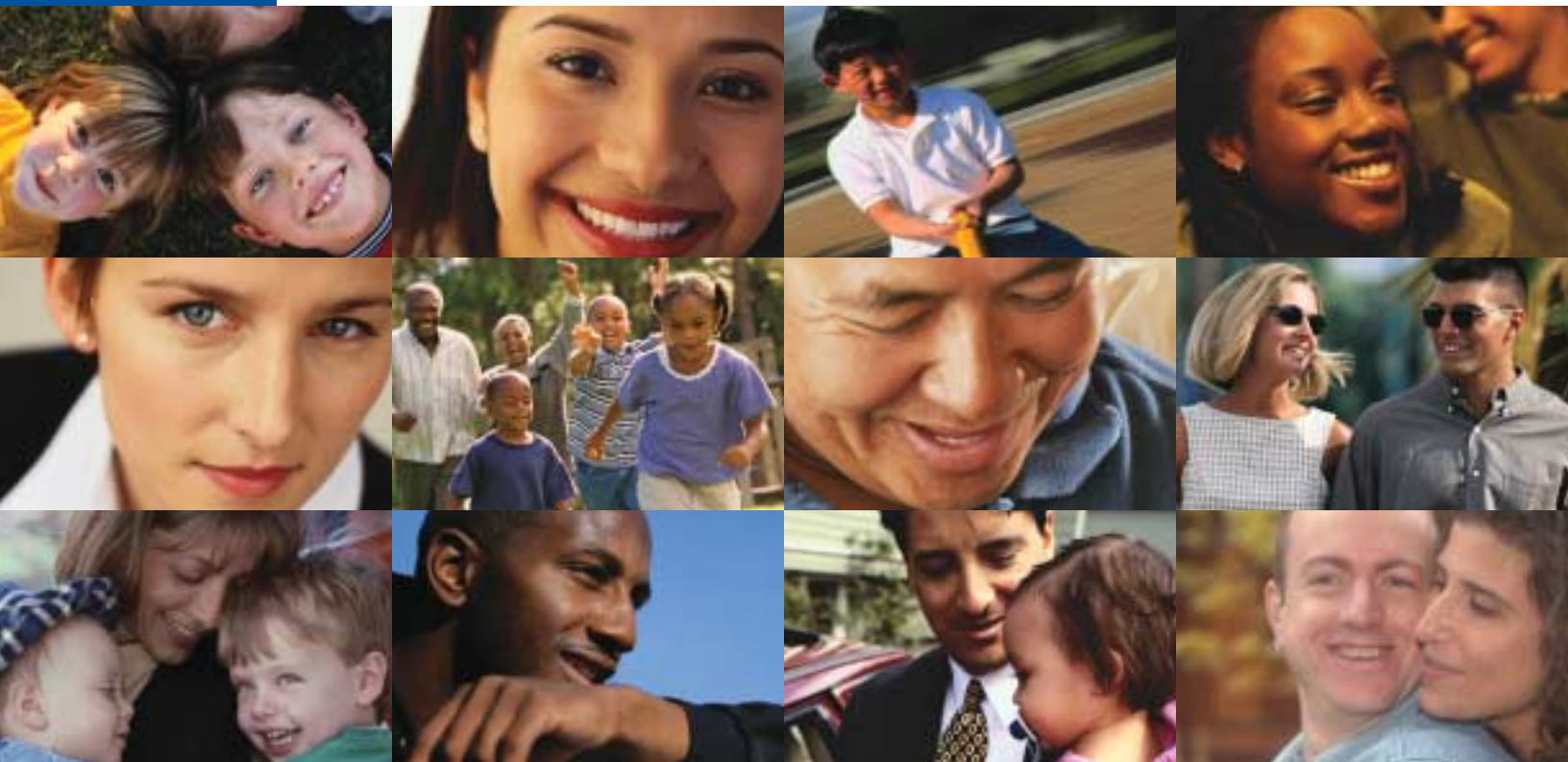


Health Plans

for individuals and families



THESE PLANS ARE ISSUED ON AN INDIVIDUAL BASIS AND ARE REGULATED AS INDIVIDUAL HEALTH INSURANCE PLANS.

www.goldenrule.com

Connecticut

Golden Rule®

Golden Rule Insurance Company



A UnitedHealthcare Company

Why Choose Golden Rule?



Experience and Expertise

Golden Rule 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 2004 results

** www.unitedhealthgroup.com

Copay Plan

Benefit Highlights

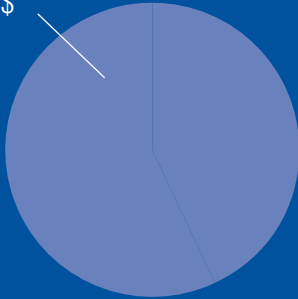
	Copay 25 SM
Design Basics	
Network Type	Preferred Network Included
Calendar-Year Deductible Choices (maximum 2 per family, per calendar year)	\$500, \$750, \$1,250
Coinsurance (per covered person, per calendar year)	80/20 to \$5,000 then 100%
Lifetime Maximum Benefit (per covered person)	\$3 million
Initial Rate Guarantee (subject to benefit and address changes)	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%
Other Covered Inpatient Services	80%
Outpatient Expense Benefits	
Surgeon, Assistant Surgeon, and Facility Fees	80%
Hemodialysis, Radiation, Chemotherapy, and Organ Transplant Drugs	80%
CAT Scans, MRIs	80%
Outpatient X-ray and Lab (performed in the doctor's office or elsewhere)	80%
Emergency Room Fees	80% -- additional \$100 Copay for illness if not admitted
Other Covered Outpatient Expenses	80%
Routine Health Benefits	
Doctor Office Visit	For history and exam: \$25 Copay, then 100%
Adult Preventive Care (\$150 maximum per year after 12 months for each adult age 19 or older)	For other services, including X-ray and Lab: 80% after deductible
Mammography, Pap Smear, and PSA Testing	80%
Outpatient Prescription Drugs	Generic: \$15 Copay Name-Brand: \$250 calendar-year deductible -- then \$30 Copay for preferred, \$40 Copay for non-preferred (Name Brand reimbursed at Generic price if Generic is available)
Optional Benefits	For a complete list, see page 5.

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 6-11.

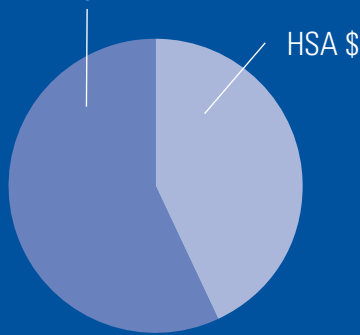
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How HSA Plans Work

Traditional Insurance Premium \$



High Deductible Insurance Premium \$



It's simple. The money you save on premiums can be put into your tax-advantaged savings account. Those savings can help pay your deductible or other qualified health care expenses tax-free. After the deductible is met, the insurance starts paying.

HSA Plans offer quality coverage and savings

HSA Plans have two components: a lower cost, high deductible health insurance plan to provide coverage for your larger health care expenses and a tax-favored savings account.

The idea is really simple. The money you save on premiums can be put into your tax-favored savings account, and then withdrawn to help pay your deductible or pay for other qualified health care expenses.

You own your savings account. You make the decisions on how and when to spend the money.

Your unspent health care savings roll over year after year. In other words, you won't lose what you don't spend in any given year.

And if used for health care now or after retirement, the money in your savings account will never be taxed.

Plus, Golden Rule credits interest on the money in your savings account.

Lower premiums, tax-deferred savings, network discounts, and an attractive interest rate

Now, it all adds up. The money you save from reduced premiums can be put into your Health Savings Account -- tax-deferred.

On top of that, at Golden Rule, you'll earn annual interest on your savings, beginning with the first dollar deposited.

Your health savings grow tax-deferred, and can be withdrawn tax-free to help pay your deductible or to pay 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.

That's good planning and extra peace of mind when you need it most. And you're in control.

Health Savings Account (HSA) Plan

Benefit Highlights

	HSA 100 SM
Design Basics	
Network Type	Preferred or Savings Based Network
Deductible Choices	See HSA Insert
Coinsurance After Deductible	100%
Lifetime Maximum Benefit (per covered person)	\$3 million
Initial Rate Guarantee (subject to benefit and address changes)	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%
Other Covered Inpatient Services	100%
Outpatient Expense Benefits	
Surgeon, Assistant Surgeon, and Facility Fees	100%
Hemodialysis, Radiation, Chemotherapy, and Organ Transplant Drugs	100%
CAT Scans, MRIs	100%
Outpatient X-ray and Lab	100%
Emergency Room Fees	100%
Other Covered Outpatient Expenses	100%
Routine Health Benefits	
Doctor Office Visit Fees	100%
Outpatient Prescription Drugs	100%
Mammography, Pap Smear, and PSA Testing	100%
Adult Preventive Care (\$150 maximum per year after 12 months for each adult age 19 or older)	100%
Optional Benefits	For a complete list, see page 5.

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 6-11.

High Deductible Plans

Benefit Highlights

	Plan 100 [®]	Plan 80 SM	Basic Plan SM
Design Basics			
Network Type	Preferred or Savings-Based Network		
Calendar-Year Deductible Choices (maximum 2 per family, per calendar year)	\$1,000, \$1,500, \$2,500, \$5,000	\$1,000, \$1,500, \$2,500, \$5,000	\$500, \$1,000, \$1,500, \$2,500, \$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 7 for details
Routine Health Benefits			
Doctor Office Visit Fees	100%	80%	Not Covered
Outpatient Prescription Drugs	100%	80%	Not Covered
Mammography, Pap Smear, and PSA Testing	100%	80%	80%
Adult Preventive Care (\$150 maximum per year after 12 months for each adult age 19 or older)	100%	80%	Not Covered
Optional Benefits	For a complete list, see page 5.		

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 6-11.

Optional Benefits

Prescription Drug Card Benefit

(Not available with Basic PlanSM.)

This optional benefit helps manage the costs of prescription drugs. 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: Name-brand drugs will be reimbursed as generic (at generic price) if generic is available.

Supplemental Accident Benefit

This benefit provides up-front coverage for unexpected injuries. This benefit is limited to \$500 of first-dollar benefits for treatment of an injury within 90 days of an accident. (Not available with HSA 100SM.)

Term Life Benefit

The optional Term Life Benefit is designed to give you extra life insurance protection with the convenience of underwriting at the same time as the health insurance.

You may choose an optional decreasing term life insurance benefit for you and your spouse if your spouse is also a covered person under the health policy. The amount of life insurance protection provided will depend on your attained age -- or your spouse's attained age -- at the time of death, as shown in the table. Coverage will automatically terminate when the covered person attains 65 years of age.

Attained Age of Insured at Death	Insured Benefit Amount
49 or less	\$30,000
50-59	18,000
60-64	12,000

The decreasing term life benefit is a convenient way to provide additional funds at your death to cover your final expenses, outstanding debts, or immediate needs of the family.

HSA Hospital Indemnity Rider

The optional HSA Hospital Indemnity Rider is designed to help protect against major hospitalization expenses during the early months of coverage while cash accumulates in your savings account.

The HSA Hospital Indemnity Rider provides a lump-sum cash benefit on the third day of hospital confinement. This money can be used to help pay your deductible or for any other purpose.

The cash benefit amount depends on your deductible amount and decreases over time (see table).

The optional rider pays once, regardless of the number of hospitalizations, and there are no benefits under this rider if the hospitalization would not have been covered by the health insurance coverage. In addition, you only pay the premium amount once.

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

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

Plan-Specific Provisions

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

Copay 25SM, HSA 100SM, Plan 100[®], and Plan 80SM

Medical Expense Benefits

- Daily hospital room-and-board and nursing services at the most common semiprivate rate.
- Charges for an 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 illness not resulting in confinement -- not available with HSA 100SM).
- 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.
- Diagnostic tests 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 the U.S., if requested by police or medical authorities at the site of an emergency.
- Charges for an operating, treatment, or recovery room for surgery.
- Dental expenses due to an injury which damages natural teeth if expenses are incurred within six months.
- Surgical treatment of TMJ disorders, subject to General Limitations -- see page 9.

- Cost and administration of an anesthetic, oxygen, and other gases.
- Radiation therapy or chemotherapy.
- Prescription drugs.
- Hemodialysis, processing and administration of blood or components.
- Mammography, Pap smear, and PSA test fees.
- Artificial limbs, eyes, larynx, nondental prostheses, maxillo-facial prostheses, or breast prostheses, subject to a yearly benefit of \$300 per prosthesis or per breast (but not replacements unless required by a physical change).

Preventive Care Expense Benefits

- After coverage has been in force 12 months, each adult age 19 or older qualifies for up to \$150 of covered expenses per calendar year for routine physicals, including lab fees.

For information on additional Plan Provisions, including Transplant Expense Benefit, Notification Requirements, Preexisting Conditions, General Exclusions, General Limitations, and Other Plan Provisions, read pages 8-10.

Basic PlanSM

Inpatient Expense Benefits

- Daily hospital room-and-board and nursing services at the most common semiprivate rate.
- Charges for an intensive care unit.
- Drugs and medicines.
- Dressings, sutures, casts, or other necessary medical supplies.
- Artificial limbs, eyes, larynx, nondental prostheses, maxillo-facial prostheses, or breast prostheses, subject to a yearly benefit of \$300 per prosthesis or per breast (but not replacements unless required by a physical change).
- 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, and other gases.
- Radiation therapy or chemotherapy.
- Diagnostic tests using radiologic, ultrasonographic, or laboratory services.

Outpatient Expense Benefits

- Charges for outpatient surgery, including:
 - the fee made by an outpatient surgical facility;
 - the fee for the primary surgeon;
 - the fee for the assistant surgeon; and/or
 - the fee for 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 a \$500 copay each time the emergency room is used for injury or illness not resulting in confinement).

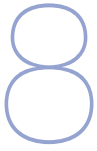
Outpatient Testing Expense Benefits

- CAT scan and MRI testing.
- Diagnostic testing, related to and performed within 14 days prior to surgery or inpatient confinement.

Exclusions

- Outpatient prescription drugs (except as provided for under Outpatient Expense Benefits).
- Outpatient medical services, including doctor office visits and diagnostic testing (except as provided for under Outpatient Testing Expense Benefits above).

Important Note: Premiums for a Basic PlanSM are significantly less because coverage is not provided for most outpatient services (doctor office visits, diagnostic testing, and prescription drugs).



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.

Transplant Expense Benefit

The following types of transplants are eligible for coverage under the Medical Expense Benefits and the Inpatient Hospital, Surgical, Medical Expense Benefits provisions: Cornea transplants, artery or vein grafts, heart valve grafts, 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/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, 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.

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 \$500.

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.

Preexisting Conditions

Preexisting conditions will not be covered during the first 12 months after an individual becomes a covered person. This exclusion will not apply to conditions which are both: (a) fully disclosed to Golden Rule in the individual's application; and (b) not excluded or limited by our underwriters.

A preexisting condition is an injury or illness for which a covered person received medical advice or treatment within 12 months prior to the applicable effective date for coverage of the illness or injury. The preexisting condition limitation may be reduced for covered persons demonstrating prior qualifying coverage.

General Exclusions

No benefits are payable for expenses which:

- 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.
- As a result of any injury or illness arising out of, or in the course of, employment for wage or profit, unless the covered person is: (a) not covered by workmen's compensation; or (b) a corporate officer of a corporation whether or not the officer is covered by workmen's compensation.
- 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 or active participation in a felony.
- Are for treatment of temporomandibular joint disorders, except as may be provided for under covered expenses.
- Are incurred for animal-to-human organ transplants, artificial or mechanical organs, procurement or transportation of the organ or tissue, or the cost of keeping a donor alive.
- Are incurred for marriage, family, or child counseling.
- Are for recreational or vocational therapy or rehabilitation.
- Are incurred for services performed by an immediate family member.
- Are not specifically provided for in the policy or incurred while your policy is not in force.
- Are for any treatment or procedure that either promotes or prevents conception, or prevents childbirth, such as abortion, sterilization, treatment of infertility, or artificial insemination.

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

General Limitations

- Expenses incurred by a covered person for treatment of tonsils, adenoids, varicose veins, hernia, or any disorders of the reproductive organs, will not be covered during the covered person's first six months of coverage under the policy. This provision will not apply if treatment is provided on an "emergency" basis. "Emergency" means a medical condition manifesting itself by acute signs or symptoms which could reasonably result in placing a person's life or limb in danger if medical attention is not provided within 24 hours.
- Covered expenses will not include more than what was determined to be the reasonable and customary charge for a service or supply.
- Transplants eligible for coverage under the Transplant Expense Benefit are limited to two transplants in a ten-year period.
- Charges for an assistant surgeon are limited to 20 percent of the primary surgeon's covered fee.
- Covered expenses for surgical treatment of TMJ will be limited to \$10,000 per covered person.
- Covered outpatient expenses relating to diagnosis or treatment of any spine or back disorders will be limited to a maximum benefit of \$2,000 per calendar year. CAT scan and MRI tests are not subject to this limitation.
- Covered expenses will be limited to no more than a 34-day supply for any one outpatient prescription drug order or refill.

Effective Date

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

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

The effective date for **illnesses** will be the same as for injuries if you are replacing prior coverage within 62 days of application for this coverage and disclose replacement information on the initial application for insurance. If replacement information is not disclosed on the initial application for insurance, the effective date for illnesses will be the 15th day after the effective date for injuries.

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Illnesses that begin prior to that 15th day will be treated as a preexisting condition and will not be covered until the individual has been a covered person for 12 months.

Premium

We may adjust the premium rates from time to time. Premium rates are set by class, and you will not be singled out for a premium change regardless of your health. The policy plan, age and sex of covered persons, type and level of benefits, time the 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 23 years of age if attending an accredited college or vocational school on a full-time basis.

Termination of a Covered Person

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

Continued Eligibility Requirements

A covered person's eligibility for insurance under the policy will cease on the earlier of:

- The date that a covered person accepts any direct or indirect contribution or reimbursement, by or on behalf of an employer for any portion of the premium for coverage under this policy; or
- The date a covered person's employer and a covered person treat this policy as part of an employer-provided health plan for any purpose, including tax purposes.

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.

Home Health Care:

To qualify for benefits, home health care must be:

- Provided as a medically appropriate alternative to covered inpatient care in a hospital or hospice;
- Provided through a licensed home health care agency; and
- Certified as medically necessary by a doctor and recertified every 60 days.

Covered expenses for home health care services will be limited to 80 home health care visits of four hours or less in a 12-month period.

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 90 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.

Other Health Plans

If you become covered under other health insurance plans after this policy is issued, benefits payable under other health insurance plans may be used to help satisfy the deductible and coinsurance provisions of this plan. To the extent that the benefits payable by all health insurance plans, including this one, would otherwise exceed the amount of covered expenses, the benefits of this policy will be reduced.

Health Care Provider Networks

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

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

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

- Reduced by 20%; and
- Subject to a separate deductible amount equal to the calendar-year deductible.

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

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



Golden Rule® 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 or account number, account 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. We will use and share it 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.
- To an insurance regulatory authority.
- 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. (If we do not agree, you may file a statement of your disagreement that we will maintain in your file.)
- To receive details about our sharing of it.

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 Golden Rule 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 Golden Rule at 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 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 January 2005, is being provided on behalf of Golden Rule Insurance Company and the following affiliated companies: *Ad-Ventures, Inc.; All Savers Insurance Company; and Golden Rule Financial Corporation.*

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

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

CONDITIONAL RECEIPT FOR

THIS FORM LIMITS OUR LIABILITY.

Proposed Insured:

Amount Received:

Date of Receipt:

NO INSURANCE WILL BECOME EFFECTIVE UNLESS ALL SIX CONDITIONS PRIOR TO COVERAGE ARE MET. NO PERSON IS AUTHORIZED TO ALTER OR WAIVE ANY OF THE FOLLOWING CONDITIONS. YOUR CANCELLED CHECK WILL BE YOUR RECEIPT.

THIS CONDITIONAL RECEIPT DOES NOT CREATE ANY TEMPORARY OR INTERIM INSURANCE AND DOES NOT PROVIDE ANY COVERAGE EXCEPT AS EXPRESSLY PROVIDED IN THE CONDITIONS PRIOR TO COVERAGE.


Signature of Secretary

Signature of Agent/Broker

CONDITIONS PRIOR TO COVERAGE (APPLICABLE WITH OR WITHOUT THE CONDITIONAL RECEIPT)

Subject to the limitations shown below, insurance will become effective if the following conditions are met:

1. The application is completed in full and is unconditionally accepted and approved by Golden Rule Insurance Company (Golden Rule) at its Home Office or Indianapolis Office.
2. All medical examinations, if required, have been *satisfactorily completed*.
3. The persons proposed for insurance must be, on the *effective date for injuries*, not less than a standard risk acceptable to Golden Rule according to its regular underwriting rules and standards for the exact plan and amount of insurance applied for.
4. The first full premium, according to the mode of premium payment chosen, has been paid on or prior to the *effective date for injuries*, and any check is honored on first presentation for payment.
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 injuries*" for a mailed application means the later of: (a) the requested effective date, if any, shown on the application; or (b) the date upon which the original application is actually received by Golden Rule at its Home Office.
3. "*Effective date for injuries*" for an application sent by any electronic method means the later of: (a) the requested effective date, if any, shown on the application; or (b) the day after the date upon which the application is actually received by Golden Rule at its Home Office.

Limitation:

If, for any reason, Golden Rule declines to issue a 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.**

Golden Rule[®]

Golden Rule Insurance Company



A UnitedHealthcare Company

Home Office
712 Eleventh Street
Lawrenceville, Illinois 62439

Indianapolis Office
7440 Woodland Drive
Indianapolis, Indiana 46278