

## **Martin's Point Generations Advantage Prime (HMO-POS) offered by MARTIN'S POINT GENERATIONS ADVANTAGE, INC. (Martin's Point Generations Advantage)**

### **Annual Notice of Change for 2026**

You're enrolled as a member of Martin's Point Generations Advantage Prime (HMO-POS).

This material describes changes to our plan's costs and benefits next year.

- **You have from October 15 - December 7 to make changes to your Medicare coverage for next year.** If you don't join another plan by December 7, 2025, you'll stay in Martin's Point Generations Advantage Prime (HMO-POS).
- To change to a **different plan**, visit [www.martinspoint.org/medicaremembers](http://www.martinspoint.org/medicaremembers) or review the list in the back of your *Medicare & You 2026* handbook.
- Note this is only a summary of changes. More information about costs, benefits, and rules is in the *Evidence of Coverage*. Get a copy at [www.martinspoint.org/medicaremembers](http://www.martinspoint.org/medicaremembers) or call Member Services at 1-866-544-7504 (TTY users call 711) to get a copy by mail.

#### **More Resources**

- *Per the final rule CMS-4205-F released on April 4, 2024, §§ 422.2267(e)(31)(ii) and 423.2267(e)(33)(ii), plans must provide a Notice of Availability of language assistance services and auxiliary aids and services that at a minimum states that our plan provides language assistance services and appropriate auxiliary aids and services free of charge. Our plan must provide the notice in English and at least the 15 languages most commonly spoken by people with limited English proficiency in the relevant state or states in our plan's service area and must provide the notice in alternate formats for people with disabilities who require auxiliary aids and services to ensure effective communication.*
- Call Member Services at 1-866-544-7504 (TTY users call 711) for more information. 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 document may be available in other formats such as large print and braille. For more information, please call Member Services.

#### **About Martin's Point Generations Advantage Prime (HMO-POS)**

- MARTIN'S POINT GENERATIONS ADVANTAGE, INC. is a HMO-MAPD plan with a Medicare contract. Enrollment in MARTIN'S POINT GENERATIONS ADVANTAGE, INC. depends on contract renewal.
- When this material 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 Prime (HMO-POS).

- **If you do nothing by December 7, 2025, you'll automatically be enrolled in Martin's Point Generations Advantage Prime (HMO-POS).** Starting January 1, 2026, you'll get your medical and drug coverage through Martin's Point Generations Advantage Prime (HMO-POS). Go to Section 3 for more information about how to change plans and deadlines for making a change.

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## Summary of Important Costs for 2026

|                                                                                                                                                                                                                                                                         | 2025<br>(this year)                                                                                                                             | 2026<br>(next year)                                                                                                                             |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Monthly plan premium*</b><br><br>* Your premium can be higher or lower than this amount. Go to Section 1.1 for details.                                                                                                                                              | \$0                                                                                                                                             | \$38                                                                                                                                            |
| <b>Maximum out-of-pocket amount</b><br>This is the <u>most</u> you'll pay out of pocket for covered Part A and Part B services. (Go to Section 1.2 for details.)                                                                                                        | From network providers: \$6,350<br>From out-of-network providers: Not Applicable<br>From network and out-of-network providers combined: \$6,350 | From network providers: \$7,000<br>From out-of-network providers: Not Applicable<br>From network and out-of-network providers combined: \$7,000 |
| <b>Primary care office visits</b>                                                                                                                                                                                                                                       | <b>In-Network:</b><br>\$0 copayment per visit<br><br><b>Out-of-Network:</b><br>\$35 copayment per visit                                         | <b>In-Network:</b><br>\$0 copayment per visit<br><br><b>Out-of-Network:</b><br>\$65 copayment per visit                                         |
| <b>Specialist office visits</b>                                                                                                                                                                                                                                         | <b>In-Network:</b><br>\$45 copayment per visit<br><br><b>Out-of-Network:</b><br>\$60 copayment per visit                                        | <b>In-Network:</b><br>\$40 copayment per visit<br><br><b>Out-of-Network:</b><br>\$65 copayment per visit                                        |
| <b>Inpatient hospital stays</b><br>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. | <b>In-Network:</b><br>\$375 copayment each day for days 1 to 7 and \$0 copayment each day for days 8 to 90 for Medicare-covered hospital care.  | <b>In-Network:</b><br>\$350 copayment each day for days 1 to 5 and \$0 copayment each day for days 6 to 90 for Medicare-covered hospital care.  |

|                                                                                                                                                  | 2025<br>(this year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 2026<br>(next year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|--------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| The day before you're discharged is your last inpatient day.                                                                                     | <b>Out-of-Network:</b><br>40% coinsurance for each Medicare-covered hospital stay.                                                                                                                                                                                                                                                                                                                                                                                                         | <b>Out-of-Network:</b><br>40% coinsurance for each Medicare-covered hospital stay.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Part D drug coverage deductible</b><br>(Go to Section 1.6 for details.)                                                                       | Deductible: \$0                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Deductible: \$300 for your Tier 3, Tier 4, and Tier 5 drugs except for covered insulin products and most adult Part D vaccines.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Part D drug coverage</b><br>(Go to Section 1.6 for details, including Yearly Deductible, Initial Coverage, and Catastrophic Coverage Stages.) | <p>Copayment/Coinsurance during the Initial Coverage Stage (30 day retail supply):</p> <ul style="list-style-type: none"> <li>• Drug Tier 1: \$0 - \$4 copayment</li> <li>• Drug Tier 2: \$10 - \$18 copayment</li> <li>• Drug Tier 3: \$42 - \$47 copayment</li> </ul> <p>You pay \$35 per month supply of each covered insulin product on this tier.</p> <ul style="list-style-type: none"> <li>• Drug Tier 4: \$95 - \$100 copayment</li> <li>• Drug Tier 5: 33% coinsurance</li> </ul> | <p>Copayment/Coinsurance during the Initial Coverage Stage (30 day retail supply):</p> <ul style="list-style-type: none"> <li>• Drug Tier 1: \$0 - \$4 copayment</li> <li>• Drug Tier 2: \$5 - \$10 copayment</li> <li>• Drug Tier 3: 25% coinsurance</li> </ul> <p>You pay \$35 per month supply of each covered insulin product on this tier.</p> <ul style="list-style-type: none"> <li>• Drug Tier 4: 30% - 32% coinsurance</li> </ul> <p>You pay \$35 per month supply of each covered insulin product on this tier.</p> <ul style="list-style-type: none"> <li>• Drug Tier 5: 29% coinsurance</li> </ul> |

|  | 2025<br>(this year)                                                                                                                                                                                                                                                                                                                   | 2026<br>(next year)                                                                                                                                                                                                                                                                                                                   |
|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|  | <p>You pay \$35 per month supply of each covered insulin product on this tier.</p> <ul style="list-style-type: none"><li>• Drug Tier 6: \$0 - \$4 copayment</li></ul> <p>Catastrophic Coverage Stage:</p> <ul style="list-style-type: none"><li>• During this payment stage, you pay nothing for your covered Part D drugs.</li></ul> | <p>You pay \$35 per month supply of each covered insulin product on this tier.</p> <ul style="list-style-type: none"><li>• Drug Tier 6: \$0 - \$4 copayment</li></ul> <p>Catastrophic Coverage Stage:</p> <ul style="list-style-type: none"><li>• During this payment stage, you pay nothing for your covered Part D drugs.</li></ul> |

SECTION 1

Changes to Benefits & Costs for Next Year

Section 1.1

Changes to the Monthly Plan Premium

|                                                                                       | 2025<br>(this year) | 2026<br>(next year) |
|---------------------------------------------------------------------------------------|---------------------|---------------------|
| Monthly plan premium<br>(You must also continue to pay your Medicare Part B premium.) | \$0                 | \$38                |

Factors that could change your Part D Premium Amount

- Late Enrollment Penalty - Your monthly plan premium will be *more* if you're required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that's at least as good as Medicare drug coverage (also referred to as creditable coverage) for 63 days or more.
- Higher Income Surcharge - If you have a higher income, you may have to pay an additional amount each month directly to the government for Medicare drug coverage.
- Extra Help - Your monthly plan premium will be *less* if you get Extra Help with your drug costs. Go to Section 4 for more information about Extra Help from Medicare.

Section 1.2

Changes to Your Maximum Out-of-Pocket Amount

Medicare requires all health plans to limit how much you pay out of pocket for the year. This limit is called the maximum out-of-pocket amount. Once you've paid this amount, you generally pay nothing for covered Part A and Part B services for the rest of the calendar year.

|                                                                                                                                                                                                                                                                                                                                                      | 2025<br>(this year) | 2026<br>(next year)                                                                                                                                                                                                                      |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Combined maximum out-of-pocket amount</b><br>Your costs for covered medical services (such as copayments) from in-network and out-of-network providers <b>count</b> toward your combined maximum out-of-pocket amount.<br><br>Our plan premium and your costs for prescription drugs <b>don't count</b> toward your maximum out-of-pocket amount. | \$6,350             | \$7,000<br><br>Once you've paid \$7,000 out-of-pocket for covered Part A and Part B services, you'll pay nothing for your covered Part A and Part B services from network or out-of-network providers for the rest of the calendar year. |

Section 1.3 Changes to the Provider Network

Our network of providers has changed for next year. Review the 2026 *Provider and Pharmacy Directory* [www.MartinsPoint.org/MedicareMembers](http://www.MartinsPoint.org/MedicareMembers) to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network. Here's how to get an updated *Provider and Pharmacy Directory*:

- Visit our website at [www.martinspoint.org/medicaremembers](http://www.martinspoint.org/medicaremembers).
- Call Member Services at 1-866-544-7504 (TTY users call 711) to get current provider information or to ask us to mail you a *Provider and Pharmacy Directory*.

We can make changes to the hospitals, doctors, and specialists (providers) that are part of our plan during the year. If a mid-year change in our providers affects you, call Member Services at 1-866-544-7504 (TTY users call 711) for help. For more information on your rights when a network provider leaves our plan, go to Chapter 3, Section 2.3 of your *Evidence of Coverage*.

Section 1.4 Changes to the Pharmacy Network

Amounts you pay for your prescription drugs can depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered *only* if they are filled at one of our network pharmacies.



Our network of pharmacies has changed for next year. Review the 2026 *Provider and Pharmacy Directory* [www.MartinsPoint.org/MedicareMembers](http://www.MartinsPoint.org/MedicareMembers) to see which pharmacies are in our network. Here's how to get an updated *Provider and Pharmacy Directory*:

- Visit our website at [www.martinspoint.org/medicaremembers](http://www.martinspoint.org/medicaremembers).
- Call Member Services at 1-866-544-7504 (TTY users call 711) to get current pharmacy information or to ask us to mail you a *Provider and Pharmacy Directory*.

We can make changes to the pharmacies that are part of our plan during the year. If a mid-year change in our pharmacies affects you, call Member Services at 1-866-544-7504 (TTY users call 711) for help.

### Section 1.5 Changes to Benefits & Costs for Medical Services

|                                                                              | 2025<br>(this year)                                                                                                                                                                                | 2026<br>(next year)                                                                                                                                                                                |
|------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Acupuncture for chronic low back pain - Cost-Sharing (in-network)</b>     | You pay a \$0 copayment for each Primary Care Physician (PCP) office visit for Medicare-covered services. You pay a \$45 copayment for each specialist office visit for Medicare-covered services. | You pay a \$0 copayment for each Primary Care Physician (PCP) office visit for Medicare-covered services. You pay a \$40 copayment for each specialist office visit for Medicare-covered services. |
| <b>Acupuncture for chronic low back pain - Cost-Sharing (out-of-network)</b> | You pay a \$35 - \$60 copayment depending on the Medicare-covered service.                                                                                                                         | You pay a \$65 copayment for each Medicare-covered service.                                                                                                                                        |
| <b>Chiropractic services - Cost-Sharing (out-of-network)</b>                 | You pay a \$55 copayment for each Medicare-covered service.                                                                                                                                        | You pay a \$65 copayment for each Medicare-covered service.                                                                                                                                        |
| <b>Dental services - Maximum plan amount</b>                                 | There is a \$750 benefit maximum every year for preventive and comprehensive dental services. Please reach out to Northeast Delta Dental for more information.                                     | There is a \$1,000 benefit maximum every year for preventive and comprehensive dental services. Please reach out to Northeast Delta Dental for more information.                                   |

|                                                                                         | <b>2025<br/>(this year)</b>                                                                                                                                                 | <b>2026<br/>(next year)</b>                                                                                                                                                 |
|-----------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Dental services - Preventive dental services - Oral Exams - Periodicity</b>          | 1 cleaning and oral exam each year                                                                                                                                          | 2 cleanings and oral exams each year                                                                                                                                        |
| <b>Emergency care - Cost-Sharing</b>                                                    | You pay a \$125 copayment for each Medicare-covered service.                                                                                                                | You pay a \$115 copayment for each Medicare-covered service.                                                                                                                |
| <b>Emergency care - Worldwide emergency coverage - Cost-Sharing</b>                     | You pay a \$125 copayment. Copayment is waived if you are admitted to a hospital.                                                                                           | You pay a \$115 copayment. Copayment is waived if you are admitted to a hospital.                                                                                           |
| <b>Hearing services - Medicare-covered hearing exam - Cost-Sharing (in-network)</b>     | You pay a \$45 copayment for each Medicare-covered service.                                                                                                                 | You pay a \$40 copayment for each Medicare-covered service.                                                                                                                 |
| <b>Hearing services - Medicare-covered hearing exam - Cost-Sharing (out-of-network)</b> | You pay a \$60 copayment for each Medicare-covered service.                                                                                                                 | You pay a \$65 copayment for each Medicare-covered service.                                                                                                                 |
| <b>Inpatient hospital care - Cost-Sharing (in-network)</b>                              | You pay a \$375 copayment each day for days 1 to 7 and \$0 copayment each day for days 8 to 90 for Medicare-covered hospital care. Medicare hospital benefit periods apply. | You pay a \$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. |

|                                                                                                                               | 2025<br>(this year)                                                                                                                                                                                                                         | 2026<br>(next year)                                                                                                                                                                                                                                           |
|-------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Inpatient services in a psychiatric hospital - Cost-Sharing (in-network)</b>                                               | You pay a \$220 copayment each day for days 1 to 7 and \$0 copayment each day for days 8 to 90 for Medicare-covered hospital care.<br>\$0 copayment for an additional 60 lifetime reserve days.<br>Medicare hospital benefit periods apply. | You pay a \$275 copayment each day for days 1 to 5 and \$0 copayment each day for days 6 to 90 for Medicare-covered hospital care.<br>\$0 copayment for an additional 60 lifetime reserve days.<br>Medicare hospital benefit periods apply.                   |
| <b>Medical nutrition therapy - Additional medical nutrition therapy - Cost-Sharing (in-network)</b>                           | You pay a \$0 copayment.                                                                                                                                                                                                                    | <u>Not</u> covered                                                                                                                                                                                                                                            |
| <b>Medical nutrition therapy - Additional medical nutrition therapy - Non-Medicare-covered diseases - Additional sessions</b> | You pay \$0 copayment.                                                                                                                                                                                                                      | <u>Not</u> covered                                                                                                                                                                                                                                            |
| <b>Medicare Part B drugs - Insulin drugs - Cost-Sharing (in-network)</b>                                                      | You pay 20% of the cost of Medicare-covered services.<br><br>You will pay no more than \$35 for a one-month supply of Part B insulin products covered by our plan.                                                                          | You pay a 0% - 20% coinsurance depending on the Medicare-covered service.<br><br>You will pay no more than \$35 for a one-month supply of Part B insulin products covered by our plan, the lesser of \$35 for a 30-day supply or 25% of the cost for 30 days. |

|                                                                                                                                          | <b>2025<br/>(this year)</b>                                       | <b>2026<br/>(next year)</b>                                       |
|------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|-------------------------------------------------------------------|
| <b>Outpatient diagnostic tests and therapeutic services and supplies - Diagnostic radiological services - Cost-Sharing (in-network)</b>  | You pay a 20% coinsurance for each Medicare-covered service.      | You pay a 15% coinsurance for each Medicare-covered service.      |
| <b>Outpatient diagnostic tests and therapeutic services and supplies - Outpatient x-ray services - Cost-Sharing (in-network)</b>         | You pay a 15% coinsurance for each Medicare-covered service.      | You pay a \$25 copayment for each Medicare-covered service.       |
| <b>Outpatient diagnostic tests and therapeutic services and supplies - Outpatient x-ray services - Cost-Sharing (out-of-network)</b>     | You pay a 15% coinsurance for each Medicare-covered service.      | You pay a \$50 copayment for each Medicare-covered service.       |
| <b>Outpatient diagnostic tests and therapeutic services and supplies - Therapeutic radiological services - Cost-Sharing (in-network)</b> | You pay a 20% coinsurance for each Medicare-covered service.      | You pay a 15% coinsurance for each Medicare-covered service.      |
| <b>Outpatient mental health care - Non-psychiatric services - Group sessions - Cost-Sharing (in-network)</b>                             | You pay a \$25 copayment for each Medicare-covered Group Session. | You pay a \$10 copayment for each Medicare-covered Group Session. |
| <b>Outpatient mental health care - Non-psychiatric services - Group sessions - Cost-Sharing (out-of-network)</b>                         | You pay a \$30 copayment for each Medicare-covered service.       | You pay a \$65 copayment for each Medicare-covered service.       |
| <b>Outpatient mental health care - Non-psychiatric services - Individual sessions - Cost-Sharing (out-of-network)</b>                    | You pay a \$30 copayment for each Medicare-covered service.       | You pay a \$65 copayment for each Medicare-covered service.       |

|                                                                                                                                        | <b>2025<br/>(this year)</b>                                       | <b>2026<br/>(next year)</b>                                       |
|----------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|-------------------------------------------------------------------|
| <b>Outpatient mental health care -<br/>Psychiatric services - Group<br/>sessions - Cost-Sharing<br/>(in-network)</b>                   | You pay a \$25 copayment for each Medicare-covered Group Session. | You pay a \$10 copayment for each Medicare-covered Group Session. |
| <b>Outpatient mental health care -<br/>Psychiatric services - Group<br/>sessions - Cost-Sharing<br/>(out-of-network)</b>               | You pay a \$30 copayment for each Medicare-covered service.       | You pay a \$65 copayment for each Medicare-covered service.       |
| <b>Outpatient mental health care -<br/>Psychiatric services - Individual<br/>sessions - Cost-Sharing<br/>(out-of-network)</b>          | You pay a \$30 copayment for each Medicare-covered service.       | You pay a \$65 copayment for each Medicare-covered service.       |
| <b>Outpatient rehabilitation services<br/>- Occupational therapy -<br/>Cost-Sharing (out-of-network)</b>                               | You pay a \$55 copayment for each Medicare-covered service.       | You pay a \$65 copayment for each Medicare-covered service.       |
| <b>Outpatient rehabilitation services<br/>- Physical therapy and<br/>speech-language pathology -<br/>Cost-Sharing (out-of-network)</b> | You pay a \$55 copayment for each Medicare-covered service.       | You pay a \$65 copayment for each Medicare-covered service.       |
| <b>Outpatient substance use<br/>disorder services - Group sessions<br/>- Cost-Sharing (in-network)</b>                                 | You pay a \$25 copayment for each Medicare-covered Group Session. | You pay a \$10 copayment for each Medicare-covered Group Session. |
| <b>Outpatient substance use<br/>disorder services - Group sessions<br/>- Cost-Sharing (out-of-network)</b>                             | You pay a \$30 copayment for each Medicare-covered service.       | You pay a \$65 copayment for each Medicare-covered service.       |
| <b>Outpatient substance use<br/>disorder services - Individual<br/>sessions - Cost-Sharing<br/>(out-of-network)</b>                    | You pay a \$30 copayment for each Medicare-covered service.       | You pay a \$65 copayment for each Medicare-covered service.       |

|                                                                                                                                                                                            | 2025<br>(this year)                                                        | 2026<br>(next year)                                                        |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|----------------------------------------------------------------------------|
| <b>Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers - Ambulatory surgical center - Cost-Sharing (in-network)</b>          | You pay a \$225 copayment for each Medicare-covered service.               | You pay a \$250 copayment for each Medicare-covered service.               |
| <b>Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers - Ambulatory surgical center - Cost-Sharing (out-of-network)</b>      | You pay a \$275 copayment for each Medicare-covered service.               | You pay a \$300 copayment for each Medicare-covered service.               |
| <b>Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers - Outpatient hospital services - Cost-Sharing (in-network)</b>        | You pay a \$0 - \$325 copayment depending on the Medicare-covered service. | You pay a \$0 - \$300 copayment depending on the Medicare-covered service. |
| <b>Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers - Outpatient hospital observation - Cost-Sharing (in-network)</b>     | You pay a \$375 copayment for each Medicare-covered service.               | You pay a \$300 copayment per stay for each Medicare-covered service.      |
| <b>Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers - Outpatient hospital observation - Cost-Sharing (out-of-network)</b> | You pay a \$375 copayment for each Medicare-covered service.               | You pay a \$450 copayment for each Medicare-covered service.               |

|                                                                                                                                              | <b>2025<br/>(this year)</b>                                               | <b>2026<br/>(next year)</b>                                               |
|----------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|---------------------------------------------------------------------------|
| <b>Partial hospitalization services - Cost-Sharing (in-network)</b>                                                                          | You pay a \$70 copayment per day for each Medicare-covered service.       | You pay a \$75 copayment per day for each Medicare-covered service.       |
| <b>Physician/Practitioner services, including doctor's office visits - Additional telehealth services - Cost-Sharing (in-network)</b>        | You pay a \$0 - \$45 copayment depending on the Medicare-covered service. | You pay a \$0 - \$40 copayment depending on the Medicare-covered service. |
| <b>Physician/Practitioner services, including doctor's office visits - Medicare-covered comprehensive dental - Cost-Sharing (in-network)</b> | You pay a \$50 copayment for each Medicare-covered service.               | You pay a \$40 copayment for each Medicare-covered service.               |
| <b>Physician/Practitioner services, including doctor's office visits - Primary care - Cost-Sharing (out-of-network)</b>                      | You pay a \$35 copayment for each Medicare-covered service.               | You pay a \$65 copayment for each Medicare-covered service.               |
| <b>Physician/Practitioner services, including doctor's office visits - Specialist - Cost-Sharing (in-network)</b>                            | You pay a \$45 copayment for each Medicare-covered service.               | You pay a \$40 copayment for each Medicare-covered service.               |
| <b>Physician/Practitioner services, including doctor's office visits - Specialist - Cost-Sharing (out-of-network)</b>                        | You pay a \$60 copayment for each Medicare-covered service.               | You pay a \$65 copayment for each Medicare-covered service.               |
| <b>Physician/Practitioner services, including doctor's office visits - Other healthcare professionals - Cost-Sharing (in-network)</b>        | You pay a \$0 - \$45 copayment depending on the Medicare-covered service. | You pay a \$0 - \$40 copayment depending on the Medicare-covered service. |

|                                                                                                                                          | <b>2025<br/>(this year)</b>                                                                                                                                                                     | <b>2026<br/>(next year)</b>                                                                                                                                                                    |
|------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Physician/Practitioner services, including doctor's office visits- Other healthcare professionals - Cost-Sharing (out-of-network)</b> | You pay a \$35 - \$60 copayment depending on the Medicare-covered service.                                                                                                                      | You pay a \$65 copayment for each Medicare-covered service.                                                                                                                                    |
| <b>Podiatry services - Medicare-covered - Cost-Sharing (in-network)</b>                                                                  | You pay a \$10 - \$45 copayment depending on the Medicare-covered service.                                                                                                                      | You pay a \$0 - \$40 copayment depending on the Medicare-covered service.                                                                                                                      |
| <b>Podiatry services - Medicare-covered - Cost-Sharing (out-of-network)</b>                                                              | You pay a \$35 - \$60 copayment depending on the Medicare-covered service.                                                                                                                      | You pay a \$65 copayment for each Medicare-covered service.                                                                                                                                    |
| <b>Skilled nursing facility (SNF) care - Cost-Sharing (in-network)</b>                                                                   | You pay a \$10 copayment each day for days 1 to 20 and \$214 copayment each day for days 21 to 100 for Medicare-covered skilled nursing facility care. Medicare hospital benefit periods apply. | You pay a \$0 copayment each day for days 1 to 20 and \$150 copayment each day for days 21 to 100 for Medicare-covered skilled nursing facility care. Medicare hospital benefit periods apply. |
| <b>Urgently needed services - Cost-Sharing</b>                                                                                           | You pay a \$55 copayment for each Medicare-covered service.<br>Copayment is waived if you are admitted to a hospital within 24 days.                                                            | You pay a \$30 copayment for each Medicare-covered service.<br>Copayment is waived if you are admitted to a hospital within 24 hours.                                                          |
| <b>Urgently needed services - Worldwide urgent care coverage - Cost-Sharing</b>                                                          | You pay a \$125 copayment. Copayment is waived if you are admitted to a hospital.                                                                                                               | You pay a \$115 copayment. Copayment is waived if you are admitted to a hospital.                                                                                                              |
| <b>Vision care - Medicare-covered eye exam - Cost-Sharing (in-network)</b>                                                               | You pay a \$0 - \$45 copayment depending on the Medicare-covered service.                                                                                                                       | You pay a \$0 - \$40 copayment depending on the Medicare-covered service.                                                                                                                      |



|                                                    | 2025<br>(this year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 2026<br>(next year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Wellness Wallet - Cost-Sharing (in-network)</b> | <p>The plan will reimburse up to \$600 each year in total.</p> <p>You'll get your <b>Wellness Wallet</b> debit card separately from your Generations Advantage ID card, closer to your enrollment date. It can be used for eligible items at select merchants.</p> <p>For a full list 2025 of covered items and services, visit:<br/><a href="http://www.MartinsPoint.org/WellnessWallet">www.MartinsPoint.org/WellnessWallet</a></p> <p>The benefit renews annually. Unused funds don't roll over, and your balance updates automatically after each purchase.</p> <p>Fitness equipment must be bought from licensed retailers. Gym and golf memberships are reimbursable up to your <b>Wellness Wallet</b> limit.</p> | <p>The plan will reimburse up to \$300 each year in total.</p> <p>You'll get your <b>Wellness Wallet</b> debit card separately from your Generations Advantage ID card, closer to your enrollment date. It can be used for eligible items at select merchants.</p> <p>For a full list 2026 of covered items and services, visit:<br/><a href="http://www.MartinsPoint.org/WellnessWallet">www.MartinsPoint.org/WellnessWallet</a></p> <p>The benefit renews annually. Unused funds don't roll over, and your balance updates automatically after each purchase.</p> <p>Fitness equipment must be bought from licensed retailers. Gym and golf memberships are reimbursable up to your <b>Wellness Wallet</b> limit.</p> |

## Section 1.6 Changes to Part D Drug Coverage

### Changes to Our Drug List

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

We made changes to our Drug List, which could include removing or adding drugs, changing the restrictions that apply to our coverage for certain drugs, or moving them to a different cost-sharing tier.

**Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions, or if your drug has been moved to a different cost-sharing tier.**

Most of the changes in the Drug List are new for the beginning of each year. However, we might make other changes that are allowed by Medicare rules that will affect you during the calendar year. We update our online Drug List at least monthly to provide the most up-to-date list of drugs. If we make a change that will affect your access to a drug you're taking, we'll send you a notice about the change.

If you're affected by a change in drug coverage at the beginning of the year or during the year, review Chapter 9 of your *Evidence of Coverage* and talk to your prescriber to find out your options, such as asking for a temporary supply, applying for an exception, and/or working to find a new drug. Call Member Services at 1-866-544-7504 (TTY users call 711) for more information.

Starting in 2026, we can immediately remove brand name drugs or original biological products on our Drug List if we replace them with new generics or certain biosimilar versions of the brand name drug or original biological product on the same or a lower cost-sharing tier and with the same or fewer restrictions. Also, when adding a new version, we can decide to keep the brand name drug or original biological product on our Drug List but immediately move it to a different cost-sharing tier or add new restrictions or both.

For example: If you take a brand name drug or biological product that's being replaced by a generic or biosimilar version, you may not get notice of the change 30 days in advance, or before you get a month's supply of the brand name drug or biological product. You might get information on the specific change after the change is already made.

Some of these drug types may be new to you. For definitions of drug types, go to Chapter 12 of your *Evidence of Coverage*. The Food and Drug Administration (FDA) also provides consumer information on drugs. Go to the FDA website: <https://www.fda.gov/drugs/biosimilars/multimedia-education-materials-biosimilars#For%20Patients>. You can also call Member Services at 1-866-544-7504 (TTY users call 711) or ask your health care provider, prescriber, or pharmacist for more information.

## Section 1.7 Changes to Prescription Drug Benefits & Costs

### Do you get Extra Help to pay for your drug coverage costs?

If you're in a program that helps pay for your drugs (Extra Help), **the information about costs for Part D drugs may not apply to you.** We have included a separate material, called the *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs*, which tells you about your drug costs. If you get Extra Help and didn't get this material with this packet, call Member Services at 1-866-544-7504-7504 (TTY users call 711) and ask for the *LIS Rider*.

### Drug Payment Stages

There are **3 drug payment stages**: the Yearly Deductible Stage, the Initial Coverage Stage, and the Catastrophic Coverage Stage. The Coverage Gap Stage and the Coverage Gap Discount Program no longer exist in the Part D benefit.

- **Stage 1: Yearly Deductible**

You start in this payment stage each calendar year. During this stage, you pay the full cost of your Tier 3, Tier 4, and Tier 5 drugs until you've reached the yearly deductible.

- **Stage 2: Initial Coverage**

Once you pay the yearly deductible, you move to the Initial Coverage Stage. In this stage, our plan pays its share of the cost of your drugs, and you pay your share of the cost. You generally stay in this stage until your year-to-date total drug costs reach \$2,100 out of pocket threshold.

- **Stage 3: Catastrophic Coverage**

This is the third and final drug payment stage. In this stage, you pay nothing for your covered Part D drugs. You generally stay in this stage for the rest of the calendar year.

The Coverage Gap Discount Program has been replaced by the Manufacturer Discount Program. Under the Manufacturer Discount Program, drug manufacturers pay a portion of our plan's full cost for covered Part D brand name drugs and biologics during the Initial Coverage Stage and the Catastrophic Coverage Stage. Discounts paid by manufacturers under the Manufacturer Discount Program don't count toward out-of-pocket costs.

Drug Costs in Stage 1: Yearly Deductible

The table shows your cost per prescription during this stage.

|                   | 2025<br>(this year)                                                                                                                                                                   | 2026<br>(next year)                                                                                                                                                                                                                                                                                                                                                         |
|-------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Yearly Deductible | Because we have no deductible, this payment stage does not apply to you.<br>During this stage, you pay the full cost of your Part D drugs until you've reached the yearly deductible. | <b>\$300</b><br><br>During this stage, you pay \$4 cost sharing for drugs on Tier 1: Preferred Generic; \$10 cost sharing for drugs on Tier 2: Generic; \$4 cost sharing for drugs on Tier 6: Select Care Drug, and the full cost of drugs on Tier 3: Preferred Brand, Tier 4: Non-Preferred Drug, and Tier 5: Specialty Tier until you have reached the yearly deductible. |

Drug Costs in Stage 2: Initial Coverage

For drugs on Preferred Brand, Preferred Brand Tier 3 includes preferred brand drugs and non-preferred generic drugs and Non-Preferred Drug Tier 4 includes non-preferred brand drugs and non-preferred generic drugs, your cost sharing in the Initial Coverage Stage is changing from a copayment to coinsurance. Go to the following table for the changes from 2025 to 2026.

The table shows your cost per prescription for a one-month (30-day) supply filled at a network pharmacy with standard and preferred cost sharing.

We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List. Most adult Part D vaccines are covered at no cost to you. For information about the costs for a long-term supply, at a network pharmacy that offers preferred cost sharing, or for mail-order prescriptions, go to Chapter 6 of your *Evidence of Coverage*.  
Once you've paid \$2,100 out of pocket for covered Part D drugs, you'll move to the next stage (the Catastrophic Coverage Stage).

|                                                                                                                                                                                                                             | 2025 (this year)                                                                                                                                                          | 2026 (next year)                                                                                                                                                                                          |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Tier 1:</b>                                                                                                                                                                                                              | <p><i>Standard cost sharing:</i> You pay \$4.</p> <p>Your cost for a one-month mail-order prescription is \$4.</p> <p><i>Preferred cost sharing:</i> You pay \$0.</p>     | <p><i>Standard cost sharing:</i> You pay \$4.</p> <p>Your cost for a one-month mail-order prescription is \$0.</p> <p><i>Preferred cost sharing:</i> You pay \$0.</p>                                     |
| <b>Tier 2:</b>                                                                                                                                                                                                              | <p><i>Standard cost sharing:</i> You pay \$18.</p> <p>Your cost for a one-month mail-order prescription is \$18.</p> <p><i>Preferred cost sharing:</i> You pay \$10 .</p> | <p><i>Standard cost sharing:</i> You pay \$10.</p> <p>Your cost for a one-month mail-order prescription is \$10.</p> <p><i>Preferred cost sharing:</i> You pay \$5.</p>                                   |
| <b>Tier 3:</b> For 2025 you paid a \$47 copayment for Preferred Brand, Preferred Brand Tier 3 includes preferred brand drugs and non-preferred generic drugs. For 2026 you will pay 25% coinsurance for drugs on this tier. | <p><i>Standard cost sharing:</i> You pay \$47.</p> <p>Your cost for a one-month mail-order prescription is \$47.</p> <p><i>Preferred cost sharing:</i> You pay \$42.</p>  | <p><i>Standard cost sharing:</i> You pay 25% of the total cost.</p> <p>Your cost for a one-month mail-order prescription is 25%.</p> <p><i>Preferred cost sharing:</i> You pay 25% of the total cost.</p> |

|                                                                                                                                                                                                                    | 2025 (this year)                                                                                                                                                                                                                                                                                                                                                                | 2026 (next year)                                                                                                                                                                                                                                                                                                                                                                |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Tier 4:</b> For 2025 you paid a \$100 copayment for Non-Preferred Drug Tier 4 includes non-preferred brand drugs and non-preferred generic drugs. For 2026 you will pay 32% coinsurance for drugs on this tier. | <p><i>Standard cost sharing:</i> You pay \$100.</p> <p>Your cost for a one-month mail-order prescription is \$100.</p> <p><i>Preferred cost sharing:</i> You pay \$95.</p>                                                                                                                                                                                                      | <p><i>Standard cost sharing:</i> You pay 32% of the total cost.</p> <p>You pay \$35 per month supply of each covered insulin product on this tier.</p> <p>Your cost for a one-month mail-order prescription is 32%.</p> <p><i>Preferred cost sharing:</i> You pay 30% of the total cost.</p> <p>You pay \$35 per month supply of each covered insulin product on this tier.</p> |
| <b>Tier 5:</b>                                                                                                                                                                                                     | <p><i>Standard cost sharing:</i> You pay 33% of the total cost.</p> <p>You pay \$35 per month supply of each covered insulin product on this tier.</p> <p>Your cost for a one-month mail-order prescription is 33%.</p> <p><i>Preferred cost sharing:</i> You pay 33% of the total cost.</p> <p>You pay \$35 per month supply of each covered insulin product on this tier.</p> | <p><i>Standard cost sharing:</i> You pay 29% of the total cost.</p> <p>Your cost for a one-month mail-order prescription is 29%.</p> <p><i>Preferred cost sharing:</i> You pay 29% of the total cost.</p> <p>You pay \$35 per month supply of each covered insulin product on this tier.</p>                                                                                    |

|         | 2025 (this year)                                                                        | 2026 (next year)                                                                                                                                        |
|---------|-----------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------|
| Tier 6: | <p>Standard cost sharing: You pay \$4.</p> <p>Preferred cost sharing: You pay \$0 .</p> | <p>Standard cost sharing: You pay \$4.</p> <p>Your cost for a one-month mail-order prescription is \$0.</p> <p>Preferred cost sharing: You pay \$0.</p> |

Changes to the Catastrophic Coverage Stage

If you reach the Catastrophic Coverage Stage, you pay nothing for your covered Part D drugs.

For specific information about your costs in the Catastrophic Coverage Stage, go to Chapter 6, Section 6 in your *Evidence of Coverage*.

SECTION 2      Administrative Changes

|                                    | 2025 (this year)                                                                                                                                                                                                                                                                             | 2026 (next year)                                                                                                                                                                                                                                                                                                                      |
|------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Medicare Prescription Payment Plan | <p>The Medicare Prescription Payment Plan is a payment option that began this year and can help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across the calendar year (January-December).</p> <p>You may be participating in this payment option.</p> | <p>If you’re participating in the Medicare Prescription Payment Plan and stay in the same Part D plan, your participation will be automatically renewed for 2026.</p> <p>To learn more about this payment option, call us at 1-866-544-7504 (TTY users call 711) or visit <a href="http://www.Medicare.gov">www.Medicare.gov</a>.</p> |

## SECTION 3      How to Change Plans

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**To stay in Martin's Point Generations Advantage Prime (HMO-POS), you don't need to do anything.** Unless you sign up for a different plan or change to Original Medicare by December 7, you'll automatically be enrolled in our Martin's Point Generations Advantage Prime (HMO-POS).

If you want to change plans for 2026, follow these steps:

- **To change to a different Medicare health plan,** enroll in the new plan. You'll be automatically disenrolled from Martin's Point Generations Advantage Prime (HMO-POS).
- **To change to Original Medicare with Medicare drug coverage,** enroll in the new Medicare drug plan. You'll be automatically disenrolled from Martin's Point Generations Advantage Prime (HMO-POS).
- **To change to Original Medicare without a drug plan,** you can send us a written request to disenroll. Call Member Services at 1-866-544-7504 (TTY users call 711) for more information on how to do this. Or call **Medicare** at 1-800-MEDICARE (1-800-633-4227) and ask to be disenrolled. TTY users can call 1-877-486-2048. If you don't enroll in a Medicare drug plan, you may pay a Part D late enrollment penalty (go to Section 1.1).
- **To learn more about Original Medicare and the different types of Medicare plans,** visit [www.Medicare.gov](http://www.Medicare.gov), check the *Medicare & You 2026* handbook, call your State Health Insurance Assistance Program (go to Section 5), or call 1-800-MEDICARE (1-800-633-4227). As a reminder, MARTIN'S POINT GENERATIONS ADVANTAGE, INC. offers other Medicare health plans AND/OR Medicare prescription drug plans. These other plans may differ in coverage, monthly premiums, and cost-sharing amounts.

### Section 3.1 Deadlines for Changing Plans

People with Medicare can make changes to their coverage from **October 15 – December 7** each year.

If you enrolled in a Medicare Advantage plan for January 1, 2026, and don't like your plan choice, you can switch to another Medicare health plan (with or without Medicare drug coverage) or switch to Original Medicare (with or without separate Medicare drug coverage) between January 1 – March 31, 2026.

### Section 3.2 Are there other times of the year to make a change?

In certain situations, people may have other chances to change their coverage during the year. Examples include people who:



- Have Medicaid
- Get Extra Help paying for their drugs
- Have or are leaving employer coverage
- Move out of our plan's service area

If you recently moved into, or currently live in, an institution (like a skilled nursing facility or long-term care hospital), you can change your Medicare coverage **at any time**. You can change to any other Medicare health plan (with or without Medicare drug coverage) or switch to Original Medicare (with or without separate Medicare drug coverage) at any time. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for 2 full months after the month you move out.

## **SECTION 4      Get Help Paying for Prescription Drugs**

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You may qualify for help paying for prescription drugs. Different kinds of help are available:

- **Extra Help from Medicare.** People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly drug plan premiums, yearly deductibles, and coinsurance. Also, people who qualify won't have a late enrollment penalty. To see if you qualify, call:
  - 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048, 24 hours a day, 7 days a week.
  - Social Security at 1-800-772-1213 between 8 a.m. and 7 p.m., Monday – Friday for a representative. Automated messages are available 24 hours a day. TTY users can call 1-800-325-0778.
  - Your State Medicaid Office.
- **Help from your state's pharmaceutical assistance program (SPAP).** Maine has a program called Drugs for the Elderly and Disabled that helps people pay for prescription drugs based on their financial need, age, or medical condition. To learn more about the program, check with your State Health Insurance Assistance Program (SHIP). To get the phone number for your state, visit [www.shiphelp.org](http://www.shiphelp.org), or call 1-800-MEDICARE.
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible people living with HIV/AIDS have access to life-saving HIV medications. To be eligible for the ADAP operating in your state, you must meet certain criteria, including proof of state residence and HIV status, low income as defined by the state, and uninsured/under-insured status. Medicare Part D drugs that are also covered by ADAP qualify for prescription cost-sharing help through the The AIDS Drug Assistance Program (ADAP).

For information on eligibility criteria, covered drugs, how to enroll in the program, or, if you're currently enrolled, how to continue getting help, call 1-207-287-3747. Be sure, when calling, to inform them of your Medicare Part D plan name or policy number.

- **The Medicare Prescription Payment Plan.** The Medicare Prescription Payment Plan is a payment option that works with your current drug coverage to help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across the calendar year (January – December). Anyone with a Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage plan with drug coverage) can use this payment option. **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs.**

Extra Help from Medicare and help from your SPAP and ADAP, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan. All members are eligible to participate in the Medicare Prescription Payment Plan payment option. To learn more about this payment option, call us at 1-866-544-7504 (TTY users call 711) or visit [www.Medicare.gov](http://www.Medicare.gov).

## SECTION 5      Questions?

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### Get Help from Martin's Point Generations Advantage Prime (HMO-POS)

- **Call Member Services at 1-866-544-7504. (TTY users call 711.)**

We're available for phone calls 8am - 8pm, seven days a week from October 1 to March 31, and Monday through Friday the rest of the year. Calls to these numbers are free.

- **Read your 2026 Evidence of Coverage**

This Annual Notice of Change gives you a summary of changes in your benefits and costs for 2026. For details, go to the 2026 Evidence of Coverage for Martin's Point Generations Advantage Prime (HMO-POS). The Evidence of Coverage is the legal, detailed description of our plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. Get the Evidence of Coverage on our website at [www.MartinsPoint.org/MedicareMembers](http://www.MartinsPoint.org/MedicareMembers) or call Member Services at 1-866-544-7504 (TTY users call 711) to ask us to mail you a copy.

- **Visit [www.martinspoint.org/medicaremembers](http://www.martinspoint.org/medicaremembers)**

Our website has the most up-to-date information about our provider network (*Provider Directory/Pharmacy Directory*) and our List of Covered Drugs (formulary/Drug List).

## Get Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is an independent government program with trained counselors in every state. In Maine, the SHIP is called Maine State Health Insurance Assistance Program (SHIP).

Call Maine State Health Insurance Assistance Program (SHIP) to get free personalized health insurance counseling. They can help you understand your Medicare plan choices and answer questions about switching plans. Call Maine State Health Insurance Assistance Program (SHIP) at 1-877-353-3771. Learn more about Maine State Health Insurance Assistance Program (SHIP) by visiting <https://www.maine.gov/dhhs/oads/get-support/older-adults-disabilities/older-adult-services/ship-medicare-assistance>.

## Get Help from Medicare

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

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

- **Chat live with [www.Medicare.gov](https://www.Medicare.gov)**

You can chat live at [www.Medicare.gov/talk-to-someone](https://www.Medicare.gov/talk-to-someone).

- **Write to Medicare**

You can write to Medicare at PO Box 1270, Lawrence, KS 66044

- **Visit [www.Medicare.gov](https://www.Medicare.gov)**

The official Medicare website has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area.

- **Read *Medicare & You 2026***

The *Medicare & You 2026* handbook is mailed to people with Medicare every fall. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. Get a copy at [www.Medicare.gov](https://www.Medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.



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](https://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>.

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## 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 quý vị cần thông dịch viên xin gọi 1-877-553-7054 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quý 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 대해 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 लिए हमारे पास मुफ्त दुभाकिया सेवाएँ उपलब्ध हैं. एक दुभाकिया प्राप्त करने के लिए, 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、無料の通訳サービスがあります。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。