ATRIO™
HEALTH PLANS

2023 Medicare Advantage
ATRIO Choice Rx & Prime Rx (PPO)

Oregon

Service area coverage for Marion & Polk Counties
Plan IDs include: H7006-007, H7006-003

January 1, 2023 - December 31, 2023

At ATRIO, you're not just another number or face in the crowd.

We're committed to helping improve our members' lives and the health and wellness of the communities we serve.

Our strong relationships with our providers make a positive difference.

More advantages.
More peace of mind.

The ATRIO Advantage

At ATRIO Health Plans, you're not just another face in the crowd. We're committed to helping improve our member's lives and the health and wellness of the communities we serve.

ATRIO Medicare Advantage plans offer coverage and cost sharing options that meet your needs. Most of our plans combine medical and prescription coverage into one plan, plus extra benefits such as dental, over the counter items, routine vision, a flex card to provide flexibility in your benefits, and much more!

Our Enrollment Kit provides you with everything you need to compare ATRIO plan options, understand the value of our extra benefits, and complete our simple enrollment process.

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

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Understanding Original Medicare

Original Medicare is offered by the federal government and has two parts: Part A and Part B.

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

Medicare Part B is medical insurance that covers doctor's office visits, diagnostic lab & x-rays, outpatient professional services including surgeries, flu shots and more.

Original Medicare does NOT include prescription drug coverage

Prescription drug coverage, also known as Part D, is not included with Original Medicare. If you delay your enrollment in a Part D plan, then you will pay a penalty equal to about 1% of the average monthly premium for each month you delayed enrollment. This must be paid monthly as long as you are enrolled in Part D.

Understanding Medicare Advantage PPO Plans

PPO stands for Preferred Provider Organization. Medicare Advantage PPO plans are a type of health plan that contracts with medical providers, such as hospitals and doctors, to create a network of participating providers. You pay less if you use providers that belong to the plan's network, but can still utilize providers outside of the network* for a higher cost out-of-pocket.

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

Medicare Advantage Plans, like ATRIO Health Plans, offer additional coverage all in one plan, above and beyond what Original Medicare offers. Our plans include:

- Hospital – Part A
- Medical – Part B
- Extras – dental, fitness, meals, OTC, vision
- Prescription Drugs – Part D (with some plans)

Benefits of a PPO Plan include:

- Emergency and urgently needed services are covered no matter where you go.
- Select a primary care provider (PCP) from the network. It's important to select a PCP from the network in your plan's service area when you enroll in the plan. However, you are not limited to this PCP. You can visit any PCP in or out of the network to oversee and help manage your care.
- No referral is needed to see an in or out-of-network specialist or other provider.
- You pay your plan copay or coinsurance when you visit a network provider.
- If you see a provider outside the network, your cost may be higher.

Use this kit to get familiar with and enroll in a Medicare Advantage plan.

Eligibility Requirements

To join an ATRIO plan you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

2023 Benefits at a glance

ATRIO Medicare Advantage Plans
Marion and Polk Counties

Medical Benefits

Plans	ATRIO Choice Rx (PPO) H7006-007		ATRIO Prime Rx (PPO) H7006-003	
Plan Costs	**In & Out of network**		**In & Out of network**	
Monthly plan premium	$0		$99	
Plan deductible	$0		$0	
Annual out-of-pocket maximum	$4,500 In network	$6,500 Combined	$2,500 In network	$5,000 Combined
Doctor Office Visits	**In network**	**Out of network**	**In network**	**Out of network**
Primary care provider (PCP)	$0	$50	$0	$30
Specialist	$40	$65	$25	$50
Telehealth	$0	Not covered	$0	Not covered
Inpatient Care	**In network**	**Out of network**	**In network**	**Out of network**
Inpatient hospital care	$400 per day 1-5; $0 per day after that	$500 per day 1-5; $0 per day 6-90	$225 per day 1-8; $0 per day after that	$350 per day 1-7; $0 per day 8-90
Skilled nursing facility (SNF)	$0 per day 1-20; $150 per day 21-100	$150 per day 1-100	$0 per day 1-20; $125 per day 21-100	$125 per day 1-100
Outpatient Services	**In network**	**Out of network**	**In network**	**Out of network**
Outpatient hospital	$300	50%	$275	$425
Ambulatory surgery center	$225	$325	$225	$225
Home health care	$0	50%	$0	50%
Diabetes supplies	$0	50%	$0	20%
Durable medical equipment	20%	50%	20%	30%
Lab Services and Other Tests	**In network**	**Out of network**	**In network**	**Out of network**
Laboratory tests	$0	$20	$0	$0
Diagnostic imaging (MRI/CT/PET)	$0 to $150	30%	$100	30%
X-rays	$15	$20	$15	$15
Emergency Services	**In network**	**Out of network**	**In network**	**Out of network**
Ambulance	$250	$250	$225	$225
Emergency room*	$110 copay		$110 copay	
Urgently needed care	$35		$25	

*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.

Extra Benefits	ATRIO Choice Rx (PPO)	ATRIO Prime Rx (PPO)
Annual physical exam	1 every year	1 every year
Routine chiropractic, acupuncture, and naturopathic services	ATRIO covers up to 30 combined visits for routine acupuncture, routine chiropractic, and naturopathy services every year.	ATRIO covers up to 30 combined visits for routine acupuncture, routine chiropractic, and naturopathy services every year.
Fitness benefit	$250 annual allowance towards gym membership fees provided through a Flex Card.	$550 annual allowance towards gym membership fees provided through a Flex Card.
Preventive & comprehensive dental services	$1,250 annual allowance through a Flex Card	$1,750 annual allowance through a Flex Card
Routine vision exam	1 every year	1 every year
Routine vision hardware	$200 allowance for frames every year $100 allowance towards contact lenses, fitting, and evaluation every year	$200 allowance for frames every year $100 allowance towards contact lenses, fitting, and evaluation every year
Routine hearing exam	1 every year (in-network only)	1 every year (in-network only)
Hearing aids	$699-$999 per hearing aid, up to 1 per ear per year (in-network only)	$699-$999 per hearing aid, up to 1 per ear 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
Transportation	ATRIO covers up to 24 one-way non-emergent medical transportation trips to any plan-approved health-related location every year.	ATRIO covers up to 24 one-way non-emergent medical transportation trips to any plan-approved health-related location every year.
Over the counter (OTC) items	$50 quarterly allowance	$75 quarterly allowance

Prescription Drug Benefits

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

Plans	ATRIO Choice Rx (PPO)		ATRIO Prime Rx (PPO)	
Tier Levels	**30-day supply**	**90-day supply**	**30-day supply**	**90-day supply**
Deductible	$100		$0	
Tier 1 (Preferred generic)	$0	$0	$0	$0
Tier 2 (Generic)	$8	$16	$8	$16
Tier 3† (Preferred brand)	$47	$94	$47	$94
Tier 4† (Non preferred drugs)	$100	$200	$100	$200
Tier 5† (Specialty)	30%	N/A	33%	N/A
Tier 6 (Select care drugs)	$0	$0	$0	$0
Coverage gap stage: When the total paid by you and the plan reaches $4,660, you move to the Coverage Gap stage.	There is a 75% discount for most brand name and Generic drugs			
Catastrophic coverage stage: After you have paid $7,400 out of pocket, you move to the Catastrophic Coverage Stage.	The greater of $4.15 for generics, $10.35 for brand-name, or 5%.			

†Part D Deductible applies

Drug Coverage

For plans that include prescription drug coverage, we have a formulary - a list of covered medications. Our formulary offers a wide selection of Medicare approved, cost-effective generic and brand name prescription drugs. For PPO Plans, each drug will be categorized into one of six tiers. A drug tier determines how much you pay for your drug.

Tier 1 "Preferred Generic" tier, contains low-cost generic drugs.

Tier 2 "Generic" tier, contains most generic drugs and a select number of brand name drugs.

Tier 3 "Preferred Brand" tier, contains preferred brand drugs and a select number of high-cost generics. Drugs in this tier will cost higher than drugs in tier 2.

Tier 4 "Non-Preferred Brand" tier, contains non-preferred brand name drugs and a select number of high-cost generics. Drugs in this tier will cost more (or have a higher cost) than the drugs in tier 3. Note: If a member has a non-formulary medication that has been approved through an ATRIO exception, it will fall under this tier.

Tier 5 "Specialty" tier, contains specialty drugs. This is the highest cost sharing tier. (These drugs are not available for mail-order or a 90-day supply.)

Tier 6 "Select Care Drugs" tier. Although this typically would be the highest cost tier, tier 6 is a $0 copay tier for certain important medications such as:

- Select Insulins
- Part D vaccines
- ACE-I/ARBs for treatment of high blood pressure or kidney protection
- Select antidiabetic drugs to treat diabetes
- Statins to treat high cholesterol

In addition, when a member enters the Coverage Gap and/or Catastrophic Coverage Stages, Part D vaccines in this tier will continue to have a $0 cost share.

What if my medication is not on the formulary?

- If you cannot locate your drug on the formulary, call Customer Service for help. We may be able to provide you with a list of alternative drugs.
- Talk to your doctor about an alternative drug on the formulary.
- You can also submit a Coverage Determination to request an exception to the formulary. For more information, visit **atriohp.com** or ask your doctor to submit one on your behalf.

Types of restrictions you might find on formulary drugs

- **Prior Authorization (PA)** – this is a request for approval in advance. Some drugs may require a prior authorization to make sure the drug is being used appropriately.
- **Quantity Limits (QL)** – certain drugs may have a specific quantity limit allowed to receive.
- **Step Therapy (ST)** – you may need to try other drugs first before we will approve the use of certain drugs to treat the same condition.
- **Part B vs. Part D review** – some drugs are covered as part of your medical Part B coverage, and others are covered under your Part D coverage.

TOP 100 DRUGS
(Commonly prescribed medicines)

For a complete listing of all drugs covered on our formulary, visit atriohp.com

DRUG NAME	TYPE OF DOSAGE	TIER LEVEL
ADVAIR DISKUS 250-50 MCG	INHALER	2
ALBUTEROL SULFATE HFA 90 MCG	INHALER	2
ALENDRONATE SODIUM 70 MG	TABLET	1
ALLOPURINOL 100 MG	TABLET	1
ALLOPURINOL 300 MG	TABLET	1
ALPRAZOLAM 0.5 MG	TABLET	1
AMLODIPINE BESYLATE 10 MG	TABLET	1
AMLODIPINE BESYLATE 2.5 MG	TABLET	1
AMLODIPINE BESYLATE 5 MG	TABLET	1
AMOXICILLIN 500 MG	CAPSULE	1
AMOXICILLIN 500 MG	TABLET	2
AMOXICILLIN-CLAVULANATE POTASS 875-125 MG	TABLET	2
ATORVASTATIN CALCIUM 10 MG	TABLET	6
ATORVASTATIN CALCIUM 20 MG	TABLET	6
ATORVASTATIN CALCIUM 40 MG	TABLET	6
ATORVASTATIN CALCIUM 80 MG	TABLET	6
AZITHROMYCIN 250 MG	TABLET	2
CARVEDILOL 3.125 MG	TABLET	1
CARVEDILOL 6.25 MG	TABLET	1
CEPHALEXIN 500 MG	CAPSULE	1
CEPHALEXIN 500 MG	TABLET	2
CITALOPRAM HBR 20 MG	TABLET	1
CLOPIDOGREL 75 MG	TABLET	1
CYCLOBENZAPRINE HCL 10 MG	TABLET	1
DULOXETINE HCL 30 MG	CAPSULE (DELAYED RELEASE)	2
DULOXETINE HCL 60 MG	CAPSULE (DELAYED RELEASE)	2
ELIQUIS 5 MG	TABLET	3
ESCITALOPRAM OXALATE 10 MG	TABLET	1
ESCITALOPRAM OXALATE 20 MG	TABLET	1
EZETIMIBE 10 MG	TABLET	2
FINASTERIDE 5 MG	TABLET	1
FLUOXETINE HCL 20 MG	CAPSULE	1
FLUTICASONE PROPIONATE 50 MCG	NASAL SPRAY	1

TOP 100 DRUGS
(Commonly prescribed medicines)

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FUROSEMIDE 20 MG	TABLET	1
FUROSEMIDE 40 MG	TABLET	1
GABAPENTIN 100 MG	CAPSULE	1
GABAPENTIN 300 MG	CAPSULE	1
GABAPENTIN 600 MG	TABLET	2
HYDROCHLOROTHIAZIDE 12.5 MG	CAPSULE	1
HYDROCHLOROTHIAZIDE 12.5 MG	TABLET	1
HYDROCHLOROTHIAZIDE 25 MG	TABLET	1
HYDROCODONE-ACETAMINOPHEN 10MG-325MG	TABLET	2
HYDROCODONE-ACETAMINOPHEN 5 MG-325MG	TABLET	2
LEVOTHYROXINE SODIUM 100 MCG	TABLET	1
LEVOTHYROXINE SODIUM 112 MCG	TABLET	1
LEVOTHYROXINE SODIUM 125 MCG	TABLET	1
LEVOTHYROXINE SODIUM 25 MCG	TABLET	1
LEVOTHYROXINE SODIUM 50 MCG	TABLET	1
LEVOTHYROXINE SODIUM 75 MCG	TABLET	1
LEVOTHYROXINE SODIUM 88 MCG	TABLET	1
LISINOPRIL 10 MG	TABLET	6
LISINOPRIL 20 MG	TABLET	6
LISINOPRIL 40 MG	TABLET	6
LISINOPRIL 5 MG	TABLET	6
LISINOPRIL-HYDROCHLOROTHIAZIDE 20-12.5 MG	TABLET	6
LOSARTAN POTASSIUM 100 MG	TABLET	6
LOSARTAN POTASSIUM 25 MG	TABLET	6
LOSARTAN POTASSIUM 50 MG	TABLET	6
MELOXICAM 15 MG	TABLET	1
METFORMIN HCL 1000 MG	TABLET	6
METFORMIN HCL 500 MG	TABLET	6
METFORMIN HCL ER 500 MG	TABLET (EXTENDED RELEASE)	6
METOPROLOL SUCCINATE 100 MG	TABLET (EXTENDED RELEASE)	1
METOPROLOL SUCCINATE 25 MG	TABLET (EXTENDED RELEASE)	1
METOPROLOL SUCCINATE 50 MG	TABLET (EXTENDED RELEASE)	1
METOPROLOL TARTRATE 25 MG	TABLET	1
METOPROLOL TARTRATE 50 MG	TABLET	1
MONTELUKAST SODIUM 10 MG	TABLET	1

TOP 100 DRUGS
(Commonly prescribed medicines)

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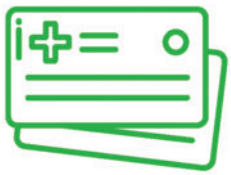
OMEPRAZOLE 20 MG	CAPSULE (DELAYED RELEASE)	1
OMEPRAZOLE 40 MG	CAPSULE (DELAYED RELEASE)	1
OXYCODONE HCL 10 MG	TABLET	2
OXYCODONE HCL 5 MG	CAPSULE	3
OXYCODONE HCL 5 MG	TABLET	2
OXYCODONE-ACETAMINOPHEN 5 MG-325MG	TABLET	2
PANTOPRAZOLE SODIUM 40 MG	TABLET DR	1
PANTOPRAZOLE SODIUM 40 MG	VIAL	2
POTASSIUM CHLORIDE 10 MEQ	CAPSULE (EXTENDED RELEASE)	2
POTASSIUM CHLORIDE 10 MEQ	TABLET (EXTENDED RELEASE)	2
POTASSIUM CHLORIDE 20 MEQ	TABLET (EXTENDED RELEASE)	2
POTASSIUM CHLORIDE 20 MEQ	TABLET (EXTENDED RELEASE)	2
PRAVASTATIN SODIUM 20 MG	TABLET	6
PRAVASTATIN SODIUM 40 MG	TABLET	6
PREDNISONE 10 MG	TABLET (DOSE PACK)	2
PREDNISONE 10 MG	TABLET	1
PREDNISONE 20 MG	TABLET	1
ROSUVASTATIN CALCIUM 10 MG	TABLET	6
ROSUVASTATIN CALCIUM 20 MG	TABLET	6
SERTRALINE HCL 100 MG	TABLET	1
SERTRALINE HCL 50 MG	TABLET	1
SHINGRIX 50 MCG/0.5	KIT	6
SIMVASTATIN 20 MG	TABLET	6
SIMVASTATIN 40 MG	TABLET	6
SPIRONOLACTONE 25 MG	TABLET	1
SULFAMETHOXAZOLE-TRIMETHOPRIM 800-160 MG	TABLET	1
TAMSULOSIN HCL 0.4 MG	CAPSULE	1
TRAMADOL HCL 50 MG	TABLET	1
TRAZODONE HCL 100 MG	TABLET	1
TRAZODONE HCL 50 MG	TABLET	1
XARELTO 20 MG	TABLET	3
ZOLPIDEM TARTRATE 10 MG	TABLET	1

Additional Benefits

When you choose an ATRIO, you get extra benefits that Original Medicare does not cover. This includes:



Flex Card

The Flex Card is a debit card that contains a set dollar amount to use for preventative and comprehensive dental services as well as a separate set amount to use for fitness membership and over-the-counter coverage. Simply swipe your Flex Card like a debit card to pay for item or services, up to your set amount. Each time you use your Flex Card, the amount spent will be deducted from your card.

Dental Benefit: *You receive an allowance to pay for dental services. You choose your provider, and you decide how to spend your dental funds. For the Choice Rx plan, you receive a $1,250 allowance. For the Prime Rx plan, you receive a $1,750 allowance.*

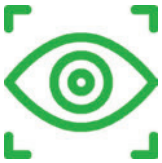
Fitness Benefit: *You receive an allowance to cover the cost of gym membership fees. For the Choice Rx plan, you receive a $250 allowance. For the Prime Rx, you receive a $550 allowance.*

OTC allowance: *For the Choice Rx plan, you receive a $50 allowance and for the Prime Rx, you receive a $75 allowance quarterly through mail order, online or in a network retail store.*

Routine Dental

(Covered services **up to** *your Flex Card allowance noted above)*

- ✓ $0 copay up to your Flex Card allowance for **preventive** dental office visits, oral exams, cleanings, fluoride treatments and x-rays
- ✓ $0 copay up to your Flex Card allowance for comprehensive dental office visits for diagnostic services, restorative services, endodontics/periodontics/extractions, and prosthodontics/maxillofacial surgery/other services
- ✓ Freedom to use any dentist you want



Routine Vision

- √ $0 copay for routine eye exam (each year) from an in-network VSP provider
- √ Receive up to a $200 (Choice Rx & Prime Rx) allowance towards frames every year. Lenses for eyeglasses are covered in full
- √ Receive up to a $100 allowance towards contact lenses in lieu of eyeglasses (visually necessary contacts are covered in full)
- √ Choose from a large network of qualified vision providers from **VSP Vision Care**

Routine Hearing Benefit

- √ $0 copay for an annual routine hearing exam from an in network Amplifon provider.
- √ Receive coverage for top-level hearing aids at affordable prices. You pay $699 – $999 copayment per hearing aid, up to 1 per ear per year. This amount can be paid over 12 monthly payments, with NO interest.
- √ Choose from a large network of qualified hearing providers from **Amplifon**.

Meals

Receive up to 28 meals with prior authorization after a qualifying event such as an inpatient stay or if you receive home health services, offered through **Mom's Meals**. Also enjoy free shipping for any meals you order as a self pay option.

Over-the-counter Items (OTC)

You'll receive a quarterly credit of $50 or $75 to buy over-the counter items from a list of eligible products. You can place your order online, over the phone, by mail through your 2023 OTC Catalog, or through a network retail store using your Flex Card. If your order total exceeds your benefit amount, credit cards are accepted. Benefit funds provided must be used in its entirety prior to other forms of payment being accepted.

Worldwide Emergency and Urgent Care

Worldwide emergency and urgent care benefits when traveling outside the country!

Telehealth

A virtual service is a visit with a doctor over the phone or via the internet using a smart phone, tablet, or a computer. Certain types of visits may require internet and a camera-enabled device.

- ✓ $0 copay for virtual services received from an in-network **Teladoc** provider.
- ✓ Virtual visit access offered 24 hours a day, 7 days a week to a board certified doctors.
- ✓ Covered services include general medical, behavioral health, dermatology, and more.

Transportation

- ✓ $0 for non-emergency medical transportation
- ✓ Receive up to 24 one-way health-related plan approved trips through **SafeRide** every year, to locations such as in-patient facilities, provider offices, pharmacies and medical centers.

Alternative Services

- ✓ $20 copay per visit from an in-network **American Specialty Health** provider.
- ✓ Receive 30 total combined visits to use on supplemental chiropractic services, supplemental acupuncture services, and naturopathy services

Contact & Access Information

Visit atriohp.com/extra-benefits for more details on the additional benefits.

Flex Card – To check balances, report a lost card, request a new card, or have other questions, call 1-800-371-2119 (TTY 711), Monday—Friday, 8 a.m. to 11 p.m. EST

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

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 – To place an order or for more information call 1-855-253-5768 (TTY 711). Catalogs can be found online at atriohp.com/extra-benefits

Teladoc – To find a provider and schedule and appointment, call 1-800-teladoc (835-2362), 24 hours a day, 7 days a week

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

American Specialty Health – To find a provider and schedule and appointment, call 1-800-678-9133 (TTY 711). October 1st - March 31st 5 a.m. to 10 p.m. (PDT), 7 days a week. April 1st to September 30th, 5 a.m. to 8 p.m. (PDT), Monday - Friday.

ATRIO™
HEALTH PLANS

2023 Summary of Benefits

Oregon

Marion and Polk Counties

ATRIO Choice Rx (PPO)
ATRIO Prime Rx (PPO)

January 1, 2023 - December 31, 2023

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Out-of-network/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 customer service number or see your Evidence of Coverage for more information, including the cost sharing that applies to out-of-network services.

2023 Summary of Benefits

January 1, 2023 – December 31, 2023

About the Summary of Benefits and Who Can Join

This is a summary of drug and health services covered by **ATRIO Choice Rx (PPO),** and **ATRIO Prime Rx (PPO)**. The benefit information provided does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please view the Evidence of Coverage at **atriohp.com**. To join an ATRIO Health Plans Medicare Advantage Plan, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

Our service area for these plans includes the following counties in **Oregon**: **Marion and Polk counties**.

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 customer service representative at 1-877-672-8620 (TTY 711), daily from 8 a.m. to 8 p.m. local time.

Understanding the Benefits	
☐	The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit **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.
☐	Review the formulary to make sure your drugs are covered.
☐	If you choose a plan that includes drug coverage, review the formulary to make sure your drugs are covered.
Understanding Important Rules	
☐	In addition to your monthly plan premium (if applicable), you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.

☐	Benefits, premiums and/or copayments/co-insurance may change on January 1, 2024.
☐	Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services, the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care. In addition, you will pay a higher co-pay for services received by non-contracted providers.

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

H7006_SB_OR_MP_2023_M
H7006-007, H7006-003

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

	ATRIO Choice Rx H7006-007	ATRIO Prime Rx H7006-003
Plan Premium	$0 per month. In addition, you must keep paying your Medicare Part B premium.	$99 per month. In addition, you must keep paying your Medicare Part B premium.
Plan Deductible	$0 per year	$0 per year
Out-of-Pocket Limits	$4,500 for services you receive from in-network providers. $6,500 for services you receive from any provider. Your limit for services received from in-network providers will count toward this limit.	$2,500 for services you receive from in-network providers. $5,000 for services you receive from any provider. Your limit for services received from in-network providers will count toward this limit.

Covered Medical and Hospital Benefits

Note: Services marked with * may require prior authorization.

	ATRIO Choice Rx H7006-007	ATRIO Prime Rx H7006-003
Inpatient Hospital Care (Acute) *	**In-network:** $400 copay per day for days 1-5; $0 copay per day for days 6 and beyond **Out-of-network:** $500 copay per day for days 1-5; $0 copay per day for days 6-90 No maximum out-of-pocket	**In-network:** $225 copay per day for days 1-8; $0 copay per day for days 9 and beyond **Out-of-network:** $350 copay per day for days 1-7; $0 copay per day for days 8-90 No maximum out-of-pocket
Outpatient Hospital *	**In-network:** $300 copay **Out-of-network:** 50% coinsurance	**In-network:** $275 copay **Out-of-network:** $425 copay
Ambulatory Surgery Center *	**In-network:** $225 copay **Out-of-network:** $325 copay	**In-network:** $225 copay **Out-of-network:** $225 copay
Doctor's Office Visits	Primary care physician: **In-network:** $0 copay **Out-of-network:** $50 copay Specialist: **In-network:** $40 copay **Out-of-network:** $65 copay	Primary care physician: **In-network:** $0 copay **Out-of-network:** $30 copay Specialist: **In-network:** $25 copay **Out-of-network:** $50 copay
Preventive Care	You pay nothing for Medicare-covered preventive services. Any additional preventive services approved by Medicare during the plan year will be covered. Our plan also covers a supplemental Annual Physical Exam at no cost.	

	ATRIO Choice Rx H7006-007	**ATRIO Prime Rx H7006-003**
Emergency Care Worldwide emergency/urgent coverage.	$110 copay (waived if admitted within 24 hours for the same condition)	$110 copay (waived if admitted within 24 hours for the same condition)
Urgent Care See "Emergency Care" for worldwide copay.	$35 copay (waived if admitted within 24 hours for the same condition)	$25 copay (waived if admitted within 24 hours for the same condition)
Diagnostic Tests, Lab, X-rays, and Radiology Services * (such as MRIs, CT scans)	Diagnostic radiology services: **In-network:** $0 to $150 copay **Out-of-network:** 30% coinsurance Other diagnostic tests and procedures: **In-network:** $20 copay **Out-of-network:** 30% coinsurance Lab services **In-network:** $0 copay **Out-of-network:** $20 copay Therapeutic radiology services (such as radiation treatment for cancer): **In-network:** $60 copay **Out-of-network:** 30% coinsurance Outpatient x-rays: **In-network:** $15 copay **Out-of-network:** $20 copay	Diagnostic radiology services: **In-network:** $100 copay **Out-of-network:** 30% coinsurance Other diagnostic tests and procedures: **In-network:** $15 copay **Out-of-network:** 30% coinsurance Lab services **In-network:** $0 copay **Out-of-network:** $0 copay Therapeutic radiology services (such as radiation treatment for cancer): **In-network:** $60 copay **Out-of-network:** 30% coinsurance Outpatient x-rays: **In-network:** $15 copay **Out-of-network:** $15 copay
Hearing Services Medicare-covered: Exams to diagnose and treat hearing and balance issues.	Medicare-covered: **In-network:** $45 copay **Out-of-network:** $65 copay Additional hearing services (not covered by Medicare): Routine hearing exam – **In-network:** $0 copay Hearing aids - $699 to $999 copay per aid, up to 2 per year (one per ear) **Out-of-network:** $0 copay (Amplifon provider must be used to receive hearing aid benefits)	Medicare-covered: **In-network:** $25 copay **Out-of-network:** $50 copay Additional hearing services (not covered by Medicare): Routine hearing exam – **In-network:** $0 copay Hearing aids - $699 to $999 copay per aid, up to 2 per year (one per ear) **Out-of-network:** $0 copay (Amplifon provider must be used to receive hearing aid benefits)

	ATRIO Choice Rx H7006-007	ATRIO Prime Rx H7006-003
Dental Services * Medicare-covered: Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth).	Medicare-covered: **In-network:** $45 copay **Out-of-network:** $65 copay Additional dental services (not covered by Medicare): **In & Out-of-network:** $0 copay up to allowance Annual allowance of $1,250 towards preventive and comprehensive dental services at any provider through a Flex Card.	Medicare-covered: **In-network:** $25 copay **Out-of-network:** $45 copay Additional dental services (not covered by Medicare): **In & Out-of-network:** $0 copay up to allowance Annual allowance of $1,750 towards preventive and comprehensive dental services at any provider through a Flex Card.
Vision Services Medicare-covered: Exams to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening).	Medicare-covered exams: **In-network:** $45 copay **Out-of-network:** $65 copay Medicare-covered glaucoma screening: **In & Out-of-network:** $0 copay Additional vision services (not covered by Medicare): Routine eye exam – **In-network:** $0 copay **Out-of-network**: 50% coinsurance Routine eyewear – **In-network:** $0 copay **Out-of-Network:** 50% coinsurance $200 allowance for frames every year; $100 allowance towards contact lenses, fitting and evaluation every year	Medicare-covered exams: **In-network:** $15 copay **Out-of-network:** $15 copay Medicare-covered glaucoma screening: **In & Out-of-network:** $0 copay Additional vision services (not covered by Medicare): Routine eye exam – **In-network:** $0 copay **Out-of-network**: 50% coinsurance Routine eyewear – **In-network:** $0 copay **Out-of-Network:** 50% coinsurance $200 allowance for frames every year; $100 allowance towards contact lenses, fitting and evaluation every year
Mental Health Services *	Inpatient mental health care: **In-network:** $370 copay per day for days 1-5; $0 copay per day for days 6-90 **Out-of-network:** $500 copay per day for days 1-5; $0 copay per day for days 6-90 Outpatient group and individual therapy visit: **In-network:** $40 copay **Out-of-network:** 50% coinsurance	Inpatient mental health care: **In-network:** $200 copay per day for days 1-8; $0 copay per day for days 9-90 **Out-of-network:** $325 copay per day for days 1-8; $0 copay per day for days 9-90 Outpatient group and individual therapy visit: **In-network:** $25 copay **Out-of-network:** 50% coinsurance

	ATRIO Choice Rx H7006-007	ATRIO Prime Rx H7006-003
Skilled Nursing Facility (SNF) *	**In-network:** $0 copay per day for days 1-20; $150 copay per day for days 21-100 **Out-of-network:** $150 copay per day for days 1-100	**In-network:** $0 copay per day for days 1-20; $125 copay per day for days 21-100 **Out-of-network:** $125 copay per day for days 1-100
Physical Therapy *	Physical & Speech therapy visit: **In-network:** $40 copay **Out-of-network:** 50% coinsurance Occupational therapy visit: **In-network:** $40 copay **Out-of-network:** 50% coinsurance	Physical & Speech therapy visit: **In-network:** $30 copay **Out-of-network:** 50% coinsurance Occupational therapy visit: **In-network:** $30 copay **Out-of-network:** 50% coinsurance
Ambulance *	**In-network:** $250 copay **Out-of-network:** $250 copay	**In-network:** $225 copay **Out-of-network:** $225 copay
Transportation	$0 copay for up to 24 one-way non-emergent medical transportation trips to any plan-approved health-related location every year (SafeRide must be used to receive routine transportation benefits)	$0 copay for up to 24 one-way non-emergent medical transportation trips to any plan-approved health-related location every year (SafeRide must be used to receive routine transportation benefits)
Medicare Part B Drugs *	**In-network:** 20% coinsurance **Out-of-network:** 50% coinsurance	**In-network:** 20% coinsurance **Out-of-network:** 50% coinsurance
Telehealth (Non-Medicare covered)	**In-network:** $0 copay **Out-of-network:** Not covered (Teladoc provider must be used to receive additional telehealth benefits)	**In-network:** $0 copay **Out-of-network:** Not covered (Teladoc provider must be used to receive additional telehealth benefits)
Foot Care Medicare-covered: Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions.	Medicare-covered: **In-network:** $45 copay **Out-of-network:** 50% coinsurance	Medicare-covered: **In-network:** $25 copay **Out-of-network:** 50% coinsurance
Medical Equipment and Supplies *	DME, prosthetic devices, medical supplies: **In-network:** 20% coinsurance **Out-of-network:** 50% coinsurance	DME, prosthetic devices, medical supplies: **In-network:** 20% coinsurance **Out-of-network:** 30% coinsurance

	ATRIO Choice Rx H7006-007	ATRIO Prime Rx H7006-003
	Diabetic supplies and services: **In-network:** $0 copay **Out-of-network:** 50% coinsurance	Diabetic supplies and services: **In-network:** $0 copay **Out-of-network:** 20% coinsurance
Fitness	$250 annual allowance towards gym membership fees provided through a Flex Card.	$550 annual allowance towards gym membership fees provided through a Flex Card.
Chiropractic Services (Medicare-covered) Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position).	Medicare-covered: **In-network:** $20 copay **Out-of-network:** $65 copay	Medicare-covered: **In-network:** $20 copay **Out-of-network:** $50 copay
Chiropractic/Acupuncture/ Naturopathy Services (Non-Medicare covered)	**In-network:** $20 copay **Out-of-network:** $65 copay Up to 30 combined visits for routine chiropractic, routine acupuncture, and naturopathy services every year	**In-network:** $20 copay **Out-of-network:** $50 copay Up to 30 combined visits for routine chiropractic, routine acupuncture, and naturopathy services every year
Over-The-Counter Items	You receive an allowance of $50 per quarter	You receive an allowance of $75 per quarter
Meals*	$0 copay 2 meals per day for 14 days after an inpatient or skilled nursing facility stay or while receiving home health services	$0 copay 2 meals per day for 14 days after an inpatient or skilled nursing facility stay or while receiving home health services

Medicare Part D Prescription Drug Benefits

Deductible Stage

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

ATRIO Choice Rx H7006-007	ATRIO Prime Rx H7006-003
$100 per year	$0 per year

Initial Coverage Stage

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

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

ATRIO Choice Rx			ATRIO Prime Rx		
Standard Retail Cost Sharing			Standard Retail Cost Sharing		
Tier	**30-day supply**	**90-day supply**	**Tier**	**30-day supply**	**90-day supply**
Tier 1 (Preferred Generic)	$0 copay	$0 copay	Tier 1 (Preferred Generic)	$0 copay	$0 copay
Tier 2 (Generic)	$8 copay	$16 copay	Tier 2 (Generic)	$8 copay	$16 copay
Tier 3 (Preferred Brand)	$47 copay	$94 copay	Tier 3 (Preferred Brand)	$47 copay	$94 copay
Tier 4 (Non-Preferred Drug)	$100 copay	$200 copay	Tier 4 (Non-Preferred Drug)	$100 copay	$200 copay
Tier 5 (Specialty Tier)	30% coinsurance	A long-term supply is not available	Tier 5 (Specialty Tier)	33% coinsurance	A long-term supply is not available
Tier 6 (Select Care Drugs)	$0 copay	$0 copay	Tier 6 (Select Care Drugs)	$0 copay	$0 copay

Coverage Gap Stage

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

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

Catastrophic Coverage Stage

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

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

Important Message About What You Pay for Vaccines - Our plan covers most Part D vaccines at no cost to you, even if you haven't paid your deductible. Call Customer Service for more information.

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

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

Come into your local ATRIO office and work with one of our advisors to complete your enrollment.
2965 Ryan Drive SE, Salem, OR

4

At Your Home

We can have a local advisor come 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:
ATRIO Health Plans
338 Jericho Turnpike #135
Syosset, NY 11791
Fax: (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 Customer Service Representative at the number listed on the back cover of this book.

Understanding the Benefits

The Evidence of Coverage (EOC) provides a completed list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit our website at atriohp.com or call our Customer Service Representative at the number listed on the back cover of this book.

- Review the Provider Directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.

- Review the Pharmacy Directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

Understanding Important Rules

- In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.

- Benefits, premiums and/or co-payments/coinsurance may change on January 1 of each year.

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

ATRIO™
HEALTH PLANS

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.

Please note, 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:

_____

_____

2023 MEDICARE ADVANTAGE PRESCRIPTION DRUG PLAN ENROLLMENT FORM

ATRIO HEALTH PLANS

Who can use this form?

People with Medicare who want to join a Medicare Advantage Prescription Drug 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 Prescription Drug 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.

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

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
338 Jericho Turnpike #135
Syosset, NY 11791

Fax:
(602) 975-4071

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.

OMB No. 0938-1378
Expires: 7/31/2024

2023 MEDICARE ADVANTAGE PRESCRIPTION DRUG PLAN ENROLLMENT FORM (MARION AND POLK COUNTIES)

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): $0/mo (H7006_007)

☐ ATRIO PRIME Rx (PPO): $99/mo (H7006_003)

FIRST name: _____ LAST name: _____ Middle Initial: _____ *(Optional)*

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

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: _____ 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 or 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.

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/oregon/members/member-portal** to sign up on our premium portal.

☐ Credit Card

For credit card payment, visit **atriohp.com/oregon/members/member-portal** 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).

- 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:** _____

If you are the authorized representative, you must sign above and fill out these fields below:

Name: _____ Address: _____

City: _____ State: ___ Zip: _____

Phone number: _____ Relationship to enrollee: _____

SECTION 2: A few questions to help us manage your plan *(optional)*

1. List your **Primary Care Physician** (PCP), clinic or health center: _____
2. Select one if you prefer plan information in another language or an accessible format.

   ☐ Spanish ☐ Large Print ☐ Other: _____

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.

3. Do you or your spouse work? ☐ Yes ☐ No
4. 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
_____	_____	_____

SECTION 2 *continued*: 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.

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, Cuban
- ☐ Yes, Puerto Rican
- ☐ Yes, another Hispanic, Latino/a, or Spanish origin
- ☐ **I choose not to answer.**

What's your race? Select all that apply.

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

SECTION 3: For licensed sales representative/agency use only

Staff member/Agent/Broker must complete:

Name (if assisted in enrollment):_____ **Writing ID#:** _____

Initial receipt date: _____ **Proposed effective date of coverage:** _____

- ☐ IEP (MA-PD enrollees)
- ☐ ICEP (MA enrollees)
- ☐ IEP (MA-PD enrollees eligible for 2nd IEP)
- ☐ OEP (Jan1 – Mar 31)
- ☐ OEP (newly eligible)
- ☐ SEP (Dual LIS change of status)
- ☐ SEP (change in residence)
- ☐ SEP (loss of EGHP coverage)
- ☐ SEP (Chronic)
- ☐ SEP (Dual LIS maintaining)
- ☐ SEP (SEP reason):_____
- ☐ AEP (October 15-December 7)
- ☐ OEPI

_____ _____

Licensed Sales Representative Signature (optional) Date

Please 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.

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 **1-877-672-8620** (TTY **711**) daily from 8 a.m. to 8 p.m. local time to see if you are eligible to enroll.

Y0084_END_1a_2023_C

2023 MEDICARE ADVANTAGE PRESCRIPTION DRUG PLAN ENROLLMENT FORM

Who can use this form?

People with Medicare who want to join a Medicare Advantage Prescription Drug 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 Prescription Drug 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.

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

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
338 Jericho Turnpike #135
Syosset, NY 11791

Fax:
(602) 975-4071

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.

OMB No. 0938-1378
Expires: 7/31/2024

2023 MEDICARE ADVANTAGE PRESCRIPTION DRUG PLAN ENROLLMENT FORM (MARION AND POLK COUNTIES)

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): $0/mo
(H7006_007)

☐ ATRIO PRIME Rx (PPO): $99/mo
(H7006_003)

FIRST name: _____ LAST name: _____ Middle Initial: _____ *(Optional)*

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

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: _____ 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 or 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.

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/oregon/members/member-portal** to sign up on our premium portal.

☐ Credit Card

For credit card payment, visit **atriohp.com/oregon/members/member-portal** 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).

- 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:** _____

If you are the authorized representative, you must sign above and fill out these fields below:

Name: _____ Address: _____

City: _____ State: ___ Zip: _____

Phone number: _____ Relationship to enrollee: _____

SECTION 2: A few questions to help us manage your plan *(optional)*

1. List your **Primary Care Physician** (PCP), clinic or health center: _____
2. Select one if you prefer plan information in another language or an accessible format.

   ☐ Spanish ☐ Large Print ☐ Other: _____

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.

3. Do you or your spouse work? ☐ Yes ☐ No
4. 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

SECTION 2 *continued*: 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.

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, Cuban
- ☐ Yes, Puerto Rican
- ☐ Yes, another Hispanic, Latino/a, or Spanish origin
- ☐ **I choose not to answer.**

What's your race? Select all that apply.

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

SECTION 3: For licensed sales representative/agency use only

Staff member/Agent/Broker must complete:

Name (if assisted in enrollment):_____ **Writing ID#:** _____

Initial receipt date: _____ **Proposed effective date of coverage:** _____

- ☐ IEP (MA-PD enrollees)
- ☐ ICEP (MA enrollees)
- ☐ IEP (MA-PD enrollees eligible for 2nd IEP)
- ☐ OEP (Jan1 – Mar 31)
- ☐ OEP (newly eligible)
- ☐ SEP (Dual LIS change of status)
- ☐ SEP (change in residence)
- ☐ SEP (loss of EGHP coverage)
- ☐ SEP (Chronic)
- ☐ SEP (Dual LIS maintaining)
- ☐ SEP (SEP reason):_____
- ☐ AEP (October 15-December 7)
- ☐ OEPI

_____ _____

Licensed Sales Representative Signature (optional) Date

Please Mail or Fax this completed form to:

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

Fax: (602) 975-4071

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☐ 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 **1-877-672-8620** (TTY **711**) daily from 8 a.m. to 8 p.m. local time to see if you are eligible to enroll.

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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): HMO DSNP or PPO

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 www.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 in (check the answer(s)):

☐ Tier 1 ☐ Tier 2 ☐ Tier 3 ☐ Tier 4 ☐ Tier 5 or ☐ ALL tiers

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 Customer Service at _____.

After you Enroll

Steps	How you get it	Description
1 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. Enrollment complete.
2 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.
3 Member ID Card	Mailed 	If you enroll during the Medicare Annual Enrollment Period (AEP), you will receive your ID card in December. If you enroll outside of AEP, you will receive this 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.
7 Welcome Call	Phone 	You will receive a call from an ATRIO representative to welcome you to the plan and answer any questions that you may have!

Notice about Nondiscrimination and Accessibility Requirements

Discrimination is Against the Law

ATRIO Health Plans complies with applicable civil rights laws and does not discriminate against, exclude, or treat differently any individual on the basis prohibited by local, state, or federal laws, including but not limited to the basis of race, color, religious creed, national origin, ancestry, disability, medical condition, marital status, age, sex, gender, gender expression, sexual orientation, genetic information, or military/veteran status.

ATRIO Health Plans:

- Provides, upon request, 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 Customer Service toll free at 1-877-672-8620 (TTY 711), daily from 8 a.m. to 8 p.m.

If you believe that ATRIO Health Plans has failed to provide these services or discriminated in another way, you can file a grievance with ATRIO Health Plans in person, by mail, fax, or email.

ATRIO Chief Compliance Officer
2965 Ryan Drive SE
Salem, OR 97301

ATRIO Compliance Hotline: 1-877-309-9952
Fax: 541-672-8670
Email: compliance@atriohp.com

If you need help filing a grievance, contact Customer Service toll free at 1-877-672-8620 (TTY 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
Phone: 1-800-368-1019
TDD: 1-800-537-7697

Complaint forms are available at www.hhs.gov/ocr/complaints/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)

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 1-877-672-8620번으로 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: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-877-672-8620. سيقوم شخص ما يتحدث العربية بمساعدتك. 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.

Portugués: 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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