Premier Senior Health Plan

Medical Rates Effective January 1, 2026 through December 31, 2026

Deductible	Age	No Co-Pay	$10 Office Visit & $50 ER Co-Pays
Mirrors "Plan F" $0 Deductible	65-69	$242.50	$232.50
	70-74	$307.50	$296.50
	75-79	$350.50	$335.50
	80-84	$404.50	$387.50
	85+	$439.50	$422.50

Deductible	Age	No Co-Pay	$10 Office Visit & $50 ER Co-Pays
*$1,000 Plan Deductible	65-69	$138.50	$132.50
	70-74	$191.50	$183.50
	75-79	$229.50	$217.50
	80-84	$275.50	$267.50
	85+	$300.50	$289.50

Deductible	Age	No Co-Pay	$10 Office Visit & $50 ER Co-Pays
*$100 Plan Deductible	65-69	$234.50	$217.50
	70-74	$298.50	$283.50
	75-79	$339.50	$324.50
	80-84	$391.50	$374.50
	85+	$427.50	$406.50

Deductible	Age	No Co-Pay	$10 Office Visit & $50 ER Co-Pays
*$1,500 Plan Deductible	65-69	$116.50	$112.50
	70-74	$161.50	$156.50
	75-79	$196.50	$191.50
	80-84	$240.50	$234.50
	85+	$259.50	$252.50

Deductible	Age	No Co-Pay	$10 Office Visit & $50 ER Co-Pays
*$500 Plan Deductible	65-69	$188.50	$179.50
	70-74	$247.50	$238.50
	75-79	$289.50	$276.50
	80-84	$340.50	$326.50
	85+	$369.50	$356.50

For More Information Contact us at: (888) 344-2522

or email: info@hismi.com

Health Insurance Services, Inc.
reliable resources you can count on

306 S Washington, Ste 206

Royal Oak, MI 48067

***PSHP Plan Deductible only applies to approved Medicare Part B out-of-pocket expenses. Also, PSHP pays 100% of Part A Deductible and co-payments, and 100% of Part B Excess Charges.**

Important note: Not available in AK, CO, NH, & ME. Restrictions apply in WA, MD, MN, NY, & FL.

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Underwritten by **United American Insurance Company**

Medical Benefits for: ABC Sponsor

Benefit Period: 1/1/2026 through 12/31/2026

MEDICARE PART A

Services	Medicare Pays	Plan Pays	You Pay
HOSPITALIZATION** Semiprivate room and board, general nursing and miscellaneous services and supplies.			**No plan deductible applies**
First 60 Days	All but $1,728	$1,728 - Part A Deductible	$0
61st thru 90th day	All but $429 a day	$429 a day	$0
91st day and after:			
While using 60 lifetime reserve days	All but $858 a day	$858 a day	$0
Once Lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $214.50 a day	Up to $214.50 a day	$0
101st day and after	$0	$0	All Costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	$0

***A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.*

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Chosen Annual Plan Amount Options:
$0 Deductible, $100 Deductible, $500 OOPM, $1000 OOPM, or $1500 OOPM*

MEDICARE PART B - No Copays

Services	Medicare Pays	Plan Pays	You Pay
Medicare Part B Deductible for 2026			Chosen Annual Plan Amount applies, then:
First $288 of Medicare Approved Amounts	$0	Part B Deductible	
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	
BLOOD			
While using 60 lifetime reserve days			
First 3 pints	$0	All Costs	$0
Remainder of Medicare Approved Amounts	80%	20%	Chosen Annual Plan Amount applies, then: $0
CLINICAL LABORATORY SERVICES			
Blood tests for Diagnostic Services	100%	$0	$0

MEDICARE PARTS A& B

HOME HEALTH CARE			
Medically necessary skilled care services ***(must be houmebound)*** and medical supplies	100%	$0	$0
Durable Medical Equipment			
First $288 of Medicare Approved Amounts	$0	Part B Deductible	Chosen Annual Plan Amount applies, then: $0
Remainder of Medicare Approved Amounts	80%	20%	

OTHER BENEFITS - NOT COVERED BY MEDICARE

FOREIGN TRAVEL			
Medically necessary emergency care services during the first 60 days of each trip outside of the USA:			
First $250 each calendar year	$0	$0	$250
Remainder of charges - Up to $50,000 Lifetime Maximum benefit	$0	80%	20%

**For the $500, $1000, & $1500 OOPM options, the $288 Medicare Part B Deductible is followed by 20% beneficiary coinurance until a calendar year out-of-pocket-maximum (OOPM) of $500, $1000, or $1,500 is reached.*

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$0 Deductible, $100 Deductible, $500 OOPM, $1000 OOPM, or $1500 OOPM*

MEDICARE PART B - With Copays

Services	Medicare Pays	Plan Pays	You Pay
Medicare Part B Deductible for 2026			Chosen Annual Plan Amount applies, then:
First $288 of Medicare Approved Amounts	$0	Part B Deductible	
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$10 office visit copay / $50 emergency room copay (ER copay is waived if member is admitted)
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	
BLOOD			
While using 60 lifetime reserve days			
First 3 pints	$0	All Costs	$0
Remainder of Medicare Approved Amounts	80%	20%	Chosen Annual Plan Amount applies, then: $0
CLINICAL LABORATORY SERVICES			
Blood tests for Diagnostic Services	100%	$0	$0

MEDICARE PARTS A& B

HOME HEALTH CARE			
Medically necessary skilled care services ***(must be houmebound)*** and medical supplies	100%	$0	$0
Durable Medical Equipment			
First $288 of Medicare Approved Amounts	$0	Part B Deductible	Chosen Annual Plan Amount applies, then:$0
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**For the $500, $1000, & $1500 OOPM options, the $288 Medicare Part B Deductible is followed by 20% beneficiary coinurance until a calendar year out-of-pocket-maximum (OOPM) of $500, $1000, or $1,500 is reached. Office visit and ER copays do not contribute toward these maximums.*