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 Hospital & Surgical Plans

Coverage when you need it most

Policy Forms IST7-P-D-GRI-HS and other state variations

UnitedHealthcare®
Golden Rule Insurance Co.

Table of Contents

Why Short Term Medical Hospital & Surgical insurance?

Short Term Medical Hospital & Surgical plans are designed as “just in case” health coverage with hospital and surgical benefits only and last 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
Short application questions help determine if you’re eligible for coverage, and plans are medically underwritten

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

Because life can be unpredictable

Coverage you need
Plans with hospital, surgical and limited urgent care benefits only

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 hospital or medical facility 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
Hospital & surgical plans only

		Hospital & Surgical
Per Person Deductible (per term; max 2 per family)	You pay up to:	**$5,000, $7,500 or $15,000**
Coinsurance (% you pay **after deductible**, per term)	You pay:	**50%**
Coinsurance Out-of-Pocket Maximum (after deductible, per person, per term)	You pay up to:	**$10,000**
Maximum Benefit (per person, per term)	We pay up to:	**$1 million**
Medical		
Urgent Care Center Visit (per person, per term)	You pay:	**$75 copay for first 2 visits**[1]
Emergency Room (Accident and Illness) (additional $500 deductible if not admitted)		**50% after deductible**
Inpatient Hospital Services, Outpatient Surgery		**50% after deductible**
Outpatient Labs & X-rays ($500 max covered expense per person, per term)		**50% after deductible**
Pharmacy		
Outpatient Prescription (Rx) Drugs		**Not Covered** Discount card provided[2]
Optional Benefits		
Add Supplemental Accident Benefit[3] (See page 13)	We pay up to:	**$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 page 6 for details. 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]Subsequent visits are subject to deductible then coinsurance. [2]Discounts vary by pharmacy, geographic area and Rx drug. [3]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

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

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 13 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, contact your broker.

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.

State-specific differences may apply

Covered expenses must be administered by a doctor, medically necessary to the diagnosis or treatment of an injury or illness, and not excluded anywhere in the policy.

Ambulance services

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

Breast reconstruction following mastectomy

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

Emergency treatment

Covered expenses are limited to emergency treatment of an injury or illness. Covered expenses for use of the emergency room are subject to an additional $500 deductible for each emergency room visit for an illness or injury unless the covered person is directly admitted to the hospital for further treatment.

Inpatient benefits

Charges for the following when incurred by a covered person as an inpatient in a hospital.

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

- Daily hospital room and board and nursing services at most common semiprivate rate.
- Eligible daily room and board and nursing service expenses for an intensive care unit.
- Inpatient use of an operating, treatment or recovery room.
- Services and supplies, including drugs and medicines, which are routinely provided in the hospital to persons for use only while they are inpatients.
- Dressings and other necessary medical supplies.
- Diagnostic testing using radiologic, ultrasonographic or laboratory services (psychometric, behavioral and educational testing are not included).
- Radiation therapy and chemotherapy.
- Cost and administration of an anesthetic or oxygen.
- Hemodialysis, processing and administration of blood or components (but not the cost of the actual blood or components).
- Basic artificial limbs, artificial eyes, and larynx and breast prosthesis. Replacement only if required by a physical change in the covered person and the item cannot be modified.
- Professional fees of doctors and medical practitioners.
- Inpatient treatment of a spine or back disorder.

Life-threatening cancer benefit

Covered expenses include outpatient diagnosis and treatment of life-threatening cancer, including surgery, chemotherapy, radiation treatment and medications related to the treatment. In addition, a person receiving treatment for life-threatening cancer also receives the following coverage for illness or injury from the time treatment begins until the covered person's coverage under the policy ends.

Medical benefits continued
(insurance plans)

Life-threatening cancer benefit, continued

- Outpatient office visits for treatment of an illness or injury (excluding surgery) performed by a doctor or medical practitioner.
- Diagnostic testing using radiologic, ultrasonographic or laboratory services (psychometric, behavioral and educational testing are not included).
- Diagnostic procedures.
- Physical therapy.
- Hemodialysis and the charges by a hospital for the processing and administration of blood or blood components.
- Rental of the following durable medical equipment: I.V. stand and I.V. tubing, infusion pump or cassette, portable commode, patient lift, bili-lights and suction machine and suction catheters.
- Dressings, crutches, orthopedic braces and splints, casts or other necessary medical supplies.
- Counseling visits with a licensed mental health counselor.
- Outpatient treatment of a spine or back disorder.
- Outpatient prescription drugs received from a licensed pharmacy for drugs that, under applicable state law, may be dispensed only upon the written prescription of a doctor.

  Covered expenses are limited to the drugs included in the Prescription Drug List ("PDL") provided by our pharmacy benefits manager, OptumRx, at the time your prescription order is filled (formulary drugs). Certain exceptions and exclusions may apply. See policy for details.
- Home health care, including:
  - Home health aide services, 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 (not to exceed 4 hours each) will be limited to $75 per visit.
  - The professional fees of a licensed respiratory, physical, occupational or speech therapist.
  - I.V. medication and pain medication.

Covered expenses for home health care do not include the charges related to respite care, custodial care or educational care.

Outpatient catastrophic medical expenses

Expenses received on outpatient basis are limited to:

- Radiation therapy, one office visit following each round of radiation therapy, and diagnostic testing performed in conjunction with, and on the same day as, the radiation therapy.
- Chemotherapy, including the cost and administration of chemotherapy, and diagnostic testing performed in conjunction with, and on the same day as, the chemotherapy.
- Hemodialysis.
- Basic artificial limbs, artificial eyes, and larynx and breast prosthesis. Replacement only if required by a physical change in the covered person and the item cannot be modified. Angiogram, arteriogram, computerized transverse tomography (CAT scan), echocardiography (transthoracic, real-time with image documentation), electroencephalogram (EEG), magnetic resonance imaging (MRI), myelogram, positron emission tomography (PET scan) and thallium stress test.
- Outpatient prescription drugs that are medically necessary to protect against rejection of an organ transplant, limited to a 34-day supply per prescription order or refill. No benefits will be paid for charges incurred for more than the predetermined managed drug limitations assigned to certain drugs or classification of drugs.
- Dental expenses only when a covered person suffers an injury, after the covered person's effective date of coverage, that results in damage to his or her natural teeth and expenses that are incurred within six months of the accident or as part of a treatment plan that was prescribed by a doctor and began within six months of the accident. **Injury to the natural teeth will not include any injury as a result of chewing.**

Medical benefits continued
(insurance plans)

Outpatient preadmission and presurgical testing (x-ray and lab)

Expenses for diagnostic testing performed before an authorized hospital stay, outpatient surgical procedure or cancer treatment when:

- The charges for the tests would have been covered expenses if the covered person were confined as an inpatient; and
- The tests are not repeated in the hospital or elsewhere.

Limited to maximum covered expenses of $500 per person, per term.

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.

Surgical expenses

Limited to the following when incurred by a covered person for surgery:

- Professional fees of surgeon.
- Assistant surgeon fees, limited to 16% of eligible expenses of the procedure.
- Outpatient use of an operating, treatment or recovery room for surgery.
- Cost and administration of an anesthetic.
- Charges made by an outpatient surgical facility or separate identifiable outpatient unit of a hospital for services and supplies related to an outpatient surgery.
- Post-operative laboratory services necessitated by the surgery.
- Surgical treatment of a spine or back disorder.

Covered surgical expenses do not include tooth extraction or charges for surgery performed in a doctor's office or in any facility other than an outpatient surgical facility or a separate identifiable outpatient unit of a hospital for services and supplies related to outpatient surgery.

Transplant expense benefit

The following transplants are covered the same as any other illness: cornea, artery or vein grafts, heart valve grafts, prosthetic tissue and joint replacement, and prosthetic lenses for cataracts. For all other covered transplants, see the policy for "Listed Transplants" under Transplant Expense Benefits. The covered person must be a good candidate, as determined by us. The transplant must not be experimental or investigational. Covered expenses for "Listed Transplants" are limited to 2 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.
- Procurement or transportation of the organ or tissue, unless expressly provided in this provision.
- Keeping a donor alive for the transplant operation.
- A live donor where the live donor is receiving a transplanted organ to replace the donated organ.
- A transplant under study in an ongoing Phase I or II clinical trial as set forth in the USFDA regulation.

Urgent care

Copay of $75 per office visit for services, including professional services, received at an urgent care center, limited to 2 visits per person, per term. Additional urgent care visits will be subject to the applicable deductible amount and coinsurance percentage.

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.

Policy details

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 modification of the physical body in order to improve psychological, mental or emotional well-being, such as sex change surgery.
- For drugs, treatment or procedures that promote 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 if the fetus were carried to term).
- For treatment of malocclusions, disorders of the temporomandibular joint (TMJ) or craniomandibular disorders.
- For routine well-baby care of a newborn infant.
- 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 hospital room and board and nursing services if admitted on a Friday or Saturday, unless for an emergency, or for medically necessary surgery that is scheduled for the next day.
- For standby availability of a medical practitioner when no treatment is rendered.
- For dental expenses, including braces and oral surgery, except as provided for in the policy.
- For cosmetic treatment.
- For diagnosis or treatment of learning disabilities, attitudinal disorders or disciplinary problems.
- For diagnosis or treatment of nicotine addiction.
- For charges related to, or in preparation for, tissue or organ transplants, except as expressly provided for in the policy.
- 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.

Exclusions/limitations continued
(insurance plans)

General exclusions, continued

No benefits are payable for expenses:

- 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 injuries from participation in professional or semi-professional sports or athletic activities for financial gain, as determined by GRIC.
- For injuries sustained during or due to participating, instructing, demonstrating, guiding or accompanying others in any of the following: sports (professional, or semiprofessional, or intercollegiate), parachute jumping, hang gliding, racing or speed testing any motorized vehicle or conveyance, scuba/skin diving (when diving 60 or more feet in depth), skydiving, bungee jumping or rodeo sports.
- For injuries sustained during or due to participating, instructing, demonstrating, guiding or accompanying others in any of the following if the covered person is paid to participate or to instruct: operating or riding on a motorcycle, racing or speed testing any non-motorized vehicle or conveyance, horseback riding, rock or mountain climbing or skiing.
- For injuries sustained while performing the duties of an aircraft crew member, including giving or receiving training on an aircraft.
- For vocational or recreational therapy, vocational rehabilitation, outpatient speech therapy or occupational therapy, except as provided for in the policy.
- For eyeglasses, contact lenses, hearing aids, eye refraction, visual therapy or any exam or fitting related to these devices.
- Due to pregnancy (except complications).
- For any expenses, including for diagnostic testing, incurred while confined primarily for well-baby care.
- For preventive care or prophylactic care, including routine physical examinations, premarital examinations and educational programs, except as expressly provided for by the policy.
- Resulting from experimental or investigational treatments, or unproven services.
- Incurred outside of the U.S., except for emergency treatment.
- Resulting from or during employment for wage or profit, if covered or required to be covered by workers' compensation insurance under state or federal law. If you entered into a settlement that waives your right to recover future medical benefits under a workers' compensation law or insurance plan, this exclusion will still apply.
- Resulting from declared or undeclared war; intentionally self-inflicted bodily harm (whether sane or insane); or participation in a riot or felony (whether or not charged).
- For or related to durable medical equipment or for its fitting, implantation, adjustment or removal or for complications therefrom, except as provided for in the policy.
- For any service a non-network provider waives, does not pursue or fails to collect any applicable copay, deductible or coinsurance owed.
- Resulting from intoxication, as defined by state law where the illness or injury occurred, or while under the influence of illegal narcotics or controlled substances, unless administered or prescribed by a doctor.
- For or related to surrogate parenting.
- For or related to treatment of hyperhidrosis (excessive sweating).
- For alternative treatments, except as specifically covered by the policy, including: acupressure, acupuncture, aromatherapy, hypnotism, massage therapy, rolfing and other alternative treatments defined by the Office of Alternative Medicine of the National Institutes of Health.
- For joint replacement, unless related to an injury covered by the policy.
- For outpatient diagnosis and treatment of a spine or back disorder.
- For diagnosis and treatment of mental disorders and substance abuse, including court-ordered treatment of substance abuse.
- For home health care, except as expressly provided for by the policy.
- For outpatient prescription drugs, except as specifically provided for by the policy.
- For services or supplies received on an outpatient basis, except as expressly provided for by the policy.
- For non-emergency treatment of tonsils, adenoids, middle ear disorders, hemorrhoids or hernia.

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

Forms SA-S-1996I-GRI and state variations

Reduce or eliminate your out-of-pocket exposure for accident-related injuries 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.

Eligibility

At time of application, the primary insured must be a minimum of 19 years of age.

Eligible expense

An eligible expense means a covered expense as follows:

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

* 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.

Plan provisions continued
(insurance plans)

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.

Non-renewable

Your Short Term Medical policy is not renewable and is issued for a specific period of time. We may cancel coverage if there is fraud or material misrepresentation made by or with the knowledge of a covered person in filing a claim for benefits. Coverage will remain in force until the termination date shown in your policy, unless the policy terminates earlier for any reason stated in the Termination section.

Rating factors

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

Right to examine

It is important to us that you are satisfied with the coverage being provided. This product has a right to examine period, also commonly referred to as “free look.” After applying and after your 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.) 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 the primary insured is the only person on the plan.

State variations
(insurance plans)

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

Georgia
Policy Form IST7-P-D-GRI-HS-10

- Covered expenses for charges incurred in a hospital are expanded to include:
  - Telehealth services for the diagnosis, consultation or treatment of a covered person.
  - Inpatient or surgical treatment, excluding tooth extraction, for the correction of congenital or developed anomalies of the temporomandibular joint (TMJ).
  - Inpatient or surgical treatment to correct functional deformities of the maxilla and mandible.
- Other covered expenses are expanded to include:
  - Child wellness services provided to a covered person from birth until the 6th birthday, exempt from deductible.
  - One routine mammography exam per female covered person, per term, or more often if ordered by doctor.
  - One cervical smear or pap smear per female covered person, per term, or more often if ordered by doctor.
  - One digital rectal exam and one prostate specific antigen (PSA) test per male covered person age 40 or older, per term, or more often if ordered by doctor.
  - 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.
  - Bone mass measurement for the prevention, diagnosis and treatment of osteoporosis as described in the policy.
  - 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.
- The exclusion for outpatient diagnosis or treatment of a spine or back disorder does not apply.
- 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-HS-16

- Covered expenses are expanded to include:
  - Surgical and non-surgical treatment, excluding tooth extraction, of craniomandibular disorders, malocclusions or disorders of the temporomandibular joint (TMJ).
  - One routine mammogram per female covered person, per term and mammograms by medical practitioner referral for covered person diagnosed with breast disease.
  - One cervical smear or pap smear per female covered person, per term.
  - Colorectal cancer exams and lab 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.
- Home Health Care Expense Benefits are covered as outlined in the policy. Covered expenses for home health aide 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. Covered expenses for intermittent private duty registered nurse visits (not more than 4 hours each) will be limited to $75 per visit. No benefits will be payable for charges related to respite care, custodial care or educational care.

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

- Covered expenses are expanded to include:
  - One baseline mammography exam per female covered person age 35-40, per term; one routine mammography every 2 years for each female covered person age 40-50, or more frequently if order by a doctor; and one routine mammography each year for each female covered person over age 50. The first $70 per mammogram will not be subject to any deductible amount, copayment amount or coinsurance.
  - 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.
  - 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.
  - 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-HS-28R

- "Eligible child" includes your child under age 26, regardless of marital status.
- "Illness" includes pregnancy."
- Covered expenses are exanded to include:
  - Diabetes self-management training and education
  - One routine mammography exam during the policy term for each female covered person age 35 years or older
  - 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.

State variations continued
(insurance plans)

New Hampshire, continued

- Covered expenses are expanded to include: (continued)
  - 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.
  - 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.
  - Telehealth services if those services would be covered under this policy if provided in person.
- Outpatient prescription drugs covered under the Life-Threatening Cancer Benefit are expanded:
  - Covered expenses include contraceptive drugs and devices that are approved by the United States Food and Drug Administration and dispensed in a quantity intended to last up to 12 months if prescribed in that quantity. At least one contraceptive drug or device for each method is available without any cost sharing. If a covered person's health care provider recommends a particular FDA-approved contraceptive drug or device based on a medical determination, the prescribed contraceptive drug or device will be covered without any cost sharing.
  - Any applicable deductible amount and/or coinsurance amount for anti-cancer medications administered orally or self-injected will not be higher than any applicable deductible amount and/or coinsurance amount for anti-cancer medications that are injected or administered intravenously by a health care provider. Any applicable deductible amount and/or coinsurance amount for orally administered anti-cancer medications will not exceed $200 per prescription order or refill.
  - The maximum amount a covered person will be required to pay for a 30-day supply of an insulin prescription will not be more than $30. Benefits for prescription insulin are not subject to any deductible amount.
- 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.

State variations continued
(insurance plans)

New Hampshire, continued

- The following exclusions do not apply: (continued)
  - 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.

North Carolina

Policy Form IST7-P-D-GRI-HS-32

- Covered surgical expenses are expanded to include reconstructive surgery incidental to or following surgery for an injury that was covered under the policy or is performed to correct a birth defect in a child who has been covered from birth until date surgery is performed.
- Other covered expenses are expanded to include:
  - Diagnostic, surgical and non-surgical treatment of temporomandibular joint disorders (TMJ). Non-surgical treatment of TMJ is limited to a maximum of $3,500 per covered person, per 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.
  - 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 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.
  - Equipment, supplies, medications, lab procedures and services for treatment of diabetes and self-management training and education.
  - 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.

State variations continued
(insurance plans)

North Carolina, continued

- Other covered expenses are expanded to include: (continued)
  - Low-dose screening mammography as follows:
    - One or more mammograms per term for a woman: who has a personal history of breast cancer; who has a personal history of biopsy-proven benign breast disease; whose mother, sister or daughter has or has had breast cancer; or who has not given birth prior to the age of 30 years.
    - One baseline mammogram for a woman ages 35 through 39.
    - One mammogram every two years for a woman ages 40 through 49 years, or more frequently if recommended by doctor.
    - One mammogram per term for a woman 50 years of age or older.
  - Cervical cancer screening, including exam, lab fee and doctor's interpretation of lab results, in accordance with most recently published American Cancer Society guidelines or guidelines adopted by the North Carolina Advisory Committee on Cancer Coordination and Control.
  - 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.
  - Prostate-specific antigen (PSA) tests for presence of prostate cancer upon recommendation of doctor.
- 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.
- "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-HS-35

- Covered expenses are expanded to include diagnosis and treatment of a spine or back disorder.
- 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.

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.

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