

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

Short Term Health Insurance | Virginia



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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 outside of Open Enrollment

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 3 months of total coverage within a 12-month period



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 facilities²



No referrals or primary care physician (PCP) required

Use any doctor in the network across the nation³

¹UnitedHealth Group Annual Form 10-K for year ended 12/31/23

² There are no 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 **Exclusions and/or Limitations** and **Plan Provisions**. This plan is medically underwritten. **No benefits will be paid for a health condition that exists prior to the date insurance takes effect.**

Plan information

Highlights of covered network expenses

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

The amount of benefits provided depends upon the plan selected, and the premium will vary with the amount of the benefits selected. These plans only pay benefits for eligible expenses from a network provider. 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 is 1 visit. **Subsequent visits are subject to deductible then coinsurance.** Doctor Office Visit copays are for injury and illness and cannot be used for preventive services. ² Discounts vary by pharmacy, geographic area and Rx drug.

Get nationwide access to quality care and cost savings

Use UnitedHealthcare Choice network for benefits



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



These plans only pay benefits for eligible expenses from a network provider. There are no non-network benefits.

No benefits are payable for non-emergency care from a non-network provider.

Emergency treatment from a non-network provider will be treated as a network eligible service.

National Network¹

 **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

¹UnitedHealth Group Annual Form 10-K for year ended 12/31/23.

Round out your coverage



Telehealth 2 ways

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

1. By adding the Virtual Care Benefit¹ 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.



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. For costs, benefits, exclusions, limitations, eligibility, waiting periods and renewal terms, call 1-800-273-8115.

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

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

How is preventive care covered?

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

What preventive care is covered?

Preventive care covered by your plan is very specific, limited to mammograms, PAP smears and prostate checks.

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

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

How does prescription drug coverage work?

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

Medical benefits

(insurance plans)

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

Ambulance services

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

Cancer treatment expenses

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

Dental injuries

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

Diabetes

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

Diagnostic testing

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

Doctor office visit copay (history and exam only)

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

Durable medical equipment

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

Home health care

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

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

Medical benefits continued

(insurance plans)

Hospital services

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

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

Medical supplies

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

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

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

Outpatient surgery

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

Physician fees

- Professional fees of doctors, medical practitioners and surgeons.
- Assistant surgeon fee limited to 16% of eligible expenses of the procedure.
- Telehealth services if those services would be covered under the policy if provided in person.

Preventive care

Preventive care expenses include:

- One routine mammography examination per term, per female covered person.
- One cervical smear or pap smear per term, per female covered person.
- One digital rectal exam and one prostate specific antigen (PSA) test per term, per male covered person age 40 years or older.

Prosthetics

- 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.
- Prosthetic devices and their repair, fitting, replacement, and prosthetic components, as defined in the policy. For the Value Direct plan, we pay 70% coinsurance, after deductible, for this benefit.

Reconstructive surgery

Reconstructive surgery incidental to or following surgery or an injury that was covered under the policy or is performed to correct a birth defect in a child who has been a covered person from its birth until the date surgery is performed.

Rehabilitation and Extended Care Facility (ECF)

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

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

Medical benefits continued

(insurance plans)

Spine and back disorders

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

Temporomandibular joint (TMJ)

Temporomandibular joint (TMJ) surgery, excluding tooth extractions, to treat craniomandibular disorders, malocclusions, disorders of the temporomandibular joint (TMJ), limited to a combined \$10,000 maximum per person, per term.

Therapeutic treatments

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

Other benefits:

- Medically necessary general anesthesia and hospital or facility charges for dental care provided to a covered person who: is less than 5 years of age; is severely disabled; or has a medical condition that requires admission to a hospital or outpatient surgical facility and general anesthesia for dental care treatment.
- Equipment, supplies, complex decongestive therapy, and outpatient self-management training and education prescribed by a doctor or qualified medical practitioner for the treatment of lymphedema.
- For a minimum stay in the hospital of not less than 23 hours following a laparoscopy-assisted vaginal hysterectomy and 48 hours following a vaginal

hysterectomy, unless the doctor, in consultation with the covered person, determines that a shorter stay is appropriate.

Transplant expense benefit

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

No benefits payable for:

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



Exclusions/limitations (insurance plans)

This is only a general outline of the exclusions. It is not an insurance contract, nor part of the insurance policy. You will find complete details in the policy.

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

General exclusions and/or limitations

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

No benefits are payable for expenses:

- For a preexisting condition: Any illness, injury or condition for which medical advice, care or treatment was recommended or received within the 12 months immediately prior to the covered person's effective date; or any illness, injury or condition for which any diagnostic procedure 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.

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.

- For non-emergency services or supplies received from a provider who is not a network provider, except as specifically provided for by the certificate.
- That would not have been charged if you did not have insurance.
- For services performed by an immediate family member.

- That are not identified and included as covered expenses under the policy or in excess of the eligible expenses.
- For services or supplies that are provided prior to the effective date or after the termination date of the coverage.
- For weight modification or surgical treatment of obesity, including wiring of the teeth and all forms of intestinal bypass surgery.
- For breast reduction or augmentation.
- For drugs, treatment or procedures that promote or prevent conception or prevent childbirth, including but not limited to artificial insemination or treatment for infertility or impotency.
- For sterilization or reversals of sterilization.
- For fetal reduction surgery or abortion (unless life of mother would be endangered).
- For treatment of malocclusions, disorders of the temporomandibular joint (TMJ) or craniomandibular disorders, except as provided for in the policy.
- For modification of the physical body in order to improve psychological, mental or emotional well-being.
- 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, except covered reconstructive surgery outlined in the policy.
- For diagnosis or treatment of learning disabilities, attitudinal disorders or disciplinary problems.
- For diagnosis or treatment of nicotine addiction.
- For surrogate parenting.
- For treatments of hyperhidrosis (excessive sweating).

Exclusions/limitations continued

(insurance plans)

General exclusions, continued

No benefits are payable for expenses:

- For eye refractive surgery, when the primary purpose is to correct nearsightedness, farsightedness or astigmatism.
- While confined for rehabilitation (except as provided for under the Rehabilitation and Extended Care benefits in the policy), 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.
- Due to pregnancy (except complications and due to pregnancy following an act of rape or incest reported to the police within 7 days following occurrence or within 180 days for a female covered person less than 13 years of age).
- For any expenses, including for diagnostic testing incurred while confined primarily for well-baby care.
- For diagnosis and treatment of mental disorders, or court-ordered treatment for substance abuse, except as provided for in the policy.
- For preventive care or prophylactic care, including routine physical examinations, premarital examinations and educational programs, except as provided in the policy.
- Incurred outside of the U.S., except for emergency treatment.
- Resulting from declared or undeclared war; intentionally self-inflicted bodily harm (whether sane or insane); participation in a riot; or commission of a felony or attempt to commit a felony.
- 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 Medical Benefits and Home Health Care Expense Benefits of the policy.
- For alternative treatments, except as specifically covered by the policy, including: acupressure, acupuncture, aromatherapy, hypnotism, massage therapy, rolfing and other alternative treatments defined by the Office of Alternative Medicine of the National Institutes of Health.
- Resulting from or during employment for wage or profit, for which benefits are paid by workers' compensation insurance under state or federal law. If workers' compensation insurance benefits are denied, this exclusion will not apply and benefits will be provided to the extent charges incurred are covered expenses under the policy.
- Resulting from covered person being drunk, or under the influence of any narcotic, unless taken on the advice of a doctor.
- For joint replacement, unless related to an injury covered by the policy.
- For injuries sustained while performing the duties of an aircraft crew member, including giving or receiving training on an aircraft.
- For vocational or recreational therapy, vocational rehabilitation or occupational therapy, except as provided for in the policy.
- Resulting from experimental or investigational treatments, or unproven services.
- For non-emergency treatment of tonsils, adenoids, middle ear disorders, hemorrhoids or hernia.
- **Value Direct Plans Only:** No benefits are payable for outpatient prescription drugs.

Plan provisions (insurance plans)

This is only a general outline of the provisions. It is not an insurance contract, nor part of the insurance policy. You will find complete details 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. A covered person will not cease to be a dependent solely because of age if the eligible child is not capable of self-sustaining employment due to intellectual disability or physical handicap that began before the age limit and is mainly dependent on you for support and maintenance.

Eligibility

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

Eligible expense

An eligible expense means a covered expense as follows:

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

Effective date

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

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

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

** Your account will be immediately charged.

Emergency

“Emergency” means, regardless of the final diagnosis, 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:

- Serious jeopardy to the mental and physical health of the covered person;
- Danger of serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part; or
- With respect to a pregnant woman, serious jeopardy to the health of the woman or her fetus.

No non-network benefits

- **These plans only pay benefits for eligible expenses from a network provider.** Visit **UHOne.com** to search for providers. (No benefits are payable for non-emergency care from a non-network provider).
- Emergency treatment from a non-network provider will be treated as a network eligible service.

Plan provisions continued

(insurance plans)

Non-renewable

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

Right to examine

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

Termination

The policy will terminate on the earliest of:

- The primary insured’s death. If the policy includes dependents, it may be continued after the primary insured’s death by a spouse, if a covered person; otherwise, by the youngest child who is a covered person.
- Nonpayment of premiums when due.
- The termination date shown on the Data Page of the policy.
- The last day for which premium has been paid, following your request to terminate the policy.
- The end of the premium period on or after the primary insured’s 65th birthday, if primary insured is the only person on the plan.

Rating factors

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



Who we are

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

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

Our plans offer easy-to-understand health insurance designed for individuals and families in times of transition and change.

Health Plan Notice of Privacy Practices

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

View Notice Here. Please review it carefully.

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

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