



PREMIER PLAN A, B, C & BRX - ADULT ONLY PLANS
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 A \$5 per visit**/ Plan B, BRX & C \$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**
 \$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
 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

Plan A, B, & BRX: \$100 per Emergency plus
 25 percent of charges above \$100
 Plan C: \$250 per visit

PRESCRIPTIONS

Generic Prescription Drugs except non-generic, non-prescriptions and contraceptives
 (NOTE: Brand drugs available at discount for all members at PMP Participating Pharmacies)

\$10/\$15/\$20/\$30 or 50% per prescription
 Plan A at contracted PCP Offices
 Plan B, C & BRX at PMP Participating 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 the applicable 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 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 NA; NB; NBRX & NC, as applicable. 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 NA; NB; NBRX & NC, as applicable, for details.