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

Policy Form IST7-E-D-GRI 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
Thse 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)

Plan information

Highlights of covered network expenses

		Copay	Premier Elite and Plus Elite	Plus	Value	Value Direct
Per Person Deductible (per term; max 2 per family)[1]	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	$500,000
Medical						
Doctor Office Visit – History and Exam Only (per person, per term)	You pay:	$50 copay[2]	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[3]
Optional Benefits						
Add Supplemental Accident Benefit[4] (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]

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.

[1] 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 and prostate checks. 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.

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.

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)

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.
- Telehealth services if those services would be covered under the policy if provided in person.

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 age 40 years or older.

Prosthetics

Basic artificial limbs, artificial eyes and larynx and breast prosthesis. Replacement only if required by a physical change in the covered person and the item cannot be modified.

Reconstructive surgery

Reconstructive surgery incidental to or following surgery or an injury that was covered under the policy or is performed to correct a birth defect in a child who has been a covered person from its birth until the date surgery is performed.

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.

Temporomandibular joint (TMJ)

Temporomandibular joint (TMJ) surgery, excluding tooth extractions, to treat craniomandibular disorders, malocclusions, disorders of the temporomandibular joint (TMJ), limited to a combined $10,000 maximum per person, per term.

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 policy. 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.

Exclusions/limitations
(insurance plans)

This is only a general outline of the exclusions. It is not an insurance contract, nor part of the insurance policy. Some state exceptions may apply (see State Variations). You will find complete details in the policy.

Some states may require that you have Minimum Essential Coverage in order to avoid a penalty. The Short-term, limited duration insurance benefits under this coverage do not meet all federal requirements to qualify as "Minimum Essential Coverage" for health insurance under the Affordable Care Act ("ACA"). This plan of coverage does not include all Essential Health Benefits as required by the ACA. Preexisting Conditions are not covered under this plan of coverage. Be sure to check your Policy carefully to make sure you understand what the Policy 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 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 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 policy.

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 policy or in excess of the eligible expenses.
- For services or supplies that are provided prior to the effective date or after the termination date of the coverage.
- For weight modification or surgical treatment of obesity, including wiring of the teeth and all forms of intestinal bypass surgery.
- For breast reduction or augmentation.
- 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 policy.
- 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 policy, 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 policy.
- For cosmetic treatment.
- For diagnosis or treatment of learning disabilities, attitudinal disorders or disciplinary problems.
- 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 in the policy.
- 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 policy.
- For eye refractive surgery, when the primary purpose is to correct nearsightedness, farsightedness or astigmatism.
- While confined for rehabilitation, custodial care, educational care or nursing services, except as provided for in the policy.
- For eyeglasses, contact lenses, hearing aids, eye refraction, visual therapy or any exam or fitting related to these devices, except as provided for in the policy.
- 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 policy.
- For diagnosis and treatment of mental disorders, or court-ordered treatment for substance abuse, except as provided for in the policy.
- For preventive care or prophylactic care, including routine physical examinations, premarital examinations and educational programs, except as provided in the policy.
- 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 policy.
- For alternative treatments, except as specifically covered by the policy, including: acupressure, acupuncture, aromatherapy, hypnotism, massage therapy, rolfing and other alternative treatments defined by the Office of Alternative Medicine of the National Institutes of Health.
- 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 policy.
- 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 policy.
- 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 policy. Some state exceptions may apply (see State Variations). You will find complete details in the policy.

Optional supplemental accident benefit for Short Term Medical plans

Form SA-S-1996I-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.

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 policy 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 policy form can be issued; and
  - E. If the application is submitted by an agent or broker, the agent or broker is properly licensed and appointed to submit applications to GRIC.

* If mailed and not postmarked by the U.S. Postal Service or if the postmark is not legible, the effective date will be the later of: (1) the date you requested; or (2) the 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 policy.

Emergency

"Emergency" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in: placing the health of the covered person (or 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 policy. We will notify you in advance of any changes in coverage or benefits, unless the policy terminates earlier for any reason stated in the Termination section.

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.

Termination

The policy will terminate on the earliest of:

- The primary insured's death. If the policy includes dependents, it may be continued after the primary insured's death by a spouse, if a covered person; otherwise, by the youngest child who is a covered person.
- Nonpayment of premiums when due.
- The termination date shown on the Data Page of the policy.
- The last day for which premium has been paid, following your request to terminate the policy.
- 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.

State variations
(insurance plans)

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

Kansas
Policy Form IST7-E-D-GRI-15

- Covered expenses include complications of pregnancy.

Louisiana
Policy Form IST7-E-D-GRI-17R

- Minimum duration of 2 months required.
- 30-day Right to Examine period.
- The $2,500 limit on Spine and Back Disorders does not apply.
- Covered expenses are expanded to include:
  - Childhood immunizations for a covered person from birth until the 6th birthday, exempt from deductible.
  - A forensic medical exam for a covered person who is the victim of a sexually oriented offense, exempt from deductible, copay and coinsurance.
- Diagnosis and treatment of a correctable medical condition that is otherwise covered under the policy will not be excluded solely because the condition results in infertility.
- The exclusion for marriage and family counseling does not apply. However, the exclusion for child counseling for the treatment of child relationship dysfunctions still applies.
- The exclusion for charges incurred as a result of the covered person's commission of a felony applies only if the person has been convicted.

Missouri
Policy Form IST7-E-D-GRI-24R

- The policy has a variable deductible feature. The variable deductible will be applied only if you become covered under other health insurance while still covered under the policy. The variable deductible equals the amount of benefits payable for covered expenses by the other plan. The actual deductible amount for each claim may vary if a covered person has coverage under any other plan.
- "Emergency" means a health care item or service furnished or required to evaluate and treat an emergency medical condition, which may include, but is not limited to, health care services that are provided in a licensed hospital's emergency facility by an appropriate provider. "Emergency medical condition" means the sudden and, at the time, unexpected onset of a medical condition manifesting itself by symptoms of sufficient severity, regardless of the final diagnosis that is given, such that would lead a prudent layperson, who possesses an average knowledge of health and medicine, to believe that immediate medical care is required, which may include, but is not limited to:
  - Placing the health of the covered person in serious jeopardy;
  - Serious impairment to bodily functions;
  - Serious dysfunction of any bodily organ or part;
  - Inadequately controlled pain; or
  - With respect to a pregnant woman who is having contractions: there is inadequate time to effect a safe transfer to another hospital before delivery; or transfer to another hospital may pose a threat to the health or safety of the woman or unborn child.
- If a covered person's age has been misstated, the benefits may be adjusted based on the relationship of the premium paid to the premium that should have been paid based on the correct age.
- Covered expenses are expanded to include:
  - 2 sessions per policy term with one or more of the following licensed providers for the purpose of diagnosis or assessment of mental disorders: psychiatrist, psychologist, professional counselor, clinical social worker, or marriage and family therapist. Covered expenses under this paragraph provided by a non-network provider will be covered the same as if provided by a network provider.
  - Testing for lead poisoning as required or authorized by Missouri laws.
  - Necessary care and treatment of loss or impairment of speech or hearing. Covered expenses do not include services to improve public speaking, care of the professional voice, or accent reduction.

State variations continued
(insurance plans)

Missouri, continued

- Covered expenses are expanded to include: (continued)
  - Formula and low protein modified food products recommended by a doctor for the treatment of a covered person who is less than 6 years old and who has been diagnosed with phenylketonuria or any inherited disease of amino and organic acids. Covered expenses under this paragraph are limited to 50% of the cost of the formula or low protein modified food product to a maximum benefit of $5,000 per covered person.
  - Low-dose mammography screening for any non-symptomatic female covered person as follows:
    - A baseline mammogram for covered female age 35 to 39, inclusive;
    - A mammogram every year for covered female age 40 or over;
    - A mammogram every year for a covered female deemed by doctor to have above-average risk for breast cancer in accordance with the American College of Radiology guidelines for breast cancer screening;
    - Any supplemental imaging (i.e. MRI or ultrasound) deemed medically necessary by doctor for covered female for proper breast cancer screening or evaluation in accordance with American College of Radiology guidelines; and
    - Ultrasound or magnetic resonance imaging services if determined by doctor to be medically necessary for screening or evaluation of breast cancer for covered female deemed by treating doctor to have an above average risk for breast cancer in accordance with American College of Radiology guidelines for breast cancer screening.
- The exclusion for abortion applies only to an elective abortion which is an abortion for any reason other than a spontaneous abortion or to prevent the death of the female upon whom the abortion is performed.
- The exclusion for intentionally self-inflicted bodily harm does not apply to harm resulting from suicide or attempted suicide while the covered person was insane.

Nevada

Policy Form IST7-E-D-GRI-27

- The covered expense for treatment of craniomandibular disorders, malocclusions or disorders of the temporomandibular joint includes surgical and non-surgical treatment. Covered expenses do not include methods of treatment that are recognized as dental procedures, including but not limited to, the extraction of teeth and the application of orthodontic devices and splints. The $10,000 maximum does not apply.
- Covered expenses for the following are exempt from any copayment amount and coinsurance provisions:
  - One routine mammography exam per female covered person, per term.
  - One cervical smear or pap smear per female covered person, per term.
- Covered expenses are expanded to include:
  - One annual FDA-approved test or screening for the detection of the human papillomavirus (HPV); and for one deoxyribonucleic acid (DNA) testing for high-risk strains of HPV every 3 years for a female covered person age 30 years or older. Benefits under this paragraph are not subject to any copayment amount or coinsurance provisions.
  - The cost and administration of a human papillomavirus vaccination approved by the federal Food and Drug Administration.
  - Colorectal cancer screening in accordance with the guidelines published by the American Cancer Society or other guidelines or reports that are published by nationally recognized professional organizations and that include current or prevailing supporting scientific data.
  - Diagnosis and treatment of severe mental illness.
  - Enteral formulas and special food products for use at home that are prescribed or ordered by a doctor for the treatment of inherited metabolic diseases originating from congenital defects or defects arising shortly after birth. The inherited metabolic diseases must be characterized by deficient metabolism or malabsorption of amino acid, organic acid, carbohydrates or fat. Covered expenses for special food products are limited to $2,500 per year per covered person.

State variations continued
(insurance plans)

Nevada, continued

- Covered expenses are expanded to include: (continued)
  - Any health care service related to hormone replacement therapy.
  - Voluntary sterilization for a female covered person.
  - Necessary case management services and medically necessary care for a covered person who has been diagnosed with sickle cell disease and its variants.
  - General anesthesia and associated dental care procedures provided in a hospital, an outpatient surgical facility, an independent center for emergency care or a rural clinic, to a covered eligible child as defined in the policy.
  - Contraceptive drugs and devices as follows:
    - Up to a 12-month supply per prescription, of a contraceptive drug, or its therapeutic equivalent, that is prescribed or ordered by a doctor and has been approved by the federal Food and Drug Administration.
    - A contraceptive device that is prescribed or ordered by a doctor and has been approved by the federal Food and Drug Administration.
    - Insertion or removal of a contraceptive device if inserted while the covered person is covered under the policy.
    - Education and counseling related to the use of contraception, and any necessary follow-up care.
    - Management of side effects relating to contraception.
    - At least one drug or device in each of the following methods of contraception is exempt from any deductible amount, copayment amount or coinsurance provision in the policy: voluntary sterilization for women; surgical sterilization implants for women; implantable rods; copper-based intrauterine devices; progesterone-based intrauterine devices; injections; combined estrogen- and progestin-based drugs; progestin-based drugs; extended or continuous regimen drugs; estrogen- and progestin-based patches; vaginal contraceptive rings; diaphragms with spermicide; sponges with spermicide; cervical caps with spermicide; female condoms; spermicide; combined estrogen- and progestin-based drugs for emergency contraception or progestin-based drugs for emergency contraception; and ulipristal acetate for emergency contraception.
  - Medical treatment as part of a clinical trial or study if certain conditions, as outlined in the policy, are met.
  - The following items and services, which are not subject to any copayment amount or coinsurance provisions:
    - Counseling, support and supplies for breastfeeding.
    - An annual screening and counseling for interpersonal and domestic violence for a female covered person, with intervention services consisting of education, strategies to reduce harm, supportive services or a referral for any other appropriate services.
    - Behavioral counseling concerning sexually transmitted diseases for a sexually active female covered person who is at increased risk for such diseases.
    - Prenatal screenings and tests recommended by the American College of Obstetricians and Gynecologists or its successor organization.
    - Screening for blood pressure abnormalities and diabetes, including gestational diabetes after at least 24 weeks of gestation or as ordered by a health care provider.
    - Screening for depression.
    - Screening and counseling for the human immunodeficiency virus consisting of a risk assessment, annual education relating to prevention and at least one screening for the virus during a covered person's lifetime or as ordered by a health care provider.
    - Smoking cessation programs for a covered person 18 years of age or older, consisting of up to 2 cessation attempts per year and 4 counseling sessions per year.
    - All vaccinations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention of the United States Department of Health and Human Services or its successor organization.
    - Well-woman preventive visits as recommended by the Health Resources and Services Administration, including at least one such visit per year beginning at 14 years of age.

State variations continued
(insurance plans)

Nevada, continued

- Hospice Care Expense Benefits are covered as defined in the policy. Benefits for hospice inpatient or outpatient care are available to a terminally ill covered person for one continuous period up to 180 days in a covered person's lifetime. For each day the covered person is confined in a hospice, benefits for room and board will not exceed:
  - For a hospice that is associated with a hospital or nursing home, the most common semiprivate room rate of the hospital or nursing home with which the hospice is associated.
  - For any other hospice, the lesser of the billed charge or $200 per day.
- The exclusion regarding conception only applies to drug, treatment, or procedure that promotes conception or prevents childbirth. It does not apply to anything that prevents conception.
- The exclusion for intentionally self-inflicted bodily harm (whether the covered person is sane or insane) does not apply if it is due to a severe mental illness.
- The exclusion for a covered person's commission of felony only applies if the person is convicted of the felony. This exclusion does not apply to acts of domestic violence regardless of whether the covered person contributed to any loss or injury.
- The exclusion does not apply for any illness or injury 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.

South Carolina

Policy Form IST7-E-GRI-39R

- A covered person will not cease to be an eligible child solely due to age if the child is not capable of self-sustaining employment due to mental retardation or physical handicap that began before the age limit was reached and mainly dependent on you for support.
- The exclusion for non-emergency services or supplies received from a non-network provider does not apply during the 90 days following the date a provider terminates from the network when ongoing care is due to the existence of a covered person's serious medical condition (cancer, acute myocardial infarction, etc.).
- Covered expenses are expanded to include:
  - The following when provided to a covered person in connection with a mastectomy:
    - 48 hours of inpatient hospitalization following the mastectomy.
    - One home care visit if ordered by the attending doctor and if attending doctor releases the covered person form the hospital earlier than 48 hours after the mastectomy.
  - Medically necessary care and treatment of cleft lip and cleft palate.
- The exclusion does not apply for expenses 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.
- 30-day Right to Examine period.

State variations continued
(insurance plans)

Wyoming
Policy Form IST7-E-D-GRI-49

- The policy does not contain comprehensive adult wellness benefits as defined by Wyoming law.
- The policy has a variable deductible feature. The variable deductible will be applied only if you become covered under other health insurance while still covered under the policy. The variable deductible equals the amount of benefits payable for covered expenses by the other plan.
- "Preexisting Condition" means any illness, injury, or condition for which medical advice, care, or treatment was recommended or received within the 6 months immediately preceding the covered person's effective date; or any illness, injury, or condition for which any diagnostic procedure or screening was recommended to or received by a covered person within the 6 months immediately preceding the covered person's effective date that results in medical care or treatment after the covered person's effective date.
- Covered expenses are expanded to include:
  - Routine patient care costs incurred by a covered person as part of a cancer clinical trial or study, if all of the conditions are met, as defined in the policy.
  - The equipment, supplies, and outpatient self-management training and education, including medical nutrition therapy, for the treatment of inherited enzymatic disorders caused by single gene defects involved in the metabolism of amino, organic, and fatty acids, if prescribed by a health care professional legally authorized by law to prescribe such items. The outpatient self-management training and education must be provided by a certified, registered, or licensed health care professional with expertise in inherited enzymatic disorders; and is limited to:
    - A one-time evaluation and training program when medically necessary, within one (1) year of diagnosis; and
    - Additional medically necessary self-management training provided upon a significant change in symptoms, condition, or treatment.

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.

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)

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

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