CHAMPION HEALTH PLAN

Summary of *Benefits*

Champion Select Plan
(HMO POS C-SNP) H6474-003

For Carson City, Churchill, Clark and Washoe Counties

H6474_SB003NV2025_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 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 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 Select Plan (HMO POS C-SNP) H6474-003

Plan Details	In-Network	Out-of-Network
Monthly Premium	$16.10	$16.10
Annual Plan Deductible	No Deductible	No Deductible
Annual Maximum Out of Pocket (MOOP)	$499	$499

Champion Select Plan (HMO POS C-SNP) H6474-003

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)	$140 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.	$140 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)	$100 Copay Copay is waived if admitted to hospital within 24 hours for related health event	$100 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

Champion Select Plan (HMO POS C-SNP) H6474-003

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 • 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 every year
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	$0 Copay for Medicare-covered dental 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 Select Plan (HMO POS C-SNP) H6474-003

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)	$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
• Routine eye exam	$0 Copay for (1) routine eye exam, refraction up to (1) per year	Not covered
• Frames and lenses, or contacts	$335 Allowance for frames and lenses and upgrades every year	Not covered
Mental Health Inpatient	$100 Copay for days 1-10 $0 Copay for days 11-60 $329 Copay for days 61-90 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 $196 Copay per day for days 21-100 Services may require authorization and a referral.	$0 Copay for days 1-20 $196 Copay per day for days 21-100 Services may require authorization and a referral.
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.

Champion Select Plan (HMO POS C-SNP) H6474-003

Plan Details	In-Network	Out-of-Network
Ambulance 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.	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.
Transportation	$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
Medicare Part B Drugs	0% - 20% of the cost	0% - 20% of the cost
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.
Dialysis Assistance Program		
• Venipuncture for Home Dialysis Treatments. 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.
• 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.

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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	$400 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
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	
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**	
Part D Deductible	No deductible	No deductible
	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	25% of the cost If you receive assistance under the Extra Help Program*, your cost will be $0 or $1.60 or $4.90 Copay.	25% of the cost If you receive assistance under the Extra Help Program*, your cost will be $0 or $1.60 or $4.90 Copay.
Tier 3: Preferred Brand	25% of the cost If you receive assistance under the Extra Help Program*, your cost will be $0 or $4.80 or $12.15 Copay.	25% of the cost If you receive assistance under the Extra Help Program*, your cost will be $0 or $4.80 or $12.15 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 $1.60 or $4.90 Copay Brands: $0 or $4.80 or $12.15 Copay	25% of the cost If you receive assistance under the Extra Help Program*, your cost will be: 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 If you receive assistance under the Extra Help Program*, your cost will be: 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

Champion Select Plan (HMO POS C-SNP) H6474-003

Prescription Drug Coverage	
Plan Details	**In-Network**
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.
*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.

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