ATRIO™
HEALTH PLANS

2026 Medicare Advantage

ATRIO Choice Rx (PPO)

ATRIO Prime Rx (PPO)

ATRIO Freedom (PPO)

Service area coverage for Klamath County*

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

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

January 1, 2026 - December 31, 2026

For over 21 years we've been Oregon's local, dependable Medicare Advantage plan.

ATRIO™
HEALTH PLANS

All the Right Reasons

You've got a lot of reasons for choosing a particular Medicare Advantage plan like savings, coverage and easy access to the care you need. Any one of these reasons is a good one, but what you really want is a plan that goes the extra mile to cover all the things that are important to you. That's ATRIO Health Plans.

ATRIO has been serving Oregon residents for over 21 years. We are community-based, and work closely with local providers to improve health outcomes for over 39,000 members in the places we serve. **Our goal: Make your plan easy to understand and use, so you're always getting the most from your ATRIO Health Plans Medicare Advantage coverage.**

This 2026 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. Whether it's protecting your health, saving money or making your life a little easier, ATRIO Health Plans checks all the boxes for Oregonians.

ATRIO is the right Medicare Advantage plan for all the right reasons

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.

H6743_MKG_KLEK_2026_M

Medicare Explained

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

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

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

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

Medicare Advantage

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

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

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

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

Drug Coverage

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

Tier 1: Preferred Generic – low-cost generic drugs

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

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

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

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

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

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

What if my drug is not on the formulary?

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

What are the types of formulary drug restrictions?

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

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

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

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

Top 100 Most Commonly Prescribed Medications

Brand Name	Strength Desc	Dosage Form	2026 Tier
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
Amitriptyline Hcl	100 Mg	Tablet	1
Amlodipine Besylate	5 Mg	Tablet	1
Amoxicillin	500 Mg	Capsule	1
Amoxicillin-Clavulanate Potass	875-125 Mg	Tablet	1
Aripiprazole	10 Mg	Tablet	2
Atenolol	25 Mg	Tablet	1
Atorvastatin Calcium	40 Mg	Tablet	6
Azithromycin	250 Mg	Tablet	1
Baclofen	10 Mg	Tablet	2
Budesonide-Formoterol Fumarate	160-4.5 Mcg	hfa Aer Inhaler	2
Bupropion Xl	150 Mg	Tablet	1
Buspirone Hcl	10 Mg	Tablet	1
Carvedilol	6.25 Mg	Tablet	1
Celecoxib	200 Mg	Tablet	1
Cephalexin	500 Mg	Capsule	1
Ciprofloxacin Hcl	500 Mg	Tablet	1
Citalopram Hbr	20 Mg	Tablet	1
Clobetasol Propionate	0.05%	Cream	2
Clonazepam	0.5 Mg	Tablet	1
Clopidogrel	75 Mg	Tablet	1
Cyclobenzaprine Hcl	10 Mg	Tablet	1
Donepezil Hcl	10 Mg	Tablet	1
Doxycycline Hyclate	100 Mg	Capsule	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
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
Glipizide Er	10 Mg	Tablet	6
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	05-3Mg/3	Ampul-Neb	1
Isosorbide Mononitrate Er	30 Mg	Tablet	1
Jardiance	10 Mg	Tablet	3
Ketoconazole	200 Mg	Tablet	1
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
Losartan-Hydrochlorothiazide	100-25 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
Metoprolol Succinate	25 Mg	Tab Er 24H	1
Metoprolol Tartrate	25 Mg	Tablet	1
Mirtazapine	15 Mg	Tablet	1
Montelukast Sodium	10 Mg	Tablet	1
Mounjaro	10 Mg/ 0.5Ml	Pen Injctr	3
Nitrofurantoin Mono-Macro	100 Mg	Capsule	1
Nystatin	100,000 Units/Gr	Ointment	1
Olanzapine	20 Mg	Tablet	2
Olmesartan Medoxomil	20 Mg	Tablet	6
Omeprazole	20 Mg	Capsule Dr	1
Ondansetron Odt	4 Mg	Tab Rapdis	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 Er	1
Pioglitazone Hcl	15 Mg	Tablet	6
Potassium Chloride	10 Meq	Tablet Er	1
Pravastatin Sodium	40 Mg	Tablet Dr	6
Prednisolone Acetate	1%	Drops Susp	4
Prednisone	20 Mg	Tablet	1
Pregabalin	150 Mg	Capsule	2
Progesterone	100 Mg	Capsule	2
Propranolol Hcl	10 Mg	Tablet	1
Quetiapine Fumarate	25 Mg	Tablet	1

Top 100 Most Commonly Prescribed Medications

Rosuvastatin Calcium	10 Mg	Tablet	6
Semglee (Yfgn) Pen	100/Ml(3)	Insulin Pen	3
Sertraline Hcl	100 Mg	Tablet	1
Simvastatin	20 Mg	Tablet	6
Spironolactone	25 Mg	Tablet	1
Sulfamethoxazole-Trimethoprim	800-160 Mg	Tablet	1
Tamsulosin Hcl	0.4 Mg	Capsule	1
Tizanidine Hcl	4 Mg	Tablet	1
Topiramate	100 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	0.10%	Cream (G)	1
Trulicity	0.75 Mg/0.5 Ml	Pen Injctr	3
Valacyclovir	500 Mg	Tablet	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

Need help managing your prescription drug costs for 2026?

Effective January 1, 2025, the Medicare Prescription Payment Plan program (M3P/MPPP) helps you manage your out-of-pocket drug costs by spreading them out across the calendar year **(although 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.

Participation in the M3P program is optional.

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 $2,100 out-of-pocket annual maximum using a standardized formula created by CMS (Centers for Medicare & Medicaid Services). Once you pay $2,100, you move to the Catastrophic Coverage phase and ATRIO pays 100% of your prescription drug costs. More information on prescription coverage and examples of monthly calculations can be found online at atriohp.com.

2026 Benefits at a Glance

ATRIO Health Plans Medicare Advantage Plans

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

ATRIO Freedom (PPO) does not include drug coverage

Klamath County (Partial), OR

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

Medical Benefits

Plan Costs	ATRIO Choice Rx (PPO) *H6743-001*		ATRIO Prime Rx (PPO) *H6743-030*		ATRIO Freedom (PPO) *H6743-031*	
Monthly plan premium	$26		$139		$0	
Plan deductible	$0		$0		$110	
Annual out-of-pocket maximum*	$6,750 In-network	$9,500 Combined *(In and Out-of-network)*	$4,200 In-network	$6,300 Combined *(In and Out-of-network)*	$5,500 In-network	$6,500 Combined *(In and Out-of-network)*
Part B premium giveback	Not Available		Not Available		$25 per month	

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

Inpatient Care	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network
Inpatient hospital care	$350 per day, 1-7 $0 per day, 8+	$450 per day, 1-7 $0 per day, 8-90	$350 per day, 1-8 $0 per day, 9+	$450 per day, 1-8 $0 per day, 9-90	$275 per day, 1-7 $0 per day, 8+	$375 per day, 1-7 $0 per day, 8-90
Skilled nursing facility (SNF)	$10 per day, 1-20 $214 per day, 21-100	$300 per day, 1-100	$20 per day, 1-20 $203 per day, 21-100	$500 per day, 1-100	$10 per day, 1-20 $203 per day, 21-100	$203 per day, 1-100

Outpatient Care	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network
Outpatient hospital	$500 copay	$600 copay	$350 copay	$450 copay	20% of total cost	30% of total cost
Ambulatory surgery center	$225 copay	$225 copay	$225 copay	$325 copay	20% of total cost	30% of total cost
Home health care	$0 copay	50% of total cost	$0 copay	50% of total cost	$0 copay	50% of total cost
Diabetic supplies	$0 copay	50% of total cost	$0 copay	50% of total cost	$0 copay	50% of total cost
Durable medical equipment	20% of total cost	50% of total cost	20% of total cost	50% of total cost	20% of total cost	30% of total cost

	ATRIO Choice Rx (PPO) *H6743-001*		ATRIO Prime Rx (PPO) *H6743-030*		ATRIO Freedom (PPO) *H6743-031*	
Labs & Tests	**In-network**	**Out-of-network**	**In-network**	**Out-of-network**	**In-network**	**Out-of-network**
Laboratory tests	$0 copay	15% of total cost	$0 copay	$0 copay	$20 copay	15% of total cost
Diagnostic imaging (MRI/CT/PET)	0 - 20% of total cost	30% of total cost	0 - 20% of total cost	50% of total cost	0 - 20% of total cost	30% of total cost
X-rays	$30 copay	30% of total cost	$15 copay	30% of total cost	$20 copay	30% of total cost
Emergency Services						
Ambulance *(air & ground)*	$350 copay		$275 copay		$275 copay	
Emergency room**	$130 copay		$150 copay		$125 copay	
Urgently needed care	$50 copay		$65 copay		$50 copay	

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

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

Supplemental Benefits

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

	ATRIO Choice Rx (PPO) *H6743-001*	ATRIO Prime Rx (PPO) *H6743-030*	ATRIO Freedom (PPO) *H6743-031*
Flex Card Benefits			
Routine chiropractic, acupuncture,and naturopathic services	$300 allowance every six months†, loaded to your Flex Card, for combined routine chiropractic, acupuncture and naturopathy services ($600 annual allowance)	$100 allowance every six months†, loaded to your Flex Card, for combined routine chiropractic, acupuncture and naturopathy services ($200 annual allowance)	$100 allowance every six months†, loaded to your Flex Card, for combined routine chiropractic, acupuncture and naturopathy services ($200 annual allowance)
Fitness benefit	$175 allowance every six months†, loaded to your Flex Card, for gym membership fees and fitness classes ($350 annual allowance)	$200 allowance every six months†, loaded to your Flex Card, for gym membership fees and fitness classes ($400 annual allowance)	$100 allowance every six months†, loaded to your Flex Card, for gym membership fees and fitness classes ($200 annual allowance)
Preventive & comprehensive dental services	$200 allowance every six months†, loaded to your Flex Card, for comprehensive and preventive dental services. Excludes cosmetic procedures ($400 annual allowance)	$350 allowance every six months†, loaded to your Flex Card, for comprehensive and preventive dental services. Excludes cosmetic procedures ($700 annual allowance)	$300 allowance every six months†, loaded to your Flex Card, for comprehensive and preventive dental services. Excludes cosmetic procedures ($600 annual allowance)
Over-the-Counter (OTC) items	$25 allowance every three months†, loaded to your Flex Card, for select OTC items ($100 annual allowance)	$75 allowance every three months†, loaded to your Flex Card, for select OTC items ($300 annual allowance)	$25 allowance every three months†, loaded to your Flex Card, for select OTC items ($100 total annual allowance)
Supplemental Benefits			
Routine vision exam	$0 copay, 1 exam per year (in-network only)	$0 copay, 1 exam per year (in-network only)	$0 copay, 1 exam per year (in-network only)
Routine vision hardware	$150 allowance for frames (standard lenses included) or contact lenses per year	$200 allowance for frames (standard lenses included) or $100 allowance for contact lenses per year	$150 allowance for frames (standard lenses included) or $100 allowance for contact lenses per year
Routine hearing exam	$0 copay 1 exam per year (in-network only)	$0 copay 1 exam per year (in-network only)	$0 copay 1 exam per year (in-network only)
Hearing aids	$699 to $999 copay, for each hearing aid, up to 2 hearing aids per year (in-network only)	$699 to $999 copay, for each hearing aid, up to 2 hearing aids per year (in-network only)	$699 to $999 copay, for each hearing aid, up to 2 hearing aids per year (in-network only)

	ATRIO Choice Rx (PPO) *H6743-001*	ATRIO Prime Rx (PPO) *H6743-030*	ATRIO Freedom (PPO) *H6743-031*
Annual physical exam	$0 copay	$0 copay	$0 copay
Transportation	$0 for 24 one-way trips every year to plan-approved health-related locations	$0 for 24 one-way trips every year to plan-approved health-related locations	$0 for 12 one-way trips every year to plan-approved health-related locations
Meals	Up to 2 meals per day for 14 days after a qualifying event	Up to 2 meals per day for 14 days after a qualifying event	Up to 2 meals per day for 14 days after a qualifying event

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

	ATRIO Choice Rx (PPO) *H6743-001*		ATRIO Prime Rx (PPO) *H6743-030*		ATRIO Freedom (PPO) *H6743-031*
Part D Deductible	$300		$0		Plan does not include drug coverage
	30-day supply	**90-day supply**	**30-day supply**	**90-day supply**	
Tier 1 (Preferred generic)	$0 copay	$0 copay	$0 copay	$0 copay	
Tier 2 (Generic)	$10 copay	$20 copay	$8 copay	$16 copay	
Tier 3* (Preferred brand)	$47 copay	$94 copay	$47 copay	$94 copay	
Tier 4* (Non-preferred drug)	$100 copay	$200 copay	$100 copay	$200 copay	
Tier 5* (Specialty)	28% of total cost	Not Available	33% of total cost	Not Available	
Tier 6 (Select care drugs)	$0 copay	$0 copay	$0 copay	$0 copay	
Catastrophic coverage stage: After you have paid $2,100 out of pocket, you move to the Catastrophic Coverage Stage.	You pay nothing through the end of the year				

**Part D deductible applies*

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

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

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

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)

ATRIO™ HEALTH PLANS

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.

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 GA Foods for in-network meal delivery benefit.

WORLDWIDE EMERGENCY AND URGENT CARE

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

Contact & Access Information

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

Flex Card – &more

To check balance or place an order call 1-855-263-6673 (TTY 711) from Monday – Friday, 8 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 – &more

To place an order or for more information call 1-855-263-6673 (TTY 711) from Monday – Friday, 8 a.m. to 8 p.m. PST. Catalogs can be found online at atriohp.com

Transportation – SafeRide

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

2026 Medicare Advantage

Summary of Benefits

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

Service area coverage for Klamath County

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

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

January 1, 2026 - December 31, 2026

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.

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 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.
- ☐ 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, 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, 2027.
- ☐ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services, the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care. In addition, you will pay a higher co-pay for services received by non-contracted providers.

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

Our plans and service areas:

H6743001000 ATRIO Choice Rx (PPO) includes these Counties in Oregon: Klamath

H6743030000 ATRIO Prime Rx (PPO) includes these Counties in Oregon: Klamath

H6743031000 ATRIO Freedom (PPO) includes these Counties in Oregon: Klamath

ATRIO is not available in these Klamath County zip codes: 97425, 97731, 97733, 97737 and 97739.

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 https://www.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.

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

	ATRIO Choice Rx (PPO) H6743001 Klamath	**ATRIO Prime Rx (PPO)** H6743030 Klamath	**ATRIO Freedom (PPO)** H6743031 Klamath
Monthly Plan Premium *(includes both medical and drugs)*	$26	$139	$0
Part B Premium Reduction	Not available	Not available	This plan offers a $25 give back every month in your Social Security check.
Deductible	No deductible for medical. See prescription drug coverage for Part D deductible.	No deductible for medical. See prescription drug coverage for Part D deductible.	$110
Maximum Out-of-Pocket *(does not include Part D prescription drugs)*	From in-network providers: $6,750 From in-network and out-of-network providers combined: $9,500	From in-network providers: $4,200 From in-network and out-of-network providers combined: $6,300	From in-network providers: $5,500 From in-network and out-of-network providers combined: $6,500

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

	ATRIO Choice Rx (PPO) H6743001 Klamath	**ATRIO Prime Rx (PPO)** H6743030 Klamath	**ATRIO Freedom (PPO)** H6743031 Klamath
Inpatient Hospital coverage	**In-Network** $350 copay each day for days 1 to 7 and $0 copay each day for days 8 to 90 for Medicare-covered hospital care.* **Out-of-Network** $450 copay each day for days 1 to 7 and $0 copay each day for days 8 to 90 for Medicare-covered hospital care.	**In-Network** $350 copay each day for days 1 to 8 and $0 copay each day for days 9 to 90 for Medicare-covered hospital care.* **Out-of-Network** $450 copay each day for days 1 to 8 and $0 copay each day for days 9 to 90 for Medicare-covered hospital care.	**In-Network** $275 copay each day for days 1 to 7 and $0 copay each day for days 8 to 90 for Medicare-covered hospital care.* **Out-of-Network** $375 copay each day for days 1 to 7 and $0 copay each day for days 8 to 90 for Medicare-covered hospital care.
Outpatient Hospital coverage			
Outpatient hospital services	**In-Network** $500 copay* **Out-of-Network** $600 copay	**In-Network** $350 copay* **Out-of-Network** $450 copay	**In-Network** 20% coinsurance* **Out-of-Network** 30% coinsurance
Outpatient hospital observation services	**In-Network** $500 copay per stay* **Out-of-Network** $600 copay	**In-Network** $350 copay per day* **Out-of-Network** $450 copay	**In-Network** $275 copay per day* **Out-of-Network** 30% coinsurance

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

	ATRIO Choice Rx (PPO) H6743001 Klamath	**ATRIO Prime Rx (PPO)** H6743030 Klamath	**ATRIO Freedom (PPO)** H6743031 Klamath
Ambulatory Surgical Center (ASC)	**In-Network** $225 copay* **Out-of-Network** $225 copay	**In-Network** $225 copay* **Out-of-Network** $325 copay	**In-Network** 20% coinsurance* **Out-of-Network** 30% coinsurance
Doctor Visits			
Primary Care Providers	**In-Network** $0 copay **Out-of-Network** $50 copay	**In-Network** $0 copay **Out-of-Network** $30 copay	**In-Network** $10 copay **Out-of-Network** $50 copay
Specialists	**In-Network** $40 copay **Out-of-Network** $50 copay	**In-Network** $25 copay **Out-of-Network** $50 copay	**In-Network** $25 copay **Out-of-Network** $65 copay
Preventive Care (e.g., flu vaccine, diabetic screenings)	**In-Network** $0 copay **Out-of-Network** $0 copay	**In-Network** $0 copay **Out-of-Network** $0 copay	**In-Network** $0 copay **Out-of-Network** $0 copay
Emergency care	$130 copay Copay is waived if you are admitted to a hospital within 24 hours.	$150 copay Copay is waived if you are admitted to a hospital within 24 hours.	$125 copay Copay is waived if you are admitted to a hospital within 24 hours.

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

	ATRIO Choice Rx (PPO) H6743001 Klamath	**ATRIO Prime Rx (PPO)** H6743030 Klamath	**ATRIO Freedom (PPO)** H6743031 Klamath
Urgently needed services	$50 copay Copay is waived if you are admitted to a hospital within 24 hours.	$65 copay Copay is waived if you are admitted to a hospital within 24 hours.	$50 copay Copay is waived if you are admitted to a hospital within 24 hours.
Diagnostic Services/Labs/Imaging			
Diagnostic tests and procedures	**In-Network** $0 - $350 copay* **Out-of-Network** 50% coinsurance	**In-Network** $0 - $250 copay* **Out-of-Network** 50% coinsurance	**In-Network** $0 - $20 copay* **Out-of-Network** 30% coinsurance
Lab services	**In-Network** $0 copay* **Out-of-Network** 15% coinsurance	**In-Network** $0 copay* **Out-of-Network** $0 copay	**In-Network** $20 copay* **Out-of-Network** 15% coinsurance
Diagnostic radiology services (e.g. MRI, CAT Scan)	**In-Network** 0% - 20% coinsurance* **Out-of-Network** 30% coinsurance	**In-Network** 0% - 20% coinsurance* **Out-of-Network** 50% coinsurance	**In-Network** 0% - 20% coinsurance* **Out-of-Network** 30% coinsurance
Outpatient X-rays	**In-Network** $30 copay* **Out-of-Network** 30% coinsurance	**In-Network** $15 copay* **Out-of-Network** 30% coinsurance	**In-Network** $20 copay* **Out-of-Network** 30% coinsurance

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

	ATRIO Choice Rx (PPO) H6743001 Klamath	**ATRIO Prime Rx (PPO)** H6743030 Klamath	**ATRIO Freedom (PPO)** H6743031 Klamath
Therapeutic Radiology	**In-Network** 20% coinsurance* **Out-of-Network** 30% coinsurance	**In-Network** 20% coinsurance* **Out-of-Network** 50% coinsurance	**In-Network** 20% coinsurance* **Out-of-Network** 30% coinsurance
Hearing services			
Medicare-covered exam to diagnose and treat hearing and balance issues	**In-Network** $45 copay **Out-of-Network** $50 copay	**In-Network** $15 copay **Out-of-Network** 50% coinsurance	**In-Network** $45 copay **Out-of-Network** $50 copay
Routine hearing exam and hearing aids (services not covered by Medicare) must be administered by an Amplifon provider for in-network copays			
Routine hearing exam	**In-Network** $0 copay Limited to 1 visit every year* **Out-of-Network** $0 copay	**In-Network** $0 copay Limited to 1 visit every year* **Out-of-Network** 50% coinsurance	**In-Network** $0 copay Limited to 1 visit every year* **Out-of-Network** $50 copay
Fitting-evaluation(s) for hearing aids	**In-Network** $0 copay Limited to 1 visit every year* **Out-of-Network** $0 copay	**In-Network** $0 copay Unlimited visits every year* **Out-of-Network** 50% coinsurance	**In-Network** $0 copay Unlimited visits every year* **Out-of-Network** 50% coinsurance

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

	ATRIO Choice Rx (PPO) H6743001 Klamath	**ATRIO Prime Rx (PPO)** H6743030 Klamath	**ATRIO Freedom (PPO)** H6743031 Klamath
Hearing aids ○ All types	**In-Network** $699 - $999 copay Limited to 2 hearing aids every year* **Out-of-Network** $699 - $999 copay*	**In-Network** $699 - $999 copay Limited to 2 hearing aids every year* **Out-of-Network** 50% coinsurance*	**In-Network** $699 - $999 copay Limited to 2 hearing aids every year* **Out-of-Network** $699 - $999 copay*
Dental services †Benefit does not roll over	**In-Network** $45 copay for each Medicare-covered service. **Out-of-Network** $65 copay for each Medicare-covered service. $200 allowance every six months† loaded to your Flex card, for all additional preventive and comprehensive dental services. Excludes cosmetic procedures.	**In-Network** $15 copay for each Medicare-covered service. **Out-of-Network** $15 copay for each Medicare-covered service. $350 allowance every six months† loaded to your Flex card, for all additional preventive and comprehensive dental services. Excludes cosmetic procedures.	**In-Network** $45 copay for each Medicare-covered service. **Out-of-Network** $45 copay for each Medicare-covered service. $300 allowance every six months† loaded to your Flex card, for all additional preventive and comprehensive dental services. Excludes cosmetic procedures.

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

	ATRIO Choice Rx (PPO) H6743001 Klamath	**ATRIO Prime Rx (PPO)** H6743030 Klamath	**ATRIO Freedom (PPO)** H6743031 Klamath
Vision care			
Medicare-covered exam to diagnose and treat diseases and conditions of the eye	**In-Network** $45 copay **Out-of-Network** $65 copay	**In-Network** $15 copay **Out-of-Network** $15 copay	**In-Network** $45 copay **Out-of-Network** $45 copay
For people with diabetes, screening for diabetic retinopathy is covered once per year.	**In-Network** $45 copay **Out-of-Network** $65 copay	**In-Network** $15 copay **Out-of-Network** $15 copay	**In-Network** $45 copay **Out-of-Network** $45 copay
Routine eye exam (services not covered by Medicare) must be administered by a **VSP** provider for in-network copays	**In-Network** $0 copay Limited to 1 visit every year **Out-of-Network** 50% coinsurance	**In-Network** $0 copay Limited to 1 visit every year **Out-of-Network** 50% coinsurance	**In-Network** $0 copay Limited to 1 visit every year **Out-of-Network** 50% coinsurance
Additional routine eyewear	$150 combined allowance every year for contact lenses, eyeglass frames and lenses and upgrades (in-network only).	$200 allowance every year for eyeglasses (lenses and frames) and $100 allowance every year for contact lenses.	$150 allowance every year for eyeglasses (lenses and frames) and $100 allowance every year for contact lenses.

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

	ATRIO Choice Rx (PPO) H6743001 Klamath	**ATRIO Prime Rx (PPO)** H6743030 Klamath	**ATRIO Freedom (PPO)** H6743031 Klamath
Mental Health Services			
Inpatient visit	**In-Network** $450 copay each day for days 1 to 5 and $0 copay each day for days 6 to 90 for Medicare-covered hospital care. $0 copay for an additional 60 lifetime reserve days.* **Out-of-Network** $395 copay each day for days 1 to 8 and $0 copay each day for days 9 to 90 for Medicare-covered hospital care.	**In-Network** $225 copay each day for days 1 to 8 and $0 copay each day for days 9 to 90 for Medicare-covered hospital care. $0 copay for an additional 60 lifetime reserve days.* **Out-of-Network** $350 copay each day for days 1 to 8 and $0 copay each day for days 9 to 90 for Medicare-covered hospital care.	**In-Network** $275 copay each day for days 1 to 7 and $0 copay each day for days 8 to 90 for Medicare-covered hospital care. $0 copay for an additional 60 lifetime reserve days.* **Out-of-Network** $375 copay each day for days 1 to 7 and $0 copay each day for days 8 to 90 for Medicare-covered hospital care.

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

	ATRIO Choice Rx (PPO) H6743001 Klamath	**ATRIO Prime Rx (PPO)** H6743030 Klamath	**ATRIO Freedom (PPO)** H6743031 Klamath
Skilled nursing facility (SNF) care	**In-Network** $10 copay each day for days 1 to 20 and $214 copay each day for days 21 to 100 for Medicare-covered skilled nursing facility care.* **Out-of-Network** $300 copay each day for days 1 to 100 for Medicare-covered skilled nursing facility care.	**In-Network** $20 copay each day for days 1 to 20 and $203 copay each day for days 21 to 100 for Medicare-covered skilled nursing facility care.* **Out-of-Network** $500 copay each day for days 1 to 100 for Medicare-covered skilled nursing facility care.	**In-Network** $10 copay each day for days 1 to 20 and $203 copay each day for days 21 to 100 for Medicare-covered skilled nursing facility care.* **Out-of-Network** $203 copay each day for days 1 to 100 for Medicare-covered skilled nursing facility care.
Physical Therapy	**In-Network** $40 copay* **Out-of-Network** 50% coinsurance	**In-Network** $30 copay* **Out-of-Network** 50% coinsurance	**In-Network** $25 copay* **Out-of-Network** 50% coinsurance

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

	ATRIO Choice Rx (PPO) H6743001 Klamath	**ATRIO Prime Rx (PPO)** H6743030 Klamath	**ATRIO Freedom (PPO)** H6743031 Klamath
Ambulance services			
Ground Ambulance	**In-Network** $350 copay *Prior Authorization required for non-emergent transportation.* **Out-of-Network** $350 copay	**In-Network** $275 copay *Prior Authorization required for non-emergent transportation.* **Out-of-Network** $275 copay	**In-Network** $275 copay *Prior Authorization required for non-emergent transportation.* **Out-of-Network** $275 copay
Air Ambulance	**In-Network** $350 copay *Prior Authorization required for non-emergent transportation.* **Out-of-Network** $350 copay	**In-Network** $275 copay *Prior Authorization required for non-emergent transportation.* **Out-of-Network** $275 copay	**In-Network** $275 copay *Prior Authorization required for non-emergent transportation.* **Out-of-Network** $275 copay

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

	ATRIO Choice Rx (PPO) H6743001 Klamath	**ATRIO Prime Rx (PPO)** H6743030 Klamath	**ATRIO Freedom (PPO)** H6743031 Klamath
Transportation (additional routine) *Must use SafeRide for covered trips*	**In-Network** $0 copay Routine transportation for up to 24 trips every year. A trip is considered one-way transportation by taxi, van, medical transport, or rideshare services to a plan approved health-related location.	**In-Network** $0 copay Routine transportation for up to 24 trips every year. A trip is considered one-way transportation by taxi, van, medical transport, or rideshare services to a plan approved health-related location.	**In-Network** $0 copay Routine transportation for up to 12 trips every year. A trip is considered one-way transportation by taxi, van, or rideshare services to a plan approved health-related location.
Medicare Part B drugs			
Chemotherapy/Radiation drugs	**In-Network** 0% - 20% coinsurance* **Out-of-Network** 50% coinsurance	**In-Network** 0% - 20% coinsurance* **Out-of-Network** 50% coinsurance	**In-Network** 0% - 20% coinsurance* **Out-of-Network** 50% coinsurance
Other Part B drugs	**In-Network** 0% - 20% coinsurance* **Out-of-Network** 50% coinsurance	**In-Network** 0% - 20% coinsurance* **Out-of-Network** 50% coinsurance	**In-Network** 0% - 20% coinsurance* **Out-of-Network** 50% coinsurance

Additional Benefits

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

	ATRIO Choice Rx (PPO) H6743001 Klamath	**ATRIO Prime Rx (PPO)** H6743030 Klamath	**ATRIO Freedom (PPO)** H6743031 Klamath
Annual routine physical exam	**In-Network** $0 copay **Out-of-Network** $0 copay	**In-Network** $0 copay **Out-of-Network** $0 copay	**In-Network** $0 copay **Out-of-Network** $0 copay
Chiropractic, Acupuncture & Naturopathy Services (Supplemental routine services) †Benefit does not roll over	$300 allowance every six months†, loaded to your Flex Card, for combined routine chiropractic, acupuncture and naturopathy services.	$100 allowance every six months†, loaded to your Flex Card, for combined routine chiropractic, acupuncture and naturopathy services.	$100 allowance every six months†, loaded to your Flex Card, for combined routine chiropractic, acupuncture and naturopathy services.
Chiropractic services Medicare-covered: Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position)	**In-Network** $15 copay **Out-of-Network** $15 copay	**In-Network** $15 copay **Out-of-Network** $15 copay	**In-Network** $15 copay **Out-of-Network** $15 copay
Durable medical equipment (DME) and related supplies DME supplies are not eligible for Flex Card OTC spend	**In-Network** 20% coinsurance* **Out-of-Network** 50% coinsurance	**In-Network** 20% coinsurance* **Out-of-Network** 50% coinsurance	**In-Network** 20% coinsurance* **Out-of-Network** 30% coinsurance

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

	ATRIO Choice Rx (PPO) H6743001 Klamath	**ATRIO Prime Rx (PPO)** H6743030 Klamath	**ATRIO Freedom (PPO)** H6743031 Klamath
Fitness program †Benefit does not roll over	$175 allowance every six months†, loaded to your Flex Card, for gym membership fees and fitness classes.	$200 allowance every six months†, loaded to your Flex Card, for gym membership fees and fitness classes.	$100 allowance every six months†, loaded to your Flex Card, for gym membership fees and fitness classes.
Meal benefit	$0 copay for up to 2 meals per day for 14 days (28 meals per episode) (inpatient or SNF direct admissions/ post hospital).*	$0 copay for up to 2 meals per day for 14 days (28 meals per episode) (inpatient or SNF direct admissions/ post hospital).*	$0 copay for up to 2 meals per day for 14 days (28 meals per episode) (inpatient or SNF direct admissions/ post hospital).*
Outpatient diagnostic tests and therapeutic services and supplies	**In-Network** 20% coinsurance* **Out-of-Network** 30% coinsurance	**In-Network** 20% coinsurance* **Out-of-Network** 50% coinsurance	**In-Network** 20% coinsurance* **Out-of-Network** 30% coinsurance
Outpatient rehabilitation services Services provided by an occupational therapist	**In-Network** $30 copay* **Out-of-Network** 50% coinsurance	**In-Network** $30 copay* **Out-of-Network** 50% coinsurance	**In-Network** $25 copay* **Out-of-Network** 50% coinsurance

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

	ATRIO Choice Rx (PPO) H6743001 Klamath	**ATRIO Prime Rx (PPO)** H6743030 Klamath	**ATRIO Freedom (PPO)** H6743031 Klamath
Over-the-counter (OTC) Benefit †Benefit does not roll over	$25 every three months†, loaded to your Flex Card for select OTC items. Find eligible OTC products using our Flex card app on your smartphone. DME items are not eligible OTC products.	$75 every three months†, loaded to your Flex Card for select OTC items. Find eligible OTC products using our Flex card app on your smartphone. DME items are not eligible OTC products.	$25 every three months†, loaded to your Flex Card for select OTC items. Find eligible OTC products using our Flex card app on your smartphone. DME items are not eligible OTC products.
Partial hospitalization services and Intensive outpatient services	**In-Network** $55 copay per day **Out-of-Network** 50% coinsurance per day	**In-Network** 20% coinsurance per day **Out-of-Network** 50% coinsurance per day	**In-Network** 20% coinsurance per day **Out-of-Network** 50% coinsurance per day
Welcome to Medicare preventive visit	**In-Network** $0 copay **Out-of-Network** $0 copay	**In-Network** $0 copay **Out-of-Network** $0 copay	**In-Network** $0 copay **Out-of-Network** $0 copay
Worldwide emergency coverage	$140 copay	$500 copay	$125 copay

Prescription Drug Coverage	**ATRIO Choice Rx (PPO)** H6743001 Klamath	**ATRIO Prime Rx (PPO)** H6743030 Klamath	**ATRIO Freedom (PPO)** H6743031 Klamath
Stage 1: Annual Prescription Deductible			
Deductible	$300 for Tier 3*, Tier 4*, Tier 5* Part D prescription drugs. For all other drugs, you will not have to pay any deductible and will start receiving coverage immediately. *Part D deductible applies.	This plan has no deductible for Part D drugs, this payment stage doesn't apply.	Not Available
Stage 2: Initial Coverage (after you pay your deductible, if applicable)			
Standard Retail cost-sharing (31-day/100-day supply)			
Tier 1 (Preferred Generic)	$0/$0 copay	$0/$0 copay	Not Available
Tier 2 (Generic)	$10/$20 copay	$8/$16 copay	Not Available
Tier 3* (Preferred Brand)	$47/$94 copay	$47/$94 copay	Not Available
Tier 4* (Non-Preferred Drug)	$100/$200 copay	$100/$200 copay	Not Available
Tier 5* (Specialty Tier)	28% coinsurance/Not Available	33% coinsurance/Not Available	Not Available
Tier 6 (Select Care Drugs)	$0/$0 copay	$0/$0 copay	Not Available

Prescription Drug Coverage	ATRIO Choice Rx (PPO) H6743001 Klamath	ATRIO Prime Rx (PPO) H6743030 Klamath	ATRIO Freedom (PPO) H6743031 Klamath
Stage 3: Catastrophic Coverage			
After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $2,100, you pay nothing.			

Cost-sharing may differ based on point-of-service (mail-order, retail, Long Term Care (LTC)), home infusion, whether the pharmacy is in our standard network, or whether the prescription is a short-term (31-day supply) or long term (100-day supply).

- 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 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.

How to Enroll

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

1

Online

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

2

By Phone

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

3

In Person

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

4

At Your Home

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

5

Mail or Fax

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

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

Fax:
1-602-975-4071

Enrollment Checklist

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

Understanding the Benefits

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

Understanding Important Rules

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

Scope of Sales Appointment Confirmation

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

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

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

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

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

Beneficiary or Authorized Representative Signature and Signature Date:

SIGNED: _____DATE: _____

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

Representative's Name: _____

Your Relationship to the Beneficiary: _____

TO BE COMPLETED BY AGENT

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

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

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

_____

_____

2026 MEDICARE ADVANTAGE & MEDICARE ADVANTAGE PRESCRIPTION DRUG ENROLLMENT FORM

(KLAMATH COUNTY)

ATRIO HEALTH PLANS

Who can use this form?

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

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

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

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

When do I use this form?

You can join a plan:

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

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

Individuals experiencing homelessness

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

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

Reminders:

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

What happens next?

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

How do I get help with this form?

Call ATRIO Health Plans at 1-877-672-8620 (TTY 711)
Or,call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.
En español: Llamea ATRIO Health Plans al 1-877-672-8620 (TTY 711) o a Medicare gratis al 1-800-633-4227 y ooprima el 8 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: 12/31/2026

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.

2026 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:	Medical Plan only (no prescription drug):
☐ **ATRIO Choice Rx (PPO):** $26 / mo. (H6743-001)	☐ **ATRIO Freedom Rx (PPO):** $0 / mo. (H6743-031)
☐ **ATRIO Prime Rx (PPO):** $139 / mo. (H6743-030)	

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

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

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

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

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

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

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

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

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

City:_____ **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.

2026 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)

2026 MEDICARE ADVANTAGE & MEDICARE ADVANTAGE PRESCRIPTION DRUG ENROLLMENT FORM

(KLAMATH COUNTY)

ATRIO HEALTH PLANS

- I understand that when my ATRIO coverage begins, I must get all of my medical and prescriptiondrug benefits (If I selected a plan with prescription drug coverage) from ATRIO. Benefits andservices provided by ATRIO and contained in my ATRIO "Evidence of Coverage" document (alsoknown as a member contract or subscriber agreement) will be covered. Neither Medicare norATRIO 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 Iintentionally 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 mybehalf) on this application means that I have read and understand the contents of this application. Ifsigned 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:
_____	_____	_____

2026 MEDICARE ADVANTAGE & MEDICARE ADVANTAGE PRESCRIPTION DRUG ENROLLMENT FORM

(KLAMATH COUNTY)

ATRIO HEALTH PLANS

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

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

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

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

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

Do you or your spouse work? ☐ YES ☐ NO

2026 MEDICARE ADVANTAGE & MEDICARE ADVANTAGE PRESCRIPTION DRUG ENROLLMENT FORM

(KLAMATH COUNTY)

ATRIO HEALTH PLANS

SECTION 3: For licensed sales representative / agency use only

Staff member/ Agent/ Broker must complete:

Name (if assisted in enrollment):

Initial receipt date:

Writing ID #:

Proposed effective date of coverage:

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

_____ _____

Licensed Sales Representative Signature *(optional)* Date

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

PRIVACY ACT STATEMENT

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

ATRIO™
HEALTH PLANS

Attestation of Eligibility for an Enrollment Period

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

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

- ☐ I am new to Medicare.
- ☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).
- ☐ I recently moved outside of the service area for my current plan or I recently moved and have new options available to 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 Medicare and get full Medicaid benefits. I want to join or switch to a plan that coordinates coverage between my Medicare and Medicaid managed care plans (called an integrated Dual Eligible Special Needs Plan (D-SNP)).
- ☐ 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'm in a qualified State Pharmaceutical Assistance Program, or I'm losing help from a State Pharmaceutical Assistance Program.
- ☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.

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

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

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

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

Scope of Sales Appointment Confirmation

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

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

☐	**Medicare Preferred Provider Organization (PPO) Plan:** A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. PPOs have network doctors and hospitals but you can also use out-of-network providers, usually at a higher cost.
☐	**Medicare Health Maintenance Organization (HMO):** A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. In most HMOs, you can only get your care from doctors or hospitals in the plan's network (except in emergencies).
☐	**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:

_____

_____

2026 MEDICARE ADVANTAGE & MEDICARE ADVANTAGE PRESCRIPTION DRUG ENROLLMENT FORM

(KLAMATH COUNTY)

ATRIO HEALTH PLANS

Who can use this form?

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

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

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

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

When do I use this form?

You can join a plan:

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

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

Individuals experiencing homelessness

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

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

Reminders:

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

What happens next?

Send your completed and signed form to:
Mail: ATRIO Health PlansFax: (602) 975-4071
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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: Llamea ATRIO Health Plans al 1-877-672-8620 (TTY 711) o a Medicare gratis al 1-800-633-4227 y oprima el 8 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: 12/31/2026

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IMPORTANT

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2026 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:	Medical Plan only (no prescription drug):
☐ **ATRIO Choice Rx (PPO):** $26 / mo. (H6743-001)	☐ **ATRIO Freedom Rx (PPO):** $0 / mo. (H6743-031)
☐ **ATRIO Prime Rx (PPO):** $139 / mo. (H6743-030)	

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

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

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

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

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

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

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

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

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

City:_____ **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.

2026 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)

2026 MEDICARE ADVANTAGE & MEDICARE ADVANTAGE PRESCRIPTION DRUG ENROLLMENT FORM

(KLAMATH COUNTY)

ATRIO HEALTH PLANS

- I understand that when my ATRIO coverage begins, I must get all of my medical and prescriptiondrug benefits (If I selected a plan with prescription drug coverage) from ATRIO. Benefits andservices provided by ATRIO and contained in my ATRIO "Evidence of Coverage" document (alsoknown as a member contract or subscriber agreement) will be covered. Neither Medicare norATRIO 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 Iintentionally 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 mybehalf) on this application means that I have read and understand the contents of this application. Ifsigned 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:
_____	_____	_____

2026 MEDICARE ADVANTAGE & MEDICARE ADVANTAGE PRESCRIPTION DRUG ENROLLMENT FORM

(KLAMATH COUNTY)

ATRIO HEALTH PLANS

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

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

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

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

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

Do you or your spouse work? ☐ YES ☐ NO

2026 MEDICARE ADVANTAGE & MEDICARE ADVANTAGE PRESCRIPTION DRUG ENROLLMENT FORM

(KLAMATH COUNTY)

ATRIO HEALTH PLANS

SECTION 3: For licensed sales representative / agency use only

Staff member/ Agent/ Broker must complete:

Name (if assisted in enrollment):

Initial receipt date:

Writing ID #:

Proposed effective date of coverage:

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

_____ _____

Licensed Sales Representative Signature *(optional)* Date

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

PRIVACY ACT STATEMENT

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

ATRIO™
HEALTH PLANS

Attestation of Eligibility for an Enrollment Period

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

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

- ☐ I am new to Medicare.
- ☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).
- ☐ I recently moved outside of the service area for my current plan or I recently moved and have new options available to 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 Medicare and get full Medicaid benefits. I want to join or switch to a plan that coordinates coverage between my Medicare and Medicaid managed care plans (called an integrated Dual Eligible Special Needs Plan (D-SNP)).
- ☐ 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'm in a qualified State Pharmaceutical Assistance Program, or I'm losing help from a State Pharmaceutical Assistance Program.
- ☐ 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.

ATRIO HEALTH PLANS

Plan Recap

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

Plan Information

My new plan is a:

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

☐ Medicare Advantage Prescription Drug Plan

☐ Medicare Advantage Special Needs Plan

The name of my new plan is: _____

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

My plan type: ☐ Requires referrals ☐ Does not require referrals

☐ Includes a medical deductible unless the state or another third party pays it for me

☐ Does not include a medical deductible

My plan will provide:

☐ All Medicare health coverage ☐ All Medicare prescription drug coverage

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

Premium Information

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

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

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

Network Provider Information

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

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

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

Prescription Drug Coverage

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

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

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

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

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

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

Contact your Licensed Sales Representative

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

_____at _____

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

What to Expect After You Enroll

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

Notes

Notes

Notice about Nondiscrimination and Accessibility Requirements

Discrimination is Against the Law

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Form Approved
OMB# 0938-1421

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

English: ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-877-672-8620 or speak to your provider.

Spanish: ATENCIÓN: Si habla español, dispone de servicios gratuitos de asistencia lingüística. También dispone de recursos y servicios auxiliares gratuitos para proporcionar información en formatos accesibles. Llame al 1-877-672-8620 o hable con su proveedor.

Chinese Mandarin: 注意：如果您讲中文普通话，我们提供免费的语言协助服务。此外，我们还免费提供相应的辅助工具和服务，以无障碍格式提供信息。请致电 1-877-672-8620 或联系您的服务提供商。

Chinese Cantonese: 注意：如果您講粵語，我們可以為您提供免費的語言協助服務。還免費提供適當的輔助工具和服務，以可存取的格式提供資訊。請致電 1-877-672-8620 或與您的提供者聯絡。

Tagalog: PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-877-672-8620 o makipag-usap sa iyong provider.

French: ATTENTION : Si vous parlez français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir de l'information dans des formats accessibles sont également offerts gratuitement. Composez le 1-877-672-8620 ou parlez-en à votre fournisseur.

Vietnamese: LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-877-672-8620 hoặc trao đổi với người cung cấp dịch vụ của bạn.

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenz-Angebote zur Verfügung. Auch entsprechende Hilfsmittel und Angebote zur barrierefreien Informationsbereitstellung sind kostenlos verfügbar. Rufen Sie 1-877-672-8620 an oder wenden Sie sich an Ihren Anbieter.

Korean: 주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-877-672-8620번으로 전화하거나 서비스 제공업체에 문의하십시오.

Russian: ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-877-672-8620 или обратитесь к своему поставщику услуг.

Arabic:
تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 1-877-672-8620 أو تحدث إلى مقدم الخدمة".

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-877-672-8620 पर कॉल करें या अपने प्रदाता से बात करें।

Italian: ATTENZIONE: Se parli italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente strumenti e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama il numero 1-877-672-8620 o rivolgiti al tuo fornitore.

Portuguese: ATENÇÃO: Se fala português, estão disponíveis para si serviços gratuitos de assistência linguística. Os recursos auxiliares e os serviços adequados para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para 1-877-672-8620 ou fale com o seu fornecedor.

French Creole: ATANSYON: Si ou pale Kreyòl, sèvis asistans lang gratis la disponib pou ou. Zouti ak sèvis yo ki bay enfòmasyon nan fòma aksesib yo disponib gratis tou. Rele 1-877-672-8620 oswa pale ak founisè ou.

Polish: UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 1-877-672-8620 lub porozmawiaj ze swoim dostawcą.

Japanese: 注：日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル（誰もが利用できるよう配慮された）な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。1-877-672-8620 までお電話ください。または、ご利用の事業者にご相談ください。

For over 21 years we've been Oregon's local, dependable Medicare Advantage plan.

Learn more now.

atriohp.com

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

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.