



*Please read legal disclaimers at the end of this printout.

Talk to a live representative at 1-800-977-8860 Monday-Friday 5am-9pm PT. Sat & Sun 7am-4pm PT

Live chat is also available at our website at www.ehealthinsurance.com 24x7.

Your Quote Summary

Coverage for: Applicant (M/44), Spouse (F/41), Child (M/12)
State / Zip Code: MI / 48823
County: INGHAM
Coverage Start Date: 9/15/2009

Quotes generated on 8/19/2009



Flexible Blue II 2500
Not Yet Rated



\$344.66
Monthly Cost

APPLY

Overview

[Optional Benefits](#)

[Customer Reviews](#)

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Information below describes the in-network coverage for this plan. The amounts shown are your share of the costs for covered benefits.

Details at a Glance

<u>Plan Type</u>	PPO
<u>Office Visit for Primary Doctor</u>	20% Coinsurance after deductible; 2 office visits, per member, per calendar year
<u>Office Visit for Specialist</u>	20% Coinsurance after deductible; 2 office visits, per member, per calendar year
<u>Coinsurance</u>	20% after deductible
<u>Annual Deductible</u>	Family:\$5,000
<u>Separate Prescription Drugs Deductible</u>	Medical Plan Deductible Applies
<u>Prescription Drugs</u>	Generic: 1-34 day supply: 50% coinsurance with \$10 minimum and \$100 maximum copay, after in-network integrated deductible; Covered up to \$2,500 per member per calendar year after in-network integrated deductible, retail and mail order combined. 84-90 day supply: 50% coinsurance with \$20 minimum and \$200 maximum copay, after in-network integrated deductible; Covered up to \$2,500 per member per calendar year after in-network integrated deductible, retail and mail order combined. Brand: Same as above

Non-Formulary: Same as above

Annual Out-of-Pocket Limit

Family:\$10,000
Includes deductible

Lifetime Maximum

\$5 Million per person

Health Savings Account (HSA) Eligible


Yes (See HSA Administrators)

Out-of-Network Coverage

Yes (Details in plan brochure below)

Out of Country Coverage

Yes. Paid as in-network benefits if through a WorldWide BlueCard Provider ([View Details](#))

 [Find Doctors](#) (Search to see if your doctors are part of this plan's network.)

Physicians

Primary Care Physician (PCP) Required

No

Specialist Referrals Required

No

Preventive Care Coverage

Periodic Health Exam

No charge before deductible; Up to a combined preventive services maximum of \$500 per member per calendar year. 90 day benefit waiting period applies

Periodic OB-GYN Exam

No charge before deductible; Up to a combined preventive services maximum of \$500 per member per calendar year. 90 day benefit waiting period applies

Well Baby Care

No charge before deductible; Up to a combined preventive services maximum of \$500 per member per calendar year. 90 day benefit waiting period applies

Prescription Drug Coverage

Generic Prescription Drugs

1-34 day supply: 50% coinsurance with \$10 minimum and \$100 maximum copay, after in-network integrated deductible; Covered up to \$2,500 per member per calendar year after in-network integrated deductible, retail and mail order combined.

84-90 day supply: 50% coinsurance with \$20 minimum and \$200 maximum copay, after in-network integrated deductible; Covered up to \$2,500 per member per calendar year after in-network integrated deductible, retail and mail order combined.

Brand Prescription Drugs

Same as above

Non-Formulary Prescription Drugs Coverage

Same as above

Mail Order for Prescription Drugs

Generic: 50% coinsurance with \$20 minimum and \$200 maximum copay, after in-network integrated deductible; Covered up to \$2,500 per member per calendar year after in-network integrated deductible, retail and mail order combined.

Brand: Same as above

Non-Formulary: Same as above

Days Supply: 35-90

Separate Prescription Drugs Deductible

Medical Plan Deductible Applies

Hospital Services Coverage

Emergency Room

20% Coinsurance after deductible for all services other than physician services. You pay \$150 for physician services (waived if admitted).

Outpatient Lab/X-Ray

20% Coinsurance after deductible

Outpatient Surgery

20% Coinsurance after deductible

Hospitalization

20% Coinsurance after deductible

Maternity Coverage

Pre & Postnatal Office Visit

Not Covered (Optional rider available)

Labor & Delivery Hospital Stay

Not Covered (Optional rider available)

Additional Coverage

Chiropractic Coverage

Not Covered

Mental Health Coverage

Inpatient :20% Coinsurance after deductible, up to 30 days with 60-day renewal period (BCBSM-approved facilities only) Outpatient: Not covered.

Additional Information

A.M. Best Rating

A- as of 09/03/2008

Application Fee

No

Electronic Signature for Application Available Yes

Will insurance company obtain and pay for medical records? N/A

Additional information about this health insurance plan is available in the documents below.

[Plan Brochure \(PDF\)](#)

[Exclusions and Limitations \(PDF\)](#)

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APPLY

IMPORTANT NOTICES AND DISCLAIMERS

- **THE BENEFITS MATRIX IS A SUMMARY FOR INFORMATIONAL PURPOSES ONLY. REVIEW THE EVIDENCE OF COVERAGE AND INSURANCE POLICY (PLAN CONTRACT) FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS, LIMITATIONS, AND EXCLUSIONS. ONLY THE TERMS AND CONDITIONS OF COVERAGE BENEFITS LISTED IN THE POLICY ARE BINDING.**
- The benefits listed may be contingent on your use of physicians, hospitals, and services within the specific insurance company's provider network.
- The Copayment, Deductible, and Coinsurance amounts are your share of the costs for covered benefits. These amounts are subject to change.
- The quotes or rates shown above are estimates only. Your premium is subject to change based on your medical history, the underwriting practices of the insurance company, the

optional benefits you selected, if any, and other relevant factors, such as changes in rates which take effect before your requested effective date. The insurance company always determines your actual premium. Insurance companies reserve the right to change the terms of a policy upon proper notification.

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