State:
LA MO

UnitedHealthcare®
Golden Rule Insurance Co.

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DIRECT

TriTerm Medical Plans

This coverage is not required to comply with certain federal market requirements for health insurance, principally those contained in the Affordable Care Act. Be sure to check your policy carefully to make sure you are aware of any exclusions or limitations regarding coverage of preexisting conditions or health benefits (such as hospitalization, emergency services, maternity care, preventive care, prescription drugs, and mental health and substance use disorder services). Your policy might also have lifetime and/or annual dollar limits on health benefits. If this coverage expires or you lose eligibility for this coverage, you might have to wait until an open enrollment period to get other health insurance coverage.

Policy forms GRI-IST-EXT1B-E-VAL and GRI-IST-EXT1D-E-VAL (applies to Value and Value Direct plans), GRI-IST-EXT1B-E and GRI-IST-EXT1D-E (applies to all other plans), and other state variations

What is TriTerm Medical? 3-Year Short Term

- Apply once for insurance coverage terms that equal one day less than 3 years.
- Choice of plans that offer $1 million or $2 million lifetime maximum benefit per covered person.
- Eligible expenses for preexisting conditions are covered after 12 months on the plan.

PREVENTIVE CARE COVERAGE

You don't have to be sick to access care with most TriTerm Medical plans. After 6 months on the plan, take your family* to the doctor for wellness checks — a $200 benefit per term, per person.

DOCTOR OFFICE COVERAGE

Doctor visits are covered on most TriTerm Medical plans. With some plans, you pay a $50 copay for the first 4 doctor visits (per term, per person) with no deductible to meet.

PRESCRIPTION DRUGS

Most TriTerm Medical plans have prescription coverage. Copay Select plans have a $25 copay for common (Tier 1) prescriptions.

3 TERMS

TERM 1 364 DAYS > **TERM 2** 365 DAYS > **TERM 3** 365 DAYS

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. **It is important to note there are State Variations, Exclusions and/or Limitations, and Plan Provisions.** This plan is medically underwritten. No benefits will be paid during the first 12 months for a health condition that exists prior to the date insurance takes effect.

*In Missouri, coverage is available on an individual basis only. No spouse or dependent can be added to your plan. Minimum issue age is 20 years old.

Highlights of Covered Network Expenses

3 TERMS — TERM 1 364 DAYS > TERM 2 365 DAYS > TERM 3 365 DAYS

		Copay Select (Max or Direct)	Plan 80 (Max or Direct)	Plan 100 (Max or Direct)	Value Direct[1]/Value
Deductible (per person, per term; max 2 per family)[1]	You pay up to:	$2,500, $5,000, $7,500, $10,000 or $12,500	$2,500, $5,000, $7,500, $10,000 or $12,500	$5,000, $7,500, $10,000 or $12,500	$2,500, $5,000, $7,500, $10,000, $12,500 or $15,000
Coinsurance (% you pay **after deductible**, per term)	You pay:	30%	20%	0%	Choose 30% or 50%
Coinsurance Out-of-Pocket Maximum (after deductible, per person, per term)	You pay up to:	$4,500	$2,000	$0	$10,000
Maximum Benefit (per person, lifetime)	We pay up to:	Max Plan: $2 million Direct Plan: $1 million	Max Plan: $2 million Direct Plan: $1 million	Max Plan: $2 million Direct Plan: $1 million	Value Direct: $1 million Value: $2 million
Medical					
Doctor Office Visit (History and Exam only) (per person, per term)	You pay:	$50 copay for first 4 visits[2]	20% after deductible	No charge after deductible	Chosen coinsurance after deductible
Urgent Care Center		$75 copay			$75 copay
Preventive Care ($200 max benefit per person, per term, after 6-month waiting period for term 1 only)		$50 copay			Preventive Care Not Covered
Emergency Room (Accident and Illness) (for illness only: additional $500 deductible if not admitted)		After deductible: 30%			Chosen coinsurance after deductible
Inpatient Hospital Services, Outpatient Surgery, Labs & X-rays		After deductible: 30%			Chosen coinsurance after deductible
Pharmacy					
Outpatient Prescription (Rx) Drugs ($5,000 max covered expenses per person, per term)	**Tier 1**	$25 copay	**20% after deductible** Using the member ID card, you pay for prescriptions at the point of sale, at the lowest price available.	**No charge after deductible** Using the member ID card, you pay for prescriptions at the point of sale, at the lowest price available.	**Not Covered** Discount card provided.[4]
	Rx Deductible (per person, per term)	$500 Rx Deductible, then:			
	Tier 2	$55 copay			
	Tier 3	$75 copay			
	Tier 4	50%			
Add Supplemental Accident Benefit[3] Matches medical deductible selected (page 11)	We pay up to:	$2,500, $5,000, $7,500, $10,000, or $12,500	$2,500, $5,000, $7,500, $10,000, or $12,500	$5,000, $7,500, $10,000, or $12,500	$2,500, $5,000, $7,500, $10,000, $12,500 or $15,000

Earliest effective date is 5 days after application. The amount of benefits provided depends upon the plan selected and the premium will vary with the amount of the benefits selected. These plans only pay benefits for eligible expenses from a network provider. See details on page 4. This coverage does not qualify as "Minimum Essential Coverage" as defined in the Affordable Care Act and may not cover all Essential Health Benefits in your state. [1] In Missouri, Value Direct plans are not available. Coverage is available on an individual basis only. No spouse or dependent can be added to your plan. Minimum issue age is 20 years old. [2] Subsequent visits are subject to deductible then coinsurance. Doctor office visit copays are for injury and illness and cannot be used for preventive services, other than those required due to state mandates. [3] Additional premium required. [4] Discounts vary by pharmacy, geographic area, and Rx drug.

Access to a Wide Network of Care & Cost-Saving

Get the most out of your benefits by staying in network. We help make it easier with:

UnitedHealthcare
Choice Network

These plans only pay benefits for eligible expenses from a network provider. **There are no non-network benefits.** No benefits are payable for non-emergency care from a non-network provider. Emergency treatment from a non-network provider will be treated as a network eligible service.

Visit UHOne.com and select Find A Doctor to search for network providers in your state.

Access to Quality Care from:

1.4 million physicians and other health care professionals.[1]

More than 6,500 hospitals and other facilities.[1]

Nationwide Network

Use any doctor in your network across the nation. See any network specialist without needing a referral.

No Balance Billing

Network providers will not charge you more than the network-negotiated rate. In-network providers agree to provide quality care at lower cost to you.

[1] UnitedHealth Group Annual Form 10-K for year ended 12/31/19.

More Coverage Choices

Underwritten by Golden Rule Insurance Company (GRIC)

OPTIONAL SUPPLEMENTAL ACCIDENT BENEFIT

Reduce or eliminate your out-of-pocket exposure for accident-related injuries. Supplemental Accident helps cover your deductible or other out-of-pocket medical expenses (before the health insurance starts paying covered expenses) for unexpected injuries. See page 11 for details.

ACCIDENT PROGAP

Need more than just accident coverage? A standalone Accident ProGap plan takes the next step by combining Accident Expense insurance with benefits for critical illness, hospitalization from sickness, and accidental death and dismemberment, as well. This plan pairs well with a medical plan to help with out-of-pocket costs like deductibles.

DENTAL & VISION

Additionally, consider coverage for those frequent expenses with standalone Dental & Vision insurance. Dental plans help take care of your smile with benefits for services ranging from routine cleanings to root canals. Vision plans cover routine eye exams and can help pay for glasses, contacts or both.

Additional premium is required for the coverage above. Accident ProGap, Dental & Vision require separate applications, and separate policies are issued. If Supplemental Accident is added to the TriTerm Medical plan, you cannot be issued an Accident ProGap plan. Product design and availability may vary by state. For costs, benefits, exclusions, limitations, eligibility, waiting periods and renewal terms, call 1-800-273-8115.

Medical Benefits
(insurance plans)

The following medical benefits are provided using network providers and are subject to Plan Provisions, Exclusions and/or Limitations, the deductible, any applicable copay or coinsurance, and all policy provisions (unless otherwise stated). Some state exceptions may apply (see State Variations.) You will find complete coverage details in the policy.

Ambulance Services

- Ground ambulance service to the nearest hospital that can provide services for necessary emergency care for the illness or injury.
- Air ambulance services requested by police or medical authorities at the site of emergency or in locations that cannot be reached by ground ambulance.

Cancer Treatment Expenses

- Radiation therapy and chemotherapy.
- Expenses in connection with a mastectomy for a covered person who elects breast reconstruction, including all stages of reconstruction of the breast on which the mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and treatment for physical complications of mastectomy, including lymphedemas.
- The cost of one wig per covered person, up to $500, necessitated by hair loss due to cancer treatments or traumatic burns.
- One mastectomy bra per year if the covered person has undergone a covered mastectomy.

Dental Injuries

Dental expenses for an injury to natural teeth suffered after the coverage effective date. Expenses must be incurred within 6 months of the accident.

No benefits payable for injuries due to chewing.

Diabetes

- Diabetes equipment, supplies, and services.
- Diabetes self-management training and education.

Diagnostic Testing

Testing using radiologic, ultrasonographic, or laboratory services (psychometric, behavioral and educational testing are not included).

Doctor Office Visit Copay (History and Exam only)

For Copay plans only, copay of $50 per office visit for treatment, excluding surgery, performed by a doctor, limited to 4 visits per person, per term. Additional office visits will be subject to the applicable deductible amount and coinsurance percentage. The office visit copayment amount does not apply to office visits for preventive care services.

Durable Medical Equipment

- Rental of standard non-motorized wheelchair, hospital bed, standard walker, wheelchair cushion, or ventilator.
- Cost of one Continuous Passive Motion (CPM) machine per covered person following a covered joint surgery.

Home Health Care

To qualify for benefits, home health care must be provided through a licensed home health-care agency. Covered expenses for home health aide services will be limited to 7 visits per week and a lifetime maximum of 365 visits. Benefits for home health care will not extend beyond the term of your plan. Each 8-hour period of home health aide services will be counted as one visit. Private duty registered nurse services will be limited to a lifetime maximum of 1,000 hours. Intermittent private duty registered nurse visits are not to exceed 4 hours each and are limited to $75 per visit (2 hours per visit are applied toward the lifetime maximum for private-duty nursing).

No benefits payable for respite care, custodial care, or educational care.

Medical Benefits
(insurance plans)

The following medical benefits are provided using network providers and are subject to Plan Provisions, Exclusions and/or Limitations, the deductible, any applicable copay or coinsurance, and all policy provisions (unless otherwise stated). Some state exceptions may apply (see State Variations.) You will find complete coverage details in the policy.

Hospice Care
To qualify for benefits, a hospice for a terminally ill covered person must be licensed by the state in which it operates. Benefits for inpatient care in a hospice are subject to deductible and coinsurance and limited to 180 days in a covered person's lifetime. Covered expenses for room and board are limited to the most common semiprivate room rate of the hospital or nursing home with which the hospice is associated (or $200 per day maximum if not associated with hospital or nursing home). Bereavement counseling maximum of $250.

Hospital Services
Daily hospital room and board at most common semiprivate rate; eligible expenses for an intensive care unit; inpatient use of an operating, treatment, or recovery room; outpatient use of an operating, treatment, or recovery room for surgery; services and supplies, including drugs and medicines, which are routinely provided in the hospital to persons for use only while they are inpatients; emergency treatment of an injury or illness. Covered expenses for use of the emergency room are subject to an additional $500 deductible for each emergency room visit for an illness unless the covered person is directly admitted to the hospital for further treatment of that illness.

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

Medical Supplies
- Dressings and other necessary medical supplies.
- Cost and administration of an anesthetic or oxygen.

Mental Nervous Disorders and Substance Abuse (excluding Value plans)
Treatment of mental disorders, substance abuse, or for court ordered treatment programs for substance abuse, limited to $5,000 of covered expenses per person, per term.

Outpatient Surgery
Surgery in a doctor's office or at an outpatient surgical facility, including services and supplies.

Physician Fees
- Professional fees of doctors, medical practitioners, and surgeons.
- Assistant surgeon fee limited to 16% of eligible expenses of the procedure.

Preventive Care (excluding Value plans)
Preventive care expenses, including but not limited to immunizations, urinalysis and blood tests, bone density screenings, Electrocardiograms (EKG's), cardiac stress tests, mammography screenings, cervical and pap smears, Human Papillomavirus (HPV) screenings and vaccinations, and ovarian cancer surveillance tests. Limited to a maximum benefit of $200 per covered person, per term. Covered expenses provided under the Medical Benefits provision will not be applied to this maximum. Preventive Care does not include computerized axial tomography (CAT or CT scan), magnetic resonance imaging (MRI), or positron emission tomography (PET scan) performed on a routine or preventive basis.

Prosthetics
Basic artificial limbs, artificial eyes, and larynx and breast prosthesis. Replacement only if required by a physical change in the covered person and the item cannot be modified.

Reconstructive Surgery
Reconstructive surgery that is incidental to or follows surgery or an injury that was covered under the policy or is performed to correct a birth defect in a child who has been a covered person from its birth until the date surgery is performed.

Rehabilitation and Extended Care Facility (ECF)
To qualify for benefits, a Rehabilitation or Extended Care Facility must be licensed by the state in which it operates. Services or confinement must begin within 14 days of a 3-day or more hospital stay, for the same illness or injury. Combined policy max of 60 days per person, per term for both rehabilitation and ECF expenses. This benefit excludes mental disorders or substance abuse.

Medical Benefits
(insurance plans)

The following medical benefits are provided using network providers and are subject to Plan Provisions, Exclusions and/or Limitations, the deductible, any applicable copay or coinsurance, and all policy provisions (unless otherwise stated). Some state exceptions may apply (see State Variations.) You will find complete coverage details in the policy.

Spine and Back Disorders

All plans except Value: $5,000 maximum covered expenses per person, per term for outpatient services. This limit does not apply to inpatient expenses or outpatient surgery.

Value plans: Limited to inpatient and surgical treatment.

Temporomandibular Joint (TMJ)

Temporomandibular Joint (TMJ) Surgery, excluding tooth extractions, to treat craniomandibular disorders, malocclusions, disorders of the temporomandibular joint (TMJ) limited to a combined $10,000 lifetime maximum for each covered person.

Therapeutic Treatments

- Hemodialysis, processing, and administration of blood or components (but not the cost of the actual blood or components).
- Occupational therapy following a covered treatment for traumatic hand injuries.

Transplant Expense Benefit

The following transplants are covered the same as any other illness: cornea, artery or vein grafts, heart valve grafts, prosthetic tissue and joint replacement, and prosthetic lenses for cataracts.

For all other covered transplants, see the policy for “Listed Transplants” under Transplant Expense Benefits.
The covered person must be a good candidate, as determined by us. The transplant must not be experimental or investigational. Covered expenses for “Listed Transplants” are limited to 2 during a 36 month policy maximum duration, per person.

GRIC has arranged for certain hospitals around the country (“Centers of Excellence” or COE) to perform specified transplant services. At a designated COE, covered expenses include the acquisition cost and transportation and lodging limited to $5,000 per transplant. If COE not used: Limit of 1 transplant per 36 month policy maximum duration, per person, limited to max benefits of $100,000; acquisition, transportation and lodging not covered.

No benefits payable for:

- Search and testing in order to locate a suitable donor.
- A prophylactic bone marrow harvest and peripheral blood stem cell collection when no “listed transplant” occurs.
- Animal-to-human transplants.
- Artificial or mechanical devices designed to replace a human organ temporarily or permanently.
- Procurement or transportation of the organ or tissue, unless expressly provided in this provision.
- Keeping a donor alive for the transplant operation.
- A live donor where the live donor is receiving a transplanted organ to replace the donated organ.
- A transplant under study in an ongoing Phase I or II clinical trial as set forth in the USFDA regulation.

Other Information (insurance plans)

This is only a general outline of the benefits, provisions and exclusions. It is not an insurance contract, nor part of the insurance policy. Some state exceptions may apply (see State Variations.) You will find complete details in the policy.

Policy Details State-specific differences may apply.

Exclusions and/or Limitations

Benefits will not be paid for services or supplies that are not administered or ordered by a doctor and medically necessary to the diagnosis or treatment of an illness or injury, as defined in the policy, or, where applicable, covered under the Preventive Care Expense Benefits provision.

For Value plans only, no benefits are payable for expenses:

- For outpatient treatment of spine and back disorders.
- For outpatient prescription drugs.

For all plans, no benefits are payable for expenses:

- For non-emergency services or supplies received from a provider who is not a network provider, except as specifically provided for by the policy.
- **For a preexisting condition** — A condition for which medical advice, diagnosis, care, treatment, any diagnostic procedure(s), or further evaluation was recommended or received within the 24 months immediately prior to the date the covered person became insured under the policy; or a condition that had manifested itself in such a manner that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment within the 12 months immediately prior to the date the covered person became insured under the policy; or a pregnancy existing on the effective date of coverage will also be considered a preexisting condition.

  NOTE: Even if you have had prior GRIC coverage and your preexisting conditions were covered under that plan, they will not be covered under this plan for the first 12 months of coverage.
- That would not have been charged if you did not have insurance.
- Imposed on you by a provider (including a hospital) that are actually the responsibility of the provider to pay.
- For services performed by an immediate family member.
- That are not identified and included as covered expenses under the policy or in excess of the eligible expenses.
- For services or supplies that are provided prior to the effective date or after the termination date of the coverage.
- For weight modification or surgical treatment of obesity, including wiring of the teeth and all forms of intestinal bypass surgery.
- For breast reduction or augmentation, except as provided for in the policy.
- For drugs, treatment, or procedures that promote or prevent conception or prevent childbirth, including but not limited to artificial insemination or treatment for infertility or impotency.
- For sterilization or reversals of sterilization.
- For fetal reduction surgery or abortion (unless life of mother would be endangered).
- For treatment of malocclusions, disorders of the temporomandibular joint (TMJ) or craniomandibular disorders, except as provided for by the policy.
- For modification of the physical body in order to improve psychological, mental, or emotional well-being, such as sex-change surgery.
- Not specifically provided for in the policy, including telephone consultations, failure to keep an appointment, television expenses, or telephone expenses.
- For marriage, family, or child counseling.
- For standby availability of a medical practitioner when no treatment is rendered.
- For hospital room and board and nursing services if admitted on a Friday or Saturday, unless for an emergency, or for medically necessary surgery that is scheduled for the next day.
- For dental expenses, including braces and oral surgery, except as provided for in the policy.
- For cosmetic treatment.
- For diagnosis or treatment of learning disabilities, attitudinal disorders, or disciplinary problems, except as provided for in the policy.
- For diagnosis or treatment of nicotine addiction.
- For surrogate parenting.
- For charges related to, or in preparation for, tissue or organ transplants, except as expressly provided for under Transplant Expense Benefits in the policy.
- For injuries from participation in professional or semi-professional sports or athletic activities for financial gain, as determined by GRIC.

Other Information (insurance plans)

This is only a general outline of the benefits, provisions and exclusions. It is not an insurance contract, nor part of the insurance policy. Some state exceptions may apply (see State Variations.) You will find complete details in the policy.

General Exclusions, continued

For all plans, no benefits are payable for expenses:

- For high-dose chemotherapy prior to, in conjunction with, or supported by ABMT/BMT, except as specifically provided under the Transplant Expense Benefits provision in the policy.
- For eye refractive surgery, when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism.
- While confined for rehabilitation, custodial care, educational care, or nursing services, except as provided for in the policy.
- For eyeglasses, contact lenses, hearing aids, eye refraction, visual therapy, or any exam or fitting related to these devices, except as provided for in the policy.
- Due to pregnancy (except complications).
- For any expenses, including for diagnostic testing, incurred while confined primarily for well-baby care, except as provided in the policy.
- For routine well-baby care of a newborn infant, except as provided for in the policy.
- For preventive care or prophylactic care, including routine physical examinations, premarital examinations, and educational programs, except as provided in the policy.
- Incurred outside of the U.S., except for emergency treatment.
- Resulting from declared or undeclared war; intentionally self-inflicted bodily harm (whether sane or insane); or participation in a riot or felony (whether or not charged).
- For or related to durable medical equipment or for its fitting, implantation, adjustment or removal or for complications therefrom, except as provided for in the policy.
- For treatments of hyperhidrosis (excessive sweating).
- For alternative treatments, except as specifically covered by the policy, including: acupressure, acupuncture, aromatherapy, hypnotism, massage therapy, rolfing, and other alternative treatments defined by the Office of Alternative Medicine of the National Institutes of Health.
- For joint replacement, unless related to an injury covered by the policy.
- Resulting from or during employment for wage or profit, if covered or required to be covered by workers' compensation insurance under state or federal law. If you entered into a settlement that waives your right to recover future medical benefits under a workers' compensation law or insurance plan, this exclusion will still apply.
- Resulting from intoxication, as defined by state law where the illness or injury occurred, or while under the influence of illegal narcotics or controlled substances, unless administered or prescribed by a doctor.
- For injuries sustained during or due to participating, instructing, demonstrating, guiding, or accompanying others in any of the following: sports (professional, or semi-professional, or intercollegiate), parachute jumping, hang-gliding, racing or speed testing any motorized vehicle or conveyance, scuba/skin diving (when diving 60 or more feet in depth), skydiving, bungee jumping, or rodeo sports.
- For injuries sustained during or due to participating, instructing, demonstrating, guiding, or accompanying others in any of the following if the covered person is paid to participate or to instruct: operating or riding on a motorcycle, racing or speed testing any non-motorized vehicle or conveyance, horseback riding, rock or mountain climbing, or skiing.
- For injuries sustained while performing the duties of an aircraft crew member, including giving or receiving training on an aircraft.
- For vocational or recreational therapy, vocational rehabilitation, outpatient speech therapy, or occupational therapy, except as provided for in the policy.
- Resulting from experimental or investigational treatments, or unproven services.
- Expenses incurred by a covered person for the treatment of tonsils, adenoids, middle ear disorders, hemorrhoids, hernia, or any disorders of the reproductive organs will not be covered during the covered person's first 6 months of coverage under the policy. This exclusion will not apply if the treatment is provided on an emergency basis.

Other Information (insurance plans)

This is only a general outline of the benefits, provisions and exclusions. It is not an insurance contract, nor part of the insurance policy. Some state exceptions may apply (see State Variations.) You will find complete details in the policy.

Optional Supplemental Accident Benefit for TriTerm Medical Plans

Forms SA-S-1899I-GRI, SA-S-1899RI-GRI and state variations

Reduce or eliminate your out-of-pocket exposure for accident-related injuries for additional premium. Supplemental Accident benefit matches your deductible, paying for treatment of an unexpected injury within 90 days of an accident. The benefit maximum amount ($2,500, $5,000, $7,500, $10,000, $12,500, or $15,000) is per accident, per covered person. NOTE: The $2,500 benefit amount is not an option with TriTerm Plan 100 Max or TriTerm Plan 100 Direct. The $15,000 benefit is only an option on the TriTerm Value and TriTerm Value Direct plan.

Application Fee

Nonrefundable $40 application fee required.

Dependents

For purposes of this coverage, eligible dependents are your lawful spouse and eligible children. Eligible children must be unmarried and under 26 years of age at time of application.

In Missouri, coverage is available on an individual basis only. No spouse or dependent can be added to your plan. Minimum issue age is 20 years old.

Effective Date

Expenses for injuries and illnesses are eligible for coverage as of your plan's effective date. Your policy will take effect on the later of:

- The requested effective date on your application; or
- The 5th day after the date received by GRIC,* but only if the following conditions are satisfied:
  - A. Your application and the appropriate premium payment are actually received by us within 15 days of your signing;**
  - B. Your application is properly completed and unaltered;
  - C. Your application is approved after review by GRIC.
  - D. You are a resident of a state in which the policy form can be issued; and
  - E. If the application is submitted by an agent or broker, the agent or broker is properly licensed and appointed to submit applications to GRIC.

* If mailed and not postmarked by the U.S. Postal Service or if the postmark is not legible, the effective date will be the later of: (1) the date you requested; or (2) the 5th day after the date received by GRIC. If the application is sent by any electronic means including fax, your coverage will take effect on the later of: (1) the requested effective date; or (2) the 5th day after the date received by GRIC.

** Your account will be immediately charged.

Eligibility

At time of application, the primary insured must be a minimum of 19 years of age.

In Missouri, the minimum issue age is 20 years old.

Eligible Expense

An eligible expense means a covered expense as follows:

- **For Network Providers:** The contracted fee for the provider.
- **For Non-Network Providers:** As defined in the policy.

Emergency

"Emergency" means an unforeseen or sudden medical condition manifesting itself by acute signs or symptoms which could reasonably result in death or serious disability if medical attention is not provided within 24 hours.

No Non-Network Benefits

- **These plans only pay benefits for eligible expenses from a network provider.** Visit UHOne.com to search for providers. (No benefits are payable for non-emergency care from a non-network provider.)
- Emergency treatment from a non-network provider will be treated as a network eligible service.
- Emergency treatment means you will owe the difference between what the non-network provider bills and what we pay for a network eligible expense.

Other Information (insurance plans)

This is only a general outline of the benefits, provisions and exclusions. It is not an insurance contract, nor part of the insurance policy. Some state exceptions may apply (see State Variations.) You will find complete details in the policy.

Non-Renewable

Your TriTerm Medical policy is not renewable and is issued for a specific period of time. We may cancel coverage if there is fraud or material misrepresentation made by or with the knowledge of a covered person in filing a claim for benefits. Coverage will remain in force until the termination date shown in your policy, unless the policy terminates earlier for any reason stated in the Termination section.

Premium

The premium amount is expected to change for each term.

Rating Factors

The plan, age and sex of covered persons, type and level of benefits, tobacco use status, underwriting class status, time the policy has been in force, and place of residence on the premium due date are some of the factors used in determining your premium rates. From time to time, we may change the rate table used. Each premium will be based on the rate table in effect on that premium's due date. At least 31 days' notice of any plan to take an action or make a change, permitted by the premium provision in the policy, will be mailed to you at your last address as shown in our records. We will make no change in your premium solely because of claims made under the policy or a change in a covered person's health.

Termination

The policy will terminate on the earliest of:

- The date all covered persons under the policy move out of the state where the policy was issued.
- The primary insured's death. If the policy includes dependents, it may be continued after the primary insured's death by a spouse, if a covered person; otherwise, by the youngest child who is a covered person.*
- Nonpayment of premiums when due.
- The termination date shown on the Data Page of the policy.
- The date we receive a request from you to terminate the policy.
- The date of the primary insured's 65th birthday.
- The date you accept any contribution from your employer for any portion of the premium, or the date you and your employer treat the plan as employer-provided insurance for any purpose, including tax purposes.

* In Missouri, coverage is available on an individual basis only. No spouse or dependent can be added to your plan. Minimum issue age is 20 years old.

State Variations (insurance plans)

Please see state availability and applicable state-specific benefits, exclusions, and limitations.

Louisiana

Policy Forms GRI-IST-EXT1B-E-17, GRI-IST-EXT1D-E-17, GRI-IST-EXT1B-E-VAL, GRI-IST-EXT1D-E-VAL-17,

- The $5,000 limit on Spine and Back Disorder does not apply.
- "Emergency" means a medical condition of recent onset and severity (including severe pain) that would lead a prudent layperson, acting reasonably and possessing an average knowledge of health and medicine, to believe that the absence of immediate medical attention could reasonably be expected to result in: 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; Serious impairment to bodily functions; or Serious dysfunction of any bodily organ or part.
- Covered expenses are expanded to include:
  - Prosthetic devices limited to $50,000 per limb.
  - Hearing aids for a covered person under age 18 years if the hearing aids are fitted and dispensed by a licensed audiologist or licensed hearing aid specialist, following medical clearance by a doctor and an audiological evaluation. Covered expenses under this paragraph are limited to $1,400 per hearing aid per ear per policy term.
- The following are covered expenses and are not subject to the Preventive Care $200 max benefit: mammography screenings, cervical smears and pap smears, in addition to prostate specific antigen tests and digital rectal examinations.
- For TriTerm Value and TriTerm Value Direct plans, covered expenses are expanded to include an annual preventive cancer screening for a covered person who was previously diagnosed with breast cancer, completed treatment for the breast cancer, underwent a bilateral mastectomy, and was subsequently determined to be clear of cancer.
- The exclusion for counseling does not apply to marriage or family counseling or counseling for the treatment of premarital, marriage, or family relationship dysfunctions.
- The exclusion as a result of covered person's commission of a felony only applies if the covered person was convicted.
- Preexisting condition is defined as: A condition for which medical advice, care, treatment, any diagnostic procedure(s), or further evaluation was recommended or received within the 12 months immediately preceding the date the covered person became insured under this policy; or a condition that had manifested itself in a manner that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment within the 12 months immediately preceding the date the covered person became insured under this policy; or a pregnancy existing on the effective date of coverage.
- A person's coverage will terminate if he or she becomes covered under other medical expense insurance while covered under the policy.

Missouri

Policy Form GRI-IST-EXT1B-E-IO-24, GRI-IST-EXT1D-E-IO-24 GRI-IST-EXT1B-E-VAL-24

- Value Direct plans are not available.
- Coverage is available on an individual basis only. No spouse or dependent can be added to your plan, and any references to spouse, dependents, children, or the like, do not apply.
- Minimum issue age is 20 years old.
- "Emergency" means a health care item or service furnished or required to evaluate and treat an emergency medical condition, which may include, but is not limited to, health care services that are provided in a licensed hospital's emergency facility by an appropriate provider.
- The covered expense for prosthetic devices includes original and replacement devices and related services.

State Variations (insurance plans)

Please see state availability and applicable state-specific benefits, exclusions, and limitations.

Missouri, continued

- Covered expenses are expanded to include:
  - One low-dose mammography screening per female covered person per policy term; and a low-dose mammography screening recommended by a doctor for a female covered person who has, or whose mother or sister has, a prior history of breast cancer.
  - Testing for lead poisoning as required or authorized by Missouri laws.
  - The necessary care and treatment of loss or impairment of speech or hearing, not including services to improve public speaking, care of the professional voice, or accent reduction.
  - The diagnosis and treatment of eating disorders as defined in the policy.
  - Bone mass measurement and other services related to the diagnosis, treatment, and appropriate management of osteoporosis.
  - General anesthesia and hospital charges for dental care provided to a covered person who is severely disabled or has a medical or behavioral condition that requires hospitalization or general anesthesia when dental care is provided.
  - Up to $75 in benefits for one human leukocyte antigen test (also referred to as histocompatibility locus antigen test) for A, B, and DR antigens for use in bone marrow transplants.
  - Services provided through telehealth if those services would otherwise be covered under the policy if provided through face-to-face diagnosis, consultation, or treatment.
  - Routine patient care costs incurred as the result of phase III or IV of a clinical trial that is undertaken for the purposes of the prevention, early detection, or treatment of cancer. Routine patient care costs will apply to clinical trials that are approved or funded by one of the following entities: National Institute of Health (NIH), NIH Cooperative Group or Center, U.S. FDA (in the form of an investigational new drug application), federal Departments of Veterans Affairs or Defense, 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 an implementation of regulations for the protection of human subjects, or a qualified research entity that meets the criteria for NIH Center support grant eligibility.
  - Treatment of breast cancer by dose-intensive chemotherapy, autologous bone marrow transplant, or stem cell transplants when performed pursuant to nationally accepted peer review protocols utilized by breast cancer treatment centers that are experienced in these services; limited to a lifetime maximum benefit of $100,000.
- Inpatient treatment of alcoholism is limited to 30 days per policy term.
- Inpatient treatment of mental disorders is limited to 90 days per policy term.
- The exclusion of an expense as a result of self-inflicted bodily harm does not apply if the covered person is insane or the harm resulted from other than an attempted suicide.

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. PLEASE REVIEW IT CAREFULLY.

MEDICAL INFORMATION PRIVACY NOTICE (Effective January 1, 2019)

We (including our affiliates listed at the end of this notice) are required by law to protect the privacy of your health information. We are also required to send you this notice, which explains how we may use information about you and when we can give out or "disclose" that information to others. You also have rights regarding your health information that are described in this notice. We are required by law to abide by the terms of this notice.

The terms "information" or "health information" in this notice include any information we maintain that reasonably can be used to identify you and that relates to your physical or mental health condition, the provision of health care to you, or the payment for such health care. We will comply with the requirements of applicable privacy laws related to notifying you in the event of a breach of your health information.

We have the right to change our privacy practices and the terms of this notice. If we make a material change to our privacy practices, we will provide to you in our next annual distribution, either a revised notice or information about the material change or how to obtain a revised notice. We will provide this information either by direct mail or electronically in accordance with applicable law. In all cases, we will post the revised notice on our websites, such as *www.uhone.com, www.myuhone.com, www.uhone4me.com, www.myallsavers.com, or www.myallsaversconnect.com.* We reserve the right to make any revised or changed notice effective for information we already have and for information that we receive in the future.

We collect and maintain oral, written and electronic information to administer our business and to provide products, services and information of importance to our customers. We maintain physical, electronic and procedural security safeguards in the handling and maintenance of our enrollees' information, in accordance with applicable state and Federal standards, to protect against risks such as loss, destruction or misuse.

How We Use or Disclose Information. We must use and disclose your health information to provide information:

- To you or someone who has the legal right to act for you (your personal representative) in order to administer your rights as described in this notice; and
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected.

We have the right to use and disclose health information for your treatment, to pay for your health care and operate our business. For example, we may use or disclose your health information:

- **For Payment** of premiums due us, to determine your coverage and to process claims for health care services you receive including for subrogation or coordination of other benefits you may have. For example, we may tell a doctor whether you are eligible for coverage and what percentage of the bill may be covered.
- **For Treatment.** We may use or disclose health information to aid in your treatment or the coordination of your care. For example, we may disclose information to your physicians or hospitals to help them provide medical care to you.
- **For Health Care Operations.** We may use or disclose health information as necessary to operate and manage our business activities related to providing and managing your health care coverage. For example, we might conduct or arrange for medical review, legal services, and auditing functions, including fraud and abuse detection or compliance programs. We may also de-identify health information in accordance with applicable laws. After that information is de-identified, the information is no longer subject to this notice and we may use the information for any lawful purpose.
- **To Provide Information on Health Related Programs or Products** such as alternative medical treatments and programs or about health-related products and services.
- **To Plan Sponsors.** If your coverage is through an employer group health plan, we may share summary health information and enrollment and disenrollment information with the plan sponsor. In addition, we may share other health information with the plan sponsor for plan administration if the plan sponsor agrees to special restrictions on its use and disclosure of the information in accordance with Federal law.
- **For Underwriting Purposes.** We may use or disclose your health information for underwriting purposes; however, we will not use or disclose your genetic information for such purposes.
- **For Reminders.** We may use or disclose health information to contact you for appointment reminders with providers who provide medical care to you.

We may use or disclose your health information for the following purposes under limited circumstances:

- **As Required by Law.** We may disclose information when required to do so by law.
- **To Persons Involved With Your Care.** We may use or disclose your health information to a person involved in your care, such as a family member, when you are incapacitated or in an emergency, or when you agree or fail to object when given the opportunity. If you are unavailable or unable to object we will use our best judgment to decide if the disclosure is in your best interests. Special rules apply regarding when we may disclose health information to family members and others involved in a deceased individual's care. We may disclose health information to any persons involved, prior to the death, in the care or payment for care of a deceased individual, unless we are aware that doing so would be inconsistent with a preference previously expressed by the deceased.
- **For Public Health Activities** such as reporting disease outbreaks to a public health authority.
- **For Reporting Victims of Abuse, Neglect or Domestic Violence** to government authorities, including a social service or protective service agency.
- **For Health Oversight Activities** such as licensure, governmental audits and fraud and abuse investigations.
- **For Judicial or Administrative Proceedings** such as in response to a court order, search warrant or subpoena.
- **For Law Enforcement Purposes** such as providing limited information to locate a missing person or report a crime.
- **To Avoid a Serious Threat to Health or Safety** by, for example, disclosing information to public health agencies or law enforcement authorities, or in the event of an emergency or natural disaster.

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- **For Specialized Government Functions** such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
- **For Workers' Compensation** including disclosures required by state workers' compensation laws that govern job-related injury or illness.
- **For Research Purposes** such as research related to the prevention of disease or disability, if the research study meets Federal privacy law requirements.
- **To Provide Information Regarding Decedents.** We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as necessary to carry out their duties.
- **For Organ Procurement Purposes.** We may use or disclose information to entities that handle procurement, banking or transplantation of organs, eyes or tissue to facilitate donation and transplantation.
- **To Correctional Institutions or Law Enforcement Officials** if you are an inmate of a correctional institution or under the custody of a law enforcement official, but only if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
- **To Business Associates** that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. Our business associates are required, under contract with us and pursuant to Federal law, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract and as permitted by Federal law.
- **Additional Restrictions on Use and Disclosure.** Certain Federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. Such laws may protect the following types of information: Alcohol and Substance Abuse, Biometric Information, Child or Adult Abuse or Neglect, including Sexual Assault, Communicable Diseases, Genetic Information, HIV/AIDS, Mental Health, Minors' Information, Prescriptions, Reproductive Health, and Sexually Transmitted Diseases.

If a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to us, it is our intent to meet the requirements of the more stringent law.

Except for uses and disclosures described and limited as set forth in this notice, we will use and disclose your health information only with a written authorization from you. This includes, except for limited circumstances allowed by Federal privacy law, not using or disclosing psychotherapy notes about you, selling your health information to others or using or disclosing your health information for certain promotional communications that are prohibited marketing communications under Federal law, without your written authorization. Once you give us authorization to release your health information, we cannot guarantee that the person to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization, except if we have already acted based on your authorization. To revoke an authorization, call the phone number listed on your health plan ID card.

What Are Your Rights. The following are your rights with respect to your health information.

- **You have the right to ask to restrict** uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures to family members or to others who are involved in your health care or payment for your health care. We may also have policies on dependent access that may authorize certain restrictions. **Please note that while we will try to honor your request and will permit requests consistent with our policies, we are not required to agree to any restriction.**
- **You have the right to ask to receive confidential communications** of information in a different manner or at a different place (for example, by sending information to a PO Box instead of your home address). We will accommodate reasonable requests where a disclosure of all or part of your health information otherwise could endanger you. In certain circumstances, we will accept verbal requests to receive confidential communications; however, we may also require you to confirm your request in writing. In addition, any request to modify or cancel a previous confidential communication request must be made in writing. Mail your request to the address listed below.
- **You have the right to see and obtain a copy** of health information that we maintain about you such as claims and case or medical management records. If we maintain your health information electronically, you will have the right to request that we send a copy of your health information in an electronic format to you. You can also request that we provide a copy of your information to a third party that you identify. In some cases you may receive a summary of this health information. You must make a written request to inspect and copy your health information or have it sent to a third party. Mail your request to the address listed below. In certain limited circumstances, we may deny your request to inspect and copy your health information. If we deny your request, you may have the right to have the denial reviewed. We may charge a reasonable fee for any copies.
- **You have the right to ask to amend information** we maintain about you such as claims and case or medical management records, if you believe the health information about you is wrong or incomplete. Your request must be in writing and provide the reasons for the requested amendment. Mail your request to the address listed below.
  If we deny your request, you may have a statement of your disagreement added to your health information.
- **You have the right to receive an accounting** of certain disclosures of your information made by us during the six years prior to your request. This accounting will not include disclosures of information: (i) for treatment, payment, and health care operations purposes; (ii) to you or pursuant to your authorization; and (iii) to correctional institutions or law enforcement officials; and (iv) other disclosures for which Federal law does not require us to provide an accounting.

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- **You have the right to a paper copy of this notice.** You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. In addition, you may obtain a copy of this notice at our websites such as *www.uhone.com, www.myuhone.com, www.uhone4me.com, www.myallsavers.com, or www.myallsaversconnect.com.*
- **You have the right to be considered a protected person.** *(New Mexico only)* *A "protected person" is a victim of domestic abuse who also is either: (i) an applicant for insurance with us; (ii) a person who is or may be covered by our insurance; or (iii) someone who has a claim for benefits under our insurance.*

Exercising Your Rights

- **Contacting your Health Plan.** If you have any questions about this notice or want to exercise any of your rights, you may contact a UnitedHealthOne Customer Call Center Representative. For Golden Rule members call us at 800-657-8205 (TTY 711). For All Savers members, call us at 1-800-291-2634 (TTY 711).
- **Filing a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with us at the address listed below.
- **Submitting a Written Request.** Mail to us your written requests to exercise any of your rights, including modifying or cancelling a confidential communication, requesting copies of your records, or requesting amendments to your record at the following address:
- Privacy Office, 7440 Woodland Drive, Indianapolis, IN 46278-1719
- **You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint.** We will not take any action against you for filing a complaint.

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

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

MIB. In conjunction with our membership in MIB, Inc., formerly known as Medical Information Bureau (MIB), we or our reinsurers may make a report of your personal information to MIB. MIB is a not-for-profit organization of life and health insurance companies that operates an information exchange on behalf of its members.

If you submit an application or claim for benefits to another MIB member company for life or health insurance coverage, the MIB, upon request, will supply such company with information regarding you that it has in its file.

If you question the accuracy of information in the MIB's file, you may seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. Contact MIB at: MIB, Inc., 50 Braintree Hill Park Ste. 400, Braintree, MA 02184-8734, 1-866-692-6901, *www.mib.com*.

FINANCIAL INFORMATION PRIVACY NOTICE (Effective January 1, 2019)

We (including our affiliates listed at the end of this notice) are committed to maintaining the confidentiality of your personal financial information. For the purposes of this notice, "personal financial information" means information, other than health information, about an insured or an applicant for coverage that identifies the individual, is not generally publicly available and is collected from the individual or is obtained in connection with providing coverage to the individual.

Information We Collect. Depending upon the product or service you have with us, we may collect personal financial information about you from the following sources:

- Information we receive from you on applications or other forms, such as name, address, age, medical information and Social Security number;
- Information about your transactions with us, our affiliates or others, such as premium payment and claims history; and
- Information from a consumer reporting agency.

Disclosure of Information. We do not disclose personal financial information about our insureds or former insureds to any third party, except as required or permitted by law. For example, in the course of our general business practices, we may, as permitted by law, disclose any of the personal financial information that we collect about you, without your authorization, to the following types of institutions:

- To our corporate affiliates, which include financial service providers, such as other insurers, and non-financial companies, such as data processors;
- To nonaffiliated companies for our everyday business purposes, such as to process your transactions, maintain your account(s), or respond to court orders and legal investigations; and
- To nonaffiliated companies that perform services for us, including sending promotional communications on our behalf.

We restrict access to personal financial information about you to employees, affiliates and service providers who are involved in administering your health care coverage or providing services to you. We maintain physical, electronic and procedural safeguards that comply with Federal standards to guard your personal financial information.

Confidentiality and Security. We maintain physical, electronic and procedural safeguards, in accordance with applicable state and Federal standards, to protect your personal financial information against risks such as loss, destruction or misuse. These measures include computer safeguards, secured files and buildings, and restrictions on who may access your personal financial information.

Questions About this Notice. If you have any questions about this notice, you may contact a UnitedHealthOne Customer Call Center Representative. For Golden Rule members call us at 1-800-657-8205 (TTY 711). For All Savers members, call us at 1-800-291-2634 (TTY 711).

The Notice of Privacy Practices, effective January 1, 2019, is provided on behalf of All Savers Insurance Company; All Savers Life Insurance Company of California; Golden Rule Insurance Company; Oxford Health Insurance, Inc.; UnitedHealthcare Insurance Company; and UnitedHealthcare Life Insurance Company. To obtain an authorization to release your personal information to another party, please go to the appropriate website listed in this Notice.

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Who we are

Golden Rule Insurance Company, a UnitedHealthcare company, is the underwriter of plans featured in this brochure. We have been serving the specific needs of individuals and families buying their own coverage for over 75 years. Plans are administered by United Healthcare Services, Inc.

Golden Rule Insurance Company is rated “A” (Excellent) by A.M. Best.* 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.

* As of 12/18/19. For the latest rating, access www.ambest.com.

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