Evidence of Coverage

JANUARY 1–DECEMBER 31, 2026

Alliance (HMO)

H5591-003

For All Maine Counties

Martin's Point

GENERATIONS ADVANTAGE

January 1 - December 31, 2026

Evidence of Coverage for 2026:

Your Medicare Health Benefits and Services as a Member of Martin's Point Generations Advantage Alliance (HMO)

This document gives the details of your Medicare health coverage from January 1 – December 31, 2026. **This is an important legal document. Keep it in a safe place.**

This document explains your benefits and rights. Use this document to understand:

- Our plan premium and cost sharing
- Our medical benefits
- How to file a complaint if you're not satisfied with a service or treatment
- How to contact us
- Other protections required by Medicare law

For questions about this document, call Member Services at 1-866-544-7504 (TTY users call 711). Hours are 8am - 8pm, seven days a week from October 1 to March 31, and Monday through Friday the rest of the year. This call is free.

This plan, Martin's Point Generations Advantage Alliance (HMO), is offered by MARTIN'S POINT GENERATIONS ADVANTAGE, INC. (Martin's Point Generations Advantage) (When this *Evidence of Coverage* says "we," "us," or "our," it means MARTIN'S POINT GENERATIONS ADVANTAGE, INC. (Martin's Point Generations Advantage). When it says "plan" or "our plan," it means Martin's Point Generations Advantage Alliance (HMO).)

This document may be available in other formats such as large print and braille. For more information, please call Member Services.

Benefits, premiums, deductibles, and/or copayments/coinsurance may change on January 1, 2027.

Our formulary, pharmacy network, and/or provider network may change at any time. You'll get notice about any changes that may affect you at least 30 days in advance.

OMB Approval 0938-1051
(Expires: August 31, 2026)

Table of Contents

CHAPTER 1:

Get started as a member

SECTION 1 You're a member of Martin's Point Generations Advantage Alliance (HMO)

Section 1.1 You're enrolled in Martin's Point Generations Advantage Alliance (HMO), which is a Medicare HMO Plan

You're covered by Medicare, and you chose to get your Medicare health coverage through our plan, Martin's Point Generations Advantage Alliance (HMO). Our plan covers all Part A and Part B services. However, cost sharing and provider access in this plan are different from Original Medicare.

Martin's Point Generations Advantage Alliance (HMO) is a Medicare Advantage HMO Plan (HMO stands for Health Maintenance Organization) approved by Medicare and run by a private company. Martin's Point Generations Advantage Alliance (HMO) doesn't include Part D drug coverage.

Section 1.2 Legal information about the *Evidence of Coverage*

This *Evidence of Coverage* is part of our contract with you about how Martin's Point Generations Advantage Alliance (HMO) covers your care. Other parts of this contract include your enrollment form and any notices you get from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called *riders* or *amendments*.

The contract is in effect for the months you're enrolled in Martin's Point Generations Advantage Alliance (HMO) between January 1, 2026, and December 31, 2026.

Medicare allows us to make changes to plans we offer each calendar year. This means we can change the costs and benefits of Martin's Point Generations Advantage Alliance (HMO) after December 31, 2026. We can also choose to stop offering our plan in your service area, after December 31, 2026.

Medicare (the Centers for Medicare & Medicaid Services) must approve Martin's Point Generations Advantage Alliance (HMO) each year. You can continue to get Medicare coverage as a member of our plan as long as we choose to continue offering our plan and Medicare renews approval of our plan.

SECTION 2 Plan eligibility requirements

Section 2.1 Eligibility requirements

You’re eligible for membership in our plan as long as you meet all these conditions:

- You have both Medicare Part A and Medicare Part B
- You live in our geographic service area (described in Section 2.2). People who are incarcerated aren't considered to be living in the geographic service area, even if they're physically located in it
- You're a United States citizen or lawfully present in the United States

Section 2.2 Plan service area for Martin's Point Generations Advantage Alliance (HMO)

Martin's Point Generations Advantage Alliance (HMO) is only available to people who live in our plan service area. To stay a member of our plan, you generally must continue to live in our plan service area. The service area is described below.

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

If you move out of our plan’s service area, you can’t stay a member of this plan. Call Member Services at 1-866-544-7504 (TTY users call 711) to see if we have a plan in your new area. When you move, you’ll have a Special Enrollment Period to either switch to Original Medicare or enroll in a Medicare health plan in your new location.

If you move or change your mailing address, it’s also important to call Social Security. Call Social Security at 1-800-772-1213 (TTY users call 1-800-325-0778).

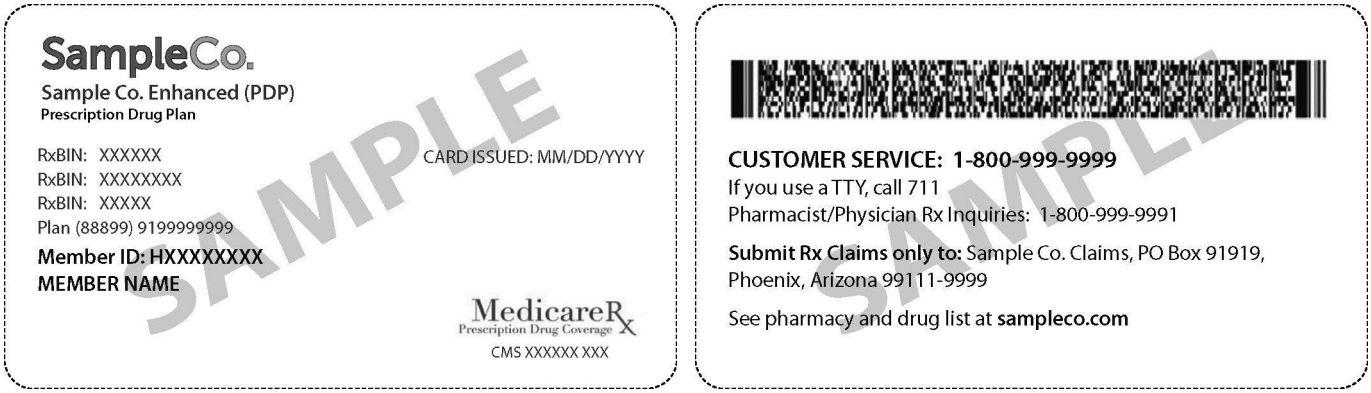
Section 2.3 U.S. citizen or lawful presence

You must be a U.S. citizen or lawfully present in the United States to be a member of a Medicare health plan. Medicare (the Centers for Medicare & Medicaid Services) will notify Martin's Point Generations Advantage Alliance (HMO) if you’re not eligible to stay a member of our plan on this basis. Martin's Point Generations Advantage Alliance (HMO) must disenroll you if you don’t meet this requirement.

SECTION 3 Important membership material

Section 3.1 Our plan membership card

Use your membership card whenever you get services covered by our plan. You should also show the provider your Medicaid card, if you have one. Sample membership card:



DON'T use your red, white and blue Medicare card for covered medical services while you're a member of this plan. If you use your Medicare card instead of your Martin's Point Generations Advantage Alliance (HMO) membership card, you may have to pay the full cost of medical services yourself. Keep your Medicare card in a safe place. You may be asked to show it if you need hospital services, hospice services, or participate in Medicare-approved clinical research studies (also called clinical trials).

If our plan membership card is damaged, lost, or stolen, call Member Services at 1-866-544-7504 (TTY users call 711) right away and we'll send you a new card.

Section 3.2 Provider Directory

The *Provider Directory* https://martinspoint.org/Generations-Advantage/Find-a-Provider, lists our current network providers. **Network providers** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and any plan cost sharing as payment in full.

You must use network providers to get your medical care and services. If you go elsewhere without proper authorization, you'll have to pay in full. The only exceptions are emergencies, urgently needed services when the network isn't available (that is, situations where it's unreasonable or not possible to get services in network), out-of-area dialysis services, and cases when Martin's Point Generations Advantage Alliance (HMO) authorizes use of out-of-network providers.

The *Provider Directory*: Your guide to all providers in the plan's network. Get the most recent list of providers on our website at https://martinspoint.org/Generations-Advantage/Find-a-Provider.

If you don’t have a *Provider Directory*, you can ask for a copy (electronically or in paper form) from Member Services at 1-866-544-7504 (TTY users call 711). Requested paper *Provider Directories* will be mailed to you within 3 business days.

SECTION 4 Your monthly costs for Martin's Point Generations Advantage Alliance (HMO)

	Your Costs in 2026
Monthly plan premium* *Your premium can be higher than this amount. Go to Section 4.1 for details.	$0
Maximum out-of-pocket amount This is the most you’ll pay out-of-pocket for covered Part A and Part B services. (Go to Chapter 4 Section 1 for details.)	$5,000
Primary care office visits	$0 copayment per visit
Specialist office visits	$15 copayment per visit
Inpatient hospital stays	$350 copayment each day for days 1 to 5 and $0 copayment each day for days 6 to 90 for Medicare-covered hospital care.

Your costs may include the following:
- Plan Premium (Section 4.1)
- Monthly Medicare Part B Premium (Section 4.2)

Section 4.1 Plan premium

You don’t pay a separate monthly plan premium for Martin's Point Generations Advantage Alliance (HMO).

Medicare Part B and Part D premiums differ for people with different incomes. If you have questions about these premiums, check your copy of *Medicare & You 2026* handbook in the section called *2026 Medicare Costs*. Download a copy from the Medicare website (www.Medicare.gov/medicare-and-you) or order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

Section 4.2 Monthly Medicare Part B Premium

Many members are required to pay other Medicare premiums

You must continue paying your Medicare premiums to stay a member of our plan. This includes your premium for Part B. You may also pay a premium for Part A if you aren't eligible for premium-free Part A.

SECTION 5 More information about your monthly plan premium

Section 5.1 Our monthly plan premium won't change during the year

We're not allowed to change our plan's monthly plan premium during the year. If the monthly plan premium changes for next year, we'll tell you in September and the new premium will take effect on January 1.

SECTION 6 Keep our plan membership record up to date

Your membership record has information from your enrollment form, including your address and phone number. It shows your specific plan coverage including your Primary Care Provider.

The doctors, hospitals, and other providers in our plan's network **use your membership record to know what services are covered and your cost-sharing amounts**. Because of this, it's very important to help us keep your information up to date.

If you have any of these changes, let us know:

- Changes to your name, address, or phone number
- Changes in any other health coverage you have (such as from your employer, your spouse or domestic partner's employer, workers' compensation, or Medicaid)
- Any liability claims, such as claims from an automobile accident
- If you have been admitted to a nursing home
- If you get care in an out-of-area or out-of-network hospital or emergency room
- If your designated responsible party (such as a caregiver) changes

- If you participate in a clinical research study (**Note:** You're not required to tell our plan about clinical research studies you intend to participate in, but we encourage you to do so.)

If any of this information changes, please let us know by calling Member Services at 1-866-544-7504 (TTY users call 711).

It's also important to contact Social Security if you move or change your mailing address. Call Social Security at 1-800-772-1213 (TTY users call 1-800-325-0778).

SECTION 7 How other insurance works with our plan

Medicare requires us to collect information about any other medical or drug coverage you have so we can coordinate any other coverage with your benefits under our plan. This is called **Coordination of Benefits**.

Once a year, we'll send you a letter that lists any other medical or drug coverage we know about. Read this information carefully. If it's correct, you don't need to do anything. If the information isn't correct, or if you have other coverage that's not listed, call Member Services at 1-866-544-7504 (TTY users call 711). You may need to give our plan member ID number to your other insurers (once you confirm their identity) so your bills are paid correctly and on time.

When you have other insurance (like employer group health coverage), Medicare rules decide whether our plan or your other insurance pays first. The insurance that pays first ("the primary payer") pays up to the limits of its coverage. The insurance that pays second ("the secondary payer") only pays if there are costs left uncovered by the primary coverage. The secondary payer may not pay the uncovered costs. If you have other insurance, tell your doctor, hospital, and pharmacy.

These rules apply for employer or union group health plan coverage:

- If you have retiree coverage, Medicare pays first.
- If your group health plan coverage is based on your or a family member's current employment, who pays first depends on your age, the number of people employed by your employer, and whether you have Medicare based on age, disability, or End-Stage Renal Disease (ESRD):
    - If you're under 65 and disabled and you (or your family member) are still working, your group health plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan has more than 100 employees.
    - If you're over 65 and you (or your spouse or domestic partner) are still working, your group health plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan has more than 20 employees.
- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

These types of coverage usually pay first for services related to each type:

- No-fault insurance (including automobile insurance)
- Liability (including automobile insurance)
- Black lung benefits
- Workers' compensation

Medicaid and TRICARE never pay first for Medicare-covered services. They only pay after Medicare, employer group health plans, and/or Medigap have paid.

CHAPTER 2:

Phone numbers and resources

SECTION 1 Martin's Point Generations Advantage Alliance (HMO) contacts

For help with claims, billing, or member card questions, call or write to Martin's Point Generations Advantage Alliance (HMO) Member Services 1-866-544-7504 (TTY users call 711). We'll be happy to help you.

Member Services – Contact Information	
Call	1-866-544-7504 Calls to this number are free. 8am - 8pm, seven days a week from October 1 to March 31, and Monday through Friday the rest of the year Member Services also has free language interpreter services for non-English speakers.
TTY	711 Calls to this number are free. 8am - 8pm, seven days a week from October 1 to March 31, and Monday through Friday the rest of the year
Fax	207-828-7821
Write	Martin's Point Generations Advantage Member Services P.O. Box 9746 Portland, ME 04104-5040
Website	www.martinspoint.org/medicaremembers

How to ask for a coverage decision or appeal about your medical care

A coverage decision is a decision we make about your benefits and coverage or about the amount we pay for your medical services. An appeal is a formal way of asking us to review and change a coverage decision. For more information on how to ask for coverage decisions or appeals about your medical care, go to Chapter 7.

Coverage Decisions and Appeals for Medical Care – Contact Information	
Call	1-866-544-7504 Calls to this number are free. 8am - 8pm, seven days a week from October 1 to March 31, and Monday through Friday the rest of the year
TTY	711 Calls to this number are free. 8am - 8pm, seven days a week from October 1 to March 31, and Monday through Friday the rest of the year
Write	Martin's Point Generations Advantage ATTN: Member Services P.O. Box 9746 Portland, ME 04104-5040 For expedited requests write to: CVS Caremark Martin's Point Generations Advantage Exception Department MC109 ATTN: Member Services PO Box 52000 Phoenix, AZ 85072-2000

How to make a complaint about your medical care

You can make a complaint about us or one of our network providers, including a complaint about the quality of your care. This type of complaint doesn't involve coverage or payment disputes. For more information on how to make a complaint about your medical care, go to Chapter 7.

Complaints about Medical Care – Contact Information	
Call	1-866-544-7504 Calls to this number are free. 8am - 8pm, seven days a week from October 1 to March 31, and Monday through Friday the rest of the year
TTY	711 Calls to this number are free.

Complaints about Medical Care – Contact Information	
	8am - 8pm, seven days a week from October 1 to March 31, and Monday through Friday the rest of the year
Write	Martin's Point Generations Advantage Grievance Department P.O. Box 9746 Portland, ME 04104-9746 For expedited requests write to: Martin's Point Generations Advantage ATTN: Grievance Department PO Box 9746 Portland, ME 04104-9746
Medicare website	To submit a complaint about Martin's Point Generations Advantage Alliance (HMO) directly to Medicare, go to www.medicare.gov/my/medicare-complaint.

How to ask us to pay our share of the cost for medical care you got

If you got a bill or paid for services (like a provider bill) you think we should pay for, you may need to ask us for reimbursement or to pay the provider bill. Go to Chapter 5 for more information.

If you send us a payment request and we deny any part of your request, you can appeal our decision. Go to Chapter 7 for more information.

Payment Requests – Contact Information	
Write	Martin's Point Generations Advantage ATTN: Claims Department PO Box 11410 Portland, ME 04104
Website	www.MartinsPoint.org/MedicareMembers

SECTION 2 Get help from Medicare

Medicare is the federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

The federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (CMS). This agency contracts with Medicare Advantage organizations including our plan.

Medicare – Contact Information	
Call	1-800-MEDICARE (1-800-633-4227) Calls to this number are free. 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are free.
Chat Live	Chat live at www.Medicare.gov/talk-to-someone.
Write	Write to Medicare at PO Box 1270, Lawrence, KS 66044
Website	www.Medicare.gov • Get information about the Medicare health and drug plans in your area, including what they cost and what services they provide. • Find Medicare-participating doctors or other health care providers and suppliers. • Find out what Medicare covers, including preventive services (like screenings, shots or vaccines, and yearly “Wellness” visits). • Get Medicare appeals information and forms. • Get information about the quality of care provided by plans, nursing homes, hospitals, doctors, home health agencies, dialysis facilities, hospice centers, inpatient rehabilitation facilities, and long-term care hospitals. • Look up helpful websites and phone numbers.

Medicare – Contact Information	
	You can also visit www.Medicare.gov to tell Medicare about any complaints you have about Martin's Point Generations Advantage Alliance (HMO). **To submit a complaint to Medicare,** go to www.Medicare.gov/my/medicare-complaint. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

SECTION 3 State Health Insurance Assistance Program (SHIP)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state that offers free help, information, and answers to your Medicare questions. In Maine, the SHIP is called Maine State Health Insurance Assistance Program (SHIP).

Maine State Health Insurance Assistance Program (SHIP) is an independent state program (not connected with any insurance company or health plan) that gets money from the federal government to give free local health insurance counseling to people with Medicare.

Maine State Health Insurance Assistance Program (SHIP) counselors can help you understand your Medicare rights, help you make complaints about your medical care or treatment, and straighten out problems with your Medicare bills. Maine State Health Insurance Assistance Program (SHIP) counselors can also help you with Medicare questions or problems, help you understand your Medicare plan choices and answer questions about switching plans.

	Maine State Health Insurance Assistance Program (SHIP) – Contact Information
Call	1-877-353-3771
TTY	711
Write	Office of Aging and Disability Services, 11 State House Station 41 Anthony Ave. Augusta, Maine 04333
Website	https://www.maine.gov/dhhs/oads/get-support/older-adults-disabilities/older-adult-services/ship-medicare-assistance

SECTION 4 Quality Improvement Organization (QIO)

A designated Quality Improvement Organization (QIO) serves people with Medicare in each state. For Maine, the Quality Improvement Organization is called Acentra Health - Maine's Quality Improvement Organization.

Acentra Health - Maine's Quality Improvement Organization has a group of doctors and other health care professionals paid by Medicare to check on and help improve the quality of care for people with Medicare. Acentra Health - Maine's Quality Improvement Organization is an independent organization. It's not connected with our plan.

Contact Acentra Health - Maine's Quality Improvement Organization in any of these situations:

- You have a complaint about the quality of care you got. Examples of quality-of-care concerns include getting the wrong medication, unnecessary tests or procedures, or a misdiagnosis.
- You think coverage for your hospital stay is ending too soon.
- You think coverage for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services is ending too soon.

	Acentra Health - Maine's Quality Improvement Organization – Contact Information
Call	1-888-319-8452 9 a.m. - 5 p.m. local time, Monday - Friday; 10 a.m. - 4 p.m. local time, weekends and holidays
TTY	711
Write	Acentra Health/Maine's Quality Improvement Organization 5201 W. Kennedy Blvd., Suite 900 Tampa, FL, 33609
Website	https://www.acentraqio.com/

SECTION 5 Social Security

Social Security determines Medicare eligibility and handles Medicare enrollment.

If you move or change your mailing address, contact Social Security to let them know.

Social Security— Contact Information	
Call	1-800-772-1213 Calls to this number are free. Available 8 am to 7 pm, Monday through Friday. Use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	1-800-325-0778 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 8 am to 7 pm, Monday through Friday.
Website	www.SSA.gov

SECTION 6 Medicaid

Medicaid is a joint federal and state government program that helps with medical costs for certain people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid. Medicaid offers programs to help people with Medicare pay their Medicare costs, such as their Medicare premiums. These **Medicare Savings Programs** include:

- **Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums, and other cost sharing (like deductibles, coinsurance, and copayments). (Some people with QMB are also eligible for full Medicaid benefits (QMB+).)
- **Specified Low-Income Medicare Beneficiary (SLMB):** Helps pay Part B premiums. (Some people with SLMB are also eligible for full Medicaid benefits (SLMB+).)
- **Qualifying Individual (QI):** Helps pay Part B premiums.
- **Qualified Disabled & Working Individuals (QDWI):** Helps pay Part A premiums.

To find out more about Medicaid and Medicare Savings Programs, contact MaineCare Services (Medicaid).

MaineCare Services (Medicaid) – Contact Information	
Call	1-866-690-5585 8 a.m. - 5 p.m. ET, Monday - Friday
TTY	711
Write	Department of Health and Human Services 109 Capitol Street 11 State house Station Augusta, Maine 04333
Website	https://mainecare.maine.gov/Default.aspx

SECTION 7 Railroad Retirement Board (RRB)

The Railroad Retirement Board is an independent federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you get Medicare through the Railroad Retirement Board, let them know if you move or change your mailing address. For questions about your benefits from the Railroad Retirement Board, contact the agency.

Railroad Retirement Board (RRB) – Contact Information	
Call	1-877-772-5772 Calls to this number are free. Press "0" to speak with an RRB representative from 9 am to 3:30 pm, Monday, Tuesday, Thursday, and Friday, and from 9 am to 12 pm on Wednesday. Press "1" to access the automated RRB HelpLine and get recorded information 24 hours a day, including weekends and holidays.
TTY	1-312-751-4701 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number aren't free.
Website	https://RRB.gov

SECTION 8 If you have group insurance or other health insurance from an employer

If you (or your spouse or domestic partner) get benefits from your (or your spouse or domestic partner's) employer or retiree group as part of this plan, call the employer/union benefits administrator or Member Services at 1-866-544-7504 (TTY users call 711) with any questions. You can ask about your (or your spouse or domestic partner's) employer or retiree health benefits, premiums, or the enrollment period. You can call 1-800-MEDICARE (1-800-633-4227) with questions about your Medicare coverage under this plan. TTY users call 1-877-486-2048.

CHAPTER 3:

Using our plan for your medical services

SECTION 1 How to get medical care as a member of our plan

This chapter explains what you need to know about using our plan to get your medical care covered.

For details on what medical care our plan covers and how much you pay when you get care, go to the Medical Benefits Chart in Chapter 4.

Section 1.1 Network providers and covered services

- **Providers** are doctors and other health care professionals licensed by the state to provide medical services and care. The term “providers” also includes hospitals and other health care facilities.
- **Network providers** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and your cost-sharing amount as payment in full. We arranged for these providers to deliver covered services to members in our plan. The providers in our network bill us directly for care they give you. When you see a network provider, you pay only your share of the cost for their services.
- **Covered services** include all the medical care, health care services, supplies, and equipment that are covered by our plan. Your covered services for medical care are listed in the Medical Benefits Chart in Chapter 4.

Section 1.2 Basic rules for your medical care to be covered by our plan

As a Medicare health plan, Martin's Point Generations Advantage Alliance (HMO) must cover all services covered by Original Medicare and follow Original Medicare’s coverage rules.

Martin's Point Generations Advantage Alliance (HMO) will generally cover your medical care as long as:

- **The care you get is included in our plan’s Medical Benefits Chart** in Chapter 4.

- **The care you get is considered medically necessary.** Medically necessary means that the services, supplies, equipment, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- **You have a network primary care provider (a PCP) providing and overseeing your care.** As a member of our plan, you must choose a network PCP (go to Section 2.1 of this chapter for more information).
    - In most situations, your network PCP must give you approval in advance (a referral) before you can use other providers in our plan's network, such as specialists, hospitals, skilled nursing facilities, or home health care agencies. For more information, go to Section 2.3.
    - You don't need referrals from your PCP for emergency care or urgently needed services. To learn about other kinds of care you can get without getting approval in advance from your PCP, go to Section 2.2.
- **You must get your care from a network provider** (go to Section 2). In most cases, care you get from an out-of-network provider (a provider who's not part of our plan's network) won't be covered. This means you have to pay the provider in full for services you get. Here are 3 exceptions*:*
    - Our plan covers emergency or urgently needed services you get from an out-of-network provider. For more information and to see what emergency or urgently needed services are, go to Section 3.
    - If you need medical care that Medicare requires our plan to cover but there are no specialists in our network that provide this care, you can get this care from an out-of-network provider at the same cost sharing you normally pay in-network. In this situation, you pay the same as you pay if you got the care from a network provider. For information about getting approval to see an out-of-network doctor, go to Section 2.4.
    - Our plan covers kidney dialysis services you get at a Medicare-certified dialysis facility when you're temporarily outside our plan's service area or when your provider for this service is temporarily unavailable or inaccessible. The cost sharing you pay our plan for dialysis can never be higher than the cost sharing in Original Medicare. If you're outside our plan's service area and get dialysis from a provider outside our plan's network, your cost sharing can't be higher than the cost sharing you pay in-network. However, if your usual in-network provider for dialysis is temporarily unavailable and you choose to get services inside our service area from a provider outside our plan's network, your cost sharing for the dialysis may be higher.

SECTION 2 Use providers in our plan's network to get medical care

Section 2.1 You must choose a Primary Care Provider (PCP) to provide and oversee your medical care

What is a PCP and what does the PCP do for you?

When you become a member of our plan you must choose a network provider to be your PCP.

- Your PCP is a health care professional who meets state requirements and is trained to give you basic medical care.
- The following types of providers may act as PCPs: General Practice, Family Practice, Internal Medicine, Pediatricians, and in certain cases, Nurse Practitioners or Physician Assistants.
- As we explain below, you must get your routine or basic care from your network PCP. Your PCP can also coordinate the rest of the covered services you get as a member of our plan. Your PCP can provide most of your care and can help you arrange or coordinate the rest of the covered services you get as a member of the plan.
- This could include:
    - X-rays
    - Laboratory tests
    - Therapies
    - Care from doctors who are specialists
    - Hospital admissions, and follow-up care
- Coordinating your services includes checking or consulting with other plan providers about your care and how it is going.
- Since your PCP will provide and coordinate your medical care, you should have all of your past medical records sent to your PCP's office.

How to choose a PCP?

When you applied for membership in our plan, you were asked to select a PCP from our list of approved network providers and call the PCP's office to establish yourself as a patient. If there is a particular Martin's Point Generations Advantage specialist or hospital that you want to use, check first to ensure your PCP makes referrals to that specialist or uses that hospital.

How to change your PCP

You can change your PCP for any reason, at any time. It's also possible that your PCP might leave our plan's network of providers, and you'd need to choose a new PCP.

If you decide to change your PCP to another participating provider, call Member Services to update your membership record. (Phone numbers for Member Services are printed on the back cover of this booklet.)

Please call us before you see your new PCP. We will update your information immediately, but you will still need to contact the PCP's office to establish yourself as a patient.

Section 2.2 Medical care you can get without a PCP referral

You can get the services listed below without getting approval in advance from your PCP:

- Routine women's health care, including breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams as long as you get them from a network provider
- Flu shots, COVID-19 vaccines, Hepatitis B vaccines, and pneumonia vaccines as long as you get them from a network provider
- Emergency services from network providers or from out-of-network providers
- Urgently needed plan-covered services are services that require immediate medical attention (but not an emergency) if you're either temporarily outside our plan's service area, or if it's unreasonable given your time, place, and circumstances to get this service from network providers. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you're temporarily outside our plan's service area. If possible, call Member Services at 1-866-544-7504 (TTY users call 711 number) before you leave the service area so we can help arrange for you to have maintenance dialysis while you're away.

Section 2.3 How to get care from specialists and other network providers

A specialist is a doctor who provides health care services for a specific disease or part of the body. There are many kinds of specialists. For example:

- Oncologists care for patients with cancer
- Cardiologists care for patients with heart conditions

- Orthopedists care for patients with certain bone, joint, or muscle conditions

It is very important to get a referral (approval in advance) from your PCP before you see a plan specialist or certain other providers. If you don't have a referral before you get services from a specialist, you may have to pay for these services yourself. If the specialist wants you to come back for more care, check first to be sure that the referral (approval in advance) you got from your PCP for the first visit covers more visits to the specialist. Before you receive a medical service or supply you should determine if it requires prior authorization (PA). This is approval in advance from the plan. You can look in Chapter 4, Section 2.1 for information about which services require prior authorization. You can also call Member Services to determine if an authorization is needed (phone numbers are printed on the back cover of this booklet). If prior approval is required, your PCP or treating provider is responsible for contacting the plan to request the approval. The plan makes the prior authorization decision. If there are specialists you want to use, find out whether your PCP sends patients to these specialists. Each plan PCP has certain plan specialists they use for referrals. This means that the PCP you select may determine the specialists you may see. If there are specific hospitals you want to use, you must first find out whether your PCP uses these hospitals.

When a specialist or another network provider leaves our plan

We may make changes to the hospitals, doctors and specialists (providers) in our plan's network during the year. If your doctor or specialist leaves our plan, you have these rights and protections:

- Even though our network of providers may change during the year, Medicare requires that you have uninterrupted access to qualified doctors and specialists.
- We'll notify you that your provider is leaving our plan so that you have time to choose a new provider.
    - If your primary care or behavioral health provider leaves our plan, we'll notify you if you visited that provider within the past 3 years.
    - If any of your other providers leave our plan, we'll notify you if you're assigned to the provider, currently get care from them or visited them within the past 3 months.
- We'll help you choose a new qualified in-network provider for continued care.
- If you're undergoing medical treatment or therapies with your current provider, you have the right to ask to continue getting medically necessary treatment or therapies. We'll work with you so you can continue to get care.
- We'll give you information about available enrollment periods and options you may have for changing plans.
- When an in-network provider or benefit is unavailable or inadequate to meet your medical needs, we'll arrange for any medically necessary covered benefit outside of our provider network at in-network cost sharing. You must get authorization from the plan prior to seeking care from an out-of-network provider.

- If you find out your doctor or specialist is leaving our plan, call Member Services at 1-866-544-7504 (TTY users call 711) so we can help you choose a new provider to manage your care.
- If you believe we haven't furnished you with a qualified provider to replace your previous provider, or that your care isn't being appropriately managed, you have the right to file a quality-of-care complaint to the QIO, a quality-of-care grievance to our plan, or both. (Go to Chapter 7)

Section 2.4 How to get care from out-of-network providers

If you need medical care that Medicare requires our plan to cover, and you are unable to get the care through an in-network provider, you can get this care through an out-of-network provider. You must get authorization from the plan prior to seeking care from an out-of-network provider. In this situation, you will pay the same as you would pay if you got the care from a network provider. Contact Member Services if you need assistance in getting the plan's authorization to see an out-of-network provider (phone numbers are printed on the back cover of this booklet).

SECTION 3 How to get services in an emergency, disaster, or urgent need for care

Section 3.1 Get care if you have a medical emergency

A **medical emergency** is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you're a pregnant woman, loss of an unborn child), loss of a limb or function of a limb, or loss of or serious impairment to a bodily function. The medical symptoms may be an illness, injury, severe pain, or a medical condition that's quickly getting worse.

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You don't need to get approval or a referral first from your PCP. You don't need to use a network doctor. You can get covered emergency medical care whenever you need it, anywhere in the United States or its territories, and from any provider with an appropriate state license even if they're not part of our network. In addition, your Martin's Point Generations Advantage Alliance (HMO) covers worldwide emergency and urgent care.
- **As soon as possible, make sure our plan has been told about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your

emergency care, usually within 48 hours. Phone numbers for Member Services are printed on the back cover of this booklet and on the back of your plan membership card.

Covered services in a medical emergency

Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. We also cover medical services during the emergency.

The doctors giving you emergency care will decide when your condition is stable, and when the medical emergency is over.

After the emergency is over, you're entitled to follow-up care to be sure your condition continues to be stable. Your doctors will continue to treat you until your doctors contact us and make plans for additional care. Your follow-up care will be covered by our plan.

If your emergency care is provided by out-of-network providers, we'll try to arrange for network providers to take over your care as soon as your medical condition and the circumstances allow.

What if it wasn't a medical emergency?

Sometimes it can be hard to know if you have a medical emergency. For example, you might go in for emergency care - thinking that your health is in serious danger - and the doctor may say that it wasn't a medical emergency after all. If it turns out that it wasn't an emergency, as long as you reasonably thought your health was in serious danger, we'll cover your care.

However, after the doctor says it wasn't an emergency, we'll cover additional care only if you get the additional care in one of these 2 ways:

- You go to a network provider to get the additional care.
- The additional care you get is considered urgently needed services and you follow the rules below for getting this urgent care.

Section 3.2 Get care when you have an urgent need for services

A service that requires immediate medical attention (but isn't an emergency) is an urgently needed service if you're either temporarily outside our plan's service area, or if it's unreasonable given your time, place, and circumstances to get this service from network providers. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. However, medically necessary routine provider visits such as annual checkups, aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable.

Urgent Care providers can respond quickly to a variety of non-life or limb threatening illnesses and injuries if your PCP office is closed. A list of in-network urgent care centers is available online through our Urgent Care Directory. For more information, please contact Member Services. You may also access

urgent care services at out-of-network urgent care centers, which offer medical care without an appointment and are not operated as a department of a hospital. For non-emergency care, our plan also provides a 24-hour nurse line to members. You can contact a Registered Nurse 24 hours a day, 7 days a week, for answers to any health questions. To reach our nurse line, call 1-800-530-1021 (TTY: 711). Our plan covers worldwide emergency and urgent care services outside the United States under the following circumstances:

- Martin's Point Generations Advantage covers urgent care. Urgently needed services are non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible. The unforeseen condition could, for example, be an unforeseen flare-up of a known condition that you have. Please see Chapter 4 Medical Benefits Chart for more information.
- Martin's Point Generations Advantage (MPGA) provides coverage for worldwide emergency care. Emergency Services are inpatient or outpatient hospital services that are necessary to prevent the death or serious impairment to an individual's health and that, because of the threat to life or health, necessitate the use of the most accessible hospital available and equipped to furnish the services. A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse. Out-of-country emergency care, including inpatient and outpatient services, is covered for stabilization only. Please see Chapter 4 Medical Benefits Chart for more information.

Section 3.3 Get care during a disaster

If the Governor of your state, the U.S. Secretary of Health and Human Services, or the President of the United States declares a state of disaster or emergency in your geographic area, you're still entitled to care from our plan.

Visit MartinsPoint.org/MedicareMembers for information on how to get needed care during a disaster.

If you can't use a network provider during a disaster, our plan will allow you to get care from out-of-network providers at in-network cost sharing.

SECTION 4 What if you're billed directly for the full cost of covered services?

If you paid more than our plan cost-sharing for covered services, or if you got a bill for the full cost of covered medical services, you can ask us to pay our share of the cost of covered services. Go to Chapter 5 for information about what to do.

Section 4.1 If services aren’t covered by our plan, you must pay the full cost

Martin's Point Generations Advantage Alliance (HMO) covers all medically necessary services as listed in the Medical Benefits Chart in Chapter 4. If you get services that aren’t covered by our plan or you get services out-of-network without authorization, you’re responsible for paying the full cost of services.

For covered services that have a benefit limitation, you also pay the full cost of any services you get after you use up your benefit for that type of covered service. The cost you pay after reaching the benefit limit for the service does not count toward your out-of-pocket maximum.

SECTION 5 Medical services in a clinical research study

Section 5.1 What is a clinical research study

A clinical research study (also called a *clinical trial*) is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. Certain clinical research studies are approved by Medicare. Clinical research studies approved by Medicare typically ask for volunteers to participate in the study. When you’re in a clinical research study, you can stay enrolled in our plan and continue to get the rest of your care (care that’s not related to the study) through our plan.

If you participate in a Medicare-approved study, Original Medicare pays most of the costs for covered services you get as part of the study. If you tell us you’re in a qualified clinical trial, then you’re only responsible for the in-network cost-sharing for the services in that trial. If you paid more—for example, if you already paid the Original Medicare cost sharing amount—we’ll reimburse the difference between what you paid and the in-network cost sharing. You’ll need to provide documentation to show us how much you paid.

If you want to participate in any Medicare-approved clinical research study, you don’t need to tell us or get approval from us or your PCP. The providers that deliver your care as part of the clinical research study don’t need to be part of our plan’s network. (This doesn’t apply to covered benefits that include require a clinical trial or registry to assess the benefit, including certain benefits requiring coverage with evidence development (NCDs-CED) and investigational exemption device (IDE) studies. These benefits may also be subject to prior authorization and other plan rules.)

While you don’t need our plan’s permission to be in a clinical research study, we encourage you to notify us in advance when you choose to participate in Medicare-qualified clinical trials.

If you participate in a study not approved by Medicare, you’ll be responsible for paying all costs for your participation in the study.

Section 5.2 Who pays for services in a clinical research study

Once you join a Medicare-approved clinical research study, Original Medicare covers the routine items and services you get as part of the study, including:

- Room and board for a hospital stay that Medicare would pay for even if you weren't in a study.
- An operation or other medical procedure if it's part of the research study.
- Treatment of side effects and complications of the new care.

After Medicare pays its share of the cost for these services, our plan will pay the difference between the cost sharing in Original Medicare and your in-network cost sharing as a member of our plan. This means you'll pay the same amount for services you get as part of the study as you would if you got these services from our plan. However, you must submit documentation showing how much cost-sharing you paid. Go to Chapter 5 for more information on submitting requests for payments.

> *Example of cost sharing in a clinical trial:* Let's say you have a lab test that costs $100 as part of the research study. Your share of the costs for this test is $20 under Original Medicare, but the test would be $10 under our plan. In this case, Original Medicare would pay $80 for the test, and you would pay the $20 copay required under Original Medicare. You would notify our plan that you got a qualified clinical trial service and submit documentation, (like a provider bill) to our plan. Our plan would then directly pay you $10. This makes your net payment for the test $10, the same amount you pay under our plan's benefits.

When you're in a clinical research study, **neither Medicare nor our plan will pay for any of the following**:

- Generally, Medicare won't pay for the new item or service the study is testing unless Medicare would cover the item or service even if you weren't in a study.
- Items or services provided only to collect data and not used in your direct health care. For example, Medicare won't pay for monthly CT scans done as part of a study if your medical condition would normally require only one CT scan.
- Items and services provided by the research sponsors free-of-charge for people in the trial.

Get more information about joining a clinical research study

Get more information about joining a clinical research study in the Medicare publication Medicare and Clinical Research Studies available at www.Medicare.gov/sites/default/files/2019-09/02226-medicare-and-clinical-research-studies.pdf. You can also call 1-800-MEDICARE (1-800-633-4227) TTY users call 1-877-486-2048.

SECTION 6 Rules for getting care in a religious non-medical health care institution

Section 6.1 A religious non-medical health care institution

A religious non-medical health care institution is a facility that provides care for a condition that would ordinarily be treated in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against a member's religious beliefs, we'll instead cover care in a religious non-medical health care institution. This benefit is provided only for Part A inpatient services (non-medical health care services).

Section 6.2 How to get care from a religious non-medical health care institution

To get care from a religious non-medical health care institution, you must sign a legal document that says you're conscientiously opposed to getting medical treatment that is **non-excepted**.

- **Non-excepted** medical care or treatment is any medical care or treatment that's *voluntary* and *not required* by any federal, state, or local law.
- **Excepted** medical treatment is medical care or treatment you get that's *not* voluntary or *is required* under federal, state, or local law.

To be covered by our plan, the care you get from a religious non-medical health care institution must meet the following conditions:

- The facility providing the care must be certified by Medicare.
- Our plan only covers *non-religious* aspects of care.
- If you get services from this institution provided to you in a facility, the following conditions apply:
    - You must have a medical condition that would allow you to get covered services for inpatient hospital care or skilled nursing facility care;
    - – and – You must get approval in advance from our plan before you're admitted to the facility, or your stay won't be covered.

Medicare Inpatient Hospital coverage limits do not apply. Please see the Medical Benefits Chart in Chapter 4 for inpatient and home health services coverage.

SECTION 7 Rules for ownership of durable medical equipment

Section 7.1 You won’t own some durable medical equipment after making a certain number of payments under our plan

Durable medical equipment (DME) includes items like oxygen equipment and supplies, wheelchairs, walkers, powered mattress systems, crutches, diabetic supplies, speech generating devices, IV infusion pumps, nebulizers, and hospital beds ordered by a provider for members to use in the home. The member always owns some DME items, like prosthetics. Other types of DME you must rent.

In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 months. **As a member of** Martin's Point Generations Advantage Alliance (HMO)**, however, you usually won’t get ownership of rented DME items no matter how many copayments you make for the item while a member of our plan**. You won’t get ownership even if you made up to 12 consecutive payments for the DME item under Original Medicare before you joined our plan. Under some limited circumstances, we’ll transfer ownership of the DME item to you. Call Member Services at 1-866-544-7504 (TTY users call 711) for more information.

What happens to payments you made for durable medical equipment if you switch to Original Medicare?

If you didn’t get ownership of the DME item while in our plan, you’ll have to make 13 new consecutive payments after you switch to Original Medicare to own the DME item. The payments you made while enrolled in our plan don’t count towards these 13 payments.

Example 1: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. The payments you made in Original Medicare don’t count.

Example 2: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. You didn’t get ownership of the item while in our plan. You then go back to Original Medicare. You’ll have to make 13 consecutive new payments to own the item once you rejoin Original Medicare. Any payments you already made (whether to our plan or to Original Medicare) don’t count.

Section 7.2 Rules for oxygen equipment, supplies and maintenance

If you qualify for Medicare oxygen equipment coverage, Martin's Point Generations Advantage Alliance (HMO) will cover:

- Rental of oxygen equipment
- Delivery of oxygen and oxygen contents
- Tubing and related oxygen accessories for the delivery of oxygen and oxygen contents
- Maintenance and repairs of oxygen equipment

If you leave Martin's Point Generations Advantage Alliance (HMO) or no longer medically require oxygen equipment, the oxygen equipment must be returned.

What happens if you leave our plan and return to Original Medicare?

Original Medicare requires an oxygen supplier to provide you services for 5 years. During the first 36 months, you rent the equipment. For the remaining 24 months, the supplier provides the equipment and maintenance (you’re still responsible for the copayment for oxygen). After 5 years, you can choose to stay with the same company or go to another company. At this point, the 5-year cycle starts over again, even if you stay with the same company, and you’re again required to pay copayments for the first 36 months. If you join or leave our plan, the 5-year cycle starts over.

CHAPTER 4:

Medical Benefits Chart (what's covered and what you pay)

SECTION 1 Understanding your out-of-pocket costs for covered services

The Medical Benefits Chart lists your covered services and shows how much you pay for each covered service as a member of Martin's Point Generations Advantage Alliance (HMO). This section also gives information about medical services that aren't covered and explains limits on certain services.

Section 1.1 Out-of-pocket costs you may pay for covered services

Out-of-pocket costs you may pay for covered services include:

- **Copayment:** the fixed amount you pay each time you get certain medical services. You pay a copayment at the time you get the medical service. (The Medical Benefits Chart in tells you more about your copayments.)
- **Coinsurance:** the percentage you pay of the total cost of certain medical services. You pay a coinsurance at the time you get the medical service. (The Medical Benefits Chart tells you more about your coinsurance.)

Most people who qualify for Medicaid or for the Qualified Medicare Beneficiary (QMB) program don't pay deductibles, copayments or coinsurance. If you're in one of these programs, be sure to show your proof of Medicaid or QMB eligibility to your provider.

Section 1.2 What's the most you'll pay for covered medical services?

Medicare Advantage Plans have limits on the total amount you have to pay out of pocket each year for in-network medical services covered by our plan. This limit is called the maximum out-of-pocket (MOOP) amount for medical services. **For calendar year 2026 the MOOP amount is $5,000.**

The amounts you pay for copayments and coinsurance for in-network covered services count toward this maximum out-of-pocket amount. If you reach the maximum out-of-pocket amount of $5,000, you won't have to pay any out-of-pocket costs for the rest of the year for in-network covered services. However, you must continue to pay the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Section 1.3 Providers aren't allowed to balance bill you

As a member of Martin's Point Generations Advantage Alliance (HMO), you have an important protection because you only have to pay your cost-sharing amount when you get services covered by our plan. Providers can't bill you for additional separate charges, called **balance billing.** This protection applies even if we pay the provider less than the provider charges for a service, and even if there's a dispute and we don't pay certain provider charges.

Here's how protection from balance billing works:

- If your cost sharing is a copayment (a set amount of dollars, for example, $15.00), you pay only that amount for any covered services from a network provider.
- If your cost sharing is a coinsurance (a percentage of the total charges), you never pay more than that percentage. However, your cost depends on which type of provider you see:
  - If you get covered services from a network provider, you pay the coinsurance percentage multiplied by our plan's reimbursement rate (this is set in the contract between the provider and our plan).
  - If you get covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers. (Our plan covers services from out-of-network providers only in certain situations, such as when you get a referral or for emergencies or urgently needed services.)
  - If you get the covered services from an out-of-network provider who doesn't participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers. (Our plan covers services from out-of-network providers only in certain situations, such as when you get a referral, or for emergencies or for urgently needed services outside the service area.)
- If you think a provider has balance billed you, call Member Services at 1-866-544-7504 (TTY users call (711).

SECTION 2 The Medical Benefits Chart shows your medical benefits and costs

The Medical Benefits Chart on the next pages lists the services Martin's Point Generations Advantage Alliance (HMO) covers and what you pay out-of-pocket for each service. The services listed in the Medical Benefits Chart are covered only when these are met:

- Your Medicare-covered services must be provided according to the Medicare coverage guidelines.

- Your services (including medical care, services, supplies, equipment, and Part B drugs) *must* be medically necessary. Medically necessary means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- For new enrollees, your MA coordinated care plan must provide a minimum 90-day transition period, during which time the new MA plan can't require prior authorization for any active course of treatment, even if the course of treatment was for a service that commenced with an out-of-network provider
- You get your care from a network provider. In most cases, care you get from an out-of-network provider wont be covered, unless it's emergency or urgent care, or unless our plan or a network provider gave you a referral. This means you pay the provider in full out-of-network for services you get.
- You have a primary care provider (a PCP) providing and overseeing your care. In most situations, your PCP must give you approval in advance (a referral) before you can see other providers in our plan's network.
- Some services listed in the Medical Benefits Chart are covered *only* if your doctor or other network provider gets approval from us in advance (sometimes called prior authorization). Covered services that need approval in advance are marked in the Medical Benefits Chart in italics.
- If your coordinated care plan provides approval of a prior authorization request for a course of treatment, the approval must be valid for as long as medically reasonable and necessary to avoid disruptions in care in accordance with applicable coverage criteria, your medical history, and the treating provider's recommendation.

Other important things to know about our coverage:

- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay *more* in our plan than you would in Original Medicare. For others, you pay *less*. (To learn more about the coverage and costs of Original Medicare, go to your *Medicare & You 2026* handbook. View it online at www.Medicare.gov or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227) TTY users call 1-877-486-2048.)
- For preventive services covered at no cost under Original Medicare, we also cover those services at no cost to you. However, if you're also treated or monitored for an existing medical condition during the visit when you get the preventive service, a copayment will apply for the care you got for the existing medical condition.
- If Medicare adds coverage for any new services during 2026, either Medicare or our plan will cover those services.

 This apple shows preventive services in the Medical Benefits Chart.

Medical Benefits Chart

Covered Service	What you pay
Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. Our plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.
Acupuncture for chronic low back pain Covered services include: Up to 12 visits in 90 days are covered under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as: • Lasting 12 weeks or longer; • nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious disease, etc.); • not associated with surgery; and • not associated with pregnancy. An additional 8 sessions will be covered for patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing. **Provider Requirements:** Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act)) may furnish acupuncture in accordance with applicable state requirements. Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa) (5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have: • a master's or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the	$0 copayment for each Primary Care Physician (PCP) office visit for Medicare-covered services. $15 copayment for each specialist office visit for Medicare-covered services. You pay these amounts until you reach the out-of-pocket maximum.

Covered Service	What you pay
Acupuncture for chronic low back pain - continued Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and, • a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e., Puerto Rico) of the United States, or District of Columbia. Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations at 42 CFR §§ 410.26 and 410.27.	
Alternative therapies The plan will reimburse members for certain services not covered by Original Medicare. *Please contact our plan for more details.	**See Wellness Wallet**
Ambulance services Covered ambulance services, whether for an emergency or non-emergency situation, include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care if they're furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by our plan. If the covered ambulance services aren't for an emergency situation, it should be documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required.	$325 copayment for each Medicare-covered Ground Ambulance service. You pay these amounts until you reach the out-of-pocket maximum. *Prior authorization may be required.* $325 copayment for each Medicare-covered Air Ambulance service. You pay these amounts until you reach the out-of-pocket maximum. *Prior authorization may be required.*
Annual routine physical exam Annual Routine Physical Exam includes comprehensive physical examination and evaluation of status of chronic diseases. Doesn't	$0 copayment*

Covered Service	What you pay
Annual routine physical exam - continued include lab tests, radiological diagnostic tests or non-radiological diagnostic tests or diagnostic tests. Additional cost share may apply to any lab or diagnostic testing performed during your visit, as described for each separate service in this Medical Benefits Chart. Annual Routine Physical Exam is limited to one each year. *Please contact our plan for more details.	
Annual wellness visit If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months. **Note**: Your first annual wellness visit can't take place within 12 months of your *Welcome to Medicare* preventive visit. However, you don't need to have had a *Welcome to Medicare* visit to be covered for annual wellness visits after you've had Part B for 12 months.	There is no coinsurance, copayment, or deductible for the annual wellness visit.
Bone mass measurement For qualified people (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.
Breast cancer screening (mammograms) Covered services include: • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for women aged 40 and older	There is no coinsurance, copayment, or deductible for covered screening mammograms.

Covered Service	What you pay
Breast cancer screening (mammograms) - continued • Clinical breast exams once every 24 months	
Cardiac rehabilitation services Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. Our plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.	$0 copayment for each Medicare-covered service. $0 copayment for each Medicare-covered service. *Prior Authorization is required.*
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.	There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.
Cardiovascular disease screening tests Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).	There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years.

Covered Service	What you pay
Cervical and vaginal cancer screening Covered services include: • For all women: Pap tests and pelvic exams are covered once every 24 months • If you're at high risk of cervical or vaginal cancer or you're of childbearing age and have had an abnormal Pap test within the past 3 years: one Pap test every 12 months	There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.
Chiropractic services Covered services include: • Manual manipulation of the spine to correct subluxation **Routine chiropractic care** Unlimited visits every year *Please contact our plan for more details.	$5 copayment for each Medicare-covered service. You pay these amounts until you reach the out-of-pocket maximum. $20 copayment*
Colorectal cancer screening The following screening tests are covered: • Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who aren't at high risk for colorectal cancer, and once every 24 months for high-risk patients after a previous screening colonoscopy. • Computed tomography colonography for patients 45 year and older who are not at high risk of colorectal cancer and is covered when at least 59 months have passed following the month in which the last screening computed tomography colonography was performed or 47 months have passed following the month in which the last	There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam, excluding barium enemas, for which coinsurance applies. If your doctor finds and removes a polyp or other tissue during the colonoscopy or flexible sigmoidoscopy, the screening exam becomes a diagnostic exam.

Covered Service	What you pay
Colorectal cancer screening - continued screening flexible sigmoidoscopy or screening colonoscopy was performed. For patients at high risk for colorectal cancer, payment may be made for a screening computed tomography colonography performed after at least 23 months have passed following the month in which the last screening computed tomography colonography or the last screening colonoscopy was performed. • Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient got a screening colonoscopy. Once every 48 months for high-risk patients from the last flexible sigmoidoscopy or computed tomography colonography. • Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months. • Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years.	
• Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare-covered non-invasive stool-based colorectal cancer screening test returns a positive result. • Colorectal cancer screening tests include a planned screening flexible sigmoidoscopy or screening colonoscopy that involves the removal of tissue or other matter, or other procedure furnished in connection with, as a result of, and in the same clinical encounter as the screening test.	If a screening colonoscopy results in biopsy or removal of any growth during the procedure, the member cost share for outpatient surgery will not be applied. If your FIT test, gFOBT, or DNA test is positive, your following colonoscopy (within 1 year) will be considered a screening colonoscopy ($0 copay). For information about diagnostic colonoscopies, please see "Outpatient hospital services."

Covered Service	What you pay
Counseling services *Please contact our plan for more details.	$0 copayment*
Dental services In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) aren't covered by Original Medicare. However, Medicare pays for dental services in a limited number of circumstances, specifically when that service is an integral part of specific treatment of a person's primary medical condition. Examples include reconstruction of the jaw after a fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams prior to organ transplantation. In addition, we cover: Medicare-covered dental services (non-routine dental care required to treat illness or injury) in-and out-of-network.	$0 copayment for each Medicare-covered service.
In addition to the Medicare-covered dental services, we cover the following preventive and comprehensive dental services:	**There is a $2,500 benefit maximum for preventive and comprehensive dental services.**
Category A: Diagnostic/Preventive Evaluations once per calendar year; this includes periodic, limited, problem-focused, and comprehensive evaluations. • X-rays (comprehensive series or panoramic film) once in a 5-calendar year period. • Bitewing x-rays once in a calendar year. • X-rays of individual teeth as necessary. • Two routine cleanings in a calendar year.	$0 copay when seeing a Delta Dental provider*

Covered Service	What you pay
Dental services - continued	
Category B: Basic Restorative • Restorative: Amalgam (silver) fillings; • Resin restorations on anterior teeth, posterior teeth, and the buccal surface of bicuspids only. • Oral Surgery: surgical and routine extractions. • Endodontics: Root canal therapy. • Periodontics: Treatment of gum disease, clinical crown lengthening once per tooth per lifetime. • Denture repair: repair of a removable denture to its original condition. • Emergency Palliative treatment. • Brush biopsy once in a calendar year.	20% coinsurance when seeing a Delta Dental provider*
Category C: Major Restorative • Removable and fixed partial dentures (bridge). • Rebase and reline (denture), crowns. • Onlays and implants.	50% coinsurance when seeing a Delta Dental provider*
*The plan is unable to pay for Medicare covered services provided by a Northeast Delta Dental provider who has opted-out of Medicare. If you have questions about what may be covered, please contact Northeast Delta Dental at 1-800- 832-5700 (TTY 1-800-332-5905).	Cleanings are limited to two per calendar year; you may choose cleanings from Coverage A (preventive/routine) and/or Coverage B (periodontal). Office visit copays and coinsurances apply. Additional costs may apply for resin filling.

Covered Service	What you pay
Dental services - continued	
Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.	There is no coinsurance, copayment, or deductible for an annual depression screening visit.
Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of these risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. You may be eligible for up to 2 diabetes screenings every 12 months following the date of your most recent diabetes screening test.	There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes screening tests.
Diabetes self-management training, diabetic services, and supplies For all people who have diabetes (insulin and non-insulin users). Covered services include: • Supplies to monitor your blood glucose: blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors.	$0 copayment for each Medicare-covered service.

Covered Service	What you pay
Diabetes self-management training, diabetic services, and supplies - continued	
• For people with diabetes who have severe diabetic foot disease: one pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and 2 additional pairs of inserts, or one pair of depth shoes and 3 pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting.	$0 copayment for each Medicare-covered service.
• Diabetes self-management training is covered under certain conditions.	$0 copayment for each Medicare-covered service.
Durable medical equipment (DME) and related supplies (For a definition of durable medical equipment, go to Chapter 10 and Chapter 3) Covered items include, but aren't limited to, wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers.	10% coinsurance for each Medicare-covered service. You pay these amounts until you reach the out-of-pocket maximum. Your cost sharing for Medicare oxygen equipment coverage is % coinsurance every month. After 36 months, your cost sharing will be $0 for the 24 months following. If you are still enrolled in the plan after 5 years, your original cost sharing would apply. If prior to enrolling in Martin's Point Generations Advantage Alliance (HMO) you had made 36 months of rental payment for oxygen equipment coverage, your cost sharing in Martin's Point Generations Advantage Alliance (HMO) is % coinsurance for each Medicare-overed service.

Covered Service	What you pay
Durable medical equipment (DME) and related supplies - continued We cover all medically necessary DME covered by Original Medicare. If our supplier in your area doesn't carry a particular brand or manufacturer, you can ask them if they can special order it for you. The most recent list of suppliers is available on our website at www.martinspoint.org/medicaremembers.	Your cost sharing for Medicare oxygen equipment coverage is % coinsurance every month. After 36 months, your cost sharing will be $0 for the 24 months following. If you are still enrolled in the plan after 5 years, your original cost sharing would apply. If prior to enrolling in Martin's Point Generations Advantage Alliance (HMO) you had made 36 months of rental payment for oxygen equipment coverage, your cost sharing in Martin's Point Generations Advantage Alliance (HMO) is % coinsurance for each Medicare-overed service.
Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition. A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you're a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that's quickly getting worse. Cost sharing for necessary emergency services you get out-of-network is the same as when you get these services in-network.	$125 copayment for each Medicare-covered service. You pay these amounts until you reach the out-of-pocket maximum. Copayment is waived if you are admitted to a hospital within 24 hours. If you get emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must move to a network hospital in order for your care to continue to be covered.

Covered Service	What you pay
Emergency care - continued	
Worldwide emergency coverage You are covered for emergency care worldwide. A $25,000 annual maximum amount applies for ambulance transportation, urgent care, and emergency services received outside of the U.S. This limit does not apply to services in the U.S. *Please contact our plan for more details.	$125 copayment You pay these amounts until you reach the out-of-pocket maximum. Copayment is waived if you are admitted to a hospital.
Worldwide emergency transportation You are covered for emergency transportation worldwide. A $25,000 annual maximum amount applies for ambulance transportation, urgent care, and emergency services received outside of the U.S. This limit does not apply to services in the U.S. *Please contact our plan for more details.	$325 copayment You pay these amounts until you reach the out-of-pocket maximum.
Worldwide urgent care coverage Worldwide coverage for 'urgently needed services' when medical services are needed right away because of an illness, injury, or condition that you did not expect or anticipate, and you can't wait until you are back in our plan's service area to obtain services. A $25,000 annual maximum amount applies for ambulance transportation, urgent care, and emergency services received outside of the U.S. This limit does not apply to services in the U.S.*Please contact our plan for more details.	$125 copayment You pay these amounts until you reach the out-of-pocket maximum. Copayment is waived if you are admitted to a hospital.
Health and wellness education programs The plan will reimburse members for certain services not covered by Original Medicare.	See **Wellness Wallet**

Covered Service	What you pay
Hearing services	
Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when you get them from a physician, audiologist, or other qualified provider.	$5 copayment for each Medicare-covered service. You pay these amounts until you reach the out-of-pocket maximum.
Hearing aids In order to use this benefit, you must receive a formal referral from Amplifon to a participating provider. Please call Amplifon, 8 am–8 pm, Monday through Friday to get started: 1-888-669- 2167 (TTY: 711).	**In-Network** There is a $1,400 benefit maximum ($700 per ear, per year).
Amplifon will assist you with locating a nearby participating provider and schedule your initial appointment.	Hearing aid devices are limited to the devices available through the Amplifon program. You receive two years of free hearing aid batteries in conjunction with your hearing aid benefit. There is a limit of 2 hearing aids per year, 1 per ear. Services must be received from an Amplifon provider.
Hearing aid fittings and evaluations	You pay $0 copayment for 1 year of hearing aid fittings and ongoing hearing aid evaluations after you receive a hearing aid through the Amplifon program. *Services must be received from an Amplifon provider.*

Covered Service	What you pay
Help with certain chronic conditions For members with a diagnosis of History of Hip Fracture or History of Falls: • Members with a diagnosis of either History of Hip Fracture or History of Falls can be reimbursed up to for bathroom safety devices, assessment, and installation. ○ Covered bathroom safety devices include: shower seats, toilet safety bars, raised toilet seats, grab bars, transfer benches, commodes, bath lifts, bathmats, and handheld shower heads. The benefit also covers installation of devices and an in-home bathroom safety inspection conducted by a qualified health professional (Occupational Therapist or Physical Therapist) to identify the need for safety devices and applicability to the specific enrollee's bathroom. • Members with a diagnosis of either History of Hip Fracture or History of Falls can attend an evidence-based falls prevention program supported by the National Council on Aging (NCOA). ○ 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). Please call Member Services for more information on how to access these benefits: 1-866-544-7504.	You can be reimbursed up to for bathroom safety devices, assessment, and installation. You pay $0 for plan sponsored programs offered either at Martin's Point facilities or in the community through plan community partners. The plan will reimburse up to $50 per year.

Covered Service	What you pay
HIV screening For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover: • One screening exam every 12 months If you are pregnant, we cover: • Up to 3 screening exams during a pregnancy	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.
Home and bathroom safety devices and modifications *Please contact our plan for more details.	$0 copayment*
Home health agency care Before you get home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but aren't limited to: • Part-time or intermittent skilled nursing and home health aide services (to be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies	$0 copayment for each Medicare-covered service.
Home infusion therapy Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to a person at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for	$0 copayment for the administration of the drugs listed in the home setting.

Covered Service	What you pay
Home infusion therapy - continued	
example, a pump), and supplies (for example, tubing and catheters). Covered services include, but aren't limited to: • Professional services, including nursing services, furnished in accordance with our plan of care • Patient training and education not otherwise covered under the durable medical equipment benefit • Remote monitoring • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier In addition to Medicare-covered home infusion services, we cover the following home infusion services for non-homebound members: • Administration of Anti-fungal Part B drugs • Administration of Anti-viral Part B drugs • Administration of Anti-bacterial Part B drugs	Part B drug cost sharing applies. See Medicare Part B Prescription drugs. Home infusion equipment and supplies are covered under your Durable Medical Equipment (DME) benefit. Please see the DME row for cost-sharing information. Home infusion drugs are covered under your Medicare Part B Drugs benefit. Please see the Medicare Part B Drugs row for cost-sharing information.
Hospice care	
You're eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. You can get care from any Medicare-certified hospice program. Our plan is obligated to help you find Medicare-certified hospice programs in our plan's service area, including programs we own, control, or have a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: • Drugs for symptom control and pain relief • Short-term respite care • Home care	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not Martin's Point Generations Advantage Alliance (HMO).

Covered Service	What you pay
Hospice care - continued When you're admitted to a hospice, you have the right to stay in our plan; if you stay in our plan you must continue to pay plan premiums. **For hospice services and services covered by Medicare Part A or B that are related to your terminal prognosis:** Original Medicare (rather than our plan) will pay your hospice provider for your hospice services and any Part A and Part B services related to your terminal prognosis. While you're in the hospice program, your hospice provider will bill Original Medicare for the services Original Medicare pays for. You'll be billed Original Medicare cost sharing. **For services covered by Medicare Part A or B not related to your terminal prognosis:** If you need non-emergency, non-urgently needed services covered under Medicare Part A or B that aren't related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network and follow plan rules (like if there's a requirement to get prior authorization). • If you get the covered services from a network provider and follow plan rules for getting service, you pay only our plan cost-sharing amount for in-network services • If you get the covered services from an out-of-network provider, you pay the cost sharing under Original Medicare **For services covered by Martin's Point Generations Advantage Alliance (HMO) but not covered by Medicare Part A or B:** Martin's Point Generations Advantage Alliance (HMO) will continue to cover plan-covered services that aren't covered under Part A or B whether or not they're related to your terminal prognosis. You pay our plan cost-sharing amount for these services. **Note:** If you need non-hospice care (care that's not related to your terminal prognosis), contact us to arrange the services.	

Covered Service	What you pay
Immunizations Covered Medicare Part B services include: • Pneumonia vaccines • Flu/influenza shots (or vaccines), once each flu/influenza season in the fall and winter, with additional flu/influenza shots (or vaccines) if medically necessary • Hepatitis B vaccines if you're at high or intermediate risk of getting Hepatitis B • COVID-19 vaccines • Other vaccines if you're at risk and they meet Medicare Part B coverage rules	There is no coinsurance, copayment, or deductible for the pneumonia, flu/influenza, Hepatitis B, and COVID-19 vaccines.
Inpatient hospital care Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you're formally admitted to the hospital with a doctor's order. The day before you're discharged is your last inpatient day. Covered services include but aren't limited to: • Semi-private room (or a private room if medically necessary) • Meals including special diets • Regular nursing services • Costs of special care units (such as intensive care or coronary care units) • Drugs and medications • Lab tests • X-rays and other radiology services • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs	$350 copayment each day for days 1 to 5 and $0 copayment each day for days 6 to 90 for Medicare-covered hospital care. Medicare hospital benefit periods apply. A benefit period begins on the first day you go to a Medicare-covered inpatient hospital or a skilled nursing facility. The benefit period ends when you haven't been an inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital (or SNF) after one benefit period has ended, a new benefit period begins. There is no limit to the number

Covered Service	What you pay
Inpatient hospital care - continued • Physical, occupational, and speech language therapy • Inpatient substance abuse services • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we'll arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you're a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If Martin's Point Generations Advantage Alliance (HMO) provides transplant services at a location outside the pattern of care for transplants in your community and you choose to get transplants at this distant location, we'll arrange or pay for appropriate lodging and transportation costs for you and a companion. • Blood - including storage and administration. Coverage of whole blood and packed red cells starts only with the fourth pint of blood you need. You must either pay the costs for the first 3 pints of blood you get in a calendar year or have the blood donated by you or someone else. All other components of blood are covered starting with the first pint • Physician services **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you're not sure if you're an inpatient or an *outpatient*, ask the hospital staff. Get more information in the Medicare fact sheet *Medicare Hospital Benefits*. This fact sheet is available on the Web at www.Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.	of benefit periods you can have. Cost shares are applied starting on the first day of admission and do not include the day of discharge. You pay these amounts until you reach the out-of-pocket maximum. *Prior Authorization is required.* If you get inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost sharing you would pay at a network hospital. Outpatient observation cost-sharing is explained in Outpatient Hospital Observation.

Covered Service	What you pay
Inpatient services in a psychiatric hospital	
Covered services include mental health care services that require a hospital stay. There is a 190-day lifetime limit for inpatient services in a psychiatric hospital. The 190-day limit doesn't apply to inpatient mental health services provided in a psychiatric unit of a general hospital. Inpatient substance use disorder services	$220 copayment each day for days 1 to 7 and $0 copayment each day for days 8 to 90 for Medicare-covered hospital care. $0 copayment for an additional 60 lifetime reserve days. Medicare hospital benefit periods apply. A benefit period begins on the first day you go to a Medicare-covered inpatient hospital or a skilled nursing facility. The benefit period ends when you haven't been an inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital (or SNF) after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have. Cost shares are applied starting on the first day of admission and do not include the day of discharge. You pay these amounts until you reach the out-of-pocket maximum. *Prior Authorization is required.*

Covered Service	What you pay
Inpatient stay: Covered services you get in a hospital or SNF during a non-covered inpatient stay	
If you've used up your inpatient benefits or if the inpatient stay isn't reasonable and necessary, we won't cover your inpatient stay. In some cases, we'll cover certain services you get while you're in the hospital or the skilled nursing facility (SNF). Covered services include, but aren't limited to:	When your stay is no longer covered, these services will be covered as described in the following sections:
• Physician services	Please refer to Physician/Practitioner Services, Including Doctor's Office Visits.
• Diagnostic tests (like lab tests)	Please refer to Outpatient Diagnostic Tests and Therapeutic Services and Supplies.
• X-ray, radium, and isotope therapy including technician materials and services	Please refer to Outpatient Diagnostic Tests and Therapeutic Services and Supplies.
• Surgical dressings	Please refer below to Outpatient Diagnostic Tests and Therapeutic Services and Supplies.
• Splints, casts, and other devices used to reduce fractures and dislocations	Please refer to Outpatient Diagnostic Tests and Therapeutic Services and Supplies.

Covered Service	What you pay
Inpatient stay: Covered services you get in a hospital or SNF during a non-covered inpatient stay - continued	
• Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices	Please refer to Prosthetic Devices and Related Supplies.
• Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition	Please refer to Prosthetic Devices and Related Supplies.
• Physical therapy, speech therapy, and occupational therapy	Please refer below to Outpatient Rehabilitation Services.
Meal benefit Meals may be offered as a supplemental benefit to address the following types of circumstances: immediately following surgery or inpatient hospitalization or for a chronic illness.*Please contact our plan for more details.	$0 copayment* *Referral is required.* *Prior Authorization is required.*
Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor. We cover 3 hours of one-on-one counseling services during the first year you get medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to get more hours of treatment with a physician's order. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year.	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.

Covered Service	What you pay
Medicare Diabetes Prevention Program (MDPP)	
MDPP services are covered for eligible people under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.	There is no coinsurance, copayment, or deductible for the MDPP benefit.
Medicare Part B drugs	
These drugs are covered under Part B of Original Medicare. Members of our plan get coverage for these drugs through our plan. Covered drugs include: • Drugs that usually aren't self-administered by the patient and are injected or infused while you get physician, hospital outpatient, or ambulatory surgical center services • Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) • Other drugs you take using durable medical equipment (such as nebulizers) that were authorized by our plan • The Alzheimer's drug, Leqembi® (generic name lecanemab), which is administered intravenously. In addition to medication costs, you may need additional scans and tests before and/or during treatment that could add to your overall costs. Talk to your doctor about what scans and tests you may need as part of your treatment. • Clotting factors you give yourself by injection if you have hemophilia • Transplant/immunosuppressive drugs: Medicare covers transplant drug therapy if Medicare paid for your organ transplant. You must have Part A at the time of the covered transplant, and you must have Part B at the time you get immunosuppressive drugs. Medicare Part D drug coverage covers immunosuppressive drugs if Part B doesn't cover them	**Medicare Part B Insulin Drugs** You pay 20% of the cost of Medicare-covered services. You will pay no more than $35 for a one-month supply of Part B insulin products covered by our plan. You pay these amounts until you reach the out-of-pocket maximum. **Other Medicare Part B Drugs** 0% - 20% coinsurance depending on the Medicare-covered service. You pay these amounts until you reach the out-of-pocket maximum. *Prior Authorization is required.*

Covered Service	What you pay
• Injectable osteoporosis drugs, if you're homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and can't self-administer the drug • Some antigens: Medicare covers antigens if a doctor prepares them and a properly instructed person (who could be you, the patient) gives them under appropriate supervision • Certain oral anti-cancer drugs: Medicare covers some oral cancer drugs you take by mouth if the same drug is available in injectable form or the drug is a prodrug (an oral form of a drug that, when ingested, breaks down into the same active ingredient found in the injectable drug) of the injectable drug. As new oral cancer drugs become available, Part B may cover them. If Part B doesn't cover them, Part D does. • Oral anti-nausea drugs: Medicare covers oral anti-nausea drugs you use as part of an anti-cancer chemotherapeutic regimen if they're administered before, at, or within 48 hours of chemotherapy or are used as a full therapeutic replacement for an intravenous anti-nausea drug • Certain oral End-Stage Renal Disease (ESRD) drugs covered under Medicare Part B • Calcimimetic and phosphate binder medications under the ESRD payment system, including the intravenous medication Parsabiv® and the oral medication Sensipar® • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary and topical anesthetics • Erythropoiesis-stimulating agents: Medicare covers erythropoietin by injection if you have End-Stage Renal Disease (ESRD) or you need this drug to treat anemia related to certain other conditions. (such as Epogen®, Procrit®, Retacrit®, Epoetin Alfa, Aranesp®, Darbepoetin or Alfa)	**Medicare Part B Chemotherapy/Radiation Drugs** 0% - 20% coinsurance depending on the Medicare-covered service. You pay these amounts until you reach the out-of-pocket maximum. *Prior Authorization is required.* Certain Part B drugs my be subject to step therapy and/or prior authorization requirements. *Services may require that your provider get prior authorization (approval in advance). Please have your provider contact the plan for more details.

Covered Service	What you pay
• Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases • Parenteral and enteral nutrition (intravenous and tube feeding) This link will take you to a list of Part B drugs that may be subject to Step Therapy: www.martinspoint.org/For-Members-and-Patient/For-Medicare-Advantage-Members We also cover some vaccines under our Part B prescription drug benefit.	
Nursing hotline Nursing hotline services are available, 24 hours a day, seven days a week. If you have questions about symptoms you're experiencing but aren't sure if you need to see your doctor, speak to a registered nurse (RN) about your medical concerns. *Please contact our plan for more details.	$0 copayment*
Obesity screening and therapy to promote sustained weight loss If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.	There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.
Opioid treatment program services Members of our plan with opioid use disorder (OUD) can get coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services: • U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications	$0 copayment for each Medicare-covered service. *Prior Authorization is required.*

Covered Service	What you pay
Opioid treatment program services - continued • Dispensing and administration of MAT medications (if applicable) • Substance use counseling • Individual and group therapy • Toxicology testing • Intake activities • Periodic assessments	
Outpatient diagnostic tests and therapeutic services and supplies Covered services include, but aren't limited to:	
• X-rays	$15 copayment for each Medicare-covered service. You pay these amounts until you reach the out-of-pocket maximum.
• Radiation (radium and isotope) therapy including technician materials and supplies	20% coinsurance for each Medicare-covered service. You pay these amounts until you reach the out-of-pocket maximum.
• Surgical supplies, such as dressings • Splints, casts, and other devices used to reduce fractures and dislocations	20% coinsurance for each Medicare-covered service. You pay these amounts until you reach the out-of-pocket maximum.
• Laboratory tests	$0 copay for COVID-19 viral testing. 20% coinsurance for genetic labs.

Covered Service	What you pay
Outpatient diagnostic tests and therapeutic services and supplies - continued	
	$5 copay for all other lab services (including COVID-19 antibody testing).
• Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood you need - you must either pay the costs for the first 3 pints of blood you get in a calendar year or have the blood donated by you or someone else. All other components of blood are covered beginning with the first pint used	$0 copayment for each Medicare-covered service.
• Diagnostic non-laboratory tests such as CT scans, MRIs, EKGs, and PET scans when your doctor or other health care provider orders them to treat a medical problem.	20% coinsurance for each Medicare-covered service. You pay these amounts until you reach the out-of-pocket maximum.
• Other outpatient diagnostic tests - Non-radiological diagnostic services	0% - 5% coinsurance depending on the Medicare-covered service. You pay these amounts until you reach the out-of-pocket maximum.
• Other outpatient diagnostic tests - Radiological diagnostic services, not including x-rays	20% coinsurance for each Medicare-covered service. You pay these amounts until you reach the out-of-pocket maximum.

Covered Service	What you pay
Outpatient hospital observation Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another person authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you aren't sure if you're an outpatient, ask the hospital staff. Get more information in the Medicare fact sheet *Medicare Hospital Benefits*. This fact sheet is available at www.Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.	$275 copayment per stay for each Medicare-covered service. You pay these amounts until you reach the out-of-pocket maximum.
Outpatient hospital services We cover medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include, but aren't limited to:	
• Services in an emergency department	Please refer to Emergency Care.
• Services performed at an outpatient clinic	Please refer to Physician/Practitioner Services, Including Doctor's Office Visits.

Covered Service	What you pay
Outpatient hospital services - continued	
• Outpatient surgery or observation	Please refer to Outpatient Hospital Observation and Outpatient Surgery, Including Services Provided at Hospital Outpatient Facilities and Ambulatory Surgical Centers.
• Laboratory and diagnostic tests billed by the hospital	Please refer to Outpatient Diagnostic Tests and Therapeutic Services and Supplies.
• Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it	Please refer to Outpatient Mental Health Care.
• X-rays and other radiology services billed by the hospital	Please refer to Outpatient Diagnostic Tests and Therapeutic Services and Supplies.
• Medical supplies such as splints and casts	Please refer to Outpatient Diagnostic Tests and Therapeutic Services and Supplies.
• Certain drugs and biologicals you can't give yourself **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you aren't sure if you're an outpatient, ask the hospital staff.	Please refer to Medicare Part B Prescription Drugs.

Covered Service	What you pay
Outpatient mental health care Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), nurse practitioner (NP), physician assistant (PA), or other Medicare-qualified mental health care professional as allowed under applicable state laws.	
• Services provided by a psychiatrist	$0 copayment for each Medicare-covered Individual Session. *Prior Authorization is required.* $0 copayment for each Medicare-covered Group Session. *Prior Authorization is required.*
• Services provided by other mental health care providers	$0 copayment for each Medicare-covered Individual Session. *Prior Authorization is required.* $0 copayment for each Medicare-covered Group Session. *Prior Authorization is required.*
Outpatient rehabilitation services Covered services include physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).	
• Services provided by a physical therapist or speech language therapist	$0 copayment for each Medicare-covered service. *Referral may be required.*

Covered Service	What you pay
Outpatient rehabilitation services - continued	
• Services provided by an occupational therapist	$0 copayment for each Medicare-covered service. *Referral may be required.*
Outpatient substance use disorder services You are covered for treatment of substance use disorder, as covered by Original Medicare.	$0 copayment for each Medicare-covered Individual Session. *Prior Authorization is required.* $0 copayment for each Medicare-covered Group Session. *Prior Authorization is required.*
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers **Note:** If you're having surgery in a hospital facility, you should check with your provider about whether you'll be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an outpatient.	
• Services provided at an outpatient hospital	$0 copay for services, such as a Hospital Outpatient Clinic Visit, performed in a Hospital Outpatient setting. $275 copayment for surgeries performed in a Hospital Outpatient setting. You pay these amounts until you reach the out-of-pocket maximum. *Prior Authorization is required.*

Covered Service	What you pay
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers - continued	
• Services provided at an ambulatory surgical center	$10 copayment for each Medicare-covered service. You pay these amounts until you reach the out-of-pocket maximum.
Over-the-counter benefit We partner with Over the Counter Health Solutions (OTCHS) to offer this benefit. For a list of designated CVS locations, the catalog detailing eligible OTC items, and instructions on how to place orders through the online portal, please visit www.MartinsPoint.org/PartD. You may also place orders by calling OTCHS at 1-888-628-2770 (TTY: 711). Reimbursement is only applicable in the event that the OTCHS online system, the call center, and enabled stores are all down at the same time. Specific items in the OTC Catalog are designated as dual purpose items. Before purchasing dual purpose items, please speak to your physician to ensure they recommend that item to you for a specific diagnosed condition. The benefit refreshes quarterly. Remaining balances do not carry over to the next quarter. For questions or help placing an order, please call OTC Health Solutions at: 1-888-628-2770 (TTY: 711).	The plan will cover up to $100 per quarter for members to purchase select CVS brand over-the-counter (OTC) products. **Phone/Online purchases:** Total may not exceed $100. In-store purchases: Members are responsible for balances exceeding the $100 allowance (of the qualifying OTC purchase).

Covered Service	What you pay
Over-the-counter benefit - continued	
Partial hospitalization services and Intensive outpatient services *Partial hospitalization* is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center that's more intense than care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office and is an alternative to inpatient hospitalization.	$0 copayment per day for each Medicare-covered service. *Prior Authorization is required.*
Intensive outpatient service is a structured program of active behavioral (mental) health therapy treatment provided in a hospital outpatient department, a community mental health center, a federally qualified health center, or a rural health clinic that's more intense than care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office but less intense than partial hospitalization.	$0 copayment per day for each Medicare-covered service.
Personal emergency response system (PERS) *Please contact our plan for more details.	$0 copayment*
Physician/Practitioner services, including doctor's office visits Covered services include:	

Covered Service	What you pay
Physician/Practitioner services, including doctor's office visits - continued	
• Medically necessary medical care or surgery services you get in a physician's office by a primary care provider	$0 copayment for each Medicare-covered service.
• Medically necessary medical care or surgery services you get in a certified ambulatory surgical center, hospital outpatient department, or any other location	See "Outpatient Surgery" earlier in this chart for any applicable cost share amounts for ambulatory surgical center visits or in a hospital outpatient setting.

Covered Service	What you pay
Physician/Practitioner services, including doctor's office visits - continued	
• Consultation, diagnosis, and treatment by a specialist	$15 copayment for each Medicare-covered service. You pay these amounts until you reach the out-of-pocket maximum.
• Other health care professionals	$0 copayment for each Primary Care Physician (PCP) office visit for Medicare-covered services. $15 copayment for each specialist office visit for Medicare-covered services. You pay these amounts until you reach the out-of-pocket maximum.

Covered Service	What you pay
Physician/Practitioner services, including doctor's office visits - continued	
• Basic hearing and balance exams performed by your PCP or specialist, if your doctor orders it to see if you need medical treatment	$5 copayment for each Medicare-covered service. You pay these amounts until you reach the out-of-pocket maximum. *Referral is required.*
• Certain telehealth services, including: ○ Primary care visits ○ Specialist visits ○ Home Health ○ Physical, Occupational and Speech therapy ○ Individual and Group Mental, Psychiatry ○ Outpatient Substance Use visits ○ Opioid Treatment Services ○ Kidney Disease Education ○ Diabetes Self-Management Training ○ Podiatry Services • You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth.	$0 copayment for Primary Care Physician (PCP) office visit for Medicare-covered srvices. $15 copayment for each specialist office visit for Medicare-covered services. You pay these amounts until you reach the out-of-pocket maximum.

Covered Service	What you pay
Physician/Practitioner services, including doctor's office visits - continued • Members must use an interactive audio and video telecommunications system that permits real-time communication between you (the member) at the originating site and the provider at the distant site • Generations Advantage allows beneficiaries in all areas of the country to receive telehealth services, including at their home.	
• Some telehealth services including consultation, diagnosis, and treatment by a physician or practitioner, for patients in certain rural areas or other places approved by Medicare	You will pay the cost-sharing that applies to specialist services (as described under "Physician/Practitioner Services, Including Doctor's Office Visits" above).

Covered Service	What you pay
Physician/Practitioner services, including doctor's office visits - continued	
• Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home	You will pay the cost-sharing that applies to specialist services (as described under "Physician/Practitioner Services, Including Doctor's Office Visits" above).
• Telehealth services to diagnose, evaluate, or treat symptoms of a stroke, regardless of your location	You will pay the cost-sharing that applies to specialist services (as described under "Physician/Practitioner Services, Including Doctor's Office Visits" above).

Covered Service	What you pay
Physician/Practitioner services, including doctor's office visits - continued	
• Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location	You will pay the cost-sharing that applies to specialist services (as described under "Physician/Practitioner Services, Including Doctor's Office Visits" above).
• Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if: ○ You have an in-person visit within 6 months prior to your first telehealth visit ○ You have an in-person visit every 12 months while getting these telehealth services ○ Exceptions can be made to the above for certain circumstances	You will pay the cost-sharing that applies to specialist services (as described under "Physician/Practitioner Services, Including Doctor's Office Visits" above).

Covered Service	What you pay
Physician/Practitioner services, including doctor's office visits - continued	
• Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers	You will pay the cost-sharing that applies to specialist services (as described under "Physician/Practitioner Services, Including Doctor's Office Visits" above).
• Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes **if**: ○ You're not a new patient **and** ○ The check-in isn't related to an office visit in the past 7 days **and** ○ The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment	You will pay the cost-sharing that applies to specialist services (as described under "Physician/Practitioner Services, Including Doctor's Office Visits" above).

Covered Service	What you pay
Physician/Practitioner services, including doctor's office visits - continued	
• Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours **if**: ○ You're not a new patient **and** ○ The evaluation isn't related to an office visit in the past 7 days **and** ○ The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment	You will pay the cost-sharing that applies to specialist services (as described under "Physician/Practitioner Services, Including Doctor's Office Visits" above).
• Consultation your doctor has with other doctors by phone, internet, or electronic health record	You will pay the cost-sharing that applies to specialist services (as described under "Physician/Practitioner Services, Including Doctor's Office Visits" above).

Covered Service	What you pay
Physician/Practitioner services, including doctor's office visits - continued • Second opinion by another network provider prior to surgery	You will pay the cost-sharing that applies to specialist services (as described under "Physician/Practitioner Services, Including Doctor's Office Visits" above).
Podiatry services Covered services include: • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs) • Routine foot care for members with certain medical conditions affecting the lower limbs	$0 copayment for each Primary Care Physician (PCP) office visit for Medicare-covered services. $5 copayment for each specialist office visit for Medicare-covered services. You pay these amounts until you reach the out-of-pocket maximum.
Pre-exposure prophylaxis (PrEP) for HIV prevention If you don't have HIV, but your doctor or other health care practitioner determines you're at an increased risk for HIV, we cover pre-exposure prophylaxis (PrEP) medication and related services. If you qualify, covered service includes: • FDA-approved oral or injectable PrEP medication. If you're getting an injectable drug, we also cover the fee for injecting the drug.	There is no coinsurance, copayment, or deductible for the PrEP benefit.

Covered Service	What you pay
Pre-exposure prophylaxis (PrEP) for HIV prevention - continued • Up to 8 individual counseling sessions (including HIV risk assessment, HIV risk reduction, and medication adherence) every 12 months. • Up to 8 HIV screenings every 12 months. A one-time hepatitis B virus screening.	
Prostate cancer screening exams For men aged 50 and older, covered services include the following once every 12 months: • Digital rectal exam • Prostate Specific Antigen (PSA) test	 $0 copayment for each Medicare-covered service. There is no coinsurance, copayment, or deductible for an annual PSA test.
Prosthetic and orthotic devices and related supplies Devices (other than dental) that replace all or part of a body part or function. These include but aren't limited to testing, fitting, or training in the use of prosthetic and orthotic devices; as well as colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic and orthotic devices, and repair and/or replacement of prosthetic and orthotic devices. Also includes some coverage following cataract removal or cataract surgery – go to *Vision Care* later in this table for more detail.	 10% coinsurance for each Medicare-covered service. You pay these amounts until you reach the out-of-pocket maximum. *Prior Authorization is required.*

Covered Service	What you pay
Pulmonary rehabilitation services Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.	$0 copayment for each Medicare-covered service. *Prior Authorization is required.*
Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults (including pregnant women) who misuse alcohol but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.
Screening for lung cancer with low dose computed tomography (LDCT) For qualified people, a LDCT is covered every 12 months. **Eligible members are** people age 50 – 77 who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years and who currently smoke or have quit smoking within the last 15 years, who get an order for LDCT during a lung cancer screening counseling and shared decision-making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner. *For LDCT lung cancer screenings after the initial LDCT screening:* the members must get an order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision-making visit for later lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	There is no coinsurance, copayment, or deductible for the Medicare covered counseling and shared decision-making visit or for the LDCT.

Covered Service	What you pay
Screening for Hepatitis C Virus infection We cover one Hepatitis C screening if your primary care doctor or other qualified health care provider orders one and you meet one of these conditions: • You're at high risk because you use or have used illicit injection drugs. • You had a blood transfusion before 1992. • You were born between 1945-1965. If you were born between 1945-1965 and aren't considered high risk, we pay for a screening once. If you're at high risk (for example, you've continued to use illicit injection drugs since your previous negative Hepatitis C screening test), we cover yearly screenings.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for the Hepatitis C Virus. **Out-of-Network** Not covered
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to 2 individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.
Services to treat kidney disease Covered services include: • Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when	$0 copayment for each Medicare-covered service. *Prior Authorization is required.*

Covered Service	What you pay
Services to treat kidney disease - continued	
referred by their doctor, we cover up to 6 sessions of kidney disease education services per lifetime	
• Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3, or when your provider for this service is temporarily unavailable or inaccessible)	20% coinsurance for each Medicare-covered service. You pay these amounts until you reach the out-of-pocket maximum. *Referral is required.* *Prior Authorization is required.*
• Inpatient dialysis treatments (if you're admitted as an inpatient to a hospital for special care)	These services will be covered as described in the following sections: Please refer to Inpatient Hospital Care.
• Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments)	$0 copayment for each Medicare-covered service. *Prior Authorization is required.*
• Home dialysis equipment and supplies	Please refer to Durable Medical Equipment and Related Supplies.
• Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply)	Please refer to Home Health Agency Care.
Certain drugs for dialysis are covered under Medicare Part B. For information about coverage for Part B Drugs, go to **Medicare Part B drugs** in this table.	
Skilled nursing facility (SNF) care	
(For a definition of skilled nursing facility care, go to Chapter 10. Skilled nursing facilities are sometimes called SNFs.) A prior hospital stay is not required.	$10 copayment each day for days 1 to 20 and $218 copayment each day for days

Covered Service	What you pay
Skilled nursing facility (SNF) care - continued	
Covered services include but aren't limited to: • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services • Physical therapy, occupational therapy and speech therapy • Drugs administered to you as part of our plan of care (this includes substances that are naturally present in the body, such as blood clotting factors.) • Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood you need - you must either pay the costs for the first 3 pints of blood you get in a calendar year or have the blood donated by you or someone else. All other components of blood are covered beginning with the first pint used • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/Practitioner services Generally, you get SNF care from network facilities. Under certain conditions listed below, you may be able to pay in-network cost sharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment. • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care) • A SNF where your spouse or domestic partner is living at the time you leave the hospital	21 to 100 for Medicare-covered skilled nursing facility care. You are covered for up to 100 days each benefit period for inpatient services in a SNF, in accordance with Medicare guidelines. A benefit period begins on the first day you go to a Medicare-covered inpatient hospital or a skilled nursing facility. The benefit period ends when you haven't been an inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital (or SNF) after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have. Cost shares are applied starting on the first day of admission and do not include the day of discharge. You pay these amounts until you reach the out-of-pocket maximum. *Prior Authorization is required.*

Covered Service	What you pay
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)	
Smoking and tobacco use cessation counseling is covered for outpatient and hospitalized patients who meet these criteria: • Use tobacco, regardless of whether they exhibit signs or symptoms of tobacco-related disease • Are competent and alert during counseling • A qualified physician or other Medicare-recognized practitioner provides counseling We cover 2 cessation attempts per year (each attempt may include a maximum of 4 intermediate or intensive sessions, with the patient getting up to 8 sessions per year.)	There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.
Supervised Exercise Therapy (SET)	
SET is covered for members who have symptomatic peripheral artery disease (PAD). Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must: • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication • Be conducted in a hospital outpatient setting or a physician's office • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms and who are trained in exercise therapy for PAD • Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.	$0 copayment for each Medicare-covered service.

Covered Service	What you pay
Telemedicine *Please contact our plan for more details.	$0 copayment*
Urgently needed services A plan-covered service requiring immediate medical attention that's not an emergency is an urgently needed service if either you're temporarily outside our plan's service area, or, even if you're inside our plan's service area, it's unreasonable given your time, place, and circumstances to get this service from network providers. Our plan must cover urgently needed services and only charge you in-network cost sharing. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable.	$0 copayment for each Medicare-covered service.
Worldwide urgent care coverage Worldwide coverage for 'urgently needed services' when medical services are needed right away because of an illness, injury, or condition that you did not expect or anticipate, and you can't wait until you are back in our plan's service area to obtain services. A $25,000 annual maximum amount applies for ambulance transportation, urgent care, and emergency services received outside of the U.S. This limit does not apply to services in the U.S. *Please contact our plan for more details.	$125 copayment You pay these amounts until you reach the out-of-pocket maximum. Copayment is waived if you are admitted to a hospital.
Vision care Covered services include: • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original	$0 copayment for each Medicare-covered service.

Covered Service	What you pay
Vision care - continued Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts.	
• For people who are at high risk for glaucoma, we cover one glaucoma screening each year. People at high risk of glaucoma include people with a family history of glaucoma, people with diabetes, African Americans who are age 50 and older and Hispanic Americans who are 65 or older.	$0 copayment for each Medicare-covered service.
• For people with diabetes, screening for diabetic retinopathy is covered once per year.	$0 copayment for each Medicare-covered service.
• One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. If you have 2 separate cataract operations, you can't reserve the benefit after the first surgery and purchase 2 eyeglasses after the second surgery.	20% coinsurance for each Medicare-covered service. You pay these amounts until you reach the out-of-pocket maximum.
Routine eye exam Limited to 1 visit(s) every year *Please contact our plan for more details.	$0 copayment*
Additional routine eyewear The plan will cover $200each year for prescription lenses, frames, and contact lenses.	
• **Contact lenses** *Please contact our plan for more details.	$0 copayment*
• **Eyeglass frames** *Please contact our plan for more details.	$0 copayment*
• **Eyeglass lenses** *Please contact our plan for more details.	$0 copayment*

Covered Service	What you pay
Vision care - continued	
• **Eyeglasses (lenses and frames)** *Please contact our plan for more details.	$0 copayment*
• **Upgrades** Eyewear upgrades are available. *Please contact our plan for more details.	$0 copayment* Debit card may be used for prescription lenses, frames, and contact lenses. Debit card is not eligible for purchases towards exam copays or eyewear accessories. Your debit card will be mailed separately from your Generations Advantage member ID card closer to your enrollment effective date. For more information, please visit www.MartinsPoint.org/eyewear
Weight management programs *Please contact our plan for more details.	See Wellness Wallet
Welcome to Medicare preventive visit Our plan covers the one-time *Welcome to Medicare* preventive visit. The visit includes a review of your health, as well as education and counseling about preventive services you need (including certain screenings and shots), and referrals for other care if needed. **Important:** We cover the *Welcome to Medicare* preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you want to schedule your *Welcome to Medicare* preventive visit.	There is no coinsurance, copayment, or deductible for the *Welcome to Medicare* preventive visit.
• Medicare-covered EKG following Welcome Visit Preventive Services	$0 copayment for each Medicare-covered service.

Covered Service	What you pay
Wellness Wallet The plan will reimburse members for certain services not covered by Original Medicare. Reimbursement requests must be received by the plan no later than 120 days following date of purchase.	The plan will reimburse up to $425 each year in total. You'll get your Wellness Wallet debit card separately from your Generations Advantage ID card, closer to your enrollment date. It can be used for eligible items at select merchants. For a full list of covered items and services, visit: www.MartinsPoint.org/WellnessWallet The benefit renews annually. Unused funds don't roll over, and your balance updates automatically after each purchase.Fitness equipment must be bought from licensed retailers. Gym and golf memberships are reimbursable up to your **Wellness Wallet** limit.
Wigs for hair loss related to chemo The plan will reimburse members for wigs needed during chemotherapy or radiation therapy. *Please contact our plan for more details.	The plan will reimburse up to $350 (lifetime) **You must have received prior authorization from the plan for chemotherapy and/or radiation therapy to be eligible for wig reimbursement services.**

Covered Service	What you pay
Wigs for hair loss related to chemo - continued	

SECTION 3 Services that aren't covered by our plan (exclusions)

This section tells you what services are *excluded* from Medicare coverage and therefore, aren't covered by this plan.

The chart below lists services and items that either aren't covered under any condition or are covered only under specific conditions.

If you get services that are excluded (not covered), you must pay for them yourself except under the specific conditions listed below. Even if you get the excluded services at an emergency facility, the excluded services are still not covered, and our plan won't pay for them. The only exception is if the service is appealed and decided upon appeal to be a medical service that we should have paid for or covered because of your specific situation. (For information about appealing a decision we made to not cover a medical service, go to Chapter 7, Section 5.3.)

Services not covered by Medicare	Covered only under specific conditions
Cosmetic surgery or procedures	Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance
Custodial care Custodial care is personal care that doesn't require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing	Not covered under any condition

Services not covered by Medicare	Covered only under specific conditions
Experimental medical and surgical procedures, equipment, and medications Experimental procedures and items are those items and procedures determined by Original Medicare to not be generally accepted by the medical community	May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan (Go to Chapter 3, Section 5 for more information on clinical research studies)
Fees charged for care by your immediate relatives or members of your household	Not covered under any condition
Full-time nursing care in your home	Not covered under any condition
Homemaker services include basic household help, including light housekeeping or light meal preparation.	Not covered under any condition
Intra-uterine devices (IUDs)	Not covered under any condition
Lab, Radiological, and Genetic Testing	We follow Medicare guidelines when determining if Lab, Radiological & Genetic Testing services are covered, even if ordered by a physician. You have the right to contact the plan prior to services being rendered to determine if the services will be covered for your condition (see Chapter 7, Section 5.2 for more detail). Medicare medical policy and coding guidelines apply to services covered by Original Medicare, including (but not limited to): diagnosis, age, and frequency criteria.
Naturopath services (uses natural or alternative treatments)	We offer reimbursement for certain naturopath services. See the Wellness Wallet section of the Medical Benefits chart above.

Services not covered by Medicare	Covered only under specific conditions
Non-routine dental care	Dental care required to treat illness or injury may be covered as inpatient or outpatient care
Orthopedic shoes or supportive devices for the feet	Shoes that are part of a leg brace and are included in the cost of the brace. Orthopedic or therapeutic shoes for people with, diabetic foot disease
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television	Not covered under any condition
Private room in a hospital	Covered only when medically necessary.
Reversal of sterilization procedures and or non-prescription contraceptive supplies	Not covered under any condition
Routine foot care	Some limited coverage provided according to Medicare guidelines (e.g., if you have diabetes)
Self-administered drugs in an outpatient setting	The plan does not generally pay for self-administered drugs in an outpatient setting unless they are specifically required for the outpatient services you are receiving. These drugs may not be covered under the medical (Part B) portion of your plan and the hospital may bill you for the drug. May be eligible for reimbursement under Part D if the member has Part D coverage.
Services considered not reasonable and necessary, according to Original Medicare standards	Not covered under any condition
Supplies for homemade cloth masks	Not covered under any condition
Travel medicine and immunizations	Not covered under any condition

Services not covered by Medicare	Covered only under specific conditions
Vasectomies	Not covered under any condition

CHAPTER 5:

Asking us to pay our share of a bill for covered medical services

SECTION 1 Situations when you should ask us to pay our share for covered services

Sometimes when you get medical care, you may need to pay the full cost. Other times, you may find you pay more than you expected under the coverage rules of our plan, or you may get a bill from a provider. In these cases, you can ask our plan to pay you back (reimburse you). It's your right to be paid back by our plan whenever you've paid more than your share of the cost for medical services covered by our plan. There may be deadlines that you must meet to get paid back. Go to Section 2 of this chapter.

There may also be times when you get a bill from a provider for the full cost of medical care you got or for more than your share of cost sharing as discussed in this material. First try to resolve the bill with the provider. If that doesn't work, send the bill to us instead of paying it. We'll look at the bill and decide whether the services should be covered. If we decide they should be covered, we'll pay the provider directly. If we decide not to pay it, we'll notify the provider. You should never pay more than plan-allowed cost sharing. If this provider is contracted, you still have the right to treatment.

Examples of situations in which you may need to ask our plan to pay you back or to pay a bill you got:

1. **When you've got emergency or urgently needed medical care from a provider who's not in our plan's network**

   Outside the service area, you can get emergency or urgently needed services from any provider, whether or not the provider is a part of our network. In these cases,

   - You're only responsible for paying your share of the cost for emergency or urgently needed services. Emergency providers are legally required to provide emergency care.
   - If you pay the entire amount yourself at the time you get the care, ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you made.
   - You may get a bill from the provider asking for payment you think you don't owe. Send us this bill, along with documentation of any payments you already made.
     - If the provider is owed anything, we'll pay the provider directly.

- If you already paid more than your share of the cost of the service, we'll determine how much you owed and pay you back for our share of the cost.

2. When a network provider sends you a bill you think you shouldn't pay

Network providers should always bill our plan directly and ask you only for your share of the cost. But sometimes they make mistakes and ask you to pay more than your share.

- You only have to pay your cost-sharing amount when you get covered services. We don't allow providers to add additional separate charges, called **balance billing**. This protection (that you never pay more than your cost-sharing amount) applies even if we pay the provider less than the provider charges for a service and even if there's a dispute and we don't pay certain provider charges.
- Whenever you get a bill from a network provider you think is more than you should pay, send us the bill. We'll contact the provider directly and resolve the billing problem.
- If you already paid a bill to a network provider, but feel you paid too much, send us the bill along with documentation of any payment you made and ask us to pay you back the difference between the amount you paid and the amount you owed under our plan.

3. If you're retroactively enrolled in our plan

Sometimes a person's enrollment in our plan is retroactive. (This means that the first day of their enrollment has already passed. The enrollment date may even have occurred last year.)

If you were retroactively enrolled in our plan and you paid out-of-pocket for any covered services after your enrollment date, you can ask us to pay you back for our share of the costs. You need to submit paperwork such as receipts and bills for us to handle the reimbursement.

When you send us a request for payment, we'll review your request and decide whether the service or drug should be covered. This is called making a **coverage decision**. If we decide it should be covered, we'll pay for our share of the cost for the service or drug. If we deny your request for payment, you can appeal our decision. Chapter 7 has information about how to make an appeal.

SECTION 2 How to ask us to pay you back or pay a bill you got

You can ask us to pay you back by sending us a request in writing. If you send a request in writing, send your bill and documentation of any payment you've made. It's a good idea to make a copy of your bill and receipts for your records. **You must submit your claim to us within one (1) year** of the date you got the service or item.

To make sure you're giving us all the information we need to make a decision, you can fill out our claim form to make your request for payment.

- You don’t have to use the form, but it’ll help us process the information faster. This form will ask you to provide procedure and diagnosis codes that you should be able to obtain from the provider as well as an itemized receipt and proof of payment.
- Download a copy of the form from our website (www.martinspoint.org/medicaremembers) or call Member Services at 1-866-544-7504 (TTY users call 711) and ask for the form.

Mail your request for payment together with any bills or paid receipts to us at this address:

Payment Request Address
Martin's Point Generations Advantage
ATTN: Claims Department
PO Box 11410
Portland, ME 04104

SECTION 3 We’ll consider your request for payment and say yes or no

When we get your request for payment, we’ll let you know if we need any additional information from you. Otherwise, we’ll consider your request and make a coverage decision.

- If we decide the medical care is covered and you followed all the rules, we’ll pay for our share of the cost. If you already paid for the service, we’ll mail your reimbursement of our share of the cost to you. If you haven’t paid for the service yet, we’ll mail the payment directly to the provider.
- If we decide the medical care is *not* covered, or you did *not* follow all the rules, we won’t pay for our share of the cost. We’ll send you a letter explaining the reasons why we aren’t sending the payment and your rights to appeal that decision.

Section 3.1 If we tell you we won’t pay for all or part of the medical care or drug, you can make an appeal

If you think we made a mistake in turning down your request for payment or the amount we’re paying, you can make an appeal. If you make an appeal, it means you’re asking us to change the decision we made when we turned down your request for payment. The appeals process is a formal process with detailed procedures and important deadlines. For the details on how to make this appeal, go to Chapter 7.

CHAPTER 6:

Your rights and responsibilities

SECTION 1 Our plan must honor your rights and cultural sensitivities

Section 1.1 We must provide information in a way that works for you and consistent with your cultural sensitivities (in languages other than English, braille, large print, or other alternate formats, etc.)

Our plan is required to ensure that all services, both clinical and non-clinical, are provided in a culturally competent manner and are accessible to all enrollees, including those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds. Examples of how a plan may meet these accessibility requirements include but are not limited to: provision of translator services, interpreter services, teletypewriters, or TTY (text telephone or teletypewriter phone) connection.

Our plan has free interpreter services available to answer questions from non-English speaking members. We can also give you materials in braille, in large print, or other alternate formats at no cost if you need it. We're required to give you information about our plan's benefits in a format that's accessible and appropriate for you. To get information from us in a way that works for you, call Member Services at 1-866-544-7504 (TTY users call 711).

Our plan is required to give female enrollees the option of direct access to a women's health specialist within the network for women's routine and preventive health care services.

If providers in our plan's network for a specialty aren't available, it's our plan's responsibility to locate specialty providers outside the network who will provide you with the necessary care. In this case, you'll only pay in-network cost sharing. If you find yourself in a situation where there are no specialists in our plan's network that cover a service you need, call our plan for information on where to go get this service at in-network cost sharing.

If you have any trouble getting information from our plan in a format that's accessible and appropriate for you, seeing a women's health specialist or finding a network specialist, call to file a grievance with Member Services at 1-866-544-7504 (TTY users call 711). You can also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights 1-800-368-1019 or TTY 1-800-537-7697.

Section 1.2 We must ensure you get timely access to covered services

You have the right to choose a primary care provider (PCP) in our plan's network to provide and arrange for your covered services. You also have the right to go to a women's health specialist (such as a gynecologist) without a referral.

You have the right to get appointments and covered services from our plan's network of providers *within a reasonable amount of time*. This includes the right to get timely services from specialists when you need that care.

If you think you aren't getting your medical care within a reasonable amount of time, Chapter 7 tells what you can do.

Section 1.3 We must protect the privacy of your personal health information

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

- Your personal health information includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information.
- You have rights related to your information and controlling how your health information is used. We give you a written notice, called a *Notice of Privacy Practice,* that tells about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.
- Except for the circumstances noted below, if we intend to give your health information to anyone who isn't providing your care or paying for your care, *we are required to get written permission from you or someone you've given legal power to make decisions for you first.*
- There are certain exceptions that don't require us to get your written permission first. These exceptions are allowed or required by law.
    - We're required to release health information to government agencies that are checking on quality of care.
    - Because you're a member of our plan through Medicare, we're required to give Medicare your health information. If Medicare releases your information for research or other uses, this will be done according to federal statutes and regulations; typically, this requires that information that uniquely identifies you not be shared.

You can see the information in your records and know how it's been shared with others

You have the right to look at your medical records held by our plan, and to get a copy of your records. We're allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we'll work with your healthcare provider to decide whether the changes should be made.

You have the right to know how your health information has been shared with others for any purposes that aren't routine.

If you have questions or concerns about the privacy of your personal health information, call Member Services at 1-866-544-7504 (TTY users call 711).

Section 1.4 We must give you information about our plan, our network of providers, and your covered services

As a member of Martin's Point Generations Advantage Alliance (HMO), you have the right to get several kinds of information from us.

If you want any of the following kinds of information, call Member Services at 1-866-544-7504 (TTY users call 711):

- **Information about our plan.** This includes, for example, information about our plan's financial condition.
- **Information about our network providers.** You have the right to get information about the qualifications of the providers in our network and how we pay the providers in our network.
- **Information about your coverage and the rules you must follow when using your coverage.** Chapters 3 and 4 provide information regarding medical services.
- **Information about why something is not covered and what you can do about it.** Chapter 7 provides information on asking for a written explanation on why a medical service isn't covered or if your coverage is restricted. Chapter 7 also provides information on asking us to change a decision, also called an appeal.

Section 1.5 You have the right to know your treatment options and participate in decisions about your care

You have the right to get full information from your doctors and other health care providers. Your providers must explain your medical condition and your treatment choices *in a way that you can understand.*

You also have the right to participate fully in decisions about your health care. To help you make decisions with your doctors about what treatment is best for you, your rights include the following:

- **To know about all your choices.** You have the right to be told about all treatment options recommended for your condition, no matter what they cost or whether they're covered by our plan.
- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- **The right to say "no."** You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. If you refuse treatment, you accept full responsibility for what happens to your body as a result.

You have the right to give instructions about what's to be done if you can't make medical decisions for yourself

Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you're in this situation. This means, *if you want to*, you can:

- Fill out a written form to give **someone the legal authority to make medical decisions for you** if you ever become unable to make decisions for yourself.
- **Give your doctors written instructions** about how you want them to handle your medical care if you become unable to make decisions for yourself.

Legal documents you can use to give directions in advance in these situations are called **advance directives.** Documents like a **living will** and **power of attorney for health care** are examples of advance directives.

How to set up an advance directive to give instructions:

- **Get a form.** You can get an advance directive form from your lawyer, a social worker, or some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare.
- **Fill out the form and sign it.** No matter where you get this form, it's a legal document. Consider having a lawyer help you prepare it.
- **Give copies of the form to the right people**. Give a copy of the form to your doctor and to the person you name on the form who can make decisions for you if you can't. You may want to give copies to close friends or family members. Keep a copy at home.

If you know ahead of time that you're going to be hospitalized, and you signed an advance directive, **take a copy with you to the hospital.**

- The hospital will ask whether you signed an advance directive form and whether you have it with you.

- If you didn’t sign an advance directive form, the hospital has forms available and will ask if you want to sign one.

Filling out an advance directive is your choice (including whether you want to sign one if you’re in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you signed an advance directive.

If your instructions aren’t followed

If you sign an advance directive and you believe that a doctor or hospital didn’t follow the instructions in it, you can file a complaint with the Maine Office of Behavioral Health at 1-207-287-3707.

Section 1.6 You have the right to make complaints and ask us to reconsider decisions we made

If you have any problems, concerns, or complaints and need to ask for coverage, or make an appeal, Chapter 7 of this document tells what you can do. Whatever you do — ask for a coverage decision, make an appeal, or make a complaint — **we’re required to treat you fairly.**

Section 1.7 If you believe you’re being treated unfairly, or your rights aren’t being respected

If you believe you’ve been treated unfairly or your rights haven’t been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, call the Department of Health and Human Services’ **Office for Civil Rights** at 1-800-368-1019 (TTY users call 1-800-537-7697), or call your local Office for Civil Rights.

If you believe you’ve been treated unfairly or your rights haven’t been respected *and* it’s *not* about discrimination, you can get help dealing with the problem you’re having from these places:

- **Call Member Services at 1-866-544-7504 (TTY users call 711)**
- **Call your local SHIP** at 1-877-353-3771
- **Call Medicare** at 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048)

Section 1.8 How to get more information about your rights

Get more information about your rights from these places:

- **Call Member Services at 1-866-544-7504 (TTY users call 711)**
- **Call your local SHIP** at 1-877-353-3771

- **Contact Medicare**
  - Visit www.Medicare.gov to read the publication *Medicare Rights & Protections*. (available at:)
  - Call 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048)

SECTION 2 Your responsibilities as a member of our plan

Things you need to do as a member of our plan are listed below. For questions, call Member Services at 1-866-544-7504 (TTY users call 711).

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this *Evidence of Coverage* document to learn what's covered and the rules you need to follow to get covered services.
  - Chapters 3 and 4 give details about medical services.
- **If you have any other health coverage in addition to our plan, or separate prescription drug coverage, you're required to tell us.** Chapter 1 tells you about coordinating these benefits.
- **Tell your doctor and other health care providers that you're enrolled in our plan.** Show our plan membership card whenever you get medical care.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
  - To help get the best care, tell your doctors and other health providers about your health problems. Follow the treatment plans and instructions you and your doctors agree on.
  - Make sure your doctors know all the drugs you're taking, including over-the-counter drugs, vitamins, and supplements.
  - If you have questions, be sure to ask and get an answer you can understand.
- **Be considerate.** We expect our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- **Pay what you owe**. As a plan member, you're responsible for these payments:
  - You must continue to pay your premium for your Medicare Part B to stay a member of our plan.
  - For some of your medical services covered by our plan, you must pay your share of the cost when you get the service.
- **If you move *within* our plan service area, we need to know** so we can keep your membership record up to date and know how to contact you.
- **If you move *outside* our plan service area, you can't stay a member of our plan.**
- **If you move, tell Social Security (or the Railroad Retirement Board).**

CHAPTER 7:

If you have a problem or complaint (coverage decisions, appeals, complaints)

SECTION 1 What to do if you have a problem or concern

This chapter explains 2 types of processes for handling problems and concerns:

- For some problems, you need to use the **process for coverage decisions and appeals.**
- For other problems, you need to use the **process for making complaints** (also called grievances).

Both processes have been approved by Medicare. Each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

The information in this chapter will help you identify the right process to use and what to do.

Section 1.1 Legal terms

There are legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people. To make things easier, this chapter uses more familiar words in place of some legal terms.

However, it’s sometimes important to know the correct legal terms. To help you know which terms to use to get the right help or information, we include these legal terms when we give details for handling specific situations.

SECTION 2 Where to get more information and personalized help

We’re always available to help you. Even if you have a complaint about our treatment of you, we’re obligated to honor your right to complain. You should always call Member Services at 1-866-544-7504 (TTY users call 711) for help. In some situations, you may also want help or guidance from someone who isn’t connected with us. Two organizations that can help you are:

State Health Insurance Assistance Program (SHIP)

Each state has a government program with trained counselors. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you're having. They can also answer questions, give you more information, and offer guidance on what to do.

The services of SHIP counselors are free. You will find phone numbers and website URLs in Chapter 2, Section 3 of this document.

Medicare

You can also contact Medicare for help.

- Call 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048
- Visit www.Medicare.gov

SECTION 3 Which process to use for your problem

Is your problem or concern about your benefits or coverage?

This includes problems about whether medical care (medical items, services and/or Part B drugs) are covered or not, the way they're covered, and problems related to payment for medical care.

Yes.

Go to **Section 4, guide to coverage decisions and appeals.**

No.

Go to **Section 9, ow to make a complaint about quality of care, waiting times, customer service, or other concerns.**

Coverage decisions and appeals

SECTION 4 A guide to coverage decisions and appeals

Coverage decisions and appeals deal with problems about your benefits and coverage for your medical care (services, items, and Part B drugs, including payment). To keep things simple, we generally refer to medical items, services, and Medicare Part B drugs as **medical care**. You use the coverage decision and appeals process for issues such as whether something is covered or not and the way in which something is covered.

Asking for coverage decisions before you get services

If you want to know if we'll cover medical care before you get it, you can ask us to make a coverage decision for you. A coverage decision is a decision we make about your benefits and coverage or about the amount we'll pay for your medical care. For example, if our plan network doctor refers you to a medical specialist not inside the network, this referral is considered a favorable coverage decision unless either you or your network doctor can show that you got a standard denial notice for this medical specialist, or the *Evidence of Coverage* makes it clear that the referred service is never covered under any condition. You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we'll cover a particular medical service or refuses to provide medical care you think you need.

In limited circumstances a request for a coverage decision will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so or if you ask for your request to be withdrawn. If we dismiss a request for a coverage decision, we'll send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

We make a coverage decision whenever we decide what's covered for you and how much we pay. In some cases, we might decide medical care isn't covered or is no longer covered for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

If we make a coverage decision, whether before or after you get a benefit, and you aren't satisfied, you can **appeal** the decision. An appeal is a formal way of asking us to review and change a coverage decision we made. Under certain circumstances, you can ask for an expedited or **fast appeal** of a coverage decision. Your appeal is handled by different reviewers than those who made the original decision.

When you appeal a decision for the first time, this is called a Level 1 appeal. In this appeal, we review the coverage decision we made to check to see if we properly followed the rules. When we complete the review, we give you our decision.

In limited circumstances a request for a Level 1 appeal will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so, or if you ask for your request to be withdrawn. If we dismiss a request for a Level 1 appeal, we'll send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

If we say no to all or part of your Level 1 appeal for medical care, your appeal will automatically go on to a Level 2 appeal conducted by an independent review organization not connected to us.

- You don't need to do anything to start a Level 2 appeal. Medicare rules require we automatically send your appeal for medical care to Level 2 if we don't fully agree with your Level 1 appeal.
- Go to **Section 5.4** for more information about Level 2 appeals for medical care.

If you aren't satisfied with the decision at the Level 2 appeal, you may be able to continue through additional levels of appeal (this chapter explains the Level 3, 4, and 5 appeals processes).

Section 4.1 Get help asking for a coverage decision or making an appeal

Here are resources if you decide to ask for any kind of coverage decision or appeal a decision:

- **Call Member Services at 1-866-544-7504 (TTY users call 711)**
- **Get free help** from your State Health Insurance Program.
- **Your doctor can make a request for you.** If your doctor helps with an appeal past Level 2, they need to be appointed as your representative. Call Member Services at 1-866-544-7504 (TTY users call 711) and ask for the *Appointment of Representative* form. (The form is also available at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at https://martinspoint.org/For-Members-and-Patients/For-Medicare-Advantage-Members/Member-Resources-2025#forms.)
    - For medical care or Part B drugs, your doctor can ask for a coverage decision or a Level 1 appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2.
- **You can ask someone to act on your behalf.** You can name another person to act for you as your *representative* to ask for a coverage decision or make an appeal.
    - If you want a friend, relative, or another person to be your representative, call Member Services at 1-866-544-7504 (TTY users call 711) and ask for the *Appointment of Representative* form. (The form is also available at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at https://martinspoint.org/For-Members-and-Patients/For-Medicare-Advantage-Members/Member-Resources-2025#forms.) This form gives that person permission to act on your behalf. It must be signed by you and by the person you want to act on your behalf. You must give us a copy of the signed form.
    - We can accept an appeal request from a representative without the form, but we can't complete our review until we get it. If we don't get the form before our deadline for making a decision on your appeal, your appeal request will be dismissed. If this happens, we'll send you a written notice explaining your right to ask the independent review organization to review our decision to dismiss your appeal.
- **You also have the right to hire a lawyer.** You can contact your own lawyer or get the name of a lawyer from your local bar association or other referral service. There are groups that will give you free legal services if you qualify. However, **you aren't required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Section 4.2 Rules and deadlines for different situations

There are 3 different situations that involve coverage decisions and appeals. Each situation has different rules and deadlines. We give the details for each of these situations:

- **Section 5:** edical care: How to ask for a coverage decision or make an appeal
- **Section 6:** ow to ask us to cover a longer inpatient hospital stay if you think you're being discharged too soon
- **Section 7:** ow to ask us to keep covering certain medical services if you think your coverage is ending too soon (*Applies to only these services*: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)

If you're not sure information applies to you, call Member Services at 1-866-544-7504 (TTY users call 711). You can also get help or information from your SHIP.

SECTION 5 Medical care: How to ask for a coverage decision or make an appeal

Section 5.1 What to do if you have problems getting coverage for medical care or want us to pay you back for our share of the cost of your care

Your benefits for medical care are described in Chapter 4 in the Medical Benefits Chart. In some cases, different rules apply to a request for a Part B drug. In those cases, we'll explain how the rules for Part B drugs are different from the rules for medical items and services.

This section tells what you can do if you're in any of the 5 following situations:

1. You aren't getting certain medical care you want, and you believe this is covered by our plan. **Ask for a coverage decision. Section 5.2.**
2. Our plan won't approve the medical care your doctor or other medical provider wants to give you, and you believe this care is covered by our plan. **Ask for a coverage decision. Section 5.2.**
3. You got medical care that you believe should be covered by our plan, but we said we won't pay for this care. **Make an Appeal. Section 5.3.**
4. You got and paid for medical care that you believe should be covered by our plan, and you want to ask our plan to reimburse you for this care. **Send us the bill. Section 5.5**
5. You're being told that coverage for certain medical care you've been getting that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health. **Make an Appeal. Section 5.3**

Note: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, go to Sections 6 and 7 of this chapter. Special rules apply to these types of care.

Section 5.2 How to ask for a coverage decision

Legal Terms:

A coverage decision that involves your medical care is called an **organization determination.**

A fast coverage decision is called an **expedited determination.**

Step 1: Decide if you need a standard coverage decision or a fast coverage decision.

A standard coverage decision is usually made within 7 calendar days when the medical item or service is subject to our prior authorization rules, 14 calendar days for all other medical items and services, or 72 hours for Part B drugs. A fast coverage decision is generally made within 72 hours, for medical services, or 24 hours for Part B drugs. To get a fast coverage decision, you must meet 2 requirements:

- You may *only ask* for coverage for medical care items and/or services (not requests for payment for items and/or services you already got).
- You can get a fast coverage decision *only* if using the standard deadlines could cause serious harm to your health or hurt your ability to regain function.

If your doctor tells us that your health requires a fast coverage decision, we'll automatically agree to give you a fast coverage decision.

If you ask for a fast coverage decision on your own, without your doctor's support, we'll decide whether your health requires that we give you a fast coverage decision. If we don't approve a fast coverage decision, we'll send you a letter that:

- Explains that we'll use the standard deadlines.
- Explains if your doctor asks for the fast coverage decision, we'll automatically give you a fast coverage decision.
- Explains that you can file a *fast complaint* about our decision to give you a standard coverage decision instead of the fast coverage decision you asked for.

Step 2: Ask our plan to make a coverage decision or fast coverage decision.

- Start by calling, writing, or faxing our plan to make your request for us to authorize or provide coverage for the medical care you want. You, your doctor, or your representative can do this. Chapter 2 has contact information.

Step 3: We consider your request for medical care coverage and give you our answer.

For standard coverage decisions, we use the standard deadlines.

This means we'll give you an answer within 7 calendar days after we get your request for a medical item or service that is subject to our prior authorization rules. If your requested medical item or service is not subject to our prior authorization rules, we'll give you an answer within 14 calendar days after we get your request. If your request is for a Part B drug, we'll give you an answer within 72 hours after we get your request.

- **However,** if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
- If you believe we *shouldn't* take extra days, you can file a *fast complaint*. We'll give you an answer to your complaint as soon as we make the decision. (The process for making a complaint is different from the process for coverage decisions and appeals. Go to Section 9 for information on complaints.)

For fast Coverage decisions, we use an expedited timeframe.

A fast coverage decision means we'll answer within 72 hours if your request is for a medical item or service. If your request is for a Part B drug, we'll answer within 24 hours.

- **However,** if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days**. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
- If you believe we *shouldn't* take extra days, you can file a *fast complaint*. (Go to Section 9 of this chapter for information on complaints.) We'll call you as soon as we make the decision.
- If our answer is no to part or all of what you asked for, we'll send you a written statement that explains why we said no.

Step 4: If we say no to your request for coverage for medical care, you can appeal.

- If we say no, you have the right to ask us to reconsider this decision by making an appeal. This means asking again to get the medical care coverage you want. If you make an appeal, it means you're going on to Level 1 of the appeals process.

Section 5.3 How to make a Level 1 appeal

Legal Terms:

An appeal to our plan about a medical care coverage decision is called a plan **reconsideration.**

A fast appeal is also called an **expedited reconsideration.**

Step 1: Decide if you need a standard appeal or a fast appeal.

A standard appeal is usually made within 30 calendar days or 7 calendar days for Part B drugs. A fast appeal is generally made within 72 hours.

- If you're appealing a decision we made about coverage for care, you and/or your doctor need to decide if you need a fast appeal. If your doctor tells us that your health requires a fast appeal, we'll give you a fast appeal.
- The requirements for getting a *fast appeal* are the same as those for getting a fast coverage decision in Section 5.2 of this chapter.

Step 2: Ask our plan for an Appeal or a Fast Appeal

- **If you're asking for a standard appeal, submit your standard appeal in writing.** Chapter 2 has contact information.
- **If you're asking for a fast appeal, make your appeal in writing or call us.** Chapter 2 has contact information.
- **You must make your appeal request within 65 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for asking for an appeal.
- **You can ask for a copy of the information regarding your medical decision. You and your doctor may add more information to support your appeal.**

Step 3: We consider your appeal, and we give you our answer.

- When our plan is reviewing your appeal, we take a careful look at all of the information. We check to see if we were following all the rules when we said no to your request.
- We'll gather more information if needed and may contact you or your doctor.

Deadlines for a fast appeal

- For fast appeals, we must give you our answer **within 72 hours after we get your appeal**. We'll give you our answer sooner if your health requires us to.
    - If you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time if your request is for a Part B drug.
    - If we don't give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we're required to automatically send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 5.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for,** we must authorize or provide the coverage we agreed to within 72 hours after we get your appeal.
- **If our answer is no to part or all of what you asked for,** we'll send you our decision in writing and automatically forward your appeal to the independent review organization for a Level 2 appeal. The independent review organization will notify you in writing when it gets your appeal.

Deadlines for a standard appeal

- For standard appeals, we must give you our answer **within 30 calendar days** after we get your appeal. If your request is for a Part B drug you didn't get yet, we'll give you our answer **within 7 calendar days** after we get your appeal. We'll give you our decision sooner if your health condition requires us to.
    - However, if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
    - If you believe we shouldn't take extra days, you can file a *fast complaint*. When you file a fast complaint, we'll give you an answer to your complaint within 24 hours. (Go to Section 9 for information on complaints.)
    - If we don't give you an answer by the deadline (or by the end of the extended time period), we'll send your request to a Level 2 appeal, where an independent review organization will review the appeal. Section 5.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for,** we must authorize or provide the coverage within **30 calendar days** if your request is for a medical item or service, or **within 7 calendar days** if your request is for a Part B drug.
- **If our plan says no to part or all of your appeal,** we'll automatically send your appeal to the independent review organization for a Level 2 appeal.

Section 5.4 The Level 2 appeal process

Legal Term:

The formal name for the independent review organization is the **Independent Review Entity.** It's sometimes called the **IRE.**

The **independent review organization is an independent organization hired by Medicare**. It isn't connected with us and isn't a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work.

Step 1: The independent review organization reviews your appeal.

- We'll send the information about your appeal to this organization. This information is called your **case file**. **You have the right to ask us for a copy of your case file**.
- You have a right to give the independent review organization additional information to support your appeal.
- Reviewers at the independent review organization will take a careful look at all the information related to your appeal.

If you had a fast appeal at Level 1, you'll also have a fast appeal at Level 2.

- For the fast appeal, the independent review organization must give you an answer to your Level 2 appeal **within 72 hours** of when it gets your appeal.
- If your request is for a medical item or service and the independent review organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The independent review organization can't take extra time to make a decision if your request is for a Part B drug.

If you had a standard appeal at Level 1, you'll also have a standard appeal at Level 2.

- For the standard appeal, if your request is for a medical item or service, the independent review organization must give you an answer to your Level 2 appeal **within 30 calendar days** of when it gets your appeal. If your request is for a Part B drug, the independent review organization must give you an answer to your Level 2 appeal **within 7 calendar days** of when it gets your appeal.
- If your request is for a medical item or service and the independent review organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The independent review organization can't take extra time to make a decision if your request is for a Part B drug.

Step 2: The independent review organization gives you its answer.

The independent review organization will tell you it's decision in writing and explain the reasons for it.

- **If the independent review organization says yes to part or all of a request for a medical item or service**, we must authorize the medical care coverage within **72 hours** or provide the service within 14 calendar days after we get the decision from the independent review organization for **standard requests**. For **expedited requests**, we have **72 hours** from the date we get the decision from the independent review organization.
- **If the independent review organization says yes to part or all of a request for a Part B drug**, we must authorize or provide the Part B drug within **72 hours** after we get the decision from the independent review organization for **standard requests**. For **expedited requests,** we have **24 hours** from the date we get the decision from the independent review organization.
- **If this organization says no to part or all of your appeal**, it means they agree with us that your request (or part of your request) for coverage for medical care shouldn't be approved. (This is called **upholding the decision** or **turning down your appeal**.) In this case, the independent review organization will send you a letter that:
    - Explains the decision.
    - Lets you know about your right to a Level 3 appeal if the dollar value of the medical care coverage meets a certain minimum. The written notice you get from the independent review organization will tell you the dollar amount you must meet to continue the appeals process.
    - Tells you how to file a Level 3 appeal.

Step 3: If your case meets the requirements, you choose whether you want to take your appeal further.

- There are 3 additional levels in the appeals process after Level 2 (for a total of 5 levels of appeal). If you want to go to a Level 3 appeal the details on how to do this are in the written notice you get after your Level 2 appeal.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 8 explains the Level 3, 4, and 5 appeals processes.

Section 5.5 If you're asking us to pay for our share of a bill you got for medical care

Chapter 5 describes when you may need to ask for reimbursement or to pay a bill you have got from a provider. It also tells how to send us the paperwork that asks us for payment.

Asking for reimbursement is asking for a coverage decision from us

If you send us the paperwork asking for reimbursement, you're asking for a coverage decision. To make this decision, we'll check to see if the medical care you paid for is covered. We'll also check to see if you followed the rules for using your coverage for medical care.

- **If we say yes to your request:** If the medical care is covered and you followed the rules, we'll send you the payment the cost typically within 30 calendar days, but no later than 60 calendar

days after we get your request. If you haven't paid for the medical care, we'll send the payment directly to the provider.

- **If we say no to your request:** If the medical care is *not* covered, or you did *not* follow all the rules, we won't send payment. Instead, we'll send you a letter that says we won't pay for the medical care and the reasons why.

If you don't agree with our decision to turn you down, **you can make an appeal**. If you make an appeal, it means you're asking us to change the coverage decision we made when we turned down your request for payment.

To make this appeal, follow the process for appeals in Section 5.3. For appeals concerning reimbursement, note:

- We must give you our answer within 60 calendar days after we get your appeal. If you're asking us to pay you back for medical care you already got and paid for, you aren't allowed to ask for a fast appeal.
- If the independent review organization decides we should pay, we must send you or the provider the payment within 30 calendar days. If the answer to your appeal is yes at any stage of the appeals process after Level 2, we must send the payment you asked for to you or the provider within 60 calendar days.

SECTION 6 How to ask us to cover a longer inpatient hospital stay if you think you're being discharged too soon

When you're admitted to a hospital, you have the right to get all covered hospital services necessary to diagnose and treat your illness or injury.

During your covered hospital stay, your doctor and the hospital staff will work with you to prepare for the day you leave the hospital. They'll help arrange for care you may need after you leave.

- The day you leave the hospital is called your **discharge date**.
- When your discharge date is decided, your doctor or the hospital staff will tell you.
- If you think you're being asked to leave the hospital too soon, you can ask for a longer hospital stay, and your request will be considered.

Section 6.1 During your inpatient hospital stay, you'll get a written notice from Medicare that tells you about your rights

Within 2 calendar days of being admitted to the hospital, you'll be given a written notice called *An Important Message from Medicare about Your Rights*. Everyone with Medicare gets a copy of this notice. If you don't get the notice from someone at the hospital (for example, a caseworker or nurse), ask any

hospital employee for it. If you need help, call Member Services at 1-866-544-7504 (TTY users call 711) or 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048).

1. **Read this notice carefully and ask questions if you don't understand it.** It tells you:
    - Your right to get Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
    - Your right to be involved in any decisions about your hospital stay.
    - Where to report any concerns you have about quality of your hospital care.
    - Your right to **request an immediate review** of the decision to discharge you if you think you're being discharged from the hospital too soon. This is a formal, legal way to ask for a delay in your discharge date, so we'll cover your hospital care for a longer time.
2. **You'll be asked to sign the written notice to show that you got it and understand your rights.**
    - You or someone who is acting on your behalf will be asked to sign the notice.
    - Signing the notice shows *only* that you got the information about your rights. The notice doesn't give your discharge date. Signing the notice **doesn't mean** you're agreeing on a discharge date.
3. **Keep your copy** of the notice so you have the information about making an appeal (or reporting a concern about quality of care) if you need it.
    - If you sign the notice more than 2 calendar days before your discharge date, you'll get another copy before you're scheduled to be discharged.
    - To look at a copy of this notice in advance, call Member Services at 1-866-544-7504 (TTY users call 711) or 1-800 MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can also get the notice online at www.CMS.gov/Medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im.

Section 6.2 How to make a Level 1 appeal to change your hospital discharge date

To ask us to cover your inpatient hospital services for a longer time, use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are:

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it.** If you have questions or need help, call Member Services at 1-866-544-7504 (TTY users call 711). Or call your State Health Insurance Assistance Program

(SHIP) for personalized help. You can call Maine State Health Insurance Assistance Program (SHIP) at 1-877-353-3771. SHIP contact information is available in Chapter 2, Section 3.

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It checks to see if your planned discharge date is medically appropriate for you. The **Quality Improvement Organization** is a group of doctors and other health care professionals paid by the federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare. These experts aren't part of our plan.

Step 1: Contact the Quality Improvement Organization for your state and ask for an immediate review of your hospital discharge. You must act quickly.

How can you contact this organization?

- The written notice you got (*An Important Message from Medicare About Your Rights*) tells you how to reach this organization. Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2.

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and **no later than midnight the day of your discharge.**
    - **If you meet this deadline**, you can stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision from the Quality Improvement Organization.
    - **If you don't meet this deadline, contact us.** If you decide to stay in the hospital after your planned discharge date, *you may have to pay all the costs* for hospital care you get after your planned discharge date.
- Once you ask for an immediate review of your hospital discharge the Quality Improvement Organization will contact us. By noon of the day after we're contacted, we'll give you a **Detailed Notice of Discharge**. This notice gives your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it's right (medically appropriate) for you to be discharged on that date.
- You can get a sample of the **Detailed Notice of Discharge** by calling Member Services at 1-866-544-7504 (TTY users call 711) or 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048.) Or you can get a sample notice online at www.CMS.gov/Medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im.

Step 2: The Quality Improvement Organization conducts an independent review of your case.

- Health professionals at the Quality Improvement Organization (the *reviewers*) will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you can if you want.

- The reviewers will also look at your medical information, talk with your doctor, and review information that we and the hospital gave them.
- By noon of the day after the reviewers told us of your appeal, you'll get a written notice from us that gives your planned discharge date. This notice also explains in detail the reasons why your doctor, the hospital, and we think it's right (medically appropriate) for you to be discharged on that date.

Step 3: Within one full day after it has all the needed information, the Quality Improvement Organization will give you its answer to your appeal.

What happens if the answer is yes?

- If the independent review organization says *yes*, **we must keep providing your covered inpatient hospital services for as long as these services are medically necessary.**
- You'll have to keep paying your share of the costs (such as deductibles or copayments if these apply). In addition, there may be limitations on your covered hospital services.

What happens if the answer is no?

- If the independent review organization says *no*, they're saying that your planned discharge date is medically appropriate. If this happens, **our coverage for your inpatient hospital services will end** at noon on the day *after* the Quality Improvement Organization gives you its answer to your appeal.
- If the independent review organization says *no* to your appeal and you decide to stay in the hospital, **you may have to pay the full cost** of hospital care you get after noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

Step 4: If the answer to your Level 1 appeal is no, you decide if you want to make another appeal

- If the Quality Improvement Organization said *no* to your appeal, *and* you stay in the hospital after your planned discharge date, you can make another appeal. Making another appeal means you're going to *Level 2* of the appeals process.

Section 6.3 How to make a Level 2 appeal to change your hospital discharge date

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at its decision on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your stay after your planned discharge date.

Step 1: Contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 calendar days** after the day the Quality Improvement Organization said *no* to your Level 1 appeal. You can ask for this review only if you stay in the hospital after the date your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all the information related to your appeal.

Step 3: Within 14 calendar days of receipt of your request for a Level 2 appeal, the reviewers will decide on your appeal and tell you it's decision.

If the independent review organization says yes:

- **We must reimburse you** for our share of the costs of hospital care you got since noon on the day after the date your first appeal was turned down by the Quality Improvement Organization. **We must continue providing coverage for your inpatient hospital care for as long as it's medically necessary.**
- You must continue to pay your share of the costs and coverage limitations may apply.

If the independent review organization says no:

- It means they agree with the decision they made on your Level 1 appeal. This is called *upholding the decision*.
- The notice you get will tell you in writing what you can do if you want to continue with the review process.

Step 4: If the answer is no, you need to decide whether you want to take your appeal further by going to Level 3

- There are 3 additional levels in the appeals process after Level 2 (for a total of 5 levels of appeal). If you want to go to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 7 How to ask us to keep covering certain medical services if you think your coverage is ending too soon

When you're getting covered **home health services, skilled nursing care, or rehabilitation care (Comprehensive Outpatient Rehabilitation Facility)**, you have the right to keep getting your services for that type of care for as long as the care is needed to diagnose and treat your illness or injury.

When we decide it's time to stop covering any of these 3 types of care for you, we're required to tell you in advance. When your coverage for that care ends, *we'll stop paying our share of the cost for your care*.

If you think we're ending the coverage of your care too soon, you can appeal our decision. This section tells you how to ask for an appeal.

Section 7.1 We'll tell you in advance when your coverage will be ending

Legal Term:

Notice of Medicare Non-Coverage. It tells you how you can ask for a **fast-track appeal.** Asking for a fast-track appeal is a formal, legal way to ask for a change to our coverage decision about when to stop your care.

1. **You get a notice in writing** at least 2 calendar days before our plan is going to stop covering your care. The notice tells you:
   - The date when we'll stop covering the care for you.
   - How to request a fast track appeal to ask us to keep covering your care for a longer period of time.
2. **You, or someone who is acting on your behalf, will be asked to sign the written notice to show that you got it.** Signing the notice shows *only* that you got the information about when your coverage will stop. **Signing it doesn't mean you agree** with our plan's decision to stop care.

Section 7.2 How to make a Level 1 appeal to have our plan cover your care for a longer time

If you want to ask us to cover your care for a longer period of time, you'll need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it.** If you have questions or need help, call Member Services at 1-866-544-7504 (TTY users call 711). Or call your State Health Insurance Program (SHIP) for personalized help. You can call Maine State Health Insurance Assistance Program (SHIP) at 1-877-353-3771. SHIP contact information is available in Chapter 2, Section 3.

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It decides if the end date for your care is medically appropriate. The **Quality Improvement Organization** is a group

of doctors and other health care experts paid by the federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing plan decisions about when it's time to stop covering certain kinds of medical care. These experts aren't part of our plan.

Step 1: Make your Level 1 appeal: contact the Quality Improvement Organization and ask for a *fast-track appeal*. You must act quickly.

How can you contact this organization?

- The written notice you got (*Notice of Medicare Non*-Coverage) tells you how to reach this organization. Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2.

Act quickly:

- You must contact the Quality Improvement Organization to start your appeal **by noon of the day before the effective date** on the *Notice of Medicare Non-Coverage.*
- If you miss the deadline, and you want to file an appeal, you still have appeal rights. Contact the Quality Improvement Organization using the contact information on the Notice of Medicare Non-coverage. The name, address, and phone number of the Quality Improvement Organization for your state may also be found in Chapter 2.

Step 2: The Quality Improvement Organization conducts an independent review of your case.

Legal Term:

Detailed Explanation of Non-Coverage. Notice that gives details on reasons for ending coverage.

What happens during this review?

- Health professionals at the Quality Improvement Organization (the *reviewers*) will ask you, or your representative, why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you can if you want.
- The independent review organization will also look at your medical information, talk with your doctor, and review information our plan gives them.
- By the end of the day the reviewers tell us of your appeal, you'll get the *Detailed Explanation of Non-Coverage,* from us that explains in detail our reasons for ending our coverage for your services.

Step 3: Within one full day after they have all the information they need; the reviewers will tell you it's decision.

What happens if the reviewers say yes?

- If the reviewers say *yes* to your appeal, then **we must keep providing your covered services for as long as it's medically necessary.**
- You'll have to keep paying your share of the costs (such as deductibles or copayments, if these apply). There may be limitations on your covered services.

What happens if the reviewers say no?

- If the reviewers say *no*, then **your coverage will end on the date we told you.**
- If you decide to keep getting the home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* this date when your coverage ends, **you'll have to pay the full cost** of this care yourself.

Step 4: If the answer to your Level 1 appeal is no, you decide if you want to make another appeal.

- If reviewers say *no* to your Level 1 appeal – and you choose to continue getting care after your coverage for the care has ended – then you can make a Level 2 appeal.

Section 7.3 How to make a Level 2 appeal to have our plan cover your care for a longer time

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at the decision on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end.

Step 1: Contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 calendar days** after the day when the Quality Improvement Organization said *no* to your Level 1 appeal. You can ask for this review only if you continued getting care after the date your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all the information related to your appeal.

Step 3: Within 14 calendar days of receipt of your appeal request, reviewers will decide on your appeal and tell you it's decision.

What happens if the independent review organization says yes?

- **We must reimburse you** for our share of the costs of care you got since the date when we said your coverage would end. **We must continue providing coverage** for the care for as long as it's medically necessary.
- You must continue to pay your share of the costs and there may be coverage limitations that apply.

What happens if the independent review organization says no?

- It means they agree with the decision made to your Level 1 appeal.
- The notice you get will tell you in writing what you can do if you want to continue with the review process. It will give you details about how to go to the next level of appeal, which is handled by an Administrative Law Judge or attorney adjudicator.

Step 4: If the answer is no, you need to decide whether you want to take your appeal further.

- There are 3 additional levels of appeal after Level 2, (for a total of 5 levels of appeal). If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 8 Taking your appeal to Levels 3, 4 and 5

Section 8.1 Appeal Levels 3, 4 and 5 for Medical Service Requests

This section may be right for you if you made a Level 1 appeal and a Level 2 appeal, and both of your appeals were turned down.

If the dollar value of the item or medical service you appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you can't appeal any further. The written response you get to your Level 2 appeal will explain how to make a Level 3 appeal.

For most situations that involve appeals, the last 3 levels of appeal work in much the same way as the first two levels. Here's who handles the review of your appeal at each of these levels.

Level 3 appeal

An **Administrative Law Judge** or an attorney adjudicator who works for the federal government will review your appeal and give you an answer.

- **If the Administrative Law Judge or attorney adjudicator says yes to your appeal, the appeals process *may* or *may not* be over.** Unlike a decision at a Level 2 appeal, we have the right to appeal a Level 3 decision that's favorable to you. If we decide to appeal, it will go to a Level 4 appeal.
    - If we decide *not* to appeal, we must authorize or provide you with the medical care within 60 calendar days after we get the Administrative Law Judge's or attorney adjudicator's decision.
    - If we decide to appeal the decision, we'll send you a copy of the Level 4 appeal request with any accompanying documents. We may wait for the Level 4 appeal decision before authorizing or providing the medical care in dispute.
- **If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process *may* or *may not* be over.**
    - If you decide to accept the decision that turns down your appeal, the appeals process is over.
    - If you don't want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

Level 4 appeal

The **Medicare Appeals Council** (Council) will review your appeal and give you an answer. The Council is part of the federal government.

- **If the answer is yes, or if the Council denies our request to review a favorable Level 3 appeal decision, the appeals process *may* or *may not* be over.** Unlike a decision at Level 2, we have the right to appeal a Level 4 decision that is favorable to you. We'll decide whether to appeal this decision to Level 5.
    - If we decide *not* to appeal the decision, we must authorize or provide you with the medical care within 60 calendar days after getting the Council's decision.
    - If we decide to appeal the decision, we'll let you know in writing.
- **If the answer is no or if the Council denies the review request, the appeals process *may* or *may not* be over.**
    - If you decide to accept this decision that turns down your appeal, the appeals process is over.

- If you don’t want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal, the notice you get will tell you whether the rules allow you to go to a Level 5 appeal and how to continue with a Level 5 appeal.

Level 5 appeal

A judge at the **Federal District Cour**t will review your appeal.

- A judge will review all the information and decide *yes* or *no* to your request. This is a final answer. There are no more appeal levels after the Federal District Court.

Making complaints

SECTION 9 How to make a complaint about quality of care, waiting times, customer service, or other concerns

Section 9.1 What kinds of problems are handled by the complaint process?

The complaint process is *only* used for certain types of problems. This includes problems related to quality of care, waiting times, and customer service. Here are examples of the kinds of problems handled by the complaint process.

Complaint	Example
Quality of your medical care	• Are you unhappy with the quality of the care you got (including care in the hospital)?
Respecting your privacy	• Did someone not respect your right to privacy or share confidential information?
Disrespect, poor customer service, or other negative behaviors	• Has someone been rude or disrespectful to you? • Are you unhappy with our Member Services? • Do you feel you’re being encouraged to leave our plan?
Waiting times	• Are you having trouble getting an appointment, or waiting too long to get it? • Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by our Member Services or other staff at our plan?

Complaint	Example
	○ Examples include waiting too long on the phone, in the waiting or exam room, or getting a prescription.
Cleanliness	• Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
Information you get from us	• Did we fail to give you a required notice? • Is our written information hard to understand?
Timeliness (These types of complaints are all about the *timeliness* of our actions related to coverage decisions and appeals)	If you asked for a coverage decision or made an appeal, and you think we aren't responding quickly enough, you can make a complaint about our slowness. Here are examples: • You asked us for a fast coverage decision or a fast appeal, and we said no; you can make a complaint. • You believe we aren't meeting the deadlines for coverage decisions or appeals; you can make a complaint. • You believe we aren't meeting deadlines for covering or reimbursing you for certain medical items or services or drugs that were approved; you can make a complaint. • You believe we failed to meet required deadlines for forwarding your case to the independent review organization; you can make a complaint.

Section 9.2 How to make a complaint

Legal Terms:

A **complaint** is also called a **grievance.**

Making a complaint is called **filing a grievance.**

Using the process for complaints is called **using the process for filing a grievance.**

A **fast complaint** is called an **expedited grievance.**

Step 1: Contact us promptly – either by phone or in writing.

- **Calling Member Services at 1-866-544-7504 (TTY users call 711) is usually the first step.** If there's anything else you need to do, Member Services will let you know.
- **If you don't want to call (or you called and weren't satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we'll respond to your complaint in writing.

  Martin's Point Generations Advantage

  ATTN: Grievance Department

  PO Box 8832 Portland, ME 04104-8832
- The **deadline** for making a complaint is 60 calendar days from the time you had the problem you want to complain about.

Step 2: We look into your complaint and give you our answer.

- **If possible, we'll answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call.
- **Most complaints are answered within 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, **we can take up to 14 more calendar days** (44 calendar days total) to answer your complaint. If we decide to take extra days, we'll tell you in writing.
- **If you're making a complaint because we denied your request for a fast coverage decision or a fast appeal, we'll automatically give you a fast complaint.** If you have a fast complaint, it means we'll give you **an answer within 24 hours.**
- **If we don't agree** with some or all of your complaint or don't take responsibility for the problem you're complaining about, we'll include our reasons in our response to you.

Section 9.3 You can also make complaints about quality of care to the Quality Improvement Organization

When your complaint is about *quality of care,* you have 2 extra options:

- **You can make your complaint directly to the Quality Improvement Organization.** The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients. Chapter 2 has contact information.

Or

- **You can make your complaint to both the Quality Improvement Organization and us at the same time**.

Section 9.4 You can also tell Medicare about your complaint

You can submit a complaint about Martin's Point Generations Advantage Alliance (HMO) directly to Medicare. To submit a complaint to Medicare, go to www.Medicare.gov/my/medicare-complaint. You can also call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users call 1-877-486-2048.

CHAPTER 8:

Ending membership in our plan

SECTION 1 Ending your membership in our plan

Ending your membership in Martin's Point Generations Advantage Alliance (HMO) may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you decide you *want* to leave. Sections 2 and 3 give information on ending your membership voluntarily.
- There are also limited situations where we're required to end your membership. Section 5 tells you about situations when we must end your membership.

If you're leaving our plan, our plan must continue to provide your medical care, and you'll continue to pay your cost share until your membership ends.

SECTION 2 When can you end your membership in our plan?

Section 2.1 You can end your membership during the Open Enrollment Period

You can end your membership in our plan during the **Open Enrollment Period** each year. During this time, review your health and drug coverage and decide about coverage for the upcoming year.

- The **Open Enrollment Period** is from **October 15 to December 7.**
- **Choose to keep your current coverage or make changes to your coverage for the upcoming year.** If you decide to change to a new plan, you can choose any of the following types of plans:
  - Another Medicare health plan, with or without drug coverage,
  - Original Medicare *with* a separate Medicare drug plan,
  - Original Medicare *without* a separate Medicare drug plan.
- **Your membership will end in our plan** when your new plan's coverage starts on January 1.

Section 2.2 You can end your membership during the Medicare Advantage Open Enrollment Period

You can make *one* change to your health coverage during the **Medicare Advantage Open Enrollment Period each year.**

- **The Medicare Advantage Open Enrollment Period** is from January 1 to March 31 and, for new Medicare enrollees in an MA plan, from the month of entitlement to Part A and Part B until the last day of the 3rd month of entitlement.
- **During the Medicare Advantage Open Enrollment Period,** you can:
  - Switch to another Medicare Advantage Plan with or without drug coverage.
  - Disenroll from our plan and get coverage through Original Medicare. If you switch to Original Medicare during this period, you can also join a separate Medicare drug plan at the same time.
- **Your membership will end** on the first day of the month after you enroll in a different Medicare Advantage plan, or we get your request to switch to Original Medicare. If you also choose to enroll in a Medicare drug plan, your membership in the drug plan will start the first day of the month after the drug plan gets your enrollment request.

Section 2.3 In certain situations, you can end your membership during a Special Enrollment Period

In certain situations, members of Martin's Point Generations Advantage Alliance (HMO) may be eligible to end their membership at other times of the year. This is known as a **Special Enrollment Period**.

You may be eligible to end your membership during a Special Enrollment Period if any of the following situations apply. These are just examples. For the full list you can contact our plan, call Medicare, or visit www.Medicare.gov

- Usually, when you move
- If you have MaineCare Services (Medicaid)
- If we violate our contract with you
- If you're getting care in an institution, such as a nursing home or long-term care (LTC) hospital

Enrollment time periods vary depending on your situation.

To find out if you're eligible for a Special Enrollment Period, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. If you're eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. You can choose:

- Another Medicare health plan with or without drug coverage.
- Original Medicare *with* a separate Medicare drug plan.
- Original Medicare *without* a separate Medicare drug plan.

Your membership will usually end on the first day of the month after we get your request to change our plan.

Section 2.4 Get more information about when you can end your membership

If you have questions about ending your membership, you can:

- **Call Member Services at 1-866-544-7504 (TTY users call 711)**
- Find the information in the ***Medicare & You 2026*** handbook
- Call **Medicare** at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048

SECTION 3 How to end your membership in our plan?

The table below explains how you can end your membership in our plan.

To switch from our plan to:	Here's what to do:
Another Medicare health plan	• Enroll in the new Medicare health plan. • You'll automatically be disenrolled from Martin's Point Generations Advantage Alliance (HMO) when your new plan's coverage starts.
Original Medicare *with* a separate Medicare drug plan	• Enroll in the new Medicare drug plan. • You'll automatically be disenrolled from Martin's Point Generations Advantage Alliance (HMO) when your new plan's coverage starts.
Original Medicare *without* a separate Medicare drug plan	• **Send us a written request to disenroll**. Call Member Services if you need more information on how to do this. • You can also call **Medicare**, at 1-800-MEDICARE (1-800-633-4227) and ask to be disenrolled. TTY users call 1-877-486-2048. • You'll be disenrolled from Martin's Point Generations Advantage Alliance (HMO) when your coverage in Original Medicare starts.

Note: If you also have creditable prescription drug coverage (e.g., a separate Medicare drug plan) and disenroll from that coverage, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later after going without creditable prescription drug coverage for 63 days or more in a row.

SECTION 4 Until your membership ends, you must keep getting your medical items, and services through our plan

Until your membership ends, and your new Medicare coverage starts, you must continue to get your medical items, services care through our plan.

- **Continue to use our network providers to get medical care.**
- **If you're hospitalized on the day your membership ends, your hospital stay will be covered by our plan until you're discharged** (even if you're discharged after your new health coverage starts).

SECTION 5 Martin's Point Generations Advantage Alliance (HMO) must end our plan membership in certain situations

Martin's Point Generations Advantage Alliance (HMO) must end your membership in the plan if any of the following happen:

- If you no longer have Medicare Part A and Part B
- If you move out of our service area
- If you're away from our service area for more than 6 months
    - If you move or take a long trip, call Member Services at 1-866-544-7504 (TTY users call 711) to find out if the place you are moving or traveling to is in our plan's area
- If you become incarcerated (go to prison)
- If you're no longer a United States citizen or lawfully present in the United States
- If you intentionally give us incorrect information when you're enrolling in our plan and that information affects your eligibility for our plan. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that's disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)

- If you let someone else use your membership card to get medical care. (We can’t make you leave our plan for this reason unless we get permission from Medicare first.)
    - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- If you don’t pay our plan premiums for 60 days.
    - We must notify you in writing that you have 60 days to pay our plan premium before we end your membership.

If you have questions or want more information on when we can end your membership, call Member Services at 1-866-544-7504 (TTY users call 711).

Section 5.1 We can’t ask you to leave our plan for any health-related reason

Martin's Point Generations Advantage Alliance (HMO) isn’t allowed to ask you to leave our plan for any health-related reason.

What should you do if this happens?

If you feel you’re being asked to leave our plan because of a health-related reason, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

Section 5.2 You have the right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership.

CHAPTER 9:

Legal notices

SECTION 1 Notice about governing law

The principal law that applies to this *Evidence of Coverage* document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, (CMS). In addition, other federal laws may apply and, under certain circumstances, the laws of the state you live in. This may affect your rights and responsibilities even if the laws aren't included or explained in this document.

SECTION 2 Notice about nondiscrimination

We don’t discriminate based on race, ethnicity, national origin, color, religion, sex, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area. All organizations that provide Medicare Advantage plans, like our plan, must obey federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, all other laws that apply to organizations that get federal funding, and any other laws and rules that apply for any other reason.

If you want more information or have concerns about discrimination or unfair treatment, call the Department of Health and Human Services’ **Office for Civil Rights** at 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights. You can also review information from the Department of Health and Human Services’ Office for Civil Rights at www.HHS.gov/ocr/index.html.

If you have a disability and need help with access to care, call Member Services at 1-866-544-7504 (TTY users call 711). If you have a complaint, such as a problem with wheelchair access, Member Services can help.

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, Martin's Point Generations Advantage Alliance (HMO), as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any state laws.

The plan's rights to recover are based on the terms of this Evidence of Coverage, as well as the provisions of the federal statutes governing the Medicare Program. Your plan coverage is always secondary to any payment made or reasonably expected to be made under:

- A workers' compensation law or plan of the United States or a State,
- Any non-fault based insurance, including automobile and non-automobile no-fault and medical payments insurance,
- Any liability insurance policy or plan (including a self-insured plan) issued under an automobile or other type of policy or coverage, and
- Any automobile insurance policy or plan (including a self-insured plan), including, but not limited to, uninsured and underinsured motorist coverages.

In these situations, your plan may make payments on your behalf for medical care, subject to the conditions set forth in this provision for the plan to recover these payments from you or from other parties. Immediately upon making any conditional payment, your plan shall be subrogated to (stand in the place of) all rights of recovery you have against any person, entity or insurer responsible for causing your injury, illness or condition or against any person, entity or insurer listed as a primary payer above.

If you receive payment from any person, entity or insurer responsible for causing your injury, illness or condition or you receive payment from any person, entity or insurer listed as a primary payer above, your plan has the right to recover from, and be reimbursed by you for all conditional payments the plan has made or will make as a result of that injury, illness or condition.

Your plan will automatically have a lien, to the extent of benefits it paid for the treatment of the injury, illness or condition, upon any recovery whether by settlement, judgment or otherwise. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the plan including, but not limited to, you, your representatives or agents, any person, entity or insurer responsible for causing your injury, illness or condition or any person, entity or insurer listed as a primary payer above.

By accepting benefits (whether the payment of such benefits is made to you or made on your behalf to any health care provider) from your plan, you acknowledge that the plan's recovery rights are a first priority claim and are to be paid to the plan before any other claim for your damages. The plan shall be entitled to full reimbursement on a first-dollar basis from any payments, even if such payment to the plan will result in a recovery to you which is insufficient to make you whole or to compensate you in part or in whole for the damages you sustained. Your plan is not required to participate in or pay court costs or attorney fees to any attorney hired by you to pursue your damage claims.

Your plan is entitled to full recovery regardless of whether any liability for payment is admitted by any person, entity or insurer responsible for causing your injury, illness or condition or by any person, entity or insurer listed as a primary payer above. The plan is entitled to full recovery regardless of whether the settlement or judgment received by you identifies the medical benefits the plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical

expenses. The plan is entitled to recover from any and all settlements or judgments, even those designated as for pain and suffering, non-economic damages and/or general damages only.

You, and your legal representatives, shall fully cooperate with the plan’s efforts to recover its benefits paid. It is your duty to notify the plan within 30 days of the date when notice is given to any party, including an insurance company or attorney, of your intention to pursue or investigate a claim to recover damages or obtain compensation due to your injury, illness or condition. You and your agents or representatives shall provide all information requested by the plan or its representatives. You shall do nothing to prejudice your plan’s subrogation or recovery interest or to prejudice the plan’s ability to enforce the terms of this provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the plan.

CHAPTER 10:

Definitions

Ambulatory Surgical Center – An Ambulatory Surgical Center is an entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization and whose expected stay in the center doesn't exceed 24 hours.

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or payment for services you already got. You may also make an appeal if you disagree with our decision to stop services that you're getting.

Balance Billing – When a provider (such as a doctor or hospital) bills a patient more than our plan's allowed cost-sharing amount. As a member of Martin's Point Generations Advantage Alliance (HMO), you only have to pay our plan's cost-sharing amounts when you get services covered by our plan. We don't allow providers to **balance bill** or otherwise charge you more than the amount of cost sharing our plan says you must pay.

Benefit Period – The way that both our plan and Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't gotten any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

Centers for Medicare & Medicaid Services (CMS) – The federal agency that administers Medicare.

Chronic-Care Special Needs Plan (C-SNP) – C-SNPs are SNPs that restrict enrollment to MA eligible people who have specific severe and chronic diseases.

Coinsurance – An amount you may be required to pay, expressed as a percentage (for example 20%) as your share of the cost for services.

Complaint – The formal name for *making a complaint* is *filing a grievance*. The complaint process is used *only* for certain types of problems. This includes problems about quality of care, waiting times, and the customer service you get. It also includes complaints if our plan doesn't follow the time periods in the appeal process.

Comprehensive Outpatient Rehabilitation Facility (CORF) – A facility that mainly provides rehabilitation services after an illness or injury, including physical therapy, social or psychological services, respiratory therapy, occupational therapy and speech-language pathology services, and home environment evaluation services.

Copayment (or copay) – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or a prescription drug. A copayment is a set amount (for example $10), rather than a percentage.

Cost Sharing – Cost sharing refers to amounts that a member has to pay when services are gotten. Cost sharing includes any combination of the following 3 types of payments: 1) any deductible amount a plan may impose before services are covered; 2) any fixed copayment amount that a plan requires when a specific service is gotten; or 3) any coinsurance amount, a percentage of the total amount paid for a service, that a plan requires when a specific service is gotten.

Covered Services – The term we use to mean all the health care services and supplies that are covered by our plan.

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty if they decide to enroll in Medicare prescription drug coverage later.

Custodial Care – Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you don't need skilled medical care or skilled nursing care. Custodial care, provided by people who don't have professional skills or training, includes help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn't pay for custodial care.

Deductible – The amount you must pay for health care before our plan pays.

Disenroll or Disenrollment – The process of ending your membership in our plan.

Dual Eligible Special Needs Plans (D-SNP) – D-SNPs enroll people who are entitled to both Medicare (Title XVIII of the Social Security Act) and medical assistance from a state plan under Medicaid (Title XIX). States cover some Medicare costs, depending on the state and the person's eligibility.

Dually Eligible Individual – A person who is eligible for Medicare and Medicaid coverage.

Durable Medical Equipment (DME) – Certain medical equipment that is ordered by your doctor for medical reasons. Examples include walkers, wheelchairs, crutches, powered mattress systems, diabetic supplies, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, or hospital beds ordered by a provider for use in the home.

Emergency – A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you're a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb, or loss of or serious impairment to a bodily function. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

Emergency Care – Covered services that are: 1) provided by a provider qualified to furnish emergency services; and 2) needed to treat, evaluate, or stabilize an emergency medical condition.

Evidence of Coverage (EOC) and Disclosure Information – This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

Extra Help – A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

Grievance - A type of complaint you make about our plan or providers, including a complaint concerning the quality of your care. This doesn't involve coverage or payment disputes.

Home Health Aide – A person who provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises).

Hospice – A benefit that provides special treatment for a member who has been medically certified as terminally ill, meaning having a life expectancy of 6 months or less. Our plan must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums, you're still a member of our plan. You can still get all medically necessary services as well as the supplemental benefits we offer.

Hospital Inpatient Stay – A hospital stay when you've been formally admitted to the hospital for skilled medical services. Even if you stay in the hospital overnight, you might still be considered an *outpatient.*

Initial Enrollment Period – When you're first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. If you're eligible for Medicare when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

Low Income Subsidy (LIS) – Go to Extra Help.

Maximum Out-of-Pocket Amount – The most that you pay out-of-pocket during the calendar year for in- network covered services. Amounts you pay for our Medicare Part A and Part B premiums don't count toward the maximum out-of-pocket amount.

Medicaid (or Medical Assistance) – A joint federal and state program that helps with medical costs for some people with low incomes and limited resources. State Medicaid programs vary, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medically Necessary – Services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

Medicare – The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

Medicare Advantage Open Enrollment Period – The time period from January 1 to March 31 when members in a Medicare Advantage plan can cancel their plan enrollment and switch to another Medicare Advantage plan or get coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time. The Medicare Advantage Open Enrollment Period is also available for a 3-month period after a person is first eligible for Medicare.

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be i) an HMO, ii) a PPO, iii) a Private Fee-for-Service (PFFS) plan, or iv) a Medicare Medical Savings Account (MSA) plan. Besides choosing from these types of plans, a Medicare Advantage HMO or PPO plan can also be a Special Needs Plan (SNP). In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**. Martin's Point Generations Advantage Alliance (HMO) does not offer Medicare prescription drug coverage.

Medicare-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans, must cover all the services that are covered by Medicare Part A and B. The term Medicare-Covered Services doesn't include the extra benefits, such as vision, dental, or hearing, that a Medicare Advantage plan may offer.

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in our plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Special Needs Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

Medicare Prescription Drug Coverage (Medicare Part D) – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

Medigap (Medicare Supplement Insurance) Policy – Medicare supplement insurance sold by private insurance companies to fill **gaps** in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage Plan is not a Medigap policy.)

Member (Member of our Plan, or Plan Member) – A person with Medicare who is eligible to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Member Services – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals.

Network – The doctors and other health care professionals, medical groups, hospitals, and other health care facilities or providers that have an agreement with us to provide covered services to our

members and to accept our payment and any plan cost-sharing as payment in full. (See Chapter 3, Section 2)

Network Provider – **Provider** is the general term for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the state to provide health care services. **Network providers** have an agreement with our plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our plan. Network providers are also called **plan providers**.

Open Enrollment Period – The time period of October 15 until December 7 of each year when members can change their health or drug plans or switch to Original Medicare.

Organization Determination – A decision our plan makes about whether items or services are covered or how much you have to pay for covered items or services. Organization determinations are called *coverage decisions* in this document.

Original Medicare (Traditional Medicare or Fee-for-Service Medicare) – Original Medicare is offered by the government, and not a private health plan like Medicare Advantage plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has 2 parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Network Provider or Out-of-Network Facility – A provider or facility that doesn't have a contract with our plan to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that aren't employed, owned, or operated by our plan.

Out-of-Pocket Costs – Go to the definition for cost sharing above. A member’s cost-sharing requirement to pay for a portion of services gotten is also referred to as the member’s out-of-pocket cost requirement.

Part C – Go to Medicare Advantage (MA) Plan.

Part D – The voluntary Medicare Prescription Drug Benefit Program.

Preferred Provider Organization (PPO) Plan – A Preferred Provider Organization plan is a Medicare Advantage Plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. A PPO plan must cover all plan benefits whether they're received from network or out-of-network providers. Member cost sharing will generally be higher when plan benefits are gotten from out-of-network providers. PPO plans have an annual limit on your out-of-pocket costs for services received from network (preferred) providers and a higher limit on your total combined out-of-pocket costs for services from both in-network (preferred) and out-of-network (non-preferred) providers.

Premium – The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Preventive services – Health care to prevent illness or detect illness at an early stage, when treatment is likely to work best (for example, preventive services include Pap tests, flu shots, and screening mammograms).

Primary Care Provider (PCP) – The doctor or other provider you see first for most health problems. In many Medicare health plans, you must see your primary care provider before you see any other health care provider.

Prior Authorization – Approval in advance to get services based on specific criteria. Covered services that need prior authorization are marked in the Medical Benefits Chart in Chapter 4.

Prosthetics and Orthotics – Medical devices including, but not limited to, arm, back and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients.

Referral – A written order from your primary care doctor for you to visit a specialist or get certain medical services. Without a referral, our plan may not pay for services from a specialist.

Rehabilitation Services – These services include inpatient rehabilitation care, physical therapy (outpatient), speech and language therapy, and occupational therapy.

Service Area – A geographic area where you must live to join a particular health plan. For plans that limit which doctors and hospitals you may use, it’s also generally the area where you can get routine (non-emergency) services. Our plan must disenroll you if you permanently move out of our plan’s service area.

Skilled Nursing Facility (SNF) Care – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Special Enrollment Period – A set time when members can change their health or drug plans or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the service area, if you move into a nursing home, or if we violate our contract with you.

Special Needs Plan – A special type of Medicare Advantage Plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid, who live in a nursing home, or who have certain chronic medical conditions.

Supplemental Security Income (SSI) – A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits aren't the same as Social Security benefits.

Urgently Needed Services – A plan-covered service requiring immediate medical attention that's not an emergency is an urgently needed service if either you're temporarily outside our plan's service area, or it's unreasonable given your time, place, and circumstances to get this service from network providers. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable.

Martin's Point

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

Martin's Point Health Care:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Martin's Point Generations Advantage Member Services Team.

If you believe that Martin's Point Health Care has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with Member Services: Member Services, Martin's Point Generations Advantage, PO Box 9746, Portland, ME 04104, 1-866-544-7504, TTY: 711, Fax: 207-828-7847. (We're available 8 am–8 pm, seven days a week from October 1 to March 31; and Monday through Friday the rest of the year.) If you need help filing a grievance, the Martin's Point Generations Advantage Member Services Team is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at ocrportal.hhs.gov/ocr/ portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-877-696-6775 (TDD: 1-800-537-7697)

Complaint forms are available at https://www.hhs.gov/civil-rights/filing-a-complaint/index.html.

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-877-553-7054 (TTY: 711). Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-877-553-7054 (TTY: 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-877-553-7054 (TTY: 711)。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-877-553-7054 (TTY: 711)。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-877-553-7054 (TTY: 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-877-553-7054 (TTY: 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-877-553-7054 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

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

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-877-553-7054 (TTY: 711)번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-877-553-7054 (TTY: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-877-553-7054 (TTY: 711). سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके ककसी भी प्रश्न के जवाब देने के किए हमारे पास मुफ्त दुभाकिया सेवाएँ उपिब्ध हैं. एक दुभाकिया प्राप्त करने के किए, बस हमें 1-877-553-7054 (TTY: 711) पर फोन करें. कोई व्यक्ति जो कहन्दी बोिता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-877-553-7054 (TTY: 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-877-553-7054 (TTY: 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-877-553-7054 (TTY: 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-877-553-7054 (TTY: 711). Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サーービスがありますございます。通訳をご用命になるには、
1-877-553-7054 (TTY: 711)にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。

Martin's Point Generations Advantage is a health plan with a Medicare contract offering HMO, HMO-POS, and Local PPO products. Enrollment in a Martin's Point Generations Advantage plan depends on contract renewal.
Y0044_2026_NOA_C

Martin's Point Generations Advantage Alliance (HMO) Member Services

Method	Member Services – Contact Information
Call	1-866-544-7504 Calls to this number are free. 8am - 8pm, seven days a week from October 1 to March 31, and Monday through Friday the rest of the year Member Services 1-866-544-7504 (TTY users call 711) also has free language interpreter services available for non-English speakers.
TTY	711 Calls to this number are free. 8am - 8pm, seven days a week from October 1 to March 31, and Monday through Friday the rest of the year
Fax	207-828-7821
Write	Martin's Point Generations Advantage Member Services P.O. Box 9746 Portland, ME 04104-5040
Website	www.martinspoint.org/medicaremembers

Maine State Health Insurance Assistance Program (SHIP)

Maine State Health Insurance Assistance Program (SHIP) is a state program that gets money from the federal government to give free local health insurance counseling to people with Medicare.

Method	Contact Information
Call	1-877-353-3771
TTY	711
Write	Office of Aging and Disability Services, 11 State House Station 41 Anthony Ave. Augusta, Maine 04333
Website	https://www.maine.gov/dhhs/oads/get-support/older-adults-disabilities/older-adult-services/ship-medicare-assistance

PRA Disclosure Statement *According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1051. If you have comments or suggestions for improving this form, write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.*

Martin's Point Generations Advantage
Alliance Plan Dental Benefit
Coverage and Limitations

Diagnostic & Preventive Benefits (Coverage A)

Diagnostic**:** Oral evaluations – One (1) time in a period of one (1) calendar year.

Problem focused exams as needed.

Radiographic images – a comprehensive series or a panoramic image once in a period of five (5) years; bitewings once in a period of one (1) calendar year; images of individual teeth as necessary.

Preventive**:** Prophylaxis (cleaning) – two (2) times in a period of one (1) calendar year. This can be a routine cleaning or a full mouth debridement under Diagnostic and Preventive Benefits (Coverage A), or periodontal maintenance under Basic Benefits (Coverage B).

A full mouth debridement under Diagnostic and Preventive Benefits (Coverage A) is covered once in a lifetime and when performed is counted towards your cleaning benefit.

NOTE: Time limitations are measured from the date the services were most recently performed.

Coverage A Exclusions and Limitations:

- If the fee for a procedure or service is "Not Billable to the Eligible Person," it is not payable by the plan, nor collectable from the Eligible Person by a Participating Dentist. Participating Dentists agree not to charge a separate fee.
- If the fee for a procedure or service is "Denied," it is not payable by the plan, but is chargeable to the Eligible Person as the procedure or service is not a benefit under the plan.

1. Oral evaluations of any kind are Not Billable to the Eligible Person if performed within ninety (90) days after periodontal surgery by the same Dentist/dental office.
2. Comprehensive oral evaluation and comprehensive periodontal evaluation are a covered benefit once in a period of one (1) calendar year (unless there is history of no care for three (3) years) and is counted toward your oral evaluation benefits. Subsequent comprehensive oral evaluations are covered as a periodic oral evaluation and are subject to frequency limitations.
3. Detailed and extensive oral evaluations are a covered benefit.
4. Pre-diagnostic services, such as a screening or an assessment of an Eligible Person, are covered benefits once in a period of twelve (12) months and crosscheck for time limitations. Payment for a screening or assessment are Not Billable to the Eligible Person if billed on the same date of service or billed with an oral evaluation.
5. Pre-visit screening of an Eligible Person is not a covered benefit. Payment for a pre-visit screening is Not Billable to the Eligible Person.
6. A panoramic radiographic image is a covered benefit once in a five (5) year period for Eligible Persons.
7. Benefits are limited to either a panoramic radiographic image or an intraoral complete series radiographic images once in a period of five (5) years.
8. Payment for additional periapical, bitewing and/or occlusal radiographic images within a thirty

(30) day period of a comprehensive series, unless there is evidence of trauma, is Not Billable to the Eligible Person.

9. Routine working and final treatment radiographic images taken for endodontic therapy by the same Dentist/dental office are considered a component of the complete treatment procedure and separate fees are Not Billable to the Eligible Person on the same date of service.
10. If the fee for bitewings, periapicals, intraoral occlusal and extraoral radiographic images is equal to or exceeds the fee for a comprehensive series, it is considered a comprehensive series for payment purposes and time limitations. Any fee in excess of the fee for the comprehensive series is Not Billable to the Eligible Person on the same date of service.
11. Intraoral tomosynthesis - comprehensive series, image capture only, received on the same day as an intraoral tomosynthesis comprehensive series by the same Dentist/dental office is Not Billable to the Eligible Person.
12. Intraoral tomosynthesis - periapical images, image capture only, received on the same day as an intraoral tomosynthesis periapical series by the same Dentist/dental office is Not Billable to the Eligible Person.
13. Intraoral periapicals are Not Billable to the Eligible Person if performed with surgical and non-surgical procedures, and all indirect restorations (crowns, onlays, bridges, inlays or implants).
14. Intraoral tomosynthesis - bitewing images, image capture only, received on the same day as an intraoral tomosynthesis bitewing radiographic image by the same Dentist/dental office is Not Billable to the Eligible Person.
15. Fees for additional bitewings (including vertical bitewings) done by the same Dentist/dental office within six (6) months of a comprehensive series is Not Billable to the Eligible Person. If performed by a different Dentist/dental office, the fee is Denied.
16. If an extra oral posterior dental radiographic image is performed within five (5) years of a prior extra oral posterior dental radiographic image by the same Dentist/dental office, the fee is Not Billable to the Eligible Person.
17. Fees for additional radiographic images taken by the same Dentist/dental office within sixty (60) days of vertical bitewings are Not Billable to the Eligible Person.
18. The fee for a full mouth debridement is Not Billable to the Eligible Person when performed by the same Dentist/dental office on the same date of service as a comprehensive periodontal evaluation.
19. Cone beam imaging and interpretation are covered benefits once in a period of twelve (12) months. Cone beam image capture only, received on the same day as a cone beam image capture and interpretation, by the same Dentist/dental office is Not Billable to the Eligible Person.
20. Cephalometric images and oral/facial photographic images are not a covered benefit.
21. Oral cancer screening, except brush biopsy, is not a covered benefit.
22. A cleaning done on the same date by the same Dentist/dental office as a periodontal maintenance, or scaling and root planing is considered to be part of and included in those procedures, and the fee is Not Billable to the Eligible Person.
23. Laboratory tests for caries susceptibility are not a covered benefit.
24. Pulp vitality tests are a covered benefit only when done in conjunction with a radiographic image, a limited oral evaluation, a palliative treatment, or placement of interim direct restoration. The fee is otherwise Not Billable to the Eligible Person.
25. Preventive resin restorations are a covered benefit once per tooth in a period of three (3) years on the occlusal surface of permanent molars for Eligible Dependents eighteen (18) years of age or younger.

26. Fees for preventive resin restorations completed on the same date of service and on the same surface as a restoration by the same Dentist/dental office are considered part of the restoration and are Not Billable to the Eligible Person.

27. Benefits for preventive resin restorations are Denied if submitted documentation or the Eligible Dependent's claim history indicates a restoration on the occlusal surface of the same tooth.

28. Benefits for preventive resin restorations or sealants include repair or replacement within twenty-four (24) months by the same Dentist/dental office. Fees for repair or replacement of a preventive resin restoration are Not Billable to the Eligible Person if performed within twenty-four (24) months of initial placement by the same Dentist/dental office.

29. Nutritional counseling, tobacco counseling and oral hygiene instruction are not covered benefits.

30. Genetic test for susceptibility to diseases is not a covered benefit.

31. Application of caries arresting medicament is a covered benefit twice per tooth in a twelve (12) month period. If the application of caries arresting medicament is placed by the same Dentist/dental office on the same day as a restoration, it is not a covered benefit and is Not Billable to the Eligible Person.

32. Fees for restorations on the same tooth by the same Dentist/dental office performed within sixty (60) days of the application of caries arresting medicament are Denied. The Eligible Person is responsible for the fee.

33. HbA1c and blood glucose testing are not covered benefits and fees are Denied. If blood glucose level testing is performed on the same day as an HbA1c test, fees for the blood glucose testing are Not Billable to the Eligible Person.

34. Assessment of salivary flow is a covered benefit once in a three (3) year period. Additional assessments are Not Billable to the Eligible Person within twelve (12) months of initial assessment. Assessments performed between twelve (12) months and three (3) years are Denied and the Eligible Person is responsible for the fee.

35. 3D intraoral surface scans, whether direct or indirect, are included as part of the definitive procedure and the fees are Not Billable to the Eligible Person.

Basic Benefits (Coverage B)

Diagnostic**:**	Brush biopsy – once in a period of one (1) calendar year.
Restorative**:**	Amalgam (silver) fillings.
	Resin (white) fillings are a covered benefit.
Oral Surgery**:**	Extractions and covered surgical procedures.
Periodontics:	Prophylaxis (cleaning) – two (2) times in a period of one (1) calendar year. This can be a routine cleaning or a full mouth debridement under Diagnostic and Preventive Benefits (Coverage A), or periodontal maintenance under Basic Benefits (Coverage B).
	A full mouth debridement under Diagnostic and Preventive Benefits (Coverage A) is covered once in a lifetime and when performed is counted towards your cleaning benefit.
Endodontics**:**	Pulpal therapy, apicoectomies, retrograde fillings, and root canal therapy.
Denture Repair**:**	Repair of a removable, complete, or partial denture to its original condition.
Clinical Crown Lengthening**:**	Once per tooth per lifetime.
Palliative Treatment**:**	Minor emergency treatment for the relief of pain.
Athletic Mouthguards:	Once in a period of twenty-four (24) months.
Anesthesia:	General anesthesia or intravenous sedation, when administered in a dental office and in conjunction with: an extraction, tooth reimplantation, surgical exposure of a tooth, surgical placement of implant body, biopsy, transseptal fiberotomy, alveoloplasty, vestibuloplasty, incision and drainage of an abscess, frenulectomy, and/or frenuloplasty.

NOTE: Time limitations are measured from the date the services were most recently performed.

Coverage B Exclusions and Limitations:

- If the fee for a procedure or service is "Not Billable to the Eligible Person," it is not payable by the plan, nor collectable from the Eligible Person by a Participating Dentist. Participating Dentists agree not to charge a separate fee.
- If the fee for a procedure or service is "Denied," it is not payable by the plan, but is chargeable to the Eligible Person as the procedure or service is not a benefit under the plan.

1. Oral Pathology laboratory services are a covered benefit when accompanied by a pathology report. If more than one of these procedures is billed for the same tooth site on the same day, by the same Dentist/ dental office, payment is allowed for the most inclusive procedure and the less inclusive procedure is Not Billable to the Eligible Person.
2. Restorations are a covered benefit only once per surface in a period of twenty-four (24) months, irrespective of the number or combination of procedures performed. The replacement of amalgam (silver) or resin (white) restorations within twenty-four (24) months by the same Dentist/dental office is Not Billable to the Eligible Person.

3. A cleaning done on the same date by the same Dentist/dental office as a periodontal maintenance, or scaling and root planing is considered to be part of and included in those procedures and the fee is Not Billable to the Eligible Person.

4. Tooth preparation, bases, copings, placement of interim direct restorations, impressions, image capture only and local anesthesia or other services that are part of the complete dental procedure, are considered components of, and included in the fee for, a complete procedure and are Not Billable to the Eligible Person.

5. Placement of interim direct restorations are Not Billable to the Eligible Person if performed on the same date of service as a definitive restoration or palliative treatment by the same Dentist/dental office.

6. The placement of interim direct restoration is a covered benefit once in a lifetime. The fee for the placement of interim direct restorations are Not Billable to the Eligible Person when performed in conjunction with definitive dental treatment on the same date of service, by the same Dentist/dental office.

7. Prefabricated stainless steel crowns are a covered benefit once in a period of two (2) years. The fee for replacement of a stainless steel crown by the same Dentist/dental office within twenty-four (24) months is included in the initial crown placement and is Not Billable to the Eligible Person.

8. Payment is made for one (1) restoration in each tooth surface irrespective of the number of combinations of restorations placed. A Northeast Delta Dental Participating Dentist agrees not to charge a separate fee.

9. Removal of an indirect restoration on a natural tooth is included in the fee for definitive treatment and the fees are Not Billable to the Eligible Person.

10. Removal of coronal remnants of a primary tooth is considered part of any other (more comprehensive) surgical procedure in the same surgical area, same date by the same Dentist/dental office and the fees are Not Billable to the Eligible Person.

11. Routine post-operative visits are considered part of, and included in the fee for, the total procedure. A Northeast Delta Dental Participating Dentist agrees not to charge a separate fee.

12. Exploratory surgical services are not a covered benefit. The Eligible Person is financially responsible.

13. Periodontal scaling and root planing is a covered benefit per quadrant (maximum of two (2) quadrants per office visit) once in a period of twenty-four (24) months.

14. Fees for periodontal scaling and root planing per quadrant are Not Billable to the Eligible Person within twenty-four (24) months when performed by the same Dentist/dental office. If treatment is done by a different Dentist/dental office within twenty-four (24) months, benefits are Denied.

15. The fee for periodontal scaling and root planing is Not Billable to the Eligible Person if performed within ninety (90) days of periodontal surgery by the same Dentist/dental office, or if more than two (2) quadrants are treated in one office visit.

16. Fees are Not Billable to the Eligible Person if more than two quadrants of periodontal scaling and root planing are performed by the same Dentist/dental office on the same date of service.

17. If periodontal surgery is performed less than four (4) weeks after periodontal scaling and root planing by the same Dentist/dental office, the fee for the surgical procedure is Not Billable to the Eligible Person.

18. Fees are Not Billable to the Eligible Person for periodontal scaling and root planning done on the same day by the same Dentist/dental office as a gingival flap procedure, surgical repair of root resorption or surgical exposure of root surface.

19. The fee for cleanings, scaling in the presence of generalized, moderate or severe inflammation, full mouth debridement and/or periodontal maintenance is Not Billable to the Eligible Person if the services are provided by the same Dentist/dental office within thirty (30) days after the most recent scaling and root planing or other periodontal therapy. The fee for cleanings, scaling in the presence of generalized, moderate or severe inflammation, full mouth debridement and/or periodontal maintenance is Denied if the services are provided by a different Dentist/dental office within thirty (30) days of periodontal therapy.

20. Periodontal surgical procedures include all necessary postoperative care, finishing procedures, and evaluations for three (3) months, as well as any surgical re-entry, except soft tissue grafts, for three (3) years. The fee for surgical re-entry by the same Dentist/dental office within three (3) years is Not Billable to the Eligible Person.

21. An adjustment will be made for two (2) or more restoration surfaces which are normally joined together. A Northeast Delta Dental Participating Dentist agrees not to charge a separate fee.

22. Clinical crown lengthening is a covered benefit once per tooth per lifetime and only when performed in a healthy periodontal environment, on natural teeth only, in which bone must be removed for placement of the restoration or crown, or prosthetic device. The fee for clinical crown lengthening is Not Billable to the Eligible Person if performed on the same date of service by the same Dentist/dental office as the crown placement.

23. Clinical crown lengthening, when done in conjunction with osseous surgery, crown preparations, or restorations is considered a component of, and included in the fee for, the complete procedure and is Not Billable to the Eligible Person.

24. Clinical crown lengthening, when performed in conjunction with other periodontal procedures, will be subject to a dental consultant's review. Payment will be based on the most comprehensive procedure.

25. Direct or indirect pulp caps are a covered benefit once in a period of three (3) years. A pulp cap performed on the same date of service as the final restoration by the same Dentist/dental office is considered part of a single complete restorative procedure and the fee for the pulp cap is Not Billable to the Eligible Person.

26. Recementation of a crown, onlay, veneer or partial coverage restoration, is a covered benefit once per tooth per lifetime. The fee is Not Billable to the Eligible Person if performed within six (6) months of the initial placement by the same Dentist/dental office.

27. Recementation of a cast or prefabricated post and core is a covered benefit once per tooth per lifetime. The fee is Not Billable to the Eligible Person if performed within six (6) months of the initial placement by the same Dentist/dental office, or if performed on the same date of service of a crown recementation by the same Dentist/dental office.

28. Anterior deciduous root canal therapy is not a covered benefit.

29. A partial pulpotomy is a covered benefit once per tooth per lifetime, on permanent teeth only. The fee for a partial pulpotomy is Not Billable to the Eligible Person if performed within thirty (30) days on the same tooth by the same Dentist/dental office as root canal therapy.

30. Pulpal therapy is a covered benefit once in a three (3) year period on primary first and second molars only. If pulpal therapy is performed on primary anterior or permanent teeth, the

procedure will be covered as a palliative treatment.

31. Therapeutic pulpotomy is a covered benefit once in a three (3) year period per tooth on primary teeth only. If the service is provided on permanent teeth, the procedure will be covered as a palliative treatment.

32. Fees for therapeutic pulpotomy or palliative treatment are Not Billable to the Eligible Person when performed on the same date of service as root canal procedure or root canal therapy.

33. Root canal therapy is a covered benefit once in a period of three (3) years. Retreatment of root canal therapy by the same Dentist/dental office within twenty-four (24) months is considered part of the original procedure. Fees for the retreatment by the same Dentist/dental office are Not Billable to the Eligible Person.

34. Root canal therapy is not a benefit in conjunction with overdentures and benefits are Denied. The Eligible Person is responsible for the additional fee.

35. Endodontic treatments and retreatments are Not Billable to the Eligible Person if performed by the same Dentist/dental office within twenty-four (24) months of an initial endodontic treatment or within twenty-four (24) months of a previous endodontic retreatment.

36. Incomplete endodontic procedure due to inoperable or fractured tooth may be covered at 50% of the fee for a completed endodontic therapy, subject to a consultant's review of radiographic images and clinical notes.

37. Root amputation performed in conjunction with an apicoectomy by the same Dentist/dental office is Not Billable to the Eligible Person.

38. An upper or lower frenulectomy or frenuloplasty is a covered benefit once per site per lifetime and is Not Billable to the Eligible Person when billed on the same date as any other surgical procedure in the same surgical area by the same Dentist/dental office.

39. Alveoloplasty is included in the fee for extractions. Separate fees for these procedures are Not Billable to the Eligible Person if performed by the same Dentist/dental office, in the same area on the same date.

40. The fee for repairs of complete or partial dentures cannot exceed half the fees for a new appliance. Any excess fee billed by the same Dentist/dental office is Not Billable to the Eligible Person on the same date of service.

41. The fee for palliative treatment is Not Billable to the Eligible Person when submitted with all procedures except radiographic images and diagnostic codes and is performed by the same Dentist/dental office on the same date.

42. Palliative treatment is part of the initiation of endodontic therapy and therefore is included in the fee when performed on the same date by the same Dentist/dental office and a separate fee is Not Billable to the Eligible Person.

43. General anesthesia is a covered benefit only when administered by a properly licensed Dentist in a dental office in conjunction with covered oral surgical procedures or when necessary due to concurrent medical conditions. Otherwise, the fee for general anesthesia is Denied.

44. Local anesthesia in conjunction with any procedure by the same Dentist/dental office is considered part of the overall procedure and fees are Not Billable to the Eligible Person.

45. The fee for nitrous oxide is Not Billable to the Eligible Person in conjunction with Intravenous sedation and/or general anesthesia.

46. The fee for non-intravenous conscious sedation is Not Billable to the Eligible Person in conjunction with intravenous sedation and/or general anesthesia.

47. Fees for repairs of complete or partial dentures, if performed within six (6) months of initial placement by the same Dentist/dental office are Not Billable to the Eligible Person. Benefits are Denied if done by a different Dentist/dental office within six (6) months of initial placement.

48. Pin retention is a covered benefit once per tooth in a period of twenty-four (24) months in conjunction with all restorations. Additional pins in the same tooth are Not Billable to the Eligible Person. Pin retention is Not Billable to the Eligible Person when billed in conjunction with a core buildup.

49. An apexification is a covered benefit once per tooth in a lifetime. Retreatment by the same Dentist/dental office within twenty-four (24) months is Not Billable to the Eligible Person.

50. An apicoectomy is a covered benefit once per tooth in a period of three (3) years. Retreatment by the same Dentist/dental office within twenty-four (24) months is Not Billable to the Eligible Person.

51. An internal root repair of perforation defects is a covered benefit once in a lifetime on permanent teeth only. If performed on a primary tooth the benefit is Denied. The fee for an internal root repair of perforation defects is Not Billable to the Eligible Person if performed on the same date of service by the same Dentist/dental office as an apicoectomy or retrograde filling.

52. Retrograde fillings are a covered benefit once per root per three (3) years. Retreatment within twenty-four (24) months of the original procedure by the same Dentist/dental office is Not Billable to the Eligible Person.

53. Surgical repair of root resorption or surgical exposure of root surface without apicoectomy or repair of root resorption without an apicoectomy performed on the same tooth, on the same date, by the same Dentist/dental office as an apicoectomy, retrograde filling, surgical repair of root resorption, surgical exposure of root surface without apicoectomy or repair of root resorption, root amputation, internal root repair of perforation defects and/or periodontal surgical services are Not Billable to the Eligible Person.

54. Pulpal debridement is a covered benefit once in a lifetime. The fee for pulpal debridement is Not Billable to the Eligible Person when performed in conjunction with endodontic therapy on the same tooth by the same Dentist/dental office or within thirty (30) days of root canal therapy or an apexification.

55. Removal of residual tooth roots is Not Billable to the Eligible Person when performed on the same date of service as an extraction by the same Dentist/dental office.

56. A partial extraction for immediate implant placement is a covered benefit once per tooth in a lifetime.

57. Reattachment of a tooth fragment, including the incisal edge or cusp, is a covered benefit. The fee is Not Billable to the Eligible Person if performed within twenty-four (24) months of a restoration on the same tooth by the same Dentist/dental office.

58. Denture adjustments, relines or tissue conditioning performed within three (3) months of a complete immediate denture are Not Billable to the Eligible Person.

59. Adjustment or repair of a denture is a covered benefit twice in a twelve (12) month period for Eligible Persons. Fees for an adjustment or repair of a denture is Not Billable to the Eligible Person if performed within six (6) months of initial placement. The fee for an adjustment or repair of a denture cannot exceed one-half of the fee for a new appliance, and any excess fee by

the same Dentist/dental office is Not Billable to the Eligible Person on the same date of service.

60. Cleaning and inspection of a removable complete or partial denture is not a covered benefit. The fee for cleaning and inspection of a removable complete or partial denture is Not Billable to the Eligible Person when done by the same Dentist/dental office on the same date of service as a reline or rebase of the denture. Otherwise, the fee for cleaning and inspection of a removable complete or partial denture is Denied.

61. A consultation is a covered benefit only if performed by a Dentist that is not performing further treatment. A consultation is Not Billable to the Eligible Person if performed in conjunction with an oral evaluation by the same Dentist/dental office on the same date of service.

62. Gingivectomy, gingival flap procedure, or mesial/distal wedge is a covered benefit once in a period of three (3) years on natural teeth. The charge for surgical re-entry by the same Dentist/dental office within three (3) years is Not Billable to the Eligible Person.

63. Bone replacement graft, biologic material, guided tissue regeneration, and tissue grafts are a covered benefit once in a period of three (3) years and limited to two teeth per quadrant per day. Fees for more than two teeth per quadrant in a day are Denied. The charge for surgical re-entry by the same Dentist/dental office within three (3) years is Not Billable to the Eligible Person.

64. Fees for guided tissue regeneration, resorbable or non-resorbable barrier per site or per implant, edentulous area, resorbable or non-resorbable barrier per site, are Denied when done in conjunction with mucogingival/soft tissue grafts in the same surgical area.

65. Guided tissue regeneration, resorbable barrier, per site in conjunction with periradicular surgery is not a covered benefit.

66. Osseous surgery is a covered benefit per quadrant (maximum of two (2) quadrants per office visit) once in a period of three (3) years. Fees are Not Billable to the Eligible Person for surgical re-entry by the same Dentist/dental office within a three (3) year period, and/or if more than two quadrants are treated in one office visit, the fee will be Denied.

67. Fees for restorations on the same tooth by the same Dentist/dental office performed within sixty (60) days of the application of caries arresting medicament are Denied. The Eligible Person is responsible for the fee.

68. Gingival irrigation is not a covered benefit and fees are Denied. Fees for gingival irrigation are Not Billable to the Eligible Person when performed in conjunction with any periodontal service.

69. The fabrication of an athletic mouthguard is a covered benefit once in a twenty-four (24) month period for Eligible Persons.

70. Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachments and management of hypertrophied and hyperplastic tissue) is not a covered benefit.

71. Nerve dissection is part of the removal of a completely bony impacted tooth and the fees are Not Billable to the Eligible Person when done on the same date of service.

Please note: Northeast Delta Dental strongly encourages Predetermination of cases involving costly or extensive treatment plans. Although it's not required, Predetermination helps avoid potential confusion regarding Northeast Delta Dental's payment and your financial obligation to the Dentist**.**

Major Benefits (Coverage C)

Restorative Crowns and Onlays**:**	Crowns and onlays when a tooth cannot be adequately restored with amalgam (silver) or resin (white) restorations.
Prosthodontics**:**	Fixed partial dentures (abutment crowns and pontics), removable, complete, and partial dentures, including rebase and reline of such prosthetic appliances, core buildups, cast and prefabricated posts and cores, and crown, and onlay repairs.
Implant Services**:**	Surgical placement of an endosteal implant body, including healing cap.
Implant Supported Prostheses**:**	Crowns, fixed or removable partial dentures, and full dentures anchored in place by an implanted device.

NOTE: Time limitations are measured from the date the services were most recently performed.

Coverage C Exclusions and Limitations:

- If the fee for a procedure or service is "Not Billable to the Eligible Person," it is not payable by the plan, nor collectable from the Eligible Person by a Participating Dentist. Participating Dentists agree not to charge a separate fee.
- If the fee for a procedure or service is "Denied," it is not payable by the plan, but is chargeable to the Eligible Person as the procedure or service is not a benefit under the plan.

1. Tissue conditioning is a covered benefit two (2) times in a period of three (3) years. The fee for tissue conditioning is Not Billable to the Eligible Person if performed on the same date of service as a denture rebase or reline by the same Dentist/dental office.
2. Coverage C time limitations:
   (a) One (1) partial, complete or immediate maxillary (upper) and one (1) partial, complete or immediate mandibular (lower) denture in a period of seven (7) years.
   (b) One (1) complete maxillary (upper) denture rebase and one (1) complete mandibular (lower) denture rebase in a period of seven (7) years.
   (c) One (1) removable or fixed partial denture per quadrant in a period of seven (7) years unless the loss of additional teeth requires the construction of a new appliance.
   (d) Crowns, onlays, core buildups, and post and cores are a covered benefit once per tooth in a period of seven (7) years.
   (e) The period of seven (7) years referred to in (a), (b), (c), and (d) above is to be measured from the date the service was last performed.
3. Inlays are not a covered benefit. An allowance will be paid equal to an amalgam (silver) restoration. If an inlay is performed, the Eligible Person is responsible for any additional fee.
4. A core buildup is a covered benefit once in a seven (7) year period per tooth for Eligible Persons. The fees for core buildups are Not Billable to the Eligible Person when buildups are performed in conjunction with inlays, 3/4 crowns or onlays and indirectly fabricated or prefabricated post and cores.
5. An indirectly fabricated or prefabricated post and core is payable only on an endodontically

treated tooth and is a covered benefit once in a seven (7) year period for Eligible Persons. Fees for post and cores are Not Billable to the Eligible Person when radiographs indicate an absence of endodontic treatment, incompletely filled canal space or unresolved pathology associated with the involved tooth. Each additional post in the same tooth is considered part of the post and core procedure. A separate fee is Not Billable to the Eligible Person.

6. A core buildup or indirectly fabricated and prefabricated post and cores in conjunction with a fixed partial denture crown are a covered benefit once in a seven (7) year period per tooth for Eligible Persons.

7. Scaling and debridement in the presence of inflammation or mucositis of a single implant is a covered benefit once in a twenty-four (24) month period. Fees for retreatment are Not Billable to the Eligible Person if performed within twelve (12) months of restoration or within twenty-four (24) months of initial therapy by the same Dentist/dental office. If performed by a different Dentist/dental office, the fee is Denied.

8. The fee for scaling and debridement in the presence of inflammation or mucositis of a single implant is Not Billable to the Eligible Person when performed in the same quadrant by the same Dentist/dental office as periodontal scaling and root planing or gingival flap procedure, and osseous surgery or debridement of peri-implant defect.

9. The fee for scaling and debridement in the presence of inflammation or mucositis of a single implant is Not Billable to the Eligible Person when performed in conjunction with a cleaning, periodontal maintenance or scaling of moderate or severe gingival inflammation.

10. Post removal is considered part of the endodontic treatment and/or retreatment, and is Not Billable to the Eligible Person.

11. A provisional crown or provisional implant crown is considered part of a crown procedure when performed by the same Dentist/dental office as a permanent crown, and a separate fee is Not Billable to the Eligible Person.

12. Prefabricated porcelain/ceramic crowns for permanent teeth and prefabricated resin crowns for anterior primary teeth are a covered benefit once in a period of twenty-four (24) months. The fee for replacement by the same Dentist/dental office within twenty-four (24) months is included in the initial crown placement and is Not Billable to the Eligible Person. Benefits are Denied if done by a different Dentist/dental office within twenty-four (24) months.

13. Prefabricated porcelain/ceramic crowns for primary teeth are a covered benefit once in a lifetime. The fee for replacement by the same Dentist/dental office within twenty-four (24) months is included in the initial crown placement and is Not Billable to the Eligible Person. Benefits are Denied if done by a different Dentist/dental office.

14. Fees for crown, inlay, onlay or veneer repairs performed on the same date of service as a new crown, inlay, onlay or veneer are Not Billable to the Eligible Person.

15. Fees for crown, inlay, onlay or veneer repairs are Not Billable to the Eligible Person if performed within twenty-four (24) months of the original restoration by the same Dentist/dental office.

16. Benefits for crown, inlay, onlay or veneer repairs are Denied if performed within twenty-four (24) months of the original restoration by a different Dentist/dental office. The Eligible Person is responsible for the fees.

17. An implant body, including healing cap, is a covered benefit once in a lifetime per site. The fees for an implant are Not Billable to the Eligible Person if the implant is part of a fixed partial denture on natural teeth.

18. Eposteal and transosteal implants are optional. An allowance will be paid equal to an endosteal implant. The Eligible Person will be responsible for any additional fee.

19. Guided tissue regeneration - resorbable barrier or non-resorbable barrier, per implant, is not a covered benefit.

20. Removal of an implant body is a covered benefit once in a lifetime per tooth site. The fee for removal of an implant is Not Billable to the Eligible Person when done by the same Dentist/dental office within three (3) months of surgical placement of an implant or a mini-implant.

21. The fee for removal of an implant body not requiring bone removal or flap elevation when performed within six (6) months of surgical placement of an implant or a mini-implant on the same tooth by the same Dentist/dental office is Not Billable to the Eligible Person. Benefits are Denied if done by a different Dentist/dental office.

22. Fees for repair of implant or abutment-supported prosthesis performed within six (6) months of the initial placement of the prosthesis by the same Dentist/dental office are Not Billable to the Eligible Person.

23. Replacement of restorative material used to close an access opening of a screw-retained implant supported prostheses, per implant, is a covered benefit once in a period of twenty-four (24) months.

24. Fees for replacement of restorative material used to close an access opening of a screw-retained implant supported prostheses, per implant, are Not Billable to the Eligible Person when performed by the same Dentist/dental office within six (6) months of placement of the implant prosthesis.

25. Fees for replacement of restorative material used to close an access opening of a screw-retained implant supported prostheses, per implant, are Not Billable to the Eligible Person on the same date of service by the same Dentist/dental office as an implant maintenance procedure when prostheses are removed and reinserted, including cleansing of prostheses and abutments or repair of implant supported prostheses.

26. Accessing and retorquing loose implant screw, per screw, is a covered benefit once in a period of twenty-four (24) months for Eligible Persons age sixteen (16) and older.

27. Fees for accessing and retorquing loose implant screw, per screw, are Not Billable to the Eligible Person when done on the same date of service by the same Dentist/dental office as implant maintenance, implant repair, or replacement of an implant screw.

28. Replacement of an implant screw is a covered benefit once per implant in a twenty-four (24) month period for Eligible Persons age sixteen (16) and older. Fees for replacement of an implant screw, if performed within six (6) months of the initial placement of the prosthesis, by the same Dentist/dental office, is Not Billable to the Eligible Person.

29. Implant maintenance procedures when a full arch fixed hybrid prosthesis is either not removed or removed and reinserted, including cleansing of prosthesis and abutments is a covered benefit once in a period of three (3) years.

30. Fee for Implant maintenance procedures when a full arch fixed hybrid prosthesis is either not removed or removed and reinserted, including cleansing of prosthesis and abutments are Not Billable to the Eligible Person if done within twelve (12) months of an implant/abutment supported fixed denture for edentulous arch, maxillary or mandibular.

31. Bone replacement graft for ridge preservation is not a covered benefit.

32. If abutment teeth have moved to partially close an edentulous area, only the number of pontics necessary to fill that area are a covered benefit. The Eligible Person will be responsible for any additional fee.

33. Recementation of a fixed partial denture is a covered benefit once in a lifetime. Fees for recementation of fixed partial dentures are Not Billable to the Eligible Person if done within six (6) months of the initial placement by the same Dentist/dental office.

34. An interim complete denture is not a covered benefit. Fees are Not Billable to the Eligible Person if billed in conjunction with a permanent appliance.

35. The relining of a denture is a covered benefit twice in a period of twelve (12) months for Eligible Persons. The fee for reline of a denture cannot exceed one-half of the fee for a new appliance, and any excess fee by the same Dentist/dental office is Not Billable to the Eligible Person on the same date of service.

36. The rebase of a denture is a covered benefit once in a period of seven (7) years for Eligible Persons. The fee for rebase of a denture cannot exceed one-half of the fee for a new appliance, and any excess fee by the same Dentist/dental office is Not Billable to the Eligible Person on the same date of service.

37. The reline or rebase of a denture is Not Billable to the Eligible Person if performed within six (6) months of initial placement by the same Dentist/dental office.

38. Sectioning of a fixed partial denture in order to remove the denture prior to placing a new denture is Not Billable to the Eligible Person. Sectioning of a fixed partial denture to preserve a portion of the denture for continued use may be covered but is subject to a dental consultant's review.

39. Placement of an intra-socket biological dressing to aid in hemostasis or clot stabilization is not a covered benefit and the fee is Denied. If placement of an intra-socket biological dressing to aid in hemostasis or clot stabilization is performed in conjunction with an extraction and/or post-operative procedure, it is considered part of that procedure and Not Billable to the Eligible Person.

40. Fees for more than one surgical placement of mini-implant placed at the same site on the same day are Not Billable to the Eligible Person.

Please note: Northeast Delta Dental strongly encourages Predetermination of cases involving costly or extensive treatment plans. Although it's not required, Predetermination helps avoid potential confusion regarding Northeast Delta Dental's payment and your financial obligation to the Dentist.

General Exclusions and Limitations

1. Unless otherwise specified in the Outline of Benefits, the dental benefits provided by Northeast Delta Dental shall not include the following:

   (a) Services for injuries or conditions compensable under worker's compensation or employer's liability laws.

   (b) Services that are determined by Northeast Delta Dental to be rendered for cosmetic reasons, such as bleaching or whitening of teeth, placement of veneers, or cosmetic surgery. (This exclusion is not intended to exclude services provided for congenital defects and/or developmental malformations.)

   (c) Services including, but not limited to endodontics and prosthodontics (including restorative crowns and onlays) completed prior to the date the Subscriber became eligible under the Agreement.

   (d) Services not provided by a Dentist, ODP or under the supervision of a Dentist, or that are not within the scope of the license of the Dentist, ODP or the person supervised by the Dentist, unless otherwise required by law.

   (e) Prescription drugs, premedications and/or relative analgesia, or the application of anti-microbial agents.

   (f) Charges for: (i) hospitalization; (ii) general anesthesia or intravenous sedation for restorative dentistry (except as noted in Section III., Coverage B Benefits); (iii) preventive control programs; (iv) splint – intra or extra coronal; (v) myofunctional therapy; (vi) treatment of temporomandibular joint (TMJ) dysfunction; and related diagnostic procedures; (vii) equilibration; and (viii) gnathological reporting.

   (g) Charges for failure to keep a scheduled visit with the Dentist.

   (h) Charges for completion of forms. Such charges shall not be made to a Subscriber by Participating Dentists.

   (i) Dental Care which is not necessary and customary, as determined by generally accepted dental practice standards.

   (j) Dental Care or supplies which are not within the classification of benefits defined in the Agreement.

   (k) Appliances, procedures, or restorations for: (i) increasing vertical dimension; (ii) analyzing, altering, restoring, or maintaining occlusion; (iii) replacing tooth structure lost by attrition or abrasion; (iv) administration of home sleep apnea test or screening for sleep related breathing disorders, custom sleep apnea appliance fabrication, placement, adjustment, repair or reline; or (v) esthetic purposes. This exclusion is not intended to exclude services provided for congenital defects and/or developmental malformations.

   (l) Payments of benefits incurred by the Subscriber after the date on which the Subscriber becomes ineligible for benefits.

   m) Charges for Dental Care or supplies for which no charge would have been made in the absence of dental benefits.

   (n) Charges for Dental Care or supplies received as a result of dental disease, defect, or injury due to an act of war, declared or undeclared.

   (o) All services, including evaluations and radiographs, performed for orthodontic purposes where the group does not have Orthodontic Benefits (Coverage D). If

services are rendered, they should be done so with the agreement of the Eligible Person to assume the additional cost.

(p) Temporary services or incomplete treatment.

(q) A consultation unless performed by a Dentist who is not performing further services.

(r) Consultation with medical health care professional and dental case management for addressing appointment compliance barriers and care coordination are part of the overall Eligible Person management and the fees are Not Billable to the Eligible Person. Dental case management for motivational interviewing and Eligible Person education are not a covered benefit. If services are provided on the same day by the same Dentist/dental office as immunization counseling, counseling for the control and prevention of adverse oral, behavioral and systemic health effects associated with high risk substance use, nutritional or tobacco counseling or oral hygiene instruction, fees for dental case management for motivational interviewing and Eligible Person education are Not Billable to the Eligible Person.

(s) Case presentation and treatment planning.

(t) Occlusal guards (nightguards).

(u) The fees for transmitting data via teledentistry are considered inclusive in the overall dental procedure(s) being performed and separate fees are Not Billable to the Eligible Person.

(v) The fees for translation services are considered inclusive in the overall patient management and are Not Billable to the Eligible Person.

(w) The duplication or copying of the Eligible Person's dental records.

(x) In accordance with state laws, a Dentist is required to submit appropriate clinical documentation for procedures. All clinical procedures are subject to review of clinical notes, radiographs, etc. to determine coverage.

(y) Covered periodontal services are only covered when performed on natural teeth for treatment of periodontal disease. Unless otherwise specified by contract, benefits for these procedures when billed in conjunction with implants, ridge augmentation, extraction sites and/or periradicular surgery are Denied and the Eligible Person is responsible for the fee.

2. Unless otherwise specified in the Outline of Benefits, the dental benefits provided by Northeast Delta Dental shall be limited as follows:

(a) Unless otherwise required by law, Dental care rendered by anyone other than a Dentist or ODP shall not be a covered benefit. Such other treatment performed by an ODP shall be a benefit, so long as the treatment is within the ODP's scope of practice and in accordance with generally accepted dental practice standards.

(b) Optional Dental Care: In all cases in which the Subscriber agrees, after consultation with their Dentist, to more expensive Dental Care than is customarily provided, Northeast Delta Dental will pay based on the applicable Co-insurance Percentage for the Dental Care which is customarily provided to restore the tooth to contour and function. The Subscriber shall be responsible for the remainder of the Dentist's fee.

(c) Predetermination does not guarantee payment. Payment is based upon eligibility, benefits selected by the group, and allowable charges at the time the Dental Care is rendered and the Dentist's participating status with Delta Dental. If Coordination of

Benefits is involved, the amount of payment may change dramatically depending on the payment made by the primary carrier.

(d) Services completed or in progress at the Subscriber's date of death will be paid in full to the limit of Northeast Delta Dental's liability.

(e) When services for Dental Care in progress are interrupted and completed thereafter by another Dentist, Northeast Delta Dental will review the claim to determine the payment, if any, due each Dentist.

(f) Maximum Payment:

(i) The Maximum amount payable in any Coverage Period, or any portion thereof, shall be limited to the amount specified in the Outline of Benefits.

(ii) Northeast Delta Dental's payment shall be reduced by any applicable Co-payments.

(g) Specialized techniques including, but not limited to: precision attachments, overdentures and procedures associated therewith and personalizations or characterization are excluded. The Eligible Person will be responsible for part of or the entire fee for these services.

(h) Diagnostic casts (study models) and/or photographs are a covered benefit as part of the total orthodontic case fee. Subsequent diagnostic casts and/or photographs are Not Billable to the Eligible Person.

(i) Benefits are paid for amalgam (silver) or resin (white) restorations for the treatment of caries. If a tooth can be restored with amalgam or resin, use of gold, an onlay or a crown is at the option of the Eligible Person and the Eligible Person will be responsible for any additional cost.

(j) Written notice of sickness or of injury must be given to Delta Dental within thirty (30) days after the date when such sickness or injury occurred or as soon thereafter as reasonably possible. Failure to give notice within such time shall not invalidate nor reduce any claim, if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible.

(k) A completed claim (or satisfactory written proof acceptable to Delta Dental) must be furnished to Delta Dental at its principal office within twenty-four (24) months from the date the Dentist provided Dental Care. No payment will be made on claims with dates of service in excess of the twenty-four (24) month limitation except for a demonstrated reason preventing submission within the twenty-four (24) month period.

(l) Delta Dental, upon receipt of a notice of claim, will furnish to you such forms as are usually furnished by it for filing claims. If such forms are not furnished within fifteen (15) days after you give such notice, you shall be deemed to have complied with the requirements of this policy with the time fixed in the policy for filing claims. Notice given by or on behalf of you to Delta Dental, or to any authorized agent of Delta Dental, with information sufficient to identify you, shall be deemed notice to Delta Dental.

(m) The Date of Incurred Liability refers to the date a covered service is subject to the applicable Co-insurance Percentage, Maximum benefit, and limitations. The total cost of the service is applied to the Coverage Period during which the service is completed, irrespective of the Coverage Period in which the service is started.

For services covered, Delta Dental's date of incurred liability for multiple visit procedures is as follows:

(i) Restorative Crowns and Onlays — Total cost for crowns and onlays shall be incurred on the date that the crown or onlay is cemented.

(ii) Fixed Partial Dentures (abutment crowns and pontics) — The total cost for fixed partial dentures shall be incurred on the date that the said appliance is cemented.

(iii) Removable Complete and Partial Dentures — Total cost for removable complete and partial dentures shall be incurred on the date that the said appliance is delivered to the Eligible Person.

(iv) Endodontics — Total cost for endodontic treatment shall be incurred when the canal is filled to completion.

(v) Implant Body — Total cost for the implant body, including healing cap, shall be incurred on the date of surgical placement.

(vi) Implant Prosthetics — Total cost for the prosthetic portion of an implant shall be incurred on the date that the said appliance is cemented or delivered to the Eligible Person.

(n) No action may be brought to recover a claim under this policy prior to the expiration of sixty (60) days after the claim has been filed or the claim review and appeal process, described in Articles VI, VII and VIII herein, has been completed. In no event shall any action be brought on a claim more than two (2) years after the completed claim has been filed.

2026 Wellness Wallet

This document outlines covered services and items available by plan. Please review carefully and consult your Evidence of Coverage for the coverage amount available under your plan.

Select PPO (H1365-005) and Essential HMO-POS (H5591-018) Members:

Coverage is available for the following:

» Gym membership, personal trainer fees and/or fitness class fees at facilities only

» Activity trackers—limited to Apple Watch, Fitbit, Garmin, and Oura Ring

» Face masks—KN95, KF94, N95, or Envo Masks when purchased through a retailer's website, retail store, or durable medical equipment (DME) provider

Select PPO (H1365-001), Alliance HMO (H5591-003), and all Prime HMO-POS (H5591-006-001, H5591-006-002, H5591-016, H5591-017) Members:

Coverage is available for the following:

» Gym membership, personal trainer fees and/or fitness class fees at facilities only

» Activity trackers—limited to Apple Watch, Fitbit, Garmin, and Oura Ring

» Face masks—KN95, KF94, N95, or Envo Masks when purchased through a retailer's website, retail store, or durable medical equipment (DME) provider

» Naturopathic visits and services provided by a licensed naturopath

» Acupuncture services provided by a licensed provider

» Acupressure

» Weight management programs through Weight Watchers or Zoom (food is not covered)

» At-home fitness equipment is limited to:

- Exercise bikes
- Treadmills
- Elliptical trainers
- Weight sets
- Free weights
- Pull-up bar

» Canoes, kayaks, paddles, personal flotation device (PFD)

» Membership or individual session fees at the following facilities, and specifically listed equipment, when applicable:

- Golf—golf clubs
- YMCA
- Pools/swimming—swim cap, swim goggles
- Yoga—yoga mat, yoga strap, yoga block and balance pad or cushion
- Biking/cycling—bicycle, bicycle helmet
- Bowling—bowling ball
- Skiing—ski boots, ski poles, ski helmets
- Tennis—tennis racquets
- Pickleball—pickleball paddle

Martin's Point Generations Advantage Prepaid Mastercard®:

The prepaid Mastercard® may be used for select items at participating retailers only. The available balance on the card is updated automatically after each card purchase is completed. Unused balances do not carry over to the next year. If you disenroll during a plan year, any unused Wellness Wallet dollars are deleted. Please contact Member Services if you need a replacement Prepaid Mastercard®.

Reimbursement Requests:

Reimbursement requests for covered items and services can be submitted online (recommended) or by mail. See www.MartinsPoint.org/WellnessWallet for more information about submission options and instructions. Reimbursement requests must be received by the plan no later than 120 days following the date of purchase.

Fitness equipment and covered items must be new items purchased from a licensed retail establishment and delivery, shipping fees, and tax are eligible for inclusion under covered costs.

The benefit amount and list of covered items and services is subject to change on January 1st each plan year.

Martin's Point Generations Advantage Member Services

Method	Contact Information
CALL	1-866-544-7504 **Calls to this number are free.** 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. Member Services also has free language interpreter services available for non-English speakers.
TTY	711 **Calls to this number are free.** 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.
FAX	207-828-7821
WRITE	Martin's Point Generations Advantage ATTN: Member Services PO Box 9746 Portland, ME 04104
WEBSITE	**MartinsPoint.org/EOC**

State Health Insurance Assistance Program (SHIP)

The State Health Insurance Assistance Program is a state program that receives money from the federal government to give free local health insurance counseling to people with Medicare.

See Chapter 2, Section 3 for phone numbers and contact information for the State Health Insurance Assistance Program in your area.