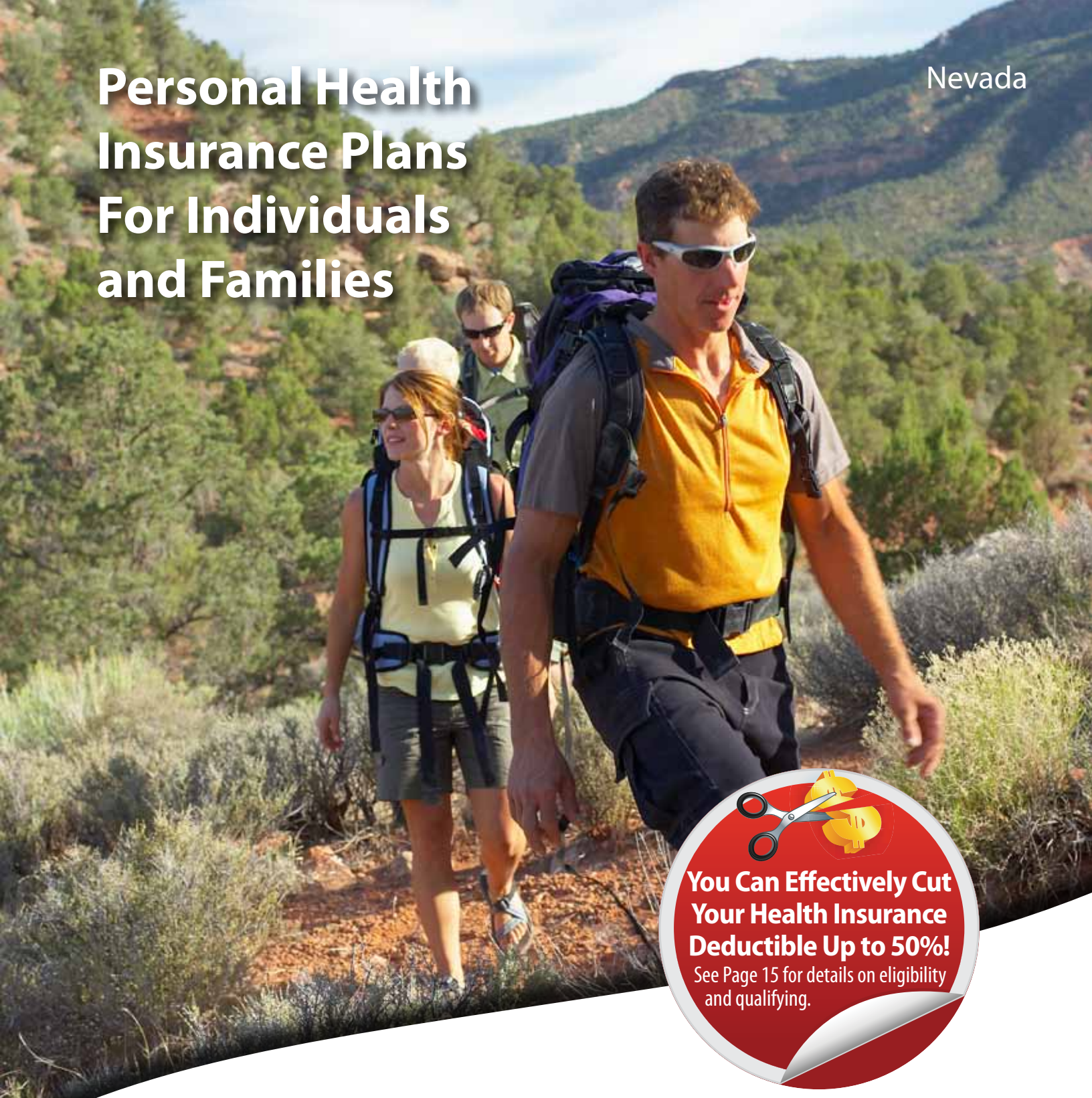
Personal Health Insurance Plans For Individuals and Families

Nevada



You Can Effectively Cut Your Health Insurance Deductible Up to 50%!
See Page 15 for details on eligibility and qualifying.

Choices you want. Coverage you need.®

UnitedHealthOne℠

These plans are administered, issued, and underwritten by Golden Rule Insurance Company, a UnitedHealthcare company, on an individual basis and are regulated as individual health insurance plans.

Policy Forms MTI00001-27 and MTI00001-27-H

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39317C2-G-0412 (includes: 39317-G-0312, 38959-G-0412, 38526-G-0212)

Why Choose Us for Health Insurance?

UnitedHealthcare

Approximately 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. We combine our strength and stability with nearly three decades of experience serving customers of all sizes, including individuals and families buying their own health coverage.

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 65 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. Our customers benefit from strong discounts on quality health care coverage made possible 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.*®

Quality Coverage from a Proven Company

Leave it to the experts

For over 65 years, Golden Rule has served individuals and families purchasing their own health insurance. Our experience and expertise has driven the development of plans that strive to make health coverage more affordable for more Americans. With our sole focus of serving individuals and families, we understand the unique needs of individuals — like you — shopping for personal health insurance.

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 a total of 754,000 physicians and other health care professionals and 5,400 hospitals nationwide in the UnitedHealthcare network.* Plus, our network can offer you provider discounts with a national average of up to 50% on quality health care.***

Initial rate guarantees

Benefit from securing your initial premium amount for 12 months (does not apply to address changes or benefit changes requested by the insured or mandated by law).

Benefits for a lifetime

Each of our plans gives you the protection of an unlimited lifetime benefit.

Coverage for your children

Your children can benefit from coverage until they reach the age of 26.

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, even traveling outside the U.S., you can rest assured knowing that in a medical emergency, coverage is available.

Health Reform Ready

Our plans will provide the benefits and meet the requirements of the Patient Protection and Affordable Care Act (these are non-grandfathered plans).

* UnitedHealth Group Annual Form 10-K for year ended 12/31/2011. Available in most areas.

** Actual 2011 results.

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

Which Plan Best Fits Your Needs?

A Variety of Plans to Choose From

Whether you are seeking lower-cost health insurance, experienced a recent change in employment or family status, or are self-employed, we can offer you and your family a variety of coverage options at competitive prices in many states.

Plan Type	May Be Ideal For	Plan Name	Out-of-Pocket*	Premium Cost	Page
Copay Plan A set copay means convenience. You know what you'll owe for a basic visit to a network doctor and for prescriptions.	Anyone who prefers the convenience of copay benefits for minor or routine health care expenses. Families with children who have regularly scheduled doctor office visits. Anyone who prefers copay benefits for prescription drugs.	Copay Select℠	Lower Copay for Dr. Office Visits / Prescriptions. Plan pays 100% of covered expenses after calendar-year deductible and coinsurance.	Higher	6
High Deductible Plans Simple to understand and use. Insurance coverage for big medical bills.	Anyone seeking lower-cost protection from unexpected accidents and illnesses. Early retirees needing a bridge to Medicare. Anyone willing to take responsibility for minor or routine health care expenses in exchange for lower premiums.	Plan 100® More Comprehensive	Lower Plan pays 100% of covered expenses after calendar-year deductible.	Higher	8
		Plan 80℠ More Affordable	Higher Plan pays 80% of covered expenses after calendar-year deductible. Then you pay 20% to calendar-year max.	Lower	8
		Saver 80℠ Most Affordable	Higher Like *Plan 80* but no coverage for doctor office visits or prescriptions.	Lowest	8
Health Savings Account Plans An insurance plan + a health savings account. You may cover your calendar-year deductible with dollars you save. Plus, the savings are tax-advantaged like an IRA. Your health care dollars go further!	Persons interested in more control over how their health care dollars are spent. Families interested in one calendar-year deductible per family. Those interested in trading low deductible health insurance for a higher deductible plan to save money on monthly premiums and taxes.	HSA 100® More Comprehensive	Lower Plan pays 100% of covered expenses after calendar-year deductible (one per family).	Higher	10
		HSA 70℠ More Affordable	Higher Plan pays 70% of covered expenses after calendar-year deductible. Then you pay 30% to calendar-year max. Savings Account - IRA-like tax advantages. - Tax-free use of savings for deductible and other qualified expenses.	Lower	10

Looking for more ways to save?

We've added a new feature, called Deductible Credit. It can help you reduce your future out-of-pocket expenses. If you don't meet your per-person calendar-year network deductible, the Deductible Credit applies to next year's network deductible. See page 15 for details.

*Out-of-pocket exposure is deductible, coinsurance, and copays. Under all plans, additional expenses may be incurred that are not eligible for reimbursement by the insurance. Both the amount of benefits and the premium will vary based upon the plan you select.

The Network Advantage

Quality Care at Significant Savings

Access to the right doctors can be the most important part of your health care.

Our network gives you:

- Access to an **extensive network** of doctors, X-ray and lab facilities, hospitals, and other ancillary providers.*
- **Quality care** at reduced costs because these providers have agreed to lower fees for covered expenses.
- **Lower premiums** — savings of up to 40% or more over the same plans without a network.

Please note: Covered expenses for nonemergency care received from a provider outside your network are:

- Subject to reasonable and customary changes;
- Reduced by 25%;
- Subject to an additional deductible amount equal to the calendar-year deductible.

For Services of Non-Network Providers: Your actual out-of-pocket expenses for covered expenses may exceed the stated coinsurance percentage because actual provider charges may not be used to determine insurer and member payment obligations.

Sample savings with our network:

(Services provided January-March 2011)**

	Charges	Repriced Charges
Dr. Office Visit	$ 80.00	$ 31.94
MRI	$ 1,300.00	$ 477.78
Lipid Panel	$ 93.00	$ 8.31
CBC	$ 29.00	$ 4.77
Metabolic Panel	$ 31.00	$ 5.19
General Panel	$ 46.00	$ 6.55
Mammogram	$ 146.00	$ 62.71

*UnitedHealthcare Choice Plus network, available in most areas. LabCorp is the preferred laboratory services provider for UnitedHealthcare networks. Network availability may vary by state, and a specific health care provider's contract status can change at any time. Therefore, before you receive care, it is recommended that you verify with the health care provider's office that they are still contracted with your chosen network.

**All these services received from network providers in ZIP Code 336--. Your actual savings may be more or less than this illustration and will vary by several factors.

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

Copay Select℠

Convenient Doctor Office Copay Benefits

Designed for individuals and families, our Copay Select℠ plan is more like traditional employer plans with a copayment for routine health care expenses. When you use a network doctor for an office visit, we pay 100% of history and exam fees after a $35 copay with Copay Select℠. Office visits outside your network are covered subject to the applicable deductible and your chosen coinsurance.

Prescription Drug* Card Benefits

- Tier 1 drugs — $15 copay.
- Tier 2-4 drugs — combined $200 deductible per person, per calendar year, then:
  — $35 copay for Tier 2 drugs.
  — $65 copay for Tier 3 drugs.
  — 25% coinsurance (you pay) for Tier 4 drugs.

Comprehensive Coverage for Inpatient and Outpatient Medical Expenses

- Covered inpatient and outpatient expenses are reimbursed after your chosen coinsurance and the deductible.

*We have a preferred drug list, which changes periodically. Tier status for a prescription drug may be determined by accessing your prescription drug benefits via our website or by calling the telephone number on your identification card. The tier to which a prescription drug is assigned may change as detailed in your policy.

Who might benefit most from a Copay Select℠ Plan?

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

In-Network Benefit Highlights

This chart summarizes standard network covered expenses, exclusions, and limitations of each plan. See pages 5, 13-17 for more information.

Copay Select℠

Deductible Choices (maximum 2 per family, per calendar year)	You pay:	$2,500, $3,500, $5,000, $7,500 or $10,000	$1,000, $1,500, $2,500, $3,500, $5,000, $7,500 or $10,000	$1,000, $1,500, $2,500, $3,500, $5,000, $7,500 or $10,000
Coinsurance Choices (% of covered expenses after deductible)	You pay:	0%	20%	30%
Coinsurance Out-of-Pocket Maximum (per person, per calendar year, after deductible)	You pay:	$0	$3,000	$5,000
Initial Rate Guarantee (does not apply to address changes or benefit changes requested by the insured or mandated by law)			12 Months	
Physician Care Benefits (Illness & Injury)				
Office Visit, History and Exam (primary care or specialist)			$35 copay — no deductible ($25 Office Visit Copay optional benefit available)	
Primary Care Physician/Specialist Referrals Required			No	
Prescription Drug Benefits				
If you purchase name-brand when generic is available, you pay your generic copay plus the additional cost above the generic price.			Tier 1 drugs — $15 copay, no deductible. Tier 2-4 drugs — combined $200 deductible per person, per calendar year, then: Tier 2 drugs — $35 copay. Tier 3 drugs — $65 copay. Tier 4 drugs — you pay 25% coinsurance.	
Wellness/Preventive Care Benefits (no waiting period, not subject to deductible, coinsurance, or copayments)				
See page 13 for details				
Outpatient Expense Benefits				
X-ray and lab (performed in the doctor's office or a network facility)			You pay: chosen coinsurance after deductible	
Facility/Hospital for Outpatient Surgery			You pay: chosen coinsurance after deductible	
Surgeon, Assistant Surgeon, and Facility Fees			You pay: chosen coinsurance after deductible	
Hemodialysis, Radiation, Chemotherapy, Organ Transplant Drugs, and CAT Scans, MRIs			You pay: chosen coinsurance after deductible	
Emergency Room Fees — Illness			You pay: chosen coinsurance after deductible (additional $100 deductible if not admitted)	
Emergency Room Fees — Injury			You pay: chosen coinsurance after deductible	
Spine and Back Disorders			You pay: chosen coinsurance after deductible	
Mental and Nervous Disorders			You pay: chosen coinsurance after deductible	
Other Outpatient Expenses			You pay: chosen coinsurance after deductible	
Inpatient Expense Benefits				
Room and Board, Intensive Care Unit, Operating Room, Recovery Room, Prescription Drugs, Physician Visit, and Professional Fees of Doctors, Surgeons, Nurses			You pay: chosen coinsurance after deductible	
Other Inpatient Services			You pay: chosen coinsurance after deductible	

High Deductible Plans

Choice of Coverage

With our High Deductible Plans, you select the level of coverage that makes you most comfortable. The higher the deductible, the lower your premiums. And you're keeping more of your money and taking responsibility for covering minor or routine health care expenses, if they come up.

Lowest Premium Plan

Saver 80℠ is our lowest premium plan. This plan provides coverage for hospital confinements, surgical procedures in or out of the hospital (but not in the doctor's office), 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®. It pays 100% of covered expenses once you meet your calendar-year deductible. Your benefits are not complicated with multiple copays or coinsurance.

Who might benefit most from a High Deductible Plan?

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

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In-Network Benefit Highlights

This chart summarizes standard network covered expenses, exclusions, and limitations of each plan. See pages 5, 13-17 for more information.

	Plan 100®	Plan 80SM	Saver 80SM
Deductible Choices (maximum 2 per family, per calendar year)	You pay: $2,500, $5,000, $7,500 or $10,000	You pay: $1,500, $2,500, $5,000, $7,500 or $10,000	You pay: $1,000, $1,500, $2,500, $5,000, $7,500 or $10,000
Coinsurance (% of covered expenses after deductible)	You pay: $0	You pay: 20%	You pay: 20%
Coinsurance Out-of-Pocket Maximum (per person, per calendar year, after deductible)	$0	$3,000	$3,000
Initial Rate Guarantee (does not apply to address changes or benefit changes requested by the insured or mandated by law)	12 Months	12 Months	12 Months
Physician Care Benefits (Illness & Injury)			
Office Visit, History and Exam (primary care or specialist)	No charge after deductible	You pay: 20% after deductible	Not covered
Primary Care Physician/Specialist Referrals Required	No	No	No
Prescription Drug Benefits			
Preferred price card (You pay for prescriptions at the point of sale, at the lowest price available, and submit a claim to Golden Rule.) -Or- Discount card (You may obtain RX drugs at an average savings of 20-25%. Discounts vary by pharmacy, geographic area, and drug.)	No charge after deductible — Preferred price card	You pay: 20% after deductible — Preferred price card	Not covered — Discount card
Wellness/Preventive Care Benefits (no waiting period, not subject to deductible or coinsurance)			
See page 13 for details			
Outpatient Expense Benefits			
X-ray and lab (performed in the doctor's office or a network facility)	No charge after deductible	You pay: 20% after deductible	You pay: 20% after deductible (must be performed within 14 days of surgery or confinement)
Facility/Hospital for Outpatient Surgery	No charge after deductible	You pay: 20% after deductible	You pay: 20% after deductible
Surgeon, Assistant Surgeon, and Facility Fees	No charge after deductible	You pay: 20% after deductible	You pay: 20% after deductible (surgery in the doctor's office not covered)
Hemodialysis, Radiation, Chemotherapy, Organ Transplant Drugs, and CAT Scans, MRIs	No charge after deductible	You pay: 20% after deductible	You pay: 20% after deductible
Emergency Room Fees — Illness	You pay: No charge after deductible (additional $100 deductible if not admitted)	You pay: 20% after deductible (additional $100 deductible if not admitted)	You pay: 20% after deductible (additional $500 deductible if not admitted)
Emergency Room Fees — Injury	No charge after deductible	You pay: 20% after deductible	You pay: 20% after deductible (additional $500 deductible if not admitted)
Spine and Back Disorders	No charge after deductible	You pay: 20% after deductible	Not covered
Mental and Nervous Disorders	No charge after deductible	You pay: 20% after deductible	Not covered
Other Outpatient Expenses	No charge after deductible	You pay: 20% after deductible	Not covered (see page 14 for details)
Inpatient Expense Benefits			
Room and Board, Intensive Care Unit, Operating Room, Recovery Room, Prescription Drugs, Physician Visit, and Professional Fees of Doctors, Surgeons, Nurses	No charge after deductible	You pay: 20% after deductible	You pay: 20% after deductible
Other Inpatient Services	No charge after deductible	You pay: 20% after deductible	You pay: 20% after deductible (see page 14 for details)

Health Savings Account (HSA) Plans

HSA Plans Offer Quality Coverage, Savings

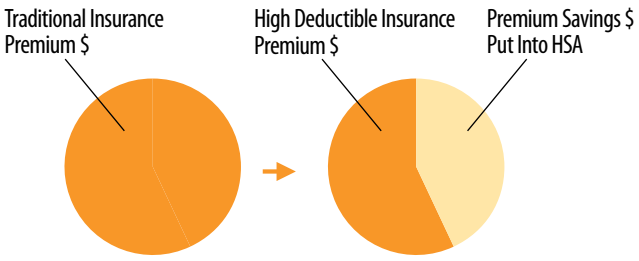
HSA Plans simply combine a lower-cost, high deductible health insurance plan and a tax-favored savings account.

Lower Premiums, Tax-Advantaged Savings, and an Attractive Interest Rate*

High deductible plans typically cost a lot less than many copay or traditional plans. This means lower premiums for you. You can then take the premium savings and place it into your health savings account.

- You get a tax deduction on the money you put in your HSA.
- Your dollars can grow tax-deferred.
- You spend the savings tax-free to help pay your deductible or for qualified medical care (including prescriptions, vision, or dental care).
- What you don't use in your account will continue to accumulate year after year. Then, if you ever need it for health care expenses, the money will be there.
- With Golden Rule's HSA custodian, you'll also earn interest on your savings, beginning with the first dollar deposited.

Bottom line — HSAs can help make health insurance more affordable.



*See HSA insert for important information.

Who might benefit most from a Health Savings Account Plan?

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

In-Network Benefit Highlights

This chart summarizes standard network covered expenses, exclusions, and limitations of each plan. See pages 5, 13-17 for more information.

	HSA 100®	HSA 70SM	
Deductible Choices (per family deductible, per calendar year)	You pay: Single — $2,500, $3,000, $3,500 or $5,000 Family — $5,000, $6,000, $7,000 or $10,000	You pay: Single — $1,250, $2,500, $3,000, $3,500 or $5,000 Family — $2,500, $5,000, $6,000, $7,000 or $10,000	
Coinsurance (% of covered expenses after deductible)	You pay: 0%	You pay: 30%	
Coinsurance Out-of-Pocket Maximum (per calendar year, after deductible per family)	$0	Single (deductible) $3,000 ($1,250) $3,000 ($2,500) $2,600 ($3,000) $2,100 ($3,500) $600 ($5,000)	Family (deductible) $6,000 ($2,500) $6,000 ($5,000) $5,200 ($6,000) $4,200 ($7,000) $1,200 ($10,000)
Initial Rate Guarantee (does not apply to address changes or benefit changes requested by the insured or mandated by law)	12 Months	12 Months	
Physician Care Benefits (Illness & Injury)			
Office Visit, History and Exam (primary care or specialist)	No charge after deductible	You pay: 30% after deductible	
Primary Care Physician/Specialist Referrals Required	No	No	
Prescription Drug Benefits			
Preferred price card (You pay for prescriptions at the point of sale, at the lowest price available, and submit a claim to Golden Rule.)	No charge after deductible — Preferred price card	You pay: 30% after deductible — Preferred price card	
Wellness/Preventive Care Benefits (no waiting period, not subject to deductible or coinsurance)			
See page 13 for details			
Outpatient Expense Benefits			
X-ray and lab (performed in the doctor's office or a network facility)	No charge after deductible	You pay: 30% after deductible	
Facility/Hospital for Outpatient Surgery	No charge after deductible	You pay: 30% after deductible	
Surgeon, Assistant Surgeon, and Facility Fees	No charge after deductible	You pay: 30% after deductible	
Hemodialysis, Radiation, Chemotherapy, Organ Transplant Drugs, and CAT Scans, MRIs	No charge after deductible	You pay: 30% after deductible	
Emergency Room Fees	No charge after deductible	You pay: 30% after deductible	
Spine and Back Disorders	No charge after deductible	You pay: 30% after deductible	
Mental and Nervous Disorders	No charge after deductible	You pay: 30% after deductible	
Other Outpatient Expenses	No charge after deductible	You pay: 30% after deductible	
Inpatient Expense Benefits			
Room and Board, Intensive Care Unit, Operating Room, Recovery Room, Prescription Drugs, Physician Visit, and Professional Fees of Doctors, Surgeons, Nurses	No charge after deductible	You pay: 30% after deductible	
Other Inpatient Services	No charge after deductible	You pay: 30% after deductible	

Optional Benefits

Further customize your health insurance coverage to meet your specific needs. Additional premium required.

$25 Office Visit Copay

Reduce the cost of doctor office visit copay from $35 to $25.

Available with Copay Select℠.

Term Life Benefit

You may choose an optional term life insurance benefit for you and/or your spouse who is also a covered person under the health plan. You and/or your spouse must be age 18 or older. The term life benefit expires when a covered person reaches age 65.

You select one of three benefit amounts. You may select different amounts for you and your spouse.

Benefit Amounts:	$50,000	$100,000	$150,000

Accidental Death Benefit

This benefit provides $50,000 in coverage in the event of an accidental death for you and/or your spouse who is also a covered person under the health plan. You and/or your spouse must be age 18 or older. The accidental death benefit expires when a covered person reaches age 65. It may be purchased with or without the term life benefit.

Motorcyclists are not eligible for this benefit.

Nevada Substance Abuse Rider

Covered expenses for substance abuse treatment are limited to:

- $1500 per covered person per calendar year for treatment for withdrawal from the physiological effect of alcohol or drugs. (Limit applies to outpatient expenses under Saver 80℠ only.)
- $2500 per calendar year for outpatient individual, group or family counseling. (Limit applies to Saver 80℠ only.)

The substance abuse treatment must be provided in:

- An alcohol or drug abuse treatment facility certified by the Health Division of the Department of Human Resources; or
- A hospital, other medical facility, or facility that is licensed by the Health Division of the Department of Human Resources, accredited by the Joint Commission on Accreditation of Healthcare Organizations, and provides a program for the treatment of abuse of alcohol or drugs as part of its accredited activities.

Supplemental Accident

You may choose an optional Supplemental Accident benefit to reduce your out-of-pocket expenses for unexpected injuries.

- Select a maximum benefit amount: $500, $1,000, $2,500, $5,000, or $10,000, per accident, per covered person.
- Helps cover your deductible or other out-of-pocket medical expenses (before the health insurance starts paying covered expenses).
- Expenses must be eligible for payment under the health insurance and incurred within 90 days of an injury.*
- Any benefit amount paid by the Supplemental Accident benefit will first be credited to the deductible and coinsurance of the health insurance.*
- Any remaining benefit payment will be made either to your health care provider under your assignment of benefits, or to you if you have already paid your provider.
- Exclusions and limitations of the health plan apply to this optional benefit, see pages 16 and 17 for details.

Policy Forms SA-S-861, SA-S-861-09, 6-C-410

*This rider will cover some expenses not otherwise covered under Saver 80℠. This type of expense will not be credited toward deductible or coinsurance.

Covered Expenses

Subject to all policy provisions, the following expenses are covered. To be considered for reimbursement, expenses must qualify as covered expenses and are also subject to eligible expense limits unless you use a network provider. Please review the additional plan information on pages 15-17.

All Plans

Preventive Care Expense Benefits

Benefits include coverage for the following (depending on the covered person's age):

- Routine vaccines for diseases
- Flu and pneumonia shots
- Routine physical exams, including well-baby and well-child doctor visits
- Screening for high blood pressure, cholesterol, diabetes
- Screening for detection of breast and other cancers through mammogram, pap smear, prostate cancer screening and colorectal screening

Preventive Care benefits are exempt from your plan deductible, coinsurance and copayments when services are provided by a network provider. Preventive health services must be appropriate for the covered person and follow these recommendations and guidelines:

(A) In general - Those of the U.S. Preventive Services Task Force that have an A or B rating;

(B) For immunizations - Those of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

(C) For preventive care and screenings for infants, children and adolescents - Those of the Health Resources and Services Administration; and

(D) For preventive care and screenings for women - Those of the Health Resources and Services Administration that are not included in section (A).

As new recommendations and guidelines are issued, those services will be considered covered expenses when required by the United States Secretary of Health and Human Services, but not earlier than one year after the recommendation or guideline is issued.

Copay Select℠, Plan 100®, Plan 80℠, HSA 100®, and HSA 70℠

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).
- Services and supplies, including drugs and medicines, which are routinely provided by the hospital to persons for use while they are inpatients.
- 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.
- Treatment of TMJ disorders.
- Cost and administration of anesthetic, oxygen, and other gases.
- Radiation therapy or chemotherapy.
- Prescription drugs.
- Hemodialysis, processing, and administration of blood and components.
- Artificial eyes, larynx, breast prosthesis, or basic artificial limbs (but not replacements).
- Surgery in a doctor's office or at an outpatient surgical facility, including services and supplies.
- Occupational therapy following a covered treatment for traumatic hand injuries.

For information on additional plan provisions, including Transplant Expense Benefit, Notification Requirements, Preexisting Conditions, General Exclusions, General Limitations, and Other Plan Provisions, read pages 15-17.

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

Covered Expenses (continued)

Subject to all policy provisions, the following expenses are covered. To be considered for reimbursement, expenses must qualify as covered expenses and are also subject to eligible expense limits unless you use a network provider. Please review the additional plan information on pages 15-17.

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.

Outpatient Expense Benefits

- Charges for outpatient surgery in an outpatient surgical facility, including the fee from the primary surgeon, the assistant surgeon, and/or administration of anesthetic (surgery performed in the doctor's office is not covered).
- Hemodialysis, radiation, and chemotherapy.
- Prescription drugs to protect against organ rejection in transplant cases.
- Hospital emergency room treatment of an injury or illness (subject to an additional $500 copay each time the emergency room is used for an illness not resulting in confinement).
- CAT scan and MRI testing.
- Diagnostic testing related to, and performed within 14 days prior to, surgery or inpatient confinement.

Important note about Saver 80SM:

Premiums for Saver 80SM 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 80SM Inpatient and Outpatient Expense Benefits.

Some expenses not covered under Saver 80SM include:

- Outpatient doctor office visit fees (except preventive), 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 surgery expenses for a surgery performed in a doctor's office; and
- Expenses incurred for mental or nervous disorders (except severe mental illness) or substance abuse.

For information on additional plan provisions, including Transplant Expense Benefit, Notification Requirements, Preexisting Conditions, General Exclusions, General Limitations, and Other Plan Provisions, read pages 15-17.

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

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. You'll find complete coverage details in the policy.

Deductible Credit

It can help you reduce your future out-of-pocket expenses.

Eligibility for a deductible credit is determined in January of each year. To qualify for a deductible credit in any given calendar year you must:

- be a qualified covered person (or family for HSA family plans) for at least 6 consecutive months the previous year.
- not meet the previous per person (or family for HSA family plans) calendar-year's deductible.

A credit will be applied towards the current calendar-year deductible, as outlined in the chart below:

Each qualified covered person (or family for HSA family plans) with at least 6 months of coverage and not meeting the plan's chosen network deductible for:	Receives this credit for the next calendar-year:
1 year	20% of chosen network deductible
2 consecutive years	40% of chosen network deductible
3 or more consecutive years	50% of chosen network deductible

With a Health Savings Account plan (HSA 100® and HSA 70℠), the deductible credit will never reduce the deductible below the minimum required by law to maintain tax-qualified status of the insurance plan. The minimum for 2011 and 2012 is $1,200 for singles and $2,400 for families.

Medical Expense Benefits

- General anesthesia for dental care provided in a hospital, an outpatient surgical facility, an independent center for emergency care, or a rural clinic is considered a covered expense for a covered child who: a) has a physical, mental, or medically compromising condition; b) has dental needs for which local anesthesia is ineffective due to an acute infection, an anatomic anomaly, or an allergy; c) is extremely uncooperative, unmanageable, or anxious; or d) has sustained extensive orofacial and dental trauma that would require unconscious sedation.
- If breast reconstruction is begun within three years after a mastectomy and if the policy was in effect at the time of the mastectomy, benefits will be provided subject to the terms, conditions, limitations, and exclusions of the policy at the time of the mastectomy. If the policy was not in effect at the time of the mastectomy or if breast reconstruction is begun more than three years after the mastectomy, benefits will be provided subject to the terms, conditions, and exclusions of the policy at the time of the breast reconstruction.
- Human Papillomavirus vaccine administered to female covered persons at recommended ages.
- Medication, equipment, supplies, and appliances to manage and treat Type 1, Type 2, or gestational diabetes.
- Self-management training and education for diabetes.
- Enteral formulas and special food products prescribed by a doctor to treat inherited metabolic diseases originating from congenital defects or defects arising shortly after birth.
- Medical treatment as part of a clinical trial or study for cancer or chronic fatigue syndrome, subject to the conditions listed in the policy.

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 a designated Center of Excellence is not used, covered expenses for a listed transplant will be reduced by 25% before application of any deductible amounts and coinsurance provisions.

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 nonlymphocyctic 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.

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% 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.

Provisions That Apply to All Plans (continued)

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.

Rehabilitation and Extended Care Facility (ECF) Benefit

Rehabilitation and inpatient Extended Care (ECF) expenses are covered if they begin within 14 days of a 3-day or more hospital stay, for the same illness or injury. There is a combined calendar-year maximum of 60 days for both Rehabilitation and ECF expenses.

Home Health Care Expense Benefit

To qualify for benefits, home health care must be provided through a licensed home health care agency.

Subject to deductible and coinsurance covered expenses for home health aide services are limited to seven visits per week and a lifetime maximum of 365 visits. Registered nurse services are limited to a lifetime maximum of 1,000 hours. Intermittent private-duty RN services (up to 4 hours each) limited to $75 per visit, and deemed to be 2 hours applied to the lifetime maximum.

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 are subject to deductible and coinsurance and 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. Bereavement counseling maximum $250.

Preexisting Conditions

This does not apply to covered persons under age 19.

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 that 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 medical advice, diagnosis, care, or treatment was recommended to or received by a covered person within 6 months prior to the applicable **effective date** the covered person becomes insured under the policy.

State of Nevada Basic and Standard portability plans (guarantee issue without preexisting conditions exclusions) are available to eligible applicants.

General Exclusions

No benefits are payable for expenses which:

- Are due to pregnancy (except for complications of pregnancy).
- 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 or in the course of employment for wage or profit, if the covered person is insured, or is required to be insured, by workers' compensation insurance pursuant to applicable state or federal law. If you enter into a settlement that waives a covered person's right to recover future medical benefits under a workers' compensation law or insurance plan, this exclusion will still apply.
- 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.
- No benefits will be paid for treatment of substance abuse, or for court-ordered treatment programs for substance abuse. (Optional benefit is available.)
- 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.
- Are incurred while your policy is not in force.
- Are for any drug treatment or procedure that promotes conception.
- Are for or related to surrogate parenting.
- Are for or related to treatment of hyperhidrosis (excessive sweating).
- Are for fetal reduction surgery.
- Are for alternative treatments, except as specifically identified as covered expenses under the policy, including: acupressure, acupuncture, aromatherapy, hypnotism, massage therapy, rolfing, and other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.

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.

Provisions That Apply to All Plans (continued)

General Limitations

- Transplants eligible for coverage under the Transplant Expense Benefit are limited to two transplants in a 10-year period, when performed in one of our "Centers of Excellence".
- Charges for an assistant surgeon are limited to 20% of the primary surgeon's covered fee.
- As with any other illness or injury, inpatient care for mental disorders (including substance abuse), as defined in the policy/certificate, that is primarily for educational or rehabilitative care is not covered.
- "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:
  - Placing the health of the covered person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
  - Serious impairment to bodily functions; or
  - Serious dysfunction of any bodily organ or part.
- Covered expenses are limited to no more than a 34-day supply for any one outpatient prescription drug order or refill.
- When using an in-network physician or facility, non-covered expenses may not be eligible for a network provider discount.

Effective Date

Unless we agree to an earlier date, the effective date will be the later of: (a) the requested effective date, or (b) 15 days after the application is received by Golden Rule.

Eligible Expense

Eligible expense means a covered expense as determined below:

- For Network Providers (excluding Transplant Benefits): the contracted fee with that provider.
- For Non-Network Providers
  - When a covered expense is received as a result of an emergency or as otherwise approved by us, the eligible expense is the lesser of the billed charge or the amount negotiated with the provider.
  - Except as provided above (excluding Transplant Benefits), the fee charged by the provider for the services; or the fee that has been negotiated with the provider; or the fee established by us by comparing rates from one or more regional or national databases or schedules for the same or similar services from a geographical area determined by us; or 110% of the fee Medicare allows for the same or similar services provided in the same geographical area; or a fee schedule that we develop.

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 policy 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 under 26 years of age at time of application or medically certified as disabled and dependent on you at time of application.

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
- Accepts an employer's contribution to the premium payment or treats the policy as part of an employer-provided health plan.

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 policies 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. Plans are subject to health underwriting. If you provide incorrect or incomplete information on your insurance application your coverage may be voided or claims denied.

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.

Golden Rule Insurance Company
7440 Woodland Drive, Indianapolis, IN 46278-1719, (800) 657-8205

Outline of Coverage for Medical Expense Plan Copay Select℠

(Please retain this outline for your records.)

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 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!

MTI00158

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 deductibles; copayment provisions; or other exclusions or limitations that may be set forth in the policy.

MTI00159

Medical Benefits

Covered expenses set forth in the policy include the charges:

A. Made by a hospital for:
   1. Daily room and board and nursing services at the most common semi-private room rate.
   2. Daily room and board and nursing services while confined in an intensive care unit, not to exceed the eligible expense.
   3. Inpatient use of an operating, treatment, or recovery room.
   4. Outpatient use of an operating, treatment, or recovery room for surgery.
   5. Other routine services and supplies provided to an inpatient.
   6. Emergency treatment of an illness or injury. However, charges for use of the emergency room itself for treatment of an illness will be reduced by $100 unless the covered person is directly admitted to the hospital for further treatment of that illness.

B. For surgery in a doctor's office or at an outpatient surgical facility.

C. Made by a doctor for professional services, including surgery.

D. Made by a doctor acting as an assistant surgeon, limited to 20 percent of the eligible expense for the surgical procedure.

E. For dressings, crutches, orthopedic braces, splints, casts, or other necessary medical supplies.

F. For diagnostic testing using radiologic, ultrasonographic, or laboratory services, but not including psychometric, behavioral, and educational testing.

G. For chemotherapy and radiation therapy or treatment.

H. For hemodialysis and hospital charges for processing and administration of blood or blood components.

I. For the cost and administration of oxygen or an anesthetic.

J. For dental expenses for a covered injury that results in damage to the natural teeth and expenses that are incurred within six months of the accident.

K. For treatment of craniomandibular disorders, malocclusions, or disorders of the temporomandibular joint, excluding tooth extraction and orthodontic devices and splints.

L. For artificial eyes or larynx, breast prosthesis, or basic artificial limbs (but not replacement unless required by a physical change in the person and the item cannot be modified.)

M. For one pair of foot orthotics per covered person.

N. For one mastectomy bra per year if the covered person has undergone a covered mastectomy.

O. For the rental of a standard hospital bed, a standard walker, a standard non-motorized wheelchair, a wheelchair cushion, and a ventilator.

P. For the cost of one Continuous Passive Motion machine per person following a covered joint surgery.

Q. For the cost of one wig per person, up to $500, that is necessitated by hair loss due to cancer treatments or traumatic burns.

R. For occupational therapy following a covered treatment for traumatic hand injuries.

S. For one pair of eyeglasses or contact lenses per person, up to $200, following a covered cataract surgery.

T. For routine annual mammograms, cervical or pap smears, digital rectal examinations and prostate specific antigen tests.

U. For colorectal cancer screenings in accordance with published guidelines.

V. For surveillance tests for ovarian cancer for females who are at risk.

W. For one human papillomavirus (HPV) test or screening each calendar year.

X. For administering the human papillomavirus vaccine to female covered persons.

Y. For breast reconstruction following a covered mastectomy, prostheses, and treatment for physical complications of mastectomy, including lymphedemas.

Z. For general anesthesia and dental care procedures provided in a hospital, an outpatient surgical facility, an emergency care facility, or a rural clinic, to a covered child who meets the criteria stated in the policy.

AA. For medication, equipment, supplies, and appliances to treat diabetes, and for diabetes self-management training and education.

BB. For enteral formulas and special food products prescribed for the treatment of inherited metabolic diseases.

CC. For medical treatment as part of a clinical trial or study, subject to the conditions stated in the policy.

DD. For emergency ground or air ambulance service to the nearest hospital or the nearest neonatal special care unit for newborns.

EE. For outpatient prescription drugs that must be prescribed by a doctor, limited to a 34-day supply for each prescription or refill (excludes drugs for addiction to, or dependency on, tobacco or foods).

MTI00280-27

Preventive Care: Covered expenses include charges for the following when incurred for preventive care: (A) routine office visits; (B) childhood immunizations; (C) adult immunizations; (D) urinalysis and blood tests; (E) bone density screenings; (F) electrocardiograms (EKGs); (G) cardiac stress tests; (H) mammography screenings; (I) cervical smears and pap smears; (J) prostate specific antigen tests and digital rectal examinations; and (K) FDA-approved screenings for the detection of the human papillomavirus (HPV) and vaccinations for HPV.

Preventive care expense benefits will not include CAT or CT scans, or MRIs or PET scans performed on a routine or preventive basis.

MTI00289

Transplant Benefits: The following types of tissue transplants are covered expenses: cornea transplants; artery or vein grafts; heart valve grafts; prosthetic tissue replacement (including joint replacement); and implantable prosthetic lenses in connection with cataracts. The policy also provides coverage for listed transplants, which include heart; lung; heart/lung; kidney; and liver transplants; and bone marrow transplants as listed in the policy. The amount of benefits under the policy for a listed transplant depends upon whether it is performed in one of our Centers of Excellence.

MTI00162

Home Health Care Benefits: The policy provides benefits for home health care. Benefits for home health aide services are limited to 7 visits per week and a lifetime maximum of 365 visits. Benefits for outpatient private duty registered nurse services are limited to a lifetime maximum of 1,000 hours. Benefits for intermittent private duty registered nurse services are limited to $75 per visit.

MTI00163

Hospice Care Expense Benefits: The policy provides benefits for hospice care for a terminally ill covered person who receives medically necessary care under a hospice care program, limited to 180 days in a covered person's lifetime.

MTI00164

Rehabilitation and Extended Care Facility Expense Benefits: The policy provides benefits for rehabilitation services or an inpatient stay in a rehabilitation facility or extended care facility 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. Covered expenses are limited to 60 days per calendar year for each covered person.

MTI00165

Limitation on Spine and Back Disorders: If the diagnosis or treatment of a spine or back disorder is rendered to a covered person while an outpatient, covered expenses for the doctor's fees and all services and supplies will be limited to no limit.

MTI00166-27

Limitation on Mental Disorders and Severe Mental Illnesses: Benefits for treatment of severe mental illness, as defined in the policy, are limited to 40 days of inpatient treatment per covered person per calendar year and 40 visits for outpatient treatment per covered person per calendar year, excluding visits for management of medications. Covered expenses for outpatient diagnosis or treatment of mental disorders that are not severe mental illnesses are limited to no limit per visit and a lifetime maximum limit of no limit per covered person.

MTI00167-27

Amount Payable

Definitions:

"Coinsurance percentage" means the percentage of covered expenses that are payable by us, as shown on the policy Data Page.

"Deductible amount" means the amount of covered expenses that must be paid by each covered person before any benefits are payable.

"Eligible expense" means a covered expense that is determined as follows:

A. For network providers (excluding Transplant Benefits), the eligible expense is the contracted fee with that provider.

B. For non-network providers:
   1. The eligible expense is the lesser of the billed charge or a lower amount negotiated with the provider or authorized by state law for covered expenses that are:
      (a) Received as a result of an emergency;
      (b) Otherwise approved by us; or
      (c) For a service or supply that is not of a type provided by any network provider.
   2. Except as provided under 1 above, when a covered expense (excluding Transplant Benefits) is received from a non-network provider, the eligible expense is determined based on:
      (a) The fee that has been negotiated with the provider; or
      (b) 110% of the fee Medicare allows for the same or similar services provided in the same geographical area; or
      (c) The fee established by us by comparing rates from one or more regional or national databases or schedules for the same or similar services from a geographical area determined by us; or
      (d) The fee charged by the provider for the services; or
      (e) A fee schedule that we develop.

MTI00316-NVD

Amount Payable: The total amount payable for each covered person under the policy will not exceed the maximum benefit limit shown as no limit.

We will pay the applicable coinsurance percentage in excess of the applicable deductible amount for a service or supply that qualifies as a covered expense and is received while the covered person's coverage is in force under the policy, if the charge for the service or supply qualifies as an eligible expense.

The amount payable will be subject to any specific benefit limits stated in the policy, a determination of eligible expenses, and any reduction for expenses incurred at a non-network provider.

Non-emergency non-network eligible expenses will be reduced by 25% before application of any applicable deductible amount(s), coinsurance provisions, and/or copayment amounts.

Note: The bill you receive for services or supplies from a non-network provider may be significantly higher than the eligible expenses for those services or supplies. In addition to the deductible amount, coinsurance, and copayment, you are responsible for the difference between the eligible expense and the amount the provider bills you for the services or supplies. Any amount you must pay to the provider in excess of the eligible expenses will not apply to your deductible amount or maximum out-of-pocket expenses.

MTI00317-NVD

Deductible Credit: A covered person will be eligible for a credit if, in any given calendar year, he or she did not meet the applicable deductible amount, and has been a covered person for at least 6 consecutive months. The deductible credit will apply to the deductible amount in the following calendar year.

MTI00301-NVD

Notification

You must notify us on or before the day a covered person begins the 4th day of an inpatient hospitalization or is evaluated for an organ or tissue transplant. If you fail to notify us, benefits will be reduced to 80% of the regular policy benefits, up to a maximum reduction of $1,000. This does not apply to an inpatient hospital admission for emergency treatment.

MTI00173

What Is Not Covered

No benefits will be paid for: (A) loss for which no charge would be made in the absence of insurance; (B) charges that are actually the responsibility of the provider to pay; (C) any services performed by a member of a covered person's immediate family; or (D) services not identified as covered expenses under the policy.

Covered expenses will not include, and no benefits will be paid for any charges that are incurred:

A. For services and supplies provided prior to the effective date or after the termination date of the policy.
B. For any portion of the charges that are in excess of the eligible expense.
C. For weight modification or surgical treatment of obesity, including wiring of the teeth and all forms of intestinal bypass surgery.
D. For breast reduction or augmentation.
E. For modification of the physical body to improve the psychological, mental, or emotional well-being of the covered person, such as sex-change surgery.
F. For any drug, treatment, or procedure that promotes conception, including, but not limited to, artificial insemination or treatment for infertility or impotency; for sterilization or reversal of sterilization; or for abortion (unless a pregnancy carried to term would endanger the mother's life).
G. For routine well-baby care of a newborn infant.
H. For television, telephone, or expenses for other persons.
I. For marriage, family, or child counseling for the treatment of premarital, marriage, family, or child relationship dysfunctions.
J. For telephone consultations or failure to keep a scheduled appointment.
K. For stand-by availability of a doctor when no treatment is rendered.
L. For dental expenses, including braces, or surgery and treatment for oral surgery, except as described in the policy.
M. For cosmetic treatment, except reconstructive surgery that is incidental to or follows surgery or an injury that was covered under the policy or is performed to correct a birth defect in a child who has been covered under the policy since birth.
N. For diagnosis or treatment of: learning disabilities; attitudinal disorders; or disciplinary problems.
O. For diagnosis or treatment of nicotine addiction.
P. For charges related to, or in preparation for, tissue or organ transplants, except as expressly provided for by the policy.
Q. For high dose chemotherapy prior to, in conjunction with, or supported by bone marrow transplant, except as specifically provided by the policy.
R. For eye refractive surgery when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism.
S. While confined primarily to receive rehabilitation, custodial care, educational care, or nursing services (unless expressly provided for by the policy).
T. For vocational or recreational therapy, vocational rehabilitation, occupational therapy , or outpatient speech therapy, except as provided by the policy.
U. For eyeglasses, contact lenses, hearing aids, eye refraction, visual therapy, or for any related examinations or fittings.
V. For pregnancy (except complications of pregnancy) or for confinement primarily for well-baby care.
W. For treatment of mental disorders, except as provided by the policy.
X. For treatment of substance abuse.
Y. For preventive or prophylactic care, including routine physical examinations, premarital examinations, and educational programs, except as provided by the policy.
Z. For experimental or investigational treatment or for unproven services, as defined in the policy.
AA. For expenses incurred outside of the United States, except for emergency treatment.
BB. For injury or illness caused by employment, except as may be covered by the policy.
CC. As a result of intentionally self-inflicted bodily harm (whether sane or insane); an injury or illness caused by an act of war; from taking part in a riot; or from the commission of a felony.
DD. For durable medical equipment, except as expressly provided for by the policy.
EE. For or related to surrogate parenting.
FF. For or related to treatment of hyperhidrosis (excessive sweating).
GG. For fetal reduction surgery.
HH. Except as expressly provided for by the policy, expenses for alternative treatments, including acupressure; acupuncture; aroma therapy; hypnotism; massage therapy; rolfing; and other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.

In no event will we pay for charges that are: (A) not made or ordered by a doctor; or (B) not medically necessary to the diagnosis or treatment of an illness or injury.

MTI00288-27

Preexisting Conditions

A "preexisting condition" means a condition for which medical advice; diagnosis; care; or treatment was recommended to or received by a covered person within the 6 months immediately preceding the applicable effective date the covered person became insured under the policy.

Expenses due to a preexisting condition will not be covered during the first 12 months after the date the covered person becomes insured under the policy.

MTI00178-27

Term of Coverage and Renewability

The policy term begins as of the effective date of the policy. You may keep the policy in force by paying us the required premium as it comes due. However, we may cancel the policy if there is fraud or material misrepresentation made by or with the knowledge of a covered person in filing a claim.

Benefits will continue to be paid for an illness or injury after a person's coverage terminates, provided the illness or injury causes a period of extended loss that begins while the covered person is still covered by the policy.

MTI00179

Golden Rule Insurance Company
7440 Woodland Drive, Indianapolis, IN 46278-1719, (800) 657-8205

Outline of Coverage for Saver 80SM

(Please retain this outline for your records.)

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 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!

MTI00158

Hospital, Surgical, Medical Expense Coverage -- Plans of this type are designed to provide covered persons with coverage for the 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 limited out-of-hospital care. Coverage is subject to any deductibles; copayment provisions; maximum dollar limits; preexisting condition limitations; or other exclusions or limitations that may be set forth in the policy.

MTI00180

IMPORTANT NOTE: Premiums for this policy are significantly less because coverage is not provided for most outpatient services. Outpatient expenses not specifically listed in the policy are not covered. Some outpatient expenses not covered are: doctor office visit fees; medical services not specifically listed in the policy; professional fees of physical therapists; durable medical equipment, and medical supplies, except those covered under home health care benefits; expenses for treatment of mental disorders other than severe mental illnesses; and expenses for treatment of substance abuse. Please review the policy's inpatient and outpatient expense benefits, exclusions, and limitations for details.

MTI00324-27

Medical Benefits

Hospital Charges: Covered expenses include charges for the following when incurred as an inpatient in a hospital:

A. Daily room and board and nursing services at the most common semi-private room rate.
B. Daily room and board and nursing services while confined in an intensive care unit, not to exceed the eligible expense.
C. Inpatient use of an operating, treatment, or recovery room.
D. Services and supplies routinely provided to an inpatient.
E. Dressings, crutches, orthopedic braces, splints, casts, or other necessary medical supplies.
F. Diagnostic testing using radiologic, ultrasonographic, or laboratory services, but not including psychometric, behavioral, and educational testing.
G. Chemotherapy and radiation therapy or treatment.
H. The cost and administration of oxygen or an anesthetic.
I. Artificial eyes or larynx, breast prostheses, or basic artificial limbs (but not replacement, unless required by a physical change in the person and the item cannot be modified).
J. Hemodialysis and the hospital charges for processing and administration of blood or blood components.
K. The professional services of a doctor.

MTI00281-27

Emergency Treatment: Covered expenses include emergency treatment of an illness or injury. However, charges for use of the emergency room itself will be reduced by $500 unless the person is directly admitted to the hospital.

MTI00182-27

Ambulance Service: Covered expenses include emergency ground or air ambulance services to the nearest hospital, or the nearest neonatal special care unit for newborns.

MTI00183

Surgical Expense: Covered expenses include the following expenses for surgery:

A. The fee charged by the primary surgeon.
B. The fee charged by a doctor acting as an assistant surgeon, limited to 20% of the primary surgeon's eligible expense.
C. Outpatient use of an operating, treatment, or recovery room.
D. The cost and administration of an anesthetic.
E. The charges made by an outpatient surgical facility.
F. Post-operative laboratory services.
G. Surgical treatment of craniomandibular disorders, malocclusions, or disorders of the temporomandibular joint, excluding tooth extraction and orthodontic devices and splints.

MTI00282-27

General Anesthesia for Dental Care: Covered expenses include the charges for general anesthesia and dental care procedures provided in a hospital, an outpatient surgical facility, an emergency care facility, or a rural clinic to a covered child who meets the criteria stated in the policy.

MTI00202-27

Breast Reconstruction Following a Mastectomy: Covered expenses include breast reconstruction, prostheses, and treatment for physical complications of mastectomy, including lymphedemas.

MTI00185

Outpatient Pre-Admission and Pre-Surgical Testing: Covered expenses include diagnostic testing done within 14 days before a hospital stay or outpatient surgical procedure.

MTI00186

Outpatient Catastrophic Expenses: Covered expenses include charges for the following:

A. Radiation therapy and chemotherapy.
B. Hemodialysis.
C. Artificial eyes or larynx, breast prostheses, or basic artificial limbs (but not replacement, unless required by a physical change in the person and the item cannot be modified).
D. CAT scans and MRIs.
E. Prescription drugs that are medically necessary to protect against rejection of an organ or tissue transplant, limited to a 34-day supply.

MTI00187

Routine Screenings and Tests: Covered expenses will include charges per covered person for:

A. Routine annual mammograms, cervical or pap smears, digital rectal examinations and prostate specific antigen tests.
B. Colorectal cancer exams in accordance with published guidelines.
C. Surveillance tests for ovarian cancer for females who are at risk for ovarian cancer.
D. One human papillomavirus (HPV) test or screening each calendar year.

MTI00188-27

Other Covered Expenses: Covered expenses include charges for the following:

A. Non-surgical treatment of craniomandibular disorders, malocclusions, or disorders of the temporomandibular joint, excluding tooth extraction and orthodontic devices and splints.
B. Administering the human papillomavirus vaccine to female covered persons.
C. Medication, equipment, supplies, and appliances to treat diabetes, and diabetes self-management training and education.
D. Enteral formulas and special food products prescribed for the treatment of inherited metabolic diseases.
E. Medical treatment as part of a clinical trial or study, subject to the conditions stated in the policy.
F. Treatment of conditions related to severe mental illness, limited to 40 days of inpatient treatment per covered person per calendar year and 40 outpatient visits per covered person per calendar year, excluding visits for management of medications.

MTI00203-27

Transplant Benefits: The following types of tissue transplants are covered expenses: cornea transplants; artery or vein grafts; heart valve grafts; prosthetic tissue replacement (including joint replacement); and implantable prosthetic lenses in connection with cataracts. The policy also provides coverage for listed transplants, which include heart; lung; heart/lung; kidney; and liver transplants; and bone marrow transplants as listed in the policy. The amount of benefits under the policy for a listed transplant depends upon whether it is performed in one of our Centers of Excellence.

MTI00162

Home Health Care Benefits: The policy provides benefits for home health care. Benefits for home health aide services are limited to 7 visits per week and a lifetime maximum of 365 visits. Benefits for outpatient private duty registered nurse services are limited to a lifetime maximum of 1,000 hours. Benefits for intermittent private duty registered nurse services are limited to $75 per visit.

MTI00163

Hospice Care Expense Benefits: The policy provides benefits for hospice care for a terminally ill covered person who receives medically necessary care under a hospice care program, limited to 180 days in a covered person's lifetime.

MTI00164

Rehabilitation and Extended Care Facility Expense Benefits: The policy provides benefits for rehabilitation services or an inpatient stay in a rehabilitation facility or extended care facility 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. Covered expenses are limited to 60 days per calendar year for each covered person.

MTI00165

Amount Payable

Definitions:

"Coinsurance percentage" means the percentage of covered expenses that are payable by us, as shown on the policy Data Page.

"Deductible amount" means the amount of covered expenses that must be paid by each covered person before any benefits are payable.

"Eligible expense" means a covered expense that is determined as follows:

A. For network providers (excluding Transplant Benefits), the eligible expense is the contracted fee with that provider.
B. For non-network providers:
   1. The eligible expense is the lesser of the billed charge or a lower amount negotiated with the provider or authorized by state law for covered expenses that are:
      (a) Received as a result of an emergency;
      (b) Otherwise approved by us; or
      (c) For a service or supply that is not of a type provided by any network provider.

2. Except as provided under 1 above, when a covered expense (excluding Transplant Benefits) is received from a non-network provider, the eligible expense is determined based on:
   (a) The fee that has been negotiated with the provider; or
   (b) 110% of the fee Medicare allows for the same or similar services provided in the same geographical area; or
   (c) The fee established by us by comparing rates from one or more regional or national databases or schedules for the same or similar services from a geographical area determined by us; or
   (d) The fee charged by the provider for the services; or
   (e) A fee schedule that we develop.

MTI00316-NVD

Amount Payable: The total amount payable for each covered person under the policy will not exceed the maximum benefit limit shown as no limit.

We will pay the applicable coinsurance percentage in excess of the applicable deductible amount for a service or supply that qualifies as a covered expense and is received while the covered person's coverage is in force under the policy, if the charge for the service or supply qualifies as an eligible expense.

The amount payable will be subject to any specific benefit limits stated in the policy, a determination of eligible expenses, and any reduction for expenses incurred at a non-network provider.

Non-emergency non-network eligible expenses will be reduced by 25% before application of any applicable deductible amount(s), coinsurance provisions, and/or copayment amounts.

Note: The bill you receive for services or supplies from a non-network provider may be significantly higher than the eligible expenses for those services or supplies. In addition to the deductible amount, coinsurance, and copayment, you are responsible for the difference between the eligible expense and the amount the provider bills you for the services or supplies. Any amount you must pay to the provider in excess of the eligible expenses will not apply to your deductible amount or maximum out-of-pocket expenses.

MTI00317-NVD

Deductible Credit: A covered person will be eligible for a credit if, in any given calendar year, he or she did not meet the applicable deductible amount, and has been a covered person for at least 6 consecutive months. The deductible credit will apply to the deductible amount in the following calendar year.

MTI00301-NVD

Notification

You must notify us on or before the day a covered person begins the 4th day of an inpatient hospitalization or is evaluated for an organ or tissue transplant. If you fail to notify us, benefits will be reduced to 80% of the regular policy benefits, up to a maximum reduction of $1,000. This does not apply to an inpatient hospital admission for emergency treatment.

MTI00173

What Is Not Covered

No benefits will be paid for: (A) loss for which no charge would be made in the absence of insurance; (B) charges that are actually the responsibility of the provider to pay; (C) any services performed by a member of a covered person's immediate family; or (D) services not identified as covered expenses under the policy.

Covered expenses will not include, and no benefits will be paid for any charges that are incurred:

A. For services and supplies provided prior to the effective date or after the termination date of the policy.
B. For any portion of the charges that are in excess of the eligible expense.
C. For weight modification or surgical treatment of obesity, including wiring of the teeth and all forms of intestinal bypass surgery.
D. For breast reduction or augmentation.
E. For modification of the physical body to improve the psychological, mental, or emotional well-being of the covered person, such as sex-change surgery.
F. For any drug, treatment, or procedure that promotes conception, including, but not limited to, artificial insemination or treatment for infertility or impotency; for sterilization or reversal of sterilization; or for abortion (unless a pregnancy carried to term would endanger the mother's life).
G. For television, telephone, or expenses for other persons.
H. For marriage, family, or child counseling for the treatment of premarital, marriage, family, or child relationship dysfunctions.
I. For telephone consultations or failure to keep a scheduled appointment.
J. For stand-by availability of a doctor when no treatment is rendered.
K. For cosmetic treatment, except reconstructive surgery that is incidental to or follows surgery or an injury that was covered under the policy or is performed to correct a birth defect in a child who has been covered under the policy since birth.
L. For diagnosis or treatment of learning disabilities, attitudinal disorders, or disciplinary problems.
M. For diagnosis or treatment of nicotine addiction.
N. For charges related to, or in preparation for, tissue or organ transplants, except as expressly provided for by the policy.
O. For high dose chemotherapy prior to, in conjunction with, or supported by bone marrow transplant, except as specifically provided by the policy.
P. For eye refractive surgery when the primary purpose is to correct nearsightedness; farsightedness; or astigmatism.
Q. For dental expenses, including braces, or surgery and treatment for oral surgery, except as described in the policy.
R. While confined primarily to receive rehabilitation, custodial care, educational care, or nursing services (unless expressly provided for by the policy).
S. For vocational or recreational therapy, vocational rehabilitation, occupational therapy, or outpatient speech therapy, except as provided by the policy.
T. For pregnancy (except complications of pregnancy) or for confinement primarily for well-baby care.
U. For treatment of mental disorders, except as provided by the policy.
V. For treatment of substance abuse.
W. For preventive or prophylactic care, including routine physical examinations, premarital examinations, and educational programs, except as provided by the policy.
X. For experimental or investigational treatment or for unproven services, as defined in the policy.
Y. For expenses incurred outside of the United States, except for emergency treatment.
Z. For injury or illness caused by employment, except as may be covered by the policy.
AA. As a result of intentionally self-inflicted bodily harm (whether sane or insane); an injury or illness caused by an act of war; from taking part in a riot; or from the commission of a felony.
BB. For durable medical equipment, except as expressly provided for by the policy.
CC. For outpatient prescription drugs, unless expressly provided for by the policy.
DD. For outpatient, office, or home medical services or supplies, unless expressly provided for by the policy.
EE. For or related to surrogate parenting.
FF. For treatment of hyperhidrosis (excessive sweating).
GG. For fetal reduction surgery.
HH. Except as expressly provided for by the policy, expenses for alternative treatments, including acupressure; acupuncture; aroma therapy; hypnotism; massage therapy; rolfing; and other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.

In no event will we pay for charges that are: (A) not made or ordered by a doctor; or (B) not medically necessary to the diagnosis or treatment of an illness or injury.

MTI00276-27

Preexisting Conditions

A "preexisting condition" means a condition for which medical advice; diagnosis; care; or treatment was recommended to or received by a covered person within the 6 months immediately preceding the applicable effective date the covered person became insured under the policy.

Expenses due to a preexisting condition will not be covered during the first 12 months after the date the covered person becomes insured under the policy.

MTI00178-27

Term of Coverage and Renewability

The policy term begins as of the effective date of the policy. You may keep the policy in force by paying us the required premium as it comes due. However, we may cancel the policy if there is fraud or material misrepresentation made by or with the knowledge of a covered person in filing a claim.

Benefits will continue to be paid for an illness or injury after a person's coverage terminates, provided the illness or injury causes a period of extended loss that begins while the covered person is still covered by the policy.

MTI00179

Golden Rule Insurance Company
7440 Woodland Drive, Indianapolis, IN 46278-1719, (800) 657-8205

Outline of Coverage for Medical Expense Plans Plan 100® and Plan 80SM

(Please retain this outline for your records.)

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 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!

MTI00158

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 deductibles; copayment provisions; or other exclusions or limitations that may be set forth in the policy.

MTI00159

Medical Benefits

Covered expenses set forth in the policy include the charges:

A. Made by a hospital for:
   1. Daily room and board and nursing services at the most common semi-private room rate.
   2. Daily room and board and nursing services while confined in an intensive care unit, not to exceed the eligible expense.
   3. Inpatient use of an operating, treatment, or recovery room.
   4. Outpatient use of an operating, treatment, or recovery room for surgery.
   5. Other routine services and supplies provided to an inpatient.
   6. Emergency treatment of an illness or injury. However, charges for use of the emergency room itself for treatment of an illness will be reduced by $100 unless the covered person is directly admitted to the hospital for further treatment of that illness.

B. For surgery in a doctor's office or at an outpatient surgical facility.

C. Made by a doctor for professional services, including surgery.

D. Made by a doctor acting as an assistant surgeon, limited to 20 percent of the eligible expense for the surgical procedure.

E. For dressings, crutches, orthopedic braces, splints, casts, or other necessary medical supplies.

F. For diagnostic testing using radiologic, ultrasonographic, or laboratory services, but not including psychometric, behavioral, and educational testing.

G. For chemotherapy and radiation therapy or treatment.

H. For hemodialysis and hospital charges for processing and administration of blood or blood components.

I. For the cost and administration of oxygen or an anesthetic.

J. For dental expenses for a covered injury that results in damage to the natural teeth and expenses that are incurred within six months of the accident.

K. For treatment of craniomandibular disorders, malocclusions, or disorders of the temporomandibular joint, excluding tooth extraction and orthodontic devices and splints.

L. For artificial eyes or larynx, breast prosthesis, or basic artificial limbs (but not replacement unless required by a physical change in the person and the item cannot be modified.)

M. For one pair of foot orthotics per covered person.

N. For one mastectomy bra per year if the covered person has undergone a covered mastectomy.

O. For the rental of a standard hospital bed, a standard walker, a standard non-motorized wheelchair, a wheelchair cushion, and a ventilator.

P. For the cost of one Continuous Passive Motion machine per person following a covered joint surgery.

Q. For the cost of one wig per person, up to $500, that is necessitated by hair loss due to cancer treatments or traumatic burns.

R. For occupational therapy following a covered treatment for traumatic hand injuries.

S. For one pair of eyeglasses or contact lenses per person, up to $200, following a covered cataract surgery.

T. For routine annual mammograms, cervical or pap smears, digital rectal examinations and prostate specific antigen tests.

U. For colorectal cancer screenings in accordance with published guidelines.

V. For surveillance tests for ovarian cancer for females who are at risk.

W. For one human papillomavirus (HPV) test or screening each calendar year.

X. For administering the human papillomavirus vaccine to female covered persons.

Y. For breast reconstruction following a covered mastectomy, prostheses, and treatment for physical complications of mastectomy, including lymphedemas.

Z. For general anesthesia and dental care procedures provided in a hospital, an outpatient surgical facility, an emergency care facility, or a rural clinic, to a covered child who meets the criteria stated in the policy.

AA. For medication, equipment, supplies, and appliances to treat diabetes, and for diabetes self-management training and education.

BB. For enteral formulas and special food products prescribed for the treatment of inherited metabolic diseases.

CC. For medical treatment as part of a clinical trial or study, subject to the conditions stated in the policy.

DD. For emergency ground or air ambulance service to the nearest hospital or the nearest neonatal special care unit for newborns.

EE. For outpatient prescription drugs that must be prescribed by a doctor, limited to a 34-day supply for each prescription or refill (excludes drugs for addiction to, or dependency on, tobacco or foods).

MTI00280-27

Preventive Care: Covered expenses include charges for the following when incurred for preventive care: (A) routine office visits; (B) childhood immunizations; (C) adult immunizations; (D) urinalysis and blood tests; (E) bone density screenings; (F) electrocardiograms (EKGs); and (G) cardiac stress tests.

Preventive care expense benefits will not include CAT or CT scans, or MRIs or PET scans performed on a routine or preventive basis.

MTI00289

Transplant Benefits: The following types of tissue transplants are covered expenses: cornea transplants; artery or vein grafts; heart valve grafts; prosthetic tissue replacement (including joint replacement); and implantable prosthetic lenses in connection with cataracts. The policy also provides coverage for listed transplants, which include heart; lung; heart/lung; kidney; and liver transplants; and bone marrow transplants as listed in the policy. The amount of benefits under the policy for a listed transplant depends upon whether it is performed in one of our Centers of Excellence.

MTI00162

Home Health Care Benefits: The policy provides benefits for home health care. Benefits for home health aide services are limited to 7 visits per week and a lifetime maximum of 365 visits. Benefits for outpatient private duty registered nurse services are limited to a lifetime maximum of 1,000 hours. Benefits for intermittent private duty registered nurse services are limited to $75 per visit.

MTI00163

Hospice Care Expense Benefits: The policy provides benefits for hospice care for a terminally ill covered person who receives medically necessary care under a hospice care program, limited to 180 days in a covered person's lifetime.

MTI00164

Rehabilitation and Extended Care Facility Expense Benefits: The policy provides benefits for rehabilitation services or an inpatient stay in a rehabilitation facility or extended care facility 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. Covered expenses are limited to 60 days per calendar year for each covered person.

MTI00165

Limitation on Spine and Back Disorders: If the diagnosis or treatment of a spine or back disorder is rendered to a covered person while an outpatient, covered expenses for the doctor's fees and all services and supplies will be limited to no limit.

MTI00166-27

Limitation on Mental Disorders and Severe Mental Illnesses: Benefits for treatment of severe mental illness, as defined in the policy, are limited to 40 days of inpatient treatment per covered person per calendar year and 40 visits for outpatient treatment per covered person per calendar year, excluding visits for management of medications. Covered expenses for outpatient diagnosis or treatment of mental disorders that are not severe mental illnesses are limited to no limit per visit and a lifetime maximum limit of no limit per covered person.

MTI00167-27

Amount Payable

Definitions:

"Coinsurance percentage" means the percentage of covered expenses that are payable by us, as shown on the policy Data Page.

"Deductible amount" means the amount of covered expenses that must be paid by each covered person before any benefits are payable.

"Eligible expense" means a covered expense that is determined as follows:

A. For network providers (excluding Transplant Benefits), the eligible expense is the contracted fee with that provider.

B. For non-network providers:
   1. The eligible expense is the lesser of the billed charge or a lower amount negotiated with the provider or authorized by state law for covered expenses that are:
      (a) Received as a result of an emergency;
      (b) Otherwise approved by us; or
      (c) For a service or supply that is not of a type provided by any network provider.

2. Except as provided under 1 above, when a covered expense (excluding Transplant Benefits) is received from a non-network provider, the eligible expense is determined based on:
   (a) The fee that has been negotiated with the provider; or
   (b) 110% of the fee Medicare allows for the same or similar services provided in the same geographical area; or
   (c) The fee established by us by comparing rates from one or more regional or national databases or schedules for the same or similar services from a geographical area determined by us; or
   (d) The fee charged by the provider for the services; or
   (e) A fee schedule that we develop.

MTI00316-NVD

Amount Payable: The total amount payable for each covered person under the policy will not exceed the maximum benefit limit shown as no limit.

We will pay the applicable coinsurance percentage in excess of the applicable deductible amount for a service or supply that qualifies as a covered expense and is received while the covered person's coverage is in force under the policy, if the charge for the service or supply qualifies as an eligible expense.

The amount payable will be subject to any specific benefit limits stated in the policy, a determination of eligible expenses, and any reduction for expenses incurred at a non-network provider.

Non-emergency non-network eligible expenses will be reduced by 25% before application of any applicable deductible amount(s), coinsurance provisions, and/or copayment amounts.

Note: The bill you receive for services or supplies from a non-network provider may be significantly higher than the eligible expenses for those services or supplies. In addition to the deductible amount, coinsurance, and copayment, you are responsible for the difference between the eligible expense and the amount the provider bills you for the services or supplies. Any amount you must pay to the provider in excess of the eligible expenses will not apply to your deductible amount or maximum out-of-pocket expenses.

MTI00317-NVD

Deductible Credit: A covered person will be eligible for a credit if, in any given calendar year, he or she did not meet the applicable deductible amount, and has been a covered person for at least 6 consecutive months. The deductible credit will apply to the deductible amount in the following calendar year.

MTI00301-NVD

Notification

You must notify us on or before the day a covered person begins the 4th day of an inpatient hospitalization or is evaluated for an organ or tissue transplant. If you fail to notify us, benefits will be reduced to 80% of the regular policy benefits, up to a maximum reduction of $1,000. This does not apply to an inpatient hospital admission for emergency treatment.

MTI00173

What Is Not Covered

No benefits will be paid for: (A) loss for which no charge would be made in the absence of insurance; (B) charges that are actually the responsibility of the provider to pay; (C) any services performed by a member of a covered person's immediate family; or (D) services not identified as covered expenses under the policy.

Covered expenses will not include, and no benefits will be paid for any charges that are incurred:

A. For services and supplies provided prior to the effective date or after the termination date of the policy.
B. For any portion of the charges that are in excess of the eligible expense.
C. For weight modification or surgical treatment of obesity, including wiring of the teeth and all forms of intestinal bypass surgery.
D. For breast reduction or augmentation.
E. For modification of the physical body to improve the psychological, mental, or emotional well-being of the covered person, such as sex-change surgery.
F. For any drug, treatment, or procedure that promotes conception, including, but not limited to, artificial insemination or treatment for infertility or impotency; for sterilization or reversal of sterilization; or for abortion (unless a pregnancy carried to term would endanger the mother's life).
G. For routine well-baby care of a newborn infant.
H. For television, telephone, or expenses for other persons.
I. For marriage, family, or child counseling for the treatment of premarital, marriage, family, or child relationship dysfunctions.
J. For telephone consultations or failure to keep a scheduled appointment.
K. For stand-by availability of a doctor when no treatment is rendered.
L. For dental expenses, including braces, or surgery and treatment for oral surgery, except as described in the policy.
M. For cosmetic treatment, except reconstructive surgery that is incidental to or follows surgery or an injury that was covered under the policy or is performed to correct a birth defect in a child who has been covered under the policy since birth.
N. For diagnosis or treatment of: learning disabilities; attitudinal disorders; or disciplinary problems.
O. For diagnosis or treatment of nicotine addiction.
P. For charges related to, or in preparation for, tissue or organ transplants, except as expressly provided for by the policy.
Q. For high dose chemotherapy prior to, in conjunction with, or supported by bone marrow transplant, except as specifically provided by the policy.
R. For eye refractive surgery when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism.
S. While confined primarily to receive rehabilitation, custodial care, educational care, or nursing services (unless expressly provided for by the policy).
T. For vocational or recreational therapy, vocational rehabilitation, occupational therapy , or outpatient speech therapy, except as provided by the policy.
U. For eyeglasses, contact lenses, hearing aids, eye refraction, visual therapy, or for any related examinations or fittings.
V. For pregnancy (except complications of pregnancy) or for confinement primarily for well-baby care.
W. For treatment of mental disorders, except as provided by the policy.
X. For treatment of substance abuse.
Y. For preventive or prophylactic care, including routine physical examinations, premarital examinations, and educational programs, except as provided by the policy.
Z. For experimental or investigational treatment or for unproven services, as defined in the policy.
AA. For expenses incurred outside of the United States, except for emergency treatment.
BB. For injury or illness caused by employment, except as may be covered by the policy.
CC. As a result of intentionally self-inflicted bodily harm (whether sane or insane); an injury or illness caused by an act of war; from taking part in a riot; or from the commission of a felony.
DD. For durable medical equipment, except as expressly provided for by the policy.
EE. For or related to surrogate parenting.
FF. For or related to treatment of hyperhidrosis (excessive sweating).
GG. For fetal reduction surgery.
HH. Except as expressly provided for by the policy, expenses for alternative treatments, including acupressure; acupuncture; aroma therapy; hypnotism; massage therapy; rolfing; and other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.

In no event will we pay for charges that are: (A) not made or ordered by a doctor; or (B) not medically necessary to the diagnosis or treatment of an illness or injury.

MTI00288-27

Preexisting Conditions

A "preexisting condition" means a condition for which medical advice; diagnosis; care; or treatment was recommended to or received by a covered person within the 6 months immediately preceding the applicable effective date the covered person became insured under the policy.

Expenses due to a preexisting condition will not be covered during the first 12 months after the date the covered person becomes insured under the policy.

MTI00178-27

Term of Coverage and Renewability

The policy term begins as of the effective date of the policy. You may keep the policy in force by paying us the required premium as it comes due. However, we may cancel the policy if there is fraud or material misrepresentation made by or with the knowledge of a covered person in filing a claim.

Benefits will continue to be paid for an illness or injury after a person's coverage terminates, provided the illness or injury causes a period of extended loss that begins while the covered person is still covered by the policy.

MTI00179

Golden Rule Insurance Company
7440 Woodland Drive, Indianapolis, IN 46278-1719, (800) 657-8205

Outline of Coverage for Medical Expense Plans HSA 100® and HSA 70℠

(Please retain this outline for your records.)

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 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!

MTI00158

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 deductibles; copayment provisions; or other exclusions or limitations that may be set forth in the policy.

MTI00159

Medical Benefits

Covered expenses set forth in the policy include the charges:

A. Made by a hospital for:
   1. Daily room and board and nursing services at the most common semi-private room rate.
   2. Daily room and board and nursing services while confined in an intensive care unit, not to exceed the eligible expense.
   3. Inpatient use of an operating, treatment, or recovery room.
   4. Outpatient use of an operating, treatment, or recovery room for surgery.
   5. Other routine services and supplies provided to an inpatient.
   6. Emergency treatment of an illness or injury.

B. For surgery in a doctor's office or at an outpatient surgical facility.

C. Made by a doctor for professional services, including surgery.

D. Made by a doctor acting as an assistant surgeon, limited to 20 percent of the eligible expense for the surgical procedure.

E. For dressings, crutches, orthopedic braces, splints, casts, or other necessary medical supplies.

F. For diagnostic testing using radiologic, ultrasonographic, or laboratory services, but not including psychometric, behavioral, and educational testing.

G. For chemotherapy and radiation therapy or treatment.

H. For hemodialysis and hospital charges for processing and administration of blood or blood components.

I. For the cost and administration of oxygen or an anesthetic.

J. For dental expenses for a covered injury that results in damage to the natural teeth and expenses that are incurred within six months of the accident.

K. For treatment of craniomandibular disorders, malocclusions, or disorders of the temporomandibular joint, excluding tooth extraction and orthodontic devices and splints.

L. For artificial eyes or larynx, breast prosthesis, or basic artificial limbs (but not replacement unless required by a physical change in the person and the item cannot be modified.)

M. For one pair of foot orthotics per covered person.

N. For one mastectomy bra per year if the covered person has undergone a covered mastectomy.

O. For the rental of a standard hospital bed, a standard walker, a standard non-motorized wheelchair, a wheelchair cushion, and a ventilator.

P. For the cost of one Continuous Passive Motion machine per person following a covered joint surgery.

Q. For the cost of one wig per person, up to $500, that is necessitated by hair loss due to cancer treatments or traumatic burns.

R. For occupational therapy following a covered treatment for traumatic hand injuries.

S. For one pair of eyeglasses or contact lenses per person, up to $200, following a covered cataract surgery.

T. For routine annual mammograms, cervical or pap smears, digital rectal examinations and prostate specific antigen tests.

U. For administering the human papillomavirus vaccine to female covered persons.

V. For colorectal cancer screenings in accordance with published guidelines.

W. For surveillance tests for ovarian cancer for females who are at risk.

X. For breast reconstruction following a covered mastectomy, prostheses, and treatment for physical complications of mastectomy, including lymphedemas.

Y. For general anesthesia and dental care procedures provided in a hospital, an outpatient surgical facility, an emergency care facility, or a rural clinic, to a covered child who meets the criteria stated in the policy.

Z. For medication, equipment, supplies, and appliances to treat diabetes, and diabetes self-management training and education.

AA. For enteral formulas and special food products prescribed for the treatment of inherited metabolic diseases.

BB. For medical treatment as part of a clinical trial or study, subject to the conditions stated in the policy.

CC. For emergency ground or air ambulance service to the nearest hospital or the nearest neonatal special care unit for newborns.

DD. For outpatient prescription drugs that must be prescribed by a doctor, limited to a 34-day supply for each prescription or refill (excludes drugs for addiction to, or dependency on, tobacco or foods).

MTI00280-27-H

Preventive Care: Covered expenses include charges for the following when incurred for preventive care: (A) routine office visits; (B) childhood immunizations; (C) adult immunizations; (D) urinalysis and blood tests; (E) bone density screenings; (F) electrocardiograms (EKGs); (G) cardiac stress tests; (H) mammography screenings; (I) cervical smears and pap smears; (J) prostate specific antigen tests and digital rectal examinations; and (K) FDA-approved screenings for the detection of the human papillomavirus (HPV) and vaccinations for HPV.

Preventive care expense benefits will not include CAT or CT scans, or MRIs or PET scans performed on a routine or preventive basis.

MTI00289

Transplant Benefits: The following types of tissue transplants are covered expenses: cornea transplants; artery or vein grafts; heart valve grafts; prosthetic tissue replacement (including joint replacement); and implantable prosthetic lenses in connection with cataracts. The policy also provides coverage for listed transplants, which include heart; lung; heart/lung; kidney; and liver transplants; and bone marrow transplants as listed in the policy. The amount of benefits under the policy for a listed transplant depends upon whether it is performed in one of our Centers of Excellence.

MTI00162

Home Health Care Benefits: The policy provides benefits for home health care. Benefits for home health aide services are limited to 7 visits per week and a lifetime maximum of 365 visits. Benefits for outpatient private duty registered nurse services are limited to a lifetime maximum of 1,000 hours. Benefits for intermittent private duty registered nurse services are limited to $75 per visit.

MTI00163

Hospice Care Expense Benefits: The policy provides benefits for hospice care for a terminally ill covered person who receives medically necessary care under a hospice care program, limited to 180 days in a covered person's lifetime.

MTI00164

Rehabilitation and Extended Care Facility Expense Benefits: The policy provides benefits for rehabilitation services or an inpatient stay in a rehabilitation facility or extended care facility 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. Covered expenses are limited to 60 days per calendar year for each covered person.

MTI00165

Limitation on Spine and Back Disorders: If the diagnosis or treatment of a spine or back disorder is rendered to a covered person while an outpatient, covered expenses for the doctor's fees and all services and supplies will be limited to no limit.

MTI00166-27

Limitation on Mental Disorders and Severe Mental Illnesses: Benefits for treatment of severe mental illness, as defined in the policy, are limited to 40 days of inpatient treatment per covered person per calendar year and 40 visits for outpatient treatment per covered person per calendar year, excluding visits for management of medications. Covered expenses for outpatient diagnosis or treatment of mental disorders that are not severe mental illnesses are limited to no limit per visit and a lifetime maximum limit of no limit per covered person.

MTI00167-27

Amount Payable

Definitions:

"Coinsurance percentage" means the percentage of covered expenses that are payable by us, as shown on the policy Data Page.

"Deductible amount" means the amount of covered expenses that must be paid by all covered persons before any benefits are payable.

"Eligible expense" means a covered expense that is determined as follows:

A. For network providers (excluding Transplant Benefits), the eligible expense is the contracted fee with that provider.

B. For non-network providers:
   1. The eligible expense is the lesser of the billed charge or a lower amount negotiated with the provider or authorized by state law for covered expenses that are:
      (a) Received as a result of an emergency;
      (b) Otherwise approved by us; or
      (c) For a service or supply that is not of a type provided by any network provider.
   2. Except as provided under 1 above, when a covered expense (excluding Transplant Benefits) is received from a non-network provider, the eligible expense is determined based on:
      (a) The fee that has been negotiated with the provider; or
      (b) 110% of the fee Medicare allows for the same or similar services provided in the same geographical area; or
      (c) The fee established by us by comparing rates from one or more regional or national databases or schedules for the same or similar services from a geographical area determined by us; or
      (d) The fee charged by the provider for the services; or
      (e) A fee schedule that we develop.

MTI00316-NVD-H

Amount Payable: The total amount payable for each covered person under the policy will not exceed the maximum benefit limit shown as no limit.

We will pay the applicable coinsurance percentage in excess of the applicable deductible amount for a service or supply that qualifies as a covered expense and is received while the covered person's coverage is in force under the policy, if the charge for the service or supply qualifies as an eligible expense.

The amount payable will be subject to any specific benefit limits stated in the policy, a determination of eligible expenses, and any reduction for expenses incurred at a non-network provider.

Non-emergency non-network eligible expenses will be reduced by 25% before application of any applicable deductible amount(s), coinsurance provisions, and/or copayment amounts.

Note: The bill you receive for services or supplies from a non-network provider may be significantly higher than the eligible expenses for those services or supplies. In addition to the deductible amount, coinsurance, and copayment, you are responsible for the difference between the eligible expense and the amount the provider bills you for the services or supplies. Any amount you must pay to the provider in excess of the eligible expenses will not apply to your deductible amount or maximum out-of-pocket expenses.

MTI00317-NVD

Deductible Credit: A covered person will be eligible for a credit if, in any given calendar year, he or she did not meet the applicable deductible amount, and has been a covered person for at least 6 consecutive months. The deductible credit will apply to the deductible amount in the following calendar year.

MTI00301-NVD

Notification

You must notify us on or before the day a covered person begins the 4th day of an inpatient hospitalization or is evaluated for an organ or tissue transplant. If you fail to notify us, benefits will be reduced to 80% of the regular policy benefits, up to a maximum reduction of $1,000. This does not apply to an inpatient hospital admission for emergency treatment.

MTI00173

What Is Not Covered

No benefits will be paid for: (A) loss for which no charge would be made in the absence of insurance; (B) charges that are actually the responsibility of the provider to pay; (C) any services performed by a member of a covered person's immediate family; or (D) services not identified as covered expenses under the policy.

Covered expenses will not include, and no benefits will be paid for any charges that are incurred:

A. For services and supplies provided prior to the effective date or after the termination date of the policy.
B. For any portion of the charges that are in excess of the eligible expense.
C. For weight modification or surgical treatment of obesity, including wiring of the teeth and all forms of intestinal bypass surgery.
D. For breast reduction or augmentation.
E. For modification of the physical body to improve the psychological, mental, or emotional well-being of the covered person, such as sex-change surgery.
F. For any drug, treatment, or procedure that promotes conception, including, but not limited to, artificial insemination or treatment for infertility or impotency; for sterilization or reversal of sterilization; or for abortion (unless a pregnancy carried to term would endanger the mother's life).
G. For routine well-baby care of a newborn infant.
H. For television, telephone, or expenses for other persons.
I. For marriage, family, or child counseling for the treatment of premarital, marriage, family, or child relationship dysfunctions.
J. For telephone consultations or failure to keep a scheduled appointment.
K. For stand-by availability of a doctor when no treatment is rendered.
L. For dental expenses, including braces, or surgery and treatment for oral surgery, except as described in the policy.
M. For cosmetic treatment, except reconstructive surgery that is incidental to or follows surgery or an injury that was covered under the policy or is performed to correct a birth defect in a child who has been covered under the policy since birth.
N. For diagnosis or treatment of: learning disabilities; attitudinal disorders; or disciplinary problems.
O. For diagnosis or treatment of nicotine addiction.
P. For charges related to, or in preparation for, tissue or organ transplants, except as expressly provided for by the policy.
Q. For high dose chemotherapy prior to, in conjunction with, or supported by bone marrow transplant, except as specifically provided by the policy.
R. For eye refractive surgery when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism.
S. While confined primarily to receive rehabilitation, custodial care, educational care, or nursing services (unless expressly provided for by the policy).
T. For vocational or recreational therapy, vocational rehabilitation, occupational therapy , or outpatient speech therapy, except as provided by the policy.
U. For eyeglasses, contact lenses, hearing aids, eye refraction, visual therapy, or for any related examinations or fittings.
V. For pregnancy (except complications of pregnancy) or for confinement primarily for well-baby care.
W. For treatment of mental disorders, except as provided by the policy.
X. For treatment of substance abuse.
Y. For preventive or prophylactic care, including routine physical examinations, premarital examinations, and educational programs, except as provided by the policy.
Z. For experimental investigational treatment or for unproven services, as defined in the policy.
AA. For expenses incurred outside of the United States, except for emergency treatment.
BB. For injury or illness caused by employment, except as may be covered by the policy.
CC. As a result of intentionally self-inflicted bodily harm (whether sane or insane); an injury or illness caused by an act of war; from taking part in a riot; or from the commission of a felony.
DD. For durable medical equipment, except as expressly provided for by the policy.
EE. For or related to surrogate parenting.
FF. For or related to treatment of hyperhidrosis (excessive sweating).
GG. For fetal reduction surgery.
HH. Except as expressly provided for by the policy, expenses for alternative treatments, including acupressure; acupuncture; aroma therapy; hypnotism; massage therapy; rolfing; and other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.

In no event will we pay for charges that are: (A) not made or ordered by a doctor; or (B) not medically necessary to the diagnosis or treatment of an illness or injury.

MTI00288-27

Preexisting Conditions

A "preexisting condition" means a condition for which medical advice; diagnosis; care; or treatment was recommended to or received by a covered person within the 6 months immediately preceding the applicable effective date the covered person became insured under the policy.

Expenses due to a preexisting condition will not be covered during the first 12 months after the date the covered person becomes insured under the policy.

MTI00178-27

Term of Coverage and Renewability

The policy term begins as of the effective date of the policy. You may keep the policy in force by paying us the required premium as it comes due. However, we may cancel the policy if there is fraud or material misrepresentation made by or with the knowledge of a covered person in filing a claim.

Benefits will continue to be paid for an illness or injury after a person's coverage terminates, provided the illness or injury causes a period of extended loss that begins while the covered person is still covered by the policy.

MTI00179

NOTICE OF INFORMATION 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 information we maintain that reasonably can be used to identify you and that relates to your physical or mental health or condition, the provision of health care to you, or the payment for such health care.

We 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 websites located at *www.goldenrule.com* or *www.eams.com*

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); and
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected.

We have the right to use and disclose health information 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. We may use your health information for underwriting purposes; however, we are prohibited by law from using or disclosing genetic information for underwriting purposes.
- **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:

- **As Required by Law.** We may disclose information when required by law.
- **To Persons Involved With Your Care.** We may use or disclose your health information to a person involved in your care, such as a family member, when you are incapacitated or in an emergency, or when 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.
- **To Correctional Institutions or Law Enforcement Officials** if you are an inmate of a correctional institution or under the custody of a law enforcement official, but only if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
- **To Business Associates** that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. Our business associates are required, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract. As of 2/17/10, our business associates are also directly subject to federal privacy laws.
- **For Data Breach Notification Purposes.** We may use your contact information to provide legally-required notices of unauthorized acquisition, access, or disclosure of your health information.
- **Additional Restrictions on Use and Disclosure.** Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. "Highly confidential information" may include confidential information under federal laws governing alcohol and drug abuse information and genetic information as well as state laws that often protect the following types of information: HIV/AIDS; mental health; genetic tests; alcohol and drug abuse; sexually transmitted diseases and reproductive health information; and child or adult abuse or neglect, including sexual assault.

If none of the above reasons applies, **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. Authorization is required for the use and disclosure of psychotherapy notes or for marketing. 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 and 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 request that a provider not send health information** to us in certain circumstances if the health information concerns a health-care item or service for which you have paid the provider out of pocket in full.
- **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). We will accommodate reasonable requests where a disclosure of all or part of your health information otherwise could endanger you. We will accept verbal requests to receive confidential communications, but request to modify or cancel a previous confidential communication request must be made in writing. Mail your request to the address listed below.
- **You have the right to see and obtain a copy** of health information that 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 certain disclosures of your information made by us during the six years prior to your request. This accounting will not include disclosures of information: (i) 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) 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 websites, *www.eAMS.com* or *www.goldenrule.com*.
- In New Mexico, you have the right to be considered a protected person. A "protected person" is a victim of domestic abuse who also is either: (1) an applicant for insurance with us: (2) a person who is or may be covered by our insurance; or (3) someone who has a claim for benefits under our insurance.

Exercising Your Rights

- **Contacting your Health Plan.** If you have any questions about this notice or want to exercise any of your rights, 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:
- Privacy Officer, Golden Rule Insurance Company, 7440 Woodland Drive, Indianapolis, IN 47278-1719
- **You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint.** We will not take any action against you for filing a complaint.

Fair Credit Reporting Act Notice

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

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

Medical Information Bureau

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

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

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

FINANCIAL INFORMATION PRIVACY NOTICE

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.

Send written requests to access, correct, amend or delete information to:

- Privacy Officer, Golden Rule Insurance Company, 7440 Woodland Drive, Indianapolis, IN 47278-1719

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 November 2010, 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, UnitedHealthcare Insurance Company, All Savers Insurance Company; and All Savers Life Insurance Company of California.

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

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 FIVE 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).
2. All medical examinations, if required, have been satisfactorily completed.
3. The persons proposed for insurance must be, on the effective date, 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.
4. The first full premium, according to the mode of premium payment chosen, has been paid on or prior to the effective date, and any check is honored on first presentation for payment.
5. The policy 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 policy or to issue a specially ridered policy.

Limitation:

If, for any reason, Golden Rule declines to issue a policy or issues a policy other than a standard policy 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.
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 ELECTRONIC FUNDS TRANSFER (EFT)

I (we) hereby authorize Golden Rule to initiate debit entries to the account indicated below. I also authorize the named depository to debit the same to such account.

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

In Tennessee and Texas, drafts may only be scheduled on 1) the premium due date; or 2) up to 10 days after the due date.

KEEP THIS DOCUMENT.
IT HAS IMPORTANT INFORMATION.

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, pharmacy benefit manager, consumer-reporting agency, MIB, Inc., formerly known as 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.

36228-G-1111

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.

Personal Health Insurance Built With You in Mind

Pick Your Doctor and Hospital

UnitedHealthOne[SM] plans offer one of the nation's largest networks of doctors and hospitals, with 754,000 physicians and other health care professionals and 5,400 hospitals in the U.S.[1]

To find or view network providers for any network, visit ***www.goldenrule.com*** and click on Find A Doctor.

Significant Savings to Help YOU.

Quality Care at Significant Savings
Providers in our extensive network agree to lower fees — you can save up to 50% on quality care[2].

No Referral Needed
With our health plans, you don't need a referral to see a specialist. See a specialist in our network and benefit from our discounts.

Deductible Credit

Think of it as a reward for being healthy!
When you don't meet your calendar-year network deductible, UnitedHealthOne[SM] plans reward you by lowering next year's deductible out-of-pocket exposure by 20%. After three consecutive years, you have a 50% credit towards your deductible during the fourth year[3].

Our Goal is Your Satisfaction

We recognize that your time is valuable. We process more than 94% of all health insurance claims within 10 working days or less[4].

[1] UnitedHealth Group Annual Form 10-K for year ended 12/31/2011. Available in most areas.

[2] Discounts vary by provider, geographic area and type of service.

[3] Eligibility requirements must be met. Subject to qualified Health Savings Account requirements.

[4] Actual 2011 results.

UnitedHealthOne

39317-G-0312

Health Savings Account Options

About Your HSA

We have chosen **OptumHealth Bank**, Member FDIC, a leading administrator of health savings accounts (HSA), as our recommended financial institution. Your HSA funds are deposited at OptumHealth Bank in a custodial account. OptumHealth Bank will service your account and send information directly to you about your HSA.

You will receive your new OptumHealth Bank Health Savings Account Debit MasterCard® and PIN 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 OptumHealth Bank fee. In addition, the bank/ATM you use to withdraw funds may charge you its own fee (variable by bank) for the transaction.)

You can also access your HSA funds through:

- Online bill payment at *www.OptumHealthBank.com*
- Checks, if you choose to purchase them.

HSA deposits are set up on the same payment plan as premiums for Golden Rule health insurance coverage. Lump-sum deposits are also accepted by OptumHealth Bank. OptumHealth Bank will provide online monthly statements detailing your account balance and activity. If you prefer to have statements mailed to your home, simply notify OptumHealth Bank. You can opt out of electronic statements at its website (*www.OptumHealthBank.com*), call customer service to do so, or send your request to P.O. Box 271629, Salt Lake City, UT 84127-1629.

Account Information by Phone or Online

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

- Toll-free customer service — representatives are available to assist you Monday through Friday, 8 a.m. to 8 p.m. Eastern time, at (866) 234-8913.
- Interactive voice response for self-service, 24/7.
- *www.OptumHealthBank.com*

You can:

- Make contributions to your HSA.
- Pay bills online.
- 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.

OptumHealthBank℠

38959-G-0412

HSA Management by OptumHealth Bank

Monthly FDIC eAccess Savings Account Maintenance Fee	Monthly Investment Fee	Other Possible Fees
$1 - average balance less than $500 **No Fee** - average balance over $500	$3 (balance of $2,000 required to invest funds)	ATM withdrawal Check order Non-sufficient funds Stop payment

All of the fees associated with your account will be provided with your OptumHealth Bank Welcome Kit.

Maximum Deposit (Tax-Deductible Limit)	
2012	$3,100 for Singles, $ 6,250 for Families
Catch-up	Individuals aged 55+ may contribute an additional $1,000 for tax years 2011 & 2012

Who is responsible for my HSA?

As custodian, OptumHealth Bank is responsible for your HSA funds. OptumHealth Bank's deposits are insured by the Federal Deposit Insurance Corporation (FDIC).

Please be aware that the money market and mutual fund investment options are NOT guaranteed by OptumHealth Bank, are NOT FDIC-insured, and may lose value. **We encourage you to read the prospectus of each fund carefully before investing and seek the advice of an investment professional you trust.**

You will receive a OptumHealth Bank Health Savings Account Debit MasterCard® from OptumHealth 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.

Health Savings Accounts (HSA) — Summary of the Law

Eligibility — Those covered under an qualified high deductible health plan, and not covered by other health insurance (except for vision or dental or other limited 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 within specified limits

Qualified Medical Withdrawals — Tax-free

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

Nonmedical Withdrawals — Income tax + penalty tax (20% for those under age 65); income tax only (for age 65 and over)

Death, Disability — Income tax only — no penalty; If the spouse is listed as a beneficiary, the spouse can have the HSA transferred to their name — assume the HSA — no tax issue

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.

Optional Vision Benefit

Keep an eye on your family's vision health by adding our optional Vision Benefit rider to your health plan today. Our diverse vision care network today includes about 33,000 private practice and retail chain providers.* We'll help keep your family seeing clearly, so you can focus on savings!

We're here to help you.

Want to know if your eye doctor is in our network already? Use the Provider Locator link on ***www.myuhcvision.com/goldenrule*** to find a provider in your area. Once you are covered under a vision plan, you can use that site to access your vision insurance information, see your claim status, find general vision information, and more.

UnitedHealthcare Vision Benefit Rider

You may use a non-network provider, but by staying in-network you are eligible to receive better discounts:

- Eye exam — $10 copay – once every 12 months.
- Frames — $25 copay – once every 24 months.
- Lenses — $25 copay – once every 12 months.
- Contacts in lieu of glasses — $25 copay – once every 12 months.

See how you can save by using our Vision network

Service/Material	In-network You Pay	In-network We Pay[1]	Out-of-network We Pay
Eye exam once every 12 months	$ 10 copay	100%	Up to $ 40
Frames[3] once every 24 months	$ 25 copay[2]	100%	Up to $ 45
Single Vision lenses	$ 25 copay[2]	100%	Up to $ 40
Bifocal lenses	$ 25 copay[2]	100%	Up to $ 60
Trifocal or Lenticular lenses	$ 25 copay[2]	100%	Up to $ 80
Contacts[4] in lieu of glasses	$ 25 copay	100%	Up to $105

www.myuhcvision.com/goldenrule

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

[1] After copay. [2] Purchase frames and lenses at the same time from a Preferred Provider and you pay only one copay. [3] You will receive a $130 retail frame allowance towards the purchase of any frame at an in-network provider. [4] Contacts chosen from the Covered Contact Lens Selection at a Preferred Provider. Non-selection lenses will receive an allowance. No copay for non-selection Contact Lenses.

*Network availability may vary by state, and a specific vision care provider's contract status can change at any time. Therefore, before you receive care, it is recommended that you verify with the vision care provider that he or she is still contracted with the network.

Policy Form SA-S-1356R

UnitedHealthOne℠ is a brand name used for products underwritten by Golden Rule Insurance Company. This product is administered by Spectera, Inc. Additional premium is required. Availability varies by state. Please see the corresponding health product brochure and important information on the back of this page.

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UnitedHealthOne™

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Covered Expenses

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

- Comprehensive eye examinations. Benefits are limited to 1 exam per 12 months.
- Prescription eyewear. Benefits are limited to 1 pair of prescription single vision lenses per 12 months and 1 pair of frames per 24 months:
  - Spectacle lenses as prescribed by an ophthalmologist or optometrist; frames and their fitting and subsequent adjustments to maintain comfort and efficiency; or
  - Elective contact lenses that are in lieu of prescription spectacle lenses and frames; and
  - Medically necessary contact lenses and professional services when prescribed or received following cataract surgery or to correct extreme visual acuity problems that cannot be corrected with spectacle lenses.

Please Note: This vision benefit program is designed to cover vision needs rather than cosmetic extras. Cosmetic extras include: blended lenses, oversize lenses, photochromic lenses, tinted lenses except pink #1 or #2, progressive multifocal lenses, coating of a lens or lenses, laminating of a lens or lenses, frames that cost more than the plan allowance, cosmetic lenses, optional cosmetic processes, and UV (ultraviolet) protected lenses.

If you or your covered dependent select a cosmetic extra, the plan will pay the medically necessary costs of the allowed lenses and you or your covered dependent will be responsible for the additional cost of the cosmetic extra.

Definitions

- **Comprehensive eye examination** means an examination by an ophthalmologist or optometrist to determine the health of the eye, including glaucoma tests and refractive examinations to measure the eye for corrective lenses.
- **Medically necessary** means a comprehensive eye examination or prescription eyewear that is necessary and appropriate to determine the health of the eye or correct visual acuity. This determination will be made by us based on our consultation with an appropriate licensed ophthalmologist or optometrist. A comprehensive eye examination or prescription eyewear will not be considered medically necessary if: (A) it is provided only as a convenience to the covered person or provider; (B) it is not appropriate for the covered person's diagnosis or symptoms; or (C) it exceeds (in scope, duration, or intensity) that level of care that is needed to provide safe, adequate, and appropriate diagnosis or treatment to the covered person.
- **Vision benefit preferred provider** is an ophthalmologist or optometrist who has contracted with the vision benefit network and is licensed and otherwise qualified to practice vision care and/or provide vision care materials.
- **Vision benefit non-preferred provider** is any ophthalmologist, optometrist, optician, or other licensed and qualified vision care provider who has not contracted with the vision benefit network to provide vision care services and/or vision care materials.

List of CO Counties with No Participating UHC Vision Providers

Archuleta, Baca, Bent, Cheyenne, Clear Creek, Conejos, Costilla, Crowley, Custer, Dolores, Gilpin, Grand, Gunnison, Hinsdale, Huerfano, Jackson, Kiowa, Kit Carson, Lake, Mineral, Moffat, Ouray, Park, Pitkin, Rio Grande, Routt, Saguache, San Juan, San Miguel, Sedgwick, Summit, Teller, Washington, and Yuma.

Exclusions and Limitations:

No benefits are payable for the following vision expenses:

- Orthoptics or vision therapy training and any associated supplemental testing;
- Plano lenses (a lens with no prescription on it);
- Replacement of lenses and frames furnished under this plan which are lost or broken except at the normal intervals when services are otherwise available;
- Medical or surgical treatment of the eyes;
- Any eye examination or any corrective eyewear, required by an employer as a condition of employment;
- Corrective vision treatment of an experimental or investigative nature;
- Corrective surgical procedures such as, but not limited to, Radial Keratotomy (RK) and Photo-refractive Keratectomy (PRK);
- Elective contact lenses if prescription spectacle lenses and frames are received in any 12 month period;
- Prescription spectacle lenses and frames if elective contact lenses are received in any 24 month period;
- Eyewear except prescription eyewear;
- Charges that exceed the allowance amount; and
- Services or treatments that are already excluded in the General Exclusions and Limitations section of the certificate or policy.

Discounts on Laser Eye Surgery

An alliance with the Laser Vision Network of America allows our policyholders access to substantial discounts on laser eye surgery procedures from highly reputable providers throughout the U.S.
Laser eye surgery is a noncovered expense.

How the Vision Program Works — Important Coverage Information

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

A) **NETWORK** vision providers – after your copay, they agree to accept the plan payment as full reimbursement for covered expenses. Check our online list of providers. They are categorized in two ways:

a. Exam and Dispense – are contracted to provide eye exams and dispense glasses at discounted rates.

b. Exam Only – are contracted to provide exams ONLY at discounted rates.

B) **OUT-OF-NETWORK** vision providers – you must pay out-of-network providers in full at time of service. Then you submit itemized copies of receipts and request reimbursement from UnitedHealthcare Vision Claims Department. **Your out-of-pocket costs may be higher with an out-of-network provider.**