Dear ATRIO Health Plans Member:

To make a change in the Medicare Advantage plan you have with ATRIO Health Plans, fill out the enclosed plan selection form to make your choice. Check off the plan you want, and sign the form. Then mail the completed form back to us by December 7th.

You can change health plans only at certain times during the year. From October 15 - December 7, you can join, switch or drop a Medicare health or drug plan for the following year. In addition, from January 1 - March 31, anyone enrolled in a Medicare Advantage Plan (except an MSA plan) can switch plans or return to Original Medicare (and join a stand-alone Medicare Prescription Drug Plan). Generally, you can't make changes at other times except in certain situations, such as if you move out of your plan's service area, want to join a plan in your area with a 5-star rating, or qualify for (or lose) Extra Help paying for prescription drug coverage.

If you select another plan and we receive your completed selection form by December 7th, your new benefit plan will begin in January 2019. Your monthly plan premiums can be found on the Plan Selection Form and you may continue to see any ATRIO Health Plan primary care doctors and specialists.

Complete the attached form only if you wish to change plans.

To help you with your decision, we have also included 2019 benefit overview for the available options.

If you have any questions, please call ATRIO Health Plans at 877-672-8620. TTY users should call 800-735-2900. We are open daily, 8 a.m. to 8 p.m.

Thank you.

ATRIO Health Plans

ATRIO Health Plans has PPO and HMO D-SNP plans with a Medicare Contract. Enrollment in ATRIO Health Plans depends on contract renewal.

2019 MEDICARE ADVANTAGE PLAN ELECTION FORM

ATRIO HEALTH PLANS

JOSEPHINE COUNTY

Fax this completed form to 866-238-1736 or 541-672-8670

Date: _____ Member name: _____

Member number: _____

I want to transfer from my current plan to the plan I have selected below. I understand that if this form is received by the end of any month, my new plan will generally be effective the 1st of the following month.

PLEASE CHECK THE APPROPRIATE BOX BELOW:			
☐	**ATRIO Bronze Rx (Rogue) (PPO)** Premium: $13 Deductible: $230 PCP: $35/50% Specialist: $45/50% Emergency Room: $90 Annual Out-of-Pocket Max: $6,700/$10,000 Prescription drug	☐	**ATRIO Silver Rx (Rogue) (PPO)** Premium: $129 Deductible: $50 PCP: $15/50% Specialist: $15/50% Emergency Room: $90 Annual Out-of-Pocket Max: $5,000/$7,500 Prescription drug, routine vision (exam only), fitness benefit

Your Plan Premium

If we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we need to know how would prefer to pay it. You can pay by mail, Electronic Funds Transfer (EFT), or credit card each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board Check each month.

You can pay your monthly plan premium (including any late enrollment penalty you have or may owe) by mail, Electronic Funds Transfer (EFT), or credit card each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board Check each month.

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office or call 1-800-MEDICARE (1-800-633-4227), 24 hours per day, 7 days per week. TTY/TDD users should call 1-877-486-2048.

If you qualify for Extra Help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium for this benefit. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare does not cover.

If you don't select a payment option, you will receive a bill each month.

Please select a premium payment option:

☐ Receive a bill

☐ Electronic funds transfer (EFT) from your checking account each month. Please enclose a VOIDED check or provide the following:

Account Holder Name:_____

Bank routing number:_____ Bank account number:_____

☐ Credit Card. Please provide the following information:

Type of Card:_____

Name of Account holder as it appears on card:_____

Account number:_____ Expiration Date:__ __ / __ __ __ __ CVC:_____

☐ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check.

I get monthly benefits from: ☐ Social Security ☐ RRB

(The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

Please check one of the boxes below if you would prefer us to send you information in language other than English or in an accessible format:

☐Spanish ☐Large Print

Please contact ATRIO Health Plans at 1-877-672-8620 daily 8:00 a.m. to 8:00 p.m. (Pacific Time). TTY/TDD users should call 1-800-735-2900 if you need information in an accessible format or language other than what is listed above. Our office hours are Monday through Friday, 8:00 a.m. to 5:00 p.m. (Pacific Time).

Signature _____Today's Date _____

If you are the authorized representative, you must sign above and provide the following information:

Name: _____

Address: _____

Phone number: (_____) _____ – _____

Relationship to enrollee: _____

Please mail this form to: ATRIO Health Plans, 2965 Ryan Drive SE – Salem, OR 97301

Office Use Only:

Name of staff member/agent/broker (if assisted enrollment):_____

Plan ID#:_____ Effective Date of Coverage:_____

ICEP/IEP:_____ AEP:_____ SEP (type):_____ Not Eligible:_____