Elite Health
MEDICARE ADVANTAGE

2027 SUMMARY OF BENEFITS

ELITE HEALTH PLAN SIGNATURE (HMO) 001

JANUARY 1, 2027 – DECEMBER 31, 2027

PROUDLY SERVING:
LOS ANGELES • SAN BERNARDINO • RIVERSIDE

H6368_SB_2027_PBP_001_M

Elite Health
MEDICARE ADVANTAGE

2027 IMPORTANT PLAN INFORMATION

Elite Health Plan is a Medicare Advantage HMO plan with a Medicare contract. Enrollment in the Plan depends on contract renewal.

The benefit information provided does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please call 1-800-958-1129 (TTY 711) and request the "Evidence of Coverage" or access it online at www.EliteHealthPlan.com.

To join Elite Health Plan (HMO), you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. Our service area includes the following counties in California: Los Angeles, Riverside, and San Bernardino.

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

For coverage and costs of Original Medicare, look in your current "**Medicare & You**" handbook. View it online at www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 7 days a week, 24 hours a day. TTY users should call 1-877-486-2048.

This document is available in other formats such as Braille, large print or audio.

For more information, please call us at 1-800-958-1129 (TTY users should call 711). Hours are 8 a.m. to 8 p.m. Monday-Friday (April 1-September 30). 7 Days (October 1-March 31).

Or email MemberServices@EliteHealthPlan.com
Or visit us at www.EliteHealthPlan.com.

MEDICAL & HOSPITAL BENEFITS

* Your plan provider may need to provide a referral
† Prior authorization may be required

BENEFITS & COSTS	SIGNATURE (HMO) 001
Monthly Plan Premium (includes both medical & drugs)	**$0** You must continue to pay your Medicare Part B premium.
Part B premium reduction (buy-down)	Not offered
Medical Deductible	**$0**
Maximum Out-of-Pocket Responsibility (MOOP) • This is the most you pay annually for covered Medicare services. • Does not include Part D prescription drugs	**$500** annually
Inpatient Hospital * † If your stay goes beyond 90 days, you can utilize your Medicare-covered lifetime reserve days.	**$0** per day for days 1-90
Outpatient Hospital * †	**$0** per visit
Ambulatory Surgical Center (ASC) * †	**$0** per visit
Doctor Visits • Primary Care Provider • Specialists * †	 **$0** per visit **$0** per visit
Preventive Care † See the EOC for details	**$0** per visit
Emergency Care • We cover emergency care anywhere in the world	**$150** per visit. Waived if admitted. **$100** per Worldwide visit. Waived if admitted. Worldwide coverage for urgent or emergency care and emergency transport anywhere in the world up to $25,000/calendar year. See Additional Benefits Section for Worldwide Coverage.
Urgently Needed Services • We cover urgent care anywhere in the world	**$0** per office visit **$50** per Urgent Care Worldwide visit. Waived if admitted. Worldwide coverage for urgent or emergency care and emergency transport anywhere in the world up to $25,000/calendar year. See Additional Benefits Section for Worldwide Coverage.

BENEFITS & COSTS	SIGNATURE (HMO) 001
Diagnostic Services/Labs/Imaging * † • Lab tests • X-rays and ultrasounds • Diagnostic tests & procedures (like EKG) • MRI, CT scans, and PET scans * †	**$0** **$50** per visit
Hearing Services • Evaluations to diagnose medical conditions. See Additional Benefits Section for routine care	**$0**
Dental Services • Medicare Covered See Additional Benefits Section for routine care	**$0**
Vision Services • Visits to diagnose and treat eye diseases & conditions (preventative glaucoma screenings) • Diabetic retinopathy services • Eyeglasses after cataract surgery See Additional Benefits Section for routine care	**$0** **$0** **$0**
Mental Health Services *† • Inpatient mental health • Outpatient group therapy • Outpatient individual therapy	 **$125** per day for days 1 through 5 of your stay and **$0** for the rest of your stay for days 6 through 90. **$0** per visit **$25** per visit
Skilled Nursing Facility * † • Cover up to 100 days per benefit period	**$0** per day for days 1 through 20 **$75** per day for days 21 through 100
Physical Therapy * †	**$0** per visit
Ambulance • Ground transport • Air transport †	**$210** per one-way trip (includes worldwide) **20%** coinsurance Air Ambulance per one-way trip
Transportation	See Additional Benefits Section for routine care
Medicare Part B Drugs † • Drugs that must be administered by a health care professional • Medicare Part B drugs are covered when you get them from a plan provider.	**$0–20% coinsurance** depending upon the drug (please call Member Services to find out which drugs are provided at a coinsurance). Some drugs may be less than 20% if those drugs are determined to exceed the amount of inflation.
Medicare Part B Insulin Drugs (up to a 30–day supply from a plan pharmacy)	Either a **$15** copayment and/or **25% (whichever is less)** for a one-month supply of Part B insulin drugs furnished through an item of Durable Medical Equipment (DME)

OUTPATIENT PRESCRIPTION DRUG Cost-Sharing may change depending on how you choose to receive your drugs.		
BENEFITS & COSTS	**SIGNATURE (HMO) 001**	
STAGE 1 ANNUAL DEDUCTIBLE	**$0** annual deductible.	
STAGE 2 INITIAL COVERAGE	You pay the following until your maximum out-of-pocket reaches $2,400.	
	Retail Pharmacy (In-network)	**Mail Order (In-network)**
Tier 1 Preferred Generic	**$0** up to 90-day supply	**$0**
Tier 2 Generic	**$0** up to 90-day supply	**$0**
Tier 3 Preferred Brand	**$35** up to 30-day supply **$70** up to 60-day supply **$105** up to 90-day supply	**$105** up to 90-day supply
Tier 4 Non-Preferred Brand	**$98** up to 30-day supply	**Not Available**
Tier 5 Specialty Tier	**33%** up to 30-day supply	**Not Available**
Tier 6 Select Care Drugs	**$0** up to 90-day supply	**$0**
STAGE 3 CATASTROPHIC COVERAGE	After the total yearly maximum out-of-pocket drug cost reaches $2,400, you will stay in this stage until the end of the calendar year.	
Tier 1 to Tier 6	**$0**	**$0**
Insulin	Regardless of the cost-share **Tier**, you will not pay more than 25% of the cost of the drug **OR** **$15** up to 30-day supply **$30** up to 60-day supply **$45** up to 90-day supply	
Vaccines	You will not pay a deductible or a copay for Advisory Committee on Immunization Practices (ACIP) recommended adult vaccines regardless of the cost-sharing tier.	
Bonus Drug Coverage	Coverage for the erectile dysfunction drug Sildenafil is available at the Tier 2 copay, subject to a quantity limit of 6 tablets per 30 days. The amount you pay does not count toward your deductible or your total drug costs used to determine eligibility for catastrophic coverage.	

ADDITIONAL BENEFITS	* Your plan provider may need to provide a referral
BENEFITS & COSTS	**SIGNATURE (HMO) 001**
Flex Benefits Allowance (Nations Debit Card) Items must be received through a "Nations Benefits" contracted provider or vendor. This allowance may be used for items and activities such as gym membership (not a personal trainer), memory or memory fitness programs, activity tracker, prescription hearing aids (at a discount) with exam and fittings. The allowance also allows for the purchase of eligible OTC health and wellness products (including hearing aids) through the Plan's OTC catalog and other Plan-approved purchasing channels. Members who qualify for SSBCI (Special Supplemental Benefits for the Chronically ill) through verification of Plan covered SSBCI conditions can use the Debit Card benefits to purchase groceries.	**This plan gives you $450.00 every three months** to spend on certain health items. Previous quarterly balance will be rolled over but must be used by 12/31/2027. Members will lose remaining funds upon disenrollment. Funds are added to the card on your start date and again on April 1, July 1, and October 1.

1. **Groceries – SSBCI Benefit**
Groceries must be received through a "Nations Benefits" contracted provider or vendor. Members who qualify for SSBCI (Special Supplemental Benefits for the Chronically ill) through verification of Plan covered SSBCI conditions can use the Debit Card benefits to purchase healthy food and produce items only if the member has an eligible chronic condition. Providers' validation of condition **is required**.
 	
ELIGIBLE CONDITION'S INCLUDE:
• Cardiovascular Disorders
  • Cardiac Arrhythmias
  • Chronic Heart Failure
  • Coronary Artery Disease
  • Peripheral Vascular Disease
  • Chronic Venous Thromboembolic Disorder
• Chronic Lung Disorders
  • Asthma
  • Chronic Bronchitis
  • Emphysema
  • Chronic Obstructive Pulmonary Disease (COPD)
• Diabetes
• Chronic Alcohol Use Disorder and/or Other Substance Use Disorder (SUDs)
• Chronic Conditions that Impair Vision, Hearing (deafness), Taste, Touch, and Smell
• Overweight, Obesity, and Metabolic Syndrome
 	
The chronic condition must be verified by the member's PCP.
 	
Alcohol, firearms, lottery and tobacco products are excluded from the Flex Benefit Allowance.
	Healthy Food & Produce (groceries) can be purchased at a contracted grocery store with available flex benefit allowance.
	
	Members must meet SSBCI eligibility requirements.

BENEFITS & COSTS	SIGNATURE (HMO) 001
2. **Fitness benefit** (this is through the flex benefit allowance for gym memberships, memory or fitness programs, activity trackers, etc.) 3. **Hearing aids** We provide prescription hearing aids at a discounted price. You can also obtain over-the-counter hearing aids with flex card dollars. Both must be purchased through a "Nations Benefits" contracted provider or vendor. Hearing exam, hearing aid fittings and evaluation of hearing aids. 4. **Over the counter (OTC) products*** Through the Flex Benefits Allowance (Nations Debit Card) - items must be received through a "Nations Benefits" contracted provider or vendor. Alcohol, firearms, lottery and tobacco products are excluded from the Flex Benefit Allowance.	**Fitness Benefit** is available through the Flex Benefit Allowance **Hearing Aids** can be purchased at a discounted rate with available flex benefit allowance **$0 up to available allowance** **OTC** items can be purchased with your available flex benefit allowance **$0 up to available allowance**
Dental Care • Diagnostic and Preventive dental • Comprehensive Dental (endodontics and periodontics) (does **not** include implants or dentures) • Oral and Maxillofacial surgery • Restorative Dental • Adjunctive General **See EOC for full details**	**$0** copay for **a maximum annual spend of $2,000**
Routine Acupuncture (non-Medicare) • 12 visits total per calendar year. No prior authorization or referral is required.	**$10** per visit
Routine Chiropractic (non-Medicare) • 12 visits total per calendar year. No prior authorization or referral is required.	**$10** per visit
Routine Eyewear • We provide a routine eye exam annually • We provide an allowance to buy eyewear (lenses/frames, contact lenses) every calendar year	**$0** per visit **$250** allowance per year
Routine Therapeutic Massage (non-Medicare) • 12 visits total per calendar year. No prior authorization or referral is required.	**$10** per visit
Transportation • Uber Health rideshare trips per year to a health-related location.	**$0** per one-way trip (24 one-way trips)
Worldwide Coverage • Worldwide emergency and urgently needed care is covered for services to evaluate or stabilize an emergency medical condition when outside of the United States.	**$25,000** Maximum Allowance for all worldwide coverage. • **$100** copayment for worldwide emergency services (waived if admitted) • **$50** copayment for worldwide urgently needed services. (waived if admitted) • **$150** copayment for worldwide emergency transportation (fixed wing and rotary aircraft not included)