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.

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	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*	**In-Network** 0% - 20% coinsurance*	**In-Network** 0% - 20% coinsurance*
	Out-of-Network 50% coinsurance	**Out-of-Network** 50% coinsurance	**Out-of-Network** 50% coinsurance
Other Part B drugs	**In-Network** 0% - 20% coinsurance*	**In-Network** 0% - 20% coinsurance*	**In-Network** 0% - 20% coinsurance*
	Out-of-Network 50% coinsurance	**Out-of-Network** 50% 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.