









<b>Prepared For:</b>	77036
<b>Prepared By:</b>	Guaranteed Health and Annuity, Inc.
<b>Phone Number:</b>	888-239-3735
<b>Date Prepared:</b>	12/8/2008
<b>Zip Code:</b>	77036
<b>Effective Date:</b>	1/15/2009
<b>Applicant:</b>	Male,age 40, non smoker

Company								
<b>Plan Name</b>	Solaura HIA Plus Plan 2		Copay Select		MedOne Plus- PPO Benefit Plan w/Rx Opt \$0/\$15/50%		CeltiCare Preferred "Any Doc" PPO Plan	
<b>Apply</b>								
<b>Estimated Monthly Premium</b>	\$192.00		\$197.43		\$220.53		\$240.35	
<b>Plan Type</b>	PPO		Network		Network		PPO	
<b>Networks</b>	See provider details		See provider details		See provider details		See provider details	
	Network	Non-Network			Network	Non-Network	Network	Non-Network
<b>Copay</b>	N/A		\$35		N/A		Select: \$15 copay Any Doc: \$35 copay 2 visits per person, per calendar year; 3+ visits subject to ded./coins	
<b>Deductible</b>	\$5,000 Individual, \$10,000 Family		\$5,000 (maximum 2 per family, per calendar year)		\$5,000(2 per family maximum) \$10,000(2 per family maximum)		Individual: \$5,000, Family: \$15,000 Out of Network Deductible is \$1500 + Annual Deductible	
<b>Coinsurance (% Paid by Insurance Company)</b>	100%	70%	100%		Plan pays 80%	Plan pays 50%	100% after deductible	
<b>Coinsurance Limit</b>	Annual Out-of-Pocket Maximum-\$5,000 Individual, \$10,000 Family	Annual Out-of-Pocket Maximum-\$10,000 Individual, \$20,000 Family	\$15,000		\$10,000	\$8,000	Equal to deductible	
<b>Out-of-Pocket Maximum</b>	Annual Out-of-Pocket Maximum-\$5,000 Individual, \$10,000 Family	Annual Out-of-Pocket Maximum-\$10,000 Individual, \$20,000 Family	\$3,000 per covered person after deductible and copays		\$7,000 per person	\$14,000 per person	see brochure	
<b>Lifetime Maximum</b>	\$5 million		\$3 million per covered person		\$5,000,000		\$7 Million	
<b>Office Visit</b>	Subject to deductible and coinsurance		\$35 copay -not subject to deductible (\$25 copay available)		Subject to deductible, then coinsurance.	Deductible, then 70% coinsurance	Select: \$15 copay Any Doc: \$35 copay 2 visits per person, per calendar year; 3+ visits subject to ded./coins	
<b>Prescription Drugs</b>	Subject to deductible and coinsurance		Tier 1 - \$15 copay, no deductible; Tier 2-4 combined \$200 calendar-year deductible, then Tier 2 - \$35 copay; Tier 3 - \$65 copay; Tier 4 you pay 25% coinsurance (If you choose name-brand when generic is available, you pay your generic copay plus the additional cost above the generic price) Annual Maximum- \$3,000 Covered (not paid) per person per calendar year (No annual maximum available)		Drug Deductible = \$0 Retail: Generic- \$15 copay; 30-day supply, Brand Name- 50% Coinsurance; 30-day supply. Mail Order: Generic-\$30 Copay; 90-day supply, Brand Name- \$60 copay; 90-day supply.		Standard Rx benefit: Generic: \$20 copay \$500 annual deductible Pref. Brand: \$40 copay Non-pref/Specialty Brand: \$75 copay Brand w/generic alternative: specified copay + 100% cost difference btwn. Brand & Generic Stand-alone Option: No annual deductible for Generic \$100 annual ded. for Brand Generic: \$20 copay Pref. Brand: \$40 copay Non-pref/Specialty Brand: \$75 copay Brand w/generic alternative: specified copay + 100% cost difference btwn. Brand & Generic Mail order: 90-day supply)	
<b>Emergency Room</b>	Initial Care of a Medical Emergency - Covered at the in-network coinsurance level Subject to reasonable and customary limitations		Illness: You pay: \$100 copay if not admitted, then chosen coinsurance after deductible Injury: You pay: chosen coinsurance after deductible		\$100 copay then subject to deductible, then coinsurance.(Copay is waived if immediately confined)		\$250 deductible [in addition to plan deductible] waived if admitted or if charges are due to an accident	
<b>Adult Preventive Care</b>	Covered 100% Certain restrictions may apply	Subject to deductible and out-of-network coinsurance Certain restrictions may apply	Doctor Office Visit: \$35 copay (3 month waiting period) X-ray & Lab: You pay: chosen coinsurance (in conjunction with the preventive office visit, performed in the doctors office or a network facility; 3 month waiting period, not subject to deductible) Preventive Mammogram, Pap Smear, PSA screening: You pay: chosen coinsurance not subject to deductible (no waiting period)		Subject to deductible, then coinsurance.	Not Covered	First-dollar \$300 per person, per calendar year; eligibility begins after 90 days of coverage	
<b>Child Preventive Care</b>	Covered 100% Certain restrictions may apply	Subject to deductible and out-of-network coinsurance Certain restrictions may apply	Doctor Office Visit: \$35 copay (3 month waiting period) X-ray & Lab: You pay: chosen coinsurance (in conjunction with the preventive office visit, performed in the doctors office or a network facility; 3 month waiting period, not subject to deductible) Child Immunizations: You pay: chosen coinsurance - not subject to deductible (3 month waiting period)		Subject to deductible, then coinsurance.	Not Covered	First-dollar \$300 per person, per calendar year; eligibility begins after 90 days of coverage	

Lab/X-ray	Subject to deductible and coinsurance	You pay: chosen coinsurance after deductible (performed in the doctors office or a network facility)	Subject to deductible, then coinsurance.	Subject to annual deductible and coinsurance
Maternity	see brochure	Optional Benefit	Not covered	Maternity (Prenatal/Postnatal)- Not Covered - Varies by State Maternity - Not Covered (except for complications of pregnancy) - Varies by State
Physical Therapy	Subject to deductible and out-of-network coinsurance May have limitations or restrictions	see brochure	Subject to deductible, then coinsurance.	Up to 30 visits per year
Skilled Nursing	Subject to deductible and out-of-network coinsurance May have limitations or restrictions	see brochure	Subject to deductible, then coinsurance. Limited to 30 days per calendar year.	see brochure
Home Health Care	Subject to deductible and out-of-network coinsurance May have limitations or restrictions	see brochure	Subject to deductible, then coinsurance. Limited to 20 visits per calendar year.	30 visits per person, per calendar year (Varies by State)
Mental Health	Subject to deductible and out-of-network coinsurance May have limitations or restrictions	You pay: chosen coinsurance after deductible (Limited benefit)	Not covered	Inpatient annual maximum of \$2,500 per person, per calendar year. \$10,000 lifetime maximum inpatient and out patient combined. Outpatient annual maximum of \$1,000 per insured per calendar year. \$10,000 lifetime maximum inpatient and out patient combined.
Hospital Care	Subject to deductible and coinsurance	You pay: chosen coinsurance after deductible	Subject to deductible, then coinsurance.	Subject to Deductible and Coinsurance
Included Benefits	see brochure	see brochure	see brochure	see brochure
(not included in base rate quotation)			<input type="checkbox"/> XL Option <input type="checkbox"/> MedOne Dental Insurance Benefits <input type="checkbox"/> Supplemental Accident Benefit <input type="checkbox"/> Voluntary Term Life and AD&D Insurance <input type="checkbox"/> Voluntary Dependent Term Life Insurance	<input type="checkbox"/> Plus Option II includes: <ul style="list-style-type: none"> <li>● Preventive- 100% up to \$300 per person per year (after 90 day wait)</li> <li>● Supplemental Accident-Covered at 100% up to \$500 per person per year</li> </ul>
Fees		<input type="checkbox"/> see carrier specific disclaimers	<input type="checkbox"/> Administrative fees, association fees, and optional benefits, such as dental coverage, are additional costs not included in the estimated premium. The billing options available are as follows: Quar	
Policy Form Number	see brochure	Policy Forms C-006.3, C-006.4, or state variation	see brochure	see brochure
Note	HIA Plus Annual Allocation- \$500 Individual coverage, \$1,000 Family coverage Unused dollars roll over year to year. There is no limit to this rollover amount.	see brochure	see brochure	see brochure
Product Brochure	<a href="#">Brochure</a>	<a href="#">Brochure</a>	<a href="#">Brochure</a>	<a href="#">Brochure</a>
Optional Riders included in the quote				
Optional Riders not included in the quote	<input type="checkbox"/> \$15,000 Term Life : \$7.50 <input type="checkbox"/> \$25,000 Term Life : \$12.50 <input type="checkbox"/> \$50,000 Term Life : \$25.00 <input type="checkbox"/> Dental : \$20.50	<input type="checkbox"/> 24 Month Rate Guarantee : \$17.77 <input type="checkbox"/> Office Visit \$25 Copay : \$11.85 <input type="checkbox"/> Prescription Drug No Annual Max : \$15.79 <input type="checkbox"/> \$5 Million Lifetime Maximum : \$7.00 <input type="checkbox"/> \$500 Supplemental Accident Benefit : \$8.15 <input type="checkbox"/> \$1,000 Supplemental Accident Benefit : \$16.30 <input type="checkbox"/> \$50,000 Term Life Benefit Primary : \$10.00 <input type="checkbox"/> \$100,000 Term Life Benefit Primary : \$14.58 <input type="checkbox"/> \$150,000 Term Life Benefit Primary : \$20.00 <input type="checkbox"/> Accidental Death Benefit Primary : \$2.00		<input type="checkbox"/> Supplemental Accident : \$7.88

## 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 not guaranteed. Please refer to the sales brochure and applicable inserts for further information.

### **Carrier Specific Disclaimers**

#### **American Medical Security Life Insurance Company**

American Medical Security Life Insurance Company (AMS) insurance plans are available only to members of the Taxpayers Network Inc. (TNI), a non-profit social welfare organization. If you are not already a member of TNI, you must join in order to be eligible for these insurance plans. If you are not already a member of TNI please complete the TNI membership enrollment provided with the AMS application for insurance. For more information on the benefits of TNI membership, visit [www.taxpayersnetwork.org](http://www.taxpayersnetwork.org). Estimated monthly premium does not include the mandatory \$7.00 per month dues for TNI membership. This membership is not applicable in Colorado, Georgia and Kansas. o Ineligible Occupations - there are some occupations that are ineligible for health insurance coverage. (Not applicable to HIPAA eligible individuals or applicable in the states of Colorado, Florida and Michigan.) o On-the-Job Protection - offers 24-hour coverage for eligible medical expenses due to work related injury or sickness. Some occupations may be excluded or considered ineligible for On-the-Job Protection coverage. These insurance plans provide only limited benefits for services provided by non-plan (non-network) providers. Benefits received from non-network providers are subject to a separate non-network deductible and coinsurance limit. Please see end of the brochure for limitations and exclusions.

#### **Golden Rule**

UnitedHealthOne is the brand name used for products underwritten or administered by the UnitedHealthcare family of companies offering personal health insurance, including Golden Rule Insurance Company and United Healthcare Insurance Company.

This screen is intended only as general information. It presents only a brief overview of some of the standard benefits of the plan(s) shown. Optional benefits may be available for additional premium.

Before you apply, please use the link(s) provided to download and review the product information for a more complete explanation of benefits, exclusions (including any that may apply to preexisting conditions), limitations, terms under which the plan(s) may not be renewed or benefits may be reduced, and any state variations applicable to any of these items.

You must meet our eligibility requirements in order to become insured, which may include medical underwriting. There is no coverage until we inform you in writing that your application has been processed and approved.

To be considered for reimbursement, expenses must qualify as "covered expenses" under the policy, and are also subject to all other policy provisions, such as reasonable and customary limits, or whether or not they were necessary.

Estimated Premium shown is based on the information you provided, and is subject to change based on the plan you select, optional benefits you select (if any), and other factors. We shall exclusively determine the premium actually required, and the effective date of any coverage issued.

In several states, 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 through Golden Rule. You will fill out the FACT enrollment form on this website prior to making application to Golden Rule for health insurance. For more information on the benefits of FACT membership, visit [www.usafact.org](http://www.usafact.org) (no need to enroll directly - Golden Rule will submit your dues to FACT). Estimated Premium does not include the mandatory \$3 per month dues for FACT membership. FACT membership is not required in every state. Please see the product information for details.

### Unicare

Read your Certificate carefully. This summary of benefits provides a very brief description of the important features of your plan. This is not the insurance contract and only the actual Certificate of Coverage provisions will apply. The Certificate sets forth, in detail, the benefits, limitations and exclusions. If there are any conflicts between the terms of the Certificate of Coverage and the information in this quote, the terms of the Certificate of Coverage will prevail.