Missouri

Health Insurance Plans

For Individuals and Families

Health insurance available only to members of FACT.

These health insurance plans are issued as association group plans and available only to members of FACT, the Federation of American Consumers and Travelers.

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

Policy Forms UHL-P-001, -CPY-B, -CPY-SB, -CPY-GA, -CPY-GB, -CPY-SA, -CPY-SC, -HSA-B, -HSA-S, -CAT-1

UnitedHealthcare®

Why Choose Us?

Strength & Experience

Nearly 27 million customers entrust UnitedHealthcare with their health insurance needs.* Within the UnitedHealthcare family of companies, we have been serving the special 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 (12-13-12). 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

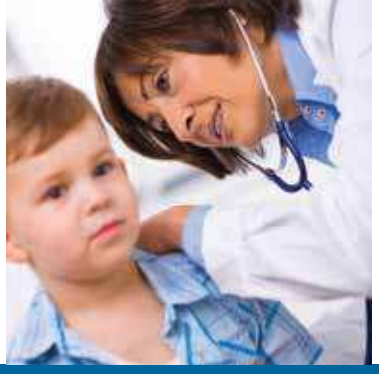
Our employees who process claims have a long history of fast service. The results – 94% of all health claims are processed within 12 working days or less.**

Nationwide Network – Big Savings

UnitedHealthcare offers one of the largest networks in the U.S. With access to nearly 780,000 physicians and other health care professionals and nearly 5,900 hospitals and other medical facilities,* chances are your current doctor is already a part of our nationwide network.

Visit www.UHCindividual.com/doctor to find providers in our network.

* UnitedHealth Group Annual Form 10-K for year ended 12/31/12.
** Actual 2012 results.


Sample Savings with our network (Services provided 08/2012-02/2013)[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
Dr. Office Visit - established patient	$83.89	$40.37	**52%**
MRI	$1,519.25	$467.13	**69%**
Lipid Panel	$77.25	$7.64	**90%**
CBC	$31.95	$4.78	**85%**
Metabolic Panel	$46.41	$6.21	**87%**
General Panel	$157.85	$30.08	**81%**
Mammogram	$32.36	$14.68	**54%**

UnitedHealthcare Choice Plus network

Our nationwide network of doctors and hospitals provides you with great value for your health care dollars. We contract with providers offering quality care at a significant discount. Getting your nonemergency care from a doctor or hospital not in our network will cost you more.

Nonemergency covered expenses

Using non-network providers you pay:[2]

- All charges above the eligible expense. See page 26 for details;
- Additional 25% of eligible expense;
- Twice the network calendar-year deductible; and
- No out-of-pocket maximum.

[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.
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. Considering these factors, seeing in-network providers can result in a big savings for what you pay for your health care.

3 Types of Health Plans

		Catastrophic	Bronze	Silver	Gold	
PAGES	**COPAY PLANS**		✓	✓	✓	
6-7	Features a set copay. You have the convenience of knowing what you'll pay for a basic doctor visit or prescription.	◄ 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 ►
PAGES	**SELECT SAVER℠ PLAN**		✓			
10-11	Certain age or other restrictions apply.	◄ More Affordable				More Comprehensive ►

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

See page 20 for a list of definitions meant to give you a general understanding of the terms commonly used by insurance companies.

How our plans work

- You can receive care from any doctor or hospital in the network.
- If you're looking for a specialist, no referral is needed.
- You receive maximum benefits from the plan when you use network providers.

Using a non-network doctor or hospital for nonemergency care will cost you more. See "Nonemergency covered expenses" on page 3 and "Non-Network Penalty" on page 26 for details.

www.UHCindividual.com/doctor

- Find a provider in your area.
- Access your plan information.
- See your claim status, and more.

UnitedHealthcare®

COPAY PLANS OFFER YOU:

- **Convenient doctor office copays.**[1]
- **Prescription drug coverage.**[2]
- **Benefits similar to employer group plans.**

OPTIONAL BENEFITS

Additional premium required. See pages 12-13.

- UnitedHealthcare Vision® Rider
- Supplemental Accident Benefit
- Accidental Death Benefit

The benefits described here are for covered expenses using network providers. In order for some benefits to be covered, Prior Authorization is required. Please see pages 18-19 for details. The chart summarizes standard network covered expenses. For more information, including General Exclusions and Limitations, see pages 18-27.

[1] Office visits to non-network doctors will cost you more. See page 26.

[2] The preferred drug list changes periodically. Tier status for a prescription drug may be determined by accessing our website 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℠	Silver Copay Select℠ 1	Silver Copay Select℠ 2	Silver Copay Select℠ 3	Gold Copay Select℠ 1	Gold Copay Select℠ 2
Deductible (per calendar year)	You pay:	$5,500 per person	$5,000 per person	$2,500 per person	$3,500 per person	$1,000 per person	$1,500 per person
Coinsurance (% you pay after deductible, per calendar year)	You pay:	20% per person	20% per person	30% per person	20% per person	20% per person	10% per person
Out-of-Pocket Maximum (includes all copays, deductibles, and coinsurance)	You pay:	$6,350 per covered person, not to exceed $12,700 for all covered persons in a family					
Doctor Office							
Preventive Care See page 21 for details.	You pay:	No charge – 100% covered in-network.					
Primary Care Physician/Specialist		You select any network physician. No referral required to see a specialist.					
Office Visit, History, and Exam only - Primary (deductible does not apply)	You pay:	$50 copay - 4 visit limit*	$35 copay	$35 copay - 4 visit limit*	$35 copay - 4 visit limit*	$25 copay	$15 copay
Office Visit, History, and Exam only - Specialist (deductible does not apply)	You pay:	$100 copay	$60 copay	$70 copay	$70 copay	$30 copay	$30 copay
Urgent Care Center	You pay:	20% after deductible	20% after deductible	30% after deductible	20% after deductible	$50 copay - 2 visit limit*	10% after deductible
Pharmacy							
Name Brand and Generic Prescription Drugs Gold and Silver plans only: 1) 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. 2) For Specialty Drugs, no tier copays. Plan deductible coinsurance apply.	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.	Tier 1 – $15 copay Tier 2-4 – combined $500 deductible per person, per calendar year, then: Tier 2 – $40 copay Tier 3 – $80 copay Tier 4 – 25% coinsurance	Tier 1 – $15 copay Tier 2-4 – combined $1,000 deductible per person, per calendar year, then: Tier 2 – $40 copay Tier 3 – $80 copay Tier 4 – 30% coinsurance	Tier 1 – $12 copay Tier 2-4 – combined $1,000 deductible per person, per calendar year, then: Tier 2 – $40 copay Tier 3 – $80 copay Tier 4 – 25% coinsurance	Tier 1 – $10 copay Tier 2-4 – combined $500 deductible per person, per calendar year, then: Tier 2 – $35 copay Tier 3 – $65 copay Tier 4 – 25% coinsurance	Tier 1 – $12 copay Tier 2-4 – combined $500 deductible per person, per calendar year, then: Tier 2 – $35 copay Tier 3 – $65 copay Tier 4 – 25% coinsurance
Outpatient							
Emergency Room Fees (additional $250 ER deductible for illness if not admitted) **X-ray and Lab** **Facility/Hospital for Outpatient Surgery** **Surgeon, Assistant Surgeon, and Facility Fees** **Radiation, Chemotherapy, Organ Transplant Drugs, CAT Scans, and MRIs** **Outpatient Therapy** See page 24 for details.	You pay:	20% after deductible	20% after deductible	30% after deductible	20% after deductible	20% after deductible	10% after deductible
Inpatient							
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	20% after deductible	30% after deductible	20% after deductible	20% after deductible	10% after deductible
Pregnancy/Maternity Care							
Prenatal Care See page 24 for details.	You pay:	No charge – 100% covered in-network.					
Delivery, Inpatient Services, and Postnatal Care	You pay:	20% after deductible	20% after deductible	30% after deductible	20% after deductible	20% after deductible	10% after deductible
Mental and Nervous Disorders (including substance abuse)							
Outpatient and Inpatient Services	You pay:	20% after deductible	20% after deductible	30% after deductible	20% after deductible	20% after deductible	10% after deductible

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

HEALTH SAVING ACCOUNT (HSA) PLANS

HSA PLANS OFFER YOU:

An HSA combines 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.

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.

OPTIONAL BENEFITS

Additional premium required. See pages 12-13.

- UnitedHealthcare Vision® Rider
- Supplemental Accident Benefit
- Accidental Death Benefit

The benefits described here are for covered expenses using network providers. In order for some benefits to be covered, Prior Authorization is required. Please see pages 18-19 for details. The chart summarizes standard network covered expenses. For more information, including General Exclusions and Limitations, see pages 18-27.

Highlights of network covered expenses		Bronze HSA 100®	Silver HSA 100®
Deductible (per calendar year)	You pay:	$6,350 per person $12,700 per family	$3,650 per person $7,300 per family
Coinsurance (% you pay after deductible, per calendar year)	You pay:	0%	0%
Out-of-Pocket Maximum (includes deductible)	You pay:	$6,350 per covered person, not to exceed $12,700 for all covered persons in a family	$3,650 per covered person, not to exceed $7,300 for all covered persons in a family
Maximum 2014 HSA Contribution		$3,300 per person (over age 55 additional $1,000 catch-up contribution) $6,550 per family	

Doctor Office

Preventive Care See page 21 for details.	You pay:	No charge – 100% covered in-network.
Primary Care Physician/Specialist		You select any network physician. No referral required to see a specialist.
Office Visit, History, and Exam only - Primary	You pay:	No charge after deductible
Office Visit, History, and Exam only - Specialist		
Urgent Care Center		

Pharmacy

You pay for prescriptions at the point of sale, at the lowest price available, and submit a claim to us.	You pay:	No charge after deductible – Preferred Price Card

Outpatient

Emergency Room Fees	You pay:	No charge after deductible
X-ray and Lab		
Facility/Hospital for Outpatient Surgery		
Surgeon, Assistant Surgeon, and Facility Fees		
Radiation, Chemotherapy, Organ Transplant Drugs, CAT Scans, and MRIs		
Outpatient Therapy See page 24 for details.		

Inpatient

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 See page 24 for details.	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

To qualify for Select Saver℠ you must either:

- **Be under age 30;** or
- **Receive a certificate of exemption** from your state's health insurance marketplace because:
  a) You cannot afford minimal essential coverage; or
  b) You are eligible for a hardship exemption.

OPTIONAL BENEFITS

Additional premium required. See pages 12-13.

- UnitedHealthcare Vision® Rider
- Supplemental Accident Benefit
- Accidental Death Benefit

SELECT SAVER℠ 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 at no charge.
- **Our lowest premiums**.

The benefits described here are for covered expenses using network providers. In order for some benefits to be covered, Prior Authorization is required. Please see pages 18-19 for details. The chart summarizes standard network covered expenses. For more information, including General Exclusions and Limitations, see pages 18-27.

Highlights of network covered expenses		Select Saver℠ (Catastrophic Plan)
Deductible (per calendar year)	You pay:	$6,350 per person
Coinsurance (% you pay after deductible, per calendar year)	You pay:	0%
Out-of-Pocket Maximum (includes deductible)	You pay:	$6,350 per covered person, not to exceed $12,700 for all covered persons in a family

Doctor Office

Preventive Care See page 21 for details.	You pay:	No charge – 100% covered in-network.
Primary Care Physician/Specialist		You select any network physician. No referral required to see a specialist.
Office Visit, History, and Exam only - Primary	You pay:	No charge for first 3 visits.*
Office Visit, History, and Exam only - Specialist	You pay:	No charge after deductible
Urgent Care Center		

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

Pharmacy

You pay for prescriptions at the point of sale, at the lowest price available, and submit a claim to us.	You pay:	No charge after deductible – Preferred Price Card

Outpatient

Emergency Room Fees	You pay:	No charge after deductible
X-ray and Lab		
Facility/Hospital for Outpatient Surgery		
Surgeon, Assistant Surgeon, and Facility Fees		
Radiation, Chemotherapy, Organ Transplant Drugs, CAT Scans, and MRIs		
Outpatient Therapy See page 24 for details.		

Inpatient

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 See page 24 for details.	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

Optional Benefit: UnitedHealthcare Vision® Rider

For primary insured and/or spouse, age 19 and over.
Additional premium required.
Policy Form SA-S-1709-UHL

Keep an eye on your vision health by adding our optional Vision Benefit rider. Our vision network offers quality care from professionals in private and retail settings across the country. You may use a non-network provider, but you are eligible to receive better discounts using network providers.

Service/Material	Network You Pay	Network We Pay[1]	Non-network We Pay
Eye exam once every 12 months	$10.00 copay	100%	Up to $40.00
Frames[2] once every 24 months	$25.00 copay	100%	Up to $45.00
Single Vision lenses	$25.00 copay	100%	Up to $40.00
Bifocal lenses	$25.00 copay	100%	Up to $60.00
Trifocal or Lenticular lenses	$25.00 copay	100%	Up to $80.00
Contacts[3] in lieu of glasses	$25.00 copay	100%	Up to $105.00

This product is administered by Spectera, Inc.

Adult Vision Covered Expenses

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

- Routine vision exams – 1 exam per 12 months.
- Prescription eyewear – 1 pair of prescription eyeglass lenses every 12 months and 1 pair of eyeglass frames every 24 months, or contact lenses or necessary contact lenses every 12 months.
  - Eyeglass lenses, including scratch resistant coating, as prescribed by an ophthalmologist or optometrist; eyeglass frames and their fitting and subsequent adjustments to maintain comfort and efficiency; or
  - Contact lenses that are in lieu of eyeglass lenses and frames; or
  - Necessary contact lenses when a provider has determined a need for and has prescribed the service. Contact lenses are necessary if the covered person has: keratoconus; anisometropia; irregular corneal/astigmatism; aphakia; facial deformity; or corneal deformity.

Please Note: This vision benefit program is designed to cover vision needs rather than cosmetic extras. If you select a cosmetic extra, the plan will pay the costs of the allowed lenses and you will be responsible for the additional cost of the cosmetic extra. Check online for a list of providers.

How the Vision Program Works

Your out-of-pocket expenses – what you'll owe for vision services – will vary depending on the type of provider you use:

- For Network Vision Providers – after your copay, they agree to accept the plan payment as full reimbursement for covered expenses. They are categorized in 3 ways:
  - Full service – are contracted to provide eye exams and prescription eyewear at discounted rates.
  - Exam Only – are contracted to provide exams ONLY at discounted rates.
  - Dispense Only – are contracted to dispense prescription eyewear ONLY at discounted rates.
- For Non-Network Vision Providers – you must pay in full at time of service. Then you submit itemized copies of receipts and request reimbursement from UnitedHealthcare Vision Claims department. Your out-of-pocket costs may be higher with a non-network provider.

Discounts: Laser Eye Surgery and Hearing Aids

Laser eye surgery is a noncovered expense, however, an alliance with the Laser Vision Network of America allows our policyholders access to substantial discounts on laser eye surgery procedures.

UnitedHealthcare Vision rider members have access to high-quality, digital hearing aids at a discount over retail, when ordering with our special promotion code.
Visit *www.hiHealthInnovations.com* for more information.

[1] After copay.
[2] You will receive a $130 retail frame allowance towards the purchase of any frame at a network provider.
[3] You are eligible to select either eyeglasses (eyeglass lenses and/or eyeglass frames) or contact lenses, not both. Contacts chosen from the covered contact lens selection at a network provider. Non-selection contact lenses will receive an allowance. No copay applies to non-selection contact lenses.

Adult Vision 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);
- Oversized lenses;
- Replacement of eyeglass lenses and frames furnished under this plan which are lost or broken except at the normal intervals when services are otherwise available;
- 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;
- Medical or surgical treatment of the eyes;
- Corrective surgical procedures such as, but not limited to, Radial Keratotomy (RK) and Photorefractive Keratectomy (PRK);
- Elective contact lenses if prescription eyeglass lenses and frames are received in any 12-month period;
- Prescription eyeglass lenses and frames if elective contact lenses are received in any 24-month period;
- Eyewear except prescription eyewear;
- Charges that exceed the allowed amount;
- Services or treatments that are already excluded in the General Exclusions and Limitations section of the policy/certificate; and
- Optional lens extras not listed in your policy/certificate.

Optional Benefit: Accidental Death Benefit

For primary insured and/or spouse, age 18 and over. Additional premium required.

Policy Form SA-S-1367R-UHL-24

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. The accidental death benefit expires when a covered person reaches age 65. Motorcyclists are not eligible for this benefit.

Optional Benefit: Supplemental Accident Benefit

Additional premium required.

Policy Form SA-S-1701-UHL

Reduce or eliminate your out-of-pocket exposure for accident-related injuries. Supplemental Accident helps cover your deductible or other out-of-pocket medical expenses (before the health insurance starts paying covered expenses) for unexpected injuries. You select a maximum amount per accident, per covered person.

Benefit Amounts:	$1,000	$1,250	$1,500	$2,000	$2,500	$3,000
$3,500	$3,650	$4,000[4]	$5,000[4]	$5,500[4]	$6,000[4]	$6,350[4]

A simple arm fracture treated in a doctor's office can cost over $2,400 (01-08-13).[5] However, an open-arm fracture can result in a hospital stay, surgery, and physical therapy — for a total cost of more than $21,000 (03-20-2013)![5]

Savings Example for $21,000 open-arm fracture	**No health plan**	**With health plan**	**Health Plan with $3,650 Supplemental Accident Benefit**
What you could pay:	$21,000	$6,350	$2,700

Supplemental Accident Provisions

- Expenses must be eligible for payment under the health insurance and incurred within 90 days of an injury.
- Benefit cannot exceed your total covered medical out-of-pocket expenses that are neither paid nor reimbursed by the underlying health insurance.
- Any benefit amount paid by the Supplemental Accident benefit will first be credited to the deductible and coinsurance of the health insurance. The payment will be made either to your health care provider under your assignment of benefits, or to you if you have already paid your provider.
- No cash payments will be paid to the insured except for reimbursement of submitted claims for covered expenses already paid by you and not paid by the underlying health insurance.
- Exclusions and Limitations of the health plan apply to this additional benefit.

[4] Not available with Silver HSA 100®. Consult a tax advisor regarding whether our HSA plan with Supplemental Accident qualifies for favorable HSA (account) tax treatment.

[5] Examples are for illustration purposes only, and assume all expenses are covered. All these services were received from network providers in ZIP Code 631--. Your actual savings may be more or less than this illustration. Discounts vary by provider, geographic area, and type of service.

Included Benefits: Pediatric Dental

Pediatric Dental is included with every plan.

- **For covered persons under the age of 19.**
- **Network providers agree to discounted pricing for covered expenses.**
- **Eligible expenses apply toward deductible (and coinsurance, if applicable).**
- **Non-network providers may bill you for any amount up to the billed charge after we have paid benefits due.**

Pediatric Dental Covered Expenses

Eligible expenses are subject to the health plan's deductible and coinsurance. Subject to all policy provisions, the following dental expenses are covered:

- Oral evaluations – 2 per calendar year.
- Routine cleaning – 2 per calendar year.
- Fluoride treatments – 2 per calendar year.
- Intraoral bitewing X-rays – 2 series per calendar year.
- Simple (nonsurgical) extractions.
- Amalgam and composite resin-based fillings.
- Space maintainers.
- Root canals.
- Stainless steel crowns.
- Periodontal maintenance – 2 per calendar year.
- Full or partial dentures – limited to 1 per 60 months.
- Oral surgery: alveoplasty, incision and drainage of abscess, surgical root removal, surgical extraction of erupted tooth and roots, and surgical extraction of impacted teeth.
- Sealants – limited to once every 36 months for first and second permanent molar only.
- Implant and placement – limited to 1 time per 60 months.

Medically Necessary Orthodontic Services

Waiting Period – a 24-month waiting period must be satisfied before medically necessary orthodontic services will be eligible for coverage.

Prior Authorization – you must obtain Prior Authorization for all orthodontic services prior to treatment. If you do not obtain Prior Authorization, we have the right to deny your claims. Prior Authorization does not guarantee payment as a covered expense.

Covered Services – only services and supplies for an identifiable syndrome such as cleft lip or palate, Crouzon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in physically handicapping malocclusion as determined by our dental consultants.

Services that are NOT covered – comprehensive orthodontic treatment for crooked teeth, excessive spacing between teeth, temporomandibular (TMJ) conditions, and/or overjet/overbite discrepancies.

Treatment and payment plans must be preauthorized by us.

Pediatric Dental Exclusions and Limitations

Subject to all policy provisions, no benefits are payable for:

- Services or expenses not identified as a covered expense.
- Charges that exceed the allowed amount.
- Services that are not rendered or that are not within the scope of the dentist's license.
- Braces, surgery, and oral surgery, except as provided in your policy/certificate.
- Incision and drainage if the abscessed tooth is removed on the same date.
- Telephone consultations or failure to keep an appointment.
- Services incurred directly or indirectly as the result of: intoxication (as defined by state law where loss occurred), or illegal narcotics or controlled substance unless administered or prescribed by a doctor.
- Investigational treatment or complications from it. This includes expenses that might otherwise be covered if not incurred as a result of or in conjunction with the investigational treatment.
- Dental services needed as the result of, or in the course of, employment for wage or profit, if the person is insured or required to be insured by workers' compensation according to the state or federal law that applies.
- Intentionally self-inflicted bodily harm (whether insane or sane); as a result of war (declared or undeclared); taking part in a riot; during the commission of a felony (whether charged or not).
- Services provided by a government plan, program, hospital, or other facility, unless by law the covered person must pay and it is a covered expense.
- Services which by law must be provided by an educational institution.
- Services that without insurance would be free of charge, unless provided by Medicaid or Veterans Administration for non-service related care and by law we are required to pay.
- Services from a family member or someone who normally resides with you or your dependent.
- Provided prior to the effective date or after termination date of the policy/certificate.
- Services received outside of the U.S., except for a dental emergency.
- Jaw or jaw-joint problems, including but not limited to, temporomandibular or craniomandibular joint dysfunction, myofunctional therapy, or physical therapy.
- Orthodontia, unless covered expenses have been preauthorized to be medically necessary and the 24-month waiting period has been satisfied.
- Acupuncture; acupressure and other forms of alternative treatment.
- Services related to: teeth that can be restored by other means; periodontal splitting; correct abrasion, erosion, attrition, bruxism, abfraction, desensitization, or teeth that are not periodontally sound or have a questionable prognosis as determined by us.
- Cosmetic dentistry, including but not limited to, bleaching, veneers, porcelain on a crown, abutment or pontics posterior to the second bicuspid, personalization or characterization of prosthetic devices, or composite restorations on molar and/or bicuspid teeth. Cosmetic services are those services that improve physical appearance.
- Bacteriological and viral cultures, extraoral radiographs, pulp vitality tests, and adjunctive pre-diagnostic testing.
- Retrograde fillings, pulp caps, and pulpal debridement.
- Osseous grafts, provisional splinting, and localized delivery of antimicrobial agents.
- Biopsies, frenectomy/frenuloplasty, vestibuloplasty, removal of benign cyst/lesions and torus, primary closure of sinus perforation, oroantral fistula closure, placement of device to facilitate eruption of impacted tooth, transseptal fiberotomy/supra crestal fiberotomy, excision of hyperplastic tissue, tooth transplantation services, bone replacement grafts for ridge preservation, and appliance removal.
- Coping and temporary crowns.
- Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
- Changing vertical dimension, restoring occlusion, bite analysis, congenital malformation.
- Orthognathic surgery.
- Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
- Treatment of malignant or benign neoplasms, cysts, or other pathology, except excisional removal.
- Replacement of full or partial removable dentures, bridges, crowns, inlays, onlays or veneers, which can be repaired or restored to natural function.
- Analgesia, anxiolysis, inhalation of nitrous oxide, desensitizing medicament, local anesthesia, and non-intravenous conscious sedation.

Included Benefits: Pediatric Dental

Pediatric Dental is included with every plan.

Policy Form SA-S-1705-UHL

Pediatric Dental Exclusions and Limitations, continued

- Mouthguards, precision or semi-precision attachments, duplicate dentures, harmful habit appliances, occlusal guards (used as safety items or to affect performance primarily in sports related activities), replacement of lost or stolen appliances, replacement of orthodontic retainers, treatment splints, bruxism appliance, sleep disorder appliance, and gold foil restorations.
- Oral hygiene instructions, plaque control, charges for completing dental claim forms, photographs, any dental supplies, including but not limited to, take-home fluoride, prescription and nonprescription drugs (with or without a prescription, unless they are dispensed and utilized in the dental office during your covered dependents' dental visit, except we will pay for injection of antibiotic drugs at the time of initial treatment), sterilization fees, diagnostic casts, treatment of halitosis and any related procedures, lab procedures.
- Replacement within 60 consecutive months of the last placement for implants and full and partial dentures, and replacement within 60 consecutive months of the last placement for crowns, bridges, inlays, onlays, and veneers. This exclusion does not apply if the replacement is necessary because of extraction of a functioning natural tooth; or a present crown, bridge, or denture is temporary and a permanent crown, bridge, or denture is installed within 12 months from the date the temporary service was installed.
- Hospital costs or any additional fees that the dentist or hospital charges for treatment at the hospital (inpatient or outpatient).
- Replacement of complete dentures, fixed and removable partial dentures, implants or crowns if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the dentist. If replacement is necessary because of your dependents' noncompliance, you are liable for the cost of the replacement.
- Removal of sound functional restorations; temporary crowns and temporary prosthetics; provisional crowns and provisional prosthesis.
- Charges for dental services that are not documented in the dentist records, not directly associated with dental disease or not performed in a dental setting.
- Bone grafts, guided tissue regeneration, biologic materials to aid in soft and osseous tissue regeneration when performed in edentulous (toothless areas, ridge augmentation or preservations).
- Any dental services for which benefits are payable under a medical policy/certificate issued by us.

Alternate Procedures: If two or more services are considered to be acceptable to correct a condition, the amount payable will be based on the covered expenses for the least expensive service that will produce a satisfactory result as determined by us or our representatives.

Request for Predetermination: If the cost of a dental treatment plan is expected to be $300 or more, we strongly encourage you or your dentist to request a predetermination from us. We will then tell the dentist what we expect to pay, subject to the Alternate Procedures section.

Included Benefits: Pediatric Vision

Pediatric Vision is included with every plan.

Policy Form SA-S-1708-UHL

- **For covered persons under the age of 19.**
- **Eligible expenses apply toward deductible (and coinsurance, if applicable).**
- **Using non-network providers:**
  - Benefits will be reduced by 25% before deductible and coinsurance.
  - You pay all billed charges at the time of service.
  - You may then seek reimbursement from us.

Pediatric Vision Covered Expenses

Eligible expenses are subject to the health plan's deductible and coinsurance. Subject to all policy provisions, the following vision expenses are covered:

- Routine vision exams – 1 exam every calendar year.
- Prescription eyewear – 1 pair of prescription eyeglass lenses every calendar year and 1 pair of eyeglass frames every calendar year, or a 12-month supply of contact lenses or necessary contact lenses.
  - Eyeglass lenses, including polycarbonate lenses and scratch resistant coating, as prescribed by an ophthalmologist or optometrist; eyeglass frames and their fitting and subsequent adjustments to maintain comfort and efficiency; or
  - Contact lenses that are in lieu of eyeglass lenses and frames; or
  - Necessary contact lenses when a provider has determined a need for and has prescribed the service. Contact lenses are necessary if the covered person has: keratoconus; anisometropia; irregular corneal/astigmatism; aphakia; facial deformity; or corneal deformity.
- Low vision benefit – available to a covered person who has severe visual problems that cannot be corrected with regular lenses. Benefit is available when a provider has a need for and has prescribed the service. The benefit includes:
  - Comprehensive low vision evaluation – limited to 1 every 5 years;
  - Follow-up care – limited to 4 visits in any 5-year period; and
  - Low vision aids, if prescribed, such as eyeglasses, magnifiers, and telescopes.

Pediatric Vision Exclusions and Limitations

Subject to all policy provisions, no benefits are payable for:

- Orthoptics or vision therapy training and any associated supplemental testing;
- Plano (no prescription) lenses;
- Oversized lenses;
- Replacement of lenses and frames furnished under this plan which are lost or broken except at the normal service intervals;
- Medical or surgical treatment of the eyes;
- Any eye exam 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 Photorefractive Keratectomy (PRK);
- Elective contact lenses if prescription eyeglass lenses and frames are received in the same calendar year;
- Prescription eyeglass lenses and frames if elective contact lenses are received in the same calendar year;
- Non-prescription eyewear;
- Optional lens extras;
- Services or treatments already excluded in the General Exclusions and Limitations section of the policy/certificate; and
- Charges that are not covered expenses or exceed the eligible expenses determined for a covered expense.

Prior Authorization Required

For the services and supplies listed below, you are required to call before receiving the listed treatment or supplies. 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, nonemergency	As soon as possible.
Clinical Trials	As soon as possible.
Dental Services – injuries only (for post-emergency treatment)	5 business days before follow-up treatment.
Durable Medical Equipment	For services, supplies, or equipment exceeding allowed range. See your certificate.
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.

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 allowed range. See your certificate.
Genetic Testing	As soon as possible.
Hearing Aids	For services, supplies, or equipment exceeding allowed range. See your certificate.
Home Health Care	5 business days before receiving services or as soon as possible.
Hospice Care	5 business days before inpatient admission or as soon as possible.
Hospital Inpatient 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.
Mental Health and Substance Abuse Services	5 business days prior to scheduled admission. For nonscheduled admission, emergency admission, or prior to receiving outpatient services: as soon as possible.
Neurobiological Disorders: Autism Services	As soon as possible.
Pharmaceutical Products: Intravenous infusions or other products	5 business days before scheduled infusion services or receiving certain other products. For nonscheduled services: within 1 business day or as soon as possible. See also Prescription Drugs – Outpatient.

Prior Authorization Required, continued

For the services and supplies listed below, you are required to call before receiving the listed treatment or supplies. Without Prior Authorization, **benefits are reduced by 20%.** Prior Authorization does not guarantee payment.

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

Service or Supply	Using a non-network provider, you must call:
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. • For scheduled delivery due to complications of pregnancy: 5 business days prior. • For nonscheduled admission: 1 business day, same day, or as soon as possible.
Prescription Drugs – Outpatient from Non-Member Pharmacies	5 business days before receiving certain prescription drugs or a soon as possible. See also Pharmaceutical Products.
Prosthetic Devices	Before obtaining prosthetic devices that exceed allowed range. See certificate.
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.
Scopic Procedures – Outpatient	5 business days prior to services. For nonscheduled services: 1 business day or as soon as possible.
Sleep Studies	5 business days prior to services.
Surgery – Outpatient	5 business days prior to scheduled services. For nonscheduled services: 1 business day or as soon as possible.
Therapeutic Treatments: Chemotherapy, Dialysis, or Radiation	5 business days prior to treatment. For nonscheduled services: 1 business day or as soon as possible.
Transplants	As soon as possibility arises or before pre-transplant evaluation at transplant center. See Transplant Services on page 24.

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.

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." See page 26 for the policy definition of "eligible expense."

emergency services - Evaluation of an emergency medical condition and treatment to keep the condition from getting worse. See page 26 for the policy definition of "emergency."

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.

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 nonemergency 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.

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 and are subject to eligible expense limits unless you use a network provider. Please review the detailed plan information on pages 18-27.

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 and prescriptions. (Copay Select℠ plans: Tier 1 only.)
- Screening and counseling for HIV.
- Human papilloma virus DNA Testing.
- Screening and counseling for interpersonal and domestic violence.
- Some prenatal care. See certificate for details.
- 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)

Medical expense benefits are covered subject to the deductible and copay/coinsurance (if applicable).

- Daily hospital room and board and nursing services at the most common semiprivate rate (hospital does not include a nursing home or convalescent home or an extended care facility).
- Intensive care unit.
- Hospital emergency room treatment of an injury or illness. (Copay plans are subject to an additional $250 ER deductible per visit if not admitted due to illness.)
- Services and supplies, including drugs and medicines, which are routinely provided in the hospital.
- Professional fees of doctors and surgeons (but not for standby availability). Assistant surgeon's fee limited to 20% of the eligible expense for the primary surgeon's covered fee. For a medical practitioner who is not a doctor and is acting as a surgical assistant, fee limited to 10% of eligible expense for the surgical procedure.
- Dressings, sutures, casts, or other necessary medical supplies.
- 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.
- For prosthetic/orthotic devices and services: if required for treatment for an injury or illness, except as limited in the policy.
- Outpatient surgery in a doctor's office or outpatient surgical facility, including treatment and supplies.
- Dental services to correct damage to a non-diseased tooth or surrounding tissue caused by an accidental injury after the covered person's effective date.
  - Initial dental repair must be performed within 12 months of the injury.
  - Injury from chewing or biting is not considered an accident.
- Medically necessary services to diagnose and treat autism spectrum disorders when prescribed by a licensed doctor or psychologist.
- Durable medical equipment, except as limited in the policy.
- Temporomandibular or craniomandibular joint disorder and craniomandibular jaw disorder treatment.
- Cost and administration of anesthetic, oxygen, and other gases.
- Pediatric dental and vision. See pages 14-17.
- Mental health and substance abuse treatment, limited to inpatient hospital and outpatient settings.
- Therapy treatments: chemotherapy, dialysis, radiation, and hemodialysis.
- Reconstructive services, except as limited in the policy.

For information on General Exclusions and General Limitations, see pages 25-26.

Covered Expenses that apply to all plans, continued

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

Diabetic Equipment, Education, and Supplies

Doctor prescribed medically necessary equipment and supplies for management and treatment of diabetes.

Covered expenses include self-management training ordered by a doctor and provided by a health care professional certified in diabetes education by the American Diabetes Association.

Habilitative Services

Outpatient habilitative services to enhance the ability of a covered person under the age of 19 to function, so long as all of the following conditions are met:

- A doctor has diagnosed the congenital, genetic, or early acquired disorder.
- Treatment is provided by a doctor, or administered upon a doctor's referral by a licensed speech-language pathologist; audiologist; occupational therapist; physical therapist; nurse; optometrist; nutritionist; social worker; or psychologist.
- Habilitative services must be medically necessary and therapeutic, and not experimental or investigational treatment.

Habilitative services DO NOT include:

- Services that are solely education in nature.
- Services from family or household members.
- Treatment of mental disorders, other than congenital, genetic, or early acquired disorders.
- Prescription drugs.

Home Health 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 limited to a maximum of 90 visits per covered person, per calendar year. Private duty nursing care is limited to 125 visits per covered person, per calendar year.

No benefits payable for:

- Food, housing, homemaker services, and home delivered meals.
- 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 Care

A covered person must have been given a prognosis that he or she has 6 months or less to live. Care must be from or in a licensed hospice program.

No benefits payable for:

- Services provided by volunteers.
- Housekeeping services.

Covered Expenses that apply to all plans, continued

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

Physical Medicine/Rehabilitation

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.
No benefits payable for:

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

Pregnancy/Maternity Care

For normal pregnancy and delivery, covered expenses are limited to:

- Prenatal checkups, tests, and 1 routine ultrasound.
- Delivery.
- Testing of newborn children.
- Up to 48 hours of inpatient care for mother and baby following an uncomplicated vaginal delivery, or up to 96 hours for an uncomplicated caesarean section.

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 or tobacco.

See the policy for additional exclusions.

Rehabilitation

Services through a day hospital or confinement.

No benefits payable for:

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

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

Transplant Services

To qualify as a covered expense, transplants must be medically necessary and not be experimental or investigational. We will determine if the covered person is a good candidate.

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

General Exclusions

No benefits are payable for expenses:

- While confined for rehabilitation, custodial care, educational care, nursing services, or while at a residential treatment facility, except as provided for in the policy/certificate.
- 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.
- Resulting from experimental or investigational treatments, or unproven services.
- Resulting from nicotine addiction (except as covered under preventive care benefits in the policy).
- For eye surgery to correct nearsightedness, farsightedness, or astigmatism.
- 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/certificate.
- For dental expenses, including braces and oral surgery, except as provided for in the policy/certificate.
- For modification of the physical body, including breast augmentation.
- For cosmetic treatment.
- For weight modification or surgical treatment of obesity, including wiring of teeth and all forms of intestinal bypass surgery.
- That would not have been charged if you did not have insurance.
- Resulting from: war; intentionally, self-inflicted, bodily harm (unless insane); or participation in a riot or felony (whether or not charged).
- For treatment of malocclusions, except as provided for in the policy/certificate.
- Resulting from animal-to-human organ transplants, artificial or mechanical organs, procurement or transport of an organ or tissue, or the cost of keeping a donor alive.
- For marriage, family, or child counseling.
- For vocational or recreational therapy, vocational rehabilitation, or occupational therapy, except as provided for in the policy/certificate.
- For services performed by an immediate family member.
- Not specifically provided for in the policy, including telephone consultations, failure to keep an appointment, television expenses, or telephone expenses.
- Incurred while your certificate is not in force.
- For drugs, treatment, or procedures promoting conception.
- For reversals of vasectomies and tubal ligations.
- 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 treatments of hyperhidrosis (excessive sweating).
- For surrogate parenting.
- For fetal reduction surgery or abortion.
- 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.
- 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.
- Due to injuries incurred while paid to participate or instruct in:
  - Motorcycle operating/riding.
  - Racing or speed testing any vehicle/conveyance, motorized or not.
  - Horseback riding.
  - Skiing.
- Due to participating, demonstrating, guiding, or accompanying others in:
  - Sports, semi- or professional or intercollegiate.
  - Parachute jumping or hang gliding.
  - Scuba/skin diving (60 or more feet in depth).
  - Skydiving, bungee jumping.
  - Rodeo sports.
  - Rock or mountain climbing.
- For injuries sustained while performing the duties of an aircraft crew member, including giving or receiving training on an aircraft.
- Incurred outside of the U.S., except for emergency treatment.

General Exclusions, continued

No benefits are payable for expenses:

- For diagnosis or treatment of learning disabilities, attitudinal disorders, or disciplinary problems, except as provided for in the policy/certificate.
- For standby availability of a medical practitioner when no treatment is rendered.
- For modification of the physical body in order to improve the psychological, mental, or emotional well-being, such as sex-change surgery.
- 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.

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/certificate.

General Limitations

- When using a network physician or facility, non-covered expenses may not be eligible for a network provider discount.
- Covered expenses will not include charges in excess of what is eligible for a service or supply.

Conditions Prior to Legal Action

The policy includes a condition to help resolve legal disputes. It requires that you provide us written notice of intent to sue before taking legal action. Your notice must identify the source of the disagreement and include all facts and information supporting your position. An action for punitive damages (or other damages not spelled out in the contract) is waived if the claims at issue or disagreement are resolved or corrected within 30 days of written notice, unless prohibited by law.

Continued Eligibility Requirements

A covered person's eligibility will end:

- When no longer a U.S. citizen or lawfully present in the U.S.;
- When the primary insured no longer resides in the same state where the certificate was issued; or
- The date a covered person no longer resides in the network service area.

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 occur.

Coordination of Benefits (including Medicare)

If after coverage is issued, a covered person becomes insured under another health plan or Medicare, benefits will be determined under the Coordination of Benefits (COB) clause.

COB allows two or more plans to work together so the total amount of all benefits is never more than 100% of covered expenses. COB also takes into account medical coverage under auto insurance contracts. To determine which plan is primary, refer to "order of benefits" in your certificate.

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 the time of application.

Eligible Expense

An eligible expense means a covered expense as follows:

- For Network Providers: the contract fee for the provider.
- For Non-Network Providers: when a covered expense is received as the result of an emergency or as otherwise approved by us, the eligible expense is the lesser of the billed charge or the amount negotiated with the provider. Except as noted above, the eligible expense is the first of the following that can be applied:
  1. The fee negotiated with the provider;
  2. 110% of the fee Medicare allows for the same or similar service in the same area;
  3. The fee set by us after comparing rates from one or more regional or national databases, or schedules for the same or similar service from a geographical area determined by us;
  4. The fee charged by the provider; or
  5. A fee schedule we develop.

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.

Enrollment Periods and Effective Dates

There are two types of enrollment periods during which you may apply for our plans – Open Enrollment and Special Enrollment. The charts below explain the possible effective dates of coverage.

Open Enrollment – the set annual time period when you apply for coverage.

Enrollment Period	Application Received	Earliest Effective Date*
October 1, 2013 – December 15, 2013	October 1, 2013 – December 15, 2013	January 1, 2014
December 16, 2013 – March 31, 2014	Day 1 – 15 of the month --- Day 16 – last day of the month	1st day of the following month --- 1st day of the 2nd following month

Special Enrollment – the time period when you can apply for coverage if you experience a qualifying event.

Event	Enrollment Period	Application Received	Earliest Effective Date**
Loss of minimum essential coverage (does not include failure to pay premium)	Within 60 days following loss of coverage	Within 60 days following loss of coverage	1st day of the month following the event
New dependent such as: birth, adoption, or placement for adoption	Within 60 days following the event	Within 60 days following the event	Date of event
Permanent move to Missouri from another state	Within 60 days following the move	Day 1 – 15 of the month --- Day 16 – last day of the month	1st day of the month following receipt of the application --- 1st day of the 2nd month following receipt of the application
Marriage or divorce	Within 60 days following the event	Within 60 days following the event	1st day of the month following the event

* Open Enrollment Earliest Effective Date is dependent upon timely receipt of premium due. We must receive all premium before the coverage can be effective. Coverage can only be effective on the first day of the month.

** Special Enrollment Earliest Effective Date is dependent upon timely receipt of premium due. We must receive all premium before the last day of the Enrollment Period. Coverage can only be effective on the first day of the month, unless a "New dependent."

Non-Network Penalty

Covered expenses for nonemergency care received from a provider outside your network are subject to:

- Eligible expense limits;
- An additional 25% of eligible expenses (this reduction does not apply to pediatric dental);
- An additional deductible amount equal to the calendar-year deductible (2 times the network deductible).

For 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.

Premium

You are responsible for your premium. Payment must be made directly to our office. We may change the premium rates as of any premium due date. We will give you notice at least 30 days prior to the date of the change.

Premium rates will be based on policy plan, age of covered persons, tobacco use, type and level of benefits, and place of residence. If a change to the policy causes any change in premium rates, the new rate will be effective on the first premium due date following the date of the change. We may prorate any premium adjustment.

Renewability

You may renew coverage by paying the premium as it comes due. We may decline renewal only: (a) for failure to pay premium; or (b) if we decline to renew all certificates just like yours issued to everyone in the state you are then living.

Termination of a Covered Person

Coverage will end on the date that a person no longer meets the eligibility requirements, moves out of Missouri, or if the covered person commits fraud or intentional misrepresentation.

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.uhcindividual.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-0913 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.

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- **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.uhcindividual.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 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 47278-1719
- **You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint.** We will not take any action against you for filing a complaint.

Fair Credit Reporting Act Notice. In some cases, we may ask a consumer-reporting agency to compile a consumer report, including potentially an investigative consumer report, about you. If we request an investigative consumer report, we will notify you promptly with the name and address of the agency that will furnish the report. You may request in writing to be interviewed as part of the investigation. The agency may retain a copy of the report. The agency may disclose it to other persons as allowed by the federal Fair Credit Reporting Act. We may disclose information solely about our transactions or experiences with you to our affiliates.

Medical Information Bureau. In conjunction with our membership in MIB, Inc., formerly known as Medical Information Bureau (MIB), we or our reinsurers may make a report of your personal information to MIB. MIB is a nonprofit organization of life and health insurance companies that operates an information exchange on behalf of its members.

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

If you question the accuracy of information in the MIB's file, you may seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. Contact MIB at: MIB, Inc., 50 Braintree Hill Ste. 400, Braintree, MA 02184-8734, (866) 692-6901, *www.mib.com* or (TTY) (866) 346-3642.

FINANCIAL INFORMATION PRIVACY NOTICE

(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.

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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: _____

Signature of Agent/Broker: _____

THIS FORM LIMITS OUR LIABILITY. NO INSURANCE WILL BECOME EFFECTIVE UNLESS ALL FOUR 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 person is a member of the Federation of American Consumers and Travelers.
3. 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.
4. The certificate 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 FACT or 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 this 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.



FACT Membership has its benefits.

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

What is FACT?

FACT is an independent consumer association whose members benefit from the "pooling" of resources. Benefits range from medical savings to consumer service discounts. FACT's principal office is in Jonesboro, Arkansas. FACT and UnitedHealthcare Life Insurance Company are separate organizations. Neither is responsible for the performance of the other. FACT has contracted with UnitedHealthcare Life Insurance Company to provide its members with access to these health insurance plans. FACT does not receive any compensation from UnitedHealthcare Life Insurance Company.

Is there a cost for joining FACT?

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

What are the basic plan benefits?

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

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

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

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

UnitedHealthcare®

42484-UL-1013