Flex (RPPO) and Select (LPPO)

Summary of Benefits

January 1–December 31, 2020

MARTIN'S POINT®

MEDICARE ADVANTAGE PLANS

GENERATIONS ADVANTAGE

Summary of Benefits

Martin's Point Generations Advantage Select (LPPO) and Flex (RPPO)
January 1 – December 31, 2020

For more information about benefits or enrollment, call us or visit our website at **www.MartinsPoint.org/Medicare**.

1-888-408-8285 (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.

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Section 1: Introduction

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

January 1, 2020 - December 31, 2020

Martin’s Point Generations Advantage is a health plan with a Medicare contract offering HMO, HMO-POS, HMO SNP, and Local and Regional 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.

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 or Flex, 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 all counties in Maine and 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.

For **Martin’s Point Generations Advantage Flex (RPPO) plan:**

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

The Flex plan has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers in our network or in the Maine or New Hampshire region, 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) and Flex (RPPO) plans.

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

Plan Name	Plan Service Area	Monthly Premium
Martin's Point Generations Advantage Select	All counties in Maine and New Hampshire.	$99
Martin's Point Generations Advantage Flex	All counties in Maine and New Hampshire	$19

Benefit	Select (LPPO) Plan	Flex (RPPO) Plan
Deductible	You pay nothing.	You pay nothing.
Maximum out-of-pocket Responsibility (does not include prescription drugs) Our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care.	From network providers: $6,700 From network and out-of-network providers combined: $10,000	From network providers: $5,500 From network and out-of-network providers combined: $8,000
Inpatient Hospital Our plan covers an unlimited number of days for an inpatient hospital stay**.**	**In Network:** You pay per admission: $325 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: $325 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.

Benefit	Select (LPPO) Plan	Flex (RPPO) Plan
Outpatient Hospital * Services may require that your provider get prior authorization (approval in advance). Please have your provider contact the plan for more details.	**In Network**: You pay $350 for Medicare-covered surgery services at a hospital outpatient facility. **Out of Network:** You pay 30% of the cost of Medicare-covered surgery services at a hospital outpatient facility.	**In Network**: You pay $350 for Medicare-covered surgery services at a hospital outpatient facility. **Out of Network:** You pay 30% of the cost of Medicare-covered surgery services at a hospital outpatient facility.
Ambulatory & Surgical Centers (ASC)	**In Network:** You pay $200 for Medicare-covered surgery services at an ambulatory surgical center. **Out of Network:** You pay 30% of the cost of Medicare-covered surgery services at an ambulatory surgical center.	**In Network:** You pay $250 for Medicare-covered surgery services at an ambulatory surgical center. **Out of Network:** You pay 30% of the cost of Medicare-covered surgery services at an ambulatory surgical center.
Doctor Visits	**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. You pay $20 for all other PCP services and visits. **Out of Network:** You pay 30% of the cost for each Primary Care Physician (PCP) office visit for Medicare-covered services. **Specialists** **In Network:** You pay $40 for each specialist office visit for Medicare-covered services. **Out of Network:** You pay 30% of the cost for each specialist office visit for Medicare-covered services.	**Primary Care** **In Network:** You pay nothing. **Out of Network:** You pay 30% of the cost for each Primary Care Physician (PCP) office visit for Medicare-covered services. **Specialists** **In Network:** You pay $45 for each specialist office visit for Medicare-covered services. **Out of Network:** You pay 30% of the cost for each specialist office visit for Medicare-covered services.

Benefit	Select (LPPO) Plan	Flex (RPPO) Plan
Preventive Care Any additional preventive services approved by Medicare during the contract year will be covered. There are some items not covered at $0 cost.	**In Network:** You pay nothing. **Out of Network:** You pay 30% of the cost for Medicare-covered services.	**In Network:** You pay nothing. **Out of Network:** You pay 30% of the cost for Medicare-covered services.
Emergency Care Note: You do not have to pay this amount if you are admitted to a hospital within 24 hours for the same condition. Emergency care is covered worldwide.	**In- and Out-of-Network:** You pay $90 for each Medicare-covered emergency room visit.	**In- and Out-of-Network:** You pay $90 for each Medicare-covered emergency room visit.
Urgently Needed Services Urgent care is covered nationwide.	**In- and Out-of-Network:** You pay $40 for each Medicare-covered urgent care visit when performed at an urgent care center.	**In- and Out-of-Network:** You pay $45 for each Medicare-covered urgent care visit when performed at an urgent care center.
Diagnostic Services / Labs / Imaging Services may require that your provider get prior authorization (approval in advance). Please see the Evidence of Coverage for more information.	**Diagnostic Radiology Service (e.g., MRI)** **In Network:** You pay 20% of the cost of complex diagnostic radiology (such as PET, CT, MRI, MRA, nuclear medicine), 20% of the cost for Medicare-covered services. **Out of Network:** You pay 30% of the cost of complex diagnostic radiology (PET, CT, MRI, MRA, nuclear medicine). **Lab Services** **In Network:** You pay 20% for genetic labs You pay $0-$5 copay for all other lab services. **Out of Network:** You pay 20% for genetic labs You pay $0-$5 copay for all other lab services.	**Diagnostic Radiology Service (e.g., MRI)** **In Network:** You pay 20% of the cost of complex diagnostic radiology (such as PET, CT, MRI, MRA, nuclear medicine), 20% of the cost for Medicare-covered services. **Out of Network:** You pay 30% of the cost of complex diagnostic radiology (PET, CT, MRI, MRA, nuclear medicine). **Lab Services** **In Network:** You pay 20% for genetic labs You pay $0-$5 copay for all other lab services. **Out of Network:** You pay 20% of the cost for lab services.

Benefit	Select (LPPO) Plan	Flex (RPPO) Plan
	Diagnostic Tests and Procedures **In Network:** You pay 15% of the cost of simple diagnostic radiology. **Out of Network:** You pay 15% of the cost of simple diagnostic radiology. **Outpatient X-rays** **In Network:** You pay 15% for X-rays. **Out of Network:** You pay 15% of the cost for x-rays.	**Diagnostic Tests and Procedures** **In Network:** You pay 20% of the cost of simple diagnostic radiology. **Out of Network:** You pay 30% of the cost of simple diagnostic radiology. **Outpatient X-rays** **In Network:** You pay $12 for X-rays. **Out of Network:** You pay 30% of the cost for x-rays.
Hearing Services	**Hearing Exam** **In Network:** You pay $40 per visit for Medicare-covered hearing services. **Out of Network:** You pay 30% of the cost. **Hearing Aid Fittings and Evaluations** **In- and 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.* **Hearing Aid** **In- and Out-of-Network:** You pay $595, $695, or $895 copay per ear, depending on Tier selected.	**Hearing Exam** **In Network:** You pay $45 per visit for Medicare-covered hearing services. **Out of Network:** You pay 30% of the cost. **Hearing Aid Fittings and Evaluations** **In- and 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.* **Hearing Aid** **In- and Out-of-Network:** You pay $595, $695, or $895 copay per ear, depending on Tier selected.

Benefit	Select (LPPO) Plan	Flex (RPPO) Plan
Dental Services (Medicare-covered) Services may require that your provider get prior authorization (approval in advance). Please see the Evidence of Coverage for more information.	*Services must be received from an Amplifon provider.* **In Network:** You pay $40 per visit for Medicare-covered dental services (non-routine dental care required to treat illness or injury). **Out of Network:** You pay 30% of the cost.	*Services must be received from an Amplifon provider.* **In Network:** You pay $5 per visit for Medicare-covered dental services (non-routine dental care required to treat illness or injury). **Out of Network:** You pay 30% of the cost.
Preventive and Comprehensive Dental Members must use Delta Dental PPO/Martin's Point Generations Advantage network dentist in Maine, New Hampshire, or Vermont to obtain these supplemental dental benefits.	Not a covered benefit.	Preventive and Comprehensive Dental services are covered. *Please see Dental page below for more information.*
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 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 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).	**Annual Routine Eye Exam** **In Network:** You pay $0 for an annual routine eye exam. **Out of Network:** You pay 30% of the cost for an annual routine eye exam. **Medicare-Covered Physician Services** **In Network:** You pay $45 for non-routine Medicare-covered physician services. **Out of Network:** You pay 30% of the cost of non-routine Medicare-covered physician services. **Glaucoma Testing** **In-Network:** You pay $0 for glaucoma testing. **Out-of-Network:** You pay 30% of the cost. **Diabetic Retinopathy** **In-Network:** You pay $0 for a diabetic eye exam (retinopathy).

Benefit	Select (LPPO) Plan	Flex (RPPO) Plan
	Out-of-Network: You pay 30% of the cost. **Eyeglass Frames, Lenses, and Contacts:** Eyeglasses are covered through the Wellness Wallet. *See Wellness Wallet section below for more information.*	**Out-of-Network:** You pay 30% of the cost. **Eyeglass Frames, Lenses, and Contacts:** Eyeglasses are covered through the Wellness Wallet. *See Wellness Wallet section below for more information.*
Mental Health Services Services may require that your provider get prior authorization (approval in advance). Please see the Evidence of Coverage for more information.	**Inpatient Visit** **In Network:** You pay per admission: $220 per day for days 1-7; $0 per day for days 8 and beyond **Out of Network:** Days 1-90: You pay per admission: 30% of the 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 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 cost of a visit for group therapy.	**Inpatient Visit** **In Network:** You pay per admission: $230 per day for days 1-7; $0 per day for days 8 and beyond **Out of Network:** Days 1-90: You pay per admission: 30% of the cost per day for a Medicare-covered hospital stay. **Outpatient Individual Therapy Visit** **In Network:** You pay $10 per visit for individual therapy. **Out of Network:** You pay 30% of the cost of a visit for individual therapy. **Outpatient Group Therapy Visit** **In Network:** You pay $10 per visit for group therapy. **Out of Network:** You pay 30% of the cost of a visit for group therapy.

Benefit	Select (LPPO) Plan	Flex (RPPO) Plan
Skilled Nursing Facility Services may require that your provider get prior authorization (approval in advance). Please see the Evidence of Coverage for more information.	**In Network:** For each benefit period you pay for Medicare-covered services: $0 per day for days 1-20; $178 per day for days 21-100 **Out of Network:** You pay 30% of the cost.	**In Network:** For each benefit period you pay for Medicare-covered services: $0 per day for days 1-20; $178 per day for days 21-100 **Out of Network:** You pay 30% of the cost.
Physical Therapy Services may require that your provider get prior authorization (approval in advance). Please see the Evidence of Coverage for more information.	**In Network:** You pay $40 for each Medicare-covered visit. **Out of Network:** You pay 30% of the cost.	**In Network:** You pay $40 for each Medicare-covered visit. **Out of Network:** You pay 30% of the cost.
Ambulance Non-emergency ambulance transportation may require that your provider get prior authorization (approval in advance). Please see the Evidence of Coverage for more information. Ambulance services are covered worldwide.	**In- and Out-of-Network:** You pay $295 for each Medicare-covered emergency ambulance service (one-way).	**In- and Out-of-Network:** You pay $295 for each Medicare-covered emergency ambulance service (one-way).
Transportation	Not a covered benefit.	Not a covered benefit.
Medicare Part B drugs 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 cost of Medicare-covered services.	You pay 20% of the cost of Medicare-covered services.

Outpatient Prescription Drugs (Generations Advantage Select (LPPO) Plan)				
	Standard Retail (30-day supply)	**Preferred Retail** (30-day supply)	**Mail-Order** (90-day supply)	
Phase 1: Initial Coverage				
Cost sharing Tier 1 (Preferred Generic)	$4	$0	$10	Cost sharing may change depending on the pharmacy you choose and when you enter another phase of the Part D benefit. For more information on the additional pharmacy-specific cost sharing and the phases of the benefit, please refer to the Evidence of Coverage for more information.
Cost sharing Tier 2 (Generic)	$18	$10	$45	
Cost sharing Tier 3 (Preferred Brand)	$47	$40	$117.50	
Cost sharing Tier 4 (Non-Preferred Drug)	$100	$95	$250	
Cost sharing Tier 5 (Specialty Tier)	33%	33%	33%	

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/Medicare.

Outpatient Prescription Drugs (Generations Advantage Flex (RPPO) Plan)				
	Standard Retail (30-day supply)	**Preferred Retail** (30-day supply)	**Mail-Order** (90-day supply)	
Deductible Phase				
$275 Part D deductible for Tiers 3 through 5 drugs				
Phase 2: Initial Coverage				
Cost sharing Tier 1 (Preferred Generic)	$4	$2	$0	Cost sharing may change depending on the pharmacy you choose and when you enter another phase of the Part D benefit. For more information on the additional pharmacy-specific cost sharing and the phases of the benefit, please refer to the Evidence of Coverage for more information.
Cost sharing Tier 2 (Generic)	$18	$10	$20	
Cost sharing Tier 3 (Preferred Brand)	$47	$40	$100	
Cost sharing Tier 4 (Non-Preferred Drug)	$100	$95	$237.50	
Cost sharing Tier 5 (Specialty Tier)	28%	28%	28%	

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/Medicare.

Additional Benefits		
	Select (LPPO) Plan	**Flex (RPPO) Plan**
Wellness Wallet (Fitness, Naturopathic Services, Acupuncture, Nutrition/Dietary Education, Weight Management Programs, Eyewear) Please see the Evidence of Coverage for more information.	The plan will reimburse up to $200 each year in total for Fitness Benefit, Naturopathic Services, Acupuncture, Nutrition/Dietary Education, Weight Management Programs, and Eyewear.	The plan will reimburse up to $200 each year in total for Fitness Benefit, Naturopathic Services, Acupuncture, Nutrition/Dietary Education, Weight Management Programs, and Eyewear.
Over-The-Counter items (OTC) More than 150 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 $50 per quarter for members to purchase select CVS brand over-the-counter (OTC) products.	The plan will cover up to $50 per quarter for members to purchase select CVS brand over-the-counter (OTC) products.

Section 3: Dental Benefit Overview

The **Generations Advantage Flex (RPPO)** plan includes the following benefits when seeing a Delta Dental PPO/Martin's Point Generations Advantage network dentist. This benefit overview is provided for summary purposes only.

Dental Benefit	Select	Flex (in-network)
Benefit Maximum*	**N/A**	**$1,000**
Office Visit Copay		**$50**
Category A: Diagnostic/Preventative		
Oral exam and routine cleaning once in a calendar year	**Not a covered benefit.**	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		
Category B: Basic Restorative		
Fillings	**Not a covered benefit.**	You pay 50% of the cost + $50 office visit copay $50 deductible applies
Surgical and routine extractions		
Root canals		
Treatment of gum disease (periodontics, including periodontal maintenance cleanings)		
Category C: Major Restorative		
Dentures	**Not a covered benefit.**	You pay 50% of the cost + $50 office visit copay $50 deductible applies
Crowns		
Implants		

* Benefit maximum and deductible apply to both in- and out-of-network services.

Flex Plan Out-of-Network Dental Coverage

The Flex plan offers out-of-network dental coverage. Please see the table below for a summary overview.

Flex Out-of-Network Dental Coverage	
Category A: Diagnostic/Preventative	50% coinsurance + $50 office visit copay
Category B: Basic Restorative	75% coinsurance + $50 office visit copay $50 deductible applies
Category C: Major Restorative	75% coinsurance + $50 office visit copay $50 deductible applies

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 Northeast Delta Dental.
Members can register online to view claims and benefit information at **www.nedelta.com**.

Non-participating Dentists

Out-of-network plan benefits are available when seeing a non-participating dentist.
Non-participating dentists are welcome to join the Delta Dental PPO/Martin's Point Generations Advantage dental network at any time.

Identification Cards

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

Delta Dental PPO/Martin's Point Generations Advantage Dental Network

In-network plan benefits are available only when you receive your dental care from a Delta Dental PPO/Martin's Point Generations Advantage network dentist in Maine, New Hampshire, or Vermont:

- **No Balance Billing**: Participating dentists accept Northeast Delta Dental's fees for services as payment in full.
- **No Claims Paperwork**: Participating dentists will prepare and submit claims for you.
- **Direct Payment**: Northeast 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 PPO/ Martin's Point Generations Advantage dental network, please visit our website at **MartinsPoint.org/Medicare**, visit **www.nedelta.com/Dentist-Search**, or call **Northeast Delta Dental's Customer Service Department at 1-800-832-5700 (TTY: 1-800-332-5905) Monday through Friday, 8 am–4:45 pm.**

MARTIN'S POINT®
HEALTH CARE

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 Grievance Specialist.

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: Grievance Department, 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 Grievance Specialist 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, 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.

English	ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-877-553-7054 (TTY: 711).
Français (French)	ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-553-7054 (ATS: 711).
Español (Spanish)	ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-553-7054 (TTY: 711).
繁體中文 (Chinese)	注意: 如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-553-7054 (TTY: 711)。
Tiếng Việt (Vietnamese)	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-553-7054 (TTY: 711).
नेपाली (Nepali)	ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-877-553-7054 (टिटिवाइ: 711) ।
العربية **(Arabic)**	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-877-553-7054 (رقم هاتف الصم والبكم: 711).
Oroomiffa (Oromo)	XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-877-553-7054 (TTY: 711).
Português (Portuguese)	ATENÇÃO: Se fala Português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-877-553-7054 (TTY: 711).
Русский (Russian)	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-553-7054 (телетайп: 711).
한국어 (Korean)	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-553-7054 (TTY: 711) 번으로 전화해 주십시오.
λληνικά (Greek)	ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-877-553-7054 (TTY: 711).
Srpsko-hrvatski (Serbo-Croatian)	OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-877-553-7054 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711).
ខ្មែរ (Cambodian)	ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-877-553-7054 (TTY: 711)។
Bahasa Indonesia (Indonesian)	PERHATIAN: Jika Anda berbicara dalam Bahasa Indonesia, layanan bantuan bahasa akan tersedia secara gratis. Hubungi 1-877-553-7054 (TTY: 711).
Polski (Polish)	UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-553-7054 (TTY: 711).

Martin's Point®

MEDICARE ADVANTAGE PLANS

GENERATIONS ADVANTAGE

For more information about benefits or enrollment, call us or visit our website at MartinsPoint.org/Medicare

1-888-408-8285 (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