Health ProtectorGuard

Fixed benefit health insurance

THIS PRODUCT PROVIDES LIMITED BENEFITS

THIS PRODUCT IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR THE MINIMUM ESSENTIAL COVERAGE REQUIRED BY THE AFFORDABLE CARE ACT (ACA).

Health ProtectorGuard (HPG) is a fixed indemnity insurance product that provides benefits in a stated amount regardless of actual expenses incurred. Golden Rule Insurance Company is the underwriter of these insurance plans.

Policy Form HPG2-GRI-36 and other state variations

UnitedHealthcare®
Golden Rule Insurance Co.

Table of Contents

Why choose us?

Strength and experience

UnitedHealthcare provides over 27 million Americans with access to health care.[1] Golden Rule Insurance Company, a UnitedHealthcare company, is the underwriter and administrator of plans featured in this brochure. We have been serving the specific needs of individuals and families buying their own coverage for over 80 years.

Highly rated

Golden Rule Insurance Company is rated "A+" (Superior) by A.M. Best.[2] This worldwide independent organization examines insurance companies and other businesses, and publishes its opinion about them. This rating is an indication of our financial strength and stability.

Your satisfaction is our goal

We understand the importance of your time and concern for the value of your health care dollars. Our goal for every customer is an insurance plan at a price that fits their needs and budget.

[1] UnitedHealth Group Annual Form 10-K for year ended 12/31/23. [2] As of 12/14/23. For the latest rating, access ambest.com. The current "A+" rating is the second highest rating out of 13 possible ratings.

This is an outline only and is not intended to serve as a legal interpretation of benefits. Reasonable effort has been made to have this outline represent the intent of contract language. However, the contract language stands alone and the complete terms of the coverage will be determined by the policy.

Health ProtectorGuard (HPG)

Coverage designed to supplement your health coverage with straightforward cash benefit amounts for the everyday and not-so-everyday health and wellness services. Designed to help ease out-of-pocket costs you might experience when getting health care.

What is fixed benefit health indemnity insurance?

"Indemnity" is insurance speak for a plan that pays you, or your provider, a specified amount – or "fixed benefit" – for medical services you receive that are covered by the plan. The benefit isn't based on the total amount of your medical bill. There are also limits on how much or how many times this policy will pay on some benefits.

Why is fixed indemnity insurance a good idea?

A fixed indemnity plan is designed to offer supplemental relief of out-of-pocket costs you may have related to covered medical services. The benefit pays a fixed amount, regardless of the actual cost billed or other insurance coverage you may have. This could mean some benefits pay more than the cost of the service or for other services, it may cover just a portion of the cost, but the amount left you owe to the provider will be less.

How does a fixed indemnity insurance plan work?

With this type of plan, there is **no deductible, no coinsurance or even copays**. When you have a covered medical service provided, this plan will pay the benefit amount (shown on the following pages) to your in-network provider, or to you. This payment, along with the discounts on services you receive using an in-network provider, helps to reduce your overall out-of-pocket responsibility.

Our HPG product offers broader benefits than many other fixed indemnity plans available

The HPG plans available in this brochure have:

- Wellness services*, doctor office visits, urgent care visits and prescription drug benefits
- Benefits for hospital stays, surgical services, emergency room visit and outpatient lab and diagnostic services
- Flexibility to use any doctor, but discounts for using the MultiPlan Limited Benefit Plan Network providers
- Increase in cash benefits for hospital stays related to injury (increasing injury reimbursement) by staying with the plan more than a year

It's also good to know:

- Available for issue ages 18 through 64
- Renewable until age 65, subject to policy provisions, when premiums are paid
- No lifetime maximum limit, so you can use your full benefit limits year after year when you stay with the plan

*A 6-month waiting period applies.

Get access to care and savings

You can use any provider you choose for medical services, but you'll get the most out of your HPG benefits when you use the MultiPlan Limited Benefit Network.[1] If you have a major medical plan, you may need to stay with certain networks/providers to get the most coverage out of that plan.

Benefits of using a Multiplan Limited Benefit Network provider:

- You'll get care at pre-negotiated lower rates for covered services
- Network providers will file claims on your behalf, when you assign your benefits to them
- With a large number of participating providers, an in-network provider may be nearby

Find a doctor

Visit **multiplan.com/HealthProtectorGuard** to see if your doctor is a part of the MultiPlan Network for Limited Benefit Plans. MultiPlan's network is not insurance. It is a discount program only.

1.4M+
providers and facilities [2]

5,600+
hospitals[2]

How to receive benefits or file a claim

For the MultiPlan Network for Limited Benefit Plans[1] discounts to apply, benefits must be paid directly to the provider. Ask your provider for the assignment of benefits form. Once you assign benefits, claims for covered services are submitted by the provider who is then paid by the insurance plan. If the payment is less than the claim amount, you pay the difference to the provider. If the payment is more than the claim amount, after the provider is paid, the remaining benefit is paid to you by check.

Alternatively, if you do not wish to assign benefits or do not use a network provider, you may submit a claim form for covered services you have paid, and we will reimburse you directly. See your policy or visit Member Hub (see page 10) for more information.

[1] A MultiPlan network flat fee of $3.25 per policy is charged per month. It is collected each month that the policy is in force and there is no pro-rating for a partial month. This fee is in addition to the premium you pay for the insurance plan. [2] **Multiplan.us/services/network-based** last updated Feb. 29, 2024.

Hospital and surgical benefit details

There are 6 plans from which to choose, so you can find coverage that is a fit for your expected needs and budget. Benefits for doctor visits, wellness, prescription and outpatient services continues on page 7.

All benefits, including maximums, are per person			Choice Value	Choice Plus	Select Value	Primary Preferred	Select Preferred	Premier Plus
Hospital Services								
Inpatient Hospital Confinement (unlimited days per calendar year)		We pay:	$1,000 per day	$2,000 per day	$3,000 per day	$4,000 per day	$5,000 per day	$5,000 per day
Increasing Injury Reimbursement (unlimited days per calendar year) Inpatient hospitalization benefits increase 25% each year, years 2-5, for injury-related hospital stays.[1]	Year 2	We pay:	$1,250 per day	$2,500 per day	$3,750 per day	$5,000 per day	$6,250 per day	$6,250 per day
	Year 3		$1,500 per day	$3,000 per day	$4,500 per day	$6,000 per day	$7,500 per day	$7,500 per day
	Year 4		$1,750 per day	$3,500 per day	$5,250 per day	$7,000 per day	$8,750 per day	$8,750 per day
	Year 5 and after		$2,000 per day	$4,000 per day	$6,000 per day	$8,000 per day	$10,000 per day	$10,000 per day
Inpatient Hospital Intensive Care Unit (ICU) **or Critical Care Unit** (CCU) (maximum per confinement)		We pay:	$2,000 per day (31 days)	$4,000 per day (31 days)	$6,000 per day (31 days)	$2,000 per day (60 days)	$2,000 per day (60 days)	$10,000 per day (31 days)
			ICU/CCU benefit amounts are in addition to Inpatient Hospital Confinement benefits.					
Inpatient Physician Visits (maximum during Inpatient Hospital Confinement)		We pay:	$100 per visit (1 visit per day)	$100 per visit (1 visit per day)	$100 per visit (1 visit per day)	$100 per visit (1 visit per day)	$100 per visit (1 visit per day)	$100 per visit (2 visits per day)
Emergency Room (maximum per calendar year)		We pay:	$200 per day (2 days)	$200 per day (2 days)	$300 per day (2 days)	$300 per day (3 days)	$300 per day (3 days)	$500 per day (2 days)
Ambulance - Ground or Water (maximum per calendar year)		We pay:	$500 per trip (1 trip)	$500 per trip (1 trip)	$500 per trip (1 trip)	$500 per trip (1 trip)	$500 per trip (1 trip)	$1,000 per trip (1 trip)
Ambulance - Air (maximum per calendar year)		We pay:	$5,000 per trip (1 trip)	$5,000 per trip (1 trip)	$5,000 per trip (1 trip)	$5,000 per trip (1 trip)	$5,000 per trip (1 trip)	$5,000 per trip (1 trip)
Surgical Services								
Outpatient Facility Fee (maximum per calendar year)		We pay:	$500 per day (2 days)	$500 per day (2 days)	$1,000 per day (2 days)	$500 per day (3 days)	$500 per day (3 days)	$1,000 per day (3 days)
Surgeon: 4-Tier Surgical Schedule (unlimited days per calendar year)[2]	Tier 1	We pay:	$10,000 per day	$10,000 per day	$10,000 per day	$10,000 per day	$10,000 per day	$10,000 per day
	Tier 2		$5,000 per day	$5,000 per day	$5,000 per day	$5,000 per day	$5,000 per day	$5,000 per day
	Tier 3		$1,000 per day	$1,000 per day	$1,000 per day	$1,000 per day	$1,000 per day	$1,000 per day
	Tier 4		$500 per day	$500 per day	$500 per day	$500 per day	$500 per day	$500 per day
Assistant Surgeon - Surgical Schedule Tiers 1 & 2 only		We pay:	20% of surgeon benefit schedule above per day					
Anesthesiologist		We pay:	30% of surgeon benefit schedule above per day					

Services received for injuries are eligible for coverage as of the plan effective date; services received due to illnesses are eligible for coverage beginning on the 6th day following the effective date. Preexisting Conditions apply. See page 12 for details. [1] If the effective date of coverage is prior to July 1, then the Second Year of coverage will begin on the following January 1. If the effective date is on or after July 1, the Second Year will begin January 1 following 12 consecutive months of coverage. Subsequent years after the Second Year will begin the following January 1. [2] If more than one surgery occurs in any given day, the largest benefit amount is paid.

Dr. visit, wellness, Rx , outpatient benefit details

Continuation of benefits available among the 6 HPG plan options.

All benefits, including maximums, are per person		Choice Value	Choice Plus	Select Value	Primary Preferred	Select Preferred	Premier Plus
Doctor Visits							
Office Visits/Urgent Care Visits for Injury or Illness (maximum per calendar year)	We pay:	$100 per visit (2 visits)	$100 per visit (2 visits)	$100 per visit (5 visits)	$100 per visit (10 visits)	$100 per visit (10 visits)	$100 per visit (5 visits)
		See rollover benefit details on page 9.					
Second Surgical Opinion (maximum per calendar year)	We pay:	$250 per day (1 day)	$250 per day (1 day)	$500 per day (1 day)	$500 per day (1 day)	$500 per day (1 day)	$500 per day (1 day)
Wellness/Preventive							
Wellness/Preventive Care Visit (maximum per calendar year after initial 6-month waiting period)	We pay:	$100 per day (1 day)	$100 per day (1 day)	$200 per day (1 day)	$250 per day (1 day)	$250 per day (1 day)	$250 per day (1 day)
Pharmacy Services							
Prescription Drugs (per Rx fill)	We pay:	Discount Card only	Generic: $20 Brand: $40	Discount Card only	Generic: $10 Brand: $40	Generic: $10 Brand: $40	Generic: $20 Brand: $40
Maximum Rx fills per calendar year (combined Brand and Generic)		N/A	12	N/A	12	12	12
Outpatient Services							
Outpatient Lab/X-ray - Non-preventive/ Non-routine (maximum per calendar year)	We pay:	$200 per test (1 test)	$200 per test (1 test)	$300 per test (1 test)	$100 per test (3 tests)	$100 per test (3 tests)	$300 per test (1 test)
Outpatient Diagnostic Imaging Services (maximum per calendar year)	We pay:	$500 per test (1 test)	$500 per test (1 test)	$500 per test (1 test)	$500 per test (1 test)	$500 per test (1 test)	$1,000 per test (1 test)
Oral Chemotherapy (maximum per calendar year)	We pay:	$1,000 per month (3 months)	$1,000 per month (3 months)	$1,000 per month (3 months)	$1,000 per month (3 months)	$1,000 per month (3 months)	$2,000 per month (6 months)
Outpatient Chemotherapy and Radiation - Non-Oral (maximum per calendar year)	We pay:	$1,000 per day (40 days)	$1,000 per day (40 days)	$1,000 per day (40 days)	$500 per day (20 days)	$500 per day (20 days)	$2,000 per day (60 days)

Services received for injuries are eligible for coverage as of the plan effective date; services received due to illnesses are eligible for coverage beginning on the 6th day following the effective date. Preexisting Conditions apply. See page 12 for details.

How the surgical tiers are determined

Each plan has a 4-tier surgical schedule based on the type of surgery being performed. The amount for the respective tier will be paid each day a covered person requires inpatient or outpatient surgery as prescribed by a doctor. If surgery falls under multiple tiers, we will pay the largest amount, and if multiple surgeries are performed in a single day, we will pay one amount for the highest tier procedure. These benefits are determined by the HPG plan selected (see page 6).

4-Tier Surgical Schedule (based on surgery type)

Tier	Listed Condition
Tier 1 Extreme	Significant, non-diagnostic, invasive surgical procedures requiring general anesthesia and open incision. Procedures include open heart surgery (including bypass), major organ transplant, and brain surgery.
Tier 2 Major	Non-diagnostic, open incision, surgical procedures requiring general anesthesia. Procedures may include knee replacement, hip replacement, rotator cuff repair, and major organ removal or repair performed on organ within chest, abdomen or pelvic cavity that is not included in Tier 1.
Tier 3 Non-Major	Surgical procedures requiring general anesthesia or conscious sedation such as colonoscopy, removal of tonsils or adenoids, stent placement, insertion of pacemaker, balloon angioplasty, heart catheterization and laparoscopic hernia repair.
Tier 4 Local/Minor	Surgical procedures requiring local or regional anesthesia such as emergency C-sections and closed treatment of a fracture or dislocation.

More ways HPG offers value

Your HPG plan offers additional savings with an Rx discount card. Also, by remaining on the plan, some benefits increase in, or rollover to, the following calendar year.

Increasing Injury Reimbursement[1]

At the beginning of each calendar year, after being on the plan for at least 6 months, your Inpatient Hospital Confinement benefit, specifically related to injuries, will increase by 25%. This happens in years 2 through 5, and the benefit stays at the highest level after year 5. If anyone covered by the policy has a hospital stay related to an injury, the Inpatient Hospital Confinement benefit is replaced with the Increasing Injury Reimbursement benefit earned, starting year 2 of your insurance plan. (This increase does not apply to Inpatient Hospital Confinement related to illness.)

Office/Urgent Care Visit rollover benefit[2]

If you can rollover your unused data, why not your doctor visits too? This unique benefit allows you to rollover any unused doctor office or urgent care visits, for illness or injury, remaining at the end of a calendar year to the next calendar year. A maximum of 5 visits are allowed to rollover.

Rx discounts with Optum Perks[3]

There's a simple way to save **30-80% on prescriptions** with an Optum Perks prescription discount card. Just visit **perks.optum.com/uho** to print your card or send it to your phone. While there, you can also compare prescription prices at stores near you. To use your savings, show your Optum Perks discount card to the pharmacy during purchase. **Plus, when you present your discount card, if your plan has prescription benefits payable, this will activate the claims process so you don't have to do any additional work to receive your plan's prescription benefit payment.**

Note: The Optum Perks card is not insurance. It is a discount program only and available to the general public.

[1] If the effective date of coverage is prior to July 1, then the Second Year of coverage will begin on the following January 1. If the effective date is on or after July 1, the Second Year will begin January 1 following 12 consecutive months of coverage. Subsequent years after the Second Year will begin the following January 1. [2] If the effective date of coverage is prior to July 1, then any eligible unused visits may rollover on the following January 1. If the effective date is on or after July 1, then unused visits cannot begin accruing until January 1 following 12 consecutive months of coverage. [3]Based on pharmacy's usual and customary price. Actual savings may vary. Average savings is based on 2023 E&I Healthcare Econ & Pricing data of UnitedHealthcare Choice Plus network; average across combined in-patient and outpatient services. Savings experience can vary by provider and service.

UHC Member Hub

Manage your Health ProtectorGuard plan with UHC Member Hub

Connecting with your plan

With UHC Member Hub, you can manage your plan at your convenience, anytime day or night. Once registered for this member website, you can:

- Access your plan documents
- View and download your ID card
- Make changes to your contact information
- Look up network doctors and hospitals
- Make premium payments
- Send secure, non-urgent questions about your coverage

UHC Member Hub is a fast and easy way to get many of your questions answered, and manage your plan without having to make a phone call. Go to **uhcmemberhub.com**.

Exclusions and/or Limitations

This is only a general outline of the basic policy provisions and exclusions. It is not an insurance contract, nor part of the insurance policy. You will find complete details in the policy.

THE POLICY MAY LIMIT OR EXCLUDE BENEFITS FOR ANY LOSS CAUSED BY, RESULTING FROM, FOR, OR RELATING TO ANY OF THE FOLLOWING:

- A loss occurring before the policy effective date, after termination of the policy, during any time that coverage is not in force, or incurred during a waiting period.
- Any act of war; intentionally, self-inflicted, bodily harm; or participation in a riot; or commission or attempt to commit a felony.
- Active service in the armed forces or related auxiliaries.
- Cosmetic treatment.
- Pregnancy or childbirth (except for complications of pregnancy).
- Hospital confinement that begins on a Friday or Saturday unless it is an emergency, or medically necessary inpatient surgery is scheduled for the day after the date of admission.
- Hospital confinement primarily to receive rehabilitation, custodial care, educational care, or nursing services (unless expressly provided for by the policy).
- Any injury sustained while paid to participate or instruct in: horseback riding, racing or speed testing any non-motorized vehicle/conveyance, skiing, or rock or mountain climbing.
- Any injury sustained while participating, demonstrating, instructing, guiding, or accompanying others in: sports (semi- or professional or intercollegiate not including intramural sports), parachute jumping, hang gliding, skydiving, bungee jumping, parakiting, racing or speed testing any motorized vehicle/conveyance, rodeo sports, or scuba/skin diving (60 or more feet in depth).
- Operating a taxi or any other passenger transportation for wage, compensation, or profit.
- Routine well-baby care of a newborn infant while inpatient, except as expressly provided for by the policy.
- Injuries sustained while operating, riding in, or descending from any type of non-commercial aircraft. If the covered person is a pilot, officer, or member of the crew of such aircraft or is giving or receiving any kind of training or instructions or otherwise has any duties that require him or her to be aboard the aircraft.
- Services performed by an immediate family member.
- Fees/surcharges imposed by a provider (including a hospital), but which are actually the responsibility of the provider to pay.
- Services or supplies that are not medically necessary to the diagnosis or treatment of an illness or injury.
- Any loss sustained while the covered person is incarcerated in any prison or other detention facility.
- Any loss related to the treatment of mental disorders, substance abuse, or for court ordered treatment programs for substance abuse.
- Any loss related to an abortion (unless the life of the mother would be endangered if the fetus were carried to term).
- Any loss for dental expenses, except as expressly provided for by the policy.
- Any loss related to any examination or fitting related to eyeglasses, contact lenses, hearing aids, eye refraction, or visual therapy.
- Any services rendered outside of the U.S., except for emergency treatment for a covered person.
- Experimental or investigational treatment(s).

Plan Provisions

This is only a general outline of the basic policy provisions and exclusions. It is not an insurance contract, nor part of the insurance policy. You will find complete details in the policy.

THIS IS NOT QUALIFYING HEALTH CARE COVERAGE ("MINIMUM ESSENTIAL COVERAGE") THAT SATISFIES THE HEALTH COVERAGE REQUIREMENT OF THE AFFORDABLE CARE ACT.

Eligibility

At time of application, the primary insured and spouse, which includes the person to whom you are legally married or domestic partner in a domestic partnership established under Oregon law, must be between 18-64 years of age (drop off on 65th birthday). Eligible children must be 0-25 years of age (drop off on 26th birthday).

Misstatement of Age, Gender or Tobacco Use

If the covered person's age, gender or use of tobacco has been misstated on the covered person's application for coverage under the policy, any future premiums may be adjusted and past premiums may be refunded or owed to us based on the correct age, gender or tobacco status. If a covered person's age has been misstated and we would not have issued coverage for that covered person, we will refund the premium paid minus any benefit amounts paid by us, and coverage would be void from the effective date.

Notice of Claim

We must receive notice of claim within 30 days of the date the loss began or as soon as reasonably possible.

Premium

Premium rates are guaranteed for 12 months then subject to change. The age, gender, and tobacco class of a covered person and type and level of coverage are some factors that could be used to determine your premium rate. You will be given at least a 31-day notice of any change in your premium.

We will make no change in your premium solely because of claims made by a covered person under the policy or a change in a covered person's health.

Preexisting Conditions

We will not pay benefits under the policy for a loss which manifests due to, results from, is caused by, or contributed to by a Preexisting Condition. The Preexisting Condition limitation will not apply longer than 12 months after a covered person's applicable effective date under the policy.

"Preexisting Condition" means an illness, injury or condition:

- For which medical advice, diagnosis, care, or treatment was recommended to or received by a covered person within 12 months immediately preceding the effective date the covered person became insured under the policy; or
- That 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.

Renewability and Termination

The policy is renewable until the earliest of the following:

- The primary insured's 65th birthday or death. If the policy includes dependents, it may be continued after the primary insured's death or 65th birthday:
  - By the spouse, if a covered person
  - Otherwise, by an eligible child who is a covered person;
- Nonpayment of premiums when due, subject to policy provisions
- The date we receive a request from you to terminate the policy or any later date stated in your request; or
- The date there is fraud or a material misrepresentation made by or with the knowledge of a covered person in filing a claim for policy benefits.

Plan Provisions (continued)

This is only a general outline of the basic policy provisions and exclusions. It is not an insurance contract, nor part of the insurance policy. You will find complete details in the policy.

Right to Examine

It is important to us that you are satisfied with the coverage being provided. This product has a right to examine period, also commonly referred to as "free look." After applying and after your policy is issued, if you are not satisfied the coverage will meet your insurance needs, you may return the policy to us within 10 days and have the paid premium refunded. Refer to policy for details.

Underwriting

Insurance plans are subject to health underwriting. If you provide incorrect or incomplete information on your application for insurance your coverage may be voided or claims denied.

Waiting Periods

There is a 5-day waiting period before benefits will be payable due to an illness. Services received due to illnesses are eligible for coverage beginning on the 6th day following the effective date.

There is a 6-month waiting period before benefits are payable for the Wellness/Preventive Care benefit.

Note to our customers about supplemental insurance

- The supplemental plan discussed in this document is separate from any health insurance or Medicare Advantage coverage you may have purchased with another insurance company
- This plan provides optional coverage for an additional premium. It is intended to supplement your health insurance and provide additional benefits for covered expenses.
- This plan is not required in order to purchase health insurance with another insurance company
- This plan should not be used as a substitute for comprehensive health insurance coverage. It is not considered Minimum Essential Coverage under the Affordable Care Act.

Health plan notices of privacy practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

View notice here. Please review it carefully.
(https://www.uhc.com/content/dam/uhcdotcom/en/npp/NPP-UHC-EI-UHOne-EN.pdf)

Conditions prior to coverage (applicable with or without the conditional receipt)

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

1. The application is completed in full and is unconditionally accepted and approved by Golden Rule Insurance Company
2. The first full premium, according to the mode of premium payment chosen, has been paid on or prior to the effective date and any check is honored on first presentation for payment
3. The policy is: (a) issued by Golden Rule Insurance Company exactly as applied for within 45 days from date of application; (b) delivered to the proposed insured; and (c) accepted by the proposed insured

After you have completed the application and before you sign it, reread it carefully. Be certain that all information has been properly recorded. Keep an electronic copy of this document. It has important information.

45173OR-G-0325

UnitedHealthcare®
Golden Rule Insurance Co.