Enhanced Health ProtectorGuard Producer Guide

THIS PRODUCT PROVIDES LIMITED BENEFITS.

HEALTH PROTECTORGUARD IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR THE MINIMUM ESSENTIAL COVERAGE REQUIRED BY THE AFFORDABLE CARE ACT (ACA). LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

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

Not For Consumer Use – All the information in this guide is confidential.

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UnitedHealthcare®
Golden Rule Insurance Co.

Combine straightforward cash benefits for Wellness, Office visits, and Rx services (WORx) with robust benefits for hospital stays and you get Enhanced Health ProtectorGuard (HPG). There's no deductible! Plans pay cash benefits for eligible medical services in key health care areas, helping ease out-of-pocket costs for your clients. Enhanced HPG is designed to meet the "day-to-day" medical needs of your client - doctor visit, Rx refill, wellness visit, just as much as the "what if" larger medical events like hospitalization and surgery. With broader coverage and more competitive set benefit amounts, HPG may just be what your clients are looking for.

Insurance that WORx

Your clients access some health services more frequently. HPG plans offer you a choice of three WORx levels (Wellness, Office Visits, Rx - Prescriptions) that pay cash benefits on many health services Your clients access most often. They can choose the level that balances coverage and cost the best for their need.

Insurance for 'what ifs'

We all worry about life's "what ifs", like "What if I get sick or hurt?" While it can't help with the worries, an HPG plan can help with medical costs. HPG has four levels of hospital, surgical, and lab benefits. Your clients can choose the right amount of coverage to help them with out-of-pocket expenses from things like hospital stays and surgeries.

Designed to help now

Every HPG plan is designed to make health care more accessible & affordable:

- Reduced fees for care with providers in the UnitedHealthcare Choice Plus network (page 12)
- Telehealth services available 24/7/365 through the HealthiestYou app from Teladoc® (page 13)
- Discounts on prescription drugs with the Optum Perks Rx card (page 13)

HPG benefits are paid at a set amount regardless of the cost of covered medical service incurred.

WORx

The WORx (Wellness, Office Visit, Rx - prescription drug) portion of these Health ProtectorGuard plans allows your client to choose a coverage level for more common health care services that works best for your client and their family.

DAY-TO-DAY MEDICAL SERVICES (PER PERSON)

			WORx 1	WORx 2	WORx 3
WELLNESS (after 30-day waiting period)[1]	**Wellness Exam** (maximum per calendar year)	We pay:	$80 per exam (1 exam)	$100 per exam (1 exam)	$125 per exam (1 exam)
	Health Screening Diagnostic Labs (maximum per calendar year)		$25 per test (2 tests)	$50 per test (2 tests)	$100 per test (2 tests)
	Health Screening X-ray (maximum per calendar year)		Not Covered	$50 per test (1 test)	$100 per test (1 test)
	Mammogram[2](females ages 30+) (maximum per calendar year)		$100 per exam (1 exam)	$150 per exam (1 exam)	$150 per exam (1 exam)
	Bone Density Screening(ages 40+) (maximum per calendar year)		Not Covered	Not Covered	$150 per exam (1 exam)
	EKG (ages 40+) (maximum per calendar year)		Not Covered	Not Covered	$100 per test (1 test)
	Stress EKG (ages 40+) (maximum per calendar year)		Not Covered	Not Covered	$125 per test (1 test)
	Colonoscopy Preventive Care (ages 50+) or Any Age if Illness Related (maximum per calendar year)		$300 per exam (1 exam)	$300 per exam (1 exam)	$500 per exam (1 exam)
OFFICE VISITS	**Doctor Office Visits[3]** (for treatment of illness or injury)	We pay:	$80 per visit	$100 per visit	$125 per visit
	Specialist Office Visit/ Urgent Care Visits		$100 per visit	$125 per visit	$150 per visit
	Office Visit with In-Office Surgery in lieu of Doctor/Specialist/Urgent Care Visit		$200 per visit	$225 per visit	$250 per visit
	Maximum Office Visits (Any Type Combined)[2] (per calendar year)		4 visits	5 visits	6 visits
	ADDITIONAL OFFICE VISITS				
	Chiropractic[3] / Physical / Occupational / Speech Therapy Visit (maximum combined per calendar year)	We pay:	Not covered	$35 per visit (10 visits)	$45 per visit (10 visits)
RX DRUGS	**Name Brand Prescription Drugs**	We pay:	$40 per fill	$60 per fill	$60 per fill
	Generic Prescription Drugs		$10 per fill	$10 per fill	$20 per fill
	Maximum Rx Fills (Any Type Combined)[2] (per calendar year)		12 fills	15 fills	20 fills

ALL WORx LEVELS
we pay (per calendar year):

UNDER AGE 18

- $25 each for up to 4 Child Immunizations / Flu Shot
- $10 each for up to 10 Child Allergy Treatments

AGES 18+

- $25 for 1 Annual Adult Flu Shot
- $100 for 1 Pap Smear[2] for Adult Females

AGES 40+

- $100 for 1 PSA Test[2] for Adult Males

Please note that the WORx Wellness benefits, including those listed above, have a 30-day waiting period in most states.[1]

[1]Waiting period does not apply in MD or UT. [2]Increased benefit in Year 2. See page 7. [3]In TN only, Chiropractic Visits are reimbursed as Doctor Office Visits, and the separate Chiropractic Visit benefit under Additional Office Visits does not apply.

HOSPITAL

Combine the WORx benefits with any of these Hospital Benefit options to complete your client's Health ProtectorGuard plan.

CRITICAL MEDICAL SERVICES (PER PERSON)		Choice	Select	Preferred	Premier
Inpatient Hospital Confinement Illness/Injury[1,2] (unlimited days per calendar year)	We pay:	$1,000 per day	$2,000 per day	$3,000 per day	$5,000 per day
Intensive Care Unit (ICU) or Critical Care Unit (CCU)[3] (maximum per calendar year)		$1,000 per day (31 days)	$2,000 per day (31 days)	$3,000 per day (31 days)	$5,000 per day (31 days)
Hospital Admission Benefit - First Inpatient Day[2] (maximum per calendar year)		$1,000 (1 day)	$2,000 per day (1 day)	$3,000 per day (1 day)	$3,000 per day (1 day)
Emergency Room (maximum per calendar year)		$400 per day (1 day)	$500 per day (1 day)	$500 per day (1 day)	$1,000 per day (1 day)
Ground / Water Ambulance	We pay:	$500 per trip	$500 per trip	$1,000 per trip	$1,000 per trip
Air Ambulance		$5,000 per trip	$5,000 per trip	$5,000 per trip	$5,000 per trip
Maximum Ambulance Trips (Any Type Combined) (per calendar year)		2 trips	2 trips	2 trips	2 trips
SURGICAL					
Surgical Procedure (unlimited days per calendar year) **See page 5 for details.**	We pay:	7 Tiers ranging from $250-$25,000	7 Tiers ranging from $500-$50,000	7 Tiers ranging from $500-$50,000	7 Tiers ranging from $500-$50,000
Outpatient Facility (maximum per calendar year)		$1,000 per day (2 days)	$1,000 per day (2 days)	$2,000 per day (3 days)	$2,500 per day (3 days)
OUTPATIENT / LAB					
Outpatient Lab	We pay:	$30 per test	$50 per test	$50 per test	$75 per test
Outpatient X-ray and Other Diagnostic Testing Ultrasound, EKG, EEG, Angiogram, Arteriogram, Thallium Stress Test, and Myelogram		$30 per test	$50 per test	$75 per test	$100 per test
Outpatient Diagnostic and Imaging Tier 2 MRI/PET/CAT Benefit per test		$250 per test	$300 per test	$400 per test	$500 per test
Maximum Outpatient Tests (Any Type Combined) (per calendar year)		4 tests	4 tests	5 tests	5 tests
Oral Chemotherapy: Benefit per month (maximum per calendar year)	We pay:	$1,000 per month (3 months)	$1,000 per month (3 months)	$1,000 per month (3 months)	$1,000 per month (3 months)
Outpatient Chemotherapy, Radiation, & Immunotherapy Non Oral (maximum per calendar year)		$1,000 per day (20 days)	$1,000 per day (40 days)	$2,000 per day (40 days)	$2,000 per day (40 days)

[1] Increased benefit in Year 2, see page 7. [2] Includes Observation Unit stays of 24 hours+ [3] ICU/CCU benefit amounts are in addition to Inpatient Hospital Confinement benefits.

Surgical Benefit Details

How the Surgical Tiers are Determined

Each plan has a 7-tier surgical schedule based on the relative value unit of the procedure being performed. The amount for the respective tier will be paid each day a covered person requires inpatient or outpatient surgery as prescribed by a doctor. If surgery falls under multiple tiers, we will pay the largest amount and if multiple surgeries are performed in a single day, we will pay one amount for the highest tier (greatest benefit amount) procedure.

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

Surgery tier examples are for illustrative purposes only. Specific tier mapping and reimbursement amount is determined by the surgery's CPT code.

Build your client's custom HPG plan

Summary of HPG Plan Options

The WORx and Hospital benefit levels come together to create different combinations of coverage so you can find the plan that is best for your client. Every HPG plan combination offers:

$2 MILLION
CALENDAR YEAR MAXIMUM
per covered person

$5 MILLION
LIFETIME MAXIMUM BENEFIT
per covered person

Health ProtectorGuard Plans

Strongest WORx Benefits

WORx 3	HPG Choice 3	HPG Select 3	HPG Preferred 3	HPG Premier 3
WORx 2	HPG Choice 2	HPG Select 2	HPG Preferred 2	HPG Premier 2
WORx 1	HPG Choice 1	HPG Select 1	HPG Preferred 1	HPG Premier 1

Highest Hospital Benefit Level

Increasing Benefits Over Time

These HPG plans are designed to pay more the longer the plan is in force. With HPG, some key benefits increase during the second year on the plan and stay at that increased benefit as long as your client keeps the plan. How many insurance plans reward loyalty like that?[1]

Increased Hospital Injury Benefit

During the second year of an HPG plan, the inpatient hospital benefit for injury increases 100%.[1] That's twice as much per day for qualifying hospital stays for injury.

Hospital Benefit Paid per day	Year 1	Years 2+
Choice	$1,000	$2,000
Select	$2,000	$4,000
Preferred	$3,000	$6,000
Premier	$5,000	$10,000

Office Visits & Wellness Benefits

HPG might make it easier for your clients to decide to see the doctor or to have that test the doctor keeps suggesting. In year 2, your HPG plan adds:

- 2 additional illness/injury office visits.[1]
- 50% increase to benefits for qualified Pap, Mammogram, or PSA testing.[1]

Office Visits	Year 1	Years 2+
WORx 1	4 visits	6 visits
WORx 2	5 visits	7 visits
WORx 3	6 visits	8 visits

Additional Rx Fills

HPG plan will pay additional benefits in the second year by adding 5 prescription fills to the number of fills your client's plan already has.[1] That's more help for those future Rx drug costs.

Rx Drugs	Year 1	Years 2+
WORx 1	12 fills	17 fills
WORx 2	15 fills	20 fills
WORx 3	20 fills	25 fills

[1] Benefits increase on the 1st day of the next full calendar year after a plan has been in force more than 6 months. If the plan has not been in force more than 6 months, the benefit increase will begin January 1 following 12 consecutive months of coverage. This increase occurs only once. This increase does not apply to Inpatient Reimbursement related to sickness.

Eligibility & Renewability

Eligibility of Applicants

Those eligible for a Health ProtectorGuard insurance plan must meet the following criteria at the time of application:

- Primary insured and spouse must be between 18-60 years of age in DE and MD and 18-64 years of age in all other states (drop off on 65th birthday)
- Have a primary address and be a legal resident in a state where Health ProtectorGuard is available for sale
- Dependent children may be included on the application so long as they are a defined dependent of the primary insured or the spouse of the primary insured and are 0-25 years of age (drop off on 26th birthday).
  A dependent child is defined as a:
  - Natural child
  - Legally adopted child
  - Child placed for adoption
  - Child for whom legal guardianship has been awarded
  - A Child of the Eligible Person for whom the Eligible Person is obligated to provide medical Child support pursuant to a Qualified Medical Support Order.
- Health ProtectorGuard does not allow for “Child Only” plans.

Misstatement of Age, Gender, or Tobacco Use

If the covered person’s age, gender, or use of tobacco has been misstated on the covered person’s application for coverage under the policy, any future premiums will be adjusted and past premiums will be refunded or owed to us based on the correct gender or tobacco status.

If a covered person’s age has been misstated and we would not have issued coverage for that covered person, we will refund the premium paid minus any benefit amounts paid by us, and coverage would be void from the effective date.

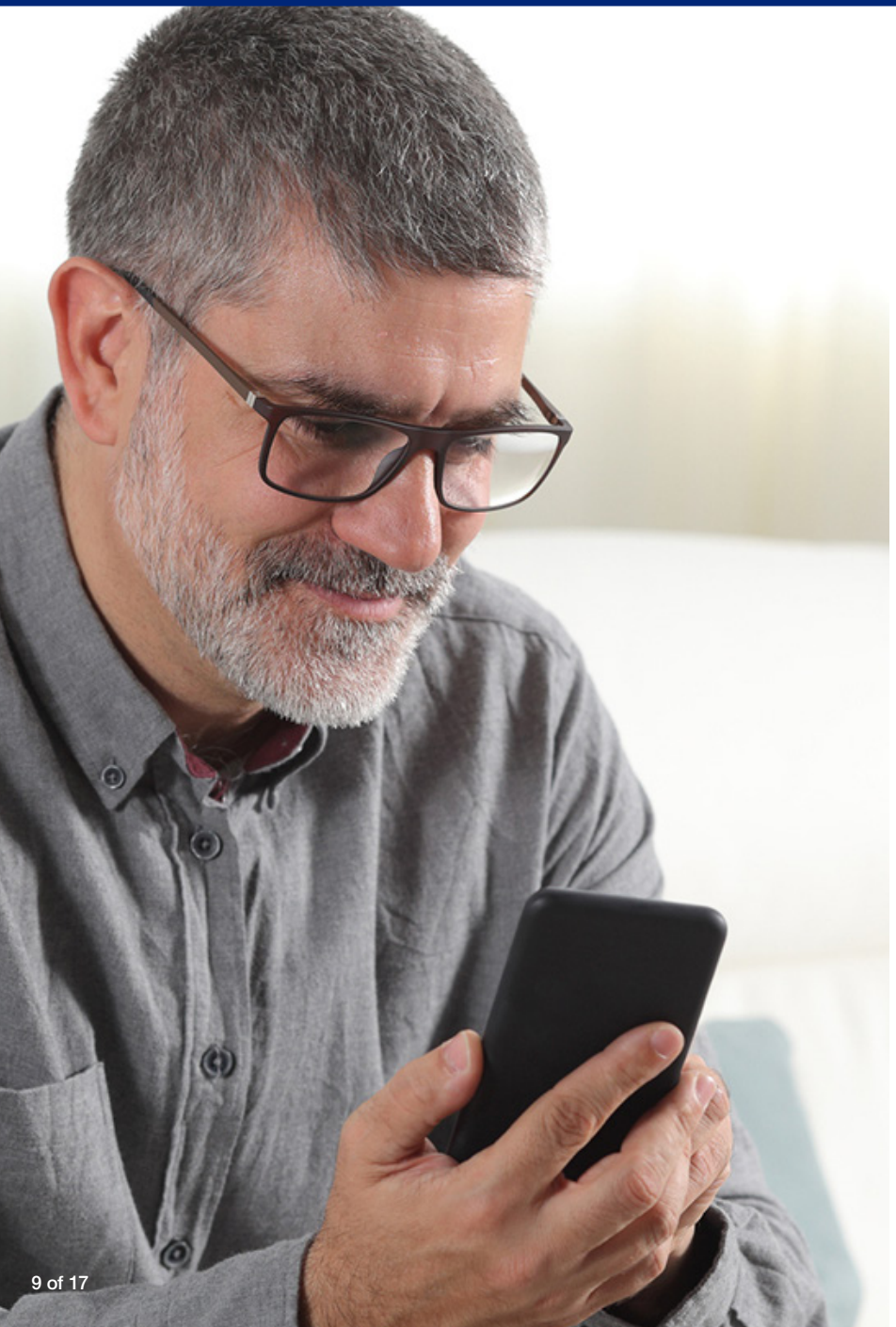
Renewability and Termination

The policy is renewable until the earliest of the following:

- The primary insured’s 65th birthday or death. If the policy includes dependents, it may be continued after the primary insured’s death or 65th birthday:
  - By the spouse, if a covered person
  - Otherwise, by an eligible child who is a covered person;
- Nonpayment of premiums when due.
- The date your client requests to terminate the policy; or
- The date there is fraud or a material misrepresentation made by or with the knowledge of a covered person in filing a claim for policy benefits.

This guide references general terms and conditions of the Health ProtectorGuard product. State variations may apply in some instances. Refer to the product brochure.

Underwriting



Health ProtectorGuard insurance plans are subject to health underwriting. If your client provides incorrect or incomplete information on the application for insurance, coverage may be voided or claims denied.

Height and Weight Chart

- The chart applies to all applicants age 18 and over.
- If an applicant exceeds the weight maximum for their height, coverage will be declined.

Height		Weight Maximum
Feet	Inches	Pounds
4	8	179
4	9	185
4	10	191
4	11	198
5	0	205
5	1	211
5	2	218
5	3	226
5	4	233
5	5	240
5	6	248
5	7	255
5	8	263
5	9	271
5	10	279

Height		Weight Maximum
Feet	Inches	Pounds
5	11	287
6	0	295
6	1	303
6	2	311
6	3	320
6	4	329
6	5	337
6	6	346
6	7	355
6	8	364
6	9	373
6	10	382
6	11	391
7	0	400

Unacceptable Medical Conditions

Please note that some medical conditions present an increased risk we are unwilling to accept.

An automatic decline will likely result if an individual has one or more of these conditions. If surgery is pending or serious ailments exist without a diagnosis, a decline will also occur. Everyone has the right to apply for coverage, and clients who appear unacceptable may apply if they choose.

If, in the last 5 years, your client has been diagnosed with or received medical or surgical care from a member of the medical profession for any of the following, an automatic decline will likely result:

- Acquired AIDS, ARC, HIV infection, or any AIDS related condition
- Alzheimer's or senile dementia
- Amyotrophic lateral sclerosis (ALS or Lou Gehrig's Disease)
- Any cancer (excluding basal cell or squamous cell skin cancer)
- Atrial fibrillation
- Bone marrow transplant
- Bypass/stents/angioplasty
- Carcinoma in Situ
- Cardiomyopathy
- Chronic kidney disease or disorder (not including stones)
- Chronic liver disease including Cirrhosis, Hepatitis B or Hepatitis C
- Chronic obstructive pulmonary disease (COPD) or chronic lung disease
- Congestive heart failure
- Crohn's Disease or Ulcerative Colitis
- Cystic Fibrosis
- Diabetes (except gestational diabetes)
- Disease or disorder of the heart or circulatory system
- Emphysema
- Heart attack
- Heart surgery (including valve replacement or correction)
- Hodgkin's or Non-Hodgkin's Lymphoma
- Implant of pacemaker/defibrillator
- Leukemia
- Multiple Sclerosis
- Muscular Dystrophy
- Organ Transplant (or awaiting an organ transplant)
- Paralysis
- Parkinson's
- Pulmonary fibrosis
- Renal hypertension
- Schizophrenia, bipolar disorder, mood (affective) disorder, or currently taking medication for depression/anxiety that were prescribed by a psychiatrist
- Stroke/Transient ischemic attack
- Systemic lupus erythematous (SLE)
- Thrombosis, embolism or hemophilia

Preexisting Conditions & Waiting Periods

Unacceptable medical conditions, continued

If, in the past 12 months, your client has been diagnosed with or received medical care from a member of the medical profession for, or experienced symptoms of any of the following, an automatic decline will likely result:

- Abnormal Pap smear without normal follow-up pap smear
- Chest pains
- A condition that has yet to be diagnosed
- Recurrent breast tumors or unexplained tumors/growths
- Irregular heartbeat
- Pulmonary hypertension
- Tachycardia
- Uncontrolled hypertension/high blood pressure
- Unexplained dizziness
- Unexplained fatigue
- Unexplained seizures
- Unexplained weight loss
- Vascular insufficiency (circulatory problems)

Preexisting Conditions

The certificate/policy defines preexisting conditions as a disease, accidental bodily injury, illness or condition for which within the 12 months immediately preceding the applicable effective date a covered person received:

- Medical advice,
- Diagnosis,
- Care,
- Treatment or was recommended to or received treatment.

Preexisting conditions also include manifested symptoms which would cause an ordinarily prudent person to seek diagnosis or treatment within the 12 months immediately preceding the applicable effective date the covered person became insured under the policy.

No benefits will be payable for services received in connection with preexisting conditions as defined above until coverage has been in effect for a 12-month period.

The definition of a preexisting condition may vary by state.

Waiting Periods

There is a 30-day waiting period before benefits are payable for any of the Wellness/Preventive Care benefits in all states except MD or UT.

A wide network of care & cost-saving

UnitedHealthcare Choice Plus Network
uhone.com/find-a-doctor

Health ProtectorGuard doesn't stop with the fixed cash payments for covered services. Every HPG plan includes access to the UnitedHealthcare Choice Plus network, to help your clients access more affordable health care services.

Network providers have agreed to offer discounts on covered services which are reflected in your client's final bill. (Discounts for non-covered services are at the provider's discretion.) Discounted costs for services mean your client may be able to reduce their out-of-pocket costs for medical services.

Your clients do not have to use network providers; they may see any licensed doctor or care provider. They may be able to reduce out-of-pocket costs by using providers that have contracted with UnitedHealthcare Choice Plus.

- Health ProtectorGuard benefits are paid the same regardless of which licensed providers your client chooses to use.
- There is no deductible to meet before the insurance plans will pay.
- **There is no coordination of benefits with other forms of insurance, which means your client is paid a fixed amount for a covered service regardless of when or how other health insurance your client may have pays the claim.**
- If your client has a major medical plan, they may need to stay with certain networks and providers to get the most coverage out of that insurance plan.
- Your clients can find a provider in the network by visiting uhone.com or the member portal at uhone4me.com and selecting the "Find a Doctor" link.

How Your Client Receives Benefits

Any time your client receives a covered medical service:

Your client should present their HPG plan ID card to the doctor or other healthcare provider. Claims for covered services are submitted by the doctor who is then paid by the client's insurance plan:

- **In order for the network discount to apply, benefits must be paid to the provider. Your client should ask the provider for the assignment of benefits form.**
- If the payment is less than the claim amount, your client will pay the difference to the provider.
- If the payment is more than the claim amount, after the provider is paid, the remaining benefit is paid to your client by check.

Alternatively, your client may choose to complete a claim form and send it with copies of the doctor's bill to us. A check will be sent directly to your client.

Whether receiving services from a doctor or filling a prescription, your client should refer to the policy for what the plan will pay and use the claim form included in the welcome packet.

Making the decision to stay in-network pays off. The national estimated Choice Plus network discount for 2020 is over 56%.[1]

UnitedHealthcare offers one of the largest networks in the U.S. With 6,500 hospitals and facilities and 1.4 million physicians and health professionals,[2] there's a good chance your choices for where to get care are already included.

[1] Actual discounts may vary based on location, provider mix and service mix. [2] UnitedHealth Group Annual Form 10-K for year ended 12/31/19.

Savings with Telehealth & Rx Discounts

Telehealth - HealthiestYou by Teladoc®[1]
healthiestyou.com

The telehealth benefit provided through HealthiestYou by Teladoc included with HPG makes it easy for your client to see a doctor without leaving their home. Just meet with a doctor by phone or video at no extra charge. They can diagnose and treat common illnesses, and often prescribe medication 24/7/365. No driving. No waiting rooms. No copays. That's access to quality healthcare without the hassle so your client's HealthiestYou can also be their happiest you.

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

Rx Discounts - Optum Perks[2]
perks.optum.com/uho

There's a simple way most can save 30-80% on prescriptions. It's called Optum Perks. Your clients will receive an Optum Perks Rx discount card along with their plan ID card, in the mail. Your client can also visit perks.optum.com/uho to send the discount card to their phone. They can also use this site to compare prescription prices at stores nearby. To take advantage of savings, tell your clients to show their Optum Perks discount card to the pharmacy during purchase. A little card could make a big difference.

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

[1] HealthiestYou by Teladoc® and UnitedHealthcare are not affiliated and each entity is responsible for its own contractual and financial obligations.
[2] Based on pharmacy's usual and customary price. Actual savings may vary.

Benefit Examples

Below are some examples of how Health ProtectorGuard can help your clients pay for medical costs resulting from an illness or injury. Benefits vary by plans and may have maximum benefit levels per calendar year.
Note that claims for services for any preexisting conditions will be denied.
All examples are HPG Select 2 plan (i.e. WORx level 2 and Select hospital benefits option)

Wellness Visit*
Ex: Female, Age 35

Benefit Category	Benefit Payment
Wellness Exam	$100
Health Screening Diagnostic Lab	$50
Mammogram	$150
Pap Smear	$100
Annual Flu Shot	$25
Total Benefit Payment:	**$425**

*30-day waiting period applies to Wellness benefits in all states except MD.

Hospital Confinement, 3 days, with 1 day in ICU
Ex: Pneumonia with complications

Benefit Category	Benefit Payment
Hospital Confinement ($2,00 per day x 3 days)	$6,000
ICU Confinement ($2,000 per day x 1 day) (Paid in addition to hospital confinement)	$2,000
Hospital Admission Benefit (Paid 1x per calendar year, upon first inpatient day)	$2,000
Total Benefit Payment:	**$10,000**

Emergency Room
Ex: Wrist Fracture

Benefit Category	Benefit Payment
Emergency Room Visit	$500
Outpatient X-Ray	$50
Generic Rx for pain medication	$10
Total Benefit Payment:	**$560**

Outpatient Surgery
Ex: Lower Back Disk Surgery

Benefit Category	Benefit Payment
Outpatient Facility Fee	$1,000
Surgeon (Tier 5 Surgery)	$2,500
Anesthesiologist (Tier 5) (30% of Surgery Tier Benefit)	$750
Total Benefit Payment:	**$4,250**

Effective Dates, Payment & Premium

Effective Dates

No insurance will become effective unless your client's application is approved and the appropriate premium is actually received by Golden Rule Insurance Company (GRIC) with the application.

The following rules apply for plan effective dates:

- The earliest effective date is the later of the requested effective date or the day after the received date of the application. If received more than 60 days from the signing date, a new application is required.
- The latest possible requested effective date of coverage is 60 days from the received date of the application.
- The original application is still acceptable 60 days from the sign date for reopens/reconsideration files. If more than 60 days from the sign date, a new application is required.

Proof of Loss

Your client or your client's covered dependent must give us written proof of loss within 90 days of the date of loss or as soon as reasonably possible. Proof of loss furnished more than one year after the date written proof of loss is required to be submitted will not be accepted, unless your client or the client's covered dependent had no legal capacity that year.

Payment

Initial Payment

- There is no application fee.
- Initial Payment must be included with the application in the form of EFT or Credit Card.
- Initial payment will be taken at the time of issue or the plan's effective date, whichever is later.

Payments are due the 1st of the month and this will pay your client's plan to the first of the next month. If your client's effective date is any day other than the first day of the month, then their first payment will be a prorated amount.

Ongoing Payment and Draft Date

The future collection of your client's payment will occur on a date determined by the plan's effective date. Generally, payment draft dates are between the 2nd and the 11th of the month. See the chart below to understand your client's draft date based on their plan's effective date.

Effective Date	New Draft Date
1st of Month	2nd of Month
2nd of Month	3rd of Month
3rd of Month	4th of Month
4th, 11th, 12th or 13th of Month	5th of Month
5th, 14th, or 15th of Month	6th of Month
6th, 16th, 17th or 18th of Month	7th of Month
7th, 19th, 20th, or 21st of Month	8th of Month
8th, 22nd, 23rd, or 24th of Month	9th of Month
9th, 25th, 26th, or 27th of Month	10th of Month
10th or 28th of Month	11th of Month

Premium

Premium rates are guaranteed for 12 months then subject to change. The age, gender, and tobacco class of a covered person and type and level of coverage are some factors that could be used to determine your premium rate. Your client will be given at least a 31-day notice (or longer if required by their state) of any change in premium. We will not make a change in the premium solely because of claims made by a covered person under the policy or a change in a covered person's health.

Upon Issue

Once your client's insurance plan is issued, he or she will receive a welcome packet in the mail that includes the policy and application. Your client should review the following:

- The Policy - It provides details about the benefits payable, as well as the limitations and exclusions.
- The Data Page - It is a summary of your client's specific benefits.
- The Application - To verify that the answers are correct and complete. Incorrect or incomplete information may result in voidance of coverage or claim denial.

Your client will receive two separate IDs in two separate mailings as follows:

- The Member ID Card with Choice Plus Network on it.
- The Optum Perks discount card.

Plan Changes After Issue

Once the policy is issued, the following will apply to your clients:

- Increasing benefits on an existing Health ProtectorGuard plan is not permitted.
- Purchasing an additional Health ProtectorGuard plan (of any generation) is not permitted.
- They may not have both a Health ProtectorGuard and a Hospital SafeGuard or Hospital SafeGuard Premier plan.

If your client wants to switch between insurance plans, they must terminate the existing policy and apply for the other insurance plan as a new applicant. Your client may have to wait 60 days before applying for a new Health ProtectorGuard plan. Waiting periods and preexisting conditions on the new insurance plan will start over.

If your HPG clients struggle with out-of-pocket medical costs, MedCents is available to help.

If after the plan benefits are paid and there is an out-of-pocket portion your clients are responsible for, but find it difficult to manage, remind your HPG clients that they have access to MedCents.

MedCents is a service that will help negotiate remaining patient responsibility with providers to help make paying a little easier. Clients should have a final bill from their provider before seeking these services. Your clients who need assistance should call MedCents at 1-800-835-2140 or email service@medcents.com

Contact Information

FOR YOUR CLIENTS

Customer Service and Hours of Operation
1-800-657-8205
8:00 am – 6:00 pm ET (Monday - Friday)

Member Portal: uhone4me.com

Customer Fax
1-801-478-5461
(Name/address/bank changes, add/delete dependents and cancellation requests can be faxed to this number)

Submit a Claim
Claims Department
PO Box 31374
Salt Lake City, UT
84131-0374
EDI #37602

Claims-Only Fax
1-801-478-7581

UnitedHealthcare Choice Plus Network
uhone.com/find-a-doctor

HealthiestYou
healthiestyou.com

Optum Perks
perks.optum.com/uho

MedCents
1-800-835-2140
service@medcents.com

FOR PRODUCERS

Broker Service Center and Hours of Operation
1-800-474-4467
8:00 am – 6:00 pm ET (Monday - Thursday)
9:00 am – 5:00 pm ET (Friday)

E-Store
www.UHOne.com/Broker

46036-G-0221

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