JANUARY 1 – DECEMBER 31, 2024

SUMMARY OF BENEFITS

PARAMOUNT ELITE **ENHANCED (HMO-POS) H3653-004**

PARAMOUNT ELITE ENHANCED IS AN HMO-POS PLAN WITH A MEDICARE CONTRACT. ENROLLMENT IN PARAMOUNT ELITE ENHANCED DEPENDS ON CONTRACT RENEWAL.

PARAMOUNT
ELITE | MEDICARE PLANS

MedicareRx
Prescription Drug Coverage

Y0140_2024004SB_M Accepted

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 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 Enhanced (HMO-POS)**).

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **Paramount Elite Enhanced (HMO-POS)** 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 1-877-486-2048.

Sections in this booklet

- Things to Know About **Paramount Elite Enhanced (HMO-POS).**
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services.
- 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 1-888-740-5670 (TTY: (888)740-5670).

Things to Know About Paramount Elite Enhanced (HMO-POS)

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: (888)740-5670.
- 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 Enhanced (HMO-POS)**, 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 Michigan: Branch, Hillsdale, Lenawee, Monroe and Washtenaw.
Our service area includes these counties in Ohio: Allen, Crawford, Defiance, Erie, Fulton, Hardin, Henry, Huron, Lucas, Mercer, Ottawa, Paulding, Putnam, Sandusky, Seneca, VanWert, Williams, Wood and Wyandot.

Which doctors, hospitals, and pharmacies can I use?

Paramount Elite Enhanced (HMO-POS) has a network of doctors, hospitals, pharmacies, and other providers. If you use the 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.

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, Coverage Gap 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 Enhanced (HMO-POS)

MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES	
Monthly Plan Premium	$68 per month. In addition, you must keep paying your Medicare Part B premiums.
Deductible	Medical Deductible: $0 Copay. Prescription Drug Deductible: $0 Copay.
Maximum Out-of-Pocket Responsibility	Your yearly limit(s) in this plan: $3,600 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	
Inpatient Hospital	**In-Network:** Days 1-5: $225 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. **May require prior authorization.**
Outpatient Hospital	**In-Network:** Outpatient Hospital: $0 - $225 Copay. $0 applies to preventive colonoscopy with polyp removal. **May require prior authorization.**
Ambulatory Surgical Center	**In-Network:** Ambulatory Surgical Center: $0 - $225 Copay. $0 applies to preventive colonoscopy with polyp removal. **May require prior authorization.**
Doctor's Office Visits	**In-Network:** Primary care physician visit: $0 Copay. Specialist visit: $35 Copay.

Virtual Doctor	**<u>In-Network:</u>** Primary care physician visit: $0 Copay. Behavioral Health visit: $35 Copay.
Preventive Care *(e.g., flu vaccine, diabetic screenings)*	**<u>In-Network:</u>** $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.
Emergency Care	**<u>In-Network and Out-of-Network:</u>** $90 Copay per visit. Worldwide Emergency Coverage: $90 Copay. You do not pay this amount if you are admitted on the same day with the same condition to the same facility. (Emergency, urgent care, and emergency ambulance services outside of the United States are covered up to a combined maximum of $25,000 each year.)
Urgently Needed Services	**<u>In-Network and Out-of-Network:</u>** $40 Copay per visit. Worldwide Urgent Coverage: $90 Copay. (Emergency, urgent care, and emergency ambulance services outside of the United States are covered up to a combined maximum of $25,000 each year.)
Diagnostic Services / Labs/ Imaging	**<u>In-Network:</u>** Diagnostic tests and procedures: $10 Copay. Lab services: $0 - $5 Copay. Diagnostic Radiology Services (such as MRI, CAT Scan): $0 Copay - $100 Copay. $0 applies to Diagnostic Mammograms. X-rays: $10 Copay. Therapeutic radiology services (such as radiation treatment for cancer): 20% Coinsurance. **May require prior authorization.**
Hearing Services	**<u>In-Network:</u>** Exam to diagnose and treat hearing and balance issues: $35 Copay. Routine hearing exam (up to 1 visit(s) every year): $0 Copay.
	<u>In-Network:</u>

Hearing Aid Coverage	Hearing Aid (up to 2 hearing aids every year): $0 Copay, up to a maximum coverage of $500 per ear per calendar year from Nations Hearing. ($0 copay for up to three follow-up visits within the first year of initial fitting date). **Must see a NationsHearing® provider to use the hearing aid benefit.**
Dental Services	**In-Network:** Preventive Services: $0 Copay for: • 2 periodic exams • 2 teeth cleanings • 2 fluoride treatments • 4 (one-set) dental bitewing X-rays per calendar year Comprehensive: $0 Copay for: • Fillings • Root Canals • Crowns • Periodontal Maintenance • Extractions **Out-of-Network:** 30% coinsurance for all dental services **$7,500** combined maximum coverage amount for Embedded PPO Preventive and Comprehensive dental services. Additional details on coverage for endodontics, periodontics, prosthodontics and restorative coverage, see your plan's Evidence of Coverage. **Dental Networks: Paramount Dental, DenteMax, Connection Dental –** *Maximum benefit when use network providers.*
Vision Services	**In-Network:** Exam to diagnose and treat diseases and conditions of the eye: $35 Copay. Routine eye exam (up to 1 visit(s) every year): $0 Copay.

Vision Hardware Benefit	**In-Network:** $200 annual combined maximum eyewear allowance for eyeglass frames and lenses. **Out-of-Network:** $100 annual combined maximum reimbursement for all eyewear. Eyewear Includes: eyeglass frames and lenses and contacts. **Vision Network: EyeMed** *Maximum benefit when use network providers.*
Mental Health Care	**In-Network:** Outpatient Mental Health Care: Group therapy visit: $35 Copay. Individual therapy visit: $35 Copay. Inpatient Psychiatric Hospital: Days 1-5: $225 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. **Inpatient Psychiatric Hospital may require prior authorization.**
Skilled Nursing Facility (SNF)	**In-Network:** Days 1-20: $0 Copay per day. Days 21-100: $188 Copay per day. **May require prior authorization.**
Outpatient Rehabilitation	**In-Network:** Occupational therapy visit: $25 Copay. Physical therapy and speech and language therapy visit: $25 Copay. **May require prior authorization.**
Ambulance	**In-Network:** Ground Ambulance: $200 Copay. Air Ambulance: $200 Copay. Worldwide Emergency Transportation: $90 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 $25,000 each year.)

<table>
<tr><td></td><td>Prior Authorization is only required for Non-Emergency Medicare-covered Services.</td></tr>
<tr><td>Transportation</td><td><u>In-Network:</u>
$0 Copay.
Your plan covers up to 24 one-way trips per calendar year to plan approved health-related locations. Transportation will be via a Taxi, Rideshare Service, or Van.
Trips requests must be scheduled 48 hours in advance. Trip mileage cannot exceed 60 miles per one-way trip unless prior authorization is approved by plan.
May require prior authorization.</td></tr>
<tr><td>Medicare Part B Drugs</td><td><u>In-Network:</u>
For Part B drugs such as chemotherapy drugs: 20% Coinsurance.
Other Part B drugs: 20% Coinsurance.
May require prior authorization.</td></tr>
<tr><td colspan="2">PRESCRIPTION DRUG BENEFITS</td></tr>
<tr><td>Deductible</td><td>Prescription Drug Deductible: $0 Copay.</td></tr>
<tr><td>Initial Coverage</td><td>You pay the following until your total yearly drug costs reach $5,030. Total yearly drug costs are the drug costs paid by both you and our Part D plan.
<table>
<tr><th colspan="3">Standard Retail Cost-Sharing</th></tr>
<tr><th>Tier</th><th>One-month supply</th><th>Three-month supply</th></tr>
<tr><td>Tier 1 (Preferred Generic)</td><td>$0 Copay
$0 Copay (Insulin)</td><td>$0 Copay
$0 Copay (Insulin)</td></tr>
<tr><td>Tier 2 (Generic)</td><td>$0 Copay
$0 Copay (Insulin)</td><td>$0 Copay
$0 Copay (Insulin)</td></tr>
<tr><td>Tier 3 (Preferred Brand)</td><td>$42 Copay
$35 Copay (Insulin)</td><td>$126 Copay
$105 Copay (Insulin)</td></tr>
<tr><td>Tier 4 (Non-Preferred Drug)</td><td>$100 Copay
$35 Copay (Insulin)</td><td>$300 Copay
$105 Copay (Insulin)</td></tr>
<tr><td>Tier 5 (Specialty Tier)</td><td>33% Coinsurance
$35 Copay (Insulin)</td><td>Not Applicable</td></tr>
</table>
<table>
<tr><th colspan="3">Standard Mail Order</th></tr>
<tr><th>Tier</th><th>One-month supply</th><th>Three-month supply</th></tr>
<tr><td>Tier 1 (Preferred Generic)</td><td>$0 Copay
$0 Copay (Insulin)</td><td>$0 Copay
$0 Copay (Insulin)</td></tr>
</table>
</td></tr>
</table>

<table>
<tr><td></td><td>
<table>
<tr><td>Tier 2 (Generic)</td><td>$0 Copay
$0 Copay (Insulin)</td><td>$0 Copay
$0 Copay (Insulin)</td></tr>
<tr><td>Tier 3 (Preferred Brand)</td><td>$42 Copay
$35 Copay (Insulin)</td><td>$84 Copay
$70 Copay (Insulin)</td></tr>
<tr><td>Tier 4 (Non-Preferred Drug)</td><td>$100 Copay
$35 Copay (Insulin)</td><td>$200 Copay
$70 Copay (Insulin)</td></tr>
<tr><td>Tier 5 (Specialty Tier)</td><td>Not Applicable</td><td>Not Applicable</td></tr>
</table>
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.
</td></tr>
<tr><td>Coverage Gap</td><td>
The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $5,030.

After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and 25% of the plan's cost for covered generic drugs until your costs total $8,000, which is the end of the coverage gap.

Our plan covers Tier 1 Preferred Generics and Tier 2 Generics in the coverage gap.
<table>
<tr><td colspan="3">Standard Retail Cost-Sharing</td></tr>
<tr><td>Tier</td><td>One-month supply</td><td>Three-month supply</td></tr>
<tr><td>Tier 1 (Preferred Generic)</td><td>$0 Copay
$0 Copay (Insulin)</td><td>$0 Copay
$0 Copay (Insulin)</td></tr>
<tr><td>Tier 2 (Generic)</td><td>$0 Copay
$0 Copay (Insulin)</td><td>$0 Copay
$0 Copay (Insulin)</td></tr>
<tr><td colspan="3">Standard Mail Order</td></tr>
<tr><td>Tier</td><td>One-month supply</td><td>Three-month supply</td></tr>
<tr><td>Tier 1 (Preferred Generic)</td><td>$0 Copay
$0 Copay (Insulin)</td><td>$0 Copay
$0 Copay (Insulin)</td></tr>
<tr><td>Tier 2 (Generic)</td><td>$0 Copay
$0 Copay (Insulin)</td><td>$0 Copay
$0 Copay (Insulin)</td></tr>
</table>
</td></tr>
<tr><td>Catastrophic Amount</td><td>After your yearly out-of-pocket drug costs reach $8,000, the plan pays the full cost for your covered Part D drugs. You pay nothing.</td></tr>
</table>

SUPPLEMENTAL BENEFITS	
Bathroom Safety Devices	**In-Network:** $0 copay up to **$100** for approved bathroom safety devices every year from the 2023 Bathroom Safety Catalog. Device options include such items as bath safety benches, gait belts, handheld shower head, chrome grab bars, raised toilet seats, toilet safety rails, transfer bench, and tub safety bars. **Bathroom safety devices must be purchased at NationsBenefits by telephone or online mail order.**
Meal Benefit	**In-Network:** $0 copay for meals. After you are discharged from an inpatient stay at a hospital or skilled nursing facility, you qualify for the plan-covered post-discharge meal benefit. This benefit includes up to 2 meals per day for 14 days after each discharge from an inpatient hospital/SNF facility up to a maximum benefit of 28 days per calendar year.
Over-the-Counter (OTC) drugs and supplies	**In-Network:** $0 copay up to plan covered benefit limit of **$160*** every calendar quarter for covered OTC items. OTC items are drugs and health related products that do not need a prescription. Members are eligible to receive up to **$160** per each calendar quarter for the purchase of covered OTC items. Members may access their OTC benefits online, via mail order, through phone order, or at approved retailers via flex card. If you do not use all your quarterly OTC benefit amount, the remaining balance will not carry over to the next quarter. ***Please note that this benefit does not apply to your In-Network Out-of-Pocket Maximum*
Personal Emergency Response System (PERS)	**In-Network:** $0 copay. PERS includes one of three options to fit your lifestyle needs. Coverage includes a device and monthly monitoring with NationsResponse. Two-way voice communication to ADT, water resistant pendants/wristbands and 24/7/365 monitoring service.

SUPPLEMENTAL BENEFITS	
SilverSneakers®	**In-Network:** $0 copay for SilverSneakers® **SilverSneakers® Fitness Program:** SilverSneakers® is a health and fitness program designed for Medicare beneficiaries at all fitness levels. Members have access to thousands of participating fitness locations across the country that may include weights and machines plus group exercise classes led by trained instructors at select locations. Classes help improve flexibility, balance, endurance, and energy. Members can also access online education on SilverSneakers.com, which includes SilverSneakers LIVE™ virtual classes, workout videos on SilverSneakers On-Demand™ or download the **SilverSneakers GO™** fitness app for additional workout ideas.

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- 691-3703, 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- 691-3703, 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, 2024.
- ☐ 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).
- ☐ Effects on current coverage.

Form Approved
OMB# 0938-1421

Multi-Language Insert

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 [1-833-554-2335]. 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 [1-833-554-2335]. 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 1-833-554-2335。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 1-833-554-2335。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 [1-833-554-2335]. 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 [1-833-554-2335]. 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 [1-833-554-2335] 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 [1-833-554-2335]. 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 [1-833-554-2335]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 [1-833-554-2335]. 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 [1-833-554-2335]. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें [1-833-554-2335] पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता 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 [1-833-554-2335]. 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 [1-833-554-2335]. 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 [1-833-554-2335]. 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 [1-833-554-2335]. 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、[1-833-554 2335]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。

Notice of Nondiscrimination and Accessibility: Discrimination is Against the Law

Paramount Elite 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)
- 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 at 833-554-2335. If you cannot hear or speak well, please call 888-740-5670 (TTY). Paramount Elite is available from 8:00 a.m. to 8:00 p.m. EST, Monday through Friday. From October 1st through March 31st, we are available 8:00 a.m. to 8:00 p.m. EST 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 with Paramount Elite:

Address:	Paramount Elite 300 Madison Avenue Suite 270 Toledo, OH 43604
Alternate in Person Delivery Address:	650 Beaver Creek Suite 100 Maumee, OH 43537
Telephone:	833-554-2335 (TTY users call 888-740-5670)
Fax:	419-887-2047
Email:	Paramount.MemberServices@ProMedica.org

You can file a grievance in person or by phone, mail, fax, or email. If you need help filing a grievance, Paramount Elite 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, 1-800-537-7697 (TDD)

Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*

THANK YOU

Connect with us

Contact Information : 1-833- 691-3703, TTY: 711

Organization Name: Paramount Elite Medicare Plans

Organization website: paramounthealthcare.com/medicareplans

This Page Is Intentionally Left Blank

This Page Is Intentionally Left Blank

This Page Is Intentionally Left Blank

PARAMOUNT
ELITE | MEDICARE PLANS

1.2619-A.R051023.LR