States:
MS NE
TN TX

UnitedHealthcare®
Golden Rule Insurance Co.

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INTERNET/FMO

TriTerm Medical Hospital Surgical Plans

Health insurance available only to members of FACT. These health insurance plans are issued as association group plans and available only to members of FACT, the Federation of American Consumers and Travelers. Golden Rule Insurance Company is the underwriter and administrator of these plans. See last page for more FACT details.

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 or health insurance, principally those contained in the Affordable Care Act. Be sure to check your certificate 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 certificate 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.

Certificate Forms GRI-STAG-EXT1B-E-C-HSM and other state variations

Highlights of Covered Network Expenses

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

		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[1]**
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[2] 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/certificate. 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] Subsequent visits are subject to deductible then coinsurance. Copay does not apply to deductible, coinsurance, or coinsurance out-of-pocket maximum. [2] 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.

Access to Quality Care from:

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

More than 7,200 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.

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

[1] UnitedHealth Group Annual Form 10-K for year ended 12/31/23.

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 certificate.

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/certificate.

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/certificate 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 certificate 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. I**njury to the natural teeth will not include any injury as a result of chewing.**

Medical Benefits (insurance plans)

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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.

Reconstructive Surgery

- Reconstructive surgery that is incidental to or follows surgery or an injury that was covered under the policy/certificate 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.
- Reconstructive craniofacial surgery and related services for a covered person of any age diagnosed as having a craniofacial anomaly if the surgery is medically necessary to improve functional impairment that results from the craniofacial anomaly, as determined by a nationally approved cleft-craniofacial team, approved by the American Cleft Palate-Craniofacial Association in Chapel Hill, North Carolina.

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/certificate 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/certificate 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/certificate 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/certificate 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.

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 certificate.

Transplant Expense Benefit, continued

No benefits payable for:

- 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.

Additional Benefits

- Children's Preventive Health Services for any covered person eligible by reason of age, subject to deductible and coinsurance. Immunization services that qualify as children's preventive health care services are exempt from any deductible amounts, coinsurance provisions, or copayment amounts.
- Diabetes equipment, supplies, and services.
- Diabetes self-management training and education when medically necessary as determined by physician or health care professional. Limited to one training program per person, per lifetime, unless additional training is prescribed due to a significant change in symptoms or condition.
- Diagnosis of and treatment of autism spectrum disorders, including evidence-based treatments.
- Outpatient applied behavior analysis for the treatment of autism spectrum disorders up to a maximum of $50,000 per policy/certificate term, per covered person.
- Colorectal cancer examinations and laboratory tests in accordance with the published American Cancer Society guidelines.
- One digital rectal examination and one prostate specific antigen test per policy/certificate term per covered person for screening for the early detection of prostate cancer (exempt from the deductible.)
- Medically necessary care and treatment of loss or impairment of speech and hearing, including communicative disorders.
- Treatment of medical disorders requiring specialized nutrients or formulas, including treatment with medical foods, regardless of whether the delivery method is enteral or oral.
- Routine in-hospital newborn infant care expenses provided while an inpatient within first five days following covered person's birth or before the mother ceases to be an inpatient, whichever occurs first.
- Medically necessary gastric pacemaker.
- Telemedicine services to the same extent that those services provided would otherwise be covered expenses under the certificate, including facility fee to originating site. Combined reimbursement to the originating site and distant site limited to the covered expense for the service when provided in person.

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 certificate. Some state exceptions may apply (see State Variations.) You will find complete details in the certificate.

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 certificate 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 certificate 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.

Certificate 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 certificate.

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/certificate; 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/certificate; 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/certificate 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/certificate.
- 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 conception, 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/certificate, 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/certificate.
- 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/certificate.

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 certificate. Some state exceptions may apply (see State Variations.) You will find complete details in the certificate.

General Exclusions, continued

No benefits are payable for expenses:

- For high-dose chemotherapy prior to, in conjunction with, or supported by ABMT/BMT, except as specifically provided under the Transplant Expense Benefits provision in the policy/certificate.
- 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/certificate.
- 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/certificate.
- 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/certificate.
- 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/certificate, 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/certificate.
- For outpatient diagnosis and treatment of a spine or back disorder.
- For diagnosis and treatment of mental disorders and substance abuse, including court-ordered treatment of substance abuse.

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 certificate. Some state exceptions may apply (see State Variations.) You will find complete details in the certificate.

General Exclusions, continued

No benefits are payable for expenses:

- For home health care, except as expressly provided for by the policy/certificate.
- For outpatient prescription drugs, except as specifically provided for by the policy/certificate.
- For services or supplies received on an outpatient basis, except as expressly provided for by the policy/certificate.
- 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/certificate. 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-1899RG-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.

Coordination of Benefits (including Medicare)

If after coverage is issued, a covered person becomes insured under another health plan or Medicare, benefits will be determined under the Coordination of Benefits (COB) clause.

COB allows two or more plans to work together so the total amount of all benefits is never more than 100% of covered expenses. COB also takes into account medical coverage under auto insurance contracts. To determine which plan is primary, refer to "order of benefits" in the certificate.

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 certificate 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 certificate 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 certificate.

Other Information (insurance plans)

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Emergency

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

No Non-Network Benefits

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

Non-Renewable

Your TriTerm Medical policy/certificate 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/certificate, unless the policy/certificate 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 certificate 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 certificate, 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 certificate or a change in a covered person's health.

Termination

The certificate will terminate on the earliest of:

- The date all covered persons under the certificate move out of the state where the certificate was issued.
- The primary insured's death. If the certificate 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 certificate.
- The date we receive a request from you to terminate the certificate.
- 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.

Mississippi

Certificate Form GRI-STAG-EXT1B-E-C-HSM-23

- Application fee is $6.
- "Preexisting condition" means an injury or illness for which medical advice, diagnosis, care or treatment was recommended to or received by a covered person within the 6 months immediately preceding the applicable effective date the covered person became insured under the policy; or which, in the opinion of a qualified doctor: (1) probably began prior to the applicable effective date the covered person became insured under the policy; and (2) manifested symptoms which would cause an ordinarily prudent person to seek diagnosis or treatment within the 6 months immediately preceding the applicable effective date the covered person became insured under the policy.
- Covered expenses are expanded to include:
  - General anesthesia and associated facility fees incurred in conjunction with dental care (regardless of whether the dental care itself is covered) for covered person when the mental or physical condition of the child or mentally handicapped adult requires dental treatment to be rendered under physician-supervise general anesthesia in a hospital setting, outpatient surgical facility, or dental office. Covered expenses do not include treatment rendered for temporomandibular joint (TMJ) disorders.
  - An annual screening by low-dose mammography for the presence of occult breast cancer for covered persons thirty-five (35) years of age or older.
- The exclusion for or related to surrogate parenting does not apply.

Nebraska

Certificate Form GRI-STAG-EXT1B-E-C-HSM-26

- "Emergency" means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including, but not limited to, severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in: placing the health of the covered person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition, placing the health of such persons or others in serious jeopardy; serious impairment to bodily functions of the covered person; serious impairment of any bodily organ or part of the covered person; or serious disfigurement of the covered person.
- Covered expenses are expanded to include:
  - Equipment, supplies, and services for the treatment of diabetes, limited to: blood glucose monitors; blood glucose monitors for the legally blind, test strips for glucose monitors, including glucose control solutions, lancets and lancing devices; visual reading and urine test strips; insulin; injection aids, syringes, and needles; insulin pumps and related supplies; FDA-approved oral agents to control blood sugar; podiatric appliances; and glucagon emergency kits and injectable glucagon.
  - Diabetes self-management training when medically necessary as determined by a physician, prescribed by a physician, and provided by an appropriately licensed health care professional who provides GRIC with a certification that the covered person has successfully completed the training. Covered expenses are limited to: one diabetes self-management training program per covered person, per lifetime; and additional diabetes self-management training prescribed by a physician as medically necessary due to a significant change in the covered person's symptoms or condition.
  - One screening mammography exam per policy term per covered person.

State Variations (insurance plans)

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

Nebraska, continued

- Covered expenses are expanded to include:
  - Screening coverage for a colorectal cancer exam and lab test for colorectal cancer in a nonsymptomatic covered person age 50 or older. Covered expenses shall include a maximum of: one screening fecal occult blood test annually and a flexible sigmoidoscopy every 5 years; a colonoscopy every 10 years, or a barium enema every 5 - 10 years; or any combination of the most reliable medically recognized screening test available when deemed appropriate by the covered person's medical practitioner.
  - One digital rectal exam and one prostate specific antigen test per policy term per covered person for screening for the early detection of prostate cancer, exempt from the deductible amount. (Coverage for screenings does not diminish or limit diagnostic benefits otherwise available under the policy/certificate.)
  - Routine in-hospital newborn infant care expenses.
  - Up to $3,000 for medically necessary hearing aids for an eligible child under the age of 19, for each ear affected by a hearing impairment.
  - The reasonable cost of general anesthesia and hospitalization in a hospital or ambulatory surgical center, for a covered eligible child to receive dental care if he or she: is age 8 years of age or under; or is developmentally disabled.
  - Up to maximum lifetime dollar amount of $2,500 for medically necessary surgical and nonsurgical treatment of temporomandibular joint disorder and craniomandibular disorder.

Tennessee

Certificate Form GRI-STAG-EXT1B-C-HSM-41

- "Emergency" is defined as: a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such as 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 in serious jeopardy;
  - Serious impairment to bodily functions; or
  - Serious dysfunction of any bodily organ or part.
- The covered expense for diabetes self-management training does not require certification of completion. It is limited to visits certified by a physician to be medically necessary:
  - Upon the diagnosis of diabetes;
  - Because of a significant change in the covered person's symptoms or condition which necessitates changes in the covered person's self-management; and
  - for re-education or refresher training.
- The covered expense for outpatient applied behavior analysis for the treatment of autism spectrum disorders up to a maximum of $50,000 per policy term, per covered person, is for neurological disorders.
- Covered expenses were expanded to include:
  - A mammography screening for diagnostic purposes on referral by a patient's physician limited to the following:
    - A baseline mammogram for covered person's thirty-five (35) to forty (40) years of age.
    - A mammogram every two (2) years, or more frequently based upon the recommendation of a physician, for covered person's forty (40) to fifty (50) years of age and over.
  - Up to $1,000 per ear per policy term for hearing aids for covered persons under eighteen (18) years of age.
  - Surgical and non-surgical treatment for disorders of the temporomandibular joint (TMJ). Non-surgical treatment is limited to diagnosis and management of TMJ categorized a Phase I treatment under guidelines adopted by the American Dental Association. Surgical expenses incurred from a dentist shall be considered covered expenses only when the services provided would fall within the scope of a licensed physician. Covered expenses for the treatment of TMJ include outpatient prescription drugs to the same extent covered under the policy/certificate for other illnesses in general.
  - Hospital expenses and the cost of general anesthesia associated with any inpatient/outpatient hospital dental procedure when the procedure is performed on a covered person 8 years of age and younger and cannot safely be performed in a dental office.

State Variations (insurance plans)

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

Tennessee, continued

• Transplant Expense Benefits are not limited to the "Listed Transplants" and do not cover any transplant determined to be experimental or investigational treatment.

• The exclusion for any service or supply that would be provided without cost to you or your covered dependent in the absence of insurance covering the charge does not apply if the billed charges are from a nongovernmental charitable research hospital that does not enforce by judicial proceedings collection from individual patients in the absence of insurance coverage.

• The exclusion for abortion applies unless the life of the mother would be endangered if the fetus were carried to term or the fetus is not viable.

• The exclusion for or related to surrogate parenting does not apply if the charges are for complications of pregnancy and the person is not being reimbursed by another party as a part of a surrogacy agreement.

Texas

Certificate Form GRI-STAG-EXT1B-E-C-HSM-42

• "Eligible child" is expanded to include stepchild; a child you or your spouse is seeking to adopt through legal proceedings; a child entitled, by virtue of a court order, to have coverage provided by you or your spouse; and your grandchild who is considered your dependent for federal income tax purposes at the time application for coverage is made.

• "Emergency" means medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that the person's condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in: placing the patient's health in serious jeopardy; serious impairment to bodily functions; serious dysfunction of any bodily organ or part; serious disfigurement; or in the case of a pregnant woman, serious jeopardy to the health of the fetus.

• Preexisting condition is defined as: a condition for which medical advice, or 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 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.

• Covered expense for outpatient applied behavior analysis is limited to covered persons 10 years of age or older.

• Covered expense for diabetes self-management training includes training provided to a covered person or a covered person's caretaker. The limit of one training program per covered person, per lifetime, does not apply. However, training must be after initial diagnosis of diabetes; authorized on written order of a medical practitioner after a significant change in symptoms that requires changes in self-management regime; or for periodic or episodic continuing education when prescribed by a medical practitioner as needed due to the development of new techniques and treatments.

• Benefits are expanded to include the following:

- The most appropriate prosthetic device or orthotic device that adequately meets the medical needs of the covered person, as recommended by the covered person's physician, podiatrist, prosthetist or orthotist.
- The treatment of breast cancer; a minimum of 48 hours of inpatient care following a mastectomy and 24 hours of inpatient care following a lymph node dissection.
- The cost of a newborn screening test kit.
- Diagnostic mammogram.
- Expenses incurred by covered persons who have been diagnosed with insulin dependent or non-insulin dependent diabetes, elevated blood glucose levels induced by pregnancy, or any other medical condition associated with elevated blood glucose levels.
- Screening for autism spectrum disorders for an eligible child at 18 and 24 months of age.

State Variations (insurance plans)

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

Texas, continued

- Benefits are expanded to include the following:
  - Medically necessary amino acid modified preparation, low protein modified food products, any other special dietary products and formulas prescribed by a doctor for the therapeutic treatment of phenylketonuria (PKU), galactosemia, organic acidemias and disorders of amino acid metabolism.
  - Medically accepted bone mass measurement for the detection of low bone mass and to determine the risk of osteoporosis and fractures associated with osteoporosis for a covered person who is: postmenopausal woman who is not receiving estrogen replacement therapy; an individual with vertebral abnormalities, primary hyperparathyroidism, or a history of bone fractures; or an individual who is receiving long-term glucocorticoid therapy, or being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.
  - One screening test for hearing loss administered within the first 30 days after birth, and related necessary diagnostic follow-up care during the first 24 months after birth. Charges incurred for the screening test and followup care shall be exempt from the deductible amount.
  - Cognitive rehabilitation therapy, cognitive communication therapy, neurocognitive therapy and rehabilitation, neurobehavioral, neurophysiological, neuropsychological, and psychophysiological testing or treatment, neurofeedback therapy, remediation, post-acute transition services, or community reintegration services necessary as a result of and related to an acquired brain injury.\
  - Diagnostic and surgical treatment of temporomandibular joint (TMJ) disorders and craniomandibular joint disorders.
  - Up to $200 every five years for one of the following noninvasive screening tests for atherosclerosis and abnormal artery structure and function: Computerized tomography (CT) scanning measuring coronary artery calcification; or Ultrasonography measuring carotid intima-media thickness and plaque. Benefits are limited to male covered persons between the ages of 45 and 76 and female covered persons between the ages of 55 and 76 who are diabetic or have an intermediate or high risk of developing coronary heart disease based on the Framingham Health Study Coronary Prediction algorithm.
  - Routine patient care costs for services, items or drugs provided in connection with a Phase I, II, III or IV clinical trial if the clinical trial is conducted in relation to the prevention, detection or treatment of a life-threatening disease or condition and is approved by: The Centers for Disease Control and Prevention; The National Institutes of Health; The United States Food and Drug Administration (USFDA); The United States Department of Defense; The United States Department of Veterans Affairs; or an institutional review board of an institution in the state of Texas that has an agreement with the Office for Human Research Protections of the United States Department of Health and Human Services.
  - Annual screening for the early detection of ovarian cancer and cervical cancer for covered persons 18 years of age or older, including: A CA 125 blood; and conventional Pap smear screening or a screening using liquid-based cytology methods, as approved by the United States Food and Drug Administration for the detection of the human papillomavirus.
  - Annual screening by low-dose mammography for the presence of occult breast cancer for covered persons 35 years of age or older.
  - Diagnosis or treatment of mental disorders or substance abuse the same as any other illness, including services received in: A psychiatric day treatment facility; a residential treatment center for children or adolescents; and a crisis stabilization unit.
  - Medically necessary hearing aids or cochlear implants for a covered eligible child up to age 18 years, limited to one hearing aid in each ear every three years and one cochlear implant in each ear with internal replacement as audiologically or medically necessary.

State Variations (insurance plans)

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

Texas, continued

• Life Threatening Cancer benefit is expanded to include covered expenses for outpatient prescription drugs dispensed according to a medication synchronization plan for a chronic illness if the medications: are otherwise eligible for benefits as covered expenses under the policy/certificate; are being used for treatment or management of chronic illness and may be prescribed refills; are a formulation that can be effectively dispensed in accordance with the medication synchronization plan for the purposes of synchronizing fills and refills. and are not Schedule II controlled substances, or Schedule III controlled substances that contain hydrocodone.

• Transplant benefits are modified as follows:

- Covered expenses include expenses actually incurred by a covered person for those services and supplies listed which are: administered or ordered by a doctor; provided in connection with a listed transplant; medically necessary to the diagnosis or treatment of an injury or illness; and not excluded anywhere in the policy. These covered expenses will be paid as a limited expansion of the Medical Benefits. They will be subject to the terms of that provision, including deductibles, coinsurance, exclusions and limitations.
- If a designated Center of Excellence is not used, covered expenses for a listed transplant will be reduced by 25% after application of any deductible amounts coinsurance provisions or copayment amounts, limited to a maximum of one.

• The 6 months waiting period does not apply for expenses incurred by a covered person for the treatment of tonsils, adenoids, middle ear disorders, hemorrhoids, hernia, or any disorders of the reproductive organs.

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

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.

- **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.

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.

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+" (Superior) 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.

Our plans offer easy-to-understand health insurance designed for individuals and families in times of transition and change. Plans only available to members of FACT, the Federation of American Consumers and Travelers (see below). If you're not already a member, you can enroll with your TriTerm Medical application to be eligible to apply for these plans.

What is FACT?

FACT is an independent consumer association whose members benefit from the "pooling" of resources. Benefits range from medical savings to consumer service discounts. FACT's principal office is in Jonesboro, Arkansas. FACT and Golden Rule Insurance Company are separate organizations. Neither is responsible for the performance of the other. FACT has contracted with Golden Rule Insurance Company to provide its members with access to these health insurance plans. FACT does not receive any compensation from Golden Rule Insurance Company.

Is there a cost for joining FACT?

Yes, there are membership dues and they can be paid with your regular health insurance premium, as opposed to making a separate payment.

What are the basic FACT membership benefits?

FACT makes it easy for members to choose from a full menu of important benefits, including:

- Accidental Death Benefit
- In-Hospital Benefit, Ambulance Reimbursement, and Medical Evacuation Coverage
- Telemedicine Access
- Dental, Vision, Hearing Aid, and Prescription Discounts
- ID Theft and Cyber Protection
- Online Health, Wellness, and Fitness Classes
- Travel Discounts
- Pet Coverage
- Scholarships and Community Grants
- Disaster Aid and Small Business Recovery Program

As a member of FACT, your information is kept private. Please visit the FACT website, www.usafact.org/privacy-policy, for a complete FACT Privacy Statement. FACT may change or discontinue any of its membership benefits at any time. For the most current information, including full detailed lists of member benefits, visit FACT's website at www.usafact.org or call toll-free at (800) USA-FACT.

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