



# 2025 Medicare Advantage

**STRAIGHT-UP  
LOCAL MEDICARE**

ATRIO Support Rx (PPO C-SNP)

Service area coverage for Marion and Polk Counties

*H7006-022*

January 1, 2025 - December 31, 2025





# STRAIGHT-UP LOCAL MEDICARE

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





# Local is Our Advantage

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

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

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

***Thank you for considering ATRIO Health Plans!***

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



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**STRAIGHT-UP  
LOCAL MEDICARE**



# Medicare Explained

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

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

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

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

## Medicare Advantage

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

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

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

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

# Drug Coverage

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

**Tier 1: Preferred Generic** – low-cost generic drugs

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

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

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

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

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

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

## What if my drug is not on the formulary?

If you can't find your drug, call Member Services or ask your pharmacist for a list of other drug options. You can also talk to your doctor about a different drug on the formulary, or you may submit a “Coverage Determination” request for a formulary exception. Visit [atriohp.com](http://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



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# Medicare prescription drug rules are changing

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

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## Prescription Coverage Changes for 2025

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

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

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

# Top 100 Most Commonly Prescribed Medications

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





## 2025 Medicare Advantage Enrollment Kit

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





# Top 100 Most Commonly Prescribed Medications

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

# 2025 Benefits at a Glance

## ATRIO Health Plans Medicare Advantage Plans



### ATRIO Support Rx (PPO C-SNP)

Marion and Polk Counties, OR

Enrollment into the ATRIO Support Rx (PPO C-SNP) plan requires one or more of the following medical conditions: Cardiovascular disorders, chronic heart failure, and/or diabetes. If none of these conditions are met, enrollment may be rejected.

### Medical Benefits

Plan Costs	ATRIO Support Rx (PPO C-SNP) H7006-022
Monthly plan premium	\$0
Plan deductible	\$0
Annual out-of-pocket maximum*	\$4,900 Combined (In and Out-of-network)

Doctor Office Visits	In-network	Out-of-network
Primary care provider (PCP)	\$0 copay	\$50 copay
Specialist	Cardiologist: \$0 copay All others: \$40 copay	50% of total cost
Telehealth (if provider offers Telehealth)	PCP: \$0 copay Specialist: Cardiologist: \$0 copay All others: \$40 copay	PCP: \$50 copay Specialist: 50% of total cost

Inpatient Care	In-network	Out-of-network
Inpatient hospital care	\$375 per day, 1-5 \$0 per day, 6+	\$3,000 for day 1 \$0 days 2+
Skilled nursing facility (SNF)	\$0 per day, 1-20 \$150 per day, 21+	\$200 per day, 1-100

Outpatient Care	In-network	Out-of-network
Outpatient hospital	\$375 copay	50% of total cost
Ambulatory surgery center	\$225 copay	50% of total cost
Home health care	\$0 copay	50% of total cost
Diabetic supplies	\$0 copay	50% of total cost
Durable medical equipment	0% – 20% of total cost	50% of total cost

ATRIO Support Rx (PPO C-SNP) H7006-022		
Labs and Tests	In-network	Out-of-network
Laboratory tests	\$0 copay	\$20 copay
Diagnostic imaging (MRI/CT/PET)	\$0 copay for diagnostic colonoscopy procedures 20% of total cost for all other procedures	50% of total cost
X-rays	\$0 copay	\$20 copay
Emergency Services		
Ambulance (air & ground)	\$250 copay	
Emergency room** (excludes Worldwide Coverage)	\$125 copay	
Urgently needed care	\$55 copay	

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

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

## Supplemental Benefits

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

ATRIO Support Rx (PPO C-SNP) H7006-022	
Annual physical exam	\$0 copay
Routine chiropractic, acupuncture, and naturopathic services	\$200 allowance every six months <sup>†</sup> , loaded to your Flex Card, for combined routine chiropractic, acupuncture and naturopathy services (\$400 annual allowance)
Fitness benefit	\$225 allowance every six months <sup>†</sup> , loaded to your Flex Card, for gym membership fees and fitness classes (\$450 annual allowance)
Preventive & comprehensive dental services	\$300 allowance every six months <sup>†</sup> , loaded to your Flex Card, for comprehensive and preventive dental services. Excludes cosmetic procedures (\$600 annual allowance)
Routine vision exam	\$0 copay, 1 exam per year (in-network only)
Routine vision hardware	\$200 allowance for frames (standard lenses included) or \$100 allowance for contact lenses per year
Routine hearing exam	\$0 copay, 1 exam per year (in-network only)
Hearing aids	\$699 to \$999 copay, for each hearing aid, up to 2 hearing aids per year (in-network only)
Meals	Up to 2 meals per day for 14 days after a qualifying event



<b>ATRIO Support Rx (PPO C-SNP)</b> <i>H7006-022</i>	
<b>Transportation</b>	\$0 for 24 one-way trips every year to plan-approved health-related locations
<b>Over-the-Counter (OTC) items</b>	\$40 allowance every three months <sup>†</sup> , loaded to your Flex Card, for select OTC items (\$160 annual allowance)
<b>Personal Emergency Response System (PERS)</b>	\$0 for wearable medical alert system and monitoring through LifeStation, including wristwatch option with heart monitor and step counter

*† Balance does not roll over*

## Prescription Drug Benefits

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

<b>ATRIO Support Rx (PPO C-SNP)</b> <i>H7006-022</i>		
<b>Part D Deductible</b>	\$0	
	<b>30-day supply</b>	<b>90-day supply</b>
<b>Tier 1</b> (Preferred generic)	\$0 copay	\$0 copay
<b>Tier 2</b> (Generic)	\$8 copay	\$16 copay
<b>Tier 3</b> (Preferred brand)	\$47 copay	\$94 copay
<b>Tier 4</b> (Non-preferred drug)	\$100 copay	\$200 copay
<b>Tier 5</b> (Specialty)	33% of total cost	Long-term not available
<b>Tier 6</b> (Select care drugs)	\$0 copay	\$0 copay
<b>Catastrophic coverage stage:</b> After you have paid \$2,000 out of pocket, you move to the Catastrophic Coverage Stage.	You pay nothing through the end of the year	

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

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

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

# Additional Benefits

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

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



## ATRIO FLEX CARD

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

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



### DENTAL

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



### FITNESS

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



### OVER THE COUNTER (OTC)

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



### ALTERNATIVE THERAPY SERVICES

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

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



## VISION

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

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



## HEARING

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

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



## TRANSPORTATION (NON-EMERGENCY)

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

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



## CASH BACK

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

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



# Additional Benefits



## MEALS

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

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



## WEARABLE DEVICES

**You pay \$0 for a wearable medical alert system and monitoring, including pendant and wristwatch options** that include a heart rate monitor and walking step counter. (select plans)

*Must use LifeStation® providers for in-network medical alert system benefit.*



## Contact & Access Information

Visit [atriohp.com](https://atriohp.com) for more information on additional benefits, or contact the appropriate service provider directly using the contact information below.

### Flex Card – Incomm

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

### Hearing – Amplifon

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

### Vision – VSP Vision Care

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

### OTC – Medline

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

### Transportation – SafeRide

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

### Wearable Alerts – LifeStation

To place an order or if you have questions call LifeStation Customer Service at 1-888-809-3112, Monday – Friday from 5 a.m. to 8 p.m. PST



# 2025 Medicare Advantage

## SUMMARY OF BENEFITS

**ATRIO Support Rx (PPO C-SNP)**

Service area coverage for Marion and Polk Counties in Oregon

*Plan IDs include: H7006-022*

January 1, 2025 - December 31, 2025



# 2025 Summary of Benefits

January 1, 2025 – December 31, 2025



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# 2025 Summary of Benefits

January 1, 2025 – December 31, 2025



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# 2025 Summary of Benefits

January 1, 2025 – December 31, 2025



## About the Summary of Benefits and Who Can Join

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This is a summary of ATRIO Health Plans health and drug services covered by ATRIO Support Rx (PPO C-SNP). The benefit information provided does not list every service that we cover or list every limitation or exclusion. For a complete list of services we cover, please view the Evidence of Coverage at [atriohp.com](http://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 Marion and Polk Counties in Oregon.

### 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. You can see our plan's Formulary (Part D prescription drug list), Provider Directory and Pharmacy Directory at our website, [atriohp.com](http://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](http://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

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Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Member Services representative at 1-877-672-8620 (TTY 711), daily from 8 a.m. to 8 p.m. local time.

### Understanding the Benefits

- The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit [atriohp.com](http://atriohp.com) or call 1-877-672-8620 (TTY 711) to view a copy of the EOC.
- Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- If you choose a plan that includes drug coverage, review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- If you choose a plan that includes drug coverage, review the formulary to make sure your drugs are covered.

### Understanding Important Rules

- In addition to your monthly plan premium (if applicable), you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- Benefits, premiums and/or copayments/co-insurance may change on January 1, 2026.
- Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services, the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care. In addition, you will pay a higher copay for services received by non-contracted providers.





## Plan Premiums, Deductible and Out-of-pocket Maximums

	ATRIO Support Rx (PPO C-SNP) H7006-022
<b>Plan Premium</b>	\$0 per month
	<i>You must also continue to pay your Medicare Part B premium</i>
<b>Plan Deductible</b>	\$0 per year
<b>Part B Premium giveback</b>	\$20
<b>Out-of-Pocket Maximums</b>	<p><b>In-network:</b> \$4,900 for services you receive from in-network providers.</p> <p><b>Combined:</b> \$4,900 for services you receive from any provider. Your limit for services received from in-network providers will count toward this limit.</p> <p><i>if you have full Medicaid eligibility, your copays will be paid by Medicaid</i></p>



## Covered Medical and Hospital Benefits

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

	ATRIO Support Rx (PPO C-SNP) H7006-022	
<b>Inpatient Hospital Care (Acute)*</b>	<b>In-network:</b> \$375 per day, 1-5 \$0 per day, 6+	<b>Out-of-network:</b> \$3,000 per stay
<b>Outpatient Hospital Services*</b>	<b>In-network:</b> \$375 copay	<b>Out-of-network:</b> 50% of total cost
<b>Ambulatory Surgery Center Services*</b>	<b>In-network:</b> \$225 copay	<b>Out-of-network:</b> 50% of total cost
<b>Doctor's Office Visits</b>	<b>Primary Care Physician (PCP)</b>	
	<b>In-network:</b> \$0 copay	<b>Out-of-network:</b> \$50 copay
	<b>Specialists</b>	
	<b>In-network:</b> \$0 - \$40 copay	<b>Out-of-network:</b> 50% of total cost
<b>Preventive Care</b>	<b>In &amp; out-of-network:</b> \$0 copay  <i>You pay nothing for Medicare covered preventive services                      Our plan also covers a supplemental Annual Physical Exam at no cost</i>	
<b>Emergency Care</b>	<b>In &amp; out-of-network:</b> \$125 copay	
<b>Urgent Care</b> See "Emergency Care" for worldwide copay	\$55 copay  <i>Urgently needed care services cost sharing is waived if you are admitted to the hospital within 24 hours for the same condition.</i>	



## Covered Medical and Hospital Benefits

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

	ATRIO Support Rx (PPO C-SNP) H7006-022	
<b>Diagnostic Tests, Lab, X-rays, and Radiology Services*</b>	<b>Diagnostic Radiology Services * (such as MRIs, CT and PET scans)</b>	
	<b>In-network:</b> \$0 copay for diagnostic colonoscopy procedures  20% of total cost for all other procedures	<b>Out-of-network:</b> 50% of total cost
	<b>Other Diagnostic Tests and Procedures</b>	
	<b>In-network:</b> \$0 - \$20 copay	<b>Out-of-network:</b> 30% of total cost
	<b>Lab Services</b>	
	<b>In-network:</b> \$0 copay	<b>Out-of-network:</b> \$20 copay
	<b>Therapeutic Radiology Services * (such as radiation treatment for cancer)</b>	
	<b>In-network:</b> 20% of the total cost	<b>Out-of-network:</b> 50% of total cost
	<b>Outpatient X-Rays</b>	
	<b>In-network:</b> \$0 copay	<b>Out-of-network:</b> \$20 copay
<b>Medicare covered:</b> Exams to diagnose and treat hearing and balance issues.  <b>Supplemental Routine services</b> (services not covered by Medicare) must be administered by an Amplifon provider	<b>Hearing Exam (Medicare-covered services)</b>	
	<b>In-network:</b> \$45 copay	<b>Out-of-network:</b> \$65 copay
	<b>Hearing Exam (Supplemental routine services)</b>	
	<b>In-network:</b> \$0 copay	<b>Out-of-network:</b> 50% of total cost
	<b>Hearing Aid fitting &amp; evaluation (Supplemental routine services)</b>	
	<b>In-network:</b> \$0 copay	<b>Out-of-network:</b> 50% of total cost
<b>Hearing Aids (Supplemental routine services)</b>		
<b>In-network:</b> \$699 to \$999 copay, for each hearing aid, up to 2 hearing aids per year (in-network only)	<b>Out-of-network:</b> Requires prior authorization	



## Covered Medical and Hospital Benefits

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

ATRIO Support Rx (PPO C-SNP) H7006-022			
<p><b>Dental Services *</b></p> <p><b>Medicare covered:</b> Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth)</p> <p><b>Supplemental routine services</b> are services not covered by Medicare</p> <p>†Benefit does not roll over</p>	<p><b>Dental Services (Medicare-covered services)</b></p>		
	<table border="0" style="width: 100%;"> <tr> <td style="width: 50%;"><b>In-network:</b> \$0 copay</td> <td style="width: 50%;"><b>Out-of-network:</b> 50% of total cost</td> </tr> </table>	<b>In-network:</b> \$0 copay	<b>Out-of-network:</b> 50% of total cost
	<b>In-network:</b> \$0 copay	<b>Out-of-network:</b> 50% of total cost	
	<p><b>Dental Services (Supplemental routine services)</b></p>		
<p><b>In &amp; out-of-network:</b> \$300 allowance every 6 months<sup>†</sup>, loaded to your Flex Card, for comprehensive and preventative dental services. Excludes cosmetic procedures (\$600 annual allowance)</p>			
<p><b>Vision Services</b></p> <p><b>Medicare covered:</b> Exams to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening).</p> <p><b>Supplemental routine services</b> (services not covered by Medicare) administered by <b>VSP</b></p>	<p><b>Vision Exams (Medicare-covered services)</b></p>		
	<table border="0" style="width: 100%;"> <tr> <td style="width: 50%;"><b>In-network:</b> \$45 copay</td> <td style="width: 50%;"><b>Out-of-network:</b> \$65 copay</td> </tr> </table> <p><i>Glaucoma screening</i></p> <p><b>In &amp; out-of-network:</b> \$0 copay</p>	<b>In-network:</b> \$45 copay	<b>Out-of-network:</b> \$65 copay
	<b>In-network:</b> \$45 copay	<b>Out-of-network:</b> \$65 copay	
	<p><b>Vision Exams (Supplemental routine services)</b></p>		
	<table border="0" style="width: 100%;"> <tr> <td style="width: 50%;"><b>In-network:</b> \$0 copay</td> <td style="width: 50%;"><b>Out-of-network:</b> 50% of total cost</td> </tr> </table>	<b>In-network:</b> \$0 copay	<b>Out-of-network:</b> 50% of total cost
	<b>In-network:</b> \$0 copay	<b>Out-of-network:</b> 50% of total cost	
<p><b>Vision Eyewear (Supplemental routine services)</b></p>			
<table border="0" style="width: 100%;"> <tr> <td style="width: 50%;"><b>In-network:</b> \$200 allowance for frames (standard lenses included) or \$100 allowance for contact lenses per year</td> <td style="width: 50%;"><b>Out-of-network:</b> \$200 allowance for frames or \$100 allowance for contact lenses per year. 50% total cost for lenses</td> </tr> </table>	<b>In-network:</b> \$200 allowance for frames (standard lenses included) or \$100 allowance for contact lenses per year	<b>Out-of-network:</b> \$200 allowance for frames or \$100 allowance for contact lenses per year. 50% total cost for lenses	
<b>In-network:</b> \$200 allowance for frames (standard lenses included) or \$100 allowance for contact lenses per year	<b>Out-of-network:</b> \$200 allowance for frames or \$100 allowance for contact lenses per year. 50% total cost for lenses		
<p><b>Mental Health Services*</b></p>	<p><b>Inpatient Mental Health Care *</b></p>		
	<table border="0" style="width: 100%;"> <tr> <td style="width: 50%;"><b>In-network:</b> \$350 per day, 1-5 \$0 per day, 6-90</td> <td style="width: 50%;"><b>Out-of-network:</b> \$3,000 per stay</td> </tr> </table>	<b>In-network:</b> \$350 per day, 1-5 \$0 per day, 6-90	<b>Out-of-network:</b> \$3,000 per stay
	<b>In-network:</b> \$350 per day, 1-5 \$0 per day, 6-90	<b>Out-of-network:</b> \$3,000 per stay	
<p><b>Outpatient Group and Individual Therapy Visits</b></p>			
<table border="0" style="width: 100%;"> <tr> <td style="width: 50%;"><b>In-network:</b> \$40 copay</td> <td style="width: 50%;"><b>Out-of-network:</b> 50% of total cost</td> </tr> </table>	<b>In-network:</b> \$40 copay	<b>Out-of-network:</b> 50% of total cost	
<b>In-network:</b> \$40 copay	<b>Out-of-network:</b> 50% of total cost		





## Covered Medical and Hospital Benefits

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

	ATRIO Support Rx (PPO C-SNP) H7006-022	
<b>Skilled Nursing Facility (SNF)*</b>	<b>In-network:</b> \$0 per day, 1-20 \$150 per day, 21+	<b>Out-of-network:</b> \$200 per day, 1-100
<b>Physical Therapy*</b>	<b>Physical &amp; Speech Therapy</b>	
	<b>In-network:</b> \$20 copay	<b>Out-of-network:</b> 50% of total cost
	<b>Occupational Therapy</b>	
	<b>In-network:</b> \$20 copay	<b>Out-of-network:</b> 50% of total cost
<b>Ambulance*</b> (Air and Ground) <i>Authorization required for nonemergent transportation</i>	<b>In &amp; out-of-network:</b> \$250 copay	
<b>Transportation</b> <i>Must use SafeRide for covered trips</i>	\$0 copay for 24 one-way trips every year to plan-approved health-related locations	
<b>Medicare Part B Drugs*</b>	<b>In-network:</b> 0% - 20% of the total cost	<b>Out-of-network:</b> 50% of total cost
<b>Telehealth</b> <i>If provider offers Telehealth visits</i>	<b>In-network:</b> PCP: \$0 copay  <b>Specialist:</b> Cardiologist: \$0 copay All other specialties: \$40 copay	<b>Out-of-network:</b> PCP: \$50 copay  <b>Specialists</b> (including Cardiologists) 50% total cost
<b>Foot Care</b>  <i>Medicare covered:</i> Foot exams and treatment if you have diabetes related nerve damage and/or meet certain conditions	<b>In-network:</b> \$40 copay	<b>Out-of-network:</b> 50% of total cost



## Covered Medical and Hospital Benefits

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

ATRIO Support Rx (PPO C-SNP) H7006-022	
<p><b>Durable Medical Equipment (DME) and Supplies, and Diabetic Supplies *</b>                      DME supplies are not eligible for Flex Card OTC spend</p>	<b>Medical Equipment, Prosthetic Devices, and Medical Supplies</b>
	<p><b>In-network:</b> 0% - 20% of total cost</p> <p><b>Out-of-network:</b> 50% of total cost</p>
	<b>Diabetic Supplies</b>
	<p><b>In-network:</b> \$0 copay</p> <p><b>Out-of-network:</b> 50% of total cost</p>
<p><b>Fitness</b>                      Covers gym membership fees and fitness classes  <i>†Benefit does not roll over</i></p>	<p>\$200 allowance every six months<sup>†</sup>, loaded to your Flex Card, for gym membership fees and fitness classes (\$400 annual allowance)</p>
<p><b>Alternative Therapies Chiropractic</b></p> <p><i>Medicare covered:</i>                      Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position)</p> <p><i>Supplemental Routine services</i>                      non-Medicarecovered services</p> <p><i>†Benefit does not roll over</i></p>	<b>Chiropractic Services (Medicare-covered services)</b>
	<p><b>In-network:</b> \$20 copay</p> <p><b>Out-of-network:</b> \$20 copay</p>
	<b>Chiropractic, Acupuncture &amp; Naturopathy Services (Supplemental routine services)</b>
	<p><b>In &amp; out-of-network:</b>                      \$225 allowance every six months<sup>†</sup>, loaded to your Flex Card, for combined routine chiropractic, acupuncture and naturopathy services (\$450 annual allowance)</p>
<p><b>Over-the-Counter (OTC) Items</b>                      Select OTC products</p> <p>Easily find eligible OTC products using our Flex Card app on your smartphone</p> <p>DME items are not eligible OTC products</p> <p><i>†Benefit does not roll over</i></p>	<p>\$40 allowance every three months<sup>†</sup>, loaded to your Flex Card, for select OTC items (\$160 total annual allowance)</p> <p><i>Find eligible OTC products using our Flex Card app on your smartphone                      DME items are not eligible OTC products</i></p>
<p><b>Meals*</b>                      Inpatient or SNF (direct admission/post hospital admits) (unlimited)</p> <p>Home health recipients with approved home health certification. (unlimited)</p>	<p>\$0 copay for up to 2 meals per day for 14 days (28 meals per episode)</p>



## Covered Medical and Hospital Benefits

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

ATRIO Support Rx (PPO C-SNP) H7006-022	
<b>Personal Emergency Response System (PERS)</b> Must use <i>LifeStation</i> For PERS benefit	\$0 for wearable medical alert system and monitoring through LifeStation, including wristwatch option with heart monitor and step counter

## Medicare Part D Prescription Drug Benefits

### Deductible Stage

ATRIO Support Rx (PPO C-SNP) H7006-022
\$0 per year

### Initial Coverage Stage

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

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

ATRIO Support Rx (PPO C-SNP) H7006-022		
Standard Retail Cost Sharing		
Tier	30-day supply	90-day supply
Tier 1 (Preferred generic)	\$0 copay	\$0 copay
Tier 2 (Generic)	\$8 copay	\$16 copay
Tier 3 (Preferred brand)	\$47 copay	\$94 copay
Tier 4 (Non-preferred)	\$100 copay	\$200 copay
Tier 5 (Specialty)	33% of the total cost	Not available
Tier 6 (Select care)	\$0	\$0



**ATRIO Support Rx (PPO C-SNP)**  
H7006-022

**Catastrophic Coverage Stage**

After you have paid \$2,000, you move to the Catastrophic Coverage Stage. You pay nothing through the end of the year. This amount and rules for counting costs toward this amount have been set by Medicare.

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

ATRIO Health Plans is a PPO, HMO, PPO C-SNP and HMO D-SNP with Medicare and Oregon Health Plan contracts. Enrollment in ATRIO Health Plans depends on contract renewal. Out-of-network/non-contracted providers are under no obligation to treat ATRIO Health Plans members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. Please call our Member Services number at 1-877-672-8620 (TTY 711), daily from 8 a.m. to 8 p.m. local time or see your Evidence of Coverage for more information, including the cost sharing that applies to out-of-network services.



**STRAIGHT-UP  
LOCAL MEDICARE**





# How to Enroll

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

1

## Online

Go online and complete an online enrollment form!  
[atriohp.com](http://atriohp.com)

2

## By Phone

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

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](http://atriohp.com) or call [1-888-201-8818 \(TTY 711\)](tel:1-888-201-8818)

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 \(TTY 711\)](tel:1-888-201-8818)

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](tel:1-602-975-4071)




# Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Member Services Representative at 1-877-672-8620 (TTY 711), daily from 8 a.m. to 8 p.m. local time.

## Understanding the Benefits

-  The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit [atriohp.com](https://atriohp.com) or call 1-877-672-8620 (TTY 711) daily from 8 a.m. to 8 p.m. local time to view a copy of the EOC.
-  Review the Provider Directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
-  If you choose a plan that includes drug coverage, review the Pharmacy Directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
-  Review the formulary to make sure your drugs are covered.

## Understanding Important Rules

-  In addition to your monthly plan premium (if applicable), you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
-  Benefits, premiums and/or co-payments/coinsurance may change on January 1 of each year.
-  ATRIO PPO plans allow you to see providers outside of our network (non-contracted providers), while our HMO plans you will only have coverage for in-network providers. However, while we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care. In addition, you may pay a higher copay for services received by non-contracted providers.

## Scope of Sales Appointment Confirmation

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

<b>Please initial below beside the type of product(s) you want the agent to discuss</b>	
<input style="width: 50px; height: 20px;" type="text"/>	Medicare Advantage Plans (further indicate below with initials)
<input style="width: 50px; height: 20px;" type="text"/>	Stand-alone Medicare Prescription Drug Plans
<input style="width: 50px; height: 20px;" type="text"/>	Dental/Vision/Hearing Products
<input style="width: 50px; height: 20px;" type="text"/>	Critical Illness and Accident Products
<input style="width: 50px; height: 20px;" type="text"/>	Medicare Supplement (Medigap) Products
<input type="checkbox"/>	<p><b>Medicare Preferred Provider Organization (PPO) Plan:</b> 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.</p>
<input type="checkbox"/>	<p><b>Medicare Health Maintenance Organization (HMO):</b> 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).</p>
<input type="checkbox"/>	<p><b>Medicare Special Needs Plan (SNP):</b> 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.</p>
<input type="checkbox"/>	<p><b>Medicare Prescription Drug Plan (PDP):</b> 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.</p>
<input type="checkbox"/>	<p><b>Medicare Private Fee-For-Service (PFFS) Plan:</b> 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.</p>
<input type="checkbox"/>	<p><b>Medicare Medical Savings Account (MSA) Plan:</b> 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.</p>
<input type="checkbox"/>	<p><b>Medicare Cost Plan:</b> 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.</p>



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

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

**Beneficiary or Authorized Representative Signature and Signature Date:**

**SIGNED:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

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

*Representative's Name:* \_\_\_\_\_

*Your Relationship to the Beneficiary:* \_\_\_\_\_

**TO BE COMPLETED BY AGENT**

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

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

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

\_\_\_\_\_  
\_\_\_\_\_

# 2025

## MEDICARE ADVANTAGE & MEDICARE ADVANTAGE PRESCRIPTION DRUG ENROLLMENT FORM (MARION AND POLK COUNTIES)



### 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.**

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.**

### Reminders:

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

### What happens next?

Send your completed and signed form to:

Mail: ATRIO Health Plans Fax: (602) 975-4071  
338 Jericho Turnpike #135  
Syosset, NY 11791

Once they process your request to join, they'll contact you.

### How do I get help with this form?

Call ATRIO Health Plans at 1-877-672-8620 (TTY 711)

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

En español: Llame a ATRIO Health Plans al 1-877-672-8620 (TTY 711) o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

### What do I need to complete this form?

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

OMB No. 0938-1378

Expires: 6/30/2026

# 2025

## MEDICARE ADVANTAGE & MEDICARE ADVANTAGE PRESCRIPTION DRUG ENROLLMENT FORM (MARION AND POLK COUNTIES)



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

#### SELECT THE PLAN YOU WANT TO JOIN:

#### Medical & Prescription Drug Plan options:

**ATRIO Choice Rx (PPO):** \$0 / mo.  
(H7006-007)

**ATRIO Prime Rx (PPO):** \$96 / mo.  
(H7006-003)

**ATRIO Support Rx (PPO C-SNP):** \$0 / mo.  
(H7006-022)

**ATRIO Prime Rx (HMO):** \$0 / mo.  
(H5995-004)

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.**

### 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](http://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](http://atriohp.com) to sign up on our premium portal
- Credit Card – for credit card payment, visit [atriohp.com](http://atriohp.com) to sign up on our premium portal
- Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check. I get my benefits from:  Social Security     Railroad Retirement Board

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

#### **IMPORTANT: Read and Sign Below**

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

# 2025

## MEDICARE ADVANTAGE & MEDICARE ADVANTAGE PRESCRIPTION DRUG ENROLLMENT FORM (MARION AND POLK COUNTIES)



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

**Signature:** \_\_\_\_\_ **Today’s Date:** \_\_\_\_\_

For individuals helping enrollee with completing this form only

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

Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Relationship to Enrollee:  Agent  Broker  SHIP counselor  Authorized representative

National Producer Number (Agents/ Brokers only): \_\_\_\_\_

Are you enrolled in your State Medicaid program?  Yes  No

If yes, please provide your Medicaid number: \_\_\_\_\_

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

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

Name of other coverage: \_\_\_\_\_ Member number for this coverage: \_\_\_\_\_ Group number for this coverage: \_\_\_\_\_

\_\_\_\_\_





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

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

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

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

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

Do you or your spouse work?  Yes  No

What is your gender? Select one.

- Woman
- Man
- Non-binary
- I use a different term: \_\_\_\_\_
- I choose not to answer

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

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

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

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

What's your race? Select all the apply.

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

# 2025

## MEDICARE ADVANTAGE & MEDICARE ADVANTAGE PRESCRIPTION DRUG ENROLLMENT FORM (MARION AND POLK COUNTIES)



### SECTION 3: For licensed sales representative / agency use only

**Staff member/ Agent/ Broker must complete:**

Name (if assisted in enrollment):

Initial receipt date:

Writing ID #:

Proposed effective date of coverage:

- |   |  |
|---|--|
| <input type="checkbox"/> AEP (Oct 15 – Dec 7)                                   | <input type="checkbox"/> SEP (Chronic)                   |
| <input type="checkbox"/> ICEP (MA enrollees)                                    | <input type="checkbox"/> SEP (Dual LIS change of status) |
| <input type="checkbox"/> IEP (MA-PD enrollees)                                  | <input type="checkbox"/> SEP (Dual LIS maintaining)      |
| <input type="checkbox"/> IEP (MA-PD enrollees eligible for 2 <sup>nd</sup> IEP) | <input type="checkbox"/> SEP (Loss of EGHP coverage)     |
| <input type="checkbox"/> OEP (Jan 1 – March 31)                                 | <input type="checkbox"/> SEP (Change in residence)       |
| <input type="checkbox"/> OEP (newly eligible)                                   | <input type="checkbox"/> SEP (SEP reason): _____         |
| <input type="checkbox"/> OEPI   |  |

\_\_\_\_\_  
Licensed Sales Representative Signature (*optional*)

\_\_\_\_\_  
Date

**Mail or fax this completed form to:**

**ATRIO Health Plans  
338 Jericho Turnpike #135  
Syosset, NY 11791  
Fax: (602) 975-4071**

#### PRIVACY ACT STATEMENT

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

**ATRIO Health Plans**  
**ATRIO Support Rx (PPO C-SNP)**  
**Pre-enrollment Qualification Assessment Tool**



ATRIO Health Plans Medicare Advantage (PPO C-SNP) is designed for people with chronic conditions such as diabetes, chronic heart failure and certain cardiovascular disorders.

**Enrollee Information (print in boxes below)**

Last Name:

First Name:

MI:

Medicare ID Number (HICN):

Phone Number:




Birthdate:

--	--	--

MM

DD

YYYY

Please complete and submit this form with your enrollment application. If you can answer “Yes” or “Not sure” to any of the following questions, you may be eligible to join our Chronic Special Needs Plan. When this form is completed and submitted along with an enrollment application, you will be enrolled into ATRIO Health Plans. We will attempt to verify your chronic condition(s) with your provider during the first month of enrollment. If we are unable to verify your chronic condition(s), we are required to disenroll you from the Chronic Special Needs Plan. If you do not qualify for this plan, ATRIO Health Plans has other plan options in this county.

**Chronic Condition Questions (mark an “x” in the box that applies)**

Have you been diagnosed with diabetes?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Not Sure <input type="checkbox"/>
Have you had prior blood test that indicate problems with high blood sugar?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Not Sure <input type="checkbox"/>
Do you take medication and/or have you been put on a special diet to control your blood sugar?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Not Sure <input type="checkbox"/>
Have you been diagnosed with chronic (or congestive) heart failure (CHF)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Not Sure <input type="checkbox"/>
Have you had problems with fluid retention in your lungs or swelling in your legs due to a heart problem?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Not Sure <input type="checkbox"/>
Do you take medication to prevent fluid retention?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Not Sure <input type="checkbox"/>
Have you been diagnosed with any of the following cardiovascular disorders? Cardiac arrhythmia, Chronic venous thromboembolic disorder, Coronary artery disease, or Peripheral vascular disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Not Sure <input type="checkbox"/>
Have you had problems with rapid, erratic heartbeats?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Not Sure <input type="checkbox"/>
Have you had problems with chest pain or tightness, shortness of breath, heart attack, or stroke?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Not Sure <input type="checkbox"/>
Has a physician ever told you that you have a blood clot?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Not Sure <input type="checkbox"/>

# Health care provider(s) who can verify your chronic condition(s)

## Provider #1

Provider Name:

Provider Address:

Provider Phone:

Provider Fax:

## Provider #2

Provider Name:

Provider Address:

Provider Phone:

Provider Fax:

### Authorization for Disclosure of Health Information to Verify Chronic Condition(s):

I hereby authorize the disclosure of my health information by the providers listed above to ATRIO Health Plans in order to verify that I have been diagnosed with a chronic condition which qualifies me for enrollment in ATRIO Health Plans Chronic Special Needs Plan. This authorization applies to all health information maintained by the provider concerning my medical history for the chronic condition(s) indicated on the first page.

Note: Information disclosed as a result of this authorization will be protected by ATRIO Health Plans in accordance with applicable state and federal laws and requirements.

## Signature

Enrollee Signature:

Date

MM

DD

YYYY

Print Broker/ Agent Name (if applicable):

Broker/ Agent Signature (if applicable):

MM

DD

YYYY

For more information or for help filling out this form, please call Member Services at 1-877-672-8620 (TTY 711) daily, from 8 am – 8 pm.

ATRIO Health Plans is a PPO, HMO, PPO C-SNP and HMO D-SNP with Medicare and Oregon Health Plan contracts. Enrollment in ATRIO Health Plans depends on contract renewal. ATRIO Health Plans has been approved by the National Committee for Quality Assurance (NCQA) to operate as a Chronic Special Needs Plan (C-SNP) through **12/31/2025** based on a review of ATRIO Health Plans SNP Model of Care.



## Attestation of Eligibility for an Enrollment Period

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

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

- I am new to Medicare.
- I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).
- I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on (insert date) \_\_\_\_\_.
- I recently was released from incarceration. I was released on (insert date) \_\_\_\_\_.
- I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) \_\_\_\_\_.
- I recently obtained lawful presence status in the United States. I got this status on (insert date) \_\_\_\_\_.
- I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date) \_\_\_\_\_.
- I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date) \_\_\_\_\_.
- I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.
- I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long term care facility). I moved/will move into/out of the facility on (insert date)\_\_\_\_\_.
- I recently left a PACE program on (insert date) \_\_\_\_\_.
- I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date)\_\_\_\_\_.
- I am leaving employer or union coverage on (insert date) \_\_\_\_\_.
- I belong to a pharmacy assistance program provided by my state.
- My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.



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

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

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

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



# Plan Recap

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

## Plan Information

**My new plan is a:**

- Medicare Advantage plan *(No prescription drug coverage)*
- Medicare Advantage Prescription Drug Plan
- Medicare Advantage Special Needs Plan

**The name of my new plan is:** \_\_\_\_\_

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

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

**My plan will provide:**

- All Medicare health coverage
- All Medicare prescription drug coverage

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

## Premium Information

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

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

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

## Network Provider Information

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

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

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

## Prescription Drug Coverage

My plan has a prescription drug deductible.  Yes  No

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

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

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

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

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

## Contact your Licensed Sales Representative

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

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

# What to Expect After You Enroll

Steps	How you get it	Description
<b>1</b> 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
<b>2</b> 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
<b>3</b> Member ID Card	 Mailed	You will receive your member ID card within 10 days of your Medicare-approved enrollment
<b>4</b> 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
<b>5</b> 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
<b>6</b> Register Online	 Online	Optional: Once your coverage begins, register online for our member portal at <a href="https://atriohp.com">atriohp.com</a> so you can access benefit information and pay your premium

# Notice about Nondiscrimination and Accessibility Requirements

## Discrimination is Against the Law

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

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

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

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

ATRIO Compliance Officer:

550 Hawthorne Avenue, Suite 140, Salem, OR 97301

1-877-672-8620 (TTY 711)

File a complaint with ATRIO Compliance Hotline:

1-877-309-9952 or [compliance@atriohp.com](mailto:compliance@atriohp.com)

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

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

U.S. Department of Health and Human Services, 200 Independence Avenue, SW

Room 509F, HHH Building

Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>



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

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

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

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

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

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

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

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

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

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

**ខ្មែរ (Cambodian)** - ប្រើសិទ្ធិជាមួយកម្មវិធីសម្រាប់ភាសាខ្មែរ, សេវាជំនួយភាសាសម្រាប់មនុស្សចាស់ និងមនុស្សមានការរីករាយ។ ចុះទូរស័ព្ទ 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 quý vị cần thông dịch viên xin gọi 1-877-672-8620 sẽ có nhân viên nói tiếng Việt giúp đỡ quý 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 대해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-877-672-8620 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

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

**Arabic:** لننقل قدم خدمات المترجم فوري للمجاني في كل لغة عن أي أسئلة تتعلق قبل الصراحة أو جدول ألديني ثلينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-877-672-8620 سيقيّم شخص خاص مياحدث ال عربي قبم س اعنتك . 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。通訳をご用命になるには、1-877-672-8620 にお電話ください。日本語を話す人 者が支援いたします。これは無料のサービスです。





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**Member Services**

**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.*

