Agent Manual 2027



CHAMPION HEALTH PLAN

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Introduction

Champion Health Plan is designed to meet the healthcare needs of Medicare beneficiaries, including individuals with chronic and complex medical conditions. Champion Health Plan provides cost-effective, coordinated care for members in approved counties in California and Nevada, including care coordination for chronic kidney disease, end-stage renal disease, diabetes, cardiovascular disease, congestive heart failure, behavioral health conditions, and other member needs addressed through Champion Health Plan products and programs.

CHAMPION HEALTH PLAN

Relationship to the Agent Agreement

This Agent Manual provides operational and compliance guidance for agents and agencies that market Champion Health Plan products. It supplements the Champion Health Plan Agent Agreement but does not amend or replace the Agreement or its exhibits.

If this Manual conflicts with the Agent Agreement, the Agent Agreement controls. Applicable federal and state law and current CMS requirements control over both documents.

Champion Health Plan may update its operational policies and procedures from time to time. Any modification of compensation, commission rights, dispute deadlines, or other contractual rights will be made in accordance with the amendment and notice provisions of the Agent Agreement.

Our Focus

Champion Health Plan is committed to helping members navigate the complex healthcare system and improve their quality of life, whether they are seeking competitive benefits or assistance with care navigation. Our approach supports the unique needs of members, caregivers, and physicians through a comprehensive Model of Care and through benefit programs designed to meet the needs of different populations.

- ✓ Affordable, reliable coverage
- ✓ Preventive care and ongoing support
- ✓ A trusted network of providers
- ✓ Experienced, friendly help from a team that cares
- ✓ Concierge-style support tailored to the member's health and living situation

Comprehensive Benefit Programs

Champion Health Plan offers tailored benefits to meet the diverse needs of members. Plans are best suited for individuals as described in this manual; however, agents cannot bar any Medicare beneficiary who meets eligibility criteria from pursuing enrollment in the Medicare Advantage plan the beneficiary believes best suits their needs or desires.

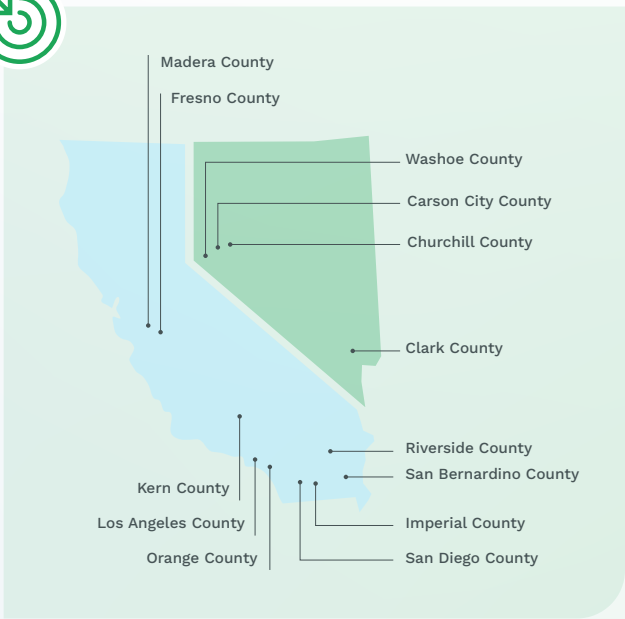
- Individuals with Medicare and qualifying secondary insurance coverage, where applicable.
- Individuals with Medicare only
- Individuals eligible for Extra Help with prescription drugs, also known as Low-Income Subsidy or LIS
- Individuals with qualifying chronic conditions for Chronic Condition Special Needs Plans (C-SNPs)
- Individuals whose cultural, health, care coordination, or living-situation needs align with specific Champion products

Service Area

Champion Health Plan is licensed in approved counties in California and Nevada. Agents must verify that the beneficiary resides in the applicable service area for the plan selected before submitting an enrollment application.

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

Nevada Counties
Carson City, Churchill, Clark, Washoe



2027 Champion Health Plan Portfolio

Champion Health Plan offers concierge-style Medicare Advantage plans tailored to each member's health and living situation, with specialized support for chronic conditions, cultural communities, higher-acuity care needs, and members looking for comprehensive, affordable healthcare coverage.

Core MAPD Plans

Product	Best Fit	STATE	Simple Agent Description
Champion Ally	General Medicare population	**CA/NV**	Our flagship everyday Medicare Advantage plan.
Champion AnWell	Vietnamese community or individuals who live in Orange County, California	**CA OC ONLY**	A culturally focused Medicare Advantage plan designed for Vietnamese members aligned to a large network of Vietnamese providers.

Chronic Condition Special Needs Plans (C-SNPs)

Product	Condition Focus	STATE	Best Fit	Simple Agent Description
Champion Care	Diabetes and cardiovascular disease	**CA/NV**	Community-based beneficiaries	Heart and diabetes-focused concierge care plan.
Champion Choice	Diabetes and cardiovascular disease	**CA/NV**	Community-based beneficiaries	Flexible heart and diabetes support plan.
Champion Plus	Chronic disabling mental illness	**CA/NV**	Behavioral health population	Behavioral health-focused concierge SNP.
Champion Advantage	CKD and ESRD	**CA/NV**	Kidney disease population	Kidney care-focused SNP with coordinated support.
Champion Connect	CKD and ESRD	**CA/NV**	Kidney disease population	Enhanced renal care and support plan.

Institutional-Level Care Plans Offered as Diabetes/Cardiovascular SNPs

Product	Setting / Population	STATE	Best Fit	Simple Agent Description
Champion Compass	Institutional equivalent; community-dwelling beneficiaries who qualify for institutional-level care	**CA**	Beneficiaries living in the community who require a higher level of coordinated care and meet qualifying Diabetes/Cardiovascular C-SNP criteria	Comprehensive support for Medicare-only members needing a higher level of coordinated care.
Champion Home	Nursing home residents	**CA**	Long-term care facility residents who meet qualifying Diabetes/ Cardiovascular C-SNP criteria	Specialized concierge care for nursing home residents.
Champion Secure	Institutional equivalent; community-dwelling beneficiaries who qualify for institutional-level care	**CA**	Beneficiaries living in the community who require a higher level of coordinated care and meet qualifying Diabetes/Cardiovascular C-SNP criteria	Comprehensive support for Medicare beneficiaries, including those with qualifying secondary insurance coverage, who require a higher level of coordinated care.

Plain-Language Product Descriptors

Brand Name	STATE	Descriptor
Champion Ally	**CA/NV**	Core MAPD
Champion AnWell	**CA**	Vietnamese/Orange County Only MAPD
Champion Care	**CA/NV**	Diabetes/Heart SNP
Champion Choice	**CA/NV**	Diabetes/Heart SNP
Champion Plus	**CA/NV**	Behavioral Health SNP
Champion Advantage	**CA/NV**	Kidney SNP
Champion Connect	**CA/NV**	Kidney SNP
Champion Compass	**CA**	Diabetes/Heart SNP Institutional-Equivalent
Champion Home	**CA**	Diabetes/Heart SNP Nursing Home
Champion Secure	**CA**	Diabetes/Heart SNP Institutional-Equivalent

How to Match a Beneficiary to a Champion Plan

Agents should begin with the beneficiary's Medicare eligibility, residence, provider and pharmacy needs, chronic condition status, and living situation. Agents must avoid steering based on compensation and must present accurate, complete, and CMS-compliant information.

Step 1: Is the beneficiary a general MAPD member or a chronic condition/SNP member?

General MAPD: Champion Ally or Champion AnWell

Chronic Condition / Special Needs: Care, Choice, Plus, Advantage, Connect, Compass, Secure, or Home, depending on qualifying condition and living situation

Step 2: What condition, cultural alignment, or living situation best describes the beneficiary?

Member Situation	Recommended Plan
Standard Medicare beneficiary	Champion Ally
Vietnamese-speaking, culturally aligned, or Orange County community fit	Champion AnWell
Diabetes or cardiovascular disease	Champion Care or Champion Choice
Serious mental illness or chronic disabling mental illness	Champion Plus
CKD or ESRD	Champion Advantage or Champion Connect
Needs institutional-level care but lives in the community	Champion Compass or Champion Secure
Lives in a nursing home	Champion Home

SSBCI Eligibility Summary



All Champion Health Plan Benefit Programs offer an Over-the-Counter (OTC) benefit. Members who meet CMS criteria for Special Supplemental Benefits for the Chronically Ill (SSBCI) may qualify for expanded benefits, including Healthy Foods and Utilities Assistance, subject to the applicable Evidence of Coverage and CMS-approved plan materials.

SSBCI benefits are available to Medicare Advantage members who **have one or more complex chronic conditions, are at high risk for hospitalization or other adverse health outcomes, and require intensive care coordination**. These benefits are in addition to traditional Medicare coverage and may include non-primarily health-related services when there is a reasonable expectation of improving or maintaining the enrollee's health or overall function.

Examples of Qualifying Chronic Conditions

- Autoimmune disorders, including systemic lupus erythematosus, rheumatoid arthritis, psoriatic arthritis, and systemic sclerosis
- Cancer, including malignant neoplasms excluding pre-cancer or in-situ conditions
- Cardiovascular disorders, including cardiac arrhythmias, coronary artery disease, peripheral vascular disease, chronic venous thromboembolic disorder, heart valve disorders, and hypertensive heart disease
- Chronic alcohol or substance use disorders
- Chronic heart failure
- Chronic and disabling mental health conditions, including bipolar disorder, major depressive disorder, paranoid disorder, schizophrenia, schizoaffective disorder, and post-traumatic stress disorder
- Chronic lung disorders, including asthma, chronic bronchitis, emphysema, pulmonary fibrosis, pulmonary hypertension, and bronchiectasis

SSBCI Criteria:

- Have one or more complex chronic conditions
- Are at high risk for hospitalization or other adverse health outcomes
- Require intensive care coordination

Examples of Qualifying Chronic Conditions (Cont.)

- Cognitive disorders, including dementia, Alzheimer's disease, and related dementias
- Diabetes mellitus, Type 1 or Type 2
- End-stage liver disease
- End-stage renal disease and chronic kidney disease stage 4 or 5
- HIV/AIDS
- Neurologic disorders, including ALS, epilepsy, multiple sclerosis, Parkinson's disease, Huntington's disease, polyneuropathy, spinal stenosis, and stroke-related neurologic deficit
- Severe hematologic disorders, including aplastic anemia, hemophilia, immune thrombocytopenic purpura, myelodysplastic syndrome, and sickle-cell disease excluding sickle-cell trait
- Stroke
- Additional CMS-recognized conditions, including chronic pain conditions, severe obesity with comorbidities, chronic inflammatory bowel disease, chronic pancreatitis, peripheral neuropathy of non-diabetic etiology, and chronic anemia due to chronic disease

SSBCI Marketing and Eligibility Requirements

- Any marketing or communication material that mentions Special Supplemental Benefits for the Chronically Ill (SSBCI) must be reviewed and approved by Champion Compliance before use and must follow CMS-required SSBCI content and disclaimer requirements.
- Materials that describe SSBCI must clearly explain that the benefits are special supplemental benefits for chronically ill enrollees, identify applicable eligibility criteria and limitations, and state that having a listed chronic condition does not guarantee the benefit.
- SSBCI eligibility must be determined under Champion Health Plan and CMS-approved objective criteria. Agents must not promise or guarantee that a beneficiary will receive SSBCI before the plan completes the applicable eligibility determination.
- Agents must not use SSBCI messaging to mislead beneficiaries, imply that benefits are available to all enrollees, or suggest that self-attestation alone guarantees eligibility.
- When a beneficiary asks about SSBCI eligibility, agents should direct the beneficiary to Champion Health Plan Member Services or the applicable eligibility-assessment process described in CMS-approved plan materials.

Enrollment Periods

Understanding Medicare enrollment windows is essential for helping beneficiaries make informed, timely decisions. Each period has its own purpose, rules, and restrictions governed by CMS guidance. Agents must verify that a valid election period applies before submitting an enrollment.

Year-Round Enrollment into C-SNPs

Individuals who qualify for a Chronic Condition Special Needs Plan may have additional special enrollment periods available. This includes individuals who receive a new chronic condition diagnosis or have an existing CMS-recognized chronic condition that qualifies them for enrollment in a C-SNP. Restrictions apply. For example, an individual currently enrolled in a C-SNP generally cannot use this SEP to switch to another C-SNP that focuses on the same chronic condition. Verification of the qualifying condition is required.

AEP Annual Enrollment Period (AEP)

- **Timing: October 15 through December 7 each year.**
- Allowed actions: switch from Original Medicare to Medicare Advantage or vice versa; change from one Medicare Advantage plan to another; join, drop, or switch Part D plans.
- Effective date: January 1 of the following year.
- Key point: AEP is an ideal time for beneficiaries to review plan changes, costs, networks, and benefits.

IEP Initial Enrollment Period (IEP)

The Initial Enrollment Period is a one-time opportunity for individuals who are first becoming eligible for Medicare to enroll in Part A, Part B, and potentially a Medicare Advantage or Part D plan.

- Eligibility: turning 65 or becoming eligible for Medicare due to disability; eligible for Medicare Part A and Part B; C-SNP enrollment also requires evidence of a qualifying diagnosis or health status.
- **Timing: the seven-month period that begins three months before the month of the beneficiary's 65th birthday, includes the birth month, and ends three months after the birth month.**
- Effective date: generally the first of the month following the plan's receipt of the enrollment request, subject to CMS effective-date rules.

OEP Medicare Advantage Open Enrollment Period (MA OEP)

- **Timing: January 1 through March 31 annually.**
- Who can use it: only individuals already enrolled in a Medicare Advantage plan.
- Allowed actions: switch to another Medicare Advantage plan or drop Medicare Advantage and return to Original Medicare, with or without a standalone Part D plan.
- Limitations: only one change is allowed during MA OEP; it is not available to individuals with Original Medicare only.

Special Enrollment Periods (SEPs)

Special Enrollment Periods allow beneficiaries to make changes outside standard enrollment windows due to specific life events or circumstances. Timeframes and documentation requirements vary by SEP.

- Change of address or move out of the plan service area
- Chronic Condition SEP for individuals who meet C-SNP eligibility criteria
- Loss of other coverage, such as employer group coverage ending
- Plan termination or Medicare contract changes
- Dual eligibility for Medicare and Medicaid, subject to CMS quarterly limitations
- Extra Help/LIS eligibility, subject to CMS quarterly limitations
- Institutional admission or discharge
- Trial period right
- Exceptional circumstances such as natural disasters or federal emergencies, when approved by CMS

Enrollment Changes Throughout The Year

Most enrollees may only switch plans during the annual period designated by CMS. However, CMS does provide for limited circumstances where an enrollee can make a change outside the annual period.

Enrollment Period Quick Guide

Beneficiary Type	Can Switch MA → MA Anytime?	Can Join MA Anytime?	Can Join C-SNP Anytime?	Needs Medical Qualification?
Standard Medicare	X Only AEP/OEP/ SEPs	X Except AEP/SEP	X Except AEP/SEP	✓ For C-SNP
Dual Eligible	✓ Quarterly (Q1–Q3)	✓ Quarterly (Q1–Q3)	✓ Quarterly + C-SNP SEP	✓ Required
C-SNP Eligible	✓ During AEP/SEP	✓ During AEP/SEP	✓ C-SNP SEP anytime	✓ Required
New-to-Medicare	✓ During ICEP/OEP	✓ During ICEP	✓ If diagnosed	✓ Required



Blackout Period for FMO Transfers

Champion Health Plan limits the timing of agent and agency movement between Field Marketing Organizations during the Medicare Annual Enrollment Period to reduce administrative disruption and support compliance.

- Blackout period start date: September 1
- Blackout period end date: January 15, subject to extension based on operational needs
- No requests for agent releases, recontracts, or FMO transfers will be processed during the blackout period
- Pending transfer requests must be completed before August 31 to be effective for the upcoming AEP
- Requests received after August 31 will be held and reviewed beginning January 16 of the following year

Exceptions

- Compliance-related termination of the existing FMO
- Carrier-initiated changes
- Systemic contracting error documented before September 1

Procedure

1. Agents seeking to change FMOs must submit a completed Transfer Request Form and required release documentation by August 15 to support processing before the blackout period.
2. Agent Support confirms eligibility, including good standing and no active sanctions.
3. Approved transfers are completed by August 31.
4. Requests received between September 1 and January 15 are acknowledged and queued for review after the blackout ends.
5. Beginning January 16, queued transfer requests are reviewed and processed in the order received.

Enforcement

Failure to follow the FMO-transfer process may result in:

- Delayed processing of the transfer request.
- Continued alignment with the existing FMO during the blackout period.
- Suspension of new marketing or sales activity when authorized by the Agent Agreement.
- Compliance review when the request involves misrepresentation, improper solicitation, or another potential violation.
- Other corrective or disciplinary action permitted by the Agent Agreement.

The FMO-transfer blackout does not independently result in forfeiture or transfer of commissions. Compensation remains subject to the Agent Agreement and applicable compensation exhibit.



Selling Champion Health Plan

Champion Health Plan requires that any individual selling Champion Health Plan programs be licensed by the applicable state Department of Insurance with no restrictions, maintain active errors and omissions insurance in an amount no less than $1,000,000 per occurrence and $1,000,000 in the aggregate, with a reasonable deductible, or any greater or different amount required by applicable state law or the Agent Agreement, and have a contract and formal appointment with Champion Health Plan before enrolling a Medicare beneficiary into a Champion Health Plan benefit plan.

Agents must complete all applicable certification, attestation, and training requirements before marketing or selling Champion products.

- California Department of Insurance licensure is required if selling in California.
- Nevada Department of Insurance licensure is required if selling in Nevada.
- An active Champion Health Plan contract and appointment are required before sales activity.
- Active E&O insurance must be maintained.

Training and Certification

Champion Health Plan provides annual Medicare certification and training. Annual Medicare certification is required before an agent may market or sell Champion Health Plan products for the applicable plan year.

AHIP/NAHU Reliance Statement

For 2027, Champion Health Plan requires all agents marketing or selling Champion Health Plan Medicare Advantage Prescription Drug products to successfully complete current plan-year AHIP/NAHU Medicare Certification, including Fraud, Waste and Abuse training. Champion Health Plan relies upon AHIP/NAHU training to satisfy general Medicare education and foundational CMS compliance training requirements.

2027 Update Note: The prior manual reference to AHIP or NAHU has been clarified for 2027. AHIP is the required foundational certification unless Champion Compliance approves an equivalent certification in writing before selling activity begins.

Champion Supplemental Certification

Champion Health Plan certification is supplemental and focuses specifically on Champion Health Plan products, operational requirements, compliance expectations, enrollment procedures, sales oversight requirements, and Champion Health Plan-specific CMS compliance obligations.

Certification Testing Standard

- Passing score: 90%.
- Certification validity: current plan year only.
- Retesting: per Champion Compliance policy.
- Failure to meet certification requirements may result in suspension of selling privileges.

Best Practice: Know When to Walk Away

Agents must always be willing to walk away from an enrollment when proceeding would not be in the prospective member's best interest or would create compliance risk. Do not accept a less than satisfactory outcome for the prospective member to get the sale.

- ✓ If the prospective enrollee frequently cancels or does not show up to appointments, do not enroll. Walk away.
- ✓ If the prospective enrollee appears hesitant to enroll, do not enroll. Walk away.
- ✓ If the prospective enrollee does not appear to understand that they are signing a legally binding enrollment request, do not enroll. Walk away.
- ✓ If the agent feels frustrated and drained by interactions with the prospective enrollee, do not enroll. Walk away.
- ✓ If it is difficult to convince the prospective enrollee why they want or need Champion Health Plan benefits, do not enroll. Walk away.
- ✓ If the prospective enrollee has rules, requirements, or requests outside standard operating procedures, do not enroll. Walk away.
- ✓ If the enrollee has a Power of Attorney and the POA is not present at the enrollment, do not enroll. If the POA is present, the POA must sign in the appropriate section and provide proof of POA or conservatorship with the enrollment form.

Training Objectives

- Accurately explain Champion Health Plan MAPD HMO/POS products
- Identify eligible beneficiaries for Champion plans
- Explain provider and pharmacy network rules
- Conduct compliant sales and enrollment activities
- Apply CMS marketing and TPMO requirements
- Properly complete enrollments and HRAs
- Protect beneficiary information and privacy
- Identify and report compliance concerns
- Follow Champion operational and compliance procedures
- Understand oversight and monitoring expectations

Compensation and Commission Policy 2027

Policy Authority and Scope

Champion Health Plan compensates agents under the signed Agent Agreement, applicable compensation exhibit, annual commission schedule, CMS requirements, and applicable law. This section incorporates the Champion 2027 Agent Commission Guide dated October 20, 2026. The signed agreement and its exhibits govern contractual rights; applicable law and CMS requirements prevail. Published amounts and processes may change with CMS guidance. This manual does not independently amend contractual commission rights.

2027 Commission Rates (California and Nevada)

The Commission Guide identifies the following maximum CMS rates paid to agents:

California: Initial-year $902; annual renewal $451.

Nevada: Initial-year $725; annual renewal $363.

Amounts are subject to the applicable CMS rate, member history, region, contract, and agency commission assignment. The examples below are based on the Guide, not a guarantee of payment.

How commissions are calculated

- Plan year 1, CMS cycle year 1, new to Medicare: 100% of the applicable initial-year rate in a lump sum; not prorated.
- Plan year 1, CMS cycle year 1, transferring from an existing MA/MAPD plan: initial-year rate prorated for months from effective date through December.
- Plan year 1, CMS cycle year 2 or later: annual renewal rate prorated for months from effective date through December.
- Plan year 2 or later, CMS cycle year 2 or later: one-twelfth of the annual renewal rate for each eligible month of continuing Champion enrollment.
- CMS MARx cycle-year and prior-plan data determine the applicable rate and adjustments.
- Worked examples — July 1 effective date (six months July–December)
- New to Medicare, initial year: California $902.00; Nevada $725.00.
- Existing MA/MAPD, initial year prorated: California $451.00; Nevada $362.50.
- Renewal prorated: California $225.50; Nevada $181.50.

Displayed monthly figures may be rounded; actual calculations use unrounded rates.

Commissionable applications

- New CMS-approved member: commissionable after CMS approval, subject to all eligibility requirements.
- Returning member after a formal termination and break in Champion coverage: commissionable, subject to eligibility.
- Internal plan change within the same state, including county-to-county moves: no new commission solely for the change. The original writing agent retains applicable renewal compensation under the agreement.
- California-to-Nevada or Nevada-to-California change: potentially commissionable only if the agent is properly licensed, contracted, and covered by the multi-state agreement, and all other requirements are met.
- Multiple applications for one beneficiary: the last application successfully processed by CMS determines enrollment credit under the Commission Guide. Agents must never submit duplicative applications to manipulate compensation or AOR status.

Commission payment requirements

Before marketing, selling, or receiving applicable commission, the agent must maintain the credentials required by the Agent Agreement, including applicable state insurance license and appointment, signed Agent Contract, current E&O coverage, annual AHIP certification or approved equivalent, Champion plan-year certification, W-9, and direct deposit authorization. The agent must not sell before receiving Broker Contracting's welcome email.

The application received date controls commission eligibility, applicable contracting/agency relationship, and any commission-assignment arrangement. Enrollments submitted before the agent's required certification date are not commissionable under the Commission Guide, including associated agency payments. Agents must maintain applicable licenses and complete annual training. The Guide specifies December 1 for terminated agents/agencies and December 15 for active agents/agencies for renewal recertification; the agreement and applicable law control the effect of noncompliance on earned or future compensation.

An agent who leaves Champion before payment for applications written while properly contracted remains eligible for those earned commissions under the Guide, paid in the normal course when CMS approval is received, subject to the Agent Agreement.

Payment timing and CMS reconciliation

The Commission Guide specifies two payment cycles: CMS approval by the fifth of a month is included in that month's first payment; approval after the fifth through the twentieth is included in the end-of-month payment. The original manual separately states that current-year commissions and residuals are paid by the fifteenth of the month. These source schedules are not identical; the operative schedule is the one established by the signed agreement and current Champion compensation instructions. Agents should confirm payment timing with Broker Support before relying on a particular date.

If an enrollment is not yet reflected in monthly CMS MARx data, Champion may make a preliminary payment based on the annual renewal rate prorated for the months remaining in the calendar year. Upon receipt of CMS data, Champion recalculates the commission and pays or recovers the difference under applicable rules.

Agent of Record versus agency commission assignment

The manual's Agent of Record (writing-agent) designation identifies the agent on the accepted enrollment for commission administration and servicing. Separately, the Commission Guide uses 'AOR arrangement' to describe an agent's contractual assignment of commission to the contracted direct agency. These are distinct concepts; an assignment of payment does not, by itself, change the writing agent or authorize transfer of another agent's book of business.

Under a signed agency commission-assignment arrangement, the full assigned commission is paid to the direct agency, which issues the agent's payments and statements; those statements are not available in Champion's agent portal. The arrangement applies according to its effective date and the application received date. The application received date also determines the relevant agency override under the Guide. Contact the agency regarding its downstream payments.

Disenrollment, chargebacks, and overpayments

When a member disenrolls, the Guide provides for reversal and recalculation of the original commission based on the months enrolled in that calendar year. The Guide further states that if the member leaves before month four, 100% of the commission earned for that member is charged back. These adjustments remain subject to CMS rules, the Agent Agreement, and applicable law.

Overpayments may arise from disenrollment, corrected CMS data, or other reconciliation. The next statement identifies affected members and recoveries. Amounts may be offset against commissions otherwise payable, where contractually and legally permitted; outstanding balances remain reflected until recovered.

Credential lapses and commission protection

Agents must immediately stop sales activity if a required license, appointment, or certification becomes invalid and promptly notify Champion. Any suspension, withholding, offset, or recovery must be administered under the Agent Agreement, applicable compensation exhibit, CMS requirements, and law. This manual does not independently authorize forfeiture of earned compensation.

Compensation disputes and contacts

Written compensation disputes must be submitted within 120 days of the member's effective date or within 120 days of when the issue arose, as applicable, to SalesCompensation@Championhealthplan.com, consistent with the existing manual. This deadline does not limit corrections or recoveries required by CMS or law.

Broker/commission support: brokersupport@championpayer.com

Member Services for plan changes: 1-800-885-8000 | TTY 711

Enrollment/mailing: Champion Health Plan, 5000 Airport Plaza Dr, Suite 100, Long Beach, CA 90815

Website: championhmo.com

Agent of Record (AOR)

Purpose

Champion Health Plan recognizes the important relationship between Medicare beneficiaries and the licensed insurance professionals who educate, enroll, and continue to serve our members.

The purpose of this policy is to:

- Protect the rights of Medicare beneficiaries to make informed healthcare decisions.
- Preserve the integrity of the Medicare enrollment process.
- Clearly define the establishment and administration of the Agent of Record (AOR).
- Protect the legitimate interests of the original writing agent.
- Prevent improper commission transfers, agent steering, and abusive marketing practices.
- Ensure compliance with CMS regulations, the Medicare Communications and Marketing Guidelines (MCMG), applicable state laws, the Champion Health Plan Agent Agreement, and Champion Health Plan Policies and Procedures.

This Agent of Record policy provides operational guidance under the Champion Health Plan Agent Agreement. It does not independently amend the Agent Agreement or its compensation exhibit. If this policy conflicts with the Agent Agreement, the Agent Agreement controls.

Policy Statement

Champion Health Plan recognizes the licensed insurance agent identified on a valid Medicare Advantage enrollment accepted by Champion Health Plan as the Agent of Record (AOR).

The Agent of Record established through a valid enrollment election shall remain the recognized writing agent for that enrollment unless:

1. The beneficiary submits a new CMS-permitted enrollment through a valid election period establishing a different writing agent;
2. Champion Health Plan corrects a documented administrative processing error; or
3. Champion Health Plan approves a documented administrative exception consistent with this policy.

Champion Health Plan does not maintain an administrative process to transfer commissions or Agent of Record status solely because a beneficiary prefers another servicing agent.

Nothing contained in this policy limits a Medicare beneficiary's right under CMS regulations to select another Medicare Advantage plan or another licensed insurance agent during a valid Medicare election period.

Definition of Agent of Record

The Agent of Record is the licensed, contracted, appointed, and certified insurance professional identified on the CMS-valid enrollment application accepted by Champion Health Plan.

Champion Health Plan recognizes only one Agent of Record for each enrollment.

The Agent of Record is recognized for purposes of:

- Commission administration
- Member servicing
- Enrollment accountability
- Compliance oversight
- Sales reporting
- Performance monitoring

Responsibilities of the Agent of Record

The Agent of Record is expected to provide ongoing professional service throughout the member's enrollment.

Responsibilities include:

- ✓ Explaining Champion Health Plan benefits and services.
- ✓ Assisting members in understanding Medicare rules and election periods.
- ✓ Helping members locate participating providers and pharmacies.
- ✓ Referring members to Champion Member Services when appropriate.
- ✓ Assisting members during Annual Enrollment Period and other applicable election periods.
- ✓ Reporting suspected compliance concerns.
- ✓ Conducting all marketing and enrollment activities honestly, ethically, and professionally.

Establishing the Agent of Record

Agent of Record status is established when:

- A CMS-compliant enrollment application is completed;
- The enrollment is accepted by Champion Health Plan;
- The writing agent is licensed, appointed, contracted, and certified;
- CMS accepts the enrollment.

Once established, the Agent of Record remains unchanged except as permitted under this policy.

When the Agent of Record May Change

A. New CMS Enrollment

A new Agent of Record is established when a beneficiary completes a new enrollment through a valid CMS election period, including but not limited to:

- Annual Enrollment Period (AEP)
- Medicare Advantage Open Enrollment Period (MA OEP)
- Initial Enrollment Period (IEP)
- Initial Coverage Election Period (ICEP)
- Valid Special Enrollment Period (SEP)

The writing agent on the new enrollment becomes the Agent of Record for that enrollment. A member's change from one Champion Health Plan product to another Champion Health Plan product does not, by itself, transfer Agent of Record status or compensation. Internal product changes are administered under the compensation provisions of the Agent Agreement. The original Agent of Record continues to receive applicable renewal compensation as provided in the Agreement, unless Champion Health Plan is correcting a documented administrative error or a different result is required by CMS or applicable law.

B. Administrative Exceptions

Champion Health Plan may approve an administrative exception only under limited circumstances, including:

- Death of the writing agent.
- Permanent disability.
- Retirement.
- Loss or suspension of insurance license.
- Contract termination.
- Champion administrative processing error.
- Compliance-directed reassignment.
- Documented inability of the original agent to reasonably service the member.

An administrative reassignment is for member-servicing and operational purposes unless the Agent Agreement, applicable compensation exhibit, CMS requirements, or applicable law expressly requires a different result. Administrative reassignment does not transfer prior or future compensation to another agent solely because that agent assumes servicing responsibilities.

Administrative exceptions are uncommon and require review by Broker Relations and Compliance.

Approval is solely within Champion Health Plan's discretion.

Submission of a request does not create an entitlement to approval.

Member Service

Champion Health Plan encourages all contracted agents to assist members who request customer service and refer to the Plan's Member Services Department as required.

However:

Providing customer service to another agent's enrolled member does **not:**

- establish Agent of Record status;
- transfer commissions;
- establish ownership of the member relationship.

The member relationship remains the exclusive property of Champion Health Plan in accordance with the Agent Agreement.

Prohibited Conduct

Agents shall not engage in conduct intended to improperly obtain another Champion Health Plan agent's book of business.

Prohibited activities include:

- Soliciting members currently assigned to another Champion Health Plan agent for the purpose of transferring commissions.
- Requesting an administrative Agent of Record change solely to obtain commissions.
- Encouraging unnecessary plan changes.
- Encouraging duplicate enrollments.
- Misrepresenting another agent's relationship with a member.
- Advising members that changing agents is necessary to receive service.
- Offering gifts, cash, rebates, or other items of value to induce an Agent of Record change.
- Interfering with another Champion Health Plan agent's established member relationships.
- Misrepresenting Medicare election rights.
- Engaging in steering, cherry-picking, or any prohibited CMS marketing activity.
- Engaging in any conduct inconsistent with the Champion Health Plan Agent Agreement, Agent Manual, Code of Conduct, or CMS regulations.

Duplicate Enrollments

Champion Health Plan will process duplicate enrollment applications in accordance with CMS enrollment rules.

Agents may never encourage duplicate enrollments for the purpose of obtaining commissions or changing the Agent of Record.

Improper duplicate enrollments may result in disciplinary action.

Commission Administration

The Agent of Record identified on the accepted enrollment application is used for commission administration.

Administrative servicing arrangements do not transfer commissions.

Administrative Agent of Record determinations affect future servicing only unless Champion Health Plan determines an administrative correction is required.

Champion Health Plan will not retroactively transfer commissions except:

- to correct a documented administrative error;
- when required by law; or
- when required by CMS.

Nothing in this policy creates any ownership interest in Champion Health Plan members, enrollments, commissions, or books of business.

Compliance Monitoring

Champion Health Plan actively monitors:

- Agent of Record activity
- Duplicate enrollments
- Rapid disenrollments
- Sales allegations
- Member complaints
- Enrollment trends
- Commission activity
- Agent switching patterns

Champion Health Plan may audit any enrollment or Agent of Record determination at any time.

Agents are required to cooperate fully with all compliance investigations.

Failure to cooperate constitutes a violation of the Agent Agreement.

Agents must provide requested enrollment, marketing, lead, Permission-to-Contact, Scope of Appointment, call-recording, and related records within four business days after Champion Health Plan's request, or within any shorter period required by CMS, another regulator, an audit, or an investigation.

Violations

Violations of this policy may result in one or more of the following:

- Coaching
- Mandatory retraining
- Written warning
- Corrective Action Plan (CAP)
- Increased compliance monitoring
- Secret shopping
- Suspension of marketing privileges
- Suspension of new sales
- Suspension of commission payments where permitted by contract
- Recovery of improperly paid commissions where permitted by law
- Termination of the Agent Agreement
- Reporting to applicable Departments of Insurance
- Reporting to CMS, when appropriate

Champion Health Plan reserves the right to impose disciplinary action consistent with the Agent Agreement and applicable law. Any suspension, withholding, recovery, offset, or termination of compensation will be administered in accordance with the Agent Agreement, its compensation exhibit, CMS requirements, and applicable law. The disciplinary provisions of this Manual do not independently create a right to forfeit earned compensation.

Sales Allegation Review Process

Champion Health Plan recognizes the seriousness of allegations of improper or incomplete sales presentations and the risk they pose to members, sales representatives, and Champion Health Plan. Champion Health Plan investigates sales allegations consistent with CMS guidance and internal procedures.

- The designated Sales Allegation Review Investigator gathers statements from the member, the sales representative, and any witnesses to the sales presentation.
- Agents may be required to provide copies of communications, including the Scope of Appointment form, emails, meeting communications, and telephonic enrollment recordings when applicable.
- Sales representatives may respond in writing to sales allegations.
- Sales representatives are not permitted to contact the beneficiary after Champion Health Plan receives the allegation.
- Sales representatives must provide a written response to a sales allegation within five business days. Supporting enrollment and marketing records requested by Champion Health Plan remain subject to the four-business-day production requirement. If the sales representative fails to respond, the member's statement may be deemed factual.
- Sales representatives should participate fully in the investigation process, including communication with the Chief Compliance Officer and/or Grievance Department when needed.

Possible Determinations

- **Fault:** documentation and testimony prove the sales representative was at fault, or a trend of similar allegations supports a fault determination.
- **No-Fault:** documentation and testimony prove there was no fault by the sales representative.
- **No Determination:** documentation and testimony are insufficient to prove or disprove fault.

If there is a finding of Fault or, in some cases, No Determination, the Sales Allegation Review Committee may recommend additional training, suspension of writing privileges, or termination of the agreement to represent Champion Health Plan.



Compliance and Sales Oversight

Zero-Tolerance Non-Compliance

Champion Health Plan has a zero-tolerance policy for the following non-compliant actions. These actions may result in termination and may be reported to CMS and/or state agencies for investigation.

- Door knocking
- Cold calling
- Enrolling beneficiaries who live outside the service area by using a fake address or P.O. Box
- Fraudulent or malicious enrollment tactics

Champion Health Plan is committed to supporting compliant sales activity. Agents must contact Broker Support or Compliance when they need information or have questions about compliant sales and enrollment activity.

Corrective Action Plan

If Champion Health Plan becomes aware of non-compliant sales activity, a Corrective Action Plan may be created for the agent based on the offense. Compliance and Sales will work together to communicate the CAP to the agent, confirm completion, and conduct ongoing monitoring when required.

Business Associate Requirements

The HIPAA Privacy Rule requires covered entities to obtain satisfactory assurances from business associates that protected health information is used only for its intended purposes and is adequately protected. Agents typically receive PHI from a beneficiary or health plan and perform services on behalf of the plan. To that extent, agents may meet the definition of a Business Associate and must have a signed Business Associate Agreement on file with Champion Health Plan.

Standards of Conduct, Fraud, Waste and Abuse

Champion Health Plan conducts business with high ethical standards. Agents must complete annual Compliance and Fraud, Waste and Abuse training and must follow Champion Health Plan standards of conduct in all sales, enrollment, and member-facing activities.

Ethical Sales Conduct

- Conduct business professionally
- Present accurate plan information
- Act in the beneficiary's best interest
- Avoid misleading or high-pressure sales tactics
- Protect beneficiaries from confusion, coercion, or incomplete information

Prohibited Conduct

- Misrepresenting benefits or provider participation
- Pressuring beneficiaries into enrollment
- Door-to-door solicitation
- Cold calling Medicare beneficiaries
- Enrolling ineligible individuals
- Falsifying enrollment documentation
- Using fraudulent or malicious enrollment tactics

Reporting Obligations

- Suspected fraud
- Improper enrollments
- Identity theft
- Compliance violations
- Privacy breaches
- Marketing concerns
- Beneficiary complaints involving sales conduct

MIPPA Guidelines and Rules

The Medicare Improvements for Patients and Providers Act of 2008 was passed to protect Medicare beneficiaries from deceptive or high-pressure marketing tactics. Agents must follow CMS Medicare Communications and Marketing Guidelines and Champion policies when conducting sales and marketing activity.



FWA Definitions

Fraud: intentional deception for unauthorized gain.

Waste: overuse or misuse of healthcare resources.

Abuse: practices inconsistent with sound business or medical standards.

Third-Party Marketing Organization (TPMO) Requirements

Agents and agencies acting as TPMOs must comply with CMS TPMO requirements. Agents must use the required TPMO/agent disclaimer where required by CMS and must follow all timing, format, and placement requirements.

Required TPMO/Agent Disclaimer

The following disclaimer must be used where required by CMS:

If the TPMO does not sell for all MA organizations and Part D sponsors in the service area, use the required CMS standardized disclaimer: "We do not offer every plan available in your area. Currently we represent [insert number of organizations] organizations which offer [insert number of plans] products in your area. Please contact Medicare.gov or 1-800-MEDICARE to get information on all of your options."

Disclaimer Requirements

- If the TPMO sells for all MA organizations and Part D sponsors in the service area, use the CMS alternate disclaimer: "Currently we represent [insert number of organizations] organizations which offer [insert number of plans] products in your area. Please contact Medicare.gov or 1-800-MEDICARE to get information on all of your options."
- For applicable sales calls, verbally convey the TPMO disclaimer before discussing plan benefits. Basic demographic intake may occur first, but agents must not discuss benefits until the disclaimer has been provided.
- Include the TPMO disclaimer on TPMO websites, in required electronic communications, and in marketing materials where CMS requires it.
- Keep represented organization and product counts current. Do not use an outdated count in calls, websites, electronic communications, advertisements, or printed materials.
- Use the disclaimer exactly as required by CMS and Champion Compliance. Do not shorten, paraphrase, or add non-approved language.

TPMO Lead Generation, Data Sharing, and Warm Transfers

- Lead-generation activity must be approved by Champion Compliance before use and must follow CMS and Champion requirements for beneficiary consent, disclosure, and privacy.
- Before transferring a beneficiary to a licensed agent or broker, the TPMO must clearly disclose that the beneficiary is being transferred to a licensed insurance agent or broker.
- Beneficiary contact information may not be sold, rented, shared, or transferred to another TPMO, agent, agency, or downstream entity unless prior express written consent authorizes the specific recipient or recipients and the purpose of the contact.
- Permission to Contact and lead forms must identify the product type or topic for which permission is granted and must not be used to contact beneficiaries about products outside the permission granted.
- Lead-generation materials must not imply that the beneficiary is contacting Medicare, CMS, Social Security, Medicaid, or any other government agency unless the communication is actually from that agency.
- Any subcontractor or downstream entity used for lead generation, marketing, sales, or enrollment support must be disclosed to Champion as required by contract and policy and must follow Champion and CMS requirements.

TPMO Oversight and Reporting

- Agents and agencies must notify Champion Health Plan within one business day after receiving notice of an actual or threatened disciplinary action, administrative action, license restriction, suspension, investigation, or proceeding in any jurisdiction.
- TPMOs must cooperate with Champion monitoring, audits, secret shopping, call reviews, complaint investigations, documentation requests, and corrective-action activities.
- Champion may require monthly or other periodic reporting from TPMOs regarding agent rosters, subcontractors, lead sources, marketing activity, sales allegations, disciplinary actions, and corrective actions.
- Failure to provide requested TPMO oversight documentation may result in suspension of marketing privileges, withholding of compensation where permitted, termination, and reporting to CMS or state regulators when appropriate.

Permission to Contact (PTC)

Agents may contact beneficiaries only through CMS-permitted methods. Permission to Contact must be documented and retained according to policy. Business reply cards and other beneficiary requests for additional information are valid for 12 months from the date of the beneficiary's initial request, but agents must limit contact to the products or topics for which permission was granted.

Agents May Not

- Cold call beneficiaries
- Approach beneficiaries without permission
- Send unsolicited marketing texts
- Send unsolicited marketing emails
- Use PTC for products or topics beyond the permission granted

Acceptable Permission-to-Contact Examples

- Business reply cards
- Website lead forms
- Beneficiary-initiated calls
- Permission documented at educational events
- Other CMS-permitted permission methods documented according to Champion policy

Permission-to-Contact Documentation Standards

- Document the date, method, source, product type or topic, and beneficiary authorization for each Permission to Contact.
- Use PTC only for the product type or topic for which permission was granted and only within applicable CMS and Champion limits.
- Business reply cards, lead forms, and other requests for information are valid for 12 months from the date of the beneficiary's initial request for information, but the scope of follow-up remains limited to the permission granted.
- Do not convert PTC into permission to market unrelated products, non-health products, or products outside the beneficiary's request.
- Retain PTC records in a secure, retrievable format and provide them to Champion upon request.

Scope of Appointment (SOA) and Telephonic/Online Enrollment

For operational and compliance purposes, Champion Health Plan requires an SOA for every interaction that meets the applicable CMS definition of a personal marketing appointment, whether the appointment occurs in person, by telephone, virtually, through a web-based interaction, as a walk-in, or through beneficiary-initiated contact. For CY 2027 marketing and communications beginning October 1, 2026, Champion Health Plan applies the CMS HPMS SOA FAQ guidance related to the new SOA rules at 42 CFR §§ 422.2264(c)(3) and 423.2264(c)(3). Discussions may only concern the products, product lines, or health-related lines of plan business documented on the Scope of Appointment.

CY 2027 SOA Rule Updates

- The prior CMS 48-hour waiting period between SOA completion and a personal marketing appointment has been eliminated for CY 2027 marketing and communications. Agents must still obtain and document the SOA before the personal marketing appointment begins.
- For in-person personal marketing appointments, the SOA must be in writing. A wet signature on paper is not required; an electronic signature or electronic record satisfies the in-writing requirement.
- For personal marketing appointments that do not occur in person, such as telephone or virtual appointments, an audio recording, audio-visual recording, or electronic record may satisfy the SOA record requirement when permitted by CMS and Champion policy.
- SOAs, business reply cards, and other beneficiary requests for additional information are valid for 12 months following the beneficiary's signature date or the date of the beneficiary's initial request for information.
- During the 12-month validity period, Champion Health Plan or an agent/broker may contact the beneficiary only regarding the agreed-upon scope of products documented in the SOA. The SOA does not permit discussion of products or health-related lines of plan business that were not identified before the appointment.
- A separate SOA is required before discussing any additional health-related line of plan business, product line, or product outside the scope previously agreed to by the beneficiary.
- If an SOA specifically references a particular plan year, a new SOA is required before discussing a different plan year. If the SOA identifies a product line but does not reference a particular plan year, a new SOA is not required solely to discuss different plan-year products within that same product line during the 12-month validity period.
- Agents may collect SOAs before October 1 that cover upcoming plan-year offerings, but agents may not engage in substantive marketing discussions about prospective plan-year offerings before October 1.
- A recorded or electronic SOA collected for a telephone or virtual personal marketing appointment may support a later in-person personal marketing appointment with the same beneficiary during the 12-month validity period, provided the scope of products discussed has not changed.
- A Scope of Appointment is not required when a current member asks non-marketing questions, such as questions about a provider bill.

Agent Workflow for Compliant SOA Handling

- Confirm the beneficiary has agreed to the scope before the appointment begins.
- Document the product lines or health-related lines of plan business to be discussed.
- Do not expand the discussion beyond the documented scope unless a new SOA is completed before the additional discussion occurs.
- Verify whether the SOA references a specific plan year before using it for a different plan-year discussion.
- Retain SOA documentation, including paper, electronic, audio, audio-visual, and related records, according to Champion Health Plan's documentation-retention requirements.
- Escalate questions about SOA sufficiency, scope changes, or plan-year applicability to Champion Compliance or Broker Support before proceeding.

SOAs at Educational Events

- At educational events, agents may distribute permitted communications materials, answer beneficiary-initiated questions, distribute business cards, and make available or receive Scope of Appointment forms in accordance with Champion Health Plan procedures.
- Collecting an SOA at an educational event does not allow the agent to conduct a sales or marketing presentation during the educational event.
- Under the Agent Agreement, agents may not distribute or collect business reply cards, enrollment applications, or plan-specific marketing materials at an educational event.
- Any personal marketing appointment based on an SOA collected at an educational event must occur only after the educational event ends and must be conducted according to the documented scope.

Telephonic Enrollment Requirements

- Calls must be recorded where required.
- Approved scripts must be used.
- Beneficiary consent must be obtained.
- Agents and TPMOs must retain all required marketing, sales, and enrollment call recordings in their entirety for ten years under the Agent Agreement. For years 1 through 3, the complete audio recording must be retained. For years 4 through 6, the complete audio recording must be retained unless Champion Health Plan expressly authorizes use of a complete and accurate transcript consistent with CMS requirements. For years 7 through 10, records must be retained in the form required by Champion Health Plan policy and the Agent Agreement. Records subject to an audit, investigation, complaint, litigation hold, or regulatory request must be retained until Champion Health Plan authorizes their disposition, even if the normal retention period has expired.
- Enrollment documents and other enrollment records remain subject to the documentation-retention requirements in this manual and must not be shortened solely because call-recording retention has changed.
- Recordings must be retrievable and provided to Champion Health Plan upon request.

Online Enrollment Requirements

- Use approved systems only.
- Include proper beneficiary authorization.
- Comply with CMS electronic enrollment requirements.
- Use CMS-approved scripts where required.
- Record the enrollment when required.
- Submit the required Champion enrollment information, including PCP, PTP, and dialysis center information where applicable.
- Indicate on the enrollee signature line when the enrollment was filed online using the CMS Online Enrollment Center, when applicable.

Health Risk Assessment (HRA) Procedures and Administrative Fees

Champion Health Plan utilizes Health Risk Assessments to support care coordination, population health management, and member engagement. Agents may assist beneficiaries with HRA completion through approved methods and only with beneficiary consent.

Permitted HRA Activities

- Explain the purpose of the HRA in plain language.
- Assist the beneficiary through approved HRA completion channels.
- Use Champion's online HRA tool when required.
- Ensure information is accurate and provided voluntarily by the beneficiary.
- Protect beneficiary PHI throughout the process.

HRA Administrative Fees

Agents may receive approved administrative compensation for compliant online HRA completion activities, subject to Champion policy. To receive administrative compensation, HRA activities must be entered into Champion's online HRA tool and must comply with all applicable policies.

Any HRA-related administrative payment must be reviewed under CMS compensation rules and Champion compensation policy. HRA compensation may not be structured to evade CMS compensation limits, steer beneficiaries, create an improper inducement, or pressure a beneficiary to complete an HRA or enroll in a plan.

Prohibited HRA Conduct

- Do not pressure beneficiaries to complete an HRA.
- Do not mislead beneficiaries about the purpose of the HRA.
- Do not tie HRA completion to improper enrollment inducements.
- Do not conduct HRA activity without beneficiary consent.
- Do not complete HRA responses inaccurately or without beneficiary input.



Provider and Pharmacy Network Rules

Agents must accurately explain Champion Health Plan provider and pharmacy network rules and must avoid guaranteeing provider acceptance or misrepresenting provider participation. Agents should encourage beneficiaries to confirm their providers, pharmacies, medications, and service needs before enrolling. Members generally must use in-network providers and in-network pharmacies, subject to the applicable plan rules and CMS-approved plan materials.

- Agents must explain PCP requirements when applicable.
- Agents must explain PTP requirements when PTPs are part of the applicable PBP, including ESRD/CKD and behavioral health PBPs when applicable.
- Agents must explain referral requirements.
- Agents must explain prior authorization requirements.
- Agents must explain out-of-network limitations.
- Agents must not misrepresent provider participation.
- Agents must not guarantee that a provider will accept the plan or remain in the network.

Activities in Provider, Healthcare, and Long-Term Care Settings

- Agents must follow CMS rules and Champion policy when conducting activity in provider offices, pharmacies, hospitals, nursing homes, assisted living facilities, board-and-care homes, dialysis centers, clinics, and other healthcare or long-term care settings.
- Providers, provider staff, social workers, facility staff, and care coordinators may not market on behalf of Champion in a manner prohibited by CMS, accept enrollment applications, accept SOAs on behalf of agents unless permitted by Champion Compliance, make enrollment calls for beneficiaries, or steer beneficiaries based on financial or contractual arrangements.
- Marketing materials may not be distributed or displayed in care-delivery areas unless CMS and Champion policy permit the specific activity. Activities in common areas must remain compliant and must not interfere with care.
- Agents may schedule appointments with long-term-care facility residents only upon the resident's request. Unrequested visits to residents are treated as prohibited unsolicited door-to-door marketing.
- Health screenings, health surveys, or other activities that could be viewed as targeting or cherry-picking beneficiaries may not be used as part of sales or marketing events.
- Agents must be especially careful with higher-acuity, ESRD/CKD, behavioral health, institutional-level-care, and nursing-home populations to ensure understanding, voluntary choice, and proper authorized-representative documentation when applicable.

Vulnerable Beneficiary Protections

Champion Health Plan serves vulnerable populations, including ESRD/CKD beneficiaries, behavioral health populations, elderly beneficiaries, individuals with cognitive impairment, and beneficiaries requiring higher levels of care coordination. Agents must take additional care to ensure beneficiary understanding and voluntary decision-making.

- Allow adequate time for decision-making.
- Use interpreters where appropriate and permitted.
- Recognize signs of confusion, coercion, pressure, or misunderstanding.
- Do not enroll a beneficiary who does not understand the enrollment decision.
- Confirm that the beneficiary understands provider, pharmacy, benefit, network, and cost-sharing implications.
- When an authorized representative or POA is involved, obtain required documentation and ensure the representative signs appropriately.

Agent Oversight and Rapid Disenrollment Monitoring

Champion Health Plan Sales Oversight is responsible for preventing, detecting, and correcting non-compliant sales activities. Ongoing monitoring may include sales-event audits, complaint review, rapid disenrollment review, coaching, feedback, and corrective action.

Sales Event and Agent Monitoring

- Monthly sales-event audits may be performed.
- Coaching and feedback may be provided to the agent and the agent's sales representative or FMO.
- Agents scoring below 90% in applicable oversight reviews may be placed on a Corrective Action Plan.
- Presenting agents must be licensed, certified for the current year, appointed, and trained as required.

Rapid Disenrollment

- A rapid disenrollment rate of 10% or less is considered acceptable.
- A rate between 8% and 10% is considered above average and may be monitored for trend development.
- A rate of 11% or greater may be investigated for possible non-compliant sales activity.
- Consistently high rapid disenrollment rates may put an agent at risk of suspension of writing privileges or termination of the agent agreement.

Events

Champion holds two kinds of events. Educational events generally inform beneficiaries about Medicare and may not be used to market specific plans. Sales/marketing events present specific Champion plans and may include enrollment.

All events must receive prior approval from Champion Health Plan. **Submit requests to the Events & Marketing contact in the Resources section at least 5 business days before the event**. CMS reporting requirements differ by event type and are described below. You can submit your Formal and Informal events by email at **events@championpayer.com** or contact Champion Health Plan Broker Support department at **1-800-885-8000**.

Sales/Marketing Events

Sales/marketing events present specific Champion plans and may include enrollment. Champion reports these events to CMS, so agents must submit each event, along with any changes or cancellations, within Champion's required timeline. Advertisements and invitations to these events must include the following statements when applicable:

- "A salesperson will be present with information and enrollment form."
- "For accommodation of persons with special needs at sales meetings call **1-800-885-8000, or TTY 711."**

Formal Sales Events

Formal sales events are structured presentations where the agent presents plan-specific information to an audience. For each formal event, agents must submit:

- **Event type:** confirm the event is a formal sales event
- **Event details:** date, time, and precise location
- **Products to be discussed:** all products and plan types (for example, HMO, HMO-POS) to be covered
- **Agent information:** names and contact details of the agents conducting the event
- **Event promotion:** how the event will be advertised or promoted

Sign-in sheets are optional. If used, they must clearly state that providing contact information is optional and is not required for attendance.

Informal Sales Events

Informal sales events are less structured. The agent is available at a table, booth, kiosk, or recreational vehicle (RV) to provide plan information on request. For each informal event, agents must submit:

- **Event type:** confirm the event is an informal sales event
- **Event details:** date, time, and specific location
- **Agent information:** names and contact details of the agents staffing the event
- **Products available for discussion:** all products and plan types agents are prepared to discuss upon beneficiary request
- **Event promotion:** how the event will be advertised or promoted

At informal events, agents must not initiate contact but may provide information upon beneficiary request.

Educational Events

Educational events must be advertised as educational and are designed to generally inform beneficiaries about Medicare, Medicare Advantage, Prescription Drug programs, or other Medicare programs. Educational events are not reported to CMS as marketing events, but their advertising and materials must be reviewed by Champion Compliance and filed with CMS when required.

- Agents may distribute permitted communications materials, answer beneficiary-initiated questions, distribute business cards, and make available or receive Scope of Appointment forms in accordance with Champion Health Plan procedures.
- Agents may not market specific Champion plans or benefits, conduct sales or marketing presentations, distribute or accept enrollment applications, or pressure beneficiaries to schedule an appointment or complete an SOA during an educational event.
- Sign-in sheets must be optional and must clearly state that contact information is optional and not required for attendance.



Transition From Educational Event to Marketing Event

- For CY 2027, CMS removed the prior 12-hour separation requirement between an educational event and a marketing event in the same location. Champion agents must still maintain a clear separation between the educational portion and any marketing activity.
- Before any marketing activity begins, the agent must clearly announce that the educational event has ended and that a sales or marketing event or personal marketing appointment will begin only after attendees have a sufficient opportunity to leave.
- Attendees must be given a genuine opportunity to exit without pressure, embarrassment, or loss of access to educational materials.
- No specific Champion plan benefits, enrollment applications, or marketing presentation may be discussed until the educational event has ended and the required transition has occurred.



Event Logistics

Event Reminders

- ✓ Events must be submitted at least 5 business days in advance.
- ✓ All written advertising materials must be approved by Champion Health Plan and CMS when required.
- ✓ Only certified and appointed Champion agents may present or staff events.
- ✓ During a Champion event, agents must exclusively market and enroll Champion Health Plan products.
- ✓ Agents must arrive at least 15 minutes before the event start time.
- ✓ Agents must stay at the event for a minimum of 15 minutes. If no one attends after 15 minutes, the agent may leave.
- ✓ Agents must dress in professional business attire and have identification.
- ✓ Events are subject to secret shopping by Champion Health Plan or CMS.
- ✓ Emergency cancellations require approved coverage or immediate notice to Champion Health Plan.

Canceling an Event

Agents must cancel events at least 48 hours before the scheduled date and time. If the event is canceled with less than 48 hours' notice, the plan sponsor must ensure a representative is present at the event site 15 minutes before and 15 minutes after the scheduled start time to inform beneficiaries that the event has been canceled. Champion must maintain internal records of event cancellation and reason.

Event Marketing Materials

Marketing Material Review

Agents may create custom materials, but they must be approved by Champion Compliance before publishing. Champion Sales and Compliance will review materials to determine whether the message is compliant and whether CMS filing is required. Once approved or submitted to CMS, materials may be used exactly as approved. Approved materials may not be altered.

- Use only CMS-approved and Champion-approved marketing materials when discussing Champion Medicare plans.
- Do not alter CMS-approved materials except to add permitted personal information such as agent name, phone number, email, or event date where allowed.
- Do not use unapproved advertisements.
- Do not create unauthorized plan comparisons.
- Do not display non-Champion materials in the immediate selling area during a Champion event.

HPMS Marketing Material Filing and Approval Workflow

- Marketing materials and election forms may not be distributed, displayed, emailed, posted, mailed, or otherwise made available until Champion Compliance confirms the material is approved, deemed approved, or eligible for File & Use under CMS rules.
- HPMS is the primary system of record for CMS marketing-material submissions. Agents must not submit materials directly to CMS or HPMS unless expressly authorized by Champion.
- Materials must be used exactly as approved. Agents may not change wording, layout, benefit descriptions, disclaimers, phone numbers, URLs, logos, or comparisons unless Champion Compliance approves the revised version before use.
- Materials developed by a TPMO for multiple plans or organizations must receive required plan review before HPMS submission and use.
- Agents must retire outdated materials immediately when Champion issues updated materials or when benefits, premiums, service areas, provider networks, formularies, ratings, disclaimers, or CMS requirements change.

Required Disclaimers and Content Checklist

- ✓ Federal Contracting Statement: include where required to convey that Champion Health Plan has a contract with Medicare and that enrollment depends on contract renewal.
- ✓ TPMO Disclaimer: include where required on TPMO calls, websites, electronic communications, advertisements, and other marketing materials.
- ✓ Star Ratings: use only CMS-approved Star Ratings content and disclaimers when referencing ratings.
- ✓ SSBCI Disclaimer: include required SSBCI eligibility and limitation language when mentioning SSBCI benefits.
- ✓ Accommodations Statement: include event accommodations language when required, including the special-needs accommodation phone and TTY number.
- ✓ Salesperson Statement: include “A salesperson will be present with information and enrollment form” on applicable sales-event advertisements and invitations.
- ✓ Promotional Giveaways: include CMS-required limitations and ensure gifts are nominal, not cash or cash equivalents, and not conditioned on enrollment.
- ✓ Provider/Pharmacy Network Statements: do not imply that non-contracted or out-of-network providers are available except as permitted by the specific CMS-approved plan materials.
- ✓ Co-Branded Provider Materials: include required disclaimers and obtain Champion Compliance approval before use.

Substantiation of Claims and Superlatives

- Do not use unsubstantiated superlatives or absolute claims such as “best,” “highest,” “most,” “largest,” “top,” “guaranteed,” “free,” or “all” unless the claim is accurate, current, substantiated, and approved by Champion Compliance.
- Any ranking, comparison, award, savings statement, provider-size claim, network claim, or quality claim must include the required source, date, scope, and limitations in the material.
- Agents may not make oral claims that would be prohibited or require substantiation if made in writing.

Logo Use

Agents must have an active logo-use contract before using the Champion Health Plan logo on materials or websites. Once countersigned by Champion Health Plan, the logo may be used only in the ways outlined in the contract.

Website Review

Agents who market Champion Health Plan Medicare products on their websites must submit their website to Champion Health Plan for review and approval. Websites must be reviewed again whenever changes are made. Agents are encouraged to link to Champion Health Plan product pages instead of posting PDFs or product information directly, to help ensure current information is available.

Agent and TPMO websites must keep Medicare Advantage and Part D content current, separate Medicare content from other lines of business, include required disclaimers, avoid misleading government affiliation, and comply with Champion and CMS review requirements. Websites must not require beneficiaries to provide more than CMS-permitted basic location information, such as ZIP code, county, or state, to access non-beneficiary-specific plan information. If a website directs users away from a Champion or Medicare-related page, it must clearly notify users when they are leaving the Medicare or plan site where required. Material benefit or plan changes must be updated promptly and no later than applicable CMS or Champion timeframes.

Social Media Review

Agents may use social media as a marketing vehicle, but messages must be approved before publishing. After approval or CMS submission, messages may be used exactly as approved and may not be altered.

Enrollment

Enrollment Form

The enrollment form submitted for the beneficiary must be for the correct coverage year, completed accurately, and completed in its entirety. Incomplete or incorrect enrollment forms may be rejected if Champion Health Plan cannot obtain missing or corrected information within required timeframes.

The Case Management Form or HRA-related form included with enrollment materials must be handled according to current Champion procedures. Agents are encouraged to ask beneficiary questions that help Champion Health Plan support ongoing supplies, care coordination, or services, but agents must follow approved HRA and enrollment procedures.

Enrollment Options

Mail: **Champion Health Plan - Enrollment**
5000 Airport Plaza Drive, Suite 100
Long Beach, CA 90815

Fax: **949-850-2552**

Email: **enrollment@championpayer.com**

Tracking Issues

If there is an issue with an enrollment form, the Champion Health Plan Enrollment Team will contact the agent. Agents must respond promptly so enrollment forms can be processed within CMS timeframes.

Cancellations

Before the effective date, an applicant may request cancellation by calling Champion Health Plan Member Services at **1-800-885-8000 | TTY 711** or by calling 1-800-MEDICARE. Applicants may also send a written, signed request to the Enrollment Department by mail, fax, or email. After the policy is in effect, members must mail or fax a written, signed request to cancel the policy, subject to applicable disenrollment rules.

Complaints and Escalations

Agents must promptly report beneficiary complaints, marketing concerns, compliance concerns, and urgent escalations. Retaliation for good-faith reporting is prohibited.

Reportable Concerns

- Beneficiary complaints
- Marketing concerns
- Compliance concerns
- Sales allegations
- Urgent escalations
- Improper enrollment concerns
- Privacy or security incidents
- Fraud, waste, or abuse concerns

Escalation Channels

- Compliance Department
- Broker Support
- Compliance Hotline, if applicable
- Sales Oversight
- Enrollment Department for enrollment-specific issues
- Events & Marketing for event or marketing-material issues

Language Access, Alternate Formats, and Accessibility

- Agents must use CMS-approved translated materials when required and must not create informal translations of marketing or enrollment materials without Champion Compliance approval.
- Required materials must be provided in applicable non-English languages and accessible formats according to CMS rules and Champion procedures, including standing requests when applicable.
- When a beneficiary needs interpreter assistance, translated materials, large print, audio, Braille, accessible electronic documents, or other alternate formats, agents must refer the request to Champion Member Services or the appropriate operational channel promptly.
- Materials must follow Section 508 and accessibility requirements when applicable. Agents must not alter CMS-approved formats in ways that reduce readability or accessibility.
- Agents should use qualified interpreters where appropriate and permitted, and should document language-access needs that the beneficiary or authorized representative identifies.

Documentation Retention

Agents must retain required records according to CMS and Champion Health Plan policy. Records must be organized, secure, and retrievable upon request. Agents must provide requested enrollment, marketing, lead, Permission-to-Contact, Scope of Appointment, call-recording, and related records within four business days after Champion Health Plan's request, or within any shorter period required by CMS, another regulator, an audit, or an investigation.

Item	Retention Period
Scope of Appointment forms and SOA records, including paper, electronic, audio, and audio-visual records	10 years. Note: SOA validity for permitted contact and appointments is 12 months from the beneficiary signature date or initial request date; retention is separate from validity.
Marketing, sales, and enrollment call recordings	Agents and TPMOs must retain all required marketing, sales, and enrollment call recordings in their entirety for ten years under the Agent Agreement. For years 1 through 3, the complete audio recording must be retained. For years 4 through 6, the complete audio recording must be retained unless Champion Health Plan expressly authorizes use of a complete and accurate transcript consistent with CMS requirements. For years 7 through 10, records must be retained in the form required by Champion Health Plan policy and the Agent Agreement. Records subject to an audit, investigation, complaint, litigation hold, or regulatory request must be retained until Champion Health Plan authorizes their disposition, even if the normal retention period has expired.
Enrollment documents, election forms, and enrollment-related records	10 years, unless a longer period is required by CMS, Champion policy, audit, investigation, or litigation hold.
Event records, including optional sign-in sheets, cancellation documentation, presentations, advertisements, and marketing materials	Minimum of 10 years after CMS contract termination or CMS audit, whichever is later.
Educational-event records, including materials, invitations, SOAs collected, and transition documentation when a marketing event follows	10 years, unless a longer period is required by CMS or Champion policy.
Training records and certification records	10 years.
Agent attestations	10 years.
Permission-to-Contact documentation, business reply cards, lead forms, and consent records	10 years, unless a longer period is required by CMS or Champion policy. PTC validity and permissible scope are separate from retention.
HRA documentation and administrative-fee support	10 years, unless a longer period is required by CMS or Champion policy.
Marketing-material approvals, HPMS filing support, substantiation files, and website/social-media approvals	10 years, unless a longer period is required by CMS or Champion policy.
Complaint, sales allegation, investigation, corrective-action, and disciplinary-action records	10 years, unless a longer period is required by CMS, Champion policy, audit, investigation, or litigation hold.

Agent Portal

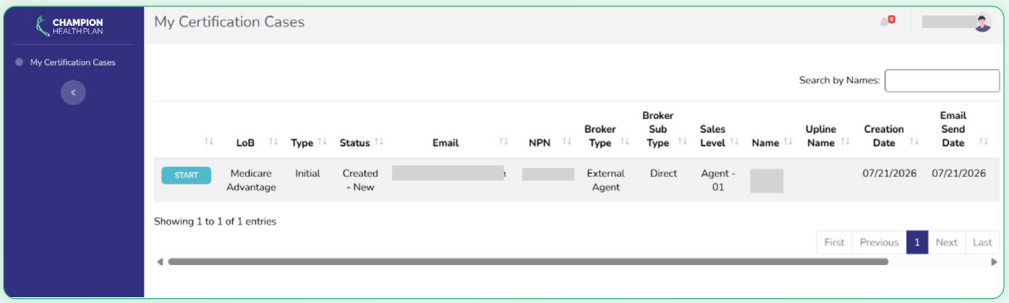
Champion Health Plan provides an Agent Portal with features that help agents manage business and certification status.

- **Check member IDs**
- **View current book of business and export it to Excel**
- **Check processed and pending applications**
- **Access disenrollment reports**
- **Order marketing and sales materials through the Champion Store**
- **Track certification status and required tasks**

How to Use the Agent Portal

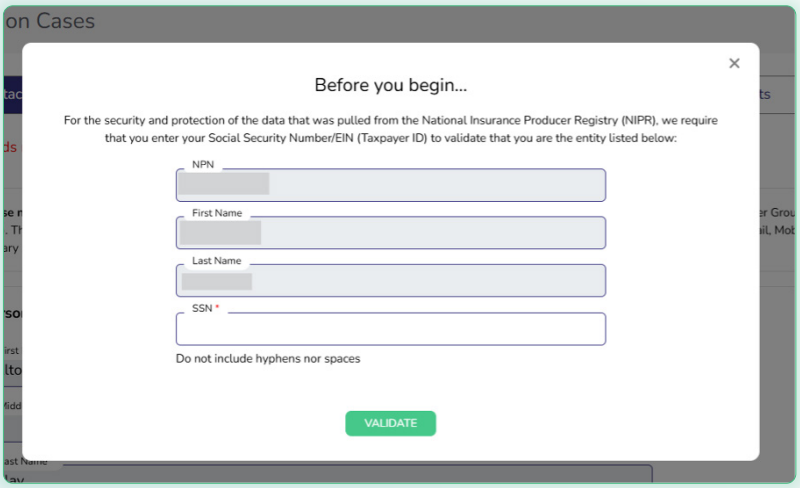
Step 1

When brokers log in, they can select “My Certification Case” and Start.



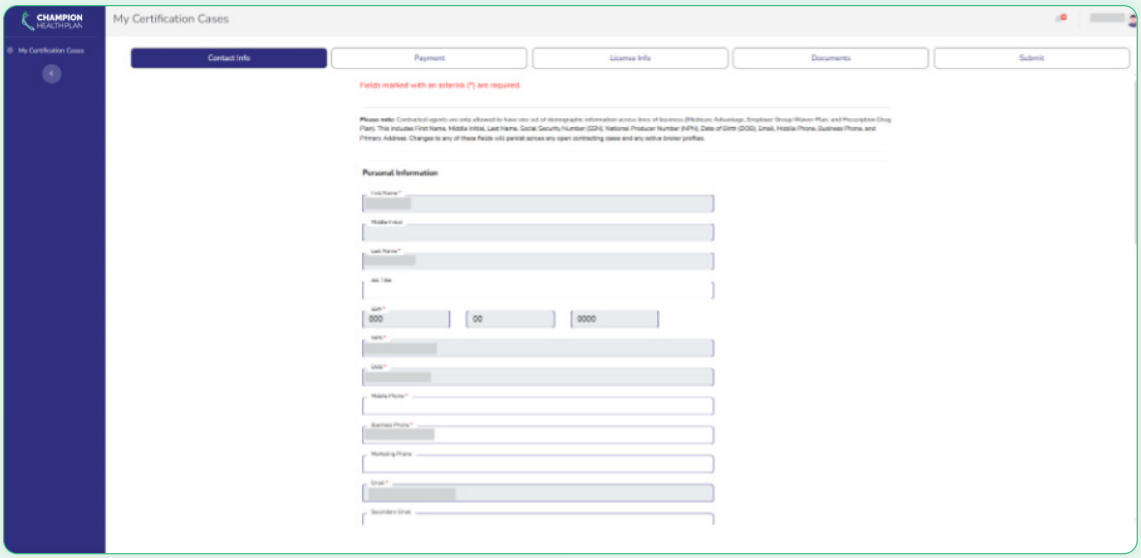
Step 2

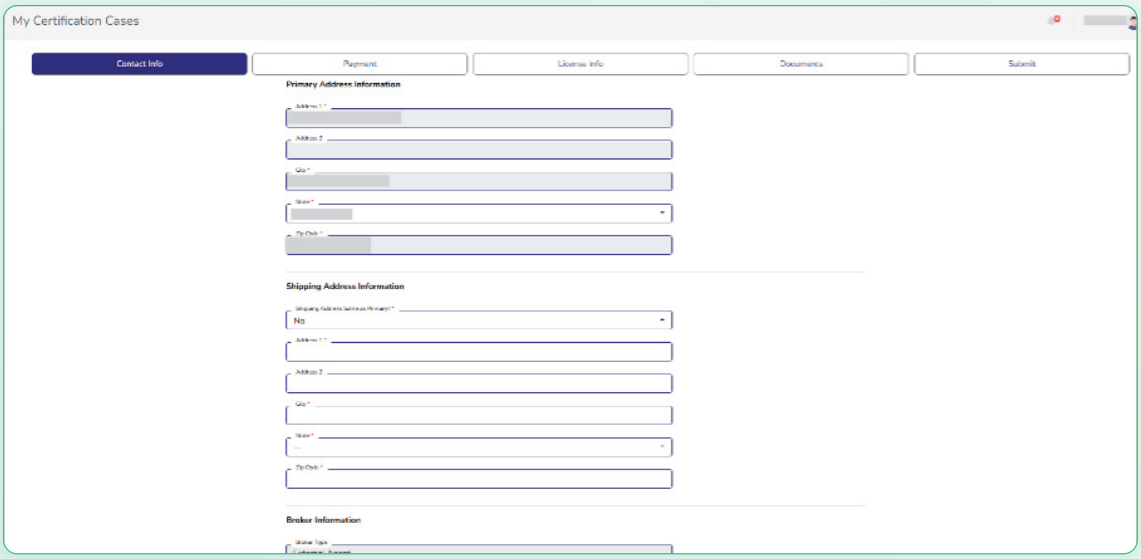
Before you begin, required fields to validate.



Step 3

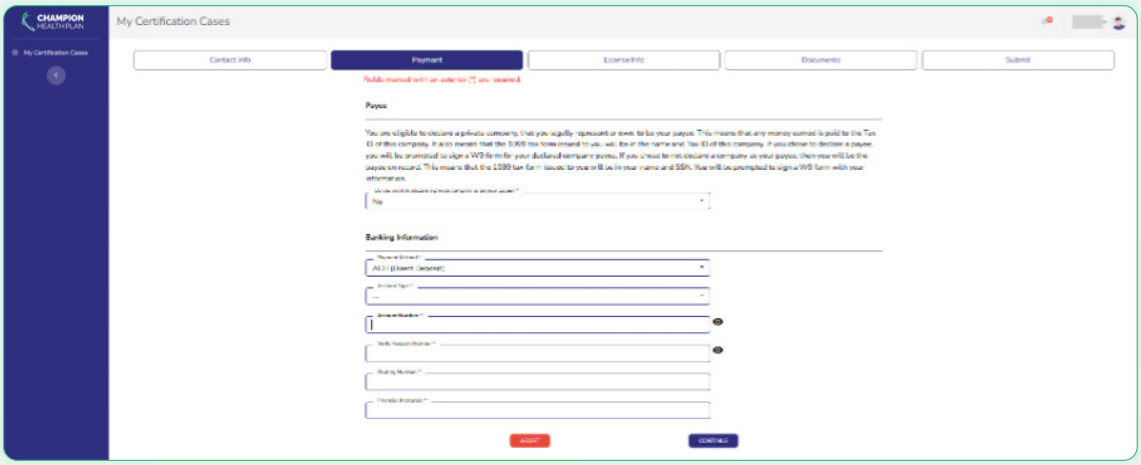
Contact Information





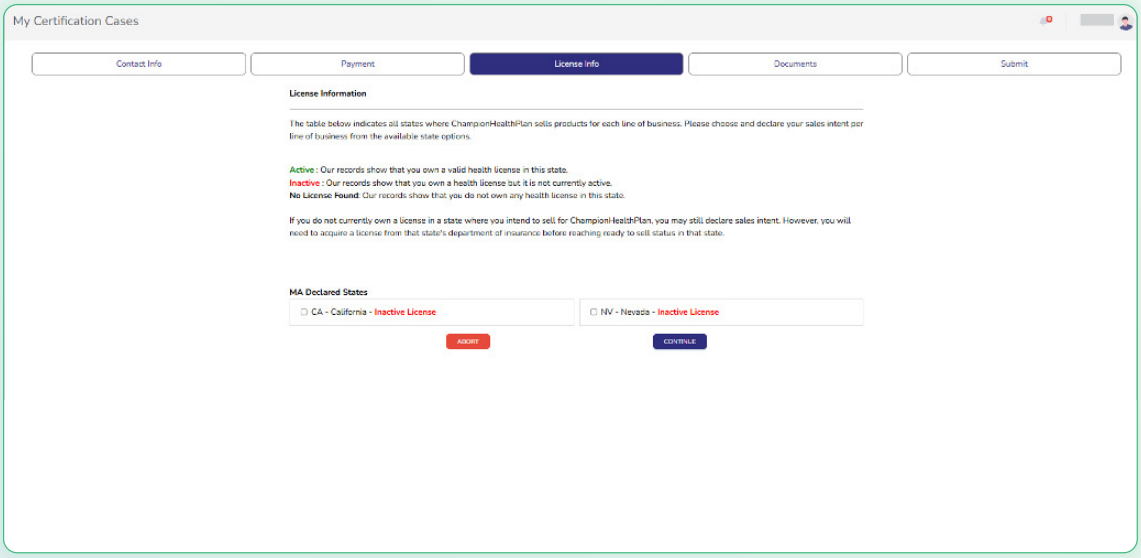
Step 4

Payment Information



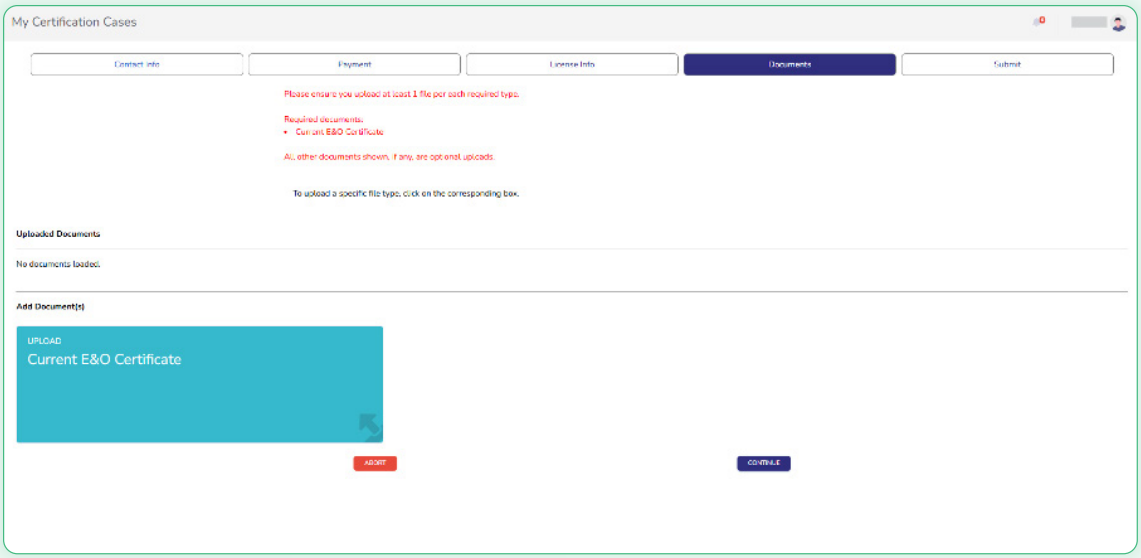
Step 5

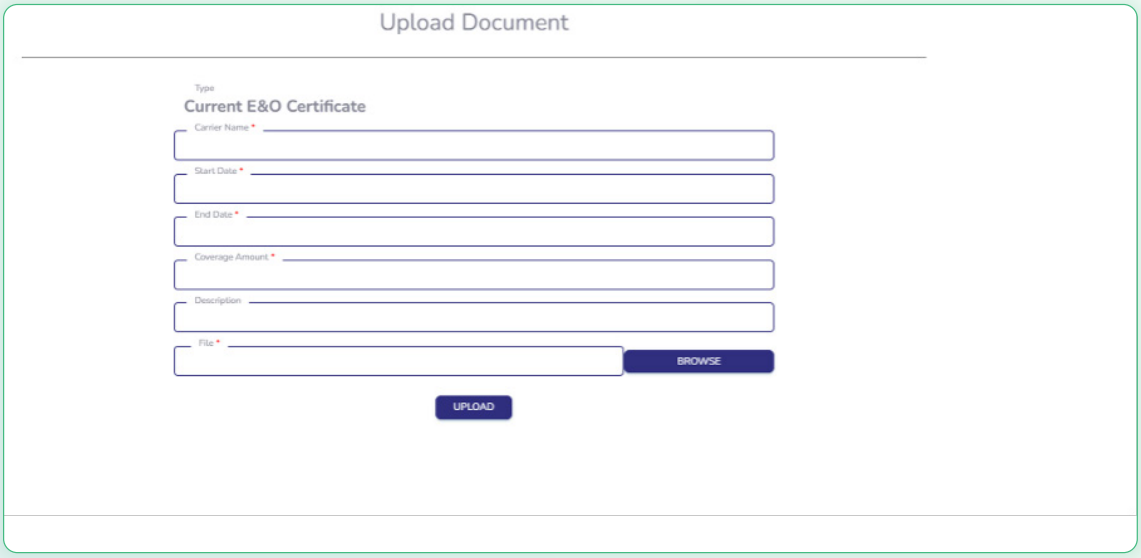
License Information



Step 6

Documents (Current E&O Certificate)

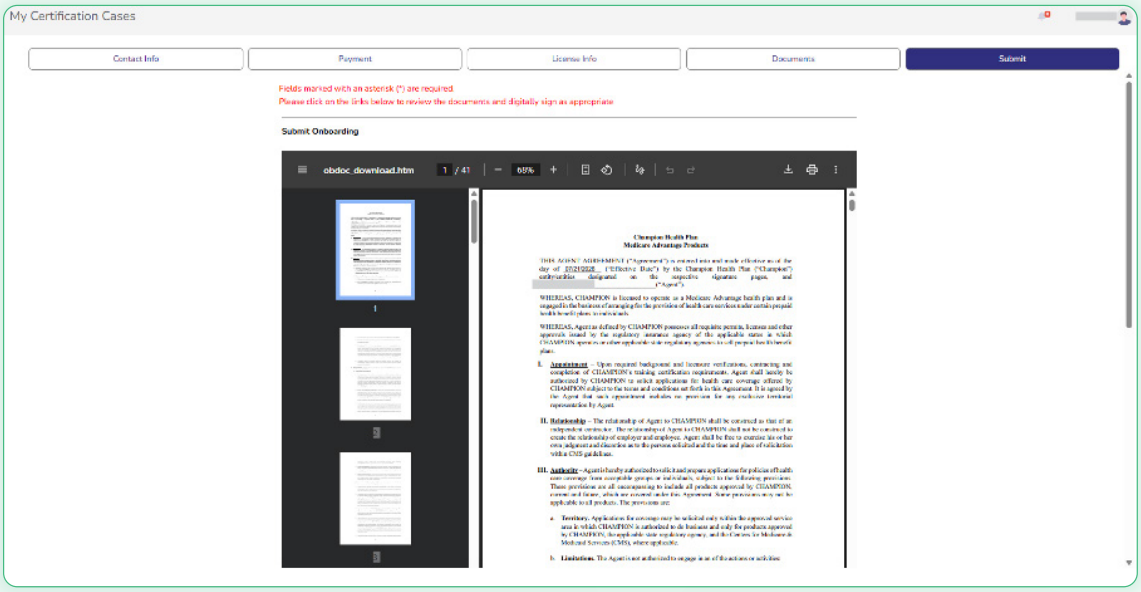


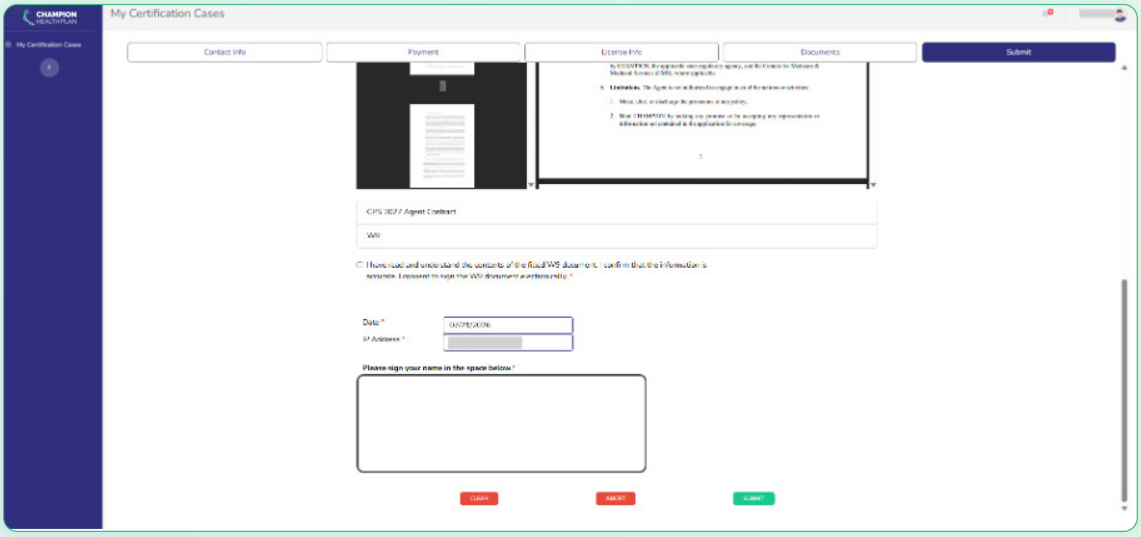


Step 7

Review and Sign Contract/Agreement

- W9

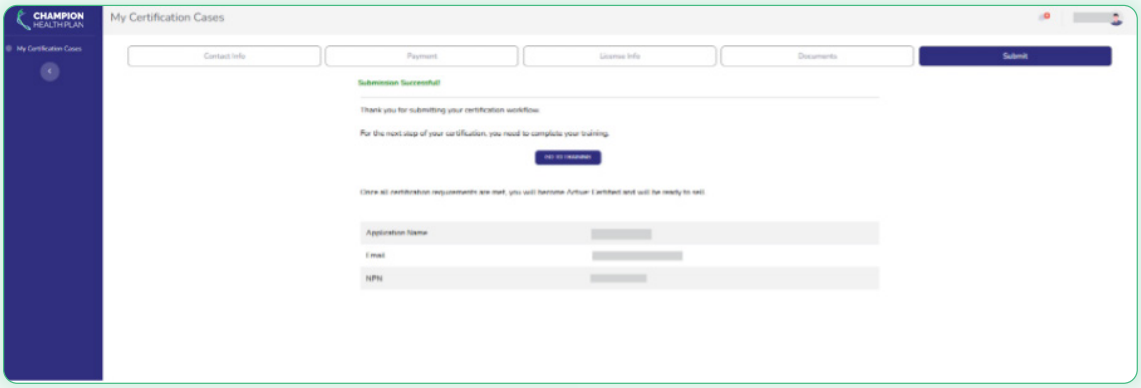




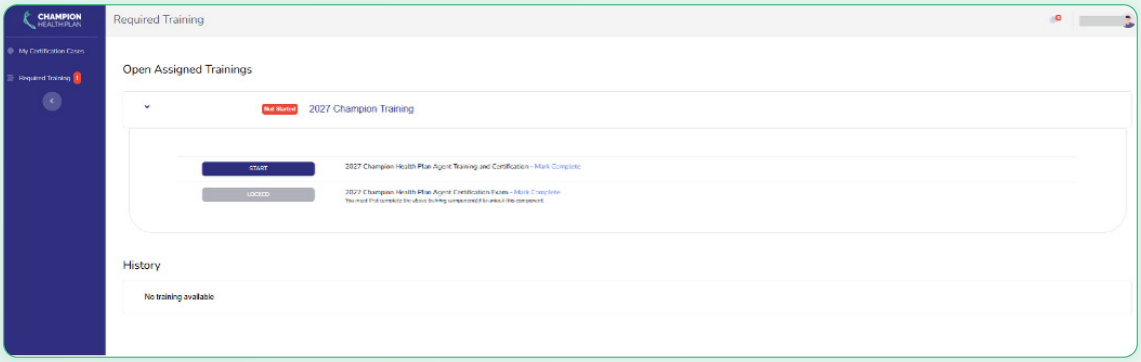
Step 8

Submission Successful

- This will allow you to go directly to the required training.



- Submit Step, this will take you to the required training



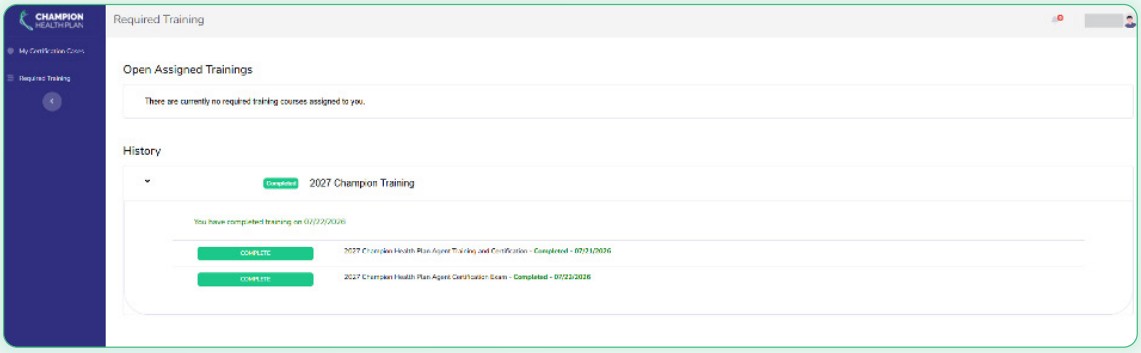
- Training materials

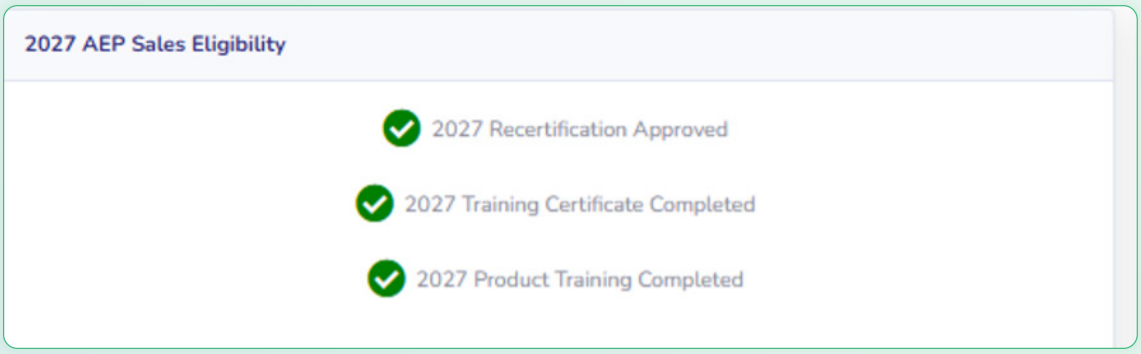


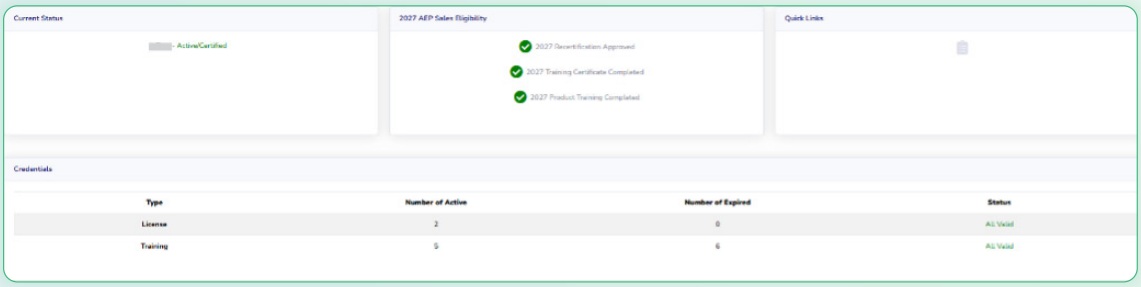
- Training Exam



- Both components complete.







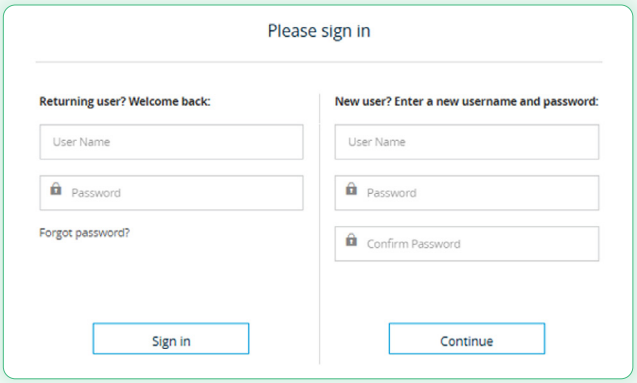
Champion Store

The Champion Store provides access to Champion sales materials and enrollment booklets. Agents must use only approved materials and must follow all ordering and usage instructions.

Registration and Dashboard Access

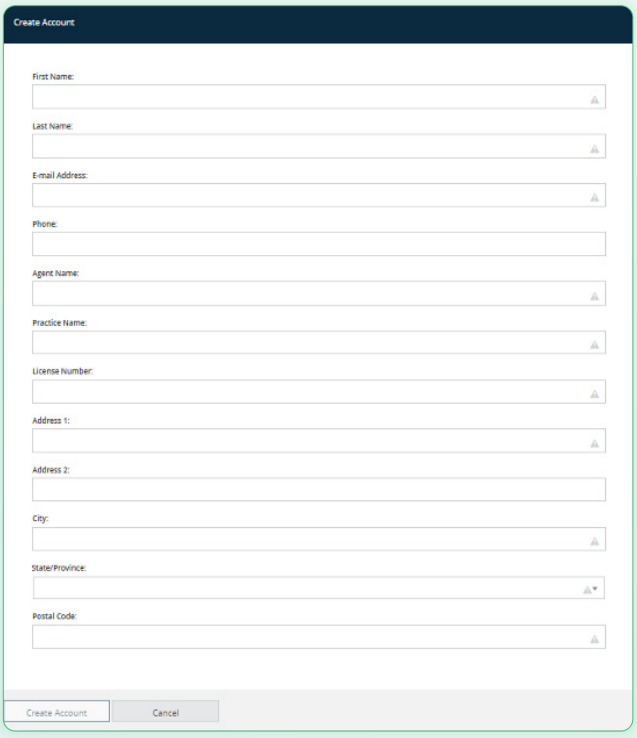
Step 1

Visit **https://www.eosprints.com/chp**. Under the “New User?”, enter your User Name and Password and click Submit.



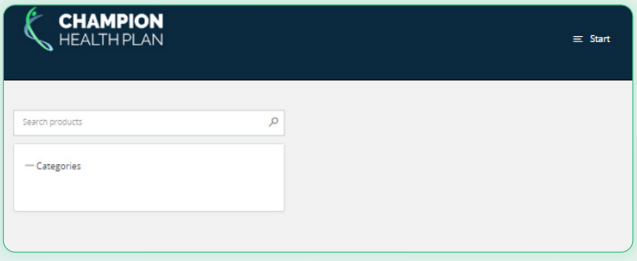
Step 2

A new page will open where you can add your account information.



Step 3

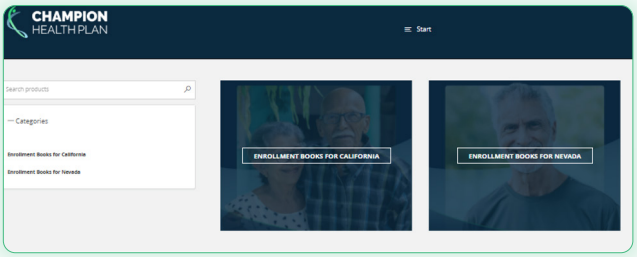
You will next see your home page which will remain empty until your profile has been approved.



Ordering Materials

Step 1

- Once your profile has been approved you can browse to view PY27 AEP Enrollment materials for California and Nevada.
- Click Browse Now in the dashboard to view available materials, including PY27 AEP Enrollment Booklets for California and Nevada and other approved Champion collateral and supplies.



Step 2

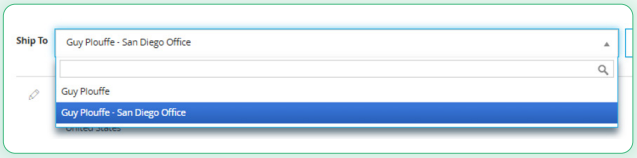
- Select a product and fill out the “Options” and optionally “Name your Product” if you want to provide a custom name for your convenience.
- Select “Add to cart” and when ready and either “Return to Products” if you want to add additional items to your cart or “Proceed to Checkout” when ready.
- Add any “Special Instructions” then “Place Order”



Step 3

You have an opportunity to add another shipping address before checking out. Then select your desired shipping address.

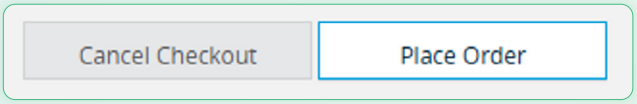




Step 4

Click “Place Order” to complete your order.

- After the order has been placed, please allow 72 hours for packaging and shipping.



Required Agent Attestations

Agents may be required to complete attestations as part of Champion Health Plan certification and ongoing compliance. Attestations must be completed truthfully and retained according to policy.

CMS Compliance Attestation

I attest that I understand and will comply with applicable CMS Medicare regulations and Champion Health Plan policies.

Ethical Conduct Attestation

I agree to conduct all sales and marketing activities ethically and in the best interest of Medicare beneficiaries.

Privacy and Security Attestation

I agree to protect beneficiary information and comply with HIPAA privacy requirements.

Reporting Obligation Attestation

I agree to promptly report suspected compliance violations, fraud, waste, abuse, privacy concerns, improper enrollments, and beneficiary complaints.

Final Certification Statement

Completion of required training, attestations, and successful passage of the Champion Health Plan certification examination authorizes the agent to market and sell approved Champion Health Plan MAPD HMO/POS products for the applicable plan year, subject to ongoing compliance with CMS regulations and Champion Health Plan policies and procedures.

Resources and Standardized Contact Channels

The following contact channels should be used consistently across the Agent Manual, training materials, and agent communications unless Champion Health Plan issues updated guidance.

Function	Contact
Member Services	1-800-885-8000, TTY 711
Broker Support / Agent Support	brokersupport@championpayer.com 1-800-885-8000, TTY 711
Enrollment	enrollment@championpayer.com | Fax: 949-850-2552 Mail: Champion Health Plan - Enrollment 5000 Airport Plaza Drive, Suite 100, Long Beach, CA 90815
Events & Marketing	events@championpayer.com
Champion Website	www.championhmo.com
CMS	1-800-MEDICARE (1-800-633-4227), TTY 711 | medicare.gov
Social Security Administration	1-800-772-1213, TTY 711 | ssa.gov

Additional Reference Resources

Centers for Medicare and Medicaid Services (CMS)
Call toll-free at 1-800-MEDICARE 1-800-633-4227 TTY | 711 24 hours a day, 7 days a week. medicare.gov

CMS Medicare Communications and Marketing Guidelines
https://www.cms.gov/files/document/medicare-communications-marketing-guidelines-2-9-2022.pdf

CY 2027 Medicare Advantage and Part D Final Rule marketing and communications provisions
https://www.federalregister.gov/documents/2026/04/06/2026-06600/medicare-program-contract-year-2027-and-certain-contract-year-2026-policy-and-technical-changes-to

Social Security Administration
Call toll-free at 1-800-772-1213, TTY 711, 7 am - 7 pm, 7 days a week | ssa.gov

CMS Eligibility and Enrollment Guidance
https://www.cms.gov/Medicare/Eligibility-and-Enrollment/MedicareMangCareEligEnrol/index.html

CMS Medicare Online Enrollment Center
medicare.gov

CMS Plan Finder
medicare.gov or (1-877-486-2048) www.medicare.gov/find-a-plan/questions/home.aspx

CMS Star Ratings
medicare.gov

HIPAA Privacy Rule and Disclosure Requirements
https://www.hhs.gov/ocr/privacy/

HIPAA Privacy Rule and Security Requirements
https://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/privacyguidance.html

Internal Revenue Service (IRS) Tax publications
https://www.irs.gov or 1-800-TAX-FORM (1-800-829-3676)

Medicare.gov Complaint Website
https://www.medicare.gov/MedicareComplaintForm/home.aspx

Marketing Models, Standard Documents, and Educational Material
https://www.cms.gov/medicare/health-drug-plans/managed-care-marketing/models-standard-documents-educational-materials

Medicare Prescription Drug Benefit Manual
https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/PartDManuals.html

National Coverage Determinations (NCD)
https://www.cms.gov/medicare-coverage-database/indexes/ncd-alphabetical-index.aspx

Section 508 of the Rehabilitation Act
https://www.section508.gov

WEDI Health Identification Card Implementation Guide
wedi.org

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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