4950 SW 8th Street
Coral Gables, FL 33134
(305) 648-4015

DELUXE PLAN A, B, C & BRX
INDIVIDUAL AND FAMILY PLAN - $5,000 DEDUCTIBLE PLANS
SUMMARY OF BENEFITS AND COPAYMENTS

PROVIDER AND PREVENTIVE SERVICES	COPAYMENTS
Periodic Well Physicals and Exams	$0 per visit*
Well Child Care and Pediatric Services	$0 per visit*
Primary Care Physician Services	$25 per visit*
Specialist Physician Services	$50 per visit
Affordable Care Act Required Preventive Services: (Includes Mammograms and Pap Smears)	$0 per visit*
Health Education	$0 per visit*
Immunizations	$0 per visit*
Podiatry Services	$50 per visit
Chiropractic Services	$50 per visit
Routine Vision and Hearing Examinations	$0 per visit*
Primary Care and Specialist Office Procedures	No charge after regular office visit copay for office-based surgeries, procedures and routine laboratory and exams. Exceptions: Infusions and Chemotherapy- outpatient copays apply.
URGENT CARE AND SERVICES	After normal business hours, $50 per visit
EMERGENCY CARE AND SERVICES (Including hospital stays initiated through ER and Ambulance)	Plans A, B & BRX: $100 copay plus 25% of all costs over $100 (Deductible applies to any inpatient portion) Plan C: $250 copay (Deductible does not apply if not admitted to inpatient setting)
LABORATORY AND ROUTINE X-RAYS	$0 per visit
INPATIENT HOSPITAL SERVICES (Including physician services related to treatment) (Additional cost-sharing for certain intensive care services may apply)	Plans A, B & BRX: After deductible, $500 per day for first 5 days. Minimum copays apply for certain services. (If admitted through ER, see applicable ER copays above). Plan C: If admitted through ER, after deductible - $250 copay; For direct admissions, after deductible - $0 copay;
OUTPATIENT SURGERY/PROCEDURES: (Including physician services related to treatment)	
- At Hospital	After deductible, $500 to $1500 copay
- At free-standing ambulatory surgery center	$500 to $1500 copay
THERAPEUTIC AND DIAGNOSTIC PROCEDURES: (Including physician services related to treatment)	
- At Hospital	After deductible, $50 to $500 copay
- At free-standing facility	$50 to $500 copay
PRESCRIPTIONS: Generic prescription drugs except brand prescriptions and non-prescription medicines (NOTE: Brand drugs available at discount for all members at PMP Participating Pharmacies)	$10/$15/$20/$30 or 50% (per 30-day supply) per prescription Plan A at contracted PCP Offices Plan B, C & BRX at PMP Participating Pharmacies
MATERNITY AND NEWBORN SERVICES	Plans A, B & C: Copayments and coinsurance apply Plan BRX: NOT COVERED
OPTIONAL RIDERS AVAILABLE	
Eyeglasses	$10 copayment
Dental	See Dental Brochure

Annual Deductible that applies to services listed above is $5,000 per Member per calendar year. Maximum annual out-of-pocket costs is $5,000 per Member per calendar year, not including any amount paid toward the fulfillment of the Deductible as well as copayments for Emergency Services and Care, and other services outlined in the applicable Attachment A, Schedule of Benefits and Covered Services. Total dollar annual benefit for essential benefits is $1,250,000 per Member per policy year. This is not a contract. All services must be pre-authorized by the Health Plan, except for Emergency Care. For specific benefits, exclusions, copayments and limitations, see the applicable Individual Medical and Hospital Services Contract offered by Preferred Medical Plan, Inc. 4950 SW 8th Street, Coral Gables, FL 33134. Above benefits are based on FORM NO. PMP-HOSP-1-(10/10) and ATT-A-(10/10), et. al for Plans R5A, R5B & R5BB; and FORM NO. PMP-HOSP-1-(12/10) and ATT-A-(12/10) for Plan R5C. 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-(10/10) for Plans R5A, R5B & R5BB; and FORM NO. HOS-1-ATT-A (12/10) FOR Plan R5C for details.