

Health Plans for Individuals and Families



Golden Rule[®]
A UnitedHealth Group Company

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Golden Rule[®]

*Providing Health Insurance Products
To Meet Individuals' Needs Since 1946.*



Health Insurance Expertise

For more than 50 years, Golden Rule has developed health insurance products specifically designed to meet the needs of individuals across America. Our insureds share a common need for quality health insurance coverage.

Responsiveness

At Golden Rule, we recognize the critical importance of being responsive to the service needs of customers. Everyone is busy today. So, we have streamlined our customer service operations and trained health insurance customer service representatives to handle claims and service requests as fast as possible.

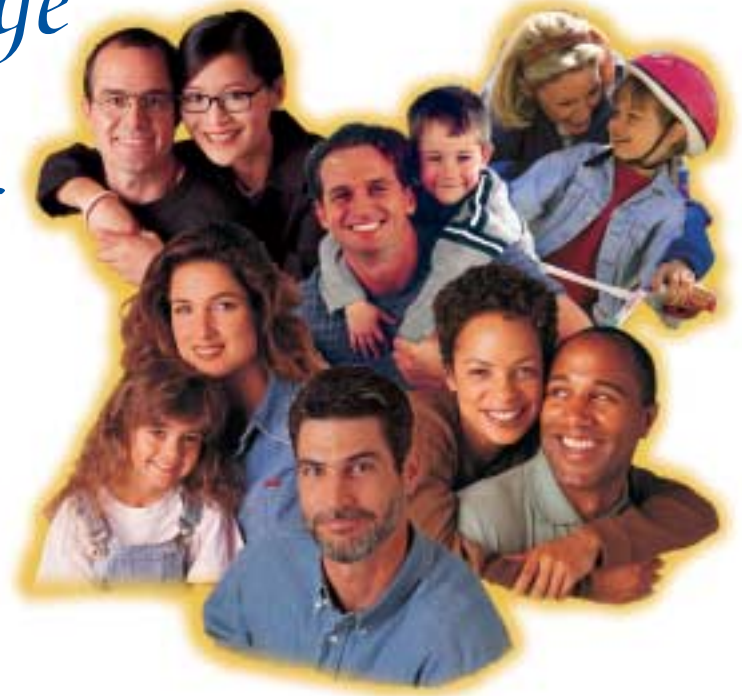
Rated Highly

Insureds must have financial stability from their health insurance carrier, and Golden Rule is a model. Golden Rule is rated highly by two leading rating agencies for health insurance companies.

Visit our Web site at goldenrule.com

Golden Rule[®]
Golden Rule Insurance Company
A UnitedHealth Group Company
Home Office
712 Eleventh Street
Lawrenceville, Illinois 62439

A Choice Of Coverage Designed To Meet Your Specific Health Insurance Needs.



	Coplay Plans SM	High Deductible and Basic Plans SM	Health Savings Account Plans
Health Insurance Category Description:	Coplay PlansSM are designed for individuals and families who want help managing their routine medical expenses , plus outstanding coverage for major health care expenses. <i>(Not available in Alaska.)</i>	High Deductible and Basic PlansSM are designed for individuals and families willing to take additional responsibility for routine health care expenses in exchange for lower premiums .	Health Savings Account Plans (HSA PlansSM) help you take control of your health care expenses with a tax-favored savings account and quality medical coverage.
Health Insurance Plans Offered in this Category:	<ul style="list-style-type: none"> • Coplay 25SM Plan A low deductible plan with a \$25 copay for Doctor Office visits. • Coplay 35SM Plan A low deductible plan with reduced premiums in exchange for higher copays. • Coplay 45SM Plan Golden Rule's most affordable Coplay PlanSM. 	<ul style="list-style-type: none"> • Plan 100[®] A high deductible plan that provides 100% for covered expenses after the deductible. • Plan 80SM A high deductible plan that reduces premium in exchange for 80/20 coinsurance. • Basic PlanSM A low-cost plan that provides coverage for hospital confinements, surgery, and the more costly outpatient tests. 	<ul style="list-style-type: none"> • HSA 100SM and HSA 80SM Plans These plans combine high deductible medical insurance with a tax-favored savings account. Money deposited in the savings account helps pay the high deductible. Once the deductible is met, the insurance starts paying. Money left in the savings account is yours to keep. Available with optional coverage to help pay early hospitalization expenses while cash accumulates in the savings account.
More Plan Information:	See page 2.	See page 3.	See pages 4 & 5.

To be considered for reimbursement, expenses must qualify as covered expenses. Expenses are also subject to reasonable and customary limits, unless you use a network. *See details on pages 2-12.*

Copay PlansSM

Copay PlansSM are designed for individuals and families who want help managing their **routine medical expenses**, plus outstanding coverage for major health care expenses.

(Not available in Alaska.)

To be considered for reimbursement, expenses must qualify as covered expenses. Expenses are also subject to reasonable and customary limits, unless you use a network. See details on pages 7-12.



<i>Plan</i>	Copay 25SM Plan	Copay 35SM Plan	Copay 45SM Plan
<i>Type</i>	• Network Required (see Network on page 6)	• Network Required (see Network on page 6)	• Network Required (see Network on page 6)
<i>Deductible Options</i> (maximum 2 per family, per year)	• \$500 • \$1,250 • \$750	• \$500 • \$1,250 • \$750	• \$500 • \$1,250 • \$750
<i>Coinsurance Options</i> (per covered person, per calendar year)	• 80/20 to \$10,000, then 100% • 70/30 to \$10,000, then 100% • 50/50 to \$ 8,000, then 100%	• 80/20 to \$10,000, then 100% • 70/30 to \$10,000, then 100% • 50/50 to \$ 8,000, then 100%	• 80/20 to \$10,000, then 100% • 70/30 to \$10,000, then 100% • 50/50 to \$ 8,000, then 100%
<i>Doctor Office Visit Fees</i>	• \$25 Copay, then 100% for history and exam	• \$35 Copay, then 100% for history and exam	• \$45 Copay, then 100% for history and exam
<i>Doctor Office X-Ray and Lab</i>	• Deductible and Coinsurance	• Deductible and Coinsurance	• Deductible and Coinsurance
<i>Preventive Care</i> (\$150 maximum per year after 12 months for each adult 19 or older)	• See Doctor Office Visit Fees and Doctor Office X-Ray and Lab	• See Doctor Office Visit Fees and Doctor Office X-Ray and Lab	• See Doctor Office Visit Fees and Doctor Office X-Ray and Lab
<i>Mammography, Pap Smear, and PSA Testing</i>	• Deductible and Coinsurance	• Deductible and Coinsurance	• Deductible and Coinsurance
<i>Outpatient Rx</i>	• Generic -- \$20 copay • Name-brand -- \$50 copay after a \$250 calendar-year, per person deductible	• Generic -- \$20 copay • Name-brand -- \$50 copay after a \$250 calendar-year, per person deductible	• Generic -- \$20 copay • Name-brand -- \$50 copay after a \$250 calendar-year, per person deductible
<i>Inpatient Hospital and Surgical Fees Included on the Hospital Bill</i>	• \$500 Copay, then Coinsurance (maximum 2 copays per person, per year)	• \$750 Copay, then Coinsurance (maximum 2 copays per person, per year)	• \$1,000 Copay, then Coinsurance (maximum 2 copays per person, per year)
<i>Outpatient Surgery and Other Covered Inpatient and Outpatient Fees</i>	• Deductible and Coinsurance	• Deductible and Coinsurance	• Deductible and Coinsurance
<i>Emergency Room Fees</i>	• Deductible and Coinsurance	• Deductible and Coinsurance	• Deductible and Coinsurance
<i>Initial Rate Guarantee</i> (subject to benefit and address changes)	• 12 months	• 12 months	• 12 months
<i>Lifetime Maximum Benefit</i> (per covered person)	• \$3 million	• \$3 million	• \$3 million
<i>Optional Benefits</i> (see page 6)	• Maternity • Supplemental Accident • Term Life Benefit	• Maternity • Supplemental Accident • Term Life Benefit	• Maternity • Supplemental Accident • Term Life Benefit

High Deductible and Basic PlansSM



High Deductible and Basic PlansSM are designed for individuals and families willing to take additional responsibility for routine health care expenses in exchange for **lower premiums**.

To be considered for reimbursement, expenses must qualify as covered expenses. Expenses are also subject to reasonable and customary limits, unless you use a network. *See details on pages 7-12.*

<i>Plan</i>	Plan 100[®]	Plan 80SM	Basic PlanSM
<i>Type</i>	• Network or No Network	• Network or No Network	• Network or No Network
<i>Deductible Options</i> (maximum 2 per family, per year)	• \$1,000 • \$2,500 • \$1,500 • \$5,000	• \$1,000 • \$2,500 • \$1,500 • \$5,000	• \$500 • \$1,500 • \$5,000 • \$1,000 • \$2,500
<i>Coinsurance Options</i> (per covered person, per calendar year)	• 100%	• 80/20 to \$5,000, then 100%	• 80/20 to \$10,000, then 100%
<i>Doctor Office Visit Fees</i>	• 100% After Deductible	• 80% After Deductible	• Not Covered
<i>Outpatient X-Ray and Lab</i>	• 100% After Deductible	• 80% After Deductible	• 80% After Deductible for MRI and CAT Scans • 80% After Deductible for Other Tests Performed Within 14 Days of Surgery or Confinement
<i>Preventive Care</i> (\$150 maximum per year after 12 months for each adult 19 or older)	• 100% After Deductible	• 80% After Deductible	• Not Covered
<i>Mammography, Pap Smear, and PSA Testing</i>	• 100% After Deductible	• 80% After Deductible	• 80% After Deductible
<i>Outpatient Rx</i>	• 100% After Deductible	• 80% After Deductible	• Not Covered
<i>Inpatient Hospital and Surgical Fees, Outpatient Surgery, and Other Covered Inpatient and Outpatient Fees</i>	• 100% After Deductible	• 80% After Deductible	• 80% After Deductible
<i>Emergency Room Fees</i>	• 100% After Deductible	• 80% After Deductible	• See Basic Plan SM , page 7
<i>Initial Rate Guarantee</i> (subject to benefit and address changes)	• 12 months	• 12 months	• 12 months
<i>Lifetime Maximum</i> (per covered person)	• \$3 million	• \$3 million	• \$3 million
<i>Optional Benefits</i> (see page 6)	• Maternity • Supplemental Accident • Term Life Benefit • Prescription Drug Card	• Maternity • Supplemental Accident • Term Life Benefit • Prescription Drug Card	• Maternity • Supplemental Accident • Term Life Benefit

Health Savings Account Plans

Health Savings Account Plans (HSA PlansSM) help you take control of your health care expenses with a **tax-favored savings account** and quality medical coverage.

To be considered for reimbursement, expenses must qualify as covered expenses. Expenses are also subject to reasonable and customary limits, unless you use a network. See details on pages 7-12.



<i>Plan</i>	HSA 100SM Plan	HSA 80SM Plan
<i>Type</i>	• Network or No Network	• Network or No Network
<i>Deductible Options</i>	• See Insert	• See Insert
<i>Coinsurance Options</i>	• 100%	• 80%
<i>Doctor Office Visit Fees</i>	• 100% After Deductible	• 80% After Deductible
<i>Outpatient X-Ray and Lab</i>	• 100% After Deductible	• 80% After Deductible
<i>Preventive Care</i> (\$150 maximum per year after 12 months for each adult 19 or older)	• 100% After Deductible	• 80% After Deductible
<i>Mammography, Pap Smear, and PSA Testing</i>	• 100% After Deductible	• 80% After Deductible
<i>Outpatient Rx</i>	• 100% After Deductible	• 80% After Deductible
<i>Inpatient Hospital and Surgical Fees, Outpatient Surgery, and Other Covered Inpatient and Outpatient Fees</i>	• 100% After Deductible	• 80% After Deductible
<i>Emergency Room Fees</i>	• 100% After Deductible	• 80% After Deductible
<i>Initial Rate Guarantee</i> (subject to benefit and address changes)	• 12 months	• 12 months
<i>Lifetime Maximum</i> (per covered person)	• \$3 million	• \$3 million
<i>Optional Benefits</i> (see page 6)	<ul style="list-style-type: none"> • Supplemental Accident • Term Life Benefit • Hospital Indemnity Rider 	<ul style="list-style-type: none"> • Supplemental Accident • Term Life Benefit • Hospital Indemnity Rider

How to Set Up an HSA

Health Coverage Benefits

Take the money currently spent on existing insurance and put a portion towards a **qualified higher deductible plan**, with the remainder going into a **tax-favored savings account**.

Use the savings account to help pay the deductible; then higher deductible medical pays for the remaining covered medical expenses.

Medical

Simple:

100% coinsurance after the deductible is met (optional 80% coinsurance to lower premium).

Predictable:

One deductible per family.

Comprehensive:

Quality medical, including adult preventive care and prescription drugs.

Savings Account

First dollar:


Savings can be used to help pay the deductible and for noncovered medical expenses, such as dental and vision.

Security:*

Savings reduce or eliminate annual out-of-pocket exposure.

Pool of money:

Savings not spent remain in the HSA, tax-deferred.



Instead of paying
all costs towards
a traditional
insurance plan . . .

Tax Benefits

Tax-deductible:

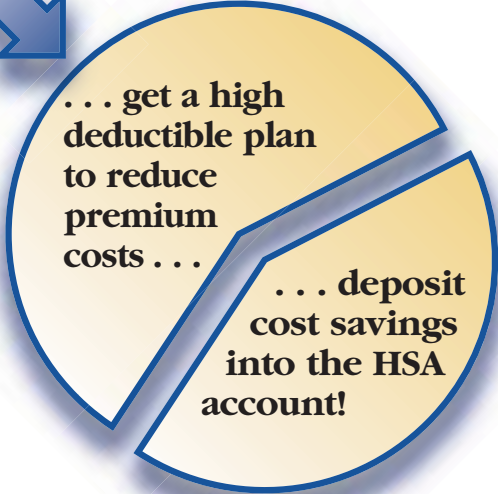
Contributions to the HSA are 100% deductible -- just like an IRA (see brochure insert for legal limit).

Tax-favored:

Withdrawals for covered medical expenses are never taxed.

Tax-deferred:

Interest earnings accumulate tax-deferred, and if used for covered medical expenses, are tax-free.



. . . get a high
deductible plan
to reduce
premium
costs . . .

. . . deposit
cost savings
into the HSA
account!

***Optional Benefit to Provide Additional Security**

If you are concerned about paying your deductible prior to accumulating the necessary funds in your savings account, consider the optional **HSA Hospital Indemnity Rider** (details on page 6).

Important Information About the USA Patriot Act

To help fight the funding of terrorism and money-laundering activities, the U.S. Government has passed the USA Patriot Act, which requires banks, including our processing agent bank (Northern Trust), to obtain, verify, and record information that identifies persons who engage in certain transactions with or through a bank.

This means that Northern Trust will need to verify the **name, residential or street address (no P.O. Boxes), date of birth, and social security number or other tax identification number** of all Health Savings Account owners.

Optional Benefits

Optional Benefits are designed to help individuals and families further customize their health insurance coverage to meet their specific needs.

Maternity Benefit

The optional Maternity Benefit is designed to help cover the costs for routine pregnancy and delivery. You choose the maximum benefit amount: \$2,500 or \$4,000. The plan will pay up to 50 percent of the maximum benefit during the first year. After the first year, the plan will pay 100 percent of the maximum benefit. To be covered, a pregnancy must begin while the maternity benefits are in effect. *(Not available with HSA PlansSM; not available in Arkansas, Maryland, or Virginia.)*

Benefit Amount	Year 1	Year 2 & On
\$2,500	50%	100%
\$4,000	50%	100%

Prescription Drug Card Benefit

The Prescription Drug Card Benefit is designed to help manage the costs of prescription drugs. This option allows you to purchase:

- Generic prescription drugs for a \$20 copay.
- Name-brand drugs for a \$50 copay after a \$250 calendar-year, per person deductible.

(Not available with Basic PlanSM or HSA PlansSM.)

Supplemental Accident Benefit

The optional Supplemental Accident Benefit is designed to provide up-front coverage to individuals and families for unexpected accidents. This option provides up to \$500 of first-dollar benefits for treatment of an injury within 90 days of an accident.

Physician and Provider Networks (Networks)

A network has contracts with many health care providers, including doctors, hospitals, and other medical professionals. To find or view network providers for any network, go to www.goldenrule.com

Selecting the network option (required with Copay PlansSM) on your health insurance plan allows you to significantly lower the premium cost.

If you receive nonemergency services from a provider outside the network, covered expenses will be reduced by 25 percent and subject to an additional deductible amount equal to the calendar-year deductible.

If you are under a Copay PlanSM, office visit expenses outside the network are not eligible for copay benefits.

(Network option is not available in Alaska.)

HSA Hospital Indemnity Rider

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

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

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

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

Month	Deductible	
	\$1,700/\$2,600	\$3,450/\$5,150
1	\$1,500	\$2,700
2	1,400	2,500
3	1,250	2,300
4	1,100	2,100
5	1,000	1,900
6	950	1,700
7	850	1,500
8	750	1,300
9	650	1,100
10	550	1,000
11	500	900
12	450	700
13	400	500
14	300	300
15	200	200
16	-0-	-0-

One-time premium amount for this option	\$40	\$100
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(Note: HSA Hospital Indemnity Rider is not available for plans with \$1,000 or \$2,000 deductibles.)

Term Life Benefit

You may choose an optional decreasing term life insurance benefit for you and your spouse if your spouse is also a covered person under the health policy. The amount of life insurance protection provided for you and your spouse will depend on the primary insured's attained age at the time of death, as shown in the table.

Attained Age of Primary Insured at Death	Primary Insured Benefit Amount	Covered Spouse Benefit Amount*
49 or less	\$30,000	\$15,000
50-59	18,000	9,000
60-64	12,000	6,000

* Equal to the *Primary Insured Benefit Amount* for certificates issued to residents of Maryland.

Covered Expenses

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

Basic PlanSM

Inpatient Expense Benefits

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

Outpatient Expense Benefits

- Charges for outpatient surgery, including the fee made by an outpatient surgical facility, the primary surgeon, the assistant surgeon, and/or administration of anesthetic.
- Hemodialysis, radiation, and chemotherapy.
- Prescription drugs to protect against organ rejection in transplant cases.
- Mammography, pap smear, and PSA test fees.
- Hospital emergency room treatment of an injury or illness (subject to an additional \$500 deductible each time the emergency room is used for injury or illness not resulting in confinement).

Outpatient Testing Expense Benefits

- CAT scan and MRI testing.
- Diagnostic testing, related to and performed within 14 days prior to surgery or inpatient confinement.

Exclusions

- Expenses incurred for mental or nervous disorders or substance abuse.
- *Outpatient* prescription drugs (except as provided for under Outpatient Expense Benefits).
- *Outpatient* medical services, including doctor office visits and diagnostic testing (except as provided for under Outpatient Testing Expense Benefits).

Important Note:

Premiums for a Basic PlanSM are significantly less because coverage is not provided for most *outpatient* services (doctor office visits, diagnostic testing, and prescription drugs).

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

Medical Expense Benefits

- Daily hospital room-and-board and nursing services at the most common semiprivate rate.
- Charges for an intensive care unit.
- Hospital emergency room treatment of an injury or illness (subject to an additional \$100 deductible each time the emergency room is used for illness not resulting in confinement). (*Does not apply to HSA PlansSM.*)
- Surgery at an outpatient surgical center.
- Professional fees of doctors and surgeons (but not for standby availability).
- Dressings, sutures, casts, or other necessary medical supplies.
- Professional fees for outpatient services of licensed physical therapists.
- Diagnostic tests 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 the U.S., if requested by police or medical authorities at the site of an emergency.
- Charges for an operating, treatment, or recovery room for surgery.
- Dental expenses due to an injury which damages natural teeth if expenses are incurred within six months.
- Surgical treatment of TMJ disorders.
- Cost and administration of an anesthetic, oxygen, and other gases.
- Radiation therapy or chemotherapy.
- Prescription drugs.
- Hemodialysis, processing and administration of blood or components.
- Mammography, pap smear, and PSA test fees.
- Artificial eyes, larynx, breast prosthesis, or basic artificial limbs (but not replacements).

Preventive Care Expense Benefits

- After coverage has been in force 12 months, each adult age 19 or older qualifies for up to \$150 of covered expenses per calendar year for routine physicals, including lab fees.

For information on additional Plan Provisions, including Transplant Expense Benefit, Limited Exclusion for AIDS or HIV-Related Disease, Notification Requirements, Preexisting Conditions, General Exclusions, General Limitations, and Other Plan Provisions, read pages 8, 9, and 10.

Provisions That Apply to All Plans

Transplant Expense Benefit

The following types of transplants are eligible for coverage under the Medical Expense Benefits and the Inpatient Hospital, Surgical, Medical Expense Benefits provisions:

Cornea transplants, artery or vein grafts, heart valve grafts, prosthetic tissue replacement, including joint replacements and implantable prosthetic lenses, in connection with cataracts.

Transplants eligible for coverage under the Transplant Expense Benefit are:

Heart, lung, heart and lung, kidney, liver, and bone marrow transplants.

Golden Rule has arranged for certain hospitals around the country (referred to as our "Centers of Excellence") to perform specified transplant services. If you use one of our "Centers of Excellence," the specified transplant will be considered the same as any other illness and will include a transportation and lodging incentive (for a family member) of up to \$5,000. Otherwise, the acquisition cost for the organ or bone marrow will not be covered, and covered expenses related to the transplant will be limited to \$100,000 and one transplant in a 12-month period.

To qualify as a covered expense under the Transplant Expense Benefit, the covered person must be a good candidate and the transplant must not be experimental or investigational. In considering these issues, we consult doctors with expertise in the type of transplant proposed.

The following conditions are eligible for bone marrow transplant coverage:

Allogenic bone marrow transplants (BMT) for treatment of: Hodgkin's lymphoma or non-Hodgkin's lymphoma, severe aplastic anemia, acute lymphocytic and nonlymphocytic leukemia, chronic myelogenous leukemia, severe combined immunodeficiency, Stage III or IV neuroblastoma, myelodysplastic syndrome, Wiskott-Aldrich syndrome, thalassemia major, multiple myeloma, Fanconi's anemia, malignant histiocytic disorders, and juvenile myelomonocytic leukemia.

Autologous bone marrow transplants (ABMT) for treatment of: Hodgkin's lymphoma, non-Hodgkin's lymphoma, acute lymphocytic and nonlymphocytic leukemia, multiple myeloma, testicular cancer, Stage III or IV neuroblastoma, pediatric Ewing's sarcoma and related primitive neuroectodermal tumors, Wilms' tumor, rhabdomyosarcoma, medulloblastoma, astrocytoma, and glioma.

Home Health Care

To qualify for benefits, home health care must be:

- Provided in lieu of medically necessary inpatient care in a hospital or hospice; and
- Provided through a licensed home health care agency.

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

Hospice Care

To qualify for benefits, a Hospice Care program for a terminally ill covered person must be licensed by the state in which it operates. Benefits for inpatient care in a hospice will be limited to 90 days in a covered person's lifetime. Covered expenses for room and board are limited to the most common semiprivate room rate of the hospital or nursing home with which the hospice is associated. Benefits for outpatient care will be limited to \$1,500 in a covered person's lifetime.

Notification Requirements

You must notify us by phone on or before the day a covered person:

- Begins the fourth day of an inpatient hospitalization; or
- Is evaluated for an organ or tissue transplant.

Failure to comply with Notification Requirements will result in a 20 percent reduction in benefits, to a maximum of \$1,000.

If it is impossible for you to notify us due to **emergency** inpatient hospital

admission, you must contact us as soon as reasonably possible.

Our receipt of notification does not guarantee either payment of benefits or the amount of benefits. Eligibility for, and payment of, benefits are subject to all terms and conditions of the policy. You may contact Golden Rule for further review if coverage for a healthcare service is denied, reduced, or terminated.

Preexisting Conditions

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

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

Limited Exclusion for AIDS or HIV-Related Disease

AIDS and HIV-related disease is treated the same as any other illness unless the onset of AIDS or HIV-related disease is: (a) diagnosed before the coverage has been in force for one year; or (b) first manifested before the coverage has been in force for one year. If diagnosed or first manifested before coverage has been in force for one year, AIDS and HIV-related disease claims will never be covered. Details of this limited exclusion are set forth in the policy and certificates.

General Exclusions

No benefits are payable for expenses which:

- Are due to pregnancy (except for complications of pregnancy) or routine newborn care (unless optional coverage is selected).

- Are for routine or preventive care unless provided for in the policy.
- Are incurred while confined primarily for custodial, rehabilitative, or educational care or nursing services.
- Result from employment-related injury or illness if the covered person is insured or is required to be insured, by workers' compensation insurance under applicable state or federal law.
- Are in relation to, or incurred in conjunction with, investigational treatment.
- Are for dental expenses or oral surgery, eyeglasses, contacts, eye refraction, hearing aids, or any examination or fitting related to these.
- Are for modification of the physical body, including breast reduction or augmentation.
- Are incurred for cosmetic or aesthetic reasons, such as weight modification or surgical treatment of obesity.
- Would not have been charged in the absence of insurance.
- Are for eye surgery to correct nearsightedness, farsightedness, or astigmatism.
- Result from war, intentionally self-inflicted bodily harm (whether sane or insane), or participation in a felony (whether or not charged).
- Are for treatment of temporomandibular joint disorders, except as may be provided for under covered expenses.
- Are incurred for animal-to-human organ transplants, artificial or mechanical organs, procurement or transportation of the organ or tissue, or the cost of keeping a donor alive.
- Are incurred for marriage, family, or child counseling.
- Are for recreational or vocational therapy or rehabilitation.
- Are incurred for services performed by an immediate family member.
- Are not specifically provided for in the policy or incurred while your certificate is not in force.
- Are for any treatment or procedure that either promotes or prevents conception, or prevents childbirth, such as abortion, sterilization, treatment of infertility, or artificial insemination.

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

General Limitations

- Expenses incurred by a covered person for treatment of tonsils, adenoids, middle ear disorders, hemorrhoids, hernia, or any disorders of the reproductive organs, will not be covered during the covered person's first six months of coverage under the policy. This provision will not apply if treatment is provided on an "emergency" basis. "Emergency" means a medical condition manifesting itself by acute signs or symptoms which could reasonably result in placing a person's life or limb in danger if medical attention is not provided within 24 hours.
- Covered expenses will not include more than what was determined to be the reasonable and customary charge for a service or supply.
- Transplants eligible for coverage under the Transplant Expense Benefit are limited to two transplants in a ten-year period.
- Charges for an assistant surgeon are limited to 20 percent of the primary surgeon's covered fee.
- Covered expenses for surgical treatment of TMJ will be limited to \$10,000 per covered person.
- All diagnoses or treatments of mental disorders, as defined in the policy, including substance abuse, will be limited to a lifetime maximum benefit of \$3,000. Covered expenses for outpatient diagnosis or treatment of mental disorders will be further limited to \$50 per visit. As with any other illness or injury, inpatient care which is primarily for educational or rehabilitative care will not be covered.
- Covered outpatient expenses relating to diagnosis or treatment of any spine or back disorders will be limited to a maximum of \$2,000 per calendar year. CAT scan and MRI tests are not subject to this limitation.
- Covered expenses will be limited to no more than a 34-day supply for any one outpatient prescription drug order or refill.

Other Plan Provisions

Effective Date:

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

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

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

Premium:

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

Dependents:

For purposes of this coverage, eligible dependents are your lawful spouse and eligible children. Eligible children must be unmarried, living with and financially dependent on you, and under 19 years of age, or under 23 years of age if attending an accredited college or vocational school on a full-time basis.

Termination of a Covered Person:

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

Continued Eligibility Requirements:

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

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

Provisions That Apply to All Plans (continued)

Renewability:

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

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

Underwriting:

Coverage will not be issued as a supplement to other health plans that you may have at the time of application.

Arbitration:

The policy contains an arbitration provision to resolve many claims disputes without litigation. The decision of the arbitrators will be final and binding unless prohibited by your state. There is also a provision that provides for resolution of disputes over medical necessity.

Group -- COB:

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

Medicare -- Carve-Out:

Covered persons who reach the age of Medicare eligibility will be provided an alternative health insurance benefit called "Carve-out." Basically, "Carve-out" pays the difference between what Golden Rule benefits normally would pay and what is paid or payable by Medicare.

Complete coverage details are provided in the policy and certificates. In most cases, coverage will be determined by the master policy issued in Illinois and subject to Illinois law.

World of FACT Value

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

- Dental and vision discounts
- Prescription drug discounts
- Eye-wear savings
- Van line discounts
- Health insurance plans
- Consumer library
- *Consumer hotline* referral service
- Amusement park discounts
- Travel service and savings
- Informative newsletter

Plus . . .

- *You may apply for:* FACT scholarships, classroom grants, and community project grants
- *You are eligible to request:* Financial assistance in the event of a natural disaster
- *You are kept aware of matters of importance through:* FACT's Eye-On-Washington Reports

Benefits and suppliers change from time to time. For the most current information:

Visit FACT's Web site (<http://www.fact-org.org>).

Or call toll-free (1-800-USA-FACT).

These health insurance plans are available as group coverage only to members of FACT. If you're not already a member, you must join FACT.

When you join FACT and sign up for insurance with Golden Rule, you enjoy group benefits and maintain your independent status!

State Variations

Please review the information provided below, which summarizes the major variations in coverage by state from those described in this brochure.

Alaska

- Copay PlansSM are not available in this state.
- Formulas necessary for the treatment of phenylketonuria are covered the same as any other illness.

Arizona

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

Arkansas

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

Colorado

- The limitation on expenses incurred during the first six months for treatment of tonsils, adenoids, middle ear disorders, hemorrhoids, hernia, or any disorders of the reproductive organs does not apply.
- The 14-day waiting period for the coverage of illnesses does not apply.
- The preexisting conditions' limitation is reduced from 24 to 6 months.
- The limited exclusion for AIDS does not apply.
- The Medicare - Carve-out provision is amended to provide no reduction in benefits or premium if a covered person does not have Medicare coverage.
- Limited routine newborn care.
- Expenses for mammography exams, prostate screening, and child health services are not subject to the deductible.

- Mental or nervous disorders: The exclusion under the Basic PlanSM and the \$3,000 lifetime limit under other plans is removed. Instead, you will receive certain limited benefits mandated by Colorado.
- Certain types of biologically-based mental illnesses will be covered, subject to all the terms and conditions of the certificate.
- The age limit for a dependent is increased from 23 to 24, and can include a dependent medically certified as disabled.
- No benefits will be paid for treatment of intractable pain as defined in the certificate.

Cover Colorado Notice Form

You and/or your dependents may qualify for health insurance from CoverColorado as Eligible Individuals, as defined under the federal "Health Insurance Portability and Accountability Act of 1996."

Generally, you are eligible if you:

- Have had 18 months of continuous prior health insurance coverage.
- Were most recently covered under a group health plan.*
- Have elected and exhausted COBRA or state continuation of benefits coverage.
- Are not eligible for any other group health coverage, Medicare, or Medicaid.
- Do not have other health insurance.

* *Group health plan = coverage existing in connection with employment.*

You also may be eligible for participation in the plan, without first requiring application to a carrier for health coverage, if a licensed physician has diagnosed you with a medical condition that is on the list of presumptive medical conditions established by the CoverColorado Board of Directors.

Other eligibility requirements, exclusions, and limitations may apply.

You may apply to CoverColorado for a determination of your eligibility for insurance on application forms available from CoverColorado. A premium will be charged for this insurance if your application is accepted.

For more information regarding CoverColorado, including benefits and exclusions, please contact:

Plan Representative
CoverColorado
425 South Cherry Street, Suite 160
Denver, CO 80246
(303) 863-1960

Florida

- Covered child health supervision services (well-child care services) are not subject to the deductible.
- Portability plans (guarantee issue without preexisting conditions' exclusions) are available to eligible applicants. Review the application for insurance for details.

Georgia

- There is a carry-over deductible feature which allows for expenses incurred and applied to the calendar-year deductible during the last three months of the year to be applied towards satisfying your deductible for the next calendar year. This does not apply to the HSA PlansSM.
- The limited exclusion for AIDS does not apply.
- The limiting age for a child attending an accredited college on a full-time basis to be considered a dependent is changed from 23 to 25.
- Child-wellness benefits are not subject to the deductible.

Indiana

- The limited exclusion for AIDS does not apply.

Iowa

- **Plans Offered by Golden Rule:** Copay PlanSM • Plan 100[®] • Plan 80SM • Basic PlanSM • HSA PlansSM • State of Iowa Basic and Standard Health Benefit Plan
- For information on availability and premium rates, please consult your insurance representative.
- The spine and back limitation does not apply.
 - The preexisting conditions' 12-month waiting period may be reduced for persons covered by qualifying prior coverage.
 - The limited exclusion for AIDS does not apply.
 - The arbitration provision does not apply.
 - The maternity expense benefits rider does not cover maternity expenses until 300 days after the rider effective date.

Maryland

- The limited exclusion for AIDS does not apply.
- Portability plans (guarantee issue without preexisting conditions' exclusions) are available to eligible applicants. Review the application for insurance for details.

Michigan

- The reference to 24 months in the definition of a preexisting condition is changed to 6 months.
- **Provider Network Continuity of Treatment:** If your provider leaves the network while you are receiving treatment for an "injury or illness," your first subsequent visit will be covered as if your provider were still in the network, and we will notify you that the provider is no longer a network provider so that you may choose a new network provider.
- **Grievance Procedure Information**
Phone Number: (317) 297-4189. Upon request, we will provide you with the telephone number for the Michigan Department of Consumer and Industry Services.
- Expenses incurred for diagnosis and treatment of pain will be covered expenses to the same extent as for any other illness or injury.

Mississippi

- The references to 24 and 12 months in the definition of a preexisting condition are both changed to 6 months.

Quality Assurance Program Summary

If you select a UnitedHealthcare network, UnitedHealthcare will administer their Quality Improvement Program to improve your health care experience. Components of the program include:

- Providing Clinical Profile reports on key clinical measures to your physician or other health care providers so he or she can deliver better quality medical care to you and your family.
- Public accountability through the accreditation process and reporting to regulatory agencies.
- Credentialing the physician and provider network.
- Reporting on and improving performance on clinical measures and measures of customer satisfaction.

Missouri

- The limited exclusion for AIDS does not apply.
- Portability plans (guarantee issue without preexisting conditions' exclusions) are available to eligible applicants. Review the application for insurance for details.
- The exclusion for intentionally self-inflicted bodily harm does not apply if the intentionally self-inflicted bodily harm resulted from a suicide attempt while insane.
- The exclusion for suicide while insane in the Decreasing Term Life Insurance Rider does not apply.
- Notification Requirements do not apply.

State Variations (continued)

Ohio

- On all plans except Basic PlanSM: The lifetime maximum benefit limit for inpatient diagnosis or treatment of a mental disorder or substance abuse and for outpatient diagnosis or treatment of substance abuse is \$3,000 per covered person; professional fees of a medical practitioner for outpatient treatment of substance abuse are limited to \$50 per visit; and professional fees of a medical practitioner for outpatient diagnosis and treatment of a mental disorder are limited to \$550 per covered person, per calendar year.
- The limited exclusion for AIDS does not apply.
- State of Ohio Basic and Standard portability plans (guarantee issue without preexisting conditions' exclusions) are available to eligible applicants.
- Limited coverage is provided for child health supervision services.

Oklahoma

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

Pennsylvania

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

South Carolina

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

Tennessee

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

Texas

- Treatment of TMJ disorders is covered the same as any other illness.

- Formulas necessary for the treatment of phenylketonuria are covered the same as any other illness.
- The optional maternity benefit is added by use of a rider and requires additional premium.
- With respect to fees charged for covered expenses, reasonable and customary charges mean the most common charge for similar expenses within the area in which the expense is incurred so long as these charges are reasonable. What is reasonable and customary will be determined by Golden Rule based on the factors stated in the policy.
- Inpatient diagnosis or treatment of mental or nervous disorders or mental incapacity will be covered the same as any other illness, subject to the \$3,000 lifetime maximum benefit and other terms of the policy. For example, as with any other illness or injury, inpatient treatment which is primarily for educational or rehabilitative care will not be covered.
- If a designated "Center of Excellence" is not used for a listed transplant, covered expenses will be reduced by 25 percent.

- A preexisting condition is an injury or illness for which the covered person received medical advice or treatment within the 12 months immediately preceding the effective date of coverage. This 12-month waiting period may be reduced for persons covered by qualifying prior coverage.
- Limited benefits are provided for the diagnosis and treatment of chemical dependency.
- AIDS and HIV-related disease claims will be limited to \$5,000 per calendar year, provided the conditions under the limited exclusion for AIDS or HIV-related disease are met.
- Medically necessary is a defined term and means that a service, medicine, or supply is necessary and appropriate for the treatment of an illness or injury as determined by Golden Rule based on factors stated in the policy.
- The Coordination of Benefits provision also takes into account personal injury protection coverage, whether provided under a group or individual contract.
- Covered childhood immunizations are not subject to the deductible.
- The limiting age is changed from 23 to 25 for a child who is a full-time student.
- Notification Requirements do not apply for plans with network.

Virginia

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

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

West Virginia

- No benefits are payable for expenses which result from employment-related injury or illness (unless the person is self-employed and not covered by Workers' Compensation).
- The lifetime maximum benefit for all diagnosis or treatment of mental disorders including substance abuse is \$10,000.
- The exclusion of TMJ disorders does not apply.
- Childhood immunizations are not subject to the deductible.
- Portability plans (guarantee issue without preexisting conditions' exclusions) are available to eligible applicants. Review the application for insurance for details.

Wisconsin

- The limited exclusion for AIDS does not apply.
- The spine and back limitation does not apply.
- Covered expenses for all diagnoses or treatments of mental or nervous disorders and substance abuse are subject to the deductible and coinsurance and will be limited to a policy year maximum benefit of \$7,000. Outpatient treatment is further limited to a maximum benefit of \$2,000.
- Limited coverage for nonsurgical treatment of TMJ is provided.
- Covered child immunization services are not subject to the deductible.
- Covered expenses for home health aide services will be limited to 40 visits in a 12-month period.

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

CONDITIONAL RECEIPT FOR _____

THIS FORM LIMITS OUR LIABILITY.

Proposed Insured: _____

Amount Received: _____

Date of Receipt: _____

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

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



Signature of Secretary

Signature of Agent/Broker

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

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

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

Definitions:

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

Limitation:

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

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

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

1. Full coverage will be provided under the new plan for preexisting health conditions: (a) that are fully disclosed in your application; and (b) for which coverage is not excluded or limited by name or specific description. Other health conditions that you now have may not be immediately or fully covered under the new plan. This could result in a claim for benefits being denied, reduced, or delayed under the new plan, whereas a similar claim might have been payable under your present plan.
2. If after due consideration, you still wish to terminate your present insurance and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information, correct information regarding the tobacco use of any applicant, or information concerning other health plans may cause the company to deny a future claim and to void your coverage as though it has never been in force. After you have completed the application and before you sign it, reread it carefully. Be certain that all information has been properly recorded.
3. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of or addition to your present plan. You should be certain that you understand all the relevant factors involved in replacing or adding to your present coverage.
4. Finally, we recommend that you not terminate your present plan until you are certain that your application for the new plan has been accepted by Golden Rule.

A COPY OF YOUR AUTHORIZATION FOR MONTHLY P.A.C.

I (we) hereby authorize Golden Rule to initiate debit entries to the account indicated below.

I also authorize the named depository to debit the same to such account.

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

A COPY OF YOUR AUTHORIZATION TO OBTAIN AND DISCLOSE HEALTH INFORMATION

I authorize Golden Rule Insurance Company's Insurance Administration and Claims Departments to obtain health information that they need to underwrite or verify my application for insurance. Any health care provider, the Medical Information Bureau (MIB), or insurance company having any information as to a diagnosis, the treatment, or prognosis of any physical or mental conditions about my family or me is authorized to give it to Golden Rule's Insurance Administration and Claims Departments. This includes information related to substance use or abuse.

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

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

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

I (we) understand the following:

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

I have retained a copy of this authorization.

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

Golden Rule Insurance Company Notice of Information Practices

THIS NOTICE DESCRIBES HOW MEDICAL AND OTHER PERSONAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. IT ALSO DESCRIBES HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THE NOTICE CAREFULLY.

You entrust us with individually identifiable health and financial information (referred to as "personal information" in the rest of this notice). You are our best and most important source of information about you and others listed on your application. We may also collect personal information about you from others. For example, we may collect it from health care providers, employers, or insurance companies.

EXAMPLES OF INFORMATION WE MAY COLLECT AND MAINTAIN

Your name, address, telephone number, social security number, date of birth, gender, marital status, assets, income, E-mail address, policy or account number, account balance, policy coverage, premium payment, claims history, premium contribution amounts, medical information, motor vehicle reports, details about your transactions with other insurance companies, and details from consumer-reporting agencies.

INFORMATION WE ARE PERMITTED TO USE AND DISCLOSE WITHOUT AN AUTHORIZATION

We may use and share the personal information described above. We will use and share it only as permitted or required by law. Examples include, but are not limited to, the following situations:

- To a company affiliated with us.
- To those who act on our behalf. They are required to keep the information confidential. They are required to use the information only to provide the services we have asked them to provide. They may include payment processing companies, mailing houses, data processing companies, business consultants, system support vendors, Internet vendors, and those that provide access to provider discounts for our insureds.
- To financial institutions with which we jointly offer, endorse, or sponsor a financial product or service.
- To the individual who is the subject of the information.
- To an insurance regulatory authority.
- For payment, such as using details received from an insurance company to coordinate benefits.
- For payment, such as to a health care provider to identify insurance coverage or benefits.
- For treatment, such as to your health care providers to help them provide medical care.
- For health care operations such as exchanging information with another insurance company to detect or prevent criminal activity, fraud, and material misrepresentation.
- To provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
- To a group health plan sponsor.
- For public health activities such as to prevent or control disease, injury, or disability.
- To persons involved with your care, such as a family member, when you are incapacitated or in an emergency.

Visit our Web site at goldenrule.com

35020-0604
Policy Forms C-006.3 or C-006.4

- To health oversight agencies for compliance purposes.
- In response to a court or administrative order.
- In response to a subpoena, discovery request, or other lawful process by another person involved in a dispute.
- For law enforcement purposes.
- To coroners, medical examiners, or funeral directors.
- To avert a serious threat to health or safety to you, another person, or the public.
- To federal officials for intelligence, counter-intelligence, and other national security activities.
- To worker's compensation or other programs that provide benefits for work-related injuries or illness.

ALL OTHER USES AND DISCLOSURES OF PERSONAL INFORMATION

All other uses and sharing of personal information, not permitted or required by law, will be made only with your written authorization. You may revoke the authorization in writing. If you do, we will no longer use or share the information for the reasons covered by the authorization -- unless we have taken action based on the authorization. We are unable to withdraw any disclosures we have already made with your authorization.

YOUR RIGHTS REGARDING YOUR PERSONAL HEALTH INFORMATION

With respect to your personal health information, you have the following rights:

- To inspect and obtain a copy of it.
- To request that we amend it.
- To receive details about our sharing of it.
- To request that we communicate with you about it by alternative means or at an alternative location if our sharing of all or part of it could endanger you.
- To request that we restrict the use and sharing of it. (We do not have to agree.)
- To receive a paper copy of this notice at any time.

Additional rights may be available under state law. There are some exceptions to these rights. Please send a written request to the address below.

FORMER CUSTOMERS

If your customer relationship with Golden Rule ends, we will still treat your information as described in this notice.

SECURITY OF PERSONAL INFORMATION

We maintain physical, administrative, and technical safeguards to guard your information. We limit employee access to information based on job duties.

FAIR CREDIT REPORTING ACT NOTICE

In some cases, we may ask a consumer-reporting agency to compile an investigative consumer report about you. If we request such a 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.

MEDICAL INFORMATION BUREAU

We or our reinsurers may make a report of personal information in conjunction with our membership in the Medical Information Bureau (MIB). This is a non-profit organization of life insurance companies, which

operates an information exchange on behalf of its members.

If an application or claim for benefits is submitted to another Bureau member company for life or health insurance coverage, the Bureau, upon request, will supply such company with information in its file.

If you question the accuracy of information in the Bureau's file, you may seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. Contact the Bureau at:

MIB, Inc.
P.O. Box 105
Essex Station
Boston, MA 02112
617-426-3660
www.mib.com

OUR DUTIES

We are required to keep your personal information private. We are providing this notice of our legal duties and privacy practices. We will abide by the terms of this notice as currently in effect.

If you believe your privacy rights have been violated, you may send a written complaint to Golden Rule at the address below. You may also write to the Secretary of the Department of Health and Human Services. We will not take action against you for filing the complaint.

You will receive this notice each year. We reserve the right to change the terms of our notice. We reserve the right to make the new notice apply to all personal information that we maintain. We will send a new notice within 60 days of any material change. We will mail it to your last known address or by E-mail if you have agreed to electronic notice. For more information or to obtain a copy, please contact:
Golden Rule Insurance Company
Attn: Privacy Official
712 Eleventh Street
Lawrenceville, IL 62439
618-943-5064

This notice, effective January 2004, is being provided on behalf of Golden Rule Insurance Company and the following affiliated companies: *Ad-Ventures, Inc.; All Savers Insurance Company; Executive Systems; Golden Rule Financial Corporation; and Rooney Life Insurance Company.*

To obtain an authorization for Golden Rule to release your personal information to another party, please go to goldenrule.com and click on "Customer Service." Then select "Download Health Insurance Forms."

KEEP FOR YOUR RECORDS
33638-0104

Golden Rule®
Golden Rule Insurance Company
 A UnitedHealth Group Company
Home Office
712 Eleventh Street
Lawrenceville, Illinois 62439