



Short Term MedicalSM Plans

Health plans for Individuals & Families in times of transition and change

**BETWEEN
JOBS**
or out of work

BRIDGE THE GAP
until the next
Open Enrollment

RETIRED EARLY
or needing a bridge to
Medicare eligibility

WAITING FOR
other coverage
to begin

THIS IS NOT QUALIFYING HEALTH COVERAGE ("MINIMUM ESSENTIAL COVERAGE") THAT SATISFIES THE HEALTH COVERAGE REQUIREMENT OF THE AFFORDABLE CARE ACT. IF YOU DO NOT HAVE MINIMUM ESSENTIAL COVERAGE, YOU MAY OWE AN ADDITIONAL PAYMENT WITH YOUR TAXES.



These plans must end by December 31, 2017, due to federal regulation.

Underwritten by Golden Rule Insurance Company.

Policy Forms IST6.0-G-10 (GA), IST6.0-G-27 (NV), IST6.0-G-36 (OR), and other state variations. For more policy form numbers, see Short Term MedicalSM State Variations insert (43854i-G).

43854C1GA-G-1216 (includes: 43854-G-1216, 43854iGA-G-0516) 1 of 20

Why choose us?



experience

NEARLY 70 YEARS IN THE
BUSINESS OF INSURING
INDIVIDUALS

You are the One with UnitedHealthOneSM

UnitedHealthOneSM is the brand name used by the UnitedHealthcare family of companies offering personal health insurance products. Golden Rule Insurance Company, a UnitedHealthcare company, is the underwriter and administrator of plans featured in this brochure. We have been serving the specific needs of individuals and families buying their own coverage for nearly 70 years.

Strength & Experience

UnitedHealthcare Employer and Individual provides approximately 30 million Americans access to health care.* We offer an array of consumer-oriented health benefit plans.



highly rated

GOLDEN RULE INSURANCE
COMPANY RATED "A"
BY A.M. BEST (03/31/15)

Highly Rated

Golden Rule Insurance Company is rated "A" (Excellent) by A.M. Best (03/31/15). 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.

Nationwide Network – Big Savings

With network providers, you will not be balance billed for eligible expenses. Health care professionals in the network agree to provide you quality care at lower fees. With access to 1 million physicians and other health care professionals, and approximately 6,000 hospitals and other facilities,* chances are your current doctor is already a part of the nationwide network.

Visit UHOne.com to find providers in the UnitedHealthcare Choice Plus network.



network

NATIONWIDE NETWORK
CAN MEAN BIG SAVINGS

* UnitedHealth Group Annual Form 10-K for year ended 12/31/15.

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. State specific differences may apply. This brochure must be used in conjunction with the Short Term MedicalSM State Variations Inserts (43854i-G, 43854iGA-G, 43854iNV-G, or 43854iOR-G).

UnitedHealthcare Choice Plus Network

Our nationwide network of doctors and hospitals provides you with great value for your health care dollars. We contract with providers offering quality care at a significant discount. Getting your non-emergency care from a doctor or hospital not in our network will cost you more.

Sample Savings with Our Network (Services provided 05/2015-12/2015)¹

Receive quality care at reduced costs because our network providers have agreed to lower fees for covered expenses. Here are some examples of the savings:

Benefit	Actual Charges	Network Repriced Charges	Network Savings
Doctor Office Visit - established patient	\$75.39	\$35.73	53%
MRI	\$847.09	\$233.25	72%
Lipid Panel (Cholesterol)	\$76.73	\$12.63	84%
CBC (Complete Blood Count)	\$29.52	\$6.28	79%
Metabolic Panel (Blood sugar/kidney and liver function)	\$45.98	\$8.03	83%
General Panel (General blood work)	\$140.38	\$29.40	79%

Nonemergency covered expenses

Using non-network providers you pay:²

- All charges above what is considered an eligible expense (see page 12 for details);
- A penalty of 25% of the eligible expense, which does not count toward the deductible; and
- A deductible equal to 2 times the network deductible.

There is no out-of-pocket maximum for non-network providers.

¹ All these services were received from network providers in ZIP Code 630--. Your actual savings may be more or less than this illustration. Discounts vary by provider, geographic area, and type of service.

² Your actual out-of-pocket expenses for covered expenses may exceed the stated coinsurance percentage because actual provider charges may not be used to determine insurer and insured's payment obligations. Considering these factors, seeing in-network providers can result in a big savings for what you pay for your health care.

How our plans work

- You can receive care from any doctor or hospital in our network.
- If you're looking for a specialist, no referral is needed.
- You receive maximum benefits from the plan when you use network providers.
- Using a non-network doctor or hospital for non-emergency care will cost you more.

A Choice of Coverage to Fit Your Specific Needs

- You select the term from 30 to 360 days,¹ deductible, and coinsurance that fit your budget. See pages 6-7 for details.
- Once you meet your deductible for the term, you pay a percentage of covered expenses (coinsurance) up to a maximum out-of-pocket amount.
- Then insurance pays 100% of the remaining covered expenses up to the lifetime maximum benefit.

PLANS AT A GLANCE

1 PLAN FEATURES

2 COVERED EXPENSES

3 WHO BENEFITS MOST?

Lifetime Maximum Benefit:
\$1,000,000

**Short Term MedicalSM
Value**

- Our lowest premium plan.
- In exchange, you take more responsibility for medical expenses.
- No Rx drug coverage.

- Pay selected deductible.
- Then pay coinsurance, (select from 2 options) up to:
 - \$5,000 per term/cause, or
 - \$10,000 per term/cause.

Consumers looking for minimal coverage.

Lifetime Maximum Benefit:
\$1,000,000

**Short Term MedicalSM
Plus**

- More coverage than Value.
- Rx drug coverage included.
- Option to add a \$20 copay on generic Rx drugs.

- Pay selected deductible.
- Then pay coinsurance, (select from 2 options) up to:
 - \$2,000 per term/cause, or
 - \$5,000 per term/cause.

Great for those seeking predictable out-of-pocket expenses.

Lifetime Maximum Benefit:
\$1,000,000

**Short Term MedicalSM
Copay Value**

- Copay for network doctor office visits.²
- No Rx drug coverage.
- Option to add Rx drug coverage or a \$20 copay on generic Rx drugs.

- Pay selected deductible.
- Then pay coinsurance, up to \$10,000 per term/cause.

Families with young children who have regularly scheduled doctor office visits.

Lifetime Maximum Benefit:
\$1,000,000

**Short Term MedicalSM
Copay**

- Copay for network doctor office visits.²
- Rx drug coverage included.
- Options to remove Rx drug coverage, add a 4-Tier Rx drug card, or add a \$20 copay on generic Rx drugs.

- Pay selected deductible.
- Then pay coinsurance, up to \$10,000 per term/cause.

Anyone who prefers the convenience of copay benefits for minor or routine health care expenses.

Lifetime Maximum Benefit:
\$1,500,000

**Short Term MedicalSM
Plus Elite³**

- Increased lifetime maximum benefit up to \$1.5 million.
- Rx drug coverage included.
- Option to add a \$20 copay on generic Rx drugs.

- Pay selected deductible.
- Then pay coinsurance, (select from 2 options) up to:
 - \$2,000 per term/cause, or
 - \$5,000 per term/cause.

Great for those seeking predictable out-of-pocket expenses and for those who are considering longer term lengths.

¹ 30-360 days in GA, ID, KY, OR, UT, and WA; 30-337 days in MD and SC; 30-184 days in CT, DE, LA, NV, and WY; 30-123 days in KS.; 1-6 months in MO.

² History and exam only: 2 visit limit for terms 180 days or less; 4 visit limit for terms 181 days and over. Additional visits subject to deductible and coinsurance.

³ Not available in all states.

Optional Benefits

Further customize your health insurance coverage to meet your specific needs. Rx options require additional premium (except Remove Rx coverage).



Prescription (Rx) Drug Options (You may only choose one.)

Rider Forms SA-S-1734-G and state variations, SA-S-1735-G and state variations, and SA-S-1736-G and state variations

Option	Plans available	Details
Add 4-Tier Rx Coverage	Short Term Medical SM Copay	Tier 1 drugs: \$20 copay, no deductible. Tier 2-4 drugs have combined \$500 deductible per person, per term, then: Tier 2 drugs: \$40 copay, Tier 3 drugs: \$75 copay, and Tier 4 drugs: you pay 40% coinsurance. Limited to a \$3,000 maximum Rx benefit per person, per term.
Add a Generic \$20 Rx Copay	Short Term Medical SM : Plus, Copay Value, Copay, and Plus Elite	Applies to all tiers with no deductible to meet. Name-brand drugs subject to regular plan benefits. May not be combined with 4-Tier Rx coverage. Limited to a \$3,000 maximum Rx benefit per person, per term.
Remove Rx Coverage	Short Term Medical SM Copay	Lowers your premium. Discount Card only.
Add Rx Coverage	Short Term Medical SM Copay Value	Adds 30% coinsurance on prescriptions after you meet your deductible. Limited to a \$3,000 maximum Rx benefit per person, per term.



Per Cause Deductible Option

Lower your premium with our Per Cause Deductible. With this option, you have a separate deductible for each illness or injury. You take more responsibility, but save about 10% on premium. **Note:** Rx benefits remain per term even if you choose the Per Cause Deductible.



Supplemental Accident Optional Benefit

Reduce or eliminate your out-of-pocket exposure for accident-related injuries for additional premium. Supplemental Accident helps cover your deductible or other out-of-pocket medical expenses (before the health insurance starts paying covered expenses) for unexpected injuries.

You select a maximum amount per accident, per covered person.

Benefit Amounts:	\$1,000	\$1,500	\$2,500	\$5,000	\$10,000
Savings example for \$37,422 femur fracture*	No health plan	Short Term MedicalSM Plus plan only (\$5,000 deductible + 30% coinsurance)		Same plan with a \$5,000 Supplemental Accident Benefit	
What you could pay:	\$37,422	\$10,000		\$5,000	

* Examples provided are for illustration purposes only and assume all expenses are covered. Adding a \$5,000 Supplemental Accident Benefit would add \$30 in monthly premium for a single person and \$60 in monthly premium for a family. All of these services were received in June-August 2015 from network providers in ZIP Code 302--. Your actual savings may be more or less than this illustration and will vary by several factors. Rider Forms SA-S-1733-G, SA-S-1733-G-16, and SA-S-1733-G-36

Supplemental Accident Provisions

Expenses must be eligible for payment under the health insurance and incurred within 90 days of an injury. Benefit cannot exceed your total covered medical out-of-pocket expenses that are neither paid nor reimbursed by the underlying health insurance.

Any benefit amount paid by the Supplemental Accident benefit will first be credited to the deductible and

coinsurance of the health insurance. The payment will be made either to your health care provider under your assignment of benefits, or to you if you have already paid your provider. No cash payments to the insured except for reimbursement of submitted claims for covered expenses already paid by you and not paid by the underlying health insurance. Exclusions and Limitations of the health plan apply to this additional benefit.



1 Choose a plan.
You have several choices.

2 Choose a term.
This is your length of coverage.

3 Choose a deductible type and amount.
Choose either per term (length of coverage) or per cause (illness or injury). The deductible amount you choose applies to each covered person.

4 Choose a coinsurance.
For Plus and Plus Elite plans, choose 20% or 30%.



Highlights of Network Covered Expenses

		Short Term Medical SM Value	Short Term Medical SM Plus	Short Term Medical SM Copay Value	Short Term Medical SM Copay	Short Term Medical SM Plus Elite ¹
Coverage Term		30-360 days in GA, ID, KY, OR, UT, and WA; 30-337 days in MD and SC; 30-184 days in CT, DE, LA, NV, and WY; 30-123 days in KS; 1-6 months in MO.	30-360 days in GA, ID, KY, OR, UT, and WA; 30-337 days in MD and SC; 30-184 days in CT, DE, LA, NV, and WY; 30-123 days in KS; 1-6 months in MO.	30-360 days in GA, ID, KY, OR, UT, and WA; 30-337 days in MD and SC; 30-184 days in CT, DE, LA, NV, and WY; 30-123 days in KS; 1-6 months in MO.	30-360 days in GA, ID, KY, OR, UT, and WA; 30-337 days in MD and SC; 30-184 days in CT, DE, LA, NV, and WY; 30-123 days in KS; 1-6 months in MO.	30-360 days in GA, ID, KY, OR, UT, and WA; 30-337 days in MD and SC; 30-184 days in CT, DE, LA, NV, and WY; 1-6 months in MO.
Deductible Type		Per Term Option: Per Cause to lower premium	Per Term Option: Per Cause to lower premium	Per Term Option: Per Cause to lower premium	Per Term Option: Per Cause to lower premium	Per Term Option: Per Cause to lower premium
Deductible Amount (per person)	You pay:	\$1,000, \$1,500, \$2,500, \$5,000, or \$10,000	\$1,000, \$1,500, \$2,500, \$5,000, or \$10,000	\$1,000, \$1,500, \$2,500, \$5,000, or \$10,000	\$1,000, \$1,500, \$2,500, \$5,000, or \$10,000	\$1,000, \$1,500, \$2,500, \$5,000, or \$10,000
Coinsurance Choices (% you pay of covered expenses after deductible, per person)	You pay:	30%	20% or 30%	30%	30%	20% or 30%
Coinsurance Out-of-Pocket Maximum (after deductible, per person)	You pay:	\$5,000 or \$10,000	\$2,000 or \$5,000	\$10,000	\$10,000	\$2,000 or \$5,000
Lifetime Maximum Benefit (per covered person)	We pay:	\$1 million	\$1 million	\$1 million	\$1 million	\$1.5 million
Doctor Office (Illness & Injury)						
Office Visit, History, and Exam only (referrals for primary care physician/specialist not required)	You pay:	30% after deductible	20% after deductible or 30% after deductible	\$50 copay ² – no deductible: - 2 visit limit* for a term 180 days or less; or - 4 visit limit* for a term 181 days and over. * Per covered person, per term. Additional visits subject to deductible and coinsurance.	\$50 copay ² – no deductible: - 2 visit limit* for a term 180 days or less; or - 4 visit limit* for a term 181 days and over. * Per covered person, per term. Additional visits subject to deductible and coinsurance.	20% after deductible or 30% after deductible
Pharmacy						
Name Brand and Generic Prescription (Rx) Drugs Plans/Options with Rx coverage: limited to \$3,000 maximum Rx benefit per person, per term.	You pay:	Not covered. Discount Card – card can help you save an average of 20-25% on your Rx drugs. Discounts vary by pharmacy, geographic area, and drug.	20% or 30% after deductible. Preferred Price Card (You pay for Rx drugs at the point of sale, at the lowest price available, and submit a claim to us.) Option: Add a Generic \$20 Rx Copay ³	Not covered. Discount Card only – can help you save an average of 20-25% on your Rx drugs. Discounts vary by pharmacy, geographic area, and drug. Option: Add a Generic \$20 Rx Copay ³ <u>OR</u> Option: Add Rx coverage. 30% after deductible. Preferred Price Card (You pay for prescriptions at the point of sale, at the lowest price available, and submit a claim to us.)	30% after deductible. Preferred Price Card (You pay for Rx drugs at the point of sale, at the lowest price available, and submit a claim to us.) Option: Add 4-Tier Rx Coverage (see page 5) <u>OR</u> Option: Add a Generic \$20 Rx Copay ³ <u>OR</u> Option: Opt for no Rx coverage. Discount Card only – can help you save an average of 20-25% on your Rx drugs. Discounts vary by pharmacy, geographic area, and drug.	20% or 30% after deductible. Preferred Price Card (You pay for Rx drugs at the point of sale, at the lowest price available, and submit a claim to us.) Option: Add a Generic \$20 Rx Copay ³
Outpatient						
X-ray and Lab, Mammogram, Pap Smear, PSA screening	You pay:	30% after deductible	20% after deductible or 30% after deductible	30% after deductible	30% after deductible	20% after deductible or 30% after deductible
Emergency Room Fees – Illness Not covered unless admitted.	You pay:	30% after deductible	20% after deductible or 30% after deductible	30% after deductible	30% after deductible	20% after deductible or 30% after deductible
Emergency Room Fees – Injury	You pay:	30% after deductible	20% after deductible or 30% after deductible	30% after deductible	30% after deductible	20% after deductible or 30% after deductible
Mental Disorders and Substance Abuse	You pay:	Not covered	20% after deductible or 30% after deductible (limited benefit - see page 8)	30% after deductible (limited benefit - see page 8)	30% after deductible (limited benefit - see page 8)	20% after deductible or 30% after deductible (limited benefit - see page 8)
Inpatient						
Room and Board, Intensive Care Unit, Operating Room, Recovery Room, Prescription Drugs, Physician Visit, and Professional Fees of Doctors, Surgeons, Nurses	You pay:	30% after deductible	20% after deductible or 30% after deductible	30% after deductible	30% after deductible	20% after deductible or 30% after deductible
Supplemental Accident Available		Yes	Yes	Yes	Yes	Yes

¹ Not available in all states.

² For copay plans, non-network office visits subject to deductible and coinsurance, \$50 copay does not apply.

³ Generic Rx drugs only. Deductible does not apply.

Short Term MedicalSM can “bridge the gaps” in health insurance coverage.



Covered Expenses

Subject to all policy provisions, the following expenses are covered. To be considered for reimbursement, expenses must qualify as covered expenses and are subject to eligible expense limits unless you use a network provider.

Ambulance Services

Ground ambulance service to a hospital for necessary emergency care.

Dental Services

Dental expenses for an injury to natural teeth suffered during the policy term. Expenses must be incurred within 6 months of the accident or as part of a treatment plan prescribed and began within 6 months of the accident.

No benefits payable for injuries due to chewing as limited in the policy.

Diabetes

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

Diagnostic Testing

Durable Medical Equipment

Rental of wheelchair, hospital bed, and other durable medical equipment.

Home Health Care

Home health aide services limited to 7 visits per week and a lifetime maximum of 365 visits. Outpatient private duty registered nurse services limited to a lifetime maximum of 1,000 hours. Benefits for intermittent private duty registered nurse services limited to \$75 per visit.

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; emergency treatment of an injury, even if not admitted; and emergency treatment of an illness, but if not admitted for that illness, emergency room charges will not be covered.

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 Disorders and Substance Abuse

- Treatment of mental disorders or substance abuse covered the same as any other illness.
- Outpatient doctor visits limited to \$50 per visit.
- Policy term combined maximum of \$3,000 due to mental disorders or substance abuse per covered person.

Mental disorders and substance abuse are not covered with the Short Term MedicalSM Value plan.

Outpatient Surgery

Physician Fees

- Professional fees of doctors, medical practitioners, and surgeons.
- Assistant surgeon fee limited to 20% of eligible expenses of the procedure.
- Fees for another medical professional acting as an assistant surgeon limited to 14% of the eligible expense.

Covered Expenses, continued

Medical Expense Benefits - subject to deductible and copay/coinsurance (if applicable)



Prescription Drugs (if applicable)

If you purchase name-brand when generic is available, you pay your generic copay plus the additional cost above the generic price.

Visit goldenrule.welcometouhc.com for a current Prescription Drug List.

Preventive Care

- Children's preventive health services for covered children as defined in the policy.
- Mammograms, Pap smears, colorectal cancer examinations, prostate-specific antigen testing, and other preventive care as specified in the policy.

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.

Rehabilitation and Extended Care Facility (ECF)

Must begin within 14 days of a 3-day or longer hospital stay for the same illness or injury. Limited to 60 days per policy term for both rehabilitation and ECF expenses.

Spine and Back Disorders

Benefits for outpatient treatment of spine and back disorders limited to \$50 per visit and 6 visits in any 3-month period.

Temporomandibular (TMJ) Services

Surgery, excluding tooth extraction, to treat craniomandibular disorders, malocclusions, or disorders of the temporomandibular joint limited to a combined \$10,000 lifetime maximum for each covered person.

Therapeutic Treatments

- Radiation therapy and chemotherapy.
- 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 your 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 during a 10-year period, per covered person.

Golden Rule has arranged for certain hospitals around the country ("Centers of Excellence") to perform specified transplant services. If you use one of our "Centers of Excellence," the specified transplant will be considered the same as any other illness and will include transportation and lodging incentive (for a family member) of up to \$5,000. If a "Center of Excellence" is not used, covered expenses for the "Listed Transplant" will be limited to one transplant in any 12-month period with a maximum benefit of \$100,000 for all expenses associated with the transplant.

If a "Center of Excellence" is not used, the acquisition cost for the organ or bone marrow is not covered.

No benefits payable for:

- Search and testing in order to locate a suitable donor.
- A prophylactic bone 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.



Plan Provisions

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

General Exclusions

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 — A condition:
(1) for which medical advice, diagnosis, care, or treatment was recommended or received within the 24 months immediately preceding the date the covered person became insured under the policy; or (2) that had manifested itself in such a manner that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment within the 12 months immediately preceding the date the covered person became insured under the policy; or (3) a pregnancy existing on the effective date of coverage will also be considered a preexisting condition.

NOTE: Even if you have had prior Golden Rule 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 that are not covered 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 prevent or promote 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.
- For 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 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 under Transplant Services.
- For injuries from participation in professional or semi-professional sports or athletic activities for financial gain, as determined by Golden Rule.
- For eye refractive surgery, when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism.
- While confined for rehabilitation, custodial care, educational care, 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 expenses, including diagnostic testing, while confined primarily for well-baby care, except as provided in the policy.
- For treatment of mental disorders, or court-ordered treatment for substance abuse, except as provided in the policy.



General Exclusions, continued

No benefits are payable for expenses:

- For preventive care or prophylactic care, including routine physical examinations, premarital examinations, and educational programs, except as provided in the policy.
- Incurred outside of the U.S., except for emergency treatment.
- Resulting from declared or undeclared war; intentionally self-inflicted bodily harm (whether sane or insane); participation in a riot; or participation in a felony (whether or not charged).
- For or related to durable medical equipment, except as provided for in the policy.
- For surrogate parenting.
- For treatments 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.
- Injury or illness cause by employment, except as provided for in the policy.
- 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 vocational or recreational therapy, vocational rehabilitation, outpatient speech therapy, or occupational therapy, except as provided for in the policy.
- Resulting from experimental or investigational treatments, or unproven services.
- For a hospital admission on Friday or Saturday (room, board, and nursing services) unless it is an emergency or medically necessary surgery is scheduled the next day.

Coordination of Benefits (including Medicare)

If after coverage is issued, a covered person becomes insured under another health plan or Medicare, benefits will be determined under the Coordination of Benefits (COB) clause.

COB allows two or more plans to work together so the total amount of all benefits is never more than 100% of covered expenses. COB also takes into account medical coverage under auto insurance contracts. To determine which plan is primary, refer to “order of benefits” in your policy.

Dependents

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

Effective Date

Your policy will take effect on the later of:

- The requested effective date on your application; or
- The day after the postmark date affixed by the U.S. Postal Service,* 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. You have answered “no” to question 2 (if other questions are answered “yes,” we will exclude the person(s) listed);
 - 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 Golden Rule.

* 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 date received by Golden Rule. 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 Golden Rule.

** Your account will be immediately charged.



Plan Provisions, continued

Eligible Expense

An eligible expense means a covered expense as follows:

- **For Network Providers:** the contract fee for the provider.
- **For Non-Network Providers:** when a covered expense is received as the result of an emergency or as otherwise approved by us, the eligible expense is the lesser of the billed charge or the amount negotiated with the provider. Except as noted above, the eligible expense is the first of the following that can be applied:
 1. The fee negotiated with the provider;
 2. 110% of the fee Medicare allows for the same or similar service in the same area;
 3. The fee set by us after comparing rates from one or more regional or national databases, or schedules for the same or similar service from a geographical area determined by us;
 4. The fee charged by the provider; or
 5. A fee schedule we develop.

Non-Renewable

Your Short Term MedicalSM policy is not renewable. You may apply for additional short term coverage (subject to state restrictions), however a condition which was a covered expense under a prior policy would be considered preexisting under a subsequent policy. Additional policies will not be continuations of any previous policy.

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.



HEALTH PLAN NOTICES OF PRIVACY PRACTICES MEDICAL INFORMATION PRIVACY NOTICE

(Effective January 1, 2016)

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.myallsavers.com, or www.myallsaversmember.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.
- **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 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 restrictions 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.
- **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 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.
- **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. "Highly confidential information" may include confidential information under Federal laws governing alcohol and drug abuse information and genetic information as well as state laws that often protect the following types of information: HIV/AIDS; mental health; genetic tests; alcohol and drug abuse; sexually transmitted diseases and reproductive health information; and child or adult abuse or neglect, including sexual assault.

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.myallsavers.com, or www.myallsaversmember.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, please call the toll-free phone number on your ID card.
- **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, 2016)

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, please **call the toll-free phone number on your ID card.**

The Notice of Privacy Practices, effective January 1, 2016, 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.

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We do not treat members differently because of sex, age, race, color, disability or national origin. If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator.

Online: UHC_Civil_Rights@uhc.com

Mail: Civil Rights Coordinator. UnitedHealthcare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again. If you need help with your complaint, please call 1-800-657-8205, TTY 711, 8 a.m. to 6 p.m. ET.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

Online: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

Complaint forms are available at
<http://www.hhs.gov/ocr/office/file/index.html>.

Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call 1-800-657-8205, TTY 711, 8 a.m. to 6 p.m. ET.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call 1-800-657-8205.

ATENCIÓN: Si habla español (**Spanish**), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al 1-800-657-8205.

請注意：如果您說中文 (**Chinese**)，我們免費為您提供語言協助服務。請致電：1-800-657-8205。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi 1-800-657-8205.

알림: 한국어(**Korean**)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-657-8205 번으로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Mangyaring tumawag sa 1-800-657-8205.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по номеру 1-800-657-8205.

تنبيه: إذا كنت تتحدث العربية (**Arabic**)، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال بـ 1-800-657-8205.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nan 1-800-657-8205.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le 1-800-657-8205.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod numer 1-800-657-8205.

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue para 1-800-657-8205.

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Si prega di chiamare il numero 1-800-657-8205.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufen Sie 1-800-657-8205 an.

注意事項：日本語 (**Japanese**)を話される場合、無料の言語支援サービスをご利用いただけます。1-800-657-8205 にお電話ください。

توجه: اگر زبان شما فارسی (**Farsi**) است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. 1-800-657-8205 تماس بگیرید.

कृपा ध्यान दें: यदि आप **हिंदी (Hindi)** भाषी हैं तो आपके लिए भाषा सहायता सेवाएं नि:शुल्क उपलब्ध हैं। कृपा पर काल करें 1-800-657-8205

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau 1-800-657-8205.

សំគាល់: បើអ្នកនិយាយ**ខ្មែរ (Khmer)** យើងផ្តល់សេវាជំនួយភាសាឥតគិតថ្លៃ បើអ្នកចង់សុំសេវា សូមទូរស័ព្ទ ទៅលេខ 1-800-657-8205

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti 1-800-657-8205.

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yánílt'go, saad bee áka'anida'awo'ígíí, t'áá jíik'eh, bee ná'ahóót'i. T'áá shoodí kohj'í 1-800-657-8205 hodiilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac 1-800-657-8205.



Short Term MedicalSM Plans

Our plans offer easy-to-understand health insurance designed for individuals and families in times of transition and change with up to \$1,500,000 of coverage.

This short term major medical policy is nonrenewable.

Short Term MedicalSM is issued for a specific period of time. If your needs for coverage extend beyond this plan, you may apply for additional short term plans. This requires a new application and is not an extension of your current plan. Any illness or condition you develop while covered by your current plan would be considered “preexisting” when you apply for a new short term plan and, as such, will not be a covered expense. Please see insert for state variations. We will notify you in advance of any changes in coverage or benefits. Not available in all states. Nonrefundable \$20 application fee is required.



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UnitedHealthOneSM is a brand representing a portfolio of insurance products offered to individuals and families through the UnitedHealthcare family of companies.

43854-G-1216

Short Term MedicalSM State Variations

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

This insert must be used with the Short Term MedicalSM brochure (43854-G).

Georgia

Policy Form IST6.0-G-10

- Application fee is refundable.
- Coverage term limited to 30 - 360 days.
- With Short Term MedicalSM Copay, Copay Value, and Value plans, you pay 25% coinsurance.
- With Short Term MedicalSM Plus and Plus Elite plans, you choose between paying 20% or 25% coinsurance.
- Covered expenses are expanded to include:
 - Evaluation and treatment of Autism Spectrum for covered persons 6 years of age or younger. Applied behavior analysis limited to \$30,000 per covered person per policy term.
 - Spine and Back disorders with no benefit limits.
 - Surgery for the correction of functional deformities of the maxilla and mandible.
- The Temporomandibular (TMJ) Services benefit is replaced with: "For surgical and non-surgical treatment, excluding tooth extraction, for the correction of congenital or developed anomalies of the temporomandibular joint."
- In the exclusion for breast reconstruction or augmentation "except as provided in the policy for breast reconstruction following a mastectomy" is added.
- The exclusion for the diagnosis and treatment of learning disabilities, attitudinal disorders, or disciplinary problems does not apply to autism spectrum disorder as expressly provided in the policy.
- "Coordination of Benefits (including Medicare)" is deleted and replaced with "Variable Deductible." If you have other coverage that pays hospital, surgical, or medical benefits, we may apply a variable deductible. If the other plan pays more than our plan's yearly deductible for a covered expense, then that amount becomes our plan's variable deductible. The result is that all of your covered, in-network, out-of-pocket expenses are paid by the two policies. Copays not included.

Golden Rule Insurance Company

Georgia

Outline of Coverage for Policy Form IST6.0-G-10

(Please retain this outline for your records.)

Read Your Policy Carefully -- This outline sets forth a brief description of the important aspects of your policy. This is not the insurance contract. Only the actual policy will control. The policy sets forth in detail your and our rights and obligations. For this reason, it is important that you **READ YOUR POLICY CAREFULLY!**

Non-Renewable Preferred Provider Limited Duration Comprehensive Health Coverage -Plans of this type are designed to provide covered persons with coverage for the major costs of hospital, medical, and surgical care. The cost must be due to a covered illness or injury. Coverage is provided for daily hospital room and board; other hospital services; surgical services; anesthesia services; inpatient medical services; and out-of-hospital care. Coverage is subject to any deductibles; copayment provisions; or other exclusions or limitations that may be set forth in the policy.

Amount Payable

Definitions:

"Coinsurance percentage" means the percentage of covered expenses that are payable by us after the stated deductible or

copayment amount has been met (as applicable), as shown in the policy Data Page. If payment is calculated using the variable deductible, the coinsurance percentage will be 100%.

"Copayment amount" means the amount of covered expenses that must be paid by a covered person for each service that is subject to a copayment amount (as shown in the policy Data Page) before benefits are payable for remaining covered expenses for that service under the policy.

"Deductible amount" means the amount of eligible expenses, shown in the policy Data Page, that must actually be incurred by each covered person during any calendar year before any benefits are payable. The stated deductible does not include any copayment amount. The deductible amount is the larger of the stated deductible shown in the policy Data Page or the variable deductible.

"Eligible expense" means a covered expense as determined below:

A. For network providers (excluding Transplant Benefits), the eligible expense is the contracted fee with that provider.

B. For non-network providers:

1. When a *covered expense* is received from a *non-network* provider as a result of an *emergency* or as otherwise approved by us, the *eligible expense* is no more than the billed charge. The *eligible expense* amount is processed at the *network* benefit level.
2. When a covered expense is received from a non-network provider because the service or supply is not of a type provided by any network provider, the *eligible expense* is no more than the billed charge. The *eligible expense* amount is processed at the *network* benefit level.
3. Except as provided under 1 and 2 above, when a covered expense (excluding Transplant Benefits) is received from a non-network provider, the eligible expense is determined based on the first of the following rules that can be applied in the order shown below:

- a. The fee that has been negotiated with the provider;
- b. 110% of the fee Medicare allows for the same or similar services provided in the same geographical area;
- c. The fee established by us based on comparing rates from one or more regional or national databases or schedules for the same or similar services from a geographical area determined by us;
- d. The fee charged by the provider for the services; or
- e. A fee schedule that we develop.

"Variable deductible" means an amount equal to the amount of benefits payable for covered expenses by any other plan. We may apply the variable deductible even though the stated deductible has been satisfied. The effect of the variable deductible is to pay 100% of the covered person's out-of-pocket expenses, excluding any copayment amounts.

Amount Payable: The total amount payable for each covered person will not exceed the lifetime maximum benefit limit shown in the policy Data Page.

We will pay the applicable coinsurance percentage in excess of the applicable deductible amount and copayment amount(s) for a service or supply that qualifies as a covered expense and is received while the covered person's coverage is in force under the policy, if the charge for the service or supply qualifies as an eligible expense.

The amount payable will be subject to any specific benefit limits stated in the policy, a determination of eligible expenses, and any reduction for expenses incurred at a non-network provider.

The deductible amount is the larger of the stated deductible or the variable deductible. We may apply the variable deductible even though the stated deductible has been satisfied.

(Please see the policy Data Page for more information.)

If payment is calculated using the variable deductible, the coinsurance percentage will be 100%. The effect of the variable deductible is to pay 100% of the covered person's out-of-pocket expenses, excluding any copayment amounts.

The stated deductible, coinsurance percentage, and copayment amount(s) are shown in the policy Data Page.

Non-emergency non-network eligible

expenses will be reduced by 20% (25% if your plan has a coinsurance percentage of 80%) before application of any applicable stated deductible(s), coinsurance provisions, and/or copayment amounts.

Note: The bill you receive for services or supplies from a non-network provider may be significantly higher than the eligible expenses for those services or supplies. In addition to the deductible amount, coinsurance, and copayment (if any), you are responsible for the difference between the eligible expense and the amount the provider bills you for the services or supplies. Any amount you must pay to the provider in excess of the eligible expenses will not apply to your deductible amount or maximum out-of-pocket expenses.

Network Availability: Your network is subject to change upon advance written notice. A network may not be available in all areas.

Medical Benefits

The following is a summary of the primary benefits of the policy. The policy explains these and additional benefits in fuller detail. Some benefits may be limited by the policy.

A. Hospital charges for:

- 1. Daily room and board and nursing services while an inpatient, at the most common semi-private room rate.
- 2. Daily room and board and nursing services while confined in an intensive care unit, not to exceed the eligible expense.
- 3. Inpatient or outpatient surgery.
- 4. Other routine services and supplies provided to inpatients, including drugs and medicines.
- 5. Emergency treatment of an injury.
- 6. Emergency treatment of an illness. However, charges for the use of the emergency room itself will not be covered unless the covered person is directly admitted to the hospital for inpatient treatment of that illness.

B. Emergency ground ambulance service to a hospital.

- C. Surgery in a doctor's office or at an outpatient surgical facility, including services and supplies.
- D. Fees charged by doctors and medical practitioners.
- E. Dressings, crutches, orthopedic braces and splints, casts, or other necessary medical supplies.
- F. Diagnostic tests.

- G. Chemotherapy, radiation therapy or treatment, and hemodialysis.
- H. Oxygen, anesthetics, and their administration.
- I. Treatment of TMJ disorders, and surgery to correct functional deformities of the maxilla and mandible.
- J. Reconstructive surgery following a covered surgery or injury or to correct a birth defect in a child covered since birth.
- K. Breast reconstruction following a mastectomy, including prostheses.
- L. Rental of durable medical equipment.
- M. Artificial eyes, larynx, breast prosthesis, or basic artificial limbs (but not replacement, unless required by a physical change in the person and the item cannot be modified).
- N. Dental services for an injury to the natural teeth that occurs during the policy term.
- O. Routine screenings and tests, including mammograms, cervical or pap smears, colorectal cancer screenings, digital rectal exam and prostate specific antigen tests, surveillance tests for ovarian cancer, human papillomavirus test, and chlamydia screening test.
- P. Human papillomavirus vaccination.
- Q. Treatment of diabetes.
- R. Limited benefits for diagnosis and treatment of a spine or back disorder.
- S. Limited benefits for treatment of mental disorders and substance abuse. (Not available for the Value plan.)
- T. General anesthesia and facility charges for dental care for a covered person who meets the criteria stated in the policy.
- U. Diagnosis and treatment of autism spectrum disorder as expressly covered in the policy.
- V. Child wellness services from birth to the 6th birthday.
- W. Routine patient care costs related to cancer clinical trials for children.
- X. Bone mass measurement for osteoporosis for a covered person who meets the criteria stated in the policy.
- Y. Home health care provided through a licensed home health care agency.
- Z. Rehabilitation and extended care facility services for an inpatient stay that begins within 14 days of a hospital stay of at least 3 days and is for treatment of, or rehabilitation related to, the same illness

or injury that required the hospital stay. Limited to 60 days per person per policy term.

AA. Organ or tissue transplants.

BB. Treatment of a terminal condition, not including treatment that would constitute assisted suicide in violation of state law.

Outpatient prescription drugs are covered in some plans and an optional benefit in some plans. The Value plan does not cover outpatient prescription drugs. Please see the brochure for more information.

What Is Not Covered

No benefits will be paid for:

- A. Any service or supply that would be provided without cost in the absence of insurance.
- B. Charges that are actually the responsibility of the provider to pay.
- C. Any services performed by a member of a covered person's immediate family.
- D. Services not identified as covered expenses under the policy.
- E. Charges that are in excess of eligible expenses.

No benefits will be paid for a service or supply unless it is administered or ordered by a doctor and medically necessary to the diagnosis or treatment of an injury or illness.

Covered expenses will not include, and no benefits will be paid for any charges that are incurred:

- A. For services and supplies provided prior to the effective date or after the termination date of the policy.
- B. For weight modification or surgical treatment of obesity, including wiring of the teeth and all forms of intestinal bypass surgery.
- C. For breast reduction or augmentation except as covered under the policy for breast reconstruction following a mastectomy.
- D. For modification of the physical body to improve the psychological, mental, or emotional well-being of the covered person, such as sex-change surgery.
- E. For any drug, treatment, or procedure that promotes conception or prevents childbirth, including, but not limited to, artificial insemination or treatment for infertility or impotency. This exclusion does not apply to *covered expenses* for prescription contraceptives.

- F. For sterilization or reversal of sterilization; or for abortion (unless a pregnancy carried to term would endanger the mother's life).
- G. For television, telephone, or expenses for other persons.
- H. For marriage, family, or child counseling for the treatment of premarital, marriage, family, or child relationship dysfunctions.
- I. For telephone consultations or failure to keep a scheduled appointment.
- J. For hospital room and board and nursing services for the first Friday or Saturday of an inpatient stay that begins on one of those days, unless it is an emergency or medically necessary inpatient surgery is scheduled for the date after the date of admission.
- K. For stand-by availability of a doctor when no treatment is rendered.
- L. For dental expenses, including braces or oral surgery, except as described in the policy.
- M. For cosmetic treatment.
- N. For diagnosis or treatment of: learning disabilities; attitudinal disorders; or disciplinary problems. This exclusion does not apply to autism spectrum disorder as expressly covered by the policy.
- O. For diagnosis or treatment of nicotine addiction.
- P. For charges related to, or in preparation for, tissue or organ transplants, except as expressly provided for by the policy.
- Q. For eye refractive surgery when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism.
- R. While confined primarily to receive rehabilitation, custodial care, educational care, or nursing services (unless expressly provided for by the policy).
- S. For any expenses that are incurred for injuries during or due to participation in any professional or semi-professional sports or athletic activities for financial compensation, as determined by us.
- T. For vocational or recreational therapy, vocational rehabilitation, occupational therapy, or outpatient speech therapy, except as provided by the policy.
- U. For eyeglasses, contact lenses, hearing aids, eye refraction, visual therapy, or for any related examinations or fittings, except as provided by the policy.

V. Due to pregnancy, except complications of pregnancy.

W. For confinement primarily for well-baby care, except as provided for by the policy.

X. For preventive or prophylactic care, including routine physical examinations, premarital examinations and educational programs, except as provided by the policy.

Y. For experimental or investigational treatment or for unproven services, as defined in the policy.

Z. For expenses incurred outside of the United States, except for emergency treatment.

AA. For injury or illness caused by employment, except as may be covered by the policy.

BB. As a result of:

1. Intentionally self-inflicted bodily harm (whether the covered person is sane or insane);
2. An injury or illness caused by any act of declared or undeclared war;
3. The covered person taking part in a riot; or
4. The covered person's commission of a felony.

CC. For durable medical equipment, except as expressly provided for by the policy.

DD. For any illness or injury that occurs as a result of the covered person being intoxicated or under the influence of illegal narcotics or controlled substance, unless administered or prescribed by a doctor.

EE. For or related to surrogate parenting.

FF. For or related to treatment of hyperhidrosis (excessive sweating).

GG. For fetal reduction surgery.

HH. Except as expressly provided for by the policy, expenses for alternative treatments, including acupressure; acupuncture; aroma therapy; hypnotism; massage therapy; rolfing; and other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.

II. For treatment of mental disorders, substance abuse, or for court-ordered treatment programs for substance abuse, except as provided for by the policy.

Preexisting Conditions

Preexisting conditions, and complications resulting from a preexisting condition, will not be covered under the policy.

A “preexisting condition” means:

- A. A condition for which medical advice, diagnosis, care, or treatment was recommended or received within the 24 months immediately preceding the date the covered person became insured under the policy;
- B. A condition that had manifested itself in a manner that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment within the 12 months immediately preceding the date the covered person became insured under the policy; or
- C. A pregnancy existing on the effective date of coverage.

Term of Coverage and Renewability

The policy term begins as of the effective date of the policy. You may keep the policy in force by paying us the required premium as it comes due. However, we may cancel the policy or deny a claim if there is fraud or material misrepresentation made by or with the knowledge of a covered person in the application or in filing a claim. At the end of the policy term, the policy will terminate and may not be renewed.

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