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Quote Prepared for: <http://ehealthinsurance.com>

Date Quote Prepared: 10/02/2009

Quoted By: Caroline Ehrental

Requested Effective Date: 11/01/2009

Quoting Zip Code: 33496

Coverage Type: Subscriber

Producer: Caroline Ehrental

Rates are subject to change based on your medical history, Aetna's underwriting guidelines, any optional benefits selected and the effective date of coverage.

FL - Preventive and Hospital Care \$3000 Deductible Plan (HSA Compatible)

Network	Coinsurance	Deductible Ind/Fam	Coinsurance Max Ind/Fam	Non Specialist OV	Outpatient Surgery	Inpatient Hosp. Copay/Ded	Prescription Drug	Specialist Office Visit	Prescription Drug Deductible	Total Rate
In-Network	20%	\$3,000 Individual/\$6,000 Family	\$2,000 Individual/\$4,000 Family	Not Covered	20%	20%	Aetna Rx Discount	Not Covered	None	\$277.00
Out of Network	40%	\$6,000 Individual/\$12,000 Family	\$4,000 Individual/\$8,000 Family		40%	40%	Not Covered			

FL - Preventive and Hospital Care \$1250 Deductible Plan

Network	Coinsurance	Deductible Ind/Fam	Coinsurance Max Ind/Fam	Non Specialist OV	Outpatient Surgery	Inpatient Hosp. Copay/Ded	Prescription Drug	Specialist Office Visit	Prescription Drug Deductible	Total Rate
In-Network	20%	\$1,250 Individual/\$2,500 Family	\$2,500 Individual/\$5,000 Family	Not Covered	20%	20%	\$15 Copay/Aetna Rx Discount	Not Covered	None	\$403.00
Out of Network	40%	\$2,500 Individual/\$5,000 Family	\$5,000 Individual/\$10,000 Family		40%	40%	40% after \$15 copay/Aetna Rx Discount			

FL - Premier \$5000 Deductible Plan

Network	Coinsurance	Deductible Ind/Fam	Coinsurance Max Ind/Fam	Non Specialist OV	Outpatient Surgery	Inpatient Hosp. Copay/Ded	Prescription Drug	Specialist Office Visit	Prescription Drug Deductible	Total Rate
In-Network	20%	\$5,000 Individual/\$10,000 Family	\$2,500 Individual/\$5,000 Family	\$40 Copay (Ded. Waived)	20%	20%	\$15/\$25/\$40/20%	\$50 Copay (Ded. Waived)	\$500 Individual/\$1,000 Family (Ded. Waived for Generic)	\$412.00
Out of Network	40%	\$10,000 Individual/\$20,000 Family		40%	40%	40%	40% after \$15/\$25/\$40/20%	40%		



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FL - High Deductible \$5000 Plan (HSA Compatible)

Network	Coinsurance	Deductible Ind/Fam	Coinsurance Max Ind/Fam	Non Specialist OV	Outpatient Surgery	Inpatient Hosp. Copay/Ded	Prescription Drug	Specialist Office Visit	Prescription Drug Deductible	Total Rate
In-Network	0%	\$5,000 Individual/\$10,000 Family	\$0 Individual/\$0 Family	0%	0%	0%	0% after Integrated Medical/Rx Deductible	0%	Integrated Medical/Rx Deductible	\$421.00
Out of Network	40%	\$10,000 Individual/\$20,000 Family	\$2,500 Individual/\$5,000 Family	40%	40%	40%	40% after Integrated Medical/Rx Deductible	40%		

FL - High Deductible \$3000 Plan (HSA Compatible)

Network	Coinsurance	Deductible Ind/Fam	Coinsurance Max Ind/Fam	Non Specialist OV	Outpatient Surgery	Inpatient Hosp. Copay/Ded	Prescription Drug	Specialist Office Visit	Prescription Drug Deductible	Total Rate
In-Network	0%	\$3,000 Individual/\$6,000 Family	\$0 Individual/\$0 Family	0%	0%	0%	0% after Integrated Medical/Rx Deductible	0%	Integrated Medical/Rx Deductible	\$488.00
Out of Network	40%	\$6,000 Individual/\$12,000 Family	\$6,500 Individual/\$13,000 Family	40%	40%	40%	40% after Integrated Medical/Rx Deductible	40%		

FL - Premier \$2500 Deductible Plan

Network	Coinsurance	Deductible Ind/Fam	Coinsurance Max Ind/Fam	Non Specialist OV	Outpatient Surgery	Inpatient Hosp. Copay/Ded	Prescription Drug	Specialist Office Visit	Prescription Drug Deductible	Total Rate
In-Network	20%	2,500 Individual/\$5,000 Family	2,500 Individual/\$5,000 Family	\$30 Copay (Ded. Waived)	20%	20%	\$15/\$25/\$40/20%	\$40 Copay (Ded. Waived)	\$500 Individual/\$1,000 Family (Ded. Waived for Generic)	\$572.00
Out of Network	40%	\$5,000 Individual/\$10,000 Family		40%	40%	40%	40% after \$15/\$25/\$40/20%	40%		



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FL - Premier \$1500 Deductible Plan

Network	Coinsurance	Deductible Ind/Fam	Coinsurance Max Ind/Fam	Non Specialist OV	Outpatient Surgery	Inpatient Hosp. Copay/Ded	Prescription Drug	Specialist Office Visit	Prescription Drug Deductible	Total Rate
In-Network	20%	\$1,500 Individual/\$3,000 Family	\$1,500 Individual/\$3,000 Family	\$25 Copay (Ded. Waived)	20%	20%	\$15/\$25/\$40/20%	\$35 Copay (Ded. Waived)	\$250 Individual/\$500 Family (Ded. Waived for Generic)	\$677.00
Out of Network	40%	\$3,000 Individual/\$6,000 Family		40%	40%	40%	40% after \$15/\$25/\$40/20%	40%		

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