Short Term Medical Plans

In times of transition and change

States:
GA KY MN
MT NC SD

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Policy Forms IST6.1-P-GRI and other state variations

INTERNET/FMO

This coverage is not required to comply with certain federal market requirements for health insurance, principally those contained in the Affordable Care Act. 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 use disorder services). Your policy might also have lifetime and/or annual dollar limits on health benefits. If this coverage expires or you lose eligibility for this coverage, you might have to wait until an open enrollment period to get other health insurance coverage.

UnitedHealthcare®

Golden Rule Insurance Company

Apr 3 2019 11:52:15 am

Short Term Medical
Understanding How it Works

A Choice of Coverage to Fit Your Specific Needs

You select the coverage term length (minimum of 30 days; maximum term length varies*), then choose your deductible, and coinsurance that fit your budget. See pages 3-4 for a comparison of the plans available. Once you meet your deductible, you pay a percentage of covered expenses (coinsurance) to the coinsurance out-of-pocket maximum amount you selected. Then insurance pays 100% of the remaining covered expenses to the lifetime maximum benefit.

UnitedHealthCare Choice Plus Network Advantages

Receive quality care at reduced costs because the network providers have agreed to lower fees for covered expenses. The large network of doctors and hospitals offer choices across the nation, so even when you're traveling, you're likely to find in-network care. See page 6 for more details.

* See State Variations for term lengths available in your state.

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. **State-specific differences may apply, see State Variations.** Short Term Medical plans do not provide coverage for preexisting conditions and are subject to medical underwriting.

Top Questions

Why should I consider this coverage? These plans can help bridge the gap in coverage if you: (a) must wait until the next Open Enrollment or are waiting for other coverage to begin; (b) are between jobs; (c) retired early; or (d) just graduated college. Keep in mind that you may owe an additional payment on your taxes because these plans are not ACA-compliant.

Is there someplace I can view and keep track of my benefits? Yes, with myUHOne.com you'll have access to your plan benefits and the ability to track your claims online. This member site also allows you to search for providers in your network and print copies of your ID card and policy.

Highlights of Covered Expenses

Network Expenses Shown Below - Per Covered Person, Per Term

Refer to page 6 for information about non-network benefits.

Lifetime Maximum Benefit we will pay (per person):	$600,000 on these plans

Short Term Medical Plans:		Value Select	Plus Select	Copay Select	Plus Elite
Coverage Term Length		Choose length: See State Variations for term lengths available in your state.			
Deductible Type		Per Term (One deductible for selected length of coverage)			
Deductible Amount (per person)	You pay up to:	Choose $1,000[1], $2,500, $5,000, $10,000, or $12,500			
> Option: Add Supplemental Accident Benefit	We pay up to:	$1,000[1], $2,500, $5,000, $10,000, or $12,500 (Choose any amount to help cover your expenses in the case of an accident.)			
Coinsurance (% of covered expenses you pay after deductible)	You pay:	Choose 30% or 40%	Choose 20% or 40%	20%	0%
Coinsurance Out-of-pocket Maximum (after deductible, per person, copays not included)	You pay up to:	Choose $5,000 or $10,000	Choose $2,000, $5,000 or $10,000	$5,000	$0

Doctor Visits[2]

Doctor Office Visit, History, and Exam only	You pay:	Chosen coinsurance after deductible	Chosen coinsurance after deductible	$50 copay[3]	Coinsurance after deductible
Urgent Care Center		$75 copay			

Outpatient[2]

Emergency Room	You pay:	$250 copay, then subject to deductible and coinsurance.
Outpatient Surgery, Labs, X-rays, and PSA Screening		Coinsurance after deductible

Inpatient[2]

Hospital Services	You pay:	Coinsurance after deductible

Pharmacy[2]

Prescription (Rx) Drugs ($3,000 max benefit)	**Not covered.** Discount Card only[4]	**Preferred Price Card & coinsurance after deductible** You pay for prescriptions at the point of sale, at the lowest price available, and submit a claim to us with the Preferred Price Card. Once your plan deductible is met, you then pay only your coinsurance.

[1] $1,000 option not available with the Plus Elite plan.

[2] Expenses for injuries are eligible for coverage as of your plan's effective date; expenses for illnesses are eligible for coverage beginning on the 6th day following the effective date.

[3] Number of visits subject to copay varies by coverage term length. Additional visits subject to deductible and coinsurance. See page 7.

[4] Discount card can help you save an average of 20-25% on your Rx drugs. Discounts vary by pharmacy, geographic area, and drug.

Highlights of Covered Expenses

Network Expenses Shown Below - Per Covered Person, Per Term

Refer to page 6 for information about non-network benefits.

Lifetime Maximum Benefit we will pay (per person):	$2 million on these plans

Short Term Medical Plans:		Value Select A	Plus Select A	Copay Select A	Plus Elite A
Coverage Term Length		Choose length: See State Variations for term lengths available in your state.			
Deductible Type		Per Term (One deductible for selected length of coverage)			
Deductible Amount (per person)	You pay up to:	Choose $1,000[1], $2,500, $5,000, $10,000, or $12,500			
> Option: Add Supplemental Accident Benefit	We pay up to:	$1,000[1], $2,500, $5,000, $10,000, or $12,500 (Choose any amount to help cover your expenses in the case of an accident.)			
Coinsurance (% of covered expenses you pay after deductible)	You pay:	Choose 30% or 40%	Choose 20% or 40%	20%	0%
Coinsurance Out-of-pocket Maximum (after deductible, per person, copays not included)	You pay up to:	Choose $5,000 or $10,000	Choose $2,000, $5,000 or $10,000	$5,000	$0

Doctor Visits[2]

Doctor Office Visit, History, and Exam only	You pay:	Chosen coinsurance after deductible	Chosen coinsurance after deductible	$50 copay[3]	Coinsurance after deductible
Urgent Care Center		$75 copay			

Outpatient[2]

Emergency Room	You pay:	$250 copay, then subject to deductible and coinsurance.
Outpatient Surgery, Labs, X-rays, and PSA Screening		Coinsurance after deductible

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Prescription (Rx) Drugs ($3,000 max benefit)	**Not covered.** Discount Card only[4]	**Preferred Price Card & coinsurance after deductible** You pay for prescriptions at the point of sale, at the lowest price available, and submit a claim to us with the Preferred Price Card. Once your plan deductible is met, you then pay only your coinsurance.

[1] $1,000 option not available with the Plus Elite A plan.

[2] Expenses for injuries are eligible for coverage as of your plan's effective date; expenses for illnesses are eligible for coverage beginning on the 6th day following the effective date.

[3] Number of visits subject to copay varies by coverage term length. Additional visits subject to deductible and coinsurance. See page 7.

[4] Discount card can help you save an average of 20-25% on your Rx drugs. Discounts vary by pharmacy, geographic area, and drug.

Optional Benefits

Available for additional premium.

Supplemental Accident Optional Benefit for All Plans

Form SA-S-1787-GRI and state variations (not available in MN)

Reduce or eliminate your out-of-pocket exposure for accident-related injuries for additional premium. Supplemental Accident helps cover your deductible or other out-of-pocket medical expenses (before the health insurance starts paying covered expenses) for unexpected injuries. You select a maximum amount ($1,000,* $2,500, $5,000, $10,000 or $12,500) per accident, per covered person.

* **Note:** The $1,000 benefit amount is not an option with the Short Term Medical Plus Elite and Plus Elite A plans.

Short Term Medical
Choice Plus Network States

These plans provide access to a network of doctors, hospitals, and other providers that offer you quality health care. You get the most value when you use network providers.

Visit UHOne.com and select Find A Doctor to search for UnitedHealthcare Choice Plus network providers.

Nationwide Network

Use any doctor in the Choice Plus network across the nation. No Primary Care Physician (PCP) required. **Note:** Use network physicians and facilities to get the highest level of benefits from your plan.[1]

Access to Quality Care from:

- Any network specialist without needing a referral.
- 1.3 million physicians and other health care professionals.[2]
- More than 6,000 hospitals and other facilities.[2]

No Balance Billing

The network providers will not balance bill you for eligible expenses. Health care professionals in the network agree to provide you quality care at lower fees.

[1] 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.

[2] UnitedHealth Group Annual Form 10-K for year ended 12/31/18.

Medical Benefits (all plans)

The following medical benefits are provided using network providers and are subject to all policy provisions, the deductible, and any applicable copay or coinsurance (unless otherwise stated). You will find complete coverage details in the policy. See State Variations for differences in the standard benefits below.

Ambulance Services

Ground ambulance service to a hospital for necessary emergency care.

Dental Services

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 as limited in the policy.

Diabetes

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

Diagnostic Testing

Doctor Office Visit Copay (History and Exam only)

Only available with Copay Select and Copay Select A plans.

Available doctor office visits: 1 copay for 30-90 day term, 2 copays for 91-180 day term, or 3 copays for 181+ day term. Additional visits subject to deductible and coinsurance.

Coverage term lengths available vary by state.

Durable Medical Equipment

Rental of wheelchair, hospital bed, and other durable medical equipment.

Home Health Care

Home health care prescribed and supervised by a doctor and provided by a licensed home health care agency. Covered expenses for home health aide services will be limited to 7 visits per week and a lifetime maximum of 365 visits. Benefits for home health care will not extend beyond the term of your plan. Each 8-hour period of home health aide services will be counted as one visit. Private duty registered nurse services will be limited to a lifetime maximum of 1,000 hours. Intermittent private duty registered nurse visits are not to exceed 4 hours each and are limited to $75 per visit (2 hours per visit are applied toward the lifetime maximum of registered nursing).

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

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; emergency treatment of an injury or illness. Covered expenses for use of the emergency room are subject to a copayment of $250 for each emergency room visit.

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.

Medical Benefits, continued (all plans)

Outpatient Surgery

Physician Fees

- Professional fees of doctors, medical practitioners, and surgeons.
- Assistant surgeon fee limited to 20% of eligible expenses of the procedure.

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.

Rehabilitation and Extended Care Facility (ECF)

Must begin within 14 days of a 3-day or longer hospital stay for the same illness or injury. Limited to 60 days per policy term for both rehabilitation and ECF expenses.

Spine and Back Disorders

Benefits for treatment of spine and back disorders limited to $250 per person, per policy term.

Therapeutic Treatments

- Radiation therapy and chemotherapy.
- 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 your 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 during a 10-year period, per covered person.

Golden Rule has arranged for certain hospitals around the country ("Centers of Excellence") to perform specified transplant services. If you use one of our "Centers of Excellence," the specified transplant will be considered the same as any other illness and will include transportation and lodging incentive (for a family member) of up to $5,000. If a "Center of Excellence" is not used, covered expenses for the "Listed Transplant" will be limited to one transplant in any 12-month period with a maximum benefit of $100,000 for all expenses associated with the transplant.

If a "Center of Excellence" is not used, the acquisition cost for the organ or bone marrow is not covered.

No benefits payable for:

- Search and testing in order to locate a suitable donor.
- A prophylactic bone 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.

Short Term Medical State Variations

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

Georgia

Policy Form IST6.1-P-GRI-10

- Coverage term length: 30-360 days.
- Application fee is refundable if coverage is not issued or policy is returned during the Free Look period.
- "Coordination of Benefits (including Medicare)" is deleted and replaced with "Variable Deductible." If you have other coverage that pays hospital, surgical, or medical benefits, including Medicare, we may apply a variable deductible. If the other plan pays more than our plan's yearly deductible for a covered expense, then that amount becomes our plan's variable deductible. The result is that all of your covered, in-network, out-of-pocket expenses are paid by the two policies. Copays not included.
- The $250 limit on the treatment of spine and back disorders does not apply.
- Covered expenses are expanded to include:
  - The following preventive care as described in the policy: routine mammography, cervical or pap smear, digital rectal exam and PSA test, colorectal cancer exam, chlamydia screening and surveillance tests for ovarian cancer.
  - General anesthesia and associated facility charges for dental care to a covered person: who is 7 years of age or younger; who is developmentally disabled; for whom local anesthesia is not an option due to a neurobiological or other medically compromising condition; or who has sustained extensive facial or dental trauma.
  - Evaluation and treatment of Autism Spectrum Disorder for a covered person 6 years of age or younger. Applied behavior analysis expenses limited to $30,000 per person per policy term.
  - Child wellness services from birth until the 6th birthday and exempt from deductible.
  - One hearing aid per hearing impaired ear for an eligible child 18 years or younger, limited to $3,000 per hearing aid.
  - Bone mass measurements for the prevention and treatment of osteoporosis as described in the policy.
  - Surgical and non-surgical treatment, excluding tooth extraction, for the correction of congenital or developed anomalies of the temporomandibular joint.
  - For surgery to correct functional deformities of the maxilla and mandible.

Kentucky

Policy Form IST6.1-P-GRI-16

- Coverage term length: 30-360 days.
- Application fee is refundable if coverage is not issued or policy is returned during the Free Look period.
- Covered expenses are expanded to include surgical and non-surgical treatment, excluding tooth extraction, of craniomandibular disorders, malocclusions, or disorders of the temporomandibular joint.
- Home Health Care Expenses - limited to 60 visits by home health aide services per policy term for each covered person. Each 4-hour period counts as one visit.

Minnesota

Policy Form IST6.1-P-GRI-22

- Coverage term length: 4, 5 or 6 months.
- Application fee is refundable if coverage is not issued or policy is returned in the Free Look period.
- Expenses for illnesses are eligible for coverage on the policy effective date.
- Dependents are expanded to include a child less than 26 (whether or not married) or a grandchild who is financially dependent upon you and who has resided with you continuously from birth. A covered person will not cease to be a dependent eligible child solely because of age if the eligible child is:
  - Not capable of self-sustaining employment due to a mental or physical disability that began before the age limit was reached.
  - Mainly dependent on you for support.
- Minnesota state law prohibits a non-network provider from billing a covered person for the difference between the eligible expense and billed charges in the following situations:
  - When a network provider is not available.
  - If the services were provided by a non-network provider without the covered person's knowledge.
  - Due to the need for unforeseen services arising at the time other services are being rendered.

  In all other situations, non-network providers and non-network facility-based physicians may bill you for any difference between the billed charges and the eligible expense, except when the eligible expense is an amount negotiated with the provider.
- Covered expenses are expanded to include:
  - Child health supervision services (exempt from any deductible amount, copayment amount, and coinsurance percentage.)
  - Prenatal care services (exempt from any deductible amount, copayment amount, and coinsurance percentage.)

State Variations, continued

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

Minnesota, continued

Policy Form IST6.1-P-GRI-22

- Covered expenses are expanded to include:
  - Special dietary treatment for phenylketonuria when recommended by a doctor.
  - Scalp hair prosthesis worn for hair loss as a result of alopecia areata, limited to one prosthesis per covered person.
  - One routine mammogram per covered person.
  - Surveillance tests for ovarian cancer for a covered person who is at risk for ovarian cancer.
  - One pap smear per covered person.
  - Colorectal cancer screening tests, when ordered or provided by a doctor.
  - Prostate cancer screening, including a prostate-specific antigen test and a digital rectal examination, for men 40 years of age or older who are symptomatic or at high risk and for all men 50 years of age or older.
  - Elimination or maximum feasible treatment of port-wine stains.
  - Anesthesia and hospital charges for dental care provided to a covered person who:
    - » Is an eligible child less than 5 years of age;
    - » Is severely disabled; or
    - » Has a medical condition that requires hospitalization or general anesthesia for dental care treatment.
  - General anesthesia and treatment rendered by a dentist for a medical condition covered by the policy, whether the services are provided in a hospital or a dental office.
  - Telemedicine.
  - Hearing aids for a covered person age 18 years or younger for hearing loss that is not correctable by other covered procedures. Covered expenses are limited to one hearing aid per ear every three years.
  - Medical and dental treatment of cleft lip and cleft palate, including orthodontic treatment and oral surgery, for an eligible child covered under the policy.
  - Treatment of Lyme disease.
  - Routine patient costs incurred by a qualified individual participating in an approved clinical trial if those costs would otherwise be covered by the policy if not participating in an approved clinical trial.
  - Nonsurgical treatment of craniomandibular disorders, malocclusions, or disorders of the temporomandibular joint.
- Home Health Care expense benefits are expanded to include: Up to 120 hours of communicator or interpreter services provided by a private-duty registered nurse or home health aide for a covered person who is ventilator dependent, during the time the person is confined in a hospital, in order to assure that the hospital staff is adequately trained to communicate with the covered person and to understand the covered person's unique comfort, safety, and personal care needs.
- The exclusion for modification of physical body does not apply if medically necessary for the treatment of gender dysphoria.
- The exclusion for intentionally self-inflicted bodily harm does not apply if as a result of suicide or attempted suicide.
- The exclusion for an expense as a result of the covered person's commission of a felony includes the attempt to commit a felony or to which a contributing cause was the covered person's being engaged in an illegal occupation.
- The exclusion for illness or injury as a result of intoxication does not apply. Illness or injury incurred as a result of the covered person being under the influence of illegal narcotics or controlled substance unless administered or prescribed by a doctor is excluded.
- "Emergency" means an unforeseen or sudden medical condition manifesting itself by acute signs or symptoms, including severe pain, that would cause a reasonable layperson to believe that death or serious disability could occur if medical attention is not provided before the next working day or next available clinic appointment.
- The optional Supplemental Accident Benefit is not available.

Montana

Policy Form IST6.1-P-GRI-25R

- Coverage term length: 30-184 days.
- Effective date requested for policy cannot be more than 30 days from the date of application.
- Covered expenses are expanded to include:
  - Diagnosis and treatment of severe mental illness.
  - Diagnosis and treatment of autism spectrum disorders for covered persons under age 19.
  - Preventive care is expanded, as defined in the policy.
- The exclusion for treatment of mental disorders, or court-ordered treatment for substance abuse is amended to add the exception for covered expenses for severe mental illness as expressly provided by policy.
- The exclusion for self-inflicted bodily harm does not apply.

State Variations, continued

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

Montana, continued

Policy Form IST6.1-P-GRI-25R

- The exclusion for 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 does not apply.
- The exclusion due to pregnancy does not apply.
- Medical practitioner also means acupuncturist, speech therapist or occupational therapist.

North Carolina

Policy Form IST6.1-P-GRI-32

- Coverage term length: 30-360 days.
- "Coordination of Benefits (including Medicare)" is deleted and replaced with "Variable Deductible." If you have other coverage that pays hospital, surgical, or medical benefits, we may apply a variable deductible. If the other plan pays more than our plan's yearly deductible for a covered expense, then that amount becomes our plan's variable deductible. The result is that all of your covered, in-network, out-of-pocket expenses are paid by the two policies. Copays not included.
- There is an out-of-pocket maximum for non-network providers that is equal to two times the network out-of-pocket maximum.
- The definition of complications of pregnancy includes medically necessary fetal reduction.
- Covered expenses are expanded to include:
  - General anesthesia, facility fees, and other related charges incurred in conjunction with dental care (but not the actual dental services) provided in a hospital or an outpatient surgical facility, when medically necessary to safely and effectively perform the procedure, for: an eligible child under 9 years of age; covered persons with serious mental or physical conditions or with significant behavioral problems.
  - Diagnosis and evaluation of osteoporosis or low bone mass for qualified individuals.
  - A newborn hearing screening when ordered by the attending doctor.
  - An annual screening for ovarian cancer using a transvaginal ultrasound and rectovaginal pelvic examination for women age 25 and older who are at risk for ovarian cancer.
  - Medically necessary costs of health care services associated with a clinical trial, medically necessary monitoring, and the diagnosis and treatment of complications to the extent these costs are not funded by national agencies, commercial manufacturers, distributors or other sponsors of participants in the clinical trial. Covered expenses do not include clinical trial 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.
  - Mammography screenings. Specific details in policy at issue.
  - One annual FDA-approved test or screening for the detection of the human papillomavirus (HPV).
  - Diagnosis, evaluation, and treatment of lymphedema, including equipment, supplies, complex decongestive therapy, and self-management training.
  - 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 lifetime maximum of $3,500 per covered person. Non-surgical treatment of TMJ disorders does not include tooth extraction, orthodontic braces, crowns, bridges, dentures, treatment for periodontal disease, dental root implants, or root canals.
  - Colorectal cancer exams and lab tests in accordance with American Cancer Society guidelines.
  - One digital rectal exam and one PSA test, upon the recommendation of a doctor.
  - Screening, diagnosis, and treatment of autism spectrum disorder.
  - One hearing aid per ear up to $2,500 per hearing aid for a covered person less than 22 years of age.
- The exclusion for expenses incurred due to an injury or illness arising out of, or in the course of, employment for wage or profit is hereby deleted and replaced with the following: Covered expenses will not include services or supplies for the treatment of an occupational injury or illness which is 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.

State Variations, continued

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

North Carolina, continued

Policy Form IST6.1-P-GRI-32

- The exclusion for expenses resulting from intoxication or while under the influence of illegal narcotics or a controlled substance, does not apply.
- "Emergency" means a medical condition manifesting itself by acute symptoms of sufficient severity, including, but not limited to, severe pain, or by acute symptoms developing from a chronic medical condition that would lead a prudent layperson, possessing an average knowledge of health and medicine, to reasonably expect the absence of immediate medical attention to result in any of the following: a. Placing the health of an individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy; b. Serious impairment to bodily functions; or c. Serious dysfunction of any bodily organ or part.
- The definition of preexisting condition is replaced with: Preexisting condition means those conditions for which medical advice, diagnosis, care or treatment was received or recommended, or a condition that had manifested itself, within the one-year period immediately preceding the effective date of a person's coverage; or a pregnancy existing on the effective date of coverage.

South Dakota

Policy Form IST6.1-P-GRI-40

- Coverage term length: 30-180 days.
- Application fee is refundable if coverage is not issued or policy is returned in the Free Look period.
- The spine and back disorders limit does not apply to MRI and CAT scan expenses.
- The maximum age of an eligible child is 30.
- "Emergency" means the sudden and, at the time, unexpected onset of a health condition that requires immediate medical attention if failure to provide medical attention would result in: serious impairment to bodily functions; serious dysfunction of a bodily organ or part; or placing the covered person's health in serious jeopardy.
- The covered expense for dental expenses from an injury that results in damage to teeth includes teeth that have had minor dental work.
- The covered expense for equipment and supplies for treatment of diabetes includes medical nutrition therapy.
- Covered expenses are expanded to include:
  - Inpatient treatment of alcoholism in a licensed hospital or residential primary treatment facility that is using an approved program pursuant to the diagnosis and recommendation of a doctor. Benefits under this paragraph are limited to 30 days per covered person.
  - Testing, diagnosis, and treatment of phenylketonuria, limited to: Dietary management; Formulas; Case management; Intake and screening; Assessment; and Comprehensive care planning and service referral.
  - Diagnostic screening for prostate cancer, including a digital rectal examination and a prostate-specific antigen test, for a male covered person who is: Age 50 years or older and is asymptomatic; or Age 45 years or older and at high risk for prostate cancer.
  - For a male covered person of any age who has a prior history of prostate cancer, a digital rectal examination, a prostate-specific antigen test, and a bone scan at intervals recommended by a doctor.
  - Anesthesia and hospital charges for dental care provided in a hospital or a dental office to a covered person who is a child less than 5 years of age or is severely disabled or otherwise suffers from a developmental disability, as determined by a licensed doctor, which places the person at serious risk.
- The exclusion for services performed by a member of covered person's immediate family does not apply if the immediate family member is the only doctor in the covered person's area and the services are provided within the scope of his or her license.
- The exclusion for any services not identified and included as covered expenses under the policy 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 narcotics does not apply.
- In the definition of a preexisting condition, a condition for which medical advice, diagnosis care, or treatment was recommended or received was modified to be within 12 months immediately preceding the date the covered person became insured under the policy. The rest of the definition remains the same.
- The prescription drug exclusion for drugs labeled "Caution - limited by federal law to investigational use" does not apply to a prescription drug for the treatment of cancer or a life-threatening condition that has not been approved by the U.S. Food and Drug Administration for that indication if the drug is recognized for treatment of that indication in one of the standard reference compendia or in medical literature.

What's not covered (all plans)

This is only a general outline of the coverage provisions and exclusions. It is not an insurance contract, nor part of the insurance policy. You will find complete coverage details in the policy. Also see State Variations.

General Exclusions

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 — A condition: (1) for which medical advice, diagnosis, care, or treatment was recommended or received within the 24 months immediately preceding the date the covered person became insured under the policy; (2) that had manifested itself in such a manner that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment within the 12 months immediately preceding the date the covered person became insured under the policy; or (3) a pregnancy existing on the effective date of coverage will also be considered a preexisting condition.

  NOTE: Even if you have had prior Golden Rule 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.
- Incurred while your coverage is not in force.
- 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 that are not covered 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.
- For 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 expressly provided for by 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 reconstructive surgery unless incidental to or following surgery or for a covered injury, or to correct a birth defect in a child who has been a covered person since childbirth until the surgery.
- 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 under Transplant Services.
- For injuries from participation in professional or semi-professional sports or athletic activities for financial gain, as determined by Golden Rule.

What's not covered, continued (all plans)

General Exclusions, continued

No benefits are payable for expenses:

- For high-dose chemotherapy prior to, in conjunction with, or supported by ABMT/BMT, except as specifically provided under the Transplant Expense Benefits provision.
- 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), except as provided in the policy.
- For diagnostic testing while confined primarily for well-baby care, except as provided in the policy.
- For treatment of mental disorders, or court-ordered treatment for substance abuse.
- 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 outpatient prescription drugs, except as provided for in the policy.
- For surrogate parenting.
- For treatments 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.
- 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 non-emergency treatment of tonsils, adenoids, hemorrhoids or hernia.
- For injuries sustained during or due to participating, instructing, demonstrating, guiding, or accompanying others in any of the following: sports (professional, or semi-professional, 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.
- Resulting from experimental or investigational treatments, or unproven services.

Other Details (all plans)

Coordination of Benefits (including Medicare)

If after coverage is issued, a covered person becomes insured under another health plan or Medicare, benefits will be determined under the Coordination of Benefits (COB) clause.

COB allows two or more plans to work together so the total amount of all benefits is never more than 100% of covered expenses. COB also takes into account medical coverage under auto insurance contracts. To determine which plan is primary, refer to "order of benefits" in the policy.

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.

Effective Date

Expenses for injuries are eligible for coverage as of your plan's effective date; expenses for illnesses are eligible for coverage beginning on the 6th day following the effective date. Your policy will take effect on the later of:

- The requested effective date on your application; or
- The day after the postmark date affixed by the U.S. Postal Service,* 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. You have answered "no" to question 2 (if other questions are answered "yes," we will exclude the person(s) listed);

  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 Golden Rule.

* 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 date received by Golden Rule. 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 Golden Rule.

** Your account will be immediately charged.

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 an unforeseen or sudden medical condition manifesting itself by acute signs or symptoms which could reasonably result in death or serious disability if medical attention is not provided within 24 hours.

Non-Renewable

Your Short Term Medical policy is not renewable. 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.

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 date we receive a request from you to terminate the policy.
- The date there is fraud or material misrepresentation made by or with the knowledge of a covered person filing a claim for benefits.

HEALTH PLAN NOTICE OF PRIVACY PRACTICES
MEDICAL INFORMATION PRIVACY NOTICE

(Effective January 1, 2018)

We (including our affiliates listed at the end of this notice) are required by law to protect the privacy of your health information. We are also required to send you this notice, which explains how we may use information about you and when we can give out or "disclose" that information to others. You also have rights regarding your health information that are described in this notice. We are required by law to abide by the terms of this notice.

The terms "information" or "health information" in this notice include any information we maintain that reasonably can be used to identify you and that relates to your physical or mental health condition, the provision of health care to you, or the payment for such health care. We will comply with the requirements of applicable privacy laws related to notifying you in the event of a breach of your health information.

We have the right to change our privacy practices and the terms of this notice. If we make a material change to our privacy practices, we will provide to you in our next annual distribution, either a revised notice or information about the material change or how to obtain a revised notice. We will provide this information either by direct mail or electronically in accordance with applicable law. In all cases, we will post the revised notice on our websites, such as *www.uhone.com, www.myuhone.com, www.myallsavers.com, or www.myallsaversmember.com.* We reserve the right to make any revised or changed notice effective for information we already have and for information that we receive in the future.

We collect and maintain oral, written and electronic information to administer our business and to provide products, services and information of importance to our customers. We maintain physical, electronic and procedural security safeguards in the handling and maintenance of our enrollees' information, in accordance with applicable state and Federal standards, to protect against risks such as loss, destruction or misuse.

How We Use or Disclose Information. We must use and disclose your health information to provide information:

- To you or someone who has the legal right to act for you (your personal representative) in order to administer your rights as described in this notice; and
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected.

We have the right to use and disclose health information for your treatment, to pay for your health care and operate our business. For example, we may use or disclose your health information:

- **For Payment** of premiums due us, to determine your coverage and to process claims for health care services you receive including for subrogation or coordination of other benefits you may have. For example, we may tell a doctor whether you are eligible for coverage and what percentage of the bill may be covered.
- **For Treatment.** We may use or disclose health information to aid in your treatment or the coordination of your care. For example, we may disclose information to your physicians or hospitals to help them provide medical care to you.
- **For Health Care Operations.** We may use or disclose health information as necessary to operate and manage our business activities related to providing and managing your health care coverage. For example, we might conduct or arrange for medical review, legal services, and auditing functions, including fraud and abuse detection or compliance programs. We may also de-identify health information in accordance with applicable laws. After that information is de-identified, the information is no longer subject to this notice and we may use the information for any lawful purpose.
- **To Provide Information on Health Related Programs or Products** such as alternative medical treatments and programs or about health-related products and services.
- **To Plan Sponsors.** If your coverage is through an employer group health plan, we may share summary health information and enrollment and disenrollment information with the plan sponsor. In addition, we may share other health information with the plan sponsor for plan administration if the plan sponsor agrees to special restrictions on its use and disclosure of the information in accordance with Federal law.
- **For Underwriting Purposes.** We may use or disclose your health information for underwriting purposes; however, we will not use or disclose your genetic information for such purposes.
- **For Reminders.** We may use or disclose health information to contact you for appointment reminders with providers who provide medical care to you.

We may use or disclose your health information for the following purposes under limited circumstances:

- **As Required by Law.** We may disclose information when required to do so by law.
- **To Persons Involved With Your Care.** We may use or disclose your health information to a person involved in your care, such as a family member, when you are incapacitated or in an emergency, or when you agree or fail to object when given the opportunity. If you are unavailable or unable to object we will use our best judgment to decide if the disclosure is in your best interests. Special rules apply regarding when we may disclose health information to family members and others involved in a deceased individual's care. We may disclose health information to any persons involved, prior to the death, in the care or payment for care of a deceased individual, unless we are aware that doing so would be inconsistent with a preference previously expressed by the deceased.
- **For Public Health Activities** such as reporting disease outbreaks to a public health authority.
- **For Reporting Victims of Abuse, Neglect or Domestic Violence** to government authorities, including a social service or protective service agency.
- **For Health Oversight Activities** such as licensure, governmental audits and fraud and abuse investigations.
- **For Judicial or Administrative Proceedings** such as in response to a court order, search warrant or subpoena.
- **For Law Enforcement Purposes** such as providing limited information to locate a missing person or report a crime.
- **To Avoid a Serious Threat to Health or Safety** by, for example, disclosing information to public health agencies or law enforcement authorities, or in the event of an emergency or natural disaster.

- **For Specialized Government Functions** such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
- **For Workers' Compensation** including disclosures required by state workers' compensation laws that govern job-related injury or illness.
- **For Research Purposes** such as research related to the prevention of disease or disability, if the research study meets Federal privacy law requirements.
- **To Provide Information Regarding Decedents.** We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as necessary to carry out their duties.
- **For Organ Procurement Purposes.** We may use or disclose information to entities that handle procurement, banking or transplantation of organs, eyes or tissue to facilitate donation and transplantation.
- **To Correctional Institutions or Law Enforcement Officials** if you are an inmate of a correctional institution or under the custody of a law enforcement official, but only if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
- **To Business Associates** that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. Our business associates are required, under contract with us and pursuant to Federal law, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract and as permitted by Federal law.
- **Additional Restrictions on Use and Disclosure.** Certain Federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. "Highly confidential information" may include confidential information under Federal laws governing alcohol and drug abuse information and genetic information as well as state laws that often protect the following types of information: HIV/AIDS; mental health; genetic tests; alcohol and drug abuse; sexually transmitted diseases and reproductive health information; and child or adult abuse or neglect, including sexual assault.

If a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to us, it is our intent to meet the requirements of the more stringent law.

Except for uses and disclosures described and limited as set forth in this notice, we will use and disclose your health information only with a written authorization from you. This includes, except for limited circumstances allowed by Federal privacy law, not using or disclosing psychotherapy notes about you, selling your health information to others or using or disclosing your health information for certain promotional communications that are prohibited marketing communications under Federal law, without your written authorization. Once you give us authorization to release your health information, we cannot guarantee that the person to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization, except if we have already acted based on your authorization. To revoke an authorization, call the phone number listed on your health plan ID card.

What Are Your Rights. The following are your rights with respect to your health information.

- **You have the right to ask to restrict** uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures to family members or to others who are involved in your health care or payment for your health care. We may also have policies on dependent access that may authorize certain restrictions. **Please note that while we will try to honor your request and will permit requests consistent with our policies, we are not required to agree to any restriction.**
- **You have the right to ask to receive confidential communications** of information in a different manner or at a different place (for example, by sending information to a PO Box instead of your home address). We will accommodate reasonable requests where a disclosure of all or part of your health information otherwise could endanger you. In certain circumstances, we will accept verbal requests to receive confidential communications; however, we may also require you to confirm your request in writing. In addition, any request to modify or cancel a previous confidential communication request must be made in writing. Mail your request to the address listed below.
- **You have the right to see and obtain a copy** of health information that we maintain about you such as claims and case or medical management records. If we maintain your health information electronically, you will have the right to request that we send a copy of your health information in an electronic format to you. You can also request that we provide a copy of your information to a third party that you identify. In some cases you may receive a summary of this health information. You must make a written request to inspect and copy your health information or have it sent to a third party. Mail your request to the address listed below. In certain limited circumstances, we may deny your request to inspect and copy your health information. If we deny your request, you may have the right to have the denial reviewed. We may charge a reasonable fee for any copies.
- **You have the right to ask to amend information** we maintain about you such as claims and case or medical management records, if you believe the health information about you is wrong or incomplete. Your request must be in writing and provide the reasons for the requested amendment. Mail your request to the address listed below. If we deny your request, you may have a statement of your disagreement added to your health information.
- **You have the right to receive an accounting** of certain disclosures of your information made by us during the six years prior to your request. This accounting will not include disclosures of information: (i) for treatment, payment, and health care operations purposes; (ii) to you or pursuant to your authorization; and (iii) to correctional institutions or law enforcement officials; and (iv) other disclosures for which Federal law does not require us to provide an accounting.

- **You have the right to a paper copy of this notice.** You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. In addition, you may obtain a copy of this notice at our websites such as *www.uhone.com, www.myuhone.com, www.myallsavers.com, or www.myallsaversmember.com.*

  You have the right to be considered a protected person. *(New Mexico only) A "protected person" is a victim of domestic abuse who also is either: (i) an applicant for insurance with us; (ii) a person who is or may be covered by our insurance; or (iii) someone who has a claim for benefits under our insurance.*

Exercising Your Rights

- **Contacting your Health Plan.** If you have any questions about this notice or want to exercise any of your rights, you may contact a UnitedHealthOne Customer Call Center Representative. For Golden Rule members call us at 800-657-8205 (TTY 711). For All Savers members, call us at 1-800-291-2634 (TTY 711).
- **Filing a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with us at the address listed below.
- **Submitting a Written Request.** Mail to us your written requests to exercise any of your rights, including modifying or cancelling a confidential communication, requesting copies of your records, or requesting amendments to your record at the following address:
- Privacy Manager, 7440 Woodland Drive, Indianapolis, IN 46278-1719
- **You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint.** We will not take any action against you for filing a complaint.

Fair Credit Reporting Act Notice. In some cases, we may ask a consumer-reporting agency to compile a consumer report, including potentially an investigative consumer report, about you. If we request an investigative consumer report, we will notify you promptly with the name and address of the agency that will furnish the report. You may request in writing to be interviewed as part of the investigation. The agency may retain a copy of the report. The agency may disclose it to other persons as allowed by the Federal Fair Credit Reporting Act.

We may disclose information solely about our transactions or experiences with you to our affiliates.

MIB. In conjunction with our membership in MIB, Inc., formerly known as Medical Information Bureau (MIB), we or our reinsurers may make a report of your personal information to MIB. MIB is a not-for-profit organization of life and health insurance companies that operates an information exchange on behalf of its members.

If you submit an application or claim for benefits to another MIB member company for life or health insurance coverage, the MIB, upon request, will supply such company with information regarding you that it has in its file.

If you question the accuracy of information in the MIB's file, you may seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. Contact MIB at: MIB, Inc., 50 Braintree Hill Park Ste. 400, Braintree, MA 02184-8734, 1-866-692-6901, *www.mib.com*.

FINANCIAL INFORMATION PRIVACY NOTICE

(Effective January 1, 2018)

We (including our affiliates listed at the end of this notice) are committed to maintaining the confidentiality of your personal financial information. For the purposes of this notice, "personal financial information" means information, other than health information, about an insured or an applicant for coverage that identifies the individual, is not generally publicly available and is collected from the individual or is obtained in connection with providing coverage to the individual.

Information We Collect. Depending upon the product or service you have with us, we may collect personal financial information about you from the following sources:

- Information we receive from you on applications or other forms, such as name, address, age, medical information and Social Security number;
- Information about your transactions with us, our affiliates or others, such as premium payment and claims history; and
- Information from a consumer reporting agency.

Disclosure of Information. We do not disclose personal financial information about our insureds or former insureds to any third party, except as required or permitted by law. For example, in the course of our general business practices, we may, as permitted by law, disclose any of the personal financial information that we collect about you, without your authorization, to the following types of institutions:

- To our corporate affiliates, which include financial service providers, such as other insurers, and non-financial companies, such as data processors;
- To nonaffiliated companies for our everyday business purposes, such as to process your transactions, maintain your account(s), or respond to court orders and legal investigations; and
- To nonaffiliated companies that perform services for us, including sending promotional communications on our behalf.

We restrict access to personal financial information about you to employees, affiliates and service providers who are involved in administering your health care coverage or providing services to you. We maintain physical, electronic and procedural safeguards that comply with Federal standards to guard your personal financial information.

Confidentiality and Security. We maintain physical, electronic and procedural safeguards, in accordance with applicable state and Federal standards, to protect your personal financial information against risks such as loss, destruction or misuse. These measures include computer safeguards, secured files and buildings, and restrictions on who may access your personal financial information.

Questions About this Notice. If you have any questions about this notice, you may contact a UnitedHealthOne Customer Call Center Representative. For Golden Rule members call us at 800-657-8205 (TTY 711). For All Savers members, call us at 1-800-291-2634 (TTY 711).

The Notice of Privacy Practices, effective January 1, 2018, is provided on behalf of All Savers Insurance Company; All Savers Life Insurance Company of California; Golden Rule Insurance Company; Oxford Health Insurance, Inc.; UnitedHealthcare Insurance Company; and UnitedHealthcare Life Insurance Company.

To obtain an authorization to release your personal information to another party, please go to the appropriate website listed in this Notice.

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 70 years. Plans are administered by United Healthcare Services, Inc.

Golden Rule Insurance Company is rated "A" (Excellent) 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.

Your short term major medical policy is not renewable.
We will notify you in advance of any changes in coverage or benefits. $20 application fee is required. This fee is nonrefundable in most states. (See State Variations for exceptions.)

* As of 06/21/18. For the latest rating, access www.ambest.com.

45072P-G-0419

UnitedHealthcare®
Golden Rule Insurance Company

Apr 3 2019 11:52:15 am

Golden Rule Insurance Company
7440 Woodland Drive
Indianapolis, IN 46278-1719
For Inquiries: (800) 657-8205

In this outline, *"you"* or *"your"* will refer to the person for whom this outline has been prepared, and *"we," "our,"* or *"us"* will refer to Golden Rule Insurance Company.

SHORT TERM NETWORK PROVIDER MEDICAL EXPENSE COVERAGE
Outline of Coverage for Policy Form IST6.1-P-GRI-10
(Please retain this outline for your records)

Read Your Policy Carefully -- This outline sets forth a brief description of the important aspects of *your* policy. This is not the insurance contract. Only the actual policy will control. The policy sets forth in detail *your* and *our* rights and obligations. For this reason, it is important that *you* READ *YOUR* POLICY CAREFULLY!

Medical Expense Coverage -- Plans of this type are designed to provide covered persons with coverage for the major costs of hospital, medical, and surgical care. The cost must be due to a covered illness or injury. Coverage is provided for daily hospital room and board, other hospital services, surgical services, anesthesia services, inpatient medical services, and out-of-hospital care. Coverage is subject to any *deductible amounts*, copayment provisions, or other limitations that may be set forth in the policy.

DEFINITIONS

"Coinsurance percentage" means the percentage of covered expenses that are payable by *us* after the *deductible amount* or *copayment amount* has been met, as applicable, as shown in the policy Data Page.

"Copayment amount" means the amount of covered expenses that must be paid by a covered person for each service that is subject to a *copayment amount* (as shown in the policy Data Page) before benefits are payable for remaining covered expenses for that service under the policy.

"Deductible amount" means the amount of *eligible expenses*, shown in the policy Data Page, that must actually be incurred by each covered person before any benefits are payable. The *deductible amount* does not include any *copayment amount*.

"Effective date" means the applicable date a covered person becomes insured for illness or injury. The applicable *effective date* is shown in the Data Page of the policy. The *effective date* for illness will always be on the 6th day after the *effective date* for injury.

"Eligible expense" means a covered expense as determined below:

A. For *network providers*: When a covered expense is received from a *network provider*, the *eligible expense* is the contracted fee with that provider.

B. For non-*network providers:*

1. When a covered expense is received from a non-*network provider* as a result of an emergency, the *eligible expense* is no more than the billed charge. The *eligible expense* is processed at the *network* benefit level.
2. For non-emergency covered expenses received at a *network* facility from a non-*network* facility-based physician, the *eligible expense* is based on 110% of the published rates allowed by *CMS* for the same or similar service within the geographic market with the exception of the following:
   a. 50% of the published rates allowed by *CMS* for the same or similar laboratory service.
   b. 45% of the published rates allowed by *CMS* for the same or similar durable medical equipment, or *CMS* competitive bid rates.

   When a rate is not published by *CMS* for the service:
   a. A gap methodology will be applied that uses a relative value scale, which is usually based on the difficulty, time, work, risk, and resources of the service. The relative value scale currently used is

created by OptumInsight. If the OptumInsight relative value scale becomes no longer available, a comparable scale will be used. *We* and OptumInsight are related companies through common ownership by UnitedHealth Group.

b. For pharmaceutical products, gap methodologies are applied that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by RJ Health Systems, Thomson Reuters (published in its Red Book), or UnitedHealthcare based on an internally developed pharmaceutical pricing resource.

c. If a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under the *CMS* published rates or a gap methodology, the *eligible expense* is based on 50% of the provider's billed charge.

3. Except as provided under B.1 and B.2 above, when a covered expense is received from a non-*network provider,* the *eligible expense* is determined based on the first of the following rules that can be applied in the order shown below:

   a. The fee that has been negotiated with the provider.

   b. 110% of the fee Medicare allows for the same or similar services provided in the same geographical area.

   c. The fee established based on rates from one or more regional or national databases or schedules for the same or similar services from a geographical area determined by *us*.

   d. A fee based on a gap methodology that uses a relative value scale, which is usually based on the difficulty, time, work, risk, and resources of the service. The relative value scale currently used is created by OptumInsight. If the OptumInsight relative value scale becomes no longer available, a comparable scale will be used. *We* and OptumInsight are related companies through common ownership by UnitedHealth Group:

      i. For pharmaceutical products, gap methodologies are applied that are similar to the pricing methodology used by *CMS* and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by RJ Health Systems, Thomson Reuters (published in its Red Book), or UnitedHealthcare based on an internally developed pharmaceutical pricing resource.

      ii. When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under the *CMS* published rates or a gap methodology, the *eligible expense* is based on 50% of the provider's billed charge.

   e. The fee charged by the provider for the services.

   f. A fee schedule that *we* develop.

IMPORTANT NOTE: Except when the *eligible expense* is an amount negotiated with the provider, non-*network providers* and non-*network* facility-based physicians may bill *you* for any difference between the billed charges and the *eligible expense*.

"Network" means a group of doctors and providers who have contracts that include an agreed upon price for health care expenses that are covered expenses under the policy.

"Network provider" means a doctor, provider, or member pharmacy who is identified in the most current list for the *network* shown on *your* identification card.

AMOUNT PAYABLE

AMOUNT PAYABLE: The total amount payable for each covered person will not exceed the lifetime maximum benefit limit shown in the policy Data Page.

We will pay the applicable *coinsurance percentage* in excess of the applicable *deductible amount* and *copayment amount(s)* for a service or supply that qualifies as a covered expense and is received while the covered person's coverage is in force under the policy, if the charge for the service or supply qualifies as an *eligible expense*.

The amount payable will be subject to any specific benefit limits stated in the policy, a determination of *eligible expenses*, and any reduction for expenses incurred at a non-*network provider*.

The *deductible amount(s)*, *coinsurance percentage*, and *copayment amount(s)* are shown in the policy Data Page.

Non-emergency non-*network eligible expenses* will be reduced by 25% before application of any applicable *deductible amount*, coinsurance provisions, and/or *copayment amounts*.

Note: The bill *you* receive for services or supplies from a non-*network provider* may be significantly higher than the *eligible expenses* for those services or supplies. In addition to the *deductible amount*, *copayment amount* (if any), and coinsurance, *you* are responsible for the difference between the *eligible expense* and the amount the provider bills *you* for the services or supplies. Any amount *you* must pay to the provider in excess of the *eligible expenses* will not apply to *your deductible amount* or maximum out-of-pocket expenses.

MEDICAL BENEFITS

COVERED EXPENSES: Covered expenses set forth in the policy are limited to charges:

A. Made by a hospital for:

   1. Daily room and board and nursing services, at the hospital's most common semi-private room rate.
   2. Daily room and board and nursing services while confined in an intensive care unit, not to exceed the *eligible expense*.
   3. Inpatient use of an operating, treatment, or recovery room.
   4. Outpatient use of an operating, treatment, or recovery room for surgery.
   5. Other routine services and supplies, provided to inpatients, including drugs and medicines.
   6. Emergency treatment of an injury or illness, even if confinement is not required. Covered expenses for use of the emergency room for treatment of an injury or illness will be subject to the *copayment amount* shown in the policy Data Page.

B. For emergency ground ambulance service to a hospital.

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

D. Made by a doctor for professional services, including surgery.

E. Made by a medical practitioner for professional services.

F. Made by a doctor acting as an assistant surgeon, limited to 20 percent of the *eligible expense* for the surgical procedure; or made by another medical practitioner acting as an assistant surgeon, limited to 14 percent of the *eligible expense* for the surgical procedure.

G. For dressings, crutches, orthopedic braces and splints, casts, or other necessary medical supplies.

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

I. For chemotherapy and radiation therapy or treatment.

J. For hemodialysis and the charges by a hospital for processing and administration of blood or blood components.

K. For oxygen or anesthetic, and their administration.

L. For surgical and non-surgical treatment, excluding tooth extraction, for the correction of congenital or developed anomalies of the temporomandibular joint.

M. For surgery for the correction of functional deformities of the maxilla and mandible.

N. For reconstructive surgery that is incidental to or follows 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.

O. For breast reconstruction following a mastectomy, prostheses, and treatment for physical complications of mastectomy, including lymphedemas.

P. For the rental of a standard hospital bed, a standard walker, a standard non-motorized wheelchair, a wheelchair cushion, and a ventilator.

Q. For artificial eyes or larynx, breast prosthesis, or basic artificial limbs (but not replacement, unless required by a physical change in the covered person and the item cannot be modified). If more than one prosthetic device can meet a covered person's functional needs, only the charge for the most cost effective prosthetic device will be considered a covered expense.

R. For dental expenses when a covered person suffers an injury during the policy term that results in:

1. Damage to his or her natural teeth; and
2. 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.

S. For equipment, supplies, and services for the treatment of diabetes, and for diabetes self-management training and education.

T. For diagnosis or treatment of a spine or back disorder.

U. For one routine mammography exam and one cervical smear or pap smear for each covered person during the policy term, or more often if ordered by a physician.

V. For one digital rectal examination and one prostate specific antigen test during the policy term, upon the recommendation of a licensed physician, for each covered person age 40 or older, or more often if ordered by a physician.

W. For colorectal cancer examinations and laboratory tests in accordance with the published American Cancer Society guidelines.

X. For one chlamydia screening test during the policy term for a covered person age 29 years or younger.

Y. For surveillance tests for ovarian cancer for a covered person age 35 or older who is at risk for ovarian cancer.

Z. For general anesthesia and associated hospital or outpatient surgical facility charges for dental care provided to a covered person:

1. Who is age 7 years or younger or is developmentally disabled;
2. For whom a successful result cannot be expected if the services were provided under local anesthesia due to a neurobiological or other medically compromising condition; or
3. Who has sustained extensive facial or dental trauma.

AA. For treatment of autism spectrum disorders for a covered person 6 years of age or younger, as described in the policy.

BB. For child wellness services provided to a covered person from birth until the 6th birthday.

CC. For 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 meets the criteria stated in the policy.

DD. For scientifically proven bone mass measurement for the prevention, diagnosis, and treatment of osteoporosis for a covered person who meets the criteria stated in the policy.

EE. For diagnostic testing to determine the cause of infertility or that results in an incidental finding of infertility. However, expenses incurred for the treatment of infertility, including office visits and diagnostic testing performed during the active treatment of infertility, are not covered expenses.

FF. For treatment of a terminal condition when such treatment has been prescribed by a doctor as medically appropriate and has been agreed to by the covered person or his or her representative.

HOME HEALTH CARE BENEFITS: The policy provides benefits for home health care. Benefits for home health aide services are limited to 7 visits per week and a lifetime maximum of 365 visits. Benefits for outpatient private duty registered nurse services are limited to a lifetime maximum of 1,000 hours. Benefits for intermittent private duty registered nurse services are limited to $75 per visit.

REHABILITATION AND EXTENDED CARE FACILITY BENEFITS: The policy provides benefits for rehabilitation services or an inpatient stay in a rehabilitation facility or extended care facility that begins within 14 days of a hospital stay of at least 3 days and is for treatment of, or rehabilitation related to, the same illness or injury that required the

hospital stay. Covered expenses are limited to a combined maximum of 60 days per policy term for each covered person.

TRANSPLANT BENEFITS: The following types of tissue transplants are covered expenses: cornea transplants, artery or vein grafts, heart valve grafts, prosthetic tissue replacement (including joint replacement), and implantable prosthetic lenses in connection with cataracts. The policy also provides coverage for listed transplants, which include heart, lung, heart/lung, kidney, and liver transplants, and bone marrow transplants as listed in the policy. The amount of benefits under the policy for a listed transplant depends upon whether it is performed in a Center of Excellence.

WHAT IS NOT COVERED

No benefits will be paid for:

A. Any service or supply that would be provided without cost in the absence of insurance.

B. Charges that are actually the responsibility of the provider to pay.

C. Any services performed by a member of a covered person's immediate family.

D. Services not identified as covered expenses under the policy.

E. Charges incurred that are in excess of *eligible expenses*.

Even if not excluded by the policy, no benefit will be paid for a service or supply unless it is administered or ordered by a doctor and medically necessary to the diagnosis or treatment of an injury or illness.

Covered expenses will not include, and no benefits will be paid for any charges that are incurred:

A. For services and supplies provided prior to the *effective date* or after the termination date of the policy.

B. For weight modification or surgical treatment of obesity, including wiring of the teeth and all forms of intestinal bypass surgery.

C. For breast reduction or augmentation, except as covered by the policy for breast reconstruction following a mastectomy.

D. For modification of the physical body to improve the psychological, mental, or emotional well-being of the covered person, such as sex-change surgery.

E. For any drug, treatment, or procedure that promotes or prevents conception or prevents childbirth, including but not limited to, artificial insemination or treatment for infertility or impotency; for sterilization or reversal of sterilization; or for abortion (unless a pregnancy carried to term would endanger the mother's life).

F. For television, telephone, or expenses for other persons.

G. For marriage, family, or child counseling for the treatment of premarital, marriage, family, or child relationship dysfunctions.

H. For telephone consultations or failure to keep a scheduled appointment.

I. For hospital room and board and nursing services for the first Friday or Saturday of an inpatient stay that begins on one of those days, unless it is an emergency or medically necessary inpatient surgery is scheduled for the date after the date of admission.

J. For stand-by availability of a medical practitioner when no treatment is rendered.

K. For dental expenses, including braces, or surgery and treatment for oral surgery, except as described in the policy.

L. For cosmetic treatment.

M. For diagnosis or treatment of learning disabilities, attitudinal disorders, or disciplinary problems. This exclusion does not apply to treatment of autism spectrum disorder as covered by the policy.

N. For diagnosis or treatment of nicotine addiction.

O. For charges related to, or in preparation for, tissue or organ transplants, except as expressly provided for by the policy.

P. For high dose chemotherapy prior to, in conjunction with, or supported by ABMT/BMT, except as specifically provided in the Transplant Expense Benefits provision in the policy.

Q. For eye refractive surgery when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism.

R. While confined primarily to receive rehabilitation, custodial care, educational care, or nursing services, unless expressly provided for by the policy.

S. For any expenses that are incurred for injuries sustained during or due to participation in any professional or semi-

professional sports or athletic activities for financial compensation, as determined by *us*.

T. As a result of any injury sustained during or due to participating, instructing, demonstrating, guiding, or accompanying others in any of the following: 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.

U. As a result of any injury 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 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.

V. As a result of any injury sustained while operating, riding in, or descending from any type of aircraft if the covered person is a pilot, officer, or member of the crew of such aircraft or is giving or receiving any kind of training or instructions or otherwise has any duties that require him or her to be aboard the aircraft.

W. For vocational or recreational therapy, vocational rehabilitation, occupational therapy, or outpatient speech therapy, except as provided for by the policy.

X. For eyeglasses, contact lenses, hearing aids, eye refraction, visual therapy, or for any related examinations or fittings, except as provided for by the policy.

Y. Due to pregnancy (except for complications of pregnancy).

Z. For expenses incurred while confined primarily for well-baby care, except as provided for by the policy.

AA. For preventive or prophylactic care, including routine physical examinations, premarital examinations and educational programs, except as provided by the policy.

BB. For experimental or investigational treatment or for unproven services, as defined in the policy.

CC. For expenses incurred outside of the United States, except for emergency treatment.

DD. For injury or illness caused by employment, except as may be covered by the policy.

EE. As a result of:

1. Intentionally self-inflicted bodily harm, (whether the covered person is sane or insane);
2. An injury or illness caused by any act of declared or undeclared war;
3. The covered person taking part in a riot; or
4. The covered person's commission of a felony, whether or not charged.

FF. For or related to durable medical equipment, except as expressly provided for by the policy.

GG. For any illness or injury that occurs as a result of the covered person being intoxicated or under the influence of illegal narcotics or controlled substance, unless administered or prescribed by a doctor.

HH. For or related to surrogate parenting.

II. For or related to treatment of hyperhidrosis (excessive sweating).

JJ. For fetal reduction surgery.

KK. Except as expressly provided for by the policy, expenses for alternative treatments, including acupressure, acupuncture, aroma therapy, hypnotism, massage therapy, rolfing, and other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.

LL. For joint replacement, unless related to an injury that is covered by the policy.

MM. For non-emergency treatment of tonsils, adenoids, hemorrhoids, or hernia.

NN. For treatment of mental disorders, substance abuse, or for court-ordered treatment programs for substance abuse.

OO. For outpatient prescription drugs, except as provided for by the policy.

PREEXISTING CONDITIONS

Preexisting conditions, and complications resulting from a *preexisting condition,* will not be covered under the policy.

A *"preexisting condition"* means:

A. A condition for which medical advice, diagnosis, care, or treatment was recommended or received within the 24 months immediately preceding the date the covered person became insured under the policy;

B. A condition that had manifested itself in a manner that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment within the 12 months immediately preceding the date the covered person became insured under the policy; or

C. A pregnancy existing on the *effective date* of coverage.

TERM OF COVERAGE AND RENEWABILITY

The policy term begins as of the *effective date* of the policy. *You* may keep the policy in force by paying *us* the required premium as it comes due. However, *we* may cancel the policy or deny a claim if there is fraud or material misrepresentation made by or with the knowledge of a covered person in the application form, subject to the Time Limit on Certain Defenses provision in the policy. At the end of the policy term, the policy will terminate and may not be renewed.