2026 Summary of Benefits

Jan. 1, 2026 – Dec. 31, 2026

Paramount Elite Preferred PPO (H5232-001-000)

Ohio: Fulton, Lucas, Ottawa, Sandusky and Wood Counties

Michigan: Branch, Hillsdale, Lenawee, Monroe and Washtenaw Counties

PARAMOUNT
ELITE | MEDICARE PLANS

Summary of Benefits

This booklet gives you a summary of what we cover and what you pay. It doesn't list every service we cover or list every limitation or exclusion. To get a complete list of services we cover, see our Evidence of Coverage by visiting ParamountHealthCare.com/MAPlanInfo.

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 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 Medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.

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 1-844-958-4620 (TTY 711).

Things to know about Paramount Elite Preferred

Phone Numbers and Website

- If you are a member of one of these plans, call toll-free 1-833-554-2335 (TTY 711).
- Our website: ParamountHealthCare.com/Medicare.

Hours of Operation

- From Oct. 1 to March 31 (except Thanksgiving and Christmas), you can call us seven days a week from 8 a.m. to 8 p.m.
- From April 1 to Sept. 30 (except holidays), you can call us Monday through Friday from 8 a.m. to 8 p.m.

Who can join?

To join, you must be entitled to Medicare Part A, be enrolled in Medicare Part B and live in our service area. Our service area includes the following counties in Ohio: Fulton, Lucas, Ottawa, Sandusky and Wood, and Michigan: Branch, Hillsdale, Lenawee, Monroe and Washtenaw.

Which doctors, hospitals and pharmacies can I use?

Our plans 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. Out-of-network/non-contracted providers are under no obligation to treat Paramount members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost sharing that applies to out-of-network 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 directories at our website ParamountHealthCare.com/MAPlanInfo.
- 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.

- Our plan members get all of the benefits covered by Original Medicare. For some of these benefits, you may pay more in our plan than you would in Original Medicare. For others, you may pay less.
- Our plan members also get more than what is covered by Original Medicare. Some of the extra benefits are outlined in this booklet.

We cover Part D drugs. In addition, we cover Part B drugs, such as chemotherapy and insulin, as well as 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 ParamountHealthCare.com/MAPlanInfo.
- 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 following benefit stages: Deductible, Initial Coverage and Catastrophic Coverage.

Summary of Benefits

Premium and Benefits	Paramount Elite Preferred (PPO)
Monthly Plan Premium	$0 per month You must continue to pay your Medicare Part B premium.
Deductible	This plan does not have a deductible.
Maximum Out-of-Pocket Responsibility (Does not include Part D prescription drugs)	You pay no more than: ▪ $5,300 annually for services you receive from in-network providers ▪ $8,800 annually for services you receive from any provider. Your limit for services received from in-network providers will count toward this limit. Includes copayments and other costs for medical services for the year. 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.
Inpatient Hospital Coverage (Services may require prior authorization)	There is no limit to the number of days covered by the plan. ▪ In-network: – $400 copay per day for days 1 through 5 – $0 copay per day for days 6 and thereafter ▪ Out-of-network: $425 days 1-90
Outpatient Hospital Coverage (Services may require prior authorization)	Outpatient hospital surgery: ▪ In-network: $375 copay ▪ Out-of-network: 40% coinsurance Observation services: ▪ In-network: $360 copay ▪ Out-of-network: 40% coinsurance
Ambulatory Surgical Center (ASC) Services (Services may require prior authorization)	Ambulatory surgery center: ▪ In-network: $375 copay ▪ Out-of-network: 40% coinsurance
Doctor's Office Visits (Services may require prior authorization)	You have the option to get these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a provider who offers the service by telehealth.

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Doctor's Office Visits (continued) (Services may require prior authorization)	Primary care physician visit: ▪ In-network: $0 copay ▪ Out-of-network: $10 copay Specialist visit: ▪ In-network: $35 copay ▪ Out-of-network: $55 copay There is no coinsurance, copay or deductible for the Welcome to Medicare physical or annual wellness visit when performed at an in-network provider.
Preventive Care	In-network: $0 copay Out-of-network: 0% coinsurance Our plan covers many preventive services, including: ■ Abdominal aortic aneurysm screening ■ Alcohol misuse screening and counseling ■ Annual wellness visit ■ Bone mass measurement ■ Breast cancer screening (mammogram) ■ Cardiovascular disease testing ■ Cervical and vaginal cancer screening ■ Colorectal cancer screening ■ Depression screening ■ Diabetes screening ■ HIV screening ■ Immunizations, including flu, COVID-19, hepatitis B and pneumonia shots ■ Lung cancer screening ■ Medical nutrition therapy services ■ Medicare Diabetes Prevention Program (MDPP) ■ Obesity screening and therapy ■ Prostate cancer screening exams ■ Sexually transmitted infections screening and counseling ■ Smoking and tobacco use cessation counseling ■ Welcome to Medicare preventive visit (one-time) Other preventive services are available. There are some covered services that have a cost.

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Emergency Care	$130 copay for each covered emergency room visit. If you are admitted to the hospital within 24 hours, you do not have to pay the $130 copay. You may get covered emergency medical care/urgently needed services whenever you need it, anywhere in the world, up to $100,000 per calendar year.
Urgently Needed Services	$35 copay for each covered urgent care center visit. An urgently needed service is a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical care. You may get covered emergency medical care/urgently needed services whenever you need it, anywhere in the world, up to $100,000 per calendar year.
Diagnostic Services, Labs and Imaging (Costs for these services may be different if received in an outpatient surgery setting. Services may require prior authorization.)	Diagnostic tests and services: ▪ In-network: $50 copay ▪ Out-of-network: 10% coinsurance Diagnostic radiological services (CT/MRI/PET scans): ▪ In-network: $130 copay for each covered service ▪ Out-of-network: 10% coinsurance Lab services: ▪ In-network: $0 copay ▪ Out-of-network: 40% coinsurance Outpatient X-rays: ▪ In-network: $50 copay ▪ Out-of-network: 10% coinsurance Therapeutic radiology services (such as radiation therapy for cancer): ▪ In-network: 20% coinsurance ▪ Out-of-network: 40% coinsurance

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Hearing Services (Additional in-network services provided by TruHearing providers)	Original Medicare covered hearing services: ▪ In-network: $30 copay ▪ Out-of-network: 10% coinsurance Additional hearing services: ▪ Routine hearing exam (1 every year): $0 copay ▪ Hearing aid fitting-evaluation visit: $0 copay TruHearing-branded hearing aids (1 per ear per year): ▪ $499 copay for each covered Standard hearing aid ▪ $699 copay for each covered Advanced hearing aid ▪ $999 copay for each covered Premium hearing aid Any cost you pay for hearing aids will not count toward your maximum out-of-pocket.
Dental Services (Preventive, diagnostic and comprehensive services covered in-network and out-of-network)	**Preventive and Diagnostic Dental** ▪ Oral exams (2 every year) ▪ Cleanings (2 every year) ▪ Dental bitewing X-ray (1 every year) ▪ Fluoride treatments (2 every year) – In-network: $0 copay – Out-of-network: 30% coinsurance **Comprehensive Dental** ▪ In-network: 0% coinsurance for restorative services and extractions ▪ Out-of-network: 30% coinsurance for restorative services and extractions ▪ Dentures – In-network: 0% coinsurance – Out-of-network: 30% coinsurance This plan covers up to a maximum of $4,000 per calendar year for select comprehensive and preventive dental services, including diagnostic X-rays; restorative services, such as fillings; non-surgical extractions; denture repair, reline or adjustment; crowns; endodontic services; and periodontic services. For coverage and cost information, see this plan's Evidence of Coverage.

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Vision Services	Original Medicare covered vision services, including yearly diabetic eye exam ▪ In-network: $0 copay ▪ Out-of-network: $40 copay Eyeglasses or contact lenses after cataract surgery: ▪ In-network: $0 copay ▪ Out-of-network: $25-$150 reimbursement. Please see your Evidence of Coverage for more details Routine eye exam (1 every year): ▪ In-network: $0 copay ▪ Out-of-network: $30 copay Contact lenses or eyeglasses (frames and lenses, 1 pair every year): In-network/out-of-network: $200 allowance and you are responsible for any amount more than $200. See Evidence of Coverage for more information.
Mental Health Care (Services may require prior authorization)	Inpatient visit: There is a 190-day lifetime limit for inpatient services in a psychiatric hospital. The 190-day limit does not apply to Mental Health services provided in a psychiatric unit of a general hospital. The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period starts on the first day you go into the hospital. The benefit period ends when you haven't had any inpatient hospital care for 60 days in a row. The plan covers 90 days each benefit period. You have 60 lifetime reserve days that can be used for an inpatient psychiatric admission. You have no copayment for these extra days. ▪ In-network: – $295 copay per day for days 1 through 5 – $0 copay per day for days 6 through 90 ▪ Out-of-network: $295 copay days 1 through 90 Outpatient individual therapy visit: ▪ In-network: $35 copay ▪ Out-of-network: $60 copay Outpatient group therapy visit: ▪ In-network: $35 copay Out-of-network: $60 copay

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Skilled Nursing Facility (SNF) Care (Services may require prior authorization)	We will pay for skilled nursing facility care for up to 100 days per benefit period. A benefit period starts on the first day you stay in a skilled nursing facility. It ends when you have not had care as an inpatient in a hospital or skilled nursing facility for 60 days in a row. If you go into a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to how many benefit periods you can have. ▪ In-network: – $0 copay per day for days 1 through 20 – $218 copay per day for days 21 through 100 ▪ Out-of-network: 40% coinsurance per stay
Outpatient Rehabilitation Services (Services may require prior authorization)	Occupational therapy visit: ▪ In-network: $15 copay ▪ Out-of-network: $30 copay Physical therapy or speech/ language therapy visit: ▪ In-network: $15 copay ▪ Out-of-network: 10% coinsurance Cardiac (heart) rehabilitation services: ▪ In-network: $25 copay ▪ Out-of-network: 10% coinsurance Pulmonary (lung) rehabilitation services: ▪ In-network: $35 copay ▪ Out-of-network: 10% coinsurance
Ambulance (Services may require prior authorization)	▪ In-network: $295 copay for each covered ground ambulance trip and $295 copay for air ambulance services ▪ Out-of-network: $295 copay for each covered ground ambulance trip and $295 copay for air ambulance services

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Prescription Drug Benefits	
Medicare Part B Drugs (Part B drugs may require prior authorization and may be subject to step therapy requirements)	Some drugs are covered by Medicare Part B and some are covered by Medicare Part D. Part B drugs do not count toward your Part D out-of-pocket costs. For chemotherapy and other drugs covered by Medicare Part B: ▪ In-network: 0-20% coinsurance ▪ Out-of-network: 0-20% coinsurance **For Part B Insulin:** ▪ You will pay no more than a $35 copayment for a one-month supply of insulin. To view a list of Part B drugs that may be subject to Step Therapy, visit ParamountHealthCare.com/MAPlanInfo
Outpatient Prescription Drugs	
Deductible	$300 for Part D prescription drugs except for drugs listed on Tier 1 and Tier 2 which are excluded from the deductible. The deductible also does not apply to covered insulin products and most adult Part D vaccines.
Initial Coverage	You pay the following until your total out-of- pocket costs reach $2,100. You may get your drugs at any network retail or mail order pharmacy. **Retail cost sharing:** (standard) ▪ Tier 1 (preferred generic drugs): – 1-30 day supply: $0 copay – 31-90 day supply: $0 copay ▪ Tier 2 (generic drugs): – 1-30 day supply: $0 copay – 31-90 day supply: $0 copay ▪ Tier 3 (preferred brand and generic drugs): – 1-30 day supply: 21% coinsurance – 31-90 day supply: 21% coinsurance ▪ Tier 4 (non-preferred drugs): – 1-30 day supply: 41% coinsurance – 31-90 day supply: 41% coinsurance

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Outpatient Prescription Drugs	
Initial Coverage (continued)	**Retail cost sharing:** (preferred/standard) ▪ Tier 5 (specialty tier drugs): – 1-30 day supply: 29% coinsurance **Mail-order cost sharing:** (standard) ▪ Tier 1 (preferred generic drugs): – 1-30 day supply: $0 copay – 31-90 day supply: $0 copay ▪ Tier 2 (generic drugs): – 1-30 day supply: $0 copay – 31-90 day supply: $0 copay ▪ Tier 3 (preferred brand and generic drugs): – 1-30 day supply: 21% coinsurance – 31-90 day supply: 21% coinsurance ▪ Tier 4 (non-preferred drugs): – 1-30 day supply: 41% coinsurance – 31-90 day supply: 41% coinsurance ▪ Tier 5 (specialty tier drugs): – 1-30 day supply: 29% coinsurance You won't pay more than $35 for a one-month supply of each covered insulin product regardless of the cost- sharing tier, even if you haven't met your deductible. If you reside in a long-term care facility, you pay the same as at a standard retail pharmacy. In most cases, your prescriptions are covered only if they are filled at the plan's network pharmacies.

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Outpatient Prescription Drugs	
Catastrophic Coverage	When you (or those paying on your behalf) have spent a total of $2,100 in out-of-pocket costs within the calendar year, you will move from the Initial Coverage Stage to the Catastrophic Coverage Stage. During the Catastrophic Coverage Stage, you pay nothing for your covered Part D drugs.
Additional Benefits	
Over-the-Counter Items	Your plan includes a $75 quarterly allowance to be used toward the purchase of over-the-counter (OTC) health and wellness supplies. Visit our website Paramounthealthcare.com/Medicare/OTC-Benefits to see our list of over-the-counter supplies.
Personal Emergency Response System (PERS)	$0 copay Members will have access to a PERS offering featuring: ■ Two-way voice communication to monitoring center ■ Water resistant pendants or wristbands ■ 24/7/365 monitoring service See your Evidence of Coverage or contact the plan for more information.
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. Various devices are available. Please contact plan for details.
Outpatient Substance Use Disorder Services	▪ In-network: $40 copay ▪ Out-of-network: 10% coinsurance This applies to an individual or group therapy visit.
Foot Care (Podiatry services) (Services may require prior authorization)	▪ In-network: $25 copay ▪ Out-of-network: 40% coinsurance
Durable Medical Equipment (Wheelchairs, oxygen, etc.) (Services may require prior authorization)	▪ In-network: 25% coinsurance ▪ Out-of-network: 50% coinsurance We only cover Dexcom Continuous glucose monitors (CGMs), other brands are excluded. Coinsurance may apply. See Diabetic Supplies and Services or your Evidence of Coverage for more information.

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Prosthetic and Orthotic Devices and Related Supplies (Braces, artificial limbs, etc.) (Services may require prior authorization)	▪ In-network: 20% coinsurance ▪ Out-of-network: 20% coinsurance
Diabetes Supplies and Services (Services may require prior authorization)	▪ In-network: 0-20% coinsurance ▪ Out-of-network: 0-20% coinsurance 0% coinsurance for the following diabetic supplies: ▪ A blood glucose meter (excluding continuous glucose monitors) ▪ Blood glucose test strips Continuous Glucose Monitors (CGMs) are covered at a 25% coinsurance. We only cover Dexcom, other brands are excluded. See Evidence of Coverage for more details. In order to qualify for 0% coinsurance, diabetic test strips and meters must be produced by a preferred manufacturer and purchased at an in-network retail or mail order pharmacy. Non-preferred diabetic test strips and meters are covered (with 20% coinsurance) when filled by an in-network durable medical equipment supplier. See the Evidence of Coverage for more details. You will pay no more than a $35 copay for a one-month supply of insulin. 20% coinsurance for all other diabetic supplies.

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Health and Wellness Education Programs (Services may require prior authorization)	Wellness programs included at no additional cost **Health Education** One-on-one comprehensive health coaching, written materials, newsletters and web-based interactive tools and online support. **Home Meals Program** After an inpatient stay within 30 days of discharge, you are eligible to receive a one-week course of meals at no extra cost. You will receive two meals a day for seven days delivered to your home. Prior authorization rules may apply. Please contact the plan for details

Premium and Benefits	Paramount Elite Preferred (PPO)
Health and Wellness Education Programs (continued)	**SilverSneakers® Fitness Program** SilverSneakers is a complete health and fitness program designed for Medicare beneficiaries at all fitness levels. Members will have access to participating gyms and fitness centers to help them meet their personal wellness goals. Please note: Nonstandard fitness center services that usually have an extra fee are not included in your membership. **Smoking and Tobacco Cessation** You pay a $0 copay for smoking and tobacco use cessation support. See your Evidence of Coverage for more information
Chiropractic Care (Services may require prior authorization)	We only cover manual manipulation of the spine to correct subluxation: ▪ In-network: $15 copay ▪ Out-of-network: $60 copay
Home Health Care (Services may require prior authorization)	▪ In-network: $0 copay ▪ Out-of-network: 10% coinsurance
Renal Dialysis (Services may require prior authorization)	Covered dialysis equipment: ▪ In-network: 25% coinsurance ▪ Out-of-network: 50% coinsurance Covered dialysis supplies: ▪ In-network: 20% coinsurance ▪ Out-of-network: 20% coinsurance See Evidence of Coverage for more information.
Hospice	When you enroll in a Medicare certified hospice program, your hospice services (and any Part A or Part B services related to your terminal prognosis) are paid for by Original Medicare.

Paramount Elite plans are HMO-POS and PPO plans offered by Paramount with a Medicare contract. Enrollment in a Paramount Elite plan depends on contract renewal.