Health Plans

For Individuals and Families

UnitedHealthcare®
Underwritten By Golden Rule

Policy Forms C-006.3 or C-006.4
Health Insurance Available Only to Members of FACT

Why Choose Us for Health Insurance?

UnitedHealthcare

Today, UnitedHealthcare serves more than 26 million customers. Our network plans can ease access to high-quality care from more than 535,000 physicians and 4,700 hospitals across all 50 states and in four international markets.* We combine our strength and stability with nearly three decades of experience serving customers of all sizes.

Golden Rule Insurance Company

Golden Rule Insurance Company is the underwriter and administrator of these plans. Golden Rule merged with UnitedHealthcare in 2003, and has served individuals and families with health insurance solutions for over 60 years. This experience and knowledge is reflected in high-quality products, timely claims handling, and outstanding customer service.

Experience and Expertise

Golden Rule's experience and expertise has driven the development of easy-to-use and innovative health insurance products. A recognized leader — and one of the nation's largest providers of health savings account plans — Golden Rule continues building plans that meet the needs of individuals and families. Golden Rule is rated "A" (Excellent) by A.M. Best and "A+" (Strong) by Standard and Poor's. These worldwide, independent organizations examine insurance companies and other businesses and publish their opinions about them. These ratings are an indication of our financial strength and stability.

Customer Satisfaction

- More than 92% of all health insurance claims are processed in 10 working days or less.**
- Up to 35%-45% discounts are provided on quality care thanks to our extensive network of doctors and hospitals.***
- We're easy to reach with a toll-free customer service line: (800) 657-8205. We respond quickly to customer questions and concerns.

*As of 1/3/2008.
**Actual 2007 results.
***Discounts vary by provider, geographic area, and type of service.

A Guide to Buying Health Insurance

We agree — buying health insurance can be difficult. There are many companies offering several plans. Benefits are different. Fine print is hard to read. Terms are unfamiliar. And the cost can be surprising.

On this page, we offer six clear steps to help you through the process of selecting a health plan that fits your budget and a company that meets your needs as well.

1) Determine what you are looking for in a health insurance plan.
   - Copay for doctor visits for young children?
   - Lower premiums — most concerned with serious illness?
   - Are tax-advantages important?
2) Review plans from reputable companies.
   - Check an independent rating agency like A.M. Best or Standard and Poor's.
3) Know what you are responsible to pay.
   - **Copay:** fixed amount an insured must pay at the time of service (i.e., doctor visit or prescription).
   - **Deductible:** a flat amount that an insured is required to pay before the insurance will pay any benefits.
   - **Coinsurance:** the percentage (for example, 80%) paid by the insurance company and percentage (20%) paid by the insured of all covered medical expenses once the deductible is met.
4) Understand what's covered and what's not covered by the insurance plan.
   - All plans have exclusions and limitations and you need to know what they are (see pages 13-16).
5) Research the network.
   - **Network:** health-care providers (physicians, hospitals, and other facilities) that are contracted by the insurance company to provide care at a discounted price.
   - Are the doctors and hospitals you want to use part of the network offered by the company?
6) Figure out the bottom line — your total annual cost in a good health year and a bad health year.

Which Plan Best Fits Your Needs?

Whether you are seeking lower-cost health insurance, experienced a recent change in employment or family status, or are self-employed, we offer you and your family a variety of coverage options at competitive prices in many states.

Plan Type	May Be Ideal For:	Plan Name	Out-of-Pocket*	Premium Cost	Page
High Deductible Plans Simple-to-Understand Plans – Lower Premiums, Higher Deductible	Anyone willing to take responsibility for routine health-care expenses in exchange for lower premiums. Anyone seeking lower-cost protection from unexpected accidents and illnesses. Early retirees needing a bridge to Medicare.	Plan 100® More Comprehensive	Lower	Higher	4
		Plan 80℠ More Affordable	Higher	Lower	4
		Saver 80℠ Even More Affordable	Higher	Lower	4
Copay Plans More Traditional Plans – Higher Premiums, Lower Deductible	Anyone who prefers the convenience of copay benefits for routine health-care expenses. Families with children who have regularly scheduled doctor office visits. Adults who want copay benefits for preventive care and prescription drugs.	Copay Select℠ More Comprehensive	Lower	Higher	6
		Copay Saver℠ More Affordable	Higher	Lower	6
Health Savings Account Plans Market-Leading Plans – High Deductible Plan plus Savings Account	Persons interested in more control over how their health-care dollars are spent. Families interested in one annual deductible per family. Those interested in trading low deductible health insurance for a higher deductible plan to save money on monthly premiums and taxes.	HSA 100® More Comprehensive	Lower	Higher	8
		HSA Saver® More Affordable	Higher	Lower	8

Both the amount of benefits and the premium will vary based upon the plan you select.

*Out-of-pocket exposure is deductible, coinsurance, and copays. Under all plans, additional expenses may be incurred that are not eligible for reimbursement by the insurance.

Quality Care at Significant Savings — The Network Advantage

Access to the right doctors can be the most important part of your health care.

Preferred network

Select our Preferred network* as part of your health insurance plan, and you have:

- Access to an **extensive network** of doctors, X-ray and lab facilities, hospitals, and other ancillary providers.*
- **Quality care** at reduced costs because these providers have agreed to lower fees for covered expenses.
- **Lower premiums** — savings up to 35%-45% over the same plans without a Preferred network.

Please note: Covered expenses for nonemergency care received from a provider outside your Preferred network are:

- Subject to reasonable and customary charges;
- Reduced by 25%;
- Subject to an additional deductible amount equal to the per person, calendar-year deductible.

For Services of Non-Network Providers: Your actual out-of-pocket expenses for covered expenses may exceed the stated coinsurance percentage because actual provider charges may not be used to determine insurer and member payment obligations.

Sample savings with our Preferred network:

(Services provided September 2006 to April 2007)**

	Charges	Repriced Charges
Dr. Office Visit (illness)	$ 73.00	$ 54.54
Mammogram	$ 200.00	$ 99.80
MRI	$ 1,909.00	$ 573.34
Lab Work – Cholesterol, Glucose, Insulin Fasting	$ 149.00	$ 10.33

*UnitedHealthcare Choice Plus network, available in most areas. LabCorp is the preferred laboratory services provider for UnitedHealthcare networks.
**All these services received from network providers in ZIP Code 462--. Your actual savings may be more or less than this illustration and will vary by several factors.

To find or view network providers for any network, visit *www.goldenrule.com*

High Deductible Plans

Lower Premiums

With high deductible plans, you're keeping more of your money and taking responsibility for covering minor or routine health-care expenses — if they come up. The higher the deductible, the lower your premiums.

Saver 80℠ is our lowest premium plan. This plan provides coverage for hospital confinements, surgical procedures in or out of the hospital, and the more costly outpatient expenses, such as CAT scans and MRIs.

Simple to Use

Golden Rule's top-selling high deductible plan — Plan 100® — pays 100% of covered expenses once you meet your calendar-year deductible. Your benefits are not complicated with multiple copays or coinsurance.

Comprehensive Coverage

- You choose $3 million or $5 million lifetime maximum benefit per covered person.
- Plan 100® and Plan 80℠ include preventive care and child immunizations with no waiting period (first-dollar coverage available).
- Add optional benefits to increase coverage (see Optional Benefits on page 10 for details).

Who might benefit most from a High Deductible Plan?

- Anyone willing to take responsibility for routine health-care expenses in exchange for lower premiums.
- Anyone seeking lower-cost protection from unexpected accidents and illnesses.
- Early retirees needing a bridge to Medicare.

Benefit Highlights:	Plan 100®	Plan 80℠	Saver 80℠
Design Basics			
Calendar-Year Deductible Choices (maximum 2 per family, per calendar year)	You pay: $1,500, $2,500, $3,500, or $5,000	You pay: $1,500, $2,500, $3,500, or $5,000	You pay: $500, $1,000, $1,500, $2,500, $3,500, or $5,000
Coinsurance After Deductible (per covered person, per calendar year)	You pay: Nothing We pay: 100%	You pay: 20% to $3,000 We pay: 80% to $12,000, then, 100%	You pay: 20% to $3,000 We pay: 80% to $12,000, then, 100%
Lifetime Maximum Benefit (per covered person)	$3 million ($5 million available)	$3 million ($5 million available)	$3 million ($5 million available)
Initial Rate Guarantee (subject to benefit and address changes)	12 months	12 months	12 months
	We pay the percentages below AFTER you pay the deductible unless otherwise indicated.		
Preventive Care Benefits			
Doctor Office Visit (X-ray and lab performed in the doctor's office or a network facility. Go to *www.goldenrule.com* to find a lab near you.)	History and exam: 100% X-ray and lab: 100%	History and exam: 80% X-ray and lab: 80%	Not covered
Child Immunizations (age 0-18)	Vaccine: 100%	Vaccine: 80%	Not covered
Preventive Mammogram, Pap Smear, PSA Testing	Testing: 100%	Testing: 80%	Testing: 80%
Outpatient Expense Benefits			
Doctor Office Visit Fees – Illness & Injury	100%	80%	Not covered
Outpatient X-ray and Lab (performed in the doctor's office or a network facility. Go to *www.goldenrule.com* to find a lab near you.)	100%	80%	80% if performed within 14 days of surgery or confinement
Outpatient Prescription Drugs	100% Preferred price card included	80% Preferred price card included	Not covered – Discount card included
Surgeon, Assistant Surgeon, and Facility Fees	100%	80%	80%
Hemodialysis, Radiation, Chemotherapy, and Organ Transplant Drugs	100%	80%	80%
CAT Scans, MRIs	100%	80%	80%
Emergency Room Fees	Illness: 100%, additional $100 copay if not admitted Injury: 100%	Illness: 80%, additional $100 copay if not admitted Injury: 80%	Illness & Injury: 80%, additional $500 copay if not admitted
Other Covered Outpatient Expenses	100%	80%	See page 12 for details
Inpatient Expense Benefits			
Room and Board, Intensive Care Unit, Operating Room, Recovery Room, and Professional Fees of Doctors, Surgeons, Nurses	100%	80%	80%
Other Covered Inpatient Services	100%	80%	80%
Dental and Vision Discounts – Programs Are Not Insurance	Discounts through FACT membership provided by Health Allies – save up to 50% on dental and vision.		
Optional Benefits – For a complete list, see page 10.	• $5 Million Lifetime Maximum Benefit • Prescription Drug Card Benefit • Term Life Benefit	• Enhanced Preventive Care Benefits Package • First-Dollar Accident Benefit • Maternity Benefit	

Preferred price card and Discount card details

Preferred price card – Receive the lowest price available from your chosen pharmacy at the time of purchase on prescription drugs. You pay for the prescription at the point of sale and submit a claim to Golden Rule for reimbursement based on your medical plan.

Discount card – If you choose a plan without an outpatient drug benefit, this card allows you to obtain prescription drugs at an average savings of 20% to 25%.*

This chart only summarizes standard covered expenses, exclusions, and limitations of each plan. 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. We recommend review of the more detailed plan information on pages 11-16 and the state variations on pages 17-19.

*Discounts vary by pharmacy, geographic area, and drug.

Copay Plans

Convenient Doctor Office Copay Benefits

Copay plans are more like traditional employer plans with a copayment for routine health-care expenses. When you use a Preferred network doctor for an office visit, we pay 100% of history and exam fees after a $35 copay with Copay Select℠. Office visit expenses outside your network are not eligible for copay benefits.

Adult and Child Preventive Care Included

You pay $35 for the doctor office visit with Copay Select℠. X-rays and lab tests are covered at 80% — you pay 20%.

Prescription Drug* Card Benefits (Copay Select℠ Only)

- Tier 1 drugs — $15 copay.
- Tiers 2-4 drugs — combined $150 per person, per calendar-year deductible, then:

  — $30 copay for Tier 2 drugs.

  — $60 copay for Tier 3 drugs.

  — 25% coinsurance (you pay) for Tier 4 drugs.

Comprehensive Coverage for Inpatient and Outpatient Medical Expenses (Copay Select℠ Only)

- You choose $3 million or $5 million lifetime maximum benefit per covered person.
- Covered inpatient and outpatient expenses are reimbursed at 80% once the deductible has been met.

Copay Saver℠

The Copay Saver℠ plan provides the convenience of copays for doctor office visits (limited to 2 visits per person, per calendar year) for a lower monthly premium.

Who might benefit most from a Copay Select℠ plan?

- Anyone who prefers the convenience of copay benefits for routine health-care expenses.
- Families with young children who have regularly scheduled doctor office visits.
- Adults who want copay benefits for preventive care and prescription drugs.

*We have a preferred drug list, which changes periodically.

Benefit Highlights:	Copay Select℠	Copay Saver℠
Design Basics		
Calendar-Year Deductible Choices (maximum 2 per family, per calendar year)	You pay: $500, $1,000, $1,500, $2,500, or $5,000	You pay: $1,500, $2,500, or $5,000
Coinsurance After Deductible (per covered person, per calendar year)	You pay: 20% to $2,000 We pay: 80% to $8,000, then, 100%	You pay: 20% to $3,000 We pay: 80% to $12,000, then, 100%
Lifetime Maximum Benefit (per covered person)	$3 million ($5 million available)	$3 million ($5 million available)
Initial Rate Guarantee (subject to benefit and address changes)	12 months	12 months
	We pay the percentages below AFTER you pay the deductible unless otherwise indicated.	
Preventive Care Benefits		
Doctor Office Visit (X-ray and lab performed in the doctor's office or a network facility. Go to *www.goldenrule.com* to find a lab near you.)	(Not subject to deductible) History and exam: $35 copay X-ray and Lab: 80%	Not covered
Child Immunizations (age 0-18)	Vaccine: 80% (not subject to deductible)	Not covered
Preventive Mammogram, Pap Smear, PSA Testing	Testing: 80% (not subject to deductible)	Testing: 80%
Outpatient Expense Benefits		
Doctor Office Visit – Illness & Injury (not subject to the deductible)	For history and exam: $35 copay	For history and exam: $35 copay, then 100% (maximum 2 visits per person, per year – with an option to buy 2 more, see page 10)
Outpatient X-ray and Lab (performed in the doctor's office or a network facility. Go to *www.goldenrule.com* to find a lab near you.)	80%	80% if performed within 14 days of surgery or confinement
Outpatient Prescription Drugs* (Maximum $3,000 per covered person, per calendar year for Copay Select℠. Or choose the optional Prescription Drug Benefit Buy-Up to eliminate this annual limit. See page 10.)	Tier 1 drugs – $15 copay Tiers 2-4 drugs – combined $150 per person, per calendar-year deductible, then: Tier 2 drugs – $30 copay Tier 3 drugs – $60 copay Tier 4 drugs – you pay 25% coinsurance	Generic: $15 copay Name-brand: not covered (Texas, see page 18)
Surgeon, Assistant Surgeon, and Facility Fees	80%	80%
Hemodialysis, Radiation, Chemotherapy, and Organ Transplant Drugs	80%	80%
CAT Scans, MRIs	80%	80%
Emergency Room Fees	Illness: 80%, additional $100 copay if not admitted Injury: 80%	Illness & Injury: 80%, additional $500 copay if not admitted
Other Covered Outpatient Expenses	80%	See page 12
Inpatient Expense Benefits		
Room and Board, Intensive Care Unit, Operating Room, Recovery Room, and Professional Fees of Doctors, Surgeons, Nurses	80%	80%
Other Covered Inpatient Services	80%	80%
Dental and Vision Discounts – Programs Are Not Insurance	Discounts through FACT membership provided by Health Allies – save up to 50% on dental and vision.	
Optional Benefits – For a complete list, see page 10.	• $5 Million Lifetime Maximum Benefit • First-Dollar Accident Benefit • Term Life Benefit • Maternity Benefit	• Enhanced Preventive Care Benefits Package • Two Additional Doctor Office Visits (Copay Saver℠) • Prescription Drug Benefit Buy-Up (Copay Select℠)

This chart only summarizes standard covered expenses, exclusions, and limitations of each plan. 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. We recommend review of the more detailed plan information on pages 11-16 and the state variations on pages 17-19.

*NOTE: Tier status for a prescription drug may be determined by accessing your prescription drug benefits via our Web site or by calling the telephone number on your identification card. The tier to which a prescription drug is assigned may change as detailed in your policy/certificate.

Health Savings Account (HSA) Plans

HSA Plans Offer Quality Coverage, Savings

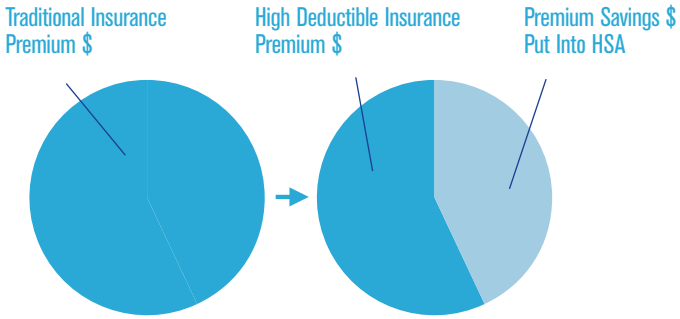
HSA Plans simply combine a lower-cost, high deductible health insurance plan and a tax-favored savings account.

Lower Premiums, Tax-Advantaged Savings, and an Attractive Interest Rate*

High deductible plans typically cost a lot less than many copay or traditional plans. This means lower premiums for you. You can then take the premium savings and place it into your health savings account.

- You get a tax deduction on the money you put in your HSA.
- Your dollars can grow tax-deferred.
- You spend the savings tax-free to help pay your deductible or for qualified medical care (including prescriptions, vision, or dental care).
- What you don't use in your account will continue to accumulate year after year. Then, if you ever need it for health-care expenses, the money will be there.
- With Golden Rule's HSA custodian, you'll also earn interest on your savings, beginning with the first dollar deposited.

Bottom line — HSAs can help make health insurance more affordable.



Who might benefit most from a Health Savings Account plan?

- Persons interested in more control over how their health-care dollars are spent.
- Families interested in one annual deductible per family.
- Those interested in trading low deductible health insurance for a higher deductible plan to save money on monthly premiums and taxes.

*See HSA insert for important information.

Benefit Highlights:	HSA 100®	HSA Saver®
Design Basics		
Calendar-Year Deductible Choices (one per family)	See HSA insert	See HSA insert
Coinsurance After Deductible	You pay: Nothing We pay: 100%	You pay: Nothing We pay: 100%
Lifetime Maximum Benefit (per covered person)	$3 million ($5 million available)	$3 million ($5 million available)
Initial Rate Guarantee (subject to benefit and address changes)	12 months	12 months
	We pay the percentages below AFTER you pay the deductible unless otherwise indicated.	
Preventive Care Benefits		
Doctor Office Visit (X-ray and lab performed in the doctor's office or a network facility. Go to *www.goldenrule.com* to find a lab near you.)	For history and exam: 100% X-ray and Lab: 100%	Not covered
Child Immunizations (age 0-18)	Vaccine: 100%	Not covered
Preventive Mammogram, Pap Smear, PSA Testing	Testing: 100%	Testing: 100%
Outpatient Expense Benefits		
Doctor Office Visit – Illness & Injury	100%	Not covered
Outpatient X-ray and Lab (performed in the doctor's office or a network facility. Go to *www.goldenrule.com* to find a lab near you.)	100%	100% if performed within 14 days of surgery or confinement
Outpatient Prescription Drugs	100% Preferred price card included	Not covered – Discount card included
Surgeon, Assistant Surgeon, and Facility Fees	100%	100%
Hemodialysis, Radiation, Chemotherapy, and Organ Transplant Drugs	100%	100%
CAT Scans, MRIs	100%	100%
Emergency Room Fees	100%	100% if admitted; if not admitted – limited to $250/person/year
Other Covered Outpatient Expenses	100%	See page 12 for details
Inpatient Expense Benefits		
Room and Board, Intensive Care Unit, Operating Room, Recovery Room, and Professional Fees of Doctors, Surgeons, Nurses	100%	100%
Other Covered Inpatient Services	100%	100%
Dental and Vision Discounts – Programs Are Not Insurance	Discounts through FACT membership provided by Health Allies – save up to 50% on dental and vision.	
Optional Benefits – For a complete list, see page 10.	• $5 Million Lifetime Maximum Benefit • Term Life Benefit	• Enhanced Preventive Care Benefits Package • HSA Hospital Indemnity Rider

Preferred price card and Discount card details

Preferred price card – Receive the lowest price available from your chosen pharmacy at the time of purchase on prescription drugs. You pay for the prescription at the point of sale and submit a claim to Golden Rule for reimbursement based on your medical plan.

Discount card – If you choose a plan without an outpatient drug benefit, this card allows you to obtain prescription drugs at an average savings of 20% to 25%.*

This chart only summarizes standard covered expenses, exclusions, and limitations of each plan. 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. We recommend review of the more detailed plan information on pages 11-16 and the state variations on pages 17-19.

*Discounts vary by pharmacy, geographic area, and drug.

Optional Benefits

Further customize your health insurance coverage to meet your specific needs. Additional premium required.

$5 Million Lifetime Maximum Benefit

This option is not available in VA.

Upgrade your coverage to $5,000,000 of covered expenses per person.

Enhanced Preventive Care Benefits Package

This option is available with any Preferred network plan except Copay Select℠; not available in AK.

- $35 copay on each preventive care office visit (primary care, OBGYN, etc).
- The following charges for preventive care that are performed in conjunction with the office visit are exempt from the deductible and coinsurance whether performed in the doctor's office or elsewhere:
  - Child (under age 19) and adult immunizations.
  - Mammogram, cervical and Pap smears, PSA.
  - Urinalysis and blood tests.
  - Bone density screens.
  - EKG and cardiac stress tests.

Prescription Drug Card Benefit

This option is only available with Plan 100® and Plan 80℠.

With this benefit, you pay:

- Tier 1 drugs – $15 copay.
- Tiers 2-4 drugs – combined $150 per person, per calendar-year deductible, then:
  - Tier 2 drugs – $30 copay.
  - Tier 3 drugs – $60 copay.
  - Tier 4 drugs – you pay 25% coinsurance.

(Maximum $3,000 per covered person, per calendar year.)

Prescription Drug Benefit Buy-Up

This option is only available with Copay Select℠.

Eliminates the $3,000 annual limit.

Two Additional Doctor Office Visits

This option is only available with Copay Saver℠.

Increase the number of Copay Doctor Office Visits from 2 to 4 per person, per calendar year.

First-Dollar Accident Benefit

This option is only available with Plan 100®, Plan 80℠, Saver 80℠, Copay Select℠, and Copay Saver℠.

This benefit provides up-front coverage for unexpected injuries and is limited to your choice of $500 or $1,000 of first-dollar coverage for treatment of an injury within 90 days of an accident. Plan deductible must be greater than or equal to the maximum benefit amount.

HSA Hospital Indemnity Rider

This option is only available with HSA 100® and HSA Saver℠.

HSA Hospital Indemnity Rider is designed to help protect against major hospitalization expenses during early months of coverage when cash hasn't yet accumulated in your savings account. (See HSA insert for details.)

Maternity Benefit

This option is only available with Plan 100®, Plan 80℠, Saver 80℠, Copay Select℠, and Copay Saver℠; not available in AR, MD, NC, or VA.

This optional benefit helps cover the costs for routine pregnancy and delivery. You pay 20%; we pay 80% of covered expenses. After 4 benefit years, the maximum covered expense amount is $7,500.

No covered expenses will be considered for reimbursement for a pregnancy beginning before the maternity benefit's effective date.

Benefit Years	Maximum Covered Expense	Maximum We Pay
1 & 2	$2,500	$2,000
3 & 4	$5,000	$4,000
5+	$7,500	$6,000

Covered Expenses

Subject to all policy provisions, the following expenses are covered.

Copay Select℠, HSA 100®, Plan 100®, and Plan 80℠

Medical Expense Benefits

- Daily hospital* room and board and nursing services at the most common semiprivate rate.
- Charges for intensive care unit.
- Hospital emergency room treatment of an injury or illness (subject to an additional $100 copay each time the emergency room is used for an illness not resulting in confinement – does not apply to HSA Plans).
- Services and supplies, including drugs and medicines, which are routinely provided by the hospital to persons for use while they are inpatients.
- Professional fees of doctors and surgeons (but not for standby availability).
- Dressings, sutures, casts, or other necessary medical supplies.
- Professional fees for outpatient services of licensed physical therapists.
- Diagnostic testing using radiologic, ultrasonographic, or laboratory services in or out of the hospital.
- Local ground ambulance service to the nearest hospital for necessary emergency care. Air ambulance, within U.S., if requested by police or medical authorities at the site of emergency.
- Charges for operating, treatment, or recovery room for surgery.
- Dental expenses due to an injury which damages natural teeth if expenses are incurred within six months.
- Surgical treatment of TMJ disorders (see limitations on page 14).
- Cost and administration of anesthetic, oxygen, and other gases.
- Radiation therapy or chemotherapy.
- Prescription drugs.
- Hemodialysis, processing, and administration of blood and components.
- Mammography, Pap smear, and PSA test fees.
- Artificial eyes, larynx, breast prosthesis, or basic artificial limbs (but not replacements).
- Surgery in a doctor's office or at an outpatient surgical facility, including services and supplies.
- Occupational therapy following a covered treatment for traumatic hand injuries.
- Rehabilitation and extended care facility services that begin within 14 days of a 3-day or more hospital stay, for the same illness or injury. Combined calendar year maximum of 60 days for both rehabilitation and extended care facilities expenses.

Preventive Care Expense Benefits

- No waiting period for wellness benefits. See pages 5, 7, and 9 for coverage details.

For information on additional Plan provisions, including Transplant Expense Benefit, Limited Exclusion for AIDS or HIV-related Disease, Notification Requirements, Preexisting Conditions, General Exclusions, General Limitations, and Other Plan Provisions, read pages 13-16.

*Hospital does not include a nursing home or convalescent home or an extended care facility.

Covered Expenses (continued)

Subject to all policy provisions, the following expenses are covered.

Saver Plans — Copay Saver℠, HSA Saver®, and Saver 80℠

Inpatient Expense Benefits

- Daily hospital* room and board and nursing services at the most common semiprivate rate.
- Charges for intensive care unit.
- Drugs, medicines, dressings, sutures, casts, or other necessary medical supplies.
- Artificial limbs, eyes, larynx, or breast prosthesis (but not replacements).
- Professional fees of doctors and surgeons (but not for standby availability).
- Hemodialysis, processing, and administration of blood or components.
- Charges for an operating, treatment, or recovery room for surgery.
- Cost and administration of an anesthetic, oxygen, or other gases.
- Radiation therapy or chemotherapy and diagnostic tests using radiologic, ultrasonographic, or laboratory services.
- Local ground ambulance service to the nearest hospital for necessary emergency care. Air ambulance, within U.S., if requested by police or medical authorities at the site of the emergency.

Outpatient Expense Benefits

- Charges for outpatient surgery, including the fee made by an outpatient surgical facility, the primary surgeon, the assistant surgeon, and/or administration of anesthetic.
- Hemodialysis, radiation, and chemotherapy.
- Prescription drugs to protect against organ rejection in transplant cases.
- Mammography, Pap smear, and PSA test fees.
- Hospital emergency room treatment of an injury or illness (subject to limitations shown on pages 5, 7, and 9).
- CAT scan and MRI testing.
- Diagnostic testing related to, and performed within, 14 days prior to surgery or inpatient confinement.
- Copay Saver℠ plan includes two doctor office copay visits per year (see page 7).
- Copay Saver℠ plan includes coverage for generic prescription drugs (see page 7).

Important note about Saver Plans:

Premiums for Saver Plans are significantly less because coverage is not provided for most outpatient services. Outpatient expenses not specifically listed in the policy are not covered. Please review the Saver Plans' inpatient and outpatient expense benefits, exclusions, and limitations for details.

Some outpatient expenses not covered under the Saver Plans include:

- Outpatient doctor office visit fees (limited benefit provided under Copay Saver℠ – see page 7), diagnostic testing, prescription drugs (limited benefit provided under Copay Saver℠ – see page 7), and other outpatient medical services not specifically listed under the Inpatient, Outpatient, or Transplant Expense Benefits;
- Outpatient professional fees of licensed physical therapists, durable medical equipment, and medical supplies, except those covered under the Home Health Care Expense Benefits;
- Outpatient expenses incurred for mental or nervous disorders or substance abuse; and
- Preventive care office visits (unless the optional Preventive Care Package is added).

*Hospital does not include a nursing home or convalescent home or an extended care facility.

Provisions That Apply to All Plans

This brochure is only a general outline of the coverage provisions. It is not an insurance contract, nor part of the insurance policy or certificate. You'll find complete coverage details in the policy and certificates. In most cases, coverage will be determined by the master policy issued in Illinois and subject to Illinois law.

Health-Care Provider Networks

Choosing a Preferred network offers you a significant premium discount, and in most cases, an extensive network of doctors and hospitals.* Otherwise, Golden Rule health insurance plans include access to one of our savings-based networks.

Transplant Expense Benefit

The following types of transplants are eligible for coverage under the Medical Benefits provision:

Cornea transplants, artery or vein grafts, heart valve grafts, and prosthetic tissue replacement, including joint replacements and implantable prosthetic lenses, in connection with cataracts.

Transplants eligible for coverage under the Transplant Expense Benefit are:

Heart, lung, heart and lung, kidney, liver, and bone marrow transplants.

Golden Rule has arranged for certain hospitals around the country (referred to as our "Centers of Excellence") to perform specified transplant services. If you use one of our "Centers of Excellence," the specified transplant will be considered the same as any other illness and will include a transportation and lodging incentive (for a family member) of up to $5,000. Otherwise, the acquisition cost for the organ or bone marrow will not be covered, and covered expenses related to the transplant will be limited to $100,000 and one transplant in a 12-month period.

To qualify as a covered expense under the Transplant Expense Benefit, the covered person must be a good candidate, and the transplant must not be experimental or investigational. In considering these issues, we consult doctors with expertise in the type of transplant proposed.

The following conditions are eligible for bone marrow transplant coverage:

Allogenic bone marrow transplants (BMT) for treatment of: Hodgkin's lymphoma or non-Hodgkin's lymphoma, severe aplastic anemia, acute lymphocytic and nonlymphocytic leukemia, chronic myelogenous leukemia, severe combined immunodeficiency, Stage III or IV neuroblastoma, myelodysplastic syndrome, Wiskott-Aldrich syndrome, thalassemia major, multiple myeloma, Fanconi's anemia, malignant histiocytic disorders, and juvenile myelomonocytic leukemia.

Autologous bone marrow transplants (ABMT) for treatment of: Hodgkin's lymphoma, non-Hodgkin's lymphoma, acute lymphocytic and nonlymphocyctic leukemia, multiple myeloma, testicular cancer, Stage III or IV neuroblastoma, pediatric Ewing's sarcoma and related primitive neuroectodermal tumors, Wilms' tumor, rhabdomyosarcoma, medulloblastoma, astrocytoma, and glioma.

Notification Requirements

You must notify us by phone on or before the day a covered person:

- Begins the fourth day of an inpatient hospitalization; or
- Is evaluated for an organ or tissue transplant.

Failure to comply with Notification Requirements will result in a 20% reduction in benefits, to a maximum of $1,000.

If it is impossible for you to notify us due to emergency inpatient hospital admission, you must contact us as soon as reasonably possible.

Our receipt of notification does not guarantee either payment of benefits or the amount of benefits. Eligibility for and payment of benefits are subject to all terms and conditions of the policy. You may contact Golden Rule for further review if coverage for a health-care service is denied, reduced, or terminated.

Preexisting Conditions

Preexisting conditions will not be covered during the first 12 months after an individual becomes a covered person. This exclusion will not apply to conditions that are both: (a) fully disclosed to Golden Rule in the individual's application; and (b) not excluded or limited by our underwriters.

A preexisting condition is an injury or illness: (a) for which a covered person received medical advice or treatment within 24 months prior to the applicable **effective date** for coverage of the illness or injury; or (b) which manifested symptoms which would cause an ordinarily prudent person to seek diagnosis or treatment within 12 months prior to the applicable **effective date** for coverage of the illness or injury.

Limited Exclusion for AIDS or HIV-Related Disease

AIDS or HIV-related disease are treated the same as any other illness unless the onset of AIDS or HIV-related disease is: (a) diagnosed before the coverage has been in force for one year; or (b) first manifested before the coverage has been in force for one year. If diagnosed or first manifested before coverage has been in force for one year, AIDS or HIV-related disease claims will never be covered. Details of this limited exclusion are set forth in the policy and certificates.

*Using UnitedHealthcare Choice Plus network, available in most areas.

General Exclusions

No benefits are payable for expenses which:

- Are due to pregnancy (except for complications of pregnancy) or routine newborn care (unless optional coverage is selected, if available).
- Are for routine or preventive care unless provided for in the policy.
- Are incurred while confined primarily for custodial, rehabilitative, or educational care or nursing services.
- Result from or in the course of employment for wage or profit, if the covered person is insured, or is required to be insured, by workers' compensation insurance pursuant to applicable state or federal law. If you enter into a settlement that waives a covered person's right to recover future medical benefits under a workers' compensation law or insurance plan, this exclusion will still apply.
- Are in relation to, or incurred in conjunction with, investigational treatment.
- Are for dental expenses or oral surgery, eyeglasses, contacts, eye refraction, hearing aids, or any examination or fitting related to these.
- Are for modification of the physical body, including breast reduction or augmentation.
- Are incurred for cosmetic or aesthetic reasons, such as weight modification or surgical treatment of obesity.
- Would not have been charged in the absence of insurance.
- Are for eye surgery to correct nearsightedness, farsightedness, or astigmatism.
- Result from war, intentionally self-inflicted bodily harm (whether sane or insane), or participation in a felony (whether or not charged).
- Are for treatment of temporomandibular joint disorders, except as may be provided for under covered expenses.
- Are incurred for animal-to-human organ transplants, artificial or mechanical organs, procurement or transportation of the organ or tissue, or the cost of keeping a donor alive.
- Are incurred for marriage, family, or child counseling.
- Are for recreational or vocational therapy or rehabilitation.
- Are incurred for services performed by an immediate family member.
- Are not specifically provided for in the policy or incurred while your certificate is not in force.
- Are for any drug treatment or procedure that promotes conception.
- Are for any procedure that prevents conception or childbirth.
- Result from intoxication, as defined by applicable state law in the state where the illness or injury occurred, or under the influence of illegal narcotics or controlled substances unless administered or prescribed by a doctor.
- Are for or related to surrogate parenting.
- Are for or related to treatment of hyperhidrosis (excessive sweating).
- Are for fetal reduction surgery.
- Are for alternative treatments, except as specifically identified as covered expenses under the policy/certificate, including: acupressure, acupuncture, aromatherapy, hypnotism, massage therapy, rolfing, and other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.

Benefits will not be paid for services or supplies that are not medically necessary to the diagnosis or treatment of an illness or injury, as defined in the policy.

General Limitations

- Expenses incurred by a covered person for treatment of tonsils, adenoids, middle ear disorders, hemorrhoids, hernia, or any disorders of the reproductive organs are not covered during the covered person's first six months of coverage under the policy. This provision will not apply if treatment is provided on an "emergency" basis. "Emergency" means a medical condition manifesting itself by acute signs or symptoms that could reasonably result in placing a person's life or limb in danger if medical attention is not provided within 24 hours.
- Covered expenses will not include more than what was determined to be the reasonable and customary charge for a service or supply.
- Transplants eligible for coverage under the Transplant Expense Benefit are limited to two transplants in a 10-year period.
- Charges for an assistant surgeon are limited to 20% of the primary surgeon's covered fee.
- Covered expenses for surgical treatment of TMJ, excluding tooth extractions, are limited to $10,000 per covered person.
- All diagnoses or treatments of mental disorders, as defined in the policy, including substance abuse, are limited to a lifetime maximum benefit of $3,000 (not covered in Saver Plans, subject to state variations). Covered expenses for outpatient diagnosis or treatment of mental disorders are further limited to $50 per visit. As with any other illness or injury, inpatient care that is primarily for educational or rehabilitative care is not covered.

- Covered outpatient expenses relating to diagnosis or treatment of any spine or back disorders are limited to a maximum of $2,000 per calendar year. CAT scan and MRI tests are not subject to this limitation.
- Covered expenses are limited to no more than a 34-day supply for any one outpatient prescription drug order or refill.

Effective Date

For **injuries**, the effective date for a mailed application will be the later of: (a) the requested effective date, if any, shown on the application; or (b) the date upon which the original application is actually received by Golden Rule.

For an application sent by any electronic method, the effective date for injuries will be the later of: (a) the requested effective date, if any, shown on the application; or (b) the day after the date upon which the application is actually received by Golden Rule.

The effective date for **illnesses** will be the same as for injuries if you are replacing prior coverage within 62 days of application for this coverage and disclose replacement information on the initial application for insurance. If replacement information is not disclosed on the initial application for insurance, the effective date for illnesses will be the 15th day after the effective date for injuries. Illnesses that begin prior to that 15th day will be treated as preexisting conditions and will not be covered until the individual has been a covered person for 12 months.

Premium

We may adjust the premium rates from time to time. Premium rates are set by class, and you will not be singled out for a premium change regardless of your health. The policy plan, age and sex of covered persons, type and level of benefits, time the certificate has been in force, and your place of residence are factors that may be used in setting rate classes. Premiums will increase the longer you are insured.

Home Health Care

To qualify for benefits, home health care must be provided through a licensed home health-care agency.

Covered expenses for home health aide services are limited to seven visits per week and a lifetime maximum of 365 visits. Registered nurse services are limited to a lifetime maximum of 1,000 hours.

Hospice Care

To qualify for benefits, a Hospice Care program for a terminally ill covered person must be licensed by the state in which it operates. Benefits for inpatient care in a hospice are limited to 180 days in a covered person's lifetime. Covered expenses for room and board are limited to the most common semiprivate room rate of the hospital or nursing home with which the hospice is associated.

Dependents

For purposes of this coverage, eligible dependents are your lawful spouse and eligible children. Eligible children must be unmarried and under 25 years of age at time of application.

Termination of a Covered Person

A covered person's coverage will terminate on the date that person no longer meets the eligibility requirements or if the covered person commits fraud or intentional misrepresentation.

Continued Eligibility Requirements

A covered person's eligibility will cease on the earlier of the date a covered person:

- Ceases to be a dependent; or
- Becomes insured under an individual plan providing medical or hospital, surgical, or medical services or benefits. (This does not apply to stand-alone cancer, ICU, or accident-only policies.)

Renewability

You may renew coverage by paying the premium as it comes due. We may decline renewal only:

- For failure to pay premium; or
- If we decline to renew all certificates just like yours issued to everyone in the state where you are then living.

Underwriting

Coverage will not be issued as a supplement to other health plans that you may have at the time of application. Plans are subject to health underwriting.

Conditions Prior to Legal Action

To help resolve disputes before litigation, the policy requires that you provide us with written notice of intent to sue as a condition prior to legal action. This notice must identify the source of the disagreement, including all relevant facts and information supporting your position. Unless prohibited by law, any action for extra-contractual or punitive damages is waived if the contract claims at issue are paid or the disagreement is resolved or corrected within 30 days of the written notice.

Group — COB

If, after coverage is issued, a covered person becomes insured under a group plan, benefits will be determined under the Coordination of Benefits (COB) clause. COB allows two or more plans to work together so that the total amount of all benefits will never be more than 100% of covered expenses. COB also takes into account medical coverage under auto insurance contracts.

Medicare — Carve-Out

Covered persons who reach the age of Medicare eligibility and obtain Medicare coverage may continue coverage under these plans. Benefits will be provided according to the Medicare Carve-Out Benefit Reduction provision. Basically, “carve-out” pays the difference between what Golden Rule benefits normally would pay and what is paid by Medicare.

State Variations

Please review the information provided below, which summarizes the major variations in coverage by state from these described in this brochure.

Alaska

- Copay Plans are not available in this state.
- Formulas necessary for the treatment of phenylketonuria are covered the same as any other illness.

Arizona

- The references to 24 and 12 months in the definition of a preexisting condition are changed to 6 months.
- The limited exclusion for AIDS does not apply.
- Portability plans (guarantee issue without preexisting conditions exclusions) are available to eligible applicants. Review the application for insurance for details.

Arkansas

- The exclusion for TMJ disorders does not apply.
- Limited coverage is provided for children's preventive health care services.
- Child immunizations are not subject to the deductible.

Colorado

- The limitation on expenses incurred during the first six months for treatment of tonsils, adenoids, middle ear disorders, hemorrhoids, hernia, or any disorders of the reproductive organs does not apply.
- The 14-day waiting period for the coverage of illnesses does not apply.
- The preexisting conditions limitation is reduced from 24 to 6 months.
- The limited exclusion for AIDS does not apply.
- Limited routine newborn care.
- Expenses for mammography exams, prostate screening, and child health services are not subject to the deductible.
- Mental or nervous disorders: The exclusion under the Saver Plans and the $3,000 lifetime limit under other plans are removed. Instead, you will receive certain limited benefits mandated by Colorado.
- Certain types of biologically based mental illnesses are covered, subject to all the terms and conditions of the certificate.
- No benefits will be paid for treatment of intractable pain as defined in the certificate.
- Notification requirements do not apply.

CoverColorado Notice Form

You and/or your dependents may qualify for health insurance from CoverColorado as Eligible Individuals, as defined under the federal "Health Insurance Portability and Accountability Act of 1996."

Generally, you are eligible if you:

- Have had 18 months of continuous prior health insurance coverage;
- Were most recently covered under a group health plan;*
- Have elected and exhausted COBRA or state continuation of benefits coverage;
- Are not eligible for any other group health coverage, Medicare, or Medicaid; and
- Do not have other health insurance.

* *Group health plan = coverage existing in connection with employment.*

You also may be eligible for participation in the plan, without first requiring application to a carrier for health coverage, if a licensed physician has diagnosed you with a medical condition that is on the list of presumptive medical conditions established by the CoverColorado Board of Directors.

Other eligibility requirements, exclusions, and limitations may apply.

You may apply to CoverColorado for a determination of your eligibility for insurance on application forms available from CoverColorado. A premium will be charged for this insurance if your application is accepted.

For more information regarding CoverColorado, including benefits and exclusions, please contact:

Plan Representative
CoverColorado
425 South Cherry Street, Suite 160
Glendale, CO 80246
(877) 461-3811
(800) 259-2656 (TDD)

District of Columbia

- All treatments of mental disorders, as defined in the policy, will be limited to: (a) 60 days per calendar year for inpatient treatment in a hospital or in a certified residential facility; (b) 40 outpatient visits per calendar year at a certified outpatient treatment facility payable at 75% coinsurance; additional outpatient visits in each calendar year shall be payable at 60% coinsurance. Maximum lifetime benefits for any one covered person for all losses due to mental disorders shall not exceed 1/3 of policy maximum.
- All treatments of substance abuse, as defined in the policy, will be limited to: (a) 12 days per calendar year for inpatient detoxification; (b) 60 days per calendar year for inpatient treatment in a hospital or in a certified residential facility; (c) 40 outpatient visits per calendar year at a certified outpatient treatment facility or office of a licensed physician, psychologist, or social worker payable at 75% coinsurance. Additional outpatient visits in each calendar year shall be payable at 60% coinsurance. Maximum lifetime benefits for any one covered person for all losses due to substance abuse shall not exceed $3,000.
- Expenses for mammography exams and Pap smears are not subject to the deductible, copayment, or coinsurance.
- Well-child care services from birth to age 21 are a covered expense.
- The exclusion of expenses incurred as a result of the covered person being intoxicated or under the influence of narcotics does not apply.

Indiana

- The limited exclusion for AIDS does not apply.
- The preexisting conditions reference to treatment within 24 months prior to the applicable effective date is changed to 12 months. This 12-month waiting period may be reduced for persons previously covered by small employer coverage.

Iowa

- The spine and back limitation does not apply.
- The preexisting conditions 12-month waiting period may be reduced for persons covered by qualifying prior coverage.
- The limited exclusion for AIDS does not apply.
- The optional maternity benefit does not cover maternity expenses until 300 days after the rider effective date.

Maryland

- The limited exclusion for AIDS does not apply.

Michigan

- The reference to 24 months in the definition of a preexisting condition is changed to 6 months.
- **Provider Network Continuity of Treatment:** If your provider leaves the network while you are receiving treatment for an "injury or illness," your first subsequent visit will be covered as if your provider were still in the network, and we will notify you that the provider is no longer a network provider so that you may choose a new network provider.
- **Grievance Procedure Information Phone Number:** (317) 297-4189. Upon request, we will provide you with the telephone number for the Michigan Department of Consumer and Industry Services.
- Expenses incurred for diagnosis and treatment of pain are covered expenses the same as any other illness or injury.

Mississippi

- The references to 24 and 12 months in the definition of a preexisting condition are changed to 6 months.

Quality Assurance Program Summary

If you select a UnitedHealthcare network, UnitedHealthcare will administer its Quality Improvement Program to improve your health-care experience. Components of the program include:

- Providing Clinical Profile reports on key clinical measures to your physician or other health-care providers so he or she can deliver better quality medical care to you and your family;
- Public accountability through the accreditation process and reporting to regulatory agencies;
- Credentialing the physician and provider network; and
- Reporting on, and improving performance on, clinical measures and measures of customer satisfaction.

Missouri

- The limited exclusion for AIDS does not apply.
- Portability plans (guarantee issue without preexisting conditions exclusions) are available to eligible applicants. Review the application for insurance for details.
- The exclusion for intentionally self-inflicted bodily harm does not apply if the intentionally self-inflicted bodily harm resulted from a suicide attempt while insane.
- The exclusion for suicide while insane in the Decreasing Term Life Insurance Rider does not apply.
- Notification Requirements do not apply.
- Covered child immunizations as specified under Missouri law are exempt from deductible and coinsurance until a child's sixth birthday.

Nebraska

- Child immunizations for your covered dependent children from birth through age 5 are covered, not subject to the deductible.

North Carolina

- Nonsurgical treatment of TMJ is provided, up to a lifetime maximum of $3,500.
- The lifetime maximum for surgical treatment of TMJ does not apply.
- Portability plans (guarantee issue without preexisting conditions exclusions) are available to eligible applicants. Review the application for insurance for details.
- Occupational injuries or illnesses are not covered expenses if paid under the North Carolina Workers' Compensation Act.
- The preexisting conditions reference to treatment within 24 months prior to the applicable effective date is changed to 12 months. This 12-month waiting period may be reduced for persons covered by qualifying prior coverage.
- The limited exclusion for AIDS does not apply.

Ohio

- On all plans except Saver Plans: The lifetime maximum benefit limit for inpatient diagnosis or treatment of a mental disorder or substance abuse (as defined) and for outpatient diagnosis or treatment of substance abuse is $3,000 per covered person; professional fees of a medical practitioner for outpatient treatment of substance abuse are limited to $50 per visit; and professional fees of a medical practitioner for outpatient diagnosis and treatment of a mental disorder are limited to $550 per covered person, per calendar year.
- The limited exclusion for AIDS does not apply.
- State of Ohio Basic and Standard portability plans (guarantee issue without preexisting conditions exclusions) are available to eligible applicants.
- Limited coverage is provided for child health supervision services.
- Diagnosis and treatment of alcoholism on an outpatient business, or an intermediate primary care services basis, are limited to a combined maximum benefit of $550 per calendar year.
- Diagnosis and treatment of a biologically based mental illness are covered, subject to all the terms and conditions of the certificate.

Oklahoma

- Expenses for mammography exams are not subject to the deductible or coinsurance.
- The spine and back limitation does not apply.
- The preexisting conditions 12-month waiting period may be reduced for persons covered by qualifying prior coverage.
- Covered child immunizations are not subject to the deductible.

Pennsylvania

- Covered child immunizations are not subject to the deductible.
- Formulas or nutritional supplements for PKU and other metabolic disorders are covered and are not subject to the deductible.

South Carolina

- The preexisting conditions reference to treatment within 24 months prior to the applicable effective date is changed to 12 months. This 12-month waiting period may be reduced for persons covered by qualifying prior coverage.

Tennessee

- Portability plans (guarantee issue without preexisting conditions exclusions) are available to eligible applicants. Review the application for insurance for details.

Texas

- Copay Saver℠ prescription drugs not covered.
- Treatment of TMJ disorders is covered the same as any other illness.
- Formulas necessary for the treatment of phenylketonuria are covered the same as any other illness.
- The optional maternity benefit is added by use of a rider and requires additional premium.
- With respect to fees charged for covered expenses, reasonable and customary charges mean the most common charge for similar expenses within the area in which the expense is incurred so long as these charges are reasonable. What is reasonable and customary will be determined by Golden Rule based on the factors stated in the policy.
- Inpatient diagnosis or treatment of mental or nervous disorders or mental incapacity is covered the same as any other illness, subject to the $3,000 lifetime maximum benefit and other terms of the policy. For example, as with any other illness or injury, inpatient treatment which is primarily for educational or rehabilitative care will not be covered.
- If a designated "Center of Excellence" is not used for a listed transplant, covered expenses will be reduced by 25%.
- A preexisting condition is an injury or illness for which the covered person received medical advice or treatment within the 12 months immediately preceding the effective date of coverage.
- Limited benefits are provided for the diagnosis and treatment of chemical dependency.
- AIDS and HIV-related disease claims are limited to $5,000 per calendar year, provided the conditions under the limited exclusion for AIDS or HIV-related disease are met.
- Medically necessary is a defined term and means that a service, medicine, or supply is necessary and appropriate for the treatment of an illness or injury as determined by Golden Rule based on factors stated in the policy.
- The Coordination of Benefits provision also takes into account personal injury protection coverage, whether provided under a group or individual contract.
- Covered child immunizations are not subject to the deductible.
- Notification requirements do not apply.
- The 14-day waiting period for the coverage of illnesses does not apply.

Virginia

- Work-related injuries are covered unless benefits are payable by Workers' Compensation.

- **Coordination of Benefits:** If, after Golden Rule coverage is issued, a person becomes insured under (an)other group plan(s), benefits of the plans will be determined under the Coordination of Benefits (COB) clause. One plan will be determined to pay primary based on COB rules described in the policy/certificate. Some of the rules which usually result in a plan paying primary include: not having an appropriate COB clause; covering a person as other than a dependent; with regard to a dependent covered under both parents' plans, the plan issued to the parent with the earlier date of birth or determined to be primary under the terms of a court decree or determinations based on custody; covering the person as an active employee/dependent of an active employee; or which plan has provided coverage longer.
- Portability plans (guarantee issue without preexisting conditions exclusions) are available to eligible applicants. Review the application for insurance for details.

West Virginia

- The lifetime maximum benefit for all diagnosis or treatment of mental disorders, including substance abuse, is $10,000.
- The exclusion of TMJ disorders does not apply.
- Covered child immunizations are not subject to the deductible.
- Portability plans (guarantee issue without preexisting conditions exclusions) are available to eligible applicants. Review the application for insurance for details.

Wisconsin

- The limited exclusion for AIDS does not apply.
- The spine and back limitation does not apply.
- Covered expenses for all diagnoses or treatments of mental or nervous disorders and substance abuse are subject to the deductible and coinsurance, and are limited to a policy year maximum benefit of $7,000. Outpatient treatment is further limited to a maximum benefit of $2,000.
- Limited coverage for nonsurgical treatment of TMJ disorders is provided.
- Covered child immunizations are not subject to the deductible.
- Covered expenses for home health aide services are limited to 40 visits in a 12-month period.

NOTICE OF INFORMATION PRACTICES

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We (including our affiliates listed at the end of this notice) are required by law to protect the privacy of your health information. We are also required to send you this notice, which explains how we may use information about you and when we can give out or "disclose" that information to others. You also have rights regarding your health information that are described in this notice.

The terms "information" or "health information" in this notice include any personal information that is created or received by a health care provider or health plan that relates to your physical or mental health or condition, the provision of health care to you, or the payment for such health care.

We have the right to change our privacy practices. If we do, we will provide the revised notice to you within 60 days by direct mail or post it on our Web sites listed at the bottom of this page.

How We Use or Disclose Information

We must use and disclose your health information to provide information:

- To you or someone who has the legal right to act for you (your personal representative);
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected; and
- Where required by law.

We have the right to use and disclose health information to pay for your health care and operate our business. For example, we may use your health information:

- **For Payment** of premiums due us and to process claims for health care services you receive.
- **For Treatment.** We may disclose health information to your physicians or hospitals to help them provide medical care to you.
- **For Health Care Operations.** We may use or disclose health information as necessary to operate and manage our business and to help manage your health care coverage. For example, we might conduct or arrange for medical review, legal services, and auditing functions, including fraud and abuse detection or compliance programs.
- **To Provide Information on Health Related Programs or Products** such as alternative medical treatments and programs or about health related products and services.
- **To Plan Sponsors.** If your coverage is through an employer group health plan, we may share summary health information and enrollment and disenrollment information with the plan sponsor. In addition, we may share other health information with the plan sponsor for plan administration if the plan sponsor agrees to special restriction on its use and disclosure of the information.
- **For Appointment Reminders.** We may use health information to contact you for appointment reminders with providers who provide medical care to you.

We may use or disclose your health information for the following purposes under limited circumstances:

- **To Persons Involved With Your Care.** We may use or disclose your health information to a person involved in your care, such as a family member, when you are incapacitated or in an emergency, or when permitted by law.
- **For Public Health Activities** such as reporting disease outbreaks.
- **For Reporting Victims of Abuse, Neglect, or Domestic Violence** to government authorities, including a social service or protective service agency.
- **For Health Oversight Activities** such as governmental audits and fraud and abuse investigations.
- **For Judicial or Administrative Proceedings** such as in response to a court order, search warrant or subpoena.
- **For Law Enforcement Purposes** such as providing limited information to locate a missing person.
- **To Avoid a Serious Threat to Health or Safety** by, for example, disclosing information to public health agencies.
- **For Specialized Government Functions** such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
- **For Workers Compensation** including disclosures required by state workers compensation laws of job-related injuries.
- **For Research Purposes** such as research related to the prevention of disease or disability, if the research study meets all privacy law requirements.
- **To Provide Information Regarding Decedents.** We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as necessary to carry out their duties.
- **For Organ Procurement Purposes.** We may use or disclose information for procurement, banking, or transplantation of organs, eyes, or tissue.

If none of the above reasons apply, **then we must get your written authorization to use or disclose your health information.** If a use or disclosure of health information is prohibited or materially limited by other applicable law, it is our intent to meet the requirements of the more stringent law. In some states, your authorization may also be required for disclosure of your health information. In many states, your authorization may be required in order for us to disclose your highly confidential health information. Once you give us authorization to release your health information, we cannot guarantee that the person to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization, except if we have already acted based on your authorization. To revoke an authorization, contact the phone number listed on your ID card.

What Are Your Rights

The following are your rights with respect to your health information.

- **You have the right to ask to restrict** uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures to family members or to others who are involved in your health care or payment for your health care. We may also have policies on dependent access that may authorize certain restrictions. **Please note that while we will try to honor your request and will permit requests consistent with its policies, we are not required to agree to any restriction.**
- **You have the right to ask to receive confidential communications** of information in a different manner or at a different place (for example, by sending information to a P.O. Box instead of your home address).
- **You have the right to see and obtain a copy** of health information that may be used to make decisions about you such as claims and case or medical management records. You also may receive a summary of this health information. You must make a written request to inspect and copy your health information. In certain limited circumstances, we may deny your request to inspect and copy your health information.
- **You have the right to ask to amend** information we maintain about you if you believe the health information about you is wrong or incomplete. We will notify you within 30 days if we deny your request and provide a reason for our decision. If we deny your request, you may have a statement of your disagreement added to your health information. We will notify you in writing of any amendments we make at your request. We will provide updates to all parties that have received information from us within the past two years (seven years for support organizations).
- **You have the right to receive an accounting** of disclosures of your information made by us during the six years prior to your request. This accounting will not include disclosures of information: (i) made prior to April 14, 2003; (ii) for treatment, payment, and health care operations purposes; (iii) to you or pursuant to your authorization; and (iv) to correctional institutions or law enforcement officials; and (v) other disclosures that federal law does not require us to provide an accounting.
- **You have the right to a paper copy of this notice.** You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice upon request. In addition, you may obtain a copy of this notice at our Web sites, *www.eAMS.com* or *www.goldenrule.com.*

Exercising Your Rights

- **Contacting your Health Plan.** If you have any questions about this notice or want to exercise any of your rights, please call the phone number on your ID card.
- **Filing a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with us at the following address: Golden Rule Insurance Company, Privacy Officer, 7440 Woodland Drive, Indianapolis, IN 46278-1719

You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint. **We will not take any action against you for filing a complaint.**

Fair Credit Reporting Act Notice

In some cases, we may ask a consumer-reporting agency to compile an investigative consumer report about you. If we request such a report, we will notify you promptly with the name and address of the agency that will furnish the report. You may request in writing to be interviewed as part of the investigation. The agency may retain a copy of the report. The agency may disclose it to other persons as allowed by the federal Fair Credit Reporting Act.

We may disclose information solely about our transactions or experiences with you to our affiliates.

Medical Information Bureau

In conjunction with our membership in the Medical Information Bureau (MIB), we or our reinsurers may make a report of your personal information to MIB. MIB is a nonprofit organization of life and health insurance companies that operates an information exchange on behalf of its members.

If you submit an application or claim for benefits to another MIB member company for life or health insurance coverage, the MIB, upon request, will supply such company with information regarding you that it has in its file.

If you question the accuracy of information in the MIB's file, you may seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. Contact MIB at: MIB, Inc., P.O. Box 105, Essex Station, Boston, MA 02112, (866) 692-6901, *www.mib.com* or (TTY) (866) 346-3642.

FINANCIAL INFORMATION PRIVACY NOTICE

We (including our affiliates listed at the end of this notice) are committed to maintaining the confidentiality of your personal financial information. For the purposes of this notice, "personal financial information" means information, other than health information, about an insured or an applicant for health care coverage that identifies the individual, is not generally publicly available and is collected from the individual or is obtained in connection with providing health care coverage to the individual.

We collect personal financial information about you from the following sources:

- Information we receive from you on applications or other forms such as name, address, age and social security number; and
- Information about your transactions with us, our affiliates or others, such as premium payment history.

We do not disclose personal financial information about our insureds or former insureds to any third party, except as required or permitted by law.

We restrict access to personal financial information about you to employees, affiliates, and service providers who are involved in administering your health care coverage or providing services to you. We maintain physical, electronic, and procedural safeguards that comply with federal standards to guard your personal financial information.

We may disclose personal financial information to financial institutions which perform services for us. These services may include marketing our products or services or joint marketing of financial products or services.

The Notice of Information Practices, effective November 2006, is provided on behalf of American Medical Security Life Insurance Company; Golden Rule Insurance Company; PacifiCare Life & Health Insurance Company; All Savers Insurance Company; and UnitedHealthcare, Inc.

To obtain an authorization to release your personal information to another party, please go to the appropriate Web site listed at the bottom of the page.

TO BE COMPLETED BY BROKER ONLY IF PERSONALLY COLLECTING INITIAL PREMIUM PAYMENT.

CONDITIONAL RECEIPT FOR _____ **THIS FORM LIMITS OUR LIABILITY.**

Proposed Insured: _____

Amount Received: _____ Date of Receipt: _____

NO INSURANCE WILL BECOME EFFECTIVE UNLESS ALL SIX CONDITIONS PRIOR TO COVERAGE ARE MET. NO PERSON IS AUTHORIZED TO ALTER OR WAIVE ANY OF THE FOLLOWING CONDITIONS. YOUR CANCELLED CHECK WILL BE YOUR RECEIPT.

THIS CONDITIONAL RECEIPT DOES NOT CREATE ANY TEMPORARY OR INTERIM INSURANCE AND DOES NOT PROVIDE ANY COVERAGE EXCEPT AS EXPRESSLY PROVIDED IN THE CONDITIONS PRIOR TO COVERAGE.

Patrick F. Carr

Signature of Secretary

Signature of Agent/Broker

CONDITIONS PRIOR TO COVERAGE (APPLICABLE WITH OR WITHOUT THE CONDITIONAL RECEIPT)

Subject to the limitations shown below, insurance will become effective if the following conditions are met:

1. The application is completed in full and is unconditionally accepted and approved by Golden Rule Insurance Company (Golden Rule).
2. The person is a member of the Federation of American Consumers and Travelers.
3. All medical examinations, if required, have been satisfactorily completed.
4. The persons proposed for insurance must be, on the effective date for injuries, not less than a standard risk acceptable to Golden Rule according to its regular underwriting rules and standards for the exact plan and amount of insurance applied for.
5. The first full premium, according to the mode of premium payment chosen, has been paid on or prior to the effective date for injuries, and any check is honored on first presentation for payment.
6. The certificate is: (a) issued by Golden Rule exactly as applied for within 45 days from date of application; (b) delivered to the proposed insured; and (c) accepted by the proposed insured.

Definitions:

1. "Satisfactorily completed" means that no adverse medical conditions or abnormal findings have been detected which would lead Golden Rule to decline issuing the certificate or to issue a specially ridered certificate.
2. "Effective date for injuries" for a mailed application means the later of: (a) the requested effective date, if any, shown on the application; or (b) the date upon which the original application is actually received by Golden Rule.
3. "Effective date for injuries" for an application sent by any electronic method means the later of: (a) the requested effective date, if any, shown on the application; or (b) the day after the date upon which the application is actually received by Golden Rule.

Limitation:

If, for any reason, Golden Rule declines to issue a certificate or issues a certificate other than a standard certificate as applied for, Golden Rule shall incur no liability under this receipt except to return any premium amount received. Interest will not be paid on premium refunds.

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

If you intend to lapse or otherwise terminate existing insurance and replace it with a new plan from Golden Rule, you should be aware of and seriously consider certain factors that may affect your coverage under the new plan.

1. Full coverage will be provided under the new plan for preexisting health conditions: (a) that are fully disclosed in your application; and (b) for which coverage is not excluded or limited by name or specific description. Other health conditions that you now have may not be immediately or fully covered under the new plan. This could result in a claim for benefits being denied, reduced, or delayed under the new plan, whereas a similar claim might have been payable under your present plan.
2. If after due consideration, you still wish to terminate your present insurance and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history.
3. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of or addition to your present plan. You should be certain that you understand all the relevant factors involved in replacing or adding to your present coverage.
4. Finally, we recommend that you not terminate your present plan until you are certain that your application for the new plan has been accepted by Golden Rule.

A COPY OF YOUR AUTHORIZATION FOR ELECTRONIC FUNDS TRANSFER (EFT)

I (we) hereby authorize FACT or Golden Rule to initiate debit entries to the account indicated below. I also authorize the named depository to debit the same to such account.

I agree this authorization will remain in effect until you actually receive written notification of its termination from me.

In Tennessee and Texas, drafts may only be scheduled on 1) the premium due date; or 2) up to 10 days after the due date.

A COPY OF YOUR AUTHORIZATION TO OBTAIN AND DISCLOSE HEALTH INFORMATION

I authorize Golden Rule Insurance Company's Insurance Administration and Claims Departments to obtain health information that they need to underwrite or verify my application for insurance. Any health care provider, the Medical Information Bureau (MIB), or insurance company having any information as to a diagnosis, the treatment, or prognosis of any physical or mental conditions about my family or me is authorized to give it to Golden Rule's Insurance Administration and Claims Departments. This includes information related to substance use or abuse.

I understand any existing or future requests I have made or may make to restrict my protected health information do not and will not apply to this authorization, unless I revoke this authorization.

Golden Rule may release this information about my family or me to the MIB or any member company for the purposes described in Golden Rule's Notice of Information Practices.

I (we) have received Golden Rule's Notice of Information Practices. This authorization shall remain valid for 30 months from the date below.

I (we) understand the following:

- A photocopy of this authorization is as valid as the original.
- I (we) or my (our) authorized representative may obtain a copy of this authorization by writing to Golden Rule.
- I (we) may request revocation of this authorization as described in Golden Rule's Notice of Information Practices.
- Golden Rule may condition enrollment in its health plan or eligibility for benefits on my (our) refusal to sign this authorization.
- The information that is used or disclosed in accordance with this authorization may be redisclosed by the receiving entity and may no longer be protected by federal or state privacy laws regulating health insurers.

I have retained a copy of this authorization.

Failure to include all material medical information, correct information regarding the tobacco use of any applicant, or information concerning other health plans may cause the Company to deny a future claim and to void your coverage as though it has never been in force. After you have completed the application and before you sign it, reread it carefully. Be certain that all information has been properly recorded.

KEEP THIS DOCUMENT.
IT HAS IMPORTANT INFORMATION.

Health Insurance for Individuals and Families Built with YOU in Mind.

These health insurance plans are issued as association group plans and available only to members of FACT, Federation of American Consumers and Travelers.

What is FACT?

FACT is an independent consumer association whose members benefit from the "pooling" of resources. Benefits range from medical savings to consumer service discounts. If you're not already a member, you are required to join FACT.

Is there a cost for joining FACT?

Yes, the membership dues are simply $3 a month and can be paid with your regular health insurance premium, as opposed to making a separate payment.

What are FACT's association benefits?

FACT makes it possible for members to pick and choose from a full menu of important benefits:

- Dental discounts — you can save up to 50% on general dental, X-rays, and orthodontics
- Vision discounts — typical savings of 20%-60% for eye exams, eyeglasses, contact lenses, and LASIK correction surgery
- Prescription drug discounts
- Van line discounts
- Consumer library
- Consumer hotline referral service
- Amusement park discounts
- Travel service and savings
- Informative newsletter

Plus …

- You may apply for FACT scholarships, classroom grants, and community project grants.
- You are eligible to request financial assistance in the event of a natural disaster.
- You are kept aware of matters of importance through FACT's Eye-on-Washington Reports.

Benefits and suppliers change from time to time. For the most current information, visit FACT's Web site at *www.usafact.org* or call toll-free at 1-800-USA-FACT.

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UnitedHealthcare®
Underwritten By Golden Rule