Personal Health Insurance Plans For Individuals and 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 or C-006.4

38960C9-G-0210 (includes: 38960-G-1009, 38959-G-0210, 39002-G-1009, 38222-G-0609, 38221-G-1009)

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Why Choose Us for Health Insurance?

UnitedHealthcare

More than 26 million customers entrust UnitedHealthcare with their health insurance needs.* Our network plans can ease access to high-quality care from physicians and hospitals nationwide. Together, we combine our strength and stability with nearly three decades of experience serving customers of all sizes.

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. You will find we go far beyond the industry average, processing an overwhelming majority of health insurance claims in less than two weeks and offering strong discounts 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.*

We're easy to reach with a toll-free customer service line: (800) 657-8205. We respond quickly to customer questions and concerns.

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Quality Coverage from a Proven Company

Leave it to the experts

For over 60 years, our experience and expertise in the individual health market has driven the development of plans that strive to make health coverage more affordable for more Americans. Because our primary focus is serving individuals and families, we understand the unique needs of people like you.

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 580,000 physicians and care professionals and 4,900 hospitals nationwide in the UnitedHealthcare network.* Plus, our network can offer you provider discounts of up to 35-45% on quality health care.***

Initial rate guarantees

Benefit from securing your initial premium amount for 12 months with an option on all plans to extend up to 24 months.****

Benefits for a lifetime

Each of our plans gives you the protection of a $3 million lifetime benefit with an option to enhance your plan to a $5 million lifetime benefit.

Coverage for your children

Your children can benefit from coverage until they marry or 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, country to country - rest assured knowing that if you have a medical emergency coverage is available, even when travelling outside the U.S.

Membership has its benefits

FACT members have access to not only UnitedHealthOne health plans from Golden Rule, but also discounts on vision, dental, prescription drug, and even travel expenses. See the back cover of this brochure for more.

* As of 1/22/2009.
** Actual 2008 results.
*** Discounts vary by provider, geographic area, and type of service.
**** See pages 7, 9, 11, and 12 for details.

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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 Plans More Traditional Plans — Higher Premiums, Lower Deductible	Anyone who prefers the convenience of copay benefits for routine health-care expenses. Families with children who have regularly scheduled doctor office visits. Adults who want copay benefits for preventive care and prescription drugs.	Copay Select℠ More Comprehensive	Lower	Higher	6
		Copay Saver℠ More Affordable	Higher	Lower	6
Health Savings Account Plans Market-Leading Plans — High Deductible Plan plus Savings Account	Persons interested in more control over how their health-care dollars are spent. Families interested in one 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	8
		HSA 70℠ More Affordable	Higher	Lower	8
High Deductible Plans Simple-to-Understand Plans — Lower Premiums, Higher Deductible	Anyone willing to take responsibility for routine health-care expenses in exchange for lower premiums. Anyone seeking lower-cost protection from unexpected accidents and illnesses. Early retirees needing a bridge to Medicare.	Plan 100® More Comprehensive	Lower	Higher	10
		Plan 80℠ More Affordable	Higher	Lower	10
		Saver 80℠ Even More Affordable	Higher	Lower	10

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

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

New!

Looking for more ways to save?

We've added a new feature just for you, 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.

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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 up to 35%-45% over the same plans without a network.

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

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

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

Sample savings with our network:

(Services provided July 2009)**

	Charges	Repriced Charges
Dr. Office Visit (illness)	$ 160.08	$ 72.04
Mammogram	$ 93.00	$ 41.21
MRI	$2,650.00	$ 733.71
Lab Work — Cholesterol, Glucose, Insulin Fasting	$ 192.00	$ 60.58

*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 478--. 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*

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Copay Plans

Convenient Doctor Office Copay Benefits

Designed for individuals and families, our copay plans are 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 with Copay Select[SM]. Office visits outside your network are covered subject to the applicable deductible and your chosen coinsurance.

Adult and Child Preventive Care Included

After a 3-month waiting period, you pay $35 for the doctor office visit with Copay Select[SM]. X-rays and lab tests are covered after you pay your chosen coinsurance (0%, 20%, or 30%).

Prescription Drug* Card Benefits (Copay Select[SM] Only)

- Tier 1 drugs — $15 copay.
- Tier 2-4 drugs — combined $200 deductible per person, per calendar year, then:
  — $35 copay for Tier 2 drugs.
  — $65 copay for Tier 3 drugs.
  — 25% coinsurance (you pay) for Tier 4 drugs.

Comprehensive Coverage for Inpatient and Outpatient Medical Expenses

(Copay Select[SM] Only)

- You choose $3 million or $5 million lifetime maximum benefit per covered person.
- Covered inpatient and outpatient expenses are reimbursed after your chosen coinsurance and the deductible.

Copay Saver[SM]

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

*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.

Who might benefit most from a copay plan?

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

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Benefit Highlights:	Copay Select℠	Copay Saver℠
Calendar-Year Deductible Choices (maximum 2 per family, per calendar year)	You pay: $500, $1,000, $1,500, $2,500, $3,500, $5,000, $7,500 or $10,000	You pay: $1,500, $2,500, $5,000, $7,500 or $10,000
Coinsurance Choices (% of covered expenses after deductible)	You pay: 0% 20% 30%	You pay: 30%
Coinsurance Out-of-Pocket Maximum (in-network, per person, per calendar year, after deductible)	$0 $3,000 $5,000	$6,000
Lifetime Maximum Benefit (per covered person)	$3 Million ($5 Million plan enhancement available)	$3 Million ($5 Million plan enhancement available)
Initial Rate Guarantee (does not apply to benefit and address changes)	12 Months (24 Months plan enhancement available)	12 Months (24 Months plan enhancement available)
Physicians (Illness & Injury)		
Office Visit — History and Exam (Primary Care or Specialist, in-network only)	$35 copay — no deductible ($25 Copay plan enhancement available)	$35 copay — no deductible, 2 visits per person per calendar year, including wellness office visits (2 Additional Visits plan enhancement available)
Primary Care Physician/Specialist Referrals Required	No	No
Prescription Drugs		
If you purchase name-brand when generic is available, you pay your generic copay plus the additional cost above the generic price (*Copay Select* only).	Tier 1 drugs — $15 copay, no deductible. Tier 2-4 drugs — combined $200 deductible per person, per calendar year, then: Tier 2 drugs — $35 copay. Tier 3 drugs — $65 copay. Tier 4 drugs — you pay 25% coinsurance.	Generic: $15 copay, no deductible Brand: not covered (Texas, see page 20)
Annual Maximum (covered expense, per person, per calendar year)	$3,000 (No Annual Max. plan enhancement available)	Not Applicable
Wellness/Preventive Care Benefits (3-month waiting period, not subject to deductible unless otherwise indicated)		
Doctor Office Visit (adult or child, in-network only)	$35 copay	$35 copay — subject to visit limit stated above
X-ray and lab (in conjunction with the preventive office visit, performed in the doctor's office or a network facility)	You pay: chosen coinsurance	Not covered
Child Immunizations (ages 0-18)	You pay: chosen coinsurance	Not covered
Preventive Mammogram, Pap Smear, PSA screening (no waiting period, see pages 13-14 for additional covered benefits)	You pay: chosen coinsurance	You pay: 30% after deductible
Outpatient Expense Benefits		
X-ray and lab (performed in the doctor's office or a network facility)	You pay: chosen coinsurance after deductible	You pay: 30% after deductible (Must be performed within 14 days of surgery or confinement)
Facility/Hospital for Outpatient Surgery	You pay: chosen coinsurance after deductible	You pay: 30% after deductible
Surgeon, Assistant Surgeon, and Facility Fees	You pay: chosen coinsurance after deductible	You pay: 30% after deductible (Surgery in the doctor's office not covered)
Hemodialysis, Radiation, Chemotherapy, Organ Transplant Drugs, and CAT Scans, MRIs	You pay: chosen coinsurance after deductible	You pay: 30% after deductible
Emergency Room Fees — Illness	You pay: $100 copay if not admitted, then chosen coinsurance after deductible	You pay: $500 copay if not admitted, then 30% after deductible
Emergency Room Fees — Injury	You pay: chosen coinsurance after deductible	You pay: $500 copay if not admitted, then 30% after deductible
Spine and Back Disorders (CAT scan and MRI tests are not subject to this limitation)	You pay: chosen coinsurance after deductible (Limited benefit)	Not covered
Mental and Nervous Disorders (including substance abuse)	You pay: chosen coinsurance after deductible (Limited benefit)	Not covered
Other Outpatient Expenses	You pay: chosen coinsurance after deductible	Not covered
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	You pay: 30% after deductible
Other Inpatient Services	You pay: chosen coinsurance after deductible	You pay: 30% after deductible

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

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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*

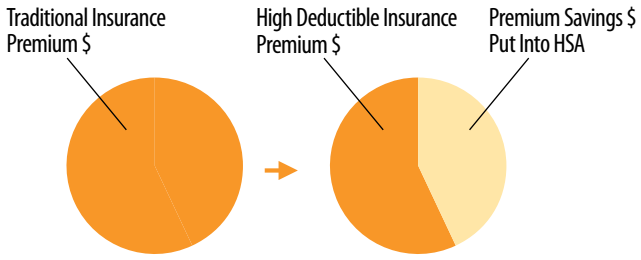
High deductible plans typically cost a lot less than many copay or traditional plans. This means lower premiums for you. You can then take the premium savings and place it into your health savings account.

- 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.

Adult and Child Preventive Care Included

With our HSA plans, after a 3-month waiting period, you pay a $35 copay (in-network) for the doctor office visit.

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



*See HSA insert for important information.

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.

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Benefit Highlights:	HSA 100®	HSA 70SM
Calendar-Year Deductible Choices (per family deductible)	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 Choices (% of covered expenses after deductible)	You pay: 0%	You pay: 30%
Coinsurance Out-of-Pocket Maximum (in-network, per calendar year, after deductible per family)	$0	Single (deductible) / Family (deductible) $3,000 ($1,250) / $6,000 ($2,500) $3,000 ($2,500) / $6,000 ($5,000) $2,600 ($3,000) / $5,200 ($6,000) $2,100 ($3,500) / $4,200 ($7,000) $600 ($5,000) / $1,200 ($10,000)
Lifetime Maximum Benefit (per covered person)	$3 Million ($5 Million plan enhancement available)	$3 Million ($5 Million plan enhancement available)
Initial Rate Guarantee (does not apply to benefit and address changes)	12 Months (24 Months plan enhancement available)	12 Months (24 Months plan enhancement available)
Physicians (Illness & Injury)		
Office Visit — History and Exam (Primary Care or Specialist, in-network only)	No charge after deductible	You pay: 30% after deductible
Primary Care Physician/Specialist Referrals Required	No	No
Prescription Drugs		
Preferred price card (You pay for prescriptions at the point of sale, at the lowest price available, and submit a claim to Golden Rule.)	Preferred price card — no charge after deductible	Preferred price card — You pay: 30% after deductible
Annual Maximum (covered expense, per person, per calendar year)	$3,000 (No Annual Max. plan enhancement available)	$3,000 (No Annual Max. plan enhancement available)
Wellness/Preventive Care Benefits (3-month waiting period, not subject to deductible)		
Doctor Office Visit (adult or child, in-network only)	$35 copay	$35 copay
X-ray and lab (in conjunction with the preventive office visit, performed in the doctor's office or a network facility)	You pay: $0	You pay: 30%
Child Immunizations (ages 0-18)	You pay: $0	You pay: 30%
Preventive Mammogram, Pap Smear, PSA screening (no waiting period, see pages 13-14 for additional covered benefits)	You pay: $0	You pay: 30%
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 (CAT scan and MRI tests are not subject to this limitation)	No charge after deductible (Limited benefit)	You pay: 30% after deductible (Limited benefit)
Mental and Nervous Disorders (including substance abuse)	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

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

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Health Savings Account Options

Health Savings Account Debit MasterCard®

UnitedHealthOne℠

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

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About Your HSA

We have chosen **OptumHealth Bank**, 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, Member FDIC, will service your account and send information directly to you about your HSA.

You will receive your new Health Savings Account Card℠ 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 *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 Web site (*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 7 p.m. Eastern time, at 1-866-234-8913.
- Interactive voice response for self-service, 24/7.
- *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℠

HSA Management by OptumHealth Bank

HSA Balance Between	Annual Percentage Yield (APY)*	Access to Funds	Monthly Maintenance	Minimum Monthly Deposit
$ 0.00 - $ 499.99	0.10%	Health Savings Account card	$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%			

*As of 2/1/10, subject to change at any time.

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

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Deductible, Coinsurance, and Monthly Health Savings Account (HSA) Deposit Options

	HSA 100® Single					HSA 70℠ Single				
Deductible	$1,250	$2,500	$3,000*	$3,500	$5,000	$1,250	$2,500	$3,000*	$3,500	$5,000
Amount of Coinsurance after Deductible	$0 You pay 0% We pay 100%	$0 You pay 0% We pay 100%	$0 You pay 0% We pay 100%	$0 You pay 0% We pay 100%	$0 You pay 0% We pay 100%	$10,000 You pay 30% We pay 70%	$10,000 You pay 30% We pay 70%	$8,667 You pay 30% We pay 70%	$7,000 You pay 30% We pay 70%	$2,000 You pay 30% We pay 70%
Your Out-of-pocket Maximum	$1,250	$2,500	$3,000	$3,500	$5,000	$4,250	$5,500	$5,600	$5,600	$5,600
Maximum deposit (tax-deductible limit)	2010					$3,050				
	Catch-up					Individuals aged 55+ may contribute an additional $1,000 for tax year 2010				

	HSA 100® Family					HSA 70℠ Family				
Deductible	$2,500	$5,000	$6,000*	$7,000	$10,000	$2,500	$5,000	$6,000*	$7,000	$10,000
Amount of Coinsurance after Deductible	$0 You pay 0% We pay 100%	$0 You pay 0% We pay 100%	$0 You pay 0% We pay 100%	$0 You pay 0% We pay 100%	$0 You pay 0% We pay 100%	$20,000 You pay 30% We pay 70%	$20,000 You pay 30% We pay 70%	$17,333 You pay 30% We pay 70%	$14,000 You pay 30% We pay 70%	$4,000 You pay 30% We pay 70%
Your Out-of-pocket Maximum	$2,500	$5,000	$6,000	$7,000	$10,000	$8,500	$11,000	$11,200	$11,200	$11,200
Maximum deposit (tax-deductible limit)	2010					$6,150				
	Catch-up					Individuals aged 55+ may contribute an additional $1,000 for tax year 2010				

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

*Deductible not available in all states — see the product brochure.

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 Health Savings Account card 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 a 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 + 10% penalty tax (under age 65); income tax only (for age 65 and over)

Death, Disability — Income tax only — no penalty

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.

Optional Insurance Benefit: HSA Hospital Indemnity Rider

The optional HSA Hospital Indemnity Rider is designed to help protect against major hospitalization expenses during the early months of coverage while cash accumulates in your savings account.

The HSA Hospital Indemnity Rider provides a lump-sum cash benefit on the third day of hospital confinement. This money can be used to help pay your deductible or for any other purpose.

The cash benefit amount depends on your deductible amount and decreases over time (see table).

The optional rider pays once, regardless of the number of hospitalizations, and there are no benefits under this rider if the hospitalization would not have been covered by the medical coverage. In addition, you only pay the premium amount once.

Note: HSA Hospital Indemnity Rider is not available for plans with $1,250 (single) or $2,500 (family) deductibles.

The rider does not change, waive, or extend any part of the policy/certificate other than as set forth above. Please see the attached brochure for complete details regarding applicable exclusions and limitations.

Hospital Indemnity Rider Cash Benefit

Month	Single Benefit	Family Benefit
1	$1,500	$3,200
2	$1,400	$2,950
3	$1,250	$2,700
4	$1,150	$2,450
5	$1,050	$2,225
6	$950	$2,000
7	$850	$1,775
8	$750	$1,550
9	$675	$1,325
10	$600	$1,125
11	$525	$925
12	$450	$725
13	$400	$550
14	$350	$400
15	$300	$250
16	-$0-	-$0-
One-Time Premium Amount For This Option	**$40**	**$150**

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Policy Form numbers: SA-S-1019

Golden Rule Insurance Company

7440 Woodland Drive
Indianapolis, IN 46278-1719

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High Deductible Plans

Lower Premiums

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

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

Comprehensive Coverage

- You choose $3 million or $5 million lifetime maximum benefit per covered person.
- Plan 100® and Plan 80℠ include preventive care and child immunizations with no waiting period.
- Add optional benefits to increase coverage (see Optional Benefits on page 12 for details).

Who might benefit most from a High Deductible Plan?

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

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Benefit Highlights:	Plan 100®	Plan 80SM	Saver 80SM
Calendar-Year 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: $500, $1,000, $1,500, $2,500, $5,000, $7,500 or $10,000
Coinsurance Choices (% of covered expenses after deductible)	You pay: 0%	You pay: 20%	You pay: 20%
Coinsurance Out-of-Pocket Maximum (in-network, per person, per calendar year, after deductible)	$0	$3,000	$3,000
Lifetime Maximum Benefit (per covered person)	$3 Million ($5 Million plan enhancement available)	$3 Million ($5 Million plan enhancement available)	$3 Million ($5 Million plan enhancement available)
Initial Rate Guarantee (does not apply to benefit and address changes)	12 Months (24 Months plan enhancement available)	12 Months (24 Months plan enhancement available)	12 Months (24 Months plan enhancement available)
Physicians (Illness & Injury)			
Office Visit — History and Exam (Primary Care or Specialist, in-network only)	No charge after deductible	You pay: 20% after deductible	Not covered
Primary Care Physician/Specialist Referrals Required	No	No	No
Prescription Drugs			
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.)	Preferred price card — no charge after deductible (Copay Card plan enhancement available)	Preferred price card — You pay: 20% after deductible (Copay Card plan enhancement available)	Not covered — Discount card included
Annual Maximum (covered expense, per person, per calendar year)	$3,000 (No Annual Max. plan enhancement available)	$3,000 (No Annual Max. plan enhancement available)	Not applicable
Wellness/Preventive Care Benefits (no waiting period)			
Doctor Office Visit (adult or child, in-network only)	No charge after deductible	You pay: 20% after deductible	Not covered
X-ray and lab (in conjunction with the preventive office visit, performed in the doctor's office or a network facility)	No charge after deductible	You pay: 20% after deductible	Not covered
Child Immunizations (ages 0-18)	No charge after deductible	You pay: 20% after deductible	Not covered
Preventive Mammogram, Pap Smear, PSA screening (see pages 13-14 for additional covered benefits)	No charge after deductible	You pay: 20% after deductible	You pay: 20% after deductible
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 (CAT scan and MRI tests are not subject to this limitation)	No charge after deductible (Limited benefit)	You pay: 20% after deductible (Limited benefit)	Not covered
Mental and Nervous Disorders (including substance abuse)	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
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

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

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Plan Enhancements & Optional Benefits

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

Plan Enhancements

$5 Million Lifetime Maximum

This option is not available in VA.

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

24-Month Initial Rate Guarantee

Extend your rate guarantee to 24 months. Does not apply to benefit and address changes.

No Annual Maximum Prescription Drug

This option is not available with Saver 80℠ or Copay Saver℠

Eliminates the $3,000 calendar-year limit.

$25 Office Visit Copay

This option is available with Copay Select℠.

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

2 Additional Dr. Office Visits

This option is available with Copay Saver℠.

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

Prescription Drug* Copay

This option is available with Plan 100® and Plan 80℠. Cannot be combined with the No Annual Maximum Prescription Drug Plan Enhancement.

With this benefit, you pay:

- Tier 1 drugs — $15 copay.
- Tier 2-4 drugs — combined $200 deductible per person, per calendar year, then:
  - Tier 2 drugs — $35 copay.
  - Tier 3 drugs — $65 copay.
  - Tier 4 drugs — you pay 25% coinsurance.

(Maximum $3,000 in covered expenses, 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.

Optional Benefits

Preventive Care

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

- $35 copay on preventive care network office visits (primary care, OBGYN, etc).
- The following charges for preventive care that are performed in conjunction with the network office visit are exempt from the deductible and coinsurance whether performed in the doctor's office or elsewhere:
  - Child (under age 19) and adult immunizations.
  - Mammogram, cervical and Pap smears.
  - Urinalysis and blood tests.
  - Bone density screens.
  - EKG and cardiac stress tests.
  - PSA tests and digital rectal exams.
  - FDA-approved screenings for HPV.
- Copay Saver℠
  - 3-month waiting period eliminated.
  - Not subject to the office visit limit.

Maternity Benefit

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

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

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

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

*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.

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Optional Enhanced Term Life Benefit and Accidental Death Benefit

Personalize Your Coverage

You've made the decision to help protect your family's health by seeking insurance; shouldn't you consider helping protect their financial future too?

Term life insurance may be an ideal benefit to make sure you provide for your loved ones' future.

Consider your current financial picture and ask, "Without a term life insurance benefit paid to my loved ones upon my death, would they be able to:

- Pay for funeral expenses?
- Pay the mortgage or other debts?
- Save for college or retire comfortably?"

Remember to select this option as you apply for health coverage.

Enhanced Term Life Benefit

You may choose an optional term life insurance benefit for you and/or a 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 if your spouse 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.

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

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Policy Forms SA-S-1366R; SA-S-1366R-24; SA-S-1366R-32; SA-S-1366R-35; SA-S-1366R-42; SA-S-1366R-45; SA-S-1367R; SA-S-1367R-24; SA-S-1367R-32; SA-S-1367R-35; SA-S-1367R-45

Additional premium is required. Availability varies by state. Exclusions for suicide, military service, and certain hazardous activities apply. Please see the corresponding health product brochure. Enhanced Term Life Benefit replaces any term life benefit in the corresponding health product brochure.

UnitedHealthOne

Optional Dental Benefits

Personalize Your Coverage

UnitedHealthOne

UnitedHealthOne is a brand name used for products underwritten by Golden Rule Insurance Company. This product is administered by Dental Benefit Providers, Inc.

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

Policy Form SAS-1374, -05, -06, -10, -35, -40, and -42

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Something to Smile About.

Keeping your smile beautiful doesn't have to be expensive. You can now upgrade your health plan with an optional dental benefit that can help keep you smiling brightly. UnitedHealthcare's extensive network of dental care providers can offer you significant savings.

UnitedHealthcare Dental Benefit Rider — Two Options to Choose From

UnitedHealthcare Dental Premier℠ Benefit Rider

- Best option if your dentist is **not** in our network.
  Visit *www.myuhcdental.com/goldenrule* for a list of dentists.
- Pays more than *Dental Value* for care from non-network dentists.

UnitedHealthcare Dental Value℠ Benefit Rider (not available in all areas)

- Best option if you use a network dentist.
  Visit *www.myuhcdental.com/goldenrule* for a list of dentists.
- Lowest premiums.

With both of our options, you can take advantage of:

- Preventive care covered at 100% with NO deductible or waiting period.
- Access to an extensive network that today has over 73,000 dentists!
- Two options with the flexibility of using in- and out-of-network dentists.
- A $50 calendar-year deductible per person (limited to 3 individual $50 deductibles per family for Basic Services and Major Services). Then we pay 80% for Basic Services and 50% for Major Services.*
- A calendar-year maximum benefit of $1,000 per covered person.

*Six-month waiting period for Basic Services. Twelve-month waiting period for Major Services.

We're here to help you.

Use ***www.myuhcdental.com/goldenrule*** to find a dentist in your area, access your plan information, see your claim status, find general dental information, and more. You also can call customer service anytime toll-free at (866) 877-6187 and speak to a dental specialist for fast, knowledgeable service.

With Dental Coverage From UnitedHealthcare — You Have the Advantage.

With a UnitedHealthcare dental rider, your family has access to over 73,000 network dentists. The result can be significant discounts on quality care, and you never file a claim form. A healthy smile can be easier than you thought.

Preventive services have no waiting period and include routine dental exams, routine X-rays, cleaning, fluoride treatment, sealants, and space maintainers.

Basic services have a 6-month waiting period and include dental exams, X-rays, routine extractions, treatment to ease dental pain, and simple fillings.

Major services have a 12-month waiting period and include treatment for diseases of the pulp (including root canals), bone and other tissues supporting the teeth, crowns, inlays, onlays, veneers, bridges, dentures, and oral surgery for impactions.

UnitedHealthcare Dental Network Savings Examples (as of May 2008)

	Procedure (ADA Code)	Dentists' Retail Charge	Both Options In-network You Pay	*Dental Premier* Out-of-network You Pay	*Dental Value* Out-of-network You Pay
Preventive	Adult Prophylaxis (D1110)	$ 75.00	$0	$ 4.00	$ 28.00
	Child Prophylaxis (D1120)	$ 88.00	$0	$ 33.00	$ 53.00
	Child Topical Application of Fluoride (D1203)	$ 49.50	$0	$ 14.50	$ 30.50
Basic	Amalgam One Surface, Primary or Permanent (D2140)	$140.00	$ 13.20	$ 32.00	$ 87.20
	Resin-Based Composite, One Surface Anterior (D2330)	$150.00	$ 16.00	$ 39.60	$ 86.00
	Resin-Based Composite, One Surface Posterior (D2391)	$160.00	$ 18.40	$ 40.80	$ 86.40
Major	Molar Root Canal (D3330)	$985.00	$335.00	$502.50	$650.00
	Removal of Impacted Tooth, Soft Tissue (D7220)	$300.00	$ 84.50	$ 160.00	$ 215.50

- Utilizing network dentists reduces costs under **both options** because these dentists have agreed to lower fees (network negotiated rate) for covered expenses.
- If you use an out-of-network dentist, ***Dental Premier*** pays benefits based on the reasonable and customary charge.
- If you use an out-of-network dentist, ***Dental Value*** pays benefits based on the network negotiated rate — which is usually less than the reasonable and customary charge.
- After benefits have been paid under the policy, an out-of-network dentist can bill a patient for any remaining amount up to the billed charge.

Fees in examples are based on national averages and network coverage for ZIP Code 432XX. This chart assumes $50 deductible has been satisfied.

This brochure is only a general outline of the coverage provisions. It is not an insurance contract, nor part of the insurance policy. You'll find complete coverage details in the policy.

Covered Expenses

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

- Oral evaluations – two per calendar year.
- Routine cleaning – two per calendar year.
- Fluoride treatment, covered person under age 16 – two per calendar year.
- Routine X-rays – once per calendar year.
- Simple (nonsurgical) extractions.
- Amalgam fillings and direct resin fillings.
- Stainless steel crowns on primary teeth.
- Space maintainers for premature loss of primary teeth, under age 16.
- Repair of dental work but not within 6 months of the initial placement and not more than once in any 12-month period.
- Root canals and pulpotomies on primary teeth.
- Treatment for disease of the gums and bone-supporting teeth – two per calendar year.
- Inlays, onlays, or veneers limited to one time per 60 consecutive months.
- First installation of bridgework to replace one or more lost functioning natural teeth.
- Full or partial dentures or overdentures, payable once every 5 years.
- Oral surgery, including: Alveoloplasty, Biopsy, Frenectomy, Incision and Drainage, Removal of a Benign Cyst, Removal of Exostosis, Root Recovery, Root Removal, Simple Extractions, Surgical Extraction of Erupted Teeth and Roots, and Surgical Extraction of Impacted Teeth.
- Sealants – once per first or second permanent molar every 36 months, under age 16.

Definitions

- Preventive services have no waiting period and include routine dental exams, routine X-rays, cleaning, fluoride treatment, sealants, and space maintainers.
- Basic services have a 6-month waiting period and include dental exams, X-rays, routine extractions, treatment to ease dental pain, and simple fillings.
- Major services have a 12-month waiting period and include treatment for diseases of the pulp (including root canals), bone and other tissues supporting the teeth, crowns, inlays, onlays, veneers, bridges, dentures, and oral surgery for impactions.

Exclusions

No benefits are payable for dental expenses which:

- Are for orthodontia; braces.
- Are for dental implants.
- Are for oral surgery, except as expressly provided for under the rider.
- Result from intoxication, as defined by applicable state law in the state where the illness or injury occurred, or under the influence of illegal narcotics or controlled substance unless administered or prescribed by a doctor.
- Are in relation to, or incurred in conjunction with, investigational treatment.
- Are for jaw/joint problems or malposition of jaw bones.
- Are for mouthguards; duplicate dentures; harmful habit appliances; replacement of lost or stolen appliances; sleep disorder appliance; and gold foil restorations.
- 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 for cosmetic dentistry.
- Are for replacement of dental work which can be repaired or restored to natural function.
- Are for hospital or other facility charges and related anesthesia charges, except if expressly provided for under the policy.
- Result from war, intentionally self-inflicted bodily harm (whether sane or insane), or participation in a felony (whether or not charged).
- Are provided by a family member or by someone who ordinarily resides with you or your covered dependent.
- Are received outside of the United States, except for a dental emergency.
- Are for changing vertical dimension, restoring occlusion, bite analysis, or congenital malformation.
- Are for setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
- Are for initial placement of dentures or bridges to replace functional natural teeth that are congenitally missing or lost before the rider is in effect.
- Are for acupuncture, acupressure, and other forms of alternative treatment.
- Are for any dental services for which benefits are payable under a medical policy issued by us.

EXCLUSION ON CHARGES IN EXCESS OF REASONABLE AND CUSTOMARY: Charges in excess of reasonable and customary will not qualify as a covered expense under the rider. This only applies to Dental Premier. Information regarding how the usual and customary fee is determined is available upon request.

Dental Claims: Mail to Claims Unit, P.O. Box 30567 Salt Lake City, UT 84130-0567

List of CO Counties with No Participating UHC Dental Providers

Archuleta, Baca, Bent, Cheyenne, Crowley, Custer, Dolores, Eagle, Elbert, Gilpin, Grand, Gunnison, Hinsdale, Jackson, Kiowa, Lake, Mineral, Moffat, Ouray, Park, Phillips, Pitkin, Rio Blanco, Saguache, San Juan, San Miguel, Sedgwick, Teller, Yuma

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UnitedHealthOne

Optional Enhanced Supplemental Accidental Benefit

Higher deductibles don't have to be scary!

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

- Up-front coverage can pay your deductible.
- Select a 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 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 Enhanced Supplemental Accident benefit will be credited to the network deductible and coinsurance of the health insurance.
- Additional premium is required for the optional Enhanced Supplemental Accident benefit rider.

Accidents happen. And unexpected injuries can hurt your budget. A simple arm fracture treated in the doctor's office can cost $324. While 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 — Enhanced Supplemental Accident Benefit

	Health Plan Only	Health Plan with $2,500 Supplemental Accident Benefit	Health Plan with $5,000 Supplemental Accident Benefit
Health Plan deductible	$5,000	$5,000	$5,000
Coinsurance maximum (80/20 to $10,000) for open-arm fracture costing $23,000*	$2,000	$2,000	$2,000
Supplemental Accident Coverage	$0	- $2,500	- $5,000
Your out-of-pocket covered expenses for the calendar-year	**$7,000**	**$4,500**	**$2,000**
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 Enhanced Supplemental Accident qualifies for favorable HSA (account) tax treatment.

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Policy Forms SA-S-1367R; SA-S-1367R-24; SA-S-1367R-32; SA-S-1367R-35; SA-S-1367R-45

*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. Additional premium is required. Availability varies by state. Please see the corresponding health product brochure.

UnitedHealthOne

Covered Expenses

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

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

To be considered for reimbursement, expenses must qualify as covered expenses. Expenses are also subject to reasonable and customary limits unless you use a network provider. We recommend review of the more detailed plan information on pages 15-18 and the state variations on pages 19-21.

Medical Expense Benefits

- Daily hospital* room and board and nursing services at the most common semiprivate rate.
- Charges for intensive care unit.
- Hospital emergency room treatment of an injury or illness (subject to an additional $100 copay each time the emergency room is used for an illness not resulting in confinement — does not apply to HSA Plans).
- Services and supplies, including drugs and medicines, which are routinely provided by the hospital to persons for use while they are inpatients.
- Professional fees of doctors and surgeons (but not for standby availability).
- Dressings, sutures, casts, or other necessary medical supplies.
- Professional fees for outpatient services of licensed physical therapists.
- Diagnostic testing using radiologic, ultrasonographic, or laboratory services in or out of the hospital.
- Local ground ambulance service to the nearest hospital for necessary emergency care. Air ambulance, within U.S., if requested by police or medical authorities at the site of emergency.
- Charges for operating, treatment, or recovery room for surgery.
- Dental expenses due to an injury which damages natural teeth if expenses are incurred within six months.
- Surgical treatment of TMJ disorders (see limitations on page 17).
- Cost and administration of anesthetic, oxygen, and other gases.
- Radiation therapy or chemotherapy.
- Prescription drugs.
- Hemodialysis, processing, and administration of blood and components.
- Mammography, Pap smear, and PSA test fees.
- Artificial eyes, larynx, breast prosthesis, or basic artificial limbs (but not replacements).
- Surgery in a doctor's office or at an outpatient surgical facility, including services and supplies.
- Occupational therapy following a covered treatment for traumatic hand injuries.
- Rehabilitation and extended care facility services that begin within 14 days of a 3-day or more hospital stay, for the same illness or injury. Combined calendar year maximum of 60 days for both rehabilitation and extended care facilities expenses.

Preventive Care Expense Benefits

Three-month waiting period for wellness benefits (not applicable to Plan 100® and Plan 80℠).

(Plan 100® and Plan 80℠ subject to the applicable deductible amount and coinsurance percentage. Copay Select℠, HSA 100®, and HSA 70℠ exempt from any applicable deductible amount.)

Covered expenses are expanded to include charges for the following when incurred for preventive care:

- Routine office visits (including well-baby).
- Childhood immunizations for each eligible child under 19 years of age.
- Urinalysis and blood tests.
- Bone density screenings.
- Electrocardiograms (EKG's).
- Cardiac stress tests.

The following are not subject to the 3-month waiting period:

- Mammography screenings.
- Cervical smears and pap smears.
- Prostate-specific antigen tests and digital rectal examinations.

Preventive Care Expense Benefits will not include and no benefits will be paid for computerized axial tomography (CAT or CT scan), magnetic resonance imaging (MRI) or positron emission tomography (PET scan) performed on a routine or preventive basis.

See pages 7, 9, and 11 for coverage details.

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

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

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Covered Expenses (continued)

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

Saver Plans — Copay Saver℠ and Saver 80℠

To be considered for reimbursement, expenses must qualify as covered expenses. Expenses are also subject to reasonable and customary limits unless you use a network provider. We recommend review of the more detailed plan information on pages 15-18 and the state variations on pages 19-21.

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.
- Mammography, Pap smear, and PSA test fees.
- Hospital emergency room treatment of an injury or illness (subject to limitations shown on pages 7 and 11).
- CAT scan and MRI testing.
- Diagnostic testing related to, and performed within 14 days prior to, surgery or inpatient confinement.
- Copay Saver℠ plan includes two doctor office copay visits per person, per year (see page 7).
- Copay Saver℠ plan includes coverage for generic prescription drugs (see page 7).

Important note about Saver Plans:

Premiums for Saver Plans are significantly less because coverage is not provided for most outpatient services. Outpatient expenses not specifically listed in the policy are not covered. Please review the Saver Plans' Inpatient and Outpatient Expense Benefits. 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.

Some expenses not covered under the Saver Plans include:

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

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

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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 2010 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.

Preexisting Conditions

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

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

*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.

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

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

General Limitations

- Expenses incurred by a covered person for treatment of tonsils, adenoids, middle ear disorders, hemorrhoids, hernia, or any disorders of the reproductive organs are not covered during the covered person's first six months of coverage under the policy. This provision will not apply if treatment is provided on an "emergency" basis. "Emergency" means a medical condition manifesting itself by acute signs or symptoms that could reasonably result in placing a person's life or limb in danger if medical attention is not provided within 24 hours.
- Covered expenses will not include more than what was determined to be the reasonable and customary charge for a service or supply.
- Transplants eligible for coverage under the Transplant Expense Benefit are limited to two transplants in a 10-year period.
- Charges for an assistant surgeon are limited to 20% of the primary surgeon's covered fee.

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Provisions That Apply to All Plans (continued)

- Covered expenses for surgical treatment of TMJ, excluding tooth extractions, are limited to $10,000 per covered person.
- All diagnoses or treatments of mental disorders, as defined in the policy, including substance abuse, are limited to a lifetime maximum benefit of $3,000 (not covered in Saver Plans, subject to state variations). Covered expenses for outpatient diagnosis or treatment of mental disorders are further limited to $50 per visit. As with any other illness or injury, inpatient care that is primarily for educational or rehabilitative care is not covered.
- Covered outpatient expenses relating to diagnosis or treatment of any spine or back disorders are limited to a maximum of $2,000 per calendar year. CAT scan and MRI tests are not subject to this limitation.
- Covered expenses are limited to no more than a 34-day supply for any one outpatient prescription drug order or refill.

Effective Date

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

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

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

Premium

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

Home Health Care

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

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

Hospice Care

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

Dependents

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

Termination of a Covered Person

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

Continued Eligibility Requirements

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

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

Renewability

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

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

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Provisions That Apply to All Plans (continued)

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.

Conditions Prior to Legal Action

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

Group — COB

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

Medicare — Carve-Out

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

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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.

Arizona

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

Arkansas

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

District of Columbia

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

Illinois

- A child will continue to be eligible after 26 if the child: is 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 coverage.

Iowa

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

Maryland

- The limited exclusion for AIDS does not apply.

Michigan

- The reference to 24 months in the definition of a preexisting condition is changed to 6 months.
- **Provider Network Continuity of Treatment:** If your provider leaves the network while you are receiving treatment for an "injury or illness," your first subsequent visit will be covered as if your provider were still in the network, and we will notify you that the provider is no longer a network provider so that you may choose a new network provider.
- **Grievance Procedure Information Phone Number:** (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.

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

Nebraska

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

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.

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State Variations (continued)

- 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 reasonable and customary charges; 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

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

Oklahoma

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

Pennsylvania

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

South Carolina

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

Tennessee

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

Texas

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

Virginia

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

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State Variations (continued)

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

West Virginia

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

Wisconsin

- The limited exclusion for AIDS does not apply.
- The spine and back limitation does not apply.
- Covered expenses for all diagnoses or treatments of mental or nervous disorders and substance abuse are subject to the deductible and coinsurance, and are limited to a policy year maximum benefit of $7,000. Outpatient treatment is further limited to a maximum benefit of $2,000.
- Limited coverage for nonsurgical treatment of TMJ disorders is provided.
- Covered child immunizations are not subject to the deductible or waiting period.
- Covered expenses for home health aide services are limited to 40 visits in a 12-month period.
- Eligible children must be unmarried and under 27 years of age at time of application.

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NOTICE OF INFORMATION PRACTICES

NOTICE OF PRIVACY PRACTICES

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

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

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

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

How We Use or Disclose Information

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

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

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

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

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

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

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

What Are Your Rights

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

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

Exercising Your Rights

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

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

Fair Credit Reporting Act Notice

In some cases, we may ask a consumer-reporting agency to compile 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.

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 July 2009, 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 United HealthCare Services, Inc.

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

33638-X-0709 Products are either underwritten or administered by: American Medical Security Life Insurance Company, PacifiCare Life and Health Insurance Company, PacifiCare Life Assurance Company, UnitedHealthcare Insurance Company, *www.eAMS.com*; or All Savers Insurance Company, United HealthCare Services, Inc., and/or Golden Rule Insurance Company, *www.goldenrule.com*

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

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

Proposed Insured: _____

Amount Received: _____ Date of Receipt: _____

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

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

Patrick F. Can _____

Signature of Secretary Signature of Agent/Broker

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

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

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

Definitions:

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

Limitation:

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

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

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

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

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

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

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

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

KEEP THIS DOCUMENT.
IT HAS IMPORTANT INFORMATION.

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, the Medical Information Bureau (MIB), or insurance company having any information as to a diagnosis, the treatment, or prognosis of any physical or mental conditions about my family or me is authorized to give it to Golden Rule's Insurance Administration and Claims Departments. This includes information related to substance use or abuse.

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

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

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

I (we) understand the following:

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

I have retained a copy of this authorization.

36228-0208

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.

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

These health insurance plans are issued as association group plans and available only to members of FACT, the Federation of American Consumers and Travelers. If you're not already a member, you are required to join FACT.

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

FACT privacy notice

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.

What are FACT's association benefits?

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

- Dental care discounts — you can save up to 35% on general dental care, X-rays, cosmetic dentistry, and orthodontics.
- Vision care discounts — typical savings of 5%-40% for eye exams, eyeglasses, contact lenses, and LASIK eye correction surgery.
- Hearing aids & care discounts.
- Prescription drug discounts.
- Wellness benefits.
- Durable medical equipment.
- Diabetes needs.
- OTC meds.
- Scholarships & grants.
- Consumer newsletter & bulletins.
- Job-search & employee search assistance.
- Consumer hotline & library.

Plus …

- Discounts on everything from travel & auto mufflers to rental cars, amusement parks, & motels.

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

UnitedHealthOne℠

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