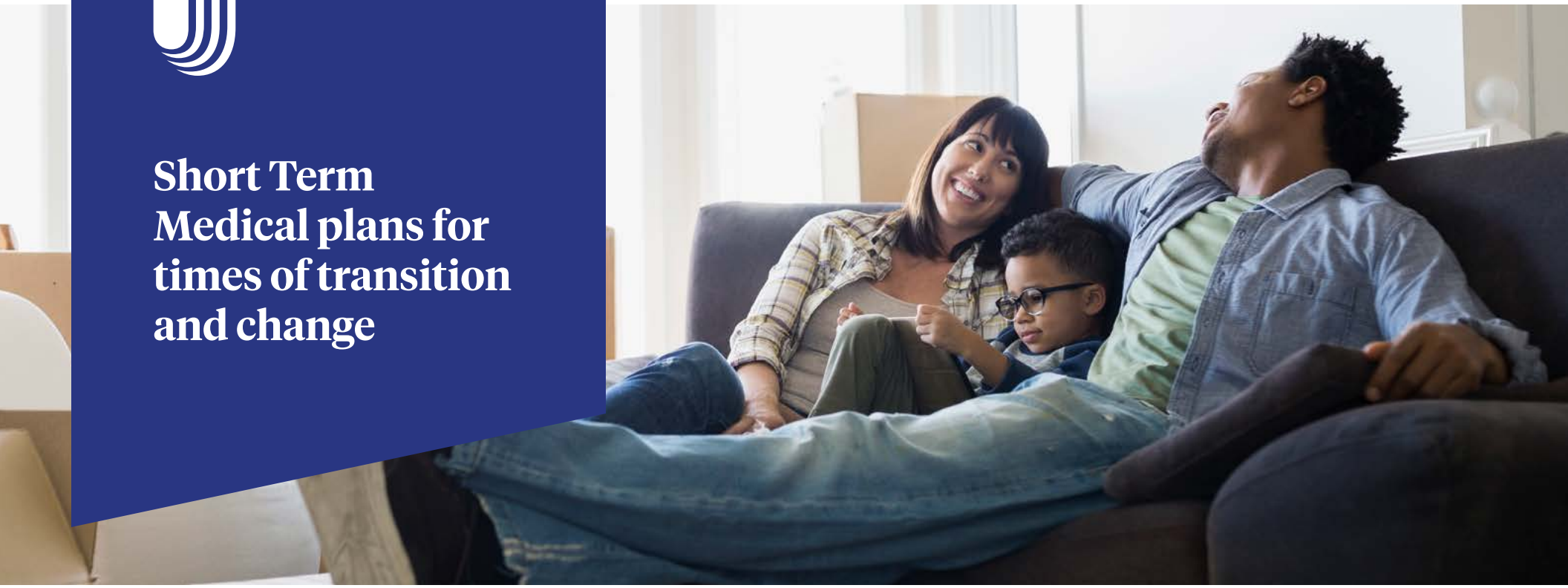
# Short Term Medical plans for times of transition and change



This coverage is not required to comply with certain federal market requirements for health insurance, principally those contained in the Affordable Care Act. Be sure to check your policy carefully to make sure you are aware of any exclusions or limitations regarding coverage of preexisting conditions or health benefits (such as hospitalization, emergency services, maternity care, preventive care, prescription drugs and mental health and substance use disorder services). Your policy might also have lifetime and/or annual dollar limits on health benefits. If this coverage expires or you lose eligibility for this coverage, you might have to wait until an open enrollment period to get other health insurance coverage.

Policy Form IST7-P-D-GRI 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
Choose from 1 month to just under 12 months, depending on your state

### 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 1.4 million physicians and health care professionals and 6,500 hospitals and medical facilities[1]

### No referrals or primary care physician (PCP) required
Use any doctor in the network across the nation[2]

[1] UnitedHealth Group Annual Form 10-K for year ended 12/31/20
[2] There are reduced non-network benefits, except for emergencies (see page 5)

This coverage does not qualify as "Minimum Essential Coverage" (MEC) as defined in the Affordable Care Act and may not cover all Essential Health Benefits in your state. And, while enforcement of the federal tax penalty is not occurring in 2021, some states may impose a tax penalty if you do not have MEC coverage. 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

## Highlights of Covered Network Expenses

### Choice of Plan Duration: 1 - 12 Months (less one day) See state variations for availability

| | | 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 9 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 Virtual Care Benefit**[3] (see page 6) | | $0 video doctor visits available through Amwell | $0 video doctor visits available through Amwell | $0 video doctor visits available through Amwell | $0 video doctor visits available through Amwell | $0 video doctor visits available through Amwell |
| **Add Supplemental Accident Benefit**[3] (see page 13) | 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 5.** 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, 4–6 months = 2 visits, 7–9 months = 3 visits, 10+ months = 4 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

- Pay in full up front and receive 18% off[1]
- 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[2]**

**1.4M+** providers

**6,500+** 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.

[1] Single pay option is not available when the optional benefit for a second plan is selected during application process. See state variations for availability.
[2] UnitedHealth Group Annual Form 10-K for year ended 12/31/20.

# Round out your coverage

## Telehealth two 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.

## 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 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.

[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.

# 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

However, if two (or more) short term plans are applied for in a single instance (also known as back-to-back or consecutive coverage, in states where available), then any condition you first develop while covered with the first plan will not be considered as a preexisting condition on the next 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 and prostate checks. 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.

# 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.

### 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, 2, 3 or 4 visits per person, per term, depending on plan duration (see page 4). 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

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.

## 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).

## 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. 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.

### 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 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 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, such as sex-change surgery.
- Not specifically provided for in the policy, including telephone consultations, failure to keep an appointment, television expenses or telephone expenses.
- For marriage, family or child counseling.
- For standby availability of a medical practitioner when no treatment is rendered.
- For hospital room and board and nursing services if admitted on a Friday or Saturday, unless for an emergency, or for medically necessary surgery that is scheduled for the next day.
- For dental expenses, including braces and oral surgery, except as provided for in the policy.
- For cosmetic treatment.
- For 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 charges related to, or in preparation for, tissue or organ transplants, except as expressly 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 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.
- For eye refractive surgery, when the primary purpose is to correct nearsightedness, farsightedness or astigmatism.
- While confined for rehabilitation, custodial care, educational care or nursing services, except as provided for in the policy.
- For eyeglasses, contact lenses, hearing aids, eye refraction, visual therapy or any exam or fitting related to these devices, except as provided for in the policy.
- Due to pregnancy (except complications).
- For any expenses, including for diagnostic testing incurred while confined primarily for well-baby care, except as provided in the policy.
- 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); 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 alternative treatments, except as specifically covered by the policy, including: acupressure, acupuncture, aromatherapy, hypnotism, massage therapy, rolfing and other alternative treatments defined by the Office of Alternative Medicine of the National Institutes of Health.
- Resulting from or during employment for wage or profit, if covered or required to be covered by workers' compensation insurance under state or federal law. If you entered into a settlement that waives your right to recover future medical benefits under a workers' compensation law or insurance plan, this exclusion will still apply.
- Resulting from intoxication, as defined by state law where the illness or injury occurred, or while under the influence of illegal narcotics or controlled substances, unless administered or prescribed by a doctor.
- For joint replacement, unless related to an injury covered by the policy.
- For 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 policy.
- 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.

# 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

Form SA-S-1996I-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.

## 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.

* 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 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.

## 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.

# 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.

## Termination

The policy will terminate on the earliest of:

- The primary insured's death. If the policy includes dependents, it may be continued after the primary insured's death by a spouse, if a covered person; otherwise, by the youngest child who is a covered person.
- Nonpayment of premiums when due.
- The termination date shown on the Data Page of the policy.
- The date we receive a request from you to terminate the policy.
- The 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.

# State Variations
## (insurance plans)

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

### Georgia

Policy Form IST7-P-D-GRI-10

- Plan duration: 1 to 12 months (less one day).
- The $2,500 limit on Spine and Back Disorders does not apply.
- Coverage for TMJ includes:
  - Nonsurgical treatment for the correction of congenital or developed anomalies of the temporomandibular joint.
  - Surgical treatment to correct functional deformities of the maxilla and mandible; $10,000 limit does not apply.
- Covered expenses are expanded to include:
  - Child wellness services provided to a covered person from birth until the 6th birthday, exempt from deductible.
  - Colorectal cancer examinations and laboratory test in accordance with the published American Cancer Society guidelines.
  - One chlamydia screening test during the policy term for a covered person, age 29 years or younger.
  - Surveillance tests for ovarian cancer for a covered person age 35 or older who is at risk for ovarian cancer.
  - General anesthesia and associated hospital or outpatient surgical facility charges for dental care provided to a covered person: who is age 7 years or younger; who is developmentally disabled; for whom a successful result cannot be expected if the services were provided under local anesthesia due to a medically compromising condition; or who has sustained extensive facial or dental trauma.
  - Evaluation and treatment of Autism Spectrum Disorder for a covered person 20 years of age or younger. Applied behavior analysis expenses are limited to $35,000 per person, per term.
  - Routine patient care costs incurred in connection with an approved clinical trial program in Georgia for the treatment of cancer for a covered eligible child who: has been diagnosed with cancer prior to the child's 19th birthday; is enrolled in an approved clinical trial program for the treatment of children's cancer; and is not otherwise eligible for benefits, payments, or reimbursement from any other third-party payers or similar sources.
  - Bone mass measurement for the prevention, diagnosis and treatment of osteoporosis as described in the policy.
  - Diagnostic testing to determine the cause of infertility or that results in an incidental finding of infertility.
  - Treatment of a terminal condition as described in the policy.
- The limits for listed transplants do not apply to ABMT for breast cancer and BMT or ABMT for Hodgkin's Lymphoma.
- Preexisting Condition means any illness, injury or condition for which medical advice, care or treatment was recommended or received within the 6 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 6 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 6 months immediately prior to the covered person's effective date.
- An optional benefit is available during the initial application to apply for a second plan. This would provide a continuous, uninterrupted period of coverage for the two plans when applied for together. Continuous, uninterrupted period of coverage means a period of coverage beginning when your first plan with us becomes effective and continuing, without a gap in coverage, to the end of a second plan with us. Coverage with us before the first plan or after the second plan will not be considered continuous, uninterrupted period of coverage.
  - A condition that began before the effective date of the first plan with us is subject to preexisting limitations.
  - A condition that began during the first plan term with us will not be a preexisting condition under the second plan term with us.
  - For each of the two plans, you must meet a plan deductible, coinsurance and coinsurance out-of-pocket maximum.
  - The option for consecutive plans results in higher prices for your two plans.

# State Variations continued
(insurance plans)

## Kentucky
Policy Form IST7-P-D-GRI-16

- Plan duration: 1 to 12 months (less one day).
- The Office Visit copay applies to preventive visits for mammograms, cervical or pap smears and colorectal cancer screenings as outlined in the policy. It does not apply to any other preventive visits.
- The covered expenses for surgery, excluding tooth extraction, craniomandibular disorders, malocclusions or disorders of the temporomandibular joint include both surgical and non-surgical treatment. The $10,000 maximum does not apply.
- Covered expenses are expanded to include:
  - Colorectal cancer exams and laboratory tests in accordance with the guidelines published by the American Cancer Society.
  - Diagnosis and treatment of endometriosis or endometritis not including expenses primarily for the treatment of infertility.
  - Bone density testing for a female covered person age 35 years or older to obtain baseline data for the purpose of early detection of osteoporosis.
- Covered expenses for home health aide services for Home Health Care are limited to 60 visits per person, per term. Each visit by an authorized representative of a home health care agency is considered as one visit, except that 4 hours of home health aide services will be considered as one visit.
- An optional benefit is available during the initial application to apply for a second plan. This would provide a continuous, uninterrupted period of coverage for the two plans when applied for together. Continuous, uninterrupted period of coverage means a period of coverage beginning when your first plan with us becomes effective and continuing, without a gap in coverage, to the end of a second plan with us. Coverage with us before the first plan or after the second plan will not be considered continuous, uninterrupted period of coverage.
  - A condition that began before the effective date of the first plan with us is subject to preexisting limitations.
  - A condition that began during the first plan term with us will not be a preexisting condition under the second plan term with us.
  - For each of the two plans, you must meet a plan deductible, coinsurance, and coinsurance out-of-pocket maximum.
  - The option for consecutive plans results in higher prices for your two plans.

## Montana
Policy Form IST7-P-D-GRI-25

- Plan duration: 1 to 6 months.
- Under the covered expense for one routine mammography exam during the policy term for each female covered person, the first $70 per mammogram will not be subject to any deductible amount, copayment amount or coinsurance.
- Covered expenses are expanded to include:
  - Well-child care services provided by a single medical practitioner during a single visit for any covered person from birth through age 7, exempt from deductible.
  - Treatment of inborn errors of metabolism as defined in the policy.
  - Pregnancy care services, including at least 48 hours of inpatient hospital care following a vaginal delivery and at least 96 hours inpatient hospital care following a cesarean section for a mother an newborn infant.
  - Diagnosis and treatment of severe mental illness, limited to: schizophrenia, schizoaffective disorder, bipolar disorder, major depression, panic disorder, obsessive-compulsive disorder and autism, subject to the applicable policy limits.
  - Diagnosis and treatment of autism spectrum disorders for a covered person less than age 19 as defined in the policy, limited to a maximum of $50,000 per year for a covered person age 8 or younger and $20,000 per year for a covered person age 9 through 18.
- The exclusion for pregnancy applies to surrogate pregnancy only, unless the surrogate contract fails (covered expenses would include what would have been covered under that surrogacy contract only.)
- The exclusion as a result of the covered person's felony applies only if the person is convicted.
- The exclusion for intentionally self-inflicted bodily harm does not apply.
- The exclusion for any illness or injury incurred as a result of the covered person being intoxicated or under the influence of illegal narcotics or controlled substance does not apply.

# State Variations continued
## (insurance plans)

### North Carolina
Policy Form IST7-P-D-GRI-32

- Plan duration: 1 to 12 months (less one day).
- The covered expenses for surgery, excluding tooth extraction, include diagnostic, surgical and non-surgical treatment of temporomandibular joint disorders (TMJ), including splinting and use of intraoral prosthetic appliances. Non-surgical treatment of TMJ is limited to a maximum of $3500 per covered person per policy term. Non-surgical treatment of TMJ does not include tooth extraction, orthodontic braces, crowns, bridges, dentures, treatment for periodontal disease, dental root implants or root canals.
- The covered expenses for one cervical smear or pap smear also include a human papillomavirus screening.
- The covered expenses for one digital rectal exam and one prostate specific antigen test for each male covered person are not limited to age 40; however, they must be recommended by a licensed doctor.
- Covered Expenses are expanded to include:
  - An annual screening for ovarian cancer using transvaginal ultrasound and rectovaginal pelvic examination for women age 25 and older who: have a family history with at least one first-degree relative with ovarian cancer and a second relative, either first-degree or second-degree with breast, ovarian or nonpolyposis colorectal cancer; or tests positive for a hereditary ovarian cancer syndrome.
  - Colorectal cancer examinations and laboratory tests in accordance with the published American Cancer Society guidelines.
  - General anesthesia and other related charges incurred for dental care (but not including the actual dental services) that is provided in hospital or outpatient surgical facility to the following covered persons, when medically necessary to safely and effectively perform the procedure: an eligible child less than 9 years of age; a covered person with a serious mental or physical condition; or a covered person with significant behavioral problems.
  - The diagnosis and evaluation of osteoporosis or low bone mass for a covered person, as defined in the policy.
  - The screening, diagnosis and treatment of autism spectrum disorder, as defined in the policy. Adaptive behavior treatment is limited to maximum of $40,000 or the limit set by the state of North Carolina.
  - Medically necessary costs of health care services associated with participation in a clinical trial, medically necessary monitoring and the diagnosis and treatment of complications, only to the extent such costs are not funded by national agencies, commercial manufacturers, distributors or other sponsored of participants in the clinical trial. Covered expenses do not include the costs of the actual investigational drug or device, services that are not health care services, services provided solely to satisfy data collection, services not provided for direct clinical management or non-USFDA-approved drugs provided after the clinical trial has been concluded.
  - A newborn hearing screening when ordered by the attending doctor.
  - The diagnosis, evaluation and treatment of lymphedema.
  - One hearing aid per hearing-impaired ear up to $2,500 per hearing aid for a covered person less than 22 years of age, limited to: initial hearing aids and replacement hearing aids not more frequently than every 36 months; a new hearing aid when alterations to the existing hearing aid cannot adequately meet the covered person's needs; and services ordered by a physician or a licensed audiologist.
- The exclusion for expenses as a result of an injury or illness arising out of, or in the course of employment for wage was replaced with exclusion for services or supplies for the treatment of an occupational injury or illness that are paid under the North Carolina Workers' Compensation Act only to the extent such services or supplies are the liability of the employee, employer or workers' compensation insurance carrier according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act.
- The exclusion for any illness or injury incurred as a result of the covered person being intoxicated or under the influence of illegal narcotics or controlled substance does not apply.

# State Variations continued
(insurance plans)

## North Carolina, continued

- "Preexisting condition" means: Any illness, injury or condition for which medical advice, care or treatment was recommended or received within the 12 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 12 months immediately preceding the covered person's effective date that results in medical care or treatment after the covered person's effective date.
- An optional benefit is available during the initial application to apply for a second plan. This would provide a continuous, uninterrupted period of coverage for the two plans when applied for together. Continuous, uninterrupted period of coverage means a period of coverage beginning when your first plan with us becomes effective and continuing, without a gap in coverage, to the end of a second plan with us. Coverage with us before the first plan or after the second plan will not be considered continuous, uninterrupted period of coverage.
  - A condition that began before the effective date of the first plan with us is subject to preexisting limitations.
  - A condition that began during the first plan term with us will not be a preexisting condition under the second plan term with us.
  - For each of the two plans, you must meet a plan deductible, coinsurance and coinsurance out-of-pocket maximum.
  - The option for consecutive plans results in higher prices for your two plans.

## Oklahoma

Policy Form IST7-P-D-GRI-35

- Plan duration: 1 to 12 months (not to exceed 364 days).
- The $2,500 maximum on spine and back disorders does not apply.
- The exclusion for charges incurred as a result of any injury sustained during or due to participating, instructing, demonstrating, guiding or accompanying others in any of the following applies only if the covered person is paid to participate or instruct: professional or semi-professional sports; intercollegiate sports (not including intramural sports); parachute jumping; hang-gliding; racing or speed testing any motorized vehicle or conveyance; scuba/skin diving (when diving 60 or more feet in depth); skydiving; bungee jumping; or rodeo sports.
- The exclusion for charges as a result of an injury or illness caused by an act of war specifically applies to any charges that are incurred while serving in the military or naval services, or any auxiliary unit, of the United States.
- The exclusion for charges for any illness or injury incurred as a result of the covered person being intoxicated does not apply. However, the exclusion still applies for the person being under the influence of illegal narcotics or controlled substance unless administered or prescribed by a doctor.
- An optional benefit is available during the initial application to apply for a second plan. This would provide a continuous, uninterrupted period of coverage for the two plans when applied for together. Continuous, uninterrupted period of coverage means a period of coverage beginning when your first plan with us becomes effective and continuing, without a gap in coverage, to the end of a second plan with us. Coverage with us before the first plan or after the second plan will not be considered continuous, uninterrupted period of coverage.
  - A condition that began before the effective date of the first plan with us is subject to preexisting limitations.
  - A condition that began during the first plan term with us will not be a preexisting condition under the second plan term with us.
  - For each of the two plans, you must meet a plan deductible, coinsurance and coinsurance out-of-pocket maximum.
  - The option for consecutive plans results in higher prices for your two plans.

# 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 75 years. Plans are administered by United Healthcare Services, Inc.

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

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

* As of 12/18/20. For the latest rating, access www.ambest.com.



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UnitedHealthcare®
Golden Rule Insurance Co.

## HEALTH PLAN NOTICES 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. PLEASE REVIEW IT CAREFULLY.**

### MEDICAL INFORMATION PRIVACY NOTICE (Effective January 1, 2019)

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

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

We have the right to change our privacy practices and the terms of this notice. If we make a material change to our privacy practices, we will provide to you in our next annual distribution, either a revised notice or information about the material change or how to obtain a revised notice. We will provide this information either by direct mail or electronically in accordance with applicable law. In all cases, we will post the revised notice on our websites, such as *www.uhone.com, www.myuhone.com, www.uhone4me.com, www.myallsavers.com, or www.myallsaversconnect.com.* We reserve the right to make any revised or changed notice effective for information we already have and for information that we receive in the future.

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

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

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

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

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

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

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

33638-X-201902 Products are either underwritten or administered by: All Savers Insurance Company, All Savers Life Insurance Company of California, Golden Rule Insurance Company, Oxford Health Insurance, Inc., UnitedHealthcare Insurance Company, and/or UnitedHealthcare Life Insurance Company.

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

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

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

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

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

- **You have the right to a paper copy of this notice.** You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. In addition, you may obtain a copy of this notice at our websites such as *www.uhone.com, www.myuhone.com, www.uhone4me.com, www.myallsavers.com, or www.myallsaversconnect.com*.
- **You have the right to be considered a protected person.** *(New Mexico only)* *A "protected person" is a victim of domestic abuse who also is either: (i) an applicant for insurance with us; (ii) a person who is or may be covered by our insurance; or (iii) someone who has a claim for benefits under our insurance*.

## Exercising Your Rights

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

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

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

**MIB.** In conjunction with our membership in MIB, Inc., formerly known as Medical Information Bureau (MIB), we or our reinsurers may make a report of your personal information to MIB. MIB is a not-for-profit organization of life and health insurance companies that operates an information exchange on behalf of its members.
If you submit an application or claim for benefits to another MIB member company for life or health insurance coverage, the MIB, upon request, will supply such company with information regarding you that it has in its file.

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

## FINANCIAL INFORMATION PRIVACY NOTICE (Effective January 1, 2019)

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

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

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

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

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

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

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

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

The Notice of Privacy Practices, effective January 1, 2019, is provided on behalf of All Savers Insurance Company; All Savers Life Insurance Company of California; Golden Rule Insurance Company; Oxford Health Insurance, Inc.; UnitedHealthcare Insurance Company; and UnitedHealthcare Life Insurance Company. To obtain an authorization to release your personal information to another party, please go to the appropriate website listed in this Notice.

33638-X-201902 Products are either underwritten or administered by: All Savers Insurance Company, All Savers Life Insurance Company of California, Golden Rule Insurance Company, Oxford Health Insurance, Inc., UnitedHealthcare Insurance Company, and/or UnitedHealthcare Life Insurance Company.