ATRIO™
HEALTH PLANS

2025 Medicare Advantage

ATRIO Choice Rx (PPO), Select Rx (HMO), Prime Rx (PPO), and Freedom (PPO)

Service area coverage for Klamath County*

Plan IDs include: H6743-001, H3814-031 , H6743-030, H6743-031

**Covered zip codes in Klamath County: 97601, 97602, 97603, 97604, 97621, 97622, 97623, 97624, 97625, 97626, 97627, 97632, 97633, 97634, 97639*

January 1, 2025 - December 31, 2025

STRAIGHT-UP LOCAL MEDICARE

For over 20 years we've been Oregon's local, dependable Medicare Advantage plan.

Local is Our Advantage

For over 20 years, ATRIO Health Plans has been providing high value, high quality and truly local Medicare coverage to thousands of our neighbors across Oregon and northern Nevada. We believe this is what makes us a different kind of health plan, a difference we're truly proud of.

While much has changed over 20 years, our commitment to improving the lives of the members we serve, and the health and wellness of our shared communities, remains stronger than ever. We still have our offices across the state to support our members in person. Our plans are still supported by our strong and diverse network of doctors, hospitals, and other partners who manage the care our members receive everyday. And we're still focused on bringing you affordable coverage and excellent service, so you can focus on your life – not your health and drug coverage.

This 2025 ATRIO Enrollment Kit has everything you need to compare your ATRIO Medicare Advantage plan options, see the value of our extra benefits, and complete the enrollment process. Come join us and find out why more and more of your neighbors are choosing ATRIO for their Medicare Advantage coverage each year.

Thank you for considering ATRIO Health Plans!

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

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Medicare Explained

Original Medicare is offered by the federal government and has two "Parts":

Medicare Part A is hospital insurance, and generally covers inpatient hospital care, skilled nursing facility, hospice, and home health care.

Medicare Part B is medical insurance that covers doctor's office visits, diagnostic lab and x-rays, outpatient services like surgery, flu shots, some medications, and more.

Part D Prescription Drug Coverage is not included with Original Medicare and is offered by private insurance companies. Note if you do not enroll in a Part D plan when you first become eligible for Medicare, you may have to pay a "late enrollment penalty" (LEP) for each month you delayed your Part D coverage. This LEP must be paid monthly for as long you are in a Part D plan.

Medicare Advantage

Medicare Advantage (MA) Plans (sometimes called "Part C") are offered by private companies and combine Medicare Part A and Part B coverage together with other benefits Medicare doesn't cover – like dental, vision, and hearing. Many also offer Part D coverage, bringing all these benefits into a single plan!

Like most MA plans, ATRIO Health Plans has networks of participating doctors, hospitals, pharmacies, and other care providers. Our members can visit any provider they choose,* but usually pay less with those in our networks. You do not have to choose a Primary Care Physician (PCP), but we encourage you to! A network PCP helps coordinate your care and get the most out of your benefits.

MA Eligibility: To join an ATRIO MA plan you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. If you are enrolled in one our plans you must continue to pay your monthly Medicare Part B premium.

**Out-of-network / non-contracted providers are under no obligation to treat Plan members, except in emergency situations. Please call Member Services or see your Evidence of Coverage for more information, including the cost sharing that applies to out-of-network services.*

Drug Coverage

Like most MA plans with drug coverage, ATRIO Health Plans has a "formulary" or list of drugs covered by the plan. The formulary offers a wide selection of Medicare-approved, cost-effective generic and brand name options. Each drug is on one of six drug "tiers." Your cost-share usually increases by tier, up to the highest cost-sharing tier 5 (tier 6 drugs have $0 copays).

Tier 1: Preferred Generic – low-cost generic drugs

Tier 2: Generic – most generic drugs and select brand drugs

Tier 3: Preferred Brand – preferred-brand and some high-cost generic drugs

Tier 4: Non-Preferred Brand – non-preferred brand and some high-cost generic drugs (approved non-formulary exception drugs are on this tier)

Tier 5: Specialty – specialty drugs (limited to a one-month supply)

Tier 6: Select Care Drugs – some important drugs at a $0 copay, like Part D vaccines, and selected generic ACE/ARB, anti-diabetic drugs, and statins for treatment of chronic conditions

The formulary also covers some over-the-counter (OTC) drugs, with a prescription from your doctor, at no cost to you.

What if my drug is not on the formulary?

If you can't find your drug, call Member Services or ask your pharmacist for a list of other drug options. You can also talk to your doctor about a different drug on the formulary, or you may submit a "Coverage Determination" request for a formulary exception. Visit atriohp.com for more information or you can ask your doctor to submit one for you.

What are the types of formulary drug restrictions?

Prior Authorization (PA) – an approval needed before getting the drug

Quantity Limits (QL) – a limit on how much of the drug you can get at a time

Step Therapy (ST) – a need to try another drug(s) for the same condition first

Part B vs. D Review – a check if the drug is covered under Part B or Part D

Medicare prescription drug rules are changing

To-date, if your prescription costs rose beyond a certain amount each year, you moved into the coverage gap, also known as the "donut hole," where you paid 100% of the costs yourself up to $8,000 annually. Beginning January 2025, the "donut hole" is being eliminated, and the most you will ever have to pay out of pocket for prescription drugs is $2,000 per year. Once you pay $2,000, you move to the Catastrophic Coverage phase and ATRIO pays 100% of your prescription drug costs.

Prescription Coverage Changes for 2025

A new program is available to you to help spread out your prescription drug costs

The new Medicare Prescription Payment Plan program (M3P/MPPP) will be available to you January 1, 2025. Participation in the M3P program is optional and can help you manage your out-of-pocket drug costs by spreading them out across the calendar year, **though it will not save you money or lower your drug costs**. ATRIO members who are most likely to benefit from the program will receive more details in the mail. Information will also be available online at atriohp.com on October 15, 2024.

For eligible prescriptions, you pay $0 at the pharmacy for covered Part D drugs and will be billed monthly by ATRIO. The amount billed monthly will be based on your monthly prescription costs as well as the $2,000 out-of-pocket annual maximum using a standardized formula created by CMS (Centers for Medicare & Medicaid Services). More information will be available online at atriohp.com/ Examples of monthly calculations can be found online at atiohp.com/.

Top 100 Most Commonly Prescribed Medications

Brand Name	Strength Desc	Dosage Form	2025 Tier
Albuterol Sulfate	2.5 Mg/3Ml	Vial-Neb	1
Albuterol Sulfate Hfa	90 Mcg	Hfa Aer Ad	2
Alendronate Sodium	70 Mg	Tablet	1
Allopurinol	100 Mg	Tablet	1
Alprazolam	0.5 Mg	Tablet	1
Amiodarone Hcl	200 Mg	Tablet	2
Amlodipine Besylate	5 Mg	Tablet	1
Amoxicillin	500 Mg	Capsule	1
Amoxicillin-Clavulanate Potass	875-125 Mg	Tablet	1
Atenolol	25 Mg	Tablet	1
Atorvastatin Calcium	40 Mg	Tablet	6
Azithromycin	250 Mg	Tablet	1
Baclofen	10 Mg	Tablet	2
Bupropion Xl	150 Mg	Tab Er 24H	1
Carvedilol	6.25 Mg	Tablet	1
Celecoxib	200 Mg	Capsule	2
Cephalexin	500 Mg	Capsule	1
Chlorhexidine Gluconate	0.12 %	Mouthwash	1
Chlorthalidone	25 Mg	Tablet	1
Ciprofloxacin Hcl	500 Mg	Tablet	1
Citalopram Hbr	20 Mg	Tablet	1
Clonazepam	0.5 Mg	Tablet	1
Clonidine Hcl	0.1 Mg	Tablet	1
Clopidogrel	75 Mg	Tablet	1
Cyclobenzaprine Hcl	10 Mg	Tablet	1
Diazepam	5 Mg	Tablet	1
Donepezil Hcl	10 Mg	Tablet	1
Dorzolamide-Timolol	22.3-6.8/1	Drops	1
Duloxetine Hcl	60 Mg	Capsule Dr	1
Eliquis	5 Mg	Tablet	3
Escitalopram Oxalate	20 Mg	Tablet	1
Estradiol	0.01 %	Cream/Appl	2
Ezetimibe	10 Mg	Tablet	1

Brand Name	Strength Desc	Dosage Form	2025 Tier
Famotidine	20 Mg	Tablet	1
Farxiga	10 Mg	Tablet	3
Finasteride	5 Mg	Tablet	1
Fluconazole	150 Mg	Tablet	1
Fluoxetine Hcl	20 Mg	Capsule	1
Fluticasone Propionate	50 Mcg	Spray Susp	1
Fluticasone-Salmeterol	250-50 Mcg	Blst W/Dev	1
Furosemide	20 Mg	Tablet	1
Gabapentin	300 Mg	Capsule	1
Hydrochlorothiazide	25 Mg	Tablet	1
Hydrocodone-Acetaminophen	5 Mg-325Mg	Tablet	1
Hydroxyzine Hcl	25 Mg	Tablet	1
Ibuprofen	800 Mg	Tablet	1
Ipratropium-Albuterol	0.5-3Mg/3	Ampul-Neb	1
Isosorbide Mononitrate Er	30 Mg	Tab Er 24H	1
Jardiance	10 Mg	Tablet	3
Lamotrigine	100 Mg	Tablet	1
Latanoprost	0.005 %	Drops	1
Levothyroxine Sodium	50 Mcg	Tablet	1
Lisinopril	20 Mg	Tablet	6
Lisinopril-Hydrochlorothiazide	20-12.5 Mg	Tablet	6
Lorazepam	1 Mg	Tablet	1
Losartan Potassium	50 Mg	Tablet	6
Lovastatin	40 Mg	Tablet	6
Meloxicam	15 Mg	Tablet	1
Metformin Hcl	500 Mg	Tablet	6
Metformin Hcl Er	500 Mg	Tab Er 24H	6
Methocarbamol	500 Mg	Tablet	1

Top 100 Most Commonly Prescribed Medications

Brand Name	Strength Desc	Dosage Form	2025 Tier
Methylprednisolone	4 Mg	Tab Ds Pk	1
Metoprolol Succinate	25 Mg	Tab Er 24H	1
Metoprolol Tartrate	25 Mg	Tablet	1
Montelukast Sodium	10 Mg	Tablet	1
Mupirocin	2 %	Oint. (G)	1
Naproxen	500 Mg	Tablet	1
Nitrofurantoin Mono-Macro	100 Mg	Capsule	1
Nitroglycerin	0.4 Mg	Tab Subl	1
Omeprazole	20 Mg	Capsule Dr	1
Ondansetron Odt	4 Mg	Tab Rapdis	2
Oxybutynin Chloride	5 Mg	Tablet	1
Oxycodone Hcl	5 Mg	Tablet	2
Oxycodone-Acetaminophen	5 Mg-325Mg	Tablet	2
Ozempic	.25 Or 0.5	Pen Injctr	3
Pantoprazole Sodium	40 Mg	Tablet Dr	1
Potassium Chloride	10 Meq	Tablet Er	1
Pravastatin Sodium	40 Mg	Tablet	6
Prednisolone Acetate	1 %	Drops Susp	4
Prednisone	20 Mg	Tablet	1
Progesterone	100 Mg	Capsule	2
Quetiapine Fumarate	25 Mg	Tablet	2
Rosuvastatin Calcium	10 Mg	Tablet	6
Semglee (Yfgn) Pen	100/Ml (3)	Insuln Pen	3
Sertraline Hcl	100 Mg	Tablet	1
Simvastatin	20 Mg	Tablet	6
Spironolactone	25 Mg	Tablet	1
Sulfamethoxazole-Trimethoprim	800-160 Mg	Tablet	1
Tamsulosin Hcl	0.4 Mg	Capsule	1
Timolol Maleate	0.5 %	Drops	1
Tizanidine Hcl	4 Mg	Tablet	1
Torsemide	20 Mg	Tablet	1
Tramadol Hcl	50 Mg	Tablet	1
Trazodone Hcl	50 Mg	Tablet	1
Trelegy Ellipta	100-62.5	Blst W/Dev	3
Triamcinolone Acetonide	0.1 %	Cream (G)	1
Venlafaxine Hcl Er	75 Mg	Cap Er 24H	1
Warfarin Sodium	5 Mg	Tablet	1
Xarelto	20 Mg	Tablet	3
Zolpidem Tartrate	10 Mg	Tablet	1

2025 Benefits at a Glance

ATRIO Health Plans Medicare Advantage Plans

ATRIO Choice Rx (PPO), ATRIO Prime Rx (PPO), ATRIO Freedom (PPO)

ATRIO Freedom (PPO) does not include drug coverage

ATRIO HEALTH PLANS

Klamath County (Partial), OR

Covered zip codes: 97601, 97602, 97603, 97604, 97621, 97622, 97623, 97624, 97625, 97626, 97627, 97632, 97633, 97634, 97639

Medical Benefits

Plan Costs	ATRIO Choice Rx (PPO) *H6743-001*		ATRIO Prime Rx (PPO) *H6743-030*		ATRIO Freedom (PPO) *H6743-031*	
Monthly plan premium	$35		$116		$0	
Plan deductible	$0		$0		$110	
Annual out-of-pocket maximum*	$4,950 In-network	$6,500 Combined *(In and Out-of-network)*	$4,150 In-network	$6,200 Combined *(In and Out-of-network)*	$5,500 In-network	$6,500 Combined *(In and Out-of-network)*

Doctor Office Visits	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network
Primary care provider (PCP)	$0 copay	$50 copay	$0 copay	$30 copay	$10 copay	$50 copay
Specialist	$40 copay	$50 copay	$25 copay	$50 copay	$25 copay	$65 copay
Telehealth (if provider offers Telehealth)	PCP: $0 copay Specialist: $40 copay	PCP: $50 copay Specialist: $50 copay	PCP: $0 copay Specialist: $25 copay	PCP: $30 copay Specialist: $50 copay	PCP: $10 copay Specialist: $25 copay	PCP: $50 copay Specialist: $65 copay

Inpatient Care	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network
Inpatient hospital care	$290 per day, 1-8 $0 per day, 9+	$395 per day, 1-7 $0 per day, 8-90	$350 per day, 1-8 $0 per day, 9+	$450 per day, 1-8 $0 per day, 9-90	$275 per day, 1-7 $0 per day, 8+	$375 per day, 1-7 $0 per day, 8-90
Skilled nursing facility (SNF)	$10 per day, 1-20 $214 per day, 21-100	$300 per day, 1-100	$20 per day, 1-20 $203 per day, 21-100	$203 per day, 1-100	$10 per day, 1-20 $203 per day, 21-100	$203 per day, 1-100

Outpatient Care	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network
Outpatient hospital	$500 copay	$600 copay	$275 copay	$325 copay	20% of total cost	30% of total cost
Ambulatory surgery center	$225 copay	$225 copay	$225 copay	$325 copay	20% of total cost	30% of total cost
Home health care	$0 copay	50% of total cost	$0 copay	50% of total cost	$0 copay	50% of total cost
Diabetic supplies	$0 copay	20% of total cost	$0 copay	50% of total cost	$0 copay	50% of total cost
Durable medical equipment	20% of total cost	30% of total cost	20% of total cost	25% of total cost	20% of total cost	30% of total cost

	ATRIO Choice Rx (PPO) *H6743-001*		ATRIO Prime Rx (PPO) *H6743-030*		ATRIO Freedom (PPO) *H6743-031*	
Labs & Tests	**In-network**	**Out-of-network**	**In-network**	**Out-of-network**	**In-network**	**Out-of-network**
Laboratory tests	$20 copay	15% of total cost	$0 copay	$0 copay	$20 copay	15% of total cost
Diagnostic imaging (MRI/CT/PET)	0 - 20% of total cost	30% of total cost	0 - 20% of total cost	30% of total cost	0 - 20% of total cost	30% of total cost
X-rays	$30 copay	30% of total cost	$15 Copay	30% of total cost	$20 copay	30% of total cost
Emergency Services						
Ambulance *(air & ground)*	$350 copay		$225 copay		$275 copay	
Emergency room**	$120 copay		$140 copay		$125 copay	
Urgently needed care	$55 copay		$55 copay		$55 copay	

**The most you will pay in a year for covered medical services*

***Coverage is worldwide. Copay waived if admitted within 24 hours for the same condition*

Supplemental Benefits

See the "Extra Benefits" section of the Enrollment Kit for a more detailed overview.

	ATRIO Choice Rx (PPO) *H6743-001*	ATRIO Prime Rx (PPO) *H6743-030*	ATRIO Freedom (PPO) *H6743-031*
Annual physical exam	$0 copay	$0 copay	$0 copay
Routine chiropractic, acupuncture,and naturopathic services	$300 allowance every six months†, loaded to your Flex Card, for combined routine chiropractic, acupuncture and naturopathy services ($600 annual allowance)	$100 allowance every six months†, loaded to your Flex Card, for combined routine chiropractic, acupuncture and naturopathy services ($200 annual allowance)	$100 allowance every six months†, loaded to your Flex Card, for combined routine chiropractic, acupuncture and naturopathy services ($200 annual allowance)
Fitness benefit	$175 allowance every six months†, loaded to your Flex Card, for gym membership fees and fitness classes ($350 annual allowance)	$200 allowance every six months†, loaded to your Flex Card, for gym membership fees and fitness classes ($400 annual allowance)	$100 allowance every six months†, loaded to your Flex Card, for gym membership fees and fitness classes ($200 annual allowance)
Preventive & comprehensive dental services	$200 allowance every six months†, loaded to your Flex Card, for comprehensive and preventive dental services. Excludes cosmetic procedures ($400 annual allowance)	$350 allowance every six months†, loaded to your Flex Card, for comprehensive and preventive dental services. Excludes cosmetic procedures ($700 annual allowance)	$300 allowance every six months†, loaded to your Flex Card, for comprehensive and preventive dental services. Excludes cosmetic procedures ($600 annual allowance)
Routine vision exam	$0 copay, 1 exam per year (in-network only)	$0 copay, 1 exam per year (in-network only)	$0 copay, 1 exam per year (in-network only)
Routine vision hardware	$150 allowance for frames (standard lenses included) or $100 allowance for contact lenses per year	$200 allowance for frames (standard lenses included) or $100 allowance for contact lenses per year	$150 allowance for frames (standard lenses included) or $100 allowance for contact lenses per year
Routine hearing exam	$0 copay, 1 exam per year (in-network only)	$0 copay, 1 exam per year (in-network only)	$0 copay, 1 exam per year (in-network only)
Hearing aids	$699 to $999 copay, for each hearing aid, up to 2 hearing aids per year (in-network only)	$699 to $999 copay, for each hearing aid, up to 2 hearing aids per year (in-network only)	$699 to $999 copay, for each hearing aid, up to 2 hearing aids per year (in-network only)
Meals	Up to 2 meals per day for 14 days after a qualifying event	Up to 2 meals per day for 14 days after a qualifying event	Up to 2 meals per day for 14 days after a qualifying event

	ATRIO Choice Rx (PPO) *H6743-001*	ATRIO Prime Rx (PPO) *H6743-030*	ATRIO Freedom (PPO) *H6743-031*
Transportation	$0 for 24 one-way trips every year to plan-approved health-related locations	$0 for 24 one-way trips every year to plan-approved health-related locations	Not Covered
Over-the-Counter (OTC) items	$25 allowance every three months†, loaded to your Flex Card, for select OTC items ($100 annual allowance)	$75 allowance every three months†, loaded to your Flex Card, for select OTC items ($300 annual allowance)	$25 allowance every three months†, loaded to your Flex Card, for select OTC items ($100 total annual allowance)

† Balance does not roll over

Prescription Drug Benefits

Save 1 monthly copay on a 90-day prescription. $0 out-of-pocket for many generic drugs, selected insulins and vaccines.

	ATRIO Choice Rx (PPO) *H6743-001*		ATRIO Prime Rx (PPO) *H6743-030*		ATRIO Freedom (PPO) *H6743-031*
Part D Deductible	$0				Plan does not include drug coverage
	30-day supply	**90-day supply**	**30-day supply**	**90-day supply**	
Tier 1 (Preferred generic)	$0 copay	$0 copay	$0 copay	$0 copay	
Tier 2 (Generic)	$8 copay	$16 copay	$8 copay	$16 copay	
Tier 3 (Preferred brand)	$47 copay	$94 copay	$47 copay	$94 copay	
Tier 4 (Non-preferred drug)	$100 copay	$200 copay	$100 copay	$200 copay	
Tier 5 (Specialty)	33% of total cost	Not Available	33% of total cost	Not Available	
Tier 6 (Select care drugs)	$0 copay	$0 copay	$0 copay	$0 copay	
Catastrophic coverage stage: After you have paid $2,000 out of pocket, you move to the Catastrophic Coverage Stage.	You pay nothing through the end of the year				

Save one month's copay by switching to a 90-day supply at a network retail or mail-order pharmacy. Ask your doctor about a 100-day supply and save even more (restrictions may apply).

NOTE: You will not pay more than $35 for a one-month supply of insulin, even if you have a deductible or if you have an insulin pump and your insulin is covered under Part B. $0 for adult vaccines recommended by the Centers for Disease Control, such as Shingles vaccine.

ATRIO Health Plans is a PPO, HMO, PPO C-SNP and HMO D-SNP with Medicare and Oregon Health Plan contracts. Enrollment in ATRIO Health Plans depends on contract renewal. Out-of-network / non-contracted providers are under no obligation to treat Plan members except in emergency situations. Please call Member Services or see your Evidence of Coverage for more information, including the cost sharing that applies to out-of-network services.

2025 Benefits at a Glance

ATRIO Health Plans Medicare Advantage Plans

ATRIO Select Rx (HMO)

Klamath County (Partial), OR

Covered zip codes: 97601, 97602, 97603, 97604, 97621, 97622, 97623, 97624, 97625, 97626, 97627, 97632, 97633, 97634, 97639

Medical Benefits

Plan Costs	ATRIO Select Rx (HMO) *H3814-031*
Monthly plan premium	$40
Plan deductible	$0
Annual out-of-pocket maximum*	$6,750 In-network

Doctor Office Visits	In-network
Primary care provider (PCP)	$0
Specialist (no referral needed)	$40
Telehealth (if provider offers Telehealth)	PCP: $0 copay Specialist: $40 copay

Inpatient Care	In-network
Inpatient hospital care	$350 per day, 1-6 $0 per day, 7+
Skilled nursing facility (SNF)	$10 per day, 1-20 $203 per day, 21-100

Outpatient Care	In-network
Outpatient hospital	$350 copay
Ambulatory surgery center	$300 copay
Home health care	$0 copay
Diabetes supplies	$0 copay
Durable medical equipment	20% of total cost

	ATRIO Select Rx (HMO) *H3814-031*
Labs and Tests	**In-network**
Laboratory tests	$20 copay
Diagnostic imaging (MRI/CT/PET)	0% - 20% of total cost
X-rays	$20 copay
Emergency Services	
Ambulance *(air & ground)*	$350 copay
Emergency room**	$120 copay
Urgently needed care	$55 copay

**The most you will pay in a year for covered medical services*

***Copay waived if admitted within 24 hours for the same condition*

Supplemental Benefits

See the "Extra Benefits" section of the Enrollment Kit for a more detailed overview.

	ATRIO Select Rx (HMO) *H3814-031*
Annual Physical exam	$0 copay
Routine chiropractic, acupuncture, and naturopathic services	$300 allowance every six months†, loaded to your Flex Card, for combined routine chiropractic, acupuncture and naturopathy services ($600 annual allowance)
Fitness benefit	$300 annual allowance†, loaded to your Flex Card, for gym membership fees and fitness classes
Routine Preventive & comprehensive dental services	$200 allowance every 6 months†, loaded to your Flex Card, for comprehensive and preventative dental services. Excludes cosmetic procedures ($400 annual allowance)
Routine vision exam	$0 copay, 1 exam per year (in-network only)
Routine vision hardware	$150 allowance for frames (standard lenses included) or contact lenses every year (in-network only)
Routine hearing exam	$0 copay, 1 exam per year (in-network only)
Hearing aids	$699 to $999 copay, for each hearing aid, up to 2 hearing aids per year (in-network only)
Meals	Up to 2 meals per day for 14 days after a qualifying event
Transportation	$0 for 12 one-way trips every year to plan-approved health-related locations
Over-the-Counter (OTC) items	$30 allowance every three months†, loaded to your Flex Card, for select OTC items ($120 annual allowance)

† Balance does not roll over

Prescription Drug Benefits

Save 1 monthly copay on a 90-day prescription. $0 out-of-pocket for many generic drugs, selected insulins and vaccines. Part D deductible applies to tiers 3,4, and 5.

	ATRIO Select Rx (HMO) *H3814-031*	
Part D Deductible	$350	
	30-day supply	**90-day supply**
Tier 1 (Preferred generic)	$5 copay	$10 copay
Tier 2 (Generic)	$20 copay	$40 copay
Tier 3 (Preferred brand)*	$47 copay	$94 copay
Tier 4 (Non-preferred drug)*	$100 copay	$200 copay
Tier 5 (Specialty)*	27% of total cost	Long-term not available
Tier 6 (Select care drugs)	$0 copay	$0 copay
Catastrophic coverage stage: After you have paid $2,000 out of pocket, you move to the Catastrophic Coverage Stage.	You pay nothing through the end of the year	

* Part D deductible applies

Save one month's copay by switching to a 90-day supply at a network retail or mail-order pharmacy. Ask your doctor about a 100-day supply and save even more (restrictions may apply).

NOTE: You will not pay more than $35 for a one-month supply of insulin, even if you have a deductible or if you have an insulin pump and your insulin is covered under Part B. $0 for adult vaccines recommended by the Centers for Disease Control, such as Shingles vaccine.

ATRIO Health Plans is a PPO, HMO, C-SNP and HMO D-SNP with Medicare and Oregon Health Plan contracts. Enrollment in ATRIO Health Plans depends on contract renewal. Out-of-network / non-contracted providers are under no obligation to treat Plan members except in emergency situations. Please call Member Services or see your Evidence of Coverage for more information, including the cost sharing that applies to out-of-network services.

Additional Benefits

When you choose ATRIO, you get extra benefits that Original Medicare does not cover.

Every ATRIO Medicare Advantage plan features the **Flex Card:** *a special debit card preloaded with dollars for* **dental, fitness, select over-the-counter drugstore items, as well as routine chiropractic, acupuncture, and naturopathy services.**

ATRIO FLEX CARD

Just swipe your Flex Card to pay for eligible items or services, and the amount will be deducted from your card's balance.

See included 'Summary of Benefits' for plan allowances and more information on all additional benefits

DENTAL

You receive an allowance to spend on dental care. **You choose your dentist and how to spend your dental funds**, up to your ATRIO plan's Flex Card allowance, on dental services including routine preventive care (like office visits, oral exams, cleanings, fluoride treatments and x-rays) and comprehensive care (like diagnostic or restorative services, tooth extractions, or oral surgeries).

FITNESS

You receive an allowance to spend on gym membership fees and fitness classes. **You choose your gym and how to spend your Flex Card fitness funds.**

OVER THE COUNTER (OTC)

You receive an allowance to spend on select health-related OTC items each quarter. **Use your Flex Card to get what you need by catalog, online or on the app, by phone, or at participating retailers.**

ALTERNATIVE THERAPY SERVICES

You receive an allowance to spend on **routine chiropractic, acupuncture, and naturopathy services.** You choose the provider!

(Allowances do not roll over - be sure to use them before the end of each benefit period)

VISION

You receive a $0 routine eye exam each year, **plus an allowance for eyeglasses** (frames and lenses) **or for contact lenses each year** (depending on your plan).

Must use VSP Vision Care® providers for supplemental exams and eyewear benefits.

HEARING

You pay $0 a routine hearing exam each year, plus an annual hearing aid benefit to use for a broad selection of high-quality devices.

Must use Amplifon® providers for supplemental exams and hearing aid benefits.

TRANSPORTATION (NON-EMERGENCY)

You pay $0 up to 12 or 24 one-way rides each year (depending on your plan) to your doctor, pharmacy, gym, or other plan-approved, health-related location.

Must use SafeRide® providers for in-network non-emergency transportation.

CASH BACK

You will get cash back monthly in your Social Security check* (Applies to most plans)

**To be eligible for the cash-back benefit, you must pay your own Part B premium.*

Additional Benefits

MEALS

You pay $0 for up to 28 meals (2 per day for 14 days) after each hospital or SNF stay or with some Home Health services. Meals are delivered to your home and can be tailored to your specific health or dietary needs.

Must use Mom's Meals® for in-network meal delivery benefit.

WORLDWIDE EMERGENCY AND URGENT CARE

Travel with confidence knowing **you have coverage for emergency and urgent care anywhere you go!**

Contact & Access Information

Visit atriohp.com for more information on additional benefits, or contact the appropriate service provider directly using the contact information below.

Flex Card – Incomm

To check balance or place an order call 1-833-287-3622 (TTY 711) from Monday – Friday, 5 a.m. to 8 p.m. PST. To report a lost or stolen card call ATRIO Member Services at 1-877-672-8620 (TTY 711).

Hearing – Amplifon

To find a provider near you and schedule an appointment, please call 1-866-375-0563 (TTY 711), Monday – Friday 8 a.m. to 5 p.m., PST

Vision – VSP Vision Care

To find a VSP Advantage network eye doctor, call 1-844-344-0572 (TTY 1-800-428-4833), daily from 8 a.m. to 8 p.m., local time

OTC – Medline

To place an order or for more information call 1-833-287-3622 (TTY 711). Catalogs can be found online at atriohp.com

Transportation – SafeRide

To schedule a ride, call 1-888-617-0467 (TTY 711), Monday – Saturday, 6 a.m. to 6 p.m., local time

STRAIGHT-UP LOCAL MEDICARE

2025 Medicare Advantage

SUMMARY OF BENEFITS

ATRIO Choice Rx (PPO), Select Rx (HMO), Prime Rx (PPO), and Freedom (PPO)

Service area coverage for Klamath County*

Plan IDs include: H6743-001, H3814-031 , H6743-023-3, H6743-024-3

**Covered zip codes in Klamath County: 97601, 97602, 97603, 97604, 97621, 97622, 97623, 97624, 97625, 97626, 97627, 97632, 97633, 97634, 97639*

January 1, 2025 - December 31, 2025

2025 Summary of Benefits

January 1, 2025 – December 31, 2025

ATRIO HEALTH PLANS

Table of Contents

About the Summary of Benefits and Who Can Join

This is a summary of ATRIO Health Plans health and drug services covered by ATRIO Choice Rx (PPO), ATRIO Select Rx (HMO), ATRIO Prime Rx (PPO) and ATRIO Freedom (PPO). The benefit information provided does not list every service that we cover or list every limitation or exclusion. For a complete list of services we cover, please view the Evidence of Coverage at atriohp.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 zip codes in Klamath County, Oregon: 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. 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, 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 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 Member Services 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 atriohp.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.
- [ ] 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, 2026.
- [ ] 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 copay for services received by non-contracted providers.

Plan Premiums, Deductible and Out-of-pocket Maximums

	ATRIO Choice Rx (PPO) *H6743-001*	ATRIO Select Rx (HMO) *H3814-031*	ATRIO Prime Rx (PPO) *H6743-030*	ATRIO Freedom (PPO) *H6743-031*
Plan Premium	$35 per month	$40 per month	$116 per month	$0 per month
	You must also continue to pay your Medicare Part B premium			
Part B premium giveback	$15 per month	$15 per month	$15 per month	Not Available
Plan Deductible	$0 per year	$0 per year	$0 per year	$0 per year
Out-of-Pocket Maximums	**In-network:** $4,950 for services you receive from in-network providers **Combined:** $6,500 for services you receive from any provider. Your limit for services received from in-network providers will count toward this limit.	**In-network:** $6,750 for services you receive from in-network providers	**In-network:** $4,150 for services you receive from in-network providers **Combined:** $6,200 for services you receive from any provider. Your limit for services received from in-network providers will count toward this limit.	**In-network:** $5,500 for services you receive from in-network providers **Combined:** $6,500 for services you receive from any provider. Your limit for services received from in-network providers will count toward this limit.

ATRIO HEALTH PLANS

Covered Medical and Hospital Benefits

*(Services marked with an * may require prior authorization)*

	ATRIO Choice Rx (PPO) *H6743-001*	ATRIO Select Rx (HMO) *H3814-031*	ATRIO Prime Rx (PPO) *H6743-030*	ATRIO Freedom (PPO) *H6743-031*
Inpatient Hospital Care (Acute) * Inpatient hospital stay copays do not count towards max out-of-pocket (MOOP)	**In-network:** $290 per day, 1-8 $0 per day, 9+ **Out-of-network:** $395 per day, 1-7 $0 per day, 8-90	**In-network:** $350 per day, 1-6 $0 per day, 7+	**In-network:** $350 per day 1-8 $0 per day, 9+ **Out-of-network:** $450 per day, 1-8 $0 per day, 9-90	**In-network:** $275 per day, 1-7 $0 per day, 8+ **Out-of-network:** $375 per day, 1-7 $0 per day, 8-90
Outpatient Hospital Services*	**In-network:** $500 copay **Out-of-network:** $600 copay	**In-network:** $350 copay	**In-network:** $275 copay **Out-of-network:** $325 copay	**In-network:** 20% of total cost **Out-of-network:** 30% of total cost
Ambulatory Surgery Center Services*	**In & out-of-network:** $225 copay	**In-network:** $300 copay	**In-network:** $225 copay **Out-of-network:** $325 copay	**In-network:** 20% of total cost **Out-of-network:** 30% of total cost
Doctor's Office Visits	**Primary Care Physician (PCP)**			
	In-network: $0 copay **Out-of-network:** $50 copay	**In-network:** $0 copay	**In-network:** $0 copay **Out-of-network:** $30 copay	**In-network:** $10 copay **Out-of-network:** $50 copay
	Specialists			
	In-network: $40 copay **Out-of-network:** $50 copay	**In-network:** $40 copay	**In-network:** $25 copay **Out-of-network:** $50 copay	**In-network:** $25 copay **Out-of-network:** $65 copay
Preventive Care	**In & out-of-network:** $0 copay	**In network:** $0 copay	**In & out-of-network:** $0 copay	**In & out-of-network:** $0 copay
	You pay nothing for Medicare-covered preventive services *Our plan also covers a supplemental Annual Physical Exam at no cost*			

ATRIO HEALTH PLANS

Covered Medical and Hospital Benefits

*(Services marked with an * may require prior authorization)*

	ATRIO Choice Rx (PPO) *H6743-001*	ATRIO Select Rx (HMO) *H3814-031*	ATRIO Prime Rx (PPO) *H6743-030*	ATRIO Freedom (PPO) *H6743-031*
Emergency Care Worldwide emergency/urgent coverage	$120 copay	$120 copay	$140 copay	$125 copay
	Worldwide ER services cost sharing is waived if you are admitted to the hospital within 24 hours for the same condition			
Urgent Care See "Emergency Care" for world-wide copay	$55 copay	$55 copay	$55 copay	$55 copay
	Urgently needed care services cost sharing is waived if you are admitted to the hospital within 24 hours for the same condition			
Diagnostic Tests, Lab, X-rays, and Radiology Services *	**Diagnostic Radiology Services * (such as MRIs, CT and PET scans)**			
	In-network: 0% - 20% of total cost **Out-of-network:** 30% of total cost	**In-network:** 0% - 20% of total cost	**In-network:** 0% - 20% of total cost **Out-of-network:** 30% of total cost	**In-network:** 0% - 20% of total cost **Out-of-network:** 30% of total cost
	Other Diagnostic Tests and Procedures			
	In-network: $0 - $20 copay **Out-of-network:** 30% of total cost	**In-network:** $20 - $50 copay	**In-network:** $0 - $15 copay **Out-of-network:** 30% of total cost	**In-network:** $0 - $20 copay **Out-of-network:** 30% of total cost
	Lab Services			
	In-network: $20 copay **Out-of-network:** 15% of total cost	**In-network:** $20 copay	**In-network:** $0 copay **Out-of-network:** $0 copay	**In-network:** $20 copay **Out-of-network:** 15% of total cost
	Therapeutic Radiology Services * *(such as radiation treatment for cancer)*			
	In-network: 20% of total cost **Out-of-network:** 30% of total cost	**In-network:** 20% of total cost	**In-network:** 20% of total cost **Out-of-network:** 30% of total cost	**In-network:** 20% of total cost **Out-of-network:** 30% of total cost

ATRIO HEALTH PLANS

Covered Medical and Hospital Benefits

*(Services marked with an * may require prior authorization)*

	ATRIO Choice Rx (PPO) *H6743-001*	ATRIO Select Rx (HMO) *H3814-031*	ATRIO Prime Rx (PPO) *H6743-030*	ATRIO Freedom (PPO) *H6743-031*
Diagnostic Tests, Lab, X-rays, and Radiology Services*	**Outpatient X-Rays**			
	In-network: $30 copay **Out-of-network:** 30% of total cost	**In-network:** $20 copay	**In-network:** $15 copay **Out-of-network:** 30% of total cost	**In-network:** $20 copay **Out-of-network:** 30% of total cost
Medicare covered: Exams to diagnose and treat hearing and balance issues **Supplemental Routine services** (services not covered by Medicare) must beadministered by an Amplifon provider	**Hearing Exam** *(Medicare-covered services)*			
	In-network: $45 copay **Out-of-network:** $50 copay	**In-network:** $0 copay	**In-network:** $15 copay **Out-of-network:** $50 copay	**In-network:** $45 copay **Out-of-network:** $50 copay
	Hearing Exam *(Supplemental routine services)*			
	In-network: $0 copay **Out-of-network:** $0 with prior authorization	**In-network:** $0 copay	**In-network:** $0 copay **Out-of-network:** 50% of total cost	**In-network:** $0 copay **Out-of-network:** 50% of total cost
	Hearing Aid fitting & evaluation *(Supplemental routine services)*			
	In-network: $0 copay **Out-of-network:** $0 with prior authorization	**In-network:** $0 copay	**In-network:** $0 copay **Out-of-network:** 50% of total cost	**In-network:** $0 copay **Out-of-network:** 50% of total cost
	Hearing Aids *(Supplemental routine services)*			
	In-network: $699 to $999 copay, for each hearing aid, up to 2 hearing aids per year **Out-of-network:** Requires prior authorization	**In-network:** $699 to $999 copay, for each hearing aid, up to 2 hearing aids per year	**In-network:** $699 to $999 copay, for each hearing aid, up to 2 hearing aids per year **Out-of-network:** Requires prior authorization	**In-network:** $699 to $999 copay, for each hearing aid, up to 2 hearing aids per year **Out-of-network:** Requires prior authorization

ATRIO HEALTH PLANS

Covered Medical and Hospital Benefits

*(Services marked with an * may require prior authorization)*

	ATRIO Choice Rx (PPO) *H6743-001*	ATRIO Select Rx (HMO) *H3814-031*	ATRIO Prime Rx (PPO) *H6743-030*	ATRIO Freedom (PPO) *H6743-031*
Dental Services* **Medicare covered:** Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth) †Benefit does not roll over	**Dental Services** *(Medicare-covered services)*			
	In-network: $45 copay **Out-of-network:** $65 copay	**In-network:** $40 copay	**In-network:** $15 copay **Out-of-network:** $15 copay	**In-network:** $45 copay **Out-of-network:** $45 copay
	Dental Services *(Supplemental routine services)*			
	In & out-of-network: $200 allowance every six months†, loaded to your Flex Card, for comprehensive and preventive dental services. Excludes cosmetic procedures ($400 annual allowance)	**In & out-of-network:** $200 allowance every six months†, loaded to your Flex Card, for comprehensive and preventive dental services. Excludes cosmetic procedures ($400 annual allowance)	**In & out-of-network:** $350 allowance every six months†, loaded to your Flex Card, for comprehensive and preventive dental services. Excludes cosmetic procedures ($700 annual allowance)	**In & out-of-network:** $300 allowance every six months†, loaded to your Flex Card, for comprehensive and preventive dental services. Excludes cosmetic procedures ($600 annual allowance)
Vision Services **Medicare covered:** Exams to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening) **Supplemental routine services** (services not covered by Medicare) administered by **VSP**	**Vision Exams** *(Medicare-covered services)*			
	In-network: $45 copay **Out-of-network:** $65 copay *Glaucoma screening* **In & out-of-network:** $0 copay	**In-network:** $0 copay *Glaucoma screening* **In & out-of-network:** $0 copay	**In-network:** $15 copay **Out-of-network:** $15 copay *Glaucoma screening* **In & out-of-network:** $0 copay	**In-network:** $45 copay **Out-of-network:** $45 copay *Glaucoma screening* **In & out-of-network:** $0 copay
	Vision Exams *(Supplemental routine services)*			
	In-network: $0 copay **Out-of-network:** 50% of total cost	**In-network:** $0 copay	**In-network:** $0 copay **Out-of-network:** 50% of total cost	**In-network:** $0 copay **Out-of-network:** 50% of total cost

Covered Medical and Hospital Benefits

*(Services marked with an * may require prior authorization)*

	ATRIO Choice Rx (PPO) *H6743-001*	ATRIO Select Rx (HMO) *H3814-031*	ATRIO Prime Rx (PPO) *H6743-030*	ATRIO Freedom (PPO) *H6743-031*
Vision Services **Supplemental routine services** (services not covered by Medicare) administered by **VSP**	**Vision Eyewear** *(Supplemental routine services)*			
	In-network: $150 allowance for frames (standard lenses included) or $100 allowance for contact lenses per year **Out-of-network:** $150 allowance for frames or $100 allowance for contact lenses per year. 50% total cost for lenses	**In-network:** $150 allowance for frames (standard lenses included) or $100 allowance for contact lenses per year	**In-network:** $200 allowance for frames (standard lenses included) or $100 allowance for contact lenses per year **Out-of-network:** $200 allowance for frames or $100 allowance for contact lenses per year. 50% total cost for lenses	**In-network:** $150 allowance for frames (standard lenses included) or $100 allowance for contact lenses per year **Out-of-network:** $150 allowance for frames or $100 allowance for contact lenses per year. 50% total cost for lenses
Mental Health Services*	**Inpatient Mental Health Care ***			
	In-network: $450 per day, 1-5 $0 per day, 6-90 **Out-of-network:** $395 per day, 1-8 $0 per day, 9-90	**In-network:** $350 per day, 1-6 $0 per day, 7-90	**In-network:** $225 per day, 1-8 $0 per day, 9-90 **Out-of-network:** $350 per day, 1-8 $0 per day, 9-90	**In-network:** $275 per day, 1-7 $0 per day, 8-90 **Out-of-network:** $375 per day, 1-7 $0 per day, 8-90
	Outpatient Group and Individual Therapy Visits			
	In-network: $40 copay **Out-of-network:** 50% of total cost	**In-network:** $40 copay	**In-network:** $25 copay **Out-of-network:** 50% of total cost	**In-network:** $25 copay **Out-of-network:** 50% of total cost
Skilled Nursing Facility (SNF)*	**In-network:** $10 per day, 1-20 $214 per day, 21-100 **Out-of-network:** $300 per day, 1-100	**In-network:** $10 per day, 1-20 $203 per day, 21-100	**In-network:** $20 per day, 1-20 $203 per day, 21-100 **Out-of-network:** $203 per day, 1-100	**In-network:** $10 per day, 1-20 $203 per day, 21-100 **Out-of-network:** $203 per day, 1-100

ATRIO HEALTH PLANS

Covered Medical and Hospital Benefits

*(Services marked with an * may require prior authorization)*

	ATRIO Choice Rx (PPO) *H6743-001*	ATRIO Select Rx (HMO) *H3814-031*	ATRIO Prime Rx (PPO) *H6743-030*	ATRIO Freedom (PPO) *H6743-031*
Physical Therapy*	**Physical & Speech Therapy**			
	In-network: $40 copay **Out-of-network:** 50% of total cost	**In-network:** $35 copay	**In-network:** $30 copay **Out-of-network:** 50% of total cost	**In-network:** $25 copay **Out-of-network:** 50% of total cost
	Occupational Therapy			
	In-network: $30 copay **Out-of-network:** 50% of total cost	**In-network:** $35 copay	**In-network:** $30 copay **Out-of-network:** 50% of total cost	**In-network:** $25 copay **Out-of-network:** 50% of total cost
Ambulance* (Air and Ground) *Authorization required for nonemergent transportation*	**In & out-of-network:** $350 copay	**In & out-of-network:** $350 copay	**In & out-of-network:** $225 copay	**In & out-of-network:** $275 copay
Transportation *Must use **SafeRide** for covered trips*	$0 copay for 24 one-way trips every year to plan-approved health-related locations	$0 copay for 12 one-way trips every year to plan-approved health-related locations	$0 copay for 24 one-way trips every year to plan-approved health-related locations	Not covered
Medicare Part B Drugs *	**In-network:** 0% - 20% of total cost **Out-of-network:** 50% of total cost	**In-network:** 0% - 20% of total cost	**In-network:** 0% - 20% of total cost **Out-of-network:** 50% of total cost	**In-network:** 0% - 20% of total cost **Out-of-network:** 50% of total cost
Telehealth *If provider offers Telehealth visits*	**In-network:** PCP: $0 copay Specialist: $40 copay **Out-of-network:** PCP: $50 copay Specialist: $50 copay	**In-network:** PCP: $0 copay Specialist: $40 copay	**In-network:** PCP: $0 copay Specialist: $25 copay **Out-of-network:** PCP: $30 copay Specialist: $50 copay	**In-network:** PCP: $10 copay Specialist: $25 copay **Out-of-network:** PCP: $50 copay Specialist: $65 copay

Covered Medical and Hospital Benefits

*(Services marked with an * may require prior authorization)*

	ATRIO Choice Rx (PPO) *H6743-001*	ATRIO Select Rx (HMO) *H3814-031*	ATRIO Prime Rx (PPO) *H6743-030*	ATRIO Freedom (PPO) *H6743-031*
Foot Care ***Medicare covered:*** Foot exams and treatment if you have diabetes related nerve damage and/or meet certain conditions	**Foot Care** *(Medicare-covered servicess)*			
	In-network: $45 copay **Out-of-network:** 50% of total cost	**In-network:** $45 copay	**In-network:** $25 copay **Out-of-network:** 50% of total cost	**In-network:** $25 copay **Out-of-network:** 50% of total cost
Durable Medical Equipment (DME) and Supplies, and Diabetic Supplies* DME supplies are not eligible for Flex Card OTC spend	**Medical Equipment, Prosthetic Devices, and Medical Supplies**			
	In-network: 20% of total cost **Out-of-network:** 30% of total cost	**In-network:** 20% of total cost	**In-network:** 20% of total cost **Out-of-network:** 25% of total cost	**In-network:** 20% of total cost **Out-of-network:** 30% of total cost
	Diabetic Supplies			
	In-network: $0 copay **Out-of-network:** 20% of total cost	**In-network:** $0 copay	**In-network:** $0 copay **Out-of-network:** 50% of total cost	**In-network:** $0 copay **Out-of-network:** 50% of total cost
Fitness Covers gym membership fees and fitness classes *†Benefit does not roll over*	$175 allowance every six months† loaded to your Flex Card, for gym membership fees and fitness classes ($350 annual allowance)	$300 annual allowance† loaded to your Flex Card, for gym member-ship fees and fitness classes	$200 allowance every six months† loaded to your Flex Card, for gym membership fees and fitness classes ($400 annual allowance	$100 allowance every six months† loaded to your Flex Card, for gym membership fees and fitness classes ($200 annual allowance

ATRIO HEALTH PLANS

Covered Medical and Hospital Benefits

*(Services marked with an * may require prior authorization)*

	ATRIO Choice Rx (PPO) *H6743-001*	ATRIO Select Rx (HMO) *H3814-031*	ATRIO Prime Rx (PPO) *H6743-030*	ATRIO Freedom (PPO) *H6743-031*
Alternative Therapies Chiropractic ***Medicare covered:*** Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position) ***Supplemental Routine services*** non-Medicare covered services *†Benefit does not roll over*	**Chiropractic Services** *(Medicare-covered servicess)*			
	In-network: $20 copay **Out-of-network:** $20 copay	**In-network:** $20 copay	**In-network:** $20 copay **Out-of-network:** $20 copay	**In-network:** $20 copay **Out-of-network:** $20 copay
	Chiropractic, Acupuncture & Naturopathy Services *(Supplemental routine services)*			
	In & out-of-network: $300 allowance every six months† loaded to your Flex Card, for combined routine chiropractic, acupuncture and naturopathy services ($600 annual allowance)	**In & out-of-network:** $300 allowance every six months† loaded to your Flex Card, for combined routine chiropractic, acupuncture and naturopathy services ($600 annual allowance)	**In & out-of-network:** $100 allowance every six months† loaded to your Flex Card, for combined routine chiropractic, acupuncture and naturopathy services ($200 annual allowance)	**In & out-of-network:** $100 allowance every six months† loaded to your Flex Card, for combined routine chiropractic, acupuncture and naturopathy services ($200 annual allowance)
Over-the-Counter (OTC) Items Select OTC products *†Benefit does not roll over*	$25 allowance every three months† loaded to your Flex Card, for select OTC items ($100 total annual allowance)	$30 allowance every three months† loaded to your Flex Card, for select OTC items ($120 total annual allowance	$75 allowance every three months† loaded to your Flex Card, for select OTC items ($300 total annual allowance)	$25 allowance every three months† loaded to your Flex Card, for select OTC items ($100 total annual allowance)
	Easily find eligible OTC products using our Flex Card app on your smartphone *DME items are not eligible OTC products*			
Meals*	$0 copay for up to 2 meals per day for 14 days (28 meals per episode)	$0 copay for up to 2 meals per day for 14 days (28 meals per episode)	$0 copay for up to 2 meals per day for 14 days (28 meals per episode)	$0 copay for up to 2 meals per day for 14 days (28 meals per episode)
	Inpatient or SNF (direct admission/post hospital admits) (unlimited) *Home health recipients with approved home health certification (unlimited)*			

Medicare Part D Prescription Drug Benefits

Deductible Stage

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

ATRIO Choice Rx (PPO) *H6743-001*	ATRIO Select Rx (HMO) *H3814-031*	ATRIO Prime Rx (PPO) *H6743-030*	ATRIO Freedom (PPO) *H6743-031*
$0 per year	$350 per year	$0 per year	**Plan does not include drug coverage**

Initial Coverage Stage

You pay the following until your total yearly drug costs reach $2,000.

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.

ATRIO Choice Rx (PPO) *H6743-001*			ATRIO Select Rx (HMO) *H3814-031*		ATRIO Prime Rx (PPO) *H6743-030*		ATRIO Freedom (PPO) *H6743-031*
Standard Retail Cost Sharing			**Standard Retail Cost Sharing**		**Standard Retail Cost Sharing**		**Plan does not include drug coverage**
Tier	**30-day supply**	**90-day supply**	**30-day supply**	**90-day supply**	**30-day supply**	**90-day supply**	
Tier 1 (Preferred generic)	$0 copay	$0 copay	$5 copay	$10 copay	$0 copay	$0 copay	
Tier 2 (Generic)	$8 copay	$16 copay	$20 copay	$40 copay	$8 copay	$16 copay	
Tier 3 (Preferred brand)*	$47 copay	$94 copay	$47 copay	$94 copay	$47 copay	$94 copay	
Tier 4 (Non-preferred)*	$100 copay	$200 copay	$100 copay	$200 copay	$100 copay	$200 copay	
Tier 5 (Specialty)*	33% of the total cost	Not available	27% of the total cost	Not available	33% of the total cost	Not available	
Tier 6 (Select care)	$0	$0	$0	$0	$0	$0	

ATRIO Choice Rx (PPO) *H6743-001*	ATRIO Select Rx (HMO) *H3814-031*	ATRIO Prime Rx (PPO) *H6743-030*	ATRIO Freedom (PPO) *H6743-031*
Catastrophic Coverage Stage			
After you have paid $2,000, you move to the Catastrophic Coverage Stage. You pay nothing through the end of the year. This amount and rules for counting costs toward this amount have been set by Medicare.			

* Part D deductible applies

- Save one month's copay by switching to a 90-day supply at a network retail or mail-order pharmacy. Ask your doctor about a 100-day supply and save even more (restrictions apply).
- If you reside in a long-term facility, you pay the same as at a 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.
- What you pay for vaccines – our plan covers most Part D vaccines at no cost to you, even if you haven't met your deductible. Please call ATRIO Member Services for more information.
- What you pay for insulin – our plan covers select insulin products, for which you will pay no more than $35 for a one-month supply no matter what tier it is on, and even if you haven't met your deductible.

ATRIO Health Plans is a PPO, HMO, PPO C-SNP and HMO D-SNP with Medicare and Oregon Health Plan contracts. Enrollment in ATRIO Health Plans depends on contract renewal. Out-ofnetwork/non-contracted providers are under no obligation to treat 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 Member Services number at 1-877-672-8620 (TTY 711), daily from 8 a.m. to 8 p.m. local time or see your Evidence of Coverage for more information, including the cost sharing that applies to out-of-network services.


STRAIGHT-UP
LOCAL MEDICARE

How to Enroll

It's easy to enroll in an ATRIO Medicare Advantage Plan. Choose one of the 5 ways listed below.

1

Online

Go online and complete an online enrollment form!
atriohp.com

2

By Phone

Call us and one of our advisors can assist you in completing your enrollment.
1-888-201-8818 (TTY 711)

3

In Person

Visit your nearest ATRIO Health Plans office and one of our advisors can help you with your enrollment.
Find an office: atriohp.com or call 1-888-201-8818 (TTY 711)

4

At Your Home

We can send a local advisor to your home or provide a virtual appointment to help you complete your enrollment.
1-888-201-8818 (TTY 711)

5

Mail or Fax

Complete the paper Enrollment Form found in this kit and mail or fax the form to us at:

Mail:
ATRIO Health Plans
338 Jericho Turnpike #135
Syosset, NY 11791

Fax:
1-602-975-4071

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 Member Services 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 atriohp.com or call 1-877-672-8620 (TTY 711) daily from 8 a.m. to 8 p.m. local time 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 medicine 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.

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 co-payments/coinsurance may change on January 1 of each year.
- ATRIO PPO plans allow you to see providers outside of our network (non-contracted providers), while our HMO plans you will only have coverage for in-network 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 situation, non-contracted providers may deny care. In addition, you may pay a higher copay for services received by non-contracted providers.

Scope of Sales Appointment Confirmation

The Centers for Medicare and Medicaid Services requires agents to document the scope of a marketing appointment prior to any face-to-face sales meeting to ensure understanding of what will be discussed between the agent and the Medicare beneficiary (or their authorized representative). All information provided on this form is confidential and should be completed by each person with Medicare or his/her authorized representative.

Please initial below beside the type of product(s) you want the agent to discuss	
☐	Medicare Advantage Plans (further indicate below with initials)
☐	Stand-alone Medicare Prescription Drug Plans
☐	Dental/Vision/Hearing Products
☐	Critical Illness and Accident Products
☐	Medicare Supplement (Medigap) Products

☐	**Medicare Preferred Provider Organization (PPO) Plan:** A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. PPOs have network doctors and hospitals but you can also use out-of-network providers, usually at a higher cost.
☐	**Medicare Health Maintenance Organization (HMO):** A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. In most HMOs, you can only get your care from doctors or hospitals in the plan's network (except in emergencies).
☐	**Medicare Special Needs Plan (SNP):** A Medicare Advantage Plan that has a benefit package designed for people with special health care needs. Examples of the specific groups served include people who have both Medicare and Medicaid, people who reside in nursing homes, and people who have certain chronic medical conditions.
☐	**Medicare Prescription Drug Plan (PDP):** A stand-alone drug plan that adds prescription drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private-Fee-for-Service Plans, and Medicare Medical Savings Account Plans.
☐	**Medicare Private Fee-For-Service (PFFS) Plan:** A Medicare Advantage Plan in which you may go to any Medicare-approved doctor, hospital and provider that accepts the plan's payment, terms and conditions and agrees to treat you – not all providers will. If you join a PFFS Plan that has a network, you can see any of the network providers who have agreed to always treat plan members. You will usually pay more to see out-of-network providers.
☐	**Medicare Medical Savings Account (MSA) Plan:** MSA Plans combine a high deductible health plan with a bank account. The plan deposits money from Medicare into the account. You can use it to pay your medical expenses until your deductible is met.
☐	**Medicare Cost Plan:** In a Medicare Cost Plan, you can go to providers both in and out of network. If you get services outside of the plan's network, your Medicare-covered services will be paid for under Original Medicare but you will be responsible for Medicare coinsurance and deductibles.

By signing this form, you agree to a meeting with a sales agent to discuss the types of products you initialed.

- The person who will discuss the products is either employed or contracted by a Medicare plan. They do not work directly for the Federal government. This individual may also be paid based on your enrollment in a plan.
- Signing this form does NOT obligate you to enroll in a plan, affect your current enrollment, or enroll you in a Medicare plan.

Beneficiary or Authorized Representative Signature and Signature Date:

SIGNED: _____DATE: _____

If you are the authorized representative, please sign above and print below:

Representative's Name: _____

Your Relationship to the Beneficiary: _____

TO BE COMPLETED BY AGENT

Agent Name:	Agent Phone:
Beneficiary Name:	Beneficiary Phone (Optional):
Beneficiary Address (Optional):	
Initial Method of Contact:	
Agent's Signature:	
Plan(s) the Agent Represented During this Meeting:	
Date Appointment Completed	
[Plan Use Only]	

*Scope of Appointment documentation is subject to CMS record retention requirements *

Agent: Please Note - If the beneficiary signed the form at the time of appointment, provide explanation why SOA was not documented prior to meeting:

_____

_____

2025 MEDICARE ADVANTAGE & MEDICARE ADVANTAGE PRESCRIPTION DRUG ENROLLMENT FORM (KLAMATH COUNTY)

ATRIO HEALTH PLANS

Who can use this form?

People with Medicare who want to join a Medicare Advantage Plan. To join a plan, you must:

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area

Important: To join a Medicare Advantage Plan, you must also have both:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)

When do I use this form?

You can join a plan:

- Between October 15 - December 7 each year (for coverage starting January 1)
- Within 3 months of first getting Medicare
- In certain situations where you're allowed to join or switch plans

Visit Medicare.gov to learn more about when you can sign up for a plan.

Individuals experiencing homelessness

If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g., social security checks) may be considered your permanent residence address.

Note: You must complete all items in Section 1. The items in Section 2 are optional - you can't be denied coverage because you don't fill them out.

Reminders:

- If you want to join a plan during fall open enrollment (October 15–December 7), the plan must get your completed form by December 7.
- Your plan will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

What happens next?

Send your completed and signed form to:
Mail: ATRIO Health Plans Fax: (602) 975-4071
338 Jericho Turnpike #135
Syosset, NY 11791
Once they process your request to join, they'll contact you.

How do I get help with this form?

Call ATRIO Health Plans at 1-877-672-8620 (TTY 711)
Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.
En español: Llame a ATRIO Health Plans al 1-877-672- 8620 (TTY 711) o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

What do I need to complete this form?

- Your Medicare Number (the number on your red, white, and blue Medicare card)
- Your permanent address and phone number

OMB No. 0938-1378
Expires: 6/30/2026

IMPORTANT

Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan. See "What happens next?" on this page to send your completed form to the plan.

2025 MEDICARE ADVANTAGE & MEDICARE ADVANTAGE PRESCRIPTION DRUG ENROLLMENT FORM (KLAMATH COUNTY)

ATRIO HEALTH PLANS

Section 1: All fields on this page are required (unless marked optional)

SELECT THE PLAN YOU WANT TO JOIN:

Medical & Prescription Drug Plan options:

- ☐ **ATRIO Choice Rx (PPO)**: $35 / mo. (H6743-001)
- ☐ **ATRIO Prime Rx (PPO)**: $116 / mo. (H6743-030)
- ☐ **ATRIO Select Rx (HMO)**: $40 / mo. (H3814-031)

Medical ONLY Plan options:

- ☐ **ATRIO Freedom (PPO)**: $0 / mo. (H6743-031)

First Name:_____ **Last Name**:_____ **Middle Initial**: _____ *(Optional)*

Birth Date:_____ **Sex**: ☐ M ☐ F **Home Phone Number**:_____
(MM / DD / YYYY)

Cell Phone Number:_____ **Email:** _____

Please know that by providing your email address, you are agreeing to receive email notifications from us, and by providing your cell phone number, you are agreeing to receive text message notifications from us, as applicable. We will always give you the opportunity to opt-out of future communications.

***Permanent Physical Address*:** (Do NOT enter a PO Box)

Street Address:_____ **Apt. #**: _____

City:_____**County**:_____ **State**:_____ **Zip Code**: _____

Mailing Address: (If different from your permanent residence address (PO Box allowed)):

Street Address: _____ **Apt. #**: _____

City:_____ **County**:_____ **State**:_____ **Zip Code**: _____

Your Medicare information

Please take out your red, white, and blue Medicare card to complete this section.
Fill out this information as it appears on your Medicare card – OR – attach a copy of your Medicare card from your letter from Social Security or the Railroad Retirement Board

Medicare Number: _____
(Example: 1234-123-1234)

Hospital (Part A) Effective Date:_____

Medical (Part B) Effective Date: _____

You must have Medicare Part A or Part B (or both) to join a Medicare Prescription Drug Plan.

2025 MEDICARE ADVANTAGE & MEDICARE ADVANTAGE PRESCRIPTION DRUG ENROLLMENT FORM (KLAMATH COUNTY)

ATRIO HEALTH PLANS

Paying your plan premiums

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail, Electronic Funds Transfer (EFT), credit card, over the phone or on our website each month. You can also choose to pay your premium by having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month.

If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium. The amount is usually taken out of your Social Security benefit, or you may get a bill from Medicare (or the RRB). DO NOT pay ATRIO Health Plans the Part D-IRMAA.

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Even if you have Extra Help now you may need to reapply for recertification. Many people are eligible for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.socialsecurity.gov/prescriptionhelp. If you qualify for Extra Help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare does not cover. If you don't select a payment option, you will receive a bill/invoice each month.

Please select a payment option and follow any further instructions for full set-up:

- ☐ Receive a bill/invoice monthly
- ☐ Automatic Electronic Funds Transfer (EFT) from your bank account – for EFT, visit atriohp.com to sign up on our premium portal
- ☐ Credit Card – for credit card payment, visit atriohp.com to sign up on our premium portal
- ☐ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check. I get my benefits from: ☐ Social Security ☐ Railroad Retirement Board

(The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction or approves deductions to begin after the enrollment effective date, we will send you a bill for your monthly premiums.)

IMPORTANT: Read and Sign Below

- I must keep both Hospital (Part A) and Medical (Part B) to stay in this plan. I must keep paying my Part B premium if I have one, unless Medicaid or someone else pays for it
- By joining this Medicare Advantage Plan, I acknowledge that ATRIO Health Plans will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below)
- I understand that I can be enrolled in only one MA or Part D plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA or Part D plan (exceptions apply for MA PFFS, MA MSA plans)

2025 MEDICARE ADVANTAGE & MEDICARE ADVANTAGE PRESCRIPTION DRUG ENROLLMENT FORM (KLAMATH COUNTY)

ATRIO HEALTH PLANS

- I understand that when my ATRIO coverage begins, I must get all of my medical and prescription drug benefits (If I selected a plan with prescription drug coverage) from ATRIO. Benefits and services provided by ATRIO and contained in my ATRIO "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor ATRIO will pay for benefits or services that are not covered.
- The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.
- I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative, this signature certifies that:
  1. This person is authorized under State law to complete this enrollment, and
  2. Documentation of this authority is available upon request by Medicare

Signature:_____ **Today's Date**: _____

For individuals helping enrollee with completing this form only

Complete this section if you're an individual (ie. Agents, brokers, SHIP counselors, family members or other third parties? Helping an enrollee fill out this form.

Name: _____ Signature:_____

Relationship to Enrollee : ☐ Agent ☐ Broker ☐ SHIP counselor ☐ Authorized representative

National Producer Number (Agents/ Brokers only): _____

Are you enrolled in your State Medicaid program? ☐ Yes ☐ No

If yes, please provide your Medicaid number: _____

Do you have other prescription drug or medical coverage (like group, VA, TRICARE) in addition to this plan? ☐ Yes ☐ No

If yes, please list your other coverage and your ID number for this coverage:

Name of other coverage:	Member number for this coverage:	Group number for this coverage:
_____	_____	_____

2025 MEDICARE ADVANTAGE & MEDICARE ADVANTAGE PRESCRIPTION DRUG ENROLLMENT FORM (KLAMATH COUNTY)

ATRIO HEALTH PLANS

SECTION 2: A few questions to help us manage your plan *(optional)*. Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

List your Primary Care Physician (PCP), clinic or health center: _____

Select one if you prefer plan information in another language or an accessible format:

- ☐ Spanish
- ☐ Braille
- ☐ Large Print
- ☐ Audio CD
- ☐ Data CD

Please contact ATRIO at 1-877-672-8620 (TTY 711) if you need information in an accessible format other than what is listed above. Our office hours are daily, 8:00 a.m. to 8:00 p.m. local time.

Do you or your spouse work? ☐ Yes ☐ No

What is your gender? Select one.

- ☐ Woman
- ☐ Man
- ☐ Non-binary
- ☐ I use a different term:_____
- ☐ **I choose not to answer**

Which of the following best represents how you think of yourself? Select one.

- ☐ Lesbian or gay
- ☐ Straight
- ☐ Bisexual
- ☐ I use a different term:_____
- ☐ I don't know
- ☐ **I choose not to answer**

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply

- ☐ No, not of Hispanic, Latino/a or Spanish origin
- ☐ Yes, Mexican, Mexican American, Chicano/a
- ☐ Yes, another Hispanic, Latino/a or Spanish origin
- ☐ Yes, Cuban
- ☐ Yes, Puerto Rican
- ☐ **I choose not to answer**

What's your race? Select all the apply.

- ☐ American Indian or Alaska Native
- ☐ Chinese
- ☐ Japanese
- ☐ Other Asian
- ☐ Vietnamese
- ☐ Asian Indian
- ☐ Filipino
- ☐ Korean
- ☐ Other Pacific Islander
- ☐ White
- ☐ Black or African American
- ☐ Guamanian or Chamorro
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ **I choose not to answer**

2025 MEDICARE ADVANTAGE & MEDICARE ADVANTAGE PRESCRIPTION DRUG ENROLLMENT FORM (KLAMATH COUNTY)

ATRIO HEALTH PLANS

SECTION 3: For licensed sales representative / agency use only

Staff member/ Agent/ Broker must complete:

Name (if assisted in enrollment):

Initial receipt date:

Writing ID #:

Proposed effective date of coverage:

- ☐ AEP (Oct 15 – Dec 7)
- ☐ ICEP (MA enrollees)
- ☐ IEP (MA-PD enrollees)
- ☐ IEP (MA-PD enrollees eligible for 2nd IEP)
- ☐ OEP (Jan 1 – March 31)
- ☐ OEP (newly eligible)
- ☐ OEPI
- ☐ SEP (Chronic)
- ☐ SEP (Dual LIS change of status)
- ☐ SEP (Dual LIS maintaining)
- ☐ SEP (Loss of EGHP coverage)
- ☐ SEP (Change in residence)
- ☐ SEP (SEP reason):_____

_____ _____

Licensed Sales Representative Signature *(optional)* Date

Mail or fax this completed form to:
ATRIO Health Plans
338 Jericho Turnpike #135
Syosset, NY 11791
Fax: (602) 975-4071

PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50 and 422.60 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) “Medicare Advantage Prescription Drug (MARx)”, System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

ATRIO™
HEALTH PLANS

Attestation of Eligibility for an Enrollment Period

Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

☐ I am new to Medicare.

☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).

☐ I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on (insert date) _____.

☐ I recently was released from incarceration. I was released on (insert date) _____.

☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) _____.

☐ I recently obtained lawful presence status in the United States. I got this status on (insert date) _____.

☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date) _____.

☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date) _____.

☐ I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.

☐ I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long term care facility). I moved/will move into/out of the facility on (insert date)_____.

☐ I recently left a PACE program on (insert date) _____.

☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date)_____.

☐ I am leaving employer or union coverage on (insert date) _____.

☐ I belong to a pharmacy assistance program provided by my state.

☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.

☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date)

☐ I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date) _____.

☐ I was affected by an emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA) or by a Federal, state or local government entity. One of the other statements here applied to me, but I was unable to make my enrollment request because of the disaster.

If none of these statements applies to you or you're not sure, please contact ATRIO Health Plans at 877-672-8620 (TTY 711) to see if you are eligible to enroll. We are open daily, 8:00 a.m. - 8:00 p.m.

Scope of Sales Appointment Confirmation

The Centers for Medicare and Medicaid Services requires agents to document the scope of a marketing appointment prior to any face-to-face sales meeting to ensure understanding of what will be discussed between the agent and the Medicare beneficiary (or their authorized representative). All information provided on this form is confidential and should be completed by each person with Medicare or his/her authorized representative.

Please initial below beside the type of product(s) you want the agent to discuss	
☐	Medicare Advantage Plans (further indicate below with initials)
☐	Stand-alone Medicare Prescription Drug Plans
☐	Dental/Vision/Hearing Products
☐	Critical Illness and Accident Products
☐	Medicare Supplement (Medigap) Products
☐	**Medicare Preferred Provider Organization (PPO) Plan:** A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. PPOs have network doctors and hospitals but you can also use out-of-network providers, usually at a higher cost.
☐	**Medicare Health Maintenance Organization (HMO):** A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. In most HMOs, you can only get your care from doctors or hospitals in the plan's network (except in emergencies).
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☐	**Medicare Prescription Drug Plan (PDP):** A stand-alone drug plan that adds prescription drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private-Fee-for-Service Plans, and Medicare Medical Savings Account Plans.
☐	**Medicare Private Fee-For-Service (PFFS) Plan:** A Medicare Advantage Plan in which you may go to any Medicare-approved doctor, hospital and provider that accepts the plan's payment, terms and conditions and agrees to treat you – not all providers will. If you join a PFFS Plan that has a network, you can see any of the network providers who have agreed to always treat plan members. You will usually pay more to see out-of-network providers.
☐	**Medicare Medical Savings Account (MSA) Plan:** MSA Plans combine a high deductible health plan with a bank account. The plan deposits money from Medicare into the account. You can use it to pay your medical expenses until your deductible is met.
☐	**Medicare Cost Plan:** In a Medicare Cost Plan, you can go to providers both in and out of network. If you get services outside of the plan's network, your Medicare-covered services will be paid for under Original Medicare but you will be responsible for Medicare coinsurance and deductibles.

By signing this form, you agree to a meeting with a sales agent to discuss the types of products you initialed.

- The person who will discuss the products is either employed or contracted by a Medicare plan. They do not work directly for the Federal government. This individual may also be paid based on your enrollment in a plan.
- Signing this form does NOT obligate you to enroll in a plan, affect your current enrollment, or enroll you in a Medicare plan.

Beneficiary or Authorized Representative Signature and Signature Date:

SIGNED: _____DATE: _____

If you are the authorized representative, please sign above and print below:

Representative's Name: _____

Your Relationship to the Beneficiary: _____

TO BE COMPLETED BY AGENT

Agent Name:	Agent Phone:
Beneficiary Name:	Beneficiary Phone (Optional):
Beneficiary Address (Optional):	
Initial Method of Contact:	
Agent's Signature:	
Plan(s) the Agent Represented During this Meeting:	
Date Appointment Completed	
[Plan Use Only]	

*Scope of Appointment documentation is subject to CMS record retention requirements *

Agent: Please Note - If the beneficiary signed the form at the time of appointment, provide explanation why SOA was not documented prior to meeting:

_____

_____

2025 MEDICARE ADVANTAGE & MEDICARE ADVANTAGE PRESCRIPTION DRUG ENROLLMENT FORM (KLAMATH COUNTY)

ATRIO HEALTH PLANS

Who can use this form?

People with Medicare who want to join a Medicare Advantage Plan. To join a plan, you must:

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area

Important: To join a Medicare Advantage Plan, you must also have both:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)

When do I use this form?

You can join a plan:

- Between October 15 - December 7 each year (for coverage starting January 1)
- Within 3 months of first getting Medicare
- In certain situations where you're allowed to join or switch plans

Visit Medicare.gov to learn more about when you can sign up for a plan.

Individuals experiencing homelessness

If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g., social security checks) may be considered your permanent residence address.

Note: You must complete all items in Section 1. The items in Section 2 are optional - you can't be denied coverage because you don't fill them out.

Reminders:

- If you want to join a plan during fall open enrollment (October 15–December 7), the plan must get your completed form by December 7.
- Your plan will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

What happens next?

Send your completed and signed form to:
Mail: ATRIO Health Plans Fax: (602) 975-4071
338 Jericho Turnpike #135
Syosset, NY 11791
Once they process your request to join, they'll contact you.

How do I get help with this form?

Call ATRIO Health Plans at 1-877-672-8620 (TTY 711)
Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.
En español: Llame a ATRIO Health Plans al 1-877-672- 8620 (TTY 711) o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

What do I need to complete this form?

- Your Medicare Number (the number on your red, white, and blue Medicare card)
- Your permanent address and phone number

OMB No. 0938-1378
Expires: 6/30/2026

IMPORTANT

Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan. See "What happens next?" on this page to send your completed form to the plan.

2025 MEDICARE ADVANTAGE & MEDICARE ADVANTAGE PRESCRIPTION DRUG ENROLLMENT FORM (KLAMATH COUNTY)

ATRIO HEALTH PLANS

Section 1: All fields on this page are required (unless marked optional)

SELECT THE PLAN YOU WANT TO JOIN:

Medical & Prescription Drug Plan options:

- ☐ **ATRIO Choice Rx (PPO)**: $35 / mo. (H6743-001)
- ☐ **ATRIO Prime Rx (PPO)**: $116 / mo. (H6743-030)
- ☐ **ATRIO Select Rx (HMO)**: $40 / mo. (H3814-031)

Medical ONLY Plan options:

- ☐ **ATRIO Freedom (PPO)**: $0 / mo. (H6743-031)

First Name:_____ **Last Name**:_____ **Middle Initial**: _____ *(Optional)*

Birth Date:_____ **Sex**: ☐ M ☐ F **Home Phone Number**:_____
(MM / DD / YYYY)

Cell Phone Number:_____ **Email:** _____

Please know that by providing your email address, you are agreeing to receive email notifications from us, and by providing your cell phone number, you are agreeing to receive text message notifications from us, as applicable. We will always give you the opportunity to opt-out of future communications.

***Permanent Physical Address*:** (Do NOT enter a PO Box)

Street Address:_____ **Apt. #**: _____

City:_____**County**:_____ **State**:_____ **Zip Code**: _____

Mailing Address: (If different from your permanent residence address (PO Box allowed)):

Street Address: _____ **Apt. #**: _____

City:_____ **County**:_____ **State**:_____ **Zip Code**: _____

Your Medicare information

Please take out your red, white, and blue Medicare card to complete this section.
Fill out this information as it appears on your Medicare card – OR – attach a copy of your Medicare card from your letter from Social Security or the Railroad Retirement Board

Medicare Number: _____
(Example: 1234-123-1234)

Hospital (Part A) Effective Date:_____

Medical (Part B) Effective Date: _____

You must have Medicare Part A or Part B (or both) to join a Medicare Prescription Drug Plan.

2025 MEDICARE ADVANTAGE & MEDICARE ADVANTAGE PRESCRIPTION DRUG ENROLLMENT FORM (KLAMATH COUNTY)

ATRIO HEALTH PLANS

Paying your plan premiums

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail, Electronic Funds Transfer (EFT), credit card, over the phone or on our website each month. You can also choose to pay your premium by having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month.

If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium. The amount is usually taken out of your Social Security benefit, or you may get a bill from Medicare (or the RRB). DO NOT pay ATRIO Health Plans the Part D-IRMAA.

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Even if you have Extra Help now you may need to reapply for recertification. Many people are eligible for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.socialsecurity.gov/prescriptionhelp. If you qualify for Extra Help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare does not cover. If you don't select a payment option, you will receive a bill/invoice each month.

Please select a payment option and follow any further instructions for full set-up:

- ☐ Receive a bill/invoice monthly
- ☐ Automatic Electronic Funds Transfer (EFT) from your bank account – for EFT, visit atriohp.com to sign up on our premium portal
- ☐ Credit Card – for credit card payment, visit atriohp.com to sign up on our premium portal
- ☐ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check. I get my benefits from: ☐ Social Security ☐ Railroad Retirement Board

(The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction or approves deductions to begin after the enrollment effective date, we will send you a bill for your monthly premiums.)

IMPORTANT: Read and Sign Below

- I must keep both Hospital (Part A) and Medical (Part B) to stay in this plan. I must keep paying my Part B premium if I have one, unless Medicaid or someone else pays for it
- By joining this Medicare Advantage Plan, I acknowledge that ATRIO Health Plans will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below)
- I understand that I can be enrolled in only one MA or Part D plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA or Part D plan (exceptions apply for MA PFFS, MA MSA plans)

2025 MEDICARE ADVANTAGE & MEDICARE ADVANTAGE PRESCRIPTION DRUG ENROLLMENT FORM (KLAMATH COUNTY)

ATRIO HEALTH PLANS

- I understand that when my ATRIO coverage begins, I must get all of my medical and prescription drug benefits (If I selected a plan with prescription drug coverage) from ATRIO. Benefits and services provided by ATRIO and contained in my ATRIO "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor ATRIO will pay for benefits or services that are not covered.
- The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.
- I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative, this signature certifies that:
  1. This person is authorized under State law to complete this enrollment, and
  2. Documentation of this authority is available upon request by Medicare

Signature:_____ **Today's Date**: _____

For individuals helping enrollee with completing this form only

Complete this section if you're an individual (ie. Agents, brokers, SHIP counselors, family members or other third parties? Helping an enrollee fill out this form.

Name: _____ Signature:_____

Relationship to Enrollee : ☐ Agent ☐ Broker ☐ SHIP counselor ☐ Authorized representative

National Producer Number (Agents/ Brokers only): _____

Are you enrolled in your State Medicaid program? ☐ Yes ☐ No

If yes, please provide your Medicaid number: _____

Do you have other prescription drug or medical coverage (like group, VA, TRICARE) in addition to this plan? ☐ Yes ☐ No

If yes, please list your other coverage and your ID number for this coverage:

Name of other coverage:	Member number for this coverage:	Group number for this coverage:
_____	_____	_____

2025 MEDICARE ADVANTAGE & MEDICARE ADVANTAGE PRESCRIPTION DRUG ENROLLMENT FORM (KLAMATH COUNTY)

ATRIO HEALTH PLANS

SECTION 2: A few questions to help us manage your plan *(optional)*. Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

List your Primary Care Physician (PCP), clinic or health center: _____

Select one if you prefer plan information in another language or an accessible format:

- ☐ Spanish
- ☐ Braille
- ☐ Large Print
- ☐ Audio CD
- ☐ Data CD

Please contact ATRIO at 1-877-672-8620 (TTY 711) if you need information in an accessible format other than what is listed above. Our office hours are daily, 8:00 a.m. to 8:00 p.m. local time.

Do you or your spouse work? ☐ Yes ☐ No

What is your gender? Select one.

- ☐ Woman
- ☐ Man
- ☐ Non-binary
- ☐ I use a different term:_____
- ☐ **I choose not to answer**

Which of the following best represents how you think of yourself? Select one.

- ☐ Lesbian or gay
- ☐ Straight
- ☐ Bisexual
- ☐ I use a different term:_____
- ☐ I don't know
- ☐ **I choose not to answer**

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply

- ☐ No, not of Hispanic, Latino/a or Spanish origin
- ☐ Yes, Mexican, Mexican American, Chicano/a
- ☐ Yes, another Hispanic, Latino/a or Spanish origin
- ☐ Yes, Cuban
- ☐ Yes, Puerto Rican
- ☐ **I choose not to answer**

What's your race? Select all the apply.

- ☐ American Indian or Alaska Native
- ☐ Chinese
- ☐ Japanese
- ☐ Other Asian
- ☐ Vietnamese
- ☐ Asian Indian
- ☐ Filipino
- ☐ Korean
- ☐ Other Pacific Islander
- ☐ White
- ☐ Black or African American
- ☐ Guamanian or Chamorro
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ **I choose not to answer**

2025 MEDICARE ADVANTAGE & MEDICARE ADVANTAGE PRESCRIPTION DRUG ENROLLMENT FORM (KLAMATH COUNTY)

ATRIO HEALTH PLANS

SECTION 3: For licensed sales representative / agency use only

Staff member/ Agent/ Broker must complete:

Name (if assisted in enrollment):

Initial receipt date:

Writing ID #:

Proposed effective date of coverage:

- ☐ AEP (Oct 15 – Dec 7)
- ☐ ICEP (MA enrollees)
- ☐ IEP (MA-PD enrollees)
- ☐ IEP (MA-PD enrollees eligible for 2nd IEP)
- ☐ OEP (Jan 1 – March 31)
- ☐ OEP (newly eligible)
- ☐ OEPI
- ☐ SEP (Chronic)
- ☐ SEP (Dual LIS change of status)
- ☐ SEP (Dual LIS maintaining)
- ☐ SEP (Loss of EGHP coverage)
- ☐ SEP (Change in residence)
- ☐ SEP (SEP reason):_____

_____ _____

Licensed Sales Representative Signature *(optional)* Date

Mail or fax this completed form to:
ATRIO Health Plans
338 Jericho Turnpike #135
Syosset, NY 11791
Fax: (602) 975-4071

PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50 and 422.60 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) “Medicare Advantage Prescription Drug (MARx)”, System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

ATRIO™
HEALTH PLANS

Attestation of Eligibility for an Enrollment Period

Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

☐ I am new to Medicare.

☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).

☐ I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on (insert date) _____.

☐ I recently was released from incarceration. I was released on (insert date) _____.

☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) _____.

☐ I recently obtained lawful presence status in the United States. I got this status on (insert date) _____.

☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date) _____.

☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date) _____.

☐ I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.

☐ I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long term care facility). I moved/will move into/out of the facility on (insert date)_____.

☐ I recently left a PACE program on (insert date) _____.

☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date)_____.

☐ I am leaving employer or union coverage on (insert date) _____.

☐ I belong to a pharmacy assistance program provided by my state.

☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.

☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date)

☐ I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date) _____.

☐ I was affected by an emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA) or by a Federal, state or local government entity. One of the other statements here applied to me, but I was unable to make my enrollment request because of the disaster.

If none of these statements applies to you or you're not sure, please contact ATRIO Health Plans at 877-672-8620 (TTY 711) to see if you are eligible to enroll. We are open daily, 8:00 a.m. - 8:00 p.m.

Plan Recap

We want to make sure you know what to expect with the new plan you've chosen. Please fill out this plan recap with your Licensed Sales Representative (if applicable).

Plan Information

My new plan is a:

☐ Medicare Advantage plan *(No prescription drug coverage)*

☐ Medicare Advantage Prescription Drug Plan

☐ Medicare Advantage Special Needs Plan

The name of my new plan is: _____

My plan type is a (circle one): PPO or PPO C-SNP or HMO or HMO D-SNP

My plan type: ☐ Requires referrals ☐ Does not require referrals
☐ Includes a medical deductible unless the state or another third party pays it for me
☐ Does not include a medical deductible

My plan will provide:
☐ All Medicare health coverage ☐ All Medicare prescription drug coverage

I must live in the plan's service area, which is _____. If I move out of the plan's service area for more than 6 months in a row, I will need to choose a new plan.

Premium Information

My plan has a premium ☐Yes ☐No If yes, my premium amount is $ _____ monthly, which I must pay to stay in this plan. If I qualify for Extra Help, my premium may be less.* In addition, I must remain enrolled in Medicare Part A and Part B and must continue to pay my Medicare Part B premium, unless the state or another third party pays it for me. If I owe a Late Enrollment Penalty (LEP), it is not included in my premium. I will need to add it to my premium each month.

** Extra Help is a program for people with limited incomes who need help paying Part D premiums, deductibles and copays. To see if you qualify for Extra Help, call:*

- The Social Security Administration at 1-800-772-1213, TTY 1-800-325-0778
- Your state Medicaid office

Network Provider Information

Understanding your network is important. With my plan, I can see any provider inside or outside the network nationwide that accepts Medicare. If I get my care from out-of-network providers, I may pay a higher out-of-pocket amount. ☐ Yes ☐ No

List the doctors and hospitals you use in this table. Be sure to note whether they are part of the ATRIO plan provider network or not. To find out if they are part of the plan network, please visit *atriohp.com*.

Provider Name	**Provider Type** (PCP/Specialist/Hospital)	**Network** (Yes/No)

Prescription Drug Coverage

My plan has a prescription drug deductible. ☐ Yes ☐ No

If I have a deductible, the amount is $ _____ and it applies to drugs on Tier 3, Tier 4, and Tier 5 only.

List the medications you use in this table. Be sure to note their tier level, whether there are any limits on the drug, and if the prescription drug deductible applies.

Medication	**Tier Level**	**Has Limits (Yes/No)**	**Deductible (Yes/No)**

NOTE: My actual out of pocket costs may vary based on:

- The drug stage I am in
- The drug tier level
- The pharmacy I use (retail / mail-order)
- If I have Extra Help

Contact your Licensed Sales Representative

If I have questions about my plan, I will call my Licensed Sales Representative,

_____at _____

or Member Services at 1-877-672-8620 (TTY 711) from 8 a.m. to 8 p.m. local time.

What to Expect After You Enroll

Steps	How you get it	Description
1 **Enrollment Verification**	Mailed	If you enrolled with an agent or broker, you will receive a letter to confirm you understand the type of plan you are enrolling in
2 **Acknowledgement of Receipt of Completed Enrollment Form**	Mailed	Within 7 calendar days of Medicare's approval of enrollment, you will receive a letter stating we received your completed enrollment form, and that Medicare has approved your enrollment
3 **Member ID Card**	Mailed	You will receive your member ID card within 10 days of your Medicare-approved enrollment
4 **Review Benefits**	Mailed	You will receive a Quick Start Reference Guide with your ID card. This guide will provide important information about how to get the most out of your health plan benefits. You can also access other benefit materials on our website
5 **Premium Assistance**	Mailed	You may receive a letter on how to get extra help with your Medicare premiums and other health care costs, if you qualify
6 **Register Online**	Online	Optional: Once your coverage begins, register online for our member portal at atriohp.com so you can access benefit information and pay your premium

Notice about Nondiscrimination and Accessibility Requirements

Discrimination is Against the Law

ATRIO Health Plans complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATRIO Health Plans does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. ATRIO Health Plans:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need any of the services listed above, contact ATRIO Member Services toll free at 1-877-672-8620, daily from 8 a.m. to 8 p.m. TTY users should call 711.

If you believe that ATRIO Health Plans has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

ATRIO Compliance Officer:
550 Hawthorne Avenue, Suite 140, Salem, OR 97301
1-877-672-8620 (TTY 711)
File a compliant with ATRIO Compliance Hotline:
1-877-309-9952 or compliance@atriohp.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, contact Member Services toll free at 1-877-672-8620, daily from 8 a.m. to 8 p.m. TTY users should call 711.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services 200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

Español (Spanish) - ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-672-8620 (TTY: 711).

Tiếng Việt (Vietnamese) - CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Hãy gọi số 1-877-672-8620 (TTY: 711)

繁體中文 (Chinese) - **注意：如果您講國語，您可以免費獲得語言援助服務。請致電** 1-877-672-8620 (TTY：711)。

Русский (Russian) - ВНИМАНИЕ! Если Вы говорите по-русски, Вы можете бесплатно воспользоваться услугами перевода. Телефон: 1-877-672-8620 (телетайп: 711).

한국어 (Korean) - 유의사항: 무료 한국어 지원 서비스를 이용하실 수 있습니다. 전화번호는 1-877-672-8620 (TTY: 711) 번입니다.

Українська (Ukrainian) - УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-877-672-8620 (телетайп: 711).

日本語 (Japanese) - **注意事項**：日本語でのサービスをご希望の場合、1-877-672-8620（TTY:711）までご連絡ください。このサービスは無料です。

"إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-877-672-8620 (رقم هاتف الصم والبكم: 1-800-735-2900)."

فارسی (Farsi) – توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما موجود است. با شماره 1-877-672-8620 تماس بگیرید (TTY: 1-800-735-2900).

Română (Romanian) - ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-877-672-8620 (TTY: 711).

ខ្មែរ (Cambodian) - ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរទូរស័ព្ទ 1-877-672-8620 (TTY: 711)។

Oroomiffa (Oromo) - XIYYEEFFANNAA: Afaandubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, niargama. 1-877-672-8620 (TTY: 711) Bilbilaa.

Deutsch (German) - ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-672-8620 (TTY: 711).

فارسی (Farsi) – توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما موجود است. با شماره 1-877-672-8620 تماس بگیرید (TTY: 1-800-735-2900).

Français (French) - ATTENTION : Si vous parlez français, des services d'aide linguistique sont disponibles gratuitement. Appelez le 1-877-672-8620 (ATS : 711).

ภาษาไทย (Thai) - โปรดทราบ: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-877-672-8620 (TTY: 711)

Form Approved
OMB# 0938-1421

Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-877-672-8620. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-877-672-8620. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-877-672-8620。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-877-672-8620。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-877-672-8620. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-877-672-8620. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-877-672-8620 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-877-672-8620. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-877-672-8620 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-877-672-8620. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: لدينا خدمات مترجمين فوري مجانية عن أي أسئلة لديك حول الأدوية أو خطة الصحة. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-877-672-8620 يوجد شخص ما يتحدث العربية لمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-877-672-8620 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-877-672-8620. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-877-672-8620. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-877-672-8620. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-877-672-8620. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。通訳をご用命になるには、1-877-672-8620 にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサービスです。

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