CHAMPION HEALTH PLAN

Enrollment Book 2027

California

Care That *Champions You*

Champion Ally (HMO)

Champion Ally
(HMO MAPD) H6170-007

California
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 (MAPD - HMO)

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.

H6170_2027rightforyouCA_C

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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CHAMPION HEALTH PLAN

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.

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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

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

H6170_SB007CA2027_M

2027 Summary of *Benefits*

CHAMPION HEALTH PLAN

Champion Health Plan

January 1, 2027 - December 31, 2027

Champion Health Plan is an HMO, HMO C-SNP and HMO-POS 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.

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 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 at 1-800-885-8000. From October 1 - March 31, we're available 7 days a week, 8 am to 8 pm Pacific time (PT). From April 1 - September 30, we're available Monday through Friday, 8 am to 8 pm PT. 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)	$499

PLAN DETAILS	CHAMPION ALLY
Inpatient Hospital*	$0 Per Stay
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
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) **Worldwide Emergency Care**	$150 Copay Copay is waived if admitted to hospital within 24 hours for related health event. $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) **Worldwide Urgently Needed Care**	$0 Copay $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.

*Services may require authorization and/or a referral.

PLAN DETAILS	CHAMPION ALLY
Hearing Services	
• Medicare-covered services	$0 Copay for Medicare-covered services every year
• Routine hearing exam and fitting/ evaluation for hearing aid	$0 Copay for one routine exam and one fitting/ evaluation for hearing aids every year
• Hearing Aid	$149 Copay per hearing aid (all models) up to (2) aids every (3) years for TruHearing Advanced hearing aids.
Dental Services*	$0 Copay for Preventive Dental Services and Medicare-covered dental services
• Medicare covered dental services	20% to 40% of the Cost for Comprehensive Dental Services. Limitations may apply.
• Preventive dental services (exams, cleanings, fluoride treatments, x-rays, other dental services)	$3,000 yearly benefit coverage limit for preventive and comprehensive dental services combined
• Comprehensive dental services (restorative, periodontics, endodontics, prosthodontics, surgeries)	
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
• Routine frames and lenses, or contacts	$350 Allowance for eyeglasses (routine frames and lenses) and upgrades every year
Mental Health Inpatient*	$100 Copay for days 1-5 $0 Copay for days 6-90
Mental Health Outpatient* (Medicare-covered individual and group sessions)	$0 Copay
Skilled Nursing Facility*	$0 Copay for days 1-20 $221 per day for days 21-100

*Services may require authorization and/or a referral.

PLAN DETAILS	CHAMPION ALLY
Outpatient Rehabilitation* • Physical Therapy • Speech Therapy • Occupational Therapy	$0 Copay
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.
Transportation	$0 Copay 48 one-way plan-approved health-related locations. Maximum mileage per trip is 25 miles.
Medicare Part B Drugs*	0% to 20% of the Cost $0 to $35 Copay for a 30-day supply of insulin.
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
Over-the-Counter Items / Healthy Foods / Utilities Benefit	$225 Allowance every quarter. $0 Copay for quarterly allowance to use for healthy foods and produce, over-the-counter items, and/or assistance with utilities. Some of the benefits mentioned are a part of a 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 more information about eligibility and a full listing of qualifying conditions. Unused monies from the first quarter will roll to the second quarter; but not to subsequent quarters. This rolling schedule for rollover of unused funds applies to the remaining quarters of the year.

*Services may require authorization and/or a referral.

PLAN DETAILS	CHAMPION ALLY
Acupuncture • Medicare-covered acupuncture • Routine acupuncture	 $0 Copay for Medicare-covered services $0 Copay for up to 50 routine visits every year (combined with routine chiropractic)
Chiropractic • Medicare-covered chiropractic care • Routine chiropractic care	 $0 Copay for Medicare-covered services $0 Copay for up to 50 routine visits every year (combined with routine acupuncture)
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
Hospice	Covered by Original Medicare
Respite Service (Support for Caregivers)	$0 Copay for up to twelve (12) 4-hour sessions of Helper Bees support for member's caregiver
Personal Emergency Response System (PERS)	$0 Copay
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

*Services may require authorization and/or a referral.

PART D 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 (including insulins)	$0 Copay	$0 Copay
Tier 2: Generic • **Insulins**	$5 Copay Lesser of $5 Copay or 25% of the Cost	$10 Copay Lesser of $10 Copay or 25% of the Cost
Tier 3: Preferred Brand • **Insulins**	$47 Copay Lesser of $35 Copay or 25% of the Cost	$94 Copay Lesser of $70 Copay or 25% of the Cost
Tier 4: Non-Preferred Brand • **Insulins**	$100 Copay Lesser of $35 Copay or 25% of the Cost	$200 Copay Lesser of $70 Copay or 25% of the Cost
Tier 5: Specialty Tier • **Insulins**	33% of the Cost Lesser of $35 Copay or 25% of the Cost	A 100-day supply is not available in Tier 5
Tier 6: Select Care Drugs (including insulins)	$0 Copay	$0 Copay
Catastrophic Coverage (after you or others on your behalf pay $2,400)	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 $35 for a one-month supply or $105 for a three-month supply of each insulin product covered by our plan on Tiers 2, 3 and 4. 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 $70 for a three month supply of each insulin product covered by our plan on Tiers 2, 3 and 4. Long term supplies of insulins in Tier 5 are not available through retail or mail order.	

PART D PRESCRIPTION DRUG COVERAGE	
PLAN DETAILS	**CHAMPION ALLY**
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

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.

Nurse Advice 24/7
Call a registered nurse anytime, day or night. Carenet nurses are available 24/7 to answer health questions, discuss symptoms, and help you make decisions with confidence.

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

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

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

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.

Respite
Some plans provide respite care through The Helper Bees, connecting members with short-term support services at home.

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

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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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OMB No. 0938-1378
Expires: 12/31/2026

2027 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
5000 Airport Plaza Dr., Ste. 100
Long Beach, CA 90815-1273

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.

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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 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:

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- ☐ **Champion Ally (HMO) 007 $0 premium per month**
- ☐ **Champion AnWell (HMO) 018 $0 premium per month**
- ☐ **Champion Care (HMO C-SNP) 008 $0 premium per month**
- ☐ **Champion Choice (HMO C-SNP) 009 $2.60 premium per month**
- ☐ **Champion Advantage (HMO-POS C-SNP) 001 $0 premium per month**
- ☐ **Champion Connect (HMO-POS C-SNP) 002 $0 premium per month**
- ☐ **Champion Plus (HMO C-SNP) 010 $7.30 premium per month**
- ☐ **Champion Compass (HMO C-SNP) 015 $0 premium per month**
- ☐ **Champion Home (HMO C-SNP) 016 $0 premium per month**
- ☐ **Champion Secure (HMO C-SNP) 017 $0 premium per month**

FIRST Name _____ **LAST Name** _____ **M.I. (Optional)** _____

Birth Date (MM/DD/YYYY) _____ **Sex** ☐ **Male** ☐ **Female**

Phone Number _____ **Mobile Number (Optional)** _____

☐ 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.

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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: __ __ __ __ – __ __ __ – __ __ __ __

Medicaid Number: __ __ __ __ __ __ __ __ __ __ __ __ __ __

Part A effective date (MM/DD/YYYY): __ __ / __ __ / __ __ __ __

Part B effective date (MM/DD/YYYY): __ __ / __ __ / __ __ __ __

(This information is located on your Medicare card)

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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

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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

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- 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

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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

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

☐ Evidence of Coverage (EOC) ☐ Provider/Pharmacy Directory ☐ Formulary

Email address: _____

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

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

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CHAMPION HEALTH PLAN

Paying your plan premium

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

You can also choose to pay your premium by having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month. If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium. 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): _____

Plan ID#: _____ Effective Date of Coverage: _____

AEP: _____ ICEP: _____ SEP (type): _____ Agent received date: _____

Licensed Sales Agent Signature (required): _____

Agents can fax completed enrollment forms and associated documents to **1-949-850-2552**.

Method of Plan Presentation

To ensure this enrollment request accurately reflects how plan options were reviewed, please select the primary method used:

- ☐ In-person meeting
- ☐ Telephone call
- ☐ Video call (e.g., telehealth platform, video conference)
- ☐ Mailed/written materials reviewed independently
- ☐ Online/digital self-enrollment (no agent assisted)
- ☐ Other: _____

Date of presentation/discussion: _____

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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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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

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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 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 لدينا. 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.

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「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

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