

Health Plans

for individuals and families

Health insurance available only to members of FACT



 **UnitedHealthcare®**
A UnitedHealth Group Company

Golden Rule®
A UnitedHealthcare Company

Why Choose Golden Rule?



Experience and Expertise

Golden Rule Insurance Company has been a leader in the individual health market for nearly 60 years. Serving individuals and families is our primary focus. Because we are dedicated to this market, we have developed a unique understanding of the health insurance needs of individuals and families. This knowledge is reflected throughout your experience with Golden Rule -- in our high quality products, our handling of claims, and our customer service.

Product Leadership

Golden Rule's experience and expertise in the individual health market drive the development of plans that strive to make health coverage more affordable for more Americans. A recognized pioneer -- and one of the nation's leading providers -- of Health Savings Account plans, Golden Rule continues to seek and embrace new ways to build plans with the benefits you need at prices you can afford.

Claims Satisfaction

At Golden Rule, 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.* With Golden Rule, you can be confident that your claims will be promptly processed.

Preferred Network Discounts

With a Golden Rule insurance plan, you gain access to a quality network of health care professionals and facilities available in your area. Having access to our Preferred Networks can mean substantial discounts in what you pay for your health care. The combined buying power of networks on behalf of large numbers of customers can translate into significant savings for you, including covered out-of-pocket health care expenses incurred before you meet your deductible.

Strength in Numbers

Golden Rule is proud to be a member of the UnitedHealth Group family of businesses. As an innovative leader in the health and well-being industry, UnitedHealth Group currently serves nearly 55 million individuals nationwide, with products and services to help people achieve better health.**

* Actual 2005 results

** www.unitedhealthgroup.com

The Network Advantage

All Golden Rule health insurance plans include access to one of our Savings-Based Networks. Preferred Networks are also available, and offer significant premium discounts.

Savings-Based Networks

Savings-Based Networks are included with all plans and provide:

- Access to a broad network of physicians and hospitals to help reduce your costs; and
- Freedom to use non-network physicians and hospitals.

While you are free to use any health care professional, using a Savings-Based Network physician or hospital benefits you in the following ways:

- You may pay less for services incurred before your deductible is met;
- Network physicians and hospitals will not bill above the accepted network fee; and
- Network physicians and hospitals will file your claim for you.

Preferred Networks

Available in most areas. A Preferred Network includes physicians, hospitals, and other health care providers that have agreed to provide quality health care at reduced costs.

Lower costs mean lower premiums. Most applicants choose one of our Preferred Networks to take advantage of these premium reductions.

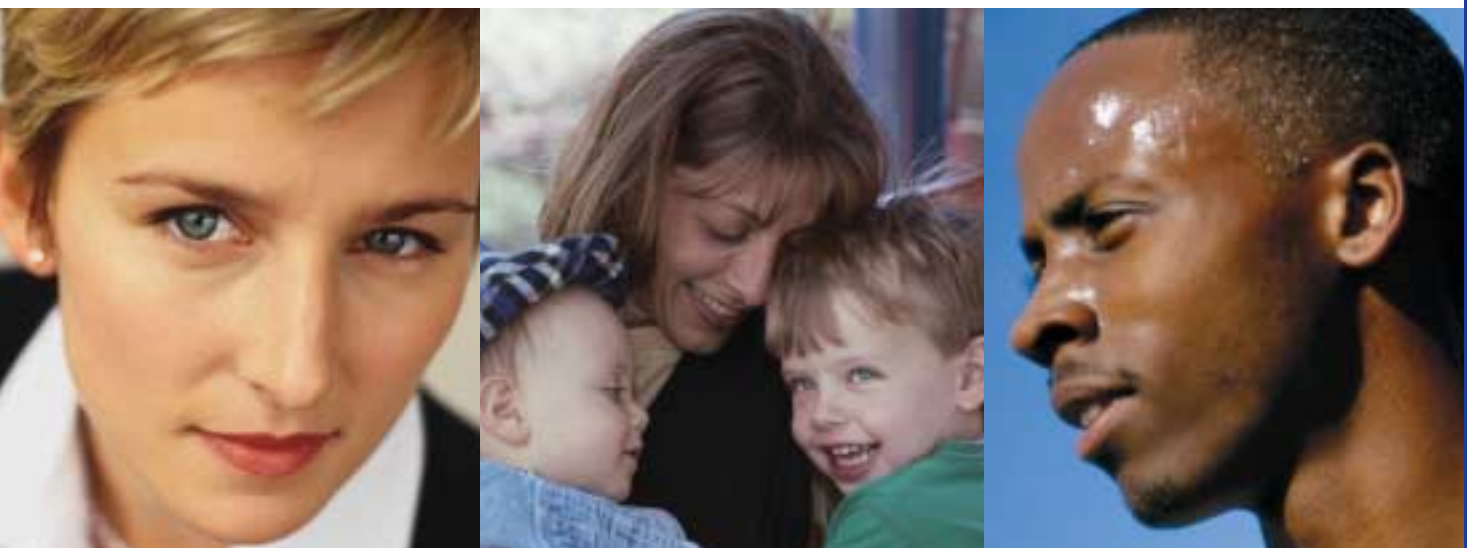
In return for the premium reduction, you agree to use physicians, hospitals, and other health care providers in your Preferred Network.

If you are insured under a Preferred Network plan and receive non-emergency services outside your Preferred Network, covered expenses are:

- Reduced by 25%; and
- Subject to a separate deductible amount equal to the calendar-year deductible.

If you are under a Copay Plan (which requires Preferred Network), office visit expenses outside your network are not eligible for copay benefits.

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



2 Copay Plans

Who might benefit most from a Copay SelectSM plan?

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



How Copay SelectSM Works

Convenient doctor office copay benefits

When you use a Preferred Network doctor for an office visit, we pay 100% of history and exam fees after a \$25 copay.

Adult and Child Preventive Care included

Preventive Care office visits are covered the same as other doctor office visits -- with copay benefits.

Prescription drug card benefits

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

Comprehensive Coverage for inpatient and outpatient medical expenses

- Up to \$3 million lifetime maximum benefit per covered person
- Covered inpatient and outpatient expenses are reimbursed at 80% once the deductible has been met

Copay SaverSM

The **Copay SaverSM** plan provides the convenience of copays for doctor office visits (limited to 2 visits per person, per calendar year) for a lower monthly premium.

Copay Plans -- Benefit Highlights

	Copay Select SM	Copay Saver SM
Design Basics		
Network Type	Preferred Network Included	
Calendar-Year Deductible Choices (maximum 2 per family, per calendar year)	\$500, \$1,000, \$1,500, \$2,500	\$2,000
Coinsurance (per covered person, per calendar year)	80/20 to \$10,000 then 100%	80/20 to \$15,000 then 100%
Lifetime Maximum Benefit (per covered person)	\$3 million	\$3 million
Initial Rate Guarantee (subject to benefit and address changes)	12 months	12 months
Coverage percentages below are effective AFTER deductibles have been met unless otherwise indicated.		
Inpatient Expense Benefits		
Room and Board, Intensive Care Unit, Operating Room, Recovery Room, and Professional Fees of Doctors, Surgeons, Nurses	80%	80%
Other Covered Inpatient Services	80%	80%
Outpatient Expense Benefits		
Surgeon, Assistant Surgeon, and Facility Fees	80%	80%
Hemodialysis, Radiation, Chemotherapy, and Organ Transplant Drugs	80%	80%
CAT Scans, MRIs	80%	80%
Outpatient X-ray and Lab (performed in the doctor's office or elsewhere)	80%	80% if performed within 14 days of surgery or confinement
Emergency Room Fees	80% -- additional \$100 Copay for illness if not admitted	80% -- additional \$500 Copay if not admitted
Other Covered Outpatient Expenses	80%	See page 10
Routine Health Benefits		
Doctor Office Visit	For history and exam: \$25 Copay, then 100% (not subject to deductible)	For history and exam: \$35 Copay, then 100% (maximum 2 visits per person, per year) Other services: Not Covered
Mammography, Pap Smear, and PSA Testing	For history and exam: \$25 Copay, then 100%	80%
Adult Preventive Care (age 19 or older)	For other services performed in or out of doctor's office, including, but not limited to, X-ray and Lab, subject to the deductible, then 80%	Not Covered
Well Child Care/Immunizations (ages 0-18)		Not Covered
Outpatient Prescription Drugs	Generic: \$15 Copay Name-Brand: \$100 per person, calendar year deductible -- then \$30 Copay for preferred, \$60 Copay for non-preferred (If Generic is available, Name-Brand reimbursed at Generic price)	Not Covered -- Preferred Price Card Included
Dental and Vision Discounts -- <i>Programs Are Not Insurance</i>	Discounts through FACT membership provided by Health Allies -- save up to 50% on dental and vision.	
Optional Benefits	For a complete list, see page 8.	

This chart only summarizes standard covered expenses, exclusions, and limitations of each plan. 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. We recommend review of the more detailed plan information on pages 9-13, and the state variations on pages 14 and 15.

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Health Savings Account (HSA) Plans

Who might benefit most from an HSA plan?

- Anyone interested in more control over how their health care dollars are spent.
- Families interested in one annual deductible per family.
- Those interested in trading low deductible health insurance for a higher deductible plan to save money on monthly premiums and taxes.



How HSAs Work

HSA Plans offer quality coverage, savings

HSA Plans have two components: a lower cost, high deductible health insurance plan and a tax-favored health savings account.

The money you save on premiums can be put into your tax-favored health savings account (HSA). You can withdraw the money to help pay your deductible or other qualified health care expenses. Once your deductible is met, the insurance plan starts paying for covered expenses.

Your unspent savings roll over year after year.

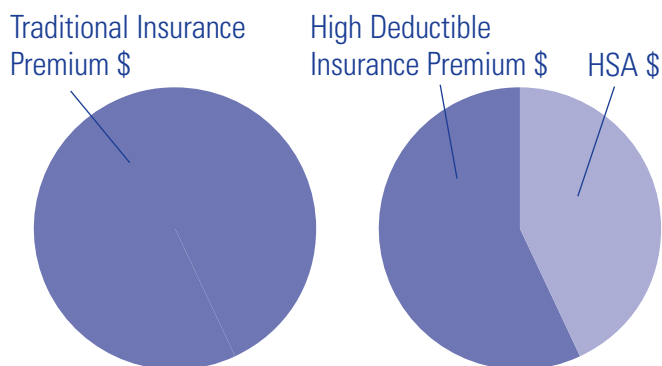
Lower premiums, tax-advantaged savings, and an attractive interest rate*

The money you save from reduced premiums can be put into your Health Savings Account -- tax deductible.

Your health savings grow tax-deferred, and can be withdrawn tax-free to help pay your deductible or for other qualified health care expenses like prescriptions, vision, or dental care.

What you don't use will continue to accumulate year after year. Then, if you ever need it for health care expenses, the money will be there.

You'll earn interest on your savings, beginning with the first dollar deposited.



* See HSA Insert for important information.

HSA Plans -- Benefit Highlights

	HSA 100®	HSA Saver®
Design Basics		
Network Type	Preferred or Savings Based Network	
Calendar-Year Deductible Choices (one per family)	See HSA Insert	See HSA Insert
Coinsurance After Deductible	100%	100%
Lifetime Maximum Benefit (per covered person)	\$3 million	\$3 million
Initial Rate Guarantee (subject to benefit and address changes)	12 months	12 months
Coverage percentages below are effective AFTER deductibles have been met unless otherwise indicated.		
Inpatient Expense Benefits		
Room and Board, Intensive Care Unit, Operating Room, Recovery Room, and Professional Fees of Doctors, Surgeons, Nurses	100%	100%
Other Covered Inpatient Services	100%	100%
Outpatient Expense Benefits		
Surgeon, Assistant Surgeon, and Facility Fees	100%	100%
Hemodialysis, Radiation, Chemotherapy, and Organ Transplant Drugs	100%	100%
CAT Scans, MRIs	100%	100%
Outpatient X-ray and Lab	100%	100% if performed within 14 days of surgery or confinement
Emergency Room Fees	100%	100% if admitted; if not admitted -- limited to \$250/person/year
Other Covered Outpatient Expenses	100%	See page 10 for details
Routine Health Benefits		
Doctor Office Visit Fees	100%	Not Covered
Outpatient Prescription Drugs (Preferred Price Card included with all plans)	100%	Not Covered -- Preferred Price Card Included
Mammography, Pap Smear, and PSA Testing	100%	100%
Adult Preventive Care (Up to \$500 annually for each adult age 19 or older; subject to 3-month waiting period)	100%	Not Covered
Childhood Immunizations (Up to \$500 annually for ages 0-18; subject to 3-month waiting period)	100%	Not covered
Dental and Vision Discounts -- <i>Programs Are Not Insurance</i>	Discounts through Health Allies (benefit of FACT membership) -- save up to 50% on dental and vision.	
Optional Benefits	For a complete list, see page 8.	

This chart only summarizes standard covered expenses, exclusions, and limitations of each plan. 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. We recommend review of the more detailed plan information on pages 9-13, and the state variations on pages 14 and 15.

High Deductible Plans

Who might benefit most from a high deductible plan?

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



How High Deductible Plans Work

Lower Premiums

With high deductible plans, you're keeping more of your money and taking responsibility for covering minor or routine health care expenses -- if they come up. The higher the deductible, the lower your premiums.

Saver 80SM is our lowest premium plan. This plan provides coverage for hospital confinements, surgical procedures in or out of the hospital, and the more costly outpatient expenses, such as CAT scans and MRIs.

Simple to use

Golden Rule's top-selling high deductible plan -- **Plan 100[®]** -- pays 100% of covered expenses once you meet your calendar-year deductible. Your benefits are not complicated with multiple copays or coinsurance.

Comprehensive Coverage

- Up to \$3 million lifetime maximum benefit per covered person
- Up to \$500 annually for adult preventive care or childhood immunizations (see page 7 for details)
- Add optional benefits to increase coverage (see page 8 for details)

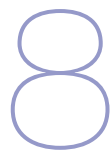
High Deductible Plans -- Benefit Highlights

	Plan 100®	Plan 80 SM	Saver 80 SM
Design Basics			
Network Type	Preferred or Savings-Based Network		
Calendar-Year Deductible Choices (maximum 2 per family, per calendar year)	\$2,500 \$3,500, \$5,000	\$2,500 \$3,500, \$5,000	\$500, \$1,000, \$1,500 \$2,500, \$3,500, \$5,000
Coinsurance (per covered person, per calendar year)	100%	80/20 to \$15,000 then 100%	80/20 to \$15,000 then 100%
Lifetime Maximum Benefit (per covered person)	\$3 million	\$3 million	\$3 million
Initial Rate Guarantee (subject to benefit and address changes)	12 months	12 months	12 months

Coverage percentages below are effective AFTER deductibles have been met unless otherwise indicated.

Inpatient Expense Benefits			
Room and Board, Intensive Care Unit, Operating Room, Recovery Room, and Professional Fees of Doctors, Surgeons, Nurses	100%	80%	80%
Other Covered Inpatient Services	100%	80%	80%
Outpatient Expense Benefits			
Surgeon, Assistant Surgeon, and Facility Fees	100%	80%	80%
Hemodialysis, Radiation, Chemotherapy, and Organ Transplant Drugs	100%	80%	80%
CAT Scans, MRIs	100%	80%	80%
Outpatient X-ray and Lab	100%	80%	80% if performed within 14 days of surgery or confinement
Emergency Room Fees	100% -- additional \$100 Copay for illness if not admitted	80% -- additional \$100 Copay for illness if not admitted	80% -- additional \$500 Copay if not admitted
Other Covered Outpatient Expenses	100%	80%	See page 10 for details
Routine Health Benefits			
Doctor Office Visit Fees	100%	80%	Not Covered
Outpatient Prescription Drugs (Preferred Price Card included with all plans)	100%	80%	Not Covered -- Preferred Price Card Included
Mammography, Pap Smear, and PSA Testing	100%	80%	80%
Adult Preventive Care (Up to \$500 annually for each adult, 19 or older; subject to 3-month waiting period.)	100%	80%	Not Covered
Childhood Immunizations (Up to \$500 annually for ages 0-18; subject to 3-month waiting period.)	100%	80%	Not Covered
Dental and Vision Discounts -- <i>Programs Are Not Insurance</i>	Discounts through FACT membership provided by Health Allies -- save up to 50% on dental and vision.		
Optional Benefits	For a complete list, see page 8.		

This chart only summarizes standard covered expenses, exclusions, and limitations of each plan. 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. We recommend review of the more detailed plan information on pages 9-13, and the state variations on pages 14 and 15.



Optional Benefits

Optional Benefits

Further customize your health insurance coverage to meet your specific needs.

Preventive Care Benefits Package

(Not available with Copay SelectSM Plan.)

This option is available with our Preferred Network health insurance plans. If elected, this option replaces preventive care benefits otherwise included within the plan. This package waives the deductible and provides 100% for the following covered expenses:

Preventive Care Benefits Package
Routine well child care visits through age 18 100% in network for covered services; deductible does not apply
Childhood immunizations 100% in network; deductible does not apply
Mammogram, Pap smear, and PSA test 100% in network for one of each test per calendar year; deductible does not apply
Adult preventive care age 19 and older (12 month wait on adult preventive care) \$35 copay, then 100% in network -- limited to \$300 per calendar year

Maternity Benefit

(Not available with HSA Plans; not available in AR, MD, or VA.)

This optional benefit helps cover the costs for routine pregnancy and delivery. You choose the maximum benefit amount -- \$2,500 or \$4,000. Payment is limited to 50% of the maximum benefit during the first year. After the first year, the plan will pay 100% of the maximum benefit. To be covered, pregnancy must begin while maternity benefits are in effect.

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

Prescription Drug Card Benefit

(Not available with any Saver or HSA Plans or Copay SelectSM.)

With this benefit, you can purchase:

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

IMPORTANT: If generic is available, name-brand drugs will be reimbursed at generic price.

Supplemental Accident Benefit

(Not available with HSA Plans.)

This benefit provides up-front coverage for unexpected injuries and is limited to \$500 of first-dollar coverage for treatment of an injury within 90 days of an accident.

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 depends 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's benefit amount for certificates issued to residents of Maryland.

HSA Hospital Indemnity Rider

(See HSA Insert for details.)

HSA Hospital Indemnity Rider is designed to help protect against major hospitalization expenses during early months of coverage when cash hasn't yet accumulated in your savings account.

Covered Expenses

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

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

Medical Expense Benefits

- Daily hospital room-and-board and nursing services at the most common semiprivate rate.
- Charges for intensive care unit.
- Hospital emergency room treatment of an injury or illness (subject to an additional \$100 copay each time the emergency room is used for an illness not resulting in confinement -- does not apply to HSA Plans).
- 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 testing using radiologic, ultrasonographic, or laboratory services, in or out of the hospital.
- Local ground ambulance service to the nearest hospital for necessary emergency care. Air ambulance, within U.S., if requested by police or medical authorities at the site of emergency.
- Charges for operating, treatment, or recovery room for surgery.

- Dental expenses due to an injury which damages natural teeth if expenses are incurred within six months.
- Surgical treatment of TMJ disorders (see limitations on page 12).
- Cost and administration of anesthetic, oxygen, and other gases.
- Radiation therapy or chemotherapy.
- Prescription drugs.
- Hemodialysis, processing, and administration of blood and components.
- Mammography, Pap smear, and PSA test fees.
- Artificial eyes, larynx, breast prosthesis, or basic artificial limbs (but not replacements).

Preventive Care Expense Benefits

- See pages 3, 5, and 7 for coverage details.

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 11-13.

Covered Expenses (continued)

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

Saver Plans -- Copay SaverSM, HSA Saver[®], and Saver 80SM

Inpatient Expense Benefits

- Daily hospital room-and-board and nursing services at the most common semiprivate rate.
- Charges for intensive care unit.
- Drugs, medicines, dressings, sutures, casts, or other necessary medical supplies.
- Artificial limbs, eyes, larynx, or breast prosthesis (but not replacements).
- Professional fees of doctors and surgeons (but not for standby availability).
- Hemodialysis, processing, and administration of blood or components.
- Charges for an operating, treatment, or recovery room for surgery.
- Cost and administration of an anesthetic, oxygen, or other gases.
- Radiation therapy or chemotherapy and diagnostic tests using radiologic, ultrasonographic, or laboratory services.
- Local ground ambulance service to the nearest hospital for necessary emergency care. Air ambulance, within U.S., if requested by police or medical authorities at the site of the emergency.
- Mammography, Pap smear, and PSA test fees.
- Hospital emergency room treatment of an injury or illness (subject to limitations shown on pages 3, 5, and 7).
- CAT scan and MRI testing.
- Diagnostic testing related to, and performed within, 14 days prior to surgery or inpatient confinement.
- Copay SaverSM plan includes two doctor office copay visits per year (see page 3).

Important note about Saver Plans:

Premiums for Saver Plans are significantly less because coverage is not provided for most outpatient services. Outpatient expenses not specifically listed in the policy are not covered. Please review the Saver Plans' inpatient and outpatient expense benefits, exclusions, and limitations for details.

Some outpatient expenses not covered under the Saver Plans include:

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.
- Outpatient doctor office visit fees (limited benefit provided under Copay SaverSM -- see page 3), diagnostic testing, prescription drugs, and other outpatient medical services not specifically listed under the Inpatient, Outpatient, or Transplant Expense Benefits;
- Outpatient professional fees of licensed physical therapists, durable medical equipment, and medical supplies, except those covered under the Home Health Care Expense Benefits;
- Outpatient expenses incurred for mental or nervous disorders or substance abuse; and
- Preventive care office visits (unless the optional Preventive Care Package is added).

Provisions That Apply to All Plans

This brochure is only a general outline of the coverage provisions. It is not an insurance contract, nor part of the insurance policy or certificate. You'll find complete coverage details in the policy and certificates. In most cases, coverage will be determined by the master policy issued in Illinois and subject to Illinois law.

Health Care Provider Networks

All Golden Rule plans include access to one of our Savings-Based Networks. Preferred Networks are also available, and offer significant premium discounts. See page 1 of this brochure for more information.

Transplant Expense Benefit

The following types of transplants are eligible for coverage under the Medical Benefits provision:

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

Transplants eligible for coverage under the Transplant Expense Benefit are:

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

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

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

The following conditions are eligible for bone marrow transplant coverage:

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

Autologous bone marrow transplants (ABMT) for treatment of: Hodgkin's lymphoma, non-Hodgkin's lymphoma, acute lymphocytic and 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 180 days in a covered person's lifetime. Covered expenses for room and board are limited to the most common semiprivate room rate of the hospital or nursing home with which the hospice is associated.

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 health care 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 or HIV-related disease are treated the same as any other illness unless the onset of AIDS or HIV-related disease is: (a) diagnosed before the coverage has been in force for one year; or (b) first manifested before the coverage has been in force for one year. If diagnosed or first manifested before coverage has been in force for one year, AIDS or HIV-related disease claims will never be covered. Details of this limited exclusion are set forth in the policy 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 drug treatment or procedure that promotes conception.
- Are for any procedure that prevents conception or childbirth.

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

General Limitations

- Expenses incurred by a covered person for treatment of tonsils, adenoids, middle ear disorders, hemorrhoids, hernia, or any disorders of the reproductive organs, 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, excluding tooth extractions, 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 (not covered in Saver Plans, subject to state variations). 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.

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, or accident-only policies.)

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.

Conditions Prior to Legal Action

To help resolve disputes before litigation, the policy requires that you provide us with written notice of intent to sue as a condition prior to legal action. This notice must identify the source of the disagreement, including all relevant facts and information supporting your position. Unless prohibited by law, any action for extra-contractual or punitive damages is waived if the contract claims at issue are paid or the disagreement is resolved or corrected within 30 days of the written notice.

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 and obtain Medicare coverage will be provided an alternative health insurance benefit called "Carve-out." Basically, "Carve-out" pays the difference between what Golden Rule benefits normally would pay and what is paid by Medicare.

14 State Variations

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

Alaska

- Copay Plans 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.
- 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 Saver Plans and the \$3,000 lifetime limit under other plans are 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.
- Notification requirements do not apply.

CoverColorado 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; and
- 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
Glendale, CO 80246
(877) 461-3811
(800) 259-2656 (TDD)

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.

Indiana

- The limited exclusion for AIDS does not apply.

Iowa

- 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 maternity expense benefits rider does not cover maternity expenses until 300 days after the rider effective date.

Kentucky

- The exclusion for TMJ disorders does not apply.
- The preexisting conditions reference to treatment within 24 months prior to the applicable effective date is changed to 6 months. This 6-month waiting period may be reduced for persons covered by qualifying prior coverage.
- The \$250 limit on HSA Saver® Emergency Room fees does not apply.

Maryland

- The limited exclusion for AIDS does not apply.

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; and
- 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 pre-existing 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.
- Covered childhood immunizations are not subject to the deductible.

Ohio

- On all plans except Saver Plans: 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 pre-existing 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.
- Dependent children are covered to age 25.
- 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 pre-existing conditions exclusions) are available to eligible applicants. Review the application for insurance for details.

West Virginia

- 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 pre-existing 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.

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, such as 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, income, E-mail address, policy number, HSA account number and balance, policy coverage, premium payment, claims history, medical information, and motor vehicle reports.

INFORMATION WE ARE PERMITTED TO USE AND DISCLOSE WITHOUT AN AUTHORIZATION

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

- To affiliates, but limited to transaction and experience information.
- 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.
- 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.
- 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 INFORMATION

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

- To view it during regular business hours and to obtain a copy of it.
- To request that we amend it. (We will notify you within 30 days of your request with our reason for any refusal. You may file a statement of your disagreement that we will keep in your file.)
- To receive written notice from us, if we amend it at your request. We will provide updates to all parties that have received information from us within the past 2 years (7 years for support organizations).
- To receive details about our sharing of it, including the types of sources it came from.

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

- 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.)

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 us 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 nonprofit 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, 866-692-6901, 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 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 send it 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 April 2006, is being provided on behalf of *UnitedHealthcare, Inc., Golden Rule Insurance Company, All Savers Insurance Company, Golden Rule Financial Corporation, Ovations, Inc., Specialized Care Services, Inc., Rooney Life Insurance Company, Spectera, Inc., Uniprise, Inc., and United HealthCare Services, Inc.*

To obtain an authorization for us 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

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 FACT or 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.**

World of FACT Value



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

World of FACT Value

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

- Dental Discounts -- you can save up to 50% on general dental, x-rays, and orthodontics
- Vision discounts -- typical savings of 20-60% for eye exams, eyeglasses, contact lenses, and LASIK correction surgery
- Prescription drug discounts
- 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 at www.fact-org.org or call toll-free at 1-800-USA-FACT.



Health Savings Account Options



Golden Rule®

A UnitedHealthcare Company



**Health Savings Account MasterCard®
Prepaid Debit Card**

About Your HSA

We have chosen **Exante Bank**, a leading administrator of Health Savings Accounts, as our financial institution. Your HSA funds are deposited in a custodial account at Exante Bank. Exante Bank, member FDIC, will service your account and will send information directly to you about your HSA.

You will receive your new Health Savings Account CardSM and a PIN mailer in separate mailings. Once you activate your card, you can use it at:

- Any point-of-service location (such as a doctor's office or pharmacy) that accepts MasterCard® debit cards
- Any ATM displaying the MasterCard brand mark (\$1.50 per transaction. In addition to Exante's fee, the bank/ATM you use to withdraw funds will charge you their own fee (variable by bank) for the transaction)

You can also access your HSA funds through:

- On-line bill payment at *ExanteBankHSA.com* -- limit one transaction per business day
- Checks, if you choose to purchase them

HSA Deposits are set up on the same payment plan as premiums for the health insurance coverage. Lump-sum deposits are also accepted; however, you must continue to deposit the \$25 monthly minimum with your premium payment. Exante Bank will provide on-line monthly statements detailing your account balance and activity. If you prefer to have statements mailed to your home, simply notify Exante Bank. You can opt-out of electronic statements at *ExanteBankHSA.com*, call customer service to do so, or send your request to P.O. Box 271629, Salt Lake City, UT 84127-1629.

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

Account Information by Phone or On-line

With an Exante Bank HSA, your account information is available, day or night, through:

- Toll-free customer service -- representatives are available to assist you Monday through Friday, 9:00 a.m. to 7:00 p.m. Eastern time, at 1-866-234-8913
- Interactive voice response for self service, 24/7
- *ExanteBankHSA.com*

You can:

- Make lump-sum contributions to your HSA
- Pay bills on-line
- Check current balance
- See how much interest has been paid
- Transfer funds
- Check last five (5) account transactions (deposits and/or withdrawals)
- Activate the Health Savings Account Card
- Report the card lost or stolen
- Set or reset password
- View frequently asked questions
- View monthly statements



Health Savings Accounts (HSAs) -- Summary of the Law

Eligibility -- Those covered under a qualified high deductible health plan, and not covered by other health insurance (except for vision or dental coverage) or enrolled in Medicare, and who may not be claimed as a dependent on another person's tax return

HSA Contributions -- 100% tax-deductible from gross income

Qualified Medical Withdrawals -- Tax-free

Interest Earned -- Tax-deferred; if used for qualified medical expenses, tax-free

Non-medical Withdrawals -- Income tax +10% penalty tax (under age 65); income tax only (for age 65 and over)

Death, Disability -- Income tax only -- no penalty

Deductible and out-of-pocket maximums may be adjusted annually based on changes in the Consumer Price Index.

This is only a brief summary of the applicable federal law. Consult your tax advisor for more details of the law.

Deductibles and Monthly Health Savings Account (HSA) Deposit Options

	Singles					Families				
Deductible	\$1,050	\$1,800	\$2,700	\$3,500*	\$5,000*	\$2,100	\$3,650	\$5,450	\$7,500*	\$10,000*
Plan out-of-pocket maximum	Equal to the deductible									
Maximum monthly deposit (tax-deductible limit)**	\$87.50	\$150.00	\$225.00	\$225.00	\$225.00	\$175.00	\$304.16	\$454.16	\$454.16	\$454.16

* Deductibles not available in Connecticut and Delaware.

** Those individuals aged 55 and over may contribute an additional \$700 for tax year 2006.

HSA Management by Exante Bank

Current Interest Credited	Access to Funds	One-Time Set-Up Fee	Monthly Maintenance	Minimum Monthly Deposit
5%*	Health Savings Account Card	\$10	\$3	\$25

Exante Bank is an FDIC insured institution, and is responsible for the money in your Health Savings Account.

You will receive a Health Savings Account Card from Exante Bank shortly after your qualified medical coverage becomes effective. **HSA Withdrawals** can

be made by simply using your Health Savings Account Card at any point-of-service location (such as a doctor's office or pharmacy) that accepts MasterCard® debit cards.

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

*As of 7/1/06, subject to change.

Optional Benefit from Golden Rule: 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. In addition, you only pay the premium amount once.

Hospital Indemnity Rider Cash Benefit		
Month	Single Benefit	Family Benefit
1	\$1,500	\$3,200
2	\$1,400	\$2,950
3	\$1,250	\$2,700
4	\$1,150	\$2,450
5	\$1,050	\$2,225
6	\$950	\$2,000
7	\$850	\$1,775
8	\$750	\$1,550
9	\$675	\$1,325
10	\$600	\$1,125
11	\$525	\$925
12	\$450	\$725
13	\$400	\$550
14	\$350	\$400
15	\$300	\$250
16	-\$0-	-\$0-
One-Time Premium Amount For This Option	\$40	\$150

Note: HSA Hospital Indemnity Rider is not available for plans with \$1,050 or \$2,100 deductibles.