ATRIO™
HEALTH PLANS

2024 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 , H6743-023-3, 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, 2024 - December 31, 2024

ATRIO™
HEALTH PLANS

home

Get to know **ATRIO.**

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

ATRIO™
HEALTH PLANS

Local is Our Advantage

ATRIO Health Plans is celebrating our 20th Anniversary! 20 years of providing high value, high quality, and truly local Medicare Advantage 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 2024 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 and HMO D-SNP with Medicare and Oregon Health Plan contracts. Enrollment in ATRIO Health Plans depends on contract renewal.

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Original Medicare

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

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 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 our customer service number 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 some insulins, 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 Customer Service 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

$0 Drug Deductible and
$0 Tier 1, 2, and 6 *Drugs

**Deductible and drug costs may vary by plan - see included Summary of Benefits for more information on your plan's drug costs. Note Freedom PPO plans do not include Part D drug coverage*

Top 100 Most Commonly Prescribed Medications

Drug Name	Strength / Dosage	Dosage Form	Drug Tier
Acyclovir	400 Mg	Tablet	2
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	1
Amlodipine Besylate	5 Mg	Tablet	1
Amoxicillin	500 Mg	Capsule	1
Amoxicillin-clavulanate Potassium	875-125 Mg	Tablet	1
Anoro Ellipta	62.5-25mcg	Blst W/Dev	3
Atenolol	25 Mg	Tablet	1
Atorvastatin Calcium	40 Mg	Tablet	6
Azithromycin	250 Mg	Tablet	1
Baclofen	10 Mg	Tablet	2
Bumetanide	2 Mg	Tablet	2
Bupropion Xl	150 Mg	Tab Er 24h	2
Carvedilol	3.125 Mg	Tablet	1
Celecoxib	200 Mg	Capsule	2
Cephalexin	500 Mg	Capsule	1
Chlorthalidone	25 Mg	Tablet	2
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
Doxycycline	100 Mg	Tab or Capsule	2
Duloxetine Hcl	60 Mg	Capsule Dr	2
Eliquis	5 Mg	Tablet	3
Escitalopram Oxalate	10 Mg	Tablet	1
Ezetimibe	10 Mg	Tablet	1
Famotidine	20 Mg	Tablet	1
Finasteride	5 Mg	Tablet	1
Fluconazole	150 Mg	Tablet	2

Drug Name	Strength / Dosage	Dosage Form	Drug Tier
Fluoxetine Hcl	20 Mg	Capsule	1
Fluticasone Propionate	50 Mcg	Spray Susp	1
Fluticasone-salmeterol (Generic Advair Disk) or Wixela Inhaler	250-50 Mcg	Blst W/Dev	2
Furosemide	20 Mg	Tablet	1
Gabapentin	300 Mg	Capsule	1
Glimepiride	4 Mg	Tablet	6
Glipizide	5 Mg	Tablet	6
Hydrochlorothiazide	25 Mg	Tablet	1
Hydrocodone-acetaminophen	5 Mg-325mg	Tablet	2
Hydroxychloroquine Sulfate	200 Mg	Tablet	2
Hydroxyzine Hcl	25 Mg	Tablet	1
Ibuprofen	800 Mg	Tablet	1
Isosorbide Mononitrate Er	30 Mg	Tab Er 24h	1
Jardiance	10 Mg	Tablet	3
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
Meloxicam	15 Mg	Tablet	1
Metformin Hcl	500 Mg	Tablet	6
Metformin Hcl Er	500 Mg	Tab Er 24h	6
Methotrexate	2.5 Mg	Tablet	2
Methylprednisolone	4 Mg	Tab Ds Pk	2
Metoprolol Succinate	25 Mg	Tab Er 24h	1
Metoprolol Tartrate	25 Mg	Tablet	1
Montelukast Sodium	10 Mg	Tablet	1
Morphine Sulfate Er	15 Mg	Tablet Er	2
Nitrofurantoin Mono-macro	100 Mg	Capsule	2
Nitroglycerin	0.4 Mg	Tab Subl	2
Insulin Aspart	100/Ml (3)	Insulin Pen	6
Olmesartan Medoxomil	20 Mg	Tablet	6

Top 100 Most Commonly Prescribed Medications

Drug Name	Strength / Dosage	Dosage Form	Drug Tier
Omeprazole	20 Mg	Capsule Dr	1
Ondansetron or ODT	4 Mg	Tab or Tab Rapids	2
Oxybutynin Chloride	5 Mg	Tablet	2
Oxycodone Hcl	10 Mg	Tablet	2
Oxycodone-acetaminophen	5 Mg-325mg	Tablet	2
Pantoprazole Sodium	40 Mg	Tablet Dr	1
Pioglitazone Hcl	15 Mg	Tablet	6
Potassium Chloride	10 Meq	Tablet Er	2
Pravastatin Sodium	40 Mg	Tablet	6
Prednisone	20 Mg	Tablet	1
Pregabalin	150 Mg	Capsule	2
Progesterone	100 Mg	Capsule	2
Quetiapine Fumarate	25 Mg	Tablet	2
Rosuvastatin Calcium	10 Mg	Tablet	6
Semglee (Yfgn) Pen	100/Ml (3)	Insulin Pen	6
Sertraline Hcl	100 Mg	Tablet	1
Shingrix	50 Mcg/0.5	Kit	6
Simvastatin	20 Mg	Tablet	6
Sod Sulf-potassium Sulf-mag Sulf	17.5-3.13g	Soln Recon	3
Spiriva Respimat	2.5 Mcg	Mist Inhaler	3
Spironolactone	25 Mg	Tablet	1
Sulfamethoxazole-trimethoprim	800-160 Mg	Tablet	1
Tamsulosin Hcl	0.4 Mg	Capsule	1
Tizanidine Hcl	4 Mg	Tablet	2
Torsemide	20 Mg	Tablet	2
Tramadol Hcl	50 Mg	Tablet	1
Trazodone Hcl	50 Mg	Tablet	1
Trelegy Ellipta	100-62.5	Blst W/Dev	3
Triamterene-hydrochlorothiazid	37.5-25 Mg	Tablet	1
Trulicity	1.5 Mg/0.5	Pen Injector	3
Venlafaxine Hcl Er	150 Mg	Cap Er 24h	1
Warfarin Sodium	5 Mg	Tablet	1
Xarelto	20 Mg	Tablet	3
Zolpidem Tartrate	10 Mg	Tablet	1

2024 Benefits at a Glance

ATRIO Health Plans Medicare Advantage Plans

Klamath County (Partial), OR

Medical Benefits

Plan Costs	ATRIO Choice Rx (PPO) *H6743-001*		ATRIO Select Rx (HMO) *H3814-031*
	In and Out of network		**In network***
Monthly premium	$20		$40.60
Plan deductible	$0		$0
Annual out-of-pocket maximum	$4,950 In network	$6,500 Combined	$4,500 In network
Doctor Office Visits	**In network**	**Out of network**	**In network**
Primary care provider (PCP)	$0	$50	$0
Specialist	$40	$65	$40
Telehealth	$0	Not Covered	$0
Inpatient Care	**In network**	**Out of network**	**In network**
Inpatient hospital care	$500 per day 1–5; $0 days 6–90	$600 per day 1–5; $0 days 6–90	$350 per day 1–5; $0 days 6–90
Skilled nursing facility (SNF)	$10 per day 1–20; $203 per day 21–100	$203 per day 1–100	$10 per day 1–20; $203 per day 21–100
Outpatient Services	**In network**	**Out of network**	**In network**
Outpatient hospital	$500	$600	$350
Ambulatory surgery center	$225	$325	$225
Home health care	$0	50%	$0
Diabetes supplies	$0	20%	$0
Durable medical equipment	20%	30%	20%
Lab Services and Other Tests	**In network**	**Out of network**	**In network**
Laboratory tests	$20	15%	$20
Diagnostic imaging (MRI/CT/PET)	0%–20%	30%	$0–$20
X-rays	$20	30%	$20
Emergency Services	**In network**	**Out of network**	**In network**
Ambulance	$350		$300
Emergency room**	$120		$120
Urgently needed care	$60		$60

*Out of network coverage not included except for emergency and urgently needed care

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

2024 Benefits at a Glance

ATRIO Health Plans Medicare Advantage Plans

Klamath County (Partial), OR

Supplemental Benefits

Extra Benefits	ATRIO Choice Rx (PPO) *H6743-001*	ATRIO Select Rx (HMO) *H3814-031*
Annual physical exam	$0 for 1 every year	$0 for 1 every year
Routine chiropractic and acupuncture, and naturopathic services	Up to 30 combined in-network visits per year for routine chiropractic and acupuncture, and naturopathy services (copays may apply)	Up to 30 combined in-network visits per year for routine chiropractic and acupuncture, and naturopathy services (copays may apply)
Fitness benefit	$250 annual allowance for gym membership fees and classes on Flex Card	$300 annual allowance for gym membership fees and classes on Flex Card
Preventive & comprehensive dental services	$1,000 annual allowance on Flex Card	$850 annual allowance on Flex Card
Routine vision exam	$0 for 1 every year (In network only)	$0 for 1 every year (In network only)
Routine eyewear	$150 allowance for frames and lenses, or $100 allowance for contact lenses per year	$150 allowance for frames and lenses, or $100 allowance for contact lenses per year
Routine hearing exam	$0 for 1 every year	$0 for 1 every year
Hearing aids	$699 or $999 copay per hearing aid, up to 2 per year through Amplifon	$699 or $999 copay per hearing aid, up to 2 per year through Amplifon
Meals	Up to 2 meals per day for 14 days after a qualifying health event	Up to 2 meals per day for 14 days after a qualifying health event
Transportation	Up to 24 one-way trips per year to plan-approved, health-related locations	Up to 12 one-way trips per year to plan-approved, health-related locations
Over the counter (OTC) items	$35 quarterly allowance on Flex Card	$30 quarterly allowance on Flex Card

See the “Extra Benefits” section of the Enrollment Kit for a more detailed overview

2024 Benefits at a Glance

ATRIO Health Plans Medicare Advantage Plans

Klamath County (Partial), OR

Prescription Drug Benefits

	ATRIO Choice Rx (PPO) *H6743-001*		ATRIO Select Rx (HMO) *H3814-031*	
Drug deductible	$250		$350	
Drug Tiers	**30-day supply**	**90-day supply**	**30-day supply**	**90-day supply**
Tier 1 Preferred Generic	$7	$14	$5	$10
Tier 2 Generic	$20	$40	$20	$40
Tier 3* Preferred Brand	$45	$90	$47	$94
Tier 4* Non-Preferred Drugs	$95	$190	$100	$200
Tier 5* Specialty Drugs	28%	N/A	27%	N/A
Tier 6 Select Care Drugs	$0	$0	$0	$0
Coverage Gap Stage: When the total paid by you and the plan reaches $5,030, you move to the Coverage Gap Stage	There is a 75% discount for most brand name and generic drugs		There is a 75% discount for most brand name and generic drugs	
Catastrophic Coverage Stage: After you have paid $8,000 out of pocket, you move to the Catastrophic Coverage Stage	You pay nothing through the end of the year		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, you are in the Coverage Gap, 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.

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2024 Benefits at a Glance

ATRIO Health Plans Medicare Advantage Plans

Klamath County (Partial), OR

Medical Benefits

Plan Costs	ATRIO Prime Rx (PPO) *H6743-023-003*		ATRIO Freedom (PPO) *H6743-024-003*	
	In and Out of network		**In and Out of network**	
Monthly premium	$104		$0	
Plan deductible	$0		$110	
Annual out-of-pocket maximum	$3,850 In network	$5,750 Combined	$4,500 In network	$6,500 Combined
Doctor Office Visits	**In network**	**Out of network**	**In network**	**Out of network**
Primary care provider (PCP)	$10	$30	$10	$50
Specialist	$25	$50	$25	$65
Telehealth	$0	Not Covered	$0	Not Covered
Inpatient Care	**In network**	**Out of network**	**In network**	**Out of network**
Inpatient hospital care	$350 per day 1–8; $0 days 9–90	$450 per day 1–5; $0 days 6–90	$275 per day 1–7; $0 days 8–90	$375 per day 1–7; $0 days 8–90
Skilled nursing facility (SNF)	$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 Services	**In network**	**Out of network**	**In network**	**Out of network**
Outpatient hospital	$275	$325	20%	30%
Ambulatory surgery center	$225	$325	20%	30%
Home health care	$0	50%	$0	50%
Diabetes supplies	$0	20%	$0	20%
Durable medical equipment	20%	25%	20%	30%
Lab Services and Other Tests	**In network**	**Out of network**	**In network**	**Out of network**
Laboratory tests	$0	$0	$20	50%
Diagnostic imaging (MRI/CT/PET)	0%–20%	30%	$0–$20	30%
X-rays	$15	30%	$20	30%
Emergency Services	**In network**	**Out of network**	**In network**	**Out of network**
Ambulance	$225		$275	
Emergency room*	$110		$120	
Urgently needed care	$25		$60	

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

2024 Benefits at a Glance

ATRIO Health Plans Medicare Advantage Plans

Klamath County (Partial), OR

Supplemental Benefits

Extra Benefits	ATRIO Prime Rx (PPO) *H6743-023-003*	ATRIO Freedom (PPO) *H6743-024-003*
Annual physical exam	$0 for 1 every year	$0 for 1 every year
Routine chiropractic and acupuncture, and naturopathic services	Up to 30 combined in-network visits per year for routine chiropractic and acupuncture, and naturopathy services (copays may apply)	Up to 30 combined in-network visits per year for routine chiropractic and acupuncture, and naturopathy services (copays may apply)
Fitness benefit	$550 annual allowance for gym membership fees and classes on Flex Card	$250 annual allowance for gym membership fees and classes on Flex Card
Preventive & comprehensive dental services	$1,000 annual allowance on Flex Card	$750 annual allowance on Flex Card
Routine vision exam	$0 for 1 every year (In network only)	$0 for 1 every year (In network only)
Routine eyewear	$200 allowance for frames and lenses, or $100 allowance for contact lenses per year	$150 allowance for frames and lenses, or $100 allowance for contact lenses per year
Routine hearing exam	$0 for 1 every year	$0 for 1 every year
Hearing aids	$699 or $999 copay per hearing aid, up to 2 per year through Amplifon	$699 or $999 copay per hearing aid, up to 2 per year through Amplifon
Meals	Up to 2 meals per day for 14 days after a qualifying health event	Up to 2 meals per day for 14 days after a qualifying health event
Transportation	Up to 24 one-way trips per year to plan-approved, health-related locations	Not covered
Over the counter (OTC) items	$75 quarterly allowance on Flex Card	$35 quarterly allowance on Flex Card

See the “Extra Benefits” section of the Enrollment Kit for a more detailed overview

2024 Benefits at a Glance

ATRIO Health Plans Medicare Advantage Plans

Klamath County (Partial), OR

Prescription Drug Benefits

	ATRIO Prime Rx (PPO) *H6743-023-003*		ATRIO Freedom (PPO) *H6743-024-003*
Drug deductible	$0		*Plan does not include drug coverage*
Drug Tiers	**30-day supply**	**90-day supply**	
Tier 1 Preferred Generic	$0	$0	
Tier 2 Generic	$8	$16	
Tier 3* Preferred Brand	$47	$94	
Tier 4* Non-Preferred Drugs	$100	$200	
Tier 5* Specialty Drugs	33%	N/A	
Tier 6 Select Care Drugs	$0	$0	
Coverage Gap Stage: When the total paid by you and the plan reaches $5,030, 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 $8,000 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, you are in the Coverage Gap, 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.

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Additional Benefits

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

Every ATRIO Medicare Advantage plan features the **Flex Card:** *a special debit card preloaded with dollars for* **dental, fitness, and select over-the-counter items**

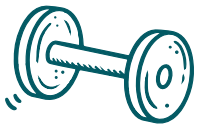
ATRIO Flex Card

So flexible! 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

Smile! You receive an annual 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

No Sweat! You receive an annual 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)

Running low? 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.**

(OTC allowances do not "roll over" – be sure to spend them before the end of each quarter!)

Vision

Don't miss a thing! No cost for 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

Sounds good! No cost for a routine hearing exam each year, plus an annual hearing aid benefit for a broad selection of high-quality devices.

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

Alternative Therapies

What a relief! Up to **30 combined visits for supplemental chiropractic and acupuncture services, and naturopathy services each year** (depending on your plan; copays may apply).

Must use American Specialty Health® providers for in-network Medicare-covered and supplemental chiropractic and acupuncture services.

Transportation (Non-Emergency)

Need a lift? No cost for 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.

Additional Benefits

Meals

Dinner on us! No cost 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.

Virtual Visits (Telehealth)

Skip the trip. No cost for online and telephonic visits with a doctor from the comfort of home. (Note not all care can be provided virtually or telephonically; you may be referred to a provider in person.)

Must use Teladoc® providers for in-network virtual visit and telehealth benefits.

Worldwide Emergency and Urgent Care

Let's go! 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 balances, report a lost card, request a new card, or have other questions, call 1-833-287-3622 (TTY 711), Monday — Friday, 5 a.m. to 8 p.m. PST

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

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

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

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

ATRIO™ HEALTH PLANS

2024 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, 2024 - December 31, 2024

2024 Summary of Benefits

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*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.

2024 Summary of Benefits

January 1, 2024 – December 31, 2024

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 show every service that we cover or 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 parts of Klamath County in Oregon. *We cover the following zip codes in Klamath County: 97601, 97602, 97603, 97604, 97621, 97622, 97623, 97624, 97625, 97626, 97627, 97632, 97633, 97634, 97639***

Which Doctors, Hospitals and Pharmacies Can I Use?

ATRIO Health Plans has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers in our network, you may pay less for your covered services. 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.
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, 2025.
☐	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.

2024 Summary of Benefits

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Klamath County (*Partial*), OR

	ATRIO Choice Rx (PPO) H6743-001	ATRIO Select Rx (HMO) H3814-031	ATRIO Prime Rx (PPO) H6743-023-3	ATRIO Freedom (PPO) H6743-024-3
Plan Premium	$20 per month	$40.60 per month	$104 per month	$0 per month
	You must also continue to pay your Medicare Part B premium			
Plan Deductible	$0 per year	$0 per year	$0 per year	$110 per year
Out-of-Pocket Maximums What you pay for in-network services also applies to any out-of-pocket limits	**In-network**: • $4,950 for services received from in-network providers **Combined**: • $6,500 for services received from any provider	**In-network**: • $4,500 for services received from in-network providers ***Note**: This HMO plan has no out-of-network coverage except for emergent / urgent care*	**In-network**: • $3,850 for services received from in-network providers **Combined**: • $5,750 for services received from any provider	**In-network**: • $4,500 for services received from in-network providers **Combined** • $6,500 for services received from any provider
Covered Medical and Hospital Benefits *(Services marked with * may require prior authorization)*				
Inpatient Hospital Care (Acute) *	**In-network**: • $500 copay per day for days 1-5; $0 days 6-90 **Out-of-network**: • $600 copay per day for days 1-5; $0 days 6-90	**In-network:** • $350 copay per day for days 1–5; $0 days 6–90	**In-network**: • $350 copay per day for days 1–8; $0 days 9–90 **Out-of-network**: • $450 copay per day for days 1–8; $0 days 9–90	**In-network**: • $275 copay per day for days 1–7; $0 days 8–90 **Out-of-network**: • $375 copay per day for days 1–7; $0 days 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% coinsurance **Out-of-network**: • 30% coinsurance
Ambulatory Surgery Center Services *	**In-network**: • $225 copay **Out-of-network**: • $325 copay	**In-network**: • $225 copay	**In-network**: • $225 copay **Out-of-network**: • $325 copay	**In-network**: • 20% coinsurance **Out-of-network**: • 30% coinsurance
Doctor's Office Visits	**Primary Care Physician (PCP)**			
	In-network: • $0 copay **Out-of-network**: • $50 copay	**In-network**: • $0 copay	**In-network**: • $10 copay **Out-of-network**: • $30 copay	**In-network**: • $10 copay **Out-of-network**: • $50 copay
	Specialists			
	In-network: • $40 copay **Out-of-network**: • $65 copay	**In-network**: • $40 copay	**In-network**: • $25 copay **Out-of-network**: • $50 copay	**In-network**: • $25 copay **Out-of-network**: • $65 copay

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January 1, 2024 – December 31, 2024

Klamath County (*Partial*), OR

	ATRIO Choice Rx (PPO) H6743-001	ATRIO Select Rx (HMO) H3814-031	ATRIO Prime Rx (PPO) H6743-023-3	ATRIO Freedom (PPO) H6743-024-3
Preventive Care	• You pay nothing for Medicare covered preventive services • Our plan also covers a supplemental Annual Physical Exam at no cost			
Emergency Care Worldwide emergent / urgent care coverage	**In- and Out-of-network:** • $120 copay (waived if admitted within 24 hours for the same condition)	**In- and Out-of-network:** • $120 copay (waived if admitted within 24 hours for the same condition)	**In- and Out-of-network:** • $110 copay (waived if admitted within 24 hours for the same condition)	**In- and Out-of-network:** • $120 copay (waived if admitted within 24 hours for the same condition)
Urgent Care	**In- and Out-of-network:** • $60 copay (waived if admitted within 24 hours for the same condition)	**In- and Out-of-network:** • $60 copay (waived if admitted within 24 hours for the same condition)	**In- and Out-of-network:** • $25 copay (waived if admitted within 24 hours for the same condition)	**In- and Out-of-network:** • $60 copay (waived if admitted within 24 hours for the same condition)
Diagnostic Tests, Lab, X-Rays, and Diagnostic / Therapeutic Radiology Services *	**Diagnostic Radiology Services *** *(such as MRIs, CT scans)*			
	In-network: • 0%-20% coinsurance **Out-of-network:** • 30% coinsurance	**In-network:** • 0%-20% coinsurance	**In-network:** • 0%-20% coinsurance **Out-of-network:** • 30% coinsurance	**In-network:** • 0%-20% coinsurance **Out-of-network:** • 30% coinsurance
	Other Diagnostic Tests and Procedures *			
	In-network: • $0-$20 copay **Out-of-network:** • 30% coinsurance	**In-network:** • $20-$50 copay	**In-network:** • $0-$15 copay **Out-of-network:** • 30% coinsurance	**In-network:** • $0-$20 copay **Out-of-network:** • 30% coinsurance
	Lab Services *			
	In-network: • $20 copay **Out-of-network:** • 15% coinsurance	**In-network:** • $20 copay	**In- and Out-of-network:** • $0 copay	**In-network:** • $20 copay **Out-of-network:** • 15% coinsurance
	Therapeutic Radiology Services * *(such as radiation treatment for cancer)*			
	In-network: • 20% coinsurance **Out-of-network:** • 30% coinsurance	**In-network:** • 20% coinsurance	**In-network:** • 20% coinsurance **Out-of-network:** • 30% coinsurance	**In-network:** • 20% coinsurance **Out-of-network:** • 30% coinsurance
	Outpatient X-Rays			
	In-network: • $20 copay **Out-of-network:** • 30% coinsurance	**In-network:** • $20 copay	**In-network:** • $15 copay **Out-of-network:** • 30% coinsurance	**In-network:** • $20 copay **Out-of-network:** • 30% coinsurance

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ATRIO HEALTH PLANS

Klamath County (*Partial*), OR

	ATRIO Choice Rx (PPO) H6743-001	ATRIO Select Rx (HMO) H3814-031	ATRIO Prime Rx (PPO) H6743-023-3	ATRIO Freedom (PPO) H6743-024-3
Hearing Services Exams to diagnose and treat hearing and balance issues, and an annual routine exam *Amplifon provider must be used for hearing aid benefits*	**Hearing Exams** (*Medicare-covered and supplemental hearing care*)			
	In-network: • $45 copay **Out-of-network**: • $50 copay **In- and Out-of-network:** • $0 copay for one routine exam per year	**In-network**: • $0 copay • $0 copay for one routine exam per year	**In-network**: • $15 copay **Out-of-network**: • $50 copay **In- and Out-of-network:** • $0 copay for one routine exam per year	**In-network**: • $45 copay **Out-of-network**: • $50 copay **In- and Out-of-network:** • $0 copay for one routine exam per year
	Hearing Aids			
	In-network: • $699 or $999 copay per aid, up to two per year	**In-network**: • $699 or $999 copay per aid, up to two per year	**In-network**: • $699 or $999 copay per aid, up to two per year	**In-network**: • $699 or $999 copay per aid, up to two per year
Dental Services Limited dental services (does not include services in connection with care, treatment, filling, removal, or replacement of teeth)	**Dental Care** (*Medicare-covered and supplemental dental care*)			
	In-network: • $45 copay **Out-of-network**: • $65 copay **In- and Out-of-network:** • Up to $1,000 allowance per year on Flex Card for preventive and comprehensive services at any dental provider	**In-network**: • $0 copay **In- and Out-of-network:** • Up to $850 allowance per year on Flex Card for preventive and comprehensive services at any dental provider	**In-network**: • $15 copay **Out-of-network**: • $15 copay **In- and Out-of-network:** • Up to $1,000 allowance per year on Flex Card for preventive and comprehensive services at any dental provider	**In-network**: • $45 copay **Out-of-network**: • $45 copay **In- and Out-of-network:** • Up to $750 allowance per year on Flex Card for preventive and comprehensive services at any dental provider
Vision Services Exams to diagnose and treat eye diseases and conditions of the eye (including yearly glaucoma screening), and an annual routine exam	**Vision Exams** (*Medicare-covered and supplemental vision care*)			
	In-network: • $45 copay **Out-of-network**: • $65 copay **In-network**: • $0 copay for annual exam **Out-of-network**: • 50% coinsurance for annual exam	**In-network**: • $0 copay • $0 copay for one routine exam per year	**In-network**: • $15 copay **Out-of-network**: • $15 copay **In-network**: • $0 copay for annual exam **Out-of-network**: • 50% coinsurance for annual exam	**In-network**: • $45 copay **Out-of-network**: • $45 copay **In-network**: • $0 copay for annual exam **Out-of-network**: • 50% coinsurance for annual exam

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Klamath County (*Partial*), OR

	ATRIO Choice Rx (PPO) H6743-001	ATRIO Select Rx (HMO) H3814-031	ATRIO Prime Rx (PPO) H6743-023-3	ATRIO Freedom (PPO) H6743-024-3
Vision Services (Continued) *Eyeglasses includes lenses and frames*	**Eyewear**			
	In- and Out-of-network: • Up to $150 allowance for eyeglasses *or* $100 for contact lenses, per year	**In- and Out-of-network:** • Up to $150 allowance for eyeglasses *or* $100 for contact lenses, per year	**In- and Out-of-network:** • Up to $200 allowance for eyeglasses *or* $100 for contact lenses, per year	**In- and Out-of-network:** • Up to $150 allowance for eyeglasses *or* $100 for contact lenses, per year
Mental Health Services * *No cost for individual virtual visit / telehealth sessions in-network with Teladoc*	**Inpatient Mental Health Care ***			
	In-network: • $500 copay per day for days 1–4; $0 days 5–90 **Out-of-network**: • $600 copay per day for days 1–5; $0 days 6–90	**In- and Out-of-Network**: • $350 copay per day for days 1–5; $0 days 6–90	**In-network**: • $225 copay per day for days 1–8; $0 days 9–90 **Out-of-network**: • $350 copay per day for days 1–8; $0 days 9-90	**In-network**: • $275 copay per day for days 1–7; $0 days 8–90 **Out-of-network**: • $375 copay per day for days 1–7; $0 days 8–90
	Outpatient Group and Individual Therapy Visits			
	In-network: • $40 copay **Out-of-network**: • 50% coinsurance	**In-network**: • $40 copay	**In-network**: • $25 copay **Out-of-network**: • 50% coinsurance	**In-network**: • $25 copay **Out-of-network**: • 50% coinsurance
Skilled Nursing Facility (SNF)*	**In-network**: • $10 copay per day for days 1–20; $203 per day 21-100 **Out-of-network**: • $203 copay per day 1–100	**In-network**: • $10 copay per day for days 1–20; $203 per day 21-100	**In-network**: • $20 copay per day for days 1–20; $203 per day 21-100 **Out-of-network**: • $203 copay per day 1–100	**In-network**: • $10 copay per day for days 1–20; $203 per day 21-100 **Out-of-network**: • $203 copay per day 1–100
Occupational, Physical, and Speech Therapy *	**In-network**: • $40 copay **Out-of-network**: • 50% coinsurance	**In-network**: • $35 copay	**In-network**: • $30 copay **Out-of-network**: • 50% coinsurance	**In-network**: • $25 copay **Out-of-network**: • 50% coinsurance

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Ambulance * *Authorization required for non-emergent transportation*	**In- and Out-of-network:** • $350 copay	**In-network:** • $300 copay	**In- and Out-of-network:** • $225 copay	**In- and Out-of-network:** • $275 copay
Transport * *Must use SafeRide for covered trips*	24 one-way trips per year to plan-approved, health-related locations	12 one-way trips per year to plan-approved, health-related locations	24 one-way trips per year to plan-approved, health-related locations	Not Covered
Medicare Part B Drugs*	**In-network**: • 0%-20% coinsurance **Out-of-network**: • 50% coinsurance	**In-network**: • 0%-20% coinsurance	**In-network**: • 0%-20% coinsurance **Out-of-network**: • 20% coinsurance	**In-network**: • 0%-20% coinsurance **Out-of-network**: • 50% coinsurance
Virtual Visits / Telehealth *Must use Teladoc for covered visits*	**In-network**: • $0 copay **Out-of-network**: • Not covered	**In-network**: • $0 copay	**In-network**: • $0 copay **Out-of-network**: • Not covered	**In-network**: • $0 copay **Out-of-network**: • Not covered
Durable Medical Equipment (DME) and Supplies, and Diabetic Supplies *	**Medical Equipment, Prosthetic Devices, and Medical Supplies**			
	In-network: • 20% coinsurance **Out-of-network**: • 30% coinsurance	**In-network**: • 20% coinsurance	**In-network**: • 20% coinsurance **Out-of-network**: • 25% coinsurance	**In-network**: • 20% coinsurance **Out-of-network**: • 30% coinsurance
	Diabetes Supplies			
	In-network: • $0 copay **Out-of-network**: • 20% coinsurance	**In-network**: • $0 copay	**In-network**: • $0 copay **Out-of-network**: • 20% coinsurance	**In-network**: • $0 copay **Out-of-network**: • 20% coinsurance
Fitness Covers gym membership fees / classes	$250 annual allowance on Flex Card	$300 annual allowance on Flex Card	$550 annual allowance on Flex Card	$250 annual allowance on Flex Card
Over the Counter (OTC) Items	$35 quarterly allowance on Flex Card for select OTC items	$30 quarterly allowance on Flex Card for select OTC items	$75 quarterly allowance on Flex Card for select OTC items	$35 quarterly allowance on Flex Card for select OTC items

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Meals After inpatient stay and some Home Health services	Up to 2 meals per day for 14 days (28 meals total) per stay	Up to 2 meals per day for 14 days (28 meals total per stay)	Up to 2 meals per day for 14 days (28 meals total per stay)	Up to 2 meals per day for 14 days (28 meals total per stay)
Chiropractic Services Manipulation of the spine to correct subluxation *Must use ASH for in-network benefits*	**In-network:** • $20 copay **Out-of-network:** • $65 copay	**In-network:** • $20 copay	**In-network:** • $20 copay **Out-of-network:** • $50 copay	**In-network:** • $20 copay **Out-of-network:** • $65 copay
Alternative Therapies (Chiropractic, Acupuncture, and Naturopathy Services) *Must use ASH for in-network benefits*	**In-network:** • $20 copay **Out-of-network:** • $65 copay Up to 30 combined visits for routine chiropractic and acupuncture, and naturopathy services, per year	**In-network:** • $20 copay Up to 30 combined visits for routine chiropractic and acupuncture, and naturopathy services, per year	**In-network:** • $20 copay **Out-of-network:** • $50 copay Up to 30 combined visits for routine chiropractic and acupuncture, and naturopathy services, per year	**In-network:** • $20 copay **Out-of-network:** • $65 copay Up to 30 combined visits for routine chiropractic and acupuncture, and naturopathy services, per year

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Medicare Part D Prescription Drug Benefits							
Drug Deductible	$250		$350		$0		*This plan does not cover prescription drugs*
Drug Tiers	**30-day supply**	**90-day supply**	**30-day supply**	**90-day supply**	**30-day supply**	**90-day supply**	
Tier 1 Preferred Generic	$7	$14	$5	$10	$0	$0	
Tier 2 Generic	$20	$40	$20	$40	$8	$16	
Tier 3* Preferred Brand	$45	$90	$47	$94	$47	$94	
Tier 4* Non-Preferred Drugs	$95	$190	$100	$200	$100	$200	
Tier 5* Specialty Drugs	28%	Not Available	27%	Not Available	33%	Not Available	
Tier 6 Select Care Drugs	$0	$0	$0	$0	$0	$0	
Coverage Gap Stage							
When the total paid by you and the plan reaches $5,030, you move to the Coverage Gap Stage. There is a 75% discount for most brand name and generic drugs in this stage.							
Catastrophic Coverage Stage							
After you have paid $8,000 out of pocket, you move to the Catastrophic Coverage Stage. You pay nothing through the end of the year.							

*The Part D deductible applies to drugs in this tier

- 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).
- 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 or have reached the coverage gap. Please call Customer Service 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 or have reached the coverage gap


Oh so easy

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 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) 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.
- 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.

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:

_____

_____

_____

2024 MEDICARE ADVANTAGE & MEDICARE ADVANTAGE PRESCRIPTION DRUG ENROLLMENT FORM

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: 7/31/2024

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1378. The time required to complete this information is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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.

2024 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)**: $20 / mo. (H6743-001-000)
- ☐ **ATRIO Prime Rx (PPO)**: $104 / mo. (H6743-023-003)
- ☐ **ATRIO Select Rx (HMO)**: $40.60 / mo. (H3814-031-000)

Medical ONLY Plan options:

- ☐ **ATRIO Freedom (PPO)**: $0 / mo. (H6743-024-003)

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.

2024 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)

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**: _____

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

Name: _____ **Address**: _____

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

Cell 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:
_____	_____	_____

2024 MEDICARE ADVANTAGE & MEDICARE ADVANTAGE PRESCRIPTION DRUG ENROLLMENT FORM (KLAMATH COUNTY)

ATRIO HEALTH PLANS

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

What's your race? Select all that apply:

- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Black or African 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 (Jan 1 – 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.

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:

_____

_____

_____

2024 MEDICARE ADVANTAGE & MEDICARE ADVANTAGE PRESCRIPTION DRUG ENROLLMENT FORM

ATRIO HEALTH PLANS

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Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.
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ATRIO HEALTH PLANS

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Medical ONLY Plan options:

- ☐ **ATRIO Freedom (PPO)**: $0 / mo. (H6743-024-003)

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. #**: _____

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Your Medicare information

Please take out your red, white, and blue Medicare card to complete this section.
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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.)

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- 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 and fill out these fields below:

Name: _____ **Address**: _____

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

Cell 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:
_____	_____	_____

2024 MEDICARE ADVANTAGE & MEDICARE ADVANTAGE PRESCRIPTION DRUG ENROLLMENT FORM (KLAMATH COUNTY)

ATRIO HEALTH PLANS

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

What's your race? Select all that apply:

- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Black or African 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 (Jan 1 – 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.

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 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 *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 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 Customer Service at 1-877-672-8620 (TTY 711) daily from 8 a.m. to 8 p.m. local time.

What to Expect 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	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
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 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 Customer Service 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:
2965 Ryan Drive SE 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 Customer Service 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)

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.

Multi-Language Insert

Multi-language Interpreter Services

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.

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。

Notes

Notes

Get to know **ATRIO.**

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

Learn more now.

www.atriohp.com

To Enroll, call
1-888-201-8818 (TTY 711)

ATRIO Customer Service
1-877-672-8620 (TTY 711)

Daily from 8 a.m. to 8 p.m. local time

Messages received on holidays and outside of our business hours will be returned within one business day.