

What Choices Empower You?

Health Plans For Individuals and Families



UnitedHealthOne 

These plans are administered, issued, and underwritten by Golden Rule Insurance Company, a UnitedHealthcare company, on an individual basis and are regulated as individual health insurance plans.

Policy Forms GRI-N23M-06 and GRI-N23S-06

Why Choose Us for Health Insurance?



UnitedHealthcare

More than 25 million customers have entrusted 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.

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 583,000 physicians and 4,910 hospitals across all 50 states and in four international markets.** 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.

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 27.

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.

Emergency? You're covered

From state to state, country to country - rest assured knowing that if you have a medical emergency you are covered, even when travelling outside the U.S.

* Actual 2008 results.

** As of 12/31/2008

*** Discounts vary by provider, geographic area, and type of service.



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.

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.	Copay 100 SM <small>More Comprehensive</small>	Lower	Higher	6
	Families with children who have regularly scheduled doctor office visits.	Copay 80 SM <small>More Affordable</small>	Higher	Lower	6
	Adults who want copay benefits for preventive care and prescription drugs.	Copay Saver SM <small>Even More Affordable</small>	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.	HSA 100 [®] <small>More Comprehensive</small>	Lower	Higher	8
	Families interested in one calendar-year deductible per family.	HSA Saver SM <small>More Affordable</small>	Higher	Lower	8
	Those interested in trading low deductible health insurance for a higher deductible plan to save money on monthly premiums and taxes.				
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.	Plan 100 [®] <small>More Comprehensive</small>	Lower	Higher	10
	Anyone seeking lower-cost protection from unexpected accidents and illnesses.	Plan 80 SM <small>More Affordable</small>	Higher	Lower	10
	Early retirees needing a bridge to Medicare.	Saver 80 SM <small>Even More Affordable</small>	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.

The Network Advantage

Quality Care at Significant Savings

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

Our network gives you:

- Access to an **extensive network** of doctors, X-ray and lab facilities, hospitals, and other ancillary providers.*
- **Quality care** at reduced costs because these providers have agreed to lower fees for covered expenses.
- **Lower premiums** — savings of up to 35%-45% with our 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. See the next page for more information.

Sample savings with our network:

(Services provided August to September 2008)**

	Charges	Repriced Charges
Dr. Office Visit (illness)	\$ 122.00	\$ 38.44
Mammogram	\$ 315.00	\$ 122.58
MRI	\$2,550.90	\$ 733.71
Lab Work — Cholesterol, Glucose, Insulin Fasting	\$ 166.00	\$ 10.60

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

**All these services received from network providers in ZIP Code 336--. Your actual savings may be more or less than this illustration and will vary by several factors.

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



Copay 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 copay. Office visit expenses outside your network are not eligible for copay benefits. Out-of-network office visits are subject to the deductible, then coinsurance rather than copay; non-network penalty still applies.

Adult and Child Preventive Care Included

You pay \$30 for the doctor office visit with Copay 80SM and Copay SaverSM, \$25 with Copay 100SM. With Copay 100SM or Copay 80SM, X-rays and lab tests are covered after you pay your coinsurance (0% or 20%).

Prescription Drug* Benefits

- **Copay 100SM** — \$15 Generic prescription copay with no deductible. \$30-\$40 Brand prescription copay after a combined \$150 deductible per person, per calendar year.
- **Copay 80SM** — \$15 Tier 1 prescription copay with no deductible. After a combined \$150 deductible per person, per calendar year for Tier 2-4 prescriptions, you pay: \$30 copay for Tier 2, \$40 copay for Tier 3, and 25% coinsurance for Tier 4.
- **Copay SaverSM** — \$15 Generic prescription copay with no deductible. Brand prescriptions are not covered.

Comprehensive Coverage for Inpatient and Outpatient Medical Expenses

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

Copay SaverSM

The Copay SaverSM 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.

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.

Benefit Highlights:

Copay 100SM

Copay 80SM

Copay SaverSM

Calendar-Year Deductible Choices (maximum 2 per family, per calendar year)	You pay: \$500, \$1,000, \$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	You pay: \$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	\$2,000	\$3,000
Lifetime Maximum Benefit (per covered person)	\$3 Million (\$5 Million available)	\$3 Million (\$5 Million available)	\$3 Million (\$5 Million available)
Initial Rate Guarantee (subject to benefit and address changes)	12 Months	12 Months	12 Months
Physicians (Illness & Injury)			
Office Visit — History and Exam (Primary Care & Specialist — no deductible required)	You pay: \$25 copay	You pay: \$30 copay	\$30 copay — 2 visits per person per calendar year, including wellness office visits (2 Additional Visits available)
Primary Care Physician/Specialist Referrals Required	No	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.	Generic — \$15 copay, no deductible. Brand — combined \$150 deductible per person, per calendar year, then: Preferred — \$30 copay. Nonpreferred — \$40 copay.	Tier 1 drugs — \$15 copay, no deductible. Tier 2-4 drugs — combined \$150 deductible per person, per calendar year, then: Tier 2 drugs — \$30 copay. Tier 3 drugs — \$40 copay. Tier 4 drugs — you pay 25% coinsurance.	Generic — \$15 copay, no deductible. Brand — not covered.
Annual Maximum (covered expenses-not paid, benefit-per person, per calendar year)	\$3,000 (Prescription Drug Benefit Buy-Up available)	\$3,000 (Prescription Drug Benefit Buy-Up available)	Not applicable
Wellness/Preventive Care Benefits (no waiting period, not subject to deductible unless indicated)			
Doctor Office Visit (adult or child, in-network only)	You pay: \$25 copay	You pay: \$30 copay	You pay: \$30 copay — subject to limit above
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: 20%	Not covered
Child Immunizations (age 0-18)	You pay: \$0	You pay: 20%	Not covered
Preventive Mammogram, Pap Smear, PSA screening (see page 13 for additional covered benefits)	You pay: \$0	You pay: 20%	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 (surgery/chemo/radiation only)
Surgeon, Assistant Surgeon, and Facility Fees	No charge after deductible	You pay: 20% after deductible	You pay: 20% after deductible
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 — Injury or Illness	No charge after deductible	You pay: 20% after deductible	You pay: 20% after deductible (if not admitted, covered expenses for emergency room itself are limited to \$250 per person, per calendar year)
Other Covered Outpatient Expenses	No charge after deductible	You pay: 20% after deductible	You pay: 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	You pay: 20% after deductible	You pay: 20% 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: 20% after deductible	You pay: 20% after deductible
Other Covered 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, 13-17 for more information.

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*

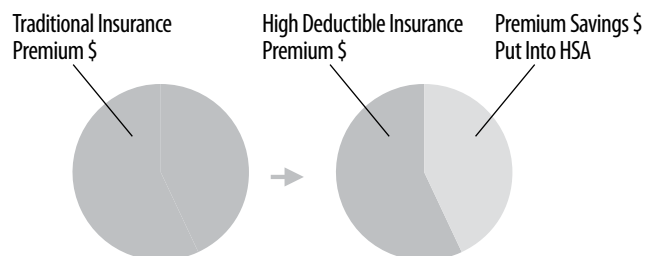
High deductible plans typically cost a lot less than many copay or traditional plans. This means lower premiums for you. You can then take the premium savings and place it into your health savings account.

- 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 HSA 100®, you pay a \$30 copay (in-network) for the doctor office visit. You pay nothing for X-rays and lab tests.

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.

Benefit Highlights:

HSA 100[®]HSA SaverSM

Calendar-Year Deductible Choices (per family deductible)	You pay: Single — \$1,150, \$1,900, \$2,900, \$3,500 or \$5,000 Family — \$2,300, \$3,850, \$5,800, \$7,500 or \$10,000	You pay: Single — \$1,150, \$1,900, \$2,900, \$3,500 or \$5,000 Family — \$2,300, \$3,850, \$5,800, \$7,500 or \$10,000
Coinsurance Choices (% of covered expenses after deductible)	You pay: 0%	You pay: 0%
Coinsurance Out-of-Pocket Maximum	\$0	\$0
Lifetime Maximum Benefit (per covered person)	\$3 Million (\$5 Million available)	\$3 Million (\$5 Million available)
Initial Rate Guarantee (subject to benefit and address changes)	12 Months	12 Months
Physicians (Illness & Injury)		
Office Visit — History and Exam (Primary Care, Specialist)	No charge after deductible	Not covered
Primary Care Physician/Specialist Referrals Required	No	No
Prescription Drugs		
Preferred price card: allows you to pay for prescriptions at the point of sale, at the lowest price available, and submit a claim to Golden Rule. Discount card: allows you to obtain prescription drugs at an average savings of 20% to 25% (discounts vary by pharmacy, geographic area, and drug).	Covered — no charge after deductible Preferred price card included	Not covered Discount card included
Annual Maximum	None	N/A
Wellness/Preventive Care Benefits (no waiting period, not subject to deductible unless indicated)		
Doctor Office Visit (adult or child, in-network only)	You pay: \$30 copay	Not covered
X-ray and lab (in conjunction with the preventive office visit, performed in the doctor's office or a network facility)	You pay: \$0	Not covered
Child Immunizations (0-18)	You pay: \$0	Not covered
Preventive Mammogram, Pap Smear, PSA screening (see page 13 for additional covered benefits)	You pay: \$0	No charge after deductible
Outpatient Expense Benefits		
X-ray and lab (performed in the doctor's office or a network facility)	No charge after deductible	No charge after deductible (must be performed within 14 days of surgery or confinement)
Facility/Hospital for Outpatient Surgery	No charge after deductible	No charge after deductible (surgery/chemo/radiation only)
Surgeon, Assistant Surgeon, and Facility Fees	No charge after deductible	No charge after deductible
Hemodialysis, Radiation, Chemotherapy, Organ Transplant Drugs, and CAT Scans, MRIs	No charge after deductible	No charge after deductible
Emergency Room Fees	No charge after deductible	No charge after deductible (if not admitted, covered expenses for emergency room itself are limited to \$250 per person, per calendar year)
Other Covered Outpatient Expenses	No charge after deductible	No charge after deductible
Spine and Back Disorders (CAT scan and MRI tests are not subject to this limitation)	No charge after deductible (Limited benefit)	Not covered
Mental and Nervous Disorders (including substance abuse)	No charge after deductible	No charge 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	No charge after deductible
Other Covered Inpatient Services	No charge after deductible	No charge after deductible

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

Simple to Use

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

Comprehensive Coverage

- You choose \$3 million or \$5 million lifetime maximum benefit per covered person.
- Plan 100[®] and Plan 80SM 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.

Benefit Highlights:

Plan 100[®]Plan 80SMSaver 80SM

Calendar-Year Deductible Choices (maximum 2 per family, per calendar year)	You pay: \$1,000, \$1,500, \$2,500, \$5,000, \$7,500 or \$10,000	You pay: \$1,000, \$1,500, \$2,500, \$5,000, \$7,500 or \$10,000	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 available)	\$3 Million (\$5 Million available)	\$3 Million (\$5 Million available)
Initial Rate Guarantee (subject to benefit and address changes)	12 Months	12 Months	12 Months
Physicians (Illness & Injury)			
Office Visit — History and Exam (Primary Care, Specialist)	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: allows you to pay for prescriptions at the point of sale, at the lowest price available, and submit a claim to Golden Rule. Discount card: allows you to obtain prescription drugs at an average savings of 20% to 25% (discounts vary by pharmacy, geographic area, and drug).	Covered — no charge after deductible Preferred price card included (Copay Card available)	Covered — you pay: 20% after deductible Preferred price card included (Copay Card available)	Not covered Discount card included
Annual Maximum (covered expenses-not paid, benefit-per person, per calendar year)	None	None	Not applicable
Wellness/Preventive Care Benefits (no waiting period)			
Doctor Office Visit (adult or child)	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 (age 0-18)	No charge after deductible	You pay: 20% after deductible	Not covered
Preventive Mammogram, Pap Smear, PSA screening (see page 13 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 (surgery/chemo/radiation only)
Surgeon, Assistant Surgeon, and Facility Fees	No charge after deductible	You pay: 20% after deductible	You pay: 20% after deductible
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 — Injury or Illness	No charge after deductible	You pay: 20% after deductible	You pay: 20% after deductible (if not admitted, covered expenses for emergency room itself are limited to \$250 per person, per calendar year)
Other Covered Outpatient Expenses	No charge after deductible	You pay: 20% after deductible	You pay: 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.	You pay: 20% after deductible	You pay: 20% 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: 20% after deductible	You pay: 20% after deductible
Other Covered 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, 13-17 for more information.

Optional Benefits

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

\$5 Million Lifetime Maximum

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

Prescription Drug Benefit Buy-Up

This option is available with Copay 100SM and Copay 80SM.

Eliminates the \$3,000 calendar-year limit.

2 Additional Dr. Office Visits

This option is available with Copay SaverSM.

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

Prescription Drug* Copay Card

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

With this benefit, you pay:

- Tier 1 drugs — \$15 copay.
- Tier 2-4 drugs — combined \$150 deductible per person, per calendar year, then:
 - Tier 2 drugs — \$30 copay.
 - Tier 3 drugs — \$40 copay.
 - Tier 4 drugs — you pay 25% coinsurance.

(Maximum \$3,000 per covered 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.

Preventive Care

This option is available with Plan 100[®], Plan 80SM, Saver 80SM, HSA SaverSM, and Copay SaverSM.

- \$30 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 SaverSM
 - Not subject to the office visit limit.

Supplemental Accident

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

*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.

Covered Expenses

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

Copay 100SM, Copay 80SM, HSA 100[®], Plan 100[®], and Plan 80SM

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 15-17.

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.
- 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 or occupational therapists.
- Diagnostic testing using radiologic, ultrasonographic, or laboratory services in or out of the hospital.
- Local ground ambulance service to the 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 16).
- 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). Subject to a yearly benefit of \$300 per prosthesis or per breast.
- 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.
- Diagnosis and treatment of mental disorders.
- 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.

- Routine patient care costs for cancer clinical trials as stated in the policy.
- Treatment of Lyme disease limited to 30 days of intravenous antibiotic therapy and 60 days of oral antibiotic therapy or further treatment if recommended by a board certified rheumatologist, licensed infectious disease specialist, or a licensed neurologist.
- Hearing aids for covered eligible child age 12 or under up to a maximum benefit of \$1,000 every two calendar years.
- Limited benefits for early intervention services as stated in the policy.
- Surgical removal of tumors and treatment of leukemia.

Preventive Care Expense Benefits

No waiting period for wellness benefits. See pages 7, 9, and 11 for coverage details.

(Except where noted, Plan 80 and Plan 100 subject to the applicable deductible amount and coinsurance percentage. Copay Select and HSA 100 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 ages 0-18.
- Adult immunizations.
- Urinalysis and blood tests.
- Bone density screenings.
- Electrocardiograms. (EKGs).
- Cardiac stress tests.
- Mammography screenings.
- Cervical smears and pap smears.
- Prostate-specific antigen tests and digital rectal examinations.
- FDA-approved screenings for the detection of the human papillomavirus (HPV) and vaccinations for HPV.

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.

For information on additional Plan provisions, including Transplant Expense Benefit, Notification Requirements, Preexisting Conditions, General Exclusions, General Limitations, and Other Plan Provisions, read pages 15-17.

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

Covered Expenses (continued)

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

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

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 15-17.

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, non-dental, maxillofacial, or breast prosthesis (but not replacements) limited to \$300 per year per prosthesis or breast.
- 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.

- Copay SaverSM plan includes two doctor office copay visits per year (see page 7).
- Copay SaverSM plan includes coverage for generic prescription drugs (see page 7).

Important note about Saver Plans:

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

Some outpatient expenses not covered under the Saver Plans include:

- Outpatient doctor office visit fees (limited benefit provided under Copay SaverSM — see page 7), diagnostic testing, prescription drugs (limited benefit provided under Copay SaverSM — 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;
- Preventive care office visits (unless the optional Preventive Care benefit is added). Limited benefit provided under Copay SaverSM — see page 7.

Outpatient Expense Benefits

- Charges for outpatient surgery, including the fee made by an outpatient surgical facility, the primary surgeon, the assistant surgeon, and/or administration of anesthetic.
- Hemodialysis, radiation, and chemotherapy.
- Prescription drugs to protect against organ rejection in transplant cases.
- Mammography, Pap smear, and PSA test fees.
- Hospital emergency room treatment of an injury or illness (subject to limitations shown on pages 7, 9, and 11).
- CAT scan and MRI testing.
- Diagnostic testing related to, and performed within, 14 days prior to surgery or inpatient confinement.

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

Provisions That Apply to All Plans

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

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. Covered expenses for listed transplants will be limited to two transplants during any 10-year period per covered person.

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 nonlymphocytic 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 \$500.

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 for which the covered person received medical advice or treatment within 12 months immediately preceding the date the covered person would have otherwise become insured for the condition under the policy. This 12-month period may be reduced if a covered person's preexisting condition was covered by qualifying prior coverage.

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.

Provisions That Apply to All Plans (continued)

- 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 (unless due to covered person's mental disorder), 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 policy is not in force.
- Are for abortion, sterilization, reversal of sterilization, or treatment for impotency.
- 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, 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, hernia, varicose veins, or any disorders of the reproductive organs are not covered during the covered person's first six months of coverage under the policy. This provision will not apply if treatment is provided on an "emergency" basis. "Emergency" means a medical condition manifesting itself by acute signs or symptoms that could reasonably result in placing a person's life or limb in danger if medical attention is not provided within 24 hours.

- Covered expenses will not include more than what was determined to be the reasonable and customary charge for a service or supply.
- Transplants eligible for coverage under the Transplant Expense Benefit are limited to two transplants in a 10-year period.
- Charges for an assistant surgeon are limited to 20% of the primary surgeon's covered fee.
- Covered expenses for surgical treatment of TMJ, excluding tooth extractions, are limited to \$10,000 per covered person.
- Mental disorders, 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 policy 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.

Provisions That Apply to All Plans (continued)

Home Health Care

Covered expenses may be subject to an additional \$50 deductible for some plans.

Covered expenses for home health care services are limited to 80 home health care visits in a 12-month period. Medical social services are limited to \$200 per year.

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, any adult with whom you have obtained a certificate of civil union from the State of Connecticut, and eligible children. Eligible children must be unmarried and under 26 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.

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
- Accepts any direct or indirect contribution or reimbursement, by or on behalf of an employer for any portion of the premium for coverage under this policy; or
- The date a covered person's employer and a covered person treat this policy as part of an employer-provided health plan for any purpose, including tax purposes.

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 policies just like yours issued to everyone in the state where you are then living.

Underwriting

Coverage will not be issued as a supplement to other health plans that you may have at the time of application. Plans are subject to health underwriting. If you provide incorrect or incomplete information on your insurance application your coverage may be voided or claims denied.

Rehabilitation and Extended Care Facility

Subject to deductible, then 100%. Must 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 ECF expenses.

Prior to Legal Action

To help resolve disputes before litigation, the policy requests that you provide us with written notice of intent to sue prior to legal action. This notice should 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.

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

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

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

FINANCIAL INFORMATION PRIVACY NOTICE

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

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

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

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

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

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

The Notice of Information Practices, effective May 2008, 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; United HealthCare 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.

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 FIVE CONDITIONS PRIOR TO COVERAGE ARE MET. NO PERSON IS AUTHORIZED TO ALTER OR WAIVE ANY OF THE FOLLOWING CONDITIONS. YOUR CANCELLED CHECK WILL BE YOUR RECEIPT.

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

Patrick F. Carr

Signature of Secretary

Signature of Agent/Broker

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

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

1. The application is completed in full and is unconditionally accepted and approved by Golden Rule Insurance Company (Golden Rule).
2. All medical examinations, if required, have been satisfactorily completed.
3. 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.
4. 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.
5. The policy 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 policy or to issue a specially ridered policy.
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 policy or issues a policy other than a standard policy 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 Golden Rule to initiate debit entries to the account indicated below. I also authorize the named depository to debit the same to such account.

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

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

A COPY OF YOUR AUTHORIZATION TO OBTAIN AND DISCLOSE HEALTH INFORMATION

I authorize Golden Rule Insurance Company's Insurance Administration and Claims Departments to obtain health information that they need to underwrite or verify my application for insurance. Any health-care provider, consumer-reporting agency, 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.

**KEEP THIS DOCUMENT.
IT HAS IMPORTANT INFORMATION.**

