



Prime (HMO-POS), Alliance (HMO), Select (LPPO),  
Value Plus (HMO-POS), and Access (LPPO)

## Summary of Benefits

January 1–December 31, 2024



**MARTIN'S POINT**<sup>®</sup>

MEDICARE ADVANTAGE PLANS

GENERATIONS ADVANTAGE

# Summary of Benefits

**Martin's Point Generations Advantage Prime (HMO-POS), Alliance (HMO),  
Select (LPPO), Value Plus (HMO-POS), and Access (LPPO)**

**January 1 – December 31, 2024**

For more information about benefits or enrollment, call us or visit our website at **[www.MartinsPoint.org/MedicareMembers](http://www.MartinsPoint.org/MedicareMembers)**.

**1-888-408-8285 (TTY: 711)**

We are available 8am - 8pm, seven days a week from October 1 to March 31; and Monday through Friday the rest of the year.

Y0044\_2024\_SB\_M\_REV Accepted 9/6/2023

# Contents

Martin’s Point Generations Advantage Prime (HMO-POS) .....	4
Section 1: Introduction.....	5
Section 2: Summary of Benefits .....	6
Section 3: Dental Benefit Overview .....	20
Section 3: Dental Benefit Overview (Continued).....	21
Martin's Point Generations Advantage Alliance (HMO) .....	22
Section 1: Introduction.....	23
Section 2: Summary of Benefits .....	24
Section 3: Dental Benefit Overview .....	31
Martin's Point Generations Advantage Select (LPPO).....	32
Section 1: Introduction.....	33
Section 2: Summary of Benefits .....	34
Martin's Point Generations Advantage Value Plus (HMO-POS).....	46
Section 1: Introduction.....	47
Section 2: Summary of Benefits .....	48
Section 3: Dental Benefit Overview .....	57
Section 3: Dental Benefit Overview (Continued).....	58
Martin's Point Generations Advantage Access (LPPO) .....	59
Section 1: Introduction.....	60
Section 2: Summary of Benefits .....	60
Section 3: Dental Benefit Overview .....	70
Section 3: Dental Benefit Overview (Continued).....	71
Section 3: Dental Benefit Overview .....	72
Section 3: Dental Benefit Overview (Continued).....	73



**Martin's Point Generations Advantage Prime (HMO-POS)**

## Section 1: Introduction

**This is a summary of drug and health services covered by Martin's Point Generations Advantage.**

### **January 1, 2024 - December 31, 2024**

Martin's Point Generations Advantage is a health plan with a Medicare contract offering HMO, HMO-POS, and Local PPO products.

Enrollment in a Martin's Point Generations Advantage plan depends on contract renewal.

This information may be available in other formats such as large print, braille, or an electronic copy on our website. For more information call Generations Advantage at 1-866-544-7504.

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 see the Evidence of Coverage on our website, or you may contact us. To join Martin's Point Generations Advantage Prime, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

### **For Generations Advantage Prime (HMO-POS) plan:**

Our service area includes all counties in Maine and New Hampshire.

The plan has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers in our network, you may pay less for your covered services. But if you want to, you can also use providers that are not in our network for some services.

## Section 2: Summary of Benefits

This is a summary of the premiums and benefits covered by the Martin’s Point Generations Advantage Prime (HMO-POS).

The table below shows the monthly plan premium amount for each of the regions we serve. In addition, you must keep paying your Medicare Part B premium.

Monthly Plan Premium	Plan Service Area	Monthly Premium
<b>Martin's Point Generations Advantage Prime</b> <i>Note: Your premium is based on your service area.</i>	Androscoggin, Cumberland, and York counties in Maine; and Cheshire, Hillsborough, Merrimack, Rockingham, Strafford, and Sullivan counties in New Hampshire	\$0
	Aroostook, Franklin, Hancock, Knox, Penobscot, and Washington counties in Maine	\$25.10
	Kennebec and Sagadahoc counties in Maine	\$29
	Lincoln, Oxford, Piscataquis, Somerset, and Waldo counties in Maine; and Belknap, Carroll, Coos, and Grafton counties in New Hampshire	\$89

Benefit	Prime (HMO-POS) Plan
<b>Deductible</b> (our plan does not have a medical deductible)	You pay \$0 annually
<b>Maximum Out-of-Pocket</b> (does not include prescription drugs)  Our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care.  <i>Note: Your Maximum Out-of-Pocket is based on your service area.</i>	For members living in Androscoggin, Aroostook, Cumberland, Franklin, Hancock, Kennebec, Knox, Penobscot, Sagadahoc, Washington, and York counties in Maine: \$6,350 Annually  For members living in Lincoln, Oxford, Piscataquis, Somerset, and Waldo counties in Maine; or Belknap, Carroll, Chesire,

Benefit	Prime (HMO-POS) Plan
<p><b>Inpatient hospital</b> Services may require that your provider get prior authorization (approval in advance). Please have your provider contact the plan for more details.</p> <p><i>Note: Your copay is based on your service area.</i></p>	<p>Coos, Grafton, Hillsborough, Merrimack, Rockingham, Strafford, and Sullivan, counties in NH: \$6,750 Annually</p> <p><b>In-network</b> for members living in Aroostook, Franklin, Hancock, Knox, Penobscot, and Washington counties in Maine: <b>You pay per admission:</b> \$360 per day for days 1-7; \$0 per day for days 8+</p> <p><b>In-network</b> for members living in Androscoggin, Cumberland, Kennebec, Lincoln, Oxford, Piscataquis, Sagadahoc, Somerset, Waldo, and York Counties in Maine; or Belknap, Carroll, Cheshire, Coos, Grafton, Hillsborough, Merrimack, Rockingham, Strafford, and Sullivan counties in New Hampshire: <b>You pay per admission:</b> \$340 per day for days 1-7; \$0 per day for days 8+</p>
<p><b>Outpatient hospital</b> Services may require that your provider get prior authorization (approval in advance). Please have your provider contact the plan for more details. <i>Note: Your copay is based on your service area.</i></p>	<p><b>In-network</b> for members living in Cumberland, Lincoln, Oxford, Piscataquis, Somerset, and Waldo counties in Maine; or Belknap, Carroll, Coos, and Grafton counties in New Hampshire: You pay \$275 for Medicare-covered surgery services at a hospital outpatient facility.</p> <p><b>In-network</b> for members living in Androscoggin, Aroostook, Franklin, Hancock, Kennebec, Knox, Penobscot, Sagadahoc, Washington, and York counties in Maine; or Cheshire, Hillsborough, Merrimack, Rockingham, Strafford, and Sullivan counties in New Hampshire: You pay \$250 for Medicare-covered surgery services at a hospital outpatient facility.</p>

Benefit	Prime (HMO-POS) Plan
<p><b>Ambulatory &amp; Surgical Center (ASC)</b>            Services may require that your provider get prior authorization (approval in advance). Please have your provider contact the plan for more details.</p>	<p><b>In-network</b> for members living in Androscoggin, Kennebec, Lincoln, Oxford, Piscataquis, Sagadahoc, Somerset, and Waldo counties in Maine;            or Belknap, Carroll, Cheshire, Coos, Grafton, Hillsborough, Merrimack, Rockingham, Strafford, and Sullivan counties in NH:            You pay \$150 for Medicare-covered surgery services at an ambulatory surgical center.</p> <p><b>In-network</b> for members living in Aroostook, Cumberland, Franklin, Hancock, Knox, Penobscot, Washington, and York counties in Maine:            You pay \$175 for Medicare-covered surgery services at an ambulatory surgical center.</p>
<p><b>Doctor visits</b>  <i>Note: Your copay is based on your service area.</i></p>	<p><b>In-network:</b>  <b>Primary care</b>            You pay \$0 for each Primary Care Physician (PCP) office visit for Medicare-covered services.</p> <p><b>Specialists</b>            For members living in Androscoggin, Cumberland, Kennebec, Sagadahoc, and York counties in Maine;            or Cheshire, Hillsborough, Merrimack, Rockingham, Strafford, and Sullivan counties in New Hampshire;            You pay \$40 for each specialist office visit for Medicare-covered services.</p> <p>For members living in Aroostook, Franklin, Hancock, Knox, Lincoln, Oxford, Penobscot, Piscataquis, Somerset, Waldo, and Washington counties in Maine;            or Belknap, Carroll, Coos, and Grafton counties in New Hampshire;            You pay \$45 for each specialist office visit for Medicare-covered services.</p>

Benefit	Prime (HMO-POS) Plan
<p><b>Preventive care</b> Any additional preventive services approved by Medicare during the contract year will be covered. There are some items not covered at \$0 cost.</p>	<p><b>In-network:</b> You pay \$0 for additional preventive services approved by Medicare</p>
<p><b>Emergency care</b> <i>Note: You do not have to pay this amount if you are admitted to a hospital within 24 hours for the same condition.</i></p> <p>Emergency care is covered worldwide.</p> <p>There is a \$25,000 limit for worldwide emergency, urgent care, and ambulance transport, this limit does not apply to services in the U.S.</p>	<p><b>In- and Out-of-network</b> for members living in Lincoln, Oxford, Piscataquis, Somerset, and Waldo counties in Maine; or Belknap, Carroll, Cheshire, Coos, Grafton, Hillsborough, Merrimack, Rockingham, Strafford, and Sullivan counties in New Hampshire: You pay \$100 for each Medicare-covered emergency room visit.</p> <p><b>In- and Out-of-network</b> for members living in Androscoggin, Aroostook, Cumberland, Franklin, Kennebec, Hancock, Knox, Penobscot, Sagadahoc, Washington, and York counties in Maine: You pay \$120 for each Medicare-covered emergency room visit.</p>
<p><b>Urgently needed services</b> Urgent care is covered nationwide.</p> <p>There is a \$25,000 limit for worldwide emergency, urgent care, and ambulance transport, this limit does not apply to services in the U.S.</p> <p><i>Note: Your copay is based on your service area.</i></p>	<p><b>In- and Out-of-network</b> for members living in Lincoln, Oxford, Piscataquis, Somerset, and Waldo counties in Maine; or Belknap, Carroll, Coos, and Grafton counties in New Hampshire: You pay \$55 for each Medicare-covered urgent care visit when performed at an urgent care center.</p> <p><b>In- and Out-of-network</b> for members living in Androscoggin, Aroostook, Cumberland, Franklin, Hancock, Kennebec, Knox, Penobscot, Sagadahoc, Washington, and York counties in Maine; or members in Cheshire, Hillsborough, Merrimack, Rockingham, Strafford, and Sullivan counties in New Hampshire pay \$50 for each Medicare-covered urgent care visit when performed at an urgent care center.</p>

Benefit	Prime (HMO-POS) Plan
<p><b>Urgently needed services (continued)</b></p>	<p><b>Out-of-country</b> for members living in Lincoln, Oxford, Piscataquis, Somerset, and Waldo counties in Maine; or Belknap, Carroll, Cheshire, Coos, Grafton, Hillsborough, Merrimack, Rockingham, Strafford, and Sullivan counties in New Hampshire: You pay \$100 for each Medicare-covered urgent care visit when performed at an urgent care center outside of the United States and its associated territories.</p> <p><b>Out-of-country</b> for members living in Androscoggin, Aroostook, Cumberland, Franklin, Hancock, Kennebec, Knox, Penobscot, Sagadahoc, Washington, and York counties in Maine: You pay \$120 for each Medicare-covered urgent care visit when performed at an urgent care center outside of the United States and its associated territories.</p>
<p><b>Diagnostic Services / Labs / Imaging</b> Services may require that your provider get prior authorization (approval in advance). Please see the Evidence of Coverage for more information.</p>	<p><b>In-network:</b>  <b>Diagnostic Radiology Service (e.g., MRI)</b> You pay 20% of the contracted rate for complex diagnostic radiology (PET, CT, MRI, MRA, nuclear medicine)</p> <p><b>Lab Services</b> You pay 20% of the contracted rate for genetic labs. You pay \$0/\$5 copay for all other lab services.</p> <p><b>Diagnostic Tests and Procedures</b> You pay 15% of the contracted rate for simple diagnostic radiology.</p> <p><b>Outpatient X-rays</b> You pay 15% of the contracted rate for X-rays.</p>

Benefit	Prime (HMO-POS) Plan
<p><b>Hearing services</b>  <i>Note: Your copay is based on your service area.</i></p>	<p><b>Hearing Exam</b></p> <p><b>In-network</b> for members living in Androscoggin, Cumberland, Kennebec, Sagadahoc, and York counties in Maine; or Cheshire, Hillsborough, Merrimack, Rockingham, Strafford, and Sullivan counties in New Hampshire:  You pay \$40 per visit for Medicare-covered hearing services.</p> <p><b>In-network</b> for members living in Aroostook, Franklin, Hancock, Knox, Lincoln, Oxford, Penobscot, Piscataquis, Somerset, Waldo, and Washington counties in Maine; or Belknap, Carroll, Coos, and Grafton counties in New Hampshire:  You pay \$45 per visit for Medicare-covered hearing services.</p> <p><b>Hearing Aid Fittings and Evaluations</b>  You pay \$0 for 1 year of hearing aid fittings and ongoing hearing aid evaluations when used in conjunction with your hearing aid benefit.  <i>Services must be received from an Amplifon provider.</i></p> <p><b>Hearing Aids</b>  There is a \$1,000 benefit maximum (\$500 per ear, per year).  <i>Services must be received from an Amplifon provider.</i></p>
<p><b>Dental services (Medicare-covered)</b>  Services may require that your provider get prior authorization (approval in advance). Please see the Evidence of Coverage for more information.</p>	<p><b>In-network:</b>  You pay \$50 per visit for Medicare-covered dental services (non-routine dental care required to treat illness or injury).</p>
<p><b>Preventive and comprehensive dental</b>  Members must use a Martin’s Point Generations Delta Dental PPO or Premier dentist in Maine, New Hampshire, or Vermont to obtain these supplemental dental benefits.</p>	<p>Preventive and comprehensive dental services are covered.  <i>Please see Dental Overview on page 20 for more information.</i></p>

<b>Benefit</b>	<b>Prime (HMO-POS) Plan</b>
<p><b>Vision services</b>  <i>Note: Your copay is based on your service area.</i></p>	<p><b>In-network:</b>  <b>Annual routine eye exam</b>            You pay \$0 for an annual routine eye exam.</p> <p><b>Medicare-covered physician services</b></p> <p><b>In-network</b> for members living in Androscoggin, Cumberland, Kennebec, Sagadahoc, and York counties in Maine; or Cheshire, Hillsborough, Merrimack, Rockingham, Strafford, and Sullivan counties in New Hampshire:            You pay \$40 for non-routine Medicare-covered services.</p> <p><b>In-network</b> for members living in Aroostook, Franklin, Hancock, Knox, Lincoln, Oxford, Penobscot, Piscataquis, Somerset, Waldo, and Washington counties in Maine; or Belknap, Carroll, Coos, and Grafton counties in New Hampshire:            You pay \$45 for non-routine Medicare-covered physician services.</p> <p><b>Glaucoma testing</b>            You pay \$0 for glaucoma testing.</p> <p><b>Diabetic retinopathy</b>            You pay \$0 for a diabetic eye exam (retinopathy).</p> <p><b>Eyeglass frames, lenses, and contacts:</b>            The plan will reimburse up to \$150 for prescription frames, lenses, and contacts.</p>

Benefit	Prime (HMO-POS) Plan
<p><b>Mental health services</b>            Services may require that your provider get prior authorization (approval in advance). Please see the Evidence of Coverage for more information.</p> <p><i>Note: Your copay is based on your service area.</i></p>	<p><b>In-network:</b>  <b>Inpatient visit</b>            You pay per admission:            \$220 per day for days 1-7;            \$0 per day for days 8+.</p> <p><b>Outpatient individual therapy visit</b>            You pay \$25 per visit for individual therapy.</p> <p><b>Outpatient group therapy visit</b>  <b>In-network</b> for members in Androscoggin, Aroostook, Franklin, Hancock, Knox, Lincoln, Oxford, Penobscot, Piscataquis, Somerset, Waldo, and Washington counties in Maine; or Belknap, Carroll, Coos, and Grafton counties in New Hampshire:            You pay \$10 per visit for group therapy.</p> <p><b>In-network</b> for members living in Cumberland, Kennebec, Sagadahoc, and York counties in Maine; or Cheshire, Hillsborough, Merrimack, Rockingham, Strafford, and Sullivan counties in New Hampshire:            You pay \$25 per visit for group therapy.</p>
<p><b>Skilled nursing facility</b>            Services may require that your provider get prior authorization (approval in advance). Please see the Evidence of Coverage for more information.</p>	<p><b>In-network:</b>  <b>For each benefit period you pay for Medicare-covered services:</b>            \$0 per day for days 1-20;            \$203 per day for days 21-100</p>
<p><b>Physical therapy</b>  <i>Note: Your copay is based on your service area.</i></p>	<p><b>In-network</b> for members living in Lincoln, Oxford, Piscataquis, Somerset, and Waldo counties in Maine; or Belknap, Carroll, Coos, and Grafton counties in New Hampshire:            You pay \$30 for each Medicare-covered visit.</p>

Benefit	Prime (HMO-POS) Plan
<p><b>Physical therapy (continued)</b></p>	<p><b>In-network</b> for members living in Androscoggin, Aroostook, Cumberland, Franklin, Hancock, Knox, Kennebec, Penobscot, Sagadahoc, Washington, and York counties in Maine; or Cheshire, Hillsborough, Merrimack, Rockingham, Strafford, and Sullivan counties in New Hampshire: You pay \$40 for each Medicare-covered visit.</p>
<p><b>Ambulance</b> Non-emergency ambulance transportation services may require that your provider get prior authorization (approval in advance). Please see the Evidence of Coverage for more information.</p> <p>Ambulance services are covered worldwide.</p> <p>There is a \$25,000 limit for worldwide emergency, urgent care, and ambulance transport. This limit does not apply to services in the U.S.</p>	<p><b>In- and Out-of-network:</b> You pay \$325 for each Medicare-covered emergency ambulance service (one-way).</p>
<p><b>Transportation</b></p> <p><b>Medicare Part B drugs</b> Services may require that your provider get prior authorization (approval in advance). Please see the Evidence of Coverage for more information.</p>	<p>Not a covered benefit.</p> <p><b>In-network:</b> You pay 20% of the contracted rate for Medicare-covered services.</p>

## Outpatient Prescription Drugs Prime (HMO-POS) Plan

**Prescription Deductible:** You pay \$0

	<b>Standard Retail</b> (30-day supply)	<b>Preferred Retail</b> (30-day supply)	<b>Mail-Order</b> (30-day supply)	
<b>Phase 1: Initial Coverage</b>				
<b>Cost sharing Tier 1</b> (Preferred Generic)	\$4	\$0	\$4	Cost sharing may change depending on the pharmacy you choose and when you enter another phase of the Part D benefit. You won't pay more than \$35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on. For more information on the additional pharmacy-specific cost sharing and the phases of the benefit, please refer to the Evidence of Coverage
<b>Cost sharing Tier 2</b> (Generic)	\$18	\$10	\$18	
<b>Cost sharing Tier 3</b> (Preferred Brand)	\$47	\$40	\$47	
<b>Cost sharing Tier 4</b> (Non-Preferred Drug)	\$100	\$95	\$100	
<b>Cost sharing Tier 5</b> (Specialty Tier)	33%	33%	33%	
<b>Cost sharing Tier 6</b> (Select Care Drug)	\$4	\$0	\$4	

**Phase 2: Coverage Gap** (after you or others on your behalf pay \$5,030)

During this phase you will pay 25% for generic or brand-name drugs in Tiers 1-5, and 15% for generic or brand name drugs in Tier 6.

**Phase 3: Catastrophic Coverage** (after you or others on your behalf pay \$8,000)

**Generic or Brand-Name Drugs**

During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.

**Outpatient Prescription Drugs Prime (HMO-POS) Plan**

**Prescription Deductible:** You pay \$0

	<b>Standard Retail</b> (90-day supply)	<b>Preferred Retail</b> (90-day supply)	<b>Mail-Order</b> (90-day supply)	
<b>Phase 1: Initial Coverage</b>				
<b>Cost sharing Tier 1</b> (Preferred Generic)	\$12	\$0	\$10	Cost sharing may change depending on the pharmacy you choose and when you enter another phase of the Part D benefit. You won't pay more than \$70 for up to a two-month supply or \$105 for up to a three-month supply of each covered insulin product regardless of the cost-sharing tier. For more information on the additional pharmacy-specific cost sharing and the phases of the benefit, please refer to the Evidence of Coverage
<b>Cost sharing Tier 2</b> (Generic)	\$54	\$30	\$45	
<b>Cost sharing Tier 3</b> (Preferred Brand)	\$141	\$120	\$117.50	
<b>Cost sharing Tier 4</b> (Non-Preferred Drug)	\$300	\$285	\$250	
<b>Cost sharing Tier 5</b> (Specialty Tier)	Not covered	Not covered	Not covered	
<b>Cost sharing Tier 6</b> (Select Care Drug)	\$12	\$0	\$0	

**Phase 2: Coverage Gap** (after you or others on your behalf pay \$5,030)

During this phase you will pay 25% for generic or brand-name drugs in Tiers 1-5, and 15% for generic or brand name drugs in Tier 6.

**Phase 3: Catastrophic Coverage** (after you or others on your behalf pay \$8,000)

**Generic or Brand-Name Drugs**

During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.

**Additional Benefits**

**Prime (HMO-POS) Plan**

**Wellness Wallet** (Fitness, Naturopathic Services, Acupuncture, Nutrition/Dietary Education, Weight Management Programs, and Face Masks)  
Please see the Evidence of Coverage for more information.

For members living in Androscoggin, Aroostook, Franklin, Hancock, Kennebec, Knox, Lincoln, Oxford, Piscataquis, Penobscot, Sagadahoc, Somerset, Washington, and Waldo counties in Maine; or Belknap, Carroll, Cheshire, Coos, Grafton, Hillsborough, Merrimack, Rockingham, Strafford, and Sullivan counties in NH:

The plan will reimburse up to \$425 each year in total for Fitness Benefit, Naturopathic Services, Acupuncture, Nutrition/Dietary Education, Weight Management Programs, and Face Masks.

For members living in Cumberland and York counties in Maine:  
The plan will reimburse up to \$650 each year in total for Fitness Benefit, Naturopathic Services, Acupuncture, Nutrition/Dietary Education, Weight Management Programs, and Face Masks.

**Over-The-Counter items (OTC)**  
More than 350 covered items including: non-prescription medicine (pain relief, cough, allergies), toothpaste, first aid items, and vitamins. Members can order online, over the phone, or visit a designated store location.

For members living in Cheshire, Hillsborough, Merrimack, Rockingham, Strafford, and Sullivan counties in New Hampshire:  
The plan will cover up to \$25 per quarter for members to purchase select CVS brand over-the-counter (OTC) products.

Please see the Evidence of Coverage for more information.

For members living in Androscoggin, Aroostook, Cumberland, Franklin, Hancock, Kennebec, Knox, Lincoln, Oxford, Penobscot, Piscataquis, Sagadahoc, Somerset, Waldo, Washington, and York counties in Maine; Belknap, Carroll, Coos, and Grafton counties in New Hampshire:

*Note: Your allowance is based on your service area.*

	<p>The plan will cover up to \$50 per quarter for members to purchase select CVS brand over-the-counter (OTC) products.</p> <p><i>The benefit refreshes quarterly. Remaining balances do not carry over to the next quarter.</i></p>
<p><b>Nutrition and dietary</b>  <b>Telenutrition:</b> Members have access to an online nutrition/dietary platform and unlimited visits with a registered dietitian via video connection, email, or telephone through third-party vendor FoodSmart™.</p> <p><i>Note: Food cost and delivery of meals/groceries are not covered under this benefit.</i></p>	<p>\$0 cost for telenutrition services through FoodSmart™</p>

All plans cover Part B drugs such as chemotherapy and some drugs administered by your provider.

In addition, **Generations Advantage Prime** Covers Part D drugs.

You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions, our plan’s pharmacy directory and our plan’s provider directory on our website at **[www.MartinsPoint.org/MedicareMembers](http://www.MartinsPoint.org/MedicareMembers)**.

If you want to know more about the coverage and costs of Original Medicare, look in your Medicare & You 2024 Handbook. You can download a copy of from the Medicare website (**[www.medicare.gov](http://www.medicare.gov)**) or ask for a printed copy 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.

<b>Benefit</b>	<b>Prime (HMO-POS) Plan</b>
<p><b>Point-of-Service</b></p> <p>The Prime plan has a Point-of-Service (POS) benefit where you can use an out-of-network provider for certain services. Under the POS, you will generally pay a higher cost share when using an out-of-network provider. Please refer to the Evidence of Coverage for more information.</p>	<p>Services available in the POS benefit:</p> <p><b>Doctor visits (Primary Care and Specialist)</b></p> <ul style="list-style-type: none"> <li>➤Chiropractic visits \$55</li> <li>➤Physician Specialist visits \$55</li> <li>➤Podiatry visits \$55</li> <li>➤Primary Care visits \$35</li> </ul> <p>(Allowed only outside the plan’s service area)</p>
	<p><b>Inpatient hospital care</b></p> <ul style="list-style-type: none"> <li>➤You pay 40% of the cost per admission. Prior authorization is required.</li> </ul>
	<p><b>Outpatient services</b></p> <ul style="list-style-type: none"> <li>➤Diabetes self-management 20% of the Medicare-allowed cost for supplies and shoes; \$0 for training</li> <li>➤Durable medical equipment 30% of the Medicare-allowed cost</li> <li>➤Medicare Part B prescription drugs, including chemotherapy 20% of the Medicare-allowed cost</li> <li>➤Outpatient diagnostic tests/procedures, X-rays, and lab services 0-20% of the Medicare-allowed cost; all other labs: \$5</li> <li>➤Outpatient mental health and substance abuse group and individual therapy: \$30</li> <li>➤Outpatient rehabilitation services (Physical, Occupational, and Speech therapy) \$55</li> <li>➤Outpatient surgery in a hospital or ambulatory surgical center \$400/\$200</li> <li>➤Radiation therapy 30% of the Medicare-allowed cost</li> </ul>
	<p><b>Dental services</b></p> <p>Medicare-covered dental services \$55</p>
	<p><b>Hearing services</b></p> <p>Medicare-covered hearing services \$55</p>
	<p><b>Vision services</b></p> <ul style="list-style-type: none"> <li>➤Medicare-covered vision services \$55</li> <li>➤Annual routine eye exam 30% of the Medicare- allowed cost</li> </ul>

### Section 3: Dental Benefit Overview

The **Generations Advantage Prime (HMO-POS)** plan includes the following benefits when seeing a Delta Dental network dentist. This benefit overview is provided for summary purposes only.

#### Delta Dental Network

Plan benefits are available only when you receive your dental care from a Delta Dental network dentist in Maine, New Hampshire, or Vermont:

- ▶ **No Balance Billing:** Participating dentists accept Delta Dental’s fees for services as payment in full.
- ▶ **No Claims Paperwork:** Participating dentists will prepare and submit claims for you.
- ▶ **Direct Payment:** Delta Dental pays participating dentists directly, so you don’t have to pay the covered amount up front and wait for reimbursement.

To find out if your dentist participates in the Delta Dental network, please visit our website at [www.MartinsPoint.org/MedicareMembers](http://www.MartinsPoint.org/MedicareMembers), visit [www.nedelta.com/Dentist-Search](http://www.nedelta.com/Dentist-Search), or call **Delta Dental’s Customer Service Department at 1-800-832-5700 (TTY: 711) Monday through Friday, 8am – 4:45pm.**

**\*Note:** Cleanings are limited to two per calendar year (once for members living in Cumberland and York counties in Maine); you may choose from Category A (preventative/routine) and/or Category B (periodontal). Office visit copays and coinsurances apply.

Dental Benefit	Prime
<b>Benefit Maximum for members living in</b> Lincoln, Oxford, Piscataquis, Somerset, and Waldo counties in Maine or Belknap, Carroll, Coos, and Grafton counties in New Hampshire:	<b>\$500</b>
<b>Benefit Maximum for members living in</b> Aroostook, Franklin, Hancock, Knox, Penobscot, and Washington counties in Maine:	<b>\$750</b>
<b>Benefit Maximum for members living in</b> Androscoggin, Cumberland, Kennebec, Sagadahoc, and York Counties in Maine or members living in Cheshire, Hillsborough, Merrimack, Rockingham, Strafford, and Sullivan counties in New Hampshire:	<b>\$1,000</b>
<b>Office Visit copay</b>	<b>\$50</b>
<b>Category A: Diagnostic/Preventative</b>	
Oral exam and routine cleaning* twice in a calendar year (once for members living in Cumberland and York counties in Maine)	No cost sharing (must pay office visit copay)
Problem-focused exams as needed	
Bitewing x-rays once every calendar year and panoramic x-rays once in a 5 calendar year period	
X-rays of individual teeth as needed	
<b>Category B: Basic Restorative</b>	
Amalgam (silver) fillings	You pay 50% of the cost + \$50 office visit copay
Resin restoration on anterior teeth, posterior teeth, and the buccal surface of bicuspid only	
Surgical and routine extractions	
Root canals	
Treatment of gum disease (periodontics, including periodontal maintenance cleanings*)	
<b>Category C: Major Restorative</b>	
Dentures	You pay 50% of the cost + \$50 office visit copay
Crowns	
Implants	

## **Section 3: Dental Benefit Overview (Continued)**

### **Claim Process for Participating Dentists**

Present your Generations Advantage member ID card to your participating dentist at the time of your visit. Your participating dentist will submit your claim to Delta Dental.

Members can register online to view claims and benefit information at [www.nedelta.com](http://www.nedelta.com).

### **Non-participating Dentists**

No benefits are available under your policy if you choose to visit a dentist who is not participating in the Delta Dental network. Non-participating dentists are welcome to join the Delta Dental network at any time.

### **Identification Cards**

Your Generations Advantage member ID card includes your dental group number and the Delta Dental customer service number. Your member ID number for dental benefits is the same as your Generations Advantage Prime plan member ID number.

**Martin's Point Generations Advantage Alliance (HMO)**

## Section 1: Introduction

**This is a summary of drug and health services covered by Martin's Point Generations Advantage Alliance Plan.**

**January 1, 2024 - December 31, 2024**

Martin's Point Generations Advantage is a health plan with a Medicare contract offering HMO, HMO-POS, and Local PPO products.

Enrollment in a Martin's Point Generations Advantage plan depends on contract renewal.

This information may be available in other formats such as large print, Braille, or an electronic copy on our website. For more information call Generations Advantage at 1-866-544-7504.

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 see the Evidence of Coverage on our website, or you may contact us. To join Martin's Point Generations Advantage Alliance, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

Our service area includes all counties in Maine and New Hampshire.

The plan 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.

**This plan does not cover Part D prescription drugs.**

## Section 2: Summary of Benefits

This is a summary of drug and health services covered by Martin's Point Generations Advantage Alliance (HMO) plan.

Plan Name	Alliance (HMO) Plan	Part B Premium Buy-Down
You must continue to pay your Medicare Part B premium	\$0	\$50

Benefit	Alliance (HMO) Plan
<b>Deductible</b> Our plan does not have a deductible.	You pay \$0 annually.
<b>Maximum out-of-pocket</b> ( <i>does not include prescription drugs</i> ) Our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care.	\$5,000 annually.
<b>Inpatient hospital</b> Services may require that your provider get prior authorization (approval in advance). Please have your provider contact the plan for more details.	You pay per admission: \$360 per day for days 1-7; \$0 per day for days 8+.
<b>Outpatient hospital</b> Services may require that your provider get prior authorization (approval in advance). Please have your provider contact the plan for more details.	You pay \$275 for Medicare-covered surgery services at a hospital outpatient facility.
<b>Ambulatory &amp; Surgical Centers</b> Services may require that your provider get prior authorization (approval in advance). Please have your provider contact the plan for more details.	You pay \$10 for Medicare-covered surgery services at an ambulatory surgical center.
<b>Doctor visits</b>	<b>Primary care</b> You pay \$0 for each Primary Care Physician (PCP) office visit for Medicare-covered services. <b>Specialists</b> You pay \$5 for each specialist office visit for Medicare-covered services.
<b>Preventive care</b> Any additional preventive services approved by Medicare during the contract year will be covered. There are some items not covered at \$0 cost.	You pay \$0 for additional preventive services approved by Medicare.

Benefit	Alliance (HMO) Plan
<p><b>Emergency care</b>  <i>Note: You do not have to pay this amount if you are admitted to a hospital within 24 hours for the same condition.</i></p> <p>Emergency care is covered worldwide.</p> <p>There is a \$25,000 limit for worldwide emergency, urgent care, and ambulance transport, this limit does not apply to services in the U.S.</p>	<p><b>In- and Out-of-network:</b>            You pay \$120 for each Medicare-covered emergency room visit.</p>
<p><b>Urgently needed services</b>            Urgent care is covered nationwide.</p> <p>There is a \$25,000 limit for worldwide emergency, urgent care, and ambulance transport, this limit does not apply to services in the U.S.</p> <p><b>Diagnostic Services / Labs / Imaging</b>            Services may require that your provider get prior authorization (approval in advance). Please see the Evidence of Coverage booklet for more information.</p>	<p><b>In- and Out-of-network:</b>            You pay \$0 for each Medicare-covered urgent care visit when performed at an urgent care center.</p> <p><b>Out-of-Country:</b>            You pay \$120 for each Medicare-covered urgent care visit when performed at an urgent care center outside of the United States and its associated territories.</p> <p><b>Diagnostic Radiology service (e.g., MRI)</b>            You pay 20% of the contracted rate for complex diagnostic radiology (PET, CT, MRI, MRA, nuclear medicine)</p> <p><b>Lab services</b>            You pay 20% of the contracted rate for genetic labs.            You pay \$0/\$5 copay for lab services.</p> <p><b>Diagnostic tests and procedures</b>            You pay 5% of the contracted rate for simple diagnostic radiology.</p> <p><b>Outpatient x-rays</b>            You pay 5% of the contracted rate for x-rays.</p>

Benefit	Alliance (HMO) Plan
<p><b>Hearing services</b></p>	<p><b>Hearing exam</b> You pay \$5 per visit for Medicare-covered hearing services.</p> <p><b>Hearing aid fittings and evaluations</b> You pay \$0 for 1 year of hearing aid fittings and ongoing hearing aid evaluations when used in conjunction with your hearing aid benefit. <i>Services must be received from an Amplifon provider.</i></p> <p>Hearing aids There is a \$1,400 benefit maximum (\$700 copay per ear, per year). <i>Services must be received from an Amplifon provider.</i></p>
<p><b>Dental services (Medicare-covered)</b> Services may require that your provider get prior authorization (approval in advance). Please see the Evidence of Coverage for more information.</p> <p><b>Preventive and comprehensive dental</b> Members must use Delta Dental’s PPO/Premier or Martin's Point Generations Advantage network dentist in Maine, New Hampshire, or Vermont to obtain these supplemental dental benefits.</p>	<p>You pay \$5 per visit for Medicare-covered dental services (non-routine dental care required to treat illness or injury).</p> <p>Preventive and Comprehensive Dental services are covered. <i>Please see Dental Overview on page 31 for more information.</i></p>
<p><b>Vision services</b></p>	<p><b>Annual routine eye exam:</b> You pay \$0 for an annual routine eye exam.</p> <p><b>Medicare-covered physician services:</b> You pay \$5 for non-routine Medicare-covered physician services.</p> <p><b>Glaucoma testing:</b> You pay \$0 for glaucoma testing.</p> <p><b>Diabetic retinopathy:</b> You pay \$0 for a diabetic eye exam (retinopathy).</p>

Benefit	Alliance (HMO) Plan
<p><b>Vision services (continued)</b></p>	<p><b>Eyeglass frames, lenses, and contacts:</b> The plan will reimburse up to \$300 for prescription frames, lenses, and contacts.</p>
<p><b>Mental health services</b> Services may require that your provider get prior authorization (approval in advance). Please see the Evidence of Coverage for more information.</p>	<p><b>Inpatient visit:</b> You pay per admission: \$220 per day for days 1-7; \$0 per day for days 8+</p> <p><b>Outpatient individual therapy visit</b> You pay \$0 per visit for individual therapy.</p> <p><b>Outpatient group therapy visit</b> You pay \$0 per visit for group therapy.</p>
<p><b>Skilled nursing facility</b> Services may require that your provider get prior authorization (approval in advance). Please see the Evidence of Coverage for more information.</p>	<p><b>In-network:</b> For each benefit period you pay for Medicare-covered services: \$10 per day for days 1-20; \$203 per day for days 21-100</p>
<p><b>Physical therapy</b></p>	<p>You pay \$0 for each Medicare-covered visit.</p>
<p><b>Ambulance</b> Non-emergency ambulance transportation may require that your provider get prior authorization (approval in advance). Please see the Evidence of Coverage for more information.</p> <p>Ambulance services covered worldwide.</p> <p>There is a \$25,000 limit for worldwide emergency, urgent care, and ambulance transport, this limit does not apply to services in the U.S.</p>	<p><b>In- and Out-of-network:</b> You pay \$325 for each Medicare-covered emergency ambulance service (one-way).</p>
<p><b>Transportation</b></p>	<p>Not a covered benefit.</p>

Benefit	Alliance (HMO) Plan
<b>Medicare Part B drugs</b> Services may require that your provider get prior authorization (approval in advance). Please see the Evidence of Coverage for more information.	You pay 20% of the contracted rate for Medicare-covered services.
<b>Health education</b> Coverage is for plan-sponsored health coaching, support groups, and cooking classes.	You pay \$0 for plan-sponsored health coaching support groups, and cooking classes.

Additional Benefits Alliance (HMO) Plan	
<b>Outpatient substance use</b>	You pay \$0 per visit for individual therapy; \$0 per visit for group therapy.
<b>Smoking and tobacco cessation counseling</b>	You pay \$0 for 2 additional sessions beyond Medicare-covered benefit.
<b>Over-The-Counter (OTC)</b> More than 350 covered items including: non-prescription medicine (pain relief, cough, allergies), toothpaste, first aid items, and vitamins. Members can order online, over the phone, or visit a designated store location. Please see the Evidence of Coverage for more information.	The plan will cover up to \$100 per quarter for members to purchase select CVS brand over-the-counter (OTC) products.  <i>The benefit refreshes quarterly. Remaining balances do not carry over to the next quarter.</i>
<b>Eyewear (contacts, frames, lenses)</b>	The plan will cover \$300 each year for lenses, frames, and contact lenses (cannot be used in conjunction with Medicare-covered eyewear benefit).
<b>Wellness Wallet</b> (Fitness, Naturopathic Services, and Acupuncture, Nutrition/Dietary Education, and Weight Management Programs and Face Masks) Please see the Evidence of Coverage for more information.	The plan will reimburse up to \$450 each year in total for Fitness Benefit, Naturopathic Services, and Acupuncture, Nutrition/Dietary Education, Weight Management Programs, and Face Masks.

## Additional Benefits Alliance (HMO) Plan

<p><b>Personal Emergency Response System (Device and Monitoring)</b>  <b>Bathroom safety devices</b>          (Assessment, Devices and Installation)</p>	<p>You pay \$0.</p> <p>The plan will reimburse up to \$400 per year for non-Medicare-covered safety devices, installation, and assessment to prevent injuries in the bathroom.</p>
<p><b>Meals</b>          Up to 3 weeks (42 meals) per inpatient stay or surgery.          Up to 1 week (14 meals) per year as part of supervised program to transition into lifestyle modifications.</p>	<p>You pay \$0</p>
<p><b>Fall prevention program</b></p>	<p>The plan will cover the cost of plan sponsored evidence-based falls prevention programs, such as Healthy Steps for Older Adults, facilitated by Southern Maine Agency on Aging.</p> <p>The plan will reimburse up to \$50 per year for members to attend an evidence-based falls prevention program supported by the National Council on Aging (NCOA).</p>
<p><b>Routine chiropractic services</b></p>	<p>You pay \$20 for each visit for routine chiropractic services.</p>
<p><b>Nutrition and dietary:</b>  <b>Telenutrition:</b> Members have access to an online nutrition/dietary platform and unlimited visits with a registered dietitian via video connection, email, or telephone through third-party vendor FoodSmart™.  <i>Note: Food cost and delivery of meals/groceries are not covered under this benefit.</i></p>	<p>\$0 cost for telenutrition services through FoodSmart™</p>

All plans cover Part B drugs such as chemotherapy and some drugs administered by your provider.

You can see our plan's provider directory on our website at [www.MartinsPoint.org/MedicareMembers](http://www.MartinsPoint.org/MedicareMembers).

If you want to know more about the coverage and costs of Original Medicare, look in your *Medicare & You 2024* Handbook. You can download a copy of from the Medicare website ([www.medicare.gov](http://www.medicare.gov)) or ask for a printed copy 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.

## Section 3: Dental Benefit Overview

The Generations Advantage Alliance (HMO) plan includes the following benefits when seeing a Delta Dental network dentist. This benefit overview is provided for summary purposes only.

Alliance	
<b>Benefit Maximum</b>	<b>\$2,500</b>
<b>Office Visit Copay</b>	<b>\$0</b>
<b>Category A: Diagnostic/Preventative</b>	
Oral exam twice in a calendar year	No cost sharing
Routine cleaning twice per calendar year*	
Problem-focused exams as needed	
Bitewing x-rays once every calendar year and panoramic x-rays once in a 5calendar year period	
X-rays of individual teeth as needed	
<b>Category B: Basic Restorative</b>	
Amalgam (silver) fillings	You pay 20% of the cost
Resin restoration on anterior teeth and the buccal surface of bicuspids only	
Surgical and routine extractions	
Root canals	
Treatment of gum disease (periodontics, including periodontal maintenance cleanings*)	
<b>Category C: Major Restorative</b>	
Dentures	You pay 50% of the cost
Crowns	
Implants	

\***Note:** Cleanings are limited to twice per calendar year; you may choose from Category A (preventative/routine) and/or Category B (periodontal). Office visit copays and coinsurances apply.

### Identification Cards

Your Generations Advantage member ID card includes your dental group number and the Delta Dental customer service number. Your member ID number for dental benefits is the same as your Generations Advantage Alliance plan member ID number.

### Delta Dental Network:

Plan benefits are available only when you receive your dental care from a Delta Dental network dentist in Maine, New Hampshire, or Vermont:

- ▶ **No Balance Billing:** Participating dentists accept Delta Dental's fees for services as payment in full.
- ▶ **No Claims Paperwork:** Participating dentists will prepare and submit claims for you.
- ▶ **Direct Payment:** Delta Dental pays participating dentists directly, so you don't have to pay the covered amount up front and wait for reimbursement.

To find out if your dentist participates in the Delta Dental network, please visit our website at [www.MartinsPoint.org/MedicareMembers](http://www.MartinsPoint.org/MedicareMembers), visit [www.nedelta.com/Dentist-Search](http://www.nedelta.com/Dentist-Search), or call **Delta Dental's Customer Service Department at 1-800-832-5700 (TTY: 711) Monday through Friday, 8am – 4:45pm.**

### Claim Process for Participating Dentists

Present your Generations Advantage member ID card to your participating dentist at the time of your visit. Your participating dentist will submit your claim to Delta Dental.

Members can register online to view claims and benefit information at [www.nedelta.com](http://www.nedelta.com).

### Non-participating Dentists

No benefits are available under your policy if you choose to visit a dentist who is not participating in the Delta Dental network. Non-participating dentists are welcome to join the Delta Dental network at any time.

**Martin's Point Generations Advantage Select (LPPO)**

## Section 1: Introduction

**This is a summary of drug and health services covered by Martin's Point Generations Advantage Select (LPPO) plan.**

**January 1, 2024 - December 31, 2024**

Martin's Point Generations Advantage is a health plan with a Medicare contract offering HMO, HMO-POS, and Local PPO products.

Enrollment in a Martin's Point Generations Advantage plan depends on contract renewal.

This information may be available in other formats such as large print, braille, or an electronic copy on our website. For more information call Generations Advantage at 1-866-544-7504.

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 see the Evidence of Coverage on our website, or you may contact us. To join Martin's Point Generations Advantage Select, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

**For Martin's Point Generations Advantage Select (LPPO) plan:**

► Our service area includes: Androscoggin, Aroostook, Cumberland, Franklin, Hancock, Kennebec, Knox, Lincoln, Oxford, Penobscot, Piscataquis, Sagadahoc, Somerset, Waldo, Washington, and York counties in Maine; and Cheshire, Coos, Hillsborough, Merrimack, Rockingham, Strafford, and Sullivan counties in New Hampshire.

The Select plan has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers in our network, you may pay less for your covered services. But if you want to, you can also use providers that are not in our network.

## Section 2: Summary of Benefits

This is a summary of drug and health services covered by Martin's Point Generations Advantage Select (LPPO) plan.

Plan Name	Plan Service Area	Monthly Premium
<b>Martin's Point Generations Advantage Select</b>  <i>Note: Your premium is based on your service area.</i>	Androscoggin, Aroostook, Cumberland, Franklin, Hancock, Kennebec, Knox, Lincoln, Oxford, Penobscot, Piscataquis, Sagadahoc, Somerset, Waldo, Washington, and York counties in Maine; or Cheshire, Coos, Hillsborough, Merrimack, Rockingham, Strafford, and Sullivan counties in New Hampshire	\$99

Benefit	Select (LPPO) Plan
<b>Deductible</b>  <b>Maximum out-of-pocket</b> (does not include prescription drugs) Our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care.  <i>Note: Your Maximum Out-of-Pocket is based on your service area.</i>	You pay \$0 annually  \$6,750 annually
<b>Inpatient hospital</b>  <i>Note: Your copay is based on your service area.</i>  Services may require that your provider get prior authorization (approval in advance). Please have your provider contact the plan for more details.	<b>In-network:</b> <b>You pay per admission:</b> \$340 per day for days 1-7; \$0 per day for days 8+  <b>Out-of-network:</b> <b>You pay per admission:</b> 40% of the Medicare-allowed cost for a Medicare-covered hospital stay.

Benefit	Select (LPPO) Plan
<p><b>Outpatient hospital</b> Services may require that your provider get prior authorization (approval in advance). Please have your provider contact the plan for more details.</p> <p><i>Note: Your copay is based on your service area.</i></p>	<p><b>In-network:</b> You pay \$175 for Medicare-covered surgery services at a hospital outpatient facility.</p> <p><b>Out-of-network:</b> You pay 30% of the Medicare-allowed cost of Medicare-covered surgery services at a hospital outpatient facility.</p>
<p><b>Ambulatory &amp; Surgical Centers (ASC)</b> <i>Note: Your copay is based on your service area.</i></p> <p>Services may require that your provider get prior authorization (approval in advance). Please have your provider contact the plan for more details.</p>	<p><b>In-network:</b> You pay \$125 for Medicare-covered surgery services at an ambulatory surgical center.</p> <p><b>Out-of-network:</b> You pay 30% of the Medicare-allowed cost of Medicare-covered surgery services at an ambulatory surgical center.</p>
<p><b>Doctor visits</b> <i>Note: Your copay is based on your service area.</i></p>	<p><b>Primary care</b></p> <p><b>In-network:</b> You pay \$0 for post-operative and post-discharge visits with your PCP. You pay \$0 for a brief emotional/behavioral assessment with your PCP. You pay \$10 for all other PCP services and visits.</p> <p><b>Out-of-network:</b> You pay 30% of the Medicare-allowed cost for each Primary Care Physician (PCP) office visit for Medicare-covered services.</p> <p><b>Specialists</b></p> <p><b>In-network:</b> You pay \$40 for each specialist office visit for Medicare-covered services.</p> <p><b>Out-of-network:</b> You pay 30% of the Medicare-allowed cost for each specialist office visit for Medicare-covered services.</p>

<b>Benefit</b>	<b>Select (LPPO) Plan</b>
<p><b>Preventive care</b> Any additional preventive services approved by Medicare during the contract year will be covered. There are some items not covered at \$0 cost. <i>Note: Your copay is based on your service area.</i></p>	<p><b>In-network:</b> You pay \$0 for additional preventive services approved by Medicare</p> <p><b>Out-of-network:</b> You pay \$0 for additional preventive services approved by Medicare</p>
<p><b>Emergency care</b> <i>Note: You do not have to pay this amount if you are admitted to a hospital within 24 hours for the same condition.</i> Emergency care is covered worldwide. There is a \$25,000 limit for worldwide emergency, urgent care, and ambulance transport, this limit does not apply to services in the U.S.</p>	<p><b>In- and Out-of-network:</b> You pay \$100 for each Medicare-covered emergency room visit.</p>
<p><b>Urgently needed services</b> Urgent care is covered nationwide.  There is a \$25,000 limit for worldwide emergency, urgent care, and ambulance transport, this limit does not apply to services in the U.S.</p>	<p><b>In- and Out-of-network:</b> You pay \$50 for each Medicare-covered urgent care visit when performed at an urgent care center.</p> <p><b>Out-of-Country:</b> You pay \$100 for each Medicare-covered urgent care visit when performed at an urgent care center outside of the United States and its associated territories.</p>
<p><b>Diagnostic Services / Labs / Imaging</b> Services may require that your provider get prior authorization (approval in advance). Please see the Evidence of Coverage for more information.</p>	<p><b>Diagnostic radiology service (e.g., MRI)</b></p> <p><b>In-network:</b> You pay 20% of the contracted rate for complex diagnostic radiology (such as PET, CT, MRI, MRA, nuclear medicine)</p> <p><b>Out-of-network:</b> You pay 30% of the Medicare-allowed cost of complex diagnostic radiology (PET, CT, MRI, MRA, nuclear medicine).</p> <p><b>Lab services</b></p> <p><b>In-network:</b></p>

**Benefit****Select (LPPO) Plan**

You pay 20% of the contracted rate for genetic labs.  
You pay \$0/\$5 copay for all other lab services.

**Out-of-network:**

You pay 20% of the Medicare-allowed cost for genetic labs.  
You pay \$0/\$5 copay for all other lab services.

**Diagnostic tests and procedures****In-network:**

You pay 15% of the contracted rate for simple diagnostic radiology.

**Out-of-network:**

You pay 15% of the Medicare-allowed cost of simple diagnostic radiology.

**Outpatient x-rays****In-network:**

You pay 15% of the contracted rate for X-rays.

**Out-of-network:**

You pay 15% of the Medicare-allowed cost for x-rays.

Benefit	Select (LPPO) Plan
<p><b>Hearing services</b></p>	<p><b>Hearing exam</b>  <b>In-network:</b>            You pay \$40 per visit for Medicare-covered hearing services.</p> <p><b>Out-of-network:</b>            You pay 30% of the Medicare-allowed cost.</p> <p><b>Hearing aid fittings and evaluations</b>  <b>In-network:</b>            You pay \$0 for 1 year of hearing aid fittings and ongoing hearing aid evaluations when used in conjunction with your hearing aid benefit.  <i>Services must be received from an Amplifon provider.</i></p> <p><b>Hearing aids</b>  <b>In-network:</b>            There is a \$1,000 benefit maximum (\$500 copay per ear, per year).  <i>Services must be received from an Amplifon provider.</i></p>
<p><b>Dental services (Medicare-covered)</b>            Services may require that your provider get prior authorization (approval in advance). Please see the Evidence of Coverage for more information.</p>	<p><b>In-network:</b>            You pay \$40 per visit for Medicare-covered dental services (non-routine dental care required to treat illness or injury).</p> <p><b>Out-of-network:</b>            You pay 30% of the Medicare-allowed cost.</p>
<p><b>Preventive and comprehensive dental</b>  <i>Note: Your Preventive and Comprehensive Dental Coverage is based on your service area.</i></p>	<p>Not a covered benefit.</p>

**Benefit****Select (LPPO) Plan****Vision services****Annual routine eye exam****In-network:**

You pay \$0 for an annual routine eye exam.

**Out-of-network:**

You pay 30% of the Medicare-allowed cost for an annual routine eye exam.

**Medicare-covered physician services****In-network:**

You pay \$40 for non-routine Medicare-covered physician services.

**Out-of-network:**

You pay 30% of the Medicare-allowed cost of non-routine Medicare-covered physician services.

**Glaucoma testing****In- and Out-of-network:**

You pay \$0 for glaucoma testing.

**Diabetic retinopathy****In-Network:**

You pay \$0 for a diabetic eye exam (retinopathy).

**Out-of-network:**

You pay 30% of the Medicare-allowed cost for a diabetic eye exam (retinopathy).

**Eyeglass frames, lenses, and contacts:**

The plan will reimburse up to \$150 for prescription frames, lenses, and contacts.

Benefit	Select (LPPO) Plan
<p><b>Mental health services</b>            Services may require that your provider get prior authorization (approval in advance). Please see the Evidence of Coverage for more information.</p> <p><i>Note: Your copay is based on your service area.</i></p>	<p><b>Inpatient visit</b></p> <p><b>In-network:</b>            You pay per admission:            \$220 per day for days 1-7;            \$0 per day for days 8+</p> <p><b>Out-of-network:</b>            You pay per admission: 30% of the Medicare-allowed cost per day for a Medicare-covered hospital stay.</p> <p><b>Outpatient individual therapy visit</b></p> <p><b>In-network:</b>            You pay \$25 per visit for individual therapy.</p> <p><b>Out-of-network:</b>            You pay 30% of the Medicare-allowed cost of a visit for individual therapy.</p> <p><b>Outpatient group therapy visit</b></p> <p><b>In-network:</b>            You pay \$15 per visit for group therapy.</p> <p><b>Out-of-network:</b>            You pay 30% of the Medicare-allowed cost of a visit for group therapy.</p>
<p><b>Skilled nursing facility</b>            Services may require that your provider get prior authorization (approval in advance). Please see the Evidence of Coverage for more information.</p>	<p><b>In-network:</b>            For each benefit period you pay for Medicare-covered services:            \$0 per day for days 1-20;            \$203 per day for days 21-100</p> <p><b>Out-of-network:</b>            You pay 30% of the Medicare-allowed cost.</p>

Benefit	Select (LPPO) Plan
<p><b>Physical therapy</b>  <i>Note: Your copay is based on your service area.</i></p>	<p><b>In-network:</b>            You pay \$40 for each Medicare-covered visit.</p> <p><b>Out-of-network:</b>            You pay 30% of the Medicare-allowed cost.</p>
<p><b>Ambulance</b>            Non-emergency ambulance transportation may require that your provider get prior authorization (approval in advance). Please see the Evidence of Coverage for more information.</p> <p>Ambulance services are covered worldwide.</p> <p>There is a \$25,000 limit for worldwide emergency, urgent care, and ambulance transport, this limit does not apply to services in the U.S.</p>	<p><b>In- and Out-of-network:</b>            You pay \$325 for each Medicare-covered emergency ambulance service (one-way).</p>
<p><b>Transportation</b></p>	<p>Not a covered benefit.</p>
<p><b>Medicare Part B drugs</b>            Services may require that your provider get prior authorization (approval in advance). Please see the Evidence of Coverage for more information.</p>	<p>You pay 20% of the contracted rate for Medicare-covered services.</p>

## Outpatient Prescription Drugs (Generations Advantage Select (LPPO) Plan)

**Prescription Deductible:** You pay \$275

	<b>Standard Retail</b> (30-day supply)	<b>Preferred Retail</b> (30-day supply)	<b>Mail-Order</b> (30-day supply)	
<b>Phase 1: Initial Coverage</b>				
<b>Cost sharing Tier 1</b> (Preferred Generic)	\$4	\$0	\$4	Cost sharing may change depending on the pharmacy you choose and when you enter another phase of the Part D benefit. You won't pay more than \$35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on. For more information on the additional pharmacy-specific cost sharing and the phases of the benefit, please refer to the Evidence of Coverage.
<b>Cost sharing Tier 2</b> (Generic)	\$18	\$10	\$18	
<b>Cost sharing Tier 3</b> (Preferred Brand)	\$47	\$40	\$47	
<b>Cost sharing Tier 4</b> (Non-Preferred Drug)	\$100	\$95	\$100	
<b>Cost sharing Tier 5</b> (Specialty Tier)	29%	29%	29%	
<b>Cost sharing Tier 6</b> (Select Care Drug)	\$4	\$0	\$4	
<b>Phase 2: Coverage Gap</b> (after you or others on your behalf pay \$5,030)				
During this phase you will pay 25% for generic or brand-name drugs in Tiers 1-5, and 15% for generic or brand name drugs in Tier 6.				
<b>Phase 3: Catastrophic Coverage</b> (after you or others on your behalf pay \$8,000)				

<b>Generic and Brand Name Drugs</b>	During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.
---	--

Martin's Point Generation Advantage's pharmacy network includes limited lower-cost, preferred pharmacies in suburban areas in Maine and New Hampshire. The lower costs advertised in our plan materials for these pharmacies may not be available at the pharmacy you use. For up-to-date information about our network pharmacies, including whether there are any lower-cost preferred pharmacies in your area, please call 1-866-544-7504 (TTY:711) or consult the online pharmacy directory at [www.MartinsPoint.org/MedicareMembers](http://www.MartinsPoint.org/MedicareMembers).

## Outpatient Prescription Drugs (Generations Advantage Select (LPPO) Plan)

**Prescription Deductible:** You pay \$275

Standard Retail (90-day supply)	Preferred Retail (90-day supply)	Mail-Order (90-day supply)
------------------------------------	-------------------------------------	-------------------------------

### Phase 1: Deductible Phase

\$275 Part D deductible for Tiers 3 through 5 drugs

### Phase 2: Initial Coverage

Cost sharing Tier	Standard Retail	Preferred Retail	Mail-Order	Cost sharing may change depending on the pharmacy you choose and when you enter another phase of the Part D benefit. You won't pay more than \$70 for up to a two-month supply or \$105 for up to a three-month supply of each covered insulin product regardless of the cost-sharing tier. For more information on the additional pharmacy-specific cost sharing and the phases of the benefit, please refer to the Evidence of Coverage
<b>Cost sharing Tier 1</b> (Preferred Generic)	\$12	\$0	\$10	
<b>Cost sharing Tier 2</b> (Generic)	\$54	\$30	\$45	
<b>Cost sharing Tier 3</b> (Preferred Brand)	\$141	\$120	\$117.50	
<b>Cost sharing Tier 4</b> (Non-Preferred Drug)	\$300	\$285	\$250	
<b>Cost sharing Tier 5</b> (Specialty Tier)	Not covered	Not covered	Not covered	
<b>Cost sharing Tier 6</b> (Select Care Drug)	\$12	\$0	\$0	

### Phase 2: Coverage Gap (after you or others on your behalf pay \$5,030)

During this phase you will pay 25% for generic or brand-name drugs in Tiers 1-5, and 15% for generic or brand name drugs in Tier 6.

### Phase 3: Catastrophic Coverage (after you or others on your behalf pay \$8,000)

<b>Generic or Brand Name Drugs</b>	During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.
------------------------------------	--

Martin’s Point Generation Advantage’s pharmacy network includes limited lower-cost, preferred pharmacies in suburban areas in Maine and New Hampshire. The lower costs advertised in our plan materials for these pharmacies may not be available at the pharmacy you use. For up-to-date information about our network pharmacies, including whether there are any lower-cost preferred pharmacies in your area, please call 1-866-544-7504 (TTY:711) or consult the online pharmacy directory at [www.MartinsPoint.org/MedicareMembers](http://www.MartinsPoint.org/MedicareMembers).

<b>Additional Benefits</b>	
	<b>Select (LPPO) Plan</b>
<p><b>Wellness Wallet</b> (Fitness, Naturopathic Services, Acupuncture, Nutrition/Dietary Education, Weight Management Programs, and Face Masks)</p> <p>Please see the Evidence of Coverage for more information.</p>	<p>The plan will reimburse up to \$500 each year in total for Fitness Benefit, Naturopathic Services, Acupuncture, Nutrition/Dietary Education, Weight Management Programs, and Face Masks.</p>
<p><b>Over-The-Counter items (OTC)</b> More than 350 covered items including: non-prescription medicine (pain relief, cough, allergies), toothpaste, first aid items, and vitamins. Members can order online, over the phone, or visit a designated store location.</p> <p>Please see the Evidence of Coverage for more information.</p>	<p>The plan will cover up to \$50 per quarter for members to purchase select CVS brand over-the-counter (OTC) products.</p> <p><i>The benefit refreshes quarterly. Remaining balances do not carry over to the next quarter.</i></p>
<p><b>Nutrition and dietary:</b> <b>Telenutrition:</b> Members have access to an online nutrition/dietary platform and unlimited visits with a registered dietitian via video connection, email, or telephone through third-party vendor FoodSmart™.</p> <p><i>Note: Food cost and delivery of meals/groceries are not covered under this benefit.</i></p>	<p>\$0 cost for telenutrition services through FoodSmart™</p>

**Martin's Point Generations Advantage Value Plus (HMO-POS)**

## Section 1: Introduction

**This is a summary of drug and health services covered by Martin's Point Generations Advantage Value Plus.**

**January 1, 2024 - December 31, 2024**

Martin's Point Generations Advantage is a health plan with a Medicare contract offering HMO, HMO-POS, and Local PPO products.

Enrollment in a Martin's Point Generations Advantage plan depends on contract renewal.

This information may be available in other formats such as large print, braille, or an electronic copy on our website. For more information call Generations Advantage at 1-866-544-7504.

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 see the Evidence of Coverage on our website, or you may contact us. To join Martin's Point Generations Advantage Value Plus, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

### **For Generations Advantage Value Plus (HMO-POS) plan:**

Our service area includes: Aroostook, Franklin, Hancock, Kennebec, Knox, Lincoln, Oxford, Penobscot, Piscataquis, Sagadahoc, Somerset, Waldo, and Washington counties in Maine.

The plan has a network of doctors, hospitals, pharmacies, and other providers. If you use providers that are not in our network, the plan may not pay for the services.

## Section 2: Summary of Benefits

This is a summary of the premiums and benefits covered by the Martin’s Point Generations Advantage Value Plus (HMO-POS).

The table below shows the monthly plan premium amount for each of the regions we serve. In addition, you must keep paying your Medicare Part B premium.

Monthly Plan Premium	Plan Service Area	Monthly Premium
<b>Martin's Point Generations Advantage Value Plus</b>	Aroostook, Franklin, Hancock, Kennebec, Knox, Lincoln, Oxford, Penobscot, Piscataquis, Sagadahoc, Somerset, Waldo, and Washington counties in Maine	\$0

Benefit	Value Plus (HMO-POS) Plan
<b>Deductible</b> (our plan does not have a medical deductible)	You pay \$0 annually
<b>Maximum Out-of-Pocket</b> (does not include prescription drugs) Our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. <i>Note: Your Maximum Out-of-Pocket is based on your service area.</i>	\$6,350 Annually
<b>Inpatient hospital</b> Services may require that your provider get prior authorization (approval in advance). Please have your provider contact the plan for more details.	<b>In-network:</b> <b>You pay per admission:</b> \$360 per day for days 1-7; \$0 per day for days 8+
<b>Outpatient hospital</b> Services may require that your provider get prior authorization (approval in advance). Please have your provider contact the plan for more details.	<b>In-network:</b> You pay \$275 for Medicare-covered surgery services at a hospital outpatient facility.
<b>Ambulatory &amp; Surgical Center (ASC)</b> Services may require that your provider get prior authorization (approval in advance). Please have your provider contact the plan for more details.	<b>In-network:</b> You pay \$150 for Medicare-covered surgery services at an ambulatory surgical center.

Benefit	Value Plus (HMO-POS) Plan
<p><b>Doctor visits</b></p>	<p><b>In-network:</b></p> <p><b>Primary care</b> You pay \$0 for post-operative and post-discharge visits with your PCP.</p> <p>You pay \$0 for a brief emotional/behavioral assessment with your PCP.</p> <p>You pay \$10 for all other PCP services and visits.</p> <p><b>Specialists</b> You pay \$45 for each specialist office visit for Medicare-covered services.</p>
<p><b>Preventive care</b> Any additional preventive services approved by Medicare during the contract year will be covered. There are some items not covered at \$0 cost.</p>	<p><b>In-network:</b> You pay \$0 for additional preventive services approved by Medicare</p>
<p><b>Emergency care</b> <i>Note: You do not have to pay this amount if you are admitted to a hospital within 24 hours for the same condition.</i> Emergency care is covered worldwide.</p> <p>There is a \$25,000 limit for worldwide emergency, urgent care, and ambulance transport, this limit does not apply to services in the U.S.</p>	<p><b>In- and Out-of-network:</b> You pay \$120 for each Medicare-covered emergency room visit.</p>
<p><b>Urgently needed services</b> Urgent care is covered nationwide.</p> <p>There is a \$25,000 limit for worldwide emergency, urgent care, and ambulance transport, this limit does not apply to services in the U.S.</p>	<p><b>In- and Out-of-network:</b> You pay \$50 for each Medicare-covered urgent care visit when performed at an urgent care center.</p> <p><b>Out-of-Country:</b> You pay \$120 for each Medicare-covered urgent care visit when performed at an urgent care center outside of the United States and its associated territories.</p>

Benefit	Value Plus (HMO-POS) Plan
<p><b>Diagnostic Services / Labs / Imaging</b>            Services may require that your provider get prior authorization (approval in advance). Please see the Evidence of Coverage for more information.</p>	<p><b>In-network:</b>  <b>Diagnostic radiology service</b> (e.g., MRI)            You pay 20% of the contracted rate for complex diagnostic radiology (PET, CT, MRI, MRA, nuclear medicine).</p> <p><b>Lab services</b>            You pay 20% of the contracted rate for genetic labs.            You pay \$0/5 copay for lab services.</p> <p><b>Diagnostic tests and procedures</b>            You pay 15% of the contracted rate for simple diagnostic radiology.</p> <p><b>Outpatient x-rays</b>            You pay \$15 copay for x-rays.</p>
<p><b>Hearing services</b></p>	<p><b>In-network:</b>  <b>Hearing exam</b>            You pay \$45 per visit for Medicare-covered hearing services.</p> <p><b>Hearing aid fittings and evaluations</b>            You pay \$0 for 1 year of hearing aid fittings and ongoing hearing aid evaluations when used in conjunction with your hearing aid benefit.  <i>Services must be received from an Amplifon provider.</i></p> <p><b>Hearing aids</b>            There is a \$1,000 benefit maximum (\$500 copay per ear, per year).  <i>Services must be received from an Amplifon provider.</i></p>
<p><b>Dental services (Medicare-covered)</b>            Services may require that your provider get prior authorization (approval in advance). Please see the Evidence of Coverage for more information.</p>	<p><b>In-network:</b>            You pay \$45 per visit for Medicare-covered dental services (non-routine dental care required to treat illness or injury).</p>
<p><b>Preventive and comprehensive dental</b>            Members must use Delta Dental PPO/Premier or Martin's Point Generations</p>	<p>Preventive and Comprehensive Dental services are covered.  <i>Please see Dental Overview on page 55 for more information.</i></p>

<b>Benefit</b>	<b>Value Plus (HMO-POS) Plan</b>
<p>Advantage network dentist in Maine, New Hampshire, or Vermont to obtain these supplemental dental benefits.</p>	
<p><b>Vision services</b></p>	<p><b>In-network:</b>  <b>Annual routine eye exam</b>            You pay \$0 for an annual routine eye exam.</p> <p><b>Medicare-covered physician services</b>            You pay \$45 for non-routine Medicare-covered physician services.</p> <p><b>Glaucoma testing</b>            You pay \$0 for glaucoma testing.</p> <p><b>Diabetic retinopathy</b>            You pay \$0 for a diabetic eye exam (retinopathy).</p> <p><b>Eyeglass frames, lenses, and contacts</b>            The plan will reimburse up to \$100 for prescription frames, lenses, and contacts.</p>
<p><b>Mental health services</b>            Services may require that your provider get prior authorization (approval in advance). Please see the Evidence of Coverage for more information.</p>	<p><b>In-network:</b>  <b>Inpatient visit</b>            You pay per admission:            \$365 per day for days 1-7            \$0 per day for days 8+</p> <p><b>Outpatient individual therapy visit</b>            You pay \$25 per visit for individual therapy.</p> <p><b>Outpatient group therapy visit</b>            You pay \$25 per visit for group therapy.</p>
<p><b>Skilled nursing facility</b>            Services may require that your provider get prior authorization (approval in advance). Please see the Evidence of Coverage for more information.</p>	<p><b>In-network:</b>            For each benefit period you pay for Medicare-covered services:            \$0 per day for days 1-20;            \$203 per day for days 21-100</p>

Benefit	Value Plus (HMO-POS) Plan
<p><b>Physical therapy</b></p>	<p><b>In-network:</b> You pay \$40 for each Medicare-covered visit.</p>
<p><b>Ambulance</b> Non-emergency ambulance transportation services may require that your provider get prior authorization (approval in advance). Please see the Evidence of Coverage for more information.</p> <p>Ambulance services are covered worldwide.</p> <p>There is a \$25,000 limit for worldwide emergency, urgent care, and ambulance transport, this limit does not apply to services in the U.S.</p>	<p><b>In- and Out-of-network:</b> You pay \$325 for each Medicare-covered emergency ambulance service (one-way).</p>
<p><b>Transportation</b></p>	<p>Not a covered benefit.</p>
<p><b>Medicare Part B drugs</b> Services may require that your provider get prior authorization (approval in advance). Please see the Evidence of Coverage for more information.</p>	<p><b>In-network:</b> You pay 20% of the contracted rate for Medicare-covered services.</p>

## Outpatient Prescription Drugs (Generations Advantage Value Plus (HMO-POS) Plan)

	Standard Retail (30-day supply)	Preferred Retail (30-day supply)	Mail-Order (30-day supply)	
<b>Phase 1: Deductible Phase</b>				
\$300 Part D deductible for Tiers 3 through 5 drugs				
<b>Phase 2: Initial Coverage</b>				
<b>Cost sharing Tier 1</b> (Preferred Generic)	\$4	\$0	\$4	Cost sharing may change depending on the pharmacy you choose and when you enter another phase of the Part D benefit. You won't pay more than \$35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on, even if you haven't paid your deductible. For more information on the additional pharmacy-specific cost sharing and the phases of the benefit, please refer to the Evidence of Coverage
<b>Cost sharing Tier 2</b> (Generic)	\$18	\$10	\$18	
<b>Cost sharing Tier 3</b> (Preferred Brand)	\$47	\$40	\$47	
<b>Cost sharing Tier 4</b> (Non-Preferred Drug)	\$100	\$95	\$100	
<b>Cost sharing Tier 5</b> (Specialty Tier)	28%	28%	28%	
<b>Phase 3: Coverage Gap</b> (after you or others on your behalf pay \$5,030)				
During this phase you will pay 25% for generic or brand-name drugs in Tiers 1-5, and 15% for generic or brand name drugs in Tier 6.				
<b>Phase 4: Catastrophic Coverage</b> (after you or others on your behalf pay \$8,000)				
<b>Generic or Brand Name Drugs</b>	During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.			

## Outpatient Prescription Drugs (Generations Advantage Value Plus (HMO-POS) Plan)

	Standard Retail (90-day supply)	Preferred Retail (90-day supply)	Mail-Order (90-day supply)	
<b>Phase 1: Deductible Phase</b>				
\$300 Part D deductible for Tiers 3 through 5 drugs				
<b>Phase 2: Initial Coverage</b>				
<b>Cost sharing Tier 1</b> (Preferred Generic)	\$12	\$0	\$10	Cost sharing may change depending on the pharmacy you choose and when you enter another phase of the Part D benefit. You won't pay more than \$70 for up to a two-month supply or \$105 for up to a three-month supply of each covered insulin product regardless of the cost-sharing tier. For more information on the additional pharmacy-specific cost sharing and the phases of the benefit, please refer to the Evidence of Coverage
<b>Cost sharing Tier 2</b> (Generic)	\$54	\$30	\$45	
<b>Cost sharing Tier 3</b> (Preferred Brand)	\$141	\$120	\$117.50	
<b>Cost sharing Tier 4</b> (Non-Preferred Drug)	\$300	\$285	\$250	
<b>Cost sharing Tier 5</b> (Specialty Tier)	Not covered	Not covered	Not covered	
<b>Phase 3: Coverage Gap</b> (after you or others on your behalf pay \$5,030)				
During this phase you will pay 25% for generic or brand-name drugs in Tiers 1-5, and 15% for generic or brand name drugs in Tier 6.				
<b>Phase 4: Catastrophic Coverage</b> (after you or others on your behalf pay \$8,000)				
<b>Generic or Brand Name Drugs</b>	During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.			

Additional Benefits	Value Plus (HMO-POS) Plan
<p><b>Wellness Wallet</b> (Fitness, Naturopathic Services, Acupuncture, Nutrition/Dietary Education, Weight Management Programs, and Face Masks)</p> <p>Please see the Evidence of Coverage for more information.</p>	<p>The plan will reimburse up to \$500 each year in total for Fitness Benefit, Naturopathic Services, Acupuncture, Nutrition/Dietary Education, Weight Management Programs, and Face Masks.</p>
<p><b>Over-The-Counter items (OTC)</b> More than 350 covered items including: non-prescription medicine (pain relief, cough, allergies), toothpaste, first aid items, and vitamins. Members can order online, over the phone, or visit a designated store location.</p> <p>Please see the Evidence of Coverage for more information.</p>	<p>The plan will cover up to \$60 per quarter for members to purchase select CVS brand over-the-counter (OTC) products.</p> <p><i>The benefit refreshes quarterly. Remaining balances do not carry over to the next quarter.</i></p>
<p><b>Nutrition and dietary</b> <b>Telenutrition:</b> Members have access to an online nutrition/dietary platform and unlimited visits with a registered dietitian via video connection, email, or telephone through third-party vendor FoodSmart™.</p> <p><i>Note: Food cost and delivery of meals/groceries are not covered under this benefit.</i></p>	<p>\$0 cost for telenutrition services through FoodSmart™</p>

All plans cover Part B drugs such as chemotherapy and some drugs administered by your provider.

In addition, **Generations Advantage Value Plus** covers Part D drugs.

You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions, our plan’s pharmacy directory and our plan’s provider directory on our website at [www.MartinsPoint.org/MedicareMembers](http://www.MartinsPoint.org/MedicareMembers).

If you want to know more about the coverage and costs of Original Medicare, look in your Medicare & You 2024 Handbook. You can download a copy of from the Medicare website ([www.medicare.gov](http://www.medicare.gov)) or ask for a printed copy 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.

<b>Benefit</b>	<b>Value Plus (HMO-POS) Plan</b>
<p><b>Point-of-Service</b></p> <p>The Value Plus plan has a Point-of-Service (POS) benefit where you can use an out-of-network provider for certain services. Under the POS, you will generally pay a higher cost share when using an out-of-network provider. Please refer to the Evidence of Coverage for more information.</p>	<p>Services available in the POS benefit:</p> <p><b>Doctor visits (Primary Care and Specialist)</b></p> <ul style="list-style-type: none"> <li>➤Chiropractic visits \$55</li> <li>➤Physician Specialist visits \$55</li> <li>➤Podiatry visits \$55</li> <li>➤Primary Care visits \$35 (Allowed only outside the plan’s service area)</li> </ul>
	<p><b>Inpatient hospital care</b></p> <ul style="list-style-type: none"> <li>➤You pay 40% of the cost per admission. Prior authorization is required.</li> </ul>
	<p><b>Outpatient services</b></p> <ul style="list-style-type: none"> <li>➤Diabetes self-management 20% of the Medicare-allowed cost for supplies and shoes; \$0 for training</li> <li>➤Durable medical equipment 30% of the Medicare-allowed cost</li> <li>➤Medicare Part B prescription drugs, including chemotherapy 20% of the Medicare-allowed cost</li> <li>➤Outpatient diagnostic tests/procedures, X-rays, and lab services 0-20% of the Medicare-allowed cost; all other labs: \$5</li> <li>➤Outpatient mental health and substance abuse group and individual therapy: \$30</li> <li>➤Outpatient rehabilitation services (Physical, Occupational, and Speech therapy) \$55</li> <li>➤Outpatient surgery in a hospital or ambulatory surgical center \$400/\$200</li> <li>➤Radiation therapy 30% of the Medicare-allowed cost</li> </ul>
	<p><b>Dental services</b></p> <p>Medicare-covered dental services \$55</p>
	<p><b>Hearing services</b></p> <p>Medicare-covered hearing services \$55</p>
	<p><b>Vision services</b></p> <ul style="list-style-type: none"> <li>➤Medicare-covered vision services \$55</li> <li>➤Annual routine eye exam 30% of the Medicare- allowed cost</li> </ul>

## Section 3: Dental Benefit Overview

The **Martin’s Point Generations Advantage Value Plus (HMO-POS)** plan includes the following benefits when seeing a Delta Dental network dentist. This benefit overview is provided for summary purposes only.

### Delta Dental Network

Plan benefits are available only when you receive your dental care from a Delta Dental network dentist in Maine, New Hampshire, or Vermont:

- ▶ **No Balance Billing:** Participating dentists accept Delta Dental’s fees for services as payment in full.
- ▶ **No Claims Paperwork:** Participating dentists will prepare and submit claims for you.
- ▶ **Direct Payment:** Delta Dental pays participating dentists directly, so you don’t have to pay the covered amount up front and wait for reimbursement.

To find out if your dentist participates in the Delta Dental network, please visit our website at [www.MartinsPoint.org/MedicareMembers](http://www.MartinsPoint.org/MedicareMembers), visit [www.nedelta.com/Dentist-Search](http://www.nedelta.com/Dentist-Search), or call **Delta Dental’s Customer Service Department at 1-800-832-5700 (TTY: 711) Monday through Friday, 8am – 4:45pm.**

**\*Note:** Cleanings are limited to two per calendar year; you may choose from Category A (preventative/routine) and/or Category B (periodontal). Office visit copays and coinsurances apply.

Dental Benefit	Value Plus
<b>Benefit Maximum</b>	<b>\$1,000</b>
<b>Office Visit Copay</b>	<b>\$50</b>
<b>Category A: Diagnostic/Preventative</b>	
Oral exam and routine cleaning* twice in a calendar year	No cost sharing (must pay office visit copay)
Problem-focused exams as needed	
Bitewing x-rays once every calendar year and panoramic x-rays once in a 5 calendar year period	
X-rays of individual teeth as needed	
<b>Category B: Basic Restorative</b>	
Amalgam (silver) fillings	You pay 50% of the cost + \$50 office visit copay
Resin restoration on anterior teeth, posterior teeth, and the buccal surface of bicuspids only	
Surgical and routine extractions	
Root canals	
Treatment of gum disease (periodontics, including periodontal maintenance cleanings*)	
<b>Category C: Major Restorative</b>	
Dentures	You pay 50% of the cost + \$50 office visit copay
Crowns	
Implants	

## **Section 3: Dental Benefit Overview (Continued)**

### **Claim Process for Participating Dentists**

Present your Generations Advantage member ID card to your participating dentist at the time of your visit. Your participating dentist will submit your claim to Delta Dental.

Members can register online to view claims and benefit information at [www.nedelta.com](http://www.nedelta.com).

### **Non-participating Dentists**

No benefits are available under your policy if you choose to visit a dentist who is not participating in the Delta Dental network. Non-participating dentists are welcome to join the Delta Dental network at any time.

### **Identification Cards**

Your Generations Advantage member ID card includes your dental group number and the Delta Dental customer service number. Your member ID number for dental benefits is the same as your Generations Advantage Value Plus plan member ID number.

**Martin's Point Generations Advantage Access (LPPO)**

## Section 1: Introduction

This is a summary of drug and health services covered by Martin's Point Generations Advantage Access (LPPO) plan.

Plan Name	Plan Service Area	Monthly Premium
<b>Martin's Point Generations Advantage Access</b>  <i>Note: Your premium is based on your service area.</i>	For members living in Belknap, Carroll, Coos, and Grafton counties in NH:	\$0
	For members living in Cheshire, Hillsborough, Merrimack, Rockingham, Strafford, and Sullivan counties in New Hampshire:	\$29

**January 1, 2024 - December 31, 2024**

Martin's Point Generations Advantage is a health plan with a Medicare contract offering HMO, HMO-POS, and Local PPO products. Enrollment in a Martin's Point Generations Advantage plan depends on contract renewal.

This information may be available in other formats such as large print, braille, or an electronic copy on our website. For more information call Generations Advantage at 1-866-544-7504.

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 see the Evidence of Coverage on our website, or you may contact us. To join Martin's Point Generations Advantage Access, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

**For Martin's Point Generations Advantage Access (LPPO) plan:**

► Our service area includes: Belknap, Carroll, Coos, Cheshire, Grafton, Hillsborough, Merrimack, Rockingham, Strafford, and Sullivan counties in New Hampshire.

The Access plan has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers in our network, you may pay less for your covered services. But if you want to, you can also use providers that are not in our network.

## Section 2: Summary of Benefits

This is a summary of drug and health services covered by Martin's Point Generations Advantage Access (LPPO) plan.

Benefit	Access (LPPO) Plan
<p><b>Deductible</b></p> <p><b>Maximum out-of-pocket</b> (does not include prescription drugs) Our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. <i>Note: Your Maximum Out-of-Pocket is based on your service area.</i></p>	<p>You pay \$0 annually</p> <p><b>In-network:</b> \$5,900 annually</p> <p><b>Combined In- and Out-of-network:</b> \$9,550 annually</p>
<p><b>Inpatient hospital</b></p> <p><i>Note: Your copay is based on your service area.</i></p> <p>Services may require that your provider get prior authorization (approval in advance). Please have your provider contact the plan for more details.</p>	<p><b>In-network:</b> <b>You pay per admission:</b> \$360 per day for days 1-7; \$0 per day for days 8+</p> <p><b>Out-of-network:</b> <b>You pay per admission:</b> 40% of the Medicare-allowed cost for a Medicare-covered hospital stay.</p>
<p><b>Outpatient hospital</b></p> <p>Services may require that your provider get prior authorization (approval in advance). Please have your provider contact the plan for more details.</p> <p><i>Note: Your copay is based on your service area.</i></p>	<p><b>In-network:</b> You pay \$250 for Medicare-covered surgery services at a hospital outpatient facility.</p> <p><b>Out-of-network:</b> You pay 30% of the Medicare-allowed cost of Medicare-covered surgery services at a hospital outpatient facility.</p>
<p><b>Ambulatory &amp; Surgical Centers (ASC)</b></p> <p><i>Note: Your copay is based on your service area.</i></p> <p>Services may require that your provider get prior authorization (approval in advance). Please have your provider contact the plan for more details.</p>	<p><b>In-network:</b> You pay \$150 for Medicare-covered surgery services at an ambulatory surgical center.</p> <p><b>Out-of-network:</b> You pay 30% of the Medicare-allowed cost of Medicare-covered surgery services at an ambulatory surgical center.</p>

**Benefit****Access (LPPO) Plan****Doctor visits**

*Note: Your copay is based on your service area.*

**Primary care****In-network:**

You pay \$0 for post-operative and post-discharge visits with your PCP.

You pay \$0 for a brief emotional/behavioral assessment with your PCP.

**In-network** for members living in Belknap, Carroll, Coos, and Grafton counties in New Hampshire: You pay \$10 for all other PCP services and visits.

**In-network** for members living in Cheshire, Hillsborough, Merrimack, Rockingham, Strafford, and Sullivan counties in New Hampshire: You pay \$5 for all other PCP services and visits.

**Out-of-network:**

You pay 30% of the Medicare-allowed cost for each Primary Care Physician (PCP) office visit for Medicare-covered services.

**Specialists**

**In-network** for members living in Belknap, Carroll, Coos, and Grafton counties in New Hampshire: You pay \$40 for each specialist office visit for Medicare-covered services.

**In-network** for members living in Cheshire, Hillsborough, Merrimack, Rockingham, Strafford, and Sullivan counties in New Hampshire: You pay \$35 for each specialist office visit for Medicare-covered services.

**Out-of-network:**

You pay 30% of the Medicare-allowed cost for each specialist office visit for Medicare-covered services.

Benefit	Access (LPPO) Plan
<p><b>Preventive care</b> Any additional preventive services approved by Medicare during the contract year will be covered. There are some items not covered at \$0 cost. <i>Note: Your copay is based on your service area.</i></p>	<p><b>In-network:</b> You pay \$0 for additional preventive services approved by Medicare <b>Out-of-network:</b> You pay 30% for additional preventive services approved by Medicare</p>
<p><b>Emergency care</b> <i>Note: You do not have to pay this amount if you are admitted to a hospital within 24 hours for the same condition.</i> Emergency care is covered worldwide. There is a \$25,000 limit for worldwide emergency, urgent care, and ambulance transport, this limit does not apply to services in the U.S.</p>	<p><b>In- and Out-of-network:</b> You pay \$120 for each Medicare-covered emergency room visit.</p>
<p><b>Urgently needed services</b> Urgent care is covered nationwide. There is a \$25,000 limit for worldwide emergency, urgent care, and ambulance transport, this limit does not apply to services in the U.S.</p>	<p><b>In- and Out-of-network:</b> You pay \$50 for each Medicare-covered urgent care visit when performed at an urgent care center. <b>Out-of-Country:</b> You pay \$120 for each Medicare-covered urgent care visit when performed at an urgent care center outside of the United States and its associated territories.</p>
<p><b>Diagnostic Services / Labs / Imaging</b> Services may require that your provider get prior authorization (approval in advance). Please see the Evidence of Coverage for more information.</p>	<p><b>Diagnostic radiology service (e.g., MRI)</b> <b>In-network:</b> You pay 20% of the contracted rate for complex diagnostic radiology (such as PET, CT, MRI, MRA, nuclear medicine) <b>Out-of-network:</b> You pay 30% of the Medicare-allowed cost of complex diagnostic radiology (PET, CT, MRI, MRA, nuclear medicine).</p>

**Benefit****Access (LPPO) Plan****Lab services****In-network:**

You pay 20% of the contracted rate for genetic labs.

You pay \$0/\$5 copay for all other lab services.

**Out-of-network:**

You pay 20% of the Medicare-allowed cost for genetic labs.

You pay \$0/\$5 copay for all other lab services.

**Diagnostic tests and procedures****In-network:**

You pay 15% of the contracted rate for simple diagnostic radiology.

**Out-of-network:**

You pay 15% of the Medicare-allowed cost of simple diagnostic radiology.

**Outpatient x-rays****In-network:**

You pay 15% of the contracted rate for X-rays.

**Out-of-network:**

You pay 15% of the Medicare-allowed cost for x-rays.

Benefit	Access (LPPO) Plan
<p><b>Hearing services</b></p>	<p><b>Hearing exam</b>  <b>In-network</b> for members living in Belknap, Carroll, Coos, and Grafton counties in New Hampshire: You pay \$40 per visit for Medicare-covered hearing services.  <b>In-network</b> for members living in Cheshire, Hillsborough, Merrimack, Rockingham, Strafford, and Sullivan counties in New Hampshire: You pay \$35 per visit for Medicare-covered hearing services.</p> <p><b>Out-of-network:</b>  You pay 30% of the Medicare-allowed cost.</p> <p><b>Hearing aid fittings and evaluations</b>  <b>In-network:</b>  You pay \$0 for 1 year of hearing aid fittings and ongoing hearing aid evaluations when used in conjunction with your hearing aid benefit.  <i>Services must be received from an Amplifon provider.</i></p> <p><b>Hearing aids</b>  <b>In-network:</b>  There is a \$1,000 benefit maximum (\$500 copay per ear, per year).  <i>Services must be received from an Amplifon provider.</i></p>
<p><b>Dental services (Medicare-covered)</b>  Services may require that your provider get prior authorization (approval in advance). Please see the Evidence of Coverage for more information.</p>	<p><b>In-network</b> for members living in Belknap, Carroll, Coos, and Grafton counties in New Hampshire: You pay \$40 per visit for Medicare-covered dental services (non-routine dental care required to treat illness or injury).  <b>In-network</b> for members living in Cheshire, Hillsborough, Merrimack, Rockingham, Strafford, and Sullivan counties in New Hampshire: You pay \$35 per visit for Medicare-covered dental services (non-routine dental care required to treat illness or injury).</p> <p><b>Out-of-network:</b>  You pay 30% of the Medicare-allowed cost.</p>

Benefit	Access (LPPO) Plan
<p><b>Preventive and comprehensive dental</b>  Members must use Delta Dental PPO/Premier or Martin's Point Generations network dentist in Maine, New Hampshire, or Vermont to obtain these supplemental dental benefits.</p> <p><i>Note: Your Preventive and Comprehensive Dental Coverage is based on your service area.</i></p>	<p>Preventive and comprehensive dental services are covered.  <i>Please see Dental Overview on page 69 for more information.</i></p>

## Vision services

### **Annual routine eye exam**

#### **In-network:**

You pay \$0 for an annual routine eye exam.

#### **Out-of-network:**

You pay 30% of the Medicare-allowed cost for an annual routine eye exam.

### **Medicare-covered physician services**

**In-network** for members living in Belknap, Carroll, Coos, and Grafton counties in NH:

You pay \$40 for non-routine Medicare-covered physician services.

**In-network** for members living in Cheshire, Hillsborough, Merrimack, Rockingham, Strafford, and Sullivan counties in NH:

You pay \$35 for non-routine Medicare-covered physician services.

#### **Out-of-network:**

You pay 30% of the Medicare-allowed cost of non-routine Medicare-covered physician services.

### **Glaucoma testing**

#### **In- and Out-of-network:**

You pay \$0 for glaucoma testing.

### **Diabetic retinopathy**

#### **In-Network:**

You pay \$0 for a diabetic eye exam (retinopathy).

#### **Out-of-network:**

You pay 30% of the Medicare-allowed cost for a diabetic eye exam (retinopathy).

### **Eyeglass frames, lenses, and contacts:**

For members living in Belknap, Carroll, Coos, and Grafton counties in New Hampshire:

The plan will reimburse up to \$150 for prescription frames, lenses, and contacts.

Benefit	Access (LPPO) Plan
---------	--------------------

**Mental health services**  
 Services may require that your provider get prior authorization (approval in advance). Please see the Evidence of Coverage for more information.

*Note: Your copay is based on your service area.*

**Skilled nursing facility**  
 Services may require that your provider get prior authorization (approval in advance). Please see the Evidence of Coverage for more information.

For members living in Cheshire, Hillsborough, Merrimack, Rockingham, Strafford, and Sullivan counties in New Hampshire:  
 The plan will reimburse up to \$250 for prescription frames, lenses, and contacts.

**Inpatient visit**  
**In-network:**  
 You pay per admission:  
 \$220 per day for days 1-7;  
 \$0 per day for days 8+  
**Out-of-network:**  
 You pay per admission: 30% of the Medicare-allowed cost per day for a Medicare-covered hospital stay.

**Outpatient individual therapy visit**  
**In-network:**  
 You pay \$25 per visit for individual therapy.  
**Out-of-network:**  
 You pay 30% of the Medicare-allowed cost of a visit for individual therapy.

**Outpatient group therapy visit**  
**In-network:**  
 You pay \$25 per visit for group therapy.  
**Out-of-network:**  
 You pay 30% of the Medicare-allowed cost of a visit for group therapy.

**In-network:**  
 For each benefit period you pay for Medicare-covered services:  
 \$0 per day for days 1-20;  
 \$203 per day for days 21-100  
**Out-of-network:**  
 You pay 30% of the Medicare-allowed cost.

Benefit	Access (LPPO) Plan
<p><b>Physical therapy</b>  <i>Note: Your copay is based on your service area.</i></p>	<p><b>In-network</b> for members living in Belknap, Carroll, Coos, and Grafton counties in New Hampshire:            You pay \$40 for each Medicare-covered visit.</p> <p><b>In-network</b> for members living in Cheshire, Hillsborough, Merrimack, Rockingham, Strafford, and Sullivan counties in New Hampshire:            You pay \$35 for each Medicare-covered visit.</p> <p><b>Out-of-network:</b>            You pay 30% of the Medicare-allowed cost.</p>
<p><b>Ambulance</b>            Non-emergency ambulance transportation may require that your provider get prior authorization (approval in advance). Please see the Evidence of Coverage for more information.</p> <p>Ambulance services are covered worldwide.</p> <p>There is a \$25,000 limit for worldwide emergency, urgent care, and ambulance transport, this limit does not apply to services in the U.S.</p>	<p><b>In- and Out-of-network:</b>            You pay \$325 for each Medicare-covered emergency ambulance service (one-way).</p>
<p><b>Transportation</b></p>	<p>Not a covered benefit.</p>
<p><b>Medicare Part B drugs</b>            Services may require that your provider get prior authorization (approval in advance). Please see the Evidence of Coverage for more information.</p>	<p>You pay 20% of the contracted rate for Medicare-covered services.</p>

### Section 3: Dental Benefit Overview

The **Martin’s Point Generations Advantage Access (LPPO)** plan includes the following benefits when seeing a Delta Dental network dentist. This benefit overview is provided for summary purposes only.

#### Delta Dental Network

Plan benefits are available only when you receive your dental care from a Delta Dental network dentist in Maine, New Hampshire, or Vermont:

- ▶ **No Balance Billing:** Participating dentists accept Delta Dental’s fees for services as payment in full.
- ▶ **No Claims Paperwork:** Participating dentists will prepare and submit claims for you.
- ▶ **Direct Payment:** Delta Dental pays participating dentists directly, so you don’t have to pay the covered amount up front and wait for reimbursement.

To find out if your dentist participates in the Delta Dental network, please visit our website at [www.MartinsPoint.org/MedicareMembers](http://www.MartinsPoint.org/MedicareMembers), visit [www.nedelta.com/Dentist-Search](http://www.nedelta.com/Dentist-Search), or call **Delta Dental’s Customer Service Department at 1-800-832-5700 (TTY: 711) Monday through Friday, 8am – 4:45pm.**

Dental Benefit	Access
<b>Benefit Maximum</b> for members living in Belknap, Carroll, Coos, and Grafton counties in New Hampshire:	<b>\$1,000</b>
<b>Office Visit Copay</b>	<b>\$50</b>
<b>Category A: Diagnostic/Preventative</b>	
Oral exam and routine cleaning* twice in a calendar year	No cost sharing (must pay office visit copay)
Problem-focused exams as needed	
Bitewing x-rays once every calendar year and panoramic x-rays once in a 5 calendar year period	
X-rays of individual teeth as needed	
Crowns	
Implants	

**\*Note:** Cleanings are limited to two per calendar year. Office visit copays and coinsurances apply.

## **Section 3: Dental Benefit Overview (Continued)**

### **Claim Process for Participating Dentists**

Present your Generations Advantage member ID card to your participating dentist at the time of your visit. Your participating dentist will submit your claim to Delta Dental.

Members can register online to view claims and benefit information at [www.nedelta.com](http://www.nedelta.com).

### **Non-participating Dentists**

No benefits are available under your policy if you choose to visit a dentist who is not participating in the Delta Dental network. Non-participating dentists are welcome to join the Delta Dental network at any time.

### **Identification Cards**

Your Generations Advantage member ID card includes your dental group number and the Delta Dental customer service number. Your member ID number for dental benefits is the same as your Generations Advantage Value Plus plan member ID number.

## Section 3: Dental Benefit Overview

The **Martin’s Point Generations Advantage Access (LPPO)** plan includes the following benefits when seeing a Delta Dental network dentist. This benefit overview is provided for summary purposes only.

### Delta Dental Network

Plan benefits are available only when you receive your dental care from a Delta Dental network dentist in Maine, New Hampshire, or Vermont:

- ▶ **No Balance Billing:** Participating dentists accept Delta Dental’s fees for services as payment in full.
- ▶ **No Claims Paperwork:** Participating dentists will prepare and submit claims for you.
- ▶ **Direct Payment:** Delta Dental pays participating dentists directly, so you don’t have to pay the covered amount up front and wait for reimbursement.

To find out if your dentist participates in the Delta Dental network, please visit our website at [www.MartinsPoint.org/MedicareMembers](http://www.MartinsPoint.org/MedicareMembers), visit [www.nedelta.com/Dentist-Search](http://www.nedelta.com/Dentist-Search), or call Delta Dental’s Customer Service Department at 1-800-832-5700 (TTY: 711) Monday through Friday, 8am – 4:45pm.

Dental Benefit	Access
<b>Benefit Maximum</b> for members living in Cheshire, Hillsborough, Merrimack, Rockingham, Strafford, and Sullivan counties in New Hampshire:	<b>\$2,000</b>
<b>Office Visit Copay</b>	<b>\$50</b>
<b>Category A: Diagnostic/Preventative</b>	
Oral exam and routine cleaning* twice in a calendar year	No cost sharing (must pay office visit copay)
Problem-focused exams as needed	
Bitewing x-rays once every calendar year and panoramic x-rays once in a 5 calendar year period	
X-rays of individual teeth as needed	
<b>Category B: Basic Restorative</b>	
Amalgam (silver) fillings	You pay 50% of the cost + \$50 office visit copay
Resin restoration on anterior teeth, posterior teeth, and the buccal surface of bicuspids only	
Surgical and routine extractions	
Root canals	
Treatment of gum disease (periodontics, including periodontal maintenance cleanings*)	
<b>Category C: Major Restorative</b>	
Dentures	You pay 50% of the cost + \$50 office visit copay
Crowns	
Implants	

**\*Note:** Cleanings are limited to two per calendar year; you may choose from Category A (preventative/routine) and/or Category B (periodontal). Office visit copays and coinsurances apply.

## **Section 3: Dental Benefit Overview (Continued)**

### **Claim Process for Participating Dentists**

Present your Generations Advantage member ID card to your participating dentist at the time of your visit. Your participating dentist will submit your claim to Delta Dental.

Members can register online to view claims and benefit information at [www.nedelta.com](http://www.nedelta.com).

### **Non-participating Dentists**

No benefits are available under your policy if you choose to visit a dentist who is not participating in the Delta Dental network. Non-participating dentists are welcome to join the Delta Dental network at any time.

### **Identification Cards**

Your Generations Advantage member ID card includes your dental group number and the Delta Dental customer service number. Your member ID number for dental benefits is the same as your Generations Advantage Value Plus plan member ID number.

## Outpatient Prescription Drugs (Generations Advantage Access (LPPO) Plan)

**Prescription Deductible:** You pay \$275

Standard Retail (30-day supply)	Preferred Retail (30-day supply)	Mail-Order (30-day supply)
------------------------------------	-------------------------------------	-------------------------------

### Phase 1: Deductible Phase

\$275 Part D deductible for Tiers 3 to 5

### Phase 2: Initial Coverage

Cost sharing Tier	Standard Retail	Preferred Retail	Mail-Order	
<b>Cost sharing Tier 1</b> (Preferred Generic)	\$4	\$0	\$4	Cost sharing may change depending on the pharmacy you choose and when you enter another phase of the Part D benefit. You won't pay more than \$35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on. For more information on the additional pharmacy-specific cost sharing and the phases of the benefit, please refer to the Evidence of Coverage.
<b>Cost sharing Tier 2</b> (Generic)	\$18	\$10	\$18	
<b>Cost sharing Tier 3</b> (Preferred Brand)	\$47	\$40	\$47	
<b>Cost sharing Tier 4</b> (Non-Preferred Drug)	\$100	\$95	\$100	
<b>Cost sharing Tier 5</b> (Specialty Tier)	29%	29%	29%	
<b>Cost sharing Tier 6</b> (Select Care Drug)	\$4	\$0	\$4	

### Phase 2: Coverage Gap (after you or others on your behalf pay \$5,030)

During this phase you will pay 25% for generic or brand-name drugs.

### Phase 3: Catastrophic Coverage (after you or others on your behalf pay \$8,000)

<b>Generic and Brand Name Drugs</b>	During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.
---	--

Martin's Point Generation Advantage's pharmacy network includes limited lower-cost, preferred pharmacies in suburban areas in Maine and New Hampshire. The lower costs advertised in our plan materials for these pharmacies may not be available at the pharmacy you use. For up-to-date information about our network pharmacies, including whether there are any lower-cost preferred pharmacies in your area, please call 1-866-544-7504 (TTY:711) or consult the online pharmacy directory at [www.MartinsPoint.org/MedicareMembers](http://www.MartinsPoint.org/MedicareMembers).

## Outpatient Prescription Drugs (Generations Advantage Access (LPPO) Plan)

**Prescription Deductible:** You pay \$275

	<b>Standard Retail</b> (90-day supply)	<b>Preferred Retail</b> (90-day supply)	<b>Mail-Order</b> (90-day supply)	
--	---	--	--------------------------------------	--

### Phase 1: Deductible Phase

\$275 Part D deductible for Tiers 3 through 5 drugs

### Phase 2: Initial Coverage

				Cost sharing may change depending on the pharmacy you choose and when you enter another phase of the Part D benefit. You won't pay more than \$70 for up to a two-month supply or \$105 for up to a three-month supply of each covered insulin product regardless of the cost-sharing tier. For more information on the additional pharmacy-specific cost sharing and the phases of the benefit, please refer to the Evidence of Coverage
<b>Cost sharing Tier 1</b> (Preferred Generic)	\$12	\$0	\$10	
<b>Cost sharing Tier 2</b> (Generic)	\$54	\$30	\$45	
<b>Cost sharing Tier 3</b> (Preferred Brand)	\$141	\$120	\$117.50	
<b>Cost sharing Tier 4</b> (Non-Preferred Drug)	\$300	\$285	\$250	
<b>Cost sharing Tier 5</b> (Specialty Tier)	Not covered	Not covered	Not covered	
<b>Cost sharing Tier 6</b> (Select Care Drug)	\$12	\$0	\$0	

### Phase 2: Coverage Gap (after you or others on your behalf pay \$5,030)

During this phase you will pay 25% for generic or brand-name drugs.

### Phase 3: Catastrophic Coverage (after you or others on your behalf pay \$8,000)

<b>Generic or Brand Name Drugs</b>	During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.
------------------------------------	--

Martin’s Point Generation Advantage’s pharmacy network includes limited lower-cost, preferred pharmacies in suburban areas in Maine and New Hampshire. The lower costs advertised in our plan materials for these pharmacies may not be available at the pharmacy you use. For up-to-date information about our network pharmacies, including whether there are any lower-cost preferred pharmacies in your area, please call 1-866-544-7504 (TTY:711) or consult the online pharmacy directory at [www.MartinsPoint.org/MedicareMembers](http://www.MartinsPoint.org/MedicareMembers).

<b>Additional Benefits</b>	
	<b>Access (LPPO) Plan</b>
<p><b>Wellness Wallet</b> (Fitness, Naturopathic Services, Acupuncture, Nutrition/Dietary Education, Weight Management Programs, and Face Masks)</p> <p>Please see the Evidence of Coverage for more information.</p>	<p>The plan will reimburse up to \$425 each year in total for Fitness Benefit, Naturopathic Services, Acupuncture, Nutrition/Dietary Education, Weight Management Programs, and Face Masks.</p>
<p><b>Over-The-Counter items (OTC)</b> More than 350 covered items including: non-prescription medicine (pain relief, cough, allergies), toothpaste, first aid items, and vitamins. Members can order online, over the phone, or visit a designated store location.</p> <p>Please see the Evidence of Coverage for more information.</p>	<p>The plan will cover up to \$50 per quarter for members to purchase select CVS brand over-the-counter (OTC) products.</p> <p><i>The benefit refreshes quarterly. Remaining balances do not carry over to the next quarter.</i></p>
<p><b>Nutrition and dietary:</b> <b>Telenutrition:</b> Members have access to an online nutrition/dietary platform and unlimited visits with a registered dietitian via video connection, email, or telephone through third-party vendor FoodSmart™.</p> <p><i>Note: Food cost and delivery of meals/groceries are not covered under this benefit.</i></p>	<p>\$0 cost for telenutrition services through FoodSmart™</p>

Martin's Point Health Care complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Martin's Point Health Care does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Martin's Point Health Care:

- 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 Martin's Point Generations Advantage Member Services Team.

If you believe that Martin's Point Health Care 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 Member Services: Member Services, Martin's Point Generations Advantage, PO Box 9746, Portland,

ME 04104, 1-866-544-7504, TTY: 711, Fax: 207-828-7847. (We're available 8 am-8 pm, seven days a week from October 1 to March 31; and Monday through Friday the rest of the year.) You can file a grievance in person, by mail, or by fax. If you need help filing a grievance, the Martin's Point Generations Advantage Member Services Team is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at [ocrportal.hhs.gov/ocr/portal/lobby.jsf](http://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 (TDD: 1-800-537-7697)

Complaint forms are available at [www.hhs.gov/ocr/office/file/index.html](http://www.hhs.gov/ocr/office/file/index.html).



Form Approved OMB# 0938-1421

### Multi-language Interpreter Services

**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 1-877-553-7054 (TTY: 711). 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 1-877-553-7054 (TTY: 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

**Chinese Mandarin:** 我们提供免费<sup>的</sup>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 1-877-553-7054 (TTY: 711)。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 1-877-553-7054 (TTY: 711)。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 1-877-553-7054 (TTY: 711). 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 1-877-553-7054 (TTY: 711). 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 quý vị cần thông dịch viên xin gọi 1-877-553-7054 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.

**German:** Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-877-553-7054 (TTY: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

**Korean:** 당사는 의료 보험 또는 약품 보험에 관한 질문에 대해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-877-553-7054 (TTY: 711) 번으로 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 1-877-553-7054 (TTY: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

**Arabic:** إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على (TTY: 711) 1-877-553-7054. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه 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 1-877-553-7054 (TTY: 711) 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 1-877-553-7054 (TTY: 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

**Portuguese:** 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 1-877-553-7054 (TTY: 711). 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 1-877-553-7054 (TTY: 711). 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 1-877-553-7054 (TTY: 711). 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。通訳をご用命になるには、1-877-553-7054 (TTY: 711) 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。



**MARTIN'S POINT<sup>®</sup>**

MEDICARE ADVANTAGE PLANS

GENERATIONS ADVANTAGE

For more information about benefits or enrollment, call us  
or visit our website at [MartinsPoint.org/Medicare](https://MartinsPoint.org/Medicare)

**1-833-953-3487 (TTY: 711)**

We are available 8 am–8 pm, seven days a week from  
October 1 to March 31; and Monday through Friday the rest  
of the year.

Martin's Point Generations Advantage,  
891 Washington Ave., PO Box 9746, Portland, ME 04104