

# Thank you for your interest in this product

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

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

Below is a notice required by law.

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

This is a temporary limited policy that has fewer benefits and Federal protections than other types of health insurance options, like those on [HealthCare.gov](http://HealthCare.gov)

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

### Looking for comprehensive health insurance?

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

### Questions about this policy?

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



# 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 FACT details.

**This coverage is not an Affordable Care Act (ACA) plan.** See page 10 of this brochure for information about Exclusions & Limitations. This is a general summary. This coverage is not required to comply with certain federal market requirements for health insurance, principally those contained in the Affordable Care Act. Be sure to check your 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-EXT1B-P-C-VAL-09 (applies to Value plans) and GRI-STAG-EXT1B-E-C-09 (applies to Max plans).

**UnitedHealthcare**  
Golden Rule Insurance Co.

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# What is TriTerm Medical? 3-Year Short Term

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

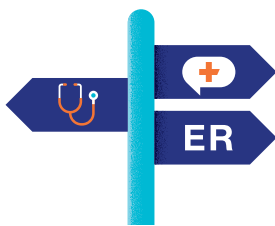


## Doctor office coverage

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

## Prescription drugs

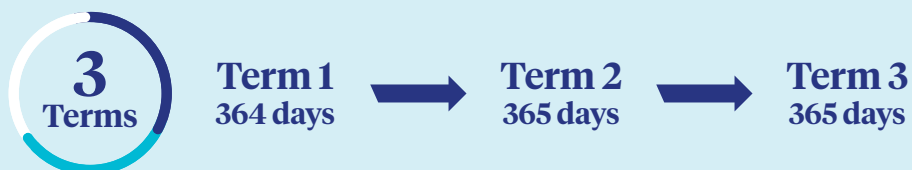
Most TriTerm Medical plans have prescription coverage. Copay  
Select plans have a \$25 copay for common (Tier 1) prescriptions.



## Hospital benefits

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

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



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/certificate. It is important to note there are Exclusions and/or Limitations, and Plan Provisions. This plan is medically underwritten. No benefits will be paid during the first 12 months for a health condition that exists prior to the date insurance takes effect.

# Highlights of covered network expenses

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

Earliest effective date is 5 days after application. The amount of benefits provided depends upon the plan selected, and the premium will vary with the amount of the benefits selected. Non-network benefits vary. See details on page 6. Copays do not apply to deductible, coinsurance, or coinsurance out-of-pocket maximum. This coverage does not qualify as "Minimum Essential Coverage" as defined in the Affordable Care Act and may not cover all Essential Health Benefits in your state. <sup>1</sup> Choice Plus Network pays reduced non-network benefits. <sup>2</sup> Choice Network pays no non-network benefits, unless it is an emergency. <sup>3</sup> 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. <sup>4</sup> Preventive Care benefit does not include Children's Preventive Health Services (CPHS). For CPHS benefits, see page 7. <sup>5</sup> Discounts vary by pharmacy, geographic area, and Rx drug. <sup>6</sup> Additional premium required.

# Access to a wide network of care and cost-saving

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

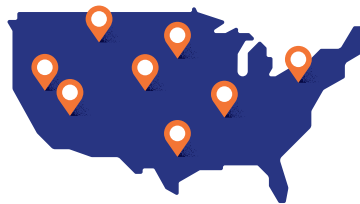


## Access to quality care

Over 1.8 million providers and over 7,000 hospitals.<sup>1</sup>

## 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.



Visit [UHOne.com](https://www.uh.com) and select *Find A Doctor* to search for network providers in your state.

## UnitedHealthcare Choice Plus Network

### APPLIES TO VALUE PLAN

In addition to the in-network benefits, Value plans pay reduced non-network benefits. Using non-network providers will cost you more due to a non-network penalty. For non-emergency care received from non-network providers, you pay:

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

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

## UnitedHealthcare Choice Network

### APPLIES TO MAX PLANS

Max 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.

<sup>1</sup> UnitedHealth Group Annual Form 10-K for year ended 12/31/23.

# Medical benefits (insurance plans)

The following medical benefits are provided using network providers and are subject to plan provisions, exclusions and/or limitations, the deductible, any applicable copay or coinsurance, and all policy/certificate provisions (unless otherwise stated). You will find complete coverage details in the policy/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, subject to deductible and coinsurance. Immunization services that qualify as children's preventive health care services are exempt from any deductible amounts, coinsurance provisions, or copayment amounts. These benefits are not subject to the \$200 Preventive Care maximum benefit.

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

## Hospice care

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

## Hospital services

Daily hospital room and board at most common semiprivate rate; eligible expenses for an intensive care unit; inpatient use of an operating, treatment, or recovery room; outpatient use of an operating, treatment, or recovery room for surgery; services and supplies, including drugs and medicines, which are routinely provided in the hospital to persons for use only while they are inpatients; emergency treatment of an injury or 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), positron emission tomography (PET scan) performed on a routine or preventive basis, or children's preventive health services. For children's preventive health services, see page 7.

## 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 max of 60 days per person, per term for both rehabilitation and ECF expenses. This benefit excludes mental disorders or substance abuse.

## Spine and back disorders

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

**Value plans:** Limited to inpatient and surgical treatment.

## 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 maximum duration, per person.

GRIC has arranged for certain hospitals around the country (Centers of Excellence or COE) to perform specified transplant services. At a designated COE, covered expenses include the acquisition cost and transportation and lodging limited to \$5,000 per transplant. If a COE is not used: Limit of 1 transplant per 36 month maximum duration, per person, limited to max benefits of \$100,000; acquisition, transportation and lodging not covered.

### No benefits payable for:

- Search and testing in order to locate a suitable donor.
- A prophylactic bone marrow harvest and peripheral blood stem cell collection when no “Listed Transplant” occurs.
- Animal-to-human transplants.
- Artificial or mechanical devices designed to replace a human organ temporarily or permanently.
- Procurement or transportation of the organ or tissue, unless expressly provided in this provision.
- Keeping a donor alive for the transplant operation.
- A live donor where the live donor is receiving a transplanted organ to replace the donated organ.
- A transplant under study in an ongoing Phase I or II clinical trial as set forth in the USFDA regulation.

### 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 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 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 5 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. You will find complete details in the certificate.

Some states may require that you have Minimum Essential Coverage in order to avoid a penalty. The Short-term, limited duration insurance benefits under this coverage do not meet all federal requirements to qualify as “Minimum Essential Coverage” for health insurance under the Affordable Care Act (“ACA”). This plan of coverage does not include all Essential Health Benefits as required by the ACA. Be sure to check your 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. You may be able to get longer term insurance that qualifies as “Minimum Essential Coverage” for health insurance under the ACA.

### Exclusions and/or limitations

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

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

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

#### For all plans except Value 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 all plans, no benefits are payable for expenses:

- **For a preexisting condition** – A condition for which medical advice, diagnosis, care, treatment, any diagnostic procedure(s), or further evaluation was recommended or received within the 24 months immediately prior to the date the covered person became insured under the 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 all plans, no benefits are payable for expenses:**  
**(list is continued from the previous page)**

- For dental expenses, including braces and oral surgery, except as provided for in the 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).
- 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.
- 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 certificate. 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-1899G-GRI

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

### Application fee

Nonrefundable \$40 application fee required.

### 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 2 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 30 years of age at time of application. 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 and cannot be 64 or older.

### Eligible expense

An eligible expense means a covered expense as follows:

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

### Reduced non-network benefits for Value Plans

**These plans pay reduced non-network benefits.**

Using non-network providers will cost you more due to a non-network penalty. **For non-emergency care received from non-network providers you pay:**

- A. all charges above what is considered an eligible expense;
- B. a penalty of 25% of the eligible expense, which does not count toward the deductible; and
- C. a deductible amount equal to 2 times the network deductible. There is no out-of-pocket maximum for non-network providers. Your actual out-of-pocket costs may be more than the stated coinsurance because the bill from a non-network provider may not be used to calculate what we pay and what you pay.

### No non-network benefits for Max plans

**Max 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/certificate 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.

### Right to Examine

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

### 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.

### 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:

- The date the covered person's hospital confinement ends; or
- The date the benefits for the hospital confinement would have ceased under any other provision of the policy/certificate.

# Who we are

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

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

Our plans offer easy-to-understand health insurance designed for individuals and families in times of transition and change. Plans are only available to members of FACT, the Federation of American Consumers and Travelers. 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 benefit
- In-hospital benefit, ambulance reimbursement, and medical evacuation coverage
- Dental, vision, hearing aid and prescription discounts

- ID theft and cyber protection
- Online health, wellness, and fitness classes
- Travel discounts
- Pet coverage
- Scholarships and community grants
- Disaster aid and small business recovery program

As a member of FACT, your information is kept private. Please visit the FACT website, [usafact.org/privacy-policy](https://usafact.org/privacy-policy), 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 [usafact.org](https://usafact.org) or call toll-free at (800) USA-FACT.

## Health Plan Notices of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

### VIEW NOTICE HERE. Please review it carefully.

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

\* As of 3/12/25. For the latest rating, access [www.ambest.com](https://www.ambest.com).

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