Table of Contents

Out-of-network/non-contracted providers are under no obligation to treat Saint Mary's ATRIO Health Plans 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.

2023 Summary of Benefits

January 1, 2023 – December 31, 2023

About the Summary of Benefits and Who Can Join

This is a summary of drug and health services covered by **Saint Mary's ATRIO Choice Rx (PPO),** and **Saint Mary's ATRIO Select 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 **saintmarysatrio.com**. To join an ATRIO Health Plans Medicare Advantage Plan, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

Our service area for these plans includes the following counties in **Nevada**: **Carson City, Churchill, Douglas, Lyon, Storey and Washoe**.

Which Doctors, Hospitals and Pharmacies Can I Use?

Saint Mary's 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. If you use providers that are not in our network, you may pay a higher out-of-pocket cost. You must generally use network pharmacies to fill your prescription drugs (if you choose a plan that includes drug coverage). You can see our plan's Formulary (Part D prescription drug list), Provider Directory and Pharmacy Directory at our website, **saintmarysatrio.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 **medicare.gov** or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY 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** (TTY 711), daily from 8 a.m. to 8 p.m. local time.

Understanding the Benefits	
☐	The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit **saintmarysatrio.com** or call **1-877-672-8620** (TTY 711) 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.
☐	If you choose a plan that includes drug coverage, 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.
☐	Review the formulary to make sure your drugs are covered.
☐	If you choose a plan that includes drug coverage, review the formulary to make sure your drugs are covered.
Understanding Important Rules	
☐	In addition to your monthly plan premium (if applicable), 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, 2024.

☐	Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services, the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care. In addition, you will pay a higher co-pay for services received by non-contracted providers.

ATRIO Health Plans is a PPO and HMO D-SNP with Medicare and Oregon Health Plan contracts. Enrollment in ATRIO Health Plans depends on contract renewal.

H7006_SB_NV_2023v2_M
H7006-010, H7006-011

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

	Saint Mary's ATRIO Choice Rx H7006-010	Saint Mary's ATRIO Select Rx H7006-011
Plan Premium	$0 per month. In addition, you must keep paying your Medicare Part B premium.	$20 per month. In addition, you must keep paying your Medicare Part B premium.
Plan Deductible	$0 per year	$0 per year
Out-of-Pocket Limits	$3,400 for services you receive from in-network providers. $5,450 for services you receive from any provider. Your limit for services received from in-network providers will count toward this limit.	$3,400 for services you receive from in-network providers. $5,450 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.

	Saint Mary's ATRIO Choice Rx H7006-010	Saint Mary's ATRIO Select Rx H7006-011
Inpatient Hospital Care (Acute) *	**In-network:** $0 per stay at Saint Mary's Regional Medical Center $100 per day for days 1 – 5, $0 per day for days 6 and beyond at all other in-network hospitals **Out-of-network:** 50% coinsurance per stay	**In-network:** $0 per stay at Saint Mary's Regional Medical Center $100 per day for days 1 – 5, $0 per dary for days 6 and beyond at all other in-network hospitals **Out-of-network:** 50% coinsurance per stay
Outpatient Hospital *	**In-network:** $0 to $350 copay **Out-of-network:** 50% coinsurance	**In-network:** $0 to $350 copay **Out-of-network:** 50% coinsurance
Ambulatory Surgery Center *	**In-network:** $25 copay **Out-of-network:** 50% coinsurance	**In-network:** $25 copay **Out-of-network:** 50% coinsurance
Doctor's Office Visits	Primary care physician: **In-network:** $0 copay **Out-of-network:** $50 copay Specialist: **In-network:** $20 copay **Out-of-network:** $50 copay	Primary care physician: **In-network:** $0 copay **Out-of-network:** $50 copay Specialist: **In-network:** $20 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 plan year will be covered. Our plan also covers a supplemental Annual Physical Exam at no cost.	

	Saint Mary's ATRIO Choice Rx H7006-010	**Saint Mary's ATRIO Select Rx H7006-011**
Emergency Care Worldwide emergency/urgent coverage.	$110 copay (waived if admitted within 24 hours for the same condition)	$125 copay (waived if admitted within 24 hours for the same condition)
Urgent Care See "Emergency Care" for worldwide copay.	$30 copay (waived if admitted within 24 hours for the same condition)	$30 copay (waived if admitted within 24 hours for the same condition)
Diagnostic Tests, Lab, X-rays, and Radiology Services * (such as MRIs, CT scans)	Diagnostic radiology services: **In-network:** $60 copay **Out-of-network:** 50% coinsurance Other diagnostic tests and procedures: **In-network:** $0 copay **Out-of-network:** 50% coinsurance Lab services **In-network:** $0 copay **Out-of-network:** 50% coinsurance Therapeutic radiology services (such as radiation treatment for cancer): **In-network:** $20 copay **Out-of-network:** 50% coinsurance Outpatient x-rays: **In-network:** $0 copay **Out-of-network:** 50% coinsurance	Diagnostic radiology services: **In-network:** $60 copay **Out-of-network:** 50% coinsurance Other diagnostic tests and procedures: **In-network:** $0 copay **Out-of-network:** 50% coinsurance Lab services **In-network:** $0 copay **Out-of-network:** 50% coinsurance Therapeutic radiology services (such as radiation treatment for cancer): **In-network:** $20 copay **Out-of-network:** 50% coinsurance Outpatient x-rays: **In-network:** $0 copay **Out-of-network:** 50% coinsurance
Hearing Services Medicare-covered: Exams to diagnose and treat hearing and balance issues.	Medicare-covered: **In-network:** $0 copay **Out-of-network:** 50% coinsurance Additional hearing services (not covered by Medicare): Routine hearing exam – **In-network:** $0 copay Hearing aids - $699 to $999 copay per aid, up to 2 per year (one per ear) **Out-of-network:** $0 copay (Amplifon provider must be used to receive hearing aid benefits)	Medicare-covered: **In-network:** $0 copay **Out-of-network:** 50% coinsurance Additional hearing services (not covered by Medicare): Routine hearing exam – **In-network:** $0 copay Hearing aids - $699 to $999 copay per aid, up to 2 per year (one per ear) **Out-of-network:** $0 copay (Amplifon provider must be used to receive hearing aid benefits)

	Saint Mary's ATRIO Choice Rx H7006-010	Saint Mary's ATRIO Select Rx H7006-011
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: **In-network:** $0 copay **Out-of-network:** 50% coinsurance Additional dental services (not covered by Medicare): **In & Out-of-network:** $0 copay up to allowance Annual allowance of $1,250 towards preventive and comprehensive dental services at any provider through a Flex Card.	Medicare-covered: **In-network:** $0 copay **Out-of-network:** 50% coinsurance Additional dental services (not covered by Medicare): **In & Out-of-network:** $0 copay up to allowance Annual allowance of $2,500 towards preventive and comprehensive dental services at any provider through a Flex Card.
Vision Services Medicare-covered: Exams to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening).	Medicare-covered exams: **In-network:** $0 copay **Out-of-network:** 50% coinsurance Medicare-covered glaucoma screening: **In & Out-of-network:** $0 copay Additional vision services (not covered by Medicare): Routine eye exam – **In-network:** $0 copay **Out-of-network**: 50% coinsurance Routine eyewear – **In-network:** $0 copay **Out-of-Network:** 50% coinsurance $150 allowance for frames every year; $100 allowance towards contact lenses, fitting and evaluation every year	Medicare-covered exams: **In-network:** $0 copay **Out-of-network:** 50% coinsurance Medicare-covered glaucoma screening: **In & Out-of-network:** $0 copay Additional vision services (not covered by Medicare): Routine eye exam – **In-network:** $0 copay **Out-of-network**: 50% coinsurance Routine eyewear – **In-network:** $0 copay **Out-of-Network:** 50% coinsurance $200 allowance for frames every year; $100 allowance towards contact lenses, fitting and evaluation every year
Mental Health Services *	Inpatient mental health care: **In-network:** $300 copay per day for days 1-5; $0 copay per day for days 6-90 **Out-of-network:** 50% coinsurance per stay Outpatient group and individual therapy visit: **In-network:** $10 copay **Out-of-network:** 50% coinsurance	Inpatient mental health care: **In-network:** $100 copay per day for days 1-5; $0 copay per day for days 6-90 **Out-of-network:** 50% coinsurance per stay Outpatient group and individual therapy visit: **In-network:** $10 copay **Out-of-network:** 50% coinsurance

	Saint Mary's ATRIO Choice Rx H7006-010	Saint Mary's ATRIO Select Rx H7006-011
Skilled Nursing Facility (SNF) *	**In-network:** $0 copay per day for days 1-20; $170 copay per day for days 21-100 **Out-of-network:** 50% coinsurance per stay	**In-network:** $0 copay per day for days 1-20; $170 copay per day for days 21-100 **Out-of-network:** 50% coinsurance per stay
Physical Therapy *	Physical & Speech therapy visit: **In-network:** $10 copay **Out-of-network:** 50% coinsurance Occupational therapy visit: **In-network:** $10 copay **Out-of-network:** 50% coinsurance	Physical & Speech therapy visit: **In-network:** $10 copay **Out-of-network:** 50% coinsurance Occupational therapy visit: **In-network:** $10 copay **Out-of-network:** 50% coinsurance
Ambulance *	**In-network:** $300 copay **Out-of-network:** $300 copay	**In-network:** $300 copay **Out-of-network:** $300 copay
Transportation	$0 copay for up to 24 one-way non-emergent medical transportation trips to any plan-approved health-related location every year. (SafeRide must be used to receive routine transportation benefits)	$0 copay for up to 24 one-way non-emergent medical transportation trips to any plan-approved health-related location every year. (SafeRide must be used to receive routine transportation benefits)
Medicare Part B Drugs *	**In-network:** 20% coinsurance **Out-of-network:** 50% coinsurance	**In-network:** 20% coinsurance **Out-of-network:** 50% coinsurance
Telehealth (Non-Medicare covered)	**In-network:** $0 copay **Out-of-network:** Not covered (Teladoc provider must be used to receive additional telehealth benefits)	**In-network:** $0 copay **Out-of-network:** Not covered (Teladoc provider must be used to receive additional telehealth benefits)
Foot Care Medicare-covered: Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions.	Medicare-covered: **In-network:** $5 copay **Out-of-network:** 50% coinsurance	Medicare-covered: **In-network:** $5 copay **Out-of-network:** 50% coinsurance
Medical Equipment and Supplies *	DME, prosthetic devices, medical supplies: **In-network:** 20% coinsurance **Out-of-network:** 50% coinsurance Diabetic supplies and services: **In-network:** 0% coinsurance	DME, prosthetic devices, medical supplies: **In-network:** 20% coinsurance **Out-of-network:** 50% coinsurance Diabetic supplies and services: **In-network:** 0% coinsurance

	Saint Mary's ATRIO Choice Rx H7006-010	Saint Mary's ATRIO Select Rx H7006-011
	Out-of-network: 50% coinsurance	**Out-of-network:** 50% coinsurance
Fitness	$250 annual allowance towards gym membership fees provided through a Flex Card.	$550 annual allowance towards gym membership fees provided through a Flex Card.
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:** $10 copay **Out-of-network:** 50% coinsurance	Medicare-covered: **In-network:** $10 copay **Out-of-network:** 50% coinsurance
Chiropractic and Acupuncture Services (Non-Medicare covered)	Not covered	**In-network:** $20 copay **Out-of-network:** 50% coinsurance Up to 30 combined visits for routine chiropractic and routine acupuncture services every year
Over-The-Counter Items	You receive an allowance of $100 per quarter	You receive an allowance of $150 per quarter
Meals*	$0 copay 2 meals per day for 14 days after an inpatient or skilled nursing facility stay or while receiving home health services	$0 copay 2 meals per day for 14 days after an inpatient or skilled nursing facility stay or while receiving home health services

Medicare Part D Prescription Drug Benefits

Deductible Stage

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

Saint Mary's ATRIO Choice Rx H7006-010	Saint Mary's ATRIO Select Rx H7006-011
$0 per year	$0 per year

Initial Coverage Stage

You pay the following until your total yearly drug costs reach $4,660.

If you reside in a long-term facility, you pay the same as at a standard retail pharmacy. If you choose mail-order, you pay the same as a retail 90-day supply at an in-network pharmacy. You may get drugs from an out-of-network pharmacy but may pay more than you pay at an in-network pharmacy.

Saint Mary's ATRIO Choice Rx			Saint Mary's ATRIO Select Rx		
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)	$0 copay	$0 copay	Tier 1 (Preferred Generic)	$0 copay	$0 copay

Saint Mary's ATRIO Choice Rx			Saint Mary's ATRIO Select Rx		
Tier 2 (Generic)	$12 copay	$24 copay	Tier 2 (Generic)	$12 copay	$24 copay
Tier 3 (Preferred Brand)	$35 copay	$105 copay	Tier 3 (Preferred Brand)	$35 copay	$105 copay
Tier 4 (Non-Preferred Drug)	$100 copay	$300 copay	Tier 4 (Non-Preferred Drug)	$100 copay	$300 copay
Tier 5 (Specialty Tier)	33% coinsurance	A long-term supply is not available	Tier 5 (Specialty Tier)	33% coinsurance	A long-term supply is not available
Tier 6 (Select Care Drugs)	$0 copay	$0 copay	Tier 6 (Select Care Drugs)	$0 copay	$0 copay

Coverage Gap Stage

Most Medicare drug plans have a coverage gap (also called the "donut hole"). The coverage gap begins once your total yearly drug costs reach $4,660.

Once you have entered the coverage gap, you pay 25% of the plan's cost for covered generic and brand name drugs until your yearly out-of-pockets costs reach $7,400, then you enter the Catastrophic Coverage Stage. This amount and rules for counting costs toward this amount have been set by Medicare.

Important Message About What You Pay for Vaccines - Our plan covers most Part D vaccines at no cost to you. Call Customer Service for more information.

Important Message About What You Pay for Insulin (Part D) - You won't pay more than $35, while you are in the Coverage Gap, for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.

Catastrophic Coverage Stage

Once your yearly out-of-pocket drug costs have reached $7,400, you will pay the greater of:

- 5% of the cost, or
- $4.15 copay for generic and a $10.35 copayment for all other drugs.