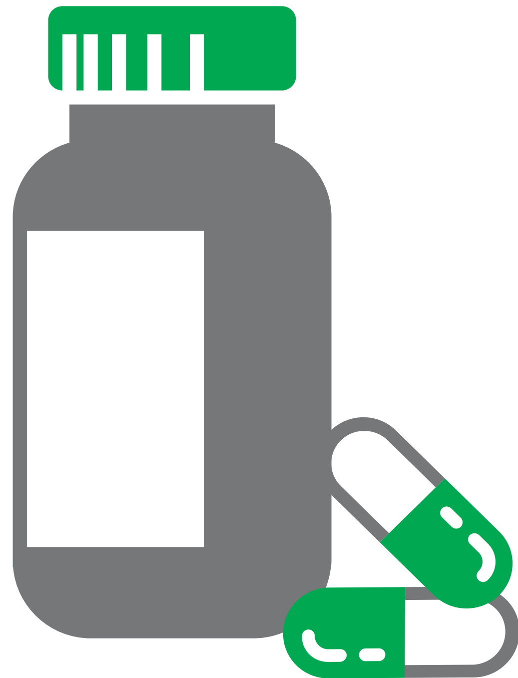
SUMMARY OF BENEFITS

PARAMOUNT ELITE ENHANCED MEDICAL & DRUG (HMO) (H3653-004)
PARAMOUNT ELITE PRIME MEDICAL & DRUG (HMO) (H3653-022)
PARAMOUNT ELITE STANDARD MEDICAL & DRUG (HMO) (H3653-015)



PARAMOUNT
ELITE|MEDICARE PLANS
Affiliate of ProMedica

MedicareRx
Prescription Drug Coverage

PARAMOUNT ELITE IS AN HMO PLAN WITH A MEDICARE CONTRACT.
Enrollment in Paramount Elite depends on contract renewal.

H3653_0040150222019SB_M Accepted

January 1, 2019 – December 31, 2019

This booklet gives you a summary of what Paramount Elite – Enhanced Medical & Drug (HMO), Paramount Elite – Prime Medical & Drug, and what Paramount Elite – Standard Medical & Drug (HMO) cover and what you pay.

It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call us and ask for the *Evidence of Coverage.*

To join Paramount Elite – Enhanced Medical & Drug (HMO), Paramount Elite – Prime Medical & Drug, or Paramount Elite – Standard Medical & Drug (HMO), you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

Our service area for these plans includes the following counties in **Ohio**: Allen, Cuyahoga, Defiance, Erie, Fulton, Hardin, Henry, Huron, Lake, Lorain, Lucas, Medina, Ottawa, Paulding, Putnam, Sandusky, Summit, Williams, and Wood; **Michigan**: Lenawee and Monroe.

Paramount Elite – Enhanced Medical & Drug (HMO), Paramount Elite – Prime Medical & Drug, and Paramount Elite – Standard Medical & Drug (HMO) have a network of doctors, hospitals, pharmacies, and other providers. If you use providers that are not in our network, the plan may not pay for these services.

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

Hours of Operation

You can call us Monday through Friday from 8:00 a.m. to 8:00 p.m. Eastern time.

October 1 to March 31, you can call us 7 days a week from 8:00 a.m. to 8:00 p.m. Eastern time.

- Call toll-free 1-800-462-3589 (TTY 1-888-740-5670)
- Our website, http://www.paramounthealthcare.com/medicareplans

Which doctors, hospitals, and pharmacies can I use?

You can see our plan's *Provider Directory* 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*.

We cover Part D drugs. In addition, we cover Part B drugs such as 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.

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 1-800-462-3589 (TTY 1-888-740-5670).

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 http://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 1-877-486-2048.

This is not a complete description of benefits. Call 1-800-462-3589 or TTY 1-888-740-5670 for more information.

Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services			
BENEFIT	**Paramount Elite Enhanced Medical & Drug (HMO)**	**Paramount Elite Prime Medical & Drug (HMO)**	**Paramount Elite Standard Medical & Drug (HMO)**
Monthly Plan Premium	**$68** per month. In addition, you must keep paying your Medicare Part B premium.	**$28** per month. In addition, you must keep paying your Medicare Part B premium.	**$0** per month. In addition, you must keep paying your Medicare Part B premium.
Deductible	This plan does not have a deductible.	This plan does not have a deductible.	This plan does not have a deductible.
Maximum Out-of-Pocket Responsibility *(Does not include Part D prescription drugs)*	Your yearly limit(s) in this plan: **$3,400** for services you receive from in-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. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.	Your yearly limit(s) in this plan: **$4,400** for services you receive from in-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. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.	Your yearly limit(s) in this plan: **$4,900** for services you receive from in-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. 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

Note: Services with a [1] may require prior authorization.

BENEFIT	Paramount Elite Enhanced Medical & Drug (HMO)	Paramount Elite Prime Medical & Drug (HMO)	Paramount Elite Standard Medical & Drug (HMO)
Inpatient Hospital Coverage [1]	• **$200** copay per day for days 1-5. • **$0** copay per day for each additional hospital day. There is no limit to the number of days covered by the plan each hospital stay. Inpatient cost-sharing is for **each inpatient hospital admission.**	• **$225** copay per day for days 1-5. • **$0** copay per day for each additional hospital day. There is no limit to the number of days covered by the plan each hospital stay. Inpatient cost-sharing is for **each inpatient hospital admission.**	• **$300** copay per day for days 1-5. • **$0** copay per day for each additional hospital day. There is no limit to the number of days covered by the plan each hospital stay. Inpatient cost-sharing is for **each inpatient hospital admission.**
Outpatient Hospital Coverage	• **$200** copay for covered medically necessary services you receive on an outpatient basis.	• **$225** copay for covered medically necessary services you receive on an outpatient basis.	• **$340** copay for covered medically necessary services you receive on an outpatient basis.
Doctor's Office Visits	Primary care physician visit: **$0** copay. Specialist visit: **$40** copay.	Primary care physician visit: **$0** copay. Specialist visit: **$35** copay.	Primary care physician visit: **$10** copay. Specialist visit: **$40** copay.

Covered Medical and Hospital Benefits

Note: Services with a 1 may require prior authorization.

BENEFIT	Paramount Elite Enhanced Medical & Drug (HMO)	Paramount Elite Prime Medical & Drug (HMO)	Paramount Elite Standard Medical & Drug (HMO)
Preventive Care	**You pay nothing.** **Our plan covers many preventive services, including:** • Abdominal aortic aneurysm screening • Annual “Wellness” visit • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) • Cardiovascular disease testing • Cervical and vaginal cancer screening • Colorectal cancer screenings • Depression screening • Diabetes screening • Diabetes self-management training, diabetic services, and supplies • Health and wellness education programs • HIV screening • Immunizations • Medical nutrition therapy services • Medicare diabetes prevention program • Obesity screening and therapy • Prostate cancer screening exams	**You pay nothing.** **Our plan covers many preventive services, including:** • Abdominal aortic aneurysm screening • Annual “Wellness” visit • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) • Cardiovascular disease testing • Cervical and vaginal cancer screening • Colorectal cancer screenings • Depression screening • Diabetes screening • Diabetes self-management training, diabetic services, and supplies • Health and wellness education programs • HIV screening • Immunizations • Medical nutrition therapy services • Medicare diabetes prevention program • Obesity screening and therapy • Prostate cancer screening exams	**You pay nothing.** **Our plan covers many preventive services, including:** • Abdominal aortic aneurysm screening • Annual “Wellness” visit • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) • Cardiovascular disease testing • Cervical and vaginal cancer screening • Colorectal cancer screenings • Depression screening • Diabetes screening • Diabetes self-management training, diabetic services, and supplies • Health and wellness education programs • HIV screening • Immunizations • Medical nutrition therapy services • Medicare diabetes prevention program • Obesity screening and therapy • Prostate cancer screening exams

Covered Medical and Hospital Benefits

Note: Services with a 1 may require prior authorization.

BENEFIT	Paramount Elite Enhanced Medical & Drug (HMO)	Paramount Elite Prime Medical & Drug (HMO)	Paramount Elite Standard Medical & Drug (HMO)
Preventive Care (continued)	• Screening and counseling to reduce alcohol misuse • Screening for lung cancer with low-dose computed tomography • Screening for sexually transmitted infections (STIs) and counseling to prevent STIs • Smoking and tobacco use cessation counseling (counseling to stop smoking or tobacco use) for people with no sign of tobacco-related disease • Vaccines, including flu shots, Hepatitis B shots, pneumococcal shots Any additional preventive services approved by Medicare during the contract year will also be covered.	• Screening and counseling to reduce alcohol misuse • Screening for lung cancer with low-dose computed tomography • Screening for sexually transmitted infections (STIs) and counseling to prevent STIs • Smoking and tobacco use cessation counseling (counseling to stop smoking or tobacco use) for people with no sign of tobacco-related disease • Vaccines, including flu shots, Hepatitis B shots, pneumococcal shots Any additional preventive services approved by Medicare during the contract year will also be covered.	• Screening and counseling to reduce alcohol misuse • Screening for lung cancer with low-dose computed tomography • Screening for sexually transmitted infections (STIs) and counseling to prevent STIs • Smoking and tobacco use cessation counseling (counseling to stop smoking or tobacco use) for people with no sign of tobacco-related disease • Vaccines, including flu shots, Hepatitis B shots, pneumococcal shots Any additional preventive services approved by Medicare during the contract year will also be covered.
Emergency Care	**$120** copay per visit. If you are admitted to the hospital within 1 day, you do not have to pay your share of the cost for emergency care. Waiver of ER copay applies only if you are admitted to the same hospital with the same diagnosis.	**$90** copay per visit. If you are admitted to the hospital within 1 day, you do not have to pay your share of the cost for emergency care. Waiver of ER copay applies only if you are admitted to the same hospital with the same diagnosis.	**$90** copay per visit. If you are admitted to the hospital within 1 day, you do not have to pay your share of the cost for emergency care. Waiver of ER copay applies only if you are admitted to the same hospital with the same diagnosis.
Urgently Needed Services	**$45** copay per visit.	**$40** copay per visit.	**$45** copay per visit.

Covered Medical and Hospital Benefits

Note: Services with a 1 may require prior authorization.

BENEFIT	Paramount Elite Enhanced Medical & Drug (HMO)	Paramount Elite Prime Medical & Drug (HMO)	Paramount Elite Standard Medical & Drug (HMO)
Diagnostic Tests, Lab and Radiology Services, and X-Rays [1]	Lab services: **$0-$10** copay, depending on the service. Diagnostic tests and procedures: **$10** copay. Outpatient X-rays: **$10** copay. Advanced diagnostic radiology services (such as MRIs, CT scans, PET scans): **$150** copay. Therapeutic radiology services (such as radiation treatment for cancer): **20%** of the cost.	Lab services: **$0-$15** copay, depending on the service. Diagnostic tests and procedures: **$15** copay. Outpatient X-rays: **$15** copay. Advanced diagnostic radiology services (such as MRIs, CT scans, PET scans): **$150** copay. Therapeutic radiology services (such as radiation treatment for cancer): **20%** of the cost.	Lab services: **$0-$20** copay, depending on the service. Diagnostic tests and procedures: **$20** copay. Outpatient X-rays: **$20** copay. Advanced diagnostic radiology services (such as MRIs, CT scans, PET scans): **$150** copay. Therapeutic radiology services (such as radiation treatment for cancer): **20%** of the cost.
Hearing Services	Exam to diagnose and treat hearing and balance issues: **$40** copay. Routine hearing exam (up to 1 exam every year): **$40** copay.	Exam to diagnose and treat hearing and balance issues: **$35** copay. Routine hearing exam (up to 1 exam every year): **$35** copay.	Exam to diagnose and treat hearing and balance issues: **$40** copay. Routine hearing exam (up to 1 exam every year): **$40** copay.

Covered Medical and Hospital Benefits

Note: Services with a 1 may require prior authorization.

BENEFIT	Paramount Elite Enhanced Medical & Drug (HMO)	Paramount Elite Prime Medical & Drug (HMO)	Paramount Elite Standard Medical & Drug (HMO)
Hearing Aids	Benefit is limited to TruHearing's Advanced (**$699** copay) and Premium (**$999** copay) hearing aids, which come in various styles and colors. Up to two TruHearing-branded hearing aids (one per ear) every year. You must see a TruHearing provider to use this benefit. Call 1-866-929-8812 to schedule an appointment. Hearing aid purchase includes: • 3 provider visits within first year of hearing aid purchase • 45-day trial period • 3-year extended warranty • 48 batteries per aid	Benefit is limited to TruHearing's Advanced (**$699** copay) and Premium (**$999** copay) hearing aids, which come in various styles and colors. Up to two TruHearing-branded hearing aids (one per ear) every year. You must see a TruHearing provider to use this benefit. Call 1-866-929-8812 to schedule an appointment. Hearing aid purchase includes: • 3 provider visits within first year of hearing aid purchase • 45-day trial period • 3-year extended warranty • 48 batteries per aid	Benefit is limited to TruHearing's Advanced (**$699** copay) and Premium (**$999** copay) hearing aids, which come in various styles and colors. Up to two TruHearing-branded hearing aids (one per ear) every year. You must see a TruHearing provider to use this benefit. Call 1-866-929-8812 to schedule an appointment. Hearing aid purchase includes: • 3 provider visits within first year of hearing aid purchase • 45-day trial period • 3-year extended warranty • 48 batteries per aid
Dental Services	Preventive dental services covered with additional premium. See **Optional Benefits** section.	Preventive dental services covered with additional premium. See **Optional Benefits** section.	Preventive dental services covered with additional premium. See **Optional Benefits** section.
Vision Services	Exam to diagnose and treat diseases and conditions of the eye: **$40** copay. Routine eye exam (up to 1 exam every year): You pay **nothing**. Eyeglasses or contact lenses after cataract surgery: **20%** of the cost.	Exam to diagnose and treat diseases and conditions of the eye: **$35** copay. Routine eye exam (up to 1 exam every year): You pay **nothing**. Eyeglasses or contact lenses after cataract surgery: **20%** of the cost.	Exam to diagnose and treat diseases and conditions of the eye: **$40** copay. Routine eye exam (up to 1 exam every year): You pay **nothing**. Eyeglasses or contact lenses after cataract surgery: **20%** of the cost.

Covered Medical and Hospital Benefits Note: Services with a [1] may require prior authorization.			
BENEFIT	**Paramount Elite Enhanced Medical & Drug (HMO)**	**Paramount Elite Prime Medical & Drug (HMO)**	**Paramount Elite Standard Medical & Drug (HMO)**
Enhanced Vision Services	Contact lenses (up to one every two years): You pay **$0** copay. Our plan pays up to **$100** every two years for contact lenses. Eyeglass frames (up to one every two years): You pay **$0** copay. Our plan pays up to **$75** every two years for eyeglass frames. Eyeglass lenses (up to one every two years): You pay **$0** copay.	Contact lenses (up to one every two years): You pay **$0** copay. Our plan pays up to **$100** every two years for contact lenses. Eyeglass frames (up to one every two years): You pay **$0** copay. Our plan pays up to **$75** every two years for eyeglass frames. Eyeglass lenses (up to one every two years): You pay **$0** copay.	Contact lenses (up to one every two years): You pay **$0** copay. Our plan pays up to **$100** every two years for contact lenses. Eyeglass frames (up to one every two years): You pay **$0** copay. Our plan pays up to **$75** every two years for eyeglass frames. Eyeglass lenses (up to one every two years): You pay **$0** copay.
Mental Health Services [1]	**Inpatient visit:** • **$200** copay per day for days 1-5. • **$0** copay per day for each additional hospital day. There is no limit to the number of days covered by the plan each hospital stay. Inpatient cost-sharing is for **each inpatient hospital admission.** Outpatient group therapy visit: **$40** copay. Outpatient individual therapy visit: **$40** copay.	**Inpatient visit:** • **$225** copay per day for days 1-5. • **$0** copay per day for each additional hospital day. There is no limit to the number of days covered by the plan each hospital stay. Inpatient cost-sharing is for **each inpatient hospital admission.** Outpatient group therapy visit: **$35** copay. Outpatient individual therapy visit: **$35** copay.	**Inpatient visit:** • **$300** copay per day for days 1-5. • **$0** copay per day for each additional hospital day. There is no limit to the number of days covered by the plan each hospital stay. Inpatient cost-sharing is for **each inpatient hospital admission.** Outpatient group therapy visit: **$40** copay. Outpatient individual therapy visit: **$40** copay.

Covered Medical and Hospital Benefits

Note: Services with a 1 may require prior authorization.

BENEFIT	Paramount Elite Enhanced Medical & Drug (HMO)	Paramount Elite Prime Medical & Drug (HMO)	Paramount Elite Standard Medical & Drug (HMO)
Skilled Nursing Facility (SNF) [1]	Our plan covers up to 100 days in a SNF each benefit period. You pay: • **$0** copay per day for days 1-9. • **$20** copay per day for days 10-20. • **$155** copay per day for days 21-100. A *benefit period* starts the day you go into a hospital or skilled nursing facility (SNF). The benefit period ends when you go for 60 days in a row without hospital or SNF care. **No prior hospital stay is required.**	Our plan covers up to 100 days in a SNF each benefit period. You pay: • **$0** copay per day for days 1-20. • **$155** copay per day for days 21-100. A *benefit period* starts the day you go into a hospital or skilled nursing facility (SNF). The benefit period ends when you go for 60 days in a row without hospital or SNF care. **No prior hospital stay is required.**	Our plan covers up to 100 days in a SNF each benefit period. You pay: • **$0** copay per day for days 1-20. • **$160** copay per day for days 21-100. A *benefit period* starts the day you go into a hospital or skilled nursing facility (SNF). The benefit period ends when you go for 60 days in a row without hospital or SNF care. **No prior hospital stay is required.**
Rehabilitation Services	Occupational therapy visit: **$25** copay per visit. Physical therapy and speech and language therapy visit: **$25** copay per visit. Cardiac (heart) rehab services (for a maximum of two 1-hour sessions per day for up to 36 sessions up to 36 weeks): **$10** copay per visit. Pulmonary (lung) rehab services: **$10** copay per visit.	Occupational therapy visit: **$20** copay per visit. Physical therapy and speech and language therapy visit: **$20** copay per visit. Cardiac (heart) rehab services (for a maximum of two 1-hour sessions per day for up to 36 sessions up to 36 weeks): **$10** copay per visit. Pulmonary (lung) rehab services: **$10** copay per visit.	Occupational therapy visit: **$40** copay per visit. Physical therapy and speech and language therapy visit: **$40** copay per visit. Cardiac (heart) rehab services (for a maximum of two 1-hour sessions per day for up to 36 sessions up to 36 weeks): **$30** copay per visit. Pulmonary (lung) rehab services: **$30** copay per visit.
Ambulance	**$150** copay per each day (one-way or round trip).	**$200** copay per each day (one-way or round trip).	**$340** copay per each day (one-way or round trip).
Transportation	**Not covered.**	**Not covered.**	**Not covered.**

Prescription Drug Benefits

Note: Services with a 1 may require prior authorization.

BENEFIT	Paramount Elite Enhanced Medical & Drug (HMO)	Paramount Elite Prime Medical & Drug (HMO)	Paramount Elite Standard Medical & Drug (HMO)
Medicare Part B Drugs	For Part B drugs such as chemotherapy drugs [1]: **20%** of the cost. Other Part B drugs [1]: **20%** of the cost.	For Part B drugs such as chemotherapy drugs [1]: **20%** of the cost. Other Part B drugs [1]: **20%** of the cost.	For Part B drugs such as chemotherapy drugs [1]: **20%** of the cost. Other Part B drugs [1]: **20%** of the cost.

Paramount Elite Enhanced Medical & Drug (HMO)

Outpatient Prescription Drugs
You pay the following until your total yearly drug costs reach **$3,820**. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.

Initial Coverage Stage
You may get your drugs at network retail pharmacies and mail-order pharmacies.

Tier	(30- / 90-day) Standard Retail Supply	(30- / 90-day) Standard Mail-Order Supply
Tier 1 (Preferred Generic)	**$0 / $0** copay	**$0 / $0** copay
Tier 2 (Generic)	**$15 / $45** copay	**$15 / $30** copay
Tier 3 (Preferred Brand)	**$45 / $135** copay	**$45 / $90** copay
Tier 4 (Non-Preferred Drug)	**$100 / $300** copay	**$100 / $200** copay
Tier 5 (Specialty Tier)	**33%** of the cost (30-day supply only)	Not available

Paramount Elite Prime Medical & Drug (HMO)

Outpatient Prescription Drugs
You pay the following until your total yearly drug costs reach **$3,820**. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.

Initial Coverage Stage
You may get your drugs at network retail pharmacies and mail-order pharmacies.

Tier	(30- / 90-day) Standard Retail Supply	(30- / 90-day) Standard Mail-Order Supply
Tier 1 (Preferred Generic)	**$0 / $0** copay	**$0 / $0** copay
Tier 2 (Generic)	**$10 / $30** copay	**$10 / $20** copay
Tier 3 (Preferred Brand)	**$45 / $135** copay	**$45 / $90** copay
Tier 4 (Non-Preferred Drug)	**$100 / $300** copay	**$100 / $200** copay
Tier 5 (Specialty Tier)	**33%** of the cost (30-day supply only)	Not available

Prescription Drug Benefits

Note: Services with a 1 may require prior authorization.

Paramount Elite Standard Medical & Drug (HMO)

Outpatient Prescription Drugs
You pay the following until your total yearly drug costs reach **$3,820**. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.

Initial Coverage Stage
You may get your drugs at network retail pharmacies and mail-order pharmacies.

Tier	(30- / 90-day) Standard Retail Supply	(30- / 90-day) Standard Mail-Order Supply
Tier 1 (Preferred Generic)	**$0 / $0** copay	**$0 / $0** copay
Tier 2 (Generic)	**$20 / $60** copay	**$20 / $40** copay
Tier 3 (Preferred Brand)	**$45 / $135** copay	**$45 / $90** copay
Tier 4 (Non-Preferred Drug)	**$100 / $300** copay	**$100 / $200** copay
Tier 5 (Specialty Tier)	**33%** of the cost (30-day supply only)	Not available

Prescription Drug Benefits

Note: Services with a 1 may require prior authorization.

BENEFIT	Paramount Elite Enhanced Medical & Drug (HMO)	Paramount Elite Prime Medical & Drug (HMO)	Paramount Elite Standard Medical & Drug (HMO)
Outpatient Prescription Drugs **Initial Coverage Stage (continued)**	If you reside in a long-term care facility, you pay the same as at a retail pharmacy. You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy. **Note:** Cost-sharing may change when you enter another phase of the Part D benefit. For more information on the phases of the Part D benefit, please call us or access our *Evidence of Coverage* online.		
Coverage Gap Stage	The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches **$3,820.** After you enter the coverage gap, you pay **25%** of the price for brand name drugs (plus a portion of the dispensing fee), and **37%** of the price for generic drugs.		
Catastrophic Stage	The catastrophic stage begins after your total yearly out-of-pocket drug cost reaches **$5,100**. After you reach **$5,100**, you pay the greater of: • **5%** of the cost, or • **$3.40** copay for generic (including brand drugs treated as generic) and a **$8.50** copay for all other drugs.		

Additional Benefits

Note: Services with a 1 may require prior authorization.

BENEFIT	Paramount Elite Enhanced Medical & Drug (HMO)	Paramount Elite Prime Medical & Drug (HMO)	Paramount Elite Standard Medical & Drug (HMO)
Chiropractic Services	**$20** copay for each Medicare-covered visit to correct subluxation.	**$20** copay for each Medicare-covered visit to correct subluxation.	**$20** copay for each Medicare-covered visit to correct subluxation.
Foot Care *(Podiatry services)*	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: **$40** copay.	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: **$35** copay.	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: **$40** copay.
Medical Equipment/ Supplies [1]	Durable medical equipment: You pay **20%** of the cost. *(Wheelchairs, oxygen, etc.)* [1] Prosthetic devices: You pay **20%** of the cost. *(Braces, artificial limbs, etc.)* [1] Diabetes monitoring supplies: You pay **0%** of the cost. Therapeutic shoes or inserts: You pay **0%** of the cost. [1]	Durable medical equipment: You pay **20%** of the cost. *(Wheelchairs, oxygen, etc.)* [1] Prosthetic devices: You pay **20%** of the cost. *(Braces, artificial limbs, etc.)* [1] Diabetes monitoring supplies: You pay **0%** of the cost. Therapeutic shoes or inserts: You pay **0%** of the cost. [1]	Durable medical equipment: You pay **20%** of the cost. *(Wheelchairs, oxygen, etc.)* [1] Prosthetic devices: You pay **20%** of the cost. *(Braces, artificial limbs, etc.)* [1] Diabetes monitoring supplies: You pay **0%** of the cost. Therapeutic shoes or inserts: You pay **0%** of the cost. [1]
Outpatient Substance Abuse [1]	Group therapy visit: **$40** copay per visit. Individual therapy visit: **$40** copay per visit.	Group therapy visit: **$35** copay per visit. Individual therapy visit: **$35** copay per visit.	Group therapy visit: **$40** copay per visit. Individual therapy visit: **$40** copay per visit.
Outpatient Surgery	**$200** copay per visit provided at outpatient hospital or ambulatory surgical center.	**$225** copay per visit provided at outpatient hospital or ambulatory surgical center.	**$340** copay per visit provided at outpatient hospital or ambulatory surgical center.
Worldwide Coverage	**$0 copay; $25,000 limit. Includes emergency coverage, urgent coverage, and emergency transportation.**	**$0 copay; $25,000 limit. Includes emergency coverage, urgent coverage, and emergency transportation.**	**$0 copay; $25,000 limit. Includes emergency coverage, urgent coverage, and emergency transportation.**

Additional Benefits

Note: Services with a 1 may require prior authorization.

BENEFIT	Paramount Elite Enhanced Medical & Drug (HMO)	Paramount Elite Prime Medical & Drug (HMO)	Paramount Elite Standard Medical & Drug (HMO)
Health and Wellness Education Programs	You pay **$0** copay for the following supplemental benefits: **SilverSneakers® Fitness Program –** SilverSneakers is a health and fitness program designed for Medicare beneficiaries at all fitness levels. Members enjoy a free basic membership to more than 13,000 participating gyms and fitness/wellness centers. Members have access to special SilverSneakers fitness classes to improve flexibility, balance, endurance, and energy. Members also have access to the **SilverSneakers® Steps –** a self-directed physical activity program – and the **SilverSneakers® FLEX™** program, which brings fitness to your favorite places. • **Health Education** • **Nursing Hotline –** Connect with a registered nurse anytime day or night. • **Enhanced Disease Management Programs** • **Tele-Monitoring Services** (requires physician referral).		
ProMedica OnDemand	Video visits with a health care provider: **$0** per visit	Video visits with a health care provider: **$0** per visit	Video visits with a health care provider: **$10** per visit

Optional Benefits (You Must Pay an Extra Premium Each Month for These Benefits)	
Paramount Elite Enhanced Medical & Drug **Paramount Elite Prime Medical & Drug** **Paramount Elite Standard Medical & Drug**	
Package #1 – Optional Dental Preventive Benefit Package	
• Up to two oral exam(s) in a calendar year • Up to two cleaning(s) in a calendar year • Up to one fluoride treatment(s) in a calendar year up to age 19 • Up to one dental X-ray in a calendar year (bitewings) • Emergency palliative treatment – to temporarily relieve pain • Brush biopsy to detect oral cancer • Full-mouth X-rays once every five years	**In-Network Delta Dental Providers** **You pay $0 copay for preventive** oral exam(s), cleaning(s), fluoride treatment, and bitewing dental X-ray. **You pay $0 copay** for emergency palliative treatment to temporarily relieve pain, brush biopsy to detect oral cancer, and full-mouth X-rays once every five years.
How much is the monthly premium?	If you elect this optional supplemental benefit, you will pay an additional **$18.10 per month.** You must also keep paying your Medicare Part B premium and your plan monthly premium.
How much is the deductible?	There is no deductible.
What is the maximum payment that this plan will pay per calendar year?	This dental plan will pay up to **$500** maximum plan coverage limit per calendar year.
What dental providers must I use for these services?	Services must be received from a dentist who participates in Delta Dental's Medicare Advantage PPO or Delta Dental's Medicare Advantage Premier network. Please note these networks only consist of dentists in the states of Michigan, Indiana, and Ohio. **Note:** No payment will be made for services received from an out-of-network dentist, and you will be responsible for the full amount charged.

Optional Benefits **(You Must Pay an Extra Premium Each Month for These Benefits)**	
Paramount Elite Enhanced Medical & Drug **Paramount Elite Prime Medical & Drug** **Paramount Elite Standard Medical & Drug**	
Package #2 – Optional Dental Preventive/Comprehensive Benefit Package	
Preventive dental services covered for you • Up to two oral exam(s) in a calendar year • Up to two cleaning(s) in a calendar year • Up to one fluoride treatment(s) in a calendar year up to age 19 • Up to one dental X-ray in a calendar year (bitewings) • Emergency palliative treatment – to temporarily relieve pain • Brush biopsy to detect oral cancer • Full-mouth X-rays once every five years	**In-Network Delta Dental Providers** **You pay $0 copay for preventive** oral exam(s), cleaning(s), fluoride treatment, and bitewing dental X-ray. **You pay $0 copay** for emergency palliative treatment to temporarily relieve pain, brush biopsy to detect oral cancer, and full-mouth X-rays once every five years.
Comprehensive dental services covered for you • Restorative services (fillings and crown repair) – one visit per tooth every 2 years • Endodontics (root canals) – up to two visits per tooth per lifetime • Periodontics (deep cleaning) – up to one visit per tooth or area every 2 years • Simple extractions	**In-Network Delta Dental Providers** **You pay 30% coinsurance** (after **$25** deductible) for restorative services, endodontics, periodontics, and simple extractions.
How much is the monthly premium?	If you elect this optional supplemental benefit, you will pay an additional **$30.00 per month.** You must also keep paying your Medicare Part B premium and your plan monthly premium.
How much is the deductible?	There is a **$25** deductible for comprehensive dental services.
What is the maximum payment that this plan will pay per calendar year?	This dental plan will pay up to **$1,000** maximum plan coverage limit per calendar year.
What dental providers must I use for these services?	Services must be received from a dentist who participates in Delta Dental's Medicare Advantage PPO or Delta Dental's Medicare Advantage Premier network. Please note these networks only consist of dentists in the states of Michigan, Indiana, and Ohio. **Note:** No payment will be made for services received from an out-of-network dentist, and you will be responsible for the full amount charged.

How do I elect the Delta Dental optional supplemental dental coverage?

Members new to Paramount Elite

- When you first enroll in a Paramount Elite plan, you can sign up by checking the appropriate box on your paper or web-based enrollment application form. You can also tell us during a telephone enrollment by one of our licensed Medicare representatives. Your supplemental benefits will be effective on the same date as your other plan benefits.
- Newly enrolled plan members will also have up to **30 days** from their effective date of enrollment to add Delta Dental as an optional supplemental benefit. This can be done by contacting one of our licensed Medicare representatives to enroll over the phone, or you can submit a completed Delta Dental enrollment form (you can find the Delta Dental Enrollment Request Form on http://www.paramounthealthcare.com/medicareplans). You can also call Member Services and request the form (phone numbers are on page 2 of this booklet). Your effective date will be the 1st of the month following the completion of one of the dental enrollment mechanisms listed above.

Members already enrolled in a Paramount Elite plan

If you are already a plan member, you can sign up for this optional dental coverage **during the Annual Election Period** (AEP) from October 15 to December 7, with an effective date of January 1 the following year. **Please note that this is the only time that current members can add the dental benefit.**

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Multi-Language Interpreter Services

English ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-462-3589 (TTY: 1-888-740-5670).

Albanian: KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-800-462-3589 (TTY: 1-888-740-5670).

Arabic: ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 9853-264-008-1 (رقم هاتف الصم والبكم: 0765-047-888-1).

Bengali: লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১-800-462-3589 (TTY: ১-888-740-5670)।

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-462-3589 (TTY：1-888-740-5670）。

Cushite: XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-462-3589 (TTY: 1-888-740-5670).

Dutch: AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 1-800-462-3589 (TTY: 1-888-740-5670).

French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-462-3589 (ATS : 1-888-740-5670).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-462-3589 (TTY: 1-888-740-5670).

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-462-3589 (TTY: 1-888-740-5670).

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-462-3589（TTY:1-888-740-5670）まで、お電話にてご連絡ください。

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-462-3589 (TTY: 1-888-740-5670) 번으로 전화해 주십시오.

Wann du [**Deitsch (Pennsylvania German / Dutch)**] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-462-3589 (TTY: 1-888-740-5670).

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-462-3589 (TTY: 1-888-740-5670).

Romanian: ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-462-3589 (TTY: 1-888-740-5670).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-462-3589 (телетайп: 1-888-740-5670).

Serbo-Croatian: OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-462-3589 (TTY-Telefon za osobe sa oštećenim govorom ili sluhom: 1-888-740-5670).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-462-3589 (TTY: 1-888-740-5670).

Syriac: ܙܘܗܪܐ: ܐܢ ܐܢܬܘܢ ܟܐ ܡܡܠܠܝܬܘܢ ܠܫܢܐ ܐܬܘܪܝܐ، ܟܡܨܝܬܘܢ ܕܩܒܠܝܬܘܢ ܚܠܝܨܘܬܐ ܕܗܝܪܬܐ ܒܠܫܢܐ ܡܓܢܐܝܬ. ܩܪܘܢ ܥܠ ܡܢܝܢܐ 1-800-462-3589 (TTY: 1-888-740-5670)

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-462-3589 (TTY: 1-888-740-5670).

Ukrainian: УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-462-3589 (телетайп: 1-888-740-5670).

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-462-3589 (TTY: 1-888-740-5670).

Notice of Nondiscrimination and Accessibility: Discrimination is Against the Law

Paramount Elite (HMO) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Paramount Elite does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Paramount Elite:

- 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 Paramount Elite Member Services at 1-800-462-3589 or, for TTY users, 1-888-740-5670, 8:00 a.m. to 8:00 p.m., Monday through Friday. From October 1 through March 31, we are available 8:00 a.m. to 8:00 p.m. seven days per week.

If you believe that Paramount Elite 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. You can file a grievance in person or by mail, fax, or email.

Paramount Elite Member Services
1901 Indian Wood Circle, Maumee, OH 43537
Phone: 419-887-2525
Toll Free: 1-800-462-3589
TTY: 1-888-740-5670
Fax: 419-887-2047
Email: Paramount.MemberServices@ProMedica.org

If you need help filing a grievance, Paramount Elite Member Services 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 *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, DC 20201,
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

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