



**SELECT PLAN B
 INDIVIDUAL AND FAMILY PLAN - \$10,000 DEDUCTIBLE NON-MATERNITY
 SUMMARY OF BENEFITS AND COPAYMENTS**

PROVIDER AND PREVENTIVE SERVICES

Periodic Well Physicals and Exams
 Well Child Care and Pediatric Services
 Primary Care Physician Services
 Specialist Physician Services
 Affordable Care Act Required Preventive Services :
 (Includes Mammograms and Pap Smears)
 Health Education
 Immunizations
 Podiatry Services
 Chiropractic Services
 Routine Vision and Hearing Examinations
 Primary Care and Specialist Office Procedures

COPAYMENTS PLAN B

\$0 per visit*
 \$0 per visit*
 \$25 per visit*
 \$50 per visit
 \$0 per visit*
 \$0 per visit*
 \$50 per visit
 \$50 per visit
 \$0 per visit*

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)

\$100 copay plus 25% of all costs over \$100
 (Deductible applies to Inpatient portion)

LABORATORY AND ROUTINE X-RAYS

\$0 per visit

INPATIENT HOSPITAL SERVICES

(Including physician services related to treatment)

After deductible, \$500 per day for first 5 days. Minimum copays apply for certain services. Additional cost-sharing for certain intensive care services. (If admitted through ER, see applicable ER copays above)

OUTPATIENT SURGERY/PROCEDURES:

(Including physician services related to treatment)

- At Hospital
- At free-standing ambulatory surgery center

After deductible, \$500 to \$1500 copay
 \$500 to \$1500 copay

THERAPEUTIC AND DIAGNOSTIC PROCEDURES:

(Including physician services related to treatment)

- At Hospital
- At free-standing facility

After deductible, \$50 to \$500 copay
 \$50 to \$500 copay

PRESCRIPTIONS: Generic prescription drugs except brand prescriptions and non-prescription medicines

\$10/\$15/\$20/\$30 or 50% (per 30-day supply)
 per prescription at PMP Participating Pharmacies

MATERNITY SERVICES

Not Covered

OPTIONAL RIDERS AVAILABLE

Eyeglasses
 Dental

\$10 copayment
 See Dental Brochure

Annual Deductible that applies to services listed above is \$10,000 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 copayments for Emergency Services and Care, and other services outlined in 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 approval 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-R10B-DADE (10/10), ATT-A-R10B-DADE (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-R10B-DADE (10/10) for details.