



2022

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)
Medicare Advantage Plan with Prescription Drugs
H9763-002**

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

**We are open 8 a.m. to 8 p.m. seven days a week from October 1st to March 31st
and 8 a.m. to 8 p.m. Monday through Friday April 1st to September 30th.**

**This is a summary of drug and health services covered by
Ochsner Health Plan Freedom (HMO POS),
January 1, 2022 - December 31, 2022**

Ochsner Health Plan Freedom (HMO POS), 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 seven (7) days a week from 8:00 a.m. to 8:00 p.m., October 1 – March 31 and Monday – Friday from 8:00 a.m. to 8:00 p.m. from April 1 – September 30. TTY/TDD users call 711, or visit our website at www.ochsnerhealthplan.com.

To join Ochsner Health Plan Freedom (HMO POS), 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 Freedom (HMO POS), has 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.

Premiums and Benefits	Ochsner Health Plan Freedom (HMO POS)	What You Should Know
Monthly Plan Premium	You pay \$0	You must continue to pay your Medicare Part B premium.
Part B Premium Reduction	N/A	There is no Part B reduction.
Annual Medical Deductible	\$0	There is no Medical deductible
Maximum Out-of-Pocket Responsibility (does not include prescription drugs or out-of-network services)	\$3700 annually	The most you pay for copays, coinsurance, and other costs for in-network medical services in a year.
Inpatient Hospital	In-network: \$65 per day for 1 through 7 days, \$0 copayment for additional Medicare-covered days. You pay these amounts until you reach the out-of-pocket maximum. Out-of-network: 20% per stay	<i>Our plan covers an unlimited number of days for inpatient hospital stays. Your provider may need to obtain prior authorization.</i>
Outpatient Hospital • Ambulatory Surgery Center • Outpatient Hospital Including Surgery • Outpatient Observation Services	In-network: \$160 copay per visit \$0 copay for diagnostic colonoscopy at an in-network facility Out of network: 20% coinsurance per visit In-network: \$130 copay per visit Out-of-network: 20% coinsurance per visit \$0 copay Out of network: 20% coinsurance per visit	<i>Your provider may need to obtain prior authorization.</i>
Doctor Visits • Primary Care • Specialist Care	In-network: \$0 copay Out-of-network: 20% coinsurance per visit In-network: \$20 copay per visit Out-of-network: 20% coinsurance per visit	

Premiums and Benefits	Ochsner Health Plan Freedom (HMO POS)	What You Should Know
Preventive Care (e.g. flu vaccine, COVID-19 vaccine, diabetic screenings)	In-network: \$0 copay Out-of-network: 20% coinsurance	Any additional preventive services approved by Medicare during the contract year will be covered.
Emergency Care (local and world-wide)	\$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)	If you are admitted to the hospital within one (1) day, the urgent care copay is waived.
Diagnostic Services/Labs/Imaging <ul style="list-style-type: none"> • Diagnostic Radiology Services (e.g. MRI) • Lab Services • Diagnostic Tests and Procedures • Therapeutic Radiology • Outpatient X-Rays 	In-network: \$0-\$85 copay \$0 copay for diagnostic mammogram Out-of-network: \$20 coinsurance In-network: \$0 copay Out-of-network: 20% coinsurance In-network: \$35 copay Out-of-network: 20% coinsurance \$35 copay Out-of-network: 20% coinsurance In-network: \$35 copay Out-of-network: 20% coinsurance	<i>Your provider may need to obtain prior authorization.</i>
Hearing Services <ul style="list-style-type: none"> • Exam to diagnose and treat hearing and balance issues • Routine Hearing Exam • Hearing Aids 	In-network: \$20 copay Out-of-network: 20% coinsurance In-network: \$20 copay Out-of-network: 20% coinsurance In-network: \$0 copay \$1000 allowance every year	One (1) routine exam every year. Plan pays up to \$500 per ear per year.

Premiums and Benefits	Ochsner Health Plan Freedom (HMO POS)	What You Should Know
<p>Dental Services (In-network only)</p> <p>Medicare covered \$20 copay Medicare-covered Benefits limited to services provided under the Medicare program</p> <ul style="list-style-type: none"> • Preventive Dental • Comprehensive Dental 	<p>\$0 copay for oral exams, cleaning and x-rays.</p> <p>\$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.</p>	<p>Medicare-covered Benefits limited to services provided under the Medicare program. Preventive Dental (oral exams, cleaning, and dental x-ray) each service limited to two (2) treatments per year.</p> <p>Comprehensive Dental - Restorative Services; Endodontics; Periodontics; Extractions; Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services</p> <p>Comprehensive and Preventive dental services are limited to up to \$2000 in total combined cost per year.</p>
<p>Vision Services</p> <ul style="list-style-type: none"> • Exam to diagnose and treat conditions and diseases of the eye • Eyewear post cataract surgery • Routine Eye Exam (In-network only) • Eyewear (In-network only) 	<p>In-network: \$20 copay Out-of-network: 20% coinsurance</p> <p>In-network: \$0 copay Out-of-network: 20% coinsurance</p> <p>\$0 copay</p> <p>\$0 copay</p>	<p>One (1) Routine exam per year.</p> <p>Eyewear - Up to \$200 every year.</p>
<p>Mental Health Services</p> <ul style="list-style-type: none"> • Inpatient visit • Outpatient Group Therapy Visit • Outpatient Individual Therapy Visit 	<p>\$65 copayment each day for days 1 - 4 for Medicare-covered hospital care. \$0 copay for days 5-90.</p> <p>Out-of-network: 20% coinsurance In-network: \$20 copay Out-of-network: 20% coinsurance</p> <p>In-network: \$20 copay Out-of-network: 20% coinsurance</p>	

Premiums and Benefits	Ochsner Health Plan Freedom (HMO POS)	What You Should Know
Skilled Nursing Facility (SNF)	In-network: \$0 per day for 1 through 20, \$178 per day for days 21 through 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 <ul style="list-style-type: none"> • Occupational Therapy Visit • Physical Therapy Visit • Speech Therapy 	In-network: \$20 copay Out-of-network: 20% coinsurance	
Ambulance (local and world-wide)	In-network: \$235 copay for ground ambulance. 20% coinsurance for air ambulance. Out-of-network: 20% coinsurance for ground ambulance.	<i>Prior authorization may be required for Medicare-covered non-emergent ambulance.</i>
Medicare Part B Drugs	You pay 20% of the cost for Medicare-covered services	Prior authorization is required.
Home Health Services	In-network: \$0 copay Out-of-network: 20% coinsurance	Prior Authorization required.
Foot Care (Podiatry)	In-network: \$20 copay per visit Out-of-network: 20% coinsurance per visit	Limited to six (6) routine podiatry services per year
Medical Equipment/Supplies <ul style="list-style-type: none"> • Durable Medical Equipment (e.g. wheelchairs, oxygen) • Prosthetics (e.g. braces, artificial limbs) • Diabetes Supplies 	In-network: 0-20% coinsurance per item Out-of-network: 20% coinsurance per item	Prior authorization is required.

Premiums and Benefits	Ochsner Health Plan Freedom (HMO POS)	What You Should Know
Over-the-Counter (OTC) Items	You pay \$0 for up to \$75 per quarter of covered items.	<p>Plan provides \$75 per quarter allowance for over-the-counter items and unused benefit are not carried forward for the next period and plan year</p> <p>Members must select OTC items through the Ochsner Health Plan OTC catalog.</p>
Chiropractic Care	In-network: \$20 copay per visit Out-of-network: 20% coinsurance per visit	Covered services include: Manual manipulation of the spine to correct subluxation
Diabetes Management <ul style="list-style-type: none"> • Diabetes Monitoring Supplies • Diabetes Self-management Training • Therapeutic Shoes or inserts 	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 In-network: \$0 copay per item Out-of-network: 20% coinsurance per item	
Fitness Program	In-network: \$0 copay	Must use network fitness facility. Program includes fitness tracker.
Meal Benefit	In-network: \$0 copay	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.
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.

Premiums and Benefits	Ochsner Health Plan Freedom (HMO POS)	What You Should Know
Opioid Treatment Services	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 Out-of-network: 20% coinsurance	In-network; \$20 copay Out-of-network: 20% coinsurance	Prior authorization required.
Renal dialysis	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 Drugs¹

\$10 copay

\$0 copay

\$0 copay

Tier 3:
Preferred Brand Drugs

\$45 copay

\$135 copay

\$135 copay

Select Insulin Drugs²

\$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/A³

N/A³

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 \$4,430, 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 \$7,050, you pay the greater of: \$3.95 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 \$9.85 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 For 2022, this plan participated in the Insulin Senior Savings Program which offers lower, stable, and predictable out of pocket costs for covered insulin through the different Part D benefit coverage stages. You will pay a maximum of \$35 for a 1-month supply of covered Senior Savings Program insulin during the deductible, initial coverage, and coverage gap or “donut hole” stages of your benefit. You will pay 5% of the cost of these covered insulin in the catastrophic stage. Your cost maybe less if you receive Extra Help from Medicare.

3 Limited to a 30-day supply.

Anti-Discrimination Notice

Ochsner Health Plan Freedom (HMO-POS), 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 Freedom (HMO-POS), does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Ochsner Health Plan Freedom (HMO-POS),:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact the Plan Compliance Officer. If you believe that Ochsner Health Plan Freedom (HMO-POS), 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:

Compliance Officer, at 1-833-937-3167, (TTY/TDD users call 711), or email
OHPCompliance@Ochsner.org

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Plan Compliance Officer is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office of Civil Rights, electronically through the Office or 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, 800-537-7697 (TDD)

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

Multi-Language Interpreter Service

English

ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call 1-833-674-2112 (TTY/TDD: 711).

Español (Spanish)

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-833-674-2112 (TTY/TDD: 711).

繁體中文 (Chinese)

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-833-674-2112 (TTY: 711)。

Deutsch (German)

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-833-674-2112(TTY/TDD: 711).

Tiếng Việt (Vietnamese)

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-833-674-2112(TTY/TDD: 711).

العربية (Arabic)

ملحوظة: إذا كنت تتحدث اذكر اللغة، نان خدمات المساعدة اللغة نترانس لك بالمجان. اتصل برقم 1-448-412-3368 (رقم هاتف الصم والبكم: 117).

Srpsko-hrvatski (Serbo-Croatian)

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-833-674-2112 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711).

日本語 (Japanese)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-833-674-2112 (TTY/TDD: 711) まで、お電話にてご連絡ください。

Français (French)

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-833-674-2112 (ATS : 711).

한국어 (Korean)

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-833-674-2112 (TTY/TDD: 711)번으로 전화해 주십시오.

Deutsch (Pennsylvania Dutch)

Wann du schwetzscht, kantscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-833-674-2112 (TTY/TDD: 711).

For more information, contact Ochsner Health Plan Freedom (HMO-POS), from 8:00 a.m. to 8:00 p.m., 7 days a week from October 1 – March 31 and Monday – Friday from 8:00a.m. to 8:00 p.m. from April 1 – September 30 at 1-833-674-2112(TTY/TDD user’s call 711) or visit www.ochsnerhealthplan.com.

You can access the Ochsner Health Plan Freedom (HMO-POS), 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 Freedom (HMO-POS), is an HMO with a Medicare Contract. Enrollment in Ochsner Health Plan Freedom (HMO-POS), 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.

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.

This information is available for free in other languages. Please call Member Services at 1-833-674-2112 (TTY/TDD users call 711) from 8 a.m. to 8 p.m., 7 days a week from October 1 – March 31 and Monday – Friday from 8 a.m. to 8 p.m. from April 1 – September 30.

This plan is available to anyone with Medicare who meets the Skilled Nursing Facility (SNF) level of care and resides in a nursing home. Ochsner Health Plan Freedom (HMO-POS), (HMO I SNP) has been approved by the National Committee for Quality Assurance (NCQA) to operate as a Special Needs Plan (SNP) until 2021 based on a review of the Ochsner Health Plan Freedom (HMO-POS), Model of Care.

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

NOTES

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

Hours: 8:00 a.m. to 8:00 p.m., 7 days a week from October 1 – March 31

and Monday – Friday 8:00 a.m. – 8:00 p.m.

ochsnerhealthplan.com



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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