CHAMPION HEALTH PLAN

Summary of *Benefits*

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

For Carson City, Churchill, Clark and Washoe Counties

H6474_SB002NV2025_M

2025 Summary of *Benefits*

CHAMPION HEALTH PLAN

Champion Health Plan
January 1, 2025 - December 31, 2025

A Medicare Advantage Prescription Drug Health Maintenance Organization Point of Service Chronic Special Needs Plan (HMO POS C-SNP) with a Medicare Contract.

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 ESRD requiring dialysis (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 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	$21.30	$21.30	$0 (with Extra Help)
Annual Plan Deductible	No Deductible	No Deductible	No Deductible
Annual Maximum Out of Pocket (MOOP)	$9,350	$9,350	$0

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Plan Details	In-Network	Out-of-Network	Your cost with Medicare and Medicaid
Inpatient Hospital	$1,752† deductible per Medicare-covered benefit period $0 Copay per benefit period $0 Copay per lifetime reserve days 1-60 Cost-sharing is charged per admission or stay. If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost sharing you would pay at a network hospital. 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)	$125† Copay per Medicare-covered visit $0 Copay for ASC services Services may require authorization and a referral.	$125† Copay per Medicare-covered visit $0 Copay for ASC services 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.
Primary Care Providers	$0 Copay	$0 Copay	$0 Copay
Specialists	$0 Copay 20%† Coinsurance for specialist visit in a facility Authorization may be required for all services except nephrology.	$0 Copay 20%† Coinsurance for specialist visit in a facility 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 for all services except nephrology.
Preventive Services (Medicare covered screenings)	$0 Copay	$0 Copay	$0 Copay

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Plan Details	In-Network	Out-of-Network	Your cost with Medicare and Medicaid
Emergency Care (Hospital emergency department)	$110† Copay Copay is waived if admitted to hospital within 24 hours for related health event	$110† Copay Copay is waived if admitted to hospital within 24 hours for related health event	$0 Copay Copay is waived if admitted to hospital within 24 hours for related health event †If you have full Medicaid benefits, you may pay $0 for your Medicare-covered services
Worldwide Emergency Care	$0 Copay for up to $100,000 maximum Worldwide benefit limit reimbursable by the plan. Combined with Worldwide Urgently Needed Care.	$0 Copay for up to $100,000 maximum Worldwide benefit limit reimbursable by the plan. Combined with Worldwide Urgently Needed Care.	$0 Copay for up to $100,000 maximum Worldwide benefit limit reimbursable by the plan. Combined with Worldwide Urgently Needed Care.
Urgent Care Services (Non-hospital urgent care center)	$0 Copay	$0 Copay	$0 Copay
Worldwide Urgently Needed Care	$0 Copay for up to $100,000 maximum Worldwide benefit limit reimbursable by the plan. Combined with Worldwide Emergency Care.	$0 Copay for up to $100,000 maximum Worldwide benefit limit reimbursable by the plan. Combined with Worldwide Emergency Care.	$0 Copay for up to $100,000 maximum Worldwide benefit limit reimbursable by the plan. Combined with Worldwide Emergency Care.
Diagnostic Services/ Labs/Imaging			
• Diagnostic tests and procedures • X-rays • Lab 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 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
• Diagnostic radiology services (such as MRI, CT scans) • 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.

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Plan Details	In-Network	Out-of-Network	Your cost with Medicare and Medicaid
Hearing Services			
• Medicare-covered services	$0 Copay for Medicare-covered services every year	$0 Copay for Medicare-covered services every year	$0 Copay for Medicare-covered services every year
• Routine hearing exam • Fitting/evaluation for hearing aid	$0 Copay for one routine exam and one fitting/evaluation for hearing aids every year	Not covered	$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	Not covered	$149 Copay per hearing aid (all models) up to 2 aids every 3 years
Dental Services	$0 for Medicare-covered and Preventive 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	$0 for Medicare-covered and Preventive Dental Services 20% of the cost for Preventive Dental Services 30% to 50% 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	$0 for Medicare-covered and Preventive 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

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Plan Details	In-Network	Out-of-Network	Your cost with Medicare and Medicaid
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)	$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 or contact lenses) after a cataract surgery	Not covered	$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	Not covered	$0 Copay for (1) routine eye exam, refraction up to (1) per year
• Frames and lenses, or contacts	$500 Allowance for frames and lenses and upgrades every year	Not covered	$500 Allowance for frames and lenses and upgrades every year
Mental Health Inpatient	$1,712† deductible per Medicare-covered benefit period $0 Copay per benefit period Services may require authorization and a referral.	Not covered	$0 Copay †If you have full Medicaid benefits, you may pay $0 for your 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 $214† 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 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	$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.
Ambulance Services	$0 Copay for non-emergency ground ambulance transport 20%† of the cost for Medicare-covered ground and air ambulance services Authorization may be required for non-emergency services.	20%† of the cost for non-emergency ground ambulance transport and for Medicare-covered ground and air ambulance services 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 Unlimited one-way plan approved trips If transportation is not used and you are privately transported to dialysis service, the private driver is reimbursed at 0.60 per mile.	Not covered	$0 Copay If transportation is not used and you are privately transported to dialysis service, the private driver is reimbursed at 0.60 per mile.
Medicare Part B Drugs	0% - 20%† of the cost	0% - 20%† of the cost	$0 Copay †If you have full Medicaid benefits, you may pay $0 for your Medicare-covered services
Dialysis	20%† of the cost	20%† of the cost	$0 Copay †If you have full Medicaid benefits, you may pay $0 for your Medicare-covered services

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Dialysis Assistance Program			
• Venipuncture for Home dialysis treatment The benefits mentioned are a part of special supplemental program for the chronically ill. Not all members qualify.	$0 Copay members receive a visit from a trained caregiver to perform fistula or graft cannulation and machine setup at the beginning of home hemodialysis treatments.	$0 Copay members receive a visit from a trained caregiver to perform fistula or graft cannulation and machine setup at the beginning of home hemodialysis treatments.	$0 Copay members receive a visit from a trained caregiver to perform fistula or graft cannulation and machine setup at the beginning of home hemodialysis treatments.
• Support for Caregivers	$0 Copay for up to 12 days per year of at-home dialysis treatments or 12, 4-hour respite care periods of coverage per year.	$0 Copay for up to 12 days per year of at-home dialysis treatments or 12, 4-hour respite care periods of coverage per year.	$0 Copay for up to 12 days per year of at-home dialysis treatments or 12, 4-hour respite care periods of coverage per year.
DME	20%† of the cost Services may require authorization.	20%† of the cost 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.
Over-The-Counter Items and Healthy Foods	$500 Allowance every (3) three months $0 Copay for weight scale and blood pressure cuff or members with diabetes, ESRD, cardiovascular disorders or chronic heart failure	Not covered	$500 Allowance every (3) three months $0 Copay for weight scale and blood pressure cuff or members with diabetes, ESRD, cardiovascular disorders or chronic heart failure
Acupuncture and Chiropractic (Medicare-covered services only)	$0 Copay	$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.	$0 Copay Services may require authorization and a referral.

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Plan Details	In-Network	Out-of-Network	Your cost with Medicare and Medicaid
Hospice	Covered by Original Medicare	Covered by Original Medicare	Covered by Original Medicare
Personal Emergency Response System (PERS)	$0 Copay	Not covered	
Fitness	$0 Copay You are reimbursed for up to $35 per month for gym memberships or fitness classes (such as yoga)	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	Not covered	
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	$545 deductible (does not apply to Tier 1 and Tier 6)	$545 deductible (does not apply to Tier 1 and Tier 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	25% of the cost	25% of the cost	$0 Copay	
Tier 3: Preferred Brand	25% of the cost	25% of the cost	$0 or $4.80 or $12.15 Copay	
Tier 4: Non-Preferred Brand	25% of the cost	25% of the cost	Generics: $0 or $1.60 or $4.90 Copay Brands: $0 or $4.80 or $12.15 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 $4.90 Copay Brands: $0 or $4.80 or $12.15 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 $2,000)	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 Medicare and Medicaid**
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, no matter what cost-sharing tier it's on, even if you haven't paid your deductible.	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, no matter what cost-sharing tier it's on, even if you haven't paid your deductible.
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.	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	N/A	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.

CHAMPION HEALTH PLAN

For Questions *Call Toll-Free*

1-800-885-8000, TTY 711

April 1 - September 30:
Monday - Friday 8 am - 8 pm

October 1 - March 31:
Monday - Sunday 8 am - 8 pm

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championhmo.com