

State: Arkansas **Filing Company:** Golden Rule Insurance Company
TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO
Product Name: Association Group
Project Name/Number: C-009/C-009

Filing at a Glance

Company: Golden Rule Insurance Company
Product Name: Association Group
State: Arkansas
TOI: H16G Group Health - Major Medical
Sub-TOI: H16G.002A Large Group Only - PPO
Filing Type: Form
Date Submitted: 09/19/2012
SERFF Tr Num: AMMS-128622950
SERFF Status: Closed-Accepted For Informational Purposes
State Tr Num:
State Status: Closed-Accepted for Informational Purposes
Co Tr Num: C-009

Implementation: On Approval
Date Requested:
Author(s): Pat Allison, Deb Paris
Reviewer(s): Rosalind Minor (primary)
Disposition Date: 09/20/2012
Disposition Status: Accepted For Informational Purposes
Implementation Date:

State Filing Description:

State: Arkansas **Filing Company:** Golden Rule Insurance Company
TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO
Product Name: Association Group
Project Name/Number: C-009/C-009

General Information

Project Name: C-009	Status of Filing in Domicile:
Project Number: C-009	Date Approved in Domicile:
Requested Filing Mode: Informational	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Large
Group Market Type: Association	Overall Rate Impact:
Filing Status Changed: 09/20/2012	
State Status Changed: 09/20/2012	Deemer Date:
Created By: Pat Allison	Submitted By: Pat Allison
Corresponding Filing Tracking Number:	

PPACA: Not PPACA-Related

PPACA Notes: null

Filing Description:

The referenced matrix forms are being filed with your Department on an informational basis for delivery to out-of-state certificateholders. Golden Rule intends to use these forms in conjunction with our previously approved group portfolio of group health forms (approved by your Department on March 14, 2012) to evidence coverage under a master policy issued to a non-employer based association group, The Federation of American Consumers and Travelers (FACT), in Jonesboro, Arkansas. These matrix forms document Golden Rule's compliance with the additional mandates/requirements of states other than Arkansas.

These forms will amend the master policies issued in Arkansas to comply with other states' requirements applicable to residents of those states where the association group products are available. As discussed with Mr. Corne and Mr. Hampton during their February 9, 2012 visit with your Department, these forms are filed on an informational basis with the understanding that they do not apply to and will not be issued to residents of Arkansas.

Company and Contact

Filing Contact Information

Debra Paris, Manager	dlparis@goldenrule.com
7440 Woodland Drive	800-926-7602 [Phone] 7771 [Ext]
Indianapolis, IN 46278-1719	317-328-9645 [FAX]

Filing Company Information

Golden Rule Insurance Company	CoCode: 62286	State of Domicile: Indiana
7440 Woodland Drive	Group Code: 707	Company Type: Life and Health
Indianapolis, IN 46278	Group Name:	State ID Number:
(800) 926-7602 ext. [Phone]	FEIN Number: 37-6028756	

Filing Fees

Fee Required?	Yes
Fee Amount:	\$1,500.00
Retaliatory?	No

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Fee Explanation: \$50 per form X 417 forms = \$20,850.00
Fees capped at \$1,500.00
Paid via EFT

Per Company: No

Company	Amount	Date Processed	Transaction #
Golden Rule Insurance Company	\$1,500.00	09/19/2012	62826182

SERFF Tracking #:

AMMS-128622950

State Tracking #:**Company Tracking #:**

C-009

State:

Arkansas

Filing Company:

Golden Rule Insurance Company

TOI/Sub-TOI:

H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO

Product Name:

Association Group

Project Name/Number:

C-009/C-009

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Accepted For Informational Purposes	Rosalind Minor	09/20/2012	09/20/2012

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Your September 19, 2012 telephone call to Deb Paris	Note To Reviewer	Pat Allison	09/19/2012	09/19/2012

SERFF Tracking #:

AMMS-128622950

State Tracking #:

Company Tracking #:

C-009

State:

Arkansas

Filing Company:

Golden Rule Insurance Company

TOI/Sub-TOI:

H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO

Product Name:

Association Group

Project Name/Number:

C-009/C-009

Disposition

Disposition Date: 09/20/2012

Implementation Date:

Status: Accepted For Informational Purposes

HHS Status: Not Reported

State Review: Reviewed-No Actuary

Comment:

Rate data does NOT apply to filing.

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TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO
Product Name: Association Group
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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Accepted for Informational Purposes	Yes
Supporting Document	Application	Accepted for Informational Purposes	Yes
Supporting Document	PPACA Uniform Compliance Summary	Accepted for Informational Purposes	Yes
Form	Agreement and Consideration	Accepted for Informational Purposes	Yes
Form	Agreement	Accepted for Informational Purposes	Yes
Form	Agreement and Consideration	Accepted for Informational Purposes	Yes
Form	Agreement and Consideration	Accepted for Informational Purposes	Yes
Form	Agreement and Consideration	Accepted for Informational Purposes	Yes
Form	Agreement and Consideration	Accepted for Informational Purposes	Yes
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Form	Agreement and Consideration	Accepted for Informational Purposes	Yes

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Golden Rule Insurance Company

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Product Name: Association Group

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Schedule	Schedule Item	Schedule Item Status	Public Access
Form	Arizona Endorsement	Accepted for Informational Purposes	Yes
Form	Arizona Endorsement	Accepted for Informational Purposes	Yes
Form	Arizona Endorsement	Accepted for Informational Purposes	Yes
Form	Arizona Endorsement	Accepted for Informational Purposes	Yes
Form	Arizona Endorsement	Accepted for Informational Purposes	Yes
Form	Arizona Endorsement	Accepted for Informational Purposes	Yes
Form	Arizona Endorsement	Accepted for Informational Purposes	Yes
Form	Arizona Endorsement	Accepted for Informational Purposes	Yes
Form	Arizona Endorsement	Accepted for Informational Purposes	Yes
Form	Arizona Endorsement	Accepted for Informational Purposes	Yes
Form	Arizona Endorsement	Accepted for Informational Purposes	Yes
Form	Colorado Endorsement	Accepted for Informational Purposes	Yes
Form	Colorado Endorsement	Accepted for Informational Purposes	Yes

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Schedule	Schedule Item	Schedule Item Status	Public Access
Form	Colorado Endorsement	Accepted for Informational Purposes	Yes
Form	Colorado Endorsement	Accepted for Informational Purposes	Yes
Form	Colorado Endorsement	Accepted for Informational Purposes	Yes
Form	Colorado Endorsement	Accepted for Informational Purposes	Yes
Form	Colorado Endorsement	Accepted for Informational Purposes	Yes
Form	Colorado Endorsement	Accepted for Informational Purposes	Yes
Form	Colorado Endorsement	Accepted for Informational Purposes	Yes
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Form	Colorado Endorsement	Accepted for Informational Purposes	Yes
Form	Colorado Endorsement	Accepted for Informational Purposes	Yes
Form	Colorado Endorsement	Accepted for Informational Purposes	Yes
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Form	Colorado Endorsement	Accepted for Informational Purposes	Yes

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Form	Colorado Endorsement	Accepted for Informational Purposes	Yes
Form	Colorado Endorsement	Accepted for Informational Purposes	Yes
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Form	Colorado Endorsement	Accepted for Informational Purposes	Yes
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Form	Colorado Endorsement	Accepted for Informational Purposes	Yes
Form	Colorado Endorsement	Accepted for Informational Purposes	Yes
Form	Colorado Endorsement	Accepted for Informational Purposes	Yes
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Form	Colorado Endorsement	Accepted for Informational Purposes	Yes
Form	Colorado Endorsement	Accepted for Informational Purposes	Yes
Form	Colorado Endorsement	Accepted for Informational Purposes	Yes
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Form	Colorado Endorsement	Accepted for Informational Purposes	Yes
Form	Colorado Endorsement	Accepted for Informational Purposes	Yes
Form	Colorado Endorsement	Accepted for Informational Purposes	Yes
Form	Colorado Endorsement	Accepted for Informational Purposes	Yes
Form	Colorado Endorsement	Accepted for Informational Purposes	Yes
Form	Colorado Endorsement	Accepted for Informational Purposes	Yes
Form	Colorado Endorsement	Accepted for Informational Purposes	Yes
Form	Colorado Endorsement	Accepted for Informational Purposes	Yes
Form	District of Columbia Endorsement	Accepted for Informational Purposes	Yes

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Schedule	Schedule Item	Schedule Item Status	Public Access
Form	District of Columbia Endorsement	Accepted for Informational Purposes	Yes
Form	District of Columbia Endorsement	Accepted for Informational Purposes	Yes
Form	District of Columbia Endorsement	Accepted for Informational Purposes	Yes
Form	District of Columbia Endorsement	Accepted for Informational Purposes	Yes
Form	District of Columbia Endorsement	Accepted for Informational Purposes	Yes
Form	District of Columbia Endorsement	Accepted for Informational Purposes	Yes
Form	District of Columbia Endorsement	Accepted for Informational Purposes	Yes
Form	District of Columbia Endorsement	Accepted for Informational Purposes	Yes
Form	District of Columbia Endorsement	Accepted for Informational Purposes	Yes
Form	District of Columbia Endorsement	Accepted for Informational Purposes	Yes
Form	District of Columbia Endorsement	Accepted for Informational Purposes	Yes
Form	District of Columbia Endorsement	Accepted for Informational Purposes	Yes
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Form	District of Columbia Endorsement	Accepted for Informational Purposes	Yes

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Schedule	Schedule Item	Schedule Item Status	Public Access
Form	District of Columbia Endorsement	Accepted for Informational Purposes	Yes
Form	District of Columbia Endorsement	Accepted for Informational Purposes	Yes
Form	District of Columbia Endorsement	Accepted for Informational Purposes	Yes
Form	District of Columbia Grievance Endorsement	Accepted for Informational Purposes	Yes
Form	District of Columbia Grievance Endorsement	Accepted for Informational Purposes	Yes
Form	District of Columbia Grievance Endorsement	Accepted for Informational Purposes	Yes
Form	District of Columbia Grievance Endorsement	Accepted for Informational Purposes	Yes
Form	District of Columbia Grievance Endorsement	Accepted for Informational Purposes	Yes
Form	District of Columbia Grievance Endorsement	Accepted for Informational Purposes	Yes
Form	District of Columbia Grievance Endorsement	Accepted for Informational Purposes	Yes
Form	District of Columbia Grievance Endorsement	Accepted for Informational Purposes	Yes
Form	District of Columbia Grievance Endorsement	Accepted for Informational Purposes	Yes
Form	District of Columbia Endorsement	Accepted for Informational Purposes	Yes

State: Arkansas

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Golden Rule Insurance Company

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Schedule	Schedule Item	Schedule Item Status	Public Access
Form	District of Columbia Endorsement	Accepted for Informational Purposes	Yes
Form	District of Columbia Endorsement	Accepted for Informational Purposes	Yes
Form	Illinois Endorsement	Accepted for Informational Purposes	Yes
Form	Illinois Endorsement	Accepted for Informational Purposes	Yes
Form	Illinois Endorsement	Accepted for Informational Purposes	Yes
Form	Illinois Endorsement	Accepted for Informational Purposes	Yes
Form	Illinois Endorsement	Accepted for Informational Purposes	Yes
Form	Illinois Endorsement	Accepted for Informational Purposes	Yes
Form	Illinois Endorsement	Accepted for Informational Purposes	Yes
Form	Illinois Appeal Procedures Notice Endorsement	Accepted for Informational Purposes	Yes
Form	Indiana Endorsement	Accepted for Informational Purposes	Yes
Form	Indiana Endorsement	Accepted for Informational Purposes	Yes
Form	Indiana Endorsement	Accepted for Informational Purposes	Yes

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Form	Indiana Endorsement	Accepted for Informational Purposes	Yes
Form	Indiana Endorsement	Accepted for Informational Purposes	Yes
Form	Indiana Endorsement	Accepted for Informational Purposes	Yes
Form	Indiana Endorsement	Accepted for Informational Purposes	Yes
Form	Indiana Endorsement	Accepted for Informational Purposes	Yes
Form	Indiana Endorsement	Accepted for Informational Purposes	Yes
Form	Indiana Endorsement	Accepted for Informational Purposes	Yes
Form	Indiana Endorsement	Accepted for Informational Purposes	Yes
Form	Indiana Endorsement	Accepted for Informational Purposes	Yes
Form	Indiana Grievance Endorsement	Accepted for Informational Purposes	Yes
Form	Indiana Grievance Endorsement	Accepted for Informational Purposes	Yes
Form	Indiana Grievance Endorsement	Accepted for Informational Purposes	Yes
Form	Indiana Grievance Endorsement	Accepted for Informational Purposes	Yes

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Golden Rule Insurance Company

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Schedule	Schedule Item	Schedule Item Status	Public Access
Form	Indiana Grievance Endorsement	Accepted for Informational Purposes	Yes
Form	Indiana Grievance Endorsement	Accepted for Informational Purposes	Yes
Form	Indiana Grievance Endorsement	Accepted for Informational Purposes	Yes
Form	Indiana Grievance Endorsement	Accepted for Informational Purposes	Yes
Form	Iowa Endorsement	Accepted for Informational Purposes	Yes
Form	Iowa Endorsement	Accepted for Informational Purposes	Yes
Form	Iowa Endorsement	Accepted for Informational Purposes	Yes
Form	Iowa Endorsement	Accepted for Informational Purposes	Yes
Form	Iowa Endorsement	Accepted for Informational Purposes	Yes
Form	Iowa Endorsement	Accepted for Informational Purposes	Yes
Form	Iowa Endorsement	Accepted for Informational Purposes	Yes
Form	Iowa Endorsement	Accepted for Informational Purposes	Yes
Form	Iowa Endorsement	Accepted for Informational Purposes	Yes
Form	Iowa Endorsement	Accepted for Informational Purposes	Yes

State: Arkansas

Filing Company:

Golden Rule Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO

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Schedule	Schedule Item	Schedule Item Status	Public Access
Form	Iowa Endorsement	Accepted for Informational Purposes	Yes
Form	Iowa Endorsement	Accepted for Informational Purposes	Yes
Form	Iowa Endorsement	Accepted for Informational Purposes	Yes
Form	Kentucky Endorsement	Accepted for Informational Purposes	Yes
Form	Kentucky Endorsement	Accepted for Informational Purposes	Yes
Form	Kentucky Endorsement	Accepted for Informational Purposes	Yes
Form	Kentucky Endorsement	Accepted for Informational Purposes	Yes
Form	Kentucky Endorsement	Accepted for Informational Purposes	Yes
Form	Kentucky Endorsement	Accepted for Informational Purposes	Yes
Form	Kentucky Endorsement	Accepted for Informational Purposes	Yes
Form	Kentucky Endorsement	Accepted for Informational Purposes	Yes
Form	Kentucky Endorsement	Accepted for Informational Purposes	Yes
Form	Kentucky Endorsement	Accepted for Informational Purposes	Yes
Form	Kentucky Endorsement	Accepted for Informational Purposes	Yes

State: Arkansas

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Golden Rule Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO

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Schedule	Schedule Item	Schedule Item Status	Public Access
Form	Kentucky Endorsement	Accepted for Informational Purposes	Yes
Form	Kentucky Endorsement	Accepted for Informational Purposes	Yes
Form	Kentucky Endorsement	Accepted for Informational Purposes	Yes
Form	Kentucky Endorsement	Accepted for Informational Purposes	Yes
Form	Kentucky Endorsement	Accepted for Informational Purposes	Yes
Form	Kentucky Endorsement	Accepted for Informational Purposes	Yes
Form	Kentucky Endorsement	Accepted for Informational Purposes	Yes
Form	Kentucky Endorsement	Accepted for Informational Purposes	Yes
Form	Kentucky Endorsement	Accepted for Informational Purposes	Yes
Form	Kentucky Endorsement	Accepted for Informational Purposes	Yes
Form	Kentucky Endorsement	Accepted for Informational Purposes	Yes
Form	Kentucky Endorsement	Accepted for Informational Purposes	Yes
Form	Kentucky Endorsement	Accepted for Informational Purposes	Yes
Form	Kentucky Endorsement	Accepted for Informational Purposes	Yes

State: Arkansas **Filing Company:** Golden Rule Insurance Company
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Schedule	Schedule Item	Schedule Item Status	Public Access
Form	Kentucky Endorsement	Accepted for Informational Purposes	Yes
Form	Kentucky Endorsement	Accepted for Informational Purposes	Yes
Form	Kentucky Endorsement	Accepted for Informational Purposes	Yes
Form	Maryland Grievance Endorsement	Accepted for Informational Purposes	Yes
Form	Maryland Endorsement	Accepted for Informational Purposes	Yes
Form	Maryland Endorsement	Accepted for Informational Purposes	Yes
Form	Maryland Endorsement	Accepted for Informational Purposes	Yes
Form	Maryland Endorsement	Accepted for Informational Purposes	Yes
Form	Maryland Endorsement	Accepted for Informational Purposes	Yes
Form	Maryland Endorsement	Accepted for Informational Purposes	Yes
Form	Maryland Endorsement	Accepted for Informational Purposes	Yes
Form	Michigan Endorsement	Accepted for Informational Purposes	Yes
Form	Mississippi Endorsement	Accepted for Informational Purposes	Yes

State: Arkansas

Filing Company:

Golden Rule Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO

Product Name: Association Group

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Schedule	Schedule Item	Schedule Item Status	Public Access
Form	Mississippi Endorsement	Accepted for Informational Purposes	Yes
Form	Mississippi Endorsement	Accepted for Informational Purposes	Yes
Form	Mississippi Endorsement	Accepted for Informational Purposes	Yes
Form	Missouri Endorsement	Accepted for Informational Purposes	Yes
Form	Missouri Endorsement	Accepted for Informational Purposes	Yes
Form	Missouri Endorsement	Accepted for Informational Purposes	Yes
Form	Missouri Endorsement	Accepted for Informational Purposes	Yes
Form	Missouri Endorsement	Accepted for Informational Purposes	Yes
Form	Missouri Endorsement	Accepted for Informational Purposes	Yes
Form	Missouri Endorsement	Accepted for Informational Purposes	Yes
Form	Missouri Endorsement	Accepted for Informational Purposes	Yes
Form	Missouri Endorsement	Accepted for Informational Purposes	Yes
Form	Missouri Endorsement	Accepted for Informational Purposes	Yes
Form	Missouri Endorsement	Accepted for Informational Purposes	Yes

State: Arkansas

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Golden Rule Insurance Company

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Schedule	Schedule Item	Schedule Item Status	Public Access
Form	Nebraska Endorsement	Accepted for Informational Purposes	Yes
Form	Nebraska Endorsement	Accepted for Informational Purposes	Yes
Form	Golden Rule Insurance Company North Carolina Utilization Review Procedures and Grievance Procedures Rider	Accepted for Informational Purposes	Yes
Form	Ohio Endorsement	Accepted for Informational Purposes	Yes
Form	Ohio Endorsement	Accepted for Informational Purposes	Yes
Form	Ohio Endorsement	Accepted for Informational Purposes	Yes
Form	Ohio Endorsement	Accepted for Informational Purposes	Yes
Form	Ohio Endorsement	Accepted for Informational Purposes	Yes
Form	Ohio Endorsement	Accepted for Informational Purposes	Yes
Form	Ohio Endorsement	Accepted for Informational Purposes	Yes
Form	Ohio Endorsement	Accepted for Informational Purposes	Yes
Form	Ohio Endorsement	Accepted for Informational Purposes	Yes
Form	Ohio Endorsement	Accepted for Informational Purposes	Yes
Form	Ohio Endorsement	Accepted for Informational Purposes	Yes

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Schedule	Schedule Item	Schedule Item Status	Public Access
Form	Ohio Endorsement	Accepted for Informational Purposes	Yes
Form	Ohio Endorsement	Accepted for Informational Purposes	Yes
Form	Ohio Endorsement	Accepted for Informational Purposes	Yes
Form	Ohio Endorsement	Accepted for Informational Purposes	Yes
Form	Ohio Endorsement	Accepted for Informational Purposes	Yes
Form	Ohio Endorsement	Accepted for Informational Purposes	Yes
Form	Ohio Endorsement	Accepted for Informational Purposes	Yes
Form	Ohio Endorsement	Accepted for Informational Purposes	Yes
Form	Ohio Endorsement	Accepted for Informational Purposes	Yes
Form	Ohio Endorsement	Accepted for Informational Purposes	Yes
Form	Ohio Endorsement	Accepted for Informational Purposes	Yes
Form	Ohio Endorsement	Accepted for Informational Purposes	Yes
Form	Ohio Appeal Procedures Rider	Accepted for Informational Purposes	Yes

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Schedule	Schedule Item	Schedule Item Status	Public Access
Form	Oklahoma Endorsement	Accepted for Informational Purposes	Yes
Form	Oklahoma Endorsement	Accepted for Informational Purposes	Yes
Form	Oklahoma Endorsement	Accepted for Informational Purposes	Yes
Form	Oklahoma Endorsement	Accepted for Informational Purposes	Yes
Form	Oklahoma Endorsement	Accepted for Informational Purposes	Yes
Form	Oklahoma Endorsement	Accepted for Informational Purposes	Yes
Form	Oklahoma Endorsement	Accepted for Informational Purposes	Yes
Form	Oklahoma Endorsement	Accepted for Informational Purposes	Yes
Form	Oklahoma Endorsement	Accepted for Informational Purposes	Yes
Form	Oklahoma Endorsement	Accepted for Informational Purposes	Yes
Form	Oklahoma Endorsement	Accepted for Informational Purposes	Yes
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Form	Oklahoma Endorsement	Accepted for Informational Purposes	Yes
Form	Oklahoma Endorsement	Accepted for Informational Purposes	Yes

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Form	Oklahoma Endorsement	Accepted for Informational Purposes	Yes
Form	Oklahoma Endorsement	Accepted for Informational Purposes	Yes
Form	Oklahoma Endorsement	Accepted for Informational Purposes	Yes
Form	Oklahoma Endorsement	Accepted for Informational Purposes	Yes
Form	Oklahoma Endorsement	Accepted for Informational Purposes	Yes
Form	Oklahoma Endorsement	Accepted for Informational Purposes	Yes
Form	Pennsylvania Endorsement	Accepted for Informational Purposes	Yes
Form	Pennsylvania Endorsement	Accepted for Informational Purposes	Yes
Form	South Carolina Endorsement	Accepted for Informational Purposes	Yes
Form	South Carolina Endorsement	Accepted for Informational Purposes	Yes
Form	South Carolina Endorsement	Accepted for Informational Purposes	Yes
Form	South Carolina Endorsement	Accepted for Informational Purposes	Yes
Form	South Carolina Endorsement	Accepted for Informational Purposes	Yes

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Schedule	Schedule Item	Schedule Item Status	Public Access
Form	South Carolina Endorsement	Accepted for Informational Purposes	Yes
Form	South Carolina Endorsement	Accepted for Informational Purposes	Yes
Form	South Carolina Endorsement	Accepted for Informational Purposes	Yes
Form	South Carolina Endorsement	Accepted for Informational Purposes	Yes
Form	South Carolina Endorsement	Accepted for Informational Purposes	Yes
Form	South Carolina Endorsement	Accepted for Informational Purposes	Yes
Form	Texas Endorsement	Accepted for Informational Purposes	Yes
Form	Texas Endorsement	Accepted for Informational Purposes	Yes
Form	Texas Endorsement	Accepted for Informational Purposes	Yes
Form	Texas Endorsement	Accepted for Informational Purposes	Yes
Form	Texas Endorsement	Accepted for Informational Purposes	Yes
Form	Texas Endorsement	Accepted for Informational Purposes	Yes
Form	Texas Endorsement	Accepted for Informational Purposes	Yes

State: Arkansas

Filing Company:

Golden Rule Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO

Product Name: Association Group

Project Name/Number: C-009/C-009

Schedule	Schedule Item	Schedule Item Status	Public Access
Form	Texas Endorsement	Accepted for Informational Purposes	Yes
Form	Texas Endorsement	Accepted for Informational Purposes	Yes
Form	Texas Endorsement	Accepted for Informational Purposes	Yes
Form	Texas Endorsement	Accepted for Informational Purposes	Yes
Form	Texas Endorsement	Accepted for Informational Purposes	Yes
Form	Texas Endorsement	Accepted for Informational Purposes	Yes
Form	Texas Endorsement	Accepted for Informational Purposes	Yes
Form	Texas Endorsement	Accepted for Informational Purposes	Yes
Form	Texas Endorsement	Accepted for Informational Purposes	Yes
Form	Texas Endorsement	Accepted for Informational Purposes	Yes
Form	Texas Endorsement	Accepted for Informational Purposes	Yes
Form	Texas Endorsement	Accepted for Informational Purposes	Yes
Form	Texas Endorsement	Accepted for Informational Purposes	Yes
Form	Texas Endorsement	Accepted for Informational Purposes	Yes

State: Arkansas

Filing Company:

Golden Rule Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO

Product Name: Association Group

Project Name/Number: C-009/C-009

Schedule	Schedule Item	Schedule Item Status	Public Access
Form	Texas Endorsement	Accepted for Informational Purposes	Yes
Form	Texas Endorsement	Accepted for Informational Purposes	Yes
Form	Texas Endorsement	Accepted for Informational Purposes	Yes
Form	Texas Endorsement	Accepted for Informational Purposes	Yes
Form	Texas Endorsement	Accepted for Informational Purposes	Yes
Form	Texas Endorsement	Accepted for Informational Purposes	Yes
Form	Texas Endorsement	Accepted for Informational Purposes	Yes
Form	Texas Endorsement	Accepted for Informational Purposes	Yes
Form	Texas Endorsement	Accepted for Informational Purposes	Yes
Form	Texas Endorsement	Accepted for Informational Purposes	Yes
Form	Texas Endorsement	Accepted for Informational Purposes	Yes
Form	Texas Endorsement	Accepted for Informational Purposes	Yes
Form	Texas Endorsement	Accepted for Informational Purposes	Yes
Form	Texas Endorsement	Accepted for Informational Purposes	Yes

State: Arkansas

Filing Company:

Golden Rule Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO

Product Name: Association Group

Project Name/Number: C-009/C-009

Schedule	Schedule Item	Schedule Item Status	Public Access
Form	Texas Endorsement	Accepted for Informational Purposes	Yes
Form	Texas Endorsement	Accepted for Informational Purposes	Yes
Form	Texas Endorsement	Accepted for Informational Purposes	Yes
Form	Texas Endorsement	Accepted for Informational Purposes	Yes
Form	Texas Endorsement	Accepted for Informational Purposes	Yes
Form	Texas Endorsement	Accepted for Informational Purposes	Yes
Form	Texas Endorsement	Accepted for Informational Purposes	Yes
Form	Texas Endorsement	Accepted for Informational Purposes	Yes
Form	Texas Endorsement	Accepted for Informational Purposes	Yes
Form	Texas Endorsement	Accepted for Informational Purposes	Yes
Form	Texas Endorsement	Accepted for Informational Purposes	Yes
Form	West Virginia Endorsement	Accepted for Informational Purposes	Yes
Form	West Virginia Endorsement	Accepted for Informational Purposes	Yes

State: Arkansas **Filing Company:** Golden Rule Insurance Company
TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO
Product Name: Association Group
Project Name/Number: C-009/C-009

Schedule	Schedule Item	Schedule Item Status	Public Access
Form	West Virginia Endorsement	Accepted for Informational Purposes	Yes
Form	West Virginia Endorsement	Accepted for Informational Purposes	Yes
Form	West Virginia Endorsement	Accepted for Informational Purposes	Yes
Form	West Virginia Endorsement	Accepted for Informational Purposes	Yes
Form	West Virginia Endorsement	Accepted for Informational Purposes	Yes
Form	West Virginia Endorsement	Accepted for Informational Purposes	Yes
Form	West Virginia Endorsement	Accepted for Informational Purposes	Yes
Form	West Virginia Endorsement	Accepted for Informational Purposes	Yes
Form	West Virginia Endorsement	Accepted for Informational Purposes	Yes
Form	West Virginia Endorsement	Accepted for Informational Purposes	Yes
Form	Wisconsin Endorsement	Accepted for Informational Purposes	Yes
Form	Wisconsin Endorsement	Accepted for Informational Purposes	Yes
Form	Wisconsin Endorsement	Accepted for Informational Purposes	Yes

State: Arkansas

Filing Company:

Golden Rule Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO

Product Name: Association Group

Project Name/Number: C-009/C-009

Schedule	Schedule Item	Schedule Item Status	Public Access
Form	Wisconsin Endorsement	Accepted for Informational Purposes	Yes
Form	Wisconsin Endorsement	Accepted for Informational Purposes	Yes
Form	Wisconsin Endorsement	Accepted for Informational Purposes	Yes
Form	Wisconsin Endorsement	Accepted for Informational Purposes	Yes
Form	Wisconsin Endorsement	Accepted for Informational Purposes	Yes
Form	Wisconsin Endorsement	Accepted for Informational Purposes	Yes
Form	Wisconsin Endorsement	Accepted for Informational Purposes	Yes
Form	Wisconsin Endorsement	Accepted for Informational Purposes	Yes
Form	Wisconsin Endorsement	Accepted for Informational Purposes	Yes
Form	Wisconsin Endorsement	Accepted for Informational Purposes	Yes
Form	Wisconsin Endorsement	Accepted for Informational Purposes	Yes
Form	Wisconsin Endorsement	Accepted for Informational Purposes	Yes
Form	Wisconsin Endorsement	Accepted for Informational Purposes	Yes
Form	Wisconsin Endorsement	Accepted for Informational Purposes	Yes

State: Arkansas

Filing Company:

Golden Rule Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO

Product Name: Association Group

Project Name/Number: C-009/C-009

Schedule	Schedule Item	Schedule Item Status	Public Access
Form	Wisconsin Endorsement	Accepted for Informational Purposes	Yes
Form	Wisconsin Endorsement	Accepted for Informational Purposes	Yes
Form	Wisconsin Endorsement	Accepted for Informational Purposes	Yes
Form	Wisconsin Endorsement	Accepted for Informational Purposes	Yes
Form	Wisconsin Endorsement	Accepted for Informational Purposes	Yes
Form	Wisconsin Endorsement	Accepted for Informational Purposes	Yes
Form	Wisconsin Endorsement	Accepted for Informational Purposes	Yes
Form	Wisconsin Endorsement	Accepted for Informational Purposes	Yes
Form	Wisconsin Endorsement	Accepted for Informational Purposes	Yes
Form	Wisconsin Endorsement	Accepted for Informational Purposes	Yes
Form	Wisconsin Endorsement	Accepted for Informational Purposes	Yes
Form	Wisconsin Endorsement	Accepted for Informational Purposes	Yes
Form	Wisconsin Endorsement	Accepted for Informational Purposes	Yes
Form	Wisconsin Endorsement	Accepted for Informational Purposes	Yes
Form	Wisconsin Endorsement	Accepted for Informational Purposes	Yes

State: Arkansas

Filing Company:

Golden Rule Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO

Product Name: Association Group

Project Name/Number: C-009/C-009

Schedule	Schedule Item	Schedule Item Status	Public Access
Form	Wisconsin Endorsement	Accepted for Informational Purposes	Yes
Form	Wisconsin Endorsement	Accepted for Informational Purposes	Yes
Form	Wisconsin Endorsement	Accepted for Informational Purposes	Yes
Form	Wisconsin Endorsement	Accepted for Informational Purposes	Yes
Form	Wisconsin Endorsement	Accepted for Informational Purposes	Yes
Form	Golden Rule Insurance Company Wisconsin Grievance and Complaint Procedures Rider (Grandfathered Plans)	Accepted for Informational Purposes	Yes
Form	Golden Rule Insurance Company Wisconsin Grievance and Complaint Procedures Rider (Non-Grandfathered Plans)	Accepted for Informational Purposes	Yes
Form	HIPAA Portability Rider	Accepted for Informational Purposes	Yes
Form	Florida Limitation of Payment for AIDS or HIV Related Disease Claims Endorsement	Accepted for Informational Purposes	Yes
Form	Copayment Amount Endorsement	Accepted for Informational Purposes	Yes
Form	Basic Coverage Supplemental Accident Expense Benefits Rider	Accepted for Informational Purposes	Yes
Form	Term Life Insurance Rider	Accepted for Informational Purposes	Yes
Form	Illinois Savings Based Preferred Provider Benefit Rider	Accepted for Informational Purposes	Yes

State: Arkansas **Filing Company:** Golden Rule Insurance Company
TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO
Product Name: Association Group
Project Name/Number: C-009/C-009

Schedule	Schedule Item	Schedule Item Status	Public Access
Form	Reimbursement/Subrogation Rider	Accepted for Informational Purposes	Yes
Form	Transplant Expense Benefits	Accepted for Informational Purposes	Yes
Form	Missouri Grievance Procedures Rider	Accepted for Informational Purposes	Yes
Form	Missouri Phase II Cancer Clinical Trials Rider	Accepted for Informational Purposes	Yes
Form	Term Life Insurance Rider	Accepted for Informational Purposes	Yes
Form	Accidental Death Insurance Rider	Accepted for Informational Purposes	Yes
Form	Missouri Chiropractice Services Copayment Amount Rider-Amendment	Accepted for Informational Purposes	Yes
Form	Missouri Prosthetic Devices and Services Rider	Accepted for Informational Purposes	Yes
Form	nebraska Grievance Procedures Rider	Accepted for Informational Purposes	Yes
Form	Nebraska UnitedHealthcare Network Rider	Accepted for Informational Purposes	Yes
Form	North Carolina Utilization Review Procedures and Grievance Procedures Rider	Accepted for Informational Purposes	Yes
Form	Term Life Insurance Rider	Accepted for Informational Purposes	Yes
Form	Accidental Death Insurance Rider	Accepted for Informational Purposes	Yes

State: Arkansas **Filing Company:** Golden Rule Insurance Company
TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO
Product Name: Association Group
Project Name/Number: C-009/C-009

Schedule	Schedule Item	Schedule Item Status	Public Access
Form	Continuity Rider	Accepted for Informational Purposes	Yes
Form	Ohio Appeals Procedures Rider	Accepted for Informational Purposes	Yes
Form	Term Life Insurance Rider	Accepted for Informational Purposes	Yes
Form	Accidental Death Insurance Rider	Accepted for Informational Purposes	Yes
Form	Continuity Rider	Accepted for Informational Purposes	Yes
Form	Term Life Insurance Rider	Accepted for Informational Purposes	Yes
Form	Disclaimer Rider	Accepted for Informational Purposes	Yes
Form	Transplant Expense Benefits	Accepted for Informational Purposes	Yes
Form	Term Life Insurance Rider	Accepted for Informational Purposes	Yes
Form	Accidental Death Insurance Rider	Accepted for Informational Purposes	Yes
Form	Rehabilitation Therapy Benefits Rider	Accepted for Informational Purposes	Yes
Form	Continuity rider	Accepted for Informational Purposes	Yes
Form	Golden Rule Insurance Wisconsin Grievance and Complaint Procedures Rider	Accepted for Informational Purposes	Yes

State: Arkansas

Filing Company:

Golden Rule Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO

Product Name: Association Group

Project Name/Number: C-009/C-009

Schedule	Schedule Item	Schedule Item Status	Public Access
Form	HIPAA Portability Rider	Accepted for Informational Purposes	Yes
Form	Alaska	Accepted for Informational Purposes	Yes
Form	Insurance Benefits UnitedHealth Continuity Rider	Accepted for Informational Purposes	Yes
Form	Dental Insurance Rider	Accepted for Informational Purposes	Yes
Form	Dental Insurance Rider	Accepted for Informational Purposes	Yes
Form	North Carolina Endorsement	Accepted for Informational Purposes	Yes
Form	North Carolina Endorsement	Accepted for Informational Purposes	Yes
Form	North Carolina Endorsement	Accepted for Informational Purposes	Yes
Form	North Carolina Endorsement	Accepted for Informational Purposes	Yes
Form	North Carolina Endorsement	Accepted for Informational Purposes	Yes
Form	North Carolina Endorsement	Accepted for Informational Purposes	Yes
Form	North Carolina Endorsement	Accepted for Informational Purposes	Yes
Form	North Carolina Endorsement	Accepted for Informational Purposes	Yes
Form	North Carolina Endorsement	Accepted for Informational Purposes	Yes

State: Arkansas

Filing Company:

Golden Rule Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO

Product Name: Association Group

Project Name/Number: C-009/C-009

Schedule	Schedule Item	Schedule Item Status	Public Access
Form	North Carolina Endorsement	Accepted for Informational Purposes	Yes
Form	North Carolina Endorsement	Accepted for Informational Purposes	Yes
Form	North Carolina Endorsement	Accepted for Informational Purposes	Yes
Form	North Carolina Endorsement	Accepted for Informational Purposes	Yes
Form	North Carolina Endorsement	Accepted for Informational Purposes	Yes
Form	North Carolina Endorsement	Accepted for Informational Purposes	Yes
Form	North Carolina Endorsement	Accepted for Informational Purposes	Yes
Form	North Carolina Endorsement	Accepted for Informational Purposes	Yes
Form	North Carolina Endorsement	Accepted for Informational Purposes	Yes
Form	North Carolina Endorsement	Accepted for Informational Purposes	Yes
Form	North Carolina Endorsement	Accepted for Informational Purposes	Yes
Form	North Carolina Endorsement	Accepted for Informational Purposes	Yes
Form	North Carolina Endorsement	Accepted for Informational Purposes	Yes
Form	North Carolina Endorsement	Accepted for Informational Purposes	Yes

State: Arkansas

Filing Company:

Golden Rule Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO

Product Name: Association Group

Project Name/Number: C-009/C-009

Schedule	Schedule Item	Schedule Item Status	Public Access
Form	North Carolina Endorsement	Accepted for Informational Purposes	Yes
Form	North Carolina Endorsement	Accepted for Informational Purposes	Yes
Form	North Carolina Endorsement	Accepted for Informational Purposes	Yes
Form	North Carolina Endorsement	Accepted for Informational Purposes	Yes
Form	North Carolina Endorsement	Accepted for Informational Purposes	Yes
Form	North Carolina Endorsement	Accepted for Informational Purposes	Yes
Form	North Carolina Endorsement	Accepted for Informational Purposes	Yes
Form	North Carolina Endorsement	Accepted for Informational Purposes	Yes
Form	North Carolina Endorsement	Accepted for Informational Purposes	Yes
Form	North Carolina Endorsement	Accepted for Informational Purposes	Yes
Form	North Carolina Endorsement	Accepted for Informational Purposes	Yes
Form	North Carolina Endorsement	Accepted for Informational Purposes	Yes
Form	North Carolina Endorsement	Accepted for Informational Purposes	Yes
Form	North Carolina Endorsement	Accepted for Informational Purposes	Yes
Form	North Carolina Endorsement	Accepted for Informational Purposes	Yes

State: Arkansas

Filing Company:

Golden Rule Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO

Product Name: Association Group

Project Name/Number: C-009/C-009

Schedule	Schedule Item	Schedule Item Status	Public Access
Form	North Carolina Endorsement	Accepted for Informational Purposes	Yes
Form	Tennessee Endorsement	Accepted for Informational Purposes	Yes
Form	Tennessee Endorsement	Accepted for Informational Purposes	Yes
Form	Tennessee Endorsement	Accepted for Informational Purposes	Yes
Form	Tennessee Endorsement	Accepted for Informational Purposes	Yes
Form	Tennessee Endorsement	Accepted for Informational Purposes	Yes
Form	Tennessee Endorsement	Accepted for Informational Purposes	Yes
Form	Tennessee Endorsement	Accepted for Informational Purposes	Yes
Form	Tennessee Endorsement	Accepted for Informational Purposes	Yes
Form	Tennessee Endorsement	Accepted for Informational Purposes	Yes
Form	Tennessee Endorsement	Accepted for Informational Purposes	Yes
Form	Tennessee Endorsement	Accepted for Informational Purposes	Yes
Form	Tennessee Endorsement	Accepted for Informational Purposes	Yes
Form	Tennessee Endorsement	Accepted for Informational Purposes	Yes

SERFF Tracking #:

AMMS-128622950

State Tracking #:**Company Tracking #:**

C-009

State:

Arkansas

Filing Company:

Golden Rule Insurance Company

TOI/Sub-TOI:

H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO

Product Name:

Association Group

Project Name/Number:

C-009/C-009

Schedule	Schedule Item	Schedule Item Status	Public Access
Form	Tennessee Endorsement	Accepted for Informational Purposes	Yes
Form	Tennessee Endorsement	Accepted for Informational Purposes	Yes
Form	Alabama Endorsement	Accepted for Informational Purposes	Yes
Form	Alabama Endorsement	Accepted for Informational Purposes	Yes

State: Arkansas **Filing Company:** Golden Rule Insurance Company
TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO
Product Name: Association Group
Project Name/Number: C-009/C-009

Note To Reviewer

Created By:

Pat Allison on 09/19/2012 12:59 PM

Last Edited By:

Rosalind Minor

Submitted On:

09/20/2012 09:10 AM

Subject:

Your September 19, 2012 telephone call to Deb Paris

Comments:

Mike Hampton confirmed February 9th, 2012 as the date of the meeting with your Department. Attendees were Rosalind Minor and Dan Honey from the AR DOI , Mike Corne and Mike Hampton from Golden Rule Insurance.

State: Arkansas

Filing Company:

Golden Rule Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO

Product Name: Association Group

Project Name/Number: C-009/C-009

Form Schedule

Lead Form Number: C-009

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
1	Accepted for Informational Purposes 09/20/2012	C-009	CERA	Agreement and Consideration	Initial:	59.140	C-009x Form.pdf
2	Accepted for Informational Purposes 09/20/2012	P-009	PJK	Agreement	Initial:	59.140	P-009x Form.pdf
3	Accepted for Informational Purposes 09/20/2012	C-009-02	PJK	Agreement and Consideration	Initial:	59.140	C-009-02 Form.pdf
4	Accepted for Informational Purposes 09/20/2012	C-008-09	CERA	Agreement and Consideration	Initial:	59.140	C-008-09 Form.pdf
5	Accepted for Informational Purposes 09/20/2012	C-009-19	CERA	Agreement and Consideration	Initial:	59.140	C-009-19 Form.pdf
6	Accepted for Informational Purposes 09/20/2012	C-009-32	CERA	Agreement and Consideration	Initial:	59.140	C-009-32 Form.pdf

State: Arkansas

Filing Company:

Golden Rule Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO

Product Name: Association Group

Project Name/Number: C-009/C-009

Lead Form Number: C-009

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
7	Accepted for Informational Purposes 09/20/2012	C-009-34	CERA	Agreement and Consideration	Initial:	59.140	C-009-34 Form.pdf
8	Accepted for Informational Purposes 09/20/2012	C-008-35	CERA	Agreement and Consideration	Initial:	59.140	OK C-008-35 Form.pdf
9	Accepted for Informational Purposes 09/20/2012	C-009-42	CERA	Agreement and Consideration	Initial:	59.140	C-009-42 Form.pdf
10	Accepted for Informational Purposes 09/20/2012	C-008-47	CERA	Agreement and Consideration	Initial:	59.140	C-008-47 Form.pdf
11	Accepted for Informational Purposes 09/20/2012	MGR03778	POLA	Arizona Endorsement	Initial:	59.140	MGRUNIAZ-003 9112.pdf
12	Accepted for Informational Purposes 09/20/2012	MGR03779	POLA	Arizona Endorsement	Initial:		

State: Arkansas

Filing Company:

Golden Rule Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO

Product Name: Association Group

Project Name/Number: C-009/C-009

Lead Form Number: C-009

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
13	Accepted for Informational Purposes 09/20/2012	MGR03780	POLA	Arizona Endorsement	Initial:		
14	Accepted for Informational Purposes 09/20/2012	MGR03781	POLA	Arizona Endorsement	Initial:		
15	Accepted for Informational Purposes 09/20/2012	MGR03782	POLA	Arizona Endorsement	Initial:		
16	Accepted for Informational Purposes 09/20/2012	MGR03783	POLA	Arizona Endorsement	Initial:		
17	Accepted for Informational Purposes 09/20/2012	MGR03784	POLA	Arizona Endorsement	Initial:		
18	Accepted for Informational Purposes 09/20/2012	MGR03785	POLA	Arizona Endorsement	Initial:		

State: Arkansas

Filing Company:

Golden Rule Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO

Product Name: Association Group

Project Name/Number: C-009/C-009

Lead Form Number: C-009

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
19	Accepted for Informational Purposes 09/20/2012	MGR03786	POLA	Arizona Endorsement	Initial:		
20	Accepted for Informational Purposes 09/20/2012	MGR03787	POLA	Arizona Endorsement	Initial:		
21	Accepted for Informational Purposes 09/20/2012	MGR03788	POLA	Arizona Endorsement	Initial:		
22	Accepted for Informational Purposes 09/20/2012	MGR04477	POLA	Colorado Endorsement	Initial:	59.140	MGRARECO-013 9112.pdf
23	Accepted for Informational Purposes 09/20/2012	MGR04418	POLA	Colorado Endorsement	Initial:		
24	Accepted for Informational Purposes 09/20/2012	MGR03676	POLA	Colorado Endorsement	Initial:		

State: Arkansas

Filing Company:

Golden Rule Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO

Product Name: Association Group

Project Name/Number: C-009/C-009

Lead Form Number: C-009

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
25	Accepted for Informational Purposes 09/20/2012	MGR04351	POLA	Colorado Endorsement	Initial:		
26	Accepted for Informational Purposes 09/20/2012	MGR03677	POLA	Colorado Endorsement	Initial:		
27	Accepted for Informational Purposes 09/20/2012	MGR03678	POLA	Colorado Endorsement	Initial:		
28	Accepted for Informational Purposes 09/20/2012	MGR04517	POLA	Colorado Endorsement	Initial:		
29	Accepted for Informational Purposes 09/20/2012	MGR03681	POLA	Colorado Endorsement	Initial:		
30	Accepted for Informational Purposes 09/20/2012	MGR03682	POLA	Colorado Endorsement	Initial:		

State: Arkansas

Filing Company:

Golden Rule Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO

Product Name: Association Group

Project Name/Number: C-009/C-009

Lead Form Number: C-009

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
31	Accepted for Informational Purposes 09/20/2012	MGR04478	POLA	Colorado Endorsement	Initial:		
32	Accepted for Informational Purposes 09/20/2012	MGR04543	POLA	Colorado Endorsement	Initial:		
33	Accepted for Informational Purposes 09/20/2012	MGR04163	POLA	Colorado Endorsement	Initial:		
34	Accepted for Informational Purposes 09/20/2012	MGR04267	POLA	Colorado Endorsement	Initial:		
35	Accepted for Informational Purposes 09/20/2012	MGR03940	POLA	Colorado Endorsement	Initial:		
36	Accepted for Informational Purposes 09/20/2012	MGR04544	POLA	Colorado Endorsement	Initial:		

State: Arkansas

Filing Company:

Golden Rule Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO

Product Name: Association Group

Project Name/Number: C-009/C-009

Lead Form Number: C-009

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
37	Accepted for Informational Purposes 09/20/2012	MGR03684	POLA	Colorado Endorsement	Initial:		
38	Accepted for Informational Purposes 09/20/2012	MGR03685	POLA	Colorado Endorsement	Initial:		
39	Accepted for Informational Purposes 09/20/2012	MGR03935	POLA	Colorado Endorsement	Initial:		
40	Accepted for Informational Purposes 09/20/2012	MGR04350	POLA	Colorado Endorsement	Initial:		
41	Accepted for Informational Purposes 09/20/2012	MGR04419	POLA	Colorado Endorsement	Initial:		
42	Accepted for Informational Purposes 09/20/2012	MGR03688	POLA	Colorado Endorsement	Initial:		

State: Arkansas

Filing Company:

Golden Rule Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO

Product Name: Association Group

Project Name/Number: C-009/C-009

Lead Form Number: C-009

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
43	Accepted for Informational Purposes 09/20/2012	MGR03887	POLA	Colorado Endorsement	Initial:		
44	Accepted for Informational Purposes 09/20/2012	MGR03689	POLA	Colorado Endorsement	Initial:		
45	Accepted for Informational Purposes 09/20/2012	MGR04120	POLA	Colorado Endorsement	Initial:		
46	Accepted for Informational Purposes 09/20/2012	MGR03912	POLA	Colorado Endorsement	Initial:		
47	Accepted for Informational Purposes 09/20/2012	MGR03934	POLA	Colorado Endorsement	Initial:		
48	Accepted for Informational Purposes 09/20/2012	MGR03936	POLA	Colorado Endorsement	Initial:		

State: Arkansas

Filing Company:

Golden Rule Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO

Product Name: Association Group

Project Name/Number: C-009/C-009

Lead Form Number: C-009

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/Action Specific Data	Readability Score	Attachments
49	Accepted for Informational Purposes 09/20/2012	MGR03691	POLA	Colorado Endorsement	Initial:		
50	Accepted for Informational Purposes 09/20/2012	MGR03692	POLA	Colorado Endorsement	Initial:		
51	Accepted for Informational Purposes 09/20/2012	MGR03662	POLA	Colorado Endorsement	Initial:		
52	Accepted for Informational Purposes 09/20/2012	MGR03939	POLA	Colorado Endorsement	Initial:		
53	Accepted for Informational Purposes 09/20/2012	MGR03937	POLA	Colorado Endorsement	Initial:		
54	Accepted for Informational Purposes 09/20/2012	MGR03938	POLA	Colorado Endorsement	Initial:		

State: Arkansas

Filing Company:

Golden Rule Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO

Product Name: Association Group

Project Name/Number: C-009/C-009

Lead Form Number: C-009

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
55	Accepted for Informational Purposes 09/20/2012	MGR03693	POLA	Colorado Endorsement	Initial:		
56	Accepted for Informational Purposes 09/20/2012	MGR03674	POLA	Colorado Endorsement	Initial:	59.140	MGRARECO-014 SAVER 9112.pdf
57	Accepted for Informational Purposes 09/20/2012	MGR04479	POLA	Colorado Endorsement	Initial:		
58	Accepted for Informational Purposes 09/20/2012	MGR04173	POLA	Colorado Endorsement	Initial:		
59	Accepted for Informational Purposes 09/20/2012	MGR04480	POLA	Colorado Endorsement	Initial:		
60	Accepted for Informational Purposes 09/20/2012	MGR04481	POLA	Colorado Endorsement	Initial:		

State: Arkansas

Filing Company:

Golden Rule Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO

Product Name: Association Group

Project Name/Number: C-009/C-009

Lead Form Number: C-009

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
61	Accepted for Informational Purposes 09/20/2012	MGR04482	POLA	Colorado Endorsement	Initial:		
62	Accepted for Informational Purposes 09/20/2012	MGR04143	POLA	District of Columbia Endorsement	Initial:	59.140	MGRUNIDC-008 9112.pdf
63	Accepted for Informational Purposes 09/20/2012	MGR04199	POLA	District of Columbia Endorsement	Initial:		
64	Accepted for Informational Purposes 09/20/2012	MGR04236	POLA	District of Columbia Endorsement	Initial:		
65	Accepted for Informational Purposes 09/20/2012	MGR04200	POLA	District of Columbia Endorsement	Initial:		
66	Accepted for Informational Purposes 09/20/2012	MGR04269	POLA	District of Columbia Endorsement	Initial:		

State: Arkansas

Filing Company:

Golden Rule Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO

Product Name: Association Group

Project Name/Number: C-009/C-009

Lead Form Number: C-009

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/Action Specific Data	Readability Score	Attachments
67	Accepted for Informational Purposes 09/20/2012	MGR04270	POLA	District of Columbia Endorsement	Initial:		
68	Accepted for Informational Purposes 09/20/2012	MGR04271	POLA	District of Columbia Endorsement	Initial:		
69	Accepted for Informational Purposes 09/20/2012	MGR04606	POLA	District of Columbia Endorsement	Initial:		
70	Accepted for Informational Purposes 09/20/2012	MGR04148	POLA	District of Columbia Endorsement	Initial:		
71	Accepted for Informational Purposes 09/20/2012	MGR04187	POLA	District of Columbia Endorsement	Initial:		
72	Accepted for Informational Purposes 09/20/2012	MGR04608	POLA	District of Columbia Endorsement	Initial:		

State: Arkansas

Filing Company:

Golden Rule Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO

Product Name: Association Group

Project Name/Number: C-009/C-009

Lead Form Number: C-009

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/Action Specific Data	Readability Score	Attachments
73	Accepted for Informational Purposes 09/20/2012	MGR04201	POLA	District of Columbia Endorsement	Initial:		
74	Accepted for Informational Purposes 09/20/2012	MGR04272	POLA	District of Columbia Endorsement	Initial:		
75	Accepted for Informational Purposes 09/20/2012	MGR04478	POLA	District of Columbia Endorsement	Initial:		
76	Accepted for Informational Purposes 09/20/2012	MGR04150	POLA	District of Columbia Endorsement	Initial:		
77	Accepted for Informational Purposes 09/20/2012	MGR04237	POLA	District of Columbia Endorsement	Initial:		
78	Accepted for Informational Purposes 09/20/2012	MGR04607	POLA	District of Columbia Endorsement	Initial:		

State: Arkansas

Filing Company:

Golden Rule Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO

Product Name: Association Group

Project Name/Number: C-009/C-009

Lead Form Number: C-009

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
79	Accepted for Informational Purposes 09/20/2012	MGR04255	POLA	District of Columbia Grievance Endorsement	Initial:	59.140	GRVENDDC-01 9112.pdf
80	Accepted for Informational Purposes 09/20/2012	MGR04256	POLA	District of Columbia Grievance Endorsement	Initial:		
81	Accepted for Informational Purposes 09/20/2012	MGR04257	POLA	District of Columbia Grievance Endorsement	Initial:		
82	Accepted for Informational Purposes 09/20/2012	MGR04526	POLA	District of Columbia Grievance Endorsement	Initial:		
83	Accepted for Informational Purposes 09/20/2012	MGR04259	POLA	District of Columbia Grievance Endorsement	Initial:		
84	Accepted for Informational Purposes 09/20/2012	MGR04260	POLA	District of Columbia Grievance Endorsement	Initial:		

State: Arkansas

Filing Company:

Golden Rule Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO

Product Name: Association Group

Project Name/Number: C-009/C-009

Lead Form Number: C-009

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
85	Accepted for Informational Purposes 09/20/2012	MGR04261	POLA	District of Columbia Grievance Endorsement	Initial:		
86	Accepted for Informational Purposes 09/20/2012	MGR04528	POLA	District of Columbia Grievance Endorsement	Initial:		
87	Accepted for Informational Purposes 09/20/2012	MGR04263	POLA	District of Columbia Grievance Endorsement	Initial:		
88	Accepted for Informational Purposes 09/20/2012	MGR04483	POLA	District of Columbia Endorsement	Initial:	59.140	MGRUNIDC-009 9112 saver.pdf
89	Accepted for Informational Purposes 09/20/2012	MGR04484	POLA	District of Columbia Endorsement	Initial:		
90	Accepted for Informational Purposes 09/20/2012	MGR04485	POLA	District of Columbia Endorsement	Initial:		

State: Arkansas

Filing Company:

Golden Rule Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO

Product Name: Association Group

Project Name/Number: C-009/C-009

Lead Form Number: C-009

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
91	Accepted for Informational Purposes 09/20/2012	MGR04411	POLA	Illinois Endorsement	Initial:	59.140	MGRAREIL-009 9112.pdf
92	Accepted for Informational Purposes 09/20/2012	MGR04615	POLA	Illinois Endorsement	Initial:		
93	Accepted for Informational Purposes 09/20/2012	MGR04570	POLA	Illinois Endorsement	Initial:		
94	Accepted for Informational Purposes 09/20/2012	MGR03915	POLA	Illinois Endorsement	Initial:		
95	Accepted for Informational Purposes 09/20/2012	MGR04567	POLA	Illinois Endorsement	Initial:		
96	Accepted for Informational Purposes 09/20/2012	MGR04572	POLA	Illinois Endorsement	Initial:		

State: Arkansas

Filing Company:

Golden Rule Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO

Product Name: Association Group

Project Name/Number: C-009/C-009

Lead Form Number: C-009

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
97	Accepted for Informational Purposes 09/20/2012	MGR04702	POLA	Illinois Endorsement	Initial:		
98	Accepted for Informational Purposes 09/20/2012	MGR03916	POLA	Illinois Appeal Procedures Notice Endorsement	Initial:	59.140	GRVENDIL-01 9112.pdf
99	Accepted for Informational Purposes 09/20/2012	MGR03807	POLA	Indiana Endorsement	Initial:	59.140	MGRAREIN-007 9112.pdf
100	Accepted for Informational Purposes 09/20/2012	MGR03808	POLA	Indiana Endorsement	Initial:		
101	Accepted for Informational Purposes 09/20/2012	MGR04676	POLA	Indiana Endorsement	Initial:		
102	Accepted for Informational Purposes 09/20/2012	MGR04516	POLA	Indiana Endorsement	Initial:		

State: Arkansas

Filing Company:

Golden Rule Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO

Product Name: Association Group

Project Name/Number: C-009/C-009

Lead Form Number: C-009

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
103	Accepted for Informational Purposes 09/20/2012	MGR03576	POLA	Indiana Endorsement	Initial:		
104	Accepted for Informational Purposes 09/20/2012	MGR04531	POLA	Indiana Endorsement	Initial:		
105	Accepted for Informational Purposes 09/20/2012	MGR04565	POLA	Indiana Endorsement	Initial:		
106	Accepted for Informational Purposes 09/20/2012	MGR04042	POLA	Indiana Endorsement	Initial:		
107	Accepted for Informational Purposes 09/20/2012	MGR04125	POLA	Indiana Endorsement	Initial:		
108	Accepted for Informational Purposes 09/20/2012	MGR03746	POLA	Indiana Endorsement	Initial:		

State: Arkansas

Filing Company:

Golden Rule Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO

Product Name: Association Group

Project Name/Number: C-009/C-009

Lead Form Number: C-009

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
109	Accepted for Informational Purposes 09/20/2012	MGR04179	POLA	Indiana Endorsement	Initial:		
110	Accepted for Informational Purposes 09/20/2012	MGR04186	POLA	Indiana Endorsement	Initial:		
111	Accepted for Informational Purposes 09/20/2012	MGR03806	POLA	Indiana Grievance Endorsement	Initial:	59.140	GRVENDIN-01 9112.pdf
112	Accepted for Informational Purposes 09/20/2012	MGR03747	POLA	Indiana Grievance Endorsement	Initial:		
113	Accepted for Informational Purposes 09/20/2012	MGR03748	POLA	Indiana Grievance Endorsement	Initial:		
114	Accepted for Informational Purposes 09/20/2012	MGR03749	POL	Indiana Grievance Endorsement	Initial:		

State: Arkansas

Filing Company:

Golden Rule Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO

Product Name: Association Group

Project Name/Number: C-009/C-009

Lead Form Number: C-009

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
115	Accepted for Informational Purposes 09/20/2012	MGR03750	POLA	Indiana Grievance Endorsement	Initial:		
116	Accepted for Informational Purposes 09/20/2012	MGR03751	POLA	Indiana Grievance Endorsement	Initial:		
117	Accepted for Informational Purposes 09/20/2012	MGR03752	POLA	Indiana Grievance Endorsement	Initial:		
118	Accepted for Informational Purposes 09/20/2012	MGR03753	OTH	Indiana Grievance Endorsement	Initial:		
119	Accepted for Informational Purposes 09/20/2012	MGR04393	POLA	Iowa Endorsement	Initial:	59.140	MGRAREIA-005 9112.pdf
120	Accepted for Informational Purposes 09/20/2012	MGR04431	POLA	Iowa Endorsement	Initial:		

State: Arkansas

Filing Company:

Golden Rule Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO

Product Name: Association Group

Project Name/Number: C-009/C-009

Lead Form Number: C-009

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
121	Accepted for Informational Purposes 09/20/2012	MGR04432	POLA	Iowa Endorsement	Initial:		
122	Accepted for Informational Purposes 09/20/2012	MGR04433	POLA	Iowa Endorsement	Initial:		
123	Accepted for Informational Purposes 09/20/2012	MGR04518	POLA	Iowa Endorsement	Initial:		
124	Accepted for Informational Purposes 09/20/2012	MGR03764	POLA	Iowa Endorsement	Initial:		
125	Accepted for Informational Purposes 09/20/2012	MGR03765	POLA	Iowa Endorsement	Initial:		
126	Accepted for Informational Purposes 09/20/2012	MGR04434	POLA	Iowa Endorsement	Initial:		

State: Arkansas

Filing Company:

Golden Rule Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO

Product Name: Association Group

Project Name/Number: C-009/C-009

Lead Form Number: C-009

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
127	Accepted for Informational Purposes 09/20/2012	MGR03766	POLA	Iowa Endorsement	Initial:		
128	Accepted for Informational Purposes 09/20/2012	MGR03767	POLA	Iowa Endorsement	Initial:		
129	Accepted for Informational Purposes 09/20/2012	MGR03768	POLA	Iowa Endorsement	Initial:		
130	Accepted for Informational Purposes 09/20/2012	MGR03776	POLA	Iowa Endorsement	Initial:		
131	Accepted for Informational Purposes 09/20/2012	MGR03848	POLA	Kentucky Endorsement	Initial:	59.140	MGRAREKY-012 9112.pdf
132	Accepted for Informational Purposes 09/20/2012	MGR03849	POLA	Kentucky Endorsement	Initial:		

State: Arkansas

Filing Company:

Golden Rule Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO

Product Name: Association Group

Project Name/Number: C-009/C-009

Lead Form Number: C-009

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/Action Specific Data	Readability Score	Attachments
133	Accepted for Informational Purposes 09/20/2012	MGR04540	POLA	Kentucky Endorsement	Initial:		
134	Accepted for Informational Purposes 09/20/2012	MGR03862	POLA	Kentucky Endorsement	Initial:		
135	Accepted for Informational Purposes 09/20/2012	MGR03881	POLA	Kentucky Endorsement	Initial:		
136	Accepted for Informational Purposes 09/20/2012	MGR03890	POLA	Kentucky Endorsement	Initial:		
137	Accepted for Informational Purposes 09/20/2012	MGR03852	POLA	Kentucky Endorsement	Initial:		
138	Accepted for Informational Purposes 09/20/2012	MGR03853	POLA	Kentucky Endorsement	Initial:		

State: Arkansas

Filing Company:

Golden Rule Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO

Product Name: Association Group

Project Name/Number: C-009/C-009

Lead Form Number: C-009

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/Action Specific Data	Readability Score	Attachments
139	Accepted for Informational Purposes 09/20/2012	MGR03854	POLA	Kentucky Endorsement	Initial:		
140	Accepted for Informational Purposes 09/20/2012	MGR03863	POLA	Kentucky Endorsement	Initial:		
141	Accepted for Informational Purposes 09/20/2012	MGR03886	POLA	Kentucky Endorsement	Initial:		
142	Accepted for Informational Purposes 09/20/2012	MGR03864	POLA	Kentucky Endorsement	Initial:		
143	Accepted for Informational Purposes 09/20/2012	MGR03914	POLA	Kentucky Endorsement	Initial:		
144	Accepted for Informational Purposes 09/20/2012	MGR03882	POLA	Kentucky Endorsement	Initial:		

State: Arkansas

Filing Company:

Golden Rule Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO

Product Name: Association Group

Project Name/Number: C-009/C-009

Lead Form Number: C-009

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/Action Specific Data	Readability Score	Attachments
145	Accepted for Informational Purposes 09/20/2012	MGR03009	POLA	Kentucky Endorsement	Initial:		
146	Accepted for Informational Purposes 09/20/2012	MGR03110	POLA	Kentucky Endorsement	Initial:		
147	Accepted for Informational Purposes 09/20/2012	MGR03865	POLA	Kentucky Endorsement	Initial:		
148	Accepted for Informational Purposes 09/20/2012	MGR03866	POLA	Kentucky Endorsement	Initial:		
149	Accepted for Informational Purposes 09/20/2012	MGR03867	POLA	Kentucky Endorsement	Initial:		
150	Accepted for Informational Purposes 09/20/2012	MGR030313	POLA	Kentucky Endorsement	Initial:		

State: Arkansas

Filing Company:

Golden Rule Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO

Product Name: Association Group

Project Name/Number: C-009/C-009

Lead Form Number: C-009

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/Action Specific Data	Readability Score	Attachments
151	Accepted for Informational Purposes 09/20/2012	MGR03014	POLA	Kentucky Endorsement	Initial:		
152	Accepted for Informational Purposes 09/20/2012	MGR03015	POLA	Kentucky Endorsement	Initial:		
153	Accepted for Informational Purposes 09/20/2012	MGR03868	POLA	Kentucky Endorsement	Initial:		
154	Accepted for Informational Purposes 09/20/2012	MGR03869	POLA	Kentucky Endorsement	Initial:		
155	Accepted for Informational Purposes 09/20/2012	MGR04541	POLA	Kentucky Endorsement	Initial:		
156	Accepted for Informational Purposes 09/20/2012	MGR04546	POLA	Kentucky Endorsement	Initial:		

State: Arkansas

Filing Company:

Golden Rule Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO

Product Name: Association Group

Project Name/Number: C-009/C-009

Lead Form Number: C-009

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
157	Accepted for Informational Purposes 09/20/2012	MGR03760	POLA	Maryland Grievance Endorsement	Initial:	59.140	GRVENDMD-01 81412.pdf
158	Accepted for Informational Purposes 09/20/2012	MGR03759	POLA	Maryland Endorsement	Initial:	59.140	MGRAREMD-004 9112.pdf
159	Accepted for Informational Purposes 09/20/2012	MGR03761	POLA	Maryland Endorsement	Initial:		
160	Accepted for Informational Purposes 09/20/2012	MGR03794	POLA	Maryland Endorsement	Initial:		
161	Accepted for Informational Purposes 09/20/2012	MGR04342	POLA	Maryland Endorsement	Initial:		
162	Accepted for Informational Purposes 09/20/2012	MGR04343	POLA	Maryland Endorsement	Initial:		

State: Arkansas

Filing Company:

Golden Rule Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO

Product Name: Association Group

Project Name/Number: C-009/C-009

Lead Form Number: C-009

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/Action Specific Data	Readability Score	Attachments
163	Accepted for Informational Purposes 09/20/2012	MGR04344	POLA	Maryland Endorsement	Initial:		
164	Accepted for Informational Purposes 09/20/2012	MGR04345	POLA	Maryland Endorsement	Initial:		
165	Accepted for Informational Purposes 09/20/2012	MGR03462	POLA	Michigan Endorsement	Initial:	59.140	MGRUNIMI-001 9112.pdf
166	Accepted for Informational Purposes 09/20/2012	MGR03755	POLA	Mississippi Endorsement	Initial:	59.140	MGRAREMS-003 9112.pdf
167	Accepted for Informational Purposes 09/20/2012	MGR03756	POLA	Mississippi Endorsement	Initial:	59.140	
168	Accepted for Informational Purposes 09/20/2012	MGR04697	POLA	Mississippi Endorsement	Initial:		

State: Arkansas

Filing Company:

Golden Rule Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO

Product Name: Association Group

Project Name/Number: C-009/C-009

Lead Form Number: C-009

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/Action Specific Data	Readability Score	Attachments
169	Accepted for Informational Purposes 09/20/2012	MGR03762	POLA	Mississippi Endorsement	Initial:		
170	Accepted for Informational Purposes 09/20/2012	MGR03577	POLA	Missouri Endorsement	Initial:	59.140	MGRAREMO-013 9112.pdf
171	Accepted for Informational Purposes 09/20/2012	MGR03822	POLA	Missouri Endorsement	Initial:		
172	Accepted for Informational Purposes 09/20/2012	MGR03578	POLA	Missouri Endorsement	Initial:		
173	Accepted for Informational Purposes 09/20/2012	MGR03823	POLA	Missouri Endorsement	Initial:		
174	Accepted for Informational Purposes 09/20/2012	MGR04329	POLA	Missouri Endorsement	Initial:		

State: Arkansas

Filing Company:

Golden Rule Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO

Product Name: Association Group

Project Name/Number: C-009/C-009

Lead Form Number: C-009

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
175	Accepted for Informational Purposes 09/20/2012	MGR03580	POLA	Missouri Endorsement	Initial:		
176	Accepted for Informational Purposes 09/20/2012	MGR04278	POLA	Missouri Endorsement	Initial:		
177	Accepted for Informational Purposes 09/20/2012	MGR03581	POLA	Missouri Endorsement	Initial:		
178	Accepted for Informational Purposes 09/20/2012	MGR04352	POLA	Missouri Endorsement	Initial:		
179	Accepted for Informational Purposes 09/20/2012	MGR04249	POLA	Missouri Endorsement	Initial:		
180	Accepted for Informational Purposes 09/20/2012	MGR04141	POLA	Nebraska Endorsement	Initial:	59.140	MGRUNINE-003 9112.pdf

State: Arkansas

Filing Company:

Golden Rule Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO

Product Name: Association Group

Project Name/Number: C-009/C-009

Lead Form Number: C-009

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
181	Accepted for Informational Purposes 09/20/2012	MGR04532	POLA	Nebraska Endorsement	Initial:		
182	Accepted for Informational Purposes 09/20/2012	SA-S-1318R	POLA	Golden Rule Insurance Company North Carolina Utilization Review Procedures and Grievance Procedures Rider	Initial:	59.140	SA-S-1318R 71912.pdf
183	Accepted for Informational Purposes 09/20/2012	MGR03452	POLA	Ohio Endorsement	Initial:	59.140	MGRAREOH-015 9112.pdf
184	Accepted for Informational Purposes 09/20/2012	MGR04387	POLA	Ohio Endorsement	Initial:		
185	Accepted for Informational Purposes 09/20/2012	MGR04273	POLA	Ohio Endorsement	Initial:		
186	Accepted for Informational Purposes 09/20/2012	MGR04274	POLA	Ohio Endorsement	Initial:		

State: Arkansas

Filing Company:

Golden Rule Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO

Product Name: Association Group

Project Name/Number: C-009/C-009

Lead Form Number: C-009

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
187	Accepted for Informational Purposes 09/20/2012	MGR04275	POLA	Ohio Endorsement	Initial:		
188	Accepted for Informational Purposes 09/20/2012	MGR04603	POLA	Ohio Endorsement	Initial:		
189	Accepted for Informational Purposes 09/20/2012	MGR04276	POLA	Ohio Endorsement	Initial:		
190	Accepted for Informational Purposes 09/20/2012	MGR04491	POLA	Ohio Endorsement	Initial:		
191	Accepted for Informational Purposes 09/20/2012	MGR03455	POLA	Ohio Endorsement	Initial:		
192	Accepted for Informational Purposes 09/20/2012	MGR03456	POLA	Ohio Endorsement	Initial:		

State: Arkansas

Filing Company:

Golden Rule Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO

Product Name: Association Group

Project Name/Number: C-009/C-009

Lead Form Number: C-009

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
193	Accepted for Informational Purposes 09/20/2012	MGR03734	POLA	Ohio Endorsement	Initial:		
194	Accepted for Informational Purposes 09/20/2012	MGR04478	POLA	Ohio Endorsement	Initial:		
195	Accepted for Informational Purposes 09/20/2012	MGR04277	POLA	Ohio Endorsement	Initial:		
196	Accepted for Informational Purposes 09/20/2012	MGR04604	POLA	Ohio Endorsement	Initial:		
197	Accepted for Informational Purposes 09/20/2012	MGR04527	POLA	Ohio Endorsement	Initial:		
198	Accepted for Informational Purposes 09/20/2012	MGR04730	POLA	Ohio Endorsement	Initial:		

State: Arkansas

Filing Company:

Golden Rule Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO

Product Name: Association Group

Project Name/Number: C-009/C-009

Lead Form Number: C-009

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
199	Accepted for Informational Purposes 09/20/2012	MGR04542	POLA	Ohio Endorsement	Initial:		
200	Accepted for Informational Purposes 09/20/2012	MGR04449	POLA	Ohio Endorsement	Initial:		
201	Accepted for Informational Purposes 09/20/2012	MGR04151	POLA	Ohio Endorsement	Initial:	59.140	MGRAREOH-016 9112SAVER.pdf
202	Accepted for Informational Purposes 09/20/2012	MGR03454	POLA	Ohio Endorsement	Initial:		
203	Accepted for Informational Purposes 09/20/2012	MGR03725	POLA	Ohio Endorsement	Initial:		
204	Accepted for Informational Purposes 09/20/2012	MGR04235	POLA	Ohio Endorsement	Initial:		

State: Arkansas

Filing Company:

Golden Rule Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO

Product Name: Association Group

Project Name/Number: C-009/C-009

Lead Form Number: C-009

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
205	Accepted for Informational Purposes 09/20/2012	SA-S-1556	POLA	Ohio Appeal Procedures Rider	Initial:	59.140	OH SA-S-1556 Appeal Proc Rdr 03 26 12 NB.pdf
206	Accepted for Informational Purposes 09/20/2012	MGR03620	POLA	Oklahoma Endorsement	Initial:	59.140	MGRAREOK-009 9112.pdf
207	Accepted for Informational Purposes 09/20/2012	MGR03609	POLA	Oklahoma Endorsement	Initial:		
208	Accepted for Informational Purposes 09/20/2012	MGR04266	POLA	Oklahoma Endorsement	Initial:		
209	Accepted for Informational Purposes 09/20/2012	MGR03610	POLA	Oklahoma Endorsement	Initial:		
210	Accepted for Informational Purposes 09/20/2012	MGR03611	POLA	Oklahoma Endorsement	Initial:		

State: Arkansas

Filing Company:

Golden Rule Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO

Product Name: Association Group

Project Name/Number: C-009/C-009

Lead Form Number: C-009

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
211	Accepted for Informational Purposes 09/20/2012	MGR04458	POLA	Oklahoma Endorsement	Initial:		
212	Accepted for Informational Purposes 09/20/2012	MGR03622	POLA	Oklahoma Endorsement	Initial:		
213	Accepted for Informational Purposes 09/20/2012	MGR04551	POLA	Oklahoma Endorsement	Initial:		
214	Accepted for Informational Purposes 09/20/2012	MGR04230	POLA	Oklahoma Endorsement	Initial:		
215	Accepted for Informational Purposes 09/20/2012	MGR04382	POLA	Oklahoma Endorsement	Initial:		
216	Accepted for Informational Purposes 09/20/2012	MGR04703	POLA	Oklahoma Endorsement	Initial:		

State: Arkansas

Filing Company:

Golden Rule Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO

Product Name: Association Group

Project Name/Number: C-009/C-009

Lead Form Number: C-009

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/Action Specific Data	Readability Score	Attachments
217	Accepted for Informational Purposes 09/20/2012	MGR03614	POLA	Oklahoma Endorsement	Initial:		
218	Accepted for Informational Purposes 09/20/2012	MGR03615	POLA	Oklahoma Endorsement	Initial:		
219	Accepted for Informational Purposes 09/20/2012	MGR04352	POLA	Oklahoma Endorsement	Initial:		
220	Accepted for Informational Purposes 09/20/2012	MGR03616	POLA	Oklahoma Endorsement	Initial:		
221	Accepted for Informational Purposes 09/20/2012	MGR03617	POLA	Oklahoma Endorsement	Initial:		
222	Accepted for Informational Purposes 09/20/2012	MGR03618	POLA	Oklahoma Endorsement	Initial:		

State: Arkansas

Filing Company:

Golden Rule Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO

Product Name: Association Group

Project Name/Number: C-009/C-009

Lead Form Number: C-009

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/Action Specific Data	Readability Score	Attachments
223	Accepted for Informational Purposes 09/20/2012	MGR04698	POLA	Oklahoma Endorsement	Initial:		
224	Accepted for Informational Purposes 09/20/2012	MGR04530	POLA	Oklahoma Endorsement	Initial:		
225	Accepted for Informational Purposes 09/20/2012	MGR04533	POLA	Pennsylvania Endorsement	Initial:	59.140	MGRUNIPA-002 9112.pdf
226	Accepted for Informational Purposes 09/20/2012	MGR04534	POLA	Pennsylvania Endorsement	Initial:		
227	Accepted for Informational Purposes 09/20/2012	MGR04552	POLA	South Carolina Endorsement	Initial:	59.140	MGRUNISC-004 9112.pdf
228	Accepted for Informational Purposes 09/20/2012	MGR04561	POLA	South Carolina Endorsement	Initial:		

State: Arkansas

Filing Company:

Golden Rule Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO

Product Name: Association Group

Project Name/Number: C-009/C-009

Lead Form Number: C-009

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
229	Accepted for Informational Purposes 09/20/2012	MGR04553	POLA	South Carolina Endorsement	Initial:		
230	Accepted for Informational Purposes 09/20/2012	MGR04561	POLA	South Carolina Endorsement	Initial:		
231	Accepted for Informational Purposes 09/20/2012	MGR03841	POLA	South Carolina Endorsement	Initial:		
232	Accepted for Informational Purposes 09/20/2012	MGR03843	POLA	South Carolina Endorsement	Initial:		
233	Accepted for Informational Purposes 09/20/2012	MGR03844	POLA	South Carolina Endorsement	Initial:		
234	Accepted for Informational Purposes 09/20/2012	MGR03845	POLA	South Carolina Endorsement	Initial:		

State: Arkansas

Filing Company:

Golden Rule Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO

Product Name: Association Group

Project Name/Number: C-009/C-009

Lead Form Number: C-009

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
235	Accepted for Informational Purposes 09/20/2012	MGR03846	POLA	South Carolina Endorsement	Initial:		
236	Accepted for Informational Purposes 09/20/2012	MGR04554	POLA	South Carolina Endorsement	Initial:		
237	Accepted for Informational Purposes 09/20/2012	MGR03847	POLA	South Carolina Endorsement	Initial:		
238	Accepted for Informational Purposes 09/20/2012	MGR03636	POLA	Texas Endorsement	Initial:	59.140	MGRARETX-014 9112.pdf
239	Accepted for Informational Purposes 09/20/2012	MGR04699	POLA	Texas Endorsement	Initial:		
240	Accepted for Informational Purposes 09/20/2012	MGR04447	POLA	Texas Endorsement	Initial:		

State: Arkansas

Filing Company:

Golden Rule Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO

Product Name: Association Group

Project Name/Number: C-009/C-009

Lead Form Number: C-009

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
241	Accepted for Informational Purposes 09/20/2012	MGR03639	POLA	Texas Endorsement	Initial:		
242	Accepted for Informational Purposes 09/20/2012	MGR03640	POLA	Texas Endorsement	Initial:		
243	Accepted for Informational Purposes 09/20/2012	MGR04520	POLA	Texas Endorsement	Initial:		
244	Accepted for Informational Purposes 09/20/2012	MGR03642	POLA	Texas Endorsement	Initial:		
245	Accepted for Informational Purposes 09/20/2012	MGR04391	POLA	Texas Endorsement	Initial:		
246	Accepted for Informational Purposes 09/20/2012	MGR04390	POLA	Texas Endorsement	Initial:		

State: Arkansas

Filing Company:

Golden Rule Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO

Product Name: Association Group

Project Name/Number: C-009/C-009

Lead Form Number: C-009

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
247	Accepted for Informational Purposes 09/20/2012	MGR04571	POLA	Texas Endorsement	Initial:		
248	Accepted for Informational Purposes 09/20/2012	MGR04502	POLA	Texas Endorsement	Initial:		
249	Accepted for Informational Purposes 09/20/2012	MGR03643	POLA	Texas Endorsement	Initial:		
250	Accepted for Informational Purposes 09/20/2012	MGR03644	POLA	Texas Endorsement	Initial:		
251	Accepted for Informational Purposes 09/20/2012	MGR04525	POLA	Texas Endorsement	Initial:		
252	Accepted for Informational Purposes 09/20/2012	MGR04421	POLA	Texas Endorsement	Initial:		

State: Arkansas

Filing Company:

Golden Rule Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO

Product Name: Association Group

Project Name/Number: C-009/C-009

Lead Form Number: C-009

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
253	Accepted for Informational Purposes 09/20/2012	MGR04478	POLA	Texas Endorsement	Initial:		
254	Accepted for Informational Purposes 09/20/2012	MGR04392	POLA	Texas Endorsement	Initial:		
255	Accepted for Informational Purposes 09/20/2012	MGR04211	POLA	Texas Endorsement	Initial:		
256	Accepted for Informational Purposes 09/20/2012	MGR04386	POLA	Texas Endorsement	Initial:		
257	Accepted for Informational Purposes 09/20/2012	MGR04492	POLA	Texas Endorsement	Initial:		
258	Accepted for Informational Purposes 09/20/2012	MGR03645	POLA	Texas Endorsement	Initial:		

State: Arkansas

Filing Company:

Golden Rule Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO

Product Name: Association Group

Project Name/Number: C-009/C-009

Lead Form Number: C-009

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/Action Specific Data	Readability Score	Attachments
259	Accepted for Informational Purposes 09/20/2012	MGR04493	POLA	Texas Endorsement	Initial:		
260	Accepted for Informational Purposes 09/20/2012	MGR03650	POLA	Texas Endorsement	Initial:		
261	Accepted for Informational Purposes 09/20/2012	MGR04529	POLA	Texas Endorsement	Initial:		
262	Accepted for Informational Purposes 09/20/2012	MGR04468	POLA	Texas Endorsement	Initial:		
263	Accepted for Informational Purposes 09/20/2012	MGR04352	POLA	Texas Endorsement	Initial:		
264	Accepted for Informational Purposes 09/20/2012	MGR04017	POLA	Texas Endorsement	Initial:		

State: Arkansas

Filing Company:

Golden Rule Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO

Product Name: Association Group

Project Name/Number: C-009/C-009

Lead Form Number: C-009

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/Action Specific Data	Readability Score	Attachments
265	Accepted for Informational Purposes 09/20/2012	MGR03652	POLA	Texas Endorsement	Initial:		
266	Accepted for Informational Purposes 09/20/2012	MGR03655	POLA	Texas Endorsement	Initial:		
267	Accepted for Informational Purposes 09/20/2012	MGR03733	POLA	Texas Endorsement	Initial:		
268	Accepted for Informational Purposes 09/20/2012	MGR03661	POLA	Texas Endorsement	Initial:		
269	Accepted for Informational Purposes 09/20/2012	MGR03662	POLA	Texas Endorsement	Initial:		
270	Accepted for Informational Purposes 09/20/2012	MGR03663	POLA	Texas Endorsement	Initial:		

State: Arkansas

Filing Company:

Golden Rule Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO

Product Name: Association Group

Project Name/Number: C-009/C-009

Lead Form Number: C-009

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
271	Accepted for Informational Purposes 09/20/2012	MGR03664	POLA	Texas Endorsement	Initial:		
272	Accepted for Informational Purposes 09/20/2012	MGR03665	POLA	Texas Endorsement	Initial:		
273	Accepted for Informational Purposes 09/20/2012	MGR03666	POLA	Texas Endorsement	Initial:		
274	Accepted for Informational Purposes 09/20/2012	MGR04117	POLA	Texas Endorsement	Initial:		
275	Accepted for Informational Purposes 09/20/2012	MGR04165	POLA	Texas Endorsement	Initial:	59.140	MGRARETX-015 9112.pdf
276	Accepted for Informational Purposes 09/20/2012	MGR04480	POLA	Texas Endorsement	Initial:		

State: Arkansas

Filing Company:

Golden Rule Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO

Product Name: Association Group

Project Name/Number: C-009/C-009

Lead Form Number: C-009

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
277	Accepted for Informational Purposes 09/20/2012	MGR04494	POLA	Texas Endorsement	Initial:		
278	Accepted for Informational Purposes 09/20/2012	MGR04495	POLA	Texas Endorsement	Initial:		
279	Accepted for Informational Purposes 09/20/2012	MGR03647	POLA	Texas Endorsement	Initial:		
280	Accepted for Informational Purposes 09/20/2012	MGR03648	POLA	Texas Endorsement	Initial:		
281	Accepted for Informational Purposes 09/20/2012	MGR04496	POLA	Texas Endorsement	Initial:		
282	Accepted for Informational Purposes 09/20/2012	MGR03602	POLA	West Virginia Endorsement	Initial:	59.140	MGRAREWV-008 9112.pdf

State: Arkansas

Filing Company:

Golden Rule Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO

Product Name: Association Group

Project Name/Number: C-009/C-009

Lead Form Number: C-009

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
283	Accepted for Informational Purposes 09/20/2012	MGR03858	POLA	West Virginia Endorsement	Initial:		
284	Accepted for Informational Purposes 09/20/2012	MGR03603	POLA	West Virginia Endorsement	Initial:		
285	Accepted for Informational Purposes 09/20/2012	MGR04535	POLA	West Virginia Endorsement	Initial:		
286	Accepted for Informational Purposes 09/20/2012	MGR04700	POLA	West Virginia Endorsement	Initial:		
287	Accepted for Informational Purposes 09/20/2012	MGR03604	POLA	West Virginia Endorsement	Initial:		
288	Accepted for Informational Purposes 09/20/2012	MGR03605	POLA	West Virginia Endorsement	Initial:		

State: Arkansas

Filing Company:

Golden Rule Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO

Product Name: Association Group

Project Name/Number: C-009/C-009

Lead Form Number: C-009

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
289	Accepted for Informational Purposes 09/20/2012	MGR04536	POLA	West Virginia Endorsement	Initial:		
290	Accepted for Informational Purposes 09/20/2012	MGR04161	POLA	West Virginia Endorsement	Initial:		
291	Accepted for Informational Purposes 09/20/2012	MGR04537	POLA	West Virginia Endorsement	Initial:		
292	Accepted for Informational Purposes 09/20/2012	MGR04341	POLA	West Virginia Endorsement	Initial:		
293	Accepted for Informational Purposes 09/20/2012	MGR04538	POLA	West Virginia Endorsement	Initial:	59.140	MGRAREWV-009 9112 Saver.pdf
294	Accepted for Informational Purposes 09/20/2012	MGR04469	POLA	Wisconsin Endorsement	Initial:	59.140	MGRAREWI-015 9112.pdf

State: Arkansas

Filing Company:

Golden Rule Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO

Product Name: Association Group

Project Name/Number: C-009/C-009

Lead Form Number: C-009

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
295	Accepted for Informational Purposes 09/20/2012	MGR04402	POLA	Wisconsin Endorsement	Initial:		
296	Accepted for Informational Purposes 09/20/2012	MGR03694	POLA	Wisconsin Endorsement	Initial:		
297	Accepted for Informational Purposes 09/20/2012	MGR04422	POLA	Wisconsin Endorsement	Initial:		
298	Accepted for Informational Purposes 09/20/2012	MGR04403	POLA	Wisconsin Endorsement	Initial:		
299	Accepted for Informational Purposes 09/20/2012	MGR04423	POLA	Wisconsin Endorsement	Initial:		
300	Accepted for Informational Purposes 09/20/2012	MGR04405	POLA	Wisconsin Endorsement	Initial:		

State: Arkansas

Filing Company:

Golden Rule Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO

Product Name: Association Group

Project Name/Number: C-009/C-009

Lead Form Number: C-009

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
301	Accepted for Informational Purposes 09/20/2012	MGR04406	POLA	Wisconsin Endorsement	Initial:		
302	Accepted for Informational Purposes 09/20/2012	MGR04497	POLA	Wisconsin Endorsement	Initial:		
303	Accepted for Informational Purposes 09/20/2012	MGR04408	POLA	Wisconsin Endorsement	Initial:		
304	Accepted for Informational Purposes 09/20/2012	MGR04414	POL	Wisconsin Endorsement	Initial:		
305	Accepted for Informational Purposes 09/20/2012	MGR03696	POLA	Wisconsin Endorsement	Initial:		
306	Accepted for Informational Purposes 09/20/2012	MGR03697	POLA	Wisconsin Endorsement	Initial:		

State: Arkansas

Filing Company:

Golden Rule Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO

Product Name: Association Group

Project Name/Number: C-009/C-009

Lead Form Number: C-009

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
307	Accepted for Informational Purposes 09/20/2012	MGR03698	POLA	Wisconsin Endorsement	Initial:		
308	Accepted for Informational Purposes 09/20/2012	MGR03699	POLA	Wisconsin Endorsement	Initial:		
309	Accepted for Informational Purposes 09/20/2012	MGR03722	POLA	Wisconsin Endorsement	Initial:		
310	Accepted for Informational Purposes 09/20/2012	MGR04459	POLA	Wisconsin Endorsement	Initial:		
311	Accepted for Informational Purposes 09/20/2012	MGR04460	POLA	Wisconsin Endorsement	Initial:		
312	Accepted for Informational Purposes 09/20/2012	MGR04415	POLA	Wisconsin Endorsement	Initial:		

State: Arkansas

Filing Company:

Golden Rule Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO

Product Name: Association Group

Project Name/Number: C-009/C-009

Lead Form Number: C-009

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
313	Accepted for Informational Purposes 09/20/2012	MGR03714	POLA	Wisconsin Endorsement	Initial:		
314	Accepted for Informational Purposes 09/20/2012	MGR04424	POLA	Wisconsin Endorsement	Initial:		
315	Accepted for Informational Purposes 09/20/2012	MGR04498	POLA	Wisconsin Endorsement	Initial:		
316	Accepted for Informational Purposes 09/20/2012	MGR04499	POLA	Wisconsin Endorsement	Initial:		
317	Accepted for Informational Purposes 09/20/2012	MGR04500	POLA	Wisconsin Endorsement	Initial:		
318	Accepted for Informational Purposes 09/20/2012	MGR04478	POLA	Wisconsin Endorsement	Initial:		

State: Arkansas

Filing Company:

Golden Rule Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO

Product Name: Association Group

Project Name/Number: C-009/C-009

Lead Form Number: C-009

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
319	Accepted for Informational Purposes 09/20/2012	MGR03717	POLA	Wisconsin Endorsement	Initial:		
320	Accepted for Informational Purposes 09/20/2012	MGR04740	POLA	Wisconsin Endorsement	Initial:		
321	Accepted for Informational Purposes 09/20/2012	MGR04046	POLA	Wisconsin Endorsement	Initial:		
322	Accepted for Informational Purposes 09/20/2012	MGR03798	POLA	Wisconsin Endorsement	Initial:		
323	Accepted for Informational Purposes 09/20/2012	MGR03719	POLA	Wisconsin Endorsement	Initial:		
324	Accepted for Informational Purposes 09/20/2012	MGR03720	POLA	Wisconsin Endorsement	Initial:		

State: Arkansas

Filing Company:

Golden Rule Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO

Product Name: Association Group

Project Name/Number: C-009/C-009

Lead Form Number: C-009

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
325	Accepted for Informational Purposes 09/20/2012	MGR03721	POLA	Wisconsin Endorsement	Initial:		
326	Accepted for Informational Purposes 09/20/2012	MGR04501	POLA	Wisconsin Endorsement	Initial:	59.140	MGRAREWI-016 9112 SAVER.pdf
327	Accepted for Informational Purposes 09/20/2012	MGR04483	POLA	Wisconsin Endorsement	Initial:		
328	Accepted for Informational Purposes 09/20/2012	SA-S-1577-48	POLA	Golden Rule Insurance Company Wisconsin Grievance and Complaint Procedures Rider (Grandfathered Plans)	Initial:	59.140	SA-S-1577-48 WI GF Grievance Procedures Rider 03 26 12.pdf
329	Accepted for Informational Purposes 09/20/2012	SA-S-1576-48	POLA	Golden Rule Insurance Company Wisconsin Grievance and Complaint Procedures Rider (Non-Grandfathered Plans)	Initial:	59.140	SA-S-1576-48 WI NGF Grievance Procedures Rider 03 27 12.pdf
330	Accepted for Informational Purposes 09/20/2012	SA-S-766	POLA	HIPAA Portability Rider	Initial:	59.140	SA-S-766 597.pdf

State: Arkansas

Filing Company:

Golden Rule Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO

Product Name: Association Group

Project Name/Number: C-009/C-009

Lead Form Number: C-009

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
331	Accepted for Informational Purposes 09/20/2012	SA-S-652	POLA	Florida Limitation of Payment for AIDS or HIV Related Disease Claims Endorsement	Initial:	59.140	SA-S-652 595.pdf
332	Accepted for Informational Purposes 09/20/2012	SA-S-832.1-09	POLA	Copayment Amount Endorsement	Initial:	59.140	SA-S-832.1-09 12210 4 visit limit.pdf
333	Accepted for Informational Purposes 09/20/2012	SA-S-861-09	POLA	Basic Coverage Supplemental Accident Expense Benefits Rider	Initial:	59.140	SA-S-861-09 11208.pdf
334	Accepted for Informational Purposes 09/20/2012	SA-S-1366R-09	POLA	Term Life Insurance Rider	Initial:	59.140	SA-S-1366R-09.pdf
335	Accepted for Informational Purposes 09/20/2012	SA-S-1164	POLA	Illinois Savings Based Preferred Provider Benefit Rider	Initial:	59.140	SA-S-1164 92402.pdf
336	Accepted for Informational Purposes 09/20/2012	SA-S-1408	POLA	Reimbursement/Subrogation Rider	Initial:	59.140	SA-S-1408 81508.pdf

State: Arkansas

Filing Company:

Golden Rule Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO

Product Name: Association Group

Project Name/Number: C-009/C-009

Lead Form Number: C-009

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
337	Accepted for Informational Purposes 09/20/2012	MGR03428	POLA	Transplant Expense Benefits	Initial:	59.140	MGR03428 MD and TX Transplant.pdf
338	Accepted for Informational Purposes 09/20/2012	SA-S-1246	POLA	Missouri Grievance Procedures Rider	Initial:	59.140	SA-S-1246.pdf
339	Accepted for Informational Purposes 09/20/2012	SA-S-1333	POLA	Missouri Phase II Cancer Clinical Trials Rider	Initial:	59.140	SA-S-1333.pdf
340	Accepted for Informational Purposes 09/20/2012	SA-S-1366R-24	POLA	Term Life Insurance Rider	Initial:	59.140	SA-S-1366R-24.pdf
341	Accepted for Informational Purposes 09/20/2012	SA-S-1367R-24	POLA	Accidental Death Insurance Rider	Initial:	59.140	SA-S-1367R-24.pdf
342	Accepted for Informational Purposes 09/20/2012	SA-S-1483	POLA	Missouri Chiropractice Services Copayment Amount Rider-Amendment	Initial:	59.140	SA-S-1483.pdf

State: Arkansas

Filing Company:

Golden Rule Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO

Product Name: Association Group

Project Name/Number: C-009/C-009

Lead Form Number: C-009

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
343	Accepted for Informational Purposes 09/20/2012	SA-S-1563	POLA	Missouri Prosthetic Devices and Services Rider	Initial:	59.140	SA-S-1563 122211 AG.pdf
344	Accepted for Informational Purposes 09/20/2012	SA-S-1329	POLA	nebraska Grievance Procedures Rider	Initial:	59.140	SA-S-1329.pdf
345	Accepted for Informational Purposes 09/20/2012	SA-S-1345	POLA	Nebraska UnitedHealthcare Network Rider	Initial:	59.140	SA-S-1345.pdf
346	Accepted for Informational Purposes 09/20/2012	SA-S-1318R	POLA	North Carolina Utilization Review Procedures and Grievance Procedures Rider	Initial:	59.140	SA-S-1318R 71912.pdf
347	Accepted for Informational Purposes 09/20/2012	SA-S-1366R-32	POLA	Term Life Insurance Rider	Initial:	59.140	SA-S-1366r-32.pdf
348	Accepted for Informational Purposes 09/20/2012	SA-S-1367R-32	POLA	Accidental Death Insurance Rider	Initial:	59.140	SA-S-1367R-32.pdf

State: Arkansas

Filing Company:

Golden Rule Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO

Product Name: Association Group

Project Name/Number: C-009/C-009

Lead Form Number: C-009

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
349	Accepted for Informational Purposes 09/20/2012	SA-S-1353R-34	POLA	Continuity Rider	Initial:	59.140	SA-S-1353R-34.pdf
350	Accepted for Informational Purposes 09/20/2012	SA-S-1556	POLA	Ohio Appeals Procedures Rider	Initial:	59.140	OH SA-S-1556 Appeal Proc Rdr 03 26 12 NB.pdf
351	Accepted for Informational Purposes 09/20/2012	SA-S-1366R-35	POLA	Term Life Insurance Rider	Initial:	59.140	SA-S-1366R-35.pdf
352	Accepted for Informational Purposes 09/20/2012	SA-S-1367R-35	POLA	Accidental Death Insurance Rider	Initial:	59.140	SA-S-1367R-35.pdf
353	Accepted for Informational Purposes 09/20/2012	SA-S-1353-42	POLA	Continuity Rider	Initial:	59.140	SA-S-1353-42.pdf
354	Accepted for Informational Purposes 09/20/2012	SA-S-1366R-42	POLA	Term Life Insurance Rider	Initial:	59.140	SA-S-1366R-42.pdf

State: Arkansas

Filing Company:

Golden Rule Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO

Product Name: Association Group

Project Name/Number: C-009/C-009

Lead Form Number: C-009

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
355	Accepted for Informational Purposes 09/20/2012	SA-S-1511	POLA	Disclaimer Rider	Initial:	59.140	SA-S-1511.pdf
356	Accepted for Informational Purposes 09/20/2012	MGR03427	POLA	Transplant Expense Benefits	Initial:	59.140	MGR03427 TX Transplant.pdf
357	Accepted for Informational Purposes 09/20/2012	SA-S-1366R-45	POLA	Term Life Insurance Rider	Initial:	59.140	SA-S-1366R-45.pdf
358	Accepted for Informational Purposes 09/20/2012	SA-S-1367R-45	POLA	Accidental Death Insurance Rider	Initial:	59.140	SA-S-1367R-45.pdf
359	Accepted for Informational Purposes 09/20/2012	SA-S-368	POLA	Rehabilitation Therapy Benefits Rider	Initial:	59.140	SA-S-368.pdf
360	Accepted for Informational Purposes 09/20/2012	SA-S-1353R-48	POLA	Continuity rider	Initial:	59.140	SA-S-1353R-48.pdf

State: Arkansas

Filing Company:

Golden Rule Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO

Product Name: Association Group

Project Name/Number: C-009/C-009

Lead Form Number: C-009

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
361	Accepted for Informational Purposes 09/20/2012	SA-S-1576-48	POLA	Golden Rule Insurance Wisconsin Grievance and Complaint Procedures Rider	Initial:	59.140	SA-S-1576-48 WI NGF Grievance Procedures Rider 03 27 12.pdf
362	Accepted for Informational Purposes 09/20/2012	SA-S-766-45	POLA	HIPAA Portability Rider	Initial:	59.140	SA-S-766-45.pdf
363	Accepted for Informational Purposes 09/20/2012	SA-S-1237	POLA	Alaska	Initial:	59.140	SA-S-1237.pdf
364	Accepted for Informational Purposes 09/20/2012	SA-S-1353R-09	POLA	Insurance Benefits UnitedHealth Continuity Rider	Initial:	59.140	SA-S-1353R-09.pdf
365	Accepted for Informational Purposes 09/20/2012	SA-S-1374-32	POLA	Dental Insurance Rider	Initial:	59.140	SA-S-1374-32.pdf
366	Accepted for Informational Purposes 09/20/2012	SA-S-1374-35	POLA	Dental Insurance Rider	Initial:	59.140	SA-S-1374-35.pdf

State: Arkansas

Filing Company:

Golden Rule Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO

Product Name: Association Group

Project Name/Number: C-009/C-009

Lead Form Number: C-009

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
367	Accepted for Informational Purposes 09/20/2012	MGR04132	POLA	North Carolina Endorsement	Initial:	59.140	MGRARENC-008 9112.pdf
368	Accepted for Informational Purposes 09/20/2012	MGR03811	POLA	North Carolina Endorsement	Initial:		
369	Accepted for Informational Purposes 09/20/2012	MGR04004	POLA	North Carolina Endorsement	Initial:		
370	Accepted for Informational Purposes 09/20/2012	MGR04043	POLA	North Carolina Endorsement	Initial:		
371	Accepted for Informational Purposes 09/20/2012	MGR04136	POLA	North Carolina Endorsement	Initial:		
372	Accepted for Informational Purposes 09/20/2012	MGR03813	POLA	North Carolina Endorsement	Initial:		

State: Arkansas

Filing Company:

Golden Rule Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO

Product Name: Association Group

Project Name/Number: C-009/C-009

Lead Form Number: C-009

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/Action Specific Data	Readability Score	Attachments
373	Accepted for Informational Purposes 09/20/2012	MGR04363	POLA	North Carolina Endorsement	Initial:		
374	Accepted for Informational Purposes 09/20/2012	MGR04365	POLA	North Carolina Endorsement	Initial:		
375	Accepted for Informational Purposes 09/20/2012	MGR04135	POLA	North Carolina Endorsement	Initial:		
376	Accepted for Informational Purposes 09/20/2012	MGR04457	POLA	North Carolina Endorsement	Initial:		
377	Accepted for Informational Purposes 09/20/2012	MGR03816	POLA	North Carolina Endorsement	Initial:		
378	Accepted for Informational Purposes 09/20/2012	MGR04085	POLA	North Carolina Endorsement	Initial:		

State: Arkansas

Filing Company:

Golden Rule Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO

Product Name: Association Group

Project Name/Number: C-009/C-009

Lead Form Number: C-009

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/Action Specific Data	Readability Score	Attachments
379	Accepted for Informational Purposes 09/20/2012	MGR04088	POLA	North Carolina Endorsement	Initial:		
380	Accepted for Informational Purposes 09/20/2012	MGR04364	POLA	North Carolina Endorsement	Initial:		
381	Accepted for Informational Purposes 09/20/2012	MGR04623	POLA	North Carolina Endorsement	Initial:		
382	Accepted for Informational Purposes 09/20/2012	MGR04741	POLA	North Carolina Endorsement	Initial:		
383	Accepted for Informational Purposes 09/20/2012	MGR04131	POLA	North Carolina Endorsement	Initial:		
384	Accepted for Informational Purposes 09/20/2012	MGR04348	POLA	North Carolina Endorsement	Initial:		

State: Arkansas

Filing Company:

Golden Rule Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO

Product Name: Association Group

Project Name/Number: C-009/C-009

Lead Form Number: C-009

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
385	Accepted for Informational Purposes 09/20/2012	MGR04008	POLA	North Carolina Endorsement	Initial:		
386	Accepted for Informational Purposes 09/20/2012	MGR04626	POLA	North Carolina Endorsement	Initial:		
387	Accepted for Informational Purposes 09/20/2012	MGR04216	POLA	North Carolina Endorsement	Initial:		
388	Accepted for Informational Purposes 09/20/2012	MGR04044	POLA	North Carolina Endorsement	Initial:		
389	Accepted for Informational Purposes 09/20/2012	MGR03819	POLA	North Carolina Endorsement	Initial:		
390	Accepted for Informational Purposes 09/20/2012	MGR04087	POLA	North Carolina Endorsement	Initial:		

State: Arkansas

Filing Company:

Golden Rule Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO

Product Name: Association Group

Project Name/Number: C-009/C-009

Lead Form Number: C-009

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
391	Accepted for Informational Purposes 09/20/2012	MGR04006	POLA	North Carolina Endorsement	Initial:		
392	Accepted for Informational Purposes 09/20/2012	MGR03820	POLA	North Carolina Endorsement	Initial:		
393	Accepted for Informational Purposes 09/20/2012	MGR04045	POLA	North Carolina Endorsement	Initial:		
394	Accepted for Informational Purposes 09/20/2012	MGR04005	POLA	North Carolina Endorsement	Initial:		
395	Accepted for Informational Purposes 09/20/2012	MGR04217	POLA	North Carolina Endorsement	Initial:		
396	Accepted for Informational Purposes 09/20/2012	MGR04133	POLA	North Carolina Endorsement	Initial:		

State: Arkansas

Filing Company:

Golden Rule Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO

Product Name: Association Group

Project Name/Number: C-009/C-009

Lead Form Number: C-009

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
397	Accepted for Informational Purposes 09/20/2012	MGR04239	POLA	North Carolina Endorsement	Initial:	59.140	MGRARENC-009 SAVER 9112.pdf
398	Accepted for Informational Purposes 09/20/2012	MGR04241	POLA	North Carolina Endorsement	Initial:		
399	Accepted for Informational Purposes 09/20/2012	MGR04489	POLA	North Carolina Endorsement	Initial:		
400	Accepted for Informational Purposes 09/20/2012	MGR04490	POLA	North Carolina Endorsement	Initial:		
401	Accepted for Informational Purposes 09/20/2012	MGR04625	POLA	North Carolina Endorsement	Initial:		
402	Accepted for Informational Purposes 09/20/2012	MGR04664	POLA	Tennessee Endorsement	Initial:	59.140	MGRARETN-002 9112.pdf

State: Arkansas

Filing Company:

Golden Rule Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO

Product Name: Association Group

Project Name/Number: C-009/C-009

Lead Form Number: C-009

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/Action Specific Data	Readability Score	Attachments
403	Accepted for Informational Purposes 09/20/2012	MGR04736	POLA	Tennessee Endorsement	Initial:		
404	Accepted for Informational Purposes 09/20/2012	MGR04735	POLA	Tennessee Endorsement	Initial:		
405	Accepted for Informational Purposes 09/20/2012	MGR04713	POLA	Tennessee Endorsement	Initial:		
406	Accepted for Informational Purposes 09/20/2012	MGR04709	POLA	Tennessee Endorsement	Initial:		
407	Accepted for Informational Purposes 09/20/2012	MGR04739	POLA	Tennessee Endorsement	Initial:		
408	Accepted for Informational Purposes 09/20/2012	MGR04738	POLA	Tennessee Endorsement	Initial:		

State: Arkansas

Filing Company:

Golden Rule Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO

Product Name: Association Group

Project Name/Number: C-009/C-009

Lead Form Number: C-009

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
409	Accepted for Informational Purposes 09/20/2012	MGR04716	POLA	Tennessee Endorsement	Initial:		
410	Accepted for Informational Purposes 09/20/2012	MGR03746	POLA	Tennessee Endorsement	Initial:		
411	Accepted for Informational Purposes 09/20/2012	MGR04710	POLA	Tennessee Endorsement	Initial:		
412	Accepted for Informational Purposes 09/20/2012	MGR03525	POLA	Tennessee Endorsement	Initial:		
413	Accepted for Informational Purposes 09/20/2012	MGR03526	POLA	Tennessee Endorsement	Initial:		
414	Accepted for Informational Purposes 09/20/2012	MGR04737	POLA	Tennessee Endorsement	Initial:		

State: Arkansas

Filing Company:

Golden Rule Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO

Product Name: Association Group

Project Name/Number: C-009/C-009

Lead Form Number: C-009

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
415	Accepted for Informational Purposes 09/20/2012	MGR04711	POLA	Tennessee Endorsement	Initial:		
416	Accepted for Informational Purposes 09/20/2012	MGR03797	POLA	Alabama Endorsement	Initial:	59.140	MGRAREAL-003 9112.pdf
417	Accepted for Informational Purposes 09/20/2012	MGR04695	POLA	Alabama Endorsement	Initial:		

Form Type Legend:

ADV	Advertising	AEF	Application/Enrollment Form
CER	Certificate	CERA	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	FND	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	NOC	Notice of Coverage
OTH	Other	OUT	Outline of Coverage
PJK	Policy Jacket	POL	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	SCH	Schedule Pages



A UnitedHealthcare Company

Golden Rule Insurance Company
Lawrenceville, IL 62438-2395

For Inquiries: (800) 657-8205

In this certificate, "you," or "your" will refer to the *primary insured* named below, and "we," "our" or "us" will refer to Golden Rule Insurance Company, a stock company. Defined terms are in italics.

AGREEMENT AND CONSIDERATION

We certify that, as of the applicable *effective date* shown below, *you* became insured under the group insurance *policy* shown below. We will pay benefits for a *loss* as set forth in the *policy*. This certificate is issued in exchange for and on the basis of the statements made on *your* application. This certificate will be void if we do not receive the initial premium for *your* coverage.

All provisions, limitations, and exclusions of the group insurance *policy* apply to the insurance evidenced by this certificate, even if not mentioned in this certificate.

President

Policy No.: {MASTER_POLICY_NO}
Policyholder: **FACT**

Check the attached application. If it is not complete or has an error, please let *us* know. An incorrect or incomplete application may cause *your* certificate to be voided and claims to be reduced or denied.

Primary Insured:
Certificate Number:
Effective Date:
Product:
Type of Plan:

Preexisting Conditions: Generally, for *covered persons* ages 19 years or older, a health condition which exists before the applicable *effective date* is not covered during the first 12 months of coverage, unless it was: (A) fully disclosed to *us* on the application for insurance; and (B) not excluded or limited by name or specific description. Certain *illnesses* are not covered during the first six months a person is insured. See the Waiting Periods clause in the General Exclusions and Limitations section.

10-Day Right to Examine: Please read *your* certificate. If *you* are not satisfied, *you* must notify *us* within 10 days of the date *you* received it. The certificate will then be void from its start and *we* will refund any premium paid, less claims paid.

This certificate contains notification requirements. Benefits may be reduced if the requirements are not met.

Golden Rule

A UnitedHealthcare Company

Golden Rule Insurance Company
[Lawrenceville, IL 62439-2395]

For Inquires: (800) 657-8205]

In this *policy*, "*we*" "*our*" or "*us*" will refer to the Golden Rule Insurance Company, a stock company. Defined terms are in italics.

AGREEMENT

On the bases of the representations, statements and agreements in the application for the *policy*, we agree with:

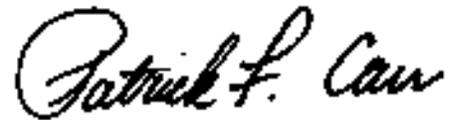
[FEDERATION OF AMERICAN CONSUMERS AND TRAVELERS]

[300 South Church Street
4th Floor
Jonesboro, AR, 72401]

referred to as the "*policyholder*", to pay benefits for a *loss* of a *covered person* as set forth in this *policy*.

We will require applications from association members desiring to insure specific persons. The *policyholder* will receive a sample copy of the *policy*. This *policy* will begin at 12:01 A.M., Standard Time, at the *policyholder's* address, on the First day of January 2011.

This *policy* is signed for *us* as of its effective date.



President

GROUP INSURANCE POLICY NUMBER: XXXXXXXXXXXX

[This certificate contains notification requirements. Benefits may be reduced if the requirements are not met.]



A UnitedHealthcare Company

Golden Rule Insurance Company
Lawrenceville, IL 62438-2395

For Inquiries: (800) 657-8205

In this certificate, "you," or "your" will refer to the *primary insured* named below, and "we," "our" or "us" will refer to Golden Rule Insurance Company, a stock company. Defined terms are in italics.

AGREEMENT AND CONSIDERATION

We certify that, as of the applicable *effective date* shown below, *you* became insured under the group insurance *policy* shown below. We will pay benefits for a *loss* as set forth in the *policy*. This certificate is issued in exchange for and on the basis of the statements made on *your* application. This certificate will be void if we do not receive the initial premium for *your* coverage.

All provisions, limitations, and exclusions of the group insurance *policy* apply to the insurance evidenced by this certificate, even if not mentioned in this certificate.

President

Policy No.: {MASTER_POLICY_NO}
Policyholder: **FACT**

Check the attached application. If it is not complete or has an error, please let *us* know. An incorrect or incomplete application may cause *your* certificate to be voided and claims to be reduced or denied.

Primary Insured:
Certificate Number:
Effective Date:
Product:
Type of Plan:

Preexisting Conditions: Generally, for *covered persons* ages 19 years and older, a health condition which exists before the applicable *effective date* is not covered during the first 12 months of coverage, unless it was: (A) fully disclosed to *us* on the application for insurance; and (B) not excluded or limited by name or specific description. Certain *illnesses* are not covered during the first six months a person is insured. See the Waiting Periods clause in the General Exclusions and Limitations section.

10-Day Right to Examine: Please read *your* certificate. If *you* are not satisfied, *you* must notify *us* within 10 days of the date *you* received it. The certificate will then be void from its start and *we* will refund any premium paid, less claims paid.

This certificate contains notification requirements. Benefits may be reduced if the requirements are not met.

The benefits of the policy providing you coverage are governed primarily by the law of a state other than Arizona.



A UnitedHealthcare Company

Golden Rule Insurance Company
Lawrenceville, IL 62438-2395

For Inquiries: (800) 657-8205

The benefits of the policy providing your coverage are governed by the law of a state other than Florida.

In this certificate, "you," or "your" will refer to the *primary insured* named below, and "we," "our" or "us" will refer to Golden Rule Insurance Company, a stock company. Defined terms are in italics.

AGREEMENT AND CONSIDERATION

We certify that, as of the applicable *effective date* shown below, *you* became insured under the group insurance *policy* shown below. We will pay benefits for a *loss* as set forth in the *policy*. This certificate is issued in exchange for and on the basis of the statements made on *your* application. This certificate will be void if we do not receive the initial premium for *your* coverage.

All provisions, limitations, and exclusions of the group insurance *policy* apply to the insurance evidenced by this certificate, even if not mentioned in this certificate.

President

Policy No.: {MASTER_POLICY_NO}
Policyholder: **FACT**

Check the attached application. If it is not complete or has an error, please let *us* know. An incorrect or incomplete application may cause *your* certificate to be voided and claims to be reduced or denied.

Primary Insured:
Certificate Number:
Effective Date:
Product:
Type of Plan:

Preexisting Conditions: Generally, for *covered* persons ages 19 years and older, a health condition which exists before the applicable *effective date* is not covered during the first 12 months of coverage, unless it was: (A) fully disclosed to *us* on the application for insurance; and (B) not excluded or limited by name or specific description. Certain *illnesses* are not covered during the first six months a person is insured. See the Waiting Periods clause in the General Exclusions and Limitations section.

10-Day Right to Examine: Please read *your* certificate. If *you* are not satisfied, *you* must notify *us* within 10 days of the date *you* received it. The certificate will then be void from its start and *we* will refund any premium paid, less claims paid.

This certificate contains notification requirements. Benefits may be reduced if the requirements are not met.

**A Limited Exclusion of Aids
or HIV Related Disease Claims is set forth in Section 7**



The benefits of the policy providing your coverage are governed primarily by the law of a state other than Maryland and may not contain some of the benefits required for a policy issued and delivered in Maryland.

Golden Rule Insurance Company
Lawrenceville, IL 62438-2395
For Inquiries: (800) 657-8205

In this certificate, "you," or "your" will refer to the *primary insured* named below, and "we," "our" or "us" will refer to Golden Rule Insurance Company, a stock company. Defined terms are in italics.

AGREEMENT AND CONSIDERATION

We certify that, as of the applicable *effective date* shown below, *you* became insured under the group insurance *policy* shown below. We will pay benefits for a *loss* as set forth in the *policy*. This certificate is issued in exchange for and on the basis of the statements made on *your* application. This certificate will be void if *we* do not receive the initial premium for *your* coverage.

All provisions, limitations, and exclusions of the group insurance *policy* apply to the insurance evidenced by this certificate, even if not mentioned in this certificate.

President

Policy No.: {MASTER_POLICY_NO}
Policyholder: FACT

Check the attached application. If it is not complete or has an error, please let *us* know. An incorrect or incomplete application may cause *your* certificate to be voided and claims to be reduced or denied.

Primary Insured:
Certificate Number:
Effective Date:
Product:
Type of Plan:

Preexisting Conditions: Generally, for *covered persons* ages 19 years older, a health condition which exists before the applicable *effective date* is not covered during the first 12 months of coverage, unless it was: (A) fully disclosed to *us* on the application for insurance; and (B) not excluded or limited by name or specific description. Certain *illnesses* are not covered during the first six months a person is insured. See the Waiting Periods clause in the General Exclusions and Limitations section.

10-Day Right to Examine: Please read *your* certificate. If *you* are not satisfied, *you* must notify *us* within 10 days of the date *you* received it. The certificate will then be void from its start and *we* will refund any premium paid, less claims paid.

This certificate contains notification requirements. Benefits may be reduced if the requirements are not met.



A UnitedHealthcare Company

Golden Rule Insurance Company
Lawrenceville, IL 62438-2395

For Inquiries: (800) 657-8205

This certificate of Insurance provides all of the benefits mandated by North Carolina law, but it is issued under a group master policy located in another state and governed by the state's laws.

AGREEMENT AND CONSIDERATION

We certify that, as of the applicable *effective date* shown below, *you* became insured under the group insurance *policy* shown below. We will pay benefits for a *loss* as set forth in the *policy*. This certificate is issued in exchange for and on the basis of the statements made on *your* application. This certificate will be void if we do not receive the initial premium for *your* coverage.

All provisions, limitations, and exclusions of the group insurance *policy* apply to the insurance evidenced by this certificate, even if not mentioned in this certificate.

President

Policy No.: {MASTER_POLICY_NO}
Policyholder: **FACT**

Check the attached application. If it is not complete or has an error, please let *us* know. An incorrect or incomplete application may cause *your* certificate to be voided and claims to be reduced or denied.

Primary Insured:
Certificate Number:
Effective Date:
Product:
Type of Plan:

Preexisting Conditions: Generally, for *covered persons* ages 19 years or older, a health condition which exists before the applicable *effective date* is not covered during the first 12 months of coverage, unless it was: (A) fully disclosed to *us* on the application for insurance; and (B) not excluded or limited by name or specific description. Certain *illnesses* are not covered during the first six months a person is insured. See the Waiting Periods clause in the General Exclusions and Limitations section.

Right to Return Certificate Within 10 Days: If for any reason you are not satisfied with your coverage, you may return your certificate to Golden Rule within 10 days of the date you received it and the premium paid will be promptly refunded.

This certificate contains notification requirements. Benefits may be reduced if the requirements are not met.

Important Cancellation Information -- Please read the provision entitled "Termination of Insurance and Renewability" in your certificate.

Coverage of preexisting conditions may be limited. See the Preexisting Conditions and Limitations section.



A UnitedHealthcare Company

Golden Rule Insurance Company
Lawrenceville, IL 62438-2395

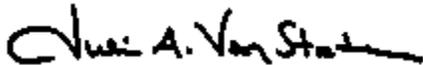
For Inquiries: (800) 657-8205

In this certificate, "you," or "your" will refer to the *primary insured* named below, and "we," "our" or "us" will refer to Golden Rule Insurance Company, a stock company. Defined terms are in italics.

AGREEMENT AND CONSIDERATION

We certify that, as of the applicable *effective date* shown below, *you* became insured under the group insurance *policy* shown below. We will pay benefits for a *loss* as set forth in the *policy*. This certificate is issued in exchange for and on the basis of the statements made on *your* application. This certificate will be void if we do not receive the initial premium for *your* coverage.

All provisions, limitations, and exclusions of the group insurance *policy* apply to the insurance evidenced by this certificate, even if not mentioned in this certificate.


Secretary
President

Policy No.: {MASTER_POLICY_NO}
Policyholder: **FACT**

Check the attached application. If it is not complete or has an error, please let *us* know. An incorrect or incomplete application may cause *your* certificate to be voided and claims to be reduced or denied.

Primary Insured:
Certificate Number:
Effective Date:
Product:
Type of Plan:

Preexisting Conditions: Generally, for *covered persons* ages 19 years and older, a health condition which exists before the applicable *effective date* is not covered during the first 12 months of coverage, unless it was: (A) fully disclosed to *us* on the application for insurance; and (B) not excluded or limited by name or specific description. Certain *illnesses* are not covered during the first six months a person is insured. See the Waiting Periods clause in the General Exclusions and Limitations section.

10-Day Right to Examine: Please read *your* certificate. If *you* are not satisfied, *you* must notify *us* within 10 days of the date *you* received it. The certificate will then be void from its start and *we* will refund any premium paid, less claims paid.

This certificate contains notification requirements. Benefits may be reduced if the requirements are not met.

Notice: If you or your family members are covered by more than one health care plan, you may not be able to collect benefits from both plans. Each plan may require you to follow its rules or use specific doctors and hospitals, and it may be impossible to comply with both plans at the same time. Read all of the rules very carefully, including the coordination of benefits section, and compare them with the rules of any other plan that covers you or your family.



A UnitedHealthcare Company

Golden Rule Insurance Company
712 Eleventh Street
Lawrenceville, IL 62438-2395
For Inquiries: (800) 657-8205

In this certificate, "you," or "your" will refer to the *primary insured* named below, and "we," "our" or "us" will refer to Golden Rule Insurance Company, a stock company. Defined terms are in italics.

AGREEMENT AND CONSIDERATION

We certify that, as of the applicable *effective date* shown below, *you* became insured under the group insurance *policy* shown below. We will pay benefits for a *loss* as set forth in the *policy*. This certificate is issued in exchange for and on the basis of the statements made on *your* application. This certificate will be rescinded, as if it never became effective, if *we* do not receive the initial premium for *your* coverage.

All provisions, limitations, and exclusions of the group insurance *policy* apply to the insurance evidenced by this certificate, even if not mentioned in this certificate.

President

Policy No.: {MASTER_POLICY_NO}
Policyholder: **FACT**

Primary Insured:
Certificate Number:
Effective Date:
Product:
Type of Plan:

Preexisting Conditions: Generally, for *covered* persons ages 19 years and older, a health condition which exists before the applicable *effective date* is not covered during the first 12 months of coverage, unless it was: (A) fully disclosed to *us* on the application for insurance; and (B) not excluded or limited by name or specific description. Certain *illnesses* are not covered during the first six months a person is insured. See the Waiting Periods clause in the General Exclusions and Limitations section.

Check the attached application. If it is not complete or has an error, please let *us* know. An incorrect or incomplete application may cause *your* certificate to be rescinded, as if it never became effective, and claims to be reduced or denied.

This certificate is guaranteed renewable, subject to the conditions set forth in Section 3, Policyholder Provisions, and Section 5, Termination of Insurance.

10-Day Right to Examine: Please read *your* certificate. If *you* are not satisfied, *you* must notify *us* within 10 days of the date *you* received it. The certificate will then be rescinded, as if it never became effective, and *we* will refund any premium paid, less claims paid.

This certificate contains notification requirements. Benefits may be reduced if the requirements are not met.

Determination of Reasonable Charges: *Eligible expenses* may be established based on rates from one or more regional databases for the same or similar services from a geographic area. This may result in an amount less than that billed by a health care provider who may then bill *you* for the difference. See the definition of "*Eligible Expenses*" and the Oklahoma Endorsement, included as part of this certificate, for more information including who to contact with questions.

WARNING: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete, or misleading information is guilty of a felony.

A Limited Exclusion of Aids or HIV Related Disease Claims is set forth in Section 7



A UnitedHealthcare Company

Golden Rule Insurance Company
Lawrenceville, IL 62438-2395

For Inquiries: (800) 657-8205

In this certificate, "you," or "your" will refer to the *primary insured* named below, and "we," "our" or "us" will refer to Golden Rule Insurance Company, a stock company. Defined terms are in italics.

AGREEMENT AND CONSIDERATION

We certify that, as of the applicable *effective date* shown below, *you* became insured under the group insurance *policy* shown below. We will pay benefits for a *loss* as set forth in the *policy*. This certificate is issued in exchange for and on the basis of the statements made on *your* application. This certificate will be void if we do not receive the initial premium for *your* coverage.

All provisions, limitations, and exclusions of the group insurance *policy* apply to the insurance evidenced by this certificate, even if not mentioned in this certificate.

President

Policy No.: {MASTER_POLICY_NO}
Policyholder: FACT

Check the attached application. If it is not complete or has an error, please let *us* know. An incorrect or incomplete application may cause *your* certificate to be voided and claims to be reduced or denied.

Primary Insured:
Certificate Number:
Effective Date:
Product:
Type of Plan:

Preexisting Conditions: Generally, for *covered persons* ages 19 years or older, a health condition which exists before the applicable *effective date* is not covered during the first 12 months of coverage, unless it was: (A) fully disclosed to *us* on the application for insurance; and (B) not excluded or limited by name or specific description. Certain *illnesses* are not covered during the first six months a person is insured. See the Waiting Periods clause in the General Exclusions and Limitations section.

10-Day Right to Examine: Please read *your* certificate. If *you* are not satisfied, *you* must notify *us* within 10 days of the date *you* received it. The certificate will then be void from its start and *we* will refund any premium paid, less claims paid.

This certificate contains notification requirements. Benefits may be reduced if the requirements are not met.

This coverage may be subject to a premium adjustment as of any premium due date. Coverage for an eligible child may terminate upon the child's attainment of the limiting age.



A UnitedHealthcare Company

Golden Rule Insurance Company
Lawrenceville, IL 62438-2395

For Inquiries: (800) 657-8205

In this certificate, "you," or "your" will refer to the *primary insured* named below, and "we," "our" or "us" will refer to Golden Rule Insurance Company, a stock company. Defined terms are in italics.

AGREEMENT AND CONSIDERATION

We certify that, as of the applicable *effective date* shown below, *you* became insured under the group insurance *policy* shown below. We will pay benefits for a *loss* as set forth in the *policy*. Subject to any express limitations and exclusion applicable to a specific *covered* person, the benefits provided under this certificate are reflected in the group insurance *policy* issued to the policyholder. This certificate is issued in exchange for and on the basis of the statements made on *your* application. This certificate will be void if we do not receive the initial premium for *your* coverage.

All provisions, limitations, and exclusions of the group insurance *policy* apply to the insurance evidenced by this certificate, even if not mentioned in this certificate.

President

Policy No.: {MASTER_POLICY_NO}
Policyholder: FACT

Check the attached application. If it is not complete or has an error, please let *us* know. An incorrect or incomplete application may cause *your* certificate to be voided and claims to be reduced or denied.

Primary Insured:
Certificate Number:
Effective Date:
Product:
Type of Plan:

Preexisting Conditions: Generally, for *covered* persons ages 19 years and older, a health condition which exists before the applicable *effective date* is not covered during the first 12 months of coverage, unless it was: (A) fully disclosed to *us* on the application for insurance; and (B) not excluded or limited by name or specific description. Certain *illnesses* are not covered during the first six months a person is insured. See the Waiting Periods clause in the General Exclusions and Limitations section.

This certificate contains notification requirements. Benefits may be reduced if the requirements are not met.

Please read this certificate. If you are not satisfied, you may return this certificate within 20 days after you received it. Mail or deliver it to us or to your agent. Any premium paid will be refunded, less claims paid. Your coverage under the policy will then be void from the beginning as if no coverage had been issued.

**A Limited Exclusion of Aids
or HIV Related Disease Claims is set forth in Section 7**

ARIZONA ENDORSEMENT

By attachment of this endorsement, the *policy/certificate* is amended to the extent of any conflict with the following:

MGR03433

A. The Preexisting Conditions Limitation provision is amended as follows:

1. The definition of *preexisting condition* is amended to read as follows:

"Preexisting condition" means an *injury* or *illness* for which medical advice, diagnosis, care or treatment was recommended to or received by a *covered person* within the 6 months immediately preceding the *covered person's* applicable *effective date*.

MGR03778

2. If a *covered person's effective date* of coverage under the *policy/certificate* occurs within 63 days of termination of the *covered person's* coverage under any *prior creditable coverage*, that *covered person* will be entitled to credit against the 12 month preexisting condition limitation waiting period for the same number of full months that the *covered person* was continuously covered, without any lapse of 63 days or more, under *prior creditable coverage*.

MGR03779

"Prior creditable coverage" means coverage as defined under Arizona I.C. 20-1379U.3.

MGR03780

B. The Coordination of Benefits "COB" provision is hereby deleted and replaced with the following:

COORDINATION OF BENEFITS ("COB")

Some people have health care coverage through more than one *plan* at the same time. COB allows these *plans* to work together so that the total amount of all benefits will never be more than 100 percent of the *allowable expenses* during any calendar year. This helps to hold down the costs of health coverage.

This Coordination of Benefits ("COB") provision applies to this *plan* when a *covered person* has health care coverage under more than one *plan*. COB does not apply to life insurance, accidental death and dismemberment, or disability benefits.

MGR03781

DEFINITIONS:

"Allowable expenses" means the necessary, reasonable and customary items of expense, at least a part of which is covered under at least one of the *plans* covering the person for whom the claim is made.

When a *plan* provides benefits in the form of service, the reasonable cash value of each service will be considered as both an *allowable expense* and a benefit paid.

A *plan* which takes *Medicare* or similar government benefits into consideration when determining the application of its coordination of benefits provision does not expand the meaning of *allowable expense*.

"Birthday anniversary" means the month and day of the month on which a person's birthday occurs.

"Plan" means any contract that offers health care benefits or services through:

1. Group insurance or group subscriber contracts;
2. Uninsured arrangements of group or group-type coverage;
3. Group or group-type coverage through HMO's and other prepayment, group practice and individual practice plans;
4. The amount by which group or group-type hospital indemnity benefits exceed \$30 per day unless the benefits are designed or administered to provide the insured the right to elect indemnity type benefits, in lieu of reimbursement type benefits, at the time of the claim;

5. The medical benefits coverage in group, group-type and individual automobile "no-fault" and traditional automobile "fault" type contracts; and
6. Medicare or other governmental programs, or coverage provided by any statute, except Medicaid.

The term "*plan*" applies separately to each policy, contract agreement or other arrangements for benefits or services. The term "*plan*" also applies separately to that part of any policy, contract, agreement or other arrangement for benefits or services that coordinates its benefits with other plans and to that part that does not.

"*Primary plan*" means a *plan* whose benefits for a person's health care coverage must be determined without taking the existence of any other *plan* into consideration.

"*Secondary plan*" means a *plan* which is not a *primary plan*.

If a person is covered by more than one *secondary plan*, the order of benefit determination rules decide the order in which their benefits are determined in relation to each other. The benefits of each *secondary plan* may take into consideration the benefits of the *primary plan* or *plans* and the benefits of any other *plan* which, under the order of benefit determination rules, has its benefits determined before those of that *secondary plan*.

MGR03782

ORDER OF BENEFIT DETERMINATION RULES: This *plan* determines its order of benefits using the first of the following rules which applies:

1. A *plan* which does not have a COB provision will always be the *primary plan*.
2. **Non-Dependent/Dependent** - The benefits of a *plan* which covers the insured as an employee, member or subscriber are determined before those of a *plan* which covers the insured as a dependent; except that, if the person is a *Medicare* beneficiary and under *Medicare* rules, *Medicare* is: (a) secondary to the *plan* covering the insured person as a dependent; and (b) primary to the *plan* covering the insured person as other than a dependent (e.g. a retired employee), then the order of benefits is reversed so that the *plan* covering the person as an employee, member, subscriber or retiree is secondary and the other *plan* is primary.
3. **Dependent Child/Parents Not Separated or Divorced** - The rules for the order of benefits for a dependent child when the parents are not separated or divorced are as follows:
 - (a) The benefits of the *plan* of the parent whose birthday falls earlier in a year will be determined before the benefits of a *plan* of the parent whose birthday falls later in the year; but
 - (b) If both parents have the same birthday, the benefits of the *plan* which covered one parent longer are determined before those of the *plan* which covered the other parent for a shorter period of time.

However, if the *plans* do not agree on the order of benefit rules because the other *plan* does not have the rule described in this section, but has a rule based upon the gender of the parent, the rule in the other *plan* will determine the order of benefits.

4. **Dependent Child/Parents Single, Never Married, Separated or Divorced** - If two or more *plans* cover an insured person as a dependent or child of a single, never married, divorced or separated parents, benefits for the child are determined in this order:
 - (a) First, the *plan* of the parent with custody of the child;
 - (b) Second, the *plan* of the *spouse* of the parent with custody;
 - (c) Finally, the *plan* of the parent not having custody of the child.

For the purposes of this *plan*, the mother will be considered to have custody of the dependent or child where the parents are single and never married. However, if the specific terms of a court decree state that one of the parents is responsible for the health care expense of the child, and the entity obligated to pay or provide the benefits of the *plan* of that parent has actual knowledge of those terms, the benefits of that *plan* are determined first. The *plan* of the other parent shall be the *secondary plan*. This does not apply with respect to any calendar year or

plan year during which any benefits are actually paid or provided before the entity has the actual knowledge.

5. **Joint Custody** - If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the *plans* covering the child shall follow the order of benefit determination rules outlined in paragraph (C).
6. **Active/Inactive Employee** - The benefits of a *plan* which covers an insured person as an employee who is neither laid off nor retired, are determined before those of a *plan* which covers that insured person as a laid off or retired employee. The same would hold true if an insured person is a dependent of a person covered as a retiree and an employee. If the other *plan* does not have this rule, and if, as a result, the *plans* do not agree on the order of benefits, this rule is ignored.
7. **Continuation Coverage** - If an insured person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another *plan*, the following shall be the order of benefit determination:
 - (a) First, the benefits of a *plan* covering the insured person as an employee, member or subscriber (or as that insured person's dependent);
 - (b) Second, the benefits under the continuation of coverage;If the other *plan* does not have the rule described above, and if, as a result, the *plans* do not agree on the order of benefits, this rule is ignored.
8. **Longer/Shorter Length of Coverage** - If none of the above rules determine the order of benefits, the benefits of the *plan* which covered an employee, member or subscriber longer are determined before those of the *plan* which covered that insured person for the shorter term.

MGR03783

EFFECT ON THE BENEFITS OF THIS PLAN: When this *plan* is the *secondary plan* in accordance with the order of benefits determination outlined above, the benefits of this *plan* may be reduced.

The benefits of this *plan* will be reduced when the sum of: (1) the benefits that would be payable for the *allowable expense* under this *plan* in the absence of the COB provision; and (2) the benefits that would be payable for the *allowable expense* under the other *plans*, in the absence of provisions with a purpose like that of this COB provision, whether or not a claim is made, exceeds those *allowable expenses* in a calendar year or plan year. In that case, the benefits of this *plan* will be reduced so that they and the benefits payable under the other *plans* do not total more than those *allowable expenses*.

When the benefits of this *plan* are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this *plan*.

MGR03784

FACILITY OF PAYMENT: If another *plan* makes a benefit payment that should have been made by *us*, *we* have the right to pay the other *plan* any amount *we* deem necessary to satisfy *our* obligation under these COB rules.

MGR03785

RIGHT OF RECOVERY: If the amount of *our* benefit payment is more than the amount needed to satisfy *our* obligation under these COB rules, *we* have the right to recover the excess amount from: (1) any persons to or for whom or with respect to whom the payments were made; (2) any insurance companies; or (3) any other organizations.

MGR03786

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION: In order to carry out these COB rules, *we* have the right, without the consent of or notice to any person, to exchange information with any person, insurance company or organization, as *we* deem necessary. Any person claiming benefits under this *plan* must give *us* any information necessary to carry out this provision.

MGR03787

C. The following subsection is added:

ARIZONA APPEALS INFORMATION PACKET: *You or your dependents* may obtain a replacement Golden Rule Insurance Company Arizona Appeals Information Packet by contacting the Golden Rule Insurance Company Grievance Administrator at (800) 657-8205. As explained in the packet, the appeals review process allows *you* to request reconsideration of decisions regarding *your* requests to have specific claims paid.

MGR03788

Except as specifically stated in this endorsement, the benefits under this endorsement are subject to all of the terms, conditions, exclusions, limitations, and notification requirements of the *policy/certificate*, including any applicable *deductible amounts*, coinsurance provisions, copay amounts, or dollar limits.

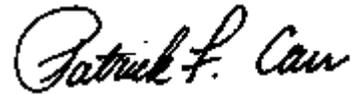
MGR03440

This endorsement applies only to *covered persons* who reside in the state of Arizona.

This endorsement does not change, waive or extend any part of the *policy* other than as stated herein.

This endorsement is effective on September 1, 2012 or at the same time as the *policy/certificate*, whichever is later.

Golden Rule Insurance Company

A handwritten signature in black ink that reads "Patrick F. Carr". The signature is written in a cursive style with a large initial "P".

President

MGR03441

COLORADO ENDORSEMENT

By attachment of this endorsement, the *policy/certificate* is amended to the extent of any conflict with the following:

MGR03433

A. The Definitions provision is amended as follows:

1. The definition of *medical practitioner* is amended to include a dental hygienist, registered professional nurse, and licensed clinical social worker. In addition, *medical practitioner* will be expanded to include a licensed professional counselor and a licensed marriage or family therapist when acting within the scope of his/her license in providing services for the treatment of *mental disorders*.

MGR04477

2. The following definitions are added:

"AICP" means the Advisory Committee on Immunization Practices to the Centers for Disease Control and Prevention in the federal Department of Health and Human Services, or any successor entity.

MGR04418

"*Child health supervision services*" means the specified services when ordered, delivered or supervised by one *doctor* during a visit at one of the age intervals specified below. *Child health supervision services* must be appropriate to the age of the child in accordance with the current recommendations for preventive pediatric care by the American Academy for Pediatrics, and shall include, but will not be limited to: a medical history, complete physical examination, developmental assessment, anticipatory guidance, appropriate immunizations, and laboratory tests.

Child health supervision services will be limited to the specified visits during the following age intervals:

- (a) One home visit for a newborn child that is released from the *hospital* within 48 hours following delivery;
- (b) 5 visits and 1 PKU screening test for children from birth through age 12 months;
- (c) 2 visits for children from age 13 months through age 35 months;
- (d) 3 visits for children from age 3 years through age 6 years; and
- (e) 3 visits for children from age 7 years through age 12 years.

MGR03676

"*Early intervention services*" means education, training and assistance in child development, parent education, therapies and other activities for infants and toddlers and their families which are designed to meet the developmental needs of infants and toddlers including, but not limited to: cognition, speech, communication, physical, motor, vision, hearing, social-emotional and self-help skills.

Early intervention services shall not include non-emergency medical transportation, respite care, service coordination (other than case management) or assistive technology.

MGR04351

"*Inherited enzymatic disorders*" include, but are not limited to, Phenylketonuria, Maternal phenylketonuria, Maple syrup urine disease, Tyrosinemia, Homocystinuria, Histidinemia, Urea cycle disorders, Hyperlysinemia, Glutaric acidemias, Methylmalonic acidemia and Propionic acidemia.

"*Intractable pain*" means pain that is incurable or resistant to therapy.

"*Medical foods*" means prescribed metabolic formulas and their modular counterparts, obtained through a pharmacy, that are specifically designated and manufactured for the treatment of *inherited enzymatic disorders*, and for which medically standard methods of diagnosis, treatment, and monitoring exist. Such formulas are specifically processed or formulated to be

deficient in one or more nutrients and are to be consumed or administered enterally either via tube or orally.

"Routine nursery care" of a newborn *eligible child* is limited to charges:

(a) Made by a hospital for: daily room and board and nursing services, including general nursery services; services and supplies routinely provided to newborns; and the use of an operating or delivery room in connection with the circumcision of the newborn; and

(b) For professional fees of a *medical practitioner*.

MGR03676

- B. Under the Eligibility provision, a *covered person* will not cease to be a *dependent* solely because of age if the *eligible child* is not capable of self-sustaining employment due to mental incapacity or physical handicap.

MGR03677

- C. The Effective Date of Insurance provision is amended as follows:

1. The following is added to the subsection entitled Adding a Newborn:

Payment of any increase in premium necessitated by the addition of the newborn child as a *covered person* will not be required for the first 31 days of the newborn's life.

MGR03678

2. The following subsection is added:

Adding an Adopted Child: An *eligible child* legally *placed* for adoption with *you* or *your spouse* within 90 days of birth will be covered until the 31st day after *placement* unless the *placement* is disrupted prior to the legal adoption and the child is removed from *your* physical custody. The adopted child may continue as a *covered person* after the 31st day only if we have received both written notice of the child's *placement* and any additional premium required.

To request coverage for a child placed for adoption with *you* or *your spouse* beyond 90 days after the child's birth, *you* must apply for insurance in accordance with the Adding Other Dependents subsection of the Effective Date of Dependent's Insurance provision.

MGR04517

- D. The terms and conditions outlined in the Termination of Insurance and Renewability provision shall prevail over any other reference in the *policy/certificate* regarding *our* right to terminate coverage.

MGR03681

- E. The Medical Benefits provision is amended as follows:

1. *Covered expenses* are amended to include charges incurred for the following:

(a) Diagnosis and treatment of *inherited enzymatic disorders* caused by single gene defects involved in the metabolism of amino, organic and fatty acids, including *medical foods*. Charges incurred for the diagnosis and treatment of phenylketonuria are limited to *covered persons* under the age of 22, or for women of childbearing age, to under the age of 35.

MGR03682

(b) Diagnosis and treatment of *mental disorders*, including substance abuse.

MGR04478

(c) *Child health supervision services*, exempt from any *deductible amount*, regardless of whether services are provided by a *network provider*.

MGR04543

(d) Physical, occupational and speech therapy for the management of congenital defects and birth abnormalities (except for cleft lip/cleft palate) for charges incurred subsequent to the covered child's third birthday and prior to the child's sixth birthday, limited to twenty therapy visits per *covered person* per year for each type of therapy, whether the condition is acute or chronic and whether the therapy is to improve or maintain functional capacity;

MGR04163

- (e) Hearing aids, including any parts or ear molds, for *covered persons* less than eighteen years of age. Coverage shall include:
 - (i) Initial hearing aids and replacement hearing aids not more frequently than every five years;
 - (ii) A new hearing aid when alterations to the existing hearing aid cannot adequately meet the needs of the child; and
 - (iii) Services and supplies, including initial assessment, fitting, adjustments and auditory training provided according to accepted professional standards.

MGR04267

- 2. *Covered expenses* incurred by a newborn child covered since birth will include:
 - (a) *Medically necessary* care and treatment of cleft lip and cleft palate including: oral and facial surgery, surgical management, and follow-up care by plastic surgeons and oral surgeons; prosthetic treatment such as obturators, speech appliances and feeding appliances; orthodontic treatment; prosthodontic treatment; habilitative speech therapy; otolaryngology treatment; and audiological assessments and treatment.
 - (b) *Routine nursery care* while the newborn is a *hospital inpatient*, limited to the first 48 hours following a vaginal delivery or the first 96 hours following a caesarean section. If the 48/96 hours end after 8:00 p.m. local time, *routine nursery care expenses* will be covered until 8:00 a.m. the following morning.

MGR03940

- 3. *Covered expenses* for mammography services are exempt from any *deductible amount*, regardless of whether services are provided by a *network provider*.

MGR04544

- 4. *Covered expenses* for prostate cancer screening services are limited to the lesser of sixty-five dollars per prostate cancer screening or regular plan benefits for the actual charge for such screening. *Covered expenses* for prostate screening services are exempt from any *deductible amount*.

MGR03684

- 5. *Covered expenses* for treatment and/or management of Type I, Type II, or gestational diabetes or for *diabetes self-management training services* are deleted and replaced with the following:

Covered expenses shall include charges for *medically necessary* treatment of diabetes incurred for equipment, supplies, and outpatient *diabetes self-management training*, including medical nutrition therapy, when prescribed by a *doctor* and provided by a certified, registered, or licensed health care professional with expertise in diabetes.

MGR03685

- 6. *Covered expenses* will include repairs for prosthetic devices, unless the repairs are due to misuse or loss.

MGR03935

- 7. *Covered expenses* are expanded to include *early intervention services* provided, pursuant to a written individualized family service plan, to an *eligible child* who has demonstrated significant delays in development or who has been diagnosed with a physical or mental condition that has a high probability of resulting in significant delays in development. *Early intervention services* shall be exempt from any *deductible amount* or copayment amount and will not be applied to the lifetime maximum benefit available under the *policy/certificate*. *Covered expenses* paid for *early intervention services* shall be limited to an annual maximum specified under Colorado law and will be adjusted annually based on the Consumer Price Index. Benefits for *early intervention services* will be paid annually in a lump sum to the Colorado Department of Human Services in trust, as required by Colorado law. Claims for payment of reimbursement of expenses must be filed with the Colorado Department of Human Services instead of *us*.

The annual maximum dollar limit shall not apply to:

- (a) Rehabilitation or therapeutic services that are necessary as the result of an acute medical condition or post-surgical rehabilitation;
- (b) Services provided to a child who is not participating in the early intervention program for infants and toddlers under the federal Individuals with Disabilities Act; or
- (c) Services that are not provided pursuant to an individualized family service plan.

MGR04350

8. *Covered expenses* for preventive health care services are expanded to include the following:
- (a) Alcohol misuse screening and *behavioral* counseling interventions for adult *covered persons* by primary care providers;
 - (b) Cholesterol screening for lipid disorders;
 - (c) Childhood immunizations, influenza vaccinations, and pneumococcal vaccinations, pursuant to the applicable schedule established by the *AICP* to the extent not covered elsewhere in the *policy/certificate* or any endorsement thereto;
 - (d) Tobacco use screening of adults and tobacco cessation interventions by primary care providers.

Covered expenses for the preventive health care services listed above shall be exempt from any *deductible amount* or coinsurance provisions.

MGR04419

- F. Under the General Exclusions and Limitations, *covered expenses* will not include any charges which are incurred for the diagnosis or treatment of *intractable pain*.

MGR03688

- G. Any and all references in the *policy/certificate* to exclusions for expenses resulting from intentionally self-inflicted bodily harm are amended as follows:

Covered expenses will not include, and no benefits will be paid for any charges which are incurred as a result of intentionally self-inflicted bodily harm, unless the *covered person* was insane.

MGR03887

- H. Any and all references in the *policy/certificate* to waiting periods for *illnesses* are deleted. The *effective date* for *illness* is the same as for *injuries*.

MGR03689

- I. The exclusion in the *policy/certificate* for *loss* incurred as a result of the *covered person* being intoxicated or under the influence is amended to read as follows:

Covered expenses will not include, and no benefits will be paid for any charges for *illness* incurred as a result of the *covered person* being intoxicated, as defined by applicable state law in the state in which the *loss* occurred, or under the influence of illegal narcotics or controlled substance unless administered or prescribed by a *doctor*.

MGR04120

- J. Any limit/exclusion for court-ordered treatment programs for substance abuse or alcoholism, if included in the *policy/certificate*, is hereby removed.

MGR03912

- K. Any exclusion and/or limit in the *policy/certificate* for services performed by a member of the *covered person's immediate family* is hereby removed.

MGR03934

- L. The Preexisting Conditions and Limitations provision and the Reinstatement provision are amended as follows:

1. The *preexisting condition* limitation will not apply to a *loss* incurred more than 6 months after the *effective date* on which a *covered person* became insured under the *policy/certificate*.

2. If a *covered person's effective date* under this *policy/certificate* occurs within 90 days of termination of the *covered person's coverage* under any prior *creditable coverage*, that *covered person* will be entitled to credit under the 6 month *preexisting conditions* limitation for the same number of full months that the *covered person* was continuously covered under the prior *creditable coverage*.

MGR03936

"*Creditable coverage*" means coverage as defined under Colorado I.C. Art.10-16-102(13.7).

MGR03691

3. The definition of "*preexisting condition*" is deleted and replaced with the following:

"*Preexisting condition*" means an *injury or illness* for which the *covered person* received medical advice or treatment within the 6 months immediately preceding the *effective date* the *covered person* became insured under the *policy*.

MGR03692

- M. The following subsections are added to the Claims provision:

MEDICAID REIMBURSEMENT: We will pay the benefits of the *policy* to the state if we receive notice that payment has been made under Medicaid for *covered expenses* incurred by a *covered person*.

Our payment to the state will be limited to the amount payable under the *policy* for the *covered expenses* for which reimbursement is due. Payment under this provision will be made in good faith. It will satisfy *our* responsibility to the extent of that payment.

The amount payable under the *policy* will not be changed or limited for reason of a *covered person's* being eligible for coverage under the Medicaid program of the state in which he or she lives.

MGR03662

NETWORK ACCESS PLAN: A *covered person* may request a copy of the access plan for the provider network shown on the front of the *covered person's* identification card regarding availability of and access to network provisions.

MGR03939

- N. **Please note below the list of counties in Colorado where there were no Preferred Providers/Network Providers listed as of December 31, 2005:**

Dolores, Gunnison, Jackson, Mineral and San Juan.

MGR03937

- O. **A *covered person* who incurs *covered expenses* at a non-Preferred Provider/non-Network Provider because a Preferred Provider/Network Provider is not reasonably accessible by the *covered person*, may be responsible for the difference between the amount paid for an expense by us and the amount of the non-Preferred Provider/non-Network Provider's billed charges.**

If you would like to obtain Golden Rule Insurance Company's reimbursement rates for services performed by non-Preferred Providers/non-Network Providers for specific covered expenses, you may call (800) 657-8205.

MGR03938

- P. Under the Health Insurance Conversion Privilege, written application for the conversion policy and the first premium must be received, in any event, within 91 days of the termination date of coverage under the *policy/certificate*.

MGR03693

Except as specifically stated in this endorsement, the benefits under this endorsement are subject to all of the terms, conditions, exclusions, limitations, and notification requirements of the *policy/certificate*, including any applicable deductible amounts, coinsurance provisions, copay amounts, or dollar limits.

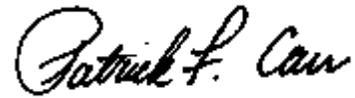
MGR03440

This endorsement applies only to *covered persons* who reside in the state of Colorado.

This endorsement will not change, waive or extend any part of the *policy* other than as stated herein.

This endorsement is effective on September 1, 2012 or at the same time as the *policy/certificate*, whichever is later.

Golden Rule Insurance Company

A handwritten signature in black ink that reads "Patrick F. Carr". The signature is written in a cursive style with a large initial "P".

President

MGR03441

COLORADO ENDORSEMENT

By attachment of this endorsement, the *policy/certificate* is amended to the extent of any conflict with the following:

MGR03433

A. The Definitions provision is amended as follows:

1. The definition of *medical practitioner* is amended to include a dental hygienist, registered professional nurse, and licensed clinical social worker. In addition, *medical practitioner* will be expanded to include a licensed professional counselor and a licensed marriage or family therapist when acting within the scope of his/her license in providing services for the treatment of *mental disorders* or *biologically based mental illnesses*.

MGR03674

2. *Mental disorder*, as defined in the *policy/certificate*, does not include autism, *biologically based mental illnesses*, or *specified mental illnesses*.

MGR04479

3. The following definitions are added:

"AICP" means the Advisory Committee on Immunization Practices to the Centers for Disease Control and Prevention in the federal Department of Health and Human Services, or any successor entity.

MGR04418

"*Biologically based mental illness*" means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder or panic disorder.

"*Child health supervision services*" means the specified services when ordered, delivered or supervised by one *doctor* during a visit at one of the age intervals specified below. *Child health supervision services* must be appropriate to the age of the child in accordance with the current recommendations for preventive pediatric care by the American Academy for Pediatrics, and shall include, but will not be limited to: a medical history, complete physical examination, developmental assessment, anticipatory guidance, appropriate immunizations, and laboratory tests.

Child health supervision services will be limited to the specified visits during the following age intervals:

- (a) One home visit for a newborn child that is released from the *hospital* within 48 hours following delivery;
- (b) 5 visits and 1 PKU screening test for children from birth through age 12 months;
- (c) 2 visits for children from age 13 months through age 35 months;
- (d) 3 visits for children from age 3 years through age 6 years; and
- (e) 3 visits for children from age 7 years through age 12 years.

MGR03676

"*Early intervention services*" means education, training and assistance in child development, parent education, therapies and other activities for infants and toddlers and their families which are designed to meet the developmental needs of infants and toddlers including, but not limited to: cognition, speech, communication, physical, motor, vision, hearing, social-emotional and self-help skills.

Early intervention services shall not include non-emergency medical transportation, respite care, service coordination (other than case management) or assistive technology.

MGR04351

"*Inherited enzymatic disorders*" include, but are not limited to, Phenylketonuria, Maternal phenylketonuria, Maple syrup urine disease, Tyrosinemia, Homocystinuria, Histidinemia, Urea

cycle disorders, Hyperlysinemia, Glutaric acidemias, Methylmalonic acidemia and Propionic acidemia.

"*Intractable pain*" means pain that is incurable or resistant to therapy.

"*Medical foods*" means prescribed metabolic formulas and their modular counterparts, obtained through a pharmacy, that are specifically designated and manufactured for the treatment of *inherited enzymatic disorders*, and for which medically standard methods of diagnosis, treatment, and monitoring exist. Such formulas are specifically processed or formulated to be deficient in one or more nutrients and are to be consumed or administered enterally either via tube or orally.

"*Routine nursery care*" of a newborn *eligible child* is limited to charges:

- (a) Made by a hospital for: daily room and board and nursing services, including general nursery services; services and supplies routinely provided to newborns; and the use of an operating or delivery room in connection with the circumcision of the newborn; and
- (b) For professional fees of a *medical practitioner*.

MGR03676

"*Specified mental illnesses*" means posttraumatic stress disorder, drug and alcohol disorders, dysthymia, cyclothymia, social phobia, agoraphobia with panic disorder, general anxiety disorder, anorexia nervosa and bulimia nervosa.

MGR04173

- B. Under the Eligibility provision, a *covered person* will not cease to be a *dependent* solely because of age if the *eligible child* is not capable of self-sustaining employment due to mental incapacity or physical handicap.

MGR03677

- C. The Effective Date of Insurance provision is amended as follows:

1. The following is added to the subsection entitled Adding a Newborn:

Payment of any increase in premium necessitated by the addition of the newborn child as a *covered person* will not be required for the first 31 days of the newborn's life.

MGR03678

2. The following subsection is added:

Adding an Adopted Child: An *eligible child* legally *placed* for adoption with *you* or *your spouse* within 90 days of birth will be covered until the 31st day after *placement* unless the *placement* is disrupted prior to the legal adoption and the child is removed from *your* physical custody. The adopted child may continue as a *covered person* after the 31st day only if *we* have received both written notice of the child's *placement* and any additional premium required.

To request coverage for a child placed for adoption with *you* or *your spouse* beyond 90 days after the child's birth, *you* must apply for insurance in accordance with the Adding Other Dependents subsection of the Effective Date of Dependent's Insurance provision.

MGR04517

- D. The terms and conditions outlined in the Termination of Insurance and Renewability provision shall prevail over any other reference in the *policy/certificate* regarding *our* right to terminate coverage.

MGR03681

- E. The Medical Benefits provision is amended as follows:

1. *Covered expenses* are amended to include charges incurred for the following:

- (a) Diagnosis and treatment of *inherited enzymatic disorders* caused by single gene defects involved in the metabolism of amino, organic and fatty acids, including *medical foods*. Charges incurred for the diagnosis and treatment of phenylketonuria are limited to *covered persons* under the age of 22, or for women of childbearing age, to under the age of 35.

(b) Diagnosis and treatment of a *biologically based mental illness*;

MGR03682

(c) *Inpatient* diagnosis and treatment of *mental disorders*;

MGR04480

(d) *Child health supervision services*, exempt from any *deductible amount*, regardless of whether services are provided by a *network provider*.

MGR04543

(e) Physical, occupational and speech therapy for the management of congenital defects and birth abnormalities (except for cleft lip/cleft palate) for charges incurred subsequent to the covered child's third birthday and prior to the child's sixth birthday, limited to twenty therapy visits per *covered person* per year for each type of therapy, whether the condition is acute or chronic and whether the therapy is to improve or maintain functional capacity;

(f) Diagnosis and treatment of *specified mental illnesses* on an inpatient, outpatient and day treatment basis. *Covered expenses* shall not include residential treatment of *specified mental illnesses*;

MGR04163

(g) Hearing aids, including any parts or ear molds, for *covered persons* less than eighteen years of age. Coverage shall include:

(i) Initial hearing aids and replacement hearing aids not more frequently than every five years;

(ii) A new hearing aid when alterations to the existing hearing aid cannot adequately meet the needs of the child; and

(iii) Services and supplies, including initial assessment, fitting, adjustments and auditory training provided according to accepted professional standards.

MGR04267

2. *Covered expenses* incurred by a newborn child covered since birth will include:

(a) *Medically necessary care* and treatment of cleft lip and cleft palate including: oral and facial surgery, surgical management, and follow-up care by plastic surgeons and oral surgeons; prosthetic treatment such as obturators, speech appliances and feeding appliances; orthodontic treatment; prosthodontic treatment; habilitative speech therapy; otolaryngology treatment; and audiological assessments and treatment.

(b) *Routine nursery care* while the newborn is a *hospital inpatient*, limited to the first 48 hours following a vaginal delivery or the first 96 hours following a caesarean section. If the 48/96 hours end after 8:00 p.m. local time, *routine nursery care expenses* will be covered until 8:00 a.m. the following morning.

MGR03940

3. *Covered expenses* for mammography services are exempt from any *deductible amount*, regardless of whether services are provided by a *network provider*.

MGR04544

4. *Covered expenses* for prostate cancer screening services are limited to the lesser of sixty-five dollars per prostate cancer screening or regular plan benefits for the actual charge for such screening. *Covered expenses* for prostate screening services are exempt from any *deductible amount*.

MGR03684

5. *Covered expenses* for treatment and/or management of Type I, Type II, or gestational diabetes or for *diabetes self-management training services* are deleted and replaced with the following:

Covered expenses shall include charges for *medically necessary* treatment of diabetes incurred for equipment, supplies, and outpatient *diabetes self-management training*, including medical

nutrition therapy, when prescribed by a *doctor* and provided by a certified, registered, or licensed health care professional with expertise in diabetes.

MGR03685

6. *Covered expenses* will include repairs for prosthetic devices, unless the repairs are due to misuse or loss.

MGR03935

7. *Covered expenses* are expanded to include *early intervention services* provided, pursuant to a written individualized family service plan, to an *eligible child* who has demonstrated significant delays in development or who has been diagnosed with a physical or mental condition that has a high probability of resulting in significant delays in development. *Early intervention services* shall be exempt from any *deductible amount* or copayment amount and will not be applied to the lifetime maximum benefit available under the *policy/certificate*. *Covered expenses* paid for *early intervention services* shall be limited to an annual maximum specified under Colorado law and will adjusted annually based on the Consumer Price Index. Benefits for *early intervention services* will be paid annually in a lump sum to the Colorado Department of Human Services in trust, as required by Colorado law. Claims for payment of reimbursement of expenses must be filed with the Colorado Department of Human Services instead of *us*.

The annual maximum dollar limit shall not apply to:

- (a) Rehabilitation or therapeutic services that are necessary as the result of an acute medical condition or post-surgical rehabilitation;
- (b) Services provided to a child who is not participating in the early intervention program for infants and toddlers under the federal Individuals with Disabilities Act; or
- (c) Services that are not provided pursuant to an individualized family service plan.

MGR04350

8. *Covered expenses* for preventive health care services are expanded to include the following:
- (a) Alcohol misuse screening and *behavioral* counseling interventions for adult *covered persons* by primary care providers;
 - (b) Cholesterol screening for lipid disorders;
 - (c) Childhood immunizations, influenza vaccinations, and pneumococcal vaccinations, pursuant to the applicable schedule established by the *AICP* to the extent not covered elsewhere in the *policy/certificate* or any endorsement thereto;
 - (d) Tobacco use screening of adults and tobacco cessation interventions by primary care providers.

Covered expenses for the preventive health care services listed above shall be exempt from any *deductible amount* or coinsurance provisions.

MGR04419

9. **LIMITED OUTPATIENT TREATMENT OF MENTAL DISORDERS:** *Covered expenses* for the diagnosis or treatment of a *mental disorder* on an outpatient basis will be limited to:
- (a) 90 days *partial hospitalization* treatment per *covered person* per calendar year. *Partial hospitalization* means continuous treatment for at least three hours, but no more than twelve hours in any twenty-four hour period; and
 - (b) A maximum of \$1,000 per *covered person*, per calendar year for all other outpatient expenses subject to a 50% coinsurance requirement.

MGR04481

Benefits paid for *covered expenses* for outpatient treatment of *biologically-based mental disorders* and *specified mental illnesses* will be applied towards the maximum outpatient benefits available for diagnosis and treatment of other *mental disorders*. In the event that the maximum outpatient benefit available for *mental disorders* during any calendar year has been exhausted, expenses incurred for the diagnosis or treatment of *biologically-based mental*

disorders and specified mental illnesses will continue to be considered *covered expenses* under the *policy* on the same basis as any other *illness*.

MGR04482

- F. Under the General Exclusions and Limitations, *covered expenses* will not include any charges which are incurred for the diagnosis or treatment of *intractable pain*.

MGR03688

- G. Any and all references in the *policy/certificate* to exclusions for expenses resulting from intentionally self-inflicted bodily harm are amended as follows:

Covered expenses will not include, and no benefits will be paid for any charges which are incurred as a result of intentionally self-inflicted bodily harm, unless the *covered person* was insane.

MGR03887

- H. Any and all references in the *policy/certificate* to waiting periods for *illnesses* are deleted. The *effective date* for *illness* is the same as for *injuries*.

MGR03689

- I. The exclusion in the *policy/certificate* for *loss* incurred as a result of the *covered person* being intoxicated or under the influence is amended to read as follows:

Covered expenses will not include, and no benefits will be paid for any charges for *illness* incurred as a result of the *covered person* being intoxicated, as defined by applicable state law in the state in which the *loss* occurred, or under the influence of illegal narcotics or controlled substance unless administered or prescribed by a *doctor*.

MGR04120

- J. Any limit/exclusion for court-ordered treatment programs for substance abuse or alcoholism, if included in the *policy/certificate*, is hereby removed.

MGR03912

- K. Any exclusion and/or limit in the *policy/certificate* for services performed by a member of the *covered person's immediate family* is hereby removed.

MGR03934

- L. The Preexisting Conditions and Limitations provision and the Reinstatement provision are amended as follows:

1. The *preexisting condition* limitation will not apply to a *loss* incurred more than 6 months after the *effective date* on which a *covered person* became insured under the *policy/certificate*.
2. If a *covered person's effective date* under this *policy/certificate* occurs within 90 days of termination of the *covered person's coverage* under any prior *creditable coverage*, that *covered person* will be entitled to credit under the 6 month *preexisting conditions* limitation for the same number of full months that the *covered person* was continuously covered under the prior *creditable coverage*.

MGR03936

"*Creditable coverage*" means coverage as defined under Colorado I.C. Art.10-16-102(13.7).

MGR03691

3. The definition of "*preexisting condition*" is deleted and replaced with the following:

"*Preexisting condition*" means an *injury* or *illness* for which the *covered person* received medical advice or treatment within the 6 months immediately preceding the *effective date* the *covered person* became insured under the *policy*.

MGR03692

- M. The following subsections are added to the Claims provision:

MEDICAID REIMBURSEMENT: We will pay the benefits of the *policy* to the state if we receive notice that payment has been made under Medicaid for *covered expenses* incurred by a *covered person*.

Our payment to the state will be limited to the amount payable under the *policy* for the *covered expenses* for which reimbursement is due. Payment under this provision will be made in good faith. It will satisfy *our* responsibility to the extent of that payment.

The amount payable under the *policy* will not be changed or limited for reason of a *covered person's* being eligible for coverage under the Medicaid program of the state in which he or she lives.

MGR03662

NETWORK ACCESS PLAN: A *covered person* may request a copy of the access plan for the provider network shown on the front of the *covered person's* identification card regarding availability of and access to network provisions.

MGR03939

- N. **Please note below the list of counties in Colorado where there were no *Preferred Providers/Network Providers* listed as of December 31, 2005:**

Dolores, Gunnison, Jackson, Mineral and San Juan.

MGR03937

- O. **A *covered person* who incurs *covered expenses* at a *non-Preferred Provider/non-Network Provider* because a *Preferred Provider/Network Provider* is not reasonably accessible by the *covered person*, may be responsible for the difference between the amount paid for an expense by *us* and the amount of the *non-Preferred Provider/non-Network Provider's* billed charges.**

If you would like to obtain Golden Rule Insurance Company's reimbursement rates for services performed by *non-Preferred Providers/non-Network Providers* for specific *covered expenses*, you may call (800) 657-8205.

MGR03938

- P. Under the Health Insurance Conversion Privilege, written application for the conversion policy and the first premium must be received, in any event, within 91 days of the termination date of coverage under the *policy/certificate*.

MGR03693

Except as specifically stated in this endorsement, the benefits under this endorsement are subject to all of the terms, conditions, exclusions, limitations, and notification requirements of the *policy/certificate*, including any applicable deductible amounts, coinsurance provisions, copay amounts, or dollar limits.

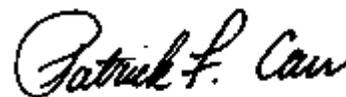
MGR03440

This endorsement applies only to *covered persons* who reside in the state of Colorado.

This endorsement will not change, waive or extend any part of the *policy* other than as stated herein.

This endorsement is effective on September 1, 2012 or at the same time as the *policy/certificate*, whichever is later.

Golden Rule Insurance Company



President

MGR03441

DISTRICT OF COLUMBIA ENDORSEMENT

By attachment of this endorsement, the *policy/certificate* is amended to the extent of any conflict with the following:

MGR03433

A. The Definitions section is amended as follows:

1. The definition of *eligible child* is amended to include a minor grandchild, niece, or nephew if:

- (a) A *covered person* is responsible for the *primary care* of the minor grandchild, niece, or nephew; and
- (b) The legal guardian of the minor grandchild, niece, or nephew is not covered by an accident or sickness policy.

MGR04143

2. The definition of *emergency* is deleted and replaced with the following:

"Emergency" means the sudden onset or worsening of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent lay person, who possesses an average knowledge of health and medicine to result in:

- (a) Placing the patient's health in serious jeopardy;
- (b) Serious impairment to bodily functions; or
- (c) Serious dysfunction of any bodily organ or part.

"Emergency" treatment shall include:

- (a) Health care services furnished in the Emergency Department of a hospital for the treatment of a medical *emergency*;
- (b) *Ancillary services* routinely available to the Emergency Department of a hospital for the treatment of a medical *emergency*; and
- (c) Emergency medical services transportation.

MGR04199

3. The definition of *terminally ill* shall mean that a *doctor* has given a prognosis that a *covered person* has twelve months or less to live.

MGR04236

4. The following definitions are added:

"Ancillary services" means standard medical procedures that are reasonably necessary for the diagnosis and treatment of a patient.

MGR04200

"Approved clinical trial" means:

- (a) A clinical research study or clinical investigation approved or funded in full or in part by one or more of the following:
 - (i) The National Institutes of Health;
 - (ii) The Centers for Disease Control and Prevention;
 - (iii) The Agency for Health Care Research and Quality;
 - (iv) The Centers for Medicare and Medicaid Services;
- (v) A bona fide clinical trial cooperative group, including the National Cancer Institute Clinical Trials Cooperative Group, the National Cancer Institute Community Clinical Oncology Program, the AIDS Clinical Trials Group, and the Community Programs for Clinical Research in AIDS; or

- (vi) The Department of Defense, the Department of Veterans Affairs, or the Department of Energy, or a qualified nongovernmental research entity to which the National Cancer Institute has awarded a support grant;
- (b) A study or investigation approved by the Food and Drug Administration ("FDA"), including those conducted under an investigational new drug or device application reviewed by the FDA; or
- (c) An investigation or study approved by an Institutional Review Board registered with the Department of Health and Human Services that is associated with an institution that has a federal-wide assurance approved by the Department of Health and Human Services specifying compliance with 45 C.F.R. Part 46.

MGR04269

"Congenital or genetic birth defect" means a defect existing at or from birth, including a hereditary defect. The term includes autism or an autism spectrum disorder and cerebral palsy.

"Habilitative services" means services, including occupational therapy, physical therapy, and speech therapy, for the treatment of a child with a *congenital or genetic birth defect* to enhance the child's ability to function.

"Hearing impairment" means a dysfunction of the auditory system, of any type of degree, which is sufficient to interfere with the acquisition and development of speech and language skills, with or without the use of sound amplification.

"Primary care" means providing food, clothing, and shelter on a regular and continuous basis for the minor grandchild, niece, or nephew during the time that the District of Columbia public schools are in regular session.

MGR04200

"Qualified individual" means a *covered person* who is eligible to participate in an *approved clinical trial* for purposes of prevention, early detection, treatment, or monitoring of cancer, chronic disease, or life-threatening *illness*.

MGR04270

"Routine patient care costs" means items, drugs and services:

- (a) That are typically provided absent a clinical trial;
- (b) Required solely for the provision of the investigational item or service (such as the administration of a non-covered chemotherapeutic agent), the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; and
- (c) Needed for reasonable and necessary care arising from the provision of an investigational item or service, including the diagnosis or treatment of complications.

Routine patient care costs shall not include:

- (a) The cost of tests or measurements conducted primarily for the purpose of the clinical trial involved or items, drugs, or services provided solely to satisfy data collection and analysis needs; or
- (b) Items, drugs, or services customarily provided by the research sponsors free of charge for any *qualified individual* enrolled in the trial.

MGR04271

- B. Under Policyholder Provisions, the subsection entitled Premium is amended. Sex of *covered persons* will not be a factor in determining *your* premium rates.

MGR04606

- C. The Medical Benefits provision is amended as follows:
 - 1. Benefits provided for mammograms and pap smears shall be exempt from any *deductible amount*, copayment or coinsurance.

MGR04148

2. *Covered expenses* shall include equipment, supplies and outpatient self-management training and education, including medical nutrition therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin using diabetes.

MGR04187

3. *Covered expenses* shall include *hospital* expenses for childbirth in accordance with the Newborns' and Mothers' Health Protection Act detailed in *your policy/certificate*. Upon release from the *hospital*, *covered expenses* shall include charges incurred for one home visit from a registered nurse provided in accordance with generally accepted standards of nursing practice for home care of a mother and newborn child and shall include services required by the mother's attending physician.

If a mother and newborn child are hospitalized for less than 48 hours following an uncomplicated vaginal delivery or less than 96 hours following a delivery by cesarean section, *covered expenses* shall be expanded to include:

- (a) One home visit scheduled to occur within 24 hours after hospital discharge; and
- (b) An additional home visit if prescribed by the mother's attending physician.

In addition, if the mother is required to remain hospitalized for medical reasons following childbirth, *covered expenses* shall include *hospital* charges for the infant to remain with the mother for up to four days.

MGR04608

4. *Covered expenses* are expanded to include charges incurred for:

- (a) *Habilitative services* provided to an *eligible child* under 21 years of age, unless these services are provided through early intervention or school services; and

MGR04201

- (b) *Routine patient care costs* of health care services, items, or drugs for a *qualified individual* participating in an *approved clinical trial* if the service, item, or drug would have been a *covered expense* had it not been administered in a clinical trial.

MGR04272

- (c) Diagnosis and treatment of *mental disorders*, including *substance abuse*.

MGR04478

- D. Benefits shall not be excluded for an *injury, illness* or condition sustained by a *covered person* based solely on the fact that it was sustained as a result of the *covered person* being intoxicated or under the influence of a narcotic.

MGR04150

- E. Under the Preexisting Conditions and Limitations provision, the definition of *preexisting condition* is deleted and replaced with the following:

A "*preexisting condition*" means an *injury* or *illness*:

1. For which the *covered person* received medical advice or treatment within the 24 months immediately preceding the applicable *effective date* the *covered person* became insured under the *policy*; or
2. Which, in the opinion of a qualified *doctor*:
 - (a) Probably began prior to the applicable *effective date* the *covered person* became insured under the *policy*; and
 - (b) Manifested symptoms which would cause a person to seek diagnosis or treatment within the 12 months immediately preceding the applicable *effective date* the *covered person* became insured under the *policy*.

MGR04237

- F. Under Uniform Provisions, the subsection Misstatement of Age or Sex is amended to read as follows:

MISSTATEMENT OF AGE: If *your age*, or *your dependent's age*, has been misstated, the benefits may be adjusted based on the relationship of the premium paid to the premium that should have been paid based on the correct age.

MGR04607

Except as specifically stated in this endorsement, the benefits under this endorsement are subject to all of the terms, conditions, exclusions, limitations and notification requirements of the *policy/certificate*, including any applicable *deductible amounts*, coinsurance provisions, copay amounts, or dollar limits.

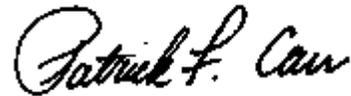
MGR03440

This endorsement applies only to *covered persons* who reside in the District of Columbia.

This endorsement will not change, waive or extend any part of the *policy/certificate*, other than as stated herein.

This endorsement is effective on September 1, 2012 or at the same time as the *policy/certificate*, whichever is later.

Golden Rule Insurance Company

A handwritten signature in black ink that reads "Patrick F. Carr". The signature is written in a cursive, flowing style.

President

MGR03441

DISTRICT OF COLUMBIA GRIEVANCE ENDORSEMENT

By attachment of this endorsement, the *policy/certificate* is amended to the extent of any conflict with the following:

MGR03433

- A. The following is added:

DISTRICT OF COLUMBIA APPEALS PROCEDURES

DEFINITIONS - As used in these procedures, the following terms have the meanings indicated:

1. "*Adverse decision*" means a determination made by *us* or a recommendation made by *our* Review Agent that an admission, availability of care, continued stay, or other health care service, which would otherwise be a covered expense under the policy, has been reviewed and does not meet the requirements for medical necessity, appropriateness, health care settings, level of care or effectiveness, and therefore expenses for the treatment/services are not considered covered expenses under the policy.
2. "*Director*" means the Director, District of Columbia Department of Health.
3. "*Grievance*" means a written request by a *covered person* or *covered person's representative* for review of an *adverse decision* or for review of any other determination made by *us* to deny, reduce, limit, terminate or delay covered health care services to a *covered person*.
4. "*Covered person's representative*" means any person acting on behalf of a *covered person* with the *covered person's* written consent.

MGR04255

RIGHTS

1. A *covered person* or *covered person's representative* may file a grievance with *us* or with *our* Review Agent.

MGR04256

CONTACT INFORMATION

For *grievances* regarding *adverse decisions* by *our* Review Agent:

Care Management
500 Colvin Woods Parkway
Tonawanda, NY 14150
Phone: (800) 999-3404

For all other *grievances*:

Golden Rule Grievance Administrator
c/o Golden Rule Insurance Company
712 Eleventh Street
Lawrenceville, Ill 62439
Phone: (800) 657-8205
Fax: (618) 943-3148

MGR04257

2. If *you* are dissatisfied with the resolution reached through *our* internal *grievance* system regarding an *adverse decision*, *you* may contact the Director, Office of the Health Care Ombudsman and Bill of Rights at the following:

District of Columbia Department of Health Care Finance
Office of the Health Care Ombudsman and Bill of Rights
825 North Capitol Street, N.E.
6th Floor
Washington, DC 20002
1 (877) 685-6391
Fax: (202) 478-1397

3. If *you* are dissatisfied with the resolution reached through *our* internal *grievance* system regarding all other *grievances*, *you* may contact the Commissioner at the following:

Commissioner Gennett Purcell
Department of Insurance, Securities and Banking
810 First Street, N.E., 7th Floor
Washington, DC 20002
(202) 727-8000
Fax: (202) 354-1085

MGR04526

4. A *covered person* who is a Medicaid enrollee or the *covered person's representative* may appeal to the Office of Fair Hearings at any time, if applicable.

MGR04259

LEVEL 1 - INFORMAL INTERNAL REVIEW

1. Any *covered person* dissatisfied with an *adverse decision* or any other determination eligible for *grievance* review will be provided an opportunity to review the decision with *our* representative or *our* Review Agent's representative.
2. The informal internal review of an *adverse decision* or of any other *grievance* where the review requires medical expertise will be conducted by a physician/specialist chosen by *us* or by *our* Review Agent. The informal internal review of all other *grievances* will be conducted by *our* designee who rendered the decision.
3. Each informal internal review will be concluded within fourteen (14) business days after the request has been filed and *we* or *our* Review Agent will orally communicate the decision to the *covered person* or *covered person's representative*.
4. *We* or *our* Review Agent will provide written explanation of the *grievance* decision to the *covered person* or *covered person's representative* and notification of the right to request a formal internal review within five (5) business days after the *grievance* decision is made. The written *grievance* decision will include the following:
 - (a) The reviewer's understanding of the *grievance*;
 - (b) The reviewer's decision in clear terms;
 - (c) The contractual basis or medical reason for the decision, provided that general terms such as experimental procedures not covered, cosmetic procedures not covered, service included under another procedure, and not medically necessary will not be used, unless reference is made to a specific provision or medical evidence that verifies *our* position; and
 - (d) All applicable instructions to request a review of the decision at the next level. The instructions will include the telephone numbers and titles of persons to contact and must be in at least twelve (12) point type face. A request for review at the next level must be made within thirty (30) business days.

MGR04260

LEVEL 2 - FORMAL INTERNAL REVIEW

1. A *covered person* or *covered person's representative* dissatisfied with the decision rendered in the informal internal review process may seek a formal internal review. For *adverse decisions* and any other determination requiring medical expertise, the review will be conducted by an appropriate health care professional selected by *us* or by *our* Review Agent based upon the specific issues presented by the *grievance*. For other determinations not requiring medical expertise, the review will be conducted by a reviewer selected by *us* based upon the specific issues presented by the *grievance*.
2. *We* or *our* Review Agent will notify the *covered person* or *covered person's representative* of receipt of a request for a formal internal review within ten (10) business days. *We* or *our* Review Agent will also determine within ten (10) business days whether *we* have sufficient information to complete the review process. If the information is insufficient, *we* or *our* Review Agent will:

- (a) Notify the *covered person* or *covered person's representative* that we can't proceed unless the additional information is provided;
 - (b) Specify all additional information required; and
 - (c) Assist the *covered person* or *covered person's representative*, to the extent possible, in gathering the necessary information without further delay.
3. Each formal internal review will be concluded no later than thirty (30) business days after we receive notice of the request (except that this 30-day period may be extended at the request of the *covered person* or *covered person's representative*) and we or our Review Agent will orally communicate the decision to the *covered person* or *covered person's representative*.
 4. If the decision is adverse to the *covered person*, we or our Review Agent will provide the *covered person* or *covered person's representative* with a written explanation of the decision and notification of the *covered person's* right to seek an external review within five (5) business days after the *grievance* decision is made. The written explanation will include the following:
 - (a) The reviewer's understanding of the *grievance*;
 - (b) The reviewer's decision in clear terms;
 - (c) The contractual basis or medical reason for the decision, provided that general terms such as experimental procedures not covered, cosmetic procedures not covered, service included under another procedure, and not medically necessary will not be used, unless reference is made to a specific provision or medical evidence that verifies *our* position; and
 - (d) All applicable instructions to request a review of the decision at the next level. The instructions will include the telephone numbers and titles of persons to contact and must be in at least twelve (12) point type face.
 5. If we or our Review Agent fail to comply with any deadline for completion of a formal internal review, the *covered person* or *covered person's representative* will be relieved of the duty to exhaust the formal internal review process, and may proceed directly to the external review process.

MGR04261

LEVEL 3 - EXTERNAL REVIEW

1. Within thirty (30) business days after the date of receipt of a written formal internal review *grievance* decision, the *covered person* or *covered person's representative* may file a request for an external review.
2. When requesting an external review regarding an *adverse decision*, you may contact the Director, Office of the Health Care Ombudsman and Bill of Rights at the following:

District of Columbia Department of Health Care Finance
 Office of the Health Care Ombudsman and Bill of Rights
 825 North Capitol Street, N.E.
 6th Floor
 Washington, DC 20002
 1 (877) 685-6391
 Fax: (202) 478-1397
3. When requesting an external review regarding all other *grievances*, you may contact the Commissioner at the following:

Commissioner Gennet Purcell
 Department of Insurance, Securities and Banking
 810 First Street, N.E., 7th Floor
 Washington, DC 20002
 (202) 727-8000
 Fax: (202) 354-1085
4. Unless an extension has been granted, a request for external review may be filed if the *grievance* decision is not received by the 30th business day after the *grievance* is filed.

Accompanying that request must be a written consent form authorizing the release of the *covered person's* medical records to third parties for the sole purpose of conducting the review. The *Director* or Commissioner may refuse to accept a request if the *covered person* fails to provide a signed consent form.

5. Within five (5) business days after receipt of a request for external review, the *Director* or Commissioner will send written notice to *us* and the *covered person* or *covered person's representative* as to whether the request has been accepted for review. *We* will provide any information requested by the *Director* or Commissioner within seven (7) business days after *we* receive written notice of the external review request.
6. For *grievances* regarding *adverse decisions*, if the request is accepted, the *Director* will assign the external review to a certified IRO (Independent Review Organization) for review.
7. The IRO will schedule and hold a hearing within fifteen (15) business days after receipt of the request. All recommendations of the IRO will be in writing and approved by the medical director of the IRO. The final determination will:
 - (a) Reference the specific terms and standards, including interpretive guidelines, upon which the final decision is based; and
 - (b) State in detailed, clear, and understandable language the specific factual basis for the decision.
8. Within five (5) business days of the receipt of the IRO's recommendation from the *Director*, *we* will submit a written report to the *Director* and the *covered person* or *covered person's representative* indicating whether *we* will accept or reject the IRO's recommendations. In the case of rejection, *we* will indicate in writing to the *Director* *our* basis for rejection.

MGR04528

EXPEDITED MEDICAL REVIEW (for all levels of review for *adverse decisions*)

1. An expedited medical review will be conducted for an *adverse decision* involving emergency or urgent medical condition if:
 - (a) The *adverse decision* is rendered for health care or services that are proposed but have not been delivered; and
 - (b) The services are necessary to treat a condition or illness that, without prompt or immediate medical attention, would place the health of the individual in serious jeopardy, result in serious impairment to bodily functions, result in serious dysfunction of any bodily organ or jeopardize the life or health of the *covered person* or their ability to regain maximum function, or cause the *covered person* to be a danger to self or others.
2. For all types of review, a final *grievance* decision for an emergency or urgent medical condition case will be rendered within twenty-four (24) hours after the *grievance* was filed.
3. For both informal and formal internal review of emergency or urgent medical conditions *we* or *our* Review Agent will notify the *covered person* or *covered person's representative* of any *adverse decision* in writing within one (1) business day after the decision has been orally communicated to the *covered person* or *covered person's representative*.
4. In emergency or urgent medical condition cases, a request for an external review may be filed with the *Director* if a *grievance* decision reached in an informal or formal internal review is not rendered within twenty-four (24) hours of the filing of the *grievance*.
5. A *covered person* or *covered person's representative* may file a *grievance* regarding an *adverse decision* without first exhausting *our* internal review process in the case of an emergency or urgent medical condition, if the *grievance* demonstrates to the *Director* a compelling reason to do so. The *grievance* must show that the potential delay in receipt of a health care service until the *covered person* exhausts the internal *grievance* process could result in loss of life, serious impairment to bodily function, serious dysfunction of a bodily organ, or the *covered person* remaining seriously mentally ill with symptoms that cause the *covered person* to be a danger to self and others, or the review is from an emergency grievance which *we* did not resolve within twenty-four (24) hours.

6. After external review by an IRO for emergency or urgent medical conditions, the *Director* will send notice to all parties of the IRO's recommendations within twenty-four (24) hours after the *Director* has informed the *covered person* or *covered person's representative* and *us* of the recommendation through oral communication.

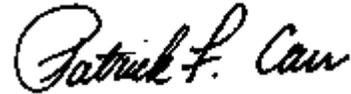
MGR04263

This endorsement applies only to *covered persons* who reside in the District of Columbia.

This endorsement will not change, waive or extend any part of the *policy/certificate*, other than as stated herein.

This endorsement is effective on September 1, 2012 or at the same time as the *policy/certificate*, whichever is later.

Golden Rule Insurance Company

A handwritten signature in black ink that reads "Patrick F. Caw". The signature is written in a cursive style with a large initial "P".

President

MGR03441

DISTRICT OF COLUMBIA ENDORSEMENT

By attachment of this endorsement, the *policy/certificate* is amended to the extent of any conflict with the following:

MGR03433

A. The Definitions section is amended as follows:

1. The definition of *eligible child* is amended to include a minor grandchild, niece, or nephew if:

- (a) A *covered person* is responsible for the *primary care* of the minor grandchild, niece, or nephew; and
- (b) The legal guardian of the minor grandchild, niece, or nephew is not covered by an accident or sickness policy.

MGR04143

2. The definition of *emergency* is deleted and replaced with the following:

"Emergency" means the sudden onset or worsening of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent lay person, who possesses an average knowledge of health and medicine to result in:

- (a) Placing the patient's health in serious jeopardy;
- (b) Serious impairment to bodily functions; or
- (c) Serious dysfunction of any bodily organ or part.

"Emergency" treatment shall include:

- (a) Health care services furnished in the Emergency Department of a hospital for the treatment of a medical *emergency*;
- (b) *Ancillary services* routinely available to the Emergency Department of a hospital for the treatment of a medical *emergency*; and
- (c) Emergency medical services transportation.

MGR04199

3. The definition of *terminally ill* shall mean that a *doctor* has given a prognosis that a *covered person* has twelve months or less to live.

MGR04236

4. The following definitions are added:

"Ancillary services" means standard medical procedures that are reasonably necessary for the diagnosis and treatment of a patient.

MGR04200

"Approved clinical trial" means:

- (a) A clinical research study or clinical investigation approved or funded in full or in part by one or more of the following:
 - (i) The National Institutes of Health;
 - (ii) The Centers for Disease Control and Prevention;
 - (iii) The Agency for Health Care Research and Quality;
 - (iv) The Centers for Medicare and Medicaid Services;
- (v) A bona fide clinical trial cooperative group, including the National Cancer Institute Clinical Trials Cooperative Group, the National Cancer Institute Community Clinical Oncology Program, the AIDS Clinical Trials Group, and the Community Programs for Clinical Research in AIDS; or

- (vi) The Department of Defense, the Department of Veterans Affairs, or the Department of Energy, or a qualified nongovernmental research entity to which the National Cancer Institute has awarded a support grant;
- (b) A study or investigation approved by the Food and Drug Administration ("FDA"), including those conducted under an investigational new drug or device application reviewed by the FDA; or
- (c) An investigation or study approved by an Institutional Review Board registered with the Department of Health and Human Services that is associated with an institution that has a federal-wide assurance approved by the Department of Health and Human Services specifying compliance with 45 C.F.R. Part 46.

MGR04269

"Congenital or genetic birth defect" means a defect existing at or from birth, including a hereditary defect. The term includes autism or an autism spectrum disorder and cerebral palsy.

"Habilitative services" means services, including occupational therapy, physical therapy, and speech therapy, for the treatment of a child with a *congenital or genetic birth defect* to enhance the child's ability to function.

"Hearing impairment" means a dysfunction of the auditory system, of any type of degree, which is sufficient to interfere with the acquisition and development of speech and language skills, with or without the use of sound amplification.

"Outpatient treatment facility" means a clinic, counseling center, or other similar establishment that is certified as a provider of outpatient services for the treatment of drug abuse, alcohol abuse, or *mental disorders*. *Outpatient treatment facility* includes a facility operated by the District, any state or territory, or the United States to provide these services on an outpatient basis.

"Primary care" means providing food, clothing, and shelter on a regular and continuous basis for the minor grandchild, niece, or nephew during the time that the District of Columbia public schools are in regular session.

MGR04200

"Qualified individual" means a *covered person* who is eligible to participate in an *approved clinical trial* for purposes of prevention, early detection, treatment, or monitoring of cancer, chronic disease, or life-threatening *illness*.

MGR04270

"Routine patient care costs" means items, drugs and services:

- (a) That are typically provided absent a clinical trial;
- (b) Required solely for the provision of the investigational item or service (such as the administration of a non-covered chemotherapeutic agent), the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; and
- (c) Needed for reasonable and necessary care arising from the provision of an investigational item or service, including the diagnosis or treatment of complications.

Routine patient care costs shall not include:

- (a) The cost of tests or measurements conducted primarily for the purpose of the clinical trial involved or items, drugs, or services provided solely to satisfy data collection and analysis needs; or
- (b) Items, drugs, or services customarily provided by the research sponsors free of charge for any *qualified individual* enrolled in the trial.

MGR04271

- B. Under Policyholder Provisions, the subsection entitled Premium is amended. Sex of *covered persons* will not be a factor in determining *your* premium rates.

MGR04606

- C. The Medical Benefits provision is amended as follows:

1. Benefits provided for mammograms and pap smears shall be exempt from any *deductible amount*, copayment or coinsurance.

MGR04148

2. *Covered expenses* shall include equipment, supplies and outpatient self-management training and education, including medical nutrition therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin using diabetes.

MGR04187

3. *Covered expenses* shall include *hospital* expenses for childbirth in accordance with the Newborns' and Mothers' Health Protection Act detailed in *your policy/certificate*. Upon release from the *hospital*, *covered expenses* shall include charges incurred for one home visit from a registered nurse provided in accordance with generally accepted standards of nursing practice for home care of a mother and newborn child and shall include services required by the mother's attending physician.

If a mother and newborn child are hospitalized for less than 48 hours following an uncomplicated vaginal delivery or less than 96 hours following a delivery by cesarean section, *covered expenses* shall be expanded to include:

- (a) One home visit scheduled to occur within 24 hours after hospital discharge; and
- (b) An additional home visit if prescribed by the mother's attending physician.

In addition, if the mother is required to remain hospitalized for medical reasons following childbirth, *covered expenses* shall include *hospital* charges for the infant to remain with the mother for up to four days.

MGR04608

4. *Covered expenses* are expanded to include charges incurred for:
 - (a) *Habilitative services* provided to an *eligible child* under 21 years of age, unless these services are provided through early intervention or school services; and

MGR04201

- (b) *Routine patient care costs* of health care services, items, or drugs for a *qualified individual* participating in an *approved clinical trial* if the service, item, or drug would have been a *covered expense* had it not been administered in a clinical trial.

MGR04272

- (c) *Inpatient* diagnosis and treatment of *mental disorders*, including *substance abuse*.

MGR04483

5. **LIMITED OUTPATIENT TREATMENT OF MENTAL DISORDERS:** *Covered expenses* for the diagnosis or treatment of a *mental disorder* on an outpatient basis will be limited to 40 visits per calendar year at a certified *outpatient treatment facility* payable at 75% coinsurance. Additional outpatient visits in each calendar year shall be payable at 60% coinsurance.

MGR04484

6. **LIMITED OUTPATIENT TREATMENT OF SUBSTANCE ABUSE:** *Covered expenses* for the diagnosis or treatment of *substance abuse* on an outpatient basis will be limited to 40 visits per calendar year at a certified *outpatient treatment facility* or office of a licensed physician, psychologist, or social worker payable at 75% coinsurance. Additional outpatient visits in each calendar year shall be payable at 60% coinsurance.

MGR04485

- D. Benefits shall not be excluded for an *injury, illness* or condition sustained by a *covered person* based solely on the fact that it was sustained as a result of the *covered person* being intoxicated or under the influence of a narcotic.

MGR04150

- E. Under the Preexisting Conditions and Limitations provision, the definition of *preexisting condition* is deleted and replaced with the following:

A "*preexisting condition*" means an *injury* or *illness*:

1. For which the *covered person* received medical advice or treatment within the 24 months immediately preceding the applicable *effective date* the *covered person* became insured under the *policy*; or
2. Which, in the opinion of a qualified *doctor*:
 - (a) Probably began prior to the applicable *effective date* the *covered person* became insured under the *policy*; and
 - (b) Manifested symptoms which would cause a person to seek diagnosis or treatment within the 12 months immediately preceding the applicable *effective date* the *covered person* became insured under the *policy*.

MGR04237

- F. Under Uniform Provisions, the subsection Misstatement of Age or Sex is amended to read as follows:

MISSTATEMENT OF AGE: If *your age*, or *your dependent's age*, has been misstated, the benefits may be adjusted based on the relationship of the premium paid to the premium that should have been paid based on the correct age.

MGR04607

Except as specifically stated in this endorsement, the benefits under this endorsement are subject to all of the terms, conditions, exclusions, limitations and notification requirements of the *policy/certificate*, including any applicable *deductible amounts*, coinsurance provisions, copay amounts, or dollar limits.

MGR03440

This endorsement applies only to *covered persons* who reside in the District of Columbia.

This endorsement will not change, waive or extend any part of the *policy/certificate*, other than as stated herein.

This endorsement is effective on September 1, 2012 or at the same time as the *policy/certificate*, whichever is later.

Golden Rule Insurance Company



President

MGR03441

ILLINOIS ENDORSEMENT

By attachment of this endorsement, the *policy/certificate* is amended to the extent of any conflict with the following:

MGR03433

A. The Definitions section is amended as follows:

1. The definition of *eligible child* is expanded to include an unmarried *dependent* under 30 years of age, providing the *eligible child*:

- (a) Is an Illinois resident;
- (b) Served as a member of the United States Armed Forces;
- (c) Has received a release or discharge other than dishonorable discharge; and
- (d) Has submitted a copy of his/her form DD2-14 Certificate of Release or Discharge from active Duty to *us* stating the date on which the *dependent* was released from service.

Upon *your* initial enrollment under the *policy/certificate*, *you* may enroll *your* eligible dependent child during the 90-day period immediately following *your effective date* of coverage. Thereafter, Illinois insureds may enroll an eligible dependent child during the 30-day open enrollment period beginning May 1st of each calendar year. Proof must be provided that the *eligible child*:

- (a) Has not been uninsured for more that 63 days prior to the enrollment; and
- (b) Was previously insured for a period of 90 continuous days.

MGR04411

2. The definition of *spouse* is expanded to include a partner in a civil union. A partner in a civil union is entitled to the same rights and benefits under the *policy* as a *spouse*.

MGR04615

3. The following definitions are added:

"*At risk for ovarian cancer*" means:

- (a) A female *covered person* having a family history of: (1) one or more first-degree relatives with ovarian cancer; (2) two or more female relatives with breast cancer; or (3) nonpolyposis colorectal cancer; or
- (b) A female *covered person* testing positive for BRCA1 or BRCA2 mutations.

MGR03924

"*Customized orthotic device*" means a supportive device for the body or a part of the body, the head, neck or extremities.

Customized orthotic device shall not include foot orthotics defined as a device inserted into the shoe designed to support the structural components of the foot during weight-bearing activities.

MGR04609

"*Habilitative services*" means occupational therapy, physical therapy, speech therapy, and other services prescribed by the *covered person's doctor* pursuant to a treatment plan to enhance the ability of a child to function with a congenital, genetic, or early acquired disorder. A congenital, genetic, or early acquired disorder includes, but is not limited to:

- (a) Hereditary disorders;
- (b) A disorder resulting from *illness, injury*, or some other event or condition suffered by a child prior to that child developing functional life skills such as, but not limited to, walking, talking, or self-help skills; or
- (c) *Autism* or an *autism spectrum disorder*, cerebral palsy, and other disorders resulting from early childhood *illness, trauma, or injury*.

Habilitative services do not include treatment of *mental disorders* other than congenital, genetic, or early acquired disorders.

MGR04360

"*Outpatient contraceptive services*" means consultations, examinations, procedures, and medical services, provided on an outpatient basis and related to the use of contraceptive methods (including natural family planning) to prevent an unintended pregnancy.

MGR03563

"*Pain therapy*" means therapy that is medically based and includes reasonably defined goals, including, but not limited to, stabilizing or reducing pain, with periodic evaluations of the efficacy of the pain therapy these goals.

MGR04440

"*Prosthetic device*" means an artificial device to replace, in whole or in part, an arm or leg. *Prosthetic device* shall include accessories essential to the effective use of the device.

MGR04610

"*Routine patient care*" means all health care services provided in the qualified clinical cancer trial that are otherwise generally covered under the *policy* if those items or services were not provided in connection with a qualified clinical cancer trial consistent with the standard of care for the treatment of cancer, including the type and frequency of any diagnostic modality, that a provider typically provides to a cancer patient who is not enrolled in a qualified clinical cancer trial.

Routine patient care does not include coverage for any of the following:

- (a) A health care service, item, or drug that is the subject of the cancer clinical trial;
- (b) A health care service, item or drug provided solely to satisfy data collection and analysis needs for the qualified clinical cancer trial that is not used in the direct clinical management of the patient;
- (c) An investigational drug or device that has not been approved for market by the United States Food and Drug Administration;
- (d) Transportation, lodging, food, or other expenses for the *covered person* or family member or companion of the *covered person* that are associated with the travel to or from a facility providing the qualified clinical cancer trial, unless the *policy* covers these expenses for a *covered person* who is not enrolled in a qualified clinical cancer trial.
- (e) A health care service, item or drug customarily provided by the qualified clinical cancer trial sponsors free of charge for any patient.
- (f) A health care service or item, which except for the fact that it is being provided in a qualified clinical cancer trial, is otherwise specifically excluded from coverage under the *covered person's policy*, including:
 - (i) Costs of extra treatments, services, procedures, tests, or drugs that would not be performed or administered except for the fact that the insured is participating in the cancer clinical trial; and
 - (ii) Costs of non-health care services that the *covered person* is required to receive as a result of participation in the approved cancer clinical trial;
- (g) Cost for services, items, or drugs that are eligible for reimbursement from a source other than a *covered person's policy* providing for third-party payment or prepayment of health or medical expenses, including the sponsor of the approved cancer clinical trial; or

- (h) Costs associated with approved cancer clinical trials designed exclusively to test toxicity or disease pathophysiology, unless the *policy* covers these expenses for a *covered person* who is not enrolled in a qualified clinical cancer trial; or
- (i) A health care service or item that is eligible for reimbursement by a source other than the *covered person's policy*, including the sponsor of the qualified clinical cancer trial.

MGR04570

"*Surveillance tests for ovarian cancer*" means annual screening using; (A) CA-125 serum tumor marker testing; (B) transvaginal ultrasound; or (C) pelvic examination.

MGR03924

- B. A *covered person* covered under a plan with a UnitedHealthcare network has the right to:
 - 1. Request a description of the financial relationships between *us* and any *network provider*;
 - 2. Request the percentage of copayment, deductibles, and total premiums spent on health care related and administrative expenses; and
 - 3. Obtain information from the *covered person's network provider* about the *network provider's* education, experience, training, specialty, board certificate (if applicable), licensure, continuing education, and names of network facilities where he or she has privileges.

MGR03915

- C. *Covered expenses* are expanded to include charges incurred for the following:

- 1. *Inpatient* treatment of alcoholism.

MGR03496

- 2. *Outpatient contraceptive services* and United States Food and Drug Administration approved outpatient contraceptive devices to the extent required by state or federal law.

MGR03632

- 3. *Surveillance tests for ovarian cancer* for female *covered persons* who are *at risk for ovarian cancer*.
- 4. One annual FDA-approved test or screening for the detection of the human papillomavirus.

MGR03925

- 5. *Habilitative services* for *covered persons* under the age of 19 years diagnosed by a *doctor* with a congenital, genetic, or early acquired disorder. Upon the referral of the *covered person's doctor*, treatment may be administered by a *doctor*, licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist, licensed nurse, licensed optometrist, licensed nutritionist, licensed social worker, or licensed psychologist.

MGR04361

- 6. *Medically necessary* amino acid-based elemental formulas, regardless of the delivery method, for the diagnosis and treatment of eosinophilic disorders and short bowel syndrome.

MGR04202

- 7. *Customized orthotic devices* and *prosthetic devices*. *Covered expenses* shall include the replacement or repair of the device when *medically necessary* based on the *covered person's* physical condition, unless necessitated by misuse or loss.

MGR04611

8. Pain medication and *pain therapy* related to the treatment of breast cancer for a *covered person* to the same extent as any other *illness*.

MGR04439

9. For oral anti-cancer medication subject to the same cost-sharing requirements as intravenous or injected anti-cancer medication, regardless of the setting in which the medication is administered.

Covered expenses for oral anti-cancer medication shall be subject to the deductible coinsurance or copayment amount as other medical services under the *policy/certificate*. Such expenses shall not be subject to an additional deductible, coinsurance, copayment amount, or any other cost-sharing amount specific to outpatient prescription drugs.

MGR04567

10. *Routine patient care* incurred by a *covered person* for cancer treatment in a qualified clinical cancer trial to the same extent that *policy/certificate* provides coverage for *routine patient care* for a *covered person* who is not enrolled in a qualified clinical cancer trials if:

- (a) The qualified cancer clinical trial meets the following criteria:
- (i) The effectiveness of the treatment has not been determined relative to established therapies;
 - (ii) The trial is under clinical investigation as part of an approved cancer research trial in Phase II, Phase III, or Phase IV of investigation;
 - (iii) The trial is:
 - (a) Approved by the Food and Drug Administration; or
 - (b) Approved and funded by:
 - A. The National Institutes of Health;
 - B. The Centers for Disease Control and Prevention;
 - C. The Agency for Healthcare Research and Quality;
 - D. The United States Department of Defense;
 - E. The United States Department of Veterans Affairs; or
 - F. The United States Department of Energy.

in the form of an investigational new drug application, or a cooperative group or center of any entity listed above; and

- (iv) The patient's *doctor* is involved in the coordination of care.

Coverage of *routine patient care* is subject to all terms, conditions, restrictions, exclusions, and limitations that apply to the same *routine patient care* received by an insured not enrolled in a qualified clinical cancer trial, including the application of any authorization requirement, utilization review, or medical management practices. The insured or enrollee shall incur no greater out-of-pocket liability than had the insured or enrollee not enrolled in a qualified clinical cancer trial.

MGR04572

- D. Breast cancer screenings, limited to the following:
- (a) One routine mammography examination per calendar year for female *covered persons*;

- (b) Additional mammograms at the intervals considered to be *medically necessary* by the *covered person's* health care provider for women with a family or personal history of, positive genetic testing for, or other risk factors for breast cancer; and
- (c) A comprehensive ultrasound screening of the breast(s) when a mammogram demonstrates heterogeneous or dense breast tissue.

Covered expenses for these services shall be exempt from *deductible amounts*, *copayment amounts*, and coinsurance when provided by a *network provider*.

MGR04702

Except as specifically stated in this endorsement, the benefits under this endorsement are subject to all of the terms, conditions, exclusions, limitations and notification requirements of the *policy/certificate*, including any applicable *deductible amounts*, coinsurance provisions, copay amounts, or dollar limits.

MGR03440

This endorsement applies only to *covered persons* who reside in the state of Illinois.

This endorsement will not change, waive or extend any part of the *policy/certificate*, other than as stated herein.

This endorsement is effective September 1, 2012 or at the same time as the *policy/certificate*, whichever is later.

**Golden Rule Insurance
Company**



President

MGR03441

Illinois Appeal Procedures Notice Endorsement

By attachment of this endorsement, the *policy/certificate* is amended to the extent of any conflict with the following:

MGR03433

A. ILLINOIS APPEAL PROCEDURES NOTICE

A *covered person* or an authorized person (a person or health care provider acting on behalf of a *covered person*) may file an appeal for claim denials, adverse medical necessity determinations, and administrative complaints.

1. **FOR CLAIM DENIALS:** The appeal may be filed orally or in writing. Golden Rule or Golden Rule's Review Agent will advise the party filing the appeal within three business days what information is needed. If a delay would greatly increase the risk to the *covered person's* health, Golden Rule or Golden Rule's Review Agent will contact the party within 24 hours. Upon receiving the requested information, Golden Rule or Golden Rule's Review Agent will make a decision within 15 business days (24 hours for an expedited review). The review will be performed by a clinical peer chosen by Golden Rule or Golden Rule's Review Agent. The decision will be provided orally and in writing.
2. **FOR ADVERSE MEDICAL NECESSITY DETERMINATIONS:** The appeal must be filed within 30 days of receiving the adverse determination. It must include any supporting information. Golden Rule will, within 30 days after receiving the appeal:
 - (a) Provide a means for Golden Rule and the *covered person* or authorized person to select an external reviewer;
 - (b) Provide a list of at least three reviewers; and
 - (c) Send all relevant information to the selected reviewer.

The reviewer must make a decision within five days after receiving all needed information. (Golden Rule will try to resolve expedited external reviews within 24 hours after receiving all information.) Golden Rule will pay the external reviewer's fees. The external reviewer will be a clinical peer who has no direct financial interest in the case and who does not know the identity of the *covered person*.

3. **FOR ADMINISTRATIVE COMPLAINTS:** For all appeals other than those regarding claim denials or adverse medical necessity determinations, a *covered person* or authorized person may file an appeal with Golden Rule. If not satisfied with Golden Rule's response, the *covered person* may appeal to the Illinois Department of Insurance (DOI). The DOI will inform Golden Rule of the complaint. Golden Rule must respond to the DOI within 21 days.

To file an appeal with Golden Rule:

Golden Rule Insurance Company
712 Eleventh Street
Lawrenceville, IL 62439
Phone (800) 657-8205

To file an administrative complaint with
the Illinois DOI:

Illinois Department of Insurance
Consumer Division of Public Services Section
320 West Washington Street
Springfield, IL 62761-0001

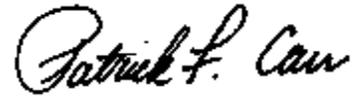
MGR03916

This endorsement applies only to *covered persons* who reside in the state of Illinois.

This endorsement will not change, waive or extend any part of the *policy/certificate*, other than as stated herein.

This endorsement is effective on September 1, 2012 or at the same time as the *policy/certificate*, whichever is later.

Golden Rule Insurance Company

A handwritten signature in black ink that reads "Patrick F. Carr". The signature is written in a cursive style with a large initial 'P'.

President

MGR03441

INDIANA ENDORSEMENT

By attachment of this endorsement, the *policy*/certificate is amended to the extent of any conflict with the following:

MGR03433

- A. Under the Definitions provision the following is added:

"Clean claim" means a claim submitted by a *provider* for payment that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment.

MGR03807

"Provider" means (for purposes of its use in the Time for Payment of Claims provision) an individual or entity duly licensed or legally authorized to provide health care services.

MGR03808

- B. The Eligibility provision is amended as follows:

We may ask for proof of the *eligible child's* incapacity and dependency annually. This continued coverage will end on:

1. The date the *policy* ends;
2. The date all coverage for *you* and *your dependents* ends;
3. The date the incapacity or dependency ends;
4. The last day of the premium period for which premium was paid, if premium for the subsequent premium period is not paid when due; or
5. The date a *covered expense* is incurred if, as part of the required *proof of loss*, we ask for proof of the child's incapacity and dependency, and the *primary insured* fails to provide proof that, as of the date the expense was incurred, the child remained incapacitated and dependent.

MGR04676

- C. The following subsection is added:

Adding an Adopted Child: An *eligible child* placed for adoption with *you* or *your spouse* will be considered a *covered person*. Coverage will be effective upon the earlier of: (A) the date of placement for the purpose of adoption; or (B) the date of the entry of an order granting *you* or *your spouse* custody of the child for the purposes of adoption. If the placement is disrupted prior to legal adoption and the child is removed from *your* custody, the child will no longer be an *eligible child* as of the date placement is disrupted.

Coverage for an adopted child or a child placed with *you* for adoption pursuant to a court order/decreed, will terminate on the 31st day after placement if the proper notification and premium are not received by the 31st day after placement.

MGR04516

- D. *Covered expenses* for the treatment of diabetes are deleted and replaced with the following:

1. *Medically necessary* supplies and equipment for the treatment of insulin-using diabetes, non-insulin-using diabetes, and elevated blood glucose levels induced by gestational diabetes or by another medical condition; and
2. *Medically necessary diabetes self-management training* ordered by a *doctor* and provided by a licensed, registered, or certified health care professional limited to:
 - (a) One visit after initially receiving a diagnosis of diabetes;
 - (b) One visit after receiving a diagnosis by a *doctor* that represents a significant change in the patient's symptoms or conditions making changes in the *covered person's* self-management *medically necessary*; and
 - (c) One visit for reeducation or refresher education.

MGR03576

- E. *Covered expenses* for breast cancer screenings shall include any additional mammography views that are required for proper evaluation.

MGR04531

- F. *Covered expenses* for physical medicine and rehabilitative services are expanded to include costs incurred by a *covered person* for those otherwise covered services when performed by an athletic trainer who is licensed under Indiana law and performing services within the scope of that license.

MGR04565

- G. The Preexisting Conditions and Limitations provision is amended as follows:

"Preexisting condition" means an *injury or illness*:

1. For which medical advice, diagnosis, care or treatment was recommended or received during the twelve (12) months immediately preceding the *effective date* of coverage under the *policy*;
2. That would have caused an ordinarily prudent person to seek medical advice, diagnosis, care or treatment during the twelve (12) months immediately preceding the *effective date* of coverage under the *policy*; or
3. A *pregnancy* existing on the *effective date* of coverage under the *policy*.

MGR04042

If a *covered person* applied for this coverage within 30 days of termination of the *covered person's* coverage under a health plan provided by a small employer, the *covered person* will be entitled to credit against the 12 month *preexisting condition* exclusion. The *preexisting condition* exclusion contained in the *policy/certificate* will be reduced by the number of months that the *covered person* was continuously covered under the prior small employer plan.

MGR04125

- H. The **CONDITIONS PRIOR TO LEGAL ACTION** provision is hereby deleted and replaced with the following:

On occasion, *we* may have a disagreement related to coverage, benefits, premiums or other provisions under the *policy*. Litigation is an expensive and time-consuming way to resolve these disagreements and should be the last resort in a resolution process. Therefore, with a view to avoiding litigation, *you* must give written notice to *us* of *your* intent to sue *us* as a condition prior to bringing any legal action. *Your* notice must identify the coverage, benefit, premium or other disagreement, refer to the specific *policy* provision(s) at issue, and include all relevant facts and information that support *your* position.

MGR03746

- I. The Time for Payment of Claims provision is deleted and replaced with the following:

Provider Submitted Claims: Within 30 days of *our* receipt of an electronically filed claim from *your provider*, *we* will:

- (a) Notify the *provider* of any additional information necessary to make the claim a *clean claim*;
or
- (b) Pay or deny a *clean claim*.

Within 45 days of *our* receipt of a paper claim submitted by *your provider*, *we* will:

- (a) Notify the *provider* of any additional information necessary to make the claim a *clean claim*;
or
- (b) Pay or deny a *clean claim*.

If *we* fail to process the claim in accordance with these time frames, *we* will pay interest from the date the applicable time frame ended through the date the claim is paid at the interest rate required by Indiana state law under IC 12-15-21-3(7)(A).

MGR04179

Insured Submitted Claims: Benefits payable for *covered expenses* will be paid within 45 days of the date that *you provide us* with written *proof of loss*.

MGR04186

Except as specifically stated in this endorsement, the benefits under this endorsement are subject to all of the terms, conditions, exclusions, limitations, and notification requirements of the *policy/certificate*, including any applicable *deductible amounts*, coinsurance provisions, copay amounts, or dollar limits.

MGR03440

This endorsement applies only to *covered persons* who reside in the state of Indiana.

This endorsement will not change, waive or extend any part of the *policy/certificate* other than as stated herein.

This endorsement is effective on September 1, 2012 or at the same time as the *policy/certificate*, whichever is later.

Golden Rule Insurance Company

A handwritten signature in black ink that reads "Patrick F. Caw". The signature is written in a cursive style with a large initial "P".

Secretary

MGR03441

INDIANA GRIEVANCE ENDORSEMENT

By attachment of this endorsement, the *policy/certificate* is amended to the extent of any conflict with the following:

MGR03433

- A. "*Grievance*" means any dissatisfaction expressed orally or in writing by or on behalf of a *covered person* regarding:
1. A determination that a proposed service is not appropriate or *medically necessary*, or
 2. A determination that a proposed service is experimental or investigational; or
 3. The availability of participating providers; or
 4. The handling or payment of claims; or
 5. Matters pertaining to the contractual relationship between Golden Rule Insurance Company ("GRIC") and a *covered person* and for which the *covered person* has a reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of the dissatisfaction.

MGR03806

- B. The following subsection is added:

1. **General Information for All Grievances**

- (a) A *covered person* or a *covered person's* representative may seek review of *grievances* either orally or in writing by contacting:

For *grievances* regarding decisions by Golden Rule's Review Agent:

For insureds with UnitedHealthcare network plans:

CARE Programs
500 Colvin Woods Parkway
Tonawanda, NY 14150
Phone: 800-999-3404

For insureds with all other plans:

Appeals Coordinator
Encompass, Inc.
1776 West Lakes Parkway
West Des Moines, IA 50266
Phone: 515-223-2983
Fax: 515-223-2990

For *grievances* regarding decisions by Golden Rule for all plans:

Grievance Administrator
Golden Rule Insurance Company
712 Eleventh Street
Lawrenceville, IL 62439
Phone: (800) 657-8205
Fax: 618-943-3148

- (b) An acknowledgment to the *covered person*, orally or in writing, will be completed within five (5) business days after receipt of the *grievance*. The review will be resolved as quickly as possible, but not more than twenty (20) business days after receiving all information reasonably necessary to complete the review. If a decision cannot be made within the twenty- (20-) day period due to circumstances beyond GRIC or its Review Agent's control, then, before the twentieth (20th) business day, the Review Agent or GRIC will notify the *covered person* in writing of the reason for the delay and issue a written decision regarding the review within an additional ten (10) business days.

- (c) The *covered person* will be notified in writing of the resolution of a *grievance* within five (5) business days after the review is complete. The resolution notice will include all of the following:
 - (i) The decision reached by GRIC or its Review Agent.
 - (ii) The reasons, policies, and procedures that are the basis of the decision.
 - (iii) The department, address, and telephone number of the department handling the *grievance*, through which a *covered person* may contact a qualified representative to obtain additional information about the decision and notice of any rights to further review.

MGR03747

2. For Medical Necessity Determinations Made by GRIC's Review Agent

- (a) A first-level review will be conducted by a health care professional, chosen by the Review Agent, who was not involved in the initial determination. If the medical condition requires an expedited decision, the Review Agent will expedite the review.
- (b) **Appeals:** In the event the results of the first level review are unsatisfactory to the *covered person*, the *covered person* has the right to appeal the Review Agent's decision to GRIC. GRIC will appoint a review panel.
 - (i) The panel must include one or more individuals who:
 - (a) Have knowledge of the medical condition, procedure, or treatment at issue; and
 - (b) Are licensed in the same profession and have similar specialty as the provider who proposed or delivered the health care procedure, treatment, or service; and
 - (c) Are not involved in the matter giving rise to the review or in the first level of review.
 - (d) Do not have a direct business relationship with the *covered person* or the health care provider who previously recommended the health care procedure, treatment, or service.
 - (ii) The *covered person* will be given the opportunity to appear in person before the panel or, if unable to appear in person, communicate with the panel. The *covered person* will be notified at least seventy-two (72) hours prior to the meeting of the panel.
 - (iii) The panel will meet during normal business hours and at a place convenient to the *covered person*.
 - (iv) The appeal will be resolved no later than forty-five (45) days after the review is requested.

MGR03748

- (c) **External Review:** In the event the appeal decision is unsatisfactory to the *covered person*, the *covered person* may, within forty-five (45) days after being notified of the resolution of the appeal, file a written request to GRIC for an external review by an independent review organization (IRO).
 - (i) An expedited external review will be conducted for a *grievance* related to an *illness*, disease, condition, *injury*, or disability if the time frame for a standard review would seriously jeopardize the *covered person's* life or health or ability to reach and maintain maximum function.
 - (ii) When a request for external review is filed, GRIC will:
 - (a) Select a different IRO for each external review filed from a list of IRO's that are certified by the Indiana Department of Insurance; and
 - (b) Rotate the choice of an IRO among all certified IRO's before repeating a selection.
 - (iii) The *covered person* will be required to submit twenty-five dollars (\$25) with the written request for external review.

- (iv) GRIC will cooperate with the IRO by promptly providing any information requested by the IRO.
 - (v) The IRO will:
 - (a) Make a standard external review determination within fifteen (15) business days after the request for external review is filed.
 - (b) Make an expedited external review determination within three (3) business days after the request for external review is filed.
 - (vi) When making the determination, the IRO will apply:
 - (a) Standards of decision making that are based on objective clinical evidence; and
 - (b) The terms of the *covered person's* insurance *policy/certificate*.
 - (vii) The IRO will notify GRIC and the *covered person* within twenty-four (24) hours after making an expedited external review determination and within seventy-two (72) hours for a standard external review.
 - (viii) If, at any time during an external review, the *covered person* submits information to GRIC that is relevant to GRIC's resolution during the internal review or appeals process, GRIC may reconsider the resolution under the internal review process.
 - (ix) If GRIC chooses to reconsider the IRO will cease the external review process until the reconsideration is completed. GRIC will notify the *covered person* of its decision within fifteen (15) business days after the information is submitted for standard review and seventy-two (72) hours after the information is submitted for an expedited review.
 - (x) If a decision reached is adverse to the *covered person*, the *covered person* may request that the IRO resume the external review. If GRIC chooses not to reconsider, GRIC will forward the submitted information to the IRO within two (2) business days after receipt of the information.
- (d) *Grievances* under Medicare Supplement policies are not eligible for external review.

MGR03749

3. **For Medical Necessity or Experimental/Investigational Determinations Made by GRIC**

- (a) A first-level review will be conducted by a health care professional chosen by GRIC who was not involved in the initial determination.
- (b) If the results of the above review remain unsatisfactory to the *covered person*, the *covered person* may request a second-level review. The second-level review will be the same as the appeal review described in section 2(b).
- (c) If the results of the second-level review are unsatisfactory to the *covered person*, the *covered person* may file a written request for an external review by an IRO. The procedures for external review are the same as described in section 2(c).

MGR03750

4. **For Network Related Grievances**

Grievances pertaining to a *covered person's* complaint regarding a provider's participation in a network and complaints regarding provider quality of care will be handled by the appropriate network.

MGR03751

5. **For All Other Grievances**

- (a) A request for reconsideration (RFR) will be handled by the original reviewer or a designated representative of the area responsible for the issue presented by the *grievance*.
- (b) An appeal of an RFR decision will be handled by GRIC management.

MGR03752

6. With regard to any *grievance* involving a determination of medical necessity, the *grievance* procedures applicable under this rider will be followed in lieu of any procedures that would otherwise be applicable under the Determination of Medical Necessity provision, if included in the *policy/certificate*.

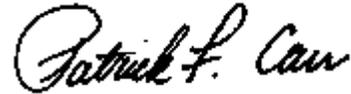
MGR03753

This endorsement applies only to *covered persons* who reside in the state of Indiana.

This endorsement will not change, waive or extend any part of the *policy/certificate* other than as stated herein.

This endorsement is effective on September 1, 2012 or at the same time as the *policy/certificate*, whichever is later.

Golden Rule Insurance Company

A handwritten signature in black ink that reads "Patrick F. Caw". The signature is written in a cursive style with a large initial "P".

Secretary

MGR03441

IOWA ENDORSEMENT

By attachment of this endorsement, the *policy/certificate* is amended to the extent of any conflict with the following:

MGR03433

A. The Definitions section is amended as follows:

1. The definition of *spouse* is amended to include a partner in a civil union or same sex marriage.

MGR04393

2. The following definitions are added:

"Approved cancer clinical trial" means a scientific study of a new therapy for the treatment of cancer in human beings that meets the requirements set forth in the Medical Benefits provision below and consists of the following:

- (a) A scientific plan of treatment that includes specified goals;
- (b) A rationale and background for the plan;
- (c) Criteria for patient selection;
- (d) Specific directions for administering therapy and monitoring patients;
- (e) A definition of quantitative measures for determining treatment response; and
- (f) Methods for documenting and treating adverse reactions.

MGR04431

"Routine patient care costs" means medically necessary services or treatments that are a benefit under a *policy/certificate* that would be covered if the *covered person* were receiving standard cancer treatment.

Routine patient care costs does not include any of the following:

- (a) Costs of any treatments, procedures, drugs, devices, services, or items that are the subject of the *approved cancer clinical trial* or any other investigational treatments, procedures, drugs, devices, services or items;
- (b) Costs of nonhealth care services that the *covered person* is required to receive as a result of participation in the *approved cancer clinical trial*;
- (c) Costs associated with managing the research that is associated with the *approved cancer clinical trial*;
- (d) Costs that would not be a *covered expense* if noninvestigational treatments were provided;
- (e) Costs of any services, procedures, or tests provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the *covered person* participating in an *approved cancer clinical trial*;
- (f) Costs paid for, or not charged for, by the *approved cancer clinical trial* providers;
- (g) Costs for transportation, lodging, food, or other expenses for the *covered person*, a family member, or a companion of the *covered person* that are associated with travel to or from a facility where an *approved cancer clinical trial* is conducted;
- (h) Costs for services, items, or drugs that are eligible for reimbursement from a source other than a *covered person's policy/certificate*, including the sponsor of the *approved cancer clinical trial*;
- (i) Costs associated with *approved cancer clinical trials* designed exclusively to test toxicity or disease pathophysiology; or
- (j) Costs of extra treatments, services, procedures, tests, or drugs that would not be performed or administered except for participation in the *approved cancer clinical trial*.

MGR04432

"*Therapeutic intent*" means that a treatment is aimed at improving a *covered person's* health outcome relative to either survival or quality of life.

MGR04433

- B. The Effective Date of Dependents Insurance provision is amended by the addition of the following subsection:

Adding an Adopted Child: An *eligible child* legally placed for adoption with *you* or *your spouse* will be covered from the *date of placement* until the 31st day after *placement* unless the *placement* is disrupted prior to legal adoption and the child is removed from *your* custody.

The child may continue as a *covered person* beyond the 31st day only if *we* have received notice of the adoption and any additional premium required for the addition of the child within 60 days of the *date of placement*. The required premium will be calculated from the *date of placement*.

"*Date of placement*" or "*placement*", when used in reference to an adoption, means the earlier of:

1. The date *you* assume physical custody of the child for the purpose of adoption;
2. The date of entry of an order granting *you* or *your spouse* custody of the child for the purpose of adoption; or
3. The effective date of adoption.

MGR04518

- C. The Medical Benefits provision is amended as follows:

1. Benefits for *diabetes self-management training* are deleted and replaced with the following:

For participation in a state certified *diabetes self-management training* program, limited to 10 hours in any 12 consecutive month period, and a one hour follow-up training session annually thereafter.

MGR03764

2. If included in *your policy/certificate*, the subsection entitled Limitation on Spine and Back Disorders is hereby deleted.

MGR03765

3. *Covered expenses* are expanded to include *routine patient care costs* incurred for cancer treatment in an *approved cancer clinical trial* to the same extent that the *policy/certificate* provides coverage for treating any other *illness, injury, disease* or condition covered under the *policy/certificate* if:

(a) The *covered person* has been referred for the cancer treatment by two (2) oncologists; and

(b) The *approved cancer clinical trial* meets the following criteria:

- (i) The treatment is provided with *therapeutic intent* and is authorized or approved by one of the following:

(a) The National Institutes of Health;

(b) The United States Food and Drug Administration;

(c) The United States Department of Defense; or

(d) The United States Department of Veterans Affairs.

- (ii) The proposed treatment has been reviewed and approved by the applicable qualified institutional review board.

- (iii) The available clinical or preclinical data indicate that the treatment will be at least as effective as the standard therapy and is anticipated to constitute an improvement in therapeutic effectiveness for the treatment of the disease in question.

MGR04434

- D. The Preexisting Conditions Limitation provision is amended as follows:

1. The definition of *preexisting condition* is amended to read as follows:

"Preexisting condition" means an *injury* or *illness*: (1) for which the *covered person* received medical advice or treatment within the 24 months immediately preceding the applicable *effective date* the *covered person* became insured under the *policy*; or (2) which, in the opinion of a qualified *doctor*, manifested symptoms which would cause an ordinarily prudent person to seek diagnosis or treatment within the 12 months immediately preceding the applicable *effective date* the *covered person* became insured under the *policy*.

MGR03766

2. If a *covered person's effective date* under this *policy/certificate* occurs within 63 days of termination of the *covered person's coverage* under any *qualifying prior coverage*, then that *covered person* will be entitled to credit under the Preexisting Conditions Limitation waiting period set forth in the *policy/certificate* for the same number of full months that the *covered person* was continuously covered under that *qualifying prior coverage*.

MGR03767

"Qualifying prior coverage" means coverage as defined under Iowa I.C. 513C.3.

MGR03768

- E. The Reimbursement provision is deleted and replaced by the following Subrogation provision:

SUBROGATION RIGHTS: For purposes of this provision, "*covered person*" will include anyone receiving payment under this *policy*, either directly or indirectly.

In the event of any payment under the *policy*, we will, to the extent of the payment, be subrogated to all the rights of recovery of the *covered person*, arising out of the acts or omissions of any person or organization. The *covered person* hereby agrees to reimburse us for any benefits paid hereunder, out of any monies recovered from any person or organization as the result of judgment, settlement or otherwise which exceeds the *covered person's actual loss*. The *covered person* also agrees to execute and deliver all necessary instruments, to furnish such information and assistance, and to take any action we may require to facilitate enforcement of our rights. The *covered person* will do nothing after a *loss* to prejudice our rights. We will participate, on a pro-rata basis, in the payment of any legal fees that are the result of a judgment or settlement from which we receive reimbursement for any benefits paid on behalf of the *covered person*.

This provision will not apply, however, to a recovery obtained by any *covered person* from any insurance company on a policy under which the *covered person* is entitled to benefits as a named insured person or an insured dependent of a named person.

MGR03776

Except as specifically stated in this endorsement, the benefits under this endorsement are subject to all of the terms, conditions, exclusions, limitations, and notification requirements of the *policy/certificate*, including any applicable *deductible amounts*, coinsurance provisions, copay amounts, or dollar limits.

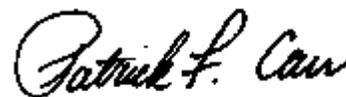
MGR03440

This endorsement applies only to *covered persons* who reside in the state of Iowa.

This endorsement will not change, waive or extend any part of the *policy/certificate* other than as stated herein.

This endorsement is effective on September 1, 2012 or at the same time as the *policy/certificate*, whichever is later.

Golden Rule Insurance Company



President

MGR03441

KENTUCKY ENDORSEMENT

By attachment of this endorsement, the *policy/certificate* is amended to the extent of any conflict with the following:

MGR03433

A. The Definitions section is amended as follows:

1. The definition of *eligible child* is amended to include a child for whom *you* or *your spouse* is a court-appointed guardian from the date of the filing of the application for appointment of guardianship with a court of competent jurisdiction.
2. The definition of *medical practitioner* is amended to include a pharmacist, an advanced registered nurse practitioner, a registered nurse first assistant, and a certified surgical assistant.

MGR03848

3. The following definitions are added:

- (a) "*Amino acid modified preparations*" means a product intended for the dietary treatment of an *inherited metabolic disease* under the direction of a *doctor*.
- (b) "*Inherited metabolic disease*" means phenylketonuria; hyperphenylalaninemia; tyrosinemia (types I, II, and III); maple syrup urine disease; a-ketoacid dehydrogenase deficiency; isovaleryl-CoA dehydrogenase deficiency; 3-methylcrotonyl-CoA carboxylase deficiency; 3-methylglutaconyl-CoA hydratase deficiency; 3-hydroxy-3-methylglutaryl-CoA lyase deficiency (HMG-CoA lyase deficiency); b-ketothiolase deficiency; homocystinuria; glutaric aciduria (types I and II); lysinuric protein intolerance; non-ketotic hyperglycinemia; propionic acidemia; gyrate atrophy; hyperornithinemia/hyperammonemia/homocitrullinuria syndrome; carbamoyl phosphate synthetase deficiency; ornithine carbamoyl transferase deficiency; citrullinemia; arginosuccinic aciduria; methylmalonic acidemia; and argininemia.

Inherited metabolic disease does not include lactose intolerance, protein intolerance, food allergy, food sensitivity, or any other condition not listed above.

- (c) "*Low-protein modified food product*" means a product formulated to have less than one gram of protein per serving and intended for the dietary treatment of an *inherited metabolic disease* under the direction of a *doctor*.

MGR03849

B. The Effective Date of Dependent's Insurance section is amended as follows:

1. The following is added to the Adding a Newborn provision:

The required premium will be calculated from the 31st day after the birth of the child. If the child's mother is a *covered person*, any calendar year *deductible amount* already met by the child's mother, will be considered as met for the newborn child.

2. The following two subsections are added:

Adding an Adopted Child: An *eligible child* legally placed for adoption with *you* or *your spouse* will be covered from the date of the filing of the petition for adoption, subject to the terms of the *policy*, until the 31st day after the date of the filing of the petition for adoption, unless the adoption is disrupted prior to the legal adoption and the child is removed from *your* or *your spouse's* physical custody. The child may continue as a *covered person* after the 31st day only if we have received both written notice of the child's pending adoption and any additional premium required.

Adding a Child Under Guardianship: An *eligible child* for whom *you* or *your spouse* is a court-appointed guardian will be covered from the date of the filing of the application for appointment of guardianship with a court of competent jurisdiction, subject to the terms of the *policy*, until the 31st day after that date, unless the guardianship is disrupted prior to the date the court appoints *you* or *your spouse* as guardian and the child is removed from *your* or *your spouse's* physical custody. The child may continue as a *covered person* after the 31st day only if we have received both written notice of the child's pending guardianship status and any additional premium required.

- C. The following is added to the Termination of Insurance and Renewability provision:
1. In the event of termination of insurance, we will promptly return any unearned portion of any premium paid. Termination of insurance will be without prejudice to any claim for expenses incurred prior to the date of termination.

- D. The Guaranteed Renewable subprovision of the Termination of Insurance and Renewability provision is amended by the addition of the following:
1. If we refuse renewal for failure to pay premiums when due, we will provide written notice to *you* at least 30 days prior to the date *your* coverage will be terminated. Written notice will be mailed to *you* by regular United States mail to *your* last address shown in *our* records. If premium has not been paid by the end of the 30-day period, *your* coverage will terminate on the last date through which premium was paid.
 2. If we fail to provide 30 days notice as described in this subprovision, *your* coverage will remain in effect until 30 days after the notice is given or until the effective date of replacement coverage, whichever occurs first. However, no benefits will be paid for expenses incurred during any period of time for which premium has not been paid.

- E. The *policy/certificate* is amended to clarify that *we* also may not refuse renewal of *your* certificate unless *you* engage in intentional and abusive noncompliance with material provisions of the *policy*.

- F. *Covered expenses* are expanded to include the following. Any dollar limits, visit limits, or exclusions specific to the following benefits otherwise stated in the *policy/certificate* and that conflict with the *covered expenses* stated below will not apply.
1. Surgical and non-surgical treatment of craniomandibular disorders, malocclusions, and disorders of the temporomandibular joint.
 2. Cochlear implants for a *covered person* who has been diagnosed with profound hearing impairment.
 3. One *hearing aid* per hearing-impaired ear for *covered persons* under 18 years of age, limited to \$1,400 per *covered person* in a 36-month period, and for all *related services*, prescribed by a licensed audiologist and provided by a licensed audiologist or hearing instrument specialist. As used in this paragraph:
 - (a) "*Hearing aid*" means any wearable, nondisposable instrument or device designed to aid or compensate for impaired human hearing, and any parts, attachments, or accessories, including earmolds, but excluding batteries and cords; and
 - (b) "*Related services*" means those services necessary to assess, select, and appropriately adjust or fit the *hearing aid* to ensure optimal performance.
 4. *Amino acid modified preparations*, limited to \$25,000 per *covered person* per calendar year, and *low-protein modified food products*, limited to \$4,000 per *covered person* per calendar year, prescribed for the therapeutic treatment of *inherited metabolic diseases* and administered under the direction of a *doctor*.
 5. Diagnosis and treatment of endometriosis or endometritis (not including expenses primarily for the treatment of infertility).
 6. Telehealth consultation services to the same extent as face-to-face consultation services, excluding services provided by the use of an audio-only telephone, facsimile machine, or electronic mail.
 7. General anesthesia and *hospital or outpatient surgical facility* charges for dental care provided to a *covered person* for whom the treating dentist or admitting *doctor* certifies that hospitalization or general anesthesia is required to safely and effectively provide dental care and who:

- (a) Is an *eligible child* under age nine (9) years; or
- (b) Has a *serious mental condition*, a *serious physical condition*, or a *significant behavioral problem*.

As used in this paragraph:

- (a) "*Serious mental condition*" or "*significant behavioral problem*" means a condition:
 - (i) Identified by a diagnostic code from the most recent edition of the:
 - (a) International Classification of Diseases -- Clinical Modification, ICD-9-CM, including only diagnosis codes ranging from 290 through 299.9, 300 through 316, and 317 through 319; or
 - (b) Diagnostic and Statistical Manual of Mental Disorders, DSM-IV; and
 - (ii) In a *covered person* whose:
 - (a) Inability to cooperate during dental care performed by a dentist in a location other than a *hospital* or *outpatient surgical facility* can reasonably be inferred from the *covered person's* diagnosis and medical history; or
 - (b) Airway, breathing, or circulation of blood may be compromised during dental care performed by a dentist in a location other than a *hospital* or *outpatient surgical facility*.
- (b) "*Serious physical condition*" means a disease or condition requiring ongoing medical care that may cause compromise of the airway, breathing, or circulation of blood of the *covered person* during dental care performed by a dentist in a location other than a *hospital* or *outpatient surgical facility*.

MGR03852

- G. *Covered expenses* for the treatment of diabetes and *diabetes self-management training services* are deleted and replaced with the following:

Covered expenses include the following charges incurred by a *covered person* for the treatment of insulin-dependent diabetes, insulin-using diabetes, non-insulin-using diabetes, or gestational diabetes, when prescribed by a legally authorized health care provider:

1. Medication, equipment, and supplies used in the treatment of diabetes; and
2. Outpatient self-management training and education, including medical nutrition therapy, provided by a certified, registered, or licensed health care professional with expertise in diabetes.

MGR03853

- H. In the Transplant Expense Benefits provision, the list of covered bone marrow transplants in the definition of *listed transplant* is amended to include *BMT* or *ABMT* for breast cancer.

MGR03854

- I. The Hospice Care Expense Benefits provision is amended as follows. Any dollar limits, visit limits, or exclusions specific to the following benefits otherwise stated in the *policy/certificate* and that conflict with the *covered expenses* stated below will not apply.

1. For the purposes of this Hospice Care Expense Benefits provision, the list of *covered expenses* in the Medical Benefits provision is expanded to include:
 - (a) Room and board in an *extended care facility* while the *covered person* is an *inpatient*;
 - (b) Medical social services provided by a social worker under the direction of a *doctor*;
 - (c) Respite care as an *inpatient* in a *hospice* for up to 5 consecutive days provided on an intermittent, nonroutine, and occasional basis; and
 - (d) *Home health aide services* and homemaker services during periods of crisis and only as necessary to maintain the *terminally ill covered person* at home.

MGR03863

2. *Covered expenses* under the Hospice Care Expense Benefits provision are not subject to any *deductible amounts* or coinsurance provisions.

MGR03886

3. **EXCLUSIONS AND LIMITATIONS:**

- (a) No payments will be made for expenses that are not provided as part of a *hospice care program* or that are provided as part of a *hospice care program* that begins after coverage under the *policy* ceases.

MGR03864

J. The General Exclusions and Limitations section is amended as follows:

1. The exclusion for charges incurred as a result of the *covered person's* commission of a felony is amended by deleting the phrase "whether or not charged."
2. The Waiting Period provision is amended by the addition of the following: Any waiting period will be reduced by the same number of full months that the *covered person* was continuously covered, without any lapse of 63 days or more, under prior *creditable coverage*.

MGR03914

K. The Preexisting Conditions Limitation provision is amended as follows:

1. "*Preexisting condition*" means an *injury* or *illness* for which medical advice, diagnosis, care, or treatment was recommended to or received by a *covered person* within the six (6) months immediately preceding the *covered person's* applicable *effective date*. If *your* certificate includes the optional Pregnancy Expense Benefits Rider, a *pregnancy* may be a *preexisting condition*. *Preexisting condition* does not include: (a) domestic violence or domestic abuse; or (b) genetic information in the absence of a diagnosis of a condition related to the genetic information.
2. If a *covered person's* *effective date* of coverage under the *policy/certificate* occurs within 63 days of termination of the *covered person's* coverage under any prior *creditable coverage*, that *covered person* will be entitled to credit against the 12-month *preexisting condition* limitation waiting period for the same number of full months that the *covered person* was continuously covered, without any lapse of 63 days or more, under prior *creditable coverage*.
3. "*Creditable coverage*" means coverage under any of the following:
 - (a) A group health plan;
 - (b) Health insurance coverage;
 - (c) Part A or Part B of Title XVIII of the Social Security Act (Medicare);
 - (d) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928 (Medicaid);
 - (e) Chapter 55 of Title 10 of the U.S. Code (CHAMPUS);
 - (f) A medical care program of the Indian Health Service or of a tribal organization;
 - (g) A state health benefit risk pool;
 - (h) A health plan offered under Chapter 89 of Title 5 of the U.S. Code (government employees);
 - (i) A public health plan (as defined in regulations);
 - (j) A health benefit plan under section 5(e) of the Peace Corps Act.
 - (k) Title XXI of the Social Security Act (State Children's Health Insurance Program).

"*Creditable Coverage*" does not include:

- (a) The following coverages:
 - (i) Coverage only for accident or disability income insurance, or any combination thereof;
 - (ii) Coverage issued as a supplement to liability insurance;
 - (iii) Liability insurance, including general liability insurance and automobile liability insurance;

- (iv) Worker's compensation or similar insurance;
 - (v) Automobile medical payment insurance;
 - (vi) Credit-only insurance;
 - (vii) Coverage for on-site medical clinics; or
 - (viii) Other similar insurance coverage under which benefits for medical care are secondary or incidental to other insurance benefits.
- (b) The following coverages if offered separately:
- (i) Limited scope dental or vision benefits;
 - (ii) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and
 - (iii) Similar, limited coverages as specified in regulations.
- (c) The following coverages if offered as independent noncoordinated coverages:
- (i) Coverage only for a specified disease or illness; and
 - (ii) Hospital indemnity or other fixed indemnity insurance.
- (d) The following coverages if offered as a separate policy:
- (i) Medicare supplement health insurance;
 - (ii) Coverage supplemental to the coverage provided under chapter 55 of Title 10 of the U.S. Code; and
 - (iii) Similar supplemental coverage provided to coverage under a *group health plan*.

MGR03882

- L. The Coordination of Benefits (COB) provision is hereby deleted and replaced with the following:

Some people have health care coverage through more than one *plan* at the same time. COB allows these *plans* to work together so that the total amount of all benefits will never be more than 100 percent of the *allowable expenses* during any calendar year. This helps to hold down the costs of health coverage. The order of benefit determination rules determine which *plan* will pay as the *primary plan* and which will be considered the *secondary plan*.

This Coordination of Benefits ("COB") provision applies to this *plan* when a *covered person* has health care coverage under more than one *plan*. COB does not apply to life insurance, accidental death and dismemberment, or disability benefits.

MGR03009

DEFINITIONS: As used in this provision, the following terms have the meanings set forth below:

MGR03110

1. "*Allowable expense*" means a health care service or expense, including deductibles and copayments, that is covered at least in part by any of the *plans* covering the person. When a *plan* provides benefits in the form of service, the reasonable cash value of each service will be considered as both an *allowable expense* and a benefit paid. An expense or service that is not covered by any of the *plans* is not an *allowable expense*. The following are examples of expenses or services that may not be *allowable expenses*:
 - (a) The difference between the cost of a semi-private and a private room in the *hospital*.
 - (b) Any amount in excess of the highest of the reasonable and customary fees allowed by any of the *plans* for a specific benefit.
 - (c) Any amount in excess of the highest negotiated fee determined by any of the *plans*.
 - (d) The amount that benefits are reduced under the *primary plan* because a *covered person* does not comply with the *plan* provisions.
2. "*Benefit reserve*" means the savings recorded for claims paid for a *covered person* under this *plan* as a *secondary plan* rather than as a *primary plan*.

3. "*Claim determination period*" means the 12-month calendar year. However, it does not include any part of a year during which a person has no coverage under this *plan*.
4. "*Closed panel plan*" is a *plan* that provides health benefits to *covered persons* primarily in the form of services through a panel of providers who have contracted with or are employed by the *plan* and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.
5. "*Custodial parent*" means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.
6. "*Plan*" includes any of the following that provides benefits or services for medical or dental care or treatment:
 - (a) Group insurance, or group-type coverage (whether insured or uninsured);
 - (b) Individual or family insurance;
 - (c) Hospital indemnity benefits in excess of \$200 per day;
 - (d) Medical care components of group long-term care contracts, such as skilled nursing care;
 - (e) Medical benefits under group or individual automobile contracts; and
 - (f) Medicare or other governmental benefits, as permitted by law.

Each contract for coverage is a separate *plan*. If a *plan* has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate *plan*.

7. "*Primary plan*" is the *plan* that pays first without regard to the possibility that another *plan* may cover some expenses.
8. "*Secondary plan*" is the *plan* that pays after the *primary plan*. The *secondary plan* may reduce the benefits it pays so that payments from all group *plans* do not exceed 100% of the total *allowable expenses*.

MGR03865

ORDER OF BENEFIT DETERMINATION RULES: When two or more *plans* pay benefits, the rules for determining the order of payment are as follows:

1. The *primary plan* pays or provides its benefits as if the *secondary plan* or *plans* did not exist.
2. A *plan* that does not have a COB provision will always be the *primary plan*. There is one exception: coverage that is obtained by virtue of membership in a group and that is designated to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the *plan* provided by the *policyholder*. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a *closed panel plan* to provide out-of-network benefits.
3. A *plan* may consider the benefits paid or provided by another *plan* in determining its benefits only when it is *secondary* to that other *plan*.
4. The first of the following rules that describes which *plan* pays its benefits before another *plan* is the rule to use.
 - (a) **Non-Dependent/Dependent** - The *plan* that covers the person other than as a dependent, for example as an employee, member, subscriber, or retiree, is *primary* and the *plan* that covers the person as a dependent is *secondary*. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is *secondary* to the *plan* covering the person as a dependent and *primary* to the *plan* covering the insured person as other than a dependent (e.g. a retired employee), then the order of benefits between the two *plans* is reversed so that the *plan* covering the person as an employee, member, subscriber, or retiree is *secondary* and the other *plan* is *primary*.
 - (b) **Child Covered Under More Than One Plan** - The order of benefits when a child is covered by more than one *plan* is:

- (i) The *primary plan* is the *plan* of the parent whose birthday falls earlier in a year if:
 - (a) The parents are married;
 - (b) The parents are not separated (whether or not they have ever been married); or
 - (c) A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

If both parents have the same birthday, the *plan* that covered either of the parents longer is *primary*.

- (ii) If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the *plan* of that parent has actual knowledge of those terms, that *plan* is *primary*.
- (iii) If the parents are not married, or are separated (whether or not they ever have been married), or are divorced, the order of benefits is:
 - (a) The *plan* of the *custodial parent*;
 - (b) The *plan* of the spouse of the *custodial parent*;
 - (c) The *plan* of the noncustodial parent; and then
 - (d) The *plan* of the spouse of the noncustodial parent.
- (c) **Active/Inactive Employee** - The *plan* that covers a person as an employee who is neither laid off nor retired is *primary*. The same would hold true if a person is a dependent of a person covered as a retiree and an employee. If the other *plan* does not have this rule, and if, as a result, the *plans* do not agree on the order of benefits, this rule is ignored. Coverage provided an individual as a retired worker and as a dependent of an actively working spouse will be determined under rule 4(a).
- (d) **Continuation Coverage** - If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another *plan*, the *plan* covering the person as an employee, member, subscriber, or retiree (or as that person's dependent) is *primary*, and the continuation coverage is *secondary*. If the other *plan* does not have this rule, and if, as a result, the *plans* do not agree on the order of benefits, this rule is ignored.
- (e) **Longer/Shorter Length of Coverage** - The *plan* that covered the person as an employee, member, subscriber, or retiree longer is *primary*.
- (f) If the preceding rules do not determine the *primary plan*, the *allowable expenses* shall be shared equally between the plans meeting the definition of *plan*. In addition, this *plan* will not pay more than it would have paid had it been *primary*.

MGR03866

EFFECT ON THE BENEFITS OF THIS PLAN:

1. When this *plan* is *secondary*, it may reduce its benefits so that the total benefits paid or provided by all *plans* during a *claim determination period* are not more than 100 percent of total *allowable expenses*. The difference between the benefit payments that this *plan* would have paid had it been the *primary plan*, and the benefit payments that it actually paid or provided shall be recorded as a *benefit reserve* for the *covered person* and used by this *plan* to pay any *allowable expenses* not otherwise paid during a *claim determination period*. As each claim is submitted, this *plan* will:
 - (a) Determine its obligation to pay or provide benefits under the *policy*;
 - (b) Determine whether a *benefit reserve* has been recorded for the *covered person*; and
 - (c) Determine whether there are any unpaid *allowable expenses* during that *claim determination period*.

If there is a *benefit reserve*, the *secondary plan* will use the *covered person's benefit reserve* to pay up to 100% of total *allowable expenses* incurred during the *claim determination period*. At

the end of the *claim determination period*, the *benefit reserve* returns to zero. A new *benefit reserve* must be created for each new *claim determination period*.

2. If a person is enrolled in two or more *closed panel plans* and if, for any reason, including the provision of service by a nonpanel provider, benefits are not payable by one *closed panel plan*, COB shall not apply between that *plan* and other *closed panel plans*.

MGR03867

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION: Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this *plan* and other *plans*. Claims Administration may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this *plan* and other *plans* covering the person claiming benefits. Claims Administration need not tell, or get the consent of, any person to do this. Each person claiming benefits under this *plan* must give Claims Administration any facts it needs to apply those rules and determine benefits payable.

MGR03013

FACILITY OF PAYMENT: A payment made under another *plan* may include an amount that should have been paid under this *plan*. If it does, Claims Administration may pay that amount to the organization that made that payment. That amount will be treated as though it were a benefit paid under this *plan*. Claims Administration will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

MGR03014

RIGHT OF RECOVERY: If the amount of payments made by Claims Administration is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid, or any other person or organization that may be responsible for the benefits or services provided for the *covered person*. The "amount of payments made" includes the reasonable cash value of any benefits provided in the form of services.

MGR03015

- M. The Notice of Claim provision is deleted and replaced with the following:
 1. We must receive written notice of claim within 60 days of the date the *loss* began or as soon as is reasonably possible.

MGR03868

- N. The Time for Payment of Claims provision is amended as follows:
 1. For claims other than those involving organ transplants, *clean claims* will be paid, denied, or contested within 30 calendar days from the date we receive the *clean claim*. For claims involving organ transplants, *clean claims* will be paid, denied, or contested within 60 calendar days after we receive the *clean claim*.
 2. "*Clean claim*" means a properly completed paper or electronic billing instrument, including any required health claim attachments.

MGR03869

- O. The following provision is added to the *policy/certificate*:

Continuity of Treatment by Terminated Network Providers: If a *covered person* receives treatment for *special circumstances* from a provider who ceases to be a *network provider* during the course of treatment, the *covered person* and/or the provider may request that benefits for the treatment for those *special circumstances* continue to be paid as if that provider were still a *network provider*. *Covered expenses* for treatment of the *special circumstances* will continue to be paid as follows:

1. For the first 90 days after the date the provider ceases to be a *network provider*; or
2. For a *covered person* who has been diagnosed as *terminally ill*, for nine months after the date the provider ceases to be a *network provider*; or

3. For a *pregnancy* that is past the 24th week, through the delivery of the child, for immediate postpartum care, and for an examination within the first six weeks following delivery.

As used in this provision, "*special circumstances*" means a disability, congenital condition, life-threatening *illness*, or a *pregnancy* that is past the 24th week, and for which the treating provider reasonably believes disruption of the continuity of care could cause harm to the *covered person*.

MGR04541

Except as specifically stated in this endorsement, the benefits under this endorsement are subject to all of the terms, conditions, exclusions, limitations, and notification requirements of the *policy/certificate*, including any applicable *deductible amounts*, coinsurance provisions, copay amounts, or dollar limits.

MGR03440

This endorsement applies only to *covered persons* who reside in the state of Kentucky.

This endorsement will not change, waive or extend any part of the *policy/certificate*, other than as stated herein.

This endorsement is effective on September 1, 2012 or at the same time as the *policy/certificate*, whichever is later.

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



President

MGR04546

MARYLAND GRIEVANCE ENDORSEMENT

By attachment of this endorsement, the *policy/certificate* is amended to the extent of any conflict with the following:

MGR03433

- A. The General Benefits provision is amended to include the following:

Grievances - General Information

1. The designated employee or representative of Golden Rule Insurance Company ("GRIC") who has responsibility for GRIC internal *grievance* process is:

Golden Rule Grievance Administrator
c/o Golden Rule Insurance Company
7440 Woodland Drive
Indianapolis, IN 46278-1719
Phone: (800) 657-8205
Fax: (317) 715-7648

2. A *covered person* or a *health care provider* acting on behalf of a *covered person* has the right to file a *complaint* with the Maryland Insurance Commissioner ("the Commissioner") within 30 working days after receipt of a *grievance decision*.
3. A *complaint* may be filed by either of these parties without first filing a *grievance* if the filing party can demonstrate to the Commissioner a *compelling reason* to do so.
4. The *complaint* referenced immediately above may be filed with:

Maryland Insurance Administration Appeals and Grievance Unit
200 St. Paul Place, Suite 2700
Baltimore, MD 21202
Phone: 1-800-492-6116 or 1-410-468-2000
Fax: 410-468-2270

5. The Health Education and Advocacy Unit is available to assist a *covered person* in both mediating and filing a *grievance* under GRIC internal *grievance* procedure. This office may be contacted as follows:

Health Education and Advocacy Unit
Office of the Attorney General
200 St. Paul Place, 16th Floor
Baltimore, MD 21202
Phone: 410-528-1840 or 1-877-261-8807
Fax: 410-576-6571
e-mail: heau@oag.state.md.us

Summary of GRIC's Internal Grievance Procedure

1. An *adverse decision* will be communicated to a *covered person* orally and then in writing. The written notice of the *adverse decision* shall be sent to the *covered person* within 5 working days after the *adverse decision* is made. The written notice will include:
 - (a) The specific factual basis for the decision stated in detail in clear, understandable language;
 - (b) Reference to the specific criteria and standards, including interpretive guidelines, on which the decision was based, and will not use only generalized terms such as "experimental procedure not covered," "cosmetic procedure not covered," "service included under another procedure," or "not medically necessary";
 - (c) The name, business address and telephone number of the designated representative of GRIC's Review Agent or GRIC who is responsible for the *grievance* process;
 - (d) Details of GRIC's internal *grievance* process and procedures;

- (e) That the *covered person* has the right to file a *complaint* with the Commissioner within 30 working days after receipt of a *grievance decision*, which shall include the Commissioner's address, telephone number and facsimile number, as follows:

Maryland Insurance Administration Appeals and Grievance Unit
200 St. Paul Place, Suite 2700
Baltimore, MD 21202
Phone: 1-800-492-6116 or 1-410-468-2000
Fax: 410-468-2270;

- (f) That a *complaint* may be filed with the Commissioner without first filing a *grievance* if the *covered person* can demonstrate to the Commissioner a *compelling reason* to do so; and
- (g) That the Health Education and Advocacy Unit of the State of Maryland is available to assist the *covered person* with both mediating and filing a *grievance*. This office may be contacted as follows:

Health Education and Advocacy Unit
Office of the Attorney General
200 St. Paul Place, 16th Floor
Baltimore, MD 21202
Phone: 410-528-1840 or 1-877-261-8807
Fax: 410-576-6571
e-mail: heau@oag.state.md.us

2. A *covered person* or a *covered person's health care provider* may file a *grievance* with GRIC or GRIC's Review Agent regarding an adverse decision concerning the *covered person*.
3. The review of a *grievance* will be conducted by the original reviewer. The review will be completed and a written decision sent to the *covered person* or the *covered person's health care provider* that filed the *grievance* on behalf of the *covered person* within 30 working days after the date the *grievance* was filed (or 45 working days in the event the *grievance* involves a retrospective denial). An extension of an additional 30 working days may be requested by the reviewer, subject to the written consent of the *covered person* or the *covered person's health care provider* that filed the *grievance* on behalf of the *covered person*.
4. If there is insufficient information to complete the review, the reviewer will provide written notification to the *covered person* or the *covered person's health care provider* that filed the *grievance* on behalf of the *covered person* within 5 working days after the filing date of the *grievance*, and the reviewer will advise that additional information is required before the review can take place. GRIC's Review Agent will be available to assist the *covered person* or the *covered person's health care provider* in their efforts to obtain all necessary information for review of an *adverse decision* without further delay.
5. If the *covered person's* medical condition is certified by the *covered person's health care provider* as an *emergency case* that requires a decision in a time frame less than the standard review process described above, an expedited review will be conducted. Expedited reviews will be completed and a written decision notice containing information similar to that described in 1. above will be sent to the *covered person* or the *covered person's health care provider* that filed the *grievance* on behalf of the *covered person* within 24 hours.

Summary of GRIC's Internal Appeal Procedures for Coverage Decisions

1. Written notice of all *coverage decisions* shall be sent to the *covered person* within 30 calendar days after the *coverage decision* is made. The written notice will include:
 - (a) The specific factual basis for the decision stated in detail in clear, understandable language;
 - (b) That the *covered person* has the right to file an *appeal* with GRIC;
 - (c) That the *covered person* may file a *complaint* with the Commissioner without first filing an *appeal* if the *coverage decision* involves an urgent medical condition for which care has not yet been rendered, and shall include the Commissioner's address and telephone number, as follows:

Maryland Insurance Administration Appeals and Grievance Unit

200 St. Paul Place, Suite 2700
Baltimore, MD 21202
Phone: 1-800-492-6116 or 1-410-468-2000;

and

- (d) That the Health Education and Advocacy Unit of the State of Maryland is available to assist the *covered person* with both mediating and filing an *appeal*. This office may be contacted as follows:

Health Education and Advocacy Unit
Office of the Attorney General
200 St. Paul Place, 16th Floor
Baltimore, MD 21202
Phone: 410-528-1840 or 1-877-261-8807
Fax: 410-576-6571
e-mail: heau@oag.state.md.us

2. *Appeals* will be handled by the original reviewer or a designated representative.
3. Written notice of all *appeal* decisions shall be sent to the *covered person* and the *health care provider* acting on behalf of the *covered person*, if any, within the earlier of:
 - (a) 30 calendar days after an *appeal* decision is made, or
 - (b) 60 working days after the *appeal* was filed.

The written notice will include:

- (a) The specific factual basis for the *appeal* decision in detail in clear, understandable language;
 - (b) That the *covered person* or *health care provider* has the right to file a *complaint* with the Commissioner within 60 working days of receipt of the final *appeal* decision; and
 - (c) The Commissioner's address, telephone number and facsimile number.
4. GRIC's internal *appeal* procedures must be exhausted prior to the filing of a *complaint* with the Commissioner, unless the *coverage decision* involves an urgent medical condition, as defined by the Commissioner, for which care has not yet been rendered.

Definitions: As used in this rider the following words and phrases have the following meanings:

1. "*Adverse decision*" means a *utilization review* determination by GRIC's Review Agent or by GRIC that:
 - (a) A proposed or delivered health care service that would otherwise be a *covered expense* under the *covered person's policy/certificate* is or was not *medically necessary*, appropriate, or efficient; and
 - (b) May result in noncoverage of the health care service.
2. "*Appeal*" means a protest filed by a *covered person* or a *health care provider* under GRIC's internal *appeal* procedures regarding a coverage decision concerning a *covered person*.
3. "*Compelling reason*" means a demonstration to the satisfaction of the Commissioner, including a showing that a potential delay in receipt of health care until after exhaustion of the internal *grievance* procedure and obtaining of a final decision under the *grievance* process could result in loss of life, serious impairment to a bodily function, serious dysfunction of a bodily organ or remaining seriously mentally ill with symptoms that cause danger to self or others.
4. "*Complaint*" means a protest filed with the Commissioner involving an *adverse decision*, *grievance decision* or a *coverage decision* concerning the *covered person*.
5. "*Coverage decision*" means an initial determination by GRIC or a representative of GRIC that results in noncoverage of a health care service. *Coverage decision* includes nonpayment of all or any part of a claim, except that *coverage decision* does not include an *adverse decision*.

6. *"Emergency case"* means a case involving an *adverse decision* for which an expedited review is required under Maryland regulations. Those cases are those in which:
 - (a) The *adverse decision* is rendered for health care services that are proposed but have not been delivered; and
 - (b) The health care services are necessary to treat a condition or illness that, without immediate medical attention, would:
 - (i) Seriously jeopardize the life or health of the *covered person* or the *covered person's* ability to regain maximum function; or
 - (ii) Cause the *covered person* to be a danger to self or others.
7. *"Grievance"* means a written protest filed by a *covered person* or a *health care provider* acting on behalf of a *covered person* with GRIC or its Review Agent through GRIC's internal *grievance* procedure regarding an *adverse decision* concerning a *covered person*.
8. *"Grievance decision"* means a final determination by GRIC or its Review Agent that arises from a *grievance* filed with GRIC under its internal *grievance* procedure regarding an *adverse decision* concerning a *covered person*.
9. *"Health care provider"* means:
 - (a) An individual who is licensed or otherwise authorized in the state of Maryland to provide health care services in the ordinary course of business or practice of a profession and is a treating provider; or
 - (b) A hospital as defined by Maryland law.
10. *"Utilization review"* means a system for reviewing the appropriate and efficient allocation of health care resources and services given or proposed to be given to a *covered person*.

These grievance procedures apply only:

1. To residents of Maryland who are *covered persons* under a *policy/certificate* issued in the state of Maryland; or
2. To *covered persons* who reside or work in the state of Maryland whose insurance *policy/certificate* was issued in a state that the Maryland Insurance Commissioner determines does not have an external complaint process for adverse decisions or grievances comparable to the process required in the state of Maryland.

MGR03760

This endorsement applies only to *covered persons* who reside in the state of Maryland.

The endorsement will not change, waive or extend any part of the *policy/certificate*, other than as stated herein.

This endorsement is effective on September 1, 2012 or at the same time as the *policy/certificate*, whichever is later.

Golden Rule Insurance Company



President

MGR03441

MARYLAND ENDORSEMENT

By attachment of this endorsement, the *policy/certificate* is amended to the extent of any conflict with the following:

MGR03433

- A. Under the Definitions provision, *medical practitioner* is amended to include a licensed clinical professional counselor, licensed clinical marriage therapist and family therapist, licensed clinical alcohol and drug counselor, licensed certified social worker, or registered nurse practitioner.

MGR03759

- B. *Covered Expenses* are expanded to include the following charges:

1. For cleft lip and cleft palate services performed by a state-licensed practitioner for the correction or management of a cleft lip or cleft palate: (a) orthodontics; (b) oral surgery; (c) otologic treatments; (d) audiological treatments; and (e) speech/language treatments; and

1. For F.D.A.-approved prescription contraceptive drugs or devices, including medically necessary examinations associated with the insertion, use of, or removal of contraceptive drugs or devices.

MGR03761

- C. The General Exclusions and Limitations section of the *policy/certificate* is amended as follows:

1. Benefits under the *policy/certificate* will not be reduced due to the fact that treatment is received at no cost to the *covered person*: (1) under Medicaid; or (2) in a hospital or institution administered or maintained by the State of Maryland, or any county or municipality thereof.

2. Any references to "*medically necessary*" or "medical necessity" will not apply to the Hospice Care Expense Benefits.

MGR03794

- D. The Preexisting Conditions Limitation is amended as follows:

1. The definition of preexisting condition is deleted and replaced with the following:

A "*preexisting condition*" means an *injury or illness*:

For which medical advice, diagnosis, care or treatment was recommended or received within the 12 months immediately preceding the applicable effective date the *covered person* because insured under the *policy*.

MGR04342

2. **CREDIT FOR PRIOR CREDITABLE COVERAGE:** If a *covered person's effective date* of coverage under the *policy/certificate* occurs within 63 days of termination of the *covered person's* coverage under any prior *creditable coverage*, that *covered person* will be entitled to credit against the 12 months preexisting condition limitation waiting period of the *policy/certificate* for the same number of full months that the *covered person* was continuously covered, without any lapse of 63 days or more, under prior *creditable coverage*.

MGR04343

3. **WAIVER OF PREEXISTING CONDITIONS LIMITATION:** The *preexisting condition* limitation shall not apply to a newborn child covered under *creditable coverage* within 30 days of birth providing there has been no subsequent lapse of coverage of 63 days or greater.

MGR04344

4. As used in this endorsement:

"*Creditable coverage*" means coverage of an individual under: (a) an employer-sponsored plan; (b) a health benefit plan; (c) Medicare; (d) Medicaid; (e) coverage provided to members of the armed forces, including CHAMPUS; (f) Indian Health Service or tribal organization coverage; (g) any state health benefits risk pool (CHIP) plan coverage; (h) a governmental plan; (i) Public health coverage; or (j) health benefit coverage provided through the Peace Corps Act.

MGR04345

Except as specifically stated in this endorsement, the benefits under this endorsement are subject to all of the terms, conditions, exclusions, limitations and notification requirements of the *policy/certificate*, including any applicable *deductible amounts*, coinsurance provisions, copay amounts, or dollar limits.

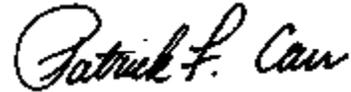
MGR03440

This endorsement applies only to *covered persons* who reside in the state of Maryland.

The endorsement will not change, waive or extend any part of the *policy/certificate*, other than as stated herein.

This endorsement is effective on September 1, 2012 or at the same time as the *policy/certificate*, whichever is later.

Golden Rule Insurance Company

A handwritten signature in black ink that reads "Patrick F. Carr". The signature is written in a cursive, flowing style.

President

MGR03441

MICHIGAN ENDORSEMENT

By attachment of this endorsement, the *policy/certificate* is amended to the extent of any conflict with the following:

MGR03433

Any Preexisting Conditions Limitation is amended as follows:

A "*preexisting condition*" means an *injury* or *illness* for which the *covered person* received medical advice or treatment within the 6 months immediately preceding the applicable *effective date* the *covered person* became insured under the *policy*.

MGR03462

Except as noted in this endorsement, the benefits under this endorsement are subject to all of the terms, conditions, exclusions, limitations and notification requirements of the *policy/certificate*, including any applicable *deductible amounts*, coinsurance provisions, copay amounts, or dollar limits.

MGR03440

This endorsement applies only to *covered persons* who reside in the state of Michigan.

This endorsement will not change, waive or extend any part of the *policy/certificate*, other than as stated herein.

This endorsement is effective on September 1, 2012 or at the same time as the *policy/certificate*, whichever is later.

Golden Rule Insurance Company

A handwritten signature in black ink that reads "Patrick F. Carr". The signature is written in a cursive style with a large initial "P".

President

MGR03441

MISSISSIPPI ENDORSEMENT

By attachment of this endorsement, the *policy*/certificate is amended to the extent of any conflict with the following:

MGR03433

- A. The Definitions provision is amended to include the following:

"*Clean claim*" means proper *proof of loss* which requires no further information, adjustment, or alteration by the provider of the services or the insured in order to be processed and paid or denied by the insurer. A claim is clean if it has no defect or impropriety, including any lack of substantiating documentation, or particular circumstances requiring special treatment that prevents timely payment from being made on the claim under this provision. A clean claim includes resubmitted claims with previously identified deficiencies corrected.

"*Clean claim*" does not include:

1. A duplicate claim, which means an original claim and its duplicate when the duplicate is filed within (30) days of the original claim;
2. Claims which are submitted fraudulently or that are based upon material misrepresentations;
3. Claims that require information essential for the insurer to administer preexisting condition, coordination of benefits or subrogation provisions; or
4. Claims submitted by a provider more than thirty (30) days after the date of service; if the provider does not submit the claim on behalf of the insured, then a claim is not clean when submitted more than thirty (30) days after the date of billing by the provider to the insured.

MGR03755

- B. The definition of "*preexisting condition*," as set forth in the Preexisting Conditions Limitation provision, is deleted and replaced with the following:

"*Preexisting condition*" means an *injury* or *illness* for which medical advice, diagnosis, care or treatment was recommended to or received by a *covered person* within the 6 months immediately preceding the applicable *effective date* the *covered person* became insured under the *policy*; or which, in the opinion of a qualified *doctor*: (1) probably began prior to the applicable *effective date* the *covered person* became insured under the *policy*; and (2) manifested symptoms which would cause an ordinarily prudent person to seek diagnosis or treatment within the 6 months immediately preceding the applicable *effective date* the *covered person* became insured under the *policy*.

MGR03756

- C. Under the Coordination of Benefits "COB" provision, the definition of *plan* is amended to include: (1) medical benefits under homeowner's insurance plans; and (2) medical benefits coverage provided by worker's compensation.

Plan does not include hospital indemnity coverages.

MGR04697

- D. The time for Payment of Claims subsection is amended to read as follows:

TIME FOR PAYMENT OF CLAIMS: Benefits will be paid within 25 days of receipt of proper *proof of loss* that evidences a *clean claim* where claims are submitted electronically, and within 35 days of receipt of proper *proof of loss* of a clean claim when submitted in paper format. If additional information is needed to determine *our* liability, the claim will be paid within 20 days after receipt of proper *proof of loss*. Claims not paid within the periods specified for the manner in which they were submitted will accrue interest at the rate of 1 and 1/2% per month on the unpaid balance, commencing with the day after payment was due, until the date the claim is paid. If we do not pay in the appropriate time, *you* may bring action to recover such benefits and any other damages allowed by law.

MGR03762

Except as specifically stated in this endorsement, the benefits under this endorsement are subject to all of the terms, conditions, exclusions, limitations and notification requirements of the *policy/certificate*, including any applicable *deductible amounts*, coinsurance provisions, copay amounts, or dollar limits.

MGR03440

This endorsement applies only to *covered persons* who reside in the state of Mississippi.

This endorsement will not change, waive or extend any part of the *policy/certificate*, other than as stated herein.

This endorsement is effective September 1, 2012 or at the same time as the *policy/certificate*, whichever is later.

**Golden Rule Insurance
Company**

A handwritten signature in black ink that reads "Patrick F. Caw". The signature is written in a cursive style with a large initial "P".

President

MGR03441

MISSOURI ENDORSEMENT

By attachment of this endorsement, the *policy*/certificate is amended to the extent of any conflict with the following:

MGR03433

A. The Definitions provision is amended as follows:

1. The definition of *extended care facility* is deleted and replaced with:

"*Extended care facility*" means an institution, or a distinct part of an institution, which:

- (a) Is licensed at a *hospital, extended care facility or rehabilitation facility* by the state in which it operates;
- (b) Is regularly engaged in providing 24-hour skilled nursing care under the regular supervision of a *doctor* and the direct supervision of a *registered nurse*;
- (c) Maintain a daily record on each patient;
- (d) Provides each patient with a planned program of observation prescribed by a *doctor*; and
- (e) Provides each patient with active treatment of an *illness or injury*, or related *rehabilitation*, in accordance with existing standards of medical practice for that condition.

Extended care facility does not include a facility primarily for rest, the aged, *substance abuse, custodial care*, nursing care, or for care of *mental disorders* or the mentally incompetent.

MGR03577

2. The following definitions are added:

"*Child immunization services*" means the vaccines specified below when provided in the time period between a *covered person's* date of birth and the *covered person's* 6th birthday:

- (a) Poliomyelitis;
- (b) Rubella;
- (c) Rubeola;
- (d) Mumps;
- (e) Tetanus;
- (f) Pertussis;
- (g) Diphtheria;
- (h) Hepatitis A;
- (i) Hepatitis B;
- (j) Haemophilus influenzae type b (Hib);
- (k) Pneumococcal;
- (l) Influenza; and
- (m) Varicella.

MGR03822

"*Routine patient care costs*" means reasonable and *medically necessary* services needed to administer the drug or device under evaluation in the clinical trial, including all items and services that are otherwise generally available to a qualified individual that are provided in the clinical trial except:

- (a) The investigational item or service itself;
- (b) Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and.

- (c) Items and services customarily provided by the research sponsors free of charge for any enrollee in the trial.

MGR03578

B. The Medical Benefits provision is amended as follows::

Covered expenses are amended to include the following:

- 1. Charges for *child immunizations* services when provided to any *covered person* eligible by reason of age. *Child immunization services* will be exempt from any *deductible amounts* and coinsurance provisions stated in the *policy/certificate*. The immunizations required under this rule as well as the manner and frequency of their administration shall conform to recognized standards of medical practice.

MGR03823

- 2. Office charges and charges for the administration of general anesthesia incurred at a dentist's office for a *covered person* who:
 - (a) Is an *eligible child* age six (6) and under;
 - (b) Has a medical condition that requires hospitalization or general anesthesia for dental care; or
 - (c) Has a chronic disability that: (a) can be attributed to a mental or physical impairment or a combination of mental and physical impairments; (b) is likely to continue; and (c) results in substantial functional limitations in one or more of the following areas of major life activity: self-care, receptive and expressive language; learning, mobility, capacity for independent living, or economic self-sufficiency.

MGR04329

- 3. Charges for *routine patient care costs* incurred as the result of phase III or IV of a clinical trial that is approved by an entity listed below and is undertaken for the purposes of the prevention, early detection, or treatment of cancer. *Routine patient care costs* shall apply to clinical trials that are approved or funded by one of the following entities:
 - (a) One of the National Institutes of Health (NIH);
 - (b) An NIH Cooperative Group or Center;
 - (c) The FDA in the form of an investigational new drug application;
 - (d) The federal Departments of Veterans Affairs or Defense;
 - (e) An institutional review board in the state of Missouri that has an appropriate assurance approved by the Department of Health and Human Services assuring compliance with and implementation of regulations for the protection of human subjects; or
 - (f) A qualified research entity that meets the criteria for NIH Center support grant eligibility.
- 4. Charges for diagnosis, treatment, and appropriate management of osteoporosis, if incurred by a *covered person* with a condition or medical history that indicates to *us* that bone mass measurement is *medically necessary*. In determining whether testing or treatment is medically appropriate, due consideration shall be given to peer-reviewed medical literature.

MGR03580

- C. If *you* indicated on *your* application that *you* rejected coverage of contraceptives due to *your* moral, ethical, or religious beliefs, any benefits under the *policy/certificate* for contraceptive drugs and devices are deleted.

MGR04278

- D. The General Exclusions and Limitations provision is amended to the extent that it conflicts with the following:

Covered expenses will not include, and no benefits will be paid for any charges which are incurred as a result of:

1. Intentionally self-inflicted bodily harm, unless the *covered person* was insane, or the harm resulted from other than an attempted suicide;
2. *Injury or illness* caused by an act of declared or undeclared war; or
3. The *covered person* taking part in a riot or the commission of a felony, whether or not charged.

MGR03581

- E. Notification requirements are not applicable to residents of Missouri.

MGR04352

- F. The Reimbursement provision will not apply to residents of Missouri.

MGR04249

Except as specifically stated in this endorsement, the benefits under this endorsement are subject to all of the terms, conditions, exclusions, limitations and notification requirements of the *policy/certificate*, including any applicable *deductible amounts*, coinsurance provisions, copay amounts, or dollar limits.

MGR03440

This endorsement applies only to *covered persons* who reside in the state of Missouri.

This endorsement will not change, waive or extend any part of the *policy/certificate*, other than as stated herein.

This endorsement is effective September 1, 2012 or at the same time as the *policy/certificate*, whichever is later.

**Golden Rule Insurance
Company**



President

MGR03441

NEBRASKA ENDORSEMENT

By attachment of this endorsement, the *policy/certificate* is amended to the extent of any conflict with the following:

MGR03433

- A. The Definitions provision is amended by the addition of the following:

"Child immunizations" means the specified vaccines when provided between a *covered person's* date of birth and 6th birthday in a manner and frequency conforming to recognized standards of medical practice. *Child immunizations* include vaccinations for diphtheria; haemophilus influenza type B (Hib); measles; mumps; pertussis; poliomyelitis; rubella and tetanus.

MGR04141

- B. *Child immunizations* will be exempt from any *deductible amounts, copayment amounts* and coinsurance requirements, regardless of whether services are provided by a *network provider*.

MGR04532

Except as specifically stated in this endorsement, the benefits under this endorsement are subject to all of the terms, conditions, exclusions, limitations and notification requirements of the *policy/certificate*, including any applicable *deductible amounts*, coinsurance provisions, copay amounts, or dollar limits.

MGR03440

This endorsement applies only to *covered persons* who reside in the state of Nebraska.

This endorsement will not change, waive or extend any part of the *policy/certificate*, other than as stated herein.

This endorsement is effective on September 1, 2012 or at the same time as the *policy/certificate*, whichever is later.

Golden Rule Insurance Company



President

MGR03441

Golden Rule Insurance Company
North Carolina Utilization Review Procedures and Grievance Procedures
Rider

This rider is effective on August 18, 2010, or at the same time as the *policy/certificate*, whichever is later.

By the attachment of this rider, the *policy/certificate* is amended to include the following:

- A. **DEFINITIONS:** As used in this rider, the following terms have the meanings indicated:
1. "*Grievance*" means a written complaint submitted by a *covered person* regarding:
 - (a) *Our* decisions, policies, or actions related to the availability, delivery, or quality of health care services;
 - (b) Claims payment, handling, or reimbursement for services;
 - (c) The contractual relationship between a *covered person* and *us*; or
 - (d) The outcome of an appeal of a *noncertification*.

Grievance does not include a written complaint submitted by a *covered person* about a decision based solely on the fact that the *covered person's policy/certificate* contains an exclusion for the expense in question.
 2. "*Noncertification*" means a recommendation by *our* Review Agent, or a determination by *us*, that an admission, availability of care, continued stay, or other health care service has been reviewed and, based upon the information provided, does not meet the *policy's/certificate's* requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, or does not meet the prudent layperson standard for coverage of *emergency* services, and coverage of the requested service is therefore denied, reduced, or terminated. A *noncertification* includes any situation in which *we* make a decision, or *our* Review Agent makes a recommendation, about whether a requested treatment for a *covered person's* condition is experimental, investigational, or cosmetic, and how coverage is affected. A *noncertification* is not a decision made solely on the basis that the *policy/certificate* does not provide benefits for the health care service in question, if the service is denied under an exclusion stated in the *policy/certificate*.
 3. As used in this rider, the term *covered person* will also include a person who is authorized to act on behalf of a *covered person*.
- B. **UTILIZATION REVIEW PROCEDURES**
1. **Applicability of Part B.** This Part B applies to reviews of medical necessity, appropriateness, health care setting, level of care or effectiveness, or services that are experimental, investigational, or cosmetic treatment.
 2. *Our* Review Agent or *we* will obtain all information required to make a recommendation or determination, including clinical information. Information requests will be limited to the information necessary to certify the health care service.
 3. A *covered person* or a health care provider acting on behalf of a *covered person* may contact *our* Review Agent by calling toll-free at 1-800-999-3404.
 4. Notice of utilization review decisions will be consistent with North Carolina law and *our* policies.
 5. A medical *doctor* licensed to practice medicine in North Carolina will evaluate the clinical appropriateness of *noncertifications*.
 6. For prospective and concurrent reviews, *our* Review Agent or *we* will communicate a decision in clear terms within 3 business days of receipt of all necessary information.
 - (a) For a certification, *our* Review Agent or *we* will notify the *covered person's* provider.

- (b) For a *noncertification*, our Review Agent or we will notify the *covered person's* provider and send written or electronic confirmation to the *covered person*.
 - (c) For concurrent reviews, we will remain responsible for coverage of the health care service until the *covered person* has been notified of a *noncertification* in writing.
7. For retrospective reviews, our Review Agent or we will communicate a decision in clear terms within 30 days after receipt of all necessary information.
- (a) For a certification, our Review Agent or we will notify the *covered person's* provider in writing.
 - (b) For a *noncertification*, our Review Agent or we will notify the *covered person* and the *covered person's* provider in writing within 5 business days after making the decision.
8. The written notification of a *noncertification* will include:
- (a) All reasons for the *noncertification*, including:
 - (i) The clinical rationale;
 - (ii) The instructions for initiating a voluntary appeal or reconsideration of the *noncertification*; and
 - (iii) The instructions for requesting a written statement of the clinical review criteria used to make the *noncertification*.
 - (b) A statement that assistance is available from the Managed Care Patient Assistance Program by contacting:

North Carolina Managed Care Patient Assistance Program
 Health Insurance Smart NC
 North Carolina Department of Insurance
 1201 Mail Service Center
 Raleigh, North Carolina 27699-1201
 Toll free Telephone: (877) 885-0231
9. If the necessary information is not provided, our Review Agent or we will notify the *covered person* or provider. The *covered person* or provider will be given 45 calendar days to provide the necessary information. If a *covered person* or provider fails to provide the necessary information, it may result in a *noncertification*.

C. PROCEDURES FOR APPEALS OF NONCERTIFICATIONS

- 1. The procedures in this part are voluntary.
- 2. A *covered person* or a provider acting on behalf of a *covered person* may file an appeal of a *noncertification*.
- 3. The review will be completed by a medical doctor, licensed to practice medicine in North Carolina, who was not involved in the *noncertification*.
- 4. Within 3 business days after receiving an appeal request, we will provide the *covered person* with:
 - (a) The name, address, and telephone number of the person assigned to coordinate the review; and
 - (b) Information on how to submit written material.
- 5. We will notify the *covered person* and the *covered person's* provider of the appeal decision in clear terms within 30 days after we receive the appeal request. If the decision is not in favor of the *covered person*, the written decision will contain:
 - (a) The professional qualifications and licensure of the person or persons reviewing the appeal.
 - (b) A statement of the reviewer's understanding of the reason for the appeal.

- (c) The reviewer's decision in clear terms and the medical rationale in sufficient detail for the *covered person* to respond further to *our* position.
- (d) A reference to the evidence or documentation that is the basis for the decision, including the clinical review criteria used to make the determination, and instructions for requesting the clinical review criteria.
- (e) A statement advising the *covered person* of the *covered person's* right to request a second level *grievance* review and a description of the procedure for submitting a second level *grievance* review.
- (f) Notice of the availability of assistance from the Managed Care Patient Assistance Program by contacting:

North Carolina Managed Care Patient Assistance Program
 Health Insurance Smart NC
 North Carolina Department of Insurance
 1201 Mail Service Center
 Raleigh, North Carolina 27699-1201
 Toll free Telephone: (877) 885-0231

6. EXPEDITED APPEALS

- (a) A *covered person* or a provider acting on behalf of a *covered person* may request an expedited appeal of a *noncertification* if a standard appeal would reasonably appear to seriously jeopardize the life or health of a *covered person* or jeopardize the *covered person's* ability to regain maximum function.
 - (b) The attending physician must provide a statement or certification that the *covered person's* medical condition is such that the time frame for a standard appeal would reasonably appear to seriously jeopardize the life or health of a *covered person* or jeopardize the *covered person's* ability to regain maximum function.
 - (c) The expedited review must take place in consultation with a licensed medical *doctor*.
 - (d) We will notify the *covered person* and the *covered person's* provider in writing, in clear terms, of the appeal decision within 4 days after receiving the information justifying an expedited review.
 - (e) If the expedited appeal involves a concurrent review determination, we will remain responsible for coverage of the health care service until the *covered person*, provider, and/or facility has been notified of the appeal decision verbally and by mail.
 - (f) We do not provide expedited reviews for appeals of *noncertifications* of retrospective reviews.
7. A second level review of a *noncertification* will be handled under the second level review procedures in Parts D.5 or D.6 of this rider.

D. PROCEDURES FOR GRIEVANCES

- 1. The procedures in this part are voluntary.
- 2. The North Carolina Department of Insurance is available to assist *covered persons* with insurance related problems and questions. You may contact the Department at:

North Carolina Department of Insurance
 1201 Mail Service Center
 Raleigh, NC 27699-1201
 Phone: 1-800-546-5664

- 3. Help is also available from the Managed Care Patient Assistance Program by contacting:

North Carolina Managed Care Patient Assistance Program
 Health Insurance Smart NC
 North Carolina Department of Insurance

4. FIRST LEVEL REVIEWS

- (a) A *covered person* or a provider acting on behalf of a *covered person* may file a *grievance* with us.
- (b) The *covered person* and/or provider is not permitted to attend the first level review, but may submit written material for consideration.
- (c) Within 3 business days of receiving a *grievance*, we will inform the *covered person* of the name, address, and telephone number of the person assigned to coordinate the review and information on how to submit written material to the reviewer.
- (d) We will send a written decision in clear terms to the *covered person*, and the *covered person's* provider, if applicable, within 30 days of receipt of the *grievance*. If the decision is not in favor of the *covered person*, the written decision will contain:
 - (i) The professional qualifications and licensure of the person or persons reviewing the *grievance*.
 - (ii) A statement of the reviewer's understanding of the *grievance*.
 - (iii) The reviewer's decision in clear terms and the contractual basis or medical rationale in sufficient detail for the *covered person* to respond further to *our* position.
 - (iv) A reference to the evidence or documentation used as the basis for the decision.
 - (v) A statement advising the *covered person* of his or her right to request a second level *grievance* review and a description of the procedure for submitting a second level *grievance*.
 - (vi) Notice of the availability of assistance from the Managed Care Patient Assistance Program by contacting:

North Carolina Managed Care Patient Assistance Program
Health Insurance Smart NC
North Carolina Department of Insurance
1201 Mail Service Center
Raleigh, North Carolina 27699-1201
Toll free Telephone: (877) 885-0231

5. SECOND LEVEL REVIEWS FOR NONCERTIFICATIONS AND GRIEVANCES

- (a) A *covered person*, or a provider acting on behalf of a *covered person*, who is dissatisfied with a first level *grievance* review decision or a *noncertification* appeal decision may file a request for a second level *grievance* review.
- (b) Within 10 business days of receipt of a request for a second level review, we will inform the *covered person* of the name, address, and telephone number of the person assigned to coordinate the review and of the right to:
 - (i) Request and receive from us all information relevant to the case.
 - (ii) Attend the review meeting and present his or her case to the review panel.
 - (iii) Submit supporting material to the review panel both before and at the review meeting.
 - (iv) Ask questions of any member of the review panel.
 - (v) Be assisted or represented at the review meeting by a person of his or her choice, which person may be a provider, family member, employer, representative, or attorney. If the *covered person* chooses to be represented by an attorney, we may also be represented by an attorney.

- (c) The review panel will schedule and hold a review meeting within 45 days of receipt a request for a second level review.
- (d) The *covered person* will be notified in writing at least 15 days before the review meeting date.
- (e) A *covered person* does not have to attend the second level review meeting to receive a full review.
- (f) The review panel will send a written decision in clear terms to the *covered person* and, if applicable, to the *covered person's* provider, within 7 business days after the review meeting. The decision will include:
 - (i) The professional qualifications and licensure of the members of the review panel.
 - (ii) A statement of the review panel's understanding of the nature of the *grievance* and all pertinent facts.
 - (iii) The review panel's recommendation to *us* and the rationale behind that recommendation.
 - (iv) A description of or reference to the evidence or documentation considered by the review panel in making the recommendation.
 - (v) In the review of the *noncertification* or other clinical matter, a written statement of the clinical rationale, including the clinical review criteria, that was used by the review panel to make the recommendation.
 - (vi) The rationale for *our* decision if it differs from the review panel's recommendation.
 - (vii) A statement that the decision is *our* final determination in the matter.
 - (viii) If the review concerned a *noncertification* and *our* decision is to uphold *our* initial *noncertification*, a statement advising the *covered person* of his or her right to request an external review and a description of the procedure for submitting a request for external review to the Commissioner of Insurance.
 - (ix) Notice of the availability of the Commissioner's office for assistance by contacting:

By Mail:

North Carolina Department of Insurance
Healthcare External Review Program
1201 Mail Service Center
Raleigh, NC 27699-1201
Phone toll-free in NC: 1-877-885-0231
Phone out of NC: 1-919-807-6860
Fax: 1-919-807-6865

In Person:

Dobbs Building
430 N. Salisbury St.
4th Floor, Suite 4105
Raleigh, NC
www.ncdoi.com for External Review Information and Request Form

- (x) Notice of the availability of assistance from the Managed Care Patient Assistance Program by contacting:

North Carolina Managed Care Patient Assistance Program
Health Insurance Smart NC
North Carolina Department of Insurance
1201 Mail Service Center
Raleigh, North Carolina 27699-1201
Toll free Telephone: (877) 885-0231

6. SECOND LEVEL EXPEDITED REVIEW FOR NONCERTIFICATIONS AND GRIEVANCES

- (a) An expedited second level review will be made available where medically justified, whether or not the initial review was expedited.
- (b) The provisions in D.5 will apply to an expedited review, except that *we* will conduct the review and send the written decision within 4 days after receiving all information needed. The review meeting may take place by way of a telephone conference call or through the exchange of written information.

E. FOR GRIEVANCES RELATED TO QUALITY OF CLINICAL CARE

Within 10 business days after *we* receive a *grievance* about the quality of care received from a provider, *we* will acknowledge the *grievance*. The acknowledgement will advise a *covered person* that:

- 1. The *grievance* will be referred to the network for handling and resolution, if applicable.
- 2. North Carolina law does not allow for a second level review for *grievances* concerning quality of care.

F. EXTERNAL REVIEW OF NONCERTIFICATIONS

- 1. North Carolina law provides for review of *noncertification* decisions by an external, independent review organization (IRO). The North Carolina Department of Insurance (NCDOI) administers this service at no charge to *you*, arranging for an IRO to review *your* case once the NCDOI establishes that *your* request is complete and eligible for review. *You* or someone *you* have authorized to represent *you* may request an external review.
- 2. *We* will notify *you* in writing of *your* right to request an external review each time *you* receive:
 - (a) A *noncertification* decision; or
 - (b) An appeal decision upholding a noncertification decision; or
 - (c) A second level *grievance* review decision upholding the original *noncertification*.
- 3. In order for *your* request to be eligible for external review, the NCDOI must determine the following:
 - (a) That *your* request is about a medical necessity determination that resulted in a *noncertification* decision;
 - (b) That *you* had coverage with *us* in effect when the *noncertification* decision was issued;
 - (c) That the service for which the *noncertification* was issued appears to be a covered service under *your policy/certificate*; and
 - (d) That *you* have exhausted *our* internal review process as described below.
- 4. External review is performed on a standard and expedited timetable, depending on which is requested and on whether medical circumstances meet the criteria for expedited review.
- 5. STANDARD EXTERNAL REVIEW
 - (a) For a standard external review, *you* will be considered to have exhausted *our* internal review process if *you* have:
 - (i) Completed *our* appeal and second level *grievance* review and have received a written second level determination from *us*; or
 - (ii) Filed a second level grievance and, except to the extent that *you* have requested or agreed to a delay, have not received *our* written decision within 60 days after the date *you* submitted the request; or
 - (iii) Received notification that *we* have agreed to waive the requirement to exhaust *our* internal appeal and *grievance* process.
 - (b) If *your* request for a standard external review is related to a retrospective *noncertification* (a *noncertification* that occurs after *you* have received the services in question), *you* will not be

eligible to request a standard review until *you* have completed *our* internal review process and received a written final determination from *us*.

- (c) If *you* wish to request a standard external review, *you* (or *your* representative) must make this request to the NCDOI within 120 days after receiving *our* written notice of final determination that the services in question are not approved.
- (d) When processing *your* request for external review, the NCDOI will require *you* to provide the NCDOI with a written, signed authorization for the release of any of *your* medical records that may need to be reviewed for the purpose of reaching a decision on the external review.
- (e) Within 10 business days of receipt of *your* request for a standard external review, the NCDOI will notify *you* and *your* provider of whether *your* request is complete and whether it is accepted. If the NCDOI notifies *you* that *your* request is incomplete, *you* must provide all requested additional information to the NCDOI within 150 days of the date of *our* written notice of final determination. If the NCDOI accepts *your* request, the acceptance notice will include:
 - (i) The name and contact information for the IRO assigned to *your* case;
 - (ii) A copy of the information about *your* case that *we* provided to the NCDOI;
 - (iii) Notice that *we* will provide *you* with a copy of the documents and information considered in making the denial decision (which will also be sent to the IRO); and
 - (iv) Notice that *you* may submit additional written information and supporting documentation relevant to the initial *noncertification* to the assigned IRO within 7 days of the date of the acceptance notice.
- (f) If *you* choose to provide any additional information to the IRO, *you* must also provide the same information to *us* at the same time using the same means of communication (e.g., *you* must fax the information to *us* if *you* faxed it to the IRO). When faxing information to *us*, send it to 1-920-661-2003. If *you* choose to mail *your* information, send it to:

Appeals and Grievances
P.O. Box 13597
Green Bay, WI 54307-3597
E-mail: AppealsCoordinator@eAMS.com

- (g) Please note that *you* may also provide this additional information to the NCDOI within the 7-day deadline rather than sending it directly to the IRO and *us*. The NCDOI will forward this information to the IRO and *us* within 2 business days of receiving *your* additional information.
 - (h) The IRO will send *you* written notice of its determination within 45 days of the date the NCDOI receives *your* standard external review request. If the IRO's decision is to reverse the *noncertification*, *we* will:
 - (i) Reverse the *noncertification* decision within 3 business days of receiving notice of the IRO's decision;
 - (ii) Provide coverage for the requested service or supply that was the subject of the *noncertification* decision. If *you* are no longer covered by *us* at the time *we* receive notice of the IRO's decision to reverse the *noncertification*, *we* will only provide coverage for those services or supplies *you* actually received or would have received prior to termination of *your* *policy*/certificate if the service had not been noncertified when first requested.
6. EXPEDITED EXTERNAL REVIEW
- (a) An expedited review of a *noncertification* decision may be available if the *covered person* has a medical condition where the time required to complete either an expedited internal appeal or second level *grievance* review or a standard external review would reasonably be expected to seriously jeopardize the life or health of the *covered person* or would jeopardize

the *covered person's* ability to regain maximum function. If this is the case, *you* may make a written request to the NCDOI for an expedited review after *you* receive:

- (i) A *noncertification* decision from *us* AND file a request with *us* for an expedited appeal; or
 - (ii) An appeal decision upholding a *noncertification* decision AND file a request with *us* for an expedited second level *grievance* review; or
 - (iii) A second level *grievance* review decision upholding the original *noncertification*.
- (b) *You* may also make a request for an expedited external review if *you* receive an adverse second level *grievance* review decision concerning a *noncertification* of an admission, availability of care, continued stay, or *emergency care*, but have not been discharged from the *inpatient* facility.
- (c) In consultation with a medical professional, the NCDOI will review *your* request and determine whether it qualifies for expedited review. *You* and *your* provider will be notified within 3 business days if *your* request is accepted for expedited external review. If *your* request is not accepted for expedited review, the NCDOI may:
- (i) Accept the case for standard external review if *our* internal review process was already completed; or
 - (ii) Require the completion of *our* internal review process before *you* may make another request for an external review with the NCDOI.
- (d) An expedited external review is not available for retrospective *noncertifications*.
- (e) The IRO will communicate its decision to *you* within 4 business days of the date the NCDOI receives *your* request for an expedited external review. If the IRO's decision is to reverse the *noncertification*, *we* will, within one (1) day of receiving notice of the IRO's decision, reverse the *noncertification* decision for the requested service or supply that is the subject of the *noncertification* decision. If *you* are no longer covered by *us* at the time *we* receive notice of the IRO's decision to reverse the *noncertification*, *we* will only provide coverage for those services or supplies *you* actually received or would have received prior to termination of *your policy/certificate* if the service had not been noncertified when first requested.
7. The IRO's external review decision is binding on *us* and *you*, except to the extent *you* may have other remedies available under applicable federal or state law.
8. *You* may not file a subsequent request for an external review involving the same *noncertification* decision for which *you* have already received an external review decision.
9. For further information about external review or to request an external review, contact the NCDOI at:

By Mail:

North Carolina Department of Insurance
Healthcare External Review Program
1201 Mail Service Center
Raleigh, NC 27699-1201
Fax: 1-919-807-6865

In Person:

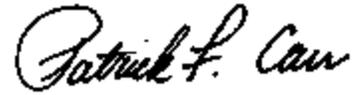
Dobbs Building
430 N. Salisbury St.
4th Floor, Suite 4105
Raleigh, NC
Phone toll-free in NC: 1-877-885-0231
Phone out of NC: 1-919-807-6860
www.ncdoi.com for External Review Information and Request Form

The Healthcare Review Program is available to provide Consumer Counseling on utilization review and internal appeals and grievance issues.

This rider applies only to *covered persons* who reside in the state of North Carolina.

This rider does not change, waive or extend any part of the *policy/certificate*, other than as stated herein.

Golden Rule Insurance Company

A handwritten signature in black ink that reads "Patrick F. Carr". The signature is written in a cursive, flowing style.

President

OHIO ENDORSEMENT

By attachment of this endorsement, the *policy/certificate* is amended to the extent of any conflict with the following:

MGR03433

A. The Definitions section is amended as follows:

1. The definitions of *emergency*, and *substance abuse* are deleted and replaced with the following:

"*Emergency*" means a medical condition that manifests itself by such acute symptoms of sufficient severity, including severe pain, that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

- (a) Placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;
- (b) Serious impairment to bodily functions; or
- (c) Serious dysfunction of any bodily organ or part.

If *you* or a *covered person* experiences an *emergency* medical condition, one of the ways to access emergency services is to call 9-1-1.

MGR03452

2. Subject to all other terms and conditions of the *policy/certificate*, the definition of *eligible child* is expanded to include *your* or *your spouse's* child 26 years of age over who is:

- (a) Unmarried; and
- (b) Under 28 years of age.

MGR04387

3. The following definitions are added:

"*Disease pathophysiology*" means the functional changes that happen to the body that are caused by cancer.

MGR04273

"*Eligible cancer clinical trial*" means a cancer clinical trial that meets all of the following criteria:

- (a) A purpose of the trial is to test whether the intervention potentially improves the *covered person's* health outcomes;
- (b) The treatment provided as part of the trial is given with the intention of improving the *covered person's* health outcomes;
- (c) The trial has a therapeutic intent and is not designed exclusively to test toxicity or *disease pathophysiology*;
- (d) The trial does one of the following:
 - (i) Tests how to administer a health care service, item, or drug for the treatment of cancer;
 - (ii) Tests responses to a health care service, item, or drug for the treatment of cancer;
 - (iii) Compares the effectiveness of a health care service, item, or drug for the treatment of cancer with that of other health care services, items, or drugs for the treatment of cancer;

- (iv) Studies new uses of a health care service, item, or drug for the treatment of cancer;
- (e) The trial is approved by one of the following:
 - (i) The National Institutes of Health or one of its cooperative groups or centers under the United States Department of Health and Human Services;
 - (ii) The United States Food and Drug Administration;
 - (iii) The United States Department of Defense; or
 - (iv) The United States Department of Veterans' Affairs.

MGR04274

"Routine patient care" means all health care services covered in the *policy* for the treatment of cancer; including the type and frequency of any diagnostic testing method, if the *covered person* was not a participant in a cancer clinical trial and that was not necessitated solely because of the trial.

MGR04275

Stabilize means to provide the treatment of a medical *emergency* necessary to assure, within reasonable medical probability, that no medical deterioration of the condition is likely to result from or occur during the transfer of the *covered person* from a facility.

MGR04603

"Subject of the cancer clinical trial" means the health care service, item, or drug that is being evaluated in the clinical trial and that is not *routine patient care*.

MGR04276

- 4. The definition of *medical practitioner* is amended to include a certified mechanotherapist, professional counselor, social worker and clinical nurse specialist whose nursing specialty is mental health.

MGR04491

B. TERM OF POLICY AND RIGHT TO TERMINATE:

This certificate is issued for an indefinite term, beginning on the effective date of the certificate shown on the *face page*. Subject to the provisions of the *policy/certificate*, including the eligibility requirements, maximum benefit limits and termination for fraud provisions the certificate continues in force so long as premiums are paid when due, until terminated according to the following paragraphs.

The *policyholder* may terminate the *policy* by giving written notice to *us*. *You* may also terminate coverage under this certificate by giving written notice to *us*. Termination will be effective on the later of: (A) the date we receive notice; or (B) the requested termination date.

We may terminate any or all of the insurance under the *policy*, as of any premium due date, by giving written notice to the *policyholder* and affected members prior to that date as specified below. We will not terminate *your* certificate unless we terminate all certificates just like *yours* issued under the *policy* to those then residing in *your* state.

MGR03455

Notice of Termination By Us: We will provide written notice to the *policyholder* and affected members at least 90 days prior to the date that we terminate all certificates just like *yours* issued under the *policy* to those then residing in *your* state. *You* will be offered an option to purchase any other *individual market coverage* we offer in *your* state at the time of discontinuation of this certificate. This option to purchase other *individual market coverage* will be on a guaranteed issue basis without regard to health status. However, if

underwriting medical riders have been issued to *you* under this certificate, they will be transferred to whatever Golden Rule *individual market coverage* policy or certificate *you* are issued. As used in this provision, "*individual market coverage*" means non-employer based health insurance coverage.

We will provide written notice to the *policyholder*, the Ohio Commissioner of Insurance and affected members at least 180 days prior to the date that we discontinue offering and terminate existing *individual market coverage* in the state of Ohio.

MGR03456

C. The Eligibility provision is amended as follows:

1. Proof of an *eligible child's* incapacity and dependency must be provided to *us* within 31 days of the child's attainment of the limiting age in order for coverage to remain in force. After a two-year period following the child's attainment of the limiting age, we may ask for proof of incapacity and dependency annually.

MGR03734

D. The *policy/certificate* is amended to include charges incurred for the following as *covered expenses*:

1. Diagnosis and treatment of *mental disorders*, including *substance abuse*;

MGR04478

2. *Routine patient care* incurred by a *covered person* participating in an *eligible cancer clinical trial* when such care would have been a *covered expense* if the *covered person* had not been participating in a clinical trial.

Covered expenses under the *policy* will not include charges incurred for:

- (a) A health care service, item, or drug:
 - (i) That is the subject of the cancer clinical trial; or
 - (ii) Provided solely to satisfy data collection and analysis needs for the cancer clinical trial that is not used in the direct clinical management of the covered person;
- (b) A service, item or drug that is eligible for reimbursement by a person other than *us*, including the sponsor of the cancer clinical trial;
- (c) An *investigational* or *experimental* drug or device that has not been approved for market by the United States Food and Drug Administration;
- (d) Transportation, lodging, food, or other expenses for the covered person, or a family member or companion of the covered person, that are associated with the travel to or from a facility providing the cancer clinical trial; and
- (e) An item or drug provided by the cancer clinical trial sponsors free of charge for the *covered person*.

MGR04277

3. Medical services to treat an *emergency* medical condition as necessary to *stabilize* the *covered person*.

MGR04604

E. A comprehensive list of services and supplies which are considered *covered expenses* under the Preventive Care Expense Benefits, as required by federal law, may be found at www.healthcare.gov/center/regulations/prevention.html. If after visiting the website *you* still have questions, *you* may contact Client Services at the toll-free number on the face page of *your* certificate.

MGR04527

- F. The Coordination of Benefits ("COB") provision is deleted and replaced with the following:

COORDINATION OF THIS CONTRACTS BENEFITS WITH OTHER BENEFITS

The Coordination of Benefits ("COB") provision applies when a person has health care coverage under more than one *plan*. *Plan* is defined below.

The order of benefits determination rules govern the order in which each *plan* will pay a claim for benefits. The *plan* that pays first is called the *primary plan*. The *primary plan* must pay benefits in accordance with its policy terms without regard to the possibility that another *plan* may cover some expenses. The *plan* that pays after the *primary plan* is the *secondary plan*. The *secondary plan* may reduce the benefits it pays so that payments from all *plans* does not exceed 100% of the total *allowable expense*.

DEFINITIONS

1. A "*plan*" is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.
 - (a) *Plan* includes: group and nongroup insurance contracts, health insuring corporation ("HIC") contracts, *closed panel plans* or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal government plan, as permitted by law.
 - (b) *Plan* does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; supplemental coverage as described in Revised Code sections 3923.37 and 1751.56; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under (a) or (b) is a separate *plan*. If a *plan* has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate *plan*.

2. "*This plan*" means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other *plans*. Any other part of the contract providing health care benefits is separate from *this plan*. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.
3. The order of benefit determination rules determine whether *this plan* is a *primary plan* or *secondary plan* when the person has health care coverage under more than one *plan*.

When *this plan* is primary, it determines payment for its benefits first before those for any other *plan* without considering any other *plan's* benefits. When *this plan* is secondary, it determines its benefits after those of another *plan* and may reduce the benefits it pays so that all *plan* benefits do not exceed 100% of the total *allowable expense*.

4. "*Allowable expense*" is a health care expense, including deductibles, coinsurance and *copayments*, that is covered at least in part by the *plan* covering the person. When a *plan* provides benefits in the form of services, the reasonable cash value of each service will be considered as both an *allowable expense* and a benefit paid. An

expense that is not covered by any *plan* covering the person is not an *allowable expense*. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a *covered person* is not an *allowable expense*.

The following are examples of expenses that are not *allowable expenses*:

- (a) The difference between the cost of a semi-private *hospital* room and a private *hospital* room is not an *allowable expense*, unless one of the *plans* provides coverage for private *hospital* room expenses.
 - (b) If a person is covered by 2 or more *plans* that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an *allowable expense*.
 - (c) If a person is covered by 2 or more *plans* that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an *allowable expense*.
 - (d) If a person is covered by one *plan* that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another *plan* that provides its benefits or services on the basis of negotiated fees, the *primary plan's* payment agreement shall be the *allowable expense* for all *plans*. However, if the provider has contracted with the *secondary plan* to provide the benefit or service for a specific negotiated fee or payment amount that is different than the *primary plan's* payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the *allowable expense* used by the *secondary plan* to determine benefits.
 - (e) The amount of any benefit reduction by the *primary plan* because a *covered person* has failed to comply with the *plan* provisions is not an *allowable expense*. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.
5. "*Closed panel plan*" is a *plan* that provides health care benefits to *covered persons* primarily in the form of services through a panel of providers that have contracted with or are employed by the *plan*, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.
 6. "*Custodial parent*" is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

When a person is covered by two or more *plans*, the rules for determining the order of benefit payments are as follows:

1. The *primary plan* pays or provides its benefits according to its terms of coverage without regard to the benefits of any other *plan* or *plans*.
2. (a) Except as provided in Paragraph (b), a *plan* that does not contain a coordination of benefits provision that is consistent with this provision is always *primary* unless the provisions of both *plans* state that the complying plan is primary.

(b) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the *plan* provided by the contract holder. Examples of these types of situations are major medical

coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a *closed panel plan* to provide out-of-network benefits.

3. A *plan* may consider the benefits paid or provided by another *plan* in calculating payment of its benefits only when it is *secondary* to that other *plan*.
4. Each *plan* determines its order of benefits using the first of the following rules that apply:
 - (a) Non-Dependent or Dependent. The *plan* that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the *primary plan* and the *plan* that covers the person as a dependent is the *secondary plan*. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the *plan* covering the person as a dependent, and primary to the *plan* covering the insured person as other than a dependent (e.g. a retired employee), then the order of benefits between the two *plans* is reversed so that the *plan* covering the person as an employee, member, policyholder, subscriber or retiree is the *secondary plan* and the other *plan* is the *primary plan*.
 - (b) Dependent child covered under more than one *plan*. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one *plan* the order of benefits is determined as follows:
 - (iii) For a dependent child whose parents are married or are living together, whether or not they have been married:
 - (a) The *plan* of the parent whose birthday falls earlier in the calendar year is the *primary plan*; or
 - (b) If both parents have the same birthday, the *plan* that has covered the parent the longest is the *primary plan*.
 - (c) However, if one spouse's *plan* has some other coordination rule (for example, a "gender rule" which says the father's plan is always primary) we will follow the rules of that *plan*.
 - (iv) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
 - (a) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the *plan* of that parent has actual knowledge of those terms, that *plan* is *primary*. That rule applies to plan years commencing after the *plan* is given notice of the court decree;
 - (b) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph (i) above shall determine the order of benefits;
 - (c) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph (i) above shall determine the order of benefits; or
 - (d) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
 - A. The plan covering the custodial parent;

- B. The plan covering the spouse of the custodial parent,
 - C. The plan covering the non-custodial parent; and then
 - D. The plan covering the spouse of the non-custodial parent
- (v) For a dependent child covered under more than one *plan* of individuals who are not the parents of the child, the provisions of subparagraph (i) or (ii) above shall determine the order of benefits as if those individuals were the parents of the child.
- (c) Active employee or retired or laid-off employee. The *plan* that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the *primary plan*. The plan covering that same person as a retired or laid-off employee is the *secondary plan*. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other *plan* does not have this rule, and as a result, the *plans* do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled 4(a) can determine the order of benefits.
- (d) COBRA or state continuation coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another *plan*, the *plan* covering the person as an employee, member, subscriber, or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the *primary plan*, and the COBRA or state or other federal continuation coverage is the *secondary plan*. If the other *plan* does not have this rule, and as a result, the *plans* do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled 4(a) can determine the order of benefits.
- (e) Longer or shorter length of coverage. The *plan* that covered the person as an employee, member, policyholder, subscriber or retiree longer is the *primary plan* and the *plan* that covered the person the shorter period of time is the *secondary plan*.
- (f) If the preceding rules do not determine the order of benefits, the *allowable expenses* shall be shared equally between the *plans* meeting the definition of *plan*. In addition, *this plan* will not pay more than it would have paid had it been the *primary plan*.

EFFECT ON THE BENEFITS OF THIS PLAN

1. When *this plan* is secondary it may reduce its benefits so that the total benefits paid or provided by all *plans* during a plan year are not more than the total *allowable expenses*. In determining the amount to be paid for any claim, the *secondary plan* will calculate the benefits it would have paid in the absence of other health coverage and apply that calculated amount to any *allowable expense* under its *plan* that is unpaid by the *primary plan*. The *secondary plan* may reduce its payment by the amount so that, when combined with the amount paid by the *primary plan*, the total benefits paid or provided by all *plans* for the claim do not exceed the total *allowable expense* for that claim. In addition, the *secondary plan* shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.
2. If a covered person is enrolled in two or more *closed panel plans* and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one *closed panel plan*, COB shall not apply between that *plan* and other *closed panel plans*.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under *this plan* and other *plans*. Claims Administration may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under *this plan* and other *plans* covering the person claiming benefits. Claims Administration need not tell, or get the consent of, any person to do this. Each person claiming benefits under *this plan* must give Claims Administration any facts it needs to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A payment made under another *plan* may include an amount that should have been paid under *this plan*. If it does, Claims Administration may pay that amount to the organization that made that payment. That amount will be treated as though it were a benefit paid under *this plan*. Claims Administration will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

RIGHT TO RECOVERY

If the amount of payments made by Claims Administration is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the *covered person*. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

COORDINATION DISPUTES

If *you* believe that *we* have not paid a claim properly, *you* should first attempt to resolve the problem by contacting *us* at 1-800-657-8205 or at www.goldenrule.com. If *you* are still not satisfied, *you* may call the Ohio Department of Insurance for instructions on filing a consumer complaint. Call 1-800-686-1526, or visit the Department's website at <http://insurance.ohio.gov>.

MGR04730

- G. The Rescission provisions is amended to read as follows:

RESCISSION: *We* may not rescind *your* certificate based on a misrepresentation on the application for coverage unless *you* or a person seeking coverage on *your* behalf performed an act or practice that constitutes fraud, or made an intentional misrepresentation of material fact, as prohibited by the terms of the *policy/certificate*.

We must provide at least 30 days advance written notice before *your* certificate may be rescinded. *You* have the right to appeal any such rescission.

MGR04542

- H. Under Uniform Provisions, the Misstatement of Tobacco Use provision is deleted and replaced with the following:

MISSTATEMENT OF TOBACCO USE: The answer to the tobacco question on the application is material to *our* correct underwriting. If a *covered persons* use of tobacco has been willfully and fraudulently misstated on the *covered persons* application for coverage under the *policy*, *we* have the right to rescind that persons coverage, subject to the Incontestability clause under Uniform Provisions.

MGR04449

Except as specifically stated in this endorsement, the benefits under this endorsement are subject to all of the terms, conditions, exclusions, limitations and notification requirements of the *policy/certificate*, including any applicable *deductible amounts*, coinsurance provisions, copay amounts, or dollar limits.

MGR03440

The benefits of this endorsement apply only to *covered persons* who reside in the state of Ohio.

This endorsement will not change, waive or extend any part of the *policy/certificate*, other than as stated herein.

This endorsement is effective September 1, 2012 or at the same time as the *policy/certificate*, whichever is later.

**Golden Rule Insurance
Company**

A handwritten signature in black ink that reads "Patrick F. Carr". The signature is written in a cursive style with a large initial "P".

President

MGR03441

OHIO ENDORSEMENT

By attachment of this endorsement, the *policy/certificate* is amended to the extent of any conflict with the following:

MGR03433

A. The Definitions section is amended as follows:

1. The definitions of *emergency*, and *substance abuse* are deleted and replaced with the following:

"*Emergency*" means a medical condition that manifests itself by such acute symptoms of sufficient severity, including severe pain, that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

- (a) Placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;
- (b) Serious impairment to bodily functions; or
- (c) Serious dysfunction of any bodily organ or part.

If *you* or a *covered person* experiences an *emergency* medical condition, one of the ways to access emergency services is to call 9-1-1.

MGR03452

2. Subject to all other terms and conditions of the *policy/certificate*, the definition of *eligible child* is expanded to include *your* or *your spouse's* child 26 years of age over who is:

- (a) Unmarried; and
- (b) Under 28 years of age.

MGR04387

3. The following definitions are added:

"*Biologically-based mental illness*" means: (1) Schizophrenia; (2) Schizoaffective disorder; (3) Major depressive disorder; (4) Bipolar disorder; (5) Paranoia and other psychotic disorders; (6) Obsessive-compulsive disorder; and (7) Panic disorder, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

MGR04151

"*Disease pathophysiology*" means the functional changes that happen to the body that are caused by cancer.

MGR04273

"*Eligible cancer clinical trial*" means a cancer clinical trial that meets all of the following criteria:

- (a) A purpose of the trial is to test whether the intervention potentially improves the *covered person's* health outcomes;
- (b) The treatment provided as part of the trial is given with the intention of improving the *covered person's* health outcomes;
- (c) The trial has a therapeutic intent and is not designed exclusively to test toxicity or *disease pathophysiology*;
- (d) The trial does one of the following:

- (i) Tests how to administer a health care service, item, or drug for the treatment of cancer;
- (ii) Tests responses to a health care service, item, or drug for the treatment of cancer;
- (iii) Compares the effectiveness of a health care service, item, or drug for the treatment of cancer with that of other health care services, items, or drugs for the treatment of cancer;
- (iv) Studies new uses of a health care service, item, or drug for the treatment of cancer;
- (e) The trial is approved by one of the following:
 - (i) The National Institutes of Health or one of its cooperative groups or centers under the United States Department of Health and Human Services;
 - (ii) The United States Food and Drug Administration;
 - (iii) The United States Department of Defense; or
 - (iv) The United States Department of Veterans' Affairs.

MGR04274

"Routine patient care" means all health care services covered in the *policy* for the treatment of cancer; including the type and frequency of any diagnostic testing method, if the *covered person* was not a participant in a cancer clinical trial and that was not necessitated solely because of the trial.

MGR04275

Stabilize means to provide the treatment of a medical *emergency* necessary to assure, within reasonable medical probability, that no medical deterioration of the condition is likely to result from or occur during the transfer of the *covered person* from a facility.

MGR04603

"Subject of the cancer clinical trial" means the health care service, item, or drug that is being evaluated in the clinical trial and that is not *routine patient care*.

MGR04276

4. The definition of *medical practitioner* is amended to include "a mechanotherapist who has been issued a certificate as a mechanotherapist under Ohio law and who has completed all educational requirements in mechanotherapy, as defined by Ohio state law".

MGR03454

B. TERM OF POLICY AND RIGHT TO TERMINATE:

This certificate is issued for an indefinite term, beginning on the effective date of the certificate shown on the *face page*. Subject to the provisions of the *policy/certificate*, including the eligibility requirements, maximum benefit limits and termination for fraud provisions the certificate continues in force so long as premiums are paid when due, until terminated according to the following paragraphs.

The *policyholder* may terminate the *policy* by giving written notice to *us*. *You* may also terminate coverage under this certificate by giving written notice to *us*. Termination will be effective on the later of: (A) the date *we* receive notice; or (B) the requested termination date.

We may terminate any or all of the insurance under the *policy*, as of any premium due date, by giving written notice to the *policyholder* and affected members prior to that date

as specified below. *We* will not terminate *your* certificate unless *we* terminate all certificates just like *yours* issued under the *policy* to those then residing in *your* state.

MGR03455

Notice of Termination By Us: *We* will provide written notice to the *policyholder* and affected members at least 90 days prior to the date that *we* terminate all certificates just like *yours* issued under the *policy* to those then residing in *your* state. *You* will be offered an option to purchase any other *individual market coverage* *we* offer in *your* state at the time of discontinuation of this certificate. This option to purchase other *individual market coverage* will be on a guaranteed issue basis without regard to health status. However, if underwriting medical riders have been issued to *you* under this certificate, they will be transferred to whatever Golden Rule *individual market coverage* policy or certificate *you* are issued. As used in this provision, "*individual market coverage*" means non-employer based health insurance coverage.

We will provide written notice to the *policyholder*, the Ohio Commissioner of Insurance and affected members at least 180 days prior to the date that *we* discontinue offering and terminate existing *individual market coverage* in the state of Ohio.

MGR03456

C. The Eligibility provision is amended as follows:

1. Proof of an *eligible child's* incapacity and dependency must be provided to *us* within 31 days of the child's attainment of the limiting age in order for coverage to remain in force. After a two-year period following the child's attainment of the limiting age, *we* may ask for proof of incapacity and dependency annually.

MGR03734

D. The *policy/certificate* is amended to include charges incurred for the following as *covered expenses*:

1. Diagnosis and treatment of *alcoholism* when provided on other than an *inpatient* basis by or under the supervision of a *doctor*, subject to the following limitations:
 - (a) Benefits provided on *outpatient* basis, or on an intermediate primary care services basis, are limited to a combined maximum benefit of \$550 per calendar year; and
 - (b) Intermediate primary care services must be provided in a *hospital*, a community mental health facility (as defined by state law), or an alcoholism treatment facility that has been approved by the joint commission on accreditation of hospitals or certified by the department of health

MGR03725

2. *Routine patient care* incurred by a *covered person* participating in an *eligible cancer clinical trial* when such care would have been a *covered expense* if the *covered person* had not been participating in a clinical trial.

Covered expenses under the *policy* will not include charges incurred for:

- (a) A health care service, item, or drug:
 - (i) That is the subject of the cancer clinical trial; or
 - (ii) Provided solely to satisfy data collection and analysis needs for the cancer clinical trial that is not used in the direct clinical management of the covered person;
- (b) A service, item or drug that is eligible for reimbursement by a person other than *us*, including the sponsor of the cancer clinical trial;

- (c) An *investigational* or *experimental* drug or device that has not been approved for market by the United States Food and Drug Administration;
- (d) Transportation, lodging, food, or other expenses for the covered person, or a family member or companion of the covered person, that are associated with the travel to or from a facility providing the cancer clinical trial; and
- (e) An item or drug provided by the cancer clinical trial sponsors free of charge for the *covered person*.

MGR04277

- 3. Medical services to treat an *emergency* medical condition as necessary to *stabilize* the *covered person*.

MGR04604

- E. The *policy/certificate* is amended to include charges incurred for the following as *covered expenses* when incurred by a *covered person* as an *inpatient* in a *hospital*:
 - 1. Diagnosis and treatment of a *biologically-based mental illness* clinically diagnosed by a *doctor*, psychologist, professional counselor, independent social worker or clinical nurse specialist whose nursing specialty is mental health. The prescribed treatment must: (1) not be considered experimental or *investigational treatment*; (2) be *medically necessary*; and (3) have been proven to be clinically effective in accordance with generally accepted medical standards.

MGR04235

- F. A comprehensive list of services and supplies which are considered *covered expenses* under the Preventive Care Expense Benefits, as required by federal law, may be found at www.healthcare.gov/center/regulations/revention.html. If after visiting the website *you* still have questions, *you* may contact Client Services at the toll-free number on the face page of *your* certificate.

MGR04527

- G. The Coordination of Benefits ("COB") provision is deleted and replaced with the following:

COORDINATION OF THIS CONTRACTS BENEFITS WITH OTHER BENEFITS

The Coordination of Benefits ("COB") provision applies when a person has health care coverage under more than one *plan*. *Plan* is defined below.

The order of benefits determination rules govern the order in which each *plan* will pay a claim for benefits. The *plan* that pays first is called the *primary plan*. The *primary plan* must pay benefits in accordance with its policy terms without regard to the possibility that another *plan* may cover some expenses. The *plan* that pays after the *primary plan* is the *secondary plan*. The *secondary plan* may reduce the benefits it pays so that payments from all *plans* does not exceed 100% of the total *allowable expense*.

DEFINITIONS

- 1. A "*plan*" is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.
 - (a) *Plan* includes: group and nongroup insurance contracts, health insuring corporation ("HIC") contracts, *closed panel plans* or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal government plan, as permitted by law.

- (b) *Plan* does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; supplemental coverage as described in Revised Code sections 3923.37 and 1751.56; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under (a) or (b) is a separate *plan*. If a *plan* has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate *plan*.

- 2. "*This plan*" means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other *plans*. Any other part of the contract providing health care benefits is separate from *this plan*. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.
- 3. The order of benefit determination rules determine whether *this plan* is a *primary plan* or *secondary plan* when the person has health care coverage under more than one *plan*.

When *this plan* is primary, it determines payment for its benefits first before those for any other *plan* without considering any other *plan's* benefits. When *this plan* is secondary, it determines its benefits after those of another *plan* and may reduce the benefits it pays so that all *plan* benefits do not exceed 100% of the total *allowable expense*.

- 4. "*Allowable expense*" is a health care expense, including deductibles, coinsurance and *copayments*, that is covered at least in part by the *plan* covering the person. When a *plan* provides benefits in the form of services, the reasonable cash value of each service will be considered as both an *allowable expense* and a benefit paid. An expense that is not covered by any *plan* covering the person is not an *allowable expense*. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a *covered person* is not an *allowable expense*.

The following are examples of expenses that are not *allowable expenses*:

- (a) The difference between the cost of a semi-private *hospital* room and a private *hospital* room is not an *allowable expense*, unless one of the *plans* provides coverage for private *hospital* room expenses.
- (b) If a person is covered by 2 or more *plans* that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an *allowable expense*.
- (c) If a person is covered by 2 or more *plans* that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an *allowable expense*.
- (d) If a person is covered by one *plan* that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another *plan* that provides its benefits or services on the basis of negotiated fees, the *primary plan's* payment agreement shall be the *allowable expense* for all *plans*. However, if the provider has contracted with the *secondary plan* to provide the benefit or service for a specific negotiated fee or payment amount that is different than the

primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the *allowable expense* used by the *secondary plan* to determine benefits.

- (e) The amount of any benefit reduction by the *primary plan* because a *covered person* has failed to comply with the *plan* provisions is not an *allowable expense*. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.
- 5. "*Closed panel plan*" is a *plan* that provides health care benefits to *covered persons* primarily in the form of services through a panel of providers that have contracted with or are employed by the *plan*, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.
- 6. "*Custodial parent*" is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

When a person is covered by two or more *plans*, the rules for determining the order of benefit payments are as follows:

- 1. The *primary plan* pays or provides its benefits according to its terms of coverage without regard to the benefits of any other *plan* or *plans*.
- 2. (a) Except as provided in Paragraph (b), a *plan* that does not contain a coordination of benefits provision that is consistent with this provision is always *primary* unless the provisions of both *plans* state that the complying plan is primary.

(b) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the *plan* provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a *closed panel plan* to provide out-of-network benefits.
- 3. A *plan* may consider the benefits paid or provided by another *plan* in calculating payment of its benefits only when it is *secondary* to that other *plan*.
- 4. Each *plan* determines its order of benefits using the first of the following rules that apply:
 - (a) Non-Dependent or Dependent. The *plan* that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the *primary plan* and the *plan* that covers the person as a dependent is the *secondary plan*. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the *plan* covering the person as a dependent, and primary to the *plan* covering the insured person as other than a dependent (e.g. a retired employee), then the order of benefits between the two *plans* is reversed so that the *plan* covering the person as an employee, member, policyholder, subscriber or retiree is the *secondary plan* and the other *plan* is the *primary plan*.
 - (b) Dependent child covered under more than one *plan*. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one *plan* the order of benefits is determined as follows:
 - (iii) For a dependent child whose parents are married or are living together, whether or not they have been married:

- (a) The *plan* of the parent whose birthday falls earlier in the calendar year is the *primary plan*; or
 - (b) If both parents have the same birthday, the *plan* that has covered the parent the longest is the *primary plan*.
 - (c) However, if one spouse's *plan* has some other coordination rule (for example, a "gender rule" which says the father's plan is always primary) we will follow the rules of that *plan*.
- (iv) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
- (a) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the *plan* of that parent has actual knowledge of those terms, that *plan* is *primary*. That rule applies to plan years commencing after the *plan* is given notice of the court decree;
 - (b) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph (i) above shall determine the order of benefits;
 - (c) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph (i) above shall determine the order of benefits; or
 - (d) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
 - A. The plan covering the custodial parent;
 - B. The plan covering the spouse of the custodial parent,
 - C. The plan covering the non-custodial parent; and then
 - D. The plan covering the spouse of the non-custodial parent
- (v) For a dependent child covered under more than one *plan* of individuals who are not the parents of the child, the provisions of subparagraph (i) or (ii) above shall determine the order of benefits as if those individuals were the parents of the child.
- (c) Active employee or retired or laid-off employee. The *plan* that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the *primary plan*. The plan covering that same person as a retired or laid-off employee is the *secondary plan*. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other *plan* does not have this rule, and as a result, the *plans* do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled 4(a) can determine the order of benefits.
 - (d) COBRA or state continuation coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another *plan*, the *plan* covering the person as an employee, member, subscriber, or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the *primary plan*, and the COBRA or state or other federal continuation coverage is the *secondary plan*. If the other *plan* does not have this rule, and as a result, the *plans* do not agree on

the order of benefits, this rule is ignored. This rule does not apply if the rule labeled 4(a) can determine the order of benefits.

- (e) Longer or shorter length of coverage. The *plan* that covered the person as an employee, member, policyholder, subscriber or retiree longer is the *primary plan* and the *plan* that covered the person the shorter period of time is the *secondary plan*.
- (f) If the preceding rules do not determine the order of benefits, the *allowable expenses* shall be shared equally between the *plans* meeting the definition of *plan*. In addition, *this plan* will not pay more than it would have paid had it been the *primary plan*.

EFFECT ON THE BENEFITS OF THIS PLAN

- 5. When *this plan* is secondary it may reduce its benefits so that the total benefits paid or provided by all *plans* during a plan year are not more than the total *allowable expenses*. In determining the amount to be paid for any claim, the *secondary plan* will calculate the benefits it would have paid in the absence of other health coverage and apply that calculated amount to any *allowable expense* under its *plan* that is unpaid by the *primary plan*. The *secondary plan* may reduce its payment by the amount so that, when combined with the amount paid by the *primary plan*, the total benefits paid or provided by all *plans* for the claim do not exceed the total *allowable expense* for that claim. In addition, the *secondary plan* shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.
- 6. If a covered person is enrolled in two or more *closed panel plans* and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one *closed panel plan*, COB shall not apply between that *plan* and other *closed panel plans*.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under *this plan* and other *plans*. Claims Administration may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under *this plan* and other *plans* covering the person claiming benefits. Claims Administration need not tell, or get the consent of, any person to do this. Each person claiming benefits under *this plan* must give Claims Administration any facts it needs to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A payment made under another *plan* may include an amount that should have been paid under *this plan*. If it does, Claims Administration may pay that amount to the organization that made that payment. That amount will be treated as though it were a benefit paid under *this plan*. Claims Administration will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

RIGHT TO RECOVERY

If the amount of payments made by Claims Administration is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the *covered person*. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

COORDINATION DISPUTES

If *you* believe that *we* have not paid a claim properly, *you* should first attempt to resolve the problem by contacting *us* at 1-800-657-8205 or at www.goldenrule.com. If *you* are still not satisfied, *you* may call the Ohio Department of Insurance for instructions on filing a consumer complaint. Call 1-800-686-1526, or visit the Department's website at <http://insurance.ohio.gov>.

MGR04730

- H. The Rescission provisions is amended to read as follows:

RESCISSION: *We* may not rescind *your* certificate based on a misrepresentation on the application for coverage unless *you* or a person seeking coverage on *your* behalf performed an act or practice that constitutes fraud, or made an intentional misrepresentation of material fact, as prohibited by the terms of the *policy/certificate*.

We must provide at least 30 days advance written notice before *your* certificate may be rescinded. *You* have the right to appeal any such rescission.

MGR04542

- I. Under Uniform Provisions, the Misstatement of Tobacco Use provision is deleted and replaced with the following:

MISSTATEMENT OF TOBACCO USE: The answer to the tobacco question on the application is material to *our* correct underwriting. If a *covered persons* use of tobacco has been willfully and fraudulently misstated on the *covered persons* application for coverage under the *policy*, *we* have the right to rescind that persons coverage, subject to the Incontestability clause under Uniform Provisions.

MGR04449

Except as specifically stated in this endorsement, the benefits under this endorsement are subject to all of the terms, conditions, exclusions, limitations and notification requirements of the *policy/certificate*, including any applicable *deductible amounts*, coinsurance provisions, copay amounts, or dollar limits.

MGR03440

The benefits of this endorsement apply only to *covered persons* who reside in the state of Ohio.

This endorsement will not change, waive or extend any part of the *policy/certificate*, other than as stated herein.

This endorsement is effective September 1, 2012 or at the same time as the *policy/certificate*, whichever is later.

Golden Rule Insurance
Company



President

MGR03441

OHIO APPEAL PROCEDURES RIDER

This rider is effective on DATE or at the same time as the *policy/certificate*, whichever is later.

By the attachment of this rider, the *policy/certificate* is amended to include the following:

OHIO APPEAL PROCEDURES

- A. **APPLICABILITY:** These procedures apply only to the medical benefits under the *policy/certificate*. They do not apply to benefits under the optional vision, term life, or accidental death riders, if attached to the *policy/certificate*.
- B. **DEFINITIONS:** As used in this rider, the following terms have the meanings indicated:
1. "*Adverse benefit determination*" means a decision by us:
 - (a) To deny, reduce, or terminate a requested *health care service* or payment, in whole or in part, including all of the following:
 - (i) A determination that the *health care service* does not meet the *health plan issuer's* requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, including *experimental or investigational treatments*.
 - (ii) A determination of an individual's eligibility for individual health insurance coverage, including coverage offered to individuals through a non-employer group, to participate in a plan or health insurance coverage.
 - (iii) A determination that a *health care service* is not a *covered benefit*.
 - (iv) The imposition of an exclusion, including exclusions for preexisting conditions, source of *injury, network*, or any other limitation on benefits that would otherwise be covered.
 - (b) Not to issue individual health insurance coverage to an applicant, including coverage offered to individuals through a nonemployer group.
 - (c) To rescind coverage on a health benefit plan.
 2. "*Authorized representative*" means an individual who represents a *covered person* in an internal appeal or external review process of an *adverse benefit determination* and who is any of the following:
 - (a) A person to whom a *covered person* has given express, written consent to represent that individual in an internal appeals process or external review process of an *adverse benefit determination*.
 - (b) A person authorized by law to provide substituted consent for a *covered person*.
 - (c) A family member or a treating health care professional, but only when the *covered person* is unable to provide consent.
 3. "*Covered person*" means a policyholder, subscriber, enrollee, member, or individual covered by a *health benefit plan*. This includes a person who has applied for insurance and who was declined or rescinded. *Covered person* does include the *covered person's authorized representative* with regard to an internal appeal or external review.
 4. "*Covered benefits*" or "*benefits*" means those *health care services* to which a *covered person* is entitled under the terms of a *health benefit plan*.
 5. "*Emergency medical condition*" means a medical condition that manifests itself by such acute symptoms of sufficient severity, including severe pain, that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:
 - (a) Placing the health of the *covered person* or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.
 - (b) Serious impairment to bodily functions.

- (c) Serious dysfunction of any bodily organ or part.
6. "Emergency services" means the following:
- (a) A medical screening examination, as required by federal law, that is within the capability of the emergency department of a *hospital*, including ancillary services routinely available to the emergency department, to evaluate an *emergency medical condition*.
 - (b) Such further medical examination and treatment that are required by federal law to *stabilize* an *emergency medical condition* and are within the capabilities of the staff and facilities available at the *hospital*, including any trauma and burn center of the *hospital*.
7. "Final adverse benefit determination" means an *adverse benefit determination* that is upheld or modified at the completion of a *health plan issuer's* internal appeals process.
8. "Health benefit plan" means a policy, contract, certificate, or agreement offered by a *health plan issuer* to provide, deliver, arrange for, pay for, or reimburse any of the costs of *health care services*.
9. "Health care services" means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.
10. "Health plan issuer" means an entity subject to the insurance laws and rules of this state, or subject to the jurisdiction of the *superintendent* of insurance, that contracts, or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of *health care services* under a *health benefit plan*, including a sickness and accident insurance company, a health insuring corporation, a fraternal benefit society, a self-funded multiple employer welfare arrangement, or a nonfederal, government health plan. *Health plan issuer* includes a third party administrator to the extent that the *benefits* that such an entity is contracted to administer under a *health benefit plan* are subject to the insurance laws and rules of this state or subject to the jurisdiction of the *superintendent*.
11. "Independent review organization" or "IRO" means an entity that is accredited by a nationally recognized private accrediting organization to conduct independent external reviews of *adverse benefit determinations*.
12. "Notification involving urgent care" means any request which meets any of the following conditions:
- (a) The time periods for making non-urgent care review recommendations:
 - (i) Could seriously jeopardize the life or health of the *covered person* or the ability of the *covered person* to regain maximum function; or
 - (ii) In the opinion of a *physician* with knowledge of the *covered person's* medical condition, would subject the *covered person* to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.
 - (b) Other than above, the decision as to whether a condition involves urgent care is to be determined by the attending provider, and we must defer to such determination.
13. "Pre-service claim" means any claim for *benefits* for medical care or treatment that requires *our* approval in advance of the *covered person* obtaining the medical care.
14. "Post-service claim" means any claim for *benefits* for medical care or treatment that is not a *pre-service claim*.
15. "Rescission" (or "to rescind") means a cancellation or discontinuance of coverage that has a retroactive effect. *Rescission* does not include a cancellation or discontinuance of coverage that has only a prospective effect or a cancellation or discontinuance of coverage that is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.
16. "Stabilize" means the provision of such medical treatment as may be necessary to assure, within reasonable medical probability, that no material deterioration of an individual's medical condition is likely to result from or occur during a transfer, if the medical condition could result in any of the following:
- (a) Placing the health of the individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;

- (i) Serious impairment to bodily functions;
- (ii) Serious dysfunction of any bodily organ or part.
- (b) In the case of a woman having contractions, *stabilize* means such medical treatment as may be necessary to deliver, including the placenta.

17. "*Superintendent*" means the superintendent of insurance.

C. INTERNAL APPEALS

1. Eligibility

- (a) Regardless of the cost of the requested *health care service* related to the *adverse benefit determination*, an *adverse benefit determination* shall be eligible for internal appeal.
- (b) The *covered person* or their *authorized representative* has 180 days following receipt of an initial notification of an *adverse benefit determination* to file for an internal appeal.

2. Internal Appeals Process

- (a) The *covered person* has the right to:
 - (i) Submit written comments, documents, records, and other information relating to the claim for *benefits*.
 - (ii) Review the claim file and to present evidence and testimony as part of the internal review process.
 - (iii) Request reasonable access to, and copies of, all documents, records, and other information relevant to the claim for *benefits* free of charge.
- (b) All comments, documents, records and other information submitted by the *covered person* relating to the claim for *benefits*, regardless of whether such information was submitted or considered in the initial benefit determination, will be considered in the internal appeal.
- (c) The *covered person* will receive from the *health plan issuer*, as soon as possible, any new or additional evidence considered by the reviewer. The reviewer will give the *covered person* **10 calendar days** to respond to the new information before making a determination, unless the state turnaround time for response is due in less than 10 days. If the state turnaround time is less than 10 days, the *covered person* will have the option of delaying the determination for a reasonable period of time to respond to the new information.
 - (i) The *covered person* will receive from the *health plan issuer*, any new or additional evidence considered by the reviewer 10 calendar days in advance of the *health plan issuer's* response in order to give the *covered person* time to respond;
 - (ii) The *covered person* will receive from the *health plan issuer* any new or additional medical rationale used to make the decision 10 calendar days in advance of the date of the response so that the *covered person* can have time to respond.
- (d) Review of the internal appeal will be conducted by an individual selected by *us* who is not the individual who made the initial *adverse benefit determination* and is not the subordinate of the original reviewer.
- (e) If the *adverse benefit determination* is based in whole or in part on a medical judgment, *we* will consult with a health care professional who has appropriate expertise in the field of medicine involved in the medical issue and who was not consulted in connection with the original *adverse benefit determination* to review the internal appeal.
- (f) If the *adverse benefit determination* is not based in whole or in part on a medical judgment, it will be reviewed by an impartial person who was not involved in making the original *adverse benefit determination*.
- (g) If the internal appeal concerns a *rescission* action, a panel of individuals who were not involved in the original *adverse benefit determination* will review the appeal.
- (h) Ongoing treatment or a request for an extension of ongoing treatment cannot be reduced or terminated without the *health plan issuer* providing advance notice and an opportunity for

advance review to the *covered person*. The *health plan issuer* is required to provide continued coverage pending the outcome of an internal appeal. A person may request an internal appeal and external review be conducted simultaneously for an ongoing course of treatment involving urgent care.

(i) Resolution Timeframes

- (i) Post-service appeals: We will notify the *covered person* in writing with the appeal decision within **60 days** after receipt of the *covered person's* request for internal appeal, unless we determine that special circumstances require an extension of time for processing the review. If so, we will give the *covered person* notice prior to the close of the initial 60-day period noting the special circumstances and the date by which we expect to render the decision.
- (ii) Pre-service appeals: We will notify the *covered person* in writing with the appeal decision within **30 days** after receipt of the *covered person's* request for internal appeal.
- (iii) Urgent care appeals: We will notify the *covered person* within **72 hours** of request for internal appeal.

These timeframes may be stopped if we are waiting on additional information from the *covered person*.

3. Written Response

We will provide the *final adverse benefit determination* in writing with the following:

- (a) The specific reason or reasons for the *adverse benefit determination*.
- (b) Reference to the specific plan provision on which the determination is based.
- (c) A description of any additional material or information necessary for the *covered person* to perfect the claim and an explanation of why such material or information is necessary.
- (d) The right to request, and a description of, both the standard and expedited external review procedures, including:
 - (i) Information regarding how to initiate an external review, highlighting provisions that give the *covered person* the opportunity to submit additional information; and
 - (ii) Information that the *covered person* may have a right to bring a civil action under state or federal law.
- (e) The specific rule, guideline, protocol, or other similar criterion, if used to make the determination, or that it will be provided free of charge upon request.
- (f) The medical judgment applying the terms of the plan to the *covered person's* medical circumstances, or a statement that such explanation will be provided free of charge upon request.
- (g) The date of service.
- (h) The health care provider's name.
- (i) The claim amount.
- (j) The diagnosis and procedure codes with their corresponding meanings, or an explanation that the diagnosis and/or procedure codes are available upon request.
- (k) Our denial code with corresponding meaning.
- (l) A description of any standard used, if any, in denying the claim.
- (m) That assistance is available by contacting: your state's consumer assistance dept (details in section D.6. If You Have Questions About Your Rights or Need Assistance).
- (n) A culturally linguistic statement based upon the *covered person's* county or state of residence that provides for oral translation of the *adverse benefit determination*.

- (o) Any forms used to process an external review, including a copy of the form that authorizes *us* and the *covered person's* treating health care provider to disclose protected health information, including medical records, concerning the *covered person* that are related in any manner to the external review.
- (p) Statements informing the *covered person*:
 - (i) A written request for an external review must be submitted to *us* within 180 days after the date of the notice of *final adverse benefit determination*.
 - (ii) If the *covered person's* treating physician certifies that the *covered person* has a medical condition for which the time frame for completion of a standard external review would seriously jeopardize the life or health of the *covered person* or would jeopardize the *covered person's* ability to regain maximum function, the *covered person* may file a request for an expedited external review.
 - (iii) If the *final adverse benefit determination* concerns a *health care service* for which the *covered person* received *emergency services*, but has not been discharged from a facility, the *covered person* may request an expedited external review.
 - (iv) If the *final adverse benefit determination* concerns denial of coverage based on a determination that the recommended or requested *health care service* or treatment is experimental or investigational, the *covered person* may file a request for an external review to be conducted, or if the *covered person's* treating physician certifies that the recommended or requested *health care service* that is the subject of the request would be significantly less effective if not promptly initiated, the *covered person* may request an expedited external review to be conducted.
- (q) The following statement:

If your claim has been denied on the basis that the service is not medically necessary, or you have been diagnosed with a terminal condition and the service has been denied on the basis that it is experimental or investigational, you may have a right to request an independent review by an outside medical practitioner. Submit your request in writing to Grievance Administrator, 7440 Woodland Drive, Indianapolis, IN 46278-1719.

If your claim has been denied on the basis that it is not a covered service, you have the right to file a complaint with the Ohio Department of Insurance, ATTN: Consumer Affairs, 50 West Town Street, Suite 300, Columbus, Ohio 43215 (614)-644-2673, toll free in Ohio (800) 686-1526.

Complaints may also be filed via the internet at <http://insurance.ohio.gov>.

D. UNDERSTANDING THE EXTERNAL REVIEW PROCESS

Under Chapter 3922 of the Ohio Revised Code, all *health plan issuers* must provide a process that allows a person covered under a *health benefit plan* or a person applying for *health benefit plan* coverage to request an independent external review of an *adverse benefit determination*. This is a summary of that external review process. An *adverse benefit determination* is a decision by *us* to deny *benefits* because services are not covered, are excluded, or limited under the plan, or the *covered person* is not eligible to receive the benefit.

The *adverse benefit determination* may involve an issue of medical necessity, appropriateness, health care setting, or level of care or effectiveness. An *adverse benefit determination* can also be a decision to deny *health benefit plan* coverage or to *rescind* coverage.

1. Opportunity for External Review

An external review may be conducted by an *Independent Review Organization (IRO)* or by the Ohio Department of Insurance. The *covered person* does not pay for the external review. There is no minimum cost of *health care services* denied in order to qualify for an external review.

The *covered person* must generally *exhaust* the *health plan issuer's* internal appeal process before seeking an external review. "*Exhaust*" means that the *covered person* may not request an external review until after we issue a decision on the internal appeal. However, the internal appeal process

will be considered exhausted and the *covered person* may request an external review if any of the following occur:

- (i) We agree to waive the exhaustion requirement;
 - (ii) The *covered person* has requested an internal appeal and has not received a written decision from us within the required timeframe; or
 - (iii) We fail to adhere to all requirements of the internal appeals process.
- (a) External Review by an IRO: A *covered person* is entitled to an external review by an *IRO* in the following instances:
- (i) The *adverse benefit determination* involves a medical judgment or is based on any medical information.
 - (ii) The *adverse benefit determination* indicates the requested service is experimental or investigational, the requested *health care service* is not explicitly excluded in the *covered person's health benefit plan*, and the treating physician certifies at least one of the following:
 - (a) Standard *health care services* have not been effective in improving the condition of the *covered person*;
 - (b) Standard *health care services* are not medically appropriate for the *covered person*; or
 - (c) No available standard *health care service* covered by us is more beneficial than the requested *health care service*.

There are two types of *IRO* reviews, standard and expedited. A standard review is normally completed within 30 days. An expedited review for urgent medical situations is normally completed within 72 hours and can be requested if any of the following applies:

- (i) The *covered person's* treating physician certifies that the *adverse benefit determination* involves a medical condition that could seriously jeopardize the life or health of the *covered person* or would jeopardize the *covered person's* ability to regain maximum function if treatment is delayed until after the time frame of an expedited internal appeal;
- (ii) The *covered person's* treating physician certifies that the *final adverse benefit determination* involves a medical condition that could seriously jeopardize the life or health of the *covered person* or would jeopardize the *covered person's* ability to regain maximum function if treatment is delayed until after the time from of a standard external review;
- (iii) The *final adverse benefit determination* concerns an admission, availability of care, continued stay, or *health care service* for which the *covered person* received *emergency services*, but has not yet been discharged from a facility; or
- (iv) An expedited internal appeal is already in progress for an *adverse benefit determination* of experimental or investigational treatment and the *covered person's* treating physician certifies in writing that the recommended *health care service* or treatment would be significantly less effective if not promptly initiated.

NOTE: An expedited external review is not available for retrospective *final adverse benefit determinations* (meaning the *health care service* has already been provided to the *covered person*).

- (b) External Review by the Ohio Department of Insurance: A *covered person* is entitled to an external review by the Department in the either of the following instances:
- (i) The *adverse benefit determination* is based on a contractual issue that does not involve a medical judgment or medical information; or
 - (ii) The *adverse benefit determination* for an *emergency medical condition* indicates that medical condition did not meet the definition of *emergency* and our decision has already been upheld through an external review by an *IRO*.

2. Request for External Review

Regardless of whether the external review case is to be reviewed by an *IRO* or the Department of Insurance, the *covered person*, or an *authorized representative*, must request an external review through *us* within 180 days of the date of the notice of *final adverse benefit determination* issued by *us*.

All requests must be in writing, except for a request for an expedited external review. Expedited external reviews may be requested electronically or orally; however, written confirmation of the request must be submitted to *us* no later than five (5) days after the initial request. The *covered person* will be required to consent to the release of applicable medical records and sign a medical records release authorization.

If the request is complete, *we* will initiate the external review and notify the *covered person* in writing, or immediately in the case of an expedited review, that the request is complete and eligible for external review. The notice will include the name and contact information for the assigned *IRO* or the Ohio Department of Insurance (as applicable) for the purpose of submitting additional information. When a standard review is requested, the notice will inform the *covered person* that, within 10 business days after receipt of the notice, they may submit additional information in writing to the *IRO* or the Ohio Department of Insurance (as applicable) for consideration in the review. *We* will also forward all documents and information used to make the *adverse benefit determination* to the assigned *IRO* or the Ohio Department of Insurance (as applicable).

If the request is not complete, *we* will inform the *covered person* in writing and specify what information is needed to make the request complete. If *we* determine that the *adverse benefit determination* is not eligible for external review, *we* must notify the *covered person* in writing and provide the *covered person* with the reason for the denial and inform the *covered person* that the denial may be appealed to the Ohio Department of Insurance.

The Ohio Department of Insurance may determine the request is eligible for external review regardless of the decision by *us* and require that the request be referred for external review. The Department's decision will be made in accordance with the terms of the *health benefit plan* and all applicable provisions of the law.

3. *IRO* Assignment

When *we* initiate an external review by an *IRO*, the Ohio Department of Insurance web based system randomly assigns the review to an accredited *IRO* that is qualified to conduct the review based on the type of *health care service*. An *IRO* that has a conflict of interest with *us*, the *covered person*, the health care provider or the health care facility will not be selected to conduct the review.

4. *IRO* Review and Decision

The *IRO* must consider all documents and information considered by *us* in making the *adverse benefit determination*, any information submitted by the *covered person* and other information such as: the *covered person's* medical records, the attending health care professional's recommendation, consulting reports from appropriate health care professionals, the terms of coverage under the *health benefit plan*, the most appropriate practice guidelines, clinical review criteria used by *us* or *our* utilization review organization, and the opinions of the *IRO's* clinical reviewers.

The *IRO* will provide a written notice of its decision within 30 days of our receipt of a request for a standard review or within 72 hours of receipt by *us* of a request for an expedited review. This notice will be sent to the *covered person*, *us* and the Ohio Department of Insurance and must include the following information:

- (i) A general description of the reason for the request for external review;
- (ii) The date the *independent review organization* was assigned by the Ohio Department of Insurance to conduct the external review;
- (iii) The dates over which the external review was conducted;
- (iv) The date on which the *independent review organization's* decision was made;
- (v) The rationale for its decision; and

- (vi) References to the evidence or documentation, including any evidence based standards, which was used or considered in reaching its decision.

NOTE: Written decisions of an *IRO* concerning an *adverse benefit determination* that involves a health care treatment or service that is stated to be experimental or investigational also includes the principle reason(s) for the *IRO*'s decision and the written opinion of each clinical reviewer including their recommendation and their rationale for the recommendation.

5. Binding Nature of External Review Decision

An external review decision is binding on *us* except to the extent *we* have other remedies available under state law. The decision is also binding on the *covered person* except to the extent the *covered person* has other remedies available under applicable state or federal law.

A *covered person* may not file a subsequent request for an external review involving the same *adverse benefit determination* that was previously reviewed unless new medical or scientific evidence is submitted to *us*.

6. If You Have Questions About Your Rights or Need Assistance

You may contact *us*:

Grievance Administrator
7440 Woodland Drive
Indianapolis, IN 46278-1719
(800) 657-8205
(317) 715-7648 (fax)

You may also contact the Ohio Department of Insurance:

Ohio Department of Insurance
ATTN: Consumer Affairs
50 West Town Street, Suite 300
Columbus, OH 43215
(800) 686-1526 or (614) 644-2673
(614) 644-3744 (fax)
(614) 644-3745 (TDD)

Contact ODI Consumer Affairs:

<https://secured.insurance.ohio.gov/ConsumServ/ConServComments.asp>

File a Consumer Complaint:

<http://insurance.ohio.gov/Consumer/OCS/Pages/ConsCompl.aspx>

This rider applies only to *covered persons* who reside in the state of Ohio.

This rider will not change, waive, or extend any part of the *policy/certificate*, other than as stated herein.

Golden Rule Insurance Company



President

OKLAHOMA ENDORSEMENT

By attachment of this endorsement, the *policy/certificate* is amended to the extent of any conflict with the following:

MGR03433

A. The Definitions section is amended as follows:

1. The definitions of *diabetes self-management training services* is amended to include *medically necessary* training related to medical nutritional therapy, when ordered by a *doctor* and provided by a licensed registered dietician or licensed certified nutritionist.
2. The following definitions are added:

"Biologically based mental illness" any of the following *mental disorders*: schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorder, obsessive-compulsive disorder, and panic disorder.

"Child immunization services" means the specified vaccines provided through a *covered person's* 18th birthday in a manner and frequency conforming to recognized standards of medical practice. Immunizations include diphtheria, hepatitis b, measles, mumps, pertussis, polio, rubella, tetanus, varicella, haemophilus influenzae type B, hepatitis A, and any other immunization subsequently required by the state of Oklahoma.

"Prior creditable coverage" means coverage, other than limited benefits coverage, under any of the following:

- (a) An employee benefit plan that provides medical care to employees or the employee's dependents directly or through insurance, reimbursement or otherwise pursuant to the employee Retirement Income Security Act of 1974 ("ERISA");
- (b) Any other individual or group hospital or medical expense-incurred policy or health benefits plan or contract;
- (c) Part A or Part B of Title XVIII of the Social Security Act (Medicare);
- (d) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under Section 1928 (Medicaid);
- (e) Title 10 of Chapter 55 of the U.s. Code (CHAMPUS);
- (f) A medical care program of the Indian Health Service or a Tribal organization;
- (g) A health benefit risk pool operated by any state of the United States;
- (h) A health benefit plan offered pursuant to Title 5, Chapter 89 of the U.S. Code (government employees);
- (i) A public health benefit plan, as defined by federal law;
- (j) A health benefit plan offered pursuant to Section 5e of the Peace Corps Act;

MGR03620

Prior creditable coverage does not include:

- (a) Coverage only for short term accident only or disability income insurance, or any combination thereof;
- (b) Worker's compensation or similar insurance;
- (c) Automobile medical payment or personal injury insurance;
- (d) Credit only insurance;

- (e) Specified disease or specified accident coverage;
- (f) Limited scope dental or vision benefit coverage;
- (g) Benefits for long-term care, nursing home care, home health care or community based care;
- (h) Coverage only for a specified disease or illness;
- (i) Hospital indemnity or fixed indemnity insurance;
- (j) Medicare supplement insurance; or
- (k) Coverage supplemental to the coverage provided under Chapter 56 of Title 10 of the U.S. Code.

MGR03609

- 3. The definition of *medical practitioner* is amended to include a licensed clinical social worker, licensed professional counselor, licensed marriage and family therapist, licensed alcohol and drug counselor, licensed behavioral practitioner, licensed psychologist and advanced practice nurse when providing mental health, behavioral health, alcohol or drug treatment services that are *covered expenses* under the *policy/certificate*.

MGR04266

- B. The Policyholder Provisions section is amended to include the following provision:
INDIVIDUAL CERTIFICATES: *We will issue certificate describing the insurance protection to which each primary insured is entitled. We will either:*
 - 1. Deliver the certificate directly to each *primary insured*; or
 - 2. Provide the certificate to the broker for delivery to each *primary insured*.

MGR03610

- C. The Effective Date of Insurance provision is amended as follows:
 - 1. Coverage provided on behalf to a newborn child will include charges for transportation necessary for the provision of medical care when:
 - (a) The newborn child is transported to the nearest *hospital* capable of providing the *medically necessary* treatment on a timely basis; and
 - (b) The mode of transportation is the most economical mode available consistent with the well-being of the newborn child.

Transportation coverage shall not exceed the reasonable cost, and an itemized statement of costs shall accompany each claim.

MGR03611

- 2. The following subsection is added:
ADDING AN ADOPTED CHILD:
An eligible child legally placed for adoption with *you* or *your spouse* will be considered a *covered person* from the date of *placement*, is disrupted prior to legal adoption and the child is removed from *your* custody, the child will no longer be an *eligible child* as of the date *placement* is disrupted.

The child will be covered for loss due to *injury* and *illness*, including *medically necessary* care and treatment of conditions existing prior to the date of *placement*. In addition *covered expenses* shall also include costs associated with the birth of the adopted child if the child is adopted prior to 18 months of age. The insured must submit:

- (a) Medical bills and records associated with the birth of the adopted child;
- (b) Proof that the insured has paid, or is responsible for payment of the costs associated with the birth, and
- (c) Proof that the birth was not covered by another health insurance plan, including Medicaid.

Coverage for an adopted child or a child placed with *you* for adoption pursuant to a court order/decreed, will terminate on the 31st day after *placement* if the proper notification and premium are not received by the 31st day after *placement*.

MGR04458

"*Placement*" means the assumption by the insured of the physical custody of the child and the financial responsibility for the support and care of the child.

MGR03622

- D. The following subsection is added:

Disclosure of Reasonable Charges Determination: *Eligible expenses* may be established based on rates from one or more regional/national databases for the same or similar services for a geographic area. This may result in an amount less than that billed by a health care provider who may then bill *you* for the difference.

A health care provider may request the information used to determine rates from one or more regional/national databases for the same or similar services for a geographic area. Such information shall be provided to the health care provider for a reasonable cost within ten (10) working days of the request. Inquiries should be directed to:

Golden Rule Insurance Company
7440 Woodland Drive
Indianapolis, Indiana 46278-1719
800-657-8205
www.goldenrule.com

If the requested information is not provided, *you* or *your* health care provider may contact the Oklahoma Insurance Commissioner at the address provided below:

Oklahoma Department of Insurance
3625 NW 56th street, Suite 100
Oklahoma City, Oklahoma 73112
405-521-2828

MGR04551

- E. The Medical Benefits provision is amended as follows:

1. *Covered expenses* for dental anesthesia are deleted and replaced with the following:
Covered expenses will include general anesthesia and services incurred at a *hospital* or *ambulatory surgical center* for any *medically necessary* dental procedure when provided to a *covered person* who is: (1) severely disabled; or (2) eight years old or younger with a medical or emotional condition which requires hospitalization or general anesthesia for dental care.
2. Benefits for one digital rectal examination and one prostate specific antigen test each calendar year for male *covered persons* for the detection of prostate cancer will not be subject to the *deductible amount*.

MGR04230

3. Benefits for routine mammography examinations will not be subject to the *deductible amounts*, copayments and coinsurance provisions of the *policy/certificate*, regardless of whether services are provided by a *network provider*.

MGR04382

4. *Covered expenses* for treatment and/or management of Type I, Type II, or gestational diabetes are amended as follows:
 - (a) *Covered expenses* are expanded to include the following *medically necessary* equipment and supplies when ordered by a *doctor* or *medical practitioner* legally authorized to prescribe under Oklahoma law:
 - (i) Cartridges for the legally blind;
 - (ii) Insulin infusion devices; and
 - (iii) Podiatric appliances to prevent complications associated with diabetes.
 - (b) The limitation on visits provided for *diabetes self-management training services* is deleted.

MGR04703

5. *Covered expenses* are amended to include charges incurred for the following:
 - (a) Up to \$15.00 annually for wigs or other scalp prostheses necessary for the comfort and dignity of a *covered person* prescribed chemotherapy or radiation therapy;
 - (b) Audiological services and hearing aids for *covered persons* less than eighteen (18) years of age;
 - (c) diagnosis and/or treatment of *biologically based mental illnesses*;
 - (d) *Child immunization services*, exempt from any *deductible amounts* and coinsurance provisions; and
 - (e) Up to \$150 per test for bone density tests provided to a female *covered person* at least 45 years of age who:
 - (iv) Has an estrogen hormone deficiency;
 - (v) Has vertebral abnormalities, primary hyperparathyroidism or a history of fragility bone fractures;
 - (vi) Is receiving long-term glucocorticoid; or
 - (vii) Is under treatment for osteoporosis.

MGR03614

6. The Limitation on Spine and Back Disorders is deleted.

MGR03615

- F. Notification requirements are not applicable to residents of Oklahoma.

MGR04352

- G. The General Exclusions and Limitations provision is amended to deleted the exclusion for *covered expenses* for *injuries* or *illnesses* caused by an act of declared or undeclared war and replace it with the following:

Covered expenses will not include, and no benefits will be paid for any charges which are caused by war or an act of war, declared or undeclared, while serving in the military or naval service, or any auxiliary unit, of the United States, including but not limited to:

1. Service as a member of a Regular or Reserve component of the U.S. Army, Air Force, Navy, Coast Guard, or Marine Corps;

2. Services as a commissioned officer of the Public Health Service or the National Oceanic and Atmospheric Administration; or
3. Military or naval service in an auxiliary military organization, including but not limited to the Coast Guard Auxiliary, the temporary Coast Guard Reserve, the Civilian Auxiliary to the Military Police or the Civil Air Patrol.

MGR03616

- H. The Preexisting Conditions Limitation provision is amended by the addition of the following:

CREDIT FOR PRIOR CREDITABLE COVERAGE: If application for coverage occurs within 63 days of termination of a *covered person's* coverage under *prior creditable coverage*, the *preexisting condition* limitation will be reduced for that *covered person*. The *preexisting condition* limitation will be limited to the amount of time that was remaining for that *covered person* to satisfy the preexisting condition exclusion or waiting period under the *prior creditable coverage*, if the *covered person* has remained under that coverage.

MGR03617

- I. The Coordination of Benefits (COB) provision is amended as follows:

1. The definition of *plan* is amended to include medical benefits under group and individual automobile "no fault" contracts and medical benefits under traditional group automobile contracts. The definition of *plan* shall not include traditional individual automobile contracts.
2. The right of recovery may be exercised within 2 years of an overpayment. However, the two year limit does not apply to an overpayment that occurred as a result of a fraudulent misrepresentation.

MGR03618

- J. The Conditions Prior to Legal Action provisions does not apply to residents of Oklahoma.

MGR04698

- K. The Rescission provision is amended to read as follows:

RESCISSION: No incorrect statement, misrepresentation, omission, or concealment of fact regarding a *covered person* during the application process that relates to insurability will be used to void/rescind coverage or deny a claim unless:

1. It is fraudulent and/or made with the intent to deceive;
2. It is material to the acceptance of the risk or the hazard assumed by *us*; and
3. *We* would either not have issued coverage, or would not have provided coverage with respect to the hazard resulting in the *loss*.

MGR04530

Except as specifically stated in this endorsement, the benefits under this endorsement are subject to all of the terms, conditions, exclusions, limitations and notification requirements of the *policy/certificate*, including any applicable *deductible amounts*, coinsurance provisions, copay amounts, or dollar limits.

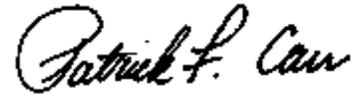
MGR03440

The benefits of this endorsement apply only to *covered persons* who reside in the state of Oklahoma.

This endorsement will not change, waive or extend any part of the *policy/certificate*, other than as stated herein.

This endorsement is effective September 1, 2012 or at the same time as the *policy/certificate*, whichever is later.

**Golden Rule Insurance
Company**

A handwritten signature in black ink that reads "Patrick F. Caw". The signature is written in a cursive style with a large initial 'P'.

President

MGR03441

PENNSYLVANIA ENDORSEMENT

By attachment of this endorsement, the *policy/certificate* is amended to the extent of any conflict with the following:

MGR03433

Covered expenses are amended as follows:

- A. Child immunizations will be exempt from any *deductible amount* regardless of whether services are provided by a *network provider*.

MGR04533

- B. *Covered expenses* are amended to include charges for *medically necessary* nutritional supplements administered under the direction of a *doctor* for the treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria, exempt from any *deductible amount*.

MGR04534

Except as specifically stated in this endorsement, the benefits under this endorsement are subject to all of the terms, conditions, exclusions, limitations and notification requirements of the *policy/certificate*, including any applicable *deductible amounts*, coinsurance provisions, copay amounts, or dollar limits.

MGR03440

This endorsement applies only to *covered persons* who reside in the state of Pennsylvania.

This endorsement will not change, waive or extend any part of the *policy/certificate*, other than as stated herein.

This endorsement is effective on September 1, 2012 or at the same time as the *policy/certificate*, whichever is later.

Golden Rule Insurance Company



President

MGR03441

SOUTH CAROLINA ENDORSEMENT

By attachment of this endorsement, the *policy/certificate* is amended to the extent of any conflict with the following:

MGR03433

- A. The following definitions are added to the *policy/certificate*:

"Continuation of care" means the provision of in-network level benefits for services rendered by certain out-of-network *providers* for a definite period of time in order to ensure continuity of care for a *covered person* for a *serious medical condition*. *Continuation of care* will be provided for ninety (90) days.

MGR04552

"Provider" means a *medical practitioner* or other person or facility properly licensed to furnish health care under the laws of South Carolina.

MGR04561

"Serious medical condition" means a health condition or *illness* that requires medical attention, and where the treating *doctor* attests in writing upon request on a form established by South Carolina law that failure to provide the current course of treatment through the current *provider* would place the *covered person's* health in serious jeopardy, and includes cancer, acute myocardial infarction, and *pregnancy*.

MGR04553

"Terminated provider" means a *provider* whose contract to provide services to insureds is terminated or not renewed by UnitedHealthcare network. A *terminated provider* is not a *provider* who voluntarily terminates his/her contract with UnitedHealthcare network.

MGR04561

- B. The following subsection is added to the provision entitled "Policyholder Provisions":

INDIVIDUAL CERTIFICATES: We will issue certificates describing the insurance protection to which each *primary insured* is entitled. These certificates will be given to the *policyholder* for delivery to each *primary insured*. It is the responsibility of the *policyholder* to give a certificate to each *primary insured*.

MGR03841

- C. The provision entitled "Preexisting Condition Limitation" is deleted and replaced with the following:

PREEXISTING CONDITIONS LIMITATION Does Not Apply to Life Insurance or AD&D, if Any

Definitions: As used in this provision, the following terms have the meanings indicated:

"Continuous coverage" means group health insurance coverage maintained by an individual without a gap in such coverage of more than 30 days.

"Preexisting conditions" means conditions for which medical advice or treatment was received or recommended no more than twelve months before the *effective date* of a person's coverage.

MGR03843

Exclusion: Expenses incurred due to a *preexisting condition* will be covered no later than twelve months without medical care, treatment, or supplies ending after the *effective date* of the coverage or twelve months after the *effective date* of the coverage, whichever occurs first.

MGR03844

Waiver of Preexisting Conditions: For *covered persons* who applied for coverage under the *policy* within 30 days of termination of *continuous coverage*, the *preexisting conditions* exclusionary period will be reduced by any time that *continuous coverage* was maintained.

MGR03845

Affect on Other Provisions: This Preexisting Conditions Limitation does not affect *our* rights with respect to:

1. Fraudulent misstatements made in an application; or
2. Material misstatements made in an application about a *preexisting condition*, if *our* full knowledge of that *preexisting condition* would have caused *us* to decline coverage.

These rights are set forth in the Incontestability clause in Section 9 of the *policy*.

MGR03846

D. **CONTINUATION OF CARE:** If a *provider* contract is terminated or nonrenewed, the following will apply to *continuation of care* for *serious medical conditions*:

1. Upon receipt of a *covered person's* request accompanied by a *doctor's* attestation on the form required by South Carolina law, *we* will send a notice of the *provider's* termination date and the *continuation of care* provisions.
2. *We* will determine if a *covered person* qualifies for *continuation of care* and may request additional information in reaching such determination.
3. *We* may require the *terminated provider* whose services are continued beyond the contract termination date, to agree in writing to be subject to the same contractual terms and conditions that were imposed upon the *provider* under the contract with the UnitedHealthcare network, including, but not limited to, credentialing, hospital privileging, utilization review, peer review, and quality assurance requirements. If the *terminated provider* does not agree to comply or does not comply with these contractual terms and conditions, *we* are not required to continue coverage of the *provider's* services beyond the date the *provider's* contract with UnitedHealthcare network was terminated or not renewed.
4. *Covered expenses* will be subject to the *policy/certificate's* regular benefit limits, including the same deductible or copayment as would apply to in-network services. The *provider* shall accept the reimbursement as payment in full, and shall not bill the *covered person* for any amount in excess of the reimbursement rate, with the exception of copayments and deductibles pursuant to item 5.
5. The payment of copayments, deductibles, or other cost-sharing components by the *covered person* during the period of completion of covered services with a *terminated provider* shall be the same copayments, deductibles, or other cost-sharing components that would be paid by the *covered person* when receiving care from a *provider* currently contracting with the UnitedHealthcare network.
6. If *we* delegate the responsibility of complying with this section to *our* contracting entities, *we* shall ensure that the requirements of this section are met.
7. This section shall not require *us* or the UnitedHealthcare network to provide for the completion of covered services by a *provider* whose contract with *us* or the UnitedHealthcare network has been suspended or revoked.
8. *We* are not required to cover services or provide benefits that are not otherwise *covered expenses* under the terms and conditions of the *policy/certificate*.
9. The provisions for continuity of care included above are in addition to any other of *our* responsibilities to provide continuity of care. Nothing shall preclude *us* from providing continuity of care beyond the provisions indicated above.

MGR04554

E. Under the Health Insurance Conversion Privilege, the covered *spouse* of a *primary insured* will be entitled to a conversion policy, without *proof of good health*, if he or she ceases to be a *dependent* of the *primary insured* due to entry of a valid decree of divorce.

Written application for the conversion policy and the first premium must be received at *our* Home Office within 60 days after the later of entry of the decree or expiration of the continuation of coverage period.

MGR03847

Except as specifically stated in this endorsement, the benefits under this endorsement are subject to all of the terms, conditions, exclusions, limitations and notification requirements of the *policy/certificate*, including any applicable *deductible amounts*, coinsurance provisions, copay amounts, or dollar limits.

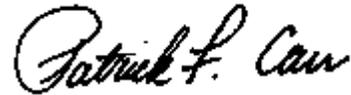
MGR03440

This endorsement applies only to *covered persons* who reside in the state of South Carolina.

This endorsement will not change, waive or extend any part of the *policy/certificate*, other than as stated herein.

This endorsement is effective on September 1, 2012 or at the same time as the *policy/certificate*, whichever is later.

Golden Rule Insurance Company

A handwritten signature in black ink that reads "Patrick F. Caw". The signature is written in a cursive style with a large initial "P".

President

MGR03441

TEXAS ENDORSEMENT

By attachment of this endorsement, the *policy/certificate* is amended to the extent of any conflict with the following:

MGR03433

A. The Definitions section is amended as follows:

1. The definitions of *diabetes self-management training services* is amended to include instruction enabling a *covered person* and/or his or her *caretaker* to understand the care and management of diabetes, including nutritional counseling and proper use of diabetes equipment and supplies.

Diabetes self-management training may be received from:

- (a) A diabetes self-management training program recognized by the American Diabetes Association;
- (b) A multidisciplinary team consisting of at least a dietitian and a nurse educator, coordinated by a Certified Diabetes Educator;
- (c) A Certified Diabetes Educator; or
- (d) A physician, physician's assistant, *registered nurse*, licensed or registered dietitian, or a pharmacist, each of whom must be appropriately licensed, registered or certified in Texas, and determined by his or her licensing board to have recent didactic and experiential preparation in diabetes clinical and educational issues.

MGR03636

2. The definition of *doctor* is amended to include an acupuncturist, advanced practice nurse, chemical dependency counselor, dietitian, hearing instrument fitter and dispenser, occupational therapist, psychological associate, and speech pathologist.

MGR04699

3. Subject to all other terms and conditions of the *policy/certificate*, the definition of *eligible child* is expanded to include:
 - (a) A child that *you* or *your spouse* are seeking to adopt through court legal proceedings;
 - (b) A child entitled, by virtue of a court order, to have coverage provided by *you* or *your spouse*; or;
 - (c) *Your* .grandchild who is considered *your* dependent for federal income tax purposes at the time application for coverage is made.

MGR04447

4. The definition of *emergency* is deleted and replaced with the following.

"*Emergency*" means medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that the person's condition, sickness, or *injury* is of such a nature that failure to get immediate medical care could result in: (a) placing the patient's health in serious jeopardy; (b) serious impairment to bodily functions; (c) serious dysfunction of any bodily organ or part; (d) serious disfigurement; or (e) in the case of a pregnant woman, serious jeopardy to the health of the fetus.

MGR03639

5. The definition of *medical practitioner* is amended to include a master social worker - advanced clinical practitioner, professional counselor and marriage and family therapist. In addition to otherwise meeting the definition of *covered expenses*, services performed by a master social worker - advanced clinical practitioner, professional counselor or marriage and family therapist must have the prior recommendation of a Doctor of Medicine or a Doctor of Osteopathy.

MGR03640

6. The definition of *network* is amended to read as follows:

"*Network*" means a group of *doctors* and providers who have contracts with *us* or *our* affiliates that include an agreed upon price for health care expenses.

MGR04520

7. The following definitions are added:

"*Caretaker*" means any person who regularly assists a *covered person* who is rendered by age or infirmity unable to manage his or her own *illness*.

"*Child immunizations*" means the specified vaccines when provided between a *covered person's* date of birth and 6th birthday in a manner and frequency conforming to recognized standards of medical practice. *Child immunizations* include vaccines for diphtheria; haemophilus influenzae type b (Hib); hepatitis B; measles; mumps; pertussis; polio; rubella; tetanus; varicella; and any other immunization that is required by law for the child.

MGR03642

"*Life-threatening disease or condition*" means a disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

MGR04391

"*Routine patient care costs*" means the costs of *medically necessary* health care services or supplies which are considered *covered expenses* under this plan regardless of whether the *covered person* is participating in a clinical trial.

Routine patient care costs do not include:

- (a) The cost of an investigational new drug or device that is not approved for an indication by the United States Food and Drug Administration, including a drug or device that is the subject of the clinical trial;
- (b) The cost of a service that is not a health care service, regardless of whether the service is the subject of the clinical trial;
- (c) The cost of a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
- (d) The cost of managing the clinical trial; or
- (e) The cost of any health care service specifically excluded from coverage under this plan.

In addition, *covered expenses* will not include:

- (a) *Routine patient care costs* provided through the research institution, person or entity conducting the clinical trial unless the institution and each health care provider agrees to accept reimbursement at the rate established under this plan as payment in full; or

- (b) Any costs incurred for services that are a part of the subject matter of the clinical trial and that are customarily paid for by the institution, person or entity conducting the clinical trial.

MGR04390

"*Telemedicine*" means medical services delivered by telecommunication technologies to rural or underserved health care facilities in collaboration with an academic health care center and an associated teaching hospital or tertiary center or with another health care facility. *Telemedicine* include consultive services, diagnostic services, interactive video consultation, teleradiology, and telepathology.

MGR03642

- B. The Policyholder Provisions section is amended as follows:

We may change the premium rates as of any premium due date. *We* will give *you* written notice at least 60 days prior to the date of the change.

MGR04571

- C. The Effective Date of Dependent's Insurance provision is amended as follows:

Coverage of a newborn child, adopted child or child added under a medical court order will terminate on the 31st day unless *we* have received notification of the birth, intended adoption or medical court order and any additional premium necessitated by the addition of the child by the 90th day following the birth, placement for adoption or effective date of the medical court order.

MGR04502

Under the Termination of Insurance and Renewability provision, any reference to the "individual market" means non-employer based health benefit plans.

MGR03643

- D. The Medical Benefits provision is amended as follows:

- 1. *Covered expenses* are amended to include charges incurred for the following:

- (a) For the formulas necessary for the treatment of phenylketonuria or other inherited diseases that may result in mental or physical retardation or death.
- (b) For covered services provided by *telemedicine*.
- (c) For *reconstructive surgery* performed to improve the function or to attempt to create a normal appearance of a craniofacial abnormality of a *dependent* less than 18 years of age which was caused by congenital defects, developmental abnormalities, trauma, tumors, infection, or disease.
- (d) For one screening test for hearing loss administered within the first 30 days after birth, and related necessary diagnostic follow-up care during the first 24 months after birth. Charges incurred for the screening test and follow-up care shall be exempt from the *deductible amount*.
- (e) For diagnostic and surgical treatment of temporomandibular joint disorders and craniomandibular joint disorders.

MGR03644

- (f) For *child immunizations*, exempt from any *deductible amounts*, *copayment amounts* and coinsurance requirements, regardless of whether the services are provided by a *network provider*.

MGR04525

- (g) For *medically necessary* amino acid-based elemental formulas, regardless of the delivery method, that are used for the diagnosis and treatment of the following:

- (i) Immunoglobulin E and non-immunoglobulin E mediated allergies to multiple food proteins; therapy;
- (ii) Severe food protein-induced enterocolitis syndrome;
- (iii) Eosinophilic disorders, as evidenced by the results of a biopsy; and
- (iv) Impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract.

MGR04421

- (h) For diagnosis and treatment of *mental disorders*;

MGR04478

- (i) For *routine patient care costs* for services, items or drugs provided in connection with a Phase I, II, III or IV clinical trial is conducted in relation to the prevention, detection or treatment of a *life-threatening disease or condition* and is approved by:
 - (i) The Centers for Disease Control and Prevention;
 - (ii) The National Institutes of Health;
 - (iii) The United States Food and Drug Administration (USFDA);
 - (iv) The United States Department of Defense;
 - (v) The United States Department of Veterans Affairs; or
 - (vi) An institutional review board of an institution in the state of Texas that has an agreement with the Office for Human Research Protections of the United States Department of Health and Human Services.

MGR04392

- (j) For diagnosis and treatment of an acquired brain injury, including: cognitive rehabilitation therapy; cognitive communication therapy; neurocognitive therapy and rehabilitation; neurobehavioral, neurophysiological, neuropsychological and psychophysiological testing and treatment; neurofeedback therapy; and remediation. *Covered expenses* will also include the *reasonable and customary charges* associated with periodic reevaluation of the care of a *covered person* with an acquired brain injury who had been unresponsive to treatment, but becomes responsive to treatment at a later date. Post-acute care for acquired brain injuries, including post-acute transition services, community integration services, outpatient day treatment services, or other post-acute care treatment services necessary as a result of and related to an acquired brain injury will be limited to a lifetime maximum of 60 days per *covered person*.

MGR04211

- (k) Up to \$200 every five years for one of the following noninvasive screening tests for atherosclerosis and abnormal artery structure and function:
 - (i) Computerized tomography (CT) scanning measuring coronary artery calcification; or
 - (ii) Ultrasonography measuring carotid intima-media thickness and plaque.
 Benefits are limited to male *covered persons* between the age of 45 and 76 and female *covered persons* between the age of 55 and 76 who:
 - (i) Are diabetic; or

- (ii) Have an intermediate or high risk of developing coronary heart disease based on the Framingham Health Study Coronary Prediction algorithm.

MGR04386

- 2. *Covered expenses* for the diagnosis and treatment of *autism spectrum disorders* are deleted and replaced with the following:

Covered expenses shall include charges incurred for generally recognized services prescribed for the diagnosis and treatment of *autism spectrum disorder* including: (1) evaluation and assessment services; (2) *applied behavior analysis*; (3) behavior training and behavior management; (4) speech therapy; (5) occupational therapy; (6) physical therapy; and (7) medications or nutritional supplements used to address symptoms of *autism spectrum disorder*.

MGR04492

- 3. *Covered expenses* incurred by *covered persons* who have been diagnosed with insulin dependent or non-insulin dependent diabetes, elevated blood glucose levels induced by pregnancy, or any other medical condition associated with elevated blood glucose levels are expanded to include:

- (a) Immunizations for influenza and pneumococcus;
- (b) Daily room and board, nursing services, and routinely provided *inpatient* services while confined in an *extended care facility* or a *rehabilitation facility*, subject to the same limits as if the *covered person* were confined in a *hospital*;
- (c) The following additional equipment and supplies:
 - (i) Insulin pumps and insulin infusion devices;
 - (ii) Repairs and maintenance of insulin pumps to the extent not covered under a manufacturer's warranty, and rental fees for replacement pumps during a period of repair, both of which are limited to the purchase price of a similar new pump;
 - (iii) Visual reading and urine test strips, and tablets that test for glucose, ketones and protein;
 - (iv) Insulin analogs and injection aids, including devices used to assist with insulin injection and needleless systems;
 - (v) Biohazard disposal containers;
 - (vi) Batteries, skin preparation items, adhesive supplies, infusion sets, insulin cartridges, and durable and disposable devices to assist in the injection of insulin;
 - (vii) Prescription and non-prescription medications for controlling blood sugar level;
 - (viii) Podiatric appliances for the prevention of complications associated with diabetes, including no more than 2 pairs of therapeutic footwear per *covered person*, per calendar year.
 - (ix) Any new or improved treatment or monitoring equipment or supplies approved by the United States Food and Drug Administration and available to the public on or after the *covered person's effective date*; and
- (d) *Diabetes self-management training* provided to a *covered person* or a *covered person's caretaker*: (1) after the initial diagnosis of diabetes; (2) for additional training authorized on the written order of a *medical practitioner* after the significant change in symptoms that requires changes in the self-management regime; and (3) for periodic or episodic continuing education when prescribed by

a *medical practitioner* as needed due to the development of new techniques and treatments for diabetes.

MGR03645

4. **TREATMENT OF MENTAL DIORDERS (NOT INCLUDING CHEMICAL DEPENDENCY):** If a *covered person* incurs an expense for treatment of a *mental disorder* while under the supervision of a *doctor* of medicine and osteopathy in a *psychiatric day treatment facility*, the *covered expense* will be considered on the same basis as *inpatient* benefits.

If a *covered person* incurs and expense for treatment of a *mental disorder* in a *residential treatment center for children or adolescents* or a *crisis stabilization unit*, the *covered expense* will be considered on the same basis as *inpatient* benefits.

MGR04493

Definitions:

"*Crisis stabilization unit*" means a 24-hour residential program that is usually short-term in nature and that provides intensive supervision and highly structured activities to persons who are demonstrating an acute demonstrable psychiatric crisis of moderate to severe proportions.

"*Psychiatric day treatment facility*" means a mental health facility which:

- (a) Provides treatment for individuals suffering from acute *mental disorders* in a structured psychiatric program utilizing individualized treatment plans with specific attainable goals and objectives appropriate both to the patient and the treatment modality of the program; and
- (b) Which is clinically supervised by a *doctor* of medicine who is certified in psychiatry by the American Board of Psychiatry and Neurology.

The facility must be accredited by the Joint Commission on Accreditation of Hospitals and must not treat a patient for more than eight hours in any 24-hour period.

"*Residential treatment center for children and adolescents*" means a child-care institution that provides residential care and treatment for emotionally disturbed children and adolescents and that is accredited as a residential treatment center by the Council on Accreditation of Hospitals, or the American Association of Psychiatric Services for Children.

MGR03650

- E. Depending on a *covered person's* age, Preventive Care Expense Benefits include, but are not limited to: routine vaccines for diseases; flu and pneumonia shots; routine physical exams, including well-baby and well-child doctor visits; screenings for high blood pressure, cholesterol and diabetes; and screenings for the detection of breast and other cancers through mammogram, pap smear, prostate cancer screening and colorectal screening. A comprehensive list of services and supplies which are considered *covered expenses* under the Preventive Care Expense Benefits, as required by federal law, may be found at www.healthcare.gov/center/regulations/prevention.html. If after visiting the website *you* still have questions, *you* may contact Client Services toll-free at 1-800-926-7602.

MGR04529

- F. To the extent that *your policy/certificate* provides coverage for prescription drugs, *covered expenses* will include any drug prescribed to treat a chronic, disabling, or life-threatening illness if:
- 1. The drug has been approved by the United States Food and Drug Administration (*USFDA*) for at least one indication;

2. The drug is recognized for treatment of the indication for which the drug is prescribed in:
 - (a) The American Hospital Formulary Service Drug Information;
 - (b) The United States Pharmacopoeia-Drug Information; or
 - (c) Substantially accepted per-reviewed medical literature.

Covered expenses will include the services *medically necessary* to administer the drug, including any supply *medically necessary* to administer the drug, provided that the supply is a *covered expense* under this plan.

Covered expenses will NOT include:

1. Experimental drugs that are not otherwise approved for an indication by the *USFDA*;
2. Drugs prescribed for treatment of a disease or condition that is excluded from coverage under the plan;
3. Any drug found to be not *medically necessary* for the treatment of the current disease, condition or syndrome, so long as the finding is not based on the fact that the drug is being prescribed for an off-label use; or
4. A drug that the *USFDA* has determined to be contraindicated for treatment of the current indication.

MGR04468

- G. Notification requirements are not applicable to residents of Texas.

MGR04352

- H. The Subprovision entitled "WAITING PERIODS" in Section 7 General Exclusions and Limitations, is deleted. Any reference to the term "Effective Date" is amended so that the *effective date* for *illness* is the same as for *injuries*.

MGR04017

- I. The Preexisting Conditions Limitation provision is amended as follows:

The definition of *preexisting condition* is deleted and replaced with the following:

"Preexisting condition" means an *injury* or *illness* for which the *covered person* received medical advice or treatment within the 12 months immediately preceding the applicable *effective date* the *covered person* became insured under the *policy*.

MGR03652

- J. Under the Coordination of Benefits (COB) provision, the definition of "*plan*" is amended to include personal injury protection.

MGR03655

- K. The Conditions Prior to Legal Action provision is amended to read as follows:

On occasion, we may have a disagreement related to coverage, benefits, premiums or other provisions under the *policy*. Litigation is an expensive and time-consuming way to resolve these disagreements and should be the last resort in a resolution process. Therefore, with a view to avoiding litigation, please give written notice to *us* of any such a disagreement. *Your* notice must identify the coverage, benefit, premium or other disagreement, refer to the specific *policy* provision(s) at issue, and include all relevant facts and information that supports *your* position. Unless prohibited by law, *you* agree that *you* waive any action for statutory or common law extra-contractual or punitive damages that *you* may have if the specified contractual claims are paid or the issues giving rise to the disagreement are resolved or corrected within 30 days after *we* receive *your* written notice of intention to sue *us*.

MGR03733

- L. Under the Health Insurance Conversion Privilege, the premium rate for the conversion policy will be based on the *covered person's* age, the place of residence and type of coverage in effect on its effective date.

MGR03661

- M. The Claims provision is amended as follows:

1. The following provisions are added:

MEDICAID REIMBURSEMENT: *We will pay benefits of the policy to the state if we receive notice that payment has been made under Medicaid for covered expenses incurred by a covered person.*

Our payment to the state will be limited to the amount payable under the policy for the covered expenses for which reimbursement is due. Payment under this provision will be made in good faith. It will satisfy our responsibility to the extent of that payment.

The amount payable under the policy will not be changed or limited for reason of a covered person's being eligible for coverage under the Medicaid program of the state in which he or she lives.

MGR03662

CONSERVATORS: *If this certificate is a Family One-Parent Family Plan, benefits paid on behalf of any eligible child will be paid to the Texas Department of Human Services after written notice to us at our home office if the parent is:*

- (a) *A possessory conservator of the eligible child under an order issued by a court in the state of Texas or is not entitled to possession of or access to the child; and*
(b) *Is required by court order or court-approved agreement to pay child support.*

Benefits will also be paid to the Texas Department of Human Services if the Department is:

- (a) *Paying benefits on behalf of the eligible child under Chapter 31 or Chapter 32 of the Human Resources Code; and*
(b) *We are notified through an attachment to the claim for benefits when the claim is first submitted to us that the benefits must be paid directly to the Texas Department of Human Services.*

We may pay benefits on behalf of any eligible child to a non-covered person if a court order providing for the managing conservator of the eligible child has been issued by a court of competent jurisdiction.

Before any benefits will be paid to a managing conservator, we must receive a certified copy of the court order establishing the person as managing conservator, or evidence designated by the Texas State Board of Insurance that the non-covered person qualifies to be paid benefits.

MGR03663

2. The Notice of Claim subsection is modified to clarify that *we* must receive initial written notice of claim within 30 days of the date the *loss* began or as soon as is reasonably possible.

MGR03664

3. Under the Assignment subsection, *we* will reimburse a *hospital* or health care provider if *your* health insurance benefits are assigned by *you* in writing and verified by *us*.

MGR03665

N. Under Uniform Provisions:

1. The subsection entitled Contract is modified to state that:

- (a) All statements contained in the applications will be deemed representations and not warranties; and
- (b) No agent may change the *policy*, waive any provisions of the *policy*, extend the time for payment of premiums, or waive any of *our* rights or requirements.

MGR03666

2. The subsection entitled Legal Action is deleted and replaced with the following:

LEGAL ACTION: No action at law or in equity may be brought to recover reimbursement under the *policy* until 60 days after written *proof of loss* has been furnished. No such action may be brought after the end of three years after the time written *proof of loss* is required to be furnished.

MGR04117

Except as specifically stated in this endorsement, the benefits under this endorsement are subject to all of the terms, conditions, exclusions, limitations and notification requirements of the *policy/certificate*, including any applicable *deductible amounts*, coinsurance provisions, copay amounts, or dollar limits.

MGR03440

The benefits of this endorsement apply only to *covered persons* who reside in the state of Texas.

This endorsement will not change, waive or extend any part of the *policy/certificate*, other than as stated herein.

This endorsement is effective September 1, 2012 or at the same time as the *policy/certificate*, whichever is later.

**Golden Rule Insurance
Company**



President

MGR03441

TEXAS ENDORSEMENT

By attachment of this endorsement, the *policy/certificate* is amended to the extent of any conflict with the following:

MGR03433

A. The Definitions section is amended as follows:

1. The definitions of *diabetes self-management training services* is amended to include instruction enabling a *covered person* and/or his or her *caretaker* to understand the care and management of diabetes, including nutritional counseling and proper use of diabetes equipment and supplies.

Diabetes self-management training may be received from:

- (a) A diabetes self-management training program recognized by the American Diabetes Association;
- (b) A multidisciplinary team consisting of at least a dietitian and a nurse educator, coordinated by a Certified Diabetes Educator;
- (c) A Certified Diabetes Educator; or
- (d) A physician, physician's assistant, *registered nurse*, licensed or registered dietitian, or a pharmacist, each of whom must be appropriately licensed, registered or certified in Texas, and determined by his or her licensing board to have recent didactic and experiential preparation in diabetes clinical and educational issues.

MGR03636

2. The definition of *doctor* is amended to include an acupuncturist, advanced practice nurse, chemical dependency counselor, dietitian, hearing instrument fitter and dispenser, occupational therapist, psychological associate, and speech pathologist.

MGR04699

3. Subject to all other terms and conditions of the *policy/certificate*, the definition of *eligible child* is expanded to include:
 - (a) A child that *you* or *your spouse* are seeking to adopt through court legal proceedings;
 - (b) A child entitled, by virtue of a court order, to have coverage provided by *you* or *your spouse*; or;
 - (c) *Your* .grandchild who is considered *your* dependent for federal income tax purposes at the time application for coverage is made.

MGR04447

4. The definition of *emergency* is deleted and replaced with the following.

"*Emergency*" means medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that the person's condition, sickness, or *injury* is of such a nature that failure to get immediate medical care could result in: (a) placing the patient's health in serious jeopardy; (b) serious impairment to bodily functions; (c) serious dysfunction of any bodily organ or part; (d) serious disfigurement; or (e) in the case of a pregnant woman, serious jeopardy to the health of the fetus.

MGR03639

5. The definition of *medical practitioner* is amended to include a master social worker - advanced clinical practitioner, professional counselor and marriage and family

therapist. In addition to otherwise meeting the definition of *covered expenses*, services performed by a master social worker - advanced clinical practitioner, professional counselor or marriage and family therapist must have the prior recommendation of a Doctor of Medicine or a Doctor of Osteopathy.

MGR03640

6. The definition of *network* is amended to read as follows:

"*Network*" means a group of *doctors* and providers who have contracts with *us* or *our* affiliates that include an agreed upon price for health care expenses.

MGR04520

7. The following definitions are added:

"*Caretaker*" means any person who regularly assists a *covered person* who is rendered by age or infirmity unable to manage his or her own *illness*.

"*Child immunizations*" means the specified vaccines when provided between a *covered person's* date of birth and 6th birthday in a manner and frequency conforming to recognized standards of medical practice. *Child immunizations* include vaccines for diphtheria; haemophilus influenzae type b (Hib); hepatitis B; measles; mumps; pertussis; polio; rubella; tetanus; varicella; and any other immunization that is required by law for the child.

MGR03642

"*Life-threatening disease or condition*" means a disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

MGR04391

"*Routine patient care costs*" means the costs of *medically necessary* health care services or supplies which are considered *covered expenses* under this plan regardless of whether the *covered person* is participating in a clinical trial.

Routine patient care costs do not include:

- (a) The cost of an investigational new drug or device that is not approved for an indication by the United States Food and Drug Administration, including a drug or device that is the subject of the clinical trial;
- (b) The cost of a services that is not a health care service, regardless of whether the service is the subject of the clinical trial;
- (c) The cost of a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
- (d) The cost of managing the clinical trial; or
- (e) The costs of any health care service specifically excluded from coverage under this plan.

In addition, *covered expenses* will not include:

- (a) *Routine patient care costs* provided through the research institution, person or entity conducting the clinical trial unless the institution and each health care provider agrees to accept reimbursement at the rate established under this plan as payment in full; or
- (b) Any costs incurred for services that are a part of the subject matter of the clinical trial and that are customarily paid for by the institution, person or entity conducting the clinical trial.

MGR04390

"*Serious mental illness*" means the following psychiatric illnesses as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual:

- (a) Schizophrenia;
- (b) Paranoid and other psychotic disorders;
- (c) Bipolar disorders (hypomanic, manic, depressive, and mixed);
- (d) Major depressive disorders (single episode or recurrent);
- (e) Schizo-affective disorders (bipolar or depressive);
- (f) Obsessive-compulsive disorders; or
- (g) Depression in childhood and adolescence.

MGR04165

"*Telemedicine*" means medical services delivered by telecommunication technologies to rural or underserved health care facilities in collaboration with an academic health care center and an associated teaching hospital or tertiary center or with another health care facility. *Telemedicine* include consultative services, diagnostic services, interactive video consultation, teleradiology, and telepathology.

MGR03642

- B. The Policyholder Provisions section is amended as follows:

We may change the premium rates as of any premium due date. We will give you written notice at least 60 days prior to the date of the change.

MGR04571

- C. The Effective Date of Dependent's Insurance provision is amended as follows:

Coverage of a newborn child, adopted child or child added under a medical court order will terminate on the 31st day unless we have received notification of the birth, intended adoption or medical court order and any additional premium necessitated by the addition of the child by the 90th day following the birth, placement for adoption or effective date of the medical court order.

MGR04502

Under the Termination of Insurance and Renewability provision, any reference to the "individual market" means non-employer based health benefit plans.

- D. The Medical Benefits provision is amended as follows:

MGR03643

- E. The Medical Benefits provision is amended as follows:

1. *Covered expenses* are amended to include charges incurred for the following:
 - (a) For the formulas necessary for the treatment of phenylketonuria or other inherited diseases that may result in mental or physical retardation or death.
 - (b) For covered services provided by *telemedicine*.
 - (c) For *reconstructive surgery* performed to improve the function or to attempt to create a normal appearance of a craniofacial abnormality of a *dependent* less than 18 years of age which was caused by congenital defects, developmental abnormalities, trauma, tumors, infection, or disease.
 - (d) For one screening test for hearing loss administered within the first 30 days after birth, and related necessary diagnostic follow-up care during the first 24 months after birth. Charges incurred for the screening test and follow-up care shall be exempt from the *deductible amount*.

- (e) For diagnostic and surgical treatment of temporomandibular joint disorders and craniomandibular joint disorders.

MGR03644

- (f) For *child immunizations*, exempt from any *deductible amounts*, *copayment amounts* and coinsurance requirements, regardless of whether the services are provided by a *network provider*.

MGR04525

- (g) For diagnosis and treatment of *mental disorders*;

MGR04480

- (h) For *routine patient care costs* for services, items or drugs provided in connection with a Phase I, II, III or IV clinical trial is conducted in relation to the prevention, detection or treatment of a *life-threatening disease or condition* and is approved by:
 - (i) The Centers for Disease Control and Prevention;
 - (ii) The National Institutes of Health;
 - (iii) The United States Food and Drug Administration (USFDA);
 - (iv) The United States Department of Defense;
 - (v) The United States Department of Veterans Affairs; or
 - (vi) An institutional review board of an institution in the state of Texas that has an agreement with the Office for Human Research Protections of the United States Department of Health and Human Services.

MGR04392

- (i) For diagnosis and treatment of an acquired brain injury, including: cognitive rehabilitation therapy; cognitive communication therapy; neurocognitive therapy and rehabilitation; neurobehavioral, neurophysiological, neuropsychological and psychophysiological testing and treatment; neurofeedback therapy; and remediation. *Covered expenses* will also include the *reasonable and customary charges* associated with periodic reevaluation of the care of a *covered person* with an acquired brain injury who had been unresponsive to treatment, but becomes responsive to treatment at a later date. Post-acute care for acquired brain injuries, including post-acute transition services, community integration services, outpatient day treatment services, or other post-acute care treatment services necessary as a result of and related to an acquired brain injury will be limited to a lifetime maximum of 60 days per *covered person*.

MGR04211

- (j) Up to \$200 every five years for one of the following noninvasive screening tests for atherosclerosis and abnormal artery structure and function:
 - (i) Computerized tomography (CT) scanning measuring coronary artery calcification; or
 - (ii) Ultrasonography measuring carotid intima-media thickness and plaque.Benefits are limited to male *covered persons* between the age of 45 and 76 and female *covered persons* between the age of 55 and 76 who:
 - (i) Are diabetic; or
 - (ii) Have an intermediate or high risk of developing coronary heart disease based on the Framingham Health Study Coronary Prediction algorithm.

MGR04386

2. *Covered expenses* for the diagnosis and treatment of *autism spectrum disorders* are deleted and replaced with the following:

Covered expenses shall include charges incurred for generally recognized services prescribed for the diagnosis and treatment of *autism spectrum disorder* including: (1) evaluation and assessment services; (2) *applied behavior analysis*; (3) behavior training and behavior management; (4) speech therapy; (5) occupational therapy; (6) physical therapy; and (7) medications or nutritional supplements used to address symptoms of *autism spectrum disorder*.

MGR04492

3. *Covered expenses* incurred by *covered persons* who have been diagnosed with insulin dependent or non-insulin dependent diabetes, elevated blood glucose levels induced by pregnancy, or any other medical condition associated with elevated blood glucose levels are expanded to include:

- (a) Immunizations for influenza and pneumococcus;
- (b) Daily room and board, nursing services, and routinely provided *inpatient* services while confined in an *extended care facility* or a *rehabilitation facility*, subject to the same limits as if the *covered person* were confined in a *hospital*;
- (c) The following additional equipment and supplies:
 - (i) Insulin pumps and insulin infusion devices;
 - (ii) Repairs and maintenance of insulin pumps to the extent not covered under a manufacturer's warranty, and rental fees for replacement pumps during a period of repair, both of which are limited to the purchase price of a similar new pump;
 - (iii) Visual reading and urine test strips, and tablets that test for glucose, ketones and protein;
 - (iv) Insulin analogs and injection aids, including devices used to assist with insulin injection and needleless systems;
 - (v) Biohazard disposal containers;
 - (vi) Batteries, skin preparation items, adhesive supplies, infusion sets, insulin cartridges, and durable and disposable devices to assist in the injection of insulin;
 - (vii) Prescription and non-prescription medications for controlling blood sugar level;
 - (viii) Podiatric appliances for the prevention of complications associated with diabetes, including no more than 2 pairs of therapeutic footwear per *covered person*, per calendar year.
 - (ix) Any new or improved treatment or monitoring equipment or supplies approved by the United States Food and Drug Administration and available to the public on or after the *covered person's effective date*; and
- (d) *Diabetes self-management training* provided to a *covered person* or a *covered person's caretaker*: (1) after the initial diagnosis of diabetes; (2) for additional training authorized on the written order of a *medical practitioner* after the significant change in symptoms that requires changes in the self-management regime; and (3) for periodic or episodic continuing education when prescribed by a *medical practitioner* as needed due to the development of new techniques and treatments for diabetes.

MGR03645

4. **TREATMENT OF MENTAL DIORDERS (NOT INCLUDING CHEMICAL DEPENDENCY):** If a *covered person* incurs an expense for treatment of a *mental disorder* while under the supervision of a *doctor* of medicine and osteopathy in a *psychiatric day treatment facility*, the *covered expense* will be considered on the same basis as *inpatient* benefits.

If a *covered person* incurs and expense for treatment of a *mental disorder* in a *residential treatment center for children or adolescents* or a *crisis stabilization unit*, the *covered expense* will be considered on the same basis as *inpatient* benefits.

MGR04493

Definitions:

"*Crisis stabilization unit*" means a 24-hour residential program that is usually short-term in nature and that provides intensive supervision and highly structured activities to persons who are demonstrating an acute demonstrable psychiatric crisis of moderate to severe proportions.

"*Psychiatric day treatment facility*" means a mental health facility which:

- (a) Provides treatment for individuals suffering from acute *mental disorders* in a structured psychiatric program utilizing individualized treatment plans with specific attainable goals and objectives appropriate both to the patient and the treatment modality of the program; and
- (b) Which is clinically supervised by a *doctor* of medicine who is certified in psychiatry by the American Board of Psychiatry and Neurology.

The facility must be accredited by the Joint Commission on Accreditation of Hospitals and must not treat a patient for more than eight hours in any 24-hour period.

"*Residential treatment center for children and adolescents*" means a child-care institution that provides residential care and treatment for emotionally disturbed children and adolescents and that is accredited as a residential treatment center by the Council on Accreditation of Hospitals, or the American Association of Psychiatric Services for Children.

MGR03650

- F. **OUTPATIENT TREATMENT OF SERIOUS MENTAL ILLNESS:** *Covered expenses* will include charges incurred for outpatient diagnosis or treatment of a *serious mental illness* limited to a maximum of 60 outpatient visits each calendar year (not include medication management visits).

MGR04494

- G. **OUTPATIENT TREATMENT OF CHEMICAL DEPENDENCY:** *Outpatient treatment of chemical dependency* is limited to a lifetime maximum of three separate series of treatments for each *covered person*. A series of treatment is a planned, structured, and organized program to promote chemical free status which may include different facilities or modalities and is complete when the *covered person*:

1. Is discharged on medical advice from partial hospitalization, intensive outpatient treatment, or a series of these levels of treatments without lapse in treatment; or
2. When the *covered person* fails to materially comply with the treatment program for a period of 30 days.

MGR04495

Exclusions: No benefits are payable under this benefit for: (a) addition to, or dependency on, tobacco products or foods; (b) detoxification on an outpatient basis; or (c) drug maintenance, as opposed to drug rehabilitation.

MGR03647

Definitions:

"*Chemical dependency*" means the abuse of or psychological or physical dependence on or addiction to alcohol or a *controlled substance*. The term includes *alcoholism* and *substance abuse*.

"*Chemical dependency treatment facility*" means a facility which provides a state-approved program for the treatment of *chemical dependency* and which is:

- (a) A private facility licensed, certified or approved as a *chemical dependency* treatment program or center by the Texas Commission on Alcohol or Drug Abuse or any other state agency having the legal authority to do so;
- (b) Affiliated with a *hospital* under a contractual agreement with an established system of patient referral; or
- (c) A facility accredited as such by the Joint Commission on Accreditation of Hospitals.

"*Controlled substance*" means a toxic inhalent or a substance designated as a controlled substance under the Texas Toxic Controlled Substance Act.

MGR03648

"*Outpatient treatment of chemical dependency*" means the use of one or more of the following therapeutic techniques identified in, and as part of, a written *chemical dependency* treatment plan approved and monitored by a *doctor*; (a) medical testing; (b) counseling; (c) psychotherapy; and (d) drug therapy.

MGR04496

- H. Depending on a *covered person's* age, Preventive Care Expense Benefits include, but are not limited to: routine vaccines for diseases; flu and pneumonia shots; routine physical exams, including well-baby and well-child doctor visits; screenings for high blood pressure, cholesterol and diabetes; and screenings for the detection of breast and other cancers through mammogram, pap smear, prostate cancer screening and colorectal screening. A comprehensive list of services and supplies which are considered *covered expenses* under the Preventive Care Expense Benefits, as required by federal law, may be found at www.healthcare.gov/center/regulations/prevention.html. If after visiting the website *you* still have questions, *you* may contact Client Services toll-free at 1-800-926-7602.

MGR04529

- I. To the extent that *your policy/certificate* provides coverage for prescription drugs, *covered expenses* will include any drug prescribed to treat a chronic, disabling, or life-threatening illness if:
 - 1. The drug has been approved by the United States Food and Drug Administration (*USFDA*) for at least one indication;
 - 2. The drug is recognized for treatment of the indication for which the drug is prescribed in:
 - (a) The American Hospital Formulary Service Drug Information;
 - (b) The United States Pharmacopoeia-Drug Information; or
 - (c) Substantially accepted per-reviewed medical literature.

Covered expenses will include the services *medically necessary* to administer the drug, including any supply *medically necessary* to administer the drug, provided that the supply is a *covered expense* under this plan.

Covered expenses will NOT include:

1. Experimental drugs that are not otherwise approved for an indication by the *USFDA*;
2. Drugs prescribed for treatment of a disease or condition that is excluded from coverage under the plan;
3. Any drug found to be not *medically necessary* for the treatment of the current disease, condition or syndrome, so long as the finding is not based on the fact that the drug is being prescribed for an off-label use; or
4. A drug that the *USFDA* has determined to be contraindicated for treatment for the current indication.

MGR04468

- J. Notification requirements are not applicable to residents of Texas.

MGR04352

- K. The Subprovision entitled "WAITING PERIODS" in Section 7 General Exclusions and Limitations, is deleted. Any reference to the term "Effective Date" is amended so that the *effective date for illness* is the same as for *injuries*.

MGR04017

- L. The Preexisting Conditions Limitation provision is amended as follows:

The definition of *preexisting condition* is deleted and replaced with the following:

"Preexisting condition" means an *injury* or *illness* for which the *covered person* received medical advice or treatment within the 12 months immediately preceding the applicable *effective date* the *covered person* became insured under the *policy*.

MGR03652

- M. Under the Coordination of Benefits (COB) provision, the definition of "*plan*" is amended to include personal injury protection.

MGR03655

- N. The Conditions Prior to Legal Action provision is amended to read as follows:

On occasion, *we* may have a disagreement related to coverage, benefits, premiums or other provisions under the *policy*. Litigation is an expensive and time-consuming way to resolve these disagreements and should be the last resort in a resolution process. Therefore, with a view to avoiding litigation, please give written notice to *us* of any such a disagreement. *Your* notice must identify the coverage, benefit, premium or other disagreement, refer to the specific *policy* provision(s) at issue, and include all relevant facts and information that supports *your* position. Unless prohibited by law, *you* agree that *you* waive any action for statutory or common law extra-contractual or punitive damages that *you* may have if the specified contractual claims are paid or the issues giving rise to the disagreement are resolved or corrected within 30 days after *we* receive *your* written notice of intention to sue *us*.

MGR03733

- O. Under the Health Insurance Conversion Privilege, the premium rate for the conversion policy will be based on the *covered person's* age, the place of residence and type of coverage in effect on its effective date.

MGR03661

- P. The Claims provision is amended as follows:

1. The following provisions are added:

MEDICAID REIMBURSEMENT: *We* will pay benefits of the *policy* to the state if *we* receive notice that payment has been made under Medicaid for *covered expenses* incurred by a *covered person*.

Our payment to the state will be limited to the amount payable under the *policy* for the *covered expenses* for which reimbursement is due. Payment under this provision will be made in good faith. It will satisfy *our* responsibility to the extent of that payment.

The amount payable under the *policy* will not be changed or limited for reason of a *covered person's* being eligible for coverage under the Medicaid program of the state in which he or she lives.

MGR03662

CONSERVATORS: If this certificate is a Family One-Parent Family Plan, benefits paid on behalf of any *eligible child* will be paid to the Texas Department of Human Services after written notice to *us* at *our home office* if the parent is:

- (a) A possessory conservator of the *eligible child* under an order issued by a court in the state of Texas or is not entitled to possession of or access to the child; and
- (b) Is required by court order or court-approved agreement to pay child support.

Benefits will also be paid to the Texas Department of Human Services if the Department is:

- (a) Paying benefits on behalf of the *eligible child* under Chapter 31 or Chapter 32 of the Human Resources Code; and
- (b) *We* are notified through an attachment to the claim for benefits when the claim is first submitted to *us* that the benefits must be paid directly to the Texas Department of Human Services.

We may pay benefits on behalf of any *eligible child* to a non-covered person if a court order providing for the managing conservator of the *eligible child* has been issued by a court of competent jurisdiction.

Before any benefits will be paid to a managing conservator, *we* must receive a certified copy of the court order establishing the person as managing conservator, or evidence designated by the Texas State Board of Insurance that the non-covered person qualifies to be paid benefits.

MGR03663

2. The Notice of Claim subsection is modified to clarify that *we* must receive initial written notice of claim within 30 days of the date the *loss* began or as soon as is reasonably possible.

MGR03664

3. Under the Assignment subsection, *we* will reimburse a *hospital* or health care provider if *your* health insurance benefits are assigned by *you* in writing and verified by *us*.

MGR03665

Q. Under Uniform Provisions:

1. The subsection entitled Contract is modified to state that:
 - (a) All statements contained in the applications will be deemed representations and not warranties; and
 - (b) No agent may change the *policy*, waive any provisions of the *policy*, extend the time for payment of premiums, or waive any of *our* rights or requirements.

MGR03666

2. The subsection entitled Legal Action is deleted and replaced with the following:

LEGAL ACTION: No action at law or in equity may be brought to recover reimbursement under the *policy* until 60 days after written *proof of loss* has been furnished. No such action may be brought after the end of three years after the time written *proof of loss* is required to be furnished.

MGR04117

Except as specifically stated in this endorsement, the benefits under this endorsement are subject to all of the terms, conditions, exclusions, limitations and notification requirements of the *policy/certificate*, including any applicable *deductible amounts*, coinsurance provisions, copay amounts, or dollar limits.

MGR03440

The benefits of this endorsement apply only to *covered persons* who reside in the state of Texas.

This endorsement will not change, waive or extend any part of the *policy/certificate*, other than as stated herein.

This endorsement is effective September 1, 2012 or at the same time as the *policy/certificate*, whichever is later.

**Golden Rule Insurance
Company**

A handwritten signature in black ink that reads "Patrick F. Carr". The signature is written in a cursive style with a large initial "P" and "C".

President

MGR03441

WEST VIRGINIA ENDORSEMENT

By attachment of this endorsement, the *policy/certificate* is amended to the extent of any conflict with the following:

MGR03433

A. The Definitions section is amended as follows:

1. The definition of *medical practitioner* is amended to include a registered nurse and nurse practitioner.

MGR03602

2. The following definitions are added:

- (a) "*Child immunization services*" means vaccinations, including the cost of the vaccines if incurred by the health care provider, against: a) Measles; b) Mumps; c) Rubella; d) Polio; e) Diphtheria; f) Pertussis; g) Tetanus; h) Haemophilus Influenza Type B; i) Hepatitis-B; and j) any other vaccine preventives of disease as may be deemed necessary or required by West Virginia law.

MGR03858

- (b) "*Clinical trial*" means a study that determines whether new drugs, treatments, or medical procedures are safe and effective on humans.
- (c) "*Cooperative group*" means a formal network of facilities that collaborate on research projects and have an established NIH-approved peer review program operating within the group. *Cooperative group* includes:
 - (i) The national cancer institute clinical cooperative group;
 - (ii) The national cancer institute community clinical oncology program;
 - (iii) The AIDS clinical trial group; and
 - (iv) The community programs for clinical research in AIDS.
- (d) "*Life-threatening condition*" means that the *covered person* has a terminal condition or *illness* that, according to current diagnosis, has a high probability of death within two years, even with treatment with an existing generally accepted treatment protocol.
- (e) "*Patient costs*" means the routine costs of a *medically necessary* health care service that are incurred by a *covered person* as a result of treatment being provided in connection with participation in a *clinical trial*. *Patient costs* does not include:
 - (i) The cost of the investigational drug or device;
 - (ii) The cost of non-healthcare services that the *covered person* is required to receive as a result of the treatment being provided to the *covered person* for the purposes of the *clinical trial*;
 - (iii) Services customarily provided by the research sponsor free of charge for any participant in the *clinical trial*;
 - (iv) Costs associated with managing the research that is associated with the *clinical trial*, including but not limited to, services furnished to satisfy data collection and analysis needs that are not used in the direct clinical management of the participant;
 - (v) Costs that would not be considered *covered expenses* under the *policy/certificate* for noninvestigational treatments; or
 - (vi) Costs for adverse events during treatment that are a direct result of the experimental treatment.

MGR03603

- (f) "*Serious mental illness*" means an illness included in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, as periodically revised, under the diagnostic categories or subclassifications of: (A) Schizophrenia and other psychotic

disorders; (B) bipolar disorders; (C) depressive disorders; (D) substance-related disorders, but not including caffeine-related disorders or nicotine-related disorders; (E) anxiety disorders; and (F) anorexia and bulimia.

MGR04535

B. The Medical Benefits section is amended as follows:

1. *Covered expenses* for the diagnosis or treatment of craniomandibular disorders, malocclusions or disorders of the temporomandibular joint are limited to: a health history; clinical exam; imaging/X-rays; conventional diagnostic and therapeutic injections; temporary orthotics (one every 3 years) and adjustments during the first 6 months following installation; physical medicine; physiotherapy (including ultrasound, diathermy, High Voltage Galvanic Stimulation, and Transcutaneous Nerve Stimulation); and *surgery* on the temporomandibular joint.

Covered expenses will not include appliances designed for orthodontic purposes, such as bionators, functional regulators, Frankel devices and other similar devices.

MGR04700

2. *Covered expenses* for treatment and/or management of Type 1, Type II, or gestational diabetes are expanded to include the following *medically necessary* equipment and supplies:

- (a) Monitor supplies;
- (b) Injection aids;
- (c) Orthotics; and
- (d) Insulin infusion devices;

3. *Covered expenses* for *diabetes self-management training services* are deleted and replaced with the following:

Covered expenses for *diabetes self-management training services* are limited to \$100 per *covered person*, per calendar year.

4. When determining *covered expenses* for *dental expenses*, *injury* will include damage to the natural teeth incurred as a result of chewing if the damage was caused by a non-edible foreign object found in food.
5. *Covered expenses* will include *patient costs* resulting from a *covered person's* participation in a *clinical trial* as a result of:

- (a) Treatment provided for a *life-threatening condition*; or
- (b) Prevention of, early detection of, or treatment studies on cancer;

provided that:

- (c) The treatment is being provided or the studies are being conducted in a Phase II, III, or IV *clinical trial* for cancer or any other *life-threatening condition* and have therapeutic intent;

- (d) The treatment is being provided in a *clinical trial* approved by:

- (i) One of the national institutes of health (NIH);
- (ii) AN NIH *cooperative group* or center;
- (iii) The United States Food and Drug Administration in the form of an investigational new drug application or investigational device exemption;
- (iv) The United States Department of Veterans Affairs; or

- (v) An institutional review board of an institution that has a multiple project assurance contract approved by the office of protection from research risks of the NIH;
- (e) The facility and personnel providing the treatment are capable of doing so by virtue of their experience, training, and volume of patients treated to maintain expertise;
- (f) There is clearly no superior, noninvestigational treatment alternative;
- (g) The available clinical or preclinical data provide a reasonable expectation that the treatment will be more effective than the noninvestigational treatment alternative; and
- (h) The treatment is provided in West Virginia, unless otherwise approved by us.

MGR03604

Covered expenses will not include, and no benefits will be paid for any charges which are incurred for *patient costs* resulting from a *covered person's* participation in a *clinical trial* if the purpose of the *clinical trial* is to:

- (i) Extend the patent of any existing drug, to gain approval or coverage of a metabolite of an existing drug, or to gain approval or coverage relating to additional clinical indications for an existing drug;
- (j) Keep a generic version of a drug from becoming available on the market; or
- (k) Gain approval of or coverage for a reformulated or repackaged version of an existing drug.

MGR03605

6. *Covered expenses* for *child immunizations services* provided prior to the a *covered person's* 17th birthday will be exempt from any *deductible amounts*, *copayment amounts* and coinsurance provisions, regardless of whether services were provided by a *network provider*.

MGR04536

7. *Covered expenses* are expanded to include an annual kidney disease screening using any combination of blood pressure testing, urine albumin or urine protein testing as recommended by the National Kidney Foundation.

MGR04161

8. *Covered expenses* are expanded to include charges incurred for the diagnosis and treatment of a *serious mental illness*. *Covered expenses* shall not include any expenses related to custodial care, residential care or schooling.

MGR04537.

9. *Covered expenses* are expanded to include charges for general anesthesia, facility fees, and other related charges incurred in conjunction with dental care (but not including the actual dental services) that are provided in a *hospital* or an *outpatient surgical facility* to a *covered person* who:

- (a) Is an *eligible child* age seven (7) or under;
- (b) Is an *eligible child* age twelve (12) or under with a documented phobia or *mental disorder*.
 - (i) Who has dental needs of such magnitude that treatment should not be delayed or deferred;
 - (ii) When a lack of treatment can be expected to result in infection, loss of teeth, or other increased oral or dental morbidity; and

- (iii) When a successful result cannot be expected under local anesthesia because of such condition, but a superior result can be expected under general anesthesia;
- (c) Has a medical condition that requires hospitalization or general anesthesia for dental care;
- (d) Is developmentally disabled and successful results cannot be expected from dental care provided under local anesthesia due to the *covered person's* physical, intellectual or medically compromising condition; or
- (e) Has a chronic disability that:
 - (i) Can be attributed to a mental or physical impairment or a combination of mental and physical impairments;
 - (ii) Is likely to continue; and
 - (iii) Results in substantial functional limitations in one or more of the following areas of major life activity: Self-care, receptive and expressive language, learning, mobility, capacity for independent living, or economic self sufficiency.

MGR04341

Except as specifically stated in this endorsement, the benefits under this endorsement are subject to all of the terms, conditions, exclusions, limitations and notification requirements of the *policy/certificate*, including any applicable *deductible amounts*, coinsurance provisions, copay amounts, or dollar limits.

MGR03440

This endorsement applies only to *covered persons* who reside in the state of West Virginia.

This endorsement will not change, waive or extend any part of the *policy/certificate*, other than as stated herein.

This endorsement is effective September 1, 2012 or at the same time as the *policy/certificate*, whichever is later.

**Golden Rule Insurance
Company**



President

MGR03441

WEST VIRGINIA ENDORSEMENT

By attachment of this endorsement, the *policy/certificate* is amended to the extent of any conflict with the following:

MGR03433

A. The Definitions section is amended as follows:

1. The definition of *medical practitioner* is amended to include a registered nurse and nurse practitioner.

MGR03602

2. The following definitions are added:

- (a) "*Child immunization services*" means vaccinations, including the cost of the vaccines if incurred by the health care provider, against: a) Measles; b) Mumps; c) Rubella; d) Polio; e) Diphtheria; f) Pertussis; g) Tetanus; h) Haemophilus Influenza Type B; i) Hepatitis-B; and j) any other vaccine preventives of disease as may be deemed necessary or required by West Virginia law.

MGR03858

- (b) "*Clinical trial*" means a study that determines whether new drugs, treatments, or medical procedures are safe and effective on humans.
- (c) "*Cooperative group*" means a formal network of facilities that collaborate on research projects and have an established NIH-approved peer review program operating within the group. *Cooperative group* includes:
 - (i) The national cancer institute clinical cooperative group;
 - (ii) The national cancer institute community clinical oncology program;
 - (iii) The AIDS clinical trial group; and
 - (iv) The community programs for clinical research in AIDS.
- (d) "*Life-threatening condition*" means that the *covered person* has a terminal condition or *illness* that, according to current diagnosis, has a high probability of death within two years, even with treatment with an existing generally accepted treatment protocol.
- (e) "*Patient costs*" means the routine costs of a *medically necessary* health care service that are incurred by a *covered person* as a result of treatment being provided in connection with participation in a *clinical trial*. *Patient costs* does not include:
 - (i) The cost of the investigational drug or device;
 - (ii) The cost of non-healthcare services that the *covered person* is required to receive as a result of the treatment being provided to the *covered person* for the purposes of the *clinical trial*;
 - (iii) Services customarily provided by the research sponsor free of charge for any participant in the *clinical trial*;
 - (iv) Costs associated with managing the research that is associated with the *clinical trial*, including but not limited to, services furnished to satisfy data collection and analysis needs that are not used in the direct clinical management of the participant;
 - (v) Costs that would not be considered *covered expenses* under the *policy/certificate* for noninvestigational treatments; or
 - (vi) Costs for adverse events during treatment that are a direct result of the experimental treatment.

MGR03603

- (f) "*Serious mental illness*" means an illness included in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, as periodically revised, under the diagnostic categories or subclassifications of: (A) Schizophrenia and other psychotic

disorders; (B) bipolar disorders; (C) depressive disorders; (D) substance-related disorders, but not including caffeine-related disorders or nicotine-related disorders; (E) anxiety disorders; and (F) anorexia and bulimia.

MGR04535

B. The Medical Benefits section is amended as follows:

1. *Covered expenses* for the diagnosis or treatment of craniomandibular disorders, malocclusions or disorders of the temporomandibular joint are limited to: a health history; clinical exam; imaging/X-rays; conventional diagnostic and therapeutic injections; temporary orthotics (one every 3 years) and adjustments during the first 6 months following installation; physical medicine; physiotherapy (including ultrasound, diathermy, High Voltage Galvanic Stimulation, and Transcutaneous Nerve Stimulation); and *surgery* on the temporomandibular joint.

Covered expenses will not include appliances designed for orthodontic purposes, such as bionators, functional regulators, Frankel devices and other similar devices.

MGR04700

2. *Covered expenses* for treatment and/or management of Type 1, Type II, or gestational diabetes are expanded to include the following *medically necessary* equipment and supplies:

- (a) Monitor supplies;
- (b) Injection aids;
- (c) Orthotics; and
- (d) Insulin infusion devices;

3. *Covered expenses* for *diabetes self-management training services* are deleted and replaced with the following:

Covered expenses for *diabetes self-management training services* are limited to \$100 per *covered person*, per calendar year.

4. When determining *covered expenses* for *dental expenses*, *injury* will include damage to the natural teeth incurred as a result of chewing if the damage was caused by a non-edible foreign object found in food.
5. *Covered expenses* will include *patient costs* resulting from a *covered person's* participation in a *clinical trial* as a result of:

- (a) Treatment provided for a *life-threatening condition*; or
- (b) Prevention of, early detection of, or treatment studies on cancer;

provided that:

- (c) The treatment is being provided or the studies are being conducted in a Phase II, III, or IV *clinical trial* for cancer or any other *life-threatening condition* and have therapeutic intent;

- (d) The treatment is being provided in a *clinical trial* approved by:

- (i) One of the national institutes of health (NIH);
- (ii) AN NIH *cooperative group* or center;
- (iii) The United States Food and Drug Administration in the form of an investigational new drug application or investigational device exemption;
- (iv) The United States Department of Veterans Affairs; or

- (v) An institutional review board of an institution that has a multiple project assurance contract approved by the office of protection from research risks of the NIH;
- (e) The facility and personnel providing the treatment are capable of doing so by virtue of their experience, training, and volume of patients treated to maintain expertise;
- (f) There is clearly no superior, noninvestigational treatment alternative;
- (g) The available clinical or preclinical data provide a reasonable expectation that the treatment will be more effective than the noninvestigational treatment alternative; and
- (h) The treatment is provided in West Virginia, unless otherwise approved by us.

MGR03604

Covered expenses will not include, and no benefits will be paid for any charges which are incurred for *patient costs* resulting from a *covered person's* participation in a *clinical trial* if the purpose of the *clinical trial* is to:

- (i) Extend the patent of any existing drug, to gain approval or coverage of a metabolite of an existing drug, or to gain approval or coverage relating to additional clinical indications for an existing drug;
- (j) Keep a generic version of a drug from becoming available on the market; or
- (k) Gain approval of or coverage for a reformulated or repackaged version of an existing drug.

MGR03605

- 6. *Covered expenses* for *child immunizations services* provided prior to the a *covered person's* 17th birthday will be exempt from any *deductible amounts*, *copayment amounts* and coinsurance provisions, regardless of whether services were provided by a *network provider*.

MGR04536

- 7. *Covered expenses* are expanded to include charges incurred while an inpatient in a hospital for the diagnosis and treatment of a *serious mental illness*. *Covered expenses* shall not include any expenses related to custodial care, residential care or schooling.

MGR04538

- 8. *Covered expenses* are expanded to include charges for general anesthesia, facility fees, and other related charges incurred in conjunction with dental care (but not including the actual dental services) that are provided in a *hospital* or an *outpatient surgical facility* to a *covered person* who:
 - (a) Is an *eligible child* age seven (7) or under;
 - (b) Is an *eligible child* age twelve (12) or under with a documented phobia or *mental disorder*:
 - (i) Who has dental needs of such magnitude that treatment should not be delayed or deferred;
 - (ii) When a lack of treatment can be expected to result in infection, loss of teeth, or other increased oral or dental morbidity; and
 - (iii) When a successful result cannot be expected under local anesthesia because of such condition, but a superior result can be expected under general anesthesia;

- (c) Has a medical condition that requires hospitalization or general anesthesia for dental care;
- (d) Is developmentally disabled and successful results cannot be expected from dental care provided under local anesthesia due to the *covered person's* physical, intellectual or medically compromising condition; or
- (e) Has a chronic disability that:
 - (i) Can be attributed to a mental or physical impairment or a combination of mental and physical impairments;
 - (ii) Is likely to continue; and
 - (iii) Results in substantial functional limitations in one or more of the following areas of major life activity: Self-care, receptive and expressive language, learning, mobility, capacity for independent living, or economic self sufficiency.

MGR04341

Except as specifically stated in this endorsement, the benefits under this endorsement are subject to all of the terms, conditions, exclusions, limitations and notification requirements of the *policy/certificate*, including any applicable *deductible amounts*, coinsurance provisions, copay amounts, or dollar limits.

MGR03440

This endorsement applies only to *covered persons* who reside in the state of West Virginia.

This endorsement will not change, waive or extend any part of the *policy/certificate*, other than as stated herein.

This endorsement is effective September 1, 2012 or at the same time as the *policy/certificate*, whichever is later.

**Golden Rule Insurance
Company**



President

MGR03441

WISCONSIN ENDORSEMENT

By attachment of this endorsement, the *policy/certificate* is amended to the extent of any conflict with the following:

MGR03433

A. The Definitions section is amended as follows:

1. The following definitions are added:

"Adult eligible child" means *your* or *your spouse's* unmarried child age 26 or over but less than 27 years of age who:

- (a) Is not eligible for his or her employer-sponsored coverage;
- (b) Is eligible for his or her employer-sponsored coverage, but the premium for the employer coverage would be more expensive than the child's premium under this plan; or
- (c) Is employed by an employer who does not offer health coverage to its employees.

Coverage will be extended to an *adult eligible child* beyond age 27 if he or she:

- (d) Was called to federal active duty in the National Guard or in a Reserve component of the United States armed forces for the first time in any four year period while:
 - (i) Unmarried;
 - (ii) Under the age of 27; and
 - (iii) A full-time student.
- (e) Remains unmarried; and
- (f) Becomes a full-time student again within 12 months from the date the active duty obligation is fulfilled.

MGR04469

"Behavioral" means interactive therapies that target observable behaviors to build needed skills and to reduce problem behaviors using well-established principles of learning utilized to change socially important behaviors with the goal of building a range of communication, social, and learning skills, as well as reducing challenging behaviors.

MGR04402

"Child immunizations" means the specified vaccines provided between a *covered person's* date of birth and 6th birthday in a manner and frequency conforming to recognized standards of medical practice. *Child immunizations* are limited to vaccines against Diphtheria, Pertussis, Tetanus, Polio, Measles, Mumps, Rubella, Hemophilus Influenza B, Hepatitis B, and Varicella.

MGR03694

"Cochlear implant" means any implantable instrument or device that is designed to enhance hearing.

MGR04422

"Evidenced-based therapies" means therapy based on medical and scientific evidence determined to be an effective treatment strategy.

MGR04403

"Hearing aid" means any externally wearable instrument or device that is designed for or offered for the purpose of aiding or compensating for impaired human hearing and any parts, attachments, or accessories of such an instrument or device, except batteries and cords.

MGR04423

"Intensive-level services" means *evidence-based therapies* based on a *covered person's* therapeutic goals and skills as prescribed by a *doctor* who knows the *covered person's* needs

MGR04405

"*Nonintensive-level services*" means *evidence based therapy* that occurs after the completion of treatment with *intensive-level services* and that is designed to sustain and maximize gains made during treatment with *intensive-level services*, or for a *covered person* who has not and will not receive *intensive-level services*, *evidence-based therapy* that will improve the individual's condition.

MGR04406

"*Qualified paraprofessional*" means an individual working under the active supervision of a psychologist, psychiatrist, or social worker and who has met all the applicable qualifications specified in Wisconsin law.

MGR04497

"*Qualified professional*" means an individual who is a licensed treatment professional working under the supervision of an outpatient mental health clinic and who has met all the applicable qualifications of a *qualified professional*, including at least 2080 hours of education and training, as specified in the laws of the state of Wisconsin.

MGR04408

2. The definition of *dependent* is expanded to include an *adult eligible child*.

MGR04414

3. The definition of *diabetes self-management training services* is hereby deleted and replaced with:

"*Diabetic outpatient self-management education program*" means a program which:

- (a) Consists of instruction which will enable diabetic patients and their families to gain an understanding of the diabetic disease process and the daily management of diabetic therapy;
- (b) Meets the standards developed by the state department of health for certification of outpatient diabetes education programs;
- (c) Is directed and supervised by a licensed *doctor* knowledgeable in the treatment of diabetes; and
- (d) Is provided by health care professionals, including, but not limited to, *doctors*, registered nurses, and pharmacists who are knowledgeable about the disease process of diabetes and in the treatment of diabetic patients.

MGR03696

4. The definition of *extended care facility* is amended to include an institution which is approved for *Medicare* benefits, or qualified to receive this approval upon request.

MGR03697

5. An investigational new drug that is approved under federal regulations for the treatment of HIV infection or for an *illness* or medical condition arising from or related to HIV infection and that is in or has completed, a phase III clinical investigation performed in accordance 21 CFR 312.20 to 312.33 and is prescribed in accordance with the treatment protocol approved for investigational new drugs under 21 CFR 312.34 to 312.36 shall not be considered *investigational treatment*.

MGR03698

- B. Under Policyholder Provisions, the subsection entitled Premium is amended to require 60 days notice of any change in premium if the premiums are increased by 25% or more.

MGR03699

- C. The terms and conditions in the Termination of Insurance and Renewability provision shall prevail over any other reference in the *policy/certificate* regarding *our* right to terminate coverage.

MGR03722

D. The Effective Date of Dependent's Insurance provision is amended as follows:

1. The subsection entitled Adding a Newborn Child is amended as follows:

An *eligible child* born to *you, your spouse* or *your covered dependent* under eighteen years of age will be covered from the time of birth through the 60th day after birth.

When additional premium is required to provide continued coverage of the child, the coverage of the child will terminate on the 60th day following its birth, unless within one year following the birth we have received written notice of the child's birth, the required payment of all past due premiums, and payment of interest on past due payments at the rate of five and one half percent per year. The required premium will be calculated from the child's date of birth.

Coverage of a child born to *your covered dependent* will cease as of the date *your covered dependent* turns eighteen years of age.

MGR04459

2. The following subsection is added:

Adding an Adopted Child: An *eligible child* legally *placed* for adoption with *you* or *your spouse* will be covered until the 61st day after placement unless the placement is disrupted prior to the legal adoption and the child is removed from *your* physical custody. When additional premium is required to provide continued coverage of the child, the coverage of the child will terminate on the 60th day following placement, unless we have received written notice that the child was legally placed for adoption with *you* or *your spouse*, and the required payment of all premiums due. The required premium will be calculated from the child's date of placement. If coverage terminates, we will require *proof of good health* to insure the adopted child again.

An adopted child added within the required timeframes will be covered for the *medically necessary* care and treatment of *preexisting conditions*.

MGR04460

3. The following subsection is added:

Adding an Adult Eligible Child: If:

- (a) *You* apply in writing for insurance on the dependent;
- (b) *You* pay the required premiums;
- (c) *You* furnish a complete health history, at no cost to us; and
- (d) *You* furnish proof that the child is an adult eligible child,

then the *effective date* will be shown in the written notice to *you* that the *dependent* is insured.

MGR04415

E. The Medical Benefits provision is amended as follows:

1. Benefits for the diagnosis and treatment of diabetes are deleted and replaced with the following:

Covered expenses for the diagnosis and treatment of diabetes will include:

- (a) Necessary medical supplies for the treatment of diabetes;
- (b) Charges for the installation and use of one insulin infusion pump per calendar year, providing that the device has been used by the *covered person* for at least thirty days prior to purchase;
- (c) Insulin and any other prescription medication; and

(d) *Diabetic self-management education programs.*

MGR03714

2. *Covered expenses* are amended to include charges incurred for the cost of *hearing aids* and *cochlear implants*, treatment related to *hearing aids* and *cochlear implants*, and procedures for the implantation of cochlear devices, when such devices are prescribed by a *doctor*, or by a licensed audiologist for an *eligible child* covered under the *policy/certificate* who is:

- (a) Under 18 years of age; and
- (b) Certified as deaf or hearing impaired by a *doctor* or an audiologist.

Covered expenses for the cost of *hearing aids* is limited to the cost of one *hearing aid* per ear every three (3) years for each *eligible child* who meets the requirements in (a) and (b) above.

MGR04424

3. *Covered expenses* for diagnosis and treatment of *autism spectrum disorders* are expanded to include:

(a) *Evidence-based behavioral intensive-level services*, the majority of which is to be provided when the parent or legal guardian is present and engaged, for the treatment of *autism spectrum disorders* for *covered persons* based on a treatment plan developed by a *qualified provider* that includes at least 20 hours per week over a six-month period of time of *evidence-based behavioral intensive therapy*, treatment, and services with specific cognitive, social, communicative, self-care, or *behavioral* goals that are clearly defined, directly observed and continually measured and that address the characteristics of *autism spectrum disorder* when such treatment is ordered by a *doctor* and provided by a *doctor* and provided by a *doctor* or *medical practitioner*.

(b) *Nonintensive-level services*

Covered intensive-level services and *nonintensive-level services* for *autism spectrum disorders* include treatment prescribed by a *doctor* and provided by any of the following who are qualified to provide the treatment:

- (c) *Qualified paraprofessional*;
- (d) *Qualified professional*;
- (e) Licensed social worker;
- (f) Speech-language pathologist or occupational therapist.

MGR04498

4. **TREATMENT OF MENTAL DISORDERS AND SUBSTANCE ABUSE:** *Covered expenses* shall include the following charges incurred for the treatment of *mental disorders*, including *substance abuse*:

- (a) Outpatient charges incurred by a *collateral* at any of the following for the purpose of enhancing the *covered person's* treatment:
 - (i) A program in an outpatient treatment facility;
 - (ii) A licensed physician who has completed a residency in psychiatry;
 - (iii) A psychologist; or
 - (iv) A licensed mental health professional practicing within the scope of his or her license.

- (b) Charges incurred by a *covered person* in a *transitional treatment arrangement* offered by a provider or program certified by the Department of Health and Family Services or provided in accordance with criteria of the American Society of Addiction Medicine.

MGR04499

DEFINITIONS: As used in this provision:

"Collateral" means a member of the *covered person's immediate family* who seeks outpatient counseling to enhance the treatment of the *covered person*. A *collateral* is limited to the *spouse*, children, parents, grandparents, brothers and sisters of the *covered person* and their *spouses*.

"Transitional treatment arrangement" means services for the treatment of *mental disorders* or *substance abuse* that are provided to an insured in a less restrictive manner than are *inpatient hospital* services, but in a more intensive manner than are outpatient services.

MGR04500

5. *Covered expenses* are expanded to include:

- (a) Diagnosis and treatment of *mental disorders*, including *substance abuse*.

MGR04478

- (b) *Child immunizations*, exempt from any *deductible amount*, copayments, and/or coinsurance provisions stated in the *policy/certificate*; and
- (c) Non-surgical treatment for the correction of temporomandibular disorders if the disorder is the result of congenital, developmental or acquired deformity, disease or *injury* and the treatment is designed to control or eliminate infection, pain, disease or dysfunction. Benefits for non-surgical treatment of temporomandibular disorders are limited to \$1250 per calendar year for each *covered person* and do not include coverage for cosmetic or elective orthodontic care, periodontic care or general dental care.

MGR03717

- (d) Services, items or drugs for the treatment of cancer which are administered under a clinical trial if:
 - (i) The service, item or drug would be considered a *covered expense* under the *policy* if not provided in conjunction with a clinical trial; and
 - (ii) The clinical trial satisfies all of the following:
 - (a) The clinical trial does one of the following:
 - A. Tests how to administer a health care service, item, or drug for the treatment of cancer;
 - B. Tests responses to a health care service, item, or drug for the treatment of cancer;
 - C. Compares the effectiveness of health care services, items, or drugs for the treatment of cancer with that of other health care services, items, or drugs for the treatment of cancer; or
 - D. Studies new uses of health care services, items, or drugs for the treatment of cancer; and
 - (b) The clinical trial is approved by one of the following:
 - A. A National Institute of Health, or one of its cooperative groups or centers, under the federal Department of Health or Human Services;

- B. The federal Food and Drug Administration;
- C. The federal Department of Defense;
- D. The federal Department of Veteran's Affairs; or
- E. An institutional review board of an institution that is approved by the Office for Human Research Protections of the federal Department of Health and Human Services.

MGR04046

- 6. The subsection entitled Limitation on Spine and Back Disorders, if included in *your* certificate, is hereby deleted.

MGR03798

- F. The Home Health Care Expense Benefits provision is amended as follows:

- 1. *Covered expenses* are amended to include the following:

Laboratory services, to the extent they would have been covered under the *policy* if the *covered person* had been in a *hospital*;

Nutrition counseling provided by or under the supervision of a registered dietician; and

Evaluation of the need for, and development of a plan for home care when approved or requested by the attending *doctor*.

MGR03719

- 2. The limitation applicable to *home health aide services* is deleted and replaced with the following:

- (a) For *home health aide services* to qualify as *covered expenses*, a *doctor* must certify that:

- (i) Confinement in a *hospital* or *extended care facility* would be required if *home health care* was not provided;

- (ii) Necessary care and treatment are not available from members of the insured's immediate family or other persons residing with the insured without causing undue hardship; and

- (iii) The *home health care* services will be provided or coordinated by a *home health care agency*.

The *doctor* must recertify every 60 days that continued *home health care* is *medically necessary* to the treatment of an *injury* or *illness*;

- (b) *Covered expenses* for *home health aide services* will be limited to 40 *home health care* visits in a 12-month period. (Each visit by an authorized representative of a *home health care agency* will be deemed a separate *home health care* visit, except that each four-hour period of *home health aide services* during a single visit will be counted as one *home health care* visit. If the length of a visit for *home health aide services* is longer than four hours, but not evenly divisible by four, the remaining period will also be counted as one *home health care* visit); and

- (c) The maximum weekly benefit for *home health care* will be limited to the reasonable and customary charge for weekly care in an *extended care facility*.

MGR03720

- G. The General Exclusions and Limitations provision and the Transplant Expense Benefits provision is amended by the addition of the following:

LIMITATION ON KIDNEY DISEASE TREATMENT: *Covered expenses* for kidney disease treatment will be limited to dialysis, transplantation and donor-related services. The maximum benefit shall be further limited to \$30,000 per *covered person* annually.

MGR03721

Except as specifically stated in this endorsement, the benefits under this endorsement are subject to all of the terms, conditions, exclusions, limitations and notification requirements of the *policy/certificate*, including any applicable *deductible amounts*, coinsurance provisions, copay amounts, or dollar limits.

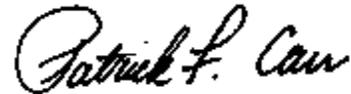
MGR03440

This endorsement applies only to *covered persons* who reside in the state of Wisconsin.

This endorsement will not change, waive or extend any part of the *policy/certificate*, other than as stated herein.

This endorsement is effective September 1, 2012 or at the same time as the *policy/certificate*, whichever is later.

**Golden Rule Insurance
Company**

A handwritten signature in black ink that reads "Patrick F. Carr". The signature is written in a cursive, flowing style.

President

WISCONSIN ENDORSEMENT

By attachment of this endorsement, the *policy/certificate* is amended to the extent of any conflict with the following:

MGR03433

A. The Definitions section is amended as follows:

1. The following definitions are added:

"Adult eligible child" means *your* or *your spouse's* unmarried child age 26 or over but less than 27 years of age who:

- (a) Is not eligible for his or her employer-sponsored coverage;
- (b) Is eligible for his or her employer-sponsored coverage, but the premium for the employer coverage would be more expensive than the child's premium under this plan; or
- (c) Is employed by an employer who does not offer health coverage to its employees.

Coverage will be extended to an *adult eligible child* beyond age 27 if he or she:

- (d) Was called to federal active duty in the National Guard or in a Reserve component of the United States armed forces for the first time in any four year period while:
 - (i) Unmarried;
 - (ii) Under the age of 27; and
 - (iii) A full-time student.
- (e) Remains unmarried; and
- (f) Becomes a full-time student again within 12 months from the date the active duty obligation is fulfilled.

MGR04469

"Behavioral" means interactive therapies that target observable behaviors to build needed skills and to reduce problem behaviors using well-established principles of learning utilized to change socially important behaviors with the goal of building a range of communication, social, and learning skills, as well as reducing challenging behaviors.

MGR04402

"Child immunizations" means the specified vaccines provided between a *covered person's* date of birth and 6th birthday in a manner and frequency conforming to recognized standards of medical practice. *Child immunizations* are limited to vaccines against Diphtheria, Pertussis, Tetanus, Polio, Measles, Mumps, Rubella, Hemophilus Influenza B, Hepatitis B, and Varicella.

MGR03694

"Cochlear implant" means any implantable instrument or device that is designed to enhance hearing.

MGR04422

"Evidenced-based therapies" means therapy based on medical and scientific evidence determined to be an effective treatment strategy.

MGR04403

"Hearing aid" means any externally wearable instrument or device that is designed for or offered for the purpose of aiding or compensating for impaired human hearing and any parts, attachments, or accessories of such an instrument or device, except batteries and cords.

MGR04423

"Intensive-level services" means *evidence-based therapies* based on a *covered person's* therapeutic goals and skills as prescribed by a *doctor* who knows the *covered person's* needs

MGR04405

"*Nonintensive-level services*" means *evidence based therapy* that occurs after the completion of treatment with *intensive-level services* and that is designed to sustain and maximize gains made during treatment with *intensive-level services*, or for a *covered person* who has not and will not receive *intensive-level services*, *evidence-based therapy* that will improve the individual's condition.

MGR04406

"*Qualified paraprofessional*" means an individual working under the active supervision of a psychologist, psychiatrist, or social worker and who has met all the applicable qualifications specified in Wisconsin law.

MGR04497

"*Qualified professional*" means an individual who is a licensed treatment professional working under the supervision of an outpatient mental health clinic and who has met all the applicable qualifications of a *qualified professional*, including at least 2080 hours of education and training, as specified in the laws of the state of Wisconsin.

MGR04408

2. The definition of *dependent* is expanded to include an *adult eligible child*.

MGR04414

3. The definition of *diabetes self-management training services* is hereby deleted and replaced with:

"*Diabetic outpatient self-management education program*" means a program which:

- (a) Consists of instruction which will enable diabetic patients and their families to gain an understanding of the diabetic disease process and the daily management of diabetic therapy;
- (b) Meets the standards developed by the state department of health for certification of outpatient diabetes education programs;
- (c) Is directed and supervised by a licensed *doctor* knowledgeable in the treatment of diabetes; and
- (d) Is provided by health care professionals, including, but not limited to, *doctors*, registered nurses, and pharmacists who are knowledgeable about the disease process of diabetes and in the treatment of diabetic patients.

MGR03696

4. The definition of *extended care facility* is amended to include an institution which is approved for *Medicare* benefits, or qualified to receive this approval upon request.

MGR03697

5. An investigational new drug that is approved under federal regulations for the treatment of HIV infection or for an *illness* or medical condition arising from or related to HIV infection and that is in or has completed, a phase III clinical investigation performed in accordance 21 CFR 312.20 to 312.33 and is prescribed in accordance with the treatment protocol approved for investigational new drugs under 21 CFR 312.34 to 312.36 shall not be considered *investigational treatment*.

MGR03698

- B. Under Policyholder Provisions, the subsection entitled Premium is amended to require 60 days notice of any change in premium if the premiums are increased by 25% or more.

MGR03699

- C. The terms and conditions in the Termination of Insurance and Renewability provision shall prevail over any other reference in the *policy/certificate* regarding *our* right to terminate coverage.

MGR03722

D. The Effective Date of Dependent's Insurance provision is amended as follows:

1. The subsection entitled Adding a Newborn Child is amended as follows:

An *eligible child* born to *you*, *your spouse* or *your covered dependent* under eighteen years of age will be covered from the time of birth through the 60th day after birth.

When additional premium is required to provide continued coverage of the child, the coverage of the child will terminate on the 60th day following its birth, unless within one year following the birth we have received written notice of the child's birth, the required payment of all past due premiums, and payment of interest on past due payments at the rate of five and one half percent per year. The required premium will be calculated from the child's date of birth.

Coverage of a child born to *your covered dependent* will cease as of the date *your covered dependent* turns eighteen years of age.

MGR04459

2. The following subsection is added:

Adding an Adopted Child: An *eligible child* legally *placed* for adoption with *you* or *your spouse* will be covered until the 61st day after placement unless the placement is disrupted prior to the legal adoption and the child is removed from *your* physical custody. When additional premium is required to provide continued coverage of the child, the coverage of the child will terminate on the 60th day following placement, unless we have received written notice that the child was legally placed for adoption with *you* or *your spouse*, and the required payment of all premiums due. The required premium will be calculated from the child's date of placement. If coverage terminates, we will require *proof of good health* to insure the adopted child again.

An adopted child added within the required timeframes will be covered for the *medically necessary* care and treatment of *preexisting conditions*.

MGR04460

3. The following subsection is added:

Adding an Adult Eligible Child: If:

- (a) *You* apply in writing for insurance on the dependent;
- (b) *You* pay the required premiums;
- (c) *You* furnish a complete health history, at no cost to us; and
- (d) *You* furnish proof that the child is an *adult eligible child*,

then the *effective date* will be shown in the written notice to *you* that the *dependent* is insured.

MGR04415

E. The Medical Benefits provision is amended as follows:

1. Benefits for the diagnosis and treatment of diabetes are deleted and replaced with the following:

Covered expenses for the diagnosis and treatment of diabetes will include:

- (a) Necessary medical supplies for the treatment of diabetes;
- (b) Charges for the installation and use of one insulin infusion pump per calendar year, providing that the device has been used by the *covered person* for at least thirty days prior to purchase;
- (c) Insulin and any other prescription medication; and

(d) *Diabetic self-management education programs.*

MGR03714

2. *Covered expenses* are amended to include charges incurred for the cost of *hearing aids* and *cochlear implants*, treatment related to *hearing aids* and *cochlear implants*, and procedures for the implantation of cochlear devices, when such devices are prescribed by a *doctor*, or by a licensed audiologist for an *eligible child* covered under the *policy/certificate* who is:

(a) Under 18 years of age; and

(b) Certified as deaf or hearing impaired by a *doctor* or an audiologist.

Covered expenses for the cost of *hearing aids* is limited to the cost of one *hearing aid* per ear every three (3) years for each *eligible child* who meets the requirements in (a) and (b) above.

MGR04424

3. *Covered expenses* for diagnosis and treatment of *autism spectrum disorders* are expanded to include:

(a) *Evidence-based behavioral intensive-level services*, the majority of which is to be provided when the parent or legal guardian is present and engaged, for the treatment of *autism spectrum disorders* for *covered persons* based on a treatment plan developed by a *qualified provider* that includes at least 20 hours per week over a six-month period of time of *evidence-based behavioral intensive therapy*, treatment, and services with specific cognitive, social, communicative, self-care, or *behavioral* goals that are clearly defined, directly observed and continually measured and that address the characteristics of *autism spectrum disorder* when such treatment is ordered by a *doctor* and provided by a *doctor* and provided by a *doctor* or *medical practitioner*.

(b) Outpatient *intensive-level services* are limited to a maximum benefit of \$50,000 per *covered person*, per calendar year, subject to annual adjustment in the consumer price index, including a minimum of 30 to 35 hours of care per week for up to a lifetime maximum of 4 years; and

(c) Outpatient *nonintensive-level services*, limited to a maximum of \$25,000 per *covered person*, per calendar year, subject to an annual adjustment in the consumer price index.

(d) *Qualified paraprofessional*;

(e) *Qualified professional*;

(f) Licensed social worker;

(g) Speech-language pathologist or occupational therapist.

MGR04501

4. **TREATMENT OF MENTAL DISORDERS AND SUBSTANCE ABUSE:** *Covered expenses* shall include the following charges incurred for the treatment of *mental disorders*, including *substance abuse*:

(a) Outpatient charges incurred by a *collateral* at any of the following for the purpose of enhancing the *covered person's* treatment:

(i) A program in an outpatient treatment facility;

(ii) A licensed physician who has completed a residency in psychiatry;

(iii) A psychologist; or

- (iv) A licensed mental health professional practicing within the scope of his or her license.
- (b) Charges incurred by a *covered person* in a *transitional treatment arrangement* offered by a provider or program certified by the Department of Health and Family Services or provided in accordance with criteria of the American Society of Addiction Medicine.

MGR04499

DEFINITIONS: As used in this provision:

"Collateral" means a member of the *covered person's immediate family* who seeks outpatient counseling to enhance the treatment of the *covered person*. A *collateral* is limited to the *spouse*, children, parents, grandparents, brothers and sisters of the *covered person* and their *spouses*.

"Transitional treatment arrangement" means services for the treatment of *mental disorders* or *substance abuse* that are provided to an insured in a less restrictive manner than are *inpatient hospital* services, but in a more intensive manner than are outpatient services.

MGR04500

5. *Covered expenses* are expanded to include:

- (a) Inpatient diagnosis and treatment of mental disorders, including substance abuse.

MGR04483

- (b) *Child immunizations*, exempt from any *deductible amount*, copayments, and/or coinsurance provisions stated in the *policy/certificate*; and

MGR03717

- (c) Diagnostic procedures and *medically necessary* surgical or non-surgical treatment for the correction of temporomandibular disorders if all of the following apply:
 - (i) The condition is caused by congenital, developmental or acquired deformity, disease or *injury*.
 - (ii) Under accepted standards of the profession of the provider rendering the service, the procedure or device is reasonable and appropriate for the diagnosis or treatment of the condition.
 - (iii) The purpose of the procedure or device is to control or eliminate infection, pain, disease or dysfunction.

Benefits for non-surgical treatment of temporomandibular disorders are limited to \$1250 per calendar year for each *covered person* and do not include coverage for cosmetic or elective orthodontic care, periodontic care or general dental care.

MGR04740

- (d) Services, items or drugs for the treatment of cancer which are administered under a clinical trial if:
 - (i) The service, item or drug would be considered a *covered expense* under the *policy* if not provided in conjunction with a clinical trial; and
 - (ii) The clinical trial satisfies all of the following:
 - (a) The clinical trial does one of the following:

- A. Tests how to administer a health care service, item, or drug for the treatment of cancer;
 - B. Tests responses to a health care service, item, or drug for the treatment of cancer;
 - C. Compares the effectiveness of health care services, items, or drugs for the treatment of cancer with that of other health care services, items, or drugs for the treatment of cancer; or
 - D. Studies new uses of health care services, items, or drugs for the treatment of cancer; and
- (b) The clinical trial is approved by one of the following:
- A. A National Institute of Health, or one of its cooperative groups or centers, under the federal Department of Health or Human Services;
 - B. The federal Food and Drug Administration;
 - C. The federal Department of Defense;
 - D. The federal Department of Veteran's Affairs; or
 - E. An institutional review board of an institution that is approved by the Office for Human Research Protections of the federal Department of Health and Human Services.

MGR04046

F. The Home Health Care Expense Benefits provision is amended as follows:

1. *Covered expenses* are amended to include the following:

Laboratory services, to the extent they would have been covered under the *policy* if the *covered person* had been in a *hospital*;

Nutrition counseling provided by or under the supervision of a registered dietician; and

Evaluation of the need for, and development of a plan for home care when approved or requested by the attending *doctor*.

MGR03719

2. The limitation applicable to *home health aide services* is deleted and replaced with the following:

(a) For *home health aide services* to qualify as *covered expenses*, a *doctor* must certify that:

(i) Confinement in a *hospital* or *extended care facility* would be required if *home health care* was not provided;

(ii) Necessary care and treatment are not available from members of the insured's immediate family or other persons residing with the insured without causing undue hardship; and

(iii) The *home health care* services will be provided or coordinated by a *home health care agency*.

The *doctor* must recertify every 60 days that continued *home health care* is *medically necessary* to the treatment of an *injury* or *illness*;

(b) *Covered expenses* for *home health aide services* will be limited to 40 *home health care* visits in a 12-month period. (Each visit by an authorized representative of a *home health care agency* will be deemed a separate *home*

health care visit, except that each four-hour period of *home health aide services* during a single visit will be counted as one *home health care* visit. If the length of a visit for *home health aide services* is longer than four hours, but not evenly divisible by four, the remaining period will also be counted as one *home health care* visit); and

- (c) The maximum weekly benefit for *home health care* will be limited to the reasonable and customary charge for weekly care in an *extended care facility*.

MGR03720

- G. The General Exclusions and Limitations provision and the Transplant Expense Benefits provision is amended by the addition of the following:

LIMITATION ON KIDNEY DISEASE TREATMENT: *Covered expenses* for kidney disease treatment will be limited to dialysis, transplantation and donor-related services. The maximum benefit shall be further limited to \$30,000 per *covered person* annually.

MGR03721

Except as specifically stated in this endorsement, the benefits under this endorsement are subject to all of the terms, conditions, exclusions, limitations and notification requirements of the *policy/certificate*, including any applicable *deductible amounts*, coinsurance provisions, copay amounts, or dollar limits.

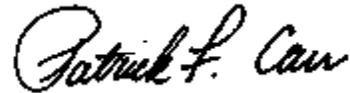
MGR03440

This endorsement applies only to *covered persons* who reside in the state of Wisconsin.

This endorsement will not change, waive or extend any part of the *policy/certificate*, other than as stated herein.

This endorsement is effective September 1, 2012 or at the same time as the *policy/certificate*, whichever is later.

**Golden Rule Insurance
Company**



President

MGR03441

**GOLDEN RULE INSURANCE COMPANY
WISCONSIN GRIEVANCE AND COMPLAINT PROCEDURES RIDER
(GRANDFATHERED PLANS)**

This rider is effective on March 1, 2012, or at the same time as the *policy/certificate*, whichever is later.

This rider replaces any grievance/appeal procedure(s) previously included in the *policy/certificate*.

By attachment of this rider, the *policy/certificate* is amended to the extent of any conflict with the following:

A. **DEFINITIONS:** As used in this rider, the following terms have the meanings indicated:

1. "*Adverse determination*" means a determination by *us* or on *our* behalf to which all of the following apply:
 - (a) An admission to a health care facility, the availability of care, the continued stay or other treatment that is a covered benefit has been reviewed.
 - (b) Based on the information provided, the treatment does not meet the health benefit plan's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness.
 - (c) Based on the information provided, *we* reduced, denied or terminated the treatment or payment for the treatment.
 - (d) The amount of the reduction or the cost or expected cost of the denied or terminated treatment or payment exceeds \$295, or will exceed \$295 during the course of the treatment.

Regarding the independent review procedures, this includes the denial of a request for a referral for out-of-network services when *you* request health care services from a provider that does not participate in *our* provider network because the clinical expertise of the provider may be medically necessary for treatment of *your* medical condition and that expertise is not available in *our* provider network.
2. "*Complaint*" means any expression of dissatisfaction expressed to *us* by *you*, or *your* authorized representative, about *us* or the providers with whom *we* have a direct or indirect contract.
3. "*Coverage denial determination*" means an *adverse determination*, an *experimental treatment determination*, a *preexisting condition exclusion denial determination*, or the *rescission* of a policy or certificate. It also includes, for individual insurance products, a policy *reformation* or change in premium charged based upon underwriting or claims information greater than 25% from the premium in effect during the period of contestability except to the extent the modification is due to the applicant's age or a rate increase applied by *us* to all similar individual policy forms applied uniformly.
4. "*Expedited grievance*" means a *grievance* where any of the following applies:
 - (a) The duration of the standard resolution process will result in serious jeopardy to *your* life or health or *your* ability to regain maximum function.
 - (b) In the opinion of a physician with knowledge of *your* medical condition, *you* are subject to severe pain that cannot be adequately managed without the care or treatment that is the subject of the *grievance*.
 - (c) A physician with knowledge of *your* medical condition determines that the *grievance* shall be treated as an *expedited grievance*.
5. "*Experimental treatment determination*" means a determination by *us* which all of the following apply:
 - (a) A proposed treatment has been reviewed.

- (b) Based on the information provided, the treatment is determined to be experimental under the terms of the health benefit plan.
 - (c) Based on the information provided, we denied the treatment or payment for the treatment.
 - (d) The cost or expected cost of the denied treatment or payment exceeds \$295, or will exceed \$295 during the course of the treatment.
6. "*Grievance*" means any dissatisfaction with *us* in writing in any form to *us* by *you*, or on *your* behalf, including any of the following:
- (a) Provision of services.
 - (b) Determination to reform or rescind a policy.
 - (c) Determination of a diagnosis or level of service required for evidence-based treatment of autism spectrum disorders.
 - (d) Claims practices.
7. "*Preexisting condition exclusion*" means with respect to coverage, a limitation or exclusion of benefits relating to a condition of an individual that existed before the individual's date of enrollment for coverage.
8. "*Preexisting condition exclusion denial determination*" means a determination by *us* or on *our* behalf denying or terminating treatment or payment for treatment on the basis of a *preexisting condition exclusion*.
9. "*Reformation*" of a policy means a determination by *us* to modify the terms of the policy or adjust the premium rate by more than 25% from the premium in effect during the period of contestability. A modification in premium based upon the applicant's or insured's age or a rate increase uniformly applied by *us* to all similar individual policy forms is not a *reformation* of a policy.
10. "*Rescission*" of a policy means a determination by *us* to withdraw the coverage back to the initial date of coverage.

B. INTERNAL REVIEW

1. Applicability/Eligibility
- (a) The internal *grievance* procedures apply to:
 - (i) Any hospital or medical *policy* or certificate including ridered dental and vision.
 - (ii) Conversion plans.
 - (b) An eligible grievant includes:
 - (i) You.
 - (ii) Person authorized by law to act on *your* behalf. **Note:** Written authorization is not required; however, if received, *we* will accept any written expression of authorization without requiring specific form, language, or format.
 - (iii) In the event *you* are unable to give consent: a spouse, family member, or the treating provider.
 - (iv) In the event of an *expedited grievance*: the person for whom *you* have verbally given authorization to represent *you*.
2. Grievances
- There is not a time limit for submitting a *grievance*.
- Grievances* will be promptly investigated and presented to the internal *grievance* panel.

(a) Resolution Timeframe

A *grievance* shall be resolved within **30 calendar days** of receipt.

The time period may be extended for an additional 30 calendar days if *we* provide *you* and *your* authorized representative, if applicable, written notification of the following within the first 30 calendar days:

- (i) That *we* have not resolved the *grievance*;
- (ii) When *our* resolution of the *grievance* may be expected; and
- (iii) The reason why the additional time is needed.

The maximum time for the entire *grievance* process is 60 calendar days.

(b) Acknowledgement

Within **five business days** of receipt of a *grievance*, a written acknowledgment to *you* or *your* authorized representative confirming receipt of the *grievance* must be delivered or deposited in the mail.

When acknowledging a *grievance* filed by an authorized representative, the acknowledgment shall include a clear and prominent notice that health care information or medical records may be disclosed only if permitted by law.

- (i) The acknowledgment shall state that unless otherwise permitted under applicable law, informed consent is required and the acknowledgment shall include an informed consent form for that purpose.
- (ii) If such disclosure is prohibited by law, health care information or medical records may be withheld from an authorized representative, including information contained in its resolution of the *grievance*.
- (iii) A *grievance* submitted by an authorized representative will be processed regardless of whether health care information or medical records may be disclosed to the authorized representative under applicable law.

(c) Right to Appear

The insured who filed the *grievance*, or the insured's authorized representative, has the right to appear in person before the *grievance* panel to present written or oral information. The grievant may submit written questions to the person or persons responsible for making the determination that resulted in the *grievance*.

- (i) Written notification must be sent to *you* indicating the time and place of the *grievance* panel meeting at least **seven calendar days** before the meeting.
- (ii) Reasonable accommodations must be provided to allow *you* or *your* authorized representative, to participate in the *grievance* panel.

(d) Grievance Panel

The *grievance* panel will not include the person who made the initial determination. The panel may, however, consult with the initial decision-maker. If the panel consists of at least three persons, the panel may then include no more than one subordinate of the person who made the initial determination.

The *grievance* panel will include:

- (i) At least one individual authorized to take corrective action on the *grievance*; and
- (ii) At least one insured other than the grievant, if an insured is available to serve on the *grievance* panel. The insured member of the panel shall not be an employee of the plan, to the extent possible.

The *grievance* panel will consult with a licensed health care provider with expertise in the field relating to the *grievance*, if appropriate.

(e) Expedited Grievance

An *expedited grievance* shall be resolved as expeditiously as *your* health condition requires but not more than 72 hours after receipt of the *grievance*.

Due to the 72-hour resolution timeframe, the standard requirements for notification, *grievance* panel/right to appear, and acknowledgement do not apply to *expedited grievances*.

Upon written request, we will mail or electronically mail a copy of *your* complete policy to *you* or *your* authorized representative as expeditiously as the *grievance* is handled.

(f) Written Grievance Response

Grievance response letters shall describe, in detail, the *grievance* procedure and the notification shall include the specific reason for the denial, determination or initiation of disenrollment.

The panel's written decision to the grievant must include:

- (i) The disposition of the *grievance*;
- (ii) Any corrective action taken on the *grievance*;
- (iii) The signature of one voting member of the panel; and
- (iv) A written description of position titles of panel members involved in making the decision.

For responses affirming *coverage denial determinations*, the written response must also provide notification of *your*, or *your* authorized representative's, right to request an independent review and include all of the following:

- (i) A copy of the informational brochure developed by the Wisconsin Office of the Commissioner of Insurance (OCI) describing the independent review process. It is available at: http://oci.wi.gov/pub_list/pi-203.pdf.
- (ii) A copy of the current listing of certified Independent Review Organizations (IROs). This listing is maintained by the Commissioner and revised at least quarterly. It is posted on the OCI's website: <http://oci.wi.gov/iros-cert.pdf>.
- (iii) Statements indicating the request for an independent review must:
 - (a) Be made within four months from the date of *our coverage denial determination* or from the date of receipt of notice of the *grievance* panel decision, whichever is later.
 - (b) Be made in writing.
 - (c) Indicate the name of the IRO as selected by *you*, or *your* authorized representative, from the list of certified IROs which accompanied the notice.
 - (d) Indicate the address and name of the person or position to whom the request is to be sent.
 - (e) Only be requested when the amount of the reduction or the cost or expected cost of the denied or terminated payment is more than \$295, or will be more than \$295.
- (iv) A statement informing *you* that once the IRO makes a determination, the determination may be binding upon *us* and *you*. For *preexisting condition exclusion denial determinations* and *rescissions*, the notice shall indicate that the IRO determination is not binding on *you*.

- (v) A statement informing *you*, or *your* authorized representative, that they need not exhaust the internal *grievance* procedure if either of the following conditions are met:
 - (a) Both *we* and *you*, or *your* authorized representative, agree that the *grievance* should proceed directly to independent review.
 - (b) The IRO determines that an expedited review is appropriate upon receiving a request from *you* or *your* authorized representative that is simultaneously sent to *us*.
- (vi) A brief summary statement regarding Health Insurance Risk Sharing Plan eligibility when the *coverage denial determination* involved a policy *rescission*.

3. Complaints

Basic elements of a *complaint* include:

- (a) The complainant is *you* or *your* authorized representative;
- (b) The submission may or may not be in writing; and
- (c) The issue may refer to any dissatisfaction about:
 - (i) *Us* (as the insurer); e.g., customer service *complaints* - “the person to whom I spoke on the phone was rude to me;”
 - (ii) Providers with whom *we* have a direct or indirect contract;
 - (a) Lack of availability and/or accessibility of network providers not tied to an unresolved benefit denial;
 - (b) Quality of care/quality of service issues;
 - A. Written expressions of dissatisfaction regarding quality of care/quality of service are processed as *grievances*.
 - B. Oral expressions of dissatisfaction regarding quality of care/quality of service are processed as *complaints*.
 - (iii) Any of the issues listed as part of the definition of *grievance* received from *you* or *your* authorized representative where the caller has not submitted a written request but calls *us* to escalate their dissatisfaction and request a verbal/oral review.

Complaints received from the OCI

The Commissioner may require *us* to treat and process any *complaint* received by the OCI by *you*, or on *your* behalf, as a *grievance* as appropriate. *We* will process the OCI *complaint* as a *grievance* when the Commissioner provides *us* with a written description of the *complaint*.

C. EXTERNAL REVIEW

You have four months from receipt of an internal *grievance* decision to make a written request to the Grievance Administrator for external review. In this written request, *you* must note the choice of the independent reviewer selected from the listing either provided by *us* or available at the OCI’s website <http://oci.wi.gov/iroscert.pdf>.

Nothing in this section affects *your* right to commence a civil proceeding relating to a *coverage denial determination*.

All external review expenses are paid for by *us*.

1. Applicability/Eligibility

- (a) The Wisconsin external *grievance* procedures apply to:
 - (i) Any hospital or medical *policy* or certificate.
 - (ii) Conversion plans.

- (b) An eligible grievant includes:
 - (i) You.
 - (ii) *Your* authorized representative.
- (c) Eligibility criteria for independent review:
 - (i) Disputes that are related to administrative matters, including enrollment eligibility, not related to treatment or services are **not** eligible for independent review determinations.
 - (ii) A dispute between *you* and *us* regarding eligibility for independent review shall be considered a *coverage denial determination* and *you* may seek independent review of the determination.
 - (iii) *Coverage denial determinations* **are** eligible for independent review.
 - (a) *Our* internal *grievance* procedures are required to be exhausted before an independent review of a *coverage denial determination* can be requested, unless either of the following conditions are met:
 - A. *We* and *you* or *your* authorized representative, agree that the matter may proceed directly to independent review.
 - B. The IRO determines that an expedited review is appropriate upon receiving a request from *you* or *your* authorized representative that is simultaneously sent to *us*.
 - (b) An independent review of an *adverse determination* or an *experimental treatment determination* may be requested only when the amount of the reduction or the cost or expected cost of the denied or terminated payment is more than \$295, or will be more than \$295.
 - (iv) *We* will apply the adjusted dollar amount as follows:
 - (a) For *adverse determinations* when treatment was received by *you*, *we* will determine the proper adjusted dollar amount based on the date treatment was received.
 - (b) For *adverse determinations* when a course of treatment was received by *you* or terminated by *us*, *we* will determine the proper adjusted dollar amount based on the later of the following dates:
 - A. The last date treatment was received by *you*; or
 - B. The date *we* mailed written notification to *you*, or *your* authorized representative, that the course of treatment was terminated or denied.
 - (c) For *experimental treatment determinations*, *we* will determine the proper adjusted dollar amount based on the date *we* mailed written notification to *you* or *your* authorized representative, that for the proposed treatment *we* have either denied the treatment or denied payment for the treatment.

2. Acknowledgement

The Commissioner and the IRO selected by *you* or *your* authorized representative must receive written notification of a request for an independent review within **two business days** of *our* receipt of the request.

Without including any identifying information regarding *you*, include the following details in the written notification:

- (a) Name of insurance company;
- (b) A reference number for the file (e.g., claim number, identification number);

- (c) The date the IRO request was received;
- (d) The IRO chosen by *you* or *your* authorized representative; and
- (e) Brief description of denial (if an *adverse determination*).

The IRO has three days to inform *you*, the Commissioner, and *us* if there is a conflict of interest that prevents the IRO from taking the case.

3. Independent Review Process

- (a) Within **five business days** after receiving written notice of a request for independent review, *we* will submit copies of all of the following to the IRO without requiring a written release from *you*:
 - (i) Any information submitted to *us* by *you* in support of *your* position in *our* internal *grievance* review.
 - (ii) The relevant provisions or evidence of coverage from *your* health benefit plan.
 - (iii) Any other relevant documents or information *we* used in the internal *grievance* review.
- (b) Within **five business days** after receiving the provided information, the IRO shall request any additional information that it requires for the review from *you* or *us*.
- (c) Within **five business days** after receiving a request for additional information, *we* or *you* will submit the information or an explanation of why the information is not being submitted.

Information submitted to the IRO at the request of the IRO by either *you*, *your* authorized representative, or *us* shall also be promptly provided to the other party to the review.

The IRO may accept for consideration any typed or printed verifiable medical or scientific evidence that the IRO determines is relevant, regardless of whether the evidence has been submitted for consideration at any time previously.

- (d) If, on the basis of any additional information, *we* reconsider *your grievance* and determine that the treatment that was the subject of the *grievance* should be covered, or that the policy or certificate that was rescinded should be reinstated, the independent review is terminated.
- (e) The IRO will make a decision on the basis of all documents and information submitted within **30 business days** after all time limits expire.

The decision shall be in writing, signed on behalf of the independent review organization and served by personal delivery or by mailing a copy to *you* or *your* authorized representative and to *us* within two days of the IRO's decision.

The decision of the IRO may be binding on both *you* and *us*. However, a decision of an IRO regarding a *preexisting condition exclusion denial determination* or a *rescission* is not binding on *you*.

- (f) For each independent review in which it is involved, *we* will pay a fee to the IRO. *We* will pay the fee submitted by the IRO within **30 days** of receipt of a written invoice or billing record from the IRO.
- (g) An independent review may not include appearances by *you* or *your* authorized representative, any person representing *us*, or any witness on behalf of either *you* or *us*.
- (h) *We* will provide, upon written request from *you* or *your* authorized representative, a complete copy of *your* policy. *We* will respond to the written request within **three business days** of the request by mailing or electronically mailing the copy to *you* or *your* authorized representative in the format requested.

4. Expedited Independent Review

If the IRO determines that *your* health condition is such that following the standard review procedures would jeopardize *your* life, health, or ability to regain maximum function, the standard review procedures shall be completed with the following differences:

- (a) Within **one day** after receiving written notice of a request for independent review, we will submit to the IRO copies of all of the information described above in section C.3.1.
- (b) Within **two business days** after receiving the provided information, the IRO shall request any additional information that it requires for the review from *you* or *us*.
- (c) Within **two days** after receiving a request for additional information, *we* or *you* will submit the information or an explanation of why the information is not being submitted.
- (d) The IRO shall make its decision within **72 hours** after the expiration of the time limits described in this section.

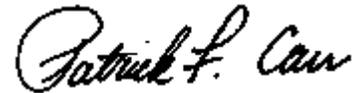
The IRO shall provide its decision within one hour or as expeditiously as practicable to *you*, or *your* authorized representative, and *us*.

An expedited review shall be resolved as expeditiously as *your* health condition requires.

This rider applies only to insureds who reside in the state of Wisconsin.

This rider will not change, waive, or extend any part of the *policy*/certificate, other than as stated herein.

Golden Rule Insurance Company



President

**GOLDEN RULE INSURANCE COMPANY
WISCONSIN GRIEVANCE AND COMPLAINT PROCEDURES RIDER
(NON-GRANDFATHERED PLANS)**

This rider is effective on March 1, 2012, or at the same as the *policy*/certificate, whichever is later.

This rider replaces any grievance/appeal procedure(s) previously included in the *policy*/certificate.

By attachment of this rider, the *policy*/certificate is amended to the extent of any conflict with the following:

A. **DEFINITIONS:** As used in this rider, the following terms have the meanings indicated:

1. "*Adverse benefit determination*" means:

- (a) Any claim denial, reduction, or termination of, or a failure to provide, or make payment (in whole or in part) for a benefit, including:
 - (i) deductible credits; coinsurance; co-pay; provider network reductions or exclusions, or other cost sharing requirements;
 - (ii) any instance where the plan pays less than the total expenses submitted resulting in claimant responsibility;
 - (iii) a benefit resulting from the application of any utilization review;
 - (iv) a covered benefit that is otherwise denied as not medically necessary or appropriate;
 - (v) a covered benefit that is otherwise denied as experimental or investigational;
- (b) Any denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's eligibility to participate in the plan, including any decision to deny coverage at the time of application or placing a medical rider; and
- (c) Any *rescission* of coverage, including offering the option of accepting a medical rider in lieu of *rescission*, (whether or not the *rescission* has an adverse effect on any particular benefit at that time).
- (d) It also includes, for individual insurance products, a *policy reformation* or change in premium charged based upon underwriting or claims information greater than 25% from the premium in effect during the period of contestability except to the extent the modification is due to the applicant's age or a rate increase applied by *us* to all similar individual policy forms applied uniformly.

Regarding the independent review procedures, this includes the denial of a request for a referral for out-of-network services when *you* request health care services from a provider that does not participate in *our* provider network because the clinical expertise of the provider may be medically necessary for treatment of *your* medical condition and that expertise is not available in *our* provider network.

- 2. "*Complaint*" means any expression of dissatisfaction expressed to *us* by *you*, or *your* authorized representative, about *us* or the providers with whom *we* have a direct or indirect contract.
- 3. "*Expedited grievance*" means a *grievance* where any of the following applies:
 - (a) The duration of the standard resolution process will result in serious jeopardy to *your* life or health or *your* ability to regain maximum function.
 - (b) In the opinion of a physician with knowledge of *your* medical condition, *you* are subject to severe pain that cannot be adequately managed without the care or treatment that is the subject of the *grievance*.
 - (c) A physician with knowledge of *your* medical condition determines that the *grievance* shall be treated as an *expedited grievance*.

4. "*Grievance*" means any dissatisfaction with *us* that is expressed in writing in any form to *us* by *you*, or on *your* behalf, including any of the following:
 - (a) Provision of services.
 - (b) Determination to reform or rescind a policy.
 - (c) Determination of a diagnosis or level of service required for evidence-based treatment of autism spectrum disorders.
 - (d) Claims practices.
5. "*Post-service claim*" means any claim for benefits for medical care or treatment that is not a *pre-service claim*.
6. "*Pre-service claim*" means any claim for benefits for medical care or treatment that requires the approval of the plan in advance of the covered person obtaining the medical care.
7. "*Reformation*" of a policy means a determination by *us* to modify the terms of the policy or adjust the premium rate by more than 25% from the premium in effect during the period of contestability. A modification in premium based upon the applicant's or insured's age or a rate increase uniformly applied by *us* to all similar individual policy forms is not a *reformation* of a policy.
8. "*Rescission*" of a policy means a determination by *us* to withdraw the coverage back to the initial date of coverage.

B. INTERNAL PROCEDURES

1. Applicability/Eligibility
 - (a) The internal *grievance* procedures apply to:
 - (i) Any hospital or medical *policy* or certificate.
 - (ii) Conversion plans.
 - (b) An eligible grievant includes:
 - (i) You.
 - (ii) Person authorized to act on *your* behalf. **Note:** Written authorization is not required; however, if received, *we* will accept any written expression of authorization without requiring specific form, language, or format.
 - (iii) In the event *you* are unable to give consent: a spouse, family member, or the treating provider.
 - (iv) In the event of an *expedited grievance*: the person for whom *you* have verbally given authorization to represent *you*.

2. Grievances

There is not a time limit for submitting a *grievance*.

Claimants have the right to submit written comments, documents, records, and other information relating to the claim for benefits. Claimants have the right to review the claim file and to present evidence and testimony as part of the internal review process.

Grievances will be promptly investigated and presented to the internal *grievance* panel.

A plan that is providing benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice and an opportunity for advance review. The plan is required to provide continued coverage pending the outcome of an appeal.

(a) Resolution Timeframes

Grievances regarding quality of care, quality of service, or reformation will be resolved within **30 calendar days** of receipt.

The time period may be extended for an additional 30 calendar days (making the maximum time for the entire *grievance* process **60 calendar days**) if we provide you and your authorized representative, if applicable, written notification of the following within the first 30 calendar days:

- (i) That we have not resolved the *grievance*;
- (ii) When our resolution of the *grievance* may be expected; and
- (iii) The reason why the additional time is needed.

All other *grievances* will be resolved and we will notify the claimant in writing with the appeal decision within the following timeframes:

- (i) Post-service claim: within **60 calendar days** after receipt of the claimant's request for internal appeal.
- (ii) Pre-service claim: within **30 calendar days** after receipt of the claimant's request for internal appeal.

A claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. All comments, documents, records and other information submitted by the claimant relating to the claim for benefits, regardless of whether such information was submitted or considered in the initial *adverse benefit determination*, will be considered in the internal appeal.

- (i) The claimant will receive from the plan, as soon as possible, any new or additional evidence considered by the reviewer. The plan will give the claimant **10 calendar days** to respond to the new information before making a determination, unless the state turnaround time for response is due in less than 10 days. If the state turnaround time is less than 10 days, the claimant will have the option of delaying the determination for a reasonable period of time to respond to the new information.
- (ii) The claimant will receive from the plan, as soon as possible, any new or additional medical rationale considered by the reviewer. The plan will give the claimant **10 calendar days** to respond to the new medical rationale before making a determination, unless the state turnaround time for response is due in less than 10 days. If the state turnaround time is less than 10 days, the claimant will have the option of delaying the determination for a reasonable period of time to respond to the new medical rationale.

Refer to section B.2.(e) for information regarding internal *expedited grievances*.

(b) Acknowledgement

Within **five business days** of receipt of a *grievance*, a written acknowledgment to you or your authorized representative confirming receipt of the *grievance* must be delivered or deposited in the mail.

When acknowledging a *grievance* filed by an authorized representative, the acknowledgement shall include a clear and prominent notice that health care information or medical records may be disclosed only if permitted by law.

- (i) The acknowledgement shall state that unless otherwise permitted under applicable law, informed consent is required and the acknowledgement shall include an informed consent form for that purpose.
- (ii) If such disclosure is prohibited by law, health care information or medical records may be withheld from an authorized representative, including information contained in its resolution of the *grievance*.

(iii) A *grievance* submitted by an authorized representative will be processed regardless of whether health care information or medical records may be disclosed to the authorized representative under applicable law.

(c) Right to Appear

The insured who filed the *grievance*, or the insured's authorized representative, has the right to appear in person before the *grievance* panel to present written or oral information. The grievant may submit written questions to the person or persons responsible for making the determination that resulted in the *grievance*.

- (i) Written notification must be sent to *you* indicating the time and place of the *grievance* panel meeting at least seven calendar days before the meeting.
- (ii) Reasonable accommodations must be provided to allow *you*, or *your* authorized representative, to participate in the *grievance* panel.

(d) Grievance Panel

The *grievance* panel will not include the person who made the initial determination and is not the subordinate of the original reviewer. The panel may, however, consult with the initial decision-maker. If the panel consists of at least three persons, the panel may then include no more than one subordinate of the person who made the initial determination.

The *grievance* panel will include:

- (i) At least one individual authorized to take corrective action on the *grievance*; and
- (ii) At least one insured other than the grievant, if an insured is available to serve on the *grievance* panel. The insured member of the panel shall not be an employee of the plan, to the extent possible.

When the *adverse benefit determination* is based in whole or in part on a medical judgment, the *grievance* panel will consult with a licensed health care provider with expertise in the field relating to the *grievance* and who was not consulted in connection with the original *adverse benefit determination*.

(e) Expedited Grievance

An *expedited grievance* may be submitted orally or in writing.

All necessary information, including *our* determination on review, will be transmitted between the claimant and us by telephone, facsimile, or other available similarly expeditious method.

An *expedited grievance* shall be resolved as expeditiously as *your* health condition requires but not more than 72 hours after receipt of the *grievance*.

Due to the 72-hour resolution timeframe, the standard requirements for notification, *grievance* panel/right to appear, and acknowledgement do not apply to *expedited grievances*.

Upon written request, we will mail or electronically mail a copy of *your* complete policy to *you* or *your* authorized representative as expeditiously as the *grievance* is handled.

(f) Written Grievance Response

Grievance response letters shall describe, in detail, the *grievance* procedure and the notification shall include the specific reason for the denial, determination or initiation of disenrollment.

The panel's written decision to the grievant must include:

- (i) The disposition of and the specific reason or reasons for the decision;
- (ii) Any corrective action taken on the *grievance*;

- (iii) The signature of one voting member of the panel; and
- (iv) A written description of position titles of panel members involved in making the decision.
- (v) When the *adverse benefit determination* involved a *rescission*, include a brief summary statement regarding Health Insurance Risk Sharing Plan eligibility.
- (vi) If upheld or partially upheld, it is also necessary to include:
 - (a) A clear explanation of the decision;
 - (b) Reference to the specific plan provision on which the determination is based;
 - (c) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits.
 - (d) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request;
 - (e) If the *adverse benefit determination* is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;
 - (f) Identification of medical experts whose advice was obtained on behalf of the health plan, without regard to whether the advice was relied upon in making the *adverse benefit determination*;
 - (g) The date of service;
 - (h) The health care provider's name;
 - (i) The claim amount;
 - (j) The diagnosis and procedure codes with their corresponding meanings, or an explanation that the diagnosis and/or procedure codes are available upon request;
 - (k) The health plan's denial code with corresponding meaning;
 - (l) A description of any standard used, if any, in denying the claim;
 - (m) A description of the external review procedures, if applicable;
 - (n) The right to bring a civil action under state or federal law;
 - (o) A copy of the form that authorizes the health plan to disclose protected health information, if applicable.
 - (p) That assistance is available by contacting the specific state's consumer assistance department, if applicable; and
 - (q) A culturally linguistic statement based upon the claimant's county or state of residence that provides for oral translation of the *adverse benefit determination*, if applicable.

3. Complaints

Basic elements of a *complaint* include:

- (a) The complainant is *you* or *your* authorized representative;
- (b) The submission may or may not be in writing; and
- (c) The issue may refer to any dissatisfaction about:
 - (i) *Us* (as the insurer); e.g., customer service *complaints* - "the person to whom I spoke on the phone was rude to me;"
 - (ii) Providers with whom *we* have a direct or indirect contract;
 - (a) Lack of availability and/or accessibility of network providers not tied to an unresolved benefit denial;
 - (b) Quality of care/quality of service issues;
 - A. Written expressions of dissatisfaction regarding quality of care/quality of service are processed as *grievances*.
 - B. Oral expressions of dissatisfaction regarding quality of care/quality of service are processed as *complaints*.
 - (iii) Any of the issues listed as part of the definition of *grievance* received from *you* or *your* authorized representative where the caller has not submitted a written request but calls *us* to escalate their dissatisfaction and request a verbal/oral review.

Complaints received from the Wisconsin Office of the Commissioner of Insurance (OCI)

The Commissioner may require *us* to treat and process any *complaint* received by the OCI by *you*, or on *your* behalf, as a *grievance* as appropriate. *We* will process the OCI *complaint* as a *grievance* when the Commissioner provides *us* with a written description of the *complaint*.

C. EXTERNAL REVIEW

An external review decision is binding on *us*. An external review decision is binding on the claimant except to the extent the claimant has other remedies available under applicable federal or state law.

We will pay for the costs of the external review performed by the independent reviewer.

1. Applicability/Eligibility

- (a) The external *grievance* procedures apply to:
 - (i) Any hospital or medical *policy* or certificate.
 - (ii) Conversion plans.
- (b) After exhausting the internal review process, *you* have four months to make a written request to the Grievance Administrator for external review after the date of receipt of *our* internal response.
 - (i) The internal appeal process must be exhausted before the claimant may request an external review unless *you* file a request for an expedited external review at the same time as an internal *expedited grievance* or *we* either provide a waiver of this requirement or fail to follow the appeal process.
 - (ii) A health plan must allow a claimant to make a request for an expedited external review with the plan at the time the claimant receives:
 - (a) An *adverse benefit determination* if the determination involves a medical condition of the claimant for which the timeframe for completion of an internal *expedited grievance* would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function and the claimant has filed a request for an internal *expedited grievance*;

- (b) A final internal *adverse benefit determination*, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the final internal *adverse benefit determination* concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.
- (iii) Claimants may request an expedited external review at the same time the internal *expedited grievance* is requested and an Independent Review Organization (IRO) will determine if the internal *expedited grievance* needs to be completed before proceeding with the expedited external review.
- (c) External review is available for *grievances* that involve:
 - (i) Medical judgment, including but not limited to those based upon requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit; or the determination that a treatment is experimental or investigational, as determined by an external reviewer;
 - (ii) *Rescissions* of coverage; or
 - (iii) *Reformation*.

2. External Review Process

- (a) We have **five business days (immediately** for expedited) following receipt of the request to conduct a preliminary review of the request to determine whether:
 - (i) The individual was a covered person at the time the item or service was requested;
 - (ii) The service is a covered service under the claimant's health plan but for the plan's *adverse benefit determination* with regard to medical necessity experimental/investigational, medical judgment, or *rescission*;
 - (iii) The claimant has exhausted the internal process; and
 - (iv) The claimant has provided all of the information required to process an external review.
- (b) Within **one business day (immediately** for expedited) after completion of the preliminary review, we will notify the claimant in writing as to whether the request is complete but not eligible for external review and the reasons for its ineligibility or, if the request is not complete, the additional information needed to make the request complete.
- (c) We must allow a claimant to perfect the request for external review within the four-month filing period or within the 48-hour period following the receipt of notification.
- (d) We will assign an IRO on a rotating basis from *our* list of contracted IROs.
- (e) Within **five business days** after the date of assignment of the IRO, we must provide the documents and any information considered in making the *adverse benefit determination* to the IRO.

Note: For expedited, after assignment of the IRO, we must provide the documents and any information considered in making the *adverse benefit determination* to the IRO electronically or by telephone or facsimile or any other available expeditious method.
- (f) If we fail to timely provide the documents and information, the IRO may terminate the external review and make a decision to reverse the *adverse benefit determination*.
- (g) Within 10 business days, the assigned IRO will timely notify the claimant in writing of the request's eligibility and acceptance for external review. The notice will include a

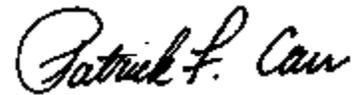
statement that the claimant may submit in writing additional information to the IRO to consider.

- (h) Upon receipt of any information submitted by the claimant, the IRO must forward the information to *us* within one business day.
- (i) Upon receipt of the information, *we* may reconsider *our* determination. If *we* reverse *our* *adverse benefit determination*, *we* must provide written notice of the decision to the claimant and the IRO within **one business day** after making such decision. The external review would be considered terminated.
- (j) Within 45 days (72 hours for expedited) after the date of receipt of the request for an external review by the health plan, the IRO will review all of the information and provide written notice of its decision to uphold or reverse the *adverse benefit determination* to the claimant and to *us*. If the notice for an expedited review is not in writing, the IRO must provide written confirmation within 48 hours after the date of providing the notice.
- (k) Upon receipt of a notice of a decision by the IRO reversing the *adverse benefit determination*, *we* will approve the covered benefit that was the subject of the *adverse benefit determination*.

This rider applies only to insureds who reside in the state of Wisconsin.

This rider will not change, waive, or extend any part of the *policy/certificate*, other than as stated herein.

Golden Rule Insurance Company



President

HIPAA PORTABILITY RIDER

By the attachment of this rider, *your policy/certificate* is amended as follows:

- A. In Section 8, the Preexisting Conditions Limitation provision will not apply to *individuals with portability rights*, as defined in this rider.
- B. **Definitions:** As used in this rider form, the following terms have the meanings indicated:
1. "*Individuals with portability rights*" means, as of the date the individual applied for coverage under this *policy/certificate*, an individual:
 - (a) Who has 18 or more months of prior *creditable coverage* and no gap of 63 days or more between any periods of *creditable coverage*;
 - (b) Whose most recent period of *creditable coverage* was under a *group health plan*, governmental plan, or church plan (or under health insurance coverage offered in connection with any such plan);
 - (c) Who is not eligible for coverage under:
 - (i) a group health plan;
 - (ii) Part A or Part B of Title XVIII of the Social Security Act (Medicare); or
 - (iii) a state plan under Title XIX of such Act (Medicaid) or any successor program;
 - (d) Who does not have other health insurance coverage;
 - (e) Whose most recent *group health plan* coverage was not terminated due to the commission of fraud or the nonpayment of premium when due; and
 - (f) Who, if eligible for continuation of coverage under COBRA or state continuation of coverage under the most recent prior *group health plan* coverage, has elected and exhausted his or her full rights to continuation of coverage.
 2. "*Group health plan*" means an employee benefit plan to the extent that the plan provides medical care to employees or their dependents directly or through insurance reimbursement or otherwise.
 3. "*Creditable coverage*" means, with respect to an *individual with portability rights*, coverage of the individual under any of the following:
 - (a) A group health plan;
 - (b) Health insurance coverage;
 - (c) Part A or Part B of Title XVIII of the Social Security Act (Medicare);
 - (d) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928 (Medicaid);
 - (e) Chapter 55 of Title 10 of the U.S. Code (CHAMPUS);
 - (f) A medical care program of the Indian Health Service or of a tribal organization;
 - (g) A state health benefit risk pool;
 - (h) A health plan offered under Chapter 89 of Title 5 of the U.S. Code (government employees);
 - (i) A public health plan (as defined in regulations);
 - (j) A health benefit plan under section 5(e) of the Peace Corps Act."*Creditable Coverage*" does not include:
 - (a) The following coverages:

- (i) Coverage only for accident or disability income insurance, or any combination thereof;
 - (ii) Coverage issued as a supplement to liability insurance;
 - (iii) Liability insurance, including general liability insurance and automobile liability insurance;
 - (iv) Worker's compensation or similar insurance;
 - (v) Automobile medical payment insurance;
 - (vi) Credit-only insurance;
 - (vii) Coverage for on-site medical clinics; or
 - (viii) Other similar insurance coverage under which benefits for medical care are secondary or incidental to other insurance benefits.
- (b) The following coverages if offered separately:
- (i) Limited scope dental or vision benefits;
 - (ii) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof ; and
 - (iii) Similar, limited coverages as specified in regulations.
- (c) The following coverages if offered as independent noncoordinated coverages:
- (i) Coverage only for a specified disease or illness; and
 - (ii) Hospital indemnity or other fixed indemnity insurance.
- (d) The following coverages if offered as a separate policy:
- (i) Medicare supplement health insurance;
 - (ii) Coverage supplemental to the coverage provided under chapter 55 of Title 10 of the U.S. Code; and
 - (iii) Similar supplemental coverage provided to coverage under a *group health plan*.

This rider will not change, waive or extend any part of the *policy/certificate*, other than as stated herein.

This rider is effective at the same time as the *policy/certificate*, unless a later date is shown below.

Golden Rule Insurance Company



President

FLORIDA LIMITATION OF PAYMENT FOR AIDS OR HIV RELATED DISEASE CLAIMS ENDORSEMENT

By attachment of this endorsement, the *policy/certificate*, including any other endorsement which is attached to and made a part of the *policy/certificate*, is amended as follows:

The provision in Section 7 entitled "Limitation of Payment for AIDS or AIDS Related Claims," and any reference to that provision in any other endorsement which is attached to and made a part of the *policy/certificate*, is deleted and replaced with the following:

Limitation of Payment for AIDS or HIV Related Disease Claims

Limitation: If, prior to the first anniversary of the *covered person's* insurance under the *policy*, the *covered person*:

- A. In the opinion of a qualified *doctor* first exhibited *HIV related disease* or *objective manifestations of AIDS*; or
- B. Was diagnosed as having *HIV related disease* or *AIDS*,

we will not pay any benefits for *opportunistic conditions* or other claims related to *HIV related disease* or *AIDS*. This limitation will not apply if *we* do not assert it before the *covered person's* insurance under the *policy* has been in force for two years. If *we* fail to notify a *covered person*, in writing, within 90 days after it has first been determined by *us* that the *covered person* would be subject to the effect of this limited exclusion, this exclusion will not apply. *We* must notify the *covered person* within the 90 day period, even if there are no claims for *AIDS* or *HIV related disease*.

If this limitation does not apply, *we* will pay regular *policy* benefits for *opportunistic conditions* or other claims related to *HIV related disease* or *AIDS*.

This provision controls over any other provision of the *policy*.

Definitions:

"*AIDS*" means Acquired Immune Deficiency Syndrome, as that term is defined by the *CDC*.

"*CDC*" means the United States Centers for Disease Control and Prevention.

"*Definitive method*" means the definitive diagnostic methodology for certain diseases indicative of *AIDS* established by the *CDC*.

"*HIV related disease*" means any *illness* or condition evidenced by at least 1 of the following clinical features:

- A. Persistent recurrent fever greater than 100 degrees Fahrenheit for 3 weeks or more;
- B. Unexplained weight loss of 10% of body weight or more than 15 pounds;
- C. Unexplained chronic diarrhea for one month or more;
- D. Chronic fatigue for one month or more;
- E. Night sweats for one month or more;
- F. Lymphadenopathy (swollen lymph glands) for one month or more involving at least two extra inguinal sites in the absence of any current *illness* or drugs known to cause lymphadenopathy.
- G. Chronic cough for one month or more;
- H. General pruritic dermatitis;
- I. Recurrent herpes zoster;
- J. Propharyngeal candidiasis; and
- K. Progressive, disseminated herpes simplex.

In addition, at least 1 of the following laboratory abnormalities must be present:

- A. Depressed helper T-cell count;
- B. Reversed helper/suppressor T-cell ratio;

- C. Positive P-24 antigen;
- D. Abnormal skin tests;
- E. Elevated serum globulin levels;
- F. At least one type of cytopenia including leukopenia, lymphopenia, thrombocytopenia, or anemia; or
- G. Abnormal HIV serological tests.

"Laboratory evidence regarding HIV infection" means that laboratory evidence defined by the CDC as being positive for infection, negative against infection, or inconclusive.

"Objective manifestations of AIDS" means:

- A. Without *laboratory evidence regarding HIV infection*, an *opportunistic condition* diagnosed by *definitive method*;
- B. With positive *laboratory evidence regarding HIV infection*, an *opportunistic condition* diagnosed by *definitive method* or *presumptive method*, even if other causes of immunodeficiency are present; and
- C. With negative *laboratory evidence regarding HIV infection*, but with no other causes of immunodeficiency, either:
 - 1. Pneumocystis carinii pneumonia diagnosed by a *definitive method*; or
 - 2. An *opportunistic condition* diagnosed by a *definitive method* and a T-helper (CD4) lymphocyte count less than 400/cubic millimeter.

"Opportunistic conditions" means those conditions included in, but not limited to, Clinical Categories B and C of the most recent Revised Classification System for HIV Infection and Expanded Surveillance Case Definitions for AIDS Among Adolescents and Adults published by the CDC. It also means those conditions included in but not limited to, Clinical Categories A, B and C of the most recent Revised Classification System for Human Immunodeficiency Virus Infection in Children Less Than 13 Years of Age published by the CDC.

"Presumptive method" means the presumptive diagnostic methodology for certain diseases indicative of AIDS established by the CDC.

This provision applies only to association groups and does not apply to employer/employee groups.

This endorsement will not change, waive or extend any part of the *policy/certificate* other than as stated herein.

This endorsement is effective at the same time as the *policy/certificate*, unless a later date is shown below.

Golden Rule Insurance Company



President

COPAYMENT AMOUNT RIDER

By attachment of this rider the *policy/certificate* is amended as follows:

Section 6, General Benefit Provisions, is amended by the addition of the following:

"*Copayment Amount*" means the amount of *covered expenses* which must be paid by a *covered person* for each service which is subject to a *copayment amount* (as shown in Section 1), before benefits are payable for remaining *covered expenses* for that service under the *policy/certificate*.

- A. **Doctor Office Visits:** *Covered expenses* for outpatient *doctor office visits* will be payable as follows:
1. **At network providers:** The first four visits per calendar year for each *covered person* will be subject to the *copayment amount* (as shown in Section 1) before the benefits are payable under the *policy/certificate*. Subsequent visits incurred by the *covered person* during the same calendar year will be subject to the applicable *deductible amount* and *coinsurance percentage*.
 2. **AT non-network providers:** *Covered expenses* for visits incurred at a *non-network provider* will be reduced by 25%. The remaining *covered expenses* will be subject to the *non-network provider deductible amount* and the applicable *coinsurance percentage* (as shown on the Data Page).

If you move to an area where we are not offering access to a *network*, the *covered expenses* for outpatient *doctor visits* will be subject to any applicable *deductible amount* and *coinsurance percentage* (as shown on the Data Page).

Except as otherwise specified above, *covered expenses* under this rider are subject to all the terms, conditions, exclusions and limits of the *policy/certificate*, other than as set forth above.

This rider does not change, waive or extend any part of the *policy/certificate*, other than as set forth above.

This rider is effective at the same time as the *policy/certificate*, to which it is attached, unless a later date is shown below.

Golden Rule Insurance
Company



President

BASIC COVERAGE SUPPLEMENTAL ACCIDENT EXPENSE BENEFITS ENDORSEMENT

By attachment of this rider, the *policy/certificate* is amended as follows:

- A. As a supplemental benefit, we will pay up to [\$500; \$1,000; \$2,500; \$5,000; or \$10,000] in first dollar coverage for the *covered expenses* specified in paragraph (B) below, if the charges:
 - 1. Result from any one accident which causes *injury* to a *covered person*; and
 - 2. Are incurred within 90 days after the *injury*.
- B. Subject to the conditions stated in Paragraph (A) above and only under the terms of this rider, up to [\$500; \$1,000; \$2,500; \$5,000; or \$10,000] in first dollar coverage will be considered *covered expenses* for:
 - 1. *Covered expenses* stated in the Medical Benefits under the section titled Charges Incurred in a Hospital;
 - 2. *Covered expenses* stated in the Medical Benefits under the section titled Surgical Expenses;
 - 3. *Outpatient* charges:
 - (a) Made by a *hospital* for:
 - (i) Use of an operating, treatment or recovery room for surgery;
 - (ii) *Emergency* treatment of an *injury* if confinement is not required; and
 - (iii) Processing and administration of blood or blood components;
 - (b) Made by a *doctor* for professional services;
 - (c) For the professional services of a *medical practitioner*;
 - (d) For the professional services of a licensed physical therapist;
 - (e) For local professional ambulance service to a *hospital* where necessary *emergency* care or treatment is rendered;
 - (f) For dressings, sutures, casts, or other necessary medical supplies;
 - (g) For diagnostic testing using radiologic, ultrasonographic, or laboratory services (psychometric, behavioral and educational testing are not included); and
 - (h) For oxygen and other gases and their administration.
- C. A *covered person's* insurance must have been in force under the *policy* on the date of the *injury* to receive benefits under this rider.
- D. If the amount actually incurred exceeds the [\$500; \$1,000; \$2,500; \$5,000; or \$10,000] first dollar coverage under this rider, any remaining *covered expenses* under the *policy* for that *injury*, will be subject to any applicable *deductible* or *coinsurance percentage*.

This rider will not change, waive or extend any part of the *policy/certificate*, other than as stated herein.

This rider is effective at the same time as the *policy/certificate*, unless a later date is shown below.

**Golden Rule Insurance
Company**



President

TERM LIFE INSURANCE RIDER

By attachment of this rider, the *policy* or certificate is amended as follows:

If a *covered person* dies while insured under this rider, we will pay, subject to the terms and conditions of this rider, to the *covered person's beneficiary* the term life *proceeds* in one lump sum.

DEFINITIONS

As used in this rider:

"*Beneficiary*" means the person designated by the *covered person*, on a form approved by us, to receive any amount of the term life *proceeds* becoming payable under the terms of the *policy* or certificate due to a *covered person's* death.

"*Covered Person*" means the *primary insured* and/or *spouse* who has applied for and been approved under this rider.

"*Due proof of death*" shall mean sufficient information to allow us to determine if *proceeds* are payable and in the form of written documentation such as a certified copy of the death certificate, autopsy report, police/accident reports and other information and proof necessary to establish liability.

"*Proceeds*" means the amount for which a *covered person's* life is insured under this rider at the time of death. The respective term life *proceeds* for each *covered person* under this rider are shown in Section 1.

"*Spouse*" means the person named as *your* spouse in the application or any amendment. This term does not include a spouse who is not a *covered person*.

PREMIUM

The premiums for this rider are shown on the Data Page, Section 1. This premium is to be paid at the same time and in the same manner as the premium for the *policy* or certificate. The premium for this rider will cease when the rider ends. If the type of plan shown on the Data Page of the *policy* or certificate is changed because of an addition or removal of a *covered person* insured by this rider, the premium for this rider will change. The new premium for this rider will be shown in the written notice sent to *you*.

NOTICE OF DEATH

We will pay to the *beneficiary* the term life *proceeds* of this rider upon receipt of *due proof of death*. Written proof of death must be furnished to us within 90 days from the *covered person's* date of death or as soon as reasonably possible.

BENEFICIARY

The *covered person* can name any person, other than the *covered person's* employer, as *beneficiary*. The *covered person* can change the *beneficiary* at any time without the consent of the designated *beneficiary* by notifying us in writing on a form furnished by us. The new designation will be effective when the notice is received by us. If we pay the *proceeds* before we receive the *covered person's* change request, we are released from further liability to the extent of *our* payment. A new designation of *beneficiary* terminates the interests of the previous *beneficiary*.

If more than one *beneficiary* is designated, but their respective interests are not specified, the *beneficiaries* will share the *proceeds* equally. The interest of a *beneficiary* who dies before the *covered person* will terminate and be shared equally by the *beneficiaries* surviving the *covered person*, unless otherwise provided in the *beneficiary* designation. If the *beneficiary* dies at the same time as the *covered person*, or within 15 days after the date the *covered person* dies, payment will be made by us as if the *covered person* survived the *beneficiary*. If there is not a designated *beneficiary* surviving at the death of the *covered person*, payment will be made in a single sum to the *covered person's* estate; however, at our option, payment may be made to one or more of the following surviving relatives of the *covered person*:

- A. Spouse;
- B. Children, including legally adopted children;
- C. Parents; or

- D. Brothers and sisters.

In the absence of a parent or the appointment of a legal guardian, if any *beneficiary* is:

- A. A minor; or
- B. In our opinion, legally incapable of giving valid receipt for any payment due

we may pay term life *proceeds* in monthly installments to the person or persons who, in *our* opinion, have assumed custody and principal support of the *beneficiary*.

If *proceeds* are not paid within 30 days after *we* received *due proof of death* *we* will pay interest on the *proceeds*. Interest will be paid at the rate of 3% a year from the date *we* receive *due proof of death* until the date the *proceeds* are paid. If the law in the state where the *policy* or certificate is issued requires payment of a greater amount, *we* will pay that amount.

We may, at *our* option, pay an amount of up to \$250 to any person appearing to be entitled to the payment who incurred expense because of the last illness or burial of the *covered person*. Any payment *we* make in good faith fully discharges *us* to the extent of the payment.

TERMINATION OF THIS RIDER

All insurance under this rider will cease on its termination. This rider will terminate on the earlier of:

- A. The date *we* receive a written request from the *covered person* for its termination, or on any later date stated in *your* request;
- B. The date no *covered person* remains insured under this rider; or
- C. The date the *covered person's* coverage under the *policy* or certificate terminates.

We will refund any premium paid and not earned due to termination of this rider. The refund will be based on the number of full months that remain in the premium period.

TERMINATION OF COVERED PERSONS

You will cease to be a *covered person* under this rider at the end of the premium period in which *you* attain 65 years of age.

Your spouse will cease to be a *covered person* under this rider at the end of the premium period in which any of these events occur:

- A. He or she attains 65 years of age; or
- B. *You* become legally divorced, if earlier.

ASSIGNING YOUR RIDER

During *your* life, *you* may assign some or all of *your* rights under this rider to someone else.

A signed copy of the assignment trust must be sent to *our* home office on a form *we* accept. The assignment will go into effect when it is signed, subject to any payments *we* make or other actions *we* take before *we* record it. *We* are not responsible for the validity or effect of any assignment.

MISTAKE OF AGE, SEX OR TOBACCO STATUS

If *your* or *your spouse's* age, sex or tobacco status is misstated in the application, *we* will adjust the *proceeds*. The *proceeds* of this rider will then be those *your* premiums would have bought at the correct age, sex and tobacco status. By age, *we* mean age as of *your* or *your spouse's* last birthday on the *policy's* or certificate's *effective date*.

GENERAL TERMS

This rider is made a part of *your policy* or certificate in consideration of *your* application and payment of the first premium for this rider. The following clauses indicate whether the *policy* or certificate provisions will apply to this rider. The *policy* or certificate provisions will either apply to this rider, not apply to this rider, or apply to this rider as modified below.

- A. **Policy or certificate provisions that do not apply to this rider** - The following *policy* or certificate provisions do not apply to this rider:
 - 1. The Preexisting Conditions Limitations section, and the Reimbursement section; and
 - 2. The Dependent Coverage section, except for the Dependent Eligibility clause and the Adding Other Dependents clause.
- B. **Policy or certificate provisions that apply to this rider with modification** - The following *policy* or certificate provision applies to this rider as modified below:

The Reinstatement clause, as found in the Termination section of the *policy* or certificate, will apply to this rider. However, death/accidental death occurring between the date the *policy* or certificate lapses and the date the *policy* or certificate is reinstated will not be covered under this rider.
- C. **Policy or certificate provisions that do not apply to this rider** - Other than as stated in (A) or (B) above, all other *policy*/certificate provisions will apply to this rider.

BENEFIT EXCLUSIONS

No *proceeds* are payable if a loss results from:

- A. Suicide or intentionally self-inflicted *injury* or *illness* while sane or insane if committed during the first 24 months of coverage under this rider;
- B. Service in the armed forces of any country, including non-military units supporting such forces;
- C. An act of declared or undeclared war; or
- D. Death due to an accident occurring while riding in or on, boarding or alighting from any aircraft as a:
 - 1. Pilot, crewmember, or student pilot; or
 - 2. Flight instructor or examiner

LIFE INSURANCE CONVERSION PRIVILEGE

A *covered person* will be eligible to convert coverage under this rider to an individual policy of life insurance ("*conversion policy*"), made available, without evidence of insurability, under this provision, if:

- A. The *covered person's* coverage under this rider terminates for reasons other than:
 - 1. Termination of the *policy*; or
 - 2. Failure to make the required premium payment when due; or
 - 3. The attainment of age 65.
- B. The covered person has been continuously insured under this rider for at least one(1) year immediately prior to the termination.

This privilege is subject to the following additional terms and conditions:

- A. Written application and the first premium payment are submitted as directed on the *conversion policy* application by the later of:
 - 1. 31 days after termination of coverage under this rider; or
 - 2. A later date as required by the statutes or regulations of the state in which the *covered person* resides at that time; but

In no event later than 60 days after the date of termination of coverage under this rider.
- B. The amount of coverage under the *conversion policy* will not exceed the amount of coverage for which the *covered person* is insured under this rider. The terms of coverage under the conversion policy will not be the same as the terms of coverage under this rider.
- C. The *conversion policy* will be a policy offered by a life insurer designated by *us* in the state in which the *covered person* resides.
- D. The premium to be paid for the *conversion policy* by the former *covered person* will depend on:

1. Rates for that *conversion policy* in that state at that time;
 2. The attained age of the *covered person*;
 3. The class of risk to which the *covered person* belongs; and
 4. The form and amount of the *conversion policy* coverage.
- E. Any *conversion policy* issued in accordance with the provisions of this rider:
1. Will become effective the date immediately following termination of coverage under this rider; and
 2. Will be in place of the terminated coverage under this rider.
- F. A *covered person's* insurance under this rider will remain in force during the thirty-one (31) days within which the *covered person* is eligible to exercise the conversion privilege, whether or not there has been an application for conversion. If the *covered person* dies during that period, we will:
1. Pay, as a death benefit, the maximum amount eligible for conversion;
 2. Void any *conversion policy* issued in accordance with this conversion privilege; and
 3. Return any premium paid for that *conversion policy*.
- G. If the life insurer designated by *us* to offer *conversion policies* in the state in which a *covered person* resides ceases to offer conversion policies in that state, no *conversion policies* will be available in that state under this provision.

This rider will not change, waive, or extend any part of the *policy* or certificate, other than as stated herein.

This rider is effective at the same time as the *policy* or certificate to which it is attached, unless a later date is shown below.

Golden Rule Insurance Company



President

ILLINOIS SAVINGS BASED PREFERRED PROVIDER BENEFIT RIDER

By attachment of this Rider, the *policy/certificate* is amended by the addition of the following:

Savings Based Networks: A Savings Based Network (SBN) is a group of preferred providers who offer discounts to attract patients. This is a voluntary program offered at no cost to *you*. It may not always be available in all areas. Here is how an SBN works. *We provide you* with an ID card that includes the name and the logo of the SBN. *We also provide you* with a provider listing and information on how to access the network for up-to-date provider information. *We encourage you* to use the SBN providers to save money.

To the extent that *we* pay the charges and share in the savings, there may also be a benefit to *you* in preserving *your* lifetime benefits. There is also an indirect benefit. When *you* and others on *your* plan use the SBN providers, aggregate claim costs are lower. This should result in future premium costs that are less than they would be otherwise.

Here are two examples - one involving an SBN provider and one involving a non-SBN provider. Both assume that the deductible has been satisfied and that an 80% *coinsurance percentage* is applicable:

Example 1:

You incur \$5000 in *covered expenses* from an SBN provider. The SBN discount may reduce those charges to \$4000. The 80% *coinsurance percentage* would be applied to that discounted amount, resulting in \$3200 *covered expenses* paid by Golden Rule. *You* would be responsible for the remaining \$800 (20%). \$4000 is the total cost.

Example 2:

You incur \$5000 in *covered expenses* from a non-SBN provider. The 80% *coinsurance percentage* would be applied to the undiscounted \$5000, resulting in \$4000 in *covered expenses* paid by Golden Rule. *You* would be responsible for the remaining \$1000 (20%). \$5000 is the total cost.

Actual discounts vary by provider, but each discount will be shared between *you* and *us* in direct proportion to the respective provider payment.

Payment for *emergency* care is not dependent upon whether such services are performed by a Savings Based Preferred Provider. *We* will pay the same *coinsurance percentage* regardless of which provider is used. However, *you* may be responsible for additional amounts, if any. This additional amount *you* owe may vary depending upon which provider *you* use.

SBN providers agree not to "balance bill" *you* for the discounted amount as long as *you* pay *your* portion of the bill within a reasonable time. If a provider ever tries to charge *you* for the discounted amount, please do not pay it and notify *us* immediately.

This rider applies only to *covered persons* who reside in Illinois.

This rider will not change, waive or extend any part of the *policy/certificate*, other than as stated herein. This Rider is effective at the same time as the *policy/certificate* unless a later date is shown below.

Golden Rule Insurance
Company



President

REIMBURSEMENT/SUBROGATION RIDER

By attachment of this rider, the Reimbursement provision is hereby deleted and replaced with the following:

REIMBURSEMENT: If a *covered person* recovers expenses for *illness* or *injury* that occurred due to the negligence of a third party, we have the right to first reimbursement for all benefits we paid from any and all damages collected from the negligent third party for those same expenses whether by action at law, settlement, or compromise, by the *covered person*, the *covered person's* parents if the *covered person* is a minor, or the *covered person's* legal representative as a result of that *illness* or *injury*. You are required to furnish any information or assistance, or provide any documents that we may reasonably require in order to exercise *our* rights under this provision. This provision applies whether or not the third party admits liability.

SUBROGATION: We are assigned the right to recover from the negligent third party, or his or her insurer, to the extent of the benefits we paid for that *illness* or *injury*. You are required to furnish any information or assistance, or provide any documents that we may reasonably require in order to exercise *our* rights under this provision. This provision applies whether or not the third party admits liability.

This endorsement applies only to *covered persons* who reside in the state of Illinois.

This rider will not change, waive or extend any part of the *policy/certificate*, other than as stated herein.

This rider is effective at the same time as the *policy/certificate*, unless a later date is shown below.

Golden Rule Insurance Company

A handwritten signature in black ink that reads "Patrick F. Carr". The signature is written in a cursive style with a large initial "P".

President

[TRANSPLANT EXPENSE BENEFITS]

LIMITATIONS ON TRANSPLANT EXPENSE BENEFITS: In addition to the exclusions and limitations specified elsewhere in this section:

- (A) *Covered expenses for listed transplants* will be limited to two transplants during any 10-year period for each *covered person*;
- (A) If a designated *Center of Excellence* is not used, *covered expenses for a listed transplant* will be reduced by 20% after application of any *deductible amounts* coinsurance provisions or copayment amounts.
- (B) Benefits may be limited by the Coordination of Benefits Provision, the exclusions and limitations stated in the General Exclusions and Limitations section of the *policy* or other terms and conditions of the *policy*.

MGR03428

MISSOURI GRIEVANCE PROCEDURES RIDER

By attachment of this rider, the *policy/certificate* is amended to include the following as a new section:

MISSOURI GRIEVANCE PROCEDURES

A. APPLICABILITY

Under UnitedHealthcare Choice Plus network plans, a *covered person* or a person acting on behalf of a *covered person*, including a provider, may seek a review of any *adverse determination* or *grievance*.

B. DEFINITIONS: As used in this rider, the following terms have the meanings indicated:

1. "*Adverse determination*" means a determination by Golden Rule Insurance Company (GRIC) that an admission, availability of care, continued stay or other health care service has been reviewed and, based upon the information provided, does not meet GRIC's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness; and the payment for the requested service is therefore denied, reduced, or terminated.
2. "*Grievance*" means a written complaint submitted by a *covered person*, the *covered person's* representative, or a provider acting on behalf of the *covered person* regarding the:
 - (a) Availability, delivery or quality of health care services;
 - (b) Claims payment, handling or reimbursement for health care services; or
 - (c) Matters pertaining to the contractual relationship between a *covered person* and GRIC

C. FIRST-LEVEL GRIEVANCE REVIEW

1. GRIC will acknowledge receipt of the request for a first-level *grievance* review within ten working days.
2. GRIC will conduct a complete investigation of the *grievance* within 20 working days after receipt of a *grievance*, unless the investigation cannot be completed within this time. If the investigation cannot be completed within 20 working days after receipt of a *grievance*, the *covered person* should be notified in writing of the delay on or before the 20th working day. The investigation of the *grievance* must be completed within 30 working days thereafter. The notice of delay must contain the specific reasons why additional time is needed to complete the investigation.
3. Within five working days after the investigation is completed, a representative of GRIC, not involved in the circumstances giving rise to the *grievance* or its investigation, will decide upon the appropriate resolution of the *grievance* and will notify the *covered person* in writing of the decision and of the right to file an appeal for a second-level review.
4. Within 15 working days after the investigation is completed, GRIC will notify the person who submitted the *grievance* of the resolution, if that person is not the *covered person* identified in C.3.

D. SECOND-LEVEL GRIEVANCE REVIEW

1. A second-level review of a *grievance* will be submitted to a *grievance* advisory panel consisting of:
 - (a) Other covered persons;
 - (b) Representatives of GRIC who were not involved in the circumstances giving rise to the *grievance* or any subsequent investigation or determination of the *grievance*; and
 - (c) If the *grievance* involves an *adverse determination*, a majority of the panel will be appropriate clinical peers in the same or similar specialty as would typically

manage the case being reviewed and who were not involved in the circumstances giving rise to the *grievance* or in subsequent investigation or determination of the *grievance*.

2. The time frames for the second-level review are the same as the first-level review, unless the review is an expedited review.
3. Any decision of the *grievance* panel must include notice of the *covered person's* right to file an appeal with the Director's office and provide the address and toll-free telephone number of the Director's office listed near the end of this rider.

E. EXPEDITED REVIEW

1. An expedited review will be provided if the timeframe of the standard levels of review would seriously jeopardize the life or health of a *covered person* or would jeopardize the *covered person's* ability to regain maximum function.
 2. A request for an expedited review may be submitted orally or in writing by the *covered person*, the *covered person's* representative, or a provider acting on behalf of the *covered person*.
 3. Within 72 hours of receiving the request for expedited review, GRIC will orally notify the person who submitted the request of the determination.
 4. Within three working days of providing the determination, we will provide written confirmation of the determination.
- F. The *covered person* or a person acting on behalf of a *covered person*, including a provider, has the right to contact the Director of Insurance for assistance at any time. The address and telephone number of the Missouri DOI are as follows:

Missouri Department of Insurance
301 West High Street
P.O. Box 690
Jefferson City, MO 65102
1-800-726-7390

This rider applies only to *covered persons* who reside in the state of Missouri.

This rider does not change, waive or extend any part of the *policy/certificate* other than as stated herein.

This rider is effective at the same time as the *policy/certificate*.

Golden Rule Insurance Company



President

MISSOURI PHASE II CANCER CLINICAL TRIALS RIDER

By the attachment of this rider, *covered expenses* under the *policy/certificate* are amended to include charges for *routine patient care costs* incurred at an *approved facility* as a result of participation in a phase II clinical trial subject to the following conditions:

- A. The *covered person* is enrolled in, and not just following the protocol for, the clinical trial;
- B. Phase II of the clinical trial is approved by the National Institutes of Health (NIH) or National Cancer Institute and conducted at Academic or National Cancer Institute Center;
- C. The clinical trial is for the prevention, early detection or treatment of cancer;
- D. The treating facility and personnel must have the expertise and training to provide the treatment and treat a sufficient volume of patients;
- E. Clinical or preclinical data must exist that provides a reasonable expectation that the treatment will be superior to treatment that is not *investigational treatment*; and
- F. Providers participating in the clinical trial must obtain the *covered person's* informed consent for participation in the clinical trial in a manner consistent with legal and ethical standards.

Definitions: As used in this rider, the following terms have the meanings indicated:

1. "*Approved facility*" means a network or *preferred provider facility* as listed on your identification card. However, for transplants, costs must be incurred at a *Center of Excellence*, as defined in the Transplant Expense Benefits section of the *policy/certificate*;
2. "*Routine patient care costs*" means reasonable and *medically necessary* services needed to administer the drug or device under evaluation in the clinical trial, including all items and services that are otherwise generally available to a qualified individual that are provided in the clinical trial except:
 - (a) The investigational item or service itself;
 - (b) Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and
 - (c) Items and services customarily provided by the research sponsors free of charge for any enrollee in the trial.

Covered expenses under this rider are subject to all the terms, conditions, exclusions, limitations and notification requirements of the *policy/certificate*, including any applicable *deductible amounts*, coinsurance provisions, copay amounts, or maximum dollar limits.

This rider applies only to *covered persons* who reside in the state of Missouri.

The rider will not change, waive, or extend any part of the *policy/certificate*, other than as stated herein.

This rider is effective on August 28, 2006 or at the same time as the *policy/certificate*, whichever is later.

Golden Rule Insurance Company



President

TERM LIFE INSURANCE RIDER

By attachment of this rider, the *policy* or certificate is amended as follows:

If a *covered person* dies while insured under this rider, we will pay, subject to the terms and conditions of this rider, to the *covered person's beneficiary* the term life *proceeds* in one lump sum.

DEFINITIONS

As used in this rider:

"*Beneficiary*" means the person designated by the *covered person*, on a form approved by us, to receive any amount of the term life *proceeds* becoming payable under the terms of the *policy* or certificate due to a *covered person's* death.

"*Covered Person*" means the *primary insured* and/or *spouse* who has applied for and been approved under this rider.

"*Due proof of death*" shall mean sufficient information to allow us to determine if *proceeds* are payable and in the form of written documentation such as a certified copy of the death certificate, autopsy report, police/accident reports and other information and proof necessary to establish liability.

"*Proceeds*" means the amount for which a *covered person's* life is insured under this rider at the time of death. The respective term life *proceeds* for each *covered person* under this rider are shown in Section 1.

"*Spouse*" means the person named as *your* spouse in the application or any amendment. This term does not include a spouse who is not a *covered person*.

PREMIUM

The premiums for this rider are shown on the Data Page, Section 1. This premium is to be paid at the same time and in the same manner as the premium for the *policy* or certificate. The premium for this rider will cease when the rider ends. If the type of plan shown on the Data Page of the *policy* or certificate is changed because of an addition or removal of a *covered person* insured by this rider, the premium for this rider will change. The new premium for this rider will be shown in the written notice sent to *you*.

NOTICE OF DEATH

We will pay to the *beneficiary* the term life *proceeds* of this rider upon receipt of *due proof of death*. Written proof of death must be furnished to us within 90 days from the *covered person's* date of death or as soon as reasonably possible.

BENEFICIARY

The *covered person* can name any person, other than the *covered person's* employer, as *beneficiary*. The *covered person* can change the *beneficiary* at any time without the consent of the designated *beneficiary* by notifying us in writing on a form furnished by us. The new designation will be effective when the notice is received by us. If we pay the *proceeds* before we receive the *covered person's* change request, we are released from further liability to the extent of our payment. A new designation of *beneficiary* terminates the interests of the previous *beneficiary*.

If more than one *beneficiary* is designated, but their respective interests are not specified, the *beneficiaries* will share the *proceeds* equally. The interest of a *beneficiary* who dies before the *covered person* will terminate and be shared equally by the *beneficiaries* surviving the *covered person*, unless otherwise provided in the *beneficiary* designation. If the *beneficiary* dies at the same time as the *covered person*, or within 15 days after the date the *covered person* dies, payment will be made by us as if the *covered person* survived the *beneficiary*. If there is not a designated *beneficiary* surviving at the death of the *covered person*, payment will be made in a single sum to the *covered person's* estate; however, at our option, payment may be made to one or more of the following surviving relatives of the *covered person*:

- A. Spouse;
- B. Children, including legally adopted children;
- C. Parents; or
- D. Brothers and sisters.

In the absence of a parent or the appointment of a legal guardian, if any *beneficiary* is:

- A. A minor; or
- B. In our opinion, legally incapable of giving valid receipt for any payment due

we may pay term life *proceeds* in monthly installments to the person or persons who, in *our* opinion, have assumed custody and principal support of the *beneficiary*.

If *proceeds* are not paid within 30 days after we received *due proof of death* we will pay interest on the *proceeds*. Interest will be paid at the rate of 3% a year from the date we receive *due proof of death* until the date the *proceeds* are paid. If the law in the state where the *policy* or certificate is issued requires payment of a greater amount, we will pay that amount.

We may, at *our* option, pay an amount of up to \$250 to any person appearing to be entitled to the payment who incurred expense because of the last illness or burial of the *covered person*. Any payment we make in good faith fully discharges us to the extent of the payment.

TERMINATION OF THIS RIDER

All insurance under this rider will cease on its termination. This rider will terminate on the earlier of:

- A. The date we receive a written request from the *covered person* for its termination, or on any later date stated in *your* request;
- B. The date no *covered person* remains insured under this rider; or
- C. The date the *covered person's* coverage under the *policy* or certificate terminates.

We will refund any premium paid and not earned due to termination of this rider. The refund will be based on the number of full months that remain in the premium period.

TERMINATION OF COVERED PERSONS

You will cease to be a *covered person* under this rider at the end of the premium period in which you attain 65 years of age.

Your spouse will cease to be a *covered person* under this rider at the end of the premium period in which any of these events occur:

- A. He or she attains 65 years of age; or
- B. You become legally divorced, if earlier.

ASSIGNING YOUR RIDER

During *your* life, you may assign some or all of *your* rights under this rider to someone else.

A signed copy of the assignment trust must be sent to *our* home office on a form we accept. The assignment will go into effect when it is signed, subject to any payments we make or other actions we take before we record it. We are not responsible for the validity or effect of any assignment.

MISTAKE OF AGE, SEX OR TOBACCO STATUS

If *your* or *your spouse's* age, sex or tobacco status is misstated in the application, we will adjust the *proceeds*. The *proceeds* of this rider will then be those *your* premiums would have bought at the correct age, sex and tobacco status. By age, we mean age as of *your* or *your spouse's* last birthday on the *policy's* or certificate's *effective date*.

GENERAL TERMS

This rider is made a part of *your policy* or certificate in consideration of *your* application and payment of the first premium for this rider. The following clauses indicate whether the *policy* or certificate provisions will apply to this rider. The *policy* or certificate provisions will either apply to this rider, not apply to this rider, or apply to this rider as modified below.

- A. **Policy or certificate provisions that do not apply to this rider** - The following *policy* or certificate provisions do not apply to this rider:
 - 1. The Preexisting Conditions Limitations section, and the Reimbursement section; and
 - 2. The Dependent Coverage section, except for the Dependent Eligibility clause and the Adding Other Dependents clause.

- B. **Policy or certificate provisions that apply to this rider with modification** - The following *policy* or certificate provision applies to this rider as modified below:

The Reinstatement clause, as found in the Termination section of the *policy* or certificate, will apply to this rider. However, death/accidental death occurring between the date the *policy* or certificate lapses and the date the *policy* or certificate is reinstated will not be covered under this rider.

- C. **Policy or certificate provisions that do not apply to this rider** - Other than as stated in (A) or (B) above, all other *policy*/certificate provisions will apply to this rider.

BENEFIT EXCLUSIONS

No *proceeds* are payable if a loss results from:

- A. Suicide or intentionally self-inflicted *injury* or *illness* while sane if committed during the first 12 months of coverage under this rider. If a *covered person* dies as a result of suicide during the first 12 months of coverage, we will promptly refund all premiums paid for coverage under this rider;
- B. Service in the armed forces of any country, including non-military units supporting such forces;
- C. An act of declared or undeclared war; or
- D. Death due to an accident occurring while riding in or on, boarding or alighting from any aircraft as a:
 - 1. Pilot, crewmember, or student pilot; or
 - 2. Flight instructor or examiner

LIFE INSURANCE CONVERSION PRIVILEGE

A *covered person* will be eligible to convert coverage under this rider to an individual policy of life insurance ("*conversion policy*"), made available, without evidence of insurability, under this provision, if:

- A. The *covered person's* coverage under this rider terminates for reasons other than:
 - 1. Termination of the *policy*; or
 - 2. Failure to make the required premium payment when due; or
 - 3. The attainment of age 65.
- B. The covered person has been continuously insured under this rider for at least one(1) year immediately prior to the termination.

This privilege is subject to the following additional terms and conditions:

- A. Written application and the first premium payment are submitted as directed on the *conversion policy* application by the later of:
 - 1. 31 days after termination of coverage under this rider; or
 - 2. A later date as required by the statutes or regulations of the state in which the *covered person* resides at that time; but

In no event later than 60 days after the date of termination of coverage under this rider.

- A. The amount of coverage under the *conversion policy* will not exceed the amount of coverage for which the *covered person* is insured under this rider. The terms of coverage under the conversion policy will not be the same as the terms of coverage under this rider.
- B. The *conversion policy* will be a policy offered by a life insurer designated by *us* in the state in which the *covered person* resides.
- C. The premium to be paid for the *conversion policy* by the former *covered person* will depend on:
 - 1. Rates for that *conversion policy* in that state at that time;
 - 2. The attained age of the *covered person*;
 - 3. The class of risk to which the *covered person* belongs; and
 - 4. The form and amount of the *conversion policy* coverage.
- D. Any *conversion policy* issued in accordance with the provisions of this rider:

1. Will become effective the date immediately following termination of coverage under this rider; and
 2. Will be in place of the terminated coverage under this rider.
- E. A *covered person's* insurance under this rider will remain in force during the thirty-one (31) days within which the *covered person* is eligible to exercise the conversion privilege, whether or not there has been an application for conversion. If the *covered person* dies during that period, we will:
1. Pay, as a death benefit, the maximum amount eligible for conversion;
 2. Void any *conversion policy* issued in accordance with this conversion privilege; and
 3. Return any premium paid for that *conversion policy*.
- F. If the life insurer designated by *us* to offer *conversion policies* in the state in which a *covered person* resides ceases to offer conversion policies in that state, no *conversion policies* will be available in that state under this provision.

This rider will not change, waive, or extend any part of the *policy* or certificate, other than as stated herein.

This rider is effective at the same time as the *policy* or certificate to which it is attached, unless a later date is shown below.

Golden Rule Insurance Company

A handwritten signature in black ink that reads "Patrick F. Carr". The signature is written in a cursive style with a large initial "P".

President

ACCIDENTAL DEATH INSURANCE RIDER

By attachment of this rider, the *policy* or certificate is amended as follows:

If a *covered person* suffers an *accidental death* while insured under this rider, we will pay, subject to the terms and conditions of this rider, to the *covered person's beneficiary* the *accidental death proceeds* in one lump sum.

In order to qualify for a benefit:

- A. The death must occur within 180 consecutive days after the accident that caused the death; and
- B. The accident must occur while the *covered person* is covered under this rider.

DEFINITIONS

As used in this rider:

"*Accidental death*" means loss of life resulting directly from:

- A. *Injury* from an unexpected or unintended event;
- B. Infection caused by injury, or resulting from accidental ingestion of contaminated substances; or
- C. Drowning.

"*Beneficiary*" means the person designated by the *covered person*, on a form approved by us, to receive any amount of the *accidental death proceeds* becoming payable under the terms of the *policy* or certificate due to a *covered person's* death.

"*Covered Person*" means the *primary insured* and/or *spouse* who has applied for and been approved under this rider.

"*Due proof of death*" shall mean sufficient information to allow us to determine if *accidental death proceeds* are payable and in the form of written documentation such as a certified copy of the death certificate, autopsy report, police/accident reports and other information and proof necessary to establish liability.

"*Proceeds*" means the amount for which a *covered person's* life is insured under this rider at the time of death. The respective *accidental death proceeds* for each *covered person* under this rider are shown in Section 1.

"*Spouse*" means the person named as *your* spouse in the application or any amendment. This term does not include a spouse who is not a *covered person*.

PREMIUM

The premiums for this rider are shown on the Data Page, Section 1. This premium is to be paid at the same time and in the same manner as the premium for the *policy*. The premium for this rider will cease when the rider ends. If the type of plan shown on the Data Page of the *policy* or certificate is changed because of an addition or removal of a *covered person* insured by this rider, the premium for this rider will change. The new premium for this rider will be shown in the written notice sent to *you*.

NOTICE OF DEATH

We will pay to the *beneficiary* the *accidental death proceeds* of this rider upon receipt of *due proof of death*. Written proof of death must be furnished to us within 90 days from the *covered person's* date of death or as soon as reasonably possible.

BENEFICIARY

The *covered person* can name any person, other than the *covered person's* employer, as a *beneficiary*. The *covered person* can change the *beneficiary* at any time without the consent of the designated *beneficiary* by notifying us in writing on a form furnished by us. The new designation will be effective when the notice is received by us. If we pay the *proceeds* before we receive the *covered person's* change request, we are released from further liability to the extent of *our* payment. A new designation of *beneficiary* terminates the interests of the previous *beneficiary*.

If more than one *beneficiary* is designated, but their respective interests are not specified, the *beneficiaries* will share the *proceeds* equally. The interest of a *beneficiary* who dies before the *covered person* will

terminate and be shared equally by the *beneficiaries* surviving the *covered person*, unless otherwise provided in the *beneficiary* designation. If the *beneficiary* dies at the same time as the *covered person*, or within 15 days after the date the *covered person* dies, payment will be made by *us* as if the *covered person* survived the *beneficiary*. If there is not a designated *beneficiary* surviving at the death of the *covered person*, payment will be made in a single sum to the *covered person's* estate; however, at our option, payment may be made to one or more of the following surviving relatives of the *covered person*:

- A. Spouse;
- B. Children, including legally adopted children;
- C. Parents; or
- D. Brothers and sisters.

In the absence of a parent or the appointment of a legal guardian, if any *beneficiary* is:

- A. A minor; or
- B. In our opinion, legally incapable of giving valid receipt for any payment due

we may pay *accidental death proceeds* in monthly installments to the person or persons who, in our opinion, have assumed custody and principal support of the *beneficiary*.

If *proceeds* are not paid within 30 days after *we* received *due proof of death* *we* will pay interest on the *proceeds*. Interest will be paid at the rate of 3% a year from the date *we* receive *due proof of death* until the date the *proceeds* are paid. If the law in the state where the *policy* is issued requires payment of a greater amount, *we* will pay that amount.

We rely on an affidavit to determine payment of *proceeds*, unless *we* receive written notice of a valid claim from a person before *we* make the payment. The affidavit releases *us* from further liability.

We may, at *our* option, pay an amount of up to \$250 to any person appearing to be entitled to the payment who incurred expense because of the last illness or burial of the *covered person*. Any payment *we* make in good faith fully discharges *us* to the extent of the payment.

TERMINATION OF THIS RIDER

All insurance under this rider will cease on its termination. This rider will terminate on the earlier of:

- A. The date *we* receive a written request from the *covered person* for its termination, or on any later date stated in *your* request;
- B. The date no *covered person* remains insured under this rider; or
- C. The date the *covered person's* coverage under the *policy* or certificate terminates.

We will refund any premium paid and not earned due to termination of this rider. The refund will be based on the number of full months that remain in the premium period.

TERMINATION OF COVERED PERSONS

You will cease to be a *covered person* under this rider at the end of the premium period in which *you* attain 65 years of age.

Your spouse will cease to be a *covered person* under this rider at the end of the premium period in which any of these events occur:

- A. He or she attains 65 years of age; or
- B. *You* become legally divorced, if earlier.

ASSIGNING YOUR RIDER

During *your* life, *you* may assign some or all of *your* rights under this rider to someone else.

A signed copy of the assignment must be sent to *our* home office on a form *we* accept. The assignment will go into effect when it is signed, subject to any payments *we* make or other actions *we* take before *we* record it. *We* are not responsible for the validity or effect of any assignment.

If there are permanent *beneficiaries*, *you* need their consent before assigning the payment of *proceeds*.

GENERAL TERMS

This rider is made a part of *your policy* or certificate in consideration of *your* application and payment of the first premium for this rider. The following clauses indicate whether the *policy* or certificate provisions will apply to this rider. The *policy* or certificate provisions will either apply to this rider, not apply to this rider, or apply to this rider as modified below.

- A. **Policy or certificate provisions that do not apply to this rider** - The following *policy* or certificate provisions do not apply to this rider:
1. The Preexisting Conditions Limitations section, and the Reimbursement section; and
 2. The Dependent Coverage section, except for the Dependent Eligibility clause and the Adding Other Dependents clause.
- B. **Policy or certificate provisions that apply to this rider with modification** - The following *policy* or certificate provision applies to this rider as modified below:
- The Reinstatement clause, as found in the Termination section of the *policy* or certificate, will apply to this rider. However, death/accidental death occurring between the date the *policy* or certificate lapses and the date the *policy* or certificate is reinstated will not be covered under this rider.
- C. **Policy or certificate provisions that do not apply to this rider** - Other than as stated in (A) or (B) above, all other *policy*/certificate provisions will apply to this rider.

BENEFIT EXCLUSIONS

No *proceeds* are payable if a loss results from:

- A. Suicide or intentionally self-inflicted *injury* or *illness* while sane if committed during the first 12 months of coverage under this rider. If a *covered person* dies as a result of suicide during the first 12 months of coverage, we will promptly refund all premiums paid for coverage under this rider;
- B. Voluntary taking of any sedative or drug, or inhalation of any gas, unless taken or inhaled as *your doctor* prescribes or administers it;
- C. Death due to an accident occurring while riding in or on, boarding or alighting from any aircraft as a:
 1. Pilot, crewmember, or student pilot; or
 2. Flight instructor or examiner
- D. *Your* committing or attempting to commit a civil or criminal battery or felony;
- E. Service in the armed forces of any country, including non-military units supporting such forces;
- F. An act of declared or undeclared war;
- G. Participating in a riot, rebellion or insurrection. Participating means *you* are taking an active part in common with others. Riot means any use or threat to use force or violence by three or more persons without authority of law;
- H. Bodily or mental infirmity, or related surgery or medical treatment or any infection, unless direct result of *injury*, or unless resulting from accidental ingestion of a contaminated substance or unless the infection is a pyogenic infection directly resulting from an accidental bodily injury;
- I. *Injury* or *illness* arising from any occupation or employment;
- J. Participating in hazardous activities including but not limited to: auto or motorcycle racing; hang gliding; bungee jumping; rock climbing; skydiving and any extreme sports; or
- K. Driving while legally intoxicated from alcohol, or driving while under the influence of drugs unless taken as prescribed by a doctor.

This rider will not change, waive, or extend any part of the *policy* or certificate, other than as stated herein.

This rider is effective at the same time as the *policy* or certificate to which it is attached, unless a later date is shown below.

Golden Rule Insurance Company

Patrick F. Carr

President

MISSOURI CHIROPRACTIC SERVICES COPAYMENT RIDER-AMENDMENT

This rider-amendment is effective on August 28, 2009, or at the same time as the *policy/certificate* whichever is later.

By the attachment of this rider-amendment, the *policy/certificate* is amended as follows:

Any copayment amount applied to an office visit during which chiropractic services are provided (as specified on the Data Page) will never be more than 50% (fifty percent) of the total cost of services subject to that copayment for that office visit under the *policy/certificate*.

Any *policy/certificate* provision, limitation, or exclusion that conflicts with this rider-amendment is amended to conform with this rider-amendment, but only to the extent of the conflict.

Covered expenses under this rider-amendment are subject to all the terms, conditions, exclusions, and limitations of the *policy/certificate*, including any applicable *deductible amounts*, coinsurance provisions, notification requirements, or maximum dollar limits.

This rider-amendment will not change, waive or extend any part of the *policy/certificate*, other than as set forth above.

**Golden Rule Insurance
Company**

A handwritten signature in black ink that reads "Patrick F. Carr". The signature is written in a cursive style with a large initial "P".

President

MISSOURI PROSTHETIC DEVICES AND SERVICES RIDER

The rider is effective on April 14, 2011 or at the same time as the *policy/certificate*, whichever is later.

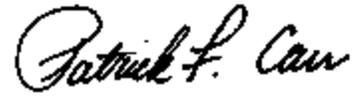
By attachment of this rider, the *policy/certificate* is amended to the extent of any conflict or inconsistency with the following:

- A. The definition of *prosthetic device* is amended to read as follows:
 - 1. "*Prosthetic device*" means an artificial device (other than dental), to replace, in whole or in part, an internal body organ, including the following:
 - (a) Colostomy bags and supplies directly related to colostomy care, including replacement of such devices;
 - (b) One pair of conventional eyeglasses or contact lenses furnished subsequent to each cataract surgery with insertion of an intraocular lens;
 - (c) Leg, arm, back, and neck braces; and
 - (d) Artificial legs, arms, and eyes, including replacements if required because of a change in the *covered person's* physical condition.
- B. The following definition is added:
 - 1. "*Prosthetic device services*" means:
 - (a) Design, fabrication, and customization of the *prosthetic device*;
 - (b) Required visits or fittings with the *prosthetic device* supplier prior to receiving the *prosthetic device*;
 - (c) Proper fitting of the *prosthetic device*;
 - (d) Visits with qualified medical professionals, where such visits are necessary to train the *covered person* who is the recipient of the *prosthetic device* in the use of the *prosthetic device*, and visits necessary to train family members or caregivers, if applicable;
 - (e) Post-fitting and adjustment visits after receiving the *prosthetic device*, no less than annually or more frequently if necessary;
 - (f) Necessary modifications after receiving the *prosthetic device* because of physical changes or excessive stump shrinkage;
 - (g) Repair or replacement due to defects in materials and workmanship, to the extent that such is not already covered by a warranty offered by the manufacturer or supplier of the *prosthetic device*;
 - (h) Repair or replacement of the *prosthetic device* due to structural integrity issues; and/or
 - (i) Periodic evaluation and patient care in order to assess the *prosthetic device's* effect on the *covered person's* tissues and to assure continued proper fit and function.
- C. *Covered expenses* are expanded to include the charges incurred by a *covered person* for *prosthetic devices* and *prosthetic device services*, including replacement *prosthetic devices* to the extent that a warranty offered by a manufacturer or supplier does not cover the *prosthetic device*.

Benefits for *prosthetic devices* and *prosthetic services* are subject to applicable *deductible amounts*, coinsurance provisions, copay amounts, or dollar limits the same extent as any other *illness* in the *policy/certificate*.

The rider does not change, waive or extend any part of the *policy/certificate*, other than as stated herein.

Golden Rule Insurance Company

A handwritten signature in black ink that reads "Patrick F. Carr". The signature is written in a cursive style with a large initial "P" and "C".

President

NEBRASKA GRIEVANCE PROCEDURES RIDER

By the attachment of this rider, the *policy/certificate* is amended by the addition of the following:

A. NEBRASKA GRIEVANCE PROCEDURES

1. APPLICABILITY

These procedures apply to reviews of *adverse determinations* and *grievances*.

2. DEFINITIONS:

- (a) "*Adverse determination*" means a determination by Golden Rule Insurance Company or a recommendation by GRIC's Review Agent that an admission, availability of care, continued stay, or other health care service has been reviewed and, based upon the information provided, does not meet GRIC's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, and coverage for the requested health care service is therefore denied, reduced, or terminated.
- (b) "*Clinical peer*" means a physician or other *health care professional* who holds a nonrestricted license in a state of the United States and in the same or similar specialty as typically manages the medical condition, procedure, or treatment under review.
- (c) "*Clinical review criteria*" means the written screening procedures, decision abstracts, clinical protocols, and practice guidelines used by GRIC's Review Agent to determine the necessity and appropriateness of health care services.
- (d) "*Grievance*" means a written complaint submitted according to GRIC's formal *grievance* procedures, by or on behalf of a *covered person*, regarding any aspect of the *covered person's* GRIC's health insurance coverage, such as:
 - (i) Availability, delivery, or quality of health care services, including a complaint regarding an *adverse determination* made pursuant to *utilization review*;
 - (ii) Claims payment, handling, or reimbursement for health care services; or
 - (iii) Matters pertaining to the contractual relationship between the *covered person* and GRIC.
- (e) "*Health care professional*" means a physician or other health care practitioner licensed, certified, or registered to perform specified health services consistent with state law.
- (f) "*Retrospective review*" means a review of medical necessity conducted after services have been provided to a *covered person*, but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication for payment.
- (g) "*Utilization review*" means a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, providers, or facilities. Techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management discharge planning, or *retrospective review*. *Utilization review* does not include elective requests for clarification of coverage.

3. NOTICE OF AN ADVERSE DETERMINATION

- (a) Upon making an *adverse determination*, GRIC or GRIC's Review Agent will provide the *covered person* with an explanation of the reasons for the *adverse determination*, a written notice of how to submit a *grievance*, and the telephone number to call for information and assistance.
- (b) Upon making an *adverse determination*, GRIC's Review Agent will inform the provider of the right to submit a *grievance* or a request for an expedited review and will, upon request, explain GRIC's procedures for initiating a review.

4. FIRST-LEVEL REVIEW OF AN ADVERSE DETERMINATION OR GRIEVANCE

- (a) For a grievance involving an adverse determination:
 - (i) A *grievance* involving an *adverse determination* may be submitted by the *covered person*, the *covered person's* representative, or a provider acting on behalf of a *covered person*, except when prohibited by law.
 - (ii) The review shall be evaluated by one or more appropriate *clinical peers* who are in the same or similar specialty as would typically manage the case being reviewed, but who were not involved in the initial *adverse determination*.
 - (iii) GRIC will notify both the *covered person* and the provider in writing of the review decision within 15 working days after receipt of the request for review. The written decision will include the items stated in paragraph A.4(c).
 - (iv) If the results of the review remain unsatisfactory, the *covered person* or provider acting on behalf of the *covered person* may submit a request for a second-level review, unless prohibited by law.
- (b) For all other *grievances*:
 - (i) All other *grievances* may be submitted by a *covered person* or the *covered person's* representative.
 - (ii) The person(s) who reviews the *grievance* will not be the same as the one(s) who made the initial determination denying a claim or handling the matter that is the subject of the *grievance*.
 - (iii) GRIC will issue a written decision within 15 working days after receipt of the *grievance*. The written decision will include the items stated in paragraph A.4(c).
 - (iv) If GRIC cannot make a decision within 15 working days after receipt of the *grievance* due to circumstances beyond GRIC's control, GRIC may take up to an additional 15 working days to respond. GRIC will provide written notice to the *covered person* of the extension and the reasons for the delay on or before the 15th working day after GRIC receives the *grievance*.
 - (v) Within 3 working days after receiving a *grievance*, GRIC will inform the *covered person* of the following:
 - (a) A *covered person* or the *covered person's* representative may not attend the first-level *grievance* review.
 - (b) A *covered person* may submit written material for the first-level *grievance* review.
 - (c) GRIC will provide the *covered person* the name, address, and telephone number of the person designated to coordinate the first-level *grievance* review.
- (c) For all *grievances*, the written decision will include the following:
 - (i) The names, titles, and qualifying credentials of the reviewer(s) participating in the review process.
 - (ii) A statement of the reviewers' understanding of the *covered person's grievance*.
 - (iii) The reviewers' decision in clear terms and the contract basis or medical rationale in sufficient detail for the *covered person* to respond further to GRIC's position.
 - (iv) A reference to the evidence or documentation used as the basis for the decision.
 - (v) For a *grievance* involving an *adverse determination*, the instructions for requesting a written statement of the clinical rationale, including the *clinical review criteria* used to make the determination.
 - (vi) If applicable, a statement indicating:
 - (a) A description of the process to obtain a second-level review of a decision; and
 - (b) The written procedures governing a second-level review, including any required time frame for review.

(vii) Notice of the *covered person's* right to contact the office of the Director of Insurance, including that office's address and telephone number, as shown in paragraph A.7.

5. SECOND-LEVEL REVIEW OF AN ADVERSE DETERMINATION OR GRIEVANCE

- (a) GRIC will appoint a review panel, the majority of which will be persons who were not previously involved in the *grievance*. For review of an *adverse determination*, GRIC will ensure that a majority of the reviewers are *health care professionals* who have appropriate expertise.
- (b) The review panel will have the legal authority to bind GRIC to the panel's decision.
- (c) The review panel will schedule and hold a review meeting within 45 working days after receiving the request for a second-level review.
- (d) GRIC will notify the *covered person* that the *covered person* has the right to:
 - (i) Attend the review panel meeting;
 - (ii) Present the *covered person's* case to the review panel;
 - (iii) Submit supporting material both before and at the review panel meeting;
 - (iv) Ask questions of any representative of GRIC's review panel during the review meeting; and
 - (v) Be assisted or represented by a person of the *covered person's* choice.
- (e) If the *covered person* cannot appear in person before the review panel, GRIC will offer the opportunity to communicate with the review panel by conference call or other available technology.
- (f) Upon the request of the *covered person*, GRIC will provide all relevant information that is not confidential or privileged.
- (g) The review panel will issue a written decision within 5 working days after completing the review meeting.

6. EXPEDITED REVIEW

- (a) A *grievance* may be given an expedited review if the time frame of the standard review would seriously jeopardize the life or health of a *covered person* or would jeopardize the *covered person's* ability to regain maximum function. However, GRIC is not required to provide an expedited review for retrospective *adverse determinations*.
- (b) A request for an expedited review of an *adverse determination* may be submitted orally or in writing.
- (c) An expedited review will be provided for all requests concerning an admission, availability of care, continued stay, or health care service for a *covered person* who has received emergency services but has not been discharged from a facility.
- (d) An expedited review may be requested by a *covered person*, a *covered person's* representative, or a provider acting on behalf of a *covered person*.
- (e) All necessary information, including the decision, will be transmitted between GRIC and the requestor by telephone, facsimile, or the most expeditious method available.
- (f) An expedited review that results in an *adverse determination* will be evaluated by one or more appropriate *clinical peers* who are in the same or similar specialty as would typically manage the case being reviewed, but who were not involved in the initial *adverse determination*.
- (g) GRIC will notify the requestor of the decision as timely as the *covered person's* medical condition requires, but no more than 72 hours after the review is begun. If the expedited review is a concurrent review determination, the health care service will be continued without liability to the *covered person* until the *covered person* has been notified of the decision.

- (h) If the notification under A.6(g) was not in writing, GRIC will provide written confirmation of the decision within 2 working days after providing the notification under A.6(g). The written decision will include all elements listed under A.4(c).
- (i) GRIC will provide reasonable access, not to exceed one (1) business day after receiving a request for an expedited review, to a *clinical peer* who can perform the expedited review.
- (j) If the results of the expedited review remain unsatisfactory, the *covered person* or provider acting on behalf of the *covered person* may submit a request for a second-level review, unless prohibited by law.

7. RIGHT TO ASSISTANCE

A *covered person* has the right to contact the office of the Director of Insurance for assistance at any time. The address and telephone number are:

Director of Insurance
Nebraska Department of Insurance
Terminal Building
941 O Street, Suite 400
Lincoln, NE 68508-3639
(402) 471-2201

This rider applies only to *covered persons* who reside in the state of Nebraska and who are insured under a plan with a UnitedHealthcare network.

This rider does not change, waive, or extend any part of the *policy/certificate*, other than as stated herein.

This rider is effective at the same time as the *policy/certificate*.

Golden Rule Insurance Company



President

NEBRASKA UNITEDHEALTHCARE NETWORK RIDER

By the attachment of this rider, the *policy/certificate* is amended by the addition of the following:

A. NEBRASKA GRIEVANCE PROCEDURES

1. APPLICABILITY

These procedures apply to reviews of *adverse determinations* and *grievances*.

2. DEFINITIONS:

- (a) "*Adverse determination*" means a determination by Golden Rule Insurance Company GRIC or a recommendation by GRIC's Review Agent that an admission, availability of care, continued stay, or other health care service has been reviewed and, based upon the information provided, does not meet GRIC's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, and coverage for the requested health care service is therefore denied, reduced, or terminated.
- (b) "*Clinical peer*" means a physician or other *health care professional* who holds a nonrestricted license in a state of the United States and in the same or similar specialty as typically manages the medical condition, procedure, or treatment under review.
- (c) "*Clinical review criteria*" means the written screening procedures, decision abstracts, clinical protocols, and practice guidelines used by GRIC's Review Agent to determine the necessity and appropriateness of health care services.
- (d) "*Grievance*" means a written complaint submitted according to GRIC's formal *grievance* procedures, by or on behalf of a *covered person*, regarding any aspect of the *covered person's* GRIC health insurance coverage, such as:
 - (i) Availability, delivery, or quality of health care services, including a complaint regarding an *adverse determination* made pursuant to *utilization review*;
 - (ii) Claims payment, handling, or reimbursement for health care services; or
 - (iii) Matters pertaining to the contractual relationship between the *covered person* and GRIC.
- (e) "*Health care professional*" means a physician or other health care practitioner licensed, certified, or registered to perform specified health services consistent with state law.
- (f) "*Retrospective review*" means a review of medical necessity conducted after services have been provided to a *covered person*, but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication for payment.
- (g) "*Utilization review*" means a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, providers, or facilities. Techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management discharge planning, or *retrospective review*. *Utilization review* does not include elective requests for clarification of coverage.

3. NOTICE OF AN ADVERSE DETERMINATION

- (a) Upon making an *adverse determination*, GRIC or GRIC's Review Agent will provide the *covered person* with an explanation of the reasons for the *adverse determination*, a written notice of how to submit a *grievance*, and the telephone number to call for information and assistance.
- (b) Upon making an *adverse determination*, GRIC or GRIC's Review Agent will inform the provider of the right to submit a *grievance* or a request for an expedited review and will, upon request, explain GRIC's procedures for initiating a review.

4. FIRST-LEVEL REVIEW OF AN ADVERSE DETERMINATION OR GRIEVANCE

- (a) For a grievance involving an adverse determination:

- (i) A *grievance* involving an *adverse determination* may be submitted by the *covered person*, the *covered person's* representative, or a provider acting on behalf of a *covered person*, except when prohibited by law.
 - (ii) The review shall be evaluated by one or more appropriate *clinical peers* who are in the same or similar specialty as would typically manage the case being reviewed, but who were not involved in the initial *adverse determination*.
 - (iii) GRIC will notify both the *covered person* and the provider in writing of the review decision within 15 working days after receipt of the request for review. The written decision will include the items stated in paragraph A.4(c).
 - (iv) If the results of the review remain unsatisfactory, the *covered person* or provider acting on behalf of the *covered person* may submit a request for a second-level review, unless prohibited by law.
- (b) For all other *grievances*:
- (i) All other *grievances* may be submitted by a *covered person* or the *covered person's* representative.
 - (ii) The person(s) who reviews the *grievance* will not be the same as the one(s) who made the initial determination denying a claim or handling the matter that is the subject of the *grievance*.
 - (iii) GRIC will issue a written decision within 15 working days after receipt of the *grievance*. The written decision will include the items stated in paragraph A.4(c).
 - (iv) If GRIC cannot make a decision within 15 working days after receipt of the *grievance* due to circumstances beyond GRIC's control, GRIC may take up to an additional 15 working days to respond. GRIC will provide written notice to the *covered person* of the extension and the reasons for the delay on or before the 15th working day after GRIC receives the *grievance*.
 - (v) Within three working days after receiving a *grievance*, GRIC will inform the *covered person* of the following:
 - (a) A *covered person* or the *covered person's* representative may not attend the first-level *grievance* review.
 - (b) A *covered person* may submit written material for the first-level *grievance* review.
 - (c) GRIC will provide the *covered person* the name, address, and telephone number of the person designated to coordinate the first-level *grievance* review.
- (c) For all *grievances*, the written decision will include the following:
- (i) The names, titles, and qualifying credentials of the reviewer(s) participating in the review process.
 - (ii) A statement of the reviewers' understanding of the *covered person's grievance*.
 - (iii) The reviewers' decision in clear terms and the contract basis or medical rationale in sufficient detail for the *covered person* to respond further to GRIC's position.
 - (iv) A reference to the evidence or documentation used as the basis for the decision.
 - (v) For a *grievance* involving an *adverse determination*, the instructions for requesting a written statement of the clinical rationale, including the *clinical review criteria* used to make the determination.
 - (vi) If applicable, a statement indicating:
 - (a) A description of the process to obtain a second-level review of a decision; and
 - (b) The written procedures governing a second-level review, including any required time frame for review.
 - (vii) Notice of the *covered person's* right to contact the office of the Director of Insurance, including that office's address and telephone number, as shown in paragraph A.7.

5. SECOND-LEVEL REVIEW OF AN ADVERSE DETERMINATION OR GRIEVANCE

- (a) GRIC will appoint a review panel, the majority of which will be persons who were not previously involved in the *grievance*. For review of an *adverse determination*, GRIC will ensure that a majority of the reviewers are *health care professionals* who have appropriate expertise.
- (b) The review panel will have the legal authority to bind GRIC to the panel's decision.
- (c) The review panel will schedule and hold a review meeting within 45 working days after receiving the request for a second-level review.
- (d) GRIC will notify the *covered person* that the *covered person* has the right to:
 - (i) Attend the review panel meeting;
 - (ii) Present the *covered person's* case to the review panel;
 - (iii) Submit supporting material both before and at the review panel meeting;
 - (iv) Ask questions of any representative of GRIC's review panel during the review meeting; and
 - (v) Be assisted or represented by a person of the *covered person's* choice.
- (e) If the *covered person* cannot appear in person before the review panel, GRIC will offer the opportunity to communicate with the review panel by conference call or other available technology.
- (f) Upon the request of the *covered person*, GRIC will provide all relevant information that is not confidential or privileged.
- (g) The review panel will issue a written decision within five working days after completing the review meeting.

6. EXPEDITED REVIEW

- (a) A *grievance* may be given an expedited review if the time frame of the standard review would seriously jeopardize the life or health of a *covered person* or would jeopardize the *covered person's* ability to regain maximum function. However, GRIC is not required to provide an expedited review for retrospective *adverse determinations*.
- (b) A request for an expedited review of an *adverse determination* may be submitted orally or in writing.
- (c) An expedited review will be provided for all requests concerning an admission, availability of care, continued stay, or health care service for a *covered person* who has received emergency services but has not been discharged from a facility.
- (d) An expedited review may be requested by a *covered person*, a *covered person's* representative, or a provider acting on behalf of a *covered person*.
- (e) All necessary information, including the decision, will be transmitted between GRIC and the requestor by telephone, facsimile, or the most expeditious method available.
- (f) An expedited review that results in an *adverse determination* will be evaluated by one or more appropriate *clinical peers* who are in the same or similar specialty as would typically manage the case being reviewed, but who were not involved in the initial *adverse determination*.
- (g) GRIC will notify the requestor of the decision as timely as the *covered person's* medical condition requires, but no more than 72 hours after the review is begun. If the expedited review is a concurrent review determination, the health care service will be continued without liability to the *covered person* until the *covered person* has been notified of the decision.
- (h) If the notification under A.6(g) was not in writing, GRIC will provide written confirmation of the decision within two working days after providing the notification under A.6(g). The written decision will include all elements listed under A.4(c).

- (i) GRIC will provide reasonable access, not to exceed one business day after receiving a request for an expedited review, to a *clinical peer* who can perform the expedited review.
- (j) If the results of the expedited review remain unsatisfactory, the *covered person* or provider acting on behalf of the *covered person* may submit a request for a second-level review, unless prohibited by law.

7. RIGHT TO ASSISTANCE

A *covered person* has the right to contact the office of the Director of Insurance for assistance at any time. The address and telephone number are:

Director of Insurance

Nebraska Department of Insurance
Terminal Building
941 O Street, Suite 400
Lincoln, NE 68508-3639
(402) 471-2201

B. STATEMENT OF QUALITY IMPROVEMENT PROGRAM

1. UnitedHealthcare (UHC) will administer its Quality Improvement Program, which includes:
 - (a) Providing Clinical Profile reports on key clinical measures to *your medical practitioner*;
 - (b) Establishing an accreditation process and reporting to regulatory agencies;
 - (c) Credentialing the physician and provider network;
 - (d) Reporting on and efforts to enhance clinical measures and determine customer satisfaction.
2. A description of the Quality Improvement Program can be obtained by calling {CO_INSURER_SHORT} and asking for the Health Services Department.

C. STATEMENT OF RIGHTS AND RESPONSIBILITIES

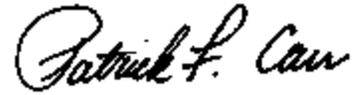
1. **Your Rights:** Subject to provisions stated elsewhere in the *policy/certificate*, *you* have the right to:
 - (a) Medical services from any *medical practitioner* *you* choose whether or not the *medical practitioner* is a UnitedHealthcare Choice Plus network, subject to *policy* provisions reducing benefits for non-*emergency* treatment from a non-*preferred provider*;
 - (b) Medical services from a *medical practitioner* who is not subject to required pre-established medical practice guidelines or required to obtain prior authorization;
 - (c) Protection of medical records and other health information in *our* custody as required by state and federal law; and
 - (d) Timely and fair resolution of inquiries and disputes with *us*.
2. **Your Responsibilities:** Subject to provisions stated elsewhere in the *policy/certificate*, *you* have the responsibility to:
 - (a) Take an active role in medical treatment decisions affecting *you* by reading and understanding coverage under the *policy* as stated in *your* certificate of coverage;
 - (b) Recognize that the *policy* does not cover all medical expenses and requires that *you* share in the cost of medical expenses, especially when non-*emergency* treatment services are received from a non-*preferred provider*;
 - (c) Follow the treatment plans and instructions of *your medical practitioner*; and
 - (d) As required in the *policy/certificate*, notify *us* in advance of certain lengthy *inpatient* stays or organ transplants.

This rider applies only to *covered persons* who reside in the state of Nebraska and who are enrolled in the UnitedHealthcare Choice Plus network.

This rider does not change, waive, or extend any part of the *policy/certificate*, other than as stated herein.

This rider is effective at the same time as the *policy/certificate*.

Golden Rule Insurance Company

A handwritten signature in black ink that reads "Patrick F. Caw". The signature is written in a cursive style with a large initial "P".

President

Golden Rule Insurance Company
North Carolina Utilization Review Procedures and Grievance Procedures
Rider

This rider is effective on August 18, 2010, or at the same time as the *policy/certificate*, whichever is later.

By the attachment of this rider, the *policy/certificate* is amended to include the following:

A. **DEFINITIONS:** As used in this rider, the following terms have the meanings indicated:

1. "*Grievance*" means a written complaint submitted by a *covered person* regarding:
 - (a) *Our* decisions, policies, or actions related to the availability, delivery, or quality of health care services;
 - (b) Claims payment, handling, or reimbursement for services;
 - (c) The contractual relationship between a *covered person* and *us*; or
 - (d) The outcome of an appeal of a *noncertification*.

Grievance does not include a written complaint submitted by a *covered person* about a decision based solely on the fact that the *covered person's policy/certificate* contains an exclusion for the expense in question.

2. "*Noncertification*" means a recommendation by *our* Review Agent, or a determination by *us*, that an admission, availability of care, continued stay, or other health care service has been reviewed and, based upon the information provided, does not meet the *policy's/certificate's* requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, or does not meet the prudent layperson standard for coverage of *emergency* services, and coverage of the requested service is therefore denied, reduced, or terminated. A *noncertification* includes any situation in which *we* make a decision, or *our* Review Agent makes a recommendation, about whether a requested treatment for a *covered person's* condition is experimental, investigational, or cosmetic, and how coverage is affected. A *noncertification* is not a decision made solely on the basis that the *policy/certificate* does not provide benefits for the health care service in question, if the service is denied under an exclusion stated in the *policy/certificate*.
3. As used in this rider, the term *covered person* will also include a person who is authorized to act on behalf of a *covered person*.

B. **UTILIZATION REVIEW PROCEDURES**

1. **Applicability of Part B.** This Part B applies to reviews of medical necessity, appropriateness, health care setting, level of care or effectiveness, or services that are experimental, investigational, or cosmetic treatment.
2. *Our* Review Agent or *we* will obtain all information required to make a recommendation or determination, including clinical information. Information requests will be limited to the information necessary to certify the health care service.
3. A *covered person* or a health care provider acting on behalf of a *covered person* may contact *our* Review Agent by calling toll-free at 1-800-999-3404.
4. Notice of utilization review decisions will be consistent with North Carolina law and *our* policies.
5. A medical *doctor* licensed to practice medicine in North Carolina will evaluate the clinical appropriateness of *noncertifications*.
6. For prospective and concurrent reviews, *our* Review Agent or *we* will communicate a decision in clear terms within 3 business days of receipt of all necessary information.
 - (a) For a certification, *our* Review Agent or *we* will notify the *covered person's* provider.

- (b) For a *noncertification*, our Review Agent or we will notify the *covered person's* provider and send written or electronic confirmation to the *covered person*.
 - (c) For concurrent reviews, we will remain responsible for coverage of the health care service until the *covered person* has been notified of a *noncertification* in writing.
7. For retrospective reviews, our Review Agent or we will communicate a decision in clear terms within 30 days after receipt of all necessary information.
- (a) For a certification, our Review Agent or we will notify the *covered person's* provider in writing.
 - (b) For a *noncertification*, our Review Agent or we will notify the *covered person* and the *covered person's* provider in writing within 5 business days after making the decision.
8. The written notification of a *noncertification* will include:
- (a) All reasons for the *noncertification*, including:
 - (i) The clinical rationale;
 - (ii) The instructions for initiating a voluntary appeal or reconsideration of the *noncertification*; and
 - (iii) The instructions for requesting a written statement of the clinical review criteria used to make the *noncertification*.
 - (b) A statement that assistance is available from the Managed Care Patient Assistance Program by contacting:

North Carolina Managed Care Patient Assistance Program
Health Insurance Smart NC
North Carolina Department of Insurance
1201 Mail Service Center
Raleigh, North Carolina 27699-1201
Toll free Telephone: (877) 885-0231
9. If the necessary information is not provided, our Review Agent or we will notify the *covered person* or provider. The *covered person* or provider will be given 45 calendar days to provide the necessary information. If a *covered person* or provider fails to provide the necessary information, it may result in a *noncertification*.

C. PROCEDURES FOR APPEALS OF NONCERTIFICATIONS

- 1. The procedures in this part are voluntary.
- 2. A *covered person* or a provider acting on behalf of a *covered person* may file an appeal of a *noncertification*.
- 3. The review will be completed by a medical doctor, licensed to practice medicine in North Carolina, who was not involved in the *noncertification*.
- 4. Within 3 business days after receiving an appeal request, we will provide the *covered person* with:
 - (a) The name, address, and telephone number of the person assigned to coordinate the review; and
 - (b) Information on how to submit written material.
- 5. We will notify the *covered person* and the *covered person's* provider of the appeal decision in clear terms within 30 days after we receive the appeal request. If the decision is not in favor of the *covered person*, the written decision will contain:
 - (a) The professional qualifications and licensure of the person or persons reviewing the appeal.
 - (b) A statement of the reviewer's understanding of the reason for the appeal.

- (c) The reviewer's decision in clear terms and the medical rationale in sufficient detail for the *covered person* to respond further to *our* position.
- (d) A reference to the evidence or documentation that is the basis for the decision, including the clinical review criteria used to make the determination, and instructions for requesting the clinical review criteria.
- (e) A statement advising the *covered person* of the *covered person's* right to request a second level *grievance* review and a description of the procedure for submitting a second level *grievance* review.
- (f) Notice of the availability of assistance from the Managed Care Patient Assistance Program by contacting:

North Carolina Managed Care Patient Assistance Program
Health Insurance Smart NC
North Carolina Department of Insurance
1201 Mail Service Center
Raleigh, North Carolina 27699-1201
Toll free Telephone: (877) 885-0231

6. EXPEDITED APPEALS

- (a) A *covered person* or a provider acting on behalf of a *covered person* may request an expedited appeal of a *noncertification* if a standard appeal would reasonably appear to seriously jeopardize the life or health of a *covered person* or jeopardize the *covered person's* ability to regain maximum function.
 - (b) The attending physician must provide a statement or certification that the *covered person's* medical condition is such that the time frame for a standard appeal would reasonably appear to seriously jeopardize the life or health of a *covered person* or jeopardize the *covered person's* ability to regain maximum function.
 - (c) The expedited review must take place in consultation with a licensed medical *doctor*.
 - (d) *We* will notify the *covered person* and the *covered person's* provider in writing, in clear terms, of the appeal decision within 4 days after receiving the information justifying an expedited review.
 - (e) If the expedited appeal involves a concurrent review determination, *we* will remain responsible for coverage of the health care service until the *covered person*, provider, and/or facility has been notified of the appeal decision verbally and by mail.
 - (f) *We* do not provide expedited reviews for appeals of *noncertifications* of retrospective reviews.
7. A second level review of a *noncertification* will be handled under the second level review procedures in Parts D.5 or D.6 of this rider.

D. PROCEDURES FOR GRIEVANCES

- 1. The procedures in this part are voluntary.
- 2. The North Carolina Department of Insurance is available to assist *covered persons* with insurance related problems and questions. You may contact the Department at:

North Carolina Department of Insurance
1201 Mail Service Center
Raleigh, NC 27699-1201
Phone: 1-800-546-5664

- 3. Help is also available from the Managed Care Patient Assistance Program by contacting:

North Carolina Managed Care Patient Assistance Program
Health Insurance Smart NC
North Carolina Department of Insurance

4. FIRST LEVEL REVIEWS

- (a) A *covered person* or a provider acting on behalf of a *covered person* may file a *grievance* with us.
- (b) The *covered person* and/or provider is not permitted to attend the first level review, but may submit written material for consideration.
- (c) Within 3 business days of receiving a *grievance*, we will inform the *covered person* of the name, address, and telephone number of the person assigned to coordinate the review and information on how to submit written material to the reviewer.
- (d) We will send a written decision in clear terms to the *covered person*, and the *covered person's* provider, if applicable, within 30 days of receipt of the *grievance*. If the decision is not in favor of the *covered person*, the written decision will contain:
 - (i) The professional qualifications and licensure of the person or persons reviewing the *grievance*.
 - (ii) A statement of the reviewer's understanding of the *grievance*.
 - (iii) The reviewer's decision in clear terms and the contractual basis or medical rationale in sufficient detail for the *covered person* to respond further to *our* position.
 - (iv) A reference to the evidence or documentation used as the basis for the decision.
 - (v) A statement advising the *covered person* of his or her right to request a second level *grievance* review and a description of the procedure for submitting a second level *grievance*.
 - (vi) Notice of the availability of assistance from the Managed Care Patient Assistance Program by contacting:

North Carolina Managed Care Patient Assistance Program
Health Insurance Smart NC
North Carolina Department of Insurance
1201 Mail Service Center
Raleigh, North Carolina 27699-1201
Toll free Telephone: (877) 885-0231

5. SECOND LEVEL REVIEWS FOR NONCERTIFICATIONS AND GRIEVANCES

- (a) A *covered person*, or a provider acting on behalf of a *covered person*, who is dissatisfied with a first level *grievance* review decision or a *noncertification* appeal decision may file a request for a second level *grievance* review.
- (b) Within 10 business days of receipt of a request for a second level review, we will inform the *covered person* of the name, address, and telephone number of the person assigned to coordinate the review and of the right to:
 - (i) Request and receive from us all information relevant to the case.
 - (ii) Attend the review meeting and present his or her case to the review panel.
 - (iii) Submit supporting material to the review panel both before and at the review meeting.
 - (iv) Ask questions of any member of the review panel.
 - (v) Be assisted or represented at the review meeting by a person of his or her choice, which person may be a provider, family member, employer, representative, or attorney. If the *covered person* chooses to be represented by an attorney, we may also be represented by an attorney.

- (c) The review panel will schedule and hold a review meeting within 45 days of receipt a request for a second level review.
- (d) The *covered person* will be notified in writing at least 15 days before the review meeting date.
- (e) A *covered person* does not have to attend the second level review meeting to receive a full review.
- (f) The review panel will send a written decision in clear terms to the *covered person* and, if applicable, to the *covered person's* provider, within 7 business days after the review meeting. The decision will include:
 - (i) The professional qualifications and licensure of the members of the review panel.
 - (ii) A statement of the review panel's understanding of the nature of the *grievance* and all pertinent facts.
 - (iii) The review panel's recommendation to *us* and the rationale behind that recommendation.
 - (iv) A description of or reference to the evidence or documentation considered by the review panel in making the recommendation.
 - (v) In the review of the *noncertification* or other clinical matter, a written statement of the clinical rationale, including the clinical review criteria, that was used by the review panel to make the recommendation.
 - (vi) The rationale for *our* decision if it differs from the review panel's recommendation.
 - (vii) A statement that the decision is *our* final determination in the matter.
 - (viii) If the review concerned a *noncertification* and *our* decision is to uphold *our* initial *noncertification*, a statement advising the *covered person* of his or her right to request an external review and a description of the procedure for submitting a request for external review to the Commissioner of Insurance.
 - (ix) Notice of the availability of the Commissioner's office for assistance by contacting:

By Mail:

North Carolina Department of Insurance
 Healthcare External Review Program
 1201 Mail Service Center
 Raleigh, NC 27699-1201
 Phone toll-free in NC: 1-877-885-0231
 Phone out of NC: 1-919-807-6860
 Fax: 1-919-807-6865

In Person:

Dobbs Building
 430 N. Salisbury St.
 4th Floor, Suite 4105
 Raleigh, NC
www.ncdoi.com for External Review Information and Request Form

- (x) Notice of the availability of assistance from the Managed Care Patient Assistance Program by contacting:

North Carolina Managed Care Patient Assistance Program
 Health Insurance Smart NC
 North Carolina Department of Insurance
 1201 Mail Service Center
 Raleigh, North Carolina 27699-1201
 Toll free Telephone: (877) 885-0231

6. SECOND LEVEL EXPEDITED REVIEW FOR NONCERTIFICATIONS AND GRIEVANCES

- (a) An expedited second level review will be made available where medically justified, whether or not the initial review was expedited.
- (b) The provisions in D.5 will apply to an expedited review, except that *we* will conduct the review and send the written decision within 4 days after receiving all information needed. The review meeting may take place by way of a telephone conference call or through the exchange of written information.

E. FOR GRIEVANCES RELATED TO QUALITY OF CLINICAL CARE

Within 10 business days after *we* receive a *grievance* about the quality of care received from a provider, *we* will acknowledge the *grievance*. The acknowledgement will advise a *covered person* that:

- 1. The *grievance* will be referred to the network for handling and resolution, if applicable.
- 2. North Carolina law does not allow for a second level review for *grievances* concerning quality of care.

F. EXTERNAL REVIEW OF NONCERTIFICATIONS

- 1. North Carolina law provides for review of *noncertification* decisions by an external, independent review organization (IRO). The North Carolina Department of Insurance (NCDOI) administers this service at no charge to *you*, arranging for an IRO to review *your* case once the NCDOI establishes that *your* request is complete and eligible for review. *You* or someone *you* have authorized to represent *you* may request an external review.
- 2. *We* will notify *you* in writing of *your* right to request an external review each time *you* receive:
 - (a) A *noncertification* decision; or
 - (b) An appeal decision upholding a noncertification decision; or
 - (c) A second level *grievance* review decision upholding the original *noncertification*.
- 3. In order for *your* request to be eligible for external review, the NCDOI must determine the following:
 - (a) That *your* request is about a medical necessity determination that resulted in a *noncertification* decision;
 - (b) That *you* had coverage with *us* in effect when the *noncertification* decision was issued;
 - (c) That the service for which the *noncertification* was issued appears to be a covered service under *your policy/certificate*; and
 - (d) That *you* have exhausted *our* internal review process as described below.
- 4. External review is performed on a standard and expedited timetable, depending on which is requested and on whether medical circumstances meet the criteria for expedited review.
- 5. STANDARD EXTERNAL REVIEW
 - (a) For a standard external review, *you* will be considered to have exhausted *our* internal review process if *you* have:
 - (i) Completed *our* appeal and second level *grievance* review and have received a written second level determination from *us*; or
 - (ii) Filed a second level grievance and, except to the extent that *you* have requested or agreed to a delay, have not received *our* written decision within 60 days after the date *you* submitted the request; or
 - (iii) Received notification that *we* have agreed to waive the requirement to exhaust *our* internal appeal and *grievance* process.
 - (b) If *your* request for a standard external review is related to a retrospective *noncertification* (a *noncertification* that occurs after *you* have received the services in question), *you* will not be

eligible to request a standard review until *you* have completed *our* internal review process and received a written final determination from *us*.

- (c) If *you* wish to request a standard external review, *you* (or *your* representative) must make this request to the NCDOI within 120 days after receiving *our* written notice of final determination that the services in question are not approved.
- (d) When processing *your* request for external review, the NCDOI will require *you* to provide the NCDOI with a written, signed authorization for the release of any of *your* medical records that may need to be reviewed for the purpose of reaching a decision on the external review.
- (e) Within 10 business days of receipt of *your* request for a standard external review, the NCDOI will notify *you* and *your* provider of whether *your* request is complete and whether it is accepted. If the NCDOI notifies *you* that *your* request is incomplete, *you* must provide all requested additional information to the NCDOI within 150 days of the date of *our* written notice of final determination. If the NCDOI accepts *your* request, the acceptance notice will include:
 - (i) The name and contact information for the IRO assigned to *your* case;
 - (ii) A copy of the information about *your* case that *we* provided to the NCDOI;
 - (iii) Notice that *we* will provide *you* with a copy of the documents and information considered in making the denial decision (which will also be sent to the IRO); and
 - (iv) Notice that *you* may submit additional written information and supporting documentation relevant to the initial *noncertification* to the assigned IRO within 7 days of the date of the acceptance notice.
- (f) If *you* choose to provide any additional information to the IRO, *you* must also provide the same information to *us* at the same time using the same means of communication (e.g., *you* must fax the information to *us* if *you* faxed it to the IRO). When faxing information to *us*, send it to 1-920-661-2003. If *you* choose to mail *your* information, send it to:

Appeals and Grievances
P.O. Box 13597
Green Bay, WI 54307-3597
E-mail: AppealsCoordinator@eAMS.com

- (g) Please note that *you* may also provide this additional information to the NCDOI within the 7-day deadline rather than sending it directly to the IRO and *us*. The NCDOI will forward this information to the IRO and *us* within 2 business days of receiving *your* additional information.
 - (h) The IRO will send *you* written notice of its determination within 45 days of the date the NCDOI receives *your* standard external review request. If the IRO's decision is to reverse the *noncertification*, *we* will:
 - (i) Reverse the *noncertification* decision within 3 business days of receiving notice of the IRO's decision;
 - (ii) Provide coverage for the requested service or supply that was the subject of the *noncertification* decision. If *you* are no longer covered by *us* at the time *we* receive notice of the IRO's decision to reverse the *noncertification*, *we* will only provide coverage for those services or supplies *you* actually received or would have received prior to termination of *your* *policy/certificate* if the service had not been noncertified when first requested.
6. EXPEDITED EXTERNAL REVIEW
- (a) An expedited review of a *noncertification* decision may be available if the *covered person* has a medical condition where the time required to complete either an expedited internal appeal or second level *grievance* review or a standard external review would reasonably be expected to seriously jeopardize the life or health of the *covered person* or would jeopardize

the *covered person's* ability to regain maximum function. If this is the case, *you* may make a written request to the NCDOI for an expedited review after *you* receive:

- (i) A *noncertification* decision from *us* AND file a request with *us* for an expedited appeal; or
 - (ii) An appeal decision upholding a *noncertification* decision AND file a request with *us* for an expedited second level *grievance* review; or
 - (iii) A second level *grievance* review decision upholding the original *noncertification*.
- (b) *You* may also make a request for an expedited external review if *you* receive an adverse second level *grievance* review decision concerning a *noncertification* of an admission, availability of care, continued stay, or *emergency care*, but have not been discharged from the *inpatient* facility.
- (c) In consultation with a medical professional, the NCDOI will review *your* request and determine whether it qualifies for expedited review. *You* and *your* provider will be notified within 3 business days if *your* request is accepted for expedited external review. If *your* request is not accepted for expedited review, the NCDOI may:
- (i) Accept the case for standard external review if *our* internal review process was already completed; or
 - (ii) Require the completion of *our* internal review process before *you* may make another request for an external review with the NCDOI.
- (d) An expedited external review is not available for retrospective *noncertifications*.
- (e) The IRO will communicate its decision to *you* within 4 business days of the date the NCDOI receives *your* request for an expedited external review. If the IRO's decision is to reverse the *noncertification*, *we* will, within one (1) day of receiving notice of the IRO's decision, reverse the *noncertification* decision for the requested service or supply that is the subject of the *noncertification* decision. If *you* are no longer covered by *us* at the time *we* receive notice of the IRO's decision to reverse the *noncertification*, *we* will only provide coverage for those services or supplies *you* actually received or would have received prior to termination of *your policy/certificate* if the service had not been noncertified when first requested.
7. The IRO's external review decision is binding on *us* and *you*, except to the extent *you* may have other remedies available under applicable federal or state law.
8. *You* may not file a subsequent request for an external review involving the same *noncertification* decision for which *you* have already received an external review decision.
9. For further information about external review or to request an external review, contact the NCDOI at:

By Mail:

North Carolina Department of Insurance
Healthcare External Review Program
1201 Mail Service Center
Raleigh, NC 27699-1201
Fax: 1-919-807-6865

In Person:

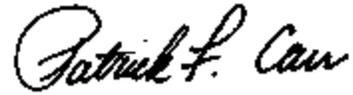
Dobbs Building
430 N. Salisbury St.
4th Floor, Suite 4105
Raleigh, NC
Phone toll-free in NC: 1-877-885-0231
Phone out of NC: 1-919-807-6860
www.ncdoi.com for External Review Information and Request Form

The Healthcare Review Program is available to provide Consumer Counseling on utilization review and internal appeals and grievance issues.

This rider applies only to *covered persons* who reside in the state of North Carolina.

This rider does not change, waive or extend any part of the *policy/certificate*, other than as stated herein.

Golden Rule Insurance Company

A handwritten signature in black ink that reads "Patrick F. Carr". The signature is written in a cursive style with a large initial "P".

President

TERM LIFE INSURANCE RIDER

By attachment of this rider, the *policy* or certificate is amended as follows:

If a *covered person* dies while insured under this rider, we will pay, subject to the terms and conditions of this rider, to the *covered person's beneficiary* the term life *proceeds* in one lump sum.

DEFINITIONS

As used in this rider:

"*Beneficiary*" means the person designated by the *covered person*, on a form approved by us, to receive any amount of the term life *proceeds* becoming payable under the terms of the *policy* or certificate due to a *covered person's* death.

"*Covered Person*" means the *primary insured* and/or *spouse* who has applied for and been approved under this rider.

"*Due proof of death*" shall mean sufficient information to allow us to determine if *proceeds* are payable and in the form of written documentation such as a certified copy of the death certificate, autopsy report, police/accident reports and other information and proof necessary to establish liability.

"*Proceeds*" means the amount for which a *covered person's* life is insured under this rider at the time of death. The respective term life *proceeds* for each *covered person* under this rider are shown in Section 1.

"*Spouse*" means the person named as *your* spouse in the application or any amendment. This term does not include a spouse who is not a *covered person*.

PREMIUM

The premiums for this rider are shown on the Data Page, Section 1. This premium is to be paid at the same time and in the same manner as the premium for the *policy* or certificate. The premium for this rider will cease when the rider ends. If the type of plan shown on the Data Page of the *policy* or certificate is changed because of an addition or removal of a *covered person* insured by this rider, the premium for this rider will change. The new premium for this rider will be shown in the written notice sent to *you*.

NOTICE OF DEATH

We will pay to the *beneficiary* the term life *proceeds* of this rider upon receipt of *due proof of death*. Written proof of death must be furnished to us within 90 days from the *covered person's* date of death or as soon as reasonably possible.

BENEFICIARY

The *covered person* can name any person, other than the *covered person's* employer, as *beneficiary*. The *covered person* can change the *beneficiary* at any time without the consent of the designated *beneficiary* by notifying us in writing on a form furnished by us. The new designation will be effective when the notice is received by us. If we pay the *proceeds* before we receive the *covered person's* change request, we are released from further liability to the extent of our payment. A new designation of *beneficiary* terminates the interests of the previous *beneficiary*.

If more than one *beneficiary* is designated, but their respective interests are not specified, the *beneficiaries* will share the *proceeds* equally. The interest of a *beneficiary* who dies before the *covered person* will terminate and be shared equally by the *beneficiaries* surviving the *covered person*, unless otherwise provided in the *beneficiary* designation. If the *beneficiary* dies at the same time as the *covered person*, or within 15 days after the date the *covered person* dies, payment will be made by us as if the *covered person* survived the *beneficiary*. If there is not a designated *beneficiary* surviving at the death of the *covered person*, payment will be made in a single sum to the *covered person's* estate; however, at our option, payment may be made to one or more of the following surviving relatives of the *covered person*:

- A. Spouse;
- B. Children, including legally adopted children;
- C. Parents; or
- D. Brothers and sisters.

In the absence of a parent or the appointment of a legal guardian, if any *beneficiary* is:

- A. A minor; or
- B. In our opinion, legally incapable of giving valid receipt for any payment due

we may pay term life *proceeds* in monthly installments to the person or persons who, in *our* opinion, have assumed custody and principal support of the *beneficiary*.

If *proceeds* are not paid within 30 days after we received *due proof of death* we will pay interest on the *proceeds*. Interest will be paid at the rate of 3% a year from the date we receive *due proof of death* until the date the *proceeds* are paid. If the law in the state where the *policy* or certificate is issued requires payment of a greater amount, we will pay that amount.

We may, at *our* option, pay an amount of up to \$250 to any person appearing to be entitled to the payment who incurred expense because of the last illness or burial of the *covered person*. Any payment we make in good faith fully discharges us to the extent of the payment.

TERMINATION OF THIS RIDER

All insurance under this rider will cease on its termination. This rider will terminate on the earlier of:

- A. The date we receive a written request from the *covered person* for its termination, or on any later date stated in *your* request;
- B. The date no *covered person* remains insured under this rider; or
- C. The date the *covered person's* coverage under the *policy* or certificate terminates.

We will refund any premium paid and not earned due to termination of this rider. The refund will be based on the number of full months that remain in the premium period.

TERMINATION OF COVERED PERSONS

You will cease to be a *covered person* under this rider at the end of the premium period in which you attain 65 years of age.

Your spouse will cease to be a *covered person* under this rider at the end of the premium period in which any of these events occur:

- A. He or she attains 65 years of age; or
- B. You become legally divorced, if earlier.

ASSIGNING YOUR RIDER

During *your* life, you may assign some or all of *your* rights under this rider to someone else.

A signed copy of the assignment trust must be sent to *our* home office on a form we accept. The assignment will go into effect when it is signed, subject to any payments we make or other actions we take before we record it. We are not responsible for the validity or effect of any assignment.

MISTAKE OF AGE, SEX OR TOBACCO STATUS

If *your* or *your spouse's* age, sex or tobacco status is misstated in the application, we will adjust the *proceeds*. The *proceeds* of this rider will then be those *your* premiums would have bought at the correct age, sex and tobacco status. By age, we mean age as of *your* or *your spouse's* last birthday on the *policy's* or certificate's *effective date*.

GENERAL TERMS

This rider is made a part of *your policy* or certificate in consideration of *your* application and payment of the first premium for this rider. The following clauses indicate whether the *policy* or certificate provisions will apply to this rider. The *policy* or certificate provisions will either apply to this rider, not apply to this rider, or apply to this rider as modified below.

- A. **Policy or certificate provisions that do not apply to this rider** - The following *policy* or certificate provisions do not apply to this rider:

1. The Preexisting Conditions Limitations section, and the Reimbursement section; and
 2. The Dependent Coverage section, except for the Dependent Eligibility clause and the Adding Other Dependents clause.
- B. **Policy or certificate provisions that apply to this rider with modification** - The following *policy* or certificate provision applies to this rider as modified below:
- The Reinstatement clause, as found in the Termination section of the *policy* or certificate, will apply to this rider. However, death/accidental death occurring between the date the *policy* or certificate lapses and the date the *policy* or certificate is reinstated will not be covered under this rider.
- C. **Policy or certificate provisions that do not apply to this rider** - Other than as stated in (A) or (B) above, all other *policy*/certificate provisions will apply to this rider.

BENEFIT EXCLUSIONS

No *proceeds* are payable if a loss results from:

- A. Suicide or intentionally self-inflicted *injury* or *illness* while sane or insane if committed during the first 24 months of coverage under this rider;
- B. Service in the armed forces of any country, including non-military units supporting such forces. This exclusion does not apply when the *covered person* is a member of the United States military armed services and that information is disclosed to *us* on the *covered person's* application for insurance with *us*.
- C. An act of declared or undeclared war. This exclusion does not apply when the *covered person* is a member of the United States military armed services and the information is disclosed to *us* on the *covered person's* application for insurance with *us*; or
- D. Death due to an accident occurring while riding in or on, boarding or alighting from any aircraft as a:
 1. Pilot, crewmember, or student pilot; or
 2. Flight instructor or examiner

LIFE INSURANCE CONVERSION PRIVILEGE

A *covered person* will be eligible to convert coverage under this rider to an individual policy of life insurance ("*conversion policy*"), made available, without evidence of insurability, under this provision, if:

- A. The *covered person's* coverage under this rider terminates for reasons other than:
 1. Termination of the *policy*; or
 2. Failure to make the required premium payment when due; or
 3. The attainment of age 65.
- B. The covered person has been continuously insured under this rider for at least one(1) year immediately prior to the termination.

This privilege is subject to the following additional terms and conditions:

- A. Written application and the first premium payment are submitted as directed on the *conversion policy* application by the later of:
 1. 31 days after termination of coverage under this rider; or
 2. A later date as required by the statutes or regulations of the state in which the *covered person* resides at that time; but

In no event later than 60 days after the date of termination of coverage under this rider.

- B. The amount of coverage under the *conversion policy* will not exceed the amount of coverage for which the *covered person* is insured under this rider. The terms of coverage under the conversion policy will not be the same as the terms of coverage under this rider.
- C. The *conversion policy* will be a policy offered by a life insurer designated by *us* in the state in which the *covered person* resides.

- D. The premium to be paid for the *conversion policy* by the former *covered person* will depend on:
 - 1. Rates for that *conversion policy* in that state at that time;
 - 2. The attained age of the *covered person*;
 - 3. The class of risk to which the *covered person* belongs; and
 - 4. The form and amount of the *conversion policy* coverage.
- E. Any *conversion policy* issued in accordance with the provisions of this rider:
 - 1. Will become effective the date immediately following termination of coverage under this rider; and
 - 2. Will be in place of the terminated coverage under this rider.
- F. A *covered person's* insurance under this rider will remain in force during the thirty-one (31) days within which the *covered person* is eligible to exercise the conversion privilege, whether or not there has been an application for conversion. If the *covered person* dies during that period, we will:
 - 1. Pay, as a death benefit, the maximum amount eligible for conversion;
 - 2. Void any *conversion policy* issued in accordance with this conversion privilege; and
 - 3. Return any premium paid for that *conversion policy*.
- G. If the life insurer designated by *us* to offer *conversion policies* in the state in which a *covered person* resides ceases to offer conversion policies in that state, no *conversion policies* will be available in that state under this provision.

This rider will not change, waive, or extend any part of the *policy* or certificate, other than as stated herein.

This rider is effective at the same time as the *policy* or certificate to which it is attached, unless a later date is shown below.

Golden Rule Insurance Company



President

ACCIDENTAL DEATH INSURANCE RIDER

By attachment of this rider, the *policy* or certificate is amended as follows:

If a *covered person* suffers an *accidental death* while insured under this rider, we will pay, subject to the terms and conditions of this rider, to the *covered person's beneficiary* the *accidental death proceeds* in one lump sum.

In order to qualify for a benefit:

- A. The death must occur within 180 consecutive days after the accident that caused the death; and
- B. The accident must occur while the *covered person* is covered under this rider.

DEFINITIONS

As used in this rider:

"*Accidental death*" means loss of life resulting directly from:

- A. Injury;
- B. Infection caused by injury, or resulting from accidental ingestion of contaminated substances; or
- C. Drowning.

"*Beneficiary*" means the person designated by the *covered person*, on a form approved by us, to receive any amount of the *accidental death proceeds* becoming payable under the terms of the *policy* or certificate due to a *covered person's* death.

"*Covered Person*" means the *primary insured* and/or *spouse* who has applied for and been approved under this rider.

"*Due proof of death*" shall mean sufficient information to allow us to determine if *accidental death proceeds* are payable and in the form of written documentation such as a certified copy of the death certificate, autopsy report, police/accident reports and other information and proof necessary to establish liability.

"*Proceeds*" means the amount for which a *covered person's* life is insured under this rider at the time of death. The respective *accidental death proceeds* for each *covered person* under this rider are shown in Section 1.

"*Spouse*" means the person named as *your* spouse in the application or any amendment. This term does not include a spouse who is not a *covered person*.

PREMIUM

The premiums for this rider are shown on the Data Page, Section 1. This premium is to be paid at the same time and in the same manner as the premium for the *policy*. The premium for this rider will cease when the rider ends. If the type of plan shown on the Data Page of the *policy* or certificate is changed because of an addition or removal of a *covered person* insured by this rider, the premium for this rider will change. The new premium for this rider will be shown in the written notice sent to *you*.

NOTICE OF DEATH

We will pay to the *beneficiary* the *accidental death proceeds* of this rider upon receipt of *due proof of death*. Written proof of death must be furnished to us within 90 days from the *covered person's* date of death or as soon as reasonably possible.

BENEFICIARY

The *covered person* can name any person, other than the *covered person's* employer, as a *beneficiary*. The *covered person* can change the *beneficiary* at any time without the consent of the designated *beneficiary* by notifying us in writing on a form furnished by us. The new designation will be effective when the notice is received by us. If we pay the *proceeds* before we receive the *covered person's* change request, we are released from further liability to the extent of *our* payment. A new designation of *beneficiary* terminates the interests of the previous *beneficiary*.

If more than one *beneficiary* is designated, but their respective interests are not specified, the *beneficiaries* will share the *proceeds* equally. The interest of a *beneficiary* who dies before the *covered person* will terminate and be shared equally by the *beneficiaries* surviving the *covered person*, unless otherwise provided in the *beneficiary* designation. If the *beneficiary* dies at the same time as the *covered person*, or within 15 days after the date the *covered person* dies, payment will be made by *us* as if the *covered person* survived the *beneficiary*. If there is not a designated *beneficiary* surviving at the death of the *covered person*, payment will be made in a single sum to the *covered person's* estate; however, at our option, payment may be made to one or more of the following surviving relatives of the *covered person*:

- A. Spouse;
- B. Children, including legally adopted children;
- C. Parents; or
- D. Brothers and sisters.

In the absence of a parent or the appointment of a legal guardian, if any *beneficiary* is:

- A. A minor; or
- B. In our opinion, legally incapable of giving valid receipt for any payment due

we may pay *accidental death proceeds* in monthly installments to the person or persons who, in our opinion, have assumed custody and principal support of the *beneficiary*.

If *proceeds* are not paid within 30 days after *we* received *due proof of death* *we* will pay interest on the *proceeds*. Interest will be paid at the rate of 3% a year from the date *we* receive *due proof of death* until the date the *proceeds* are paid. If the law in the state where the *policy* is issued requires payment of a greater amount, *we* will pay that amount.

We rely on an affidavit to determine payment of *proceeds*, unless *we* receive written notice of a valid claim from a person before *we* make the payment. The affidavit releases *us* from further liability.

We may, at *our* option, pay an amount of up to \$250 to any person appearing to be entitled to the payment who incurred expense because of the last illness or burial of the *covered person*. Any payment *we* make in good faith fully discharges *us* to the extent of the payment.

TERMINATION OF THIS RIDER

All insurance under this rider will cease on its termination. This rider will terminate on the earlier of:

- A. The date *we* receive a written request from the *covered person* for its termination, or on any later date stated in *your* request;
- B. The date no *covered person* remains insured under this rider; or
- C. The date the *covered person's* coverage under the *policy* or certificate terminates.

We will refund any premium paid and not earned due to termination of this rider. The refund will be based on the number of full months that remain in the premium period.

TERMINATION OF COVERED PERSONS

You will cease to be a *covered person* under this rider at the end of the premium period in which *you* attain 65 years of age.

Your spouse will cease to be a *covered person* under this rider at the end of the premium period in which any of these events occur:

- A. He or she attains 65 years of age; or
- B. *You* become legally divorced, if earlier.

ASSIGNING YOUR RIDER

During *your* life, *you* may assign some or all of *your* rights under this rider to someone else.

A signed copy of the assignment must be sent to *our* home office on a form *we* accept. The assignment will go into effect when it is signed, subject to any payments *we* make or other actions *we* take before *we* record it. *We* are not responsible for the validity or effect of any assignment.

If there are permanent *beneficiaries*, *you* need their consent before assigning the payment of *proceeds*.

GENERAL TERMS

This rider is made a part of *your policy* or certificate in consideration of *your* application and payment of the first premium for this rider. The following clauses indicate whether the *policy* or certificate provisions will apply to this rider. The *policy* or certificate provisions will either apply to this rider, not apply to this rider, or apply to this rider as modified below.

- A. **Policy or certificate provisions that do not apply to this rider** - The following *policy* or certificate provisions do not apply to this rider:
 - 1. The Preexisting Conditions Limitations section, and the Reimbursement section; and
 - 2. The Dependent Coverage section, except for the Dependent Eligibility clause and the Adding Other Dependents clause.
- B. **Policy or certificate provisions that apply to this rider with modification** - The following *policy* or certificate provision applies to this rider as modified below:

The Reinstatement clause, as found in the Termination section of the *policy* or certificate, will apply to this rider. However, death/accidental death occurring between the date the *policy* or certificate lapses and the date the *policy* or certificate is reinstated will not be covered under this rider.
- C. **Policy or certificate provisions that do not apply to this rider** - Other than as stated in (A) or (B) above, all other *policy* or certificate provisions will apply to this rider.

BENEFIT EXCLUSIONS

No *proceeds* are payable if a loss results from:

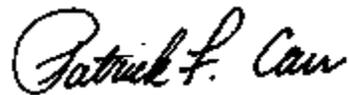
- A. Suicide or intentionally self-inflicted *injury* or *illness* while sane or insane if committed during the first 24 months of coverage under this rider;
- B. Voluntary taking of any sedative or drug, or inhalation of any gas, unless taken or inhaled as *your doctor* prescribes or administers it;
- C. Death due to an accident occurring while riding in or on, boarding or alighting from any aircraft as a:
 - 1. Pilot, crewmember, or student pilot; or
 - 2. Flight instructor or examiner
- D. *Your* committing or attempting to commit a civil or criminal battery or felony;
- E. Service in the armed forces of any country, including non-military units supporting such forces. This exclusion does not apply when the *covered person* is a member of the United States military armed services and that information is disclosed to *us* on the *covered person's* application for insurance with *us*;
- F. An act of declared or undeclared war. This exclusion does not apply when the *covered person* is a member of the United States military armed services and that information is disclosed to *us* on the *covered person's* application for insurance with *us*;
- G. Participating in a riot, rebellion or insurrection. Participating means *you* are taking an active part in common with others. Riot means any use or threat to use force or violence by three or more persons without authority of law;
- H. Bodily or mental infirmity, or related surgery or medical treatment or any infection, unless direct result of *injury*, or unless resulting from accidental ingestion of a contaminated substance;
- I. *Injury* or *illness* arising from any occupation or employment;
- J. Participating in hazardous activities including but not limited to: auto or motorcycle racing; hang gliding; bungee jumping; rock climbing; skydiving and any extreme sports; or

- K. Driving while legally intoxicated from alcohol, or driving while under the influence of drugs unless taken as prescribed by a doctor.

This rider will not change, waive, or extend any part of the *policy* or certificate, other than as stated herein.

This rider is effective at the same time as the *policy* or certificate to which it is attached, unless a later date is shown below.

Golden Rule Insurance Company

A handwritten signature in black ink that reads "Patrick F. Carr". The signature is written in a cursive style with a large initial "P".

President

INSURANCE BENEFITS UNITEDHEALTH CONTINUITY RIDER

By attachment of this Insurance Benefits UnitedHealth Continuity Rider ("rider"), the *policy/certificate* is amended to the extent of any conflict or inconsistency with the following:

DEFINITIONS:

In addition to the definitions in the *policy/certificate*, the following definitions apply to this rider:

- "Active", under this rider, means eligible for *insurance benefits*.
- "Covered spouse" means your spouse who is a *covered person* under the *policy/certificate*.
- "UnitedHealth continuity rider premium" means the amount *you* must pay to keep this rider in force and maintain the benefits of this rider.
- "Dormant", under this rider means ineligible for *insurance benefits*.
- "Employer-sponsored medical coverage" means any employer-sponsored medical insurance or HMO coverage.
- "Insurance benefits" means the right to receive reimbursement for *covered expenses*, according to the terms of the *policy/certificate*.
- "Insurance benefits premium" means premium for the *policy/certificate*, excluding the *UnitedHealth continuity rider premium*.
- "Involuntary terminates" means ceases for reason other than *voluntary termination*.
- "Policy active status" means the period of time that at least one (1) *covered person* is *active*.
- "Policy effective date" means the earliest date an individual becomes a *covered person* under the *policy/certificate*.
- "Satisfactory proof of employer coverage" means written documentation that clearly shows the person is currently, or will soon be, covered by *employer-sponsored medical coverage*.
- "Total premium" means the combined *insurance benefits premium* and *UnitedHealth continuity rider premium*.
- "Voluntary termination" or "voluntarily terminates" means *employer-sponsored medical coverage* ceases for any *covered person*: (a) because *you* or *your spouse* requests termination of the coverage, not including termination of the coverage of employment; or (b) due to failure to pay required premium when due.

BENEFITS OF THIS RIDER:

The benefit of this rider is to enable a *covered person* to be *active* or *dormant* under the terms of the *policy/certificate*. A *covered person's* status depends on whether that person has *employer-sponsored medical coverage* and the terms of this rider.

If *employer-sponsored medical coverage* *involuntarily terminates*, the benefits of this rider continue.

If *employer-sponsored medical coverage* (other than COBRA coverage) for any *covered person*:

- A. *Voluntarily terminates*; and
- B. Is not replaced with other *employer-sponsored medical coverage* within 62 days;

then the benefits of this rider will be exhausted and no longer available for all *covered persons*. *UnitedHealth continuity rider premium* will no longer be required.

INSURANCE BENEFITS STATUS FOR COVERED PERSONS:

Before the *policy effective date*, *you* must declare in writing whether each *covered person* will begin *active* or *dormant*. A *covered person* may only begin in a *dormant* state if that *covered person* has *employer-sponsored medical coverage* on the *policy effective date*. One *covered person* may be *active* under this rider while another *covered person* is *dormant* under this rider.

WHEN A COVERED PERSON IS ACTIVE UNDER THIS RIDER:

- A. You are required to pay the *total premium* for all *covered persons* while *active*.
- B. When a *covered person* is *active*, that *covered person* will have the right to receive reimbursement for *covered expenses* according to the terms of the *policy/certificate*.

DEACTIVATION OF INSURANCE BENEFITS:

- A. You may request that we make a *covered person dormant* by providing us with *satisfactory proof of employer coverage* for that person. Upon receipt of such proof, that person will be *dormant* on the later of:
 - 1. The date that person is eligible to receive benefits under *employer-sponsored medical coverage*; or
 - 2. The date we receive the written request to make the person *dormant*.
- B. Each time a *covered person* is made *dormant*, we will provide written notice indicating that *insurance benefits* are not available.

WHEN A COVERED PERSON IS DORMANT UNDER THIS RIDER:

- A. You are required to pay the *UnitedHealth continuity rider premium* for all *covered persons* who are *dormant*.
- B. When a *covered person* is *dormant*, that *covered person* will not have the right to receive reimbursement for *covered expenses* according to the terms of the *policy/certificate*.
- C. In order to remain *dormant*, a *covered person* must be covered under *employer-sponsored medical coverage*. If *employer-sponsored medical coverage* terminates, see "Activation of Insurance Benefits" below.
- D. If you or your *covered spouse voluntarily terminates employer-sponsored medical coverage* for any *covered person(s)*, also see "Benefits of This Rider", page 1 of this rider.

ACTIVATION OF INSURANCE BENEFITS:

- A. If *employer-sponsored medical coverage* terminates for any *covered person*, that person will immediately be *active* under this rider.
 - 1. You have an obligation to provide us with written notice and pay the required premium within 62 days after a *covered person* becomes *active*; and
 - 2. If you do not pay the required premium within the 62 days, coverage for that person will lapse. We will refund all premiums for that person back to the date coverage lapsed.
- B. Each time a *covered person* becomes *active*, you have 120 days to provide us with written evidence that shows that the person has been covered by *employer-sponsored medical coverage*, with no lapse greater than 63 days, since the date the person was most recently made *dormant*. This evidence may include certificates of creditable coverage or other documents from the person's employers or insurers.
- C. If, within this 120 day period, you do not provide us with proof of coverage as explained in B. above, we will refund *UnitedHealth continuity rider premium* less any claims paid during the 120 day period and coverage will lapse for the affected person back to the date the person became *dormant*.

PREMIUMS:

You may keep the *policy/certificate* in force by timely payment of the *total premium* for *covered persons* who are *active* and the *UnitedHealth continuity rider premium* for *covered persons* who are *dormant*. If the benefits of this rider have been exhausted, you will only have to pay the *insurance benefits premium*.

- A. The *UnitedHealth continuity rider premium* will be a minimum dollar amount or percentage of each *covered person's insurance benefits premium*, whichever is greater. These minimum dollar and percentage amounts are set forth in the Data Page.
- B. The percentage will vary depending on whether each *covered person* is *active* or *dormant* as reflected in the Data Page.

- C. Any time there is an increase in *insurance benefits premium*, we will send you written notification, so you are informed of what the *total premium* will be when *active* and what the *UnitedHealth continuity rider premium* will be when *dormant*. The *insurance benefits premium* will increase even when *covered persons* are *dormant*.
- D. As long as the *policy/certificate* starts in *policy active status* and remains in *policy active status* for at least 12 months, the *UnitedHealth continuity rider premium* for that *covered person* will be reduced as set forth in the Data Page.

NEWBORNS:

- A. A child born to a *covered person* will be covered under the *policy/certificate* from the time of birth until the 31st day after that child's birth.
- B. Additional *total premium* or *UnitedHealth continuity rider premium* will be required to continue coverage beyond the 31st day after the birth of the child and will be calculated from the child's date of birth. Coverage of the child will terminate on the 31st day after his/her birth, unless we have received written notice of the child's birth and the required *total premium* or *UnitedHealth continuity rider premium* within 90 days of the child's birth.
- C. Once we are notified of the child's birth, we will inform the *covered person* of the required *total premium* amount and *UnitedHealth continuity rider premium* amount for the child. If the *covered person* elects to have the child's coverage be *active* under this rider, the *covered person* should pay the *total premium* amount. If the *covered person* elects to have the child's coverage be *dormant* under this rider, the *covered person* should pay the *UnitedHealth continuity rider premium* and provide us with *satisfactory proof of employer coverage* for the child.

ADDING OTHER DEPENDENTS:

If a *dependent* is added as insured under the terms of the *policy/certificate*, you must declare in writing whether the added *dependent* will be *active* or *dormant* under this rider. You must provide *satisfactory proof of employer coverage* for the added *dependent* to be *dormant*.

CHANGES TO YOUR DEDUCTIBLE:

- A. You may make a written request to change the *deductible amount* to an amount currently available at the time regardless of whether the *covered persons* are *active* or *dormant*.
- B. A written request to decrease the *deductible amount* will require *satisfactory proof of good health*.
- C. Any change in the *deductible amount* will become effective as of the next premium due date after we receive and, if required, approve the request. The *total premium* and *UnitedHealth continuity rider premium* will then be adjusted to reflect this change.

REINSTATEMENT:

A *covered person* must provide *satisfactory proof of employer coverage* for a *covered person* to be *dormant* upon reinstatement. If we approve reinstatement of coverage and include this rider, we will confirm the *active* or *dormant* status for each *covered person*.

12-MONTH EXCLUSION:

The 12-month exclusion period for expenses due to a *preexisting condition* or natural progression of a *preexisting condition* will be satisfied twelve (12) months after a *covered person's policy effective date*, even if a *covered person* is *dormant* during that 12-month period.

DISCONTINUANCE:

If a *covered person* is *dormant* at the time we notify you that:

- A. We are going to discontinue offering or refuse to renew this *policy/certificate* in your state; and
- B. We will not be offering a new *policy/certificate* with benefits similar to those under the *policy/certificate*, we will stop collecting the *UnitedHealth continuity rider premium* and refund any *UnitedHealth continuity rider premium* you have paid in the prior 36 months.

BENEFITS AFTER COVERAGE TERMINATES:

Benefits for *covered expenses* incurred after an individual ceases to be a *covered person* under the *policy* are provided for certain *illnesses* and *injuries* only if that *covered person* is *active* at the time of termination.

EFFECT ON DECREASING TERM LIFE RIDER/ACCIDENTAL DEATH:

A *covered person* is never *dormant* with regard to insurance under a decreasing term life rider/accidental death rider. Therefore, premium required to maintain the decreasing term life rider/accidental death rider is not affected by the Insurance Benefits UnitedHealth Continuity Rider.

EFFECT ON BENEFITS AVAILABLE UNDER OPTIONAL PREGNANCY EXPENSE BENEFITS RIDER (“Pregnancy Rider”):

- A. Benefits for *covered expenses* under the optional *Pregnancy Rider*, if any, will be available for a *covered person* who is *active* under this rider.
- B. If a female *covered person* is *dormant* and under a *Pregnancy Rider* with us, the female *covered person* will be *dormant* with respect to the *Pregnancy Rider*. If you want the female *covered person* to have the right to receive reimbursement for *covered expenses* under the *Pregnancy Rider* despite her *dormant* status for the base coverage, you must notify us in writing and pay the required premium. We will advise you of this option when a female *covered person* becomes *dormant*.
- C. Only the months that a *covered person* is *active* and insured under a *Pregnancy Rider* will be counted to satisfy a benefit year, as defined in the *Optional Pregnancy Rider*.

EFFECT ON PRESCRIPTION DRUG DISCOUNT CARD:

Discounts on prescription drug expenses available through use of any prescription drug discount card provided as a non-insurance benefit will be available only if a *covered person* is *active*.

TERMINATION OF UNITEDHEALTH CONTINUITY RIDER:

This rider will terminate if:

- A. You give us 10 days advance written notice that you wish to terminate it; or
- B. You fail to pay the *UnitedHealth continuity rider premium* within 30 days after it is due.

If this rider is terminated for any reason:

- A. It cannot be added back at any later date;
- B. *UnitedHealth continuity rider premium* will no longer be required; and
- C. You will be responsible to continue payment of the *insurance benefits premium* under the *policy* for any *covered person* who is *active* under this rider.

Except as specifically stated in this endorsement, the provisions in this endorsement are subject to all of the terms, conditions, exclusions, and limitations of the *policy/certificate*.

The rider will not change, waive or extend any part of the *policy/certificate*, other than as stated herein.

This rider is effective on the same day as the *policy/certificate*.

Golden Rule Insurance Company



President

OHIO APPEAL PROCEDURES RIDER

This rider is effective on DATE or at the same time as the *policy/certificate*, whichever is later.

By the attachment of this rider, the *policy/certificate* is amended to include the following:

OHIO APPEAL PROCEDURES

- A. **APPLICABILITY:** These procedures apply only to the medical benefits under the *policy/certificate*. They do not apply to benefits under the optional vision, term life, or accidental death riders, if attached to the *policy/certificate*.
- B. **DEFINITIONS:** As used in this rider, the following terms have the meanings indicated:
1. "*Adverse benefit determination*" means a decision by us:
 - (a) To deny, reduce, or terminate a requested *health care service* or payment, in whole or in part, including all of the following:
 - (i) A determination that the *health care service* does not meet the *health plan issuer's* requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, including *experimental or investigational treatments*.
 - (ii) A determination of an individual's eligibility for individual health insurance coverage, including coverage offered to individuals through a non-employer group, to participate in a plan or health insurance coverage.
 - (iii) A determination that a *health care service* is not a *covered benefit*.
 - (iv) The imposition of an exclusion, including exclusions for preexisting conditions, source of *injury, network*, or any other limitation on benefits that would otherwise be covered.
 - (b) Not to issue individual health insurance coverage to an applicant, including coverage offered to individuals through a nonemployer group.
 - (c) To rescind coverage on a health benefit plan.
 2. "*Authorized representative*" means an individual who represents a *covered person* in an internal appeal or external review process of an *adverse benefit determination* and who is any of the following:
 - (a) A person to whom a *covered person* has given express, written consent to represent that individual in an internal appeals process or external review process of an *adverse benefit determination*.
 - (b) A person authorized by law to provide substituted consent for a *covered person*.
 - (c) A family member or a treating health care professional, but only when the *covered person* is unable to provide consent.
 3. "*Covered person*" means a policyholder, subscriber, enrollee, member, or individual covered by a *health benefit plan*. This includes a person who has applied for insurance and who was declined or rescinded. *Covered person* does include the *covered person's authorized representative* with regard to an internal appeal or external review.
 4. "*Covered benefits*" or "*benefits*" means those *health care services* to which a *covered person* is entitled under the terms of a *health benefit plan*.
 5. "*Emergency medical condition*" means a medical condition that manifests itself by such acute symptoms of sufficient severity, including severe pain, that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:
 - (a) Placing the health of the *covered person* or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.
 - (b) Serious impairment to bodily functions.

- (c) Serious dysfunction of any bodily organ or part.
6. "Emergency services" means the following:
- (a) A medical screening examination, as required by federal law, that is within the capability of the emergency department of a *hospital*, including ancillary services routinely available to the emergency department, to evaluate an *emergency medical condition*.
 - (b) Such further medical examination and treatment that are required by federal law to *stabilize* an *emergency medical condition* and are within the capabilities of the staff and facilities available at the *hospital*, including any trauma and burn center of the *hospital*.
7. "Final adverse benefit determination" means an *adverse benefit determination* that is upheld or modified at the completion of a *health plan issuer's* internal appeals process.
8. "Health benefit plan" means a policy, contract, certificate, or agreement offered by a *health plan issuer* to provide, deliver, arrange for, pay for, or reimburse any of the costs of *health care services*.
9. "Health care services" means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.
10. "Health plan issuer" means an entity subject to the insurance laws and rules of this state, or subject to the jurisdiction of the *superintendent* of insurance, that contracts, or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of *health care services* under a *health benefit plan*, including a sickness and accident insurance company, a health insuring corporation, a fraternal benefit society, a self-funded multiple employer welfare arrangement, or a nonfederal, government health plan. *Health plan issuer* includes a third party administrator to the extent that the *benefits* that such an entity is contracted to administer under a *health benefit plan* are subject to the insurance laws and rules of this state or subject to the jurisdiction of the *superintendent*.
11. "Independent review organization" or "IRO" means an entity that is accredited by a nationally recognized private accrediting organization to conduct independent external reviews of *adverse benefit determinations*.
12. "Notification involving urgent care" means any request which meets any of the following conditions:
- (a) The time periods for making non-urgent care review recommendations:
 - (i) Could seriously jeopardize the life or health of the *covered person* or the ability of the *covered person* to regain maximum function; or
 - (ii) In the opinion of a *physician* with knowledge of the *covered person's* medical condition, would subject the *covered person* to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.
 - (b) Other than above, the decision as to whether a condition involves urgent care is to be determined by the attending provider, and we must defer to such determination.
13. "Pre-service claim" means any claim for *benefits* for medical care or treatment that requires *our* approval in advance of the *covered person* obtaining the medical care.
14. "Post-service claim" means any claim for *benefits* for medical care or treatment that is not a *pre-service claim*.
15. "Rescission" (or "to rescind") means a cancellation or discontinuance of coverage that has a retroactive effect. *Rescission* does not include a cancellation or discontinuance of coverage that has only a prospective effect or a cancellation or discontinuance of coverage that is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.
16. "Stabilize" means the provision of such medical treatment as may be necessary to assure, within reasonable medical probability, that no material deterioration of an individual's medical condition is likely to result from or occur during a transfer, if the medical condition could result in any of the following:
- (a) Placing the health of the individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;

- (i) Serious impairment to bodily functions;
- (ii) Serious dysfunction of any bodily organ or part.
- (b) In the case of a woman having contractions, *stabilize* means such medical treatment as may be necessary to deliver, including the placenta.

17. "*Superintendent*" means the superintendent of insurance.

C. INTERNAL APPEALS

1. Eligibility

- (a) Regardless of the cost of the requested *health care service* related to the *adverse benefit determination*, an *adverse benefit determination* shall be eligible for internal appeal.
- (b) The *covered person* or their *authorized representative* has 180 days following receipt of an initial notification of an *adverse benefit determination* to file for an internal appeal.

2. Internal Appeals Process

- (a) The *covered person* has the right to:
 - (i) Submit written comments, documents, records, and other information relating to the claim for *benefits*.
 - (ii) Review the claim file and to present evidence and testimony as part of the internal review process.
 - (iii) Request reasonable access to, and copies of, all documents, records, and other information relevant to the claim for *benefits* free of charge.
- (b) All comments, documents, records and other information submitted by the *covered person* relating to the claim for *benefits*, regardless of whether such information was submitted or considered in the initial benefit determination, will be considered in the internal appeal.
- (c) The *covered person* will receive from the *health plan issuer*, as soon as possible, any new or additional evidence considered by the reviewer. The reviewer will give the *covered person* **10 calendar days** to respond to the new information before making a determination, unless the state turnaround time for response is due in less than 10 days. If the state turnaround time is less than 10 days, the *covered person* will have the option of delaying the determination for a reasonable period of time to respond to the new information.
 - (i) The *covered person* will receive from the *health plan issuer*, any new or additional evidence considered by the reviewer 10 calendar days in advance of the *health plan issuer's* response in order to give the *covered person* time to respond;
 - (ii) The *covered person* will receive from the *health plan issuer* any new or additional medical rationale used to make the decision 10 calendar days in advance of the date of the response so that the *covered person* can have time to respond.
- (d) Review of the internal appeal will be conducted by an individual selected by *us* who is not the individual who made the initial *adverse benefit determination* and is not the subordinate of the original reviewer.
- (e) If the *adverse benefit determination* is based in whole or in part on a medical judgment, *we* will consult with a health care professional who has appropriate expertise in the field of medicine involved in the medical issue and who was not consulted in connection with the original *adverse benefit determination* to review the internal appeal.
- (f) If the *adverse benefit determination* is not based in whole or in part on a medical judgment, it will be reviewed by an impartial person who was not involved in making the original *adverse benefit determination*.
- (g) If the internal appeal concerns a *rescission* action, a panel of individuals who were not involved in the original *adverse benefit determination* will review the appeal.
- (h) Ongoing treatment or a request for an extension of ongoing treatment cannot be reduced or terminated without the *health plan issuer* providing advance notice and an opportunity for

advance review to the *covered person*. The *health plan issuer* is required to provide continued coverage pending the outcome of an internal appeal. A person may request an internal appeal and external review be conducted simultaneously for an ongoing course of treatment involving urgent care.

(i) Resolution Timeframes

- (i) Post-service appeals: We will notify the *covered person* in writing with the appeal decision within **60 days** after receipt of the *covered person's* request for internal appeal, unless we determine that special circumstances require an extension of time for processing the review. If so, we will give the *covered person* notice prior to the close of the initial 60-day period noting the special circumstances and the date by which we expect to render the decision.
- (ii) Pre-service appeals: We will notify the *covered person* in writing with the appeal decision within **30 days** after receipt of the *covered person's* request for internal appeal.
- (iii) Urgent care appeals: We will notify the *covered person* within **72 hours** of request for internal appeal.

These timeframes may be stopped if we are waiting on additional information from the *covered person*.

3. Written Response

We will provide the *final adverse benefit determination* in writing with the following:

- (a) The specific reason or reasons for the *adverse benefit determination*.
- (b) Reference to the specific plan provision on which the determination is based.
- (c) A description of any additional material or information necessary for the *covered person* to perfect the claim and an explanation of why such material or information is necessary.
- (d) The right to request, and a description of, both the standard and expedited external review procedures, including:
 - (i) Information regarding how to initiate an external review, highlighting provisions that give the *covered person* the opportunity to submit additional information; and
 - (ii) Information that the *covered person* may have a right to bring a civil action under state or federal law.
- (e) The specific rule, guideline, protocol, or other similar criterion, if used to make the determination, or that it will be provided free of charge upon request.
- (f) The medical judgment applying the terms of the plan to the *covered person's* medical circumstances, or a statement that such explanation will be provided free of charge upon request.
- (g) The date of service.
- (h) The health care provider's name.
- (i) The claim amount.
- (j) The diagnosis and procedure codes with their corresponding meanings, or an explanation that the diagnosis and/or procedure codes are available upon request.
- (k) Our denial code with corresponding meaning.
- (l) A description of any standard used, if any, in denying the claim.
- (m) That assistance is available by contacting: your state's consumer assistance dept (details in section D.6. If You Have Questions About Your Rights or Need Assistance).
- (n) A culturally linguistic statement based upon the *covered person's* county or state of residence that provides for oral translation of the *adverse benefit determination*.

- (o) Any forms used to process an external review, including a copy of the form that authorizes *us* and the *covered person's* treating health care provider to disclose protected health information, including medical records, concerning the *covered person* that are related in any manner to the external review.
- (p) Statements informing the *covered person*:
 - (i) A written request for an external review must be submitted to *us* within 180 days after the date of the notice of *final adverse benefit determination*.
 - (ii) If the *covered person's* treating physician certifies that the *covered person* has a medical condition for which the time frame for completion of a standard external review would seriously jeopardize the life or health of the *covered person* or would jeopardize the *covered person's* ability to regain maximum function, the *covered person* may file a request for an expedited external review.
 - (iii) If the *final adverse benefit determination* concerns a *health care service* for which the *covered person* received *emergency services*, but has not been discharged from a facility, the *covered person* may request an expedited external review.
 - (iv) If the *final adverse benefit determination* concerns denial of coverage based on a determination that the recommended or requested *health care service* or treatment is experimental or investigational, the *covered person* may file a request for an external review to be conducted, or if the *covered person's* treating physician certifies that the recommended or requested *health care service* that is the subject of the request would be significantly less effective if not promptly initiated, the *covered person* may request an expedited external review to be conducted.
- (q) The following statement:

If your claim has been denied on the basis that the service is not medically necessary, or you have been diagnosed with a terminal condition and the service has been denied on the basis that it is experimental or investigational, you may have a right to request an independent review by an outside medical practitioner. Submit your request in writing to Grievance Administrator, 7440 Woodland Drive, Indianapolis, IN 46278-1719.

If your claim has been denied on the basis that it is not a covered service, you have the right to file a complaint with the Ohio Department of Insurance, ATTN: Consumer Affairs, 50 West Town Street, Suite 300, Columbus, Ohio 43215 (614)-644-2673, toll free in Ohio (800) 686-1526.

Complaints may also be filed via the internet at <http://insurance.ohio.gov>.

D. UNDERSTANDING THE EXTERNAL REVIEW PROCESS

Under Chapter 3922 of the Ohio Revised Code, all *health plan issuers* must provide a process that allows a person covered under a *health benefit plan* or a person applying for *health benefit plan* coverage to request an independent external review of an *adverse benefit determination*. This is a summary of that external review process. An *adverse benefit determination* is a decision by *us* to deny *benefits* because services are not covered, are excluded, or limited under the plan, or the *covered person* is not eligible to receive the benefit.

The *adverse benefit determination* may involve an issue of medical necessity, appropriateness, health care setting, or level of care or effectiveness. An *adverse benefit determination* can also be a decision to deny *health benefit plan* coverage or to *rescind* coverage.

1. Opportunity for External Review

An external review may be conducted by an *Independent Review Organization (IRO)* or by the Ohio Department of Insurance. The *covered person* does not pay for the external review. There is no minimum cost of *health care services* denied in order to qualify for an external review.

The *covered person* must generally *exhaust* the *health plan issuer's* internal appeal process before seeking an external review. "*Exhaust*" means that the *covered person* may not request an external review until after we issue a decision on the internal appeal. However, the internal appeal process

will be considered exhausted and the *covered person* may request an external review if any of the following occur:

- (i) *We* agree to waive the exhaustion requirement;
 - (ii) The *covered person* has requested an internal appeal and has not received a written decision from *us* within the required timeframe; or
 - (iii) *We* fail to adhere to all requirements of the internal appeals process.
- (a) External Review by an IRO: A *covered person* is entitled to an external review by an *IRO* in the following instances:
- (i) The *adverse benefit determination* involves a medical judgment or is based on any medical information.
 - (ii) The *adverse benefit determination* indicates the requested service is experimental or investigational, the requested *health care service* is not explicitly excluded in the *covered person's health benefit plan*, and the treating physician certifies at least one of the following:
 - (a) Standard *health care services* have not been effective in improving the condition of the *covered person*;
 - (b) Standard *health care services* are not medically appropriate for the *covered person*; or
 - (c) No available standard *health care service* covered by *us* is more beneficial than the requested *health care service*.

There are two types of *IRO* reviews, standard and expedited. A standard review is normally completed within 30 days. An expedited review for urgent medical situations is normally completed within 72 hours and can be requested if any of the following applies:

- (i) The *covered person's* treating physician certifies that the *adverse benefit determination* involves a medical condition that could seriously jeopardize the life or health of the *covered person* or would jeopardize the *covered person's* ability to regain maximum function if treatment is delayed until after the time frame of an expedited internal appeal;
- (ii) The *covered person's* treating physician certifies that the *final adverse benefit determination* involves a medical condition that could seriously jeopardize the life or health of the *covered person* or would jeopardize the *covered person's* ability to regain maximum function if treatment is delayed until after the time from of a standard external review;
- (iii) The *final adverse benefit determination* concerns an admission, availability of care, continued stay, or *health care service* for which the *covered person* received *emergency services*, but has not yet been discharged from a facility; or
- (iv) An expedited internal appeal is already in progress for an *adverse benefit determination* of experimental or investigational treatment and the *covered person's* treating physician certifies in writing that the recommended *health care service* or treatment would be significantly less effective if not promptly initiated.

NOTE: An expedited external review is not available for retrospective *final adverse benefit determinations* (meaning the *health care service* has already been provided to the *covered person*).

- (b) External Review by the Ohio Department of Insurance: A *covered person* is entitled to an external review by the Department in the either of the following instances:
- (i) The *adverse benefit determination* is based on a contractual issue that does not involve a medical judgment or medical information; or
 - (ii) The *adverse benefit determination* for an *emergency medical condition* indicates that medical condition did not meet the definition of *emergency* and *our* decision has already been upheld through an external review by an *IRO*.

2. Request for External Review

Regardless of whether the external review case is to be reviewed by an *IRO* or the Department of Insurance, the *covered person*, or an *authorized representative*, must request an external review through *us* within 180 days of the date of the notice of *final adverse benefit determination* issued by *us*.

All requests must be in writing, except for a request for an expedited external review. Expedited external reviews may be requested electronically or orally; however, written confirmation of the request must be submitted to *us* no later than five (5) days after the initial request. The *covered person* will be required to consent to the release of applicable medical records and sign a medical records release authorization.

If the request is complete, *we* will initiate the external review and notify the *covered person* in writing, or immediately in the case of an expedited review, that the request is complete and eligible for external review. The notice will include the name and contact information for the assigned *IRO* or the Ohio Department of Insurance (as applicable) for the purpose of submitting additional information. When a standard review is requested, the notice will inform the *covered person* that, within 10 business days after receipt of the notice, they may submit additional information in writing to the *IRO* or the Ohio Department of Insurance (as applicable) for consideration in the review. *We* will also forward all documents and information used to make the *adverse benefit determination* to the assigned *IRO* or the Ohio Department of Insurance (as applicable).

If the request is not complete, *we* will inform the *covered person* in writing and specify what information is needed to make the request complete. If *we* determine that the *adverse benefit determination* is not eligible for external review, *we* must notify the *covered person* in writing and provide the *covered person* with the reason for the denial and inform the *covered person* that the denial may be appealed to the Ohio Department of Insurance.

The Ohio Department of Insurance may determine the request is eligible for external review regardless of the decision by *us* and require that the request be referred for external review. The Department's decision will be made in accordance with the terms of the *health benefit plan* and all applicable provisions of the law.

3. *IRO* Assignment

When *we* initiate an external review by an *IRO*, the Ohio Department of Insurance web based system randomly assigns the review to an accredited *IRO* that is qualified to conduct the review based on the type of *health care service*. An *IRO* that has a conflict of interest with *us*, the *covered person*, the health care provider or the health care facility will not be selected to conduct the review.

4. *IRO* Review and Decision

The *IRO* must consider all documents and information considered by *us* in making the *adverse benefit determination*, any information submitted by the *covered person* and other information such as: the *covered person's* medical records, the attending health care professional's recommendation, consulting reports from appropriate health care professionals, the terms of coverage under the *health benefit plan*, the most appropriate practice guidelines, clinical review criteria used by *us* or *our* utilization review organization, and the opinions of the *IRO's* clinical reviewers.

The *IRO* will provide a written notice of its decision within 30 days of our receipt of a request for a standard review or within 72 hours of receipt by *us* of a request for an expedited review. This notice will be sent to the *covered person*, *us* and the Ohio Department of Insurance and must include the following information:

- (i) A general description of the reason for the request for external review;
- (ii) The date the *independent review organization* was assigned by the Ohio Department of Insurance to conduct the external review;
- (iii) The dates over which the external review was conducted;
- (iv) The date on which the *independent review organization's* decision was made;
- (v) The rationale for its decision; and

- (vi) References to the evidence or documentation, including any evidence based standards, which was used or considered in reaching its decision.

NOTE: Written decisions of an *IRO* concerning an *adverse benefit determination* that involves a health care treatment or service that is stated to be experimental or investigational also includes the principle reason(s) for the *IRO*'s decision and the written opinion of each clinical reviewer including their recommendation and their rationale for the recommendation.

5. Binding Nature of External Review Decision

An external review decision is binding on *us* except to the extent *we* have other remedies available under state law. The decision is also binding on the *covered person* except to the extent the *covered person* has other remedies available under applicable state or federal law.

A *covered person* may not file a subsequent request for an external review involving the same *adverse benefit determination* that was previously reviewed unless new medical or scientific evidence is submitted to *us*.

6. If You Have Questions About Your Rights or Need Assistance

You may contact *us*:

Grievance Administrator
7440 Woodland Drive
Indianapolis, IN 46278-1719
(800) 657-8205
(317) 715-7648 (fax)

You may also contact the Ohio Department of Insurance:

Ohio Department of Insurance
ATTN: Consumer Affairs
50 West Town Street, Suite 300
Columbus, OH 43215
(800) 686-1526 or (614) 644-2673
(614) 644-3744 (fax)
(614) 644-3745 (TDD)

Contact ODI Consumer Affairs:

<https://secured.insurance.ohio.gov/ConsumServ/ConServComments.asp>

File a Consumer Complaint:

<http://insurance.ohio.gov/Consumer/OCS/Pages/ConsCompl.aspx>

This rider applies only to *covered persons* who reside in the state of Ohio.

This rider will not change, waive, or extend any part of the *policy/certificate*, other than as stated herein.

Golden Rule Insurance Company



President

TERM LIFE INSURANCE RIDER

By attachment of this rider, the *policy* or certificate is amended as follows:

If a *covered person* dies while insured under this rider, we will pay, subject to the terms and conditions of this rider, to the *covered person's beneficiary* the term life *proceeds* in one lump sum.

DEFINITIONS

As used in this rider:

"*Beneficiary*" means the person designated by the *covered person*, on a form approved by us, to receive any amount of the term life *proceeds* becoming payable under the terms of the *policy* or certificate due to a *covered person's* death.

"*Covered Person*" means the *primary insured* and/or *spouse* who has applied for and been approved under this rider.

"*Due proof of death*" shall mean sufficient information to allow us to determine if *proceeds* are payable and in the form of written documentation such as a certified copy of the death certificate, autopsy report, police/accident reports and other information and proof necessary to establish liability.

"*Proceeds*" means the amount for which a *covered person's* life is insured under this rider at the time of death. The respective term life *proceeds* for each *covered person* under this rider are shown in Section 1.

"*Spouse*" means the person named as *your* spouse in the application or any amendment. This term does not include a spouse who is not a *covered person*.

PREMIUM

The premiums for this rider are shown on the Data Page, Section 1. This premium is to be paid at the same time and in the same manner as the premium for the *policy* or certificate. The premium for this rider will cease when the rider ends. If the type of plan shown on the Data Page of the *policy* or certificate is changed because of an addition or removal of a *covered person* insured by this rider, the premium for this rider will change. The new premium for this rider will be shown in the written notice sent to *you*.

NOTICE OF DEATH

We will pay to the *beneficiary* the term life *proceeds* of this rider upon receipt of *due proof of death*. Written proof of death must be furnished to us within 90 days from the *covered person's* date of death or as soon as reasonably possible.

BENEFICIARY

The *covered person* can name any person, other than the *covered person's* employer, as *beneficiary*. The *covered person* can change the *beneficiary* at any time without the consent of the designated *beneficiary* by notifying us in writing on a form furnished by us. The new designation will be effective when the notice is received by us. If we pay the *proceeds* before we receive the *covered person's* change request, we are released from further liability to the extent of our payment. A new designation of *beneficiary* terminates the interests of the previous *beneficiary*.

If more than one *beneficiary* is designated, but their respective interests are not specified, the *beneficiaries* will share the *proceeds* equally. The interest of a *beneficiary* who dies before the *covered person* will terminate and be shared equally by the *beneficiaries* surviving the *covered person*, unless otherwise provided in the *beneficiary* designation. If the *beneficiary* dies at the same time as the *covered person*, or within 15 days after the date the *covered person* dies, payment will be made by us as if the *covered person* survived the *beneficiary*. If there is not a designated *beneficiary* surviving at the death of the *covered person*, payment will be made in a single sum to the *covered person's* estate; however, at our option, payment may be made to one or more of the following surviving relatives of the *covered person*:

- A. Spouse;
- B. Children, including legally adopted children;
- C. Parents; or

- D. Brothers and sisters.

In the absence of a parent or the appointment of a legal guardian, if any *beneficiary* is:

- A. A minor; or
- B. In our opinion, legally incapable of giving valid receipt for any payment due

we may pay term life *proceeds* in monthly installments to the person or persons who, in *our* opinion, have assumed custody and principal support of the *beneficiary*.

If *proceeds* are not paid within 30 days after *we* received *due proof of death* *we* will pay interest on the *proceeds*. Interest will be paid at the rate of 3% a year from the date *we* receive *due proof of death* until the date the *proceeds* are paid. If the law in the state where the *policy* or certificate is issued requires payment of a greater amount, *we* will pay that amount.

We may, at *our* option, pay an amount of up to \$250 to any person appearing to be entitled to the payment who incurred expense because of the last illness or burial of the *covered person*. Any payment *we* make in good faith fully discharges *us* to the extent of the payment.

TERMINATION OF THIS RIDER

All insurance under this rider will cease on its termination. This rider will terminate on the earlier of:

- A. The date *we* receive a written request from the *covered person* for its termination, or on any later date stated in *your* request;
- B. The date no *covered person* remains insured under this rider; or
- C. The date the *covered person's* coverage under the *policy* or certificate terminates.

We will refund any premium paid and not earned due to termination of this rider. The refund will be based on the number of full months that remain in the premium period.

TERMINATION OF COVERED PERSONS

You will cease to be a *covered person* under this rider at the end of the premium period in which *you* attain 65 years of age.

Your spouse will cease to be a *covered person* under this rider at the end of the premium period in which any of these events occur:

- A. He or she attains 65 years of age; or
- B. *You* become legally divorced, if earlier.

ASSIGNING YOUR RIDER

During *your* life, *you* may assign some or all of *your* rights under this rider to someone else.

A signed copy of the assignment trust must be sent to *our* home office on a form *we* accept. The assignment will go into effect when it is signed, subject to any payments *we* make or other actions *we* take before *we* record it. *We* are not responsible for the validity or effect of any assignment.

MISTAKE OF AGE, SEX OR TOBACCO STATUS

If *your* or *your spouse's* age, sex or tobacco status is misstated in the application, *we* will adjust the *proceeds*. The *proceeds* of this rider will then be those *your* premiums would have bought at the correct age, sex and tobacco status. By age, *we* mean age as of *your* or *your spouse's* last birthday on the *policy's* or certificate's *effective date*.

GENERAL TERMS

This rider is made a part of *your policy* or certificate in consideration of *your* application and payment of the first premium for this rider. The following clauses indicate whether the *policy* or certificate provisions will apply to this rider. The *policy* or certificate provisions will either apply to this rider, not apply to this rider, or apply to this rider as modified below.

- A. **Policy or certificate provisions that do not apply to this rider** - The following *policy* or certificate provisions do not apply to this rider:
 - 1. The Preexisting Conditions Limitations section, and the Reimbursement section; and
 - 2. The Dependent Coverage section, except for the Dependent Eligibility clause and the Adding Other Dependents clause.
- B. **Policy or certificate provisions that apply to this rider with modification** - The following *policy* or certificate provision applies to this rider as modified below:

The Reinstatement clause, as found in Section 8, will apply to this rider. However, death/accidental death occurring between the date the *policy* or certificate lapses and the date the *policy* or certificate is reinstated will not be covered under this rider.
- C. **Policy or certificate provisions that do not apply to this rider** - Other than as stated in (A) or (B) above, all other *policy*/certificate provisions will apply to this rider.

BENEFIT EXCLUSIONS

No *proceeds* are payable if a loss results from:

- A. Suicide or intentionally self-inflicted *injury* or *illness* while sane or insane if committed during the first 24 months of coverage under this rider;
- B. Service in the armed forces of any country, including non-military units supporting such forces;
- C. Any act of war, declared or undeclared, while serving in the armed forces of any country or any auxiliary unit attached thereto; or
- D. Death due to an accident occurring while riding in or on, boarding or alighting from any aircraft as a:
 - 1. Pilot, crewmember, or student pilot; or
 - 2. Flight instructor or examiner

LIFE INSURANCE CONVERSION PRIVILEGE

A *covered person* will be eligible to convert coverage under this rider to an individual policy of life insurance ("*conversion policy*"), made available, without evidence of insurability, under this provision, if:

- A. The *covered person's* coverage under this rider terminates for reasons other than:
 - 1. Termination of the *policy*;
 - 2. Failure to make the required premium payment when due; or
 - 3. The attainment of age 65.
- B. The covered person has been continuously insured under this rider for at least one(1) year immediately prior to the termination.

This privilege is subject to the following additional terms and conditions:

- A. Written application and the first premium payment are submitted as directed on the *conversion policy* application by the later of:
 - 1. 31 days after termination of coverage under this rider; or
 - 2. A later date as required by the statutes or regulations of the state in which the *covered person* resides at that time; but

In no event later than 60 days after the date of termination of coverage under this rider.

- B. The amount of coverage under the *conversion policy* will not exceed the amount of coverage for which the *covered person* is insured under this rider. The terms of coverage under the conversion policy will not be the same as the terms of coverage under this rider.
- C. The *conversion policy* will be a policy offered by a life insurer designated by *us* in the state in which the *covered person* resides.
- D. The premium to be paid for the *conversion policy* by the former *covered person* will depend on:

1. Rates for that *conversion policy* in that state at that time;
 2. The attained age of the *covered person*;
 3. The class of risk to which the *covered person* belongs; and
 4. The form and amount of the *conversion policy* coverage.
- E. Any *conversion policy* issued in accordance with the provisions of this rider:
1. Will become effective the date immediately following termination of coverage under this rider; and
 2. Will be in place of the terminated coverage under this rider.
- F. A *covered person's* insurance under this rider will remain in force during the thirty-one (31) days within which the *covered person* is eligible to exercise the conversion privilege, whether or not there has been an application for conversion. If the *covered person* dies during that period, we will:
1. Pay, as a death benefit, the maximum amount eligible for conversion;
 2. Void any *conversion policy* issued in accordance with this conversion privilege; and
 3. Return any premium paid for that *conversion policy*.
- G. If the life insurer designated by *us* to offer *conversion policies* in the state in which a *covered person* resides ceases to offer conversion policies in that state, no *conversion policies* will be available in that state under this provision.

This rider will not change, waive, or extend any part of the *policy* or certificate, other than as stated herein.

This rider is effective at the same time as the *policy* or certificate to which it is attached, unless a later date is shown below.

Golden Rule Insurance Company



President

ACCIDENTAL DEATH INSURANCE RIDER

By attachment of this rider, the *policy* or certificate is amended as follows:

If a *covered person* suffers an *accidental death* while insured under this rider, we will pay, subject to the terms and conditions of this rider, to the *covered person's beneficiary* the *accidental death proceeds* in one lump sum.

In order to qualify for a benefit:

- A. The death must occur within 180 consecutive days after the accident that caused the death; and
- B. The accident must occur while the *covered person* is covered under this rider.

DEFINITIONS

As used in this rider:

"*Accidental death*" means loss of life resulting directly from:

- A. Injury;
- B. Infection caused by injury, or resulting from accidental ingestion of contaminated substances; or
- C. Drowning.

"*Beneficiary*" means the person designated by the *covered person*, on a form approved by us, to receive any amount of the *accidental death proceeds* becoming payable under the terms of the *policy* or certificate due to a *covered person's* death.

"*Covered Person*" means the *primary insured* and/or *spouse* who has applied for and been approved under this rider.

"*Due proof of death*" shall mean sufficient information to allow us to determine if *accidental death proceeds* are payable and in the form of written documentation such as a certified copy of the death certificate, autopsy report, police/accident reports and other information and proof necessary to establish liability.

"*Proceeds*" means the amount for which a *covered person's* life is insured under this rider at the time of death. The respective *accidental death proceeds* for each *covered person* under this rider are shown in Section 1.

"*Spouse*" means the person named as *your* spouse in the application or any amendment. This term does not include a spouse who is not a *covered person*.

PREMIUM

The premiums for this rider are shown on the Data Page, Section 1. This premium is to be paid at the same time and in the same manner as the premium for the *policy*. The premium for this rider will cease when the rider ends. If the type of plan shown on the Data Page of the *policy* or certificate is changed because of an addition or removal of a *covered person* insured by this rider, the premium for this rider will change. The new premium for this rider will be shown in the written notice sent to *you*.

NOTICE OF DEATH

We will pay to the *beneficiary* the *accidental death proceeds* of this rider upon receipt of *due proof of death*. Written proof of death must be furnished to us within 90 days from the *covered person's* date of death or as soon as reasonably possible.

BENEFICIARY

The *covered person* can name any person, other than the *covered person's* employer, as a *beneficiary*. The *covered person* can change the *beneficiary* at any time without the consent of the designated *beneficiary* by notifying us in writing on a form furnished by us. The new designation will be effective when the notice is received by us. If we pay the *proceeds* before we receive the *covered person's* change request, we are released from further liability to the extent of *our* payment. A new designation of *beneficiary* terminates the interests of the previous *beneficiary*.

If more than one *beneficiary* is designated, but their respective interests are not specified, the *beneficiaries* will share the *proceeds* equally. The interest of a *beneficiary* who dies before the *covered person* will terminate and be shared equally by the *beneficiaries* surviving the *covered person*, unless otherwise provided in the *beneficiary* designation. If the *beneficiary* dies at the same time as the *covered person*, or within 15 days after the date the *covered person* dies, payment will be made by *us* as if the *covered person* survived the *beneficiary*. If there is not a designated *beneficiary* surviving at the death of the *covered person*, payment will be made in a single sum to the *covered person's* estate; however, at our option, payment may be made to one or more of the following surviving relatives of the *covered person*:

- A. Spouse;
- B. Children, including legally adopted children;
- C. Parents; or
- D. Brothers and sisters.

In the absence of a parent or the appointment of a legal guardian, if any *beneficiary* is:

- A. A minor; or
- B. In our opinion, legally incapable of giving valid receipt for any payment due

we may pay *accidental death proceeds* in monthly installments to the person or persons who, in our opinion, have assumed custody and principal support of the *beneficiary*.

If *proceeds* are not paid within 30 days after *we* received *due proof of death* *we* will pay interest on the *proceeds*. Interest will be paid at the rate of 3% a year from the date *we* receive *due proof of death* until the date the *proceeds* are paid. If the law in the state where the *policy* is issued requires payment of a greater amount, *we* will pay that amount.

We rely on an affidavit to determine payment of *proceeds*, unless *we* receive written notice of a valid claim from a person before *we* make the payment. The affidavit releases *us* from further liability.

We may, at *our* option, pay an amount of up to \$250 to any person appearing to be entitled to the payment who incurred expense because of the last illness or burial of the *covered person*. Any payment *we* make in good faith fully discharges *us* to the extent of the payment.

TERMINATION OF THIS RIDER

All insurance under this rider will cease on its termination. This rider will terminate on the earlier of:

- A. The date *we* receive a written request from the *covered person* for its termination, or on any later date stated in *your* request;
- B. The date no *covered person* remains insured under this rider; or
- C. The date the *covered person's* coverage under the *policy* or certificate terminates.

We will refund any premium paid and not earned due to termination of this rider. The refund will be based on the number of full months that remain in the premium period.

TERMINATION OF COVERED PERSONS

You will cease to be a *covered person* under this rider at the end of the premium period in which *you* attain 65 years of age.

Your spouse will cease to be a *covered person* under this rider at the end of the premium period in which any of these events occur:

- A. He or she attains 65 years of age; or
- B. *You* become legally divorced, if earlier.

ASSIGNING YOUR RIDER

During *your* life, *you* may assign some or all of *your* rights under this rider to someone else.

A signed copy of the assignment must be sent to *our* home office on a form *we* accept. The assignment will go into effect when it is signed, subject to any payments *we* make or other actions *we* take before *we* record it. *We* are not responsible for the validity or effect of any assignment.

If there are permanent *beneficiaries*, *you* need their consent before assigning the payment of *proceeds*.

GENERAL TERMS

This rider is made a part of *your policy* or certificate in consideration of *your* application and payment of the first premium for this rider. The following clauses indicate whether the *policy* or certificate provisions will apply to this rider. The *policy* or certificate provisions will either apply to this rider, not apply to this rider, or apply to this rider as modified below.

- A. **Policy or certificate provisions that do not apply to this rider** - The following *policy* or certificate provisions do not apply to this rider:
 - 1. The Preexisting Conditions Limitations section, and the Reimbursement section; and
 - 2. The Dependent Coverage section, except for the Dependent Eligibility clause and the Adding Other Dependents clause.
- B. **Policy or certificate provisions that apply to this rider with modification** - The following *policy* or certificate provision applies to this rider as modified below:

The Reinstatement clause, as found in the Termination section of the *policy* or certificate, will apply to this rider. However, death/accidental death occurring between the date the *policy* or certificate lapses and the date the *policy* or certificate is reinstated will not be covered under this rider.
- C. **Policy or certificate provisions that do not apply to this rider** - Other than as stated in (A) or (B) above, all other *policy*/*certificate* provisions will apply to this rider.

BENEFIT EXCLUSIONS

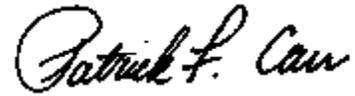
No *proceeds* are payable if a loss results from:

- A. Suicide or intentionally self-inflicted *injury* or *illness* while sane or insane if committed during the first 24 months of coverage under this rider;
- B. Voluntary taking of any sedative or drug, or inhalation of any gas, unless taken or inhaled as *your doctor* prescribes or administers it;
- C. Death due to an accident occurring while riding in or on, boarding or alighting from any aircraft as a:
 - 1. Pilot, crewmember, or student pilot; or
 - 2. Flight instructor or examiner
- D. *Your* committing or attempting to commit a civil or criminal battery or felony;
- E. Service in the armed forces of any country, including non-military units supporting such forces;
- F. Any act of war; declared or undeclared, while serving in the armed forces of any country or any auxiliary unit attached thereto;
- G. Participating in a riot, rebellion or insurrection. Participating means *you* are taking an active part in common with others. Riot means any use or threat to use force or violence by three or more persons without authority of law;
- H. Bodily or mental infirmity, or related surgery or medical treatment or any infection, unless direct result of *injury*, or unless resulting from accidental ingestion of a contaminated substance;
- I. *Injury* or *illness* arising from any occupation or employment;
- J. Participating in hazardous activities including but not limited to: auto or motorcycle racing; hang gliding; bungee jumping; rock climbing; skydiving and any extreme sports; or
- K. Driving while legally intoxicated from alcohol, or driving while under the influence of drugs unless taken as prescribed by a doctor.

This rider will not change, waive, or extend any part of the *policy* or certificate, other than as stated herein.

This rider is effective at the same time as the *policy* or certificate to which it is attached, unless a later date is shown below.

Golden Rule Insurance Company

A handwritten signature in black ink that reads "Patrick F. Carr". The signature is written in a cursive style with a large initial "P".

President

INSURANCE BENEFITS HEALTH CONTINUITY RIDER

By attachment of this Insurance Benefits Health Continuity Rider ("rider"), the *policy/certificate* is amended to the extent of any conflict or inconsistency with the following:

DEFINITIONS:

In addition to the definitions in the *policy/certificate*, the following definitions apply to this rider:

- "*Active*", under this rider, means eligible for *insurance benefits*.
- "*Covered spouse*" means *your spouse* who is a *covered person* under the *policy/certificate*.
- "*Health continuity rider premium*" means the amount *you* must pay to keep this rider in force and maintain the benefits of this rider.
- "*Dormant*", under this rider means ineligible for *insurance benefits*.
- "*Employer-sponsored medical coverage*" means any employer-sponsored medical insurance or HMO coverage.
- "*Insurance benefits*" means the right to receive reimbursement for *covered expenses*, according to the terms of the *policy/certificate*.
- "*Insurance benefits premium*" means premium for the *policy/certificate*, excluding the *health continuity rider premium*.
- "*Involuntary terminates*" means ceases for reason other than *voluntary termination*.
- "*Policy active status*" means the period of time that at least one (1) *covered person* is *active*.
- "*Policy effective date*" means the earliest date an individual becomes a *covered person* under the *policy/certificate*.
- "*Satisfactory proof of employer coverage*" means written documentation that clearly shows the person is currently, or will soon be, covered by *employer-sponsored medical coverage*.
- "*Total premium*" means the combined *insurance benefits premium* and *health continuity rider premium*.
- "*Voluntary termination*" or "*voluntarily terminates*" means *employer-sponsored medical coverage* ceases for any *covered person*: (a) because *you* or *your spouse* requests termination of the coverage; or (b) due to failure to pay required premium when due.

BENEFITS OF THIS RIDER:

The benefit of this rider is to enable a *covered person* to be *active* or *dormant* under the terms of the *policy/certificate*. A *covered person's* status depends on whether that person has *employer-sponsored medical coverage* and the terms of this rider.

If *employer-sponsored medical coverage involuntarily terminates*, the benefits of this rider continue.

If *employer-sponsored medical coverage* (other than COBRA coverage) for any *covered person*:

- A. *Voluntarily terminates*; and
- B. Is not replaced with other *employer-sponsored medical coverage* within 62 days;

then the benefits of this rider will be exhausted and no longer available for all *covered persons*. *Health continuity rider premium* will no longer be required.

INSURANCE BENEFITS STATUS FOR COVERED PERSONS:

Before the *policy effective date*, *you* must declare in writing whether each *covered person* will begin *active* or *dormant*. A *covered person* may only begin in a *dormant* state if that *covered person* has *employer-sponsored medical coverage* on the *policy effective date*. One *covered person* may be *active* under this rider while another *covered person* is *dormant* under this rider.

WHEN A COVERED PERSON IS ACTIVE UNDER THIS RIDER:

- A. *You* are required to pay the total premium for all *covered persons* while *active*.

- B. When a *covered person* is *active*, that *covered person* will have the right to receive reimbursement for *covered expenses* according to the terms of the *policy/certificate*.

DEACTIVATION OF INSURANCE BENEFITS:

- A. You may request that we make a *covered person dormant* by providing us with *satisfactory proof of employer coverage* for that person. Upon receipt of such proof, that person will be *dormant* on the later of:
 - 1. The date that person is eligible to receive benefits under *employer-sponsored medical coverage*; or
 - 2. The date we receive the written request to make the person *dormant*.
- B. Each time a *covered person* is made *dormant*, we will provide written notice indicating that *insurance benefits* are not available.

WHEN A COVERED PERSON IS DORMANT UNDER THIS RIDER:

- A. You are required to pay the *health continuity rider premium* for all *covered persons* who are *dormant*.
- B. When a *covered person* is *dormant*, that *covered person* will not have the right to receive reimbursement for *covered expenses* according to the terms of the *policy/certificate*.
- C. In order to remain *dormant*, a *covered person* must be covered under *employer-sponsored medical coverage*. If *employer-sponsored medical coverage* terminates, see "Activation of Insurance Benefits" below.
- D. If you or your *covered spouse voluntarily terminates employer-sponsored medical coverage* for any *covered person(s)*, also see "Benefits of This Rider", page 1 of this rider.

ACTIVATION OF INSURANCE BENEFITS:

- A. If *employer-sponsored medical coverage* terminates for any *covered person*, that person will immediately be *active* under this rider.
 - 1. You have an obligation to provide us with written notice and pay the required premium within 62 days after a *covered person* becomes *active*; and
 - 2. If you do not pay the required premium within the 62 days, coverage for that person will lapse. We will refund all premiums for that person back to the date coverage lapsed.
- B. Each time a *covered person* becomes *active*, you have 120 days to provide us with written evidence that shows that the person has been covered by *employer-sponsored medical coverage*, with no lapse greater than 63 days, since the date the person was most recently made *dormant*. This evidence may include certificates of creditable coverage or other documents from the person's employers or insurers.
- C. If, within this 120 day period, you do not provide us with proof of coverage as explained in B. above, we will refund *health continuity rider premium* less any claims paid during the 120 day period and coverage will lapse for the affected person back to the date the person became *dormant*.

PREMIUMS:

You may keep the *policy/certificate* in force by timely payment of the *total premium* for *covered persons* who are *active* and the *health continuity rider premium* for *covered persons* who are *dormant*. If the benefits of this rider have been exhausted, you will only have to pay the *insurance benefits premium*.

- A. The *health continuity rider premium* will be a minimum dollar amount or percentage of each *covered person's insurance benefits premium*, whichever is greater. These minimum dollar and percentage amounts are set forth in the Data Page.
- B. The percentage will vary depending on whether each *covered person* is *active* or *dormant* as reflected in the Data Page.
- C. Any time there is an increase in *insurance benefits premium*, we will send you written notification, so you are informed of what the *total premium* will be when *active* and what the *health continuity*

rider premium will be when dormant. The insurance benefits premium will increase even when covered persons are dormant.

- D. As long as the *policy/certificate* starts in *policy active status* and remains in *policy active status* for at least 12 months, the *health continuity rider premium* for that *covered person* will be reduced as set forth in the Data Page.

ADDING DEPENDENTS:

If a *dependent* is added as insured under the terms of the certificate, you must declare in writing whether the added *dependent* will be *active* or *dormant* under this rider. You must provide *satisfactory proof of employer coverage* for the added *dependent* to be *dormant*.

CHANGES TO YOUR DEDUCTIBLE:

- A. You may make a written request to change the *deductible amount* to an amount currently available at the time regardless of whether the *covered persons* are *active* or *dormant*.
- B. A written request to decrease the *deductible amount* will require *satisfactory proof of good health*.
- C. Any change in the *deductible amount* will become effective as of the next premium due date after we receive and, if required, approve the request. The *total premium and health continuity rider premium* will then be adjusted to reflect this change.

REINSTATEMENT:

A *covered person* must provide *satisfactory proof of employer coverage* for a *covered person* to be *dormant* upon reinstatement. If we approve reinstatement of coverage and include this rider, we will confirm the *active* or *dormant* status for each *covered person*.

12-MONTH EXCLUSION:

The 12-month exclusion period for expenses due to a *preexisting condition* or natural progression of a *preexisting condition* will be satisfied twelve (12) months after a *covered person's policy effective date*, even if a *covered person* is *dormant* during that 12-month period.

DISCONTINUANCE:

If a *covered person* is *dormant* at the time we notify you that:

- A. We are going to discontinue offering or refuse to renew this *policy/certificate* in *your state*; and
- B. We will not be offering a new *policy/certificate* with benefits similar to those under the *policy/certificate*, we will stop collecting the *health continuity rider premium* and refund any *health continuity rider premium* you have paid in the prior 36 months.

BENEFITS AFTER COVERAGE TERMINATES:

Benefits for *covered expenses* incurred after an individual ceases to be a *covered person* under the *policy* are provided for certain *illnesses* and *injuries* only if that *covered person* is *active* at the time of termination.

EFFECT ON DECREASING TERM LIFE RIDER/ACCIDENTAL DEATH:

A *covered person* is never *dormant* with regard to insurance under a decreasing term life rider/accidental death rider. Therefore, premium required to maintain the decreasing term life rider/accidental death rider is not affected by the Insurance Benefits Health Continuity Rider.

EFFECT ON BENEFITS AVAILABLE UNDER OPTIONAL PREGNANCY EXPENSE BENEFITS RIDER ("Pregnancy Rider"):

- A. Benefits for *covered expenses* under the optional *Pregnancy Rider*, if any, will be available for a *covered person* who is *active* under this rider.
- B. If a female *covered person* is *dormant* and under a *Pregnancy Rider* with us, the female *covered person* will be *dormant* with respect to the *Pregnancy Rider*. If you want the female *covered person* to have the right to receive reimbursement for *covered expenses* under the *Pregnancy Rider* despite her *dormant* status for the base coverage, you must notify us in writing and pay the required premium. We will advise you of this option when a female *covered person* becomes *dormant*.

- C. Only the months that a *covered person* is *active* and insured under a *Pregnancy Rider* will be counted to satisfy a benefit year, as defined in the *Optional Pregnancy Rider*.

EFFECT ON PRESCRIPTION DRUG DISCOUNT CARD:

Discounts on prescription drug expenses available through use of any prescription drug discount card provided as a non-insurance benefit will be available only if a *covered person* is *active*.

TERMINATION OF HEALTH CONTINUITY RIDER:

This rider will terminate if:

- A. You give us 30 days advance written notice that you wish to terminate it; or
- B. You fail to pay the *health continuity rider premium* within 30 days after it is due.

If this rider is terminated for any reason:

- A. It cannot be added back at any later date;
- B. *Health continuity rider premium* will no longer be required; and
- C. You will be responsible to continue payment of the *insurance benefits premium* under the *policy* for any *covered person* who is *active* under this rider.

Except as specifically stated in this endorsement, the provisions in this endorsement are subject to all of the terms, conditions, exclusions, and limitations of the *policy/certificate*.

The rider will not change, waive or extend any part of the *policy/certificate*, other than as stated herein.

This rider is effective on the same time as the *policy/certificate*.

Golden Rule Insurance Company



President

TERM LIFE INSURANCE RIDER

By attachment of this rider, the *policy* or certificate is amended as follows:

If a *covered person* dies while insured under this rider, we will pay, subject to the terms and conditions of this rider, to the *covered person's beneficiary* the term life *proceeds* in one lump sum.

DEFINITIONS

As used in this rider:

"*Beneficiary*" means the person designated by the *covered person*, on a form approved by us, to receive any amount of the term life *proceeds* becoming payable under the terms of the *policy* or certificate due to a *covered person's* death.

"*Covered Person*" means the *primary insured* and/or *spouse* who has applied for and been approved under this rider.

"*Due proof of death*" shall mean sufficient information to allow us to determine if *proceeds* are payable and in the form of written documentation such as a certified copy of the death certificate, autopsy report, police/accident reports and other information and proof necessary to establish liability.

"*Proceeds*" means the amount for which a *covered person's* life is insured under this rider at the time of death. The respective term life *proceeds* for each *covered person* under this rider are shown in Section 1.

"*Spouse*" means the person named as *your* spouse in the application or any amendment. This term does not include a spouse who is not a *covered person*.

PREMIUM

The premiums for this rider are shown on the Data Page, Section 1. This premium is to be paid at the same time and in the same manner as the premium for the *policy* or certificate. The premium for this rider will cease when the rider ends. If the type of plan shown on the Data Page of the *policy* or certificate is changed because of an addition or removal of a *covered person* insured by this rider, the premium for this rider will change. The new premium for this rider will be shown in the written notice sent to *you*.

NOTICE OF DEATH

We will pay to the *beneficiary* the term life *proceeds* of this rider no later than two months after the receipt of *due proof of death*. Written proof of death must be furnished to us within 90 days from the *covered person's* date of death or as soon as reasonably possible.

BENEFICIARY

The *covered person* can name any person, other than the *covered person's* employer, as *beneficiary*. The *covered person* can change the *beneficiary* at any time without the consent of the designated *beneficiary* by notifying us in writing on a form furnished by us. The new designation will be effective when the notice is received by us. If we pay the *proceeds* before we receive the *covered person's* change request, we are released from further liability to the extent of *our* payment. A new designation of *beneficiary* terminates the interests of the previous *beneficiary*.

If more than one *beneficiary* is designated, but their respective interests are not specified, the *beneficiaries* will share the *proceeds* equally. The interest of a *beneficiary* who dies before the *covered person* will terminate and be shared equally by the *beneficiaries* surviving the *covered person*, unless otherwise provided in the *beneficiary* designation. If the *beneficiary* dies at the same time as the *covered person*, or within 15 days after the date the *covered person* dies, payment will be made by us as if the *covered person* survived the *beneficiary*. If there is not a designated *beneficiary* surviving at the death of the *covered person*, payment will be made in a single sum to the *covered person's* estate; however, at our option, payment may be made to one or more of the following surviving relatives of the *covered person*:

- A. Spouse;
- B. Children, including legally adopted children;
- C. Parents; or

- D. Brothers and sisters.

In the absence of a parent or the appointment of a legal guardian, if any *beneficiary* is:

- A. A minor; or
- B. In our opinion, legally incapable of giving valid receipt for any payment due

we may pay term life *proceeds* in monthly installments to the person or persons who, in *our* opinion, have assumed custody and principal support of the *beneficiary*.

If *proceeds* are not paid within 30 days after *we* received *due proof of death* *we* will pay interest on the *proceeds*. Interest will be paid at the rate of 3% a year from the date *we* receive *due proof of death* until the date the *proceeds* are paid. If the law in the state where the *policy* or certificate is issued requires payment of a greater amount, *we* will pay that amount.

We may, at *our* option, pay an amount of up to \$250 to any person appearing to be entitled to the payment who incurred expense because of the last illness or burial of the *covered person*. Any payment *we* make in good faith fully discharges *us* to the extent of the payment.

TERMINATION OF THIS RIDER

All insurance under this rider will cease on its termination. This rider will terminate on the earlier of:

- A. The date *we* receive a written request from the *covered person* for its termination, or on any later date stated in *your* request;
- B. The date no *covered person* remains insured under this rider; or
- C. The date the *covered person's* coverage under the *policy* or certificate terminates.

We will refund any premium paid and not earned due to termination of this rider. The refund will be based on the number of full months that remain in the premium period.

TERMINATION OF COVERED PERSONS

You will cease to be a *covered person* under this rider at the end of the premium period in which *you* attain 65 years of age.

Your spouse will cease to be a *covered person* under this rider at the end of the premium period in which any of these events occur:

- A. He or she attains 65 years of age; or
- B. *You* become legally divorced, if earlier.

ASSIGNING YOUR RIDER

During *your* life, *you* may assign some or all of *your* rights under this rider to someone else.

A signed copy of the assignment trust must be sent to *our* home office on a form *we* accept. The assignment will go into effect when it is signed, subject to any payments *we* make or other actions *we* take before *we* record it. *We* are not responsible for the validity or effect of any assignment.

MISTAKE OF AGE, SEX OR TOBACCO STATUS

If *your* or *your spouse's* age, sex or tobacco status is misstated in the application, *we* will adjust the *proceeds*. The *proceeds* of this rider will then be those *your* premiums would have bought at the correct age, sex and tobacco status. By age, *we* mean age as of *your* or *your spouse's* last birthday on the *policy's* or certificate's *effective date*.

INCONTESTABILITY

For the purposes of this rider, the following provision applies:

No statement that *you* make which relates to insurability will be used to void the insurance or deny a claim unless:

- A. It is contained in a written instrument signed by *you*; and
- B. A copy of that instrument has been furnished to *you* or *your beneficiary*.

Once a *covered person* has been insured under this rider for two years with no lapse in coverage, the rider cannot be contested except for non-payment of premium.

In the absence of fraud, a statement made by *you* is a representation and not a warranty.

GENERAL TERMS

This rider is made a part of *your policy* or certificate in consideration of *your* application and payment of the first premium for this rider. The following clauses indicate whether the *policy* or certificate provisions will apply to this rider. The *policy* or certificate provisions will either apply to this rider, not apply to this rider, or apply to this rider as modified below.

- A. **Policy or certificate provisions that do not apply to this rider** - The following *policy* or certificate provisions do not apply to this rider:
 - 1. The Preexisting Conditions Limitations section, and the Reimbursement section; and
 - 2. The Dependent Coverage section, except for the Dependent Eligibility clause and the Adding Other Dependents clause.
- B. **Policy or certificate provisions that apply to this rider with modification** - The following *policy* or certificate provision applies to this rider as modified below:

The Reinstatement clause, as found in the Termination section of the *policy* or certificate, will apply to this rider. However, death/accidental death occurring between the date the *policy* or certificate lapses and the date the *policy* or certificate is reinstated will not be covered under this rider.
- C. **Policy or certificate provisions that do not apply to this rider** - Other than as stated in (A) or (B) above, all other *policy*/certificate provisions will apply to this rider.

BENEFIT EXCLUSIONS AND LIMITATIONS

No *proceeds* are payable if a loss results from:

- A. Suicide or intentionally self-inflicted *injury* or *illness* while sane or insane, if committed during the first 24 months of coverage under this rider;
- B. Service in the armed forces of any country, including non-military units supporting such forces;
- C. Death due to an accident occurring while riding in or on, boarding or alighting from any aircraft as a:
 - 1. Pilot, crewmember, or student pilot; or
 - 2. A flight instructor or examiner.

When *proceeds* are not payable due to exclusion A. above, we will refund the *covered person's* premiums paid for this rider.

LIFE INSURANCE CONVERSION PRIVILEGE

A *covered person* will be eligible to convert coverage under this rider to an individual policy of life insurance ("*conversion policy*"), made available, without evidence of insurability, under this provision, if:

- A. The *covered person's* coverage under this rider terminates for reasons other than:
 - 1. Termination of the *policy*; or
 - 2. Failure to make the required premium payment when due; or
 - 3. The attainment of age 65.
- B. The *covered person* has been continuously insured under this rider for at least one (1) year immediately prior to the termination.

This privilege is subject to the following additional terms and conditions:

- A. Written application and the first premium payment are submitted as directed on the *conversion policy* application by the later of:
 - 1. 31 days after termination of coverage under this rider; or

2. A later date as required by the statutes or regulations of the state in which the *covered person* resides at that time; but

In no event later than 60 days after the date of termination of coverage under this rider.

- B. The amount of coverage under the *conversion policy* will not exceed the amount of coverage for which the *covered person* is insured under this rider. The terms of coverage under the conversion policy will not be the same as the terms of coverage under this rider.
- C. The *conversion policy* will be a policy offered by a life insurer designated by *us* in the state in which the *covered person* resides.
- D. The premium to be paid for the *conversion policy* by the former *covered person* will depend on:
 1. Rates for that *conversion policy* in that state at that time;
 2. The attained age of the *covered person*;
 3. The class of risk to which the *covered person* belongs; and
 4. The form and amount of the *conversion policy* coverage.
- E. Any *conversion policy* issued in accordance with the provisions of this rider:
 1. Will become effective the date immediately following termination of coverage under this rider; and
 2. Will be in place of the terminated coverage under this rider.
- F. A *covered person's* insurance under this rider will remain in force during the thirty-one (31) days within which the *covered person* is eligible to exercise the conversion privilege, whether or not there has been an application for conversion. If the *covered person* dies during that period, we will:
 1. Pay, as a death benefit, the maximum amount eligible for conversion;
 2. Void any *conversion policy* issued in accordance with this conversion privilege; and
 3. Return any premium paid for that *conversion policy*.
- G. If the life insurer designated by *us* to offer *conversion policies* in the state in which a *covered person* resides ceases to offer conversion policies in that state, no *conversion policies* will be available in that state under this provision.

This rider will not change, waive, or extend any part of the *policy* or certificate, other than as stated herein.

This rider is effective at the same time as the *policy* or certificate to which it is attached, unless a later date is shown below.

Golden Rule Insurance Company



President

NON-INSURANCE BENEFITS DISCOUNTS DISCLAIMER RIDER

By attachment of this Non-Insurance Benefits Discounts Disclaimer Rider ("rider"), the *policy/certificate* is amended to the extent of any conflict or inconsistency with the following:

GENERAL BENEFITS

From time to time we may arrange for pharmacy benefit managers to provide discounted goods and services through a pharmacy discount program to *you* and *your dependents*. It is *your* choice as to whether or not to receive the discounted goods and/or services. While we have made arrangements for these prescription drug discounts to be made available, the pharmacy benefit managers are liable to *you* and *your dependents* for the provision of such discounted goods and/or services. Access to discounts for these goods and services are provided to *you* and *your dependents* at no additional cost to *you*. These discounted goods and services are not eligible for reimbursement under the *policy/certificate* and payment for any such discounted goods and services will be *your* responsibility. We are not responsible for the provision of such goods, services, and/or discounts nor are we liable for the failure of the provision of the same. Further, we are not liable to *you* and *your dependents* for any negligent provision of such goods, services, and/or discounts by pharmacy benefit managers.

Termination of non-insurance benefits. A non-insurance discount program may be terminated if the pharmacy discount program manager operating the program notifies *us* that they are terminating the program. We will provide *you* at least 30 days notice of the program's termination. While we cannot guarantee replacement of the program, we will attempt to find a replacement program.

Except as specifically stated in this rider, the provisions of this rider are subject to all of the terms, conditions, exclusions, and limitations of the *policy/certificate*.

This rider applies only to *covered persons* who reside in the state of Texas. The rider will not change, waive, or extend any part of the certificate, other than as stated herein.

This rider is effective on August 22, 2008 or at the same time as the certificate, whichever is later.

Golden Rule Insurance Company

A handwritten signature in black ink that reads "Patrick F. Carr". The signature is written in a cursive style with a large initial "P".

President

[TRANSPLANT EXPENSE BENEFITS]

If we determine that a *covered person* is an appropriate candidate for a *listed transplant*, using the criteria stated above, Medical Benefits *covered expenses* will be provided for:

- (A) Pre-transplant evaluation;
- (A) Pre-transplant harvesting;
- (B) Pre-transplant stabilization, meaning an *inpatient* stay to medically stabilize a *covered person* to prepare for a later transplant, whether or not the transplant occurs;
- (C) High dose chemotherapy;
- (D) Peripheral stem cell collection;
- (E) The transplant itself, not including the acquisition cost for the organ or bone marrow; and
- (F) Post transplant follow-up.

MGR03427

TERM LIFE INSURANCE RIDER

By attachment of this rider, the *policy* or certificate is amended as follows:

If a *covered person* dies while insured under this rider, we will pay, subject to the terms and conditions of this rider, to the *covered person's beneficiary* the term life *proceeds* in one lump sum.

DEFINITIONS

As used in this rider:

"*Beneficiary*" means the person designated by the *covered person*, on a form approved by us, to receive any amount of the term life *proceeds* becoming payable under the terms of the *policy* or certificate due to a *covered person's* death.

"*Covered Person*" means the *primary insured* and/or *spouse* who has applied for and been approved under this rider.

"*Due proof of death*" shall mean sufficient information to allow us to determine if *proceeds* are payable and in the form of written documentation such as a certified copy of the death certificate, autopsy report, police/accident reports and other information and proof necessary to establish liability.

"*Proceeds*" means the amount for which a *covered person's* life is insured under this rider at the time of death. The respective term life *proceeds* for each *covered person* under this rider are shown in Section 1.

"*Spouse*" means the person named as *your* spouse in the application or any amendment. This term does not include a spouse who is not a *covered person*.

PREMIUM

The premiums for this rider are shown on the Data Page, Section 1. This premium is to be paid at the same time and in the same manner as the premium for the *policy* or certificate. The premium for this rider will cease when the rider ends. If the type of plan shown on the Data Page of the *policy* or certificate is changed because of an addition or removal of a *covered person* insured by this rider, the premium for this rider will change. The new premium for this rider will be shown in the written notice sent to *you*.

NOTICE OF DEATH

We will pay to the *beneficiary* the term life *proceeds* of this rider upon receipt of *due proof of death*. Written proof of death must be furnished to us within 90 days from the *covered person's* date of death or as soon as reasonably possible.

BENEFICIARY

The *covered person* can name any person, other than the *covered person's* employer, as *beneficiary*. The *covered person* can change the *beneficiary* at any time without the consent of the designated *beneficiary* by notifying us in writing on a form furnished by us. The new designation will be effective when the notice is received by us. If we pay the *proceeds* before we receive the *covered person's* change request, we are released from further liability to the extent of *our* payment. A new designation of *beneficiary* terminates the interests of the previous *beneficiary*.

If more than one *beneficiary* is designated, but their respective interests are not specified, the *beneficiaries* will share the *proceeds* equally. The interest of a *beneficiary* who dies before the *covered person* will terminate and be shared equally by the *beneficiaries* surviving the *covered person*, unless otherwise provided in the *beneficiary* designation. If the *beneficiary* dies at the same time as the *covered person*, or within 15 days after the date the *covered person* dies, payment will be made by us as if the *covered person* survived the *beneficiary*. If there is not a designated *beneficiary* surviving at the death of the *covered person*, payment will be made in a single sum to the *covered person's* estate; however, at our option, payment may be made to one or more of the following surviving relatives of the *covered person*:

- A. Spouse;
- B. Children, including legally adopted children;
- C. Parents; or

- D. Brothers and sisters.

In the absence of a parent or the appointment of a legal guardian, if any *beneficiary* is:

- A. A minor; or
- B. In our opinion, legally incapable of giving valid receipt for any payment due

we may pay term life *proceeds* in monthly installments to the person or persons who, in *our* opinion, have assumed custody and principal support of the *beneficiary*.

If *proceeds* are not paid within 30 days after *we* received *due proof of death* *we* will pay interest on the *proceeds*. Interest will be paid at the rate of 3% a year from the date *we* receive *due proof of death* until the date the *proceeds* are paid. If the law in the state where the *policy* or certificate is issued requires payment of a greater amount, *we* will pay that amount.

We may, at *our* option, pay an amount of up to \$250 to any person appearing to be entitled to the payment who incurred expense because of the last illness or burial of the *covered person*. Any payment *we* make in good faith fully discharges *us* to the extent of the payment.

TERMINATION OF THIS RIDER

All insurance under this rider will cease on its termination. This rider will terminate on the earlier of:

- A. The date *we* receive a written request from the *covered person* for its termination, or on any later date stated in *your* request;
- B. The date no *covered person* remains insured under this rider; or
- C. The date the *covered person's* coverage under the *policy* or certificate terminates.

We will refund any premium paid and not earned due to termination of this rider. The refund will be based on the number of full months that remain in the premium period.

TERMINATION OF COVERED PERSONS

You will cease to be a *covered person* under this rider at the end of the premium period in which *you* attain 65 years of age.

Your spouse will cease to be a *covered person* under this rider at the end of the premium period in which any of these events occur:

- A. He or she attains 65 years of age; or
- B. *You* become legally divorced, if earlier.

ASSIGNING YOUR RIDER

During *your* life, *you* may assign some or all of *your* rights under this rider to someone else.

A signed copy of the assignment trust must be sent to *our* home office on a form *we* accept. The assignment will go into effect when it is signed, subject to any payments *we* make or other actions *we* take before *we* record it. *We* are not responsible for the validity or effect of any assignment.

MISTAKE OF AGE, SEX OR TOBACCO STATUS

If *your* or *your spouse's* age, sex or tobacco status is misstated in the application, *we* will adjust the *proceeds*. The *proceeds* of this rider will then be those *your* premiums would have bought at the correct age, sex and tobacco status. By age, *we* mean age as of *your* or *your spouse's* last birthday on the *policy's* or certificate's *effective date*.

GENERAL TERMS

This rider is made a part of *your policy* or certificate in consideration of *your* application and payment of the first premium for this rider. The following clauses indicate whether the *policy* or certificate provisions will apply to this rider. The *policy* or certificate provisions will either apply to this rider, not apply to this rider, or apply to this rider as modified below.

- A. **Policy or certificate provisions that do not apply to this rider** - The following *policy* or certificate provisions do not apply to this rider:
 - 1. The Preexisting Conditions Limitations section, and the Reimbursement section; and
 - 2. The Dependent Coverage section, except for the Dependent Eligibility clause and the Adding Other Dependents clause.
- B. **Policy or certificate provisions that apply to this rider with modification** - The following *policy* or certificate provision applies to this rider as modified below:

The Reinstatement clause, as found in the Termination section of the *policy* or certificate, will apply to this rider. However, death/accidental death occurring between the date the *policy* or certificate lapses and the date the *policy* or certificate is reinstated will not be covered under this rider.
- C. **Policy or certificate provisions that do not apply to this rider** - Other than as stated in (A) or (B) above, all other *policy*/certificate provisions will apply to this rider.

BENEFIT EXCLUSIONS

No *proceeds* are payable if a loss results from:

- A. Suicide or intentionally self-inflicted *injury* or *illness* while sane or insane if committed during the first 24 months of coverage under this rider;
- B. Service in the armed forces of any country, including non-military units supporting such forces;
- C. An act of declared or undeclared war; or
- D. Death due to an accident occurring while riding in or on, boarding or alighting from any aircraft as a:
 - 1. Pilot, crewmember, or student pilot; or
 - 2. Flight instructor or examiner

LIFE INSURANCE CONVERSION PRIVILEGE

A *covered person* will be eligible to convert coverage under this rider to an individual policy of life insurance ("*conversion policy*"), made available, without evidence of insurability, under this provision, if:

- A. The *covered person's* coverage under this rider terminates for reasons other than:
 - 1. Termination of the *policy*; or
 - 2. Failure to make the required premium payment when due; or
 - 3. The attainment of age 65.
- B. The covered person has been continuously insured under this rider for at least one (1) year immediately prior to the termination.

This privilege is subject to the following additional terms and conditions:

- A. Written application and the first premium payment are submitted as directed on the *conversion policy* application by the later of:
 - 1. 31 days after termination of coverage under this rider; or
 - 2. A later date as required by the statutes or regulations of the state in which the *covered person* resides at that time; butIn no event later than 60 days after the date of termination of coverage under this rider.
- B. The amount of coverage under the *conversion policy* will not exceed the amount of coverage for which the *covered person* is insured under this rider. The terms of coverage under the conversion policy will not be the same as the terms of coverage under this rider.
- C. The *conversion policy* will be a policy offered by a life insurer designated by *us* in the state in which the *covered person* resides.
- D. The premium to be paid for the *conversion policy* by the former *covered person* will depend on:

1. Rates for that *conversion policy* in that state at that time;
 2. The attained age of the *covered person*;
 3. The class of risk to which the *covered person* belongs; and
 4. The form and amount of the *conversion policy* coverage.
- E. Any *conversion policy* issued in accordance with the provisions of this rider:
1. Will become effective the date immediately following termination of coverage under this rider; and
 2. Will be in place of the terminated coverage under this rider.
- F. A *covered person's* insurance under this rider will remain in force during the thirty-one (31) days within which the *covered person* is eligible to exercise the conversion privilege, whether or not there has been an application for conversion. If the *covered person* dies during that period, we will:
1. Pay, as a death benefit, the maximum amount eligible for conversion;
 2. Void any *conversion policy* issued in accordance with this conversion privilege; and
 3. Return any premium paid for that *conversion policy*.
- G. If the life insurer designated by *us* to offer *conversion policies* in the state in which a *covered person* resides ceases to offer conversion policies in that state, no *conversion policies* will be available in that state under this provision.

This rider will not change, waive, or extend any part of the *policy* or certificate, other than as stated herein.

This rider is effective at the same time as the *policy* or certificate to which it is attached, unless a later date is shown below.

Golden Rule Insurance Company



President

ACCIDENTAL DEATH INSURANCE RIDER

By attachment of this rider, the *policy* or certificate is amended as follows:

If a *covered person* suffers an *accidental death* while insured under this rider, we will pay, subject to the terms and conditions of this rider, to the *covered person's beneficiary* the *accidental death proceeds* in one lump sum.

In order to qualify for a benefit:

- A. The death must occur within 180 consecutive days after the accident that caused the death; and
- B. The accident must occur while the *covered person* is covered under this rider.

DEFINITIONS

As used in this rider:

Accidental death means loss of life resulting directly from:

- A. Injury;
- B. Infection caused by injury, or resulting from accidental ingestion of contaminated substances; or
- C. Drowning.

Beneficiary means the person designated by the *covered person*, on a form approved by us, to receive any amount of the *accidental death proceeds* becoming payable under the terms of the *policy* or certificate due to a *covered person's* death.

Covered Person means the *primary insured* and/or *spouse* who has applied for and been approved under this rider.

Due proof of death shall mean sufficient information to allow us to determine if *accidental death proceeds* are payable and in the form of written documentation such as a certified copy of the death certificate, autopsy report, police/accident reports and other information and proof necessary to establish liability.

Proceeds means the amount for which a *covered person's* life is insured under this rider at the time of death. The respective *accidental death proceeds* for each *covered person* under this rider are shown in Section 1.

Spouse means the person named as *your* spouse in the application or any amendment. This term does not include a spouse who is not a *covered person*.

PREMIUM

The premiums for this rider are shown on the Data Page, Section 1. This premium is to be paid at the same time and in the same manner as the premium for the *policy*. The premium for this rider will cease when the rider ends. If the type of plan shown on the Data Page of the *policy* or certificate is changed because of an addition or removal of a *covered person* insured by this rider, the premium for this rider will change. The new premium for this rider will be shown in the written notice sent to *you*.

NOTICE OF DEATH

We will pay to the *beneficiary* the *accidental death proceeds* of this rider upon receipt of *due proof of death*. Written proof of death must be furnished to us within 90 days from the *covered person's* date of death or as soon as reasonably possible.

BENEFICIARY

The *covered person* can name any person, other than the *covered person's* employer, as a *beneficiary*. The *covered person* can change the *beneficiary* at any time without the consent of the designated *beneficiary* by notifying us in writing on a form furnished by us. The new designation will be effective when the notice is received by us. If we pay the *proceeds* before we receive the *covered person's* change request, we are released from further liability to the extent of *our* payment. A new designation of *beneficiary* terminates the interests of the previous *beneficiary*.

If more than one *beneficiary* is designated, but their respective interests are not specified, the *beneficiaries* will share the *proceeds* equally. The interest of a *beneficiary* who dies before the *covered person* will

terminate and be shared equally by the *beneficiaries* surviving the *covered person*, unless otherwise provided in the *beneficiary* designation. If the *beneficiary* dies at the same time as the *covered person*, or within 15 days after the date the *covered person* dies, payment will be made by *us* as if the *covered person* survived the *beneficiary*. If there is not a designated *beneficiary* surviving at the death of the *covered person*, payment will be made in a single sum to the *covered person's* estate; however, at our option, payment may be made to one or more of the following surviving relatives of the *covered person*:

- A. Spouse;
- B. Children, including legally adopted children;
- C. Parents; or
- D. Brothers and sisters.

In the absence of a parent or the appointment of a legal guardian, if any *beneficiary* is:

- A. A minor; or
- B. In our opinion, legally incapable of giving valid receipt for any payment due

we may pay *accidental death proceeds* in monthly installments to the person or persons who, in our opinion, have assumed custody and principal support of the *beneficiary*.

If no legal action is commenced interest will be paid at the rate of 2.5% a year from the date of death until the date *the proceeds* are paid. If a legal action has been brought to recover *proceeds* and results in a judgment against the insurer, interest at the rate of 2.5% will be paid from the date of presentation of the *due proof of death* until the date the *proceeds* are paid in full. If the law in the state where the *policy* or certificate is issued requires payment of a greater amount, *we* will pay that amount.

We rely on an affidavit to determine payment of *proceeds*, unless *we* receive written notice of a valid claim from a person before *we* make the payment. The affidavit releases *us* from further liability.

We may, at *our* option, pay an amount of up to \$250 to any person appearing to be entitled to the payment who incurred expense because of the last illness or burial of the *covered person*. Any payment *we* make in good faith fully discharges *us* to the extent of the payment.

TERMINATION OF THIS RIDER

All insurance under this rider will cease on its termination. This rider will terminate on the earlier of:

- A. The date *we* receive a written request from the *covered person* for its termination, or on any later date stated in *your* request;
- B. The date no *covered person* remains insured under this rider; or
- C. The date the *covered person's* coverage under the *policy* or certificate terminates.

We will refund any premium paid and not earned due to termination of this rider. The refund will be based on the number of full months that remain in the premium period.

TERMINATION OF COVERED PERSONS

You will cease to be a *covered person* under this rider at the end of the premium period in which *you* attain 65 years of age.

Your spouse will cease to be a *covered person* under this rider at the end of the premium period in which any of these events occur:

- A. He or she attains 65 years of age; or
- B. *You* become legally divorced, if earlier.

ASSIGNING YOUR RIDER

During *your* life, *you* may assign some or all of *your* rights under this rider to someone else.

A signed copy of the assignment must be sent to *our* home office on a form *we* accept. The assignment will go into effect when it is signed, subject to any payments *we* make or other actions *we* take before *we* record it. *We* are not responsible for the validity or effect of any assignment.

If there are permanent *beneficiaries*, you need their consent before assigning the payment of *proceeds*.

GENERAL TERMS

This rider is made a part of *your policy* or certificate in consideration of *your* application and payment of the first premium for this rider. The following clauses indicate whether the *policy* or certificate provisions will apply to this rider. The *policy* or certificate provisions will either apply to this rider, not apply to this rider, or apply to this rider as modified below.

- A. **Policy or certificate provisions that do not apply to this rider** - The following *policy* or certificate provisions do not apply to this rider:
 - 1. The Preexisting Conditions Limitations section, and the Reimbursement section; and
 - 2. The Dependent Coverage section, except for the Dependent Eligibility clause and the Adding Other Dependents clause.
- B. **Policy or certificate provisions that apply to this rider with modification** - The following *policy* or certificate provision applies to this rider as modified below:

The Reinstatement clause, as found in the Termination section of the *policy* or certificate, will apply to this rider. However, death/accidental death occurring between the date the *policy* or certificate lapses and the date the *policy* or certificate is reinstated will not be covered under this rider.
- C. **Policy or certificate provisions that do not apply to this rider** - Other than as stated in (A) or (B) above, all other *policy* or certificate provisions will apply to this rider.

BENEFIT EXCLUSIONS

No *proceeds* are payable if a loss results from:

- A. Suicide or intentionally self-inflicted *injury* or *illness* while sane or insane if committed during the first 24 months of coverage under this rider;
- B. Voluntary taking of any sedative or drug, or inhalation of any gas, unless taken or inhaled as *your doctor* prescribes or administers it;
- C. Death due to an accident occurring while riding in or on, boarding or alighting from any aircraft as a:
 - 1. Pilot, crewmember, or student pilot; or
 - 2. Flight instructor or examiner
- D. *Your* committing or attempting to commit a civil or criminal battery or felony;
- E. Service in the armed forces of any country, including non-military units supporting such forces;
- F. An act of declared or undeclared war;
- G. Participating in a riot, rebellion or insurrection. Participating means *you* are taking an active part in common with others. Riot means any use or threat to use force or violence by three or more persons without authority of law;
- H. Bodily or mental infirmity, or related surgery or medical treatment or any infection, unless direct result of *injury*, or unless resulting from accidental ingestion of a contaminated substance;
- I. *Injury* or *illness* arising from any occupation or employment;
- J. Participating in hazardous activities including but not limited to: auto or motorcycle racing; hang gliding; bungee jumping; rock climbing; skydiving and any extreme sports; or
- K. Driving while legally intoxicated from alcohol, or driving while under the influence of drugs unless taken as prescribed by a doctor.

This rider will not change, waive, or extend any part of the *policy* or certificate, other than as stated herein.

This rider is effective at the same time as the *policy* or certificate to which it is attached, unless a later date is shown below.

Golden Rule Insurance Company

Patrick F. Carr

President

REHABILITATION THERAPY BENEFITS RIDER

By attachment of this rider, the *policy/certificate* is amended to include, as *covered expenses*, certain losses incurred for *rehabilitation therapy*. Recognizing that the *policy/certificate* to which this rider is attached provides very limited benefits for rehabilitation, *you* have chosen to pay an additional premium to add this rider to *your policy/certificate*, thereby providing greater benefits for *rehabilitation therapy*.

REHABILITATION THERAPY EXPENSES: Under this clause, *covered expenses* are limited to charges for *rehabilitation therapy* services.

DEFINITIONS:

"*Rehabilitation therapy*" means those services which are designed to remediate a patient's condition or restore patients to their optimal physical, medical, psychological, social, and emotional status. *Rehabilitation therapy* includes diagnostic testing, assessment, monitoring, and treatment of the patient for an *injury* or *illness*, including, but not limited to:

- A. Stroke;
- B. Spinal cord injury;
- C. Congenital deformity;
- D. Amputation;
- E. Major multiple trauma;
- F. Fracture of femur;
- G. Brain injury;
- H. Polyarthritis, such as rheumatoid arthritis;
- I. Neurological disorders, such as multiple sclerosis, motor neuron diseases, polyneuropathy, muscular dystrophy, and Parkinson's disease;
- J. Cardiac disorders, such as acute myocardial infarction, angina pectoris, coronary arterial insufficiency, angioplasty, heart transplantation, chronic arrhythmias, congestive heart failure, and valvular heart disease; and
- K. Burns.

Covered expenses: For the purpose of this rider, the term "*covered expenses*" means expenses actually incurred by a *covered person* for *rehabilitation therapy* services rendered by an *approved facility* and which are:

- A. Administered or ordered by a *doctor*;
- B. *Medically necessary* to the diagnosis or treatment of, or rehabilitation after a covered *injury* or *illness*; and
- C. Not excluded anywhere in the *policy/certificate* or rider.

"Approved facility" means a:

- A. Licensed *hospital* that meets the requirements for rehabilitation hospitals as described in Section 2803.2 of the Medicare Provider Reimbursement Manual, Part 1, as published by the U.S. Health Care Financing Administration;
- B. Distinct part rehabilitation unit in a licensed *hospital*. The distinct part rehabilitation unit must meet the requirements of Section 2803.61 of the Medicare Provider Reimbursement Manual, Part 1; and
- C. Licensed *hospital* which meets the requirements for cardiac rehabilitation as described in Section 35-25, Transmittal 41, dated August, 1989, as promulgated by the U.S. Health Care Financing Administration.

CALCULATION OF BENEFITS: Benefits under this rider will be calculated as though the *covered expenses* under this rider are *covered expenses* under the Medical Benefits provision of the *policy/certificate*. These *covered expenses* are subject to:

- A. The deductible amount and coinsurance percentage shown in Section 1 and discussed in the General Benefits Provisions; and
- B. The same exclusions, limitations, notification requirements, and other terms, as apply to other covered expenses.

EXCLUSIONS: No benefits are payable under this amendment for services related to mental health, chemical dependency, vocational rehabilitation, long-term care maintenance, or custodial services.

TERMINATION OF THIS RIDER: This rider will only be in force so long as the *policy/certificate* to which it is attached is in force. This rider will also terminate on the premium due date following:

- A. A request by *you* to terminate this rider; or
- B. When *you* fail to pay the additional premium required for this rider, subject to the grace period provision.

This rider does not change, waive or extend any part of the *policy/certificate* other than as set forth above.

This rider is effective at the same time as the *policy/certificate*, unless a later date is shown below.

Golden Rule Insurance Company



President

INSURANCE BENEFITS UNITEDHEALTH CONTINUITY RIDER

By attachment of this Insurance Benefits UnitedHealth Continuity Rider ("rider"), the *policy/certificate* is amended to the extent of any conflict or inconsistency with the following:

DEFINITIONS:

In addition to the definitions in the *policy/certificate*, the following definitions apply to this rider:

- "*Active*", under this rider, means eligible for *insurance benefits*.
- "*Covered spouse*" means your spouse who is a *covered person* under the *policy/certificate*.
- "*UnitedHealth continuity rider premium*" means the amount *you* must pay to keep this rider in force and maintain the benefits of this rider.
- "*Dormant*", under this rider means ineligible for *insurance benefits*.
- "*Employer-sponsored medical coverage*" means any employer-sponsored medical insurance or HMO coverage.
- "*Insurance benefits*" means the right to receive reimbursement for *covered expenses*, according to the terms of the *policy/certificate*.
- "*Insurance benefits premium*" means premium for the *policy/certificate*, excluding the *UnitedHealth continuity rider premium*.
- "*Involuntary terminates*" means ceases for reason other than *voluntary termination*.
- "*Policy active status*" means the period of time that at least one (1) *covered person* is *active*.
- "*Policy effective date*" means the earliest date an individual becomes a *covered person* under the *policy/certificate*.
- "*Satisfactory proof of employer coverage*" means written documentation that clearly shows the person is currently, or will soon be, covered by *employer-sponsored medical coverage*.
- "*Total premium*" means the combined *insurance benefits premium* and *UnitedHealth continuity rider premium*.
- "*Voluntary termination*" or "*voluntarily terminates*" means *employer-sponsored medical coverage* ceases for any *covered person*: (a) because *you* or *your spouse* requests termination of the coverage; or (b) due to failure to pay required premium when due.

BENEFITS OF THIS RIDER:

The benefit of this rider is to enable a *covered person* to be *active* or *dormant* under the terms of the *policy/certificate*. A *covered person's* status depends on whether that person has *employer-sponsored medical coverage* and the terms of this rider.

If *employer-sponsored medical coverage involuntarily terminates*, the benefits of this rider continue.

If *employer-sponsored medical coverage* (other than COBRA coverage) for any *covered person*:

- A. *Voluntarily terminates*; and
- B. Is not replaced with other *employer-sponsored medical coverage* within 62 days;

then the benefits of this rider will be exhausted and no longer available for all *covered persons*. *UnitedHealth continuity rider premium* will no longer be required.

INSURANCE BENEFITS STATUS FOR COVERED PERSONS:

Before the *policy effective date*, *you* must declare in writing whether each *covered person* will begin *active* or *dormant*. A *covered person* may only begin in a *dormant* state if that *covered person* has *employer-sponsored medical coverage* on the *policy effective date*. One *covered person* may be *active* under this rider while another *covered person* is *dormant* under this rider.

WHEN A COVERED PERSON IS ACTIVE UNDER THIS RIDER:

- A. *You* are required to pay the *total premium* for all *covered persons* while *active*.

- B. When a *covered person* is *active*, that *covered person* will have the right to receive reimbursement for *covered expenses* according to the terms of the *policy/certificate*.

DEACTIVATION OF INSURANCE BENEFITS:

- A. You may request that we make a *covered person dormant* by providing us with *satisfactory proof of employer coverage* for that person. Upon receipt of such proof, that person will be *dormant* on the later of:
 - 1. The date that person is eligible to receive benefits under *employer-sponsored medical coverage*; or
 - 2. The date we receive the written request to make the person *dormant*.
- B. Each time a *covered person* is made *dormant*, we will provide written notice indicating that *insurance benefits* are not available.

WHEN A COVERED PERSON IS DORMANT UNDER THIS RIDER:

- A. You are required to pay the *UnitedHealth continuity rider premium* for all *covered persons* who are *dormant*.
- B. When a *covered person* is *dormant*, that *covered person* will not have the right to receive reimbursement for *covered expenses* according to the terms of the *policy/certificate*.
- C. In order to remain *dormant*, a *covered person* must be covered under *employer-sponsored medical coverage*. If *employer-sponsored medical coverage* terminates, see "Activation of Insurance Benefits" below.
- D. If you or your *covered spouse voluntarily terminates employer-sponsored medical coverage* for any *covered person(s)*, also see "Benefits of This Rider", page 1 of this rider.

ACTIVATION OF INSURANCE BENEFITS:

- A. If *employer-sponsored medical coverage* terminates for any *covered person*, that person will immediately be *active* under this rider.
 - 1. You have an obligation to provide us with written notice and pay the required premium within 62 days after a *covered person* becomes *active*; and
 - 2. If you do not pay the required premium within the 62 days, coverage for that person will lapse. We will refund all premiums for that person back to the date coverage lapsed.
- B. Each time a *covered person* becomes *active*, you have 120 days to provide us with written evidence that shows that the person has been covered by *employer-sponsored medical coverage*, with no lapse greater than 63 days, since the date the person was most recently made *dormant*. This evidence may include certificates of creditable coverage or other documents from the person's employers or insurers.
- C. If, within this 120 day period, you do not provide us with proof of coverage as explained in B. above, we will refund *UnitedHealth continuity rider premium* less any claims paid during the 120 day period and coverage will lapse for the affected person back to the date the person became *dormant*.

PREMIUMS:

You may keep the *policy/certificate* in force by timely payment of the *total premium* for *covered persons* who are *active* and the *UnitedHealth continuity rider premium* for *covered persons* who are *dormant*. If the benefits of this rider have been exhausted, you will only have to pay the *insurance benefits premium*.

- A. The *UnitedHealth continuity rider premium* will be a minimum dollar amount or percentage of each *covered person's insurance benefits premium*, whichever is greater. These minimum dollar and percentage amounts are set forth in the Data Page.
- B. The percentage will vary depending on whether each *covered person* is *active* or *dormant* as reflected in the Data Page.
- C. Any time there is an increase in *insurance benefits premium*, we will send you written notification, so you are informed of what the *total premium* will be when *active* and what the *UnitedHealth continuity*

rider premium will be when dormant. The insurance benefits premium will increase even when covered persons are dormant.

- D. As long as the *policy/certificate starts in policy active status and remains in policy active status for at least 12 months, the UnitedHealth continuity rider premium for that covered person will be reduced as set forth in the Data Page.*

NEWBORNS and ADOPTED CHILDREN:

- A. A child born to a *covered person* or adopted by a *covered person* will be covered under the *policy/certificate* from the time of birth until the 60th day after that child's birth or placement unless the placement is disrupted prior to the legal option and the child is removed from the physical custody of the *covered person*.
- B. Additional *total premium* or *UnitedHealth continuity rider premium* will be required to continue coverage beyond the 60th day after the birth or placement of the child and will be calculated from the child's date of birth. Coverage for the child will terminate on the 60th day after his/her birth or placement, unless we have received written notice of the child's birth or written notice that the child was legally placed for adoption with you or a *covered person* and the required *total premium* or *UnitedHealth continuity rider premium* within one year following the child birth unless within one year after the birth or placement of the child you must all past-due payments and in addition pay interest on such payment at the rate of 5 1/2% per year.
- C. Once we are notified of the child's birth or adoption, we will inform the *covered person* of the required *total premium* amount and *UnitedHealth continuity rider premium* amount for the child. If the *covered person* elects to have the child's coverage be *active* under this rider, the *covered person* should pay the *total premium* amount. If the *covered person* elects to have the child's coverage be *dormant* under this rider, the *covered person* should pay the *UnitedHealth continuity rider premium* and provide us with *satisfactory proof of employer coverage* for the child.

ADDING OTHER DEPENDENTS:

If a *dependent* is added as insured under the terms of the *policy/certificate*, you must declare in writing whether the added *dependent* will be *active* or *dormant* under this rider. You must provide *satisfactory proof of employer coverage* for the added *dependent* to be *dormant*.

CHANGES TO YOUR DEDUCTIBLE:

- A. You may make a written request to change the *deductible amount* to an amount currently available at the time regardless of whether the *covered persons* are *active* or *dormant*.
- B. A written request to decrease the *deductible amount* will require *satisfactory proof of good health*.
- C. Any change in the *deductible amount* will become effective as of the next premium due date after we receive and, if required, approve the request. The *total premium and UnitedHealth continuity rider premium* will then be adjusted to reflect this change.

REINSTATEMENT:

A *covered person* must provide *satisfactory proof of employer coverage* for a *covered person* to be *dormant* upon reinstatement. If we approve reinstatement of coverage and include this rider, we will confirm the *active* or *dormant* status for each *covered person*.

12-MONTH EXCLUSION:

The 12-month exclusion period for expenses due to a *preexisting condition* or natural progression of a *preexisting condition* will be satisfied twelve (12) months after a *covered person's policy effective date*, even if a *covered person* is *dormant* during that 12-month period.

DISCONTINUANCE:

If a *covered person* is *dormant* at the time we notify you that:

- A. We are going to discontinue offering or refuse to renew this *policy/certificate* in your state; and
- B. We will not be offering a new *policy/certificate* with benefits similar to those under the *policy/certificate*, we will stop collecting the *UnitedHealth continuity rider premium* and refund any *UnitedHealth continuity rider premium* you have paid in the prior 36 months.

BENEFITS AFTER COVERAGE TERMINATES:

Benefits for *covered expenses* incurred after an individual ceases to be a *covered person* under the *policy* are provided for certain *illnesses* and *injuries* only if that *covered person* is *active* at the time of termination.

EFFECT ON DECREASING TERM LIFE RIDER/ACCIDENTAL DEATH:

A *covered person* is never *dormant* with regard to insurance under a decreasing term life rider/accidental death rider. Therefore, premium required to maintain the decreasing term life rider/accidental death rider is not affected by the Insurance Benefits UnitedHealth Continuity Rider.

EFFECT ON BENEFITS AVAILABLE UNDER OPTIONAL PREGNANCY EXPENSE BENEFITS RIDER (“Pregnancy Rider”):

- A. Benefits for *covered expenses* under the optional *Pregnancy Rider*, if any, will be available for a *covered person* who is *active* under this rider.
- B. If a female *covered person* is *dormant* and under a *Pregnancy Rider* with us, the female *covered person* will be *dormant* with respect to the *Pregnancy Rider*. If you want the female *covered person* to have the right to receive reimbursement for *covered expenses* under the *Pregnancy Rider* despite her *dormant* status for the base coverage, you must notify us in writing and pay the required premium. We will advise you of this option when a female *covered person* becomes *dormant*.
- C. Only the months that a *covered person* is *active* and insured under a *Pregnancy Rider* will be counted to satisfy a benefit year, as defined in the *Optional Pregnancy Rider*.

EFFECT ON PRESCRIPTION DRUG DISCOUNT CARD:

Discounts on prescription drug expenses available through use of any prescription drug discount card provided as a non-insurance benefit will be available only if a *covered person* is *active*.

TERMINATION OF UNITEDHEALTH CONTINUITY RIDER:

This rider will terminate if:

- A. You give us 10 days advance written notice that you wish to terminate it; or
- B. You fail to pay the *UnitedHealth continuity rider premium* within 31 days after it is due.

If this rider is terminated for any reason:

- A. It cannot be added back at any later date;
- B. *UnitedHealth continuity rider premium* will no longer be required; and
- C. You will be responsible to continue payment of the *insurance benefits premium* under the *policy* for any *covered person* who is *active* under this rider.

Except as specifically stated in this endorsement, the provisions in this endorsement are subject to all of the terms, conditions, exclusions, and limitations of the *policy/certificate*.

The rider will not change, waive or extend any part of the *policy/certificate*, other than as stated herein.

This rider is effective on the same day as the *policy/certificate*.

Golden Rule Insurance Company



President

**GOLDEN RULE INSURANCE COMPANY
WISCONSIN GRIEVANCE AND COMPLAINT PROCEDURES RIDER
(NON-GRANDFATHERED PLANS)**

This rider is effective on March 1, 2012, or at the same as the *policy/certificate*, whichever is later.

This rider replaces any grievance/appeal procedure(s) previously included in the *policy/certificate*.

By attachment of this rider, the *policy/certificate* is amended to the extent of any conflict with the following:

A. **DEFINITIONS:** As used in this rider, the following terms have the meanings indicated:

1. "*Adverse benefit determination*" means:

- (a) Any claim denial, reduction, or termination of, or a failure to provide, or make payment (in whole or in part) for a benefit, including:
 - (i) deductible credits; coinsurance; co-pay; provider network reductions or exclusions, or other cost sharing requirements;
 - (ii) any instance where the plan pays less than the total expenses submitted resulting in claimant responsibility;
 - (iii) a benefit resulting from the application of any utilization review;
 - (iv) a covered benefit that is otherwise denied as not medically necessary or appropriate;
 - (v) a covered benefit that is otherwise denied as experimental or investigational;
- (b) Any denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's eligibility to participate in the plan, including any decision to deny coverage at the time of application or placing a medical rider; and
- (c) Any *rescission* of coverage, including offering the option of accepting a medical rider in lieu of *rescission*, (whether or not the *rescission* has an adverse effect on any particular benefit at that time).
- (d) It also includes, for individual insurance products, a *policy reformation* or change in premium charged based upon underwriting or claims information greater than 25% from the premium in effect during the period of contestability except to the extent the modification is due to the applicant's age or a rate increase applied by *us* to all similar individual policy forms applied uniformly.

Regarding the independent review procedures, this includes the denial of a request for a referral for out-of-network services when *you* request health care services from a provider that does not participate in *our* provider network because the clinical expertise of the provider may be medically necessary for treatment of *your* medical condition and that expertise is not available in *our* provider network.

- 2. "*Complaint*" means any expression of dissatisfaction expressed to *us* by *you*, or *your* authorized representative, about *us* or the providers with whom *we* have a direct or indirect contract.
- 3. "*Expedited grievance*" means a *grievance* where any of the following applies:
 - (a) The duration of the standard resolution process will result in serious jeopardy to *your* life or health or *your* ability to regain maximum function.
 - (b) In the opinion of a physician with knowledge of *your* medical condition, *you* are subject to severe pain that cannot be adequately managed without the care or treatment that is the subject of the *grievance*.
 - (c) A physician with knowledge of *your* medical condition determines that the *grievance* shall be treated as an *expedited grievance*.

4. "*Grievance*" means any dissatisfaction with *us* that is expressed in writing in any form to *us* by *you*, or on *your* behalf, including any of the following:
 - (a) Provision of services.
 - (b) Determination to reform or rescind a policy.
 - (c) Determination of a diagnosis or level of service required for evidence-based treatment of autism spectrum disorders.
 - (d) Claims practices.
5. "*Post-service claim*" means any claim for benefits for medical care or treatment that is not a *pre-service claim*.
6. "*Pre-service claim*" means any claim for benefits for medical care or treatment that requires the approval of the plan in advance of the covered person obtaining the medical care.
7. "*Reformation*" of a policy means a determination by *us* to modify the terms of the policy or adjust the premium rate by more than 25% from the premium in effect during the period of contestability. A modification in premium based upon the applicant's or insured's age or a rate increase uniformly applied by *us* to all similar individual policy forms is not a *reformation* of a policy.
8. "*Rescission*" of a policy means a determination by *us* to withdraw the coverage back to the initial date of coverage.

B. INTERNAL PROCEDURES

1. Applicability/Eligibility
 - (a) The internal *grievance* procedures apply to:
 - (i) Any hospital or medical *policy* or certificate.
 - (ii) Conversion plans.
 - (b) An eligible grievant includes:
 - (i) You.
 - (ii) Person authorized to act on *your* behalf. **Note:** Written authorization is not required; however, if received, *we* will accept any written expression of authorization without requiring specific form, language, or format.
 - (iii) In the event *you* are unable to give consent: a spouse, family member, or the treating provider.
 - (iv) In the event of an *expedited grievance*: the person for whom *you* have verbally given authorization to represent *you*.

2. Grievances

There is not a time limit for submitting a *grievance*.

Claimants have the right to submit written comments, documents, records, and other information relating to the claim for benefits. Claimants have the right to review the claim file and to present evidence and testimony as part of the internal review process.

Grievances will be promptly investigated and presented to the internal *grievance* panel.

A plan that is providing benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice and an opportunity for advance review. The plan is required to provide continued coverage pending the outcome of an appeal.

(a) Resolution Timeframes

Grievances regarding quality of care, quality of service, or reformation will be resolved within **30 calendar days** of receipt.

The time period may be extended for an additional 30 calendar days (making the maximum time for the entire *grievance* process **60 calendar days**) if we provide you and your authorized representative, if applicable, written notification of the following within the first 30 calendar days:

- (i) That we have not resolved the *grievance*;
- (ii) When our resolution of the *grievance* may be expected; and
- (iii) The reason why the additional time is needed.

All other *grievances* will be resolved and we will notify the claimant in writing with the appeal decision within the following timeframes:

- (i) Post-service claim: within **60 calendar days** after receipt of the claimant's request for internal appeal.
- (ii) Pre-service claim: within **30 calendar days** after receipt of the claimant's request for internal appeal.

A claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. All comments, documents, records and other information submitted by the claimant relating to the claim for benefits, regardless of whether such information was submitted or considered in the initial *adverse benefit determination*, will be considered in the internal appeal.

- (i) The claimant will receive from the plan, as soon as possible, any new or additional evidence considered by the reviewer. The plan will give the claimant **10 calendar days** to respond to the new information before making a determination, unless the state turnaround time for response is due in less than 10 days. If the state turnaround time is less than 10 days, the claimant will have the option of delaying the determination for a reasonable period of time to respond to the new information.
- (ii) The claimant will receive from the plan, as soon as possible, any new or additional medical rationale considered by the reviewer. The plan will give the claimant **10 calendar days** to respond to the new medical rationale before making a determination, unless the state turnaround time for response is due in less than 10 days. If the state turnaround time is less than 10 days, the claimant will have the option of delaying the determination for a reasonable period of time to respond to the new medical rationale.

Refer to section B.2.(e) for information regarding internal *expedited grievances*.

(b) Acknowledgement

Within **five business days** of receipt of a *grievance*, a written acknowledgment to you or your authorized representative confirming receipt of the *grievance* must be delivered or deposited in the mail.

When acknowledging a *grievance* filed by an authorized representative, the acknowledgement shall include a clear and prominent notice that health care information or medical records may be disclosed only if permitted by law.

- (i) The acknowledgement shall state that unless otherwise permitted under applicable law, informed consent is required and the acknowledgement shall include an informed consent form for that purpose.
- (ii) If such disclosure is prohibited by law, health care information or medical records may be withheld from an authorized representative, including information contained in its resolution of the *grievance*.

(iii) A *grievance* submitted by an authorized representative will be processed regardless of whether health care information or medical records may be disclosed to the authorized representative under applicable law.

(c) Right to Appear

The insured who filed the *grievance*, or the insured's authorized representative, has the right to appear in person before the *grievance* panel to present written or oral information. The grievant may submit written questions to the person or persons responsible for making the determination that resulted in the *grievance*.

- (i) Written notification must be sent to *you* indicating the time and place of the *grievance* panel meeting at least seven calendar days before the meeting.
- (ii) Reasonable accommodations must be provided to allow *you*, or *your* authorized representative, to participate in the *grievance* panel.

(d) Grievance Panel

The *grievance* panel will not include the person who made the initial determination and is not the subordinate of the original reviewer. The panel may, however, consult with the initial decision-maker. If the panel consists of at least three persons, the panel may then include no more than one subordinate of the person who made the initial determination.

The *grievance* panel will include:

- (i) At least one individual authorized to take corrective action on the *grievance*; and
- (ii) At least one insured other than the grievant, if an insured is available to serve on the *grievance* panel. The insured member of the panel shall not be an employee of the plan, to the extent possible.

When the *adverse benefit determination* is based in whole or in part on a medical judgment, the *grievance* panel will consult with a licensed health care provider with expertise in the field relating to the *grievance* and who was not consulted in connection with the original *adverse benefit determination*.

(e) Expedited Grievance

An *expedited grievance* may be submitted orally or in writing.

All necessary information, including *our* determination on review, will be transmitted between the claimant and us by telephone, facsimile, or other available similarly expeditious method.

An *expedited grievance* shall be resolved as expeditiously as *your* health condition requires but not more than 72 hours after receipt of the *grievance*.

Due to the 72-hour resolution timeframe, the standard requirements for notification, *grievance* panel/right to appear, and acknowledgement do not apply to *expedited grievances*.

Upon written request, we will mail or electronically mail a copy of *your* complete policy to *you* or *your* authorized representative as expeditiously as the *grievance* is handled.

(f) Written Grievance Response

Grievance response letters shall describe, in detail, the *grievance* procedure and the notification shall include the specific reason for the denial, determination or initiation of disenrollment.

The panel's written decision to the grievant must include:

- (i) The disposition of and the specific reason or reasons for the decision;
- (ii) Any corrective action taken on the *grievance*;

- (iii) The signature of one voting member of the panel; and
- (iv) A written description of position titles of panel members involved in making the decision.
- (v) When the *adverse benefit determination* involved a *rescission*, include a brief summary statement regarding Health Insurance Risk Sharing Plan eligibility.
- (vi) If upheld or partially upheld, it is also necessary to include:
 - (a) A clear explanation of the decision;
 - (b) Reference to the specific plan provision on which the determination is based;
 - (c) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits.
 - (d) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request;
 - (e) If the *adverse benefit determination* is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;
 - (f) Identification of medical experts whose advice was obtained on behalf of the health plan, without regard to whether the advice was relied upon in making the *adverse benefit determination*;
 - (g) The date of service;
 - (h) The health care provider's name;
 - (i) The claim amount;
 - (j) The diagnosis and procedure codes with their corresponding meanings, or an explanation that the diagnosis and/or procedure codes are available upon request;
 - (k) The health plan's denial code with corresponding meaning;
 - (l) A description of any standard used, if any, in denying the claim;
 - (m) A description of the external review procedures, if applicable;
 - (n) The right to bring a civil action under state or federal law;
 - (o) A copy of the form that authorizes the health plan to disclose protected health information, if applicable.
 - (p) That assistance is available by contacting the specific state's consumer assistance department, if applicable; and
 - (q) A culturally linguistic statement based upon the claimant's county or state of residence that provides for oral translation of the *adverse benefit determination*, if applicable.

3. Complaints

Basic elements of a *complaint* include:

- (a) The complainant is *you* or *your* authorized representative;
- (b) The submission may or may not be in writing; and
- (c) The issue may refer to any dissatisfaction about:
 - (i) *Us* (as the insurer); e.g., customer service *complaints* - "the person to whom I spoke on the phone was rude to me;"
 - (ii) Providers with whom *we* have a direct or indirect contract;
 - (a) Lack of availability and/or accessibility of network providers not tied to an unresolved benefit denial;
 - (b) Quality of care/quality of service issues;
 - A. Written expressions of dissatisfaction regarding quality of care/quality of service are processed as *grievances*.
 - B. Oral expressions of dissatisfaction regarding quality of care/quality of service are processed as *complaints*.
 - (iii) Any of the issues listed as part of the definition of *grievance* received from *you* or *your* authorized representative where the caller has not submitted a written request but calls *us* to escalate their dissatisfaction and request a verbal/oral review.

Complaints received from the Wisconsin Office of the Commissioner of Insurance (OCI)

The Commissioner may require *us* to treat and process any *complaint* received by the OCI by *you*, or on *your* behalf, as a *grievance* as appropriate. *We* will process the OCI *complaint* as a *grievance* when the Commissioner provides *us* with a written description of the *complaint*.

C. EXTERNAL REVIEW

An external review decision is binding on *us*. An external review decision is binding on the claimant except to the extent the claimant has other remedies available under applicable federal or state law.

We will pay for the costs of the external review performed by the independent reviewer.

1. Applicability/Eligibility

- (a) The external *grievance* procedures apply to:
 - (i) Any hospital or medical *policy* or certificate.
 - (ii) Conversion plans.
- (b) After exhausting the internal review process, *you* have four months to make a written request to the Grievance Administrator for external review after the date of receipt of *our* internal response.
 - (i) The internal appeal process must be exhausted before the claimant may request an external review unless *you* file a request for an expedited external review at the same time as an internal *expedited grievance* or *we* either provide a waiver of this requirement or fail to follow the appeal process.
 - (ii) A health plan must allow a claimant to make a request for an expedited external review with the plan at the time the claimant receives:
 - (a) An *adverse benefit determination* if the determination involves a medical condition of the claimant for which the timeframe for completion of an internal *expedited grievance* would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function and the claimant has filed a request for an internal *expedited grievance*;

- (b) A final internal *adverse benefit determination*, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the final internal *adverse benefit determination* concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.
- (iii) Claimants may request an expedited external review at the same time the internal *expedited grievance* is requested and an Independent Review Organization (IRO) will determine if the internal *expedited grievance* needs to be completed before proceeding with the expedited external review.
- (c) External review is available for *grievances* that involve:
 - (i) Medical judgment, including but not limited to those based upon requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit; or the determination that a treatment is experimental or investigational, as determined by an external reviewer;
 - (ii) *Rescissions* of coverage; or
 - (iii) *Reformation*.

2. External Review Process

- (a) We have **five business days (immediately** for expedited) following receipt of the request to conduct a preliminary review of the request to determine whether:
 - (i) The individual was a covered person at the time the item or service was requested;
 - (ii) The service is a covered service under the claimant's health plan but for the plan's *adverse benefit determination* with regard to medical necessity experimental/investigational, medical judgment, or *rescission*;
 - (iii) The claimant has exhausted the internal process; and
 - (iv) The claimant has provided all of the information required to process an external review.
- (b) Within **one business day (immediately** for expedited) after completion of the preliminary review, we will notify the claimant in writing as to whether the request is complete but not eligible for external review and the reasons for its ineligibility or, if the request is not complete, the additional information needed to make the request complete.
- (c) We must allow a claimant to perfect the request for external review within the four-month filing period or within the 48-hour period following the receipt of notification.
- (d) We will assign an IRO on a rotating basis from *our* list of contracted IROs.
- (e) Within **five business days** after the date of assignment of the IRO, we must provide the documents and any information considered in making the *adverse benefit determination* to the IRO.

Note: For expedited, after assignment of the IRO, we must provide the documents and any information considered in making the *adverse benefit determination* to the IRO electronically or by telephone or facsimile or any other available expeditious method.
- (f) If we fail to timely provide the documents and information, the IRO may terminate the external review and make a decision to reverse the *adverse benefit determination*.
- (g) Within 10 business days, the assigned IRO will timely notify the claimant in writing of the request's eligibility and acceptance for external review. The notice will include a

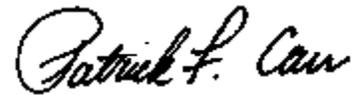
statement that the claimant may submit in writing additional information to the IRO to consider.

- (h) Upon receipt of any information submitted by the claimant, the IRO must forward the information to *us* within one business day.
- (i) Upon receipt of the information, *we* may reconsider *our* determination. If *we* reverse *our* *adverse benefit determination*, *we* must provide written notice of the decision to the claimant and the IRO within **one business day** after making such decision. The external review would be considered terminated.
- (j) Within 45 days (72 hours for expedited) after the date of receipt of the request for an external review by the health plan, the IRO will review all of the information and provide written notice of its decision to uphold or reverse the *adverse benefit determination* to the claimant and to *us*. If the notice for an expedited review is not in writing, the IRO must provide written confirmation within 48 hours after the date of providing the notice.
- (k) Upon receipt of a notice of a decision by the IRO reversing the *adverse benefit determination*, *we* will approve the covered benefit that was the subject of the *adverse benefit determination*.

This rider applies only to insureds who reside in the state of Wisconsin.

This rider will not change, waive, or extend any part of the *policy/certificate*, other than as stated herein.

Golden Rule Insurance Company



President

HIPAA PORTABILITY RIDER

By the attachment of this rider, *your policy/certificate* is amended as follows:

- A. In Section 8, the Preexisting Conditions Limitation provision will not apply to *individuals with portability rights*, as defined in this rider.
- B. **Definitions:** As used in this rider form, the following terms have the meanings indicated:
 1. "*Individuals with portability rights*" means, as of the date the individual applied for coverage under this *policy/certificate*, an individual:
 - (a) Who:
 - (i) Has 18 months or more of prior *creditable coverage*; or
 - (ii) Has 12 months or more of prior *creditable coverage* under Individual health insurance which was nonrenewed by the health insurance issuer under the conditions allowed in Subdivision C2 of Section 38.2-3430.7;
 - (iii) And there has been no gap of 63 days or more between any periods of *creditable coverage*.
 - (b) Whose most recent period of *creditable coverage* was under a *group health plan*, governmental plan, or church plan (or under health insurance coverage offered in connection with any such plan);
 - (c) Who is not eligible for coverage under:
 - (i) A group health plan;
 - (ii) Part A or Part B of Title XVIII of the Social Security Act (Medicare); or
 - (iii) A state plan under Title XIX of such Act (Medicaid) or any successor program;
 - (d) Who does not have other health insurance coverage;
 - (e) Whose most recent *group health plan* coverage was not terminated due to the commission of fraud or the nonpayment of premium when due; and
 - (f) Who, if eligible for continuation of coverage under COBRA or state continuation of coverage under the most recent prior *group health plan* coverage, has elected and exhausted his or her full rights to continuation of coverage.
 2. "*Group Health Plan*" means an employee benefit plan to the extent that the plan provides medical care to employees or their dependents directly or through insurance reimbursement or otherwise.
 3. "*Creditable Coverage*" means, with respect to an *individual with portability rights*, coverage of the individual under any of the following:
 - (a) A group health plan;
 - (b) Health insurance coverage;
 - (c) Part A or Part B of Title XVIII of the Social Security Act (Medicare);
 - (d) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928 (Medicaid);
 - (e) Chapter 55 of Title 10 of the U.S. Code (CHAMPUS);
 - (f) A medical care program of the Indian Health Service or of a tribal organization;
 - (g) A state health benefit risk pool;
 - (h) A health plan offered under Chapter 89 of Title 5 of the U.S. Code (government employees);
 - (i) A public health plan (as defined in regulations);
 - (j) A health benefit plan under section 5(e) of the Peace Corps Act.

"Creditable Coverage" does not include:

(a) The following coverages:

- (i) Coverage only for accident or disability income insurance, or any combination thereof;
- (ii) Coverage issued as a supplement to liability insurance;
- (iii) Liability insurance, including general liability insurance and automobile liability insurance;
- (iv) Worker's compensation or similar insurance;
- (v) Automobile medical payment insurance;
- (vi) Credit-only insurance;
- (vii) Coverage for on-site medical clinics; or
- (viii) Other similar insurance coverage under which benefits for medical care are secondary or incidental to other insurance benefits.

(b) The following coverages if offered separately:

- (i) Limited scope dental or vision benefits;
- (ii) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof ; and
- (iii) Similar, limited coverages as specified in regulations.

(c) The following coverages if offered as independent noncoordinated coverages:

- (i) Coverage only for a specified disease or illness; and
- (ii) Hospital indemnity or other fixed indemnity insurance.

(d) The following coverages if offered as a separate policy:

- (i) Medicare supplement health insurance;
- (ii) Coverage supplemental to the coverage provided under chapter 55 of Title 10 of the U.S. Code; and
- (iii) Similar supplemental coverage provided to coverage under a *group health plan*.

This rider will not change, waive or extend any part of the *policy/certificate*, other than as stated herein.

This rider is effective at the same time as the *policy/certificate*, unless a later date is shown below.

Golden Rule Insurance Company



President

CONTRACEPTIVE DRUG AND DEVICES RIDER

By attachment of this rider the *policy/certificate* is amended to the extent of any conflict with the following:

- A. The *policy/certificate* will include the following definition:
“*Outpatient contraceptive services*” means consultations, examinations, procedures, and medical services, provided on an *outpatient* basis and related to the use of contraceptive methods (including natural family planning) to prevent an unintended pregnancy. *Outpatient contraceptive services* does not include services related to an abortion or services related to permanent sterilization requiring a surgical procedure.
- B. The *policy/certificate* will include expenses incurred by a *covered person* for *outpatient contraceptive services* and the United States Food and Drug Administration (USFDA) approved *outpatient* contraceptive drugs and services.
- C. Any exclusion or limitation for outpatient contraceptive services or USFDA approved outpatient contraceptive drugs and devices is hereby deleted.

This rider only applies to residents of Alaska.

This rider does not change, waive or extend any part of the *policy/certificate*, other than as set forth above.

This rider is effective on February 10, 2004, or at the same time as the *policy/certificate*, whichever is later.

Golden Rule Insurance
Company



President

INSURANCE BENEFITS UNITEDHEALTH CONTINUITY RIDER

IMPORTANT NOTE: This rider may not be beneficial to an insured that may become eligible for an off-group conversion policy. You should consider this when deciding whether to keep this rider. You may drop this rider and receive a refund of your UnitedHealth continuity premium if you notify us within 30 days after you received the rider.

By attachment of this Insurance Benefits UnitedHealth Continuity Rider ("rider"), the *policy/certificate* is amended to the extent of any conflict or inconsistency with the following:

DEFINITIONS:

In addition to the definitions in the *policy/certificate*, the following definitions apply to this rider:

- "Active", under this rider, means eligible for *insurance benefits*.
- "Covered spouse" means your spouse who is a *covered person* under the *policy/certificate*.
- "UnitedHealth continuity rider premium" means the amount *you* must pay to keep this rider in force and maintain the benefits of this rider.
- "Dormant", under this rider means ineligible for *insurance benefits*.
- "Employer-sponsored medical coverage" means any employer-sponsored medical insurance or HMO coverage.
- "Insurance benefits" means the right to receive reimbursement for *covered expenses*, according to the terms of the *policy/certificate*.
- "Insurance benefits premium" means premium for the *policy/certificate*, excluding the *UnitedHealth continuity rider premium*.
- "Involuntary terminates" means ceases for reason other than *voluntary termination*.
- "Policy active status" means the period of time that at least one (1) *covered person* is *active*.
- "Policy effective date" means the earliest date an individual becomes a *covered person* under the *policy/certificate*.
- "Satisfactory proof of employer coverage" means written documentation that clearly shows the person is currently, or will soon be, covered by *employer-sponsored medical coverage*.
- "Total premium" means the combined *insurance benefits premium* and *UnitedHealth continuity rider premium*.
- "Voluntary termination" or "voluntarily terminates" means *employer-sponsored medical coverage* ceases for any *covered person*: (a) because *you* or *your spouse* requests termination of the coverage; or (b) due to failure to pay required premium when due.

BENEFITS OF THIS RIDER:

The benefit of this rider is to enable a *covered person* to be *active* or *dormant* under the terms of the *policy/certificate*. A *covered person's* status depends on whether that person has *employer-sponsored medical coverage* and the terms of this rider.

If *employer-sponsored medical coverage* *involuntarily terminates*, the benefits of this rider continue.

If *employer-sponsored medical coverage* (other than COBRA coverage) for any *covered person*:

- A. *Voluntarily terminates*; and
- B. Is not replaced with other *employer-sponsored medical coverage* within 62 days;

then the benefits of this rider will be exhausted and no longer available for all *covered persons*. *UnitedHealth continuity rider premium* will no longer be required.

INSURANCE BENEFITS STATUS FOR COVERED PERSONS:

Before the *policy effective date*, you must declare in writing whether each *covered person* will begin *active* or *dormant*. A *covered person* may only begin in a *dormant* state if that *covered person* has *employer-sponsored medical coverage* on the *policy effective date*. One *covered person* may be *active* under this rider while another *covered person* is *dormant* under this rider.

WHEN A COVERED PERSON IS ACTIVE UNDER THIS RIDER:

- A. You are required to pay the *total premium* for all *covered persons* while *active*.
- B. When a *covered person* is *active*, that *covered person* will have the right to receive reimbursement for *covered expenses* according to the terms of the *policy/certificate*.

DEACTIVATION OF INSURANCE BENEFITS:

- A. You may request that we make a *covered person dormant* by providing us with *satisfactory proof of employer coverage* for that person. Upon receipt of such proof, that person will be *dormant* on the later of:
 - 1. The date that person is eligible to receive benefits under *employer-sponsored medical coverage*; or
 - 2. The date we receive the written request to make the person *dormant*.
- B. Each time a *covered person* is made *dormant*, we will provide written notice indicating that *insurance benefits* are not available.

WHEN A COVERED PERSON IS DORMANT UNDER THIS RIDER:

- A. You are required to pay the *UnitedHealth continuity rider premium* for all *covered persons* who are *dormant*.
- B. When a *covered person* is *dormant*, that *covered person* will not have the right to receive reimbursement for *covered expenses* according to the terms of the *policy/certificate*.
- C. In order to remain *dormant*, a *covered person* must be covered under *employer-sponsored medical coverage*. If *employer-sponsored medical coverage* terminates, see "Activation of Insurance Benefits" below.
- D. If you or your *covered spouse* voluntarily terminates *employer-sponsored medical coverage* for any *covered person(s)*, also see "Benefits of This Rider", page 1 of this rider.

ACTIVATION OF INSURANCE BENEFITS:

- A. If *employer-sponsored medical coverage* terminates for any *covered person*, that person will immediately be *active* under this rider.
 - 1. You have an obligation to provide us with written notice and pay the required premium within 62 days after a *covered person* becomes *active*; and
 - 2. If you do not pay the required premium within the 62 days, coverage for that person will lapse. We will refund all premiums for that person back to the date coverage lapsed.
- B. Each time a *covered person* becomes *active*, you have 120 days to provide us with written evidence that shows that the person has been covered by *employer-sponsored medical coverage*, with no lapse greater than 63 days, since the date the person was most recently made *dormant*. This evidence may include certificates of creditable coverage or other documents from the person's employers or insurers.
- C. If, within this 120 day period, you do not provide us with proof of coverage as explained in B. above, we will refund *UnitedHealth continuity rider premium* less any claims paid during the 120 day period and coverage will lapse for the affected person back to the date the person became *dormant*.

PREMIUMS:

You may keep the *policy/certificate* in force by timely payment of the *total premium* for *covered persons* who are *active* and the *UnitedHealth continuity rider premium* for *covered persons* who are *dormant*. If the benefits of this rider have been exhausted, you will only have to pay the *insurance benefits premium*.

- A. The *UnitedHealth continuity rider premium* will be a minimum dollar amount or percentage of each *covered person's insurance benefits premium*, whichever is greater. These minimum dollar and percentage amounts are set forth in the Data Page.
- B. The percentage will vary depending on whether each *covered person* is *active* or *dormant* as reflected in the Data Page.
- C. Any time there is an increase in *insurance benefits premium*, we will send you written notification, so you are informed of what the *total premium* will be when *active* and what the *UnitedHealth continuity rider premium* will be when *dormant*. The *insurance benefits premium* will increase even when *covered persons* are *dormant*.
- D. As long as the *policy/certificate* starts in *policy active status* and remains in *policy active status* for at least 12 months, the *UnitedHealth continuity rider premium* for that *covered person* will be reduced as set forth in the Data Page.

NEWBORNS:

- A. A child born to a *covered person* will be covered under the *policy/certificate* from the time of birth until the 31st day after that child's birth.
- B. Additional *total premium* or *UnitedHealth continuity rider premium* will be required to continue coverage beyond the 31st day after the birth of the child and will be calculated from the child's date of birth. Coverage of the child will terminate on the 31st day after his/her birth, unless we have received written notice of the child's birth and the required *total premium* or *UnitedHealth continuity rider premium* within 90 days of the child's birth.
- C. Once we are notified of the child's birth, we will inform the *covered person* of the required *total premium* amount and *UnitedHealth continuity rider premium* amount for the child. If the *covered person* elects to have the child's coverage be *active* under this rider, the *covered person* should pay the *total premium* amount. If the *covered person* elects to have the child's coverage be *dormant* under this rider, the *covered person* should pay the *UnitedHealth continuity rider premium* and provide us with *satisfactory proof of employer coverage* for the child.

ADDING OTHER DEPENDENTS:

If a *dependent* is added as insured under the terms of the *policy/certificate*, you must declare in writing whether the added *dependent* will be *active* or *dormant* under this rider. You must provide *satisfactory proof of employer coverage* for the added *dependent* to be *dormant*.

CHANGES TO YOUR DEDUCTIBLE:

- A. You may make a written request to change the *deductible amount* to an amount currently available at the time regardless of whether the *covered persons* are *active* or *dormant*.
- B. A written request to decrease the *deductible amount* will require *satisfactory proof of good health*.
- C. Any change in the *deductible amount* will become effective as of the next premium due date after we receive and, if required, approve the request. The *total premium* and *UnitedHealth continuity rider premium* will then be adjusted to reflect this change.

REINSTATEMENT:

A *covered person* must provide *satisfactory proof of employer coverage* for a *covered person* to be *dormant* upon reinstatement. If we approve reinstatement of coverage and include this rider, we will confirm the *active* or *dormant* status for each *covered person*.

12-MONTH EXCLUSION:

The 12-month exclusion period for expenses due to a *preexisting condition* or natural progression of a *preexisting condition* will be satisfied twelve (12) months after a *covered person's policy effective date*, even if a *covered person* is *dormant* during that 12-month period.

DISCONTINUANCE:

If a *covered person* is *dormant* at the time we notify you that:

- A. We are going to discontinue offering or refuse to renew this *policy/certificate* in your state; and

- B. We will not be offering a new *policy/certificate* with benefits similar to those under the *policy/certificate*, we will stop collecting the *UnitedHealth continuity rider premium* and refund any *UnitedHealth continuity rider premium* you have paid in the prior 36 months.

BENEFITS AFTER COVERAGE TERMINATES:

Benefits for *covered expenses* incurred after an individual ceases to be a *covered person* under the *policy* are provided for certain *illnesses* and *injuries* only if that *covered person* is *active* at the time of termination.

EFFECT ON DECREASING TERM LIFE RIDER/ACCIDENTAL DEATH:

A *covered person* is never *dormant* with regard to insurance under a decreasing term life rider/accidental death rider. Therefore, premium required to maintain the decreasing term life rider/accidental death rider is not affected by the Insurance Benefits UnitedHealth Continuity Rider.

EFFECT ON BENEFITS AVAILABLE UNDER OPTIONAL PREGNANCY EXPENSE BENEFITS RIDER (“Pregnancy Rider”):

- A. Benefits for *covered expenses* under the optional *Pregnancy Rider*, if any, will be available for a *covered person* who is *active* under this rider.
- B. If a female *covered person* is *dormant* and under a *Pregnancy Rider* with us, the female *covered person* will be *dormant* with respect to the *Pregnancy Rider*. If you want the female *covered person* to have the right to receive reimbursement for *covered expenses* under the *Pregnancy Rider* despite her *dormant* status for the base coverage, you must notify us in writing and pay the required premium. We will advise you of this option when a female *covered person* becomes *dormant*.
- C. Only the months that a *covered person* is *active* and insured under a *Pregnancy Rider* will be counted to satisfy a benefit year, as defined in the *Optional Pregnancy Rider*.

EFFECT ON PRESCRIPTION DRUG DISCOUNT CARD:

Discounts on prescription drug expenses available through use of any prescription drug discount card provided as a non-insurance benefit will be available only if a *covered person* is *active*.

TERMINATION OF UNITEDHEALTH CONTINUITY RIDER:

This rider will terminate if:

- A. You give us 10 days advance written notice that you wish to terminate it; or
- B. You fail to pay the *UnitedHealth continuity rider premium* within 30 days after it is due.

If this rider is terminated for any reason:

- A. It cannot be added back at any later date;
- B. *UnitedHealth continuity rider premium* will no longer be required; and
- C. You will be responsible to continue payment of the *insurance benefits premium* under the *policy* for any *covered person* who is *active* under this rider.

Except as specifically stated in this endorsement, the provisions in this endorsement are subject to all of the terms, conditions, exclusions, and limitations of the *policy/certificate*.

The rider will not change, waive or extend any part of the *policy/certificate*, other than as stated herein.

This rider is effective on the same day as the *policy/certificate*.

Golden Rule Insurance Company



President

DENTAL INSURANCE RIDER

By the attachment of this rider, the *policy/certificate* is amended as follows:

DEFINITIONS: For the purposes of this rider, the following terms have the meaning indicated:

- A. "*Basic service*" includes dental exams, X-rays, routine extractions, palliative treatment for dental pain, and simple restorative service (filling).
- B. "*Covered expense*" means a dental service that is:
 - 1. *Incurred* while the *covered person* is insured under this rider;
 - 2. Prescribed, ordered, recommended, authorized or approved for a *covered person* by a *dentist*;
 - 3. *Dentally necessary*;
 - 4. Covered by a specific benefit provision specified in this rider;
 - 5. Not excluded in the *policy/certificate*; and
 - 6. Allowed under all other applicable terms and conditions of the *policy/certificate/rider*.

We will not pay benefits for that part of a *covered expense* which:

- 1. Is subject to a *deductible amount*, or coinsurance or penalty;
- 2. Exceeds any applicable benefit maximum;
- 3. Exceeds the frequency limits described in this rider; or
- 4. Is subject to a *waiting period*.

We will not pay benefits for that part of a *covered expense* which exceeds:

- 1. The negotiated or contracted rate that would be reimbursed if that service or treatment were performed by a *preferred provider*, if the Data Page of the *policy/certificate* identifies *your* plan choice as Dental Value; or
 - 2. The *reasonable and customary charge* for that expense if the Data Page of the *policy/certificate* identifies *your* plan choice as Dental Premier.
- C. "*Dental emergency*" means severe pain, swelling or bleeding of the teeth or supporting tissue which occurs as the direct result of unforeseen events or circumstances and in the judgment of a reasonable person, requires immediate care and treatment, which is sought or received within 24 hours of onset.
 - D. "*Dental service*" means any of the following services or items that are provided for dental care or treatment provided by a *dentist* to the teeth or supporting tissue:
 - 1. Consultation, advice, diagnosis, surgery, visit, or referral;
 - 2. Procedure, treatment, or other care;
 - 3. Supply, equipment; or
 - 4. Drug or medicine.

However, if a *policy/certificate* section describes only certain services or items as dental services, then we will only pay benefits under that section for those services or items. In addition, we will not pay benefits for any *dental service* unless it satisfies the definition of a *covered expense*.

- E. "*Dentally necessary*" means necessary from a dental perspective, satisfying all of the following requirements:
 - 1. Does not exceed in scope, duration or intensity that level of care which is needed to provide safe, adequate, and appropriate diagnosis or treatment to the *covered person*;
 - 2. It is known to be safe, effective and appropriate by most U.S. *dentists* with regard to accepted standards of dental practice at the time when the *dental service* is provided;
 - 3. Cannot be provided primarily for the comfort or convenience of a *covered person* or *dentist*;

4. Cannot be omitted without an adverse affect;
5. Is appropriate for the *covered person's* diagnosis or symptoms; and
6. Is the most cost-effective treatment that is appropriate for the *covered person's* diagnosis. This means there is no other similar or alternate appropriate *dental service* as determined by *us* available at a lower cost.

A final decision to provide *dental services* can only be made by the *covered person* and his/her *dentist*. However, *we* will determine if a *dental service* is *dentally necessary* based on *our* consultation with an appropriate *dentist/consultant*.

To determine what is *dentally necessary*, *we* may require copies of dental records with information to support that treatment, level or frequency of treatment or that the appliance or device is consistent with the dental condition.

The fact that any particular *dentist* may prescribe, order, recommend, or approve a treatment, test, or procedure does not, of itself, make the treatment, test, or procedure, *dentally necessary*. A determination of what is *dentally necessary* does not constitute a dental treatment decision.

- F. "*Dentist*" means a legally licensed *dentist* practicing within the scope of the license and currently licensed by the state in which the services are provided. *Dentist* also includes:
1. A legally licensed oral surgeon, endodontist, periodontist, prosthodontist and pedodontist, practicing within the scope of his or her license; and
 2. A legally licensed dental hygienist practicing within the scope of the license while under the supervision of a *dentist*.

A *dentist* cannot be a family member of a *covered person*.

- G. "*Emergency palliative treatment*" means necessary procedures for the initial treatment of *dental emergency*. This treatment does not include periodontal treatment or any *dental service* to restore or replace a tooth.
- H. "*Incurred*" means that a *dental service* has been provided to a *covered person* and a fee or charge is owed to the *dentist* for the service. *Covered expenses* for *dental services* will be considered to be *incurred* for:
1. Appliances or a modification of appliances on the date the master impression is made;
 2. A crown, a bridge, a veneer or inlay or onlay restoration on the date the tooth or teeth are prepared;
 3. Root canal therapy, on the date the pulp chamber is opened; and
 4. All other charges on the date the *dental service* is rendered or a supply furnished.
- I. "*Major service*" includes endodontics, periodontics, major restorative services (crowns, inlays, onlays and veneers), prosthetics (bridges and dentures), or oral surgery for impactions.
- J. "*Network*" means a *preferred provider* organization comprised of a group of *dentists* that contracts with *us* to provide services covered by this plan at a contracted rate.
- K. "*Network area*" means a designated area where there are a sufficient number of *preferred provider dentists* to be identified as a *network area* on the Golden Rule website.
- L. "*Non-network area*" means an area where there are few or no *preferred provider dentists* and which is not identified as a *network area* on the Golden Rule website.
- M. "*Non-preferred provider*" means a *dentist* who has not agreed with a *network* to provide *dental services* at the contracted rate.
- N. "*Preferred provider*" means a *dentist* who has agreed with a *network* to provide *dental services* at the contracted rate and who is identified in the most current list of *preferred providers* for the *network* shown on *your* dental identification card.

- O. "*Preventive service*" includes dental exams, X-rays, prophylactic cleaning, fluoride treatment, sealants, and space maintainers.
- P. "*Proof of loss*" means information required by *us* to decide if a claim is payable and the amount that is payable. It includes, but is not limited to, claim forms, dental bills or records, other plan information, and network repricing information. *Proof of loss* must include a copy of all Explanation of Benefit forms from any other carrier, including Medicare.
- Q. "*Reasonable and customary charge*" means, with respect to fees charged, a fee calculated by *us* based on available data resources (Ingenix Survey of Dental Charges) of competitive fees in that geographic area. A fee will not be a *reasonable and customary charge* if it exceeds what the provider would charge any similarly situated payor for the same services. If a provider routinely waives coinsurance and/or the annual deductible for benefits, the fee for the *dental services* for which the coinsurance and/or the annual deductible are waived will not be a *reasonable and customary charge*.

"*Reasonable and customary charges*" are determined solely in accordance with *our* reimbursement policy guidelines. The reimbursement policy guidelines are developed by *us*, at *our* discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:
 1. As indicated in the most recent edition of the Current Procedural Terminology (publication of the American Dental Association);
 2. As reported by generally recognized professionals or publications;
 3. As utilized for Medicare;
 4. As determined by medical or dental staff and outside medical or dental consultants;
 5. Pursuant to any other appropriate source or determination accepted by *us*.
- R. "*Waiting Period*" means a period of time for which a *covered person* must wait, after the *effective date* of coverage, before *dental services* listed in Dental Benefits will be covered.

INDIVIDUAL AND FAMILY DEDUCTIBLES: *You* and/or *your covered dependent* may have to pay an individual *deductible amount* before *we* pay any benefits. The *deductible amount* may apply per calendar year or per lifetime as shown in the Data Page.

We may limit the number of deductibles for *you* and *your covered dependent* to a specific number of deductibles as shown in the Data Page.

COINSURANCE: *We* may require *you* and each covered *dependent* to pay a coinsurance amount. Coinsurance is a percentage of *covered expenses*. Coinsurance applies after applicable *deductible amounts* are met. Coinsurance amounts may vary for certain types of *dental services*. Coinsurance amounts are shown in the Data Page.

COPAYMENT: *You* or *your covered dependent* may have to pay a copayment for certain services payable under the *policy/certificate*. *You* are responsible for the payment of any copayment directly to the provider at the time of service, or when billed by the provider. If copayments apply, the amounts will be shown in the Data Page.

CALENDAR YEAR MAXIMUM: The total amount *we* will pay under this rider, may be limited to a yearly maximum as shown in the Data Page. The maximum applies each calendar year.

WAITING PERIOD: Benefits for certain types of *dental services* will not be payable until after a waiting period as shown in the Data Page has been satisfied.

PREDETERMINATION: If the total cost for a dental treatment plan is expected to be \$300 or more, *we* strongly encourage *you* or *your covered dependent* or the *dentist* to request a predetermination from *us*. The request must include information about the treatment plan. *We* will tell the *dentist* what benefit amount *we* expect to pay, subject to the Alternate Procedures section.

Our estimate is valid for 180 days from the date *we* provide it to the *dentist*, as long as *your* or *your covered dependent's* insurance is in force when the *dental expense* is *incurred*. If *you* or *your covered dependent* will not receive the *dental services* within the 180 days, *you* or *your covered dependent* or the *dentist* must

request another predetermination from us. *Dental services* must be *incurred* while *you or your covered dependents* are insured by the plan.

DENTAL BENEFITS: Benefits are limited to the *dental services* described below, per *covered person*, but only when each service is a *covered expense*:

- A. Oral evaluations (periodic, comprehensive and problem focused); payable twice in any calendar year.
- B. Prophylaxis or cleaning teeth, payable twice in any calendar year.
- C. Topical fluoride for a *covered person* who is not yet age 16, payable twice in any calendar year. Topical fluoride treatment should be done in conjunction with dental prophylaxis.
- D. Full mouth (which includes bitewings) or panorex X-rays, payable once every 36 months. An exception will be made to the 36-month limit if the full mouth or panorex X-rays is for diagnosis of third molars, cysts, or neoplasm.
- E. Up to four bitewing X-rays, payable once in any calendar year.
- F. Periapical X-rays.
- G. Sealants or preventive resin restorations, limited to once per first or second permanent molar every 36 consecutive months, for a *covered person* who is not yet age 16.
- H. Simple (nonsurgical) extractions.
- I. Injection of antibiotic drugs at the time of initial treatment.
- J. Palliative treatment when no other service, other than X-rays and exam, was done on the same tooth during the same visit.
- K. *Emergency palliative treatment* for dental pain.
- L. Amalgam fillings and direct resin fillings. Multiple restorations on one surface will be treated as a single filling.
- M. Analgesia, for a *covered person* who is not yet age 13.
- N. Sedative fillings as a separate benefit when no other service, other than X-rays and exam, was done on the same tooth during the same visit.
- O. Stainless steel crowns on primary teeth.
- P. Space maintainers to maintain space because of prematurely lost primary teeth, including the cost of recementing limited to once per lifetime, for a *covered person* who is not yet age 16. This includes all adjustments within 6 months of installation.
- Q. Repair or recementing of crowns, inlays, onlays, veneers, bridgework, or dentures, relines and rebases, but not within 6 months of the initial placement and not more than once in any 12-month period.
- R. Endodontic treatment, including root canals, pulpotomies on primary teeth and apicoectomy. To be a *covered expense*, pulpotomies performed on permanent teeth must be combined with the completed root canal.
- S. Periodontics, including procedures necessary for treatment of disease of the gums and bone supporting teeth. Periodontal maintenance and gingival inflammation cleaning procedures are covered as a routine prophylaxis benefit under *preventive services* if no active therapy has been performed. Active periodontal therapy means periodontal surgical or non-surgical treatment.

Periodontal maintenance procedures are payable twice in any calendar year. Periodontal root planing and scaling is payable every 24-month period, limited to four quadrants. Full mouth debridement, limited to once every 36 consecutive months.

The benefit for periodontal surgery includes three months of post-surgical care. Any periodontal surgery performed in the same quadrant within 36 consecutive months after the initial surgery was

performed is not payable. If more than one surgical service is performed on the same day, only the most inclusive surgical service performed will be considered a *covered expense*.

- T. Osseous grafts with or without restorable or nonrestorable GTR membrane replacement are limited to once every consecutive 36 months per quadrant or surgical site.
- U. Pin retention, limited to 2 pins per tooth; this is not a *covered expense* if pin retention is in addition to cast restoration. (Cast restoration is defined as crowns, inlays and onlays.)
- V. Inlays, onlays, or veneers limited to one time per 60 consecutive months.
- W. Core buildup, cast and prefabricated post and core. Posts and cores are *covered expenses* only for teeth that have had a root canal therapy.
- X. First installation of bridgework to replace one or more functioning natural teeth lost while *you* or *your* covered *dependents* are insured by this plan. This includes inlays and crowns as abutments.
- Y. Full or partial dentures or overdentures, payable once every 5 years. The amount we will pay for overdentures will not exceed the benefit we would pay for full dentures.
- Z. Oral surgery, including surgical extractions and removal of impacted teeth. Charges for diagnostic X-rays must be included in the charges for oral surgery to be a *covered expense*.
- AA. Congenital defects or anomalies, including but not limited to, all necessary treatment and care needed by individuals born with cleft lip or cleft palate for an *eligible child* who is a newborn, an adopted child or a foster child.
- BB. General anesthesia, but only:
 - 1. For removal of impacted teeth;
 - 2. For removal of seven or more teeth; or
 - 3. If *dentally necessary* in conjunction with complex oral surgery.

For all *covered expenses*, the following *dental services* will be considered part of the entire *dental service* and not eligible for benefits as a separate service: cement bases; pulp caps; study models/diagnostic casts; acid etch; bonding agents; and local anesthetic.

ALTERNATE PROCEDURES: If two or more services are considered to be acceptable to correct the same dental condition, the amount payable will be based on the *covered expenses* for the least expensive service that will produce a professionally satisfactory result as determined by *us* or *our* representatives.

If *you* decide or *your dentist* decides on a more costly treatment than *we* have determined to be satisfactory for treatment of the condition, payment will be subject to any applicable *deductible amount* and *coinsurance percentage* and will be limited to:

- 1. The negotiated or contracted rate that would be reimbursed if that service or treatment were performed by a *preferred provider*, if the Data Page of the *policy/certificate* identifies *your* plan choice as Dental Value; or
- 2. The *reasonable and customary charge* for that expense if the Data Page of the *policy/certificate* identifies *your* plan choice as Dental Premier.

EXCLUSIONS AND LIMITATIONS: For purposes of this rider only the following exclusion is removed from the *policy/certificate*:

For *dental expenses*, including braces for any medical or dental condition, *surgery* and treatment for oral *surgery*, except as expressly provided for under Medical Benefits.

And replaced with:

For *dental expenses*, including braces for any medical or dental condition, *surgery* and treatment for oral *surgery*, except as expressly provided for under the Medical Benefits provision of the health *policy/certificate* or this dental benefit rider.

Covered expenses will not include, and no benefits under this rider will be paid for any charges that are *incurred* for:

- A. Any expense or service related to that expense:
 - 1. That is not a *covered expense*.
 - 2. *Incurred* during the *waiting period*.
 - 3. To the extent that expense exceeds:
 - (a) The negotiated or contracted rate that would be reimbursed if that service or treatment were performed by a *preferred provider*, if the Data Page of the *policy/certificate* identifies *your* plan choice as Dental Value; or
 - (b) The *reasonable and customary charge* for that expense, if the Data Page of the *policy/certificate* identifies *your* plan choice as Dental Premier.
 - 4. For which no benefit is described in this rider or in the Data Page.
 - 5. For a *dental service* that is not rendered or that is not rendered within the scope of the *dentist's* license.
 - 6. Billed for incision and drainage if the involved abscessed tooth is removed on the same date of service.
 - 7. For telephone consultations or for failure to keep a scheduled appointment.
 - 8. For any *dental service incurred* directly or indirectly as a result of the *covered person* being intoxicated, as defined by applicable state law in the state in which the *loss* occurred, or under the influence of illegal narcotics or controlled substance unless administered or prescribed by a *doctor*.
 - 9. For or while receiving *investigational treatment* or for complications therefrom, including expenses that might otherwise be covered if they were not *incurred* in conjunction with, as a result of, or while receiving *investigational treatment*.
 - 10. For the treatment of an occupational injury or illness which are paid under the North Carolina Workers Compensation Act only to the extent such services or supplies are the liability of the employee, employer, or workers compensation insurance carrier according to a final adjudication under the North Carolina Workers Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers Compensation Act.
 - 11. As a result of:
 - (a) Intentionally self-inflicted bodily harm (whether the *covered person* is sane or insane);
 - (b) *Dental Services* necessitated due to any act of declared or undeclared war;
 - (c) The *covered person's* active participation in a riot; or
 - (d) The *covered person's* commission of a felony, whether or not charged.
- B. Any *dental service*:
 - 1. Provided by a government plan, program, *hospital* or other facility, unless by law *you* or *your* *covered dependent* must pay and it is otherwise a *covered expense*.
 - 2. Which by law must be provided by an educational institution.
 - 3. Which would be free of charge without this insurance, unless provided by Medicaid, or by the Veterans Administration for non-service related *dental services* and by law *we* are required to pay.
 - 4. Provided prior to the effective date or after the termination date of this rider.
 - 5. Provided by a family member or by someone who ordinarily resides with *you* or *your* *covered dependent*.

6. Received outside of the United States, except for a *dental emergency*.
 7. For jaw-joint problems, including but not limited to: temporomandibular or craniomandibular joint dysfunction, myofunctional therapy, physical therapy.
 8. Relating to: teeth that can be restored by other means; for purposes of periodontal splinting; to correct abrasion, erosion, attrition, bruxism, abfraction, or for desensitization; or teeth that are not periodontally sound or have a questionable prognosis as determined by *us*.
 9. That is considered cosmetic dentistry, including, but not limited to: porcelain on a crown, abutment or pontics posterior to the second bicuspid; personalization or characterization of prosthetic devices; or composite restorations on molar and/or bicuspid teeth. Alternate services will be applied allowing benefits for amalgam restoration; bleaching; and services done to alter the shape or size of teeth. (Cosmetic services are those services that improve physical appearance.)
- C. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
 - D. Changing vertical dimension; restoring occlusion; bite analysis; congenital malformation.
 - E. Orthognathic surgery to correct malposition of jaw bones.
 - F. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
 - G. Treatment of malignant or benign neoplasms, cysts, or other pathology, except excisional removal.
 - H. Replacement of full or partial removable dentures, bridges, crowns, inlays, onlays or veneers which can be repaired or restored to natural function.
 - I. Mouthguards; precision or semi-precision attachments; duplicate dentures; harmful habit appliances; occlusal guard; replacement of lost or stolen appliances; replacement of orthodontic retainers; treatment splints; bruxism appliance; sleep disorder appliance; and gold foil restorations.
 - J. Oral hygiene instructions; plaque control; charges for completing dental claim forms; photographs; any dental supplies including but not limited to take-home fluoride; prescription and non-prescription drugs, with or without a prescription, unless they are dispensed and utilized in the dental office during *your* or *your covered dependent's* dental visit, except *we* will pay for injection of antibiotic drugs at the time of initial treatment; sterilization fees; diagnostic casts; treatment of halitosis and any related procedures; lab procedures.
 - K. Initial placement of full or partial dentures or bridges and related services, to replace functional natural teeth that are:
 1. Congenitally missing, except as expressly provided for under the Dental Benefits provision of this rider; or
 2. Lost before insurance under this rider is in effect.

However, benefits are available for *covered expenses* for initial placement of full or partial dentures or bridges to replace loss of functional natural teeth, including necessary adjustments during the first 6 months following the date of placement, only if:

 1. The teeth were lost while the *covered person* was under the *policy/certificate* and this rider and the initial placement is within 12 months of the date of loss of the teeth; or
 2. The extraction took place while the *covered person* was both under age 16 and insured under this rider.
 - L. Replacement within 60 consecutive months of the last placement for full and partial dentures and replacement within 60 consecutive months of the last placement for crowns, bridges, inlays, onlays and veneers. This exclusion does not apply if the replacement is necessary because of extraction of a functioning natural tooth; or a present crown, bridge, or denture is temporary and a permanent crown, bridge or denture is installed within 12 months from the date the temporary service was installed.

- M. Replacement of crowns, bridges, dentures and fixed or removable prosthetic appliances inserted prior to plan coverage unless the *covered person* has been insured under the plan for 12 continuous months. If loss of a tooth requires the addition of a clasp, pontic, and/or abutment(s) within this 12-month period, *dental services* associated with the addition will be covered when the service is a *covered expense*.
- N. Replacement of complete dentures, fixed and removable partial dentures or crowns if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the *dentist*. If replacement is necessary because of *your* or *your dependent's* non-compliance, *you* are liable for the cost of the replacement.
- O. Dental implants and any related procedures, including but not limited to crowns, bridges, and dentures.
- P. *Hospital* or other facility charges and related anesthesia charges.
- Q. Removal of sound functional restorations; temporary crowns and temporary prosthetics; provisional crowns and provisional prosthesis.
- R. Local anesthetic; analgesia; and behavior management and conscious sedation.
- S. Charges for *dental services* that are not documented in the *dentist* records, not directly associated with dental disease or not performed in a dental setting.
- T. Orthodontia.
- U. Acupuncture; acupressure and other forms of alternative treatment.
- V. Bone grafts, guided tissue regeneration, biologic materials to aid in soft and osseous tissue regeneration when performed in edentulous (toothless areas, ridge augmentation or preservations).
- W. Any *dental services* for which benefits are payable under the medical *policy/certificate*. *We* will not duplicate benefits under this dental rider that are also payable under the *covered person's* health coverage.
- X. Any *dental services* for which benefits are excluded in the General Exclusions and Limitations section of the *policy/certificate*.

PREEXISTING CONDITIONS LIMITATION: The Preexisting Conditions Limitation does not apply to dental.

HEALTH INSURANCE FOR DENTAL SERVICES: *We* will not duplicate benefits under this dental rider that are also payable under the *covered person's* health coverage. If any *covered expenses* under the *policy/certificate* are also payable under health insurance or other health coverage, *we* will not make payment under this dental rider until after *we* determine what benefits are paid or payable by the health insurance or other health coverage plan.

Our payment under this rider will be reduced by the amount of any benefits that are payable for a *covered person* by any other dental or health plan.

Your out-of-pocket expenses for dental benefits will not apply to *your out-of-pocket expenses* for medical benefits.

DENTAL EXAM: At *our* expense, *we* have the authority to require *you* or *your covered dependent* to have a dental exam with a *dentist* at any time regarding a claim for benefits.

PROVIDER DISCOUNTS: *We* may have established an arrangement with certain *dentists* to offer a discount on services rendered. For the purposes of this provision, discount means any negotiated reduction or variation from the schedule of billed charges that a *dentist* otherwise would require a patient and/or *us* to pay to that *dentist*.

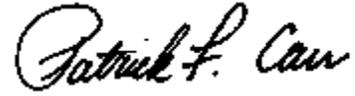
DENTAL CLAIMS INCURRED PRIOR TO A TERMINATION DATE: Termination of insurance or termination of a benefit will not apply to a valid claim for benefits *incurred* before the termination date.

TERMINATION OF DENTAL COVERAGE: Dental coverage provided under this rider terminates for any *covered person* when medical coverage for that *covered person* terminates.

This rider will not change, waive, or extend any part of the *policy/certificate*, other than as stated herein.

This rider is effective at the same time as the *policy/certificate*, unless a later date is specified.

Golden Rule Insurance Company

A handwritten signature in black ink that reads "Patrick F. Carr". The signature is written in a cursive style with a large initial "P".

President

DENTAL INSURANCE RIDER

By the attachment of this rider, the *policy/certificate* is amended as follows:

DEFINITIONS: For the purposes of this rider, the following terms have the meaning indicated:

- A. "*Basic service*" includes dental exams, X-rays, routine extractions, palliative treatment for dental pain, and simple restorative service (filling).
- B. "Covered expense" means a dental service that is:
 - 1. *Incurred* while the *covered person* is insured under this rider;
 - 2. Prescribed, ordered, recommended, authorized or approved for a *covered person* by a *dentist*;
 - 3. *Dentally necessary*;
 - 4. Covered by a specific benefit provision specified in this rider;
 - 5. Not excluded in the *policy/certificate*; and
 - 6. Allowed under all other applicable terms and conditions of the *policy/certificate/rider*.

We will not pay benefits for that part of a *covered expense* which:

- 1. Is subject to a *deductible amount*, coinsurance or penalty;
- 2. Exceeds any applicable benefit maximum;
- 3. Exceeds the frequency limits described in this rider; or
- 4. Is subject to a *waiting period*.

We will not pay benefits for that part of a *covered expense* which exceeds:

- 1. The negotiated or contracted rate that would be reimbursed if that service or treatment were performed by a *preferred provider*, if the Data Page of the *policy/certificate* identifies *your* plan choice as Dental Value; or
 - 2. The *reasonable and customary charge* for that expense if the Data Page of the *policy/certificate* identifies *your* plan choice as Dental Premier.
- C. "*Dental emergency*" means severe pain, swelling or bleeding of the teeth or supporting tissue which occurs as the direct result of unforeseen events or circumstances and in the judgment of a reasonable person, requires immediate care and treatment, which is sought or received within 24 hours of onset.
 - D. "*Dental service*" means any of the following services or items that are provided for dental care or treatment provided by a *Dentist* to the teeth or supporting tissue:
 - 1. Consultation, advice, diagnosis, surgery, visit, or referral;
 - 2. Procedure, treatment, or other care;
 - 3. Supply, equipment; or
 - 4. Drug or medicine.

However, if a *policy/certificate* section describes only certain services or items as dental services, then we will only pay benefits under that section for those services or items. In addition, we will not pay benefits for any *dental service* unless it satisfies the definition of a *covered expense*.

- E. "*Dentally necessary*" means necessary from a dental perspective, satisfying all of the following requirements:
 - 1. Does not exceed in scope, duration or intensity that level of care which is needed to provide safe, adequate, and appropriate diagnosis or treatment to the *covered person*;
 - 2. It is known to be safe, effective and appropriate by most U.S. *dentists* with regard to accepted standards of dental practice at the time when the *dental service* is provided;

3. Cannot be provided primarily for the comfort or convenience of a *covered person* or *dentist*;
4. Cannot be omitted without an adverse affect;
5. Is appropriate for the *covered person's* diagnosis or symptoms; and
6. Is the most cost-effective treatment that is appropriate for the *covered person's* diagnosis. This means there is no other similar or alternate appropriate *dental service* as determined by *us* available at a lower cost.

A final decision to provide *dental services* can only be made by the *covered person* and his/her *dentist*. However, we will determine if a *dental service* is *dentally necessary* based on our consultation with an appropriate *dentist/consultant*.

To determine what is *dentally necessary*, we may require copies of dental records with information to support that treatment, level or frequency of treatment or that the appliance or device is consistent with the dental condition.

The fact that any particular *dentist* may prescribe, order, recommend, or approve a treatment, test, or procedure does not, of itself, make the treatment, test, or procedure, *dentally necessary*. A determination of what is *dentally necessary* does not constitute a dental treatment decision.

- F. "*Dentist*" means a legally licensed *dentist* practicing within the scope of the license and currently licensed by the state in which the services are provided. *Dentist* also includes:
1. A legally licensed oral surgeon, endodontist, periodontist, prosthodontist and pedodontist, practicing within the scope of his or her license; and
 2. A legally licensed dental hygienist practicing within the scope of the license while under the supervision of a *dentist*.
- A *dentist* cannot be a family member of a *covered person*.
- G. "*Emergency palliative treatment*" means necessary procedures for the initial treatment of *dental emergency*. This treatment does not include periodontal treatment or any *dental service* to restore or replace a tooth.
- H. "*Incurred*" means that a *dental service* has been provided to a *covered person* and a fee or charge is owed to the *dentist* for the service. *Covered expenses* for *dental services* will be considered to be *incurred* for:
1. Appliances or a modification of appliances on the date the master impression is made;
 2. A crown, a bridge, a veneer or inlay or onlay restoration on the date the tooth or teeth are prepared;
 3. Root canal therapy, on the date the pulp chamber is opened; and
 4. All other charges on the date the *dental service* is rendered or a supply furnished.
- I. "*Major service*" includes endodontics, periodontics, major restorative services (crowns, inlays, onlays and veneers), prosthetics (bridges and dentures), or oral surgery for impactions.
- J. "*Network*" means a *preferred provider* organization comprised of a group of *dentists* that contracts with *us* to provide services covered by this plan at a contracted rate.
- K. "*Network area*" means a designated area where there are a sufficient number of *preferred provider dentists* to be identified as a *network area* on the Golden Rule website.
- L. "*Non-network area*" means an area where there are few or no *preferred provider dentists* and which is not identified as a *network area* on the Golden Rule website.
- M. "*Non-preferred provider*" means a *dentist* who has not agreed with a *network* to provide *dental services* at the contracted rate.
- N. "*Preferred provider*" means a *dentist* who has agreed with a *network* to provide *dental services* at the contracted rate and who is identified in the most current list of *preferred providers* for the *network* shown on *your* dental identification card.

- O. "*Preventive service*" includes dental exams, X-rays, prophylactic cleaning, fluoride treatment, sealants, and space maintainers.
- P. "*Proof of loss*" means information required by *us* to decide if a claim is payable and the amount that is payable. It includes, but is not limited to, claim forms, dental bills or records, other plan information, and network repricing information. *Proof of loss* must include a copy of all Explanation of Benefit forms from any other carrier, including Medicare.
- Q. "*Reasonable and customary charge*" means, with respect to fees charged, a fee calculated by *us* based on available data resources (Ingenix Survey of Dental Charges) of competitive fees in that geographic area. A fee will not be a *reasonable and customary charge* if it exceeds what the provider would charge any similarly situated payor for the same services. If a provider routinely waives coinsurance and/or the annual deductible for benefits, the fee for the *dental services* for which the coinsurance and/or the annual deductible are waived will not be a *reasonable and customary charge*.

"*Reasonable and customary charges*" are determined solely in accordance with *our* reimbursement policy guidelines. The reimbursement policy guidelines are developed by *us*, at *our* discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:
 1. As indicated in the most recent edition of the Current Procedural Terminology (publication of the American Dental Association);
 2. As reported by generally recognized professionals or publications;
 3. As utilized for Medicare;
 4. As determined by medical or dental staff and outside medical or dental consultants;
 5. Pursuant to any other appropriate source or determination accepted by *us*.
- R. "*Waiting Period*" means a period of time for which a *covered person* must wait, after the *effective date* of coverage, before *dental services* listed in Dental Benefits will be covered.

INDIVIDUAL AND FAMILY DEDUCTIBLES: *You* and/or *your* covered *dependent* may have to pay an individual *deductible amount* before *we* pay any benefits. The *deductible amount* may apply per calendar year or per lifetime as shown in the Data Page.

We may limit the number of deductibles for *you* and *your* covered *dependent* to a specific number of deductibles as shown in the Data Page.

COINSURANCE: *We* may require *you* and each covered *dependent* to pay a coinsurance amount. Coinsurance is a percentage of *covered expenses*. Coinsurance applies after applicable *deductible amounts* are met. Coinsurance amounts may vary for certain types of *dental services*. Coinsurance amounts are shown in the Data Page.

COPAYMENT: *You* or *your* covered *dependent* may have to pay a copayment for certain services payable under the *policy/certificate*. *You* are responsible for the payment of any copayment directly to the provider at the time of service, or when billed by the provider. If copayments apply, the amounts will be shown in the Data Page.

CALENDAR YEAR MAXIMUM: The total amount *we* will pay under this rider, may be limited to a yearly maximum as shown in the Data Page. The maximum applies each calendar year.

WAITING PERIOD: Benefits for certain types of *dental services* will not be payable until after a waiting period as shown in the Data Page has been satisfied.

PREDETERMINATION: If the total cost for a dental treatment plan is expected to be \$300 or more, *we* strongly encourage *you* or *your* covered *dependent* or the *dentist* to request a predetermination from *us*. The request must include information about the treatment plan. *We* will tell the *dentist* what benefit amount *we* expect to pay, subject to the Alternate Procedures section.

Our estimate is valid for 180 days from the date *we* provide it to the *dentist*, as long as *your* or *your* covered *dependent's* insurance is in force when the *dental expense* is *incurred*. If *you* or *your* covered *dependent* will not receive the *dental services* within the 180 days, *you* or *your* covered *dependent* or the *dentist* must

request another predetermination from us. *Dental services* must be *incurred* while *you or your covered dependents* are insured by the plan.

DENTAL BENEFITS: Benefits are limited to the *dental services* described below, per *covered person*, but only when each service is a *covered expense*:

- A. Oral evaluations (periodic, comprehensive and problem focused); payable twice in any calendar year.
- B. Prophylaxis or cleaning teeth, payable twice in any calendar year.
- C. Topical fluoride for a *covered person* who is not yet age 16, payable twice in any calendar year. Topical fluoride treatment should be done in conjunction with dental prophylaxis.
- D. Full mouth (which includes bitewings) or panorex X-rays, payable once every 36 months. An exception will be made to the 36-month limit if the full mouth or panorex X-rays is for diagnosis of third molars, cysts, or neoplasm.
- E. Up to four bitewing X-rays, payable once in any calendar year.
- F. Periapical X-rays.
- G. Sealants or preventive resin restorations, limited to once per first or second permanent molar every 36 consecutive months, for a *covered person* who is not yet age 16.
- H. Simple (nonsurgical) extractions.
- I. Injection of antibiotic drugs at the time of initial treatment.
- J. Palliative treatment when no other service, other than X-rays and exam, was done on the same tooth during the same visit.
- K. *Emergency palliative treatment* for dental pain.
- L. Amalgam fillings and direct resin fillings. Multiple restorations on one surface will be treated as a single filling.
- M. Analgesia, for a *covered person* who is not yet age 13.
- N. Sedative fillings as a separate benefit when no other service, other than X-rays and exam, was done on the same tooth during the same visit.
- O. Stainless steel crowns on primary teeth.
- P. Space maintainers to maintain space because of prematurely lost primary teeth, including the cost of recementing limited to once per lifetime, for a *covered person* who is not yet age 16. This includes all adjustments within 6 months of installation.
- Q. Repair or recementing of crowns, inlays, onlays, veneers, bridgework, or dentures, relines and rebases, but not within 6 months of the initial placement and not more than once in any 12-month period.
- R. Endodontic treatment, including root canals, pulpotomies on primary teeth and apicoectomy. To be a *covered expense*, pulpotomies performed on permanent teeth must be combined with the completed root canal.
- S. Periodontics, including procedures necessary for treatment of disease of the gums and bone supporting teeth. Periodontal maintenance and gingival inflammation cleaning procedures are covered as a routine prophylaxis benefit under *preventive services* if no active therapy has been performed. Active periodontal therapy means periodontal surgical or non-surgical treatment.

Periodontal maintenance procedures are payable twice in any calendar year. Periodontal root planing and scaling is payable every 24-month period, limited to four quadrants. Full mouth debridement, limited to once every 36 consecutive months.

The benefit for periodontal surgery includes three months of post-surgical care. Any periodontal surgery performed in the same quadrant within 36 consecutive months after the initial surgery was performed is not payable. If more than one surgical service is performed on the same day, only the most inclusive surgical service performed will be considered a *covered expense*.

- T. Osseous grafts with or without restorable or nonrestorable GTR membrane replacement are limited to once every consecutive 36 months per quadrant or surgical site.
- U. Pin retention, limited to 2 pins per tooth; this is not a *covered expense* if pin retention is in addition to cast restoration. (Cast restoration is defined as crowns, inlays and onlays.)
- V. Inlays, onlays, or veneers limited to one time per 60 consecutive months.
- W. Core buildup, cast and prefabricated post and core. Posts and cores are *covered expenses* only for teeth that have had a root canal therapy.
- X. First installation of bridgework to replace one or more functioning natural teeth lost while *you or your covered dependents* are insured by this plan. This includes inlays and crowns as abutments.
- Y. Full or partial dentures or overdentures, payable once every 5 years. The amount *we* will pay for overdentures will not exceed the benefit *we* would pay for full dentures.
- Z. Oral surgery, including surgical extractions and removal of impacted teeth. Charges for diagnostic X-rays must be included in the charges for oral surgery to be a *covered expense*.
- AA. General anesthesia, but only:
 1. For removal of impacted teeth;
 2. For removal of seven or more teeth; or
 3. If *dentally necessary* in conjunction with complex oral surgery.

For all *covered expenses*, the following *dental services* will be considered part of the entire *dental service* and not eligible for benefits as a separate service: cement bases; pulp caps; study models/diagnostic casts; acid etch; bonding agents; and local anesthetic.

ALTERNATE PROCEDURES: If two or more services are considered to be acceptable to correct the same dental condition, the amount payable will be based on the *covered expenses* for the least expensive service that will produce a professionally satisfactory result as determined by *us* or *our* representatives.

If *you* decide or *your dentist* decides on a more costly treatment than *we* have determined to be satisfactory for treatment of the condition, payment will be subject to any applicable *deductible amount* and *coinsurance percentage* and will be limited to:

1. The negotiated or contracted rate that would be reimbursed if that service or treatment were performed by a *preferred provider*, if the Data Page of the *policy/certificate* identifies *your* plan choice as Dental Value; or
2. The *reasonable and customary charge* for that expense if the Data Page of the *policy/certificate* identifies *your* plan choice as Dental Premier.

EXCLUSIONS AND LIMITATIONS: For purposes of this rider only the following exclusion is removed from the *policy/certificate*:

For *dental expenses*, including braces for any medical or dental condition, *surgery* and treatment for oral *surgery*, except as expressly provided for under Medical Benefits.

And replaced with:

For *dental expenses*, including braces for any medical or dental condition, *surgery* and treatment for oral *surgery*, except as expressly provided for under the Medical Benefits provision of the health *policy/certificate* or this dental benefit rider.

Covered expenses will not include, and no benefits under this rider will be paid for any charges that are *incurred* for:

- A. Any expense or service related to that expense:
 1. That is not a *covered expense*.
 2. Incurred during the waiting period.
 3. To the extent that expense exceeds:

- (a) The negotiated or contracted rate that would be reimbursed if that service or treatment were performed by a *preferred provider*, if the Data Page of the *policy/certificate* identifies *your* plan choice as Dental Value; or
 - (b) The *reasonable and customary charge* for that expense, if the Data Page of the *policy/certificate* identifies *your* plan choice as Dental Premier.
4. For which no benefit is described in this rider or in the Data Page.
 5. For a *dental service* that is not rendered or that is not rendered within the scope of the *dentist's* license.
 6. Billed for incision and drainage if the involved abscessed tooth is removed on the same date of service.
 7. For telephone consultations or for failure to keep a scheduled appointment.
 8. For any *dental service incurred* directly or indirectly as a result of the *covered person* being intoxicated, as defined by applicable state law in the state in which the *loss* occurred, or under the influence of illegal narcotics or controlled substance unless administered or prescribed by a *doctor*.
 9. For or while receiving *investigational treatment* or for complications therefrom, including expenses that might otherwise be covered if they were not *incurred* in conjunction with, as a result of, or while receiving *investigational treatment*.
 10. As a result of *dental services* arising out of, or in the course of, employment for wage or profit, if the *covered person* is insured, or is required to be insured, by workers' compensation insurance pursuant to the applicable state or federal law.
 11. As a result of:
 - (a) Intentionally self-inflicted bodily harm (whether the *covered person* is sane or insane);
 - (b) *Dental Services* necessitated due to any act of declared or undeclared war when the *covered person* is serving in the military or an auxiliary unit;
 - (c) The *covered person* taking part in a riot; or
 - (d) The *covered person's* commission of a felony, whether or not charged.

B. Any *dental service*:

1. Provided by a government plan, program, *hospital* or other facility, unless by law *you* or *your* covered *dependent* must pay and it is otherwise a *covered expense*.
2. Which by law must be provided by an educational institution.
3. Which would be free of charge without this insurance, unless provided by Medicaid, or by the Veterans Administration for non-service related *dental services* and by law *we* are required to pay.
4. Provided prior to the effective date or after the termination date of this rider.
5. Provided by a family member or by someone who ordinarily resides with *you* or *your* covered *dependent*.
6. Received outside of the United States, except for a *dental emergency*.
7. For jaw-joint problems, including but not limited to: temporomandibular or craniomandibular joint dysfunction, myofunctional therapy, physical therapy.
8. Relating to: teeth that can be restored by other means; for purposes of periodontal splinting; to correct abrasion, erosion, attrition, bruxism, abfraction, or for desensitization; or teeth that are not periodontally sound or have a questionable prognosis as determined by *us*.
9. That is considered cosmetic dentistry, including, but not limited to: porcelain on a crown, abutment or pontics posterior to the second bicuspid; personalization or characterization of prosthetic devices; or composite restorations on molar and/or bicuspid teeth. Alternate services

will be applied allowing benefits for amalgam restoration; bleaching; and services done to alter the shape or size of teeth. (Cosmetic services are those services that improve physical appearance.)

- C. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
- D. Changing vertical dimension; restoring occlusion; bite analysis; congenital malformation.
- E. Orthognathic surgery to correct malposition of jaw bones.
- F. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
- G. Treatment of malignant or benign neoplasms, cysts, or other pathology, except excisional removal.
- H. Replacement of full or partial removable dentures, bridges, crowns, inlays, onlays or veneers which can be repaired or restored to natural function.
- I. Mouthguards; precision or semi-precision attachments; duplicate dentures; harmful habit appliances; occlusal guard; replacement of lost or stolen appliances; replacement of orthodontic retainers; treatment splints; bruxism appliance; sleep disorder appliance; and gold foil restorations.
- J. Oral hygiene instructions; plaque control; charges for completing dental claim forms; photographs; any dental supplies including but not limited to take-home fluoride; prescription and non-prescription drugs, with or without a prescription, unless they are dispensed and utilized in the dental office during *your* or *your covered dependent's* dental visit, except we will pay for injection of antibiotic drugs at the time of initial treatment; sterilization fees; diagnostic casts; treatment of halitosis and any related procedures; lab procedures.
- K. Initial placement of full or partial dentures or bridges and related services, to replace functional natural teeth that are:

- 1. Congenitally missing; or
- 2. Lost before insurance under this rider is in effect.

However, benefits are available for *covered expenses* for initial placement of full or partial dentures or bridges to replace loss of functional natural teeth, including necessary adjustments during the first 6 months following the date of placement, only if:

- 1. The teeth were lost while the *covered person* was under the *policy/certificate* and this rider and the initial placement is within 12 months of the date of loss of the teeth; or
 - 2. The extraction took place while the *covered person* was both under age 16 and insured under this rider.
- L. Replacement within 60 consecutive months of the last placement for full and partial dentures and replacement within 60 consecutive months of the last placement for crowns, bridges, inlays, onlays and veneers. This exclusion does not apply if the replacement is necessary because of extraction of a functioning natural tooth; or a present crown, bridge, or denture is temporary and a permanent crown, bridge or denture is installed within 12 months from the date the temporary service was installed.
 - M. Replacement of crowns, bridges, dentures and fixed or removable prosthetic appliances inserted prior to plan coverage unless the covered person has been insured under the plan for 12 continuous months. If loss of a tooth requires the addition of a clasp, pontic, and/or abutment(s) within this 12-month period, dental services associated with the addition will be covered when the service is a covered expense.
 - N. Replacement of complete dentures, fixed and removable partial dentures or crowns if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the *dentist*. If replacement is necessary because of *your* or *your dependent's* non-compliance, *you* are liable for the cost of the replacement.
 - O. Dental implants and any related procedures, including but not limited to crowns, bridges, and dentures.

- P. *Hospital* or other facility charges and related anesthesia charges.
- Q. Removal of sound functional restorations; temporary crowns and temporary prosthetics; provisional crowns and provisional prosthesis.
- R. Local anesthetic; analgesia; and behavior management and conscious sedation.
- S. Charges for *dental services* that are not documented in the *dentist* records, not directly associated with dental disease or not performed in a dental setting.
- T. Orthodontia.
- U. Acupuncture; acupressure and other forms of alternative treatment.
- V. Bone grafts, guided tissue regeneration, biologic materials to aid in soft and osseous tissue regeneration when performed in edentulous (toothless areas, ridge augmentation or preservations).
- W. Any *dental services* for which benefits are payable under the medical *policy/certificate*.
- X. Any *dental services* for which benefits are excluded in the General Exclusions and Limitations section of the *policy/certificate*.

PREEXISTING CONDITIONS LIMITATION: The Preexisting Conditions Limitation does not apply to dental.

HEALTH INSURANCE FOR DENTAL SERVICES: If any *covered expenses* under the *policy/certificate* are also payable under health insurance or other health coverage, we will not make payment under this dental rider until after we determine what benefits are paid or payable by the health insurance or other health coverage plan.

Our payment under this rider will be reduced by the amount of any benefits that are payable for a *covered person* by any other dental or health plan.

Your *out-of-pocket expenses* for dental benefits will not apply to your *out-of-pocket expenses* for medical benefits.

DENTAL EXAM: At our expense, we have the authority to require you or your *covered dependent* to have a dental exam with a *dentist* at any time regarding a claim for benefits.

PROVIDER DISCOUNTS: We may have established an arrangement with certain *dentists* to offer a discount on services rendered. For the purposes of this provision, discount means any negotiated reduction or variation from the schedule of billed charges that a *dentist* otherwise would require a patient and/or us to pay to that *dentist*.

DENTAL CLAIMS INCURRED PRIOR TO A TERMINATION DATE: Termination of insurance or termination of a benefit will not apply to a valid claim for benefits *incurred* before the termination date.

TERMINATION OF DENTAL COVERAGE: Dental coverage provided under this rider terminates for any *covered person* when medical coverage for that *covered person* terminates.

This rider will not change, waive, or extend any part of the *policy/certificate*, other than as stated herein.

This rider is effective at the same time as the *policy/certificate*, unless a later date is specified.

Golden Rule Insurance Company



President

NORTH CAROLINA ENDORSEMENT

By attachment of this endorsement, the *policy/certificate* is amended to the extent of any conflict with the following:

MGR03433

A. The Definitions section is amended as follows:

1. The definition of *complications of pregnancy* is amended to include *medically necessary fetal reduction*.

MGR04132

2. The definition of *medical practitioner* is amended to include an advanced practice nurse, licensed registered nurse, licensed clinical social worker, certified substance abuse professional, licensed professional counselor, certified fee-based pastoral counselor, licensed marriage and family therapist and licensed pharmacist.

MGR03811

3. The definition of *emergency* is deleted and replaced with the following:

"Emergency" means a medical condition manifesting itself by acute symptoms of sufficient severity, including, but not limited to, severe pain, or by acute symptoms developing from a chronic medical condition that would lead a prudent layperson, possessing an average knowledge of health and medicine, to reasonably expect the absence of immediate medical attention to result in any of the following:

- (a) Placing the health of an individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;
- (b) Serious impairment to bodily functions; or
- (c) Serious dysfunction of any bodily organ or part.

If *you* or a *covered person* experiences an *emergency* medical condition, one of the ways to access emergency services is to call 9-1-1.

MGR04004

4. As defined, the term *hospital* shall include a tax-supported institution, including a community mental health center or other health clinic certified as a Medicaid provider.

MGR04043

5. The definition of *medically necessary* is deleted and replaced with the following:

"Medically necessary" means those covered services or supplies that are:

- (a) Provided for the diagnosis, treatment, cure or relief of a health condition, *illness, injury, or disease* and, except for participation in a covered clinical trial, are not for experimental, investigational, or cosmetic purposes;
- (b) Necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, *illness, injury, disease or its symptoms*;
- (c) Within generally accepted standards of medical care in the community; and
- (d) Not solely for the convenience of the insured, the insured's family, or the provider.

For *medically necessary* services, nothing in this subsection precludes an insurer from comparing the cost-effectiveness of alternate services or supplies when determining which of the services or supplies will be covered.

MGR04136

6. The following definitions are added:

"Clinical trials" means phase II, phase III, and phase IV patient research studies designed to evaluate new treatments, including prescription drugs, that:

- (a) Involve the treatment of life-threatening medical conditions;

- (b) Are medically indicated and preferable for the covered person compared to available noninvestigational treatment alternatives; and
- (c) Have clinical and preclinical data that shows the trial will likely be more effective for the *covered person* than available noninvestigational alternatives.

Clinical trials must:

- (a) Involve determinations by treating physicians, relevant scientific data, and opinions of experts in relevant medical specialties;
- (b) Be trials approved by centers or cooperative groups that are funded by the National Institutes of Health, the United States Food and Drug Administration ("USFDA"), the Centers for Disease Control, the Agency for Health Care Research and Quality, the Department of Defense, or the Department of Veterans Affairs; and
- (c) Be conducted in a setting and by personnel that maintain a high level of expertise because of their training, experience, and volume of patients.

MGR03813

"Creditable coverage" means, with respect to an individual, coverage of the individual under any of the following:

- (a) A group health plan as defined in G.S. 58-68-35(a)(4B);
- (b) Health insurance coverage without regard to whether the coverage is offered in the group market, the individual market, or otherwise;
- (c) Part A or Part B of Title XVIII of the Social Security Act;
- (d) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under Section 1928;
- (e) Chapter 55 of Title 10, United States Code;
- (f) A medical program of the Indian Health Service or of a tribal organization;
- (g) A State health benefits risk pool;
- (h) A health plan offered under Chapter 89 of Title 5, United States Code;
- (i) A public health plan (as defined in federal regulations);
- (j) A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C. s 2504(e)); or
- (k) Title XXI of the Social Security Act (State Children's Health Insurance Program).

Creditable coverage does not include coverage consisting solely of excepted benefits. However, short-term, limited duration health insurance coverage shall be considered *creditable coverage*.

MGR04363

"Gradient compression garments" means garments custom-fit for the covered person that require a prescription. It does not include disposable medical supplies such as over-the-counter compression or elastic knee-high or other stocking products.

MGR04365

"Our" refers to Golden Rule Insurance Company.

"Placement" or being *"placed"*, when used in reference to a foster child or adopted child, means the assumption and retention of a legal obligation for partial or total support of the child.

"Qualified individual" means an individual:

- (a) Who is estrogen-deficient and at clinical risk of osteoporosis or low bone mass;
- (b) With radiographic osteopenia anywhere in the skeleton;
- (c) Who is receiving long-term glucocorticoid (steroid) therapy;
- (d) With permanent hyperparathyroidism;

- (e) Who is being monitored to assess the response to or efficacy of commonly accepted osteoporosis drug therapies;
- (f) Who has a history of low-trauma fractures; or
- (g) With other conditions or medical therapies known to cause osteoporosis or low bone mass.

"Us" refers to Golden Rule Insurance Company.

"We" refers to Golden Rule Insurance Company.

"You" or "your" refers to the *primary insured* named on the face page of the certificate.

MGR03813

- B. Initial premium rates are guaranteed for a period of twelve months unless a change in the coverage is initiated by the insured. After *your* coverage has been in force for one year, *we* may change *your* premium rates once every six months with 45 days written notice to the *primary insured* prior to the effective date of the change.

MGR04135

- C. The following subsection is hereby added to the Effective Date of Insurance provision.

Adding an Adopted Child or Foster Child: An *eligible child* legally placed with *you* or *your spouse* for foster care or adoption will be covered from the date of *placement* until the 31st day after *placement* unless the legal obligation is terminated and the child is removed from *your* physical custody

The foster child or adopted child may continue as a *covered person* after the 31st day only if *we* have received both notice of the child's *placement* and any additional premium required. Coverage for a foster child will cease when the child is removed from *your* physical custody.

MGR04457

- D. The Medical Benefits provision is amended as follows:

- 1. *Covered expenses* are amended to include:

- (a) General anesthesia, facility fees, and other related charges incurred in conjunction with dental care (but not including the actual dental services) that is provided in a *hospital* or an *outpatient surgical facility*, when certified by the *covered person's doctor* as *medically necessary* to safely and effectively perform the procedure, for:
 - (i) An *eligible child* under nine (9) years of age;
 - (ii) *Covered persons* with serious mental or physical conditions; and
 - (iii) *Covered persons* with significant behavioral problems;
- (b) Charges incurred for the diagnosis and evaluation of osteoporosis or low bone mass for *qualified individuals*;
- (c) An annual screening for ovarian cancer using transvaginal ultrasound and rectovaginal pelvic examination for women age 25 and older who are *at risk for ovarian cancer*;
- (d) *Medically necessary* costs of health care services associated with a *clinical trial*, *medically necessary* monitoring, and the diagnosis and treatment of complications to the extent these costs are not funded by national agencies, commercial manufacturers, distributors or other sponsors of participants in the *clinical trial*.

Covered expenses do not include clinical trial costs of the actual investigational drug or device, services that are not health care services, services provided solely to satisfy data collection, services not provided for direct clinical management, or non-USFDA approved drugs provided after the clinical trial has been concluded.

MGR03816

- (e) *Medically necessary* services, including diabetes outpatient self-management training provided by a health care professional designated by a *doctor*, equipment and supplies, medications, and laboratory procedures used in the treatment of diabetes;

MGR04085

- (f) Charges incurred for the diagnosis or treatment of *mental disorders*; and

MGR04488.

- (g) Charges incurred for the diagnosis, evaluation and treatment of lymphedema, including equipment, supplies, complex decongestive therapy, *gradient compression garments* and self-management training and education. Services may be provided by a licensed occupational or physical therapist, licensed nurse that has experience providing this treatment, or other *medical practitioner* acting within the scope of his or her license.

MGR04364

- (h) A maximum of \$2,500 per hearing aid per hearing-impaired ear every 36 months for *covered persons* under the age of 22, including:
 - (i) Medically necessary services ordered by a licensed physician or licensed audiologist;
 - (ii) A new hearing aid when alterations to the existing hearing aid cannot adequately meet the needs of the covered person; and
 - (iii) All services, including the initial hearing and evaluation, fitting and adjustments, and supplies, including ear molds.

MGR04623

- (i) Diagnostic, surgical and non-surgical treatment of temporomandibular joint disorders (TMJ), including splinting and use of intraoral prosthetic appliances. Non-surgical treatment of TMJ is limited to a lifetime maximum of \$3,500 per *covered person*. Non-surgical treatment of temporomandibular joint disorders does not include tooth extraction, orthodontic braces, crowns, bridges, dentures, treatment for periodontal disease, dental root implants, or root canals.

MGR04741

- 2. Benefits provided under the policy/certificate for breast prosthesis are deleted and replaced with the following:

- (a) For *medically necessary* breast prosthesis.

MGR04131

- E. If *your policy/certificate* provides coverage for prescription drugs approved by the federal Food and Drug Administration for the treatment of certain types of cancer, coverage shall not be excluded on the basis that the drug has been prescribed for treatment of a type of cancer for which the drug has not been approved by the federal Food and Drug Administration provided that the drug:

- 1. Has been approved by the Food and Drug Administration;
- 2. Has been proven effective and accepted for the treatment of the specific type of cancer for which the drug has been prescribed in any one of the following established reference compendia:
 - (a) The National Comprehensive Cancer Network Drugs & Biologics Compendium;
 - (b) The Thomsonmicromedex Drugdex;
 - (c) The Elsevier Gold Standard's Clinical Pharmacology;
 - (d) Or any other authoritative compendia as recognized periodically by the United States Secretary of Health and Human Services; and
- 3. Has not been determined by the USFDA to be contraindicated for treatment of the specific type of cancer for which the drug has been prescribed.

MGR04348

- F. The prescription drug formulary listings are available upon request.

MGR04008

- G. The Outpatient Prescription Drug Expense Benefits provision is amended as follows:

1. We shall not penalize *you* for purchasing *your* prescription drugs at a non-network pharmacy if a *member pharmacy* is not reasonably available to meet *your* needs without unreasonable delay.
2. The Designated Pharmacies subsection will not apply to residents of North Carolina.

MGR04626

- H. The Notification and Predetermination provision is amended as follows:

If we provide a predetermination that services, supplies, or items are *covered expenses*, we will not retract the determination or reduce benefits for a service, supply or other item furnished in reliance on *our* predetermination unless the predetermination was based on a material misrepresentation about the insured's health that was knowingly made by the insured or the provider of the service, supply, or other item.

MGR04216

- I. Any exclusion in the *policy/certificate* for expenses incurred as a result of the *covered person* being intoxicated, or under the influence of illegal narcotics or a controlled substance, will not apply.

MGR04044

- J. Any exclusion for expenses incurred due to an *injury* or *illness* arising out of, or in the course of, employment for wage or profit is hereby deleted and replaced with the following:

Covered expenses will not include services or supplies for the treatment of an occupational injury or illness which are paid under the North Carolina Workers' Compensation Act only to the extent such services or supplies are the liability of the employee, employer, or worker's compensation insurance carrier according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act.

MGR03819

- K. Any exclusion expressly for expenses incurred as a result of a self-inflicted injury is amended to apply only to intentionally self-inflicted injury.

MGR04087

- L. The Preexisting Conditions and Limitations provision is amended as follows:

1. The definition of *preexisting condition* is deleted and replaced with the following:

"Preexisting condition" means those conditions for which medical advice, diagnosis, care or treatment was received or recommended within the one-year period immediately preceding the *effective date* of the *covered person's* coverage.

2. If a *covered person's effective date* of coverage under the *policy/certificate* occurs within 63 days of termination of the *covered person's* coverage under any prior *creditable coverage*, that *covered person* will be entitled to credit against the 12 month preexisting condition limitation waiting period of the *policy/certificate* for the same number of full months that the *covered person* was continuously covered, without any lapse of 63 days or more, under prior *creditable coverage*. *You or your dependent* must provide *us* with documentation of the prior *creditable coverage* from *your* previous insurer.

MGR03584

3. In the event that *you or your dependent* cease to be covered under the *policy*, we will provide a Certification of Creditable Coverage detailing the time period of coverage under the *policy*. We will provide this certification within 30 days of the date that coverage under the *policy* ceases, and within 30 days of the receipt of a request from the previously *covered person* for an additional copy during the 24 months following his or her cessation of coverage.

MGR04006

- M. Under the Coordination of Benefits provision, the definition of "plan" will not include blanket, franchise individual, medical benefits under group or individual automobile contracts, or homeowner coverage.

MGR03820

- N. The Reimbursement provision is hereby deleted.

MGR04045

- O. The Proof of Loss provision is amended to state that *you* or *your covered dependent* must provide *us* with written *proof of loss* within 180 days of the date of the *loss*, or as soon as is reasonably possible. Proof furnished more than one year from the date of the *loss* will not be accepted, unless *you* or *your covered dependent* had no legal capacity in that year.

MGR04005

- P. The following are examples of how we calculate benefit amounts and payment obligations for covered expenses:

Example 1: In-Network		Repriced	Covered	Ded Credit	Coinsurance	Benefit Paid
Calendar Year Deductible:	\$1000					
Prior Accumulation:	\$750					
Coinsurance: \$10,000 @	80%					
Prior Coinsurance:	\$0					
Submitted Claim:	\$500	\$400	\$400	\$250	\$150 x 80%	\$120
Insured's Liability:	\$280					

Example 2: In-Network		Repriced	Covered	Ded Credit	Coinsurance	Benefit Paid
Calendar Year Deductible:	\$1000					
Prior Accumulation:	\$1000					
Coinsurance: \$10,000 @	80%					
Prior Coinsurance:	\$8000 x 80%					
Submitted Charges:	\$4000	\$3000	\$3000	\$0	\$2000 @ 80% \$1000 @ 100%	\$2600
Insured's Liability:	\$400					

Example 3: Out-of-Network		Not Covered	Covered	Ded Credit	Coinsurance	Benefit Paid
Calendar Year Deductible:	\$1000					
Prior Accumulation:	\$1000					
Out-of-Network Deductible:	\$1000					
Prior Accumulation:	\$1000					
Coinsurance: \$10,000 @	80%					
Prior Coinsurance:	\$8000 x 80%					
Submitted Charges:	\$1100	\$100	\$1000	\$0	\$1000 @ 80%	
Out-of-Network Reduction:					25% of \$800	\$600
Insured's Liability:	\$500					

Network providers are obligated to accept the repriced amount for covered services. Out-of-network providers may charge whatever he/she feels is appropriate for the services provided.

We accept claims filed from the insured and provider/network. It is ultimately the insured's responsibility to make sure all claims are filed. However, claims are generally submitted to *us* by the provider/network (or repricing agent).

MGR04217

- Q. The subsection entitled Legal Action is deleted and replaced with the following:

LEGAL ACTION: No action at law or in equity may be brought to recover on the *policy* until 60 days after written *proof of loss* has been furnished. No such action may be brought after the end of three years after the time written *proof of loss* is required to be furnished.

MGR04133

Except as specifically stated in this endorsement, the benefits under this endorsement are subject to all of the terms, conditions, exclusions, limitations and notification requirements of the *policy/certificate*, including any applicable *deductible amounts*, coinsurance provisions, copay amounts, or dollar limits.

MGR03440

This endorsement applies only to *covered persons* who reside in the state of North Carolina.

The endorsement will not change, waive or extend any part of the *policy/certificate*, other than as stated herein.

This endorsement is effective on September 1, 2012 or at the same time as the *policy/certificate*, whichever is later.

Golden Rule Insurance Company

A handwritten signature in black ink that reads "Patrick F. Carr". The signature is written in a cursive style with a large initial "P".

President

MGR03441

NORTH CAROLINA ENDORSEMENT

By attachment of this endorsement, the *policy/certificate* is amended to the extent of any conflict with the following:

MGR03433

A. The Definitions section is amended as follows:

1. The definition of *complications of pregnancy* is amended to include *medically necessary fetal reduction*.

MGR04132

2. The definition of *medical practitioner* is amended to include an advanced practice nurse, licensed registered nurse, licensed clinical social worker, certified substance abuse professional, licensed professional counselor, certified fee-based pastoral counselor, licensed marriage and family therapist and licensed pharmacist.

MGR03811

3. The definition of *emergency* is deleted and replaced with the following:

"Emergency" means a medical condition manifesting itself by acute symptoms of sufficient severity, including, but not limited to, severe pain, or by acute symptoms developing from a chronic medical condition that would lead a prudent layperson, possessing an average knowledge of health and medicine, to reasonably expect the absence of immediate medical attention to result in any of the following:

- (a) Placing the health of an individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;
- (b) Serious impairment to bodily functions; or
- (c) Serious dysfunction of any bodily organ or part.

If *you* or a *covered person* experiences an *emergency* medical condition, one of the ways to access emergency services is to call 9-1-1.

MGR04004

4. As defined, the term *hospital* shall include a tax-supported institution, including a community mental health center or other health clinic certified as a Medicaid provider.

MGR04043

5. The definition of *medically necessary* is deleted and replaced with the following:

"Medically necessary" means those covered services or supplies that are:

- (a) Provided for the diagnosis, treatment, cure or relief of a health condition, *illness, injury*, or disease and, except for participation in a covered clinical trial, are not for experimental, investigational, or cosmetic purposes;
- (b) Necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, *illness, injury*, disease or its symptoms;
- (c) Within generally accepted standards of medical care in the community; and
- (d) Not solely for the convenience of the insured, the insured's family, or the provider.

For *medically necessary* services, nothing in this subsection precludes an insurer from comparing the cost-effectiveness of alternate services or supplies when determining which of the services or supplies will be covered.

MGR04136

6. The definition of mental disorder is deleted and replaced with the following:

"Mental disorder" means those *illnesses* listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association, except for:

- (a) Those coded as substance-related disorders;
- (b) Those coded as sexual dysfunctions not due to organic disease;
- (c) Those coded as "V" diagnosis codes;
- (d) Sex changes or modification and related care; or
- (e) *Specified mental illnesses*, as defined in the *policy/certificate*.

MGR04239

7. The following definitions are added:

"At risk for ovarian cancer" means either:

- (a) Having a family history with:
 - (i) At least one first-degree relative with ovarian cancer; and
 - (ii) A second relative, either first-degree or second-degree, with breast, ovarian, or nonpolyposis colorectal cancer; or
- (b) Testing positive for a hereditary ovarian cancer syndrome.

"Clinical trials" means phase II, phase III, and phase IV patient research studies designed to evaluate new treatments, including prescription drugs, that:

- (a) Involve the treatment of life-threatening medical conditions;
- (b) Are medically indicated and preferable for the covered person compared to available noninvestigational treatment alternatives; and
- (c) Have clinical and preclinical data that shows the trial will likely be more effective for the *covered person* than available noninvestigational alternatives.

Clinical trials must:

- (a) Involve determinations by treating physicians, relevant scientific data, and opinions of experts in relevant medical specialties;
- (b) Be trials approved by centers or cooperative groups that are funded by the National Institutes of Health, the United States Food and Drug Administration ("USFDA"), the Centers for Disease Control, the Agency for Health Care Research and Quality, the Department of Defense, or the Department of Veterans Affairs; and
- (c) Be conducted in a setting and by personnel that maintain a high level of expertise because of their training, experience, and volume of patients.

MGR03813

"Creditable coverage" means, with respect to an individual, coverage of the individual under any of the following:

- (a) A group health plan as defined in G.S. 58-68-35(a)(4B);
- (b) Health insurance coverage without regard to whether the coverage is offered in the group market, the individual market, or otherwise;
- (c) Part A or Part B of Title XVIII of the Social Security Act;
- (d) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under Section 1928;
- (e) Chapter 55 of Title 10, United States Code;
- (f) A medical program of the Indian Health Service or of a tribal organization;
- (g) A State health benefits risk pool;
- (h) A health plan offered under Chapter 89 of Title 5, United States Code;
- (i) A public health plan (as defined in federal regulations);

- (j) A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C. s 2504(e)); or
- (k) Title XXI of the Social Security Act (State Children's Health Insurance Program).

Creditable coverage does not include coverage consisting solely of excepted benefits. However, short-term, limited duration health insurance coverage shall be considered creditable coverage.

MGR04363

"Gradient compression garments" means garments custom-fit for the covered person that require a prescription. It does not include disposable medical supplies such as over-the-counter compression or elastic knee-high or other stocking products.

MGR04365

"Our" refers to Golden Rule Insurance Company.

"Placement" or being *"placed"*, when used in reference to a foster child or adopted child, means the assumption and retention of a legal obligation for partial or total support of the child.

"Qualified individual" means an individual:

- (a) Who is estrogen-deficient and at clinical risk of osteoporosis or low bone mass;
- (b) With radiographic osteopenia anywhere in the skeleton;
- (c) Who is receiving long-term glucocorticoid (steroid) therapy;
- (d) With permanent hyperparathyroidism;
- (e) Who is being monitored to assess the response to or efficacy of commonly accepted osteoporosis drug therapies;
- (f) Who has a history of low-trauma fractures; or
- (g) With other conditions or medical therapies known to cause osteoporosis or low bone mass.

"Specified mental illnesses" means:

- (a) Bipolar disorder;
- (b) Major Depressive Disorder;
- (c) Obsessive Compulsive Disorder;
- (d) Paranoid and other Psychotic Disorder;
- (e) Schizoaffective Disorder;
- (f) Schizophrenia;
- (g) Post-traumatic Stress Disorder;
- (h) Anorexia Nervosa; and
- (i) Bulimia

MGR04240

"Us" refers to Golden Rule Insurance Company.

"We" refers to Golden Rule Insurance Company.

"You" or *"your"* refers to the *primary insured* named on the face page of the certificate.

MGR03813

- B. Initial premium rates are guaranteed for a period of twelve months unless a change in the coverage is initiated by the insured. After *your* coverage has been in force for one year, we may change *your* premium rates once every six months with 45 days written notice to the *primary insured* prior to the effective date of the change.

MGR04135

- C. The following subsection is hereby added to the Effective Date of Insurance provision.

Adding an Adopted Child or Foster Child: An *eligible child* legally placed with *you* or *your spouse* for foster care or adoption will be covered from the date of *placement* until the 31st day after *placement* unless the legal obligation is terminated and the child is removed from *your* physical custody

The foster child or adopted child may continue as a *covered person* after the 31st day only if we have received both notice of the child's *placement* and any additional premium required. Coverage for a foster child will cease when the child is removed from *your* physical custody.

MGR04457

D. The Medical Benefits provision is amended as follows:

1. *Covered expenses* are amended to include:

- (a) General anesthesia, facility fees, and other related charges incurred in conjunction with dental care (but not including the actual dental services) that is provided in a *hospital* or an *outpatient surgical facility*, when certified by the *covered person's doctor* as *medically necessary* to safely and effectively perform the procedure, for:
 - (i) An *eligible child* under nine (9) years of age;
 - (ii) *Covered persons* with serious mental or physical conditions; and
 - (iii) *Covered persons* with significant behavioral problems;
- (b) Charges incurred for the diagnosis and evaluation of osteoporosis or low bone mass for *qualified individuals*;
- (c) An annual screening for ovarian cancer using transvaginal ultrasound and rectovaginal pelvic examination for women age 25 and older who are *at risk for ovarian cancer*;
- (d) *Medically necessary* costs of health care services associated with a *clinical trial*, *medically necessary* monitoring, and the diagnosis and treatment of complications to the extent these costs are not funded by national agencies, commercial manufacturers, distributors or other sponsors of participants in the *clinical trial*.

Covered expenses do not include clinical trial costs of the actual investigational drug or device, services that are not health care services, services provided solely to satisfy data collection, services not provided for direct clinical management, or non-USFDA approved drugs provided after the clinical trial has been concluded.

MGR03816

- (e) Diagnostic, surgical and non-surgical treatment of temporomandibular joint disorders (TMJ), including splinting and use of intraoral prosthetic appliances. Non-surgical treatment of TMJ is limited to a lifetime maximum of \$3,500 per *covered person*. Non-surgical treatment of temporomandibular joint disorders does not include tooth extraction, orthodontic braces, crowns, bridges, dentures, treatment for periodontal disease, dental root implants, or root canals.

MGR04741

- (f) *Medically necessary* services, including diabetes outpatient self-management training provided by a health care professional designated by a *doctor*, equipment and supplies, medications, and laboratory procedures used in the treatment of diabetes;

MGR04085

- (g) Charges incurred for the diagnosis and treatment of *specified mental illnesses*.

MGR04241

- (h) Charges incurred for *inpatient* diagnosis or treatment of *mental disorders*; and

MGR04489.

- (i) Charges incurred for the diagnosis, evaluation and treatment of lymphedema, including equipment, supplies, complex decongestive therapy, *gradient compression garments* and self-management training and education. Services may be provided by a licensed

occupational or physical therapist, licensed nurse that has experience providing this treatment, or other *medical practitioner* acting within the scope of his or her license.

MGR04364

- (j) A maximum of \$2,500 per hearing aid per hearing-impaired ear every 36 months for *covered persons* under the age of 22, including:
 - (i) *Medically necessary* services ordered by a licensed physician or licensed audiologist;
 - (ii) A new hearing aid when alterations to the existing hearing aid cannot adequately meet the needs of the *covered person*; and
 - (iii) All services, including the initial hearing and evaluation, fitting and adjustments, and supplies, including ear molds.

MGR04623

- 2. **LIMITED OUTPATIENT TREATMENT OF MENTAL DISORDERS:** *Covered expenses* for the diagnosis or treatment of a *mental disorder* on an outpatient basis will be limited to:
 - (a) Thirty outpatient days per calendar year; and
 - (b) Thirty office visits per calendar year.

MGR04490

- 3. Benefits provided under the policy/certificate for breast prosthesis are deleted and replaced with the following:
 - (a) For *medically necessary* breast prosthesis.

MGR04131

- E. If *your policy/certificate* provides coverage for prescription drugs approved by the federal Food and Drug Administration for the treatment of certain types of cancer, coverage shall not be excluded on the basis that the drug has been prescribed for treatment of a type of cancer for which the drug has not been approved by the federal Food and Drug Administration provided that the drug:
 - 1. Has been approved by the Food and Drug Administration;
 - 2. Has been proven effective and accepted for the treatment of the specific type of cancer for which the drug has been prescribed in any one of the following established reference compendia:
 - (a) The National Comprehensive Cancer Network Drugs & Biologics Compendium;
 - (b) The Thomsonmicromedex Drugdex;
 - (c) The Elsevier Gold Standard's Clinical Pharmacology;
 - (d) Or any other authoritative compendia as recognized periodically by the United States Secretary of Health and Human Services; and
 - 3. Has not been determined by the USFDA to be contraindicated for treatment of the specific type of cancer for which the drug has been prescribed.

MGR04348

- F. The prescription drug formulary listings are available upon request.

MGR04008

- G. Golden Rule Insurance Company (GRIC) may provide persons insured with *us* a discount drug card and arrange for pharmacies to provide those *covered persons* prescription drugs at a discounted rate. While Golden Rule has entered into a relationship with a company to arrange these discounts, prescription drugs are not *covered expenses* under *your* plan and *you* are responsible for the entire discounted cost of prescriptions. The pharmacy is liable for the provision of such goods and/or services. Golden Rule is not responsible for the provision of such goods or services, nor is it liable for the failure of the provision of the same. Further, Golden Rule is not liable to insureds for the negligent provision of such goods and/or services by these third party providers.

MGR04625

H. The Notification and Predetermination provision is amended as follows:

If we provide a predetermination that services, supplies, or items are *covered expenses*, we will not retract the determination or reduce benefits for a service, supply or other item furnished in reliance on *our* predetermination unless the predetermination was based on a material misrepresentation about the insured's health that was knowingly made by the insured or the provider of the service, supply, or other item.

MGR04216

I. Any exclusion in the *policy/certificate* for expenses incurred as a result of the *covered person* being intoxicated, or under the influence of illegal narcotics or a controlled substance, will not apply.

MGR04044

J. Any exclusion for expenses incurred due to an *injury* or *illness* arising out of, or in the course of, employment for wage or profit is hereby deleted and replaced with the following:

Covered expenses will not include services or supplies for the treatment of an occupational injury or illness which are paid under the North Carolina Workers' Compensation Act only to the extent such services or supplies are the liability of the employee, employer, or worker's compensation insurance carrier according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act.

MGR03819

K. Any exclusion expressly for expenses incurred as a result of a self-inflicted injury is amended to apply only to intentionally self-inflicted injury.

MGR04087

L. The Preexisting Conditions and Limitations provision is amended as follows:

1. The definition of *preexisting condition* is deleted and replaced with the following:

"Preexisting condition" means those conditions for which medical advice, diagnosis, care or treatment was received or recommended within the one-year period immediately preceding the *effective date* of the *covered person's* coverage.

2. If a *covered person's effective date* of coverage under the *policy/certificate* occurs within 63 days of termination of the *covered person's* coverage under any prior *creditable coverage*, that *covered person* will be entitled to credit against the 12 month preexisting condition limitation waiting period of the *policy/certificate* for the same number of full months that the *covered person* was continuously covered, without any lapse of 63 days or more, under prior *creditable coverage*. *You or your dependent* must provide *us* with documentation of the prior *creditable coverage* from *your* previous insurer.

MGR03584

3. In the event that *you or your dependent* cease to be covered under the *policy*, we will provide a Certification of Creditable Coverage detailing the time period of coverage under the *policy*. We will provide this certification within 30 days of the date that coverage under the *policy* ceases, and within 30 days of the receipt of a request from the previously *covered person* for an additional copy during the 24 months following his or her cessation of coverage.

MGR04006

M. Under the Coordination of Benefits provision, the definition of *"plan"* will not include blanket, franchise individual, medical benefits under group or individual automobile contracts, or homeowner coverage.

MGR03820

N. The Reimbursement provision is hereby deleted.

MGR04045

O. The Proof of Loss provision is amended to state that *you or your covered dependent* must provide *us* with written *proof of loss* within 180 days of the date of the *loss*, or as soon as is reasonably

possible. Proof furnished more than one year from the date of the *loss* will not be accepted, unless *you* or *your covered dependent* had no legal capacity in that year.

MGR04005

- P. The following are examples of how we calculate benefit amounts and payment obligations for *covered expenses*:

<u>Example 1: In-Network</u>		<u>Repriced</u>	<u>Covered</u>	<u>Ded Credit</u>	<u>Coinsurance</u>	<u>Benefit Paid</u>
Calendar Year Deductible:	\$1000					
Prior Accumulation:	\$750					
Coinsurance: \$10,000 @	80%					
Prior Coinsurance:	\$0					
Submitted Claim:	\$500	\$400	\$400	\$250	\$150 x 80%	\$120
Insured's Liability:	\$280					

<u>Example 2: In-Network</u>		<u>Repriced</u>	<u>Covered</u>	<u>Ded Credit</u>	<u>Coinsurance</u>	<u>Benefit Paid</u>
Calendar Year Deductible:	\$1000					
Prior Accumulation:	\$1000					
Coinsurance: \$10,000 @	80%					
Prior Coinsurance:	\$8000 x 80%					
Submitted Charges:	\$4000	\$3000	\$3000	\$0	\$2000 @ 80% \$1000 @ 100%	\$2600
Insured's Liability:	\$400					

<u>Example 3: Out-of-Network</u>		<u>Not Covered</u>	<u>Covered</u>	<u>Ded Credit</u>	<u>Coinsurance</u>	<u>Benefit Paid</u>
Calendar Year Deductible:	\$1000					
Prior Accumulation:	\$1000					
Out-of-Network Deductible:	\$1000					
Prior Accumulation:	\$1000					
Coinsurance: \$10,000 @	80%					
Prior Coinsurance:	\$8000 x 80%					
Submitted Charges:	\$1100	\$100	\$1000	\$0	\$1000 @ 80%	
Out-of-Network Reduction:					25% of \$800	\$600
Insured's Liability:	\$500					

Network providers are obligated to accept the repriced amount for covered services. Out-of-network providers may charge whatever he/she feels is appropriate for the services provided.

We accept claims filed from the insured and provider/network. It is ultimately the insured's responsibility to make sure all claims are filed. However, claims are generally submitted to *us* by the provider/network (or repricing agent).

MGR04217

- Q. The subsection entitled Legal Action is deleted and replaced with the following:

LEGAL ACTION: No action at law or in equity may be brought to recover on the *policy* until 60 days after written *proof of loss* has been furnished. No such action may be brought after the end of three years after the time written *proof of loss* is required to be furnished.

MGR04133

Except as specifically stated in this endorsement, the benefits under this endorsement are subject to all of the terms, conditions, exclusions, limitations and notification requirements of the *policy/certificate*, including any applicable *deductible amounts*, coinsurance provisions, copay amounts, or dollar limits.

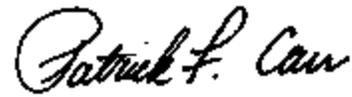
MGR03440

This endorsement applies only to *covered persons* who reside in the state of North Carolina.

The endorsement will not change, waive or extend any part of the *policy/certificate*, other than as stated herein.

This endorsement is effective on September 1, 2012 or at the same time as the *policy/certificate*, whichever is later.

Golden Rule Insurance Company

A handwritten signature in black ink that reads "Patrick F. Caw". The signature is written in a cursive style with a large initial "P".

President

MGR03441

TENNESSEE ENDORSEMENT

By attachment of this endorsement, the *policy*/certificate is amended to the extent of any conflict with the following:

MGR03433

A. The Definitions provision is amended as follows:

1. The definition of *medically necessary* is deleted and replaced with the following:

"*Medically necessary*" means healthcare services that a *doctor*, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an *illness, injury, disease* or its symptoms, and that are:

- (a) In accordance with generally accepted standards of medical practice;;
- (b) Clinically appropriate, in terms of type, frequency, extent, site and duration; and considered effective for the patient's *illness, injury* or disease;
- (c) Not primarily for the convenience of the patient, physician, or other healthcare provider; and
- (d) Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the patient's *illness, injury* or disease.

MGR04664

2. The definition of total disability is amended to read as follows:

"Total disability" or "totally disabled" means a condition resulting from illness or injury because of which the patient is not engaged in any gainful occupation for wage or profit and, as certified by a doctor, is unable to perform all of the substantial and material duties or activities of a homemaker (if a homemaker), a full-time student (if a full-time student) or any occupation or business for which he or she is qualified by education, training or experience.

MGR04736

B. The Premium Section is deleted and replaced with the following:

PREMIUM: *You* are responsible for *your* premium. Payment must be made to the designated office of the *policyholder* unless *you* have been notified to make payment directly to *our* office.

We may change the premium rates as of any premium due date. *We* will give *you* written notice at least 30 days prior to the date of the change.

Premium rates will be based on the rate table in effect on that premium due date. The *policy* plan, age and sex of *covered persons*, type and level of benefits, and *your* place of residence on the premium due date are factors used in determining *your* premium rates.

If a change to the *policy* causes any change in premium rates, the new rate will be effective on the first of the [policy month/calendar month] following the date of the change. *We* may prorate any premium adjustment.

MGR04735

C. The Medical Expense Benefits provision is amended as follows:

1. *Covered expenses* for diagnosis and treatment of *diabetes* are expanded to include infusion devices, and appurtenances thereto when *medically necessary* and ordered by a *doctor*.

2. *Diabetes self-management training services* shall be limited to:

- (a) Visits certified as *medically necessary* by a *doctor* upon the initial diagnosis of *diabetes*;

- (b) Visits certified by a *doctor as medically necessary* because of a significant change in symptoms or condition which necessitates changes in the *covered person's* self-management program; and
- (c) Visits which are certified by a *doctor to be medically necessary* for re-education or refresher training.

MGR04713

3. *Covered expenses* are expanded to include:

- (a) Surgical and non-surgical treatment for disorders of the temporomandibular joint (TMJ). Non-surgical treatment shall be limited to diagnosis and management of TMJ categorized as Phase I treatment under guidelines adopted by the American Dental Association that require the written prescription of a *doctor* or dentist, including soft diet, thermal agents, temporary splints and voluntary self-disengagement of the teeth. Surgical expenses incurred from a dentist shall be considered *covered expenses* only when the services provided would fall within the scope of licensed physician. *Covered expenses* for the treatment of TMJ shall include outpatient prescription drugs to the same extent covered under the *policy/certificate* for other *illnesses* in general.
- (b) *Hospital* expenses and the cost of general anesthesia associated with any *inpatient/outpatient hospital* dental procedure when the procedure is performed on a *covered person* 8 years of age and younger and cannot safely be performed in a dental office.

MGR04709

- D. Under the Home Health Care Expense Benefits provision, the Limitations subsection is deleted and replaced with the following:

LIMITATION: *Covered expenses for home health aide services* will be limited to a maximum of 90 visits per calendar year.

MGR04739

- E. The Hospice Care Expense Benefits provision is amended as follows:

Benefits for hospice inpatient or outpatient care are available to a terminally ill covered person up to 180 days per calendar year.

MGR04738

- F. Under the Outpatient Prescription Drug Expense Benefits provision, the No Assignment of Benefits provision, if included in *your* plan, is deleted and replaced with the following:

NON-MEMBER PHARMACY BENEFITS: Charges incurred for *prescription drugs* dispensed by a *non-member pharmacy*, or at a *member pharmacy* when a *PBM* card is not used are the responsibility of the insured. For plans containing a prescription drug copayment, *our pharmacy benefits manager* will reimburse *covered expenses* incurred minus the applicable *copayment amount* upon receipt of a paper claim. For all other plans, a paper claim for reimbursement should be filed directly with *us*.

MGR04716

- G. The **CONDITIONS PRIOR TO LEGAL ACTION** provision is hereby deleted and replaced with the following:

On occasion, we may have a disagreement related to coverage, benefits, premiums or other provisions under the *policy*. Litigation is an expensive and time-consuming way to resolve these disagreements and should be the last resort in a resolution process. Therefore, with a view to avoiding litigation, *you* must give written notice to *us* of *your* intent to sue *us* as a condition prior to bringing any legal action. *Your* notice must identify

the coverage, benefit, premium or other disagreement, refer to the specific *policy* provisions(s) at issue, and include all relevant facts and information that support *your* positions.

MGR03746

H. The Reimbursement provision is deleted and replaced with the following:

If a *covered person's illness* or *injury* is caused by the acts or omissions of a *third party*, we will not cover a *loss* to the extent that it is paid as part of a settlement or judgment by any *third party*. However, if payment by or for the *third party* has not been made by the time we receive acceptable *proof of loss*, we will pay regular *policy* benefits for the *covered person's loss*. We will have the right to be reimbursed to the extent of benefits we paid for the *illness* or *injury* if the *covered person* subsequently receives any payment from any *third party*. The *covered person* (or the guardian, legal representatives, estate, or heirs of the *covered person*) shall promptly reimburse Golden Rule from the settlement, judgment, or any payment received from any *third party*.

As a condition for *our* payment, the *covered person* or anyone acting on his or her behalf (including, but not limited to, the guardian, legal representatives, estate, or heirs) agrees:

1. To fully cooperate with *us* in order to obtain information about the *loss* and its cause;
2. To immediately inform *us* in writing of any claim made or lawsuit filed on behalf of a *covered person* in connection with the *loss*;
3. To include the amount of benefits paid by *us* on behalf of a *covered person* in any claim made against any *third party*;
4. That we:
 - (a) Will have a lien on all money received by a *covered person* in connection with the *loss* equal to the amount we have paid;
 - (b) May give notice of that lien to any *third party* or *third party's* agent or representative;
 - (c) Will have the right to intervene in any suit or legal action to protect *our* rights;
 - (d) Are subrogated to all of the rights of the *covered person* against any *third party* to the extent of the benefits paid on the *covered person's* behalf; and
 - (e) May assert that subrogation right independently of the *covered person*.
5. To take no action that prejudices *our* reimbursement and subrogation rights;
6. To sign, date and deliver to *us* any documents we request which protect *our* reimbursement and subrogation rights;
7. To not settle any claim or lawsuit against a *third party* without providing *us* with written notice of the intent to do so;
8. To reimburse *us* from any money received from any *third party*, to the extent of benefits we paid for the *illness* or *injury*, whether obtained by settlement, judgment, or otherwise; and
9. That we may reduce other benefits under the *policy* by the amounts a *covered person* has agreed to reimburse *us*.

Furthermore, as a condition of *our* payment, we may require the *covered person* or the *covered person's* guardian (if the *covered person* is a minor or legally incompetent) to execute a written reimbursement agreement. However, the terms of this provision remain in effect regardless of whether or not an agreement is actually signed.

We will not pay attorney fees or costs associated with the *covered person's* claim or lawsuit unless we previously agreed in writing to do so.

If a dispute arises as to the amount a *covered person* must reimburse us, the *covered person* (or the guardian, legal representatives, estate, or heirs of the *covered person*) agrees to place sufficient funds in an escrow or trust account to satisfy the maximum lien amount asserted by us until the dispute is resolved.

MGR04710

Definition: As used in this provision, the following term has the meaning indicated:

MGR03525

"*Third party*" means a person or other entity which is or may be obligated or liable to the *covered person* for payment of any of the *covered person's* expenses for *illness* or *injury*. The term "*third party*" includes, but is not limited to, an individual person; a for-profit or non-profit business entity or organization; a government agency or program; and an insurance company. However, the term "*third party*" will not include any insurance company with a policy under which the *covered person* is entitled to benefits as a named insured person or an insured *dependent* of a named insured person except in those jurisdictions where statutes or common law does not specifically prohibit *our* right to recover from these sources.

MGR03526

- I. The Reinstatement Provision is amended to read as follows:

REINSTATEMENT: If *your* coverage under the *policy* lapses due to nonpayment of premium, coverage may be reinstated provided:

1. We receive from *you* a written application for reinstatement within one year after the date coverage lapsed;
2. The written application for reinstatement is accompanied by:
 - (a) The required premium payment; and
 - (b) *Proof of good health* at no cost to us; and
3. We approve the *proof of good health* and would agree to insure *you* if *you* were applying for initial coverage under the *policy*.

If we would not agree to insure *you* if *you* were applying for initial coverage under the *policy*, we will not reinstate coverage.

Premium accepted for reinstatement may be applied to a period for which premium had not been paid. The period for which back premium may be required will not begin more than 60 days before the date of reinstatement.

The reinstated coverage will cover *loss* resulting:

1. From an *injury* sustained after the date of reinstatement; and
2. From *illness* beginning 10 days following the date of reinstatement.

Changes may be made in *your* coverage in connection with the reinstatement. These changes will be sent to *you* for attachment to *your* certificate. In the event of reinstatement, the Rescission clause will apply to statements made on the reinstatement application, based on the date of reinstatement.

MGR04737

- J. Under the Assignment subsection, we will reimburse a *hospital* or health care provider if *your* health insurance benefits are assigned by *you* in writing and verified by us.

MGR04711

Except as specifically stated in this endorsement, the benefits under this endorsement are subject to all of the terms, conditions, exclusions, limitations and notification requirements of the *policy/certificate*, including any applicable *deductible amounts*, coinsurance provisions, copay amounts, or dollar limits.

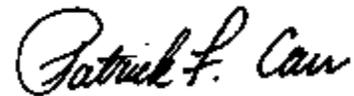
MGR03440

This endorsement applies only to *covered persons* who reside in the state of Tennessee.

This endorsement will not change, waive or extend any part of the *policy/certificate*, other than as stated herein.

This endorsement is effective on September 1, 2012 or at the same time as the *policy/certificate*, whichever is later.

**Golden Rule Insurance
Company**

A handwritten signature in black ink that reads "Patrick F. Carr". The signature is written in a cursive style with a large initial "P".

President

MGR03441

ALABAMA ENDORSEMENT

By attachment of this endorsement, the *policy/certificate* is amended to the extent of any conflict with the following:

MGR03433

- A. The Definitions section is amended as follows:

The definition of *medical practitioner* is amended to include a certified registered nurse anesthetist, and a licensed professional counselor.

MGR03797

- B. The Coordination of Benefits provision is amended as follows:

In addition to the coverages listed, the definition of "plan" shall not include a non-group or individual health or medical reimbursement contract.

MGR04695

Except as specifically stated in this endorsement, the benefits under this endorsement are subject to all of the terms, conditions, exclusions, limitations, and notification requirements of the *policy/certificate*, including any applicable *deductible amounts*, coinsurance provisions, copay amounts, or dollar limits.

MGR03440

This endorsement applies only to *covered persons* who reside in the state of Alabama.

The endorsement will not change, waive or extend any part of the *policy/certificate*, other than as stated herein.

This endorsement is effective on September 1, 2012 or at the same time as the *policy/certificate*, whichever is later.

Golden Rule Insurance Company



President

MGR03441

SERFF Tracking #:

AMMS-128622950

State Tracking #:

Company Tracking #:

C-009

State: Arkansas

Filing Company: Golden Rule Insurance Company

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO

Product Name: Association Group

Project Name/Number: C-009/C-009

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Accepted for Informational Purposes	09/20/2012
Comments:			
Attachment(s):	P-008 C-008 Readability Signed and Dated.pdf P-009 C-009 Readability Signed and Dated.pdf		

		Item Status:	Status Date:
Bypassed - Item:	Application	Accepted for Informational Purposes	09/20/2012
Bypass Reason:	Does not apply to this filing.		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	PPACA Uniform Compliance Summary	Accepted for Informational Purposes	09/20/2012
Bypass Reason:	Does not apply to this filing.		
Comments:			

Certification of Reading Ease

RE: Form (s) P-009 et al

C-009 et al

Golden Rule Insurance Company, by Michael L. Corne, its Vice President, does hereby certify to the best of our knowledge and belief that:

1. The Flesch reading ease test score of the above is: P-009 et al (59.06)
C-009 et al (59.14)
2. The above is printed (except for : specification pages, schedules, tables and, with regard to any application, minor instructions concerning preparation) in not less than ten point type, one point leaded.
3. All text has been included in arriving at the above score(s), except for the following: Headings, italicized words, and form numbers.
4. The entire text of the form(s) was analyzed in arriving at the above score(s), except as follows: See #3 above.
5. The readability of the above form(s) complies with the statutory and/or regulatory requirements of the following states: All
6. The above form(s) will be used in:
 individual health insurance individual life insurance
 group health insurance group life insurance

MAR 27 2012

Date



Michael L. Corne
Vice President