



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

Summary of Benefits

January 1–December 31, 2021



MARTIN'S POINT[®]

MEDICARE ADVANTAGE PLANS

GENERATIONS ADVANTAGE

Summary of Benefits

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

January 1 – December 31, 2021

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

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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Table of Contents

Martin’s Point Generations Advantage Prime (HMO-POS)	3
Section 1: Introduction.....	3
Section 2: Summary of Benefits	4
Section 3: Dental Benefit Overview	13
Section 3: Dental Benefit Overview (Continued).....	14
Martins Point Generations Advantage Flex (RPPO).....	15
Section 1: Introduction.....	15
Section 2: Summary of Benefits	16
Section 3: Dental Benefit Overview	25
Martin's Point Generations Advantage Alliance (HMO)	27
Section 1: Introduction.....	27
Section 2: Summary of Benefits	28
Section 3: Dental Benefit Overview	34
Martin's Point Generations Advantage Select (LPPO).....	35
Section 1: Introduction.....	35
Section 2: Summary of Benefits	36
Martin's Point Generations Advantage Value Plus (HMO)	45
Section 1: Introduction.....	45
Section 2: Summary of Benefits	46

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, 2021 - December 31, 2021

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 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.

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.

Plan Name	Plan Service Area	Monthly Premium
Martin's Point Generations Advantage Prime	Cumberland and York counties in Maine Cheshire, Hillsborough, Merrimack, Rockingham, Strafford, and Sullivan counties in New Hampshire	\$0
	Androscoggin, Kennebec, and Sagadahoc counties in Maine;	\$29
	Aroostook, Franklin, Hancock, Knox, Lincoln, Oxford, Penobscot, Piscataquis, Somerset, Waldo, and Washington counties in Maine; Belknap, Carroll, Coos, and Grafton counties in New Hampshire	\$89

Benefit	Prime (HMO-POS) Plan
Deductible (our plan does not have a medical deductible)	You pay \$0 annually
Maximum Out-of-Pocket (does not include prescription drugs) Our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. Note: Your Maximum Out-of-Pocket is based on your service area.	For members living in Aroostook, Franklin, Hancock, Knox, Lincoln, Oxford, Penobscot, Piscataquis, Somerset, Waldo, and Washington counties in Maine; Belknap, Carroll, Coos, and Grafton counties in New Hampshire: \$6,850 Annually For members living in Androscoggin, Cumberland, Kennebec, Sagadahoc, and York counties in Maine; Cheshire, Hillsborough, Merrimack, Rockingham, Strafford, and Sullivan counties in New Hampshire: \$7,050 Annually

Benefit	Prime (HMO-POS) Plan
<p>Inpatient Hospital Our plan covers an unlimited number of days for an inpatient hospital stay.</p> <p>Note: Your copay is based on your service area.</p>	<p>In-Network for members living in Belknap, Carroll, Coos, and Grafton counties in New Hampshire or Androscoggin, Aroostook, Cumberland, Franklin, Hancock, Kennebec, Knox, Lincoln, Oxford, Penobscot, Piscataquis, Sagadahoc, Somerset, Waldo, Washington, and York counties in Maine:</p> <p>You pay per admission: \$375 per day for days 1-5; \$0 per day for days 6 and beyond</p> <p>In-Network for members living in Cheshire, Hillsborough, Merrimack, Rockingham, Strafford, and Sullivan counties in New Hampshire:</p> <p>You pay per admission: \$333 per day for days 1-5; \$0 per day for days 6 and beyond</p>
<p>Outpatient Hospital Services may require that your provider get prior authorization (approval in advance). Please have your provider contact the plan for more details.</p>	<p>In-Network: You pay \$350 for Medicare-covered surgery services at a hospital outpatient facility.</p>
<p>Ambulatory & Surgical Center (ASC)</p>	<p>In-Network: You pay \$175 for Medicare-covered surgery services at an ambulatory surgical center.</p>
<p>Doctor visits</p>	<p>In-Network:</p> <p>Primary Care You pay \$0 for each Primary Care Physician (PCP) office visit for Medicare-covered services.</p> <p>Specialists You pay \$40 for each specialist office visit for Medicare-covered services.</p>

Benefit	Prime (HMO-POS) Plan
<p>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.</p>	<p>In-Network: You pay \$0 for additional preventive services approved by Medicare</p>
<p>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.</p>	<p>In- and Out-of-Network: You pay \$90 for each Medicare-covered emergency room visit.</p>
<p>Urgently Needed Services Urgent care is covered nationwide.</p>	<p>In- and Out-of-Network: You pay \$40 for each Medicare-covered urgent care visit when performed at an urgent care center.</p>
<p>Diagnostic Services / Labs / Imaging Services may require that your provider get prior authorization (approval in advance). Please see the <i>Evidence of Coverage</i> for more information.</p>	<p>In-Network: Diagnostic Radiology Service (e.g., MRI) You pay 20% of the Medicare-allowed cost of complex diagnostic radiology (PET, CT, MRI, MRA, nuclear medicine) Lab Services 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 You pay 15% of the Medicare-allowed cost of simple diagnostic radiology. Outpatient X-rays You pay 15% of the Medicare-allowed cost for X-rays. COVID Testing You pay \$0 for COVID-19 viral testing. You pay \$5 for COVID-19 antibody testing.</p>

Benefit	Prime (HMO-POS) Plan
<p>Hearing Services</p>	<p>In-Network: Hearing Exam You pay \$40 per visit for Medicare-covered hearing services.</p> <p>Hearing Aid Fittings and Evaluations 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 You pay \$495, \$695, or \$1095 copay per ear, per year, depending on Tier selected. <i>Services must be received from an Amplifon provider.</i></p>
<p>Dental Services (Medicare-covered) Services may require that your provider get prior authorization (approval in advance). Please see the <i>Evidence of Coverage</i> for more information.</p>	<p>In-Network: You pay \$50 per visit for Medicare-covered dental services (non-routine dental care required to treat illness or injury).</p>
<p>Preventive and Comprehensive Dental Members must use Martin’s Point Generations Advantage-Northeast Delta Dental PPO or Premier network 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 13 for more information.</i></p>

Benefit**Prime (HMO-POS) Plan****Vision Services****In-Network:****Annual Routine Eye Exam**

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

Medicare-Covered Physician Services

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

Glaucoma Testing

You pay \$0 for glaucoma testing.

Diabetic Retinopathy

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

Eyeglass Frames, Lenses, and Contacts:

Eyewear may be reimbursed using the Wellness Wallet benefit.

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.

In-Network:**Inpatient Visit**

You pay per admission:

\$220 per day for days 1-7;

\$0 per day for days 8 and beyond

Outpatient Individual Therapy Visit

You pay \$25 per visit for individual therapy.

Outpatient Group Therapy Visit

You pay \$25 per visit for group therapy.

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

Benefit	Prime (HMO-POS) Plan
<p>Physical Therapy Services may require that your provider get prior authorization (approval in advance). Please see the <i>Evidence of Coverage</i> for more information.</p>	<p>In-Network: You pay \$40 for each Medicare-covered visit.</p>
<p>Ambulance Non-emergency ambulance transportation services may require that your provider get prior authorization (approval in advance). Please see the <i>Evidence of Coverage</i> for more information.</p> <p>Ambulance services are covered worldwide.</p>	<p>In- and Out-of-Network: You pay \$295 for each Medicare-covered emergency ambulance service (one-way).</p>
<p>Transportation</p>	<p>Not a covered benefit.</p>
<p>Medicare Part B drugs Services may require that your provider get prior authorization (approval in advance). Please see the <i>Evidence of Coverage</i> for more information.</p>	<p>In-Network: You pay 20% of the Medicare-allowed cost of Medicare-covered services.</p>

Outpatient Prescription Drugs Prime (HMO-POS) 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 <i>Evidence of Coverage</i>
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/PartD.

Part D Senior Savings Program	Mail Order and Retail
Members are eligible for reduced cost sharing on select insulins.	\$35 for 30-day supply \$70 for 60-day supply \$105 for 90-day supply

Additional Benefits	Prime (HMO-POS) Plan
<p>Wellness Wallet (Fitness, Naturopathic Services, Acupuncture, Nutrition/Dietary Education, Weight Management Programs, Eyewear, Face Masks)</p> <p>Please see the <i>Evidence of Coverage</i> for more information.</p>	<p>The plan will reimburse up to \$400 each year in total for Fitness Benefit, Naturopathic Services, Acupuncture, Nutrition/Dietary Education, Weight Management Programs, Eyewear, and Face Masks.</p>
<p>Over-The-Counter items (OTC)</p> <p>More than 300 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 <i>Evidence of Coverage</i> 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>

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 **MartinsPoint.org/PartD**.

If you want to know more about the coverage and costs of Original Medicare, look in your Medicare & You 2021 Handbook. You can download a copy of from the Medicare website (**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.

Benefit	Prime (HMO-POS) Plan
<p>Point-of-Service</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 <i>Evidence of Coverage</i> for more information.</p>	<p>Services available in the POS benefit:</p> <p>Doctor Visits (Primary Care and Specialist)</p> <ul style="list-style-type: none"> ➤Chiropractic visits \$55 ➤Physician Specialist visits \$55 ➤Podiatry visits \$55 ➤Primary Care visits \$35 (allowed only outside the plan’s service area)
	<p>Outpatient Services</p> <ul style="list-style-type: none"> ➤Diabetes self-management 20% of the Medicare- allowed cost for supplies and shoes; \$0 for training ➤Durable medical equipment 30% of the Medicare- allowed cost ➤Medicare Part B prescription drugs, including chemotherapy 20% of the Medicare- allowed cost ➤Outpatient diagnostic tests/procedures, X-rays, and lab services 0-20% of the Medicare- allowed cost; all other labs: \$5 ➤Outpatient mental health and substance abuse visits \$30 individual/group ➤Outpatient rehabilitation services (Physical, Occupational, and Speech therapy) \$55 ➤Outpatient surgery in a hospital or ambulatory surgical center \$400/\$200 ➤Radiation therapy 30% of the Medicare- allowed cost
	<p>Dental Services</p> <p>Medicare-covered only dental services \$55</p>
	<p>Hearing Services</p> <p>Medicare-covered hearing services \$55</p>
	<p>Vision Services</p> <ul style="list-style-type: none"> ➤Medicare-covered vision services \$55 ➤Annual routine eye exam 30% of the Medicare- allowed cost

Section 3: Dental Benefit Overview

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

Prime Dental Benefit	
Benefit Maximum	\$1,000
Office Visit Copay	\$50
Category A: Diagnostic/Preventative	
Oral exam and routine cleaning once 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	
Category B: Basic Restorative	
Fillings	You pay 50% of the cost + \$50 office visit copay
Surgical and routine extractions	
Root canals	
Treatment of gum disease (periodontics, including periodontal maintenance cleanings)	\$50 annual deductible applies
Category C: Major Restorative	
Dentures	You pay 50% of the cost + \$50 office visit copay
Crowns	
Implants	
	\$50 annual deductible applies

Martin’s Point Generations Advantage-Northeast Delta Dental PPO or Premier network

Plan benefits are available only when you receive your dental care from a Martin’s Point Generations Advantage-Northeast Delta Dental PPO or Premier 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 Martin’s Point Generations Advantage-Northeast Delta Dental PPO or Premier network please visit our website at MartinsPoint.org/MedicareMembers, visit www.nedelta.com/Dentist-Search, or call **Delta Dental’s Customer Service Department at 1-800-832-5700 (TTY: 1-800-332-5905) Monday through Friday, 8 am–4:45 pm.**

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.

Non-participating Dentists

No benefits are available under your policy if you choose to visit a dentist who is not participating in the Martin’s Point Generations Advantage-Northeast Delta Dental PPO or Premier network. Non-participating dentists are welcome to join the Martin’s Point Generations Advantage-Northeast Delta Dental PPO or Premier network at any time.

Section 3: Dental Benefit Overview (Continued)...

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.

Martins Point Generations Advantage Flex (RPPO)

Section 1: Introduction

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

January 1, 2021 – December 31, 2021

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 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 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 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 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 Flex (RPPO) plan.

The table below shows the monthly plan premium for all counties in Maine and New Hampshire. In addition, you must keep paying your Medicare Part B premium.

Plan Name	Plan Service Area	Monthly Premium
Martin's Point Generations Advantage Flex	All counties in Maine and New Hampshire	\$53

Benefit	Flex (RPPO) Plan
Deductible	You pay \$0 annually
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.	In-Network: \$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: \$395 per day for days 1-5; \$0 per day for days 6 and beyond Out-of-Network: You pay per admission: 30% of the Medicare-allowed cost for a Medicare-covered hospital stay.
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 Medicare-allowed cost of Medicare-covered surgery services at a hospital outpatient facility.

Benefit	Flex (RPPO) Plan
Ambulatory & Surgical Centers (ASC)	<p>In-Network: You pay \$250 for Medicare-covered surgery services at an ambulatory surgical center.</p> <p>Out-of-Network: You pay 30% of the Medicare-allowed cost of Medicare-covered surgery services at an ambulatory surgical center.</p>
Doctor Visits	<p>Primary Care</p> <p>In-Network: You pay \$0 for each Primary Care Physician (PCP) office visit for Medicare-covered services.</p> <p>Out-of-Network: You pay 30% of the Medicare-allowed cost for each Primary Care Physician (PCP) office visit for Medicare-covered services.</p> <p>Specialists</p> <p>In-Network: You pay \$50 for each specialist office visit for Medicare-covered services.</p> <p>Out-of-Network: You pay 30% of the Medicare-allowed cost for each specialist office visit for Medicare-covered services.</p>
<p>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.</p>	<p>In-Network: You pay \$0 for additional preventive services approved by Medicare</p> <p>Out-of-Network: You pay 30% of the Medicare-allowed cost for Medicare-covered services.</p>
<p>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.</p>	<p>In- and Out-of-Network: You pay \$90 for each Medicare-covered emergency room visit.</p>

Benefit	Flex (RPPO) Plan
<p>Urgently Needed Services Urgent care is covered nationwide.</p>	<p>In- and Out-of-Network: You pay \$45 for each Medicare-covered urgent care visit when performed at an urgent care center</p>
<p>Diagnostic Services / Labs / Imaging Services may require that your provider get prior authorization (approval in advance). Please see the <i>Evidence of Coverage</i> for more information.</p>	<p>Diagnostic Radiology Service (e.g., MRI) In-Network: You pay 20% of the Medicare-allowed cost of complex diagnostic radiology (such as PET, CT, MRI, MRA, nuclear medicine) Out-of-Network: You pay 30% of the Medicare-allowed cost of complex diagnostic radiology (PET, CT, MRI, MRA, nuclear medicine).</p> <p>Lab Services In-Network: You pay 20% of the Medicare-allowed cost 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 lab services.</p> <p>Diagnostic Tests and Procedures In-Network: You pay 20% of the Medicare-allowed cost of simple diagnostic radiology. Out-of-Network: You pay 30% of the Medicare-allowed cost of simple diagnostic radiology.</p> <p>Outpatient X-rays In-Network: You pay \$12 for X-rays. Out-of-Network: You pay you pay 30% of the Medicare-allowed cost for x-rays.</p>

Benefit	Flex (RPPO) Plan
<p>Diagnostic Services / Labs / Imaging (continued)...</p>	<p>COVID Testing In- and Out-of-Network You pay \$0 for COVID-19 viral testing. You pay \$5 for COVID-19 antibody testing.</p>
<p>Hearing Services</p>	<p>Hearing Exam In-Network: You pay \$45 per visit for Medicare-covered hearing services.</p> <p>Out-of-Network: You pay 30% of the Medicare-allowed cost.</p> <p>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. <i>Services must be received from an Amplifon provider.</i></p> <p>Hearing Aids In- and Out-of-Network: You pay \$495, \$695, or \$1095 copay per ear, per year, depending on Tier selected. <i>Services must be received from an Amplifon provider.</i></p>
<p>Dental Services (Medicare-covered) Services may require that your provider get prior authorization (approval in advance). Please see the <i>Evidence of Coverage</i> for more information.</p>	<p>In-Network: You pay \$50 per visit for Medicare-covered dental services (non-routine dental care required to treat illness or injury).</p> <p>Out-of-Network: You pay 30% of the Medicare-allowed cost</p>
<p>Preventive and Comprehensive Dental Members must use Martin’s Point Generations Advantage-Northeast Delta Dental PPO or Premier network dentist in Maine, New Hampshire, or Vermont to obtain these supplemental dental benefits at an in-network cost share. Members may also see an out-of-network dentist; out-of network cost shares apply. .</p>	<p>Preventive and Comprehensive Dental services are covered. <i>Please see Dental Overview Error! Bookmark not defined. for more information.</i></p>

Benefit**Flex (RPPO) 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 \$45 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-Network:**

You pay \$0 for glaucoma testing.

Out-of-Network:

You pay 30% of the Medicare-allowed cost 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:

Eyewear may be reimbursed using the Wellness Wallet benefit.

See Wellness Wallet page 12 below for more information.

Benefit	Flex (RPPO) Plan
<p>Mental Health Services Services may require that your provider get prior authorization (approval in advance). Please see the <i>Evidence of Coverage</i> for more information.</p>	<p>Inpatient Visit In-Network: You pay per admission: \$230 per day for days 1-7; \$0 per day for days 8 and beyond</p> <p>Out-of-Network: Days 1-90: You pay per admission: 30% of the Medicare-allowed cost per day for a Medicare-covered hospital stay.</p> <p>Outpatient Individual Therapy Visit In-Network: You pay \$25 per visit for individual therapy.</p> <p>Out-of-Network: You pay 30% of the Medicare-allowed cost of a visit for individual therapy.</p> <p>Outpatient Group Therapy Visit In-Network: You pay \$25 per visit for group therapy.</p> <p>Out-of-Network: You pay 30% of the Medicare-allowed cost of a visit for group therapy.</p>
<p>Skilled Nursing Facility Services may require that your provider get prior authorization (approval in advance). Please see the <i>Evidence of Coverage</i> for more information.</p>	<p>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</p> <p>Out-of-Network: You pay 30% of the Medicare-allowed cost for days 1-100.</p>

Benefit	Flex (RPPO) Plan
<p>Physical Therapy Services may require that your provider get prior authorization (approval in advance). Please see the <i>Evidence of Coverage</i> for more information.</p>	<p>In-Network: You pay \$40 for each Medicare-covered visit.</p> <p>Out-of-Network: You pay 30% of the Medicare-allowed cost.</p>
<p>Ambulance Non-emergency ambulance transportation may require that your provider get prior authorization (approval in advance). Please see the <i>Evidence of Coverage</i> for more information.</p> <p>Ambulance services are covered worldwide.</p>	<p>In- and Out-of-Network: You pay \$295 for each Medicare-covered emergency ambulance service (one-way).</p>
<p>Transportation</p>	<p>Not a covered benefit.</p>
<p>Medicare Part B drugs Services may require that your provider get prior authorization (approval in advance). Please see the <i>Evidence of Coverage</i> for more information.</p>	<p>You pay 20% of the Medicare-allowed cost Medicare-covered services.</p>

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 <i>Evidence of Coverage</i> .
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/PartD.

Part D Senior Savings Program	Mail Order	Retail
Members are eligible for reduced cost sharing on select insulins.	\$35 for 30-day supply \$70 for 60-day supply \$100 for 90-day supply	\$35 for 30-day supply \$70 for 60-day supply \$105 for 90-day supply

Additional Benefits

	Flex (RPPO) Plan
<p>Wellness Wallet (Fitness, Naturopathic Services, Acupuncture, Nutrition/Dietary Education, Weight Management Programs, Eyewear, Face Masks)</p> <p>Please see the <i>Evidence of Coverage</i> for more information.</p>	<p>The plan will reimburse up to \$200 each year in total for Fitness Benefit, Naturopathic Services, Acupuncture, Nutrition/Dietary Education, Weight Management Programs, Eyewear, and Face Masks.</p>
<p>Over-The-Counter items (OTC) More than 300 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 <i>Evidence of Coverage</i> 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>

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 **MartinsPoint.org/PartD**.

If you want to know more about the coverage and costs of Original Medicare, look in your Medicare & You 2021 Handbook. You can download a copy of from the Medicare website (**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 Flex (RPPO)** plan includes the following benefits when seeing a Martin’s Point Generations Advantage-Northeast Delta Dental PPO or Premier network dentist. This benefit overview is provided for summary purposes only.

Flex Dental Benefit	
Benefit Maximum	\$1,000
Office Visit Copay	\$50
Category A: Diagnostic/Preventative	
Oral exam and routine cleaning once 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	
Category B: Basic Restorative	
Fillings	You pay 50% of the cost + \$50 office visit copay
Surgical and routine extractions	
Root canals	
Treatment of gum disease (periodontics, including periodontal maintenance cleanings)	\$50 annual deductible applies
Category C: Major Restorative	
Dentures	You pay 50% of the cost + \$50 office visit copay \$50 annual 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 annual deductible applies
Category C: Major Restorative	75% coinsurance + \$50 office visit copay \$50 annual deductible applies

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.

Non-participating Dentists

Out-of-network plan benefits are available when seeing a non-participating dentist. Non-participating dentists are welcome to join the Martin's Point Generations Advantage-Northeast Delta Dental PPO or Premier 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 Flex plan member ID number.

Martin's Point Generations Advantage-Northeast Delta Dental PPO or Premier 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 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 Martin's Point Generations Advantage-Northeast Delta Dental PPO or Premier network, please visit our website at

MartinsPoint.org/MedicareMembers, visit www.nedelta.com/Dentist-Search, or call **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 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, 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 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.

The table below shows the monthly plan premium amount for all counties in Maine and New Hampshire. In addition, you must keep paying your Medicare Part B premium.

Plan Name	Plan Service Area	Monthly Premium	Part B Premium Buy-Down
Alliance (HMO) Plan	All counties in Maine and New Hampshire	\$0	\$60

Benefit	Alliance (HMO) Plan
Deductible Our plan does not have a deductible.	You pay \$0 annually.
Maximum out-of-pocket <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.
Inpatient Hospital Our plan covers an unlimited number of days for an inpatient hospital stay.	You pay per admission: \$300 per day for days 1-5; \$0 per day for days 6 and beyond.
Outpatient Hospital * Services may require that your provider get prior authorization (approval in advance). Please have your provider contact the plan for more details.	You pay \$350 for Medicare-covered surgery services at a hospital outpatient facility.
Ambulatory & Surgical Centers	You pay \$10 for Medicare-covered surgery services at an ambulatory surgical center.
Doctor Visits	Primary Care You pay \$0 for each Primary Care Physician (PCP) office visit for Medicare-covered services. Specialists You pay \$5 for each specialist office visit for Medicare-covered services.

Benefit	Alliance (HMO) Plan
<p>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.</p>	<p>You pay \$0 for additional preventive services approved by Medicare.</p>
<p>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</p>	<p>In- and Out-of-network: You pay \$90 for each Medicare-covered emergency room visit.</p>
<p>Urgently Needed Services Urgent care is covered nationwide.</p>	<p>In- and Out-of-network: You pay \$0 for each Medicare-covered urgent care visit when performed at an urgent care center.</p>
<p>Diagnostic Services / Labs / Imaging Services may require that your provider get prior authorization (approval in advance). Please see the <i>Evidence of Coverage</i> booklet for more information.</p>	<p>In-Network</p> <p>Diagnostic Radiology Service (e.g., MRI) You pay 20% of the Medicare-allowed cost of complex diagnostic radiology (PET, CT, MRI, MRA, nuclear medicine)</p> <p>Lab services You pay \$0/\$5 copay for lab services.</p> <p>Diagnostic tests and procedures You pay 5% of the Medicare-allowed cost of simple diagnostic radiology.</p> <p>Outpatient x-rays You pay 5% of the Medicare-allowed cost for x-rays.</p> <p>COVID Testing You pay \$0 for COVID-19 viral testing. You pay \$5 for COVID-19 antibody testing.</p>

Benefit	Alliance (HMO) Plan
<p>Hearing Services</p>	<p>Hearing Exam You pay \$5 per visit for Medicare-covered hearing services.</p> <p>Hearing Aid Fittings and Evaluations 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 You pay \$295, \$495 or \$895 copay per ear, per year, depending on Tier selected. <i>Services must be received from an Amplifon provider.</i></p>
<p>Dental Services (Medicare-Covered) Services may require that your provider get prior authorization (approval in advance). Please see the <i>Evidence of Coverage</i> for more information.</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 Members must use Martin’s Point Generations Advantage-Northeast Delta Dental PPO or Premier network 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 34 for more information.</i></p>
<p>Vision Services</p>	<p>Annual Routine Eye Exam: You pay \$0 for an annual routine eye exam.</p> <p>Medicare-Covered Physician Services: You pay \$5 for non-routine Medicare-covered physician services.</p> <p>Glaucoma Testing: You pay \$0 for glaucoma testing.</p> <p>Diabetic Retinopathy: You pay \$0 for a diabetic eye exam (retinopathy).</p> <p>Eyeglass Frames, Lenses, and Contacts: The plan will reimburse up to \$400 for prescription frames, lenses, and contacts.</p>

Benefit	Alliance (HMO) Plan
<p>Mental Health Services Services may require that your provider get prior authorization (approval in advance). Please see the <i>Evidence of Coverage</i> for more information.</p>	<p>Inpatient Visit: You pay per admission: \$220 per day for days 1-7; \$0 per day for days 8 and beyond</p> <p>Outpatient Individual Therapy Visit You pay \$0 per visit for individual therapy.</p> <p>Outpatient Group Therapy Visit You pay \$0 per visit for group therapy.</p>
<p>Skilled Nursing Facility Services may require that your provider get prior authorization (approval in advance). Please see the <i>Evidence of Coverage</i> for more information.</p>	<p>For each benefit period you pay for Medicare-covered services: \$0 per day for days 1-20; \$178 per day for days 21-100</p>
<p>Physical Therapy Services may require that your provider get prior authorization (approval in advance). Please see the <i>Evidence of Coverage</i> for more information.</p>	<p>You pay \$0 for each Medicare-covered visit.</p>
<p>Ambulance Non-emergency ambulance transportation may require that your provider get prior authorization (approval in advance). Please see the <i>Evidence of Coverage</i> for more information. Ambulance services covered worldwide.</p>	<p>In- and Out-of-network: You pay \$295 for each Medicare-covered emergency ambulance service (one-way).</p>
<p>Transportation</p>	<p>Not a covered benefit.</p>
<p>Medicare Part B Drugs Services may require that your provider get prior authorization (approval in advance). Please see the <i>Evidence of Coverage</i> for more information.</p>	<p>You pay 20% of the Medicare-allowed cost of Medicare-covered services.</p>
<p>Health Education Coverage is for eligible health coaching, support groups, and cooking classes.</p>	<p>You pay \$0 for eligible health coaching support groups, and cooking classes.</p>

Additional Benefits Alliance (HMO) Plan

<p>Outpatient Substance Use</p>	<p>You pay \$0 per visit for individual therapy; \$0 per visit for group therapy.</p>
<p>Smoking and Tobacco Cessation Counseling</p>	<p>You pay \$0 for 2 additional sessions beyond Medicare-covered benefit.</p>
<p>Over-The-Counter (OTC) More than 300 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 <i>Evidence of Coverage</i> for more information.</p>	<p>The plan will cover up to \$180 per quarter for members to purchase select CVS brand over-the-counter (OTC) products.</p>
<p>Eyewear (Contacts, Frames, Lenses)</p>	<p>The plan will cover \$400 each year for lenses, frames, and contact lenses not covered by Original Medicare</p>
<p>Wellness Wallet (Fitness, Naturopathic Services, and Acupuncture, Nutrition/Dietary Education, and Weight Management Programs and Face Masks) Please see the <i>Evidence of Coverage</i> for more information.</p>	<p>The plan will reimburse up to \$350 each year in total for Fitness Benefit, Naturopathic Services, and Acupuncture, Nutrition/Dietary Education, Weight Management Programs, and Face Masks.</p>
<p>Personal Emergency Response System (Device and Monitoring)</p>	<p>You pay \$0.</p>
<p>Bathroom Safety Devices (Assessment, Devices, and Installation)</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>Health Education Coverage is for eligible health coaching, support groups, and cooking classes.</p>	<p>You pay \$0 for eligible health coaching support groups, and cooking classes.</p>

Additional Benefits Alliance (HMO) Plan

Meals Up to 1 week (14 meals) per inpatient stay or surgery (4 weeks maximum per year). Up to 1 week (14 meals) per year as part of supervised program to transition into lifestyle modifications.	You pay \$0
Fall Prevention Program	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. 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).
Routine Chiropractic Services	You pay \$20 for each visit for routine chiropractic services.
Occupational Therapy	You pay \$0 for each Medicare-covered visit.

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 MartinsPoint.org/MedicareMembers.

If you want to know more about the coverage and costs of Original Medicare, look in your *Medicare & You 2020* Handbook. You can download a copy of from the Medicare website (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

Plan benefits are available only when you receive your dental the following benefits when seeing a Martin’s Point Generations Advantage-Northeast Delta Dental PPO or Premier network dentist. This benefit overview is provided for summary purposes only.

Alliance Dental Benefit	
Benefit Maximum	\$2,000
Office Visit Copay	\$5
Category A: Diagnostic/Preventative	
Oral exam and routine cleaning once 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	
Category B: Basic Restorative	
Fillings	You pay 20% of the cost + \$5 office visit copay (no deductible)
Surgical and routine extractions	
Root canals	
Treatment of gum disease (periodontics, including periodontal maintenance cleanings)	
Category C: Major Restorative	
Dentures	You pay 50% of the cost + \$5 office visit copay (no deductible)
Crowns	
Implants	

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.

Martin’s Point Generations Advantage-Northeast Delta Dental PPO or Premier network:

Plan benefits are available only when you receive your dental care from a Martin’s Point Generations Advantage-Northeast Delta Dental PPO or Premier network 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 Martin’s Point Generations Advantage-Northeast Delta Dental PPO or Premier network, please visit our website at MartinsPoint.org/MedicareMembers, visit www.nedelta.com/Dentist-Search, or call **Delta Dental’s Customer Service Department at 1-800-832-5700 (TTY: 1-800-332-5905) Monday through Friday, 8 am–4:45 pm.**

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.

Non-participating Dentists

No benefits are available under your policy if you choose to visit a dentist who is not participating in the Martin’s Point Generations Advantage-Northeast Delta Dental PPO or Premier network. Non-participating dentists are welcome to join the Martin’s Point Generations Advantage-Northeast Delta Dental PPO or Premier 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, 2021 - December 31, 2021

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 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 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.

Section 2: Summary of Benefits

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

The table below shows the monthly plan premium amount for all counties in Maine and New Hampshire. 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

Benefit	Select (LPPO) Plan
Deductible	You pay \$0 annually
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: \$7,300 From network and out-of-network providers combined: \$10,000
Inpatient Hospital Our plan covers an unlimited number of days for an inpatient hospital stay.	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 Medicare-allowed cost for a Medicare-covered hospital stay.
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 Medicare-allowed cost of Medicare-covered surgery services at a hospital outpatient facility.

Benefit	Select (LPPO) Plan
<p>Ambulatory & Surgical Centers (ASC)</p>	<p>In-Network: You pay \$200 for Medicare-covered surgery services at an ambulatory surgical center.</p> <p>Out-of-Network: You pay 30% of the Medicare-allowed cost of Medicare-covered surgery services at an ambulatory surgical center.</p>
<p>Doctor Visits</p>	<p>Primary Care</p> <p>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.</p> <p>Out-of-Network: You pay 30% of the Medicare-allowed cost for each Primary Care Physician (PCP) office visit for Medicare-covered services.</p> <p>Specialists</p> <p>In-Network: You pay \$40 for each specialist office visit for Medicare-covered services.</p> <p>Out-of-Network: You pay 30% of the Medicare-allowed cost for each specialist office visit for Medicare-covered services.</p>
<p>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.</p>	<p>In-Network: You pay \$0 for additional preventive services approved by Medicare</p> <p>Out-of-Network: You pay 30% of the Medicare-allowed cost for Medicare-covered services.</p>
<p>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.</p>	<p>In- and Out-of-Network: You pay \$90 for each Medicare-covered emergency room visit.</p>

Benefit	Select (LPPO) Plan
<p>Urgently Needed Services Urgent care is covered nationwide.</p>	<p>In- and Out-of-Network: You pay \$40 for each Medicare-covered urgent care visit when performed at an urgent care center.</p>
<p>Diagnostic Services / Labs / Imaging Services may require that your provider get prior authorization (approval in advance). Please see the <i>Evidence of Coverage</i> for more information.</p>	<p>Diagnostic Radiology Service (e.g., MRI) In-Network: You pay 20% of the Medicare-allowed cost of complex diagnostic radiology (such as PET, CT, MRI, MRA, nuclear medicine) Out-of-Network: You pay 30% of the Medicare-allowed cost of complex diagnostic radiology (PET, CT, MRI, MRA, nuclear medicine).</p> <p>Lab Services In-Network: You pay 20% of the Medicare-allowed cost 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.</p> <p>Diagnostic Tests and Procedures In-Network: You pay 15% of the Medicare-allowed cost of simple diagnostic radiology. Out-of-Network: You pay 30% of the Medicare-allowed cost of simple diagnostic radiology.</p> <p>Outpatient X-rays In-Network: You pay 15% of the Medicare-allowed cost for X-rays. Out-of-Network: You pay you pay 15% of the Medicare-allowed cost for x-rays.</p>

Benefit	Select (LPPO) Plan
<p>Diagnostic Services / Labs / Imaging (continued)... Services may require that your provider get prior authorization (approval in advance). Please see the <i>Evidence of Coverage</i> for more information.</p>	<p>COVID Testing In- and Out-of-Network You pay \$0 for COVID-19 viral testing. You pay \$5 for COVID-19 antibody testing.</p>
<p>Hearing Services</p>	<p>Hearing Exam In-Network: You pay \$40 per visit for Medicare-covered hearing services. Out-of-Network: You pay 30% of the Medicare-allowed cost.</p> <p>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. <i>Services must be received from an Amplifon provider.</i></p> <p>Hearing Aids In- and Out-of-Network: You pay \$495, \$695, or \$1095 copay per ear, per year, depending on Tier selected. <i>Services must be received from an Amplifon provider.</i></p>
<p>Dental Services (Medicare-covered) Services may require that your provider get prior authorization (approval in advance). Please see the <i>Evidence of Coverage</i> for more information.</p>	<p>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 Medicare-allowed cost.</p>
<p>Preventive and Comprehensive Dental</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-Network:**

You pay \$0 for glaucoma testing.

Out-of-Network:

You pay 30% of the Medicare-allowed cost 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:

Eyewear may be reimbursed using the Wellness Wallet benefit.

See Wellness Wallet below for more information.

Benefit	Select (LPPO) Plan
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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 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.

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 Medicare-allowed cost for days 1-100.

Benefit	Select (LPPO) Plan
<p>Physical Therapy Services may require that your provider get prior authorization (approval in advance). Please see the <i>Evidence of Coverage</i> for more information.</p>	<p>In-Network: You pay \$40 for each Medicare-covered visit.</p> <p>Out-of-Network: You pay 30% of the Medicare-allowed cost.</p>
<p>Ambulance Non-emergency ambulance transportation may require that your provider get prior authorization (approval in advance). Please see the <i>Evidence of Coverage</i> for more information.</p> <p>Ambulance services are covered worldwide.</p>	<p>In- and Out-of-Network: You pay \$295 for each Medicare-covered emergency ambulance service (one-way).</p>
<p>Transportation</p>	<p>Not a covered benefit.</p>
<p>Medicare Part B drugs Services may require that your provider get prior authorization (approval in advance). Please see the <i>Evidence of Coverage</i> for more information.</p>	<p>You pay 20% of the Medicare-allowed cost for Medicare-covered services.</p>

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 <i>Evidence of Coverage</i> .
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/PartD.

Part D Senior Savings Program	Mail Order and Retail
Members are eligible for reduced cost sharing on select insulins.	\$35 for 30-day supply \$70 for 60-day supply \$105 for 90-day supply

Additional Benefits	
	Select (LPPO) Plan
<p>Wellness Wallet (Fitness, Naturopathic Services, Acupuncture, Nutrition/Dietary Education, Weight Management Programs, Eyewear, Face Masks)</p> <p>Please see the <i>Evidence of Coverage</i> for more information.</p>	<p>The plan will reimburse up to \$200 each year in total for Fitness Benefit, Naturopathic Services, Acupuncture, Nutrition/Dietary Education, Weight Management Programs, Eyewear, and Face Masks.</p>
<p>Over-The-Counter items (OTC)</p> <p>More than 300 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 <i>Evidence of Coverage</i> 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>

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 **MartinsPoint.org/PartD**.

If you want to know more about the coverage and costs of Original Medicare, look in your Medicare & You 2021 Handbook. You can download a copy of from the Medicare website (**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.

Martin's Point Generations Advantage Value Plus (HMO)

Section 1: Introduction

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

January 1, 2021 - December 31, 2021

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 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) plan:

Our service area includes Androscoggin, Aroostook, Franklin, Hancock, Kennebec, Knox, Lincoln, Oxford, Penobscot, Piscataquis, Sagadahoc, Somerset, Waldo, Washington, and York counties in Maine, as well as Hillsborough and Strafford counties in New Hampshire.

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).

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.

Plan Name	Plan Service Area	Monthly Premium	Part B Premium Buy-Down
Martin's Point Generations Advantage Value Plus	Androscoggin, Kennebec, Sagadahoc, and York counties in Maine; Hillsborough and Strafford counties in New Hampshire	\$0	\$10
	Aroostook, Franklin, Hancock, Knox, Lincoln, Oxford, Penobscot, Piscataquis, Somerset, Waldo, and Washington counties in Maine	\$29	N/A

Benefit	Value Plus (HMO) Plan
Deductible (our plan does not have a medical deductible)	You pay \$0 annually
Maximum Out-of-Pocket (does not include prescription drugs) Our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care.	\$7,550 annually
Inpatient Hospital Our plan covers an unlimited number of days for an inpatient hospital stay.	In-Network: You pay per admission: \$380 per day for days 1-5; \$0 per day for days 6 and beyond
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.
Ambulatory & Surgical Center (ASC)	In-Network: You pay \$200 for Medicare-covered surgery services at an ambulatory surgical center.

Benefit	Value Plus (HMO) Plan
<p>Doctor visits</p>	<p>In-Network: Primary Care 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>Specialists You pay \$50 for each specialist office visit for Medicare-covered services.</p>
<p>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.</p>	<p>In-Network: You pay \$0 for additional preventive services approved by Medicare</p>
<p>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.</p>	<p>In- and Out-of-Network: You pay \$90 for each Medicare-covered emergency room visit.</p>
<p>Urgently Needed Services Urgent care is covered nationwide.</p>	<p>In- and Out-of-Network: You pay \$40 for each Medicare-covered urgent care visit when performed at an urgent care center.</p>

Benefit**Value Plus (HMO) Plan****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.

In-Network:**Diagnostic Radiology Service** (e.g., MRI)

You pay 20% of the Medicare-allowed cost of complex diagnostic radiology (PET, CT, MRI, MRA, nuclear medicine)

Lab Services

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

Diagnostic Tests and Procedures

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

Outpatient X-rays

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

COVID Testing

You pay \$0 for COVID-19 viral testing.
You pay \$5 for COVID-19 antibody testing.

Hearing Services**In-Network:****Hearing Exam**

You pay \$50 per visit for Medicare-covered hearing services.

Hearing Aid Fittings and Evaluations

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 Aids

You pay \$495, \$695, or \$1095 copay per ear, per year, depending on Tier selected.

Services must be received from an Amplifon provider.

Benefit	Value Plus (HMO) Plan
<p>Dental Services (Medicare-covered) Services may require that your provider get prior authorization (approval in advance). Please see the <i>Evidence of Coverage</i> for more information.</p> <p>Preventive and Comprehensive Dental</p>	<p>In-Network: You pay \$50 per visit for Medicare-covered dental services (non-routine dental care required to treat illness or injury). Not a covered benefit</p>
<p>Vision Services</p>	<p>In-Network: Annual Routine Eye Exam You pay \$0 for an annual routine eye exam.</p> <p>Medicare-Covered Physician Services You pay \$50 for non-routine Medicare-covered physician services.</p> <p>Glaucoma Testing You pay \$0 for glaucoma testing.</p> <p>Diabetic Retinopathy You pay \$0 for a diabetic eye exam (retinopathy).</p> <p>Eyeglass Frames, Lenses, and Contacts: Eyewear may be reimbursed using the Wellness Wallet benefit. <i>See Wellness Wallet section below for more information.</i></p>
<p>Mental Health Services Services may require that your provider get prior authorization (approval in advance). Please see the <i>Evidence of Coverage</i> for more information.</p>	<p>In-Network: Inpatient Visit You pay per admission: \$220 per day for days 1-7; \$0 per day for days 8 and beyond</p> <p>Outpatient Individual Therapy Visit You pay \$25 per visit for individual therapy.</p> <p>Outpatient Group Therapy Visit You pay \$25 per visit for group therapy.</p>

Benefit	Value Plus (HMO) Plan
<p>Skilled Nursing Facility Services may require that your provider get prior authorization (approval in advance). Please see the <i>Evidence of Coverage</i> for more information.</p>	<p>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</p>
<p>Physical Therapy Services may require that your provider get prior authorization (approval in advance). Please see the <i>Evidence of Coverage</i> for more information.</p>	<p>In-Network: You pay \$40 for each Medicare-covered visit.</p>
<p>Ambulance Non-emergency ambulance transportation services may require that your provider get prior authorization (approval in advance). Please see the <i>Evidence of Coverage</i> for more information.</p> <p>Ambulance services are covered worldwide.</p>	<p>In- and Out-of-Network: You pay \$295 for each Medicare-covered emergency ambulance service (one-way).</p>
<p>Transportation</p>	<p>Not a covered benefit.</p>
<p>Medicare Part B drugs Services may require that your provider get prior authorization (approval in advance). Please see the <i>Evidence of Coverage</i> for more information.</p>	<p>In-Network: You pay 20% of the Medicare-allowed cost of Medicare-covered services.</p>

Outpatient Prescription Drugs (Generations Advantage Value Plus (HMO) 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	\$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 <i>Evidence of Coverage</i>
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)	28%	28%	28%	

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Part D Senior Savings Program	Mail Order and Retail
Members are eligible for reduced cost sharing on select insulins.	\$35 for 30-day supply \$70 for 60-day supply \$105 for 90-day supply

Additional Benefits	Value Plus (HMO) Plan
<p>Wellness Wallet (Fitness, Naturopathic Services, Acupuncture, Nutrition/Dietary Education, Weight Management Programs, Eyewear and Face Masks)</p> <p>Please see the <i>Evidence of Coverage</i> for more information.</p>	<p>The plan will reimburse up to \$300 each year in total for Fitness Benefit, Naturopathic Services, Acupuncture, Nutrition/Dietary Education, Weight Management Programs, Eyewear and Face Masks.</p>
<p>Over-The-Counter items (OTC) More than 300 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 <i>Evidence of Coverage</i> 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>

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.

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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