

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

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

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

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

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

Looking for comprehensive health insurance?

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

Questions about this policy?

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



Short Term Medical Hospital & Surgical Plans

Coverage when you need it most

Short Term Hospital & Surgical Insurance | KS, LA, MO, NV, SC, and WY



Table of Contents

| | |
|------------------------------------|----|
| Why Short Term Hospital & Surgical | 4 |
| Plan information | 5 |
| Savings and network | 6 |
| More coverage choices | 7 |
| Medical benefits | 8 |
| Exclusions/limitations | 11 |
| Plan provisions | 13 |
| State variations | 15 |
| Who we are and privacy notice | 20 |



Why Short Term Medical Hospital & Surgical insurance?

Short Term Medical Hospital & Surgical plans are designed as “just in case” health coverage with hospital and surgical benefits only and last for a limited time when longer term insurance isn’t available to you

Because life moves fast



Apply for coverage any day of the year

No qualifying event needed and no waiting for an enrollment period



Apply fast

Short application questions help determine if you’re eligible for coverage, and plans are medically underwritten



Choose your plan length

These plans offer up to 4 months of total coverage within a 12-month period¹

Because life can be unpredictable



Coverage you need

Plans with hospital, surgical and limited urgent care benefits only



Nationwide network

Access to quality care at reduced rates from 1.8 million physicians and health care professionals and 7,200 hospitals and medical facilities²



No referrals or primary care physician (PCP) required

Use any hospital or medical facility in the network across the nation³

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

Plan information

Hospital & Surgical plans only

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

The amount of benefits provided depends upon the plan selected, and the premium will vary with the amount of the benefits selected. These plans only pay benefits for eligible expenses from a network provider. See page 6 for details. Copays do not apply to deductible, coinsurance or coinsurance out-of-pocket maximum. This coverage does not qualify as "Minimum Essential Coverage" as defined in the Affordable Care Act and may not cover all Essential Health Benefits in your state. ¹Subsequent visits are subject to deductible then coinsurance. ²Discounts vary by pharmacy, geographic area and Rx drug. ³Additional premium required.

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+**  **7,200+**
providers 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 12/31/21.

Round out your coverage



Telehealth

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



Accident benefit

The Supplemental Accident Benefit¹ can help cover your deductible or other out-of-pocket medical costs (before insurance starts paying covered expenses) for accident-related injuries. You choose the benefit level amount you want, and it's paid per accident, per covered person. See page 13 for more details.



Dental and vision

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

¹Additional premium is required for coverage.

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

Medical benefits

(insurance plans)

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

State-specific differences may apply

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

Ambulance services

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

Breast reconstruction following mastectomy

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

Emergency treatment

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

Inpatient benefits

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

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

- Daily hospital room and board and nursing services at most common semiprivate rate.
- Eligible daily room and board and nursing service expenses for an intensive care unit.
- Inpatient use of an operating, treatment or recovery room.
- Services and supplies, including drugs and medicines, which are routinely provided in the hospital to persons for use only while they are inpatients.
- Dressings and other necessary medical supplies.
- Diagnostic testing using radiologic, ultrasonographic or laboratory services

(psychometric, behavioral and educational testing are not included).

- Radiation therapy and chemotherapy.
- Cost and administration of an anesthetic or oxygen.
- Hemodialysis, processing and administration of blood or components (but not the cost of the actual blood or components).
- Basic artificial limbs, artificial eyes and larynx and breast prosthesis. Replacement only if required by a physical change in the covered person and the item cannot be modified.
- Professional fees of doctors and medical practitioners.
- Inpatient treatment of a spine or back disorder.

Life-threatening cancer benefit

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

Medical benefits continued

(insurance plans)

Life-threatening cancer benefit, continued

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

included in the Prescription Drug List (“PDL”) provided by our pharmacy benefits manager, OptumRx, at the time your prescription order is filled (formulary drugs). Certain exceptions and exclusions may apply. See policy for details.

- Home health care, including:
 - Home health aide services, limited to 7 visits per week. Each 8-hour period of home health aide services will be counted as one visit.
 - Intermittent private-duty registered nurse visits (not to exceed 4 hours each) will be limited to \$75 per visit.
 - The professional fees of a licensed respiratory, physical, occupational or speech therapist.
 - IV. medication and pain medication.

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

Outpatient catastrophic medical expenses

Expenses received on outpatient basis are limited to:

- Radiation therapy, one office visit following each round of radiation therapy, and diagnostic testing performed in conjunction with, and on the same day as, the radiation therapy.
- Chemotherapy, including the cost and administration of chemotherapy, and diagnostic testing performed in conjunction with, and on the same day as, the chemotherapy.
- Hemodialysis.

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

Medical benefits continued

(insurance plans)

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

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

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

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

Rehabilitation and Extended Care Facility (ECF)

To qualify for benefits, a rehabilitation or extended care facility must be licensed by the state in which it operates. Services or confinement must begin within 14 days of a 3-day or more hospital stay, for the same illness or injury. Combined policy max of 60 days per person, per term for both rehabilitation and ECF expenses. This benefit excludes mental disorders or substance abuse.

Surgical expenses

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

- Professional fees of surgeon.
- Assistant surgeon fees, limited to 16% of eligible expenses of the procedure.
- Outpatient use of an operating, treatment or recovery room for surgery.

- Cost and administration of an anesthetic.
- Charges made by an outpatient surgical facility or separate identifiable outpatient unit of a hospital for services and supplies related to an outpatient surgery.
- Post-operative laboratory services necessitated by the surgery.
- Surgical treatment of a spine or back disorder.

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

Transplant expense benefit

The following transplants are covered the same as any other illness: cornea, artery or vein grafts, heart valve grafts, prosthetic tissue and joint replacement, and prosthetic lenses for cataracts. For all other covered transplants, see the policy for "Listed Transplants" under Transplant Expense Benefits. The covered person must be a good candidate, as determined by us. The transplant must not be experimental or investigational. Covered expenses for "Listed Transplants" are limited to 2 per person.

GRIC has arranged for certain hospitals around the country ("Centers of Excellence" or COE) to perform specified transplant services. At a designated COE, covered expenses include the acquisition cost and transportation and lodging limited to \$5,000 per transplant. If COE not used: Limit of 1 transplant per person, limited to max benefits of \$100,000; acquisition, transportation and lodging not covered.

No benefits payable for:

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

Urgent care

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

Exclusions/limitations

(insurance plans)

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

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

Policy details

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

No benefits are payable for expenses:

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

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

For non-emergency services or supplies received from a provider who is not a network provider, except as specifically provided for by the policy.

- That would not have been charged if you did not have insurance.
- Imposed on you by a provider (including a hospital) that are actually the responsibility of the provider to pay.
- For services performed by an immediate family member.
- That are not identified and included as covered expenses under the policy or in excess of the eligible expenses.
- For services or supplies that are provided prior to the effective date or after the termination date of the coverage.
- For weight modification or surgical treatment of obesity, including wiring of the teeth and all forms of intestinal bypass surgery.
- For breast reduction or augmentation.
- For modification of the physical body in order to improve psychological, mental or emotional well-being, such as sex change surgery.
- For drugs, treatment or procedures that promote or prevent conception or prevents childbirth, including but not limited to artificial insemination or treatment for infertility or impotency.
- For sterilization or reversals of sterilization.
- For fetal reduction surgery or abortion (unless life of mother would be endangered if the fetus were carried to term).

- For treatment of malocclusions, disorders of the temporomandibular joint (TMJ) or craniomandibular disorders.
- For routine well-baby care of a newborn infant.
- Not specifically provided for in the policy, including telephone consultations, failure to keep an appointment, television expenses or telephone expenses.
- For marriage, family or child counseling.
- For hospital room and board and nursing services if admitted on a Friday or Saturday, unless for an emergency, or for medically necessary surgery that is scheduled for the next day.
- For standby availability of a medical practitioner when no treatment is rendered.
- For dental expenses, including braces and oral surgery, except as provided for in the policy.
- For cosmetic treatment.
- For diagnosis or treatment of learning disabilities, attitudinal disorders or disciplinary problems.
- For diagnosis or treatment of nicotine addiction.
- For charges related to, or in preparation for, tissue or organ transplants.
- For high-dose chemotherapy prior to, in conjunction with, or supported by ABMT/BMT, except as specifically provided under the Transplant Expense Benefits provision in the policy.

Exclusions/limitations continued

(insurance plans)

General exclusions, continued

No benefits are payable for expenses:

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

Plan provisions

(insurance plans)

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

Optional supplemental accident benefit for Short Term Medical plans

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

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

Dependents

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

Effective date

Expenses for injuries and illnesses are eligible for coverage as of your plan's effective date.

Your policy will take effect on the later of:

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

Eligibility

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

Eligible expense

An eligible expense means a covered expense as follows:

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

Emergency

“Emergency” means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the covered person (or unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

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

** Your account will be immediately charged.

Plan provisions continued

(insurance plans)

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.

This means you will owe the difference between what the non-network provider bills and what we pay for a network eligible expense.

Non-renewable

Your Short Term Medical policy is not renewable and is issued for a specific period of time.

We may cancel coverage if there is fraud or material misrepresentation made by or with the knowledge of a covered person in filing a claim for benefits. Coverage will remain in force until the termination date shown in your policy, unless the policy terminates earlier for any reason stated in the Termination section.

Rating factors

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

Right to examine

It is important to us that you are satisfied with the coverage being provided. This product has a right to examine period, also commonly referred to as “free look.” After applying and after your policy is issued, if you are not satisfied the coverage will meet your insurance needs, you may return the policy to us within 10 days (or as required by state) 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 the primary insured is the only person on the plan.



State variations

(insurance plans)

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

Kansas

Policy Form IST7-E-D-GRI-HS-15

- Covered expenses include complications of pregnancy.

Louisiana

Policy Form IST7-E-D-GRI-HS-17R

- Minimum duration of 2 months required.
- 30-day Right to Examine period.
- Covered expenses are expanded to include:
 - Childhood immunizations for a covered person from birth until the 6th birthday, exempt from deductible.
 - A forensic medical exam for a covered person who is the victim of a sexually oriented offense, exempt from deductible, copay and coinsurance.
- Diagnosis and treatment of a correctable medical condition that is otherwise covered under the policy will not be excluded solely because the condition results in infertility.
- The exclusion for outpatient diagnosis or treatment of a spine or back disorder does not apply.
- The exclusion for marriage and family counseling does not apply. However, the exclusion for child counseling for the treatment of child relationship dysfunctions still applies.
- The exclusion for charges incurred as a result of the covered person's commission of a felony applies only if the person has been convicted.

Missouri

Policy Form IST7-E-D-GRI-HS-24R

- The policy has a variable deductible feature. The variable deductible will be applied only if you become covered under other health insurance while still covered under the policy. The variable deductible equals the amount of benefits payable for covered expenses by the other plan. The actual deductible amount for each claim may vary if a covered person has coverage under any other plan.

- “Emergency” means a health care item or service furnished or required to evaluate and treat an emergency medical condition, which may include, but is not limited to, health care services that are provided in a licensed hospital's emergency facility by an appropriate provider. “Emergency medical condition” means the sudden and, at the time, unexpected onset of a medical condition manifesting itself by symptoms of sufficient severity, regardless of the final diagnosis that is given, such that would lead a prudent layperson, who possesses an average knowledge of health and medicine, to believe that immediate medical care is required, which may include, but is not limited to:
 - Placing the health of the covered person in serious jeopardy;
 - Serious impairment to bodily functions;
 - Serious dysfunction of any bodily organ or part;
 - Inadequately controlled pain; or
 - With respect to a pregnant woman who is having contractions: there is inadequate time to effect a safe transfer to another hospital before delivery; or transfer to another hospital may pose a threat to the health or safety of the woman or unborn child.
- If a covered person's age has been misstated, the benefits may be adjusted based on the relationship of the premium paid to the premium that should have been paid based on the correct age.
- Covered expenses are expanded to include:
 - 2 sessions per policy term with one or more of the following licensed providers for the purpose of diagnosis or assessment of mental disorders: psychiatrist, psychologist, professional counselor, clinical social worker, or marriage and family therapist. Covered expenses under this paragraph provided by a non-network provider will be covered the same as if provided by a network provider.
 - Testing for lead poisoning as required or authorized by Missouri laws.
 - Necessary care and treatment of loss or impairment of speech or hearing. Covered expenses do not include services to improve public speaking, care of the professional voice, or accent reduction.

State variations continued

(insurance plans)

Missouri, continued

- Covered expenses are expanded to include: (continued)
 - Formula and low protein modified food products recommended by a doctor for the treatment of a covered person who is less than 6 years old and who has been diagnosed with phenylketonuria or any inherited disease of amino and organic acids. Covered expenses under this paragraph are limited to 50% of the cost of the formula or low protein modified food product to a maximum benefit of \$5,000 per covered person.
 - Low-dose mammography screening for any non-symptomatic female covered person as follows:
 - > A baseline mammogram for covered female age 35 to 39, inclusive;
 - > A mammogram every year for covered female age 40 or over;
 - > A mammogram every year for a covered female deemed by doctor to have above-average risk for breast cancer in accordance with the American College of Radiology guidelines for breast cancer screening;
 - > Any supplemental imaging (i.e. MRI or ultrasound) deemed medically necessary by doctor for covered female for proper breast cancer screening or evaluation in accordance with American College of Radiology guidelines; and
 - > Ultrasound or magnetic resonance imaging services if determined by doctor to be medically necessary for screening or evaluation of breast cancer for covered female deemed by treating doctor to have an above average risk for breast cancer in accordance with American College of Radiology guidelines for breast cancer screening.
- The exclusion for abortion applies only to an elective abortion which is an abortion for any reason other than a spontaneous abortion or to prevent the death of the female upon whom the abortion is performed.
- The exclusion for intentionally self-inflicted bodily harm does not apply to harm resulting from suicide or attempted suicide while the covered person was insane.

Nevada

Policy Form IST7-E-D-GRI-HS-27

- Under Life-Threatening Cancer benefits: Prescription drugs administered orally will be covered the same as prescription drugs administered by injection or intravenously as chemotherapy for the treatment of cancer. The covered person's cost for the oral chemotherapy prescription drug will not exceed \$100 per prescription order. Covered expenses for outpatient prescription drugs also include:
 - Charges incurred by a covered person for hormone replacement therapy that is prescribed or ordered by a doctor and that has been approved by the federal Food and Drug Administration. Covered expenses do not include fertility drugs. These covered expenses are exempt from copay and coinsurance.
 - Medically necessary outpatient prescription drugs to treat sickle cell disease and its variants.
 - Charges incurred by a covered person for a partial refill dispensed by a member pharmacy for less than a 30-day supply if for the purpose of synchronization of a covered person's chronic medications and: the prescriber or pharmacist determines that filling or refilling the prescription in that manner is in the best interest of the covered person; and the covered person requests less than a 30-day supply. Covered expenses under this paragraph do not apply to a controlled substance or to unit-of-use packaging.
 - Charges incurred by a covered person for an early refill of a topical ophthalmic product when the original prescription indicates additional quantities as needed and the additional refill is requested: 21 days or more after receiving a 30-day supply; 42 days or more after receiving a 60-day supply; or 63 days or more after receiving a 90-day supply.

State variations continued

(insurance plans)

Nevada, continued

- Covered expenses are expanded to include:
 - Surgical and nonsurgical treatment of craniomandibular disorders, malocclusions or disorders of the temporomandibular joint. Covered expenses do not include methods of treatment that are recognized as dental procedures, including but not limited to, the extraction of teeth and the application of orthodontic devices and splints.
 - One routine mammography exam per female covered person, per term, exempt from copay and coinsurance.
 - One cervical smear or pap smear per female covered person, per term, exempt from copay and coinsurance.
 - One digital rectal exam and one prostate specific antigen test during the policy term for each male covered person age 40 years or older.
 - One annual FDA-approved test or screening for the detection of the human papillomavirus (HPV); and for one deoxyribonucleic acid (DNA) testing for high-risk strains of HPV every 3 years for a female covered person age 30 years or older, exempt from copay and coinsurance.
 - The cost and administration of a human papillomavirus vaccination approved by the federal Food and Drug Administration.
 - Colorectal cancer screening in accordance with the guidelines published by the American Cancer Society or other guidelines or reports that are published by nationally recognized professional organizations and that include current or prevailing supporting scientific data.
 - Telehealth services if those services would be covered under the policy if provided in person.
 - Equipment, supplies and services for the treatment of diabetes, and for diabetes self-management training and education.
 - Diagnosis and treatment of severe mental illness.
 - Enteral formulas and special food products for use at home that are prescribed or ordered by a doctor for the treatment of inherited metabolic diseases originating from congenital defects or defects arising shortly after birth.
The inherited metabolic diseases must be characterized by deficient metabolism or malabsorption of amino acid, organic acid, carbohydrates or fat. Covered expenses for special food products are limited to \$2,500 per year per covered person.
- Any health care service related to hormone replacement therapy.
- Voluntary sterilization for a female covered person.
- Necessary case management services and medically necessary care for a covered person who has been diagnosed with sickle cell disease and its variants.
- General anesthesia and associated dental care procedures provided in a hospital, an outpatient surgical facility, an independent center for emergency care or a rural clinic, to a covered eligible child, as defined in the policy.
- Contraceptive drugs and devices as follows:
 - › Up to a 12-month supply per prescription, of a contraceptive drug, or its therapeutic equivalent, that is prescribed or ordered by a doctor and has been approved by the federal Food and Drug Administration.
 - › A contraceptive device that is prescribed or ordered by a doctor and has been approved by the federal Food and Drug Administration.
 - › Insertion or removal of a contraceptive device if inserted while the covered person is covered under the policy.
 - › Education and counseling related to the use of contraception, and any necessary follow-up care.
 - › Management of side effects relating to contraception.
 - › At least one drug or device in each of the following methods of contraception, exempt from any deductible amount, copayment amount or coinsurance provision in the policy: voluntary sterilization for women; surgical sterilization implants for women; implantable rods; copper-based intrauterine devices; progesterone-based intrauterine devices; injections; combined estrogen- and progestin-based drugs; progestin-based drugs; extended or continuous regimen drugs; estrogen- and progestin-based patches; vaginal contraceptive rings; diaphragms with spermicide; sponges with spermicide; cervical caps with spermicide; female condoms; spermicide; combined estrogen- and progestin-based drugs for emergency contraception or progestin-based drugs for emergency contraception; and ulipristal acetate for emergency contraception.

State variations continued

(insurance plans)

Nevada, continued

- Covered expenses are expanded to include: (continued)
 - Medical treatment as part of a clinical trial or study if certain conditions, as outlined in the policy, are met.
 - The following items and services, exempt from copay and coinsurance:
 - › Counseling, support and supplies for breastfeeding.
 - › An annual screening and counseling for interpersonal and domestic violence for a female covered person, with intervention services consisting of education, strategies to reduce harm, supportive services or a referral for any other appropriate services.
 - › Behavioral counseling concerning sexually transmitted diseases for a sexually active female covered person who is at increased risk for such diseases.
 - › Prenatal screenings and tests recommended by the American College of Obstetricians and Gynecologists or its successor organization.
 - › Screening for blood pressure abnormalities and diabetes, including gestational diabetes after at least 24 weeks of gestation or as ordered by a health care provider.
 - › Screening for depression.
 - › Screening and counseling for the human immunodeficiency virus consisting of a risk assessment, annual education relating to prevention, and at least one screening for the virus during a covered person's lifetime or as ordered by a health care provider.
 - › Smoking cessation programs for a covered person 18 years of age or older, consisting of up to 2 cessation attempts per year and 4 counseling sessions per year.
 - › All vaccinations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention of the United States Department of Health and Human Services or its successor organization.
 - › Well-woman preventive visits as recommended by the Health Resources and Services Administration, including at least one such visit per year beginning at 14 years of age.
- Hospice Care Expense Benefits are covered as defined in the policy. Benefits for hospice inpatient or outpatient care are available to a terminally ill covered person for one continuous period up to 180 days in a covered person's lifetime. For each day the covered person is confined in a hospice, benefits for room and board will not exceed:
 - For a hospice that is associated with a hospital or nursing home, the most common semiprivate room rate of the hospital or nursing home with which the hospice is associated.
 - For any other hospice, the lesser of the billed charge or \$200 per day.
- If a designated Center of Excellence is not used for a listed transplant, the \$100,000 maximum does not apply. However, the covered expenses will be reduced by 25% before application of any deductible and coinsurance.
- The exclusion regarding conception only applies to drug, treatment or procedure that promotes conception or prevents childbirth. It does not apply to anything that prevents conception.
- The exclusion for intentionally self-inflicted bodily harm (whether the covered person is sane or insane) does not apply if it is due to a severe mental illness.
- The exclusion for a covered person's commission of felony only applies if the person is convicted of the felony. This exclusion does not apply to acts of domestic violence regardless of whether the covered person contributed to any loss or injury.
- The exclusion does not apply for any illness or injury incurred as a result of the covered person being intoxicated, as defined by applicable state law in the state in which the loss occurred, or under the influence of illegal narcotics or controlled substance unless administered or prescribed by a doctor.

State variations continued

(insurance plans)

South Carolina

Policy Form IST7-E-GRI-HS-39R

- A covered person will not cease to be an eligible child solely due to age if the child is not capable of self-sustaining employment due to mental retardation or physical handicap that began before the age limit was reached and mainly dependent on you for support.
- Covered expenses are expanded to include:
 - The following when provided to a covered person in connection with a mastectomy:
 - > 48 hours of inpatient hospitalization following the mastectomy.
 - > One home care visit if ordered by the attending doctor and if attending doctor releases the covered person from the hospital earlier than 48 hours after the mastectomy.
 - One routine mammography examination for breast cancer screening per term, per covered female, in accordance with the most recent published guidelines of the American Cancer Society.
 - One cervical smear or pap smear per term, per covered female, or more often if recommended by a doctor.
 - Prostate cancer examination, screenings, and laboratory services in accordance with the most recent published guidelines of the American Cancer Society.
 - Medically necessary care and treatment of cleft lip and cleft palate.
 - Equipment, supplies, and services provided for the treatment of diabetes and for outpatient diabetes self-management training and education.
- The exclusion does not apply for expenses 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.
- The exclusion for non-emergency services or supplies received from a non-network provider does not apply during the 90 days following the date a provider terminates from the network when ongoing care is due to the existence of a covered person's serious medical condition (cancer, acute myocardial infarction, etc.).
- 30-day Right to Examine period.

Wyoming

Policy Form IST7-E-D-GRI-HS-49

- The policy does not contain comprehensive adult wellness benefits as defined by Wyoming law.
- The policy has a variable deductible feature. The variable deductible will be applied only if you become covered under other health insurance while still covered under the policy. The variable deductible equals the amount of benefits payable for covered expenses by the other plan.
- “Preexisting Condition” means any illness, injury, or condition for which medical advice, care, or treatment was recommended or received within the 6 months immediately preceding the covered person's effective date; or any illness, injury, or condition for which any diagnostic procedure or screening was recommended to or received by a covered person within the 6 months immediately preceding the covered person's effective date that results in medical care or treatment after the covered person's effective date.
- Covered expenses are expanded to include:
 - Routine patient care costs incurred by a covered person as part of a cancer clinical trial or study, if all of the conditions are met, as defined in the policy.
 - The equipment, supplies, and outpatient self-management training and education, including medical nutrition therapy, for the treatment of inherited enzymatic disorders caused by single gene defects involved in the metabolism of amino, organic, and fatty acids, if prescribed by a health care professional legally authorized by law to prescribe such items. The outpatient self-management training and education must be provided by a certified, registered, or licensed health care professional with expertise in inherited enzymatic disorders; and is limited to:
 - > A one-time evaluation and training program when medically necessary, within one (1) year of diagnosis; and
 - > Additional medically necessary self-management training provided upon a significant change in symptoms, condition, or treatment.

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.
©2025 United HealthCare Services, Inc. All Rights Reserved.
47002E-G-0325

