



*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: UT / 84115
 County: SALT LAKE
 Coverage Start Date: 9/15/2009

Quotes generated on 8/19/2009



Monogram Total/7500 Plus Rx
 Customer Reviews & Ratings ★★★★★



\$140.18

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>	0% Coinsurance after deductible
<u>Office Visit for Specialist</u>	0% Coinsurance after deductible
<u>Coinsurance</u>	0% after deductible
<u>Annual Deductible</u>	Family:\$15,000(\$7,500 per person, 2 persons maximum)
<u>Separate Prescription Drugs Deductible</u>	\$1,000 Individual Applies to Levels 2, 3, 4
<u>Prescription Drugs</u>	Rx Deductible for Levels 2, 3, 4 Level 1: \$15 copay Level 2: \$40 copay Level 3: \$65 copay Level 4: 25% copay up to \$2500 maximum out of pocket. Levels based on specific drug
<u>Annual Out-of-Pocket Limit</u>	Family:\$15,000(\$7,500 per person, 2 persons maximum) Includes deductible
<u>Lifetime Maximum</u>	\$2 Million per person
<u>Health Savings Account (HSA) Eligible</u>	No
<u>Out-of-Network Coverage</u>	

Yes (Details in plan brochure below)

Out of Country Coverage

Emergency Care Only. Paid as out-of-network, and member must submit an itemized bill with services rendered and a diagnosis in order to be reimbursed.

Physicians

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

Primary Care Physician (PCP) Required No

Specialist Referrals Required No

Preventive Care Coverage

Periodic Health Exam 0% Coinsurance/ No Deductible to \$300/Calendar Year Preventive Care Maximum
NO Waiting Period

Periodic OB-GYN Exam Exam/Pap Smear/Mammogram: 0% Coinsurance/ No Deductible to \$300/Calendar Year Preventive Care Maximum
No Waiting Period

Well Baby Care 0% Coinsurance/ No Deductible to \$300/ Calendar Year Preventive Care Maximum
No Waiting Period

Prescription Drug Coverage

Prescription Drugs Other Coverage Rx Deductible for Levels 2, 3, 4
Level 1: \$15 copay
Level 2: \$40 copay
Level 3: \$65 copay
Level 4: 25% copay up to \$2500 maximum out of pocket.
Levels based on specific drug

Mail Order for Prescription Drugs Rx Deductible for Levels 2, 3, 4
Level 1: \$45 copay
Level 2: \$120 copay
Level 3: \$195 copay
Level 4: 75% copay up to \$2500 maximum out of pocket.
Levels based on specific drug

Days Supply: 90

Separate Prescription Drugs Deductible \$1,000 Individual
Applies to Levels 2, 3, 4

Hospital Services Coverage

Emergency Room \$125 Copay plus 0% Coinsurance after deductible
(copay waived if admitted)

Outpatient Lab/X-Ray 0% Coinsurance after deductible

Outpatient Surgery 0% Coinsurance after deductible

Hospitalization 0% Coinsurance after deductible

Maternity Coverage

Not Covered

Labor & Delivery Hospital Stay

Not Covered

Additional Coverage

Chiropractic Coverage

0% Coinsurance after deductible. 20 Visits/Calendar Year (Combined with Physical, Occupational, Speech, Cognitive and Audiology Therapy)

Mental Health Coverage

50% Coinsurance after deductible. \$2500/Calendar Year Maximum. Outpatient care not to exceed \$500 of the \$2500 Calendar Year Maximum; (Combined Mental Disorders/Alcohol and Chemical Dependence Calendar Year Max) No waiting period

Additional Information

A.M. Best Rating

A- as of 06/05/2008

Application Fee

No

Electronic Signature for Application Available Yes

Will insurance company obtain and pay for medical records? Yes

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

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

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

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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.