CHAMPION HEALTH PLAN

Summary of *Benefits*

Champion Connect Plan
(HMO-POS C-SNP) H6474-002

For Carson City, Churchill, Clark and Washoe Counties

2026 Summary of *Benefits*

CHAMPION HEALTH PLAN

Champion Health Plan

January 1, 2026 - December 31, 2026

Champion Health Plan is a (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 Connect (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). This plan is designed to meet the needs of individuals who qualify for Medicaid and do not receive institutional-level type of care (long-term care). 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 a 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 1-800-885-8000 from October 1 - March 31, 7 days a week from 8 am to 8 pm pacific standard time (PST) and from April 1 - September 30, Monday through Friday from 8 am to 8 pm PST. You can also visit us at championhmo.com.

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Plan Details	In-Network	Out-of-Network	Your cost with Medicare and Medicaid
Monthly Premium	$9.50	$9.50	$0 (with Extra Help)
Deductible	No Plan Deductible $257 Part B deductible. (This is the 2025 amount. The Plan will update this on its website once the 2026 amount is released.)	No Plan Deductible $257 Part B deductible. (This is the 2025 amount. The Plan will update this on its website once the 2026 amount is released.)	No Deductible $0 for Part B Deductible

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Plan Details	In-Network	Out-of-Network	Your cost with Medicare and Medicaid
Annual Maximum Out of Pocket (MOOP)	$9,250	$9,250	$0
Inpatient Hospital	$1,676†* Deductible per Medicare-covered benefit period $0 Copay for days 1 - 60 $419 Copay for days 61 - 90 $838 Copay for each lifetime reserve day after day 90 for each benefit period (up to 60 days over your lifetime) 100% of all costs beyond the lifetime reserve days *These are 2025 cost sharing amounts and may change for 2026. Champion Health Plan will provide updated rates on its website when 2026 rates are released. Services may require authorization and a referral.	Not Covered	$0 †if you have full Medicaid benefits, you may pay $0 for your Medicare-covered services Services may require authorization and a referral.
Outpatient Hospital and Ambulatory Surgery Centers (ASC)	20% of the Cost for outpatient hospital services 20% of the Cost for surgery in an Ambulatory Surgery Center 20% of the Cost for outpatient hospital observation Services may require authorization and a referral.	20% of the Cost for outpatient hospital services $0 Copay for surgery in an Ambulatory Surgery Center 20% of the Cost for outpatient hospital observation Services may require authorization and a referral.	$0 Copay †if you have full Medicaid benefits, you may pay $0 for your Medicare-covered services Services may require authorization and a referral.

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Plan Details	In-Network	Out-of-Network	Your cost with Medicare and Medicaid
Primary Care Providers	$0 Copay	$0 Copay	$0 Copay
Specialists	20% of the Cost Authorization may be required for all services except nephrology.	20% of the Cost Authorization may be required for all services except nephrology.	$0 Copay †if you have full Medicaid benefits, you may pay $0 for your Medicare-covered services Authorization may be required.
Preventive Services (Medicare covered screenings)	$0 Copay	$0 Copay	$0 Copay
Emergency Care (Hospital emergency department) **Worldwide Emergency Care**	$115 Copay Copay is waived if admitted to hospital within 24 hours for related health event.	$115 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.	$0 Copay †If you have full Medicaid benefits, you may pay $0 for your Medicare-covered services
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.	$0 Copay

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Plan Details	In-Network	Out-of-Network	Your cost with Medicare and Medicaid
Diagnostic Services/ Labs/Imaging			
• Diagnostic tests and procedures • X-rays • Lab services • Diagnostic radiology services (such as MRI, CT scans)	$0 Copay for lab services and X-rays 20%† of the cost for all other services	$0 Copay for lab services and X-rays 20%† of the cost for all other services	$0 Copay for lab services and X-rays $0 Copay for all other services †If you have full Medicaid benefits, you may pay $0 for your Medicare-covered services
• Therapeutic radiology services (such as radiation treatment for cancer)	Diagnostic tests and procedures and lab services may require authorization and a referral.	Diagnostic tests and procedures and lab services may require authorization and a referral.	Diagnostic tests and procedures and lab services may require authorization and a referral.
Hearing Services			
• Medicare-covered services	$0 Copay for Medicare-covered services every year	$0 Copay for Medicare-covered services	$0 Copay for Medicare-covered services every year
• Routine hearing exam and fitting/ evaluation for hearing aid	$0 Copay for one routine exam and one fitting/evaluation for hearing aids every year		$0 Copay for one routine exam and one fitting/evaluation for hearing aids every year
• Hearing aid	$149 Copay per hearing aid (all models) up to (2) aids every (3) years		$149 Copay per in-network hearing aid (all models) up to 2 aids every 3 years

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Plan Details	In-Network	Out-of-Network	Your cost with Medicare and Medicaid
Dental Services	$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 Comprehensive dental services may require authorization and a referral.	Preventive and Comprehensive Dental Services are not covered out-of-network.	$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 in-network preventive and comprehensive dental services combined Comprehensive dental services may require authorization and a referral.
Vision Services			
• Medicare-covered eye exam	$0 Copay for Medicare-covered services every year	Not Covered	$0 Copay for Medicare-covered services every year
• 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 one routine eye exam every year		$0 Copay for one routine eye exam every year
• Frames and lenses	$500 Allowance for eyeglasses (lenses and frames) and upgrades every year.		$500 Allowance for eyeglasses (lenses and frames) and upgrades every year.

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Plan Details	In-Network	Out-of-Network	Your cost with Medicare and Medicaid
Mental Health Inpatient	$1,676 deductible per benefit period $0 for days 1 - 60 $419 copay for days 61 - 90 $838 copay for each lifetime reserve day after day 90 for each benefit period (up to 60 days over your lifetime) 100% of all costs beyond the lifetime reserve days These are 2025 cost sharing amounts and may change for 2026. Champion Health Plan will provide updated rates on its website when 2026 rates are released. Services may require authorization and a referral.	Not Covered	$0 Copay †If you have full Medicaid benefits, you may pay $0 for your in-network Medicare-covered services Services may require authorization and a referral.
Mental Health Outpatient (Medicare-covered individual and group sessions)	$0 Copay Services may require authorization and a referral.	$0 Copay Services may require authorization and a referral.	$0 Copay Services may require authorization and a referral.
Skilled Nursing Facility	$0 Copay for days 1-20 $218 Copay for days 21-100 Services may require authorization and a referral.	Not Covered	$0 Copay for days 1-100 †If you have full Medicaid benefits, you may pay $0 for your in-network Medicare-covered services Services may require authorization and a referral.

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Plan Details	In-Network	Out-of-Network	Your cost with Medicare and Medicaid
Outpatient Rehabilitation • Physical Therapy • Speech Therapy • Occupational Therapy	20% of the Cost for physical and speech therapy services $0 Copay for occupational therapy services Services may require authorization and a referral.	20% of the Cost for physical and speech therapy services $0 Copay for occupational therapy services Services may require authorization and a referral.	$0 Copay Services may require authorization and a referral.
Ambulance Services	20%† of the Cost for Medicare-covered air ambulance services. $0 to $125 Copay for Medicare-covered ground ambulance services. Minimum cost share applies to non-emergency ground ambulance transports. Authorization may be required for non-emergency services.	20%† of the Cost for Medicare-covered air ambulance services. $0 to $125 Copay for Medicare-covered ground ambulance services. Minimum cost share applies to non-emergency ground ambulance transports. Authorization may be required for non-emergency services.	$0 Copay †If you have full Medicaid benefits, you may pay $0 for your Medicare-covered services Authorization may be required for non-emergency services.
Transportation	$0 Copay 36 one-way plan-approved locations	Not Covered	$0 Copay
Medicare Part B Drugs	20%† of the Cost You pay no more than $24 for a 30-day supply of insulin	20%† of the Cost You pay no more than $24 for a 30-day supply of insulin	$0 Copay †If you have full Medicaid benefits, you may pay $0 for your Medicare-covered services

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Plan Details	In-Network	Out-of-Network	Your cost with Medicare and Medicaid
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.	$0 Copay †If you have full Medicaid benefits, you may pay $0 for your Medicare-covered services
Durable Medical Equipment (DME)	DME, Prosthetics, and Medical Supplies: $0 for items $100 or less 20% of the Cost for items over $100 Services may require authorization.	DME, Prosthetics, and Medical Supplies: $0 for items $100 or less 20% of the Cost for items over $100 Services may require authorization.	$0 Copay †If you have full Medicaid benefits, you may pay $0 for your Medicare-covered services Services may require authorization.

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Plan Details	In-Network	Out-of-Network	Your cost with Medicare and Medicaid
ESRD Care Healthy Foods / Over-the- Counter Items / Utilities Benefit	$511 Allowance every (3) months 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. Remaining balance does not roll over to the next quarter.	Not Covered	$511 Allowance every (3) months 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. Remaining balance does not roll over to the next quarter.
Transportation for Dialysis Treatment	Eligible members also receive up to 132 one-way trips to dialysis treatments. If transportation is not used and you are privately transported to dialysis service, private driver reimbursed at $0.67 per mile. The benefits mentioned are a part of special supplemental program for the chronically ill. 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.		Eligible members also receive up to 132 one-way trips to dialysis treatments. If transportation is not used and you are privately transported to dialysis service, private driver reimbursed at $0.67 per mile. The benefits mentioned are a part of special supplemental program for the chronically ill. 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.
Acupuncture • Medicare-covered acupuncture	$0 Copay	$0 Copay	$0 Copay

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Plan Details	In-Network	Out-of-Network	Your cost with Medicare and Medicaid
Chiropractic • Medicare-covered chiropractic care	$0 Copay	$0 Copay	$0 Copay
Podiatry Services (Medicare-covered services only)	20%† of the Cost †If you have full Medicaid benefits, you may pay $0 for your Medicare-covered services.	20%† of the Cost †If you have full Medicaid benefits, you may pay $0 for your Medicare-covered services.	$0 Copay †If you have full Medicaid benefits, you may pay $0 for your Medicare-covered services.
Hospice	Covered by Original Medicare	Covered by Original Medicare	Covered by Original Medicare
Respite Service	$0 Copay Up to 12 sessions every year.	Not Covered	
Personal Emergency Response System (PERS)	$0 Copay	Not Covered	
Silver&Fit Fitness Benefit	$0 Copay for receiving up to $35 reimbursed each month on gym membership or fitness classes	Not Covered	
Remote Access Technologies (including 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	

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Plan Details	In-Network	Out-of-Network	Your cost with Medicare and Medicaid
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	Not Covered	

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Prescription Drug Coverage				
Plan Details	**In-Network**		**Your cost with the Extra Help Program (for low-income subsidy)***	
Part D Deductible	$615 Deductible (does not apply to Tiers 1, 2 and 6)		$0 Copay	
	Participating Retail Pharmacy	**Mail Order**	**Participating Retail Pharmacy**	**Mail Order**
Initial Coverage	Up to a 30-day supply	100-day supply	Up to a 30-day supply	100-day supply
Tier 1: Preferred Generic	$0 Copay	$0 Copay	$0 Copay	
Tier 2: Generic	$0 Copay	$0 Copay	$0 Copay	
Tier 3: Preferred Brand	25% of the cost	25% of the cost	Generics: $0 or $1.60 or $5.10 Copay Brands: $0 or $4.90 or $12.65 Copay	
Tier 4: Non-Preferred Brand	25% of the cost	25% of the cost	Generics: $0 or $1.60 or $5.10 Copay Brands: $0 or $4.90 or $12.65 Copay	
Tier 5: Specialty Tier	25% of the cost	A 100-day supply is not available in Tier 5	Generics: $0 or $1.60 or $5.10 Copay Brands: $0 or $4.90 or $12.65 Copay	A 100-day supply is not available in Tier 5
Tier 6: Select Care Drugs	$0 Copay	$0 Copay	$0 Copay	
Catastrophic Coverage (after you or others on your behalf pay $2,100)	During this stage, the plan pays the full cost for your covered Part D drugs.			

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Prescription Drug Coverage		
Plan Details	**In-Network**	**Your cost with Extra Help**
Important message about what you pay for insulin	You won't pay more than $20 for a one-month supply or $60 for a three-month supply of each insulin product covered by our plan on Tiers 1, 2, 3, 4 and 6 and no more than $35 for a one-month supply of insulin on Tier 5, even if you haven't paid your deductible.	Generics: $0 or $1.60 or $5.10 Copay Brands: $0 or $4.90 or $12.65 Copay
Important message about what you pay for vaccines	Our plan covers most Part D vaccines at no cost to you, even if you haven't paid your deductible. Call Member Services for more information.	
***Extra Help Program**	If you have Medicaid, you qualify for the Extra Help program that assists individuals with Part D cost shares, including deductibles. You may pay $0 for your Part D premium, deductible and no more than the low-income subsidy amounts for all of your Part D drugs.	