



Summary of *Benefits*

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

Carson City, Churchill, Clark and Washoe Counties

2027 Summary of Benefits



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 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 an out-of-network provider that is not participating in Medicare, neither Medicare nor Champion Connect (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	YOUR COST WITH MEDICARE AND MEDICAID
Monthly Premium	\$7.30	\$0	\$0 (with Extra Help)
Plan Deductible	No Plan Deductible \$283 Part B Deductible (This 2026 cost sharing amount may change for 2027. Champion Health Plan will provide updated rates on its website when 2027 rates are released.)	No Plan Deductible \$283 Part B Deductible. (This 2026 cost sharing amount may change for 2027. Champion Health Plan will provide updated rates on its website when 2027 rates are released.)	No Plan Deductible \$0 for Part B Deductible [†]
Annual Maximum Out of Pocket (MOOP)	\$9,850 (combined for in-network and out-of-network Medicare-covered services)		\$0 [†]

[†]If you have full Medicaid benefits, you may pay \$0 for your Med

PLAN DETAILS	IN-NETWORK	OUT-OF-NETWORK	YOUR COST WITH MEDICARE AND MEDICAID
Inpatient Hospital*	\$1,736 Deductible per benefit period \$0 Copay for days 1 - 60 \$434 Copay per day for days 61 - 90 \$868 Copay per day 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 2026 cost sharing amounts may change for 2027. Champion Health Plan will provide updated rates on its website when 2027 rates are released.)	Not Covered	\$0 [†]
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	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	\$0 Copay [†]

*Services may require authorization and/or a referral.

[†]If you have full Medicaid benefits, you may pay \$0 for your Medicare-covered services.

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 [†]
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 [†]
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

*Services may require authorization and/or a referral.

[†]If you have full Medicaid benefits, you may pay \$0 for your Medicare-covered services.

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) - Therapeutic radiology services (such as radiation treatment for cancer)	\$0 Copay for lab services and X-rays 20%[†] of the cost for all other services Diagnostic tests and procedures and lab services may require authorization and a referral.	\$0 Copay for lab services and X-rays 20%[†] of the cost for all other services Diagnostic tests and procedures and lab services may require authorization and a referral.	\$0 Copay for lab services and X-rays \$0 Copay for all other services[†]
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.	\$0 Copay[†]

*Services may require authorization and/or a referral.

[†]If you have full Medicaid benefits, you may pay \$0 for your Medicare-covered services.

PLAN DETAILS	IN-NETWORK	OUT-OF-NETWORK	YOUR COST WITH MEDICARE AND MEDICAID
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.	\$0 Copay [†]
Vision Services - Medicare covered eye exam - Medicare covered frames and lenses or contacts - Routine eye exam - Routine frames and lenses, or contacts	\$0 Copay for Medicare-covered services every year \$0 Copay for (1) pair of Medicare-covered eyewear (eyeglasses (lenses and frames)) after a cataract surgery \$0 Copay for one routine eye exam every year \$350 Allowance for routine eyeglasses (lenses and frames) and upgrades every year.	\$0 Copay for Medicare-covered services every year \$0 Copay for (1) pair of Medicare-covered eyewear (eyeglasses (lenses and frames)) after a cataract surgery Routine eye exams and eyewear are not covered.	\$0 Copay [†]

*Services may require authorization and/or a referral.

[†]If you have full Medicaid benefits, you may pay \$0 for your Medicare-covered services.

PLAN DETAILS	IN-NETWORK	OUT-OF-NETWORK	YOUR COST WITH MEDICARE AND MEDICAID
Mental Health Inpatient*	\$1,736 deductible per benefit period \$0 Copay for days 1 - 60 \$434 Copay per day for days 61 - 90 \$868 Copay per day 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 2026 cost sharing amounts may change for 2027. Champion Health Plan will provide updated rates on its website when 2027 rates are released.)	Not Covered	\$0 Copay [†]
Mental Health Outpatient* (Medicare-covered individual and group sessions)	\$0 Copay	\$0 Copay	\$0 Copay
Skilled Nursing Facility*	\$0 Copay for days 1-20 \$221 Copay for days 21-100	Not Covered	\$0 Copay for days 1-100 [†]
Outpatient Rehabilitation* - Physical Therapy - Speech Therapy - Occupational Therapy	\$0 Copay for physical and speech therapy services \$0 Copay for occupational therapy services	20% of the Cost for physical and speech therapy services \$0 Copay for occupational therapy services	\$0 Copay

*Services may require authorization and/or a referral.

[†]If you have full Medicaid benefits, you may pay \$0 for your Medicare-covered services.

PLAN DETAILS	IN-NETWORK	OUT-OF-NETWORK	YOUR COST WITH MEDICARE AND MEDICAID
Ambulance Services*	20% of the Cost for Medicare-covered air ambulance services. 0% to 20% of the Cost for Medicare-covered ground ambulance services, not to exceed \$125 Copay. Minimum Cost share applies to non-emergency ground ambulance transports.	20% of the Cost for Medicare-covered air ambulance services. 0% to 20% of the Cost for Medicare-covered ground ambulance services, not to exceed \$125 Copay. Minimum Cost share applies to non-emergency ground ambulance transports.	\$0 Copay [†]
Transportation	\$0 Copay 60 one-way plan-approved health-related locations. Maximum mileage per trip is 25 miles.	Not Covered	
Medicare Part B Drugs	20% of the Cost \$0 to \$35 Copay for a 30-day supply of insulin	20% of the Cost \$0 to \$35 Copay for a 30-day supply of insulin	\$0 Copay [†]
Dialysis	20% of the Cost	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 [†]
Durable Medical Equipment (DME)*	DME, Prosthetics, and Medical Supplies: 20% of the Cost	DME, Prosthetics, and Medical Supplies: 20% of the Cost	\$0 Copay [†]

*Services may require authorization and/or a referral.

[†]If you have full Medicaid benefits, you may pay \$0 for your Medicare-covered services.

PLAN DETAILS	IN-NETWORK	OUT-OF-NETWORK	YOUR COST WITH MEDICARE AND MEDICAID
Over-the-Counter Items / Healthy Foods / Utilities Benefit	\$495 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 unlimited one-way trips to dialysis treatments. [^]	Not Covered	
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	

[^]The benefits mentioned are a part of a 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 about eligibility.

PLAN DETAILS	IN-NETWORK	OUT-OF-NETWORK	YOUR COST WITH MEDICARE AND MEDICAID
Acupuncture - Medicare-covered acupuncture - Routine acupuncture	\$0 Copay for Medicare-covered services \$0 Copay for up to 50 routine visits every year (combined with routine chiropractic)	\$0 Copay for Medicare-covered services Not Covered	\$0 Copay [†]
Chiropractic - Medicare-covered chiropractic care - Routine chiropractic care	\$0 Copay for Medicare-covered services \$0 Copay for up to 50 routine visits every year (combined with routine acupuncture)	\$0 Copay for Medicare-covered services Not Covered	\$0 Copay [†]
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	20% of the Cost	\$0 Copay [†]
Hospice	Covered by Original Medicare	Covered by Original Medicare	Covered by Original Medicare
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	
Personal Emergency Response System (PERS)	\$0 Copay	Not Covered	

*Services may require authorization and/or a referral.

[†]If you have full Medicaid benefits, you may pay \$0 for your Medicare-covered services.

PLAN DETAILS	IN-NETWORK	OUT-OF-NETWORK	YOUR COST WITH MEDICARE AND MEDICAID
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	Not Covered	

PART D PRESCRIPTION DRUG COVERAGE

PLAN DETAILS	CHAMPION CONNECT		YOUR COST WITH MEDICARE AND MEDICAID
Part D Deductible	\$700 Deductible (does not apply to Tiers 1, 2 and 6)		\$0 Copay
	Participating Retail Pharmacy	Mail Order	LIS COPAY (with Extra Help)
Initial Coverage	Up to a 30-day supply	100-day supply	
Tier 1: Preferred Generic (including insulins)	\$0 Copay	\$0 Copay	\$0 Copay
Tier 2: Generic (including insulins)	\$0 Copay	\$0 Copay	\$0 Copay
Tier 3: Preferred Brand • Insulins	25% of the Cost Lesser of \$35 Copay or 25% of the Cost	25% of the Cost Lesser of \$105 Copay or 25% of the Cost	Generics: \$0 or \$1.65 or \$5.80 Copay Brands: \$0 or \$5 or \$14.40 Copay
Tier 4: Non-Preferred Brand • Insulins	25% of the Cost Lesser of \$35 Copay or 25% of the Cost	25% of the Cost Lesser of \$105 Copay or 25% of the Cost	Generics: \$0 or \$1.65 or \$5.80 Copay Brands: \$0 or \$5 or \$14.40 Copay
Tier 5: Specialty Tier • Insulins	25% of the Cost Lesser of \$35 Copay or 25% of the Cost	A 100-day supply is not available in Tier 5	Generics: \$0 or \$1.65 or \$5.80 Copay Brands: \$0 or \$5 or \$14.40 Copay A 100-day supply is not available in Tier 5
Tier 6: Select Care Drugs (including insulins)	\$0 Copay	\$0 Copay	\$0 Copay

PART D PRESCRIPTION DRUG COVERAGE

PLAN DETAILS	CHAMPION CONNECT	YOUR COST WITH MEDICARE AND MEDICAID
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.	
Important Message About What You Pay for Insulin	You won't pay more than \$35 for a one-month supply or \$105 for a three-month supply of each insulin product covered by our plan on Tiers 3 and 4 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 \$1.65 or \$5.80 Copay Brands: \$0 or \$5 or \$14.40 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 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.	