Golden Rule®

Copay Plans℠

Copay Plans℠ are designed for individuals and families who want help managing their **routine medical expenses** plus outstanding coverage for major health care expenses. *(Not available in Alaska.)*

Optional Benefits are designed to help individuals and families further customize their health insurance coverage to meet their specific needs. *Please see page 7 for descriptions of Optional Benefits.*

Plan	**Copay 25℠ Plan**	**Copay 35℠ Plan**	**Copay 45℠ Plan**
Type	• Full PPO Required (see PPO on page 7)	• Full PPO Required (see PPO on page 7)	• Full PPO Required (see PPO on page 7)
Deductible Options (maximum 2 per family, per year)	• $500 • $750	• $500 • $750	• $1,000
Coinsurance Options	• 70/30 • 50/50	• 70/30 • 50/50	• 70/30 • 50/50
Coinsurance Maximum Out-of-pocket (per covered person, per calendar year)	• $2,500	• $3,500	• $4,500
Doctor Office Visit Fees Including X-Ray and Lab (performed in the Doctor's office on the same day of service)	• $25 Copay, then 100%	• $35 Copay, then 100%	• $45 Copay, then 100%
Outpatient Rx	$50 deductible per person, per year, then: • $25 Copay Generic • $35 Copay Name Brand	$100 deductible per person, per year, then: • $25 Copay Generic • $35 Copay Name Brand	$150 deductible per person, per year, then: • $25 Copay Generic • $35 Copay Name Brand
Preventive Care, Including Routine Physicals and Lab Fees ($150 maximum per year after 12 months for each adult 19 or older)	• $25 Copay, then 100%	• $35 Copay, then 100%	• $45 Copay, then 100%
Mammography, Pap Smear, and PSA Testing	• Deductible and Coinsurance	• Deductible and Coinsurance	• Deductible and Coinsurance
Inpatient Hospital and Surgical Fees Included on the Hospital Bill	• $500 Copay, then Coinsurance (maximum 2 copays per person, per year)	• $1,000 Copay, then Coinsurance (maximum 2 copays per person, per year)	• $1,000 Copay, then Coinsurance (maximum 2 copays per person, per year)
Outpatient Surgery and Other Covered Inpatient and Outpatient Fees	• Deductible and Coinsurance	• Deductible and Coinsurance	• Deductible and Coinsurance
Emergency Room Fees	• Deductible and Coinsurance	• Deductible and Coinsurance	• Deductible and Coinsurance
Initial Rate Guarantee (subject to benefit and address changes)	• 12 months	• 12 months	• 12 months
Lifetime Maximum Benefit (per covered person)	• $3 million	• $3 million	• $3 million
Optional Benefits (see page 7)	• Maternity • Supplemental Accident • Term Life Rider	• Maternity • Supplemental Accident • Term Life Rider	• Maternity • Supplemental Accident • Term Life Rider

To be considered for reimbursement, expenses must qualify as covered expenses. ***Visit our Web site at goldenrule.com***

33208-0402
Policy Forms C-006.3 or C-006.4

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Covered Expenses

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

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 treatment of an injury or illness (subject to an additional $100 deductible each time the emergency room is used for illness not resulting in confinement).
- Surgery at an outpatient surgical center.
- Professional fees of doctors and surgeons (but not for standby availability).
- Dressings, sutures, casts, or other necessary medical supplies.
- Professional fees for outpatient services of licensed physical therapists.
- Diagnostic 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.
- 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 eyes, larynx, breast prosthesis, or basic artificial limbs (but not replacements).

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.

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 nonlymphocyctic leukemia, multiple myeloma, testicular cancer, Stage III or IV neuroblastoma, pediatric Ewing's sarcoma and related primitive neuroectodermal tumors, Wilms' tumor, rhabdomyosarcoma, medulloblastoma, astrocytoma, and glioma.

Other Plan Provisions

Limited Exclusion for AIDS or HIV-Related Disease

AIDS and HIV-related disease is treated the same as any other illness unless the onset of AIDS or HIV-related disease is: (a) diagnosed before the coverage has been in force for one year; or (b) first manifested before the coverage has been in force for one year. If diagnosed or first manifested before coverage has been in force for one year, AIDS and HIV-related disease claims will never be covered. Details of this limited exclusion are set forth in the policy and certificates.

Notification Requirements

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

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

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

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

Our receipt of notification does not guarantee either payment of benefits or the amount of benefits. Eligibility for and payment of benefits are subject to all terms and conditions of the policy.

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: (a) for which a covered person received medical advice or treatment within 24 months prior to the applicable effective date for coverage of the illness or injury; or (b) which manifested symptoms which would cause an ordinarily prudent person to seek diagnosis or treatment within 12 months prior to the applicable effective date for coverage of the illness or injury.

General Exclusions

No benefits are payable for expenses which:

- Are due to pregnancy (except for complications of pregnancy) or routine newborn care (unless optional coverage is selected).
- Are for routine or preventive care unless provided for in the policy.
- Are incurred while confined primarily for custodial, rehabilitative, or educational care or nursing services.
- Result from employment-related injury or illness if the covered person is insured or is required to be insured, by workers' compensation insurance under applicable state or federal law.
- Are in relation to, or incurred in conjunction with, investigational treatment.
- Are for dental expenses or oral surgery, eyeglasses, contacts, eye refraction, hearing aids, or any examination or fitting related to these.
- Are for modification of the physical body, including breast reduction or augmentation.
- Are incurred for cosmetic or aesthetic reasons, such as weight modification or surgical treatment of obesity.
- Would not have been charged in the absence of insurance.
- Are for eye surgery to correct nearsightedness, farsightedness, or astigmatism.
- Result from war, intentionally self-inflicted bodily harm (whether sane or insane), or participation in a felony (whether or not charged).
- Are 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 certificate 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, middle ear disorders, hemorrhoids, 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.
- All diagnoses or treatments of mental disorders, as defined in the policy, including substance abuse will be limited to a lifetime maximum benefit of $3,000. Covered expenses for outpatient diagnosis or treatment of mental disorders will be further limited to $50 per visit. As with any other illness or injury, inpatient care which is primarily for educational or rehabilitative care will not be covered.
- Covered outpatient expenses relating to diagnosis or treatment of any spine or back disorders will be limited to a maximum 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 will be the later of: (a) the requested effective date, if any, shown on the application; or (b) 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. 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 certificate 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 eligibility requirements, or if the covered person commits fraud or intentional misrepresentation.

Continued Eligibility Requirements:

A covered person's eligibility will cease on the earlier of the date a covered person:

- Enters the armed forces on an active full-time basis;
- Ceases to be a dependent; or
- Becomes insured under an individual plan providing medical or hospital, surgical, or medical services or benefits. (This does not apply to stand-alone cancer-/ICU-/-accident-only policies.)

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

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

Hospice Care:

To qualify for benefits, a Hospice Care program for a terminally ill covered person must be licensed by the state in which it operates. Benefits for inpatient care in a hospice will be limited to 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. Benefits for outpatient care will be limited to $1,500 in a covered person's lifetime.

Arbitration:

The policy contains an arbitration provision to resolve many claims disputes without litigation. The decision of the arbitrators will be final and binding unless prohibited by your state. There is also a provision that provides for resolution of disputes over medical necessity.

Group -- COB:

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

Medicare -- Carve-Out:

Covered persons who reach the age of Medicare eligibility will be provided an alternative health insurance benefit called "Carve-out." Basically, "Carve-out" pays the difference between what Golden Rule benefits normally would pay and what is paid or payable by Medicare, whether or not the covered person is covered by Medicare.

Complete coverage details are provided in the policy and certificates. In most cases, coverage will be determined by the master policy issued in Illinois and subject to Illinois law.

State Variations

Please review the information provided below, which summarizes the major variations in coverage by state from those described in this brochure.

Alaska

- Copay Plans[SM] are not available in this state.
- Formulas necessary for the treatment of phenylketonuria are covered the same as any other illness.

Arizona

- The references to 24 and 12 months in the definition of a preexisting condition are both changed to 6 months.
- Dependent children do not have to live with you to meet the definition of eligible children.
- The limited exclusion for AIDS does not apply.
- Portability plans (guarantee issue without preexisting conditions' exclusions) are available to eligible applicants. Review the application for insurance for details.

Arkansas

- The exclusion for TMJ disorders does not apply.
- Limited coverage is provided for children's preventive health care services.
- Childhood immunizations are not subject to the deductible.

Colorado

- MSA Plans℠ are not available in this state.
- The limitation on expenses incurred during the first six months for treatment of tonsils, adenoids, middle ear disorders, hemorrhoids, hernia, or any disorders of the reproductive organs does not apply.
- The 14-day waiting period for the coverage of illnesses does not apply.
- The preexisting conditions limitation is reduced from 24 to 6 months.
- The limited exclusion for AIDS does not apply.
- The Medicare -- Carve-out provision is amended to provide no reduction in benefits or premium if a covered person does not have Medicare coverage.
- Expenses for mammography exams, prostrate screening, and child health services are not subject to the deductible.
- Mental or nervous disorders: The exclusion under the Basic Plan℠ and the $3,000 lifetime limit under other plans is removed. Instead, you will receive certain limited benefits mandated by Colorado.
- Certain types of biologically-based mental illnesses will be covered, subject to all the terms and conditions of the certificate.
- The age limit for a dependent is increased from 23 to 24, and can include a dependent certified as disabled.
- No benefits will be paid for treatment of intractable pain as defined in the certificate.

Florida

- Covered child health supervision services (well-child care services) are not subject to the deductible.
- Portability plans (guarantee issue without preexisting conditions' exclusions) are available to eligible applicants. Review the application for insurance for details.

Georgia

- There is a carry-over deductible feature which allows for expenses incurred and applied to the calendar-year deductible during the last three months of the year to be applied towards satisfying your deductible for the next calendar year. This does not apply to the MSA.
- The limited exclusion for AIDS does not apply.
- The limiting age for a child attending an accredited college on a full-time basis to be considered a dependent is changed from 23 to 25.
- Child-wellness benefits are not subject to the deductible.

Iowa

- **Plans Offered by Golden Rule:**

  Copay Plan℠ • Plan 100® • Plan 80℠ • Basic Plan℠ • MSA Plans℠ • State of Iowa Basic and Standard Health Benefit Plan

  For information on availability and premium rates, please consult your insurance representative.
- The spine and back limitation does not apply.
- The preexisting conditions 12-month waiting period may be reduced for persons covered by qualifying prior coverage.
- The limited exclusion for AIDS does not apply.
- The arbitration provision does not apply.
- The maternity expense benefits rider does not cover maternity expenses until 300 days after the rider effective date.

Maryland

- The limited exclusion for AIDS does not apply.
- Portability plans (guarantee issue without preexisting conditions' exclusions) are available to eligible applicants. Review the application for insurance for details.

Michigan

- The reference to 24 months in the definition of a preexisting condition is changed to 6 months.
- **Provider Network Continuity of Treatment:** If your provider leaves the network while you are receiving treatment for an "injury or illness," your first subsequent visit will be covered as if your provider were still a preferred provider, and we will notify you that the provider is no longer a network provider so that you may choose a new network provider.
- **Grievance Procedure Information Phone Number:** (317) 297-4189. Upon request, we will provide you with the telephone number for the Michigan Department of Consumer and Industry Services.
- Expenses incurred for diagnosis and treatment of intractable pain will be covered expenses to the same extent as for any other illness or injury.

Mississippi

- The references to 24 and 12 months in the definition of a preexisting condition are both changed to 6 months.

Missouri

- The limited exclusion for AIDS does not apply.
- Portability plans (guarantee issue without preexisting conditions' exclusions) are available to eligible applicants. Review the application for insurance for details.
- The exclusion for intentionally self-inflicted bodily harm does not apply if the intentionally self-inflicted bodily harm resulted from a suicide attempt while insane.
- The exclusion for suicide while insane in the Decreasing Term Life Insurance Rider does not apply.

Ohio

- On all plans except Basic Plan℠: The lifetime maximum benefit limit for inpatient diagnosis or treatment of a mental disorder or substance abuse and for outpatient diagnosis or treatment of substance abuse is $3,000 per covered person; professional fees of a medical practitioner for outpatient treatment of substance abuse are limited to $50 per visit; and professional fees of a medical practitioner for outpatient diagnosis and treatment of a mental disorder are limited to $550 per covered person, per calendar year.
- **Plans Offered by Golden Rule:**

  Copay Plans℠ • Plan 100® • Plan 80℠ • Basic Plan℠ • MSA Plans℠ • State of Ohio Basic and Standard Plans.
- Limited coverage is provided for child health supervision services.

Oklahoma

- Expenses for mammography exams are not subject to the deductible or coinsurance.
- The spine and back limitation does not apply.
- The preexisting conditions 12-month waiting period may be reduced for persons covered by qualifying prior coverage.
- Covered childhood immunizations are not subject to the deductible.

Pennsylvania

- Covered childhood immunizations are not subject to the deductible.
- Formulas or nutritional supplements for PKU and other metabolic disorders are covered and are not subject to the deductible.

South Carolina

- The preexisting conditions reference to treatment within 24 months prior to the applicable effective date is changed to 12 months. This 12-month waiting period may be reduced for persons covered by qualifying prior coverage.

Tennessee

- Portability plans (guarantee issue without preexisting conditions' exclusions) are available to eligible applicants. Review the application for insurance for details.

Texas

- Treatment of TMJ disorders is covered the same as any other illness.
- Formulas necessary for the treatment of phenylketonuria are covered the same as any other illness.
- The optional maternity benefit is added by use of a rider and requires additional premium.
- With respect to fees charged for covered expenses, reasonable and customary charges mean the most common charge for similar expenses within the area in which the expense is incurred so long as these charges are reasonable. What is reasonable and customary will be determined by Golden Rule based on the factors stated in the policy.
- Inpatient diagnosis or treatment of mental or nervous disorders or mental incapacity will be covered the same as any other illness, subject to the $3,000 lifetime maximum benefit and other terms of the policy. For example, as with any other illness or injury, inpatient treatment which is primarily for educational or rehabilitative care will not be covered.
- If a designated "Center of Excellence" is not used for a listed transplant, covered expenses will be reduced by 25 percent.
- A preexisting condition is an injury or illness for which the covered person received medical advice or treatment within the 12 months immediately preceding the effective date of coverage. This 12-month waiting period may be reduced for persons covered by qualifying prior coverage.
- Limited benefits are provided for the diagnosis and treatment of chemical dependency.
- AIDS and HIV-related disease claims will be limited to $5,000 per calendar year, provided the conditions under the limited exclusion for AIDS or HIV-related disease are met.
- Medically necessary is a defined term and means that a service, medicine, or supply is necessary and appropriate for the treatment of an illness or injury as determined by Golden Rule based on factors stated in the policy.
- The Coordination of Benefits provision also takes into account personal injury protection coverage, whether provided under a group or individual contract.
- Covered childhood immunizations are not subject to the deductible.
- The limiting age is changed from 23 to 25 for a child who is a full-time student.
- Applicants will not be declined solely on the basis of other insurance.

Virginia

- Work-related injuries are covered unless benefits are payable by Workers' Compensation.
- **Coordination of Benefits:** If, after Golden Rule coverage is issued, a person becomes insured under (an)other group plan(s), benefits of the plans will be determined under the Coordination of Benefits (COB) clause. One plan will be determined to pay primary based on COB rules described in the policy/certificate. Some of the rules which usually result in a plan paying primary include: not having an appropriate COB clause; covering a person as other than a dependent; with regard to a dependent covered under both parents' plans, the plan issued to the parent with the earlier date of birth or determined to be primary under the terms of a court decree or determinations based on custody; covering the person as an active employee/dependent of an active employee; or which plan has provided coverage longer.
- Portability plans (guarantee issue without preexisting conditions' exclusions) are available to eligible applicants. Review the application for insurance for details.

West Virginia

- No benefits are payable for expenses which result from employment-related injury or illness (unless the person is self-employed and not covered by Workers' Compensation).
- Portability plans (guarantee issue without preexisting conditions' exclusions) are available to eligible applicants. Review the application for insurance for details.

Wisconsin

- The limited exclusion for AIDS does not apply.
- The spine and back limitation does not apply.
- Covered expenses for all diagnoses or treatments of mental or nervous disorders and substance abuse are subject to the deductible and coinsurance and will be limited to a policy year maximum benefit of $7,000. Outpatient treatment is further limited to a maximum benefit of $2,000.
- Limited coverage for nonsurgical treatment of TMJ is provided.
- Covered child immunization services are not subject to the deductible.
- Covered expenses for home health aide services will be limited to 40 visits in a 12-month period.

Optional Benefits

Maternity Benefit

The optional Maternity Benefit is designed to help cover the costs for routine pregnancy and delivery. You choose the maximum benefit amount: $2,500 or $4,000. The plan will pay up to 50 percent of the maximum benefit during the first year. After the first year, the plan will pay 100 percent of the maximum benefit. To be covered, a pregnancy must begin while the maternity benefits are in effect. *(Not available in Arkansas, Maryland, or Virginia.)*

Benefit Amount	*Year 1*	*Year 2 & On*
$2,500	50%	100%
$4,000	50%	100%

Supplemental Accident Benefit

The optional Supplemental Accident Benefit is designed to provide up-front coverage to individuals and families for unexpected accidents. This option provides up to $500 of first-dollar benefits for treatment of an injury within 90 days of an accident.

Preferred Provider Organizations (PPO)

Selecting the PPO option (required with Copay Plans[SM]) on your health insurance plan allows you to significantly lower the premium cost.

If you receive nonemergency services from a provider outside the network, covered expenses will be reduced by 25 percent and subject to an additional deductible amount equal to the calendar-year deductible.

Office visit expenses outside the network are not eligible for copay benefits.

Term Life Benefit

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 for you and your spouse will depend on the primary insured's attained age at the time of death, as shown in the table.

Attained Age of Primary Insured at Death	*Primary Insured Benefit Amount*	*Covered Spouse Benefit Amount**
49 or less	$30,000	$15,000
50-59	18,000	9,000
60-64	12,000	6,000

* Equal to the *Primary Insured Benefit Amount* for certificates issued to residents of Maryland.

World of FACT Value

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

- Prescription drug discounts
- Eye-wear savings
- Van line discounts
- Vitamins, minerals, and other health products at a 20% savings
- Health insurance plans
- Utilization review services
- Consumer library
- *Consumer hotline* referral service
- Amusement park discounts
- Travel service and savings
- Informative newsletter
- Other special buying opportunities as they become available throughout the year

Plus . . .

- *You may apply for:* FACT scholarships, classroom grants, and community project grants
- *You are eligible to request:* Financial assistance in the event of a natural disaster
- *You are kept aware of matters of importance through:* FACT's legislative watch

Benefits and suppliers change from time to time. For the most current information:
Visit FACT's Web site (http://www.fact-org.org).
Or call toll-free (1-800-USA-FACT).

These health insurance plans are available as group coverage only to members of FACT. If you're not already a member, you must join FACT. When you join FACT and sign up for insurance with Golden Rule, you enjoy group benefits and maintain your independent status!

Notice of Information Practices

When you apply to Golden Rule Insurance Company for insurance or financial services, you entrust us with personal health and financial information. This information is necessary because we rely on you as the best and most important source of information about you and other persons listed on your application. We may also collect personal information about you from other sources.

Information We Collect

As a part of providing you with Golden Rule health insurance and financial services products, we may obtain public and nonpublic personal information, including:

- Information from applications or other forms such as: name, address, telephone number, social security number, date of birth, gender, marital status, assets, income, and E-mail address;
- Information about transactions with us or our affiliates, such as type of product purchased, policy or account number, account balance, policy coverage, and payment and claims history;
- Information provided by employers, benefit plan sponsors or associations, such as employee premium contribution amounts and employee or association eligibility;
- Information from other sources, such as motor vehicle reports, medical information, and information about your transactions with other insurance companies; and
- Information from consumer reporting agencies.

Information We Disclose

Golden Rule does not disclose nonpublic personal information about our customers or former customers to anyone, except as permitted or required by law.

During the normal course of business, Golden Rule may share the personal information as described above with a company affiliated with Golden Rule.

Also, Golden Rule may disclose information we collect, as described above, to persons or companies with which we have contracts to perform functions on our behalf.

These include financial services providers such as: insurance companies, payment processing companies and nonfinancial services providers such as: mailing houses, data processing companies, and those that provide access to provider discounts for our insureds. These companies might assist us, for example, in fulfilling your service request, processing your transaction, or mailing account statements.

In addition, we may share the information listed above with financial institutions with which we jointly offer, endorse, or sponsor a financial product or service.

All of these persons or companies, which act with us or on our behalf, are contractually obligated to keep the information that we provide to them confidential and to use the information only to provide the services we have asked them to perform for you and us.

Former Customers

If your customer relationship with Golden Rule is terminated, we will continue to treat and safeguard your information as described in this notice.

Security of Information

Golden Rule maintains policies and practices that protect the security and confidentiality of customer information. This includes: limiting nonpublic personal information to employees who need the information in order to perform their job duties, maintaining user passwords, and protecting information through security-enhancing software, such as virus and intrusion detection software.

Fair Credit Reporting Act Notice

In some cases, Golden Rule may ask a consumer reporting agency to compile an investigative consumer report about you. If a consumer report is requested, we will notify you promptly with the name and address of the consumer reporting agency that will furnish the report. Upon written request, you may request to be interviewed in connection with the investigation. The agency may retain a copy of the report and may disclose it to other persons to the extent permitted by the federal Fair Credit Reporting Act.

Medical Information Bureau

Golden Rule or its reinsurers may make a report of nonpublic information in conjunction with its membership to the Medical Information Bureau, 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. Upon your request, the Bureau will arrange disclosure of any information it has in your 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, telephone number (617) 426-3660. Or go to: *www.mib.com*

Access to and Correction of Your Information

You have a right of access and correction with respect to information collected about you. You may obtain access to personal information about you that is contained in our files. You may also request correction, amendment, or deletion of any information in those files you believe to be inaccurate. The procedures for access and correction of your information will be provided to you upon your request.

Golden Rule is unable to provide you with information collected in connection with, or in anticipation of, any claim, lawsuit, or medical information we have obtained from a health care provider.

This notice is being provided on behalf of Golden Rule Insurance Company and the following affiliated companies:

Ad-Ventures, Inc.
All Savers Insurance Company
Central States Securities, Inc.
Executive Systems, Inc.
Golden Rule Acquisition Corporation
Golden Rule Financial Corporation
Plan LTC Inc.
Rooney Life Insurance Company

You will receive an annual written notice of our privacy policy. A copy is always available by writing:

Golden Rule Insurance Company
Attn: Privacy Official
712 Eleventh Street
Lawrenceville, IL 62439

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. The person is a member of the Federation of American Consumers and Travelers.
3. All medical examinations, if required, have been *satisfactorily completed*.
4. 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.
5. 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.
6. The certificate 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 certificate or to issue a specially ridered certificate.
2. *"Effective date for injuries"* 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.

Limitation:

If, for any reason, Golden Rule declines to issue a certificate or issues a certificate other than a standard certificate 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.

KEEP THIS DOCUMENT. IT HAS IMPORTANT INFORMATION.