**Exhibit 12**

**Medicare Supplement Plan Benefits Summary**
All Benefits are Based on Medicare-Approved Amounts

**[Supplier Name]**

**Plan Year 2023**

1. All Part D pharmacy coverage descriptions and benefits listed must reflect compliance with CMS benefit guidance and meet the Creditable Coverage definition. Bidder’s Medicare Supplement Plan (MSP) shall at minimum meet specifications for Medicare Supplement Plan G with a prescription drug component.
	1. Bidder may refer to the HealthChoice SilverScript MSP for guidance at <https://oklahoma.gov/healthchoice/medicare-member/plans-overview/hc-silverscript-high-low-plan.html>.
2. List complete benefits when submitting “PY2023 No Plan Changes” and the “PY2023 With Proposed Plan Changes.”
3. Column “PY2023 No Plan Changes” is required for all Bidders and should list complete plan benefits.
	1. For Bidders with current contracts with the OEIBA Program, this column should list the Supplier’s current plan benefits with no changes.
4. Only Bidders with current contracts have the option to also complete column “PY2023 with Proposed Plan Changes.”

This column should include all PY2022 plan benefits along with proposed plan changes for PY2023. **Proposed plan changes must be in bold.**.

1. All plan design options must correspond to Exhibit 13 for MSP premium quotes
2. No more than one (1) MSP plan by the Supplier will be accepted for PY2023.

MSP Benefit Summary must be completed and signed by the Supplier’s President, Chief Executive Officer or authorized representative.

1. MSP Benefit Summary must be signed by the Bidder’s President, Chief Executive Officer or authorized representative.

**Example**

|  |  |  |
| --- | --- | --- |
| **Network Services** | **PY2023****No Plan Changes****(Required)** | **PY2023****With Proposed Plan Changes** **(Optional. Only for current Suppliers)** |
| **Pharmacy Co-pay** | 30-Day SupplyPreferred Generic $0 | 30-Day SupplyPreferred Generic **$10** |

|  |  |  |
| --- | --- | --- |
| **Part A Network Services****All benefits are based on Medicare-approved amounts** | **PY2023 No Plan Changes**(Required) | **PY 2023 With Plan Changes**(Optional) |
| **HOSPITALIZATION** |   |   |
| Includes semiprivate room, meals, drugs as part of your inpatient treatment, and other hospital services and supplies |   |   |
| First sixty 60 days |   |   |
| Days 61 through 90 |   |   |
| Days 91 and after while using Medicare's 60 lifetime reserve days |   |   |
| Once Medicare's lifetime reserve days are used, the plan provides additional lifetime reserve days |   |   |
| Beyond the plan's lifetime reserve days |   |   |
| **SKILLED NURSING FACILITY CARE** |   |   |
|  |
| Must meet Medicare requirements, including inpatient hospitalization for at least 3 days and entering a Medicare-approved facility within 30 days of leaving the hospital; limited to 100 days per calendar year |   |   |
| First 20 days |   |   |
| Days 21 through 100 |   |   |
| Days 101 and after |   |   |
| **HOSPICE CARE** |   |   |
| Your doctor and hospice provider must certify you are terminally ill and you elect hospice Includes physical care, counseling, equipment, supplies, respite care, inpatient care and drugs for pain and symptom control |   |   |
| **BLOOD** |   |   |
| Limited to the first 3 pints unless you or someone else donates blood to replace what you use |   |   |
|   |  |   |
|  |  |  |
| **Part B Network Services** | **PY 2023 No Plan Changes** | **PY 2023 With Plan Changes** |
| **MEDICAL EXPENSES** |   |   |
| Medically necessary outpatient services and supplies |   |   |
| Includes doctor’s visits, out-patient hospital treatment, surgical services, physical and speech therapy and diagnostic tests |   |   |
| **CLINICAL DIAGNOSTIC LABORATORY SERVICES** |   |   |
| Includes blood tests, urinalysis and tissue pathology |   |   |
| **HOME HEALTH CARE** |   |   |
| Includes intermittent skilled care and medical supplies |   |   |
| **DURABLE MEDICAL EQUIPMENT** |   |   |
| Includes items such as nebulizers, wheelchairs and walkers |   |   |
| **DIABETES MONITORING SUPPLIES** |   |   |
| Includes coverage for glucose monitors, test strips and lancets for those with diabetes Must be requested by your doctor |   |   |
| **OSTOMY SUPPLIES** |   |   |
| All Medicare beneficiaries who have a need based on their condition. Includes ostomy bags, wafers and other ostomy supplies for those who have a need based on their condition |   |   |
| **BLOOD** |   |   |
| Includes amounts in addition to the coverage under Part A unless you or someone else donates blood to replace what you use |   |   |
| **OUTPATIENT PRESCRIPTIONS** |   |   |
| Includes infused, oral end-stage renal disease drugs and some cancer and transplant drugs |   |   |
| Providers who do not accept Medicare assignment cannot charge a Medicare beneficiary more than 115% of the Medicare-approved amount. |
| **Coverage for Other Medical Services** |
|   |  |   |
| **Service** | **PY 2023 No Plan Changes** | **PY 2023 With Plan Changes** |
| **FOREIGN TRAVEL** |   |   |
| Medically necessary emergency care services beginning during the first 60 days of each trip outside the U.S.A. |   |   |
| **BARIATRIC SURGERY** |   |   |
|  |  |  |
| **DIABETES PREVENTION PROGRAM**CDC-recognized |   |   |
|  |  |  |
|   |  |   |
| **Medicare Preventive Services**  |
|   |  |   |
| **Part B Network Services** | **PY 2023 No Plan Changes** | **PY 2023 With Plan Changes** |
| **INITIAL PREVENTIVE PHYSICAL EXAM** |   |   |
| Includes a one-time “Welcome to Medicare Visit” for Medicare beneficiaries during the first 12 months of Part B coverage |   |   |
| **ANNUAL WELLNESS VISIT** |   |   |
| Includes one visit every 12 months for Medicare beneficiaries who have been enrolled in Part B for more than 12 months |   |   |
| **SCREENING MAMMOGRAM** |   |   |
| Once every 12 months for female Medicare beneficiaries ages 40 and older |   |   |
| **CARDIOVASUCLAR DISEASE SCREENING** |   |   |
| Once every five years for all Medicare beneficiaries |   |   |
| **PAP TEST AND PELVIC EXAM** |   |   |
| Once every 24 months; includes a clinical breast exam |   |   |
| Once every 12 months if high risk or abnormal Pap test in preceding 36 months |   |   |
| **BONE MASS MEASUREMENTS** |   |   |
| Once every 24 months for all Medicare beneficiaries at risk of losing bone mass |   |   |
| **GLAUCOMA SCREENING** |   |   |
| Once every 12 months for Medicare beneficiaries at high risk or a family history of glaucoma |   |   |
| Must be performed or supervised by an optometrist or ophthalmologist |   |   |
| **COLORECTAL CANCER SCREENING** |   |   |
| For all Medicare beneficiaries ages 50 and older |   |   |
| **FECAL OCCULT BLOOD TEST** |   |   |
| Once every 12 months |   |   |
| **FLEXIBLE SIGNOIDOSCOPY** |   |   |
| Once every 4 years for those at high risk for colorectal cancer |   |   |
| For those at normal risk, once every 4 years, or 119 months after a previous screening colonoscopy |   |   |
| **COLONOSCOPY** |   |   |
| Once every 2 years for those at high risk for colorectal cancer |   |   |
| For those at normal risk, once every 10 years, or 47 months after a previous flexible sigmoidoscopy |   |   |
| **BARIUM ENEMA** |   |   |
| Doctor can substitute this test for a sigmoidoscopy or colonoscopy |   |   |
| Procedure must be performed in an outpatient hospital setting or an ambulatory surgical center |   |   |
| **PROSTATE CANCER SCREENING** |   |   |
| For all male Medicare beneficiaries ages 50 and older |   |   |
| **DIGITAL RECTAL EXAM** |   |   |
| Once every 12 months |   |   |
| **PROSTATE SPECIFIC ANTIGEN TEST (PSA)** |   |   |
| Once every 12 months |   |   |
| Providers who do not accept Medicare assignment cannot charge a Medicare beneficiary more than 115% of the Medicare-approved amount. |
|   |  |   |
| **Preventive Services - Vaccinations** |
| Medicare covers the vaccine and administration at 100% if the provider accepts Medicare assignment. |  |   |
| **Vaccination** | **PY 2023 No Plan Changes** | **PY 2023 With Plan Changes** |
| **Flu Vaccination**  |   |   |
| One per flu season |   |   |
| **Pneumonia Vaccination** |   |   |
| A pneumococcal vaccination is approved annually for members ages 50 and older. |   |   |
| **Hepatitis B Vaccination** |   |   |
| Medicare beneficiaries at medium to high risk for Hepatitis B |   |   |
| Providers who do not accept Medicare assignment cannot charge a Medicare beneficiary more than 115% of the Medicare-approved amount. |
|   |  |   |
|   |  |   |
| **Pharmacy Copay Structure for Network Benefits** |
| Note: If the plan has more than five (5) tiers, insert a new row below the “Tier 5” row within the 30-day supply or the 31 to 90-day supply sections to include pharmacy benefit tier information. |
|   |  |   |
| **General Information** | **PY2023 No Plan Changes** | **PY2023 With Plan Changes** |
| These plans use a formularyMandatory generic and formulary medications you get at a Network Pharmacy |   |   |
| **30- Day Supply****Specify any differences between Preferred and Standard Retail** |
|  [Tier 1 and name, ex. Preferred Generic Drugs] |
|   |   |
| Quantity limits apply to certain drugs |  [Tier 2 and name] |
|   |   |
| Only copays for covered drugs purchased at Network Pharmacies count toward out-of-pocket maximums | [Tier 3 and name] |
|   |   |
| Some drugs require prior authorization | [Tier 4 and name] |
|   |   |
| Pharmacy benefits must meet the minimum requirements for benefits as outlined in the Medicare Modernization Act of 2003 |  [Tier 5 and name] |
|   |   |
| You will be notified before any changes are made to your plan's formulary | **[Up to 90]-Day Supply** |
|  [Tier 1 and name] |
|   |   |
| [Tier 2 and name] |
|   |   |   |
| [Tier 3 and name] |
|   |   |   |
| [Tier 4 and name] |
|   |   |   |
| [Tier 5 and name] |
|   |   |   |
| Once the out-of-pocket maximum is reached, member pays 0% of Allowable Fees for covered prescription drugs purchased |

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Signature Printed Name Date

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Title Supplier Name

(To be signed by the Supplier’s President, Chief Executive

Officer or authorized representative.)