Kentucky
South Dakota
Wyoming

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-N22M-16, GRI-N22S-16, GRI-N22M-49, GRI-N22S-49, GRI-N22M-40, GRI-N22S-40

39316C3-G-1210 (includes: 39316-G-1210, 38526-G-1110)

Why Choose Us for Health Insurance?

UnitedHealthcare

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

UnitedHealthOne

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

Experience and Expertise

Golden Rule's experience and expertise has driven the development of easy-to-use and innovative health insurance products. A recognized leader — and one of the nation's largest providers of health savings account plans — Golden Rule continues building plans that meet the needs of individuals and families.

Our Goal: Your Satisfaction

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

Quality Coverage from a Proven Company

Leave it to the experts

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

Don't just take our word for it

Golden Rule is rated "A" (Excellent) by A.M. Best and "A+" (Strong) by Standard and Poor's. These worldwide, independent organizations examine insurance companies and other businesses and publish their opinions about them. These ratings are an indication of our financial strength and stability.

Fast claims processing

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

Big network, big savings

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

Initial rate guarantees

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

Benefits for a lifetime

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

Coverage for your children

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

Get the specialized care you need

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

In case of emergency

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

Health Reform Ready

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

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

Which Plan Best Fits Your Needs?

A Variety of Plans to Choose From

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

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

*Out-of-pocket exposure is deductible, coinsurance, and copays. Under all plans, additional expenses may be incurred that are not eligible for reimbursement by the insurance. Both the amount of benefits and the premium will vary based upon the plan you select.

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 range from 20-35% 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:

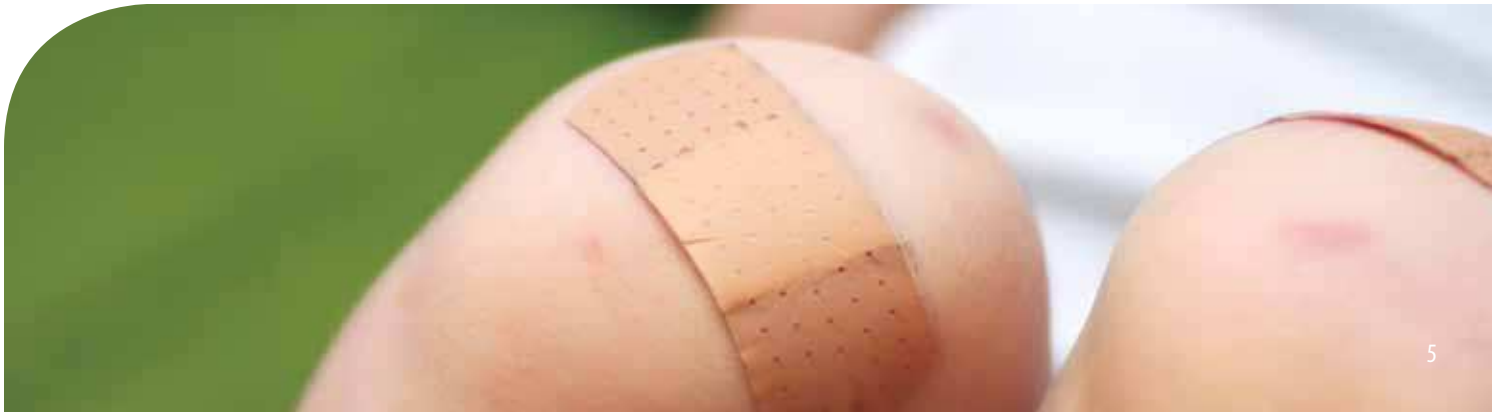
(Services provided February-March 2010)**

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

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

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

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



Copay Select℠

Convenient Doctor Office Copay Benefits

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

Prescription Drug* Card Benefits

- Generic drugs — $15 copay.
- Name-brand drugs — $100 per person, per calendar-year deductible, then:
  - — $30 copay for preferred* brands
  - — $60 copay for non-preferred brands

Comprehensive Coverage for Inpatient and Outpatient Medical Expenses

- Covered inpatient and outpatient expenses are reimbursed at 80% after the deductible has been met.

*We have a preferred drug list, which changes periodically. Status for a prescription drug may be determined by accessing your prescription drug benefits via our website or by calling the telephone number on your identification card.

Who might benefit most from a Copay Select℠ Plan?

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

In-Network Benefit Highlights

This chart summarizes standard network covered expenses, exclusions, and limitations of each plan. See pages 5, 13-17 for more information.

	Copay Select℠
Deductible Choices (maximum 2 per family, per calendar year)	You pay: $1,000, $1,500, $2,500, or $5,000
Coinsurance (% of covered expenses after deductible)	You pay: 20%
Coinsurance Out-of-Pocket Maximum (per person, per calendar year, after deductible)	$2,000
Initial Rate Guarantee (does not apply to benefit & address changes)	12 Months
Physician Care Benefits (Illness & Injury)	
Office Visit, History and Exam (primary care or specialist, not subject to the deductible)	$35 copay — no deductible
Primary Care Physician/Specialist Referrals Required	No
Prescription Drug Benefits	
If you purchase name-brand when generic is available, you pay your generic copay plus the additional cost above the generic price.	Generic: $15 copay Brand: $100 per person, per calendar year deductible, then: $30 copay for preferred, $60 copay for non-preferred.
Wellness/Preventive Care Benefits (no waiting period, not subject to deductible, coinsurance, or copayments)	
See page 13 for details	
Outpatient Expense Benefits	
X-ray and lab (performed in the doctor's office or a network facility)	You pay: 20% after deductible
Facility/Hospital for Outpatient Surgery	You pay: 20% after deductible
Surgeon, Assistant Surgeon, and Facility Fees	You pay: 20% after deductible
Hemodialysis, Radiation, Chemotherapy, Organ Transplant Drugs, and CAT Scans, MRIs	You pay: 20% after deductible
Emergency Room Fees — Illness	You pay: $100 copay if not admitted, then 20% after deductible
Emergency Room Fees — Injury	You pay: 20% after deductible
Spine and Back Disorders	You pay: 20% after deductible
Mental and Nervous Disorders (including substance abuse)	You pay: 20% after deductible
Other Outpatient Expenses	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	You pay: 20% after deductible
Other Inpatient Services	You pay: 20% after deductible

High Deductible Plans

Choice of Coverage

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

Lowest Premium Plan

Saver 80℠ is our lowest premium plan. This plan provides coverage for hospital confinements, surgical procedures in or out of the hospital (but not in the doctor's office), and the more costly outpatient expenses, such as CAT scans and MRIs.

Simple to Use

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

Who might benefit most from a High Deductible Plan?

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

In-Network Benefit Highlights

This chart summarizes standard network covered expenses, exclusions, and limitations of each plan. See pages 5, 13-17 for more information.

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

Health Savings Account (HSA) Plan

HSA Plans Offer Quality Coverage, Savings

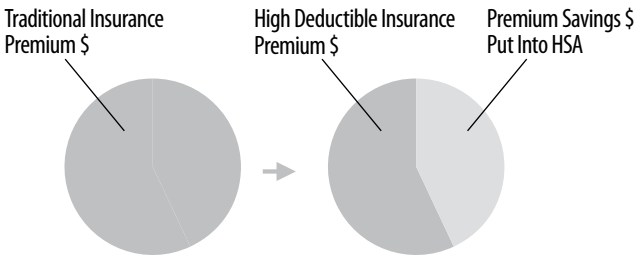
HSA Plans simply combine a lower-cost, high deductible health insurance plan and a tax-favored savings account.

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

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

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

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



*See page 12 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.

In-Network Benefit Highlights

This chart summarizes standard network covered expenses, exclusions, and limitations of each plan. See pages 5, 13-17 for more information.

	HSA 100®
Deductible Choices (per family deductible, per calendar year)	You pay: Single — $1,200, $1,900, $2,900, $3,500 or $5,000 Family — $2,400, $3,850, $5,800, $7,500 or $10,000
Coinsurance (% of covered expenses after deductible)	You pay: 0%
Coinsurance Out-of-Pocket Maximum (per calendar year, after deductible per family)	$0
Initial Rate Guarantee (does not apply to benefit & address changes)	12 Months
Physician Care Benefits (Illness & Injury)	
Office Visit, History and Exam (primary care or specialist)	No charge after deductible
Primary Care Physician/Specialist Referrals Required	No
Prescription Drug Benefits	
Preferred price card (You pay for prescriptions at the point of sale, at the lowest price available, and submit a claim to Golden Rule.)	No charge after deductible — Preferred price card
Wellness/Preventive Care Benefits (no waiting period, not subject to deductible or coinsurance)	
See page 13 for details	
Outpatient Expense Benefits	
X-ray and lab (performed in the doctor's office or a network facility)	No charge after deductible
Facility/Hospital for Outpatient Surgery	No charge after deductible
Surgeon, Assistant Surgeon, and Facility Fees	No charge after deductible
Hemodialysis, Radiation, Chemotherapy, Organ Transplant Drugs, and CAT Scans, MRIs	No charge after deductible
Emergency Room Fees	No charge after deductible
Spine and Back Disorders	No charge after deductible
Mental and Nervous Disorders (including substance abuse)	No charge after deductible
Other Outpatient Expenses	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
Other Inpatient Services	No charge after deductible

Optional Benefits

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

SD Alcoholism Treatment Benefit

This optional benefit covers treatment of alcoholism the same as any illness. Inpatient treatment must take place at a licensed hospital or residential primary treatment facility.

Available to South Dakota residents.

KY Mental Illness Benefit

The state of Kentucky requires that we offer an optional benefit for mental disorders.

Available to Kentucky residents with Saver 80℠ plans.

Term Life Benefit

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

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

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

Accidental Death Benefit

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

Motorcyclists are not eligible for this benefit.

Supplemental Accident Benefit

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.

Available with Copay Select℠, Plan 100®, Plan 80℠, and Saver 80℠.

Health Savings Account Management

Health Savings Account Debit MasterCard®

HSA holders can choose to save up to $3,050 for an individual and $6,150 for a family in 2011 (HSA holders 55 and older get to save an extra $1,000 which means $4,050 for an individual and $7,150 for a family) – and these contributions are 100% tax deductible from gross income.

HSA Management by OptumHealth Bank

With OptumHealth Bank, your money is easily available with a Health Savings Account Debit MasterCard®. Plus, you can manage your account online or by phone and be confident knowing that regular savings is FDIC insured. OptumHealth Bank's interest rate is tiered based on your balance. See the chart below for more information.

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

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

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

Optional Vision Benefit

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

We're here to help you.

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

UnitedHealthcare Vision Benefit Rider

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

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

See how you can save by using our Vision network

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

[1] After copay.

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

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

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

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

Policy Form SA-S-1356R

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

38526-G-1110

UnitedHealthOne

Covered Expenses

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

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

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

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

Definitions

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

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

How the Vision Program Works

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

A. Vision benefit preferred provider; or

B. Vision benefit non-preferred provider.

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

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

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

Exclusions and Limitations:

No benefits are payable for the following vision expenses:

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

Discounts on Laser Eye Surgery

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

Covered Expenses

Subject to all policy provisions, the following expenses are covered. To be considered for reimbursement, expenses must qualify as covered expenses and are also subject to reasonable and customary limits unless you use a network provider. Please review the additional plan information on pages 15-17 and the state variations on page 18.

All Plans

Preventive Care Expense Benefits

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

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

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

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

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

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

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

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

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

Medical Expense Benefits

- Daily hospital* room and board and nursing services at the most common semiprivate rate.
- Charges for intensive care unit.
- Hospital emergency room treatment of an injury or illness (subject to an additional $100 copay each time the emergency room is used for an illness not resulting in confinement — does not apply to HSA Plans).
- Services and supplies, including drugs and medicines, which are routinely provided by the hospital to persons for use while they are inpatients.
- Professional fees of doctors and surgeons (but not for standby availability).
- Dressings, sutures, casts, or other necessary medical supplies.
- Professional fees for outpatient services of licensed physical therapists.
- Diagnostic testing using radiologic, ultrasonographic, or laboratory services in or out of the hospital.
- Local ground ambulance service to the nearest hospital for necessary emergency care. Air ambulance, within U.S., if requested by police or medical authorities at the site of emergency.
- Charges for operating, treatment, or recovery room for surgery.
- Dental expenses due to an injury which damages natural teeth if expenses are incurred within six months.
- Surgical treatment of TMJ disorders (see General Limitations on page 16).
- Cost and administration of anesthetic, oxygen, and other gases.
- Radiation therapy or chemotherapy.
- Prescription drugs.
- Hemodialysis, processing, and administration of blood and components.
- Artificial eyes, larynx, breast prosthesis, or basic artificial limbs (but not replacements).
- Surgery in a doctor's office or at an outpatient surgical facility, including services and supplies.
- Occupational therapy following a covered treatment for traumatic hand injuries.
- 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.

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 15-17.

*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. To be considered for reimbursement, expenses must qualify as covered expenses and are also subject to reasonable and customary limits unless you use a network provider. Please review the additional plan information on pages 15-17 and the state variations on page 18.

Saver 80SM

Inpatient Expense Benefits

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

Outpatient Expense Benefits

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

Important note about Saver 80SM:

Premiums for Saver 80SM are significantly less because coverage is not provided for most outpatient services. Outpatient expenses not specifically listed in the policy are not covered. Please review the Saver 80SM Inpatient and Outpatient Expense Benefits.

Some expenses not covered under Saver 80SM include:

- Outpatient doctor office visit fees (except preventive), diagnostic testing, prescription drugs, and other outpatient medical services not specifically listed under the Inpatient, Outpatient, or Transplant Expense Benefits;
- Outpatient professional fees of licensed physical therapists, durable medical equipment, and medical supplies, except those covered under the Home Health Care Expense Benefits;
- Outpatient surgery expenses for surgery performed in a doctor's office; and
- Expenses incurred for mental or nervous disorders.

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 15-17.

*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.

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. Notification requirements are not applicable in KY.

Rehabilitation and Extended Care Facility (ECF) Benefit

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

Home Health Care Expense Benefit

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

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

Hospice Care

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

Preexisting Conditions

This does not apply to covered persons under age 19.

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

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

Provisions That Apply to All Plans (continued)

Limited Exclusion for AIDS or HIV-Related Disease

AIDS or HIV-related disease is 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. Not applicable in KY.

General Exclusions

No benefits are payable for expenses which:

- Are due to pregnancy (except for complications of pregnancy) or routine newborn care.
- Are for routine or preventive care unless provided for in the policy.
- Are incurred while confined primarily for custodial, rehabilitative, or educational care or nursing services.
- Result from or in the course of employment for wage or profit, if the covered person is insured, or is required to be insured, by workers' compensation insurance pursuant to applicable state or federal law. If you enter into a settlement that waives a covered person's right to recover future medical benefits under a workers' compensation law or insurance plan, this exclusion will still apply.
- Are in relation to, or incurred in conjunction with, 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.
- Are incurred while your policy is not in force.
- Are for any drug treatment or procedure that promotes conception.
- Are for any procedure that prevents conception or childbirth.

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

General Limitations

- Expenses incurred by a covered person for treatment of tonsils, adenoids, middle ear disorders, hemorrhoids, hernia, or any disorders of the reproductive organs (except cancer) are not covered during the covered person's first six months of coverage under the policy. This provision will not apply if treatment is provided on an "emergency" basis.
- "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:
  - Placing the health of the covered person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
  - Serious impairment to bodily functions; or
  - Serious dysfunction of any bodily organ or part.
- 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.
- As with any other illness or injury, inpatient care for mental disorders (including substance abuse), as defined in the policy/certificate, that is primarily for educational or rehabilitative care is not covered.
- Covered expenses for surgical treatment of TMJ, excluding tooth extractions, are limited to $10,000 per covered person.
- Covered expenses are limited to no more than a 34-day supply for any one outpatient prescription drug order or refill.
- When using an in-network physician or facility, non-covered expenses may not be eligible for a network provider discount.

Provisions That Apply to All Plans (continued)

Dependents

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

Effective Date

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

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

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.

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
- Accepts an employer's contribution to the premium payment or treats the policy as part of an employer-provided health plan.

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.

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. Not applicable in KY.

Medicare — Carve-Out

Covered persons who reach the age of Medicare eligibility and obtain Medicare coverage will be provided an alternative health insurance benefit called "Carve-out." Basically, "Carve-out" pays the difference between what Golden Rule benefits normally would pay and what is paid by Medicare. Not applicable in KY and SD.

State Variations

Kentucky

- The limited exclusion for AIDS does not apply.
- The exclusion for TMJ disorders does not apply.
- The 12-month exclusion period for preexisting conditions may be reduced for persons covered by qualifying prior coverage.
- A preexisting condition is an injury or illness for which medical advice, diagnosis, care, or treatment was recommended to or received by a covered person from a medical practitioner, licensed or similarly authorized to provide such services under state law and operating within the scope of practice authorized under state law, within the 6 months immediately preceding the covered person's applicable effective date.
- Covered expenses for home health aide services will be limited to 60 visits per calendar year, for each covered person. Each visit by an authorized representative of a home health-care agency shall be considered as 1 home health-care visit, except that 4 hours of home health aide service shall be considered as 1 home health visit.
- Covered expenses include mammograms for a covered person, regardless of age, who has been diagnosed with breast disease upon referral by a medical practitioner.
- The care and treatment of medically diagnosed inherited metabolic diseases are limited to: $25,000 per covered person, per calendar year for amino acid modified preparations; and $4,000 per covered person, per calendar year for low protein modified food products.
- Covered expenses include BMT and ABMT for breast cancer.
- Covered expenses include the refill of a prescription order dispensed prior to the expiration of your supply of a medication, limited to 3 refills in a 90-day period.
- Covered expenses include 1 hearing aid per ear for ages 0-17 years, limited to $1,400 per person in a 36-month period.
- Plans without UnitedHealthcare Choice Plus network not available.
- The following exclusions apply:
  - 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, 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.

South Dakota

- The preexisting condition reference to treatment within 24 months prior to applicable effective date is changed to 12 months. A preexisting condition does not include an injury that occurs on or after a covered person's effective date for injuries under the policy.
- A child will continue to be eligible until age 30 if unmarried and enrolled as a fulltime student.
- No benefits are payable for expenses as a result of any injury or illness for which benefits are paid pursuant to workers' compensation or similar law.
- Covered expenses include diagnosis or treatment of biologically based mental disorders.
- Covered expenses include diabetes equipment, supplies, and self-management training.
- Covered expenses include off-label prescription drugs for cancer or life-threatening conditions, subject to the conditions stated in the policy.
- Testing, diagnosis, and treatment of phenylketonuria are covered the same as any other illness.
- Anesthesia and hospital services for dental care are covered expenses when provided in a hospital or dental office for a covered person who is under age 5 years or a covered person who is severely disabled or at risk due to a developmental disability as determined by a physician.
- Substance abuse does not include alcoholism.
- If, after coverage is issued, a covered person becomes insured under a group or individual 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 benefits will never be more than 100 percent of covered expenses. COB also takes into account medical coverage under auto insurance contracts.
- 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 must identify the source of the disagreement, including all relevant facts and information supporting your position.
- A covered person's eligibility will cease on the earlier of the date a covered person:
  - Ceases to be a dependent; or
  - The next premium due date after receipt of notice from us that the covered person's eligibility has ceased due to accepting an employer's contribution to the premium payment or treating the policy as part of an employer-provided health plan.
- The South Dakota Risk Pool (guarantee issue without preexisting conditions exclusions) is available to eligible applicants. For more information visit *www.state.sd.us/bop/riskpool.htm* or call (605) 773-3148 and ask for a Risk Pool representative.

Wyoming

This policy does not contain comprehensive adult wellness benefits as defined by Wyoming law.

- Diabetes equipment, supplies, and outpatient self-management training and education provided by a doctor with expertise in diabetes are covered the same as any illness. Outpatient self-management training and education is limited to: (1) a one-time evaluation and training program within one year of diagnosis; and (2) additional self-management training upon a significant change in symptoms, condition, or treatment, limited to three hours per covered person, per calendar year.
- A preexisting condition is an injury or illness for which medical advice, diagnosis, care, or treatment was recommended to or received by a covered person within 6 months immediately preceding the applicable effective date the covered person became insured under the policy.
  - A covered person's 12-month preexisting condition exclusion period may be reduced due to qualifying prior coverage.
- The following exclusions apply:
  - 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, 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.

NOTICE OF INFORMATION PRACTICES

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

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

The terms "information" or "health information" in this notice include any information we maintain that reasonably can be used to identify you and that relates to your physical or mental health or condition, the provision of health care to you, or the payment for such health care.

We have the right to change our privacy practices. If we do, we will provide the revised notice to you within 60 days by direct mail or post it on our websites located at *www.goldenrule.com* or *www.eams.com*

How We Use or Disclose Information

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

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

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

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

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

- **As Required by Law.** We may disclose information when required by law.
- **To Persons Involved With Your Care.** We may use or disclose your health information to a person involved in your care, such as a family member, when you are incapacitated or in an emergency, or when permitted by law.
- **For Public Health Activities** such as reporting disease outbreaks.
- **For Reporting Victims of Abuse, Neglect or Domestic Violence** to government authorities, including a social service or protective service agency.
- **For Health Oversight Activities** such as governmental audits and fraud and abuse investigations.
- **For Judicial or Administrative Proceedings** such as in response to a court order, search warrant or subpoena.
- **For Law Enforcement Purposes** such as providing limited information to locate a missing person.
- **To Avoid a Serious Threat to Health or Safety** by, for example, disclosing information to public health agencies.
- **For Specialized Government Functions** such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
- **For Workers Compensation** including disclosures required by state workers compensation laws of job-related injuries.
- **For Research Purposes** such as research related to the prevention of disease or disability, if the research study meets all privacy law requirements.
- **To Provide Information Regarding Decedents.** We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as necessary to carry out their duties.
- **For Organ Procurement Purposes.** We may use or disclose information for procurement, banking or transplantation of organs, eyes or tissue.
- **To Correctional Institutions or Law Enforcement Officials** if you are an inmate of a correctional institution or under the custody of a law enforcement official, but only if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
- **To Business Associates** that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. Our business associates are required, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract. As of 2/17/10, our business associates are also directly subject to federal privacy laws.
- **For Data Breach Notification Purposes.** We may use your contact information to provide legally-required notices of unauthorized acquisition, access, or disclosure of your health information.
- **Additional Restrictions on Use and Disclosure.** Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. "Highly confidential information" may include confidential information under federal laws governing alcohol and drug abuse information and genetic information as well as state laws that often protect the following types of information: HIV/AIDS; mental health; genetic tests; alcohol and drug abuse; sexually transmitted diseases and reproductive health information; and child or adult abuse or neglect, including sexual assault.

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

What Are Your Rights

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

- **You have the right to ask to restrict** uses or disclosures of your information for treatment, payment, or health-care operations and to ask to restrict disclosures to family members or to others who are involved in your health care or payment for your health care. We may also have policies on dependent access that may authorize certain restrictions. **Please note that while we will try to honor your request and will permit requests consistent with its policies, we are not required to agree to any restriction.**
- **You have the right to request that a provider not send health information** to us in certain circumstances if the health information concerns a health-care item or service for which you have paid the provider out of pocket in full.
- **You have the right to ask to receive confidential communications** of information in a different manner or at a different place (for example, by sending information to a P.O. Box instead of your home address). We will accommodate reasonable requests where a disclosure of all or part of your health information otherwise could endanger you. We will accept verbal requests to receive confidential communications, but request to modify or cancel a previous confidential communication request must be made in writing. Mail your request to the address listed below.
- **You have the right to see and obtain a copy** of health information that may be used to make decisions about you such as claims and case or medical management records. You also may receive a summary of this health information. You must make a written request to inspect and copy your health information. In certain limited circumstances, we may deny your request to inspect and copy your health information.
- **You have the right to ask to amend information** we maintain about you if you believe the health information about you is wrong or incomplete. We will notify you within 30 days if we deny your request and provide a reason for our decision. If we deny your request, you may have a statement of your disagreement added to your health information. We will notify you in writing of any amendments we make at your request. We will provide updates to all parties that have received information from us within the past two years (seven years for support organizations).
- **You have the right to receive an accounting** of certain disclosures of your information made by us during the six years prior to your request. This accounting will not include disclosures of information: (i) made prior to April 14, 2003; (ii) for treatment, payment, and health-care operations purposes; (iii) to you or pursuant to your authorization; and (iv) to correctional institutions or law enforcement officials; and (v) that federal law does not require us to provide an accounting.
- **You have the right to a paper copy of this notice.** You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice upon request. In addition, you may obtain a copy of this notice at our websites, *www.eAMS.com* or *www.goldenrule.com*.
- In New Mexico, you have the right to be considered a protected person. A "protected person" is a victim of domestic abuse who also is either: (1) an applicant for insurance with us: (2) a person who is or may be covered by our insurance; or (3) someone who has a claim for benefits under our insurance.

Exercising Your Rights

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

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

- Privacy Officer, Golden Rule Insurance Company, 7440 Woodland Drive, Indianapolis, IN 46278-1719

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

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

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

33638-X-1110 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, All Savers Life Insurance Company of California, 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 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.

_____ _____

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, 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, 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.

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.

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

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

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

I (we) have received Golden Rule's Notice of Information Practices. This authorization shall remain valid for 30 months (24 months in KY) from the date below.

I (we) understand the following:

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

I have retained a copy of this authorization.

36228-0709

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

UnitedHealthOne