

2020 MEDICARE ADVANTAGE PLAN



SUMMARY OF BENEFITS

Serving Members in Jackson County

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ATRIO Health Plans has PPO and HMO-SNP plans with a Medicare contract. Enrollment in ATRIO Health Plans depends on contract renewal. Out-of-network/non-contracted providers are under no obligation to treat ATRIO Health Plan members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

2020 Summary of Benefits

January 1, 2020 – December 31, 2020

About the Summary of Benefits and Who Can Join

This is a summary of drug and health services covered by **ATRIO Bronze (PPO)**, **ATRIO Bronze Rx (Rogue) (PPO)** and **ATRIO Silver Rx (PPO)**. The benefit information provided does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please view the Evidence of Coverage at atriohp.com. Our service area includes the following county in Oregon: **Jackson County**.

Which doctors, hospitals and pharmacies can I use?

ATRIO Health Plans has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers in our network, you may pay less for your covered services. But if you want to, you can also use providers that are not in our network. You must generally use network pharmacies to fill your prescription drugs.

You can see our plan's Formulary (Part D prescription drug list), Provider Directory and Pharmacy Directory at our website, atriohp.com.

Tips for comparing your Medicare choices

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at <http://www.medicare.gov> or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY/TDD users should call 1-877-486-2048.

Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at 1-877-672-8620

Understanding the Benefits	
<input type="checkbox"/>	Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services that you routinely see a doctor. Visit atriohp.com or call 1-877-672-8620 to view a copy of the EOC.
<input type="checkbox"/>	Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
<input type="checkbox"/>	Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
Understanding Important Rules	
<input type="checkbox"/>	In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
<input type="checkbox"/>	Benefits, premiums and/or copayments/co-insurance may change on January 1, 2021.
<input type="checkbox"/>	Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situations, non-contracted providers may deny care. In addition, you will pay a higher co-pay for services received by non-contracted providers.

H6743_SB_JA_2020_M
022-001, 018-001, 020-001

Monthly Premium, Deductibles, and Limits on How Much You Pay for Covered Services

	ATRIO Bronze (PPO) H6743-022-001	ATRIO Bronze Rx (Rogue) (PPO) H6743-018-001	ATRIO Silver Rx (PPO) H6743-020-001
Plan Premium	\$0 per month. In addition, you must keep paying your Medicare Part B premium.	\$0 per month. In addition, you must keep paying your Medicare Part B premium.	\$99 per month. In addition, you must keep paying your Medicare Part B premium.
Plan Deductible	\$150	\$150	This plan does not have a deductible
Out-of-Pocket Limits	\$3,900 for services you receive from in-network providers. \$5,500 for services you receive from any provider. Your limit for services received from in-network providers will count toward this limit.	\$3,900 for services you receive from in-network providers. \$5,500 for services you receive from any provider. Your limit for services received from in-network providers will count toward this limit.	\$3,500 for services you receive from in-network providers. \$5,500 for services you receive from any provider. Your limit for services received from in-network providers will count toward this limit.

Covered Medical and Hospital Benefits

Note: Services marked with * may require prior authorization.

	ATRIO Bronze (PPO) H6743-022-001	ATRIO Bronze Rx (Rogue) (PPO) H6743-018-001	ATRIO Silver Rx (PPO) H6743-020-001
Inpatient Hospital Care (Acute) * Our plan covers an unlimited number of days for an inpatient hospital (acute) stay.	In-network: <ul style="list-style-type: none"> \$300 copay per day for days 1-7 \$0 copay per day for days 8-90 \$0 copay per day for days 91 and beyond Out-of-network: <ul style="list-style-type: none"> \$375 copay per day for days 1-7 \$0 copay per day for days 8-90 There is a \$2,100 out-of-pocket maximum for Inpatient Hospital Care every benefit period.	In-network: <ul style="list-style-type: none"> \$300 copay per day for days 1-7 \$0 copay per day for days 8-90 \$0 copay per day for days 91 and beyond Out-of-network: <ul style="list-style-type: none"> \$375 copay per day for days 1-7 \$0 copay per day for days 8-90 There is a \$2,100 out-of-pocket maximum for Inpatient Hospital Care every benefit period.	In-network: <ul style="list-style-type: none"> \$200 copay per day for days 1-8 \$0 copay per day for days 9-90 \$0 copay per day for days 91 and beyond Out-of-network: <ul style="list-style-type: none"> \$325 copay per day for days 1-8 \$0 copay per day for days 9-90 There is a \$1,600 out-of-pocket maximum for Inpatient Hospital Care every benefit period.
Outpatient Hospital *	Outpatient hospital: In-network: \$325 copay Out-of-network: \$325 copay	Outpatient hospital: In-network: \$325 copay Out-of-network: \$425 copay	Outpatient hospital: In-network: \$275 copay Out-of-network: \$375 copay

Summary of Benefits: January 1, 2020 – December 31, 2020

	ATRIO Bronze (PPO) H6743-022-001	ATRIO Bronze Rx (Rogue) (PPO) H6743-018-001	ATRIO Silver Rx (PPO) H6743-020-001
Ambulatory Surgery Center *	Ambulatory surgery center: In-network: \$225 copay Out-of-network: \$325 copay	Ambulatory surgery center: In-network: \$225 copay Out-of-network: \$325 copay	Ambulatory surgery center: In-network: \$225 copay Out-of-network: \$325 copay
Doctor's Office Visits	Primary care physician: In-network: \$20 copay Out-of-network: \$40 copay Specialist: In-network: \$45 copay Out-of-network: 50% copay	Primary care physician: In-network: \$20 copay Out-of-network: \$40 copay Specialist: In-network: \$45 copay Out-of-network: \$50 copay	Primary care physician: In-network: \$15 copay Out-of-network: \$30 copay Specialist: In-network: \$20 copay Out-of-network: \$40 copay
Preventive Care	You pay nothing for Medicare covered preventive services. Any additional preventive services approved by Medicare during the contract year will be covered. Our plan also covers an Annual Physical Exam at no cost.		
Emergency Care Worldwide emergency/urgent coverage.	\$90 copay	\$90 copay	\$90 copay
Urgently Needed Services Worldwide emergency/urgent coverage, see "Emergency Care".	\$35 copay	\$35 copay	\$25 copay
Diagnostic Tests, Lab and Radiology Services, and X-rays *	Diagnostic tests and procedures: In-network: \$20 copay Out-of-network: 30% of the cost Lab Services In-network: \$20 copay Out-of-network: 15% of the cost Diagnostic radiology services (such as MRIs, CT scans): In-network: 20% of the cost Out-of-network: 30% of the cost	Diagnostic tests and procedures: In-network: \$20 copay Out-of-network: 30% of the cost Lab Services In-network: \$20 copay Out-of-network: 15% of the cost Diagnostic radiology services (such as MRIs, CT scans): In-network: 20% of the cost Out-of-network: 30% of the cost	Diagnostic tests and procedures: In-network: \$10 copay Out-of-network: 30% of the cost Lab Services In-network: \$0 copay Out-of-network: \$0 copay Diagnostic radiology services (such as MRIs, CT scans): In-network: 20% of the cost Out-of-network: 30% of the cost

Summary of Benefits: January 1, 2020 – December 31, 2020

	ATRIO Bronze (PPO) H6743-022-001	ATRIO Bronze Rx (Rogue) (PPO) H6743-018-001	ATRIO Silver Rx (PPO) H6743-020-001
	<p>Therapeutic radiology services (such as radiation treatment for cancer):</p> <p style="padding-left: 40px;">In-network: 20% of the cost</p> <p style="padding-left: 40px;">Out-of-network: 30% of the cost</p> <p>Outpatient x-rays:</p> <p style="padding-left: 40px;">In-network: \$20 copay</p> <p style="padding-left: 40px;">Out-of-network: 30% of the cost</p>	<p>Therapeutic radiology services (such as radiation treatment for cancer):</p> <p style="padding-left: 40px;">In-network: 20% of the cost</p> <p style="padding-left: 40px;">Out-of-network: 30% of the cost</p> <p>Outpatient x-rays:</p> <p style="padding-left: 40px;">In-network: \$20 copay</p> <p style="padding-left: 40px;">Out-of-network: 30% of the cost</p>	<p>Therapeutic radiology services (such as radiation treatment for cancer):</p> <p style="padding-left: 40px;">In-network: 20% of the cost</p> <p style="padding-left: 40px;">Out-of-network: 30% of the cost</p> <p>Outpatient x-rays:</p> <p style="padding-left: 40px;">In-network: \$10 copay</p> <p style="padding-left: 40px;">Out-of-network: 30% of the cost</p>
<p>Hearing Services</p> <p>Medicare-covered: Exam to diagnose and treat hearing and balance issues.</p>	<p>Medicare-covered:</p> <p style="padding-left: 40px;">In-network: \$45 copay</p> <p style="padding-left: 40px;">Out-of-network: 50% of the cost</p>	<p>Medicare-covered:</p> <p style="padding-left: 40px;">In-network: \$45 copay</p> <p style="padding-left: 40px;">Out-of-network: 50% of the cost</p>	<p>Medicare-covered:</p> <p style="padding-left: 40px;">In-network: \$15 copay</p> <p style="padding-left: 40px;">Out-of-network: 50% of the cost</p>
<p>Dental Services *</p> <p>Medicare-covered: Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth).</p>	<p>Medicare-covered:</p> <p style="padding-left: 40px;">In-network: \$45 copay</p> <p style="padding-left: 40px;">Out-of-network: \$45 copay</p> <p>Preventive dental services are an optional supplemental benefit that are covered with an additional premium. See the Optional Supplemental Benefits section for details.</p>	<p>Medicare-covered:</p> <p style="padding-left: 40px;">In-network: \$45 copay</p> <p style="padding-left: 40px;">Out-of-network: \$45 copay</p> <p>Preventive dental services are an optional supplemental benefit that are covered with an additional premium. See the Optional Supplemental Benefits section for details.</p>	<p>Medicare-covered:</p> <p style="padding-left: 40px;">In-network: \$15 copay</p> <p style="padding-left: 40px;">Out-of-network: \$15 copay</p> <p>Preventive dental services are an optional supplemental benefit that are covered with an additional premium. See the Optional Supplemental Benefits section for details.</p>
<p>Vision Services</p> <p>Medicare-covered: Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening).</p>	<p>Medicare-covered:</p> <p style="padding-left: 40px;">In-network: \$45 copay</p> <p style="padding-left: 40px;">Out-of-network: \$45 copay</p> <p>Routine vision services are an optional supplemental benefit that are covered with an additional premium. See the Optional Supplemental Benefits section for details.</p>	<p>Medicare-covered:</p> <p style="padding-left: 40px;">In-network: \$45 copay</p> <p style="padding-left: 40px;">Out-of-network: \$45 copay</p> <p>Routine vision services are an optional supplemental benefit that are covered with an additional premium. See the Optional Supplemental Benefits section for details.</p>	<p>Medicare-covered:</p> <p style="padding-left: 40px;">In-network: \$15 copay</p> <p style="padding-left: 40px;">Out-of-network: \$15 copay</p> <p>Routine vision services are an optional supplemental benefit that are covered with an additional premium. See the Optional Supplemental Benefits section for details.</p>
<p>Mental Health Services *</p>	<p>Inpatient mental health care:</p> <p>In-network:</p> <ul style="list-style-type: none"> • \$250 copay per day for days 1-7 • \$0 copay per day for days 8-90 	<p>Inpatient mental health care:</p> <p>In-network:</p> <ul style="list-style-type: none"> • \$250 copay per day for days 1-7 • \$0 copay per day for days 8-90 	<p>Inpatient mental health care:</p> <p>In-network:</p> <ul style="list-style-type: none"> • \$200 copay per day for days 1-8 • \$0 copay per day for days 9-90

Summary of Benefits: January 1, 2020 – December 31, 2020

	ATRIO Bronze (PPO) H6743-022-001	ATRIO Bronze Rx (Rogue) (PPO) H6743-018-001	ATRIO Silver Rx (PPO) H6743-020-001
	<p>Out-of-network:</p> <ul style="list-style-type: none"> \$375 copay per day for days 1-7 \$0 copay per day for days 8-90 <p>Outpatient group and individual therapy visit:</p> <p>In-network: \$40 copay Out-of-network: 50% of the cost</p>	<p>Out-of-network:</p> <ul style="list-style-type: none"> \$375 copay per day for days 1-7 \$0 copay per day for days 8-90 <p>Outpatient group and individual therapy visit:</p> <p>In-network: \$40 copay Out-of-network: 50% of the cost</p>	<p>Out-of-network:</p> <ul style="list-style-type: none"> \$325 copay per day for days 1-8 \$0 copay per day for days 9-90 <p>Outpatient group and individual therapy visit:</p> <p>In-network: \$20 copay Out-of-network: 50% of the cost</p>
Skilled Nursing Facility (SNF) *	<p>In-Network:</p> <ul style="list-style-type: none"> \$0 copay per day for days 1-20 \$125 copay per day for days 21-100 <p>Out-of-network: \$125 copay per day for days 1-100</p>	<p>In-Network:</p> <ul style="list-style-type: none"> \$0 copay per day for days 1-20 \$125 copay per day for days 21-100 <p>Out-of-network: \$125 copay per day for days 1-100</p>	<p>In-Network:</p> <ul style="list-style-type: none"> \$0 copay per day for days 1-20 \$125 copay per day for days 21-100 <p>Out-of-network: \$125 copay per day for days 1-100</p>
Rehabilitation Services *	<p>Cardiac Rehabilitation, Pulmonary Rehabilitation, and Supervised Exercise Therapy (SET) visit:</p> <p>In-network: 20% of the cost Out-of-network: 50% of the cost</p> <p>Occupational, Physical and Speech/Language Therapy visit:</p> <p>In-network: \$40 copay Out-of-network: 50% of the cost</p>	<p>Cardiac Rehabilitation, Pulmonary Rehabilitation, and Supervised Exercise Therapy (SET) visit:</p> <p>In-network: 20% of the cost Out-of-network: 50% of the cost</p> <p>Occupational, Physical and Speech/Language Therapy visit:</p> <p>In-network: \$40 copay Out-of-network: 50% of the cost</p>	<p>Cardiac Rehabilitation, Pulmonary Rehabilitation, and Supervised Exercise Therapy (SET) visit:</p> <p>In-network: 20% of the cost Out-of-network: 50% of the cost</p> <p>Occupational, Physical and Speech/Language Therapy visit:</p> <p>In-network: \$20 copay Out-of-network: 50% of the cost</p>
Ambulance *	<p>In-network: \$250 copay Out-of-network: \$250 copay</p>	<p>In-network: \$250 copay Out-of-network: \$250 copay</p>	<p>In-network: \$200 copay Out-of-network: \$200 copay</p>
Transportation	Not Covered	Not Covered	Not Covered
Medicare Part B Drugs *	<p>In-network: 20% of the cost Out-of-network: 50% of the cost</p>	<p>In-network: 20% of the cost Out-of-network: 50% of the cost</p>	<p>In-network: 20% of the cost Out-of-network: 50% of the cost</p>
Foot Care Medicare-covered: Foot exams and treatment if you have diabetes-related	<p>Medicare-covered:</p> <p>In-network: \$45 copay Out-of-network: 50% of the cost</p>	<p>Medicare-covered:</p> <p>In-network: \$45 copay Out-of-network: 50% of the cost</p>	<p>Medicare-covered:</p> <p>In-network: \$20 copay Out-of-network: 50% of the cost</p>

Summary of Benefits: January 1, 2020 – December 31, 2020

	ATRIO Bronze (PPO) H6743-022-001	ATRIO Bronze Rx (Rogue) (PPO) H6743-018-001	ATRIO Silver Rx (PPO) H6743-020-001
nerve damage and/or meet certain conditions.			
Medical Equipment and Supplies *	DME, Prosthetic/Medical supplies: In-network: 20% of the cost Out-of-network: 40% of the cost Diabetic supplies and services: In-network: 0% coinsurance Out-of-network: 20% coinsurance	DME, Prosthetic/Medical supplies: In-network: 15% of the cost Out-of-network: 18% of the cost Diabetic supplies and services: In-network: 0% coinsurance Out-of-network: 20% coinsurance	DME, Prosthetic/Medical supplies: In-network: 20% of the cost Out-of-network: 50% of the cost Diabetic supplies and services: In-network: 0% coinsurance Out-of-network: 20% coinsurance
Wellness Programs	Not covered	Not covered	Fitness Benefit: \$500 maximum plan benefit coverage every calendar year.
Chiropractic Services Medicare-covered: Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position).	Medicare-covered: In-network: \$20 copay Out-of-network: 50% of the cost	Medicare-covered: In-network: \$20 copay Out-of-network: 50% of the cost	Medicare-covered: In-network: \$15 copay Out-of-network: 50% of the cost

Optional Supplemental Benefits

The chart below describes the optional supplemental benefit package offered.

Premium	\$26
Preventive Dental	In-network and out-of-network: \$35 copay for a single office visit that includes: <ul style="list-style-type: none"> • Cleaning (for up to 2 every year) • Dental x-ray(s) (for up to 1 every year) • Fluoride treatment (for up to 2 every year) • Oral exam (for up to 2 every year) Our plan pays up to \$500 every calendar year for preventive dental services from any provider.
Routine Vision Exam	In-network and out-of-network: \$35 copay for 1 routine vision exam every calendar year.
Routine Eyewear	Our plan pays up to \$100 every two calendar years for eyewear from any provider.

Prescription Drug Benefits

There is no Prescription Drug Benefit (Part D) for **ATRIO Bronze (PPO)**.

Deductible Stage

The Part D Deductible applies only to drugs in tiers 3, 4 and 5.

ATRIO Bronze Rx (Rogue) (PPO) H6743-018-001	ATRIO Silver Rx (PPO) H6743-020-001
The Part D deductible is \$275	The Part D deductible is \$200

Initial Coverage Stage

You pay the following until your total yearly drug costs reach \$4,020.

ATRIO Bronze Rx (Rogue) (PPO)			ATRIO Silver Rx (PPO)		
Standard Retail Cost Sharing			Standard Retail Cost Sharing		
Tier	30-day supply	90-day supply	Tier	30-day supply	90-day supply
Tier 1 (Preferred Generic)	\$10 copay	\$20 copay	Tier 1 (Preferred Generic)	\$6 copay	\$12 copay
Tier 2 (Generic)	\$20 copay	\$40 copay	Tier 2 (Generic)	\$15 copay	\$30 copay
Tier 3 (Preferred Brand)	\$45 copay	\$90 copay	Tier 3 (Preferred Brand)	\$40 copay	\$80 copay
Tier 4 (Non-Preferred Drug)	\$95 copay	\$190 copay	Tier 4 (Non-Preferred Drug)	\$85 copay	\$170 copay
Tier 5 (Specialty Tier)	28% of the cost	Not Available	Tier 5 (Specialty Tier)	29% of the cost	Not Available
Tier 6 (Select Care Drugs)	\$0	\$0	Tier 6 (Select Care Drugs)	\$0	\$0

Coverage Gap Stage

Most Medicare drug plans have a coverage gap (also called the "donut hole"). The coverage gap begins after the total yearly drug cost reaches \$4,020.

After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and 25% of the plan's cost for covered generic drugs until your costs total \$6,350, which is the end of the coverage gap.

Catastrophic Coverage Stage

After your yearly out-of-pocket drug costs reach \$6,350, you pay the greater of:

- 5% of the cost, or
- \$3.60 copay for generic and an \$8.95 copayment for all other drugs.



**JACKSON
COUNTY OFFICE**

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1(877)672-8620

TTY/TDD: 1(800)735-2900

OFFICE HOURS

Daily, 8 a.m. - 5 p.m. Pacific

**CUSTOMER
SERVICE HOURS**

Daily, 8 a.m. - 8 p.m. Pacific

You may be able to get Extra Help to pay for your prescription drug premiums and costs. To see if you qualify for Extra Help, Call:

- 1(800)MEDICARE
TTY/TDD users should call
1(877)486-2048, 24 hours a
day/7 days a week.
- The Social Security Office at
1(800)772-1213 between 7 a.m.
and 7 p.m., Monday through
Friday. TTY/TDD users should
call 1(800)325-0778, or your
Medicaid Office.

ATRIO Health Plans has PPO and HMO
D-SNP plans with a Medicare contract.
Enrollment in ATRIO Health Plans
depends on contract renewal.

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