Health ProtectorGuard

Fixed benefits health insurance

THIS PRODUCT PROVIDES LIMITED BENEFITS

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

This fixed indemnity insurance product provides benefits in a stated amount regardless of actual expenses incurred. Golden Rule Insurance Company is the underwriter of these insurance plans.

Policy Form HPG3-GRI and other state variations

United Healthcare

Golden Rule Insurance Co.

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Why choose us?

Strength and experience

UnitedHealthcare provides over 29 million Americans with access to health care.[1] Golden Rule Insurance Company, a UnitedHealthcare company, is the underwriter and administrator of plans featured in this brochure. We have been serving the specific needs of individuals and families buying their own coverage for over 80 years.

Highly rated

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

Your satisfaction is our goal

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

[1] UnitedHealth Group Annual Form 10-K for year ended 12/31/24. [2] As of 3/12/25.
For the latest rating, access ambest.com.

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. State specific differences may apply.

Health ProtectorGuard (HPG)

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

What is fixed benefit health indemnity insurance?

"Indemnity" is insurance speak for a plan that pays you[1], or your provider, a specified amount – or "fixed benefit" – for medical services you receive that are covered by the plan. The benefit isn't based on the total amount of your medical bill. There are also limits on how much or how many times this policy will pay on some benefits.

Why is fixed indemnity insurance a good idea?

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

How does a fixed indemnity insurance plan work?

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

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

The HPG plans available in this brochure have:

- Wellness services[2], doctor office visits, urgent care visits and prescription drug benefits
- Benefits for hospital stays, surgical services, emergency room visit and outpatient lab and diagnostic services
- Unlimited, no-cost virtual health visits (through HealthiestYou by Teladoc® Health) for general non-urgent medical issues
- Flexibility to use any doctor, but discounts for using UnitedHealthcare Choice Plus network providers
- Increase in cash benefits for qualifying services by staying with the plan more than a year

It's also good to know:

- Available for issue ages 18 through 64 in most states
- Renewable until age 65, subject to policy provisions, when premiums are paid
- $2 million calendar year maximum, per covered person
- $5 million lifetime maximum benefit, per covered person
- Increased benefit amounts if you keep the plan for at least 2 years **(see pg 7-8 for details)**

[1]If you assign your policy benefits to a hospital or any other provider of health care services, benefits will be paid to the provider. [2]A 30-day waiting period applies in most states.

Get nationwide access to quality care and savings

You can use any provider you choose for medical services, but you'll get the most out of your HPG benefits when you use the UnitedHealthcare Choice Plus network.[1]

Great reasons to use a UnitedHealthcare Choice Plus network provider:

- You'll get care at pre-negotiated lower rates
- Network providers will file claims on your behalf
- With a large nationwide network, an in-network provider may be nearby

1.8M+ providers[2]

7,000+ hospitals[2]

58% average discount savings[3]

Example savings

Take a look at these sample claims, the network savings, and how it works with the plan.

Treatment (services claimed)	**Actual treatment cost**	**Treatment cost after Choice Plus Network discount**	**Plan benefit** (HPG Preferred plan with benefit level 2)	**Total member responsibility using Network provider**	**Total member responsibility using non-network provider**
Office visit (1 visit)	$175	$72	$100	$0 ($28 paid to member)	$75
Health screening diagnostic lab (1 test)	$42	$16	$50	$0 ($34 paid to member)	$0 ($8 paid to member)
Emergency room (1 visit)	$5,770	$2,400	$500	$1,900	$5,270
Hospital admission & room/board (6 nights, standard stay)	$15,600	$6,425	$21,000	$0 ($14,575 paid to member)	$0 ($5,400 paid to member)

These are samples based on actual claims. Amounts have been rounded for simplification. Actual treatment cost and network discounts vary by area. Benefits vary by plan (state variations may apply). These samples are for illustration only, to depict how the plan works.

More on filing a claim

When you present your plan ID card to your in-network provider, they file the claim with us, and we send the benefit payment to them. The provider will apply the payment toward the amount you owe for the service provided. This, in addition to the network discount, helps to reduce your final bill and lowers your total out-of-pocket cost. If the eligible benefit payment is more than the cost of coverage, even after the discount, you will receive the difference mailed to you as a check from us. If you do not use a network provider, you can submit your claim directly to us. Refer to your policy for more information or go to uhcmemberhub.com. (See page 11.)

[1] If you have a major medical plan, you may need to stay with certain networks/providers to get the most coverage out of that plan. [2] UnitedHealth Group Annual Form 10-K for year ended 12/31/23. [3] Based on 2023 E&I Healthcare Econ & Pricing data of UnitedHealthcare Choice Plus network; average across combined in-patient and outpatient services. Savings experience can vary by provider and service.

Start here: build a plan that's right for you

HPG plans have 2 parts that together make up all the benefits of your plan: (1) a hospital benefit base plan and (2) a "wellness, office visit, Rx" benefit level. There are different benefit amounts with each plan and level. You pick what works best for you out of each offering. Together this is your plan designed by you, for you.

Step 1: Choose a hospital benefit base plan

On the next page **(page 7)** you will find 4 plans ranging in benefit amounts. This is the start of your plan build.

Each of these plans covers hospital stays including intensive care unit and ambulance trips, surgical procedures and outpatient/lab.

Listed below, from lowest to highest benefit amounts, the base plan options are:

- **Choice**
- **Select**
- **Preferred**
- **Premier**

The difference in each plan is the fixed benefit amount we pay for the service, and for some benefits, how many times or days the benefit will pay out in a calendar year.

Step 2: Choose a wellness, office visit, prescription (Rx) level

On **page 8** you will find 3 levels of wellness, office visit, Rx coverage, also known as "WORx." This part is added to the hospital base plan you select.

Each level covers select wellness procedures, doctor office visits for illness and specialist visits, including urgent care, and prescription drug benefits for brand name and generic.

Listed below, from lowest to highest benefit amounts, the level options are:

- **Level 1**
- **Level 2**
- **Level 3**

The difference in each level is the fixed benefit we pay for covered services and the number of times the benefit is payable. It is important to note there are some wellness benefits only covered in the higher levels, and all wellness benefits have a 30-day waiting period in most states before we will pay benefits.

	Health ProtectorGuard Plans				
Strongest Benefit	Level 3	HPG Choice 3	HPG Select 3	HPG Preferred 3	HPG Premier 3
	Level 2	HPG Choice 2	HPG Select 2	HPG Preferred 2	HPG Premier 2
	Level 1	HPG Choice 1	HPG Select 1	HPG Preferred 1	HPG Premier 1

Highest Hospital Benefit Level

Hospital base plan benefit details

Step 1: Choose a hospital benefit base plan as the foundation of your HPG coverage.

All benefits, including maximums are per person, per calendar year.		Choice	Select	Preferred	Premier
Critical medical services					
Inpatient Hospital Confinement Illness/Injury[1] (unlimited days)	Year 1 we pay: Year 2 we pay:[2]	$1,000 per day $2,000 per day	$2,000 per day $4,000 per day	$3,000 per day $6,000 per day	$5,000 per day $10,000 per day
Intensive Care Unit (ICU) or Critical Care Unit (CCU)[3]	We pay:	$1,000 per day (31 days)	$2,000 per day (31 days)	$3,000 per day (31 days)	$5,000 per day (31 days)
Hospital Admission Benefit - First Inpatient Day[1]	We pay:	$1,000 per day (1 day)	$2,000 per day (1 day)	$3,000 per day (1 day)	$3,000 per day (1 day)
Emergency Room	We pay:	$400 per day (1 day)	$500 per day (1 day)	$500 per day (1 day)	$1,000 per day (1 day)
Ambulance (maximum combined trips of any type)		2 trips	2 trips	2 trips	2 trips
Ground/Water Ambulance	We pay:	$500 per trip	$500 per trip	$1,000 per trip	$1,000 per trip
Air Ambulance	We pay:	$5,000 per trip	$5,000 per trip	$5,000 per trip	$5,000 per trip
Surgical benefits (represent a range for 7 surgical tiers; **see page 8** for additional details)					
Surgical Procedure (unlimited days)	We pay:	$250-$25,000	$500-$50,000	$500-$50,000	$500-$50,000
Outpatient Facility	We pay:	$1,000 per day (2 days)	$1,000 per day (2 days)	$2,000 per day (3 days)	$2,500 per day (3 days)
Outpatient/Lab (maximum combined of any type)		4 tests	4 tests	5 tests	5 tests
Outpatient Lab	We pay:	$30 per test	$50 per test	$50 per test	$75 per test
Outpatient X-ray and Other Diagnostic Testing (Ultrasound, EKG, EEG, Angiogram, Arteriogram, Thallium Stress Test, and Myelogram)	We pay:	$30 per test	$50 per test	$75 per test	$100 per test
Outpatient Diagnostic and Imaging Tier 2 (MRI/PET/CAT Benefit per test)	We pay:	$250 per test	$300 per test	$400 per test	$500 per test
Outpatient Chemotherapy					
Oral Chemotherapy	We pay:	$1,000 per month (3 months)	$1,000 per month (3 months)	$1,000 per month (3 months)	$1,000 per month (3 months)
Outpatient Chemotherapy, Radiation, & Immunotherapy Non Oral	We pay:	$1,000 per day (20 days)	$1,000 per day (40 days)	$2,000 per day (40 days)	$2,000 per day (40 days)

Benefit availability, amounts, periods, and limitations may vary by state. See State Variations. Benefits are subject to Preexisting Conditions. **See page 13** for details. [1] Includes Observation Unit stays of 24 hours+. [2] This increase in benefits does not apply to Inpatient Hospital Confinement for illness. Benefits for injury increase on the 1st day of the next full calendar year after the plan has been in force more than 6 months. If the plan has not been in force more than 6 months, the benefit increase will begin January 1 following 12 consecutive months of coverage. This increase occurs only once. [3] ICU/CCU benefit amounts are in addition to Inpatient Hospital Confinement benefits.

Wellness, Dr. visit, Rx level benefit details

Step 2: Choose a wellness, office visit, prescription Rx level, also known as "WORx," to finish your plan build.

All benefit maximums (max) are per person, per calendar year.		Level 1	Level 2	Level 3
Wellness (after 30-day waiting period in most states)				
Physical Exam	We pay:	$80 per exam (1 exam)	$100 per exam (1 exam)	$125 per exam (1 exam)
Health Screening Diagnostic Labs	We pay:	$25 per test (2 tests)	$50 per test (2 tests)	$100 per test (2 tests)
Health Screening X-ray	We pay:	Not covered	$50 per test (1 test)	$100 per test (1 test)
Adult Flu Shot (ages 18+)	We pay:	$25 per shot (max 1)	$25 per shot (max 1)	$25 per shot (max 1)
Child Immunizations/Flu Shot (under age 18)	We pay:	$25 per shot (max 4)	$25 per shot (max 4)	$25 per shot (max 4)
Child Allergy Treatments (under age 18+)	We pay:	$10 per treatment (max 10)	$10 per treatment (max 10)	$10 per treatment (max 10)
Bone Density Screening (ages 40+)	We pay:	Not covered	Not covered	$150 per exam (max 1)
Mammogram (females ages 30+)	Year 1 we pay: Year 2 we pay[1]:	$100 per exam (max 1) $150 per exam (max 1)	$150 per exam (max 1) $225 per exam (max 1)	$150 per exam (max 1) $225 per exam (max 1)
Pap Smear (females ages 18+) **or PSA Test** (males ages 40+)	Year 1 we pay: Year 2 we pay[1]:	$100 per exam (max 1) $150 per exam (max 1)	$100 per exam (max 1) $150 per exam (max 1)	$100 per exam (max 1) $150 per exam (max 1)
EKG (ages 40+)	We pay:	Not covered	Not covered	$100 per test (1 test)
Stress EKG (ages 40+)	We pay:	Not covered	Not covered	$125 per test (1 test)
Colonoscopy (ages 50+ preventive; or any age if illness related)	We pay:	$300 per exam (1 exam)	$300 per exam (1 exam)	$500 per exam (1 exam)
Office Visits (maximum Office Visits, any type combined)	Year 1 max: Year 2 max[1]:	4 visits 6 visits	5 visits 7 visits	6 visits 8 visits
Doctor Office Visits	We pay:	$80 per visit	$100 per visit	$125 per visit
Specialist Office Visits/Urgent Care Visits	We pay:	$100 per visit	$125 per visit	$150 per visit
Office Visits with in-office surgery in lieu of Doctor/Specialist/Urgent Care Visits	We pay:	$200 per visit	$225 per visit	$250 per visit
Therapy Visits				
Chiropractic/Physical/Occupational/ Speech Therapy Visits	We pay:	Not covered	$35 per visit (10 visits)	$45 per visit (10 visits)
Rx Drugs (maximum fills, any type combined)	Year 1 max: Year 2 max[1]:	12 fills 17 fills	15 fills 20 fills	20 fills 25 fills
Name Brand Prescription Drugs	We pay:	$40 per fill	$60 per fill	$60 per fill
Generic Prescription Drugs	We pay:	$10 per fill	$10 per fill	$20 per fill

Benefit availability, amounts, periods, and limitations may vary by state. See State Variations. Benefits are subject to Preexisting Conditions. **See page 13** for details. [1] Benefits increase on the 1st day of the next full calendar year after the plan as been in force more than 6 months. If the plan has not been in force more than 6 months, the benefit increase will begin January 1 following 12 consecutive months of coverage.

How the surgical tiers are determined

Each plan has a 7-tier surgical schedule based on the relative value unit[1] of the procedure being performed. The amount for the respective tier will be paid each day a covered person requires inpatient or outpatient surgery as prescribed by a doctor. If surgery falls under multiple tiers, we will pay the largest amount and if multiple surgeries are performed in a single day, we will pay one amount for the highest tier procedure. These benefits are determined by the hospital base plan you chose in step 1.

		Choice	Select	Preferred	Premier
Surgical Benefits Surgery Tier examples are for illustrative purposes only					
Tier 1 Surgeries for major organ/tissue failure transplants payable once per each of the following major organ types per covered person's lifetime: liver, heart, lung, kidney, pancreas, bone marrow, stem cell, or small intestine.	We pay:	$25,000	$50,000	$50,000	$50,000
Tier 2 Surgeries such as intracranial vessel surgery or removal of esophagus.	We pay:	$10,000	$20,000	$20,000	$20,000
Tier 3 Surgeries such as endoscopy, partial removal of pancreas or replacement of mitral valve.	We pay:	$5,000	$10,000	$10,000	$10,000
Tier 4 Surgeries such as lumbar spine fusion, colectomy, or repair of mitral valve.	We pay:	$2,500	$5,000	$5,000	$5,000
Tier 5 Surgeries such as total knee/hip arthroplasty or lower back disk surgery.	We pay:	$1,250	$2,500	$2,500	$2,500
Tier 6 Surgeries such as appendectomy, knee/shoulder reconstruction, or carpal tunnel surgery.	We pay:	$500	$1,000	$1,000	$1,000
Tier 7 Surgeries such as removal of tonsils and adenoids, breast biopsy or creation of eardrum opening (tubes in ear).	We pay:	$250	$500	$500	$500
Assistant Surgeon (payable per day, when a covered surgery requires)	We pay:	20% of surgical benefits	20% of surgical benefits	20% of surgical benefits	20% of surgical benefits
Anesthesiologist (payable per day)	We pay:	30% of surgical benefits	30% of surgical benefits	30% of surgical benefits	30% of surgical benefits

Benefits are subject to Preexisting Conditions. **See page 13** for details. [1]Relative value unit (RVU) is the value of service/procedure relative to all other service /procedures based upon the work, practice expense, and malpractice expense. These are established by the Centers for Medicare and Medicaid Services (CMS). Specific tier mapping and reimbursement amount is determined by the surgery's Current Procedural Terminology (CPT) code.

More ways to help you save money

Included with all plans is access to unlimited $0 virtual doctor visits through HealthiestYou[1] and discounts on prescription drugs through Optum Perks.

Telehealth - HealthiestYou by Teladoc Health[1]

Not feeling well, but not sure you want to go to the doctor? The telehealth benefit provided through HealthiestYou by Teladoc® Health makes it easy to see a doctor without leaving home. Just meet with a doctor by phone or video at no extra charge to you. They can diagnose and treat illnesses and prescribe medication when necessary 24/7/365. **Unlimited visits. No additional cost**. That's access to quality health care without the hassle.

Note: For additional fees, visits with psychiatrists, psychologists and dermatologists are also available.

Rx discounts with Optum Perks[2]

There's a simple way to save **30-80% on prescription drugs** with an Optum Perks prescription drug discount card. Just visit **perks.optum.com/uho** to print your card or send it to your phone. While there you can also compare prescription drug prices at stores near you. To use your savings, show your Optum Perks discount card to the pharmacy during purchase.

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

Nationwide network of savings[3]

You can use any provider you choose for medical services, but you'll get the most out of your benefits when you use the UnitedHealthcare Choice Plus network with an average of 58% savings. Visit **uhone.com** and select "Find A Doctor" to search for network providers in your state.

Note: If you have a major medical plan, you may need to stay with certain networks and providers to get the most coverage out of that plan.

[1] HealthiestYou by Teladoc Health and UnitedHealthcare are not affiliated and each entity is responsible for its own contractual and financial obligations. This specific program is not insurance; no benefits are payable for the use of this service. [2] Based on pharmacy's usual and customary price. Actual savings may vary. [3] Average savings is based on 2023 E&I Healthcare Econ & Pricing data of UnitedHealthcare Choice Plus network; average across combined in-patient and outpatient services. Savings experience can vary by provider and service.

UHC Member Hub

Manage your Health ProtectorGuard plan with UHC Member Hub

Connecting with your plan

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

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

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

Exclusions and/or Limitations

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

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

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

Plan Provisions

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

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

Eligibility

At time of application, the primary insured and spouse (as defined by state) must be between 18-64 years of age (drop off on 65th birthday), or as required by state. Eligible children must be 0-25 years of age (drop off on 26th birthday), or as required by state.

Misstatement of Age, Gender, or Tobacco Use

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

Notice of Claim

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

Premium

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

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

Preexisting Conditions

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

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

- For which medical advice, diagnosis, care, or treatment was recommended to or received by a covered person within 12 months immediately preceding the effective date the covered person became insured under the policy; or
- That manifested symptoms which would cause an ordinarily prudent person to seek diagnosis or treatment within the 12 months immediately preceding the applicable effective date the covered person became insured under the policy.

Renewability and Termination

The policy is renewable until the earliest of the following:

- The primary insured's 65th birthday (or next premium due date, dependent on state) or death. If the policy includes dependents, it may be continued after the primary insured's death or 65th birthday:
  - By the spouse, if a covered person;
  - Otherwise, by an eligible child who is a covered person;
- Nonpayment of premiums when due;
- The date we discontinue offering and refuse to renew all policies issued on this form for all residents of the state where you reside;
- The date we receive a request from you to terminate the policy; or
- The date there is fraud or a material misrepresentation made by or with the knowledge of a covered person.

Plan Provisions (continued)

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

Right to Examine

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

Underwriting

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

Waiting Periods

There is a 30-day waiting period before benefits are payable for the Wellness/Preventive Care benefit in most states.

State Variations

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

Maryland

Policy Form HPG3-GRI-19

- Maximum issue age is 60.
- There is no waiting period for Wellness/Preventive services.
- The following exclusions do not apply:
  - The covered person taking part in a riot.
  - The covered person's commission or attempt to commit a felony, whether or not charged.
  - A loss incurred as a result of the covered person being intoxicated, as defined by applicable state law in the state in which the loss occurred, or under the influence of illegal narcotics or controlled substance unless administered or prescribed by a doctor or voluntary taking of any over the counter drug unless taken in accordance with the manufacturer's recommended dosage.
  - Services incurred during the waiting period.
  - Any loss related to the treatment of mental disorders, substance abuse, or for court ordered treatment programs for substance abuse.
- The policy does not pay benefits for any loss caused by, resulting from, for, or relating to expenses of a prohibited referral, as required by Maryland laws and regulations.
- We will not pay benefits under the policy for a loss which manifests due to, results from, is caused or otherwise contributed to by, a Preexisting Condition, or complications resulting from a Preexisting Condition unless:
  - A covered person's Preexisting Condition was fully disclosed to us on your application for insurance under the policy; and
  - Coverage of the Preexisting Condition has not been excluded or limited by name or specific description on a signed waiver rider, attached to the policy.
- If a covered person is hospital confined on the date the covered person ceases to be insured under this policy, we will continue to pay benefits for the hospital confinement until the earlier of:
  - The date the covered person is discharged from the hospital; or
  - 12 months after the date the covered person ceases to be insured under this policy.

  However, no benefits are provided under this provision if this policy is terminated because of:
  - A request by you;
  - Fraud or material misrepresentation on your part; or
  - Your failure to pay the required premiums when due; or
  - Coverage is provided to a covered person by a succeeding health benefit plan that: is provided at a cost to a covered person that is less than or equal to the cost of the covered person of the extended benefit provided under this provision; and does not result in an interruption of benefits.
- In the Premium Change provision, you will be given at least a 45-day notice of changes.

Ohio

Policy Form HPG3-GRI-34

- The 12 month rate change guarantee does not apply.

Pennsylvania

Policy Form HPG3-GRI-37

- The exclusion for participation in a riot is specifically for injuries due to participating in a riot.
- In the exclusion for a loss incurred due to a covered person being intoxicated or under the influence of narcotics or controlled substances, "the taking of over the counter drugs other than as the recommended dosage" does not apply.
- Cosmetic treatment, including hospital confinement for such services, is not excluded when necessitated by a loss from a covered illness or injury.
- "Preexisting Condition" means an illness or injury for which medical advice, diagnosis, care, or treatment was recommended to or received by a covered person within 12 months immediately preceding the effective date the covered person became insured under this policy.

Note to our customers about supplemental insurance

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

Health plan notices of privacy practices

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

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

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

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

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

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

46034-G-0625

UnitedHealthcare®
Golden Rule Insurance Co.