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-P-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
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 in most states

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 reduced 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** (not available in UT) **and Plus Elite**	Plus	Value	**Value Direct** (not available in NH and UT)
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. Non-network benefits vary. 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] In Utah, coverage is available on an individual basis only. No spouse or dependent can be added to your plan. [2] 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. [3] Discounts vary by pharmacy, geographic area and Rx drug. [4] Additional premium required.

Get nationwide access to quality care and cost savings

Get the most out of your benefits when you use the UnitedHealthcare Choice Plus network

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

In addition to the network benefits, these plans pay reduced non-network benefits. For non-emergency care received from non-network providers, you pay:

- All charges above what is considered an eligible expense
- A penalty of 25% of the eligible expense, which does not count toward the deductible
- A deductible amount equal to 2 times the network deductible

There is no out-of-pocket maximum for non-network providers. Your actual out-of-pocket costs may be more than your stated coinsurance because the bill from a non-network provider may not be used to calculate what we pay and what you pay. 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 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.

- 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.

Reduced non-network benefits

These plans pay reduced non-network benefits. Using non-network providers will cost you more due to a non-network penalty—see below. **For non-emergency care received from non-network providers you pay:** (a) all charges above what is considered an eligible expense; (b) a penalty of 25% of the eligible expense, which does not count toward the deductible; and (c) a deductible amount equal to 2 times the network deductible. There is no out-of-pocket maximum for non-network providers. Your actual out-of-pocket costs may be more than the stated coinsurance because the bill from a non-network provider may not be used to calculate what we pay and what you pay.

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.

Georgia

Policy Form IST7-P-D-GRI-10

- The $2,500 limit on Spine and Back Disorders does not apply.
- Coverage for TMJ includes:
  - Nonsurgical treatment for the correction of congenital or developed anomalies of the temporomandibular joint.
  - Surgical treatment to correct functional deformities of the maxilla and mandible; $10,000 limit does not apply.
- Covered expenses are expanded to include:
  - Child wellness services provided to a covered person from birth until the 6th birthday, exempt from deductible.
  - Colorectal cancer examinations and laboratory test in accordance with the published American Cancer Society guidelines.
  - One chlamydia screening test during the policy term for a covered person, age 29 years or younger.
  - Surveillance tests for ovarian cancer for a covered person age 35 or older who is at risk for ovarian cancer.
  - General anesthesia and associated hospital or outpatient surgical facility charges for dental care provided to a covered person: who is age 7 years or younger; who is developmentally disabled; for whom a successful result cannot be expected if the services were provided under local anesthesia due to a medically compromising condition; or who has sustained extensive facial or dental trauma.
  - Evaluation and treatment of Autism Spectrum Disorder for a covered person 20 years of age or younger. Applied behavior analysis expenses are limited to $35,000 per person, per term.
  - Routine patient care costs incurred in connection with an approved clinical trial program in Georgia for the treatment of cancer for a covered eligible child who: has been diagnosed with cancer prior to the child's 19th birthday; is enrolled in an approved clinical trial program for the treatment of children's cancer; and is not otherwise eligible for benefits, payments, or reimbursement from any other third-party payers or similar sources.
  - Bone mass measurement for the prevention, diagnosis and treatment of osteoporosis as described in the policy.
  - Diagnostic testing to determine the cause of infertility or that results in an incidental finding of infertility.
  - Treatment of a terminal condition as described in the policy.
- The limits for listed transplants do not apply to ABMT for breast cancer and BMT or ABMT for Hodgkin's Lymphoma.
- Preexisting Condition means any illness, injury or condition for which medical advice, care or treatment was recommended or received within the 6 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 6 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 6 months immediately prior to the covered person's effective date.

State variations continued
(insurance plans)

Kentucky
Policy Form IST7-P-D-GRI-16

- The Office Visit copay applies to preventive visits for mammograms, cervical or pap smears and colorectal cancer screenings as outlined in the policy. It does not apply to any other preventive visits.
- The covered expenses for surgery, excluding tooth extraction, craniomandibular disorders, malocclusions or disorders of the temporomandibular joint include both surgical and non-surgical treatment. The $10,000 maximum does not apply.
- Covered expenses are expanded to include:
  - Colorectal cancer exams and laboratory tests in accordance with the guidelines published by the American Cancer Society.
  - Diagnosis and treatment of endometriosis or endometritis not including expenses primarily for the treatment of infertility.
  - Bone density testing for a female covered person age 35 years or older to obtain baseline data for the purpose of early detection of osteoporosis.
- Covered expenses for home health aide services for Home Health Care are limited to 60 visits per person, per term. Each visit by an authorized representative of a home health care agency is considered as one visit, except that 4 hours of home health aide services will be considered as one visit.

Montana
Policy Form IST7-P-D-GRI-25

- Under the covered expense for one routine mammography exam during the policy term for each female covered person, the first $70 per mammogram will not be subject to any deductible amount, copayment amount or coinsurance.
- Covered expenses are expanded to include:
  - Well-child care services provided by a single medical practitioner during a single visit for any covered person from birth through age 7, exempt from deductible.
  - Treatment of inborn errors of metabolism as defined in the policy.
  - Pregnancy care services, including at least 48 hours of inpatient hospital care following a vaginal delivery and at least 96 hours inpatient hospital care following a cesarean section for a mother an newborn infant.
  - Diagnosis and treatment of severe mental illness, limited to: schizophrenia, schizoaffective disorder, bipolar disorder, major depression, panic disorder, obsessive-compulsive disorder and autism, subject to the applicable policy limits.
  - Diagnosis and treatment of autism spectrum disorders for a covered person less than age 19 as defined in the policy, limited to a maximum of $50,000 per year for a covered person age 8 or younger and $20,000 per year for a covered person age 9 through 18.
- The exclusion for pregnancy applies to surrogate pregnancy only, unless the surrogate contract fails (covered expenses would include what would have been covered under that surrogacy contract only.)
- The exclusion as a result of the covered person's felony applies only if the person is convicted.
- The exclusion for intentionally self-inflicted bodily harm does not apply.
- The exclusion for any illness or injury incurred as a result of the covered person being intoxicated or under the influence of illegal narcotics or controlled substance does not apply.

State variations continued
(insurance plans)

New Hampshire
Policy Form IST7-P-D-GRI-28R

- The Value Direct plan is not available.
- "Eligible child" includes your child under age 26, regardless of marital status.
- "Illness" includes pregnancy."
- Covered expenses are exanded to include:
  - Nonprescription enteral formulas for the treatment of impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length, or motility of the gastrointestinal tract. The prescribing physician must issue a written order stating that the enteral formula is needed to sustain life, is medically necessary, and is the least restrictive and most cost-effective means for meeting the needs of the covered person.
  - Nonprescription enteral formulas and food products required for a covered person with an inherited disease of amino acids and organic acids. The prescribing physician must issue a written order stating that the enteral formula or food product is medically necessary and is the least restrictive and most cost-effective means for meeting the needs of the covered person. Covered expenses for food products modified to be low in protein are limited to $1,800 per covered person per policy term.
  - Up to $150 per policy term for laboratory fee expenses for human leukocyte antigen testing (also known as histocompatibility locus antigen testing) for use in bone marrow transplantation. The testing must be performed in a facility that is accredited by the American Association of Blood Banks or its successors, or the College of American Pathologists or its successors, or any other national accrediting body with substantially equivalent requirements. The covered person must complete and sign an informed consent at the time of testing that authorizes the use of the test results in the National Marrow Donor Program and acknowledges the covered person's willingness to be a bone marrow donor if a suitable match is found.
  - Treatment of illnesses caused by obesity and morbid obesity, including medically necessary bariatric surgery, for a covered person 18 years of age or older. The treatment must be prescribed by a doctor who has issued a written order stating that the treatment is medically necessary in accordance with the patient qualifications and treatment standards set forth by the American Society for Metabolic and Bariatric Surgery or the American College of Surgeons. Covered expenses under this paragraph include, but are not limited to: pre-operative psychological screening, behavior modification, weight loss, exercise regimens, and nutritional counseling; and post-operative follow-up, overview, and counseling of dietary, exercise, and lifestyle changes.
  - Hearing aids and the related professional services necessary to assess, select, fit, dispense, and service the hearing aids, as needed, limited to $1,500 per hearing aid per ear. The hearing aid must be prescribed and dispensed by a licensed audiologist or hearing instrument specialist.
  - Blood lead tests.
  - Outpatient contraceptive services, including consultations, examinations, and medical services.
  - Diagnosis and treatment of biologically-based mental illnesses. Covered expenses for pervasive developmental disorder or autism include:
    1. Professional services and treatment programs, including applied behavioral analysis, necessary to produce socially significant improvements in human behavior or to prevent loss of attained skill or function. Applied behavioral analysis must be provided or supervised by a person certified by the national Behavior Analyst Certification Board.
    2. Prescribed pharmaceuticals the same as other prescription drugs, if covered by the policy.
    3. Direct or consultative services provided by a licensed psychiatrist, advanced practice registered nurse, psychologist, or clinical social worker.
    4. Services provided by a licensed speech, occupational, or physical therapist.
  - Pregnancy and complications of pregnancy.
  - Services of licensed and credentialed occupational therapists, physical therapists, speech-language pathologists, and clinical social workers working with a covered person from birth to 36 months of age to treat a developmental disability and/or delay. Benefits under this paragraph are limited to a maximum of $3,200 per covered person per policy term and to $9,600 by the covered person's third birthday, exempt from any applicable deductible amount, copayment amount, and coinsurance percentage.

State variations continued
(insurance plans)

New Hampshire, continued

- Covered expenses are expanded to include: (continued)
  - Blood testing for perfluoroalkyls (PFAs) and perfluorinated compound (PFC).
  - Long-term antibiotic therapy for tick-borne illness when determined to be medically necessary and ordered by a licensed infectious disease physician.
- The limit of 60 days per policy term for Rehabilitation and Extended Care Facility benefits does not apply.
- The limit of 2 transplants per person for Transplant Expense Benefit does not apply.
- The exclusion of benefits 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.
- The exclusion of benefits for sterilization does not apply, but the exclusion for reversal of sterilization still applies.
- The exclusion of benefits as a result of any injury sustained during or due to participating, instructing, demonstrating, guiding, or accompanying others in professional or semi-professional sports applies. However, this exclusion does not apply to intercollegiate sports, parachute jumping, hang-gliding, racing or speed testing any motorized vehicle or conveyance, scuba/skin diving (when diving 60 or more feet in depth), skydiving, bungee jumping; or rodeo sports.
- The following exclusions do not apply:
  - 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 eye refractive surgery, when the primary purpose is to correct nearsightedness, farsightedness or astigmatism.
  - 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.
  - Due to pregnancy
  - Resulting from intentionally self-inflicted bodily harm (whether sane or insane); or participation in a riot or felony (whether or not charged).
  - 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 surrogate parenting.
  - For treatments of hyperhidrosis (excessive sweating).
  - For fetal reduction surgery.
  - For non-emergency treatment of tonsils, adenoids, middle ear disorders, hemorrhoids or hernia.
- "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; 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 6 months immediately preceding the covered person's effective date; or a pregnancy existing on the effective date of coverage.

State variations continued
(insurance plans)

North Carolina
Policy Form IST7-P-D-GRI-32

- The covered expenses for surgery, excluding tooth extraction, include diagnostic, surgical and non-surgical treatment of temporomandibular joint disorders (TMJ), including splinting and use of intraoral prosthetic appliances. Non-surgical treatment of TMJ is limited to a maximum of $3500 per covered person per policy term. Non-surgical treatment of TMJ does not include tooth extraction, orthodontic braces, crowns, bridges, dentures, treatment for periodontal disease, dental root implants or root canals.
- The covered expenses for one cervical smear or pap smear also include a human papillomavirus screening.
- The covered expenses for one digital rectal exam and one prostate specific antigen test for each male covered person are not limited to age 40; however, they must be recommended by a licensed doctor.
- Covered Expenses are expanded to include:
  - An annual screening for ovarian cancer using transvaginal ultrasound and rectovaginal pelvic examination for women age 25 and older who: have a family history with at least one first-degree relative with ovarian cancer and a second relative, either first-degree or second-degree with breast, ovarian or nonpolyposis colorectal cancer; or tests positive for a hereditary ovarian cancer syndrome.
  - Colorectal cancer examinations and laboratory tests in accordance with the published American Cancer Society guidelines.
  - General anesthesia and other related charges incurred for dental care (but not including the actual dental services) that is provided in hospital or outpatient surgical facility to the following covered persons, when medically necessary to safely and effectively perform the procedure: an eligible child less than 9 years of age; a covered person with a serious mental or physical condition; or a covered person with significant behavioral problems.
  - The diagnosis and evaluation of osteoporosis or low bone mass for a covered person, as defined in the policy.
  - The screening, diagnosis and treatment of autism spectrum disorder, as defined in the policy. Adaptive behavior treatment is limited to maximum of $40,000 or the limit set by the state of North Carolina.
  - Medically necessary costs of health care services associated with participation in a clinical trial, medically necessary monitoring and the diagnosis and treatment of complications, only to the extent such costs are not funded by national agencies, commercial manufacturers, distributors or other sponsored of participants in the clinical trial. Covered expenses do not include the costs of the actual investigational drug or device, services that are not health care services, services provided solely to satisfy data collection, services not provided for direct clinical management or non-USFDA-approved drugs provided after the clinical trial has been concluded.
  - A newborn hearing screening when ordered by the attending doctor.
  - The diagnosis, evaluation and treatment of lymphedema.
  - One hearing aid per hearing-impaired ear up to $2,500 per hearing aid for a covered person less than 22 years of age, limited to: initial hearing aids and replacement hearing aids not more frequently than every 36 months; a new hearing aid when alterations to the existing hearing aid cannot adequately meet the covered person's needs; and services ordered by a physician or a licensed audiologist.
- The exclusion for expenses as a result of an injury or illness arising out of, or in the course of employment for wage was replaced with exclusion for services or supplies for the treatment of an occupational injury or illness that are paid under the North Carolina Workers' Compensation Act only to the extent such services or supplies are the liability of the employee, employer or workers' compensation insurance carrier according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act.
- The exclusion for any illness or injury incurred as a result of the covered person being intoxicated or under the influence of illegal narcotics or controlled substance does not apply.

State variations continued
(insurance plans)

North Carolina, continued

- "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.

Oklahoma

Policy Form IST7-P-D-GRI-35

- The $2,500 maximum on spine and back disorders does not apply.
- The exclusion for charges incurred as a result of any injury sustained during or due to participating, instructing, demonstrating, guiding or accompanying others in any of the following applies only if the covered person is paid to participate or instruct: professional or semi-professional sports; intercollegiate sports (not including intramural sports); parachute jumping; hang-gliding; racing or speed testing any motorized vehicle or conveyance; scuba/skin diving (when diving 60 or more feet in depth); skydiving; bungee jumping; or rodeo sports.
- The exclusion for charges as a result of an injury or illness caused by an act of war specifically applies to any charges that are incurred while serving in the military or naval services, or any auxiliary unit, of the United States.
- The exclusion for charges for any illness or injury incurred as a result of the covered person being intoxicated does not apply. However, the exclusion still applies for the person being under the influence of illegal narcotics or controlled substance unless administered or prescribed by a doctor.

Utah

Policy Form IST7-P-D-GRI-43R

- The Premier Elite and Value Direct plans are not available.
- Coverage is available for individual adults only. No spouse or dependent can be added to the plan. Any references to spouse or dependent, throughout, do not apply.
- Covered expenses are expanded to include dietary products used for the treatment of inborn errors of amino acid or urea cycle metabolism.
- Rehabilitation services or confinement in a rehabilitation facility or extended care facility is not required to begin within 14 days of a hospital stay of at least 3 consecutive days.
- The following exclusions do not apply:
  - For sterilization or reversals of sterilization.
  - For treatment of malocclusions, disorders of the temporomandibular joint (TMJ) or craniomandibular disorders, except as provided for in the policy.
  - For marriage, family or child counseling.
  - 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 injuries from participation in professional or semi-professional sports or athletic activities for financial gain, as determined by GRIC.
  - For injuries sustained during or due to participating, instructing, demonstrating, guiding, or accompanying others in any of the following 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 any expenses, including for diagnostic testing incurred while confined primarily for well-baby care, except as provided in the policy.
  - 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 surrogate parenting.
  - For fetal reduction surgery.
  - For joint replacement, unless related to an injury covered by the policy.
  - For non-emergency treatment of tonsils, adenoids, middle ear disorders, hemorrhoids or hernia.

State variations continued
(insurance plans)

Utah, continued

- The exclusion for expenses as a result of any injury sustained during or due to participating, instructing, demonstrating, guiding, or accompanying others in certain activities applies only to intercollegiate sports.
- "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; 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 preceding the covered person's effective date.

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.

47004P-G-0225

UnitedHealthcare®
Golden Rule Insurance Co.