Thank you for your interest in this product

It is the mission of Golden Rule Insurance Company, as a UnitedHealthcare company, to help people live healthier lives.

We are available to answer your questions and help you without any obligation to buy. If you need help understanding this product, call Golden Rule Insurance Company, visit uhone.com, or contact your health insurance agent.

Below is a notice required by law.

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

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

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

Looking for comprehensive health insurance?

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

Questions about this policy?

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

TriTerm Medical Plans

This coverage is not an Affordable Care Act (ACA) plan. See page 10 of this brochure for information about Exclusions & Limitations, followed by state variations. This is a general summary. 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 GRI-IST-EXT1B-P-VAL (applies to Value plans), GRI-IST-EXT1B-P (applies to Max plans), and other state variations..

UnitedHealthcare®
Golden Rule Insurance Co.

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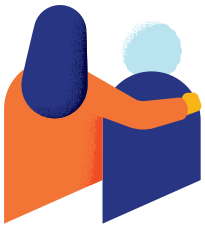
UnitedHealthcare®
Golden Rule Insurance Co.

What is TriTerm Medical? 3-Year Short Term

TriTerm Medical Insurance offers nearly 3 years of coverage with benefits to support your health from minor injuries to major hospitalizations. Plus, after 12 months on the plan, expenses related to preexisting conditions may be covered too. Short term plan with long-term-like benefits. An ideal option for those needing health insurance that lasts a little longer than just a few months. Experience flexible coverage that's there for you when you need it most.

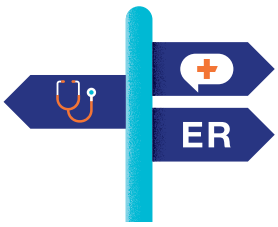


Doctor office coverage

Doctor visits are covered on most TriTerm Medical plans. With some plans, you pay a $50 copay for the first 4 doctor visits (per term, per person) with no deductible to meet.

Prescription drugs

Most TriTerm Medical plans have prescription coverage. Copay Select plans have a $25 copay for common (Tier 1) prescriptions.



Hospital benefits

TriTerm Medical plans offer healthcare coverage for both outpatient and inpatient needs for life's unexpected moments. Whether you need urgent care, a visit to the emergency room, or even an intensive care unit stay, these plans help cover a wide range of medical situations.

Apply once for insurance coverage terms that equal one day less than 3 years.

Term 1 364 days → **Term 2** 365 days → **Term 3** 365 days

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 during the first 12 months for a health condition that exists prior to the date insurance takes effect.

Highlights of covered network expenses

			Value	Copay Select Max	Plan 80 Max	Plan 100 Max
Deductible (per person, per term; max 2 per family)		You pay up to:	**$2,500, $5,000, $7,500, $10,000, $12,500 or $15,000**	**$2,500, $5,000, $7,500, $10,000 or $12,500**	**$2,500, $5,000, $7,500, $10,000 or $12,500**	**$5,000, $7,500, $10,000 or $12,500**
Coinsurance (% you pay **after deductible**, per term)		You pay:	**30% or 50%**	**30%**	**20%**	**0%**
Coinsurance out-of-pocket maximum (after deductible, per person, per term)		You pay up to:	**$10,000**	**$4,500**	**$2,000**	**$0**
Maximum benefit (per person, lifetime)		We pay up to:	**$2 million**	**$2 million**	**$2 million**	**$2 million**
Medical						
Doctor office visit (history and exam only) (per person, per term)		You pay:	**Chosen coinsurance after deductible**	**$50 copay for first 4 visits[1]**	**20% after deductible**	**No charge after deductible**
Urgent Care Center			**$75 copay**	**$75 copay**		
Preventive care ($200 max benefit per person, per term, after 6-month waiting period for term 1 only)			**Preventive care not covered**	**$50 copay**		
Emergency room (accident and illness) (for illness only: additional $500 deductible if not admitted)			**Chosen coinsurance after deductible**	**30% after deductible**		
Inpatient hospital services, outpatient surgery, labs & x-rays			**Chosen coinsurance after deductible**	**30% after deductible**		
Pharmacy						
Outpatient prescription (Rx) drugs	**Tier 1**	You pay:	**Not covered** Discount card provided.[2]	**$25 copay**	**20% after deductible** Using the member ID card, you pay for prescriptions at the point of sale, at the lowest price available. ($5,000 max covered expenses per person, per term)	**No charge after deductible** Using the member ID card, you pay for prescriptions at the point of sale, at the lowest price available. ($5,000 max covered expenses per person, per term)
	Rx deductible (per person, per term)			**$500 deductible, then:**		
	Tier 2			**$55 copay**		
	Tier 3			**$75 copay**		
	Tier 4			**50% after Rx deductible** ($5,000 max covered expenses per person, per term)		
Add Supplemental Accident benefit[3] Matches medical deductible selected (page 12)		We pay up to:	**$2,500, $5,000, $7,500, $10,000, $12,500 or $15,000**	**$2,500, $5,000, $7,500, $10,000, or $12,500**	**$2,500, $5,000, $7,500, $10,000, or $12,500**	**$5,000, $7,500, $10,000, or $12,500**

Earliest effective date is 5 days after application. The amount of benefits provided depends upon the plan selected, and the premium will vary with the amount of the benefits selected. Non-network benefits vary. See details on page 6. Copays do not apply to deductible, coinsurance, or coinsurance out-of-pocket maximum. This coverage does not qualify as "Minimum Essential Coverage" as defined in the Affordable Care Act and may not cover all Essential Health Benefits in your state. [1] Subsequent visits are subject to deductible then coinsurance. Doctor office visit copays are for injury and illness and cannot be used for preventive services, other than those required due to state mandates. [2] Discounts vary by pharmacy, geographic area, and Rx drug. [3] Additional premium required.

Access to a wide network of care and cost-saving

Get the most out of your benefits by staying in the network. We help make it easier with:

Access to quality care

Over 1.8 million providers and over 7,000 hospitals.[1]

Nationwide network

Use any doctor in your network across the nation. See any network specialist without needing a referral.

No balance billing

Network providers will not charge you more than the network-negotiated rate. In-network providers agree to provide quality care at lower cost to you.

UnitedHealthcare Choice Plus Network

In addition to the in-network benefits, these plans pay reduced non-network benefits. Using non-network providers will cost you more due to a non-network penalty. 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; and
- 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 alculate what we pay and what you pay.

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

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

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). You will find complete coverage details in the policy.

Ambulance services

- Ground ambulance service to the nearest hospital that can provide services for necessary emergency care.
- Air ambulance services requested by police or medical authorities at the site of emergency or in locations that cannot be reached by ground ambulance.

Cancer treatment expenses

- Radiation therapy and chemotherapy.
- Expenses in connection with a mastectomy for a covered person who elects breast reconstruction, including all stages of reconstruction of the breast on which the mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and treatment for physical complications of mastectomy, including lymphedemas.
- The cost of one wig per covered person, up to $500, necessitated by hair loss due to cancer treatments or traumatic burns.
- One mastectomy bra per year if the covered person has undergone a covered mastectomy.

Dental injuries

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

Diabetes

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

Diagnostic testing

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

Doctor office visit copay (history and exam only)

For Copay plans only, copay of $50 per office visit for treatment, excluding surgery, performed by a doctor, limited to 4 visits per person, per term. Additional office visits will be subject to the applicable deductible amount and coinsurance percentage. The office visit copayment amount does not apply to office visits for preventive care services.

Durable medical equipment

- Rental of standard non-motorized wheelchair, hospital bed, standard walker, wheelchair cushion, or ventilator.
- Cost of one Continuous Passive Motion (CPM) machine per covered person following a covered joint surgery.

Home health care

To qualify for benefits, home health care must be provided through a licensed home healthcare agency. Covered expenses for home health aide services will be limited to 7 visits per week and a lifetime maximum of 365 visits. Benefits for home health care will not extend beyond the term of your plan. Each 8-hour period of home health aide services will be counted as one visit. Private duty registered nurse services will be limited to a lifetime maximum of 1,000 hours. Intermittent private duty registered nurse visits are not to exceed 4 hours each and are limited to $75 per visit (2 hours per visit are applied toward the lifetime maximum for private-duty nursing). **No benefits payable for respite care, custodial care, or educational care.**

Hospice care

To qualify for benefits, a hospice for a terminally ill covered person must be licensed by the state in which it operates. Benefits for inpatient care in a hospice are subject to deductible and coinsurance and limited to 180 days in a covered person's lifetime. Covered expenses for room and board are limited to the most common semiprivate room rate of the hospital or nursing home with which the hospice is associated (or $200 per day maximum if not associated with hospital or nursing home). Bereavement counseling maximum of $250.

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 or

Medical benefits (insurance plans)

Continued from page 7

illness. Covered expenses for use of the emergency room are subject to an additional $500 deductible for each emergency room visit for an illness unless the covered person is directly admitted to the hospital for further treatment of that illness. **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 Nervous Disorders and Substance Abuse (excluding Value plans)

Treatment of mental disorders, substance abuse, or for court ordered treatment programs for substance abuse, limited to $5,000 of covered expenses per person, per term.

Outpatient surgery

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

Physician fees

- Professional fees of doctors, medical practitioners and surgeons.
- Assistant surgeon fee limited to 16% of eligible expenses of the procedure.

Preventive care (excluding Value plans)

Preventive care expenses, including but not limited to immunizations, urinalysis and blood tests, bone density screenings, electrocardiograms (EKG's), cardiac stress tests, mammography screenings, cervical and pap smears, Human Papillomavirus (HPV) screenings and vaccinations, and ovarian cancer surveillance tests. Limited to a maximum benefit of $200 per covered person, per term, after a 6-month waiting period. Covered expenses provided under the Medical Benefits provision will not be applied to this maximum. Preventive care does not include computerized axial tomography (CAT or CT scan), magnetic resonance imaging (MRI), or positron emission tomography (PET scan) performed on a routine or preventive basis.

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. If more than one device can meet covered person's functional needs, only the charge for the most cost effective device will be considered a covered expense.

Reconstructive surgery

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

Rehabilitation and extended care facility (ECF)

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

Spine and back disorders

All plans except Value: $5,000 maximum covered expenses per person, per term for outpatient services. This limit does not apply to inpatient expenses or outpatient surgery.

Value plans: Limited to inpatient and surgical treatment.

Temporomandibular Joint (TMJ)

Temporomandibular Joint (TMJ) Surgery, excluding tooth extractions, to treat craniomandibular disorders, malocclusions, disorders of the temporomandibular joint (TMJ) limited to a combined $10,000 lifetime maximum for each covered person.

Therapeutic treatments

- Hemodialysis, processing, and administration of blood or components (but not the cost of the actual blood or components).
- Occupational therapy following a covered treatment for traumatic hand injuries.

Medical benefits (insurance plans)

Continued from page 8

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 during a 36 month maximum duration, 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 a COE is not used: Limit of 1 transplant per 36 month maximum duration, 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.

Other information (insurance plans)

This is only a general outline of the benefits, provisions and 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. 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. You may be able to get longer term insurance that qualifies as "Minimum Essential Coverage" for health insurance under the ACA.

Exclusions and/or limitations

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

For Value plans only, no benefits are payable for expenses:

- For outpatient treatment of spine and back disorders.
- For outpatient prescription drugs.

For all plans, no benefits are payable for expenses:

- **For a preexisting condition –** A condition for which medical advice, diagnosis, care, treatment, any diagnostic procedure(s), or further evaluation was recommended or received within the 24 months immediately prior to the date the covered person became insured under the policy; or 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 prior to the date the covered person became insured under the policy; or a pregnancy existing on the effective date of coverage.

  NOTE: Even if you have had prior GRIC coverage and your preexisting conditions were covered under that plan, they will not be covered under this plan for the first 12 months of coverage.
- 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, except as provided for in policy.
- For drugs, treatment, or procedures that promote conception and prevent childbirth, including but not limited to artificial insemination or treatment for infertility or impotency.
- For sterilization or reversals of sterilization.
- For fetal reduction surgery or abortion (unless life of mother would be endangered).
- For treatment of malocclusions, disorders of the temporomandibular joint (TMJ) or craniomandibular disorders, except as provided for by the policy.
- For modification of the physical body in order to improve psychological, mental, or emotional well-being, such as sex-change surgery.
- Not specifically provided for in the policy, including telephone consultations, failure to keep an appointment, television expenses, or telephone expenses.
- For marriage, family, or child counseling.
- For standby availability of a medical practitioner when no treatment is rendered.
- For hospital room and board and nursing services if admitted on a Friday or Saturday, unless for an emergency, or for medically necessary surgery that is scheduled for the next day.

Other information (insurance plans)

Continued from page 10

For all plans, no benefits are payable for expenses:
(list is continued from the previous page)

- 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, except as provided for in the policy.
- For diagnosis or treatment of nicotine addiction.
- For surrogate parenting.
- For treatments of hyperhidrosis (excessive sweating).
- For charges related to, or in preparation for, tissue or organ transplants, except as expressly provided for under Transplant Expense Benefits in the policy.
- For injuries from participation in professional or semi-professional sports or athletic activities for financial gain, as determined by GRIC.
- For high-dose chemotherapy prior to, in conjunction with, or supported by ABMT/BMT, except as specifically provided under the Transplant Expense Benefits provision in the policy.
- For eye refractive surgery, when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism.
- While confined for rehabilitation, custodial care, educational care, or nursing services, except as provided for in the policy.
- For eyeglasses, contact lenses, hearing aids, eye refraction, visual therapy, or any exam or fitting related to these devices, except as provided for in the policy.
- Due to pregnancy (except complications).
- For any expenses, including for diagnostic testing incurred while confined primarily for well-baby care, except as provided in the policy.
- For routine well-baby care of a newborn infant, except as provided for in the policy.
- For preventive care or prophylactic care, including routine physical examinations, premarital examinations, and educational programs, except as provided in the policy.
- Incurred outside of the U.S., except for emergency treatment.
- Resulting from declared or undeclared war; intentionally self-inflicted bodily harm (whether sane or insane); or participation in a riot or felony (whether or not charged).
- For or related to durable medical equipment or for its fitting, implantation, adjustment or removal or for complications therefrom, except as provided for in the policy.
- For alternative treatments, except as specifically covered by the policy, including: acupressure, acupuncture, aromatherapy, hypnotism, massage therapy, rolfing, and other alternative treatments defined by the Office of Alternative Medicine of the National Institutes of Health.
- Resulting from or during employment for wage or profit, if covered or required to be covered by workers' compensation insurance under state or federal law. If you entered into a settlement that waives your right to recover future medical benefits under a workers' compensation law or insurance plan, this exclusion will still apply.
- Resulting from intoxication, as defined by state law where the illness or injury occurred, or while under the influence of illegal narcotics or controlled substances, unless administered or prescribed by a doctor.
- For joint replacement, unless related to an injury covered by the policy.
- For injuries sustained during or due to participating, instructing, demonstrating, guiding, or accompanying others in any of the following: sports (professional, or semi-professional, 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, or occupational therapy, except as provided for in the policy.
- Resulting from experimental or investigational treatments, or unproven services.
- Expenses incurred by a covered person for the treatment of tonsils, adenoids, middle ear disorders, hemorrhoids, hernia, or any disorders of the reproductive organs will not be covered during the covered person's first 6 months of coverage under the policy. This exclusion will not apply if the treatment is provided on an emergency basis.

Other information (insurance plans)

Continued from page 11

Optional Supplemental Accident benefit for TriTerm Medical Plans

Form SA-S-1899I-GRI, SA-S-1899RI-GRI and state variations

Reduce or eliminate your out-of-pocket exposure for an accident-related injury for additional premium. Supplemental Accident benefit matches your deductible, paying for treatment of an unexpected injury within 90 days of an accident. The benefit maximum amount ($2,500, $5,000, $7,500, $10,000, $12,500, or $15,000) is per accident, per covered person. NOTE: The $2,500 benefit amount is not an option with TriTerm Plan 100 Max. The $15,000 benefit amount is only an option on the TriTerm Value Plan.

Application fee

Nonrefundable $40 application fee required.

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

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 5th day after the date received by GRIC,* but only if the following conditions are satisfied:
  - A. Your application and the appropriate premium payment are actually received by us within 15 days of your signing;**
  - B. Your application is properly completed and unaltered;
  - C. Your application is approved after review by GRIC.
  - D. You are a resident of a state in which the policy form can be issued; and
  - E. If the application is submitted by an agent or broker, the agent or broker is properly licensed and appointed to submit applications to GRIC.

* If mailed and not postmarked by the U.S. Postal Service or if the postmark is not legible, the effective date will be the later of: (1) the date you requested; or (2) the 5th 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 5th day after the date received by GRIC.

** Your account will be immediately charged.

Eligibility

At time of application, the primary insured must be a minimum of 19 years of age and cannot be 64 or older.

Eligible expense

An eligible expense means a covered expense as follows:

- **For network providers:** The contracted fee for the provider.
- **For non-network providers:** As defined in the policy.

Emergency

"Emergency" means an unforeseen or sudden medical condition manifesting itself by acute signs or symptoms which could reasonably result in death or serious disability if medical attention is not provided within 24 hours.

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. **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

TriTerm Medical 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. We will notify you in advance of any changes in coverage or benefits, unless the policy terminates earlier for any reason stated in the Termination section.

Premium

The premium amount is expected to change for each term.

Other information (insurance plans)

Continued from page 12

Rating factors

The plan, age and sex of covered persons, type and level of benefits, tobacco use status, underwriting class status, time the policy has been in force, and place of residence on the premium due date are some of the factors used in determining your premium rates. From time to time, we may change the rate table used. Each premium will be based on the rate table in effect on that premium's due date. At least 31 days' notice of any plan to take an action or make a change, permitted by the premium provision in the policy, will be mailed to you at your last address as shown in our records. We will make no change in your premium solely because of claims made under the policy or a change in a covered person's health.

Right to Examine

It is important to us that you are satisfied with the coverage being provided. This product has a right to examine period, also commonly referred to as a "free look". After applying and after your policy is issued, if you are not satisfied the coverage will meet your insurance needs, you may return the policy to us within 30 days and have the paid premium refunded.

Termination

The policy will terminate on the earliest of:

- The date all covered persons under the policy move out of the state where the policy was issued.
- The primary insured's death. If the policy includes dependents, it may be continued after the primary insured's death by a spouse, if a covered person; otherwise, by the youngest child who is a covered person.
- Nonpayment of premiums when due.
- The termination date shown on the Data Page of the policy.
- The date we receive a request from you to terminate the policy.
- The date of the primary insured's 65th birthday.
- The date you accept any contribution from your employer for any portion of the premium, or the date you and your employer treat the plan as employer-provided insurance for any purpose, including tax purposes.

State variations (insurance plans)

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

Georgia

Policy Forms:
GRI-IST-EXT1B-P-10,
GRI-IST-EXT1B-P-VAL-10

- Application fee is refundable if coverage is not issued or policy is returned during the Free Look period.
- The $5,000 limit on Spine and Back Disorders does not apply.
- Coverage for TMJ includes nonsurgical treatment for the correction of congenital or developed anomalies of the temporomandibular joint; $10,000 limit does not apply.
- For a covered person age 20 years or younger for the treatment of autism spectrum disorders covered expenses for applied behavior analysis are limited to $35,000 per covered person per coverage term.
- If a Center of Excellence is not used, covered expenses for a listed transplant will be limited to a maximum of one transplant per covered person per coverage term, and a maximum benefit limit of $100,000 for all expenses associated with the transplant.
- Exclusion for treatment of malocclusions, disorders of TMJ, or craniomandibular disorders does not apply.
- Exclusion for diagnosis or treatment of learning disabilities, attitudinal disorders, or disciplinary problems does not apply to treatment of autism spectrum disorders as expressly covered by the policy.
- "Emergency" means a condition of recent onset and sufficient severity, including, but not limited to, severe pain, that would lead a reasonably prudent layperson, who possesses an average knowledge of health and medicine, to believe that his or her condition, sickness, or injury is of such a nature that failure to obtain immediate medical attention could result in: placing the health of the covered person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.
- "Preexisting condition" means:

  A. Any illness, injury or condition for which medical advice, care or treatment was recommended or received within the 6 months immediately preceding the covered person's effective date;

  B. Any illness, injury or condition for which any diagnostic procedure or screening was recommended to or received by the covered person within the 6 months immediately preceding the covered person's effective date that results in medical care or treatment after the covered person's effective date; or

  C. Any illness, injury 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 preceding the covered person's effective date.

  For prior medical advice, care, treatment or recommended diagnostic procedure, the condition or diagnostic procedure at issue must be the ultimate condition or diagnostic procedure for which medical advice, care, treatment or diagnostic procedure was recommended or received prior to the covered person's effective date, excluding any preventive services.
- The following applies to TriTerm Value plans only:
  - Covered expenses include outpatient diagnosis and treatment of spine or back disorder.

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Policy Forms:
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- Application fee is refundable if coverage is not issued or policy is returned during the Free Look period.
- The covered expense for treatment, excluding tooth extraction, of craniomandibular disorders, malocclusions, or disorders of the temporomandibular joint includes both surgical and non-surgical treatment. The $10,000 lifetime maximum does not apply.
- Home Health visits are limited to 60 visits per coverage term for each covered person. Each visit by an authorized representative of a home health care agency up to 4 hours of home health aide services will be considered as one home health care visit.
- For all plans except TriTerm Value, room and board for Hospice Care Expense Benefits includes extended care facility.
- The exclusion for abortion is for "elective" abortions. An "elective abortion" means an abortion for any reason other than to preserve the life of the female upon whom the abortion is performed.

State variations (insurance plans)

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(list is continued from the previous page)

- For TriTerm Value plans, covered expenses are expanded to include:
  - One routine mammography examination during the policy term for each female covered person, and for mammograms upon referral by a medical practitioner for a covered person who has been diagnosed with breast disease.
  - Bone density testing of a female covered person age 35 years or older to obtain baseline data for the purpose of early detection of osteoporosis.

Who we are

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

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

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.

VIEW NOTICE HERE. Please review it carefully.

https://www.uhc.com/content/dam/uhcdotcom/en/npp/NPP-UHC-EI-UHOne-EN.pdf

* As of 3/12/25. For the latest rating, access www.ambest.com.

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