

Medicare Advantage plan
with prescription drugs



Annual Notice of Changes 2025

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

If you have any questions about this notice, please contact Member Services at 1-833-674-2112 (TTY users should call 711) 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 or at www.ochsnerhealthplan.com.

OMB Approval 0938-1051 (Expires: August 31, 2026)

Ochsner Health Plan Premier (HMO) offered by Ochsner Health Plan, Inc.

Annual Notice of Changes for 2025

You are currently enrolled as a member of Ochsner Health Plan Premier. Next year, there will be 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 www.ochsnerhealthplan.com. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

- **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.
 - Review the changes to medical care costs (doctor, hospital).
 - Review the changes to our drug coverage, including coverage restrictions and cost sharing.
 - Think about how much you will spend on premiums, deductibles, and cost sharing.
 - Check the changes in the 2025 "Drug List" to make sure the drugs you currently take are still covered.
 - Compare the 2024 and 2025 plan information to see if any of these drugs are moving to a different cost-sharing tier or will be subject to different restrictions, such as prior authorization, step therapy, or a quantity limit, for 2025.
- Check to see if your primary care doctors, specialists, hospitals, and other providers, including pharmacies, will be in our network next year.
- Check if you qualify for help paying for prescription drugs. People with limited incomes may qualify for "Extra Help" from Medicare.
- 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 the www.medicare.gov/plan-compare website or review the list in the back of your *Medicare & You 2025* handbook. For additional support, contact your State Health Insurance Assistance Program (SHIP) to speak with a trained counselor.
- 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, 2024, you will stay in Ochsner Health Plan Premier.
- To change to a **different plan**, you can switch plans between October 15 and December 7. Your new coverage will start on **January 1, 2025**. This will end your enrollment with Ochsner Health Plan Premier.
- If you recently moved into or currently live in 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. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for two full months after the month you move out.

Additional Resources

- Please contact our Member Services number at 1-833-674-2112 for additional information. (TTY 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. This call is free.
- This document is available in alternate formats (e.g., braille, large print, etc.) upon request. Please contact Member Services for more information. (Phone numbers are printed on the back cover of this booklet).
- **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 Ochsner Health Plan Premier

- Ochsner Health Plan is a Medicare Advantage HMO and HMO D-SNP plan with a Medicare contract. Dual Special Needs Plans also have a contract with the State Medicaid Program. Enrollment in the plan depends on contract renewal.
- When this document says “we,” “us,” or “our,” it means Ochsner Health Plan, Inc. When it says “plan” or “our plan,” it means Ochsner Health Plan Premier.

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Summary of Important Costs for 2025

The table below compares the 2024 costs and 2025 costs for Ochsner Health Plan Premier in several important areas. **Please note this is only a summary of costs.**

Cost	2024 (this year)	2025 (next year)
<p>Monthly plan premium*</p> <p>* Your premium may be higher than this amount. See Section 1.1 for details.</p>	\$0	\$0
		There is no change for the upcoming benefit year.
<p>Maximum out-of-pocket amount</p> <p>This is the <u>most</u> you will pay out of pocket for your covered Part A and Part B services. (See Section 1.2 for details.)</p>	\$4,500	\$4,500
<p>Doctor office visits</p>	<p>Primary care visits:</p> <p>\$0 copayment per visit</p> <p>Specialist visits:</p> <p>\$25 copayment per visit</p>	<p>Primary care visits:</p> <p>\$0 copayment per visit</p> <p>Specialist visits:</p> <p>\$25 copayment per visit</p>
<p>Inpatient hospital stays</p>	<p>For each Medicare-covered inpatient stay, your copayment is:</p> <p>Days 1-10: \$175 copayment per day</p> <p>Days 11-90: \$0 copayment per day</p>	<p>For each Medicare-covered inpatient stay, your copayment is:</p> <p>Days 1-10: \$180 copayment per day</p> <p>Days 11-90: \$0 copayment per day</p>

Cost	2024 (this year)	2025 (next year)
<p>Part D prescription drug coverage (See Section 1.5 for details.)</p>	<p>Copayment/Coinsurance during the Initial Coverage Stage:</p> <ul style="list-style-type: none"> • Drug Tier 1: \$0 copayment • Drug Tier 2¹: \$10 copayment • Drug Tier 3: \$45 copayment <ul style="list-style-type: none"> • You pay \$35 per month supply of each covered insulin product on this tier. • Drug Tier 4: \$100 copayment <ul style="list-style-type: none"> • You pay \$35 per month supply of each covered insulin product on this tier. • Drug Tier 5²: 33% of the total cost <ul style="list-style-type: none"> • You pay \$35 per month supply of each covered insulin product on this tier. <p>Catastrophic Coverage</p> <ul style="list-style-type: none"> • During this payment stage, the plan pays the full cost for your covered Part D drugs. • You may have cost sharing for drugs that are covered under our enhanced benefit. 	<p>Copayment/Coinsurance during the Initial Coverage Stage:</p> <ul style="list-style-type: none"> • Drug Tier 1: \$0 copayment • Drug Tier 2¹: \$10 copayment • Drug Tier 3: \$45 copayment <ul style="list-style-type: none"> • You pay \$35 per month supply of each covered insulin product on this tier. • Drug Tier 4: \$100 copayment <ul style="list-style-type: none"> • You pay \$35 per month supply of each covered insulin product on this tier. • Drug Tier 5²: 33% of the total cost <ul style="list-style-type: none"> • You pay \$35 per month supply of each covered insulin product on this tier. <p>Catastrophic Coverage:</p> <ul style="list-style-type: none"> • During this payment stage, you pay nothing for your covered Part D drugs. • You may have cost sharing for drugs that are covered under our enhanced benefit.

¹ Tier 2 copayment for a 3-month supply \$25. Tier 2 also includes enhanced drug coverage.

² Limited up to a 30-day supply.

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2024 (this year)	2025 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	\$0	\$0 There is no change for the upcoming benefit year.
Part B premium reduction	Up to \$10	Not applicable

- Your monthly plan premium will be *more* if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as creditable coverage) for 63 days or more.
- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.

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 Part A and Part B services for the rest of the year.

Cost	2024 (this year)	2025 (next year)
Maximum out-of-pocket amount 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.	\$4,500	\$4,500 Once you have paid \$4,500 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. There is no change for the upcoming benefit year.

Section 1.3 – Changes to the Provider and Pharmacy Networks

Amounts you pay for your prescription drugs may depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered *only* if they are filled at one of our network pharmacies.

Updated directories are located on our website at www.ochsnerhealthplan.com. You may also call Member Services for updated provider and/or pharmacy information or to ask us to mail you a directory, which we will mail within three business days.

There are changes to our network of providers for next year. **Please review the 2025 *Provider Directory* at www.ochsnerhealthplan.com 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 2025 *Pharmacy Directory* at www.ochsnerhealthplan.com 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 Member Services so we may assist.

Section 1.4 – Changes to Benefits and Costs for Medical Services

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

Cost	2024 (this year)	2025 (next year)
Blood	Coverage of whole blood and packed red cells begins only with the fourth pint of blood that you need.	Coverage of whole blood and packed red cells begins only with the first pint of blood that you need.
Comprehensive dental services	Service category applies to the Maximum Out-of-Pocket (MOOP)	Service category does not apply to the Maximum Out-of-Pocket (MOOP)
Medicare-covered dental services	Service category does not apply to the Maximum Out-of-Pocket (MOOP)	Service category applies to the Maximum Out-of-Pocket (MOOP)

Cost	2024 (this year)	2025 (next year)
<p>Combined supplemental dental services</p>	<p>Non-Medicare preventive and comprehensive dental services are limited to up to \$3,000 in total combined cost per calendar year.</p> <p>Oral Exams Prophylaxis (Cleaning) Dental X-Rays Non-routine Services Diagnostic Services Restorative Services Endodontics Periodontics Extractions Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services</p>	<p>Non-Medicare preventive and comprehensive dental services are limited to up to \$3,000 in total combined cost per calendar year.</p> <p>Oral Exams Prophylaxis (Cleaning) Dental X-Rays Restorative Services Endodontics Periodontics Prosthodontics, removable Oral/Maxillofacial Surgery Adjunctive General Service</p>
<p>Emergency services</p>	<p>\$90 copayment per visit</p>	<p>\$140 copayment per visit</p>
<p>Inpatient hospital - acute</p>	<p>For each Medicare-covered inpatient stay, your copayment is:</p> <p>Days 1-10: \$175 copayment per day</p> <p>Days 11-90: \$0 copayment per day</p>	<p>For each Medicare-covered inpatient stay, your copayment is:</p> <p>Days 1-10: \$180 copayment per day</p> <p>Days 11-90: \$0 copayment per day</p>

Cost	2024 (this year)	2025 (next year)
Inpatient hospital - psychiatric	<p>For each Medicare-covered inpatient stay, your copayment is:</p> <p>Days 1-10: \$175 copayment per day</p> <p>Days 11-90: \$0 copayment per day</p>	<p>For each Medicare-covered inpatient stay, your copayment is:</p> <p>Days 1-10: \$180 copayment per day</p> <p>Days 11-90: \$0 copayment per day</p>
OTC (Over-the-Counter) Benefit	<p>\$85 maximum allowance per calendar quarter for covered over-the-counter (OTC) drugs and health-related items.</p> <p>Members access this allowance through a designated “wallet” on the Ochsner Health Plan Flex Card. See Over-the-Counter (OTC) Benefit in Chapter 4 of the Evidence of Coverage for more information.</p>	<p>\$90 maximum allowance per calendar quarter for covered over-the-counter (OTC) drugs and health-related items.</p> <p>Members access this allowance through a designated “wallet” on the Ochsner Health Plan Flex Card. See Over-the-Counter (OTC) Benefit in Chapter 4 of the Evidence of Coverage for more information.</p>
Therapeutic radiological services	\$20 copayment per visit	\$80 copayment per visit
Skilled nursing facility (SNF)	<p>Days 1 – 20: \$0 copayment per day</p> <p>Days 21 – 100: \$165 copayment per day</p> <p>Three (3) consecutive day inpatient hospital stay required prior to SNF admission.</p>	<p>Days 1 – 20: \$0 copayment per day</p> <p>Days 21 – 100: \$165 copayment per day</p> <p>Prior inpatient hospital stay not required.</p>
Value-Based Incentive Design (VBID)	Not covered.	Eligible members may use the \$85 maximum allowance per calendar quarter for covered over-the-counter (OTC) items

Cost	2024 (this year)	2025 (next year)
Value-Based Incentive Design (VBID) (continued)		and health-related items for food and produce, and transportation services to any health-related location. Members access this allowance through a designated “wallet” on the Ochsner Health Plan Flex Card.
Urgently needed services	\$25 copayment per visit	\$35 copayment per visit
Worldwide emergency services	\$90 copayment per visit	\$140 copayment per visit
Worldwide urgently needed services	\$25 copayment per visit	\$35 copayment per visit

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. The Drug List includes many – but not all – of the drugs that we will cover next year. If you don’t see your drug on this list, it might still be covered. **You can get the *complete Drug List*** by calling Member Services (see the back cover) or visiting our website (www.ochsnerhealthplan.com).

We made changes to our “Drug List,” which could include removing or adding drugs, changing the restrictions that apply to our coverage for certain drugs or moving them to a different cost-sharing tier. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions, or if your drug has been moved to a different cost-sharing tier.**

Most of the changes in the Drug List are new for the beginning of each year. However, we might make other changes that are allowed by Medicare rules that will affect you during the plan year. We update our online Drug List at least monthly to provide the most up-to-date list of drugs. If we make a change that will affect your access to a drug you are taking, we will send you a notice about the change.

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 Member Services for more information.

We currently can immediately remove a brand name drug on our Drug List if we replace it with a new generic drug version on the same or a lower cost-sharing tier and [Plans that do not use tiers may omit “on the same or a lower cost-sharing tier and.”] with the same or fewer restrictions as the brand name drug it replaces. Also, when adding a new generic, we may also decide to keep the brand name drug on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions or both.

Starting in 2025, we can immediately replace original biological products with certain biosimilars. This means, for instance, if you are taking an original biological product that is being replaced by a biosimilar, you may not get notice of the change 30 days before we make it or get a month’s supply of your original biological product at a network pharmacy. If you are taking the original biological product at the time we make the change, you will still get information on the specific change we made, but it may arrive after we make the change. Some of these drug types may be new to you. For definitions of drug types, please see Chapter 12 of your Evidence of Coverage. The Food and Drug Administration (FDA) also provides consumer information on drugs. See FDA website: <https://www.fda.gov/drugs/biosimilars/multimedia-education-materials-biosimilars#For%20Patients>. You may also contact Member Services or ask your health care provider, prescriber, or pharmacist for more information.

Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs (“Extra Help”), **the information about costs for Part D prescription drugs: may not apply to you.** We have included 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 didn’t receive this insert with this packet, please call Member Services and ask for the *LIS Rider*.

Beginning in 2025, there are three **drug payment stages:** the Yearly Deductible Stage, the Initial Coverage Stage and the Catastrophic Coverage Stage. The Coverage Gap Stage and the Coverage Gap Discount Program will no longer exist in the Part D benefit.

The Coverage Gap Discount Program will also be replaced by the Manufacturer Discount Program. Under the Manufacturer Discount Program, drug manufacturers pay a portion of the plan’s full cost for covered Part D brand name drugs and biologics during the Initial Coverage Stage and the Catastrophic Coverage Stage. Discounts paid by manufacturers under the Manufacturer Discount Program do not count toward out-of-pocket costs.

Changes to the Deductible Stage

Stage	2024 (this year)	2025 (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

Please see the following chart for the changes from 2024 to 2025.

Stage	2024 (this year)	2025 (next year)
<p>Stage 2: Initial Coverage Stage</p> <p>During this stage, the plan pays its share of the cost of your drugs, and you pay your share of the cost.</p> <p>The costs in this chart are for a one-month (30-day) supply when you fill your prescription at a network pharmacy that provides standard cost sharing.</p> <p>For information about the costs for a long-term supply look in Chapter 6, Section 5 of your <i>Evidence of Coverage</i>.</p> <p>We changed the tier for some of the drugs on our “Drug List.” To see if your drugs will be in a different tier, look them up on the “Drug List.”</p> <p>Most adult Part D vaccines are covered at no cost to you.</p>	<p>Your cost for a one-month supply filled at a network pharmacy with standard cost sharing:</p> <p>Tier 1 - Preferred Generics You pay \$0 per prescription.</p> <p>Tier 2 – Generic Drugs¹ You pay \$10 per prescription</p> <p>Tier 3 – Preferred Brands You pay \$45 per prescription</p> <p>Tier 4 – Non-Preferred Drugs You pay \$100 per prescription</p> <p>Tier 5 – Specialty Drugs² You pay 33% per prescription</p> <p>Once your total drug costs have reached \$5,030 you will move to the next stage (the Coverage Gap Stage).</p>	<p>Your cost for a one-month supply filled at a network pharmacy with standard cost sharing:</p> <p>Tier 1 - Preferred Generics You pay \$0 per prescription.</p> <p>Tier 2 – Generic Drugs¹ You pay \$10 per prescription</p> <p>Tier 3 – Preferred Brands You pay \$45 per prescription</p> <p>Tier 4 – Non-Preferred Drugs You pay \$100 per prescription</p> <p>Tier 5 – Specialty Drugs² You pay 33% per prescription</p> <p>Once you have paid \$2,000 out of pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).</p>

¹ Tier 2 also includes enhanced drug coverage.

² Limited up to a 30-day supply.

Changes to the Catastrophic Coverage Stages

The Catastrophic Coverage Stage is the third and final stage. Beginning in 2025, drug manufacturers pay a portion of the plan’s full cost for covered Part D brand name drugs and biologics during the Catastrophic Coverage Stage. Discounts paid by manufacturers under the Manufacturer Discount Program do not count toward out-of-pocket costs.

If you reach the Catastrophic Coverage Stage, you pay nothing for your covered Part D drugs. You may have cost sharing for excluded drugs that are covered under our enhanced benefit.

For specific information about your costs in these stages, look at Chapter 6, Section 6 in your *Evidence of Coverage*.

SECTION 2 Administrative Changes

Description	2024 (this year)	2025 (next year)
Medicare Prescription Payment Plan	Not applicable	<p>The Medicare Prescription Payment Plan is a new payment option that works with your current drug coverage, and it can help you manage your drug costs by spreading them across monthly payments that vary throughout the year (January – December).</p> <p>To learn more about this payment option, please contact us (see the back cover) or visit Medicare.gov.</p>

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in Ochsner Health Plan Premier

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 Ochsner Health Plan Premier.

Section 3.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change plans for 2025 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. If you do not enroll in a Medicare drug plan, please see Section 1.1 regarding a potential Part D late enrollment penalty.

To learn more about Original Medicare and the different types of Medicare plans, use the Medicare Plan Finder (www.medicare.gov/plan-compare), read the *Medicare & You 2025* handbook, call your State Health Insurance Assistance Program (see Section 4), or call Medicare (see Section 6.2).

Step 2: Change your coverage

- To **change to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from Ochsner Health Plan Premier.
- To **change to Original Medicare with a prescription drug plan**, enroll in the new drug plan. You will automatically be disenrolled from Ochsner Health Plan Premier.
- To **change to Original Medicare without a prescription drug plan**, you must either:
 - Send us a written request to disenroll. Contact Member Services 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.

SECTION 4 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, 2025.

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, 2025, 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, 2025.

If you recently moved into or currently live in 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. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for two full months after the month you move out.

SECTION 5 Programs That Offer Free Counseling about Medicare

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

It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. Louisiana Senior Health Insurance Information Program 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 the Louisiana Senior Health Insurance Information Program at 1-800-259-5300. You can learn more about the Louisiana Senior Health Insurance Information Program by visiting their website (<https://www.ldi.la.gov/consumers/senior-health-shiip>).

SECTION 6 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.** 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, yearly deductibles, and coinsurance. Additionally, those who qualify will not have a late enrollment penalty. 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 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.
- **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. 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. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the Louisiana Health Access

Program, 504-568-7474 or by email lahap@la.gov. For information on eligibility criteria, covered drugs, how to enroll in the program or if you are currently enrolled how to continue receiving assistance, call, Louisiana Health Access Program, 504-568-7474 or by email lahap@la.gov. Be sure, when calling, to inform them of your Medicare Part D plan name or policy number.

- **The Medicare Prescription Payment Plan.** The Medicare Prescription Payment Plan is a new payment option to help you manage your out-of-pocket drug costs, starting in 2025. This new payment option works with your current drug coverage, and it can help you manage your drug costs by spreading them across **monthly payments that vary throughout the year (January – December)**. **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs.**

“Extra Help” from Medicare and help from your ADAP, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan. All members are eligible to participate in this payment option, regardless of income level, and all Medicare drug plans and Medicare health plans with drug coverage must offer this payment option. To learn more about this payment option, please contact us at (see the back cover) or visit Medicare.gov.

SECTION 7 Questions?

Section 7.1 – Getting Help from Ochsner Health Plan Premier

Questions? We're here to help. Please call Member Services at 1-833-674-2112. (TTY only, call 711). We are available for phone calls 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. Calls to these numbers are free.

Read your 2025 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 2025. For details, look in the *2025 Evidence of Coverage* for Ochsner Health Plan Premier. 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 www.ochsnerhealthplan.com. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

Visit our Website

You can also visit our website at www.ochsnerhealthplan.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 7.2 – 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

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 2025*

Read the *Medicare & You 2025* 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.