Ochsner Health Plan

2023 Summary of Benefits

Ascension, East Baton Rouge, East Feliciana, Iberville, Jefferson, Lafourche, Livingston, Orleans, St. Charles, St. John the Baptist, St. Tammany, West Baton Rouge

Ochsner Health Plan Freedom (HMO POS) H9763-002

Ochsner Health Plan Premier (HMO) H9763-003-001

Ochsner Health Plan Premier (HMO) H9763-003-002

Medicare Advantage Plans with Prescription Drugs

Please contact Ochsner Health Plan at 1-833-674-2112. TTY: 711.

Hours are 8:00 a.m. to 8:00 p.m. seven days a week from October 1st to March 31st and 8:00 a.m. to 8:00 p.m. Monday through Friday, April 1st to September 30th.

H9763_SB_2023_M

This is a summary of drug and health services covered by

Ochsner Health Plan Freedom (HMO POS) H9763-002
Ochsner Health Plan Premier (HMO) H9763-003-001
Ochsner Health Plan Premier (HMO) H9763-003-002

January 1, 2023 - December 31, 2023

Ochsner Health Plan is a Medicare Advantage HMO plan with a Medicare contract. Enrollment in the Plan depends on contract renewal.

The benefit information provided is a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please request the "Evidence of Coverage" by calling Member Services toll-free at 1-833-674-2112. Hours are 8:00 a.m. to 8:00 p.m. seven days a week from October 1st to March 31st and 8:00 a.m. to 8:00 p.m. Monday through Friday, April 1st to September 30th (TTY users call 711), or visit our website at www.ochsnerhealthplan.com.

To join an Ochsner Health Plan, you must be entitled to Medicare Part A, be enrolled in Medicare Part B and live in our service area. Our service area includes the following Louisiana Parishes: Ascension, East Baton Rouge, East Feliciana, Iberville, Jefferson, Lafourche, Livingston, Orleans, St. Charles, St. John the Baptist, St. Tammany, West Baton Rouge.

Ochsner Health Plan Medicare Advantage plans have a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, the plan may not pay for these services.

Because Ochsner Health Plan Freedom is an HMO-POS plan, you may use Point-of-Service (POS) providers that are outside of our network for an additional cost. Out-of-network/non-contracted providers are under no obligation to treat Ochsner Health Plan Freedom members, except in emergency situations. Please call our member services number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

Ochsner Health Plan

Premiums and Benefits	Ochsner Health Plan Premier (HMO)	Ochsner Health Plan Premier (HMO) St. Tammany	Ochsner Health Plan Freedom (HMO POS)	What You Should Know
Monthly Plan Premium	You Pay $0	You Pay $0	You Pay $0	You must continue to pay your Medicare Part B premium
Part B Premium Reduction	Up to $30 per month	Up to $17 per month	N/A	
Annual Medical Deductible	$0	$0	$0	There is no medical deductible
Maximum Out-of-Pocket Responsibility (does not include prescription drugs or out-of-network services)	$3500 annually	$3500 annually	$3700 annually	The most you pay for copays, coinsurance, and other costs for in-network medical services in a year.
Inpatient Hospital	$65 copay per day for days 1-10 for Medicare-covered hospital care. $0 copay for additional Medicare-covered days. You pay these amounts until you reach the out-of-pocket maximum.	$65 copay per day for days 1-10 for Medicare-covered hospital care. $0 copay for additional Medicare-covered days. You pay these amounts until you reach the out-of-pocket maximum.	In-network: $65 copay per day for days 1-7 for Medicare-covered hospital care. $0 copay for additional Medicare-covered days. You pay these amounts until you reach the out-of-pocket maximum. Out-of-network: 20% per stay	Our plan covers an unlimited number of days for inpatient hospital stays. *Your provider may need to obtain prior authorization*

Premiums and Benefits	Ochsner Health Plan Premier (HMO)	Ochsner Health Plan Premier (HMO) St. Tammany	Ochsner Health Plan Freedom (HMO POS)	What You Should Know
Outpatient Hospital				
• Ambulatory Surgery Center	$125 copay per visit $0 copay for diagnostic colonoscopy	$125 copay per visit $0 copay for diagnostic colonoscopy	In-network: $160 copay per visit $0 copay for diagnostic colonoscopy at an in-network facility Out-of-network: 20% coinsurance per visit	*Your provider may need to obtain prior authorization.*
• Outpatient Hospital Including Surgery	$125 copay per visit $0 copay for diagnostic colonoscopy	$125 copay per visit $0 copay for diagnostic colonoscopy	In-network: $130 copay per visit Out-of-network: 20% coinsurance per visit	
• Outpatient Observation Services	$0 copay per visit	$0 copay per visit	In-network: $0 copay per visit Out-of-network: 20% coinsurance per visit	
Doctor Visits • Primary Care	$0 copay per visit	$0 copay per visit	In-network: $0 copay per visit Out-of-network: 20% coinsurance per visit	
• Specialist Care	$20 copay per visit	$20 copay per visit	In-network: $20 copay per visit Out-of-network: 20% coinsurance per visit	
Preventive Care (e.g. flu vaccine, COVID-19 vaccine, diabetic screenings)	You pay $0 copay	You pay $0 copay	In-network: $0 copay Out-of-network: 20% coinsurance	**What You Pay for Vaccines** - Our plan covers most Part D vaccines at no cost to you. Call Member Services for more information.

Premiums and Benefits	Ochsner Health Plan Premier (HMO)	Ochsner Health Plan Premier (HMO) St. Tammany	Ochsner Health Plan Freedom (HMO POS)	What You Should Know
Emergency Care (local and world-wide)	$90 copay per visit (for both in-network and out-of-network)	$90 copay per visit (for both in-network and out-of-network)	$90 copay per visit (for both in-network and out-of-network)	If you are admitted to the hospital within one (1) day, the emergency room copay is waived.
Urgently Needed Services (local and world-wide)	$20 copay per visit (for both in-network and out-of-network)	$20 copay per visit (for both in-network and out-of-network)	$20 copay per visit (for both in-network and out-of-network)	If you are admitted to the hospital within one (1) day, the urgent care copay is waived.
Diagnostic Services/Labs/ Imaging				*Your provider may need to obtain prior authorization.*
• Diagnostic Radiology Services (e.g. MRI)	$0 copay for diagnostic mammogram	$0 copay for diagnostic mammogram	In-network: $0-$85 copay $0 copay for diagnostic mammogram Out-of-network: 20% coinsurance	
• Lab Services	$0 copay for each Medicare-covered lab service	$0 copay for each Medicare-covered lab service	In-network: $0 copay for each Medicare-covered lab service Out-of-network: 20% coinsurance	
• Diagnostic Tests and Procedures	$10 copay	$10 copay	In-network: $10 copay Out-of-network: 20% coinsurance	
• Therapeutic Radiology	$20 copay	$20 copay	In-network: $35 copay Out-of-network: 20% coinsurance	
• Outpatient X-Rays	$20 copay	$20 copay	In-network: $35 copay Out-of-network: 20% coinsurance	

Premiums and Benefits	Ochsner Health Plan Premier (HMO)	Ochsner Health Plan Premier (HMO) St. Tammany	Ochsner Health Plan Freedom (HMO POS)	What You Should Know
Hearing Services				
• Medicare-covered exam to diagnose and treat hearing and balance issues	$20 copay per visit	$20 copay per visit	In-network: $20 copay per visit Out-of-network: 20% coinsurance per visit	
• Routine hearing exam	$20 copay	$20 copay	In-network: $20 copay Out-of-network: 20% coinsurance	One (1) routine exam per calendar year.
• Hearing Aids	Reimbursement up to $1,000 maximum per calendar year for two hearing aids (one hearing aid per year) for both ears combined.	Reimbursement up to $1,000 maximum per calendar year for two hearing aids (one hearing aid per year) for both ears combined.	Reimbursement up to $1,000 maximum per calendar year for two hearing aids (one hearing aid per year) for both ears combined.	Plan will reimburse up to $1,000 maximum per calendar year for two hearing aids (one hearing aid per ear) both ears combined. Reimbursement request forms are available at www.ochsnerhealthplan.com.

Premiums and Benefits	Ochsner Health Plan Premier (HMO)	Ochsner Health Plan Premier (HMO) St. Tammany	Ochsner Health Plan Freedom (HMO POS)	What You Should Know
Dental Services				
• Preventive Dental	$0 copay for oral exams, cleaning and x-rays.	$0 copay for oral exams, cleaning and x-rays.	$0 copay for oral exams, cleaning and x-rays.	Preventive Dental (oral exams, cleaning, and dental x-ray) each service limited to two (2) treatments per year.
• Comprehensive Dental (Restorative Services, Periodontics, Extractions, Prosthodontics, Other Oral/ Maxillofacial Surgery, Other Services)	$50 deductible applies before coverage begins. $11- $295 copay for restorative services $15 for extractions $20-$217.75 copay for prosthetics, other oral/ maxillofacial surgery, & other services	$50 deductible applies before coverage begins. $11- $295 copay for restorative services $15 for extractions $20-$217.75 copay for prosthetics, other oral/ maxillofacial surgery, & other services	$50 deductible applies before coverage begins. $11- $295 copay for restorative services $15 for extractions $20-$217.75 copay for prosthetics, other oral/ maxillofacial surgery, & other services. No out-of-network coverage.	Comprehensive and Preventive dental services are limited to up to $2,000 maximum in total combined cost per calendar year. Services must be obtained from plan specified vendor. See website at www.ochsnerhealthplan.com for more information.

Ochsner Health Plan

Premiums and Benefits	Ochsner Health Plan Premier (HMO)	Ochsner Health Plan Premier (HMO) St. Tammany	Ochsner Health Plan Freedom (HMO POS)	What You Should Know
Vision Services				
• Exam to diagnose and treat conditions and diseases of the eye	$20 copay per visit	$20 copay per visit	In-network: $20 copay per visit Out-of-network: 20% coinsurance per visit	
• Eyewear post cataract surgery	$0 copay	$0 copay	In-network: $0 copay Out-of-network: 20% coinsurance	
• Routine Eye Exam	$0 copay	$0 copay	$0 copay	One (1) Routine eye exam per calendar year. Eyewear (Frames & Lenses, or Contact Lenses) - Up to $200 per calendar year. Supplemental Vision Services must be obtained from plan specified vendor. See website at www.ochsnerhealthplan.com for more information.
• Eyewear (Frames & Lenses)	$0 copay	$0 copay	$0 copay	

Premiums and Benefits	Ochsner Health Plan Premier (HMO)	Ochsner Health Plan Premier (HMO) St. Tammany	Ochsner Health Plan Freedom (HMO POS)	What You Should Know
Mental Health Services				*Your provider may need to obtain prior authorization.*
• Inpatient visit	$65 copay per day for days 1-10 for Medicare-covered hospital care. $0 copay for days 11-90	$65 copay per day for days 1-10 for Medicare-covered hospital care. $0 copay for days 11-90	$65 copay per day for days 1-4 for Medicare-covered hospital care. $0 copay for days 5-90. Out-of-network: 20% coinsurance	
• Outpatient Group Therapy Visit	$20 copay	$20 copay	In-network: $20 copay Out-of-network: 20% coinsurance	
• Outpatient Individual Therapy Visit	$20 copay	$20 copay	In-network: $20 copay Out-of-network: 20% coinsurance	

Premiums and Benefits	Ochsner Health Plan Premier (HMO)	Ochsner Health Plan Premier (HMO) St. Tammany	Ochsner Health Plan Freedom (HMO POS)	What You Should Know
Skilled Nursing Facility (SNF)	$0 copay per day for days 1-20 $165 copay per day 21-100	$0 copay per day for days 1-20 $165 copay per day 21-100	In-network: $0 per day for days 1-20, $178 per day for days 21-100 Out-of-network: 20% per day	Our plan covers up to 100 days in a SNF Zero (0) hospital days required prior to SNF admission.
Therapy Services • Occupational Therapy Visit • Physical Therapy Visit • Speech Therapy Visit	 $10 copay $10 copay $10 copay	 $10 copay $10 copay $10 copay	 In-network: $20 copay Out-of-network: 20% coinsurance	 *Your provider may need to obtain prior authorization.*
Ambulance (local and world-wide)	$235 copay for ground ambulance 20% coinsurance for air ambulance	$235 copay for ground ambulance 20% coinsurance for air ambulance	In-network: $235 copay for ground ambulance. 20% coinsurance for air ambulance. Out-of-network: 20% coinsurance for ground/air ambulance.	*Your provider may need to obtain prior authorization for Non-emergency transportation.*
Transportation	Not Covered	Not Covered	Not Covered	

Premiums and Benefits	Ochsner Health Plan Premier (HMO)	Ochsner Health Plan Premier (HMO) St. Tammany	Ochsner Health Plan Freedom (HMO POS)	What You Should Know
Medicare Part B Drugs	You pay 20% of the cost for Medicare-covered services	You pay 20% of the cost for Medicare-covered services	You pay 20% of the cost for Medicare-covered services	*Your provider may need to obtain prior authorization. For the administration of these drugs, you will pay the cost-sharing that applies to primary care provider services, specialist services, or outpatient hospital services (as described under "Physician/ Practitioner Services, including Doctor's Office Visits" or "Outpatient Hospital Services" in the Evidence of Coverage) depending on where you receive drug administration or infusion services.*
Home Health Services	You pay $0 copay for Medicare-covered services	You pay $0 copay for Medicare-covered services	In-network: You pay $0 copay for Medicare-covered services Out-of-network: 20% coinsurance for Medicare-covered services	*Your provider may need to obtain prior authorization.*
Foot Care (Podiatry)	$20 copay per visit	$20 copay per visit	In-network: $20 copay per visit Out-of-network: 20% coinsurance per visit	Your provider may need to obtain prior authorization.

Premiums and Benefits	Ochsner Health Plan Premier (HMO)	Ochsner Health Plan Premier (HMO) St. Tammany	Ochsner Health Plan Freedom (HMO POS)	What You Should Know
Medical Equipment/ Supplies • Durable Medical Equipment (e.g. wheelchairs, oxygen) • Prosthetics (e.g. braces, artificial limbs)	0% for DME from preferred provider. 20% for DME from other providers.	0% for DME from preferred provider. 20% for DME from other providers.	In-network: 0% for DME from preferred provider. Out-of-network: 20% for DME from other providers.	*Your provider may need to obtain prior authorization.*
Over-the-Counter (OTC) Items	$85 allowance every calendar quarter for specific over-the-counter-drugs and other health-related products.	$85 allowance every calendar quarter for specific over-the-counter-drugs and other health-related products.	$85 allowance every calendar quarter for specific over-the-counter-drugs and other health-related products.	Members must select OTC items through the Ochsner Health Plan OTC catalog. Any unused allowance will expire at the end of each calendar quarter.
Chiropractic Care	$20 copay per visit	$20 copay per visit	In-network: $20 copay per visit Out-of-network: 20% coinsurance per visit	Manual manipulation of the spine to correct subluxation

Ochsner Health Plan

Premiums and Benefits	Ochsner Health Plan Premier (HMO)	Ochsner Health Plan Premier (HMO) St. Tammany	Ochsner Health Plan Freedom (HMO POS)	What You Should Know
Diabetes Management				Diabetic Testing Supplies (i.e., continuous glucose monitors, glucometers, blood glucose strips, etc.) are limited to the manufacturers and brands provided by in-network DME (Durable Medical Equipment) providers or those covered by Ochsner Health Plan through participating pharmacies. All other manufacturers and brands of diabetic testing supplies are not covered for OHP Premier Plans. 20% coinsurance on OHP Freedom Plan.
• Diabetes Monitoring Supplies	$0 copay per item	$0 copay per item	In-network: $0 copay per item Out-of-network: 20% coinsurance per item	
• Diabetes Self-management Training	$0 copay per item	$0 copay per item	In-network: $0 copay per item Out-of-network: 20% coinsurance per item	
• Medicare-covered therapeutic shoes or inserts	You pay 20% coinsurance	You pay 20% coinsurance	In-network: You pay 20% coinsurance Out-of-network: 20% coinsurance	
Fitness Program	$0 copay	$0 copay	In-network: $0 copay. No out-of-network coverage.	Must use network fitness facility. Program includes fitness tracker.

Premiums and Benefits	Ochsner Health Plan Premier (HMO)	Ochsner Health Plan Premier (HMO) St. Tammany	Ochsner Health Plan Freedom (HMO POS)	What You Should Know
Meal Benefit	$0 copay	$0 copay	In-network: $0 copay. No out-of-network coverage.	Immediately following surgery or inpatient hospital stay. Nutritional need must meet CMS criteria for this benefit. Allowance: 2 meals per day for 7 days per Medicare-covered inpatient discharge. No maximum number of meals per year. Prior Authorization required.
Hospice	You pay nothing for hospice care from any Medicare-approved hospice	You pay nothing for hospice care from any Medicare-approved hospice	You pay nothing for hospice care from any Medicare-approved hospice	You may have to pay part of the costs for drugs and respite care. Hospice is covered by Original Medicare, outside of our plan.
Opioid Treatment Services	$0 copay	$0 copay	In-network: $0 copay Out-of-network: 20% coinsurance	Must be provided by a CMS certified Opioid Treatment Services Program.
Outpatient substance abuse treatment – group or individual	$20 copay	$20 copay	In-network: $20 copay Out-of-network: 20% coinsurance	*Prior authorization required.*
Renal dialysis	20% coinsurance	20% coinsurance	In-network: 20% coinsurance Out-of-network: 20% coinsurance	*Prior authorization required.*

Prescription Drugs

Stage 1: Annual Prescription Deductible	Since you have no deductible for Part D drugs, this payment stage doesn't apply.		
Stage 2: Initial Coverage (After you pay your deductible, if applicable)	**Retail 30-day supply**	**90-day supply**	**Mail Order 90-day supply**
Tier 1: Preferred Generic Drugs	$0 copay	$0 copay	$0 copay
Tier 2: Generic Drugs[1]	$10 copay	$0 copay	$0 copay
Tier 3: Preferred Brand Drugs	$45 copay	$135 copay	$135 copay
Select Insulin Drugs[2]	$35 copay	$105 copay	$105 copay
Tier 4: Non-Preferred Brand Drugs	$100 copay	$300 copay	$300 copay
Tier 5: Specialty Tier Drugs	33% coinsurance	N/A[3]	N/A[3]
Stage 3: Coverage Gap Stage	Tier 1 and Tier 2 Drugs are covered in the gap. For covered drugs on other tiers, after your total drug costs reach $4,660, you pay 25% coinsurance for generic drugs and 25% coinsurance for brand name drugs during the coverage gap.		

Prescription Drugs

Stage 4: Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $7,400, you pay the greater of: $4.15 for those generic or preferred multisource drugs with a retail price under $79 and 5% for those with a retail price greater than $79. For brand-name drugs, you would pay $10.35 for those drugs with a retail price under $197 and 5% for those with a retail price over $197.

Other Limitations May Apply

1. Tier includes enhanced drug coverage

2. **Important Message About What You Pay for Insulin** - You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on. If you have questions about the Drug List, you can also call the Pharmacy Health Desk at 1-800-910-1837, TTY users should call 711, 24 hours a day/365 days a year.

3. Limited to a 30-day supply.

Multi-Language Interpreter Service

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-833-674-2112. Someone who speaks English can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-833-674-2112. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-833-674-2112。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-833-674-2112。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-833-674-2112. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-833-674-2112. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-833-674-2112 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-833-674-2112. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-833-674-2112 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-833-674-2112. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、1-833-674-2112 にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。

Multi-Language Interpreter Service

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-833-674-2112 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-833-674-2112. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-833-674-2112. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-833-674-2112. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-833-674-2112. Ta usługa jest bezpłatna.

Arabic: **إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-833-674-2112 سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.**

Ochsner Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Ochsner Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. Ochsner Health Plan provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). Ochsner Health Plan also provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact the OHP Compliance Department. If you believe that Ochsner Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: OHP Compliance, 1450 Poydras St., PO Box #65, New Orleans, LA 70112, Phone number 1-833-937-3167, TTY 711, OHPcompliance@ochsner.org.

You can file a grievance in person or by mail, fax, or email. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 1-800-368-1019, 1-800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

For more information, contact Ochsner Health Plan from 8:00 a.m. to 8:00 p.m. seven days a week from October 1st to March 31st and 8:00 a.m. to 8:00 p.m. Monday through Friday April 1st to September 30th at 1-833-674-2112(TTY users call 711) or visit www.ochsnerhealthplan.com.

You can access the Ochsner Health Plan provider or pharmacy directory on our website at www.ochsnerhealthplan.com.

For coverage and costs of Original Medicare look in your current "Medicare & You" handbook. View it online at www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Ochsner Health Plan is an HMO with a Medicare Contract. Enrollment in Ochsner Health Plan depends on contract renewal.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premium and/or copayments/coinsurance may change on January 1 of each year.

You must continue to pay your Medicare Part B premium.

This document is available in alternate formats (braille, large print, etc.) and other languages upon request. Please call Member Services at 1-833-674-2112 (TTY/TDD users call 711) from 8:00 a.m. to 8:00 p.m. seven days a week from October 1st to March 31st and 8:00 a.m. to 8:00 p.m. Monday through Friday April 1st to September 30th.

The pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

Toll-free: 1-833-674-2112 (TTY/TDD users should call 711)

Hours are 8:00 a.m. to 8:00 p.m. seven days a week from October 1st to March 31st

and 8:00 a.m. to 8:00 p.m. Monday through Friday, April 1st to September 30th.

ochsnerhealthplan.com

Ochsner Health Plan

Ochsner Health Plan
1450 Poydras St., Suite 110
New Orleans, LA 70112
1-833-674-2112 Member Services
www.ochsnerhealthplan.com

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