

State:
LA MO SC



Table of Contents

Plan Information	2
Network	3
Benefits	4
Exclusions & Limitations	7
Plan Provisions	9
State Variations	11
Notice of Privacy Practices	15
Who we are	18

DIRECT

TriTerm Medical Hospital Surgical Plans

This coverage is not an Affordable Care Act (ACA) plan. See page 7 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 GRHST-EXT1B-E-HSM (applies to Hospital & Surgical Plans), GRIHST-EXT1D-E-HSM (applies to Hospital & Surgical Direct Plans), and other state variations

Highlights of Covered Network Expenses



TERM 1
364 DAYS¹



TERM 2
365 DAYS¹



TERM 3
365 DAYS¹

		Hospital & Surgical	Hospital & Surgical Direct (NOT AVAILABLE IN MISSOURI)
Deductible (per person, per term; max 2 per family) ²	You pay up to:	\$5,000, \$7,500, \$10,000, \$12,500 or \$15,000	\$5,000, \$7,500, \$10,000, \$12,500 or \$15,000
Coinsurance (% you pay after deductible, per term)	You pay:	Choose 30% or 50%	Choose 30%, 40% or 50%
Coinsurance Out-of-Pocket Maximum (after deductible, per person, per term)	You pay up to:	\$10,000	\$10,000
Maximum Benefit (per person, lifetime)	We pay up to:	\$2 million	\$1 million

Medical

Urgent Care Center Visit (per person, per term)		\$75 copay for first 2 visits ³	\$75 copay for first 2 visits ³
Emergency Room (Accident and Illness) (for illness only: additional \$500 deductible if not admitted)	You pay:	Chosen coinsurance after deductible	Chosen coinsurance after deductible
Inpatient Hospital Services, Outpatient Surgery		Chosen coinsurance after deductible	Chosen coinsurance after deductible
Outpatient Labs & X-rays (\$500 max covered expense per person, per term)		Chosen coinsurance after deductible	Chosen coinsurance after deductible

Add Supplemental Accident Benefit⁴ Matches medical deductible selected (page 9)	We pay up to:	\$5,000, \$7,500, \$10,000, \$12,500 or \$15,000	\$5,000, \$7,500, \$10,000, \$12,500 or \$15,000
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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. These plans only pay benefits for eligible expenses from a network provider. 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 SC terms are 11 months each. ² In Missouri, coverage is available on an individual basis only. No spouse or dependent can be added to your plan. Minimum age is 20 years old. ³ Subsequent visits are subject to deductible then coinsurance. Copay does not apply to deductible, coinsurance, or coinsurance out-of-pocket maximum. ⁴ Additional premium required.

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.

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-Threatening 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-Threatening 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.

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 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 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, hypnosis, 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. In Missouri, coverage is available on an individual basis only. 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, 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.

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.

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.

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-HST-EXT1B-E-HSM-17
and GRI-HST-EXT1D-E-HSM-17

- The policy is conditionally renewable for one day less than 36 months.
- 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, limited to \$1,400 per hearing aid per ear per policy term.
 - One routine mammography examination per policy term for each female covered person, not subject to the deductible amount.
 - One cervical smear or pap smear per policy term for each female covered person, not subject to the deductible amount.
 - One digital rectal examination and one prostate specific antigen test per policy term for each male covered person age 40 or older, not subject to the deductible amount.
 - Secondary conditions and treatment due to cleft lip and cleft palate, limited to the services outlined in the policy.
 - The services of a qualified interpreter or transliterator if the services: are provided in connection with diagnostic consultations or medical treatment by a doctor; would otherwise be a covered expense under the policy; and are required due to a hearing impairment of the covered person or a failure of the covered person to understand or otherwise communicate in spoken language.
 - Childhood immunizations for a covered person from birth until the 6th birthday, not subject to the deductible amount.
 - Diagnosis and treatment of attention deficit/hyperactivity disorder (ADHD), subject to the following conditions and limitations: the diagnosis and treatment must be provided by a doctor or medical practitioner; the maximum benefit payable for each covered person for the initial diagnosis is limited to \$600; the maximum benefit payable for each covered person for outpatient treatment is limited to \$50 per visit to a doctor or medical practitioner; and the maximum benefit payable for each covered person for all diagnosis and treatment is limited to \$2,500 per policy term.
- Bone mass measurement for the diagnosis and treatment of osteoporosis for a covered person who is: an estrogen deficient woman at clinical risk of osteoporosis; receiving long-term steroid therapy; or being monitored to assess response to or efficacy of approved osteoporosis drug therapies.
- Routine patient care costs incurred by a covered person as a result of treatment provided with a clinical trial for cancer, if all of the following conditions are met:
 - » The treatment is provided with a therapeutic or palliative intent for a covered person with cancer or for the prevention or early detection of cancer.
 - » The treatment is provided, or the studies are conducted, in a Phase II, III, or IV clinical trial for cancer.
 - » The clinical trial is approved by one of the organizations specified in the policy.
 - » The proposed protocol has been reviewed and approved by a qualified institutional review board that operates in Louisiana and that has a multiple project assurance contract approved by the Office of Protection from Research Risks.
 - » The facility and personnel provide the treatment within their scope of practice, experience, and training, and they are capable of doing so by virtue of their experience, training, and volume of patients treated to maintain expertise.
 - » There is no clearly superior, non-investigational approach.
 - » The available clinical or preclinical data provide a reasonable expectation that the treatment will be at least as effective as the non-investigational alternative.
 - » The covered person has signed a consent form approved by an institutional review board.
- Services provided by a registered nurse first assistant before, during, and after surgery.

State Variations (insurance plans)

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

Louisiana, continued

- Covered expenses are expanded to include:
 - Anesthesia and related hospital charges when the mental or physical condition of the covered person requires dental treatment to be rendered in a hospital setting.
 - The treatment of lymphedema provided or prescribed by a doctor or received in a hospital or other facility authorized to provide lymphedema treatment.
 - Oral and intravenous anticancer medication for the treatment of cancer whether administered orally, intravenously, or by injection.
 - Covered expenses for a forensic medical exam for a covered person who is the victim of a sexually oriented offense, the covered expenses for the forensic medical exam will not be subject to any deductible amount, copayment, or coinsurance provision.
- 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.
- "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.
- 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 the 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 the 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 hospital or medical expense insurance while covered under the policy.

Missouri

Policy Form GRI-HST-EXT1B-E-HSM-24R

- The Hospital & Surgical Direct Plan is 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.
- Where applicable in the policy, "prescription drug" includes prescription contraceptive drugs and devices approved by the U.S. Food and Drug Administration, but does not include drugs and devices that are intended to induce an abortion.
- Covered expense for chemotherapy and radiation therapy or treatment are expanded to cover prescribed anticancer medications administered orally the same as those administered intravenously or injected.
- Covered expense for prosthetic devices includes original and replacement devices and related services.
- 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.

State Variations (insurance plans)

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

Missouri, continued

- Covered expenses are expanded to include:
 - 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.
 - 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.
 - 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, limited to 30 days per policy term.
 - Treatment of substance abuse, including: outpatient treatment through a nonresidential treatment program, or through partial- or full-day program services, for 26 days per policy term; a residential treatment program for 21 days per policy term; medical or social setting detoxification for 6 days per policy term; and medication-assisted treatment.
 - Treatment of mental disorders including: outpatient treatment, including treatment through partial- or full-day program services; a residential treatment program when prescribed by a licensed professional and rendered in a licensed or accredited psychiatric residential treatment center; inpatient hospital treatment for 90 days per policy term; and two sessions per policy term with one or more of the following licensed providers for the purpose of diagnosis or assessment: psychiatrist, psychologist, professional counselor, clinical social worker, or marriage and family therapist. Covered expenses under this paragraph provided by a non-network provider will be covered the same as if provided by a network provider.
- 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.
- A pelvic examination and pap smear, in accordance with the current American Cancer Society guidelines.
- A prostate examination and laboratory tests for cancer, in accordance with the current American Cancer Society guidelines.
- A colorectal cancer examination and laboratory tests for cancer, in accordance with the current American Cancer Society guidelines.
- The exclusion for more than a 34-day supply of outpatient prescription drugs when dispensed in any one prescription order or refill does not apply to prescription eye drop refills, which may be obtained prior to the last day of the prescribed dosage period as long as the prescribing health care provider authorizes an early refill and either you or the health care provider notifies us.

State Variations (insurance plans)

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

Missouri, continued

- The exclusion for abortion applies to an elective abortion, which is an abortion for any reason other than a spontaneous abortion or to prevent the death of the female upon whom the abortion is performed.
- 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.

South Carolina

Policy Form GRI-IST-EXT1B-E-HSM-39
and GRI-IST-EXT1D-E-HSM-39

- Each term is 11 months.
- A covered person will not cease to be a dependent eligible child solely because of age if the eligible child is: not capable of self-sustaining employment due to mental retardation or physical handicap that began before the age limit was reached; and mainly dependent on you for support. Proof of the child's incapacity and dependency must be furnished to us within 31 days of the child's 26th birthday.
- Covered expenses are expanded to include:
 - The following for a mastectomy: 48 hours of inpatient hospitalization following the mastectomy; one home care visit if ordered by the attending doctor and if the attending doctor releases the covered person earlier than 48 hours after the mastectomy.
 - Medically necessary care and treatment of cleft lip or cleft palate.
 - Equipment, supplies and services provided for the treatment of diabetes and for outpatient diabetes self-management training and education.
 - One routine mammography examination for breast cancer screening during the policy term for each female covered person in accordance with the most recent published guidelines of the American Cancer Society.
 - One cervical smear or pap smear cancer examination during the policy term for each female covered person, or more often if recommended by a doctor.

- Prostate cancer examination, screenings and laboratory services in accordance with the most recent published guidelines of the American Cancer Society.
- The exclusion for illness or injury as a result of the covered person being intoxicated or under the influence of illegal narcotics or controlled substances does not apply.

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.

- **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.

• **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 12/18/20. For the latest rating, access www.ambest.com.

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