CHAMPION HEALTH PLAN

Summary of *Benefits*

Champion Select
(HMO-POS C-SNP) H6170-003

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

H6170_SB003CA2026_M

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 Select (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 California: Fresno, Imperial, Kern, Los Angeles, Madera, Orange, Riverside, San Bernardino and San Diego.

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
Monthly Premium	$8.40	$8.40
Annual Plan Deductible	No Deductible	No Deductible
Annual Maximum Out of Pocket (MOOP)	$499	$499

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Plan Details	In-Network	Out-of-Network
Inpatient Hospital	$0 Per Stay Services may require authorization and a referral.	Not Covered
Outpatient Hospital and Ambulatory Surgery Centers (ASC)	$100 Copay for outpatient hospital services $0 Copay for surgery in an Ambulatory Surgery Center $0 Copay for outpatient hospital observation Services may require authorization and a referral.	$100 Copay for outpatient hospital services $0 Copay for surgery in an Ambulatory Surgery Center $0 Copay for outpatient hospital observation Services may require authorization and a referral.
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)	$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
Worldwide Emergency Care		$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)	$0 Copay	$0 Copay
Worldwide Urgently Needed Care		$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.

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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	$0 Copay for Medicare-covered services
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.

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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)	Not Covered
• Medicare-covered frames and lenses or contacts	$0 Copay for (1) pair of Medicare-covered eyewear (eyeglasses or contact lenses) after a cataract surgery	
• Routine eye exam	$0 Copay for (1) routine eye exam, refraction up to (1) per year	
• Frames and lenses	$335 Allowance for frames and lenses and upgrades every year	
Mental Health Inpatient	$100 Copay for days 1-10 $0 Copay for days 11-90 Services may require authorization and a referral.	Not Covered
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.
Skilled Nursing Facility	$0 Copay for days 1-20 $218 Copay per day for days 21-100 Services may require authorization and a referral.	Not Covered
Outpatient Rehabilitation		
• Physical Therapy • Speech Therapy • Occupational Therapy	$0 Copay Services may require authorization and a referral.	$0 Copay Services may require authorization and a referral.

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Plan Details	In-Network	Out-of-Network
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 Authorization may be required for non-emergency 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 Authorization may be required for non-emergency services.
Transportation	$0 Copay 24 one-way plan-approved health-related locations	Not Covered
Medicare Part B Drugs	0% to 20% of the Cost You pay no more than $24 for a 30-day supply of insulins.	0% to 20% of the Cost You pay no more than $24 for a 30-day supply of insulins.
Dialysis	$0 Copay	$0 Copay 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 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.

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Plan Details	In-Network	Out-of-Network
ESRD Care **Healthy Foods / Over-the-Counter Items / Utilities Benefit** **Transportation for Dialysis Treatment**	$400 Allowance every (3) months Eligible members pay $0 Copay for a quarterly allowance to use for healthy foods and produce, over-the-counter items, wellness products and/or assistance with utilities. Benefit does not rollover to the next period. Eligible members also receive up to 76 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.	Not Covered
Acupuncture • Medicare-covered acupuncture	$0 Copay	$0 Copay
Chiropractic • Medicare-covered chiropractic care	$0 Copay	$0 Copay
Podiatry Services (Medicare-covered services only)	$0 Copay Services may require authorization and a referral.	$0 Copay Services may require authorization and a referral.
Hospice	Covered by Original Medicare	Covered by Original Medicare
Respite Service	$0 Copay Up to 12 sessions every year.	Not Covered

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Plan Details	In-Network	Out-of-Network
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
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**	
Part D Deductible	$615 Deductible (does not apply to Tiers 1, 2 and 6)	
	Participating Retail Pharmacy	**Mail Order**
Initial Coverage	Up to a 30-day supply	100-day supply
Tier 1: Preferred Generic	$0 Copay	$0 Copay
Tier 2: Generic	$0 Copay	$0 Copay
Tier 3: Preferred Brand	25% of the Cost If you receive assistance under the Extra Help Program*, your cost will be: Generics: $0 or $4.80 or $15.30 Copay Brands: $0 or $14.70 or $37.95 Copay	25% of the Cost If you receive assistance under the Extra Help Program*, your cost will be: Generics: $0 or $3.20 or $10.20 Copay Brands: $0 or $9.80 or $25.30 Copay
Tier 4: Non-Preferred Brand	25% of the Cost If you receive assistance under the Extra Help Program*, your cost will be: Generics: $0 or $4.80 or $15.30 Copay Brands: $0 or $14.70 or $37.95 Copay	25% of the Cost If you receive assistance under the Extra Help Program*, your cost will be: Generics: $0 or $3.20 or $10.20 Copay Brands: $0 or $9.80 or $25.30 Copay
Tier 5: Specialty Tier	25% of the cost If you receive assistance under the Extra Help Program*, your cost will be: Generics: $0 or $4.80 or $15.30 Copay Brands: $0 or $14.70 or $37.95 Copay	A 100-day supply is not available in Tier 5
Tier 6: Select Care Drugs	$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**
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 1, 2, 3, 4 and 6. You will not pay more than $35 for a one-month supply of insulin on Tier 5, even if you haven't paid your deductible. 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 1, 2, 3, 4 and 6. 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 Program**	If you meet federal low income limits, 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.