UnitedHealthOne

Personal Health Insurance

Plans For Individuals & Families

Choices you want.
Coverage you need.®

UnitedHealthOne

Golden Rule Insurance Company, a UnitedHealthcare company, is the underwriter and administrator of these plans.

Health Insurance Available Only to Members of FACT. Policy Forms C-006.3, C-006.4, MGR03928

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Why Choose Us for Health Insurance?

UnitedHealthcare

Approximately 25 million customers entrust UnitedHealthcare with their health insurance needs.* Our network plans can ease access to high-quality care from physicians and hospitals nationwide. We combine our strength and stability with nearly three decades of experience serving customers of all sizes, including individuals and families buying their own health coverage.

UnitedHealthOne

UnitedHealthOne is the brand name of the UnitedHealthcare family of companies that offers personal health insurance products. Golden Rule Insurance Company, a UnitedHealthcare company, is the underwriter and administrator of these plans. With over 60 years of experience serving individuals and families, Golden Rule provides 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.

Our Goal: Your Satisfaction

We understand the importance of your time and concern for the value of your health-care dollars. Our customers benefit from strong discounts on quality health-care coverage made possible when using our vast network of quality health-care providers. Our goal for every customer is an insurance plan at a price that fits his or her needs and budget. UnitedHealthOne — *Choices you want. Coverage you need.®*

Quality Coverage from a Proven Company

Leave it to the experts

For over 60 years, Golden Rule has served individuals and families purchasing their own health insurance. Our experience and expertise has driven the development of plans that strive to make health coverage more affordable for more Americans. With our sole focus of serving individuals and families, we understand the unique needs of individuals — like you — shopping for personal health insurance.

Don't just take our word for it

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.

Fast claims processing

We recognize the critical importance of being responsive to the service needs of our customers. That's why more than 94% of all health insurance claims are processed within 10 working days or less.**

Big network, big savings

You can find many providers in your area with more than 700,000 physicians and care professionals and 5,200 hospitals nationwide in the UnitedHealthcare network.* Plus, our network can offer you provider discounts with a national average of up to 50% on quality health care.***

Initial rate guarantees

Benefit from securing your initial premium amount for 12 months.****

Benefits for a lifetime

Each of our plans gives you the protection of an unlimited lifetime benefit.

Coverage for your children

Your children can benefit from coverage until they reach the age of 26.

Get the specialized care you need

If you require care from a specialist, a referral is not required — making it easier for you to receive the care you need.

In case of emergency

From state to state, even travelling outside the U.S., you can rest assured knowing that in a medical emergency, coverage is available.

Membership has its benefits

FACT members have access not only to UnitedHealthOne health plans from Golden Rule, but also Accidental Death benefits and discounts on a wide range of services, pet coverage, and even travel expenses. See the back cover of this brochure for more details.

Health Reform Ready

Our plans will provide the benefits and meet the requirements of the Patient Protection and Affordable Care Act (these are non-grandfathered plans).

* UnitedHealth Group Annual Form 10-K for year ended 12/31/09.
** Actual 2009 results.
*** Discounts vary by provider, geographic area, and type of service.
**** See pages 7, 9, and 11 for details.

Which Plan Best Fits Your Needs?

A Variety of Plans to Choose From

Whether you are seeking lower-cost health insurance, experienced a recent change in employment or family status, or are self-employed, we can 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
Copay Plan A set copay means convenience. You know what you'll owe for a basic visit to a network doctor and for prescriptions.	Anyone who prefers the convenience of copay benefits for minor or routine health-care expenses. Families with children who have regularly scheduled doctor office visits. Anyone who prefers copay benefits for prescription drugs.	Copay Select℠ More Comprehensive	Lower	Higher	6
High Deductible Plans Simple to understand and use. Insurance coverage for big medical bills.	Anyone seeking lower-cost protection from unexpected accidents and illnesses. Early retirees needing a bridge to Medicare. Anyone willing to take responsibility for minor or routine health-care expenses in exchange for lower premiums.	Plan 100® More Comprehensive	Lower	Higher	8
		Plan 80℠ More Affordable	Higher	Lower	8
		Saver 80℠ Even More Affordable	Higher	Lower	8
Health Savings Account Plans An insurance plan + a savings account. You may cover your annual deductible with dollars you save. Plus, the savings are tax-advantaged like an IRA. Your health-care dollars go further!	Persons interested in more control over how their health-care dollars are spent. Families interested in one calendar-year 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	10
		HSA 70℠ More Affordable	Higher	Lower	10

Looking for more ways to save?

We've added a new feature, called Deductible Credit. It can help you reduce your future out-of-pocket expenses. If you don't meet your per-person calendar-year network deductible, the Deductible Credit applies to next year's network deductible. See page 15 for details.

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

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The Network Advantage

Quality Care at Significant Savings

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

Our network gives you:

- 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 of up to 30% or more over the same plans without a network.

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

- Subject to eligible expense limits;
- Reduced by 25%;
- Subject to an additional deductible amount equal to the 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 network:

(Services provided February-March 2010)**

	Charges	Repriced Charges
Dr. Office Visit	$ 159.21	$ 93.40
MRI	$ 792.39	$ 439.62
Lipid Panel	$ 91.41	$ 8.02
CBC	$ 37.10	$ 4.20
Metabolic Panel	$ 45.80	$ 3.94
General Panel	$ 176.23	$ 19.58
Mammogram	$ 269.72	$ 132.33

*UnitedHealthcare Choice Plus network, available in most areas. LabCorp is the preferred laboratory services provider for UnitedHealthcare networks. Network availability may vary by state, and a specific health-care provider's contract status can change at any time. Therefore, before you receive care, it is recommended that you verify with the health-care provider's office that they are still contracted with your chosen network.

**All these services received from network providers in ZIP Code 336--. 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*

Copay Select℠

Convenient Doctor Office Copay Benefits

Designed for individuals and families, Copay Select℠ is more like traditional employer plans with a copayment for routine health-care expenses. When you use a network doctor for an office visit, we pay 100% of history and exam fees after a $35 copay. Office visits outside your network are covered subject to the applicable deductible and your chosen coinsurance.

Prescription Drug* Card Benefits

- Tier 1 drugs — $15 copay, no deductible.
- Tier 2 drugs — $35 copay.
- Tier 3 drugs — $65 copay.
- Tier 4 drugs — you pay 25% coinsurance.

  Tier 2-4 drugs have a combined $500 deductible per person, per calendar year.

Comprehensive Coverage for Inpatient and Outpatient Medical Expenses

- Covered inpatient and outpatient expenses are reimbursed after your chosen coinsurance and the deductible.

Who might benefit most from Copay Select℠?

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

Note: Copay Select℠ is not available in Alaska.

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

In-Network Benefit Highlights

This chart summarizes standard network covered expenses, exclusions, and limitations of each plan. See pages 5, 13-18 for more information.

	Copay Select℠
Deductible Choices (maximum 2 per family, per calendar year)	You pay: $1,000, $1,500, $2,500, $3,500, $5,000, $7,500 or $10,000
Coinsurance Choices (% of covered expenses after deductible)	You pay: 0% 20% 30%
Coinsurance Out-of-Pocket Maximum (per person, per calendar year, after deductible)	$0 $3,000 $5,000
Initial Rate Guarantee (does not apply to benefit & address changes)	12 Months
Physician Care Benefits (Illness & Injury)	
Office Visit, History and Exam (primary care or specialist)	$35 copay — no deductible (4-Dr. Office Visit Copay & $25 Office Visit Copay optional benefits available)
Primary Care Physician/Specialist Referrals Required	No
Prescription Drug Benefits	
If you purchase name-brand when generic is available, you pay your generic copay plus the additional cost above the generic price.	Tier 1 drugs — $15 copay, no deductible. Tier 2-4 drugs — combined $500 deductible per person, per calendar year, then: Tier 2 drugs — $35 copay. Tier 3 drugs — $65 copay. Tier 4 drugs — you pay 25% coinsurance. ($200 Deductible, Generic Only, and Discount Card Only optional benefits available)
Wellness/Preventive Care Benefits (no waiting period, not subject to deductible, coinsurance, or copayments)	
See page 13 for details.	
Outpatient Expense Benefits	
X-ray and lab (performed in the doctor's office or a network facility)	You pay: chosen coinsurance after deductible
Facility/Hospital for Outpatient Surgery	You pay: chosen coinsurance after deductible
Surgeon, Assistant Surgeon, and Facility Fees	You pay: chosen coinsurance after deductible
Hemodialysis, Radiation, Chemotherapy, Organ Transplant Drugs, and CAT Scans, MRIs	You pay: chosen coinsurance after deductible
Emergency Room Fees — Illness	You pay: $100 copay if not admitted, then chosen coinsurance after deductible
Emergency Room Fees — Injury	You pay: chosen coinsurance after deductible
Spine and Back Disorders	You pay: chosen coinsurance after deductible (limited benefit)
Other Outpatient Expenses	You pay: chosen coinsurance after deductible
Inpatient Expense Benefits	
Room and Board, Intensive Care Unit, Operating Room, Recovery Room, Prescription Drugs, Physician Visit, and Professional Fees of Doctors, Surgeons, Nurses	You pay: chosen coinsurance after deductible
Other Inpatient Services	You pay: chosen coinsurance after deductible

High Deductible Plans

Choice of Coverage

With our High Deductible Plans, you select the level of coverage that makes you most comfortable. The higher the deductible, the lower your premiums. And you're keeping more of your money and taking responsibility for covering minor or routine health-care expenses, if they come up.

Lowest Premium Plan

Saver 80[SM] is our lowest premium plan. This plan provides coverage for hospital confinements, surgical procedures in or out of the hospital (but not in the doctor's office), 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®. It pays 100% of covered expenses once you meet your calendar-year deductible. Your benefits are not complicated with multiple copays or coinsurance.

Who might benefit most from a High Deductible Plan?

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

In-Network Benefit Highlights

This chart summarizes standard network covered expenses, exclusions, and limitations of each plan. See pages 5, 13-18 for more information.

	Plan 100®	Plan 80SM	Saver 80SM
Deductible Choices (maximum 2 per family, per calendar year)	You pay: $1,500, $2,500, $5,000, $7,500 or $10,000	You pay: $1,500, $2,500, $5,000, $7,500 or $10,000	You pay: $1,000, $1,500, $2,500, $5,000, $7,500 or $10,000
Coinsurance (% of covered expenses after deductible)	You pay: $0	You pay: 20%	You pay: 20%
Coinsurance Out-of-Pocket Maximum (per person, per calendar year, after deductible)	$0	$3,000	$3,000
Initial Rate Guarantee (does not apply to benefit & address changes)	12 Months	12 Months	12 Months
Physician Care Benefits (Illness & Injury)			
Office Visit, History and Exam (primary care or specialist)	No charge after deductible	You pay: 20% after deductible	Not covered
Primary Care Physician/Specialist Referrals Required	No	No	No
Prescription Drug Benefits			
Preferred price card (You pay for prescriptions at the point of sale, at the lowest price available, and submit a claim to Golden Rule.) -Or- Discount card (You may obtain RX drugs at an average savings of 20-25%. Discounts vary by pharmacy, geographic area, and drug.)	No charge after deductible — Preferred price card (Copay Card and Discount Card Only optional benefits available)	You pay: 20% after deductible — Preferred price card (Copay Card and Discount Card Only optional benefits available)	Not covered — Discount card
Wellness/Preventive Care Benefits (no waiting period, not subject to deductible or coinsurance)			
See page 13 for details.			
Outpatient Expense Benefits			
X-ray and lab (performed in the doctor's office or a network facility)	No charge after deductible	You pay: 20% after deductible	You pay: 20% after deductible (must be performed within 14 days of surgery or confinement)
Facility/Hospital for Outpatient Surgery	No charge after deductible	You pay: 20% after deductible	You pay: 20% after deductible
Surgeon, Assistant Surgeon, and Facility Fees	No charge after deductible	You pay: 20% after deductible	You pay: 20% after deductible (surgery in the doctor's office not covered)
Hemodialysis, Radiation, Chemotherapy, Organ Transplant Drugs, and CAT Scans, MRIs	No charge after deductible	You pay: 20% after deductible	You pay: 20% after deductible
Emergency Room Fees — Illness	You pay: $100 copay if not admitted, then no charge after deductible	You pay: $100 copay if not admitted, then 20% after deductible	You pay: $500 copay if not admitted, then 20% after deductible
Emergency Room Fees — Injury	No charge after deductible	You pay: 20% after deductible	You pay: $500 copay if not admitted, then 20% after deductible
Spine and Back Disorders	No charge after deductible (limited benefit)	You pay: 20% after deductible (limited benefit)	Not covered
Other Outpatient Expenses	No charge after deductible	You pay: 20% after deductible	Not covered (see page 14 for details)
Inpatient Expense Benefits			
Room and Board, Intensive Care Unit, Operating Room, Recovery Room, Prescription Drugs, Physician Visit, and Professional Fees of Doctors, Surgeons, Nurses	No charge after deductible	You pay: 20% after deductible	You pay: 20% after deductible
Other Inpatient Services	No charge after deductible	You pay: 20% after deductible	You pay: 20% after deductible (see page 14 for details)

Health Savings Account (HSA) Plans

HSA Plans Offer Quality Coverage, Savings

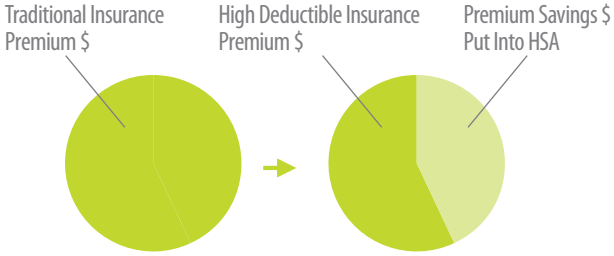
HSA Plans simply combine a lower-cost, high deductible health insurance plan and a tax-favored savings account.

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 calendar-year 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.

In-Network Benefit Highlights

This chart summarizes standard network covered expenses, exclusions, and limitations of each plan. See pages 5, 13-18 for more information.

	HSA 100®	HSA 70SM	
Deductible Choices (per family deductible, per calendar year)	You pay: Single — $1,250, $2,500, $3,000, $3,500 or $5,000 Family — $2,500, $5,000, $6,000, $7,000 or $10,000	You pay: Single — $1,250, $2,500, $3,000, $3,500 or $5,000 Family — $2,500, $5,000, $6,000, $7,000 or $10,000	
Coinsurance (% of covered expenses after deductible)	You pay: $0	You pay: 30%	
Coinsurance Out-of-Pocket Maximum (per calendar year, after deductible per family)	$0	Single (deductible) $3,000 ($1,250) $3,000 ($2,500) $2,600 ($3,000) $2,100 ($3,500) $600 ($5,000)	Family (deductible) $6,000 ($2,500) $6,000 ($5,000) $5,200 ($6,000) $4,200 ($7,000) $1,200 ($10,000)
Initial Rate Guarantee (does not apply to benefit & address changes)	12 Months	12 Months	
Physician Care Benefits (Illness & Injury)			
Office Visit, History and Exam (primary care or specialist)	No charge after deductible	You pay: 30% after deductible	
Primary Care Physician/Specialist Referrals Required	No	No	
Prescription Drug Benefits			
Preferred price card (You pay for prescriptions at the point of sale, at the lowest price available, and submit a claim to Golden Rule.)	No charge after deductible — Preferred price card (Discount Card Only optional benefit available)	You pay: 30% after deductible — Preferred price card (Discount Card Only optional benefit available)	
Wellness/Preventive Care Benefits (no waiting period, not subject to deductible or coinsurance)			
See page 13 for details.			
Outpatient Expense Benefits			
X-ray and lab (performed in the doctor's office or a network facility)	No charge after deductible	You pay: 30% after deductible	
Facility/Hospital for Outpatient Surgery	No charge after deductible	You pay: 30% after deductible	
Surgeon, Assistant Surgeon, and Facility Fees	No charge after deductible	You pay: 30% after deductible	
Hemodialysis, Radiation, Chemotherapy, Organ Transplant Drugs, and CAT Scans, MRIs	No charge after deductible	You pay: 30% after deductible	
Emergency Room Fees	No charge after deductible	You pay: 30% after deductible	
Spine and Back Disorders	No charge after deductible (limited benefit)	You pay: 30% after deductible (limited benefit)	
Other Outpatient Expenses	No charge after deductible	You pay: 30% after deductible	
Inpatient Expense Benefits			
Room and Board, Intensive Care Unit, Operating Room, Recovery Room, Prescription Drugs, Physician Visit, and Professional Fees of Doctors, Surgeons, Nurses	No charge after deductible	You pay: 30% after deductible	
Other Inpatient Services	No charge after deductible	You pay: 30% after deductible	

Health Savings Account Options

About Your HSA

We have chosen **OptumHealth Bank**, Member FDIC, a leading administrator of health savings accounts (HSA), as our financial institution. Your HSA funds are deposited at OptumHealth Bank in a custodial account. OptumHealth Bank will service your account and send information directly to you about your HSA.

You will receive your new OptumHealth Bank Health Savings Account Debit MasterCard® and PIN in separate mailings. Once you activate your card, you can use it at:

- Any point-of-service location (such as a doctor's office or pharmacy) that accepts MasterCard® debit cards.
- Any ATM displaying the MasterCard® brand mark. ($1.50 per transaction OptumHealth Bank fee. In addition, the bank/ATM you use to withdraw funds may charge you its own fee (variable by bank) for the transaction.)

You can also access your HSA funds through:

- Online bill payment at *www.OptumHealthBank.com*
- Checks, if you choose to purchase them.

HSA deposits are set up on the same payment plan as premiums for Golden Rule health insurance coverage. Lump-sum deposits are also accepted by OptumHealth Bank; however, you must continue to deposit the $25 monthly minimum with your premium payment. OptumHealth Bank will provide online monthly statements detailing your account balance and activity. If you prefer to have statements mailed to your home, simply notify OptumHealth Bank. You can opt out of electronic statements at its website (*www.OptumHealthBank.com*), call customer service to do so, or send your request to P.O. Box 271629, Salt Lake City, UT 84127-1629.

Account Information by Phone or Online

With an OptumHealth Bank HSA, your account information is available, day or night, through:

- Toll-free customer service — representatives are available to assist you Monday through Friday, 8 a.m. to 8 p.m. Eastern time, at (866) 234-8913.
- Interactive voice response for self-service, 24/7.
- *www.OptumHealthBank.com*

You can:

- Make contributions to your HSA.
- Pay bills online.
- Check current balance.
- See how much interest has been paid.
- Transfer funds.
- Check last five (5) account transactions (deposits and/or withdrawals).
- Activate the Health Savings Account card.
- Report the card lost or stolen.
- Set or reset password.
- View frequently asked questions.
- View monthly statements.

OptumHealthBank℠

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HSA Management by OptumHealth Bank

HSA Balance Between	Annual Percentage Yield (APY)*	Monthly Maintenance	Minimum Monthly Deposit
$ 0.00 - $ 499.99	0.10%	$3**	$25
$ 500.00 - $ 999.99	0.10%		
$ 1,000.00 - $ 1,999.99	0.70%		
$ 2,000.00 - $ 4,999.99	1.00%		
$ 5,000.00 - $14,999.99	1.50%		
$15,000.00 - Unlimited	2.25%		

Maximum Deposit (Tax-Deductible Limit)	
2010/2011	$3,050 for Singles, $6,150 for Families
Catch-up	Individuals aged 55+ may contribute an additional $1,000 for tax years 2010 & 2011

Who is responsible for my HSA?

As custodian, OptumHealth Bank is responsible for your HSA funds. OptumHealth Bank's deposits are insured by the Federal Deposit Insurance Corporation (FDIC).

Please be aware that the money market and mutual fund investment options are NOT guaranteed by OptumHealth Bank, are NOT FDIC-insured, and may lose value. **We encourage you to read the prospectus of each fund carefully before investing and seek the advice of an investment professional you trust.**

You will receive a OptumHealth Bank Health Savings Account Debit MasterCard® from OptumHealth Bank shortly after your qualified medical coverage becomes effective. **HSA withdrawals** can be made by simply using your Health Savings Account card at any point-of-service location (such as a doctor's office or pharmacy) that accepts MasterCard® debit cards.

If you prefer, you can purchase the qualified health insurance coverage from Golden Rule and set up your savings account with another qualified custodian.

Health Savings Accounts (HSA) — Summary of the Law

Eligibility — Those covered under an qualified high deductible health plan, and not covered by other health insurance (except for vision or dental or other limited coverage) or enrolled in Medicare, and who may not be claimed as a dependent on another person's tax return

HSA Contributions — 100% tax-deductible from gross income

Qualified Medical Withdrawals — Tax-free

Interest Earned — Tax-deferred; if used for qualified medical expenses, tax-free

Nonmedical Withdrawals — Income tax + penalty tax (10% in 2010, 20% in 2011 for those under age 65); income tax only (for age 65 and over)

Death, Disability — Income tax only — no penalty; If the spouse is listed as a beneficiary, the spouse can have the HSA transferred to their name — assume the HSA — no tax issue

Deductible and out-of-pocket maximums may be adjusted annually based on changes in the Consumer Price Index. This is only a brief summary of the applicable federal law. Consult your tax advisor for more details of the law.

Health savings accounts (HSAs) are individual accounts offered by OptumHealth Bank℠, Member FDIC, and are subject to eligibility and restrictions, including but not limited to restrictions on distributions for qualified medical expenses set forth in section 213(d) of the Internal Revenue Code. This communication is not intended as legal or tax advice. Please contact a competent legal or tax professional for personal advice on eligibility, tax treatment, and restrictions. Federal and state laws and regulations are subject to change.

*As of 2/1/10, subject to change at any time without notice.

**The $3 monthly maintenance fee is waived when the Average Balance exceeds $5,000.

Optional Benefits

Further customize your health insurance coverage to meet your specific needs.

Benefits to Enhance Your Health Plan

Add more benefits to your plan for an additional premium.

$25 Office Visit Copay

Reduce the doctor office visit copay from $35 to $25.

Available with Copay Select℠.

Prescription Drug — $200 Deductible

Reduce the combined per person, per calendar-year deductible for tier 2-4 drugs from $500 to $200.

Available with Copay Select℠.

Prescription Drug* — Copay Card

With this benefit, you pay:

- Tier 1 drugs — $15 copay, no deductible.
- Tier 2 drugs — $35 copay.
- Tier 3 drugs — $65 copay.
- Tier 4 drugs — you pay 25% coinsurance.

  Tier 2-4 drugs have a combined $500 deductible per person, per calendar year.

If **you** purchase name-brand when generic is available, **you** pay your generic copay plus the additional cost above the generic price.

Available with Plan 100® and Plan 80℠.

Term Life Benefit

You may choose an optional term life insurance benefit for you and/or your spouse who is also a covered person under the health plan. You and/or your spouse must be age 18 or older. The term life benefit expires when a covered person reaches age 65.

You select one of three benefit amounts. You may select different amounts for you and your spouse.

Benefit Amounts:	$50,000	$100,000	$150,000

Accidental Death Benefit

This benefit provides $50,000 in coverage in the event of an accidental death for you and/or your spouse who is also a covered person under the health plan. You and/or your spouse must be age 18 or older. The accidental death benefit expires when a covered person reaches age 65. It may be purchased with or without the term life benefit.

Motorcyclists are not eligible for this benefit.

Mental Disorders and Substance Abuse

This benefit covers expenses for the diagnosis and treatment of mental disorders and substance abuse like any other illness. Charges are subject to your plan's deductible, coinsurance, or copayment amounts.

Not available with Saver 80℠ except in AR. Not available in DC, NC, OH, TX, and WI.

Benefits to Reduce Premium

Adjust your plan benefits for a lower premium.

4-Dr. Office Visit Copay

For the first 4 network doctor office visits per person, per calendar year you pay a $35 copay, no deductible or coinsurance. For the fifth visit, and thereafter, you pay your deductible, then coinsurance.

Available with Copay Select℠ and cannot be combined with the $25 Office Visit Copay optional benefit.

Prescription Drug — Discount Card Only

You may obtain prescription drugs at an average savings of 20-25%. Discounts vary by pharmacy, geographic area, and drug. A discount-only card is provided. This discount program (card) is not insurance. By choosing this option, you are replacing the prescription drug insurance on your plan with a discount-only card.

Not available with Saver 80℠.

Prescription Drug — Generic Only

You pay a $15 copay for generic drugs, no deductible. Name-brand prescription drugs are not covered.

Available with Copay Select℠. Not available in TX.

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

Supplemental Accident Benefit

Higher deductibles don't have to be scary!

You may choose an optional Supplemental Accident benefit to reduce your out-of-pocket expenses for unexpected injuries.

- Select a maximum benefit amount: $500, $1,000, $2,500, $5,000, or $10,000, per accident, per covered person.
- Helps cover your deductible or other out-of-pocket medical expenses (before the health insurance starts paying covered expenses).
- Expenses must be eligible for payment under the health insurance and incurred within 90 days of an injury.*
- Any benefit amount paid by the Supplemental Accident benefit will first be credited to the deductible and coinsurance of the health insurance.*
- Any remaining benefit payment will be made either to your health care provider under your assignment of benefits, or to you if you have already paid your provider.
- Additional premium is required for the optional Supplemental Accident benefit rider.
- Exclusions and limitations of the health plan apply to this optional benefit, see product brochure for details.

Accidents happen. Unexpected injuries can hurt your budget. A simple arm fracture treated in the doctor's office can cost $324. However, an open-arm fracture can result in a hospital stay, surgery, and physical therapy — for a total cost of more than $23,000!**

Savings Examples — Supplemental Accident Benefit

	Health Plan Only	Health Plan with up to $2,500 Supplemental Accident Benefit	Health Plan with up to $5,000 Supplemental Accident Benefit
Health Plan deductible	$5,000	$5,000	$5,000
Coinsurance maximum (80/20 to $15,000) for open-arm fracture costing $23,000**	$3,000	$3,000	$3,000
Supplemental Accident Coverage	$0	- $2,500	- $5,000
Your out-of-pocket covered expenses for the calendar-year	**$8,000**	**$5,500**	**$3,000**
Additional yearly Supplemental Accident premium for a single person	N/A	$ 240	$ 300
Additional yearly Supplemental Accident premium for a family	N/A	$ 420	$ 525

Consult a tax advisor regarding whether our HSA plan with the optional Supplemental Accident qualifies for favorable HSA (account) tax treatment.

*_Saver_ plans: This rider will cover some expenses not otherwise covered under a _Saver_ plan. This type of expense will not be credited toward deductible or coinsurance.

**Examples are as of 07/27/09, are for illustration purposes only, and assume all expenses are covered. All these services received from network providers in ZIP Codes 495-- and 110--. Your actual savings may be more or less than this illustration and will vary by several factors.

Golden Rule Insurance Company, a UnitedHealthcare company, is the underwriter and administrator of these plans marketed under the UnitedHealthOne brand.

Availability varies by state. Please see the corresponding health product brochure.

Policy Forms SA-S-861, SA-S-861-09, 6-C-410

39002-G-1110

UnitedHealthOne

Optional Vision Benefit

Keep an eye on your family's vision health by adding our optional Vision Benefit rider to your health plan today. Our extensive vision care network today includes about 24,000 private practice and retail chain providers.* We'll help keep your family seeing clearly, so you can focus on savings!

We're here to help you.

Use *www.myuhcvision.com/goldenrule* to find a provider in your area, access your plan information, see your claim status, find general vision information, and more.

UnitedHealthcare Vision Benefit Rider

You may use a non-network provider, but by staying in-network you are eligible to receive better discounts:

- Eye exam — $10 copay – once every 12 months.
- Frames — $25 copay – once every 24 months.
- Lenses — $25 copay – once every 12 months.
- Contacts in lieu of glasses — $25 copay – once every 12 months.

See how you can save by using our Vision network

Service/Material	In-network You Pay	In-network We Pay[1]	Out-of-network We Pay
Eye exam once every 12 months	$ 10 copay	100%	Up to $ 40
Frames[3] once every 24 months	$ 25 copay[2]	100%	Up to $ 45
Single Vision lenses	$ 25 copay[2]	100%	Up to $ 40
Bifocal lenses	$ 25 copay[2]	100%	Up to $ 60
Trifocal or Lenticular lenses	$ 25 copay[2]	100%	Up to $ 80
Contacts[4] in lieu of glasses	$ 25 copay	100%	Up to $105

[1] After copay.

[2] Purchase frames and lenses at the same time from a Preferred Provider and you pay only one copay.

[3] Frames chosen from the Covered Frames Selection at a Preferred Provider. For non-selection Frames, there is an allowance of $50 wholesale or $130 retail, depending on type of Preferred Provider. No copay with non-selection Frames.

[4] Contacts chosen from the Covered Contact Lens Selection at a Preferred Provider. Non-selection lenses will receive an allowance. No copay for non-selection Contact Lenses.

*Network availability may vary by state, and a specific vision care provider's contract status can change at any time. Therefore, before you receive care, it is recommended that you verify with the vision care provider that he or she is still contracted with the network.

Policy Form SA-S-1356R

UnitedHealthOne is a brand name used for products underwritten by Golden Rule Insurance Company. This product is administered by Spectera, Inc. Additional premium is required. Availability varies by state. Please see the corresponding health product brochure and important information on the back of this page.

38526-G-1110

UnitedHealthOne

Covered Expenses

Subject to all policy provisions, the following vision expenses are covered:

- Comprehensive eye examinations. Benefits are limited to 1 exam per 12 months.
- Prescription eyewear. Benefits are limited to 1 pair of prescription single vision lenses per 12 months and 1 pair of frames per 24 months:
  - Spectacle lenses as prescribed by an ophthalmologist or optometrist; frames and their fitting and subsequent adjustments to maintain comfort and efficiency; or
  - Elective contact lenses that are in lieu of prescription spectacle lenses and frames; and
  - Medically necessary contact lenses and professional services when prescribed or received following cataract surgery or to correct extreme visual acuity problems that cannot be corrected with spectacle lenses.

Please Note: This vision benefit program is designed to cover vision needs rather than cosmetic extras. Cosmetic extras include: blended lenses, oversize lenses, photochromic lenses, tinted lenses except pink #1 or #2, progressive multifocal lenses, coating of a lens or lenses, laminating of a lens or lenses, frames that cost more than the plan allowance, cosmetic lenses, optional cosmetic processes, and UV (ultraviolet) protected lenses.

If you or your covered dependent select a cosmetic extra, the plan will pay the medically necessary costs of the allowed lenses and you or your covered dependent will be responsible for the additional cost of the cosmetic extra.

Definitions

- **Comprehensive eye examination** means an examination by an ophthalmologist or optometrist to determine the health of the eye, including glaucoma tests and refractive examinations to measure the eye for corrective lenses.
- **Medically necessary** means a comprehensive eye examination or prescription eyewear that is necessary and appropriate to determine the health of the eye or correct visual acuity. This determination will be made by us based on our consultation with an appropriate licensed ophthalmologist or optometrist. A comprehensive eye examination or prescription eyewear will not be considered medically necessary if: (A) it is provided only as a convenience to the covered person or provider; (B) it is not appropriate for the covered person's diagnosis or symptoms; or (C) it exceeds (in scope, duration, or intensity) that level of care that is needed to provide safe, adequate, and appropriate diagnosis or treatment to the covered person.
- **Vision benefit preferred provider** is an ophthalmologist or optometrist who has contracted with the vision benefit network and is licensed and otherwise qualified to practice vision care and/or provide vision care materials.
- **Vision benefit non-preferred provider** is any ophthalmologist, optometrist, optician, or other licensed and qualified vision care provider who has not contracted with the vision benefit network to provide vision care services and/or vision care materials.

<u>List of CO Counties with No Participating UHC Vision Providers</u>
Archuleta, Baca, Bent, Cheyenne, Clear Creek, Conejos, Costilla, Crowley, Custer, Dolores, Gilpin, Grand, Gunnison, Hinsdale, Huerfano, Jackson, Kiowa, Kit Carson, Lake, Mineral, Moffat, Ouray, Park, Pitkin, Rio Grande, Routt, Saguache, San Juan, San Miguel, Sedgwick, Summit, Teller, Washington, and Yuma.

How the Vision Program Works

Copayment, deductible amounts and coinsurance may differ when services are rendered and billed directly by a:

A. Vision benefit preferred provider; or

B. Vision benefit non-preferred provider.

We have a contract with a vision benefit network. Vision benefit preferred providers agree to discount their service fees. You or your covered dependents pay any applicable copayments, deductible amount or coinsurance. Vision benefit preferred providers then agree to accept our benefit payment as payment in full for covered expenses.

We do not have a contract with vision benefit non-preferred providers. You or your covered dependent must pay any applicable copayments, deductible amount or coinsurance. After satisfaction of applicable copayments, deductible amount or coinsurance benefits are limited up to the applicable allowance amount.

When the amount of actual charges exceeds the allowance amount, the vision benefit non-network providers may bill you or your covered dependent for the excess amount.

Exclusions and Limitations:

No benefits are payable for the following vision expenses:

- Orthoptics or vision therapy training and any associated supplemental testing;
- Plano lenses (a lens with no prescription on it);
- Replacement of lenses and frames furnished under this plan which are lost or broken except at the normal intervals when services are otherwise available;
- Medical or surgical treatment of the eyes;
- Any eye examination or any corrective eyewear, required by an employer as a condition of employment;
- Corrective vision treatment of an experimental or investigative nature;
- Corrective surgical procedures such as, but not limited to, Radial Keratotomy (RK) and Photo-refractive Keratectomy (PRK);
- Elective contact lenses if prescription spectacle lenses and frames are received in any 12 month period;
- Prescription spectacle lenses and frames if elective contact lenses are received in any 24 month period;
- Eyewear except prescription eyewear;
- Charges that exceed the allowance amount; and
- Services or treatments that are already excluded in the General Exclusions and Limitations section of the certificate or policy.

Discounts on Laser Eye Surgery

An alliance with the Laser Vision Network of America allows our policyholders access to substantial discounts on laser eye surgery procedures from highly reputable providers throughout the U.S.
Laser eye surgery is a noncovered expense.

Covered Expenses

Subject to all policy provisions, the following expenses are covered. To be considered for reimbursement, expenses must qualify as covered expenses and are subject to eligible expense limits unless you use a network provider. Please review the detailed plan information on pages 15-18 and the state variations on pages 19-21.

All Plans

Preventive Care Expense Benefits

Benefits include coverage for the following (depending on the covered person's age):

- Routine vaccines for diseases
- Flu and pneumonia shots
- Routine physical exams, including well-baby and well-child doctor visits
- Screening for high blood pressure, cholesterol, diabetes
- Screening for detection of breast and other cancers through mammogram, pap smear, prostate cancer screening and colorectal screening

Preventive Care benefits are exempt from your plan deductible, coinsurance and copayments when services are provided by a network provider. Preventive health services must be appropriate for the covered person and follow these recommendations and guidelines:

(A) In general - Those of the U.S. Preventive Services Task Force that have an A or B rating;

(B) For immunizations - Those of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

(C) For preventive care and screenings for infants, children and adolescents - Those of the Health Resources and Services Administration; and

(D) For preventive care and screenings for women - Those of the Health Resources and Services Administration that are not included in section (A).

As new recommendations and guidelines are issued, those services will be considered covered expenses when required by the United States Secretary of Health and Human Services, but not earlier than one year after the recommendation or guideline is issued.

Copay Select℠, Plan 100®, Plan 80℠, HSA 100®, and HSA 70℠

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 General Limitations on page 17).
- Cost and administration of anesthetic, oxygen, and other gases.
- Radiation therapy or chemotherapy.
- Prescription drugs.
- Hemodialysis, processing, and administration of blood and components.
- 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.

For information on additional plan provisions, including Transplant Expense Benefit, Notification Requirements, Preexisting Conditions, Limited Exclusion for AIDS or HIV-related Disease, General Exclusions, General Limitations, and Other Plan Provisions, read pages 15-18.

*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. To be considered for reimbursement, expenses must qualify as covered expenses and are subject to eligible expense limits unless you use a network provider. Please review the detailed plan information on pages 15-18 and the state variations on pages 19-21.

Saver 80SM

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 in an outpatient surgical facility, including the fee from the primary surgeon, the assistant surgeon, and/or administration of anesthetic (surgery performed in the doctor's office is not covered).
- Hemodialysis, radiation, and chemotherapy.
- Prescription drugs to protect against organ rejection in transplant cases.
- Hospital emergency room treatment of an injury or illness (subject to an additional $500 copay each time the emergency room is used not resulting in confinement).
- CAT scans and MRI testing.
- Diagnostic testing related to, and performed within 14 days prior to, surgery or inpatient confinement.

Important note about Saver 80SM:

Premiums for Saver 80SM 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 80SM Inpatient and Outpatient Expense Benefits.

Some expenses not covered under Saver 80SM include:

- Outpatient doctor office visit fees (except preventive), diagnostic testing, prescription drugs, 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;
- Expenses incurred for Spine and back disorders.
- Outpatient surgery expenses for a surgery performed in a doctor's office.

For information on additional plan provisions, including Transplant Expense Benefit, Notification Requirements, Preexisting Conditions, Limited Exclusion for AIDS or HIV-related Disease, General Exclusions, General Limitations, and Other Plan Provisions, read pages 15-18.

*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.

Deductible Credit

It can help you reduce your future out-of-pocket expenses. If you don't meet your per-person calendar-year network deductible, the Deductible Credit applies to next year's network deductible.

Each qualified covered person* not meeting the plan's chosen network deductible** for:	Receives this credit for the next calendar year:
1 year	20% of chosen network deductible
2 consecutive years	40% of chosen network deductible
3 or more consecutive years	50% of chosen network deductible

With a Health Savings Account plan (HSA 100® and HSA 70℠), the deductible credit will never reduce the deductible below the minimum required by law to maintain tax-qualified status of the insurance plan. The minimum for 2011 is $1,200 for singles and $2,400 for families.

With the optional Continuity rider, deductible credit is only received when a covered person is "active."

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.

Rehabilitation and Extended Care Facility (ECF) Benefit

Rehabilitation and Extended Care (ECF) expenses are covered if they begin within 14 days of a 3-day or more hospital stay, for the same illness or injury. There is a combined calendar-year maximum of 30 days for both Rehabilitation and ECF expenses.

Home Health Care Expense Benefit

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

Subject to deductible and coinsurance, 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. Intermittent private-duty RN services (up to 4 hours each) limited to $75 per visit, and deemed to be 2 hours applied to the lifetime maximum.

*Must be a covered person and in active status for six consecutive months.
**For family HSA plans, when combined per family deductible is not met.

Provisions That Apply to All Plans (continued)

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 subject to deductible and coinsurance and 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. Bereavement counseling maximum of $250.

Preexisting Conditions

This does not apply to covered persons under age 19.

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: (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.

General Exclusions

No benefits are payable for expenses which:

- Are due to pregnancy (except for complications of pregnancy) or routine newborn care.
- 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, experimental or investigational treatment.
- Are for unproven services.
- 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 for diagnosis or treatment of mental disorders and substance abuse — inpatient and outpatient (unless optional coverage is selected).
- 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.
- Are 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 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.

Provisions That Apply to All Plans (continued)

- 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 (except cancer) 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.
- Covered expenses will not include more than what was determined to be the eligible expense 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.
- Covered outpatient expenses relating to diagnosis or treatment of any spine or back disorders are limited to 15 visits per person, per calendar year. CAT scans 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.
- When using an in-network physician or facility, non-covered expenses may not be eligible for a network provider discount.

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.

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.)

Dependents

For purposes of this coverage, eligible dependents are your lawful spouse and eligible children. Eligible children must be under 26 years of age at time of application.

Effective Date

Unless we agree to an earlier date, the effective date will be the later of: (a) the requested effective date, or (b) 30 days after the application is received by Golden Rule. Both injuries and illnesses will have the same effective date.

Plans issued with an effective date less than 30 days after the application received date will include a 14-day wait for illness coverage.

Eligible Expense

Eligible expense means a covered expense as determined below:

- For Network Providers (excluding Transplant Benefits): the contracted fee with that provider.
- For Non-Network Providers

  - When a covered expense is received as a result of an emergency or as otherwise approved by us, the eligible expense is the lesser of the billed charge or the amount negotiated with the provider.

  - Except as provided above (excluding Transplant Benefits), the fee charged by the provider for the services; or the fee that has been negotiated with the provider; or the fee established by us by comparing rates from one or more regional or national databases or schedules for the same or similar services from a geographical area determined by us; or 110% of the fee Medicare allows for the same or similar services provided in the same geographical area; or a fee schedule that we develop.

Provisions That Apply to All Plans (continued)

Emergency

A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the covered person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Coordination of Benefits (including Medicare)

If, after coverage is issued, a covered person becomes insured under a group plan or Medicare, 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.

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.

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.

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.

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. If you provide incorrect or incomplete information on your insurance application your coverage may be voided or claims denied.

MISSTATEMENT OF TOBACCO USE:

The answer to the question concerning tobacco use on the application is material (legally important) to correct underwriting. If a covered person misstates their tobacco use when applying for coverage, we have the right to cancel coverage, subject to the Recissions clause under Uniform Provisions.

State Variations

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

Alabama

- There are no state variations.

Alaska

- Copay Select℠ is not available in this state.
- Formulas necessary for the treatment of phenylketonuria are covered the same as any other illness.
- Reasonable and customary charges apply in place of eligible expense limits.

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 (you may be eligible for a portability plan if statements 1-6 all apply to you).
  1. I do not have any health insurance coverage.
  2. I have been insured for the last 18 months or more with no lapse in coverage of more than 63 days.
  3. My most recent coverage was under a group health plan, a government plan, or a church plan.
  4. My most recent coverage was not terminated due to nonpayment of premiums, fraud, or intentional misrepresentations.
  5. I am not eligible for any coverage under a group health plan, Medicare, or Medicaid.
  6. I accepted and exhausted any group continuation of coverage (including COBRA) that was offered me.

  If you are eligible and want to apply, talk to your broker or contact us.

Arkansas

- The exclusion for TMJ disorders does not apply.
- Optional Arkansas Hearing Aids Rider (not available with HSA plans.) removes the general exclusion for hearing aids or any examination or fitting related to hearing aids. Covered expenses for hearing aids shall be exempt from any deductible amount, copayment, and coinsurance, with a maximum three-year benefit per covered person of $1,400 per ear.

District of Columbia

- Portability plans (guarantee issue without preexisting conditions exclusions) are available to eligible applicants. Review the application for insurance for details.
- The exclusion of expenses incurred as a result of the covered person being intoxicated or under the influence of narcotics does not apply.
- The limited exclusion for AIDs does not apply.
- The policy provides coverage for mental disorders and substance abuse as required by applicable state law. Specific details are included in the certificate at issue.

Florida

- A child will continue to be eligible after age 26 if the child is unmarried and under age 30.
- Portability plans (guarantee issue without preexisting conditions exclusions) are available to eligible applicants. Review the application for insurance for details.

Illinois

- A child will continue to be eligible after age 26 if the child: is unmarried and under age 30; is an Illinois resident; served in active or reserve branches of the U.S. Armed Forces, and received other than a dishonorable discharge.

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 group 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.

Maryland

- The limited exclusion for AIDS does not apply.
- A "preexisting condition" means an injury or illness for which medical advice, diagnosis, care or treatment was recommended or received within the 12 months immediately preceding the applicable effective date the covered person became insured under the policy/certificate.
- Waiver of preexisting conditions limitation: The preexisting condition limitation shall not apply to a newborn child covered under creditable coverage within 30 days of birth providing there has been no subsequent lapse of coverage of 63 days or greater.
- Covered persons with prior health coverage (creditable) may have the preexisting condition waiting period of this plan reduced. The creditable coverage must be in force within 63 days prior to the effective date of the new health plan. The 12-month preexisting condition waiting period will be reduced by the same number of months that prior creditable coverage was continuously in force. No lapse in prior coverage can be greater than 63 days.

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:** (800) 657-8205. 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.

State Variations (continued)

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.
- 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 optional term life insurance and accidental death benefits does not apply.
- Notification requirements do not apply.

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.
- Nonemergency care provided out-of-network will be: reduced by 25% of the in-network benefit paid rather than 25% of the covered expense. (Still subject to eligible expense limits; and an additional deductible amount equal to the per person, calendar-year deductible.)
- Send medical claims to:
  Golden Rule Insurance Company
  7440 Woodland Dr.
  Indianapolis, IN 46278-1720

Ohio

- The policy provides coverage for mental disorders and substance abuse as required by applicable state law. Specific details are included in the certificate at issue.
- 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.
- A child will continue to be eligible until age 28 if unmarried.

Oklahoma

- 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.

Pennsylvania

- 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.
- The limited exclusion for AIDS does not apply.

Tennessee

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

Texas

- 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.
- 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.
- The limited exclusion for AIDS does not apply.
- Eligible children will also include your grandchild (under 26) who is your dependent for federal income tax purposes at time of application.
- The policy provides coverage for mental disorders and substance abuse as required by applicable state law. Specific details are included in the certificate at issue.
- 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.
- Notification requirements do not apply.
- The 14-day waiting period for the coverage of illnesses does not apply.

State Variations (continued)

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 exclusion of TMJ disorders does not apply.
- 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.
- The policy provides coverage for mental disorders and substance abuse as required by applicable state law. Specific details are included in the certificate at issue.
- Limited coverage for nonsurgical treatment of TMJ disorders is provided.
- Covered expenses for home health aide services are limited to 40 visits in a 12-month period.
- Eligible children must be under 27 years of age at time of application. If age 26 at time of application, must also be unmarried.

NOTICE OF INFORMATION 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 information we maintain that reasonably can be used to identify you and 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 websites located at *www.goldenrule.com* or *www.eams.com*

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); and
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected.

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. We may use your health information for underwriting purposes; however, we are prohibited by law from using or disclosing genetic information for underwriting purposes.
- **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:

- **As Required by Law.** We may disclose information when required by law.
- **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.
- **To Correctional Institutions or Law Enforcement Officials** if you are an inmate of a correctional institution or under the custody of a law enforcement official, but only if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
- **To Business Associates** that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. Our business associates are required, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract. As of 2/17/10, our business associates are also directly subject to federal privacy laws.
- **For Data Breach Notification Purposes.** We may use your contact information to provide legally-required notices of unauthorized acquisition, access, or disclosure of your health information.
- **Additional Restrictions on Use and Disclosure.** Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. "Highly confidential information" may include confidential information under federal laws governing alcohol and drug abuse information and genetic information as well as state laws that often protect the following types of information: HIV/AIDS; mental health; genetic tests; alcohol and drug abuse; sexually transmitted diseases and reproductive health information; and child or adult abuse or neglect, including sexual assault.

If none of the above reasons applies, **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. Authorization is required for the use and disclosure of psychotherapy notes or for marketing. 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 and 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 request that a provider not send health information** to us in certain circumstances if the health information concerns a health-care item or service for which you have paid the provider out of pocket in full.
- **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). We will accommodate reasonable requests where a disclosure of all or part of your health information otherwise could endanger you. We will accept verbal requests to receive confidential communications, but request to modify or cancel a previous confidential communication request must be made in writing. Mail your request to the address listed below.
- **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 certain 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) 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 websites, *www.eAMS.com* or *www.goldenrule.com*.
- In New Mexico, you have the right to be considered a protected person. A "protected person" is a victim of domestic abuse who also is either: (1) an applicant for insurance with us: (2) a person who is or may be covered by our insurance; or (3) someone who has a claim for benefits under our insurance.

Exercising Your Rights

- **Contacting your Health Plan.** If you have any questions about this notice or want to exercise any of your rights, 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:
- Privacy Officer, Golden Rule Insurance Company, 7440 Woodland Drive, Indianapolis, IN 47278-1719
- **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 a consumer report, including potentially an investigative consumer report, about you. If we request an investigative consumer 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 MIB, Inc., formerly known as 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., 50 Braintree Hill Ste. 400, Braintree, MA 02184-8734, (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.

Send written requests to access, correct, amend or delete information to:

- Privacy Officer, Golden Rule Insurance Company, 7440 Woodland Drive, Indianapolis, IN 47278-1719

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 2010, is provided on behalf of American Medical Security Life Insurance Company; Golden Rule Insurance Company; PacifiCare Life and Health Insurance Company; PacifiCare Life Assurance Company, UnitedHealthcare Insurance Company, All Savers Insurance Company; and All Savers Life Insurance Company of California.

To obtain an authorization to release your personal information to another party, please go to appropriate website 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.

_____ _____

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.

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, consumer-reporting agency, MIB, Inc., formerly known as 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.

36228-0709

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.

Personal Health Insurance Built With You in Mind

These health insurance plans are issued as association group plans and available only to members of FACT, the Federation of American Consumers and Travelers. If you're not already a member, enroll now to be eligible to apply for these plans.

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. FACT's principle office is in Edwardsville, Illinois. FACT and Golden Rule are separate organizations. Neither is responsible for the performance of the other. FACT has contracted with Golden Rule to provide its members with access to these health insurance plans. FACT does not receive any compensation from Golden Rule.

Is there a cost for joining FACT?

Yes, there are membership dues and they can be paid with your regular health insurance premium, as opposed to making a separate payment.

What are the Basic plan benefits?

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

- Accidental Death Benefits
- Consumer Information & Hotline
- Retail & Service Discounts
- Travel Discounts
- Pet Coverage
- Scholarships

Need more benefits? Upgrade your membership to a Choice or Elite plan.

- Expanded Accidental Death Benefits
- Enhanced In-Hospital Benefit
- Family Crisis Fund & Disaster Aid
- 24/7 Doctor Consultations
- 24/7 Nurseline
- Entrepreneur/Small Business Package
- Expanded Travel Program
- Dental Discounts
- Vision Discounts
- Prescription Drug Savings
- Wellness Benefits
- Grants
- And much more!

As a member of FACT, your information is kept private and is not shared with any third parties. Please visit *www.usafact.org/privacy_policy.html* for a complete FACT Privacy Statement.

FACT may change or discontinue any of its membership benefits at any time. For the most current information, including full detailed lists of member benefits, visit FACT's website at *www.usafact.org* or call toll-free at (800) USA-FACT.

UnitedHealthOne℠

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