H1365-004-002

Belknap, Carroll, and Grafton Counties in New Hampshire

Martin's Point Generations Advantage Select *(*LPPO*)* offered by Martin's Point Generations Advantage, Inc.

Annual Notice of Changes for 2022

You are currently enrolled as a member of Martin's Point Generations Advantage Select. Next year, there will be some changes to the plan's costs and benefits. *This booklet tells about the changes.*

- **You have from October 15 until December 7 to make changes to your Medicare coverage for next year.**

What to do now

1. ASK: Which changes apply to you

☐ Check the changes to our benefits and costs to see if they affect you.

- It's important to review your coverage now to make sure it will meet your needs next year.
- Do the changes affect the services you use?
- Look in Sections 1.1 and 1.5 for information about benefit and cost changes for our plan.

☐ Check the changes in the booklet to our prescription drug coverage to see if they affect you.

- Will your drugs be covered?
- Are your drugs in a different tier, with different cost sharing?
- Do any of your drugs have new restrictions, such as needing approval from us before you fill your prescription?
- Can you keep using the same pharmacies? Are there changes to the cost of using this pharmacy?
- Review the 2022 Drug List and look in Section 1.6 for information about changes to our drug coverage.

OMB Approval 0938-1051 (Expires: December 31, 2022)

- Your drug costs may have risen since last year. Talk to your doctor about lower cost alternatives that may be available for you; this may save you in annual out-of-pocket costs throughout the year. To get additional information on drug prices visit go.medicare.gov/drugprices and click on the "dashboards" link in the middle of the second Note toward the bottom of the page. These dashboards highlight which manufacturers have been increasing their prices and also show other year-to-year drug price information. Keep in mind that your plan benefits will determine exactly how much your own drug costs may change.

☐ Check to see if your doctors and other providers will be in our network next year.

- Are your doctors, including specialists you see regularly, in our network?
- What about the hospitals or other providers you use?
- Look in Section 1.3 for information about our Provider Directory.

☐ Think about your overall health care costs.

- How much will you spend out-of-pocket for the services and prescription drugs you use regularly?
- How much will you spend on your premium and deductibles?
- How do your total plan costs compare to other Medicare coverage options?

☐ Think about whether you are happy with our plan.

2. COMPARE: Learn about other plan choices

☐ Check coverage and costs of plans in your area.

- Use the personalized search feature on the Medicare Plan Finder at www.medicare.gov/plan-compare website.
- Review the list in the back of your Medicare & You handbook.
- Look in Section 3.2 to learn more about your choices.

☐ Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan's website.

3. CHOOSE: Decide whether you want to change your plan

- If you don't join another plan by December 7, 2021, you will be enrolled in Martin's Point Generations Advantage Select.
- To change to a **different plan** that may better meet your needs, you can switch plans between October 15 and December 7.

4. ENROLL: To change plans, join a plan between **October 15** and **December 7, 2021**

- If you don't join another plan by **December 7, 2021**, you will be enrolled in Martin's Point Generation Advantage Select.

- If you join another plan by **December 7, 2021**, your new coverage will start on **January 1, 2022**. You will be automatically disenrolled from your current plan.

Additional Resources

- Please contact our Member Services number at 1-866-544-7504 for additional information. (TTY users should call 711. Hours are 8am-8pm, seven days a week from October 1 to March 31; and Monday through Friday the rest of the year.
- This information may be available in other formats such as large print and braille. For more information call Generations Advantage.
- **Coverage under this Plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About Martin's Point Generations Advantage Select

- Martin's Point Generations Advantage is a health plan with a Medicare contract offering HMO, HMO-POS, HMO SNP, Local and Regional PPO products. Enrollment in a Martin's Point Generations Advantage plan depends on contract renewal.
- When this booklet says "we," "us," or "our," it means Martin's Point Generations Advantage, Inc. When it says "plan" or "our plan," it means Martin's Point Generations Advantage Select.

H1365-004-002_2022SelectANOC_M CMS Approved 08/24/2021

Summary of Important Costs for 2022

The table below compares the 2021 costs and 2022 costs for Martin's Point Generations Advantage Select in several important areas. **Please note this is only a summary of changes**. A copy of the *Evidence of Coverage* is located on our website at **MartinsPoint.org/EOC**. Review the enclosed instructions for accessing the *Evidence of Coverage* to see if other benefit or cost changes affect you. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

Cost	2021 (this year)	2022 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 1.1 for details.	$99	$39
Maximum out-of-pocket amounts This is the most you will pay out-of-pocket for your covered Part A and Part B services including inpatient hospital acute, worldwide emergency, eye exams, and hearing exams. (See Section 1.2 for details.)	**In-network:** For services you receive from in-network providers: $7,300 **In- and out-of-network:** For services you receive from in- and out-of-network providers: $10,000	**In-network:** For services you receive from in-network providers: $6,700 **In- and out-of-network:** For services you receive from in- and out-of-network providers: $10,000
Doctor office visits	**In network:** You pay: **Primary Care visits:** • $0 for post-operative and post-discharge visits with your PCP. • $0 for a brief emotional/behavioral assessment with your PCP. • $20 for all other PCP services and visits.	**In network:** You pay: **Primary Care visits:** • $0 for post-operative and post-discharge visits with your PCP. • $0 for a brief emotional/behavioral assessment with your PCP. • $20 for all other PCP services and visits.

Cost	2021 (this year)	2022 (next year)
	Specialist visits: • $40 for each specialist office visit for Medicare-covered services. **Out-of-network:** You pay: **Primary care visits:** • 30% of the cost for each Primary Care Physician (PCP) office visit for Medicare-covered services. **Specialist visits:** • 30% of the cost for each specialist office visit for Medicare-covered services.	**Specialist visits:** • $40 for each specialist office visit for Medicare-covered services. **Out-of-network:** You pay: **Primary care visits:** • 30% of the cost for each Primary Care Physician (PCP) office visit for Medicare-covered services. **Specialist visits:** • 30% of the cost for each specialist office visit for Medicare-covered services.
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.	**In network:** You pay per admission: • $375 per day for days 1-5; • $0 per day for days 6 and beyond **Out-of-network:** You pay per admission: • 30% of the cost for a Medicare-covered hospital stay.	**In network:** You pay per admission: • $385 per day for days 1-5; • $0 per day for days 6 and beyond **Out-of-network:** You pay per admission: • 30% of the cost for a Medicare-covered hospital stay.

Part D prescription drug coverage (See Section 1.6 for details.)	Copayment/Coinsurance during the Initial Coverage Stage: **Drug Tier 1:** *Standard cost sharing:* You pay $4 per prescription. *Preferred cost sharing:* You pay $0 per prescription. **Drug Tier 2:** *Standard cost sharing:* You pay $18 per prescription. *Preferred cost sharing:* You pay $10 per prescription. **Drug Tier 3:** *Standard cost sharing:* You pay $47 per prescription. *Preferred cost sharing:* You pay $40 per prescription. **Drug Tier 4:** *Standard cost sharing:* You pay $100 per prescription. *Preferred cost sharing:* You pay $95 per prescription. **Drug Tier 5:** *Standard cost sharing:* You pay 33% of the total cost. *Preferred cost sharing:* You pay 33% of the total cost.	Copayment/Coinsurance during the Initial Coverage Stage: **Drug Tier 1:** *Standard cost sharing:* You pay $4 per prescription. *Preferred cost sharing:* You pay $0 per prescription. **Drug Tier 2:** *Standard cost sharing:* You pay $18 per prescription. *Preferred cost sharing:* You pay $10 per prescription. **Drug Tier 3:** *Standard cost sharing:* You pay $47 per prescription. *Preferred cost sharing:* You pay $40 per prescription. **Drug Tier 4:** *Standard cost sharing:* You pay $100 per prescription. *Preferred cost sharing:* You pay $95 per prescription. **Drug Tier 5:** *Standard cost sharing:* You pay 33% of the total cost. *Preferred cost sharing:* You pay 33% of the total cost.
Select Insulins (Senior Savings, Part D) To find out which drugs are select insulins, review the most recent Drug List we provided electronically. You can identify Select Insulins by the abbreviation "SI" in the comprehensive formulary. If you have questions about the Drug List, you can also call	**Select Insulins** Standard cost sharing: You pay $35 per 30-day prescription. Preferred cost sharing: You pay $35 per 30-day prescription. Mail Order Cost sharing: You pay $35 per 30-day prescription.	**Select Insulins** Standard cost sharing: You pay $35 per 30-day prescription. Preferred cost sharing: You pay $25 per 30-day prescription. Mail Order Cost sharing: You pay $25 per 30-day prescription.

Cost	2021 (this year)	2022 (next year)
Member Services (Phone numbers for Member Services are printed on the back cover of this booklet). Qualifying insulins will also be identified in the online formulary search tool.	Standard cost sharing: You pay $70 per 60-day prescription. Preferred cost sharing: You pay $70 per 60-day prescription. Mail Order Cost sharing: You pay $70 per 60-day prescription. Standard cost sharing: You pay $105 per 90-day prescription. Preferred cost sharing: You pay $105 per 90-day prescription. Mail Order Cost sharing: You pay $105 per 90-day prescription.	Standard cost sharing: You pay $70 per 60-day prescription. Preferred cost sharing: You pay $50 per 60-day prescription. Mail Order Cost sharing: You pay $50 per 60-day prescription. Standard cost sharing: You pay $105 per 90-day prescription. Preferred cost sharing: You pay $75 per 90-day prescription. Mail Order Cost sharing: You pay $62.50 per 90-day prescription.

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SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2021 (this year)	2022 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$99	$39

- Your monthly plan premium will be *more* if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as "creditable coverage") for 63 days or more.
- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.
- Your monthly premium will be *less* if you are receiving "Extra Help" with your prescription drug costs. Please see Section 6 regarding "Extra Help" from Medicare.

Section 1.2 – Changes to Your Maximum Out-of-Pocket Amounts

To protect you, Medicare requires all health plans to limit how much you pay "out-of-pocket" during the year. These limits are called the "maximum out-of-pocket amounts." Once you reach this amount, you generally pay nothing for covered Part A and Part B services, including inpatient hospital acute, worldwide emergency, eye exams and hearing exams for the rest of the year.

Cost	2021 (this year)	2022 (next year)
In-network maximum out-of-pocket amount Your costs for covered medical services (such as copays) from network providers count toward your in-network maximum out-of-pocket amount. Your plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$7,300 Once you have paid $7,300 out-of-pocket for covered Part A and Part B services you will pay nothing for your covered Part A and Part B services (including the services listed in the section above) from network providers for the rest of the calendar year.	$6,700 Once you have paid $6,700 out-of-pocket for covered Part A and Part B services you will pay nothing for your covered Part A and Part B services (including the services listed in the section above) from network providers for the rest of the calendar year.
Combined maximum out-of-pocket amount Your costs for covered medical services (such as copays) from in-network and out-of-network providers count toward your combined maximum out-of-pocket amount. Your plan premium does not count toward your maximum out-of-pocket amount.	$10,000 Once you have paid $10,000 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services (including the services listed in the section above) from in-network or out-of-network providers for the rest of the calendar year.	$10,000 Once you have paid $10,000 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services (including the services listed in the section above) from in-network or out-of-network providers for the rest of the calendar year.

Section 1.3 – Changes to the Provider Network

There are changes to our network of providers for next year. An updated Provider Directory is located on our website at **MartinsPoint.org/MedicareMembers.** You may also call Member Services for updated provider information or to ask us to mail you a Provider Directory. **Please review the 2022 Provider Directory to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network**.

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan, but if your doctor or specialist does leave your plan, you have certain rights and protections summarized below:

- Even though our network of providers may change during the year, we must furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.

- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider to manage your care.

Section 1.4 – Changes to the Pharmacy Network

Amounts you pay for your prescription drugs may depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered *only* if they are filled at one of our network pharmacies. Our network includes pharmacies with preferred cost sharing, which may offer you lower cost sharing than the standard cost sharing offered by other network pharmacies for some drugs.

There are changes to our network of pharmacies for next year. An updated Pharmacy Directory is located on our website at **MartinsPoint.org/PartD.** You may also call Member Services for updated provider information or to ask us to mail you a Pharmacy Directory. **Please review the 2022 Pharmacy Directory to see which pharmacies are in our network**.

Section 1.5 – Changes to Benefits and Costs for Medical Services

We are changing our coverage for certain medical services next year. The information below describes these changes. For details about the coverage and costs for these services, see Chapter 4, *Medical Benefits Chart (what is covered and what you pay)*, in your *2022 Evidence of Coverage.*

Opioid treatment program services

Members of our plan with opioid use disorder (OUD) can receive coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services:

- U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications.
- Dispensing and administration of MAT medications (if applicable)
- Substance use counseling
- Individual and group therapy
- Toxicology testing
- Intake activities
- Periodic assessments

Cost	2021 (this year)	2022 (next year)
Dental - Preventive	Not a covered benefit.	• $1,000 benefit maximum in-network and out-of-network combined **In network:** • Category A: Diagnostic/Preventive (You pay: $50 office visit copay) o Oral exam and routine cleaning once in a calendar year o Problem-focused exams as needed o Bitewing x-rays once every calendar year and panoramic x-rays once in a 5-calendar year period o X-rays of individual teeth as needed **Out of network:** •Category A: Diagnostic/Preventive (You pay: $50 office visit copay, 50% coinsurance for individual services)
Hearing services	**In network:** • You pay $40 per visit for Medicare-covered hearing services. **Out of network:** • You pay 30% of the cost.	**In network:** • You pay $40 per visit for Medicare-covered hearing services. **Out of network:** • You pay 30% of the cost.
Hearing Aids *(Please see Evidence of Coverage at MartinsPoint.org/EOC for more information and instructions on how to use the benefit).*	**In network:** • You pay $495, $695, or $1,095 copay per ear, per year, depending on Tier selected. **Out of network:** • You pay $495, $695, or $1,095 copay per ear, per	**In network:** • You pay $495, $695, $1,095, $1,495 or $2,095 copay per ear, per year, depending on Tier selected. **Out of network:** • You pay $495, $695, $1,095, $1,495 or $2,095 copay per

Cost	2021 (this year)	2022 (next year)
Hearing aid fittings and evaluations	year, depending on Tier selected. *Services must be received from an Amplifon provider*. **In network:** • You pay $0 for 1 year of hearing aid fittings and ongoing hearing aid evaluations when used in conjunction with your hearing aid benefit. **Out of network:** • You pay $0 for 1 year of hearing aid fittings and ongoing hearing aid evaluations when used in conjunction with your hearing aid benefit. *Services must be received from an Amplifon provider.*	ear, per year, depending on Tier selected. *Services must be received from an Amplifon provider*. **In network:** • You pay $0 for 1 year of hearing aid fittings and ongoing hearing aid evaluations when used in conjunction with your hearing aid benefit. **Out of network:** • You pay $0 for 1 year of hearing aid fittings and ongoing hearing aid evaluations when used in conjunction with your hearing aid benefit. *Services must be received from an Amplifon provider.*
Help with Certain Chronic Conditions	Members with a diagnosis of Chronic Kidney Disease, Diabetes, or Prediabetes can enroll in a 12-month nutrition and dietary program through Good Measures at no cost. *Please note, if you enrolled in 2021 you will continue to receive the 12 months of service indicated in your 2021 plan benefits.*	Not a covered benefit.

Cost	2021 (this year)	2022 (next year)
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day**.**	**In network:** You pay per admission: • $375 per day for days 1-5; • $0 per day for days 6 and beyond **Out-of-network:** You pay per admission: 30% of the cost for a Medicare-covered hospital stay.	**In network:** You pay per admission: • $385 per day for days 1-5; • $0 per day for days 6 and beyond **Out-of-network:** You pay per admission: 30% of the cost for a Medicare-covered hospital stay.
Outpatient Hospital Observation Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet the Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests.	You pay for Medicare-covered services: **In-network:** • $200 copay for outpatient observation services. **Out-of-network:** • 30% of the cost for outpatient hospital observation.	You pay for Medicare-covered services: **In-network:** • $350 copay for outpatient observation services. **Out-of-network:** • 30% of the cost for outpatient hospital observation.
Outpatient rehabilitation services Including physical therapy, speech therapy, and occupational therapy.	Authorization is required for outpatient rehabilitation services in 2021.	Authorization is not required for outpatient rehabilitation services in 2022.

Cost	2021 (this year)	2022 (next year)
Nutrition and Dietary Support Telenutrition: 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™. Members can call 888-837-5325 to schedule an appointment with a registered dietitian. Members can find information about how to access the FoodSmart benefit on the MartinsPoint.org website. Go to "For Members and Patients" >> "Generations Advantage">>"Member Resources" and then click on "Foodsmart Personal Nutrition Benefit." Note: Food cost and delivery of meals/groceries are not covered under this benefit.	Not a covered benefit.	$0 cost for telenutrition services through FoodSmart™
Physician/Practitioner services, including doctor's office visits **Telehealth Service** You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers	• $20 for each Primary Care Physician (PCP) office visit • $40 for specialist visits. • $0 for Medicare-covered Home Health Services • $40 for outpatient rehabilitation services • $25 for individual and group mental health, psychiatry.	• $20 for each Primary Care Physician (PCP) office visit • $40 for specialist visits. • $0 for Medicare-covered Home Health Services • $40 for outpatient rehabilitation services • $25 for individual and group mental health, psychiatry.

Cost	2021 (this year)	2022 (next year)
the service by telehealth. *Please note, the treating provider's determination is appropriate for the service and may require the member to come to their office or facility.*	• $25 for outpatient substance use visits. • $0 for opioid treatment. services. • $0 for Kidney Disease education services. • $0 for Diabetes Self-Management Training services • Podiatry Services were not covered via telehealth in 2021.	• $25 for outpatient substance use visits. • $0 for opioid treatment. services. • $0 for Kidney Disease education services. • $0 for Diabetes Self-Management Training services • $40 for Podiatry Services
Special Supplemental Benefits for the Chronically Ill	In order to use this benefit, members with a diagnosis of Congestive Heart Failure (CHF) or End Stage Renal Disease (ESRD) must be screened for food insecurity by the health plan and meet the necessary requirement.	Members with diagnoses of Congestive Heart Failure (CHF) or End Stage Renal Disease (ESRD), post-discharge or surgery; or members with CHF or ESRD who indicate need and meet objective screening priority for food insecurity, are eligible to receive home-delivered meals.
	• Up to 7 days (14 meals) of coverage for each qualifying event identified by care manager (post-discharge, post-surgery, indication on Health Risk Assessment, or need identified during care plan update). • Up to an additional 7 days (14 meals) of coverage beyond limited meal benefit when extended need and high risk is identified by care manager while coordinating access to community support for food insecurity. • Receive up to $15/calendar year in fresh food/produce subsidy. • When receiving meal delivery, members will also receive 1-2 visual safety check-ins per week of meal delivery, assessment/application support for meals on wheels (whether full/partial), (2) follow-up visits by a community resource specialist for well-being assessment and	• Up to 7 days (14 meals) of coverage for each qualifying event (post-discharge, post-surgery, indication on Health Risk Assessment, or need identified during care plan update). • Up to an additional 7 days (14 meals) of coverage beyond limited meal benefit when extended need and high risk is identified by care manager while coordinating access to community support for food insecurity. • Not a covered benefit • When receiving meal delivery, members will also receive 1-2 visual safety check-ins per week of meal delivery, assessment/application support for meals on wheels (whether full/partial), (2) follow-up visits by a community resource specialist for well-being assessment and

Cost	2021 (this year)	2022 (next year)
	community service support plan. • Members receive services supporting cooking, shopping, and budgeting when experiencing food insecurity.	community service support plan. • Members receive services supporting cooking, shopping, and budgeting when experiencing food insecurity.

Section 1.6 – Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a Formulary or "Drug List." A copy of our Drug List is provided electronically.

We made changes to our Drug List, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions.**

If you are affected by a change in drug coverage, you can:

- **Work with your doctor (or other prescriber) and ask the plan to make an exception** to cover the drug. **We encourage current members** to ask for an exception before next year.
  - To learn what you must do to ask for an exception, see Chapter 9 of your *Evidence of Coverage (What to do if you have a problem or complaint (coverage decisions, appeals, complaints))* or call Member Services.
- **Work with your doctor (or other prescriber) to find a different drug** that we cover. You can call Member Services to ask for a list of covered drugs that treat the same medical condition.

Approved formulary exceptions will be covered into the next plan year if the end date of the exception continues into the next year. After the exception ends, you or your doctor must request a new formulary exception in order for us to continue to cover this drug. Please refer to the letter sent which granted the exception to see whether the exception continues beyond the 2021 plan year.

Most of the changes in the Drug List are new for the beginning of each year. However, during the year, we might make other changes that are allowed by Medicare rules.

When we make these changes to the Drug List during the year, you can still work with your doctor (or other prescriber) and ask us to make an exception to cover the drug. We will also continue to update our online Drug List as scheduled and provide other required information to reflect drug changes. (To learn more about changes we may make to the Drug List, see Chapter 5, Section 6 of the Evidence of Coverage.)

Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs may not apply to you.** We have included a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also called the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug costs. Because you receive "Extra Help" if you haven't received this insert by September 30th, please call Member Services and ask for the "LIS Rider."

There are four "drug payment stages." How much you pay for a Part D drug depends on which drug payment stage you are in. (You can look in Chapter 6, Section 2 of your *Evidence of Coverage* for more information about the stages.)

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 **MartinsPoint.org/PartD**.

The information below shows the changes for next year to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage. To get information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in the *Evidence of Coverage*, which is located on our website at **MartinsPoint.org/EOC.**. You can also review the *Evidence of Coverage* to see if other benefit or cost changes affect you. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.)

Changes to the Deductible Stage

Stage	2021 (this year)	2022 (next year)
Stage 1: Yearly Deductible Stage	Because we have no deductible, this payment stage does not apply to you.	Because we have no deductible, this payment stage does not apply to you.

Changes to Your Cost Sharing in the Initial Coverage Stage

To learn how copayments and coinsurance work, look at Chapter 6, Section 1.2, *Types of out-of-pocket costs you may pay for covered drugs* in your *Evidence of Coverage*.

Stage	2021 (this year)	2022 (next year)
Stage 2: Initial Coverage Stage Once you pay the yearly deductible, you move to the Initial Coverage Stage. During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost.** The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy that provides standard cost-sharing. For information about the costs for a long-term supply; at a network pharmacy that offers preferred cost-sharing; or for mail-order prescriptions, look in Chapter 6, Section 5 of your Evidence of Coverage. We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.	Your cost for a one-month supply filled at a network pharmacy: **Drug Tier 1:** *Standard cost sharing:* You pay $4 per prescription. *Preferred cost sharing:* You pay $0 per prescription. **Drug Tier 2:** *Standard cost sharing:* You pay $18 per prescription. *Preferred cost sharing:* You pay $10 per prescription. **Drug Tier 3:** *Standard cost sharing:* You pay $47 per prescription. *Preferred cost sharing:* You pay $40 per prescription. **Drug Tier 4:** *Standard cost sharing:* You pay $100 per prescription. *Preferred cost sharing:* You pay $95 per prescription. **Drug Tier 5:** *Standard cost sharing:* You pay 33% of the total cost. *Preferred cost sharing:* You pay 33% of the total cost.	Your cost for a one-month supply filled at a network pharmacy: **Drug Tier 1:** *Standard cost sharing:* You pay $4 per prescription. *Preferred cost sharing:* You pay $0 per prescription. **Drug Tier 2:** *Standard cost sharing:* You pay $18 per prescription. *Preferred cost sharing:* You pay $10 per prescription. **Drug Tier 3:** *Standard cost sharing:* You pay $47 per prescription. *Preferred cost sharing:* You pay $40 per prescription. **Drug Tier 4:** *Standard cost sharing:* You pay $100 per prescription. *Preferred cost sharing:* You pay $95 per prescription. **Drug Tier 5:** *Standard cost sharing:* You pay 33% of the total cost. *Preferred cost sharing:* You pay 33% of the total cost.

Stage	2021 (this year)	2022 (next year)
Stage 2: Initial Coverage Stage (continued)		
Select Insulins (Senior Savings, Part D) To find out which drugs are select insulins, review the most recent Drug List we provided electronically. If you have questions about the Drug List, you can also call Member Services (Phone numbers for Member Services are printed on the back cover of this booklet). Qualifying insulins will be identified by "SI" (select insulin) in the Drug List you can access electronically. Qualifying insulins will also be identified in the online formulary search tool.	**Select Insulins** Standard cost sharing: You pay $35 per 30-day prescription. Preferred cost sharing: You pay $35 per 30-day prescription. Mail Order Cost sharing: You pay $35 per 30-day prescription. Standard cost sharing: You pay $70 per 60-day prescription. Preferred cost sharing: You pay $70 per 60-day prescription. Mail Order Cost sharing: You pay $70 per 60-day prescription. Standard cost sharing: You pay $105 per 90-day prescription. Preferred cost sharing: You pay $105 per 90-day prescription. Mail Order Cost sharing: You pay $105 per 90-day prescription. Once your total drug costs have reached $4,130 you will move to the next stage (the Coverage Gap Stage).	**Select Insulins** Standard cost sharing: You pay $35 per 30-day prescription. Preferred cost sharing: You pay $25 per 30-day prescription. Mail Order Cost sharing: You pay $25 per 30-day prescription. Standard cost sharing: You pay $70 per 60-day prescription. Preferred cost sharing: You pay $50 per 60-day prescription. Mail Order Cost sharing: You pay $50 per 60-day prescription. Standard cost sharing: You pay $105 per 90-day prescription. Preferred cost sharing: You pay $75 per 90-day prescription. Mail Order Cost sharing: You pay $62.50 per 90-day prescription. Once your total drug costs have reached $4,430 you will move to the next stage (the Coverage Gap Stage).

Changes to the Coverage Gap and Catastrophic Coverage Stages

The other two drug coverage stages – the Coverage Gap Stage and the Catastrophic Coverage Stage – are for people with high drug costs. Martin's Point Generations Advantage Select offers additional gap coverage for select insulins. During the Coverage Gap stage, your out-of-pocket costs for select insulins will be $35 for each 30-day supply when filled at a standard pharmacy or $25 for each 30-day supply when filled at a preferred pharmacy. If select insulins are filled through the mail order pharmacy, your out-of-pocket costs are $25 for each 30-day supply; $50 for each 60-day supply, or $62.50 for each 90-day supply. This applies to select Part D insulins and does not apply to insulins covered under Part B.
To find out which drugs are select insulins, review the most recent Drug List we provided electronically. If you have questions about the Drug List, you can also call Member Services (Phone numbers for Member Services are printed on the back cover of this booklet).

Qualifying insulins will be identified by "SI" (select insulin) in the Drug List you can access electronically.

Qualifying insulins will also be identified in the online formulary search tool.

Most members do not reach the Coverage Gap Stage or the Catastrophic Coverage Stage. For information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in your *Evidence of Coverage*.

SECTION 2 Administrative Changes

This section is intended to inform you of any administrative changes to your plan benefits for 2022.

Description	2021 (this year)	2022 (next year)
Medicare Part B prescription drugs – Step Therapy	Step therapy program did not exist.	Certain Part B drugs may be subject to step therapy requirements. Please refer to your Evidence of Coverage for more information.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in Martin's Point Generations Advantage Select

To stay in our plan you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically be enrolled in our Martin's Point Generations Advantage Select.

Section 3.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change for 2022 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan timely,
- – *OR*– You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan. If you do not enroll in a Medicare drug plan, please see Section 1.1 regarding a potential Part D late enrollment penalty.

To learn more about Original Medicare and the different types of Medicare plans, read the *Medicare & You 2022* handbook call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to www.medicare.gov/plan-compare. **Here, you can find information about costs, coverage, and quality ratings for Medicare plans.**

As a reminder, Martin's Point Generations Advantage, Inc. offers other Medicare health plans. These other plans may differ in coverage, monthly premiums, and cost-sharing amounts.

Step 2: Change your coverage

- To **change to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from Martin's Point Generations Advantage Select.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Martin's Point Generations Advantage Select.
- To **change to Original Medicare without a prescription drug plan**, you must either:
  - Send us a written request to disenroll. Contact Member Services if you need more information on how to do this (phone numbers are in Section 7.1 of this booklet).

- – *OR* – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

SECTION 4 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7.** The change will take effect on January 1, 2022.

Are there other times of the year to make a change?

In certain situations, changes are also allowed at other times of the year. For example, people with Medicaid, those who get "Extra Help" paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area may be allowed to make a change at other times of the year. For more information, see Chapter 10, Section 2.3 of the *Evidence of Coverage.*

If you enrolled in a Medicare Advantage Plan for January 1, 2022, and don't like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2022. For more information, see Chapter 10, Section 2.2 of the *Evidence of Coverage*.

SECTION 5 Programs That Offer Free Counseling about Medicare

New Hampshire Residents:

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In New Hampshire, the SHIP is called ServiceLink Resource Center.

ServiceLink Resource Center is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. ServiceLink Resource Center counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans.

You can call the New Hampshire Health Insurance Assistance Program (ServiceLink) at 1-866-634-9412. You can learn more about New Hampshire State Health Insurance Assistance Program by visiting their website (www.servicelink.nh.gov/medicare/index.htm).

SECTION 6 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs. Below we list different kinds of help:

- **"Extra Help" from Medicare.** People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. Many people are eligible and don't even know it. To see if you qualify, call:
  - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
  - The Social Security Office at 1-800-772-1213 between 7 am and 7 pm, Monday through Friday. TTY users should call 1-800-325-0778 (applications); or
  - Your State Medicaid Office (applications).
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status.

  Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the New Hampshire Ryan White CARE Program. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call the New Hampshire Ryan White CARE Program at (603) 271-4502 or (800) 852-3345, ext. 4502 (toll-free within NH).

SECTION 7 Questions?

Section 7.1 – Getting Help from Martin's Point Generations Advantage Select.

Questions? We're here to help. Please call Member Services at 1-866-544-7504. (TTY only, call 711.) We are available for phone calls 8 am-8 pm, seven days a week from October 1 to March 31; and Monday through Friday the rest of the year. Calls to these numbers are free.

Read your 2022 *Evidence of Coverage* (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2022. For details, look in the 2022 *Evidence of Coverage* for Martin's Point Generations Advantage Select. The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is located on our website at **MartinPoint.org/EOC**. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

Visit our Website

You can also visit our website at **MartinsPoint.org/MedicareMembers**. As a reminder, our website has the most up-to-date information about our provider network (Provider Directory) and our list of covered drugs (Formulary/Drug List).

Section 7.2 – Getting Help from Medicare

To get information directly from Medicare:

Call 1-800-MEDICARE (1-800-633-4227)

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Visit the Medicare Website

You can visit the Medicare website (www.medicare.gov). It has information about cost, coverage, and quality ratings to help you compare Medicare health plans. You can find information about plans available in your area by using the Medicare Plan Finder on the Medicare website. (To view the information about plans, go to www.medicare.gov/plan-compare).

Read *Medicare & You 2022*

You can read the *Medicare & You 2022* handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (www.medicare.gov) or 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.