

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



Douglas County, OR

Medical Benefits

Plan Costs	ATRIO Choice Rx (PPO) H6743-007		ATRIO Prime Rx (PPO) H6743-028		ATRIO Freedom (PPO) H6743-029	
Monthly plan premium	\$0		\$90.00		\$0	
Plan deductible	\$0		\$0		\$0	
Annual out-of-pocket maximum*	\$5,000 In-network	\$5,000 Combined (In and Out-of-network)	\$4,200 In-network	\$6,300 Combined (In and Out-of-network)	\$4,500 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	\$0 copay	\$50 copay
Specialist	\$40 copay	50% of total	\$35 copay	\$60 copay	\$25 copay	\$65 copay
Telehealth (if provider offers Telehealth)	PCP: \$0 copay Specialist: \$40 copay	PCP: \$50 copay Specialist: 50% of total	PCP: \$0 copay Specialist: \$35 copay	PCP: \$30 copay Specialist: \$60 copay	PCP: \$0 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	\$450 per day, 1-5 \$0 per day, 6+	\$600 per day, 1-5 \$0 per day, 6-90	\$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 \$200 per day, 21-100	\$225 per day, 1-100	\$20 per day, 1-20 \$175 per day, 21-100	\$175 per day, 1-100	\$0 per day, 1-20 \$150 per day, 21-100	\$150 per day, 1-100

Outpatient Care	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network
Outpatient hospital	\$400 copay	50% of total cost	\$275 copay	\$375 copay	20% of total cost	30% of total cost
Ambulatory surgery center	\$225 copay	\$325 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	30% of total cost	20% of total cost	30% of total cost

	ATRIO Choice Rx (PPO) <i>H6743-007</i>		ATRIO Prime Rx (PPO) <i>H6743-028</i>		ATRIO Freedom (PPO) <i>H6743-029</i>	
Labs & Tests	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network
Laboratory tests	\$0 copay	\$20 copay	\$0 copay	\$0 copay	\$20 copay	15% of total cost
Diagnostic imaging (MRI/CT/PET)	\$0 - \$200 copay	30% of total cost	\$0 - \$100 copay	30% of total cost	0 - 20% of total cost	30% of total cost
X-rays	\$15 copay	30% of total cost	\$15 copay	\$15 copay	\$20 copay	30% of total cost
Emergency Services						
Ambulance (air & ground)	\$300 copay		\$295 copay		\$275 copay	
Emergency room**	\$130 copay		\$140 copay		\$125 copay	
Urgently needed care	\$45 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) <i>H6743-007</i>	ATRIO Prime Rx (PPO) <i>H6743-028</i>	ATRIO Freedom (PPO) <i>H6743-029</i>
Flex Card Benefits			
Routine chiropractic, acupuncture, and naturopathic services	\$100 allowance every six months [†] , loaded to your Flex Card, for combined routine chiropractic, acupuncture and naturopathy services (\$200 annual allowance)	\$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)
Fitness benefit	\$225 allowance every six months [†] , loaded to your Flex Card, for gym membership fees and fitness classes (\$450 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
Preventive & comprehensive dental services	\$300 allowance every three months [†] , loaded to your Flex Card, for comprehensive and preventive dental services. Excludes cosmetic procedures (\$1,200 annual allowance)	\$350 allowance every three months [†] , loaded to your Flex Card, for comprehensive and preventive dental services. Excludes cosmetic procedures (\$1,400 annual allowance)	\$400 allowance every six months [†] , loaded to your Flex Card, for comprehensive and preventive dental services. Excludes cosmetic procedures (\$800 annual allowance)
Over-the-Counter (OTC) items	\$50 allowance every three months [†] , loaded to your Flex Card, for select OTC items (\$200 annual allowance)	\$75 allowance every three months [†] , loaded to your Flex Card, for select OTC items (\$300 annual allowance)	\$50 allowance every three months [†] , loaded to your Flex Card, for select OTC items (\$200 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	\$200 allowance for frames (standard lenses included) or for contact lenses per year	\$200 allowance for frames (standard lenses included) or for contact lenses per year	\$150 allowance for frames (standard lenses included) or 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)	\$1,500 annual allowance (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) H6743-007	ATRIO Prime Rx (PPO) H6743-028	ATRIO Freedom (PPO) H6743-029
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 12 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
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
Personal Emergency Response System (PERS)	Not covered	\$0 for wearable medical alert system and monitoring through LifeStation, including wristwatch option with heart monitor and step counter	\$0 for wearable medical alert system and monitoring through LifeStation, including wristwatch option with heart monitor and step counter

† Balance does not roll over

Prescription Drug Benefits

Save 1 monthly copay on a 90-day prescription. \$0 out-of-pocket for many generic drugs, selected insulins and vaccines. The Part D Deductible applies only to drugs in tiers 3, 4 and 5.

	ATRIO Choice Rx (PPO) H6743-007		ATRIO Prime Rx (PPO) H6743-028		ATRIO Freedom (PPO) H6743-029
Part D Deductible	\$300		\$400		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)	29% of total cost	Not Available	28% 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.