STRAIGHT-UP LOCAL MEDICARE

2025 Medicare Advantage

SUMMARY OF BENEFITS

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

Service area coverage for Jackson and Josephine Counties

Plan IDs include: H6743-025, H6743-026, H6743-027

January 1, 2025 - December 31, 2025

2025 Summary of Benefits
January 1, 2025 – December 31, 2025

ATRIO HEALTH PLANS

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2025 Summary of Benefits

January 1, 2025 – December 31, 2025

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 service area for these plans includes Jackson and Josephine Counties in Oregon.

Which Doctors, Hospitals and Pharmacies Can I Use?

ATRIO Health Plans has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers in our network, you may pay less for your covered services. If you use providers that are not in our network, you may pay a higher out-of-pocket cost. You must generally use network pharmacies to fill your prescription drugs (if you choose a plan that includes drug coverage). You can see our plan's Formulary (Part D prescription drug list), Provider Directory and Pharmacy Directory at our website, atriohp.com.

Tips for Comparing Your Medicare Choices

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Pre-enrollment Checklist

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

Understanding the Benefits

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

Understanding Important Rules

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

Plan Premiums, Deductible and Out-of-pocket Maximums

	ATRIO Choice Rx (PPO) *H6743-025*	ATRIO Prime Rx (PPO) *H6743-026*	ATRIO Freedom (PPO) *H6743-027*
Plan Premium	$0 per month	$37 per month	$0 per month
	You must also continue to pay your Medicare Part B premium		
Part B premium giveback	$20 per month	$20 per month	Not Available
Plan Deductible	$0 per year	$0 per year	$0 per year
Out-of-Pocket Maximums	**In-network:** $6,750 for services you receive from in-network providers. **Combined:** $7,900 for services you receive from any provider. Your limit for services received from in-network providers will count toward this limit.	**In-network:** $4,150 for services you receive from in-network providers. **Combined:** $6,200 for services you receive from any provider. Your limit for services received from in-network providers will count toward this limit.	**In-network:** $6,750 for services you receive from in-network providers. **Combined:** $7,900 for services you receive from any provider. Your limit for services received from in-network providers will count toward this limit.

Covered Medical and Hospital Benefits

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

	ATRIO Choice Rx (PPO) *H6743-025*	ATRIO Prime Rx (PPO) *H6743-026*	ATRIO Freedom (PPO) *H6743-027*
Inpatient Hospital Care (Acute)*	**In-network:** $450 per day, 1-5 $0 per day, 6+ **Out-of-network:** $2,000 copay per stay	**In-network:** $375 per day, 1-8 $0 per day, 9+ **Out-of-network:** $1,750 copay per stay	**In-network:** $375 per day, 1-7 $0 per day, 8+ **Out-of-network:** $475 per day, 1-7 $0 per day, 8-90
Outpatient Hospital Services*	**In-network:** $450 copay **Out-of-network:** 50% of total cost	**In-network:** $375 - $575 copay **Out-of-network:** $575 copay	**In-network:** $375 copay **Out-of-network:** 30% of total cost
Ambulatory Surgery Center Services *	**In-network:** $300 copay **Out-of-network:** $400 copay	**In-network:** $225 copay **Out-of-network:** $325 copay	**In-network:** 20% of total cost **Out-of-network:** 30% of total cost
Doctor's Office Visits	**Primary Care Physician (PCP)**		
	In-network: $0 copay **Out-of-network:** $50 copay	**In-network:** $0 copay **Out-of-network:** $30 copay	**In-network:** $0 copay **Out-of-network:** $50 copay
	Specialists		
	In-network: $40 copay **Out-of-network:** $65 copay	**In-network:** $25 copay **Out-of-network:** $50 copay	**In-network:** $35 copay **Out-of-network:** $65 copay
Preventive Care	**In & out-of-network:** $0 copay	**In & out-of-network:** $0 copay	**In & out-of-network:** $0 copay
	You pay nothing for Medicare-covered preventive services *Our plan also covers a supplemental Annual Physical Exam at no cost*		

Covered Medical and Hospital Benefits

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

	ATRIO Choice Rx (PPO) *H6743-025*	ATRIO Prime Rx (PPO) *H6743-026*	ATRIO Freedom (PPO) *H6743-027*
Emergency Care Worldwide emergency/urgent coverage	$125 copay	$140 copay	$125 copay
	Worldwide ER services cost sharing is waived if you are admitted to the hospital within 24 hours for the same condition		
Urgent Care See "Emergency Care" for worldwide copay	$55 copay	$60 copay	$55 copay
	Urgently needed care services cost sharing is waived if you are admitted to the hospital within 24 hours for the same condition		
Diagnostic Tests, Lab, X-rays, and Radiology Services *	**Diagnostic Radiology Services * (such as MRIs, CT and PET scans)**		
	In-network: $0 - $150 copay **Out-of-network:** 30% of total cost	**In-network:** $0 - $100 copay **Out-of-network:** 30% of total cost	**In-network:** 0% - 20% of total cost **Out-of-network:** 30% of total cost
	Other Diagnostic Tests and Procedures		
	In-network: $0 - $20 copay **Out-of-network:** 30% of total cost	**In-network:** $0 - $50 copay **Out-of-network:** 30% of total cost	**In-network:** $0 - $50 copay **Out-of-network:** 30% of total cost
	Lab Services		
	In-network: $0 copay **Out-of-network:** $20 copay	**In-network:** $0 copay **Out-of-network:** $0 copay	**In-network:** $0 copay **Out-of-network:** 15% of total cost
	Therapeutic Radiology Services * *(such as radiation treatment for cancer)*		
	In-network: $60 copay **Out-of-network:** 30% of total cost	**In-network:** $60 copay **Out-of-network:** 30% of total cost	**In-network:** 20% of the total cost **Out-of-network:** 30% of total cost

Covered Medical and Hospital Benefits

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

	ATRIO Choice Rx (PPO) *H6743-025*	ATRIO Prime Rx (PPO) *H6743-026*	ATRIO Freedom (PPO) *H6743-027*
Diagnostic Tests, Lab, X-rays, and Radiology Services *	**Outpatient X-Rays**		
	In-network: $20 copay **Out-of-network:** $20 copay	**In-network:** $15 copay **Out-of-network:** $15 copay	**In-network:** $20 copay **Out-of-network:** 30% of total cost
Medicare covered: Exams to diagnose and treat hearing and balance issues. **Supplemental Routine services** (services not covered by Medicare) must be administered by an Amplifon provider	**Hearing Exam** *(Medicare-covered services)*		
	In-network: $45 copay **Out-of-network:** $65 copay	**In-network:** $25 copay **Out-of-network:** $50 copay	**In-network:** $45 copay **Out-of-network:** $50 copay
	Hearing Exam *(Supplemental routine services)*		
	In-network: $0 copay 1 exam per year **Out-of-network:** 50% of total cost	**In-network:** $0 copay 1 exam per year **Out-of-network:** $0 copay	**In-network:** $0 copay 1 exam per year **Out-of-network:** $0 copay
	Hearing Aid fitting & evaluation *(Supplemental routine services)*		
	In-network: $0 copay **Out-of-network:** 50% of total cost	**In-network:** $0 copay **Out-of-network:** $0 with prior authorization	**In-network:** $0 copay **Out-of-network:** $0 with prior authorization
	Hearing Aids *(Supplemental routine services)*		
	In-network: $1,500 annual allowance **Out-of-network:** Requires prior authorization	**In-network:** $1,500 annual allowance **Out-of-network:** Requires prior authorization	**In-network:** $1,500 annual allowance **Out-of-network:** Requires prior authorization

Covered Medical and Hospital Benefits

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

	ATRIO Choice Rx (PPO) *H6743-025*	ATRIO Prime Rx (PPO) *H6743-026*	ATRIO Freedom (PPO) *H6743-027*
Dental Services * **Medicare covered:** Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth) †Benefit does not roll over	**Dental Services** *(Medicare-covered services)*		
	In-network: 45% of total cost **Out-of-network:** $65 copay	**In-network:** $25 copay **Out-of-network:** $45 copay	**In-network:** $45 copay **Out-of-network:** $45 copay
	Dental Services *(Supplemental routine services)*		
	In & out-of-network: $200 allowance every three months†, loaded to your Flex Card, for comprehensive and preventive dental services. Excludes cosmetic procedures ($800 annual allowance)	**In & out-of-network:** $200 allowance every three months†, loaded to your Flex Card, for comprehensive and preventive dental services. Excludes cosmetic procedures ($800 annual allowance)	**In & out-of-network:** $400 allowance every six months†, loaded to your Flex Card, for comprehensive and preventive dental services. Excludes cosmetic procedures ($800 annual allowance)
Vision Services **Medicare covered:** Exams to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening). **Supplemental routine services** (services not covered by Medicare) administered by **VSP**.	**Vision Exams** *(Medicare-covered services)*		
	In-network: $45 copay **Out-of-network:** $65 copay *Glaucoma screening* **In & out-of-network:** $0 copay	**In-network:** $15 copay **Out-of-network:** $15 copay *Glaucoma screening* **In & out-of-network:** $0 copay	**In-network:** $45 copay **Out-of-network:** $45 copay *Glaucoma screening* **In & out-of-network:** $0 copay
	Vision Exams *(Supplemental routine services)*		
	In-network: $0 copay **Out-of-network:** 50% of total cost	**In-network:** $0 copay **Out-of-network:** 50% of total cost	**In-network:** $0 copay **Out-of-network:** 50% of total cost

Covered Medical and Hospital Benefits

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

	ATRIO Choice Rx (PPO) *H6743-025*	ATRIO Prime Rx (PPO) *H6743-026*	ATRIO Freedom (PPO) *H6743-027*
Vision Services **Supplemental routine services** (services not covered by Medicare) administered by **VSP**	**Vision Eyewear** *(Supplemental routine services)*		
	In-network: $150 allowance for frames (standard lenses included) or $100 allowance for contact lenses per year **Out-of-network:** $150 allowance for frames or $100 allowance for contact lenses per year. 50% total cost for lenses	**In-network:** $200 allowance for frames (standard lenses included) or $100 allowance for contact lenses per year **Out-of-network:** $200 allowance for frames or $100 allowance for contact lenses per year. 50% total cost for lenses	**In-network:** $150 allowance for frames (standard lenses included) or $100 allowance for contact lenses per year **Out-of-network:** $150 allowance for frames or $100 allowance for contact lenses per year. 50% total cost for lenses
Mental Health Services*	**Inpatient Mental Health Care ***		
	In-network: $450 per day, 1-5 $0 per day, 6-90 **Out-of-network:** $2,000 copay per stay	**In-network:** $375 per day, 1-5 $0 per day, 6-90 **Out-of-network:** $1,750 copay per stay	**In-network:** $375 per day, 1-5 $0 per day, 6-90 **Out-of-network:** $475 per day, 1-7 $0 per day, 8-90
	Outpatient Group and Individual Therapy Visits		
	In-network: $40 copay **Out-of-network:** 50% of total cost	**In-network:** $25 copay **Out-of-network:** 50% of total cost	**In-network:** $25 copay **Out-of-network:** 50% of total cost
Skilled Nursing Facility (SNF) *	**In-network:** $10 per day, 1-20 $200 per day, 21-100 **Out-of-network:** $200 per day, 1-100	**In-network:** $20 per day, 1-20 $125 per day, 21-100 **Out-of-network:** $200 per day, 1-100	**In-network:** $10 per day, 1-20 $200 per day, 21-100 **Out-of-network:** $200 per day, 1-100

Covered Medical and Hospital Benefits

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

	ATRIO Choice Rx (PPO) *H6743-025*	ATRIO Prime Rx (PPO) *H6743-026*	ATRIO Freedom (PPO) *H6743-027*
Physical Therapy*	**Physical & Speech Therapy**		
	In-network: $40 copay **Out-of-network:** 50% of total cost	**In-network:** $30 copay **Out-of-network:** 50% of total cost	**In-network:** $25 copay **Out-of-network:** 50% of total cost
	Occupational Therapy		
	In-network: $40 copay **Out-of-network:** 50% of total cost	**In-network:** $30 copay **Out-of-network:** 50% of total cost	**In-network:** $25 copay **Out-of-network:** 50% of total cost
Ambulance* (Air and Ground) *Authorization required for nonemergent transportation*	**In & out-of-network:** $275 copay	**Ground** In-network: $325 Out-of-network: $225 **Air** In & out-of-network: $225	**In & out-of-network:** $275 copay
Transportation *Must use **SafeRide** for covered trips*	Not covered	$0 copay for 24 one-way trips every year to plan-approved health-related locations	$0 copay for 24 one-way trips every year to plan-approved health-related locations
Medicare Part B Drugs *	**In-network:** 0% - 20% of total cost **Out-of-network:** 50% of total cost	**In-network:** 0% - 20% of total cost **Out-of-network:** 50% of total cost	**In-network:** 0% - 20% of total cost **Out-of-network:** 50% of total cost
Telehealth *If provider offers Telehealth visits*	**In-network:** PCP: $0 copay Specialist: $40 copay **Out-of-network:** PCP: $50 copay Specialist: $65 copay	**In-network:** PCP: $0 copay Specialist: $25 copay **Out-of-network:** PCP: $30 copay Specialist: $50 copay	**In-network:** PCP: $0 copay Specialist: $35 copay **Out-of-network:** PCP: $50 copay Specialist: $65 copay

Covered Medical and Hospital Benefits

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

	ATRIO Choice Rx (PPO) *H6743-025*	ATRIO Prime Rx (PPO) *H6743-026*	ATRIO Freedom (PPO) *H6743-027*
Foot Care ***Medicare covered:*** Foot exams and treatment if you have diabetes related nerve damage and/or meet certain conditions	**Foot Care** *(Medicare-covered servicess)*		
	In-network: $45 copay **Out-of-network:** 50% of total cost	**In-network:** $25 copay **Out-of-network:** 50% of total cost	**In-network:** $25 copay **Out-of-network:** 50% of total cost
Durable Medical Equipment (DME) and Supplies, and Diabetic Supplies * DME supplies are not eligible for Flex Card OTC spend	**Medical Equipment and Medical Supplies**		
	In-network: 0% - 20% of total cost **Out-of-network:** 50% of total cost	**In-network:** 0% - 20% of total cost **Out-of-network:** 30% of total cost	**In-network:** 0% - 20% of total cost **Out-of-network:** 30% of total cost
	Diabetic Supplies		
	In-network: $0 copay **Out-of-network:** 50% of total cost	**In-network:** $0 copay **Out-of-network:** 50% of total cost	**In-network:** $0 copay **Out-of-network:** 50% of total cost
Fitness Covers gym membership fees and fitness classes *†Benefit does not roll over*	$250 allowance every six months†, loaded to your Flex Card, for gym membership fees and fitness classes ($500 annual allowance)	$200 allowance every six months†, loaded to your Flex Card, for gym membership fees and fitness classes ($400 annual allowance)	$250 annual allowance†, loaded to your Flex Card, for gym membership fees and fitness classes

Covered Medical and Hospital Benefits

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

	ATRIO Choice Rx (PPO) *H6743-025*	ATRIO Prime Rx (PPO) *H6743-026*	ATRIO Freedom (PPO) *H6743-027*
Alternative Therapies Chiropractic ***Medicare covered:*** Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position) ***Supplemental Routine services*** non-Medicare covered services *†Benefit does not roll over*	**Chiropractic Services** *(Medicare-covered servicess)*		
	In-network: $20 copay **Out-of-network:** $20 copay	**In-network:** $20 copay **Out-of-network:** $20 copay	**In-network:** $20 copay **Out-of-network:** $20 copay
	Chiropractic, Acupuncture & Naturopathy Services *(Supplemental routine services)*		
	In & out-of-network: $300 allowance every six months†, loaded to your Flex Card, for combined routine chiropractic, acupuncture and naturopathy services ($600 annual allowance)	**In & out-of-network:** $100 allowance every six months†, loaded to your Flex Card, for combined routine chiropractic, acupuncture and naturopathy services ($200 annual allowance)	**In & out-of-network:** $100 allowance every six months†, loaded to your Flex Card, for combined routine chiropractic, acupuncture and naturopathy services ($200 annual allowance)
Over-the-Counter (OTC) Items Select OTC products *†Benefit does not roll over*	$50 allowance every three months†, loaded to your Flex Card, for select OTC items ($200 total annual allowance)	$60 allowance every three months†, loaded to your Flex Card, for select OTC items ($240 total annual allowance)	$50 allowance every three months†, loaded to your Flex Card, for select OTC items ($200 total annual allowance)
	Easily find eligible OTC products using our Flex Card app on your smartphone *DME items are not eligible OTC products*		
Meals*	$0 copay for up to 2 meals per day for 14 days (28 meals per episode)	$0 copay for up to 2 meals per day for 14 days (28 meals per episode)	$0 copay for up to 2 meals per day for 14 days (28 meals per episode)
	Inpatient or SNF (direct admission/post hospital admits) (unlimited) *Home health recipients with approved home health certification (unlimited)*		

Medicare Part D Prescription Drug Benefits

Deductible Stage

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

ATRIO Choice Rx (PPO) *H6743-025*	ATRIO Prime Rx (PPO) *H6743-026*	ATRIO Freedom (PPO) *H6743-027*
$200 per year	$0 per year	**Plan does not include drug coverage**

Initial Coverage Stage

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

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

ATRIO Choice Rx (PPO) *H6743-025*			ATRIO Prime Rx (PPO) *H6743-026*		ATRIO Freedom (PPO) *H6743-027*
Standard Retail Cost Sharing			**Standard Retail Cost Sharing**		**Plan does not include drug coverage**
Tier	**30-day supply**	**90-day supply**	**30-day supply**	**90-day supply**	
Tier 1 (Preferred generic)	$0 copay	$0 copay	$0 copay	$0 copay	
Tier 2 (Generic)	$8 copay	$16 copay	$8 copay	$16 copay	
Tier 3 (Preferred brand)*	$47 copay	$94 copay	$47 copay	$94 copay	
Tier 4 (Non-preferred)*	$100 copay	$200 copay	$100 copay	$200 copay	
Tier 5 (Specialty)*	30% of the total cost	Not available	33% of the total cost	Not available	
Tier 6 (Select care)	$0	$0	$0	$0	

ATRIO Choice Rx (PPO) *H6743-025*	ATRIO Prime Rx (PPO) *H6743-026*	ATRIO Freedom (PPO) *H6743-027*
Catastrophic Coverage Stage		
After you have paid $2,000, you move to the Catastrophic Coverage Stage. You pay nothing through the end of the year. This amount and rules for counting costs toward this amount have been set by Medicare.		

*Part D deductible applies

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

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