

**PREMIER PLAN BRX - ADULT ONLY  
SUMMARY OF BENEFITS AND COPAYMENTS**

**OUTPATIENT SERVICES**

Primary Care Physician Services  
Specialist Physician Services  
Sub-Specialist Physician Services  
Surgical Services  
Treatment rooms and all appropriate equipment  
Application, changes, removal of dressings,  
splints, plaster cast and removal of sutures  
Medical supplies for use at Provider's Office/Facility  
Laboratory examinations and services  
Periodic physical examinations  
Affordable Care Act Required Preventive Services  
Health Education  
Immunizations  
Allergy testing  
Allergy Visits & Immunotherapy  
Podiatry services  
Chiropractic Services  
Routine Vision and Hearing Examinations  
Therapeutic and Diagnostic Services  
Major Procedures and Surgeries

**CO-PAYMENTS PLAN BRX**

\$10 per visit\*\*  
\$10 per visit  
\$50 per visit  
No Charge  
No Charge  
No Charge  
No Charge  
No Charge\*\*  
No Charge\*\*  
No Charge\*\*  
No Charge\*\*  
No Charge\*\*  
\$50 per visit  
\$10 per visit  
\$10 per visit  
\$10 per visit  
\$0 per visit\*\*  
\*Co-payment  
\*Co-payment

**INPATIENT HOSPITAL SERVICES**

Semi-private room, board, nursing care, and meals  
Intensive, critical, special and coronary care units  
Operating, treatment and recovery rooms  
Application, change and, removal of dressings,  
splints, plaster casts and removal of sutures  
Drugs, medicine, intravenous injections and solutions  
prescribed by attending Physician for use in the hospital  
Medical supplies for use in the hospital  
Oxygen and its administration  
Laboratory examinations, electrocardiograms and inhalation  
therapy

No Charge  
\*Copayment  
No Charge  
No Charge  
  
No Charge  
  
No Charge  
No Charge  
No Charge

**MATERNITY AND NEWBORN SERVICES**

Not Covered

**URGENT SERVICES AND CARE**, after regular office hours

\$40 per visit

**EMERGENCY SERVICES AND CARE**, and hospital stays initiated through the emergency room, including emergency ambulance services

\$100 per Emergency plus 25 percent of charges above \$100

**PRESCRIPTIONS**

Generic prescription drugs except non-generic, non-prescriptions and contraceptives

\$10/\$15/\$20/\$30 or 50% per prescription at contracted pharmacies

**OPTIONAL RIDERS AVAILABLE**

Coverage for Eyeglasses  
Dental

\$10 Co-payment  
See Dental Brochure

\*The sum of all co-payments will not exceed \$5,000 per member per calendar year, except these limits are not applicable to co-payments for Emergency Services and Care and other services outlined in Attachment A. Total dollar annual limit will not exceed \$1,250,000 per member per policy year for essential benefits. This is not a contract. All services must be pre-authorized by the Health Plan, except for emergency care. For specific benefits, exclusions, co-payments and limitations, see the appropriate Medical and Hospitals Services Contract offered by Preferred Medical Plan, Inc., 4950 SW 8<sup>th</sup> Street, Coral Gables, FL 33134. Above benefits are based on FORM NO. PMP HOSP-1-NBRX-BRWD (10/10), ATT-A-NBRX-BRWD (10/10) et.al. Prices subject to change. You may contact PMP at (305) 648-4015, if you have questions.\*\* Under the Affordable Care Act, certain preventive services will be covered without you having to pay a copayment or coinsurance. Please refer to Form No. PMP-HOSP-1-ATT-A-NBRX-BRWD (10/10) for details.