Thank you for your interest in this product. It is the mission of Golden Rule Insurance Company, as a UnitedHealthcare company, to help people live healthier lives. We are available to answer your questions and help you without any obligation to buy. **If you need help understanding this product, call Golden Rule Insurance Company, visit uhone.com, or contact your health insurance agent.**

Questions about this product may be answered by the details found in this brochure. Below is a notice required by law.

IMPORTANT: This is a short-term, limited-duration policy, NOT comprehensive health coverage

This is a temporary limited policy that has fewer benefits and Federal protections than other types of health insurance options, like those on HealthCare.gov

This policy	Insurance on HealthCare.gov
Might not cover you due to preexisting health conditions like diabetes, cancer, stroke, arthritis, heart disease, mental health & substance use disorders	Can't deny you coverage due to preexisting health conditions
Might not cover things like prescription drugs, preventive screenings, maternity care, emergency services, hospitalization, pediatric care, physical therapy & more	Covers all essential health benefits
Might have **no limit on what you pay** out-of-pocket for care	Protects you with limits on what you pay each year out-of-pocket for essential health benefits
You **won't qualify** for Federal financial help to pay premiums & out-of-pocket costs	Many people qualify for Federal financial help
Doesn't have to meet Federal standards for comprehensive health coverage	All plans must meet Federal standards

Looking for comprehensive health insurance?

- **Visit HealthCare.gov** or call **1-800-318-2596** (TTY: 1-855-889-4325) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member's job, contact the employer.

Questions about this policy?

For questions or complaints about this policy, contact your State Department of Insurance. Find their number on the National Association of Insurance Commissioners' website (naic.org) under "Insurance Departments."

Short Term Medical plans for times of transition and change

HEALTH INSURANCE AVAILABLE ONLY TO MEMBERS OF FACT, THE FEDERATION OF AMERICAN CONSUMERS AND TRAVELERS. THESE HEALTH INSURANCE PLANS ARE ISSUED AS ASSOCIATION GROUP PLANS AND AVAILABLE ONLY TO MEMBERS OF FACT. GOLDEN RULE INSURANCE COMPANY IS THE UNDERWRITER AND ADMINISTRATOR OF THESE PLANS. SEE LAST PAGE FOR MORE FACT DETAILS.

Certificate Form GRI-STAG20-C-E-D and other state variations

UnitedHealthcare®
Golden Rule Insurance Co.

Table of Contents

Why Short Term Medical?

Short Term Medical plans are designed as health coverage for a limited time when longer term insurance isn't available to you

Because life moves fast

Apply for coverage any day of the year
No qualifying event needed and no waiting for an enrollment period

Apply fast
Plans are medically underwritten, and short application questions help determine if you're eligible for coverage

Choose your plan length
These plans offer up to 4 months of total coverage within a 12-month period[1]

Pick your plan
Multiple plans with different benefit and deductible options available, including plan options specifically for families

Because life can be unpredictable

Coverage you need
For doctor office visits, urgent care visits, hospitalization, limited preventive care and more

Prescription coverage
Available on most plans

Nationwide network
Access to quality care at reduced rates from 1.8 million physicians and health care professionals and 7,200 hospitals and medical facilities[2]

No referrals or primary care physician (PCP) required
Use any doctor in the network across the nation[3]

[1] 3 months term length with up to a one-month extension for a total of 4 months of coverage.
[2] UnitedHealth Group Annual Form 10-K for year ended 12/31/23
[3] There are no non-network benefits, except for emergencies (see page 6)

This is an outline only and is not intended to serve as a legal interpretation of benefits. Reasonable effort has been made to have this outline represent the intent of contract language. However, the contract language stands alone, and the complete terms of the coverage will be determined by the policy. It is important to note there are **State Variations, Exclusions and/or Limitations** and **Plan Provisions**. This plan is medically underwritten. **No benefits will be paid for a health condition that exists prior to the date insurance takes effect.**

Plan information

Highlights of Covered Network Expenses

		Copay	Premier Elite and Plus Elite	Plus	Value	Value Direct Not available in Indiana
Per Person Deductible (per term; max 2 per family)	You pay up to:	$2,500, $5,000, $7,500, $10,000 or $15,000	**Plus Elite Only:** $2,500, $5,000, $7,500, $10,000 or $15,000	$2,500, $5,000, $7,500 or $15,000	$2,500, $5,000, $7,500 or $15,000	$5,000, $10,000 or $15,000
Family Deductible (per term; one deductible to meet for all covered family members combined)	You pay up to:	Not Available	**Premier Elite Only:** $5,000, $10,000 or $14,000	Not Available	Not Available	Not Available
Coinsurance (% you pay **after deductible**, per term)	You pay:	20%	0%	20%	30%	40%
Coinsurance Out-of-Pocket Maximum (after deductible, per person, per term)	You pay up to:	$5,000	$0	$2,000	$10,000	$10,000
Maximum Benefit (per person, per term)	We pay up to:	$2 million	$2 million	$2 million	$1 million **Indiana only:** $2 million	$500,000
Medical						
Doctor Office Visit – History and Exam Only (per person, per term)	You pay:	$50 copay[1]	No charge after deductible	20% after deductible	30% after deductible	40% after deductible
Urgent Care Center Visit (per person, per term)		$50 copay	$50 copay	$50 copay	$50 copay	40% after deductible
Preventive Care (see page 10 for details and limitations)		20% after deductible	No charge after deductible	20% after deductible	30% after deductible	40% after deductible
Emergency Room – Accident and Illness		20% after deductible (additional $500 deductible if not admitted)	No charge after deductible (additional $500 deductible if not admitted)	20% after deductible (additional $500 deductible if not admitted)	30% after deductible (additional $500 deductible if not admitted)	40% after deductible (additional $750 deductible if not admitted)
Inpatient Hospital Services, Outpatient Surgery, Labs & X-rays		20% after deductible	No charge after deductible	20% after deductible	30% after deductible	40% after deductible
Pharmacy						
Outpatient Prescription (Rx) Drugs (for plans that provide coverage, using the member ID card, you pay for prescriptions at the point of sale, at the lowest price available)	You pay:	**Tier 1:** $25 copay, no deductible **Tiers 2–4:** 20% after deductible ($5,000 max covered expense per person, per term)	**Tier 1:** $25 copay, no deductible **Tiers 2–4:** No charge after deductible ($5,000 max covered expense per person, per term)	**Tier 1:** $25 copay, no deductible **Tiers 2–4:** 20% after deductible ($5,000 max covered expense per person, per term)	**Tier 1:** $25 copay, no deductible **Tiers 2–4:** 30% after deductible ($2,500 max covered expense per person, per term)	**Not Covered** Discount card provided[2]
Optional Benefits						
Add Supplemental Accident Benefit[3] (see page 14)	We pay up to:	$2,500, $5,000, $7,500, $10,000 or $15,000	$2,500, $5,000, $7,500, $10,000 or $15,000	$2,500, $5,000, $7,500, $10,000 or $15,000	$2,500, $5,000, $7,500, $10,000 or $15,000	$2,500, $5,000, $7,500, $10,000 or $15,000

The amount of benefits provided depends upon the plan selected, and the premium will vary with the amount of the benefits selected. These plans only pay benefits for eligible expenses from a network provider. See details on page 6. Copays do not apply to deductible, coinsurance or coinsurance out-of-pocket maximum. 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] Available number of doctor office visits for a copay varies by plan duration: 1–3 months = 1 visit, 4 months = 2 visits. **Subsequent visits are subject to deductible then coinsurance.** Doctor Office Visit copays are for injury and illness and cannot be used for preventive services, other than those required due to state mandates. [2] Discounts vary by pharmacy, geographic area and Rx drug. [3] Additional premium required.

Get nationwide access to quality care and cost savings

Use UnitedHealthcare Choice network for benefits

Save on premium

- Choose a higher deductible: If you agree to cover more before insurance starts paying, you can reduce your plan premium

Save on health care costs

- Network care available at negotiated lower rates
- Network providers agree not to bill you above that negotiated rate

National Network*

1.8M+ providers

7,200+ hospitals

- No referrals to see a network specialist
- Use any doctor or facility in the national network

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

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.

*UnitedHealth Group Annual Form 10-K for year ended 12/31/23.

Round out your coverage

Telehealth 2 ways

If you're looking for coverage for virtual visits, your Short Term Medical plan can help.

1. By adding the Virtual Care Benefit[1] to your plan, you can use Amwell to visit with a doctor 24 hours a day, 7 days a week to get quick care and a prescription when needed. With no appointments or long wait times, it's a great option for care when you think you might have the flu, sinus infection, cough, cold, fever, pink eye, nausea and more. You can have unlimited $0 cost video visits with a doctor when you need it.
2. If a regular network doctor offers telehealth services, you can take advantage of that service at network negotiated lower rates. Your plan's deductible and coinsurance rates apply.

This option is no longer available

Accident benefit

The Supplemental Accident Benefit[1] can help cover your deductible or other out-of-pocket medical costs (before insurance starts paying covered expenses) for accident-related injuries. You choose the benefit level amount you want, and it's paid per accident, per covered person. See page 14 for more details.

Dental and vision

Consider help for other regular expenses not covered by health insurance with standalone dental and vision coverage.[1] Dental insurance can provide benefits for services ranging from routine cleanings to root canals, while vision insurance covers routine eye exams and can help pay for glasses, contacts or both.

[1] Additional premium is required for coverage.
Amwell and UnitedHealthcare are not affiliated and each entity is responsible for its own contractual and financial obligations. Dental and Vision require separate applications, and separate policies are issued. Product design and availability may vary by state. For costs, benefits, exclusions, limitations, eligibility, waiting periods and renewal terms, call 1-800-273-8115.

FAQs

What to Expect from Short Term Medical plans

Here are some of the most common questions - and answers - on Short Term Medical. We want you to feel confident that a short term plan is right for you.

What are preexisting conditions and does a short term plan cover them?

No. Short Term Medical plans generally don't cover expenses related to preexisting conditions. This means your plan won't cover costs if:

- You're currently taking medicine or getting treatment for an illness, injury or condition
- You've had a condition in the past that resurfaces
- You're already pregnant before signing up for a plan

If you need coverage for preexisting conditions, exploring Affordable Care Act insurance options may be your best choice.

How is preventive care covered?

The cost of preventive care services applies toward your deductible, then your coinsurance. This means you will likely have to pay for preventive care services out of pocket, but these costs are applied to your deductible. When you meet your deductible, then the services are subject to your share of coinsurance. Remember, when you use a network provider, you are saving each time because providers have agreed to lower rates than you would pay without insurance.

What preventive care is covered?

Preventive care covered by your plan is very specific, limited to mammograms, PAP smears, prostate checks and some preventive care for children on the plan. Immunization services that qualify as children's preventive health care services are exempt from any deductible, coinsurance or copayment amounts. However, adult immunizations, like the flu shot, for example, would not be covered. Some states may require additional coverage.

If I'm responsible for more out-of-pocket costs with a high deductible, what am I getting out of my plan?

While having a higher deductible means you agree to pay more before insurance starts to pay, those payments are not the only way your Short Term Medical plan "pays" for itself. Network providers agree to lower rates for your care. So even if you're still paying on your deductible, what you're paying is less than you would pay without your Short Term Medical plan.

How does prescription drug coverage work?

It varies by plan. Some have copays with no deductible for more common drugs, and payments that apply to your deductible for other drugs. Some lower cost plans have no drug coverage, but come with a drug discount card. You pick the plan that works best for you.

Medical benefits
(insurance plans)

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

Ambulance services

- Ground ambulance service to the nearest hospital that can provide services for necessary emergency care.
- Air ambulance services requested by police or medical authorities at the site of emergency or in locations that cannot be reached by ground ambulance, limited to $5,000 in covered expenses per person, per term.

Cancer treatment expenses

- Radiation therapy and chemotherapy.
- Expenses in connection with a mastectomy for a covered person who elects breast reconstruction, including all stages of reconstruction of the breast on which the mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and treatment for physical complications of mastectomy, including lymphedemas.

Children's preventive health services

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.

Dental injuries

Dental expenses for an injury to natural teeth suffered after the coverage effective date. Expenses must be incurred within 6 months of the accident. **No benefits payable for injuries due to chewing.**

Diabetes

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

Diagnostic testing

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

Doctor office visit copay (history and exam only)

For Copay plans only, copay of $50 per office visit for treatment, excluding surgery, performed by a doctor, limited to 1 or 2 visits per person, per term, depending on plan duration (see page 5). Additional office visits will be subject to the applicable deductible amount and coinsurance percentage. The office visit copayment amount does not apply to office visits for preventive care services.

Durable medical equipment

Rental of standard non-motorized wheelchair, hospital bed, standard walker, wheelchair cushion or ventilator.

Home health care

To qualify for benefits, home health care must be provided through a licensed home health-care agency. Covered expenses for home health aide services will be limited to 7 visits per week. Each 8-hour period of home health aide services will be counted as one visit. Intermittent private duty registered nurse visits are not to exceed 4 hours each and are limited to $75 per visit.

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

Medical benefits continued
(insurance plans)

Hospital services

Daily hospital room and board at most common semiprivate rate; eligible expenses for an intensive care unit; inpatient use of an operating, treatment or recovery room; outpatient use of an operating, treatment or recovery room for surgery; services and supplies, including drugs and medicines, which are routinely provided in the hospital to persons for use only while they are inpatients; and emergency treatment of an injury or illness. Covered expenses for use of the emergency room are subject to an additional $500 or $750 deductible, depending on plan you choose, for each emergency room visit for an illness or injury unless the covered person is directly admitted to the hospital for further treatment.

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

Medical supplies

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

Mental and substance-related & addictive disorders (Plus plans ONLY unless required by state. See State variations.)

Diagnosis and treatment of mental disorders and substance-related and addictive disorders, including court-ordered treatment programs for substance-related and addictive disorders.

Outpatient surgery

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

Physician fees

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

Preventive care

Preventive care expenses include:

- One routine mammography examination per term, per female covered person.
- One cervical smear or pap smear per term, per female covered person.
- One digital rectal exam and one prostate specific antigen (PSA) test per term, per male covered person for screening for the early detection of prostate cancer, exempt from deductible. Coverage for screening does not diminish or limit other covered diagnostic benefits.

For Children's Preventive Health Services, see page 9.

Prosthetics

Artificial eyes or larynx, breast prosthesis, orthotic and prosthetic devices/services. Orthotic and prosthetic devices/services limited to one device/service or replacement every 3 years unless proven to be medically necessary. If more than one device can meet covered person's functional needs, only the charge for the most cost effective device will be considered a covered expense.

Reconstructive surgery

- Reconstructive surgery incidental to or following surgery or an injury that was covered under the 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 max of 60 days per person, per term for both rehabilitation and ECF expenses. This benefit excludes mental disorders or substance abuse.

Medical benefits continued
(insurance plans)

Spine and back disorders

Diagnosis or treatment of spine and back disorders. Outpatient non-surgical services are limited to $2,500 maximum covered expense.

Therapeutic treatments

Hemodialysis, processing and administration of blood or components (but not the cost of the actual blood or components).

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 "Listed Transplants" under Transplant Expense Benefits in the certificate. 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 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 person, limited to max benefits of $100,000; acquisition, transportation and lodging not covered.

No benefits payable for:

- Search and testing in order to locate a suitable donor.
- A prophylactic bone marrow harvest and peripheral blood stem cell collection when no "listed transplant" occurs.
- Animal-to-human transplants.
- Artificial or mechanical devices designed to replace a human organ temporarily or permanently 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.

Additional benefits

- 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 term, per covered person.
- Colorectal cancer examinations and laboratory tests in accordance with the published American Cancer Society guidelines.
- 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.
- Newborn screening tests for hypothyroidism, phenylketonuria, galactosemia, sickle-cell anemia and other genetic disorders as mandated by state law.
- 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.

Exclusions/limitations
(insurance plans)

This is only a general outline of the 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. Preexisting Conditions are not covered under this plan of coverage. Be sure to check your Policy/Certificate carefully to make sure you understand what the Policy/Certificate does and does not cover. If this coverage expires or you lose eligibility for this coverage, you might have to wait until the next 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 and help to pay for it at **www.healthcare.gov**. Be sure to check your Policy/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 abuse use disorder services). Your Policy/Certificate might also have lifetime and/or dollar limits on health benefits.

General 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 a preexisting condition: Any illness, injury or condition for which medical advice, care or treatment was recommended or received within the 24 months immediately prior to the covered person's effective date; or any illness, injury or condition for which any diagnostic procedure or screening was recommended to or received by a covered person within the 12 months immediately prior to the covered person's effective date that results in medical care or treatment after the covered person's effective date; or any illness, injury, condition or symptom(s) that, in the opinion of a doctor, manifested itself in a manner that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care, treatment or further evaluation within the 12 months immediately prior to the covered person's effective date; or a pregnancy existing on the effective date of coverage.

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 non-emergency services or supplies received from a provider who is not a network provider, except as specifically provided for by the certificate.
- 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 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.
- For drugs, treatment or procedures that promote or prevent conception or prevent childbirth, including but not limited to artificial insemination or treatment for infertility or impotency.
- For sterilization or reversals of sterilization.
- For fetal reduction surgery or abortion (unless life of mother would be endangered).
- For treatment of malocclusions, disorders of the temporomandibular joint (TMJ) or craniomandibular disorders, except as provided for in the certificate.
- For modification of the physical body in order to improve psychological, mental, or emotional well-being, such as sex-change surgery.
- Not specifically provided for in the certificate, including telephone consultations, failure to keep an appointment, television expenses or telephone expenses.
- For marriage, family or child counseling.
- For standby availability of a medical practitioner when no treatment is rendered.
- For hospital room and board and nursing services if admitted on a Friday or Saturday, unless for an emergency, or for medically necessary surgery that is scheduled for the next day.
- For dental expenses, including braces and oral surgery, except as provided for in the certificate.
- For cosmetic treatment.
- For diagnosis or treatment of learning disabilities, attitudinal disorders or disciplinary problems, except as provided for in the certificate.
- For diagnosis or treatment of nicotine addiction.
- For surrogate parenting.
- For treatments of hyperhidrosis (excessive sweating).

Exclusions/limitations continued
(insurance plans)

General exclusions, continued

No benefits are payable for expenses:

- For charges related to, or in preparation for, tissue or organ transplants, except as expressly provided for under Transplant Expense Benefits in the certificate.
- For injuries from participation in professional or semi-professional sports or athletic activities for financial gain, as determined by GRIC.
- 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 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 certificate.
- For eyeglasses, contact lenses, hearing aids, eye refraction, visual therapy or any exam or fitting related to these devices, except as provided for in the certificate.
- Due to pregnancy (except complications).
- For any expenses, including for diagnostic testing incurred while confined primarily for well-baby care, except as provided in the certificate.
- For diagnosis and treatment of mental disorders, or court-ordered treatment for substance abuse, except as provided for in the certificate.
- For preventive care or prophylactic care, including routine physical examinations, premarital examinations and educational programs, except as provided in the certificate.
- Incurred outside of the U.S., except for emergency treatment.
- Resulting from declared or undeclared war; intentionally self-inflicted bodily harm (whether sane or insane); or participation in a riot or felony (whether or not charged).
- For or related to durable medical equipment or for its fitting, implantation, adjustment or removal or for complications therefrom, except as provided for in the certificate.
- For alternative treatments, except as specifically covered by the 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.
- Resulting from or during employment for wage or profit, if covered or required to be covered by workers' compensation insurance under state or federal law. If you entered into a settlement that waives your right to recover future medical benefits under a workers' compensation law or insurance plan, this exclusion will still apply.
- Resulting from intoxication, as defined by state law where the illness or injury occurred, or while under the influence of illegal narcotics or controlled substances, unless administered or prescribed by a doctor.
- For joint replacement, unless related to an injury covered by the certificate.
- 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, hanggliding, 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 or occupational therapy, except as provided for in the certificate.
- Resulting from experimental or investigational treatments, or unproven services.
- For non-emergency treatment of tonsils, adenoids, middle ear disorders, hemorrhoids or hernia.
- For a service for which a non-network provider waives, does not pursue or fails to collect any applicable copayment amount, deductible amount or coinsurance percentage owed.
- **Value Direct Plans Only:** No benefits are payable for outpatient prescription drugs.

Plan provisions
(insurance plans)

This is only a general outline of the provisions. 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.

Optional supplemental accident benefit for Short Term Medical plans

Form SA-S-1996G-GRI and state variations

Reduce or eliminate your out-of-pocket exposure for an accident-related injury for additional premium. Supplemental Accident benefit pays for treatment of an unexpected injury within 90 days of an accident. The benefit maximum amount ($2,500, $5,000, $7,500, $10,000 or $15,000) is per accident, per covered person.

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, or as defined by state.

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 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 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 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:

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

Emergency

"Emergency" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in: placing the health of the covered person (or unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

No non-network benefits

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

Plan provisions continued
(insurance plans)

Non-renewable

Short Term Medical plans are 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 certificate. We will notify you in advance of any changes in coverage or benefits, unless the certificate terminates earlier for any reason stated in the Termination section.

Termination

The certificate will terminate on the earliest of:

- 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 last day for which premium has been paid, following your request to terminate the certificate.
- The end of the premium period on or after the primary insured's 65th birthday, if primary insured is the only person on the plan.

Rating factors

The chosen plan design, gender, issue age, tobacco use, area of residence, effective date of coverage, number of insureds covered under the product, coverage term and election of optional benefits are some of the factors used in determining your premium rates. Any coverage period during the term that is less than a full month will be prorated.

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 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 (or as required by state) and have the paid premium refunded. Refer to certificate for details.

State variations
(insurance plans)

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

Florida

Certificate Form C-020.1D with FL Endorsement MGRENDFL-ST4

- An eligible child may remain a covered person through age 30.
- A newborn child will be covered from the time of birth for loss due to injury and illness, including complications of birth, premature birth and congenital birth defects. Covered expenses include:
  - Up to a maximum of $1,000 for charges incurred for medically necessary transportation of newborn to and from nearest available facility appropriately staffed and equipped to treat the newborn's condition.
  - Newborn hearing screenings provided by a licensed audiologist to any covered person eligible by reason of age, in accordance with Florida law. Newborn hearing screenings are exempt from deductible.
- Covered expenses are expanded to include:
  - General anesthesia and services incurred at hospital or outpatient surgical facility for treatment of necessary dental care for a covered person who: is an eligible child less than 8 years of age and is determined by licensed dentist and the child's doctor to require necessary dental care due to a significantly complex dental condition or a developmental disability which has caused treatment in a dental office to be ineffective; or has one or more medical conditions that would create significant or undue medical risk if the necessary dental care was provided somewhere other than a hospital or outpatient surgical facility.
  - Coverage of mastectomy including: medically necessary inpatient hospital coverage; medically necessary outpatient post-surgical follow up care; and coverage for prosthetic devices and medically necessary breast reconstructive surgery.
  - Child supervision services, exempt from deductible if they are: provided during periodic intervals consistent with recommendations for preventive pediatric health care of the American Academy of Pediatrics; and limited to the services of one provider for all services provided at each visit.
  - Services and treatment prescribed by attending doctor as medically necessary to the treatment of cleft lip or palate for a covered child under age 18.
  - Medically necessary diagnosis and treatment of osteoporosis for high-risk individuals as defined in certificate.
  - Mammography services limited to:
    - > One or more mammograms each year for covered female at risk for breast cancer based on doctor's recommendation;
    - > One baseline mammogram for a covered female age 35 to 39 not at risk for breast cancer;
    - > One mammogram for covered female age 40 to 49, not at risk for breast cancer: every 2 years, or more frequently based on doctor's recommendation; or more frequently than every 2 years if covered female obtains a mammogram in office, facility, or health testing service that uses radiological equipment registered with the Department of Health and Rehabilitative services for breast cancer screening; and
    - > One mammogram each year for covered female age 50 not at risk for breast cancer.
  - Diagnostic or surgical procedures involving bones or joints of the jaw and facial region medically necessary to treat conditions caused by congenital or developmental deformity, disease or injury.
  - Routine follow-up care to determine whether a breast cancer has recurred in a person who has been previously determined to be free of breast cancer does not constitute medical advice, diagnosis, care, or treatment for purposes of determining preexisting conditions unless evidence of breast cancer is found during or as a result of the follow-up care.

Indiana

Certificate Form GRI-STAG20-C-E-D-13

- Value Direct Plan is not available.
- Maximum Benefit on Value plan is $2 million per person, per term.
- An eligible child is not required to be unmarried but must be under the age of 26.
- "Preexisting condition" means: Any illness, injury or condition for which medical advice, care or treatment was recommended or received within the 12 months immediately preceding the covered person's effective date; or any illness, injury or condition for which any diagnostic procedure or screening was recommended to or received by a covered person within the 12 months immediately preceding the covered person's effective date that results in medical care or treatment after the covered person's effective date.

State variations continued
(insurance plans)

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

Michigan
Certificate Form GRI-STAG20-C-E-D-21

- The exclusions for the following do not apply:
  - As a result of intentionally self-inflicted bodily harm
  - As a result of the covered person taking part in a riot.
- No benefits will be paid for any illness or injury incurred as a result of the covered person committing or attempting to commit a misdemeanor or felony, whether or not charged, or to which a contributing cause was the covered person's being engaged in an illegal occupation or other willful criminal activity.
- The exclusion for modification of the physical body in order to improve the psychological, mental or emotional well-being of the covered person does not apply if it is for medically necessary treatment of gender dysphoria.

Mississippi
Certificate Form GRI-STAG20-C-E-D-23

- "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: probably began prior to the applicable effective date the covered person became insured under the policy; and 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-supervised 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-STAG20-C-E-D-26R

- "Eligible child" is expanded to include: a child that remains chiefly dependent on you or your spouse for support and maintenance due to mental or physical disability. The disabled child's coverage will not terminate due to age. The dependent may remain covered for the duration of the policy term.
- The covered expenses for screening coverage for a colorectal cancer examination and laboratory tests for colorectal cancer applies to a nonsymptomatic covered person 50 years or older and includes a maximum of: one screening fecal occult blood test annually and a flexible sigmoidoscopy every five years; a colonoscopy every ten years; or a barium enema every five to ten years; or any combination or the most reliable, medically recognized screening test available when deemed appropriate by the covered person's medical practitioner.
- The covered expense for one screening mammography per person per term is not specific to females.
- Covered expenses are expanded to include:
  - Up to $2,500 for medically necessary surgical and non-surgical treatment of temporomandibular joint disorders and craniomandibular disorders.
  - The reasonable cost of general anesthesia and facility charges incurred at a hospital or ambulatory surgical center for dental care (but not the dental care itself) for covered persons: age eight (8) or under; or for whom general anesthesia for dental care is required due to developmental disability.

State variations continued
(insurance plans)

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

Nebraska, continued

- Covered expenses are expanded to include: (continued)
  - Up to $3000 for medically necessary hearing aids for an eligible child under the age of 19, for each ear affected by a hearing impairment. Covered expenses shall include the following items and services for a hearing aid:
    - A hearing aid purchased from a licensed audiologist with the medical clearance from an otolaryngologist and costs related for dispensing.
    - Evaluation for, fitting, and programming. Probe microphone measurements for verification of that hearing aid gain and output meet the prescribed targets.
    - Repairs, follow-up adjustments, servicing, and maintenance.
    - Ear mold impressions.
    - Ear molds.
    - Auditory rehabilitation and training.
    - Replacement of a hearing aid and the associated services within 3 months of the dispensing date if the hearing aid gain and output fail to meet prescribed target or it is unable to be repaired or adjusted.

Pennsylvania

Certificate Form GRI-STAG20-C-E-D-37

- Covered expenses are expanded to include:
  - General anesthesia, facility fees, and other related charges incurred in conjunction with dental care (but not including the actual dental services) provided in a hospital or an outpatient surgical facility when the covered person is:
    1. An eligible child seven (7) years of age or younger.
    2. Developmentally disabled and a successful result cannot be expected under local anesthesia, but a superior result can be expected for treatment under general anesthesia.
  - Childhood immunizations, as defined in the policy, are exempt from any deductible amount or maximum dollar limits, but limited to 150% of the average wholesale price of the immunizing agent as published by the Pennsylvania Department of Health (or as determined in good faith by us in the absence of such publication of the average wholesale price).
  - One routine gynecological exam including a pelvic exam and clinical breast exam during the policy term for each female covered person.

Tennessee

Certificate Form GRI-STAG20-C-E-D-41

- If emergency services are provided at a network facility by a non-network facility-based physician because we do not have a network physician at that facility, the non-network facility-based physician's charges will be covered as if the services were provided by a network physician. "Emergency services"means, with respect to an emergency medical condition, health care items and services furnished in a hospital which are required to determine, evaluate and/or treat an emergency medical condition, until the condition is stabilized, as directed or ordered by a doctor or directed by hospital protocol.
- The $2,500 outpatient maximum on spine and back disorders does not apply.
- Termination dates are expanded to include the end of the grace period after the primary insured fails to pay any renewal premium due.
- The covered expense for diabetes self-management training and education, when medically necessary, is limited to visits which are certified by a physician to be: medically necessary upon the diagnosis of diabetes; medically necessary because of a significant change in the covered person's symptoms or condition which necessitates changes in the covered person's self-management; and medically necessary for reeducation or refresher training.
- The covered expense for mammography screening is for diagnostic purposes on referral by a patient's physician, limited to the following: a baseline mammogram for covered persons 35 to 40 years of age; and a mammogram every two years or more frequently based upon the recommendation of a physician for covered persons 40 years of age and over.
- Covered expenses are expanded to include:
  - Up to a $1,000 per ear per policy term for hearing aids for covered persons under 18 years of age.

State variations continued
(insurance plans)

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

Tennessee, continued

- Covered expenses are expanded to include: (continued)
  - Surgical and non-surgical treatment for disorders of the temporomandibular joint (TMJ). Non-surgical treatment shall be limited to diagnosis and management of TMJ categorized as Phase I treatment under guidelines adopted by the American Dental Association that require the written prescription of a doctor or dentist, including soft diet, thermal agents, temporary splints, and voluntary self-disengagement of the teeth. 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 shall 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.
- The exclusion for charges that would not have been charged if you did not have insurance does not apply if the billed charges are from a non-governmental charitable research hospital that does not enforce by judicial proceedings collection from individual patients in the absence of insurance coverage.
- The exclusion for fetal reduction surgery or abortion does not apply if the life of mother would be endangered or if the fetus is not viable.
- The exclusion for surrogate parenting does not apply if it is for complications of pregnancy and the person is not being reimbursed by another party as a part of a surrogacy agreement.
- The exclusion does not apply for charges of a service for which a non-network provider waives, does not pursue, or fails to collect any applicable copayment amount, deductible amount or coinsurance percentage owed.

Texas

Certificate Form GRI-STAG20-C-E-D-42R

- "Eligible child" is expanded to include: a stepchild; a child that you or your spouse are seeking to adopt through court legal proceedings; a child entitled, by virtue of a court order, to have coverage provided by you or your spouse; or your grandchild who is considered your dependent for federal income tax purposes at the time application for coverage is made. A child that is unmarried and remains chiefly dependent on you or your spouse for support and maintenance due to mental or physical disability will be considered an eligible child under the policy/certificate regardless of age. The disabled child's coverage will not terminate due to age. The dependent may remain covered for the duration of the policy term.
- "Preexisting condition" means an injury or illness for which the covered person received medical advice or treatment within the 12 months immediately preceding the applicable effective date the covered person became insured under the policy.
- "Emergency" means a medical condition 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; or
  - Serious disfigurement; or
  - In the case of a pregnant woman, serious jeopardy to the health of the fetus.
- Covered expenses for diabetes and diabetes self-management training are expanded. The limit of one training program per covered person, per lifetime does not apply. See certificate for full details.
- Covered expenses for reconstructive craniofacial surgery are expanded to include services to attempt to create a normal appearance of a craniofacial abnormality of a dependent less than 18 years of age which was caused by congenital defects, developmental abnormalities, trauma, tumors, infection, or disease.

State variations continued
(insurance plans)

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

Texas, continued

- Covered expenses for prosthetics include:
  - Artificial eyes or larynx
  - The most appropriate model of 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, including:
    - Professional services related to the fitting and use of the device.
    - Repair and replacement of the device unless necessitated by the misuse or loss of the device by the covered person
- Covered expenses for autism spectrum disorders include:
  - Screening for autism spectrum disorders for an eligible child at 18 and 24 months of age.
  - Generally recognized services prescribed for the diagnosis and treatment of autism spectrum disorder for covered persons, including: evidence -based treatments; evaluation and assessment services; applied behavior analysis; behavior training and behavior management; speech therapy; occupational therapy; physical therapy; and medications or nutritional supplements used to address symptoms of autism spectrum disorder. For covered persons 10 years of age or older, outpatient applied behavior analysis for the treatment of autism spectrum disorders shall be limited to a maximum of $50,000 per policy term.
- Covered expenses are expanded to include:
  - 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.
  - Medically necessary amino acid modified preparations, low protein modified food products, and 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 necessary hearing aids or cochlear implants for a covered eligible child up to age 18 years. This benefit includes the following:
    - Fitting and dispensing services and the provision of ear molds as necessary to maintain optimal fit of hearing aids;
    - Any treatment related to hearing aids and cochlear implants, including coverage for habilitation and rehabilitation as necessary for education gain.

    Covered expenses are 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.
  - Child immunizations, exempt from deductible, copay, and coinsurance.
  - 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:
    - A 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 follow-up care shall be exempt from the deductible amount.
  - Diagnostic and surgical treatment of temporomandibular joint disorders and craniomandibular joint disorders.
  - Charges incurred for 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.

State variations continued
(insurance plans)

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

Texas, continued

- Covered expenses are expanded to include: (continued)
  - 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.
  - An 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 a 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.
  - An annual screening by low-dose mammography for the presence of occult breast cancer for covered persons 35 years of age or older. This age limit does not apply to diagnostic mammogram.
  - 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.
  - Diagnostic mammogram
  - Diagnosis and treatment of mental disorders, substance-related and addictive disorders the same as any other illness, including services received in: a psychiatric day treatment facility; a residential treatment center for children or adolescents; a crisis stabilization unit; and a chemical dependency treatment center.
- In regards to limits on covered expenses for listed transplants, 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, coinsurance, or copay.

West Virginia

Certificate Form GRI-STAG20-C-E-D-47

- The covered expense for equipment, supplies, and services for the treatment of diabetes is expanded to include: monitor supplies, insulin infusion devices, orthotics, orthopedic appliances, blood pressure monitoring devices and regular foot exams by doctor.
- The covered expense for diabetes self-management training is limited to $100 per covered person, per calendar year. The standard limits (one program per lifetime or additional training prescribed by physician as medically necessary) do not apply.
- The covered expense for dental expenses does not include injury to the natural teeth as a result of chewing unless damage to natural teeth is incurred as a result of a non-edible foreign object found in food.
- Covered expenses are expanded to include:
  - An annual kidney disease screening using any combination of blood pressure testing, urine albumin or urine protein testing as recommended by the National Kidney Foundation.

State variations continued
(insurance plans)

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

West Virginia, continued

- Covered expenses are expanded to include: (continued)
  - Charges for general anesthesia, facility fees, and other related charges incurred in conjunction with dental care (but not including the actual dental services) that are provided in a hospital or an outpatient surgical facility to a covered person who:
    1. is an eligible child seven (7) years of age or younger.
    2. Is an eligible child age twelve (12) or under with a documented phobia or mental disorder:
       a. Who has dental needs of such magnitude that treatment should not be delayed or deferred;
       b. When a lack of treatment can be expected to result in infection, loss of teeth, or other increased oral or dental morbidity; and
       c. When a successful result cannot be expected under local anesthesia because of such condition, but a superior result can be expected under general anesthesia.
  - Charges incurred by a covered person for medically necessary long-term antibiotic therapy to treat Lyme disease, when prescribed by a doctor, after making thorough evaluation of the covered person's: symptoms; diagnostic test results; or response to treatment.
  - Charges incurred by a covered person for up to 20 visits for the treatment of chronic pain, per pain causing event while the policy/certificate is in force, when ordered by a medical practitioner, advanced practice nurse or occupational therapist, for the following services: physical therapy; occupational therapy; osteopathic manipulation; a chronic pain management program; chiropractic services.
  - Abuse-deterrent opioid analgesic drug products and opioid analgesic drug products found on the Prescription Drug List. Covered expenses include the medication product, administration devices, and any pharmacy administration fees related to the dispensing of the product.
  - The following cancer screenings:
    - Mammograms when medically appropriate and consistent with the current guidelines from the United States Preventive Services task Force.
    - One pap smear per policy term, either conventional or liquid-based cytology, whichever is medically appropriate and consistent with the current guidelines from the United States Preventive Services Task Force or The American College of Obstetricians and Gynecologists, for covered persons 18 years of age or older.
    - A test for the human papilloma virus (HPV) for covered persons 18 years of age or older, when medically appropriate and consistent with the current guidelines from the United States Preventive Services Task Force or the American College of Obstetricians and Gynecologists.
    - 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 deductible. Coverage for screenings does not diminish or limit diagnostic benefits otherwise available under the policy/certificate.

Wisconsin

Certificate Form GRI-STAG20-C-E-D-48

- An adult eligible child may be added as a covered person if:
  - You apply in writing for insurance on the dependent;
  - You pay the required premiums;
  - You furnish a complete health history, at no cost to us; and
  - You furnish proof that the child is an adult eligible child.
- Covered expenses for diabetes and diabetes self-management training are expanded. The limit of one training program per covered person, per lifetime does not apply. Equipment, supplies, and services for diagnosis and treatment of diabetes include:
  - Necessary medical supplies for the treatment of diabetes;
  - Charges for installation and use of one insulin infusion pump per calendar year, providing that the device has been used by the covered person for at least thirty days prior to purchase.
  - Insulin and any other prescription medication.
  - Diabetic self-management education programs.

State variations continued
(insurance plans)

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

Wisconsin, continued

- Coverage for diagnosis or treatment of spine and back disorders is not subject to the $2,500 maximum covered expense on outpatient non-surgical services.
- Covered expenses are expanded to include:
  - Services, items or drugs for the treatment of cancer which are administered under a clinical trial as defined in the certificate.
  - Charges made by a hospital or ambulatory surgical center for general anesthesia and dental care provided to a covered person who: is under age 5; has a chronic disability; or has a medical condition that requires hospitalization or general anesthesia for dental care.
  - Charges for blood lead tests provided to an eligible child under age 6 years to screen for lead poisoning.
  - Diagnosis and treatment of mental disorders, including:
    - Substance-related and addictive disorders.
    - Outpatient charges incurred by a collateral at any of the following for the purpose of enhancing the covered person's treatment: a program in an outpatient treatment facility; a licensed physician who has completed a residency in psychiatry; a psychologist; or a licensed mental health professional practicing within the scope of his or her license.
    - Charges incurred by a covered person in a transitional treatment arrangement offered by a provider or program certified by the Department of Health and Family Services or provided in accordance with criteria of the American Society of Addiction Medicine.

    If a dependent student incurs expenses for treatment of a mental disorder, including substance-related and addictive disorders, at a non-network provider located in Wisconsin and in reasonably close proximity to the dependent student's vocational school, college, or university, those expenses will be treated the same as if they were incurred at a network provider.
  - Diagnostic procedures and medically necessary surgical or non-surgical treatment for the correction of temporomandibular disorders if all of the following apply:
    - The condition is caused by congenital, developmental or acquired deformity, disease or injury.
    - Under accepted standards of the profession of the provider rendering the service, the procedure or device is reasonable and appropriate for the diagnosis or treatment of the condition.
    - The purpose of the procedure or device is to control or eliminate infection, pain, disease or dysfunction.

    Benefits for non-surgical treatment of temporomandibular disorders are limited to $1250 per policy term for each covered person and do not include coverage for cosmetic or elective orthodontic care, periodontic care or general dental care.
  - Second opinions from another practitioner.
  - Kidney disease treatment limited to dialysis, transplantation and donor-related services. The maximum benefit shall be limited to $30,000 per covered person annually.
- Covered expenses for diagnosis of and treatment for autism spectrum disorders are expanded to include:
  - Evidence-based behavioral intensive-level services, the majority of which is to be provided when the parent or legal guardian is present and engaged, for the treatment of autism spectrum disorders for covered persons based on a treatment plan developed by a qualified provider that includes at least 20 hours per week over a six-month period of time of evidence-based behavioral intensive therapy, treatment, and services with specific cognitive, social, communicative, self-care, or behavioral goals that are clearly defined, directly observed and continually measured and that address the characteristics of autism spectrum disorder when such treatment is ordered by a doctor and provided by a doctor or medical practitioner.
  - Nonintensive-level service

State variations continued
(insurance plans)

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

Wisconsin, continued

- Covered expenses for Home Health Care are expanded to include:
  - Laboratory services to the extent they would have been covered under the policy if the covered person had been in a hospital.
  - Nutrition counseling provided by or under the supervision of a registered dietician.
  - Evaluation of the need for, and development of, a plan for home care when approved or requested by the attending doctor.
- Home health care is limited as follows:
  - For home health aide services to qualify as covered expenses, a doctor must certify that:
    - Confinement in a hospital or extended care facility would be required if home health care was not provided;
    - Necessary care and treatment are not available from members of the insured's immediate family or other persons residing with the insured without causing undue hardship; and
    - The home health care services will be provided or coordinated by a home health care agency.

      The doctor must recertify every 60 days that continued home health care is medically necessary to the treatment of an injury or illness;
  - Covered expenses for home health aide services will be limited to 40 home health care visits in a 12-month period. (Each visit by an authorized representative of a home health care agency will be deemed a separate home health care visit, except that each four-hour period of home health aide services during a single visit will be counted as one home health care visit. If the length of a visit for home health aide services is longer than four hours, but not evenly divisible by four, the remaining period will also be counted as one home health care visit); and
  - The maximum weekly benefit for home health care will be limited to the reasonable and customary charge for weekly care in an extended care facility.
  - Covered expenses for intermittent private duty registered nurse visits (not more than 4 hours each) will be limited to $75 per visit.
- The exclusion for treatment of malocclusions, disorders of the temporomandibular joint, or craniomandibular disorders does not apply.
- The exclusion for modification of the physical body in order to improve the psychological, mental or emotional well-being of the covered person does not apply if it is for medically necessary treatment of gender dysphoria.

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 80 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. If you're not already a member, you can enroll with your Short Term Medical application to be eligible to apply for these plans.

Health Plan Notice 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)

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
- Dental, Vision, Hearing Aid, and Prescription Discounts
- ID Theft and Cyber Protection
- Travel Discounts
- Online Health, Wellness, and Fitness Classes
- 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.

* As of 12/14/23. For the latest rating, access www.ambest.com.

46995E-G-0225

UnitedHealthcare®
Golden Rule Insurance Co.