Health Risk Assessment (HRA) Form (Cont.)

Frequent Urinary Tract Infections	☐ Yes ☐ No	If Yes, Provider name(s):
Kidney Failure or End Stage Renal Disease (ESRD)	☐ Yes ☐ No	If Yes, Provider name(s):
Bowel Problems	☐ Yes ☐ No	If Yes, Provider name(s):
Other	☐ Yes ☐ No	If Yes, Provider name(s):

FOLD - HOLD - TEAR

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

FOLD - HOLD - TEAR

FOLD - HOLD - TEAR

FOLD - HOLD - TEAR

CHAMPION HEALTH PLAN

Health Risk Assessment (HRA) Form (Cont.)

FOLD - HOLD - TEAR

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	☐ Not at All ☐ Several Days ☐ More than Half the Days ☐ Nearly Every Day
Little interest/pleasure in doing things	☐ Not at All ☐ Several Days ☐ More than Half the Days ☐ Nearly Every Day
Crying Spells	☐ Not at All ☐ Several Days ☐ More than Half the Days ☐ Nearly Every Day
Difficulty Sleeping	☐ Not at All ☐ Several Days ☐ More than Half the Days ☐ Nearly Every Day
Nervousness / Anxious / Worried	☐ Not at All ☐ Several Days ☐ More than Half the Days ☐ Nearly Every Day
Agitated / Irritable / Angry	☐ Not at All ☐ Several Days ☐ More than Half the Days ☐ Nearly Every Day
Thought of hurting myself or others	☐ Not at All ☐ Several Days ☐ More than Half the Days ☐ 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

FOLD - HOLD - TEAR

FOLD - HOLD - TEAR

CHAMPION HEALTH PLAN

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

FOLD - HOLD - TEAR

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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.

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┌提供免┌的翻┌服┌，┌助┌解答┌于健康或┌物保┌的任何疑┌。如果┌需要此翻┌服┌，┌致┌1-800-885-8000。我┌的中文工作人┌很┌意┌助┌。┌是一┌免┌服┌。

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 panggamot. 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 quí vị cần thông dịch viên xin gọi 1-800-885-8000 sẽ có nhân viên nói tiếng Việt giúp đỡ quí 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 답해 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: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لديك. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على **1-800-885-8000.** سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

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.

Português: 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┌ビスがありますございます。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┌ビスです。

Notes

CHAMPION
HEALTH PLAN

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

championhmo.com