

Connecticut

# Health Plans

for individuals and families



 **UnitedHealthcare**<sup>®</sup>  
A UnitedHealth Group Company

**Golden Rule**<sup>®</sup>  
A UnitedHealthcare Company

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

# Why Choose Golden Rule?



## **Experience and Expertise**

Golden Rule Insurance Company has been a leader in the individual health market for more than 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 90% 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 70 million individuals nationwide, with products and services to help people achieve better health.\*\*

\* Actual 2006 results

\*\* [www.unitedhealthgroup.com](http://www.unitedhealthgroup.com)

# Copay Plan

## Benefit Highlights

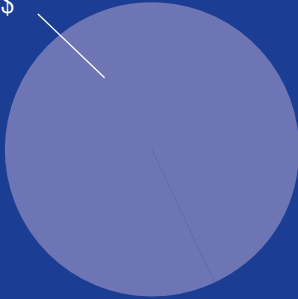
	Copay 25 <sup>SM</sup>
<b>Design Basics</b>	
Network Type	Preferred Network Included
Calendar-Year Deductible Choices (maximum 2 per family, per calendar year)	\$500, \$750, \$1,250
Coinsurance (per covered person, per calendar year)	80/20 to \$5,000 then 100%
Lifetime Maximum Benefit (per covered person)	\$3 million
Initial Rate Guarantee (subject to benefit and address changes)	12 months
<b>Coverage percentages below are effective AFTER deductibles have been met unless otherwise indicated.</b>	
<b>Inpatient Expense Benefits</b>	
Room and Board, Intensive Care Unit, Operating Room, Recovery Room, and Professional Fees of Doctors, Surgeons, Nurses	80%
Other Covered Inpatient Services	80%
<b>Outpatient Expense Benefits</b>	
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%
<b>Routine Health Benefits</b>	
Doctor Office Visit	For history and exam: \$25 Copay, then 100%
Adult Preventive Care (limited to \$150 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: per person \$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.**

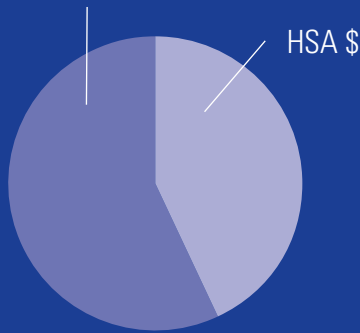
# 2

## 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 health 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.

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

### **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.

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®
<b>Design Basics</b>	
Network Type	Preferred or Savings Based Network
Deductible Choices (one per family per calendar year)	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
<b>Coverage percentages below are effective AFTER deductibles have been met unless otherwise indicated.</b>	
<b>Inpatient Expense Benefits</b>	
Room and Board, Intensive Care Unit, Operating Room, Recovery Room, and Professional Fees of Doctors, Surgeons, Nurses	100%
Other Covered Inpatient Services	100%
<b>Outpatient Expense Benefits</b>	
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%
<b>Routine Health Benefits</b>	
Doctor Office Visit Fees	100%
Outpatient Prescription Drugs	100%
Mammography, Pap Smear, and PSA Testing	100%
Adult Preventive Care (limited to \$150 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.**

# Health Savings Account Options

Health Savings Account  
MasterCard® Prepaid Debit Card



## About Your HSA

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

**You will receive your new Health Savings Account Card<sup>SM</sup> and a PIN mailer in separate mailings.** Once you activate your card, you can use it at:

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

You can also access your HSA funds through:

- Online bill payment at *OptumHealthBank.com* — limit one transaction per business day.
- Checks, if you choose to purchase them.

HSA deposits are set up on the same payment plan as premiums for Golden Rule health insurance coverage. Lump-sum deposits are also accepted by OptumHealth Bank; however, you must continue to deposit the \$25 monthly minimum with your premium payment.

OptumHealth Bank will provide online monthly statements detailing your account balance and activity. If you prefer to have statements mailed to your home, simply notify OptumHealth Bank. You can opt out of electronic statements at its Web site (*OptumHealthBank.com*), call customer service to do so, or send your request to P.O. Box 271629, Salt Lake City, UT 84127-1629.

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

## Account Information by Phone or Online

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

- Toll-free customer service — representatives are available to assist you Monday through Friday, 8 a.m. to 7 p.m. Eastern time, at 1-866-234-8913.
- Interactive voice response for self-service, 24/7.
- *OptumHealthBank.com*

**You can:**

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

## Health Savings Accounts (HSA) — Summary of the Law

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

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

**Qualified Medical Withdrawals** — Tax-free

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

**Nonmedical Withdrawals** — Income tax + 10% penalty tax (under age 65); income tax only (for age 65 and over)

**Death, Disability** — Income tax only — no penalty

Deductible and out-of-pocket maximums may be adjusted annually based on changes in the Consumer Price Index. This is only a brief summary of the applicable federal law. Consult your tax advisor for more details of the law.

## 2008 Deductibles and Monthly Health Savings Account (HSA) Deposit Options

	Singles					Families				
Deductible <sup>1</sup>	\$1,100	\$1,900	\$2,900	\$3,500 <sup>2</sup>	\$5,000 <sup>2</sup>	\$2,200	\$3,850	\$5,800	\$7,500 <sup>2</sup>	\$10,000 <sup>2</sup>
Plan out-of-pocket maximum	Equal to the deductible									
Maximum deposit (tax-deductible limit) <sup>3</sup>	\$241.66 month/\$2,900 year					\$483.33 month/\$5,800 year				

<sup>1</sup>Both the amount of benefits and the premium will vary based upon the plan you select.

<sup>2</sup>Deductibles not available in Connecticut.

<sup>3</sup>Those individuals aged 55 and over may contribute an additional \$900 for tax year 2008.

## 2009 Deductibles and Monthly Health Savings Account (HSA) Deposit Options

	Singles					Families				
Deductible <sup>1</sup>	\$1,150	\$1,900	\$2,900	\$3,500 <sup>2</sup>	\$5,000 <sup>2</sup>	\$2,300	\$3,850	\$5,800	\$7,500 <sup>2</sup>	\$10,000 <sup>2</sup>
Plan out-of-pocket maximum	Equal to the deductible									
Maximum deposit (tax-deductible limit) <sup>3</sup>	\$250.00 month/\$3,000 year					\$495.83 month/\$5,950 year				

<sup>1</sup>Both the amount of benefits and the premium will vary based upon the plan you select.

<sup>2</sup>Deductibles not available in Connecticut.

<sup>3</sup>Those individuals aged 55 and over may contribute an additional \$1,000 for tax year 2009.

## HSA Management by OptumHealth Bank

Current Interest Credited	Access to Funds	One-Time Set-Up Fee	Monthly Maintenance	Minimum Monthly Deposit
2.7%*	Health Savings Account card	\$10	\$3**	\$25

### Who is responsible for my HSA?

As custodian, OptumHealth Bank is responsible for your HSA funds. OptumHealth Bank's deposits are insured by the Federal Deposit Insurance Corporation (FDIC) for at least \$100,000 for each depositor.

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

You will receive a Health Savings Account card from OptumHealth Bank shortly after your qualified medical coverage becomes effective. **HSA withdrawals** can be made by simply using your Health Savings Account card at any point-of-service location (such as a doctor's office or pharmacy) that accepts MasterCard® debit cards.

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

\*As of 8/1/08, subject to change.

\*\*The \$3 monthly maintenance fee is waived when the Minimum Daily Balance exceeds \$5,000. If, however, after the first three months, your Minimum Daily Balance falls below \$100, an additional Below Minimum Balance Fee of \$3 per month will automatically be deducted from



## Optional Insurance Benefit: HSA Hospital Indemnity Rider

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

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

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

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

**Note:** HSA Hospital Indemnity Rider is not available for plans with \$1,100 or \$2,200 deductibles for 2008 and \$1,150 or \$2,300 deductibles for 2009.

The rider does not change, waive, or extend any part of the policy/certificate other than as set forth above. Please see the attached brochure for complete details regarding applicable exclusions and limitations.

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
<b>One-Time Premium Amount For This Option</b>	<b>\$40</b>	<b>\$150</b>

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Policy Form numbers: C-006.3; C-006.4; GRI-N21M; GRI-N21M-15; GRI-N21M-30; GRI-N21S-07; GRI-N21S-15; GRI-N21S-30; GRI-N22M-16; GRI-N22S-16; GRI-N22M-40; GRI-N22S-40; GRI-N22M-49; GRI-N22S-49; GRI-N22M-27-HSA; GRI-PA-20.1-06; -21.1-06; -22.1-10; -23.1-10; UHC06-N21M-17; UHC06-N21S-17. In LA, plans are offered by United HealthCare Insurance Company and administered by Golden Rule.

Golden Rule Insurance Company  
7440 Woodland Drive  
Indianapolis, IN 46278-1719

# High Deductible Plans

## Benefit Highlights

	Plan 100 <sup>®</sup>	Plan 80 <sup>SM</sup>	Basic Plan <sup>SM</sup>
<b>Design Basics</b>			
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
<b>Coverage percentages below are effective AFTER deductibles have been met unless otherwise indicated.</b>			
<b>Inpatient Expense Benefits</b>			
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%
<b>Outpatient Expense Benefits</b>			
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
<b>Routine Health Benefits</b>			
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 (limited to \$150 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 Plan<sup>SM</sup>, HSA 100<sup>®</sup>, or Copay 25<sup>SM</sup>.)

This optional benefit helps manage the costs of prescription drugs. With this benefit, you can purchase:

- Generic prescription drugs for a \$15 copay; and
- Name-brand drugs for a \$30 copay for preferred or \$40 copay for non-preferred 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 100<sup>®</sup>.)

## 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 \$1,100 or \$2,200 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-
<b>One-Time Premium Amount For This Option</b>	<b>\$40</b>	<b>\$150</b>

# Plan-Specific Provisions

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

## Copay 25<sup>SM</sup>, HSA 100<sup>®</sup>, Plan 100<sup>®</sup>, and Plan 80<sup>SM</sup>

### 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 applicable to HSA 100<sup>®</sup>).
- 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 Plan<sup>SM</sup>

## 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).

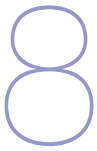
## Outpatient Testing Expense Benefits

- 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 Plan<sup>SM</sup> are significantly less because coverage is not provided for most outpatient services (For example, 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 Plan<sup>SM</sup> (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](http://www.goldenrule.com)

# NOTICE OF INFORMATION PRACTICES

## NOTICE OF PRIVACY 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 personal information that is created or received by a health care provider or health plan 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 Web sites listed at the bottom of this page.

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

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.
- **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:

- **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.

If none of the above reasons apply, **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. 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. You also have the right 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 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).
- **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 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) other disclosures 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 Web sites, [www.eAMS.com](http://www.eAMS.com) or [www.goldenrule.com](http://www.goldenrule.com).

#### Exercising Your Rights

- **Contacting your Health Plan.** If you have any questions about this notice or want to exercise any of your rights, please 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: Golden Rule Insurance Company, Privacy Officer, 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 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.

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

#### Medical Information Bureau

In conjunction with our membership in the 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., P.O. Box 105, Essex Station, Boston, MA 02112, (866) 692-6901, [www.mib.com](http://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.

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.

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The Notice of Information Practices, effective November 2006, is provided on behalf of American Medical Security Life Insurance Company; Golden Rule Insurance Company; PacifiCare Life & Health Insurance Company; All Savers Insurance Company; and UnitedHealthcare, Inc.

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

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

CONDITIONAL RECEIPT FOR

THIS FORM LIMITS OUR LIABILITY.

Proposed Insured:

Amount Received:

Date of Receipt:

**NO INSURANCE WILL BECOME EFFECTIVE UNLESS ALL 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.

*Patrick F. Can*  
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.**

