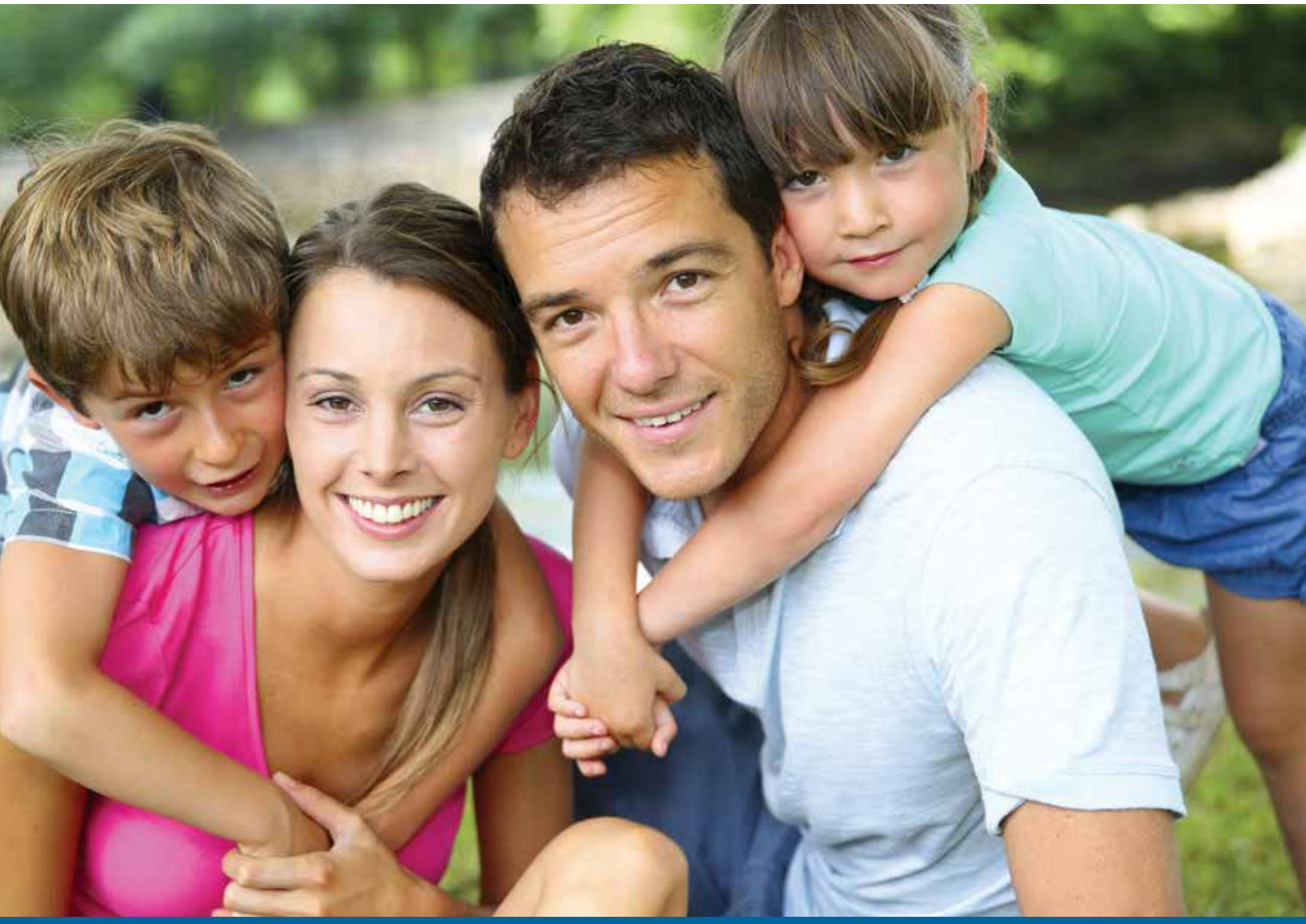
Missouri

Health Insurance Plans
For Individuals and Families

ACA Plans with Minimum Essential Coverage -
These Off-Exchange plans are not ACA tax credit eligible.



UnitedHealthcare Life Insurance Company (UHCLIC) is the underwriter and administrator of these plans offered Off-Exchange.
Policy Forms GIP-X15-P: -CPY-B1-24, -CPY-B2-24, -CPY-S1-24, -CPY-S2-24, -CPY-G1-24, -CPY-G2-24, -CPY-P-24, -HSA-B-24, -HSA-S-24, -SS-24

UnitedHealthcare®
UnitedHealthcare Life Insurance Company

Why Choose Us?

Strength & Experience

UnitedHealthcare provides over 30 million Americans access to health care.* Within the UnitedHealthcare family of companies, we have been serving the specific needs of individuals and families buying their own coverage for nearly 70 years.

Highly Rated

UnitedHealthcare Life Insurance Company, the underwriter and administrator of plans featured in this brochure, is rated "A" (Excellent) by A.M. Best (12-11-13). This worldwide independent organization examines insurance companies and other businesses, and publishes its opinion about them. This rating is an indication of our financial strength and stability.

Outstanding Claims Service

Our employees who process claims have a long history of fast service. The results – 94% of all health claims are processed within 12 working days or less.**

* UnitedHealth Group Annual Form 10-K for year ended 12/31/13.
** Actual 2013 results.

This is an outline only and is not intended to serve as a legal interpretation of benefits. Reasonable effort has been made to have this outline represent the intent of contract language. However, the contract language stands alone and the complete terms of the coverage will be determined by the policy.

UnitedHealthcare Navigate Plus® network

Our network of doctors and hospitals provides you with great value for your health care dollars. Our network providers offer quality care at a significant discount, costing you less. Getting your non-emergency care from a doctor or hospital not in our network will cost you more.

Sample Savings with our network (Services provided 03/2014-08/2014)[1]

Receive quality care at reduced costs because our network providers have agreed to lower fees for covered expenses. Here are some examples of the savings:

Benefit	Actual Charges	Network Repriced Charges	Network Savings
Doctor Office Visit - established patient	$86.37	$39.39	**54%**
MRI	$1,156.93	$403.67	**65%**
Lipid Panel (Cholesterol)	$80.48	$8.38	**90%**
CBC (Complete Blood Count)	$31.35	$4.57	**85%**
Metabolic Panel (Blood sugar/kidney and liver function)	$46.45	$5.98	**87%**
General Panel (General blood work)	$161.29	$20.26	**87%**

Non-emergency covered expenses

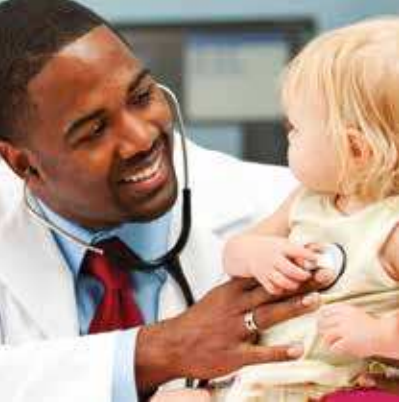
Using non-network providers you pay:[2]

- All charges above what is considered an eligible expense;
- A penalty of 25% of the eligible expense, which does not count toward the deductible; and
- A deductible equal to 2 times the network deductible.

There is no out-of-pocket maximum for non-network providers.

[1] All these services were received from network providers in ZIP Code 336--. Your actual savings may be more or less than this illustration. Discounts vary by provider, geographic area, and type of service.

[2] No benefits payable for non-network chiropractic services. Also your actual out-of-pocket costs may be more than the stated coinsurance because the bill from a non-network provider may not be used to calculate what we pay and what you pay. Considering these factors, seeing in-network providers can result in a savings for what you pay for your health care.



Types of Health Plans

PAGES	COPAY PLANS	Catastrophic	Bronze	Silver	Gold	Platinum
6-7	Features a set copay. You have the convenience of knowing what you'll pay for a basic doctor visit or prescription.	✓	✓	✓	✓	✓
10-11	Select Saver℠ is our catastrophic copay plan (certain age or other restrictions apply).					

◄ More Affordable More Comprehensive ►

PAGES	HEALTH SAVINGS ACCOUNT (HSA) PLANS					
8-9	An insurance plan and an available savings account. Pay qualified medical expenses with your account. Save on taxes, too!		✓	✓		

◄ More Affordable More Comprehensive ►

How our plans work

- You select a Primary Care Physician (PCP) within our network and your state of residence. A PCP is considered Family Practice, General Practice, Internal Medicine, or Pediatrics for kids. Your PCP provides routine care – such as annual well visits, preventive care, and for illness and injury.
- Your PCP refers you to network specialists when additional care is needed. It is your responsibility to obtain a referral from your PCP. If no referral is obtained from a PCP, network benefits will be reduced by 20%. No referral is needed for a network obstetrician or gynecologist.
- If you do not select a PCP, we will assign one to manage your care.

Important note: Your PCP may be a part of a group of doctors. If all are practicing under the same Tax Identification Number (TIN), you may see or obtain a referral from any PCP in the group. With Copay Select℠ plans, visits to a network PCP outside the group will be subject to the specialist copay amount.

This insurance coverage is not designed or marketed as employer-provided insurance. It does not comply with Missouri small-employer group health insurance laws. These plans cannot be used, now or in the future, by you or an employer to provide insurance for employees.

Health Care Definitions

Note: These definitions are provided only to give you a general understanding of how these words are sometimes used by health insurance companies. Please refer to your coverage documents for a complete list of defined terms that apply to your specific coverage.

benefit - A service or supply that is covered under a health insurance plan. This might include office visits, lab tests, and procedures during the course of treatment.

coinsurance - Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the eligible expense for the service. You pay coinsurance after you pay your deductible.

complications of pregnancy - Severe conditions due to pregnancy, labor, and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and elective caesarean section are not complications of pregnancy.

copay/copayment - A fixed amount (for example, $35) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

deductible - The amount of money you owe for health care services your health insurance covers before your health insurance or plan begins to pay.

eligible expenses - Maximum amount on which payment is based for covered health care services. This may also be called "allowed amount," "payment allowance," "negotiated rate," or "covered expense."

emergency services - Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

excluded services - Health care services that your health insurance doesn't pay for or cover.

limitation - The most, in terms of cost and services, a health plan will cover.

minimum essential coverage - The type of coverage an individual needs to have to meet the individual responsibility requirement under the Affordable Care Act (ACA).

network - The facilities, providers, and suppliers your health insurer or plan has contracted with to provide health care services.

network provider - A provider who has a contract with your health plan's network to provide services to you at a discount.

non-network provider - A provider who doesn't have a contract with your health plan's network. You'll pay more to see an out-of-network provider for non-emergency services. This may also be called an "out-of-network provider."

premium - The amount that must be paid for your health insurance. You usually pay it monthly or quarterly.

prescriptions/Rx drugs - Drugs and medications that by law require a prescription.

urgent care center - A facility, not including a hospital emergency room or doctor's office, that provides treatment or services that are required: (a) to prevent serious deterioration of a covered person's health; and (b) as a result of an unforeseen illness, injury, or the onset of acute severe symptoms.

A Copay Plan Offers You:

- **Convenient doctor office copays.***
- **Prescription drug coverage.****
- **Pediatric dental and vision coverage. See page 16.**

The benefits described here are for covered expenses using network providers. In order for some benefits to be covered at the highest level, Prior Authorization is required. Please see page 12 for details.
The chart summarizes standard network covered expenses. For more information, including General Exclusions and Limitations, see pages 13-20.

Select Saver℠ is our catastrophic copay plan (certain age or other restrictions apply), see pages 10-11.

* Office visits to non-network doctors will cost you more. See page 20. You must be referred by your Primary Care Physician to see a specialist.

** The preferred drug list changes periodically. Tier status for a prescription drug may be determined by visiting www.myuhone.com or by calling the telephone number on your identification card. The tier to which a prescription drug is assigned may change.

Highlights of network covered expenses		Bronze Copay Select℠ 1	Bronze Copay Select℠ 2	Silver Copay Select℠ 1	Silver Copay Select℠ 2	Gold Copay Select℠ 1	Gold Copay Select℠ 2	Platinum Copay Select℠
Deductible (per calendar year)	You pay:	$5,000 per person	$5,000 per person	$5,000 per person	$2,500 per person	$1,000 per person	$1,500 per person	$750 per person
Coinsurance (% you pay after deductible, per calendar year)	You pay:	20% per person	30% per person	20% per person	30% per person	20% per person	10% per person	10% per person
Out-of-Pocket Maximum (includes all copays, deductibles, and coinsurance)	You pay:	$6,600 per person, $13,200 per family	$6,600 per person, $13,200 per family	$6,450 per person, $12,900 per family	$6,600 per person, $13,200 per family	$6,600 per person, $13,200 per family	$6,600 per person, $13,200 per family	$1,500 per person, $3,000 per family
Doctor Office								
Primary Care Physician (PCP) / Specialist		You select a network Primary Care Physician (PCP) to manage your care. PCP referral required to see a network specialist.						
Preventive Care See page 13 for details.	You pay:	No charge – 100% covered in-network.						
Office Visit, History, and Exam only - Primary (deductible does not apply)	You pay:	$50 copay - 4 visit limit[1,2]	$50 copay	$35 copay	$35 copay - 4 visit limit[1,2]	$25 copay	$15 copay	$15 copay
Office Visit, History, and Exam only - Specialist Referral required (deductible does not apply)	You pay:	$100 copay	$100 copay	$60 copay	$70 copay	$30 copay	$30 copay	$30 copay
Urgent Care Center	You pay:	20% after deductible	30% after deductible	20% after deductible	30% after deductible	$50 copay - 2 visit limit[2]	10% after deductible	10% after deductible
Pharmacy								
Name Brand and Generic Prescription Drugs If you purchase name-brand prescription when generic is available, you pay your generic copay plus the additional cost above the generic price. Generic drugs may reside in any tier.	**Prescription Deductible** You pay:	Combined medical and drug	Combined medical and drug	Tiers 2-4 combined: $500 per person	Tiers 2-4 combined: $1,000 per person	Tiers 2-4 combined: $500 per person	Tiers 2-4 combined: $500 per person	Tiers 2-4 combined: $250 per person
	Tier 1[3] You pay:	$20 copay	$20 copay	$15 copay	$15 copay	$10 copay	$12 copay	$8 copay
	Tier 2 You pay:	20% after deductible, Preferred Price Card: You pay for prescriptions at the point of sale, at the lowest price available, and submit a claim to us.	30% after deductible, Preferred Price Card: You pay for prescriptions at the point of sale, at the lowest price available, and submit a claim to us.	$40 copay after Rx deductible	$40 copay after Rx deductible	$35 copay after Rx deductible	$35 copay after Rx deductible	$25 copay after Rx deductible
	Tier 3 You pay:			$80 copay after Rx deductible	$80 copay after Rx deductible	$65 copay after Rx deductible	$65 copay after Rx deductible	$50 copay after Rx deductible
	Tier 4 You pay:			25% coinsurance after Rx deductible	30% coinsurance after Rx deductible	25% coinsurance after Rx deductible	25% coinsurance after Rx deductible	25% coinsurance after Rx deductible
Outpatient								
Emergency Room Fees (additional $250 ER deductible for illness if not admitted)	You pay:	20% after deductible	30% after deductible	20% after deductible	30% after deductible	20% after deductible	10% after deductible	10% after deductible
X-ray and Lab								
Facility/Hospital for Outpatient Surgery								
Inpatient								
Hospital 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	$500 copay per admit, then 30% after deductible	20% after deductible	30% after deductible	20% after deductible	10% after deductible	10% after deductible
Pregnancy/Maternity Care								
Prenatal Care	You pay:	No charge – 100% covered in-network.						
Delivery, Inpatient Services, and Postnatal Care	You pay:	20% after deductible	30% after deductible	20% after deductible	30% after deductible	20% after deductible	10% after deductible	10% after deductible
Mental and Nervous Disorders (including substance abuse)								
Outpatient Office Visit, History, and Exam only (deductible does not apply)	You pay:	$50 copay - part of 4 office visit limit above	$50 copay	$35 copay	$35 copay - part of 4 office visit limit above	$25 copay	$15 copay	$15 copay
Inpatient Services	You pay:	20% after deductible	30% after deductible	20% after deductible	30% after deductible	20% after deductible	10% after deductible	10% after deductible

[1] Includes Outpatient Mental and Nervous visits.
[2] Per covered person, per calendar year. Additional visits subject to deductible and coinsurance.
[3] Deductible does not apply.

HEALTH SAVINGS ACCOUNT (HSA) PLANS

An HSA Plan Offers You:

A lower-cost, high deductible health insurance plan and a savings account with important tax benefits.

- **Lower premiums** than most copay plans.
- **Simple design**: meet your deductible and the plan pays 100% of covered expenses for the calendar year.
- **Savings account** you can use for qualified health care expenses or for retirement after age 65.
- **Pediatric dental and vision coverage. See page 16.**

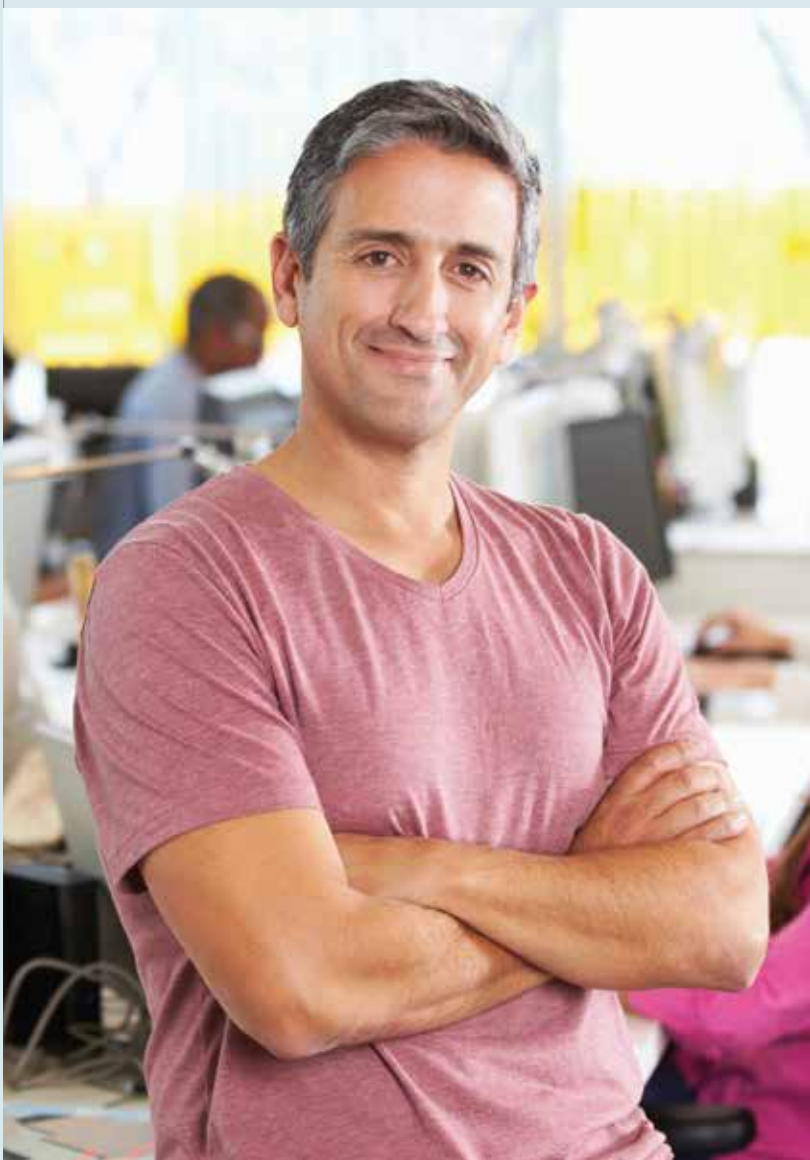
We have chosen Optum Bank℠, Member FDIC, a leading custodian of health savings accounts, as our recommended financial institution. Optum Bank℠ will service your account and send information directly to you about your HSA.

- **Eligibility** - account holder must:
  - Be the primary insured for an HSA 100® plan
  - Not be enrolled in Medicare
  - Not be a dependent on another person's tax return
- **Tax-deductible** - HSA contributions are 100% tax-deductible from gross income up to IRS limits.
- **Tax-free** - for qualified medical withdrawals.
- **Nonmedical withdrawals:**
  - Income tax + penalty tax (20% for those under age 65).
  - Income tax only (for age 65 and over).
- **Death, Disability of the account holder:**
  - Spouse assumes HSA with no tax issue.
  - Non-spouse: HSA withdrawals are subject to income tax, but there is no penalty.

Deductible and out-of-pocket maximum may be adjusted annually based on changes in the Consumer Price Index. This is only a brief summary of the applicable federal law. Consult your tax advisor for more details of the law. Any fees associated with your account will be provided with your Optum Bank℠ Welcome Kit.

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

The benefits described here are for covered expenses using network providers. In order for some benefits to be covered at the highest level, Prior Authorization is required. Please see page 12 for details.
The chart summarizes standard network covered expenses. For more information, including General Exclusions and Limitations, see pages 13-20.



Highlights of network covered expenses		Bronze HSA 100®	Silver HSA 100®
Deductible (per calendar year)	You pay:	$6,300 per person **OR** $12,600 per family[1]	$3,650 per person **OR** $7,300 per family[1]
Coinsurance (% you pay after deductible, per calendar year)	You pay:	0%	0%
Out-of-Pocket Maximum (includes deductible)	You pay:	$6,300 individual plan, $12,600 family plan	$3,650 individual plan, $7,300 family plan
Maximum 2015 HSA Contribution		$3,350 per person (over age 55 additional $1,000 catch-up contribution) $6,650 per family	

[1] With HSA family plans, there is no 'per person' deductible, only the family deductible.

Doctor Office

Primary Care Physician (PCP) / Specialist		You select a network Primary Care Physician (PCP) to manage your care. PCP referral required to see a network specialist.
Preventive Care See page 13 for details.	You pay:	No charge – 100% covered in-network.
Office Visit, History, and Exam only - Primary	You pay:	No charge after deductible
Office Visit, History, and Exam only - Specialist Referral required		
Urgent Care Center		

Pharmacy

Name Brand and Generic Prescription Drugs	**Prescription Deductible**	You pay:	Combined medical and drug
	Tier 1	You pay:	No charge after deductible – Preferred Price Card: You pay for prescriptions at the point of sale, at the lowest price available, and submit a claim to us.
	Tier 2		
	Tier 3		
	Tier 4		

Outpatient

Emergency Room Fees	You pay:	No charge after deductible
X-ray and Lab		
Facility/Hospital for Outpatient Surgery		

Inpatient

Hospital Room and Board, Intensive Care Unit, Operating Room, Recovery Room, Prescription Drugs, Physician Visit, and Professional Fees of Doctors, Surgeons, Nurses	You pay:	No charge after deductible

Pregnancy/Maternity Care

Prenatal Care	You pay:	No charge – 100% covered in-network.
Delivery, Inpatient Services, and Postnatal Care	You pay:	No charge after deductible

Mental and Nervous Disorders (including substance abuse)

Outpatient and Inpatient Services	You pay:	No charge after deductible

SELECT SAVER℠ PLAN - QUALIFICATIONS APPLY
(CATASTROPHIC PLAN)

Two Ways To Qualify

You must either:

- **Be under age 30; or**
- **Receive a "Certificate of Exemption"** from the Federal Marketplace because:
  a) You cannot afford Minimum Essential Coverage; or
  b) You are eligible for a hardship exemption.

If you are under age 30, you may continue the plan as Minimum Essential Coverage (MEC) until the end of the year during which you turn age 30.

If you are age 30 or over and do not receive a "Certificate of Exemption" from the Federal Marketplace:

- The Select Saver℠ plan will not serve as Minimum Essential Coverage; and
- **You may be subject to a tax penalty.**

This Plan Offers You:

- **Simple design**: meet your deductible and the plan pays 100% of covered expenses.
- **Three primary care doctor office visits** (per covered person, per calendar year) for history and exam with a $35 copay.
- **Our lowest premiums**.
- **Pediatric dental and vision coverage. See page 16.**

The benefits described here are for covered expenses using network providers. In order for some benefits to be covered at the highest level, Prior Authorization is required. Please see page 12 for details.
The chart summarizes standard network covered expenses. For more information, including General Exclusions and Limitations, see pages 13-20.

Highlights of network covered expenses		Select Saver℠ (Catastrophic Plan)
Deductible (per calendar year)	You pay:	$6,600 per person
Coinsurance (% you pay after deductible, per calendar year)	You pay:	0%
Out-of-Pocket Maximum (includes all copays and deductible)	You pay:	$6,600 per covered person, not to exceed $13,200 for all covered persons in a family

Doctor Office

Primary Care Physician (PCP) / Specialist		You select a network Primary Care Physician (PCP) to manage your care. PCP referral required to see a network specialist.
Preventive Care See page 13 for details.	You pay:	No charge – 100% covered in-network.
Office Visit, History, and Exam only - Primary	You pay:	$35 copay – 3 visit limit.*
Office Visit, History, and Exam only - Specialist Referral required	You pay:	No charge after deductible
Urgent Care Center		

* Per covered person, per calendar year. Additional visits subject to deductible.

Pharmacy

Name Brand and Generic Prescription Drugs	**Prescription Deductible**	You pay:	Combined medical and drug
	Tier 1	You pay:	No charge after deductible – Preferred Price Card: You pay for prescriptions at the point of sale, at the lowest price available, and submit a claim to us.
	Tier 2		
	Tier 3		
	Tier 4		

Outpatient

Emergency Room Fees	You pay:	No charge after deductible
X-ray and Lab		
Facility/Hospital for Outpatient Surgery		

Inpatient

Hospital Room and Board, Intensive Care Unit, Operating Room, Recovery Room, Prescription Drugs, Physician Visit, and Professional Fees of Doctors, Surgeons, Nurses	You pay:	No charge after deductible

Pregnancy/Maternity Care

Prenatal Care	You pay:	No charge – 100% covered in-network.
Delivery, Inpatient Services, and Postnatal Care	You pay:	No charge after deductible

Mental and Nervous Disorders (including substance abuse)

Outpatient and Inpatient Services	You pay:	No charge after deductible

Prior Authorization Required

Network providers are responsible for obtaining Prior Authorization for most services. However, before receiving the services or supplies listed below, you are required to call the notification phone number on your I.D. card. Without Prior Authorization, **benefits are reduced by 20%.** Prior Authorization does not guarantee payment.

You must call before receiving the services or supplies below.

Service or Supply	Using either a network provider or a non-network provider, you must call:
Ambulance, non-emergency	As soon as possible.
Clinical Trials	As soon as the possibility arises.
Dental Services – injuries only (for post-emergency treatment)	5 business days before follow-up treatment.
Durable Medical Equipment	For services, supplies, or equipment exceeding $1,000.
Pediatric Orthodontic Services	30 days prior to treatment. Failure to obtain Prior Authorization may result in the denial of claim rather than the 20% benefit reduction.
Transplants	As soon as possibility arises and before pre-transplant evaluation at transplant center. See Transplant Services on page 17.

You must call for non-network providers of the services and supplies below.

Service or Supply	Using a non-network provider, you must call:
Diabetes Services	For services, supplies, or equipment exceeding $1,000.
Home Health Care	5 business days before receiving services or as soon as possible.
Inpatient Hospice Care	5 business days before inpatient admission or as soon as possible.
Inpatient Hospital Stay	5 business days before scheduled admission. For nonscheduled admission, including emergency admission: as soon as possible.
Lab, X-ray, and Major Diagnostics (includes CT, PET, MRI, MRA, and Nuclear Medicine)	5 business days before services. For nonscheduled services: within 1 business day or as soon as possible.
Pregnancy and Delivery	For normal vaginal delivery: as soon as possible if inpatient stay for mother and/or newborn will be more than 48 hours after delivery. For caesarean section: as soon as possible if inpatient stay will be more than 96 hours following delivery.
Prosthetic Devices	Before obtaining prosthetic devices exceeding $1,000.
Reconstructive Surgery	5 business days prior for outpatient surgery. For nonscheduled surgery: 1 business day or as soon as possible.
Rehabilitation and Extended Care Facility Services	5 business days prior or as soon as possible for outpatient or inpatient services.
Surgery – Outpatient	5 business days prior to scheduled services. For nonscheduled services: 1 business day or as soon as possible.
Temporomandibular Joint (TMJ) Services	5 business days prior to an inpatient hospital stay.
Therapeutic Treatments: Chemotherapy, Dialysis, or Radiation	5 business days prior to treatment. For nonscheduled services: 1 business day or as soon as possible.

Certain outpatient prescription drugs require Prior Authorization before dispensing. Your doctor's office or pharmacist should call to receive the Prior Authorization. Failure to receive Prior Authorization will result in reduced benefits or no benefits.

Covered Expenses that apply to all plans

Subject to all policy provisions, the following expenses are covered. To be considered for reimbursement, expenses must qualify as covered expenses. Expenses are subject to eligible expense limits unless you use a network provider. Please review the detailed plan information on pages 13-20.

Primary Care Physician (PCP)

You select a Primary Care Physician (PCP) within our network and your state of residence. A PCP is considered Family Practice, General Practice, Internal Medicine, or Pediatrics for kids. Your PCP provides routine care – such as annual well visits, preventive care, and for illness and injury. Your PCP refers you to network specialists when additional care is needed. It is your responsibility to obtain a referral from your PCP. If no referral is obtained from a PCP, network benefits will be reduced by 20%. No referral is needed for a network obstetrician or gynecologist. If you do not select a PCP, we will assign one to manage your care.

Important note: Your PCP may be a part of a group of doctors. If all are practicing under the same Tax Identification Number (TIN), you may see or obtain a referral from any PCP within the group. With Copay Select℠ plans, visits to a network PCP outside the group will be subject to the specialist copay amount.

Preventive Care Benefits

Preventive services are covered without a deductible, copay, or coinsurance, when a network provider is used.

Covered preventive services are those services described in one of the following:

- United States Preventive Services Task Force recommendations (A and B only).
- Advisory Committee on Immunization Practices (ACIP) recommendations.
- Health Resources and Service Administration guidelines for women and children.

The following are some examples of these benefits. Please note, however, these may change as the recommendations and guidelines change.

Preventive Benefits for All Covered Persons:

- Annual wellness visits.
- Standard immunizations recommended by the ACIP.
- Screening and counseling in a primary care setting for alcohol or substance abuse, tobacco use, obesity, and diet and nutrition.
- Specific screenings (e.g., PSA (men only), colorectal cancer, elevated cholesterol, lipids, sexually transmitted diseases, HIV, high blood pressure, diabetes, and depression).

Preventive Benefits for Women:

- Breastfeeding support, supplies, and counseling.
- Evaluation and testing for breast cancer BRCA gene.
- Counseling women at high risk of breast cancer for chemoprevention.
- Contraceptive services.
- Some contraceptive prescriptions are covered under preventive at no cost. Copay plans limited to Tier 1 only.
- Screening and counseling for HIV.
- Human papillomavirus DNA Testing.
- Screening and counseling for interpersonal and domestic violence.
- Some prenatal care.
- Counseling for sexually transmitted infections.
- Specific screenings (e.g., mammography, cervical cancer including pap smears, gonorrhea, chlamydia, syphilis screenings, and osteoporosis screening).

Preventive Benefits for Children:

- Counseling for fluoride treatment.
- Screening for major depressive disorders.
- Standard metabolic screening panel for inherited enzyme deficiency diseases.
- Screening for newborns (e.g., hearing, thyroid, phenylketonuria, and sickle cell anemia).
- Counseling for obesity.
- Specific screenings (e.g., vision, developmental, autism, lead, and tuberculosis).

The Affordable Care Act (ACA) does not require first-dollar coverage for diagnostic services. A diagnostic service is performed on someone who exhibits symptoms that require further testing or diagnosis.

A preventive service is performed on someone who does not have symptoms (the service is done for "preventive" reasons). 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. The timing of these changes may vary based on the implementation of the laws requiring the change. Visit www.healthcare.gov for complete information.

Covered Expenses that apply to all plans, continued

Medical Expense Benefits - subject to deductible and copay/coinsurance (if applicable)

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

Ambulance Services

Local ground ambulance service to the nearest hospital for necessary emergency care. Air ambulance, within the U.S., if requested by police or medical authorities at the site of an emergency.

No benefits payable for: local government expenses, unless required by law; non-emergency air ambulance; or ambulance service for a covered person's comfort or convenience.

Autism Services

Medically necessary services to diagnose and treat autism spectrum disorders.

Behavioral Health Services

Inpatient and outpatient treatment for a recognized mental illness, including substance abuse.

Dental Services – Accident Only

Initial repair of an accidental injury to sound, natural teeth, mouth, or face. Services must take place within 12 months of the injury.

No benefits payable for injuries resulting from chewing or biting, or for routine dental services.

Dental Services – Anesthesia

General anesthesia and associated charges for a covered person: age 4 or younger; who is severely disabled; with a medical or behavioral condition that requires hospitalization or general anesthesia when dental services are provided.

Diabetic Equipment, Education, and Supplies

Medically necessary equipment, supplies, and self-management training.

Diagnostic Testing

Diagnostic services and materials using radiologic, ultrasonographic, or laboratory services.

Emergency

Hospital emergency room (ER) treatment of an injury or illness. Copay Select℠ plans have an additional $250 ER deductible per illness visit if not admitted.

General Exclusions and General Limitations

See pages 18-19.

Habilitative Services

For treatment of a congenital, genetic, or early acquired disorder. Treatment must be administered by licensed practitioners and must be proven, not experimental or investigational.

Habilitative services do not include:

- Services provided by family or household members.
- Services that are solely educational in nature or otherwise paid under state or federal law for purely educational services.
- Treatment of mental disorders, other than congenital, genetic, or early acquired disorders.
- Custodial care, respite care, day care, therapeutic recreation, vocational training, and residential treatment.

Covered Expenses that apply to all plans, continued

Medical Expense Benefits - subject to deductible and copay/coinsurance (if applicable)

Home Care Services

When confined to the home for medical reasons and physically unable to obtain needed medical services on an outpatient basis. Home health care services are limited to a maximum of 90 visits per covered person, per calendar year. Private duty nursing care is limited to 125 visits per calendar year, per covered person.

No benefits payable for:

- Food, housing, homemaker services, and home delivered meals.
- Home or outpatient hemodialysis services (these are covered under Therapy Services).
- Doctor charges.
- Helpful environmental materials such as hand rails, ramps, telephones, air conditioners, and similar services, appliances, and devices.
- Services provided by registered nurses and other health workers who are not acting as employees or under approved arrangements with a contracting home health care provider.
- Services provided by a member of the covered person's immediate family.
- Services provided by volunteer ambulance associations for which the covered person is not obligated to pay, visiting teachers, vocational guidance and other counselors, and services related to outside, occupational, and social activities.

Hospice Services

A covered person must have been given a prognosis that he or she has 6 months or less to live.

No benefits payable for:

- Services provided by volunteers.
- Housekeeping services.

Inpatient Services

Daily hospital room and board not to exceed the hospital's most common semi-private room rate; intensive care; services and supplies routinely provided in the hospital to persons for use only while they are inpatients; and outpatient use of operating, treatment, or recovery room for surgery.

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

Maternity Services

Normal pregnancy, birth, and any complications, includes inpatient, outpatient, and doctor services.

Medical Supplies, Durable Medical Equipment, and Appliances

Including prosthetic and orthotic devices, except as limited in the policy.

Outpatient Services

Professional charges and facility use for diagnostic and therapy services, surgery, and rehabilitation.

Covered Expenses that apply to all plans, continued

Medical Expense Benefits - subject to deductible and copay/coinsurance (if applicable)

Pediatric Dental/Pediatric Vision

- For covered persons under the age of 19.
- Subject to the deductible and coinsurance (if applicable).

Exclusions and limitations apply, as defined in the policy.

Physical Medicine and Rehabilitation Services

Structured therapeutic program with the goal to obtain practical improvement in a reasonable length of time, either in the appropriate inpatient setting, or in a day rehabilitation program for those who do not require inpatient care, but still require an intensive level and variety of therapy. A day rehabilitation program requires a minimum of 2 therapy services to be provided for the program to be covered.

No benefits payable for:

- Admission to a hospital mainly for physical therapy.
- Long term rehabilitation in an inpatient setting.

Physician Fees

Assistant surgeon limited to 20% of the eligible expense for the procedure. Fees for a medical practitioner who is not a doctor and who is acting as a surgical assistant limited to 14% of the eligible expenses for the procedure.

Prescription Drugs

All prescriptions are limited to a 34-day supply for each outpatient prescription drug order or refill.

No prescription coverage for:

- Amounts above the managed drug limitation.
- Treatment of impotency or enhanced sexual performance.
- Dependency or addiction to food.

Additional exclusions apply, as defined in the policy.

Reconstructive Services

Certain reconstructive services required to correct a deformity caused by disease, congenital anomalies, or previous therapeutic process. Reconstructive services required due to prior therapeutic process are covered expenses only if the original procedure would have been a covered expense under the policy.

Reconstructive services limited to:

- Medically diagnosed congenital defects and birth abnormalities of a newborn child.
- Breast reconstruction following a mastectomy.
- Hemangiomas, and port wine stains of the head and neck areas for children ages 18 years of age or younger.
- Limb deformities such as club hand, club foot, syndactyly (webbed digits), polydactyly (supernumerary digits), macrodactylia.
- Otoplasty when performed to improve hearing by directing sound in the ear canal, when ear or ears absent or deformed from trauma, surgery, disease, or congenital defect.
- Tongue release for diagnosis of tongue-tied.
- Congenital disorders that cause skull deformity such as Crouzon's disease.
- Cleft lip or cleft palate.

Covered Expenses that apply to all plans, continued

Medical Expense Benefits - subject to deductible and copay/coinsurance (if applicable)

Temporomandibular (TMJ) or Cranionmandibular Joint Disorder and Craniomandibular Jaw Disorder Treatment

Treatment for covered persons with temporomandibular (joint connecting the lower jaw to the temporal bone at the side of the head) and craniomandibular (head and neck muscle) disorders.

Therapy Services

With the expectation that outpatient therapy will result in a practical improvement in the level of functioning within a reasonable period of time and as limited in the policy, the following services are covered, per calendar year:

- Physical and manipulation therapy limited to a combined 20 visits per covered person.
- Occupational therapy limited to 20 visits per covered person.
- Chiropractic Services limited to services from a network provider and 26 visits per covered person.
- Cardiac rehabilitation limited 36 visits per covered person.
- Pulmonary rehabilitation limited to 20 visits per covered person.

Transplant Services

Transplants must be medically necessary and not be experimental or investigational. We will determine if the covered person is a good candidate. Network benefits for transplant services are only available at a designated facility.

Transplant Donor Expenses: We will cover the medical expenses incurred by a live donor as if they were medical expenses of the covered person if:

- The covered person received an organ or bone marrow of the live donor.
- The expenses would otherwise be considered covered expenses under the policy.

Travel and Lodging Expenses: We will pay a maximum of $5,000 per transplant for the transportation and lodging for the covered person, live donor, and any immediate family member to accompany the covered person.

No benefits will be paid for:

- Search and testing in order to locate a suitable donor.
- A prophylactic bone harvest or peripheral blood stem cell collection when no transplant occurs.
- Animal-to-human transplants.
- Artificial or mechanical devices designed to replace a human organ temporarily or permanently.
- Procurement or transportation of the organ or tissue unless expressly provided for in this provision.
- Keeping a donor alive for the transplant operation.
- A live donor where the live donor is receiving a transplanted organ to replace the donated organ.
- A transplant under study in an ongoing Phase I or II clinical trial as set forth in the USFDA regulation.

Provisions that apply to all plans

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

General Exclusions

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

No benefits are payable for expenses:

- That would not have been charged if you did not have insurance.
- Imposed on you by a provider (including a hospital) that are actually the responsibility of the provider to pay.
- For services performed by an immediate family member.
- That are not identified and included as covered expenses under the policy or in excess of the eligible expenses. You are responsible for payment of services not covered by the policy.
- For services or supplies that are provided prior to the effective date or after the termination date of the policy.
- For weight modification or surgical treatment of obesity, including wiring of the teeth and all forms of intestinal bypass surgery.
- For breast augmentation or reduction.
- For modification of the physical body in order to improve psychological, mental, or emotional well-being, such as sex-change surgery.
- For drugs, treatment, or procedures promoting conception or preventing childbirth.
- For male reversals of sterilization.
- For fetal reduction surgery or abortion (unless life of mother would be endangered).
- For telephone consultations, failure to keep an appointment, television expenses, or telephone expenses.
- For marriage, family, or child counseling.
- For a hospital admission on Friday or Saturday (room, board, and nursing services), unless it is an emergency or medically necessary surgery is scheduled on the next day.
- For standby availability of a medical practitioner when no treatment is rendered.
- For dental expenses, including braces and oral surgery, except as provided for in the policy.
- For cosmetic treatment.
- For diagnosis or treatment of learning disabilities, attitudinal disorders, or disciplinary problems.
- Resulting from nicotine addiction (except as covered under preventive care benefits in the policy).
- For charges related to, or in preparation for, tissue or organ transplants, except as expressly provided for under Transplant Services.
- For eye refractive surgery, when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism.
- While confined for rehabilitation, custodial care, educational care, nursing services, or while at a residential treatment facility, except as provided for in the policy.
- For vocational or recreational therapy, vocational rehabilitation, outpatient speech therapy, or occupational therapy, except as provided for in the policy.
- For alternative or complementary medicine using non-orthodox practices that do not follow conventional medicine, including but not limited to: wilderness or outdoor therapy, boot camp, and equine therapy.
- For eyeglasses, contact lenses, hearing aids, eye refraction, visual therapy, or any exam or fitting related to these devices, except as provided for in the policy.
- For premarital examinations and educational programs, except as provided for in the policy.
- Resulting from experimental or investigational treatments, or unproven services, except as provided for in the policy.
- Incurred outside of the U.S., except for emergency treatment.
- Resulting from or during employment for wage or profit, if covered or required to be covered by workers' compensation insurance under state or federal law. If you entered into a settlement that waives your right to recover future medical benefits under a workers' compensation law or insurance plan, this exclusion will still apply. Should a workers' compensation insurance carrier deny coverage for a covered person's claim, this exclusion will still apply unless the denial is appealed to and upheld by the proper government agency.

Provisions that apply to all plans, continued

General Exclusions, continued

No benefits are payable for expenses:

- Resulting from, declared or undeclared war, or participation in a riot or felony (whether or not charged).
- For durable medical equipment, except as provided for in the policy.
- Resulting from intoxication, as defined by state law where the illness or injury occurred, or while under the influence of illegal narcotics or controlled substances, unless administered or prescribed by a doctor.
- For surrogate parenting.
- For treatments of hyperhidrosis (excessive sweating).
- For alternative treatments, except as specifically covered by the policy, including: acupressure, acupuncture, aromatherapy, hypnotism, massage therapy, rolfing, and other alternative treatments defined by the Office of Alternative Medicine of the National Institutes of Health.
- Due to injuries incurred while paid to participate or instruct in: horseback riding, motorcycle operating/riding, racing or speed testing any vehicle/conveyance (motorized or not), rock or mountain climbing, or skiing.
- Due to participating, instructing, demonstrating, guiding, or accompanying others in: sports (semi- or professional or intercollegiate), parachute jumping, hang gliding, scuba/skin diving (60 or more feet in depth), skydiving, bungee jumping, or rodeo sports.
- For injuries sustained while performing the duties of an aircraft crew member, including giving or receiving training on an aircraft.
- For routine foot care, treatment of flat feet or subluxation, shoes, shoe orthotics, shoe inserts, and arch supports.
- For services for which a non-network provider routinely waives any applicable copayment amount, deductible amount, and/or coinsurance amount.

General Limitations

When using a network physician or facility, non-covered expenses may not be eligible for a network provider discount.

Continued Eligibility Requirements

A covered person's eligibility will end: on the date that a covered person accepts any direct or indirect contribution or reimbursement by or on behalf of any health care provider or any health care provider sponsored organization for any portion of the premium for coverage under the policy; or when the primary insured no longer resides in the same state where the policy was issued.

A dependent's eligibility ends when he or she ceases to be your dependent due to divorce or no longer meeting eligibility requirements. The dependent will be covered until the end of the premium period in which either of these cases occurs.

Dependents

For purposes of this coverage, eligible dependents are your lawful spouse and the eligible children of you or your spouse. An eligible child must be under age 26 to apply and may remain covered up until he or she turns age 26.

A "child" may be: (A) a natural child; (B) a legally adopted child; (C) a child placed with you for adoption; or (D) a child for whom legal guardianship has been awarded to you or your spouse.

Eligible Expense

An eligible expense means a covered expense as follows:

- **For Network Providers:** The contracted fee for the provider.
- **For Non-Network Providers:** As defined in the policy.

Emergency

A medical condition with acute symptoms that are severe enough (including severe pain) that a prudent person, with average knowledge of health and medicine, could reasonably expect that without immediate medical attention: the health of the covered person (if pregnant, the health of the mother or unborn child) would be in serious jeopardy; bodily functions would be seriously impaired; or serious dysfunction of a body part or organ would result.

Provisions that apply to all plans, continued

Non-Network Penalty

For non-emergency care received from non-network providers you pay: (a) all charges above what is considered an eligible expense; (b) a penalty of 25% of the eligible expense, which does not count toward the deductible (this does not apply to pediatric dental); and (c) a deductible amount equal to 2 times the network deductible. There is no out-of-pocket maximum for non-network providers. Also your actual out-of-pocket costs may be more than the stated coinsurance because the bill from a non-network provider may not be used to calculate what we pay and what you pay.

Premium

You are responsible for your premium. Payment must be made directly to our office. We may change the premium rates on January 1 of each calendar year. We will give you at least 31 days notice prior to the date of the change. Some of the factors used in determining your premium rates are the policy plan, tobacco use status, type and level of benefits, place of residence on the premium due date, and age of covered persons as of the effective date or renewal date of coverage. Premium rates are expected to increase over time.

Renewability

You may renew your coverage by paying the premium as it comes due. We may refuse to renew if: (a) you fail to pay the premium; (b) we do not renew all policies just like yours for everyone in the state where you then live; or (c) there is fraud or a material misrepresentation made by or with knowledge of a covered person in the filing of a claim for benefits.

Specialist Without a Referral Penalty

If you use a specialist without a referral from a Primary Care Physician (PCP), network benefits will be reduced by 20%. Your PCP may be a part of a group of doctors. If all are practicing under the same Tax Identification Number (TIN), you may see or obtain a referral from any PCP in the group.

HEALTH PLAN NOTICE OF INFORMATION PRACTICES
MEDICAL INFORMATION PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. (Effective September 23, 2013)

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. We are required by law to abide by the terms of 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 will comply with the requirements of applicable privacy laws related to notifying you in the event of a breach of your health information.

We have the right to change our privacy practices and the terms of this notice. If we make a material change to our privacy practices, we will provide to you in our next annual distribution, either a revised notice or information about the material change or how to obtain a revised notice. We will provide this information either by direct mail or electronically in accordance with applicable law. In all cases, we will post the revised notice on our websites, such as *www.myuhone.com, www.myallsavers.com, www.myallsaversmember.com, www.goldenrule.com,* or *www.unitedhealthone.com* We reserve the right to make any revised or changed notice effective for information we already have and for information that we receive in the future.

We collect and maintain oral, written and electronic information to administer our business and to provide products, services and information of importance to our customers. We maintain physical, electronic and procedural security safeguards in the handling and maintenance of our enrollees' information, in accordance with applicable state and federal standards, to protect against risks such as loss, destruction or misuse.

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) in order to administer your rights as described in this notice; 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 for your treatment, to pay for your health care and operate our business. For example, we may use or disclose your health information:

- **For Payment** of premiums due us, to determine your coverage and to process claims for health care services you receive including for subrogation or coordination of other benefits you may have. For example, we may tell a doctor whether you are eligible for coverage and what percentage of the bill may be covered.
- **For Treatment.** We may use or disclose health information to aid in your treatment or the coordination of your care. For example, we may disclose 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 restrictions on its use and disclosure of the information in accordance with federal law.
- **For Underwriting Purposes.** We may use or disclose your health information for underwriting purposes; however, we will not use or disclose your genetic information for such purposes.
- **For 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 to do so 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 you agree or fail to object when given the opportunity. If you are unavailable or unable to object we will use our best judgment to decide if the disclosure is in your best interests. Special restrictions apply regarding when we may disclose health information to family members and others involved in a deceased individual's care. We may disclose health information to any persons involved, prior to the death, in the care or payment for care of a deceased individual, unless we are aware that doing so would be inconsistent with a preference previously expressed by the deceased.
- **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 or report a crime.

33638-X-1213 Products are either underwritten or administered by: All Savers Insurance Company, All Savers Life Insurance Company of California, Golden Rule Insurance Company, PacifiCare Life and Health Insurance Company, UnitedHealthcare Insurance Company, and/or UnitedHealthcare Life Insurance Company.

- **To Avoid a Serious Threat to Health or Safety** by, for example, disclosing information to public health agencies or law enforcement authorities, or in the event of an emergency or natural disaster.
- **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 federal 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 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 and pursuant to federal law, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract and as permitted by federal law.
- **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 a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to us, it is our intent to meet the requirements of the more stringent law.

Except for uses and disclosures described and limited as set forth in this notice, we will use and disclose your health information only with a written authorization from you. This includes, except for limited circumstances allowed by federal privacy law, not using or disclosing psychotherapy notes about you, selling your health information to others or using or disclosing your health information for certain promotional communications that are prohibited marketing communications under federal law, without your written authorization. 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 our 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 PO 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. In certain circumstances, we will accept verbal requests to receive confidential communications; however, we may also require you to confirm your request in writing. In addition, any 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 we maintain about you such as claims and case or medical management records. If we maintain your health information electronically, you will have the right to request that we send a copy of your health information in an electronic format to you. You can also request that we provide a copy of your information to a third party that you identify. In some cases you may receive a summary of this health information. You must make a written request to inspect and copy your health information or have it sent to a third party. Mail your request to the address listed below. In certain limited circumstances, we may deny your request to inspect and copy your health information. If we deny your request, you may have the right to have the denial reviewed. We may charge a reasonable fee for any copies.
- **You have the right to ask to amend information** we maintain about you such as claims and case or medical management records, if you believe the health information about you is wrong or incomplete. Your request must be in writing and provide the reasons for the requested amendment. Mail your requests to the address listed below. If we deny your request, you may have a statement of your disagreement added to your health information.
- **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) for treatment, payment, and health care operations purposes; (ii) to you or pursuant to your authorization; and (iii) to correctional institutions or law enforcement officials; and (iv) other disclosures for which 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 such as *www.myuhone.com, www.myallsavers.com, www.myallsaversmember.com, www.goldenrule.com,* or *www.unitedhealthone.com.*
- **You have the right to be considered a protected person.** (New Mexico only) A "protected person" is a victim of domestic abuse who also is either: (i) an applicant for insurance with us; (ii) a person who is or may be covered by our insurance; or (iii) 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, please call the toll free 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 address listed below.
- **Submitting a Written Request.** Mail to us your written requests to exercise any of your rights, including modifying or cancelling a confidential communication, requesting copies of your records, or requesting amendments to your record at the following address:
- Privacy Office, 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

(Effective September 23, 2013)

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 coverage that identifies the individual, is not generally publicly available and is collected from the individual or is obtained in connection with providing coverage to the individual.

Information We Collect. 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, medical information and Social Security number; and
- Information about your transactions with us, our affiliates or others, such as premium payment and claims history; and
- Information from consumer reports.

Disclosure of Information. We do not disclose personal financial information about our insureds or former insureds to any third party, except as required or permitted by law. For example, in the course of our general business practices, we may, as permitted by law, disclose any of the personal financial information that we collect about you, without your authorization, to the following types of institutions:

- To our corporate affiliates, which include financial service providers, such as other insurers, and non-financial companies, such as data processors;
- To nonaffiliated companies for our everyday business purposes, such as to process your transactions, maintain your account(s), or respond to court orders and legal investigations; and
- To nonaffiliated companies that perform services for us, including sending promotional communications on our behalf.

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.

Confidentiality and Security. We maintain physical, electronic and procedural safeguards, in accordance with applicable state and federal standards, to protect your personal financial information against risks such as loss, destruction or misuse. These measures include computer safeguards, secured files and buildings, and restrictions on who may access your personal financial information.

Questions About this Notice. If you have any questions about this notice, please **call the toll-free member phone number on the back of your health plan ID card.**

The Notice of Information Practices, effective September 23, 2013, is provided on behalf of All Savers Insurance Company; All Savers Life Insurance Company of California; Golden Rule Insurance Company; PacifiCare Life and Health Insurance Company; UnitedHealthcare Insurance Company; and UnitedHealthcare Life Insurance Company.

To obtain an authorization to release your personal information to another party, please go to the appropriate website listed in this Notice.

33638-X-1213 Products are either underwritten or administered by: All Savers Insurance Company, All Savers Life Insurance Company of California, Golden Rule Insurance Company, PacifiCare Life and Health Insurance Company, UnitedHealthcare Insurance Company, and/or UnitedHealthcare Life Insurance Company.

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

Conditional Receipt for: _____

Proposed Insured: _____

Amount Received: _____

Date of Receipt: _____

Signature of Secretary: Richard C. Sullivan

Signature of Agent/Broker: _____

THIS FORM LIMITS OUR LIABILITY. NO INSURANCE WILL BECOME EFFECTIVE UNLESS ALL THREE 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.

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 UnitedHealthcare Life Insurance Company.
2. 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.
3. The policy is: (a) issued by UnitedHealthcare Life Insurance Company exactly as applied for within 45 days from date of application; (b) delivered to the proposed insured; and (c) accepted by the proposed insured.

A copy of your Authorization for Electronic Funds Transfer (EFT)

I (we) hereby authorize UnitedHealthcare Life Insurance Company to initiate debit entries to the account indicated below.

I also authorize the named financial institution 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.

EFT-UL-1013

Notice to applicant regarding replacement of accident and sickness insurance

1. 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.
2. We recommend that you not terminate your present plan until you are certain that your coverage has been approved by UnitedHealthcare Life Insurance Company.

Incorrect or incomplete information on your application may result in voidance of coverage and claim denial. 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.

UnitedHealthcare®

UnitedHealthcare Life Insurance Company

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