

Georgia

Health Plans

for individuals and families



UnitedHealthcare[®]
A UnitedHealth Group Company

Golden Rule[®]
A UnitedHealthcare Company

Why Choose Golden Rule?



Experience and Expertise

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

Product Leadership

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

Claims Satisfaction

At Golden Rule, we recognize the critical importance of being responsive to the service needs of our customers. That's why more than 94% of all health

insurance claims are processed within 10 working days or less.* With Golden Rule, you can be confident that your claims will be promptly processed.

Preferred Network Discounts

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

Strength in Numbers

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

* Actual 2005 results

** www.unitedhealthgroup.com

The Network Advantage

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

Savings-Based Networks

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

- Access to a broad network of physicians and hospitals to help reduce your costs; and
- Freedom to use non-network physicians and hospitals if Savings-Based Network providers aren't available in your area.

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

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

Preferred Networks

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

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

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

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

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

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

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



2 Copay Plans

Who might benefit most from a copay plan?

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



How Copay SelectSM Works

Convenient doctor office copay benefits

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

Adult and Child Preventive Care included

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

Prescription drug card benefits

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

Comprehensive Coverage for inpatient and outpatient medical expenses

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

Copay SaverSM

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

Copay Plans — Benefit Highlights

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

This chart only summarizes standard covered expenses, exclusions, and limitations of each plan. To be considered for reimbursement, expenses must qualify as covered expenses. Expenses are also subject to reasonable and customary limits unless you use a network. We recommend review of the more detailed plan information on pages 9-13.

4

Health Savings Account (HSA) Plans

Who might benefit most from an HSA plan?

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



How HSAs Work

HSA Plans offer quality coverage, savings

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

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

Your unspent savings roll over year after year.

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

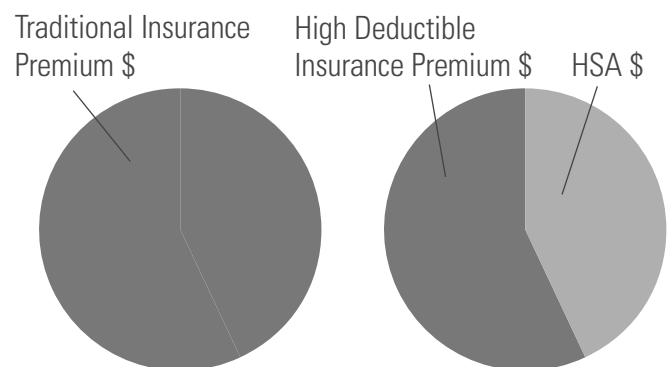
The money you save from reduced premiums can be put into your Health Savings Account — tax deductible.

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

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

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

*See HSA Insert for important information.



HSA Plans — Benefit Highlights

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

This chart only summarizes standard covered expenses, exclusions, and limitations of each plan. To be considered for reimbursement, expenses must qualify as covered expenses. Expenses are also subject to reasonable and customary limits unless you use a network. We recommend review of the more detailed plan information on pages 9-13.

6

High Deductible Plans

Who might benefit most from a high deductible plan?

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



How High Deductible Plans Work

Lower Premiums

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

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

Simple to use

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

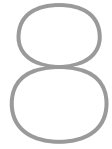
Comprehensive Coverage

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

High Deductible Plans — Benefit Highlights

	Plan 100®	Plan 80 SM	Saver 80 SM
Design Basics			
Network Type	Preferred or Savings-Based Network		
Calendar-Year Deductible Choices (maximum 2 per family, per calendar year)	\$2,500 \$3,500, \$5,000	\$2,500 \$3,500, \$5,000	\$500, \$1,000, \$1,500 \$2,500, \$3,500, \$5,000
Coinsurance (per covered person, per calendar year)	100%	80/20 to \$15,000 then 100%	80/20 to \$15,000 then 100%
Lifetime Maximum Benefit (per covered person)	\$3 million	\$3 million	\$3 million
Initial Rate Guarantee (subject to benefit and address changes)	12 months	12 months	12 months
Coverage percentages below are effective AFTER deductibles have been met unless otherwise indicated.			
Inpatient Expense Benefits			
Room and Board, Intensive Care Unit, Operating Room, Recovery Room, and Professional Fees of Doctors, Surgeons, Nurses	100%	80%	80%
Other Covered Inpatient Services	100%	80%	80%
Outpatient Expense Benefits			
Surgeon, Assistant Surgeon, and Facility Fees	100%	80%	80%
Hemodialysis, Radiation, Chemotherapy, and Organ Transplant Drugs	100%	80%	80%
CAT Scans, MRIs	100%	80%	80%
Outpatient X-ray and Lab	100%	80%	80% if performed within 14 days of surgery or confinement
Emergency Room Fees	100% — additional \$100 Copay for illness if not admitted	80% — additional \$100 Copay for illness if not admitted	80% — additional \$500 Copay if not admitted
Other Covered Outpatient Expenses	100%	80%	See page 10 for details
Routine Health Benefits			
Doctor Office Visit Fees	100%	80%	Not Covered
Outpatient Prescription Drugs (Preferred Price Card included with all plans)	100%	80%	Not Covered — Preferred Price Card Included
Mammography, Pap Smear, and PSA Testing	100%	80%	80%
Adult Preventive Care (Up to \$500 annually for each adult, 19 or older; subject to 3-month waiting period.)	100%	80%	Not Covered
Childhood Immunizations (Up to \$500 annually for ages 0-18; subject to 3-month waiting period.)	100%	80%	Not Covered
Optional Benefits	For a complete list, see page 8.		

This chart only summarizes standard covered expenses, exclusions, and limitations of each plan. To be considered for reimbursement, expenses must qualify as covered expenses. Expenses are also subject to reasonable and customary limits unless you use a network. We recommend review of the more detailed plan information on pages 9-13.



Optional Benefits

Optional Benefits

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

Preventive Care Benefits Package

(Not available with Copay SelectSM Plan.)

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

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

Prescription Drug Card Benefit

(Available only with Plan 100[®] and Plan 80SM.)

With this benefit, you can purchase:

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

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

Supplemental Accident Benefit

(Not available with HSA Plans.)

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

HSA Hospital Indemnity Rider

(See HSA Insert for details.)

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

Mental Disorders Benefit Rider

The state of Georgia requires that we offer an optional benefit for mental disorders that is different from the benefit already in the policy. Please see page 12 of this brochure for a description of the policy's benefit for mental disorders. The optional Mental Disorders Benefit Rider removes the policy's benefit and limits for mental disorders and replaces it with the following benefit and limits: inpatient diagnosis or treatment is limited to a maximum of 30 days per covered person per calendar year and outpatient diagnosis or treatment is limited to a maximum of 50 visits per covered person per calendar year.

Covered Expenses

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

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

Medical Expense Benefits

- Daily hospital room-and-board and nursing services at the most common semiprivate rate.
- Charges for intensive care unit.
- Hospital emergency room treatment of an injury or illness (subject to an additional \$100 copay each time the emergency room is used for an illness not resulting in confinement — does not apply to HSA Plans).
- Surgery at an outpatient surgical center.
- Professional fees of doctors and surgeons (but not for standby availability).
- Dressings, sutures, casts, or other necessary medical supplies.
- Professional fees for outpatient services of licensed physical therapists.
- Diagnostic testing using radiologic, ultrasonographic, or laboratory services, in or out of the hospital.
- Local ground ambulance service to the nearest hospital for necessary emergency care. Air ambulance, within U.S., if requested by police or medical authorities at the site of emergency.
- Charges for operating, treatment, or recovery room for surgery.
- Dental expenses due to an injury which damages natural teeth if expenses are incurred within six months.
- Surgical and non-surgical 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.
- Mammography, Pap smear, and PSA test fees.
- Artificial eyes, larynx, breast prosthesis, or basic artificial limbs (but not replacements).
- Child wellness services from birth until the child's sixth birthday (not subject to the calendar-year deductible). Adds benefits to Well Child Care/Immunizations on pages 3, 5, and 7.

Preventive Care Expense Benefits

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

For information on additional Plan provisions, including Transplant Expense Benefit, Notification Requirements, Preexisting Conditions, General Exclusions, General Limitations, and Other Plan Provisions, read pages 11-13.



Covered Expenses (continued)

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

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

Inpatient Expense Benefits

- Daily hospital room-and-board and nursing services at the most common semiprivate rate.
- Charges for intensive care unit.
- Drugs, medicines, dressings, sutures, casts, or other necessary medical supplies.
- Artificial limbs, eyes, larynx, or breast prosthesis (but not replacements).
- Professional fees of doctors and surgeons (but not for standby availability).
- Hemodialysis, processing, and administration of blood or components.
- Charges for an operating, treatment, or recovery room for surgery.
- Cost and administration of an anesthetic, oxygen, or other gases.
- Radiation therapy or chemotherapy and diagnostic tests using radiologic, ultrasonographic, or laboratory services.
- Local ground ambulance service to the nearest hospital for necessary emergency care. Air ambulance, within U.S., if requested by police or medical authorities at the site of the emergency.
- CAT scan and MRI testing.
- Diagnostic testing related to, and performed within, 14 days prior to surgery or inpatient confinement.
- Copay SaverSM plan includes two doctor office copay visits per year (see page 3).
- Generic outpatient prescription drugs (Copay SaverSM only).
- Child wellness services from birth until the child's sixth birthday (not subject to the calendar-year deductible). Adds benefits to Well Child Care/Immunizations on pages 3, 5, and 7.

Important note about Saver Plans:

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

Some outpatient expenses not covered under the Saver Plans include:

Outpatient Expense Benefits

- Charges for outpatient surgery, including the fee made by an outpatient surgical facility, the primary surgeon, the assistant surgeon, and/or administration of anesthetic.
- Hemodialysis, radiation, and chemotherapy.
- Prescription drugs to protect against organ rejection in transplant cases.
- Mammography, Pap smear, and PSA test fees.
- Hospital emergency room treatment of an injury or illness (subject to limitations shown on pages 3, 5, and 7).
- Outpatient doctor office visit fees (limited benefit provided under Copay SaverSM — see page 3), diagnostic testing, prescription drugs (except generic under Copay SaverSM plan), and other outpatient medical services not specifically listed under the Inpatient, Outpatient, or Transplant Expense Benefits;
- Outpatient professional fees of licensed physical therapists, durable medical equipment, and medical supplies, except those covered under the Home Health Care Expense Benefits;
- Outpatient expenses incurred for mental or nervous disorders or substance abuse; and
- Preventive care office visits (unless the optional Preventive Care Package is added).

Provisions That Apply to All Plans

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

Health Care Provider Networks

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

Transplant Expense Benefit

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

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

Transplants eligible for coverage under the Transplant Expense Benefit are:

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

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

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

The following conditions are eligible for bone marrow transplant coverage:

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

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

Home Health Care

To qualify for benefits, home health care must be:

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

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

Hospice Care

To qualify for benefits, a Hospice Care program for a terminally ill covered person must be licensed by the state in which it operates. Benefits for inpatient care in a hospice will be limited to 180 days in a covered person's lifetime. Covered expenses for room and board are limited to the most common semiprivate room rate of the hospital or nursing home with which the hospice is associated.

Notification Requirements

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

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

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

If it is impossible for you to notify us due to emergency inpatient hospital admission, you must contact us as soon as reasonably possible.

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

11

12 Preexisting Conditions

Preexisting conditions will not be covered during the first 12 months after an individual becomes a covered person. This exclusion will not apply to conditions 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 a covered person received medical advice or treatment within 24 months prior to the applicable effective date for coverage of the illness or injury; or (b) that manifested symptoms that would cause an ordinarily prudent person to seek diagnosis or treatment within 12 months prior to the applicable effective date for coverage of the illness or injury.

General Exclusions

No benefits are payable for expenses that:

- Are due to pregnancy (except for complications of pregnancy) or routine newborn care.
- Are for routine or preventive care unless provided for in the policy.
- Are incurred while confined primarily for custodial, rehabilitative, or educational care or nursing services.
- Result from employment-related injury or illness if the covered person is insured or is required to be insured, by Workers' Compensation insurance under applicable state or federal law.
- Are in relation to, or incurred in conjunction with, investigational treatment.
- Are for dental expenses or oral surgery, eyeglasses, contacts, eye refraction, hearing aids, or any examination or fitting related to these.
- Are for modification of the physical body, including breast reduction or augmentation.
- Are incurred for cosmetic or aesthetic reasons, such as weight modification or surgical treatment of obesity.
- Would not have been charged in the absence of insurance.
- Are for eye surgery to correct nearsightedness, farsightedness, or astigmatism.
- Result from war, intentionally self-inflicted bodily harm (whether sane or insane), or participation in a felony (whether or not charged).
- Are incurred for animal-to-human organ transplants, artificial or mechanical organs, procurement or transportation of the organ or tissue, or the cost of keeping a donor alive.

- Are incurred for marriage, family, or child counseling.
- Are for recreational or vocational therapy or rehabilitation.
- Are incurred for services performed by an immediate family member.
- Are not specifically provided for in the policy or are incurred while your policy is not in force.
- Are for any drug, treatment, or procedure that promotes conception.
- Are for any procedure that prevents childbirth.

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

General Limitations

- Covered expenses will not include more than what was determined to be the reasonable and customary charge for a service or supply.
- Transplants eligible for coverage under the Transplant Expense Benefit are limited to two transplants in a ten-year period.
- Charges for an assistant surgeon are limited to 20 percent of the primary surgeon's covered fee.
- All diagnoses or treatments of mental disorders, as defined in the policy, including substance abuse, will be limited to a lifetime maximum benefit of \$3,000. Covered expenses for outpatient diagnosis or treatment of mental disorders will be further limited to \$50 per visit. As with any other illness or injury, inpatient care that is primarily for educational or rehabilitative care will not be covered.
- Covered expenses will be limited to no more than a 34-day supply for any one outpatient prescription drug order or refill.

Effective Date

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

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

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 unmarried, living with and financially dependent on you, and under 19 years of age, or under 26 years of age if attending an accredited college or vocational school on a full-time basis.

Termination of a Covered Person

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

Continued Eligibility Requirements

A covered person's eligibility will cease on the date a covered person ceases to be a dependent.

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.

Prior to Legal Action

To help resolve disputes before litigation, the policy requests that you provide us with written notice of intent to sue prior to legal action. This notice must identify the source of the disagreement, including all relevant facts and information supporting your position.

Medicare — Carve-Out

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

14 Outline of Coverage for Policy Form GRI-PA-23.1-10

Copay SelectSM, HSA 100[®], 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!

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, coinsurance provisions, maximum dollar limits, copayment provisions, preexisting condition limitations, or other exclusions or limitations that may be set forth in the policy. (Note: Plans of this type provide coverage for the major costs of hospital, medical, and surgical care, in place of coverage of only basic costs as would be the case under a basic hospital or basic medical-surgical expense insurance plan.)

Benefits

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

- A. Hospital charges for daily room and board and nursing services and other hospital services while an inpatient.
- B. Inpatient or outpatient surgery.
- C. Emergency treatment of any illness or injury, subject to an emergency room deductible (except for HSA 100[®]) for each visit for an illness if the covered person is not directly admitted to the hospital for further treatment of that illness.
- D. Fees charged by doctors and medical practitioners.
- E. Outpatient prescription drugs.
- F. Diagnostic tests, routine screenings and tests, and child wellness services from birth to age 6.
- G. Necessary medical supplies.
- H. Basic artificial eyes, larynx, or breast prostheses, or basic artificial limbs.
- I. Rental of durable medical equipment.
- J. Ambulance services to the nearest hospital or neonatal special care unit.
- K. Organ or tissue transplants.
- L. Home health care provided through a licensed home health care agency.

- M. Hospice care for a terminally ill covered person.
- N. Charges made by a hospital, rehabilitation facility, or extended care facility for rehabilitation services or confinement in a rehabilitation facility or extended care facility.

The policy provides limited benefits for treatment of mental disorders and substance abuse.

Exclusions and Limitations

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

- A. Pregnancy or routine well-baby care. However, complications of pregnancy are covered.
- B. Work-related injuries or illness if the covered person is insured, or is required to be insured, by Workers' Compensation insurance.
- C. Routine physical examinations, immunizations, and educational programs. Optional coverage for routine physical exams and lab services for adults is available on some plans.
- D. Confinement primarily for custodial care, educational care, or nursing services.
- E. Vocational or recreational therapy, vocational rehabilitation, outpatient speech therapy, or occupational therapy.
- F. Investigational treatment.
- G. Dental expenses, braces, or oral surgery, except for injuries under certain conditions.
- H. Eyeglasses, contact lenses, hearing aids, visual therapy, or related examinations or fittings.
- I. Eye refractive surgery primarily to correct nearsightedness, farsightedness, or astigmatism.
- J. Cosmetic treatment, breast reduction or augmentation, or modification of the physical body to improve the person's well-being (such as sex-change surgery). However, reconstructive surgery is covered when it follows a covered surgery or injury or is performed to correct a birth defect in a child covered under the policy since birth.
- K. Weight modification or surgical treatment of obesity.
- L. A drug, treatment, or procedure that promotes conception or prevents childbirth.

- M. Injuries or illnesses as a result of:
 - (1) intentionally self-inflicted bodily harm (whether the covered person is sane or insane);
 - (2) any act of declared or undeclared war;
 - (3) participation in a riot;
 - (4) commission of a felony, whether or not charged; or
 - (5) being intoxicated or under the influence of an illegal narcotic or controlled substance that was not prescribed by a doctor.
- N. Services performed by a member of the covered person's immediate family.
- O. Charges that are:
 - (1) not actually incurred by a covered person;
 - (2) not administered or ordered by a doctor;
 - (3) not medically necessary to the diagnosis or treatment; or
 - (4) in excess of the reasonable and customary charge.

Unless otherwise provided for in the policy, expenses due to a preexisting condition will not be covered in the first 12 months after the date the covered person becomes insured under the policy. The preexisting condition limitation will not apply to a preexisting condition that was fully disclosed to us on the application for the policy and is not subject to a restrictive rider. A preexisting condition is an injury or illness: (A) for which medical advice, diagnosis, care, or treatment was recommended or received within 24 months before the covered person's effective date of coverage; or (B) that in the opinion of a doctor: (1) began prior to the covered person's effective date of coverage; or (2) manifested symptoms that would cause an ordinarily prudent person to seek medical advice, diagnosis, or treatment within the 12 months before the covered person's effective date of coverage.

Renewability

You may renew the policy for life by paying the premiums as they come due, or within the 31-day grace period that follows. We may decline to renew the policy only:

- A. For fraud or false statements made in filing a claim for policy benefits.
- B. For nonpayment of premiums when due.
- C. If we decline to renew all policies just like yours issued to residents of the state where you are then living. (This is explained in the Discontinuance clause in the policy.)

We will not change your premium because of the number of claims filed or because of a change in a covered person's health. Renewal premiums will be based on the rate table in effect on the premium due date. Your type of plan, age, sex, place of residence, the period the policy has been in force, and the type and level of benefits on the premium due date will be used to figure the required premium.

Outline of Coverage for Policy Form GRI-PA-22.1-10

Copay SaverSM, HSA Saver[®], and 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!**

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, coinsurance provisions, maximum dollar limits, copayment provisions, preexisting condition limitations, or other exclusions or limitations that may be set forth in the policy.

Benefits

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

- A. Charges incurred in a hospital for daily room and board and nursing services; use of an operating, treatment, or recovery room; diagnostic testing; chemotherapy and radiation therapy or treatment; anesthesia or oxygen; artificial eyes, larynx, breast prostheses, or basic artificial limbs; hemodialysis; the professional services of a medical practitioner; and other hospital services and supplies routinely provided for use by inpatients.
- B. Ambulance services to the nearest hospital or neonatal special care unit.
- C. Inpatient or outpatient surgery; the primary surgeon's fees; the fee charged by a medical practitioner acting as an assistant surgeon (limited to 20% of the reasonable and customary charge); outpatient use of an operating, treatment, or recovery room; anesthesia; outpatient surgical facility charges; and post-operative laboratory services.
- D. Emergency treatment of an illness or injury, subject to an emergency room deductible or limit for each visit for an illness if the covered person is not directly admitted to the hospital for further treatment of that illness.
- E. Breast reconstruction following a mastectomy.
- F. Outpatient preadmission and presurgical testing performed before a hospital stay or outpatient surgery.
- G. Outpatient catastrophic expenses, such as: radiation therapy; chemotherapy for the

treatment of cancer; hemodialysis; artificial eyes, larynx, breast prostheses, pacemaker, nerve stimulator, or basic artificial limbs; CAT scans and MRIs; and prescription drugs to protect against rejection of an organ or tissue transplant.

- H. Routine screenings and tests, and child wellness services from birth to age 6.
- I. Organ or tissue transplants.
- J. Home health care provided through a licensed home health care agency.
- K. Hospice care for a terminally ill covered person.
- L. Charges made by a hospital, rehabilitation facility, or extended care facility for rehabilitation services or confinement in a rehabilitation facility or extended care facility.

Exclusions and Limitations

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

- A. Pregnancy or routine well-baby care. However, complications of pregnancy are covered.
- B. Treatment of mental disorders or substance abuse.
- C. Work-related injuries or illness if the covered person is insured, or is required to be insured, by Workers' Compensation insurance.
- D. Vocational or recreational therapy, vocational rehabilitation, outpatient speech therapy, or occupational therapy.
- E. Confinement primarily for custodial care, educational care, or nursing services.
- F. Investigational treatment.
- G. Dental expenses, braces, or oral surgery, except for injuries under certain conditions.
- H. Outpatient drugs and medicines, with or without a doctor's prescription (except generic under Copay SaverSM).
- I. Eye refractive surgery primarily to correct nearsightedness, farsightedness, or astigmatism.
- J. Cosmetic treatment, breast reduction or augmentation, or modification of the physical body to improve the person's well-being (such as sex-change surgery). However, reconstructive surgery is covered when it follows a covered surgery or injury or is performed to correct a birth defect in a child covered under the policy since birth.
- K. Weight modification or surgical treatment of obesity.
- L. A drug, treatment, or procedure that promotes or prevents conception or prevents childbirth.

- M. Injuries or illnesses as a result of:
 - (1) intentionally self-inflicted bodily harm (whether the covered person is sane or insane);
 - (2) any act of declared or undeclared war;
 - (3) participation in a riot; (4) commission of a felony, whether or not charged; or (5) being intoxicated or under the influence of an illegal narcotic or controlled substance that was not prescribed by a doctor.
- N. Services performed by a member of the covered person's immediate family.
- O. Charges that are: (1) not actually incurred by a covered person; (2) not administered or ordered by a doctor; (3) not medically necessary to the diagnosis or treatment; or (4) in excess of the reasonable and customary charge.

Unless otherwise provided for in the policy, expenses due to a preexisting condition will not be covered in the first 12 months after the date the covered person becomes insured under the policy. The preexisting condition limitation will not apply to a preexisting condition that was fully disclosed to us on the application for the policy and is not subject to a restrictive rider. A preexisting condition is an injury or illness: (A) for which medical advice, diagnosis, care, or treatment was recommended or received within 24 months before the covered person's effective date of coverage; or (B) that in the opinion of a doctor: (1) began prior to the covered person's effective date of coverage; or (2) manifested symptoms that would cause an ordinarily prudent person to seek medical advice, diagnosis, or treatment within the 12 months before the covered person's effective date of coverage.

Renewability

You may renew the policy for life by paying the premiums as they come due, or within the 31-day grace period that follows. We may decline to renew the policy only:

- A. For fraud or false statements made in filing a claim for policy benefits.
- B. For nonpayment of premiums when due.
- C. If we decline to renew all policies just like yours issued to residents of the state where you are then living. (This is explained in the Discontinuance clause in the policy.)

We will not change your premium because of the number of claims filed or because of a change in a covered person's health. Renewal premiums will be based on the rate table in effect on the premium due date. Your type of plan, age, sex, place of residence, the period the policy has been in force, and the type and level of benefits on the premium due date will be used to figure the required premium.

Notice of Information Practices

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

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

EXAMPLES OF INFORMATION WE MAY COLLECT AND MAINTAIN

Your name, address, telephone number, Social Security Number, date of birth, income, E-mail address, policy number, HSA account number and balance, policy coverage, premium payment, claims history, medical information, and motor vehicle reports.

INFORMATION WE ARE PERMITTED TO USE AND DISCLOSE WITHOUT AN AUTHORIZATION

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

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

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

ALL OTHER USES AND DISCLOSURES OF PERSONAL INFORMATION

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

YOUR RIGHTS REGARDING YOUR PERSONAL INFORMATION

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

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

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

- To request that we communicate with you about it by alternative means or at an alternative location if our sharing of all or part of it could endanger you.
- To request that we restrict the use and sharing of it. (We do not have to agree.)

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

FORMER CUSTOMERS

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

SECURITY OF PERSONAL INFORMATION

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

FAIR CREDIT REPORTING ACT NOTICE

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

MEDICAL INFORMATION BUREAU

We or our reinsurers may make a report of personal information in conjunction with our membership in the Medical Information Bureau (MIB). This is a nonprofit organization of life insurance companies, which operates an information exchange on behalf of its members.

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

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

OUR DUTIES

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

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

You will receive this notice each year. We reserve the right to change the terms of our notice. We reserve the right to make the new notice apply to all personal information that we maintain. We will send a new notice within 60 days of any material change. We will mail it to your last known address or send it by E-mail if you have agreed to electronic notice. For more information or to obtain a copy, please contact:

Golden Rule Insurance Company
Attn: Privacy Official
712 Eleventh Street
Lawrenceville, IL 62439
618-943-5064

This notice, effective June 2006, is being provided on behalf of *UnitedHealthcare, Inc., Golden Rule Insurance Company, All Savers Insurance Company*

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

KEEP FOR YOUR RECORDS

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

CONDITIONAL RECEIPT FOR _____

THIS FORM LIMITS OUR LIABILITY.

Proposed Insured: _____

Amount Received: _____ Date of Receipt: _____

NO INSURANCE WILL BECOME EFFECTIVE UNLESS ALL 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) at its Home Office or Indianapolis Office.
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.
2. "*Effective date*" for a mailed application means the later of: (a) the requested effective date, if any, shown on the application; or (b) the date upon which the original application is actually received by Golden Rule at its Home Office.
3. "*Effective date*" for an application sent by any electronic method means the later of: (a) the requested effective date, if any, shown on the application; or (b) the day after the date upon which the application is actually received by Golden Rule at its Home Office.

Limitation:

If, for any reason, Golden Rule declines to issue a 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. Failure to include all material medical information, correct information regarding the tobacco use of any applicant, or information concerning other health plans may cause the company to deny a future claim and to void your coverage as though it has never been in force. After you have completed the application and before you sign it, reread it carefully. Be certain that all information has been properly recorded.
3. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of or addition to your present plan. You should be certain that you understand all the relevant factors involved in replacing or adding to your present coverage.
4. Finally, we recommend that you not terminate your present plan until you are certain that your application for the new plan has been accepted by Golden Rule.

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

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

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

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

A COPY OF YOUR AUTHORIZATION TO OBTAIN AND DISCLOSE HEALTH INFORMATION

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

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

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

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

I (we) understand the following:

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

I have retained a copy of this authorization.

KEEP THIS DOCUMENT. IT HAS IMPORTANT INFORMATION.

 **UnitedHealthcare**
A UnitedHealth Group Company

Golden Rule[®]
A UnitedHealthcare Company