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.


ATRIO™
HEALTH PLANS