CHAMPION HEALTH PLAN



Summary of *Benefits*

Champion Advantage (HMO-POS C-SNP) H6474-001

Carson City, Churchill, Clark and Washoe Counties

H6474_SB001NV2027_M

2027 Summary of *Benefits*

CHAMPION HEALTH PLAN

Champion Health Plan

January 1, 2027 - December 31, 2027

Champion Health Plan is an HMO, HMO C-SNP and HMO-POS C-SNP with a Medicare contract. Enrollment in Champion Health Plan depends on contract renewal.

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

To join **Champion Advantage (HMO-POS C-SNP)** you must be entitled to Medicare Part A, be enrolled in Medicare Part B, live in our service area, and have Chronic Kidney Disease (CKD), including those with End Stage Renal Disease (ESRD) (any mode of dialysis). Our service area includes the following counties in Nevada: Carson City, Churchill, Clark and Washoe.

As a Point-of-Service (POS) plan, you can use providers outside of the plan's network but you may have an additional cost. If you use an out-of-network provider that is not participating in Medicare, neither Medicare nor Champion Advantage (HMO-POS C-SNP) will pay for those services. Make sure your provider participates in Medicare.

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

For more information, please call us toll-free at 1-800-885-8000. From October 1 - March 31, we're available 7 days a week, 8 am to 8 pm Pacific time (PT). From April 1 - September 30, we're available Monday through Friday, 8 am to 8 pm PT. You can also visit us at championhmo.com.

PLAN DETAILS	IN-NETWORK	OUT-OF-NETWORK
Monthly Premium	$0	$0
Plan Deductible	No Deductible	No Deductible
Annual Maximum Out of Pocket (MOOP)	$999 (combined for in-network and out-of-network covered services)	
Inpatient Hospital*	$0 Copay per stay	Not Covered

*Services may require authorization and/or a referral.

PLAN DETAILS	IN-NETWORK	OUT-OF-NETWORK
Outpatient Hospital and Ambulatory Surgery Centers (ASC)*	$100 Copay per visit outpatient hospital services $0 Copay for surgery in an Ambulatory Surgery Center $0 Copay for outpatient hospital observation	$100 Copay per visit outpatient hospital services $0 Copay for surgery in an Ambulatory Surgery Center $0 Copay for outpatient hospital observation
Primary Care Providers	$0 Copay	$0 Copay
Specialists*	$0 Copay Authorization may be required for all services except nephrology.	$0 Copay Authorization may be required for all services except nephrology.
Preventive Services (Medicare Covered Screenings)	$0 Copay	$0 Copay
Emergency Care (Hospital Emergency Department) **Worldwide Emergency Care**	$150 Copay Copay is waived if admitted to hospital within 24 hours for related health event.	$150 Copay Copay is waived if admitted to hospital within 24 hours for related health event. $0 Copay for up to $100,000 maximum Worldwide benefit limit reimbursable by the plan not to exceed 60% of local Medicare rates. Combined with Worldwide Urgently Needed Care.
Urgent Care Services (Non-hospital Urgent Care Center) **Worldwide Urgently Needed Care**	$0 Copay	$0 Copay $0 Copay for up to $100,000 maximum Worldwide benefit limit reimbursable by the plan not to exceed 60% of local Medicare rates. Combined with Worldwide Emergency Care.

*Services may require authorization and/or a referral.

PLAN DETAILS	IN-NETWORK	OUT-OF-NETWORK
Diagnostic Services/Labs/ Imaging* • Diagnostic tests and procedures • X-Rays • Lab Services • Diagnostic radiology services (such as MRI, CT Scans) • Therapeutic radiology services (such as radiation treatment for cancer)	$0 Copay Diagnostic tests and procedures and lab services may require authorization and a referral.	$0 Copay Diagnostic tests and procedures and lab services may require authorization and a referral.
Hearing Services • Medicare-covered services • Routine hearing exam and fitting/evaluation for hearing aid • Hearing Aid	$0 Copay for Medicare-covered services every year $0 Copay for one routine exam and one fitting/evaluation for hearing aids every year $149 Copay per hearing aid (all models) up to (2) aids every (3) years for TruHearing Advanced hearing aids.	$0 Copay for Medicare-covered services Routine hearing exam, hearing aid fitting/evaluations, and hearing aids are not covered.
Dental Services* • Medicare covered dental services • Preventive dental services (exams, cleanings, fluoride treatments, x-rays, other dental services) • Comprehensive dental services (restorative, periodontics, endodontics, prosthodontics, surgeries)	$0 Copay for Preventive Dental Services and Medicare-covered dental services 20% to 40% of the Cost for Comprehensive Dental Services $3,000 yearly benefit coverage limit for preventive and comprehensive dental services combined	$0 Copay for Medicare-covered dental services Preventive and Comprehensive Dental Services are not covered out-of-network.

*Services may require authorization and/or a referral.

PLAN DETAILS	IN-NETWORK	OUT-OF-NETWORK
Vision Services		
• Medicare covered eye exam	$0 Copay for a Medicare-covered exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening)	$0 Copay for a Medicare-covered exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening)
• Medicare covered frames and lenses or contacts	$0 Copay for (1) pair of Medicare-covered eyewear (eyeglasses (lenses and frames)) after a cataract surgery	$0 Copay for (1) pair of Medicare-covered eyewear (eyeglasses (lenses and frames)) after a cataract surgery
• Routine eye exam	$0 Copay for (1) routine eye exam, refraction up to (1) per year	Routine eye exams and eyewear are not covered
• Routine frames and lenses, or contacts	$350 Allowance for routine frames and lenses and upgrades every year	
Mental Health Inpatient*	$100 Copay for days 1-10 $0 Copay for days 11-90	Not Covered
Mental Health Outpatient* (Medicare-covered individual and group sessions)	$0 Copay	$0 Copay
Skilled Nursing Facility*	$0 Copay for days 1-20 $221 Copay for days 21-100	Not Covered
Outpatient Rehabilitation*		
• Physical Therapy • Speech Therapy • Occupational Therapy	$0 Copay	$0 Copay
Ambulance Services*	20% of the Cost for Medicare covered air ambulance services $0 or $125 of the Cost for Medicare-covered ground ambulance services Minimum Cost share applies to non-emergency ground ambulance transport	20% of the Cost for Medicare-covered air ambulance services $0 or $125 of the Cost for Medicare-covered ground ambulance services Minimum Cost share applies to non-emergency ground ambulance transport

*Services may require authorization and/or a referral.

PLAN DETAILS	IN-NETWORK	OUT-OF-NETWORK
Transportation	$0 Copay 40 one-way plan-approved health-related locations. Maximum mileage per trip is 25 miles.	Not Covered
Medicare Part B Drugs	0% to 20% of the Cost $0 to $15 Copay for a 30-day supply of insulins	0% to 20% of the Cost $0 to $15 Copay for a 30-day supply of insulins
Dialysis	$0 Copay	20% of the Cost You are eligible for reimbursement at 80% of the Medicare rate up to a maximum allowance of $25,000 per year for dialysis services received in Mexico.
Durable Medical Equipment (DME)*	DME, prosthetics, and medical supplies: $0 for items $100 or less 20% of the Cost for items over $100	DME, prosthetics, and medical supplies: $0 for items $100 or less 20% of the Cost for items over $100
Over-the-Counter Items / Healthy Foods / Utilities Benefit	$270 Allowance every quarter. Eligible members pay $0 Copay for a debit card to use on over-the-counter items, healthy foods and produce, and assistance with utility costs. Any unused monthly amounts not used within 90 days do not roll over to the next period.^	Not Covered
ESRD Care / Transportation for Dialysis Treatment	Eligible members receive up to 200 one-way trips to dialysis treatments.^	Not Covered

*Services may require authorization and/or a referral.
^The benefits mentioned are a part of a special supplemental program for the chronically ill (SSBCI). Not all members qualify. You must be on any mode of dialysis. Please see your Evidence of Coverage, Chapter 4, Section 2's Medical Benefit Chart for more information about eligibility and SSBCI benefits.

PLAN DETAILS	IN-NETWORK	OUT-OF-NETWORK
ESRD Care / Start Dialysis Treatment	$0 Copay. Members new to dialysis treatments receive a visit from an RN to demonstrate/assist with placing the needle in the fistula (or patient's axis point) for home dialysis treatments.^	Not Covered
Acupuncture		
• Medicare-covered acupuncture	$0 Copay	$0 Copay for Medicare-covered services
• Routine acupuncture	$0 Copay for up to 50 routine visits every year (combined with routine chiropractic)	Not Covered
Chiropractic		
• Medicare-covered chiropractic care	$0 Copay	$0 Copay for Medicare-covered services
• Routine chiropractic care	$0 Copay for up to 50 routine visits every year (combined with routine acupuncture)	Not Covered
Silver&Fit Fitness Benefit	$0 Copay for receiving up to $35 reimbursed each month on gym membership or fitness classes	Not Covered
Podiatry Services (Medicare-covered services only)*	$0 Copay	$0 Copay
Hospice	Covered by Original Medicare	Covered by Original Medicare
Personal Emergency Response System (PERS)	$0 Copay	Not Covered

*Services may require authorization and/or a referral.

^The benefits mentioned are a part of a special supplemental program for the chronically ill (SSBCI). Not all members qualify. You must be on any mode of dialysis. Please see your Evidence of Coverage, Chapter 4, Section 2's Medical Benefit Chart for more information about eligibility and SSBCI benefits.

PLAN DETAILS	IN-NETWORK	OUT-OF-NETWORK
Respite Service (Support for Caregivers)	$0 Copay for up to twelve (12) 4-hour sessions per year with Helper Bees to support member's caregiver.	Not Covered
Remote Access Technologies (Web/Phone-based technologies and Nursing Hotline)	$0 Copay You have access to a 24/7 specialized nephrology call center staffed by licensed nephrologists designed to assist members with ESRD-related issues that may require diagnosis and treatment, questions, concerns and other resources relating to their ESRD dialysis care	Not Covered
Annual Physical Exam	$0 Copay for one (1) annual exam	$0 Copay for one (1) annual exam
Home and Bathroom Safety Devices and Modifications	$0 Copay for the provision of a shower chair	Not Covered
Health Education	$0 Copay for in-person or virtual interactive educational sessions with health professionals	$0 Copay for in-person or virtual interactive educational sessions with health professionals

PART D PRESCRIPTION DRUG COVERAGE		
PLAN DETAILS	**CHAMPION ADVANTAGE**	
Part D Deductible	No Deductible	No Deductible
	Participating Retail Pharmacy	**Mail Order**
Initial Coverage	Up to a 30-day supply	100-day supply
Tier 1: Preferred Generic (including insulins)	$0 Copay	$0 Copay
Tier 2: Generic • **Insulins**	$5 Copay Lesser of $5 Copay or 25% of the Cost	$10 Copay Lesser of $10 Copay or 25% of the Cost
Tier 3: Preferred Brand • **Insulins**	$47 Copay Lesser of $20 Copay or 25% of the Cost	$94 Copay Lesser of $40 Copay or 25% of the Cost
Tier 4: Non-Preferred Brand • **Insulins**	$100 Copay Lesser of $20 Copay or 25% of the Cost	$200 Copay Lesser of $40 Copay or 25% of the Cost
Tier 5: Specialty Tier • **Insulins**	33% of the Cost Lesser of $20 Copay or 25% of the Cost	A 100-day supply is not available in Tier 5
Tier 6: Select Care Drugs (including insulins)	$0 Copay	$0 Copay
Catastrophic Coverage (after you or others on your behalf pay $2,400)	During this stage, the plan pays the full cost for your covered Part D drugs.	

PART D PRESCRIPTION DRUG COVERAGE	
PLAN DETAILS	**CHAMPION ADVANTAGE**
Important Message About What You Pay for Insulin	At retail pharmacy locations, you won't pay more than $20 for a one-month supply or $60 for a three-month supply of each insulin product covered by our plan on Tiers 2, 3, and 4. You will not pay more than $20 for a one-month supply of insulin on Tier 5. For mail order, you won't pay more than $40 for a three month supply of each insulin product covered by our plan on Tiers 2, 3, and 4. Long term supplies of insulins in Tier 5 are not available through mail order.
Important Message About What You Pay for Vaccines	Our plan covers most Part D vaccines at no cost to you. Call Member Services for more information.
Extra Help from Medicare	Medicare and Social Security have a program called Extra Help that can help pay drug costs for people with limited income and resources. If you qualify, you get help paying for your Medicare drug plan's monthly plan premium, yearly deductible, and copayments. Extra Help also counts toward your out-of-pocket costs.