Short Term Medical Hospital & Surgical Plans

Coverage when you need it most

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 Forms IST7-P-D-GRI-HS and other state variations

UnitedHealthcare®
Golden Rule Insurance Co.

Table of Contents

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
Choose from 1 month to just under 12 months, depending on your state

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 1.5 million physicians and health care professionals and 7,000 hospitals and medical facilities[1]

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

[1] UnitedHealth Group Annual Form 10-K for year ended 12/31/21.
[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 2022, 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
Hospital & Surgical plans only

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

		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 Virtual Care Benefit[3] (See page 6)		**$0 video doctor visits available through Amwell**
Add Supplemental Accident Benefit[3] (See page 6)	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. Non-network benefits vary. See page 5 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. [1] Subsequent visits are subject to deductible then coinsurance. [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
- Choose a higher deductible: If you agree to cover more before insurance starts paying, you can reduce your plan premium

Save on health care costs

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

National Network*

1.5M+ providers

7,000+ hospitals

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

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

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

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

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

*UnitedHealth Group Annual Form 10-K for year ended 12/31/21.

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 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 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 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 12 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, 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.
  - I.V. 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.

- 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 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 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, except as expressly provided for in the policy.
- 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.
- 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.

* 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)

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.

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.

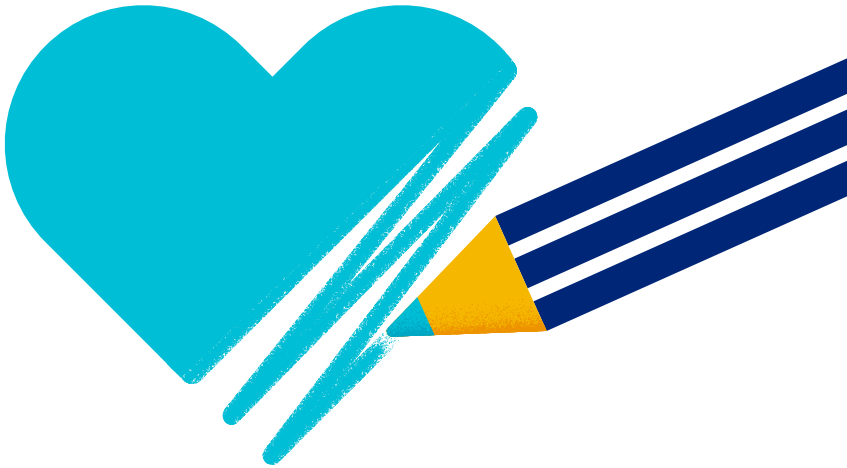
Rating Factors

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.

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.

Georgia
Policy Form IST7-P-D-GRI-HS-10

- Plan duration: 1 to 12 months (less one day).
- Covered expenses for charges incurred in a hospital are expanded to include:
  - Telehealth services for the diagnosis, consultation or treatment of a covered person.
  - Inpatient or surgical treatment, excluding tooth extraction, for the correction of congenital or developed anomalies of the temporomandibular joint (TMJ).
  - Inpatient or surgical treatment to correct functional deformities of the maxilla and mandible.
- Other covered expenses are expanded to include:
  - Child wellness services provided to a covered person from birth until the 6th birthday, exempt from deductible.
  - One routine mammography exam per female covered person, per term, or more often if ordered by doctor.
  - One cervical smear or pap smear per female covered person, per term, or more often if ordered by doctor.
  - One digital rectal exam and one prostate specific antigen (PSA) test per male covered person age 40 or older, per term, or more often if ordered by doctor.
  - 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.
  - Bone mass measurement for the prevention, diagnosis and treatment of osteoporosis as described in the policy.
  - 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.
- The exclusion for outpatient diagnosis or treatment of a spine or back disorder does not apply.
- 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.

State Variations continued
(insurance plans)

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

- Plan duration: 1 to 12 months (less one day).
- Covered expenses are expanded to include:
  - Surgical and non-surgical treatment, excluding tooth extraction, of craniomandibular disorders, malocclusions or disorders of the temporomandibular joint (TMJ).
  - One routine mammogram per female covered person, per term and mammograms by medical practitioner referral for covered person diagnosed with breast disease.
  - One cervical smear or pap smear per female covered person, per term.
  - Colorectal cancer exams and lab 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.
- Home Health Care Expense Benefits are covered as outlined in the policy. Covered expenses for home health aide 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. Covered expenses for intermittent private duty registered nurse visits (not more than 4 hours each) will be limited to $75 per visit. No benefits will be payable for charges related to respite care, custodial care or educational care.

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

- Plan duration: 1 to 6 months.
- Covered expenses are expanded to include:
  - One baseline mammography exam per female covered person age 35-40, per term; one routine mammography every 2 years for each female covered person age 40-50, or more frequently if order by a doctor; and one routine mammography each year for each female covered person over age 50. The first $70 per mammogram will not be subject to any deductible amount, copayment amount or coinsurance.
  - 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.
  - 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.
  - 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.

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

- Plan duration: 1 to 12 months (less one day).
- Covered surgical expenses are expanded to include reconstructive surgery incidental to or following surgery for an injury that was covered under the policy or is performed to correct a birth defect in a child who has been covered from birth until date surgery is performed.
- Other covered expenses are expanded to include:
  - Diagnostic, surgical and non-surgical treatment of temporomandibular joint disorders (TMJ). Non-surgical treatment of TMJ is limited to a maximum of $3,500 per covered person, per 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.
  - 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.

State Variations continued
(insurance plans)

North Carolina, continued

- Other covered expenses are expanded to include: (continued)
  - 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.
  - Equipment, supplies, medications, lab procedures and services for treatment of diabetes and self-management training and education.
  - 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.
  - Low-dose screening mammography as follows:
    - > One or more mammograms per term for a woman: who has a personal history of breast cancer; who has a personal history of biopsy-proven benign breast disease; whose mother, sister or daughter has or has had breast cancer; or who has not given birth prior to the age of 30 years.
    - > One baseline mammogram for a woman ages 35 through 39.
    - > One mammogram every two years for a woman ages 40 through 49 years, or more frequently if recommended by doctor.
    - > One mammogram per term for a woman 50 years of age or older.
  - Cervical cancer screening, including exam, lab fee and doctor's interpretation of lab results, in accordance with most recently published American Cancer Society guidelines or guidelines adopted by the North Carolina Advisory Committee on Cancer Coordination and Control.
  - 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.
  - Prostate-specific antigen (PSA) tests for presence of prostate cancer upon recommendation of doctor.
- 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.
- "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.

State Variations continued
(insurance plans)

Oklahoma
Policy Form IST7-P-D-GRI-HS-35

- Plan duration: 1 to 12 months (not to exceed 364 days).
- Covered expenses are expanded to include diagnosis and treatment of a spine or back disorder.
- 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.

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+” (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.

* As of 12/9/21. For the latest rating, access **www.ambest.com**.

47005P-G-1122

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.