UnitedHealthOne

Choices you want.
Coverage you need.®

SHORT TERM MEDICAL℠ PLANS

HEALTH PLANS FOR INDIVIDUALS & FAMILIES IN **TIMES OF TRANSITION AND CHANGE**

UnitedHealthOne

Health Insurance Available Only to Members of FACT. Underwritten by Golden Rule Insurance Company.

Policy Forms C-006.4 and MGR03927 (TX)

QUALITY COVERAGE
FROM A PROVEN COMPANY

UnitedHealthcare
Approximately 26 million customers entrust UnitedHealthcare with their health insurance needs.[1] 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.®*

Leave It to the Experts
For over 65 years, Golden Rule has served individuals and families purchasing their own health insurance. 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 (01-26-12) 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
Being responsive to the needs of our customers is critical. That's why more than 94% of all health insurance claims are processed within 10 working days or less.[2]

Big Network, Big Savings
You can find many providers in your area with nearly 754,000 physicians and other health care professionals and nearly 5,400 hospitals nationwide in the UnitedHealthcare network.[1] Plus, our network can offer you provider discounts with a national average of up to 50% on quality health care.[3]

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

Membership has its Benefits
FACT members have access not only to UnitedHealthOne℠ health plans from Golden Rule, but also Accidental Death benefits and discounts on a wide range of services, pet coverage, and even travel expenses. See the back cover of this brochure for more details.

[1] UnitedHealth Group Annual Form 10-K for year ended 12/31/11.
[2] Actual 2011 results.
[3] Discounts vary by provider, geographic area, and type of service.

SHORT TERM MEDICAL[SM] PLANS

Our plans offer easy-to-understand health insurance designed for individuals and families in times of transition and change with up to **$1,500,000** of coverage. Plans available to members of FACT — see back cover.

Short Term Medical[SM] can help "bridge the gaps" in health insurance coverage if:

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

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

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

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

This brochure is only a general outline of our standard short-term benefits. Please see pages 15-16 for state variations. This is not an insurance contract. Please read your certificate carefully. Complete coverage details are provided in the policy and certificates. In most cases, coverage will be determined by the master policy issued in Illinois and subject to Illinois law. We will notify you in advance of any changes in coverage or benefits.

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

A choice of coverage to fit your specific needs

You select the coverage period from 1 to 11 months*, and a deductible that fits your budget. See pages 6-7 for details.

Short Term Medical℠ Plus Elite*

- $1.5 million Lifetime Maximum Benefit
- Offers more coverage than our Plus and Value plans. Great for those seeking predictable out-of-pocket expenses.

You pay the selected deductible for the term.	Then insurance pays 80% of next $10,000 of covered expenses. You pay 20%.	Then insurance pays 100% of remaining covered expenses to $1,500,000.

Short Term Medical℠ Copay

- 2-Doctor Office Visits (In-network) with $50 Copay — No deductible. (per person/per term — Additional Dr. Office Visits subject to chosen deductible and coinsurance)
- Prescription drug copay coverage.

You pay the selected deductible for the term.	Then insurance pays 80% of next $20,000 of covered expenses. You pay 20%.	Then insurance pays 100% of remaining covered expenses to $1,000,000.

Short Term Medical℠ Plus

- Offers more coverage than our Value plan. Great for those seeking predictable out-of-pocket expenses.

You pay the selected deductible for the term.	Then insurance pays 80% of next $10,000 of covered expenses. You pay 20%.	Then insurance pays 100% of remaining covered expenses to $1,000,000.

Short Term Medical℠ Value New

- Costs less than our Plus Elite, Copay, and Plus plans. In exchange, you take more responsibility for medical expenses.

You pay the selected deductible for the term.	Then insurance pays 70% of next $16,666 of covered expenses. You pay 30%.	Then insurance pays 100% of remaining covered expenses to $250,000.

* Not available in all states.

IN-NETWORK BENEFIT HIGHLIGHTS

	Short Term Medical℠ Plus Elite*
Deductible Choices (per person)	You pay: $1,000, $1,500, $2,500, $5,000, or $10,000
Coverage Term	1-11 Months*
Coinsurance (% of covered expenses after deductible, per person)	You pay: 20%
Coinsurance Out-of-Pocket Maximum (after deductible, per person)	$2,000 per term
Lifetime Maximum Benefit (per covered person)	$1.5 million
Physician Care Benefits (Illness & Injury)	
Office Visit, History, and Exam only (no primary care physician/specialist referral required)	You pay: 20% after deductible
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. Short Term Medical℠ Copay: Limited to $3,000 per person per term maximum benefit.	You pay: 20% after deductible — Preferred Price Card (You pay for prescriptions at the point of sale, at the lowest price available, and submit a claim to Golden Rule.)
Outpatient Expense Benefits	
X-ray and Lab, Mammogram, Pap Smear, PSA screening	You pay: 20% after deductible
Emergency Room Fees — Illness	You pay: 20% after deductible Not covered unless admitted.
Emergency Room Fees — Injury	You pay: 20% after deductible
Mental and Nervous Disorders (including Substance Abuse)	You pay: 20% after deductible (limited benefit)
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: 20% after deductible

* Not available in all states.

Short Term Medical℠ Copay	Short Term Medical℠ Plus	Short Term Medical℠ Value New
You pay: $1,000, $1,500, $2,500, $5,000, or $10,000	You pay: $1,000, $1,500, $2,500, $5,000, or $10,000	You pay: $1,000, $1,500, $2,500, $5,000, or $10,000
1-11 Months*	1-11 Months*	1-11 Months*
You pay: 20%	You pay: 20%	You pay: 30%
$4,000 per term	$2,000 per term	$5,000 per term
$1 million	$1 million	$250,000
You pay: $50 copay — no deductible 2 Dr. Office Visits per person/per term — Additional Dr. Office Visits subject to chosen deductible and coinsurance.	You pay: 20% after deductible	You pay: 30% after deductible
Tier 1 drugs — $15 copay, no deductible. Tier 2 drugs — $35 copay. Tier 3 drugs — $65 copay. Tier 4 drugs — you pay 25% coinsurance. Tier 2-4 drugs have combined $500 deductible per person, per term.	You pay: 20% after deductible — Preferred Price Card (You pay for prescriptions at the point of sale, at the lowest price available, and submit a claim to Golden Rule.)	Not covered — Discount Card (You may obtain RX drugs at an average savings of 20-25%. Discounts vary by pharmacy, geographic area, and drug.)
You pay: 20% after deductible	You pay: 20% after deductible	You pay: 30% after deductible
You pay: 20% after deductible Not covered unless admitted.	You pay: 20% after deductible Not covered unless admitted.	You pay: 30% after deductible Not covered unless admitted.
You pay: 20% after deductible	You pay: 20% after deductible	You pay: 30% after deductible
You pay: 20% after deductible (limited benefit)	You pay: 20% after deductible (limited benefit)	Not covered
You pay: 20% after deductible	You pay: 20% after deductible	You pay: 30% after deductible

SIGNIFICANT SAVINGS

QUALITY CARE AT SIGNIFICANT SAVINGS

Using UnitedHealthcare Choice Plus Network

With a Golden Rule health insurance plan, you gain access to the UnitedHealthcare Choice Plus network.[1] Physicians, hospitals, and other health care providers participating in the network have agreed to provide you quality care at reduced costs. The result is lower premiums, and in return, you agree to use the physicians, hospitals, and other providers in the network.

You can find many providers in your area with nearly 754,000 physicians and care professionals and nearly 5,400 hospitals nationwide in the UnitedHealthcare network.[2] Plus, our network can offer you provider discounts of up to 50% on quality health care.[3]

To locate providers for the network, visit *www.goldenrule.com/dr*

Sample savings with our network:
(Services provided January - June 2012)[4]

	Charges	Repriced Charges	Network Savings
Dr. Office Visit - established patient	$ 81.37	$ 39.71	51%
MRI	$ 1,356.86	$ 424.85	69%
Lipid Panel	$ 73.84	$ 10.16	90%
CBC	$ 32.11	$ 6.43	87%
Metabolic Panel	$ 78.56	$ 1.53	86%
General Panel	$ 168.76	$ 23.58	87%
Mammogram	$ 265.78	$ 82.13	69%

[1] 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.

[2] UnitedHealth Group Annual Form 10-K for year ended 12/31/11.

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

[4] 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.

[5] Not available in all states.

If you do need to go to a doctor out of network, you can, but at a reduced benefit.

Short Term Medical[SM] Copay
Out-of-Network Benefit Reduction

Receiving nonemergency services outside the Choice Plus network results in substantially less benefits. Your covered expenses are reduced by 25%.

Also, you will be subject to an additional deductible amount equal to the per person deductible with no coinsurance out-of-pocket maximum.

Please note: $50 doctor office visit copay is for in-network providers only. Out-of-network office visits are subject to deductible and coinsurance.

Short Term Medical[SM] Plus Elite[5], Short Term Medical[SM] Plus, and Short Term Medical[SM] Value New
Out-of-Network Benefit Reduction

Receiving nonemergency services outside the Choice Plus network results in substantially less benefits. Your covered expenses are reduced by 25%.

Also, you will be subject to an additional deductible amount equal to the per person deductible with no coinsurance out-of-pocket maximum.

OPTIONAL BENEFIT

Further customize your health insurance coverage to meet your specific needs. Additional premium required. This optional benefit is only available with Short Term Medical℠ Copay and Short Term Medical℠ Plus Elite plans.

Supplemental Accident Benefit

Higher deductibles don't have to be scary! You may choose an optional Supplemental Accident benefit to reduce your out-of-pocket expenses for unexpected injuries. You select a maximum benefit amount, per accident, per covered person.

Benefit Amounts:	$1,000	$1,500	$2,500	$5,000	$10,000

- Up-front coverage can pay your deductible.
- 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 will be made either to your health care provider under your assignment of benefits, or to you if you have already paid your provider.
- Additional premium is required for the optional Supplemental Accident benefit rider.
- Exclusions and limitations of the health plan apply to this optional benefit.

Savings Examples

	Short Term Medical℠ Copay Plan Only	**Short Term Medical℠ Copay Plan with up to $2,500 Supplemental Accident Benefit**	**Short Term Medical℠ Copay Plan with up to $5,000 Supplemental Accident Benefit**
Health Plan deductible	$5,000	$5,000	$5,000
Coinsurance maximum (80/20 to $20,000) for open-arm fracture costing $26,000*	$4,000	$4,000	$4,000
Supplemental Accident Coverage	$0	- $2,500	- $5,000
Your out-of-pocket covered expenses for the calendar year	**$9,000**	**$6,500**	**$4 ,000**
Additional yearly Supplemental Accident premium for a single person	N/A	$240	$300
Additional yearly Supplemental Accident premium for a family	N/A	$420	$525

*Examples are as of 12/01/11, are for illustration purposes only, and assume all expenses are covered. All these services received from network providers in ZIP Codes 495-- and 110--. Your actual savings may be more or less than this illustration and will vary by several factors. Availability varies by state. Please see the corresponding health product brochure.

Covered Expenses

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

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

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.

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

Limitations

Diagnosis or treatment of mental or nervous disorders, including mental incapacity and substance abuse, will be limited to a lifetime maximum of $3,000 per covered person. Outpatient diagnosis or treatment of mental or nervous disorders will be further limited to $50 per visit. (Short Term Medical℠ Plus Elite, Short Term Medical℠ Copay, and Short Term Medical℠ Plus only). Not covered with Short Term Medical℠ Value plan.

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

Transplant Expense Benefit

The following types of transplants are eligible for coverage:

Tissue Transplants: cornea transplants; artery or vein grafts; heart valve grafts; prosthetic tissue and joint replacement; and prosthetic lenses for cataracts.

Listed Transplants: heart; lung; heart and lung; bone marrow; liver; and kidney.

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

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

The following conditions are eligible for bone marrow transplant coverage:

Allogenic bone marrow transplants (BMT) for treatment of: 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.

Rehabilitation & Extended Care Facility (ECF)

Must begin within 14 days of a 3-day or longer hospital stay for the same illness or injury. Deductible then coinsurance and also limited to a policy term maximum of 60 days for both rehabilitation and ECF expenses.

Exclusions

NO BENEFITS ARE PAYABLE FOR EXPENSES THAT:

- Are not specifically provided for in the certificate.
- Would not have been charged in the absence of insurance.
- Are for preventive care, except as expressly provided for under the certificate.
- Are incurred while confined primarily for custodial, rehabilitative or educational care, or nursing services.
- Are incurred for modification of the body, cosmetic treatment, or aesthetic reasons.
- Result from self-inflicted injury, act of war, or participation in a riot or felony.
- Exceed the eligible expenses.
- Are incurred as a result of participating in professional or semiprofessional athletic events.

NO BENEFITS ARE PAYABLE FOR:

- Preexisting condition — A condition: (1) for which medical advice, diagnosis, care, or treatment was recommended or received within the 24 months immediately preceding the date the covered person became insured under the policy/certificate; or (2) that had manifested itself in such a manner that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment within the 12 months immediately preceding the date the covered person became insured under the policy/certificate.

  A pregnancy existing on the effective date of coverage will also be considered a preexisting condition.

  NOTE: Even if you have had prior Golden Rule coverage and your preexisting conditions were covered under that plan, they will not be covered under this plan.
- Expenses which 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.
- Pregnancy or routine well-baby care.
- Dental services or procedures, eyeglasses, contacts, eye refraction, visual therapy, hearing aids, or any examination or fitting related to these.
- Charges for use of hospital emergency room due to illness (unless confined).
- Any drug, treatment, or procedure that promotes or prevents conception or prevents childbirth, including abortion, sterilization, artificial insemination, or treatment for infertility or impotency (see pages 15-16 for state variations).
- Television, telephone, or expenses of other persons.
- Treatment of temporomandibular disorders (except as stated in covered expenses).
- Marriage, family, or child counseling.
- Recreational or vocational therapy or rehabilitation.
- Services performed by an immediate family member.
- Procedures, services, or supplies that are considered to be investigational treatment.
- Treatment of mental disorders or substance abuse, unless expressly provided for by the certificate.

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

Effective Date

Your certificate will take effect on the later of:

(1) the requested effective date; or

(2) the day after the postmark date affixed by the U.S. Postal Service,* but only if the following conditions are satisfied:

(a) Your application and the appropriate premium payment are actually received by us within 15 days of your signing;**

(b) You are a member of the Federation of American Consumers and Travelers (FACT);

(c) Your application is properly completed and unaltered;

(d) You have answered "no" to question 2 (if other questions are answered "yes," we will exclude the person(s) listed);

(e) You are a resident of a state in which the certificate form can be issued; and

(f) If the application is submitted by an agent or broker, the agent or broker is properly licensed to submit applications to Golden Rule.

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

** Your account will be immediately charged.

Renewability

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

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

Group — Coordination of Benefits

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

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.

STATE VARIATIONS

Alabama
- There are no state variations.

Arizona
- 7-11 months not available.

Arkansas
- Any limitation or exclusion specific to treatment of craniomandibular disorders, malocclusions or disorders of the tempromandibular joint does not apply.

Florida
- Eligible children must be unmarried and under 31 years of age at the time of application.

Illinois
- A child will continue to be eligible after age 26 if the child: is unmarried and under age 30; is an Illinois resident; served in active or reserve branches of the U.S. Armed Forces, and received other than a dishonorable discharge.

Indiana
- 7-11 months not available.

Iowa
- The spine and back limitation does not apply.

Michigan
- 7-11 months not available.

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

Missouri
- The exclusion for expenses incurred as a result of self-inflicted injury does not apply if the covered person was insane or if the injury resulted from an attempted suicide.

Nebraska
- There are no state variations.

North Carolina
- Limited coverage for nonsurgical treatment of TMJ up to lifetime maximum of $3,500.
- The lifetime maximum for surgical treatment of TMJ does not apply.
- Occupational injuries or illnesses are not covered expenses if paid under the North Carolina Workers' Compensation Act.
- The preexisting conditions reference to treatment within 24 months prior to the applicable effective date is changed to 12 months.
- For covered expenses received outside of the Choice Plus network, benefits will be reduced by 25%. This reduction is limited to $2,000 per term for Short Term Medical[SM] Plus Elite and Short Term Medical[SM] Plus, $4,000 per term for Short Term Medical[SM] Copay, and $5,000 for Short Term Medical[SM] Value.

Ohio
- Short Term Medical[SM] Plus Elite not available.
- Outpatient treatment for alcoholism is limited to $550 per coverage term.
- Outpatient treatment for mental or nervous disorders is limited to $550 per coverage term (Short Term Medical[SM] Copay and Short Term Medical[SM] Plus only).
- 7-11 months not available.
- Eligible children must be unmarried and under 28 years of age at time of application.

Oklahoma
- The spine and back limitation does not apply.
- 7-11 months not available.

Pennsylvania
- Formulas or nutritional supplements for phenylketonuria (PKU) and other metabolic disorders are covered and are not subject to the deductible.

Tennessee

- There are no state variations.

Texas

- Treatment of TMJ disorders are covered the same as any other illness.
- Formulas necessary for the treatment of phenylketonuria (PKU) are covered the same as any other illness.
- With respect to fees charged for covered expenses, eligible expenses mean the most common charge for similar expenses within the area in which the expense is incurred, so long as these charges are reasonable.
- Any limited benefits for diagnosis or treatment of mental or nervous disorders or mental incapacity remain subject to all other terms of the policy. For example, as with any other illness or injury, inpatient treatment which is primarily for educational or rehabilitative care will not be covered.
- If a designated "Center of Excellence" is not used for a listed transplant, covered expenses will be reduced by 25%.
- A preexisting condition is an injury or illness for which the covered person received medical advice or treatment within the 12 months immediately preceding the effective date of coverage.
- Limited benefits are provided for the diagnosis and treatment of chemical dependency.
- The policy provides coverage for mental disorders and substance abuse as required by applicable state law. Specific details are included in the certificate at issue.
- Covered expenses will include diagnosis and treatment of autism spectrum disorder for covered persons two through five years of age.
- Covered expenses will include diagnosis and treatment of an acquired brain injury. Post-acute care for an acquired brain injury will be limited to a lifetime maximum of 60 days per covered person.
- "Medically necessary" is a defined term and means that a service, medicine, or supply is necessary and appropriate for the treatment of an illness or injury, as determined by Golden Rule, based on factors stated in the certificate.
- The Coordination of Benefits provision also takes into account personal injury protection coverage, whether provided under a group or individual contract.
- Eligible children will also include your grandchild (under 26) who is your dependent for federal income tax purposes at time of application.

Virginia

- A preexisting condition is an injury or illness for which the covered person received medical advice or treatment within the 12 months immediately preceding the effective date of coverage.
- 7-11 months not available.

West Virginia

- Covered expenses are expanded to include an annual kidney disease screening.

Wisconsin

- The policy provides coverage for mental disorders and substance abuse as required by applicable state law. Specific details are included in the certificate at issue.
- Limited coverage for nonsurgical treatment of TMJ is provided.
- The spine and back limitation does not apply.
- There must be at least 64 days after the first short term coverage ends before applying for an additional short term certificate/policy.
- Eligible children must be under 27 years of age at time of application. If age 26 at time of application, must also be unmarried.
- A child called to active military duty prior to age 27 may be eligible after age 27 if a full-time student.

Have you lost coverage through recent job or life changes?

Have you recently completed COBRA insurance coverage?

Or recently graduated and are no longer covered by your parents' plan?

Have you begun enjoying early retirement and are waiting for Medicare?

Do you have a job as a seasonal worker?

Short Term Medical[SM] can "bridge the gaps" in health insurance coverage.

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.

FACT MEMBERSHIP HAS ITS BENEFITS

These health insurance plans are issued as association group plans and available only to members of FACT, the Federation of American Consumers and Travelers. If you're not already a member, enroll now to be eligible to apply for these plans.

What is FACT?

FACT is an independent consumer association whose members benefit from the "pooling" of resources. Benefits range from medical savings to consumer service discounts. FACT's principal office is in Edwardsville, Illinois. FACT and Golden Rule are separate organizations. Neither is responsible for the performance of the other. FACT has contracted with Golden Rule to provide its members with access to these health insurance plans. FACT does not receive any compensation from Golden Rule.

Is there a cost for joining FACT?

Yes, there are membership dues and they can be paid with your regular health insurance premium, as opposed to making a separate payment.

What are the basic plan benefits?

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

- Accidental Death Benefits
- Consumer Information & Hotline
- Retail & Service Discounts
- Travel Discounts
- Pet Coverage
- Scholarships

Need more benefits? Upgrade your membership to a Choice or Elite plan.

- Expanded Accidental Death Benefits
- Enhanced In-Hospital Benefit
- Family Crisis Fund & Disaster Aid
- 24/7 Doctor Consultations
- 24/7 Nurseline
- Entrepreneur/Small Business Package
- Expanded Travel Program
- Dental Discounts
- Vision Discounts
- Prescription Drug Savings
- Wellness Benefits
- Grants
- And much more!

As a member of FACT, your information is kept private and is not shared with any third parties. Please visit the FACT website for a complete FACT Privacy Statement: ***www.usafact.org/privacy_policy.html***

FACT may change or discontinue any of its membership benefits at any time. For the most current information, including full detailed lists of member benefits, visit FACT's website at ***www.usafact.org*** or call toll-free at (800) USA-FACT.

UnitedHealthOne