ATRIO Bronze (PPO) offered by ATRIO Health Plans

Annual Notice of Changes for 2019

You are currently enrolled as a member of ATRIO Bronze (PPO). Next year, there will be some changes to the plan's costs and benefits. *This booklet tells about the changes.*

- **You have from October 15 until December 7 to make changes to your Medicare coverage for next year.**

What to do now

1. ASK: Which changes apply to you

☐ Check the changes to our benefits and costs to see if they affect you.

- It's important to review your coverage now to make sure it will meet your needs next year.
- Do the changes affect the services you use?
- Look in Section 1 for information about benefit and cost changes for our plan.

☐ Check to see if your doctors and other providers will be in our network next year.

- Are your doctors in our network?
- What about the hospitals or other providers you use?
- Look in Section 1.3 for information about our Provider Directory.

☐ Think about your overall health care costs.

- How much will you spend out-of-pocket for the services and prescription drugs you use regularly?
- How much will you spend on your premium and deductibles?
- How do your total plan costs compare to other Medicare coverage options?

☐ Think about whether you are happy with our plan.

2. COMPARE: Learn about other plan choices

☐ Check coverage and costs of plans in your area.

- Use the personalized search feature on the Medicare Plan Finder at https://www.medicare.gov website. Click "Find health & drug plans."
- Review the list in the back of your Medicare & You handbook.
- Look in Section 2.2 to learn more about your choices.

☐ Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan's website.

3. CHOOSE: Decide whether you want to change your plan

- If you want to **keep** ATRIO Bronze, you don't need to do anything. You will stay in ATRIO Bronze.

- To change to a **different plan** that may better meet your needs, you can switch plans between October 15 and December 7.

4. **ENROLL:** To change plans, join a plan between **October 15** and **December 7, 2018**
   - If you **don't join another plan by December 7, 2018**, you will stay in ATRIO Bronze.
   - If you join another plan by December 7, 2018, your new coverage will start on January 1, 2019.

Additional Resources

- This document may be available in other formats such as large print or audio CD.
- **Coverage under this Plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at https://www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About ATRIO Bronze

- ATRIO Health Plans has PPO and HMO D-SNP plans with a Medicare contract. Enrollment in ATRIO Health Plans depends on contract renewal.
- This information is not a complete description of benefits. Call 1-877-672-8620, TTY 1-800-735-2900 for more information.
- When this booklet says "we," "us," or "our," it means ATRIO Health Plans. When it says "plan" or "our plan," it means ATRIO Bronze.

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Summary of Important Costs for 2019

The table below compares the 2018 costs and 2019 costs for ATRIO Bronze in several important areas. **Please note this is only a summary of changes**. **It is important to read the rest of this *Annual Notice of Changes*** and review the *Evidence of Coverage* located on our website at atriohp.com to see if other benefit or cost changes affect you.

Cost	2018 (this year)	2019 (next year)
Monthly plan premium	$0	$0
Deductible	$110	$110
Maximum out-of-pocket amounts This is the most you will pay out-of-pocket for your covered services. (See Section 1.2 for details.)	From network providers: $3,400 From in-network and out-of-network providers combined: $5,100	From network providers: $6,700 From in-network and out-of-network providers combined: $10,000
Doctor office visits	**Primary care visits:** In-network $15 copay per visit Out-of-network: $40 copay per visit **Specialist visits:** In-network $25 copay per visit Out-of-network: $50 copay per visit	**Primary care visits:** In-network $15 copay per visit Out-of-network: 50% of the cost per visit **Specialist visits:** In-network $25 copay per visit Out-of-network: 50% of the cost per visit
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.	In-network: • $275 copay per day for days 1-7 • $0 copay per day for days 8-90 • $0 copay per day for days 91 and beyond Out-of-network: • $375 copay per day for days 1-7 • $0 copay per day for days 8-90	In-network: • $275 copay per day for days 1-7 • $0 copay per day for days 8-90 • $0 copay per day for days 91 and beyond Out-of-network: • $375 copay per day for days 1-7 • $0 copay per day for days 8-90

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SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2018 (this year)	2019 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$0	$0

Section 1.2 – Changes to Your Maximum Out-of-Pocket Amounts

To protect you, Medicare requires all health plans to limit how much you pay "out-of-pocket" during the year. These limits are called the "maximum out-of-pocket amounts." Once you reach this amount, you generally pay nothing for covered services for the rest of the year.

Cost	2018 (this year)	2019 (next year)
In-network maximum out-of-pocket amount Your costs for covered medical services (such as copays and deductibles) from network providers count toward your in-network maximum out-of-pocket amount.	$3,400	$6,700 Once you have paid $6,700 out-of-pocket for covered services from network providers, you will pay nothing for your covered services from network providers for the rest of the calendar year.
Combined maximum out-of-pocket amount Your costs for covered medical services (such as copays and deductibles) from in-network and out-of-network providers count toward your combined maximum out-of-pocket amount.	$5,100	$10,000 Once you have paid $10,000 out-of-pocket for covered services, you will pay nothing for your covered services from in-network or out-of-network providers for the rest of the calendar year.

Section 1.3 – Changes to the Provider Network

Our network has changed more than usual for 2019. An updated Provider Directory is located on our website at atriohp.com. You may also call Customer Service for updated provider information or to ask us to mail you a Provider Directory. **We strongly suggest that you review our current Provider Directory to see if your providers (primary care provider, specialists, hospitals, etc.) are still in our network.**

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan but if your doctor or specialist does leave your plan you have certain rights and protections summarized below:

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider and managing your care.

Section 1.4 – Changes to Benefits and Costs for Medical Services

We are changing our coverage for certain medical services next year. The information below describes these changes. For details about the coverage and costs for these services, see Chapter 4, *Medical Benefits Chart (what is covered and what you pay)*, in your *2019 Evidence of Coverage*.

Cost	2018 (this year)	2019 (next year)
Inpatient Hospital (Psychiatric)	In-network: You pay • $250 copay per day for days 1-7 • $0 copay per day for days 8-90	In-network: You pay • $225 copay per day for days 1-7 • $0 copay per day for days 8-90
Skilled Nursing Facility	In-network: You pay • $20 copay per day for days 1-20 • $65 copay per day for days 21-100	In-network: You pay • $0 copay per day for days 1-20 • $85 copay per day for days 21-100
Cardiac & Pulmonary Rehabilitation Services	Out-of-network: You pay 30% of the total cost	Out-of-network: You pay 50% of the total cost
Emergency Care	You pay a $100 copay	You pay a $90 copay
Worldwide Emergency/Urgent Coverage	You pay a $100 copay	You pay a $90 copay
Partial Hospitalization	Out-of-network: You pay 30% of the total cost	Out-of-network: You pay 50% of the total cost

Cost	2018 (this year)	2019 (next year)
Home Health Services	In-network: You pay 10% of the total cost Out-of-network: You pay 15% of the total cost	In-network: You pay 0% of the total cost Out-of-network: You pay 50% of the total cost
Primary Care Physician Services (PCP)	Out-of-network: You pay a $40 copay	Out-of-network: You pay 50% of the total cost
Occupational Therapy Services	Out-of-network: You pay 30% of the total cost	Out-of-network: You pay 50% of the total cost
Physician Specialist Services	Out-of-network: You pay a $50 copay	Out-of-network: You pay 50% of the total cost
Mental Health Specialty Services (Individual and Group)	Out-of-network: You pay 30% of the total cost	Out-of-network: You pay 50% of the total cost
Podiatry Services (Medicare Covered)	Out-of-network: You pay 30% of the total cost	Out-of-network: You pay 50% of the total cost
Other Health Care Professional	Out-of-network: You pay 30% of the total cost	Out-of-network: You pay 50% of the total cost
Psychiatric Services (Individual and Group)	Out-of-network: You pay 30% of the total cost	Out-of-network: You pay 50% of the total cost
Physical Therapy and Speech-Language Pathology Services	Out-of-network: You pay 30% of the total cost	Out-of-network: You pay 50% of the total cost
Laboratory Services	Out-of-network: You pay 25% of the total cost	Out-of-network: You pay 15% of the total cost
Outpatient Substance Abuse Services (Individual and Group)	Out-of-network: You pay 30% of the total cost	Out-of-network: You pay 50% of the total cost
Outpatient Blood Services	Out-of-network: You pay 0% of the total cost	Out-of-network: You pay 50% of the total cost
Durable Medical Equipment (DME)	In-network: You pay 20% of the total cost	In-network: You pay 15% of the total cost

Cost	2018 (this year)	2019 (next year)
	Out-of-network: You pay 30% of the total cost	Out-of-network: You pay 18% of the total cost
Prosthetics/Medical Supplies	In-network: You pay 20% of the total cost Out-of-network: You pay 30% of the total cost	In-network: You pay 15% of the total cost Out-of-network: You pay 18% of the total cost
Diabetic Supplies, Services & Therapeutic Shoes/Inserts	Out-of-network: You pay 0% of the total cost Quantity limits for Blood Glucose Monitoring Supplies: No quantity limits	Out-of-network: You pay 20% of the total cost Quantity limits for Blood Glucose Monitoring Supplies: Quantity limit of 100 Test Strips and 100 lancets per 90-day supply for individuals who are non-Insulin dependent Quantity limit of 300 Test Strips and 300 lancets per 90-day supply for individuals who are Insulin dependent Quantity limit of 1 lancet device per 6 months for both Insulin dependent and non-Insulin dependent individuals Prior Authorization is required for amounts exceeding this quantity limit
End-Stage Renal Disease Services	Out-of-network: You pay 30% of the total cost	Out-of-network: You pay 50% of the total cost
Health Education	Health Education is covered	Health Education is not covered
Medicare Part B Rx Drugs	Out-of-network: You pay 30% of the total cost	Out-of-network: You pay 50% of the total cost
Comprehensive Dental (Medicare Covered)	Out-of-network: You pay a $50 copay	Out-of-network: You pay a $45 copay
Eye Exams (Medicare Covered)	Out-of-network: You pay a $50 copay	Out-of-network: You pay a $45 copay
Hearing Exams (Medicare Covered)	Out-of-network: You pay a $50 copay	Out-of-network: You pay 50% of the total cost

SECTION 2 Deciding Which Plan to Choose

Section 2.1 – If you want to stay in ATRIO Bronze

To stay in our plan you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically stay enrolled as a member of our plan for 2019.

Section 2.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change for 2019 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- -- *OR*-- You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan.

To learn more about Original Medicare and the different types of Medicare plans, read *Medicare & You 2019*, call your State Health Insurance Assistance Program (see Section 4), or call Medicare (see Section 6.2).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to https://www.medicare.gov and click "Find health & drug plans." **Here, you can find information about costs, coverage, and quality ratings for Medicare plans.**

As a reminder, ATRIO Health Plans offers other Medicare health plans. These other plans may differ in coverage, monthly premiums, and cost-sharing amounts.

Step 2: Change your coverage

- To change **to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from ATRIO Bronze.
    - To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from ATRIO Bronze.
- To **change to Original Medicare without a prescription drug plan,** you must either:
    - Send us a written request to disenroll. Contact Customer Service if you need more information on how to do this (phone numbers are in Section 6.1 of this booklet).
    - – *or* – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

SECTION 3 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7.** The change will take effect on January 1, 2019.

Are there other times of the year to make a change?

In certain situations, changes are also allowed at other times of the year. For example, people with Medicaid, those who get "Extra Help" paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area may be allowed to make a change at other times of the year. For more information, see Chapter 8, Section 2.3 of the *Evidence of Coverage*.

If you enrolled in a Medicare Advantage plan for January 1, 2019, and don't like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2019. For more information, see Chapter 8, Section 2.2 of the *Evidence of Coverage*.

SECTION 4 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In Oregon, the SHIP is called Senior Health Insurance Benefits Assistance Program (SHIBA).

SHIBA is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. SHIBA counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call SHIBA at 1-800-722-4134. TTY/TDD users should call 1-800-735-2900.

SECTION 5 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs.

- **"Extra Help" from Medicare.** People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. Many people are eligible and don't even know it. To see if you qualify, call:
    - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
    - The Social Security Office at 1-800-772-1213 between 7 am and 7 pm, Monday through Friday. TTY users should call, 1-800-325-0778 (applications); or
    - Your State Medicaid Office (applications).
- **What if you have coverage from an AIDS Drug Assistance Program (ADAP)?** The AIDS Drug Assistance Program (ADAP) helps ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance. In Oregon, the ADAP is called CAREAssist. CAREAssist can be reached by calling 1-800-805-2323. Note: To be eligible for the ADAP operating in your State, individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status.
- If you are currently enrolled in an ADAP, it can continue to provide you with Medicare Part D prescription cost-sharing assistance for drugs on the ADAP formulary. In order to be sure you continue receiving this assistance, please notify your local ADAP enrollment worker of any changes in your Medicare Part D plan name or policy number. CAREAssist can be reached by calling 1-800-805-2323.

  For information on eligibility criteria, covered drugs, or how to enroll in the program, please call CAREAssist at 1-800-805-2323.

SECTION 6 Questions?

Section 6.1 – Getting Help from ATRIO Bronze

Questions? We're here to help. Please call Customer Service at 1-877-672-8620. (TTY only, call 1-800-735-2900.) We are available for phone calls daily, 8 a.m. to 8 p.m. PST. Calls to these numbers are free.

Read your 2019 *Evidence of Coverage* (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2019. For details, look in the 2019 *Evidence of Coverage* for ATRIO Bronze. The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is included in this envelope.

Visit our Website

You can also visit our website at atriohp.com. As a reminder, our website has the most up-to-date information about our provider network (Provider Directory).

Section 6.2 – Getting Help from Medicare

To get information directly from Medicare:

Call 1-800-MEDICARE (1-800-633-4227)

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Visit the Medicare Website

You can visit the Medicare website (https://www.medicare.gov). It has information about cost, coverage, and quality ratings to help you compare Medicare health plans. You can find information about plans available in your area by using the Medicare Plan Finder on the Medicare website. (To view the information about plans, go to https://www.medicare.gov and click on "Find health & drug plans.")

Read *Medicare & You 2019*

You can read *Medicare & You 2019* Handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (https://www.medicare.gov) or 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.