JANUARY 1 – DECEMBER 31, 2025

SUMMARY OF BENEFITS

PARAMOUNT ELITE **PREFERRED (PPO) H5232-001**

Paramount Elite Medicare Plans include HMO and PPO plans each with a Medicare contract. Enrollment in Paramount Elite Plans depends on contract renewal.

PARAMOUNT ELITE | MEDICARE PLANS

MedicareRx Prescription Drug Coverage

Y0121_P_S1883_2025_M

1 SECTION I - INTRODUCTION TO SUMMARY OF BENEFITS

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 and items we cover, call us and ask for the "Evidence of Coverage." You can also see the Evidence of Coverage on our website, www.paramounthealthcare.com/medicareplans.

You have choices about how to get your Medicare benefits

- One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government.
- Another choice is to get your Medicare benefits by joining a Medicare health plan (such as **Paramount Elite Preferred (PPO)**).

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **Paramount Elite Preferred (PPO)** covers and what you pay.

- If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on www.medicare.gov.
- 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 www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 711.

Sections in this booklet

- Things to Know About **Paramount Elite Preferred (PPO).**
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services and items.
- Covered Medical and Hospital Benefits.
- Prescription Drug Benefits.

This document is available in other formats such as Braille and large print.

This document may be available in a non-English language. For additional information, call us at 1-833-554-2335 (TTY: 711).

Things to Know About Paramount Elite Preferred (PPO)

Hours of Operation & Contact Information

- From October 1 to March 31, we're open 8 a.m. – 8 p.m., 7 days a week.
- From April 1 to September 30, we're open 8 a.m. – 8 p.m., Monday through Friday.
- If you are a member of this plan, call us at 1-833-554-2335, TTY: 711.
- If you are not a member of this plan, call us at 1-833-691-3703, TTY: 711.
- Our website: www.paramounthealthcare.com/medicareplans.

Who can join?

To join **Paramount Elite Preferred (PPO)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and you must live in our service area. Our service area includes these counties in Indiana: Adams, Allen, Dearborn, DeKalb, Franklin, Noble, Ohio and Switzerland.
Our service area includes these counties in Kentucky: Boone, Campbell and Kenton.
Our service area includes these counties in Michigan: Branch, Hillsdale, Lenawee, Monroe and Washtenaw.
Our service area includes these counties in Ohio: Adams, Allen, Ashland, Auglaize, Brown, Butler, Champaign, Clark, Clermont, Clinton, Crawford, Cuyahoga, Darke, Defiance, Erie, Fayette, Fulton, Geauga, Greene, Hamilton, Hardin, Henry, Highland, Huron, Lake, Lorain, Lucas, Madison, Medina, Mercer, Miami, Montgomery, Ottawa, Paulding, Portage, Preble, Putnam, Sandusky, Seneca, Shelby, Summit, Van Wert, Warren, Wayne, Williams, Wood and Wyandot.

Which doctors, hospitals, and pharmacies can I use?

Paramount Elite Preferred (PPO) has a network of doctors, hospitals, pharmacies, and other providers. If you use any providers that are not in our network, the plan may not pay for these services and items.

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.

You can see our plan's provider and pharmacy directory at our website (http://www.paramounthealthcare.com/medicareplans).

Or, call us and we will send you a copy of the provider and pharmacy directories.

What do we cover?

Like all Medicare health plans, we cover everything that Original Medicare covers – and *more*. Some of the extra benefits are outlined in this booklet.

We cover Part D drugs. In addition, we cover Part B drugs including chemotherapy and some drugs administered by your provider.

- You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, http://www.paramounthealthcare.com/medicareplans.
- Or, call us and we will send you a copy of the formulary.

How will I determine my drug costs?

Our plan groups each medication into one of five "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the benefit stages that occur: Initial Coverage and Catastrophic Coverage.

If you have any questions about this plan's benefits or costs, please contact Paramount Elite Medicare Plans

2 SECTION II - SUMMARY OF BENEFITS

Paramount Elite Preferred (PPO)

MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES	
Premiums and Benefits	**Paramount Elite Preferred (PPO)**
Plan Premium	You do not pay a separate monthly plan premium for Paramount Elite Preferred (PPO). You must continue to pay your Medicare Part B premium.
Deductible	Medical Deductible: $0. Prescription Drug Deductible: $0.
Maximum Out-of-Pocket Responsibility	Your yearly limit(s) in this plan: • $4,200 for services you receive from in-network providers. • $5,700 for services you receive from out-of-network providers. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Your yearly limit(s) in this plan: • $4,200 for services you receive from in-network providers. • $5,700 for services you receive from in and out-of-network providers combined. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.

COVERED MEDICAL AND HOSPITAL BENEFITS	
Benefits/Services	**Paramount Elite Preferred (PPO)**
Inpatient Hospital	**<u>In-Network:</u>** Days 1-5: $360 copay per day for each admission. Days 6-90: $0 copay per day. Our plan covers an unlimited number of days for an inpatient hospital stay. **<u>Out-of-Network:</u>** Days 1-90: $360 copay per day.
Outpatient Hospital	**<u>In-Network:</u>** Outpatient Hospital: $0 - $275 copay. Outpatient Surgery: $0 - $275 copay. $0 applies to preventive colonoscopy with/without polyp removal. **<u>Out-of-Network:</u>** Outpatient Hospital: 40% coinsurance. Outpatient Surgery: 40% coinsurance. **May require prior authorization.**

COVERED MEDICAL AND HOSPITAL BENEFITS	
Benefits/Services	**Paramount Elite Preferred (PPO)**
Ambulatory Surgical Center	**In-Network:** Ambulatory Surgical Center: $0 - $275 copay. $0 applies to preventive colonoscopy with/without polyp removal. **Out-of-Network:** Ambulatory Surgical Center: 40% coinsurance. **May require prior authorization.**
Doctor's Office Visits	**In-Network:** Primary care physician visit: $0 copay. Specialist visit: $25 copay. **Out-of-Network:** Primary care physician visit: $10 copay. Specialist visit: $40 copay.
Preventive Care ***(e.g., flu vaccine, diabetic screenings)***	**In-Network:** $0 copay for all preventive services covered under Original Medicare at zero cost sharing. Any additional preventive services approved by Medicare during the contract year will be covered. **Out-of-Network:** 0% coinsurance for all preventive services covered under Original Medicare at zero cost sharing.
Emergency Care	**In-Network and Out-of-Network:** $100 copay per visit. You do not pay this amount if you are admitted on the same day with the same condition to the same facility. Worldwide Emergency Coverage: $100 copay.
Urgently Needed Services	**In-Network and Out-of-Network:** $35 copay per visit. Worldwide Urgent Coverage: $100 copay.

COVERED MEDICAL AND HOSPITAL BENEFITS	
Benefits/Services	**Paramount Elite Preferred (PPO)**
Diagnostic Services / Labs/ Imaging	**<u>In-Network:</u>** Diagnostic tests and procedures: $50 copay. Lab services: $0 copay Diagnostic Radiology Services (such as MRI, CAT Scan): $0 copay - $130 copay X-rays: $50 copay. Therapeutic radiology services (such as radiation treatment for cancer): 20% coinsurance. **<u>Out-of-Network:</u>** Diagnostic tests and procedures: 10% coinsurance. Lab services: 40% coinsurance. Diagnostic Radiology Services (such as MRI, CAT Scan): 10% coinsurance. X-rays: 10% coinsurance. Therapeutic radiology services (such as radiation treatment for cancer): 40% coinsurance. **May require prior authorization.**
Hearing Services	**<u>In-Network:</u>** Exam to diagnose and treat hearing and balance issues: $30 copay. Routine hearing exam (up to 1 visit(s) every year): $0 copay. **You must use a NationsHearing network provider for a Routine hearing exam to be covered.** **<u>Out-of-Network:</u>** Exam to diagnose and treat hearing and balance issues: 10% coinsurance.
Hearing Aid Coverage	**<u>In-Network and Out-of-Network:</u>** Hearing Aid (up to 2 hearing aids every year): $0 copay, up to a maximum coverage of $675 per ear per calendar year from NationsHearing. $0 copay for up to three follow-up visits within the first year of initial fitting date. **You must use a NationsHearing network provider for your Hearing Aid benefits.**

COVERED MEDICAL AND HOSPITAL BENEFITS	
Benefits/Services	**Paramount Elite Preferred (PPO)**
Dental Services	**<u>In-Network and Out-of-Network:</u>** **$7,500** combined maximum coverage amount for Embedded PPO Preventive and Comprehensive dental services. ***May require prior authorization.*** For additional details on coverage for endodontics, periodontics, prosthodontics and restorative coverage, see your plan's Evidence of Coverage. **<u>In-Network:</u>** Preventive Services: $0 copay for: • 2 periodic exams • 2 teeth cleanings • 2 fluoride treatments • 4 (one-set) dental bitewing X-rays Comprehensive Services: $0 Copay for: • Fillings • Root Canals • Crowns • Dentures • Periodontal Maintenance • Extractions **<u>Out of network:</u>** 30% coinsurance for all covered dental services. Out-of-network dentists have not agreed to provide services at contracted fees. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions. Members may be billed by the out-of-network provider for any amount greater than the payment made by Paramount.

COVERED MEDICAL AND HOSPITAL BENEFITS	
Benefits/Services	**Paramount Elite Preferred (PPO)**
Vision Services (Eye Exams)	**In-Network:** Exam to diagnose and treat diseases and conditions of the eye: $30 copay. Routine eye exam (up to 1 visit(s) every calendar year): $0 copay. **You must use an EyeMed network provider for a Routine eye exam to be covered.** **Out-of-Network:** Exam to diagnose and treat diseases and conditions of the eye: $40 copay.
Vision Hardware	**In-Network:** $200 annual combined maximum eyewear allowance for eyeglass frames, contacts and lenses. **Out-of-Network:** $200 max annual reimbursement for contact lenses. **Vision Hardware Network: EyeMed** *Maximum benefit achieved when using network providers.*

COVERED MEDICAL AND HOSPITAL BENEFITS	
Benefits/Services	**Paramount Elite Preferred (PPO)**
Mental Health Care	**In-Network:** Outpatient group therapy visit: $30 copay. Individual therapy visit: $30 copay. Inpatient Mental Health Care: Days 1-5: $295 copay per day for each admission. Days 6-90: $0 copay per day. **Out-of-Network:** Outpatient group therapy visit: $60 copay. Individual therapy visit: $60 copay. Days 1-90: $295 copay per day.
Skilled Nursing Facility (SNF)	**In-Network:** Days 1-20: $0 copay per day. Days 21-100: $214 copay per day. **Out-of-Network:** Days 1-100: 40% coinsurance per day. **May require prior authorization.**
Outpatient Rehabilitation	**In-Network:** Occupational therapy visit: $15 copay. Physical therapy or speech pathology therapy visit: $15 copay. **Out-of-Network:** Occupational therapy visit: $30 copay. Physical therapy or speech pathology therapy visit: 10% coinsurance. **May require prior authorization.**

COVERED MEDICAL AND HOSPITAL BENEFITS	
Benefits/Services	**Paramount Elite Preferred (PPO)**
Ambulance	**In-Network:** Ground Ambulance: $295 copay. Air Ambulance: $295 copay. Worldwide Emergency Transportation: $100 Copay per one way trip. Copays apply to one-way trips for Medicare-covered ambulance services. (Emergency, urgent care, and emergency ambulance services outside of the United States are covered up to a combined maximum of $100,000 each year.) **Out-of-Network:** Ground Ambulance: $295 copay. Air Ambulance: $295 copay. Worldwide Emergency Transportation: $100 Copay per one way trip. Copays apply to one-way trips for Medicare-covered ambulance services. (Emergency, urgent care, and emergency ambulance services outside of the United States are covered up to a combined maximum of $100,000 each year.)
Medicare Part B Drugs	**In-Network:** For Part B drugs such as chemotherapy drugs: 0% - 20% coinsurance. Other Part B drugs: 0% - 20% coinsurance. Minimum cost share ensures member cost sharing does not exceed the adjusted Medicare coinsurance for Part B rebatable drugs. **Out-of-Network:** For Part B drugs such as chemotherapy drugs: 20% coinsurance. Other Part B drugs: 20% coinsurance.

<table>
<tr><th colspan="2">PRESCRIPTION DRUG BENEFITS</th></tr>
<tr><td>Deductible</td><td>Prescription Drug Deductible: $0.</td></tr>
<tr><td>Initial Coverage</td><td>You pay the following until your Part D total yearly drug costs reach $2,000 paid by you.
<table>
<tr><th colspan="4">Standard Retail Network Cost-Sharing</th></tr>
<tr><th>Tier</th><th>One-month supply</th><th>Two-month supply</th><th>Three-month supply</th></tr>
<tr><td>Tier 1 (Preferred Generic)</td><td>$0 Copay</td><td>Not Applicable</td><td>$0 Copay</td></tr>
<tr><td>Tier 2 (Generic)</td><td>$0 Copay</td><td>Not Applicable</td><td>$0 Copay</td></tr>
<tr><td>Tier 3 (Preferred Brand)</td><td>$45 copay</td><td>Not Applicable</td><td>$135 copay</td></tr>
<tr><td>Tier 4 (Non-Preferred Drug)</td><td>$100 copay</td><td>Not Applicable</td><td>$300 copay</td></tr>
<tr><td>Tier 5 (Specialty Tier)</td><td>33% coinsurance</td><td>Not Applicable</td><td>Not Applicable</td></tr>
<tr><th colspan="4">Standard Mail Order</th></tr>
<tr><th>Tier</th><th>One-month supply</th><th>Two-month supply</th><th>Three-month supply</th></tr>
<tr><td>Tier 1 (Preferred Generic)</td><td>$0 Copay</td><td>Not Applicable</td><td>$0 Copay</td></tr>
<tr><td>Tier 2 (Generic)</td><td>$0 Copay</td><td>Not Applicable</td><td>$0 Copay</td></tr>
<tr><td>Tier 3 (Preferred Brand)</td><td>$45 copay</td><td>Not Applicable</td><td>$90 copay</td></tr>
<tr><td>Tier 4 (Non-Preferred Drug)</td><td>$100 copay</td><td>Not Applicable</td><td>$200 copay</td></tr>
</table></td></tr>
</table>

PRESCRIPTION DRUG BENEFITS				
	Tier 5 (Specialty Tier)	Not Applicable	Not Applicable	Not Applicable
	Your cost-sharing may be different if you use a Long Term Care pharmacy, or an out-of-network pharmacy, or if you purchase a long-term supply (up to 90 days) of a drug. Please call us or see the plan's **"Evidence of Coverage"** on our website (www.paramounthealthcare.com/medicareplans) for complete information about your costs for covered drugs.			
Catastrophic Amount	After your calendar year Part D out-of-pocket drug costs reach $2,000, you pay nothing for the remainder of the year for your covered Part D drugs.			
Insulins and Vaccines	Important message about what you pay for Part D vaccines: Our plan covers most vaccines at no cost to you. Important message about what you pay for Part D insulins: You won't pay more than $35 for a one month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on or Part D phase you are in.			

OTHER COVERED BENEFITS	
Benefit	**Your Costs**
Home and Bathroom Safety Devices	Our plan offers members an allowance amount of up to $100 per calendar year for purchasing plan-approved safety devices to help prevent falls in the home. These items must be ordered through the NationsBenefit member portal.
Meals	Our plan will provide up to 14 meals (2 meals per day for up to 7 days) after you are discharged from an Inpatient Acute, Inpatient Psychiatric Hospital or Skilled Nursing Facility stay.
Over The Counter drugs & supplies (OTC)	Our plan provides members with an allowance up to $175 on a calendar quarter basis. The benefit is available through the member's NationsBenefit member portal or at participating network retail locations via a flex benefit card.
Personal Emergency Response System (PERS)	Our plan covers a PERS through NationsResponse helping to provide safety and peace of mind 24/7 in the event of an emergency.
Physical Fitness	Our plans provide members access to thousands of participating fitness locations across the country through a membership in SilverSneakers. Members will also have access to online education on SilverSneakers.com, which includes SilverSneakers LIVE virtual classes, workout videos on SilverSneakers On-Demand and many more resources.

DISCLAIMERS

This document is available in other alternate formats.

ATTENTION: If you speak Spanish, language assistance services, free of charge, are available to you. Call 1-833-554-2335 (TTY: 711).

ATENCIÓN: Si habla español, hay servicios de traducción, libre de cargos, disponibles para usted. Llame al 1-833-554-2335 (TTY: 711).

Paramount Elite Medicare Plans include HMO and PPO plans each with a Medicare contract. Enrollment in **Paramount Elite Medicare Plans** depends on contract renewal.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, coinsurance and restrictions may apply. Benefits, premiums and/or copayments/coinsurance may change on January 1 of each year.

You must continue to pay your Medicare Part B premium.

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

Out-of-network/non-contracted providers are under no obligation to treat Paramount Elite Medicare Plans members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. Please call our Member Services number or see your “Evidence of Coverage” for more information, including the cost-sharing.

Health coverage is offered by Paramount Insurance Co.

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 1-833-554-2335 (TTY 711).

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.paramounthealthcare.com/medicareplans or call 1-833-554-2335 (TTY 711) 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 medicine 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, 2025.
- ☐ 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. In addition, you will pay a higher co-pay for services received by non-contracted providers.
- ☐ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory) unless it is for dental service. While we will pay for covered dental services outside of the network, the provider must agree to treat you. You will pay a higher cost for services received by non-contracted providers.
- ☐ I understand that I can be enrolled in only one MA plan at a time-and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA PFFS, MA MSA plans).

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