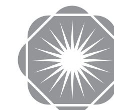
Prime (HMO-POS), Flex (RPPO), Select (LPPO)
Value Plus (HMO), and Alliance (HMO)

Summary of Benefits

January 1–December 31, 2022



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, 2022

For more information about benefits or enrollment, call us or visit our website at **www.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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Martin's Point Generations Advantage Prime (HMO-POS)

This is a cover page

Section 1: Introduction

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

January 1, 2022 - December 31, 2022

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.

Monthly Plan Premium	Plan Service Area	Monthly Premium
Martin's Point Generations Advantage Prime	Androscoggin, Cumberland, and York counties in Maine Cheshire, Hillsborough, Merrimack, Rockingham, Strafford, and Sullivan counties in New Hampshire	$0
	Aroostook, Franklin, Hancock, Knox, Kennebec, Penobscot, Washington, and Sagadahoc counties in Maine;	$29
	Lincoln, Oxford, Piscataquis, Somerset, and Waldo 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 Androscoggin, Aroostook, Cumberland, Franklin, Hancock, Kennebec, Knox, Lincoln, Oxford, Penobscot, Piscataquis, Sagadahoc, Somerset, Waldo, Washington, and York counties in Maine; Belknap, Carroll, Coos, and Grafton counties in New Hampshire: $6,500 Annually For members living in Cheshire, Hillsborough, Merrimack, Rockingham, Strafford, and Sullivan counties in New Hampshire: $7,050 Annually

Benefit	Prime (HMO-POS) Plan
Inpatient Hospital Our plan covers an unlimited number of days for an inpatient hospital stay. Note: Your copay is based on your service area.	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: **You pay per admission:** $375 per day for days 1-5; $0 per day for days 6 and beyond In Network for members living in Cheshire, Hillsborough, Merrimack, Rockingham, Strafford, and Sullivan counties in New Hampshire: **You pay per admission:** $345 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 $175 for Medicare-covered surgery services at an ambulatory surgical center.
Doctor visits	**In Network:** **Primary Care** You pay $0 for each Primary Care Physician (PCP) office visit for Medicare-covered services. **Specialists** You pay $40 for each specialist office visit for Medicare-covered services.

Benefit	Prime (HMO-POS) 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 $0 for additional preventive services approved by Medicare
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. There is a $25,000 limit for worldwide emergency, urgent care, and ambulance transport, this limit does not apply to services in the U.S.	**In- and Out-of-Network:** You pay $90 for each Medicare-covered emergency room visit.
Urgently Needed Services Urgent care is covered nationwide. There is a $25,000 limit for worldwide emergency, urgent care, and ambulance transport, this limit does not apply to services in the U.S.	**In- and Out-of-Network:** You pay $40 for each Medicare-covered urgent care visit when performed at an urgent care center. **Out-of-Country:** You pay $90 for each Medicare-covered urgent care visit when performed at an urgent care center outside of the United States and its associated territories.
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 contracted rate for complex diagnostic radiology (PET, CT, MRI, MRA, nuclear medicine) **Lab Services** You pay 20% of the contracted rate for genetic labs. You pay $0/$5 copay for all other lab services. **Diagnostic Tests and Procedures** You pay 15% of the contracted rate for simple diagnostic radiology. **Outpatient X-rays** You pay 15% of the contracted rate for X-rays.

Benefit	Prime (HMO-POS) Plan
Hearing Services	**In Network:** **Hearing Exam** You pay $40 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, $1095, $1495, or $2095 copay per ear, per year depending on Tier selected. *Services must be received from an Amplifon provider.*
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.	**In Network:** You pay $50 per visit for Medicare-covered dental services (non-routine dental care required to treat illness or injury).
Preventive and Comprehensive Dental Members must use a Martin's Point Generations Delta Dental PPO or Premier dentist in Maine, New Hampshire, or Vermont to obtain these supplemental dental benefits.	Preventive and Comprehensive Dental services are covered. *Please see Dental Overview on page 14 for more information.*

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
Physical Therapy	**In Network:** You pay $40 for each Medicare-covered visit.
Ambulance Non-emergency ambulance transportation services may require that your provider get prior authorization (approval in advance). Please see the Evidence of Coverage for more information. Ambulance services are covered worldwide. There is a $25,000 limit for worldwide emergency, urgent care, and ambulance transport, this limit does not apply to services in the U.S.	**In- and Out-of-Network:** You pay $295 for each Medicare-covered emergency ambulance service (one-way).
Transportation	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.	**In Network:** You pay 20% of the contracted rate for Medicare-covered services.

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 Evidence of Coverage
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%	

Senior Savings Program	Standard Cost Sharing	Preferred Cost Sharing	Mail Order Cost Sharing
Members are eligible for reduced cost sharing on select insulins.	You pay $35 per 30-day supply. You pay $70 per 60-day supply. You pay $105 per 90-day supply.	You pay $25 per 30-day supply. You pay $50 per 60-day supply. You pay $75 per 90-day supply.	You pay $25 per 30-day supply. You pay $50 per 60-day supply. You pay $62.50 per 90-day supply.

Additional Benefits	Prime (HMO-POS) Plan
Wellness Wallet (Fitness, Naturopathic Services, Acupuncture, Nutrition/Dietary Education, Weight Management Programs, Eyewear, Face Masks) Please see the Evidence of Coverage for more information.	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.
Over-The-Counter items (OTC) More than 350 covered items including: non-prescription medicine (pain relief, cough, allergies), toothpaste, first aid items, and vitamins. Members can order online, over the phone, or visit a designated store location. 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.
Nutrition and Dietary: **Telenutrition:** Members have access to an online nutrition/dietary platform and unlimited visits with a registered dietitian via video connection, email, or telephone through third-party vendor FoodSmart™. Note: Food cost and delivery of meals/groceries are not covered under this benefit.	$0 cost for telenutrition services through FoodSmart™

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

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

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

If you want to know more about the coverage and costs of Original Medicare, look in your Medicare & You 2022 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
Point-of-Service The Prime plan has a Point-of-Service (POS) benefit where you can use an out-of-network provider for certain services. Under the POS, you will generally pay a higher cost share when using an out-of-network provider. Please refer to the Evidence of Coverage for more information.	Services available in the POS benefit: **Doctor Visits (Primary Care and Specialist)** ➤Chiropractic visits $55 ➤Physician Specialist visits $55 ➤Podiatry visits $55 ➤Primary Care visits $35 (allowed only outside the plan's service area)
	Outpatient Services ➤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 group and individual therapy: $30 ➤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
	Dental Services Medicare-covered only dental services $55
	Hearing Services Medicare-covered hearing services $55
	Vision Services ➤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 Delta Dental network dentist. This benefit overview is provided for summary purposes only.

Delta Dental Network

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

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

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

Dental Benefit	Prime
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	
Amalgam (silver) fillings	You pay 50% of the cost + $50 office visit copay $50 annual deductible applies
Resin restoration on anterior teeth and the buccal surface of bicuspids only	
Surgical and routine extractions	
Root canals	
Treatment of gum disease (periodontics, including periodontal maintenance cleanings*)	
Category C: Major Restorative	
Dentures	You pay 50% of the cost + $50 office visit copay $50 annual deductible applies
Crowns	
Implants	

***Note:** Cleanings are limited to once per calendar year; you may choose from either a routine cleaning (Coverage A) or a periodontal cleaning (Coverage B).

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

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

Identification Cards

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

Martins Point Generations Advantage Flex (RPPO)

This is a cover page

Section 1: Introduction

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

January 1, 2022 – December 31, 2022

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.

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

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.

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:** $7,000 From network and out-of-network providers combined: $9,500
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)	**In Network:** You pay $250 for Medicare-covered surgery services at an ambulatory surgical center. **Out of Network:** You pay 30% of the Medicare-allowed cost of Medicare-covered surgery services at an ambulatory surgical center.
Doctor Visits	**Primary Care** **In Network:** You pay $0 for each Primary Care Physician (PCP) office visit for Medicare-covered services. **Out of Network:** You pay 30% of the Medicare-allowed cost for each Primary Care Physician (PCP) office visit for Medicare-covered services. **Specialists** **In Network:** You pay $50 for each specialist office visit for Medicare-covered services. **Out of Network:** You pay 30% of the Medicare-allowed cost for each specialist office visit for Medicare-covered services.
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 $0 for additional preventive services approved by Medicare **Out of Network:** You pay 30% of the Medicare-allowed 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. There is a $25,000 limit for worldwide emergency, urgent care, and ambulance transport, this limit does not apply to services in the U.S.	**In- and Out-of-Network:** You pay $90 for each Medicare-covered emergency room visit.

Benefit	Flex (RPPO) Plan
Urgently Needed Services Urgent care is covered nationwide. There is a $25,000 limit for worldwide emergency, urgent care, and ambulance transport, this limit does not apply to services in the U.S.	**In- and Out-of-Network:** You pay $45 for each Medicare-covered urgent care visit when performed at an urgent care center **Out-of-Country:** You pay $90 for each Medicare-covered urgent care visit when performed at an urgent care center outside of the United States and its associated territories.
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 contracted rate for 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). **Lab Services** **In Network:** You pay 20% of the contracted rate for genetic labs You pay $0/$5 copay for all other lab services. **Out of Network:** You pay 20% of the Medicare-allowed cost for lab services. **Diagnostic Tests and Procedures** **In Network:** You pay 20% of the contracted rate for simple diagnostic radiology. **Out of Network:** You pay 30% of the Medicare-allowed cost of simple diagnostic radiology. **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.

Benefit	Flex (RPPO) Plan
Hearing Services	**Hearing Exam** **In Network:** You pay $45 per visit for Medicare-covered hearing services. **Out of Network:** You pay 30% of the Medicare-allowed 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 $495, $695, $1095, $1495, or $2095 copay per ear, depending on Tier selected. *Services must be received from an Amplifon provider.*
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.	**In Network:** You pay $50 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
Preventive and Comprehensive Dental Members must use Delta Dental PPO/Premier or Martin's Point Generations network dentist in Maine, New Hampshire, or Vermont to obtain these supplemental dental benefits.	Preventive and Comprehensive Dental services are covered. *Please see Dental Overview on page 27 for more information.*

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% for glaucoma testing. **Diabetic Retinopathy** **In Network:** You pay $0 for a diabetic eye exam (retinopathy). **Out of Network:** You pay 30% for a diabetic eye exam (retinopathy). **Eyeglass Frames, Lenses, and Contacts:** Eyewear may be reimbursed using the Wellness Wallet benefit. *See Wellness Wallet page 26 below for more information.*

Benefit	Flex (RPPO) Plan
Mental Health Services Services may require that your provider get prior authorization (approval in advance). Please see the Evidence of Coverage for more information.	**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 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.

Benefit	Flex (RPPO) Plan
Physical Therapy	**In Network:** You pay $40 for each Medicare-covered visit. **Out of Network:** You pay 30% of the Medicare-allowed 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. There is a $25,000 limit for worldwide emergency, urgent care, and ambulance transport, this limit does not apply to services in the U.S.	**In- and Out-of-Network:** You pay $295 for each Medicare-covered emergency ambulance service (one-way).
Transportation	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 contracted rate for Medicare-covered services.

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.
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%	

Senior Savings Program	Standard Cost Sharing	Preferred Cost Sharing	Mail Order Cost Sharing
Members are eligible for reduced cost sharing on select insulins.	You pay $35 per 30-day supply. You pay $70 per 60-day supply. You pay $105 per 90-day supply.	You pay $25 per 30-day supply. You pay $50 per 60-day supply. You pay $75 per 90-day supply.	You pay $25 per 30-day supply. You pay $50 per 60-day supply. You pay $62.50 per 90-day supply.

Additional Benefits	
	Flex (RPPO) Plan
Wellness Wallet (Fitness, Naturopathic Services, Acupuncture, Nutrition/Dietary Education, Weight Management Programs, Eyewear, and Face Masks) 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, Eyewear, and Face Masks.
Over-The-Counter items (OTC) More than 350 covered items including: non-prescription medicine (pain relief, cough, allergies), toothpaste, first aid items, and vitamins. Members can order online, over the phone, or visit a designated store location. 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.
Nutrition and Dietary: **Telenutrition**: Members have access to an online nutrition/dietary platform and unlimited visits with a registered dietitian via video connection, email, or telephone through third-party vendor FoodSmart™. Note: Food cost and delivery of meals/groceries are not covered under this benefit.	$0 cost for telenutrition services through FoodSmart™

Section 3: Dental Benefit Overview

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

Dental Benefit	Flex
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	
Amalgam (silver) fillings	You pay 50% of the cost + $50 office visit copay $50 annual deductible applies
Resin restoration on anterior teeth and the buccal surface of bicuspids only	
Surgical and routine extractions	
Root canals	
Treatment of gum disease (periodontics, including periodontal maintenance cleanings**)	
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.

****Note:** Cleanings are limited to once per calendar year; you may choose from either a routine cleaning (Coverage A) or a periodontal cleaning (Coverage B).

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**.

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.

Delta Dental Network

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

➤**No Balance Billing**: Participating dentists accept Delta Dental's fees for services as payment in full.

➤**No Claims Paperwork**: Participating dentists will prepare and submit claims for you.

➤**Direct Payment**: Delta Dental pays participating dentists directly, so you don't have to pay the covered amount up front and wait for reimbursement.

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

Martin's Point Generations Advantage Alliance (HMO)

This is a cover page

Section 1: Introduction

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

January 1, 2022 - December 31, 2022

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.

Plan Name	Alliance (HMO) Plan	Part B Premium Buy-Down
You must continue to pay your Medicare Part B premium	$0	$60

Benefit	Alliance (HMO) Plan
Deductible Our plan does not have a 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.	$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.
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.	You pay $0 for additional preventive services approved by Medicare.

Benefit	Alliance (HMO) Plan
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 There is a $25,000 limit for worldwide emergency, urgent care, and ambulance transport, this limit does not apply to services in the U.S.	**In- and Out-of-network:** You pay $90 for each Medicare-covered emergency room visit.
Urgently Needed Services Urgent care is covered nationwide. There is a $25,000 limit for worldwide emergency, urgent care, and ambulance transport, this limit does not apply to services in the U.S.	**In- and Out-of-network:** You pay $0 for each Medicare-covered urgent care visit when performed at an urgent care center. **Out-of-Country:** You pay $90 for each Medicare-covered urgent care visit when performed at an urgent care center outside of the United States and its associated territories.
Diagnostic Services / Labs / Imaging Services may require that your provider get prior authorization (approval in advance). Please see the Evidence of Coverage booklet for more information.	**Diagnostic Radiology Service *(e.g., MRI)*** You pay 20% of the contracted rate for complex diagnostic radiology (PET, CT, MRI, MRA, nuclear medicine) **Lab services** You pay $0/$5 copay for lab services. **Diagnostic tests and procedures** You pay 5% of the contracted rate for simple diagnostic radiology. **Outpatient x-rays** You pay 5% of the contracted rate for x-rays.

Benefit	Alliance (HMO) Plan
Hearing Services	**Hearing Exam** You pay $5 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 $295, $495, $895, $1295, or $1895 copay per ear, per year, depending on Tier selected. *Services must be received from an Amplifon provider.*
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.	You pay $5 per visit for Medicare-covered dental services (non-routine dental care required to treat illness or injury).
Preventive and Comprehensive Dental Members must use Delta Dental’s PPO/Premier or Martin's Point Generations Advantage network dentist in Maine, New Hampshire, or Vermont to obtain these supplemental dental benefits.	Preventive and Comprehensive Dental services are covered. *Please see Dental Overview on page 37 for more information.*
Vision Services	**Annual Routine Eye Exam:** You pay $0 for an annual routine eye exam. **Medicare-Covered Physician Services:** You pay $5 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).

Benefit	Alliance (HMO) Plan
Vision Services(continued)…	**Eyeglass Frames, Lenses, and Contacts:** The plan will reimburse up to $400 for prescription frames, lenses, and contacts.
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:** 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 $0 per visit for individual therapy. **Outpatient Group Therapy Visit** You pay $0 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.	For each benefit period you pay for Medicare-covered services: $0 per day for days 1-20; $178 per day for days 21-100
Physical Therapy	You pay $0 for each Medicare-covered visit.
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 covered worldwide. There is a $25,000 limit for worldwide emergency, urgent care, and ambulance transport, this limit does not apply to services in the U.S.	**In- and Out-of-network:** You pay $295 for each Medicare-covered emergency ambulance service (one-way).
Transportation	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 contracted rate for Medicare-covered services.
Health Education Coverage is for plan-sponsored health coaching, support groups, and cooking classes.	You pay $0 for plan-sponsored health coaching support groups, and cooking classes.

Additional Benefits Alliance (HMO) Plan	
Outpatient Substance Use	You pay $0 per visit for individual therapy; $0 per visit for group therapy.
Smoking and Tobacco Cessation Counseling	You pay $0 for 2 additional sessions beyond Medicare-covered benefit.
Over-The-Counter (OTC) More than 350 covered items including: non-prescription medicine (pain relief, cough, allergies), toothpaste, first aid items, and vitamins. Members can order online, over the phone, or visit a designated store location. Please see the Evidence of Coverage for more information.	The plan will cover up to $180 per quarter for members to purchase select CVS brand over-the counter (OTC) products.
Eyewear (Contacts, Frames, Lenses)	The plan will cover $400 each year for lenses, frames, and contact lenses (cannot be used in conjunction with Medicare-covered eyewear benefit).
Wellness Wallet (Fitness, Naturopathic Services, and Acupuncture, Nutrition/Dietary Education, and Weight Management Programs and Face Masks) Please see the Evidence of Coverage for more information.	The plan will reimburse up to $450 each year in total for Fitness Benefit, Naturopathic Services, and Acupuncture, Nutrition/Dietary Education, Weight Management Programs, and Face Masks.
Personal Emergency Response System (Device and Monitoring)	You pay $0.
Bathroom Safety Devices (Assessment, Devices and Installation)	The plan will reimburse up to $400 per year for non-Medicare-covered safety devices, installation, and assessment to prevent injuries in the bathroom.

Additional Benefits	Alliance (HMO) Plan
Meals Up to 3 weeks (42 meals) per inpatient stay or surgery. Up to 1 week (14 meals) per year as part of supervised program to transition into lifestyle modifications.	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.
Nutrition and Dietary: **Telenutrition:** Members have access to an online nutrition/dietary platform and unlimited visits with a registered dietitian via video connection, email, or telephone through third-party vendor FoodSmart™. Note: Food cost and delivery of meals/groceries are not covered under this benefit**.**	$0 cost for telenutrition services through FoodSmart™

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

You can see our plan's provider directory on our website at **www.MartinsPoint.org/MedicareMembers**.

If you want to know more about the coverage and costs of Original Medicare, look in your *Medicare & You 2022* 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 Alliance (HMO) plan includes the following benefits when seeing a Delta Dental network dentist. This benefit overview is provided for summary purposes only.

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

***Note:** Cleanings are limited to twice per calendar year; you may choose from either a routine cleaning (Coverage A) or a periodontal cleaning (Coverage B).

Identification Cards

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

Delta Dental Network:

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

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

To find out if your dentist participates in the Delta Dental network, please visit our website at **www.MartinsPoint.org/MedicareMembers**, visit **www.nedelta.com/Dentist-Search**, or call **Delta Dental's Customer Service Department at 1-800-832-5700 (TTY: 711) 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**.

Section 3: Dental Benefit Overview (continued…)

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

Martin's Point Generations Advantage Select (LPPO)

This is a cover page

Section 1: Introduction

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

January 1, 2022 - December 31, 2022

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.

Plan Name	Plan Service Area	Monthly Premium
Martin's Point Generations Advantage Select	Belknap, Carroll, and Grafton counties in New Hampshire	$39
	Androscoggin, Aroostook, Cumberland, Franklin, Hancock, Kennebec, Knox, Lincoln, Oxford, Penobscot, Piscataquis, Sagadahoc, Somerset, Waldo, Washington, and York counties in Maine; Cheshire, Coos, Hillsborough, Merrimack, Rockingham, Strafford, and Sullivan counties in New Hampshire	$99

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.

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. Note: Your Maximum Out-of-Pocket is based on your service area.	For members living in Belknap, Carroll, and Grafton counties in New Hampshire from network providers:$6,700 From network and out-of-network providers combined: $10,000 For members living in Androscoggin, Aroostook, Cumberland, Franklin, Hancock, Kennebec, Knox, Lincoln, Oxford, Penobscot, Piscataquis, Sagadahoc, Somerset, Waldo, Washington, and York counties in Maine; Cheshire, Coos, Hillsborough, Merrimack, Rockingham, Strafford, and Sullivan counties in New Hampshire from network providers: $7,300 From network and out-of-network providers combined: $10,000

Benefit	Select (LPPO) Plan
Inpatient Hospital Our plan covers an unlimited number of days for an inpatient hospital stay**.**	**In Network:** **You pay per admission:** $385 per day for days 1-5; $0 per day for days 6 and beyond **Out of Network:** **You pay per admission:** 30% of the 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.
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 Medicare-allowed cost of Medicare-covered surgery services at an ambulatory surgical center.

Benefit	Select (LPPO) Plan
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 Medicare-allowed 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 Medicare-allowed cost for each specialist office visit for Medicare-covered services.
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 $0 for additional preventive services approved by Medicare **Out of Network:** You pay 30% of the Medicare-allowed 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. There is a $25,000 limit for worldwide emergency, urgent care, and ambulance transport, this limit does not apply to services in the U.S.	**In- and Out-of-Network:** You pay $90 for each Medicare-covered emergency room visit.

Benefit	Select (LPPO) Plan
Urgently Needed Services Urgent care is covered nationwide. There is a $25,000 limit for worldwide emergency, urgent care, and ambulance transport, this limit does not apply to services in the U.S.	**In- and Out-of-Network:** You pay $40 for each Medicare-covered urgent care visit when performed at an urgent care center. **Out-of-Country:** You pay $90 for each Medicare-covered urgent care visit when performed at an urgent care center outside of the United States and its associated territories.
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 contracted rate for 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). **Lab Services** **In Network:** You pay 20% of the contracted rate for genetic labs You pay $0/$5 copay for all other lab services. **Out of Network:** You pay 20% of the Medicare-allowed cost for genetic labs You pay $0/$5 copay for all other lab services.

Benefit	Select (LPPO) Plan
Diagnostic Services / Labs / Imaging (continued)… Services may require that your provider get prior authorization (approval in advance). Please see the Evidence of Coverage for more information.	**Diagnostic Tests and Procedures** **In Network:** You pay 15% of the contracted rate for simple diagnostic radiology. **Out of Network:** You pay 15% of the Medicare-allowed cost of simple diagnostic radiology. **Outpatient X-rays** **In Network:** You pay 15% of the contracted rate for X-rays. **Out of Network:** You pay you pay 30% of the Medicare-allowed 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 Medicare-allowed 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 $495, $695, $1095, $1495, or $2095 copay per ear, depending on Tier selected. *Services must be received from an Amplifon provider.*

Benefit	Select (LPPO) 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.	**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.
Preventive and Comprehensive Dental Members must use Delta Dental PPO/Premier or Martin's Point Generations network dentist in Maine, New Hampshire, or Vermont to obtain these supplemental dental benefits. Note: Your Preventive and Comprehensive Dental Coverage is based on your service area.	For members living in Belknap, Carroll, and Grafton counties in New Hampshire: Preventive and Comprehensive Dental services are covered. Please see Dental Overview on page 52 for more information. For members living in Androscoggin, Aroostook, Cumberland, Franklin, Hancock, Kennebec, Knox, Lincoln, Oxford, Penobscot, Piscataquis, Sagadahoc, Somerset, Waldo, Washington, and York counties in Maine; Cheshire, Coos, Hillsborough, Merrimack, Rockingham, Strafford, and Sullivan counties in New Hampshire: Not a covered benefit.

Benefit	Select (LPPO) Plan
Vision Services	**Annual Routine Eye Exam** **In Network:** You pay $0 for an annual routine eye exam. **Out of Network:** You pay 30% of the Medicare-allowed cost for an annual routine eye exam. **Medicare-Covered Physician Services** **In Network:** You pay $40 for non-routine Medicare-covered physician services. **Out of Network:** You pay 30% of the Medicare-allowed cost of non-routine Medicare-covered physician services. **Glaucoma Testing** **In- and Out-of-Network:** You pay $0 for glaucoma testing. **Diabetic Retinopathy** **In- and Out-of-Network:** 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 page 51 below for more information.*

Benefit	Select (LPPO) Plan
Mental Health Services Services may require that your provider get prior authorization (approval in advance). Please see the Evidence of Coverage for more information.	**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.

Benefit	Select (LPPO) Plan
Physical Therapy	**In Network:** You pay $40 for each Medicare-covered visit. **Out of Network:** You pay 30% of the Medicare-allowed 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. There is a $25,000 limit for worldwide emergency, urgent care, and ambulance transport, this limit does not apply to services in the U.S.	**In- and Out-of-Network:** You pay $295 for each Medicare-covered emergency ambulance service (one-way).
Transportation	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 contracted rate for 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.
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%	

Senior Savings Program	Standard Cost Sharing	Preferred Cost Sharing	Mail Order Cost Sharing
Members are eligible for reduced cost sharing on select insulins.	You pay $35 per 30-day supply. You pay $70 per 60-day supply. You pay $105 per 90-day supply.	You pay $25 per 30-day supply. You pay $50 per 60-day supply. You pay $75 per 90-day supply.	You pay $25 per 30-day supply. You pay $50 per 60-day supply. You pay $62.50 per 90-day supply.

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

Additional Benefits	
	Select (LPPO) Plan
Wellness Wallet (Fitness, Naturopathic Services, Acupuncture, Nutrition/Dietary Education, Weight Management Programs, Eyewear, **Face Masks**) 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, Eyewear, and Face Masks.
Over-The-Counter items (OTC) More than 350 covered items including: non-prescription medicine (pain relief, cough, allergies), toothpaste, first aid items, and vitamins. Members can order online, over the phone, or visit a designated store location. 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.
Nutrition and Dietary: **Telenutrition:** Members have access to an online nutrition/dietary platform and unlimited visits with a registered dietitian via video connection, email, or telephone through third-party vendor FoodSmart™. Note: Food cost and delivery of meals/groceries are not covered under this benefit.	$0 cost for telenutrition services through FoodSmart™

Section 3: Dental Benefit Overview

Please note, for members living in Belknap, Carroll, and Grafton counties in New Hampshire: Preventive Dental services are covered.

For members living in Androscoggin, Aroostook, Cumberland, Franklin, Hancock, Kennebec, Knox, Lincoln, Oxford, Penobscot, Piscataquis, Sagadahoc, Somerset, Waldo, Washington, and York counties in Maine counties in Maine; Cheshire, Coos, Hillsborough, Merrimack, Rockingham, Strafford, and Sullivan in New Hampshire: Preventive Dental services are not a covered benefit.

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

Dental Benefit	Select
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	

Select Plan Out-of-Network Dental Coverage

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

Select Out-of-Network Dental Coverage	
Category A: Diagnostic/Preventative	50% coinsurance + $50 office visit copay

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

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**.

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 Select plan member ID number.

Delta Dental Network

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

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

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

Martin's Point Generations Advantage Value Plus (HMO)

This will be a cover page

Section 1: Introduction

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

January 1, 2022 - December 31, 2022

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 Belknap, Carroll, Grafton, 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.

Monthly Plan Premium	Plan Service Area	Monthly Premium
Martin's Point Generations Advantage Value Plus	Androscoggin, Aroostook, Franklin, Hancock, Kennebec, Knox, Lincoln, Oxford, Penobscot, Piscataquis, Sagadahoc, Somerset, Waldo, Washington, and York counties in Maine; Belknap, Carroll, Grafton, Hillsborough and Strafford counties in New Hampshire	$0

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. Note: Your Maximum Out-of-Pocket is based on your service area.	For Members living in Androscoggin, Kennebec, Sagadahoc, and York Counties in Maine; Belknap, Carroll, Grafton, Hillsborough, and Strafford Counties in New Hampshire: $6,500 Annually For members living in Aroostook, Franklin, Hancock, Knox, Lincoln, Oxford, Penobscot, Piscataquis, Somerset, Waldo, and Washington Counties in Maine: $7,100 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.

Benefit	Value Plus (HMO) Plan
Ambulatory & Surgical Center (ASC)	**In Network:** You pay $200 for Medicare-covered surgery services at an ambulatory surgical center.
Doctor visits	**In Network:** **Primary Care** You pay $0 for post-operative and post-discharge visits with your PCP. You pay $0 for a brief emotional/behavioral assessment with your PCP. You pay $10 for all other PCP services and visits. **Specialists** You pay $50 for each specialist office visit for Medicare-covered services.
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 $0 for additional preventive services approved by Medicare
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. There is a $25,000 limit for worldwide emergency, urgent care, and ambulance transport, this limit does not apply to services in the U.S.	**In- and Out-of-Network:** You pay $90 for each Medicare-covered emergency room visit.
Urgently Needed Services Urgent care is covered nationwide. There is a $25,000 limit for worldwide emergency, urgent care, and ambulance transport, this limit does not apply to services in the U.S.	**In- and Out-of-Network:** You pay $40 for each Medicare-covered urgent care visit when performed at an urgent care center. **Out-of-Country:** You pay $90 for each Medicare-covered urgent care visit when performed at an urgent care center outside of the United States and its associated territories.

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 contracted rate for complex diagnostic radiology (PET, CT, MRI, MRA, nuclear medicine) **Lab Services** You pay 20% of the contracted rate for genetic labs. You pay $0/$5 copay for all other lab services. **Diagnostic Tests and Procedures** You pay 15% of the contracted rate for simple diagnostic radiology. **Outpatient X-rays** You pay 15% of the contracted rate for X-rays.
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, $1095, $1495, or $2095 copay per ear, per year, depending on Tier selected. *Services must be received from an Amplifon provider.*

Benefit	Value Plus (HMO) 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.	**In Network:** You pay $50 per visit for Medicare-covered dental services (non-routine dental care required to treat illness or injury).
Preventive and Comprehensive Dental Members must use Delta Dental PPO/Premier or Martin's Point Generations Advantage network dentist in Maine, New Hampshire, or Vermont to obtain these supplemental dental benefits.	Not a covered benefit.
Vision Services	**In Network:** **Annual Routine Eye Exam** You pay $0 for an annual routine eye exam. **Medicare-Covered Physician Services** You pay $50 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.*

Benefit	Value Plus (HMO) Plan
Mental Health Services Services may require that your provider get prior authorization (approval in advance). Please see the Evidence of Coverage for more information.	**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
Physical Therapy	**In Network:** You pay $40 for each Medicare-covered visit.
Ambulance Non-emergency ambulance transportation services may require that your provider get prior authorization (approval in advance). Please see the Evidence of Coverage for more information. Ambulance services are covered worldwide. There is a $25,000 limit for worldwide emergency, urgent care, and ambulance transport, this limit does not apply to services in the U.S.	**In- and Out-of-Network:** You pay $295 for each Medicare-covered emergency ambulance service (one-way).
Transportation	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.	**In Network:** You pay 20% of the contracted rate for Medicare-covered services.

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 Evidence of Coverage
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%	

Senior Savings Program	Standard Cost Sharing	Preferred Cost Sharing	Mail Order Cost Sharing
Members are eligible for reduced cost sharing on select insulins.	You pay $35 per 30-day supply. You pay $70 per 60-day supply. You pay $105 per 90-day supply.	You pay $25 per 30-day supply. You pay $50 per 60-day supply. You pay $75 per 90-day supply.	You pay $25 per 30-day supply. You pay $50 per 60-day supply. You pay $62.50 per 90-day supply.

Additional Benefits	Value Plus (HMO) Plan
Wellness Wallet (Fitness, Naturopathic Services, Acupuncture, Nutrition/Dietary Education, Weight Management Programs, Eyewear and Face Masks) Please see the Evidence of Coverage for more information.	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.
Over-The-Counter items (OTC) More than 350 covered items including: non-prescription medicine (pain relief, cough, allergies), toothpaste, first aid items, and vitamins. Members can order online, over the phone, or visit a designated store location. Note: Your Maximum Over-the-Counter benefit is based on your service area. Please see the Evidence of Coverage for more information.	For members living in Aroostook, Franklin, Hancock, Knox, Lincoln, Oxford, Penobscot, Piscataquis, Somerset, Waldo, and Washington Counties in Maine: The plan will cover up to $50 per quarter for members to purchase select CVS brand over-the-counter (OTC) products. For Members living in Androscoggin, Kennebec, Sagadahoc, and York Counties in Maine; Belknap, Carroll, Grafton, Hillsborough, and Strafford Counties in New Hampshire: The plan will cover up to $55 per quarter for members to purchase select CVS brand over-the-counter (OTC) products.
Nutrition and Dietary: **Telenutrition:** Members have access to an online nutrition/dietary platform and unlimited visits with a registered dietitian via video connection, email, or telephone through third-party vendor FoodSmart™. Note: Food cost and delivery of meals/groceries are not covered under this benefit.	$0 cost for telenutrition services through FoodSmart™

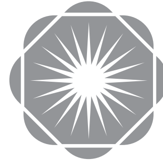
All plans cover Part B drugs such as chemotherapy and some drugs administered by your provider.

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

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

If you want to know more about the coverage and costs of Original Medicare, look in your Medicare & You 2022 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.

Value Plus (HMO) Plan
Point-of-Service: Not covered under this plan.



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