Thank you for your interest in this product. It is the mission of Golden Rule Insurance Company, as a UnitedHealthcare company, to help people live healthier lives. We are available to answer your questions and help you without any obligation to buy. **If you need help understanding this product, call Golden Rule Insurance Company, visit uhone.com, or contact your health insurance agent.**

Questions about this product may be answered by the details found in this brochure. Below is a notice required by law.

IMPORTANT: This is a short-term, limited-duration policy, NOT comprehensive health coverage

This is a temporary limited policy that has fewer benefits and Federal protections than other types of health insurance options, like those on HealthCare.gov

This policy	Insurance on HealthCare.gov
Might not cover you due to preexisting health conditions like diabetes, cancer, stroke, arthritis, heart disease, mental health & substance use disorders	Can't deny you coverage due to preexisting health conditions
Might not cover things like prescription drugs, preventive screenings, maternity care, emergency services, hospitalization, pediatric care, physical therapy & more	Covers all essential health benefits
Might have **no limit on what you pay** out-of-pocket for care	Protects you with limits on what you pay each year out-of-pocket for essential health benefits
You **won't qualify** for Federal financial help to pay premiums & out-of-pocket costs	Many people qualify for Federal financial help
Doesn't have to meet Federal standards for comprehensive health coverage	All plans must meet Federal standards

Looking for comprehensive health insurance?

- **Visit HealthCare.gov** or call **1-800-318-2596** (TTY: 1-855-889-4325) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member's job, contact the employer.

Questions about this policy?

For questions or complaints about this policy, contact your State Department of Insurance. Find their number on the National Association of Insurance Commissioners' website (naic.org) under "Insurance Departments."

Short Term Medical plans for times of transition and change

HEALTH INSURANCE AVAILABLE ONLY TO MEMBERS OF FACT, THE FEDERATION OF AMERICAN CONSUMERS AND TRAVELERS. THESE HEALTH INSURANCE PLANS ARE ISSUED AS ASSOCIATION GROUP PLANS AND AVAILABLE ONLY TO MEMBERS OF FACT. GOLDEN RULE INSURANCE COMPANY IS THE UNDERWRITER AND ADMINISTRATOR OF THESE PLANS. SEE LAST PAGE FOR MORE FACT DETAILS.

Certificate Form GRI-STAG20-C-P-D and other state variations

UnitedHealthcare®
Golden Rule Insurance Co.

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Why Short Term Medical?

Short Term Medical plans are designed as health coverage for a limited time when longer term insurance isn't available to you

Because life moves fast

Apply for coverage any day of the year
No qualifying event needed and no waiting for an enrollment period

Apply fast
Plans are medically underwritten, and short application questions help determine if you're eligible for coverage

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

Pick your plan
Multiple plans with different benefit and deductible options available, including plan options specifically for families

Because life can be unpredictable

Coverage you need
For doctor office visits, urgent care visits, hospitalization, limited preventive care and more

Prescription coverage
Available on most plans

Nationwide network
Access to quality care at reduced rates from 1.8 million physicians and health care professionals and 7,200 hospitals and medical facilities[2]

No referrals or primary care physician (PCP) required
Use any doctor in the network across the nation[3]

[1] 3 months term length with up to a one-month extension for a total of 4 months of coverage.
[2] UnitedHealth Group Annual Form 10-K for year ended 12/31/23
[3] There are reduced non-network benefits, except for emergencies (see page 6)

This is an outline only and is not intended to serve as a legal interpretation of benefits. Reasonable effort has been made to have this outline represent the intent of contract language. However, the contract language stands alone, and the complete terms of the coverage will be determined by the policy. It is important to note there are **State Variations, Exclusions and/or Limitations** and **Plan Provisions**. This plan is medically underwritten. **No benefits will be paid for a health condition that exists prior to the date insurance takes effect.**

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Plan information

Highlights of covered network expenses

		Copay	Premier Elite and Plus Elite	Plus	Value	Value Direct
Per Person Deductible (per term; max 2 per family)	You pay up to:	$2,500, $5,000, $7,500, $10,000 or $15,000	**Plus Elite Only:** $2,500, $5,000, $7,500, $10,000 or $15,000	$2,500, $5,000, $7,500 or $15,000	$2,500, $5,000, $7,500 or $15,000	$5,000, $10,000 or $15,000
Family Deductible (per term; one deductible to meet for all covered family members combined)	You pay up to:	Not Available	**Premier Elite Only:** $5,000, $10,000 or $14,000	Not Available	Not Available	Not Available
Coinsurance (% you pay **after deductible**, per term)	You pay:	20%	0%	20%	30%	40%
Coinsurance Out-of-Pocket Maximum (after deductible, per person, per term)	You pay up to:	$5,000	$0	$2,000	$10,000	$10,000
Maximum Benefit (per person, per term)	We pay up to:	$2 million	$2 million	$2 million	$1 million	$500,000
Medical						
Doctor Office Visit – History and Exam Only (per person, per term)	You pay:	$50 copay[1]	No charge after deductible	20% after deductible	30% after deductible	40% after deductible
Urgent Care Center Visit (per person, per term)		$50 copay	$50 copay	$50 copay	$50 copay	40% after deductible
Preventive Care (see page 10 for details and limitations)		20% after deductible	No charge after deductible	20% after deductible	30% after deductible	40% after deductible
Emergency Room – Accident and Illness		20% after deductible (additional $500 deductible if not admitted)	No charge after deductible (additional $500 deductible if not admitted)	20% after deductible (additional $500 deductible if not admitted)	30% after deductible (additional $500 deductible if not admitted)	40% after deductible (additional $750 deductible if not admitted)
Inpatient Hospital Services, Outpatient Surgery, Labs & X-rays		20% after deductible	No charge after deductible	20% after deductible	30% after deductible	40% after deductible
Pharmacy						
Outpatient Prescription (Rx) Drugs (for plans that provide coverage, using the member ID card, you pay for prescriptions at the point of sale, at the lowest price available)	You pay:	**Tier 1:** $25 copay, no deductible **Tiers 2–4:** 20% after deductible ($5,000 max covered expense per person, per term)	**Tier 1:** $25 copay, no deductible **Tiers 2–4:** No charge after deductible ($5,000 max covered expense per person, per term)	**Tier 1:** $25 copay, no deductible **Tiers 2–4:** 20% after deductible ($5,000 max covered expense per person, per term)	**Tier 1:** $25 copay, no deductible **Tiers 2–4:** 30% after deductible ($2,500 max covered expense per person, per term)	**Not Covered** Discount card provided[2]
Optional Benefits						
Add Supplemental Accident Benefit[3] (see page 14)	We pay up to:	$2,500, $5,000, $7,500, $10,000 or $15,000	$2,500, $5,000, $7,500, $10,000 or $15,000	$2,500, $5,000, $7,500, $10,000 or $15,000	$2,500, $5,000, $7,500, $10,000 or $15,000	$2,500, $5,000, $7,500, $10,000 or $15,000

The amount of benefits provided depends upon the plan selected, and the premium will vary with the amount of the benefits selected. Non-network benefits vary. See details on page 6. Copays do not apply to deductible, coinsurance or coinsurance out-of-pocket maximum. This coverage does not qualify as "Minimum Essential Coverage" as defined in the Affordable Care Act and may not cover all Essential Health Benefits in your state. [1] Available number of doctor office visits for a copay varies by plan duration: 1–3 months = 1 visit, 4 months = 2 visits. **Subsequent visits are subject to deductible then coinsurance.** Doctor Office Visit copays are for injury and illness and cannot be used for preventive services, other than those required due to state mandates. [2] Discounts vary by pharmacy, geographic area and Rx drug. [3] Additional premium required.

Get nationwide access to quality care and cost savings

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

Save on premium

- Choose a higher deductible: If you agree to cover more before insurance starts paying, you can reduce your plan premium

Save on health care costs

- Network care available at negotiated lower rates
- Network providers agree not to bill you above that negotiated rate

National Network*

1.8M+ providers

7,200+ hospitals

- No referrals to see a network specialist
- Use any doctor or facility in the national network

Visit UHOne.com and select Find A Doctor to search for network providers in your state

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

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

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

*UnitedHealth Group Annual Form 10-K for year ended 12/31/23.

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Round out your coverage

Telehealth 2 ways

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

1. By adding the Virtual Care Benefit[1] to your plan, you can use Amwell to visit with a doctor 24 hours a day, 7 days a week to get quick care and a prescription when needed. With no appointments or long wait times, it's a great option for care when you think you might have the flu, sinus infection, cough, cold, fever, pink eye, nausea and more. You can have unlimited $0 cost video visits with a doctor when you need it.
2. If a regular network doctor offers telehealth services, you can take advantage of that service at network negotiated lower rates. Your plan's deductible and coinsurance rates apply.

This option is no longer available

Accident benefit

The Supplemental Accident Benefit[1] can help cover your deductible or other out-of-pocket medical costs (before insurance starts paying covered expenses) for accident-related injuries. You choose the benefit level amount you want, and it's paid per accident, per covered person. See page 14 for more details.

Dental and vision

Consider help for other regular expenses not covered by health insurance with standalone dental and vision coverage.[1] Dental insurance can provide benefits for services ranging from routine cleanings to root canals, while vision insurance covers routine eye exams and can help pay for glasses, contacts or both.

[1] Additional premium is required for coverage.

Amwell and UnitedHealthcare are not affiliated and each entity is responsible for its own contractual and financial obligations. Dental and Vision require separate applications, and separate policies are issued. Product design and availability may vary by state. For costs, benefits, exclusions, limitations, eligibility, waiting periods and renewal terms, call 1-800-273-8115.

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FAQs

What to Expect from Short Term Medical plans

Here are some of the most common questions - and answers - on Short Term Medical. We want you to feel confident that a short term plan is right for you.

What are preexisting conditions and does a short term plan cover them?

No. Short Term Medical plans generally don't cover expenses related to preexisting conditions. This means your plan won't cover costs if:

- You're currently taking medicine or getting treatment for an illness, injury or condition
- You've had a condition in the past that resurfaces
- You're already pregnant before signing up for a plan

If you need coverage for preexisting conditions, exploring Affordable Care Act insurance options may be your best choice.

How is preventive care covered?

The cost of preventive care services applies toward your deductible, then your coinsurance. This means you will likely have to pay for preventive care services out of pocket, but these costs are applied to your deductible. When you meet your deductible, then the services are subject to your share of coinsurance. Remember, when you use a network provider, you are saving each time because providers have agreed to lower rates than you would pay without insurance.

What preventive care is covered?

Preventive care covered by your plan is very specific, limited to mammograms, PAP smears, prostate checks and some preventive care for children on the plan. Immunization services that qualify as children's preventive health care services are exempt from any deductible, coinsurance or copayment amounts. However, adult immunizations, like the flu shot, for example, would not be covered. Some states may require additional coverage.

If I'm responsible for more out-of-pocket costs with a high deductible, what am I getting out of my plan?

While having a higher deductible means you agree to pay more before insurance starts to pay, those payments are not the only way your Short Term Medical plan "pays" for itself. Network providers agree to lower rates for your care. So even if you're still paying on your deductible, what you're paying is less than you would pay without your Short Term Medical plan.

How does prescription drug coverage work?

It varies by plan. Some have copays with no deductible for more common drugs, and payments that apply to your deductible for other drugs. Some lower cost plans have no drug coverage, but come with a drug discount card. You pick the plan that works best for you.

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Medical benefits
(insurance plans)

The following medical benefits are provided using network providers and are subject to Plan Provisions, Exclusions and/or Limitations, the deductible, any applicable copay or coinsurance and all policy provisions (unless otherwise stated). Some state exceptions may apply (see State Variations). This is only a general outline of the benefits. You will find complete coverage details in the policy.

Ambulance services

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

Cancer treatment expenses

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

Children's preventive health services

Services for any covered person eligible by reason of age, subject to deductible and coinsurance. Immunization services that qualify as children's preventive health care services are exempt from any deductible amounts, coinsurance provisions or copayment amounts.

Dental injuries

Dental expenses for an injury to natural teeth suffered after the coverage effective date. Expenses must be incurred within 6 months of the accident. **No benefits payable for injuries due to chewing.**

Diabetes

- Diabetes equipment, supplies and services.
- Diabetes self-management training and education when medically necessary as determined by physician or health care professional. Limited to one training program per person, per lifetime, unless additional training is prescribed due to a significant change in symptoms or condition.

Diagnostic testing

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

Doctor office visit copay (history and exam only)

For Copay plans only, copay of $50 per office visit for
treatment, excluding surgery, performed by a doctor, limited to 1 or 2 visits per person, per term, depending on plan duration (see page 5). Additional office visits will be subject to the applicable deductible amount and coinsurance percentage. The office visit copayment amount does not apply to office visits for preventive care services.

Durable medical equipment

Rental of standard non-motorized wheelchair, hospital bed, standard walker, wheelchair cushion or ventilator.

Home health care

To qualify for benefits, home health care must be provided through a licensed home health-care agency. Covered expenses for home health aide services will be limited to 7 visits per week. Each 8-hour period of home health aide services will be counted as one visit. Intermittent private duty registered nurse visits are not to exceed 4 hours each and are limited to $75 per visit.

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

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Medical benefits continued
(insurance plans)

Hospital services

Daily hospital room and board at most common semiprivate rate; eligible expenses for an intensive care unit; inpatient use of an operating, treatment or recovery room; outpatient use of an operating, treatment or recovery room for surgery; services and supplies, including drugs and medicines, which are routinely provided in the hospital to persons for use only while they are inpatients; and emergency treatment of an injury or illness. Covered expenses for use of the emergency room are subject to an additional $500 or $750 deductible, depending on plan you choose, for each emergency room visit for an illness or injury unless the covered person is directly admitted to the hospital for further treatment.

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

Medical supplies

- Dressings and other necessary medical supplies.
- Cost and administration of an anesthetic or oxygen.

Mental and substance-related & addictive disorders (Plus plans ONLY)

Diagnosis and treatment of mental disorders and substance-related and addictive disorders, including court-ordered treatment programs for substance-related and addictive disorders.

Outpatient surgery

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

Physician fees

- Professional fees of doctors, medical practitioners and surgeons.
- Assistant surgeon fee limited to 16% of eligible expenses of the procedure.

Preventive care

Preventive care expenses include:

- One routine mammography examination per term, per female covered person.
- One cervical smear or pap smear per term, per female covered person.
- One digital rectal exam and one prostate specific antigen (PSA) test per term, per male covered person for screening for the early detection of prostate cancer, exempt from deductible. Coverage for screening does not diminish or limit other covered diagnostic benefits.

For Children's Preventive Health Services, see page 9.

Prosthetics

Artificial eyes or larynx, breast prosthesis, orthotic and prosthetic devices/services. Orthotic and prosthetic devices/services limited to one device/service or replacement every 3 years unless proven to be medically necessary. If more than one device can meet covered person's functional needs, only the charge for the most cost effective device will be considered a covered expense.

Reconstructive surgery

- Reconstructive surgery incidental to or following surgery or an injury that was covered under the certificate 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.
- Reconstructive craniofacial surgery and related services for a covered person of any age diagnosed as having a craniofacial anomaly if the surgery is medically necessary to improve functional impairment that results from the craniofacial anomaly, as determined by a nationally approved cleft-craniofacial team, approved by the American Cleft Palate-Craniofacial Association in Chapel Hill, North Carolina.

Rehabilitation and Extended Care Facility (ECF)

To qualify for benefits, a Rehabilitation or Extended Care Facility must be licensed by the state in which it operates.

Services or confinement must begin within 14 days of a 3-day or more hospital stay, for the same illness or injury. Combined policy max of 60 days per person, per term for both rehabilitation and ECF expenses. This benefit excludes mental disorders or substance abuse.

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Medical benefits continued
(insurance plans)

Spine and back disorders

Diagnosis or treatment of spine and back disorders. Outpatient non-surgical services are limited to $2,500 maximum covered expense.

Therapeutic treatments

Hemodialysis, processing and administration of blood or components (but not the cost of the actual blood or components).

Transplant expense benefit

The following transplants are covered the same as any other illness: cornea, artery or vein grafts, heart valve grafts, prosthetic tissue and joint replacement and prosthetic lenses for cataracts.
For all other covered transplants, see "Listed Transplants" under Transplant Expense Benefits in the certificate. The covered person must be a good candidate, as determined by us. The transplant must not be experimental or investigational. Covered expenses for "Listed Transplants" are limited to 2 per person.
GRIC has arranged for certain hospitals around the country ("Centers of Excellence" or COE) to perform specified transplant services. At a designated COE, covered expenses include the acquisition cost and transportation and lodging limited to $5,000 per transplant. If COE not used: Limit of 1 transplant per person, limited to max benefits of $100,000; acquisition, transportation and lodging not covered.

No benefits payable for:

- Search and testing in order to locate a suitable donor.
- A prophylactic bone marrow harvest and peripheral blood stem cell collection when no "listed transplant" occurs.
- Animal-to-human transplants.
- Artificial or mechanical devices designed to replace a human organ temporarily or permanently or transportation of the organ or tissue, unless expressly provided in this provision.
- Keeping a donor alive for the transplant operation.
- A live donor where the live donor is receiving a transplanted organ to replace the donated organ.
- A transplant under study in an ongoing Phase I or II clinical trial as set forth in the USFDA regulation.

Additional benefits

- Diagnosis of and treatment of autism spectrum disorders, including evidence-based treatments.
- Outpatient applied behavior analysis for the treatment of autism spectrum disorders up to a maximum of $50,000 per policy term, per covered person.
- Colorectal cancer examinations and laboratory tests in accordance with the published American Cancer Society guidelines.
- Medically necessary care and treatment of loss or impairment of speech and hearing, including communicative disorders.
- Treatment of medical disorders requiring specialized nutrients or formulas, including treatment with medical foods, regardless of whether the delivery method is enteral or oral.
- Routine in-hospital newborn infant care expenses.
- Newborn screening tests for hypothyroidism, phenylketonuria, galactosemia, sickle-cell anemia and other genetic disorders as mandated by state law.
- Medically necessary gastric pacemaker.
- Telemedicine services to the same extent that those services provided would otherwise be covered expenses under the certificate, including facility fee to originating site. Combined reimbursement to the originating site and distant site limited to the covered expense for the service when provided in person.

Exclusions/limitations
(insurance plans)

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

Some states may require that you have Minimum Essential Coverage in order to avoid a penalty. The Short-term, limited duration insurance benefits under this coverage do not meet all federal requirements to qualify as "Minimum Essential Coverage" for health insurance under the Affordable Care Act ("ACA"). This plan of coverage does not include all Essential Health Benefits as required by the ACA. Preexisting Conditions are not covered under this plan of coverage. Be sure to check your Policy/Certificate carefully to make sure you understand what the Policy/Certificate does and does not cover. If this coverage expires or you lose eligibility for this coverage, you might have to wait until the next open enrollment period to get other health insurance coverage. You may be able to get longer term insurance that qualifies as "Minimum Essential Coverage" for health insurance under the ACA and help to pay for it at **www.healthcare.gov**. Be sure to check your Policy/Certificate carefully to make sure you are aware of any exclusions or limitations regarding coverage of preexisting conditions or health benefits (such as hospitalization, emergency services, maternity care, preventive care, prescription drugs and mental health and substance abuse use disorder services). Your Policy/Certificate might also have lifetime and/or dollar limits on health benefits.

General exclusions and/or limitations

Benefits will not be paid for services or supplies that are not administered or ordered by a doctor and medically necessary to the diagnosis or treatment of an illness or injury, as defined in the certificate.

No benefits are payable for expenses:

- For a preexisting condition: Any illness, injury or condition for which medical advice, care or treatment was recommended or received within the 24 months immediately prior to the covered person's effective date; or any illness, injury or condition for which any diagnostic procedure or screening was recommended to or received by a covered person within the 12 months immediately prior to the covered person's effective date that results in medical care or treatment after the covered person's effective date; or any illness, injury, condition or symptom(s) that, in the opinion of a doctor, manifested itself in a manner that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care, treatment or further evaluation within the 12 months immediately prior to the covered person's effective date; or a pregnancy existing on the effective date of coverage.

NOTE: Even if you have had prior GRIC coverage and your preexisting conditions were covered under that plan, they will not be covered under this plan.

- That would not have been charged if you did not have insurance.
- Imposed on you by a provider (including a hospital) that are actually the responsibility of the provider to pay.
- For services performed by an immediate family member.
- That are not identified and included as covered expenses under the certificate or in excess of the eligible expenses.
- For services or supplies that are provided prior to the effective date or after the termination date of the coverage.
- For weight modification or surgical treatment of obesity, including wiring of the teeth and all forms of intestinal bypass surgery.
- For breast reduction or augmentation.
- For drugs, treatment or procedures that promote or prevent conception or prevent childbirth, including but not limited to artificial insemination or treatment for infertility or impotency.
- For sterilization or reversals of sterilization.
- For fetal reduction surgery or abortion (unless life of mother would be endangered).
- For treatment of malocclusions, disorders of the temporomandibular joint (TMJ) or craniomandibular disorders, except as provided for in the certificate.
- 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 certificate, 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 certificate.
- For cosmetic treatment.
- For diagnosis or treatment of learning disabilities, attitudinal disorders or disciplinary problems, except as provided for in the certificate.
- For diagnosis or treatment of nicotine addiction.
- For surrogate parenting.
- For treatments of hyperhidrosis (excessive sweating).

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Exclusions/limitations continued
(insurance plans)

General exclusions, continued

No benefits are payable for expenses:

- For charges related to, or in preparation for, tissue or organ transplants, except as expressly provided for under Transplant Expense Benefits in the certificate.
- For injuries from participation in professional or semi-professional sports or athletic activities for financial gain, as determined by GRIC.
- For high-dose chemotherapy prior to, in conjunction with, or supported by ABMT/BMT, except as specifically provided under the Transplant Expense Benefits provision in the certificate.
- 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 certificate.
- 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 certificate.
- Due to pregnancy (except complications).
- For any expenses, including for diagnostic testing incurred while confined primarily for well-baby care, except as provided in the certificate.
- For treatment of mental disorders, or court-ordered treatment for substance abuse, except as provided for in the certificate.
- For preventive care or prophylactic care, including routine physical examinations, premarital examinations and educational programs, except as provided in the certificate.
- 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 certificate.
- For alternative treatments, except as specifically covered by the certificate, 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 certificate.
- For injuries sustained during or due to participating, instructing, demonstrating, guiding or accompanying others in any of the following: sports (professional, or semiprofessional, or intercollegiate), parachute jumping, hanggliding, racing or speed testing any motorized vehicle or conveyance, scuba/skin diving (when diving 60 or more feet in depth), skydiving, bungee jumping or rodeo sports.
- For injuries sustained during or due to participating, instructing, demonstrating, guiding or accompanying others in any of the following if the covered person is paid to participate or to instruct: operating or riding on a motorcycle, racing or speed testing any non-motorized vehicle or conveyance, horseback riding, rock or mountain climbing or skiing.
- For injuries sustained while performing the duties of an aircraft crew member, including giving or receiving training on an aircraft.
- For vocational or recreational therapy, vocational rehabilitation or occupational therapy, except as provided for in the certificate.
- Resulting from experimental or investigational treatments, or unproven services.
- For non-emergency treatment of tonsils, adenoids, middle ear disorders, hemorrhoids or hernia.
- For a service for which a non-network provider waives, does not pursue or fails to collect any applicable copayment amount, deductible amount or coinsurance percentage owed.
- **Value Direct Plans Only:** No benefits are payable for outpatient prescription drugs.

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Plan provisions
(insurance plans)

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

Optional supplemental accident benefit for Short Term Medical plans

Form SA-S-1996G-GRI and state variations

Reduce or eliminate your out-of-pocket exposure for an accident-related injury for additional premium. Supplemental Accident benefit pays for treatment of an unexpected injury within 90 days of an accident. The benefit maximum amount ($2,500, $5,000, $7,500, $10,000 or $15,000) is per accident, per covered person.

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 certificate.

Dependents

For purposes of this coverage, eligible dependents are your lawful spouse and eligible children. Eligible children must be unmarried and under 26 years of age at time of application, or as defined by state.

Effective date

Expenses for injuries and illnesses are eligible for coverage as of your plan's effective date. Your certificate will take effect on the later of:

- The requested effective date on your application; or
- The day after the date received by GRIC,* but only if the following conditions are satisfied:
  - A. Your application and the appropriate premium payment are actually received by us within 15 days of your signing;**
  - B. Your application is properly completed and unaltered;
  - C. Your application is approved after review by GRIC.
  - D. You are a resident of a state in which the certificate form can be issued; and
  - E. If the application is submitted by an agent or broker, the agent or broker is properly licensed and appointed to submit applications to GRIC.

* If mailed and not postmarked by the U.S. Postal Service or if the postmark is not legible, the effective date will be the later of: (1) the date you requested; or (2) the day after the date received by GRIC. If the application is sent by any electronic means including fax, your coverage will take effect on the later of: (1) the requested effective date; or (2) the day after the date received by GRIC.

** Your account will be immediately charged.

Eligibility

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

Eligible expense

An eligible expense means a covered expense as follows:

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

Emergency

"Emergency" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in: placing the health of the covered person (or unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

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Plan provisions continued
(insurance plans)

Reduced non-network benefits

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

Non-renewable

Short Term Medical plans are issued for a specific period of time. We may cancel coverage if there is fraud or material misrepresentation made by or with the knowledge of a covered person in filing a claim for benefits. Coverage will remain in force until the termination date shown in your certificate. We will notify you in advance of any changes in coverage or benefits, unless the policy terminates earlier for any reason stated in the Termination section.

Termination

The certificate will terminate on the earliest of:

- The primary insured's death. If the certificate 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 certificate.
- The last day for which premium has been paid, following your request to terminate the certificate.
- The end of the premium period on or after the primary insured's 65th birthday, if primary insured is the only person on the plan.

Rating factors

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

Right to examine

It is important to us that you are satisfied with the coverage being provided. This product has a right to examine period, also commonly referred to as "free look." After applying and after your certificate is issued, if you are not satisfied the coverage will meet your insurance needs, you may return the certificate to us within 10 days (or as required by state) and have the paid premium refunded. Refer to certificate for details.

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State variations
(insurance plans)

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

Alabama
Certificate Form GRI-STAG20-C-P-D-01

- Covered expense for mammography includes one routine screening mammography exam for each female covered person as follows:
  - For ages 40 to 49, inclusive, a mammogram at least every two years or more frequently based on the recommendation of the covered person's physician.
  - For ages 50 or over, a mammogram every year or more frequently based on the recommendation of the covered person's physician.

Arizona
Certificate Form GRI-STAG20-C-P-D-02

- There are no variations

Arkansas
Certificate Form C-020.1D

- There are no variations.

Ohio
Certificate Form GRI-STAG20-C-P-D-34R

- Dependents of the primary insured are eligible on the primary insured's effective date if born more than 30 days prior to the primary insured's effective date of coverage.
- Covered expenses are expanded to include:
  - Diagnosis or treatment of alcoholism, limited to $550 per policy term.
  - Child health supervision services, as defined in the certificate, from the moment of birth until age 9.
  - Dialysis treatments of an acute or chronic kidney ailment, provided on an inpatient or outpatient basis.
  - Provider charges, facility fees, and professional interpretation fees for routine mammography services, subject to the stated limitations:
    - One breast cancer screening mammography for a covered female who is not considered at risk and who is at least age 35 but less than age 40.
    - One breast cancer screening mammography every two year period for a covered female who is at least age 40 but less than age 50.
    - One breast cancer screening mammography every year for a covered female who is either a woman at risk or at least age 50 but less than age 65.

    Covered expenses for these screenings are limited to 130 percent of the lowest Medicare reimbursement rate for the state of Ohio. Charges the provider may bill you for these services are limited to the deductible amount and coinsurance.
  - One medically necessary hearing aid per hearing-impaired ear up to $2,500 dollars every 48 months for a covered person twenty-one years of age or younger who is verified as being deaf or hearing impaired by a licensed audiologist or an otolaryngologist or other licensed physician for:
    1. All related services prescribed by an otolaryngologist; or
    2. Recommended by a licensed audiologist; and
    3. Dispensed by a licensed: audiologist; hearing aid dealer or fitter; or otolaryngologist.

    Benefits for hearing aids up to $2,500 per ear and any related services necessary to assess, select, adjust, or fit a hearing aid are not subject to any deductible amounts, coinsurance, or copayment amounts, but are subject to the general exclusions and/or limitations. A covered person may choose a higher priced hearing aid and may pay the cost that is above the $2,500 dollars without any financial contractual penalty to the covered person or the provider.
- We will cover medically necessary eligible expenses for chiropractic services, physical therapy, and occupational therapy to treat a covered injury or illness on an inpatient or outpatient basis subject to all plan provisions, including specific exclusions and limitations. The plan's regular deductible, copayment, or coinsurance for covered services from a chiropractor, physical therapist, or occupational therapist will not be higher than what would apply to a visit to any other covered provider for a covered illness or injury.

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Who we are

Golden Rule Insurance Company, a UnitedHealthcare company, is the underwriter of plans featured in this brochure. We have been serving the specific needs of individuals and families buying their own coverage for over 80 years. Plans are administered by United Healthcare Services, Inc.

Golden Rule Insurance Company is rated "A+" (Superior) by A.M. Best.* This worldwide independent organization examines insurance companies and other businesses, and publishes its opinion about them. This rating is an indication of our financial strength and stability.

Our plans offer easy-to-understand health insurance designed for individuals and families in times of transition and change. Plans only available to members of FACT, the Federation of American Consumers and Travelers. If you're not already a member, you can enroll with your Short Term Medical application to be eligible to apply for these plans.

Health Plan Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

View Notice Here. Please review it carefully.

(https://www.uhc.com/content/dam/uhcdotcom/en/npp/NPP-UHC-EI-UHOne-EN.pdf)

What is FACT?

FACT is an independent consumer association whose members benefit from the "pooling" of resources. Benefits range from medical savings to consumer service discounts. FACT's principal office is in Jonesboro, Arkansas. FACT and Golden Rule Insurance Company are separate organizations. Neither is responsible for the performance of the other. FACT has contracted with Golden Rule Insurance Company to provide its members with access to these health insurance plans. FACT does not receive any compensation from Golden Rule Insurance Company.

Is there a cost for joining FACT?

Yes, there are membership dues and they can be paid with your regular health insurance premium, as opposed to making a separate payment.

What are the basic FACT membership benefits?

FACT makes it easy for members to choose from a full menu of important benefits, including:

- Accidental Death Benefit
- In-Hospital Benefit, Ambulance Reimbursement, and Medical Evacuation Coverage
- Dental, Vision, Hearing Aid, and Prescription Discounts
- ID Theft and Cyber Protection
- Travel Discounts
- Online Health, Wellness, and Fitness Classes
- Pet Coverage
- Scholarships and Community Grants
- Disaster Aid and Small Business Recovery Program

As a member of FACT, your information is kept private. Please visit the FACT website, **www.usafact.org/privacy-policy**, for a complete FACT Privacy Statement. FACT may change or discontinue any of its membership benefits at any time. For the most current information, including full detailed lists of member benefits, visit FACT's website at **www.usafact.org** or call toll-free at (800) USA-FACT.

UnitedHealthcare®
Golden Rule Insurance Co.

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

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