Ochsner Health Plan

Baton Rouge & New Orleans Region

2025 Summary of Benefits

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

Ochsner Health Plan Freedom (HMO POS)
H9763-004-001

Ochsner Health Plan Heroes (HMO POS)
H9763-006

Ochsner Health Plan
1-833-674-2112 (TTY: 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.

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

H9763_003-1_004-1_006_SB2_2025_M

Ochsner Health Plan

MEMBER SERVICES:

1-833-674-2112 (TTY: 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.

ochsnerhealthplan.com

Ochsner Health Plan
1450 Poydras St., Suite 110
New Orleans, LA 70112

H9763_003-1_004-1_006_SB2_2025_M

THIS IS A SUMMARY OF DRUG AND HEALTH SERVICES COVERED BY

Ochsner Health Plan Premier (HMO) H9763-003-001
Ochsner Health Plan Freedom (HMO POS) H9763-004-001
Ochsner Health Plan Heroes (HMO) H9763-006

JANUARY 1, 2025 – DECEMBER 31, 2025

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.

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. The service area for Ochsner Health Plan Premier 003-001, Freedom 004-001, and Heroes 006 plans includes the following Louisiana parishes*: Ascension, East Baton Rouge, East Feliciana, Iberville, Jefferson, Lafourche, Livingston, Plaquemines*, Orleans, St. Bernard*,St. Charles, St. John the Baptist, 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 and Ochsner Health Plan Heroes are HMO-POS plans, 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 or Ochsner Health Plan Heroes 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.

** Heroes 006 does not include Plaquemines and St. Bernard.*

Ochsner Health Plan

Premiums and Benefits	Ochsner Health Plan Premier (HMO)	Ochsner Health Plan Freedom (HMO POS)	Ochsner Health Plan Heroes (HMO POS)	What You Should Know
Monthly Plan Premium	You pay $0 per month	You pay $0 per month	You pay $0 per month	You must continue to pay your Medicare Part B premium.
Part B Premium Reduction	$24 per month	Not applicable.	$100 per month	
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)	$2,900 annually	**In-network** $4,100 annually **Out-of-network** $8,000 annually	**In-network** $4,450 annually **Out-of-network** $8,000 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 per admission $0 copay for days 11 and beyond per admission You pay these amounts until you reach the out-of-pocket maximum.	**In-network** $175 copay per day for days 1-10 per admission $0 copay for days 11 and beyond per admission You pay these amounts until you reach the out-of-pocket maximum. **Out-of-network** 20% per admission	**In-network** $175 copay per day for days 1-10 per admission $0 copay for days 11 and beyond per admission You pay these amounts until you reach the out-of-pocket maximum. **Out-of-network** 20% per admission	*Your provider may need to obtain prior authorization.*

Premiums and Benefits	Ochsner Health Plan Premier (HMO)	Ochsner Health Plan Freedom (HMO POS)	Ochsner Health Plan Heroes (HMO POS)	What You Should Know
Outpatient Hospital				
Ambulatory Surgery Center	$100 copay per visit $0 copay for diagnostic colonoscopy	**In-network** $130 copay per visit $0 copay for diagnostic colonoscopy **Out-of-network** 20% coinsurance per visit	**In-network** $175 copay per visit $0 copay for diagnostic colonoscopy **Out-of-network** 20% coinsurance per visit	*Your provider may need to obtain prior authorization.*
Outpatient Hospital Including Surgery	$100 copay per visit $0 copay for diagnostic colonoscopy	**In-network** $130 copay per visit $0 copay for diagnostic colonoscopy **Out-of-network** 20% coinsurance per visit	**In-network** $175 copay per visit $0 copay for diagnostic colonoscopy **Out-of-network** 20% coinsurance per visit	*Your provider may need to obtain prior authorization.*
Outpatient Observation Services	$0 copay per visit	**In-network** $0 copay per visit **Out-of-network** 20% coinsurance per visit	**In-network** $0 copay per visit **Out-of-network** 20% coinsurance per visit	*Your provider may need to obtain prior authorization.*
Doctor Visits				
Primary Care	$0 copay per visit	**In-network** $0 copay per visit **Out-of-network** 20% coinsurance per visit	**In-network** $0 copay per visit **Out-of-network** 20% coinsurance per visit	
Specialist Care	$25 copay per visit	**In-network** $25 copay per visit **Out-of-network** 20% coinsurance per visit	**In-network** $25 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	**In-network** $0 copay per visit **Out-of-network** Not covered.	**In-network** $0 copay per visit **Out-of-network** Not covered.	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 Freedom (HMO POS)	Ochsner Health Plan Heroes (HMO POS)	What You Should Know
Emergency Care (local and world-wide)	$140 copay per visit (for both in-network and out-of-network)	$140 copay per visit (for both in-network and out-of-network)	$125 in-network. $140 copay per visit worldwide emergency care.	If you are admitted to the hospital within 24 hours, the emergency room copay is waived.
Urgently Needed Services (local and world-wide)	$35 copay per visit (for both in-network and out-of-network)	$35 copay per visit (for both in-network and out-of-network)	$35 copay per visit (for both in-network and out-of-network)	
Diagnostic Services/ Labs/Imaging	$0 copay for diagnostic mammogram	**In-network** $0 copay for diagnostic mammogram	**In-network** $0 copay per visit **Out-of-network** 20% coinsurance per visit	*Your provider may need to obtain prior authorization.*
Diagnostic Radiology Services (e.g. MRI)	$100 copay for Medicare-covered radiological diagnostic services	$85 copay for Medicare-covered radiological diagnostic services **Out-of-network** 20% coinsurance	$125 copay for Medicare-covered radiological diagnostic services **Out-of-network** 20% coinsurance	*Your provider may need to obtain prior authorization.*
Lab Services	$0 copay for each Medicare-covered lab service	**In-network** $0 copay for each Medicare-covered lab service **Out-of-network** 20% coinsurance	**In-network** $0 copay for each Medicare-covered lab service **Out-of-network** 20% coinsurance	*Your provider may need to obtain prior authorization.*
Diagnostic Tests and Procedures	$10 copay for diagnostic tests/ procedures	**In-network** $10 copay for diagnostic tests/ procedures **Out-of-network** 20% coinsurance	**In-network** $10 copay per visit **Out-of-network** Not covered.	*Your provider may need to obtain prior authorization.*
Therapeutic Radiology	$80 copay for Medicare-covered therapeutic radiology	**In-network** $80 copay for Medicare-covered therapeutic radiology **Out-of-network** 20% coinsurance	**In-network** $50 copay copay for diagnostic tests/ procedures **Out-of-network** 20% coinsurance	*Your provider may need to obtain prior authorization.*
Outpatient X-Rays	$20 copay for Medicare-covered outpatient x-rays	**In-network** $35 copay for Medicare-covered outpatient x-rays **Out-of-network** 20% coinsurance	**In-network** $50 copay for Medicare-covered outpatient x-rays **Out-of-network** 20% coinsurance	*Your provider may need to obtain prior authorization.*

Premiums and Benefits	Ochsner Health Plan Premier (HMO)	Ochsner Health Plan Freedom (HMO POS)	Ochsner Health Plan Heroes (HMO POS)	What You Should Know
Hearing Services				
Medicare-covered diagnostic hearing and balance evaluation exam	$25 copay	**In-network** $20 copay **Out-of-network** 20% coinsurance	**In-network** $20 copay **Out-of-network** 20% coinsurance	
Prescription hearing aids **Routine hearing exams** **Hearing aid fitting/evaluations**	Members receive a $2,000 combined maximum allowance per calendar year for: - Prescription hearing aids - Routine hearing exams - Hearing aid fitting/ evaluations Members access this allowance through a designated "wallet" on the Ochsner Health Plan Flex Card. See Ochsner Health Plan Flex Card section for more information.	Members receive a $2,000 combined maximum allowance per calendar year for: - Prescription hearing aid - Routine hearing exams - Hearing aid fitting/ evaluations Members access this allowance through a designated "wallet" on the Ochsner Health Plan Flex Card. See Ochsner Health Plan Flex Card section for more information.	Members receive a $1,000 combined maximum allowance per calendar year for: - Prescription hearing aid - Routine hearing exams - Hearing aid fitting/ evaluations Members access this allowance through a designated "wallet" on the Ochsner Health Plan Flex Card. See Ochsner Health Plan Flex Card section for more information.	The Ochsner Health Plan Flex Card hearing allowance can be used to help cover costs for routine hearing care including, prescription hearing aids, routine hearing exams and hearing aid fitting/evaluations at participating retailers, online and at qualified hearing provider locations. Visit https://flex.ochsnerhealthplan.com/ for more information.

Premiums and Benefits	Ochsner Health Plan Premier (HMO)	Ochsner Health Plan Freedom (HMO POS)	Ochsner Health Plan Heroes (HMO POS)	What You Should Know
Dental Services				
Preventive Dental	$0 copay per Medicare-covered visit	**In-network** $0 copay per Medicare-covered visit	**In-network** $0 copay per Medicare-covered visit	Preventive Dental (oral exams and cleanings) each service limited to two (2) treatments per year.
Comprehensive Dental	$3,000 combined maximum allowance per calendar year for preventive and comprehensive dental services. Covered services include: preventive oral exams, cleanings, x-rays, restorative services, endodontics, periodontics, prosthodontics (removable), oral and maxillofacial surgery, and adjunctive general services. Copays vary, please see your Evidence of Coverage for more information.	$3,000 combined maximum allowance per calendar year for preventive and comprehensive dental services. Covered services include: preventive oral exams, cleanings, x-rays, restorative services, endodontics, periodontics, prosthodontics (removable), oral and maxillofacial surgery, and adjunctive general services. Copays vary, please see your Evidence of Coverage for more information.	$3,000 combined maximum allowance per calendar year for preventive and comprehensive dental services. Covered services include: preventive oral exams, cleanings, x-rays, restorative services, endodontics, periodontics, prosthodontics (removable), oral and maxillofacial surgery, and adjunctive general services. Copays vary, please see your Evidence of Coverage for more information.	Preventive and comprehensive dental services must be obtained from plan specified vendor. Visit www.ochsnerhealthplan.com for more information. *Your provider may need to obtain prior authorization.*

Premiums and Benefits	Ochsner Health Plan Premier (HMO)	Ochsner Health Plan Freedom (HMO POS)	Ochsner Health Plan Heroes (HMO POS)	What You Should Know
Vision Services				
Medicare-covered eye exam to diagnose and treat conditions and diseases of the eye **Medicare-covered glaucoma screening**	$25 copay per visit **In-network** $0 copay **Out-of-network** Not covered.	**In-network** $20 copay per visit **Out-of-network** 20% coinsurance **In-network** $0 copay **Out-of-network** 20% coinsurance	**In-network** $20 copay per visit **Out-of-network** 20% coinsurance **In-network** $0 copay **Out-of-network** 20% coinsurance	
Medicare-covered eyewear (frames and lenses, or contact lenses) post cataract surgery	$0 copay	**In-network** $0 copay **Out-of-network** 20% coinsurance	**In-network** $0 copay **Out-of-network** 20% coinsurance	
Routine eye exams	$25 copay	$20 copay	$20 copay	Routine eye exams are limited to one (1) exam per calendar year.
Routine eyewear (frames and lenses or contact lenses)	$400 maximum allowance per calendar year	$400 maximum allowance per calendar year No out-of-network coverage for routine eye exams and routine eyewear.	$300 maximum allowance per calendar year No out-of-network coverage for routine eye exams and routine eyewear.	Routine eye exams and routine eyewear services must be obtained from plan specified vendor. Visit www.ochsnerhealthplan.com for more information.

Premiums and Benefits	Ochsner Health Plan Premier (HMO)	Ochsner Health Plan Freedom (HMO POS)	Ochsner Health Plan Heroes (HMO POS)	What You Should Know
Mental Health Services				
Inpatient visit	$65 copay per day for days 1-10 per admission $0 copay for days 11-90 per admission You pay these amounts until you reach the out-of-pocket maximum.	**In-network** $175 copay per day for days 1-10 per admission $0 copay for days 11-90 per admission You pay these amounts until you reach the out-of-pocket maximum. **Out-of-network** 20% coinsurance	**In-network** $175 copay per day for days 1-10 per admission $0 copay for days 11-90 per admission You pay these amounts until you reach the out-of-pocket maximum. **Out-of-network** 20% coinsurance	*Your provider may need to obtain prior authorization.*
Outpatient Group Therapy Visit	$25 copay	**In-network** $25 copay **Out-of-network** 20% coinsurance	**In-network** $25 copay **Out-of-network** 20% coinsurance	*Your provider may need to obtain prior authorization.*
Outpatient Individual Therapy Visit	$25 copay	**In-network** $25 copay **Out-of-network** 20% coinsurance	**In-network** $25 copay **Out-of-network** 20% coinsurance	*Your provider may need to obtain prior authorization.*

Premiums and Benefits	Ochsner Health Plan Premier (HMO)	Ochsner Health Plan Freedom (HMO POS)	Ochsner Health Plan Heroes (HMO POS)	What You Should Know
Skilled Nursing Facility (SNF)	$0 copay per day for days 1-20 per admission $165 copay for days 21-100 per admission	**In-network** $0 copay per day for days 1-20 per admission $178 copay for days 21-100 per admission **Out-of-network** 20% per admission	**In-network** $0 copay per day for days 1-20 per admission $178 copay for days 21-100 per admission **Out-of-network** 20% per admission	Your provider may need to obtain prior authorization. Our plan covers up to 100 days in a SNF. Inpatient hospital stay is not required prior to SNF admission.
Therapy Services Occupational Therapy Visit Physical Therapy Visit Speech Therapy Visit	$10 copay per visit $10 copay per visit $10 copay per visit	**In-network** $20 copay per visit **Out-of-network** 20% coinsurance per visit	**In-network** $20 copay per visit **Out-of-network** 20% coinsurance per visit	*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	$235 copay for ground ambulance 20% coinsurance for 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 Freedom (HMO POS)	Ochsner Health Plan Heroes (HMO POS)	What You Should Know
Medicare Part B Drugs	You pay 0% - 20% of the cost for Medicare-covered Part B drugs You pay $35 copay for one month supply of covered Medicare Part B insulin.	**In-network** You pay 0% - 20% of the cost for Medicare-covered Part B drugs You pay $35 copay for one month supply of covered Medicare Part B insulin. **Out-of-network** 20% coinsurance	**In-network** You pay 0% - 20% of the cost for Medicare-covered Part B drugs You pay $35 copay for one month supply of covered Medicare Part B insulin. **Out-of-network** 20% coinsurance	*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 the 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.
Chiropractic Care	$20 copay per visit	**In-network** $20 copay per visit **Out-of-network** 20% coinsurance per visit	**In-network** $20 copay per visit **Out-of-network** 20% coinsurance per visit	Manual manipulation of the spine to correct subluxation.

Premiums and Benefits	Ochsner Health Plan Premier (HMO)	Ochsner Health Plan Freedom (HMO POS)	Ochsner Health Plan Heroes (HMO POS)	What You Should Know
Diabetes Management				
Diabetes Monitoring Supplies	$0 copayment for preferred brand Abbott test strips and diabetic testing supplies (e.g., solutions, lancets and lancing devices) supplied from a participating pharmacy. Abbott (Freestyle and Precision) glucose monitors are available at no charge from the manufacturer through a participating pharmacy or by calling 1-855-220-9552. Limited to one monitor per year. 20% coinsurance for each Medicare-covered diabetic testing supply from a participating DME supplier	**In-network** $0 copayment for preferred brand Abbott test strips and diabetic testing supplies (e.g., solutions, lancets and lancing devices) supplied from a participating pharmacy. Abbott (Freestyle and Precision) glucose monitors are available at no charge from the manufacturer through a participating pharmacy or by calling 1-855-220-9552. Limited to one monitor per year. 20% coinsurance for each Medicare-covered diabetic testing supply from a participating DME supplier **Out-of-network** 20% coinsurance per item	**In-network** $0 copayment for preferred brand Abbott test strips and diabetic testing supplies (e.g., solutions, lancets and lancing devices) supplied from a participating pharmacy. Abbott (Freestyle and Precision) glucose monitors are available at no charge from the manufacturer through a participating pharmacy or by calling 1-855-220-9552. Limited to one monitor per year. 20% coinsurance for each Medicare-covered diabetic testing supply from a participating DME supplier **Out-of-network** 20% coinsurance per item	*Your provider may need to obtain prior authorization*
Diabetes Self-Management Training	$0 copay per item	**In-network** $0 copay per item **Out-of-network** 20% coinsurance per item	**In-network** $0 copay per item **Out-of-network** 20% coinsurance per item	*Your provider may need to obtain prior authorization*
Medicare-Covered Therapeutic Shoes or Inserts	You pay 20% coinsurance	**In-network** you pay 20% coinsurance **Out-of-network** 20% coinsurance	**In-network** you pay 20% coinsurance **Out-of-network** 20% coinsurance	*Your provider may need to obtain prior authorization*

Premiums and Benefits	Ochsner Health Plan Premier (HMO)	Ochsner Health Plan Freedom (HMO POS)	Ochsner Health Plan Heroes (HMO POS)	What You Should Know
Fitness Program	$0 copay.	**In-network** $0 copay. No **out-of-network** coverage.	**In-network** $0 copay. No **out-of-network** coverage.	Must use network fitness facility. Program includes free Home Fitness Kit.
Foot Care (Podiatry)	$25 copay per visit	**In-network** $25 copay per visit **Out-of-network** 20% coinsurance per visit	**In-network** $25 copay per visit **Out-of-network** 20% coinsurance per visit	*Your provider may need to obtain prior authorization.*
Home Health 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	**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.*

Premiums and Benefits	Ochsner Health Plan Premier (HMO)	Ochsner Health Plan Freedom (HMO POS)	Ochsner Health Plan Heroes (HMO POS)	What You Should Know
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.
Meal Benefit	$0 copay	**In-network** $0 copay. No out-of-network coverage.	**In-network** $0 copay. No out-of-network coverage.	*Your provider may need to obtain prior authorization and a referral.* 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.

Premiums and Benefits	Ochsner Health Plan Premier (HMO)	Ochsner Health Plan Freedom (HMO POS)	Ochsner Health Plan Heroes (HMO POS)	What You Should Know
Medical Equipment/Supplies				
Durable Medical Equipment (e.g. wheelchairs, oxygen)	0% - 20% coinsurance for each Medicare-covered durable medical equipment	**In-network** 0% - 20% coinsurance for each Medicare-covered durable medical equipment **Out-of-network** 20% coinsurance	**In-network** 0% - 20% coinsurance for each Medicare- covered durable medical equipment **Out-of-network** 20% coinsurance	*Specific manufacturers covered and other limits may apply.* *Your provider may need to obtain prior authorization.*
Supplies	20% coinsurance for medical supplies	20% coinsurance for medical supplies **Out-of-network** 20% coinsurance	20% coinsurance for medical supplies **Out-of-network** 20% coinsurance	*Specific manufacturers covered and other limits may apply.* *Your provider may need to obtain prior authorization.*
Prosthetics (e.g. braces, artificial limbs)	20% coinsurance for prosthetic devices	20% coinsurance for prosthetic devices **Out-of-network** 20% coinsurance	20% coinsurance for prosthetic devices **Out-of-network** 20% coinsurance	*Specific manufacturers covered and other limits may apply.* *Your provider may need to obtain prior authorization.*

Premiums and Benefits	Ochsner Health Plan Premier (HMO)	Ochsner Health Plan Freedom (HMO POS)	Ochsner Health Plan Heroes (HMO POS)	What You Should Know
Ochsner Health Plan Flex Card	The Ochsner Health Plan Flex Card provides members access to two (2) separate "wallets" on a Visa debit card for the following benefits:	The Ochsner Health Plan Flex Card provides members access to two (2) separate "wallets" on a Visa debit card for the following benefits:	The Ochsner Health Plan Flex Card provides members access to two (2) separate "wallets" on a Visa debit card for the following benefits:	
	- $105 maximum allowance per calendar quarter for covered over-the-counter (OTC) drugs and health related items. Any funds left on the card at the end of each calendar quarter will expire. These funds will not roll over to the following calendar quarter.	- $110 maximum allowance per calendar quarter for covered over-the-counter (OTC) drugs and health related items. Any funds left on the card at the end of each calendar quarter will expire. These funds will not roll over to the following calendar quarter.	- $85 maximum allowance per calendar quarter for covered over-the-counter (OTC) drugs and health related items. Any funds left on the card at the end of each calendar quarter will expire. These funds will not roll over to the following calendar quarter.	See Over-the-Counter Benefit in Chapter 4 of the Evidence of Coverage for more information. Visit https://flex.ochsnerhealthplan.com/ for more information.
	- $2,000 combined maximum allowance per calendar year for routine hearing care. Any funds left on the card at the end of the calendar year will expire. These funds will not roll over to the following calendar year.	- $2,000 combined maximum allowance per calendar year for routine hearing care. Any funds left on the card at the end of the calendar year will expire. These funds will not roll over to the following calendar year.	- $1,000 combined maximum allowance per calendar year for routine hearing care. Any funds left on the card at the end of the calendar year will expire. These funds will not roll over to the following calendar year.	See Hearing Services in Chapter 4 of the Evidence of Coverage for more information. Visit https://flex.ochsnerhealthplan.com/ for more information.

Premiums and Benefits	Ochsner Health Plan Premier (HMO)	Ochsner Health Plan Freedom (HMO POS)	Ochsner Health Plan Heroes (HMO POS)	What You Should Know
Opioid Treatment Services	$0 copay	**In-network** $0 copay **Out-of-network** 20% coinsurance	**In-network** $0 copay **Out-of-network** 20% coinsurance	*Your provider may need to obtain prior authorization* Must be provided by a CMS certified Opioid Treatment Services Program.
Outpatient Substance Abuse Treatment – Group or Individual	$25 copay	**In-network** $20 copay **Out-of-network** 20% coinsurance	**In-network** $20 copay **Out-of-network** 20% coinsurance	
Over-the-Counter (OTC) Benefit	$105 maximum allowance per calendar quarter for over-the-counter (OTC) drugs and health related items. Members access this allowance through a designated "wallet" on the Ochsner Health Plan Flex Card. See Ochsner Health Plan Flex Card for more information.	$110 maximum allowance per calendar quarter for over-the-counter (OTC) drugs and health related items. Members access this allowance through a designated "wallet" on the Ochsner Health Plan Flex Card. See Ochsner Health Plan Flex Card for more information.	$85 maximum allowance per calendar quarter for over-the-counter (OTC) drugs and health related items. Members access this allowance through a designated "wallet" on the Ochsner Health Plan Flex Card. See Ochsner Health Plan Flex Card for more information.	The Ochsner Health Plan Flex Card can be used to purchase covered over-the-counter (OTC) drugs and health related items at participating retailers, or by phone, mail, or web order through the Ochsner Health Plan OTC store. Visit https://flex.ochsnerhealthplan.com/ for more information.
Renal dialysis	20% coinsurance	**In-network** 20% coinsurance **Out-of-network** 20% coinsurance	**In-network** 20% coinsurance **Out-of-network** 20% coinsurance	*Prior authorization required.*


Ochsner
Health Plan

Prescription Drugs

	Ochsner Health Plan Premier (HMO)			Ochsner Health Plan Freedom (HMO POS)			Ochsner Health Plan Heroes (HMO POS)
Stage 1: Annual Prescription Deductible	**Since you have no deductible for Part D drugs, this payment stage does not apply**			**Since you have no deductible for Part D drugs, this payment stage does not apply**			**No Part D coverage**
Stage 2: Initial Coverage	**Retail 30-day supply**	**Retail 90-day supply**	**Mail Order 90-day supply**	**Retail 30-day supply**	**Retail 90-day supply**	**Mail Order 90-day supply**	**No Part D coverage**
Tier 1: Preferred Generic Drugs	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	**No Part D coverage**
Tier 2: Generic Drugs[1]	$10 copay	$25 copay	$25 copay	$10 copay	$25 copay	$25 copay	**No Part D coverage**
Tier 3: Preferred Brand Drugs	$45 copay	$135 copay	$135 copay	$45 copay	$135 copay	$135 copay	**No Part D coverage**
Covered Insulin Drugs[2]	$35 copay	$105 copay	$105 copay	$35 copay	$105 copay	$105 copay	
Tier 4: Non-Preferred Brand Drugs	$100 copay	$300 copay	$300 copay	$100 copay	$300 copay	$300 copay	**No Part D coverage**
Covered Insulin Drugs[2]	$35 copay	$105 copay	$105 copay	$35 copay	$105 copay	$105 copay	
Tier 5: Specialty Tier Drugs[3]	33% coinsurance	N/A[3]	N/A[3]	33% coinsurance	N/A[3]	N/A[3]	**No Part D coverage**
Covered Insulin Drugs[2]	$35 copay			$35 copay			

Prescription Drugs

	Ochsner Health Plan Premier (HMO)	Ochsner Health Plan Freedom (HMO POS)	Ochsner Health Plan Heroes (HMO POS)
Stage 3: Catastrophic Coverage	After your yearly out-of-pocket drug costs (drugs purchased through our network pharmacies) reach $2,000 you pay $0 or 0% of the costs.		**No Part D coverage**

Other Limitations May Apply

1. Tier includes enhanced drug coverage.
2. You won't pay more than $35 for a one-month supply of each covered insulin product regardless of the cost-sharing tier.
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 1-833-674-2112번으로 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.

Multi-Language Interpreter Service

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

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.

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。

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 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.

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.

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Ochsner Health Plan

Ochsner Health Plan
1450 Poydras St., Suite 110
New Orleans, LA 70112

Member Services:
1-833-674-2112 (TTY: 711)

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ochsnerhealthplan.com

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