



Short Term MedicalSM Plans

Health insurance for individuals and families in times of transition and change

UnitedHealthOne 



Available Only to Members of FACT.
(See back cover)

Policy Forms C-006.4 and MRR03927 (TX)
37806-G-0908

Why Choose Us for Health Insurance?

UnitedHealthcare

Today, UnitedHealthcare serves more than 70 million customers. Our network plans can ease access to high-quality care from more than 560,000 physicians and 4,800 hospitals across all 50 states and in four international markets.* We combine our strength and stability with nearly three decades of experience serving customers of all sizes.

UnitedHealthOne

UnitedHealthOne is the brand name of the UnitedHealthcare family of companies that offers personal health insurance products. Golden Rule Insurance Company, a UnitedHealthcare company, is the underwriter and administrator of these plans. With over 60 years of experience serving individuals and families, Golden Rule provides high-quality products, timely claims handling, and outstanding customer service.

Experience and Expertise

Golden Rule's experience and expertise has driven the development of easy-to-use and innovative health insurance products. A recognized leader — and one of the nation's largest providers of health savings account plans — Golden Rule continues building plans that meet the needs of individuals and families. Golden Rule is rated "A" (Excellent) by A.M. Best and "A+" (Strong) by Standard and Poor's. These worldwide, independent organizations examine insurance companies and other businesses and publish their opinions about them. These ratings are an indication of our financial strength and stability.

Customer Satisfaction

- More than 92% of all health insurance claims are processed in 10 working days or less.**
- Up to 35%-45% discounts are provided on quality care thanks to our extensive network of doctors and hospitals.***
- We're easy to reach with a toll-free customer service line: (800) 657-8205. We respond quickly to customer questions and concerns.

*As of 7/31/2008.

**Actual 2007 results.

***Discounts vary by provider, geographic area, and type of service.

Short Term MedicalSM



The plan that offers easy-to-understand health insurance designed for individuals and families in times of transition and change. Plans available to members of FACT — see back panel.

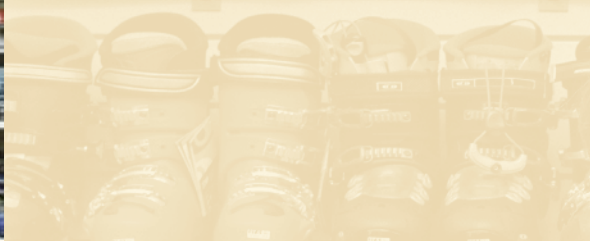
***Short Term Medical* can “bridge the gaps” in health insurance coverage if:**

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

Because we know that life can change quickly, Golden Rule gives you the flexibility to drop your *Short Term Medical* coverage at any time without penalty or to apply for another 1-6 months of coverage.

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

Note: *Short Term Medical* is temporary health insurance and non-renewable. You may apply for one additional certificate. A second certificate is not a continuation of the first; preexisting conditions will not be covered.



How Short Term Medical Works:

- 1** You pay the stated deductible for each illness or injury.
- 2** The insurance pays 80% of the next \$5,000 of covered expenses. You pay 20%.
- 3** The insurance pays 100% of remaining covered expenses.

Optional Periods of Coverage:

1-6 months.

Deductible Amounts Available:

\$250, \$500, \$1,000, \$1,500, or \$2,500.

12-Month Extension of Benefits

If an insured is confined as an inpatient during the coverage term and the confinement continues after the term ends, we will extend coverage until the earlier of the discharge date or 12 months after the end of the policy term.

60-Day Extension of Benefits

Benefits (up to \$1,000 maximum) can be paid for up to 60 days after the end of the policy term for an illness or injury. This is provided that the deductible is met, that the covered expenses are first incurred in excess of the deductible for that illness or injury during the policy term, and that the illness or injury does not result in an inpatient hospital confinement that begins during the policy term.

This brochure is only a general outline of our standard short-term benefits. Please see pages 11 and 12 for state variations. This is not an insurance contract. Please read your certificate carefully.

Complete coverage details are provided in the policy and certificates. In most cases, coverage will be determined by the master policy issued in Illinois and subject to Illinois law. We will notify you in advance of any changes in coverage or benefits.

Not available in all states.



UnitedHealthcare Choice Plus Network Using Preferred Networks

With a Golden Rule health insurance plan, you gain access to the UnitedHealthcare Choice Plus network.

Physicians, hospitals, and other health-care providers participating in UnitedHealthcare Choice Plus network have agreed to provide you quality care at reduced costs. The result is lower premiums, and in return, you agree to use the physicians, hospitals, and other providers in the network.

This extensive network of health-care professionals and facilities provides you substantial discounts on medical services.

To locate providers for the network, visit www.goldenrule.com (our Web site).

1. *Select Networks.*
2. *Choose Networks Available for New Applicants.*
3. *Select State.*
4. *Select UnitedHealthcare Choice Plus.*

Out-of-Network Benefit Reduction

Receiving nonemergency services outside the Choice Plus network results in substantially less benefits. Your covered expenses are reduced by 25%. This reduction is limited to \$5,000 in covered expenses, per covered person.



Deductible and Benefit Period per Condition

For each condition (illness or injury), you will have a deductible and a maximum benefit period. A benefit period begins when you are hospital-confined or meet the full amount of the deductible for an illness or injury during the certificate term. You may have more than one benefit period running at a time if you have more than one illness or injury for which you are hospital-confined or have met the full amount of the deductible.

Group — Coordination of Benefits

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

Dependents

For purposes of this coverage, eligible dependents are your lawful spouse and eligible children. Eligible children must be unmarried and under 25 years of age at time of application.

Limitations

Diagnosis or treatment of mental or nervous disorders, including mental incapacity and substance abuse, will be limited to a lifetime maximum of \$3,000 per covered person. Outpatient diagnosis or treatment of mental or nervous disorders will be further limited to \$50 per visit.

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

Covered Expenses

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

- Daily hospital* room and board at most common semiprivate rate; reasonable and customary charges for intensive care unit.
- Hospital charges for inpatient use of an operating, treatment, or recovery room.
- Hospital emergency treatment of an injury (even if confinement is not required).
- Professional fees of doctors and surgeons.
- Diagnostic X-ray and laboratory tests, in or out of the hospital.
- Prescription drugs.
- Ground ambulance service to a hospital for necessary emergency care.
- Cost and administration of an anesthetic.
- Radiation therapy and chemotherapy.
- Hemodialysis, processing, and administration of blood or components (but not the cost of the actual blood or components).
- Cost and administration of oxygen and other gases.
- Rental of wheelchair, hospital bed, and other durable medical equipment.
- Diagnostic tests, in or out of the hospital.
- Dressings and other necessary medical supplies.
- Artificial eyes, limbs, breast prosthesis, or larynx (but not replacement).
- Surgery to treat craniomandibular disorders, malocclusions, or disorders of the temporomandibular joint (TMJ), limited to a combined \$10,000 lifetime maximum per covered person.
- Outpatient surgery at an outpatient surgical center.
- Mammograms, Pap smears, prostate-specific antigen testing, and other preventive care as specified in the certificate.

- Home health care prescribed and supervised by a doctor and provided by a licensed home health-care agency. Covered expenses for home health aide services will be limited to 7 visits per week and a lifetime maximum of 365 visits. Registered nurse services will be limited to a lifetime maximum of 1,000 hours.

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

Transplant Expense Benefit

The following types of transplants are eligible for coverage.

Tissue Transplants

- Cornea transplants
- Artery or vein grafts
- Heart valve grafts
- Prosthetic tissue and joint replacement
- Prosthetic lenses for cataracts

Listed Transplants

- Heart
- Lung
- Heart and lung
- Bone marrow
- Liver
- Kidney

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

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

The following conditions are eligible for bone marrow transplant coverage:

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

Autologous bone marrow transplants (ABMT) for treatment of: Hodgkin’s lymphoma, non-Hodgkin’s lymphoma, acute lymphocytic and 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.

Exclusions

No benefits are payable for expenses that:

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

No benefits are payable for:

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

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

NOTE: Even if you have had prior Golden Rule coverage and your preexisting conditions were covered under that plan, they will not be covered under this plan.

- Employment-related injury or illness (unless self-employed and not covered by Workmen's Compensation coverage).

- Pregnancy or routine well-baby care.
- Dental services or procedures, eyeglasses, contacts, eye refraction, visual therapy, hearing aids, or any examination or fitting related to these.
- Charges for use of hospital emergency room due to illness (unless confined).
- Any drug, treatment, or procedure that promotes or prevents conception or prevents childbirth, including abortion, sterilization, artificial insemination, or treatment for infertility or impotency (see pages 11-12 for state variations).
- Television, telephone, or expenses of other persons.
- Treatment of temporomandibular disorders (except as stated in covered expenses).
- Marriage, family, or child counseling.
- Recreational or vocational therapy or rehabilitation.
- Services performed by an immediate family member.
- Procedures, services, or supplies that are considered to be investigational treatment.
- Treatment of mental disorders or substance abuse, unless expressly provided for by the certificate.
- Durable medical equipment, except as provided for under covered expenses.
- Expenses incurred outside of the United States, except for expenses incurred in conjunction with emergency treatment of a covered person.
- Diagnosis or treatment of learning disabilities, attitudinal disorders, or disciplinary problems.
- Occupational therapy or outpatient speech therapy, except as provided for by the certificate.
- Services or supplies that are not ordered or administered by a doctor, or that are not medically necessary to the diagnosis or treatment of an illness or injury.

Effective Date

Your certificate will take effect on the later of: (1) the requested effective date; or (2) the day after the postmark date affixed by the U.S. Postal Service,* but only if the following conditions are satisfied:

- (a) Your application and the appropriate premium payment are actually received by us within 15 days of your signing;**
- (b) You are a member of the Federation of American Consumers and Travelers (FACT) or another qualified association;
- (c) Your application is properly completed and unaltered;
- (d) You have answered “no” to question 2 (if other questions are answered “yes,” we will exclude the person(s) listed);
- (e) You are a resident of a state in which the certificate form can be issued;
- (f) If the application is submitted by an agent or broker, the agent or broker is properly licensed to submit applications to Golden Rule; and
- (g) You have not been insured under more than one prior Golden Rule *Short Term Medical* policy/certificate.

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

** Your account will be immediately charged.

Renewability

Your *Short Term Medical* certificate is not renewable. You may apply for one additional certificate. This second certificate will not be a continuation of the first.

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

State Variations

Arkansas

- The exclusion for TMJ disorders does not apply.
- Childhood immunizations are not subject to the deductible.

Florida

- Child health supervision services (well-child care services) are not subject to the deductible.

Iowa

- The spine and back limitation does not apply.

Mississippi

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

Missouri

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

Nebraska

- Childhood immunizations for your covered dependent children from birth through age 5 are covered, not subject to the deductible.

North Carolina

- Limited coverage for nonsurgical treatment of TMJ up to lifetime maximum of \$3,500.
- The lifetime maximum for surgical treatment of TMJ does not apply.
- Occupational injuries or illnesses are not covered expenses if paid under the North Carolina Worker's Compensation Act.
- The preexisting conditions reference to treatment within 24 months prior to the applicable effective date is changed to 12 months.
- For covered expenses received outside of the Choice Plus network, benefits will be reduced by 25%. This reduction is limited to \$1,000 per benefit period.

Ohio

- Outpatient treatment for alcoholism or mental or nervous disorders is limited to \$550 a calendar year.

Oklahoma

- Mammograms are not subject to the deductible or coinsurance.
- The spine and back limitation does not apply.

Pennsylvania

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

Texas

- Treatment of TMJ disorders are covered the same as any other illness.
- Formulas necessary for the treatment of phenylketonuria (PKU) are covered the same as any other illness.
- With respect to fees charged for covered expenses, 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 certificate.
- The limited benefits for diagnosis or treatment of mental or nervous disorders or mental incapacity remain subject to all other terms of the policy. For example, as with any other illness or injury, inpatient treatment which is primarily for educational or rehabilitative care will not be covered.
- If a designated "Center of Excellence" is not used for a listed transplant, covered expenses will be reduced by 25%.
- A preexisting condition is an injury or illness for which the covered person received medical advice or treatment within the 12 months immediately preceding the effective date of coverage.
- Limited benefits are provided for the diagnosis and treatment of chemical dependency.

- Covered expenses will include diagnosis or treatment of serious mental illness, as defined in the policy/certificate, limited to 45 days of inpatient treatment and 60 outpatient visits per calendar year, per covered person.
- Covered expenses will include diagnosis and treatment of autism spectrum disorder for covered persons two through five years of age.
- Covered expenses will include diagnosis and treatment of an acquired brain injury. Post-acute care for an acquired brain injury will be limited to a lifetime maximum of 60 days per covered person.
- “Medically necessary” is a defined term and means that a service, medicine, or supply is necessary and appropriate for the treatment of an illness or injury, as determined by Golden Rule, based on factors stated in the certificate.
- The Coordination of Benefits provision also takes into account personal injury protection coverage, whether provided under a group or individual contract.
- Childhood immunizations are not subject to the deductible.

Virginia

- A preexisting condition is an injury or illness for which the covered person received medical advice or treatment within the 12 months immediately preceding the effective date of coverage.

West Virginia

- Childhood immunizations (until 17th birthday) are not subject to the deductible.
- Covered expenses are expanded to include an annual kidney disease screening.

Wisconsin

- 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 maximum benefit of \$7,000 or 30 days' treatment, whichever is less. Outpatient treatment is further limited to a maximum benefit of \$2,000.
- Limited coverage for nonsurgical treatment of TMJ is provided.
- The spine and back limitation does not apply.
- Covered child immunization services are not subject to the deductible.

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 or 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 46278-1719

You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint. **We will not take any action against you for filing a complaint.**

Fair Credit Reporting Act Notice

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

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

Medical Information Bureau

In conjunction with our membership in 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 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.

The Notice of Information Practices, effective May 2008, is provided on behalf of American Medical Security Life Insurance Company; Golden Rule Insurance Company; PacifiCare Life and Health Insurance Company; PacifiCare Life Assurance Company, United HealthCare Insurance Company; All Savers Insurance Company; and United HealthCare Services, 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.

33638-0508 Products are either underwritten or administered by: American Medical Security Life Insurance Company, PacifiCare Life and Health Insurance Company, PacifiCare Life Assurance Company, United HealthCare Insurance Company, www.eAMS.com; or All Savers Insurance Company, United HealthCare Services, Inc., and/or Golden Rule Insurance Company, www.goldenrule.com

Rates and Application Inside Pocket.

Short Term MedicalSM may be perfect for those in times of transition:

- Recent graduate or student no longer eligible under parents' health insurance plan
- Between jobs or out of work
- Waiting for other coverage to begin
- Retired early and needing a bridge to Medicare eligibility

Health Insurance for Individuals and Families Built with YOU in Mind.

These health insurance plans are issued as association group plans and available only to members of FACT, the Federation of American Consumers and Travelers. If you're not already a member, you are required to join FACT.

What is FACT?

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

Is there a cost for joining FACT?

Yes, the membership dues are simply \$3 a month and can be paid with your regular health insurance premium, as opposed to making a separate payment.

FACT privacy notice

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

What are FACT's association benefits?

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

- Dental discounts – you can save up to 35% on general dental, X-rays, and orthodontics.
- Vision discounts – typical savings of 5%-50% for eye exams, eyeglasses, contact lenses, and LASIK correction surgery.
- Prescription drug discounts.
- Van line discounts.
- Consumer library.
- Consumer hotline referral service.
- Amusement park discounts.
- Travel service and savings.
- Informative newsletter.

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 Eye-on-Washington Reports.

FACT may change or discontinue any of its membership benefits at any time. For the most current information, visit FACT's Web site at www.usafact.org or call toll-free at (800) USA-FACT.

Short Term Medical Application Checklist

- 1) Read the brochure carefully.
- 2) Read and understand the Instructions for Applying for Coverage.
- 3) Complete the Calculate Payment(s) section and choose your method of payment.
- 4) Complete the Application for *Short Term Medical* Insurance.
- 5) Complete FACT Membership Enrollment Form.
- 6) Select your method of payment and complete the appropriate payment information:
 - **Single Payment:** Include check or money order OR fill out the Credit Card Authorization.
 - **Monthly Payment:** Fill out the Electronic Funds Transfer (EFT) Authorization.
- 7) Place a postal stamp if mailing back.



Place
Postage
Here

UnitedHealthOne
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