



Premium Health Plan



Services	Blue Cross Deductibles & Coinsurance	Embrace Pays*	You Pay
<i>The following services are subject to the indicated fixed dollar co-payment only; the Deductible and Coinsurance do not apply to office visits, prescription drugs, emergency room, outpatient lab/x-ray, vision, or urgent care services.</i>			
Office Visits (Co-payments Only)			
Primary Care Office Visits – including one annual Gynecological Exam per year for women	\$15	\$0	\$15
Well Baby Care	\$15	\$0	\$15
Specialist Office Visits	\$25	\$0	\$25
Chiropractic (<i>Limitations Apply</i>)	\$25	\$0	\$25
Outpatient Mental Health (<i>Limitations Apply</i>)	\$25	\$0	\$25
Outpatient Substance Abuse (<i>Limitations Apply</i>)	\$25	\$0	\$25
Retail Prescriptions (Co-payments Only)			
Generic Drugs	\$7	\$0	\$7
Preferred Brand Drugs	\$30	\$0	\$30
Non-Preferred Brand Drugs	\$50	\$0	\$50
Specialty Drugs	\$50	\$0	\$50
Mail Order Prescriptions	3 month supply for 2 ½ co-payments	\$0	3 month supply for 2 ½ co-payments
Emergency Room & Urgent Care Services (Co-payments Only)			
Emergency Room	\$100	\$0	\$100
Urgent Care (i.e. Walk-in Treatment Facility)	\$25	\$0	\$25
Outpatient Lab and X-ray Services			
Outpatient Lab and X-ray	\$0	\$0	\$0
Vision Coverage			
Eye Exams	\$25	\$0	\$25
Eyeglasses & Contact Lenses	\$0	\$100/member/year	Cost in excess of \$100/member/year
<i>The following services are subject to the Deductible and Coinsurance, up to the maximum out of pocket expense.</i>			
Annual Deductible	\$5,000 per Individual \$10,000 per Family	\$5,000 per Individual \$10,000 per Family	\$0 \$0
Coinsurance	20% after deductible is met	20%	0%
Out of Pocket Maximum	\$6,000 per Individual \$12,000 per Family	\$6,000 per Individual \$12,000 per Family	\$0 \$0
Outpatient Services (Deductible plus Coinsurance apply)			
Outpatient Surgery	20%	20%	0%
Home Health Care	20%	20%	0%
Outpatient Therapy (Physical, Occupational, etc.)	20%	20%	0%
Ambulance Services	\$50	\$0	\$50
Inpatient Hospital Services (Deductible plus Coinsurance apply)			
Inpatient Hospitalization	20%	20%	0%
Inpatient Lab and X-ray	20%	20%	0%
Inpatient Mental Health	20%	20%	0%
Inpatient Substance Abuse (<i>Limited to 30 days per calendar year</i>)	20%	20%	0%
Other Services (Deductible plus Coinsurance apply)			
Physical Therapy & Durable Medical Equipment	20%	20%	0%
Prosthetic Devices	20%	20%	0%
Out of Network Services			
Annual Deductible	\$5,000 per Individual \$10,000 per Family	\$0.00 per Individual \$0.00 per Family	\$5,000 per Individual \$10,000 per Family
Coinsurance	40%	0%	40%
Out of Pocket Maximum	\$12,000 per Individual \$24,000 per Family	\$0.00 per Individual \$0.00 per Family	\$6,000 per Individual \$12,000 per Family

*covered deductible and coinsurance items are reimbursed by Embrace through **Primarily Care, Inc.**

This comparison is for descriptive purposes only. Please consult detailed plan literature for actual benefit levels. If this summary and the actual plan literature disagree, the benefits described in plan literature will apply.