

Prominence Giveback HMO offered by *Prominence Health Plan in Washoe County, Nevada*

Annual Notice of Change for 2026

You're enrolled as a member of Prominence Giveback.

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 Prominence Giveback.
- To change to a **different plan**, visit www.Medicare.gov 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.prominencemedicare.com or call Member Services at 1-855-969-5882 (TTY users call 711) to get a copy by mail.

More Resources

- This material is available for free in Spanish.
- Call Member Services at 1-855-969-5882 (TTY users call 711) for more information. Hours are 8 a.m. to 8 p.m., seven days a week from October 1 through March 31, and Monday through Friday from April 1 through September 30. This call is free.
- This document is available in other formats such as large print, braille, and audio.

About *Prominence Health*

- Prominence Health Plan is an HMO and HMO Special Needs Plan (SNP) with a Medicare contract and a contract with the Medicaid program. Enrollment in Prominence Health Plan depends on contract renewal. See Evidence of Coverage for eligibility qualifications.
- When this material says “we,” “us,” or “our,” it means *Prominence Health Plan*. When it says “plan” or “our plan,” it means Prominence Giveback.
- **If you do nothing by December 7, 2025, you'll automatically be enrolled in *Prominence Giveback*.** Starting January 1, 2026, you'll get your medical and drug coverage through *Prominence Giveback*. 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 (this year)	2026 (next year)
<p>Monthly plan premium*</p> <p>* Your premium can be higher than this amount. Go to Section 1.1 for details.</p>	\$0	\$0
<p>Maximum out-of-pocket amount</p> <p>This is the <u>most</u> you'll pay out of pocket for covered A and Part B services. (Go to Section 1.2 for details.)</p>	\$6,750	\$6,750
<p>Primary care office visits</p>	\$0 per visit	\$0 per visit
<p>Specialist office visits</p>	\$45 copay per visit	\$0-45 copay per visit
<p>Inpatient hospital stays</p> <p>Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you're formally admitted to the hospital with a doctor's order. The day before you're discharged is your last inpatient day.</p>	<p>Tier 1 hospitals: You pay \$275 Copay per day for Days 1-6</p> <p>You pay \$0 Copay per day for days 7-90.</p> <p>Tier 2 hospitals: You pay \$425 Copay per day for Days 1-6.</p> <p>You pay \$0 Copay per day for days 7-90.</p>	<p>Tier 1 hospitals: You pay \$325 Copay per day for Days 1-6</p> <p>You pay \$0 Copay per day for days 7-90.</p> <p>Tier 2 hospitals: You pay \$450 Copay per day for Days 1-6.</p> <p>You pay \$0 Copay per day for days 7-90.</p>

	2025 (this year)	2026 (next year)
<p>Part D drug coverage deductible (Go to Section 1.6 for details.)</p>	\$590	\$450, except for covered insulin products and most adult Part D vaccines
<p>Part D drug coverage (Go to Section 1.6 for details, including Yearly Deductible, Initial Coverage, and Catastrophic Coverage Stages.)</p>	<p>Copayment/Coinsurance during the Initial Coverage Stage:</p> <p>Drug Tier 1: \$0 copay</p> <p>Drug Tier 2: \$12 copay</p> <p>Drug Tier 3: 24% coinsurance. You pay \$35 per month supply of each covered insulin product on this tier.</p> <p>Drug Tier 4: 40% coinsurance</p> <p>Drug Tier 5: 25% coinsurance. You pay \$35 per month supply of each covered insulin product on this tier.</p> <p>Tier 6: \$0 copay</p> <p>Catastrophic Coverage Stage:</p> <p>During this payment stage, you pay nothing for your covered Part D drugs and for excluded drugs that are covered under our enhanced benefit.</p>	<p>Copayment/Coinsurance during the Initial Coverage Stage:</p> <p>Drug Tier 1: \$0 copay</p> <p>Drug Tier 2: \$12 copay</p> <p>Drug Tier 3: 23% coinsurance. You pay \$35 per month supply of each covered insulin product on this tier.</p> <p>Drug Tier 4: 45% coinsurance</p> <p>Drug Tier 5: 27% coinsurance. You pay \$35 per month supply of each covered insulin product on this tier.</p> <p>Tier 6: \$0 copay</p> <p>Catastrophic Coverage Stage:</p> <p>During this payment stage, you pay nothing for your covered Part D drugs and for excluded drugs that are covered under our enhanced benefit.</p>

SECTION 1 Changes to Benefits & Costs for Next Year

Section 1.1 Changes to the Monthly Plan Premium

	2025 (this year)	2026 (next year)
Monthly plan premium (You must also continue to pay your Medicare Part B premium.)	\$0	\$0 There is no change for the upcoming benefit year
Part B premium reduction This amount will be deducted from your Part B premium. This means you'll pay less for Part B.	\$75	\$105
Additional premium for optional supplemental benefits – Dental \$7,500 Annual allowance	\$64	Not covered

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.

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 the rest of the calendar year.

	2025 (this year)	2026 (next year)
<p>Maximum out-of-pocket amount</p> <p>Your costs for covered medical services (such as copayments) count toward your maximum out-of-pocket amount.</p> <p>Your costs for prescription drugs don't count toward your maximum out-of-pocket amount.</p>	\$6,750	<p>\$6,750 There is no change for the upcoming benefit year</p> <p>Once you've paid \$6,750 out of pocket for covered Part A and Part B services, you'll pay nothing for your covered Part A and Part B services for the rest of the calendar year.</p>

Section 1.3 Changes to the Provider Network

Our network of providers has changed for next year. Review the 2026 *Provider Directory* www.prominencemedicare.com to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network. Here's how to get an updated *Provider Directory*:

- Visit our website at www.prominencemedicare.com.
- Call Member Services at 1-855-969-5882 (TTY users call 711) to get current provider information or to ask us to mail you a *Provider 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 1-855-969-5882 (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 *Pharmacy Directory* www.prominencemedicare.com to see which pharmacies are in our network. Here's how to get an updated *Pharmacy Directory*:

- Visit our website at www.prominencemedicare.com.
- Call Member Services at 1-855-969-5882 (TTY users call 711) to get current pharmacy information or to ask us to mail you a *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 1-855-969-5882 (TTY users call 711) for help.

Section 1.5 Changes to Benefits & Costs for Medical Services

	<p align="center">2025 (this year)</p>	<p align="center">2026 (next year)</p>
<p>Dental Services</p>	<p>This dental plan will pay up to \$1,000 combined limit maximum plan coverage limit per calendar year.</p> <p>Preventive Dental Services:</p> <ul style="list-style-type: none"> • Oral Exams (up to 2 visits every year): \$0 Copay • Dental X-Rays (up to 2 visits every year): \$0 Copay • Cleaning (up to 2 visits every year): \$0 Copay • Fluoride Treatment (up to 2 visits every year): \$0 Copay <p>Comprehensive Dental Services:</p> <ul style="list-style-type: none"> • Restorative Services: \$50-\$100 copay • Crowns: \$50-\$100 copay • Endodontics: \$100 copay • Periodontics: \$50-\$100 copay • Prosthodontics: \$50-\$100 copay • Oral and Maxillofacial Surgery: \$50-\$100 copay • Adjunctive General Services: \$0-\$50 copay 	<p>This dental plan will pay up to \$1,000 combined limit maximum plan coverage limit per calendar year.</p> <p>Preventive Dental Services:</p> <ul style="list-style-type: none"> • Oral Exams (up to 2 visits every year): \$0 Copay • Dental X-Rays (up to 2 visit every year): \$0 Copay • Cleaning (up to 2 visits every year): \$0 Copay • Fluoride Treatment (up to 2 visits every year): \$0 Copay <p>Comprehensive Dental Services:</p> <ul style="list-style-type: none"> • Restorative Services: 10%-50% coinsurance • Crowns: Not covered • Endodontics: 50% coinsurance • Periodontics: 10%-50% coinsurance • Prosthodontics: 10%-50% coinsurance • Oral and Maxillofacial Surgery: 10%-50% coinsurance

	2025 (this year)	2026 (next year)
	<p>Must use FCL Dental network of providers.</p> <p>Visit ProminenceMedicare.com/dental or call our Care Advocate Team to find a dentist.</p>	<ul style="list-style-type: none"> • Adjunctive General Services: 10%-50% coinsurance <p>Must use FCL Dental network of providers.</p> <p>Visit ProminenceMedicare.com/dental or call our Care Advocate Team to find a dentist.</p>
Dental Services– Optional Supplemental Benefits	<p>\$7,500 Annual Allowance</p> <p>Implant services: Covered</p>	<p>Not Covered</p> <p>Implant services: Not covered</p> <p>If Care plan is in progress, please call our Care Advocate Team for assistance.</p>
Extra Benefit (OTC) Card	<p>Not covered</p>	<p>\$50 per quarter for over the counter (OTC) drugs and supplies.</p> <p>You will be receiving a new OTC card in the mail.</p> <p>OTC products available through an online catalog with andmorehealth.com, or by calling 855-AND-MORE. You can also visit the ProminenceMedicare.com website for an up to date 2026 OTC catalog.</p>

	2025 (this year)	2026 (next year)
Inpatient Acute Medicare-covered stay	<p>Tier 1 hospitals: You pay \$275 Copay per day for Days 1-6</p> <p>You pay \$0 Copay per day for days 7-90.</p> <p>Tier 2 hospitals: You pay \$425 Copay per day for Days 1-6.</p> <p>You pay \$0 Copay per day for days 7-90.</p>	<p>Tier 1 hospitals: You pay \$325 Copay per day for Days 1-6</p> <p>You pay \$0 Copay per day for days 7-90.</p> <p>Tier 2 hospitals: You pay \$450 Copay per day for Days 1-6.</p> <p>You pay \$0 Copay per day for days 7-90.</p>
Medicare-covered Emergency Care	You pay a \$125 Copay per visit for Medicare-covered Emergency Care.	You pay a \$130 copay per visit for Medicare-covered Emergency Care.
Medicare-covered Other Health Care Professional Services (Physician Assistant/Nurse Practitioner)	<p>You pay a minimum \$0 Copay per visit for Medicare-covered Other Health Care Professional Services with a Primary Care Provider.</p> <p>You pay a \$45 Copay per visit for Medicare-covered Other Health Care Professional Services with a Specialist provider.</p>	<p>You pay a minimum \$0 Copay per visit for Medicare-covered Other Health Care Professional Services with a Primary Care Provider or Rheumatologist.</p> <p>You pay a \$45 Copay per visit for Medicare-covered Other Health Care Professional Services with any other Specialist provider.</p>
Medicare-covered Physician Specialist Services	You pay a \$45 Copay per visit for Medicare-covered Other Health Care Professional Services with a Specialist provider.	<p>You pay a minimum \$0 copay for Rheumatologist Specialist Services.</p> <p>You pay a \$45 Copay per visit for all other Medicare-covered Physician Specialist services.</p>

	2025 (this year)	2026 (next year)
Skilled Nursing Facility (SNF) Medicare-covered stay	\$10 copay per day for days 1-20 \$214 copay per day for days 21-100	\$10 copay per day for days 1-20 \$218 copay per day for days 21-100
Worldwide emergency services	You pay a \$125 copay per visit.	You pay a \$130 copay per visit.

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 1-855-969-5882 (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 lower cost-sharing tier and 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: www.FDA.gov/drugs/biosimilars/multimedia-education-materials-biosimilars#For%20Patients. You can also call Member Services at 1-855-969-5882 (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 sent you 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 you don't get this material by October 1, 2025, please call Member Services at 1-855-969-5882 (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, 4 and 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.

- **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 (this year)	2026 (next year)
Yearly Deductible	\$590	\$450
		<p>During this stage, you pay a \$0 copay for drugs on Tier 1, a \$12 copay for drugs on Tier 2 and a \$0 copay for drugs on Tier 6. You pay the full cost of drugs on Tiers 3, 4 and 5 until you've reached the yearly deductible.</p>

Drug Costs in Stage 2: Initial Coverage

The table shows your cost per prescription for a one-month (30 days) supply filled at a network pharmacy with standard 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 more information about the costs of vaccines, or information about the costs

for a long-term supply 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)
Tier 1 – Preferred Generic	You pay \$0 per prescription	You pay \$0 per prescription
Tier 2 – Generic	You pay \$12 per prescription	You pay \$12 per prescription
Tier 3 – Preferred Brand	You pay 24% of the total cost	You pay 23% of the total cost
Tier 4 – Non-Preferred Drug	You pay 40% of the total cost	You pay 45% of the total cost

	2025 (this year)	2026 (next year)
Tier 5 – Specialty	You pay 25% of the total cost	You pay 27% of the total cost
Tier 6 – Select Care Drugs	You pay \$0 per prescription	You pay \$0 per prescription

Changes to the Catastrophic Coverage Stage

If you reach the Catastrophic Coverage Stage, you pay nothing for your covered Part D drugs and for excluded drugs that are covered under our enhanced benefit.

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	The Medicare Prescription Payment Plan is a payment option that began this year and can help you	If you’re participating in the Medicare Prescription Payment Plan and stay in the

	2025 (this year)	2026 (next year)
	<p>manage your out-of-pocket costs for drugs covered by our plan by spreading them across the calendar year (January-December). You may be participating in this payment option.</p>	<p>same Part D plan, your participation will be automatically renewed for 2026.</p> <p>To learn more about this payment option, call us at 1-855-969-5882 (TTY users call 711) or visit www.Medicare.gov.</p>

SECTION 3 How to Change Plans

To stay in *Prominence Giveback* 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 *Prominence Giveback*.

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 *Prominence Giveback*.
- **To change to Original Medicare with Medicare drug coverage**, enroll in the new Medicare drug plan. You'll be automatically disenrolled from *Prominence Giveback*.
- **To change to Original Medicare without a drug plan**, you can send us a written request to disenroll. Call Member Services at 1-855-969-5882 (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.
- **To learn more about Original Medicare and the different types of Medicare plans**, visit www.Medicare.gov, check the *Medicare & You 2026* handbook, call your State Health Insurance Assistance Program, or call 1-800-MEDICARE (1-800-633-4227).

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

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).** Nevada has a program called SeniorRx 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 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 Nevada office of HIV/AIDS. 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 702-274-2453. 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 1-855-969-5882 (TTY users call 711) or visit www.Medicare.gov.

SECTION 5 Questions?

Get Help from *Prominence Health*

- **Call Member Services at 1-855-969-5882 (TTY users call 711)**

We're available for phone calls 8 a.m. to 8 p.m., seven days a week from October 1 through March 31, and Monday through Friday from April 1 through September 30. 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 Prominence Giveback*. 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.prominencemedicare.com or call Member Services at 1-855-969-5882 (TTY users call 711) to ask us to mail you a copy.

- **Visit www.prominencemedicare.com**

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 *Nevada*, the SHIP is called Nevada Medicare State Health Insurance Assistance Program.

Call Nevada Medicare State Health Insurance Assistance Program to get free personalized health insurance counseling. They can help you understand your Medicare plan choices and answer questions about switching plans. Call Nevada Medicare State Health Insurance Assistance Program at 1-800-307-4444.

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**

You can chat live at 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**

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 or by calling 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.