States:
GA KY NC OK

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INTERNET/FMO

TriTerm Medical Hospital Surgical Plans

This coverage is not an Affordable Care Act (ACA) plan. See page 8 of this brochure for information about Exclusions & Limitations, followed by state variations. This is a general summary. 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-P-HSM and other state variations

Highlights of Covered Network Expenses

TERM 1 364 DAYS TERM 2 365 DAYS[1] TERM 3 365 DAYS[1]

		Hospital & Surgical
Deductible (per person, per term; max 2 per family)	You pay up to:	**$5,000, $7,500, $10,000, $12,500 or $15,000**
Coinsurance (% you pay **after deductible**, per term)	You pay:	**Choose 30% or 50%**
Coinsurance Out-of-Pocket Maximum (after deductible, per person, per term)	You pay up to:	**$10,000**
Maximum Benefit (per person, lifetime)	We pay up to:	**$2 million**

Medical

Urgent Care Center Visit (per person, per term)	You pay:	**$75 copay for first 2 visits[2]**
Emergency Room (Accident and Illness) (for illness only: additional $500 deductible if not admitted)		**Chosen coinsurance after deductible**
Inpatient Hospital Services, Outpatient Surgery		**Chosen coinsurance after deductible**
Outpatient Labs & X-rays ($500 max covered expense per person, per term)		**Chosen coinsurance after deductible**
Add Supplemental Accident Benefit[3] Matches medical deductible selected (page 10)	We pay up to:	**$5,000, $7,500, $10,000, $12,500 or $15,000**

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. 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 benefits selected. Non-network benefits vary. See details on page 3. 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] Each Oklahoma term equals 364 days. [2] Subsequent visits are subject to deductible then coinsurance. Copays do not apply to deductible, coinsurance, or coinsurance out-of-pocket maximum. [3] Additional premium required.

UnitedHealthcare Choice Plus Network

In addition to the in-network benefits, these plans pay reduced non-network benefits. Using non-network providers will cost you more due to a non-network penalty - see below. **For non-emergency care received from Non-Network Providers you pay:** (a) all charges above what is considered an eligible expense; (b) a penalty of 25% of the eligible expense, which does not count toward the deductible; and (c) a deductible amount equal to 2 times the network deductible. There is no out-of-pocket maximum for non-network providers. Your actual out-of-pocket costs may be more than the stated coinsurance because the bill from a non-network provider may not be used to calculate what we pay and what you pay.

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

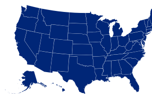
Access to a Wide Network of Care & Cost-Saving

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

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.

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). 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 coverage details in the policy.

State-specific differences may apply.

Covered expenses must be administered by a doctor, medically necessary to the diagnosis or treatment of an injury or illness, and not excluded anywhere 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.

Breast Reconstruction Following Mastectomy

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.

Emergency Treatment

Covered expenses are limited to 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.

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.

Inpatient Benefits

Charges for the following when incurred by a covered person as an inpatient in a hospital. **Hospital does not include a nursing or convalescent home or an extended care facility.**

- Daily hospital room and board and nursing services at most common semiprivate rate.
- Eligible daily room and board and nursing service expenses for an intensive care unit.
- Inpatient use of an operating, treatment, or recovery room.
- Services and supplies, including drugs and medicines, which are routinely provided in the hospital to persons for use only while they are inpatients.
- Dressings and other necessary medical supplies.
- Diagnostic testing using radiologic, ultrasonographic, or laboratory services (psychometric, behavioral and educational testing are not included).
- Radiation therapy and chemotherapy.
- Cost and administration of an anesthetic or oxygen.
- Hemodialysis, processing, and administration of blood or components (but not the cost of the actual blood or components.)
- 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.
- Professional fees of doctors and medical practitioners.
- Inpatient treatment of a spine or back disorder.

Life-Threating Cancer Benefit

Covered expenses include outpatient diagnosis and treatment of life-threatening cancer, including surgery, chemotherapy, radiation treatment, and medications related to the treatment.

In addition, a person receiving treatment for life-threatening cancer also receives the following coverage for illness or injury from the time treatment begins until the covered person's coverage under the policy ends:

Medical Benefits (insurance plans)

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Life-Threating Cancer Benefit, continued

- Outpatient office visits for treatment of an illness or injury (excluding surgery) performed by a doctor or medical practitioner.
- Diagnostic testing using radiologic, ultrasonographic, or laboratory services (psychometric, behavioral, and educational testing are not included).
- Diagnostic procedures.
- Physical therapy.
- Hemodialysis and the charges by a hospital for the processing and administration of blood or blood components.
- Rental of the following durable medical equipment: I.V. stand and I.V. tubing, infusion pump or cassette, portable commode, patient life, bili-lights, and suction machine and suction catheters.
- Dressings, crutches, orthopedic braces and splints, casts, or other necessary medical supplies.
- Counseling visits with a licensed mental health counselor.
- Outpatient treatment of a spine or back disorder.
- Outpatient prescription drugs received from a licensed pharmacy for drugs that, under applicable state law, may be dispensed only upon the written prescription of a doctor. Covered expenses are limited to the drugs included in the Prescription Drug List (“PDL”) provided by our pharmacy benefits manager, OptumRx, at the time your prescription order is filled (formulary drugs). Certain exceptions and exclusions may apply. See policy for details.
- Home health care, including:
  - Home health aide services, limited to 7 visits per week and a lifetime maximum of 365 visits. Each 8-hour period of home health aide services will be counted as one visit.
  - The services of a private-duty registered nurse provided on an outpatient basis, limited to a lifetime maximum of 1,000 hours. Intermittent private-duty registered nurse visits (not to exceed 4 hours each) will be limited to $75 per visit and deemed to be 2 hours applied toward the 1,000-hour maximum limit.
  - The professional fees of a licensed respiratory, physical, occupational, or speech therapist.
  - I.V. medication and pain medication.

Covered expenses for home health care do not include the charges related to respite care, custodial care, or educational care.

Outpatient Catastrophic Medical Expenses

Expenses received on outpatient basis are limited to:

- Radiation therapy, one office visit following each round of radiation therapy, and diagnostic testing performed in conjunction with, and on the same day as, the radiation therapy.
- Chemotherapy, including the cost and administration of chemotherapy, and diagnostic testing performed in conjunction with, and on the same day as, the chemotherapy.
- Hemodialysis.
- 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.
- Angiogram, arteriogram, computerized transverse tomography (CAT scan), echocardiography (transthoracic, real-time with image documentation), electroencephalogram (EEG), magnetic resonance imaging (MRI), myelogram, positron emission tomography (PET scan), and thallium stress test.
- Outpatient prescription drugs that are medically necessary to protect against rejection of an organ transplant, limited to a 34-day supply per prescription order or refill. No benefits will be paid for charges incurred for more than the predetermined managed drug limitations assigned to certain drugs or classification of drugs.
- Dental expenses only when a covered person suffers an injury, after the covered person’s effective date of coverage, that results in damage to his or her natural teeth and expenses that are incurred within six months of the accident or as part of a treatment plan that was prescribed by a doctor and began within six months of the accident. **Injury to the natural teeth will not include any injury as a result of chewing.**

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). 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 coverage details in the policy.

Outpatient Preadmission and Presurgical Testing (X-ray and Lab)

Expenses for diagnostic testing performed before an authorized hospital stay, outpatient surgical procedure, or cancer treatment when:

A. The charges for the tests would have been covered expenses if the covered person were confined as an inpatient; and

B. The tests are not repeated in the hospital or elsewhere.

Limited to maximum covered expenses of $500 per person, per term.

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.

Surgical Expenses

Limited to the following when incurred by a covered person for surgery:

- Professional fees of surgeon.
- Assistant surgeon fees, limited to 16% of eligible expenses of the procedure.
- Outpatient use of an operating, treatment, or recovery room for surgery.
- Cost and administration of an anesthetic.
- Charges made by an outpatient surgical facility or separate identifiable outpatient unit of a hospital for services and supplies related to an outpatient surgery.
- Post-operative laboratory services necessitated by the surgery.
- Surgical treatment of a spine or back disorder.

Covered surgical expenses do not include tooth extraction or charges for surgery performed in a doctor's office or in any facility other than an outpatient surgical facility or a separate identifiable outpatient unit of a hospital for services and supplies related to outpatient surgery.

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). 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 coverage details in the policy.

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.

Urgent Care

Copay of $75 per office visit for services, including professional services, received at an urgent care center, limited to 2 visits per person, per term. Additional urgent care visits will be subject to the applicable deductible amount and coinsurance percentage.

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.

Some states may require that you have Minimum Essential Coverage in order to avoid a penalty. The Short-term, limited duration insurance benefits under this coverage do not meet all federal requirements to qualify as "Minimum Essential Coverage" for health insurance under the Affordable Care Act ("ACA"). This plan of coverage does not include all Essential Health Benefits as required by the ACA. 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. You may be able to get longer term insurance that qualifies as "Minimum Essential Coverage" for health insurance under the ACA.

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.

No benefits are payable for expenses:

- **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 modification of the physical body in order to improve psychological, mental, or emotional well-being, such as sex change surgery.
- 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 if the fetus were carried to term).
- For treatment of malocclusions, disorders of the temporomandibular joint (TMJ) or craniomandibular disorders.
- 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 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 standby availability of a medical practitioner when no treatment is rendered.
- 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.
- For diagnosis or treatment of nicotine addiction.
- 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 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 routine well-baby care of a newborn infant.

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

No benefits are payable for expenses:

- 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 injuries from participation in professional or semi-professional sports or athletic activities for financial gain, as determined by GRIC.
- For injuries sustained during or due to participating, instructing, demonstrating, guiding, or accompanying others in any of the following: sports (professional, or semiprofessional, 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.
- For eyeglasses, contact lenses, hearing aids, eye refraction, visual therapy, or any exam or fitting related to these devices.
- Due to pregnancy (except complications).
- For any expenses, including for diagnostic testing, incurred while confined primarily for well-baby care.
- For preventive care or prophylactic care, including routine physical examinations, premarital examinations, and educational programs.
- Resulting from experimental or investigational treatments, or unproven services.
- Incurred outside of the U.S., except for emergency treatment.
- 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 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.
- 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 or related to surrogate parenting.
- For or related to treatment 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.
- For outpatient diagnosis and treatment of a spine or back disorder, except as expressly provided for by the policy.
- For diagnosis and treatment of mental disorders and substance abuse, including court-ordered treatment of substance abuse.
- For home health care, except as expressly provided for by the policy.

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

No benefits are payable for expenses:

- For outpatient prescription drugs, except as specifically provided for by the policy.
- For services or supplies received on an outpatient basis, except as expressly provided for by the policy.
- 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.

Optional Supplemental Accident Benefit for TriTerm Medical Plans

Forms 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 ($5,000, $7,500, $10,000, $12,500, or $15,000) is per accident, per covered person.

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.

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.

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.

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.

Emergency

"Emergency" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention 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.

Reduced Non-Network Benefits

These plans pay reduced non-network benefits.

Using non-network providers will cost you more due to a non-network penalty - see below. **For non-emergency care received from Non-Network Providers you pay:**

(a) all charges above what is considered an eligible expense; (b) a penalty of 25% of the eligible expense, which does not count toward the deductible; and

(c) a deductible amount equal to 2 times the network deductible. There is no out-of-pocket maximum for non-network providers. Your actual out-of-pocket costs may be more than the stated coinsurance because the bill from a non-network provider may not be used to calculate what we pay and what you pay.

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.

State Variations (insurance plans)

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

Georgia

Policy Form GRI-IST-EXT1B-P-HSM-10

- Application fee is refundable if coverage is not issued or policy is returned during the Free Look period.
- Coverage for professional services of a doctor or medical practitioner include telemedicine services for the diagnosis, consultation or treatment of a covered person.
- Covered expenses are expanded to include:
  - Inpatient or surgical treatment, excluding tooth extraction, for the correction of congenital or developed anomalies of the temporomandibular joint.
  - General anesthesia and associated hospital or outpatient surgical facility charges in conjunction with dental care provided to a covered person less than age 7 who is developmentally disabled, has a medically compromised condition, or has sustained extensive facial or dental trauma.
  - For a covered person age 20 years or younger for the treatment of autism spectrum disorders covered expenses for applied behavior analysis are limited to $35,000 per covered person per coverage term.
  - Child wellness services provided to a covered person from birth until the covered person's 6th birthday. Benefits for child wellness services are exempt from the deductible.
  - One routine mammography examination during the policy term for each female covered person, or more often if ordered by a doctor.
  - One cervical smear or pap smear during the policy term for each female covered person, or more often if ordered by a doctor.
  - One digital rectal examination and one prostate specific antigen test during the policy term for each male covered person age 40 years or older, or more often if ordered by a doctor.
  - Colorectal cancer examinations and laboratory tests in accordance with the published American Cancer Society guidelines.
  - Osteoporosis screening for covered persons who are at clinical risk as determined by a doctor.
  - Surveillance tests for ovarian cancer in a covered person age 35 or older who is at risk for ovarian cancer.
- Exclusion for diagnosis or treatment of learning disabilities, attitudinal disorders, or disciplinary problems does not apply to treatment of autism spectrum disorders as expressly covered by the policy.
- "Preexisting condition" means:

  A. Any illness, injury or condition for which medical advice, care or treatment was recommended or received within the 6 months immediately preceding the covered person's effective date;

  B. Any illness, injury or condition for which any diagnostic procedure or screening was recommended to or received by the covered person within the 6 months immediately preceding the covered person's effective date that results in medical care or treatment after the covered person's effective date; or

  C. Any illness, injury or symptom(s) that, in the opinion of a doctor, manifested itself in a manner that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care, treatment or further evaluation within the 6 months immediately preceding the covered person's effective date.

  For prior medical advice, care, treatment or recommended diagnostic procedure, the condition or diagnostic procedure at issue must be the ultimate condition or diagnostic procedure for which medical advice, care, treatment or diagnostic procedure was recommended or received prior to the covered person's effective date, excluding any preventive services.
- "Emergency" means a condition of recent onset and sufficient severity, including, but not limited to, severe pain, that would lead a reasonably prudent layperson, who possesses an average knowledge of health and medicine, to believe that his or her condition, sickness, or injury is of such a nature that failure to obtain immediate medical attention could 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.
- "Listed Transplant" includes ABMT for breast cancer.

State Variations (insurance plans)

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

Kentucky

Policy Form GRI-IST-EXT1B-P-HSM-16

- Application fee is refundable if coverage is not issued or policy is returned during the Free Look period.
- Covered expenses are expanded to include:
  - Inpatient or surgical treatment of craniomandibular disorders, malocclusions, or disorders of the temporomandibular joint.
  - Home health care visit expenses limited to no more than 60 days during any continuous 12-month period for each covered person for whom an attending doctor certifies confinement in a hospital or skilled nursing facility would otherwise be required when home health care is not provided. Covered expenses are limited to:
    1. Part-time or intermittent skilled nursing services provided by an advanced practice registered nurse, registered nurse or licensed practical nurse;
    2. Physical therapy, respiratory therapy, occupational therapy or speech therapy;
    3. Home health aide services; and
    4. Assistance with medical appliances or equipment, prescription drugs and laboratory services, to the extent such services would have been covered when the covered person is confined in a hospital.
  - One routine mammography examination during the policy term for each female covered person, and for mammograms upon referral by a medical practitioner for a covered person who has been diagnosed with breast disease.
  - Diagnosis and treatment of endometriosis or endometritis (not including expenses primarily for the treatment of infertility).
  - Bone density testing of a female covered person age 35 years or older to obtain baseline data for the purpose of early detection of osteoporosis.

North Carolina

Policy Form GRI-IST-EXT1B-P-HSM-32

- “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:
  - 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.
  - If a covered person experiences an emergency medical condition, one of the ways to access emergency services is to call 9-1-1.
- Covered expenses are expanded to include:
  - Diagnostic, surgical and nonsurgical treatment of temporomandibular joint disorders (TMJ). Non-surgical treatment of TMJ is limited to a lifetime maximum of $3,500 per covered person.
  - Reconstructive surgery that is incidental to or follows surgery for an injury that was covered under this 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.
  - The screening, diagnosis, and treatment of autism spectrum disorder. Adaptive behavior treatment is limited to a maximum benefit of $40,000 (or to the dollar amount set by the State of North Carolina based on the Consumer Price Index) for a covered person age 18 years or younger.
  - Equipment, supplies, medications, laboratory procedures, and services for the treatment of diabetes, and for diabetes self-management training and education.

North Carolina, continued

- Covered expenses are expanded to include:
  - Low-dose screening mammograms at the intervals stated in the policy.
  - Cervical cancer screening in accordance with the most recently published American Cancer Society guidelines or guidelines adopted by the North Carolina Advisory Committee on Cancer Coordination and Control, including the examination, the laboratory fee, and the doctor's interpretation of the laboratory results.
  - Prostate-specific antigen (PSA) tests for the presence of prostate cancer upon the recommendation of a doctor.
  - General anesthesia, facility fees, and other related charges incurred for dental care (but not including the actual dental services) that is provided in a hospital or an outpatient surgical facility to the following covered persons, when certified by the covered person's doctor as medically necessary to safely and effectively perform the procedure: an eligible child less than 9 years of age; a covered person with a serious mental or physical condition; or a covered person with significant behavioral problems.
  - Annual screening for ovarian cancer using transvaginal ultrasound and rectovaginal pelvic examination for women age 25 and older who: have a family history as defined in the policy; or tests positive for a hereditary ovarian cancer syndrome.
  - Medically necessary costs of health care services associated with participation in a clinical trial, medically necessary monitoring, and the diagnosis and treatment of complicantion, only to the extend such costs are not funded by national agencies, commercial manufacturers, distributors, or other sponsored of participants in the clinical trial. Covered expenses do not include the 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.
  - Newborn hearing screening when ordered by the attending doctor.
  - Diagnosis, evaluation, and treatment of lymphedema. The treatment must be provided by a licensed occupational or physical therapist or licensed nurse who has experience providing such treatment, or other medical practitioner acting within the scope of his or her license.
  - One hearing aid per hearing-impaired ear up to $2,500 per hearing aid for a covered person less than 22 years of age. Covered expenses are limited to: initial hearing aids and replacement hearing aids not more frequently than every 36 months; a new hearing aid when alterations to the existing hearing aid cannot adequately meet the covered person's needs; services ordered by a physician or a licensed audiologist, including the initial hearing aid evaluation, fitting, and adjustments, and supplies, including ear molds.
- Exclusion for injury or illness in the course of employment was restated to exclude services or supplies for the treatment of an occupational injury or illness that 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.
- Exclusion for injury or illness as a result of intoxication or under the influence of illegal narcotics does not apply.
- "Preexisting condition" means 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 the policy; or a condition that had manifested itself within the 12 months immediately preceding the date the covered person became insured under the policy; or a pregnancy existing on the effective date of coverage.

State Variations (insurance plans)

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

Oklahoma

Policy Form GRI-IST-EXT1B-P-HSM-35

- Plans have three terms of 364 days each.
- Covered expenses are expanded to include:
  - Diagnosis or treatment of a spine or back disorder.
  - Bone density test to detect low bone mass and to determine a qualified individual's, as defined in the policy, risk of osteoporosis, limited to $150 per test.
- The exclusion for injury or illness caused by war only applies while serving in the military or naval services, or any auxiliary unit, of the United States.
- The exclusion for illness or injury incurred as a result of covered person being intoxicated does not apply. (NOTE: The exclusion for illness or injury incurred as a result of covered person being under the influence of illegal narcotics still applies.)
- The 6-month waiting period for certain conditions does not apply to middle ear disorders.
- The policy includes Coordination of Benefits (COB) Provision for covered persons who have health care coverage through more than one plan at the same time. COB allows 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. The order of benefit determination rules, as outlined in the policy, determines which plan will pay as the primary plan and which will be considered the secondary plan. COB does not apply to life insurance, accidental death and dismemberment, or disability benefits.

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.

33638-X-201902 Products are either underwritten or administered by: All Savers Insurance Company, All Savers Life Insurance Company of California, Golden Rule Insurance Company, Oxford Health Insurance, Inc., UnitedHealthcare Insurance Company, and/or UnitedHealthcare Life Insurance Company.

- **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.

33638-X-201902 Products are either underwritten or administered by: All Savers Insurance Company, All Savers Life Insurance Company of California, Golden Rule Insurance Company, Oxford Health Insurance, Inc., UnitedHealthcare Insurance Company, and/or UnitedHealthcare Life Insurance Company.

- **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.

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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