



# Summary of *Benefits*

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

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For Carson City, Churchill, Clark, and Washoe Counties

# 2025 Summary of *Benefits*



## 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 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 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**.

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

Plan Details	In-Network	Out-of-Network
Monthly Premium	\$0	\$0
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 Copay Services may require authorization and a referral.	Not covered
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 Services may require authorization and a referral.	\$100 Copay per visit 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)	\$140 Copay Copay is waived if admitted to hospital within 24 hours for related health event	\$140 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. 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
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.

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Plan Details	In-Network	Out-of-Network
<b>Diagnostic Services/Labs/Imaging</b> <ul style="list-style-type: none"> <li>• Diagnostic tests and procedures</li> <li>• X-rays</li> <li>• Lab services</li> <li>• Diagnostic radiology services (such as MRI, CT Scans)</li> <li>• Therapeutic radiology services (such as radiation treatment for cancer)</li> </ul>	\$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.
<b>Hearing Services</b> <ul style="list-style-type: none"> <li>• Medicare-covered services</li> <li>• Routine hearing exam</li> <li>• Fitting/evaluation for hearing aid</li> <li>• Hearing aid</li> </ul>	\$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 every year  Not covered  Not covered
<b>Dental Services</b>	\$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	\$0 Copay for Medicare-covered services  20% coinsurance 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

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

Plan Details	In-Network	Out-of-Network
<b>Vision Services</b> <ul style="list-style-type: none"> <li>• Medicare-covered eye exam</li> <li>• Medicare-covered frames and lenses or contacts</li> <li>• Routine eye exam</li> <li>• Frames and lenses, or contacts</li> </ul>	<p>\$0 Copay for a Medicare-covered exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening)</p> <p>\$0 Copay for (1) pair of Medicare-covered eyewear (eyeglasses or contact lenses) after a cataract surgery</p> <p>\$0 Copay for (1) routine eye exam, refraction up to (1) per year</p> <p>\$335 Allowance for frames and lenses and upgrades every year</p>	<p>\$0 Copay for a Medicare-covered exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening)</p> <p>Not covered</p> <p>Not covered</p> <p>Not covered</p>
<b>Mental Health Inpatient</b>	<p>\$100 Copay for days 1-10            \$0 Copay for days 11-60            \$329 Copay for days 61-90</p> <p>Services may require authorization and a referral.</p>	<p>Not covered</p>
<b>Mental Health Outpatient</b> (Medicare-covered individual and group sessions)	<p>\$0 Copay</p> <p>Services may require authorization and a referral.</p>	<p>\$0 Copay</p> <p>Services may require authorization and a referral.</p>
<b>Skilled Nursing Facility</b>	<p>\$0 Copay for days 1-20            \$214 Copay for days 21-100</p> <p>Services may require authorization and a referral.</p>	<p>Not covered</p>
<b>Outpatient Rehabilitation</b> <ul style="list-style-type: none"> <li>• Physical therapy</li> <li>• Speech therapy</li> <li>• Occupational therapy</li> </ul>	<p>\$0 Copay</p> <p>Services may require authorization and a referral.</p>	<p>\$0 Copay</p> <p>Services may require authorization and a referral.</p>

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Plan Details	In-Network	Out-of-Network
<b>Ambulance Services</b>	0% or 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 air and ground ambulance transport Authorization may be required for non-emergency services.	0% or 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 air and ground ambulance transport Authorization may be required for non-emergency services.
<b>Transportation</b>	\$0 Copay 100 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
<b>Medicare Part B Drugs</b>	0% - 20% of the cost	0% - 20% of the cost
<b>Dialysis</b>	\$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.
<b>Dialysis Assistance Program</b> <ul style="list-style-type: none"> <li>• Venipuncture for Home Dialysis Treatments. The benefits mentioned are a part of special supplemental program for the chronically ill. Not all members qualify.</li> <li>• Support for Caregivers</li> </ul>	\$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 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 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 for up to 12 days per year of at-home dialysis treatments or 12, 4-hour respite care periods of coverage per year

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

Plan Details	In-Network	Out-of-Network
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.
Over-The-Counter Items and Healthy Foods	\$300 Allowance every (3) three months \$0 Copay for weight scale and blood pressure cuff for members with diabetes, ESRD, cardiovascular disorders or chronic heart failure	Not covered
Acupuncture and Chiropractic (Medicare-covered services only)	\$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
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



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

## Prescription Drug Coverage

Plan Details	In-Network	
Part D Deductible	No deductible	No deductible
	<b>Participating Retail Pharmacy</b>	<b>Mail Order</b>
Initial Coverage	Up to a 30-day supply	100-day supply
Tier 1: Preferred Generic	\$0 Copay	\$0 Copay
Tier 2: Generic	\$3 Copay	\$6 Copay
Tier 3: Preferred Brand	\$47 Copay	\$94 Copay
Tier 4: Non-Preferred Brand	\$100 Copay	\$200 Copay
Tier 5: Specialty Tier	33% of the cost	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 \$2,000)	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 \$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.	
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.	





## 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](http://championhmo.com)