**Exhibit 9**

**MAPD Benefits Summary**

**[Supplier Name]**

**Plan Year 2023**

What type of MAPD plan is being offered by Supplier for this bid?

 [ ]  MAPD in combination with a non-Medicare HMO?

 [ ]  MAPD in combination with an MSP and a non-Medicare HMO

 [ ]  Standalone nationwide MAPD

# Instructions:

1. All plan design options must correspond to Exhibit 10 MAPD Premium Rate.
2. All Part D pharmacy coverage descriptions and benefits listed must reflect compliance with CMS benefit guidance for MAPD plans and meet the Creditable Coverage definition.
	1. Refer to K.11.7.1. in Bidder Instructions for additional MAPD PPO benefit requirements.
3. List complete benefits when submitting “PY 2023 No Plan Changes” and the “PY 2020 With Proposed Plan Changes.”
4. Column “PY2023 No Plan Changes” is required for all Bidders and should list complete plan benefits unless the Supplier’s current MAPD plan is not an option for this solicitation.
	1. For Bidders with current contracts with the OEIBA Program, this column should list the Supplier’s current plan benefits with no changes.
5. Only Bidders with current contracts have the option to also complete column “PY2023 with Proposed Plan Changes.”
6. This column should include all PY2022 plan benefits along with proposed plan changes for PY2023. **Proposed plan changes must be in bold.**
7. Benefit Summary must be from the member’s perspective.
8. No more than one (1) MAPD plan proposed by the Supplier will be accepted for PY 2023.
9. MAPD Benefit Summary must be signed by the Bidder’s President, Chief Executive Officer or authorized representative.

**Example**

|  |  |  |
| --- | --- | --- |
| **Services** | **PY 2023****No Plan Changes****(Required)** | **PY 2023****With Proposed Plan Changes (Optional. Only for current Suppliers)** |
| **In-Area Urgent Care Services** |  $10 copay for each visit | **$15 copay** for each visit |

**All Benefits Based on Medicare-covered Services**

|  |  |  |
| --- | --- | --- |
| **Services** | **PY 2023****No Plan Changes****(Required for all Bidders)** | **PY 2023****With Proposed Plan Changes (Optional for current Suppliers)** |
| **HOSPITALIZATION**Semi-private room (private if medically necessary)Nursing Services and medicationsAll meals, including special dietsLaboratory testsX-rays and other radiology servicesInpatient physician and surgical services, includinganesthesiaNecessary medical supplies and appliancesBlood and its administrationOperating room, Special care units and rehabilitation services |   |  |
| **ORGAN TRANSPLANTS AT A MEDICARE-APPROVED TRANSPLANT FACILITY** |   |  |
| **OUTPATIENT HOSPITAL SERVICES**Including outpatient surgical services in an ambulatory surgical center or outpatient hospital facility |  |  |
| **Radiation therapy** |  |  |
|  |
|  |
| **Blood** |  |  |
| **IN-AREA URGENT CARE SERVICES** |  |  |
| **OUT-OF-AREA URGENT CARE SERVICES**Urgently needed services worldwide (during a temporary absence from the service area) |   |  |
| **EMERGENCY SERVICES**Emergency services needed worldwide |  |  |
| **AMBULANCE SERVICES**Medically necessary |   |  |
| **SKILLED NURSING FACILITY CARE****(Inpatient Services)**Semi-private roomRegular nursing services (except private-duty nurse)All meals, including special dietsPhysical, occupational, and speech therapyDrugs furnished by the facilityNecessary medical equipment and suppliesBlood and its administrationInpatient radiology and pathologyUse of appliances such as a wheelchair |  |  |
| **PROFESSIONAL SERVICES**Office VisitsConsultation, diagnosis, and treatment by specialistMedical and surgical careAllergy tests and treatment (serum)Diagnostic tests and treatmentsMedical supplies including casts, dressings and splints |   |  |
| **PHYSICAL, OCCUPATIONAL AND SPEECH THERAPY SERVICES** |  |  |
| **X-RAY/Diagnostic Radiology SERVICES**Including annual mammography screening, if medically indicated. |  |  |
| **LABORATORY SERVICES**  |   |  |
| **Physical, speech, and occupational therapy** |  |  |
| **HEARING EXAMINATIONS** |  |  |
| **CHIROPRACTIC**Limited to manual manipulation of the spine |  |  |
| **PART-TIME OR INTERMITTENT SKILLED NURSING CARE**Home health aide in conjunction with skilled careMedical social services under direction of a physicianMedical supplies (other than drugs) and equipment provided by the agency |   |  |
| **DURABLE MEDICAL EQUIPMENT**DME and supplies, prosthetic devices, therapeutic shoes/inserts for severe diabetes |  |  |
| **BARIATRIC SURGERY** |  |  |
| **CDC-RECOGNIZED DIABETES PREVENTION PROGRAM** |   |  |
| **Telehealth/Telemedicine/Virtual Visits** |  |  |
| **IMMUNIZATIONS**Includes flu injections and all Medicare-approved immunizations |  |  |
| **PHYSICAL EXAM**Examination |  |  |
| **WELL FEMALE EXAM**ExaminationPap Smear |  |  |
| **INPATIENT MENTAL HEALTH CARE**Inpatient services and supplies in a Medicare-approved psychiatric hospital. |   |  |
| **OUTPATIENT MENTAL HEALTH CARE**Outpatient services of psychiatrist, psychologists and other mental health and substance abuse providers |   |  |
| **ALCOHOL/DRUG TREATMENT**InpatientOutpatient |   |  |
| **PODIATRY CARE**Treatment of disease or injuries of the foot. |  |  |
| **SELF-ADMINISTERED ORAL ANTI-CANCER DRUGS**Includes drugs as approved by Medicare or its generic equivalent |   |  |
| **SELF-ADMINSTERED ERYTHROPOIETIN**Drug for dialysis patients |   |  |
| **INJECTABLE DRUGS FOR OSTEOPOROSIS**Post-menopausal homebound women under physician’s supervision. |   |  |
| **IMMUNOSUPPRESSIVE DRUGS**Includes Imuran, Sandimmune & any other FDA-approved outpatient immunosuppressive agent |   |  |
| **OPTIONAL BENEFITS**DentalHealth educationVision careOther (Please explain) |   |  |

**Pharmacy Copay Structure for Network Benefits**

|  |  |  |  |
| --- | --- | --- | --- |
| **General Information** | **PY 2023****No Plan Changes****(Required)** | Specify if there is a difference between retail and mail order, preferred retail or standard | **PY 2023****No Plan Changes****(Optional)** |
| Mandatory generic and formulary medications you get at a Network PharmacySome drugs require prior authorizationQuantity limits apply to certain drugsOnly copays for covered drugs purchased at Network Pharmacies count toward out-of-pocket maximumsPharmacy benefits must meet the minimum requirements for benefits as outlined in the Medicare Modernization Act of 2003Pharmacy benefits must meet the minimum requirements for benefits as outlined in the Medicare Modernization Act of 2003You will be notified before any changes are made to your plan's formulary | **30- Day Supply (**Fill in type of drug for each tier. **Example**: generic drugs) |
|   | **(Tier 1)** \_\_\_\_\_\_Drugs |   |
|   | **(Tier 2)**\_\_\_\_\_\_Drugs |   |
|   | **(Tier 3)**\_\_\_\_\_\_Drugs |   |
|   | **(Tier 4)**\_\_\_\_\_\_Drugs |   |
|  | **(Tier 5)**\_\_\_\_\_\_Drugs |  |
|
| **31- to 90-Day Supply (Fill in type of drug for each tier)** |
|   | **(Tier 1)** \_\_\_\_\_\_Drugs |   |
|   | **(Tier 2)** \_\_\_\_\_\_Drugs |   |
|   | **(Tier 3)** \_\_\_\_\_\_Drugs |   |
|   | **(Tier 4)**\_\_\_\_\_\_Drugs |   |
|  | **(Tier 5)**\_\_\_\_\_\_Drugs |  |
|   | **Catastrophic Coverage/Out-of-Pocket Maximum/Gap Coverage** |   |
|  |  | **Additional Notes** |  |

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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.)