ATRIO Special Needs Plan (Willamette) (HMO D-SNP) offered by ATRIO Health Plans

Annual Notice of Changes for 2023

You are currently enrolled as a member of ATRIO Special Needs Plan (Willamette) (HMO D-SNP). Next year, there will be some changes to the plan's costs and benefits. ***Please see page 4 for a Summary of Important Costs, including Premium.***

This document tells about the changes to your plan. To get more information about costs, benefits, or rules please review the *Evidence of Coverage*, which is located on our website at **atriohp.com**. You may also call Customer Service to ask us to mail you an *Evidence of Coverage*.

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.

- Review the changes to Medical care costs (doctor, hospital).
- Review the changes to our drug coverage, including authorization requirements and costs.
- Think about how much you will spend on premiums, deductibles, and cost sharing.

☐ Check the changes in the 2023 Drug List to make sure the drugs you currently take are still covered.

☐ Check to see if your primary care doctors, specialists, hospitals and other providers, including pharmacies will be in our network next year.

☐ 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 Medicare Plan Finder at www.medicare.gov/plan-compare website or review the list in the back of your *Medicare & You 2023* handbook.

☐ 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 don't join another plan by December 7, 2022, you will stay in ATRIO Special Needs Plan (Willamette).

- To **change to a different plan,** you can switch plans between October 15 and December 7. Your new coverage will start on January 1, 2023. This will end your enrollment with ATRIO Special Needs Plan (Willamette).
- Look in section *2*, page 11, to learn more about your choices.
- If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can switch plans or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

Additional Resources

- This document is available for free in Spanish.
- Please contact our Customer Service number at **1-877-672-8620** for additional information. (TTY users should call). Hours are 8 a.m. to 8 p.m. local time, seven days a week from October 1 to March 31. From April 1 to September 30 hours are 8 a.m. to 8 p.m. local time, Monday through Friday.
- This document is available in other alternative formats, such as large print.
- **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 **www.irs.gov/Affordable-Care-Act/Individuals-and-Families** for more information.

About ATRIO Special Needs Plan (Willamette)

- ATRIO Health Plans has PPO and HMO D-SNP plans with Medicare and Oregon Health Plans contracts. Enrollment in ATRIO Health Plans depends on contract renewal.
- When this document says "we," "us," or "our," it means ATRIO Health Plans. When it says "plan" or "our plan," it means ATRIO Special Needs Plan (Willamette).

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Summary of Important Costs for 2023

The table below compares the 2022 costs and 2023 costs for ATRIO Special Needs Plan (Willamette) in several important areas. **Please note this is only a summary of costs**. If you are eligible for Medicare cost-sharing assistance under Oregon Health Plan (Medicaid), you pay $0 for your deductible, doctor office visits, and inpatient hospital stays.

Cost	2022 (this year)	2023 (next year)
Monthly plan premium* * Your premium may be higher than this amount. See Section 1.1 for details.	$0	$0
Doctor office visits	Primary care visits: $0 copay per visit Specialist visits: $0 copay per visit	Primary care visits: $0 copay per visit Specialist visits: $0 copay per visit
Inpatient hospital stays	$0 copay for days 1-90	$0 copay for days 1-90
Part D prescription drug coverage (See Section 1.5 for details.)	Deductible: $0 Copayment during the Initial Coverage Stage: **Drug Tier 1** LIS level 1: $3.95 for Generic drugs $9.85 for Brand and all other drugs LIS level 2: $1.35 for Generic drugs $4.00 for Brand and all other drugs LIS level 3: $0	Deductible: $0 Copayment during the Initial Coverage Stage: **Drug Tier 1** LIS level 1: $4.15 for Generic drugs $10.35 for Brand and all other drugs LIS level 2: $1.45 for Generic drugs $4.30 for Brand and all other drugs LIS level 3: $0

Cost	2022 (this year)	2023 (next year)
Maximum out-of-pocket amount This is the most you will pay out-of-pocket for your covered services. (See Section 1.2 for details.)	$6,700 You are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.	$6,700 You are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2022 (this year)	2023 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium unless it is paid for you by Oregon Health Plan (Medicaid).)	$0	$0

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

Medicare requires all health plans to limit how much you pay “out-of-pocket” for the year. This limit is called the “maximum out-of-pocket amount.” Once you reach this amount, you generally pay nothing for covered services for the rest of the year.

Cost	2022 (this year)	2023 (next year)
Maximum out-of-pocket amount **Because our members also get assistance from Medicaid, very few members ever reach this out-of-pocket maximum.** You are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services. Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount. Your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$6,700	$6,700 Once you have paid $6,700 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year.

Section 1.3 – Changes to the Provider and Pharmacy Networks

Updated *directories* are located on our website at **atriohp.com**. You may also call Customer Service for updated provider or pharmacy information or to ask us to mail you a *directory*.

There are changes to our network of providers for next year. **Please review the 2023 *Provider Directory* to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network**.

There are changes to our network of pharmacies for next year. **Please review the 2023 Pharmacy Directory to see which pharmacies are in our network**.

It is important that you know that we may make changes to the hospitals, doctors, and specialists (providers) and pharmacies that are part of your plan during the year. If a mid-year change in our providers affects you, please contact Customer Service so we may assist.

Section 1.4 – Changes to Benefits and Costs for Medical Services

Please note that the *Annual Notice of Changes* tells you about changes to your Medicare benefits and costs.

We are making changes to cost and benefits for certain medical services next year. The information below describes these changes.

Cost	2022 (this year)	2023 (next year)
Acupuncture (Non-Medicare-Covered)	Not covered	You pay $0 copay for each visit. Our plan covers up to 30 combined visits for routine acupuncture, routine chiropractic and naturopathy services every year. Must use American Specialty Health providers to pay in-network cost sharing for acupuncture services, chiropractic services and naturopathy services.
Chiropractic Services (Non-Medicare-covered)	Not covered	You pay $0 copay for each visit Our plan covers up to 30 combined visits for routine acupuncture, routine chiropractic and naturopathy services every year. Must use American Specialty Health providers to pay in-network cost sharing for acupuncture services, chiropractic services and naturopathy services.
Diabetic Services and Supplies	Prior authorization is required for items over $750. 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. 1 lancet device per 6 months for both Insulin dependent and non-Insulin dependent individuals. 1 continuous glucose monitor per 6 months for both Insulin	Prior authorization is required for items over $750. Quantity limits may apply. Diabetic supplies and services are limited to certain manufacturers. For Preferred Test Strips - OneTouch by LifeScan or FreeStyle by Abbott's. For Preferred Continuous Glucose Monitoring system - FreeStyle Libre (Abbott's) or Dexcom.

Cost	2022 (this year)	2023 (next year)
	dependent and non-Insulin dependent individuals. Prior Authorization is required for amounts exceeding this quantity limit. No limits to manufacturers for diabetic supplies or services.	
Durable Medical Equipment (DME) and Related Supplies	Prior authorization is required for all rentals. Prior authorization is required for purchases over $500	Prior authorization is required for all rentals. Prior authorization is required for purchases over $750
Fitness Benefit	The plan reimburses members up to the monthly benefit maximum of $35 for monthly membership dues to an approved community fitness center.	$450 annual allowance towards gym membership fees provided through a Flex Card.
Meals Service	Our Plan will cover up to 2 meals per day for 14 days (28 meals per episode) after an inpatient (excluding observations) or skilled nursing stay (direct admission/post hospital admits). Our Plan will cover this benefit once per year from hospital discharges. Our Plan will cover up to 2 meals per day for 14 days (28 meals per episode) for home health recipients.	Our Plan will cover up to 2 meals per day for 14 days (28 meals per episode) after an inpatient (excluding observations) or skilled nursing stay (direct admission/post hospital admits) **with prior authorization (unlimited)**. Our Plan will cover up to 2 meals per day for 14 days (28 meals per episode) for home health recipients with approved home health certification.
Medicare Part B Prescription Drugs	Step therapy is required for Part B to B drugs	Step therapy is required for Part B to B drugs, and Part D to B drugs

Cost	2022 (this year)	2023 (next year)
Naturopathy Services (Non-Medicare covered)	Not covered	You pay $0 copay for each visit Our plan covers up to 30 combined visits for routine acupuncture, routine chiropractic, and naturopathy services every year. Must use American Specialty Health providers to pay in-network cost sharing for acupuncture services, chiropractic services and naturopathy services.
Occupational Therapy Services	Prior authorization is required after 10 visits	Prior authorization is required after 20 visits
Outpatient Hospital Services	No prior authorization for Medicare-covered observation required	Prior authorization for Medicare-covered observation required
Over-the-Counter Items	You receive an allowance of $90 per quarter.	You receive an allowance of $170 per quarter.
Physical & Speech Therapy Services	Prior authorization is required after 10 visits (combined)	Prior authorization is required after 20 visits (combined)
Prosthetic Devices	Prior authorization is required for supplies over $500	Prior authorization is required for supplies over $750
Telehealth Services (Non-Medicare covered)	Not covered	You pay $0 copay for additional telehealth services. Must use Teladoc providers.
Transportation Services	Not covered	You pay $0 copay for transportation services (up to 24 one-way trips every year to plan-approved health-related locations). Must use SafeRide

Section 1.5 – Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a Formulary or "Drug List." A copy of our Drug List is provided electronically.

We made changes to our Drug List, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions.**

Most of the changes in the Drug List are new for the beginning of each year. However, during the year, we might make other changes that are allowed by Medicare rules. For instance, we can immediately remove drugs considered unsafe by the FDA or withdrawn from the market by a product manufacturer. We update our online Drug List to provide the most up to date list of drugs.

If you are affected by a change in drug coverage at the beginning of the year or during the year, please review Chapter 9 of your Evidence of Coverage and talk to your doctor to find out your options, such as asking for a temporary supply, applying for an exception and/or working to find a new drug. You can also contact Customer Service for more information.

Changes to Prescription Drug Costs

If you receive "Extra Help" to pay your Medicare prescription drugs, you may qualify for a reduction or elimination of your cost sharing for Part D drugs. Some of the information described in this section may not apply to you.

***Note**:* If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs does not apply to you.** We sent you a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also called the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug costs. If you receive "Extra Help", and you have not received this insert by September 30th, please call Customer Service and ask for the "LIS Rider."

There are four "drug payment stages." The information below shows the changes to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage).

Important Message About What You Pay for Vaccines - Our plan covers most Part D vaccines at no cost to you. Call Customer Service for more information.

Important Message About What You Pay for Insulin (Part D) - You won't pay more than $35, while you are in the Coverage Gap, for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.

Changes to the Deductible Stage

Stage	2022 (this year)	2023 (next year)
Stage 1: Yearly Deductible Stage	Because we have no deductible, this payment stage does not apply to you.	Because we have no deductible, this payment stage does not apply to you.

Changes to Your Cost Sharing in the Initial Coverage Stage

Stage	2022 (this year)	2023 (next year)
Stage 2: Initial Coverage Stage During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost.** The costs in this row are for a one-month (31-day) supply when you fill your prescription at a network pharmacy that provides standard cost sharing. The number of days in a one-month supply has changed from 2022 to 2023 as noted in the chart. For information about the costs for a long-term supply or for mail-order prescriptions, look in Chapter 6, Section 5 of your *Evidence of Coverage*.	Your cost for a 30-day supply filled at a network pharmacy with standard cost sharing: **Drug Tier 1** **LIS level 1:** You pay $3.95 per prescription for Generic drugs and $9.85 per prescription for Brand and all other drugs. **LIS level 2:** You pay $1.35 per prescription for Generic drugs and $4.00 per prescription for Brand and all other drugs. **LIS level 3:** You pay $0 per prescription. Once you have paid $7,050 out-of-pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).	Your cost for a 31-day supply filled at a network pharmacy with standard cost sharing: **Drug Tier 1** **LIS level 1:** You pay $4.15 per prescription for Generic drugs and $10.35 per prescription for Brand and all other drugs. **LIS level 2:** You pay $1.45 per prescription for Generic drugs and $4.30 per prescription for Brand and all other drugs. **LIS level 3:** You pay $0 per prescription. Once you have paid $7,400 out-of-pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).

SECTION 2 Deciding Which Plan to Choose

Section 2.1 – If you want to stay in ATRIO Special Needs Plan (Willamette)

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 be enrolled in our ATRIO Special Needs Plan (Willamette).

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 plans for 2023 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, the use the Medicare Plan Finder (www.medicare.gov/plan-compare), read the *Medicare & You 2023* handbook, call your State Health Insurance Assistance Program (see Section 4), or call Medicare (see Section 6.2).

As a reminder, ATRIO Health Plans offers other Medicare health plans and/or Medicare prescription drug 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 Special Needs Plan (Willamette).
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from ATRIO Special Needs Plan (Willamette).
- 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 so.
    - – *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.

  If you switch to Original Medicare and do **not** enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan unless you have opted out of automatic enrollment.

SECTION 3 Changing Plans

If you want to change to a different plan or Original Medicare for next year, you can do it from **October 15 until December 7**. The change will take effect on January 1, 2023.

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

In certain situations, changes are also allowed at other times of the year. Examples include 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.

If you enrolled in a Medicare Advantage plan for January 1, 2023, 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, 2023.

If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can change your Medicare coverage **at any time**. You can change to any other Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

SECTION 4 Programs That Offer Free Counseling about Medicare and Oregon Health Plan (Medicaid)

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

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 1-888-370-4307). You can learn more about SHIBA by visiting their website (**shiba.oregon.gov**).

For questions about your Oregon Health Plan (Medicaid) benefits, contact Oregon Health Plan at 1-800-273-0557 (TTY 711). Ask how joining another plan or returning to Original Medicare affects how you get your Oregon Health Plan (Medicaid) coverage.

SECTION 5 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs. Below we list different kinds of help:

- **"Extra Help" from Medicare.** Because you have Oregon Health Plan (Medicaid), you are already enrolled in "Extra Help," also called the Low Income Subsidy. "Extra Help" pays some of your prescription drug premiums, annual deductibles and coinsurance.

  Because you qualify, you do not have a coverage gap or late enrollment penalty. If you have questions about "Extra Help", 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 8 am and 7 pm, Monday through Friday for a representative. Automated messages are available 24 hours a day. TTY users should call, 1-800-325-0778; or
- Your State Medicaid Office (applications).

- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. 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. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the CAREAssist program. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call 1-971-673-0144 (TTY 711).

SECTION 6 Questions?

Section 6.1 – Getting Help from ATRIO Special Needs Plan (Willamette)

Please call Customer Service at **1-877-672-8620.** (TTY only call 711). We are available for phone calls are 8 a.m. to 8 p.m. local time, seven days a week from October 1 to March 31. From April 1 to September 30 hours are 8 a.m. to 8 p.m. local time, Monday through Friday. Calls to these numbers are free.

Read your 2023 *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 2023. For details, look in the 2023 *Evidence of Coverage* for ATRIO Special Needs Plan (Willamette). 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 located on our website at **atriohp.com**. You may also call Customer Service to ask us to mail you an *Evidence of Coverage*.

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*) and our list of covered drugs (Formulary/Drug List).

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 (**www.medicare.gov**). It has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area. To view the information about plans, go to **www.medicare.gov/plan-compare**.

Read *Medicare & You 2023*

Read the *Medicare & You 2023* handbook. Every fall, this document 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 document, you can get it at the Medicare website (https://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf) 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.

Section 6.3 – Getting Help from Oregon Health Plan (Medicaid)

To get information from Medicaid, you can call Oregon Health Plan at 1-800-273-0557. TTY users should call 711.