Short Term Medical[SM] Plans

Health Plans for Individuals and Families
in Times of Transition and Change

UnitedHealthOne[SM]

Policy Forms GRI-H-5.7-05 (CO), GRI-H-5.7-06 (CT), GRI-H-5.7 (DE), GRI-H-5.7-10 (GA), GRI-H-5.7-15 (KS), GRI-H-5.7-16 (KY), GRI-H-5.7-17 (LA), GRI-H-5.7-30 (NM), GRI-H-5.7-39 (SC), GRI-H-5.7-40R (SD), GRI-H-5.7-49 (WY)

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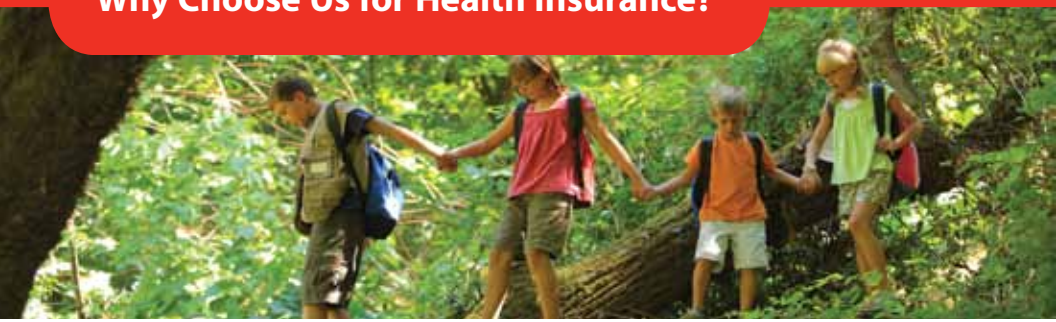
Why Choose Us for Health Insurance?



UnitedHealthcare

More than 26 million customers entrust UnitedHealthcare with their health insurance needs.* Our network plans can ease access to high-quality care from physicians and hospitals nationwide. Together, we combine our strength and stability with nearly three decades of experience serving customers of all sizes.

UnitedHealthOne

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

Experience and Expertise

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

Our Goal: Your Satisfaction

We understand the importance of your time and concern for the value of your health-care dollars. You will find we go far beyond the industry average, processing an overwhelming majority of health insurance claims in less than two weeks and offering strong discounts when using our vast network of quality health-care providers. Our goal for every customer is an insurance plan at a price that fits his or her needs and budget. UnitedHealthOne — *Choices you want. Coverage you need.*

We're easy to reach with a toll-free customer service line: (800) 657-8205. We respond quickly to customer questions and concerns.

Leave it to the experts

For over 60 years, our experience and expertise in the individual health market has driven the development of plans that strive to make health coverage more affordable for more Americans. Because our primary focus is serving individuals and families, we understand the unique needs of people like you.

Don't just take our word for it

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

Fast claims processing

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

Big network, big savings

You can find many providers in your area with more than 580,000 physicians and care professionals and 4,900 hospitals nationwide in the UnitedHealthcare network.* Plus, our network can offer you provider discounts of up to 35-45% on quality health care.***

Get the specialized care you need

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

In case of emergency

From state to state, country to country — rest assured knowing that if you have a medical emergency coverage is available, even when travelling outside the U.S.

* As of 1/22/2009.

** Actual 2008 results.

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

Short Term Medical℠

Our plan offers easy-to-understand health insurance designed for individuals and families in times of transition and change with up to **$1,000,000** of coverage.

Short Term Medical **can "bridge the gaps" in health insurance coverage if:**

- You've lost coverage through recent job or life changes;
- You're a student or graduate no longer eligible for coverage under your parents' plan;
- You're a seasonal worker;
- You've retired and are waiting for Medicare eligibility.

Because we know that life can change quickly, Golden Rule gives you the flexibility to drop your *Short Term Medical* coverage at any time without penalty or to apply for another term of coverage.

With Golden Rule, you can choose from a range of deductibles, payment options, and length of coverage that best meets your needs. In addition, you have access to a wide choice of physicians and health-care facilities.

Note: *Short Term Medical* is issued for a specific period of time. If your needs for coverage extend beyond this plan, you may apply for additional short term plans.* This requires a new application and is not an extension of your current plan. Any illness or condition you develop while covered by your current plan would be considered "preexisting" when you apply for a new short term plan and, as such, will not be a covered expense.

* Not available in Connecticut.

How *Short Term Medical* Works:

1. **You pay the stated deductible for each illness or injury.**
2. **The insurance pays 80% of the next $5,000 of covered expenses.** You pay 20%.
3. **The insurance pays 100% of remaining covered expenses.**

Optional Periods of Coverage:

1-6 months (1-4 months in Kansas).

Deductible Amounts Available:

$250,* $500,* $1,000, $1,500, or $2,500.

12-Month Extension of Benefits

If an insured is confined as an inpatient during the coverage term and the confinement continues after the term ends, we will extend coverage until the earlier of the discharge date or 12 months after the end of the policy term.

60-Day Extension of Benefits

Benefits (up to $1,000 maximum) can be paid for up to 60 days after the end of the policy term for an illness or injury. This is provided that the deductible is met, that the covered expenses are first incurred in excess of the deductible for that illness or injury during the policy term, and that the illness or injury does not result in an inpatient hospital confinement that begins during the policy term.

This brochure is only a general outline of our standard short-term benefits. Please see pages 9 through 16 for state variations. This is not an insurance contract. Please read your policy carefully.

Complete coverage details are provided in the policy. We will notify you in advance of any changes in coverage or benefits.

Not available in all states. Nonrefundable $20 application fee required.

* Not available in Kansas.

Quality Care at Significant Savings

Using UnitedHealthcare Choice Plus Network

With a Golden Rule health insurance plan, you gain access to the UnitedHealthcare Choice Plus network. Physicians, hospitals, and other health-care providers participating in the network have agreed to provide you quality care at reduced costs. The result is lower premiums, and in return, you agree to use the physicians, hospitals, and other providers in the network.

To locate providers for the network, visit *www.goldenrule.com* (our Web site).

1. *Select* Find A Doctor.
2. *Choose* New Applicant Doctor Lookup.
3. *Select* State.
4. *Select* UnitedHealthcare Choice Plus, and again on directory page.

Out-of-Network Benefit Reduction

Receiving nonemergency services outside the Choice Plus network results in substantially less benefits. Your covered expenses are reduced by 25%. This reduction is limited to $5,000 in covered expenses, per covered person.

Deductible and Benefit Period per Condition

For each condition (illness or injury), you will have a deductible and a maximum benefit period. A benefit period begins when you are hospital-confined or meet the full amount of the deductible for an illness or injury during the policy term. You may have more than one benefit period running at a time if you have more than one illness or injury for which you are hospital-confined or have met the full amount of the deductible.

Dependents

For purposes of this coverage, eligible dependents are your lawful spouse and eligible children. Eligible children must be unmarried and under 25 years of age at time of application.

Covered Expenses

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

- Daily hospital* room and board at most common semiprivate rate; reasonable and customary charges for intensive care unit.
- Hospital charges for inpatient use of an operating, treatment, or recovery room.
- Hospital emergency treatment of an injury (even if confinement is not required).
- Professional fees of doctors and surgeons.
- Diagnostic X-ray and laboratory tests in or out of the hospital.
- Prescription drugs.
- Ground ambulance service to a hospital for necessary emergency care.
- Cost and administration of an anesthetic.
- Radiation therapy and chemotherapy.
- Hemodialysis, processing, and administration of blood or components (but not the cost of the actual blood or components).
- Cost and administration of oxygen and other gases.
- Rental of wheelchair, hospital bed, and other durable medical equipment.
- Diagnostic tests in or out of the hospital.
- Dressings and other necessary medical supplies.
- Artificial eyes, limbs, breast prosthesis, or larynx (but not replacement).
- Surgery to treat craniomandibular disorders, malocclusions, or disorders of the temporomandibular joint (TMJ), limited to a combined $10,000 lifetime maximum per covered person.
- Outpatient surgery at an outpatient surgical center.
- Mammograms, Pap smears, prostate-specific antigen testing, and other preventive care as specified in the policy.
- Home health care prescribed and supervised by a doctor and provided by a licensed home health-care agency. Covered expenses for home health aide services will be limited to 7 visits per week and a lifetime maximum of 365 visits. Registered nurse services will be limited to a lifetime maximum of 1,000 hours.

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

Limitations

Diagnosis or treatment of mental or nervous disorders, including mental incapacity and substance abuse, will be limited to a lifetime maximum of $3,000 per covered person. Outpatient diagnosis or treatment of mental or nervous disorders will be further limited to $50 per visit.

Expenses relating to diagnosis or treatment of any spine or back disorders will be limited to $50 per visit and to no more than six visits in any three-month period (except in LA).

Transplant Expense Benefit

The following types of transplants are eligible for coverage:

Tissue Transplants

- Cornea transplants
- Artery or vein grafts
- Heart valve grafts
- Prosthetic tissue and joint replacement
- Prosthetic lenses for cataracts

Listed Transplants

- Heart
- Lung
- Heart and lung
- Bone marrow
- Liver
- Kidney

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 policy term.

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: 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, and multiple myeloma.

Autologous bone marrow transplants (ABMT) for treatment of: Hodgkin's lymphoma, non-Hodgkin's lymphoma, acute lymphocytic and nonlymphocyctic leukemia, multiple myeloma, testicular cancer, Stage III or IV neuroblastoma, and acute myelogenous leukemia.

Exclusions

NO BENEFITS ARE PAYABLE FOR EXPENSES THAT:

- Are not specifically provided for in the policy or that are not incurred during a benefit period.
- Would not have been charged in the absence of insurance.
- Are for preventive care, except as expressly provided for under the policy.
- Are incurred while confined primarily for custodial, rehabilitative or educational care, or nursing services.
- Are incurred for modification of the body, cosmetic treatment, or aesthetic reasons.
- Result from intentional self-inflicted injury (except in Connecticut or if in Colorado and the covered person is insane), act of war, or participation in a riot or felony.
- Exceed the reasonable and customary charges.
- Are incurred as a result of participating in professional or semiprofessional athletic events.

NO BENEFITS ARE PAYABLE FOR:

- Preexisting condition — A condition: (1) for which medical advice, diagnosis, care, or treatment was recommended or received within the 60 months immediately preceding the date the covered person became insured under the policy; or (2) that, in the opinion of a qualified doctor, probably began prior to the date the covered person became insured under the policy and that had manifested itself in a manner that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment within the 60 months immediately preceding the date the covered person became insured under the policy. A pregnancy existing on the effective date of coverage will also be considered a preexisting condition.
  NOTE: Even if you have had prior Golden Rule coverage and your preexisting conditions were covered under that plan, they will not be covered under this plan.
- Employment-related injury or illness (unless self-employed and not covered by Workmen's Compensation coverage).
- Pregnancy or routine well-baby care.
- Dental services or procedures; eyeglasses, contacts, eye refraction, visual therapy, hearing aids, or any examination or fitting related to these.
- Charges for use of hospital emergency room due to illness (unless confined).
- Any drug, treatment, or procedure that promotes or prevents conception or prevents childbirth, including abortion, sterilization, artificial insemination, or treatment for infertility or impotency.
- Television, telephone, or expenses of other persons.
- Treatment of temporomandibular disorders (except as stated in covered expenses).
- Marriage, family, or child counseling.
- Recreational or vocational therapy or rehabilitation.
- Services performed by an immediate family member.
- Procedures, services, or supplies that are considered to be investigational treatment.
- Treatment of mental disorders or substance abuse, unless expressly provided for by the policy.
- Durable medical equipment, except as provided for under covered expenses.

- Expenses incurred outside of the United States, except for expenses incurred in conjunction with emergency treatment of a covered person.
- Diagnosis or treatment of learning disabilities, attitudinal disorders, or disciplinary problems.
- Occupational therapy or outpatient speech therapy, except as provided for by the policy.
- Services or supplies that are not ordered or administered by a doctor, or that are not medically necessary to the diagnosis or treatment of an illness or injury.

Grievance and Appeal Procedures

Information Phone Number: (800) 657-8205.
Upon request, we will provide you with a description of our grievance and appeal procedures.

Effective Date

Your policy will take effect on the later of: (1) the requested effective date; or (2) the day after the postmark date affixed by the U.S. Postal Service,* but only if the following conditions are satisfied:

(a) Your application and the appropriate premium payment are actually received by us within 15 days of your signing;**
(b) Your application is properly completed and unaltered;
(c) You have answered "no" to the question "Are you or any family member an expectant mother or father?" (if other questions are answered "yes," we will exclude the person(s) listed);
(d) You are a resident of a state in which the policy form can be issued; and
(e) If the application is submitted by an agent or broker, the agent or broker is properly licensed to submit applications to Golden Rule.

* If mailed and not postmarked by the U.S. Postal Service or if the postmark is not legible, the effective date will be the later of: (1) the date you requested; or (2) the date received by Golden Rule. If the application is sent by any electronic means including fax, your policy will take effect on the later of: (1) the requested effective date; or (2) the day after the date received by Golden Rule.

** Your account will be immediately charged.

Renewability

Your *Short Term Medical* certificate is not renewable. You may apply for additional short term coverage (subject to state restrictions), however a condition which was a covered expense under a prior certificate would be considered preexisting under a subsequent certificate. Additional certificates will not be continuations of any previous certificate.

We may cancel coverage if there is fraud or material misrepresentation made by or with the knowledge of a covered person in filing a claim for benefits.

State Variations

Colorado

- Preexisting condition — A condition for which medical advice, diagnosis, care, or treatment was recommended or received within the 12 months immediately preceding the date the covered person became insured under the policy. A pregnancy existing on the effective date of coverage will also be considered a preexisting condition.
- Eligible child means not married and either: (a) under 25 years of age and financially dependent on you for support; or (b) medically certified as disabled and dependent on you.
- Child health supervision services up to age 13. Covered expenses under this benefit are not subject to the deductible.
- Covered expenses for diabetes equipment and outpatient training.
- Covered expenses for home health aide services will be limited to 7 visits per week and 60 visits per calendar year.
- Limited coverage of hospice care is included.

Connecticut

THIS POLICY EXCLUDES COVERAGE FOR CONDITIONS FOR WHICH MEDICAL ADVICE, DIAGNOSIS, CARE, OR TREATMENT WAS RECOMMENDED OR RECEIVED DURING THE 24 MONTHS IMMEDIATELY PRECEDING THE EFFECTIVE DATE OF COVERAGE.

THIS PLAN IS ISSUED ON AN INDIVIDUAL BASIS AND IS REGULATED AS AN INDIVIDUAL HEALTH INSURANCE PLAN.

- Mental disorders (as defined by the policy) are covered the same as any other illness.
- Coverage for emergency ambulance service is not limited to ground ambulance service but is limited to the maximum allowable rate established by the Department of Public Health.
- The out-of-network benefit reduction is 20%.
- Subject to all policy provisions, covered expenses include:
  - Emergency treatment of an illness (even if confinement is not required).
  - Emergency treatment for accidental ingestion or consumption of a controlled drug limited to $500 each calendar year and up to 30 days per covered person, per calendar year for inpatient hospital confinement.
  - Limited benefits for treatment of Lyme disease and diabetes.
  - Employment-related injury or illness of a covered person who is a corporate officer of a corporation, whether or not covered by workmen's compensation.
  - Prescription contraceptives.
  - Hearing aids for a covered eligible child age 12 or under, up to a maximum benefits limit of $1,000 every two calendar years.
  - Charges for routine patient care costs related to cancer clinical trials, as described in the policy.
  - Specialized formulas prescribed by a doctor for a covered person age 12 and under.
  - Appliances and supplies related to ostomy surgery, limited to a maximum of $1,000 per covered person, per calendar year.
  - Treatment of pain ordered by a pain management specialist, as described in the policy.
  - Amino acid modified preparations and low protein modified food products (as defined by the policy) for the treatment of inherited metabolic diseases.
  - General anesthesia, nursing, and related hospital charges provided in conjunction with dental care provided to a covered person with a significantly complex dental condition or a developmental disability, subject to the terms and conditions stated in the policy.
  - Early intervention services for a covered child up to 3 years.
  - Orthodontic processes and appliances for a covered person up to age 18 years for treatment of craniofacial disorders.
  - Up to $350 per calendar year for a wig prescribed by an oncologist for a covered person who suffers hair loss as a result of chemotherapy.
- Refundable $20 application fee.

Delaware

- Biologically based mental disorders (as defined by the policy) are covered the same as any other illness.
- Treatment of substance abuse is covered the same as any other illness.

Georgia

- Eligible child means unmarried, living with you, financially dependent on you for support, and either: (1) under 19 years of age; or (2) under 26 years of age and enrolled in or attending as a full-time student an accredited vocational school, college, or university or, if not enrolled, would have been eligible to be enrolled and was prevented due to an illness or injury.
- A preexisting condition is a condition: (1) for which medical advice, diagnosis, care, or treatment was recommended or received within the 60 months immediately preceding the date the covered person became insured under the policy; or (2) that, in the opinion of a qualified doctor, began prior to the date the covered person became insured under the policy,

or manifested symptoms that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment within the 60 months immediately preceding the date the covered person became insured under the policy; or (3) a pregnancy existing on the effective date of coverage.

- Refundable $20 application fee.

GOLDEN RULE INSURANCE COMPANY Outline of Coverage for Policy Form GRI-H-5.7-10 Short Term Preferred Provider Medical Expense Coverage (Please retain this outline for your records.)

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY.

Read Your Policy Carefully — This outline sets forth a brief description of the important aspects of your policy. This is not the insurance contract. Only the actual policy you will control. The policy sets forth in detail your and our rights and obligations. For this reason, it is important that you READ YOUR POLICY CAREFULLY!

Medical Expense Coverage — Plans of this type are designed to provide covered persons with coverage for the major costs of hospital, medical, and surgical care. The cost must be due to a covered illness or injury. Coverage is provided for daily hospital room and board, other hospital services, surgical services, anesthesia services, inpatient medical services, and out-of-hospital care. Coverage is subject to any deductible amounts, coinsurance provisions, or other limitations that may be set forth in the policy. (Note: Plans of this type provide coverage for the major costs of hospital, medical, and surgical care, in place of coverage of only basic costs as would be the case under a basic hospital or basic medical-surgical expense insurance plan.)

Medical Benefits

The following is a summary of the primary benefits of the policy. The policy explains these and additional benefits in fuller detail. Some benefits may be limited by the policy.

A. Hospital charges for daily room and board and nursing services while an inpatient at the most common semi-private room rate.
B. Hospital charges for room and board and nursing services while confined in an intensive care unit, not to exceed the reasonable and customary charge.
C. Hospital charges for inpatient or outpatient surgery.
D. Emergency treatment of an illness or injury.
E. Fees charged by doctors and medical practitioners.
F. Emergency ground ambulance service to a hospital.
G. Outpatient prescription drugs.
H. Necessary medical supplies.
I. Diagnostic tests.
J. Chemotherapy, radiation therapy or treatment, and hemodialysis.
K. Oxygen, anesthetics, and other gases.
L. Treatment of TMJ disorders and surgery to correct functional deformities of the maxilla and mandible.
M. Reconstructive surgery when it follows a covered surgery or injury or is performed to correct a birth defect in a child covered under the policy since birth.
N. Rental of durable medical equipment.
O. Artificial eyes, larynx, breast prosthesis, or basic artificial limbs.
P. Routine screenings and tests, including mammograms, cervical or Pap smears, PSA tests, colorectal cancer screenings, chlamydia screening test, and surveillance tests for ovarian cancer.
Q. General anesthesia and facility charges for dental care.
R. Treatment of diabetes.
S. Treatment of autism.
T. Child wellness services from birth to the 6th birthday.
U. Routine patient care costs related to cancer clinical trials for children.
V. Bone mass measurement for osteoporosis for a covered person who meets the criteria stated in the policy.
W. Home health care provided through a licensed home health-care agency.
X. Rehabilitation and extended care facility services for an inpatient stay that begins within 14 days of a hospital stay of at least 3 days and is for treatment of, or rehabilitation related to, the same illness or injury that required the hospital stay.
Y. Organ or tissue transplants.
Z. Limited benefits for treatment of mental disorders and substance abuse.

Amount Payable

Preferred Provider Benefits: Subject to the requirements stated in the Amount Payable provision in the policy, we will pay the applicable coinsurance percentage in excess of the applicable deductible amount for services and supplies that are covered expenses received during a benefit period that begins during the policy term and that are received while the person's coverage is in force under the policy.

Non-Preferred Provider Benefits: Subject to the requirements stated in the Amount Payable provision in the policy, nonemergency covered expenses incurred at a non-preferred provider will be reduced by 25 percent before application of the deductible amount and coinsurance percentage. This means, for example, $100 of covered expenses incurred at a non-preferred provider will be considered as $75 in covered expenses for purposes of determining benefits. These reduced covered expenses will then be subject to the deductible amount and coinsurance percentage. This reduction is limited to $5,000 in covered expenses per covered person.

Covered expenses incurred at a non-preferred provider for emergency treatment of an illness or injury, or for services and supplies that are not of the type provided at any preferred provider, will be treated as if they had been incurred at a preferred provider.

Maximum Benefit: The maximum benefit per covered person, for all benefit periods, is $1,000,000.

What Is Not Covered

The primary exclusions and limitations of the policy are listed below. Please see the policy for a complete list of exclusions and limitations. The policy does not provide benefits for charges incurred for:

A. Services or supplies not actually provided during a benefit period.
B. (1) intentionally self-inflicted injury (whether the covered person is sane or insane); (2) any act of declared or undeclared war; (3) participation in a riot; or (4) commission of a felony, whether or not charged.
C. Work-related injuries or illness.
D. Weight modification or surgical treatment of obesity.
E. Cosmetic treatment, breast reduction or augmentation, or modification of the physical body to improve the person's well-being (such as sex-change surgery).
F. Pregnancy or routine well-baby care. However, complications of pregnancy are covered.
G. Any drug, treatment, or procedure that promotes conception or prevents childbirth. However, prescription contraceptive drugs and devices approved by the USFDA are covered.
H. Sterilization or reversal of sterilization.
I. Prescription drugs for the treatment of impotency or enhancement of sexual performance.
J. Abortion (unless the life of the mother would be endangered if the fetus were carried to term).
K. Confinement primarily for rehabilitation, custodial care, educational care, or nursing services.
L. Dental expenses, braces, or oral surgery, except for injuries under certain conditions.
M. Investigational treatment.
N. Eyeglasses, contact lenses, eye refractive surgery, hearing aids, visual therapy, or related examinations or fittings.
O. Preventive care, routine physical examinations, immunizations, and educational programs, unless expressly provided for by the policy.
P. Marriage, family, or child counseling for treatment of relationship dysfunctions.
Q. Vocational rehabilitation or vocational, recreational, occupational, or outpatient speech therapy.
R. Diagnosis or treatment of nicotine addiction.
S. Expenses incurred outside the United States, except for emergency medical treatment.
T. Diagnosis or treatment of learning disabilities, attitudinal disorders, or disciplinary problems.
U. Injuries sustained during or due to participation in professional or semi-professional sports or athletic activities for financial compensation, as determined by Golden Rule.
V. Services performed by a member of the covered person's immediate family.

W. Charges that are: (1) not actually incurred by a covered person; (2) not made or ordered by a doctor; (3) not medically necessary to the diagnosis or treatment of an illness or injury; or (4) in excess of the reasonable and customary charge.

X. Preexisting conditions.

Policy Term

You may keep the policy in force by paying the premiums as they come due, or within the 31-day grace period that follows. We may cancel the policy only for: (A) fraud or material misrepresentation made in filing a claim for policy benefits; or (B) nonpayment of premiums when due.

At the end of the policy term, the policy will terminate and may not be renewed.

Benefits may continue to be paid for an illness or injury after the policy terminates if the benefit period for that illness or injury begins while the person is covered by the policy.

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Kansas

- Some prescription drugs are limited by the amount prescribed (managed) and/or the quantity prescribed over a certain time period (limitations). Prescription drugs that are subject to managed drug limitations are generally selected because there is a potential for abuse or misuse, serious side effects, addiction; or they are not essential to a chronic condition. Managed Drug Limitations are based on FDA approved usage/guidelines for each medication.
  Quantity Duration (QD) indicates that some medications have a limited amount that can be covered for a specific time period. For example, only 30 pills may be obtained in a 90-day period. Quantity Level (QL) indicates that some medications have a limited amount that can be covered at one time. For example, only 30 pills may be obtained with each prescription fill.
- Mental/Nervous: The $3,000 limit does not apply. Inpatient is limited to 30 days per calendar year, per person. Outpatient is limited per calendar year to 100% of the first $100, 80% of the next $100, and 50% of the next $1,640, and $7,500 lifetime maximum per person. Excludes diversion agreements and court-ordered programs and testing.
- Spine and Back Disorders Limit: Changed to 10 visits in a 6-month period.
- Maximum period of coverage is 4 months.
- $250 and $500 deductible amounts are not available.
- Routine childhood immunizations are covered from birth to the 6th birthday. This benefit is not subject to the deductible or coinsurance.
- Covered expenses also include:
  - Diabetes equipment, supplies, and self-management training.
  - General anesthesia and facility charges for a covered person who is age 5 years or younger, severely disabled, or has a medical or behavioral condition.
  - Osteoporosis diagnosis and treatment.
- Refundable $20 application fee.

Kentucky

- Eligible child means your or your dependent's child, if that child is: (A) not married; and (B) under 26 years of age. A child will not cease to be an eligible child if the child is not capable of self-sustaining employment due to mental incapacity or physical handicap that began before the age limit is reached and the child is mainly dependent on you for support.
- Covered expenses include surgical and non-surgical treatment of craniomandibular disorders, malocclusions, or TMJ disorders. The $10,000 lifetime maximum does not apply. The exclusion for TMJ disorders does not apply.
- If, after coverage is issued, a covered person becomes insured under a group or individual plan, benefits will be determined under the coordination of benefits (COB) clause. COB allows two or more plans to work together so that the total amount of benefits will never be more than 100% of covered expenses.

- Covered expenses for home health aide services will be limited to 60 visits per covered person per calendar year.
- Refundable $20 application fee.

Louisiana

You and your spouse may also insure your grandchildren. All children or grandchildren applying must be unmarried, and either (1) under 26 years of age; or (2) incapable of self-sustaining employment or attending school as a full-time student by reason of mental or physical handicap that began prior to reaching age 21.

A newborn child adopted by you or a covered person within 90 days of birth and while the policy is in force will be a covered person from the date of placement for adoption.

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

- Covered expenses for mammograms, cervical or Pap smears, and PSA tests are exempt from the stated deductible.
- Secondary conditions and treatment due to cleft lip or cleft palate.
- The services of a qualified interpreter/transliterator if the services: Are provided in connection with diagnostic consultations or medical treatment by a doctor; Would otherwise be a covered expense under the policy; and Are required due to a hearing impairment or a failure of the covered person to understand or otherwise communicate in spoken language.
- Childhood immunizations from birth until the covered person's sixth birthday, not subject to the stated deductible.
- Diagnosis and treatment of ADHD. The maximum benefit payable for each covered person:
  - initial diagnosis and treatment: $600;
  - outpatient treatment to a doctor or medical practitioner: $50 per visit;
  - $2,500 per calendar year maximum;
  - $10,000 lifetime maximum.
- Bone mass measurement for the diagnosis and treatment of osteoporosis.
- Routine patient costs as a result of treatment provided with a clinical trial for cancer.
- Diabetes equipment, supplies and outpatient self-management training and education, including medical nutrition therapy, if prescribed by a medical practitioner, and for additional diabetes self-management training if prescribed by a medical practitioner due to a significant change in a covered person's symptoms or condition, limited to: A lifetime benefit of $500 per covered person for outpatient self-management training and education; and $100 per calendar per covered person and a $2,000 lifetime benefit per covered person for additional diabetes self-management training.
- Services provided by a registered nurse first assistant before, during, and after surgery.
- Hearing aids for a covered person under age 18 years, limited to $1,400 per hearing aid per ear every 36 months.
- Anesthesia and related hospital charges when the mental or physical condition of the covered person requires dental treatment to be rendered in a hospital setting.
- The service charges assessed by a hospital or outpatient surgical facility pursuant to Louisiana statute section R.S. 22:239. These charges are exempt from the stated deductible and coinsurance percentage.

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

New Mexico

- Eligible child means either: (a) not married and under 25 years of age; or (b) not capable of self-sustaining employment due to mental handicap or physical handicap that began before 25 years of age and is mainly dependent on you for support.
- A preexisting condition is a condition: (1) for which medical advice, diagnosis, care, or treatment was recommended or received within the 6 months immediately preceding the date the covered person became insured under the policy; or (2) that, in the opinion of a qualified doctor, probably began prior to the date the covered person became insured under

the policy, and that had manifested itself in a manner that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment within the 6 months immediately preceding the date the covered person became insured under the policy.

- Subject to all policy provisions, covered expenses include:
  - Equipment and supplies including medically necessary podiatric appliances and new or improved equipment, prescription drugs, insulin, or supplies approved by the FDA and self-management training, education, and medical nutrition therapy for diabetes.
  - Nonsurgical procedures for temporomandibular joint (TMJ).
  - Prescription contraceptives.
  - Early intervention services for children from birth to 48 months of age, up to maximum benefit of $3,500.
  - One human papillomavirus screening for females ages 30 years and older.
  - Childhood immunizations.
- To qualify for benefits, home health care must be:
  - Prescribed and supervised by a doctor;
  - Renewed at least every 60 days; and
  - Provided through a licensed home health care agency.

Covered expenses for home health aide services will be limited to 100 visits per person, per calendar year.

South Carolina

- A preexisting condition is a condition: (1) for which medical advice, diagnosis, care, or treatment was recommended or received within the 60 months immediately preceding the date the covered person became insured under the policy; or (2) that, in the opinion of a qualified doctor, probably began prior to the date the covered person became insured under the policy, and that had manifested itself in a manner that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment within the 12 months immediately preceding the date the covered person became insured under the policy. A pregnancy existing on the effective date of coverage will also be considered a preexisting condition.
- Covered expenses also include equipment, supplies, and medication for the treatment of diabetes mellitus.

South Dakota

- The employment related exclusion is defined as any injury or illness for which benefits are paid pursuant to workers' compensation or similar law.
- For purposes of this coverage, eligible dependents are your lawful spouse and eligible children. Eligible children must be unmarried and under the age of 25 at the time of application, or under the age of 30 if a full-time student.
- A preexisting condition is a condition: for which medical advice, diagnosis, care, or treatment was recommended or received within the 12 months immediately preceding the date the covered person became insured under this policy; that had manifested itself in a manner that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment within the 12 months immediately preceding the date the covered person became insured under this policy; or a pregnancy existing on the effective date of coverage.
- Substance abuse does not include alcoholism.
- Subject to all policy provisions, covered expenses include:
  - Hospital emergency treatment of an illness, even if confinement is not required.
  - Testing, diagnosis and treatment of phenylketonuria, limited to: dietary management; formulas; case management; intake and screening; assessment; and comprehensive care planning and service referral.
  - Treatment of alcoholism the same as any other illness. Benefits for inpatient treatment will be limited to 30 days care in any six-month period, and a lifetime maximum of 90 days per covered person. Inpatient treatment must be rendered in a hospital or a licensed residential primary treatment facility. Inpatient care which is primarily for educational or rehabilitative care will not be covered.

- If, after coverage is issued, a covered person becomes insured under a group or individual plan, benefits will be determined under the Coordination of Benefits (COB) clause. COB allows two or more plans to work together so that the total amount of benefits will never be more than 100 percent of covered expenses. COB also takes into account medical coverage under auto insurance contracts.
- The South Dakota Risk Pool (guarantee issue without preexisting conditions exclusions) is available to eligible applicants. For more information visit *www.state.sd.us/bop/riskpool.htm* or call (605) 773-3148 and ask for a Risk Pool representative.

Wyoming

THIS POLICY DOES NOT CONTAIN COMPREHENSIVE ADULT WELLNESS BENEFITS AS DEFINED BY WYOMING LAW.

- A preexisting condition is a condition for which medical advice, diagnosis, care, or treatment was recommended or received within the 6 months immediately preceding the date the covered person became insured under the policy. A pregnancy existing on the effective date of coverage will also be considered a preexisting condition.

NOTICE OF INFORMATION PRACTICES
NOTICE OF PRIVACY PRACTICES

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

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

The terms "information" or "health information" in this notice include any personal information that is created or received by a health care provider or health plan that relates to your physical or mental health or condition, the provision of health care to you, or the payment for such health care.

We have the right to change our privacy practices. If we do, we will provide the revised notice to you within 60 days by direct mail or post it on our Web sites listed at the bottom of this page.

How We Use or Disclose Information

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

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

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

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

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

- **To Persons Involved With Your Care.** We may use or disclose your health information to a person involved in your care, such as a family member, when you are incapacitated or in an emergency, or when permitted by law.
- **For Public Health Activities** such as reporting disease outbreaks.
- **For Reporting Victims of Abuse, Neglect, or Domestic Violence** to government authorities, including a social service or protective service agency.
- **For Health Oversight Activities** such as governmental audits and fraud and abuse investigations.
- **For Judicial or Administrative Proceedings** such as in response to a court order, search warrant or subpoena.
- **For Law Enforcement Purposes** such as providing limited information to locate a missing person.
- **To Avoid a Serious Threat to Health or Safety** by, for example, disclosing information to public health agencies.
- **For Specialized Government Functions** such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
- **For Workers Compensation** including disclosures required by state workers compensation laws of job-related injuries.

- **For Research Purposes** such as research related to the prevention of disease or disability, if the research study meets all privacy law requirements.
- **To Provide Information Regarding Decedents.** We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as necessary to carry out their duties.
- **For Organ Procurement Purposes.** We may use or disclose information for procurement, banking, or transplantation of organs, eyes, or tissue.

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

What Are Your Rights

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

- **You have the right to ask to restrict** uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures to family members or to others who are involved in your health care or payment for your health care. We may also have policies on dependent access that may authorize certain restrictions. **Please note that while we will try to honor your request and will permit requests consistent with its policies, we are not required to agree to any restriction.**
- **You have the right to ask to receive confidential communications** of information in a different manner or at a different place (for example, by sending information to a P.O. Box instead of your home address).
- **You have the right to see and obtain a copy** of health information that may be used to make decisions about you such as claims and case or medical management records. You also may receive a summary of this health information. You must make a written request to inspect and copy your health information. In certain limited circumstances, we may deny your request to inspect and copy your health information.
- **You have the right to ask to amend** information we maintain about you if you believe the health information about you is wrong or incomplete. We will notify you within 30 days if we deny your request and provide a reason for our decision. If we deny your request, you may have a statement of your disagreement added to your health information. We will notify you in writing of any amendments we make at your request. We will provide updates to all parties that have received information from us within the past two years (seven years for support organizations).
- **You have the right to receive an accounting** of disclosures of your information made by us during the six years prior to your request. This accounting will not include disclosures of information: (i) made prior to April 14, 2003; (ii) for treatment, payment, and health care operations purposes; (iii) to you or pursuant to your authorization; and (iv) to correctional institutions or law enforcement officials; and (v) other disclosures that federal law does not require us to provide an accounting.
- **You have the right to a paper copy of this notice.** You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice upon request. In addition, you may obtain a copy of this notice at our Web sites, *www.eAMS.com* or *www.goldenrule.com*.

Exercising Your Rights

- **Contacting your Health Plan.** If you have any questions about this notice or want to exercise any of your rights, please call the phone number on your ID card.
- **Filing a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with us at the following address: Golden Rule Insurance Company, Privacy Officer, 7440 Woodland Drive, Indianapolis, IN 46278-1719

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

Fair Credit Reporting Act Notice

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

We may disclose information solely about our transactions or experiences with you to our affiliates.

Medical Information Bureau

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

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

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

FINANCIAL INFORMATION PRIVACY NOTICE

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

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

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

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

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

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

The Notice of Information Practices, effective May 2008, is provided on behalf of American Medical Security Life Insurance Company; Golden Rule Insurance Company; PacifiCare Life and Health Insurance Company; PacifiCare Life Assurance Company, United HealthCare Insurance Company; All Savers Insurance Company; and United HealthCare Services, Inc.

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

33638-0508 Products are either underwritten or administered by: American Medical Security Life Insurance Company, PacifiCare Life and Health Insurance Company, PacifiCare Life Assurance Company, United HealthCare Insurance Company, *www.eAMS.com*; or All Savers Insurance Company, United HealthCare Services, Inc., and/or Golden Rule Insurance Company, *www.goldenrule.com*

Rates and Application Inside Pocket.

Short Term Medical℠ may be perfect for those in times of transition:

- Recent graduate or student no longer eligible under parents' health insurance plan.
- Between jobs or out of work.
- Waiting for other coverage to begin.
- Retired early and needing a bridge to Medicare eligibility.

Short Term Medical Application Checklist

1) Read the brochure carefully.
2) Read and understand the Instructions for Applying for Coverage.
3) Complete the Calculate Payment(s) section and choose your method of payment.
4) Complete the Application for *Short Term Medical* Insurance.
5) Select your method of payment and complete the appropriate payment information:
   – Single Payment: Include check or money order OR fill out the Credit Card Authorization.
   – Monthly Payment: Fill out the Electronic Funds Transfer (EFT) Authorization.
6) Place a postal stamp on the envelope if mailing the application back.

Place
Postage
Here

Jun 15 2009 01:56:49 pm

UnitedHealthOne
Golden Rule Insurance Company

HEALTH APPLICATION, STM
PO Box 68994
Indianapolis, Indiana 46268-0994

REMOIST GLUE AREA