States:
FL IN MS NE
TN TX WV

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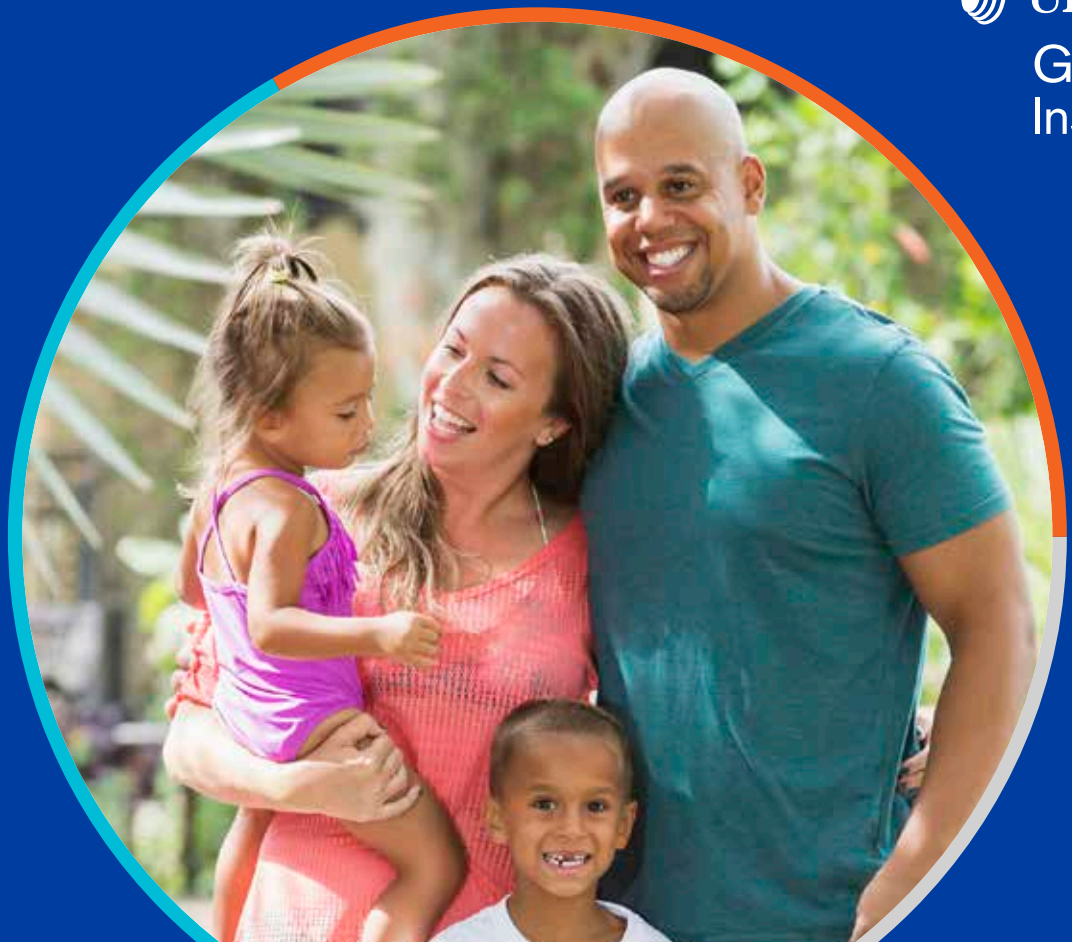

UnitedHealthcare®
Golden Rule Insurance Company

NOTICE - This brochure includes two parts:

- **45747E-G-0820 (pages 1-21) applies to all TriTerm Medical plans in the states listed in upper left corner of this page EXCEPT Florida TriTerm Medical Value & Value Direct plan.**
- **45747iFL-G-0820 (pages 22-30) applies to Florida TriTerm Medical Value & Value Direct plans ONLY.**

DIRECT

TriTerm Medical Plans

Health insurance available only to members of FACT. These health insurance plans are issued as association group plans and available only to members of FACT, the Federation of American Consumers and Travelers. Golden Rule Insurance Company is the underwriter and administrator of these plans. See last page for more details.

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 certificate 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 certificate 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.

Certificate Forms GRI-STAG-EXT1D-E-C-VAL (applies to Value and Value Direct plans where available, except Florida), GRI-STAG-EXT1D-E-C (applies to all other plans), and other state variations

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What is TriTerm Medical? 3-Year Short Term

- Apply once for insurance coverage terms that equal one day less than 3 years.*
- Choice of plans that offer $1 million or $2 million lifetime maximum benefit per covered person.
- Eligible expenses for preexisting conditions are covered after 12 months on the plan.

PREVENTIVE CARE COVERAGE

You don't have to be sick to access care with most TriTerm Medical plans. After 6 months on the plan, take your family to the doctor for wellness checks — a $200 benefit per term, per person.

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.

3 TERMS

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.

*Indiana only: Each term equals 364 days.

Highlights of Covered Network Expenses

3 TERMS — TERM 1 364 DAYS > TERM 2 365 DAYS[1] > TERM 3 365 DAYS[1]

		Copay Select (Max or Direct[1])	Plan 80 (Max or Direct[1])	Plan 100 (Max or Direct[1])	Value/Value Direct (Available in MS, NE & TX; for FL, see insert)
Deductible (per person, per term; max 2 per family)	You pay up to:	$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	$2,500, $5,000, $7,500, $10,000, $12,500 or $15,000
Coinsurance (% you pay **after deductible**, per term)	You pay:	30%	20%	0%	Value: 30% or 50% Value Direct: 30%, 40% or 50%
Coinsurance Out-of-Pocket Maximum (after deductible, per person, per term)	You pay up to:	$4,500	$2,000	$0	$10,000
Maximum Benefit (per person, lifetime[1])	We pay up to:	Max Plan: $2 million Direct Plan[1]: $1 million	Max Plan: $2 million Direct Plan[1]: $1 million	Max Plan: $2 million Direct Plan[1]: $1 million	Value: $2 million Value Direct: $1 million
Medical					
Doctor Office Visit, History, and Exam only (per person, per term)	You pay:	$50 copay for first 4 visits[2]	20% after deductible	No charge after deductible	Chosen coinsurance 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)		$50 copay			Preventive Care Not Covered
Emergency Room (Accident and Illness) (for illness only: additional $500 deductible if not admitted)		After deductible: 30%			Chosen coinsurance after deductible
Inpatient Hospital Services, Outpatient Surgery, Labs & X-rays		After deductible: 30%			Chosen coinsurance after deductible
Pharmacy					
Outpatient Prescription (Rx) Drugs ($5,000 max covered expenses per person, per term)	**Tier 1**	$25 copay	20% after deductible Using the member ID card, you pay for prescriptions at the point of sale, at the lowest price available.	No charge after deductible Using the member ID card, you pay for prescriptions at the point of sale, at the lowest price available.	Not Covered Discount card provided.[4]
	Rx Deductible (per person, per term)	$500 deductible, then:			
	Tier 2	$55 copay			
	Tier 3	$75 copay			
	Tier 4	50% after Rx deductible			
Add Supplemental Accident Benefit[3] Matches medical deductible selected (page 11)	We pay up to:	$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	$2,500, $5,000, $7,500, $10,000, $12,500 or $15,000

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 benefits selected. These plans only pay benefits for eligible expenses from a network provider. See details on page 4. 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] For Indiana plans: each term equals 364 days; Direct Plans are not available; Maximum Benefit is per person, per term. [2] 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. [3] Additional premium required. [4] Discounts vary by pharmacy, geographic area, and Rx drug.

Access to a Wide Network of Care & Cost-Saving

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

UnitedHealthcare
Choice Network

These plans only pay benefits for eligible expenses from a network provider. **There are no non-network benefits.** No benefits are payable for non-emergency care from a non-network provider. Emergency treatment from a non-network provider will be treated as a network eligible service.

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

Access to Quality Care from:

1.4 million physicians and other health care professionals.[1]

More than 6,500 hospitals and other facilities.[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.

[1] UnitedHealth Group Annual Form 10-K for year ended 12/31/19.

More Coverage Choices

Underwritten by Golden Rule Insurance Company (GRIC)

OPTIONAL SUPPLEMENTAL ACCIDENT BENEFIT

Reduce or eliminate your out-of-pocket exposure for accident-related injuries. Supplemental Accident helps cover your deductible or other out-of-pocket medical expenses (before the health insurance starts paying covered expenses) for unexpected injuries. See page 11 for details.

ACCIDENT PROGAP

Need more than just accident coverage? A standalone Accident ProGap plan takes the next step by combining Accident Expense insurance with benefits for critical illness, hospitalization from sickness, and accidental death and dismemberment, as well. This plan pairs well with a medical plan to help with out-of-pocket costs like deductibles.

DENTAL & VISION

Additionally, consider coverage for those frequent family expenses with standalone Dental & Vision insurance. Dental plans help take care of your smile with benefits for services ranging from routine cleanings to root canals. Vision plans cover routine eye exams and can help pay for glasses, contacts or both.

Additional premium is required for the coverage above. Accident ProGap, Dental & Vision require separate applications, and separate policies are issued. If Supplemental Accident is added to the TriTerm Medical plan, you cannot be issued an Accident ProGap plan. Product design and availability may vary by state. For costs, benefits, exclusions, limitations, eligibility, waiting periods and renewal terms, call 1-800-273-8115.

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 certificate.

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.

Children's Preventive Health Services

Services for any covered person eligible by reason of age. Immunization services that qualify as children's preventive health care services are exempt from any deductible amounts, coinsurance provisions, or copayment amounts.

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 when medically necessary as determined by physician or health care professional. Limited to one training program per person, per lifetime, unless additional training is prescribed due to a significant change in symptoms or condition.

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 health-care 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.

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 certificate.

Hospice Care, continued

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 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.

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. 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

Artificial eyes or larynx, breast prosthesis, orthotic and prosthetic devices/services. Orthotic and prosthetic devices/services limited to one device/service or replacement every 3 years unless proven to be medically necessary. 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 certificate 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.
- Reconstructive craniofacial surgery and related services for a covered person of any age diagnosed as having a craniofacial anomaly if the surgery is medically necessary to improve functional impairment that results from the craniofacial anomaly, as determined by a nationally approved cleft-craniofacial team, approved by the American Cleft Palate-Craniofacial Association in Chapel Hill, North Carolina.

Rehabilitation and Extended Care Facility (ECF)

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

Medical Benefits
(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 certificate.

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.

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.

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 certificate 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 policy 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 COE not used: Limit of 1 transplant per 36 month policy 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.

Additional Benefits

- Diagnosis of and treatment of autism spectrum disorders, including evidence-based treatments.
- Outpatient applied behavior analysis for the treatment of autism spectrum disorders up to a maximum of $50,000 per coverage term, per covered person.
- Colorectal cancer examinations and laboratory tests in accordance with the published American Cancer Society guidelines.
- One digital rectal examination and one prostate specific antigen test per coverage term per covered person for screening for the early detection of prostate cancer (exempt from the deductible.)
- Medically necessary care and treatment of loss or impairment of speech and hearing, including communicative disorders.
- Treatment of medical disorders requiring specialized nutrients or formulas, including treatment with medical foods, regardless of whether the delivery method is enteral or oral.
- Routine in-hospital newborn infant care expenses provided while an inpatient within first five days following covered person's birth or before the mother ceases to be an inpatient, whichever occurs first.
- Medically necessary gastric pacemaker.
- Telemedicine services to the same extent that those services provided would otherwise be covered expenses under the certificate, including facility fee to originating site. Combined reimbursement to the originating site and distant site limited to the covered expense for the service when provided in person.

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 certificate. Some state exceptions may apply (see State Variations.) You will find complete details in the certificate.

Certificate Details State-specific differences may apply.

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 certificate, or, where applicable, covered under the Preventive Care Expense Benefits provision.

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

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

For all plans, no benefits are payable for expenses:

- For non-emergency services or supplies received from a provider who is not a network provider, except as specifically provided for by the certificate.
- **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 certificate; 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 certificate; 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 certificate 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 certificate.
- For drugs, treatment, or procedures that promote conception, 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 certificate.
- 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 certificate, including telephone consultations, failure to keep an appointment, television expenses, or telephone expenses.
- For marriage, family, or child counseling.
- For standby availability of a medical practitioner when no treatment is rendered.
- For hospital room and board and nursing services if admitted on a Friday or Saturday, unless for an emergency, or for medically necessary surgery that is scheduled for the next day.
- For dental expenses, including braces and oral surgery, except as provided for in the certificate.
- For cosmetic treatment.

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 certificate. Some state exceptions may apply (see State Variations.) You will find complete details in the certificate.

General Exclusions, continued

For all plans, no benefits are payable for expenses:

- For diagnosis or treatment of learning disabilities, attitudinal disorders, or disciplinary problems, except as provided for in the certificate.
- 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 certificate.
- 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 certificate.
- 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 certificate.
- 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 certificate.
- Due to pregnancy (except complications), except as provided in the certificate.
- For any expenses, including for diagnostic testing incurred while confined primarily for well-baby care, except as provided in the certificate.
- For treatment of mental disorders, or court-ordered treatment for substance abuse.
- For preventive care or prophylactic care, including routine physical examinations, premarital examinations, and educational programs, except as provided in the certificate.
- 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 certificate.
- For alternative treatments, except as specifically covered by the certificate, 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 certificate.
- 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.

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 certificate. Some state exceptions may apply (see State Variations.) You will find complete details in the certificate.

General Exclusions, continued

No benefits are payable for expenses:

- 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 certificate.
- 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.

Optional Supplemental Accident Benefit for TriTerm Medical Plans

Forms SA-S-1899G-GRI , SA-S-1899RG-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 or TriTerm Plan 100 Direct. The $15,000 benefit amount is only an option on the TriTerm Value or TriTerm Value Direct plan.

Application Fee

Nonrefundable $40 application fee required in most states.

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 the certificate.

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 certificate 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 certificate 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.

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 certificate.

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 certificate. Some state exceptions may apply (see State Variations.) You will find complete details in the certificate.

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.

No Non-Network Benefits

- **These plans only pay benefits for eligible expenses from a network provider.** Visit UHOne.com to search for providers. (No benefits are payable for non-emergency care from a non-network provider.)
- Emergency treatment from a non-network provider will be treated as a network eligible service.
- Emergency treatment means you will owe the difference between what the non-network provider bills and what we pay for a network eligible expense.

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 certificate. 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.

Rating Factors

The plan, age and sex of covered persons, type and level of benefits, tobacco use status, underwriting class status, time the certificate 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 certificate, 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 certificate or a change in a covered person's health.

Termination

The certificate will terminate on the earliest of:

- The date all covered persons under the certificate move out of the state where the certificate was issued.
- The primary insured's death. If the certificate 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 certificate.
- The date we receive a request from you to terminate the certificate.
- 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.

Florida

Certificate Form GRI-STAG-EXT1D-E-C-09

- Eligible child must be under age 31 and unmarried. A child that is unmarried and remains chiefly dependent on you or your spouse for support and maintenance due to mental or physical disability will be considered an eligible child under the policy/certificate regardless of age. The disabled child's coverage will not terminate due to age. The dependent may remain covered for the duration of the coverage term.
- Provision is included for Extension of Benefits upon Termination of the Master Policy: If a covered person is an inpatient in a hospital on the date that the master policy is terminated and the master policy is replaced without any gap in coverage by a group health insurance policy with another insurer or by a self-funded health care plan, benefits for covered expenses for the continuous hospital confinement will be extended. These extended benefits will be paid solely for covered expenses incurred during the inpatient hospital confinement. Any extended benefit will cease on the earliest of:
  - A. The date the covered person's hospital confinement ends; or
  - B. The date the benefits for the hospital confinement would have ceased under any other provision of the policy/certificate.

Indiana

Certificate Form GRI-STAG-EXT1D-E-C-13

- Only Copay Select Max, Plan 80 Max, and Plan 100 Max are available.
- Plans have three terms of 364 days each.
- The Maximum Benefit is $2 million per person, per term.
- Application fee is refundable if coverage is not issued or not taken.
- Preexisting condition is defined as: A condition for which medical advice, care, treatment, or diagnostic procedure was received within the 12 months immediately preceding the date the covered person became insured under the policy.

Mississippi

Certificate Forms GRI-STAG-EXT1D-E-C-23 and GRI-STAG-EXT1D-E-C-VAL-23

- Application fee is $6.
- "Preexisting condition" means an injury or illness for which medical advice, diagnosis, care or treatment was recommended to or received by a covered person within the 6 months immediately preceding the applicable effective date the covered person became insured under the policy; or which, in the opinion of a qualified doctor: (1) probably began prior to the applicable effective date the covered person became insured under the policy; and (2) manifested symptoms which would cause an ordinarily prudent person to seek diagnosis or treatment within the 6 months immediately preceding the applicable effective date the covered person became insured under the policy.
- Benefits are expanded to include general anesthesia and associated facility fees incurred in conjunction with dental care (regardless of whether the dental care itself is covered) for a covered person when the mental or physical condition of the child or mentally handicapped adult requires dental treatment to be rendered under physician-supervised general anesthesia in a hospital setting, outpatient surgical facility, or dental office. Covered expenses do not include treatment rendered for temporomandibular joint (TMJ) disorders.
- Covered expenses include annual screening by low-dose mammography for the presence of occult breast cancer for covered persons thirty-five (35) years of age or older. This would not be considered preventive care.
- The exclusion for or related to surrogate parenting does not apply.

State Variations (insurance plans)

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

Nebraska

Certificate Form GRI-STAG-EXT1D-E-C-26 and GRI-STAG-EXT1D-E-C-VAL-26

- "Emergency" means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including, but not limited to, severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in: placing the health of the covered person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition, placing the health of such persons or others in serious jeopardy; serious impairment to bodily functions of the covered person; serious impairment of any bodily organ or part of the covered person; or serious disfigurement of the covered person.
- Annual mammography screenings are not considered Preventive Care and are not subject to the Preventive Care limits.
- Colorectal screening coverage is as follows: screening coverage for a colorectal cancer examinations and laboratory tests for colorectal cancer in a non-symptomatic covered person fifty years of age or older. Covered expenses shall include a maximum of: one screening fecal occult blood test annually and a flexible sigmoidoscopy every five years; a colonoscopy every ten years, or a barium enema every five to ten years; or any combination of the most reliable medically recognized screening test available when deemed appropriate by the covered person's medical practitioner
- Benefits are expanded to include the following:
  - Up to $3,000 for medically necessary hearing aids for an eligible child under the age of 19, for each ear affected by a hearing impairment.
  - Up to maximum lifetime dollar amount of $2,500 for medically necessary surgical and non-surgical treatment of temporomandibular joint (TMJ) disorder and craniomandibular disorder.
  - The reasonable cost of general anesthesia and hospitalization in a hospital or ambulatory surgical center, for a covered eligible child to receive dental care if he or she: is age eight (8) or under; or Is developmentally disabled.

Tennessee

Certificate Form GRI-STAG-EXT1D-E-C-41

- The $5,000 limit on Spine and Back Disorders does not apply.
- "Emergency" is defined as: a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such as prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:
  - Placing the health of the covered person in serious jeopardy;
  - Serious impairment to bodily functions; or
  - Serious dysfunction of any bodily organ or part.
- The covered expense for diabetes self-management training does not require certification of completion. It is limited to visits certified by a physician to be medically necessary:
  - upon the diagnosis of diabetes;
  - because of a significant change in the covered person's symptoms or condition which necessitates changes in the covered person's self-management; and
  - for re-education or refresher training.
- Covered expenses were expanded to include a mammography screening for diagnostic purposes on referral by a patient's physician limited to the following:
  - A baseline mammogram for covered person's thirty-five (35) to forty (40) years of age.
  - A mammogram every two (2) years, or more frequently based upon the recommendation of a physician, for covered person's forty (40) to fifty (50) years of age and over.
- Transplant Expense Benefits are not limited to the "Listed Transplants."
- Transplant Expense Benefits do not cover any transplant determined to be experimental or investigational treatment.

State Variations (insurance plans)

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

Texas

Certificate Form GRI-STAG-EXT1D-E-C-42, GRI-STAG-EXT1D-E-C-VAL-42

- "Eligible child" is expanded to include stepchild; a child you or your spouse is seeking to adopt through legal proceedings; a child entitled, by virtue of a court order, to have coverage provided by you or your spouse; and your grandchild who is considered your dependent for federal income tax purposes at the time application for coverage is made.
- "Emergency" means medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that the person's condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in: placing the patient's health in serious jeopardy; serious impairment to bodily functions; serious dysfunction of any bodily organ or part; serious disfigurement; or in the case of a pregnant woman, serious jeopardy to the health of the fetus.
- Preexisting condition is defined as: a condition for which medical advice, or treatment, any diagnostic procedure(s), or further evaluation was recommended or received within the 12 months immediately preceding the date the covered person became insured under the policy; or a condition 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 a pregnancy existing on the effective date of coverage.
- Covered expense for outpatient applied behavior analysis is limited to covered persons 10 years of age or older.
- Covered expense for diabetes self-management training includes training provided to a covered person or a covered person's caretaker. The limit of one training program per covered person, per lifetime, does not apply. However, training must be after initial diagnosis of diabetes; authorized on written order of a medical practitioner after a significant change in symptoms that requires changes in self-management regime; or for periodic or episodic continuing education when prescribed by a medical practitioner as needed due to the development of new techniques and treatments.
- Benefits are expanded to include the following:
  - The most appropriate prosthetic device or orthotic device that adequately meets the medical needs of the covered person, as recommended by the covered person's physician, podiatrist, prosthetist or orthotist.
  - The treatment of breast cancer; a minimum of 48 hours of inpatient care following a mastectomy and 24 hours of inpatient care following a lymph node dissection.
  - The cost of a newborn screening test kit.
  - Diagnostic mammogram. (The 35 year age limit does not apply.) This is not considered Preventive Care, so it is not subject to Preventive Care limit.
  - Expenses incurred by covered persons who have been diagnosed with insulin dependent or non-insulin dependent diabetes, elevated blood glucose levels induced by pregnancy, or any other medical condition associated with elevated blood glucose levels.
  - Screening for autism spectrum disorders for an eligible child at 18 and 24 months of age.
  - Medically necessary amino acid modified preparation, low protein modified food products, any other special dietary products and formulas prescribed by a doctor for the therapeutic treatment of phenylketonuria (PKU), galactosemia, organic adicdemias and disorders of amino acid metabolism.
  - Medically accepted bone mass measurement for the detection of low bone mass and to determine the risk of osteoporosis and fractures associated with osteoporosis for a covered person who is: postmenopausal woman who is not receiving estrogen replacement therapy; an individual with vertebral abnormalities, primary hyperparathyroidism, or a history of bone fractures; or an individual who is receiving long-term glucocorticoid therapy, or being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.

State Variations (insurance plans)

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

Texas, continued

- One screening test for hearing loss administered within the first 30 days after birth, and related necessary diagnostic follow-up care during the first 24 months after birth. Charges incurred for the screening test and follow-up care shall be exempt from the deductible amount.
- Cognitive rehabilitation therapy, cognitive communication therapy, neurocognitive therapy and rehabilitation, neurobehavioral, neurophysiological, neuropsychological, and psychophysiological testing or treatment, neurofeedback therapy, remediation, post-acute transition services, or community reintegration services necessary as a result of and related to an acquired brain injury.
- Diagnostic and surgical treatment of temporomandibular joint disorders and craniomandibular joint disorders.
- Up to $200 every five years for one of the following noninvasive screening tests for atherosclerosis and abnormal artery structure and function: Computerized tomography (CT) scanning measuring coronary artery calcification; or Ultrasonography measuring carotid intima-media thickness and plaque. Benefits are limited to male covered persons between the ages of 45 and 76 and female covered persons between the ages of 55 and 76 who are diabetic or have an intermediate or high risk of developing coronary heart disease based on the Framingham Health Study Coronary Prediction algorithm.
- Routine patient care costs for services, items or drugs provided in connection with a Phase I, II, III or IV clinical trial if the clinical trial is conducted in relation to the prevention, detection or treatment of a life-threatening disease or condition and is approved by: The Centers for Disease Control and Prevention; The National Institutes of Health; The United States Food and Drug Administration (USFDA); The United States Department of Defense; The United States Department of Veterans Affairs; or an institutional review board of an institution in the state of Texas that has an agreement with the Office for Human Research Protections of the United States Department of Health and Human Services.
- Annual screening for the early detection of ovarian cancer and cervical cancer for covered persons 18 years of age or older, including: A CA 125 blood; and conventional Pap smear screening or a screening using liquid-based cytology methods, as approved by the United States Food and Drug Administration for the detection of the human papillomavirus.
- Annual screening by low-dose mammography for the presence of occult breast cancer for covered persons 35 years of age or older.
- Diagnosis or treatment of mental disorders or substance abuse the same as any other illness, including services received in: A psychiatric day treatment facility; a residential treatment center for children or adolescents; and a crisis stabilization unit.
- Medically necessary hearing aids or cochlear implants for a covered eligible child up to age 18 years, limited to one hearing aid in each ear every three years and one cochlear implant in each ear with internal replacement as audiologically or medically necessary.

- Transplant benefits are modified as follows:
  - Covered expenses include expenses actually incurred by a covered person for those services and supplies listed which are: administered or ordered by a doctor; provided in connection with a listed transplant; medically necessary to the diagnosis or treatment of an injury or illness; and not excluded anywhere in the policy. These covered expenses will be paid as a limited expansion of the Medical Benefits. They will be subject to the terms of that provision, including deductibles, coinsurance, exclusions and limitations.
  - If a designated Center of Excellence is not used, covered expenses for a listed transplant will be reduced by 25% after application of any deductible amounts coinsurance provisions or copayment amounts, limited to a maximum of one.
- The 6 months waiting period does not apply for expenses incurred by a covered person for the treatment of tonsils, adenoids, middle ear disorders, hemorrhoids, hernia, or any disorders of the reproductive organs.

State Variations (insurance plans)

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

West Virginia

Certificate Form GRI-STAG-EXT1D-E-C-47

- "Eligible child" is expanded to include a child that is unmarried and remains chiefly dependent on you or your spouse for support and maintenance due to mental or physical disability will be considered an eligible child under the certificate regardless of age. The disabled child's coverage will not terminate due to age. The dependent may remain covered for the duration of the coverage term.

HEALTH PLAN NOTICES OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

MEDICAL INFORMATION PRIVACY NOTICE (Effective January 1, 2019)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Exercising Your Rights

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

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

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

MIB. In conjunction with our membership in MIB, Inc., formerly known as Medical Information Bureau (MIB), we or our reinsurers may make a report of your personal information to MIB. MIB is a not-for-profit organization of life and health insurance companies that operates an information exchange on behalf of its members.

If you submit an application or claim for benefits to another MIB member company for life or health insurance coverage, the MIB, upon request, will supply such company with information regarding you that it has in its file.

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

FINANCIAL INFORMATION PRIVACY NOTICE (Effective January 1, 2019)

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

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

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

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

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

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

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

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

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

Who we are

Golden Rule Insurance Company, a UnitedHealthcare company, is the underwriter of plans featured in this brochure. We have been serving the specific needs of individuals and families buying their own coverage for over 75 years. Plans are administered by United Healthcare Services, Inc.

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

Our plans offer easy-to-understand health insurance designed for individuals and families in times of transition and change. Plans only available to members of FACT, the Federation of American Consumers and Travelers (see below). If you're not already a member, you can enroll with your TriTerm Medical application to be eligible to apply for these plans.

What is FACT?

FACT is an independent consumer association whose members benefit from the "pooling" of resources. Benefits range from medical savings to consumer service discounts. FACT's principal office is in Jonesboro, Arkansas. FACT and Golden Rule Insurance Company are separate organizations. Neither is responsible for the performance of the other. FACT has contracted with Golden Rule Insurance Company to provide its members with access to these health insurance plans. FACT does not receive any compensation from Golden Rule Insurance Company.

Is there a cost for joining FACT?

Yes, there are membership dues and they can be paid with your regular health insurance premium, as opposed to making a separate payment.

What are the basic FACT membership benefits?

FACT makes it easy for members to choose from a full menu of important benefits, including:

- Accidental Death Benefits
- Medical Evacuation Coverage
- Retail & Service Discounts
- Travel Discounts
- Pet Coverage
- Scholarships

As a member of FACT, your information is kept private and is not shared with any third parties. Please visit the FACT website, www.usafact.org/privacy_policy.html, for a complete FACT Privacy Statement. FACT may change or discontinue any of its membership benefits at any time. For the most current information, including full detailed lists of member benefits, visit FACT's website at www.usafact.org or call toll-free at (800) USA-FACT.

UnitedHealthcare®
Golden Rule Insurance Company

* As of 12/18/19. For the latest rating, access www.ambest.com.

45747E-G-0820

State:
FL

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DIRECT

TriTerm Medical Value & Value Direct Plans

Plans underwritten by Golden Rule Insurance Company.

This insert must be used with our TriTerm brochure 45747E-G for the state of Florida.

Certificate Form GRI-STAG-EXT1D-P-C-VAL-09 applies to Florida TriTerm Medical Value and Value Direct plans only.

Highlights of Covered Network Expenses

3 TERMS — TERM 1 364 DAYS > TERM 2 365 DAYS > TERM 3 365 DAYS

		Florida Value/Value Direct
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**
Coinsurance (% you pay **after deductible**, per term)	You pay:	**Value: 30% or 50% Value Direct: 30%, 40% or 50%**
Coinsurance Out-of-Pocket Maximum (after deductible, per person, per term)	You pay up to:	**$10,000**
Maximum Benefit (per person, lifetime)	We pay up to:	**Value: $2 million Value Direct: $1 million**

Medical

Doctor Office Visit (History and Exam only) (per person, per term)	You pay:	**Chosen coinsurance after deductible**
Urgent Care Center		**$75 copay**
Preventive Care		**Not Covered**
Emergency Room (Accident and Illness) (for illness only: additional $500 deductible if not admitted)		**Chosen coinsurance after deductible**
Inpatient Hospital Services, Outpatient Surgery, Labs & X-rays		**Chosen coinsurance after deductible**

Pharmacy

Outpatient Prescription (Rx) Drugs	**Not Covered** Discount card provided.[2]

Add Supplemental Accident Benefit[1] Matches medical deductible selected (page 8)	We pay up to:	**$2,500, $5,000, $7,500, $10,000, $12,500 or $15,000**

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 above right. 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] Additional premium required. [2] Discounts vary by pharmacy, geographic area, and Rx drug.

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 - see below. **For non-emergency care received from Non-Network Providers you pay:** (a) all charges above what is considered an eligible expense; (b) a penalty of 25% of the eligible expense, which does not count toward the deductible; and (c) a deductible amount equal to 2 times the network deductible. There is no out-of-pocket maximum for non-network providers. Your actual out-of-pocket costs may be more than the stated coinsurance because the bill from a non-network provider may not be used to calculate what we pay and what you pay.

Visit UHOne.com and select Find A Doctor to search for network

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

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.

Children's Preventive Health Services

Services for any covered person eligible by reason of age. Immunization services that qualify as children's preventive health care services are exempt from any deductible amounts, coinsurance provisions, or copayment amounts.

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 when medically necessary as determined by physician or health care professional. Limited to one training program per person, per lifetime, unless additional training is prescribed due to a significant change in symptoms or condition.

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

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 health-care 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.

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

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 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.

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.

Prosthetics

Artificial eyes or larynx, breast prosthesis, orthotic and prosthetic devices/services. Orthotic and prosthetic devices/services limited to one device/service or replacement every 3 years unless proven to be medically necessary. 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 certificate 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.
- Reconstructive craniofacial surgery and related services for a covered person of any age diagnosed as having a craniofacial anomaly if the surgery is medically necessary to improve functional impairment that results from the craniofacial anomaly, as determined by a nationally approved cleft-craniofacial team, approved by the American Cleft Palate-Craniofacial Association in Chapel Hill, North Carolina.

Rehabilitation and Extended Care Facility (ECF)

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

Spine and Back Disorders

Limited to inpatient and surgical treatment.

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.

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 certificate for "Listed Transplants" under Transplant Expense Benefits. The covered person must be a good candidate, as determined by us.

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

Transplant Expense Benefit, continued

The transplant must not be experimental or investigational. Covered expenses for "Listed Transplants" are limited to 2 during a 36 month policy 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 COE not used: Limit of 1 transplant per 36 month policy 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.

Additional Benefits

- Diagnosis of and treatment of autism spectrum disorders, including evidence-based treatments.
- Outpatient applied behavior analysis for the treatment of autism spectrum disorders up to a maximum of $50,000 per policy term, per covered person.
- Colorectal cancer examinations and laboratory tests in accordance with the published American Cancer Society guidelines.
- One digital rectal examination and one prostate specific antigen test per policy term per covered person for screening for the early detection of prostate cancer (exempt from the deductible.)
- Medically necessary care and treatment of loss or impairment of speech and hearing, including communicative disorders.
- Treatment of medical disorders requiring specialized nutrients or formulas, including treatment with medical foods, regardless of whether the delivery method is enteral or oral.
- Routine in-hospital newborn infant care expenses provided while an inpatient within first five days following covered person's birth or before the mother ceases to be an inpatient, whichever occurs first.
- Medically necessary gastric pacemaker.
- Telemedicine services to the same extent that those services provided would otherwise be covered expenses under the certificate, including facility fee to originating site. Combined reimbursement to the originating site and distant site limited to the covered expense for the service when provided in person.
- General anesthesia and services incurred at a hospital or outpatient surgical facility for necessary dental care for an eligible child: less than 8 years old with a significantly complex dental condition or development disability for which treatment in a dental office would be ineffective; or who has one or more medical conditions that create a significant or undue risk if the necessary dental care was not performed in a hospital or outpatient surgical center.
- Medically necessary services and treatment for cleft lip and palate for an eligible child under age 18.
- Diagnostic or surgical procedures involving bones or joints of the jaw and facial region, if under accepted medical standards, the procedure or surgery is medically necessary to treat conditions caused by congenital or developmental deformity, disease, or injury.

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 certificate. You will find complete details in the certificate.

Certificate Details

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 certificate, or, where applicable, covered under the Preventive Care Expense Benefits provision.

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 certificate; 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 certificate; 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 certificate 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 outpatient treatment of spine and back disorders.
- For outpatient prescription drugs.
- 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 certificate.
- For drugs, treatment, or procedures that promote conception, 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 certificate.
- 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 certificate, including telephone consultations, failure to keep an appointment, television expenses, or telephone expenses.
- For marriage, family, or child counseling.
- For standby availability of a medical practitioner when no treatment is rendered.
- For hospital room and board and nursing services if admitted on a Friday or Saturday, unless for an emergency, or for medically necessary surgery that is scheduled for the next day.
- For dental expenses, including braces and oral surgery, except as provided for in the certificate.
- For cosmetic treatment.
- For diagnosis or treatment of learning disabilities, attitudinal disorders, or disciplinary problems, except as provided for in the certificate.
- For diagnosis or treatment of nicotine addiction.
- For surrogate parenting.
- For treatments of hyperhidrosis (excessive sweating).

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 certificate. You will find complete details in the certificate.

General Exclusions, continued

No benefits are payable for expenses:

- For charges related to, or in preparation for, tissue or organ transplants, except as expressly provided for under Transplant Expense Benefits in the certificate.
- 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 certificate.
- 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 certificate.
- 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 certificate.
- Due to pregnancy (except complications), except as provided in the certificate.
- For any expenses, including for diagnostic testing incurred while confined primarily for well-baby care, except as provided in the certificate.
- For treatment of mental disorders, or court-ordered treatment for substance abuse.
- For preventive care or prophylactic care, including routine physical examinations, premarital examinations, and educational programs, except as provided in the certificate.
- 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 certificate.
- For alternative treatments, except as specifically covered by the certificate, 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 certificate.
- 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 certificate.

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 certificate. You will find complete details in the certificate.

General Exclusions, continued

No benefits are payable for expenses:

- 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.

Optional Supplemental Accident Benefit for TriTerm Medical Plans

Form SA-S-1899RG-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.

Application Fee

Nonrefundable $40 application fee required.

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 the certificate.

Dependents

For purposes of this coverage, eligible dependents are your lawful spouse and eligible children. Eligible child must be under age 31 and unmarried. A child that is unmarried and remains chiefly dependent on you or your spouse for support and maintenance due to mental or physical disability will be considered an eligible child under the policy/certificate regardless of age. The disabled child's coverage will not terminate due to age. The dependent may remain covered for the duration of the coverage term.

Effective Date

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

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 certificate.

Other Information (insurance plans)

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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 - see below. **For non-emergency care received from Non-Network Providers you pay:** (a) all charges above what is considered an eligible expense; (b) a penalty of 25% of the eligible expense, which does not count toward the deductible; and (c) a deductible amount equal to 2 times the network deductible. There is no out-of-pocket maximum for non-network providers. Your actual out-of-pocket costs may be more than the stated coinsurance because the bill from a non-network provider may not be used to calculate what we pay and what you pay.

Non-Renewable

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 certificate. 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.

Rating Factors

The plan, age and sex of covered persons, type and level of benefits, tobacco use status, underwriting class status, time the certificate 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 certificate, 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 certificate or a change in a covered person's health.

Termination

The certificate will terminate on the earliest of:

- The date all covered persons under the certificate move out of the state where the certificate was issued.
- The primary insured's death. If the certificate 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 certificate.
- The date we receive a request from you to terminate the certificate.
- 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.

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