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Date Prepared:	6/20/2006
Zip Code:	80210
Effective Date:	7/1/2006
Applicant:	Female, age 39, non smoker
Spouse:	Male, age 42, non smoker
Dependent 1:	Female, age 10, non smoker
Dependent 2:	Male, age 8, non smoker
Dependent 3:	Female, age 6, non smoker
Dependent 4:	Male, age 3, non smoker

Company					
Plan Name	Colorado HSA Qualified Plan For Individuals	Family HSA 100	4000 Deductible Plan with HSA Option (100%)	HumanaOne HSA	
Estimated Monthly Premium	\$371.40	\$396.52 (June 30 eff date) - (Q3 quote = \$404.50)	\$472.66	\$480.87	
Plan Type	PPO	Network		PPO	
Networks	Blue Cross Network	Networks UnitedHealthcare Choice Plus Premiums \$414.75	Kaiser HMO Facilities	Humana Choice Care Network	
	Network Non-Network			Network Non-Network	
Copay	N/A	N/A	N/A	N/A	
Deductible	\$8,000 Family Double the network deductible.	\$5,450 (one per family)	\$4,000 Family	\$5,150 Family	
Coinsurance (% Paid by Insurance Company)	100% covered 60% covered	100%	100%	100% 70%	
Coinsurance Limit	\$0	\$0	\$0	\$0 N/A	
Out-of-Pocket Maximum	equal to deductible	Equal to deductible	\$4,000 Family (includes deductible and coinsurance)	Equal to deductible	
Lifetime Maximum	\$2,000,000 per member.	\$3 million per covered person per year	No Lifetime Maximum	\$5 Million per covered person.	
Office Visit	Subject to coinsurance after deductible.	Subject to deductible	<input type="checkbox"/> Routine medical office visits: No charge after deductible is met	Subject to deductible and coinsurance	
Prescription Drugs	Accumulates towards the medical deductible	<input type="checkbox"/> Subject to deductible <input type="checkbox"/> Covered expenses will be limited to no more than a 34-day supply for any one outpatient prescription drug order or refill.	<input type="checkbox"/> After the deductible is met: ● No charge, up to a 30-day supply. ● 90-day refill available by mail order.	Subject to deductible and coinsurance	
Emergency Room	100% covered after deductible. 80% covered after deductible.	<input type="checkbox"/> Subject to deductible <input type="checkbox"/> Hospital emergency room treatment of an injury or illness	<input type="checkbox"/> After deductible is met, there is no charge per visit at a designated Kaiser Permanente emergency room or a non-Plan emergency room	Subject to deductible and coinsurance	
Adult Preventive Care	<input type="checkbox"/> Subject to coinsurance after deductible <input type="checkbox"/> With maximum annual benefit of \$500 per member in each benefit year. <input type="checkbox"/> Mammogram screening and prostate screening are covered and are not subject to deductible or coinsurance, which are not subject to the maximum payment but do reduce the maximum payment of \$500. <input type="checkbox"/> Age guidelines apply.	<input type="checkbox"/> Not covered except for mammogram screening and prostate screening are covered and are not subject to deductible or coinsurance. <input type="checkbox"/> Age guidelines apply.	<input type="checkbox"/> Subject to deductible <input type="checkbox"/> After coverage has been in force 3 months, each adult age 19 or older qualifies for up to \$500 of covered expenses per calendar year for routine physicals, including lab fees. <input type="checkbox"/> Mammography, pap smear, and PSA test fees are covered at 100% After Deductible	No charge (not subject to deductible)	<input type="checkbox"/> Routine annual physical exam, Routine Immunizations (to age 18), and Routine Pap smears and PSA (Age and/or frequency limits apply): Covered at 100%, \$300 of covered expenses per person per calendar year, subject to applicable coinsurance. Benefits payable after 90-day waiting period for preventive care and 12-month waiting period for mental health. <input type="checkbox"/> Routine Mammograms: Covered at 100% (Age and/or frequency limits apply) <input type="checkbox"/> Routine lab, pathology, and X-ray: 100% after deductible, \$300 of covered expenses per person per calendar year, subject to applicable coinsurance. Benefits payable after 90-day waiting period for preventive care and 12-month waiting period for mental health.
Child Preventive Care	<input type="checkbox"/> Subject to coinsurance after deductible. <input type="checkbox"/> Children services, not subject to deductible for age appropriate visits and routine immunizations (up to age 13).	After coverage has been in place 3 months 100% after deductible for childhood immunizations up to \$500 per year.	No charge (not subject to deductible)	see brochure	
Lab/X-ray	<input type="checkbox"/> Inpatient care: Included with inpatient hospital. <input type="checkbox"/> Outpatient care: Subject to coinsurance after deductible.	Subject to deductible	No charge after the deductible is met.	Subject to deductible and coinsurance	

Maternity	<input type="checkbox"/> Prenatal care: Not covered. <input type="checkbox"/> Delivery & Inpatient well baby care: Delivery not covered. Inpatient well baby care, subject to coinsurance after deductible.	Not Covered	Not covered	<input type="checkbox"/> Available as optional benefit rider during the application process. <input type="checkbox"/> For immediate information please contact agent.
Physical Therapy	see brochure	Subject to Deductible	see brochure	Subject to deductible and coinsurance (20 visits per year maximum)
Skilled Nursing	Not covered	see brochure	see brochure	Subject to deductible and coinsurance(30 days per year maximum)
Home Health Care	Subject to coinsurance after deductible (limited to 60 visits per member in each benefit year, in- and out-of-network combined).	To qualify for benefits, home health care must be: <input type="checkbox"/> Provided in lieu of medically necessary inpatient care in a hospital or hospice; and <input type="checkbox"/> Provided through a licensed home health care agency. Covered expenses for home health aide services will be limited to seven visits per week and a lifetime maximum of 365 visits. Registered nurse services will be limited to a lifetime maximum of 1,000 hours.	see brochure	Subject to deductible and coinsurance (60 visits per year maximum)
Mental Health	<p>Biologically-Based Mental Illness Care:</p> <input type="checkbox"/> Coverage is no less extensive than the coverage provided for any other physical illness. Other Mental Healthcare: <input type="checkbox"/> Inpatient Care: Subject to coinsurance after deductible, limited to 45 full or 90 partial days per member in each benefit year in and out-of-network combined. <input type="checkbox"/> Outpatient Care: Subject to coinsurance after deductible, up to a maximum of \$500 per member in each benefit year in- and out-of-network combined. <input type="checkbox"/> Maximum payment for inpatient and outpatient care is limited to \$10,000 per member per lifetime.	<input type="checkbox"/> All diagnoses or treatments of mental disorders, as defined in the policy, including substance abuse, will be limited to a lifetime maximum benefit of \$3,000. <input type="checkbox"/> Covered expenses for outpatient diagnosis or treatment of mental disorders will be further limited to \$50 per visit.	see brochure	<input type="checkbox"/> Mental Health: 50% after deductible (\$2500 per year maximum, 1 year waiting period). <input type="checkbox"/> Mental Health Office Visits: 50% after deductible(\$500 per year maximum, 1 year waiting period). <input type="checkbox"/> Separate from medical out of pocket.
Hospital Care	Subject to coinsurance after deductible	<input type="checkbox"/> Subject to deductible <input type="checkbox"/> Daily hospital room-and-board and nursing services at the most common semiprivate rate. <input type="checkbox"/> Charges for an intensive care unit are covered. <input type="checkbox"/> Professional fees of doctors and surgeons (but not for standby availability) are covered.	No charge after the deductible is met.	Subject to deductible and coinsurance
Optional Benefits (not included in base rate quotation)	see brochure	<input type="checkbox"/> Term Life Benefit <input type="checkbox"/> Hospital Indemnity Benefit <input type="checkbox"/> Preventive Care Benefits Package	see brochure	see brochure
Fees	see brochure	<input type="checkbox"/> see carrier specific disclaimers	see brochure	see brochure
Policy Form Number	96319	Policy Forms C-006.3, C-006.4, or state variation	see brochure	see brochure
Note	N/A	see brochure	see brochure	see brochure

General Disclaimers

The quotes shown above are estimates only, and are subject to change based on the proposed insured's medical history, the underwriting practices of the health plan, the selection of the appropriate Provider Network, the optional benefits selected, occupation (where allowed by state), if any, and other relevant factors. The insurance company reserves the right to change the terms of a policy upon proper notification.

The quotes shown above are for the requested effective date ONLY. If the actual effective date of coverage is different from the requested effective date, the actual cost may differ from the quote above due to rate increases or policy changes from the insurance company and/or one or more family members having a birthday. (Rates are highly dependent on age.) The carrier selected may not guarantee its rates for any period of time.

Applicants should not cancel any in-force health coverage until written formal approval from the insurance company selected is received.

This is not a complete solicitation of health insurance coverage. Please refer to sales brochure and applicable inserts for further information. Sales brochures and applicable inserts may be downloaded or can be obtained by calling our contact number near the top of this page.

The benefits shown in the details summary are are not guaranteed. Please refer to the sales brochure and applicable inserts for further information.

Carrier Specific Disclaimers

United HealthCare

This information is presented only as a very brief overview of some of the benefits of this plan, and is intended only for general education. The amount of benefits provided depends on the plan selected. Premium will vary with the type of benefits selected. These plans contain exclusions from and limitations of coverage. Please see the product brochure for more complete information, as well as information about terms of renewability, preexisting conditions, out-of-network penalties, and notification requirements. Plans are subject to health underwriting. To be considered for reimbursement, expenses must qualify as covered expenses. Expenses are also subject to reasonable and customary limits, unless you use a network, and all other policy provisions, including determinations of medical necessity.

These plans are available only to members of the Federation of American Consumers and Travelers (FACT), an independent consumer organization. If you are not already a member of FACT, you must join in order to be eligible for these plans. Through a special agreement between FACT and Golden Rule, you can enroll in the association on this web site. You will fill out the FACT enrollment form prior to making application to Golden Rule for health insurance. For more information on the benefits of FACT membership, visit www.fact-org.org. Estimated Monthly Premium does not include the mandatory \$3 per month dues for FACT membership. FACT membership is not required of Connecticut, Delaware or Georgia residents.

Be sure to download the brochure before you apply. It contains important information regarding benefits, exclusions, limitations, renewability, and other terms of coverage.

Humana

Applicants who have not had major medical coverage within 63 days of applying are required to choose an effective date 30 days to 45 days after the date of application.

