ATRIO™
HEALTH PLANS

2021 MEDICARE
ADVANTAGE PLAN

SUMMARY OF BENEFITS

*Serving Members in **Klamath 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.

2021 Summary of Benefits

January 1, 2021 – December 31, 2021

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 (Basin) (PPO), ATRIO Silver (PPO), ATRIO Silver Rx (PPO)** and **ATRIO Gold 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: **Klamath* County.**

***We cover the following zip codes in Klamath County: 97601, 97602, 97603, 97604, 97621, 97622, 97623, 97624, 97625, 97626, 97627, 97632, 97633, 97634, 97639.**

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	
☐	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.
☐	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.
☐	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	
☐	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.
☐	Benefits, premiums and/or copayments/co-insurance may change on January 1, 2022.
☐	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_K_2021_M

022-004, 001, 019-004, 020-004, 021-004

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

	ATRIO Bronze (PPO) H6743-022-004	ATRIO Bronze Rx (Basin) (PPO) H6743-001	ATRIO Silver (PPO) H6743-019-004	ATRIO Silver Rx (PPO) H6743-020-004	ATRIO Gold Rx (PPO) H6743-021-004
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.	$65 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.	$200 per month. In addition, you must keep paying your Medicare Part B premium.
Plan Deductible	$110	This plan does not have a deductible	This plan does not have a deductible	This plan does not have a deductible	This plan does not have a deductible
Out-of-Pocket Limits	$4,500 for services you receive from in-network providers. $6,500 for services you receive from any provider. Your limit for services received from in-network providers will count toward this limit.	$4,500 for services you receive from in-network providers. $6,500 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. $6,500 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. $6,500 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. $6,000 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) H6743-022-004	ATRIO Bronze Rx (Basin) (PPO) H6743-001	ATRIO Silver (PPO) H6743-019-004	ATRIO Silver Rx (PPO) H6743-020-004	ATRIO Gold Rx (PPO) H6743-021-004
Inpatient Hospital Care (Acute) * Our plan covers an unlimited number of days for an inpatient hospital (acute) stay.	In-network: • $275 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: • $375 copay per day for days 1-7 • $0 copay per day for days 8-90	In-network: • $315 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: • $415 copay per day for days 1-7 • $0 copay per day for days 8-90	In-network: • $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: • $325 copay per day for days 1-8 • $0 copay per day for days 9-90	In-network: • $225 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: • $350 copay per day for days 1-8 • $0 copay per day for days 9-90	In-network: • $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: • $325 copay per day for days 1-8 • $0 copay per day for days 9-90
Outpatient Hospital *	Outpatient hospital: In-network: 20% of the cost Out-of-network: 30% of the cost	Outpatient hospital: In-network: 25% of the cost Out-of-network: 40% of the cost	Outpatient hospital: In-network: $275 copay Out-of-network: $325 copay	Outpatient hospital: In-network: $275 copay Out-of-network: $325 copay	Outpatient hospital: In-network: $225 copay Out-of-network: $325 copay
Ambulatory Surgery Center *	Ambulatory surgery center: In-network: 20% of the cost Out-of-network: 30% of the cost	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	Ambulatory surgery center: In-network: $200 copay Out-of-network: $325 copay
Doctor's Office Visits	Primary care physician: In-network: $10 copay Out-of-network: $50 copay Specialist: In-network: $25 copay Out-of-network: $65 copay	Primary care physician: In-network: $10 copay Out-of-network: $50 copay Specialist: In-network: $45 copay Out-of-network: $65 copay	Primary care physician: In-network: $10 copay Out-of-network: $30 copay Specialist: In-network: $25 copay Out-of-network: $50 copay	Primary care physician: In-network: $10 copay Out-of-network: $30 copay Specialist: In-network: $25 copay Out-of-network: $50 copay	Primary care physician: In-network: $10 copay Out-of-network: $25 copay Specialist: In-network: $25 copay Out-of-network: $50 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.				

	ATRIO Bronze (PPO) H6743-022-004	ATRIO Bronze Rx (Basin) (PPO) H6743-001	ATRIO Silver (PPO) H6743-019-004	ATRIO Silver Rx (PPO) H6743-020-004	ATRIO Gold Rx (PPO) H6743-021-004
Emergency Care Worldwide emergency/urgent coverage.	$90 copay	$90 copay	$90 copay	$90 copay	$90 copay
Urgently Needed Services Worldwide emergency/urgent coverage, see “Emergency Care”.	$35 copay	$35 copay	$25 copay	$25 copay	$15 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 Outpatient x-rays: In-network: $20 copay 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 Outpatient x-rays: In-network: $20 copay Out-of-network: 30% of the cost	Diagnostic tests and procedures: In-network: $15 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 Outpatient x-rays: In-network: $15 copay Out-of-network: 30% of the cost	Diagnostic tests and procedures: In-network: $15 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 Outpatient x-rays: In-network: $15 copay 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: 15% of the cost Out-of-network: 30% of the cost Outpatient x-rays: In-network: $10 copay Out-of-network: 30% of the cost
Hearing Services Medicare-covered: Exam to diagnose and treat hearing and balance issues.	Medicare-covered: In-network: $45 copay Out-of-network: $50 copay	Medicare-covered: In-network: $45 copay Out-of-network: $50 copay	Medicare-covered: In-network: $15 copay Out-of-network: $50 copay	Medicare-covered: In-network: $15 copay Out-of-network: $50 copay	Medicare-covered: In-network: $15 copay Out-of-network: $50 copay Routine hearing exam: In-network: $15 copay Out-of-network: $50 copay Hearing aid fitting/evaluation: In-network: $15 copay Out-of-network: $50 copay Our plan pays up to $300 every year for routine hearing exams, hearing aid fitting/evaluations, and hearing aids from any provider.

	ATRIO Bronze (PPO) H6743-022-004	ATRIO Bronze Rx (Basin) (PPO) H6743-001	ATRIO Silver (PPO) H6743-019-004	ATRIO Silver Rx (PPO) H6743-020-004	ATRIO Gold Rx (PPO) H6743-021-004
Dental Services * Medicare-covered: Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth).	Medicare-covered Dental Services only. Preventive dental services are an optional supplemental benefit that are covered with an additional premium. See the Optional Supplemental Benefits section for details.	Medicare-covered Dental Services only. Preventive dental services are an optional supplemental benefit that are covered with an additional premium. See the Optional Supplemental Benefits section for details.	Medicare-covered Dental Services only. Preventive dental services are an optional supplemental benefit that are covered with an additional premium. See the Optional Supplemental Benefits section for details.	Medicare-covered Dental Services only. Preventive dental services are an optional supplemental benefit that are covered with an additional premium. See the Optional Supplemental Benefits section for details.	Medicare-covered Dental Services. Preventive dental services: • In and out-of-network: $15 copay • Up to 2 oral exams every calendar year • Up to 2 Prophylaxis (cleanings) every calendar year • Up to 2 Fluoride treatments every calendar year • Up to 2 dental x-rays every calendar year Our plan pays up to $500 every year for preventive dental services from any provider.
Vision Services Medicare-covered: Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening).	Medicare-covered Vision Services only. Routine vision services are an optional supplemental benefit that are covered with an additional premium. See the Optional Supplemental Benefits section for details.	Medicare-covered Vision Services only. Routine vision services are an optional supplemental benefit that are covered with an additional premium. See the Optional Supplemental Benefits section for details.	Medicare-covered Vision Services only. Routine vision services are an optional supplemental benefit that are covered with an additional premium. See the Optional Supplemental Benefits section for details.	Medicare-covered Vision Services only. Routine vision services are an optional supplemental benefit that are covered with an additional premium. See the Optional Supplemental Benefits section for details.	Medicare-covered Vision Services. Routine eye exam: 1 routine vision exam every calendar year. In-network: $15 copay Out-of-network: $15 copay Our plan pays up to $200 every two calendar years for eyewear from any provider.
Mental Health Services *	Inpatient mental health care: In-network: • $225 copay per day for days 1-7 • $0 copay per day for days 8-90 Out-of-network: • $375 copay per day for days 1-7 • $0 copay per day for days 8-90 Outpatient group and individual therapy visit: In-network: $25 copay Out-of-network: 50% of the cost	Inpatient mental health care: In-network: • $250 copay per day for days 1-6 • $0 copay per day for days 7-90 Out-of-network: • $375 copay per day for days 1-7 • $0 copay per day for days 8-90 Outpatient group and individual therapy visit: In-network: $40 copay Out-of-network: 50% of the cost	Inpatient mental health care: In-network: • $200 copay per day for days 1-8 • $0 copay per day for days 9-90 Out-of-network: • $325 copay per day for days 1-8 • $0 copay per day for days 9-90 Outpatient group and individual therapy visit: In-network: $25 copay Out-of-network: 50% of the cost	Inpatient mental health care: In-network: • $200 copay per day for days 1-8 • $0 copay per day for days 9-90 Out-of-network: • $325 copay per day for days 1-8 • $0 copay per day for days 9-90 Outpatient group and individual therapy visit: In-network: $25 copay Out-of-network: 50% of the cost	Inpatient mental health care: In-network: • $200 copay per day for days 1-8 • $0 copay per day for days 9-90 Out-of-network: • $325 copay per day for days 1-8 • $0 copay per day for days 9-90 Outpatient group and individual therapy visit: In-network: $25 copay Out-of-network: 50% of the cost
Skilled Nursing Facility (SNF) *	In-Network: • $0 copay per day for days 1-20 • $150 copay per day for days 21-100 Out-of-network: $150 copay per day for days 1-100	In-Network: • $0 copay per day for days 1-20 • $150 copay per day for days 21-100 Out-of-network: $150 copay per day for days 1-100	In-Network: • $0 copay per day for days 1-20 • $125 copay per day for days 21-100 Out-of-network: $125 copay per day for days 1-100	In-Network: • $0 copay per day for days 1-20 • $125 copay per day for days 21-100 Out-of-network: $125 copay per day for days 1-100	In-Network: • $0 copay per day for days 1-20 • $125 copay per day for days 21-100 Out-of-network: $125 copay per day for days 1-100
Rehabilitation Services *	Occupational, Physical and Speech/Language Therapy visit: In-network: $25 copay Out-of-network: 50% of the cost	Occupational, Physical and Speech/Language Therapy visit: In-network: $40 copay Out-of-network: 50% of the cost	Occupational, Physical and Speech/Language Therapy visit: In-network: $25 copay Out-of-network: 50% of the cost	Occupational, Physical and Speech/Language Therapy visit: In-network: $25 copay Out-of-network: 50% of the cost	Occupational, Physical and Speech/Language Therapy visit: In-network: $25 copay Out-of-network: 50% of the cost

	ATRIO Bronze (PPO) H6743-022-004	ATRIO Bronze Rx (Basin) (PPO) H6743-001	ATRIO Silver (PPO) H6743-019-004	ATRIO Silver Rx (PPO) H6743-020-004	ATRIO Gold Rx (PPO) H6743-021-004
Ambulance *	In-network: $275 copay Out-of-network: $275 copay	In-network: $275 copay Out-of-network: $275 copay	In-network: $225 copay Out-of-network: $225 copay	In-network: $225 copay Out-of-network: $225 copay	In-network: $175 copay Out-of-network: $175 copay
Transportation	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Medicare Part B Drugs *	In-network: 20% of the cost Out-of-network: 50% of the cost	In-network: 20% of the cost Out-of-network: 50% of the cost	In-network: 20% of the cost Out-of-network: 50% of the cost	In-network: 20% of the cost Out-of-network: 50% of the cost	In-network: 15% of the cost Out-of-network: 50% of the cost
Foot Care Medicare-covered: Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions.	Medicare-covered: In-network: $25 copay Out-of-network: 50% of the cost	Medicare-covered: In-network: $45 copay Out-of-network: 50% of the cost	Medicare-covered: In-network: $25 copay Out-of-network: 50% of the cost	Medicare-covered: In-network: $25 copay Out-of-network: 50% of the cost	Medicare-covered: In-network: $25 copay Out-of-network: 50% of the cost Routine foot care: In-network: $15 copay Out-of-network: 50% of the cost Our plan pays up to $500 every calendar year for routine foot care.
Medical Equipment and Supplies *	DME, Prosthetic/Medical supplies: In-network: 15% of the cost Out-of-network: 30% of the cost Diabetic supplies and services: In-network: 0% of the cost Out-of-network: 20% of the cost	DME, Prosthetic/Medical supplies: In-network: 17% of the cost Out-of-network: 30% of the cost Diabetic supplies and services: In-network: 0% of the cost Out-of-network: 20% of the cost	DME, Prosthetic/Medical supplies: In-network: 17% of the cost Out-of-network: 25% of the cost Diabetic supplies and services: In-network: 0% of the cost Out-of-network: 20% of the cost	DME, Prosthetic/Medical supplies: In-network: 18% of the cost Out-of-network: 25% of the cost Diabetic supplies and services: In-network: 0% of the cost Out-of-network: 20% of the cost	DME, Prosthetic/Medical supplies: In-network: 15% of the cost Out-of-network: 50% of the cost Diabetic supplies and services: In-network: 0% of the cost Out-of-network: 20% of the cost
Wellness Programs	Fitness Benefit: $200 maximum plan benefit coverage every calendar year.	Not covered	Fitness Benefit: $500 maximum plan benefit coverage every calendar year.	Fitness Benefit: $500 maximum plan benefit coverage every calendar year.	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 Chiropractic Services only.	Medicare-covered Chiropractic Services only.	Medicare-covered Chiropractic Services only.	Medicare-covered Chiropractic Services only.	Medicare-covered Chiropractic Services. Routine Chiropractic: In-network: $15 copay Out-of-network: 50% of the cost Our plan pays up to $500 every calendar year for routine chiropractic services.

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: • 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)** and **ATRIO Silver (PPO)**.

Deductible Stage

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

ATRIO Bronze Rx (Basin) (PPO) H6743-001	ATRIO Silver Rx (PPO) H6743-020-004	ATRIO Gold Rx (PPO) H6743-021-004
The Part D deductible is $250	The Part D deductible is $200	There is no Part D deductible

Initial Coverage Stage

You pay the following until your total yearly drug costs reach $4,130.

ATRIO Bronze Rx (Basin) (PPO)			ATRIO Silver Rx (PPO)			ATRIO Gold Rx (PPO)		
Standard Retail Cost Sharing			Standard Retail Cost Sharing			Standard Retail Cost Sharing		
Tier	**30-day supply**	**90-day supply**	**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 1 (Preferred Generic)	$4 copay	$8 copay
Tier 2 (Generic)	$20 copay	$40 copay	Tier 2 (Generic)	$15 copay	$30 copay	Tier 2 (Generic)	$10 copay	$20 copay
Tier 3 (Preferred Brand)	$45 copay	$90 copay	Tier 3 (Preferred Brand)	$40 copay	$80 copay	Tier 3 (Preferred Brand)	$35 copay	$70 copay
Tier 4 (Non-Preferred Drug)	$95 copay	$190 copay	Tier 4 (Non-Preferred Drug)	$85 copay	$170 copay	Tier 4 (Non-Preferred Drug)	$75 copay	$150 copay
Tier 5 (Specialty Tier)	28% of the cost	Not Available	Tier 5 (Specialty Tier)	29% of the cost	Not Available	Tier 5 (Specialty Tier)	33% of the cost	Not Available
Tier 6 (Select Care Drugs)	$0	$0	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 $4,130.

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 $6,550, which is the end of the coverage gap.

Catastrophic Coverage Stage

After your yearly out-of-pocket drug costs reach $6,550, you pay the greater of:

- 5% of the cost, or
- $3.70 copay for generic and a $9.20 copayment for all other drugs.

ATRIO™
HEALTH PLANS

KLAMATH COUNTY OFFICE

4509 S. 6th Street, Suite 305
Klamath Falls, OR 97603

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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