Martin's Point

GENERATIONS ADVANTAGE

# Summary of Benefits

JANUARY 1–DECEMBER 31, 2026

## Prime (HMO-POS)

**H5591-017**

For Aroostook, Franklin, Hancock, Knox, Penobscot, and Washington Counties in Maine

# 2026 Summary of Benefits

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

H5591, Plan 017

January 1, 2026 - December 31, 2026

**Martin's Point Generations Advantage Prime (HMO-POS)** is a Medicare Advantage HMO Plan (HMO stands for Health Maintenance Organization) with a Medicare contract. Enrollment in the Plan depends on contract renewal.

The benefit information provided is a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please call Member Services at 1-866-544-7504 (TTY 711) and request the *Evidence of Coverage* or access it online at www.martinspoint.org/medicaremembers.

To join Martin's Point Generations Advantage Prime (HMO-POS), you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

Our service area includes these counties in Maine: Aroostook, Franklin, Hancock, Knox, Penobscot, and Washington.

Martin's Point Generations Advantage Prime (HMO-POS) has a network of doctors, hospitals, pharmacies, and other providers that can be found on our website at www.martinspoint.org/medicaremembers. Except in emergency situations, if you use providers that are not in our network, the plan may not pay for these services.

If you want to know more about the coverage and costs of Original Medicare, look in your current **"Medicare & You"** handbook. View it online at https://www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 7 days a week, 24 hours a day. TTY users should call 1-877-486-2048.

| | **Martin's Point Generations Advantage Prime (HMO-POS)** |
|---|---|
| **Monthly Plan Premium** *(includes both medical and drugs)* | $109 |
| **Deductible** | No deductible for medical. See prescription drug coverage for Part D deductible. |
| **Maximum out-of-pocket amount** *(does not include Part D prescription drugs)* | From network providers: $7,000<br>From out-of-network providers: Not Applicable<br>From network and out-of-network providers combined: $7,000 |
| **Inpatient Hospital coverage** | **In-Network**<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.<br>*Prior Authorization is required.*<br><br>**Out-of-Network**<br>40% coinsurance for each Medicare-covered hospital stay.<br>*Prior Authorization may be required.* |
| **Outpatient Hospital coverage** | |
| Outpatient hospital services | **In-Network**<br>$0 - $300 copayment<br>*Prior Authorization may be required.*<br><br>**Out-of-Network**<br>$450 copayment<br>*Prior Authorization may be required.* |
| Outpatient hospital observation services | **In-Network**<br>$300 copayment per stay<br><br>**Out-of-Network**<br>$450 copayment |
| **Ambulatory Surgical Center (ASC)** | **In-Network**<br>$250 copayment<br><br>**Out-of-Network**<br>$300 copayment |

| | **Martin's Point Generations Advantage Prime (HMO-POS)** |
|---|---|
| **Doctor Visits** | |
| Primary Care Providers | **In-Network**<br>$0 copayment<br><br>**Out-of-Network**<br>$65 copayment |
| Specialists | **In-Network**<br>$40 copayment<br><br>**Out-of-Network**<br>$65 copayment<br>*Referral may be required.* |
| **Preventive Care (e.g., flu vaccine, diabetic screenings)** | **In-Network**<br>$0 copayment<br><br>**Out-of-Network**<br>Not covered |
| **Emergency care** | $115 copayment in country and out-of-country<br>Copayment is waived if you are admitted to a hospital within 24 hours. ($25,000 out-of-country limit for emergency care) |
| **Urgently needed services** | $30 copayment<br>Copayment is waived if you are admitted to a hospital within 24 hours.<br>Cost-sharing for necessary urgently needed services furnished out-of-network is the same as for such services furnished in-network.Copayment is waived if you are admitted to a hospital within 24 hours. ($25,000 out-of-country limit for emergency care) |

| | **Martin's Point Generations Advantage Prime (HMO-POS)** |
|---|---|
| **Diagnostic Services/Labs/Imaging** | |
| Diagnostic tests and procedures | **In-Network**<br>0% coinsurance for cardiopulmonary tests, ambulatory blood pressure monitors, and spirometry<br>15% coinsurance for all other outpatient diagnostic tests and therapeutic services/supplies<br><br>*Prior Authorization may be required.*<br><br>**Out-of-Network**<br>0% coinsurance for cardiopulmonary tests, ambulatory blood pressure monitors, and spirometry<br>15% coinsurance for all other outpatient diagnostic tests and therapeutic services/supplies<br>*Prior Authorization may be required.* |
| Lab services | **In-Network**<br>$0 copayment for Preventive labs and COVID-19 viral testing<br>$5 copayment for all other lab testing (including COVID-19 antibody testing)<br>0% coinsurance for lab services<br>20% coinsurance for lab services related to genetic testing<br><br>*Prior Authorization may be required.*<br><br>**Out-of-Network**<br>$0 copayment for Preventive labs and COVID-19 viral testing<br>$5 copayment for all other lab testing (including COVID-19 antibody testing)<br>0% coinsurance for lab services<br>20% coinsurance for lab services related to genetic testing<br>*Prior Authorization may be required.* |
| Diagnostic radiology services (e.g. MRI, CAT Scan) | **In-Network**<br>15% coinsurance<br><br>*Prior Authorization may be required.*<br><br>**Out-of-Network**<br>30% coinsurance<br>*Prior Authorization may be required.* |

| | **Martin's Point Generations Advantage Prime (HMO-POS)** |
|---|---|
| Outpatient X-rays | **In-Network**<br>$25 copayment<br><br>*Prior Authorization may be required.*<br><br>**Out-of-Network**<br>$50 copayment<br>*Prior Authorization may be required.* |
| Therapeutic Radiology | **In-Network**<br>15% coinsurance<br><br>*Prior Authorization may be required.*<br><br>**Out-of-Network**<br>30% coinsurance<br>*Prior Authorization may be required.* |
| **Hearing services** | |
| Exam to diagnose and treat hearing and balance issues | **In-Network**<br>$40 copayment<br><br>**Out-of-Network**<br>$65 copayment |
| **Hearing aids** | $1,000 benefit allowance ($500 per ear every year) for hearing aids. |
| ○ All types | **In-Network**<br>$0 copayment<br>Limited to 2 hearing aid(s) every year<br><br>**Out-of-Network**<br>Not covered |

| | **Martin's Point Generations Advantage Prime (HMO-POS)** |
|---|---|
| **Dental services** | There is a $750 benefit maximum every year for preventive and comprehensive dental services. Please reach out to Northeast Delta Dental for more information. |
| **Preventive dental services** | **In-Network**<br>$50 copayment for each office visit. |
| ○ Oral Exams | **In-Network**<br>Limited to 2 oral exam(s) every year |
| ○ Prophylaxis (Cleaning) | **In-Network**<br>Limited to 2 cleaning(s) every year |
| ○ Dental X-Rays | **In-Network**<br>Limited to 1 x-ray(s) every year<br><br>**Out-of-Network**<br>Not covered |
| **Comprehensive dental services** | |
| ○ Diagnostic Services | **In-Network**<br>$50 copayment per office visit, 50% coinsurance when seeing a Delta Dental provider.<br><br>**Out-of-Network**<br>Not covered |
| ○ Other Services | **In-Network**<br>$50 copayment per office visit, 50% coinsurance when seeing a Delta Dental provider.<br><br>**Out-of-Network**<br>Not covered |

| | Martin's Point Generations Advantage Prime (HMO-POS) |
|---|---|
| ○ Restorative Services | **In-Network**<br>$50 copayment per office visit, 50% coinsurance when seeing a Delta Dental provider.<br><br>**Out-of-Network**<br>Not covered |
| ○ Periodontics | **In-Network**<br>$50 copayment per office visit, 50% coinsurance when seeing a Delta Dental provider.<br><br>**Out-of-Network**<br>Not covered |
| ○ Endodontics | **In-Network**<br>$50 copayment per office visit, 50% coinsurance when seeing a Delta Dental provider.<br><br>**Out-of-Network**<br>Not covered |
| ○ Oral and Maxillofacial Surgery | **In-Network**<br>$50 copayment per office visit, 50% coinsurance when seeing a Delta Dental provider.<br><br>**Out-of-Network**<br>Not covered |
| ○ Maxillofacial Prosthetics | **In-Network**<br>$50 copayment per office visit, 50% coinsurance when seeing a Delta Dental provider.<br><br>**Out-of-Network**<br>Not covered |
| ○ Prosthodontics - fixed | **In-Network**<br>$50 copayment per office visit, 50% coinsurance when seeing a Delta Dental provider.<br><br>**Out-of-Network**<br>Not covered |

| | Martin's Point Generations Advantage Prime (HMO-POS) |
|---|---|
| ○ Prosthodontics - removable | **In-Network**<br>$50 copayment per office visit, 50% coinsurance when seeing a Delta Dental provider.<br><br>**Out-of-Network**<br>Not covered |
| **Vision care** | |
| Exam to diagnose and treat diseases and conditions of the eye | **In-Network**<br>$0 copayment for diabetic eye exams<br>$40 copayment for Medicare-covered eye exams<br><br>**Out-of-Network**<br>$65 copayment |
| For people with diabetes, screening for diabetic retinopathy is covered once per year. | **In-Network**<br>$0 - $40 copayment<br><br>**Out-of-Network**<br>$65 copayment |
| Eyewear after cataract surgery | **In-Network**<br>20% coinsurance<br><br>**Out-of-Network**<br>20% coinsurance |
| Glaucoma screening | **In-Network**<br>$0 copayment<br><br>**Out-of-Network**<br>$0 copayment |
| Routine eye exam | **In-Network**<br>$0 copayment<br>Limited to 1 visit(s) every year<br><br>**Out-of-Network**<br>Not covered |

| | **Martin's Point Generations Advantage Prime (HMO-POS)** |
|---|---|
| **Additional routine eyewear** | There is a $150 benefit maximum every year for prescription lenses, frames, and contact lenses. |
| ○ Contact lenses | **In-Network**<br>$0 copayment<br><br>**Out-of-Network**<br>Not covered |
| ○ Eyeglass lenses | **In-Network**<br>$0 copayment<br><br>**Out-of-Network**<br>Not covered |
| ○ Eyeglass frames | **In-Network**<br>$0 copayment<br><br>**Out-of-Network**<br>Not covered |
| ○ Eyeglasses (lenses and frames) | **In-Network**<br>$0 copayment<br><br>**Out-of-Network**<br>Not covered |
| ○ Upgrades | **In-Network**<br>$0 copayment<br><br>**Out-of-Network**<br>Not covered<br><br>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. |

| | **Martin's Point Generations Advantage Prime (HMO-POS)** |
|---|---|
| **Mental Health Services** | |
| Inpatient visit | **In-Network**<br>$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>*Prior Authorization is required.*<br><br>**Out-of-Network**<br>Not covered |
| Outpatient group therapy visit | **In-Network**<br>$10 copayment<br>*Prior Authorization may be required.*<br><br>**Out-of-Network**<br>$65 copayment<br>*Prior Authorization may be required.* |
| Outpatient individual therapy visit | **In-Network**<br>$25 copayment<br>*Prior Authorization may be required.*<br><br>**Out-of-Network**<br>$65 copayment<br>*Prior Authorization may be required.* |
| **Skilled nursing facility (SNF) care** | **In-Network**<br>$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.<br>*Prior Authorization is required.*<br><br>**Out-of-Network**<br>Not covered |

| | **Martin's Point Generations Advantage Prime (HMO-POS)** |
|---|---|
| **Physical Therapy** | **In-Network**<br>$30 copayment<br>*Prior Authorization is required.*<br><br>**Out-of-Network**<br>$65 copayment<br>*Referral may be required.* |
| **Ambulance services** | |
| Ground Ambulance | **In-Network**<br>$325 copayment<br>*Prior authorization may be required for non-emergency ambulance transport and out-of-country emergency services. Ask your provider to contact the plan for details.*<br><br>**Out-of-Network**<br>$325 copayment<br>*Prior Authorization may be required.* |
| Air Ambulance | **In-Network**<br>$325 copayment<br>*Prior authorization may be required for non-emergency ambulance transport and out-of-country emergency services. Ask your provider to contact the plan for details.*<br><br>**Out-of-Network**<br>$325 copayment<br>*Prior Authorization may be required.* |
| **Medicare Part B drugs** | |
| Chemotherapy/Radiation drugs | **In-Network**<br>0% - 20% coinsurance<br>*Prior Authorization is required.*<br><br>**Out-of-Network**<br>20% coinsurance<br>*Prior Authorization may be required.* |

| | **Martin's Point Generations Advantage Prime (HMO-POS)** |
|---|---|
| Insulin drugs | **In-Network**<br>0% - 20% coinsurance<br>You will pay no more than $35 for a one-month supply of Part B insulin products covered by our plan<br><br>**Out-of-Network**<br>20% coinsurance<br>*Prior Authorization may be required.* |
| Other Part B drugs | **In-Network**<br>0% - 20% coinsurance<br>*Prior Authorization is required.*<br><br>**Out-of-Network**<br>20% coinsurance<br>*Prior Authorization may be required.* |

**Additional Benefits**

| | **Martin's Point Generations Advantage Prime (HMO-POS)** |
|---|---|
| **Alternative therapies** | See **Wellness Wallet** |
| **Annual routine physical exam** | **In-Network**<br>$0 copayment<br><br>**Out-of-Network**<br>Not covered |
| **Chiropractic services** | Medicare-covered services only<br><br>**In-Network**<br>$15 copayment<br><br>**Out-of-Network**<br>$65 copayment |
| **Diabetic monitoring supplies** | **In-Network**<br>$0 copayment<br><br>**Out-of-Network**<br>20% coinsurance |
| **Diabetic therapeutic shoes or inserts** | **In-Network**<br>$0 copayment<br><br>**Out-of-Network**<br>20% coinsurance |
| **Durable medical equipment (DME) and related supplies** | **In-Network**<br>20% coinsurance<br>*Prior Authorization is required.*<br><br>**Out-of-Network**<br>30% coinsurance<br>*Prior Authorization may be required.* |

| | **Martin's Point Generations Advantage Prime (HMO-POS)** |
|---|---|
| **Home health agency care** | **In-Network**<br>$0 copayment<br>*Prior authorization is required.*<br><br>**Out-of-Network**<br>Not covered |
| **Home infusion services** | **In-Network**<br>$0 copayment<br>*Prior authorization may be required.*<br><br>**Out-of-Network**<br>Not covered |
| **Intensive outpatient program services** | **In-Network**<br>$75 copayment per day<br><br>**Out-of-Network**<br>Not covered |
| **Nursing hotline** | **In-Network**<br>$0 copayment<br><br>**Out-of-Network**<br>Not covered |
| **Opioid treatment program services** | **In-Network**<br>$0 copayment<br>*Prior Authorization is required.*<br>**Out-of-Network**<br>Not covered |

| | **Martin's Point Generations Advantage Prime (HMO-POS)** |
|---|---|
| **Outpatient diagnostic tests and therapeutic services and supplies** | **In-Network**<br>15% coinsurance<br>*Prior authorization may be required.*<br><br>**Out-of-Network**<br><br>30% coinsurance<br>*Prior Authorization may be required.* |
| **Outpatient rehabilitation services:**<br>**Physical Therapy**<br>**Occupational Therapy**<br>**Speech Therapy** | **In-Network**<br>$30 copayment<br>*Prior Authorization is required*<br><br>**Out-of-Network**<br>$65 copayment<br>*Referral may be required.* |
| **Outpatient substance use disorder services** | **In-Network**<br>$25 copayment for each Medicare-covered Individual Session.<br>*Prior Authorization may be required.*<br><br>$10 copayment for each Medicare-covered Group Session.<br>*Prior Authorization may be required.*<br><br>**Out-of-Network**<br>$65 copayment for each Medicare-covered Individual Session.<br><br>$65 copayment for each Medicare-covered Group Session.<br>*Prior Authorization may be required.* |

| | **Martin's Point Generations Advantage Prime (HMO-POS)** |
|---|---|
| **Over-the-counter benefit** | **In-Network**<br>The plan will cover up to $50 per quarter for members to purchase select CVS brand over-the-counter (OTC) products.<br><br>**Phone/Online purchases:** Total may not exceed $50.<br><br>**In-store purchases:** Members are responsible for balances exceeding the $50 allowance (of the qualifying OTC purchase).<br><br>**Out-of-Network**<br>Not covered |
| **Partial hospitalization services** | **In-Network**<br>$75 copayment per day<br>*Prior Authorization is required.*<br><br>**Out-of-Network**<br>Not covered |
| **Podiatry services** | **In-Network**<br>$0 copayment for Medicare-covered podiatry services performed by a PCP<br>$40 copayment for Medicare-covered podiatry services performed by a specialist<br><br>**Out-of-Network**<br>$65 copayment |
| **Prosthetic and orthotic devices and related supplies** | **In-Network**<br>20% coinsurance<br>*Prior Authorization is required.*<br><br>**Out-of-Network**<br>30% coinsurance<br>*Prior Authorization may be required.* |

| | **Martin's Point Generations Advantage Prime (HMO-POS)** |
|---|---|
| **Pulmonary rehabilitation services** | **In-Network**<br>$0 copayment<br>*Prior Authorization is required.*<br><br>**Out-of-Network**<br>Not covered |
| **Services to treat kidney disease**<br><br>Dialysis Services | **In-Network**<br>20% coinsurance<br>*Prior Authorization is required.*<br><br>**Out-of-Network**<br>20% coinsurance<br>*Prior Authorization may be required.* |
| **Welcome to Medicare preventive visit** | **In-Network**<br>$0 copayment<br><br>**Out-of-Network**<br>Not covered |

| | **Martin's Point Generations Advantage Prime (HMO-POS)** |
|---|---|
| **Wellness Wallet** | The plan will reimburse up to $300 each year in total.<br><br>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.<br><br>For a full list of covered items and services, visit: www.MartinsPoint.org/WellnessWallet.<br><br>The benefit renews annually. Unused funds don't roll over, and your balance updates automatically after each purchase.<br><br>Fitness equipment must be bought from licensed retailers. Gym and golf memberships are reimbursable up to your **Wellness Wallet** limit. |
| **Worldwide emergency coverage** | *$115* copayment<br>*Prior authorization may be required.* |
| **Worldwide emergency transportation** | $325 copayment<br><br>*Prior authorization may be required.* |
| **Worldwide urgent care coverage** | *$115* copayment<br>*Prior authorization may be required.* |

**Prescription Drug Benefits**

| **Martin's Point Generations Advantage Prime (HMO-POS)** | | | |
|---|---|---|---|
| **Stage 1: Annual Prescription Deductible** | | | |
| $275 for Tier 3, Tier 4, and Tier 5 Part D prescription drugs. For all other drugs, you will not have to pay any deductible and will start receiving coverage immediately. | | | |
| **Stage 2: Initial Coverage (after you pay your deductible, if applicable)** | | | |
| **Retail cost-sharing** | | | |
| | **Preferred (30-day/up to 100-day supply)** | **Standard (30-day/up to 100-day supply)** | **Long-term care (LTC) (31-day supply)** |
| **Tier 1** (Preferred Generic Tier 1 is the lowest tier. Low cost preferred generic drugs are included in this tier.) | $0/$0 copayment | $4/$12 copayment | $4 copayment |
| **Tier 2** (Generic Tier 2 includes preferred generic drugs) | $0/$0 copayment | $10/$30 copayment | $10 copayment |
| **Tier 3** (Preferred Brand, Preferred Brand Tier 3 includes preferred brand drugs and non-preferred generic drugs) | 25%/25% coinsurance | 25%/25% coinsurance | 25% coinsurance |
| **Tier 4** (Non-Preferred Drug Tier 4 includes non-preferred brand drugs and non-preferred generic drugs) | 30%/30% coinsurance | 32%/32% coinsurance | 32% coinsurance |

| | | | |
|---|---|---|---|
| **Tier 5**<br>(Specialty Tier Tier 5 contains very high-cost brand and generic drugs, which may require special handling and/or close monitoring. Drugs that have an approved non-formulary exception will be included in this tier) | 29% coinsurance/Not Available | 29% coinsurance/Not Available | 29% coinsurance |
| **Tier 6**<br>(Select Care Drugs Tier 6 includes commonly prescribed generic adherence medications used to treat high blood pressure, high cholesterol, and diabetes. $0 copay applies during the deductible and initial phases at preferred pharmacies and Caremark mail-order pharmacy) | $0/$0 copayment | $4/$12 copayment | $4 copayment |
| **Mail-order-sharing** | | | |
| | **Standard (30-day/up to 100-day supply)** | | |
| **Tier 1**<br>(Preferred Generic Tier 1 is the lowest tier. Low cost preferred generic drugs are included in this tier.) | $0/$0 copayment | | |
| **Tier 2**<br>(Generic Tier 2 includes preferred generic drugs) | $10/$25 copayment | | |

| | |
|---|---|
| **Tier 3** (Preferred Brand, Preferred Brand Tier 3 includes preferred brand drugs and non-preferred generic drugs) | 25%/25% coinsurance |
| **Tier 4** (Non-Preferred Drug Tier 4 includes non-preferred brand drugs and non-preferred generic drugs) | 32%/32% coinsurance |
| **Tier 5** (Specialty Tier Tier 5 contains very high-cost brand and generic drugs, which may require special handling and/or close monitoring. Drugs that have an approved non-formulary exception will be included in this tier) | 29% coinsurance/Not Available |
| **Tier 6** (Select Care Drugs Tier 6 includes commonly prescribed generic adherence medications used to treat high blood pressure, high cholesterol, and diabetes. $0 copay applies during the deductible and initial phases at preferred pharmacies and Caremark mail-order pharmacy) | $0/$0 copayment |

| Stage 3: Catastrophic Coverage |
| --- |
| After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $2,100, you pay nothing. |

You won't pay more than $35 for tier 3, $35 for tier 4, and $35 for tier 5 for a one-month supply, $70 for tier 3 and $70 for tier 4 for a two-month supply, and $105 for tier 3 and $105 for tier 4 for a three-month supply of each covered insulin product regardless of the cost-sharing tier, even if you haven't paid your deductible.

Please contact our Member Services number at 1-866-544-7504 for additional information. (TTY users should call 711.) We are available 8am - 8pm, seven days a week from October 1 to March 31, and Monday through Friday the rest of the year. You may also visit the website at www.MartinsPoint.org/MedicareMembers.

# 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。

## Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at 1-866-544-7504.

### Understanding the Benefits

- ☐ The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit www.martinspoint.org/medicaremembers or call 1-866-544-7504 to view a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ☐ Review the formulary to make sure your drugs are covered.

### Understanding Important Rules

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2027.
- ☐ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services, the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care.

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

1-833-953-3487 (TTY: 711)

We are available 8am–8pm, every
day from Oct. 1–Mar. 31 and
weekdays from Apr. 1–Sep. 30.

Martin's Point Generations Advantage
891 Washington Ave.
PO Box 9746
Portland, ME 04104